NIGERIA ASSESSMENT AND RECOMMENDATIONS SUMMARY

Expanding access to sexual and reproductive health and rights in Nigeria

MARCH 2024

SEMA
REPRODUCTIVE HEALTH

Increasing equitable access to sexual and reproductive health (SRH) products is critical to saving lives, promoting gender equality, and advancing communities.

About SEMA

Global efforts in the last decade have enabled 60 million additional women and girls to access SRH products. However, these efforts still fall short of meeting consumer needs, particularly the needs of communities in low- and middle-income countries (LMICs).

To address the challenges, a multi-stakeholder Steering Committee undertook a consultative process from 2020 to 2021. The committee engaged with over 100 stakeholders globally to envision how to support healthier, more equitable, and more resilient SRH markets. The group consisted of country leaders, public and private implementers, civil society members, donors, and market representatives who came together to create Shaping Equitable Market Access for Reproductive Health, or SEMA Reproductive Health.

SEMA was announced in July 2021, during the Generation Equality Forum in France, and incubated within Amref Health Africa. The initiative received support from country governments in Burkina Faso, Nigeria, and Uganda, as well as strategic partnerships from the United States Agency for International Development (USAID), the Foreign, Commonwealth and Development Office of the United Kingdom (FCDO), the United Nations Population Fund (UNFPA), and the Reproductive Health Supplies Coalition (RHSC). Additionally, the Children's Investment Fund Foundation (CIFF), the Gates Foundation and the French Ministry for Europe and Foreign Affairs (MEAE) provided initial funding for SEMA.

SEMA has been acting as a collaborative platform and financing vehicle working with partners across the entire SRH ecosystem. The initiative aim has been to better coordinate donor investments, leverage existing expertise, build additional capacity, and optimize limited resources to support healthier SRH markets. By fostering collaboration and coordination, SEMA has been seeking to optimize resources and achieve greater impact in pursuit of our shared goals.

CONTENTS

01
LIST OF ACRONYMS

BHCPF	Basic Health Care Provision Fund
CIFF	Children's Investment Fund Foundation
CM4FP	Consumers' Market for Family Planning
CP	Community Pharmacist
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organizations
DHIS	District Health Information System
DMPA-SC	Subcutaneous Depot Medroxyprogesterone Acetate
ESMOH	Ekiti State Ministry of Health and Human Services
FBO	Faith-Based Organization
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus Group Discussion
FGON	Federal Government of Nigeria
FMOH	Federal Ministry of Health
FP	Family Planning
GAC	Global Affairs Canada
GDP	Gross Domestic Product
HMIS	Health Management Information System
HMF	Healthy Market Framework
IBILE	Ikeja, Badagry, Ikorodu, Lagos and Epe
IUD	Intrauterine Device
IUS	Intrauterine System
KII	Key Informative Interview
LARC	Long-Acting Reversible Contraceptives
LGAs	Local Government Areas
LMCU	Logistics Management Coordination Unit
LSMOH	Lagos State Ministry of Health
mCPR	Modern Contraceptive Prevalence Rate
MDAs	Ministries, Departments and Agencies
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NAFDAC	National Agency for Food and Drugs Administration and Control
NGO	Non-Governmental Organization

NHLMIS	Nigeria Health Logistics Management Information System
NRHTWG	National Reproductive Health TWG
OCP	Oral Contraceptive Pills
OSHIA	Osun Health Insurance Agency
PPMV	Patent and Proprietary Medicine Vendor
PCN	Pharmacy Council of Nigeria
PHC	Primary Health Center
PMA	Performance Monitoring for Action
PQ	Pre-qualified
PSM	Procurement Supply Management
QA	Quality Assurance
RH	Reproductive Health
RHTWG	Reproductive Health TWG
RIRF	Requisition Issue and Report Form
RMNCH	Reproductive Maternal Neonatal and Child Health
SACA	State AIDS Control Agency
SCW	State Central Warehouse
SDP	Service Delivery Points
SDRF	Sustainable Drug Revolving Fund
SEMA	Shaping Equitable Market Access
SFH	Society For Family Health
SMOs	Social Marketing Organizations
SMOH	State Ministry of Health
SOML	Saving One Million Lives
SON	Standards Organization of Nigeria
SPHCB	State Primary Health Care Board
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and Reproductive Health
SRHTWG	State Reproductive Health TWG
TCI	The Challenge Initiative
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

02
INTRODUCTION

Access to sexual and reproductive health (SRH) services and products can transform the lives of women and girls and improve communities. This access is currently hampered by a range of factors, including inadequate funding, restrictive policies, weak health systems and infrastructure, misinformation, poor counseling, and social stigma. In addition to these obstacles, inadequate product availability, inequitable pricing and choice are also key and growing constraints to faster progress in many countries.

Shaping Equitable Market Access for Reproductive Health (SEMA) was created to transform public and private markets for SRH products. SEMA envisioned a world where SRH markets in low- and middle-income countries (LMICs) are healthy, equitable and resilient so that women and girls can access the SRH products they need.

SEMA partnered with national stakeholders - governments, civil society, private enterprises - to identify market challenges that restrict access to SRH products, analyze the root causes and recommend market interventions to address these challenges. This Nigeria assessment was produced by Clinton Health Access Initiative (CHAI), PharmAccess, Halcyon, Private Sector Health Alliance of Nigeria (PSHAN) and SEMA, in consultation with various local stakeholders. Through this work, SEMA aims to catalyze action to transform private and public markets to better meet SRH needs.

The initial part of this report outlines the summary of high-level findings and recommendations at the national level and in five specific states: Ekiti, Kaduna, Lagos, Niger and Osun.

The annexes in the last section of the report provide comprehensive data regarding the scoring of each level, including the national level and the aforementioned states, based on factors that include financing, supply chain, consumer demand, pricing, quality, and product adoption.

03
COUNTRY BACKGROUND

COUNTRY BACKGROUND

Nigeria is Africa's most populous country, with an estimated population of over 211 million. It comprises 36 states, with the Federal Capital Territory (FCT) in Abuja. The states are divided into 774 Local Government Areas (LGAs), while the FCT is divided into six area councils.

Nigeria is a federal republic with a three-tier system consisting of Federal, State, and Local Governments. The country has a young population structure, with a median age of 17.9. Approximately 42% of the population are aged 15 and below. Half of the female population (51.1%) are of reproductive age (15- 49 years), and 33.1% are young people aged 10-24. This demographic profile emphasises the significance of addressing SRH issues to ensure the well-being and development of Nigeria's population.

Nigeria's total fertility rate (TFR) is 5.3, and if current trends continue, its population is projected to reach 379 million by 2050, positioning it as the fourth most populous country globally.[2] While 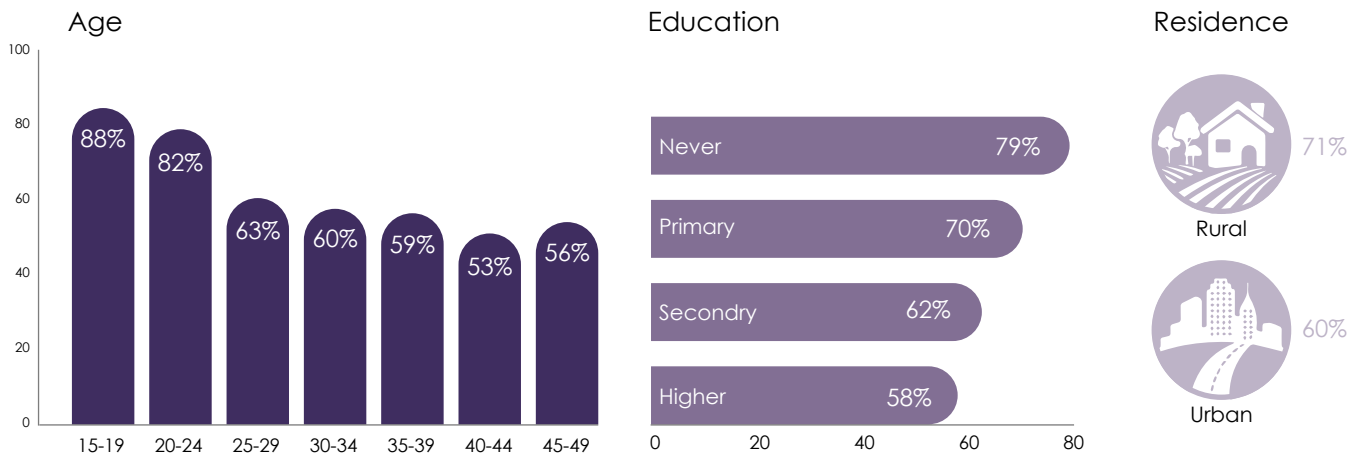Nigeria has significantly reduced maternal mortality in the past two decades, the maternal mortality rates (MMR) remain high.[3] Nigeria accounts for approximately 19% of global maternal deaths annually.[4] For every 1,000 live births in Nigeria during the seven years before the 2018 Nigeria Demographic and Health Survey (NDHS), approximately five women died during pregnancy, childbirth, or within two months after childbirth. Similar to global trends, 70% of maternal deaths in Nigeria result from five complications: postpartum hemorrhage, infection, unsafe abortion, hypertensive diseases of pregnancy such as pre-eclampsia, and obstructed labour.[5] Other factors contributing to high maternal deaths include inadequate antenatal care, limited access to skilled birth attendants, and delays in seeking healthcare services.[6] A 2017 survey showed that the annual incidence of abortions in Nigeria was 29.0 per 1,000, equating to over 1.2 million abortions. An estimated 6 out of 10 abortions were considered unsafe, with women in rural areas, women with no education, the poorest women, and girls aged 15-19 most likely to have an unsafe abortion.[7]

Figure 1. Nigeria population pyramid, 2020
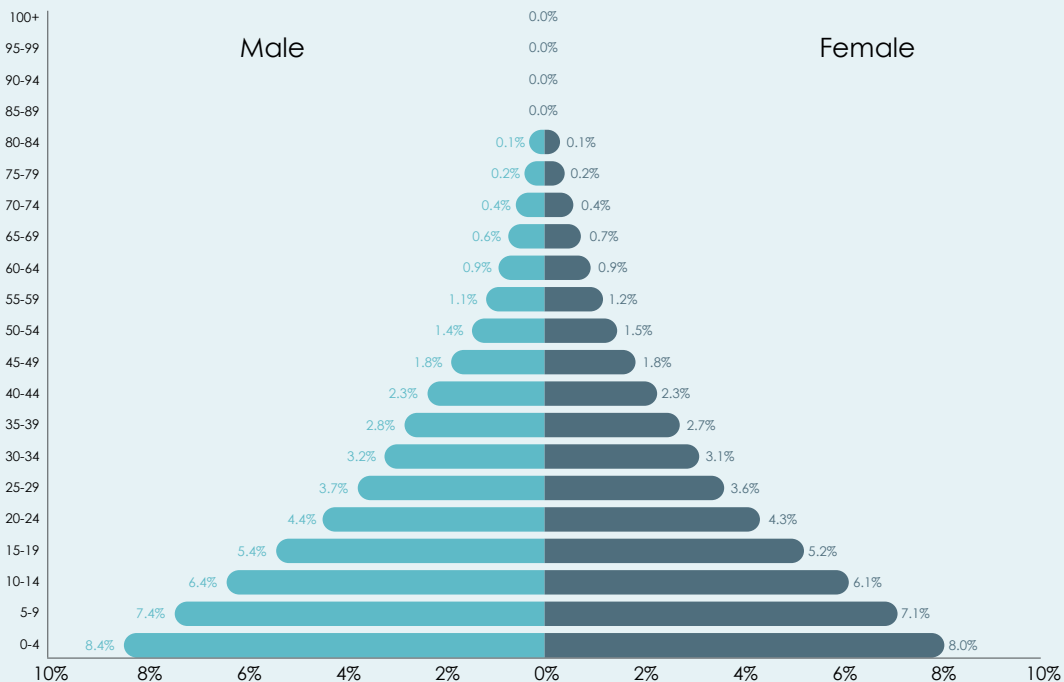
[1]UN-DESA. (2015). World Population Prospects.
[2]NDHS. (2018). Nigeria Demographic and Health Survey 2018. National Population Commission, Abuja, Nigeria.
[3]UNICEF. (2015). "Levels and Trends in Child Mortality, Report 2015. Available online at: www.childmortality.org/files_v20/download/IGME%20 report%20 2015%20child%20mortality%20final.pdf
[4]World Health Organization (WHO). (2019). Maternal mortality in 1990-2017. Available online at: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
[5]Maternal mortality in Nigeria: A consideration of infection control factor. Available online at: https://www.oatext.com/maternal-mortality-in-nigeria-a-consideration-of-infection-control-factor.php#:~:text=Several%20articles%20identified%20major%20causes,obstructed%20labour%20(Figure%202)
[6]Ogunbode, O., Odunayo, S. I., & Jimoh, A. A. (2018). Maternal healthcare services utilization in Nigeria: A systematic review and metaregression analysis. BMC Pregnancy and Childbirth, 18(1), 1-14.
[7]PMA Abortion Survey results. (2018). Available online at: NG-AbortionModule-Brief-v2-2020-03-18.pdf (pmadata.org).

Figure 2. Percent of abortions considered unsafe by background characteristics

Age

Age group	Percent
15-19	88%
20-24	82%
25-29	63%
30-34	60%
35-39	59%
40-44	53%
45-49	56%

Education

Never	79%
Primary	70%
Secondry	62%
Higher	58%

Residence

Rural 71%

Urban 60%

The country has seen improved access and uptake of family planning (FP) services and commodities, with the modern contraceptive prevalence rate (mCPR) increasing from 9.8% in 2013 to 12% in 2018. In 2022, approximately 6,560,000 women were using a modern method of contraception. As a result, 2.3 million unintended pregnancies were prevented, and 822,000 unsafe abortions and 15,000 maternal deaths were averted.[8] Despite this increase, more concerted efforts are required to ensure the country meets the target of 27% mCPR by 2030 – this has been extended to 2030, based on Nigeria's FP2030 commitment.

Figure 3. Trend in impacts of modern contraceptive use among all women[9]

Legend:
- Total users of modern methods of contraception
- Number of unintended pregnancies averted
- Number of unsafe abortions averted
- Number of maternal deaths averted
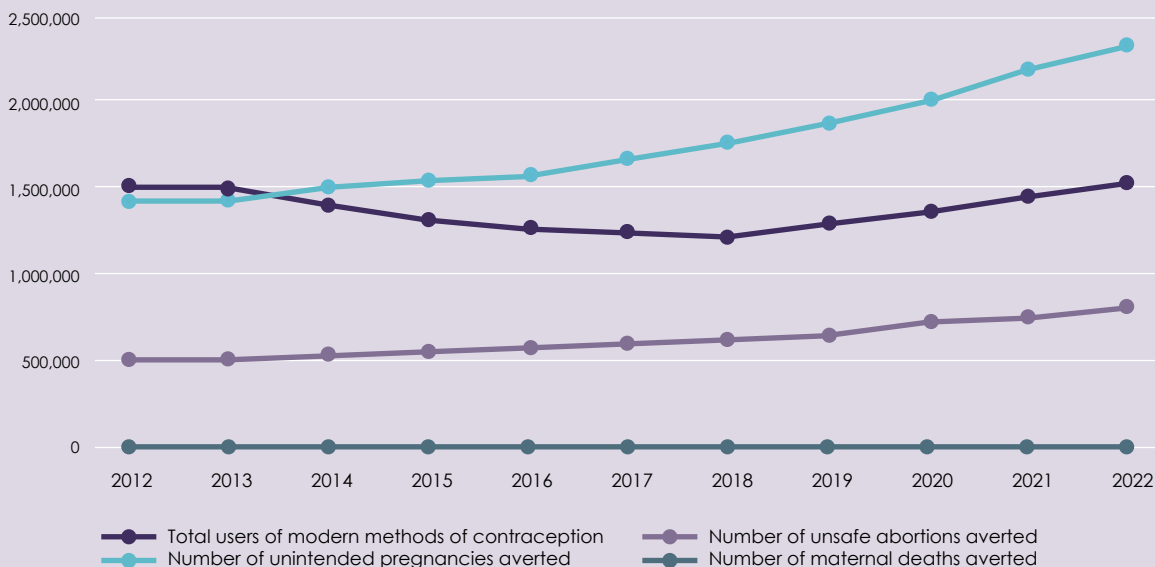
In Nigeria, there are disparities in healthcare access between rural and urban areas, resulting in inequities in SRH outcomes. Challenges include cultural and religious beliefs, conceptual factors, and limited access to SRH products and services. This is worsened by poor healthcare infrastructures, a shortage of healthcare professionals, and financial constraints, particularly in underserved communities. Moreover, the penetration of comprehensive sex education in schools is often inadequate, lacking standardized curricula and comprehensive coverage.[5] Key state information is provided in Table 1 and expanded upon in the sections below.

Table 1. Nigeria key statistics

	Nigeria	Ekiti	Kaduna	Lagos	Osun	Niger
Population	211,000,000[10]	3,885,829[11]	8,900,000[12]	28,000,000[13]	5,521,901[14]	6,783,325[15]
Latest CPR, modern CPR	17%, 12%[16]	38.5%, 25.4%[17]	14.9%, 13.7%[2]	49.4%, 29.0%[2]	29.4% 27%[2]	7.6%, 6.4%[2]
Unmet need for FP	18.9%[18]	18.2%[19]	12.3%[20]	16.5%[21]	25.6%f[22]	19.2%[23]
Total demand for FP (modern methods)	35.5%[24]	56.7%[25]	27.2%[26]	65.9%[27]	55%[28]	26.8%[29]
% demand satisfied with a modern method	33.9%[30]	44.7%[31]	50.6%[32]	44.1%[33]	49.1%[34]	24%[35]
Total fertility rate (source; year)	5.3[36]	4.6[37]	5.9[38]	3.4[39]	3.8[40]	5.8[41]

[10]National Population Commission. (2011). Population Estimates. Abuja, Nigeria.
[11]District Health Information System (DHIS2). (2022). Ekiti State portal.
[12]Kaduna State Bureau of Statistics. (2020).
[13]Lagos State Citizens Budget. (2021). Available online at: https://lagosstate.gov.ng/LAGCTBNEW.pdf
[14-15]National Population Commission. (2022).
[16-41]National Demographic and Health Survey. (2018).

Ekiti:

Ekiti State is located in the southwestern geopolitical zone of Nigeria and has a population of approximately 3.9 million people.[42] It was established on October 1, 1996, out of the neighboring Ondo State and is home to an ethnically unique population with one common dialect. There are 16 LGAs: Ado, Ikere, Ise-Orun, Emure, Gboyin, Irepodun-Ifelodun, Oye, Ikole, Ido-Osi, Ijero, Moba, Ekiti Southwest, Ekiti East, Ekiti West, Efon, and Ilejemeje. The state capital Ado is the only predominantly urban LGA. Ilejemeje, Gbonyin, and Emure are rural and the others are semi-urban areas.

The demographics of Ekiti State indicate a young and growing population, with 49.3% of residents below the age of 20 years and an annual population growth rate of 3.11%. Approximately 22% of the population are women of reproductive age (15 to 49 years). The State has a total fertility rate of 4.3 children per woman, and the current contraceptive prevalence rate (CPR) stands at an estimated 38.5% for all married women. However, only 25.4% of married women using contraceptives rely on modern methods, with approximately 10% of those using long-acting options. Married women using modern methods primarily rely on short-acting methods such as pills, condoms, and injectables. The median age at first birth in Ekiti State is 22.8 years, which is higher than the national median age of 20.2 years.[43]

Ekiti State faces the second highest unmet need for FP in the southwestern zone of Nigeria, at 18.2%.[44] Indeed, 71.6% of the women of reproductive age in the State are not using any contraceptive method and the teenage pregnancy rate stands at 4.5%. Contraceptive use is low among adolescents and young adults, which has resulted in a high prevalence of undesired pregnancies, unsafe abortions, and a correspondingly elevated rate of abortion-related fatalities. This underscores the urgent need to ensure access to FP for young, unmarried women in the State.[45] The State hosts three universities (two public and one private) and other tertiary educational institutions, making it home to a substantial population of male and female adolescents and young adults.

[42] The District Health Information System (DHIS2). (2022). Ekiti State portal.
[43] Ekiti State Ministry of Health and Human Services. (2019). Ekiti State Family Planning Costed Implementation Plan 2019 – 2021.
[44] National Demographic and Health Survey. (2018).
[45] Ekiti State Ministry of Health and Human Services. (2019). Ekiti State Family Planning Costed Implementation Plan 2019 – 2021.

Kaduna:

Kaduna State in northern Nigeria is the country's fourth largest state. The 2006 census reported a population of 6,113,503, however 2020 estimates from the Kaduna State Bureau of Statistics placed the State's total population at 8.9 million. Kaduna has a young population, with 43% of inhabitants aged 14 or younger, 3% over the age of 65, and 54% between the ages of 15 and 64. This suggests that approximately half of the female population are within the RH brackets, with implications for the state's high demand for sexual health services and resources. The male-to-female population ratio stands at 107:100, although the slight excess in the male population is among those 60 years and above.[46]

Religion and culture significantly influence the utilization of SRH services in Kaduna State. For example, all cultures in the state place a high premium on large family size, which directly influences the use of contraceptive services. Among the Muslim population, many believe that FP is a method to restrict having children out of fear of economic hardship and depending on the Islamic community in question, this religious belief potentially hinders the use of contraceptive and abortion services in the state. This may contribute to the fact that Kaduna State has a total fertility rate that is slightly higher than the national average (5.9 and 5.3 respectively), and the lowest median birth interval among all the seven northwestern states in Nigeria, at 29 months.[47]

[46]Kaduna State Bureau of Statistics. Available online at: https://kdbs.ng/domains/demography/
[47]National Demographic and Health Survey. (2018).

Lagos:

Lagos State is the most populous state in Nigeria, with an estimated population of 28 million and an annual population growth rate of 3.2%.[48] It has the smallest landmass in Nigeria and is divided into 20 LGAs and 37 local council development areas. Politically, it has three senatorial districts (Lagos East, Lagos West, and Lagos Central) and is also organized into five administrative divisions - Ikeja, Badagry, Ikorodu, Lagos and Epe (IBILE).[49] Lagos is Africa's most significant metropolitan area and is a thriving tech hub. It's diverse economy, predominantly fueled by an expansive private sector spanning micro, small, and medium enterprises to large corporations, is the largest contributor to Nigeria's gross domestic product (GDP).[50] Lagos State generates approximately 10% of Nigeria's total GDP of $440.8 billion among the 36 states and the Federal Capital Territory (FCT).[51] The State occupies a strategic position in the country for several reasons including its vast human capital advantage; economic productivity; and historical influence on Nigeria's political economy, entertainment, education, tourism, art, and fashion sectors. The State is a global socio-cultural melting pot attracting people from other States of Nigeria, Africa, and other continents.[52] Rural-urban migration accounts for up to 80% of its population increase.[53] Nevertheless, the State's enormous population presents immense challenges for existing infrastructure and social services, resulting in the proliferation of slum areas. According to the 2022 Global Liveability Index, Lagos is the second least livable urban area out of 172 countries, reflecting the strain on its urban living conditions.[54]

[48-49]Lagos State Government. Available online at: https://lagosstate.gov.ng/LAGCTBNEW.pdf
[50]Lagos State Government. Available online at: https://lagosstate.gov.ng/about-lagos/
[51]World Economic Forum. (2022). Available online at: https://www.weforum.org/agenda/2022/01/lagos-africa-startup-capital/
[52]Law Nigeria. (2019). Available online at: https://lawnigeria.com/2019/07/profile-of-lagos-state/
[53]Urbanet. (2018). Available online at: https://www.urbanet.info/nigeria-lagos-slums-urban-health/
[54]Bailey. (2022). Available online at: https://businessday.ng/news/article/lagos-ranked-171-out-of-172-liveable-cities-in-the-world-eiu/

Osun:

Osun State is in southwestern Nigeria and has 30 LGAs and one Area Office. It has an area size of 14,875 km2 and the state capital is in Osogbo. In 1991, Osun State was excised from the old Oyo State. The State was home to an estimated population of only 3,416,959 with a projected population of 4,435,800 by 2022.[55] The median household income within that population is $5,614 per annum. Primarily inhabited by the Yorubas with different dialects, cultural values within Osun State are generally homogenous with conservative attitudes towards contraception. Noteworthy is the fact that Osun State has the second highest literacy rate in the country, yet this has not translated to knowledge of, or demand for, contraceptive services.[56] Among women and girls of childbearing age in Osun State, the uptake of SRH services is low. This is predominantly due to a culture of silence around sexuality and safe sex practices, as well as barriers to access.[57]

[55]National Population Commission of Nigeria. Available online at: https://citypopulation.de/en/nigeria/admin/NGA030__osun/
[56]Idowu, A., Ukandu, G. C., Mattu, J., Olawuyi, D., Abiodun, A., Adegboye, P., Chibu-Jonah, C., Siakpere, A. E., Ishola, A. E., Adeyeye, T., & Alabi, S. (2020). Modern Contraception: Uptake and Correlates among Women of Reproductive Age-Group in a Rural Community of Osun State, Nigeria. Ethiopian journal of health sciences, 30(4), 531–540. Available from: https://doi.org/10.4314/ejhs.v30i4.8
[57]Adeleke N.A., Farinloye E.O., Adebimpe W.O. (2015). Patterns of Reproductive Health and Sexual Behaviours Among Female Undergraduates in Osun State South West Nigeria. Sierra Leone J Biomed Res Dec. 2015 Vol.7 No.2. Available from: https://dx.doi.org/10.4314/sljbr.v7i2.4

Niger:

Niger State is located in the North Central geopolitical zone with a land mass of 76,481.1 square kilometers which is 9.3% of Nigeria's land area, making it the largest state in the country. According to the 2006 census, the State population was 3,950,249, consisting of 2,032,725 males and 1,917,524 females.[58] The estimated population for 2023 is 6,783,325 based on an annual growth rate of 3.4%, with an average population density of 91 people per square kilometer. About two-thirds of the population live in rural areas, which mostly lack modern social amenities.

Large expanses of sparsely populated land occur in most parts of the State while the urban centers like Minna, Bida, and Suleja have high population density. Niger State, like most other states in Nigeria, continues to grapple with inequities in essential healthcare services and commodity availability for sexual, reproductive, maternal, neonatal, and child health (SRMNCH). Coverage of fundamental services such as antenatal care and the presence of skilled birth attendants at deliveries remains low in many communities, primarily due to geographical, financial, security or policy-related challenges.

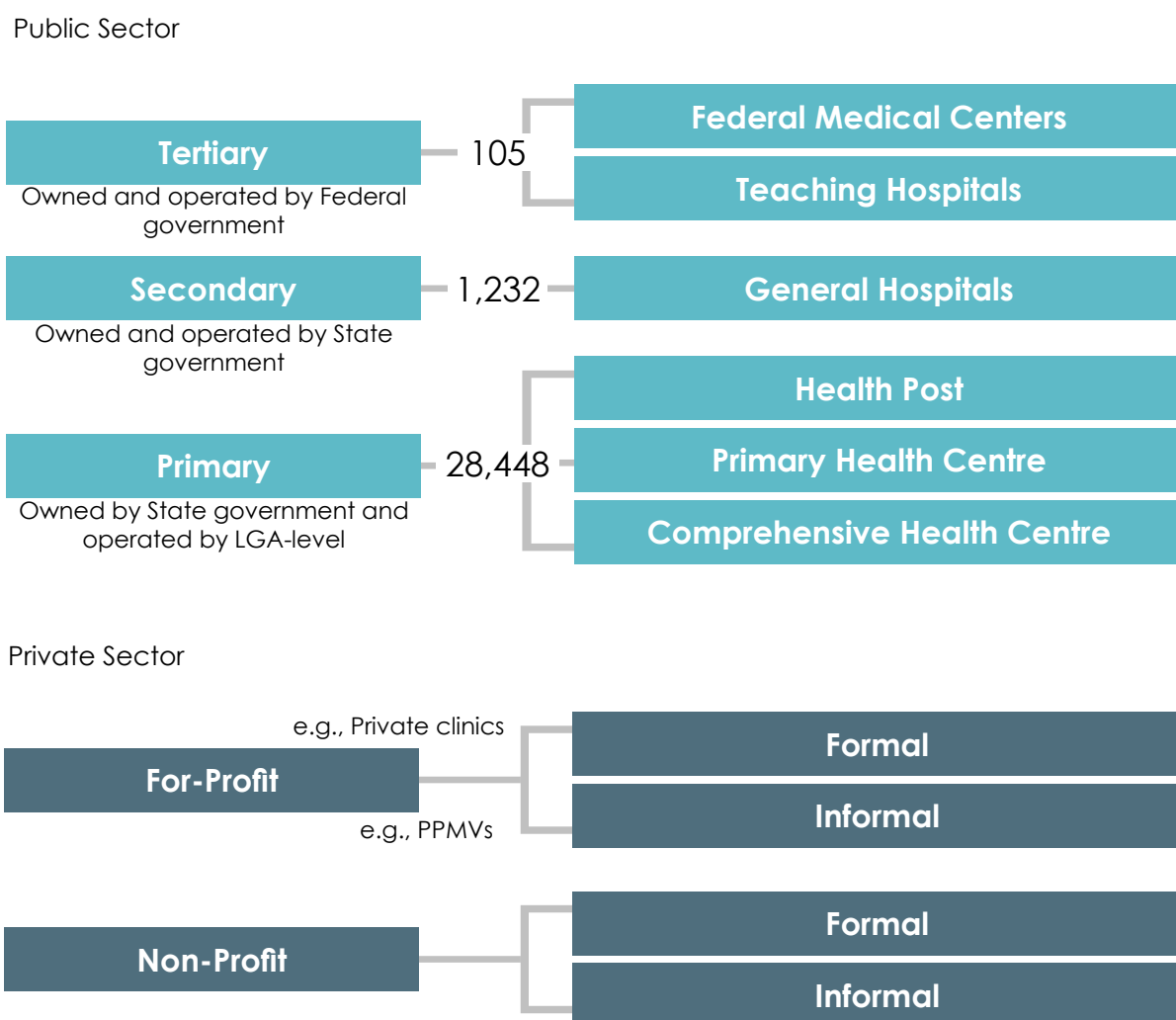[58]National Bureau of Statistics. (2012).

04
HEALTH SYSTEM STRUCTURE

The public health system in Nigeria functions as a three-tiered structure and works in parallel with the private sector. Figure 4 below shows the structure and distribution of health facilities nationwide. In the Nigerian federal system, some functions are solely performed by the Federal Government (exclusive list), while the State Governments have autonomy over other functions (concurrent list). Healthcare provision, including FP products and services, falls under the concurrent list. Tertiary, secondary, and primary healthcare services are funded by the Federal, State, and Local Governments, respectively. Health policy formulation is a shared responsibility between the Federal and State Governments, but the State has autonomy over its budget, including healthcare budgets.

Figure 4. Distribution of Health facilities in Nigeria[59]

Public Sector

Tertiary		
Owned and operated by Federal government	105	Federal Medical Centers
		Teaching Hospitals

Secondary		
Owned and operated by State government	1,232	General Hospitals

Primary		
Owned by State government and operated by LGA-level	28,448	Health Post
		Primary Health Centre
		Comprehensive Health Centre

Private Sector

For-Profit	e.g., Private clinics	Formal
	e.g., PPMVs	Informal

Non-Profit		Formal
		Informal

[59]Makinde OA, Sule A, Ayankogbe O, Boone D. Distribution of health facilities in Nigeria: Implications and options for Universal Health Coverage. Int J Health Plann Manage. 2018 Oct;33(4):e1179-e1192. doi: 10.1002/hpm.2603. Epub 2018 Aug 9. PMID: 30091473.

Key components of the health system are as follows:

Tertiary Health System

Specialised services covering specific diseases are provided at tertiary hospitals. The Federal Government provides tertiary health services through a network of teaching hospitals and specialist hospitals. Still, several states manage and finance tertiary healthcare facilities within their states' territories. Through the Federal Ministry of Health (FMOH), the Federal Government is primarily responsible for overall stewardship and leadership for health and the provision of tertiary healthcare.[60]

Secondary Health System:

The State Ministries of Health provide healthcare services through secondary-level health facilities and technical assistance to the LGA Health Departments. Secondary healthcare provides specialized services to patients through outpatient and inpatient services in hospitals under the control of State Governments.

Primary Health System:

Primary healthcare (PHC) remains the cornerstone of the Nigerian health system, with services delivered through three types of units: the health post, the primary health clinic, and the primary health centre. PHC is the first level of care and the entry point into the healthcare system providing basic primary care services, spanning promotive, preventive, curative, and rehabilitative services. LGAs own and fund PHC facilities and are responsible for this level of care. The LGA health departments are primarily responsible for managing primary care facilities.

Ward Health System:

The Ward Health System takes on the political ward as the functional unit for PHC service delivery. This was adopted as a strategy for accelerating progress in attaining the Millennium Development Goals (MDGs). The PHC currently has the Ward system and the Minimum Health Care Package delivery platform at its core operational approach. The Ward is the smallest political structure, consisting of a geographical area with a population range of 10,000 to 30,000 people.[61] There are, on average, ten wards per LGA, each represented by an elected councilor. The Ward Minimum Health Care Package (WMHCP) targets the grassroots to deliver a minimum set of primary healthcare interventions needed to meet the basic health requirements of most Nigerians. The components of the WMHCP include the minimum package for child survival, maternal and newborn care, and nutrition.

[60]Federal Ministry of Health. (2004). Federal Republic of Nigeria: Revised National Health Policy. Available online at: http://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf
[61]National Primary Health Development Agency Ward Minimum Health Care Package 2007-2012.

05
METHODOLOGY

SEMA's work has been to strengthen SRH country and product markets to improve SRH outcomes. To support this goal, SEMA developed a Healthy Markets Framework (HMF)[62] for assessing the health of national and product markets using different qualitative and quantitative indicators. The HMF seeks to reflect all major dimensions of market health. For SEMA, healthy markets have the following dimensions:

- **Adequate supply capable of meeting funded demand and to ensure a range of products are available at the service delivery point (SDP)**
- **Resilient financing that meets system demand, which in turn meets consumer demand**
- **Ability to meet consumer demand and preferences across the product mix**
- **Prices that ensure a sustainable level of affordability and equity across all channels, geographies and social groups, while maintaining manufacturer economic viability**
- **High product quality**
- **An effective product adoption pathway for introducing innovations in a timely and rational manner**
- **Adequate market foundations for market management, regulation, procurement and market data and analytics**

The HMF includes a list of indicators to facilitate the assessment of market dimensions. The indicators guide a data collection process for developing composite scores of 1-5 (with 1 being 'unhealthy' and 5 being 'very healthy'). These are then used to populate a simple visual representation of overall market health. The market assessments are intended to serve as a platform for building consensus on key market challenges, as well as opportunities for action and investment among stakeholders. SEMA recommends that assessments be routinely updated to monitor results and track progress towards healthier market conditions.

Approach in Nigeria

The SRH landscape was assessed at the national level and in five states (Ekiti, Kaduna, Lagos, Niger, and Osun). All of these states have unique SRH markets, although the challenges and opportunities are quite similar. The assessment commenced with a desk review to understand the SRH market at the federal and five selected state levels. Stakeholder consultations and desk review findings were used to inform the population of the HMF. A series of workshops including with 66 PSHAN stakeholders, 28 government stakeholders, 3 donors and 35 private sector participants were conducted to review and refine the HMF ranking across the federal and state levels. The assessment concluded with the development of a road map defining the "future state" and recommendations to be implemented to accelerate the strengthening of SRH markets. The next section provides a summary of the high-level findings and recommendations from the national and state level assessments, with a more detailed scoring available in the appendix.
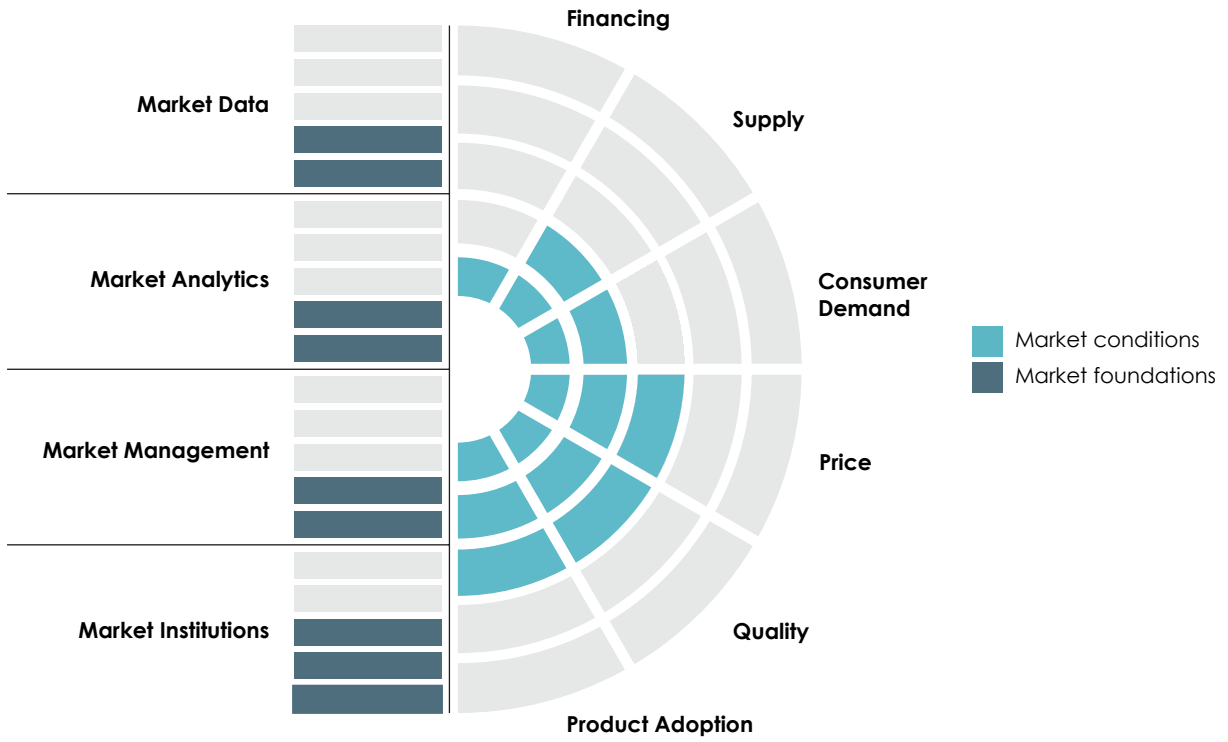
[62]For detailed descriptions of the HMF and its intended use, see SEMA HMF Overview. Available online at: www.semareprohealth.org/resources.

06
FINDINGS

Assessment scores

Figure 5. Federal Level HMF scores

- Market Data
- Market Analytics
- Market Management
- Market Institutions

Financing
Supply
Consumer Demand
Price
Quality
Product Adoption

Market conditions
Market foundations

Figure 6. Osun HMF scores

- Market Data
- Market Analytics
- Market Management
- Market Institutions

Financing
Supply
Consumer Demand
Price
Quality
Product Adoption

Market conditions
Market foundations
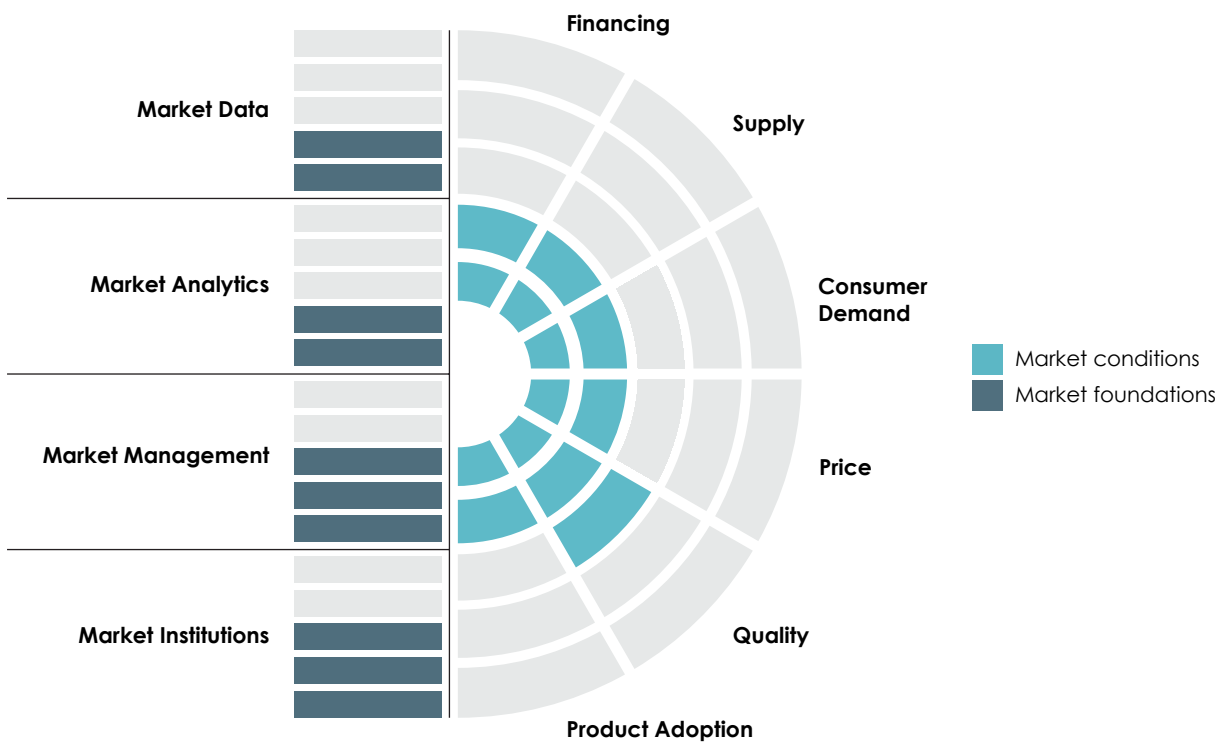
Figure 7. Lagos HMF scores (FP products)

Market Data
Market Analytics
Market Management
Market Institutions

Financing
Supply
Consumer Demand
Price
Quality
Product Adoption

Market conditions
Market foundations
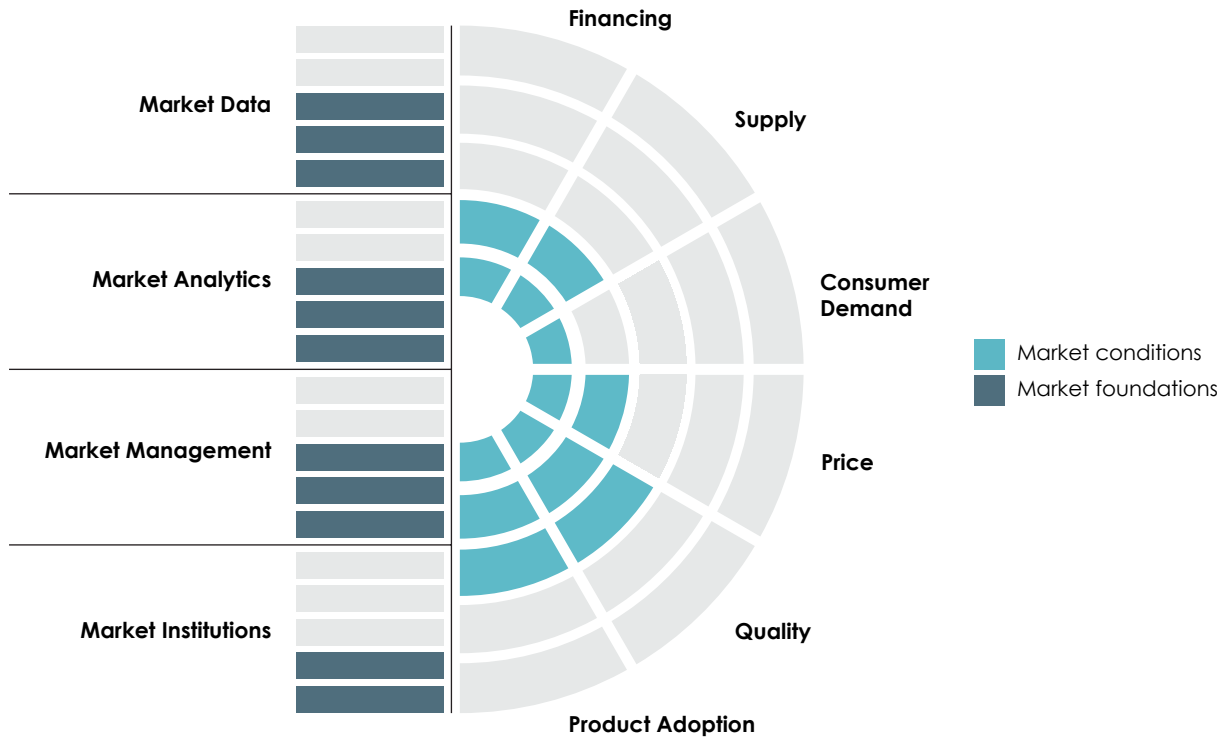
Figure 8. Lagos HMF scores (safe motherhood products)

Market Data
Market Analytics
Market Management
Market Institutions

Financing
Supply
Consumer Demand
Price
Quality
Product Adoption

Market conditions
Market foundations
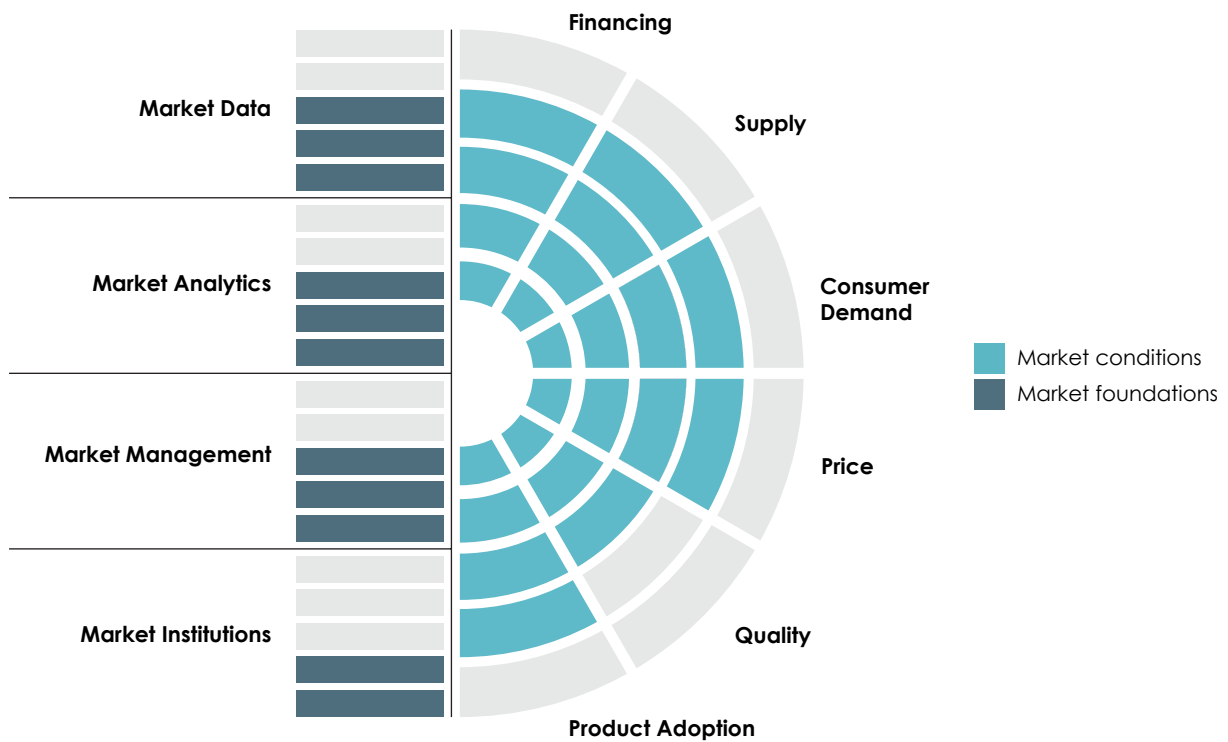
Figure 9. Kaduna HMF scores
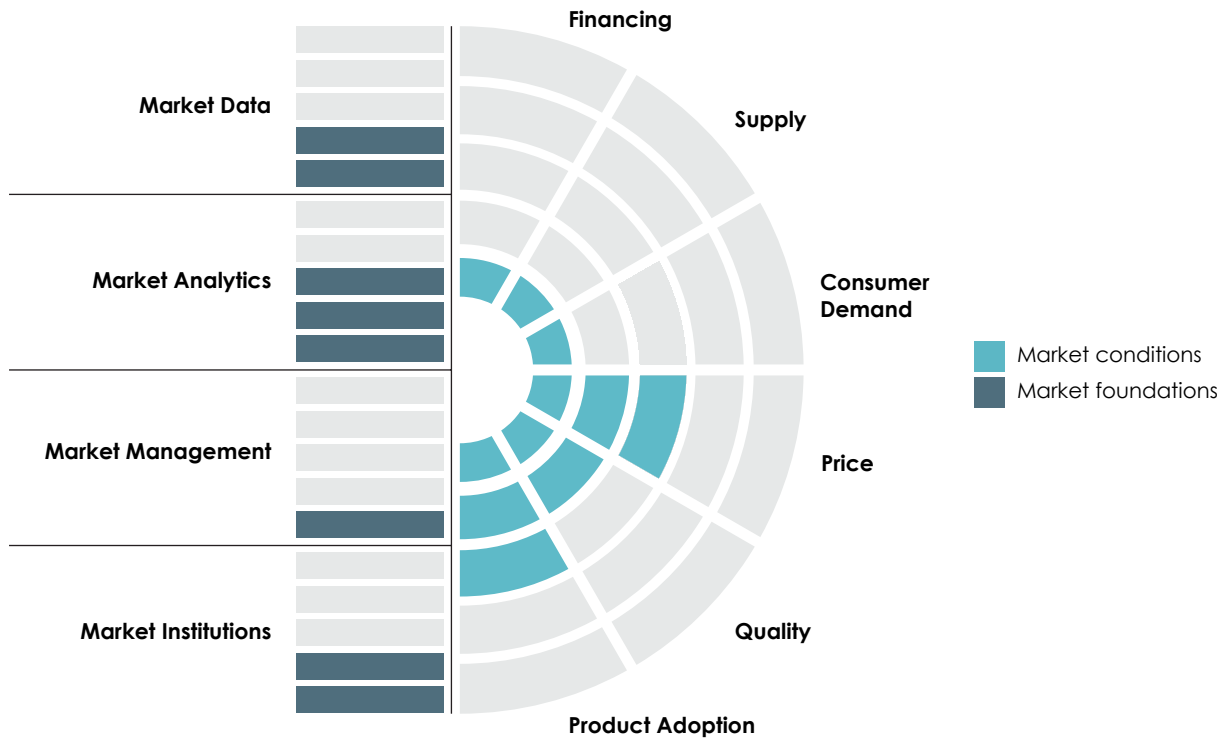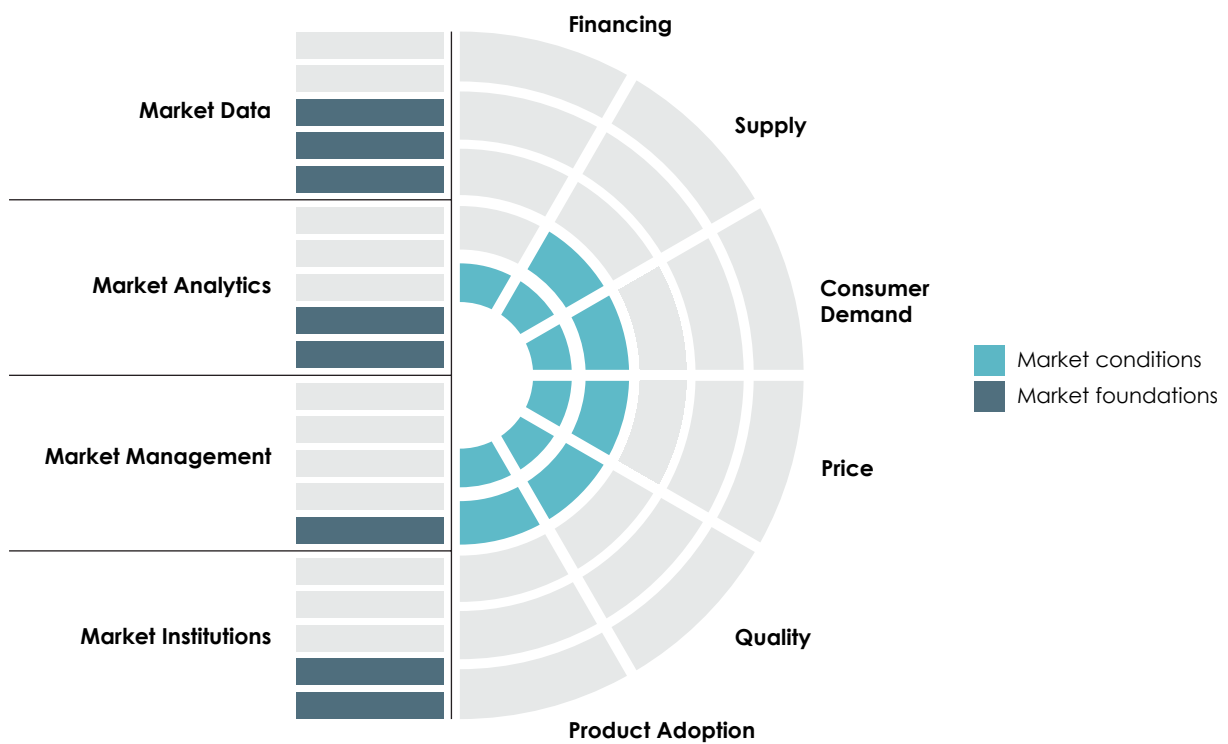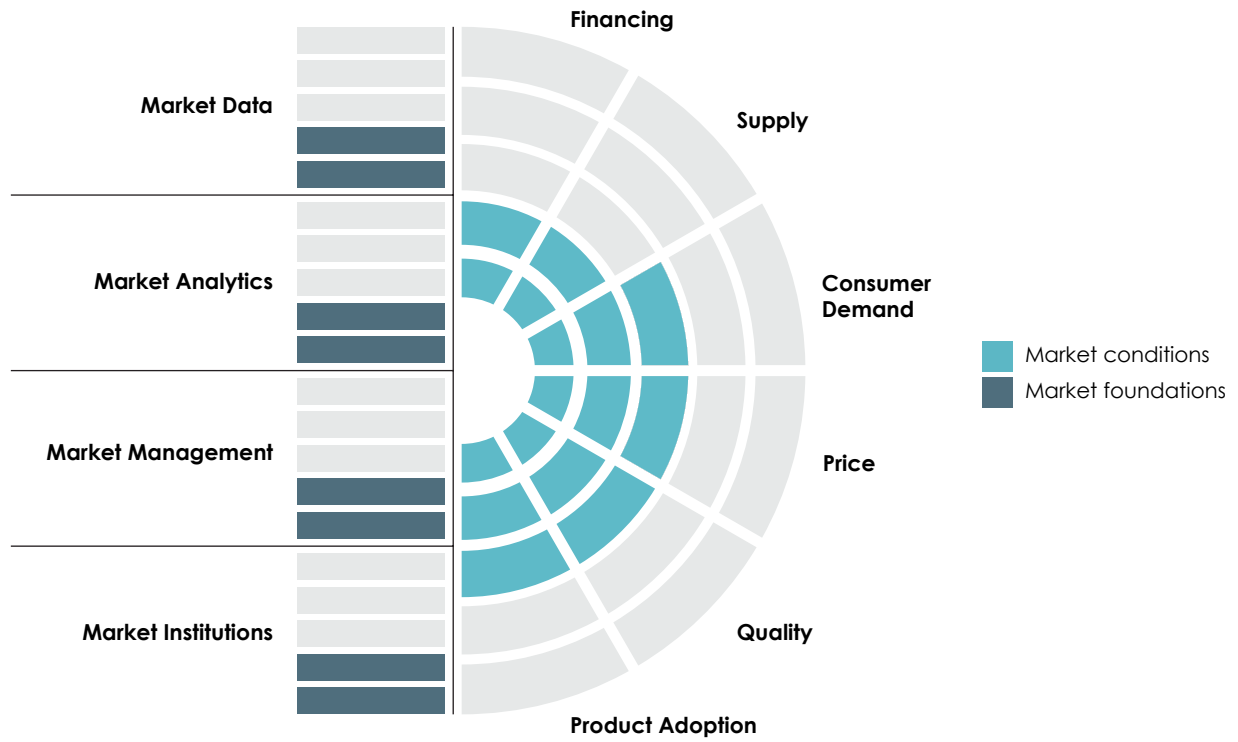

Figure 10. Ekiti HMF scores

Figure 11. Niger HMF scores

Assessment findings

The full assessment findings and scoring are elaborated on in detail in the annexes. Here we highlight a number of shared findings which emerged as common challenges across the federal and state assessments:

01
Market data

Total market data is a foundational element to designing market interventions and yet this area is a key gap. Data is often incomplete and lacks harmonization across different sources. There is poor capacity for data sharing and transmission, influenced by factors such as staff attrition and inconsistent and unstandardized processes. There is a dearth of private sector market data to facilitate holistic and comprehensive data driven decisions. While some tools and systems exist, there are no tools that are used to analyze the market holistically. Tools are siloed and largely used to understand the public sector and the private sector separately. For example, DHIS2 and the F&Q analytical tools almost exclusively analyze public sector data. Private sector analytics that exist typically are focused on the organizational level only, meaning that they are not shared with and do not support the wider SRH market. There is therefore a need for practical support to the Ministry of Health (MOH) and the private sector to share analyzed data through public-private dialogue, including discussing how to integrate this data into annual planning, forecasting and quantitative processes. Another key data gap is on consumer insights. Consumer preferences and needs are not routinely captured, representing a missed opportunity for targeted and inclusive programmes that respond to changing consumer needs.

02
Market analytics

The lack of analytical tools for examining the total market is a key barrier. There is currently limited capacity for data analytics across the entire market domain (including the public and private sectors). There is also a lack of analytical tools to integrate routine data and market data points. Whilst there is relatively good capacity for routine data analysis, health management information system (HMIS) reporting and quantification, this is insufficient to fully understand SRH market barriers and to inform future SRH interventions. There is an inadequate understanding of the SRH market situation with key components and outputs, such as supply, demand, quality, financing and consumer insights and behaviour often not tracked. As a result, market data is not used to inform policies, strategies, plans, and coordinated, market-wide interventions.

03
Market management

The capacity for market management and stewardship is limited and undermines the potential to promote an all-inclusive and effective oversight of the SRH market. Although there are frameworks in place to guide the public sector, there is limited focus on the total market. For example, the private sector is rarely mentioned in SRH policies, strategies, and plans. Existing coordination mechanisms do not focus specifically on the SRH market and there are limited efforts to bring together SRH market stakeholders (including the private sector) to develop strategic plans and targets. The collaboration between the public and the private sector is poor which limits public sector appreciation and understanding of the wider SRH market and the players within it. Additionally, due to the limited availability of data, the public sector

does not have a full appreciation of what the private sector and other market players are doing, or the importance of their role in delivering SRH.

04
Financing

There is dependence on donors and the federal state for product financing. The supply system is a centralized arrangement with UNFPA. UNFPA serves as the procurement agency and uses a basket funding mechanism consisting of contributions from the Federal Government and development partners. Procurement and delivery of supplies to the states are both based on forecast and funds availability. There is a lack of state financing for contraceptive procurement and reliance on the FMOH and donors leaves states vulnerable to shocks and limits their capacity to meet the needs of their populations. There is also limited funding to build the capacity of market actors.

05
Demand

There is limited knowledge of the demand for SRH products for effective planning. While stock-outs are critical indicators of limited availability, that alone does not provide a complete picture of demand. Social norms (non-demand factors) still restrict access to SRH services. There are barriers from myths, misconceptions, and power dynamics that affect women in patriarchal communities and biases against young people, especially young unmarried people are common in some climes.

06
Supply

Persistent stockout of FP products is

a major challenge. However, there is limited technical support being provided to the MOH to explore the feasibility of local manufacturing of SRH products. There is also lack of private sector engagement on pooled procurement, which creates inefficiencies and leads to the associated increase in the cost of services. Private sector procurement is highly individualized and disorganized, and there is a lack of engagement with State authorities. SRH procurement costs in Nigeria are reported to be on average three times higher than international prices (ranging from 0.2 to 30.7 times). This implies that price negotiations are inefficient and an average of 75% of savings could be made by improving procurement processes.[63]

07
Price

SRH price variations are very wide, sometimes amounting up to 50% for the same commodities. Pharmacies and private hospitals typically charge a higher dispensing price than Patent and Proprietary Medicine Vendors (PPMVs), with pharmacies and private hospitals adding mark-ups of between 50% to 100%. High costs remain a significant consideration for most people when products are not provided for free or paid for by health insurance.

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[63]National Health Supply Chain Strategy and Implementation Plan, 2021-2025. (2021); and State Guideline for Procurement of Contraceptive Commodities. (2021).

07
RECOMMENDATIONS

Based on the state and federal level assessment findings, the following high-level recommendations have emerged:

01
Market data

(i) strengthen coordination and integrate the private and public sector data reporting platforms; and (ii) enhance SRH data infrastructure through provision of harmonized data tools, capacity building and robust monitoring and evaluation (M&E).

02
Market analytics

(i) strengthen planning and analytics related to SRH commodities; and (ii) integrate public and private sector quantification.

03
Market management

(i) explore establishing locus for market monitoring and coordination issues.

04
Market institutions

(i) strengthen market institutions; and (ii) engage additional partners (private sector, tech and data agencies, research).

05
Financing

(i) enhance advocacy to increase government commitments; and (ii) incorporate into broader financial planning and operations.

06
Supply

(i) create an enabling environment for local or regional manufacturing; and (ii) diversify registered suppliers to manage supply risks.

07
Consumer demand

(i) strengthen efforts to improve monitoring of consumer demand trends; and (ii) explore demand-based forecasting approaches.

08
Price

(i) explore tax policy on end user prices; and (ii) mainstream SRH into benefit packages to ensure equitable pricing.

09
Quality

(i) explore cost-effective strategies to support monitoring of product quality given limited resources.

10
Product adoption

(i) enhance coordination in product adoption process; and (ii) integrate consumer research into product adoption policy decisions.
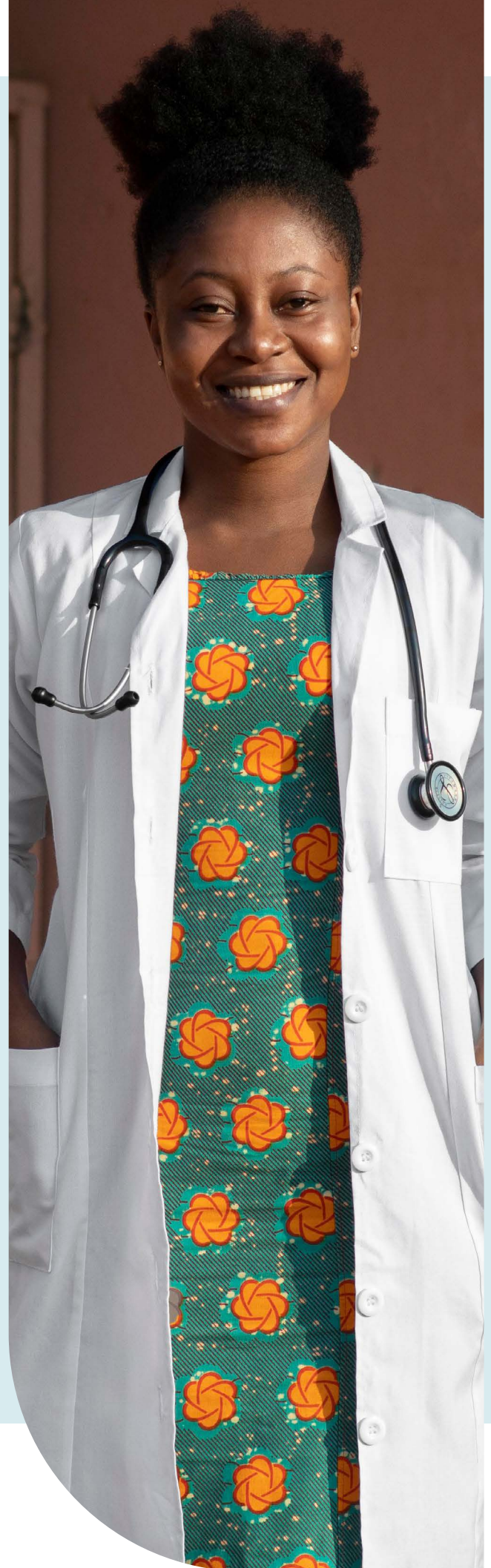
08
NEXT STEPS

NEXT STEPS

Next steps will build on the findings of this assessment to deliver several key actions:

- Collaborate with local stakeholders to implement developed roadmap for identified market interventions.

- Mobilize internal and external funding to support the execution of the roadmap.

- Advocate to state governments to re-conduct the assessment, using the HMF tool to monitor the strengths and weaknesses of the SRH market as it evolves.

- Track progress and share best practices across all SRH market developments.

09
ANNEXES

Annex 1 – Federal HMF findings

Criteria	Score /5	Supporting information
Market conditions		
Financing	1	**There is insufficient financing to meet system demand, and financing is subject to frequent shocks and unpredictability.** The government and donors provide free FP products in the public sector, but there is a huge funding gap of up to 70%. Funding needs have consistently outstripped total funding commitment, and the financial shortfall is worsened by a growing population and inconsistent funding patterns. FP products are better funded than MNH products, which are poorly coordinated with parallel delivery systems by implementing partners. Poor private sector participation, underutilization of the Basic Healthcare Provision Fund (BHCPF), and inadequate inclusion of SRH in the national development health plan are some of the missed opportunities to improve SRH commodity financing.
Supply	2	**There have been recent short-term or sporadic gaps in the supply availability to meet currently funded demand that may persist in the near-term, but changes in future supply may alleviate the shortages. National supply for most SRH products faces long recovery times to respond to shocks.** UNFPA reports state that the country has experienced shortages of FP commodities, with stock-out rates of 19%, 30%, and 47% in 2017, 2018, and 2021 respectively. The availability of SRH commodities has also been affected due to global manufacturing and supply chain disruptions during the COVID-19 pandemic. There are no local manufacturers of SRH products, so they are procured from outside the country by UNFPA for the public sector with the help of donors such as FCDO, USAID, GAC, and the Gates Foundation. Private sector procurement is carried out by social marketing organizations (SMOs). States have begun to follow national guidelines for procuring FP commodities and last-mile distribution. However, ensuring the availability and reliable distribution of innovative SRH products, especially in remote or underserved areas, can be challenging due to logistical and infrastructural limitations. SMOs like Marie Stopes Nigeria Reproductive Choices, the Society for Family Health (SFH), and DKT re-package SRH commodities in the country after original importation. Due to the high demand for long-acting methods among women, there is a global shortage of implants. Additionally, short-acting methods such as injectables (norethisterone) also experience shortages. FP products suffer prolonged and significant shortages compared to maternal and newborn health (MNH) products. One reason for this is the multiple supply sources for MNH products, some form of deregulation of the procurement and distribution system, and the availability of generic substitutes. However, additional research on MNH products would generate deeper insights. Although there are mostly two pathways for SRH commodities procurement in Nigeria, anecdotal evidence suggests a 'parallel' importation of SRH products where there is no national visibility.

Market conditions		
Consumer Demand	2	**The overall system is not meeting consumer demand. However, projections indicate that policy, financing, and other conditions may be in place to meet system demand in the next three to five years and potentially reach additional consumers and geographies.** Nigeria's SRH system is facing several challenges that hinder its ability to meet consumer needs. These include geographic disparities, inadequate infrastructure, shortage of trained healthcare professionals, cultural factors, and financial barriers. The situation is further worsened by social norms, limited awareness of available options, and service provider competence issues. It's high time we come together and address these challenges to ensure that every citizen, regardless of their location, income, or cultural background, has access to comprehensive SRH services and products. Additionally, we need to adopt policies that ensure competitive and sustainable pricing for SRH commodities, which will help reduce limitations to access and promote manufacturer financial sustainability. With concerted efforts and strategic investments, we can overcome these challenges and improve the overall SRH system in Nigeria.
Price	3	**Current pricing or projected pricing trends limit consumer needs and access (via public or private channels) and manufacturer financial sustainability, but existing investments or projected market growth should reduce limitations in the next 5-10 years.** Nigeria's commodities market operates as a free market, which means that suppliers can set prices for most SRH products without significant limitations from prevailing pricing policies. This approach supports competition, innovation, and product diversity. However, pricing is influenced by factors such as procurement source, supply and demand, government policies, infrastructure, and transportation costs. The government provides subsidies in the public sector, particularly for those who cannot access services through the private sector, and regulates the quality of services in the private sector. In the public sector, SRH commodities are fully subsidized by the government and are provided at no cost to end-users. In the private sector, products are available at varied prices across the value chain. The basket fund mechanisms within the FMOH, UNFPA, FCDO, GAC, and USAID finance the procurement of SRH products for the public sector, ensuring competitive negotiated prices with manufacturers. While public sector services often provide free FP services and products, in some cases clients still pay for certain consumables. A free pricing system driven by the forces of demand and supply prevails in the private sector. There are regional disparities, with SRH products being more affordable in the south compared to the north, which affects access, especially in low-income regions, and perpetuates health inequalities. Factors influencing the current pricing dynamics include varying pricing regimes in the public versus private sectors, lack of competition in the public sector, absence of price regulation in the private sector, insufficient local production of SRH commodities, and the nature of the commodity acquisition mechanism.

Market conditions		
Quality	3	**There are moderate concerns about the quality of products in the national market, but they are specific to a known subset of products, and ongoing policy efforts may address these. There is a risk that trends in buying practices and shifts to direct government or private sector procurement could contribute to an increase in non-quality assured products on the market.** The Nigerian Customs Service, Standards Organization of Nigeria (SON) and the National Agency for Food and Drug Administration and Control (NAFDAC) are crucial in ensuring high-quality standards for SRH products. They achieve this through border control measures and a strict process for product registration, pharmacovigilance and post-market surveillance. Publicly sourced SRH products are generally of higher quality than those obtained through private channels. This is because the UNFPA procures SRH products from international manufacturers who are pre-qualified by the World Health Organization (WHO). Although products procured through private channels are expected to meet similar regulatory requirements, it's worth noting that commodity handling (including warehousing, transport, and distribution) may differ in the public and private sectors. This can significantly affect the quality of products and patient outcomes. There are critical concerns with quality assurance in the private sector, and this is especially important as many people access SRH services through private channels. Some products have a higher potential for counterfeiting or unethical distribution. The large number of imported products is a significant risk factor for non-quality assured products in the market. Other factors contributing to non-quality assured products in the private sector include porous borders, chaotic distribution, lack of financing, inadequate supervision, and insufficient consumer education. The deployment of the mobile authentication system has helped to reduce the risk of counterfeiting, especially in malaria and other public health programs, but it has not entirely eliminated it. More research is needed on pricing mechanisms for SRH products, particularly since future product financing will not rely solely on donors. Additionally, storage conditions can affect the quality of non-FP SRH commodities that require a cold chain, such as oxytocin. There is also a need for better collaboration among government departments and agencies to optimize the systems of both organizations for greater impact.

Market conditions		
Product Adoption	3	**Current products in the national market generally meet consumer needs, but there are opportunities for improvement. There is a mechanism to consider new/additional products. Still, it's not clear to what extent those will fill gaps in consumer needs or if there is funding committed to introducing additional products.** Product adoption varies across different products, key markets, and sectors, and it is positively correlated with consumer demand. Both public and private sectors have made efforts to meet consumer needs by introducing new technology and product innovation. However, the effectiveness of these initiatives can vary. The likelihood of SRH products and technologies being widely adopted depends on factors such as the complexity of the technology, the availability of skilled service providers, myths and misconceptions surrounding the products, and provider bias. There are several main drivers of SRH product adoption in both the public and private sectors, especially for FP products. These include a wide range of contraceptive options to cater to individuals' preferences, lifestyle and reproductive goals. Female-centric products are designed specifically to meet women's needs and preferences, giving them more control over their reproductive health choices. Additionally, there are initiatives to address social norms related to life and development cycles, educational materials, and confidential counseling services to address the specific needs and concerns of adolescents and young adults. However, for certain products, such as long-acting reversible contraceptives (LARCs), consumer demand is perceived to be lower than the available product quantity. This is due to restrictions on access, particularly to FP products, because of socioeconomic factors and social norms in some settings. These factors are ultimately affecting the uptake of these products. Apart from consumer demand, myths and misconceptions about SRH products negatively impact product adoption and service uptake. Religion plays a significant role in this instance, particularly for FP commodities, shaping SRH product adoption. To support product adoption, the Best Practice Guideline for the Introduction of Reproductive Health Commodities provides policy direction for RH commodities introduction in Nigeria. The guideline outlines the key steps and processes for introducing RH products, the roles and responsibilities of relevant stakeholders, and steps toward ensuring private sector inclusion in this introduction process. Moreover, the Product Introduction Coordination Mechanism (PICM), a sub-committee of the National Reproductive Health Technical Working Group (NRHTWG), supports product introductions in the country. Since their inception in 2020, they have facilitated the introduction of the hormonal intrauterine device (IUD) in Nigeria.

Market foundations		
Market Data	2	**Limited data is available to monitor and analyse markets, and this is only for the public sector and some products; consumer insights may be available for certain products, but gaps exist**

While there have been efforts to collect and analyse data related to national markets and consumer access, more data availability, reliability, and comprehensiveness are still needed. Although there is ample data on SRH markets, these are mostly product-specific or company/brand-specific, providing little information on market dynamics.

Public sector data flows through the HMIS for all health programs. Private sector facilities comprise only 15% of total facilities reporting to DHIS2. This is attributed to issues such as partially implementing the data management SOP, a lack of incentives to report data beyond sales records, and sometimes impatience from private sector clients who may be wary of their privacy.

For MNH, monitoring, analysing, and shaping the product market for consumer insights and needs is complicated as procurement largely occurs at the state level. In addition, restrictive laws and policies are associated with using some products, e.g., medical abortion commodities.

The poor visibility of SRH market data, especially in the private sector, is further worsened by SRH commodities being self-sourced from the open market; there is no obligation from the private sector to report. Where available, collected data is insufficient and of low quality. Some contributing factors include a lack of data digitization and user-friendly tools, a lack of incentive for private sector reporting, and data hoarding that precludes data harmonization.

Implementing partners attempt to address the data management shortfall by coordinating and financing data collection efforts at each level of the data management system.

Key trends shaping market data for SRH include:
- Lack of data coordination and aggregation across both public and private sectors and within these sectors. Several parallel market surveys are not consolidated for data-driven market insights.
- Lack of harmonization of the private sector and donor reporting with public sector data and robust mechanism for harmonization of LMIS and HMIS data to inform real-time decision-making.
- Weak and inefficient data systems, despite efforts to improve the end-to-end supply chain data management for UNFPA/ government-procured products through the NHMIS.
- Current data management systems do not incorporate essential information to understand consumer needs. |

Market foundations		
		The availability of useful tools to appropriately manage the vast amount of data is limited by the lack of human resources. Additionally, there are very few studies and assessments on the private-sector health market, and those that do exist typically focus on specific areas of interest to pharmaceutical companies and non-governmental organisations (NGOs) who fund the studies. Therefore, it's important to prioritize obtaining comprehensive and valid data from both clinical and non-clinical private sector sources for future interventions. Furthermore, vertical programming has been found to negatively impact data harmonization in stakeholder engagement. It's crucial to get buy-in from the private sector to encourage the use of data tools. Sensitisation and advocacy may be necessary to encourage the private sector to be more involved in data reporting, which will increase the visibility of private sector data. Finally, even though there is a policy statement in place to regulate data collection and management in both private and public sectors, it's not adequately enforced.
Market Analytics	2	**Limited capacity and funding to support routine tools for understanding markets may be limited to one sector or a few products.** There is a need for higher institutional capacity in data analytics in both the public and private sectors, especially for SRH data collection. While the public sector has more established systematic data collections, the private sector has more advanced models for analytics. However, there is a challenge in leveraging these advantages. In the public sector, market, supply chain and service data are utilized interchangeably. The decision on supply planning is based on estimates of program targets and product distribution patterns, adjusted for procurement lead times, stock-out, etc. Unfortunately, consumer demand is seldom utilized to monitor trends and product diversity across channels. Final procurement decisions are based on available funds. In the private sector, there is a great interest in understanding price dynamics, foreign exchange rates, and benchmarks for product mark-ups to monitor and modulate equitable pricing structures. However, the visibility of private sector service utilization and supply chain data is poorly visible due to weak mechanisms for consolidating private sector data into unified LMIS and HMIS databases. Aligning SRH data collection and analysis processes and systems for both the public and private sectors has been challenging due to weak human resource capacity to transform the rich data repository into market insights, lack of political will, and funding at all government levels. Data analysis is often donor-driven rather than being part of the routine market intelligence. Moreover, there is a lack of a standardized mechanism for tracking private sector data, thereby creating the aggregation challenge. Finally, there is poor demand and use of the existing data, with reports and data sitting on shelves and not being used to inform critical decisions.

Market foundations		
Market Management	2	**Coordination mechanisms may exist but are not organised to support, or focused on development of a comprehensive market strategy and action plan.**

The country has a strong system to coordinate SRH response, covering everything from planning to delivery. The FMOH is at the forefront of coordinating SRH priorities. The National Reproductive Health Technical Working Group (NRHTWG) is the primary mechanism for setting SRH priorities. At the sub-national level, the State Reproductive Health Technical Working Group (SRHTWG) complements these efforts. These platforms encourage stakeholder collaboration, facilitate information exchange, and drive strategies to improve SRH services and products.

The key factors driving inclusiveness and coordination efforts among partners in the SRH product market include the involvement of various sectors, such as governmental bodies, NGOs, international agencies, healthcare providers, and the private sector. Technical assistance (TA) platforms and structures are also available to support SRH deliverables, such as advocacy groups, interfaith groups, and media forums.

Effective regulatory institutions, such as the Food and Drugs Services (FDS) Department of the FMOH, regulate the quality, safety, and efficacy of pharmaceutical products in Nigeria. Other divisions within the FDS with regulatory responsibility include the Pharmaceutical Services Division, which develops and reviews the Nigeria Essential Medicine List (NEML), Nigeria Essential Medicine List for Children (NEMLC), Nigeria National Drug Formulary (NNDF), and National Drug Formulary (NDF).

A robust supply chain management system for SRH products, particularly contraceptives, is essential. The Nigeria Health Logistics Management Information System (NHLMIS) captures essential logistics information, providing real-time quality data and visibility into stock availability at service delivery points. The platform addressed the end-to-end visibility gap in key supply chain processes for the five major public health program commodities: Family Planning/Reproductive Health, HIV, TB, Malaria, and Vaccines.

The private sector's contribution is viewed as instrumental in fostering innovation, resource sharing, and the expansion of high-quality SRH products and services. This is evident in the role of the government's public-private partnership with some SMOs to close public sector supply gaps through innovative social marketing models.

Despite minimal funding, political commitment to supporting coordination mechanisms is essential for sustained success. This must be coupled with an overall improvement in health systems coordination efforts from national to sub-national and facility levels.

Market foundations		
		The major risks to sustaining and improving market management include effective implementation of these coordinating platforms through sustained government funding, insufficient SRH supply chain infrastructure to support an integrated public and private sector end-to-end product management, and inadequate and unsustainable funding for human resources requirements for effective SRH market management, including regulatory, operational, and service delivery requirements. Additional areas of market management that are still evolving include: • Understanding consumer needs and utilizing insights to shape product introduction strategies • Evaluating product options • Assessing cost-effectiveness to introduce products and oversee integration Market data should guide procurement strategy rather than rationing procurement based on available resources. Further efforts are required to understand how the federal government supports states' sourcing SRH (FP & MNH) products to ensure quality, sustainable prices, and a secure supply base. Effective monitoring of financial requirements, policy strategies, and consumer ability/willingness to pay is necessary to determine pricing strategies for SRH products in the private and public sectors, rather than arbitrary price mark-ups (e.g., actuarial studies). Leveraging the advancement of the private sector is critical to understanding market drivers and reducing bottlenecks for an effective market-driven approach to closing SRH market gaps (including product, policy, and pricing gaps) in optimizing health outcomes. The major impediments affecting the effective implementation of these coordinating platforms include insufficient healthcare infrastructure, inadequate human resources, and service delivery gaps.
Market Institutions	3	**Some key market functions are in place, but others are missing or require strengthening to support markets that meet consumer needs.** There is a repository of policies and strategic documents to support the SRH market in Nigeria, especially at the national level. They include: • The National Health Policy • The National Family Planning Blueprint • National Policy on Health and Development of Adolescent and Young People in Nigeria • Task Shifting and Task Sharing (TSTS) for Essential Care Services Policy In addition, for the MNH market, the Basic Health Care Provision Fund (BCHPF) and the National Guideline on Safe Termination of Pregnancies for Legal Indications are instrumental in shaping market institutions.

Market foundations		
		Other guidelines and frameworks on SRH include (i) the National Strategy for the Scale-Up of Chlorhexidine; (ii) the Accelerated Reduction of Maternal and New-born Mortality in Nigeria. Roadmap for Action 2019 – 2021; (iii) the National Guidelines on Self-Care for Sexual, Reproductive and Maternal Health (feature self-injection of DMPA-SC) – 2021; (iv) the National Guidelines on Safe Termination of Pregnancy for Legal Indications – 2018; (v) the National Private Health Sector Engagement Strategic Plan for Family Planning Services – 2020; and (vi) the National Gender in Health Policy – 2021 – 2025.
		Agencies and parastatals under the Food and Drug Services (FDS) of the FMOH support the provision of ethical drugs and services in the country. NAFDAC has a regulatory function in ensuring the quality and safety of SRH products and combating counterfeit items. The Pharmacists Council of Nigeria (PCN) maintains ethical standards among pharmacists distributing SRH products. The Council's role in maintaining standards, preventing unscrupulous practices, and ensuring quality of care is acknowledged. However, stakeholders emphasized the need for continuous training and updates for pharmacists and patent medicines vendors to stay abreast of evolving SRH technologies and practices.

Annex 2 – Niger HMF scores

Criteria	Score /5	Supporting information
Market conditions		
Market Data	2	Currently, 1,347 public facilities report healthcare services to the District Health Information Software (DHIS). However, despite the existence of 802 private facilities, the State HMIS does not capture service statistics from this sector. Quality, comprehensive, and routine data are available for the public sector and used for planning and decision-making in Niger. In most cases, quality, comprehensive, and routine data exists for some key private sector categories of organizations – e.g., SMOs, NGOs, faith based organizations (FBOs), and the commercial sector – especially on sales and service provision volumes but are not publicly available. Data on consumer insights is generally lacking in the State. Data for some key private sector players, such as PPMVs, is not readily available. It is difficult to quantify the scale of private sector contributions. The MOH and the wider healthcare market lacks access to the complete private sector data, meaning it does not inform the development of policies and plans. This ultimately limits whole market perspectives, plans, and actions. Furthermore, it undermines our understanding of the private sector's current and future role and impact and also limits dialogue, engagement and trust between the public and private sectors. Moreover, this information gap means that many plans that are developed in Niger are exclusively focused on the public sector, inadvertently limiting the full scope of interventions that could be possible if the private sector was incorporated. This, in turn, results in other market inefficiencies and shortcomings. Past attempts by the State to obtain consumption and general SRH data from the private sector failed primarily because the private health providers source their products outside of the public sector supply system and, therefore, feel no obligation to share data without state support. There is also a limited aggregation of SRH market data by companies who typically play this role in other countries in Africa (e.g. IQVIA). The available aggregated data is expensive to purchase and is reportedly not comprehensive or easy-to-use. These findings, coupled with experiences in other SRH country markets, prove that improving the availability and accessibility of improved market data are a critical foundation to enhancing the SRH market. Through matching data availability with increased capacities in data analytics, the State MoH will be more equipped to understand its market shortcomings than at present. This will also improve the stewardship role of the State and enable them to make key decisions to improve Niger State's SRH market. Additionally, improved market data availability and quality will enhance coordination and partnerships between key market institutions, fostering improved market outputs (including enhanced supply of products and services, and improved financing). Investing in data in Niger State will, therefore, serve as a catalytic and transformative force for its SRH market.

Market conditions		
Market Analytics	2	FP product forecasting is conducted at the state level by examining FP daily consumption records, requisitions and monthly summary forms. Health facilities typically submit service delivery data to LGA supervisors (M&E officer and LGA maternal, newborn and child health [MNCH] coordinator), who then review and input the data into the DHIS2. The Logistics Management Coordination Unit (LMCU) officials then access NHLMIS to report commodity-specific data using the requisition issue and report form (RIRF). A proposal is to streamline this process by allowing FP service providers to directly submit information at the facility levels, without going through LGA supervisors and LMCU. Simultaneously, the same arrangement of commodity distribution has been proposed (from national through the state stores and delivered directly to the facilities). Currently, data from the private sector is not captured. This approach is not strategic and does not consider trends and peculiar needs of segments of the population. Data on consumer needs and preferences is not captured as a priority, and overall data collected is not utilized to inform budgeting.

Market analytical tools are very limited in the State. Some analytical tools and systems exist in the State, such as DHIS2 and quantification tools, for example. The Drug Management Agency uses an application named NiDMA, however its usage does not extend to SRH/FP commodities currently. This tool can be useful in the SRH/FP commodity forecast going forward. Thus, there are no such tools that are used to analyze the market holistically. Tools are siloed and largely used to understand the public and private sectors separately. As far as is known, there is very limited or no sharing of analytical tools and, as the sharing of private sector data is very limited to the public sector. Engagements between the private and public sector are also limited. Opportunities to share tools and potentially develop market-based tools do not currently exist. However, the State is keen to engage and capture FP delivery from the private sector. According to the State FP Coordinator, *"Capturing FP data will provide us a more comprehensive picture of the situation in the state and increase our forecast. This will attract more supply of FP commodities to the state and make it easy for us to extend supply to the private sector…We need to take concrete action as the present supply is inadequate for the public sector and it's therefore not possible to give to the private sector players."*

An SRH-specific market dashboard that captures, aggregates, and analyses data is not currently available in the State. This market fragmentation makes for an inadequate understanding of the SRH market situation with key components and outputs, such as supply, demand, quality, financing, and consumer insights and behavior, often excluded. Consequently, Niger's changing and dynamic SRH market is not routinely monitored, and market data are not used to inform policies, strategies, plans, and coordinated, market-wide interventions. Though key MoH/LMCU staff have some level of capacity to use data analytical tools, they need capacity strengthening to be able to effectively utilize analytical tools for broad based SRH market analysis. |

Market conditions		
Market Management	2	The capacity to lead and manage the market and the overall health of the market is weak at the state level. Although there are frameworks in place to guide the public sector, almost nothing across the State guides the private sector, the whole market, and all market stakeholders. Policies, strategies, and plans relating to SRH exist in Niger, although the private sector is hardly mentioned in them and largely did not contribute to their development. Activities of existing platforms such as the Reproductive Health Technical Working Group (RHTWG) and other related technical working groups (TWGs) (such as HMIS, and health financing) do not focus specifically on the market. Collaborations to bring together SRH market stakeholders to develop (for example) strategic plans, targets, or joint courses of action, are non-existent.
		Collaboration between the public and the private sector is poor, limiting the public sector's appreciation and understanding of the wider SRH market and the players within it. Additionally, due to the limited availability of data, the public sector does not have a full view of what the private sector and other market players are doing, and the importance of their role in delivering SRH, which undermines their stewardship role. Additionally, many private sector players are wary of partnering with the public sector due to mistrust and a lack of clear incentives on what would be gained.
		Strengthening market management and stewardship is a significant gap in the State, yet it is fundamental to strengthening the SRH market in a meaningful, long-term, and organic process. Without strong market management and stewardship, Niger's SRH market will not grow and thrive comprehensively and systemically. Additionally, without strong market management and stewardship, it is unlikely that the opportunities from more and better data and data analytics will be optimized, and the SRH market will largely continue to function as it currently does – with major shortcomings, systemic challenges, and operating in a fragmented and inefficient manner. Strong market management and stewardship will be key in driving sustainable changes in the SRH market.
		There are platforms that support some aspects of partnerships between the public sector and some private sector players, such as the RHTWG, forecasting and quantification coordination forum and others relating to policy and planning. However, many private sector and market players are either not invited to such key forums, or they often do not attend, except for a small number of NGOs and SMOs who may support and attend the RHTWG and some planning meetings. Except for such organizations, other key market players do not attend key meetings. Of note is the forecasting and quantification forum in which the private sector is not invited, which leads to shortcomings, as outlined above in the data availability section. There is no specific forum that intentionally brings the public and private sectors and other market actors together to discuss the SRH market. State policies and plans are overtly focused on the public sector, partly due to the lack of private sector and market data availability but also due to limited engagements between the public sector and the market players. Despite the importance of the private sector in delivering SRH results, they do not feature as key channels in policies and plans as much as they should. There is no specific plan of any kind in the State that focuses on the SRH market. Data on consumer insight is not a regular practice. Data collected does not inform budgeting.

Market conditions		
Market Institutions	2	The institutional base is weak. State-level procurement and contracting regulations are not in place to mitigate manufacturer/supplier dependencies . Data collection is still manual at the facility and LGA level. Access to timely quality data and last-mile distribution of FP commodities is challenging. This is because the FP unit relies on ad hoc arrangements with LGA officers to attend meetings at the state capital for onward distribution to facilities in the LGAs. The State seeks partnerships with implementing partners willing to fund the delivery of RH products to SDPs without reliance on storing arrangement by LMCU since there is no fund allocation at the state level for product distribution, unlike malaria prevention/treatment products. Similar to the situation under data availability, the public-private partnership is not fully matured and, therefore, private sector data is hard to come by. The state quantification process is also biased as assumptions are made based on the total number of women in the reproductive age bracket, of whom a significant portion obtain their products from the private sector. State policies do not capture comprehensively the private sector and market players and do not appear to explicitly include the private sector as key delivery channels. Various regulatory bodies are in place, but they struggle to keep up with the large numbers of private providers. There are numerous issues with supplies, which undermine the institutional base.
Financing	2	IIn Nigeria, FP financing was entirely donor-driven until 2011 when the Federal Government of Nigeria (FGON) commenced a nation's policy of free contraceptives at all public facilities through a commitment to provide funds to procure contraceptive commodities for the public sector. The purchase of FP commodities is through a 'basket-funding' mechanism with external donors. This is with a plan to ensure uninterrupted and sustained availability of financial resources/commodities that will in turn improve FP commodities' availability. UNFPA serves as the procurement agent for FP commodities using a Basket Fund which is guided by a signed Memorandum of Understanding (MoU) between the FGON and UNFPA.

The primary source of financing for FP services and commodities in Niger State is via the federal government through the basket fund mechanism described above. State-level funding is non-existent. This has led to a prevalent reliance on out-of-pocket expenditure.

In line with its FP2020 commitment, the federal government has augmented its share of the 'basket funds' to $4m annually. However, in addition to the inadequate allocation of resources to FP, the prevalence of incomplete or late release of resources for procurement is also a key issue. This leads to significant delays in purchase of commodities and the recurring need for external donors to fill the gaps.

The State's guideline for FP commodity procurement represents a good opportunity to mitigate and complement the current funding and supply shortfall. Leveraging the state guideline for FP commodity procurement and strengthening the State's drug procurement to include private sector players will be vital to bolstering commodity security. |

Market conditions		
		At present, there is no robust forecasting in place and decision-making processes are inadequate. Establishing mechanisms that foster sustainable domestic financing for FP, including leveraging private sector networks to deliver FP services and information, represents a bold new approach to meeting the health needs of clients (state guideline for procurement). Budgets for FP are typically determined based on consumption data and involve supportive policies for access – e.g. financing frameworks (insurance, subsidies). A national free contraceptive commodity policy operates across the country, including Niger State, to signify government commitment to improving availability and access to FP services. However, this policy is primarily operational in the public sector. The Contributory Health Insurance Scheme (CHIS), recently introduced in the State, is inclusive of free FP and SRH services but is not fully operational at the moment due to funding shortages. Due to funding inadequacies, the federal government has initiated the development of state guidelines for contraceptive procurement to harness state resources to meet their specific needs, and has commenced discussions on financing and supplies with the possibility of a subsidy for the most vulnerable. However, Niger State has yet to key into this initiative to bridge the gap in supply of FP commodities in the State. Although Niger State has budget lines for FP, there is no publicly available information on whether funds are released on track with the budgetary allocations.
Supply	2	The procurement of FP commodities relies heavily on supplies from the FMOH, but these supplies are mostly insufficient to meet the State's needs. Additionally, in some cases, not all of the quantities supplied to the state warehouse are distributed to healthcare facilities because of lack of budget line for last-mile distribution. The national supply planning process is only focused on the public sector – the private sector is not represented. The private sector does not receive any commodities from the public sector. The private sector sources FP commodities through individual arrangements and SMOs such as SFH, Marie Stopes Reproductive Choices, PPFN etc. The supply of FP commodities through the private sector is unregulated and disorganized. Importantly, the State is yet to key into state guidelines for the procurement of contraceptive commodities, which would provide an additional source of funding. Overall, Procurement budget gaps exist, but are not fully documented due to poor forecasting and a lack of captured private sector data. The State Primary Health Care Development Agency (SPHCDA) is responsible for FP commodity management in the State. This includes storing and distributing commodities to all SDPs (last-mile delivery), though the State does not presently procure commodities.

Market conditions		
Consumer Demand	3	The demand for contraception is increasing and is associated with high unmet need. The total demand for FP in the state is 59.2% and the unmet need for contraceptives is 33.32 %.[64] Generally, an education level above secondary school and increasing household wealth have been shown to be associated with higher uptake of FP services. [65]
Price	3	A price modulation mechanism does not exist in Niger State for FP commodities. In public facilities, commodities are free, except for payments for consumables for long-acting methods, which cost about $1.15. In the private sector, prices are fixed based on an arbitrary markup on the cost of commodity supply, which lacks uniformity. Cost of procurements of FP/RH commodities in Nigeria is reported to average 3 times international prices (range 0.2 to 30.7 times). This implies that price negotiations are inefficient and an average of 75% of savings could be made by improving procurement processes.[66]

The cost for all FP methods in private health facilities is summarized in the table below. Findings from focus group discussions (FGDs) indicate FP users do not consider price as a challenge but prefer free products.

Table 2. Commodities and average end-user prices[67]

Commodity	Average Price [Average across Pharmacies and PPMVs]
Microgynon pills	$ 1.84
Emergency pills	$ 1.15
Noristrat injection	$0.69/card
Depo Provera injection	$ 0.575
DMPA SC injection	$ 1.15
Implants	$ 6.9/11.5
Mifepristone	$ 6.9
Levofem	$0.345
Misoprostol	$3.2

Quality	3	There is no state mechanism for QA and oversight functions relating to contraceptive supply and management in the private sector. All drugs approved for usage in the State have NAFDAC's approved registration number and a code to dial for safety and QA to certify that it is of good quality. However, healthcare quality in the private sector is unknown due to a lack of private sector (mainly the PPMVs and the community pharmacists [CP]) data and information. Given the large number of unregistered private providers across the State and following interviews with key stakeholders, the quality of unregistered providers thus remains largely unknown.

A lack of active quality control mechanisms for private sector-supplied FP commodities prevails at the state level. There is a need to institute a mechanism to oversee the quality of products in the private sector in the State, as this is currently non-existent.

[64]Multiple Indicators Cluster Survey. (2021).
[65]National Demographic and Health Survey. (2018).
[66]National Health Supply Chain Strategy and Implementation Plan, 2021-2025; and State Guideline for Procurement of Contraceptive Commodities. (2021).
[67]Halcyon. (2023). Niger State SRH Commodities Market survey.

Market conditions		
Product Adoption/ Introduction	3	Product introduction is currently carried out through a centralized process led by the FMOH. A recent example is the introduction of hormonal IUDs. There are no state-specific regulatory processes to register new products. Similarly, there is no framework to assess user needs and evaluate product portfolio and value proposition of new products. A dedicated budget to coordinate product introduction efforts is also unavailable (key informant interview [KII] with FP, M&E Officers). Planning for production is mainly coordinated by FMOH with limited involvement of state officials.

Annex 3 – Osun HMF scores

Criteria	Score /5	Supporting information
Market foundations		
Market Data	2	**Quality data is available on public markets, but minimal data is available on private sector product needs. Some consumer insights are available, but gaps exist.** Quality, comprehensive, and routine data is available for the public sector data, which is mostly available on the DHIS2 and comes from both private and public facilities in the state which is used for planning and decision-making in Osun. In most cases, quality, comprehensive, and routine data exists for some key private sector categories of organizations – especially SMOs, NGOs, FBOs and the private sector (distributors, wholesale pharmacies) – on sales, service provision, consumer insights, and so on. Data for other key private sector players, such as PPMVs, is not readily available and when available, the quality of the data is generally quite low. However, while much private sector data exists, the availability of such data is limited as it is not often shared externally. This means that it is difficult to use the information available to speak to the plurality of decision-making, especially with the MOH, which is responsible for driving the state agenda, seeing as the available data is fragmented. This ultimately limits whole market perspectives, plans, and actions. It also further undermines the understanding of the role, contribution, and impact of the private sector both currently and in the future, limits dialogue and opportunities for collaboration, and engagement and understanding of the private sector by the public sector. In this, Osun State has witnessed duplication of efforts due to poor collaboration and weak cohesion. It also means that many plans that are developed in Osun are exclusively focused on the public sector, only leaving out around 60% of the population that receives care at the private facilities. Therefore, this limits the full scope of interventions that could be possible if the private sector was incorporated, which in turn results in other market inefficiencies and magnifies the shortcomings.
Market Analytics	2	**Limited capacity and/or funding to support routine market analysis tools may be limited to a single sector or a few products.** There are some analytical tools and systems in place in Osun State that are used to understand the market to some degree, such as DHIS2 and the forecasting and quantification tools. The reporting rate into the DHIS in Osun State is not consistent as deep dives have shown it as having the lowest reporting rate (72%). Most of the facilities had reported at least 10 out of 12 months (80%) to DHIS2 within the period under review. Kano had the highest reporting rate (89%) and the facilities in the southern region of the country (Osun, Delta, and Enugu) had the lowest reporting rates. Furthermore, Osun State has facilities that did not report to DHIS2 throughout 2018.[68]

[68]Olugbade O, Oluwayemisi Ishola D, DrPH Olusegun Ricketts M, Shakir Balogun M, Moreen Kamateeka Fmcp. Family Planning Indicators Assessment and Data Quality Audit in Selected Health Facilities across Nigeria. 2019;(November). Available online at: www.measureevaluation.org

Market foundations		

At the facility level service providers' (SPs), consumption data is recorded and received using the RIRF, which is then submitted to the LMCU to order FP commodities. This is done bi-monthly. The LMCU makes use of the RIRF form to track consumption and available stock in each health facility and the commodities are then allocated appropriately. Then the service provider takes the RRF to the Central medical store to pick up their FP Product. Quarterly, the state-aggregated consumption report is collated and sent to the national level commodity and logistics management unit. However, there are still issues around capacity for proper data entry into the RIRF form and this often results in overstocking or understocking of commodities (KII with FP Coordinator). Consequently, quantification is mostly based on service targets rather than demand, resulting in stock imbalances. Coupled with challenges in the delays in the central procurement procedure which had a substantial influence on product availability at the lower levels. The quantification exercise considers the stock at hand at the central and other shipments of supplies and medicines ordered, but not yet received.

Most of the analytic tools currently in existence are focused on the public sector because most private sector data is not made available to the government and is, therefore, not captured in such analytical tools and systems. Some analytical tools and systems are in place for many of the private sector players - especially SMOs, NGOs, FBOs, and the commercial sector.

Even with the availability of some tools and systems focusing largely on quantification and forecasting of commodities, there are no tools that can be used to analyze the market holistically to inform decision making. Tools are also siloed and largely used to understand the public sector and the private sector separately.

Market Management	3	**Governments and partners organize key players around specific topics but are not fully aligned around an overall market strategy and action plans are not fully inclusive of all relevant actors.**

An initiative to coordinate all the commodities being supplied to the State commenced in 2017. The initiative became a directive that stopped all Partners from donating commodities to the States directly. The State Logistics Management and Coordination Unit (LMCU) was strengthened to work through the Department of Pharmacy at the SMOH with the Central Medical Store to oversee commodity management at the state level. This is to ensure there is better coordination of FP commodities management in the State.

There are platforms in place that support some aspects of partnerships between the public sector and some private sector players, such as the RHTWG, forecasting and quantification coordination forums, and others relating to policy and planning. However, private sector players are usually either not invited or don't attend the meetings, except for a small number of NGOs and SMOs who may support and attend the RHTWG and some planning meetings. State policies and plans are overtly focused on the public sector, partly due to the lack of private sector and market data availability, but also due to limited engagements between the public sector and the private sector market players.

Market foundations

		Partnership is also weak as the public sector's appreciation and understanding of the wider SRH market and the players within it is limited. In other instances, the public sector is focused on regulating the private sector, but many private sector players are wary of partnering with the public sector due to issues such as mistrust and a lack of clear incentives on what would be gained.
Market Institutions	3	Some key market institutions especially the government institutions, are in place, but some capacity is either missing or require strengthening to support markets that meet consumer needs. Relevant procurement policies still require state level domestication as they pertain to the acquisitions of commodities through the BHCPF and funded programs originating from donors, such as the Saving One Million Lives (SOML) initiative. State policies do not capture comprehensively the private sector and market players, and do not appear to explicitly include the private sector as key delivery channels. There are several regulatory bodies in place, but they struggle to keep up with the large numbers of private providers. The State facilitates the coordination of activities among partners through the TWGs which was inaugurated September 12th, 2022, and the program was sponsored by The Challenge Initiative (TCI). The SRHTWG comprises of State MOH, Osun State Primary Health Care Board (SPHCB), Osun Health Insurance Agency (OSHIA), participants, religious leaders, private health sector, implementing partners (TCI, United Nations Children's Fund (UNICEF), MSI Reproductive Choices), Ministries, Departments and Agencies (MDAs), Civil Society Organizations (CSO), and NGOs. It leads activities by establishing various committees. However, most of the committees formed are not functional because of the focus on other health activities and programs as well as financial constraints. These are obstacles to strengthening the institutional base to provide the needed support for SRH services.

Market conditions

Financing	2	Presently, the Federal Government and key donor partners supply over 90% of funding, with the State contributing less than 10%. The commodities market is mainly funded in terms of supply by the FGON to the State through basket funding from partners. Donor agencies like UNFPA, FCDO, GAC and USAID are key providers of financial support to the states. Implementing partners in the state such as MSI, and TCI do not provide financing for FP commodities in the state. They function more in the area of capacity building for community health extension workers in the PHCs through service delivery training sessions. While the overall annual budget for FP remained steady at ₦5,000,000 from 2018-2021 ($11,303.27), the figure more than doubled in 2022 to ₦12,000,000 ($27,127.84) to accommodate increased FP needs, due to widely reported stock-outs in public facilities. However, gaps still exist with cash backing and cash release leading to continued stock-outs and poor availability.

Market conditions

		To supplement supplies received from the Federal Government, the State procures commodities and consumables (priority products are injectables, condoms, implants, oral pills, and IUDs) through interventions such as the BHCPF. In 2021, the SPHCB received ₦399,000,000 from the BHCPF.[69] Of that sum, ₦19,920,000 was used to procure FP commodities. The State Government also procured FP commodities through the SOML Initiative worth $86,085.39. All these still require significant effort with coordination to ensure that the financing is adequate to pay for products supplied and to fund demand generated by the service delivery system (both public and private channels). With regards to the private sector, there is currently no contribution from the public supply system to the private providers as the government has not demonstrated political will in procuring commodities for the private provider. Consequently, all private providers operate independently and have limited access to funding from banks or corporate institutions. Most of them procure commodities from SMOs (DKT) and NGOs (SFH) within the State and wholesale pharmacies not domiciled in the State with little or no access to credit facilities. This means that cash is paid for all purchases, limiting the amount of commodities that can be procured per time to meet the needs. The private provider supplies in the State include mainly condoms and pills. Private providers often face difficulties in obtaining affordable, quality implants, or sourcing IUDs through private supply channels. This is primarily due to the substantial capital required for these commodities, which in turn affects the prices of the available products. The pricing differential is due to markups incurred through the supply channel (logistics and distribution) and the procurement of commodities from unreliable suppliers not domiciled in the State. This results in diminished stock levels of commodities, especially implants and IUDS. In total, available financing is unable to cater for the products needed, as those generated from demand by both the private and the public sector are more than the products supplied.
Supply	2	**National supply for most SRH products faces long recovery times to respond to shocks. Due to weak health sector financing, insufficient cash backing, and cash release, financing takes a long time to adapt to changes in country demand. This is because the market is mainly reliant on donor contributions.** There is currently insufficient national supply to meet the estimated need based on the developed forecast and supply. It is not sufficiently broad, robust, diverse, and responsive to maintain supply of most SRH products in the face of shocks. Existing investments should improve resilience in 5-10 years. The State has consistently received commodities from the national/ donor funding partner procurement over the last six years (2017-2022).

[69]Adenekan, A., J. Ekpenyong, A. Carlson, J. Sine, and Ilika F. (2020). Health Financing Landscape: Osun State, Nigeria. Washington, DC: Palladium, Health Policy Plus. Available from: http://www.healthpolicyplus.com/ns/pubs/17404-17728_OsunHFL.pdf

Market conditions

While supply is largely steady in state warehouses, there are notable challenges with the physical supply of products to health facilities due to budget constraints in the public sector for distribution. Distribution of commodities in terms of vehicle availability for last-mile distribution, manpower for offloading, and warehousing are issues faced by the public sector. From the information gathered from stakeholders at FGDs and KIIs in this assessment, commodities supplied are not based on actual consumption analysis and forecasts, but on availability of products. The mainstream supply planning process currently is only focused on the public sector to the exclusion of the private sector, due to a lack of availability of consumption data from the private sector.

This above finding is in tune with a study by Olonode et al. (2016) that assessed the availability of contraceptive commodities (CCs) in Osun State, Nigeria. It showed that there was full supply of CCs at the State Central Warehouse (SCW) which did not trickle down to full supply at service delivery points (SDPs). There is a lack of quality information to guide supply, usage, and balance stocks at various levels in the public data. While all inventory for CCs were always available at the SCW for the period under review, only 25% of SDPs had all inventory CCs available all the time. Identified factors responsible for non-full supply of CCs at SDPs include a push system of inventory control which depends heavily on the distribution of what is available in the warehouses, which is accompanied by transportation inadequacy, and logistics officers that appeared to possess low capacity and low motivation.[70]

Supply of commodities to the private providers seems to be more efficient due to a few initiatives such as social marketing programs which help to mitigate many of the supply-side challenges. However, when products are not available through these initiatives, some providers source commodities from private wholesalers and distributors in which the cost of procurement may be higher, and this could reduce the quantities of commodities to be procured. Private organizations are also driven by profit from the commodities seldom allow stock-outs because of the profit margin involved. Many times, this leads to the procurement of only fast-moving methods such as condoms and pills, only leaving a short supply of other methods (e.g., implants, IUDs) in the State.

[70]Olugbade O, Oluwayemisi Ishola D, DrPH Olusegun Ricketts M, Shakir Balogun M, Moreen Kamateeka Fmcp. Family Planning Indicators Assessment and Data Quality Audit in Selected Health Facilities across Nigeria. 2019;(November). Available from: www.measureevaluation.org

Market conditions			
Consumer Demand	2	**The overall system is not meeting consumer demand due to insufficient financing to meet system demand. However, projections indicate that policy, financing, and other conditions may be in place to meet system demands in the next 3 to 5 years, and potentially reach additional consumers/geographies.**	

Several funded private sector organizations and NGOs such as Marie Stopes Reproductive Choices, SFH, DKT, and TCI focus heavily on increasing the demand for SRH in the State. While consumer demand is being improved, insufficient financing to meet the demand remains a perennial problem, especially in the public sector where most people expect free services or are unable to pay out-of-pocket for services. Subsidies in the private sector help to increase product demand. Demand forecasts per channel do not exist as the system works mainly through a push supply system. There is no data on the discontinuation and switching of FP methods at the time of writing. However, a survey of FP methods reported by Falode & Akintaro (2014) in Osun State showed that 19% of women who came for FP use oral contraceptive pills (OCPs), 53.5% uses injectables, 25.9% uses intrauterine contraceptive device, while 1.6% uses barrier method. This indicates that a larger percentage of women use injectables, but this is hardly considered when making investments in FP commodities.[71]

More recently, demand for implants seems to be increasing compared to other methods. This is due to free accessibility and consumer preference such as side effects experienced with other methods and misconceptions. Therefore, stakeholders are making a case for increased investment and accessibility of implants as an effective way of up-scaling FP uptake. This is true as KIIs with some PHCs visited mentioned that 70% of their clients prefer implants to other methods as it was accessed free.

Generally, demand in Osun State varies by geography as the urban areas experience higher demand (due to increased awareness, economic realities of raising children, free services, etc.) compared to the rural areas that experience low utilization (due to inadequate awareness and education especially at the grassroots level, unwanted method side effects, poor access by adolescents due to spousal refusal, stigmatization, cultural/tribal, and religious factors).

Among private health providers, there is a high demand for condoms and OCPs because they are mostly affordable, but a lower demand for IUDs and implants as they are deemed expensive. CPs and PPMVs were unanimous in their views on method-specific demand for condoms, perhaps because this is one of the few methods they are licensed to offer.

Another factor responsible for the low uptake seen in the private health facilities is the lack of availability of skilled healthcare workers to provide more specialized services for implants (based on KIIs and FGDs).

[71]Falode, D.T.; Akintaro, O.A. Methods of Family Planning Used Over a Period of One And A Half Years in Olorunda Local Government Area of Osun State, Nigeria. (2014). Journal of Nursing and Health Science. Volume 3, Issue 2 Ver. II (Mar-Apr. 2014), PP15-19. Available online at: https://www.researchgate. net/publication/272712324_Methods_of_Family_Planning_Used_Over_a_Period_of_One_And_A_Half_Years_in_Olorunda_Local_Government_Area_of_ Osun_State_Nigeria

Market conditions		

| Price | 2 | **Current pricing and/or policies moderately limit competitive and sustainable pricing for many products (via public or private channels) and/or create a moderate barrier to access and affordability for end users.** |
| | | This is evidenced by the price variation between retailers located in lower socioeconomic class communities and higher socioeconomic class communities. The variation is sometimes up to 50% for the same commodities. Most products are available in urban areas but specific commodities like condoms, pills, and injectables are more available at the lower quantile. Commodities are free in public facilities for vulnerable populations on health insurance. However, cost is still a significant consideration for most people when products are not provided by partners for free or paid for by health insurance, or when services are not provided for free by the government of Osun State. |

The KIIs also revealed that consumers within the higher income quantile are mostly willing to pay out-of-pocket for implants and IUDs. In Osun State, the pricing of FP commodities is not regulated by the government, resulting in unregulated markups, especially among private sector players. The major determinant for pricing remains market factors with no plans by the government to introduce any regulatory policy immediately.

Procurement from social marketing brands (DKT) is subsidized because of their affiliations with manufacturers directly, especially for certain commodities. When this is the case, retail prices for products in the private sector seem affordable across various FP commodities. Retail PPMVs have reduced markup as compared to bigger pharmacies and private hospitals that may have markups up to 50% due to transport, offloading, marketing, and other operational costs which create barriers to access services by their customers. Sometimes, the price fluctuations between the different brands of the same FP products are between 50 to 100% and can even be as high as 150%.

The PPMVs from the table below have the cheapest retail prices, generally because most procurement is from CPs as well; hence transport costs are reduced. Also, there is reduced overhead cost of outlets. The outlets have no staff as they are exclusively managed by the owner. Private hospitals and CPs, on the other hand, have huge dispensing prices mostly due to logistics costs from distributors, such as transportation and offloading costs. Marketing costs and profit margins are added as well to the FP products, resulting in this disparity in pricing shown in the table below.

Table 3. Average end-user prices[72]

Commodity	PPMVs	Pharmacies	Private Hospitals
Condoms	₦260 ($0.56)	₦540 ($1.17)	₦466 ($1.01)
OCPs	₦350 ($0.76)	₦550 ($1.19)	₦800 ($1.74)
Injectable	₦350/vial ($0.76/vial)	₦800/vial ($1.74/vial)	₦1000/vial ($2.17/vial)
IUDs	₦3000 ($6.51)	₦3500 ($7.60)	₦3500 ($7.60)
Implants	₦3500 ($7.60)	₦4000 ($8.69)	₦5000 ($10.86)

[72]Data from CPs, PPMVs, and private hospital

Market conditions		
Quality	3	**There are moderate concerns about the quality of products in the national market, but they are specific to a known subset of products and ongoing policy efforts may address these.** The quality of SRH products in the market is within acceptable standards, as the NAFDAC and SON are responsible for ensuring the quality of FP products at the national level before they are distributed to states. Pharmacy Council of Nigeria is a Federal Government parastatal that is instrumental in regulating and controlling pharmacy education, training, and practice of technicians and PPMVs. PCN conducts supportive supervision of PPMVs and CPs in the State. The LMCU in the State also performs visual inspection of commodities in various facilities in the State to check expiry dates, batch details, and storage conditions. In some instances, where commodities are not obtained from the central pool, there could be moderate concerns on the quality of products in the market. On a few occasions, scarcity of Depo-Provera resulted in an influx of generic product as an alternative. Demand therefore increased for Noristerat, another injectable with a lower price, resulting in an influx of products that may not be regulated. Healthcare providers in the public sector and some private sector players (SMOs, NGOs, and FBOs – particularly those that receive donor funds that support QA) are aware of best practices in quality management. However, communicating the quality of FP products to consumers does not form a significant part of current demand-creation efforts. State actors believe that improved funding, personnel skilled in QA, and stronger security mechanisms will further improve product quality. During FGDs the majority of respondents felt that practicing infection prevention and control demonstrated a good quality of service. Participants who attend public facilities felt that seeing the healthcare worker open a sealed product before product administration represented good quality, compared to private health facilities which sometimes dispense products from unsealed packages. FGD respondents also associated good quality with feeling lesser side-effects. In addition, participants in public facilities mentioned that some healthcare workers show clients product expiration dates. Furthermore, respondents also expressed that when their preferred SRH method works it translates to good quality. Respondents who utilized private health facilities associated good quality with the cost of the method, with higher prices translating to better quality.
Product Adoption	2	**Current products in the national market may not meet consumer needs, as there are insufficient mechanisms to consider if or when new/additional products may be needed, as well as unclear processes to identify, evaluate, and budget for the introduction of additional products.**

Market conditions

Currently in Osun State, there is no structured mechanism to consider new or additional products. A lot of the products available in both public and private health facilities are dependent on the donations received from the FGON and donors at the national level. There is seldom any opportunity to forecast based on consumer needs, as consumer needs are met from available commodities through a push system. There is little investment in the field of research, especially for innovations in technology that can identify, evaluate, or budget for the introduction of additional products. However, some of the investments that have been made by development partners include SFH, which conducted a program in the State involving the training of youths and adolescents on self-administration of DMPA-SC.

Innovative products in the state introduced by DKT were OCPs Desofem (desogestrel and ethinylestradiol combination), Dianofem (cyproterone acetate and ethinyl estradiol combination).

In the first 3 months the provider administered DMPA-SC to 625 clients, of which 200 opted for self-injection, and 68 clients were new acceptors. However, there is still a need for continued efforts towards increasing research opportunities that cater to the development of new products based on consumer needs.

Annex 4 - Lagos HMF scores

Criteria	Score /5 (FP products)	Score /5 (Safe motherhood products)	Supporting information
Market foundations			
Market Data	3	3	Quality SRH data is available on the State DHIS2 for the public and private health facilities registered on the platform. From April to June 2023, the reporting rate of public and private health facilities in Lagos was 96.9%, while timely reporting rate was 89.9%.[73]
			Retail pharmacies and patent medicine vendors are primarily supplied by social marketers but do not report FP data, except for those in the IntegratE project. The State has access to FP data collected by the IntegratE project. However, this is not integrated into the State or National DHIS2. DHIS2, by design, is of limited utility in monitoring and analyzing State or overall national markets and understanding real-time consumer insights and needs. The system is also not designed as a forecasting tool.
			The inclusion of private health sector data (e.g., consumption trends, pricing, etc.) in State forecasts and budgetary estimates is limited, although this is the major source for healthcare services. Key gaps exist in data harmonization and sharing amongst partners for optimal visibility. For instance, SMOs were initially reticent in sharing their data because of fears of empowering competitors with vital information that could result in losing market share.
			Lagos State is often a focus state for several surveys including the Performance Monitoring for Action (PMA) surveys, which is a valuable data source. Consumer insights across population segments on SRH products was limited in Lagos to inform forecasting and planning.
Analytical Tools	3	3	There is a relatively good capacity for routine data analysis, HMIS reporting, and quantification in the public sector. However, this is insufficient to fully understand the market barriers and inform interventions.
			There is limited capability for analyzing high-risk populations and dynamic market trends, triangulating multiple data points (e.g., from states and funders/technical partners), and drawing inferences to mitigate supply gaps and build investment cases to sustain SRH investments. These gaps relate to unclear systems and personnel capacity to triangulate data from various sources. Lagos State routinely convenes partners for programmatic reviews. However, there are missed opportunities to harmonize results amongst partner programs and ensure access to the State's data dashboard.

[73]District Health Information System (DHIS2) platform. https://dhis2nigeria.org.ng/

Market foundations			
Market Management	3	3	The State boasts a strong leadership which prioritizes strategic investments in health system components. The MOH has an organizational architecture with departments, agencies, and institutional arrangements (TWGs, coordination platforms) responsible for procurement, supply chain management, and regulation. It ensures the harmonization of these functions across national, State, and local government levels. The Lagos State Ministry of Health (LSMOH) has a TWG for reproductive, maternal, newborn and child health (RMNCH) which is divided into two sub-TWGs (Safe motherhood and FP). The TWG comprises public and private sector representatives and development partners. Various working groups or committees, such as RHTWG, Procurement Supply Management (PSM) TWG, and LMCU, collaborate during the annual quantification process; RHTWG has the largest number of partners. However, there is limited capacity to manage the SRH market at all levels. There are still gaps in coordination of partner interventions to minimize duplication and achieve better synergies. There is a need to strengthen institutional capabilities for key market functions and address the gaps in coordinating and standardizing quality services across both public and private health sectors.
Market Institutions	2	2	Government institutions have capacity challenges in financing, procurement, supply chain and regulation. Lagos enjoys a rich presence of partners in the SRH ecosystem, however current program priorities of development partners may not align with those of the Government which include supply of commodities, capacity building of service providers and demand generation. Lagos state relies on the national contraceptive supply mechanism which is largely donor-dependent however external funding from donors has dwindled and federal funding since 2020 has been non-existent. Government typically channels most commodities supplied to public health facilities. These provide a wider scope of commodities from short-acting to long-acting reversible contraceptives. The private sector relies mainly on social marketers for supplies and usually stocks mostly short-acting reversible contraceptives.

Market foundations

			There are several regulatory bodies in place including PCN, which regulates the practice, the products, and the premises of the CPs and the PPMVs, and the NAFDAC which regulates the quality of products in both the public and the private sectors, but they struggle to keep up with the large numbers of private providers. The decline in the Government of Nigeria's contribution to financing FP procurement has shown that FP commodity supply and security is a major challenge. Supply chain disruptions due to shocks have resulted in a scarcity of SRH commodities, contributing to the FP supply challenge. However, the advent of the Sustainable Drug Revolving Fund (SDRF) has made maternal supplies affordable and accessible. LMCU generally has a strong capacity for quantification, but a major challenge that it faces is the dearth of data from the private health sector. The State still struggles with engaging the private sector, especially in FP programming, due to limited supplies and inadequate private sector technical competencies. Currently, there is no entity at the state level with the capacity to review new products or set market strategy and objectives by SRH product category. Despite the advantages of better health infrastructure and high numbers of qualified human resources in Lagos State, the mass exodus of health workers from brain drain poses a significant challenge to the State.

Market conditions

Financing	2	4	Lagos State depends mainly on the national contraceptive basket managed jointly by the UNFPA and the Federal MoH for FP products. However, donor and federal government's contributions to the basket has dwindled in recent years, due to shifting priorities and global economic challenges. According to data from UNFPA, funding decreased from US$25 million in 2020 to US$35 million in 2022, representing a 40% reduction. UNFPA has partnered with suppliers to offer competitive negotiated prices on commodities and low overhead rates to boost procurement capacity.[74] State counterparts confirmed the existence of the State Donor Resource Mobilization Fund for health interventions; however, FP products are not prioritized for these resource mobilization efforts with high net worth individuals, corporate social responsibility programs and foundations. Government has integrated SRH (FP and MCH) services in the benefit package and is providing the insurance coverage for the poor, vulnerable and key populations.[75] Donor financing for SRH services dwindled considerably amidst shifting priorities and global macroeconomic headwinds.

[74]UNFAP. (2021). Available online at: https://www.unfpa.org/sites/default/files/pub-pdf/Welcome_to_the_UNFPA_Supplies_Partnership_2021-2030.pdf
[75]Health Policy Plus. (2022). Available online at: http://www.healthpolicyplus.com/NigeriaHlthIns.cfm

Market conditions			
			According to the most recent PMA data, 73% of public facilities in Lagos State ordered FP commodities but did not receive them, with approximately 11% of public facilities experiencing an unexpected increase in consumption. This indicates a decline in federal supplies to the state due to a tighter fiscal space despite increased population demands. SMoH respondents stated that there is no fiscal space to fully take over the procurement of FP supplies, which are more expensive than maternal supplies. There is also the likelihood of these commodities being more costly without the pooled procurement mechanism of UNFPA. Without the current subsidies, many clients may be unable to buy FP commodities. Maternal supplies are affordable and accessible through the Lagos State SDRF, retail pharmacies, and health facilities. Unlike LARCS, they are mostly one-off costs.[76] "SDRF has a percent markup for the commodities. SDRF monitoring is done. The percent markup for the MNCH commodities is 5%" (RH Coordinator, LSMOH).
Supply	2	4	A major challenge with supply security is inadequate and unreliable funding to procure FP commodities. Development partners have supported the State to make these commodities available in the past, but commodity supply is not high enough to meet the current demand. The national supply chain for most SRH products experienced long recovery times to respond to shocks, as observed during the COVID pandemic. For instance, in 2021, the first tranche of FP commodities (triannual distribution) arrived in the third quarter. Global supply chain disruption during the COVID-19 pandemic resulted in supply unavailability. This is worrisome because there are no local or regional manufacturers of FP commodities and any disruptions of the global supply chain would affect commodity security in Nigeria. The investment climate and unpredictable demand does not encourage prospective local players to consider the production of FP commodities. Moreso, FP commodities are procured through a pooled procurement mechanism (by UNFPA) from WHO prequalified pharmaceutical manufacturers. However, the extended stock-out of DMPA-SC in 2020 led to the entry of alternative brands into the market. Notably, there was parallel importation and distribution of a brand produced in Pakistan without the unique code required for authenticity verification.

[76]PMA Nigeria (Lagos), 2022

Market conditions			
			"Unfortunately, the commodities are not enough, wecan barely get what is required in the public sector, and we can't fund the private sector right now" (RH Coordinator, SMoH) New health channels and models may impact equitable access, affordability and quality. Innovative online marketplaces also run social media adverts for FP commodities. However, there is the risk of access inequities due to the limited internet connectivity and smartphones, low literacy, and high costs for those slums. Although Lagos has the highest number of health start-ups (and entrepreneurs) and service outlets, it is unclear if these address price-related inequity issues, or if quality is consistently monitored.
Consumer Demand	1	4	Stakeholders scored consumer demand for FP products low at one out of five, but ascribed demand for maternal health commodities a rather high score at four out of five. According to the NDHS 2018, the mCPR of Lagos State is 29.0%, which is higher than the national mCPR of 12.0%; total demand for FP among married women/in unions aged 15 – 49 years is 65.9% (met need for FP commodities is 49.4% and the unmet need for FP commodities is 16.5%).[77] Similarly, the MICS 2021 reported the total demand for FP among married women/in union in Lagos as 59.8% (met need for FP commodities is 46.2% and the unmet need for FP commodities 14.6%).[78] Despite the higher met need amongst women married/in unions, findings reveal that actual adoption of modern contraceptive methods amongst women is considerably lower (mCPR of 29%), hinting at reduced met need amongst unmarried women and adolescents. Donor funding of FP demand generation activities has reduced significantly in recent years and there is little or no funding from the Government stakeholders opined that the high rural-urban migration to Lagos is considerably decreasing mCPR gains because new migrants may still retain their cultural beliefs and practices without sustained awareness and behavior change communication interventions. According to the 2018 National Demographic and Health Survey, 89.5% of these women did not receive FP information or counseling, even though they had contact with a fieldworker or health worker in a health facility within the 12 months preceding the survey.[79] This finding implies a significant missed opportunity to educate and support women in making informed decisions about FP. Lack of access to FP information and counseling may contribute to unintended pregnancies and limit women's ability to make choices about their reproductive health.

[77-79] National Demographic and Health Survey. (2018).

Market conditions			
Price	2	4	From the KIIs, stakeholders confirmed that in the public sector, FP products are free while MCH products are provided at cost with a 5% mark-up. These products are generally affordable but perhaps not at prices that the government can sustain. There may be a need for more differentiated price structures based upon ability to pay. Steady dips in donor funding risk tilting the balance of SRH services towards the private sector, where there is price heterogeneity and high reliance on out-of-pocket payments, against relatively small state health insurance coverage (~800,000 enrollees).
			The Consumers' Market for Family Planning (CM4FP) study used multi-round longitudinal data collected over three quarters from 2019 to 2020 across 672 outlets (public and private health facilities, PPMV and CPs) in Lagos, Kaduna, Niger and Abia. It found high price variability between and within private contraceptive vendors in the selected FP markets. The study recommends further research on consumers' exposure to, and experience of, contraceptive price volatility; corresponding impact on access, method choice, initiation and continuation, and outlet selection; and the potential of market-shaping interventions to stabilize private sector prices.[80]
			Current macroeconomic dynamics worsened by the fuel subsidy removal and naira devaluation may potentially reduce 'individuals and families' ability and willingness to pay for SRH services, especially in the private sector. An SMO that shared its price list starting in January 2023 (including sale price and recommended retail price) had increased the prices of some commodities on its website by November 2023 (e.g., a month's supply of a OCP increased by 40% from 250 Naira to 350 Naira).
			All respondents opined that free FP commodities are unsustainable and that the Government could not afford to cover the costs if donors withdrew funding completely.
			"Service delivery is expensive, and the reality is we are not paying what we should be paying for service delivery and the public sector is heavily subsidized by the government" (RH Coordinator, LSMoH).

[80]Rothschild CW, Hu B, Archer J, et al. Differences in contraceptive prices between and within family planning outlets in urban and semiurban Nigeria: a prospective cohort study. Am J Obstet Gynecol Glob Rep 2022;2:100131.

Market conditions			
Quality	3	3	A major NAFDAC Operational Centre, which drives all related QA activities at federal level is located in Lagos. There is capacity within the State to run quality tests on commodities at the State Drug Quality Control Laboratory. Maternal supplies purchased by the State are routinely tested, but FP commodities received from FMoH are not tested, based on their expressed trust in the UNFPA procurement mechanism. There are moderate concerns about the quality of SRH products in the open market, but these are specific to a known subset of products, and ongoing policy efforts may address them. The replacement of thermolabile oxytocin by a newer analogue carbetocin, with greater biological effect, longer half-life and which is more heat-stable was cited as an example during the HMF workshop. Most SRH stakeholders concurred that decentralized state-led procurement from the weakly regulated private sector could contribute to substandard products appearing in the market.
Product Adoption	3	4	The FMOH coordinates the introduction and adoption of new SRH products with support from implementing partners and donors. Lagos State is a priority state for FP interventions and clinical trials because of its unique status as the most populous, cosmopolitan and richest state in Nigeria. The State Ministry of Health (SMOH) respondents affirmed that the state is open to testing and adopting innovative ideas and products. An example is the intrauterine system (IUS) which is undergoing review and trials. DKT also recently introduced a new diaphragm into the market.

Annex 5 – Ekiti HMF scores

Criteria	Score /5	Supporting information
Market foundations		
Market Data	3	RIRF, NHMIS tools, DHIS2, SRH Monthly Commodities Consumption, and NHLMIS are the data sources for the public sector and the Ekiti State Ministry of Health (ESMOH) There is private sector data for a few health institutions, but most other private institutions lack such data. Even though some private sector data exist, the availability of this data is limited and is usually not shared nor available in any open-access database. There is no data on the private sector to show the variability of price for SRH products within the public and private sectors. However, the products are free in the public sector, while consumers pay out-of-pocket in the private sector. There is sufficient data to guide SRH demand and supply forecasting in the public sector in Ekiti State; data in the private sector are usually not available for this purpose.
Market Analytics	2	DHIS2, NHLMIS, and the FP Dashboard are the analytical tools available that support overseeing program and supply chain performance. Market analytics related to financial and supply scenario planning or evaluating equity of availability or pricing by channels either does not exist or is not routine. These tools are used mostly for the public sectors due to the limited availability of private sector data. There is no interaction between the private and public sectors. Opportunities to share tools and develop market-based tools are currently not present.
Market Management	2	Marie Stopes Nigeria Reproductive Choices, Rotary International, and Hacey Initiative are some of the partners in the State. These partners are involved in creating awareness of FP products, with a few supplying commodities, such as condoms, to their programs. Ekiti State Government does not have supply agreements with any suppliers for any specific product; products are obtained from the FMOH. The partnership between these private sector players and the SMOH is facilitated through the RHTWG committee. These actors seldom review the state of the market. The coordination between the public and private sectors is also not effective.

Market foundations

Market Institutions	2	The institutions that are involved in the management and delivery of FP services include the SMOH, SPHCDA, private and public health facilities, other health agencies, and NGOs. There are no known functional policy instruments to optimize equitable access to SRH products and services in the State. The regulatory agency in the State is NAFDAC, which has made some routine visits to a few private and public institutions in the last couple of years, though not very frequently - probably due to inadequate personnel and logistics. The last time NAFDAC visited was in 2020. Nevertheless, the FP commodities have NAFDAC certification and registration numbers. Coordination of new FP products is usually initiated by the importers in collaboration with NGOs who are involved in FP activities. QA tests are carried out at the point of entry and ports before the products are allowed into the country.

Market conditions

Financing	1	The government budgetary allocation for the past 5 years was ₦1 milion in 2018, ₦10 million in 2019, ₦5 million in 2020, ₦8.3 million in 2021 and ₦10 million in 2022. However, none of this money has been released, despite the budget being informed by the forecasts and product procurement plans. About half a million units of contraceptive products are requested yearly in the state but these are usually not met. FMOH provides SRH financing for products and provides commodities predominantly paid for by donors.
Price	2	The purchase price per unit of the various FP products in the public sector is not available, as it is not purchased by the State Government and is provided freely by the FMOH. Data for purchasing FP products by the private sector is not available. In the public sector, consumers receive FP products for free and may need to pay for consumables. Different healthcare providers and hospitals subsequently bill patients various amounts (ranging from ₦100 [$0.23] to ₦3000 [$6.98]) based on the non-availability of consumables. This cost is not fixed but is determined by each of the healthcare providers and renders the supply of SRH commodities in public health facilities not totally free to the consumers. In the private sector, consumers must pay out-of-pocket and the price of the commodities is uniform and standard irrespective of the wealth quantile of the user as these providers generally do not get reimbursed by the Basic Health Provision Fund or health insurance mechanisms. The price of a condom in the private sector ranges from ₦100 (PPMV) to ₦500 (hotel & supermarket). Consumers report that the cost is not a deterrent to use and they would be willing to pay more.

Market conditions		
Supply	2	SRH commodities in the public sector in Ekiti State are mainly supplied by UNFPA through the FMOH, and by partners such as Marie Stopes Reproductive Choices, Rotary International, and SOML. Commodities in the Ekiti State FP store include condoms (male and female), injectables (Depo-Provera, Noristerat), implants (Implanon, Jadelle), pills (Microgynon, Exluton), and IUDs (Copper T and hormonal IUDs). High donor dependence is leading to a risk in supply security. Supplies by FMOH in the last 2 years have reduced and the State was advised to buy commodities. SOML intervention has also stopped while Marie Stopes Reproductive Choices and Rotary International have been consistent with supply over time, even though this is usually tied to outreach programs. There are currently no SRH product manufacturers and, to the best of our knowledge, there are no policy enablers to optimize local production of SRH products in the State. The FMOH supplied the State with SRH products, but there were periods of stock-outs due to reduced supply from the FMOH. Regarding the supply of commodities by the private sector, Marie Stopes Nigeria Reproductive Choices is the only private partner that supplies consumables to some health facilities, except for Rotary International which supplied hormonal and Copper IUDs and COC pills, for this year only other NGOs help in capacity building. There is no current plan for the use of diversification strategies (such as multiple suppliers registered, multi-supplier awards, etc.) in the State.
Consumer Demand	2	The unmet need for FP in the State is 18.2%, this is slightly less than the national value of 18.9%.[81] The met need for FP is 38.5% while the total demand for FP is 56.7%.[82] The demand for SRH products is higher than the supply, especially in the public sector. This demand for SRH products from the health facilities is lower than the expected demand, using the population (number of women of reproductive age) of the catchment areas covered by the health facilities. It is possible that the populations that were not coming to the public health facilities were patronizing the private sector or not using FP services. Demand in the state has been increased by the awareness created by the State AIDS Control Agency (SACA) and NGOs such as Marie Stopes Reproductive Choices, and Rotary International. Also, the high demand for products in the public sector may be due to the fact that FP commodities are free in the sector. Condoms are the most demanded/utilized FP products in Ekiti State's public and private markets. Other products in high demand include implants and injectables. The factors responsible for SRH method discontinuation in the state are availability, willingness for a child, and side effects. The SRH method/products with the highest discontinuation rate are injectables, usually because of the side effects, and DMPA-SC, due to availability.

[81-82]National Demographic and Health Survey 2018

Market conditions		
Quality	2	The quality of SRH products and services is adequate, due to the routine capacity building and training of healthcare providers, especially in the public sector. There is limited capacity in terms of manpower and other resources of the local regulatory agencies including NAFDAC. Data on quality from the private sector is not available. However, quality in the private sector may be lower than in the public sector due to poor regulation of the sector in the State.
Product Adoption	2	There is limited innovation on SRH products and services in Ekiti State. Few innovations such as selling of FP commodities (condoms and Postinor2) on social media platforms, such as WhatsApp and Instagram, have been documented. Ekiti State has no specific policy for new product adoption. New product introduction in the State is usually led by the FMOH and the hormonal IUD was the last product to be introduced. The FMOH launched this product in various states as well as conducted capacity building for healthcare providers. However, demand among users has been very low.

Annex 6 - Kaduna HMF scores

Criteria	Rating /5	Supporting information
Market foundations		
Market Data	2	Availability of quality, comprehensive and routine data is fair, although this is only used to monitor, analyse and shape the public sector markets, and data on consumer needs and insights is not available. Quality, comprehensive, and routine data exists for some private sectors (e.g., SMOs, NGOs, FBOs, and the commercial sector) on sales, service provision, and consumer insights, for example, but this is not publicly shared. Data for other key private sector players, such as PPMVs (who represent over 40% of SRH market), is not readily available. As private sector data is not shared externally, it is difficult to quantify where there are gaps in the private sector. This ultimately limits whole market perspectives and, as such, all market plans are exclusively based on public sector data. This, in turn, results in other market inefficiencies and shortcomings.
Market Institutions	2	Limited market functions including procurement, supply chain, policies and regulations are in place but are not implemented in a way that is supportive of a comprehensive market approach and meeting consumer needs. There are several regulatory bodies in place, including PCN, which regulates the practice, the products, and the premises of the CPs and the PPMVs, and NAFDAC. However, they struggle to keep up with the large numbers of private providers. There are numerous issues with supplies which undermine the institutional base. The state's procurement agency is budgeting and willing to procure products but the needed collaboration with the federal level to enable procurement has not occurred.
Market Analytics	3	There are some capacities for analytical tools and funding to support demand forecasting and quantification process (such as the DHIS2), and some technical analysis to understand barriers. However, these are focused exclusively on the public sector. Some analytical tools and systems are in place for many of the private sector players (especially SMOs, NGOs, FBOs, and the commercial sector) but these are mainly for internal market planning, although there are some efforts to support analytical tools and systems for PPMVs. While some tools and systems exist, none can analyse the market holistically. Tools are siloed and largely used to understand the public and private sector separately. There is very limited or no sharing of analytical tools and, as the sharing of private sector data with the public sector is very limited, and engagements between the private and public sector are also limited, opportunities to share and develop tools do not currently exist.
Market Management	1	There is minimal or no coordination and organization by the government among key players in the market to agree on market strategy, fund analysis and interventions, and deliver action. Some platforms support partnerships between the public sector and some private sector players, such as the RHTWG, the forecasting and quantification coordination forum, and others relating to policy and planning. However, these are generally not effective and exclude the private partners.

Market conditions		
Financing	1	There is insufficient financing to meet system demand and financing is subject to frequent shocks and unpredictability. Although SRHR products were budgeted for in 2019, 2020 ($126,220:00), 2021 ($315,550:00), and 2022 ($126,220:00), only in 2022 was the budget released, and the products are not yet purchased. The public sector is completely dependent on one supplier based on donor funding (UNFPA/the Federal MoH) which does not include the private sector. State's budgets are often not released, so funding for much of the supply is weak (and assumedly for other aspects such as regulation and quality).
Price	3	Current pricing and policies moderately create a barrier to access and affordability for some end users. Affordability is not an issue per se, as commodities at public facilities are free of charge, if available (based on the existing policy for public sector procured methods). However, the imposing of 'service fees' potentially restricts access for some consumers. Private sector prices are also quite affordable as the profit markups for contraceptive products at even the most expensive shops are not above 30%. Although there is no local policy on private sector pricing, day-to-day experience of private sector distributors enables them to realize price thresholds above which consumers cannot afford. Prices for products in the private sector seem affordable. Most brands are comparatively cheap (around N500 and rarely above N1,000:00, approximately $2.25) even in shops that reach higher and lower socio-economic groups.
Supply	1	There are extended gaps in supply availability to meet currently forecasted demand. Method-specific shortages and stockouts persist (due to financing constraints), contributing to barriers to access at the point of service. Kaduna State product supply for SRH products is volatile, severely affected by shocks, and limited to the public sector only. In some instances, not all the quantities supplied to the state warehouse are distributed to the facilities because of a lack of a budget line for last-mile distribution. In all private shops, Depo Provera is largely not available. A generic version of Depo is available, where the original Pfizer version is not on the shelves. DMPA-SC was widely available too.
Consumer Demand	1	The overall system is far from meeting the needs of consumers across geographies and channels, and demand for SRHR products is always higher than the supply in Kaduna's public sector. Several funded private sector organizations and NGOs focus heavily on increasing the demand for SRH in the state. Demand forecasts per channel do not seem to exist. Subsidies in the private sector help to increase demand for products. No data on discontinuation and switching of FP methods is being maintained by the SMOH.

Market conditions		
Quality	2	There are moderate concerns about the quality of many products in the national market, although without objective evidence. The quality of SRHR products at public facilities is judged to be reasonable due to provider training and the centralized source of products through UNFPA. Health care providers in the public sector and some of the private sector players (SMOs, NGOs, and FBOs – essentially those that receive donor funds that support QA) are regularly trained and updated on best practices around SRHR services. No insights into the quality of services in private facilities are available. Although regulatory bodies are present, there are limited policy interventions to address quality concerns.
Product Adoption	3	Kaduna has been a state where new products and service models have been introduced first. For example, Kaduna is one of the first states to scale up the use of DMPA-SC and PPMVs participation in providing longer-acting contraceptive methods. The state's primary care agency has a committee that works on the introduction of newer products.

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ACKNOWLEDGEMENT

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