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A POPULATION STRATEGY FOR NIGERIA

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Executive Summary

Over the past ten years, Nigeria's population policy evolved slowly - from a pro-development stance in 1974 to a more positive position in 1984. Since the military coup in late December 1983, numerous events have occurred which now indicate steady progress toward a formal population statement and a nationwide family planning program.

The most significant evidence of key leadership concern for Nigeria's demographic situation is the statement by General Buhari which was presented at the International Conference on Population held in Mexico in August 1984 (see Appendix A). Subsequent to the Mexico Conference, the Federal Executive Council directed the Minister of Health to launch a nationwide family planning campaign. The drafting of a master plan for program implementation is underway.

Concurrent with the development of a population policy, the Ministry of Health requested that the U.S. Government play a significant role in the design and implementation of the nationwide family planning program. Therefore, U.S. Government representatives have initiated discussions with the Director of National Planning and the health leadership of the various state governments in order to lay a firm foundation for a population strategy for Nigeria. It is evident that even limited U.S. Government support can be important.

The population strategy, outlined in this document, addresses the two areas to which the U.S. Government will contribute, the development of a policy dialogue and increased service delivery. Resources will be directed toward training and manpower development; improving information, education and motivation; commodity supply and management; as well as record and statistical management/evaluation. Financial and technical assistance to Nigeria will be provided through a variety of AID centrally funded private voluntary organizations (PVOs).

The immediate objectives of the strategy are to establish and maintain a favorable policy climate and to increase the availability and accessibility of high quality integrated family health services throughout Nigeria. The long term objective is to encourage a modest but steady increase in contraceptive prevalence. The ultimate goal is to assist Nigeria achieve its development objectives by helping to reduce demographic pressures and to improve quality of life in the country.

A Population Strategy for Nigeria

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Introduction

Nigerian population policy has evolved very slowly over the past ten years from their pro-development stance at the International Conference on Population in Bucharest in 1974 to the August 1984 follow-on conference in Mexico City during which Nigeria pledged itself to develop a well-articulated population policy.

Although there has been some movement during the past eighteen months in the family planning services area, particularly at state level, no really significant action was initiated at the federal level until after the December coup. This Population Strategy Paper is divided into two parts. The initial section describes the evolution of the policy climate through recent post-Mexico City developments. The second section outlines an action strategy for responding to the evolving policy climate in Nigeria.

I. Policy Climate

A. General Background

Though it has all the characteristics of a country in need of stemming rapid population growth, Nigeria does not have an explicit national population policy to curb growth. As the most populous nation in Africa--one out of every four Sub-Saharan Africans is a Nigerian--and the tenth largest country in the world, a policy commitment here would have ramifications beyond its borders.

Nigerians feel acutely the health consequences of their high fertility: 13 to 14 of every 100 children born die before their first birthdays, and some say 170 of every 1,000 mothers die in childbirth. Both of these indicators are high, even for Africa (see Appendix B for more data), and reflect in part multiple and too closely spaced births.

In addition, the economy in which Nigeria's rapid population growth is taking place is increasingly strained. At current rates of population growth (an estimated 3.2 percent a year), Nigeria's population will double in two decades. At the same time, the country's underdeveloped infrastructure makes it very unlikely that economic output can double as rapidly. Increasing the per capita output to raise living standards is even further from Nigeria's grasp. Even the subsistence economy in Nigeria, once insulated from declines in the international economy, is failing today. Drought and the return to rural areas of unemployed migrants has caused economic strains to be felt in both rural and urban areas.

B. Past Policy Development

Like most governments around the world, Nigerian governments have historically either welcomed population growth or viewed it with unconcern. Economically, population increases have been seen as an addition to productive capacity. Ethnic and religious competition has encouraged groups to welcome increases in their numbers as an addition to their strength. At the individual level, Christians and Muslims alike have traditionally seen children as a blessing from God that should not be questioned. These factors, combined with a quite universal distaste for government interference with something so personal as child-bearing, have kept the Nigerian government out of the business of making explicit policies to slow population growth or reduce fertility.

In spite of the foregoing, policy thinking has gradually come to favor a slower population growth rate. The change in thinking is summarized by the following quote from I. O. Orubuloye, "Toward National Policy on Population" Population and Development in Nigeria, I. O. Orubuloye and O. Y. Oyeyeye (eds.) (Nigerian Institute of Social and Economic Research: Ibadan, 1983):

"The Nigerian government recognized as far back as 1970 that the population of the country was growing at a rapid rate. However, the rate of growth was not considered to be a serious obstacle to domestic economic progress because of the general belief that the country is endowed with a large natural resource to cope with the menace of a rapidly growing population. This official position was re-emphasized by the Government delegates to the 1974 World Population Conference at Bucharest where it was officially stated that, 'given the efficient administration of the country's resources, the capacity of the economy to cope with a population growth rate of 2.5 percent per annum is not in doubt.' It is now generally recognized that the rate of growth...officially quoted by the Government is a gross underestimate of probable levels. Recent economic trend(s)... indicate that the capacity of the economy to cope with the rate of population growth of even 2.5 percent per annum is in serious doubt."

While recognition of the adverse economic consequences of rapid population growth came gradually, official support of family planning as an element of health

care came earlier. The objectives of the Second National Development Plan of 1970-74 included the integration of family planning schemes into national health and social welfare programs; each development plan since then has included support of family planning; and the Nigerian government has made grants--called "subventions"--to the Planned Parenthood Federation of Nigeria (PPFN) since 1975. Indeed, participation of officials at the highest level in PPFN affairs has been constant up to former President Shagari's services as PPFN's honorary president.

Despite PPFN's efforts, a tiny fraction of Nigerian women use modern contraception--on the order of 2 or 3 percent of married women between 15 and 44. This is not a complete indicator of family planning acceptability, though: Nigerians have practiced family planning, if unwittingly, for years in the form of prolonged breastfeeding (two to three years) and sexual abstinence during the breastfeeding period, both to ensure maternal/infant health. Sufficiently convinced of its health benefits, Nigerians might accept family planning offered as a complement to or return to traditional practices.

Other actors on the Nigerian scene did not lend their weight to the population issue. The intellectuals have generally avoided the subject. The top leadership at the National Population Commission was actively pro-natalist. The National Population Bureau was created in 1965 and given a constitutional mandate in the late seventies as the National Population Commission to carry out the long-awaited census and to report to the President on population issues. The Commission was originally headed by a northern Nigerian who held traditional values in favor of large families.

The only federal level support for family planning was the Ministry of Health and even there it was not great. However, the Director of National Health Planning, Dr. A. B. Sulaiman, worked with the AID Affairs Officer (AAO) to develop the details of the Integrated Family Health Project, which folds family planning services into primary health care such as oral rehydration therapy and immunization.

During the final months of the Shagari administration, U.S. Embassy staff was advised that the President had made a decision to proceed with family planning as a federal policy. The Vice President spoke out strongly against the dangers of rapid population growth. The Army announced that family planning would be provided

at all their health units. Before steps were taken to implement these policies, the Shagari administration was overthrown on December 31, 1983.

C. Developments in the Federal Military Government (FMG)

Shortly after the coup, there were indications that the new FMG administration would take a more positive attitude in the population field than their civilian predecessors. In fact, a few days after the military take-over, Brigadier Rimi, Director of Medical Services, Nigerian Army Medical Corps, approached the Embassy to request support for family planning programs to be initiated throughout the Army medical system. At that meeting, Embassy staff was advised that the new Head of the Federal Military Government, Major General Buhari, was firmly committed to family planning and had in his immediate past post initiated the first family planning program in the Army.

More recently, Rimi's counterpart in the Navy requested similar technical and commodity support.

More importantly Major General Babangida, Chief of Army Staff, has spoken publicly of the need for the military to practice family planning. A number of the military governors have been quoted in the press as having noted the relationship between population growth and food requirements. Brigadier Useni, Governor of Bendel, was more explicit in referring to the dangers of severe population density. Other military governors have couched their call for family planning programs in terms of its health benefits. During the Shagari administration, only one governor (Gongola) requested AID support for integrated family health. Whatever their rationale, requests have now come to the Embassy from sixteen of the nineteen States.

Similarly at the middle levels of policy development, civilian planning directors at the Ministries of Agriculture, Education, Labor, Health and National Planning have demonstrated an awareness of the implications of rapid population growth for their development goals. Except for the Ministry of Health, however, these directors appear to see no role for their staffs in dealing with the population problem.

The most dramatic post-coup shift in attitude toward population growth has occurred at the National Population

Bureau. This change is of utmost importance because the Bureau is the logical place to signal a policy change. Since the Bureau is now located in the Office of the Cabinet, it doubtless reflects top-level thinking more than individual ministries do.

After the coup, the FMG appointed a new director, Chief Fred Falodun, to the National Population Commission and renamed it the National Population Bureau. In September, Falodun is hosting a national seminar for private and public sectors and academic people to discuss the implications of the Nigerian Fertility Survey. A recommendation to the Secretary to the Cabinet, to whom Falodun reports directly, is expected to result from the seminar. At the seminar Falodun is likely to express his view that Nigeria's Fertility Survey, which reveals that Nigerians consider a very large family ideal, is proof that development is not in fact the best contraceptive, as many developing nation representatives argued at the Bucharest Conference on World Population in 1974.

At the user level, there has been nothing which could be termed a significant increase in demand over the past eighteen months. In fact, experts from the Centers for Disease Control (CDC) have estimated an increase from two percent prevalence to three percent during this period. However, some states e.g. Ogun and Kano, have increased user rates by more than 250 percent. Another indication of increasing demand at the "grass roots" level is that the high price of contraceptives here as compared to other developing countries, has not deterred an increase in demand.

D. The Mexico City Conference Developments

Surely one of the watersheds in the development of a population strategy for Nigeria was the International Conference on Population held in August 1984 in Mexico City. A number of events helped to dramatize Nigeria's perilous position. Probably the most effective instrument in highlighting the situation was the release of the World Bank's World Development Report 1984. This report draws particular attention to the demographic situation in sub-Saharan Africa. According to World Bank projections, Nigeria's population will have reached 320 million, i.e., more than in all of Africa today, before it will stabilize. This report plus speeches citing similar statistics by the President of the World Bank and the Director of FAO received wide coverage in the Nigerian press. In the wake of these articles came a spate of editorials all calling

on the Government to take action now before coercive measures were required. It is particularly noteworthy that the two quasi-governmental dailies were in the forefront of the media blitz. Equally important was the pro-family planning editorials in the Eastern and Yoruba press which less than a year ago were propounding pronatalist sentiments.

In the wake of these editorials came national television coverage of Chief Falodun from Mexico City saying that Nigeria recognized its population problem and would take steps to deal with it.

The most positive evidence of Nigeria's growing concern for its demographic situation was General Buhari's statement for the Mexico Conference. After referring to gross demographic rates including substantial rural to urban movement, the statement calls for reappraisal of the 1970's view that population growth is not a matter of concern. Specifically Buhari states that "It is Government's view that something has to be done to ensure that the galloping population growth rate and over-urbanization do not eclipse efforts being made by government to improve the economy and enhance the quality of social services available for the people."

The statement then goes on to say, "We in Nigeria now feel that in the face of rapid population growth, a well articulated population policy is necessary. Such a policy should have as main focus, guidance in fertility behaviour which will emphasize the health of both mother and child. This policy calls for the re-orientation of mothers as to the benefits of adequate birth spacing, a practice which has long been embedded in the African tradition but which is being eroded by the influence of modernization." (For full text, see Appendix A)

E. Post-Mexico City Actions

At the first meeting of the Federal Executive Council following the Mexico Conference, the Minister of Health was asked what his Ministry was doing in the family planning field. One week later (August 23), the Minister received a directive at the Executive Council's meeting to launch a family planning campaign.

This action is very much in line with the action taken by the Army in launching its own family planning program, i.e., the troops were encouraged to and informed

of the idea of having smaller families long before their clinics were able to provide services to accepters.

In the case of the Ministry of Health, family planning will be the third in a series of health campaigns, the first two being expanded immunization/oral rehydration program and safe water/sanitation. General Buhari will inaugurate the first program and may well launch the family planning campaign. Timing has not been determined.

F. Summary - Policy Climate

The climate for an effective population strategy has evolved rapidly in the past eight months, largely in response to the deteriorating economic situation in Nigeria. Indeed, Nigeria, under General Buhari, may well provide leadership for the African region in the population area. Speaking at the opening of bilateral talks between Nigeria and Togo on August 28, General Buhari said that Third World Nations ought to close ranks and work together so as to combat the worsening drought problem, and the increasing growth in population, which so many of them are finding hard to cope with.

In spite of having very limited resources at its disposal for Nigeria, there is an important role for the U.S. Government in working with the Government of Nigeria as it begins to deal with its most serious long range problem. The next section of this document outlines an action strategy for doing so.

II. Action Strategy

In response to an evolving policy climate favorable to population activities in Nigeria, the U.S. Government has undertaken a phased population strategy directed toward the development of a policy dialogue and increased service delivery. The assumptions on which this strategy is based are included in Appendix C.

Before outlining the action strategy itself it is important, at this juncture, to review the historical developments leading to its formulation.

Prior to the arrival of the current Aid Affairs Officer (AAO) in February 1983, there was a period of eight years during which there was no U.S. direct-hire AID staff in Nigeria. During these years, however, limited AID activity continued in the areas of education (under the AID Block Grant) and population (through some dozen centrally funded PVOs). The population activities during this period were primarily in the areas of training and operations research to test the acceptability of family planning among rural populations. Although these program activities were generally small and appeared to be diffused in their impact, they did, in fact, develop a core of family planning supporters throughout Nigeria.

In March 1983, the newly arrived AAO met with Dr. Sulaiman to work out a broad outline and schedule for implementation of an integrated family health program. It was agreed that the program content should be directed toward three key health interventions -- family planning, oral rehydration therapy and immunization. In addition, it was agreed that the program should be directed toward leadership and manpower development; cost-effective service delivery; improvement of service facilities; development of public information and awareness; and standardization of record and reporting systems. The underlying principle would be standardization of program elements within the federated system of Nigeria.

Subsequent to the AAO/Sulaiman discussions, a team of international experts, sponsored by the American Public Health Association (APHA) visited Nigeria for three weeks in June of 1983. The team travelled to eight states to review interest, commitment and readiness to initiate integrated health services. As a result of this visit the team recommended that three states be selected as "acceleration" states for intensified program activities.

The situation was moving so rapidly that by August 1983 five states had been designated as "acceleration" states and by December 1983, a total of eight states had been so designated. There was a pause in program development following the military coup and no additional states were designated until August 1984, when three additional states were included for a total of eleven acceleration states. During the same period (June 1983 - August 1984) UNFPA has maintained its activities in five states. Under the strategy, developed in collaboration with the Director of Health Planning, all nineteen states in Nigeria will be included in a nationwide program by December 1985. (See Appendix D for the phased schedule for program acceleration.)

In addition to the designation as an "acceleration" state, each state was placed on either Track A, B, or C, depending on its readiness for program development. The criteria used to determine program readiness and track placement include degree of leadership interest, commitment and support; availability of suitable service facilities; and availability of trained manpower for service delivery. (See Appendix E for further explanation of the track system and track assignment.)

In April 1984, at the Ministry of Health donor's coordination meeting, it was agreed that for the integrated family health program, the U. S. Government and UNFPA would take the lead in supporting population/family planning activities. UNICEF and WHO were designated as the primary agencies for activities related to oral rehydration therapy and immunization with the U. S. Government playing a supporting role. In August 1984, the Ministry of Health requested U. S. Government assistance in drafting the master plan for a nationwide family planning program.

Therefore, because of increasing U. S. involvement in population activities, the U. S. Government has developed this population strategy for Nigeria. The strategy objectives are straight forward:

- to establish and maintain a favorable policy climate which will lead to the development of an official population policy statement and lay the policy framework for the development of a nationwide family planning program; and
- to increase the availability and accessibility of high quality and integrated family planning services throughout Nigeria; and
- to coordinate all U. S. inputs so that they are standardized and systematic and are consistent with the overall national integrated family health program supported by multiple international donors.

The long term objective is to encourage a modest, but steady increase in contraceptive prevalence. The ultimate goal is to assist Nigeria achieve its development objectives by helping to reduce demographic pressures and to improve quality of life in the country.

U.S. support to population activities in Nigeria is to cover a five year period, from June 1984 to June 1989. U.S. program support is expected to phase out in five years except for continuation of the supply of contraceptive commodities, residual program monitoring, and high level policy dialogue.

The key actions for U.S. Government involvement in Nigeria through a policy dialogue and service delivery are described below in the Sections A and B.

A. Policy Dialogue

Although the attitude of the leadership (political and intellectual) toward population has shifted remarkably during the past year, and particularly the past three months, the policy dialogue necessary for full understanding of the demographic realities has only just begun. To further foster the development of an official population policy and a favorable policy climate for a nationwide family planning program, the U.S. Government, at a minimum, can:

1. Raise the demographic issue, as appropriate, when discussing development and economic issues with the highest levels of the Federal Military Government. In general, the U.S. spokesman at this level will be the Ambassador. In terms of policy determination, this is the most important level to reach.
2. Pursue similar policy initiatives at lower levels (ministers, governors, and permanent secretaries). U.S. spokesmen: the Ambassador, the Chief of Mission, counselors, as appropriate.
3. Continue the policy discussions and planning exercises already underway with directorate level leadership within federal and state bureaucracies. In terms of continuity and field action, this is the most important level of contact to maintain.
4. Provide Resources for the Awareness of Population Impacts on Development (RAPID) demonstrations for the Council of Ministers, the Supreme Military Council, and selected Governors. Chief contact point in the Nigerian Government is the Director of National Population Bureau or in his absence the Minister of National Planning.

5. Continue dialogue already underway via the presentation of the nine micro-computers with ministers, permanent secretaries and directors of planning in key Ministries of National Planning, Agriculture, Education, Health, Finance as well as the Office of the Cabinet.
6. Sponsor participants to technical and policy-making workshops. A visit to Indonesia to observe and consult with the military leadership there, regarding the key role General Suharto and his staff have assumed in motivating/monitoring a highly successful population program within an Islamic setting, would be particularly useful. Pathfinder Fund is a likely sponsor.
7. Serve, to the extent appropriate, as a marriage broker between World Bank and the Nigerian Government officials regarding Nigerian census activities and other Bank initiatives in the population field.
8. Stimulate World Bank Officials to expand their policy dialogue on population with Nigerian leadership beyond the Ministry of Health. Particular attention should be focused on Bank dialogues with Ministries of Finance, Agriculture and Education with whom the Bank has on-going projects.
9. Encourage UNDP to initiate discussions on demographic issues beyond the service programs of UNFPA.
10. Follow-up on the excellent initial entry of FAO into the population field in Africa. This effort will be coordinated through FAO/Rome.
11. Develop contacts with the media to inform them of recent trends in demography, population policy and family planning. This is a key activity for both Embassy staff and AID contractors.
12. Support the efforts, just getting underway, by private organizations including Nigerian institutions, to discuss the economic/social implications of rapid population growth. This is in the pattern of Mexico where private and public banks and other businessmen were successful in influencing the Mexican leadership to pour real resources into population programs.
13. Assist with the processing of demographic data which can be used for government decision making on population related activities.

B. Service Delivery

As a complementary exercise to the population policy dialogue described in Section A, U.S. population program support will be

provided to increase the availability and accessibility of high quality integrated family planning services in both the public and private sectors throughout all of Nigeria.

The four program elements of the service delivery strategy consist of the following:

1. Training
2. Information, education, and motivation
3. Commodity supply and management
4. Records and statistical management/evaluation.

The underlying principles of the service delivery program are cost effectiveness and patient acceptability through standardization of systems of training, information, supply, and clinic/client management. Standardization allows for the development and implementation of a nationwide program within the federated structure of the Nigerian Government. Constant vigilance is required to guard against the erosion of the standards which have been developed in full consultation with the Federal Ministry of Health, the body responsible for policy guidance to the states.

Service activities are to follow the guidelines of both the U. S. and Nigerian Governments; i.e., the programs are to be completely voluntary and are not to include any abortion related activities. Another general principle of U. S. support is that neither vehicles nor supplemental government salaries are to be provided. To the maximum degree possible, all training is to take place in-country with only fully justified exceptions being sent to the U. S. for short-term technical training, e.g., micro-surgery.

In contrast to the policy dialogue activities which are carried out largely by Embassy staff, the service delivery activities are undertaken primarily by AID/W centrally-funded contractors. (For a summary of current contractor activity in Nigeria, see Appendix F.)

Contractor inputs are coordinated to achieve maximum returns by the AAO and the AID Affairs Office in full collaboration with the AID/W project managers. In regard to AID contractor activities in Nigeria, the AAO's most important role is that of ensuring program continuity within the overall country strategy; emphasizing standardization in design of all inputs; and encouraging contractors to think at least at a state level rather than at a small discrete project level which previously characterized population activities in Nigeria. AID/W contributes significantly to coordination efforts through its quarterly meeting of the Washington Working Group on Nigeria as well as its day-to-day monitoring activities. (See Appendix G for a schematic view of the lines of coordination.)

At present, none of the AID contractors has staff based in Nigeria. In view of its wide range of activities here, the Pathfinder Fund is expected to appoint a full-time country representative and an information specialist before the end of 1984.

Typically a state becomes eligible for service delivery program support by expressing a strong interest in family planning. Often this interest initially is expressed to the Director of National Health Planning, who, in turn advises the AAO. To follow-up on these requests, the AAO and appropriate staff visit the state, meet with the state Commissioner of Health, the Permanent Secretary and other key Ministry of Health staff. At that time the AAO outlines the type of support which can be provided and notes that which is not available (vehicles and salary supplements). Then the AAO outlines what the state is expected to provide for the program (staff, facilities, vehicles and administrative support). The AAO then requests the staff to draw up a basic state implementation plan. Often it is necessary for the AAO to return to the state to work out the details of the plan. Subsequent visits are mainly undertaken by AID contractor staff who come to Nigeria for brief (approximately 2-3 weeks) field visits. The contractors then work out their specific project activities and determine the level of project input. The contractors periodically visit the state to provide technical assistance and to monitor on-going activities. (See Appendix H for a summary of projected and on-going AID-supported programs by state.)

The specific areas of program emphasis of the four service elements (training; information, education and motivation; commodity supply and management; and records and statistical management/evaluation) are outlined in the following narrative.

1. Training

The purpose of training activities is to develop a cadre of personnel capable of planning, implementing, and evaluating family planning service programs. To achieve this objective, U.S. supported activities are to focus on the following:

- a) Development of standard curricula for training of all levels of health personnel.
- b) Training programs for medical personnel to develop the clinical skills necessary for family planning service delivery.
- c) Training programs to develop in-country expertise in planning, management, and evaluation of programs.
- d) Provision and development of appropriate resource/reference materials for training.

In-country courses of up to four weeks duration in family planning, oral rehydration therapy, and immunizations will be provided for in-service doctors, nurse/midwives and health technicians. The vast majority of these trainees will be employees of the state ministries of health. However, some trainees will be from the military and from the private sector. In contrast to the in-service training programs described above, pre-service training in the same three subjects will be provided in-country to nurse/midwifery tutors at the official schools of nursing, midwifery and health technology in Nigeria. In turn, the tutors will train present and future students in family health techniques. The principal training contractors are Johns Hopkins University for pre-service training, and the University of North Carolina and the Pathfinder Fund for in-service training.

About 60 percent of the in-service training will be undertaken at state ministry of health facilities, utilizing Nigerian and U.S. teachers. Another 40 percent of training will take place at regional training centers to be located in Kano and the Universities of Ibadan, Benin, and Ahmadu Bello. These four regional training centers, being developed by Johns Hopkins, are the key to the training effort in that they will provide for training of personnel from remote states such as Gongola and Bauchi which lack training facilities.

In brief, over the next five years, the in-service and pre-service training programs will provide training, which meets international standards, to all service staff in the 19 state ministries of health. In addition, all nurse/midwifery tutors should be trained during the same period, thus insuring that all future nurse/midwives will be trained without further U.S. inputs.

In-service training of personnel in the private sector will follow the same international standards as developed for the government program. However, the training programs will, for the most part, be sponsored by and conducted at mission hospitals, e.g., Seventh Day Adventist and Anglican hospitals. Family Planning International Assistance (FPIA) and the Pathfinder Fund will be the main resources for private sector programs. These private sector efforts are expected to evolve from strictly training activities to full service centers which will serve clients who either prefer not to use public facilities or have no access to them. Private sector programs are expected to be vital to full country coverage, particularly in eastern Nigeria.

All AID supported training programs will include instruction in natural family planning which may be preferred by

couples who do not like artificial contraceptives or who have religious beliefs against using artificial methods. Efforts to interest Nigerian organizations in offering natural family planning will be continued by FPIA and Pathfinder, both of which have successful natural family planning projects in other African countries.

As the training needs in clinical skills are met, the emphasis will shift to training in planning, management, and evaluation. Major roles in this area will be assigned to the Centers for Disease Control (CDC), Pathfinder, Johns Hopkins and FPIA. Beneficiaries will be the staff of the ministries of health and Planned Parenthood Federation of Nigeria (PPFN).

To reinforce the training curricula, 13,000 copies of the book Family Planning Methods and Practices, developed by CDC with five African counterparts will be provided to tutors and trainees throughout Nigeria. Copies will also be given to program managers and service providers in the government and private sectors. In addition, training contractors will provide or assist in the development of appropriate standardized teaching and resource materials.

Because of the size and complexity of Nigeria, training is to be conducted on a phased schedule: first, Track A states, then Track B, followed by Track C. This phasing was determined by evidence of state interest and support, the general status of program readiness as well as the geographic and ethnic spread (see Appendix E).

2. Information, Education and Motivation

Almost as important as clinical services, and far more difficult to achieve, is an information component of a broad gauged population program. The purpose of the information/education component of this strategy is to ensure that every potential acceptor has adequate and accurate information upon which to make an informed decision regarding family planning. Again, an underlying theme of this program is standardization. In this case, uniform information about family planning.

Initial activities which will be carried out under this strategy include the design, development and testing of standard information/education materials. Written and visual materials will explain the health and economic benefits of child spacing, introduce the concept of family planning and the available contraceptive methods, and seek to allay fears and misconceptions regarding the various methods. In recognition of the diversity of

of language groups in Nigeria, the messages will be prepared in English, Yoruba, Hausa and pidgin English.

Family planning information generally can be divided into two categories: information which provides facts or information which seeks to be persuasive. Because of concern for client welfare, the first pamphlets produced in 1984 in Nigeria with AID support dealt with client counseling on three major contraceptives (the pill, the intra-uterine device (IUD), and the condom). Illustrated pamphlets with simple, but essential points of information in local languages were specifically designed for illiterate or semi-literate accepters. Each accepter is to receive a pamphlet to give her confidence during her early months as a contraceptive user. One of the major benefits of these pamphlets is the standardization of patient counseling which arises from their use in clinical settings.

The only other informational brochure presently scheduled is a pamphlet which explains family planning concepts to husbands. This pamphlet has been requested by a large number of men and women. Its publication date is scheduled for the spring of 1985.

In addition to the factual information for patients, materials to motivate and persuade new accepters will be designed and disseminated. Motivational materials will include television and radio spots, news features, video tapes and clinic posters. Eventually, it is hoped that these materials will be used throughout Nigeria, but the initial testing will be mounted as an integrated medical campaign, organized by PPFN, in Plateau State in January 1985.

The key Nigerian organization through which almost all of the information efforts will be funneled is the Planned Parenthood Federation of Nigeria (PPFN). For example, all informational materials developed will bear the imprimatur of PPFN and general promotion efforts will be sponsored by PPFN.

The two principal U.S. contractors involved in the information area are Johns Hopkins University and Pathfinder. Specialists from these organizations will collaborate with Nigerian and U.S. officials in the development of a three-year information/media campaign which will emphasize both the health and economic benefits of child spacing.

3. Commodity Supply and Management

The purpose of the supply component is to ensure that the necessary contraceptive commodities and equipment are

available for service delivery. To that end, AID/W will provide contraceptive supplies as needed for the expanding nationwide family planning program.

However, like an army, a family planning program succeeds or fails depending on the effectiveness of its logistics system to get supplies to the front line. The supply situation in Nigeria is complicated by the fact that, except for vaccines, there is no unified Ministry of Health logistics system. Thus, it has been necessary to design, for contraceptive materials, a parallel system capable of delivering bulky commodities to the 19 state medical warehouses.

As a gesture of good will, and without cost to the Governments of Nigeria and the United States, Sterling Products (Nigeria) Ltd. is storing and transporting all of the AID funded contraceptives and clinic equipment to the state warehouses. This system, which has been functioning since June 1984 in the first acceleration states, the Army, and Ibadan Teaching Hospital, has been extremely successful. Full credit goes to Sterling and to FPIA, together with CDC, for designing the unified system. This supply system will be extended to all states by December, 1985 (see Appendix E).

To date, two large air shipments of contraceptive supplies and clinic equipment have been received and forwarded to eight states. In addition, a consolidated sea shipment to meet contraceptive and related equipment needs for all 19 states is expected this fall. These supplies are projected to last until December 1985. Projections for this shipment were made based on an assessment of program readiness of the various states (e.g., Track A, B, or C) as well as in consultation with 14 states, the Federal Ministry of Health, CDC, FPIA and the AAO.

As an integral part of the supply component, Africare will provide a medical equipment specialist who will survey selected clinics to determine suitability and acceptability of sites as model service facilities. After the completion of this survey, Africare will provide 63 clinics with basic medical equipment and supplies necessary for family planning services. These especially equipped sites will serve as referral points for difficult cases and as centers for on-the-job training.

4. Record and Statistical Management/Evaluation

The purpose of this program component is to ensure the development and implementation of a standardized record

record and statistical system. Statistical analysis will provide a basis for comprehensive program management and evaluation.

Working in concert with the federal and state ministries of health, CDC has designed a standard record keeping system which, in addition to providing the basis for re-ordering supplies, will also serve as an important base for future evaluation of program effectiveness.

This new standardized service statistics system, already approved by the Federal Ministry of Health, will be the subject of a five-day nationwide workshop in early 1985. At the workshop, a joint staff from CDC and Pathfinder will provide nationwide to state family planning coordinators and their deputies, case-method training in program planning/management/evaluation, including the use of the supply management and service statistics systems.

In order to provide safe and effective child spacing services, each acceptor must have a record with limited but essential medical/social family planning information about the user. Again, CDC designed a standard patient record card based on input from five states. This patient record card, approved by the Federal Ministry of Health in August 1984, will be utilized at all government facilities and, on a voluntary basis, at private facilities.

The statistical forms and record cards for the system will be printed and distributed to all family planning service sites.

C. Other Program Elements

As noted earlier, policy development and service delivery are central areas of concern of the population effort in Nigeria. However, other program elements will not be neglected. The most important ones fall into the operations research/bio-medical research categories. These programs are:

1. Rural Community-based distribution (CBD)
2. Urban Community-based distribution
3. Commercial retail sales (CRS)
4. High-risk patient services
5. Contraceptive acceptability research

The community-based distribution program in rural Oyo State has been underway for several years under the leadership of Ibadan University with support from Columbia University and Pathfinder. The Oyo State Ministry of Health is very pleased with its acceptability to rural families and therefore, the CBD program will be fully transferred to the state in December, 1984.

This transfer will free the University of Ibadan to turn its attention to testing urban community based distribution. A CBD program is planned in Ibadan with market women serving as the distributors. This program is scheduled to get underway in January, 1985.

If AID/W central funds are available, a commercial retail sales program will be launched initially through pharmacists in Lagos. In designing this project, full advantage will be taken of the lessons learned from the highly successful CRS project in Bangladesh.

Nigeria has a wide distribution of physicians trained in obstetrics/gynecology. There are a large number of Nigerian women for whom another pregnancy is a life-threatening situation. These women and their husbands recognize the need for a permanent contraceptive. To meet this need, the International Project is equipping fully-trained OB/GYN specialists to respond to this growing demand from high-risk patients.

Bio-medical research, through Family Health International and the Population Council, has been underway in Nigeria for many years. Presently, this research is focusing on the acceptability of low-dose pills. It is hoped that Nigeria will also be selected for field trials for the new contraceptive implant "Norplant" from Finland. In addition to their inherent worth, this type of in-country research serves to answer potential critics who assert that U.S. pharmaceutical formulae do not suit African women.

Due to local sensitivities, it is not proposed to fund projects for the specific purpose of providing contraceptives to adolescents. Rather, support will be provided to state ministries of education to train instructors at teacher training colleges throughout Nigeria in family life education and responsible parenthood. The program, which is scheduled to get underway in October 1984, will be administered by the Center for Development and Population Activities, a Washington-based educational institution.

D. Program Coordination

With the rapid growth of the program, coordination is a must rather than a formality. It is a time-consuming but essential task in a federated system like Nigeria.

At present, there are only three international donors, i.e., the U.S. Government via AID, the United Nations via UNFPA, and the International Planned Parenthood Federation (IPPF) via PPFN. Large shares of UNFPA and IPPF funds come from AID/W grants. In August 1984,

UNICEF and WHO both indicated to the Federal Ministry of Health that they wished to become involved in the integrated family health program. In addition, the Federal Ministry of Health informed Embassy staff that the Government has recently reversed its stand not to borrow from the World Bank to support family planning activities. Therefore, there is the likelihood of six major international donors, whose efforts will need to be carefully coordinated.

Fortunately the Federal Ministry of Health took the initiative and called the first donor coordination meeting in February 1983 and has followed up with two more meetings. The tempo of these coordination meetings will accelerate markedly, however, as a result of the August 23, 1984 Council of Ministers Directive to the Federal Ministry of Health to design and launch a nationwide family planning campaign.

The Director of National Health Planning requested Embassy staff to play a significant role in developing a master plan to increase family planning information and services throughout Nigeria. It is understood that other international donors and Nigerian organizations will also participate in the master plan exercise.

The exact role of UNICEF and WHO has not yet been determined. Informal arrangements agreed to by the Federal Ministry of Health, UNFPA, PPFN, and AID are as follows:

1. UNFPA will continue to support district and state level activities in five states--Borno, Niger, Ondo, Rivers and Sokoto.
2. UNFPA will provide vehicles, injectables and audio-visual hardware to all states.
3. UNFPA supported programs will utilize AID developed informational materials in their programs.
4. UNFPA will develop uniform standing orders for family planning services for use throughout Nigeria.
5. UNFPA will consider supporting programs in additional states.
6. UNFPA will support PPFN in its information and training roles.
7. PPFN, as state governments assume a greater share of the clinical service program, will turn its attention to motivation and to testing CBD programs.

8. PPFN will take the leadership role nationwide for information development and dissemination.
9. AID will support PPFN's expanded information/motivation role.
10. AID will provide orals, IUDs, condoms and FDA approved contraceptives and associated medical equipment for the nineteen states on a phased basis (see Appendix D and E).
11. AID will provide in-country training for clinical and teaching staff throughout the country.
12. AID will provide planning/management training (policy and supervisor levels) for both the public and private sectors throughout Nigeria.

In an effort to maximize resources and avoid duplication, the U.S. Government will continue to participate in the coordination of the national integrated family health program. Embassy staff will meet frequently with leaders of the Federal Ministry of Health and with the major international donors (IPPF, UNFPA, World Bank, UNICEF, and WHO) to design the master plan and coordinate donor efforts. In addition, U.S. Embassy staff will seek to coordinate and monitor efforts of the AID centrally funded private voluntary organizations to insure that their inputs are standardized and systematic, and are consistent with the overall national program supported by international donors (see Appendix G).

A consolidated flow chart for all donor activities and Nigerian inputs will be developed after the master plan for the national family planning campaign is designed and accepted. This flow chart will become Appendix I and the master plan will become Appendix J of this document.

III. Illustrative Budget

U.S. Government Contribution
(Through AID Centrally-Funded Organizations)

ESTIMATED BUDGET BY ACTIVITY

ACTIVITY	FY 1984 ('000)	FY 1985 ('000)	FY 1986 ('000)	FY 1987 ('000)	FY 1988 ('000)	FY 1989 ('000)
Technical Assistance	400	600	650	700	650	650
Policy Dialogue	190	80	80	50	50	50
Program Planning	134	180	200	200	150	150
Physician Training	520	400	300	300	200	100
Nurse/Midwife Training	1,200	1,800	2,000	2,000	1,500	1,000
Teachers Training	500	0	0	300	300	300
Management Training	154	250	250	250	250	250
Contraceptive Commodities *	660	770	1,209	2,080	3,120	4,550
Medical Equipment	1,000	1,200	1,200	1,000	1,000	800
Information/Education	645	1,000	500	400	400	400
Community Based Distribution	595	800	400	400	400	400
Commercial Retail Sales	0	150	500	500	500	800
High Risk Service	50	75	100	100	125	125
Bio Medical Research	45	55	50	30	30	30
Social Research	90	15	15	0	0	0
Operations Research	60	60	60	30	30	30
TOTAL	6,243	7,435	7,514	8,340	8,705	9,635

* Includes Commodities provided by AID/W



SPEECH OF HEAD OF FEDERAL MILITARY GOVERNMENT
ON POPULATION IN NIGERIA TO THE INTERNATIONAL
CONFERENCE ON POPULATION HOLDING IN MEXICO CITY
FROM 6TH - 13TH AUGUST, 1984

The world over, the fear that the rate of population growth is fast outpacing the rate of growth of the resources available to mankind is giving well meaning leaders of thought some jitters.

2. The 1963 population census puts the population of Nigeria at 56 million. Forward projections of this figure using the official rate of growth of 2.5 per cent per annum, implies that the population of the country is about 91 million in 1984. This being the case, by the turn of the century, Nigeria's population will be about 150 million.

3. The population size of Nigeria is a product of a persistently high fertility coupled with a steadily declining mortality. The Crude Birth Rate is about 52 births per thousand while the Total Fertility Rate is about 5.66 life births per woman. The Crude Death Rate is about 17 per thousand while Infant Mortality Rate is about 120 per thousand life births.

4. There is substantial internal migratory movements in the country especially from the rural to the urban areas. The magnitude of these movements which have been increasing for some time now poses a lot of socio-economic problems for



On the international front, Nigeria's open door policy has kept its borders open to the nationals of neighbouring countries, particularly member nations of the Economic Community of West African States (ECOWAS).

5. In the early 70s, population growth was not considered to be a matter of great concern because of the view that Nigeria is blessed with a large area of arable land and abundant natural resources which could be exploited to achieve a better living condition for the people. It is now evident that the view has to be reappraised.

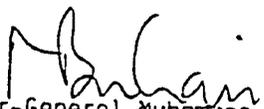
6. About 48 per cent of the population is under 15 years of age and about 56 per cent under 20 years. The aged people, i.e. those above 64 years is about 2.4 per cent of the total population, and together with the young dependants constitute a heavy burden on the working population. In a situation like this a lot of government efforts are directed away from revenue yielding capital investments into the provision of social amenities. It is Government's view that something has to be done to ensure that the galloping population growth rate and over-urbanisation do not eclipse efforts being made by government to improve the economy and enhance the quality of social services available for the people.



- 3 -

7. We in Nigeria now feel that in the face of rapid population growth, a well articulated population policy is necessary. Such a policy should have as main focus, guidance in fertility behaviour which will emphasise the healths of both mother and child. This policy calls for the re-orientation of mothers as to the benefits of adequate birth spacing, a practice which has long been embedded in the African tradition but which is being eroded by the influence of modernisation.

8. I seize this opportunity to wish the World Population Conference holding in Mexico City later in August 1984 successful deliberations and hope that results of its proceedings would help to achieve better quality of life for the people of the world.


(Major-General Muhammadu Buhari)
Head of the Federal Military Government
Commander-in-Chief of the Armed Forces.

Significant Indicators--Nigeria

Population Size, 1984	88 million
Crude Birth Rate	49 per 1,000 population
Crude Death Rate	17 per 1,000 population
Natural Increase	3.2 percent per year
Total Fertility Rate	6.9 births per woman
Population Doubling Time at Current Growth Rates	21 years
Infant Mortality Rate	134 per 1,000 births*
Maternal Mortality Rate	170 deaths per 1,000 births**
Life Expectancy at Birth	49 years
Per Capita GNP	\$860

Sources: 1984 World Population Data Sheet, Population Reference Bureau (Washington, D.C.: 1984) unless otherwise indicated.

*Field workers in Nigeria have estimated an infant mortality rate of 160 deaths per 1,000 births

**Taken from "Government Votes 5m naira for Blood Centers," Daily Times, August 4, 1984.

Projected Population Size by Year
if Replacement Fertility Reached
in 2040 (in millions)

Year:	2000	2025	2050	2100
Nigerian Population:	169	329	472	600

Source: World Bank, World Development Report 1984.

ACTION STRATEGY ASSUMPTIONS

This Action Strategy is based on the following assumptions which may or may not prove to be well founded:

- (a) That the Government of Nigeria has committed itself to dealing with the demographic situation, but will be slow to commit itself to demographic goals.
- (b) That a similar commitment also will be found at the state level.
- (c) That the nationwide program with its in-built standardization mechanisms designed by the Director of National Health Planning and the AAO in March 1983 will serve as the basic model for the Nigeria Family Planning Campaign.
- (d) That initial U.S. support should be given to the public sectors because of their relatively greater resources and also to take advantage of their commitment.
- (e) That each state will determine for itself whether to pursue a rural, an urban, or a mixed approach to providing services.
- (f) That community based distribution and commercial retail sales programs will play a major role in increasing contraceptive prevalence.
- (g) That the policy dialogue will be as influenced by the success of family planning programs as these programs will be influenced by the success of the policy dialogue.
- (h) That coordination efforts will continue to demand major attention both in Nigeria and Washington, but will not be resisted by other donors as long as the coordination leadership role is exercised by the MOH.
- (i) That standardization is perceived as beneficial to the program by the recipients and most of the donors.
- (j) That major U.S. inputs will be required for the first five years of the program.

"Population policy" as used in this paper is defined as: All deliberate government actions, such as laws, regulations, and administrative acts, directed toward some clearly defined set of demographic objectives. These demographic objectives can include a change in population growth, size, distribution, or composition.

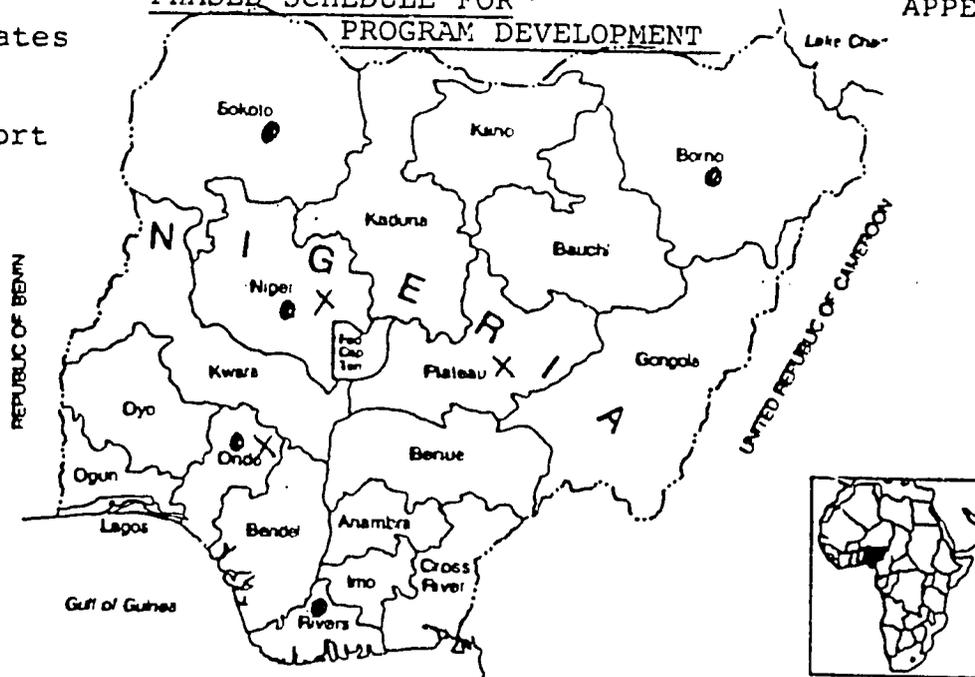
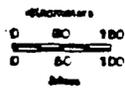
PHASED SCHEDULE FOR PROGRAM DEVELOPMENT

Acceleration States

June 1983

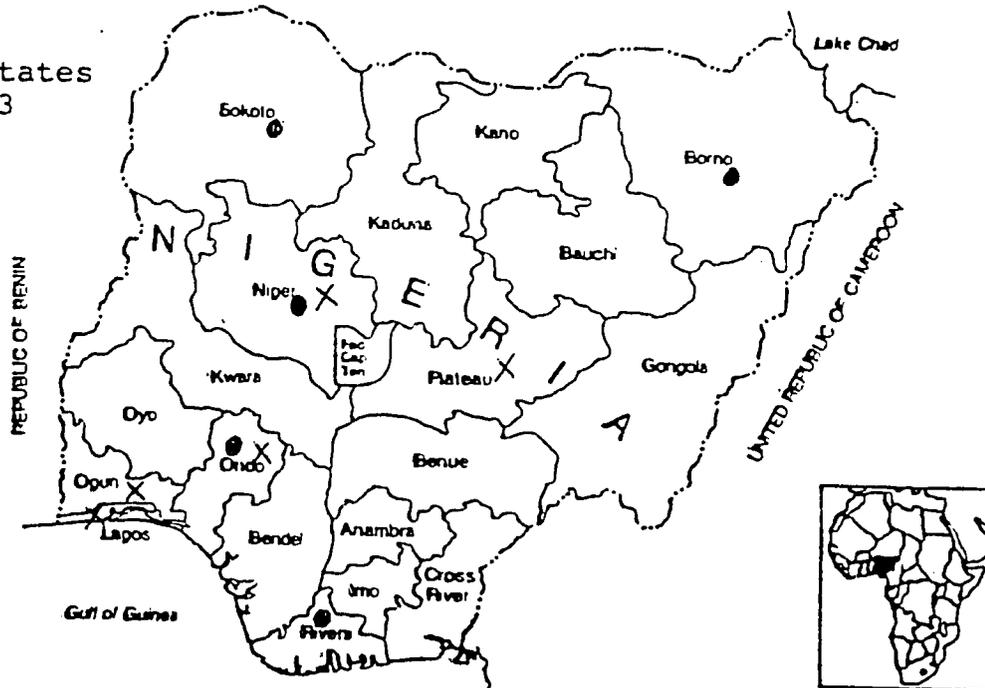
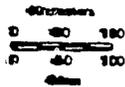
X = US Support

● = UNFPA Support



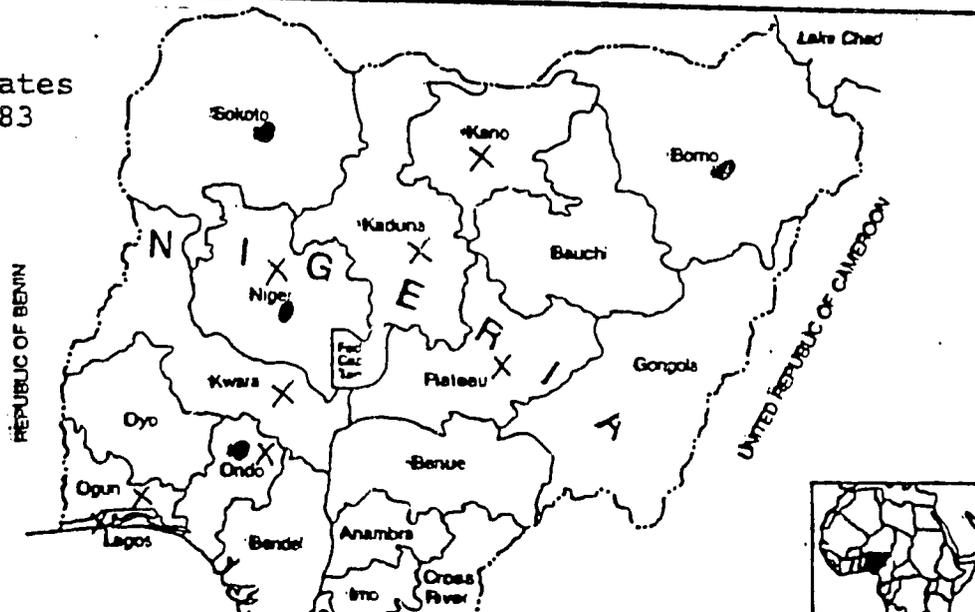
Acceleration States

August 1983



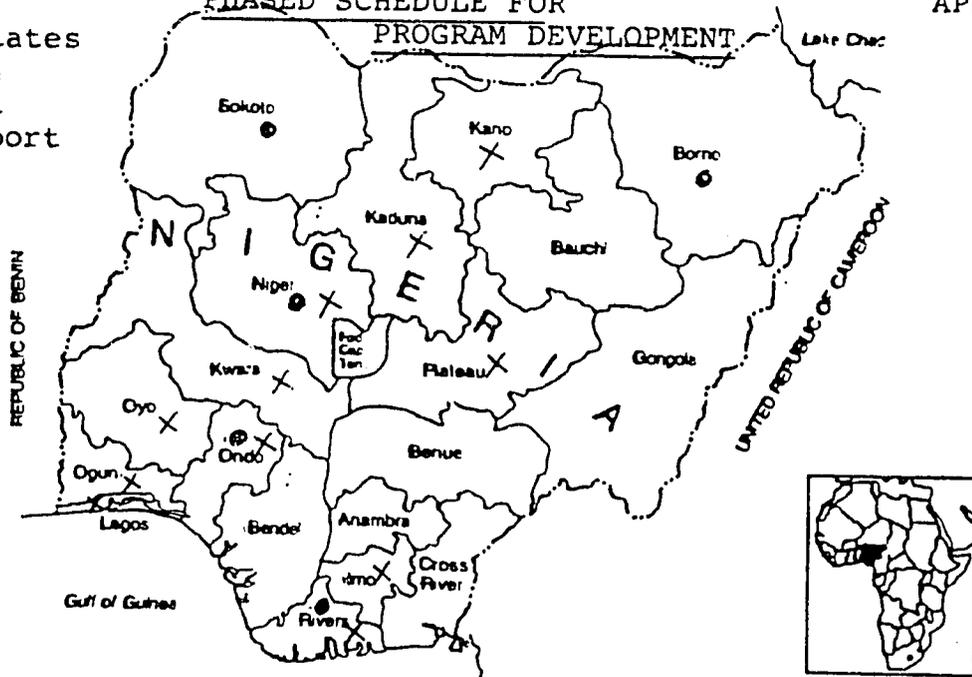
Acceleration States

December 1983

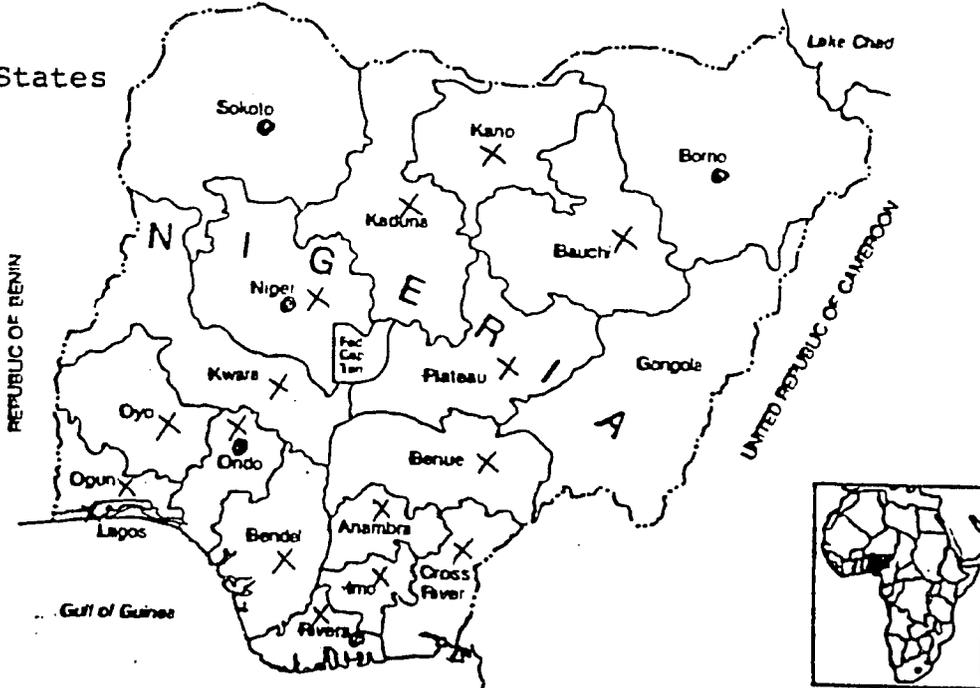


PHASED SCHEDULE FOR PROGRAM DEVELOPMENT

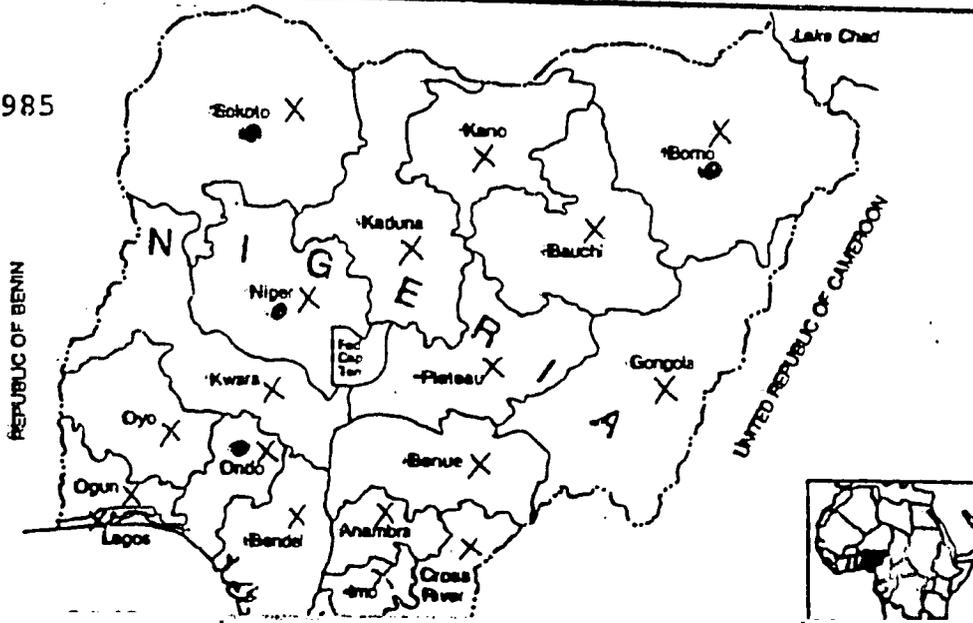
Acceleration States
August 1984
X = US Support
● = UNFPA Support



Acceleration States
June 1985



All States
December 1985



STATE PROGRAM DEVELOPMENT DESIGNATION BY PHASE AND TRACK

SCHEDULE FOR DESIGNATION AS ACCELERATION STATE	STAGE OF PROGRAM READINESS		
	TRACK A	TRACK B	TRACK C
Phase 1 June 1983	Ondo* Plateau	Niger* Rivers*	Sokoto* Borno*
Phase 2 August 1983	Ogun	Lagos	
Phase 3 December 1983		Kaduna Kano Kwara	
Phase 4 August 1984	Imo Oyo	Anambra Cross Rivers	
Phase 5 June, 1985	Bendel		Bauchi Benue
Phase 6 December 1985			Gongola

*UNFPA supported programs underway.

PHASE indicates time state designated as "acceleration" state.

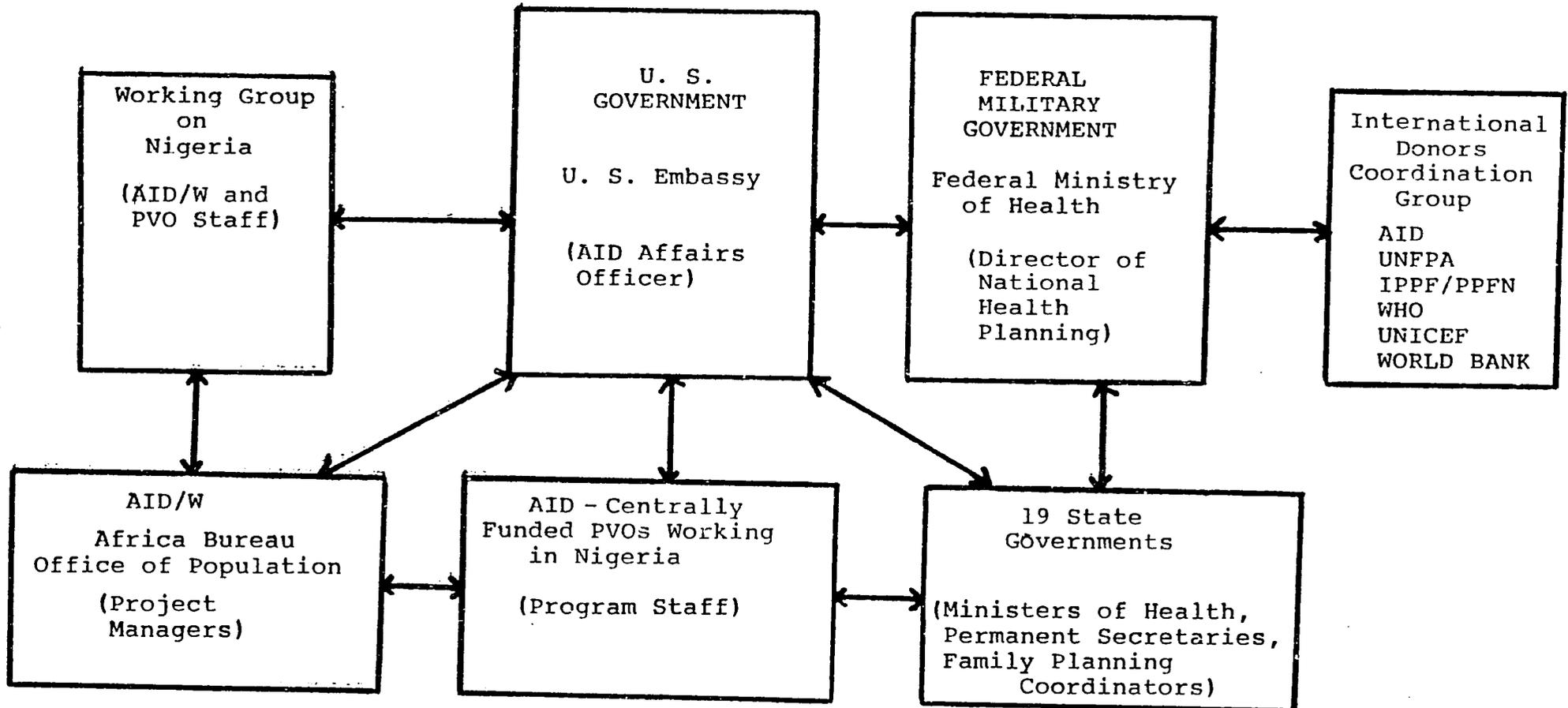
TRACK indicates stage of program readiness based on degree of leadership interest and commitment; availability of suitable facilities; and availability of trained manpower.

Track A: Strong leadership commitment; program planning has taken place; facilities and personnel available; limited services now available. Expanded program can move rapidly into place.

Track B: Leadership committed; planning underway; services available on limited scale, but facility upgrading and personnel training required before program can expand.

Track C: Leadership interested or neutral; further program development and planning necessary; needs assessment required to determine status of facilities and personnel

PATTERN OF U.S. GOVERNMENT COORDINATION FOR
POPULATION ACTIVITIES IN NIGERIA



Summary of Projected and On-Going AID-Supported Programs by State *									
State	Pop. '84** (million)	Training				Clinical Equipment	Commod- ities	Pat. Educ.	Media Promo.
		Doctors	Nurses	Midwives	Other				
Anambra	6.2		x					x	
Bauchi	4.2			x			x	x	
Bendel	4.2							x	
Benue	4.2							x	
Borno	5.2							x	
Cross Rivers	6.0							x	
Gongola	4.5					x	x	x	
Imo	6.3		x	x		x	x	x	
Kaduna	7.1		x	x		x	x	x	
Kano	10.0	x	x	x		x	x	x	
Kwara	2.6	x	x	x		x	x	x	
Lagos	2.5	x	x	x			x	x	
Niger	2.1	x	x	x		x	x	x	
Ogun	2.7		x	x		x	x	x	
Ondo	4.7	x	x	x		x	x	x	
Oyo	9.0		x	x			x	x	
Plateau	3.5	x	x	x		x	x	x	x
Rivers	3.0	x	x	x		x	x	x	
Sokoto	7.8							x	

*An "x" indicates participation by at least one clinic in a state.
 **Estimated from 1980 figures by assuming a 3.2 percent annual rate of growth; may not add to estimated total figures because of rounding.