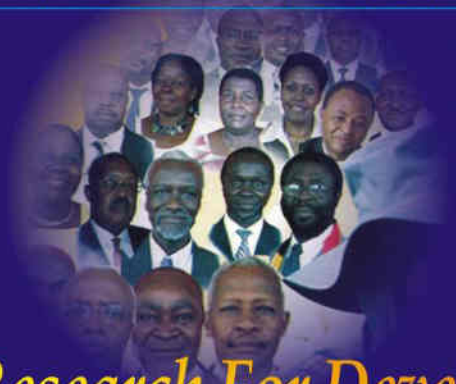
CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT (CPED)



CPED-Research For Development News

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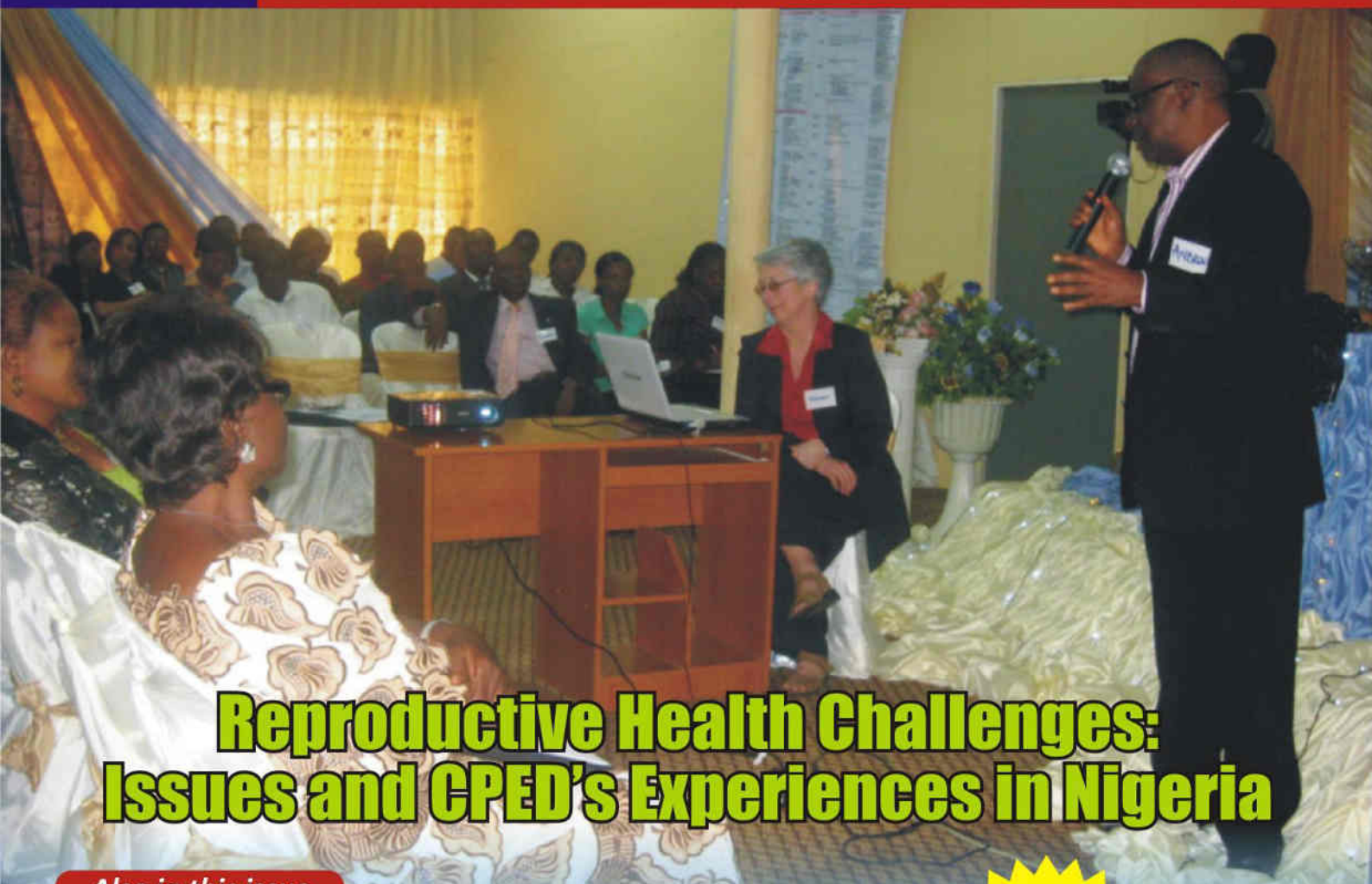

Reproductive Health Challenges: Issues and CPED's Experiences in Nigeria

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This Publication is supported by the *Think Tank Initiative Programme* initiated and managed by the *International Development Research Centre (IDRC)*

About CPED

The Centre for Population and Environmental Development (CPED) is an independent, non-partisan, non-profit and non-governmental organization dedicated to promoting sustainable development and reducing poverty and inequality through policy oriented research and active engagement on development issues. CPED started as an action research group based in the University of Benin, Benin City, Nigeria in 1985. The action research group was concerned with applied research on sustainable development and poverty reduction challenges facing Nigeria. The research group also believed that communication, outreach and intervention programmes, which can demonstrate the relevance and effectiveness of research findings and recommendations for policy and poverty reduction, especially at the grassroots level, must be key components of its action research. In order to translate its activities more widely, the Benin Social Science Research Group was transformed into an independent research and action Centre in 1998. It was formally registered in Nigeria as such by the Corporate Affairs Commission in 1999.

The establishment of CPED is influenced by three major developments. In the first place, the economic crisis of the 1980s that affected African countries including Nigeria led to poor funding of higher education, the emigration of academics to advanced countries which affected negatively, the quality of research on national development issues emanating from the universities which are the main institutions with the structures and capacity to carry out research and promote discourse on socio-economic development. Secondly, the critical linkage between an independent research or think tank organisation and an outreach programmes that translates the findings into policy and at the same time test the applicability and effectiveness of the recommendations emanating from research findings has been lacking. Finally, an independent institution that is focusing on a holistic approach to sustainable development and poverty reduction in terms of research, communications and outreach activities is needed in Nigeria. CPED recognises that the core functions of new knowledge creation (research) and the application of knowledge for development (communication and outreach) are key challenges facing sustainable development and poverty reduction in Nigeria where little attention has been paid to the use of knowledge generated in academic institutions. Thus, CPED was created as a way of widening national and regional policy and development debate, provide learning and research opportunities and give visibility to action programmes relating to sustainable development and poverty reduction in different parts of Nigeria and beyond.

The vision is to be a key non-state actor in the promotion of grassroots development in the areas of population and environment in Africa. The overall mission is to promote action-based research programmes, carry out communication to policy makers and undertake outreach/intervention programmes on population and environmental development in Africa.

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Editorial Policy of CPED's Research for Development News
CPED-RDNews

CPED's Research for Development News (CRDN) is the official publication of the Centre for Population and Environmental Development (CPED). Through this medium, CPED seeks to reach out to relevant policy makers and other stakeholders on key issues concerning development in Nigeria in particular and other parts of Africa in general.

Vision: CRDN seeks to inform, educate and report development issues and challenges as well as the progress in the research and outreach activities of the Centre for the consumption of policy makers, other stakeholders and the reading public in its quest to promote sustainable, holistic and grassroots development.

Mission Statement: To provide a medium for drawing the attention of policy makers, other key stakeholders and the general public to the issues and challenges of development and the policy response needed to promote equitable development.

Core Values: The two core values of CRDN are derived from those of CPED. The first relates to the fact that the universal ideals of intellectual and academic freedom is promoted and respected by CRDN. In this respect CRDN will remain an independent, professional and development newsletter. Secondly, CRDN is a non-partisan newsletter which is not associated with any political party or organization. However, when the need arises, CRDN in its publication of CPED's research, advocacy and outreach activities will address key political issues that have considerable impact on development, especially at the local level.

Editorial Board: The Editorial Board of CRDN shall be made up of CPED's Executive Director, two professional staff of CPED and two other members from outside CPED comprising mainly of CPED Fellows.

Editorial Policy: While CRDN will report on any development issue and the various activities of CPED, CRDN will, as much as possible, focus on a particular development theme in one edition. The theme to be addressed in a subsequent edition shall be announced for the benefit of contributors in advance.

Adverts: There shall be created in every issue, a space for advertisement. The cost of the advert placements shall be determined by the Editorial Board.

Manuscript submission: Persons interested in contributing to any edition of CRDN are welcomed to do so. Manuscripts should be original with a maximum length of five pages typewritten with double-line spacing and accompanied with biographical sketch of the author which must not be more than fifty words. Each article should be typed on A 4 paper with a margin of one inch round. Manuscripts already published elsewhere shall not be accepted.

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Editor's Note

Professor Emeritus Andrew G. Onokerhoraye, Ph.D., OON, JP
Editor

The *Centre for Population and Environmental Development* (CPED) is pleased to launch its *Research for Development News*, with support from the *Think Tank Initiative* initiated and managed by the *International Development Research Centre (IDRC)*. *CPED's Research for Development News (CRDN)* series is published twice a year in June and December. The series will report on the research, communication and intervention activities of CPED with the major aim of informing policy makers and other key stakeholders on development issues as well as informing key stakeholders on CPED's activities on research and intervention. In this respect the editorial policy of *CPED's Research for Development News* is to focus on one major development issue in each number of CRDN.

This June 2011 edition of CRDN is focusing on *Reproductive Health Issues and Challenges in Nigeria.* Despite Nigeria's commitment to the improvement of health care including SRHR, the outcomes remain extremely poor. On the basis of international, official and other statistical reports, the current reproductive health situation in Nigeria can be summarised as follows: The average Maternal Mortality Ratio (MMR) figures for Nigeria are 800 to over 1,700/100,000 live births with a life time risk of 1:14-16. These figures make Nigeria second only to India. Even though Nigeria makes up about 2 per cent of the world's population, she contributes 10 per cent of the world's maternal deaths. In Nigeria only 60% of women have received antenatal care at least once from a trained health care provider and two thirds of Nigerian women deliver outside of health institutions and without medically skilled attendants present. The Total Fertility Rate (TFR) in Nigeria has remained persistently high at a national average of about 5.7 children per woman. Nigeria has one of the lowest levels of family planning use in Africa with 12% of the women using some form of family planning and only 8% using modern method. The reproductive health status of the Nigerian adolescent is poor, and for many reasons, the average age at first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls. With about 33% of Nigeria's 140 million people classified as youths between the ages of 10 and 24, lack of sexual information and services places these young people at risk for pregnancy, abortion, sexually transmitted infections (STIs), infertility and HIV/AIDS. In Nigeria, various cultural practices such as female genital mutilation, early and forced marriage, and gender-based violence are still common. Improving the SRHR situation therefore requires the participation of the civil society.

This edition of CRDN focuses on key issues and challenges facing the promotion of reproductive health in Nigeria. CPED acknowledges the financial support of the *International Development Research Centre* (IDRC) for the project titled "HIV Prevention for Rural Youth: Mobilizing Nigerian Schools and Communities" and the *European Commission* for the project titled "Building civil society capacity for advocacy on Sexual and Reproductive Health and Rights in Nigeria" which provided most of the conceptual and practical experience reported in this newsletter.

Professor Emeritus Andrew G. Onokerhoraye
Editor,
June, 2011

PERSPECTIVES ON REPRODUCTIVE HEALTH ISSUES AND CHALLENGES IN NIGERIA

Nigeria was among the 179 countries that were signatories to the RH policy document that emanated from the *International Conference on Population and Development* in Cairo in 1994. Nigeria was also a signatory to the UN *Millennium Development Goals (MDGs)* of 2000. Nigeria also signed the *Abuja Declaration* of 2001 in which African countries pledged to set the target of allocating at least 15% of their annual budget to the improvement of their health sector. In 2001, the Federal Government in Nigeria developed a *National Reproductive Health Policy* that identified the RH needs of its citizenry. As a follow up on this, the *National RH Strategic Framework and Plan of Action* was conceptualised to complement the policy, with the aim of translating the policy into actionable plans.

Despite Nigeria's apparent interest in the improvement of the country's health care situation including SRHR, the outcomes remain extremely poor. On the basis of international, official, research findings and other statistical reports, the current reproductive health situation in Nigeria can be outlined as follows: The average Maternal Mortality Ratio (MMR) figures for Nigeria are 800 to over 1,700/100,000 live births with a life time risk of 1:14-16 (compared with 1 in 2800 in developed regions). These figures make Nigeria second only to India. Even though Nigeria makes up about 2 per cent of the world's population, she contributes 10 per cent of the world's maternal deaths. In Nigeria only 60% of women have received antenatal care at least once from a trained health care provider and two thirds of Nigerian women deliver outside of health institutions and without medically skilled attendants present. Also, 17% of women have no assistance during delivery and 26% are assisted by untrained persons. The Total Fertility Rate (TFR) in Nigeria has remained persistently high at a national average of about 5.7 children per woman. Among the reasons for this high TFR is the low contractive prevalence rate (CPR). Nigeria has one of the lowest levels of family planning use in Africa with 12% of the women using some form of family planning and only 8% using modern method. Twenty-six per cent of women aged between 15-49 years have an unmet need for family planning. Only 35% of women aged 19-24 years are aware of contraceptives.

The Reproductive Health (RH) status of the Nigerian adolescent is poor, and for many reasons, the average age at first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls. With about 33% of Nigeria's current 140 million people classified as youths between the ages of 10 and 24, it has been postulated that by 2015, the number of Nigerian youths would have exceeded 67 million. Lack of sexual health information and services places these young people at risk for pregnancy, abortion, Sexually Transmitted Infections (STIs), infertility and HIV/AIDS. The proportion of sexually active teens (15-19) using contraception is 39/47% (Male/Female). Nigerian adolescents face reproductive and sexual health risks with over 16% of teenage females reporting first intercourse by age 15, the national mean age for sexual debut M/F is 20.3/17.8. Much of the acceleration in the spread of HIV among women has taken place among adolescents as young women are particularly susceptible to HIV infection. Nigeria's STD/HIV Control Report estimates that more than 60% of new HIV infections occur in youth ages 15-24 years. In Nigeria, early and forced marriage, are still common. Among women ages 20 to 24, 19.8% reported having married by age 15, 39.6% by age 18, and 52.7% by age 20. Among men ages 25 to 29, 15.5% reported having married by age 20 (National Population Commission, 2003). There is emerging evidence that early marriage brings increased vulnerability to HIV infection. One study found that one-third of women obtaining abortions in Nigeria were adolescents and hospital-based studies showed that up to 80% of Nigerian patients with abortion-related complications were adolescents.

Nigeria is characterized by different types of harmful practices that impact reproductive rights and gender. The most common includes, Female Genital Mutilation (FGM), early marriage as noted earlier, the various taboos or practices which prevent women from controlling their own fertility, nutritional taboos and traditional birth practices. Others are male child preference and its implications for the status of the girl child, female infanticide, early pregnancy and dowry price. The prevalence of FGM is more than 50% in Nigeria and being the country with the largest number of women in Africa, it has the second largest number of women who have undergone the procedure (estimated to be about 64 million in 1998) (IAC Nigeria, 1998). Despite their harmful nature and their violation of international human rights laws, such practices persist because they are

not questioned and take on an aura of morality in the eyes of those practising them.

Although the *National Reproductive Health Policy* and the *Strategic Plan of Action* indicate Nigeria's recognition of the health challenges of its young people, a lack of sufficient political will and resources prevent the policy from being translated into operational plans and programmes at the state and local levels. To date, there is little evidence that any of the 36 states and 774 Local Government Councils in the country has formulated specific policies aimed at promoting young adult and adolescent reproductive health. On its part the Federal Government has not fairly concentrated on all the components listed in the *National RH Strategic Framework and Plan*. The Safe Motherhood Initiative and the Family Planning Programmes have not received the much expected priority and more importantly, many of the activities have been donor-driven. Other components of RH such as harmful traditional practices and screening of genital malignancies have also not received the needed drive in Nigeria. Most attention focused on the elimination of harmful practices were funded by donor organisations and operationalised by NGOs. The challenges facing the successful implementation of RH programmes/services in Nigeria are in folds and these may hinder the country from achieving the set goals of universal access to RH information and services by all in 2015. The way forward for the Nigerian weak RH services/programme is a renewed effort in terms of political support and priority at all tiers of governance, a review and wide distribution of RH services, especially to the users on the fields, better marching of policies with implementations in terms of funding and necessary leadership, periodic monitoring and evaluation of available services and legislative back-up of many SRHR issues that are begging for attention. It is in this context that local CSOs have major roles to play in advocacy to policy makers at all levels of government in Nigeria. Advocacy is critical in efforts to ensure that adolescent and sexual health programmes are enacted, funded, implemented, and maintained. To be able to do so Nigerian CSOs must acquire the necessary advocacy skills which the proposed project attempts to provide.

FERTILITY LEVELS AND THE UNDERLYING FACTORS IN NIGERIA

The findings of the National Demographic and Housing Survey (NDHS) carried out in 2008 provide some recent data the different components of the reproductive health situation in Nigeria. Current fertility rates for the three years preceding the 2008 NDHS survey indicate that the Total Fertility Rate is 5.7 births per woman. This means that, on average, a Nigerian woman will give birth to 5.7 children by the end of her childbearing years. The current TFR of 5.7 is the same as that reported for the 2003 NDHS. Fertility peaks in age group 25-29 with 265 births per 1,000 women and declines thereafter. The general fertility rate is 194, which means that there were 194 births for every 1,000 women during the three-year period preceding the survey. The crude birth rate was 40.6 per 1,000 people for the same period. Generally some slight differences exist on fertility levels among the different states in Nigeria.

The age at which childbearing commences is an important determinant of the overall level of fertility as well as the health and welfare of the mother and child. In some societies, the delay of first births as a result of an increase in the age at marriage has contributed to a decrease in fertility. The 2008 NDHS survey shows that the median age at first birth for women age 25-49 in Nigeria is between 18 and 22 years. The survey shows that 9 percent of women age 25-49 have given birth by age 15 and 47 percent have become mothers by age 20. Comparing the proportions of women who have given birth by age 15 across age groups provides another way to view trends in age at first birth over time. Whereas 3 percent of women age 15-19 gave birth by age 15, the corresponding proportion for women age 45-49 is 9 percent. This reduction in the percentage of women giving birth early supports the findings that age at first childbirth has been increasing gradually in the country.

Teenage pregnancy is a major health concern because of its association with higher morbidity and mortality for both the mother and child. Additional childbearing during the teenage years frequently has adverse social consequences, particularly regarding educational attainment, because women who become mothers in their teens are more likely to curtail their education. According to the 2008 NDHS survey the proportion of women age 15-19 that have begun childbearing is highest in Bauchi with 41.3 per cent followed by Adamawa with 19.2 per cent. The proportions are lowest in Edo with only 2.3 per cent, Ondo with 6.5 per cent and Rivers with 8.6 per cent. A larger proportion of teenagers in rural areas have begun childbearing compared with teenagers in urban areas. Teenagers with no education are more than twice as likely to start childbearing early as those with primary education.

Family Planning in Nigeria

Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods. This section presents results from the 2008 NDHS with respect to the ten target states on a number of aspects of contraception including knowledge of specific contraceptive methods, attitudes and behaviour regarding contraceptive use, ever use and current use, sources of contraceptive methods, and cost of methods. The focus in this presentation is on women who are sexually active because these women have the greatest risk of exposure to pregnancy and the need for regulating their fertility. However, the results of interviews with men are presented alongside those with women because men play an equally important role in the realisation of reproductive health and family planning decisions and behaviour.

Information on knowledge and use of family planning methods was obtained from female and male respondents by asking them to mention ways or methods by which a couple can delay or avoid pregnancy. If the respondent failed to mention a particular method spontaneously, the interviewer described the method and asked whether the respondent had heard of it. For each method known, respondents were asked if they had ever used the method. Respondents who reported ever use of family planning were asked whether they or their partners were using a method at the time of the survey. Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilisation, male sterilisation, the pill, intra-uterine device (IUD), injectables, implants, male condom, female condom, diaphragm, foam/jelly, Lactational Amenorrhoea Method (LAM), and emergency contraception. Methods such as rhythm (periodic abstinence) and withdrawal are grouped as traditional methods.

The findings of the survey show that knowledge of any contraceptive method is widespread among the sample households in the Nigeria. However, the proportion of men that have heard of any method of contraception is higher than that of women. Generally most people now have information on modern methods of contraception. Traditional methods are becoming obsolete in many of these states hence knowledge of their existence is drastically reduced among the people.

Information on the prevalence of current contraceptive use among women age 15- 49 is also the most widely used and valuable measure of the success of family planning programmes. Furthermore, it can be used to estimate the reduction in fertility attributable to contraception. The Contraceptive Prevalence Rate (CPR) is usually defined as the percentage of currently married women who are currently using a method of contraception. Generally, the overall contraceptive prevalence among all women in Nigeria is 15 percent. The use of any family planning method increases with age from 7 percent among women age 15-19 to 20 percent among women age 35-39, and then declines to 10 percent for women age 45-49. Most women currently using contraception use a modern method (11 percent), while 5 percent are using traditional methods. The male condom is the most commonly used modern method (5 percent), followed by the injectables and pills (2 percent for each), while the IUD, and female sterilisation are the least used modern methods (less than one percent each). Among the traditional methods, the rhythm method and withdrawal are the most commonly used (2 percent each).

The most commonly used modern method among currently married women is injectables (3 percent), followed by the male condom (2 percent), while the rhythm method is the most commonly used traditional method (2 percent). Among sexually active unmarried women, the most commonly used modern method is the male condom (35 percent), followed by the pill (4 percent), while the rhythm method and folk methods are the most widely used traditional methods (7 percent each). As expected, the use of modern family planning methods is higher for sexually active unmarried women than for currently married women (61 percent versus 15 percent). The most notable difference among these two groups of women is that 35 percent of sexually active unmarried women use male condoms, compared with 2 percent of married women.

The contraceptive prevalence rate for modern methods has increased from 6 percent in 1990 to 13 percent in 2003, and to 15 percent in 2008. There are remarkable variations across the states from the overall national pattern. For example it was reported that the use of any method of contraception is higher in Abia (23.9%) Akwa Ibom (32.7%), Cross River (20.1%), Edo (31.6%), Ondo (21.2%) and Rivers (27.2%). On the other hand, Adamawa, Bauchi and Kogi have less than 10 per cent of their women using any method of contraception. With respect to the use of any modern method of contraception, the same states, Abia, Akwa Ibom, Cross River, Edo, Ondo and Rivers have a higher proportion of their women using modern method of contraception compared with the other states.

Information on where women obtain their contraceptive methods is useful for family planning programme managers and implementers for logistic planning. The

2008 NDHS survey shows that for users of modern contraceptive methods, the private medical sector is the most common source (60 percent). Less than one-quarter (23 percent) of current users of modern methods obtain their method from the public sector mostly public government hospitals (12 percent). Other sources are used by 13 percent of users of modern methods. With respect to cost, women using modern methods of contraception were asked how much they paid in total the last time they obtained their method. The findings indicate that among respondents who use modern contraceptive methods, 7 percent got their method for free and 28 percent did not recall how much they paid for their method.

An important indicator of the changing demand for family planning is the extent to which non-users plan to use contraceptive methods in the future. Currently married women who were not using a contraceptive method at the time of the 2008 NDHS survey were asked about their intention to use family planning in the future. The findings show that 21 percent of currently married non-users intend to use a method of contraception in the future, 23 percent are unsure of their intentions, and 55 percent have no intention of using any method in the future. The proportion of women who intend to use a contraceptive method varies with the number of living children they have. For instance, the proportion of currently married women who intend to use contraception is 15 percent for women with no children, 25 percent for women with two children, and 23 percent for women with three children.

The media can be a major source of family planning messages. Information on the level of public exposure to a particular type of media allows policymakers to use the most effective media for various target groups in the population. To assess the effectiveness of such media on the dissemination of family planning information, all respondents in the 2008 NDHS were asked whether they had heard or seen family planning messages on the radio, on television, or in a newspaper or magazine in the few months before the survey. Exposure to family planning messages is more common among men than women and is more common in urban areas than rural areas. Among the zones, women in South West and men in South East have the highest exposure to family planning messages through any media. The more education a respondent has, the greater the likelihood that he or she has been exposed to family planning messages through each of the three types of mass media. Media exposure also increases with increasing wealth quintile for both women and men. Women were asked if they had listened to specific radio programmes or watched specific programmes on television within the past six months.

In the 2008 NDHS, women who were not using any family planning method were asked whether they had been visited by a health worker who talked with them about family planning in the 12 months preceding the survey. This information is especially useful for determining whether family planning outreach programmes are reaching non-users. Non-users were also asked if they had visited a health facility in the past 12 months for any reason other than family planning, and if so, whether any health worker at the facility had spoken to them about family planning. These questions help to assess the level of so-called "missed opportunities" to inform women about contraception. At the national level, the findings show that 4 percent of non-users reported discussing family planning when a fieldworker visited them. Six percent of non-users reported that they had visited a health facility and discussed family planning, while 13 percent of the non-users visited a health facility but did not discuss family planning.

Staff at health facilities are more likely to discuss family planning with women age 20-39 than with younger women age 15-19 or older women age 44-49 years. Overall, the majority of non-users (92 percent) did not discuss family planning with a fieldworker or at a health facility during the 12 months prior to the survey. The proportion of women who were visited by a fieldworker is twice as high in urban areas as in rural areas (6 versus 3 percent, respectively). Similarly, women in urban areas are more than twice as likely as women in rural areas to visit a health facility and discuss family planning (9 versus 4 percent, respectively). Women with higher levels of education and those in higher wealth quintiles are more likely to visit a health facility and discuss family planning with a provider than women with less education and those in lower wealth quintiles. Table 29 which presents findings with respect to the ten target states confirms the national pattern in that the proportion of non-users who contacted family planning providers were insignificant in all the states.

The 2008 NDHS survey asked married women whether their husband or partner knew that they were using a method of family planning. The findings at the national level show that 84 percent of currently married women age 15-49 who are using a method reported that their husband or partner knows about their use of contraception, 7 percent reported that their husband or partner does not know, and 9 percent reported that they were unsure whether their husband or partner knows about their use of contraception. Women with the highest educational attainment (91 percent) and women in the highest wealth quintiles (88 percent) are most likely to share information about their method choice with their husband or partner.

Maternal Health in Nigeria

Proper care during pregnancy and delivery is important for the health of both the mother and the baby, and is an indicator of the status of maternal and child health in the society. The 2008 NDHS obtained information on the extent to which women in Nigeria receive care during pregnancy, during delivery, and in the period after the baby is born. These findings are important to policymakers and programme implementers in designing appropriate strategies and interventions to improve maternal and child health care services.

The major objective of antenatal care is to ensure optimal health outcomes for the mother and the baby. Antenatal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Antenatal care provided by a skilled health worker enables: 1) early detection of complications and prompt treatment (e.g., detection and treatment of sexually transmitted infections); 2) prevention of diseases through immunisation and micronutrient supplementation; 3) birth preparedness and complication readiness; and 4) health promotion and disease prevention through health messages and counselling of pregnant women. In the 2008 NDHS, women who had given birth in the five years preceding the survey were asked a number of questions about maternal care. For the last live birth in that period, mothers were asked whether they had obtained antenatal care during the pregnancy. For women with two or more live births during the five-year period, data refer to the most recent birth. According to the World Health Organisation (WHO), a skilled health worker is "an accredited health professional such as a midwife, doctor, or nursewho has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-partum period, and in the identification, management, and referral of complications in women and newborns". WHO further states that Traditional Birth Attendants (TBA), trained or untrained, are excluded from the category of skilled health workers. In this context, the term TBA refers to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth, and the postnatal period.

The findings of the 2008 NDHS shows that 58 percent of women age 15-49 received Antenatal Care (ANC) from a skilled provider (doctor, nurse/midwife, or auxiliary nurse/midwife) during their last pregnancy. Thirty percent of women received ANC services from a nurse or midwife, while 23 percent received ANC services from a doctor. Three percent of women received ANC services from a traditional birth attendant, and 36 percent did not receive ANC services at all. Mother's age at birth is related to use of professional antenatal care services, increasing from 45 percent among women under age 20 at the time of the birth to 61 percent among women age 20-34, and then declining to 55 percent among older mothers age 35-49. Child's birth order is inversely related to the use of antenatal care. Women with higher order births are less likely to receive antenatal care from a skilled professional. The findings further show that 64 percent of women pregnant with their first child received antenatal care from a skilled health worker, compared with 47 percent of women with births of other six or higher.

The proportion who obtained ANC services from a skilled health worker is higher among women residing in urban areas (84 percent) than among women who reside in rural areas (46 percent). Mother's education is directly associated with increased use of a skilled health worker for ANC services. Almost all women (97 percent) with more than secondary education received ANC from a skilled health worker, compared with 31 percent of women with no education. Furthermore, women with more than secondary education are much more likely to receive ANC services from a doctor (68 percent) than their

counterparts with no education (7 percent). Similarly, women in the higher wealth quintiles are more likely than women in the lower wealth quintiles to visit a skilled health provider or a doctor for ANC services.

The antenatal care policy in Nigeria follows the newest WHO approach to promote safe pregnancies, recommending at least four ANC visits for women without complications. This updated approach, called Focused Antenatal Care (FANC), emphasises quality of care during each visit instead of focusing on the number of visits. Early detection of problems during pregnancy leads to more timely treatment and referrals in the case of complications. This is particularly important in Nigeria, a large country where physical barriers are a challenge to the health care delivery system. In Nigeria, the provision of ANC is in transition from the traditional approach to the FANC approach. The new schedule of visits is as follows: the first visit should occur by the end of 16 weeks of pregnancy; the second visit should be between 24 and 28 weeks of pregnancy; the third visit is at 32 weeks; and the fourth visit takes place at 36 weeks. However, women with complications, special needs, or conditions beyond the scope of basic care may require additional visits.

Findings on the number of and timing of visits show that forty-five percent of women who had a live birth in the five years preceding the survey reported visiting antenatal clinics at least four times during pregnancy, and 8 percent reported two or three antenatal visits during their last pregnancy. While 2 percent of women had just one antenatal care visit, 36 percent did not receive any antenatal care. The findings also show that only 16 percent of women had their first antenatal visit in the first trimester of pregnancy; about 45 percent had their first ANC visit before six months of pregnancy, and 15 percent of women had their first antenatal visit between their sixth or seventh months of pregnancy. The median number of months of pregnancy at the first ANC visit is five months. Differentials do not vary much by urban and rural residence. There was no substantial change in the proportion of women receiving no antenatal care between the 2003 NDHS (37 percent) and the 2008 NDHS (36 percent), and the median gestational age at the first visit has remained the same at 5 months over the five-year period.

The content of antenatal care is an essential component of the quality of services. Focused antenatal care hinges on the principle that every pregnancy is at risk of complications. Therefore, apart from receiving basic care, every pregnant woman should be monitored for complications. For that reason, ensuring that pregnant women receive information on the symptoms of complications or the danger signs of pregnancy, and screening for complications should be routinely included in all antenatal care visits. To assess ANC services, the 2008 NDHS respondents were asked a number of questions about the care they received during pregnancy for their most recent live birth. The findings of the survey at the national level on the content of ANC services, including the percentage of women who took iron tablets or syrup, who took intestinal parasite drugs, who were informed of the symptoms of pregnancy complications, and who received selected routine services during ANC visits for their most recent birth in the past five years show that for each of the specified components of antenatal care, women in urban areas were more likely to receive the component than women in rural areas. Looking at the specific ANC components, 54 percent of women took iron supplements during pregnancy. Mothers age 20 or older were more likely to take iron supplements than their younger counterparts. Women with six or more children were less likely to take iron supplements (45 percent) than women having five or less children.

There is marked variation by urban-rural residence in the proportion of women who took iron supplements (77 percent in urban areas compared with 44 percent in rural areas). The percentage of women who took iron supplements increases with level of education and wealth

quintile. As a component of antenatal care, the administration of intestinal anti-parasitic drugs is less common than the administration of iron supplements. Ten percent of women took drugs to combat intestinal parasites during their last pregnancy. There is variation in the use of de-worming mediations during pregnancy by mother's age, birth order, residence, education, and wealth quintile. Women in urban areas (12 percent) are more likely than women in rural areas (9 percent) to have taken drugs to prevent intestinal parasites during their last pregnancy. Women with more than secondary education (15 percent) and women who are in the fourth and highest wealth quintiles (about 14 percent) are more likely than other women to have taken drugs to prevent intestinal parasites. Three in five women who received antenatal care during their last pregnancy were informed of the symptoms of pregnancy complications.

The 2008 NDHS survey also shows that women whose age was under 20 years at the time of the most recent birth and those with sixth- or higher-order births are less likely than other women to receive information on pregnancy complications during antenatal care. Women in urban areas are more likely to receive such information than those in rural areas (71 percent compared with 54 percent). More than eight in ten women who received antenatal care were weighed (87 percent) and had their blood pressure measured (85 percent), while about 75 percent of women had urine and blood samples taken. Blood testing is of particular importance in the screening for maternal syphilis, HIV, and anaemia.

Increasing the percentage of births delivered in health facilities is an important factor in reducing deaths arising from the complications of pregnancy. The expectation is that if a complication arises during delivery, a skilled health worker can manage the complication or refer the mother to the next level of care. The findings of the survey relating to the proportion of all live births in the five years preceding the survey by place of delivery, and the percentage of births delivered in a health facility, show that thirty-five percent of births in Nigeria are delivered in a health facility; 20 percent of deliveries occur in public sector facilities and 15 percent occur in private sector facilities. Three in five births (62 percent) occur at home. By age, women 20-34 are most likely to deliver in a health facility (38 percent). Women having their first baby are more likely than other women to deliver in a health facility; the proportion of births occurring in a facility decreases sharply as birth order increases. Women in urban areas are more than twice as likely to deliver in a health facility as their rural counterparts (60 percent compared with 25 percent). Women with higher levels of educational attainment are more likely to deliver in a health facility than women with less education or no education. For example, women with more than secondary education (90 percent) are nine times more likely to deliver in a health facility, compared with women with no education (10 percent).

The proportion of births occurring in a health facility increases steadily with increasing wealth quintile, from 7 percent of births in the lowest wealth quintiles to 80 percent among those in the highest quintiles. Similarly, 5 percent of births to mothers in the lowest wealth quintiles occur in a public health facility, compared with 37 percent among births to women in the highest wealth quintiles. Women in the highest wealth quintiles are the only group more likely to give birth in a private facility than in a public facility (42 percent compared with 37 percent, respectively). The majority of women who received no ANC services delivered at home (96 percent).

In addition to place of birth, assistance during childbirth is an important variable influencing the birth outcome and the health of the mother and infant. The skills and performance of the person providing assistance during delivery determine whether complications are managed and hygienic practices are observed. The findings at the national level show that 39 percent of births in the five years preceding the survey were assisted by a skilled health worker (doctor, nurse, midwife, or auxiliary nurse/midwife); 9 percent by a doctor;

25 percent by a nurse or midwife; and 5 percent by auxiliary nurse/midwife. In the absence of a skilled health worker, a traditional birth attendant was the next most common person assisting a delivery (22 percent). Nineteen percent of births were assisted by a relative or other person, and an equal proportion of births were attended by no one. Women under age 20 (25 percent) are least likely to receive assistance from a skilled provider at delivery. Older women (35-49 years) are most likely to deliver without any assistance (25 percent).

A large proportion of maternal and neonatal deaths occur during the first 24 hours after delivery. Thus, prompt postnatal care is important for both the mother and the child to treat complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. It is recommended that all women receive a health check within three days of giving birth. The 2008 NDHS survey shows that more than half (56 percent) of women did not receive any postnatal care; however, 38 percent received a postnatal check-up within two days of delivery, and 3 percent of women had a check-up 3 to 41 days after delivery. Mothers age 20-34 and mothers who gave birth to their first child are most likely to receive postnatal care within the first four hours after giving birth (20 and 33 percent, respectively). Urban women are twice as likely as rural women to receive a postnatal check-up in the first four hours after delivery (44 percent compared with 22 percent). Almost six in ten women (59 percent) in urban areas obtain postnatal care within the first two days after delivery, compared with three in ten (30 percent) women in rural areas. As with other health services surrounding childbirth, better educated and wealthier mothers are more likely to receive a postnatal check-up within the first two days after delivery.

Information on type of provider performing the first postnatal check-up is important because the skills of a provider determine the ability to diagnose problems and to recommend appropriate treatment or referral. The survey shows that thirty-two percent of women received a postnatal check-up from a doctor, nurse, or midwife, 3 percent from auxiliary nurse/midwife, and 7 percent from a traditional birth attendant. Urban women and those who are better educated are more likely to receive postnatal care from a doctor, nurse, or midwife after delivery. For example, 56 percent of women in urban areas received postnatal care from a doctor, nurse, or midwife, compared with 22 percent of women in rural areas.

Many factors can prevent women from getting medical advice or treatment for themselves when they are sick. Information on such factors is particularly important in understanding and addressing the barriers some women face in seeking care during pregnancy and at the time of delivery. In the 2008 NDHS, women were asked whether each of the following factors would be a big problem in seeking medical care: getting permission to go for treatment, getting money for treatment, distance to health facility, transport cost, not wanting to go alone, concern that there may not be a female provider or any health provider, and concern that drugs may not be available. The findings on the extent to which women reported that each of these factors was a serious problem for them in accessing health care shows that three-quarters of women reported that they have at least one serious problem in accessing health care. The leading barrier to health care for Nigerian women is getting money for treatment. Fifty-six percent of women said that getting money for treatment was a serious problem in accessing health care. Forty-one percent of women said they were concerned that there would be no drugs available at the health facility. About one in three women reported that transportation, distance to the health facility, and not having a provider to attend to them are big problems. Twenty-one percent of women were concerned that there would be no female provider to attend to them. Not wanting to go alone (17 per cent) and problems getting permission to go for treatment (14 per cent) were less likely to be reported as a hindrance to seeking health care.

Promoting the Sexual Right and Voice of Women in Nigeria

At each stage of life individual needs on sexual reproductive health differ. Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems. The highest attainable level of health is not only a fundamental human right for all, it is also social and economic imperative because human energy and creativity are the driving forces of development. Such energy and creativity cannot be generated by sick, tired people, and consequently a healthy and active population becomes a prerequisite of social and economic development.

Reproductive health affects, and is affected by the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills.

Women are the most affected by the greatest burden of sexual reproductive health; they are the risk vulnerable with complications from pregnancy and childbirth, unsafe abortion, contracting of sexual transmitted diseases and reproductive tract infections. Studies have shown that amongst some women of reproductive age face unregulated fertility, maternal mortality and morbidity and sexual transmitted diseases including HIV/AIDS.

Sexual violence, sexual rights, abortion, female genital mutilation, maternal mortality remain the most menacing challenges of sexual reproductive health in Nigeria. Sexual violence against women violates not only their right to bodily integrity and socio-economic empowerment and leadership position but denies them their right to making decision and rightly choosing safe sexual reproductive health delivery service. In the health facility and particularly during armed conflict or other civil disobedience, young women are duly subjected to different forms of sexual violence (work place, institutions of learning and family), ill- health delivery support and treatment and support at socio-economic and political levels. Another prevalent concern is the high incidence of rape among teenagers in higher institution which has made some of these young girls and women to be risk vulnerable to contracting reproductive health infections and HIV/AIDS.

In this context, it is necessary to ensure that identifying key health priorities, the priorities should reflect people's concerns and health needs; for the women there should be focus of assessable health centre, assess treatment and support for women both at rural communities and urban areas in implementing health programmes that poster sexual reproductive health.

Group Photograph of Workshop Participants after training on Advocacy skills in Kogi state

Promoting Reproductive Health Through Advocacy in Nigeria

As part of the efforts to draw the attention of policy makers and other stakeholders to the challenge of sexual and reproductive health care in Nigeria, the *Centre for Population and Environmental Development (CPED)* has embarked upon the empowerment of civil society groups and the media for participation in advocacy activities on sexual and reproductive health in Nigeria. The capacity building activities entailed the training of civil society organizations and media personnel in ten states i.e. Akwa-Ibom, Cross River, Abia, Edo, Kogi, Adamawa, Bauchi, Ondo, Ogun and Rivers.

Training of 400 CSOs and media personnel is part of the objectives of the *Centre for Population and Environmental Development* (CPED) to build CSOs capacity on advocacy for sexual reproductive health in Nigeria. Civil society is one of the three important sectors of society, along with government and business. Civil society is an arena, a forum in which citizens associate to achieve a range of different purposes, some positive and peaceful, some perceived as negative and violent. These organizations have an important role to play, which includes counterbalancing the authority of the state and the government in directing policy. Steps must be taken to recreate an arena for the active development both of the institutions of civil society and of civil society organizations that promote and strengthen advocacy of SRHR. Where the government and civil society organizations are pursuing the same agenda, then the role of the latter is to support and strengthen the government's capacity to advance democratic governance.

However, in order for civil society organization to take up its rightful place in the SRH implementation process, they will need specific skills and capacities in advocacy, organizational management, and health knowledge and data information on sexual reproductive health policy analysis, policy advocacy and lobbying. These skills are essential especially in undertaking independent monitoring, influencing policy and promoting accountability of sexual reproductive health. Additionally, to disseminating information generated under a series of policy advocacy skills workshops, the policy brief with an attempt to highlight key issues in the area of policy advocacy that are important in the context of the sexual reproductive health.

The training empowered civil society groups to use advocacy in advancing and addressing issues on sexual and reproductive health issues and challenges in Nigeria. During the training the NGOs in the different states identified the main challenges facing sexual and reproductive health in their respective states which must be faced. During the training workshop, participants had the opportunity to learn and share experiences regarding effective strategies for policies and programming for advocacy at reducing the lapse attention and capacity paid on sexual reproductive health delivery services in Nigeria. Important issues touched on in the training covered conceptual areas of reproductive health. These conceptual areas were presented in sessions which presented an opportunity for participants to explore concept areas for advocacy through a critical analysis of gender, culture and rights in its relation with health delivery service of sexual reproductive health, emphatically on women and young girls.

The participants' knowledge of reproductive health issues and challenges were not only enhanced during the training but the necessary advocacy skills were imparted on them. The majority of the group rated the sessions of the training "very in depth and useful". Many of the participants mentioned that the training has given them the knowledge grasp on advocacy strengths, managing organization objectives toward a healthy environment, and using local resource to create awareness outreach activities on sexual reproductive health and also to use the data from the presentations in the training to support their coverage and awareness action for the advocacy of sexual reproductive health. Stories and experiences were shared by the trainees on the challenges which sexual and reproductive health faces in most states and communities in Nigeria.

The training met participants' expectations. Most of the participants rated the training workshop excellent and all said it was well organized. They found the contents of discourse in the sessions excellent whilst considering the faculty of the knowledge of the facilitators excellent. All participants believed they acquired new knowledge

and skills to help them improve their work and the deplorable condition of the health environment across the states in Nigeria. All the topics in the training were found useful to almost all participants. They expressed and recognised the expertise of the trainers and the ability to express views and knowledge vividly to be better understood. But some of the participants felt that they would like more of these training for them to learn, network with other CSO and media participants as so much is to be learned but the time period was short.

Some of the participants expressed their views on the workshop saying:

"I am already sharing knowledge with my colleagues via calls on each day of sessions; am becoming sensitive to sexual right from the women perspective".

"I now realize the urgent task placed on us to spur action work with the state house and policy makers to engage them into policy programmes for the development of the health environment in Nigeria"

"I am now changed in my focus; advocacy is the key to making the stakeholders and Government to stand up towards facing the challenges of SRH".

"Coming from a journalism background, reporting news has now become more than just reporting, it's now investigative and in-depth knowledge for awareness to be known and change to be born".

"The collective experience from other participants in the workshop will push forward more activities of CSO and partnership with media in influencing strategic health programming and activities on maternal mortality, sexual violence and rights, abortion and other perceived challenges hindering health delivery of SRH".

The empowered civil society and media organizations have since embarked on advocacy activities in the ten states covered in the programme.

Challenges of Sexual and Reproductive Health Rights (SRHR) in Some Nigerian States as Identified by Trainees on Advocacy Activities

In Bauchi State, trainees identified illiteracy as a big challenge to the promotion of sexual and reproductive health because illiteracy prevents people from getting effective access to information and awareness campaigns on issues relating to reproductive health. The trainees also identified low uses of antenatal services as a big challenge. This, the trainees argued, has prevented the none-users of antenatal services from getting basic information relating to reproductive health.

A critical challenge facing SRHR has to do with misplaced priorities by managers of health funds. Funds are channelled towards areas where they are not immediately needed. Relatively, this is lack of will by the politicians to substantially allocate adequate funding to the health sectors. A general challenge of SRHR to the entire society has to do with the poverty of the citizens. With limited purchasing powers, most citizens find it extremely difficult taking care of their feeding, shelter needs and having something left for medical care. This prevents a large number of people from accessing and using a wide range of reproductive health services.

Curiously, SRHR services provision in Bauchi state in the area of belief on myths; a section of the community still believed that the eating of egg will make the children to steal and so such children is deprived a basic ingredient of the nutrient needed for their health growth. In as much, most SRH providers consider some areas too remote to live in and so do not see why they should work in those areas. Thus a large number of people residents in such areas are prevented from having access to SRH services. Similarly, low capabilities of existing service providers are inimical to health development if SRHR services.

As identified in Adamawa State, the alienation of community as well as religious leaders from the design and implementation of SRHR programme has made most people to be skeptical of such programmes making their patronage of such SRHR services very minimal. Simply, the top-down approach to sexual and reproductive health programme has excluded the would-be beneficiaries from the programme.

The governments as well as other health workers have not done enough sensitization on communities to make the people aware of the availability of such reproductive health services. Thirdly, most of the participants believed that government lacks the necessary date in planning for sexual and reproductive health care which makes most

planning about sexual and reproductive health to be based on estimation. Relatively, the issue of access of health information whereby when such information are disseminated, which is usually done in urban areas is to the detriment of grassroots population who equally need such information as the people living in the urban areas.

However, a crucial challenge mentioned is that of infrastructure development. For example, most rural roads are so bad that accessing sexual and reproductive health service is almost impossible. In line with this, medical facilities in most parts of rural areas are not available and if found are most time out of date and not able to keep up with the growing population of such localities. Intricately, the refusal of government to recognize their limitations in sexual and reproductive health services provision is another problem confronting the provisions of SRHR. It is widely believed most of government institutions have become ineffective over time. However, there are known civil society groups with more know-how and commitment that are better placed to deliver SRHR services. So, governments have refused to provide the needed funding to these groups in spite of obvious failures on their part.

As against effective management of SRHR is the challenge of the prevalent traditional practice and persistent ignorance. Most communities do not see why they should change their existing ways of doing things. Differently, most grassroots population are not receptive to changes and as long as they cling to their existing parochial ways/ system of dealing with reproductive issues, getting them to practice modern ways of dealing with SRHR has remained slow.

In Kogi state, the challenge of SRHR goes beyond teenage pregnancy; some of the challenges include;

- Lack of awareness or inadequate knowledge of sexual and reproductive health situations in the state and by the state and non-state sectors;
- Decayed infrastructural facilities at the primary health care units.
- Lack of political will and commitment on the part of key stakeholders particularly government level
- High cost of treatment for maternal cases, especially where it involves surgical operations;
- Poor quality of services including poor treatment by health providers;
- Inadequate and inefficient drug supplies by government and health providers
- Lack of training and re-training of health care professionals in the state;
- Government policies on free health care system in the state not well implemented
- Low quality of care for emergency obstetrics and very low income status of many families;
- Unhealthy cultural beliefs and practices;
- Inadequate funding to carry out programmes in child survivals with poor incentives given to health care providers by Government of Nigeria.

Interactive session by workshop participants to brainstorm on the sexual reproductive health challenges in Edo State

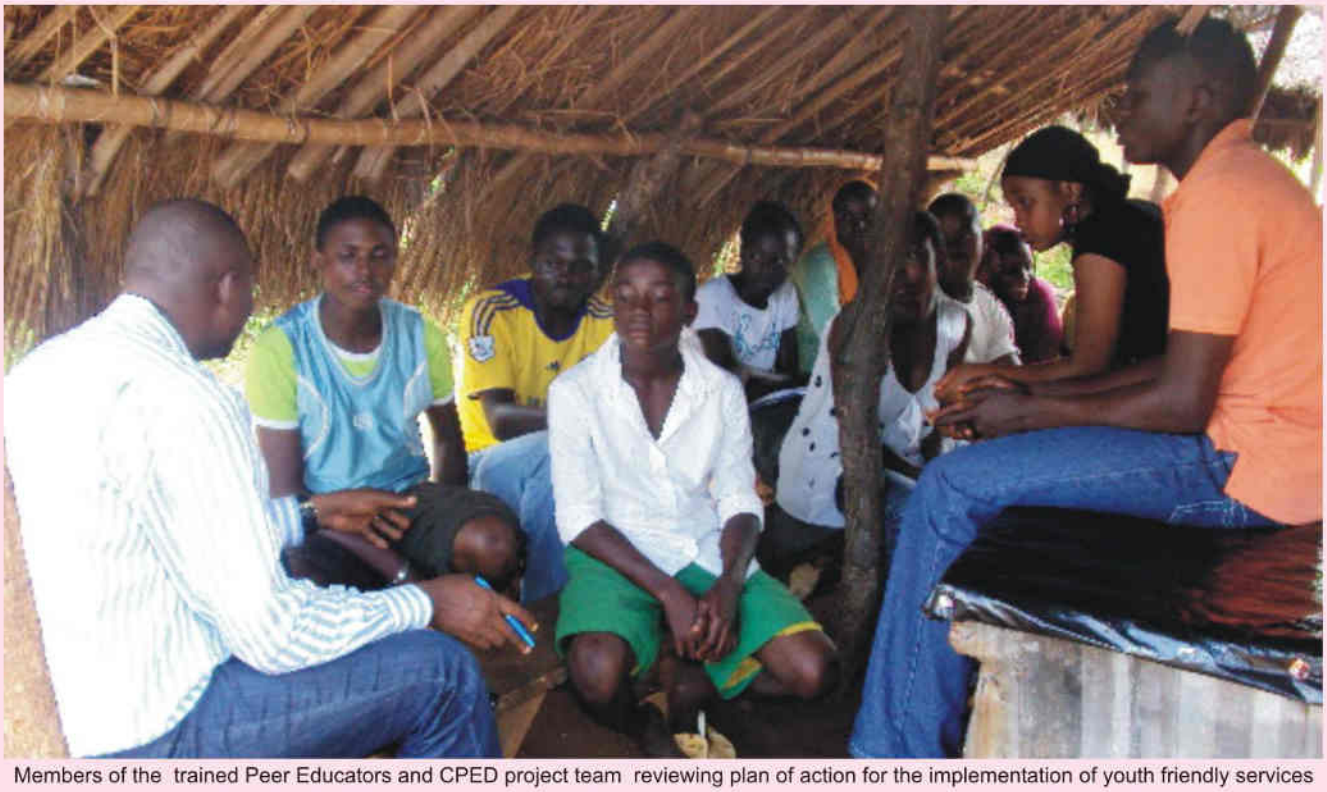
Reflections of Trainees on the level of attention paid by government, stakeholders on Sexual and Reproductive health in Nigeria

The attention being paid to SRH service is not justified; people still engage in unsafe abortion, people are not paying attention to family planning, stigma and discrimination is still very high on PLWHAs and still, people give their children out for early marriage. There is always not enough budget provision to cater for the needs of sexual reproductive health of the populace even the little that is being provided is not properly utilized. For example, in Agbaje community in Kogi state, a baseline survey was carried on family reproductive health which the community development is given to, we used the clinic hall for our focus group discussions and there was only one nurse on duty. We asked why? She said there is nothing to do and she is the only worker in that clinic and that for the past five months she has not received any drug supply from the state Ministry of Health. When some state Ministry of Health workers were asked why? They said Government did not purchase the drugs enough to go round for the whole year. I must say categorically, that attention has not been given to reproductive health service.

Government has not done much in really paying attention to the issue of reproductive health in Nigeria. Even though the Nigerian government was among the 179 united nations that were signatory to the initiative and policy documents on reproductive health, it has not really done much in that area. Most of the rural communities don't have a health facility, and where it is available, it is an empty shed with drugs or personnel to handle health issues in terms of highly qualified gynaecologist or obstetricians. The civil societies have a duty to pull their resources together to draw the attention of the state government to the deplorable situation and urge the government to do more.

In Akwa-Ibom state, attention to reproductive and sexual health by the government has been observed recently that due to poor attitudes toward reproductive health issues, maternal mortality rate seems to be on the high side so with the increase attention to the barest minimum maternal mortality rate. However, the poor health policy implementation of health policies affects reproductive health issues directly or indirectly since a greater proportion of the policy is either fully or partially implemented. Thus, policies that are health related when increased encourage stakeholders in the health sector and boost their research capacity thereby reducing other reproductive health risks.

Suffice to state, other extraneous variables such as spiritual homes, witchcraft, myths have come into play to confuse the people of the female folks from attending modern health facilities where available and also there is the lack of adequate health facilities in the rural areas to attend to those in need during emergencies.



Members of the trained Peer Educators and CPED project team reviewing plan of action for the implementation of youth friendly services

Brief Reports on CPED Activities

Report of the CPED/HP4RY Seminar held in Benin City, Nigeria February 17, 2011

HIV Prevention for Rural Youth in Nigeria (HP4RY) is an action research project funded by the Global Health Research Initiative (Canada) and being delivered by a team of Canadian and Nigerian researchers. The programme which is currently in its 4th year of implementation is one of the key programmes of Centre for Population and Environmental Development (CPED). As part of its programme of activities for the 3rd year of the project, a one day research seminar was organised. The seminar was held on February 17, 2011 at CPED conference hall, Benin City, Nigeria. The theme of the seminar was "**Youth, Sexuality and HIV/AIDS in Nigeria".**

Focus of the Seminar

The one day research seminar provided a forum for researchers, academicians, and community practitioners to exchange information about the latest activities and advances in knowledge to combat HIV and AIDS among Nigerian youths. It also offered a good opportunity for researchers to present their work and to obtain feedback from a group of people who share similar goals of working to achieve healthy communities.

Attendance

Those in attendance include members of the CPED board of trustees; Professor Emeritus Andrew Godwin Onokerhoraye (CPED Executive Director and Principal Investigator, HP4RY); Professor Eleanor Maticka-Tyndale (Principal Investigator, HP4RY and Canadian Research Chair, Social Justice and Health); The honourable Commissioner for Health Edo State, duly represented by Dr. O. A. W. Irowa (director of disease control, Ministry of Health, Edo State); the honourable Commissioner for Education, Edo State, duly represented by Mr. M.O Afekhafeh; Professor T.E. Kubenyije, Former Vice Chancellor, University of Benin and Provost College of Medicine, University of Benin; HP4RY Nigerian and Canadian team members, Professor Felicia Okoro, Dr. Francisca I. Omorodion, Dr. Koki Eghafuna and Felix-Mary Uzochi representing Adenike Esiet of Action Health International (AHI) Lagos; academic staff of University of Benin; HP4RY Project staff; staff of NGOs; representatives from ministries/agencies in Edo State; CPED research assistants; Corpers serving with CPED; students of Social Works in Nigeria (SWIN) etc.

Methods

At the planning phase of the HP4RY seminar call for paper presentation was published and advertised. Invitation to make presentation was sent to researchers, higher institutions of learning, NGOs, health institutions/agencies etc. The seminar started with registration of participants followed by a welcome address by Prof. Gideon. E. Omuta, Chairman Board of Trustees CPED and opening address by Dr. O. A. W. Irowa representing honourable Commissioner for Health, Edo State and Prof. Eleanor Maticka-Tyndale. The opening session was concluded with a Keynote Address delivered by Prof. T.E. Kubenyije, Former Vice Chancellor University of Benin, Benin City.

To make the needed impart and to meet the objective of the HP4RY seminar, two plenary sessions in which papers were presented was adopted. In the **first plenary session** HP4RY PIs and team members Prof. Emeritus Andrew G. Onokerhoraye, Prof Eleanor Maticka-Tyndale and Prof Felicia Okoro, Dr. Francisca I. Omorodion; Dr. Koki Eghafuna took turns to make presentation on the HP4RY project.

Prof Emeritus Andrew G. Onokerhoraye gave a brief overview of the HP4RY project and site selection criteria while Prof. Eleanor Maticka-Tyndale gave an insight of the Research Design and knowledge translation and exchange to stakeholders. Prof.

Felicia Okoro discussed the FLHE component of the project, the experience using schools to combat youth venerability to HIV in Nigeria and its impact on members of the communities while Prof. Francisca Omorodion talked about the experience of HP4RY using National Youth Service Corps members to raise AIDS competence of rural communities in Edo State, Nigeria.

The *second plenary session* witnessed an enthusiastic moment as presenters from higher institutions of learning and NGOs presented papers on different topics followed by questions and comments from the audience. Amongst those that made presentation were: Dr. Odion M. Odaman & Dr. J. E. Ataman from university of Benin who jointly discussed their research on Youth Sexuality and HIV/AIDS Screening Behavior in Edo Central Senatorial District, Nigeria; Ms Bella Aghagba from Association for Child Health who made presentation on her project "Youth for Change". Other presenters were Mr. Sam Ajufoh of Action for Community Development who discussed Sexual Behavior of semi-Urban and rural youth and Universal Access to HIV/AIDS Prevention, Treatment, Care and Support and Mr. Saliu Aidorolo of Ideal Development and Empowerment Agency who discussed on the subject "parent-child communication and mainstreaming HIV programming into local youth structures and activities-vital strategies to HIV prevention among rural out-of-school youth: the Udo experience.

Comments

Mr. Dododawa, Shehu of Edo Broadcasting Service (EBS) commended CPED and University of Windsor for the laudable project. He however appealed that project implementers should take a step further by buying a space in the media house to make these research findings known to the general public. Responding to his statement, Professor Emeritus Andrew G. Onokerhoraye charged the media houses to see it as a social responsibility to transfer information from conferences/workshops like this which is geared towards influencing policies that will bring about good health for all without demanding for payment for airspace.

Professor Emeritus Andrew Godwin Onokerhoraye making a Presentation of the HP4RY Activities During the CPED/HP4RY Workshop

In another statement Mr. Aghedo Collins after thanking CPED for organizing such event stated and I quote; *"I have been watching the slides and listening to all the discussions made so far with keen interest to hear something on the people living with disabilities. Most of these persons are the ones that are sexually abused because of so many reasons. Obvious of these is low self-esteem. Let us pick up and train special people to help inculcate self-esteem on the disabled ones".*

Closing Remarks

In his closing remarks, the CPED Executive Director, Professor Emeritus A. G. Onokerhoraye thanked all delegates for finding time to attend the seminar. He said he was particularly happy with the different presentations by the resource persons and contributions/comments from the audience. He further stressed the need for researchers and NGOs to get together regularly to share experiences of implementing HIV/AIDS programming and other related issues for the common good of the society.

Finally Prof. Emeritus A. G. Onokerhoraye encouraged the media houses to do more in HIV/AIDS awareness creation. He said he hope to organize a workshop for the media houses where they will be educated on the need to spread the message of HIV prevention to the society.

CPED formally concludes its human rights project titled "Enhancing the Capacity of Local Civil Society Groups to Claim Civil and Political Rights in Nigeria's Niger Delta Region"

The project titled "Enhancing the Capacity of Local Civil Society Groups to Claim Civil and Political Rights in Nigeria's Niger Delta Region" financially supported by the European Commission for the period of two years, 2009-2010, to help build the capacity of CSOs to claim their rights in target LGAs of three Niger Delta States was formally and successfully concluded in December 2010. The overall aim of the Project is to improve the civil and political rights situation in Nigeria's volatile Niger Delta region through interventions designed to strengthen the capacity of local civil society organisations and groups to play important roles as civil and political rights claim-holders in their localities. The programme was targeted at fifteen local Government Areas across Bayelsa, Delta and Rivers States. The main activities and achievements are summarised as follows:

Project Team Composition and Briefing Workshop: The inauguration and capacity building of the Project Team members was carried out during the period Monday 29th to Wednesday 31st December, 2009 during which team members were trained and informed on the implementation of the project as the various issues and challenges which they could face during implementation process were discussed and agreed upon.

Mobilisation of key stakeholders in the target communities and other collaborating institutions for participation in the action: The mobilisation of key stakeholders including State and Local Government officials in the three target states and 15 LGAs designed to solicit their support for the project was successfully carried out in the months of January and February, 2009. During the same period the 75 target communities were selected and the target groups, beneficiaries and other stakeholders were successfully mobilised for the action. Finally the identification of 501 civil society organisations and groups that were targeted for capacity building on human rights was carried out.

Constitution and Training of Local Government Project Implementation Committees (LGAPIC) and Community Project Implementation Committees (CAPIC): The constitution and training of *Local Government Project Implementation Committees (LGAPIC) and Community Project Implementation Committees (CAPIC) was carried out in February 2009 during which 750 members were trained on their responsibilities in the implementation of the project activities in their communities.*

Baseline surveys of local CSOs and the situation of civil and political rights in the target LGA/communities: The baseline surveys designed to provide background information on the socio-economic background of the target communities, the local civil society structure and the prevailing situation of civil and political rights were carried out during the months of February, March and April, 2009. The surveys collected data on the challenges and problems of local civil society structure and their capability as well as the nature of the civil and political rights situation in each of the target LGAs/communities. The information collected focused on three major components i.e. socio-economic information, the structure of local CSOs and their needs assessment; and the situation analysis of the civil and political rights.

Holding of stakeholders' workshops on the implementation of the action: The workshops brought together key stakeholders from the various target communities to discuss problems and challenges following the findings of the baseline and needs assessment surveys. The workshop informed and motivated over 1,200 stakeholders in the fifteen LGAs for contributions to the strategies for the implementation of the project.

Civil society capacity building on organisational management: Training Programme: The training of the participating civil society organizations and groups which was designed to strengthen their organisational management capacities was successfully carried out during the months of June to August, 2009 in the 15 target LGAs. This has enabled 750 leaders and representatives of 501 local civil society organisations to acquire the skills to effectively manage their organisations.

Civil society capacity building on civil and political rights: This training of representatives of the participating local organisations on civil and political rights which was designed to enlighten on the key challenges facing civil and political rights in their communities in particular and the Niger Delta region in general was carried out in August to October, 2009. Some

750 leaders and representatives of 501local civil society organisations trained.

Organising community group meetings to raise awareness on civil and political rights: The Organisation of community group meetings to raise awareness on civil and political rights which started on November 2009 led to the training of 7,500 members of the executive of local organizations and the enlightenment of over 998,000 members of the target communities on civil and political rights.

Mobilising and supporting communities and groups to claim their rights: The volunteers mobilized the members of the target communities and support them in claiming their rights whenever such rights are violated. Target community members became conscious of their civil and political rights. Public officials especially the police became careful in handling cases involving individuals in these communities. There was drastic reduction in cases of arbitrary arrests.

Youth leaders who call themselves militants reduced their violation of the civil and political rights of the people in the target communities. Cases of the abuse of civil and political rights were taken up by community volunteers and other leaders to prevent reoccurrence. Some serious civil and political rights violations were taken to the law courts.

Monitoring and reporting human rights violations and responses: The volunteers and members of the *LGAPICs and CAPICs* were trained to work with the CPED/ICWA working in the LGAs to regularly write reports about the human rights situation in their communities. They reported specific violations which occurred in their communities and found ways of handling them. These reports provided information for handling cases of civil and political rights abuses in the target communities.

Sustainability activities: CPED has continued to work with the empowered community-based groups and organisations to promote human rights activities in the target states, Local Government Areas and communities. These empowered groups have become effective agents for the claiming of human rights in the rural communities of the Niger Delta region.

EC Result Oriented Monitoring (ROM) officer, Kemi Okenyodo addressing members of the Community Project Implementation Committee in Oghara, Delta State during her monitoring visit to CPED project sites on the project "Enhancing the Capacity of Local Civil Society Groups to Claim Civil and Political Rights in Nigeria's Niger Delta Region"

CPED continues to make progress in the implementation of its five-year strategic plan

The *Centre for Population and Environmental Development (CPED)* was selected in 2009 as one of the African Think Tanks under the Canada's *International Development Research Centre (IDRC)* Institutions Global *Think Tank Grant Initiative*. IDRC is one of the world's leading institutions in the generation and application of new knowledge to meet the challenges of international development. It is well known that IDRC has worked during the past forty years in close association with researchers in developing countries to build healthier, more equitable and prosperous societies in different countries with considerable success. The institutional grant facility to CPED is a major break through in that it will provide core funding for the research, communications, intervention and capacity building of CPED and its partners.

One major output of the support for CPED under the *Think Tank Initiative* is the formulation of the five-year strategic plan. CPED's Five-Year Strategic Plan seeks to consolidate and build on its modest achievements of the past ten years to make the organisation one of the most unique independent policy research institutions in Nigeria which combines policy-oriented research with communication, outreach and intervention programmes. Under the five-year programme of work, CPED activities will focus on four broad areas reflecting the objectives set for the five-year period i.e. Research; Communications and outreach; Intervention programmes; and Capacity Building of CPED and partners.

Research Activities

In the last eighteen months of 2011which is the second year of the implementation of the strategic plan, CPED core research staff and associates have undertaken research activities and published papers on each of the four research themes being addressed during the period i.e. Growth and equity in Nigeria; Conflict and Development in Nigeria's Niger Delta region; Education and Development in Nigeria; and Health including HIV/AIDS and development in Nigeria. The targets set on the research component of the strategic plan for the first year are being achieved.

Research communications and policy linkage

In the last eighteen months, CPED has intensified disseminating its policy research results through multiple channels and formats including reports, policy briefs for policy makers, a revamped website, and an improved biannually newsletter largely for policy makers. CPED has also organised policy workshops and dialogues on socio-economic development issues, especially in the context of meeting the challenges of achieving MDGs relating to health and education. CPED has also built the capacity of local partners so as to enhance their participation in promoting policy linkage with relevant public and private agencies.

Intervention programmes on key development challenges at the local level

In the last eighteen months, CPED has carried out intervention programmes with local partners on promoting grassroots stakeholders participation on development and poverty reduction, promoting good governance at the grassroots level to hold elected representatives accountable to the people that elect them, promoting human rights-based approach to development, and projects on control of the spread of HIV/AIDS, especially for rural communities.

Strengthening the institutional capacity of CPED

In the last eighteen months, considerable attention was paid to consolidate the capacity building of CPED by improving the equipment and facilities in CPED offices; Improving the governance and management structure of CPED; putting in place clear systems for managing and appointing staff performance and dealing with promotion, progression and remuneration; revamping CPED's website with the aim of making it a key instrument in communications and outreach activities; recruiting Senior research staff to enhance the research capacity of CPED; and establishing CPED branch offices in specific parts of the country.

Empowerment of CPED partners to participate in research, policy linkage and outreach/ intervention activities

CPED has continued with its programme of identifying and build the capacity of local partners in intervention project areas in different parts of the country; continuing to build network links with the empowered local partners and other stakeholders; building a contact base that allows CPED to manage its relationships with local partners efficiently and effectively; and sourcing for funds from key donors for the core activities of CPED.

CPED makes progress on its project on building civil society capacity for advocacy on sexual and Reproductive Health and Rights in Nigeria

After about seventeen months of the implementation of the project entitled "*Building civil society capacity for advocacy on sexual and Reproductive Health and Rights in Nigeria*" steady progress is being made in the execution of some of its key activities. The overall purpose of the project is to improve the reproductive and sexual health situation in Nigeria, which has the worst indicators of Sexual and Reproductive Health and Rights (SRHR) in Africa and the second to the worst in the world, through interventions designed to strengthen the capacity of local civil society organisations to play key roles in policy dialogues on Sexual and Reproductive Health and Rights while at the same time participating in the delivery of RH care services to underserved groups and localities. The project is expected to help the target civil society organisations (NGOs) to clarify their vision, improve their organisational efficiency, increase their knowledge of SRHR, improve their knowledge of or access to policy and planning processes, improve their advocacy skills, increase their ability to deliver SRHR services and develop networks to work with key stakeholders on SRHR. The project seeks to contribute to securing the rights of women, men and adolescents in different parts of Nigeria to good reproductive and sexual health. The project has a research, intervention and policy linkage components. The three-year project initiative is funded by *European Commission.*

In the last seventeen months, the following research, intervention and policy linkage activities have been carried out.

The empowerment of the project team and other key staff/associates

(a) A 46 member Project Team composed of experts on socio-economic surveys, finance, stakeholders' mobilization, NGO management, sexual and reproductive health issues and advocacy strategies have been put in place. Our interactions with some of them show that they have relevant skills and experience to handle the schedule assigned to them in the project.

(b) A three-day workshop was organized for the 46 Project team members to keep them abreast of the issues and challenges of implementing the Project was held on Monday 1st to Wednesday 3rd of February, 2010.

(c) The workshop also empowered 15 other staff of CPED, ICWA and CPAP on the issues and strategies of the Project in case there is need to make changes in the project personnel.

(d) The workshop empowered the project team members on issues such as NGO mobilization strategies in different target states; Strategies for the identification of relevant NGOs for empowerment on advocacy on reproductive health; Stakeholders mobilization strategies for State and Local Government Officials and Local Leaders at the community level; Community mobilization strategies especially for youths in the context of the target LGAs in the different states; Preparation and discussion of survey instruments for the baseline surveys; and Methodologies for the administration of baseline survey instruments;

(e) The workshop also discussed the general principles and issues to be focused on in the preparation of the training manuals, especially Manual for the training of NGOs on organizational development and management; Manual for the training of NGOs on reproductive health challenges and issues in Nigeria; Manual for the training of NGOs on Advocacy on Reproductive Health; and Manual on Adolescents Reproductive Health and service delivery

(f) The 46 Project team members have remained part of the project implementation for the past one year which is a reflection of their continuing commitment to the implementation of the Project.

(g) Draft survey instruments and training manuals were prepared during the workshop.

Mobilisation of target groups and other stakeholders for participation in the project

From the records documented on project activities and interactions with stakeholders and target groups including beneficiaries it can be stated that mobilisation of stakeholders, target groups and beneficiaries was successfully carried out with respect to the following:

(i) Mobilisation of State Government Officials
(ii) Mobilisation of NGOs in the ten target states
(iii) Mobilisation of Media Houses for participation in the project
(iv) Mobilisation of Local Government and Health Officials
(v) Mobilisation of target groups, beneficiaries and out-of-school youths in the target LGAs
(vi) Mobilisation of target schools and in-school youths
(vii) Selection of Non-Governmental Organisations (NGOs) that will participate in the implementation of the action.
(viii) Selection of Journalists and media houses that will participate in the implementation of the action

The successful mobilisation led to the targeting of 100 State Government Officials in the ten target states to support the action; 150 Local Government and Health Officials in the ten target LGAs mobilised to support and participate in the project; 400 NGOs were initially mobilised for participation in the project; 150 journalists in media houses and agencies were mobilised for participation in the project; 500 community leaders, target groups, beneficiaries and other stakeholders mobilised in the target LGAs for participation in the project; 300 NGOs were finally selected from the initial list compiled for participation in the project and 100 journalists were finally selected from the initial list compiled for participation in the project.

Constitution and training of State and LGA Implementation committees

(a) 10 *Local Government Project Implementation Committees with an average membership of between 5 and 10 people were constituted.*
(b) 10 *Local Implementation committees with an average membership of between 10 and 15 people were constituted.*
(c) Training of the constituted state and local implementation committee members was successfully carried out.
(d) *The* State and LGA Implementation Committees have been empowered to participate in the implementation of the Action.

Collection of baseline information on SRHR and capacity building needs of target NGOs

(a) Baseline survey instruments were finalized after pre-testing in pilot NGOs and communities.
(b) Baseline surveys of target NGOs carried out and the results analysed.
(c) Baseline surveys of SRHR carried out and the results analysed.
(d) The results of the analysis of the baseline surveys were fed into the training programmes of the NGOs and Journalists

Capacity building of NGOs on management, SRHR and advocacy skills

(a) The manuals for the training activities finalised and used in the training.
(b) The management capacity building of the NGOs focused on issues such as Establishing and registering a CSO; Mission and planning; Organisational structure and management; Human resources management and supervision skills; Leadership and communications; Programme design and management; Searching for funds; Financial management; Developing public relations; Networking with other organisations; Organisational sustainability; and Monitoring and evaluation.
(c) Sexual and reproductive capacity building of the NGOs focused on issues such as The context of reproductive health challenges in Nigeria; Trends in pregnancies and child bearing; Family planning; Maternal health; HIV/AIDS; Abortion; Harmful practices, reproductive rights and gender issues; The National Reproductive Health Policy and Framework; and Advocacy issues on reproductive health

(d) Advocacy issues on reproductive health capacity building of the NGOs focused on The framework for advocacy on reproductive health; Building a constituency for support; Target audiences and goals; Going public with advocacy issues on reproductive health; Enhancing your public information efforts; Dealing with the opposition
(e) Policy linkage with the relevant state and local governments.

Capacity building of Youth Organisations on SRHR and peer education activities

(a) The manual for the training activities on adolescent reproductive health and peer education activities were finalised and used in the training.
(b) The topics covered in the training workshops focused on key reproductive health issues with particular reference to adolescent reproductive health as well as peer education skills. These include; the context of reproductive health challenges in Nigeria; Trends in pregnancies and child bearing; Family planning; Maternal health; HIV/AIDS; Abortion; Harmful practices, reproductive rights and gender issues; The National Reproductive Health Policy and Framework; Advocacy issues on reproductive health, peer education, and youth-friendly health centres.

Capacity building of Journalists on SRHR and advocacy

(a) The manuals for the training activities finalised and used in the training;
(b) Sexual and reproductive capacity building of the NGOs focused on issues such as The context of reproductive health challenges in Nigeria; Trends in pregnancies and child bearing; Family planning; Maternal health; HIV/AIDS; Abortion; Harmful practices, reproductive rights and gender issues; The National Reproductive Health Policy and Framework; and Advocacy issues on reproductive health;
(c) Advocacy issues on reproductive health capacity building of the NGOs focused on The framework for advocacy on reproductive health; Building a constituency for support; Target audiences and goals; Going public with advocacy issues on reproductive health; Enhancing your public information efforts; Dealing with the opposition.

Working with the empowered CSOs to carry out advocacy activities on SRHR

CPED has been working with the empowerment of the CSOs to advocate for increased attention by the three levels of government to SRHR service delivery by making appropriate resource allocations to SRHR. The objective of the advocacy activities being carried out by the empowered CSOs is to influence policy, programmes and resource allocation to SRHR services. High level meetings are being held with the specific target audiences. CSOs are also organising public events such as debates, radio and TV programmes, peaceful protests, and other events that draw attention to the challenges facing SRHR. Advocacy meetings with community leaders, elders, men and women are carried out on harmful traditional practices.

Working with the empowered journalists to carry out advocacy activities on SRHR

CPED is also working with the empowerment of journalists to carry out advocacy activities as well as public enlightenment campaigns. These advocacy and public enlightenment activities are focusing on informing the public and also lobby policy makers to respond to the challenges facing SRHR. As in the case with CSOs, meetings are being held with specific target audiences. Mass media campaign is a major strategy which some of the empowered media houses are using to promote improved SRHR policy and services in Nigeria.

Working with youth organisations to implement peer education on SRHR activities

In each target LGA the peer educators are working with CPED to carry out *promotional activities* such as discussion groups, music concerts, radio programmes, distributing flyers and hanging posters; *informational/educational activities* such as giving information to individuals or small groups in a

workshop setting with the purpose of educating them on specific SRHR issues; *counselling /orientation* such as direct, private contact with youth to learn extensively about and address their needs including negotiating skills so that adolescent women can say no to unprotected sex and reinforce their self-esteem; *community distribution of services and referrals* such as distribution of condoms, and other contraceptives, as well as referring youth to clinics or other services; and *advocacy* to youth and other stakeholders to build support for the recognition and improvement of SRHR.

Working with the empowered youth organisations to carry out "youth-friendly" reproductive health services

In view of the fact that peer education generates demands for services in the intended audience, peer education is being linked to services that provide access to condoms, medical care, and voluntary counselling and STI management. This is due to the fact that it is generally agreed that "youth-friendly" services are needed if adolescents are to be adequately provided with reproductive health care. Given that young people tend not to use existing reproductive health services, specialized approaches must be established to attract, serve, and retain young clients. Basic components include specially trained providers, privacy, confidentiality, and accessibility.

Supporting civil society coalitions building and networking activities to promote collaboration with the executive, legislature, the media and other CSOs on reproductive health advocacy activities

It is expected that CSOs' impact on advocacy for improved SRHR policies and the increase of resources allocation to RH in budgets will be enhanced if they collaborate with other organisations. This requires building networks and coalitions. Facilitation of coalitions and networking of empowered CSOs advocating for improved SRHR is being carried out by CPED in each state. This is being carried out by the regular meetings and reviews of the activities of the empowered CSOs during the project period starting from the time they were trained collectively in each state. This has formed the basis of their collaboration in advocacy activities on SRHR which is expected to continue even when the project formally ends.

Mallam Abubakar Usman, the Kirfi LGA Coordinator with some youth of Dewu Community

CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT (CPED)

Under the current five-year programme of work, CPED activities focus on four broad areas reflecting the objectives set for the five-year strategic plan period as follows:

(i) Research;
(ii) Communications and outreach;
(iii) Intervention programmes; and
(iv) Capacity Building of CPED and partners.

RESEARCH

Four research thematic areas will be targeted by CPED during the five year period as follows:

1. *Growth with Equity in Nigeria*
2. *Conflict and Development in Nigeria 's Niger Delta Region*
3. *Education and Development in Nigeria*
4. *Health including HI V/A IDS and Development in Nigeria.*

COMMUNICATIONS AND OUTREACH

Partnership development with public and private sector/civil society organisations

INTERVENTION PROGRAMMES ON SOCIO-ECONOMIC DEVELOPMENT

Beyond action and policy oriented research and its communications activities, our mandate entails implementing intervention activities in our identified areas of policy research during the five-year strategic plan period. In this context intervention programmes that benefit largely deprived grassroots communities and other disadvantaged people are being carried out.

CAPACITY BUILDING OF CPED AND PARTNERS

CPED believes that the strengthening partner organisations including community based organisations must be a key mechanism for the achievement of its mandate during the next five years. This also includes the strengthening of CPED to be able to fulfil its mandate during the strategic plan period.

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