Commentary

Impact of Reproductive Health on Socio-economic Development: A Case Study of Nigeria

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Abstract

The link between reproductive health, sexual and reproductive right, and development was highlighted at the International Conference on Population and Development held in Egypt. Developmental disparities are related to socio-economic differences which have led to the identification of distinct socio-economic classifications of nations. Human development represents the socio-economic standing of any nation, in addition to literacy status and life expectancy. Africa accounts for 25% of the world's landmass but remains the world's poorest continent. Nigeria, the most populous country in Africa, has policies and programmes geared towards the improvement of its socio-economic standing and overal development, with little positive result. Reproductive health is a panacea towards reversing the stalled socio-economic growth of Nigeria as evident from the linkage between reproductive health and development, highlighted in Millennium Development Goals 3, 4, 5 and 6. Fast tracking Nigeria's development requires implementation of reproductive health policies and programmes targeted on women and children (*Afr J Reprod Health 2011; 15[1]: 7-12).*

Résumé

Impact de la santé de la reproduction sur le développement socioéconomique : Le cas du Nigéria. Le lien entre la santé de la reproduction et le développement a été souligné à la Conférence Internationale sur la Population et le Développement qui a eu lieu en Egypte. Les disparités développementales sont liées aux différences qui ont mené à l'identification des classifications socioéconomiques distinctes des nations. Le développement humain représente la situation économique de n'importe quelle nation, y compris la situation d'alphabétisation et d'espérance de vie. L'Afrique est responsable de 25% du bloc international, mais elle reste le continent le plus pauvre du monde. Le Nigéria, le pays ;e plus peuplé d'Afrique, a mis en place des politique et des programmes destinés à l'amélioration de la situation socioéconomique et le développement d'ensemble, sans résultat positif appréciable. La santé de la reproduction est une panacée vers le renversement de la croissance socioéconomique retardée du Nigéria, ce qui est évident â partir de la liaison entre la santé de la reproduction et le développement, ce qui a été souligné dans les Objectifs du Millénaire pour le Développement 3, 4,5 et 6. L'accélération de développement exige la mise en œuvre des politiques et des programmes de la santé de la reproduction qui visent les femmes et les enfants (*Afr J Reprod Health 2011; 15[1]: 7-12).*

Keywords: National development; Nigeria; Reproductive health

Introduction

"Development is a prime target of any polity. A Nation bereft of development brews the invitation to insurrection" — J.I.B.

Global perception to the development of nations apparently became more lucid following the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994. The conference represented a paradigm shift in emphasis on population issues from the hitherto family planning and demography to human rights and development. Perhaps more spectacular also is the emergence of reproductive health, sexual and reproductive rights, at this conference, and this became inextricably linked to development. The sexual and reproductive rights of women was regarded as an indivisible aspect of universal human right, a situation which was re-iterated at the Fourth World Conference of Women (FWCW) held in Beijing, China, in 1995, which perforce, countries are obliged to uphold and were called upon to incorporate into their health care policies to facilitate the development of their nations. Reproductive health emphasises on people in all ramifications, nature, and dimensions, and this seemingly makes it inseparable from human development. [1, 2, 3]

Development is believed to be a dynamic and evolving process. However, the developmental disparities between the rich countries and the poor countries especially of sub-Saharan Africa seem not to entirely support this view. Although wars, famine, corruption, and bad leadership have often been adduced as reasons for the continued under-development of these poor nations, the unlikelihood of these factors being solely responsible for the underdevelopment of Africa is evident from the fact that similar disasters and vices also exist in some rich nations without any palpable rocking of their development.

This paper reviews development, and highlights the standing of Africa, and indeed Nigeria, in the world socio-economic order and the influence of reproductive health on the re-positioning of Nigeria nation towards the path to sustainable development.

Development

Over the years, a clear divide has emerged among Nations based on their various socio-economic well-beings. Countries with developed economies in which the tertiary and quaternary sectors of industry dominate have been designated as developed or advanced countries, while countries 'christened' developing are characterized by relatively low standard of living, an undeveloped industrial base, wide spread poverty, low capital formation, and per capita income.[4] Economic overlap occurs giving rise to a wider range of socio-economic grouping of countries to include Least developed, High income, and Newly industrialized countries. The emergence of such rapidly growing economies as the Asian Tiger countries — Hong Kong, Singapore, South Korea, Thailand, and Taiwan, has made such economic overlap inevitable. Table 1 below shows the Economic Classification of countries.[4]

Table 1: Economic classification of countries

Economic class	Example of countries
Developed countries	Norway, Canada
Developing countries	Libya, India
Least developed countries	Yemen, Nigeria
High income countries	France, Saudi Arabia
Newly industrialized countries	South Africa, Brazil

The economy of Nations is usually represented as Gross domestic product (GDP). GDP is the sum of value added by all resident producers in a country plus any product tax (less subsidies) not included in the valuation of output, and is used to calculate growth.[5] To allow for standardization from differences in price levels of goods in different countries, GDP is converted to, and represented as purchasing power parity (PPP) in USD. The World Bank ranks Nations annually on the basis of GDP, and has classified the world based on economy into High income, Upper Middle income, Middle income, Lower Middle income, Low and Middle income, Low income, and Heavily indebted poor countries (Least developed countries — UN classification). In 2005, the PPP value of Luxembourg ranked first in the World Bank GDP ranking, is 65,630 USD, while the value for Burundi ranked 187th (least in the list), is 100 USD.

Global development is measured in more concrete terms using the Human Development Index (HDI) which is a comparative measure of life expectancy, literacy, education, and standard of living as measured by the log of Gross Domestic Product (GDP) per capita at Purchasing Power Parity (PPP) in USD. HDI is therefore used to determine whether a country is developed, developing, or underdeveloped, as well as measuring the impact of economic policies on quality of life.[4, 6, 7] HDI values of 0.8 and above are regarded as High development and includes all countries designated as developed — countries in North America, Western Europe, Oceania, and Eastern Asia, as well as some developing countries in Eastern Europe, Central and South America, Southeast Asia, the Caribbean, and the oil-rich Arabian Peninsula. Medium development countries have HDI of 0.5 and above but less than 0.8. These include mainly developing countries notably in the Middle East Asia, Northern Africa, and few countries in sub-Saharan Africa. Countries with HDI below 0.5 are categorized as Low development and are predominantly countries of sub-Saharan Africa. Only Yemen and Haiti are non-African countries in this group. HDI has recently supplanted GDP per capita as a measure of the socio-economic performance of countries.

Africa occupies approximately 25 % of the world's land mass but remains unfortunately the most poorly developed continent — many of her countries being ravaged by wars, famine, political instability, or corruption, resulting in mass poverty, educational backwardness, and disease. Twenty nine out of the 36 countries (i.e. 80.6 %) — including Nigeria, under the World Bank economic ranking of Low income and Heavily indebted poor countries, are from sub-Saharan Africa (SSA). Similarly as high as 19 of the 21 heavily indebted poor countries of the world come from SSA.[5] Twenty nine out of the 31 countries designated as 'Low development' under the 2006 UNDP HDI ranking are from Africa[4]. Clearly therefore more than 90 % of the world's poorest countries abound in Africa. Africa accounts for approximately 12 % of the world's population, and is richly endowed with natural resources and stable climatic conditions. Unfortunately, Africa is only able to secure 1 % of the world's trade and 0.4 % of its manufacturing exports, and is therefore not economically viable.[8]

Nigeria with its current population of 140 million is the most populous country in Africa. Unfortunately the country belongs to the league of poorest income group of the world. With a Human Poverty Index (HPI) value of 38.8%, Nigeria ranks 75th out of 103 developing countries in the Human Poverty index assessment of

Table 2: Comparison of two key socio-economic indexes — HDI and GDP between Nigeria and some other countries[4, 5]

Country	GDP per capital value (PPP USD) 2005	GDP per capita rank (187 countries) 2005	HDI value (2006)	HDI rank (177 countries) (2006)
Norway	59,590	2	0.965	1
Singapore	27,490	24	0.916	25
Seychelles (Best performer in SSA)	8,290	40	0.842	47
Niger (Worst performer in SSA)	240	178	0.311	177
Nigeria	560	150	0.448	159

2005 [9]. In 1980, only 27 % of Nigeria's 66 million people were poor. Presently 90 % of Nigeria's 140 million people live on USD2 a day, 60-70 % on less than USD1 a day, and 40 % are unable to meet their basic food needs. Currently Nigeria's per capita income at PPP is USD560, and Nigeria ranks 159 out of 177 countries in the 2006 Human Development Index.[4, 9, 10]

Nigeria's journey towards poor socio-economic development is traceable to poor planning, together with corruption and bad governance. Nigeria ranks 152nd out of 158 countries in Transparency International's Corruption Perceptions Index for 2005.[11] The second National development plan of 1970-1975 failed because it was largely predicated on assumptions and conjectures — assumptions of a population growth rate of 2.5 % which almost immediately hiked up to above 3.2 %; and anticipated increasing revenue from the oil sector, which even though occurred, was short lived, oil prices nose-diving to an all time low.

The third National plan of 1975-1980 also followed similar trend and amongst other things failed to appreciate the synergistic and integral relationship between population growth and the economy, concentrating only on beefing-up economic growth on the assumption that this would automatically lead to the lowering of population growth rate.

The military intervention of the mid 80s undoubtedly apparently dealt the most disastrous blow onto an already ailing Nigerian economy. Deepening economic recesses, fall in commodity prices, and increasing indebtedness of Nigeria compelled the IMF and the World Bank to intervene to restore fiscal discipline through the introduction of the Structural Adjustment Programme (SAP), a set of macro-economic measures aimed at debt recovering in the short term and poverty reduction through the growth of the economy in the long term. Structural Adjustment Programme employed devaluation of the Naira, retrenchment of workers, and removal of subvention to institutions, to achieve its objective. This further worsened the poverty situation in the country. Free education was stopped leading to drop in school enrolment, user fees were introduced into hospitals thereby depleting patronage to hospital facilities. Equipments and infrastructures were neither maintained, nor were bad ones replaced. The basic social services in the country ground to a halt setting the stage for abysmal poverty.[12, 13, 14]

In 1999, Military rule in Nigeria gave way to a democratically elected government with high hopes towards the re-direction and resuscitation of Nigeria's stalled socio-economic development. The first four years of the new Civilian administration offered little towards the achievement of a reasonable change. The second four years (2003-2007) however witnessed a remarkably improved socio-economic thrust — the re-structuring of the Banking sector through the re-capitalization of Banks involving mergers and acquisition; privatization; and deregulation — all laudable socio-economic measures which together with the celebrated Debt relief soared-up Nigerian Foreign reserve to an un-precedented high level. Socio-economic policies directed at the Millennium Development Goals (MDGs) were popularized. Corruption was tackled head long with the establishment of the Independent Corrupt Practices Commission (ICPC), and the Economic and Financial Crime Commission (EFCC) which helped to check various forms of corruption and financial fraud including overseas money laundering. Inspite of all these, the socio-economic standing of the country improved only but marginally indicating an obvious gap that needs to be bridged. Bridging the gap apparently lies on the profound understanding, and appreciation of reproductive health as an indispensable catalyst towards national development.

Reproductive Health and Development

The concept of Reproductive Health emerged following the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994. ICPD also heralded Women's Sexual and Reproductive Rights, and constituted the framework for the development of the United Nations Millennium Development Goals (MDGs) in 2000.[15-20] Several countries in which low socio-economic development occurs, Nigeria inclusive, have been observed to be characterised by an inherent infringement of the sexual and reproductive rights of women. Unsafe motherhood; unsafe abortion; traditional harmful practices as examplified by early marriage, widowhood rites, female disinheritance, and female genital cutting; gender inequality; and violence against women are notable areas

of women's sexual and reproductive rights abuses observed in these countries.[21] It is perhaps against this background that atleast four of the eight MDGs have a direct relationship with reproductive health, vis MDGs 3, 4, 5, and 6. The MDG number 3 ─ to promote gender equality and empower women, represents a well-designed reproductive health and rights' violation remedial measure that could impact on economy and development either directly or indirectly. Its sole target ─ "eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015", and four indicators are a direct measure of development in the household, in the economy, and in the society. Similarly MDG 4 i.e Reduce child mortality, represents a response to a very important component of reproductive health ─ Infant and child survival, growth and development, which continues to pose a great challenge to many countries of the developing world especially Nigeria where no visible improvement has occured over many years. High, and unabating maternal mortality statistics in Nigeria typifies the direct relationship between reproductive health and development. MDG 5 ─ improve maternal health, has as its revised targets "reduce maternal mortality by 75% by 2015" and "provide universal access to reproductive health". Furthermore, its six indicators — maternal mortality ratio, proportion of births attended by skilled health personnel, contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning, all have direct bearing to reproductive health in general.[22] This implies that no meaningful development is likely to occur in Nigeria until enough efforts have been made to address these reproductive health issues, and in particular reduce maternal mortality to the barest minimum. The same reasoning can be extended to MDG 6 ─ Combat HIV/AIDS, Malaria, and other diseases. Undoubtedly the burden of diseases such as HIV/AIDS and Malaria scourge on the productive workforce, and indeed all the citizens of any nation can only but constitute an impediment to any form of development in that nation.

Nigeria's population of 140 million approximates to 1.2% of the world's population. Nigeria unfortunately has one of the world's worst reproductive health indices. For example, Nigeria accounts for 10 % of the world's maternal deaths, a figure highly out of proportion to her ratio to the world's population. Some key Nigeria's demographic and reproductive health indicators are shown in Table 3.

These Nigeria's poor reproductive health indicators are worrisome and undoubtedly constitute an un-spoken and un-assessed influence towards the country's poor socio-economic standing. The relationship between reproductive health and development is shown in Table 4 below which compares some key reproductive health and developmental indices between Nigeria and Singapore, both former British colonies that attained self-governance about the same time.

Table 3: Some Nigeria's demographic and reproductive health indicators.[23]

Indicator	Value
Total area (in square km)	923,768
Total population (in millions) (2006)	140
% Annual population growth rate	2.9%
Total Fertility Rate (2008)	5.7
Contraceptive prevalence rate (2008)	15.0%
Unmet need for family planning (1999)	18%
Teenage pregnancy rate (2008)	23%
Girls married before 15 years	25%
Maternal mortality ratio per 100,000 live births (2008)	545
Infant Mortality Rate per 1,000 live births (2008)	75
Life- time risk	1 in 14
Male adult literacy rate (2008)	40.7%
Female adult literacy rate (2008)	58.0%
Life Expectancy (2006)	43 yr

Table 4: Reproductive health and developmental indices: Nigeria vs Singapore [4, 5, 23, 24]

Indices	Nigeria	Singapore
Reproductive Health Indices		
Maternal mortality ratio	545 (2008)	30 (2000)
Life time risk	1 in 14	1 in 4,900
Total fertility rate	5.7	1.3
HIV/AIDS prevalence rate	5.8% (2003)	0.2% (2003)
Infant mortality rate	100 (2003)	2.5 (2006)
Developmental Indices		
Life expectancy	43 yr	79 yr
Literacy rate	49.4%	95.4%
GDP per capita (USD) (2005)	560	27,490
GDP per capita ranking	150	24
HDI value (2006)	0.448	0.916
HDI ranking (2006)	159	25

Giving the relationship between reproductive health and development, as highlighted in the UN MDGs, and that the Sexual and Reproductive Health Rights of the individual in any country represents a unit of development of that country[15], it is obvious that the development gap that needs to be bridged in Nigeria is related to the promotion of the Reproductive Health status of the totality of Nigerians. Efforts should therefore be made in this direction if Nigeria's socio-economic development is to be fast-tracked. A clear understanding of this relationship and the commitment of all stakeholders towards their marriage is paramount to the actualization of Nigeria's speedier socio-economic

development. Policy makers should of necessity focus on the development and implementation of reproductive health policies and programmes targeted primarily on women and children. Advocacy perhaps plays a very important role in reproductive health and development through the information, education, and communication of the various stakeholders involved in reproductive health support, and implementation process. Advocacy should focus on leadership even at the highest level of governance at federal, state, and local government levels, many of whom are ignorant as to the magnitude of reproductive health problems in their domain, and who infact have the executive power to appropriate funds, policies, and programmes towards reproductive health improvement efforts. Advocacy also should incorporate the re-orientation of health workers, the implementers of reproductive health programmes, towards a greater commitment to work, while sensitizing the communities, the beneficiaries of reproductive health services, towards the acceptability of reproductive health services brought to them, and greater patronage to the reproductive health facilities in their communities. Women are considered to be central towards reproductive health, and development, often playing a major role in the social and economic development of nations. The fastest growing regional economies over the past decade, East Asia, for instance, is also the region with the highest regional labour force and participation rate, as well as low unemployment rates, for women, and relatively small gender gaps in sectoral and status distribution.[25] Women should therefore be empowered educationally through compulsory basic education; economically through small loans and skills acquisition schemes; and politically through appropriate gender equality measures. It is important to ensure gender equality and equity in all aspects of the nation's social and political life using recommended approaches, notably Gender mainstreaming, and Affirmative action, both of which can be entrenched through legislation.[26] Legislation in favour of free maternal services, and against several areas of Women's Sexual and Reproductive Rights abuses such as — unsafe abortion, violence against women, women and child trafficking, and gender inequalities, has become inevitable in Nigeria if the sexual and reproductive rights of women are to be upheld in the country. Legislation is also the instrument for the domestication of the provisions of various Reproductive Rights related International Conventions such as Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), International Conference on Population and Development (ICPD), Fourth World Congress on Women (4WCW), African Child Rights Charter, etc, which is a major requisite to the enhancement of the reproductive health and rights of women as well as overall development of the nation.[21] Maternal health services should be considered to be a fundamental right of every woman. Although a few States of the federation have established free maternal health services for their women, there is the need to bring every State on board towards this laudable reproductive health action. Provision of free maternal health services — antenatal care, delivery, and family planning to all women of child bearing age, together with strengthening of immunization services for women and children to facilitate total immunization coverage, are recommended for all States of Nigeria, if possible by legislation as a measure towards accelerating reproductive health and overall human development. Nigeria's health system and structure can best be described as complex and disorganized with considerable effacement of the original three tier system. Furthermore, very low quality of health services, occasioned by inadequate funding, poorly motivated workforce, and lack of drugs and modern equiment have rendered the health facilities un-attractive to the people with resultant poor patronage.[27] It has therefore become necessary to improve the overal health system, structures, and services in order to strengthen primary health care services, as well as re-position secondary and tertiary health care services to meet with the challenges of reproductive health especially safe motherhood. The role of trained, and adequate staffing in the provision of good reproductive health services remains indubitable. For example, the number of deliveries taken by skilled birth attendant has been correlated with maternal mortality and has been aptly highlighted as one of the indicators of MDG 5.[28] Trainings that invariably build the capacity of health staff towards a wide range of reproductive health services include those on emergency obstetrics care, post abortion care and use of manual vacuum aspirator, family planning, reproductive health commodity security logistics, and immunization. Nigeria's health facilities have been universally characterized by poor staffing and overal poorly motivated workforce, largely on the account of embargo placed on employment, and subvention to health facilities following the structural adjustment programmes of 1988. [8, 14] Removal of embargo on employment, and adequate recruitment of skilled health personnel, as well as improving their conditions of service through adequate incentives and training especially on essential obstetric care would considerably improve services in public health facilities, and greatly encourage the acceptability and utilization of such facilities by community members. The ravaging effect of certain diseases of public health importance notably HIV/AIDS and Malaria on the economy of the nation has been highlighted. There is need to revisit and restructure the overal control and management of these diseases in a result oriented and sustainable manner rather than the present ad hoc donor driven approach. Malaria control for instance should focus on environmental sanitation and vector eradication measures rather than the

present therapeutic, and physical barrier control measures that have yielded little or no positive results. Finally, there is need to re-orientate reproductive health services towards community drive and health sector partnerships such as private-public partnership, and community-public partnership. A typical example of this is community-government health care financing scheme established in a few States to harness adequate funding for health services at the community level.[29]

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