PERMANENT MISSION OF NIGERIA TO THE UNITED NATIONS

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STATEMENT

BY

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NATIONAL POPULATION COMMISSION

ON

FERTILITY, REPRODUCTIVE HEALTH AND DEVELOPMENT (NATIONAL EXPERIENCE)

AT THE

44th SESSION OF COMMISSION ON POPULATION AND DEVELOPMENT (CPD)

NEW YORK, APRIL 12, 2011

Mr. Chairman,

On behalf of my delegation, may I also congratulate the Chair and members of his bureau for their appointment to preside over this session.

The focus of this year's session is in tandem with the aspirations and yearnings of the government and people of Nigeria. We see fertility and reproductive health as major challenges to overcome in order to attain sustainable development in all its ramifications. These issues require dedicated and sustained commitments if the well-being of the people especially those of women and children constitute the prioritized desire of any nation.

Mr. Chairman,

Fertility is one variable that cuts across the eight Millennium Development Goals (MDGs) and influences processes aimed at achieving all the MDGs targets. In the last few years many countries across the globe have been experiencing declining fertility rates. On the contrary, Nigeria, in the last two decades (1990-2010) has consistently experienced high fertility rate with a Total Fertility Rate (TFR) of 6.0 in 1990 (NDHS 1990), 5.7 in 2003 and 2008 (NDHS 2003 and 2008) respectively. While our population has increased from 88.9 million (1991 to 140.3 million (2006), it is estimated to reach 164.8 million in 2011, if the prevailing growth rate remains unchanged. In other words, our population is expected to increase by 75 percent in 20 years based on a growth rate of 2.8 percent in 1991 to 3.2 percent in 2006 annually. Similarly, it has been observed within the same period that our Child-woman Ratio (CWR) obtained from both censuses and NDHS data show a worrisome outcome; especially with regard to the last four NDHS (1990 and 2008). The figure declined from a CWR of 1007 in 1990, to 657 in 1999 but increased to 717 in 2003 and shot up to 761 in 2008. Thus, the claim of fertility decline if any depends on national experience. Within the context of demographic divide across the six geographical zones of the country, we have experienced increased TFR ranging from 4.5 in the South West zone to as high as 7.3 in North West zone, except for the North Central zone which witnessed a

slight decrease from a TFR of 5.7 to 5.4 between 2003 and 2008, thus sustaining a high national TFR.

Our experience of high fertility rate is as a result of early marriage. Almost half of our women are married by age 18 and 1 in 5 are married by age 15, while 23 percent of teenagers (age 15-19 years) are already mothers or pregnant with their first child. High literacy rate is apparent among girls and women who are in reproductive ages (15-49). Thus, unintended and unwanted pregnancies are common which usually results in unsafe abortion putting women at risk of death and leaving some of them with chronic incontinence - Vesico-vaginal Fistula (VVF). These outcomes though they represent some level of slight improvements still contribute to high infant and maternal death; heightened by resistance to and low practice of Family Planning (FP) among currently married women due to cultural/beliefs and misconceptions coupled with large unmet needs (estimated at 20% as reported by 2008 NDHS) of modern methods of contraception.

The current use of modern FP methods among married women is only 10 percent, representing a 2 percent increase in the last five years which is far below the expected National Population Policy target of 22 percentage point between 2004-2011.

Fifty Eight per cent (2008 NDHS) of women of reproductive age receive antenatal care (ANC) from skilled providers (doctor, nurse/midwife or auxiliary nurse) during their last pregnancy, while 62 percent of births occurred at home and a significant proportion (36%) never received ANC. All these constitute reproductive health issues that pose challenges to our development efforts.

Mr. Chairman,

Nigeria belongs to the Committee of Nations that has embraced FP as a major tool for charting its path of national development and progress and specifically to achieve MDGs 4 and 5. We remain committed to the consensus reached at the 1994 ICPD that "reproductive health care should be provided to all people by the

year 2015" as well as the MDGs in 2002 whereby nations of the world under the developing global partnership for development considered that both the MDGs and the relevant issues in the 1994 ICPD could be addressed through family planning and reproductive health; followed by agreements that countries should "meet the family planning needs of their population" and provide "universal access to a full range of safe and reliable family planning methods" (UNFPA 2004).

In order to implement these consensus and agreements and most importantly to achieve declining fertility rates, guarantee quality of life, accelerate development process, our government in recent years has undertaken various steps to include:

- Policy/reforms:
    i. Revised the National Policy on Population in 2004 tagged National Policy on Population for Sustainable Development (NPP) lunched in 2006 whose target are similar to the MDGs targets;
    ii. Revised National Health Policy-2004
    iii. National Adolescent Health Policy & Strategy-2006;
    iv. Revised the RH policy in 2010 to reflect prevailing trends;
- Implementation of the national gender policy strategic plan;
- Higher commitments to girl-child education to keep them in school and delay commencement of child birth;
- President's commitment to increase youth employment to reduce youth restiveness and teenage pregnancy;
- Currently, 20 state government (out of 37) are providing free maternal health care services;
- 18 states in the Northern part (where fertility & maternal death is very high and FP is very low) have agreed to implement free comprehensive maternal care services;
- Accorded priority to fertility, RH and development in Vision 2020 policy document;
- Massive increase in advocacy to achieve larger acceptance and practice of FP in order to achieve decline in fertility and moderate our family size;
- Accorded priority attention through adequate funding for HIV/AIDS;

- Instituted budgetary commitments for procurement and distribution of FP/child spacing commodities;
- Enforced the inclusion of HIV/AIDs and Family Life education in primary and secondary schools curriculum;
- Stepped-up partnership with Faith Based Organizations (FBO) to champion the implementation of RH programs;
- Trained 30,000 health care providers in life saving post abortion;
- Hosted the first ever national conference on FP in November, 2010 which prompted initiating a review of Resource for Awareness on Population Impact on Development (RAPID) - an advocacy tool for implementing the NPP in March, 2011.

Mr. Chairman,

The Nigerian government is quite aware of the challenges posed by the prevailing high fertility rate and RH requirements to its development aspirations and efforts at achieving the MDGs and the Vision 202020 and has commenced concerted efforts with firm commitments to implement programs that will promote RH and FP and make FP commodities available at no cost to desired users. It is gratifying to note that as always, the United Nations Population Fund (UNFPA) will work with Member States to address their specific reproductive health issues. In this regard, we want to re-affirm our commitment to work with the new leadership of UNFPA under Professor Oshotimehin, to achieve its declared vision and other UN partners to realize the goals set in the ICPD Programme.

Mr. Chairman,

May I conclude by stating that a **"healthy population is a key to the rapid development of any nation"** thus our focus is more on quality of life and health outcomes that will translate quality into numbers.

I thank you.