POLICY BRIEF

For LGA Key Decision Makers, Policy Makers, Policy Champions at State LGAs

RH VOLUME 1

Reproductive Health Situation in COMPASS States and LGAs: Critical Policy Responses in support of State and Community Level Actions

INTRODUCTION

The current understanding of reproductive health policy in Nigeria emanates from the landmark International Conference on Population and Development (ICPD) held in Cairo in 1994. Already well documented, the ICPD Program of Action (PoA) clearly showed a paradigm shift from implementing individual vertical programs addressing maternal and child health issues to a more comprehensive and expanded understanding and approach to the provision of reproductive health services. The ICPD also anchored this new focus within the context that r*eproductive health and rights* are integral to achieving sustainable development.

The Nigerian Government acting through the Federal Ministry of Heath, (FMOH) has since the 1994 ICPD, made substantial efforts aimed at improving the policy environment for the implementation of reproductive health programmes. For example, between 2003 and 2004 the Nigerian Government efforts at ensuring that quality RH services and commodities are available were focused on revising and updating policy guidelines, training manuals and standards of practice as well as improving the commodity logistics management and financing systems. These efforts eventually led to the upgrading of the Contraceptive Logistics Management System (CLMS) and the development of the National Strategic Plan for Reproductive Health Commodity Security. The Federal Government also disclosed that it had committed N44 million towards procurement of commodities. A new Federal Ministry of Health assessment report prepared in collaboration with DELIVER Project and the United Nations Population Fund (UNFPA) now indicate a marked improvement in commodity availability through out the country. The combined efforts of the Federal Government and its development partners including USAID contributed substantially to these achievements.

While successful at the Federal level, much more progress is still needed to accord reproductive health the priority it deserves especially in translating the national RH policies and strategies into plans that can be implemented at the State and LGA levels of governance.

This RH policy brief is intended to provide useful information to COMPASS States and LGAs regarding the specific RH policy and program challenge(s) States and communities face. This will help in empowering communities by providing relevant/useful information on policy related issues, challenges, and program needs. This, we believe, will garner the efforts of the States, LGAs and other strategic partners towards strengthening enabling environment in support of the delivery of reproductive health services.

It is our hope that these series of policy briefs prepared by the COMPASS Policy Unit, and with the active support and collaboration of the State Team Leaders and Program Advisors, will stimulate policy and program actions and empower communities to ensure the provision of social services, in their respective States and LGAs.

Background - Nigeria RH Indicators and Demographics

Nigeria is the largest country in sub-Saharan Africa, and the tenth most populous country in the world. With a land area of 923,768 sq. km., its population density is 96.3 persons per square kilometer. The 1991 population census put the total population figure at 88.9 million. Recent estimates put the year 2003 population at 136 million. Nigeria's population is currently growing at about 2.8% per annum, which implies that the population of the country will double in 25 years time. Efforts are also on-going to conduct a new round of national population census in 2006.

Nigerian Changing Demographics and RH Indicators

Total Pop.	136m
Annual growth rate	2.8%
Total pregnancies	6.3m
Abortions (Induced)	318,000
Maternal Deaths	50,000
Deaths due to unwanted birth	3,280
Maternal Mortality Ratio	1,000/100,000 live births
Unmet need for FP	17%

Source: Nigerian FAMPLAN Projections 2002 and NDHS, 2003

Nigeria is presently undergoing a demographic transition from a high fertility and mortality regime to a high-fertility and low mortality regime, with a large and young population base. Accordingly, the median age of the population is 17 years, and those within the age group 15-24 years constitute about 20% of the population. This has various implications for the provision of reproductive health information and services, especially for adolescents and young people.

The life expectancy at birth (average age each Nigerian is expected to live from birth to death) has shown some increase. It moved from 45 years in 1963 to 53 years in 1990 and was estimated to have dropped to 51 years in year 2002, largely due to the impact of AIDS. The 2003 Nigeria Demographic and Health Survey (NDHS) data indicate that childhood vaccination coverage of children aged 12-23 months is only 13%. However, there are regional as well as variations by States. The infant mortality rate was estimated at 100/1,000 live births and the under-five mortality rate at 201/1,000 live births based on the 2003 NDHS.

REPRODUCTIVE HEALTH SITUATION AND CHALLENGES IN COMPASS STATES AN LGAs

Nigeria is a signatory to the 1994 ICPD declaration and other global commitments concerning reproductive health and rights. Despite this, overall government support for the implementation of reproductive health programs has remained weak. To move the RH agenda forward, there is a need to strengthen political support for RH in the three tiers of government; Federal, State, and LGA. Special emphasis must be placed on strengthening the various structures and organizations mandated to coordinate and implement the country's health, including reproductive health programs.

The goal of the RH programme is to achieve for all Nigerians, a state of complete physical, mental and social well-being in all matters related to the reproductive system, its functions and processes. Nigeria's reproductive health policy therefore recognizes reproductive health as a right, and as indispensable to overall health and development.

In spite of the policy, COMPASS States presents an array of RH challenges. For example, the Total Fertility Rate (TRF) was estimated at 6.0 for Nigeria in 1990. It declined to 5.2 in 1999 (1999, NDHS), and is currently 5.7 children per woman (2003, NDHS). The corresponding contraceptive prevalence rate (CPR) in 2003 among married women of reproductive age is 13% for all methods, and only 8% of married women are using modern methods.

In COMPASS States specifically, the TFR is higher in the North Central, North East and North West zones (than Southern zones,) with women having between 5.7 and 7.0 children on the average. Bauchi, Kano and Nasarawa States lie within these zones. The use of modern contraceptive methods is correspondingly low, especially in the North East and North West Zones where Bauchi and Kano States are located. Only 3 percent of married women use any form of modern methods of contraception in these two zones. Other RH outcome indicators include higher maternal mortality ratios.

In contrast, the FCT and Lagos State have relatively higher percentage of married women using modern contraceptives – 10% and 13% respectively. The relative availability of improved facilities, personnel and general approval of FP in the FCT and Lagos State may account for this, compared to poor access to reproductive health services and low literacy rates in the North West and East Zones. (see Table 1 below).

The other reproductive health challenges discussed briefly in this session include maternal morbidity and mortality, malaria in pregnancy, antenatal care coverage, family planning/ child spacing and unmet need for family planning. Making provision of reproductive health commodity security and engaging religious leaders to achieve RH goals are some of the policy and programme responses that will be discussed later.

TABLE 1: BRIEF RH PROFILES IN COMPASS STATE

States	Current Population Size	Population Growth Rate	MMR	Infant Mortality Rate	TFR (North East Zone	CPR (Modern Methods)	Unmet Need for FP
Bauchi	4.2m	3.0%	1,500/100,000 live births	79/1,000 live births	7.0	3.0%	18%(13 spacing & 5 limiting)
Federal Capital Territory (FCT)	6.7m	4.0%	…../100,000 live births	129/1,000 live births	5.7	10%	22% (15 Spacing & 7 limiting)
Kano	12m	2.9%	1,700/100,000 live births	110/1,000 live births	6.7	3.0%	11% (10 spacing & 1 limiting)
Lagos	15m	6 –8.0%	650/100 live births	85/1,000 live births	4.1	13%	17% (11 spacing & 6 limiting)
Nasarawa	2.0m	2.83%	984/100,000 live biths	103/1,00 live births	5.7	10%	22% (15 spacing & 8 limiting)

Source: Various State SEED reports and NDHS, 2003

Maternal Morbidity and Mortality

The situational analysis of maternal mortality obtained from the 1999 Multiple Indicators Cluster Survey as reported in the National RH Policy puts the maternal mortality ratio for Nigeria at 704 deaths per 100,000 live births. There is wide geographical disparity ranging from 166 maternal deaths per 100,000 live births in the Southwest to 1,549 per 100,000 live births in the Northeast.

Estimates from NDHS 2003 indicate that MMR is 1,500 per 1,000 live births in Bauchi, 1,700 in Kano and 984/100,000 live births in Nasarawa. These are all States in the North East, North West and North Central zones were MMR is relatively high.

Lagos State has a relatively low (but still high by WHO standards) MMR of 650/100,000 live births. Several factors may be responsible for the high maternal mortality and morbidity experienced in Nigeria.

For example, according to the 1999 NDHS, only 31% of deliveries took place within health facilities and the 2003 NDHS indicates that 17% of expectant mothers had no assistance at delivery.

More than 70% of all maternal deaths are due to five major complications; hemorrhage, infection, unsafe abortion, hypertensive disease of pregnancy, and obstructed labor. In addition, fifteen (15) percent of expectant mothers suffer serious or long-term complications such as pelvic inflammatory disease and infertility. Maternal deaths as a result of high-risk teenage pregnancies either from unsafe abortion or delivery complications contribute significantly to high maternal mortality rates recorded in different parts of the country. Low access to quality RH services plays a significant role in the high maternal mortality across Nigeria.

National Malaria Treatment

Roll Back Malaria (RBM) is the overall national strategy adopted to combat malaria. The strategy seeks to establish a social movement in which the local communities, public and private sectors, all tiers of government and non government agencies come together in a partnership and network to implement malaria control activities.

The RBM intervention strategy has four key elements. These are that patients with malaria should have access to appropriate and adequate treatment within 24 hours of the onset of symptoms; pregnant women (particularly in their first and second pregnancies) should have access to effective antimalarial prophylaxis and treatment; insecticide treated nets and other materials should be available and accessible to persons at risk of malaria including pregnant women and children under age 5; and epidemics of malaria should be recognized and steps initiated for their containment.

Malaria in Pregnancy: Is Nigeria Likely to Achieve the Targets in the Abuja Declaration?

One of the common morbidity conditions affecting pregnant women in Nigeria is malaria in pregnancy. It accounts for 60% of all clinic attendance and 70.5% of pregnant women interviewed in the study mentioned above, reportedly have shown signs and symptoms suggestive of malaria. Malaria is a preventable condition. It is also treatable and curable.

Drugs and other interventions for the prevention and treatment of malaria, especially during pregnancy are widely available, within the public and private sectors. Many of the drugs are also easy to administer and are affordable and accessible. It is therefore correct to indicate that there can be no justification for women in Nigeria to continue to suffer under the severe disease and economic burden brought about by malaria.

The Abuja Declaration to which Nigeria is a signatory indicates that 60% of pregnant women should receive IPT drugs during pregnancy by the end of 2005.

Intermittent Preventive Treatment (IPT) of malaria in pregnancy is a known, tested and effective strategy recommended to reduce morbidity and mortality of malaria both for the mothers and their children in accordance with the Abuja Declaration. IPT is based on the use of preferred anti-malaria drugs given in treatment dosage at specified intervals. It is intended to clear the presumed burden of parasites and provide significant protection against maternal anemia and mortality, low birth weight and abortion.

With the adoption of the National Guidelines for Malaria Prevention and Control in Pregnancy, the FMOH has endorsed the choice of Sulfadoxine-Pyrimethamine (SP) for the intermittent preventive treatment of malaria.

The national guidelines and strategy for malaria prevention clearly spells out specific treatment targets, dosage and case management. It also details out responsibilities at various levels of health care. (This has been outlined in the "Fact Sheet" on IPT.)

What can States and LGAs Do to Prevent Malaria in Pregnancy

Various groups at State, LGA and community levels can each adopt specific responsibilities in malaria prevention and control within their areas of jurisdiction, as noted below.

At Community Level, CCs, local TBAs, CBOs, CHWs, can:

- Mobilize/sensitize the communities on the value of ANC, the risk of malaria in pregnancy and the concept and rationale of IPT;
- Promote other control measures especially the use of ITN; net-treatment and environment management;
- Prompt referral of pregnant women to appropriate level of care;
- Use BCC strategy to encourage the community to accept and use IPT in place of other remedies
- Conduct home visits; and Local research involving small-scale studies, community needs appraisals relevant to RH to ensure full application of acceptable standards of care etc.

At Local Government Level

- Provide and distribute appropriate BCC ma terials on IPT
- Provide adequate human and material resources to primary health facilities
- Promote IPT and use of ITNs
- Support and encourage ANC attendance that includes IPT
- Re-train/orientate health workers on IPT
- Provide technical support to health facilities on IPT implementation
- Establish appropriate feedback mechanisms between health facilities and RBM HQ RBM HQ Monitor and evaluate IPT program at facility and community levels

At the State Level

- Undertake advocacy for the adoption of malaria in pregnancy interventions;
- Provide adequate human and material resources especially drugs and supplies for IPT to the health facilities; also train and orient trainers on IPT and ITNs.
- Provide technical support to reduce/eliminate mosquito breeding sources;
- Provide technical support to health facilities on IPT and ITNs implementation;
- Establish appropriate feedback mechanisms between health facilities and RBM HQ to ensure compliance with guidelines and standard dosage;
- Organize State level launching of guidelines on IPT and ITN implementation involving all relevant stakeholders; and Monitor, Supervise and evaluate IPT implementation.

Antenatal Care Coverage

Recent evidence from the 2003 NDHS indicates that there has been an improvement in the utilization of antenatal services across the various zones in Nigeria. Although these improvements were noted, there still remain major challenges in specific States where maternal mortality is high, notably, Kano and Bauchi. In the North East Zone where Bauchi State is located, 53 percent of expectant mothers received some form of antenatal care during their last pregnancy. Even more revealing is the fact that 56 percent of the expectant mothers in the North East Zone did not receive tetanus toxoid (TT) injection. (This vaccine is given routinely by a health care professional during ANC visit to immunize the baby against neonatal tetanus infection).

Similarly in the North West Zone where Kano is located, ANC coverage is relatively low, with only 41 percent of expectant mothers receiving ANC. Out of this number, 73 percent did not receive tetanus toxoid (TT) injection. These areas in the Northern zones are clearly disadvantaged in the provision of social services generally compared to other States in the Southern zones.

Family Planning/Child Spacing

As a result of the international population conferences, governments including that of Nigeria have accepted family planning as a legitimate development intervention. In spite of all the declarations and commitments made at these meetings, one factor stands out above all: there has never been widespread public recognition among the countries' leaders at State and LGA levels that a very high proportion of women *and* men clearly want better spaced, limited family size and that their unmet need must be systematically targeted for reduction as the highest priority for achieving national development goals. In the six years following the 1994 Cairo conference there have been an estimated 4 million unintended pregnancies in Nigeria.

Indicators of Family Planning in COMPASS States

Contraceptive prevalence rate for married women is considered one of the best indicators of family planning practice by a community. In the five COMPASS States contraceptive use among married women range from 3.0% in Kano State to 13.0% in Lagos State. This is due to various reasons including existing high levels of poverty, socio-cultural factors, low levels of quality education, and poor access to quality reproductive health services. Additional indicators for the approval and use of family planning in COMPASS States will be presented in the next edition of the policy brief when COMPASS baseline data becomes available.

Unmet Need for FP

Policy makers and program managers responsible for the provision of reproductive health services are often concerned about the consequences of not providing services to meet the unmet need for FP services among women of reproductive age. The adverse consequences of such failures have already been mentioned above. One of the important lessons of the reproductive revolution is that successful FP programmes can be developed even in challenging social and economic environments as pertain in some COMPASS States.

REPRODUCTIVE HEALTH POLICY ENVIRONMENT, IMPLICATIONS AND RESPONSES

Nigeria through the FMOH, the National Population Commission (NPC) and the National Action Committee on AIDS (NACA) and with the support of USAID and other development partners, has achieved key RH policy and planning milestones. For example, in November 2002, the National Reproductive Health Policy and the accompanying Strategic Framework and Plan for Reproductive Health were launched. These policy commitments, together with the National Policy on Population for Sustainable Development, which was recently revised in 2004 and the National Strategic Plan for Reproductive Health Commodity Security suggest that there is evidence of an improved policy environment at the national level.

The various processes of policy development and/or endorsement/adaptation haven't always trickled down to the other two tiers of governance - State and LGA - especially regarding the necessary strategic plans and operational policies and guidelines. The overall National Health Policy was enacted in 1998 and is based on the philosophy of social justice and equity. Primary Health Care (PHC) is the cornerstone of the health system. The policy provides for a health system with three levels: primary, secondary and tertiary. The policy also spells out the functions of each tier of government and provides for the establishment of the advisory National Council

on Health to advise the Government on matters of policy and in carrying out its many responsibilities aimed at ensuring that appropriate standards are maintained in the delivery of reproductive health services.

Other organs stipulated in the National Health Policy include:

The State Health Advisory Committees and Local Government Health Committees.

The impact or the potentials of these various State and LGA bodies and institutions are yet to be fully appreciated.

REPRODUCTIVE HEALTH POLICY AND STRATEGY: IMPLICATIONS FOR SERVICE AVAILABILITY AT FEDERAL, STATE AND LGAS

The National Reproductive Health Policy was developed by a partnership of stakeholders. The policy aims to strengthen reproductive health rights within all tiers of government and to achieve an overall improvement in the reproductive health status of Nigerians through a variety of strategies.

The Policy identifies key strategic components, including safe motherhood, family planning, prevention of sexually transmitted infections, HIV/AIDS and, harmful practices, reproductive rights and gender issues, management of cancers of the reproductive system, infertility and sexual dysfunction, management of non-infectious diseases and adolescent reproductive health. Each component is further broken down into specific services to be provided at the National, State and LGA levels.

To facilitate the implementation of the national RH Policy, a National Strategic Framework and Plan for Reproductive Health (2002-2006), has been developed.

The objectives of the RH Plan are as follows:

Reduce maternal mortality – MMR by 50% of the 1999 level and perinatal mortality by 30% of the 1999 level

Reduce the prevalence of STIs and the incidence/prevalence of reproductive cancers and infertility

Limit all forms of gender based violence and harmful practices

Increase contraceptive prevalence rate

More importantly, the National RH Plan calls for the decentralization of services to the States, Local Governments and communities. In so doing, it recognizes the need for the promotion of community participation and encourages private sector support to ensure effective implementation of the strategies and activities in the plan.

Funding, however, remains a major challenge in the implementation of the plan. Other challenges include the need to develop and agree upon an integrated monitoring system to track progress and a 'minimum package' of services for reproductive health, towards which the States are encouraged to contribute.

Efforts to get improved funding to implement the strategy should not be seen only as a government driven initiative. Communities will have to be mobilized to become active stakeholders in the provision of reproductive health services at Federal, State and LGA levels. Now, there is increasing recognition that community groups are the main end-users of reproductive health and other social services provided by States and LGAs. . Thus, various collaborative efforts among government, development partners, NGOs, civil society coalitions etc., must be harnessed to improve the delivery of reproductive health services.

The COMPASS strategy is to empower community coalitions (CCs) in the States and LGAs who will in turn advocate for improve reproductive health services. Such efforts will not only strengthen the contribution of beneficiary communities to address their reproductive health needs and challenges, but will also go a long way in ensuring strong community participation and ownership, effective local level coordination, and encourage private-public partnership in support of funding to sustain efforts geared towards improving the reproductive health status of the population in the States and LGAs.

Monica Das Gupta, Varun Gauri & Stuti Khemani 2004. 'Decentralized Delivery of Primary Health Services in Nigeria: Survey Evidence from the States of Lagos and Kogi', *The World Bank.*

Opportunities for Active Engagement of Community Groups

Gupta et al., indicates that certain types of social service delivery are enhanced with the active participation of the communities they serve. Being the main end-users of the reproductive health and other social services provided by States and LGAs, the community coalitions being promoted by COMPASS have a stake in ensuring the provision of quality reproductive health services and will also be empowered to monitor the quality of the service.

Various opportunities now exist to ensure that there is heartened commitment for empowering community groups. Mechanisms are being put in place within COMPASS States and LGAs to realize this objective of ensuring active community participation in the provision of social services, especially reproductive health. These can be seen across the COMPASS thematic areas involving community mobilization activities, the various team building and PDQ processes that are geared towards building capacity in NGOs and the Nigerian implementing partners.

What is Needed for the Actualization of the National RH Plan within the States and LGAs

The State Economic Empowerment and Development Strategy (SEEDS) processes adopted by the States to appraise their current development challenges have provided thorough assessments of their larger health, including reproductive health needs. In appraising the needs in the COMPASS States for the provision of health/RH services, the following challenges have been identified. These are highlighted below.

BRIEF SYNTHESIS OF HEALTH/RH CHALLENGES IN COMPASS STATES

State	Health and RH Challenges
Bauchi	Poor coordination and joint planning between the State and the 20 LGs for health care delivery. LGs lack capacity to deliver qualitative health care including RH services No mechanism in place for State and LG operatives to interact for guidance. Clear signs of system failures for RH service provision, eg. drug revolving fund, inadequate FP commodities & CLMS management forms.
FCT	Endowed with health facilities, but facilities are over-stretched due to population pressure especially informal community dwellers and squatters leading to population facilities mis-match. Shift focus to preventive and health promotion and awareness creation for behavior change. Implementation of a Service Charter to serve as compact between providers and clients (CCs need to know content in order to help popularize Charter).
Kano	Poor dissemination of organization goals and objectives to various levels of health care. Intensify preventive and promotional health activities for improved RH outcomes. Inconsistent program and RH policy environment vis-à-vis national policy Need to address cultural beliefs, poverty, ignorance and inadequate resource allocation and distribution in support of health.
Lagos	Poor maternal and child health services Delivering health services, including reproductive health services in a vast metropolis with many areas riverine Poor and inadequate referral system
Nasarawa	Inadequate and deteriorating health infrastructure Weak PHC services, poor access to RH services These have led to poor RH service delivery

Source: Analysis from various State SEEDS Reports.

These challenges, coupled with other initiatives at the National, State and LGA levels, have propelled the key actors to set the agenda for truly responding to the reproductive health needs of their people.

A few of these initiatives are:*

Health Sector Reform

Engagement of Religious Leaders

Universal Basic Education Program

Public-Private Partnership

These initiatives, together with others already identified in the States SEEDS analysis are being used as the key policy planks in the pursuit of improving overall health including reproductive health goals and targets in the

Mechanism to Ensure Active Community Engagement for the Provision of RH Services in COMPASS States

CCs with the benefit of local information can:

Assess specific obstacles facing facilities in providing RH services.

Seek to ensure through various forms of partnership arrangements for the provision of necessary infrastructure, supplies and staff motivation where necessary.

Develop capacity with other groups in budget tracking to ensure accountability in managing resources sent to LGAs.

Help in publicizing information about the resource envelop and other constitutional responsibilities of LGs in order to make communities more aware of the capacities and duties of their local representatives.

Advocate for adaptation of national policies, operational guidelines etc at State and LGA to improve the overall environment for provision of social services including RH.

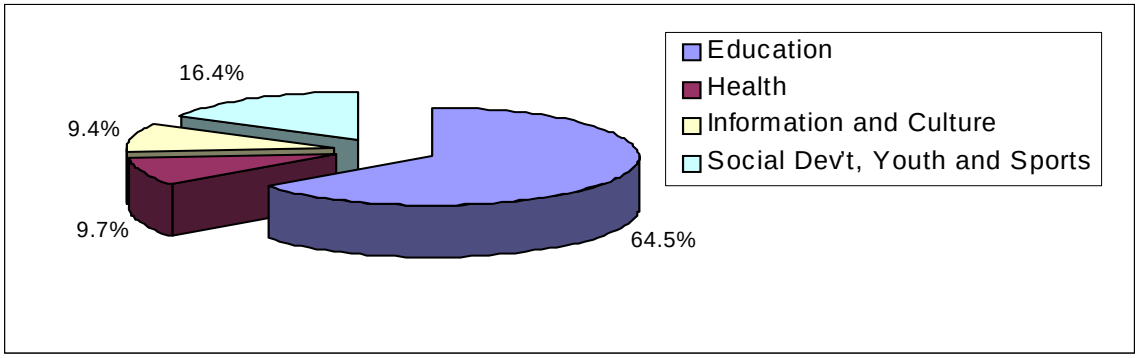
Initially discussed in the work by Gupta et al., 2004 and expanded upon by the Author of this Policy-Brief.

In Lagos State for example, the core elements of its 10 Point Agenda for Health includes deepening the current free healthcare program that covers the provision of free antenatal care and awareness creation on maternal health issues, the expansion of Ward (Neighborhood) Clinics, the pursuit of secondary health care, enhancement of medial personnel welfare, and development of strategies to increase consumers' knowledge and awareness of personal obligation for better health, and their right to quality care, among several others.

Similarly in Kano, spending on health and the provision of information and cultural programs constitutes 19.1% (N6.1 billion) of the total N32.0 billion allocated for social services during the period 2005-2007.

As shown in the pie-chart 1, the proportional share to education is rightly high, (64.5% or N20.5b), but Kano would still have to step up its allocation to the health sub-sector in order to provide more and better reproductive

health services during the next program cycle. In addition, mutually beneficial programmes must be designed and put in place to take advantage of the synergies within both the education and health sub-sectors of the social services outlay, given the proportionately huge allocation to education. Examples of such programs could include school-based preventative health promotion activities in support of achieving reproductive health goals and targets.



State Economic Empowerment and Development Strategy (K-SEEDS) Projects Summary: 2005-2007

Engaging Religious Leaders to Achieve RH Goals

Various socio-cultural, religious and gender considerations impede access to reproductive health services by women, men and youth. A national survey conducted in 2003 revealed that over 60% of Nigerians believe that religious leaders of all faiths, and the custodians of tradition do not support FP/RH programs.

To understand the specific circumstances of women in Muslim States in Nigeria, The ENHANSE Project recently completed a publication entitled 'R*eproductive Health Issues in Nigeria: The Islamic Perspectives.'* The document is a major effort by leading Islamic scholars, to inform the Muslim community on the correct Islamic position on all matters relating to RH as envisaged in the National Policy. It recognizes that Islam is a practical religion with a complete code of life and it is capable of providing solutions to all problems. It therefore enjoins Muslims to judge everything according to merit. *(Please refer to Fact Sheet on Islamic Perspectives for detailed information).*

The Islamic views on the various strategies of providing reproductive health services across the key RH components are clearly spelled out in the document. Two examples will illustrate the point. Under safe motherhood, the document notes that community ownership; male involvement and implementation of safe motherhood initiatives are all in line with Islamic teachings. And many verses from the Qur'an support this:

> *"…Help ye one another in righteousness and piety but help ye not one another in sin and rancor: fear Allah: for Allah is strict in punishment"* Qur'an 5:2

also,

> *"… the duty of feeding and clothing nursing mothers in a similar manner is upon the father of the child. Noone should be charged beyond his capacity. A mother should not be made to suffer because of her child,should he to whom the child is born (be made to suffer) because of the child….."* Qur'an 2:233

Ministry of Economic Planning and Budget. Lagos State Economic Empowerment & Development Strategy (LASEEDS) (2005 - 2007)

RH Commodity Security

In 1999, the Federal Government of Nigeria established the National Contraceptives Logistics Management System (CLMS) to improve access to quality contraceptive commodities. The CLMS was revised in 2003 to reflect new RH realities. There are six strategic components to the revised CLMS, which includes Policy, Finance, Demand, Logistics, Service Delivery and Coordination.

However, a critical challenge to ensure the implementation of the CLMS is funding. Donors unfortunately, still provide a bulk of the funding required for commodities, and this has been on the decline lately. Budgetary allocation from the three tiers of government (National, State and LGA) to support RHCS is inadequate to achieve universal access to quality RH services as the RH policy demands. Improved funding and the creation of a budget line at the National, State and LGA levels for RHCS will significantly contribute towards the realization of this objective of the RH policy- ensuring improved quality of life for all Nigerians.

CONCLUSION

To ensure the realization of the Reproductive Health Policy goal of achieving quality reproductive and sexual health services for all Nigerians, the State and LGAs are expected to play a pivotal role. COMPASS will continue to stimulate dialogue among State level decision makers and community groups to ensure that communities are galvanized towards playing the various roles assigned by existing National and State policies. In doing this, institutions within the States and LGA will be contributing significantly towards improving the environment for the delivery of improved social services.