Focus On

Maternal and newborn health in Nigeria: Developing strategies to accelerate progress

Nigeria is Africa's most populous country, with 148 million inhabitants in 2007, 25 million of them under age five. With almost 6 million births in 2007 – the third highest number in the world behind India and China – and a total fertility rate of 5.4, Nigeria's population growth continues to be rapid in absolute terms.

In addition to its sizeable population, Nigeria is known for its vast oil wealth. Nonetheless, poverty is widespread; according to the latest *World Development Indicators 2007*, published by the World Bank, more than 70 per cent of Nigerians live on less than US$1 per day, impairing their ability to afford health care.

Poverty, demographic pressures and insufficient investment in public health care, to name but three factors, inflate levels and ratios of maternal and neonatal mortality. The latest United Nations inter-agency estimates place the 2005 average national maternal mortality ratio at 1,100 deaths per 100,000 live births and the lifetime risk of maternal death at 1 in 18. When viewed in global terms, the burden of maternal death is brought into stark relief: Approximately 1 in every 9 maternal deaths occurs in Nigeria alone.

The women who survive pregnancy and childbirth may face compromised health; studies suggest that between 100,000 and 1 million women in Nigeria may be suffering from obstetric fistula. Neonatal deaths in 2004 stood at 249,000, according to the latest World Health Organization figures, with 76 per cent taking place in the early neonatal period (first week of life). Inadequate health facilities, lack of transportation to institutional care, inability to pay for services and resistance among some populations to modern health care are key factors behind the country's high rates of maternal, newborn and child mortality and morbidity.

Disparities in poverty and health among Nigeria's numerous ethnolinguistic groups and between its states are marked. Poverty rates in rural areas, estimated at 64 per cent in 2004, are roughly 1.5 times higher than the urban-area rate of 43 per cent. Moreover, the poverty rate in the north-east region, which stands at 67 per cent, is almost twice the level of 34 per cent in the more prosperous south-east.

Low levels of education, especially among women, and discriminatory cultural attitudes and practices are barriers to reducing high maternal mortality rates. A study at the Jos University Teaching Hospital in the north-central region shows that nearly three quarters of maternal deaths in 2005 occurred among illiterate women. The mortality rate among women who did not receive antenatal care was about 20 times higher than among those who did. Of the several ethnic groups represented among the patients, Hausa-Fulani women accounted for 22 per cent of all deliveries and 44 per cent of all deaths. The Hausa-Fulani represent the largest ethnic group in northern Nigeria and are therefore critically affected by this region's higher poverty rates.

Cultural attitudes and practices that discriminate against women and girls contribute to maternal mortality and morbidity. Child marriage and high rates of adolescent births are commonplace across Nigeria, exposing girls and women of reproductive age to numerous health risks.

Given these complex realities, developing strategies to accelerate progress on maternal and newborn health remains a considerable challenge. But the Government of Nigeria, together with international partners, is attempting to meet the challenge. In 2007, it began to implement a national Integrated Maternal, Newborn and Child Health (IMNCH) Strategy to fast-track high-impact intervention packages that include nutritional supplements, immunization, insecticide-treated mosquito nets and prevention of mother-to-child transmission of HIV.

The strategy is to be rolled out in three phases, each lasting three years, and has been designed along the continuum of care model to strengthen Nigeria's decentralized health system, which operates at the federal, state and local levels. In the initial phase, covering 2007–2009, the key focus will be identifying and removing bottlenecks, while delivering a basic package of services using community-based and family-care strategies. A sizeable proportion of expenditure will go towards artemisinin-based combination therapy to combat malaria in women, children and newly recruited and trained health workers, particularly in rural areas. As basic healthcare improves, it is anticipated that the demand for clinical services will increase.

The second and third phases of the IMNCH will place greater emphasis on building health infrastructure. Over nine years, the strategy aims to revitalize existing facilities, construct clinics and hospitals, and create incentives – such as dependable salaries, hardship allowances and performance-based bonuses – that will help retain skilled health professionals in Nigeria's health system.

The IMNCH strategy, if implemented in full and on time, can markedly improve maternal and newborn health. Together with this package, the country has recently passed the National Health Insurance Scheme, which integrates the public and private health sectors to make health care more affordable for Nigerians. If the government passes the National Health Bill, which is currently before the legislature, a direct funding line for primary health care will become available. These health-system improvements have the potential to set a new course for meeting Millennium Development Goals 4 and 5 in Africa's largest nation.

See References, page 107.