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Reducing Unintended Pregnancy in Nigeria

Although fertility rates are declining as modernization is increasing, Nigeria is still one of the poorest nations in the world and has the largest population in Sub-Saharan Africa. Many women are experiencing unwanted and mistimed pregnancies, with consequences ranging from interruption of schooling to health risks and economic hardship, all of which hinder efforts to improve their socioeconomic status. By educating and empowering both married and sexually active unmarried women to make informed and responsible decisions about contraceptive use and their desired fertility, the Nigerian government can improve both the health and the economic productivity of its citizens.

This report compares the childbearing aspirations of Nigerian women with their actual experience. It focuses on the high level of mistimed and unwanted births occurring in Nigeria as a result of low levels of contraceptive use among women in many parts of the country. The report reveals wide variation in levels of contraceptive use among married and sexually active unmarried women. Both groups have a significant unmet need for family planning, but the reasons for their need differ. The study directs attention toward far-reaching health policy and program responses that will be required to reduce mistimed and unwanted pregnancies and unsafe abortions in Nigeria.

Nigeria has an estimated population of more than 123 million people that is increasing at a rate of 2.8% a year.[1] Profound cultural, political and economic differences characterize the country's six geopolitical regions—differences that are often associated with wide variations in women's educational attainment, sexual behavior, early marriage, and access to and use of family planning services. The North East and North West regions are predominantly Muslim, the South East and South South regions are mostly Christian, and the North Central and South West have large representations of both religions. The numerous ethnic groups found in Nigeria contribute considerable cultural diversity. The three major groups are the Hausa-Fulani in the north, the Yoruba in the southwest and the Igbo in the southeast, each with its own values and traditions regarding marriage, sexual behavior and childbearing.

Key Points

- **There is wide regional variation in the timing of marriage among Nigerian women. More than nine in 10 women aged 20–24 in the North East and North West had married by age 20, compared with half to three-fourths of women in the three southern regions.**
- **Premarital sexual activity is most common among more educated women, who tend to postpone marriage the longest. In the southern regions, where educational levels are highest and the smallest proportion of young women are married, 41–69% of women aged 20–24 had had premarital intercourse by age 20. This compares with only 6–14% in the North West and North East, where educational levels are lowest and marriage before 20 is most common.**
- **Contraceptive use is low in Nigeria, particularly among married women. Only 13% of married women aged 15–49 use any method, traditional or modern. Use is much higher among sexually active unmarried women (47%).**
- **There is considerable regional variation in contraceptive use, with 66% of sexually active unmarried women using any method in the South West, compared with only 13% in the North East.**
- **Six in 10 married women aged 15–49 want to space or limit childbearing, and 14% of all births are either mistimed or unwanted.**
- **Thirty-two percent of married women and 54% of sexually active unmarried women have an unmet need for family planning.**
- **Many women either have never heard of any contraceptive method or do not know where to obtain contraceptives. Additionally, four in 10 married women and nearly five in 10 married men do not approve of contraceptive use.**
- **Having or performing an abortion is illegal in Nigeria except to save a woman's life. Yet the estimated abortion rate in 1996 was 25 abortions per 1,000 women aged 15–44, translating to about 610,000 abortions performed in that year.**
- **Efforts to reduce unwanted pregnancy and unsafe abortion in Nigeria require adequate provision of family planning services, as well as public education to dispel rumors and misperceptions about the health consequences and effectiveness of modern methods. Men should be encouraged to support their partner's desire to have fewer children.**

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table 1

Education, Marriage and Nonmarital Sex

Levels of education, early marriage and nonmarital sex among Nigerian women aged 20–24, 2003

Region and education	% with ≥7 years of education	% married by age 20	% who had premarital sex by age 20	% of unmarried women currently sexually active
Total	**48**	**87**	**32**	**39**
Region				
North Central	43	80	32	36
North East	24	96	14	29
North West	20	95	6	24
South East	88	76	41	31
South South	76	78	69	53
South West	77	54	51	34
Education				
<7 years	na	68	18	29
≥7 years	na	33	47	41

Note: na=not applicable. *Source:* Nigeria Demographic and Health Survey, 2003.

The country is one of the poorest in the world. The United Nations estimated that Nigeria's gross domestic product in 2002 was $860 per capita, the 16th lowest in the world, and lower than that of most neighboring western African countries.[2] However, wide economic and educational differences exist between the poorer northern regions and the more developed southern regions.

Efforts to develop appropriate reproductive health policies and services to address Nigerian women's reproductive health needs must incorporate the country's broad cultural, ethnic and socioeconomic diversity, and at the same time counter the effects that these differences have on marriage customs, sexual behavior and contraceptive use.

Women in the northern regions and those with less education marry early.

Table 1 shows wide regional differences in the proportions of women in their early 20s with seven or more years of education, from almost nine in 10 in the South East to one in four in the North East and one in five in the North West. Women with less education tend to marry earlier—68% of women with fewer than seven years of schooling had married by the time they were 20, compared with only 33% of those with seven or more years of education.

In parts of the country where educational levels are lowest, early marriage is most common. Accordingly, more than nine out of 10 women aged 20–24 in the North East and North West regions had married by age 20, compared with about one-half to three-fourths of women in the three southern regions.

Women who marry later are more likely to have premarital sex.

The longer that women wait before marrying, the greater the chances that they will engage in premarital sex. Although Nigerian society does not approve of this behavior, in regions where women stay in school longer and are, therefore, less likely to marry at a young age, premarital sexual behavior is common (Table 1).

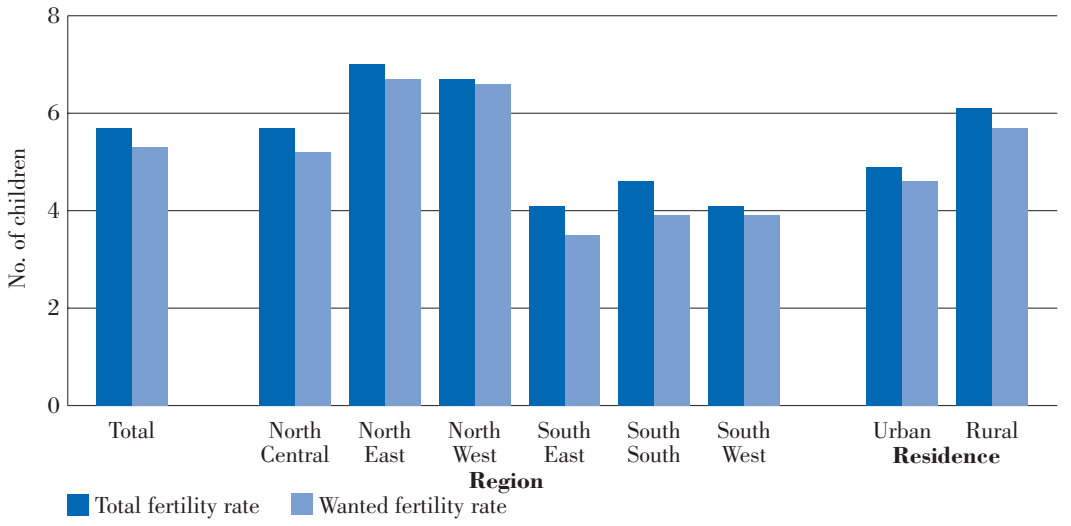
In the South South, where three-fourths of women aged 20–24 have seven or more years of education and about one-fourth had not married by age 20, 69% had had premarital sex by this age. In contrast, in the less developed North West region, where only one in five women aged 20–24 have seven or more years of education and 5% were unmarried by their 20th birthday, only 6% said they had had premarital sex by that age.

Similarly, among unmarried women in their early 20s, the proportion who are currently sexually active is one-third higher among those with more education (41% vs. 29%), and twice as high among those living in the South South region (53%) as among those in the North West (24%). These findings illustrate that in the northern regions, where most women in their early 20s have received no more than primary

chart a

Childbearing Preferences

Nationally and in all regions of the country, women aged 15–49 are having more children than they want.



Source: Nigeria Demographic and Health Survey, 2003.

table 2
Contraceptive Use

Contraceptive use among married and sexually active unmarried women aged 15–49

	Married women		Sexually active unmarried women	
	% using an effective modern method*	% using a traditional method†	% using an effective modern method	% using a traditional method
Total	**7**	**6**	**33**	**14**
Region				
North Central	9	4	32	5
North East	2	2	10	3
North West	2	3	23	3
South East	12	10	20	27
South South	12	13	35	16
South West	21	11	53	13
Education				
<7 years	4	4	17	5
≥7 years	16	11	38	17

*Injectables, implants, IUDs, the pill, the male condom, and female or male sterilization. †Periodic abstinence, lactational amenorrhea, withdrawal and other local methods. *Source:* Nigeria Demographic and Health Survey, 2003.

schooling, most sexual activity occurs within the context of marriage.

Nigerian women want and have large families.

The typical Nigerian woman now has fewer children than she did in the past. In 1978–1982, Nigeria's total fertility rate was 6.4 children per woman.[3] By 1990, it had dropped to 6.0, and by 2003 to 5.7. Rural women have about one child more than their urban counterparts (6.1 vs. 4.9—Chart A), and women in the less developed northern regions also have more children than women in the south (6.7–7.0 in the North West and North East vs. 4.1 in the South West and South East). Yet women in the South South and South East regions have the largest gaps between their wanted and actual fertility rates, while women in the North West are nearly matching their fertility goals. Overall, women living in both rural and urban areas have more children than they want.

This pattern suggests that both desired and actual family size in Nigeria will continue to decline as the country becomes increasingly urbanized.[4] The question is: Are Nigerian women using family planning methods that will allow them to realize their changing goals?

A small proportion of married women in Nigeria use a contraceptive method.

Contraceptive use in Nigeria is rare (Table 2), probably because of the preference for large families. In 2003, only 7% of married women aged 15–49 were using an effective modern method of contraception (injectables, implants, IUDs, the pill, the male condom, and female or male sterilization). Another 6% were relying on withdrawal, periodic abstinence, lactational amenorrhea or traditional folk methods.

There are wide regional differences in overall levels of contraceptive use: Only 2% of married women in the North East and North West regions are using effective modern methods, and 2–3% are using traditional methods. In the South West, in sharp contrast, 21% of married women are using effective modern methods, and an additional 11% are using traditional methods. In the remaining three regions, 9–12% of married women are using an effective modern method. It is noteworthy that overall contraceptive use is more than three times as high among married women with seven or more years of education as among those with less education (27% vs. 8%).

Contraceptive use is much higher among sexually active unmarried women.

In all regions of the country, probably because of widespread societal disapproval of out-of-wedlock pregnancies and births, sexually active unmarried women are more likely than married women to use a contraceptive method (47% vs. 13%—Table 2). In the South West region, 53% of sexually active unmarried women are using an effective modern method and 13% a traditional method, compared with 10% and 3%, respectively, in the North East region. And unmarried women with seven or more years of education are more than twice as likely to be practicing family planning as their less educated counterparts (55% vs. 22%). In addition, 46% of unmarried women who use contraceptives choose condoms, compared with only 15% of married users (not shown).[5]

Low awareness, disapproval and uncertain supply keep contraceptive use low.

Various factors help explain the low level of contraceptive use among married Nigerian women. Foremost among these is that women (and men) generally want large families. Yet low awareness of family planning, conservative cultural attitudes and uncertain contraceptive supply are also important influences.

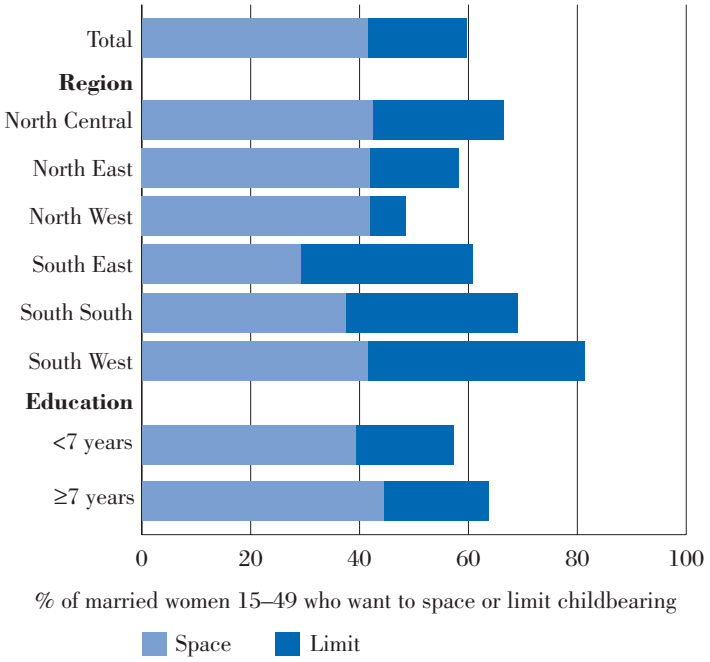
More than 20% of women aged 15–49 have never heard of any method to prevent pregnancy, traditional or modern. The women who are most aware of contraception live in urban areas, have at least seven years of educa-

Data Sources

Data presented in this report are derived from the Demographic and Health Surveys conducted in Nigeria in 1990 and 2003. The first survey was undertaken by the Federal Office of Statistics, Nigeria, and IRD/Macro International, United States. The second survey was conducted by the National Population Commission, Nigeria, and ORC Macro. These surveys are part of a worldwide project designed to collect and disseminate data on fertility, family planning, maternal and child health, and HIV/AIDS, and are sponsored mainly by the U.S. Agency for International Development. The samples are nationally representative and are large enough to permit estimates for the country's current six geopolitical regions. The 1990 survey interviewed 8,781 women aged 15–49, and the 2003 survey interviewed 7,620 women.

chart b
Reducing Births

The proportion of married women who want no more children varies considerably by region.



Source: Nigeria Demographic and Health Survey, 2003.

tion, or listen to the radio or watch television regularly (about 90% of each group). Even if women have heard of family planning, many do not know where to obtain contraceptives: Of the 78% of women who are aware of any method, only half know where they can get it. In the North East and North West regions, only 28–36% of married women and 24–28% of sexually active unmarried women who are aware of family planning know where to go for contraceptive services. A much higher proportion of aware women in the South West region know a possible source of methods—77% of married women and 82% of sexually active unmarried women.

Low contraceptive use is also partly attributable to the fact that four in 10 married women disapprove of family planning. Married women living in rural areas and in the North East and North West regions, and those with fewer than seven years of education or poor access to mass media, are the least likely to approve of family planning. Furthermore, married women are more likely than sexually active single women to disapprove of family planning (39% vs. 25%).

Married men are even more likely than their wives to disapprove of family planning. Nearly half of married men aged 15–49 disapprove, slightly less than one-third approve and the rest are unsure about their attitudes toward contraception. In the North East and North West regions, about six in 10 husbands disapprove of family planning, compared with two in 10 in the South West.

These high levels of disapproval are consistent with the stronger desire for large families among men than among their wives (10.6 vs. 7.3 children).[6] Also, some men are suspicious that their wives may be unfaithful to them if contraceptives are available.[7]

Communication about family planning between spouses is not widespread. Only 35% of married women report having discussed family planning with their partner at least once. Women with more education are about twice as likely as those with less to have talked to their partners about contraception. However, if women know or believe that their partners do not approve, such discussions may be avoided or less productive. Among women whose partners disapproved of family planning, only 15% discussed it, compared with 71% of women whose partners approved.

There are also other reasons why married Nigerian women are not practicing family planning: concerns about the perceived side effects of some modern methods, the disapproval of family members other than husbands, religious beliefs, the high cost of supplies and the difficulty or inconvenience of using some methods.[8]

Six in 10 married women do not want to get pregnant right away or in the future.

In 2003, 41% of married women aged 15–49 reported that they did not want to have a child soon, and 18% did not want to have any more children at all (Chart B). Some 32–40% of married women in the three southern regions did not want to have any more children, compared with only 7–24% in the northern regions. A higher proportion of women with seven or more years of education wanted to space or limit their childbearing, compared

table 3
Unmet Need

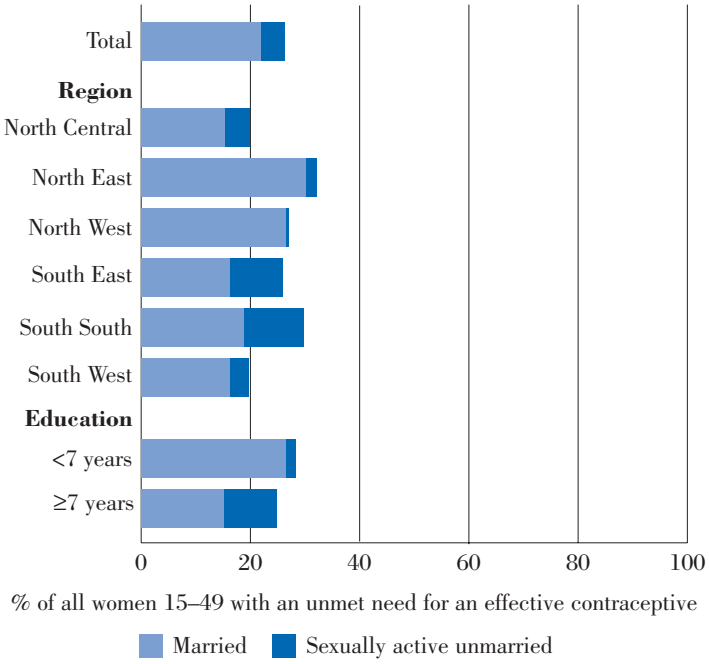
Unmet need for effective contraception to space or limit childbearing among women aged 15–49

	Married women		Sexually active unmarried women	
	% to space	% to limit	% to space	% to limit
Total	**20**	**12**	**50**	**4**
Region				
North Central	12	11	54	5
North East	24	13	60	5
North West	24	5	45	0
South East	15	18	62	7
South South	16	22	49	4
South West	14	15	33	3
Education				
<7 years	20	12	47	10
≥7 years	19	11	51	2
Residence				
Urban	19	13	46	4
Rural	20	11	53	5

Source: Nigeria Demographic and Health Survey, 2003.

chart c
Unmet Need

Unmet need is higher among married women and less educated women.



Source: Nigeria Demographic and Health Survey, 2003.

with less educated women (64% vs. 57%). Women living in urban areas were slightly more likely to want no more children than were women living in rural areas (22% vs. 17%—not shown).

Women's desire to space or limit births changes dramatically with age. Three-fourths of both married and sexually active unmarried teenagers wish to delay pregnancy, even though most will eventually want to have children. By age 45–49, 56% want no more children.

Unmet need for family planning is high.

Although a majority of married Nigerian women either do not want any more children or do not want a child soon, most of them are not using modern methods of contraception to prevent further pregnancies. Thirty-two percent of married women aged 15–49 want to regulate their fertility, but are not using the contraceptive methods that would make this possible (Table 3). These women have an unmet need for effective contraception. Unmet need is highest in the North East and South South (37–38%) and lowest in the North Central region (23%), but varies little by level of education or urban-rural residence.

Women with an unmet need require family planning either to control the timing of their next birth or to stop childbearing altogether. Among married women, 20% have an unmet need for effective contraception because they want to space their births, and 12% because they want no more children. However, there is considerable regional variation in these needs. Married women in the North East and North West regions (who generally have less education and want larger families than women in other regions) with an unmet need are most likely to want to space their births (24%). In these regions, although women may want more children than their counterparts in other regions, they nevertheless appear to be aware of the risks of closely spaced births. By contrast, married women in the South East and South South regions (who generally have more education and want smaller families) with an unmet need are more likely than their northern counterparts to want to stop having children (18–22% vs. 5–13%).

Even though sexually active unmarried women have a higher level of contraceptive use than do married women, their unmet need for effective contraception is also greater (54%). Their overwhelming need is to delay pregnancies (50%) rather than to prevent pregnancies altogether (4%), as most of these women have never been married and will want children once they marry. Unmet need among this group is higher for those with less education (57% vs. 53%) and for those living in rural areas (58% vs. 50%).

In total, 27% of women aged 15–49 are in need of an effective contraceptive method if they are to realize their childbearing desires—22% of married women and 5% of sexually active unmarried women (Chart C). Among the latter, the highest level of unmet need is in the South South region (11%), which has the highest proportion of young unmarried women who are sexually active (see Table 1). The proportion of sexually active unmarried women with unmet need is lowest in the North East and North West regions, where relatively few unmarried women are sexually active.

Many births in Nigeria are unintended.

In 2003, according to what women themselves report, 14% of births in Nigeria were unintended—mistimed (9%) or unwanted (5%)—a higher proportion than in 1990, when 11% were unintended (Table 4, page 6).[9] Again, there are large regional variations in this measure. In the South South region, for example, 14% of recent births were mistimed and 19% were unwanted, while in the North West region, only 4% of births were mistimed and 1% were unwanted.

The very high proportion of unwanted births in the South South region is disturbing, especially since the comparable proportion in 1990 was only 3%. This suggests a considerable increase in the number of women who have attained their desired family size but are unable to prevent further pregnancies.

In a 1996 study, Nigerian women who had reported that a recent pregnancy was unintended were asked why they had not wanted to be pregnant. They identified poor timing (41%), disruption of schooling (31%) and failure of their contraceptive method (19%) as the most common reasons,[10] illustrating that many women have the desire to control their fertility in order to achieve other life goals.

table 4
Unintended Births

Unintended births in Nigeria, 1990 and 2003

	Total % unintended		% mistimed		% unwanted	
	1990	2003	1990	2003	1990	2003
Total	**11**	**14**	**8**	**9**	**2**	**5**
Region						
North Central	16	14	12	9	4	5
North East	15	17	13	14	2	3
North West	4	5	4	4	0.4	1
South East	10	11	8	5	2	6
South South	13	33	10	14	3	19
South West	12	19	8	12	3	7
Education						
<7 years	10	12	8	8	2	4
≥7 years	15	19	13	12	2	7

Sources: Nigeria Demographic and Health Surveys, 1990 and 2003.

The lives of Nigerian women are changing.

In recent decades, a number of dramatic societal and economic changes—particularly increased urbanization, rising levels of education and growing access to mass media—have improved the lives of some Nigerian women (Table 5). These changes are also likely to influence their attitudes toward desired family size and the need for contraception.

Longer schooling gives women the possibility and hope of leading lives with more opportunities than were available to their mothers and grandmothers. Improved education equips women with skills that enable them to be more productive and to think independently in an ever-changing world. Urbanization, which makes possible and often compels women's greater participation in the paid labor force, can bring opportunities that enhance their status within the family. Women who earn an income often feel more empowered to make their own decisions about when to marry and when to have children.

Modernization, particularly the increasing access to television and radio, may generate aspirations of greater gender equity and may fuel women's desire to pursue their ambitions and plans, including their reproductive health goals.[11] Information disseminated through the media increases women's knowledge about their health options and wider life opportunities. Modernization is also changing the long-standing cultural expectation in Nigeria that a woman's primary role is to have a large number of children. In less rural parts of the country, it is no longer necessary to have many children to help with farmwork.

table 5
Residence, Education and Media Exposure

Increase in urban living, education and exposure to mass media among women aged 15–49 between 1990 and 2003

Measure	1990	2003
% living in urban areas	25	35
% with ≥7 years of education	31	48
% living in households with television	20	33
% who watch television at least weekly	26	36

Sources: Nigeria Demographic and Health Surveys, 1990 and 2003.

Although Nigeria remains predominantly rural and agrarian, some of the social changes observed since 1990 have occurred quite rapidly. Yet these developments—particularly in the education of girls and young women—are happening much faster in some parts of the country than in others. Moreover, longer schooling for young women is associated with reduced rates of early marriage and increased exposure to sexual intercourse before marriage. Consequently, for unmarried women living in the more developed southern regions and for those prolonging their schooling, there is an increased likelihood of out-of-wedlock pregnancy. Fortunately, contraceptive use among these groups is higher than the national average. But sexually active unmarried women also run a serious risk of contracting sexually transmitted infections, including HIV, unless their partners consistently use condoms.[12]

Nigerian women need help to achieve their fertility goals.

As women become more educated and as Nigeria continues to modernize—two trends that foster a desire for smaller families—levels of unintended pregnancy may actually rise if the increasing desire for fewer children is not matched by increased contraceptive use. The rate of induced abortion to end unwanted pregnancies may also increase. Because the laws against induced abortion are restrictive, more Nigerian women may resort to unsafe procedures and continue to suffer the adverse health consequences—already a major contributor to high maternal mortality in the country (see box).[13]

Women in all regions of the country need contraceptive services if unintended pregnancies are to decline. Health services at the national and local levels should provide comprehensive information on family planning methods, how to use them and where to obtain them, thereby enabling women to make well-informed decisions for themselves and their families. Providers must be trained to have the knowledge and skills to treat their clients, but also must be sensitive to cultural and religious differences among the populations they serve. These health programs should also serve men and offer them information about the importance and benefits of making informed decisions with their partners.

The unmet need among married and sexually active unmarried women differs dramatically across regions. Program planners must therefore be aware that services in various parts of the country will have to adopt differing approaches. For example, in the southern regions, family planning services must focus on both single women, who generally

want to delay pregnancy, and married women, who may want to space or limit their childbearing. In the north, services will have to focus largely on married women, who constitute the vast majority with unmet need, and the emphasis should be on spacing births, which is the more pressing need.

While there have been some improvements in the provision of family planning information and services over the last decade, many gaps remain in meeting women's needs. With a combination of aid from the Nigerian government, nongovernmental organizations (NGOs) and outside donors, policymakers should design and implement programs that can realistically address the growing needs of women and their partners for contraceptive services. The availability of these services can be greatly enhanced by improving access through local clinics, family planning centers, and postabortion and postpartum hospital care.

Contraceptive services are not enough.

Providing better and more accessible contraceptive services, while important, will be insufficient to reduce the incidence of unwanted pregnancy and unsafe abortion in Nigeria. Many other obstacles constrain women's ability to space births and limit their number of children.

These include a widespread lack of knowledge about contraceptive methods and where to obtain them; disapproval of family planning by many married men and women; women's erroneous perceptions about the side effects associated with modern contraceptive methods; and stigma that restricts women's access to contraceptive services. In some parts of the country, particularly in rural areas, these barriers to family planning are widespread.

The plight of young women in Nigeria's rapidly developing southern regions must not be overlooked. Because many teenage women in urbanized areas are deferring marriage and are thus more likely to become involved in premarital sexual relationships, government officials, policymakers and providers must all make a determined effort to educate schoolgirls about the risks that such behavior can pose for their health and for their prospects of completing their education.[14] Conservative groups, possibly including some teachers and health professionals, may oppose comprehensive sex education for Nigerian adolescents. But with improved awareness of the potential dangers of unsafe abortion and HIV infection to young women in Nigeria, opposition might well decline.

While efforts by the Nigerian government, NGOs and outside donors are essential and should continue, some widespread negative perceptions about family planning must be addressed. Many Nigerians in the northern regions, where contraceptive use is extremely low, mistrust both Western-sponsored family planning programs and their own government's National Policy on Population. They feel that new family planning programs are being implemented while primary health care services are declining in coverage and quality, and wonder if the true intentions of the government and donors are less to improve the health of Nigerian people and more to discourage population growth.[15]

In conclusion, the list of key actions is long:

- improvements in the quality and accessibility of family planning information and services;
- improved education for girls and young women;
- adoption of comprehensive sex education for adolescents;
- efforts to involve men in reproductive decision making and to educate them on the significant health benefits of improved fertility regulation;
- campaigns to educate the public and community leaders about the benefits of family planning; and
- efforts to gain the support of health professionals and teachers involved with adolescents and students.

Concerted action on all of these fronts is urgently needed if the incidence of unwanted pregnancy in Nigeria is to decline over the coming decades. Delaying these initiatives could have adverse consequences for many Nigerian women. Some will have their education cut short by an out-of-wedlock pregnancy. Others could jeopardize their health and lives by seeking unsafe abortions. Still other women and their families will experience economic hardship as a result of having more children than they can afford.

Many Nigerian women end unwanted pregnancies by abortion.

Although induced abortion is legal only to save a woman's life, hundreds of thousands of Nigerian women each year end unwanted pregnancies by abortion, often under unsafe conditions.

A national study estimated that 610,000 Nigerian women sought abortions in 1996, and that the abortion rate was 25 per 1,000 women aged 15–44.[1] The estimated abortion rate varied across regions, from 10–13 abortions per 1,000 women in the North East and North West regions to 32–46 per 1,000 in the South East and South West. (Nigeria was divided into four geopolitical regions at the time.) The rate was highest in the South West, which also had the largest proportion of married women who want to space or limit childbearing, as shown in Chart B.

The study estimated that 245,000 abortions in 1996 were performed by physicians. The remaining abortions were induced by pharmacists, nurses and midwives, as well as traditional healers and other unskilled providers, or the woman herself.[2] A survey of 67 health professionals, also carried out in 1996, found that nonphysician abortion providers were believed to use methods that include injections, hormonal drugs, the insertion of objects into the uterus and other indigenous treatments.[3]

Poorly performed abortions are known to contribute to Nigeria's high maternal mortality rate, which is estimated to be 800 per 100,000 live births—an exceptionally high rate even among developing countries.[4]

For these reasons, the February 2005 release of a new policy for National Population and Sustainable Development by the Nigerian government is commendable. In launching the policy, President Olusegun Obasanjo noted that it aims to promote, among other things, the acceptance and use of family planning methods, healthy sexual behavior, and better health services to reduce infant and maternal mortality.[16] The president called for increased emphasis on the education of children, especially young girls, and also appealed to Nigerians, "particularly the implementing agencies, to set aside their political, religious and cultural differences and embrace the ideals of this policy and be fully committed to its successful implementation."

All relevant government agencies and NGOs should heed this call and take bold steps to improve the health and well-being of millions of Nigerian women and their families.

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Credits

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