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THE SOCIOCULTURAL ANALYSIS

of the

USAID INTERVENTIONS IN NIGERIA:

**FHSII - FAMILY HEALTH SERVICES
CCCDII - MATERNAL/CHILD HEALTH
AIDSCAP - HIV/AIDS PREVENTION & CONTROL**

prepared on behalf of USAID, LAGOS
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SELECTED HEALTH AND DEMOGRAPHIC INDICATORS

Population/1991	88,514,501 (1991 Census ¹)
Population/1992	90,100,000 (1992 WPDS ²)
Life Expectancy at Birth	Males 49/Females 53 Years
Crude Birth Rate	46/1,000 (1992 WPDS)
Crude Death Rate	16/1,000 (1992 WPDS)
Total Fertility Rate (15-49)	6.011 (1990 NDHS ³)
Est. Population Doubling Time	23 years (1992 WPDS)
Contraceptive Prevalence	6% (1990 NDHS) 20.1 (1992 FOS/FPS ⁴)
Est. Maternal Mortality	15/1,000 live births
Est. Number of Fecund Women	17,702,900 (1991 CCCD/MIS ⁵)
Est. Number of Live Births	4,248,696 (1991 CCCD/MIS)
Infant Mortality Rate	87/1,000 (1990 NDHS)
Under-five Mortality Rate	115/1,000 (1990 NDHS)
Undernourished Children	35.7% (1990 NDHS)
Chronically Undernourished Children	43.1% (1990 NDHS)
Wasting	9.1% (1990 NDHS)

¹Nigerian Census, National Population Commission, November 1991.

²World Population Data Sheet, Population Reference Bureau, 1992.

³Nigeria Demographic and Health Survey, 1990. Federal Office of Statistics/IRD Macro Systems.

⁴Preliminary Report of Family Planning Survey: June & September 1992. Federal Office of Statistics, December 1992.

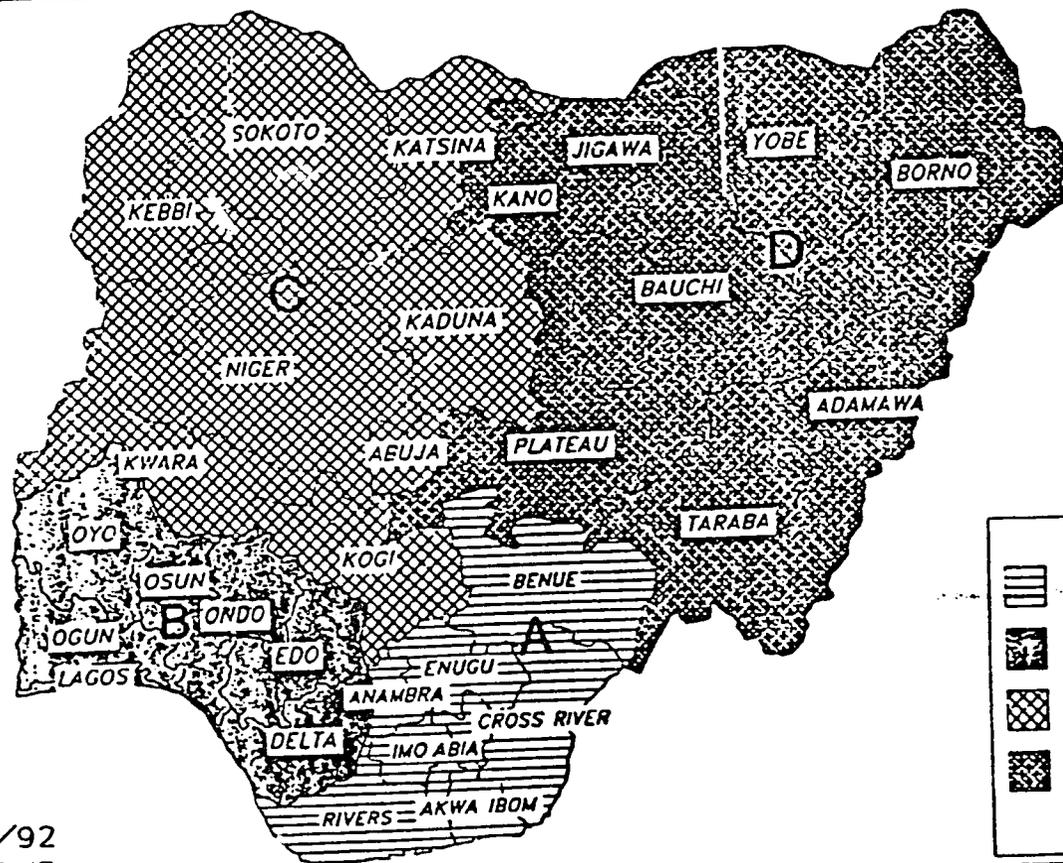
⁵CCCD/Management Information Systems, 1991.

ACRONYMS

AFRC - Armed Forces Ruling Council
AIDS - Acquired Immune Deficiency Syndrome
BLP - Better Life Programme
CBD - Community Based Distribution
CCCD - Combatting Communicable Childhood Diseases
CHAN - Christian Health Association of Nigeria
DPA - Department of Population Activities
E/N - Extension/Networkers
FHS - Family Health Services
FIDA - International Federation of Women Lawyers
FIGO - International Federation of Gynecologists and Obstetricians
GON - Government of Nigeria
HIV - Human Immunodeficiency Virus JCT
IEC - Information, Education and Communication
IUD - Intrauterine Device
JHU/PCS - John Hopkins University/Population Communication Service
LGA - Local Government Authority
KAP - Knowledge, Attitudes and Practices
MCH - Maternal/Child Health
MMSS - Federal Ministry of Health and Social Services
MSSN - Muslim Students' Society of Nigeria
NACP - National AIDS Control Programme
NCW - National Commission for Women
NCWS - National Council for Women Societies
NDHS - Nigeria Demographic and Health Survey
NERDC - Nigerian Educational Research and Development Council
NGO - Non Governmental Organization
NISER - Nigerian Institute for Social and Economic Research
NMA - Nigerian Medical Association
NTA - Nigerian Television Authority
PHC - Primary Health Care
POP/FLE - Population/Family Life Education
PPFN - Planned Parenthood Federation of Nigeria
PWA - Person With AIDS
RVF - Recto-vaginal Fistula
SCAP - State Coordinator of the AIDS Programme
SAP - Structural Adjustment Programme
SIM - Sudan Interior Mission
SMOH - State Ministry of Health
SOBGYN - Society of Obstetricians and Gynecologists of Nigeria
STD - Sexually Transmitted Disease
SWAAN - Society of Women Against AIDS (Nigeria)
TBA - Traditional Birth Attendant
TOT - Trainer of the Trainers
UNFPA - United Nations Population Fund
UNICEF - United Nations Children's Fund
USAID - United States Agency for International Development
VHW - Village or Voluntary Health Workers
VVF - Vesico-vaginal Fistula
WID - Women in Development
WHO - World Health Organization
WPDS - World Population Data Sheet

MAP OF NIGERIA

Showing The Four Health Zones



07/24/92
FHS/USAID

I. THE SOCIOCULTURAL CONTEXT

The Largest African Nation

Despite previous UN/World Bank estimates in the 120 million range, the 1991 census established 88.5 million as the total population. Nevertheless, Nigeria remains the most populous country in sub-Saharan Africa with an estimated 90,100,000 citizens in 1992. The total fertility rate is 6.0 coupled with a declining mortality rate of about 16 deaths per 1000 as of 1989. Nigeria's population is projected to double in about 23 years. The combination of a high fertility rate and a high although decreasing mortality rate with a low economic base necessitates project intervention.

The population of only one of Nigeria's four health zones is as large as Ghana. The combination of the two most populous ethnic groups is larger than that of any other African nation.

Ethnic Groups

The 250 ethnic groups in Nigeria include three major groups: Hausa/Fulani, Yoruba and Igbo; seven additional very large groups: Ekoi/Efik/Ibibio, Kanuri, Tiv, Ijaw, Edo, Urhobo, Nupe; and twenty-six small groups which nevertheless have a substantial population: Bariba, Bussawa, Dukawa, Kamberi, Kamuku, Gwari, Katab, Ningawa, Jarawa, Berom, Angas, Tangale, Jukun, Mumuye, Longuda, Batta and Chamba, all in the Middle Belt; Kare-Kare and Marghi in the Northeast; the Igbira, and Idoma, along the lower Niger basin; and the Igede, Ukelle, Iyalla and Boki in the East.

Ethnic Differences

Pervasive prejudice against and distrust of other ethnic groups is based on differing beliefs, value systems and roles for the ideal man and woman as well as on nepotism. Since Independence, inter-ethnic rivalry has increased. Not only is the common colonialist enemy no longer a unifying force, more importantly, common ethnic roots have been successfully exploited by politicians seeking votes and personal power. Moreover, within a common ethnic name or language, primordial cultures have distinct sub-cultures whose members often define their self-interest in terms of the sub-culture.

Socialization Trends

Despite rapid urbanization especially since Independence, Nigeria remains a predominantly rural nation with 65% of the population living in 97,000 settlements comprising less than 20,000 people each. However, Westernizing forces have increasingly penetrated the rural areas through communication and development channels including primary education and agricultural extension. The socialization forces of the traditional extended family and gerontocracy have been undermined throughout the country, not merely in the urban areas.

The endurance of polygamy and a heritage of strong, extended family bonds as opposed to conjugal bonds is increasingly being translated into the further

disintegration of the family. Westernization and Christianization have effectively undermined the extended family bonds. Poverty and despair in the face of unrealizable risen expectations and the breakdown of traditional patterns of self realization is fostering the further separation of many conjugal families. While most men are trying to retain control of the vestiges of their status and self-esteem, a significant number of husbands have fled to the cities, leaving the woman de facto household heads with full economic responsibilities. In addition, a few women are recognizing that they are supporting or capable of supporting their children and are freeing themselves from familial constraints to create female-headed households.

Significant Numbers of Underemployed and Unemployable

In recent years a combination of an already saturated government bureaucracy and modern economy exacerbated by the baby boom and the economic stagnation and inflation (more than sixty percent over the last year) induced by the devaluation and deregulation imposed by SAP (Structural Adjustment Program) has fostered significant numbers of underemployed and unemployable youth and young adults. Primary and secondary school dropouts are on the increase nationwide as people realize that education no longer ensures employment and comfort. On the contrary, even for university and technical school graduates, it portends unemployment. Some rural youths have begun refusing to farm with the narrow profit margins even when they can obtain no wage labor. Theft is rampant in the cities and on the rise in the rural areas where even farm crops are now subject to theft.

The "Democratic" Political Process

In August of 1993 the gradual change to a democratically elected government is projected to be completed with the installation of a president. The party platforms of the two parties were designed by the government, "a little to the right and a little to the left". The populace does not believe elected candidates will be responsive to their needs and many, if not most, have not exercised their voting rights. Some candidates have been banned, and unbanned while others have been disqualified at the last minute depriving the electorate of a real choice. The Government canceled the presidential primaries on the grounds of widespread election fraud and prescribed a new electoral procedure.

The LGA, State and Federal Levels of Government

Local Government Authority (LGA), contrary to its nomenclature, is not at the local, grassroots level; it is comparable to a county. Although the LGAs were intended to have 150,000 citizens each, according to the 1991 census their population sizes vary considerably: eight have over 500,000 including Ojo in Lagos State which has over one million; one hundred have over 200,000; and, five have less than 50,000. Most LGAs are divided into three-six districts but the larger LGAs have up to twelve districts.

Citizens elect the Chairman of the LGA Council and a representative from their district. At the grassroots level, decisions are channeled through the traditional rulers selected according to diverse local customs and acting in an advisory capacity.

Approximately 110,000 'natural' communities created by the people themselves have been identified throughout the country.

Corruption

A combination of SAP-induced inordinately low civil servant salaries, difficulty in obtaining the release of capital and recurrent funds to operate work plans, lax budgetary controls, non-punishment of financial mismanagement and the willingness of the private sector to pay enormous bribes have contributed to the institutionalization of corruption. The SAP-induced retrenchments and hiring freezes in the formal sector have generated an exploitative employers' market even for experienced graduates except in the banking and oil sectors. As a consequence, private sector employees are also forced to supplement their incomes.

Non-Accountability of Government Officials to the Public

Government officials act as though they are primarily accountable to the federal government because it is the source of continued funding. Taxpayer funds only represent a very small proportion of the budget in comparison to the centrally controlled oil wealth. At all levels of government, the funding is direct from the federal government. Although, some states and some local governments do have significant internally generated funds, even these states source most of their funds from the center. The Olowo Study on Local Institutions and National Development found very little direct accountability of the local government to the public. As an example, the federal government funds the LGAs directly to ensure that funds are not delayed by the state; however, funds for the Ojo LGA health program were held up by the federal government for more than six months in 1992.

II. PROJECT BENEFICIARIES

The Participants as Beneficiaries

In all three projects, the participants who are the basic vehicles for accessing the direct beneficiaries will be the administrative management, technical personnel and volunteers in both the public and private sectors who will receive training, technical assistance, and support for planning, implementation and evaluation of intervention activities. In addition, to officials in the three tier administrative structure, the Federal Ministry of Health and Social Services, (MHSS), the State Ministries of Health (SMOH) and the Local Government Authorities (LGA), participants from local community institutions such as traditional birth attendants and local community health committees will benefit from the project. Benefits will filter into the private sector through various types of NGOs as well as through marketing mechanisms. Numerous NGOs will themselves benefit from training and funds.

Family Planning Beneficiaries

Because spousal, decisionmaking is often undertaken separately by each spouse, four entities separately and collectively are the family planning beneficiaries: the conjugal family, the women, the men and the nation. The beneficiaries of family planning are the conjugal families including the children socialized within them and, on the global scale, the nation and its various levels of government. Reduction in dependents will improve individual living standards and the capacity of government to provide services while reducing destruction of the environment. All Nigerians will benefit from the reduced burden of additional children to feed and educate with the limited resources available. To the extent that families achieve their minimum desired number, they will consider themselves as beneficiaries.

Women are multiple beneficiaries of family planning which offers them the potential to maximize the quality of their family and personal life in several ways. First, family planning has the capacity to prevent a woman from incurring the high risk births and pregnancies which prevail in Nigeria so that she herself can survive and enjoy the increased survival of her children. Second, family planning allows her to avoid rejection of her spouse while spacing their children, thereby hopefully preventing or diminishing diversion of his affection and/or economic resources from the conjugal family. Third, limitation allows her to adjust the number of her children to the available resources ensuring greater physical comfort and reducing strain within the family. Fourth, family planning frees her to time and limit her child bearing responsibilities in such a way as to maximize her own capacities to support herself and her children and to realize herself as a person.

Males are beneficiaries of family planning to the extent that they enjoy the above mentioned benefits accruing directly to their wives and children and to the extent that they are relieved of the burden of supporting additional children.

Resources of the FHS Project will reach women the approximately 17.7 million fecund women between the ages of 15-49, and their spouses and children.

Simultaneously, the project is targeting all the women at risk to themselves and/or to their newborn children because of mistimed pregnancies. Based on a study of at-risk women between 1985 and 1990, nearly 80% of currently married women are at risk of illness and/or death to themselves, their newborn child or both because they were too young, too old, too high parity or too frequently pregnant. The FHS and CCCD combined resources will reduce the excessive maternal mortality which is currently around 150 per 100,000. All three projects will reduce morbidity caused by lack of proper medical care for pregnancies, STDs and malnutrition.

HIV/AIDS Prevention and Control: Project Beneficiaries

The direct beneficiaries of the project are the distinct target groups: the university students, commercial sex workers, military personnel and truck drivers in Cross River, Kano and Lagos States, as well as management and staff of Giwarite Company Limited, Kano and a Lagos Company as yet undetermined.

Direct beneficiaries also include secondary school students in the three states, who will be the target of activities in the later phases of the project as well as primary target groups in Jigawa state where project activities will hopefully extend within the next two years.

The indirect beneficiaries are the entire population of Nigeria. The economic and social impact of AIDS will be significant for individuals, families and communities. Since resources in the health care system will in all likelihood be insufficient to cope with increased number of cases, families and communities will have the burden of care of Persons With AIDS (PWAs). Any meaningful attainment of the project goal of reducing the rate of spread of HIV infection will contribute to easing this burden proportionally.

Resources of the HIV/AIDS Component will reach the target population through existing institutions such as the health care delivery system of the Federal Ministry of Health (FMOH): STD clinics, the primary health care infrastructure, family planning services, school authorities, student groups, the military hierarchy, non-governmental organizations, traditional leaders and religious leaders.

Within the Federal and State ministries of health, STD/HIV and AIDS prevention activities will be channeled through the AIDS control program. The AIDS control committees at both have been deeply involved in sentinel surveillance as well as data gathering concerning STDs as they impact on HIV infection. Channelling activities through these units will further strengthen the National AIDS Control Program in its coordinating role.

Benefits will reach target groups through NGOs. The commercial sex workers will be reached through the Society for Women and AIDS in Africa, Nigeria branch (SWAAN) which has branches in eleven states including the project states of Cross River, Kano and Lagos. SWAAN already has vast experience in work with CSWS in five states of the Federation. Truck drivers will be accessed through STOPAIDS,

an NGO with bases in Kano and Lagos which focusses primarily on long distance drivers. Members of many NGOs will be reached through Speakers Bureau of the NACP NGO Coordinating Committee.

The family planning program has an NGO infrastructure through which benefits could also reach the target groups. PPFN has personnel on the ground in Kano possessing a rich knowledge of cultural sensitivities and prevalent attitudes towards sexuality issues particularly among the predominantly Islamic population of Kano and Jigawa States

CCCD Project Beneficiaries

Although the country as a whole will benefit from the CCCD project, the focus is on nine states. The direct beneficiaries are Nigerian children and infants aged 0-5 (21% of the population), and women of reproductive age (24% of the population) making a combined total of nearly 50% of the population. Child health interventions will target the 4.2 million new borns annually by reducing the current infant mortality rate of 85/1000 and the even higher child mortality rate of 145/1000. Maternal health interventions will reduce the maternal mortality rates which are still very high ranging between 33 and 1,500 per 100,000 and resulting in approximately 40,000 deaths annually. The indirect beneficiary is Nigeria. Reduced child morbidity and mortality through attack on immunizable diseases and control of the most prevalent diseases, such as malaria and acute respiratory illness, will guarantee quality child growth and development. Quality growth and development lead to a productive adulthood which is directly related to a nation's long term social and economic well-being. The national community at large will derive indirect benefit also as a result of the opportunity to become familiar with the concepts of preventive health, child spacing, prolonged breast feeding, HIV and STDs.

Resources of the CCCD Component will reach the target population, reproductive age women, infants and children with vaccinations and health information, education, and policy statements. Support will continue for vaccination of infants against the six major diseases and yellow fever and for reproductive age women against tetanus. Information and education on management and treatment of diarrhoeal disease by using oral rehydration salts and home fluids will be expanded. Information and education, policy statements and operations research with respect to malaria prevention, management and treatment will be pursued. Information and education in respect of breastfeeding, infant and child nutrition, weaning foods, management of nutritional deficiencies, growth monitoring is a major component. Provision of information, education and policy statements for the treatment and management of children with ARI (acute respiratory illnesses) has been added as a new component.

Obstetrical information and counselling services for the management of pregnancy is another essential component that will interface with FHS.

III. BENEFICIARY AND PARTICIPANT PARTICIPATION IN PROJECT IMPLEMENTATION

Beneficiary and service level participant participation is largely confined to their input into focus group discussions, client and public in-depth interviews, operations research activities, training programs, pre- and post-KAP studies and evaluations. Nigerian researchers will continue to carry out research pertinent to all stages of project implementation and evaluation. Higher level participant participation has been and will continue to be extensive. The projects have been designed in conformity to government policy and requests for project interventions. Government and private sector participants have actively been involved in policy workshops designed to shape the interventions.

NGOs have been and will continue to be involved in project interventions as project beneficiaries and participants. Selected NGOs will receive technical assistance and limited funding to enable them to function as cooperating agencies transmitting their technical knowledge to other participants. NGOs will also be targeted to receive intervention messages within their NGO peer-groups to facilitate the Nigerian participatory, decisionmaking process which involves shared responsibility in risk-taking.

Female professionals are being given some preference in the structures that are relevant for the health interventions. The current deputy directors of both the Department of Population Activities (DPA) and the Nigerian AIDS Control Program (NACP) are women. Within AID and its cooperating agencies, a few women have been appointed at decisionmaking levels. At present, the highest female position is held by the director of the IEC program. A Nigerian woman is a Program Officer and a female Michigan Fellow is expected as a Program Officer.

IV. SOCIOCULTURAL FEASIBILITY

GENERAL BACKGROUND

WOMEN IN NIGERIAN SOCIETY

The Socioeconomic Status of Women

Although women are central to the project interventions, they are considered second class citizens, partially by law but mostly because of the social and cultural climate. The position of women has hardly improved over the last decades, and although there are women who have made considerable individual and personal progress both in the academic and business world, as a group women in Nigeria are clearly underprivileged. This is especially true in the case of the rural women.

In most cultures women do most of the agricultural work, in addition to their normal household chores, including fetching water and firewood, which in certain parts of the country entails walking long distances, in difficult terrain and harsh climatic conditions. Even in the urban areas, most female participation in the labor force is limited to the lower categories.

Wife Seclusion - Purdah

In the cities of the far North, most married women are secluded in their homes; they are, however, allowed to leave their houses for ceremonies, marriages and funerals. Most are permitted to visit relatives and to seek medical care. The strictness with which seclusion is enforced depends upon the husband's wishes and the wife's willingness to comply. There are women who never go out for any social occasion at all, and there are others who simply inform their husband that they are going out. Most women comply with the restrictions of purdah and go out only at night when, in theory, they cannot be seen. They take children with them as escorts and cover their faces with shawls.

In practice, male control extends primarily over the activities of wives and daughters outside the home, mainly by restricting women's spatial mobility. Purdah also restricts access to secluded women by other males. However, men delegate responsibility for the women and children within the home, for they spend very little time at home.

The Legal Status of Women

Regardless of the operative legal system, custom dictates that child custody is the prerogative of the husband. It is extremely difficult for a woman to retain custody of her children in the event of marital separation or dissolution without the cooperation of the husband. Women's behavior in all spheres of life is greatly influenced by their desire to retain custody of their children.

According to various Nigerian constitutions no discrimination is allowed in the rights of citizens irrespective of sex, ethnic group or religion. The Nigerian legal system is very complex and consists of three types of legal system: the so-called modern legal system which theoretically is applicable to all citizens, provided they and the case under consideration do not fall under either the Islamic Sharia system or the customary law system. The Sharia courts are applicable to Muslims in the northern and middle belt states while the customary law system, operational mainly in the rural areas of the south.

Customary and Islamic laws discriminate against women. Muslim women do not have access to the full protection of the Sharia system because of lack of knowledge about their legal rights. Customary law sanctions a number of very harsh and cruel practices against women and their bodily and spiritual well-being, and they have no recourse to legal protection from the modern system.

Even in the modern legal system, numerous provisions discriminate against women, not out of principle, but because of traditional and historical inertia. Upon marriage dissolution, women have to prove material contribution to the matrimonial property. Although men are given tax relief for children, none is given to the women who carry the bulk of the burden of children's upbringing. No legal minimum age at marriage has been set. Nor is there any legal provision against spouse battering. The Evidence Act discriminates against women in polygamous marriages.

A number of women NGOs, such as the International Federation of Lawyers (FIDA) and some State Ministries of Social Welfare are providing special counselling services for women, but the services provided reach a very small portion of eligible women. The Federal Government is considering the introduction of modifications in the legal system, including prohibition of certain customary practices.

Governmental Promotion of Women

The present administration vigorously promotes the enhancement of the position and status of women, and is in favor of fully integrating women into the developmental, economic, social and political processes of the country. The National Population Policy contains a section on "the role and status of women in development" to which government decrees and policies are responding. The First National Rolling Plan and Decree No. 30 of December 1989 establishing the National Commission for Women (NCW) clearly state the intention of the Government to integrate women into the process of national development and to remove the religious and cultural constraints on women development by emphasis on higher enrollment rates at all levels of education and income generating activities. Furthermore, some state governments have policies of providing automatic scholarships for female students who wish to pursue further secondary and higher education, especially in technology and science-oriented subjects.

Government is promoting a number of activities to improve the socioeconomic position of women: women in health, women in agriculture, women in education, etc.

Progress has been slow and uneven. In June 1990 the NCW was inaugurated under the Presidency with the mandate to coordinate all national, women's activities. The NCW, whose statutory chairperson is the wife of the President, coordinates the Better Life Program (BLP) and Women in Development (WID) activities. State NCW branches have been established under the Governor's Office. At the LGA level branches of the NCW will also be established to coordinate WID activities at the level.

The BLP is a loosely structured organization started in 1987 on the instigation of the First Lady of the Republic with the wives of the governors in the states as State Presidents and substantial extra-budgetary federal funding. This organization was initiated because the national bureaucratic machinery was too slow to respond to women's concerns. Having the support at the highest level of the Federal and States, BLP has significantly contributed to uplifting the position of rural women. BLP has actively embraced the population policy as well as actively promoting PHC, MCH, Family Planning and Safe Motherhood, improving of the social and economic conditions of women, adult literacy and income generating activities.

NGO Promotion of Women's Issues

At the national level there are three main women's NGOs. The National Council of Women Societies (NCWS), founded in 1958, with branches in all States is an umbrella organization for all women groups that wish to affiliate themselves. In some states, the NCWS is very well organized and active in wide variety of fields. The NCWS has been one of the NGOs supportive of the population policy since its inception. They are actively promoting the objectives of the population policy and are in some cases more radical than the policy, especially with regard to minimum age of marriage, abortion, safe motherhood, the legal position of women, etc. The Kano State branch has been in the forefront of the struggle against VVF.

Female-Oriented International Interventions

The current female-oriented international interventions designed to promote equality and facilitate fertility reduction programs may significantly contribute to the destruction of the nuclear family.

Improvements in Women's Status

Despite the threat women's advancement poses to male preferential treatment, progress has been made in the improvement of the position and status of women. The Government strongly promotes the appointment of women in positions of authority. Although there is no female member of the AFRC and the Federal Cabinet, there are an increasing number of female judges, university professors and ambassadors. Out thirty-seven Directors General at Federal level, at least nine are women. Until recently a woman was the Deputy Governor of a northern state and currently several women are deputy governors. Each State has at least one female State Commissioner and some female State Directors General. A considerable number of women were appointed as sole administrators of the LGAs.

THE MODIFIED/TRADITIONAL WORLDVIEW

Project Behavioral Change Requirements

All three projects demand a personal and societal reevaluation of core values and self-image including changes in private behaviors; faith in the germ theory of illness; deviation from existing moral authority; belief in ability to control nature with Western rather than occult powers; and, rejection of a pro-natalist and fatalist world view. At a minimum an innovator or an innovating group must have a conception of benefits accruing from behavioral change preferably from successful role models as well as faith in the moral authority of the change advocates.

The Eclectic Modified/Traditional Worldview

Virtually every Nigerian is at least partially estranged from his/her ethnic tradition. Both individuals and their societies are in transition responding to their environment with modified/traditional solutions. In contrast to the homogeneous traditional social environment, the current environment is constantly in flux with individuals operating according to overlapping and ostensibly conflicting value systems determined by their ethnicity, religion and degree of modernization. An individual modifies his combination of modern and traditional as he moves through time and space throughout his life. Even within the same day, an individual may face some situations he perceives as meriting a more traditional response and others as meriting a modern response. All those around him, because of the circumstances of their own socialization, respond according to their own combinations of modern and traditional. In fearful situations, this eclectic worldview manifests itself with both traditional and modern solutions being sought.

The African Worldview

Aspects of African religion persist as a worldview among both Muslims and Christians without their always realizing it. Traditional healers and "medicine men" still thrive and retain many of the old rites in their healing practices. In the Southeast they are known as dibias, the Yorubas refer to them as babalawos, while in the Northern parts of the country they are known as mallams. Although a mallam is a Muslim teacher/interpreter of the Koran, the mallams referred to here are the category of mallams who have adapted Islam to the traditional concepts; they divine the future and provide prevention and cures with the text of the Koran. Their methods include preparing talismans with Koranic texts and medicine with the ink used to write Koranic texts on their tablets.

The spiritual dibias, babalawos and mallams serve people as their link to the spiritual world by solving their problems, protecting their health and fertility, and divining their future. The traditional medico-religious influentials have followers in all segments of the society: rich, poor; educated, illiterate; urban, rural; male, female; and, young and old.

The spiritual world operates alongside the physical, material world. In the African world view the spiritual world modulates all occurrences and phenomenon that are

not perceivable by the biological sense organs of normal people. This spiritual world is as much a presence in the daily life of Africans as the microscopic world is a presence in the daily life of Westerners. In each case, awareness of this invisible world permeates the perception of reality.

In the African worldview, the spiritual world contains good and evil elements and phenomena which can manifest in the physical and material world. Special persons have the knowledge and power to understand, interpret, intervene and ameliorate the evil manifestations of the spirit world. Witches are harbingers of evil. Native doctors, traditional healers, Ifa priests, other priests and priestesses have the knowledge and power to do good, to prevent evil, and to harm evildoers by using a variety of prescriptions. Their prescriptions can be symbolic like breaking an egg at a major road intersection, or concrete like boiling and drinking a combination of herbs. Some prescriptions are preventive; others are curative.

It is legitimate to commission the use of evil powers against someone who is believed to be causing (by similar occult means) ones own suffering--illness, death, infertility, low fertility, failure to produce a son, etc. Jealousy, greed and anger are also recognized as reasons people use occult evil. Since family members remain financially interdependent frequently resorting to mutual assistance and competing for the same resources, people have occasion to believe that their relatives are guilty of jealousy and greed and to suspect them as possible perpetrators of their own suffering.

The distinction between physical and spiritually induced disease conditions is not very clear. Significantly, the traditional doctors, healers, priests are considered more appropriate than the Western health system for spiritually induced conditions. Education enables a person to distinguish physical diseases by explaining the rationale for their symptoms and cure and by increasing a person's understanding of and faith in the Western world view. However, the role of the spiritual increases with the intensity and longevity of an illness even for highly educated individuals.

Witchcraft

The belief in witchcraft influences fertility behavior and maternal/child survival. Witchcraft is practiced by killing one's children or the hated person's children and in some cases the adult enemy as well. If one has only three children, they could all be wiped out at once by witchcraft whereas if one has five, six or more children, one would be able to take precautionary measures once the evildoer had killed some of the children. Thus high parity is perceived by those fearful of witchcraft as a preventive measure ensuring some surviving children. Since witchcraft is also believed by some culture groups to be the cause of child mortality, and specifically the cause of measles and polio, many doubt the utility of Western vaccinations.

The Influence of Traditional Healers

It is estimated that seventy percent of Nigerians recognize and patronize traditional healers. In contrast to Western medical practice, traditional medicine has many

advantages from the viewpoint of the patient. The diagnosis and treatment not only conforms to expectations, but also includes patient responsive counselling. The patient and his relatives participate fully. After narrating his problem, if medicine is the solution, it is the patient who mixes the ingredients. If divination is part of the solution, the result is that the patient is given a rationale he accepts both for the condition and for the remedy. He is also told the prognosis rather than merely being given a prescription for unnamed syrups and tablets. Moreover, the payment is usually fully integrated into the cure in the form of a sacrifice or a token of appreciation that can be paid over time as the resources become available.

Ancestor Cults

Belief in the cult of ancestors persists and especially in consulting them on the continuity of family lineages and in solving family and personal problems. The dead ancestors retain an active identity as members of the lineage, protecting its members, when they are remembered by the surviving generations. Appropriate behavior to retain ancestral approval begins with taking adequate care of the aged dependents and performing the required rituals such as, giving him/her a decent burial.

Many societies believe in reincarnation and some children are named after dead ancestors who are reborn in them. These societies frown on small size families accusing the affected couple of preventing the dead ancestors from enjoying their right to reincarnate, thereby condemning them to be perpetual wandering ghosts. Thus, large families receive approval, and by implication, divine approval as the family is perceived as being blessed.

THE MODIFIED/TRADITIONAL FAMILY AND SOCIETY

Fertility Rather Than Virginitv as the Paramount Virtue

In the traditional environment given the African land tenure system, lack of technology and nonuse of draft animals, humans were the most valuable resource; the more humans, the greater the surplus crop and the more distributable wealth in the hands of the patriarch. As the Caldwells affirm, fertility rather than virginitv was the central female virtue. Eurasian virginitv ensures retention of land ownership within the elite, but in Africa land belonged to the deified ancestors. It could not be hoarded; instead usufruct rights to the ancestral land were withdrawn when the family lacked the people to till it. Power including control over land and economic resources including family members was reserved for the males and for the elders. Older women exerted power over other women and children, but they did this on behalf of the elders. Patriarchs redistributed the majority of the accumulated surplus wealth although adults retained direct control over their subsistence foodstuffs. This system has been greatly modified; nevertheless, it forms the basis for the modified/traditional solutions which continue to evolve.

Infertility

Traditional religious and cultural values have supported high fertility by equating fertility with virtue and ancestral approval and associating little or no fertility with evil. Barrenness rather than loss of virginity is considered a tragedy brought about by occult powers at the behest of the jealous relatives or ancestors or, in some cases, as a manifestation of the sufferer's evil. When barrenness occurs, pregnancy is delayed or infant mortality is very high, ancestral disapproval is attributed as the overriding cause and diviners are usually consulted to identify the cause of the disapproval and appease the ancestors. Barrenness can also be as a result of God's wish since he gives children. A childless adult loses the respect of others. Barrenness is considered a personal calamity, a wasted life.

High fertility is a source of joy for the parents and grandparents. For the impoverished, it is a traditional source of status. For some, it is the prime source of status, other traditional sources having been eroded. It continues to engender overt praise even when people privately express consternation about the inability of the parents to properly feed and raise the child.

Pronatalist Traditional Marriage

Traditionally, the function of marriage is primarily to ensure the supply of children to the male extended family. Men continue to be under considerable pressure from their natal families to produce children, even to the extent of the family supplying a second wife if the first wife fails to continue to produce. Children are considered as rightfully belonging to their father. A woman "has children for a man"; not for herself. A woman is also expected to defer to her husband and submit to his authority. Among virtually all ethnic groups and religious communities, men are considered the head of the household. Family health and reproductive decisions are the prerogative of the husband even if he fails to supply the necessary funds and even though the wife usually is the caretaker.

Bride price is paid in exchange for the rights to the woman's reproductive capacity and her domestic labor including cooking for her husband and caring for their children. In Igbo culture the high bride price formerly guaranteed the right to the wife's work, although women are now encouraged by their natal families to retain most of their earnings and to assist their natal families. In contrast, the low bride price among the Yoruba only confers the right to the children. The husband is expected to financially assist the wife in setting up her trade and she should use some of the earnings for the family, but she may keep most of her earnings for herself and for her obligations to her own extended family. A Yoruba wife assists the husband if there is a financial need. Among the northern Muslims, traditional practice and Islamic law require that a man provide shelter, food and clothing for his wife and children including visiting relatives of the wife with the wives' responsibility limited to providing a proper dowry for the daughters. Thus, traditionally men had varying degrees of financial obligations which were carried out within the extended family context, but significantly in all ethnic groups, wives are expected to supplement household money with their own farm produce or income in times of need.

The Non-Companionate Marriage Relationship

Polygyny ensures pleasure for the elders and maximization of the number of offspring whereas monogamy threatens the power of the elders, male and female, by tipping the balance in favor of the conjugal couple and the nuclear family.

Extended families and natal families acting through their senior members exert authority over the spouses in a conjugal family. Spouses do not act as a single economic unit. Their finances are separate as are their financial responsibilities which link them to their natal families. Men are greater assets to their natal families because their finances are not divided whereas a woman has varying degrees of obligation to the husband's family as well as to her own.

The extended family hierarchy opposes very close spousal, companionate relationships because of the possibility of diverting resources to the nuclear family. The mother-child bond is the strongest bond. In Hausa/Fulani society even that bond is subjugated to the larger familial interests in the case of the first born son. This mother-son relationship is traditionally an avoidance relationship with the child being fostered to a male relative, usually an uncle.

Many, if not most, Nigerian marriages are minimally companionate or non-companionate, especially for the older generations. At one extreme is the Hausa polygamous marriage. Hausa husbands and wives do not work together, eat together, go out together, share domestic tasks or share the same friends. Each adult has his/her own bedroom. Each woman's ultimate security is based on her children, her kin and herself. The practice of serial marriage ensures that the household is an artificial construct with changing personnel whose strongest ties may be more with kin and friends elsewhere than with members of the domestic group. Slightly more companionate traditional marriages occur among other ethnic groups and individuals living in non-traditional settings. For instance, some migrants send back home for a bride in order to preserve some of the qualities of traditional life in an alien environment. At the other extreme is the monogamous love marriage. However, many marriages are transformed by time and differing spousal viewpoints into basically non-companionate arrangements with shared socialization only at family affairs.

Marital Sexual Relations

The prime function of marital relations is to produce issue. Among many couples, mutual sexual pleasure is not perceived as a goal much less achieved. To the extent that female circumcision reduces sexual pleasure, it coincides with a social need for the wife to abstain from sexual pleasure for long postpartum periods.

Sexual Networking

Recent work by the Caldwells and Orubuloye with their Sexual Networking Group has established that sexual networking, at least in some parts of Yorubaland, traditionally was at high levels for men and significant levels for women and that contemporary sexual networking continues at high levels but is more diffuse. It now

also involves women friends in brothels and is no longer residentially localized. According to the 1990 Ekiti Sexual Networking Survey, sixty percent of the current male sexual activity is extramarital. Consequently, even the one-third of rural Ekiti women who remain virgins until marriage and the one quarter who refrain from extramarital sexual relations are at great risk for sex diseases from their husbands. Furthermore, the AIDS risk is intensified by the urban STD rate of ten percent for current cases and thirty-three percent for past, treated cases.

In traditional polygynous society, so many women were unavailable to so many men that barring priestly abstinence on the part of the men, considerable sexual networking had to involve married women. Men married at thirty; girls were married off young at sixteen or seventeen; divorce was virtually non-existent; and, widows were inherited by their in-laws. Polygyny further reduced the number of women available for marriage and the practice of long female postpartum abstinence (three years) made women unavailable to monogamous husbands for half their fecund lives (16-45 years). Even a polygynous man with two wives would find that thirty percent of the time both his wives would be unavailable. The gerontocracy reserved women for the older, wealthier men. All men were expected to wait until age thirty to marry, at which time their families' helped produce the high bride price.

The Ekiti Study established the existence of considerable sexual networking on the basis of extended in-depth interviews and surveys with the elderly as well as with the currently sexually active. Proscriptions of non-marital sex appear to have applied to the wealthy, especially to those whose first marriage had been arranged at birth and paid for over time. In any case, contrary to the widespread impression that the prevailing pattern of pre-marital sexual relations is a new phenomenon brought about by the breakdown of traditional society, discreet, surreptitious, pre-marital sexual relations were common especially in urban areas in the 1930s with two-thirds of the rural and four-fifths of the urban women sexually experienced prior to marriage. One-third of the rural women reported extra-marital relations with other members of their husband's extended family, usually their brothers-in-law or the son's of co-wives.

The extent and type of sexual networking patterns among other ethnic groups is yet to be examined.

Adolescent Sex

With the major exception of the Far North, the age at marriage has shifted slightly from marrying in the mid-teen years to marrying in the later teens. Among urbanites in Akwa Ibom State, in Lagos and perhaps also in other areas, the age at marriage has shifted much higher to the early thirties for women and the late thirties among men. This shift has been brought about by their risen expectations combined with the refusal of the future wife to live with her in-laws. Even for the educated, urban housing is so expensive that graduates experience great difficulty renting a room and parlor in which to start a family.

Although the age at marriage has risen, this rise has been partially counteracted by pre-marital sex. It is generally believed that pre-marital sex has increased over the last two decades; however, if the Ekiti study findings are valid for other areas, then what appears to be an increase is only an increase in visibility. In the South, despite societal and parental disapproval and denial, premarital sex is widespread and approved by teenagers. Many teenagers have had their first encounter by the age of sixteen. Nevertheless, most adolescents avoid premarital sex and more might avoid it if they were fully informed about the attendant risks.

This change in norms about pre-marital sexual behavior is one consequence of the gradual shift from arranged marriage to marriage of free choice. Young men and women have received more education than their parents and often live, not only in separate residences, but also in separate towns from their parents. The long delay between physical maturity and completion of education puts pressure on the couple. Most young people have been able to prevail upon their families to allow them to marry the person of their choice; however, many families now insist on the woman's becoming visibly pregnant before formalizing the marriage. Although the family relinquished control over the selection of the wife which would have involved examining her family for any defects, the family is adamant that a young man contemplating a monogamous marriage ensure that the fiancée is fertile.

The drawn-out nature of African pre-nuptial gifts and services to the wife and members of her extended family facilitates pre-marital relations and transactional sex. In the eyes of both the society and the couple, a male's ardour is partly defined by the extent and nature of the gifts and money he bestows on his beloved. This association between money and a loving sexual relationship facilitates transition to transactional, sexual relationships without love. A couple may live together when the husband has only paid part of the bride price; however, the family will not consider the marriage completed and the children his property until he has fulfilled all his obligations.

In Makinwa-Adebusoye's 1989 study of five representative urban areas, about fifty percent of the girls and forty percent of the boys had their first sexual encounter before age seventeen. By the end of their teens, the percentages have risen to eighty-two percent for the females and seventy-two percent for the males. Moreover, the trend is for increasing numbers of urban teenagers to be sexually active before age seventeen, while others will promote contraceptives. The faithful will trust and follow the guidance on child spacing and/or limitation methods which is given by their ministers or by influentials in their Bible fellowships and social/charitable organizations. To the extent that techniques are adopted within groups, they will extend to many more users. The innovators within a group will serve as the group's role models ultimately increasing the numbers of role models throughout society.

Despite their high level of sexual activity, less than half of these relatively well educated, urban-wise, young people are sufficiently knowledgeable to protect themselves from unwanted pregnancy. More than a quarter of the respondents

indicated that they had not employed contraceptives during their first sexual encounter because they thought pregnancy was not possible at first intercourse. Only about four percent of the females and two percent of the males were able to correctly identify the safe period on a calendar.

Inheritance

The number of children a woman has indirectly, but nonetheless powerfully, affects the security she can derive from her husband's wealth. Under customary law, a wife never inherits her husband's property nor can she take her children away from her husband's extended family. All property within the house is considered as belonging to the man. In many cases when a man dies, his relatives confiscate his property and sometimes his children, especially if the relationship between them and the wife is less than cordial.

A woman gains access to her husband's wealth through her children. Among the Edo speaking peoples, the first son inherits the assets and liabilities as a sort of trustee for his siblings. Among the Yorubas, the property may be divided per stripes or equally among the children. Among the Igbo, the eldest sons of each wife inherit jointly irrespective of their ages as "trustee" for their full siblings. In Hausa culture, a woman can inherit small portions in her own right as the wife, the mother, the biological grandmother, the daughter, the filial granddaughter or the sister of the deceased; however, the greatest portion goes to the children. In most cases because of the wrath of the family, the properties of persons married under the Marriage Act and who die intestate are still being divided under customary law. Moreover, relatively few men prepare wills because of the cultural aversion to planning for death.

The Marriage Act affords women little economic security. A man married under the Marriage Act can not legally marry under any form of marriage including Customary and Islamic law. Nevertheless, men disregard the law with impunity. They set up domestic arrangements in a separate home with another woman who is considered an "outside" wife. The outside wife or wives children can legally inherit from the man regardless of whether or not the legal wife was aware of their existence. Since such men will likely die intestate or specifically distribute their wealth to include their outside wives and children.

Land Tenure

The land tenure system operating across the major ethnic groups in Nigeria reinforces the desire for many children and particularly for male children, and indirectly becomes a cultural barrier to family planning. Under the customary land tenure system, only males own land and women can only gain access to land through their husbands. Moreover, land that is no longer tilled reverts to the extended family. Thus, each additional child provides the opportunity for acquiring and retaining usufruct rights to additional farmland. In cases where male children are lacking, the family loses its right to the land. Among some peoples, men consider

wives an investment because they can gain control over more land and produce by acquiring usufruct rights to family land on behalf of their wives.

In principle under Islamic law, Hausa women are entitled to inherit land and other property, although only half the portion of land inherited by their brothers. In communities where a woman can purchase land under statute law, women largely depend on men for access to land. In general, a man's property and sometimes titles pass to his sons or paternal nephews, brothers or paternal cousins.

The Status of Traditional Rulers

Today virtually all traditional rulers, especially for larger communities, are well educated and have held important business or government positions before being appointed emir or chief. Although traditional rulers have no formal role in policy definition or making, except in an advisory capacity on matters pertaining to religion and traditional affairs, their support for implementation is crucial and is openly sought after by political leaders and administrators of all levels. They fill the governmental vacuum at the grassroots community level. They also are influential with traditional NGOs as well as formal and informal channels of authority. The 1989 Constitution makes explicit provision for the creation of Councils of Traditional Rulers at State level and spells out their prerogatives and functions.

CONTEMPORARY RELIGIONS

Beyond Animism to Islam and Christianity

Islam and Christianity offer religious world views that expand beyond the geographic confines of traditional religions tied to ancestors and assist the faithful to comprehend a world comprising people from many cultures. Islam has been the official religion of the northern emirates for centuries although the extent of conversion was variable, whereas Christianity was introduced barely 150 years ago; nevertheless, throughout the country many people are first or second generation members of one of these world religions. The majority of Nigerians are very devout; however, for many of the faithful, their conception of these world religions has been influenced by their own African perspectives. These religions support family values and sexual relations within the marriage; consequently, if influentials within their religious communities mobilize their members, they may be willing to actively support forms of the child spacing and anti-HIV/AIDS interventions consonant with their religious beliefs as well as maternal/child health interventions.

The Appeal of Reformist Religions for the Youth

Reformist religions, whether Christian or Muslim, have acquired many young people as adherents but since they follow closely the sacred texts, they are often opposed to modern family planning techniques. The established religions offer the youths little opportunity for freedom from the dictates of the hierarchy of elders whereas the new religions have a more fluid power structure and promote analysis and interpretation of the sacred literature. The reformist religions also offer the opportunity of a blessed marriage without the financial constraints that accompany establishment weddings which often amount to the equivalent of a young man's salary. No dowry is paid, nor is a large party expected. Reformist Islam has the added advantage of freeing youths from genuflecting in deference to the elders; genuflecting has been declared un-Islamic since one should only genuflect for Allah.

The Family Planning Positions of the Churches

Most churches support child spacing for health reasons and have accepted, reluctantly, the necessity of limiting God's children to avoid the terrible consequences of parental financial inability to properly care for the children. Some churches prefer abstinence but permit contraception as a last resort if the faithful are unable to summon enough spiritual strength to abstain sufficiently in order to protect the welfare of their families. The Catholic Church strongly advocates child spacing and limitation but only by the Billings method and abstinence. The Anglican Church has taken no stand for or against contraceptives. Others accept contraceptives as a good solution. Still others actually promote contraception for spacing and limitation. The Baptist Church, the Methodist Church, the Four Square Gospel Church, the Seventh Day Adventist Church are among those churches which have a positive attitude towards contraceptives.

Churches and their affiliated organizations also provide contraceptives in their clinics and refer clients. Many CHAN hospitals and clinics provide contraceptive services.

In the middle belt, the TEKAN churches promote child spacing with contraceptives and have been a source of referral for many women. In Kano, SIM holds weekly women's group counselling sessions open to women of all faiths in which women advise each other on women's problems including the necessity for, types of and sources of contraceptives. The Catholic Church sponsors workshops to teach the Billings method and provides counselling to assist couples trying to use the method. CHAN has just sponsored the development of thirteen booklets on women's health including modern contraceptives; however, opposition by the Catholic Church which represents 60% of CHAN has forced the booklets to be presented under the auspices of a related group of Protestants.

Not all faithful are absolutely clear on permissible methods; however, all accept the Billings method and its variations. Seventh Day Adventists are at the other end of the continuum of attitudes towards contraceptives and also support abortion for health reasons. A few churches disapprove of withdrawal as a shameful method. Some churches such as the Celestial Church of Christ accept family planning but oppose the use of drugs for any purpose including family planning. Others indicate that drugs in general are acceptable for child spacing but volunteered that they must not be hazardous to health.

The Family Planning Positions of the Islamic Sects and Associations

The Muslim community includes the large body of faithful and two important distinct sects, the Ahmadiyyas who believe in the coming of additional prophets and the Izalla who are a reformist sect opposed to the overlay of traditional cultures. Many of the faithful are members of important associations which have congregational and local mosques. Muslim religious-based associations are usually divided into brotherhoods, sisterhoods and youth groups.

The Muslim community has been strongly opposed to contraceptives. Many influential Muslims perceive family as a misguided attempt to control the fate Allah has given them and as submission to a Western or American, Christian plot to control Islam by reducing the numbers of the faithful. Even the Al-Hikmah Awareness, a four page newspaper published by the University of Lagos Branch of the Muslim Students' Society of Nigeria (MSSN) and launched by M.K. Abiola, a political/financial leader, carried news articles and editorials in this vein in reaction to declarations by the Christian, Minister of Health that abortion should be legalized and men should come forward for sterilization. The MSSN is made up of Muslims from all brotherhoods and the Unilag Branch has a majority of Yoruba members. Similar pronouncements are made in other Muslim publications and by imams preaching to the faithful.

Significantly, Alhaji Usman Faruk, a respected Northern proponent of Islam, published a booklet in 1988 explicating the Western, anti-Islam conspiracy theory in which he also affirmed that Islam permits consensual use of certain contraceptive measures if a mother has already had the experience of becoming pregnant within a month of childbirth. Faruk was Governor of Sokoto-Niger State and also kept the

control to protect the life of the woman. Moreover, this same imam in his birth control lecture discussed the failure to properly feed children as a form of minimal murder diminishing their chances for survival. The Ahmadiyyas run hospitals and clinics offering free medical care all over the country. Many Kano women attend their clinics because they have female gynecologists. Thus, the Ahmadiyyas have the potential to wield considerable, possibly negative, influence on child spacing as a health issue.

The Izallas, reformists who believe in strict following of the Koran and Islamic traditions which have not been contaminated by local traditions, have many adherents among the youth. Their recently deceased spokesman, Abubakar Gumi a well respected Islamic scholar from within the Hausa/Fulani elite, had no choice but to come out on the issue of family planning since it is of such concern to the youth. According to Gumi, the Holy Prophet never preached against the control of family size, therefore anyone who now attributes anything to the Prophet such as telling people falsely that the Holy Prophet was against family planning, is committing a very serious offence. However, Abubakar Gumi never made any statement about what the Holy Prophet actually said about family planning.

Muslims in the Far North follow the dictates of their imams. The northern faithful have no desire to take personal responsibility for innovation or interpretation of the Koran and wish to avoid any possibility of opposing Allah. The establishment associations in the Far North, Quadriyya and Tijaniyya, have issued no statements on family planning. The opposition of their elders and imams is generally recognized; however, the young members are still asking for answers to their dilemma. The Jama'atu Nasril Islam, a national brotherhood based in Kaduna, preaches responsible family life style starting with very young people and organizes workshops and seminars on natural child spacing. Some members now teach withdrawal, which is specified in the Koran.

Ideally, further dissemination of information in the Far North should be the responsibility of the Islamic associations. In order to minimize opposition which has been strong and remains strong, especially among commoners who have only heard the negative messages in Faruk's publication, the men should be left in control of introduction of the issues to the women's groups. The Koranic exegesis and sermons preached by imams at the end of Ramadan serve as a major source of guidance to the faithful.

However, other avenues can be explored. In some states Jam'iyyar Matan Arewa (JMA), the Association of Northern Women, which has over 10,000 members in Kano and members elsewhere, will be amenable to actively promoting child spacing among its members. The potential of female Arabic literacy programs for information dissemination on child care and reproductive health should be exploited by incorporating the amount of information the decisionmakers will tolerate rather than completely foregoing the educational opportunity. Some states and NGOs may be willing to adopt the UNFPA-sponsored, Bauchi State literacy materials which

include reproductive health and child spacing issues. Northern branches of the women's associations attached to the armed forces and the police will also be amenable to child spacing interventions. The youth groups attached to the various Islamic associations will also be receptive to child spacing interventions consonant with Islamic tenets.

Despite the positive attitude towards active child spacing among many Muslim influentials, this attitude has not been transferred to the commoners who continue to believe the Koran is opposed to contraception and that family planning is promoted by an anti-Islamic conspiracy.

NON-GOVERNMENTAL ORGANIZATIONS (NGO'S) AS PARTICIPANTS AND BENEFICIARIES

NGO Participant Activity

NGOs have participated in project interventions as service providers and as social mobilizers. Private, nonprofit providers such as mission hospitals and clinics, women's groups, men's groups, employee unions and university programs have played a significant role in Nigerian health care. The Christian Health Association of Nigeria (CHAN) is an umbrella organization for a huge sector of service provision employing 16,000 workers. Planned Parenthood Federation of Nigeria (PPFN) is another large service organization. Community organizations sponsored by government including the Better Life Programme and Women in Development units in each state have been active in recent years. The National Council for Women's Societies is an umbrella organization for many socially committed organizations. Community development associations depend on the human and financial resources of the more fortunate members of communities to send assistance back home from their urban bases.

Ethical NGOs as Target Audiences for Sensitive Behavioral Change

When considering NGOs as target audiences for sensitive, private behavioral change, it is useful to distinguish NGOs which perform a value-clarifying and reinforcing function for their members from the generality of NGOs. Such NGOs may be termed "ethical NGOs" to underscore their concern with the morally correct behavior of their membership. NGOs affiliated to religious and primordial groups bring together their membership for a variety of reasons but their affiliation also ensures that members share common values.

The established and fundamentalist religions with their associated societies and religious education activities provide excellent avenues for behavioral change because their followers are self-selected members who trust their religious and societal leaders. Many ethnic-based town and village unions in the South and among the minorities in the Middle Belt maintain financially responsible, ethical organizations with strong, actualized commitment to their membership. Urban, primordial associations maintain strong ties to the place of origin and are recognized for their integrity, for their social security concerns for their urban membership, for their role in facilitating socialization beyond the confines of the home place and for their development efforts in their home places.

Other NGOs are less effective as target audiences for sensitive behavioral change because the values of the members are not shaped and reinforced by each other to the same extent. Despite important exceptions, it is generally true that social, charitable, employment and credit associations are less likely to influence the private behaviors of their membership. Nevertheless, these NGOs may be excellent channels of information and advocates of non-sensitive, behavioral change.

The Advantages of NGOs

Many NGOs are well established organizations with a committed, self-disciplined membership that selects and respects its own leaders. Their membership participates in NGO activities voluntarily; as a consequence, their involvement in intervention activities is generally greater than the involvement of civil servants or employees of large organizations. They can mobilize people from all sectors of life who might otherwise not be reached by government or profitmaking, private sector interventions. They can also attract resources from their membership and the general public which would never be contributed for government activities.

Disadvantages of NGOs

In some cases, NGO leadership present constraints to intervention efficiency. NGOs are often tightly controlled by a small leadership clique so that in fact many members are members in name only and have no sense of ownership. NGO leadership changes frequently, resulting in a change of focus and loss of knowledgeable manpower. Although NGO leaders may agree in general with a project intervention, often their leaders lack the sufficient concrete knowledge of the projects to mobilize the members to take advantage of the interventions and may not even recognize their importance to members.

Spurious NGOs

Some NGOs are controlled by corrupt leaders intent on embezzling funds. Spurious NGOs have been organized and registered in response to the government's efforts to harness the capacity of NGOs to generate development. They generate false or inflated membership lists. Sometimes they perform their stated social function to gain credibility and a government or donor grant but most of the money can never be accounted for.

All NGOs are potential targets for having corrupt leaders gain control; however, ethical NGOs are less likely to have corrupt leadership.

Limited NGO Financial Absorptive Capacity

A very real danger of using NGOs as participants for the interventions is that the large sums of money used to fund the intervention will undermine the NGOs internal organization, destroying the very qualities the NGO intervention is relying upon for success. Reports from Kenya indicate that USAID channelled considerable funds and expertise through VADA, an umbrella NGO, to facilitate its use as an information network only to discover that the funds generated animosities among the NGOs and fostered the growth of spurious NGOs. A similarly destructive NGO intervention occurred in Bangladesh.

Given the prevailing economic suffering and corruption in Nigeria, the potential for absorbing large sums of money without undermining the fabric of an NGO is low. Spurious NGOs are already flourishing in response to governmental and donor efforts to harness the NGO potential. To safeguard against unwarranted destruction of NGO integrity, an intervention with a low financial input at the ground level is

essential. Nevertheless, the financial input must be sufficient to respond to the actual expenses incurred by the NGO volunteers.

SOCIALIZATION AND HUMAN RELATIONS

Consensus, Decisionmaking: Freeing Individuals From Personal Responsibility

Decisionmaking is not an individual process; it is made by consensus with no single individual bearing responsibility. A traditional ruler will recommend change only after consultation with a few trusted councilors and then approval by the entire body of councilors. Few individuals dare or desire to be known as innovators even in matters less private than sexual practices. As a consequence, decisionmaking skills and aptitude for taking personal responsibility for one's acts are underdeveloped; instead, compliance behavior and aptitude for consensual, decisionmaking are highly developed.

Indirection

Indirection, rather than confrontation, is the human relations technique adopted to facilitate change. It provides an opportunity for gradual awareness, consideration and possible acceptance of the proposed change as well as the option of evasion, if desired, without loss of face for the parties involved. When seeking the support of an authority figure, the intervention of a respected member of his community who provides access is essential. It assures compliance with traditional norms while requesting support for a change, thereby reinforcing the source of influence whose support is being requested. It also provides the face-saving opportunity to have devised a preliminary response.

An Intermediary to Whom the Targeted Influential Is Obligated

Intermediaries are crucial not merely for their power to provide access to influentials, but also for their power to convince influentials to act. One proceeds by indirection and influence. A common strategy when making a request from an authority figure is to seek out an intervener to whom the authority figure is not in a position to say "no". Although this requires both sociocultural and personal knowledge of the principal figures, it usually ensures cooperation or at least minimal opposition. This person, whether he is a mother, other relative, a co-member of a traditional NGO or someone who has assisted the influential will entreat the influential to cooperate. In such situations, the influential will be constrained not to actively oppose the activities even if he can not be convinced to actively support them and he is likely to be convinced.

Representational Gifts

Representational gifts facilitate a rural traditional ruler's acceptance of responsibility for behavioral change and its sustainability. Strategically, the ruler would prefer not to deviate from tradition on points of form, especially when he is advocating significant behavioral change. Traditional subjects and suppliants bring gifts to a ruler's "messengers/body guards/men-in-waiting" and to the ruler's themselves. These gifts are part of the traditional exchange system.

Human relations techniques in the traditional setting indicate that representational gifts are appropriate. Part of being a "big man", an influential in the community, is

the giving of small gifts to dependents of other big men. The influential service provider who introduces a behavioral change program or reintroduces one to a rural community is a "big man". Traditional human relations techniques also recognize that a ruler's "messengers" will spread the word about the strangers and their project more favorably if their importance is recognized.

Time-Consuming Preliminaries

Patience is essential in obtaining an influential's support, especially in the case of a traditional ruler. The intermediary needs to be convinced of the need for intervention which may take several visits. He then needs to approach the influential. This whole process takes time and may last up to a month in the case of traditional rulers. To rush the process would imply that the approval of the local ruler was not seriously being sought. To go straight to the ruler himself is to fail to accord him respect. In traditional society, seniors are always approached through an intermediary; they are not asked directly for favors, nor are they directly apologized to if one has offended them.

These courtesies can be omitted by Westerners and donors bringing large sums of money for accepted interventions; however, the closer the interventionist's representative is to the culture, the greater the jeopardy to the intervention.

Courteous Non-Cooperation

Lack of obvious opposition to a new project does not necessarily mean success for a project. It is rude to refuse a request; instead, one says "Yes" and fails to perform. An offended ruler who feels his authority has been undermined may undermine the project in order to reinforce his authority. Like the unconvinced ruler, he may inform his own people directly or indirectly of his disapproval. The ruler may also be incapable of delivering whatever is requested but consider it politically unwise to acknowledge his inability.

The Power of Entreating Assistance

All these examples are reinforced by the cultural necessity to entreat people to assist one, rather than to merely ask for an expected service. One must constantly show visible appreciation for a service; not to do so is tantamount to relegating the renderer of the service to a subordinate, server position.

Sanctions and Coercion

The socialization process in all Nigerian cultures has strong authoritarian elements. Compliance behavior is achieved through sanctions or coercion. Children are beaten at home for infractions. In schools, children are beaten or threatened with beating for non-submission of their assignments and for poor performance. Older children have the power to discipline other children. Children quickly develop an outer facade of obedience, deference and respect regardless of their true assessment of their elders. Women are expected to obey and serve their husbands and their in-laws; otherwise the husband and family members will heap blame on them, instigate marital problems and even advocate a second wife.

Institutions also rely on sanctions and coercion. Churches require that all past dues to all affiliated organizations be paid prior to a church service and burial. Sanctions have also been used on behalf of health interventions. Age groups in some Igbo villages have organized to ensure complete EPI coverage by fining any resident who leaves the village for farm or work on EPI day and tracking mothers for cycle non-completion and consequent fining. A recent study of four rural villages demonstrated that the greatest gains in maternity care were achieved in the poorest town because the women's union decided that any woman who delivered a baby at home without a trained birth attendant must pay N25 to the union.

SOCIOCULTURAL INFLUENCES ON ADMINISTRATION

CONSTRAINTS TO SERVICE PROVISION

Ethnic Prejudice

Except for the most educated, targets must be disaggregated ethnically as well as in standard ways. Ethnic affiliations and nepotism are not merely for social and economic gain. Each ethnic group has its own culture and set of values which differ significantly even though they are all grounded in an African worldview with common values recognizable as non-Western.

Distrust and cross-cultural misunderstandings between ethnic groups, ethnic sub-groups, religious groups and social classes hinders acceptance of innovations promoted by them. Citizens have not replaced respect for their elders and clan leaders with respect for the human race in general and their non-tribesmen in particular. Nor has an incorruptible legal system and civil service eliminated ethnic nepotism.

The Need to Ensure Ethnic, Religious and Gender Spread Among Nigerian Researchers and Cooperating Agencies

Attention to the ethnic, religious and gender spread of Nigerian researchers and cooperating agencies is crucial to ensure a balanced analysis of problems and prospects. Southern and, in the case of family planning, Yoruba universities have a longer tradition in educating personnel relevant to health interventions and related research. Consequently, qualified personnel is more readily available among some groups. Conscious efforts are required to locate and foster the academic growth and experience of underrepresented groups.

Rejection of Social Responsibility Beyond Ones Reference Group

Rejection of social responsibility beyond ones reference group has a foundation in reality. Traditional cultures demand full reciprocity among members of ones primordial group. Realistic assessment of current need throughout the nation makes broadening of the scope of traditional social responsibility and reciprocal burden-sharing untenable. To share with all would leave one with nothing; the likelihood of reciprocation from such an anonymous group is minimal and in any case there are

not enough resources for everybody. That reliance on reciprocation from the government would be risky is evident from periodic news stories about pensioners who have not received their pensions.

Ethnic prejudice exacerbates this rejection of social responsibility. It also introduces a lack of trust on the part of the clients.

Lack of Universally Accepted Sanctions for Illegal or Unethical Behavior

Neither traditional nor religious sanctions are universally accepted nor have governmental sanctions effectively filled the gap. Traditional sanctions have been effectively undermined by colonialism and Westernization or Islamization. The traditional rulers and councils, the traditional secret societies, and the age groups have all had their power eroded. The modern religions are diverse and in some cases preach that people of other faiths are unworthy of God's blessings and should be forced to convert to their own religion. The legal system and police force lack the capacity to effectively and judiciously impose sanctions for illegal and unethical behavior; they remain underpaid and subject to pressure from the political/military rulers and the wealthy powerbrokers.

The Lack of Accountability of "Democratically" Elected Officials

It is unlikely that democratization of governance will increase the responsiveness of government to the people and their welfare. Democratically elected officials already govern at the LGA and state levels albeit hampered by central government control of their funding.

Elected officials must be responsive to officials in the federal government which is the major source of public revenue. Moreover, their parties were funded directly by the federal government, by a small number of enormously rich, power brokers, and by the candidates themselves rather than by contributions from the public. In multi-ethnic urban areas, migrants and their descendants usually are underrepresented in decisionmaking positions at the Local Government Area and as a consequence may be underrepresented as participants in public sector service delivery.

Lack of Incentive to Excel

Although many superb service providers and managers work in the public as well as the private sector, prevailing attitudes will impinge upon the success of any large scale program. In the majority of cases, government employees have insufficient incentive to excel. Management rewards conformity and support for management rather than performance which unfortunately is often not a major goal of management, especially in situations where performance bears little relation to remuneration. Employees have difficulty identifying with organizations that fail to pay a decent wage and/or have corrupt managers who divert resources necessary to the goals of the organization.

Nepotism and Influence as the Basis for Promotions and Perks

Managers are "big men" who have a responsibility to their respective communities which conflicts with and often takes precedence over their work responsibilities. A "big man" must share his wealth and power just as a traditional chief or head of a family or clan was expected to redistribute the yams or millet brought to him by his people; ceremonies and times of need provided the occasions for redistribution. Similarly, managers are under considerable pressure to provide innovative services, jobs, preferential posting and training to members of their family, village and ethnic group. These forces are frequently brought to bear by people to whom the big man "cannot say no" and result in the mismanagement of clinic equipment, supplies and service personnel.

Peer Group Pressure to Provide Minimal Service

Peer group pressure at the work site often discourages outstanding performance. Co-workers fear quality performance will induce clients to demand similar performance from themselves. Co-workers are reluctant to provide quality service partly because they are aware that they will not be rewarded for their extra work except with an anonymous thank you and an avalanche of demands. To raise the working standards would threaten the system of minimal work and invite anger and retaliation from colleagues.

Rudeness

The rudeness of civil servants including the service providers towards the public which includes the clients has multiple, mutually reinforcing causes. Service providers feel the psychological need to ensure that all involved are fully aware that their own status is in no way diminished by providing the service. They are sensitive to societal awareness that people are expected to serve their seniors in age and status; consequently, they attempt to place themselves in a position of authority as a preventive measure. Moreover, service providers are adopting the prevailing attitude of their employers and of their supervisors towards the public, an attitude of superiority and scorn that was established by the colonialists and has become part of the civil service psychology even though many civil servants have never seen a colonialist. These attitudes are reinforced by a lack of respect for those of other ethnic groups and for the weak.

Operations research has demonstrated the capacity of counselling training to motivate and empower the service providers to modify their interpersonal behavior and to improve the effectiveness of their family planning client counselling.

Necessity of Supplementary Income for Basic Needs

Public servants substantially supplement their inadequate incomes with private activities: selling cloth, jewelry or shoes, etc. to co-workers; contracting to supply items; providing professional services; and/or accepting or extorting bribes. Some civil servants manage by organizing their schedules to maximize per diem. Small amounts of money saved from workshops become important within the prevailing impoverishment.

Subordination of Goals to Human Relations

Nigerian society and individuals are more process-oriented than goal-oriented. This orientation is a constraint to NGO activities and to timely achievement of specific targets. Nigerians are reluctant to achieve goals at the expense of human relations; interpersonal relations and the process get paramount consideration.

Lack of Project "Ownership"

Although participants may perceive a "donor project" beneficial, when the project is perceived to be externally driven and beyond their control, the participants respond to their lack of ownership by continuing the prevailing attitudes to government employment. Their professional commitment and involvement remains minimal.

Transportation Problems

Expenses for vehicle purchase and maintenance for commodity distribution and supervision are excessive relative to Nigerian incomes and to effective service delivery. Vehicles are seldom adequately maintained and funding gasoline poses obstacles. Vehicles are at such a premium that they are often commandeered by government officials and diverted to other duties.

Constraints Imposed by Donor Ethnocentricity

Donor resistance to funding representational expenses undermines budgetary accountability because it leads to juggling of funds, which in turn makes it difficult to convince rank and file members to accept the argument that the grant document is a legal document.

In providing institutional support, certain sociocultural issues as well as donor attitudes and assumptions which impact on the motivation of NGO volunteers, have to be taken into consideration. Some NGOs with experience in fund raising and intervention activities have encountered the ethnocentric unwillingness on the part of the donors to make fund management correspond with the Nigerian norm for proper behavior. The reluctance to appreciate the place of cash incentives and representational expenses in community outreach activities within the sociocultural environment results in volunteers having to spend their own money for intervention programs, in addition to donating their time and skills. This tends to dampen their enthusiasm.

Extra-cultural inappropriate behavior on the part of expatriate consultants is overlooked but it is less likely to be accepted from a Nigerian. Acceptance varies depending upon how close the Nigerian is to the specific culture and how close the culture is to the traditional life style.

Underutilization of Public and Private Sector Clinics

Since the introduction of drug and service fees in public sector clinics, their clientele has diminished. Reports from clinics and the public suggest that without the incentive of free drugs, people are unwilling to experience the disadvantages of public clinics (including long waits, loss of privacy and inconsiderate service

provision) and would rather self-medicate at a chemist shop with a profit-oriented teenage salesperson or visit a nurse or traditional healer. The SAP-induced drastic reduction in disposable household incomes has also affected private sector clinics. They have experienced reductions in their patient load and increasing problems with payment defaulters. Anecdotal reports suggest that economic constraints induce patients to forgo some of their prescribed medicines.

SOCIOCULTURAL INFLUENCES ON FAMILY PLANNING⁶

FAMILY PLANNING CONSTRAINTS

Desire for More Children

The major reason for non-acceptance of contraceptives is the desire, expressed by 47.1% of fecund women in the 1990 NDHS, to have more children.

Parents deeply desire to be survived by and buried by their children. They also desire children for security in old age and for their contributions to the family welfare including the welfare of their siblings. Many men, but especially the women who are threatened by polygamy, desire children to ensure support in their old age. Their incomes are insufficient to provide savings and there is no social security system. Moreover, the rampant inflation renders pensions meaningless for the few who are eligible.

Large numbers of children improve the chances of social and financial security for both parents and children. Parents have many children partly in the hope that at least a few will be lucky enough to be successful and will provide financial security for the rest of the family. Siblings provide a chain of assistance, helping to support and educate their juniors. They also ensure better reciprocal support and security throughout life than can be expected of non-sibling relatives, especially with the breakdown of the communal lifestyle of the traditional family. However, studies show that younger children expect to receive less from their own children than has been the social custom.

Large, Family-Size Desires

Most couples desire many children, with four the minimum desired number. The desire to have children, as many as God grants, is a fundamental traditional value which is reinforced by Christianity and Islam. Christianity's support for a large number of children per couple is based on the old testament injunction that exhorts the faithful to, "Go ye, multiply and replenish the earth." The Moslems follow the Prophet's injunction, "Give birth to many children so as to increase the number of followers." Traditionally, all ethnic groups believe in many deities who, if reverently worshipped, bless adherents with children.

A Fatalistic, Religious Attitude Towards Family-Size

Non-numeric responses indicate the widespread fatalism associated with childbearing. The prevailing belief is that children constitute a continuous flow of gifts from divine providence and, as such, none should be refused. It is believed that women have no freedom to choose; it is a choice best left to a Deity or deities. Consequently, the ideal or desired family size is not numerically well defined. Some Igbos believe that

⁶Please refer to the section above entitled "Contemporary Religions" for a fuller development of religious views of family planning.

the deity has already placed their children in the womb waiting to be born. These beliefs underlie the traditional aversion to specifying actual numbers of children alive or dead.

Conformity to Perceived Societal Opposition or Disapproval

Perceived, societal opposition or disapproval greatly inhibits contraceptive use because the basis for social change is consensual decisionmaking. Many women endure the consequences of their unmet need for contraceptives rather than expose themselves to the dangers of non-conformity. The socialization process has not prepared them for taking sole responsibility for a controversial decision, especially one that may in any way threaten their ability to procreate. Nevertheless, many women engage in clandestine family planning in both rural and urban areas. Because family planning has not been culturally acceptable, most couples who use contraceptives desire secrecy.

Early Marriage

In the Muslim North, girls are married off extremely young to prevent premarital loss of virginity. Some are even married prior to puberty and many at the onset of puberty. The median age for first intercourse is fifteen years of age and has not been rising.

Parental concern about the possibility of premarital pregnancy in the early teens is a realistic concern. Hausa/Fulani girls begin flirting at age ten and in a rural Zaria area virtually all are married by age fourteen thereby pushing the prevailing age of sexual interest and activity four or more years earlier than in other areas.

Women's Desire for Excess Children in Order to Preserve a Monogamous Marriage

A woman often desires excess children as a way of retaining her husband by sexually enticing him since the rationale for sex within marriage is additional children. Women also believe social pressure will make it difficult for a man to desert a woman who has given him many children. Furthermore, some women hope that the increased financial burden will prevent him from taking on the responsibility of another wife or will prevent another woman from desiring him as a husband.

Serial Marriage, Male Domestic Arrangements with Outside Wives, and Male Remarriage Late in Life

Since each new marriage must be actualized by the birth of children, various patterns of multiple partners contribute to increased child bearing. Serial marriage for both men and women is an Islamic norm and is also practiced in some other ethnic groups. Many husbands take up "outside wives" with whom they set up a home and have children while retaining their original court marriage. Among some ethnic groups, the ideal pattern for the male is to remarry after age fifty, partly in order to ensure caretakers in old age.

Probability of a Baby-boom in the North

In a rural Zaria study in 1990, the desired number of children was 8.4 but when asked to take into account the current economic situation the number was reduced by one child to 7.4. This is a larger family-size than most northern women have been achieving, leaving room for a baby boom in the North once the level of medical care improves.

Preference for Male Issue

The vast majority of Nigerians belong to patrilineal families which desire male issue to ensure the continuity of the family line in an environment where familial extinction occurs and examples can be cited. Male children also bring honor to their parents particularly at burial. In the rural setting, a high number of children, especially males, gives the lineage access to land and political power. Societal pressure for male issue is such that virtually no one really disapproves of a man in a companionate, registry marriage who succumbs to familial pressure and takes another wife in an effort to obtain male issue. The Hausa/Fulani woman's desire for equal numbers of girls and boys is notable and perhaps related to the financial assistance the children, especially girls, provide as hawkers on her behalf.

Protection of the Husbands from the Impact of the Economic Rationale

Among all cultures, the wife's income is expected to supplement the husband's in times of need; consequently, men are protected from the economic crunch for much longer than women. In competitive polygamous situations, the wives' contributions can be substantial and, in the case of a lower class man, wives may bear virtually all the expenses for their nuclear family. With pervasive poverty, the wives' share has increased significantly even among women in purdah. In the rural areas of the Middle Belt, many husbands have absconded from the rural hardships and child care responsibilities by running off to the city where they work as wage laborers spending all their meager earnings and contributing little or nothing to the support of their wife and children.

Islamic Non-Responsiveness to the Economic Rationale

Despite crushing economic conditions and increasing difficulty in obtaining adequate food, Muslim men in many areas are unresponsive to family planning messages based on hunger or poverty. Among Muslims, their faith dictates that Allah will provide.

Avoidance of Interspousal Communication on Family Planning

A 1990 urban-based survey of innovators in the four zones established that 23.5%, with almost fifty percent among the uneducated, refrained from inter-spousal communication about their family planning intentions or practices. Women with more surviving children, and more sons, are less likely to seek the approval of their husbands before visiting a clinic. Another 1985 rural-based study among the Yoruba indicated that only seventy-two percent of spouses have ever discussed their desired number of children. Among the innovators who discussed family planning with their husbands, about thirty percent reported that the discussion was initiated by their husbands.

Clandestine Use of Marital Contraception by Wives

Female innovators are increasingly using contraceptives for their marital sex in spite of their husbands' opposition. In both urban and rural areas, the increased economic burden of children on the women is seen as the main factor.

Some clandestine, marital contraceptive use has the tacit approval of the husband. Young couples prefer that the wives remain in the marital bed rather than removing themselves to their mother or mother-in-laws as was the traditional practice. The wives want to prevent the husband from straying to other women or possibly taking a second wife and the husbands no longer have the patience for postpartum abstinence. In such situations, some wives decide to use family planning clandestinely; however, as one Berom woman pointed out, the husbands must realize that they are using some form of contraceptive because they are no longer getting pregnant. Apparently the husbands prefer to appear to be in control and save face by not acknowledging that their wives use contraceptives while continuing to enjoy unrestrained access to their wives.

Clandestine, Extra-Marital Contraception

The association of contraception with marital infidelity undermines efforts to gain societal approval for contraception. Clandestine use without spousal knowledge occurs frequently and must constitute a substantial portion of users. Men have long used contraceptives or paid for abortions for extra-marital relations that they kept hidden from their spouses. Some married women have been their own sexual partners, thereby contributing to male opposition to contraceptives for their wives.

Cost

The cost of family planning services is an obstacle to poor women who wish to practice family planning without their husbands' knowledge and to women who are dependent upon their husbands' resources.

Counterproductive Role Models: Successful Males

Most wealthy men have imitated traditional, wealthy men by marrying additional younger women and fathering additional children. In some cases, these men marry clandestinely, without the knowledge of their spouse.

Fear of Infertility Resulting from Contraceptives

Fear of modern contraceptive devices is very real to the Nigerian woman. She fears the physical effect on her womb. She fears for her reproductive capacity as a woman and for the state of health of the children she will conceive after the contraceptive use. Her fear of barrenness in one's lifetime and even beyond to future reincarnations influences her rejection of sterilization. She also fears deviating from the societal norms in general.

Fear of Rumored Actual and Non-existent Side Effects

Women reject family planning for numerous actual side effects including heavy bleeding, lack of menstruation, hypertension complications, weight gain and the

messiness of foaming tablets and jelly. They also fear non-existent side effects including a mobile IUD travelling throughout the body, illness caused by using family planning after childbirth and reincarnation as a sterile woman.

Male Disapproval and the Need to Specifically Target Males

Men have only recently been targeted with IEC through PPFN spots on television and radio. Males lack an acceptable source of contraceptive information except for condom advertisements. Most would be embarrassed to seek out information from clinics since they are associated with female methods. Consequently, much of their real and/or assumed opposition to family planning is based on ignorance. Many men who are psychologically discomfited by loss of control over their wives, oppose family planning because they perceive it as a woman's misplaced desire for control over their family affairs.

Men are preferred as family planning communicators to males not only because they can serve as role models but also because for many men, the women are less effective or even counterproductive. Such men perceive a woman's desire for family planning as a desire to be "free like a man" from the burdens of pregnancy. Post-menopausal women who have become like a men are often given male prerogatives. This fear of female desire for "masculine freedom" is especially strong when the message is coming from female relations.

Lack of Information about Family Planning Methods

In a 1990 study in rural Zaria, only twenty percent had information about how to use family planning and fifty percent reported that they did not use child spacing because of ignorance. In the 1990 NDHS, only twenty percent of the women of reproductive age knew the correct fertile period. One third believed that the fertile period occurred immediately following menstruation and another third admitted their ignorance. Although these figures must have improved between 1990 and 1992, ignorance and insufficient information to induce people to come forward and request child spacing and limiting assistance remains a problem.

Restricted Reach of Clinics as a Source of Knowledge

That the major sources of significant knowledge capable of generating selection of a contraceptive remain the clinics and health facilities (over sixty percent) partially explains the number of uninformed, fecund women. The number of service providing clinics is inadequate. Furthermore, clinic clientele is basically restricted to women with children under three or four years of age. Thus, neither adolescents nor other non-married women are within the clinic reach (except perhaps in cities where anonymity is possible). Moreover, women who no longer have small children because they have succeeded in limiting their offspring for several years through a less efficient methods are also for practical purposes not within the clinic reach.

The Lack of Reproductive Health Information for Teenagers

The lack of either in-school or out-of-school reproductive health information for teenagers puts them at unconscionable risk. Many parents and schools especially, but

not only, in the North including the Middle Belt will not permit adoption of the Population/Family Life Education (POP/FLE) curriculum which was designed to promote acceptance of the small family.

Even in the schools where the curriculum is not actively opposed, the potential for replicability and sustainability is undermined by the innovative, intervention methodology. Teachers who have been trained for two weeks by master trainers are expected to prepare original lesson plans on the basis of a booklet of guidelines despite the fact that teachers are demoralized because of inadequate salaries and excessively large classes. Moreover, both the methodology and the values clarification modules emphasize assisting students to think for themselves whereas the society prefers that youths abide by the dictates of their elders.

Disruption of Commodity Supplies

Serious shortages of commodity supplies at both federal and state levels have disrupted service and caused commodity substitutions and discontinuance. The causes are mainly managerial (e.g. under-estimation of need and consumption levels), absence of back-up arrangements to replenish supplies, maldistribution and delay in approval of funds.

Opposition of the Catholic Church to Modern Contraception

Although the Catholic Church actively promotes spacing and limitation through the Billings Method, only 8,000 people (including many husbands along with wives) have been taught the method after several years of active training using a core of trainers in sites throughout the country and regular promotion over the radio in some states. Moreover, not all trainees have successfully learned and sustained use of the technique which is complex and requires considerable active commitment.

Muslim Opposition to Family Planning

A large body of vocal Muslims consider family planning a Western and Christian plot to exterminate Muslims or at least to reduce their numbers significantly and prevent them from multiplying and having political control over their own destiny. This belief has been imbibed at the grass roots level.

Politicization of Religion and Family Planning in the Far North

The support of religious leaders would greatly enhance the child spacing programs because their combined, moral authority reaches almost every citizen. Their support would legitimize child spacing which is now largely practiced clandestinely, thus greatly facilitating increased contraceptive use. However, it would be inadvisable at this time to enlist the support of amenable Christian leaders in the North without simultaneously enlisting the support of the Muslim leaders. Concerted Christian support for child spacing may well harden Muslim opposition. Many Christians might also take up a political perspective, opposing the intervention largely because the Muslims were left free to procreate and increase their political power in the area.

The Influence of Conservative Religious Leaders in the Far North

The social order in the far North is maintained by means of patronage and coercion; both methods are underlined and supported by the system of education and religious belief. Through a monolithic hierarchical system sanctioned by Islam, the Northern traditional rulers maintain a very strong influence on the common people's values, especially the values of those above twenty-five years of age. Since the traditional rulers legitimize their rule through Islam, they are strictly governed by the interpretations of the Koran and the Islamic traditions which are provided by the most respected, and, hence, elderly and usually conservative imams. Since Islam is an all encompassing religion, dealing with both family and governmental issues, Islam determines behavior with respect to controversial life-style issues.

This monolithic structure is currently being threatened by sociocultural transformations that make it simultaneously more amenable and more resistant to change. It is being undermined by the subdivision of the North into smaller states, by Western education of all the elite and many commoners, by the rise of fundamentalist Islamic sects partly fueled by the inability of the system to satisfy the basic needs of the population, and by the inability of the system to absorb the huge population increase.

In addition, religion is being exploited in the North to ensure the political support of all social classes.

Lack of Effective Support for Family Planning from Traditional and Religious Influentials in the North

In the Far North, conservatism, ignorance and fear of having to take the burden of everyone's action contribute to the reluctance of mallams and traditional rulers to promote modern techniques of child spacing. They have no desire to be blamed for any impairment of fertility at the personal level, nor for any relative reduction of the Muslim population at the political level. They also recognize that their credibility may be challenged.

Unfortunately, commoners in the Far North will be reluctant to challenge their religious and traditional leaders who are perceived to be opposed to family planning on religious grounds. They vaguely cite the authority of a mallam from Sokoto or someplace else and are unwilling to take responsibility for interpreting the Koran themselves. A recent study revealed that some persons aware of their own unmet need would willingly adopt family planning if a doctor required it on health grounds or a mallam recommended it.

Establishing the Credibility of an Influential

Rapid ethnographic studies and/or interpersonal networking will be essential to confirm that leaders are actually representative and credible influentials. Due to the pervasiveness of corruption in Nigerian society, the people's perception of influentials has undergone radical modifications in some areas. For instance, in Nteje and Ngwo communities in Anambra and Enugu States respectively, the majority of the

individuals interviewed failed to perceive religious leaders as individuals who can influence their behavior toward family planning and improved child and maternal health. They rejected the credibility of these influentials. Most of those interviewed were of the opinion that some of these influentials were corrupt and therefore had no right to tell them how to act. Instead, they named influentials of their own choice within their communities from whom they would like to learn about modern family planning and child survival techniques. The distinguishing characteristics of those named include honesty, education, hard work, respect and a demonstrated sense of communal responsibility.

The credibility of the emirs and royalty in the North with respect to family planning has been seriously questioned by northerners in the not so distant past. About five years ago the National Population Bureau sponsored a conference at Ahmadu Bello University that backfired upon the establishment. Radical lecturers arranged for simultaneous radio and television transmission of the conference and used that platform to transform family planning into a class issue. The radicals included Usman Bala Usman, a highly respected, radical historian from the Katsina royal family. These lecturers condemned the wealthy establishment for trying to make the lower classes limit their family size while the wealthy themselves continued to father many children. They named the numbers of wives, children and in some cases concubines of the influential northerners and emirs whose families were being supported from the government purse while they were exhorting the commoners not to have more children. They declared that Nigeria had enough money, food and land to care for everyone's children if it were properly distributed. They further countered the argument that poverty was leading some uncared for children to theft by affirming that the children of the wealthy were the true criminals, stealing from the government on a regular basis.

Ambivalence Among Staff and Decisionmakers

As members of the larger society, many of the program implementors, especially junior level health staff, and many of the decisionmakers who must give the program strong support if it is to succeed are themselves ambivalent about the program's fertility reduction aims.

The Probable, Low Priority Status of Family Planning Under Democracy

Elected politicians are less likely to give high priority to an interventionist population policy because of its limited constituency and few visible short-term results.

Importance of Population to Revenue Allocation at State and LGA Level

The horizontal revenue allocation formula is now: equality among states (40%), population (30%), social development factor (10%) and land mass/terrain (10%). Thus, relative population growth impacts significantly on revenue allocated to states and LGAs. Consequently, some LGA and State level officials may decide to block family planning activities in order to increase current and future income exists.

The Dearth of Family Planning, Cost-Benefit Analysis Information for the LGA Level

The dearth of family planning, cost-benefit analysis information for the LGA level impedes progress towards PHC integration of family planning and development of sustainable public sector referral systems. The cost-benefit analysis provided by RAPID modelling for the national level is not directly applicable at the LGA level. Moreover, any LGA level, cost-benefit analysis must take into consideration the fact that a significant proportion of the LGA funding (30%) disbursed by the federal government is based directly on population size.

The Financial Impossibility of Achieving the Population Policy Targets

In 1991 the World Bank estimated that a forty-five percent Total Fertility Rate (TFR) is required to achieve the Population Policy targets and that following a Population Council formula, approximately \$US200 would be required annually throughout the rest of the decade. This amount greatly exceeds commitment by international donors and the difference is unlikely to be assumed by the government. In the past five years, population activities have been allocated only 1.3% of the MHSS budget.

Necessity of Rapid Ethnographic Studies Prior to Interventions

Given the heterogeneity of Nigerian societies and the variable influence wielded by religious and ethnic leaders, rapid ethnographic studies are essential to identify appropriate intermediaries and influentials as well as to identify possible message modifications. The WHO focussed ethnographic study (FES) developed to examine cultural perceptions of specific diseases are suggestive of appropriate methodologies. As with the FES, rapid ethnographic studies should rely on focussed group discussions and in-depth interviews with minimal participant observation; however, the focus should be broader in scope in order to encompass potential communication avenues and messages.

Such studies will also provide the opportunity for identifying individuals who may serve as role models and "anti-role models", examples of people who suffered because they lacked the benefits of the interventions. Although the time lag between prevention and benefits mitigates against finding role models for intervention successes, all curative benefits and some preventive benefits will be identifiable such as the virtual eradication of measles in small communities with complete coverage.

FACTORS CONDUCTIVE TO FAMILY PLANNING

Contraceptive Prevalence Increases Reported by the 1992 FOS/FPS

The September 1992, Federal Office of Statistics, Family Planning Survey (FOS/FPS) reported that the contraceptive prevalence rate (CPR) for Women of Reproductive Age (WRA) is now 20.2 %, having risen from 7.5 in the 1990 NDHS. The CPR for married women using modern contraceptives has risen to 8.3% from 3.5% in 1990.

Use of non-modern methods, largely periodic abstinence among married women, has risen to 7.1% from 2.4% in 1990.

The order of magnitude of current, family planning can be estimated based on the 1991 CCCD Management Information Survey estimate that there are 17,702,900 women of reproductive age. Over three and a half million women of reproductive age are using some form of contraceptive. Approximately one and a half million women are using modern contraceptives and another one and a quarter million women are using periodic abstinence.

Profile of Most Likely Contraceptors According to 1992 FOS/FPS

By far the most likely contraceptors are the educated elite. Close to a third of the women with post-secondary education are using modern contraceptives and about another fifth are using a traditional method (periodic abstinence), probably for religious reasons. Thus 52% of the educated elite were using some form of contraception. They are closely followed by women who have completed secondary school with 28.1% modern use and 43.4% total use. Contraceptive use increases steadily with increasing level of education from two percent of women with no education to more than one-quarter (twenty-eight percent) of those who have completed secondary education.

Other attributes of the contraceptors follow common patterns. Urban and peri-urban dwellers are about twice as likely to be contracepting. The percentage of modern method use was generally higher for never married women than for other women. Women between the ages of 20-34 years had the highest percentage of modern contraceptive use. However, only a small minority of teenagers were contracepting.

Dramatic Rise in Knowledge Reported by 1992 FOS/FPS

Knowledge has risen dramatically almost doubling within two years to 83.1% of WRA. The knowledge gap between the North and the South has also been reduced with less than twenty percent of the population left ignorant of a family planning/child spacing method.

The Success of Family Planning in Ibadan

A 1989 CODESIRA supported study of a sample of 1,552 women, half from Ibadan and half from the surrounding rural area, established an urban, modern contraceptive prevalence rate of 47.5% and a rural rate of 8.4%. Significantly, the Family and Reproductive Health Association Clinic at UCH, Ibadan which benefits from effective IEC and a CBD referral system, has a dedicated staff and a longer history than most clinics. Perhaps similar demand creation can be achieved elsewhere.

Promotion of Child Spacing

Promotion of child spacing, rather than family planning, is responsive to health concerns of the people and allows more citizens to adopt modern methods of contraceptive use. The child spacing intervention offers the potential to internalize activist attitudes towards fertility management as opposed to passive acceptance of

fate or God's will. It also legitimizes dissemination of contraceptive knowledge in the public and in forums where family planning advocacy would be impossible. To the extent that child spacing encourages maintenance of the conjugal bond, it may reinforce the nuclear family in face of increasing destabilization forces. In so doing, it may reduce women's competitive desire for additional children in order to retain their husbands by satisfying their perceived fertility desires and that of their in-laws.

The child spacing approach will ensure that effective knowledge rather than mere awareness reaches into the masses carrying the program beyond the innovator stage. Even though the dictates of some churches emphasize faith and prayer allowing active child spacing only through the Billings method, they introduce the concept of active, conjugal control over reproduction as opposed to abstinence. Those churches which allow contraceptives as a back-up method will provide another avenue for gradual introduction of the techniques and at least the spread of more concrete knowledge.

Urban-based Willingness to Limit Children

In a 1990 survey of urban-based active spacers, sixty percent said they would stop at four living children without accepting money and fourteen percent said they would accept money and stop. However, only twenty-three percent said they would not stop regardless of the amount of money government paid as an incentive.

Increasing Acceptance of the Economic Rationale for Family Planning

The economic crisis and ensuing diminishing purchasing power has provided the basis for an economic rationale for family planning, especially among men and women whose expectations had risen during the petrodollar boom. A survey carried out among Yoruba women in Ife early in the recession in 1987 demonstrated a genuine reduction in average desired family size from a Nigerian average of 8.36 down to 4.96 as a result of the combined effects of modernization with its concomitant higher costs for children and the economic recession. Among all socio-economic groups, desired family size declined by as much as three to four children between the 1981/82 Nigeria Fertility Study and 1987. Nevertheless, only 11.7% of those women desiring no more children were practicing contraception.

Anecdotal reports from private clinic owners indicate that urban Igbo women have begun to act on the realization that the honors traditionally accorded multiparous women are irrelevant to themselves and their children in this depressed economy. Previously, they enjoyed at least six months of relative rest and honor after the birth of a child during which their husbands outfitted them and their mothers in new clothes while their mothers took over many of their domestic duties. Since the economic crisis, such pleasures have become luxuries in the face of the need to purchase sufficient food and provide minimal clothes and books for school. Instead, additional children bring economic responsibilities that hitherto had been shouldered by their husbands who can no longer cope. Women in other cultures have also reduced their family size preferences.

Rural women with aspirations for their children are also beginning to reduce their family size desires because of the educational costs and the fragmentation of the land due to the rapid population increase.

Elder Children's Admonition That Parents Limit Their Issue

When parents or fathers continue having issue after the eldest have become young adults, these youths admonish their parents to refrain from begetting more issue. They recognize that they will be expected to support the children born late in their parents' life.

The Potential for Family Planning Advocacy and Education in the Churches

Advocacy and education within each church according to its own dictates will allow the faithful to embark on authorized behavioral change moving them from pronatalists to family planners without expecting them to deviate from the teachings of their respective churches. Some churches will confine the intervention to spreading the practice of active family planning using scientific knowledge (Billings, rhythm and to a lesser extent withdrawal) while others will promote contraceptives. The faithful will trust and follow the guidance on child spacing and/or limitation methods which is given by their ministers or by influentials in their Bible fellowships and social/charitable organizations. To the extent that techniques are adopted within groups, they will extend to many more users. The innovators within a group will serve as the group's role models ultimately increasing the numbers of role models throughout society.

The Potential for Advocacy in the Ethnic-Based Development Associations

In the minority areas of the Middle Belt, ethnic-based development associations can be used to target males and females within their gender segregated branches. Such associations bring the more enlightened, educated people together with the uneducated, impoverished men. Child spacing can be promoted in terms of the welfare of the community and in terms of male control over their wife's fertility to ensure conjugal pleasure and well-spaced, healthy children. These organizations have their own information channels and could be relied upon to nominate a male promoter to provide information and CBD community outreach so that men would not have to rely on their wives to purchase subsidized condoms.

Maternal, Altruistic Love

On account of the maternal, altruistic love for their children and the strong mother/child bond in contrast to the weaker husband/wife bond, many women will space and/or limit their children regardless of the consequences to their conjugal life.

Integrated Services

Integrated Services are preferred by women with children because they can solve several problems simultaneously. Furthermore, they permit the wives to camouflage their trips to the clinic as trips to care for their children.

Male Desire to Avoid Having Disreputable Children

In the traditional setting, no man wants the shame of fathering disreputable children who are irresponsible and roam the streets; yet this phenomenon is occurring increasingly in the rural as well as the urban areas. If a man has too many children and is unable to train and control them, he may regret his large family size. He may also serve as a negative role model for others.

Existence of Hausa/Fulani Innovators

Despite the conservatism of the Far North, the small number of family planning innovators includes the commoners as well as the elite. Young Kano City Hausa/Fulanis who have chosen to break away from the family compound and found nuclear family residences in the suburbs of Kano are among the innovators. They have come in contact with Hausa traders from other parts of Nigeria who reside in the vicinity and have broadened their worldview.

The Reliability of Educated Hausa/Fulani Wives

Survey and research findings indicate that contrary to the prevailing belief, educated Hausa/Fulani women are more reliable as wives and mothers; they remained married longer and divorced less frequently than their unschooled counterparts. Moreover, their knowledge of, belief in, and ensuing use of modern preventives and curative health measures and services enabled them to survive longer and produce more surviving children than their counterparts. The NDHS survey clearly indicates the correlation between lack of education and both stunting and wasting which are caused by a combination of under- and malnutrition complicated by the effects of illness.

The Role of Traditional Rulers in Project Interventions

Traditional rulers, most of whom are now well educated, have the power to mobilize or inhibit community action in support of project interventions.

The Moral Authority of Traditional Rulers

Traditional rulers have the power to legitimize family planning/child spacing and anti-AIDS interventions thereby obviating stigmas that may be attached to the act of becoming an acceptor. When a traditional ruler as the senior authority in the community authorizes and encourages the use of child spacing by technical means, an acceptor can always refer to his authority when defending her decision. The acceptor need not take full responsibility for the decision; the decision becomes one of a loyal follower rather than an individual deviating from the group norms. Moreover, the authority protects the acceptor from condemnation as a non-traditional woman or promiscuous woman.

Respect for Medical Advice

Neither grassroots service providers nor their clients desire to take responsibility for innovative decisions; however, the Nigerbus Surveys indicate the public's readiness to accept the advice of doctors and to a lesser extent other healthcare personnel. Development of a protocol for grassroots community-based distribution (CBD) endorsed by the Society for Obstetrics and Gynecology of Nigeria (SOBGYN) and distributed with the authorization spelled out as an authorization by medical doctors specializing in childbirth and its complications will instill greater confidence in the potential clients.

Persuasiveness of International Professional Organizations

The authority of international professional organizations can be helpful in overturning medical and governmental resistance to public health measures. For example, the International Confederation of Midwives actively supported adoption of Safe Motherhood Initiative (SMI) which calls for midwives to perform medical procedures normally reserved for doctors. The International Federation of Gynecology and Obstetrics (FIGO) accepted the Safe Motherhood Initiative and brought it back to the national body. Without the medical authority of the international body, sensitized doctors and midwives promoting SMI would probably have been unable to overcome opposition from colleagues already concerned about their dwindling incomes and reluctant to share prospective patients with midwives.

SOCIOCULTURAL INFLUENCES ON HIV/AIDS PREVENTION

CONSTRAINTS TO HIV/AIDS PREVENTION

Denial of the HIV/AIDS Threat

Although Nigeria has reached the lower point of the rising exponential curve of the HIV/AIDS epidemic, most people deny that HIV and their personal behavior poses a risk. Some even call it the "American Institution to Discourage Sex".

Misunderstandings on the Nature of HIV and AIDS

Nigerians are becoming increasingly aware of the existence of HIV infection and AIDS. Nevertheless, the disease remains strange and incomprehensible to many. The relatively low number of Persons with AIDs (PWAs) still leaves doubts in the minds of people as to the veracity of the existence of AIDS and of HIV infection in the country.

In a sociocultural environment in which scientific knowledge is still traditionally limited to what can be seen and felt, the concept of an incubation period and the notion of long term, healthy carriers are difficult to explain and to grasp. In nearly all Nigerian languages, local terms for HIV infection and AIDS are yet to emerge. The disease is still being described as "a new disease", "a disease that kills", "a disease without cure".

The Two Levels of High Risk Targets

African societies have two levels of high risk: 1) the standard high risk groups which might better be termed the super high risk groups--the CWSs, long distance truckers, STD patients and homosexuals--who by virtue of their profession, their illness and/or the nature of their sexual activity have a greater chance of contacting and spreading HIV from the smaller number of introduced cases at the early stage of the epidemic than the general population and, 2) the general sexual networking population.

High-risk behavior is not segmented in the society; rather it is integral, if somewhat clandestine, to social networks that involve at different times in ones lifetime, nearly all individuals including respectably married individuals. Although some subsections of the general population are more easily targeted such as the military and the students, the general target population is amorphous and fully integrated into the larger society. Moreover, in sheer numbers it is greater than the more easily targetable audiences with which many of its members interface sexually.

The Extensive Sexual Networking

Aspects of the Nigerian culture influence people's attitudes and behavior in ways that lead to high levels of sexual activity. Male promiscuity and male extra-marital affairs are widespread and tolerated tacitly. The continued belief that long periods of postpartum female sexual abstinence are obligatory for health reasons induces husbands to engage in extra-marital relations. The widespread practice of polygamy increases the spectrum of those involved in multiple sexual relationships. The

traditional, transactional element to sex coupled with deteriorating economic conditions is forcing more and more women to engage in multiple partner or casual sexual relations in order to obtain resources and access to opportunities for furthering economic and social ambitions.

The existence of homosexual activity and male, homosexual commercial sex workers (MCSWs) in some areas further compounds the risk factors for HIV infection among spouses and the general population. Though a very sensitive issue, it is common knowledge within at least one society that homosexuality and bisexuality is practiced, particularly among men in the more affluent and aristocratic circles. As a consequence of their status, these men usually have many dependents.

Another risk-compounding factor is the growing trend of adolescent sex. Rapid social change and modernization has engendered increased educational opportunities and resulted in delayed age at marriage while simultaneously undermining parental and societal control over teenagers. Furthermore, the early onset of menarche for female youth deriving from healthier diets has placed girls at risk at a younger age. Of the sexually active teenagers, sixty-five percent of the females and eighty-one percent of the males had sex at least once but not more than three times in the previous month. This rather high level of sporadic sexual activity suggests a high level of impermanent relationships and the likelihood of multiple partners. Thus, these youths are at a high risk for STDs including AIDS.

Different patterns of sexual activity with differing motivations exist and have different implications for social policy. For some young women (married or single), sex is a rational means to a goal; for others not only sex but even pregnancy are instruments for attaining personal advancement and for accessing resources and opportunities for social advancement; for yet another category (particularly adolescent girls) sex is a casual, spontaneous activity. The different motivations for sexual activism among men and women will need to be identified and understood for each target group or sub-population in order to design appropriate IEC messages capable of motivating behavior change.

Commercial Sex Workers and Their Clients

Commercial Sex Workers (CSWs) operate at many levels and both as full and part time sex workers: as residential CSWs working out of hotels or compounds where they have designated managers and rules and regulations; as street walkers and "club" CSWs who meet men at Five Star Hotels; as rural market-based CSWs attending periodic markets; and, as community-based CSWs who work out of their own homes. Homosexual sex workers are usually sent for by their clients through intermediaries.

Itinerant CSWs and Rural Markets in the Chain of HIV Transmission

Itinerant CSWs activity occurs at rural markets. The CSWs arrive for the market day from booking into the local "hotels" adjacent to the market which are mainly for their use, being underutilized during the rest of the week. Rural dwellers bringing stock or produce for sale to wholesalers spend some of their newly acquired disposable

income on the CWSs. Since they desire confidentiality, the hotels provide numerous entrances allowing discrete movements. This pattern has been identified in most rural markets in Benue State and in the bigger wholesale markets in Kano and Jigawa states. Further research may establish that this itinerant form of commercial sex working which reaches out to the rural areas also threatens the health of families in other states.

CSW Practice of Leaving Their Place of Origin to Work

Because of the social stigma connected with their profession, the majority of CSWs leave their place of origin to work. Many CSWs consider themselves temporarily employed as CSWs in order to earn capital for another enterprise. Many of the Badagry CSWs were married and their families' were under the impression they were trading. Igbo CSWs in Ado-Ekiti befriended their clients who failed to realize the CSWs had husbands and children elsewhere. The CSW sentinel survey in Hadejia, in which police-coerced, linked samples were taken, indicated that a high proportion of the CSWs were actually indigenes of Benue State.

Patterns of CSW mobility must be established and related to seroprevalence data.

Poor Birthing Practices of Traditional Birth Attendants

Traditional birth attendants who assist the majority of births often place their hands within the mother's vagina and always deal with the afterbirth, all without gloves. In addition, they cut the umbilical cord with unsterilized equipment. These TBAs are at risk of acquiring the HIV virus from one of their clients and of passing it on to many of their clients.

Beer Drinking and Sexual Networking

Drinking of locally brewed beer is a prime source of pleasure in many traditional cultures. Beer drinking and socialization form one of the major attractions of rural markets. Where men and women drink together, the social barriers to extramarital sex become less effective.

Hypocrisy About Clandestine Sexual Networking

The covert nature of sexual networking in the Far North as well as the deep-seated hypocrisy about sexual matters may constitute an obstacle to effective IEC activities and to public education.

The Relative Inaccessibility of Muslim CSWs

The commercial sex workers (CSWs) in the Islamic and traditional settlements in the Kano metropolis are relatively inaccessible. CSWs in Sabon Gari, the part of the city where southern Christian Nigerians reside, usually live in brothels and are easily accessible. However, in Fagge, Brigade and Hotoro, the CSWs live in gidan matas (women's houses) but do not usually receive clients in the houses. Rather, Yan Daudas (a type of pimp) link them up with potential male clients who then take the CSWs to other locations (usually the hotels in Sabon Gari) for sexual intercourse.

In order to reach this category of CSWs, the pimps/Yan Daudas and the magayiyas (older women in charge of the gidan matas) must be used as intermediaries.

Hypocrisy and Cultural Sensitivities About Open Discussion of Sexuality Issues

Hypocrisy and cultural sensitivities about open discussion of sexuality issues prevails among virtually all groups. Community leaders must be sensitized to the problem of HIV/AIDS in their communities in particular and in the country in general. Failure to do this might reinforce prejudices and misconceptions (particularly as the project involves a condoms promotion campaign) and could cost the project potential allies and local institutional and political support.

Religious Opposition to Condoms

Religious people and community leaders tend to believe that promoting the use of condoms encourages casual sex and extra-marital relationships. This belief is a potential source of opposition to condom promotion. Such opposition could, however, be overcome not only by involving beneficiaries in the development of IEC messages but also by the careful introduction of condoms as a secondary option to abstinence and mutual faithfulness.

The Physical Conditions of Dwellings are Conducive to Virus Spread from Terminal AIDS Patients

The home where terminal caretaking occurs is a potential site of mass infection. All family members participate in caretaking including children. The lack of running water for rinsing soiled cloths and toilets for disposal is compounded by the financial incapacity to purchase luxuries like bleach and other disinfectants on a regular basis or sufficient soap and fuel to sterilize by boiling soiled wrappers and clothing. Moreover, the overcrowding increases the possibility of contact with contaminated fluid and cloths.

Most HIV Positives are Lost into the Community

Currently most HIV positives are lost into the community where they continue spreading the virus because they have no awareness that they themselves are contagious. Testing to date has been for the use of the testers, whether the government or researchers. Hospitals lacking test sites lack follow-up personnel. The sentinel surveys which provide current data on prevalence rates lack the personnel and funding to provide pre- and post- test counselling and long-term follow-up of HIV positives. Some blood samples have been taken without proper identification or with intentional misinformation in the case of some professional blood donors. Some CSW blood donors who have cooperated by allowing their blood to be sampled were not informed of the purpose of the testing nor were they given the benefit of being informed about their positive or negative status.

Culturally, medical personnel and family members are extremely reluctant to inform anyone of an untimely terminal illness. Individuals themselves prefer to remain ignorant of such a calamity. Moreover, it is standard practice for medical personnel

to treat patients without naming the disease and explaining the rationale of the treatment.

The responsibility to your social network supersedes responsibility to the public and one's medical ethical responsibility for reporting cases of HIV/AIDS: thus doctors will cooperate with families to camouflage the cause of death. Under-reporting by private clinics that cater to health needs of middle and upper income brackets can be expected to become fairly standard practice.

Fatalism

The pervading fatalistic philosophy of human existence, particularly in Kano and Jigawa states, will inhibit efforts to actively prevent AIDS illness and death.

Unacknowledged AIDS Deaths

Deaths can actually occur and still not be acknowledged as caused by AIDS. This could contribute to under-reporting of AIDS cases and further compound the lack of convincing empirical evidence, an important factor in motivating behavior change.

Skewed Baseline Data

Refusal to acknowledge cause of death at present and in the future skews data of AIDS incidence and will inhibit accurate assessment of project impact since the incidence must already be much higher than acknowledged.

Dearth of Ethnographic Data to Explain the HIV Sentinel Report for November 1991 - March 1992

The HIV Sentinel Report released in August requires rapid ethnographic studies to ensure that significant super-high risk groups are not overlooked in the first phase AIDS projects. CSWs in seventy percent of the fifteen sentinel sites have an HIV prevalence rate of above ten percent: Otukpo, above 50%; Hadejia, above 40%; and three sites above 25% (Enugu, Gboko and Makurdi). STD clinic patients have an HIV prevalence in Hadejia of 23%; in Kano, 15% ; and in Rano, 10%. TB patients in five of the sentinel sites have prevalence rates above 5% (Ikeja, Makurdi, Gboko and Oturkpo) including Kano with above 14%.

Antenatal clinic patient seroprevalence which can be taken as a surrogate for the general population is also rising. In nine states the antenatal patient rate is above 2% including Gwarzu, Kano with 2.5%, Badagry, Lagos with 3.4%; Oturkpo, Benue with 3.7%; Nsukka, Enugu with 4.2% and Hadejia, Jigawa with 5.8%.

The cumulative number of AIDs cases up to July 1992 is 436 including twenty-six pediatric cases. Three-quarters of the cases are males. The number of reported cases has been doubling annually. Almost one quarter of the cases are from Lagos with significant numbers being recorded in Enugu, Borno, Kano, Cross River, Plateau, Adamawa and Kaduna. Thus, many states are fully enmeshed in the epidemic including some of the states not mentioned merely because of the paucity of data provided.

FACTORS CONDUCIVE TO HIV/AIDS PREVENTION

Government Commitment to AIDS Prevention and Control

Government launched a National War on AIDS in March 1991 providing one million naira to each state and directing that state and local government offices be set up under designated officials termed Coordinators as well as committees with a combination of government and NGO representatives to combat AIDS. These bodies receive technical assistance from the Nigerian AIDS Control Program (NACP) and the National NGO Coordinating Committee of the NACP.

Government Mass Mobilization in the LGAs

The National AIDS Control Programme (NACP) has introduced a mass mobilization strategy in one LGA in each health zone as a model for replication. The strategy is responsive to socio-cultural sensitivities and to government inertia. Workshops including AIDS awareness and Trainer of the Trainer sessions are used to mobilize the LGA officials and influentials in a tiered, sequential intervention during a three week period culminating in grassroots mobilization.

Islamic Rulers Ready to Support Intervention

The Emir of Kano has agreed to support a sensitization seminar for traditional rulers to be held in a Guest House. During the seminar the traditional rulers would develop a consensus approach to intervention. The Emir of Gumel has volunteered to publicly advocate condom-use for HIV/AIDS as a health measure.

Combatting HIV/AIDS is Consonant with Islamic Teachings

Islam advocates health and the preservation of life and opposes fornication. Promotion of condoms for HIV/AIDS prevention will not be opposed on religious grounds in the Far North.

Traditional Care Providers Potential Roles

Ethnographic research is necessary to establish the potential roles of traditional care providers in prevention of the spread of HIV, specifically in areas such as the following: the handling of STD cases by traditional care providers; the possibility of establishing a system of identification and referral of HIV infected/STD cases from the informal to the formal health sector; and, the possible role of traditional care providers in community-based counselling services.

SOCIOCULTURAL INFLUENCES ON MATERNAL/CHILD HEALTH

CONSTRAINTS TO MATERNAL/CHILD HEALTH

Need for Greater Programmatic Input from Health Education/Communications Experts

Although the basic premise of Primary Health Care is that increased client knowledge, attitudinal change and adoption of new health practices coupled with minimal medication will maximize health, the expertise operating and providing technical assistance is largely medical personnel rather than education/communications personnel. Greater programmatic input from health/education communications experts is essential in order to achieve appropriate programmatic emphasis on developing effective health education/communications to reach the communities.

Medical Practices Which Reinforce Disbelief in the Efficacy of Modern Health Establishments

Some medical practices reinforce the disbelief in the efficacy of modern health establishments. Normally, little or no information is given to patients and family members about their illness nor about the purposes of medications and treatment. Family members are allowed and often advised to carry away terminally ill patients reinforcing the belief that the scientific health system has limitations. The few occasions when such patients appeared to have recovered even for brief periods have been made into living legends for continuous IEC dissemination to community members. This strengthens the faith in the spiritual world and messengers, while reducing faith in medical science.

A Partially Fatalistic Attitude to Infant and Child Deaths

The death of children is a common phenomenon which people have been forced to accept. For this reason, children are not named until at least the seventh day and in some cultures until the third month to be sure they will truly be members of society. Although witchcraft is an explanation for spontaneous abortion, stillbirths and infant death, another very common explanation is the phenomenon of abiku (Yoruba)/ogbanje (Igbo); the child is perceived as preferring the spirit world and refusing to stay with the mother. The child is propitiated to stay and mutilated after death to prevent his return with the next pregnancy.

When a child falls ill and dies, it is accepted that a stronger force brought about the death which might have been averted if the parents had taken strong enough preventive measures. Thus, the concept of prevention exists.

Members of some religions believe that sickness is from God, so the children should be left in His care without special precautions.

Failure of Service Providers to Explain the Nature of the Sickness and the Treatment
Doctors and other service providers refrain from explaining the nature of the sickness and treatment because they rightly fear that patients will self-diagnose and self-medicate, erring in the process. Patients remain ignorant of many common disease syndromes, unable to contribute to their management and frequently discontinue medicine prior to completion of the cure.

Problems Arising from Partial Absorption of Health Messages

Partial absorption of health messages generates unhealthful practices and unrealistic expectations leading to a rejection of the health messages. Belief in the efficacy of oral rehydration is undermined by failures due to incorrect preparation. Belief is also undermined by misinformed expectation that ORT can cure all diarrhea.

Traditional Beliefs Inhibiting New Public Health Interventions

In many areas, teething (fifty-seven percent of surveyed mothers in Niger State) and dirt as well as sweets are believed to be the cause of diarrhea. In fact, excess sweets do cause diarrhea among people unaccustomed to them just as excess pepper causes diarrhea among people unaccustomed to pepper. Consequently, some women reduce or delete the sugar component from the oral rehydration drink, make no attempt to use it at all, or substitute additional salt. In remote villages, sugar is not readily available and is as costly as aspirin.

Modern Practices Inhibiting New Public Health Interventions

Adoption of oral rehydration and rejection of medication except for limited specified cases is being resisted by all levels of the medical services and by the educated population because it contraindicates their acquired academic and practical knowledge. A similar situation is occurring with the new malaria protocol stipulating a full cycle of drugs at the onset of fever. Notification of protocol changes is insufficient to induce behavioral change on the part of service providers and clients partly because they lack sufficient confidence in the MHSS personnel. However in all nations, mere notification is insufficient for most behavioral change.

Non-recognition of Symptoms

In Niger State focus group discussions dealing with disease names revealed that while the Nupe and Gwari recognize dehydration as a serious symptom, the Hausa have no word for defining dehydration and do not recognize it as a condition requiring urgent treatment. Similarly, the Ife Yoruba women do not notice the symptoms for ARI because they are unaware of a separate disease, identifiable by the symptoms.

Rumors about EPI

In focus group discussions, Lagos State mothers averred that measles is always in the body and the function of the immunization is to bring out the measles giving the child a milder case. Some Plateau State refuse to bring their children for immunization because of rumors that immunization causes illness. An Oyo State survey prior to the intensive 1990 EPI campaign, revealed the following rumors: EPI can cause fever, paralysis and even death; EPI is a means of sterilizing women to

forcefully reduce population; and, children with minor ailments should not be immunized.

Constant, Communal IEC/Gossip in Favor of Traditional Methods

Each time a child is seriously sick, relatives and friends will contribute their advice as to cause and treatment, often recounting cures achieved through traditional methods, thereby providing reinforcement for these methods.

Belief in the Efficacy of Traditional Healing

In an Ogun State LGA, ninety percent of the TBAs are traditional healers who have added childbirth to their practice. They use herbs and incantations to remove retained placenta and stop ante-partum hemorrhage. The strong belief in their omnipotence as healers, held by both themselves and their patients, places their patients at risk.

The Potential for Incomplete or Faulty Behavior Change as a Consequence of Conflicts Between Modern and Traditional Practices With Overlapping Rationales

Conflicts may arise in the minds of mothers between modern and traditional practices where the rationales overlap unless the mothers acquire a solid understanding of the modern method rationales and their relationships. For instance, among Bornu women contraceptive efficacy is a rationale for prolonged breastfeeding. A mother who adopts contraceptives may decide herself to curtail breastfeeding on the grounds that its contraceptive function is superfluous, thereby placing her child at risk.

Physical and Emotional Damage of Early Marriage

Because of the prevailing early marriages and pregnancies, short birth intervals, lack of adequate medical attention during pregnancy and delivery and the persistence of some harmful practices, especially *ginshiri* (a type of episiotomy that may damage the bladder or urethra), a considerable number of women suffer from vesicovaginal fistula (VVF) or rectovaginal fistula (RVF) caused by prolonged and obstructed labor.

Many girls become frigid from their first, excessively young, sexual experiences (girls in Kano are married by age thirteen). Thus, when they become pregnant, they are relieved and would rather breastfeed for a very long period in order to give themselves a rest from the unpleasantness of sexual relations. However, because of fear that the husband will take a new wife, the girls will be unwilling to abstain for too long. This anxiety is based more on fear of diminished economic support than fear of loss of the husband's attention.

Absence of a Tradition of Traditional Birth Attendants (TBAs)

The status and role of TBAs will be influenced in each community by traditional roles. In some areas, no traditional role for TBAs exists and, as a consequence, no traditional gift giving or other remuneration pattern exists. Lacking an expressed demand and some incentive for the extra work and responsibility, some trained TBAs

fail to perform. Appropriate incentives and modus operandi need to be confirmed for each culture.

The Persistence of Harmful Traditional Practices

Harmful traditional practices which persist include genital mutilation and uvulectomy (a throat excision done in the first few days of life), ginshiri episiotomy, and postpartum boiling bath. Female circumcision occurs in almost every state and is linked with religious and other social values. In many areas the genital mutilation is central to a "rite de passage" which is otherwise pleasurable to everyone involving new clothes, hairstyles and feasting. In some areas, especially Edo, Delta and Benue states, the clitoris is believed to be a threat to the life of the infant if his head touches it during birth. Apart from interfering with sexuality, genital mutilation can cause severe scarring with keloids, chronic infections of the kidneys and urinary tract, coital difficulty, sterility, loss of pregnancy and excessive tearing during childbirth. Complications can lead to infant brain damage and breathing problems, severe maternal blood loss and vaginal-vesico fistula (VVF) and rectal-vesico fistula (RVF).

Uvulectomy was the most commonly performed surgery on children in Kano during the neonatal period and showed a very significant correlation with infant death from neonatal tetanus (67%).

Harmful traditional practices are difficult to eradicate because they are integral to the socialization process and the young woman would have to oppose her elders to refuse the practice. In order to discard those harmful practices which purportedly safeguard the well being of loved ones, even individuals who do not quite believe this tradition must be very convinced and knowledgeable; otherwise, they will be unwilling to risk the possibility that the tradition is valid.

Harmful Birthing Practices/Unassisted Births

In the north, only fifteen percent of the births are assisted by medical personnel. More than half of the births are unassisted and twenty-four percent are assisted by TBAs. Among some Middle Belt cultures, a woman is expected to deliver her child and cut the umbilical cord without screaming or calling for any assistance. In some areas the placental blood is an abomination which must be burned, resulting in the practice of giving birth in the bush to avoid the necessity of burning ones belongings. Physical activity such as fetching water or farming is also believed to facilitate the birth process.

Delayed Ante-natal and Post-natal Care

Among the Yoruba the mean age of the pregnancy at first ante-natal attendance is about twenty weeks. It is not proper for people to know of a pregnancy before it is well established because of fear of the evil eye and its power to abort or otherwise harm a pregnancy. In the Far North, it is difficult for some women to attend a clinic at any time because of the seclusion practice. Moreover, the first forty days after childbirth, they are confined to the house as a protective measure.

The Rarity of Optimal Breastfeeding and Unenlightened Weaning Practices

According to the 1990 NDHS, only 1.3% of babies under three months of age were exclusively breastfed. Most babies receive water, herbal infusions or other liquids from the first day of birth.

The NDHS revealed that delayed introduction of complementary foods is a major problem. In the Northeast Zone, two thirds of children were not receiving complementary foods between the ages of 6-9 months; in the Northwest and the Southwest Zones, fifty percent were not receiving complementary foods at this age. Improper weaning practices and undernourishment are reflected in the high levels of stunting caused by inadequate nutrition over a long period of time and wasting caused by acute undernutrition at the time of testing. The duration of breastfeeding has been significantly reduced, especially among more educated and urban women.

Potential Reduction of Breastfeeding Due to Adoption of Contraception

Many women consider breastfeeding a form of contraception, especially where breastfeeding requires abstinence. Adoption of contraception correlates with reduction of breastfeeding duration, possibly because both correlate with education. Concerted efforts must be made to ensure that women continue prolonged breastfeeding despite adoption of contraception.

Nutritional Taboos

Nutritional taboos associated with pregnancy, childbirth and children also affect the nutritional/health status of mothers and children. Some of the forbidden foods are valuable sources of nutrients such as the following: oranges, snails, plantains, eggs, fish, okra, salt, pepper, palm oil and groundnuts.

Health Care Decisions Being the Prerogative of the Husband

In baseline surveys in five LGAs, health care decisions were made by the father in over seventy-five percent of the cases even though women actually provide the care. Transport of a difficult labor case to the hospital may be delayed while awaiting return of the decisionmaker.

Competing Priorities for Mothers

Even if the husband is contributing, mothers must work long hard hours in order to grow crops and/or earn enough for bare subsistence by trading in the depressed market. Consequently, the decision to take the time to take a child to the health center must be weighed against competing priorities also essential for survival.

Service Delivery Timing, Opportunity Costs and Humiliations

Immunizations, even in large clinics where they are given daily, are often given for only two hours a day. Clients are expected to arrive early, wait for a large group to be present, sometimes listen to a health talk, and by noon the work of the day is completed. Women arriving after 10:30 are usually told they are too late to register. The long wait in the clinic is a serious opportunity cost to the women who require public health medical care. Although a woman might earn only N10 from selling

oranges during that period, that N10 would be crucial to her budget; it would finance the evening meal. Only women convinced of the efficacy of the immunizations will undertake these losses. Moreover, nursing and even cleaning staff shout on the mothers, rudely abusing them for their ignorant behavior.

Understaffing of Competent Health Education Manpower

Health Education manpower is deficient at all levels, especially at PHC service delivery. Less than 20% of the persons who currently hold "health education" positions at the LGA level possess the competencies necessary to assure the appropriate preparation, selection and effective delivery of a health education activity. Only four of the thirty-two health education units (including the Federal units) have graduate level directors which seriously mitigates against their ability to represent health education effectively to policymakers and technocrats in key decisionmaking positions.

Cost Recovery Undermines Health of the Poor

Patient fees have also generated critical delays in seeking health care. The introduction of user fees for maternity care correlates with the three-fold increase in the proportion of complicated obstetric admissions recorded in one of Nigeria's teaching hospitals between 1983 and 1988. During the latter portion of this period maternal mortality also rose by fifty-six percent in the same hospital. Voluntary (premature) discharge from public hospitals to avoid charges has also been reported.

Avoidance of Associated Costs for Immunization Foster Rejection of Immunization

Although women are not expected to pay for the actual immunization serum, they do pay for transport, the opportunity costs of lost time, the prescribed paracetamol to relieve pain and fever, and the syringe. Most women pay for the syringe being aware of the possibility of infection from a reused syringe; however, some forego the paracetamol. The ensuing fever causes them and those about them to reject subsequent immunizations.

Undersupply of Local ORS Sachets

According to 1989 estimates revised to accord with the current population, there are an estimated 315,000 deaths annually due to diarrhoea in children under five. It is estimated that at least 10% of children with acute diarrhoea develop dehydration and require ORS solution to prevent death due to dehydration. Although minimum requirements for ORS would be eight million, only 1.8 million sachets were available. Only forty-two percent of the health facilities visited during the In-Depth Program Review of EPI/CDD in 1989 had ORS stock and another study reported only 7,600 ORS sachets in FMHSS stores. Thus, the deficit is enormous.

Unsustainability of National, Mass Immunization Campaigns

In 1990, the government at all levels, the NGOs and the donors diverted human and financial resources to a successful EPI campaign that raised the vaccination doses from one million in 1987 to 3.5 million in 1990; however, the figure dropped to 1.5 million in 1991 showing clearly that the coverage rates were unsustainable in part

because the success had been at the expense of diversion of resources from other health interventions. Nonetheless, the success of the campaign techniques have been replicated on a smaller scale although hindered by the failure of government funding and personnel focus that distinguished the 1990 campaign.

Problems With Vaccine Logistics

Maintaining a constant supply of vaccines adequately protected by refrigeration remains an on-going problem. The MHHS is continuing to supply vaccines even though states are now expected to allocate money from their own funds for vaccine supply.

Client logistics and opportunity costs in time can be just as difficult in urban areas as in rural areas. Lagos State is the worst dropout state in the nation for EPI.

Service Provider Resentment of New Interventions

Some nursing sisters complain that the Ministry continually sends out directives for new treatment approaches and just expects them to follow the new protocols without explanations.

Service Provider Reluctance to Follow Diarrhea Protocol

The diarrhea protocol is often ignored by service providers who continue routine use of antibiotics and misuse of antidiarrheals. Most facilities lack ORS packets; consequently, the provider is expected to demonstrate the preparation and use of sugar-salt solution (SSS). Instead, service providers continue to prescribe other medications.

Routine, Unnecessary Treatment With Injections

Both the service providers and the clients have an inordinate faith in the superiority of injections over tablets and syrups. Despite directives, the service providers continue to overuse injections.

FACTORS CONDUCTIVE TO MATERNAL/CHILD HEALTH

Governmental Initiative and Support for Primary Health Care

The Federal Minister of Health and Human Services has taken the initiative with his Ministry has transformed the health care delivery system to fully incorporate primary health care.

Parental Readiness to Adopt Demonstrably Successful Interventions

In a northern Cross River village, measles vaccinations in one year were able to reduce the death of children from measles from over thirty children to one child. Following this demonstrable success, immunization was fully adopted.

Preference for Medical Advice

In numerous intervention surveys, doctors are the preferred source of information followed by other medical personnel and then the electronic media with only 10-15% preferring religious and traditional leaders. This suggests the usefulness of having doctors present messages over the media to reinforce jingles, etc.

The Potential to Harness Patient Propensity to Self-Diagnose and Self-Medicare

The evident desire of patients to self-diagnose and self-medicate offers the potential of establishing areas other than ORS where patients could become the providers of first-line medical care including drug administration as in the case of malaria drugs.

The Potential of TBAs

TBAs participate in almost thirty percent of births in urban areas; therefore, their assistance must be incorporated in any MCH intervention. TBAs may also be able to provide referrals from TBAs patients for tetanus toxoid and for family planning. The Inter African Committee Against Harmful Practices (IAC) has provided TOT and training for over 1,000 TBAs in target LGAs in many states with the good will of the PHC, the BLP and the traditional rulers in order to gain their cooperation in the effort to end harmful traditional practices.

A TBA training and supervisory program attached to a mission hospital in Akwa Ibom State achieved a fifty percent reduction in the high maternal mortality rate of the indigenes. Simultaneously, the number of normal hospital deliveries fell while the number of complicated, operable deliveries (from TBA referrals) increased.

The Cooperation of NGOs

NGOs have cooperated with all the maternal/child health interventions especially EPI where they assisted significantly in mobilizing the population and ensuring that members' children and children of the general public were vaccinated. The Nigeria Association of Non-governmental Organizations of Health (NANGO) has been formed as an umbrella organization for NGOs committed to EPI and other health interventions.

The Acceptability of Mosques as Venues for VVF Awareness Talks

With the endorsement of the Islamic authorities, the National VVF Task Force has promoted awareness by scheduling pre- and post- worship awareness talks in the mosques. Use of the mosque for communal meetings forms part of the Islamic tradition which may benefit more health interventions once the Islamic community coopts them.

The Potential of School Children to Function as Health Providers and Health Educators

Children, even in primary school, function as care providers for their siblings. Consequently, health messages about infant and under-five child care are meaningful to them and can be put in practice. In many cases, parents will accept health messages written into their children's notebooks. Operations research can explore

various means of reinforcing the messages including using a doctor who is an authority figure such as the Commissioner for Health as the source of the health messages.

Lessons Learned from the Niger State Primary School Health Clubs

The inadequacies of the HealthCom experience with primary school health clubs in 1990 in Niger State had more to do with the inadequacies of the intervention modalities than with the general concept. Lessons learned include the need to define restricted goals which can be evaluated with a few indicators and without much record taking.

Traditional Breastfeeding Practices

Prior to independence and widespread availability of baby formula in the urban areas, children were breastfed in most areas for three years and in virtually all cases for at least two years. In many cultures, the lactating mother stayed with her natal family or her mother-in-law during this period of postpartum abstinence. Among the Yoruba, couples were abused if the wife became pregnant while still lactating.

SOCIOCULTURAL INFLUENCES ON IEC

TARGETING THE PEER-GROUP, NOT THE INDIVIDUAL: A PEER-GROUP AUDIENCE, IEC STRATEGY

An IEC Strategy Targeting Peer-Group Audiences

The IEC strategy should focus on the majority, the potential **peer-requestors--groups** and the individuals within them who conform to group behavioral patterns. The term "peer-requestor" is used here to refer to an individual who will only modify his or her behavior if his peer-group approves of the change. With the sanction of the group, a peer-requestor will come forward to request family planning (or any other health intervention).

The Peer-Group Audience IEC strategy capitalizes on the conformism of the masses to promote behavioral change. The vast majority of Nigerians are discomfited by innovation and prefer to modify their behavior with the approval of their peers and/or influentials as representing their peers. The strategy goes beyond dissemination of messages appropriate for specific peer-groups. It focuses on advocacy and dissemination of information within the **context of the peer-group** using selected NGOs as the targeted, peer-group audiences.

Targeting peer-group audiences differs from targeting an individual with messages appropriate for his or her peer-group. Receiving the message within the context of the group and accepting or rejecting it within the context of the group absolves the individual of taking responsibility for the decision. The decision becomes a consensual decision, transforming the hitherto, unsanctioned behavior into morally and socially appropriate behavior.

Although a conformist can more readily reach a decision to modify behavior in the company of members of his/her peer-group, he may also be induced to modify behavior when targeted individually through mass media if the message convinces him that his peers also desire change. Or the conformist may be set on the path of behavioral change, if the message convinces him to discuss the possible behavioral change with his peers. Most IEC operates in these ways. Social mobilization campaigns take advantage of both mass media audiences and peer-group audiences.

Overcoming Strong Resistance to Behavioral Change

The peer-group audience strategy is especially appropriate for inducing people to overcome strong resistance to behavioral change. It assists individuals to take difficult decisions whether these decisions are about family planning or about preparing SSS instead of using an antidiarrheal. If the decision proves unwise, the group rather than the individual will bear the responsibility.

The normal, traditional decisionmaking process involves shared responsibility in risk-taking. Even when an influential promotes behavioral change, he or she coopts the

group to take a consensual decision. The greatest obstacle to interpersonal and/or personal decisionmaking is the absence of the sanction of group approval. Individuals experience minimal risk when the responsibility is diffused or allocated to an influential. Moreover, persuasion theory indicates that persons are more suggestible in group or crowd settings than in solitary situations.

Ethical NGOs as the Significant Peer-Groups

For private behaviors, the strategy targets "ethical NGOs" as the significant peer-groups. The expression "ethical NGOs" is used here to single out those NGOs which perform a value-clarifying and reinforcing function for their members. In general, NGOs affiliated to primordial and religious groups are among the most appropriate NGOs. Members of primordial groups usually live their personal lives intertwined with their group. Members of religious NGOs usually developed and reinforce their basic values among their religious peers. Hence, these groups are the most appropriate NGOs for sensitive interventions. In contrast, worksite peer-groups, employee NGOs and even many charitable NGOs are usually inappropriate for initial, sensitive, behavioral change because of their modest influence on a persons feelings and attitudes to life.

Ethical NGOs have the potential to expand the child spacing intervention beyond the constraints of innovator-oriented and clinic-based service delivery. Using ethical NGOs as the conduit, the program can advance to targeting potential peer-requestors within their peer groups. They can also target individuals and groups who are uncomfortable in the clinic environment which is currently the major outlet for decisionmaking information. Thus, the males, women without infants and toddlers, and unmarried females who rarely benefit from clinic information but are active members of a variety of NGOs will be effectively reached.

NGO Influentials as Change Agents

Each NGO has its own influentials who may or may not be officers of the organization capable of marshaling public opinion using the time-honored and time-consuming human relations techniques. Motivated influentials who recognize the value of behavior modification for their NGO reference group have the potential to function as effective change agents for their NGO membership.

Credible Authorities as Legitimizers of Health Behavioral Change

For health behaviors, doctors are recognized as the most trustworthy authorities by the respondents in the Nigerbus survey. This survey is a bimonthly advertisers' survey which have incorporated some family planning questions on behalf of the FHS IEC division. According to the respondents, healthcare personnel are the next most reliable authorities for health problems.

The Example of a Family Planning Strategy

The targeted NGOs must have demonstrated concern and involvement in interventions to preserve and enhance the fabric of the family and to ensure the health and welfare of their members. Child spacing interventions should be designed

to build on these family and health oriented attitudes and behaviors. Messages to stimulate influentials should be developed on the basis of focus group discussions and interpersonal networking. Conceivably, appropriate messages will reinforce the conjugal bond (promoting a new way of perceiving male control over the sexual relationship, rather than denying the cultural norm), parental responsibility for physical care and nurturing (moral and educational) of children, and maternal/child health.

Ethical NGOs have the capacity to mobilize their membership as a group to request child spacing, pregnancy postponing and, in some cases, child limiting in accordance with the peer group beliefs. They have this capacity precisely because they are trusted by and responsive to their membership at the ground level. An NGO's effectiveness as a conduit will depend upon the extent to which (a) its influentials coopt the intervention and internalize it within the NGO and (b) the NGO's values diverge from values compatible with family size limitation.

A Local Technical Assistance Participating Agency (TAPA) Providing Technical Assistance Through Extension/Networkers

The NGO intervention being proposed will rely heavily upon the personnel of a technical assistance participating agency (TAPA) responsible for both overseeing and backstopping message and intervention development. Initially, the TAPA may be part of or an affiliate of an American cooperating agency. It will hire and train full time Extension/Networkers (E/Ns) who will work at the grassroots level and within the hierarchies of the larger NGOs. The E/Ns will be responsible for identifying influentials who are amenable to mobilizing their reference groups to become child spacers, convincing the influentials to become mobilizers and providing them with the requisite intervention knowledge. They will work through intermediaries to gain access. By networking and communicating some of the IEC message, the E/Ns will identify key cooperating influentials who in turn will develop the direction and scope of the IEC intervention and mobilization with their own membership and within the constraints of the prevailing attitudes and practices.

This type of intervention will thus rely heavily on dedicated, well trained and well remunerated personnel with a strong sense of social responsibility, probity and professional commitment. As a consequence, the E/Ns will need considerable monitoring and supervision. By mid-cycle the TAPA should be fully Nigerianized and institutionalized as an affiliate or as a distinct entity from the American cooperating agency. In contrast, NGO expenditures and institutional change will be minimized.

Information Kits for the Influentials

The influentials in these organizations already have agendas for the organizations as well as their own personal responsibilities in their place of work and at home. Thus, even if some influentials are already predisposed to and aware of the need for behavioral modification in terms of child spacing, they may be surprisingly uninformed about child spacing and all the health and cultural manifestations.

Furthermore, they lack the time and focused concern to conceive and carry out an information and mobilization campaign, much less an ongoing program essential to attract and maintain sufficient contraceptors to transform the norm.

Preparation of targeted, information kits consisting of an average of ten pages of information tailored to the familial and health concerns of their NGO members, providing the rationale for the child spacing intervention including Nigeria-specific statistics and information, and advocating aspects of the intervention that are compatible with their religious and cultural beliefs will be extremely useful to overworked influentials. The distribution of the kits to key cooperating influentials is for reinforcement of the messages and to facilitate message dissemination. These kits should also be backed up by the information brochures which will give more comprehensive information for those desirous of pursuing the problem.

Hand-Outs for Members

Some of the information sheets may be appropriate for duplication and distribution as hand-outs to the membership. Fancy art work is not essential if the mobilizers themselves are sufficiently dedicated. The ultimate targets are expected to receive the message positively because they are members of their group rather than because each one individually was attracted by a flyer. They are expected to read the flyers because they provide information that is of intrinsic interest to members. The hand-outs are intended as primarily as message-reinforcing materials.

Government Social Mobilization Campaigns

Campaigns maximize their impact by targeting individuals within the context of their peer-groups. Campaigns are also a vital tool for mobilizing government resources. They absolve all concerned from individual responsibility and they facilitate release of government funds to respond to the urgent, high profile project. The recent, unsustainable but successful, EPI campaign should be criticized for its excesses in mobilizing funds and resources, but not for its methodology.

AUDIENCE CATEGORIES

The Major Audience Categories: The Example of Family Planning

The target audiences in all the program components can be perceived along a continuum from those who refuse to adopt any or all of the services and recommended behavior changes through those who have become total converts. To avoid abstract discussion, the analysis which follows refers to the specifics of the family planning intervention; however, most of the methodology is easily adaptable to the other interventions.

Acceptor/Requestor Categories

The term "child spacing acceptor" is a misnomer. Current acceptors are not merely acceptors who adopt a service offered to them individually; they are "child spacing requesters" who have come forward and requested the service from a provider. The

onus is on the client to take the initiative to request family planning advice and assistance. CBD and social marketing have the important advantage of reducing the clients' individual responsibility for initiating the process. Child spacing requestors can be broadly categorized into innovative requestors, peer-requestors, uninformed non-requestors and hardcore non-requestors. Innovative requestors have individually decided to request child spacing despite widespread disapproval or skepticism towards child spacing among their peers and in the larger society. Peer-requestors are those who join the "bandwagon" of their peers conforming to group norms. Because the highly educated now approve of family planning, people in this social group can be considered peer-requestors. However, most other current requestors are innovative requestors.

Hard-core Non-Requestors

Since the hardcore non-requestors may be operating within a complex web of social, cultural and psychological constraints, attempts to move them straight from non-requestors to requestors may generate serious resistance. A better alternative is to aim at shifting them from non-requestors to potential (undecided) requestors and then on towards fully embracing the behavior to become requestors. Simultaneously, design of both the channels and the messages must take into account minimization of damage possible from influential, hardcore non-requestors.

In the Far North, despite an increase in family planning requestors among the elite, the majority of the faithful can still be categorized as hard-core non-requestors. They should be reached through their own organizations with a cautious, slow-paced program. In this authoritarian society, a combination of religious and medical leaders supported by traditional leaders will have the greatest impact. Initially a workshop with four representatives from each of the religious-based associations is suggested. They should be introduced to maternal child health issues and child spacing. This should be followed by considerable opportunity to question a group leader versed in Koranic approaches to child spacing and capable of refuting their arguments. Without offering any suggestions, the possibility of human and financial resources should be left open should they decide to pursue the issues further.

Other avenues include booklets written from the religious perspective with information on Islam and maternal/child health issues addressed to youths or adults.

Stages of Message Absorption

Audiences absorb the messages in stages. The first stage is the awareness stage which may suffice to generate an unmet need. Innovative requestors may themselves initiate the next stage, the acquisition of enough information for both informed decisionmaking about a preferred method and for access to the method. This second stage, the information stage, involves transmitting enough information about specific techniques and access to the techniques to enable an individual to decide to request a contraceptive. The information stage requires repeated, oral presentations and/or a printed explanations for effective internalization of the information. The third

stage, the reinforcing stage, is continual in order to provide the reinforcement essential to prevent backsliding and to clarify questions that arise during use.

THE MEDIA AND MESSAGES

A Protocol for Health-Message Development

A protocol for health-message development needs to be prepared and adopted within the Primary Health Care (PHC) system. Health messages must respond to the specific knowledge, attitudes and practices (KAP) of ethnic and religious groups as well as to their effective communication channels. The IEC strategy for introducing ORT into a community that lacks the vocabulary word or concept for dehydration must necessarily differ from the strategy for a community that is aware of dehydration. Similarly, the strategy for a community that favors cornstarch porridge for invalids differs from the strategy appropriate for a community that favors sour milk.

Collection and assessment of base-line data for health-message development must go beyond identification of the KAP for a particular health problem. It must identify (a) the discrete behavioral changes that are possible in the community to combat the health problem; (b) the existing KAPs that are conducive to the requisite behavioral change; (c) the existing KAP that constrain adoption of the requisite behavioral change; and (d) a limited number of discrete behaviors to be changed by the majority of the population. Once these decisions have been made the standard IEC message development and testing process can commence.

Since this Health-Message Development protocol will have to be replicated in part or in whole among each ethnic and sub-ethnic group, some degree of sensitivity will have to be sacrificed to standardization. Standardized questions and focus group discussion questions need to be developed for each health intervention. A procedure for eliminating unnecessary questions and adding crucial questions needs to be developed. A procedure for selecting the smallest sample capable of generating the requisite information also needs to be developed. The objective is rapid development of messages that are both ethnic-specific and disease prevention and control-specific.

Psychological Profiling

Psychological profiling of requestors and non-requestors involving research techniques such as imaging, in-depth interviews and focus group discussions should facilitate the development of more relevant target-specific messages. The addition of psychological profiling to the already known sociocultural profiling will benefit future IEC campaigns. For instance, a better understanding of the psychological underpinnings of the male opposition to family planning should take us beyond the fear of spousal infidelity to allow the development of messages responding to the ramifications of the threat family planning poses to male dominance.

Psychological audience analysis will also provide the basis for distinguishing the hardcore non-requestors from the uninformed non-requestors who can be reached through awareness and information campaigns. Where religious and sociocultural factors hinder the majority of the people from fully embracing an intervention, psychological profiling of the requestors and the non-requestors will provide the basis for constructing behavioral change messages. Some of the communication strategies may be constructed around the concepts of self-esteem, moral appeal, guilt, explanation, debt and reward. The general framework is the benefits to be derived from family planning, HIV/AIDS prevention, child survival and maternal child care.

Participatory Message Development

Each message to be communicated should be determined through active participation of the specific target group. Messages will be culturally determined for greater message acceptability and persuasiveness, bearing in mind the oral nature of the Nigerian society. Messages translated into local languages are interpreted on the basis of cultural orientation and beliefs and are, therefore, subject to misinterpretation. Consequently, confirmatory message testing is required throughout a much larger territory than would be necessary in a more homogenous environment.

Electronic Media

Prior to 1990 when the groundwork for IEC messages was being prepared, less than twenty-five percent of currently married women had heard any family planning message on radio or television. Almost seventy-five and fifty percent of the urban and rural women, respectively, affirmed that it was acceptable to have family planning messages on radio or television. Impact studies for the Enugu television drama incorporating family planning messages indicate a high degree of effectiveness. The number of new clients at local family planning clinics increased steadily and television was named as the source of referral by an average of forty-three percent of new clients each month. More current studies can establish the effectiveness of the advertisements which are now being aired.

The coverage of the population by the modern media is low. The network news, national coverage offers the only national audience coverage. Nigeria has thirty-eight television and forty-eight radio stations. The Nigerian Television Authority (NTA) estimates that its state satellite stations and the state television networks reach about thirty million Nigerians. Ownership of radio and television sets cuts across gender, social class and urban/rural differences. According to the Nigerbus Survey, more rural people (defined as people living in communities of less than 20,000 people and, therefore, including periurban communities) own radio sets (83%) than television sets (26%), suggesting the potential of using the radio network as a channel of reaching the rural population. Drama is the most regularly watched program type by all audience segments.

Television and radio coverage have undoubtedly increased in the last five years. Since the launching of the population policy in 1989, population issues have become an increasingly popular topic with the news media. The presentations are all

generally in favor of the full implementation of the policy and the quality of the presentations is improving; however, the human interest aspects are still generally lost in the academic aspects of the presentation.

Nevertheless, the restricted reach of the electronic media must be recognized. According to the 1990NDHS, approximately two thirds of the rural women and one third of the uneducated women have access to neither radio nor television. Moreover, while state radio stations are suitable for targeting sub-populations, the reach of some state radio stations is inadequate to serve all the rural areas.

Private Sector Subvention of Electronic Media Costs and Public Service Broadcasting

Cost of electronic media coverage is likely to increase due to the recent privatization of the government stations. Government and private media organizations donate free time and space to UNICEF messages. This public service concept should be expanded to encompass other family health messages. Equally, private companies should be approached to buy air time and print media space for the dissemination of health messages.

Print Media

Nigeria has about forty major newspapers. Readership estimates range between 5-47%. The majority of the readers including the messengers and secretaries as well as the boss read the office copy. Magazine readership follows the same trend. Concord is the most widely read newspaper throughout the nation but in particular states, the newspaper of that state or region will be the most widely read. Weekly magazines are more popular than monthly magazines. Prime People is the most widely read, soft sell magazine. Newswatch has the largest readership among the news magazines.

The print media are especially important for their capacity to disseminate complex knowledge, to provide the opportunity for review of that knowledge thereby facilitating complete comprehension and internalization, and to be available to the target audience for reference.

Flyers

The distribution of flyers at bus stops to low & middle level income, public transport users provides effective outreach to the informal sector. This technique was used with great success by anti-government sources who distributed a poorly typed list of accusations against the government which contributed significantly to the poverty riots of 1989. If the topics treated are of intrinsic public interest and presented at the Sixth Grade Reading Level, a black and white photocopy could serve the purpose as well as a colorful printed page. Information on reproductive health which would not offend the readership including information on sex diseases and the dangers of mistimed pregnancies can be expected to be discussed among friends. The format might include a story about an individual or couple that suffered because of their ignorance.

The Potential of the Private Sector Profit-making Press to Generate Readership from Human Interest Stories, Dear Abby & Yellow Journalism

The power of the human interest and the celebrity story as well as the Dear Abby type column to attract readership especially in the yellow journalism press warrants fuller exploitation. For the short period Professor Ronke Akinsete had an AIDS column in The Vanguard, she was inundated by letters. Committed health reporters could benefit from improved skills in presenting behavioral change health interventions, including the uses of human interest stories to sustain interest in their topics. All too often, the newspapers carry excessively long health articles with little human appeal. Full sensitization of the columnists may suffice to increase their proper treatment of these issues.

Editors and owners could benefit from operations research to demonstrate the readership-generation power of health information couched in the appropriate formats for their target audiences.

FAMILY PLANNING-SPECIFIC IEC

Targeting LGA Officials with Rapid II-type Modelling Graphs

Decisionmakers at the federal level were responsive to Rapid II graphs indicating the effect of population on the allocatable funds for government projects and general expenditure on job generation, food, fuel, etc. Since much of the government, intervention-related funding is now directly to the LGAs, LGA officials should be sensitized to the effect population growth has on their budgets and ability to service the basic needs of their constituents. Otherwise LGA officials may oppose child spacing. They may consider it a form of birth control liable to undermine their budgetary allocations which remain substantially dependent upon population size.

However, the necessity and the utility of a video production for LGA level should perhaps be weighed against the utility of laminated charts with five or six focussed, possibly retainable messages and a booklet to facilitate retention and discussion of the messages.

Male Targets

Family planning IEC should target those males most likely to be receptive. Young males who still feel affection for their wives and desire to meet them while they are breast feeding without jeopardizing the health of the infant should be targeted. Middle-aged men whose affection is waning under the social and economic pressures of daily life, but who do not really want to chase other women and/or pay for their sexual services should also be targeted.

Media Messages

The following are suggested as possible messages that might arise from peoples' concerns.

Message Target: Male, Young, Parity 1-2

Possibly Also Rising Middle Age, Parity 3-4

Designed to Promote Family Size Limitation, Including Monogamy For Radio & TV, Cartoons?

Modern child spacing is for your enjoyment. With modern child spacing, you can enjoy meeting your wife without harming your baby. Your wife will never again refuse you because of the children. She'll never refuse you because of what the relatives will say. Child spacing techniques are for you, so you can have pleasure with your wife and still have a healthy family.

Message Target: Male, Rising Middle Age, Parity 3-4

Designed to Promote Family Size Limitation, Including Monogamy For Radio & TV, Cartoons?

Some half-siblings are fighting over who is going to pay their father's hospital bill and who is going to nurse him now that he is ready to be discharged. Brother A tries to tell Brother B how much he should contribute. Brother B objects that they all know he just had to pay for secondary school books for his three oldest kids. Sister

C objects that she spent a lot of money on Father while he was sick prior to hospitalization and that her husband expects other siblings to fulfill their roles. Brother D objects that he had to pay his own way through Technical College without any help from Father and that Father was never around and never helped his mother or his full sister either. Others chime in to say it was the same for them. A Voice Over says, "It isn't always the number of children; sometimes it's the type of relationship that counts."

Message Target: Female, Rising Middle Age, Parity 3-4

Designed to Promote Family Size Limitation
For Radio & TV, Cartoons?

"But Sister, are you sure Brother Ayo (husband) really wants a fifth child? Even gari is so expensive and then books for school and after all that, you will be lucky if you can help the children find work. You know I used to think my husband was running around because I couldn't seem to get pregnant again. It turns out that what he really wanted was to get away from my nagging about books and clothes for the kids. He wanted some fun. He didn't want any more responsibilities even if he didn't want to admit it and didn't want to deal with my family accusing him of not wanting more issue.

Message Target: Teenagers in Schools & Tertiary Institutions

Designed to Promote Condoms

Condoms prevent abortions. They are cheaper and safer.--followed by a life story or statistics about complications.

Message Target: Teenagers

Designed to Promote Safe Sex Including No Sex

Not all sex diseases are curable. Your friend may be carrying AIDS without realizing it. Who knows who his partners' partners' were last year? Abstinence is safest but condoms are better than a slow death from AIDS.

HIV/AIDS-SPECIFIC IEC

Message Content: Abstinence and Fidelity As Well As Condoms

The success of the HIV/AIDS project will depend to a large extent on the content of IEC messages. The sociocultural diversity of the target populations implies that the project must be able to respond to the specific needs of the different groups. Involvement of community leaders, institutions and beneficiaries in the development of IEC activities will ensure that sociocultural sensitivities are respected and that messages will be acceptable and effective in motivating behavior change amongst the different sub-populations.

However, the AIDSCAP Nigeria Country Plan perspective that condoms represent "the most effective means of preventing HIV transmission", contradicts the principle of participatory target group message development. If this perspective is translated

into action, it might heavily bias the focus of IEC messages. ABSTINENCE and mutually faithful, stable relationships between uninfected persons are not only currently, culturally acceptable but are also the most effective means of preventing HIV transmission. Condom use remains the most effective means for persons who do not practice and are unwilling to adopt the practice of abstinence and who have multiple partner/casual relationships simultaneously or over time.

Failure to inform the public that condoms only reduce, but can not eliminate, the risk of transmission deprives the public of the opportunity of informed decisionmaking. This opportunity is essential especially in view of Kenya reports of 50% contraceptive failure. A condom advocacy strategy that omits or downplays abstinence may be an appropriate, public health strategy among restricted high risk, target groups for whom abstinence is not considered a realistic alternative; however, such a unifocal strategy would be irresponsible for the public as a whole. Moreover, the considerable rate of sexual networking throughout the society indicates that the wider public will rapidly become a high risk target.

The potential, moralistic opposition to the condom promotion component of the project could be overcome not only by involving beneficiaries in the development of IEC messages but also by the careful introduction of condoms as a secondary option to abstinence and mutual faithfulness.

Behavioral Research

The different motivations for sexual activism among men and women will need to be identified in all the States and understood for each target group or sub-population in order to design appropriate IEC messages capable of motivating behavior change.

CCCD-SPECIFIC IEC

Deficient Health Education/Communication (IEC) Program

Health Education/Communication (IEC) must be perceived as central to primary health care by the decisionmakers and service providers. Primary health care with minimal medication and non-professional service providers is becoming increasingly accepted. Yet it is dependent upon an informed public, capable of limited self-care and ready to request service provision without undue delay.

Too few targeted, health IEC interventions have been developed and those that have been developed are inadequately disseminated and replicated. Too many lost opportunities for education persist. Although health IEC was used to obtain the large EPI turnouts, rarely was the presence of mothers at vaccination sites used as an opportunity to ensure that they knew what the immunizations were for and why or where they should go for follow up. Nor were the mothers adequately advised about side effects.

Health talks at clinic sites are often over-ambitious, containing too much information to be reasonably absorbed at one sitting rather than developing a small portion of information in numerous ways to ensure maximum retention.

Formal Sector Health Care Providers as Educators

The formal sector health care providers must be encouraged to facilitate patient faith in their treatments by explaining the nature of the illness and the rationale for the medication or treatment.

Inadequate Dissemination of New Protocols Among Health Providers

The resistance to introduction of the new, primary health care protocols requires concerted Continuing Education (CE) and Health IEC. Given the large numbers of health workers at all levels in Nigeria, IEC may be more effective than relying on CE to communicate with service providers. They may be more likely to learn the modern protocol during a campaign in which they are training NGO trainers. However, in addition to IEC, service providers also need practical experience of the efficacy and superiority of the new protocols to the former, modern health practices. Notification of the protocol changes is insufficient.

Immunization Card as a Reminder

Redesign of the immunization card should be possible to ensure its usefulness as a reminder to the mother rather than merely serving as a document required in order to obtain the immunization.

FORMAL EDUCATION

The Largest, Captive, Mass Audience: Primary School Children

School systems provide a captive, mass audience; fourteen million children are currently attending primary school. Schools facilitate annual reinforcement of extended messages to instill comprehension of the messages and their rationales. Classrooms provide the opportunity to impart basic information that can facilitate comprehension of and receptivity to mass media, IEC messages. Failure to provide students with health information represents a lost opportunity.

The "prime messages" in the UNICEF/WHO/UNESCO publication Facts for Life should constitute the basis for the Health syllabuses. The syllabuses should be developed with the prime goal of ensuring retention of IEC messages. Although an educational program which fulfills the important goals of instilling belief in microscopic disease causation and the basic scientific method is needed at both primary and secondary school level, such an ambitious project should not be allowed to interfere with the IEC goals of primary school, health education. The Health syllabuses should be designed to maximize retention of **minimal, core messages targeted at school leavers** at each level rather than to provide the best students with an excellent health education.

Donors should pressure government at all levels to incorporate more effective Health Education as a required subject in the curriculum at all levels. Health is already in the primary school curriculum; however, it is relegated to a minor role, inappropriate to its importance for primary school leavers who constitute the vast majority of the primary school population.

Health educators in Niger and Osun States indicate that government needs to do more to promote school health education. Short and long term benefits of in-school education for children include: (a) learning about prevention and control activities, (b) learning how to introduce and reinforce health messages for their parents, and (c) acquiring some health literacy which will facilitate retention of IEC messages received in the future.

The Greatest Obstacle to Effective, In-School IEC: The Teachers

The teachers are the greatest obstacle to effective, in-school Health IEC. They are unmotivated and demoralized by low and irregular pay, excessively large classes, lack of appropriate textbooks and poor facilities. Yet teachers are the major medium of dissemination of IEC within the school systems. To transform the teachers into a modern, Health IEC medium using modern, participatory teaching methods would require an enormous, pre- and in-service education program. Thousands of teachers in the more than thirty thousand primary schools throughout the nation would have to learn new teaching methods and new health information.

Modern methods have been taught to teachers in pre-service education programs since Independence, but they are rarely used in the classroom. Instead, teachers develop lesson notes which are copied on the board for students to copy into their exercise books. After copying, the students memorize the information and reproduce it during exams. This methodology has become the centerpiece of the educational system to the extent that publishers have begun publishing lesson notes for exam preparation. As soon as teachers are hired into the Nigerian educational system, they discard the modern methods they perfected in teaching practice.

Change the Text Rather Than the Teacher and the Method

To be immediately effective, the teaching methodology should follow the existing practice: To minimize the behavioral change required for in-school Health IEC, the prevailing rote-learning method, based on lesson notes copied onto the board should be adopted. If teachers are given the lesson notes, it will be easier for them to impart the health messages than to teach other items in the syllabus. Practical exercises, such as preparing SSS, should be encouraged. However, message development should recognize the constraints in the most disadvantaged primary schools. Consequently, the messages should be designed to be transmitted without the benefit of practical exercises and role playing. Despite glaring deficiencies and an outmoded teaching method, considerable information is currently imbibed by the masses within the schools. More information could be retained if the syllabuses were less ambitious. At the moment, the syllabuses are more ambitious than the foreign syllabuses.

Health Education Incorporated into Adult Literacy

The Bauchi State Literacy Project funded by UNFPA as well as several other literacy projects are incorporating health education including child spacing into their literacy materials. This initiative should be actively replicated.

Teenage Reproductive Health Brochures for the Moralistic Viewpoint

A reconsideration of the function of schools in behavioral change and the immediate, effective utility of the schools as part of IEC strategy indicates the urgency of instituting a constrained, reproductive health education program. A program with minimal goals, it can have a widespread, immediate reach targeting each and every school child. Simultaneously, gradual efforts to improve the quality and spread of the Population/Family Life Education (POP/FLE) curriculum should continue.

Parents and religious leaders promote abstinence outside of marriage and fear that knowledge of sex and contraceptives will induce children to engage in premarital sex. Parents, religious leaders and educational authorities oppose premarital sex because of its immorality and the loss of status associated with breaking the societal standards. They also oppose premarital sex because of the sex diseases that can be acquired, because of consequences of a mistimed pregnancy, because of the possibility of recourse to abortion, and because of the possibility of infertility resulting from an undiagnosed sex disease or a botched abortion. All these are good, health reasons.

A mass education, reproductive health brochure responsive to the prevailing moralistic values and pragmatic concerns can address parental and religious concerns without specifically describing the sexual act or the condom as a safer sex tool. The sexual act can be left, for the time being, inadequately treated in biology class and the condom can be promoted over the air waves. A responsible, minimalist reproductive health education brochure promoting abstinence and describing the negative consequences of premarital sex might immediately be acceptable for use by religious groups and ultimately also prove acceptable for use by school teachers as an supplement or alternative to the POP/FLE curriculum and materials.

Information can be imparted regardless of the quality of the teacher or the methodology if that information is well presented in a written form in a standard and simplified English versions as well as in the local languages regularly read by the targets.

Such a minimalist strategy should be complemented by publication of a teenage brochure with a less negative and more explicit approach to sexuality.

The Constraints to Intervention Receptivity Arising From Low Enrollment, Especially Female Enrollment, in Formal Education

Because of the dependence of the health interventions upon both knowledge and faith in science and empowerment, lack of education limits receptivity to interventions. Thus, low enrollment in formal education effects all three projects.

Primary education is reaching fourteen million pupils a year; however, this is only half of the target population. Only about two-three million students proceed to at least some secondary school. Furthermore, the rural illiteracy rate is twice as high as the urban rate.

In 1989 only 44.8% of eligible females were enrolled in primary school out of a total enrollment rate of 63.1%. Although female enrollment in the educationally advantaged southern states like Anambra, Ondo and Bendel was comparable to male enrollment, figures for some "educationally disadvantaged" states were as follows: Bauchi 39.2% (which has a large Christian population); Kano 34.9%; and Sokoto 29.6%.

Female education significantly affects maternal care which is generally poor and variable. For example, women with secondary education received tetanus toxoid injections for seventy-two percent of their births, while only forty-two percent of births to women with no formal schooling benefitted from this preventive treatment. Similarly, antenatal care was provided by a trained healthworker for ninety-one percent of births to women with secondary schooling, but only forty-four percent of births to women with no schooling.

To date, enrollment in an educational institution has been virtually the only way to postpone early Muslim marriage. Its effectiveness is attested to by the correlation between the slight rise in marital age in the North with the period following the leadership of Murtala Mohammed (a highly respected Head of State with a Kano mother who was assassinated early in his rule six month rule in 1976) who enforced a decision that girls must not be withdrawn from school for marriage.

Operations Research to Test Innovative Programs for Retaining Children, Especially Female Children in School

Constraints to female school enrollment in the Far North derive partly from maternal need to benefit from the labor of their daughters to hawk their wares since the Muslim mothers are secluded. Constraints to rural enrollment derive partly from parental need to benefit from the farm labor of their children on a seasonal basis. Operations research should examine innovative timetables with shortened primary school days and/or varied primary school vacations. If deemed necessary, lost time can be compensated for by additional years required for primary school completion.

DISSEMINATION OF RESEARCH FINDINGS

Donor Support for Research

While research may seem a luxury, it is well worth the expense if it contributes to program needs. Because of the possibility of continuing ethnic imbalance among researchers and program implementers, concerted efforts should be made to support the professional growth of Nigerians among the less represented ethnic groups.

Inaccessibility of Donor-Supported Research Findings

The inaccessibility of research findings (donor supported operations research as well as unsubventioned academic research) to Nigerian researchers and scholars severely inhibits research productivity. Failure to ensure adequate dissemination of research results is wasteful of resources and undermines efforts to institutionalize research.

The current practice of providing a sum for publication and dissemination of research is ineffective. Most research findings are not in Nigerian libraries. Most journals are more than a year out of date and many are several years out of date. Moreover, even old issues of foreign journals with important articles on Nigeria are frequently not on the shelves.

AID-funded documents are also difficult to locate and photocopy. Some documents are missing including the background papers for the 1987 Social Soundness Analysis and several CCCD Operations Research papers although reportedly on file at the Mission Office and at the Ministry of Health, respectively. The FHS library is extremely helpful and merits continued use as a Clearinghouse. However, the lack of an accessible photocopy machine significantly increases the opportunity costs of using the facility. Although the AID-funded MEDLINE service at Yaba has the capacity to identify important articles on Nigeria related to the CCCD intervention, only seven out of thirteen are available in Lagos. The only practical way of obtaining the other articles is to travel to the universities throughout the country where they are available, according to MEDLINE.

Donor Dissemination of Research Findings

Efforts to ensure institutionalization of Nigerian library capacity to store and retrieve journals and documents should continue; however, in the near term they should be backed up by expansion of the responsibilities of donors for direct dissemination of research findings and of the role of the HIIC Library. Donors should require a minimum of five copies of research findings to be distributed to the HIIC Library and important Nigerian libraries including the National Library, the main academic library in the state of the research site, and others to be determined. In order to rapidly expand the resources of the HIIC Library and to take advantage of cooperating agency consultants' knowledge, each consulting team should be required to submit a photocopy or original of each document or publication cited (unless already in the library) in their own document. The HIIC Librarian should be required to attest to compliance with this condition prior to final payment with the proviso that the AAO or his representative may exempt some documents or publications at his discretion.

A Journal of Nigerian Family Health would facilitate the development of quality lecturers for pre-service training by ensuring better lecturers for all programs. Lecturers are hindered by the necessity of publishing for promotion and the paucity of regular journals. In order to exist, Nigerian journals require the authors to pay per word in order to cover costs. Support for the journal would also contribute to

dissemination of knowledge, improvement of academic standards, and identification of researchers.

V. PROJECT IMPACT

The three project interventions are designed to induce behavioral change among both beneficiaries and participants. Extensive intervention progress has already been made by FHSI and CCCD as well as by isolated NGO-funded HIV/AIDS activities. Future progress will depend upon behavioral change of groups of people as well as individuals.

Unorchestrated spread of project interventions across states and ethnic groups is improbable, and unlikely without interventions involving technical assistance and social mobilization especially because the visibility of most benefits is delayed. Leadership of religious groups may recognize benefits and mobilize across state lines. Some government officials and private sector organizations including NGOs have already initiated activities; however, large scale replication comparable to project intervention is unlikely without federal government and/or donor funding of specific interventions. Nevertheless, the projects provide considerable training to participants generating a cadre of professionals with a stake in intervention continuation beyond the life of the project. Personal satisfaction with the results of modified behaviors will sustain the project benefits for those who are capable of purchasing them from the private sector.

Project interventions requiring only modified, traditional behaviors and methodologies rather than fully modernized behaviors and methodologies are more likely to be integrated within the participant and beneficiary population and, hence, more likely to be replicable and sustainable.

The benefits of all three projects will reach Nigerian families by focusing on women and children; however, men will be increasingly targeted for the family planning and HIV/AIDS interventions. However, the projects will not ensure equitable distribution of benefits uniformly across the entire country nor across all ethnic groups. For CCCD2, twelve LGAs have been selected as the initial project sites with replication plans for sixty LGAs throughout the life of the project. These LGAs are located within nine focus states which are distributed throughout the four health zones. A similar focus state approach will be taken with the FHSII project to maximize impact. AIDSCAP has targeted urban areas in three out of the four zones. Both FHSII and CCCD2 interventions will impact rural as well as urban areas and AIDSCAP also has the potential to expand to rural areas.

Because the HIV/AIDS epidemic has already reached the rising exponential phase, the limited geographic focus of the AIDSCAP intervention will be incapable of significantly slowing down the epidemic. Furthermore, unless virtually all members of society choose to practice mutually faithful sex and/or safer sex for health, religious and/or ethical reasons, the AIDS epidemic will spread throughout the nation, the pace of spread having merely been slowed down by the project components.

VI. ISSUES IMPACTING ON PROJECT SUCCESS

Throughout the evolving life of each project, attention to the considerations below will influence project success and the degree of positive impact each will have on the target population:

Programmatic Concerns

1. The scope of the evaluation of process and outcome indicators should include quality as well as quantity; omission of quality indicators may result in poorly designed (irrelevant, inappropriate) project activities which waste essential funds and delay intervention success.
2. Deliverables for cooperating agency work plans should be clearly linked to the central project goals as well as linked to their training or institutionalization goals to ensure proper focus.
3. Work plan design and implementation should be sensitive to the dynamics of ethnic, religious and gender differences, prejudices and mistrust among beneficiaries and participants.
4. Concerted effort must be made to ensure that participants are representative of the ethnic, religious and gender differences in Nigeria. An ethnic, religious and gender disaggregated list of Nigerian counterpart researchers, cooperating agency personnel and the educational institutions producing such personnel is essential to identify the underrepresented groups.
5. Successful interventions rely on continually evolving, expensive, technical expertise; however, funding to the requisite levels is impossible given the magnitude of the problems. Consequently, the development of local agencies providing technical expertise is essential.

Project "Ownership"

6. Concerted efforts must be made to ensure that participants develop a sense of "project ownership". Otherwise, participants will remain uninvolved with a casual attitude towards work. Believing that credit for the project successes will be claimed for others, they refrain from offering suggestions for improvements.
7. Local professional, technical assistance participating agencies (TAPAs) should be promoted to create more stakeholders. They will also contribute to replicability and sustainability. NGO institutionalization should focus on NGOs that function (or are willing and suitable for the requisite modification) as TAPAs. They should provide technical assistance to implementing bodies. Unlike many implementing NGOs, they require at least a core of professional staff to ensure sustainability and replicability.

8. To ensure ownership and counteract fears of Western political, economic and religious repression, introduction of child spacing to Islamic groups should be done by members of each Islamic target group. Similarly, promotion of female education and delayed marriage should be handled by Muslim groups.
9. Concerted efforts must be made to accept participant advice with respect to local cultural practices. For instance, donor reluctance to recognize the legitimacy of representational expenses (beer for informants or gifts for traditional rulers) is counterproductive. For the sake of the project, participants are forced to fund these expenses themselves even though they are substantial from the standpoint of their earning power.

Pragmatic, Constrained Indicators

10. In order to be sustainable and replicable, interventions must be pragmatic. They must have constrained indicators which are realizable in stages and require only minimal changes on the part of both the participating implementors and the targets.
11. Work plans must take full cognizance of the enormity of the behavioral changes being required when new behaviors are combined with new intervention methodologies. Methodologies which rely on individual decisionmaking and values clarification rather than on the standard communal and/or authoritarian decisionmaking, expect the targets to innovate on two levels. Not only are they expected to carry out the new behavior, they must also take personal responsibility for the innovation and its possible negative consequences.

Sustainability and replicability of the POP/FLE curriculum in the school systems may seriously be hampered by the intervention methodology itself. The teachers are not only expected to promote responsible parenthood even though the society has not yet accepted the message; they are also expected to develop innovative lesson plans. The POP/FLE curriculum was designed to be introduced with modern methodologies involving student participation, inquiry and values clarification. These innovative methodologies contradict the prevailing belief that students should obey their elders implicitly.

12. Operations research should clarify the clients' counselling preferences. Nigerian clients may prefer authoritarian counselling based on medical advice as opposed to values clarification counselling for selection of family planning methods. The successes of counselling may be based on needed improvements in basic human relations techniques rather than on client desire for a choice.
13. Minimal, modified/traditional, behavioral changes must be identified and pursued as interim intervention goals. Minimal behavioral change provides a wedge away from traditional practices and puts people on track for more

extensive behavioral change. Minimal behavioral change also has greater potential for replicability and sustainability.

For example, adoption of the relatively inefficient "safe period" contraceptive method constitutes an active, self-reinforcing conjugal effort to control birth while maintaining sexual relations. Promotion of this method along with other methods provides couples with a method involving the familiar, traditional abstinence while permitting co-habitation and sexual relations. Simultaneously, the couples learn about more effective methods which they will increasingly adopt but which may constitute too great an immediate behavioral change for the majority.

14. Minimal behavioral changes are especially important as indicators for interventions moving beyond the innovator stage with its dependence upon isolated, individual decisions and into the peer-group requestor stage which is dependant upon the majority opinion. Since the majority of individuals are unwilling to distinguish themselves from their peer-groups, intervention success is dependent on mobilizing whole peer-groups.

Behavioral modification within a group requires bringing along the vast majority of the members; therefore, a wide range of gradual changes or "constrained deliverables" should be sought depending upon the sociocultural beliefs of the groups. Within a God-fearing, pronatalist, fatalist environment, some NGOs will only be willing to use non-technological interventions. For these groups, technological interventions may seem presumptuous or sinful but they may be convinced to promote systematic use of the Safe Period (rhythm method). Some will be ready to combine Safe Period with withdrawal or even condoms. In any case, eradication of the prevailing ignorance about the female menstrual cycle is a worthy deliverable that may ultimately serve to make marital, condom use more palatable.

IEC

15. IEC must respond more to the Nigerian (a) need for consensus, (b) respect for authority, (c) capacity to read, (d) lack of information, (e) and governmental inertia. The audiences must be targeted within the context of their peer-groups by influentials and authority figures. Government information campaigns offer the possibility of mobilizing people and resources for urgent, high profile interventions which would otherwise not take places. To fill the information gap, brochures and flyers with considerable information must be available for different levels of education. Simultaneously, standard mass media interventions should continue.
16. The prime targets for IEC should be **individuals within the context of their significant peer-groups**. The vast majority of Nigerians are discomfited by innovation and prefer to modify their behavior with the approval of their peers or influentials. Targeting peer-group audiences, rather than individuals,

allows the interventions to capitalize on the Nigerian preference to minimize the discomfort arising from taking responsibility for an innovative, unsanctioned behavior.

17. **Peer-group audiences** should be reached indirectly through their trusted influentials. Professional extension/networkers (E/Ns) should identify influentials who are receptive and capable of assuming the role of mobilizers for their own peers. The E/Ns should backstop these influentials providing them with information and assisting in the development of a work plan. Minimal funding assistance should be provided for IEC materials.
18. Sensitive behavioral change interventions should focus on those NGOs which perform value-reinforcing functions for their membership (mainly religious and primordial groups).
19. The authority of medical personnel, especially doctors, should be used to reinforce IEC activities.
20. Campaigns are a vital tool for mobilizing government resources. They absolve all concerned from individual responsibility and they facilitate release of government funds to respond to the urgent, high profile project. The recent, unsustainable but successful, EPI campaign should be criticized for its excesses in mobilizing funds and resources, but not for its methodology. They also maximize their impact by targeting individuals within the context of their peer-groups.
21. IEC activities must be prioritized under an overall strategy; however, considerable, diverse operations research activities must be on-going to evaluate alternative activities in response to the diversity of the audience and to the behavioral changes occurring among the audience segments.
22. Health Education/Communication (HE/C) must be perceived as central to primary health care by the decisionmakers and service providers. Primary health care is dependent upon an informed public, capable of limited self-care and ready to access service providers without undue delay. HE/C interventions targeted to particular sociocultural behaviors must be developed and disseminated and replicated, with the requisite modifications.

High and intermediate level HE/C Nigerian expertise must be assigned central roles in primary health care at all levels.

23. A protocol for rapid health-message development needs to be prepared and adopted within the Primary Health Care (PHC) system. Health messages must respond to the specific knowledge, attitudes and practices (KAP) of ethnic and religious groups as well as to their effective communication channels. For instance, the IEC strategy for introducing ORS into a

community that lacks the vocabulary word or concept for dehydration must necessarily differ from the strategy for a community that is aware of dehydration. Similarly, the strategy for a community that favors cornstarch porridge for sick people differs from the strategy appropriate for a community that favors sour milk.

Education

24. Pragmatic in-school Health Education responsive to the conditions in the schools should be actively advocated in order to reach the masses who constitute a captive audience within the schools. Student learning materials must be adapted to the prevailing methods of copying lesson notes from the blackboard and memorizing them. In addition, Health Education must be incorporated prominently into the examination systems. Otherwise, the impact of education on the intervention goals will be much less than optimal. Failure to institute pragmatic in-school health education will also restrict project sustainability and replicability.

25. Increased female enrollment in educational programs both in and out of school should be actively advocated.

Operations research should examine diverse methods of increasing enrollment. Shortened school days and/or modified vacation schedules might reduce parental resistance to schooling. Present school schedules conflict with parental need of their children's time and labor to contribute to their own subsistence.

26. Linkage of early marriage and girls education with fertility control is counterproductive in the Muslim North. Most parents are more concerned about protecting their daughters from the real threat of immoral acts since sexual activity is the norm for girls who have attained puberty.

Girls education and delayed marriage both have a significant impact on maternal/child health and merit interventions on health grounds.

27. Instructive brochures constitute an important form of continuing health education for Nigeria's large, literate population. They can fill the information gaps which exist even among the well educated. These gaps undermine project success and contribute to rumors. Brochures and pamphlets can also offer people a comprehensive rationale for interventions and a back-up source of knowledge to refer to should they become interested in an intervention when a health problem arises at a later date.

28. A teenage reproductive health brochure should be prepared for the moralistic viewpoint. A mass education brochure responsive to the prevailing moralistic values and pragmatic concerns about premarital sex can help teenagers to protect themselves. The objectives of the brochure should be minimal; it

should promote abstinence and describe the dangers of sexually transmitted diseases. The cooperation of conservative influentials should be sought in its preparation to facilitate use by religious groups and other NGOs.

The Family and Family Planning

29. Interventions that focus on ensuring female self-esteem and economic independence without providing males with similar assistance may contribute to an untimely breakdown of the conjugal family. Similarly, interventions that focus on promoting contraception among women without targeting men risk disrupting the family.
30. Because of their overwhelming influence on the desired behavioral changes, males must be targeted intensively. Interventions should be channeled through male peer-groups, coopting them and allowing them to take the lead rather than forcing them to follow the lead of women or external organizations. Realistic fears of loss of control over the economic and social aspects of their lives prevent many men from seriously considering fertility spacing and limitation.
31. Eradication of the association of contraceptives with promiscuity will free males to approve of spousal use. Legitimization of modern contraceptive use by the peer-group is a vital, goal essential to overcome the prevailing disapproval for religious and ethical reasons.
32. Behavioral research on marital relations and specifically on marital, sexual relations is essential to ascertain their influence on male and female fertility preferences and on patterns of extramarital relations. This research should include an examination of the extent to which extramarital sexual networking is as an alternative to postpartum abstinence (addressable by contraceptives); a response to incompatible sexual relations; a response to peer pressure; and/or other causes.

Research

33. Rapid ethnographic studies (RES) are essential before embarking on a variety of interventions. These studies are needed to identify: (a) relevant attitudes and practices among potential participants and beneficiaries; (b) credible influentials willing to participate; (c) grassroots communication channels; and (d) local role models and "anti-role" models (examples of the consequences of failure to adopt the interventions to be used in interpersonal social mobilization; for instance, victims of polio and AIDS).

It is essential to confirm that leaders are actually representative and credible influentials. Due to the pervasiveness of corruption in Nigerian society, the people's perception of influentials has undergone radical modifications in some areas. The people desire leadership by influentials who are distinguished by their honesty, education, hard work and demonstrated sense

of communal responsibility rather than merely by their official positions. The people recognize that officials in religious, primordial and other organizations are subjected to the temptations undermining the wider society.

34. The reliability of research on sensitive, private issues depends on the quality of the research questions and the personality of the researcher. Informants will withhold essential information unless the researcher is able to convey empathy and respect for the informant. Surveys are subject to disinformation, especially when they require an interviewer to record the responses.
35. Research must continue to develop profiles of adopters and non-adopters of the promoted behavioral changes. The profiles should be used to ensure realistic indicators and work plans as well as to provide the basis for the development of IEC messages. Psychological motivations for behavioral change should be considered in developing the profiles.
36. The program significance of increases in contraceptive prevalence among specific populations requires research to explore immediate ways of facilitating replicability. The increased contraceptive prevalence in Bornu following radio spots featuring traditional rulers and the high contraceptive prevalence in Ibadan are among the successes meriting replication.
37. The FHS Library should be expanded into a Health Information Clearinghouse. The HIIC should subscribe to the basic and project-related journals that usually carry articles on Nigeria. A photocopy machine express for the purpose of researchers should be accessible. This would greatly reduce expenses for Nigerians, for whom a day in Lagos is already an expense, and save considerable time (and therefore project money) for American consultants. The possibility of introducing an interlibrary loan type of photocopy service should also be explored.
38. Donors should require a minimum of five copies of research findings to be distributed to the HIIC Library and important Nigerian libraries including the National Library, the main academic library in the state of the research site, and others to be determined.

Financial Issues

39. Further research should be undertaken on cost recovery issues to establish the extent to which: (a) cost inhibits the spread of preventive interventions and causes significant delay in healthcare seeking for the sick child and the pregnant mother; (b) the Bamako Initiative Funding ensures drug availability and is essential as a sustainable funding source; (c) withdrawal of free drugs and especially free contraceptives is counterproductive to maximizing health care delivery; and (d) the influence of the people's will on LGA politicians can be exploited by requiring the allocation of LGA health funds on some sort of quasi-matching grant basis.

40. Measures must be designed to ensure that the poor are not deprived of intervention benefits. These measures must take into consideration the ethnic and religious diversity among LGA communities and within grassroots populations in urban and periurban areas.
41. Operations research should explore alternatives to donor vehicles including the viability of transportation allowances for supervision and local, private sector contracts for commodity transport.
42. Nigerian consultant fees and cooperating NGO personnel salaries require a thorough reassessment with a view to possible upgrading. Sustainability for any project requires not only that the salaries are not so high that they can not be sustained after the life of the project but also that they are competitive with salaries of competent, creative individuals with experience and initiative. Where Nigerians are working for and with an American CA, project-driven salary raises should be considered for the Nigerians as well as for the Americans.
43. The involvement of the private sector should be expanded to include more contract work with non-profit and profitmaking technical assistance organizations, research organizations, advertising houses and media businesses.

The Private Sector as Potential Donors

44. Private sector donations to intervention activities and NGOs carrying out intervention activities should be actively pursued for the funds themselves, for visibility, for sustainability and for replication. Public perception that all problems are being solved by international donors impedes private sector interest in public service support.

Requests are expected and honored by wealthy individuals and companies, often in a public context such as a launching. Public service broadcasting has supported several television series including Roots. Some Nigerian companies report enormous profits and a small group of Nigerians have become enormously wealthy. Banks and multinationals enjoy considerable profits. Oil companies are committed to the social welfare of the environment where their wells are located.

AIDS Prevention and Control

45. Concerted efforts to ensure minimal delay in NGO participant efforts to replicate AIDSCAP model work plans, even at the expense of quality replication, and to assist the NGOs in securing funding from local sources including affiliates of American oil and other multinationals will maximize AIDSCAP impact.

46. The State AIDS Programs can broaden the geographic spread of prevention and control interventions. Selected officials should be included in training workshops for NGOs to facilitate effective expenditure of allocated Nigerian government funds.
47. The AIDSCAP goal of "partner reduction" requires greater specificity in the African context where extra-marital sex is expected of husbands. While partner reduction as a goal encompasses pre- and extra- marital sex, since the vast majority of men and women are married, it is basically a non-judgmental euphemism for "mutual marital fidelity". Partner reduction remains appropriate for targeting pre-marital groups and extremely active, sexual networkers as well as serving as a backup to marital fidelity.
48. Activities designed specifically to overcome the lack of mutual marital faithfulness include promotion of the FHSII goal of increased, marital contraceptive use as an alternative to marital abstinence and promotion of the CCD2 goal of eradication of female circumcision with its negative consequences for mutually pleasurable sexual relations.
49. The general, sexual networking population requires targeted HIV/AIDS prevention IEC messages and behavior change support mechanisms in an effort to minimize the proportion of this group that continues risky sex with awareness but in denial.
50. A rapid ethnographic study to establish the extent and locales of itinerant commercial sex worker (CSW) activity in relation to rural markets where the peasants become clients of CSWs should be undertaken immediately. If the survey confirms that itinerant CSWs are spreading the disease throughout substantial areas of rural Nigeria, a modification of the CSW intervention strategy should be devised to cope with this non-residential, activity.
51. Given the sensitivity of the HIV/AIDS prevention project in Kano and Jigawa states, reliance on local personnel to direct the project and the involvement of indigenous groups and individuals in key program components is essential. The project in Kano should be coordinated by a male, indigenous program officer. A female, married woman would in all likelihood experience restrictions from her husband and male relatives on access to male policy-makers and CSWs, while a single unmarried woman might be stigmatized and looked upon as morally wayward and deviant.
52. Counselling is an important aspect of preventive medicine which, to be effective, must be followed up by tracking and counselling of the tracked partners. This is especially important to prevent the epidemic from infecting spouses and children who cannot otherwise protect themselves. Furthermore, protection of the familial fabric contributes to protection of the terminal

health care system in a nation where no governmental or other forms of insurance cover nursing care.

53. Tracking should become an integral aspect of prevention and control. Persons With AIDS (PWAs) may have had many sexual partners who themselves are continuing to infect others without realizing that they are carrying the infection. Tracking is also essential in order to ensure that the caretakers during the terminal stages learn how to control potential infection from contaminated fluids.
54. Research is needed to establish the roles of traditional health care providers in the handling of STDs including HIV/AIDS. The possibility of establishing a system of identification and referral of HIV infected/STD cases from the informal to the formal health sector and the possible role of traditional care providers in community based counselling services must also be considered.

VII. CONCLUSION

Sociocultural factors are central to all three project interventions and will influence their degree of success.

To a very great extent, all three projects demand a personal and societal reevaluation of core values and self-image including changes in private behaviors; faith in the microbe theory of illness; deviation from existing moral authority; belief in the ability to control nature with scientific rather than occult powers; and, rejection of a pronatalist and fatalist worldview.

This is particularly true for the family planning and HIV/AIDS projects which include behavioral changes actively opposed by large segments of the population; however, sociocultural factors will also impinge upon the success of the maternal/child health project. All three projects require that the beneficiaries be sufficiently convinced of the importance and utility of the health promoting behaviors being advocated and the services being offered to modify their personal behaviors and to come forward for the services despite competing beliefs and priorities.

The requisite behavioral change will take place only as a result of intensive and varied IEC initiatives. The support of credible influentials will be essential. These will often, but not always, include doctors and other medical personnel as well as traditional rulers, religious leaders and, in some instances, political leaders who can legitimize the requisite behavioral modifications. Given the prevailing authoritarian and communal socialization processes, the greatest IEC impact will occur when messages are received within the context of peer-groups.

Because of the vastness of the country and the multiplicity of ethnic groups and modified/traditional attitudes and practices impinging on the success of the interventions, rapid ethnographic studies must supplement epidemiological studies and operations research. The results of these studies should be transformed into specific implementation plans with the assistance of the participants and beneficiaries.

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