**Country context**

Niger is a vast landlocked country with an estimated population of 15 million, the majority of whom live along a narrow band of arable land on the country’s southern border. The economy is dominated by agricultural activity, including rearing livestock, mining (uranium and oil), and informal trading activities.¹ The average per capita income was estimated at US$340 in 2009.² GDP growth has been highly volatile but low on average.¹ Two-thirds of the population subsists on less than US $1.25 per day.³

Niger has experienced one of the highest population growth rates globally, and its population has increased almost five times since independence in 1960.¹ Niger’s large share of youth population (50 percent of the country population is younger than 15 years old³, also one of the highest in the world³) provides a window of opportunity for high growth and poverty reduction—the demographic dividend, provided fertility levels decrease rapidly and dependency ratios improve.⁴ For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth.

Gender equality and women’s empowerment are important for improving reproductive health. Higher levels of women’s autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.⁶ In Niger, the literacy rate among females ages 15 and above is 15 percent.³ Fewer girls are enrolled in secondary schools compared to boys with a 60 percent ratio of female to male secondary enrollment.³ Thirty-eight percent of adult women participate in the labor force⁷ that mostly involves work in agriculture. Gender inequalities are reflected in the country’s human development ranking; Niger ranks near the bottom of the Gender-related Development Index (155 of 157 countries).⁷

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.⁶

**Niger: MDG 5 status**

<table>
<thead>
<tr>
<th>MDG 5A indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio (maternal deaths per 100,000 live births) UN estimate³</td>
<td>820</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (percent)</td>
<td>17.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG 5B indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Prevalence Rate (percent)</td>
<td>16</td>
</tr>
<tr>
<td>Adolescent Fertility Rate (births per 1,000 women ages 15–19)</td>
<td>199</td>
</tr>
<tr>
<td>Antenatal care with health personnel (percent)</td>
<td>46.1</td>
</tr>
<tr>
<td>Unmet need for family planning (percent)</td>
<td>15.8</td>
</tr>
</tbody>
</table>

Source: Multiple sources, including WHO Global Health Observatory

**MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio**

Niger has been making progress over the past two decades on maternal health but it is not on track to achieve its 2015 targets.⁸

![Figure 1 - Maternal mortality ratio 1990–2008 and 2015 target](image)


**World Bank support for Health in Niger**

The Bank’s current *Interim Strategy Note* is for fiscal years 2009 to 2011.

**Current Projects:**
- P083350 – Instit. Strengthening & Health Sector Support Program (ISHSSP) $35m
- P096198 Multisector Demographic Project

**Pipeline Projects:** HIV/AIDS project

**Previous health projects:** None
Key challenges

High Fertility

Fertility remains high across wealth quintiles. Total fertility rate (TFR) fell slightly from 7.4 births per woman in 1992 to 7.1 in 2006, which is one of the highest in the world. TFR is 7.0 or higher among women in all quintiles except those in the highest wealth quintiles (Figure 2). Disparities exist between women in rural areas at 7.4 births per woman compared to 6.0 for those in urban areas, and vary by education levels at 7.3 births per woman with no education, and 4.6 with secondary education or higher.

![Figure 2: Total fertility rate by wealth quintile](image)

Source: DHS Final Report, Niger 2006

Adolescent fertility rate is high affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother. In Niger, there are 199 reported births per 1,000 women aged 15–19 years.

Early childbearing is high but more frequent among the poor. While almost 70 percent of the poorest 20–24 years old women have had a child before reaching 18, 41 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing mostly has taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

![Figure 3: Percent women who have had a child before age 18 years by age group and wealth quintile](image)

Source: DHS Final Report, Niger 2006 (author’s calculation)

Use of modern contraception is increasing. In Niger, a large effort has been made over the past several years to improve population health. Massive IEC and BCC campaigns (using the rural radio network) have increased the knowledge of, and demand for, reproductive health services. The contraceptive prevalence rate for modern methods has tripled between 2006 and 2010, and is now 16 percent overall and 41 percent in the region of Niamey. The pill is the most commonly used method among married women at 12 percent, followed by injections at 3 percent.

Unmet need for contraception is high at 16 percent indicating that women may not be achieving their desired family size.

Opposition to use and wanting more children are the predominant reasons women do not intend to use modern contraceptives in future. Twenty-nine percent of women not intending to use contraception expressed opposition to use, primarily by themselves, their husband, or due to their religion as the main reason while 25 percent indicated they want more children and 18 percent cited lack of knowledge. Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

More pregnant women use antenatal care than those who deliver with health personnel. Over two-fifths of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife) with 15 percent having the recommended four or more antenatal visits. However, a smaller proportion, 18 percent deliver with the assistance of skilled medical personnel predominantly in the public sector. While 59 percent of women in the wealthiest quintile delivered with skilled health personnel, only 5 percent of women in the poorest quintile obtained such assistance (Figure 4). Additionally, 13 percent of women with no education delivered with skilled health personnel as compared to 80 percent of women with secondary education or higher. With increased population growth, early childbearing trends, and very limited human resources for health, the goal of increasing the percentage of skilled attendance at birth would improve if TFR decreased significantly. Additionally, 66 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.
Of those women who did not give birth in a health facility, 81 percent never received postnatal care, and only 12.3 percent got a postnatal check-up within two days.\(^9\)

Obstetric fistula is a serious reproductive health challenge in Niger and is associated with early marriage and pregnancy, prolonged obstructed labor in the absence of skilled birth attendance, low levels of female literacy and school enrollment, and rural residence.

Over three-fifths of women who indicated problems in accessing health care cited concerns regarding inability to afford the services while about half long distance, or transport difficulties (Table 1).\(^9\)

<table>
<thead>
<tr>
<th>Reason</th>
<th>% of women age 15–49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing where to go</td>
<td>16.8</td>
</tr>
<tr>
<td>Getting permission to go for treatment</td>
<td>8.8</td>
</tr>
<tr>
<td>Having money needed for treatment</td>
<td>64.9</td>
</tr>
<tr>
<td>Distance to health facility</td>
<td>51.1</td>
</tr>
<tr>
<td>Having to take transport</td>
<td>50.6</td>
</tr>
<tr>
<td>Not wanting to go alone</td>
<td>25.8</td>
</tr>
<tr>
<td>Concern no female provider available</td>
<td>16.7</td>
</tr>
<tr>
<td>At least one problem accessing health care</td>
<td>77.7</td>
</tr>
</tbody>
</table>

Source: DHS final report, Niger 2006

**Table 1 • Barriers in accessing health care**

**Human resources for maternal health are limited** with only 0.019 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.137 per 1,000 population.\(^3\)

The high maternal mortality ratio at 820 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.\(^8\)

**STIs/HIV/AIDS prevalence is low**

Niger remains one of the countries with lowest HIV prevalence rate in sub-Saharan Africa at 0.7 percent.

Knowledge of mother to child prevention methods is limited. Slightly more than a tenth of women know that HIV can be transmitted through breast milk and that the likelihood of passing HIV from mother to child can be reduced by drugs.\(^9\)

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While most young women are aware that using a condom in every intercourse prevents HIV, less than 1 percent of them report having used condom at last intercourse (Figure 5). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

**Figure 5 • Knowledge behavior gap in HIV prevention among young women**

Source: DHS Final Report, Niger 2006 (author’s calculation)

**Technical notes:**

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at [www.worldbank.org/population](http://www.worldbank.org/population).

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

**References:**

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women’s health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women’s groups.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.
- To trigger the rapid decline in fertility in the next ten years, a commitment for family planning is necessary and huge financial resources must be implemented. Investment in family planning has important returns both in the short- and long-term in the fields of education, maternal health, and childhood immunization.4

Reducing maternal mortality

- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

Correspondence Details

This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE) and Management Science for Health (MSH). For more information contact, Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: www.worldbank.org/population.
In terms of health sector financing, “le fonds commun” (basket funding) was established by the Government, AFD and the World Bank to enhance harmonization and promote a sectoral approach, to strengthen existing health services, promote greater regional equity, develop reproductive health activities, encourage effective reforms (such as HRH), and build local capacity in plan implementation (14).

To improve maternal and child health, the Government of Niger began providing free health care and drugs to pregnant women and children under five years, and has begun establishing integrated health posts in rural areas (15).

1992 The first National Population Policy was set in the law.
1994–2000 The Health Development Plan (SDP) adopted
1996–2000 The population action plans and priority investment (PAIP) was first set up for this period.

2005–2009 The Health Development Plan (SDP) adopted
2006 Niger adopted a law on Reproductive Health (No. 2006–16 of July 21), recognizing reproductive health as a fundamental right.
2007 The Declaration of the Government’s Population Policy (DGPP) was adopted by the cabinet, and replaces the 1992 policy. The overall purpose of the PPB is to contribute to poverty reduction through reproductive and population health strengthening.
**Development partners support for reproductive health in Niger**

**AFD, and Belgian and Spanish cooperation:** Support to health sector “Fonds Commun”

**KfW:** HIV/AIDS and family planning (support to Animas Sutura)

**WHO:** Institutional capacity building and quality improvement

**UNICEF:** Changing attitudes towards early marriage; nutrition

**UNFPA:** Reproductive health policy advocacy and commodities

**IPPF, through ANBEF:** HIV/AIDS prevention; post abortion care; antenatal and post-natal care, family planning