Global Public Health, 2015
Vol. 10, No. 2, 174–176, http://dx.doi.org/10.1080/17441692.2014.986162

Routledge
Taylor & Francis Group

THEME: INTEGRATED AND COMPREHENSIVE SRH SERVICES: A GLOBAL VIEW

Commentary: Accelerating the quest for integrated and comprehensive sexual and reproductive health services in Nigeria

Babatunde Ahonsi*

United Nations Population Fund, Accra, Ghana

By centralising sexual and reproductive health (SRH) and rights, gender equality and adolescent empowerment within sustainable development, the 1994 International Conference on Population and Development (ICPD) marked a turning point in the struggles of Nigerian women, adolescents and youth for improved access to quality maternal health, sexually transmitted infections (STIs) and HIV, contraceptive and post-abortion care services. Prior to the late 1990s, the focus of policy action at the national and sub-national levels was maternal and child survival, and slowing of the population growth rate to enhance economic growth, with near-total state inaction on youth sexuality, violence against women, quality and choice in family planning services, maternal morbidity and unsafe abortion (Esiet & Whitaker, 2002; National Population Commission & UNFPA, 2013).

From 1998 to 2008, local NGO-led advocacy and pilot projects aided by several global initiatives to fast-track achievement of the Millennium Development Goals (MDGs) e.g., Global Fund to Fight AIDS, Tuberculosis and Malaria; Make Poverty History Campaign; catalysed a flurry of ICPD-informed national policies and strategic implementation plans, especially in relation to population and sustainable development; trafficking in women and children; gender equality; adolescent SRH; maternal, newborn and child health; girl-child education; control of HIV and STIs; and family planning and reproductive health (RH) commodity security (British Council & UKaid, 2013; Esiet & Whitaker, 2002; Mandara, 2012; USAID, 2010).

Yet, Nigeria (together with India) presently contributes one-third of the global burden of maternal deaths (WHO, UNICEF, UNFPA, & The World Bank, 2012), and has the second largest burden of HIV in the world (USAID, 2010). Further, contraceptive prevalence has risen to only 14% in 20 years, and unmet need for family planning has remained unchanged at 21% (Alkema, Kantorova, Menozzi, & Biddlecom, 2013).

The yawning gap between policies and their implementation through high-quality, large-scale programmes and services explains these unwholesome national statistics, as well as huge regional and rural–urban disparities. For instance, the SRH status of women and girls in rural northern Nigeria is among the worst in the world (Shittu et al., 2010). Moreover, the SRH needs of 15- to 24-year-olds, who represent over a quarter of the country's population and its most valuable resource, remain poorly addressed (USAID,

*Email: bahonsi@unfpa.org

2010). Most of the ICPD-aligned policies, programmes and services have simply not had adequate resources (funding, personnel, infrastructure and supplies), especially at the sub-national level (Mandara, 2012; USAID, 2010). Instead, the country is dotted with exemplary small-scale pilot projects that demonstrate how to deliver high-impact programmes and services to vulnerable women, adolescents and youth. Institutional actors including government, private health services and donors have ignored NGO-led advocacy for massive scale-up of these pilots (Esiet & Whitaker, 2002; Shittu et al., 2010; USAID, 2010).

One notable exception is increased attention to maternal health since 2005 by the federal government, exemplified by its Midwives Services Scheme, and by a few state governments, such as Ondo in the south-west and Kano in the north-west, which have fairly comprehensive, strategic and free safe motherhood programmes (Cooke & Tahir, 2013). But few interventions by NGOs or government adequately respond to the many demand-side barriers to universal access to SRH, especially extreme poverty among rural women and such practices as child marriage and women's need for husbands' permission to seek emergency obstetric care (British Council & UKaid, 2013; Shittu et al., 2010).

By comparison, the national HIV response has made unprecedented progress (National Agency for the Control of AIDS, 2013). Since 2003, persons accessing antiretroviral therapy have increased from fewer than 50,000 to nearly 600,000 in 2013, and curriculum-driven family life education (FLE) and HIV education, initiated by a few youth-serving NGOs in the late 1990s, are now taught in public junior secondary schools throughout the country. Though beneficial, these efforts rely heavily on international donor assistance and the treatment programme is overly vertical, both serious challenges to national ownership and sustainability. Moreover, these characteristics have hindered the integration of SRH and rights in primary health care (PHC) and have neglected women survivors of sexual violence, those desiring safe abortion and adolescents in need of contraceptives and STI prevention and treatment (Esiet & Whitaker, 2002; National Population Commission & UNFPA, 2013; USAID, 2010).

Several simultaneous actions are sorely needed. First, more concrete collaborations among relevant NGOs, government, and donors are required to generate evidence and intensive advocacy for strong community and policy responses to key neglected aspects of the ICPD agenda. Second, capitalising on increased global and local attention to family planning, maternal and newborn health and girl-child education, PHC should be strengthened as the main vehicle to deliver SRH and rights services for poor women, adolescents and youth. Such strengthening entails higher priority for scaling up, and adopting the lessons of NGO-managed SRH interventions, while also sustaining the large-scale, externally funded HIV services and augmenting them with other SRH services. Financial resourcing and the management of integrated SRH and HIV services will have to be improved by all levels of government: local, state and federal. Finally, all stakeholders need to more seriously address persistent demand- and supply-side barriers to good quality SRH services for vulnerable adolescents and disadvantaged women.

Funding

This work was carried out with the aid of a grant from Canada's International Development Research Centre.

References

Alkema, L., Kantorova, V., Menozzi, C., & Biddlecom, A. (2013). National, regional and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990

and 2015: A systematic and comprehensive analysis. *The Lancet, 381*, 1642–1652. doi:10.1016/S0140-6736(12)62204-1

British Council and UKaid. (2013). *Gender in Nigeria report 2012 – Improving the lives of girls and women in Nigeria*. Abuja: British Council Nigeria.

Cooke, J. G., & Tahir, F. (2013). *Maternal health in Nigeria: With leadership, progress is possible*. Washington, DC: Center for Strategic & International Studies.

Esiet, A. O., & Whitaker, C. (2002). Coming to terms with politics and gender: The evaluation of an adolescent reproductive health program in Nigeria. In N. Haberland & D. Measham (Eds.), *Responding to Cairo: Case studies of changing practice in reproductive health and family planning* (pp. 149–167). New York: Population Council.

Mandara, M. (2012). Family planning in Nigeria and prospects for the future. *International Journal of Gynecology and Obstetrics*, 117(1), 1–4. doi:10.1016/j.ijgo.2012.01.002

National Agency for the Control of AIDS. (2013). *President's comprehensive response plan for HIV/AIDS in Nigeria*. Abuja: The Presidency.

National Population Commission & UNFPA. (2013). *ICPD beyond 2014 review: Nigeria country implementation profile*. Abuja: Author.

Shittu, O., Ejembi, C., Adaji, S., Abdul, M., Idris, S., Abdulkarim, B., … Potts, M. (2010). The current state of reproductive health in rural northern Nigeria in the context of the pursuit of the MDGs: Perspectives from a community-based research training program. *African Journal of Reproductive Health*, *13*, 15–18.

USAID. (2010). *USAID/Nigeria: Adolescent sexual and reproductive health program review and design*. Abuja: Author.

WHO, UNICEF, UNFPA, & The World Bank. (2012). *Trends in maternal mortality 1990 to 2010*. Geneva: World Health Organization.