POLICY GAPS IN THE REPRODUCTIVE AND SEXUAL HEALTH OF INTERNALLY DISPLACED PERSONS (IDPS) IN ENUGU STATE, NIGERIA.

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Abstract:
The issue of internal displacement in Nigeria has been largely ignored. They remained largely ignored both by national authorities and international organizations in spite of their growing numbers and the debilitating condition of their existence. Two major tools were used in this study- the checklist and key informant interviews. Three categories of institutions were identified as targets for the assessments- State Agencies; Line Ministries; and Civil Society Organizations. The checklist was adapted from policy project's Policy Environment Score and FHI's (Family Health International) Technical and Organizational Capacity Assessment Tool (TOCAT) among others. The tools were used in assessing reproductive and health sexual policies as they relate to internally displaced persons (IDPs). Results show that there is a gap in policy in the reproductive health and sexual rights of these IDPs. There are so many challenges in the reproductive health of the IDPs and also in the current trend of poor reproductive health status and services. The underlying assumption is that there is a potential gap in management capacity between the sectors.

Keywords: Reproductive health, policy, rights, IDPs

Introduction

By the end of 2004, Africa accounted for over 13 million of the world's 25 million internally displaced persons in the world. In contrast, Africa's refugee population was estimated at approximately 3.5 million (2003) **(ACHPR 1981; OAU 1982/1986).** Studies have shown that internal displacement in Africa is often caused by conflicts resulting from struggles for political and economic power or control over natural resources between rival groups (Cernea, 1996).

According to Global Overview of Trends and Development in 2005, the United Nations sponsored Norwegian Internal Displacement Monitoring Centre (IDMC), Nigeria has 200,000 internally displaced persons out of the estimated 13 million in Africa. Out of this, about 9 million came from countries like Sudan, the Democratic Republic of Congo, and Uganda (Nigerian Newsday, 2006).

Although the current situation of internal displacement in Nigeria may not amount to an "emergency", especially when compared to other conflict-induced displacement crises in the West African sub-region, there is real potential for renewed violence that could quickly spread and cause major population movements. Particularly in view of the fact that Nigeria, with a population of more than 140 million people and more than 375 ethnic groups, has a multitude of religious, ethnic and political fault lines that

periodically erupt into communal violence. This has created a sizeable but fluctuating, internally displaced population, particularly since the return to democracy in 1999. Return to democracy, conversely seems to have precipitated an upsurge in the number of displaced persons, as conservative estimates put the number of people killed in communal violence across Nigeria since 1999 at around 10,000. However, some government figures stand at more than 50,000 for central Plateau state alone (Ali, 2008).

Before 1999, the military regimes kept the underlying tensions in check. Any separatist aspirations were brutally suppressed since the attempted secession of the eastern Biafra republic in 1967 led to civil war in which more than 1 million people died. Almost three decades after the war ended a return to democratic rule with the election of President Olusegun Obasanjo in 1999, opened up new opportunities for people to express their grievances and new areas of conflict were created by the competition for political spoils. The resulting rise in communal violence has been attributed to various factors, including: ethnic rivalry, religious violence, land conflicts, conflicts related to the demarcation of administrative boundaries and political elections, and conflicts linked to oil production in the Niger delta. While some of these conflicts may appear to be caused by a single factor, such as religion or ethnicity, the reality is usually more complex. The introduction of the Sharia law in 12 of Nigeria's 36 states in recent years has caused tensions; however, the clash of Muslim and Christian groups in large part has been attributed to other factors such as, pressure on land or unequal access to social services. The polarization that follows is often along religious lines, and the conflict is easily stereotyped as a "religious war". The same dynamic is often observed with regard to "ethnic conflicts". Perhaps the most significant cause of communal violence in Nigeria is the entrenched divisions throughout the country between people considered indigenous to an area, and those regarded as settlers. Studies have shown that even when settlers have lived in an area for hundreds of years, they are consistently discriminated against in terms of land ownership, control of commerce, jobs and education (Cernea, 1999). This apparently seems to be the central factor in the communal clashes that led to the displacement of the Umuode people in Nkanu East Local Government Area of Enugu State, where some people were referred to as residential non indigenes and others as residential indigenes.Although the current situation of internal displacement in Nigeria may not amount to an "emergency", especially when compared to other conflict-induced displacement crises in the West African sub-region, there is real potential for renewed violence that could quickly spread and cause major population movements. Quite apart from the endemic ethno-religious conflict in various parts of the country, there is also serious potential for increased conflict-induced displacement in Enugu state. In spite of all these, the main overriding cause of conflict is poverty and unequal access to resources. Despite its oil wealth, at least two thirds of Nigerians live on less than $1 per day. Many people believe that conflicts are created and fanned by scheming politicians, particularly elites of the former military regime, relying on the huge pools of destitute and frustrated youths to create social division.

However, the conflict that resulted in the displacement of the Umuode people in Nkanu East Local Government area ostensibly caused by the unequal relationship between the Oruku and Umuode people, but more probably by the struggle for land and prominence in the area. Therefore, addressing the root causes of conflict-induced displacement, and trying to avoid the types of humanitarian crises currently plaguing

several communities in the sub-Saharan region, must be a key priority not only for Enugu State, which has started witnessing an upsurge in communal clashes, but also for the Nigerian government. And should such a crisis occur, it is essential for the humanitarian community at all levels in Nigeria to be in a position to respond to both immediate and long term needs of internally displaced persons. As observed by one senior UN official in the country, “The issue of internal displacement in Nigeria has been largely ignored – one, because the country is so large and two, since Nigeria is not considered an emergency country, the problem of displacement doesn’t make the news. As a result IDPs here have been suffering unnoticed.”

In spite of all the growing numbers of internally displaced persons, the debilitating condition of their existence, they remained largely ignored both by national authorities and international organizations. One important aspect that requires attention among others is their reproductive health and sexual rights. According to World Health Organization, Reproductive Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health care covers a wide range of issues; pregnancy and childbirth; the protection of women, children, adolescents and men from emotional, physical and sexual abuse; family planning counselling and services to prevent unwanted pregnancies and the squeal of abortion; the treatment and prevention of sexually transmitted diseases including HIV/AIDS; and the discouragement of harmful traditional practices. The provision of reproductive health services should be based on the needs of the population, with particular attention being paid to vulnerable groups, such as women and adolescents. The socio-cultural values of the community should be respected and reproductive health services for communities experiencing the trauma of conflict and displacement ought to be considered as much a human right as the basic essentials of shelter, food, water and sanitation (WHO 2000). Buttressing further with empowerment and advocacy theory, empowerment seeks to help people to gain power of decision and action over their own lives by reducing the effect of social or personal blocks to exercising existing power, increasing capacity and self confidence to use power and transforming power from the groups and individuals, while advocacy seeks to represent the interest of powerless people to powerful individuals and social structure (Lee, 2001). Reproductive health and rights therefore imply that people are able to have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this 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 regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable one to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The concept of reproductive health care covers a wide range of services. These are defined as follows in the International Conference on Population and Development (ICDP) Programme of Action (PoA): Family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, and infant and women’s health care; prevention and treatment of infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions; and active discouragement of harmful traditional practices such as female

genital mutilation. Let me enunciate a little on this by discussing very briefly the various components of reproductive health:

Maternal morbidity and mortality: *The 1999 Multiple Indicators Cluster Survey (MICS), conducted by the Federal Office of Statistics in collaboration with UNICEF, puts the maternal mortality ratio as 704 deaths per 100,000 live births. The World Health Organization and the United Nations put it at 1,000 maternal deaths per 100,000 live births.*

Family Planning: *The level of utilization of modem contraceptive in Nigeria is still low, although it has increased over the last decade with an increase in the contraceptive prevalence rate from 3.5 percent to 8.6 percent as recorded in the 1990 and 1999 NDHS respectively. The level of contraception among sexually active adolescents is particularly low, contributing to the high level of teenage pregnancy, unsafe abortions and maternal mortality, among others. On the whole, the total demand for FP is still relatively low as only 29 percent of women demanded for family planning in 1999 as shown by the NDHS.*

HIV/AIDS and other Sexually Transmitted Infections: *The HIV epidemic is spreading rapidly in Nigeria. HIV sero-positivity rate among antenatal clinic clients has risen from 1.4% in 1991/92 to 4.5% in 1995/96 and 5.8% in 2001. As a result, there are at least 2.7 million Nigerians estimated to be living with AIDS. Young people, between the ages of 20 and 24 years, have the highest rate of Infection with a 1999 HIV sero-prevalence of 8.1 percent.*

Adolescent Reproductive Health: *The reproductive health status of the Nigerian adolescent is poor. Paramount among the factors responsible for the current high levels of reproductive ill-- health among adolescents are the observations that for many reasons, the average age at first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls. From the NDHS (1990) study, the median age at first sexual intercourse was 16.6 years, whilst about one third of women had had their first sexual intercourse by the age of 15 years. In a study of about 5500 urban youths aged 12 - 24 years, 41 percent had experienced sexual intercourse and of these, 82 percent of girls and 72 percent of boys had had sexual intercourse by the age of 19 years*

Harmful practices and reproductive rights: *Various harmful practices, which may be encountered throughout the life span, contribute to reproductive ill health in Nigeria and constitute a violation of reproductive rights. The types of harmful practices commonly encountered in the traditional setting include female genital mutilation, forced early marriage, traumatic puberty initiation rites, labour and delivery practices, wife inheritance and sexual hospitality practices. A recent national survey revealed that the prevalence of female genital mutilation/cutting varies widely from the lowest rate at 0.6 percent to the highest at 98.7 percent. Nearly 80 percent of all cases are Type 1, 9.6 percent are Type II, 10.4 percent are cases of infibulations and 1.9 percent are 'zurgu' cut, 'angrya' cut and 'gishiri' cut*

Other reproductive health conditions: *Although there are no reliable statistics relating to reproductive cancer, there is evidence of an increasing incidence of reproductive cancers, with cancer of the cervix and breast as the commonest in females and cancer of the prostate as the commonest in males.*

In addition to the commitment at the global level and in order to achieve the targets

set out in the *ICDP* Programme of Action, the member states of the African region adopted a regional strategy on reproductive health in September, 1997. Nigeria as a member of the global community and in the interest of her people's health and development is committed to the implementation of the concept of reproductive health and reproductive rights as agreed at the *ICPD*, and has adopted and launched the African regional strategy. This commitment would enable the country to effectively address the major reproductive health challenges of the *IDPs* and reserve the current trend of poor reproductive health status and services.

The role of policy in improving program outcomes in the family planning/reproductive health (FP/RH), safe motherhood, and HIV/AIDS fields has been increasingly recognized. Despite this increased recognition, "policy" is often seen as a 'black box'. Existing frameworks focus on some aspects of policy—the stages of policy development, decision makers and stakeholder institutions, the intent and content of a policy, or its implementation—yet none captures all policy components. This study provides a practical framework to analyze the National Reproductive Health Policy. It employs the seven domains of the Policy Environment Score: Policy Formulation, Political Support, Organizational Structure, Legal/Regulatory Environment, Programme Component and Evaluation and Research.This study therefore explores the gaps in policy in the reproductive and sexual health policy of internally displaced persons in Nigeria.

Methodology

Description of Data Collection Tools:

Two major tools were used in this study, the checklist and key informant interviews. Three categories of institutions were identified as targets for the assessments (i.e. State Agencies: State Emergency Agency, Enugu State Action Committee on AIDS; Line Ministries; and Civil Society Organizations and Humanitarian Organizations). The checklist was adapted from Policy Project's Policy Environment Score and FHI's (Family Health International) Technical and Organizational Capacity Assessment Tool (TOCAT). TOCAT is a capacity assessment tool that is based on the Global Fund for AIDS and Tuberculosis, and Malaria (GFATM) and combines features from a number of other tools such as MOST (Management Organizational Sustainability Tool), DOSA (Discussion Oriented Organizational Self Assessment) and OCAT (Organizational Capacity Assessment Tool), The tools were used in assessing reproductive and health sexual policies as they relate to internally displaced persons.

The assessment also examined available records to confirm issues such as policy formulation, political support, organizational structure, legal and regulatory environment, programme resources, programme components and evaluation and research. While the KII targeted key informants like directors of various ministries, senior officials of local government areas and some leaders of thought in Community (a host community for IDPs), the facilitated group discussions ensured consensus building among the respondents particularly on some contentious issues.

Data Analysis Techniques:

The assessment of the reproductive health policies as they relate to internally displaced persons was based on the application and administration of a checklist and key informant interviews. The processes involved in data collection were:

- Completion of the assessment checklist: Representative key respondents were purposively selected to fill the assessment checklist providing a score on all the attributes for the respective domains identified in the checklist

The scoring matrix assesses the extent to which reproductive health policies address the reproductive and sexual health needs of internally displaced persons for each of the 7 domains. The domains are ranked on a 1- 4 scale presented below –

1	2	3	4
Insignificant (0-25%)	**partly (26-50%)**	**Mostly (51-79%)**	**Yes (80-100%)**

The scoring system was adapted from the Technical and Organization Capacity Assessment Tools. An important feature of this system of analysis is that the scoring system is built into the checklists. As a result, ranking of various indicators in the checklist is done on a ranking value ranging from 0 to 3 (where 0= no; 1 = in part; 2 = mostly; and 3 = yes) on a form specifically designed for this (form A1). There was also a Not Relevant (NR) option which was provided for in the event the statement or indicator in question did not apply to the organization. Steps were taken to explain the use of the NR option in order to ensure that the participants did not mistake or confuse it with the No option. At the end of the facilitation of each domain, the total score was worked out on the basis of the total possible point in each domain (total possible point means the number of statement in each domain multiplied by 3, where the candidate did not opt for any NR; the choice of NR reduces the total possible score by 3 times the number of NR chosen in each domain. The percentage scored leads to a ranking of the domain on a four scale made of: insignificant (0-25%); partly (26 - 50%); mostly (51 – 79%); and Yes (80%- 100%).

Analysis of the checklist was complemented with desk review of existing documents and policies. In all, more than 5 documents were reviewed: National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians (FMoH, May 2001), National Reproductive Health Strategy Framework and Plan, 2002-2006 (FMoH, 2002); Internal Displacement Monitoring Center, Nigeria (IDMC, 2007); Constitution of the Federal Republic of Nigeria (FGN, 1999); Convention on the Elimination of all forms of Discrimination against Women. These documents and more were reviewed in order to bring out the policy gaps in the reproductive and sexual health of internally displaced persons.

The research team was composed of the researcher and two research assistants who served as note takers and observers. The administration of the instrument took into consideration the convenience and job schedules of the respondents.

Limitation of the Methodology:

The study encountered a number of both methodological and process limitations. Some of these limitations include:

- Getting the focal persons on seat for interview was a real challenge, because of their busy schedules
- The sensitive nature of internal displacement in the state, many respondent were unwilling to discuss the issue because of some perceive political undertones.

- A lot of bureaucratic procedures made it almost impossible for the documents to be sited, the custodians of the documents at times were not easily accessible, and where they were available, they required some form of authorization before they could release the documents.
- Some key informants were sceptical about the issues

Results

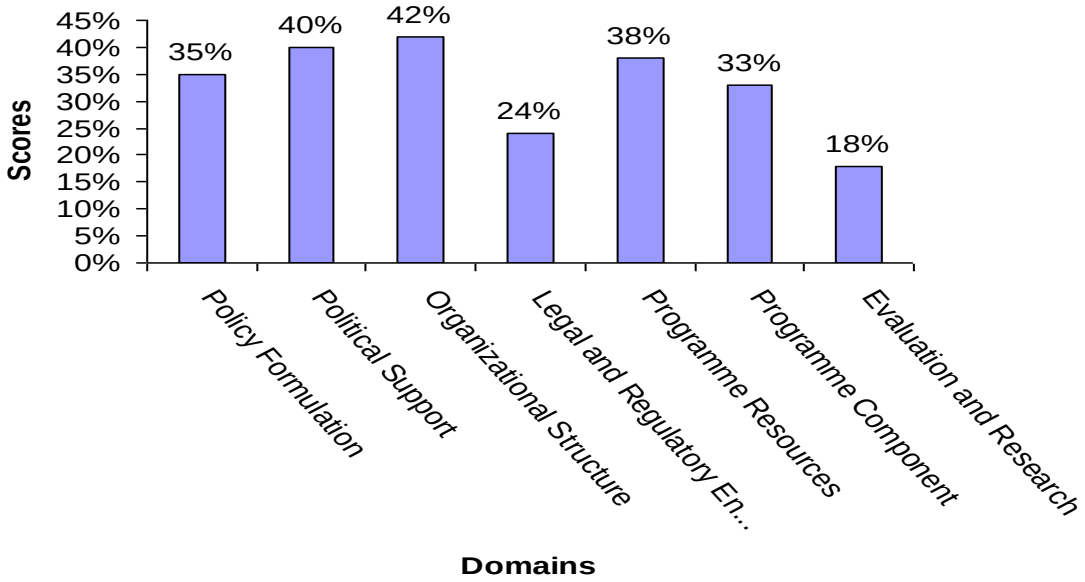
The findings of this study are presented below in sub-sections based on the various organizations studied. The presentation follows a tabular format. The triangulation of data was done in the discussion following the Tables which integrated the data from the KII. The findings are as follows:

Table 2: Summary of Key Findings by Domains

S/N	Domain	Score
1	Policy Formulation	35%
2	Political Support	40%
3	Organizational Structure	42%
4	Legal and Regulatory Environment	24%
5	Programme Resources	38%
6	Programme Component	33%
7	Evaluation and Research	18%

Source: Assessment data

Figure 1: Scores of the Policy Components



Policy Formulation:

This domain has an average score of 35%. This means that in the area of policy formulation, there are policies and plans that address sexual and reproductive health needs of Nigerians, including internally displaced persons. However, many of these laws do not adequately reflect the reproductive health concept. Nigeria has a number of policies in the health sector that are relevant to reproductive health and sexual rights

of internally displaced persons. Foremost among these, is the National Health Policy and Strategy (1988, 1998), which emphasizes Primary Health Care as the *key* to the development of the health care delivery system in Nigeria. The National Health Policy has a number of provisions which, if strictly implemented, could have led to improved access to basic health services including reproductive services for all population groups. However, the current level of access does not reflect strict adherence to this policy. Other relevant policies include the National Policy on Population for Development, Unity, Progress and Self Reliance (1988); Maternal and Child Health Policy (1994); National Adolescent Health Policy (1995); National Policy on HIV/AIDS/STIs Control (1997); National Policy on the Elimination of Female Genital Mutilation (1998); and Breastfeeding Policy (1994). While the provisions of many of these policies are relevant to the promotion of reproductive health and sexual rights of IDPs, they are sometimes contradictory. Furthermore, some of the existing relevant laws do not support some of the principles enunciated in these policies while some are non-committal

The Nigerian National Reproductive Health Policy affirms a commitment to protect, guarantee and fulfil reproductive and sexual health and rights of her citizenry. This is in line with the targets of the International Conference on Population and Development (ICPD), which marked a critical shift in the focus of population programmes and underscored the need to meet the reproductive health needs of the individuals throughout the life cycle, as a key approach to improving quality of lives of people and stabilizing the world population.

The NGOs and international aid organizations like the Nigerian Red Cross Society, UNDP, Action Aid Nigeria and many more others have a clear understanding of the reproductive and sexual health and rights issues. However they have not been able to fully translate this understanding to actual provision of reproductive and sexual health services to internally displaced persons. There is a 'Guiding Principles on Internal Displacement' as documented by the United Nations of which Nigeria is a member; however, these principles have not been domesticated as has been done in some countries. Although there is a draft policy on internal displacement in Nigeria, this policy has not been finalized after close to 10 years. There is also no deliberate attempt to popularize documents that protect and guarantee the reproductive and sexual health and rights of internally displaced persons. This was confirmed by majority of the key informants interviewed who stated that most of these policies had not been cited. These has resulted in internally displaced persons not understanding existing policies, and as such are unable to take steps to actualize their rights, as guaranteed in those documents.

Political Support

The score for this domain is 40%. The implication for this domain is that even though there is growing political support, this support has not translated to effective programme implementation. Currently, there are lots of programmes on health related issues in the country from the federal to the grassroots levels. This shows the commitment of the government in supporting programmes that protect the reproductive and sexual health rights of its citizens, including internally displaced persons. The establishment of National Emergency Management Agency (NEMA) and State Emergency Management Agency (SEMA), underscores government's commitment to addressing issues related to internally displaced persons in Nigeria.

These bodies are supported by the government through funding which complies with the national and international standards on reproductive and sexual health rights of internally displaced persons. The National Emergency Management Agency (NEMA), established in 1999, is responsible for overall disaster management in Nigeria – including the coordination of emergency relief operations as well as assisting in the rehabilitation of the victims where necessary. It has presence in most states and often supports IDPs in the emergency phase of a crisis, but it does not have the necessary resources to assist people displaced for a longer period of time, or to assist returnees to reintegrate. State Emergency Management Agencies (SEMA) also exist in some states, but with varying performance levels. However, confusion exists at the federal level over who has the mandate to respond to and assist IDPs – especially between NEMA and the National Commission for Refugees (NCR, informally mandated in 2002 to also cover IDPs) – which results in competition for resources.

Organizational Structure

The average score for this domain is 42%. The National Reproductive Health Policy and Strategy provides for a multidisciplinary and multisectoral technical advisory committee- the National Reproductive Health Working Group. However, there was no evidence to suggest that this committee has been set up and working. Although, some of the agencies alluded to the fact that the ministry of health was working hand-in-hand with the Department of Community Development and Population Activities in the provision of reproductive services and rights. However, there was no much evidence to show for the presence of other agencies / ministries. Most of the persons interviewed were not aware of the existence of the National Reproductive Health Policy and Strategy, and as a result could not answer questions that relate to the Policy. As a result of this weak coordination structure, other important stakeholders have not effectively fulfilled their roles in the provision of reproductive health and sexual rights needs of Nigerians, with particular reference to internally displaced persons. There is also a lack of community participation, particularly during decision making process; as a result members of the community were not well informed on issues relating to their reproductive and sexual health and rights. This was confirmed by some of the stakeholders in the community who were interviewed.

In the area of international response to internal displacement in Nigeria, the UN system in Nigeria, consisting numerous agencies such as UNDP, UNICEF, WHO, UNHCR, FAO, UNAIDS, UNFPA, and ILO, has been organized around a Development Assistance Framework (UNDAF). The UNDAF is essentially a planning tool designed to enhance the coordination and effectiveness of UN contributions to development in Nigeria. The three broad priority themes of the UNDAF are promoting good governance and human rights; reducing poverty; and reducing the incidence and impact of HIV/AIDS, malaria, tuberculosis and other infectious diseases. Nigeria is one of 13 countries included in the 2005 Consolidated Appeals Process (CAP) for West Africa, which focuses broadly on “transnational issues that affect the quality of the humanitarian environment in the sub-region.” Despite acknowledging that the level of violence seen in recent ethno-religious conflicts in Nigeria “form a new and alarming trend” and that “if the violence persists, cross-border and internal displacement is likely to continue in 2005,” the CAP does not contain any projects directly related to issues of internal displacement in the country (UN, 11 November 2004).

With the focus on development needs, UN assistance to IDPs in Nigeria has been

fairly ad hoc.

Legal and Regulatory Environment

The consensus score for this domain was 24%. It was noted that even though there are guidelines on the procurement of drugs relevant to reproductive health by states, local government areas and non governmental organizations, these guidelines are either outdated or are not comprehensive enough to meet the reproductive health needs of Nigerians, particularly the internally displaced, who have special needs as a result of their peculiar circumstances.

The National Reproductive Health Policy is in consonance with national and international instruments on the protection of the reproductive health and rights of IDPs. One of its strategies for intervention is to sustain the implementation of the programme of action of the International Conference on Population and Development (ICPD).

Programme Resources:

The consensus score for this domain is 38%. This follows that even though resources are allocated to health services in general and reproductive and sexual health services in particular, these resources are inadequate. An analysis of the 2007 National budgets revealed that less than 5% of the budgets was allocated to health, against the 15% Abuja Declaration. This is also reflected in the fact that all the ministries with the mandate of providing reproductive and health services were constrained by inadequate resources. More so, it was noted that budgets were not prepared in accordance with the strategic plan, and resources were also not allocated according to agreed vulnerability criteria. For example further analysis of the 2007 National budget for the Health sector revealed that allocation to the Health sector did not conform to both regional and international obligations and targets. In 2007, the real per capita budget of health using 130 million as the population of Nigeria was 941.54, this meant that Nigeria could not meet up with her treaty obligations, because the per capita budget of health can not achieve any of the stated objectives of the (National Economic Empowerment Development Strategy (NEEDS)and the Millennium Development Goals (MDGs). Within the same period, the health budget constituted 5.4% of the total budget against the stipulated 15% as stated in international agreements Nigeria is signatory to. Conversely, a staggering sum of 900,000,000 was allocated to NHIS identity cards and 55,000,000 for the finalization of the health research policy. Even though the Health sector budget was grossly inadequate; yet, the allocations still showed that important issues were under budgeted, whereas heavy amounts were allocated for meetings and identity cards.

The National Primary Health Care Development Agency received N5, 922,630,780 or 4.83% of the allocation to health. Of this amount N431, 510 606 or 7.2% went to personnel cost and N5, 232, 000, 000 (88.33%) was allocated to capital projects. However, those activities that would benefit the poor, women and vulnerable groups such as internally displaced persons, elongate their lives and reduce hospitalization and attendant costs were poorly provided for. These include: control of HIV and other communicable diseases at the primary health care level received N137, 000, 000 or 2.3% of capital allocation, while health education and promotion got N168, 000, 000 or 2.83%.

At the international level, it was also observed that among the UN agencies, inter-governmental and non governmental organizations there was still the challenge of resources, where complaints about under-funding feature prominently in the analyses of humanitarian assistance and development.

Programme Component

The score for this domain ranged from 40% to 47%, with an average of 43%

Though there is provision for the protection and enforcement of reproductive and sexual health services and rights, but most often, the decisions are taken without the consent and involvement of various sectors. Internally displaced persons (IDPs) issues are multi-sectoral. As a result, internally displaced persons do not understand clearly the range of reproductive and sexual health services that are available for safe motherhood, family planning, mental health, HIV/AIDS prevention care and support, and therefore do not have access to the services. One key observation during the facilitated group discussions was the overwhelming agreement that there was a low level of access to quality reproductive and sexual health and rights information and services particularly at the primary health care level, where most IDPs are situated. We have seen in the previous domain that this sector was seriously under-budgeted for in 2007 as in other years. This lack of resources was further complicated by lack of qualified personnel who should be in fore front to educate people at the community level on the availability of such services.

Also, as a result of the factors mentioned above, technical staffing in primary health facilities does not include the right mix and number of staff. This is because the Federal Ministry of Health does not have a capacity building plan for workers both at the tertiary and primary health care institutions. The effect of this is that at the primary health care level, there are very few trained personnel available, and it is at this level that most IDPs have access to health care. Knowledge they say is power, therefore in general, there is low level of utilization of reproductive and sexual health services among internally displaced persons because lack of knowledge.

Evaluation and Research

In this domain, the average score is 18%. This means that the evaluation and research component is weak. This is supported by the fact that there is no systematic way of collecting data on internally displaced persons. And where data collected were collected, they were not effectively used in taking decisions on issues concerning the reproductive health of internally displaced persons due to the absence of management information system at the Federal Ministry of Health level.

The coordination mechanism for internal displacement is weak, and in some cases non existent. This lack of coordination and proper registration system for IDPs, the inefficient use of resources and the lack of proper planning, monitoring and evaluation are serious problems which provide the basis of making adjustment in the plans. During the interview, most ministries interviewed said that they do send their workers to the field to monitor and evaluate the activities. All the respondents interviewed at the community level reported not to be aware of any form of data collection on internally displaced people by any agency or ministry. According to one of the key informant, this trend could be attributed to lack of programmes for addressing the reproductive health needs of internally displaced persons in the area.

As a result, there is very little useful data on internal displacement. The poor or inconsistent quality of needs assessment and impact monitoring has now been a recurring theme of humanitarian evaluations for a number of years.

This is uncertainty is also reflected in the figure released by the 2005 Humanitarian Appeal (CAP) for West Africa, which put the total number of IDPs in Nigeria at 200,000 as of November 2004, reportedly based on guesswork. The government's National Commission for Refugees said at the beginning of 2004 that some 800,000 people had been displaced over the previous four years, but gave no breakdown of figures by state or region (IRIN, 2 January 2004). The same source also reported in May 2004 that "Nigeria has more than one million internally displaced persons" and in December 2004 stated that the cumulative total of IDPs since 1999 was 3 million (Interview, Abuja, 6 December 2004).

Complex movement patterns combined with the overwhelming lack of data in Nigeria makes the issue of numbers of IDPs very problematic. There has been no systematic registration or verification of numbers of IDPs and figures are often "grossly misleading," according to Zanna Muhammed, deputy director of the National Emergency Management Agency (Interview, Abuja, 6 December 2004).

Discussion

The general legal framework for reproductive rights in Nigeria can be found in the Nigerian constitution (FRN, 1999). Chapters 3 and 4 which dealt with fundamental objectives and directive principles of state policy, citizenship, and fundamental Rights, respectively spelt out the benefits every Nigerian citizen are bound to enjoy including the internally displaced persons. It can also be found international treaties to which Nigeria is a party, and in its non-binding international obligations.

Constitution

While there is no explicit right to reproductive health in the constitution, it can be implied from several other rights given expression in the constitution. Relevant portions of the constitution include:

Section 25(i): Citizenship by birth; Section 14 (1) (2b): The Government and the people ; Section 15 (2) (36): Political objectives; Section 17(1) (2) (3): Social objectives ; Section 33(1): Right to life; Section 34 (1a-c): Right to dignity of human person ; Section 35 (1): Right to personal liberty; Section 42(1) Right to freedom from discrimination

These sections of the Constitution are meant for the citizens of the Federal Republic of Nigeria (FRN) of which the internally displace persons (IDPs) are part of. The Government has some obligations to its citizens including the IDPs. The constitution stipulates/guarantees the protection and promotion of all the fundamental human rights and shall be guided by international human rights instruments which recognize fundamental human rights.

The right to health is a basic/fundamental human right recognized in some international treaties to which Nigeria is a party: the International Covenant on

Economic, Social, and Cultural Rights (ICESCR), the African Charter on Human and People's Rights (African charter), Convention on the Elimination of All Forms of Discrimination against Women, (CEDAW), United Nations High Commissioner for Refuges (UNHCR).

Under Article 12(1) of the ICESCR, state parties recognize that each individual has the right to "the enjoyment of the highest attainable standard of physical and mental health". Further more, Nigeria is bound to "take steps… with a full view to achieving progressively the full realization of the right recognized by the covenant…'[i]. Thus, Nigeria has a positive duty to provide reproductive health services to all Nigerians in order to achieve the "highest attainable" standard of general health, and "highest attainable" must be measured in view of all of Nigeria's available resources.

Similarly, as a party to the African Charter, Nigeria guarantees to every individual, "the right to enjoy the best attainable state of physical; and mental health, "[ii] Reproductive rights may also be constructed as civil rights under the International Covenant on Civil and Political Rights (ICCPR). Relevant here is Article 17(1) which protects individuals from arbitrary interference with his/her privacy or family. Thus, any national reproductive health policy cannot be coercive under the ICCPR.

Arbitrary interference can also be seen as arbitrary denial of services: interferences as a lack of action rather than as a positive action.
Finally, CEDAW obligates state parties to "eliminate discrimination against women and children … in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"[iii]. A "basis of equality" however, presupposes that women's special needs are taken into account in planning out a reproductive health policy. Further, a policy of non-discrimination against women has at its core a policy of non-discrimination against different types of women. Article 14(2) illustrates this point by specifying that rural women must have access to adequate health care services, including explicitly, reproductive and sexual health.

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