Nigeria has had successful initiatives in human development. Nevertheless, governance and accountability issues in many sectors remains a problem, with few benefitting from Nigeria’s significant reserves of natural gas and oil. Poverty is an important challenge with nearly two-thirds of the population still subsisting on less than US $1.25 per day.

Nigeria’s large share of youth population (43 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession and the country’s large population.

Gender equality and women’s empowerment are important for improving reproductive health. Higher levels of women’s autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes. In Nigeria, the literacy rate among females ages 15 and above is 49 percent. Fewer girls are enrolled in secondary schools compared to boys with a 77 percent ratio of female to male secondary enrollment. Two-fifths of adult women participate in the labor force that mostly involves work in agriculture. Gender inequalities are reflected in the country’s human development ranking; Nigeria ranks 139 of 157 countries in the Gender-related Development Index.

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.

**Country Context**

**Nigeria: MDG 5 Status**

**MDG 5A indicators**

- Maternal Mortality Ratio (maternal deaths per 100,000 live births) UN estimate
  - 840
- Births attended by skilled health personnel (percent)
  - 39

**MDG 5B indicators**

- Contraceptive Prevalence Rate (percent)
  - 14.6
- Adolescent Fertility Rate (births per 1,000 women ages 15–19)
  - 121
- Antenatal care with health personnel (percent)
  - 57.8
- Unmet need for family planning (percent)
  - 20.2

**MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio**

Nigeria has made insufficient progress over the past two decades on maternal health and is not yet on track to achieve its 2015 targets.

**Figure 1 • Maternal mortality ratio 1990–2008 and 2015 target**


**World Bank Support for Health in Nigeria**

**Current Projects:**

- P097921 NG-Malaria Control Booster Project (07) ($154.8m)
- P110697 NG-2nd Health Sys Dev II – Add Fin (FY09) ($90m)
- P104405 GPOBA: Nigeria Health ($6.1m)
- P110696 NG-Polio Eradication – Add Fin (FY09) ($50m)
- P115036 NG: Malaria Control Booster Proj-Add Fin ($100m)
- P102119 NG-Second HIV/AIDS Prog. Dev. (FY09)

**Pipeline Project:**

- P120798 NG States Prog. Invest. (FY11) Approval date 7/5/2011
Key Challenges

High fertility

Overall fertility is high, especially among the poor, and has been stagnant for the past two decades. Nigeria's total fertility rate (TFR) of 5.7 births per woman in 2008 is about the same as in 1991. TFR is 4 births per woman among women in the highest wealth quintile but it doubles (TFR 7) among women in the lower two wealth quintiles (Figure 2). Wide disparities also exist between women in rural areas at 6.3 births per woman compared to 4.7 for those in urban areas, and by education levels at 6.7 births per woman with no education, and 2.9 with tertiary education.

Adolescent fertility rate is high (121 reported births per 1,000 women aged 15–19 years) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.

Early childbearing is very high among the poor. While almost 60 percent of the poorest 20–24 years old women have had a child before reaching 18, only 10 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing has taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

A tenth of women use modern contraception. Current use of contraception among married women was 15 percent in 2008 and more married women use modern contraceptive methods than traditional methods (15 percent and 5 percent). Injectables are the most commonly used method among married women at 3 percent. Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: it is 22 percent among women in the wealthiest quintile and 3 percent among those in the poorest quintile (Figure 4). Similarly, just 3 percent of women with no education use modern contraception as compared to 24 percent of women with tertiary education, and 7 percent for rural women versus 17 percent for urban women.

Unmet need for contraception is high at 20 percent indicating that women may not be achieving their desired family size.

Opposition to use and wanting more children are the predominant reasons women do not intend to use modern contraceptives in future. Thirty-nine percent of women not intending to use contraception expressed opposition to use, primarily by themselves, their husband, or due to their religion while 29 percent indicated they wanted another child. Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Nearly three-fifths of pregnant women receive antenatal care from health personnel (doctor, nurse, midwife, or auxiliary midwife) with 45 percent having the recommended four or more antenatal visits. However, a smaller proportion, 39 percent deliver with the assistance of health personnel. While 86 percent of women in the wealthiest quintile delivered with skilled health personnel, only 8 percent of women in the poorest quintile obtained such assistance (Figure 5). Additionally, 12 percent of women with no education delivered with skilled health personnel as compared to 94 percent of women with tertiary education.

Further, 67 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.
Additionally, 56 percent never received postnatal care, and only 33 percent got a postnatal check-up within two days.\textsuperscript{6}

\textbf{Figure 5} = Birth assisted by health personnel (percentage) by wealth quintile

![Birth assisted by health personnel (percentage) by wealth quintile](image)


Over half of women who indicated problems in accessing health care cited concerns regarding inability to afford the services. A third or above also cited unavailability of drugs, long distance, transport difficulties, or unavailability of service providers as main barriers in accessing health care (Table 1).\textsuperscript{6}

\textbf{Human resources for maternal health are limited} with only 0.4 physicians per 1,000 population but nurses and midwives are slightly more common, at 1.6 per 1,000 population.\textsuperscript{2}

The high maternal mortality ratio at 840 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.\textsuperscript{5}

\textbf{Table 1 = Reasons for not delivery in a health facility (women age 15–49)}

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one problem accessing health care</td>
<td>73.7</td>
</tr>
<tr>
<td>Getting money for treatment</td>
<td>56.4</td>
</tr>
<tr>
<td>Concern no drugs available</td>
<td>41.3</td>
</tr>
<tr>
<td>Distance to health facility</td>
<td>36.2</td>
</tr>
<tr>
<td>Having to take transport</td>
<td>34.0</td>
</tr>
<tr>
<td>Concerned no provider available</td>
<td>33.4</td>
</tr>
<tr>
<td>Concerned no female provider available</td>
<td>20.5</td>
</tr>
<tr>
<td>Not wanting to go alone</td>
<td>17.2</td>
</tr>
<tr>
<td>Getting permission to go for treatment</td>
<td>13.6</td>
</tr>
</tbody>
</table>


\textbf{STIs/HIV/AIDS is a growing public health concern}

Is estimated that 2.6 million people are infected with HIV.\textsuperscript{6} Although the percentage of adult population aged 15–49 years who have HIV is much lower than those of Southern African countries (at 3.1 percent), HIV is a serious concern mostly due to the country large population size.

Knowledge of mother to child prevention methods is limited. Despite a remarkable improvement from 2003 levels, only a quarter of women know that HIV can be transmitted through breast milk and that the likelihood of passing HIV from mother to child can be reduced by drugs.\textsuperscript{6}

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While about 50 percent of young women are aware that using a condom in every intercourse prevents HIV, only 7 percent of them report having used condom at last intercourse (Figure 6). This gap widens among older aged women.

\textbf{Figure 6 = Knowledge behavior gap in HIV prevention among young women}

![Knowledge behavior gap in HIV prevention among young women](image)

Source: DHS Final Report, Nigeria 2008 (author’s calculation).
Key Actions to Improve RH Outcomes

Strengthen gender equality

- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women’s health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women’s groups.
- Increase access to modern contraceptives for rural women and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.

Reducing maternal mortality and morbidity

- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus HIV/AIDS providing information, education and communication efforts on adolescents, youth, married women, and other high risk groups including IDUs, sex workers and their clients, and migrant workers.

References:

## Nigeria Reproductive Health Action Plan Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Level</th>
<th>Indicator</th>
<th>Year</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate (births per woman ages 15–49)</td>
<td>2008</td>
<td>5.7</td>
<td>Population, total (million)</td>
<td>2008</td>
<td>151.2</td>
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<tr>
<td>Adolescent fertility rate (births per 1,000 women ages 15–19)</td>
<td>2008</td>
<td>121</td>
<td>Population growth (annual %)</td>
<td>2008</td>
<td>2.3</td>
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<tr>
<td>Contraceptive prevalence (% of married women ages 15–49)</td>
<td>2008</td>
<td>14.6</td>
<td>Population ages 0–14 (% of total)</td>
<td>2008</td>
<td>42.7</td>
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<tr>
<td>Unmet need for contraceptives (%)</td>
<td>2008</td>
<td>20.2</td>
<td>Population ages 15–64 (% of total)</td>
<td>2008</td>
<td>54.2</td>
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<tr>
<td>Median age at first birth (years) from DHS</td>
<td>—</td>
<td>—</td>
<td>Population ages 65 and above (% of total)</td>
<td>2008</td>
<td>3.1</td>
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<tr>
<td>Median age at marriage (years)</td>
<td>2008</td>
<td>18.6</td>
<td>Age dependency ratio (% of working-age population)</td>
<td>2008</td>
<td>84.5</td>
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<td>Mean ideal number of children for all women</td>
<td>2008</td>
<td>6.1</td>
<td>Urban population (% of total)</td>
<td>2008</td>
<td>48.4</td>
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<tr>
<td>Antenatal care with health personnel (%)</td>
<td>2008</td>
<td>57.8</td>
<td>Mean size of households</td>
<td>2008</td>
<td>4</td>
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<tr>
<td>Births attended by skilled health personnel (%)</td>
<td>2008</td>
<td>39</td>
<td>GNI per capita, Atlas method (current US$)</td>
<td>2008</td>
<td>1170</td>
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<tr>
<td>Proportion of pregnant women with hemoglobin &lt;110 g/L</td>
<td>2008</td>
<td>66.7</td>
<td>GDP per capita (current US$)</td>
<td>2008</td>
<td>1370</td>
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<tr>
<td>Maternal mortality ratio (maternal deaths/100,000 live births)</td>
<td>1990</td>
<td>1100</td>
<td>GDP growth (annual %)</td>
<td>2008</td>
<td>6</td>
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<tr>
<td>Maternal mortality ratio (maternal deaths/100,000 live births)</td>
<td>1995</td>
<td>1100</td>
<td>Population living below US$1 per day</td>
<td>2004</td>
<td>64.4</td>
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<td>Maternal mortality ratio (maternal deaths/100,000 live births)</td>
<td>2000</td>
<td>980</td>
<td>Labor force participation rate, female (% of female population ages 15–64)</td>
<td>2008</td>
<td>39.5</td>
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<td>Maternal mortality ratio (maternal deaths/100,000 live births)</td>
<td>2005</td>
<td>900</td>
<td>Literacy rate, adult female (% of females ages 15 and above)</td>
<td>2008</td>
<td>48.8</td>
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<td>Maternal mortality ratio (maternal deaths/100,000 live births)</td>
<td>2008</td>
<td>840</td>
<td>Total enrollment, primary (% net)</td>
<td>2007</td>
<td>62.8</td>
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<td>Maternal mortality ratio (maternal deaths/100,000 live births) target</td>
<td>2015</td>
<td>280</td>
<td>Ratio of female to male primary enrollment (%)</td>
<td>2007</td>
<td>87.5</td>
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<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>2008</td>
<td>96</td>
<td>Ratio of female to male secondary enrollment (%)</td>
<td>2007</td>
<td>77.2</td>
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<td>Newborns protected against tetanus (%)</td>
<td>2008</td>
<td>64</td>
<td>Gender Development Index (GDI)</td>
<td>2008</td>
<td>139</td>
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<td>DPT3 immunization coverage (% by age 1)</td>
<td>2008</td>
<td>32.8</td>
<td>Health expenditure, total (% of GDP)</td>
<td>2007</td>
<td>6.6</td>
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<tr>
<td>Pregnant women living with HIV who received antiretroviral drugs (%)</td>
<td>2005</td>
<td>&lt;1</td>
<td>Health expenditure, public (% of GDP)</td>
<td>2007</td>
<td>1.7</td>
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<tr>
<td>Prevalence of HIV, total (% of population ages 15–49)</td>
<td>2007</td>
<td>3.1</td>
<td>Health expenditure per capita (current US$)</td>
<td>2007</td>
<td>74.2</td>
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<tr>
<td>Female adults with HIV (% of population ages 15+ with HIV)</td>
<td>2007</td>
<td>58.3</td>
<td>Physicians (per 1,000 population)</td>
<td>2008</td>
<td>0.395</td>
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<tr>
<td>Prevalence of HIV, female (% ages 15–24)</td>
<td>2007</td>
<td>2.3</td>
<td>Nurses and midwives (per 1,000 population)</td>
<td>2008</td>
<td>1.605</td>
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### Table: Poverty Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Survey</th>
<th>Year</th>
<th>Poorest</th>
<th>Second</th>
<th>Middle</th>
<th>Fourth</th>
<th>Richest</th>
<th>Total</th>
<th>Poorest-Richest Difference</th>
<th>Poorest/Richest Ratio</th>
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<tr>
<td>Total fertility rate</td>
<td>DHS</td>
<td>2008</td>
<td>7.1</td>
<td>7.0</td>
<td>5.9</td>
<td>5.0</td>
<td>4.0</td>
<td>5.7</td>
<td>3.1</td>
<td>1.8</td>
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<td>Current use of contraception (Modern method)</td>
<td>DHS</td>
<td>2008</td>
<td>2.5</td>
<td>3.8</td>
<td>7.8</td>
<td>14.1</td>
<td>22.3</td>
<td>9.7</td>
<td>−19.8</td>
<td>0.1</td>
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<tr>
<td>Current use of contraception (Any method)</td>
<td>DHS</td>
<td>2008</td>
<td>3.2</td>
<td>5.2</td>
<td>11.4</td>
<td>21.3</td>
<td>35.0</td>
<td>14.6</td>
<td>−31.8</td>
<td>0.1</td>
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<td>Unmet need for family planning (Total)</td>
<td>DHS</td>
<td>2008</td>
<td>18.4</td>
<td>20.3</td>
<td>21.8</td>
<td>23.1</td>
<td>18.2</td>
<td>20.2</td>
<td>0.2</td>
<td>1.0</td>
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<td>Births attended by skilled health personnel (percent)</td>
<td>DHS</td>
<td>2008</td>
<td>8.3</td>
<td>17.6</td>
<td>37.6</td>
<td>63.3</td>
<td>85.7</td>
<td>39.0</td>
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