National Reproductive Health Policy 2017

FOREWORD

In pursuance of the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) held in Cairo in 1994, the first National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians was developed in 2001. This was followed by the development of the National Reproductive Health Strategic Framework and Plans to support the policy implementation process, which spanned from 2001-2006. The gains and lessons learnt from the review of implementation of 2001 Policy informed the content of 2010 Policy, which also took into cognizance the emerging reproductive health issues of the time.

This third review of the National RH Policy presents a critical analysis of the existing situations, including on-going interventions and a set of new objectives and targets within the context of current national, regional and global perspectives. In addition, roles and responsibilities were identified for new stakeholders while contemporary funding models were explored to support policy implementation. Thus, this policy review builds on the platform of the previous achievements, addresses some of the limitations identified in the implementation of the old policy and integrates emerging issues affecting reproductive health needs of the Nigerian people. Furthermore, the review process took into cognizance the current perspectives on the reproductive health needs of the Nigerian population in the context of our national development efforts.

It is a priority for the Government of Nigeria to provide effective leadership and enabling environment required for the successful implementation of this policy with measurable outcomes that demonstrate impact at all levels of our health care system. To this end, the process of the development of relevant strategic/implementation frameworks, plans, service guidelines and standards of practice as may be relevant to each area of RH and the specified objectives of the policy was undertaken alongside the review of this policy.It is my sincere expectation that this reviewed policy will provide the strategic direction needed to drive the reproductive health agenda and provision of qualitative reproductive health care services to the peoples of Nigeria.

Professor Isaac F. Adewole
Honourable Minister of Health
December, 2016

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Dr. AdebimpeAdebiyimni
Director, Family Health Department

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APHPN	Association of Public Health Physicians of Nigeria
ARH	Adolescent Reproductive Health
ART	Anti-retroviral Therapy
BCC	Behaviour Change Communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
Corp	Community Resource Persons
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organisations
CTC	Core Technical Committee
DALYs	Disability-Adjusted Life Years
EmONC	Emergency Obstetrics and Newborn Care
FBOs	Faith-Based Organisations
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
FP	Family Planning
FP2020	Family Planning 2020
FR	Fertility Rate
FSW	Female Sex Worker
GFF	Global Financing Facility
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Biological and Behavioural Surveillance Survey
ICPD	International Conference on Population and Development
ICPD+5	Special Session of the General Assembly of the United Nations for the review of fifth year of the implementation of ICPD
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
IMNCH	Integrated Maternal, Newborn and Child Health
IMNCAH+N	Integrated Maternal, Newborn, Child and Adolescent Health + Nutrition
LGA	Local Government Area
M&E	Monitoring and Evaluation
MDCN	Medical and Dental Council of Nigeria
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MSS	Midwives Service Scheme
NANNM	National Association of Nigerian Nurses and Midwives
NARHS	National HIV/AIDS and Reproductive Health Survey

NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NGO	Non-governmental Organisation
NHA	National Health Act
NHIS	National Health Insurance Scheme
NPopC	National Population Commission
NRHWG	National Reproductive Health Working Group
NSHDP	National Strategic Health Development Plan
PCN	Pharmacists Council of Nigeria
PMTCT	Prevention of Mother-to-Child Transmission
PoA	Programme of Action
PWDs	Persons with Disabilities
RH	Reproductive Health
RVF	Recto-Vaginal Fistula
SDGs	Sustainable Development Goals
SMoH	State Ministry of Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
VVF	Vesico-Vaginal Fistula
WHO	World Health Organisation

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1.0 INTRODUCTION

The International Conference on Population and Development (ICPD)held in Cairo in 1994 marked a watershed in the population-related field, linking fertility regulation and development goals in the context of human rights. Through the ICPD, the notions of reproductive health and rights were defined and universally applied. The Programme of Action (PoA) of the ICPD defined reproductive health as follows:

> *"Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes".*

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if,when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

The ICPD consensus represents a paradigm shift from classic population control policies and large scale vertically structured family planning programmes for the control of excessive population growth to therecognition of the needs and rights of individuals and a focus on the promotion of sexual and reproductive health for all. The ICPD agenda has been reaffirmed in a number of international forumsas it continues to be relevant to international and national development efforts. The International Conference on Population and Development beyond 2014 in Addis Ababa extended the implementation of Programme of Action and the key actions of ICPD beyond 2014.The United Nations General Assembly Resolution 65/234 emphasised the need for Governments to recommit themselves at the highest political level to achieving the goals and objectives of the PoA of the ICPD and supported the extension of the PoA implementation beyond 2014 in order to fully meet its goals and objectives. The ICPD agenda has also been noted to be central to the Sustainable Development Goals (SDGs). Goal 3 - Ensure healthy lives and promote well-being for all at all ages encompasses sexual and reproductive health, while sixothers - end poverty in all its forms everywhere; end hunger, achieve food security and improved nutrition and promote sustainable agriculture; ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; achieve gender equality and empower all women and girls; build resilient infrastructure, promote inclusive and

sustainable industrialization and foster innovation; and promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels - are highly related. Thus, the need to maintain focus on reproductive health and vigorously pursue the ICPD goal is imperative for national development.

As part of her commitment to the Programme of Action (PoA) of the International Conference on Population & Development (ICPD), Nigeria launched the first "National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for All Nigerians" in 2001. This was closely followed in 2002 by the development of the "National Reproductive Health Strategic Framework and Plans" to support the policy implementation process. Both documents were reviewed in 2007 to take cognisance of RH emerging issues and the changing landscape. Since the launch of the policy, some notable progress had been made over the years and these include: improved visibility of safe motherhood agenda; increased access and utilisation of maternal health services through free maternal health services provided by some states; improved male involvement in family planning; improved policy environment for family planning services; wider implementation of the school-based National Family Life and HIV Education curriculum; greater involvement of stakeholders in the provision of adolescent reproductive health services; increased awareness of HIV/AIDS and other STIs; and the passage of the Violence Against Women Prohibition Bill, which encompasses harmful practices against women and sexual and reproductive right, by the Senate and State Legislative Houses of the federation.

In more recent times, the FGoN took some urgent steps towards creating the required favourable and conducive environment for the delivery of and access to high-quality health services by Nigerians in their different localities. Prominent among these are the Midwives Service Scheme (MSS); the policy on free family planning services in public sector facilities and life-saving maternal/RH commodities; accelerated implementation of activities around the long-acting reversible contraceptive (LARC) methods; task shifting/sharing with appropriate supervision of the community health extension workers (CHEWs); creation of budget lines and increased funding for key activities such as the procurement and distribution of required RH commodities. Other steps taken include development of guidelines for Integration of Youth & Adolescent Friendly Services into primary health care facilities; increased collaboration with the private health sector in health care delivery and the transition from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs). The review also noted the development of policy-related documents such as policy and strategic framework on HIV/AIDS, and standards of practice for family planning and STIs.

Despite the above progress, some of the constraints and challenges which hindered the implementation of the previous Policy remain unresolved to a substantial level. These include: poor funding of RH programmes; inadequate human resources particularly trained midwives; poorly

motivated health workers; poor integration of maternal and family planning services; high cost of commodities at service delivery points; negligible family planning demand creation efforts; high unmet need for family planning; inadequately equipped facilities; inadequate linkage of adolescent reproductive health (ARH) services to the regular health service delivery system; and poor coordination of ARH at state level. Other constraints and challenges reported include quality issues in STI/HIV/AIDS services, limited and inequitable access to antiretroviral drugs, and limited activities in the areas of reproductive cancers, andropause and menopause.

This present review observed that the genuine intention of the federal government to improve RH services in the country has improved in terms of her commitments and coordinating functions; however, some of the components listed in the National RH Strategic Framework and Plan were not adequately addressed. Safe motherhood initiative and the family planning have not received the much expected priority and, more importantly, many of the activities remain donor-driven. Additionally, the review aptly noted that "the attainment of the SDGswill remain a mirage to Nigerians if the provision of quality reproductive health services is not given attention and commitment by all levels of government. Thus, it is in Nigeria's best interest to refocus and strengthen efforts in the area of reproductive health; this constitutes a major rationale for a revised policy.

It is also important to note that several important developments have taken place nationally and internationally since the development of the old policy, which this revised reproductive health policy took due cognisance of and responded to. These include: the 2016 Revised National Health Policy and the Integrated Maternal, Newborn, Child and Adolescent Health plus Nutrition Strategy. The recent global focus on the transition from MDGs to SDGs and the national commitment and efforts to achieving them are also noteworthy. The population structure and insurgency in the north eastern part of the country have also added new priority dimensions to reproductive health issues such as demographic dividend and reproductive health needs of older population and persons in humanitarian crises.

In this regard, this revised policy aims to build on the platform of the achievements of the previous policy, address some of the limitations identified in the implementation of the old policy, integrate current perspectives on the reproductive health needs of the Nigerian population, embrace recent evidences on cost-effective interventions, and align with the overall direction of current developmental efforts in the health sector as well as the country as a whole.

2.0 SITUATION ANALYSIS AND RATIONALE

Reproductive Health, as defined in the ICPD PoA, encompasses the following: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, including breastfeeding; prevention and appropriate treatment of infertility; prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections, especially sexually transmitted diseases, including HIV infections and Acquired Immunodeficiency Syndrome (AIDS); promotion of healthy sexual maturation as from pre-adolescence, responsible and safe sex throughout the lifetime and gender equality; elimination of harmful practices, such as female genital mutilation (FGM), child/early/forced marriage, and domestic and sexual violence against women; management of non-infectious conditions of the reproductive system, such as genital fistula, cervical cancer, complications of female genital mutilation and reproductive health problems associated with menopause and andropause. This section describes the current situation in Nigeria with regards to these reproductive health components.

2.1 Situation Analysis

2.1.1 Family Planning and Fertility Management

The fertility level in Nigeria remains high. According to the 2013 Nigeria Demographic and Health Survey (NDHS), the Total Fertility Rate (TFR) is 5.5. This figure is slightly lower than the TFR of 5.7 reported in the 2008 NDHS. The current TFR implies that awoman in Nigeria is likely to bear approximately six children in her lifetime if she experiences the currently-observed age-specific fertility rates throughout her reproductive years. Women in rural area are likely to give birth to two more children than urbanwomen during their reproductive years (TFR of 6.2 and 4.7 respectively). The final report of the 1991 census noted that at a growth rate of 2.8 percent, Nigeria has one of the fastest growth rates in the world. The current growth rate of 3.2 percent, as reported by the2006 population census is even higher than the previous rate of population growth. At the current growth rate, it would take only 22 years for the population of Nigeria to double itself. Figures from the last two national censuses showed an increase in the population size from 88.5 million in 1991 to 140 million in 2006; it is currently estimated at over 188 million. The increase of 51.5 million in 15 years clearly evidenced the rapid increase in population size. The fertility and mortality patterns have also resulted in a young population structure, whereby there is a preponderance of young persons in the population. More than two-fifths of the population currently consists of children under the age of 15 years.

Low level of family planning is a major factor in the fertility pattern and population growth rate. According to the 2013 NDHS, the contraceptive prevalence rates(CPRs) among currently married women aged 15 – 49 years in Nigeria were15.1percent for any method and 10 percent for a modern method; these figures are the same as those reported in the 2008NDHS. In 2013, use of family

planning methods was lower in the rural areas compared to the urban areas -8.5percent versus 26.8 percent for any method and5.7 versus16.9 for a modern method. According to the Family Planning 2020 (FP2020) mid-term review/projection report, the CPRs among currently married women and all women were 13 percent and 14.7 percent respectively for a modern method. On the demand side, factors associated with the low contraceptive prevalence level include a culture that is highly supportive of large family size, myths and misconceptions about family planning methods, and male child preference. On the supply side, despite recent efforts aimed at repositioning family planning in the country, the challenges still include inadequate access to family planning services, poor quality of services and inadequate demand creation efforts. The 2014 Nigeria Family Planning Blueprint (Scale-Up Plan) is a broad but well-articulated strategy that holistically addresses these existing gaps in the provision of high-quality FP services to Nigerians of reproductive age. The Blueprint aims at strengthening the health systems for family planning in the six key areas of demand generation and behaviour change communication; service delivery; supplies and commodities; policy and environment; financing; and supervision, monitoring, and coordination.

2.1.2 Safe Motherhood

The health and well-being of the mother and the newborn are strongly linked, and constitute the key focus of safe motherhood programmes. Current statistics show that maternal and neonatal health status in Nigeria is still one of the worst globally. According to the 2015 estimates produced by the World Health Organisation, UNICEF, UNFPA and the World Bank, maternal deaths in Nigeria were estimated at 58,000;this constituted19 percent of the global estimate of 303,000 maternal deaths. According to the 2013NDHS, the country's maternal mortality ratio is 576 per 100,000 live births. The estimates from the United Nations agencies put the lifetime risk of maternal death in Nigeria as 1 in 23, which compares poorly with 1 in 4,900 for developed countries, 1 in 150 for developing countries, and 1 in 36 for sub-Saharan Africa. Most of the maternal deaths are due to bleeding after delivery (haemorrhage), post-delivery infection (sepsis), prolonged obstructed labour, eclampsia (hypertensive diseases of pregnancy), and unsafe abortion. It is estimated that malaria also contributes more than a tenth of maternal deaths in Nigeria. In general, all these conditions are preventable or readily treatable.

Furthermore, utilisation of maternal health services is low; the proportion of women who gave birth between 2008 and 2013 and who delivered their last child with the help of a health professional (doctor, nurse, or auxiliary midwife), according to the 2013 NDHS, was only 38.1 percent, while the proportion of mothers that delivered in a health facility was 36 percent. The survey also reported that 30 percent of pregnant women slept under an ITN during the previous night and 53 percent of women age 15-49 years had their last birth protected against neonatal tetanus. Through the Integrated Maternal, Newborn, and Child Health (IMNCH) strategy, the Federal Ministry of Health (FMoH) and partners had intensified efforts at attaining Universal Health Coverage for evidence-based and cost-effective MNCH interventions such as focused antenatal care, skilled birth

attendants at delivery, distribution of free contraceptive commodities, distribution of free insecticide-treated nets and provision of comprehensive and basic Emergency Obstetrics and Newborn Care (EmONC), among others.

One quarter of all under-five deaths in Nigeria are newborns – 241,000 babies each year. Nigeria's neonatal death rate (death of infants in the first 28 days of life), as indicated by the NDHS, was 37 per 1,000 live births for the 2008-2013 period. The leading causes of neonatal death are intrapartum-related, or 'birth asphyxia' (28%), complications of preterm birth (30%), and severe infections (22%). Overall, most of the neonatal deaths are preventable; for example, tetanus - a vaccine-preventable disease - is responsible for at least a tenth of neonatal deaths. More than half of neonatal deaths occur during the first week, reflecting the intimate link of newborn survival to the quality of maternal care. Factors associated with the poor state of neonatal health and survival in Nigeria include poor health seeking behaviour on the part of parents, inadequate access to maternal and neonatal health services, and poor quality of services. The wide regional variation in the neonatal mortality rate in Nigeria mirrors that of the maternal mortality pattern. The Integrated Maternal, Newborn, and Child Health (IMNCH) strategy emphasises implementation of integrated essential maternal and newborn care interventions with a focus on antenatal care, comprehensive and basic EmONC, postnatal care, and family planning for healthy timing and spacing of pregnancies and highlighting the importance of the household-to-hospital continuum of care.

2.1.3 Obstetric Fistula Prevention and Control

Vesico-vaginal fistula, VVF (breakdown in the tissue between the vaginal wall and the bladder) or recto-vaginal fistula, RVF (breakdown in the tissue between the vaginal wall and the rectum) resulting in urinary or faecal incontinence is one of the most debilitating gynaecological disabilities in women. It is caused by prolonged obstructed labour. The Nigerian National Strategic Framework for fistula prevention and control estimates that between 400,000 and 800,000 women are affected; contributing about 40 percent of the two million women worldwide who suffer from obstetric fistula. Nearly half of worldwide fistula cases occur in Nigeria, with between 50,000 to 100,000 new cases each year. These figures are however modest estimates as majority of the victims usually do not report for treatment due to stigma attached to the condition, ignorance of availability of treatment and low socio-economic status. The assumption that this group is limited to the Northern part of the country has been debunked by evidence of cases from all geopolitical regions of the country. Most fistulae occur among women living in poverty in cultures where a woman's status and self-esteem may depend almost entirely on her marriage and ability to bear children. Women who experience this preventable condition suffer constant urinary or faecal incontinence which often leads to social isolation, shame, skin infections, kidney disorders and even death if left untreated. Obstetric fistulae can largely be avoided by delaying the age of first pregnancy, cessation of harmful traditional practices and timely access to quality obstetric care. There are current interventions addressing these preventive measures while the government is working with international partners in providing

fistula repair surgery to victims. By 2017, the federal government plans to establish three additional obstetric fistula hospitals and bringing the number to sixto end the cases in the country.

2.1.4 Prevention and Control of HIV and other Sexually Transmitted Infections

HIV remains a leading health and development challenge in Nigeria. While the HIV sero-prevalence obtained among pregnant women attending antenatal clinics at sentinel sites reduced from 5.0 percent in 2003 to 4.4 percent in 2005, it rose to 4.6 percent in 2008. However, it dropped to4.1 percent in 2010. The prevalence ranged from 1.0 percent in Kebbi State to 12.7 percent in Benue State. Sixteen states and the Federal Capital Territory recorded a sero-prevalence figure of five percent or above.

The 2013 National HIV/AIDS and Reproductive Health Survey (NARHS), which has HIV testing integrated into the population-based survey, reported a national HIV prevalence rate of 3.4% among the general population, lower than 3.6% reported in 2007. It is estimated that about 3,229,757 people live with HIV in Nigeria and about 220,393 new HIV infections occurred in 2013 and 210,031 died from AIDS related cases. HIV prevalence was highest among the 35-39 years age group (4.4%) and lowest among the 15-19 years age group (2.9%)According to the 2010Integrated Biological and Behavioural Surveillance Survey (IBBSS), the HIV prevalence among key populations at higher risk of HIV infection is quite higher than that of the general population: 27.4 percent for brothel-based female sex workers, 21.7 percent for non-brothel-based FSW, 17.2 percent for men who have sex with men, and 4.2 percent for injecting drug users (IDU). Unsafe sexual behaviours such as unprotected sex and multiple sexual partners, poor perception of HIV risk, poverty, ineffective STI programming, poor integration of HIV/AIDS and sexual & reproductive health services and gender inequality constitute the leading factors in the HIV epidemic in Nigeria. The National HIV Prevention Strategy is currently utilising the Minimum Prevention Package Intervention (MPPI) Implementation Approach to deliver a combination of biomedical, behavioural and structural prevention activities at multiple levels.

Nigeria currently has the highest number of mother-to-child transmissions of HIV in the world. Thus, Nigeria has the highest burden of HIV disease among pregnant women and children worldwide; contributing about 25 percent of the global burden of mother-to-child transmission of HIV among the 21 Global Plan priority countries in 2013. One of the most devastating consequences of the HIV epidemic is transmission of HIV from mothers to children and the increasing contribution of HIV/AIDS to maternal deaths. It is therefore a priority for Nigeria to intensify efforts in ensuring that all pregnant women receive comprehensive HIV/AIDS services including Prevention of Mother-To-Child Transmission (PMTCT). Recent national estimate of PMTCT coverage was 34.3 percent; 17 percent of all pregnant women accessed HIV testing and counseling, 20.2% of HIV pregnant women received anti-retroviral drugs to reduce the risk of mother to child transmission and 6.2% of infants born to HIV infected women received anti-retroviral drugs as prophylaxis for PMTCT. The poor

PMTCT coverage and uptake in Nigeria is a reflection of factors affecting the supply and demand of PMTCT services. The National Prevention Plan 2014 – 2015 continues to promote evidence-based programming and scaling up implementation of the "Minimum Prevention Package Intervention" (MPPI) in key thematic areas, which include HIV counselling and testing, prevention of mother-to-child transmission and early infant diagnosis, treatment care and support, sexual prevention, biomedical prevention, etc.

Other STIs are important reproductive health issues and can be associated with significant level of morbidity as well as increased risk of HIV transmission. While data on incidence of STIs are not reliably available, the report of the 2013 NDHS indicated that 8 percent of women and 4 percent of men in Nigeria experienced a sexually transmitted infection and/or genital abnormal discharge or sore within the last 12 months to the survey. The 2013NDHS also indicated that 40 percent of women and 45 percent of men with self-reported STI symptoms sought advice or treatment from a clinic, hospital, private doctor, or other health professional. However, 27 percent of women and 20 percent of men sought no advice or treatment for their symptoms. The strategic focus of the National Prevention Plan 2014 – 2015 on prevention and control of STIs is to expand the provision of good quality STI care into primary health care, sexual and reproductive health services and HIV services.

2.1.5 Adolescent Sexuality and Reproductive Health

Available statistics show high prevalence of unsafe sexual behaviour, and consequently poor sexual and reproductive outcomes such as teenage pregnancy, unsafe abortions, and sexually transmitted infections among adolescents. According to the 2012 National HIV/AIDS and Reproductive Health Survey (NARHS), about a fifth of males (20 percent) and two-fifths of females (37 percent) aged 15-19 years are sexually experienced. The survey also reported the proportion of sexually experienced adolescents 15-19 years who were current users of condom in 2012 as 68.4 percent for females and 74 percent for males. This is an improvement compared to 2007 NARHS findings of 11 percent and 36 percent respectively. The survey also showed that among the general population of adolescents age 15-19 years, 2.9 percent of each of the males females are HIV positive.

Figures from the 2013 NDHS indicate that approximately a quarter (23 percent) of females age 15-19 years had begun childbearing; 17 percent have had a child and 5 percent were pregnant with their first child. Adolescent girls are disproportionately affected by poor pregnancy outcomes, including maternal deaths, maternal morbidities, and neonatal deaths. Young girls are also more vulnerable than most population groups to harmful practices and sexual rights violation such as early/child/forced marriage, sexual coercion, rape, female genital cutting, and trafficking for sex.
A major contribution to the poor adolescent health status is lack of accurate knowledge of sexual and reproductive health issues. For example, while the 2013 NDHS recorded a very high level of HIV awareness (89.5 percent for females and89.3percent for males) among adolescentsage 15-19years, the level of comprehensive knowledge remained low (22.4percent for females and 29.3percent for

males). “Comprehensive” knowledge was defined as possession of knowledge that: staying faithful to one faithful, uninfected partner and use of condom reduce HIV transmission, healthy-looking person can be HIV positive, mosquito cannot transmit HIV, and sharing meal utensils cannot transmit HIV.Specific interventions addressing the sexual and reproductive health challenges of adolescents include Family Life Health and HIV Education (FLHE) and provision of adolescent and youth-friendly services; these have improved their sexual and reproductive health status.

2.1.6 Management of Infertility and sexual dysfunction

Infertility is inability to conceive or produce offspring despite having regular unprotected sex. It occurs when a poor reproductive system impairs the ability of the body to perform necessary functions of reproduction. Infertility is a condition with severe implications for health and well-being, particularly in a pro-fertility culture as obtains in Nigeria. Individuals and couples that are affected are confronted with significant psychological and social challenges, among others. The 2008 and 2013 NDHS results suggested that primary infertility remains low with 3 percent of all women unable to have children. Recent data suggest that infertility is a growing problem in Nigeria affecting nearly 25 percent of couples; hospital-based data suggest that infertility is the commonest reason (40-45%) for seeking gynaecological consultations in major health institutions in the country.

Contrary to the gender bias with which infertility is viewed in many Nigerian communities, with females generally regarded as those with the problem, the male factor has been implicated in 30-40 percent of cases among infertile couples. The leading risk factors associated with infertility among women include reproductive tract infections, complications of abortions and unclean deliveries. STIs are also associated with infertility among males. Highly sophisticated medical care in the form of assisted reproductive techniques (ART) that may be required for the treatment of tubal disease and male factor infertility is increasingly available in Nigeria; however, majority of the infertile couples are unable to access the care as a result of low awareness and high costs of treatment. Increasing number of infertile couples are seeking and accepting child fostering and child adoption services following counselling.

2.1.7 Post-abortion care services

Unsafe abortion is a major public health problem in Nigeria as it contributes significantly to maternal morbidity and mortality. Although abortion on demand is not legally permitted in the country, a 2006 report by the Campaign Against Unwanted Pregnancy and Guttmacher Institute estimated the number of induced abortions taking place in the country annually at 760,000. Recent data showed that an estimated 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to a rate of 33 abortions per 1,000 women aged 15–49 years. The estimated unintended pregnancy rate was 59 per 1,000 women aged 15–49 years. Fifty-six percent of unintended pregnancies were resolved by abortion. About 212,000 women were treated for complications of unsafe abortion, representing a treatment rate of 5.6 per 1,000 women of reproductive age, and an additional 285,000 experienced

serious health consequences but did not receive the treatment they needed. Most of the women (54%) received post-abortion care in public health facilities. The majority of abortions conducted in recent years – about six in ten – were carried out in health facilities, most of them privately-owned facilities. The majority of females who had abortion were younger than 25 years (55 percent), never in marital union (63 percent) and never had a child previously (60 percent). Almost half of all abortions are performed surgically through either dilatation and curettage or manual vacuum aspiration.

The socio-economic status of the woman was a major determinant of the type of induced abortion they obtained. Overall, a quarter of women who obtained abortion had serious complications. Hospital-based studies suggest that young people constitute the majority of females who experienced abortion-related complications and deaths. According to the report of Guttmacher Institute, unsafe abortions account for at least 13 percent, and possibly 30-40 percent of maternal deaths in Nigeria. Poor access to relevant reproductive health information and services, lack of life skills, and low contraceptive usage are some of the factors that contribute significantly to the high vulnerability of young people to unsafe abortion. Lack of quality counseling services for potential abortion patients and poor quality of post-abortion care are some of the reasons for high level of abortion-related mortality and morbidity. Comprehensive post abortion care is currently being provided in increasing number of public and private health facilities as a combination of interventions which include counselling, access to family planning, treatment and linkage with reproductive health services.

2.1.8 Prevention and management of Reproductive System Cancers

Cancers of the reproductive systems are assuming an increasingly important position in Nigeria's health profile. Breast and cervical cancers are the leading causes of cancer-related deaths among women. Among men, cancer of the prostate is the major cause of cancer-related deaths. The 2012 NARHS reported poor awareness and practices regarding reproductive system cancers in Nigeria, particularly for cancers of the male reproductive organs. Compared to 55 percent of females and 52 percent of males who had awareness of breast cancer, only 17 percent of females and 20 percent of males were aware of cancers of the male reproductive organs. Less than a quarter of the women and men of reproductive age (21 percent of females and 21 percent of males) were aware of cancer of the womb (cervical cancer). Knowledge and utilisation of cancer screening services are also correspondingly low. The government is working closely with partners on proven interventions aimed at increasing awareness, knowledge and utilisation of screening services for male and female productive system cancers while specialist hospitals are being strengthened to provide appropriate quality treatment for affected persons.

2.1.9 Elimination of Harmful Practices and Reproductive Rights Violations

A variety of harmful practices that have negative implications for reproductive health and rights exist in Nigeria. One of these is child/early marriage, which often involves forceful marriage of teenage girls to much older men. According to the 2013 NDHS, 11.6 percent of adolescent females aged 15-19 years were already married by the age of 15 years. Among youths 20-24 years, 17.3 percent were married by the age of 15 years and 42.8 percent by the age of 18 years. The incidence of child marriage is higher in northern Nigeria compared to the south. Child marriage usually results in early childbearing, with its attendant increased risk for poor maternal and neonatal outcomes.

Female Genital Mutilation (FGM) is another prevalent harmful practice. It is more common in the south compared to the north. According to the 2013 NDHS, 25 percent compared to 30 percent in 2008 of Nigerian females aged 15-49 years had been circumcised. Similarly to NDHS 2008 data, the prevalence of 15.3 percent among 15-19 year-old females compared to 30.4percentamong women aged 35-39 years suggests a declining trend. The report also showed that 83 percent of girls age 0-14 years have not been circumcised, while 16 percent were circumcised before they celebrated their first birthday. Among women who had at least one daughter, as reported by NDHS 2008, 30 percent of them had at least one daughter who was circumcised and an additional 5 percent intend to have a daughter circumcised. The proportion of women who have at least one circumcised daughter ranges from 25 percent for women age 20-34 years to 42 percent for women age 45-49 years. Daughters of women with more than a secondary education are less likely than daughters of women at lower levels of education to have been circumcised. Daughters in households in the lowest wealth quintile (19 percent) are more likely to have been circumcised than daughters in households in the highest quintile (13 percent). Type 2 (involving the removal of the clitoris along with partial or total excision of the labia minora) appears to be the commonest type of FGM in the country. FGM is associated with several complications such ashaemorrhage and infections. It could also result in chronic reproductive health problems and maternal morbidities on a longer time basis. However, 64 percent of women and 62 percent of men think that the practice of female circumcision should not continue.

Gender-based violence, including intimate partner violence (such as domestic violence and wife battering), sexual coercion and rape are major forms of reproductive rights violation that compromise the reproductive health of victims. While data is generally scanty about gender-based violence in Nigeria, due to poor reporting, anecdotal evidences suggest that there may be increasing episodes of cases such as rape subsequent to escalating inter-community clashes, insurgency, Internally Displaced Persons (IDPs) and armed robbery incidents. Domestic violence is arguably the most common form of gender-based violence in the country. Studies have also shown that a large proportion of Nigerians, both males and females, still condone wife beating for reasons such as delay in food preparation and refusal to have sex with spouse. Among others, gender-based violence has been associated with increased risk for HIV and poor pregnancy outcomes. Other harmful practices with implications for reproductive health include: widowhood rites/practices such as wife

inheritance which have significant implications for the HIV transmission; male-child preference which may increase the risk for maternal morbidities and mortality as it may lead to high number of births with inadequate spacing; and trafficking of females for sex work, which carries increased risk for HIV/AIDS and other STIs. Transactional sex which involves the exchange of money, favours or gift for sexual intercourse is associated with a greater risk of contracting HIV and other STIs because of poverty, compromised power relations between women and men and the tendency of those involved to have multiple sexual relationships. Many victims do not present in health care facilities; for those who present, the response of the health sector to the problem is far from satisfactory. Both the government and non-governmental organisations are jointly executing mass campaigns on elimination of harmful practices and strengthening the capacity of the health systems to respond appropriately to the needs of the victims. Protection of reproductive rights is being addressed by concerned groups, advocates and legislature.

2.1.10 Reproductive Health Issues of Selected Population Groups and Special Reproductive Health Concerns

(a) Older Population

Andropause and menopause are major reproductive health challenges of older population groups. These conditions, which are related to declining sex hormone levels, may produce a range of physical and psychological symptoms. These issues have not received adequate attention in the reproductive health field in Nigeria. Available evidences indicate that most Nigerians lack appropriate information and knowledge about the symptoms of andropause and menopause. In general, health personnel also lack relevant knowledge in this respect. Reproductive system cancers (breast, cervical and prostrate) are also sexual and reproductive health (SRH) challenges that disproportionately affect older populations. With increasing proportion of the Nigerian population living to old age, SRH challenges of older populations will likely assume greater importance, and reproductive health services need to respond to them more effectively.

(b) People with Special Physical and Mental Needs

Available data from the National Baseline Survey on Persons with Disabilities (PWDs) in Nigeria reported the national prevalence rate of persons with disabilities (PWDs) as 3.2 per cent; this finding suggests that 4.8 million Nigerians were living as PWDs in 2011. Among this group of Nigerians with special physical or mental needs, 24 percent have deafness/hearing disability, 12 percent have visual disability/blindness, 27 percent have physical handicap, 13 percent have some form of mental illness, 7 percent have intellectual disability, 6 percent have speech defect, cerebral palsy (4 percent) and 6 percent have other forms of impairments. Persons with special needs have sexual and reproductive health needs just like any other human beings. However, they have limited access to mainstream health services as many of the existing services are not designed to meet their needs. Social and health workers with skills to respond to their needs appropriately are also generally scarce

in the country. In addition, they face the challenge of higher likelihood to experience sexual and reproductive health violations as a result of their conditions.

(c) Reproductive Health Needs in Humanitarian Settings

Nigeria has recently experienced increased episodes of humanitarian emergencies arising from conflicts (inter-communal clashes, civil disturbances and religious crises), natural disasters (flooding, mud sliding and erosion) and insurgency; these often result in destruction of social life and health systems amongst other effects. Consequently, they all have serious implication on reproductive health status of internally displaced persons, particularly the family planning needs of women and girls. According to the International Organisation on Migration (IOM) Displacement Tracking Matrix (DTM) Round IX Report (April, 2016), there are an estimated 1.74 million people displaced as a consequence of the conflict in Adamawa, Borno, Gombe and Yobe states, among which just under 1 million are children. Climatic changes are likely to contribute to an increase in natural disasters, thereby increasing the size of the population in humanitarian settings. Internally Displaced Persons (IDPs), for example, may not have access to essential reproductive health supplies such as condoms or other contraceptives, delivery kits and services like emergency obstetric and neonatal care and other reproductive health services. Young people (teenage girls and adolescents) are often disproportionately affected by conflicts; they also face additional barriers from lack of sufficient health care, protection, recreational activities, friendship and family support. Weakening of traditional socio-cultural constraints may also make them more vulnerable to sexual rights violations such as coercion and rapes, and likely to engage in risky sexual behaviours. It is imperative that national and international support in humanitarian settings should also implement sexual and reproductive health interventions aimed at improving the quality of life of IDPs.

(d) Male Participation and Involvement in Reproductive Health

Men have their own sexual and reproductive health concerns and needs which are not always met. Also, men's health status and behaviour affect women's SRH status and overall health. Involving men in reproductive health issues has the potential to increase their awareness of SRH issues, improve their health behaviour, as well as increase their acceptance and support to their partners' needs, choices and rights. Therefore improving male involvement and participation is key to achieving desired reproductive health outcomes in Nigeria. Not surprisingly, the ICPD PoA advocates for increased male involvement and responsibilities in RH. Until recently, male involvement remains one of the weakest areas of programmatic efforts in Nigeria's RH environment. Currently, increasing number of programmes and interventions are incorporating specific actions aimed at bringing to the fore male participation in RH issues.

2.1.11 Demographic Dividend

Nigerian population is currently estimated at over 188 million; it has an annual population growth rate of 2.5% and total fertility rate of 5.5. Thus, Nigeria has a young population structure with more than two-fifths of the population (44%) currently consisting of children under the age of 15 years. With these statistics, the population of the country is expected to grow to over 440 million people by 2050. The importance of prioritizing improved access to and uptake of family planning to reduce fertility as a prerequisite to supporting widespread economic growth cannot be underscored. Addressing the sexual and reproductive health needs of Teenage Girls age 10-14 years, particularly the current 10 year old girls and the adolescents age 15-19 years are of critical importance for realizing demographic dividend in Nigeria. If Nigeria makes substantial investments in reproductive health and family planning, particularly in parts of the country with poor health indicators, then fertility levels may begin to decline more significantly, and children will be more likely to achieve better basic levels of health. With additional investments in health and education, and economic initiatives to facilitate job creation for the large number of young people who will be entering the workforce, Nigeria may be able to experience the rapid economic growth known as a demographic dividend.

2.2 Rationale for Policy

From the foregoing, poor reproductive health outcomes are commonly seen in developing countries such as Nigeria and constitute one of the leading public health problems globally. For example, sexual and reproductive health conditions account for nearly two-thirds of Disability-Adjusted Life Years (DALYs) experienced by women of reproductive age. Without effective and efficient reproductive health programming, it might be impossible for Nigeria to advance the health and well-being of her population, harness demographic dividend and subsequently realize her national development aspirations. Such programming needs to rest on a comprehensive and sustainable policy which provides an appropriate framework for the development, implementation, monitoring and evaluation of appropriate programmes, services and interventions. Sexual and reproductive health interventions are clearly good investment and their benefits are far reaching. Reproductive health services have the potential of generating a range of benefits including medical, social and economic developments as well as yielding good returns on investments expended.

This revised RH Policy will not only consolidate the gains of existing reproductive health interventions but also provide the road map required to direct national efforts towards the realisation of the ICPD+20PoA, Addis Ababa Declaration on Population and Development, SDGs and the 2063 Agenda for Africa Development - all of which the country freely committed herself in the interest of national development and overall well-being of her people.

3.0 POLICY DECLARATIONS AND GUIDING PRINCIPLES

3.1 Policy Development Context

The revised 2017 National Reproductive Health Policy is developed within the context of the overall goal of the new 2016 NationalHealth Policy, which is 'to strengthen Nigeria's health system, particularly the primary health care sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians'.The 2017 National Reproductive HealthPolicy aligns with the 2016 National Health Policy in its response to the new realities and trends such as the unfinishedagenda of the Millennium Development Goals (MDGs), the new Sustainable Development Goals (SDGs), emerging reproductive health issues, The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), the provisions of the National Health Act 2014, the new primary health care governance reform of bringing PHC Under One Roof (PHCUOR) and Nigeria's renewed commitment to universal healthcare coverage for all Nigerians using suitable financial risk protection mechanisms.The 2017 RH policy recognises that the National Health Policy provides the platform for achieving the ICPD goal of ensuring universal access to a full range of high quality reproductive health services, including family planning and sexual health, through the primary health care system. The RH policy also takes into cognisancethat the 2016 National Health Policy prioritises Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) as one of the key thematic areas having an overall goal of reducing maternal, neonatal, child and adolescent morbidity and mortality in Nigeria and promote universalaccess to comprehensive sexual and reproductive health services for adolescents and adults throughout their life cycle.

The policy has also been formulated within the context of other relevant and important national and international development policies and frameworks:

(a) National Policy Documents

- Reviewed National Policy on Population for Sustainable Development (2004) is designed to improve the standard of living and quality of life of the people, promote maternal, child and reproductive health, achieve a lower *population* growth rate through the reduction of birth rates by voluntary fertility regulation methods compatible with the *national policy*.

- National Policy on AIDS (2005 - 2009) with the strategic goal of reducing the incidence, provision of treatment and mitigation of the impact of HIV/AIDS such that all Nigerians could achieve socially and economically productive lives free of the condition and its effect.

- Integrated Maternal, Newborn, Child and Adolescent Health Strategy (2007) articulates a comprehensive set of actions to accelerate the achievement of Sustainable Development Goal 3 which focuses on ensuring healthy lives and promote well-being for all at all ages.

- National Policy on the Health and Development of Adolescents and Young people in Nigeria (2007) provides a framework for generating required political will, mobilizing resources, creating safe and supportive environment, fostering collaborations and developing programmes aimed at achieving optimal health and development of adolescent and other young people.

- National Strategic Framework and Plan on Elimination of Obstetric Fistula in Nigeria (2011 – 2015) provides a roadmap and implementation framework for prevention, treatment and surgical repair of obstetric fistula by all stakeholders.

- National Policy on Elimination of Female Genital Mutilation (2013) which has the goal of eliminating the practice of female genital mutilation to improve the health and quality of life of girls and women.

- Task shifting/sharing Policy in Nigeria (2014) which aims to meet the universal coverage and health needs through the mobilisation of available human resources to ensure equity, accessibility and effectiveness in the delivery of essential health services.

- National HIV/AIDS Prevention Plan 2014-2015 is the third in the series of developing national prevention plan. The plan provides strategic direction and guidance for HIV programming in Nigeria and has the overall goal of scaling up evidence-based programming using targeted interventions and standardized intervention packages.

- National Health Act 2014 provides the legal framework for the implementation of the 2016National Health Policy. The Act provides a framework for the regulation, development and management of a health system which defines and provides standards required for the provision of health services. The National Health System is structured to encompass public and private providers of health services, promote a spirit of cooperation and shared responsibility among all providers of health services, provide for persons living in Nigeria the best possible health services within the limits of available resources as well as set out rights and obligations of healthcare providers, health workers, health establishments and users and protect, promote and fulfil the rights of the people to have access to healthcare services.

- National Guidelines for Integration of Reproductive Health and HIV/AIDS (2016) which aims to integrate all the reproductive health components into HIV services towards provision of a quality, equitable and sustainable healthcare.

- National Strategic Health Development Plan II (2017-2021) aims at providing an overarching framework required to significantly improve the health status of Nigerians through the development of a strengthened, sustainable and universal health care delivery system.

- Mid Term Sector Strategy (2017-2020) aims at improving the overall national development with a dedicated chapter on social sector that identifies the need for inclusive health for all Nigerians.

(*b*) ***Regional Strategies and Implementation Frameworks***

- Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, Maputo, 2003 (article 14) which affirms, among others, the rights of women in Africa to dignity, life, integrity and security, and commits states to combat all forms of discrimination against women through appropriate legislative, institutional and other measures and eliminate all harmful practices against women. Among others, it recognizes the rights of women to medical abortion in some circumstances, such as when the continuation of the pregnancy endangers the mental and physical health of the mother or the life of the mother or foetus. It states that Parties shall provide adequate, affordable and accessible health services, including Sexual and Behavioral change communication programmes to women especially those in rural areas.

- Abuja Declaration (2012) stipulates that at least 15% of National budget should be allocated to Public Health by 2015.

- Addis Ababa Declaration on Population and Development (AADPD) Beyond 2014: is the Africa's version of the further implementation of the 1994 International Conference on Population and Development (ICPD) Beyond 2014 tagged *"Unfinished Agenda" regarding Sexual & Reproductive Health for All.*It stipulates the achievement of universal access to sexual and reproductive health services, free from all forms of discrimination by providing an essential package of comprehensive sexual and reproductive health services through the primary health care system for women and men, with particular attention to the needs of adolescents, youth, older persons, persons with disabilities and indigenous people, especially in the most remote areas.

- The Africa Health Transformation Programme (2015–2020): A Vision for Universal Health Coverage seeks to ensure universal access to a basic package of essential health services in all member States of the Region and thus achieve universal health coverage with minimal financial, geographic and social obstacles to services, with focus on adolescent girls as a key indicator on health development in the region. With a strong focus on WHO priority

areas: Improving health security by tackling epidemic-prone diseases, emergencies and new health threats, driving progress towards equity and universal health coverage through health systems strengthening, pursuit of the post-2015 development agenda while ensuring that the MDGs are completed, tackling the social and economic determinants of health.

- The Maputo Plan of Action (2016-2030)for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights emphasises universal access to comprehensive sexual and reproductive health services in Africa. It's overarching goal is for African Governments, civil society, the private sector and all multisector development partners to join forces and redouble efforts so that together, the effective implementation of the continental policy framework on SRHR is achieved in order to end preventable maternal, newborn, child and adolescent deaths, expand contraceptive use, reduce levels of unsafe abortion, end child marriage, eradicate harmful traditional practices including female genital mutilation and prevent gender-based violence and ensure access of adolescents and youth to SRH by 2030 in all countries in Africa.

(c)Global Development Frameworks

- The Convention on the Elimination of All Forms of Discrimination against Women, CEDAW (1981) brings together, in a single legally binding instrument, provisions requiring the elimination of discrimination on the basis of sex in the enjoyment of civil, political, economic, social and cultural rights, and specific rights of particular concern to women and girls. It defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. It is a human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations.

- Sustainable Development Goals, SDGs (2015-2030) Goal 3on ensuring healthy lives and well-being for all at all ages with 13 targets covering the following areas: prevention and reduction of neonatal mortality and under-5 mortality; end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases; universal access to sexual and reproductive health-care services, including family planning; access to safe, effective, quality and affordable essential medicines and vaccines for all. All the other SDGs have an inter-dependent relationship with health, but particularly Goal 5- Achieve gender equality and empower all women and girls.

- The Global Strategy for Women's,Children's and Adolescents' Health (2016-2030) is a global initiative to promote a world in which every woman, child and adolescent in every setting

realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies.

- Family Planning 2020 (FP2020) - is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have.

3.2 Underlying Principles and Values

The principles and values underlying this policy are:

- Rights-based Approach: In line with global consensus declarations on human rights, the ICPD PoA and Provisions of the Constitution of the Federal Republic of Nigeria, this policy recognizes the right of all persons to the highest attainable standard of health, particularly as regards their reproductive and sexual health including the rights of individuals and couples to access relevant reproductive health information and quality services, make reproductive and sexual decisions freely and responsibly, without coercion, discrimination and violence.

- Equity - driven: Provision of quality RH care at all levels especially for the poor and most vulnerable groups and leaving no one behind.

- Participatory and Consultative: This policy recognizes the rights and duties of individuals, communities and various stakeholders' groups to participate in every aspect of the policy implementation, monitoring and evaluation.

- Evidence-based:Effectiveness of policy actions rests on the degree to which they are informed by current evidences. Thus, this policy recognizes that research findings are critical as basis for policy development and implementation as well as programme and service delivery approaches. This policy rests on evidence-based interventions along the continuum of RH care for women and children – from the reproductive years, through pregnancy, birth, the newborn period, infancy and childhood.

- Gender and Age-Responsiveness: All Nigerians, irrespective of their gender and age including adolescents from age 10 years and older population, have sexual and reproductive rights, and are equally entitled to sexual and reproductive health development and care.Furthermore, the policy recognizes that there are special health needs of females and males, which must be addressed in a gender-responsive manner.

- Cultural Sensitivity: Interventions under this policy, including those that target changes in negative cultural practices, are to be implemented in a culture-sensitive manner. Furthermore, the policy recognises that there are very many positive elements in our cultural heritage and settings as peoples of Nigeria and will build on such cultural practices.

- Partnership and Multi-Sectoral Approach: The policy supports the pursuit of effective partnership and collaboration between various health actors, engagement of private sector and the civil society and strengthening governance to effectively coordinate the partnership and collaboration. It also supports the interdependence of health on other areas such as nutrition, education, water and sanitation and gender equality to foster sustainable development.

- Universality: This policy recognises and identifies with the value of universalism in providing universal coverage of reproductive health services with an explicit focus on humanitarian settings, provision of good quality health care in all settings and preparation for emergencies.

- Adolescent-focus: In compliance with the WHO definition of Adolescent as individuals between the ages of 10 and 19 years, this policy identifies adolescent health care need as a fundamental area of intervention in Sexual and Reproductive Health Care.

- Life-cycle Approach: Critical in addressing discriminatory practices against the health, education, well-being and economic growth of women.

- Country-led: This policy underscores the principle of sustainability of all health services, including reproductive and sexual health; hence it emphasises country's ownership and leadership in health care.

- Financing and Accountability: The policy promotes resource mobilisation for financing health care and the accountability of same within acceptable global best practices.

3.3 Policy Declarations

The revised 2017 National Reproductive Health Policy shall be guided by the following declarations and commitments:

1. Government at all levels, organised private sector and all people of Nigeria hereby commit themselves to the attainment of the objectives of this policy.

2. The Governments and people of Nigeria are convinced that reproductive health constitutes an important element in the vision to achieve improved health, quality of life and well-being of individuals and families and is critical to the realisation of national economic and sustainable development goals.

3. All Nigerians, irrespective of age, sex, ethnicity, religion and social status have the right and duty to participate individually and collectively in the planning, implementation and evaluation of reproductive health care programmes and interventions.

4. All stakeholders and development partners, including the Governments of the Federation, civil society organisations and organised private sector, agree to work together in partnership to achieve the goals of this policy.

5. To achieve the objectives of this policy, the Government and the people of Nigeria are determined to formulate strategies, develop action plans and strategic frameworks, establish appropriate mechanisms and adopt a comprehensive and integrated approach in addressing the reproductive health challenges in the country.

6. The implementation of this policy will be in consonance with other relevant policies and national development strategies, particularly the National Health Act, National Health Policy, National Strategic Health Development Plan (NSHDP II), Medium Term Strategic Sector Plan and the Integrated Maternal Newborn Child Adolescent Health Strategy (IMNCAH).

7. Appropriate Strategies and mechanisms shall be put in place to define and adapt culturally sensitive solutions in addressing challenges that reduce access to quality SRH information and services. Relevant skilled health staff will be mobilised to extend support and services to those in most need, through community based outreaches and home-based continuum of care.

4.0 POLICY GOAL, OBJECTIVES AND TARGETS

4.1 Policy Goal and Objectives

Broadly, the policy aims to stimulate an enabling environment that will promote universal access of all Nigerians to comprehensive sexual and reproductive health services that meet their changing reproductive health needs throughout the life cycle.

4.1.1 Goal

To provide the framework of actions and guidance required for the attainment of complete sexual and reproductive health and wellbeing for all Nigerians throughout their life cycle.

4.1.2 Key Priority Areas of Focus

Based on the epidemiological burden of reproductive health status and conditions in Nigeria, the key priority areas of the policy, programmatically, are aimed towards:

(*a*)***Healthy pregnancy and childbearing*** through improving antenatal, delivery, perinatal, postpartum, new born and postnatal care;

(*b*)***Healthy sexual development and sexuality*** through promotion of sexual health; provision of appropriate sexual and reproductive health information; and friendly services to children, adolescents and young people;

(*c*)***Infection-free sex and reproduction*** through combating reproductive tract infections including HIV and other sexually transmitted infections (STIs), and high quality management of post-abortion complications;

(*d*)***Achieving desired and intended fertility, including prevention of mistimed and unwanted pregnancies*** through provision of high-quality services for family planning, including infertility services;

(*e*)***Achieving healthy and cancer-free reproductive life*** through provision of preventive services and high quality management of gynaecological morbidities, including menopausal and andropausal conditions, obstetric fistula and reproductive system cancers of males and females;

(*f*) ***Achieving gender equality and elimination of all forms of discrimination*** through provision of appropriate sexual and reproductive health information and enabling environment for combating sexual coercion, harmful practices and reproductive rights violations;

(g)***Achieving reproductive health needs of persons in humanitarian settings and crisis*** through promotion of sexual health; provision of appropriate sexual and reproductive health information; and friendly services specifically designed to meet the needs of internally displaced persons; and

(h)***Achieving integrated reproductive health service along the continuum of care*** through promotion and provision of comprehensive sexual and reproductive health services in an integrated manner throughout the life cycle.

4.1.3 Objectives

(a) Healthy Pregnancy and Childbearing

Objective I: To reduce maternal, perinatal, neonatal and child morbidity and mortality

(b)Healthy Sexual Development and Sexuality

Objective 2: To increase knowledge of reproductive health and promote responsible sexual behaviour among all individuals

Objective 3: To promote healthy growth and development of children, adolescents and all young persons

Objective 4: To increase access to quality reproductive health information and services for adolescents and young persons

(c) Infection-free Sex and Reproduction

Objective 5: To reduce the incidence and prevalence of sexually transmitted infections including HIV, Syphilis, human papilloma virus (HPV) and other STIs

Objective 6: To increase access to quality post-abortion care and services

(d)Achieving Desired and Intended Fertility

Objective 7: To reduce the rates of unwanted pregnancy and unsafe abortion in all women of reproductive age

Objective 8: To increase access and uptake of modern family planning methods among all sexually active individuals and couples

Objective 9: To reduce the rate of primary and secondary infertility

(e)Achieving Healthy and Cancer-free Reproductive Life

Objective 10: To reduce the incidence and prevalence of reproductive system cancers among men and women

Objective 11: To increase knowledge on and management of menopausal and andropausal conditions

Objective 12: To reduce the incidence and prevalence of obstetric fistula in all women of reproductive age and provide high quality care for those affected

(f) Gender Equality and Elimination of all Forms of Discrimination

Objective 13: To reduce the incidence and prevalence of female genital mutilation and provide appropriate care for those affected

Objective 14: To reduce the prevalence of domestic and sexual violence and provide appropriate management for victims

(g)Reproductive Health Needs of Persons in Humanitarian Settings and Crisis

Objective 15: To increase the capacity for assessing and managing reproductive health needs and vulnerabilities in humanitarian settings

Objective 16: To provide access to minimum initial service package (MISP) for reproductive health in humanitarian settings

Objective 17: To prevent and respond to sexual and reproductive health threats including rape, gender based violence (GBV) and other forms of sexual assault/abuse in humanitarian settings

(h)Achieving Integrated Reproductive Health Service along the Continuum of Care

Objective 18: To promote integration of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services and programmes along the continuum of care for every woman and every child

Objective 19: To strengthen the capacity of health systems for research, monitoring and evaluation of reproductive health programmes and services

4.1.4 Targets

Objective I: To reduce maternal, perinatal, neonatal and child morbidity and mortality.

1. Reduce neonatal mortality by 50 percent from 37 in 2013 to 18 per 1,000 live births by 2021.
2. Reduce under-five mortality by 50 percent from 128 in 2013 to 64 per 1,000 live births by 2021.
3. Increase the proportion of pregnant women delivered by skilled attendants by 50 percent from 38 percent in 2013 to 57 percent by 2021.
4. Increase the proportion of births taking place in a health facility by 50 percent from 36 percent in 2013 to at least 54 percent by 2021.
5. Reduce maternal mortality ratio by 75 percent from 576 per 100,000 live births in 2013 to 144 per 100,000 live births by 2021.
6. Achieve at least 80 percent of pregnant women attending at least 4 ANC visits throughout the course of a particular pregnancy by 2021.
7. Achieve at least 80 percent of pregnant women attending at least 8 ANC visits throughout the course of a particular pregnancy by 2021.

8. Increase the proportion of pregnant women receiving Vitamin A supplements during their last pregnancy by 50 percent from 29 percent in 2013 to 44 percent by 2021.
9. Increase the proportion of pregnant women receiving Iron tablets for 90 days or more during their last pregnancy by 50 percent from 21 percent in 2013 to 32 percent by 2021.
10. Increase the proportion of women receiving at least two doses of tetanus toxoid (TT) injection in the last pregnancy by 50 percent from 48 percent in 2013 to 72 percent by 2021.
11. Achieve 100 percent screening coverage for genotype, blood group and Rhesus typing in pregnant women by 2021.
12. Achieve 50 percent coverage for ultrasound scanning before 24 weeks of gestation in pregnant women attending antenatal care by 2021.
13. Increase the proportion of pregnant women receiving intermittent preventive treatment (IPTp-SP) by 50 percent from 23 percent in 2013 to 35 percent by 2021.
14. Achieve 100 percent staffing of a functional primary health care centre per ward with competent health personnel (trained on Life Saving Skills)by 2021.
15. Have at least 80 percent of facilities (disaggregated by levels of care) providing Basic Essential Obstetric and Newborn Care (BEONC) per 500,000 population by 2021.
16. Have at least 50 percent of facilities providing Comprehensive Essential Obstetric and Newborn Care (CEONC) per 500,000 population by 2021.
17. Achieve at least 80 percent of women receiving PAC services at all levels by 2021.
18. Achieve at least 80 percent of newborns commencing on breast feeding within 1 hour of birth by 2021.
19. Achieve at least 80 percent of women attending postnatal care services within 48hrs of delivery by 2021.
20. Achieve at least 80 percent of newborns and mothers visited by a skilled health care provider within 48 hours of delivery by 2021.
21. Achieve at least 80 percent of pregnant women who slept under an insecticide-treated net during the previous night by 2021.
22. Achieve 50 percent of wards having a functional primary health care centre per ward by 2021.
23. Have at least 80 percent of Service Delivery Points (SDPs) adequately stockedwith United Nations Life Saving maternal commodities (misoprostol, magnesium sulphate, oxytocin, chlorhexidine, Tetanus Toxoid vaccine, contraceptives, injectable antibiotics etc) per quarter by 2021.

Objective 2: To increase knowledge of reproductive health and promote responsible sexual behaviour among all individuals

1. Reduce the proportion of adolescents engaging in unprotected sex from 48 percent of males and 56 percent of females in 2013 to 20 percent or less for each sex by 2021.
2. Achieve at least 70 percent of young people from 15 to 24 years having knowledge on reproductive health services and rights by 2021.

Objective 3: To promote healthy growth and development of children, adolescents and all young persons

1. Scale-up family life and health education (FLHE)/comprehensive sexuality education coverage to 100% for adolescent boys and girls in all public schools by 2021.
2. Reduce the proportion of young people with nutritional problems by 75%by 2021.

Objective 4: To increase access to quality reproductive health information and services for adolescents and young persons

1. Achieve at least 50% coverage of young people who have access to comprehensive SRH information and services by 2021.
2. Achieve at least 50% coverage of young people who have access to comprehensive youth friendly health services by 2021.
3. Train 50% of all RH service providers on adolescent and youth reproductive health information and integrated services in all health facilities by 2021.
4. Increase the number of public health facilities delivering adolescent and youth friendly health services by 50% by 2021.
5. Achieve at least 50% reduction of unwanted pregnancy among young female by 2021.

Objective 5: To reduce the incidence and prevalence of sexually transmitted infections including HIV, Syphilis, human papilloma virus (HPV) and other STIs

1. Increase the proportion of people within reproductive age who have comprehensive knowledge about HIV transmission from 26 percent for females and 37 percent for males in 2013 to 75 percent for each sex by 2021.
2. Increase the proportion of sexually active adolescents using male condom from 29 percent for females and 20 percent for males in 2013 to 75 percent for both sexes by 2021.
3. Increase the proportion of pregnant women screened for HIV and other STIs, particularly Syphilis from 44 percent for HIV and 13.6 for Syphilis in 2015 to 90 percent for each by 2021.
4. Increase the proportion of pregnant women effectively treated for HIV and other STIs, particularly Syphilis and hepatitis from 30 percent for HIV and 61 percent for Syphilis in 2015 to 90 percent for each by 2021.
5. Increase the proportion of HIV-infected pregnant women who receive ARV prophylaxis to reduce the risk of PMTCT from 20% in 2013 to 50% by 2021.

Objective 6: To increase access to quality post-abortion care and services

1. Increase the proportion of health facilities offering post abortion care from 3.3 percent in 2016 to 10 percent by 2021.
2. Reduce the proportion of maternal deaths resulting from unsafe abortions from 11 percent in 2008 to 2 percent or less by 2021.

Objective 7: To reduce the rates of unwanted pregnancy and unsafe abortion in all women of reproductive age

1. Increase the contraceptive prevalence rate fora modern family planning method among currently married women from 10 percent in 2013 t0 42 percent by 2021.
2. Decrease unmet need for modern family planning from 16 percent in 2013 to 8 percent by 2021.

Objective 8: To increase access and uptake of modern family planning methods among sexually active individuals and couples

1. Increase the proportion of FP demand satisfied from 48.5 percent in 2013 to 80 percent by 2021.
2. Decrease the proportion of 12 months FP discontinuation from 28 percent in 2013 to 14 percent by 2021.

Objective 9: To reduce the rate of primary and secondary infertility

1. To reduce the prevalence of primary infertility among women from 3 percent in 2013 to 1 percent by 2021.

Objective 10: To decrease the incidence and prevalence of reproductive system cancers among men and women

1. Increase the proportion of the population who are aware of screening services for cervical cancer from 9.1 percent in 2012 to at least 80 percent by 2021.
2. Increase the proportion of women 30 to 49 years old who are screened for cervical cancer from about 3.5 percent in 2007 to at least 80 percent by 2021.
3. Increase the proportion of girls 9 to 13 years old who are immunized with HPV vaccine from 2 percent to at least 80 percent by 2021.
4. Achieve 100% treatment coverage for all women in reproductive age with pre-cancerous lesions of the cervix by 2021.
5. Increase the number of health facilities with the capacity to offer comprehensive cancer treatment services from 8 in 2015 to 33 by 2021.
6. Achieve at least 80 percent level of awareness among the population about screening services for prostate cancer by 2021.
7. Achieve at least 50 percent level of uptake of screening services for prostate cancer among men age 40 years and above by 2021.

Objective 11: To increase knowledge on and management of menopausal and andropausal conditions

1. Achieve 100% level of awareness on health conditions related to menopause and andropause among all older population groups by 2021.
2. Achieve at least 80% treatment coverage for all older population groups with menopausal and andropausal conditions

Objective 12: To reduce the incidence and prevalence of obstetric fistula in all women of reproductive age and provide high quality care for those affected

1. Reduce the number of women affected by obstetric fistula by 75% from 800,000 in 2014 to200,000 by 2021.
2. Increase the number of health facilities with the capacity to offer obstetric fistula repair surgery by 100% from 3 in 2016 to 6 by 2021.

Objective 13: To reduce the incidence and prevalence of female genital mutilation and provide appropriate care for those affected

1. Reduce the proportion of girls undergoing female genital mutilation from 30 percent in 2013 to 5 percent or less by 2021.
2. Increase the proportion of health facilities with the capacity to provide care, counselling and support for victims of FGM to about 80 percent by 2021.
3. Eliminate the medicalization of FGM by 2021.

Objective 14: To reduce the prevalence of domestic and sexual violence and provide appropriate management for victims

1. Achieve at least 80% reduction of prevalence of domestic and sexual violence by 2021.
2. Reduce the proportion of women who experienced violence and who did not seek for treatment from qualified health professionals from 45 percent in 2013 to 22 percent or less by 2021.

Objective 15: To increase the capacity for assessing and managing reproductive health needs and vulnerabilities in humanitarian settings

1. Achieve at least 60% level of the number of States and the FCT with a humanitarian crisis response plan by 2021.
2. Achieve at least 60% level of the number of States and the FCT with a capacity to assess and manage the SRH needs and vulnerabilities in identified humanitarian crisis by 2021.
3. Achieve at least 60% level of the number of States and the FCT with an SRH team with the capacity to respond to identified humanitarian crisis by 2021.

Objective 16: To provide access to minimum initial service package (MISP) for reproductive health in humanitarian settings

1. All 36 States and FCT to have strategic stock of SRH kits for emergency/crisis settings by 2021.

Objective 17: To prevent and respond to sexual and reproductive health threats including rape, gender based violence (GBV) and other forms of sexual assault/abuse in humanitarian settings

1. All States to have a system for collecting and synthesizing data on gender based violence (GBV) and other forms of sexual assault/abuse in humanitarian settings by 2021.
2. All States and LGAs to have a team trained in managing and treating gender based violence (GBV) and other forms of sexual assault/abuse including clinical management of rape by 2021.

Objective 18: To promote integration of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services and programmes along the continuum of care for every woman and every child

1. All States to implement the National guidelines on integration by 2021.
2. All facilities across Nigeria to have health care providers trained on the integration of services by 2021.

Objective 19: To strengthen the capacity of health systems for research, monitoring and evaluation of reproductive health programmes and services

1. Have all relevant SRH indicators incorporated in the NHMIS by 2021.
2. All States (100 percent) to have dash board for monitoring SRH indicators by 2021.
3. 100 percent of RH focal persons and M&E officers trained on M&E of RH services by 2021.
4. Have at least 80 percent of reproductive health programmes and services monitored and supervised atall levels (National, State and LGA) by 2021.
5. Have a system for regular documentation and dissemination of RH best practices established in all 36 States and the FCT (100 percent) by 2021.
6. Have at least one Institute (for research, training and services on reproductive health issues) established per geopolitical by 2021.

5.0 POLICY IMPLEMENTATION

5.1 Roles and Responsibilities

Health is on the concurrent legislative list in Nigeria. As such, the three levels of government have roles and responsibilities in delivering reproductive health care services and planning, implementing and evaluating reproductive health programmes. Secondly, reproductive health programme delivery rests on the pillar of inter-sectoral partnership, as every sector of the economy – government, non-governmental organisations, faith based organisations (formal and informal) and organised private sectors – have valuable contributions to make in the realisation of the national reproductive health goals. Thirdly, reproductive health embraces the concept of integrated health care service delivery and aims to meet the inter-related health and development needs of individuals and families. In this wise, the implementation of the reproductive health services and programmes shall be primarily within the existing health services and calls for strengthening of the health systems and improvement in the quality of service delivery at all levels especially at the primary health care level.

Emphasis shall be placed on promotive and preventive health activities to significantly reduce the burden of reproductive health problems. In line with Primary Health Care, which is the cornerstone of the National Health Policy, such programmes shall be targeted to meet individual and families where they live and work, with their own full participation and with the support of community stakeholders including community and faith-based organisations. While the implementation of the policy will be primarily that of the Nigerian government and peoples, the support and partnership of the donor communities and other international development partners are also important and relevant to actualisation of the goal and objectives of the policy. In the spirit of the provisions of the ICPD PoA and self-reliance, majority of the resources for the policy implementation (human, financial, material, and technical)shall be borne by the government and peoples of Nigeria.

5.1.1 Roles of the Health Sector

(a) Federal Ministry of Health

The FMoH shall provide overall strategic support for the implementation of this Policy. In particular, the Federal Ministry shall:

1. Foster partnership for the advancement of reproductive health agenda by creating and strengthening linkages with other sectors (such as education, women affairs, youth development, and information), its various parastatals (such as the National Primary Health Care Development Agency and the National Health Insurance Scheme) and other levels of government, non-governmental organisations as well as international development organisations.

2. Actively support the existing National Reproductive Health Working Group (NRHWG), which is a multi-disciplinary and multi-sectoral Technical Advisory Group, to meet regularly and function more effectively and efficiently. The membership of the Group shall continue to be drawn from relevant arms of the Federal Ministry of Health and its agencies, other ministries, parastatals, non-governmental organisations, the academia, the organised private sector, and faith-based organisations. The Reproductive Health Division under the Department of Family Health of the Federal Ministry of Health shall constitute the secretariat for the NRHWG.
3. Be the lead advocate for increased government and stakeholders' commitments to financially and technically support reproductive health services and programmes.
4. Operate a distinct budget line for reproductive health programmes and provide adequate funds annually to support effective implementation of the policy at the national level.
5. Promote the implementation of plans and actions that will ensure reproductive health commodity security on a sustainable basis nationally.
6. Provide an enabling environment for quality assurance on drugs at all levels.
7. Facilitate the procurement and supply of equipment and materials to ensure delivery of high quality reproductive health care in the health facilities under its jurisdiction.
8. Develop and communicate national strategic plan and implementation frameworks for health workforce development in the area of reproductive health service delivery.
9. Set standard, develop guidelines and make available tools for training and other human resources development for reproductive health services and programmes nationwide.
10. Develop, widely disseminate and periodically review national standards, minimum health packages, tools, protocols, instruments and materials in support of reproductive health service delivery and programme implementation.
11. Provide technical assistance to States, Local Government Areas, and other agencies and sectors in the implementation of relevant areas of the policy including building their capacity to plan and implement training activities; undertake information, education and communication as well as social and behaviour change communication activities; and implement high-quality reproductive health care activities.
12. Mobilise the private sector and other development partners to support reproductive health services and programmes at diverse settings, including the workplace and community level.
13. Develop national research priorities on reproductive health and mobilise resources in support of its implementation and the use of research outcomes in evidence-based programming and service provision.
14. Collect, collate and disseminate relevant national information and data on reproductive health status and issues.
15. Review, monitor and evaluate policies and programmes on reproductive health nationwide to ensure that set objectives are achieved.

16. Liaise with the Ministries of Labour &Employment and Women Affairs to create mother – baby work friendly environment (e.g. establishment of crèches in workplace, extension of maternity leave from 4 to 6 months in support of exclusive breast feeding and granting paternity leave of 10 working days per annum).
17. Provide enabling environment to cater for sexual and reproductive health emergencies including but not limited to internally displaced persons.
18. Provide a minimum package of care including reproductive health services at all levels.
19. Develop a protocol outlining the activities of lay health workers in the country.
20. Explore and use relevant technologies to build and maintain health worker capacity at all levels.
21. Develop extensive referral network and link health facilities with existing transport systems [National Union of Road Transport Workers (NURTW), Motor Bike Ambulances (MBAs)].

(b) State Ministries of Health

The State Ministries of Health (SMoH) shall provide leadership for the implementation of this policy within the State. In particular, the State Ministries shall:

1. Foster partnership with other agencies and actors in the State (including State Primary Health Care Development Agency/Board) to advance the implementation of reproductive health services and programmes.
2. Establish a Core Technical Committee (CTC) which comprises all reproductive health partners under the leadership of the State.
3. Establish (in cases where there is none) and effectively support the operations of a multi-disciplinary, multi-sectoral Technical Advisory Group – the State Reproductive Health Working Group – with the SMoH providing the secretariat.
4. Operate a distinct budget line for reproductive health programmes and provide adequate funds annually to support effective implementation of the policy at the State level.
5. Assume a leading role with regard to advocacy for increased government and stakeholders' commitments to support reproductive health care and programmes within the State.
6. Provide an enabling environment for quality assurance on drugs at all levels.
7. Facilitate the procurement and supply of equipment and materials to ensure delivery of high quality reproductive health care in the health facilities under its jurisdiction.
8. Develop and implement state strategic plan to improve quality of reproductive health services and expand access to such services as needed.
9. Develop and implement human resources plan to support effective implementation of the state strategic plan in reproductive health.
10. Provide technical assistance to Local Government Areas, agencies, organisations and institutions in the State on the implementation of relevant areas of the policy.
11. Integrate reproductive health into service delivery activities of all secondary health care facility activities.

12. Collect, collate and disseminate relevant information and data about reproductive health services and issues within the State.
13. Monitor the implementation of the policy within the State.
14. Mandate all development partners to get State approval prior to programme implementation.
15. Liaise with the Ministries of Labour &Employment and Women Affairs to create mother – baby work friendly environment (e.g. establishment of crèches in workplace, extension of maternity leave from 4 to 6 months in support of exclusive breast feeding and granting paternity leave of 10 working days per annum).
16. Provide an enabling environment to cater for sexual and reproductive health emergencies including but not limited to internally displaced persons.
17. Adapt and implement lay health worker policy and training curriculum.
18. Develop extensive referral network and link health facilities with existing transport systems [National Union of Road Transport Workers (NURTW), Motor Bike Ambulances (MBAs)].

(c) Local Government Area

The Local Government Area shall:

1. Provide reproductive health services as an integral part of primary health care services.
2. Build the capacity of health workers and other relevant staff to provide quality reproductive health services to all age groups and both sexes.
3. Create a budget line for reproductive health activities and provide adequate funds annually to support effective implementation of the policy at the LGA level.
4. Provide technical assistance and support to local non-governmental organisations and community-based organisations and institutions in the LGA in the implementation of relevant areas of the policy.
5. Collect, collate and disseminate relevant data about reproductive health services.
6. Support operational and other types of research on reproductive health issues and promote the use of research findings for evidence-based programming within their LGAs.
7. Monitor activities, services and programmes relating to reproductive health within the LGA.
8. Provide an enabling environment to cater for sexual and reproductive health emergencies including but not limited to internally displaced persons.
9. Adopt policy to create mother – baby work friendly environment (e.g. establishment of crèches in workplace, extension of maternity leave from 4 to 6 months in support of exclusive breast feeding and granting paternity leave of 10 working days per annum).
10. Develop extensive referral network and link health facilities with existing transport systems [National Union of Road Transport Workers (NURTW), Motor Bike Ambulances (MBAs)]

5.1.2 Roles of the Legislature

The Legislature at all levels shall:

1. Serve as advocate and support the implementation of the policy.
2. Make appropriate legislation in support of reproductive health issues.
3. Domesticate international treaties, charters and conventions on reproductive health matters in which Nigeria is signatory.
4. Provide adequate budgetary allocation and appropriation and timely release of fundsfor effective implementation of reproductive health activities and programmes.

5.1.3Roles of Other Ministries, Departments and Agencies

(a) Ministry of Education

The Ministry shall:

1. Expand the integration and teaching of family life and HIV/AIDS education into relevant subject curricula in relevant institutions at all levels.
2. Scale-up the training of teachers in family life and HIV/AIDS education (FLHE).
3. Integrate FLHE and other relevant reproductive health education into mass literacy, adult and non-formal educational programmes to cater for the out-of-school adolescents and other young people.
4. Support FLHE research programmes.
5. Provide curricula and co-curricular FLHE activities in schools.
6. In partnership with other organisations, integrate sexual and reproductive health issues into school health activities.
7. Monitor the standard of teaching activities and the performance of students in relation to FLHE at all levels.
8. Collect, analyse, interpret and disseminate gender-disaggregated education service statistics as well as document and disseminate best practices and programme experiences regarding FLHE, school health and other relevant reproductive health activities within the sector.
9. Make available integrated reproductive health information and services in all tertiary institutions.

(b) Ministry of Women Affairs

The Ministry shall:

1. Promote gender equality, gender equity, and women empowerment.
2. Promote awareness of reproductive health among families especially women at various levels.
3. Undertake information, education and communication (IEC) activities to sensitise the public on gender issues, reproductive health needs of women and reproductive rights violation.

4. Promote and implement measures and activities that will improve the reproductive health status of women and their families.
5. Advocate the mainstreaming of reproductive health and rights concerns into all health development activities within the sector.

6. Advocate the elimination of harmful practices that hinder the optimal reproductive health development of females, including adolescent girls.
7. Organise capacity building activities to improve parents' ability to communicate effectively with their children in pre-adolescent and adolescent stages on sexuality, sexual health and reproductive health.
8. Collaborate with FMoH to integrate reproductive health services into women empowerment programmes.

(c) Ministry of Youth and Sports

The Ministry shall:

1. Establish and manage youth centres providing relevant adolescent/youth-friendly services such as counselling to meet the needs of in and out-of-school adolescents and other young people.
2. Undertake information, education and communication (IEC) activities to sensitise the public on the reproductive health needs and concerns of young people.
3. Execute behaviour change communication programmes to improve the reproductive health knowledge and behaviour of young people.
4. Collect, collate, analyse and disseminate data on reproductive health development programmes and activities in a gender-disaggregated manner.

(d) Ministry of Finance

The Ministry shall:

1. Make sufficient budgetary allocation, release funds timely and take full accountability of money released for reproductive health activities.
2. Support the establishment of specific budget lines for reproductive health activities for different line ministries and other government agencies.
3. Providefinancial data relevant to reproductive health programming on timely basis to the National Planning Commission for inclusion in the national data bank and to other relevant government and non-governmental bodies.

(e) Ministry of Justice and Attorney - General

The Ministry shall:

1. Provide legal guidance and facilitate enactment of necessary laws on reproductive health matters.
2. Promote the integration of relevant international and regional charters and conventions on reproductive health issues into domestic laws.
3. Undertake information, education and communication activities to increase public awareness on laws pertaining to reproductive rights.
4. Actively facilitate the prosecution of cases involving reproductive rights violation and promote the enforcement of laws relevant to reproductive health in the country.

(f) Ministry of Budget and National Planning

The Ministry shall:

1. Make sufficient budgetary allocation for reproductive health activities.
2. Integrate reproductive health issues into development planning in all relevant sectors.
3. Strengthen the coordination of international co-operation and support for reproductive health activities.
4. Update reproductive health information in the national data bank regularly.
5. Liaise with FMoH in accreditation process of technical co-operation on reproductive health-related projects.
6. Provide appropriate information and support to FMoHon high yield investment and budget for effective reproductive health policy implementation.
7. Promote gender equity in development planning in all relevant sectors.

(g) National Population Commission

The Commission shall:

1. Collect, analyse, and interpret gender-disaggregated reproductive health data through censuses and sample surveys.
2. Disseminate specific reproductive health data on timely basis through the development and distribution of survey reports, monographs, fact sheets, and other print and electronic materials.
3. Support and promote national research activities on reproductive health issues, including sexual and reproductive health education.
4. Monitor and evaluate the implementation of reproductive health programmes in collaboration with other appropriate bodies and agencies.
5. Advocate and promote the implementation of reproductive health programmes and services as a critical part of population and development activities.
6. Provide relevant reproductive health data on timely basis to the Ministry of Budget and National Planning for inclusion intoand updating the national data bank.

7. Support and promote development of policy documents such as guidelines, tools and training manuals on reproductive health issues.

(h) National Bureau of Statistics

The Bureau shall:

1. Collect, analyse, interpret and disseminate gender-disaggregated socio-economic data to facilitate monitoring and evaluation of reproductive health services and programmes.
2. Provide reproductive health-related data on a regular basis to the national data bank and other relevant agencies and institutions.

(i) Ministry of Information and Culture

The Ministry shall:

1. Support the dissemination of reproductive health information through national orientation strategies at all levels.
2. Mobilise available organisational structures and institutions to support the implementation of reproductive health policy and programmes.
3. Integrate relevant reproductive health issues into the curriculum of programmes in the institutions training journalists and provide enabling environment for quality delivery of such curriculum.
4. Build the capacity of journalists and mass media practitioners in reporting and broadcasting on reproductive health issues.
5. Enforce existing laws on information dissemination and mass media activities that have relevance to reproductive health.

(j) Ministry of Agriculture

The Ministry shall:

1. Integrate relevant reproductive health issues such as family planning/child spacing and HIV/AIDS prevention into the training programmes of agricultural extension workers.
2. Build the capacity of agricultural extension workers in contributing to the health of individuals, families and communities through reproductive health information, education and communication activities.
3. Promote food security and nutritional education to improve reproductive health outcomes of females.
4. Collect, analyse and disseminate data regarding reproductive health issues within the sector.
5. Create market incentives for women of reproductive age to increase household resources.

(k) *Ministry of Labour and Employment*

The Ministry shall:

1. Promote the inclusion of reproductive health education and services as part of workplace policy.
2. Conduct regular inspections of workplaces in line with relevant national regulation to control/prevent practices and exposure to hazardous materials that may hinder reproductive capacity, performance or outcome of individuals.
3. Collect, analyse and provide relevant reproductive health data on timely basis.
4. Establish crèches in workplaces to promote mother-baby work friendly environment.
5. Promote and support extension of maternity leave from 4 to 6 months and granting of paternity leave of 10 working days annually.

(l) *Ministry of Power, Works and Housing*

The Ministry shall:

1. Provide and regularly maintain public infrastructure in support of the creation of healthy, safe and enabling environment.
2. Map infrastructural availability and provide data and standards to appropriate authorities for provision of health facilities.
3. Collect, analyse and disseminate data regarding people's health and development issues within the sector.

(m) Ministry of Interior

The Ministry shall:

1. Establish and maintain functional corrective and rehabilitation centres across the country to provide optimal services for young people needing such facilities.
2. Provide an enabling environment to cater for reproductive health emergencies including but not limited to internally displaced persons, persons in prisons and remand homes.

(n) National and State Emergency Management Agency (NEMA/SEMA)

The Agency shall:

1. Implement policy on reproductive health relating to humanitarian settings.
2. Co-ordinate the plans and programmes for efficient and effective response to sexual and reproductive health issues in humanitarian settings at national, state and local government levels.
3. Provide psycho-social support services in emergency situations including but not limited to sexual and reproductive health.

(o) The Armed Forces, Security and Law Enforcement Agencies and Other Uniformed Services

The Forces shall:

1. Provide reproductive health information and education and behaviour change communication to engender positive reproductive behaviour among members and their dependents.
2. Provide reproductive health services as part of the integrated health services in their organisation to address needs of members and their dependents in line with the national reproductive health policy.
3. Collect, analyse and use data regarding reproductive health issues within the sector to improve reproductive health planning and service delivery as relevant to their mandates.

(p) Tertiary Education Institutions and Research Institutes

The Institutions shall:

1. Provide reproductive health education, and social and behaviour change communication as part of health promotion services.
2. Provide technical and advisory services on reproductive health issues.
3. Assist in the evaluation of programmes related to this national policy.
4. Undertake basic, operational and applied research activities to generate new ideas; monitor policy implementation; and improve programme development and management activities in the areas of reproductive health.
5. Disseminate research findings on reproductive health issues widely to the public and policy makers.

(q) Regulatory Bodies:

These include Pharmaceutical Council of Nigeria (PCN), Medical and Dental Council of Nigeria (MDCN), Nursing and Midwifery Council of Nigeria (NMCN) and Community Health Practitioners Registration Board of Nigeria (CHPRBN).

The Bodies shall:

1. Regulate the activities and performance of registered members for provision of quality reproductive health care and services.
2. Integrate reproductive health into the curriculum of training programmes of their trainees.
3. Integrate reproductive health as a key content of the mandatory professional development programmes of their trainees.

(r) Professional Associations

These include Society for Obstetrics and Gynaecology of Nigeria (SOGON), Nigerian Medical Association (NMA), Paediatrics Association of Nigeria (PAN), Nigerian Association of Nurses and Midwives (NANM), Association of Public Health Physicians of Nigeria (APHPN), Guild of Medical Laboratory Association of Nigeria (GMLAN) and National Association of Community Health Practitioners of Nigeria (NACHPN).

The Associations shall:

1. Promote and support networks for reproductive health issues.
2. Advocate for relevant policy changes and programme implementation relating to reproductive health.
3. Undertake operational and other type of researches as well as use research-generated evidences to improve the effectiveness of their approaches.
4. Collaborate with relevant line ministries and government agencies in the delivery of reproductive health services and implementation of programmes.
5. Collect and submit reproductive health service statistics to relevant government agencies on regular basis.

(s) Civil Society Organisations

The Organisations shall:

1. Complement government efforts in the formulation, financing, implementation, and monitoring and evaluation of reproductive health programmes.
2. Promote and support networks for reproductive health issues.
3. Mobilise, organise and build the capacity of the informal sector to support reproductive health programmes and services.
4. Advocate for relevant policy changes and programme implementation relating to reproductive health.
5. Expand the delivery of reproductive health services and programmes at the grassroots, particularly using innovative methods to address neglectedreproductive health needs of vulnerable population groups and hard-to-reach communities.
6. Undertake operational and other type of researches as well as use research-generated evidences to improve the effectiveness of their approaches.
7. Collaborate with relevant line ministries and government agencies in the delivery of reproductive health services and implementation of programmes.
8. Collect and submit reproductive health service statistics to relevant government agencies on regular basis.
9. Monitor the implementation of this national policy.

(t) Faith-based Organisations

The Organisations shall:

1. Sensitise and provide health information and education to their members and communities on reproductive health issues.
2. Advocate for appropriate policy changes and programmes in the area of reproductive health.
3. Promote reproductive health services that are consistent with their religious beliefs and practices.
4. Organise and promote programmes that will enhance the reproductive health of their groups and the society at large.
5. Collaborate with relevant agencies to bring reproductive health servicesclose to the community.

(u) Non-formal sector

a. Lay health workers : “A lay health worker (LHW) is defined as a health worker who performs functions related to health care delivery and is trained in some way in the context of an intervention, but who has not received a formal professional or paraprofessional certificate or tertiary education degree. Other terms for lay health workers include 'community health workers' (CHWs) and 'village health workers' (VHWs).'Trained traditional birth attendants' (tTBAs) are also regarded as lay health workers” (WHO 2013). However, Nigeria does not consider CHWs as lay health workers as detailed in the Nigeria Taskshifting/sharing Policy where they are referred to as those who have undergone a 36-month course in a training institution approved by the CHPRBN.

They shall:

1. Identify danger signs in pregnancy and new born, offer basic health interventions and refer the client to the nearest health facility.
2. Be linked to a health facility in the community and receive mentorship from health care providers.
3. Mobilize and counsel women to attend antenatal care to increase and promote facility deliveries.
4. Undertake basic lifesaving procedures within the scope of their training and refer.

5.1.4 Roles of other Stakeholders

(a) Communities

The Communities shall:

1. Organise and participate in reproductive health activities to improve the reproductive health status of their members.
2. Actively work towards the elimination of harmful practices against women and other social and community norms that impact negatively on the reproductive health status of the population.
3. Actively partner with governments, civil society organisations, and other development partners in the effective operation and management of community-based reproductive health services and programmes.
4. Be mobilised by their community-based leaders, including traditional and religious leadership with regards to the promotion of reproductive health activities, elimination of harmful practices against women and children, and adoption of appropriate reproductive health behaviours, including the effective and efficient use of available reproductive health facilities.

(b) Political Parties

The Political Parties shall:

1. Integrate reproductive health concerns into party manifestos, agendas, plans and programmes.
2. Support the implementation of reproductive health programmes at all levels of governance.
3. Provide information and education on the importance of reproductive health issues in national development to their members.
4. Promote and advocate appropriate policy changes in the area of reproductive health.

(c) Media

The Media shall:

1. Produce programmes and disseminate accurate, culturally-appropriate and gender-sensitive information on reproductive health.
2. Collaborate with the government and development partners in undertaking educational campaigns on priority reproductive health issues.
3. Sensitize and create awareness on relevant policy changes and programme implementation relating to reproductive health.
4. Assist relevant agencies in dissemination of accurate and high quality reproductive health information and data.
5. Project all reproductive health issues of great importance.

6. Generate public and policy dialogue on reproductive issues.
7. Monitor and evaluate policy actions on reproductive health and use relevant data and information to stimulate increased investment.

(d) Organised Private Sector

The Private Sector shall:

1. Provide reproductive health information and education to engender positive reproductive behaviour.
2. Provide reproductive health services as part of the integrated health services in their organisation to address needs of members and their dependents.
3. Advocate for appropriate policy changes and programmes in the area of reproductive health.
4. Partner with government, development partners and communities to provide reproductive health services and organise relevant programmes as part of good corporate citizenship.

(e) International Development Partners

The implementation of the policy will be primarily that of the Nigerian government at all levels and the people. Coordinated support and partnership from multilateral agencies, bilateral agencies, private foundations, and international non-governmental organisations are important and relevant to actualise the goal and objectives of the policy and should be in line with the provisions of the National Strategic Health Development Plan (NSHDP).

Thus, the International Development Partners shall:

1. Provide technical and managerial support for sexual and reproductive health programmes as relevant to their mandate.
2. Provide financial resources to support the government and community programming efforts on sexual and reproductive health.
3. Partner with the government, other development partners and communities to provide reproductive health services and organise relevant programmes.
4. Contribute to human resources development and health systems strengthening through partnership with the government.
5. Include FMoH in project planning and obtain preliminary approval/consent of FMoHprior to submissions of projects to Ministry of Budget and National Planning for final approval.
6. Establish and operationalise Core Technical Committees (CTC) in the 36 States and the FCT.
7. Work closely with FMoH to identify and address critical reproductive health issues of national concern.
8. Promote reproductive health services in the communities taking into cognisance religious and socio-cultural beliefs as well asage appropriateness.

5.2 Resource Mobilisation

Adequate resource mobilisation and effective management are critical to the achievement of the goals and objectives of the policy. The Government of Nigeria shall have the responsibility to mobilise resources for the implementation of the policy. This will include funds provided by the government at every level, through their normal budgetary processes, particularly as budget lines established for various reproductive health activities. Resources from the Global Financing Facility and National Health Act through the Basic Health Care Provision Fund and National Health Insurance Scheme shall also be used in supporting the access of individuals to relevant reproductive health services. The SDGs funds as it relates to SDG3 shall be made available to the FMoH for the realisation of the set goals. As an implementing Ministry, the FMoH also shall demand for and access a portion of the Social Investment and the Reconstruction of the North East Budget earmarked for the provision of RH services for victims of insurgencies and IDPs. Government shall also take the leadership in mobilising resources from partners, including private sector organisations as their corporate social responsibilities (such as Telecommunication, Banking and Oil and Gas industries) as well as philanthropists, indigenous and international development partners. Communities shall mobilise resources as part of their role in partnering with government and other development partners. Households and individuals will also make some contributions as relevant.

Furthermore, there shall be active tracking of resources allocated or committed to reproductive health bundled products and services nationwide. The Government shall play an active role in establishing a sustainable mechanism for resources tracking. Civil society organisations shall also play an active role in budget and resources tracking. Report of allocated and utilised resources in the area of reproductive health shall be published annually and widely circulated to all stakeholders.

5.3 Implementation Process

Strategic frameworks and guidelines are important tools for the translation of broad policy goals into plans and other lower level managerial tools. Effective implementation of this policy shall, therefore, involve the development of relevant strategic/implementation frameworks, plans, service guidelines, and standards of practice as may be relevant to each area of RH, and the specified objectives of the policy. In line with the declaration of this policy, strategic frameworks and other implementation/managerial tools that have been developed for different elements or service areas of RH shall continue to be used. In general, however, where relevant, revision of such tools shall be promoted. Development of implementation tools in the areas where they are currently lacking and/or where new ones are clearly needed to achieve the objectives of the policy is also advocated. In addition, a National Framework for Monitoring and Evaluation of Reproductive Health Programmes and Services shall be developed and widely circulated for the use of all stakeholders. Annex 1 lists some of the relevant policy implementation tools that are in existence.

National, state and local government implementation plans shall be developed for each of the eight key priority areas (healthy pregnancy and childbearing, healthy sexual development and sexuality, infection-free sex and reproduction, and achieving desired and intended fertility, achieving healthy and cancer-free reproductive life, achieving gender equality and elimination of all forms of discrimination, achieving reproductive health needs of persons in humanitarian settings and crisis and achieving integrated reproductive health service along the continuum of care) on two-yearly basis using a participatory, multi-sectoral approach with the policy goal, objectives, and targets as the overarching guide. These plans shall form the basis of developing annual work plans for each relevant agency and development partner, in line with their mandate. Quarterly work plans will then be developed from such annual work plan.

5.4 Monitoring and Evaluation

To achieve the objectives of the policy, monitoring and evaluation shall constitute a critical part of the implementation process. In this regard, government agencies shall monitor activities in the sector within their mandate and in the context of the level of their operation in the three-tier federal structure of the country in line with relevant national laws and guidelines. The Reproductive Health Division of the Department of Family Health, Federal Ministry of Health will collect regular reports on activities nationally and serve as the clearing house for the collation and dissemination of reports on the policy implementation. For this purpose, government agencies and development partners shall submit quarterly report to the Reproductive Health Division. To ensure quality in the monitoring process, the Reproductive Health Division will develop necessary mechanisms, tools and guidelines in relation to the information and data relevant for monitoring the implementation process. These will include a National Framework for Monitoring and Evaluation of Reproductive Health Programmes and Services and the National Family Planning Dashboard.

The Reproductive Health Division of the Federal Ministry of Health will also serve as the secretariat of the National Reproductive Health Working Group (NRHWG). Its responsibilities in this respect will include presentation of progress report on the policy implementation at the regular meeting of the Working Group, which will be convened by the Division at least twice a year. The Reproductive Health Division will also actively coordinate the production and wide dissemination of an annual national report on progress in the policy implementation and the trend in the reproductive health status of the Nigerian population vis-à-vis the set objectives. As part of this effort and in line with the principle of evidenced-based interventions enunciated in this policy, relevant research findings will be collated, disseminated as well as utilised in the development of national and other reports.

A mid-term evaluation will be undertaken in 2019 - midway into policy implementation period. A comprehensive evaluation of the implementation of the policy will be undertaken nationally at the end of the five-year period of policy implementation. The results of monitoring and evaluation activities will be used to improve programme planning and implementation as well as the development of future policies.

Annex 1

Existing Reproductive Health-Related Policy Implementation Tools

- National Reproductive Health Strategic Framework and Plan 2002 - 2006

National Population Management

- National Policy on Population and Sustainable Development (2004)

Safe Motherhood

- Roadmap for Accelerating the Achievement of MDGs Related to Maternal and Newborn Health in Nigeria (Federal Ministry of Health, 2005)
- Integrated Child Survival and Development (ICSD) Strategic Framework & Plan of Action (Federal Ministry of Health, 2006)
- Integrated Maternal, Newborn and Child Health Strategy (Federal Ministry of Health, 2007)
- Saving newborn lives in Nigeria: Newborn health in the context of the Integrated Maternal, Newborn and Child Health Strategy (Federal Ministry of Health, 2011).

Adolescent Reproductive Health

- Family Life and HIV Education Curriculum (2003)
- National Education Sector HIV & AIDS Strategic Plan (2006-2010) (Federal Ministry of Education, 2006)
- Strategic Framework of the National Policy on the Health and Development of Adolescents and Other Young people in Nigeria (Federal Ministry of Health, 2007)
- National Policy on the Health and Development of Adolescents and Young Persons in Nigeria (2007)

Family Planning and Fertility Management

- Reproductive HealthCommodity Security Strategic Plan (Federal Ministry of Health, 2003)
- National Guidelines on Contraceptive Logistics Management System (Federal Ministry of health, 2003)
- **Nigeria Family Planning Blueprint (Scale-Up Plan) 2014**

Sexually Transmitted Infections, Including HIV/AIDS

- National Strategic Framework for HIV/AIDS in Nigeria, 2010-2015(National Agency for the Control of AIDS, 2009)
- National HIV/AIDS Strategic Plan 2010-2015
- National HIV/AIDS Prevention Plan 2014 -2015
- National Guidelines for Integration of Reproductive Health and HIV/AIDS, 2016

Elimination of Harmful Practices against Women and Children

- National Policy and Plan of Action on Female genital Mutilation in Nigeria (Federal Ministry of Health, 2002)

General

- Reproductive Health Behavioural Change Communication Framework (Federal Ministry of Health, 2005)
- National Guidelines on Micronutrient Deficiency Control (Federal Ministry of Health, 2005)
- National Reproductive Health Behaviour Change Communication Plan (Federal Ministry of Health, 2007)
- National Health Promotion Framework (Federal Ministry of Health, 2007)
- National Strategic Health Development Plan Framework, 2009 – 2015 (Federal Ministry of Health, 2009)
- National Action Plan for the Promotion and Protection of Human Rights in Nigeria (2009 – 2013)

RESOURCE MATERIALS

1. International Conference on Population and Development, ICPD (1994)
2. 2013 Nigeria Demographic and Health Survey (NDHS)
3. 2008 Nigeria Demographic and Health Survey (NDHS)
4. 1991 census report
5. 2006 population census report
6. Current population of Nigeria - Countrymeters. Nigeria population clock. Nigerian population 2016.
7. Momentum at the midpoint. Family Planning 2020.
8. Nigeria Family Planning Blueprint (Scale-Up Plan). Federal Government of Nigeria (2014).
9. Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. World Health Organisation 2015.
10. Integrated Maternal, Newborn, Child and Adolescent Health + Nutrition (IMNCAH+N)
11. The Gaps Report.UNAIDS (2013).
12. National HIV/AIDS Prevention Plan 2014 -2015
13. Mid-Term Review 2013
14. Saving newborn lives in Nigeria: Newborn health in the context of the Integrated Maternal, Newborn and Child Health Strategy. 2nd edition. Abuja: Federal Ministry of Health 2011.
15. Repairing Obstetric Fistula in Nigeria. USAID.
16. National HIV & AIDS and Reproductive Health Survey, 2012 (NARHS Plus). Federal Ministry of Health Abuja, Nigeria
17. 2010 National HIV Sero-prevalence Sentinel Survey. FMoH, 2010.
18. The Incidence of Abortion in Nigeria. *International Perspectives on Sexual and Reproductive Health, 2015, 41(4):170–181. AkinrinolaBankole, Isaac F.Adewole, Rubina Hussain, OlutosinAwolude, Susheela Singh and Joshua O. Akinyemi.*
19. Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences, New York: Guttmacher Institute, 2006. Bankole A, Oye-Adeniran BA, Singh S, Adewole IF, Wulf D, Sedgh G, Hussain R (2006).
20. Report of the National Baseline Survey on Persons with Disabilities (PWDs) in Nigeria funded by the Millennium Development Goals (MDGs) Office,with Statistical Support from the National Bureau of Statistics. Federal Ministry of Women Affairs & Social Development (2011).
21. International Organisation on Migration (IOM) Displacement Tracking Matrix (DTM) Round IX Report (April, 2016).
22. Demographic dividend: Investing in human capital.
23. Addis Ababa Declaration on Population and Development (AADPD) Beyond 2014. United Nations Economic Commission for Africa, African Union Commission and United Nations Population Fund. 2013.

24. Sustainable Development Goals, SDGs (2015-2030): 2030 Agenda for Sustainable Development. United Nations Development Programme.
25. 2063 Agenda for Africa Development
26. The Global Strategy on Women's, Children's and Adolescents' Health (2016-2030). United Nations.
27. *R*eviewed National Policy on Population for Sustainable Development 2004
28. National Policy on Elimination of Female Genital Mutilation (2013)
29. Mid Term Sector Strategy (2017-2020)
30. National Strategic Health Development Plan II (2017-2021)
31. National Policy on AIDS
32. National Health Act 2014
33. National Strategic Framework and Plan on Elimination of Obstetric Fistula in Nigeria
34. National Policy on the Health and Development of Adolescents and Young people in Nigeria (2007)
35. Task shifting/sharing Policy in Nigeria, (2014)
36. The Maputo Plan of Action (2016-2030). The African Union Commission.
37. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, Maputo, 2003 (article 14)
38. Abuja Declaration (2012)
39. The Africa Health Transformation Programme (2015–2020). WHO Regional Office for Africa, 2015.
40. The Convention on the Elimination of All Forms of Discrimination against Women, CEDAW (1981). United Nations Entity for Gender Equality and the Empowerment of Women.
41. Nigeria Family Planning Blueprint (Scale-Up Plan). Federal Ministry of Health (2014).
42. Integration of Reproductive Health and HIV Services(Federal Ministry of Health, 2016)

2017 National Reproductive Health Policy

Strategic Frame Work for Implementation 2017 - 2021

KEY PRIORITY AREAS	RESULTS	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	RISKS AND ASSUMPTIONS
a. Healthy Pregnancy and Childbearing through improving antenatal, delivery, perinatal, postpartum, new born and postnatal care	**Objective 1:** To reduce maternal, perinatal, neonatal and child morbidity and mortality	1. Neonatal mortality rate 2. Under-five mortality rate 3. Maternal mortality ratio 4. Proportion of pregnant women delivered by skilled attendants 5. Proportion of births taking place in a health facility 6. Proportion of pregnant women receiving Vitamin A supplements during their last pregnancy 7. Proportion of pregnant women attending at least 8. ANC visits throughout the course of a particular pregnancy 9. Proportion of women receiving at least two doses of tetanus toxoid (TT) injection in the last pregnancy 10. Proportion of pregnant women receiving intermittent preventive treatment (IPTp-SP) 11. Proportion of wards with a functional primary health care centre staffed 100 percent with competent health personnel (trained on Life Saving Skills) 12. Proportion of Service Delivery Points (SDPs) adequately stocked with United Nations Life Saving maternal commodities (misoprostol, magnesium sulphate, oxytocin, chlorhexidine, Tetanus Toxoid vaccine, contraceptives, injectable antibiotics etc) 13. Proportion of pregnant women who slept under an insecticide-treated net during the previous night 14. Proportion of facilities providing Basic Essential Obstetric and Newborn Care (BEONC) per 500,000 population	1.Population census data 2.NDHS Report 3.MICS (Multiple indicator cluster survey) 3.NISH Report 4.Report of organised research at community level 5.Sentinel Survey 6. DHIS 2 7.Malaria Indicator Survey 8.Maternal and Perinatal Death Surveillance and Response Surveillance System 9. Approved annual budget and implementation audit 10. NARHS Report 11. MPDSR	**Risks:** 1. Lack of quality Reproductive Health information services made available to all 2. Untimely release of funds **Assumptions:** 1. Stable democratic government 2.Political will and commitment to RH 3. Periodic conduct of Population census, NDHS MICS, NARHS, etc 4. Cooperation by professional regulatory bodies

	Strategies: 1. Advocacy and social mobilisation 2. Equitable access to quality RH health services 3. Capacity building 4. Research promotion 5. Resource mobilisation			
	Expected outputs: 1. Political commitment, policy makers' and opinion leaders' support for RH programmes 2. Commitment of regulatory agencies, professional associations and legislative arm of government to support RH issues 3. Equitable distribution of facilities and staff 4. Institutionalisation of skills by updating RH components of curricula for training all cadres of healthcare personnel			

	5. Development and utilisation of improved curricula to update the training of service providers and pre-service training of nurses, midwives, medical officers, community health workers 6. Provision of quality RH services 7. Established linkages between levels of care through an efficient referral system 8. Improved skills of health workers 9. Research agenda defined 10. Funding RH research initiated 11. Creation of a budget line for RH programmes and services 12. Establishment of Public-Private Partnership **Activities:** 1. Advocacy to political leaders, policy makers and opinion leaders on RH programmes			

	2. Advocacy to and engagement of regulatory agencies, professional associations and legislative arm of government on RH issues 3. Re-deployment and re-distribution of facilities and staff 4. Equipping health facilities for provision of quality maternal health services 5. Establishment of a functional and efficient referral system 6. Updating the training of service providers and pre-service training of nurses, midwives, medical officers, community health workers 7. Training of nurses, midwives and physicians on provision of basic and emergency obstetric services 8. Formation of a research group and defining research agenda 9. Mobilise funds to support RH research			

	10. Create a budget line for RH programmes and services 11. Mobilise funds from private sector			
b. Healthy Sexual Development and Sexuality through promotion of sexual health; provision of appropriate sexual and reproductive health information; and friendly services to children, adolescents and young people	**Objective 2:** a. To increase knowledge of reproductive health and promote responsible sexual behaviour among all individuals	1. Proportion of adolescents practising safe sex 2. Proportion of young people age 15-24 years having adequate knowledge on reproductive health services and rights	1. Needs assessment report 2.NDHS Report 3.MICS (Multiple indicator cluster survey) 4.NISH Report	**Risks:** 1.Lack of quality Reproductive Health information services made available to all. 2. Untimely release of funds **Assumptions:** 1. Stable democratic government 2. Political will and commitment to RH 3. Periodic conduct of NDHS MICS, NARHS, etc
	Strategies: 1. Advocacy and social mobilisation 2. Promotion of healthy reproductive behaviour 3. Access to quality RH information and services 4. Capacity building 5. Community ownership of RH programmes			

	6. Culturally sensitive approaches to disseminating information in support of RH 7. Research promotion			
	Expected outputs: 1. Increase in knowledge on RH issues 2. Responsible sexual behaviour 3. Positive parenting as role model 4. Reduction of multiple sexual partners 5. Increase in uptake of modern contraceptives 6. Reduction in STIs and unwanted pregnancies			
	Activities: 1. Media engagement 2. Development, production and distribution of IEC materials on RH issues 3. Airing of Radio, TV jingles and spots on reproductive health information and services 4. Support teaching of FLHE to in-school and out-of-school adolescents			

	5. Establishment of functional youth-friendly services 6. Conducting research to update knowledge and information on adolescent RH issues and services			
	Objective 3: To promote healthy growth and development of children, adolescents and young persons	1. Proportion of adolescent boys and girls in public schools exposed to Family Life and HIV Education/ comprehensive sexuality education 2. Proportion of young people with adequate nutrition	1. Needs assessment report 2.NDHS Report 3.MICS (Multiple indicator cluster survey) 4.NISH Report 5.Report of organised research at community level 6. NARHS 7. Advocacy report 8. Training report	**Risks:** 1. FHLE is not taught as a subject in school curriculum 2. Inadequate number of teachers trained on FHLE 3. Untimely release of funds **Assumptions:** 1. Support by State Government to scale-up FHLE through training of teachers and FHLE incorporation in school curriculum 2. Periodic conduct of NDHS, MICS, NARHS etc 3. Commencement of free school feeding programme by the government
	Strategies: 1. Advocacy and social mobilisation 2. Capacity building 3. Safety nets 4. Public-Private Partnership			

	Expected outputs: 1. Increased number of in-school adolescents exposed to FHLE 2. Increased number of FHLE-trained teachers 3. Establishment of Public-Private Partnership 4. Increased number of households with access to safety nets **Activities:** 1. Advocacy to government at all levels to support FHLE 2. Advocacy to government at all levels to commence free school feeding programme 3. Training of teachers and in-school adolescents on FHLE 4. Engage in Public-Private Partnership to provide/distribute free ITNs, de-worming drugs, etc			
	Objective 4: To increase access to quality reproductive health information and services for adolescents and young persons	1.Proportion of young people who have access to comprehensive SRH information and services 2. Proportion of young people who have access to comprehensive youth friendly health services	1. Needs assessment report 2.NDHS Report 3.MICS (Multiple indicator cluster survey) 4.NISH Report	**Risks:** 1. Lack of quality Reproductive Health information services made available to all. 2. Untimely release of funds

		3. Proportion of RH service providers trained on adolescent and youth reproductive health information and integrated services 4. Proportion of public health facilities delivering adolescent and youth friendly health services 5. Proportion of young female having unwanted pregnancy	5.Report of organised research at community level 6. NARHS 7. Advocacy report 8. Training report	**Assumptions:** 1.Stable democratic government 2.Political will and commitment to RH 3. Periodic conduct of NDHS MICS, NARHS, etc 4. Cooperation by professional regulatory bodies
	Strategies: 1. Advocacy and social mobilisation 2. Capacity building 3. Public-Private Partnership 4. Access to quality RH information and services 5. Research promotion **Expected outputs:** 1. Regulatory agencies, professional associations and legislative arm of government on RH issues engaged through advocacy 2. Health facilities equipped for provision of adolescent and youth friendly services 3. Functional and efficient referral system established			

	4. Training of service providers and pre-service training of nurses, midwives, medical officers, community health workers updated 5. Private sector participation in provision of youth friendly services 6. Research to update knowledge and information on adolescent RH issues and services conducted			
	Activities: 1. Advocacy and engagement of regulatory agencies, professional associations and legislative arm of government on RH issues 2. Equipment of health facilities for adolescent and youth friendly services 3. Establishment of a functional and efficient referral system 4. Updating the training of service providers and pre-service training of nurses, midwives, medical officers, community health workers			

	5. Private sector participation in provision of youth friendly services 6. Conducting research to update knowledge and information on adolescent RH issues and services			
c. Infection-free Sex and Reproduction through combating reproductive tract infections including HIV and other sexually transmitted infections (STIs), and high quality management of post-abortion complications	**Objective 5:** To reduce the incidence and prevalence of sexually transmitted infections including HIV, Syphilis, human papilloma virus (HPV) and other STIs	1. Proportion of people within reproductive age who have comprehensive knowledge about HIV transmission 2. Proportion of sexually active individuals consistently using male condom 3. Proportion of pregnant women screened for HIV, HPV, Syphilis and hepatitis 4. Proportion of pregnant women effectively treated for HIV and other STIs 5. Proportion of HIV-infected pregnant women who receive ARV prophylaxis to reduce the risk of PMTCT	1. NARHS 2. NDHS 3. Facility register 4. PMTCT data 5. Report of organised research at facility and community level 6. Training report 7. DHIS	**Risks:** 1. Unavailability of screening kits 2. Lack of skilled health care workers 3. Inadequate and untimely release of funds 4. Resistance to change 5. Ill-equipped health facilities 6. Poor record keeping in health facilities **Assumptions:** 1. Availability of adequate funding 2. Timely disbursement of funds 3. Receptive community 4. Regular ART and diagnostic supplies 5. Positive staff attitude 6. Periodic conduct of NDHS MICS, NARHS, etc

	Strategies: 1. Behavioural Change Communication 2. Demand creation for screening for HIV, HPV, Syphilis and hepatitis 3. Adoption of the 90-90-90 rule for HIV treatment 4. Strengthening of community structures for ownership and sustainability 5. Capacity building, including human resource and infrastructural facilities 6. RH/HIV Integration 7. Management of STIs			
	Expected outputs: 1. IEC materials produced and distributed 2. Jingles aired on radio and television 3. Increased number of sexually active individuals consistently using condoms 4. Increased number of pregnant women screened for HIV, HPV, Syphilis and hepatitis			

	5. Increased number of people living with HIV who know their HIV status, and are receiving sustained antiretroviral therapy and having viral suppression 6. Increased number of community resources committed to the programme 7. Increased number and cadre of health workers trained 9. Increased number of health facilities equipped with diagnostic and treatment capabilities 10. RH/HIV integration services commenced			
	Activities: 1. Production of IEC materials 2. Production radio and television jingles 3. Promote condom distribution (male & female), demonstration and use for dual protection 4. Conduct HIV, HPV and Syphilis screening services for pregnant women			

	5. Provision of antiretroviral therapy and viral load test for people living with HIV 6. Conduct community sensitization meetings and mobilise community resources 7. Train relevant cadres of health workers on diagnosis and treatment of HIV and other STIs 8. Equip health facilities with diagnostic and treatment capabilities for HIV and other STIs 9. Integrating RH services into care and support of persons infected or affected by HIV/AIDS			
	Objective 6: To increase access to quality post-abortion care and services	1. Proportion of health facilities offering post abortion care (PAC) 2. Proportion of maternal deaths resulting from unsafe abortions	1. NDHS 2. Report of organised research at health facility and community levels 3. Maternal and Perinatal Death Surveillance and Response 4. Approved annual budget and implementation audit.	**Risks:** 1. Socio-cultural inhibitions 2. Unavailability of commodities 3. Lack of skilled health care workers 4. Inadequate and untimely release of funds 5. Criminalisation of abortion

				Assumptions: 1. Availability of adequate funding 2. Timely disbursement of funds 3. Good health care seeking behaviours
	Strategies: 1. Advocacy for PAC at all levels 2. Behavioural Change Communication 3. Demand creation for PAC 4. Capacity building of health care workers 5. Strengthening of the supply chain 6. Strengthening of community structures for ownership and sustainability			
	Expected outputs: 1. Media engagement 2. Sensitised communities 3. Increased number of women receiving PAC 4. Increased number of health facilities offering PAC 5. Increased number of healthcare workers trained to provide PAC			

	Activities: 1. Conduct trainings on Expanded Life Saving Skills (ELSS/LSS) for medical officers and midwives 2. Equip health facilities to provide PAC 3. Conduct BCC and demand creation campaigns 4. Conduct community sensitization meetings and mobilise community resources			
d. Achieving Desired and Intended Fertility, including prevention of mistimed and unwanted pregnancies through provision of high-quality services for family planning, including infertility services	**Objective 7:** To reduce the rates of unwanted pregnancy and unsafe abortion in all women of reproductive age	1. Contraceptive prevalence rate (CPR) for a modern family planning method among currently married women 2. Unmet need for modern family planning	1. NDHS 2. NARHS 3. Community surveys	**Risks:** 1. Unavailability of fund 2. Non-acceptance of IEC content 3. Cultural and religious barriers **Assumption:** 1. Availability of adequate funding 2. Timely disbursement of funds 3. Reading and use of IEC materials by recipients 4. Community and religious leaders as advocates

	Strategies: 1. Advocacy 2. Demand creation for contraceptives through BCC 2. Strengthened contraceptive logistics management system (CLMS) 3. Capacity building of health care workers 4. Strengthening of community structures for ownership and sustainability			
	Expected outputs: 1. IEC materials on prevention of unwanted pregnancies and unsafe abortion produced 2. Increased acceptance of contraceptive commodities 3. Cultural and religious barriers overcome 4. Community and religious leaders become advocate of FP 5. Increased number of healthcare workers with comprehensive knowledge of Contraceptive Logistics Management System (CLMS)			

	6. Standard Operating Procedures and job aids produced 7. Functional and efficient CLMS for maternal commodities **Activities:** 1. Conduct advocacy to political, community and religious leaders 2. Production and dissemination of IEC materials on safer sex practices, relevance of condoms for dual protection, etc 2. Air radio jingles and TV advert in English and local languages 3. Expand access to contraceptive services , especially for adolescents (in-school and out-of-school) 4. Promote male involvement in family planning services 5. Expand contraceptive services to include emergency contraceptive pills, implants, permanent contraception and natural family planning methods			

	6. Conduct trainings on CLMS for healthcare workers providing FP services 7. Conduct on-the-job trainings on CLMS through monitoring and supportive supervisory visits to service delivery providers 8. Update operational guidelines and SOPs and job aids for quality services 9. Train health workers on operational guidelines, SOPs and job aids			
	Objective 8: To increase access and uptake of modern family planning methods among sexually active individuals and couples	1. Proportion of individuals whose FP demand is satisfied 2. Proportion of individuals who discontinued FP after 12 months 3. Proportion of persons infected or affected by HIV/AIDS who are receiving integrated RH services	1. MSS reports 2. NDHS 3. NARHS 4. Report of organised research at health facility and community levels	**Risks:** 1. Unavailability of funds for procurement and distribution of modern family planning methods **Assumption:** 1. Availability of modern family planning methods 2. Successful implementation of Task shifting/sharing method 3. Availability of modern family planning commodities 4. Increased private sector participation

	Strategies: 1. Implementation of Task shifting/sharing policy on LARC 2. Demand creation for contraceptives through BCC 3. Strengthened contraceptive logistics management system (CLMS) 4. Private sector participation 5. Capacity training 6. RH/HIV services integration **Expected outputs:** 1. IEC materials produced and disseminated 2. Increased number of health facilities providing contraceptive services 3. Increased number of FP providers 4. Increased number of FP providers trained on CLMS 5. Increased number of sexually active individuals up-taking FP services 6. Increased participation of private sector 7. Scope of contraceptive services increased			

	Activities: 1. Production & distribution of IEC materials 2. Stocking health facilities with adequate contraceptive commodities 3. Conduct CLMS training for FP providers 4. Training-of-trainers on LARC 5. Step-down trainings for community health workers on provision of LARC 6. Expand access to contraceptive services, especially for adolescents (in-school and out-of-school) 7. Promote male involvement in family planning services 8. Expand contraceptive services to include emergency contraceptive pills, implants, permanent contraception and natural family planning methods 9. Integrating RH services into care and support of persons infected or affected by HIV/AIDS			

	Objective 9: To reduce the rate of primary and secondary infertility	1. Prevalence of primary infertility among women	1. NDHS 2. Report of organised research at health facility and community levels	
	Strategies: 1. Advocacy 2. Social mobilisation 3. Integrated services 4. Linkages with adoption agencies 5. Research promotion **Expected outputs:** 1. Community awareness increased 2. Decreased number of couples with infertility 3. Infertility treatment integrated into RH services 4. Linkages with adoption agencies established 5. Increased funding for fertility research **Activities:** 1. Raising community awareness on prevention and management options 2. Integrating treatment interventions into RH services 3. Establish linkages of affected couples with adoption agencies			

	4. Strengthening community infrastructure to support affected couples 5. Conduct fertility research			
e. Achieving Healthy and Cancer-free Reproductive Life through provision of preventive services and high quality management of gynaecological morbidities, including menopausal and andropausal conditions, obstetric fistula and reproductive system cancers of males and females	**Objective 10:** To reduce the incidence and prevalence of reproductive system cancers among men and women	1. Proportion of the population who are aware of screening services for cervical cancer 2. Proportion of women 30 to 49 years old who are screened for cervical cancer 3. Proportion of girls 9 to 13 years old who are immunized with HPV vaccine 4. Proportion of women in reproductive age who received treatment for pre-cancerous lesions of the cervix 5. Number of health facilities with the capacity to offer comprehensive cancer treatment services 6. Proportion of the population who are aware about screening services for prostate cancer 7. Proportion of men age 40 years and above who are screened for prostate cancer	1. NARHS 2. NDHS 3. Cancer register 4. Immunisation records 5. Health facility records 6. Referral cards 7. KAP studies 8. Prevention programme report 9. MICS SMART	**Risks:** 1. Lack of accurate data for planning 2. Political instability 3. Declining donor support for RH and cancer issues 4. Insecurity in some parts of the country 5. Economic recession **Assumptions:** 1. Availability of funding for programme implementation and accountability 2. Political will and commitment to RH and cancer issues 3. Financial will and commitment to RH and cancer issues
	Strategies: 1. Advocacy and resource mobilisation 2. Social mobilisation 3. Capacity building 4. Equitable access to quality services 5. Preventive services 6. Research promotion			

	Expected outputs: 1. Increased community awareness of cervical and prostate cancers and their screening services 2. Increased number of health facilities providing comprehensive cancer treatment services 3. Increased number of health workers with skills to manage reproductive system cancers 4. Increased uptake of HPV vaccine by girls 9-13 years 4. Increased uptake of cervical screening services by women 30 – 49 years 5. Increased uptake of prostate screening services by men 40 years and above 6. Increased uptake of treatment for pre-cancerous lesions **Activities:** 1. Advocacy, massive education, sensitisation and mobilisation of community members, including decision makers and health workers 2. Development of policy guidelines and plans			

	3. Training of health workers on prevention and management of reproductive system cancers 4. Integration of cancer screening tests in RH services 5. Equipping health facilities to provide comprehensive cancer treatment services 6. HPV mass immunisation campaigns 7. Provide screening services 8. Treatment of pre-cancerous cervical lesions 9. Referral services including palliative care 10. Conduct research to understand risk factors for cancers			
	Objective 11: To increase knowledge on and management of menopausal and andropausal conditions	1. Proportion of older population groups who are aware of health conditions related to menopause and andropause 2. Proportion of older population groups with menopausal and andropausal conditions who are receiving treatment	1. Health facility records 2. Referral cards 3. KAP studies 4. Report of prevention and management programmes 5. Training reports 6. NDHS	**Risks:** 1. Socio-cultural inhibitions 2. Low awareness among the population, including health workers 3. Lack of skilled health care workers to manage the conditions 4. Inadequate and untimely release of funds

				Assumptions: 1. Availability of adequate funding 2. Timely disbursement of funds 3. Positive attitude of affected populations 4. Good health care seeking behaviours
	Strategies: 1. Social mobilisation 2. Strengthening of community structures for ownership and sustainability 3. mHealth 4. Capacity building 5. Equitable access to quality RH health services 6. Research promotion			
	Expected outputs: 1. Increased community awareness 2. Increased uptake of treatment interventions 3. Increased funding for geriatric activities 4. Community resources mobilised 5. Increased private sector participation 6. Increased number of skilled health workers on geriatric problems			

	7. Increased geriatric-focused research activities **Activities:** 1. Sponsor SMS and voice messages on health tips for geriatric conditions 2. Media engagement on geriatric conditions through jingles and talk shows 3. Conduct sensitization programmes at all levels 4. Engage existing community structures and resources to provide support for affected populations 5. Conduct trainings for all cadres of health workers 6. Develop and distribute IEC materials 7. Initiate and fund geriatric-focused research 8. Mobilise private sector participation			

	Objective 12: To reduce the incidence and prevalence of obstetric fistula in all women of reproductive age and provide high quality care for those affected	1. Number of women affected by obstetric fistula 2. Number of health facilities with the capacity to offer obstetric fistula repair surgery	1. NDHS 2. Health facility records 2. Referral cards 3. KAP studies 4. Report of prevention and management programmes 5. Training reports	**Risks:** 1. Socio-cultural context favourable to the condition 2. Low awareness on available treatment interventions among the population, including health workers 3. Lack of skilled health care workers to manage the condition 4. Paucity of health facilities with capability to manage the condition 5. Inadequate and untimely release of funds 6. Associated stigma and rejection **Assumptions:** 1. Availability of adequate funding 2. Timely disbursement of funds 3. Positive attitude of affected populations 4. Good health care seeking behaviours 5. Community support
	Strategies: 1. Advocacy and Social mobilisation 2. Strengthening of community structures for			

	ownership and sustainability 3. mHealth 4. Capacity building 5. Equitable access to quality RH health services 6. Research promotion			
	Expected outputs: 1. Increased community awareness 2. Decreased occurrence of obstetric fistula 3. Increased uptake of treatment interventions 4. Increased funding for obstetric fistula prevention activities 5. Community resources mobilised 6. Increased private sector participation 7. Increased number of skilled health workers in managing obstetric fistula 8. Increased number of health facilities with capability to provide obstetric fistula repair surgery 9. Decreased stigma and rejection among affected population 10. Increased research activities on obstetric fistula			

	Activities: 1. Sponsor SMS and voice messages on health tips for prevention and management of obstetric fistula 2. Media engagement on obstetric fistula through jingles and talk shows 3. Conduct sensitization programmes at all levels 4. Engage existing community structures and resources to provide support for affected populations 5. Conduct trainings for all cadres of health workers 6. Develop and distribute IEC materials 7. Establish additional treatment centres for obstetric fistula repair surgery 8. Initiate and fund research on cost-effective interventions 9. Mobilise private sector participation			

f. Achieving gender equality and elimination of all forms of discrimination through provision of appropriate sexual and reproductive health information and enabling environment for combating sexual coercion, harmful practices and reproductive rights violations	**Objective 13:** To reduce the incidence and prevalence of female genital mutilation and provide appropriate care for those affected	1. Proportion of girls undergoing female genital mutilation 2. Proportion of health facilities with the capacity to provide care, counselling and support for victims of FGM 3. Elimination of medicalisation of FGM	1. NDHS 2. Health facility records 2. Referral cards 3. KAP studies 4. Report of prevention and management programmes 5. Training reports 6. NARHS 7. Legislative Bills	**Risks:** 1. Cultural beliefs and practices **Assumptions:** 1. Existence of laws and legislation protecting against gender violence 2. Increasing interest of advocate groups and policy elites 3. Political commitment
	Strategies: 1. Advocacy 2. Social mobilisation 3. Capacity Building 4. Strengthening of community structures for ownership and sustainability 5. mHealth 6. Equitable access to quality RH health services 7. Research promotion			

	Expected outputs: 1. Increased community awareness 2. Decreased occurrence of FGM 3. Increased uptake of treatment interventions 4. Increased funding for FGM prevention activities 5. Community resources mobilised 6. Increased private sector participation 7. Increased number of skilled health workers in managing FGM complications 9. Increased inter-sectoral collaboration 10. Increased number of health facilities with capability to provide care, counselling and support for victims of FGM 11. Increased research activities on FGM **Activities:** 1. Sponsor SMS and voice messages on health tips for elimination of FGM 2. Media engagement on FGM through jingles and talk shows			

	3. Conduct sensitization programmes at all levels 4. Engage existing community structures and resources to eliminate FGM and provide support for affected populations 5. Conduct trainings for all cadres of health workers on care, counselling and support for victims of FGM 6. Develop and distribute IEC materials 7. Equip health facilities to provide care for FGM complications 8. Initiate and fund research on FGM 9. Mobilise private sector participation 10. Engage advocate groups and policy elites 11. Strengthening collaboration with relevant ministries and agencies 12. Sponsor legislation against FGM			
	Objective 14: To reduce the prevalence of domestic and sexual violence and provide appropriate management for victims	1. Prevalence of domestic and sexual violence 2. Proportion of women who experienced violence and sought for treatment from qualified health professionals	1. NDHS 2. Health facility records 2. Referral cards 3. KAP studies 4. Report of prevention and management programmes 5. Training reports	**Risks:** 1. Cultural beliefs and practices

			6. NARHS 7. Legislative Bills	**Assumptions:** 1. Existence of laws and legislation protecting against gender violence 2. Increasing interest of advocate groups and policy elites 3. Political commitment
	Strategies: 1. Advocacy 2. Social mobilisation 3. Capacity Building 4. Strengthening of community structures for ownership and sustainability 5. mHealth 6. Equitable access to quality RH health services 7. Research promotion			
	Expected outputs: 1. Increased community awareness 2. Decreased occurrence of domestic and sexual violence 3. Increased uptake of treatment interventions 4. Increased funding for domestic and sexual violence prevention activities 5. Community resources mobilised			

	6. Increased private sector participation 7. Increased male participation 8. Increased number of skilled health workers providing care, counselling and support for victims of domestic and sexual violence 9. Increased inter-sectoral collaboration 10. Increased number of health facilities with capability to provide care, counselling and support for victims of domestic and sexual violence 11. Increased research activities on domestic and sexual violence **Activities:** 1. Sponsor SMS and voice messages on health tips for elimination of domestic and sexual violence 2. Media engagement on domestic and sexual violence through jingles and talk shows 3. Conduct sensitization programmes at all levels 4. Engage existing community structures and			

	resources to eliminate domestic and sexual violence and provide support for affected populations 5. Conduct trainings for all cadres of health workers on care, counselling and support for victims of domestic and sexual violence 6. Develop and distribute IEC materials 7. Equip health facilities to provide care for victims of domestic and sexual violence 8. Initiate and fund research on domestic and sexual violence 9. Mobilise private sector participation 10. Engage advocate groups and policy elites 11. Strengthening collaboration with relevant ministries and agencies 12. Sponsor legislation against domestic and sexual violence 13. Enlist male participation to eliminate domestic and sexual violence			

g. Achieving Reproductive Health Needs of Persons in Humanitarian Settings and Crisis through promotion of sexual health; provision of appropriate sexual and reproductive health information; and friendly services specifically designed to meet the needs of internally displaced persons	**Objective 15:** To increase the capacity for assessing and managing reproductive health needs and vulnerabilities in humanitarian settings	1. Proportion of States (including FCT) with a humanitarian crisis response plan 2. Proportion of States (including FCT) with a capacity to assess and manage the SRH needs and vulnerabilities in identified humanitarian crisis 3. Proportion of States (including FCT) with an SRH team having the capacity to respond to identified humanitarian crisis	1. Copies of State Response Plan 2. Functional SRH team 3. List of SRH team members 4. Training report 5. Activity report of SRH team 6. Copies of budget plan	**RISKS:** 1. Insecurity 2. Peculiarity of Humanitarian Setting 3. Political will 4. Lack of SRH commodities 5. Lack of support from States - budget, budget release and funds release **ASSUMPTIONS:** 1. Gradual return of peace to the conflict zone 2. Increasing support from International Development Partners
	Strategies: 1. Advocacy to policy and decision makers 2. Social mobilisation on SRH needs, resource mobilisation and political support 3. BCC to promote healthy sexual and reproductive health behaviours 4. Capacity Building 5. Strengthening of community structures for ownership and sustainability 6. mHealth			

	7. Equitable access to quality RH health services 8. Research promotion			
	Expected outputs: 1. High political commitment 2. Creation of budget line 3. High awareness on sexual and reproductive health 4. Low reporting of sexual and reproductive health problems e.g. rape, gender violence 5. SRH team formed 6. Trained health workers 7. Operational Plan developed by SRH team 8. Community resources mobilised 9. Evidence-based interventions resulting survey findings			
	Activities: 1. Conduct high level advocacy to political and opinion leaders 2. Development of a budget 3. Sponsor SMS and voice messages on health tips for SRH in humanitarian settings			

	4. Media engagement on SRH through jingles and talk shows 5. Conduct sensitization programmes at all levels 6. Formation of SRH team 7. Training of health workers 8. Development of Operational Plan by SRH team 9. Mobilisation of community resources 10. Conduct surveys on SRH in humanitarian settings 11. Develop and distribute IEC materials 12. Expand access to reproductive health services 13. Initiate and fund research 14. Mobilise private sector participation 15. Engage advocate groups and policy elites to address SRH issues in humanitarian settings 16. Strengthening collaboration with relevant ministries and agencies			

	17. Conduct regular monitoring, supervisory and evaluation exercise on SRH services provided to clients in humanitarian settings to inform planning 18. Establishment of outreach centres for SRH services in Camps			
	Objective 16: To provide access to minimum initial service package (MISP) for reproductive health in humanitarian settings	1. Number of States (including FCT) having strategic stock of SRH kits for emergency/crisis settings	1. Inventory records 2. Store ledger 3. CLMS records	**Risks:** 1. Security challenges 2. Lack/untimely release of funds **Assumptions:** 1. High political commitment 2. Gradual return of peace to the conflict zone 3. Increasing support from International Development Partners
	Strategies: 1. Advocacy at all levels 2. Social mobilisation on SRH needs, resource mobilisation and political support 3. Capacity Building 4. Strengthening of community structures for ownership and sustainability 5. mHealth			

	6. Equitable access to quality RH health services			
	Expected outputs: 1. High political commitment 2. Creation of budget line 3. High awareness on availability of SRH kits 4. High uptake of SRH commodities by those needing them 5. Trained health workers 6. Utilisation of Operational Plan 7. Community resources mobilised			
	Activities: 1. Conduct high level advocacy to political and opinion leaders 2. Development of a budget 3. Sponsor SMS and voice messages on availability of SRH kits 4. Media engagement on SRH kits through jingles and talk shows 5. Conduct sensitization programmes at all levels 6. Training of health workers on CLMS			

	7. Implementation of Operational Plan by SRH team 8. Mobilisation of community resources for storage facilities, security of health workers, etc 9. Periodic inventory of SRH kits 10. Mobilise private sector participation 11. Strengthening collaboration with relevant ministries and agencies 12. Conduct regular monitoring, supervisory and evaluation exercise on SRH kits 13. Expand access to SRH kits through outreach centres			
	Objective 17: To prevent and respond to sexual and reproductive health threats including rape, gender based violence (GBV) and other forms of sexual assault/abuse in humanitarian settings	1. Number of States which have a system for collecting and synthesizing data on gender-based violence (GBV) and other forms of sexual assault/abuse in humanitarian settings 2. Number of States and LGAs which have a team trained in managing and treating gender-based violence (GBV) and other forms of sexual assault/abuse including clinical management of rape	1. Functional SRH team 2. List of SRH team members 3. Training report 4. Activity report of SRH team 5. Copies of budget plan	**RISKS:** 1. Insecurity 2. Peculiarity of Humanitarian Setting 3. Political Wheel 4. Lack of SRH commodities 5. Lack of support from States - budget, budget release and funds release 6. Cultural beliefs and practices

				ASSUMPTIONS: 1. Gradual return of peace to the conflict zone 2. Increasing support from International Development Partners 3. Existence of laws and legislation protecting against gender violence 4. Increasing interest of advocate groups and policy elites 5. Political commitment
	Strategies: 1. Advocacy to policy and decision makers 2. Social mobilisation on SRH rights, resource mobilisation and political support 3. BCC to promote healthy sexual and reproductive health behaviours 4. Capacity Building 5. Strengthening of community structures for ownership and sustainability 6. mHealth 7. Equitable access to quality RH health services 8. Research promotion			

	Expected outputs: 1. High political commitment 2. Creation of budget line 3. High awareness on sexual and reproductive health rights 4. Low reporting of sexual and reproductive health rights violations e.g. rape, gender violence 5. SRH management team formed 6. Trained health workers 7. SOPs and Job aids developed by SRH management team 8. Community resources mobilised 9. Evidence-based interventions resulting survey findings			
	Activities: 1. Conduct high level advocacy to political and opinion leaders 2. Development of a budget 3. Sponsor SMS and voice messages on health tips for SRH rights in humanitarian settings			

	4. Media engagement on SRH rights through jingles and talk shows 5. Conduct sensitization programmes at all levels 6. Formation of SRH management team 7. Training of health workers on the management of victims 8. Development of SOPs and Job aids by SRH management team 9. Mobilisation of community resources 10. Conduct surveys on violations against SRH rights 11. Develop and distribute IEC materials 12. Expand access to reproductive health services 13. Mobilise private sector participation 14. Engage advocate groups and policy elites to address SRH rights 15. Strengthening collaboration with relevant ministries and agencies 16. Conduct regular monitoring, supervisory and evaluation exercise on SRH services provided to			

	clients in humanitarian settings to inform planning 17. Establishment of outreach centres for SRH services in Camps. 18. Expand contraceptive services to include ECPs and implants			
h. Achieving Integrated Reproductive Health Service along the Continuum of Care through promotion and provision of comprehensive sexual and reproductive health services in an integrated manner throughout the life cycle	**Objective 18:** To promote integration of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services and programmes along the continuum of care for every woman and every child	1. Number of States implementing the National guidelines on integration 2. Proportion of facilities nationwide having health care providers who are trained on the integration of services	1. National guidelines on integration at State level 2. Report of implementation 3. Training report 4. Records of integrated services	**Risks:** 1. Poor orientation of health workers to accept the concept of integrated service 2. Inadequate logistics to support integration **Assumptions:** 1. Availability of adequate funding 2. Timely disbursement of funds 3. Positive attitude of health staff to be trained 4. Community support 5. Existing national guidelines on integration of services
	Strategies: 1. Social mobilisation 2. Capacity Building 3. Strengthening of community structures for ownership and			

	sustainability 4. mHealth 5. Equitable access to quality RH health services 6. Research promotion			
	Expected outputs: 1. Demand for integrated services created 2. Capability of health facilities to provide integrated services 3. Trained health workers 4. Community resources mobilised 5. Clients' satisfaction 6. Implementation of National guidelines on integration			
	Activities: 1. Sponsor SMS and voice messages on integration of services 2. Produce and distribute IEC materials 3. Media engagement to promote integration of services through jingles and talk shows 4. Development of advocacy tool along RMNCAH+N as a tool for resource mobilisation 5. Conduct sensitization programmes at all levels			

	6. Training of health workers on integration of services 7. Re-structure health facilities in a one shop approach to services of RMNCAH+N 8. Develop training manual in pre and post service on RMNCAH+N integrated approach 9. Expand the scope of services to respond to SRH issues across all ages and both sexes 10. Development of an integrated operational work plan 11. Mobilisation of community resources 12. Conduct surveys on clients' satisfaction 13. Mobilise private sector participation 14. Strengthening collaboration with relevant ministries and agencies 15. Development and implementation of supervisory M&E tools in RMNCAH+N activities 16. Conduct orientation on use of integrated M&E supervisory tools			

	17. Establishment of outreach centres to complement service integration 18. Expand contraceptive services to include ECPs and implants			
	Objective 19: To strengthen the capacity of health systems for research, monitoring and evaluation of reproductive health programmes and services	1. Number of relevant SRH indicators incorporated in the NHMIS 2. Number of States having dash board for monitoring SRH indicators 3. Proportion of RH focal persons and M & E officers trained on M & E of RH services 4. Proportion of reproductive health programmes and services monitored and supervised at all levels (National, State and LGA) 5. Number of States having a system for regular documentation and dissemination of RH best practices established 6. Number of Institutes (for research, training and services on reproductive health issues) established per geopolitical region	1. NHMIS reporting forms 2. Training report 3. Dash board 4. Report of supervision 5. Documentation on best practices 6. List of Institutes 7. Health facility records 8. National cancer surveys and registries 9. NDHS 10. NARHS	**Risks:** 1. Lack or untimely release of funds 2. Frequent downturn of internet connectivity 3. Lack of competence by health workers to interpret and use data 4. Poor feedback along channels of communication 5. Poor orientation of health workers to integrated programmes rather than vertical programmes 6. Lack of equipment to support data collection and storage 7. Weak collaboration between 'gown' and 'town' **Assumptions:** 1. Political will to support the required technology 2. Existence of RH research agenda 3. Access to e-library

				4. Experienced researchers 5. Opportunity to strengthen collaboration between 'gown' and 'town' 6. Enabling law and policy
	Strategies: 1. Advocacy and resource mobilization 2. Capacity Building 3. Coordination and collaboration 4. Strengthening of community structures for ownership and sustainability 5. Electronic records 6. Research promotion			
	Expected outputs: 1. Demand creation for integrated NHMIS 2. Availability of dash board in each State 3. Operationalisation of integrated NHMIS State 4. Health facilities equipped with infrastructural facilities for integrated NHMIS 5. Trained health workers competent in integrated NHMIS and research 6. Community resources mobilised			

	7. A functional Research Institute established in each geo-political zone 8. Community and private sector participation 9. Use of research outputs to inform planning and interventions 10. Increased collaboration between 'gown' and 'town'			
	Activities: 1. Conduct targeted advocacy to key decision makers and research institutes for support and resources 2. Establish new research centres in geo-political zones where they do not exist 3. Provide support for dash board in all States 4. Strengthen existing research centres with infrastructural facilities 5. Provide equipment and funding to strengthen health facilities for integrated NHMIS 6. Conduct trainings and award fellowships to strengthen the capacity of personnel for integrated			

	NHMIS and research 7. Mobilise community and private sector for support and participation 8. Conduct contemporary RH focused research 9. Provide overall coordination of activities			