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# Nigeria: Reproductive Health Landscape, bottlenecks and Road to Improvement

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## Abstract

Nigeria, as one of the most densely populated regions in Africa and the world, is a state with multiple religions, large young population, and socio-political conservatism. While constitutionally Nigeria is divided into 36 decentralized States, the Federal Government of Nigeria (FGON) exercised efforts aimed at addressing the high level of maternal and child morbidity and mortality rates. Despite such efforts, the poor quality of health of Nigerians persists due to poor health care infrastructure, inadequate human resources for health, and the inadequate availability of contraceptives and other life-saving maternal/reproductive health (RH) commodities. As such, this paper seeks to assess the modes and means of family planning and contraception, through various factors which influence, such as the demand for family planning, the legal framework surrounding abortion, and the significance of culture and religion in Nigeria.

***Key Words***: *Nigeria, Family Planning, Abortion, Reproductive Health, Abortion laws.*

## 1. Introduction

Nigeria is one of the most densely populated countries in Africa, with approximately 212 million people in an area of 923,768 km² (356,669 sq mi, and is also the country with the largest population in Africa with the seventh largest population in the world.

A large majority of the population is young, with 42.54% between the ages of 0–14. There is also a very high dependency ratio of the country at 88.2 dependents per 100 non-dependents. Three of the main religious groups are Muslim at 45%, Christian at 45% and other indigenous beliefs at 10%.

## 2. Exponential Increase in Population

The average growth rate of the country is 2.5% with population density of 241. The Governor of Delta State, Senator Ifeanyi Okowa, stated that the Nigeria's population is gradually out striping the country's economic growth threshold. Okowa made this remark at the PDP retreat for members of the newly elected National Working Committee (NWC). He stressed that the latest numbers from the National Bureau of Statistics showed that the economy grew at 2.8 percent per annum vis a vis the population rate at 3.5 percent, which is worrisome.

## 3. Family Planning Policies and Hierarchy of Health Systems

Constitutionally, Nigeria is divided into 36 decentralized States and one centralised Federal Capital Territory (FCT). The State governments are led by governors who strongly influence budgets and wield significant political power. The States effectively control 50 percent of all government revenue. As a result, the implementation of many health policies, including family planning, benefits significantly depend on the support of state governors. From an RH perspective, the federal government is charged with developing policies, strategies, guidelines, and plans that provide direction for the Nigerian healthcare system. However, implementation of these guidelines ultimately falls on the State Ministry of Health (SMOH).

The Federal Government of Nigeria (FGON) since the late 1980s adopted and implemented many policies and strategic plans, including the National Population Policy for Development, National Reproductive Health Policy and Strategic Plans, National Reproductive Health Commodity Security Strategic Plans, and National Guidelines on Contraceptive Logistics Management System. These efforts were aimed at addressing the high level of maternal and child morbidity and mortality rates, the poor quality of health of Nigerians due to poor health care infrastructure, inadequate human resources for health, and the inadequate availability of contraceptives and other life-saving maternal/reproductive health (RH) commodities.

However, there are other outstanding issues that need to be addressed, and these include limited financial and physical access to high-quality health services and commodities, low level of awareness about various health services, and the high prevalence of STIs, including HIV. The goal in developing and implementing these policies, programs, and strategic plans is to facilitate a continuous improvement in the health status and quality of lives of Nigerians. In more recent times, the FGON took urgent steps towards creating the required favorable and conducive environment for the delivery of and access to high-quality health services by Nigerians in their different localities. Some of these steps included the Midwife Service Scheme (MSS), the policy on free contraceptives and life-saving maternal/RH commodities, accelerated implementation of activities around the long-acting reversible contraceptive (LARC) methods, task shifting with appropriate supervision of the community health extension workers, creation of budget lines and increased funding for key activities such as the procurement and distribution of required RH commodities, as well as an increase in collaboration with the private health sector in health care delivery, among other interventions.

### 3.1 Family Planning Funding

Nigeria's family planning budget is traditionally composed of two different budget line items.

1- counterpart funding to match grants from donors (UNFPA, the U.S. Agency for International Development, UNICEF, and the Bill & Melinda Gates Foundation)

2- Government funding to improve family planning services.

FP commodity procurement is carried out solely through UNFPA, with funds contributed by the FGON and development partners, including UNFPA, USAID, the UK Department for International Development (DFID), and the Canadian International Development Agency (CIDA).

## 3.2 Current Fertility Statistics

Currently, women in Nigeria have an average of 5.3 children in their lifetime. Since 1990, fertility rate has decreased from 6.0 children per woman to the current level. 1 in 5 teenage women aged 15-19 are already mothers or pregnant with their first child. Rural teenage women are three times more likely to have begun childbearing than urban teenage women (27% versus 8%).

## 3.3 Current Use of Family Planning and Variation by Socioeconomic Cohorts

It is noted that seventeen percent of married women aged 15-49 use any method of family planning—12% use a modern method and 5% use a traditional method. The most popular methods are implants (3%), injectables (3%), and withdrawal (3%). Among sexually active, unmarried women aged 15-49, 28% use a modern method and 9% use a traditional method. The most popular methods among sexually active, unmarried women are the male condom (19%), withdrawal (5%), and the pill (3%).

The use of modern methods of family planning among married women varies by residence, wealth, and state. Modern method use is higher among urban women (18%) than rural women (8%). Modern family planning use increases with wealth; 4% of women from the poorest households use a modern method of family planning, compared to 22% of women from the wealthiest households. Women with lower levels of education and income are less likely to have access to Family Planning services. Also, men are less likely to have access to FP services as compared to women. Modern method uses ranges from a low of 2% in both Sokoto and Yobe states to a high of 29% in Lagos (represents the difference in wealth in education).

The use of family planning has increased from 6% in 1990 to 17% in 2018. During the same time period, modern method use increased from 4% in 1990 to 12% in 2018.

## 3. 4 Health Seeking Behavior and Challenges in Service Delivery

Nigerian women seek FP services from both the public and private sectors. Because intrauterine devices (IUDs), implants, and injectables require trained service delivery, they are usually sourced via the public sector. Condoms and pills are available from a wide variety of sources, including proprietary patent medicine vendors (PPMVs), informal drug sellers, pharmacies, and private and public health clinics. Delivering high-quality FP services across Nigeria depends on the providers' skills and training, as well as human resource availability at public and private points of care.

Delivering high-quality FP services across Nigeria depends on the providers' skills and training, as well as human resource availability at public and private points of care. On Staff skills and training, there exists a major shortage of skilled providers for delivering FP services, especially for injectables and long-acting reversible contraceptives (LARCs); wherein if a provider has not been trained and does not feel confident and/or comfortable about a particular method (e.g., inserting an IUD or giving an injectable), s/he is less likely to offer that method. This contributes to provider bias for certain methods over others. UNFPA estimates that 63 percent of state hospitals in Nigeria are not offering implants. As such, in addition to limiting overall access to family planning, inadequate staff skills and training contribute to other challenges

Nigeria suffers from low staffing levels across all cadres of health workers. According to the World Health Organization (WHO) Health Workforce Survey (2008), the country has approximately 0.4 doctors, 1.6 nurses, and 0.2 Community Health Workers per 1,000 people.

## 3.5 Demand for Family Planning

Nearly 1 in 5 married women (22%) want to delay childbearing (delay first birth or space another birth) for at least two years. Additionally, 14% of all married women sampled do not want any more children. Women who want to delay or stop

childbearing are said to have a demand for family planning. The total demand for family planning among married women in Nigeria is 36%. The total demand for family planning includes both the met and unmet need. The Met need is the contraceptive prevalence rate. In Nigeria, 17% of married women use any family planning method.

# 4. Factors Affecting Family Planning Services and Access

## 4.1 Culture and Religion

Historically, fertility decisions have been largely impacted by religious beliefs. Most religions in Nigeria, being patriarchal, give a lot of power and control to men over reproductive decisions of the family. However, engaging religious influence to propagate the message of family planning may benefit the Public Reproductive Health, as per the measure was used in one of the projects in Nigeria. A study led by John Hopkins Centre for Communication Programs and Nigeria Urban Reproductive Health Initiative shows the outsized role played by religious leaders in whether modern contraception is considered a taboo. Women in Nigeria whose Clerics extol the benefits of family planning were significantly more likely to adopt modern contraceptive methods.

## 4.2 Low demand for FP services and commodities

Low demand due to a low awareness and human capital remains a significant barrier to increasing CPR. Many women are not aware of the various methods of contraception or the relative benefits and side effects of each. In addition to lack of awareness, common misconceptions about side effects and efficacy persist among many men and women. Furthermore, the overall health and economic benefits of birth "spacing" and "limiting" are not well understood among families or even providers. This seems to translate into less incentive to use family planning and low usage patterns. To address this situation, all stakeholders and influential leaders should be encouraged to provide correct and appropriate information on birth spacing.

## 4.3 Low Health Literacy

It is noted that there is a low knowledge of contraceptives, especially LARCs, across Nigeria. The NDHS (2013) reported that 84.6 percent of married women of reproductive age have heard of at least one method. However, this average mask critical differences related to method type, age, wealth, and other factors. For example, only 25.9 percent of women have heard of implants in Nigeria—a much lower rate of knowledge than in other countries. From a geographical perspective, knowledge is significantly lower in the North, as is contraceptive prevalence.

## 4.4 Location of Family Planning Clinics

Another barrier to acceptability and acceptance of Family Planning in Nigeria is geographical location of FP Clinics which is not convenient to the clients. The long hours and cost of travel prevents the lower socioeconomic group from actively seeking the FP services, by increasing the capital costs.

## 4.5 Lack of Public Funded Family Planning Services

Healthcare in Nigeria is poorly funded and so are the Family Planning programs. There is limited public spending on health due to socio-political factors, and out of pocket expenditure decreases the incentive for poor and marginalized of the community to seek Family Planning services.

## 4.6 Cost of Services

The cost of family planning in Nigeria is prohibitive, specially to most rural women. The traditional copper IUD costs between N500(1.22$) – N1500(3.66$) in government hospitals and up to N3000(7.31$) in private hospitals. While this may not seem like much to American Audience, there are 100 million Nigerians living on less than $1 a day. The National Bureau of Statistics states that 60.9% of Nigerians are living in "absolute poverty". Such a situation of poverty distracts women to other priorities than reproductive health and family planning.

## 4.7 Budget Cuts for FP Programs

Nigeria's 2019 appropriation Bill reduced the national government's budget for family planning by 90% compared to the 2018 budget. Following months of deliberations and anticipation, the bill was finally signed by President Buhari on May 27, 2019. The Ministry of Budget and National Planning released the budget publicly on May 30, 2019.

## 5. Abortion Landscape of Nigeria

### 5.1 Laws of Federation of Nigeria

The section below outlines the laws of Nigeria pertaining family planning and abortion:

**Section 228. Attempts to procure abortion**

Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.

**Section 229. Attempt to procure own miscarriage**

Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her is guilty of a felony and is liable to imprisonment for seven years.

**Section 230. Supplying drugs or instruments to procure abortion**

Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child is guilty of a felony and is liable to imprisonment for three years. The offender cannot be arrested without warrant.

**Section 328 – Killing Unborn Child**

"Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had died, he would be deemed to have unlawfully killed the child, is guilty of a felony, and is liable to imprisonment for life."

### 5.2 Abortion Statistics and Maternal Mortality from Abortion

The available statistics indicate that over 1,000,000 abortions occur in Nigeria annually, representing about 33 abortions per 1,000 women of childbearing age. It has also been asserted that illegal abortion is responsible for about 11% of maternal death in Nigeria and 50% of such deaths involve adolescents and young women. It may be difficult to confirm these reports and statistics by different researchers, mainly because of the absence of official figures owing to the clandestine nature of abortion in Nigeria. For this reason, it is impossible for any pregnant woman who does not desire to have a baby, even for the most serious or justifiable reasons, except of course where her life is endangered by the pregnancy, to secure an abortion in any government hospital. Since an average Nigerian woman cannot afford the services of a willing private clinic, she is forced to resort to unsafe abortion practices by patronizing untrained personnel who use inappropriate and contaminated instruments under unhygienic conditions to perform it. The result is the staggering statistics of 1,000 out of every 100,000 maternal deaths arising from the estimated 1,000,000 abortions carried out in Nigeria each year.

## 6. Prescriptions for Action

### 6.1 Generating Demand for Contraception

Public awareness of family planning can be enhanced by increasing its public visibility. Knowledge and demand will come from the wide dissemination of accurate information about FP methods and their availability, as well as the incentive of FP use to promote the health of women and their families. Advocates at the federal, state, and LGA levels can increase interest in family planning within communities, producing a supportive environment, reducing normative barriers, and mobilizing community support. Executing high-impact, demand generation activities to close the knowledge-use gap by addressing myths and misinformation about family planning and the fear of side effects and health concerns that hinder its adoption and use is noted to be beneficial.

### 6.2 Building Partnerships

Develop partnerships with federal, state, and private media stations to promote family planning as a social responsibility. Fully integrate family planning into school health programs. Develop and deploy national, state, and community-level FP champions.

## 6.3 Enhancing and Integrating Service Delivery

The current staffing and skill levels in the public and private sectors of the Nigerian healthcare system do not provide adequate and equitable FP services to the population. It is necessary to both bolster the current delivery system through improving skills and deploy new FP service approaches to improve availability and accessibility. To ensure wide availability of family planning, it is essential to identify the health system's current FP service delivery capabilities and develop modalities for updating the gaps. The core of FP service availability is ensuring that FP health workers at each level have the appropriate training to provide FP services.

Integrating family planning into other health services should also be explored as a key strategy to enhance its availability at higher-level facilities with sufficient staff; for example, there is a need to build capacity for postpartum IUD services in labor wards. Such an exercise would increase the resilience of the system. Furthermore, referral for FP services should be stressed in the training and supervision of all healthcare workers who do not themselves provide these services to increase the same.

## 6.4 Adequate Financing of FP Program

While the overall policy environment for family planning is increasingly positive, the government's strong policy and strategic commitment has not been accompanied by a commensurate dedication of national, state, or Local Government level financial resources. To address the limited financial commitment, thereby the resilience of the family planning system within the various government budgets commensurate to need, the FMOH and partners should advocate for increased funding within national budgets, in addition to funding secured from development partners and the private sector. This study recommends the FMOH to cultivate advocates within other ministries to ensure that the national budget includes a line item for family planning that increases over time to meet the growing demand for FP services.

## 6.5 Abortion Laws Reforms

This study asserts that Abortion must be decriminalized. The law should provide for abortion on request in the first 3 months of pregnancy. This should take care of all conceivable reasons for abortion yet without any medical implication since abortion is indisputably safe. The law should prescribe the qualification of the medical practitioner to carry out the abortion and the minimum standard of facilities that must be present in the hospital (particularly private hospital) that will be authorized to carry out abortion. It should also create means of supervision and enforcement to prevent abuse particularly by private hospitals and clinics.

## Declaration of interest

The author declares no conflict of interest. The views presented in this article are author's own and do not reflect the views from any past or current organizations that author has been affiliated with

## References


Adedini, S. A. (2018, October). Role of Religious Leaders in Promoting Contraceptive Use in Nigeria: Evidence From the Nigerian Urban Reproductive Health Initiative. *Global Health: Science and Practice, vol. 6* . doi:https://doi.org/10.9745/GHSP-D-18-00135

Akinyemi, A. I. (2014, MArch). Demographic dynamics and development in Nigeria. *African Population Studies , 27*. doi:https://doi.org/10.11564/27-2-471

*Criminal Code Act*. (n.d.). Retrieved from Laws of Nigeria: http://lawsofnigeria.placng.org/laws/C38.pdf

Desmon, S. (2018, October). Study: Religious Leaders' Support May Be Key to Modern Contraception Use. Retrieved from https://ccp.jhu.edu/2018/10/15/religious-family-planning-nigeria-use/

Lysonski, S. (2013). Nigeria in Transition: Acculturation to Global Consumer Culture. *Journal of Consumer Marketing*. Retrieved from https://epublications.marquette.edu/market_fac/139/

(2018). *Nigeria Demographic and Health Survey (2018 NDHS)*. National Population Commission (NPC) [Nigeria] and ICF. 2019. 2018 Nigeria DHS Key Findings. Abuja, . Retrieved from https://dhsprogram.com/pubs/pdf/SR264/SR264.pdf

Nigeria, M. o. (2014, October). Nigeria Family Planning Blueprint - Scale up plan. Federal Government of Nigeria. Retrieved from http://www.healthpolicyproject.com/ns/docs/CIP_Nigeria.pdf#:~:text=The%20Nigeria%20Family%20Planning%20Blueprint%20%28Scale-Up%20Plan%29%2C%20as,high-quality%20FP%20services%20to%20Nigerians%20of%20reproductive%20age.

Nigeria's National Family Planning Allocation Cut by 90%. (n.d.). Retrieved from https://www.advancefamilyplanning.org/nigerias-national-family-planning-allocation-cut-90

Okorie, P. C. (2019). Abortion LAws in Nigeria: A case for reform. *Annual Survey of International & Comparative Law , 23(1)*. Retrieved from https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1215&context=annlsurvey

*Public Health Nigeria*. (2020, June). Retrieved from https://www.publichealth.com.ng/family-planning-in-nigeria/

*The World Factbook*. (n.d.). Retrieved from https://www.cia.gov/the-world-factbook/countries/nigeria/

*This Day (Online newspaper)*. (n.d.). Retrieved from https://www.thisdaylive.com/index.php/2021/11/25/population-outgrowing-economy-dangerous-okowa-warns/#

*US Census Bureau*. (n.d.). Retrieved from https://www.census.gov/data-tools/demo/idb/#/country?menu=countryViz&COUNTRY_YR_ANIM=2021&FIPS_SINGLE=NI&ANIM_PARAMS=1953,2021,5&COUNTRY_YEAR=2022