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Population Policy Implementation in Nigeria, 1988-2003

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Abstract

The first Nigerian Population Policy was written in 1988 to reduce population growth as a collaboration between the Federal Ministry of Health and the World Bank. Whether this policy was successful is in contention. Some schools of thought argue that it was unsuccessful due to cultural, religious and financial factors in play. However, a positive demographic change was noticed statistically after the policy was implemented. Achievement of policy goals was limited due to flaws in the implementation strategy adopted for the National Population Program as well as due to a cultural aversion to family planning in Northern Nigeria, among other factors. The success of the policy was greatest in Southern Nigeria where social advancement also played an integral role. This paper shows that the attitudes towards population growth differ between these two very important regions of one country. This paper also addresses, in great detail, the obstacles to the implementation of the 1988 policy, and analyzes why the policy was successful in a part of the country, but not in another. With a new Population Policy having been implemented in 2006, identifying the problems of the 1988 program implementation has limited value unless the learned lessons result in a greater determination by the upper echelons of government, the bureaucracy and the political class in the nation to reprogram efforts for the future. While the Federal Government has recently instituted reform agenda that cover economic, social and administrative reforms, the population sector, together with the political governance that will address the role of population size in allocation of resources and power, needs to be included in the reform agenda.

Keywords

Population, policy, national, natality, 1988, PAFA, PAF, NPP, Nigeria

*Prof. Olukunle Adegbola passed away before this article could reach publication. He was affiliated with the University of Lagos, Nigeria and had a long and distinguished career in demography. The abstract was written by Dr. Omopariola Adegbola.

Introduction

Nigeria embraced a new National Population Policy in August, 2006 after almost two decades of the adoption of the first formal policy in 1988. The 1988 policy was unable to achieve some of the various targets set therein. Rather than the rate of the growth of the population declining to 2.0 per cent by the year 2000 targeted by the policy, the growth rate was actually increasing at a rate of 3.0 per cent during the last fifteen years, reaching a rate of 3.5 per cent in 2006 (NPC, 2007). The inability of the policy to fully achieve its objectives can be attributed to several factors. Early studies point to a series of traditional support for high fertility in Africa (Caldwell, 1982; Bongaarts, Frank and Lesthaeghe, 1984; World Bank, 1986; Caldwell and Caldwell, 1987; van de Walle and Ebigbola, 1987; Lesthaeghe, 1989; Casterline, 2001). It is possible that the Nigerian society is still resistant to the forces breaking down this traditional support elsewhere on the continent. Other studies cite the diversity of the Nigerian population as the reason for the failure of the policy. It is argued, for example, that the differences in religion among the various peoples in the country would have serious implications for the implementation of the policy (Mazrui, 1994; Dixon-Mueller and Germain, 1994). Renne (1996) and Avong (2000) refer to the existing local suspicions among various ethnic groups about the policy as an impediment to its implementation. Recently, Okono (2003) attributes the failure of the policy to its "implicit assumption of a single, monolithic cultural reality and its disregard of male reproductive motivation".

Yet, there are indications of demographic change in the country since the policy was promulgated. Caldwell, Orubuloye and Caldwell (1992) strongly argued that fertility transition has already commenced in Southern Nigeria. In attempting to explain the transition, they stressed education, particularly female education, modernization, urbanization and economic crisis as important to the understanding of the fertility decline. But they also argued that the population policy, by putting emphasis on bringing contraceptives into the country, contributed to the transition. This observation is in contrast to Okono's (2003) claim that the policy contributed nothing to the decline in fertility and that cultural factors made nonsense of the policy. Although culture is critical and the Nigerian society differs in several ways that are important to an understanding of their attitude to any government policy, attempting to attribute the failure of the population policy to only cultural differences is insufficient and misses some salient components of policy implementation. Such a narrow argument completely ignores some salient questions that should be asked about the implementation strategy adopted. What are the contributory factors, which hindered the implementation of the policy? Which groups in the country reinforced policy objectives and which ones constituted a cog in the wheel of implementation progress? What bureaucratic politics were at play in the process of policy implementation? Were enough resources available for policy implementation? How did availability of new resources influence competition for the leading role in policy implementation? In quantitative terms, to what extent did the policy achieve the targets set therein? These are some of the questions that this article sets out to address and analyze.

The analysis uses information obtained from official reports and documents obtained from the Ministries and parastatals involved in the implementation of the policy. This body of information provides evidence to buttress the diversity argument and to show that the achievement of the policy was limited partly because of the implementation strategy adopted for the National Population Program. It is argued here, first, that the level of fertility recorded in the country is attributable, in part, to the implementation of the National Population Program. Secondly, it is asserted that the institutional structure put in place for the implementation strategy constituted a cog in the wheel of the progress of project accomplishment. Thirdly, it is contended that the strategy, which was tilted more towards process at the expense of outcome, slowed down the achievement that could have been recorded, The process approach concentrated on the provision

of equipment and materials geared towards family health (especially after the International Conference on Population and Development put emphasis on reproductive health) and the training of officials in service delivery. It was expected to go *pari passu* with the outcome approach directed at changing people's values and attitudes so that they could appreciate the benefits of fertility reduction and increase their potential for the adoption of family planning. The implementation program underestimated the extent to which aversion to family planning was ingrained in the value system of some parts of the country. Thus, while the critical issue of changing the value-system through the IEC sub-section of the program was assisted in the southern part of the country by social transformation, it would appear that neither social forces nor program efforts affected the value system relating to family planning in the north. Fourthly, a Presidential directive issued to the Federal Ministry of Health in 2000 severely disrupted program implementation. Thus, the modest success achieved between 1993 when program implementation started and 2000 when implementation was interrupted (and actually halted) by the directive was not only wiped off but fertility began to increase. Findings from the various Nigerian Demographic and Health Surveys from 1990 to 2003 strongly support the arguments presented here. The presentation of the arguments is preceded by an examination of the background to the National Population Policy.

Background to the 1988 National Population Policy: Pre-1988 Official Attitude to Population Policy

Before the adoption of its first explicit population policy in 1988 (Federal Republic of Nigeria, 1988), Nigeria pursued an implicit population policy, which was conducive to population growth. Such a tacit policy was not subject to rational planning that was being undertaken for the economy as a whole since 1946, when the Ten-Year Development Plan was adopted by the Colonial Administration (Nigeria, 1946). This Plan apparently shared the view that the high rate of population growth was simply one of the conditions that made economic development imperative. As a result of constitutional development in the country in 1951, the Plan was replaced by 'A Revised Plan of Development and Welfare' for Nigeria 1951-1956 (Nigeria, 1951). Although there was no concern over population in the Revised Plan, the Macpherson constitution of 1951 installed Nigerian leaders in both central and regional governments and provided a catalyst for developments that were to rebound on some aspects of population problem. The immediate concern of these leaders was the eradication of poverty (hunger), ignorance and disease. Consequently, they embarked on import-substitution industrialization, mass education program and provision of health care facilities. These various programs soon resulted in rural-urban migration, an aspect of population that was to be of concern to the various Nigerian governments in the years before the drawing up of the first post-independence development plan in 1962.

In the First National Development Plan (1962-68), population growth was recognized as a crippling obstacle to economic growth but nothing was to be done to tackle the issue (Nigeria, 1962). The Second National Development Plan (1970-1974) pointed out the problems high population growth rate could cause, but stressed the country's resource base and development possibilities. Hence, emphasis was put on spatial distribution of the population and on encouragement of migration from areas of low economic opportunities to areas of high economic opportunities. With respect to population growth, the Plan noted that "government (will) encourage the citizens to develop a balanced view of the opportunities for individual family planning on a voluntary basis.....the Government will pursue a qualitative population policy by integrating the various family planning schemes into the overall health and social welfare program of the country" (Federal Republic of Nigeria, 1970, 17). The document further promised to establish a National Population Council to implement the "policy" and advise the Government (1). Towards the end of the Plan period, the Government made a definitive statement on

population problem and policy. At the inaugural meeting of the Population Association of Africa in Ibadan in May 1974, the Head of State, General Yakubu Gowon, stated that population growth rate must be slowed down for Nigeria to achieve sustained social and economic development.

However, this definitive official position was not articulated in the Third National Development Plan (1975-1980). Although several population concerns were identified in the Plan, only a few of them were addressed (Federal Republic of Nigeria, 1975). For example, steps were to be taken to reduce morbidity and mortality rates in the country. But in response to the high rate of rural-urban migration, the Plan stated that since rapid urbanization was accompanying social and economic development in Nigeria, the government does not intend to discourage urbanization but rather to plan and control urban growth through integrated rural and urban development strategy and through a strategy to improve the physical environment and sanitation. As for population growth, the Plan asserted, "emphasis of policy is, therefore being deliberately placed on accelerating the rate of growth of the economy rather than in direct action to achieve a drastic or immediate reduction in overall birth rate (Federal Republic of Nigeria, 1975 p. 297). Thus, the official attitude to population was still imbued with a sense of optimism based on the expectation that social change, particularly increase in educational level of women, would be sufficient disincentive to population growth while structural economic change would also be sufficient to resolve any problems caused by rapid urban growth

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This *laissez faire* attitude towards population problem had changed to one of concern by the time of the preparation of the Fourth National Development Plan (Federal Republic of Nigeria, 1981). The Plan, recognizing the link between population growth and economic development, stated: "...appropriate measures will be introduced to influence vital population variables such as fertility, mortality, migration etc along directions that will enhance the country's growth and development prospects." It further stated that in order to bring the overall growth rate of the population down to a level that will not impose excessive burden on the economy, the fertility rate must decline through the adoption, by women, of voluntary birth control measures. Unlike in the Second Development Plan when the rationale for the provision of family planning services was essentially to "protect mothers ....from repeated and unwanted pregnancies as well as to enable parents to space their children", in the Fourth Plan, it was to "regulate the size of their family". It is thus evident that there was, by 1981, greater official concern over population issues and greater expression of intent to influence those issues than had hitherto been the case.

The new government attitude was attributable partly to the apprehension of African governments to unfulfilled global promises of development strategies that continued to worsen rather than improve the economic conditions on the continent and partly to a major economic crisis that started in the country in the early 1980s. With respect to the first factor, the Lagos Plan of Action adopted by the OAU to address the economic problems of the continent, recognized the high rates of population growth resulting from high levels of fertility and mortality as having "implications for meeting the needs of the majority of the population" (OAU, 1980: paragraph 353, p.97). Some of the population measures adopted by the Plan of Action included empowering women and raising their status (pp. 86-93). The second factor - the economic crisis - woke the bureaucrats to the risk of neglecting population problem (Adegbola, 1995a). They succeeded in convincing the country's leadership that rapid population growth exacerbated the slow growth of production and services, the rapid and disorganized urban expansion, the overcrowded public educational institutions, the overstretched public utilities and the precarious levels of health and living standards of a vast majority of the population. The result of this sensitization was the tacit approval received from the country's leaders on their concern for population issues. This change was reflected in the acceptance by Nigeria of the Program of Action of Kilimanjaro Concerning African Population and Autonomous Development, adopted at the Arusha Conference called by African countries in preparation for the 1984 World Population Conference in Mexico (ECA,

1984). At the Mexico City International Conference on Population, the country also demonstrated its transformation from pronatalist stance to even tenor of faith in reducing the size and growth of its population as a panacea for economic development.

The transformation was to be formally stamped on the country's program by the drawing up of an explicit National Population Policy with the financial assistance of the UNFPA (2). The policy, which took about four years (from 1984 to 1988) to complete and which involved the participation of several ministries, the donor community and a host of family planning organizations, was coordinated by the Federal Ministry of Health (United Nations, 1988). The policy was approved by the Federal Executive Council and launched in Lagos by the then military Vice President, Augustus Aikhomu in 1988. The Federal Ministry of Health was mandated to formally launch the policy in each state of the Federation as soon as possible.

This movement to the highly concerned, strongly antinatalist position could not, however, be reflected in the next development plan as the country changed from the five-year fixed medium term planning system to a three-tier planning system (3). The new system commenced in 1990 after a brief experiment with a policy-based plan that covered the period 1986 to 1989. The main objective of this policy-based plan, otherwise known as the Structural Adjustment Program (SAP) was to correct the imbalance in the Nigerian economy (4). Although the plan noted that population was growing at a rate of 3 per cent per annum, neither the SAP conditionalities prescribed by the International Monetary Fund (IMF) nor the key policies designed for the plan included measures to vigorously tackle the high rate of population growth (Mosley, 1992; Moser, Rogers and van Til, 1997). However, in a 1990 evaluation of SAP in Nigeria, the World Bank noted that "Significant progress has been made.... though there is still a long way to go. .....Clear cut policy statements and/or action programs have been adopted for a large number of sectors, including agriculture, industry, population, health, education and the environment" (World Bank, 1990). Thus, the commitment of the Government to its antinatalist posture, faithfully reflected in the 1988 policy, was enhanced by the new planning system.

The 1988 Policy in Perspective

The policy, titled, *National Policy on Population for Development, Unity, Progress and Self-Reliance*, had as its goals, the improvement of the standard of living, the promotion of health and welfare, the lowering of population growth rate and the achievement of even distribution of population (Federal Republic of Nigeria, 1988 : 12). The seven specific objectives identified in the policy document revolved around fertility management through the provision and marketing of family planning services. The emphasis of the services was on "free choice" of citizens to regulate their family size even though women were encouraged to have not more than four children. The policy also set twenty quantitative targets with definite measures for their achievements according to a specified timetable. Three targets were set for 1990, five for 1995 and eleven for 2000. The only target that did not specify the year of achievement was the one aimed at making family planning services available to all persons voluntarily wishing to use them with priority attention being given to reaching high-risk clients. The targets covered nuptiality, fertility and mortality (5).

The policy has been criticized on a number of grounds (Dixon-Muller and Germain, 1994:204-206; Mazrui, 1994:124-125; Adegbola, 1995b). One of the most serious of the criticisms is that in drawing up the policy, cognizance was not given to some interest groups and ethnic nationalities. This criticism ignores the fact that for between three and four years, drafts of the policy were reviewed and revised at various fora organized in all geopolitical zones of the country. At each of these meetings, the views of professionals, religious leaders, opinion leaders/leaders of thought, politicians and other interest groups from the zone the meeting was being held were sought as

part of a national consensus-building process. A less serious criticism is the programmatic infeasibility of the many of the targets set in the policy. It was doubted whether or not the people could be mobilized quickly and sufficiently to attain a level of contraceptive prevalence rate that could make the targets achievable within the time frame set and whether or not the wherewithal to reach the level would be provided by the Government. Mobilization requires a massive program oriented towards changing the values and attitudes of people towards family size, a rather difficult enterprise in a plural society like Nigeria. As for commitment to the policy, Government demonstrated its resolve not only by seeking assistance from the World Bank to finance the implementation of the policy but also by drawing up an implementation strategy for the policy (Baldwin, 1992:43-44)...

The Implementation Strategy

Setting the stage

In drawing up the implementation strategy for the policy, Government took the existing population-related programs into account. The most important of these programs was the UNFPA-funded program costing $17.3 million being executed over a five-year period (1981-1986). About half of this sum ($8.3 million) was earmarked for maternal and child health and family planning (MCH/FP) while population information, education and communication accounted for $2.15 million (UNDP, 1981). Among several other programs, those funded by bilateral agencies and international non-governmental organizations were the most important. The United States Agency for International Development (USAID) supported a project in community-based distribution of health and family planning services as well as a nutrition, health and fertility survey. The Ford Foundation funded the Family Health Projects of the Institute of Child Health of the University of Lagos. Research and training in family planning at the University of Ife, together with family-planning-related services and commodities programs were undertaken by Family Planning International. A rural maternal and child health/ family planning program in Cross River State as well as research in reproductive biomedicine at the University of Ibadan was supported by the Population Council. Both the International Planned Parenthood Federation and the Pathfinder Fund supported programs for the supply of commodities and educational material on family planning. The Association of Voluntary Sterilization supported a program for the training in mini laparotomy techniques of the University of Ibadan and another for an information and education campaign.

In order to coordinate all these and similar projects and activities which were collectively termed the National Population Program (NPP) the Federal Government of Nigeria (FGN) established, in the Federal Ministry of Health and Human Services (later known as the Federal Ministry of Health (FMOH)) in 1987, a Department of Population Activities (later known as the Department of Community Development and Population Activities (DCDPA)). To demonstrate its financial commitment to the implementation of the policy, the FGN established a fund, the Population Activities Fund (PAF) to be managed by the Population Activities Fund Agency (PAFA), which was established in 1992 as a parastatal of the FMOH and backed by law in 1994. Both DCDPA and PAFA were to work closely for the achievement of the goals and objectives of the policy. The vehicle through which both institutions were to operate was the National Population Project (NPP), an integral component of the NPP.

The national population project (NPP)

The National Population Project (NPP) was a highly innovative, multi-level and multi-sectoral project with goals and objectives which, though distinct from the goals of the policy, were geared towards the achievement of the policy goals and objectives. The overall goal of NPP was to

strengthen the institutional framework, as well as expand the experimental basis, for undertaking a large-scale, inter-sector national population program over several decades in fulfillment of the goals of the National Population Policy (World Bank. 1991a) One of the objectives was to assist Nigerian institutions collectively and individually to devise constructive approaches to the provision of population-related information and services. The other objective was to fund population-related subprojects designed by various ministries and agencies at all levels of government and by non-governmental organizations (NGOs). Its major emphasis was on institution and capacity building with the hope that this effort would eventually rebound on the demand for, and provision of, family planning services.

The NPP consisted of two parts: Part A, which covered population activities in all their ramifications, and Part B, which covered operational research. Part A was divided into phases. The first phase consisted of seven subprojects identified at negotiations with the World Bank (WB) for the provision of a credit to finance the NPP (World Bank, 1991b:14-15). The subprojects were to be implemented by the Federal Government agencies at centers located throughout the country. One center was chosen from each of the existing twenty-one states and the Federal Capital Territory (FCT), Abuja into which the country was divided at the time of the negotiation for the credit. An implementing agency was called a Collaborating Agency (CA) and it was responsible to the NPP. Subprojects for the second phase were to be sourced from agencies, private or public, which satisfied the conditions laid down by the relevant controlling authority. Progression to phase two depended on meeting certain criteria. One of these conditions was that the first three of the phase two subprojects must be submitted to the World Bank for comments. It soon became imperative, as will be seen later, for one phase two subprojects to be approved for immediate execution along with the seven phase one subprojects. These eight subprojects, each of which had its specific objectives, can be grouped into four categories:

Information, education and communication (IEC)

Prior to the establishment of the NPP, television and radio advertisements and messages, together with dramatic series, had been used to promote family planning by NGOs, specifically the Planned Parenthood Federation of Nigeria (PPFN). Several bilateral agencies and nongovernmental organizations particularly, USAID, had also sponsored dramatic series and theater plays for the same objective. An example of the radio drama series is the 'Tax Collector' and that of the theater plays is the popular Yoruba play, *'Ayitale'*. Yet, the critical mass of the population was still skeptical about family planning and population control. Consequently, three subprojects were designed to address information dissemination to promote the development of a "demographic culture" that, in turn, would enable couples and individuals to make informed and conscious decisions about reproductive matters and hence to improve their quality of life. The first subproject, titled, "Public Enlightenment on Population", was designed to strengthen the Federal Ministry of Information (FMOI) to enable it deliver public awareness programs and knowledge on family planning and population issues. Towards this end, the Population Information and Communication Branch was established in the Federal Ministry of Information (FMOI) as the CA for the implementation of the subproject. The name of the CA was later changed to Population Information and Communication Bureau (PICB). The change in name, as some of the other name-changes in this article, is a reflection of the fact that in Nigeria, designation of a governmental organization carries with it progressive levels of prestige and importance.

The second subproject was located in the Federal Ministry of Education (FMOE) with a parastatal of the ministry, the Nigerian Educational Research and Development Council (NERDC) serving as the CA. The subproject, titled, "Population Family Life Education through Primary Schools", had as its main objective, the development of desirable attitude and behavior concerning

population issues among teachers, pupils and citizens at large so that they would be able to make rational decisions on family size as a matter affecting the quality of their lives. Since 1981 when the National Policy on Education was launched, the teaching of population-related issues in home economics, science and social sciences had been emphasized in Nigerian secondary schools. However, in order to ensure that a large proportion of student population was reached, the subproject targeted primary school children. Most of these children did not progress to secondary schools. A curriculum on population life education was developed for incorporation into the primary school syllabus. The curriculum focused on human reproduction, sexual hygiene, the family, the community and health and environmental issues. It was expected that not only would the children be informed of the relationship between quality of life and family size, they would also educate their parents, most of whom were illiterates.

The promotion of family planning through health education was the third subproject. The CA in charge of the subproject was the Health Education Branch (HEB) of the FMOH. The subproject aimed to improve knowledge, attitude and practice of people with regards to family planning and to provide the citizenry with the knowledge to appreciate the benefits of child-spacing and small family size for the health of mothers and children.

Reproductive health services

In realization of the fact that the provision of family planning services is the heart of any successful population policy, the NPP gave serious attention to reproductive health services. Two departments in the FMOH were the CAs for the two subprojects in this category. One of them addressed the primary health care (PHC) system while the other was concerned with both the secondary and the tertiary health care systems. The first subproject, titled, "Integration of Family Planning into Maternal and Child Health" was the responsibility of the Maternal and Child Health/Family Planning (MCH/FP) Unit of the Department of Primary Health Care and Disease Control (later known as the Department of Primary Health Care (DPHC)). The objective of the subproject was the integration of family planning activities into maternal and child health by promoting systematic practice of family planning in the context of maternal and child health (MCH) services. The CA for the second subproject, titled, "Tertiary and Secondary Centers for Reproductive Health", was the Department of Hospital Services and Training (later known as the Department of Hospital Services (DHS)). The main objective of the subproject was to ensure that a wide range of family planning methods and services including surgical contraceptives were easily accessible to couples and individuals. However, neither of these two subprojects addressed the issue of the provision of contraceptive commodities even though the importance of the provision of contraceptive commodities was widely known.

Data management

The focus of the two subprojects in this category was the promotion of awareness of the population factor in overall national development. Thus, the sole objective of the first subproject was to integrate demographic variables into national and state development plans and programs in order to effect a more efficient distribution of resources. The CA for this subproject, titled, "Integration of Population into Planning and Budgeting", was the National Planning Commission which had the status of a Ministry and which was located in the Presidency. The second subproject, based on an experimental survey system developed at the University of North Carolina, was the "Monitoring of the NPP Impact through a Sentinel Survey System". The CA for the subproject was the National Population Commission. The main objective of the subproject was to provide continuous feedback to policy-makers, information on fertility and family planning usage so that changes in fertility could be readily detected. A change in fertility was expected to rebound on economic development indices and point to the direction the development

efforts should be focused.

Contraceptive supply and logistic management system

This subproject was necessitated by the political events in Nigeria between 1993 and 1999. At the time the phase one subprojects were designed, both the USAID and UNFPA were supplying about 98 per cent of the contraceptive requirements in the public sector. It was expected that the supply would not only continue into the foreseeable future, but would increase to 100 per cent, especially as a democratically elected Federal Government was expected to assume power in 1993. The cancellation of the results of the Presidential Elections by the Babangida regime ushered in a prolonged political crisis that impacted negatively on the NPP. While the UNFPA continued to assist the country, the USAID withdrew its assistance from the public sector. The emergency assistance offered by UNFPA to fill the gap created by the discontinuance of USAID aid saved the public sector family planning service from collapse. A National Contraceptive Logistics Management System had to be drawn up in 1995 as a subproject to be executed by the DCDPA. Its objective was to ensure both the supply, on a continuous basis, and the efficient distribution of, contraceptives such that there would never be any stock-out of the commodity in the country.

Project funding

By creating a national fund, the PAF, on which any agency, public or private, could draw on to finance population activities approved by the PAF Governing Council, the FGN demonstrated its financial commitment to the NPP. The fund was launched with a World Bank (International Development Association (IDA)) facility of $78.5 million and a counterpart fund from the FGN in accordance with the Development Credit Agreement (DCA) signed in 1991 (World Bank, 1991b). One of the rationales for the establishment of PAF and PAFA was the need to provide a responsive financing mechanism for funding population activities in the country. For a viable and successful population program, it was not sufficient to provide the initial financial resources for policy implementation, but there must also be a mechanism for mobilizing additional resources. Thus, PAFA was not only to manage the fund, it should also source for funds, more than equal to the magnitude of the task, so as to provide sustainable and continuous flow of resources to population activities in the country. The PAF adopted the following strategies in discharging its two functions of fund generation and fund disbursement

Resource generation

Two strategies were adopted in the short run to rake in more resources. The first was to encourage donors either to contribute to PAF or finance directly, subprojects which were adjudged viable by PAFA and which were within the mandate of the policy. Furthermore, PAF encouraged donors to pick any of the programs in the three-year rolling plan of PAF for funding or co-funding. The second strategy involved PAF entering into partnership with the private sector in the country to contribute a percentage of its profits to the fund. The long term strategies include cost recovery and cost reduction schemes, taxation by government of companies - which manufacture or distribute products that increase the cost of health care delivery and/or population management programs - and employment benefits, by which the organized private sector was encouraged to include reproductive health services (including family planning) in the free medical care scheme provided for their workers (Federal Ministry of Health, 2000:28-38).

Accessing PAF resources

The PAF could be accessed by institutions or organizations (not individuals), referred to as

Collaborating Agencies (CAs). These institutions were government agencies at all levels of government (Federal, State and Local) as well as NGOs. An intending CA was to submit a proposal for funding in accordance with the guidelines contained in PAF brochure and approved by the World Bank (Federal Ministry of Health, 1993a). Funds were provided to CAs as subventions (grants) for the execution of approved subprojects. The CAs contributed counterpart funds or matching grants out of their own resources towards the execution of subprojects approved for them to show their seriousness and commitment to the subproject. The proportion of the total cost of a subproject to be contributed as counterpart fund was graded according to the type of CA. Collaborating agencies of Federal and State governments contributed 15 and 10 per cent respectively while those of Local Government Administrations (LGA) and NGOs contributed 5 and 2.5 per cent respectively. A collaborating agency was required to enter into a subproject agreement with PAFA before fund could be released from PAF. The agreement specified such things as the agreed subproject objectives, indicators for monitoring subproject execution, financial arrangements (including the provision of counterpart fund), disbursement schedules, conditions to be satisfied before withdrawing each tranche of the fund in the disbursement schedule, procurement procedures, establishment of basic accounting procedures (including the keeping of records and accounts), conduct of an annual audit and preparation of brief annual narrative and financial reports. Each CA was provided a copy of the "Guidelines for the Operation of Collaborating Agencies", approved by the World Bank (Federal Ministry of Health, 1993b).

The management of the national population program (NPP)

There were two levels of management of the NPP. The first was the political level while the second was the technical/administrative level. At the political level, two organs lay claim to authority over the NPP, one a creation of the FMOH, the other established by law. With the launching of the policy in 1988, the FMOH, in accordance with the policy document, created the National Consultative Group on Population for Development (NCGPD), with the Minister of Health (MOH) as the chairman. It had fifty-eight members drawn from various parts of the country to represent a diverse of interests. Its duties included the supervision, and provision of assistance for the coordination of the implementation of the National Population Policy. It was to receive from the technical/administrative office, the reports of each of the executing agencies. Its members were to provide periodic reports of the activities and progress of the NPP to their constituents back home and to educate them in understanding the intricacies of the national population policy. Its members were also to monitor the reaction of their constituents to the activities of NPP and brief the NCGPD accordingly.

The law which established PAF also made provision for the establishment of a Governing Council of the Fund (GCF), chaired by the MOH. Its statutory membership of seven consisted of high-ranking officers of Government. They included the Minister of Education and Youth Development and that of the National Planning (or their representatives, not below the rank of a Director). It also included the Chairman of the National Population Commission and a representative of the National Consultative Group on Population for Development. Using the powers conferred on it by the law that established it, the GCF co-opted the Minister of Women Affairs and the Minister of Finance. In case any of these co-opted members was unable to attend any meeting of GCF, he/she could send a representative not below the rank of a Director.

The GCF was the policy-formulating organ of PAFA and related the activities of the agency to the Federal Executive Council through its chairman. It reviewed and approved both the annual budgets of PAF and the three-year rolling plan of the Agency. The budget and the plans, which included those of the CAs, were forwarded to the WB for concurrence before being submitted to the Ministry of Health for inclusion in the budget of the Ministry. Since the counterpart fund to be

provided by the Federal Government depended on the budget, the Ministry of Health must also approve the budget. The budget and the plans were defended at the annual budget hearing organized jointly by the Federal Ministry of Finance and the National Planning Commission. With the inauguration of the democratic government in 1999, another tier was added to budget defense - that of the relevant committees of the National Assembly. Another major function of GCF was the approval of subprojects estimated to cost $100.000 equivalent up to a maximum of $500,000 equivalent up to an aggregate amount of $10 million equivalent. It established a Technical Committee (TC) under the chairmanship of the Director of DCDPA with membership from both PAFA and DCDPA to review all major memoranda submitted to Council and make appropriate recommendations.

The professional/administrative, day to day, management of the NPP was entrusted to two institutions in the FMOH. The first was the DCDPA, which was headed by a Director who reported to the Permanent Secretary of the Ministry. The Department was responsible for the technical aspect of the program. The second organization, PAFA, was headed by an Executive Director who reported directly to the MOH. The Agency was to take charge of the financial aspects of the program. These two functions, technical and financial management, merged imperceptibly into one another, a situation that often brought about discord between the two organizations. In order to reduce the potential conflict and achieve an efficient management of the program, a Joint Working Group (JWG), comprising ten core staff of the two institutions was set up to evolve, discuss and operate strategies for the successful implementation of the program.

Within the period of its operation, the JWG reviewed work plans of CAs, developed strategies for the establishment of state level population focal points, and evolved a monthly joint meeting of all CAs to enable participants share experiences and integrate their programs. The committee reported its activities to the PAFA/DCDPA Management Committee comprising the Director of DCDPA as the chairman, the Executive Director of PAFA and a few senior officers of DCDPA and PAFA. The JWG was effective when its membership was only ten - five from each organization. When, under the pressure of DCDPA, it was decided to triple the DCDPA membership to reflect the numerical strength of the Department *vis-a vis* that of the Agency, the JWG became ineffective as quorum was difficult to obtain and the meetings became very irregular.

A significant aspect of the implementation strategy was the annual consultative meeting held among stake-holders to review the previous year's performance and chart the course of action for the following year. This meeting brought together not only government agencies but also development partners and major NGOs involved in population activities.

The implementation strategy described above for the accomplishment of the objectives of the NPP has a fair share of problems. At least three sets of problems can be identified. The first is related to the mistrustful inter-ethnic relations in such a large and pluralistic society like Nigeria. The second is the structure and culture of the political administrative system while the third consists of specific problems in the institutions designed for the NPP.

The Diversity of the Nigerian Nation as a Cog in the Wheel of Policy Implementation Strategy

Nigeria is a multiethnic, multilingual and multireligious country. There are over 350 ethnic groups in the country (Otite, 2000). According to the 1963 census (the last to obtain information on ethnicity and religion), twelve of these ethnic groups had more than one million people. The largest three are Hausa-Fulani, Yoruba and Igbo, accounting for 29, 21 and 18 per cent of the population respectively (Nigeria, 1963). In the early days of the Nigerian Federation, they were

the dominant core groups in the Northern Region, the Western Region and the Eastern Region respectively. However, none of these major ethnic groups is either a homogeneous or a cohesive entity. For example, the Yoruba alone has about twenty subgroups, each with its own social attitudes, customs and institutions. On the periphery of each of these three core major groups were several minority ethnic groups. Each of the Nigerian ethnic groups and sub-groups has rich traditions, cultures and histories of which they are proud and which they guard jealously.

These ethnic groups (some of which refer to themselves as nations) and sub-groups are characterized by linguistic diversity. Each has its own language, which is boosted by rich literature. Since the creation of more states in the Federation, the core-periphery distinction - noted above when there were three regions in the country - has manifested itself on the linguistic terrain in each state. Hardly does a language cover a state. In each state is found a dominant language and several other languages. For example, although Efik is the major language of the Cross River state, other languages spoken in the state include Ejagham, Boki, Yakkur, Yala, Ukelle, Mbembe, Utugwang, Bette, Mbube, Yache and Bakor. An additional testimony to the vibrancy of these different languages lies in the fact that although English is the official language in the country, each of the thirty-six states of the Federation recognizes more than one "official" language. In most states, legislative business in the State House of Assembly is conducted in several local languages of the state. Furthermore, state radio and television stations in each state broadcast news and have feature programs in several languages of the state.

In addition to the ethnic and linguistic differences is the religious diversity. Muslims constitute the overwhelming majority of the population of Northern Nigeria while Christians are predominant in Southern Nigeria. The 1963 census indicated that 47 per cent of Nigerians were Muslims, 35 per cent were Christians and 18 per cent were members of local indigenous congregations or no religion. Imposed upon the religious groups is a multiplicity of denominations and sects. Although the predominant form of Islam is Sunni, there are several sects. They include the Qadriyya, the Tijaniyya, the Tariqa, the Malikiya, the Ahmadiyya (Anwar-Ul Islam) and the Islamiya. The newer and more fundamentalist sects include the Izala and the Shi'ite. Similar diversity prevails among the Christian population. There are the Roman Catholics, Anglican, Methodist, Baptists, Presbyterians, Evangelical Church of West Africa (ECWA) Christians, Church of Christ in Nigeria (COCIN) Christians, African Christians and a growing number of Evangelical and Pentecostal Christians.

There are also economic and social differentials. Economic diversity has both horizontal and vertical aspects. Measured by poverty level, there are large regional disparities in economic conditions in the country. Although the poverty rate in the country increased from 27 per cent in 1980 to 66 percent in 1996, the northern parts of the country are the poorest. In 1996, the percentage of poor people in the total population was 77.2, 70.1 and 64.3 in the Northwest,

Table 1. Real take home wages and salaries in the public sector, 1979 -2003

Period	Naira/Month	Naira/Month	Naira/Month
	GL 01	GL 08	GL 15
1979-1983	244.57	737.22	1947.70
1984-1988	164.29	427.64	1064.06
1989-1993	149.23	272.64	576.14
1994-1998	82.05	189.20	369.74
1999-2003	139.38	340.26	728.87

SOURCE: Federal Republic of Nigeria (2004): 6

Northeast and North-central respectively. By contrast, the incidence of poverty in the Southeast, South-south and Southwest was 53.5, 58.2 and 60.9 per cent respectively (Federal Republic of Nigeria, 2004: 28-30). Furthermore, average household size was higher in the North than in the South, being 6 in the Northeast and 4 in the Southwest in 2003 (National Population Commission, 2003). While incidence of poverty was 59.3 per cent among household with 2-4 people, it was 74.8 among that with 5-9 people. The rural-urban differential shows that most of the poor in the country are found in rural areas. In 1996, about 69.3 per cent of rural households and 58.2 per cent of urban households were in poverty (Federal Republic of Nigeria, 2004). With respect to vertical disparity, there has been, since 1987, a widening gap between the poor and the non-poor, leading to the disappearance of the middle class and the consequent polarization of the Nigerian society into the haves and the haves-not. Table 1 shows that the decline in real take home wages and salaries for lowest cadres of junior (GL 01), intermediate (GL 08) and senior (GL 15) staff was gradual from 1984 to 1988 but assumed a sharp dimension from 1989 to 1998. The attempt by the Obasanjo administration to recreate the middle class resulted in a slight improvement in the real income between 1999 and 2004. This attempt was unsuccessful. Not only was the real income still below that of 1984-1988 period, but it was also insufficient to enable a new entrant into the senior public service cadre procure a new car as his counterpart did up to 1988.

Since the economic conditions reinforce social conditions, economic disparity is a replica of differentials in social status, measured by education. The geographical distribution of educational attainment shows a scary inequality between the North and the South. Although the South had a head start in Western education because of its earlier contact with Europeans, it was the colonial educational policy that promoted aristocratic education in the North as against the more inclusive mass education in the South that intensified the geometric gap in their educational attainment (Mustapha, 2006). This gap has been built into the fabric of the Nigerian society until today. Thus, in 2003, only 6.1, 7.6 and 17.1 per cent of women in the Northwest, Northeast and North-central respectively completed primary education compared with 14.3, 17.8 and 19.0 per cent of their counterparts in the Southeast, South-south and Southwest respectively (National Population Commission, 2004). The regional disparity is more pronounced at post-primary level. Only 7.0, 7.4 and 13 per cent of women in the Northwest, Northeast and North-central respectively had completed secondary school or gone on to post-secondary study. By contrast, 27.2, 31.1 and 39.7 of women in the South-south, Southwest and Southeast respectively had attained that educational status. Illiteracy, defined as having no formal education at all, is higher in the North than in the South. For example, while three quarters of women in the Northwest were illiterates, only one-tenth of their counterparts in the Southwest were. The level of educational attainment is higher in the urban areas relative to the rural areas. While half of the rural women were illiterates, one quarter of urban women were. Only 10.8 per cent of women in the rural areas had received complete secondary or higher education, as against 31.2 per cent of their urban counterparts. Furthermore, there is a positive correlation between economic status and educational attainment. For example, about 50 per cent of women in the highest wealth quintile had completed secondary or higher level of education compared with just 2 per cent of women in the lowest quintile. The pattern of men's education (both territorially and by economic status) is similar to those of women.

Several problems are associated with all these diversities. The first is that even though most Nigerians are pronatalists, there is a lot of variation in the degree to which each religious group tolerates or accepts the use of modern contraceptive methods to regulate fertility. Since the Catholic Church opposes the use of contraceptives for birth control, its members, especially those east of the Niger river, avoid artificial birth control methods. Brought up in rural agricultural settings where the priests are held in high esteem and where large families are respected, members of the Catholic Church defer to their priests and are apprehensive of any fertility regulation program. What is rather surprising is that some elites including some political leaders

openly opposed the NPP. In August 1999, during a tour of the country by the Minister of Health, one of the Governors of a state in the South-south zone expressed opposition to family planning because it was, according to him, against papal injunction.

The attitude of Nigerian Muslims to population program is identical with that of the Catholics. Although most of the Muslim *Ummah* in the country have misperceptions about family planning within the context of Islam, regarding it as an unnecessary disruption of their traditional way of life, a few others believe in the lawfulness of birth control in Islam. While some of them advocate complete prohibition of contraception, a view expressed by Ibn Hazm and his followers of the Zahiriyah School of Jurisprudence (Haq, 1984), others permit it either conditionally or unconditionally. (Wensinck, 1960). In general, Muslim leaders do not support a family planning program.

Northern Muslim elites, who have produced the ruling class for most part of Nigerian post independence history, in general, have had no inhibitions about opposing policies that would reduce their population so as to maintain their political advantage. Some of them who realize the impact of high fertility on the quality of life of the people remain neutral; others, confronted by measures intended to regulate fertility, respond with open hostility to the measure. Some political Muslim leaders have even gone to the extent of promoting sectional religious interest over national interest, possibly to gain political advantage. For example, Alhaji Ahmed Sani Yerima, the Governor of Zamfara state (1999-2007), introduced Sharia Criminal Law in his state in 2000, sparking off massive riots that claimed several lives and properties (6). His example was followed in quick succession by eleven other states - Bauchi, Borno, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Niger, Sokoto, and Yobe. The introduction of this puritanical code has serious implication for population programs. Deprived of protection of their reproductive rights and reduced to low status position in the society, women in the twelve northern Sharia states cannot take independent decisions on the timing and tempo of their pregnancies. Neither can they use contraceptives when they want relief from repeated childbearing because the leaders in these states subscribe to the Zahiriyah School of Jurisprudence.

The second problem thrown up by the diversity is ethnic and regional competition for power and resources. Since the relative numbers of each group form the basis for any claim to power and resources, most ethnic and regional groups are understandably suspicious of any program designed to affect the size of their population negatively. Among the three major ethnic groups, the stiff competition for power intensified with the coming into being of the 1960 Independence Constitution, which conferred enormous power on the Federal Government. At the various conferences that culminated into the promulgation of the constitution, the North demanded representation in the Federal Parliament to reflect the population of each region. For example, at the Ibadan General Conference in 1950, the northern delegates evoked the population principle to demand, and eventually to win, fifty per cent representation in the proposed Central Legislature while the southern delegates generally favored equality of regional representation. The subsequent constitutional conferences held in London in 1957 and in Lagos in 1958 consolidated the population principle and the North was guaranteed more than half of the seats in the House of Representatives. Thus, in the 312-member Parliament elected in 1959 to usher in independence, the North was allocated 174 seats (55.8 per cent) as against 73 (23.4) for the East, 62 (19.9 per cent) for the West and 3 (0.9 per cent) for Lagos. The bitterly fought elections, which produced the Parliament, were won by the Hausa-Fulani dominated Northern People's Congress. This Northern victory unleashed the fear of Hausa-Fulani domination from the Igbo and the Yoruba who were the majority ethnic groups in the Eastern and Western Regions respectively. The leadership of the East and the West hoped that the new census to be conducted in 1962 would turn the numerical advantage in their favor. Although the results of that census were never released officially, the figures published by the University of Ibadan Center for Population

Studies favored the East and the West (Okonjo, 1968). The cancellation of the officially unreleased results was to the consternation of both the East and the West. The results of the rescheduled census in 1963 dashed the hopes of Eastern Region, whose leaders perceived the results to be a loss of their political influence because of their relative decline to the third position in number. It was not a surprise, therefore, that the Premier of Eastern Region described the results of the exercise as “worse than useless" (Udo, 1968). The mistrust, which all these developments brought about, has continued to influence the acceptability of a population program and to make its implementation rather difficult.

In addition to the rivalry among the major ethnic groups is the struggle for recognition by the minority ethnic groups, who worried about what they perceived to be their marginalization in the running of the country. By the 1963 census, these groups constitute one third of the Nigerian population but the areas in which they are located produce the most of the resources that oil the Nigerian economy. Political consciousness among them has been growing since the 1950s, precipitating the setting up of a minorities commission in 1957 (Nigeria, 1958). The failure of the commission to recommend the creation of states to allay their fears was a disappointment to the minority ethnic groups. Nonetheless, they continued with their agitation for political influence, which the creation of twelve states in 1967 by the Gowon administration eventually conferred on them. Subsequent state creation exercises have continued to enhance their status. Thus, state creation can be said to have "expanded the power sharing matrix from a 3-actor set which involved only the majorities to an n-actor set in which the minorities, diverse as they are, became important actors" (Osaghae, 1991). The minority ethnic groups started to enter onto the political stage and more importantly into the Nigerian power structure. Not only are they governors of their states, but a growing proportion of federal ministers are also being drawn from their ranks. The minority ethnic groups, having observed the political power of numbers - population size is one of the criteria state agitators cite for demanding a state of their own - are highly suspicious of proposals for controlling population growth. Such suspicion makes implementation of fertility regulation program extremely arduous.

Thirdly, linguistic diversity provides a challenging task of how to disseminate information on population issues. There is the problem of how to accurately communicate the reproductive health, fertility regulation and family planning terminologies to the people in their own language without touching or hurting their sensitivities and thus generate opposition to the program. Apart from linguistic compatibility, there is also the problem of developing a national consensus on which of the Nigerian languages should be used for translating population documents. Other ethnic nationalities seem displeased with the recognition given to the three main languages by both the 1999 constitution and the National Policy on Language. Yet, the language policy makes the medium of instruction at the pre-primary school level and at the lower levels of the primary school the mother tongue or the language of the immediate community, a measure which obliges the government to develop the orthography of, and produce text books and other materials for, their languages (Federal Republic of Nigeria, 1989, 1998). The attempt, in 1994, by the Federal Ministry of Health to translate the National Population Policy into Hausa, Ibo, Yoruba and Anglo-Nigerian pidgin met with strong opposition from the other ethnic groups. Consequently, the policy was not translated into any Nigerian language.

It is as a result of these religious, ethnic and linguistic competitions that all the post independence Nigerian censuses have been contested. The contests have been so bitter that the FGN directed that religion and ethnicity (and, by implication, language) should not be canvassed in the 1991 and 2006 censuses (NPC, 1998). Although the directive polarized Nigerians along regional, religious and ethnic lines, with the Igbos and the Governors of the Southeast threatening to boycott the 2006 census, the FGN stood its ground.

The fourth problem arises from the socio-economic diversity. The states which need urgent and massive social and economic development are the ones that lack the resources for such a venture. They are also the states with high population growth rate and greatest resistance to family planning program. Although education, on the social side, and non-agricultural employment on the economic side, are known to have great impact on fertility and mortality, investments in education and non-agricultural sector in the poor states are low. The state per capita expenditure on education computed from Annex Table 2 of Hinchliffe (2002: 33) reveals that while Borno and Benue states invested only N536.5 and N759.5 per capita on education respectively in 2002, Rivers and Lagos invested N3, 963.2 and N2, 956.9 respectively during the same period. The persisting unequal investment in education is illustrated by the number of post-primary institutions in each zone in 1989. While the northeast and the northwest each accounted for 13.4 per cent and 25.6 per cent of the national population respectively, their share of post-primary institutions was 5.9 and 9.7 per cent respectively (Federal Republic of Nigeria, 2001). By contrast, the proportion of post-primary schools in the southeast and the southwest was 20.7 per cent and 27.0 per cent respectively even though each of them hosted only 12.1 per cent and 19.6 per cent of the national population respectively. In other words, the density of institutions per 100,000 people was 2.8, 2.5, 11.2 and 9.0 in the northeast, northwest, southeast and southwest respectively.

Of the two societies into which Nigeria is effectively divided following the bimodal shape of income distribution with a peak of poor people and a peak of rich, as noted earlier, the haves retain their hold on the economy, the bureaucracy and the political system. Most of them practice family planning. By contrast, most of the have-nots do not practice family planning, regarding large families as advantageous. According to the 2003 NDHS, "the currently married women in households in the highest (most economically advantaged) quintile of wealth index are more than four times as likely to use a method of contraception as those in the lowest (least advantaged) quintile [30 per cent versus 7 per cent]" (NPC, 2004). With respect to employment structure, available data show that Nigeria is still a predominantly rural society with about 65 per cent of its total population living in small, remote, rural communities (NPC, 1998). Agriculture labor force is put at 45 per cent as against the industry labor force of only 4 per cent. The balance is service labor force. In most of the states in the North, agricultural employment is as high as 70 per cent while in the more advanced states in the South, it is as low as 40 per cent. This pattern is reflected in the distribution of registered businesses. Between 1986 and 1990, about 57 per cent of the total businesses, mainly manufacturing, registered in Nigeria were in Lagos, located in the Southwest, 16 per cent in the North, !4 per cent in the East and 13 per cent in the West (Hamalai, 1994). The share of the North increased to 34 per cent of all registered establishments in 1997 while that of the South had declined to 64 per cent, still an enormous proportion (Federal Office of Statistics, 1997: 188).

All these diversities, together with the systematic and overlapping inequalities which they reveal, have serious impact on the implementation of the national population program. They produce a pattern of attitude towards the NPP along various fault-lines. In most cases, the conjunction of location, language, religion and common and differentiating customs is clearly at play. Groups which differ in one attribute often find common grounds to express hostility to, or support for, the policy while groups who have an identical characteristic may, on other bases, back or oppose the policy. It is to a few examples of this impact that attention is now turned.

The first example is the hostility to the NPP by some interest groups, which hostility manifested itself at the 30th meeting of the National Council on Health (NCH) held in Jos in 1993 (Federal Ministry of Health, 1993c). The NCH is made up of all the State Commissioners of Health in the Federation with the MOH as the chairman. Discussion on the memorandum submitted by the MOH on the NPP drew attention of the meeting to the existence of PAF that could be accessed

for population-related activities, which included, among others, family planning and fertility regulation as well as maternal and child health. The discussion of the memorandum followed geopolitical and religious lines. The Commissioners from Northern Nigeria, irrespective of their religious orientation, spoke against the memorandum, perceiving the NPP in terms of ethnic and regional political equation in Nigeria. To them, a population program is a ploy to reduce the population of their ethnic and regional group(s) and alter domestic political power balance by reducing the political advantage of their ethnic groups and region. They also asserted that the problem of Nigeria was neither the size nor the rate of growth of its population, but the efficient management of its resources. They were opposed to a "neo-colonial program and western conspiracy designed to keep developing countries weak". Those of them from the far north contended that any attempt to control population was a challenge to the will of Allah. The argument of the Minister, who was a Northern Fulani Muslim, that in its prescription for responsible parenthood and equality of treatment, Islam actually favored a population program did not convince the majority of members of the Council. The issue, as far as they were concerned, was that population control or management was not the priority of their states. The FGN should, therefore, share the WB facility among all the states, maintaining that they needed the fund to address other "pressing issues". They were not prepared to submit subproject proposals for PAF funding despite the assurance that the FMOH would provide both technical and financial assistance for the preparation of the proposal. Consequently, the memorandum was stepped down for "more consultations".

The consultations started soon after the meeting, The MOH directed some officials of the FMOH to undertake a nation-wide tour of the country to sell the NPP to the Military Administrators (who were the State Governors), members of their cabinet and officials of the states. The idea was not only to undercut the opposition of the Health Commissioners, whose hostility constituted a significant threat to the implementation of the policy, but also to educate the political leadership in the states of the advantages of the program and the need for them to mobilize public opinion in support of the population policy. In preparing for the tour, it was decided that the film depicting the adverse consequences of population growth on the Nigerian environment, economy, infrastructure, social services and standard of living should be shown at each meeting (see section 8(iv) -Project promotion and monitoring- below). The views of Egyptian and Iranian Islamic scholars on family planning were compiled for citing (where necessary) at the meetings. These views were in favor of modern contraception and had been used by Egyptian and Iranian governments in their successful family planning programs. It was also decided that emphasis should be put on two major arguments during the meeting. The first argument was based on health. It was emphasized that too many and too frequent births and births to females who are too young (under 18) or too old (over 35) would result in significantly higher mortality for children and their mothers. The second platform was the positive correlation between poverty level and size of household. It was argued that the more children there were in a household, the fewer the resources per child and the lower the quality of the child in terms of education, health, nutrition and clothing he could receive. It was to be made abundantly clear that the WB credit could not be shared among the states. The credit was obtained under an agreement that specified how the fund was to be utilized. Copies of the agreement, the PAF brochure and the National Population Policy were to be given to the political leaders in the states. The FMOH discussed and approved the format of presentation for the meeting to be held in each state and also decided that the team, which should have six members, should be led by the Director of DCDPA.

The tour only revealed how difficult old systems were hard to dislodge. It showed that the deep-seated opposition to population program in some parts of the country, particularly the North, was due to the program being seen as a challenge to firmly held values of high fertility. Opposition to the program in the North was hinged on the following arguments. The first is destiny. According to the argument, people will die when they are destined to die irrespective of how and when they

give births. Furthermore, some people are destined to be poor and others destined to be rich. They cited *Al-Isra'* 31 to support their argument that practicing birth control for fear of poverty was unlawful since it implied weakness of faith and trust in Allah as the provider and sustainer of all beings. Indeed, any attempt to interfere with destiny is a direct challenge to the will of Allah who has enjoined Muslims to be compassionate and to help the poor. This view is corroborated with the third pillar of Islam, which mandates Muslims to give *zakat* to the needy. The second argument is based on security in, and politic of, number. According to the argument, a large population is ordained by Islam and failure to achieve it deviates from the right path. Support for this view is found not only in the Quran (2:223 and 6:151) but also in the Hadith. Furthermore, a large size of Muslim population and a high rate of their growth imply power, which should not be diminished by embracing the NPP. The third argument rests on belief. It is contended that any practice that prevents pregnancy is infanticide, which is condemned and prohibited in the Quran. The contention is further supported with the hadith from Judhamah to the effect that contraception, including withdrawal ('*azl*), is prohibited by the Prophet. Therefore, the NPP, by advocating population control, is an impious attack on Islam and is totally against their belief (Federal Ministry of Health, 1993d).

The lesson the Federal officials learned from the tour is that the dislodgement of the value system has to be gradual and the winning of public opinion to fertility reduction in the North requires a lot of education which must go *pari passu* with, or even take precedence over, the provision of family planning services. In other words, attention should be paid to demand creation first, through a program directed at changing the value system of the people.

The second example illustrates the powerful influence of religious leaders over Nigerian elites and political leaders and the significance of the Nigerian Islamic opinion on any issue of national interest. This Islamic opinion seems to hold a veto over many issues in the country and must be taken into account for any success in matters as sensitive as the NPP. The opposition to public population control program of the Nigeria Islamic interest was brought to the fore in 1994 during the preparation for the International Conference on Population and Development (ICPD) held in Cairo. The FMOH, under Dr. Dalhatu Sarki Tafida, with the approval of the Head of State, General Sani Abacha, made adequate preparation for the full participation of Nigeria at the Conference. The Publicity Sub-committee of the Planning Committee for the ICPD, chaired by a Northern Hausa Muslim, Dr. Mansur Kabir, the Technical Assistant to the MOH, undertook publicity for the conference to expose the Nigerian populace to the event. It pointed out the spectacular achievement of the Nigerian delegation to both the African Population Conference held in Dakar in 1993 (Dakar, 1993) and the Preparatory Meeting for the ICPD held in New York in April, 1994. It called attention to the high expectation the conference held for a broad ranging consensus to be reached on reproductive health and population growth. The Head of State approved the list of the Nigerian delegation to the conference. It was to be led by the First Lady, Mrs. Maryam Abacha and was to include the Minister of Health, the Minister of Women Affairs and top government functionaries. However, through the influence of notable and prestigious Islamic leaders in the North, including the then Grand Kadi, Alhaji Abubakar Gumi, the respected Kano Islamic Scholar and leader of the Nigerian Qadiriyya, Alhaji Nasiru Kabara and the then octogenarian Wazir of Sokoto, Alhaji Junaidu, General Abacha's interest in the conference waned. As a result, he withdrew his support for the high profile participation of Nigeria at the conference. The Islamic leaders, who, no doubt, had popular bases of support which General Abacha did not want to ignore, argued that the Conference was on family planning and abortion, the practice of which they condemned as not being Islamic. Consequently, the size of the Nigerian delegation was reduced from twenty to two from Nigeria. They were joined by officials from the Nigerian Mission to the United Nations and from the Nigerian Embassy in Cairo. Other Nigerians at the Conference represented NGOs, the Press and the African Population Commission (Federal Ministry of Health, 1994).

Another subtle but less serious religious obstacle lay in the opposition of the Catholic Church. Although the Catholic Church in Nigeria did not need to focus on birth control as a public policy issue, given the pronatalist nature of the Nigerian society, yet, the influence of the Church on the acceptance of family planning is pervasive in Eastern Nigeria where there is a large population of Catholics. The influence is reflected in low or non-use of contraceptive commodities supplied to Eastern Nigeria by various organizations. In 1999, the FMOH sent its officials to all the health zones in the Federation to assess the needs of various zones so as to know the contraceptive mix to be purchased for distribution to the zones. The report of the mission revealed that in all the states in the Eastern Zone, the ware-houses where family planning commodities were stored were full of commodities, the shelf-life of which had expired. The explanation offered by the officials of each of the State Ministry of Health was the apathy to contraceptive use as a result of the influence of the Church (Federal Ministry of Health, 1999).

The Structure and Culture of the Political Administrative System as an Impediment to Policy Implementation

Nigeria is currently a Federation of thirty-six states and a Federal Capital Territory. The 1999 Constitution establishes three tiers of government for the Federation: the Federal, the State and the Local Government. The Federal Government has legislative powers over subjects on the Exclusive Legislative List (Second Schedule). The State Governments share power with the Federal Government over subjects on the Concurrent Legislative List but Federal legislation takes precedence over state legislation in case of conflict. The Local Governments are also assigned some local functions in the Fourth Schedule (Federal Republic of Nigeria, 1999). It is the conventional wisdom to regard subjects that are neither in the Exclusive Legislative List nor in the Concurrent Legislative List as being residual and the responsibility of states.

Since the relevant activities in the population field cut across a number of traditionally defined economic and social sectors that are in the concurrent list, there is bound to be some problems with intergovernmental relations among the three tiers of government. The first of such problems relates to fiscal federalism. The issue is whether or not each of the three levels of government has enough resources to carry out its population-related responsibilities. The most important of these responsibilities include the provision of family planning services and dissemination of population information. By the structure of Nigerian health system, which is formed into Primary Health Care (PHC), Secondary Health Care (SHC) and Tertiary Health Care (THC), each of the three tiers of government can provide family planning in the context of reproductive health (7). However, the PHC level, which is the ultimate responsibility of state governments which, in turn, assign varying roles to local governments depending on particular state policies, provides most of the family planning service, one of the nine functions specifically assigned to it in the National Health Policy (Federal Ministry of Health, 1988: 26). As for information dissemination, the broadcast of programs in local languages makes local media stations reach the grassroots. The extent to which the functions of PHC and local media can be performed is determined by the resources available to the State and Local Governments. The present revenue sharing formula, by which, in 2002, the Federal Government, the 36 State Governments and the 774 Local Governments were allocated 56, 24 and 20 per cent of the national income respectively, does not equip the states and the local government authorities with adequate resources to fulfill their expenditure obligations.

It is not just the revenue internally generated into the Federation Account that the Federal Government retains the bulk of available fund. It also controls the external funds from development partners. The National Planning Decree 71 of 1993, which replaced Decree 12 of 1992, assigns to the Federal Government, the principal responsibility for negotiating and

receiving external aid for the country and the states. Thus, external aids to states are channeled through the Federal Government. The United Nations Population Fund, the major external funder of population activities in Nigeria, in line with the provision of the law, uses the machinery of the Federal Government for its aids to states. In implementing its maternal-child health and family planning assistance to the state ministries of health during its Fourth Country Program, the UNFPA declared: "the overall responsibility for the project would rest with the Federal Ministry of Health" (UNDP, 1980 and 1981). Although the UNFPA currently works in fifteen states as part of its Fifth Country Program (2002-2007), it uses the federal execution modality to implement its program (UNFPA, 2002). The Federal Government sees the arrangement not only as an integral part of its coordinating role, but also as a means of ensuring fiscal discipline and judicious use of such aids. To the state governments, Decree 71 is not only against the letter and spirit of the federal system of government but also a contravention of the constitution.

External funds are critical to population projects in the states since it is through them that states allocate funds to population projects in form of counterpart contributions, which donors make a *sine qua non* for the aids they provide. Most of the states do not, in general, invest their resources (apart from the counterpart funds) on population programs; for the reality is that fertility control program has hardly any political support in most states. Indeed, if the external aids were for family planning *per se* and were not linked to the more acceptable issues such as reproductive health which is advertised as promoting the health of both the mother and her child and which does not encroach on the sensitivity or interest of groups, it is doubtful if the aid would have been accepted by many states.

It follows from the foregoing that the operation of political administrative authority in the Nigerian federation confers financial power on the Federal Government *vis a vis* the State Government. Yet, the state is the tier of government principally responsible for the delivery of basic services to the population. The attainment of population policy goals and objectives depends on state governments' capacity to discharge their basic service delivery mandates in an efficient and accountable manner. Furthermore, since the point of implementation of policy programs was the state level, the cooperation of state officials was critical. Such cooperation might not be forth coming even during the military regimes when the unified command structure of the military made states less independent. The adverse effect of the heavy hand of the Federal authorities on program implementation has led to the donor communities designing agreements which give states more say in how fund allocated to their states are utilized even when Federal preeminence is recognized (8).

Another source of conflict between the federal and state governments in population program implementation is the attempt by the federal government to dictate the *modi operandi* for program implementation. As the custodian of the National Population Policy, the Federal Government is of the view that it should lay down the modalities for its implementation. The states resist what they regard as undue interference in how they organize the affairs of their states. An example of such a conflict which impacts negatively on program implementation is the location of population activities within the state administrative set-up. One of the activities to be undertaken by the NPP was the establishment of population focal points in all the twenty-one sates and Abuja that constituted the Federation when the NPP was drawn up. The points were not only to sensitize government officials and the general public to population issues, but also to serve as the locus for the implementation of family planning activities. Probably because of the latter reason, the FMOH, which had been in charge of population management at the federal level since 1988 when the policy was launched, believed that such focal points should also be in the state ministries of health. However, the location of population management outfit in the states varied from state to state. In some states where population problems were perceived as poverty problems that should be solved by improving the living standard of their people through a reduction in population growth, the Ministry of Economic Development hosted the population management outfit. In

states where the problems were seen in terms of family health, the Ministry of Health was the home of the outfit. The administrative set-up of some states does not include a population unit at all. When the population focal points were to be established in the states in 1994, the directive of the Federal Ministry of Health that the points should be located in the state Ministry of Health with fund provided by PAF was vehemently opposed by some states that rejected the top-down approach of the FGN. The idea had to be shelved until the findings of a study to be undertaken by DCDPA and PAFA to determine the best location and find a compromise were discussed at a meeting of all stakeholders from the states. Consequently, the chance for the establishment of population focal points, which would have been a veritable channel of policy implementation, was lost, at least for a season.

Discord also often occurs among the states in allocation of population programs to states. States that do not have federally funded programs often complain of either their neglect, or favor of others, by the federal authorities. Such disharmony is exemplified by the reaction of some states to the distribution of PAF-funded projects. At the inception of PAF, the seven phase one subprojects had activities in each of the then 21 states of the Federation and Abuja. With the creation of new states, some of the old states were split into two and the boundaries of some states and Local Government Areas were adjusted. This exercise left either the new or the old states without PAF-funded activities. The FMOH attempted to correct this situation by encouraging both the donor agencies to cite their new programs in such states and PAFA to locate its phase two subprojects in those states. The ministry recorded only limited success because the donor-funded projects and the PAF phase two subprojects were chosen through a transparent competitive process. In the culture of political patronage that characterizes Nigeria administrative system, the leaders of affected states often prevail on members of their ethnic groups in senior positions in the ministry to persuade funding agencies to cite a project in their states or even local government areas. The insistence of the agencies on following due process often led to delay in project commencement and/or implementation as approvals were often withheld for critical activities and actions.

Problems Associated with the Institutions Designed for Implementation

The third, and probably the most serious problem that impacted negatively on policy implementation, had to do with the unhealthy bureaucratic struggles among the various Federal Government agencies vying for the heart of the population policy implementation. There were interagency and intra-agency struggles. At the center of the inter-agency struggle were the Federal Ministry of Health and the National Population Commission (NPC). As pointed out earlier, the FMOH coordinated the drawing up of the population policy; established both a Department and a parastatal for the implementation of the policy and obtained a World Bank credit facility for the implementation of the policy. The NPC, established in 1988, saw the implementation of the policy as falling within the boundary of its mission, especially as one of the functions listed in the law that established it is "to monitor the population policy" while one of its functions listed in the Third Schedule, Part 1 J of the 1999 Constitution is to "advise the President on population matters".

The NPC did not lay claim to the implementation of the population policy until, at least, two factors encouraged it to do so. The first was the preparatory meeting for the formation of the African Population Commission (APC). The invitation to this meeting was sent to the NPC since each Member State of the then Organization of African Unity (OAU) was to be represented by "a delegation led by the highest official or a representative of the National Population Commission/Council and/or analogous institution dealing with population and development matters". At the meeting, Nigeria, and by implication the chairman of NPC (Col. Chris Ugokwe) who headed the Nigerian delegation, was elected Chairman of APC and was mandated to present a case for the establishment of the Commission to both the Council of OAU Ministers and the

Assembly of African Heads of States to be held in Tunis in June 1994. Part of the working documents for the presentation was the population policy of Nigeria. The MOH protested the development to the Secretary to the Government of the Federation (SGF), pointing out that the preparation of population policy was coordinated by the FMOH that had put in place two institutions for the implementation of the policy. Therefore, if any organization was to represent Nigeria at any forum where the policy document was to be a major input, it should be the FMOH. The SGF, Alhaji Aminu Saleh, in a letter to the MOH, revealed that the request of Col Ugokwe to attend the Tunis meeting had already been approved. He, however, promised to convene an interministerial committee to look at all the issues related to population activities after the Tunis meeting.

The second factor for the new stance of the NPC towards the implementation of the policy was the availability of new resources and the power and resilience they brought. The World Bank credit, located in the FMOH, was by far the largest amount available for policy implementation. All sorts of tactics were employed to ensure that population management was removed from the FMOH. The organization successfully canvassed the creation of a Ministry of Population Affairs at both the federal and state levels at the Vision 2010 Committee set up by General Sani Abacha in November, 1996 (Federal Republic of Nigeria, 1997). At the Federal level, the NPC was to be the root and the stem of the Ministry while the branches were to include PAFA and DCDPA (of the FMOH), the Department of the National Civil Registration (of the Federal Ministry of Internal Affairs) and the Population Information and Communication Bureau (of the Federal Ministry of Information and National Orientation). Although the Obasanjo administration jettisoned the Vision 2010 in 1999 when the new government took office, the NPC continued its agitation for the control of all population activities in the country. Its efforts were rewarded when President Obasanjo decreed the transfer of all population activities in the country to NPC in 2000. President Obasanjo's directive was based on the advice of Dr. Nafis Sadik (former Executive Director of UNPA) to streamline population activities in the country so as not to 'confuse the international community'. Dr Sadik had unsuccessfully canvassed the same action during her meeting with the President in Abuja in June 2000. At that meeting, the government officials pointed out that each organization handling different aspects of population had defined functions. They directed the attention of the meeting to the report of Alhaji Ahmed Joda Committee, set up by the President on assumption of office to streamline all Federal Government parastatals. The report had identified, and action had been taken on, those agencies that were found to have either duplicate or overlapping functions. However, Dr Sadik reopened the issue with the President in September, 2000 when they met at the fifty-fifth session of the United Nations General Assembly where the Millennium Declaration was adopted. The protest of the FMOH and some other stakeholders on the President's directive came to naught. Although the law to effect the changes decreed by the President is yet to be passed by the National Assembly as of July 2007, the NPC had taken over all population activities in the country.

A much more serious obstacle to project implementation was the management structure designed for the population program at both the political and professional levels. The structure gave room for intra-agency struggle and conflicts as responsibilities were shared by two functionaries. The working arrangement among these bodies was either not clearly delineated or very contradictory. At the political level, one of the major functions of the apex advisory body, the National Consultative Group on Population for Development (NCGPD) was to address important gaps in coordination of the NPP (World Bank, 1991a). By contrast, the five main functions of the Governing Council of the Fund (GCF) gave it power over policy and financial issues (Federal Republic of Nigeria, 1994). While the NCGPD was expected to meet twice a year, it hardly met once a year because of financial constraint. The large number of its members and their far-flung locations in various parts of the country meant that the cost of hosting a meeting was about five million naira. On the other hand, the GCF met regularly as and when due. With about 95 per cent

of its few members living in Abuja, the cost of convening a meeting of GCF was only about N100, 000. Furthermore, while GCF was supposed to be a sub-committee of the NCGPD to supervise PAF operations, the GCF regarded itself as an autonomous entity established by a law that made it to be responsible only to the Federal Executive Council, through its Chairman, the MOH. Nowhere in the law was it stated that it was a sub-committee of NCGPD. Indeed, the law made a representative of the NCGPD a member of the GCF. Throughout the period under review, the representative was neither elected nor selected by the NCGPD but nominated by the MOH. Being a nominee of the Minister, the representative owed allegiance, not to the NCGPD but to the Minister. Furthermore, while the Minister hardly attended the meetings of the NCGPD, often delegating his role to the Director of DCDPA, he called, and personally presided over, all the meetings of GCF.

The day-to-day management of the NPP was marred by the conflict between PAFA and DCDPA. The two bodies formed an incongruent institutional system. The DCDPA, as a department in a Ministry, consisted of career bureaucrats, well trained and well versed in the intricacies of public administration. They were transferred from various units in the Federal Civil Service to form the department when it was created. However, in the first few years of its existence, DCDPA lacked the technical staff that was proficient in population management issues or project implementation, attributes required to perform the technical functions assigned to it by the policy. Furthermore, its staff saw themselves first and foremost as members of the Federal Civil Service deployed to the FMOH from which they drew their salaries. Under the pool system of the Federal Civil Service, they could be redeployed at any time. It was therefore important for them to be well attuned to the Civil Service system experience so as to be able to move on the promotion ladder. Movement on the ladder depended on the Director who wrote their confidential reports and to whom they owed allegiance and who, in turn, owed allegiance to the Permanent Secretary. Thus, the level of commitment of some of the staff, especially, the physicians among them, to the NPP, which they regarded as an additional responsibility, depended on the incentives available to them for assuming the duty of engaging in project implementation. Even the non-physicians demanded some share of PAF in form of incentives to square up with PAFA staff that received their salaries from the Fund.

By contrast, PAFA was a small parastatal of Government created in accordance with the Development Credit Agreement (DCA), which the FGN signed with the World Bank (WB). It started *de novo* with a full complement of skilled staff whose qualifications as well as terms and conditions of employment were satisfactory to the WB. These young professionals included accountants, procurement specialists, fund managers, project managers and population experts. They were on contract appointments for two years in the first instance renewable on condition of satisfactory performance. Their remunerations, which were paid from the credit, were far higher than the salaries of the mainstream career civil servants with the same qualifications and experience. The staff was motivated by the desire to implement the program effectively and efficiently to the satisfaction of the WB officials and the GCF so that their contracts could be renewed. Furthermore, they were guided, not by routine bureaucracy, but by an Operational Manual approved for them by the GCF and the WB (Federal Ministry of Health, 1993a).

These inherent inequalities between DCDPA and PAFA were compounded by role conflict between the two institutions. At the onset, the technical management of the NPP was assigned to DCDPA while the financial management was assigned to PAFA. In practice, the responsibilities of the two units conflicted. The notion of DCDPA was that PAFA was a 'bank' from which it could draw money for the implementation of any population project. On the other hand, PAFA saw itself as a fund manager accountable for every kobo spent. Any activity submitted to it for funding must meet the criteria set out in its operational manual. Attempts to ensure compliance with these criteria used to bring the two organizations into conflict. The rivalries between the two

extended to the control of the CAs. Before PAFA came into existence, the CAs were reporting to

Table 2. Functions assigned to the organizations responsible for the management of the National Population Program

Department of Population Activities	Population Activities Fund Agency
1. To maintain liaison with relevant agencies of the Federal, State and Local Governments and non governmental organizations to ensure adequate coordination and integration of population and development policies and programs.	To liaise and coordinate the activities of donors, multi-lateral and bilateral agencies and non-governmental organizations engaged in population activities.
2. To monitor the effects of such efforts on a continuous basis.	
3. To be responsible for the planning, facilitation and coordination of all activities at the federal level and with the states and private sector for the achievement of national population goals.	To identify, develop, appraise, monitor and evaluate population related projects.
4. To maintain the flow of needed materials and the effective management of the programs, through supply, logistical, inventory taking and related activities.	To recommend appropriate materials and technical, financial and other support for the implementation of the National Population Policy.
5. To maintain liaison with government and non-governmental agencies involved with population matters at the implementation and monitoring stage.	To maintain the flow of materials needed for the effective management of population programs through supply, logistics, inventory taking and related activities.
6. To maintain contact with donor agencies.	To act as the agency for channeling external aid into population programs.
7. To make contractual arrangement for special services.	To receive from the Federal Government such money as may be made available for purposes of population programs and disburse the money to such bodies or organizations engaged in population activities in accordance with such formula as the Agency may prescribe from time to time.
8. To manage special projects and program activities as needed.	To fund approved population projects and programs.
	To utilize the Fund (PAF), in general, on population related activities not otherwise stated in the provisions of this Decree.
	To mobilize additional financial and material resources for the successful implementation of the National Population Policy.

SOURCES: 1. Federal Republic of Nigeria (1998). 2. Federal Republic of Nigeria (1994).

DCDPA. With the inauguration of PAFA, the terms of the agreement with the World Bank that CAs must sign a subproject agreement with PAFA had to be invoked. This latter agreement made the CAs accountable to PAFA, which funded their activities. Yet, the DCDPA wanted all CA project activities that needed funding to pass through it, for onward transmission to PAFA. Since the Agency had a department that was competent to review CAs' activities, it saw this demand of DCDPA as an unnecessary bureaucracy for which provision was not made in the subproject agreement.

The rivalry was aggravated by the promulgation, in July 1993, of a decree - the National Agency for Population Programs and Development Decree Number 53 - which was to effectively convert DCDPA into a parastatal, thus rendering the existence of PAFA superfluous. The World Bank supervisory mission protested this action, pointing out that the spirit and letter of the DCA was that PAFA should be given a legal backing so that it could be a corporate body which could enter into agreement with other agencies, be able to sue and could, in turn, be sued. As a result of this protest, a law establishing PAF was enacted in 1994. The decree gave the power of the purse exclusively to PAFA. However, most of the other functions of the Agency were almost identical with those that were listed for DCDPA in the policy document. Thus, as Table 2 shows, each of them could, and did, claim responsibility for coordinating donor activities, for the provision of supply and logistics for the program and for liaison with various organizations responsible for project implementation. The conflict of interest that the identical functions brought about was illustrated by the delay in the establishment of the Donor Forum. Although the staff of both organizations visited all the donor agencies in the country in May 1993 to canvass support for the National Population Program, they (PAFA and DCPA) could not agree on which of them should host meetings of the donor agencies where coordination modalities were to be discussed. Thus, the attempt to harmonize the programs of donor agencies with the NPP had to wait until the issue was resolved by the Consultative Meeting of all stakeholders, including the World Bank, in 1995.

The rivalry created bad blood between the two organizations, a situation that adversely affected cooperation between them for a while. The ill feeling is illustrated by the attempt of DCDPA to stop the staff of PAFA from changing the titles of the offices to which they were appointed. One of the steps taken by PAFA staff to ensure that they succeeded in their work was to request and obtain the permission of the WB to align the designations of the offices to which they were appointed with those of the officials of government with whom they would interact. They argued that a change in their designation was required for effective interaction since the designation of an officer in the public service (such as Executive Director, Director, Officers) carried with it progressive levels of prestige and authority. Furthermore, when the law establishing PAF was eventually enacted, the designations assigned to the offices they held would be in line with what they suggested since their suggestion was in line with what operated in other parastatals. The DCDPA was against the change, claiming that it took a career officer not less than fifteen years to attain the position of a director, a title which some PAFA staff, with not more than five years experience would now don.

The DCDPA-PAFA imbroglio was only one aspect of intra-agency conflict. There were also conflicts within the ministries in which the CAs were located. At the conception of the subprojects, middle-level staff was nominated to handle the subprojects as subproject directors (SDs). When it became obvious that these SDs and other officers working on the subprojects were to receive donor-supported foreign training, the more senior officers became jealous. The jealousy increased as it dawned on these seniors that new resources were available to the subprojects. In some cases, unsuccessful attempts were made by the seniors to replace the SDs with their selves. In other cases, the SDs were redeployed from the subprojects and replaced with favorites of the Heads of the Department. In the former cases, cooperation in project implementation was hampered while in the latter cases, the training and experience acquired by

the redeployed officers were lost to the subprojects.

However, the impression should not be formed that the different organizations involved in the NPP were perpetually at one another's throat or that each of them was constantly in aggressive isolation, venting its venom on its 'opponent' at the slightest provocation. There was a lot of cooperation among all of them. Indeed, the head of each of them tried as much as possible not only to cultivate, but also to understand the role of, one another. Certainly, but for this cooperation, the modest success recorded by NPP would not have been possible. Nonetheless, the level of cooperation varied with the individual at the head of each organization. His perception of, and concern for, the program shaped his reactions to issues of potential conflict. Although his reaction might be influenced by the values of his subordinates on whom he relied for expert advice, he often trusted his own judgment on crucial matters, basing his decisions on circumstances surrounding specific issues and on what he considered to be right. When an immensely experienced and genial officer was at the head of each organization, accommodation of the views of others was enhanced and the level of cooperation in all areas of operation (whether between the FMOH and NPC or between DCDPA and PAFA or between GCF and NCGPD or between the SDs and the heads of their departments) was very high. It was only when over-zealous officers who wanted to assert their supposed superiority over the others or who wanted to use all subterfuge to acquire some undeserved benefits at the expense of either the program or other officers that cooperation suffered and competing interests could not be resolved. It was in such circumstances that most of the problems identified above were created.

Unfortunately, each of such problems had adverse effects on the implementation of the National Population Policy. It is, however, not possible to quantify the contribution of each problem to program performance. Nonetheless, the accomplishments of project implementation can be assessed at two levels. The first level is the final consumer of the program, which is the women (and men) whose actions were expected to bring about a reduction in population growth as envisaged by the policy. Such an assessment will review the change that has occurred in major population dynamics, particularly in fertility, during the period of implementation and compare it with the targets set by the policy. The second level is the intermediate level at which activities were concentrated at providing not only the wherewithal needed, but also preparing the ground for the final consumer. Such an appraisal must of necessity focus on the achievement of the overall NPP objectives, which put emphasis on institution and capacity building. It is to these two kinds of evaluation that attention is now turned, starting with the second type.

The Performance of the National Population Project

With respect to the performance of the National Population Project, we note that the critical issue addressed by it was capacity building at the level of project officers (service deliverers). By this process, it was expected that the people who are to implement the policy (i.e. the project officers) would have the right orientation, which would enable them to mobilize the populace (service receivers) for change. The scenario for this type of assessment would be one in which progress is measured in terms of the number of population-related operatives trained, the number of meetings organized in pursuit of capacity strengthening, the number of equipment acquired to further population activities and the number of institutions established or strengthened for population-related activities.

Institution building

Of the institutions established during the period, two, PAFA and DCPA, were located in the FMOH while one, PICB, was in the FMOI. One major achievement of DCDPA and PAFA was the putting in place of a Commodity Logistic and Management System through which a head was

created for the first time for the procurement of contraceptive commodities in the Federal Budget. The implication of this achievement was that the Federal Government would allocate fund annually for the purchase of commodities rather than rely solely on those supplied by donors. Also, the fact that the FGN was ready to commit its resources to contraceptive procurement was an encouragement to donors. The streamlining of population activities discussed above left the procurement of contraceptive commodities and their distribution in pursuit of the goals of the policy in the hands of DCDPA. Before the streamlining exercise swept away PAFA, the Agency drew up a strategy for fund generation from domestic sources for seven years in the first instance. The achievements of PICB, the third institution created, included the establishment of Population Desks at the headquarters of both the Nigerian Television Authority and the Federal Radio Corporation of Nigeria. Vehicles, furniture, production and editing materials were provided to support the Desks and the staff attached to the Desks to cover, report and disseminate population news, information and issues. A line was also created in the annual Federal Budget, an action that has enabled the Bureau to publish and disseminate population information bulletins, and carry out various IEC activities.

Physical capacity building

Just as important as the creation of new institutions was the strengthening of the existing ones. In order to create a conducive physical environment for work, the offices of all the CAs and DCDPA were rehabilitated, expanded, furnished and provided with secretarial equipments including computers and typewriters, communication facilities, particularly, telephones, air conditioners and electricity generators. In a country where public electricity supply is very erratic, a generator not only ensures that office temperatures were maintained at comfortable levels conducive to maximum productivity but also that work did not stop abruptly and/or for a long time because of lack of power supply. Telephone facilities saved a lot of time spent in traffic jam as without them, project business had to be undertaken by physical contact. Other secretarial materials supplied to the offices of each of the CAs included photocopiers, duplicating machines and file cabinets. The provision of equipment was not limited to the CAs. In the reproductive health subprojects, one computer was supplied to each of the twenty-two state general hospitals, the four teaching hospitals and the African Regional Health Education Center (ARHEC), Ibadan while a manual typewriter was provided for each of the twenty-two primary health care centers since, in these centers, power supply was unsteady. In the IEC subprojects, the ability to implement the project at the local level was enhanced through the provision of a 30-inch television set as well as a portable 5KVA generator for each of the twenty-four public rural viewing centers established by PICB in various parts of the country. The centers were to serve not only as points of relaxation and entertainment but also as foci for dissemination of family planning information. Of critical importance for the data management subprojects was the provision of one computer, one UPS, one printer and software for integrating population variables into economic planning process to each of the thirty-six state planning offices and five Federal Ministries.

The capacity of various CAs for project implementation was further enhanced by the provision of four sets of facilities/equipments. The first set consisted of a Library and Documentation Center established in the FMOI. The library was to serve as a reference center for staff of the FMOI and its parastatals, particularly NTA and FRCN on population-related issues. The second set comprised two printing presses. One of them was established in NERDC for the mass production of the textbooks, teachers' guides, and instructional materials developed for population life education. The other was located in PICB for printing of posters, pamphlets and journals to sensitize the public on population and family planning issues. These presses produced, among others during the period, five types of population IEC posters, seven types of method-specific family planning techniques and pamphlets by HEB. The materials were designed to highlight the

methods and benefits of family planning to youths as well as men and women of reproductive age and were distributed in the sixteen rural locations where HEB operated. The third set was made up of medical equipments and materials supplied to one hundred and ten PHC centers (five centers in each of twenty two states), twenty-two general hospitals and four teaching hospitals for expanded service delivery.

Finally, there was the set of vehicles for project implementation. These vehicles can be categorized into three. First, there were project vehicles. Twenty of these types of vehicles were distributed to all the seven CAs, the four teaching hospitals and ARHEC to ensure easy mobility to aid project implementation. Secondly, specialized vehicles were made available for particular and peculiar functions of the CAs. For the reproductive health subprojects, twenty-two ambulances were distributed to state general hospitals throughout the country. They were to be used for emergency referral cases so that difficult reproductive health problems could be referred to the secondary health centers from the primary health care centers while those that could not be solved there could be transferred to the tertiary centers for attention. For the IEC subprojects, five public address system vehicles were provided. They were fitted with gadgets for cinema and were to be used to propagate family information through films and outside broadcasting.

Human capacity building

Much more important than building physical institutions was the building of human capacity. All

Table 3. Local short duration training for the implementation of the National Population Program

Type of Training	Number of trainees from:			
	Federal	State	LGA	Total
1. Reproductive health				
a. Family planning logistics management	-	136	720	856
b. Family planning service delivery and clinical management	-	198	844	1042
c. Comprehensive reproductive health and clinical management	16	77	-	93
d. Management and control of STD/AIDS	-	25	-	25
Sub-total	16	436	1564	2016
2. Information, Education and Communication				
a. Population/ family planning IEC strategy	32	108	172	312
b. New curriculum on population education	-	60	175	235
Sub-total	32	168	347	547
3. Management				
a. Data management: Software for integration of population variables into planning and budgeting	45	132	-	177
b. Project management	43	-	-	43
Sub-total	88	132	-	220
Total	136	736	1911	2783

SOURCE: Federal Ministry of Health (2000)

cadres of staff of implementing agencies received a series of overseas and local training. With respect to overseas training, three tranches were identifiable. First, study tours were undertaken

by twenty staffers and policy makers (including the Minister of Health, the Minister of State for Health, Executive Directors and Directors) to Indonesia, Brazil and Zimbabwe. On their return the staffers organized seminars for other members of their units to share the knowledge and experience gained during the tour for use in program implementation. Secondly, some members of staff were sponsored to international conferences. Of these, the most important were the Fourth World Conference on Women in Beijing in 1995 and the Hague Forum (ICDP+5) in 1999 (9). Thirdly, some members of staff of CAs, DCDPA and PAFA received both long and short-term training. Four members of the FMOH received Masters degrees in the United States, two in Public Health and two in Population Management. Short-term training was given to eleven members of staff, three from DCDPA, two from each of PICB and NERDC and one each from DHS, HEB, National Planning Commission and African Regional Health Education Center (ARHEC).

The local training varied in duration. The longest duration was the one-year Masters degree training received by three members of staff of HEB at the University of Ibadan. The short duration training involved the staff of CAs and agencies billed to implement the project in the states and Local Government Areas. Table 3 shows the type of training received and the number of personnel who received them at various levels of government. It is obvious from the table that the majority of the trainees were drawn from the LGAs, constituting 69 per cent of all the 2,783 of the people trained while the Federal officers were only 5 per cent.

However, the level and sophistication of the training received increased with the level of tier of government, but varied inversely with the number of recipients. Thus, the training the Federal and state officials received - comprehensive health service and clinical management at University Teaching Hospitals, and project and data management - was much more technical and capital intensive. The table also reveals that majority of the recipients were health workers in the reproductive health subprojects. They accounted for 72 per cent of all the trainees. They included doctors, nurses and birth attendants drawn from all the three tiers of government. All the trainees in the reproductive health sector at the Federal level were physicians while the trainees at the state level were made up of medical doctors and nurses. The majority of health worker trainees at the LGA level were birth attendants. For example, the seventy-seven medical personnel who received training in comprehensive health services were made up of thirty-nine doctors and thirty-eight nurses while the 844 LGA health workers who received training in family planning service delivery consisted of 2 doctors, 226 nurses and 616 birth attendants. It may also be noted that while the state officials were trained in all the types of courses listed, the LGA officials received training in two items and the Federal officials in only one.

The IEC training was designed to promote awareness on reproductive health and family planning. It involved the training of a total of 312 health educators, primary health care coordinators, community-based health workers, local information officers and village development workers. Of this number, 10, 35 and 55 per cent were Federal, state and LGA officers respectively. In order to acquaint the stakeholders with the new curriculum on population life education drawn up by the NERDC, workshops were organized for education secretaries, inspectors of education and primary school headmasters not only on the new curriculum, but also on instructional materials, the teachers' guide and other teaching aids. Not included in the table are two items. The first is the training given to 250 media professionals, musicologists, performing artists and cartoonists who were trained in the dissemination of reproductive health and family planning messages. The second is the training of trainers from which 190 officers drawn from all the CAs benefited.

Training in management is divided into two, namely data management and project management. Of primary concern to the NPP was the generation, management and utilization of data needed for the incorporation of demographic planning, as a priority, within development plans of states

and of the Federal Government. With the coming into effect of the 1999 Constitution, the top to bottom planning approach of the command structure of the military gave way to decentralized planning framework in which each state asserted its independence of the Federal Government. In such a situation, resource allocation and budgeting within each state became the sole responsibility of states without any dictation from the center. The central administration coordinated planning, provided advice at the annual meeting of commissioners responsible for planning and gave assistance to states. One of such assistance was training to enhance the planning capacity of state officers. Thus, in the area of data management, the focus was the training of core staff of eight sectoral ministries at the Federal level and all the states of the Federation, including the Federal Capital Territory, Abuja, in the techniques of, and use of appropriate software for, integrating population variables into development planning and budgeting. As for project management, the training was restricted to acquisition of knowledge in project appraisal, monitoring and evaluation.

Project promotion, monitoring and evaluation

The promotion of the population program amongst various categories of Nigerians as well as its monitoring was an important aspect of the NPP. The most important activity performed to achieve this objective was the film shown to various categories of policy makers by the staff of DCDPA. The films were designed to bring into bold relief, the relationship between population growth on the one hand and environment and economic development on the other. Two scenarios were presented. In the first scenario, Nigerian population was growing slowly at a rate of 2 per cent per annum but in the second scenario, the rate of growth was fast, being 3 per cent. The implications of each rate of growth for flora, fauna, food supply, the environment, consumption and various aspects of the economy after a period of twenty years were depicted. The various audiences that watched the film appreciated the fact that Nigeria did have a population problem and promised to support the NPP.

In order to monitor the impact of the NPP on fertility levels and the use of family planning methods, surveys were conducted by two of the subprojects. The National Population Commission conducted sentinel surveys. The studies described the socioeconomic conditions of surveyed populations, the characteristics of contraceptive users and the demographic characteristics of the population. The results of the base line survey was published and disseminated in 1995. However, the results of the two follow-up surveys conducted were yet to be published. The results of the KAP survey conducted by the IEC subproject in sixteen pilot LGAs were also published.

Miscellaneous

Three other landmark achievements recorded by the NPP during the period under review are worthy of note. First, the NERDC successfully developed a syllabus for population/family life education in primary schools. The curriculum integrated population education into six primary school subjects. The syllabus, together with the Teachers' Guide and other instructional materials developed to accompany the syllabus, was approved by the National Council on Education. the highest policy making body on education in the country. Secondly, the PICB mounted a stand at each of the several Trade Fairs held in various parts of the country. Each year, these fairs were held in Lagos, Kaduna and Enugu. At the PICB stand, all the CAs promoted their activities, distributing posters, pamphlets and condoms. In this way, population awareness was promoted among the thousands of visitors to the stand. Thirdly, various materials were developed for project implementation. The most important of these materials, developed by Maternal and Child Health/Family Planning (MCH/FP) subproject and approved by the National Council on Health for use as a uniform guide in implementing the community-based health and family planning

program were the *Training Manual for Village Health Workers (VHW) and Traditional Birth Attendants (TBA*) and *Guide to Family Planning - Standard of Practice.*

The Demographic Impact of the National Population Program

An assessment of policy performance at the level of end-users requires the use of indicators of population dynamics to evaluate the effectiveness of a population program. Unfortunately, such a procedure has several drawbacks. As pointed out by Jain (1998), factors other than a country's policy program may contribute to a decline in both fertility rate and population growth. Improvement in socioeconomic conditions may, for example, bring about fertility decline. The experience of Latin American countries has demonstrated that sustained improvements in the level of socio-economic development can bring about a fall in fertility level even in the absence of organized family planning programs (Aramburu, 1994). In the Nigerian situation, it is extremely difficult to estimate the relative contributions of population program and social and economic changes to fertility level for two main reasons. The first is lack of effective experimental designs. Although a system of sentinel surveys was instituted to measure the effectiveness of the NPP, the system was not followed through. As pointed out above, only the results of the baseline survey were published. Of the several other subsequent surveys planned, only two were conducted but their results were not published.

The second problem relates to the deficiency in the Nigerian data. None of the censuses

Table 4. Age-specific fertility rates and total fertility rates, 1981-2003

Age group	Fertility rates (births per 1000 women)				Percent change		
	1981**	1990*	1999**	2003*	1981-90	1990-99	1999-2003
15-19	173	146	111	126	-16	-24	14
20-24	284	258	220	229	-9	-15	4
25-29	274	263	239	274	-4	-9	15
30-34	231	220	226	244	-5	3	8
35-39	147	159	138	168	8	-13	22
40-44	100	92	71	72	-8	-23	1
45-49	60	64	24	18	7	-62	-21
Total Fertility Rate	6.3	6.0	5.2	5.7	-5	-13	10
TFR, 15-49	6.34	6.01	5.15	5.7	-5.2	-14	11
TFR, 15-45	6.04	5.69	5.03	5.6	-5.8	-12	11
GFR	203	203	176	190	0.0	-13	65
CBR	46	39	38	42	-15	-3	11

na: information not available
* Calculated for three-year period preceding the survey
** Calculated for the five-year period preceding the survey

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992); National Population Bureau (Nigeria) and International Statistical Institute (1984)

conducted in Nigeria so far has produced accurate and acceptable data. Neither is there a reliable system of vital statistics throughout the country. The results of the major demographic surveys

conducted in the country are also not free of errors. According to the NPC (2000), there were omissions of births in the three-year period immediately prior to the 1999 NDHS. Similar errors have been suspected in the 1990 NDHS (FOS, 1992). Although no evidence of omission or transfer of births is reported in the 2003 NDHS, the data cannot be said to be error free (NPC, 2004). Yet, these surveys are the only sources of demographic data available at the national level to assess fertility trends in the country. The analysis that follows makes use of the data from the 1981/82 Nigerian Fertility Survey (NPB, 1984) as well as those from the 1990, 1999, and 2003 Nigeria Demographic and Health Surveys (NDHS). These data will enable us examine the pace at which fertility transition is occurring in the country. Using data from various surveys conducted in different parts of Western Nigeria, Caldwell, Orubuloye and Caldwell (1992) concluded that sustained fertility decline had begun in Nigeria. This submission is in contrast to the view of van de Walle and Foster (1990) that real and irreversible fertility decline might not be taking place in Africa. A comparison of 1999 NDHS data with those of 2003 NDHS reveals that even when allowance has been made for data deficiencies, fertility had increased in Northern Nigeria within the four-year period while Southern Nigeria recorded only very marginal declines. Thus, the results of the 2003 NDHS seem to suggest that the sustained decline is yet to begin. It is argued here that the suspension of public involvement in population activities as a result of the directive of the FGN in 2000 put a break on the fertility decline that was noticed up to 1999. In addition to fertility, other demographic indicators examined to support the argument here include nuptiality, family planning and male involvement in family planning.

Fertility trends

The 1988 population policy sets targets for two measures of fertility, the total fertility rate (TFR) and teenage and old age pregnancy. With respect to the first (TFR), the policy posited a reduction in the proportion of women bearing no more than four children by 50 per cent by 1995 and by 80 per cent by 2000. In other words, TFR was to be reduced from about six in the early 1980s to four by 2000. As for the second, the policy targeted a reduction in pregnancy to women below 18 years and above 35 years by 50 per cent by 1995 and 90 per cent by 2000.

The fertility trends revealed by data from various national surveys are shown in Table 4. The table reveals that the TFR declined from 6.3 in 1981/82 to 5.2 in 1999. Increasing rate of urbanization, rising level of education, burgeoning degree of modernization and economic factors were partly responsible for the decline. The first three factors released most Nigerians from the trammels of tradition and its emphasis on a large family size. With respect to the last factor, economic conditions, the evidence is not conclusive.

As observed by Boserup (1985), an increase in income may bring about either a reduction or an increase in fertility depending on how the increase in income is brought about. According to her, "People may enter an occupation or move to an area that is conducive to lower fertility. They may in such cases begin to restrict fertility, despite the fact that the new situation provides them with a larger income. On the other hand, if they obtain a higher income because of an increased wage, or a windfall profit in their usual occupation and residence, the only change in their situation is that they can now afford to have a larger family than before". The opposite of this situation is also not untrue. It can be asserted that movement to a higher fertility occupation or area or situation may encourage increase in fertility despite the fact that the new occupation or area or situation provides them with smaller income. On the other hand, if they obtain a lower income because of a reduction in wages or a reduction in profit in their usual occupation and residence or a reduction in various subsidies (for example, in education, health, basic food items, petroleum products, etc), the only change in their situation is that they cannot afford to have a larger family. In other words, the effects that changes in income have on fertility are different from the changes which structural changes in the economy have.

Thus, the economic argument often cited to explain fertility trend in Nigeria needs a re-evaluation. Unfortunately, appropriate data to quantify the link between fertility and economic conditions over a period of time are not available. A surrogate economic index available is the annual GDP real growth rate. If the rate reflects economic conditions and if the conditions are viewed within the context of change in income (the first scenario), a low rate would indicate a harsh economic condition, a situation that would encourage low fertility (although allowance has to be made for a lag) while a high rate would bring about a high fertility. On the other hand, if the conditions are viewed within the context of structural change (the second scenario), a harsh economic condition will promote high fertility while a robust economic condition would lead to low fertility. This is the situation when poverty promotes high fertility, which gives psychological satisfaction to the poor in the hope that the children, as assets, would improve their lives when they (the children) grow up.

According to the Central Bank of Nigeria (1981-2003), the GDP real growth rate was high in 1981, being 6.9 per cent and increased gradually to reach 7.5 per cent in 1985. The rates were low between 1986 and 1990 when they ranged between 1.8 per cent in 1987 (just after the introduction of the Structural Adjustment Program) and 4.0 in 1989. It surged to a high of 8.3 in 1990, but plummeted the following year to 4.8 and continued its downward trend until it hit 1.3 per cent in 1994. Since then, it has remained low, though rising gradually, reaching 4.6 per cent in 2002. It jumped to 9.6 in 2003. Thus, based on these surrogate indices, the condition for high fertility existed only between 1981 and 1986, in 1990 and in 2003 under the first scenario. Under the second scenario, however, the condition in those periods will give rise to low fertility.

The declining of fertility when the economic condition for it did not exist indicates that factors other than the economy influenced fertility rates. One of the major factors was the tempo of the implementation of the NPP. A disaggregation of the fertility trends in Table 4 shows that during the period 1981 to 1990, two years after the adoption of the policy but three years before the full commencement of the NPP, TFR declined marginally by only 5 per cent from 6.3 to 6.0. But between 1991, two years to the initiation of NPP and 1999, when NPP had been implemented for a few years, the TFR declined by 13 per cent from 6.0 to 5.2 at an average of 2.0 per cent per annum. Thus, the major reduction in fertility was achieved during the seven-year period from 1993 to 2000 while the nine-year period from 1981 to 1990 recorded a moderate increase. Although the TFR of four per woman was not achieved by 2000 as the policy targeted, there was a trend towards achieving the goal a few years after 2000 if the tempo of project implementation had been maintained. Unfortunately, the trend was not only halted but was also reversed when the implementation of NPP was substantially slowed down as from 2000, following a Presidential directive to streamline population activities, as evidenced by a sharp rise in TFR to 5.7 in 2003.

With respect to teenage and old age pregnancy, the age-specific fertility rates (ASFR) in Table 4 show that fertility related age patterns changed in absolute and relative terms over the 10 year period since the initiation of the NPP. The greatest reduction occurred among women aged 45-49 (62%). A large reduction was also found among the 40-44 cohort (23%). Women in the two age groups were about 30-39 years old in 1990. The fertility of younger women also declined substantially, falling by 24 and 15 per cent among the 15-19 and 20-24 age groups respectively.

The pattern of fertility decline up to 1999 suggests that although the targets for teenage and old age pregnancy were also only partially achieved, there was a trend towards postponement of births by young women below age 20 and an increase in the proportion of women who were stopping childbearing at age 35. Again, all these achievements had been wiped away by 2003. Only the women in the 45-49 age group recorded a decline in fertility between 1999 and 2003.

Table 5. Percentage of women who were first married by age 18, who were never married and median age at first marriage according to current age, 1990-2003

Current age	Percentage who were first married by 18			Percentage who were never married			Median age at first marriage		
	1990	1999	2003	1990	1999	2003	1990	1999	2003
15-19	NA	NA	NA	61.4	72.5	66.7	a	a	a
20-24	51.9	39.6	43.3	21.7	36.5	36.1	17.8	19.6	19.1
25-29	50.0	45.3	47.0	7.9	13.0	12.2	17.2	18.6	18.5
30-34	62.5	52.0	61.3	0.9	5.1	5.1	16.3	17.7	16.5
35-39	56.4	52.9	63.7	1.2	1.9	1.7	17.3	17.6	16.0
40-45	57.6	56.1	65.1	0.3	1.3	0.7	16.8	17.2	15.7
45-49	56.5	49.2	70.6	0.1	1.1	0.9	17.3	18.1	15.5
Women 20-49	56.4	47.8	55.1	7.3	13.1	13.2	17.1	18.3	17.2
Women 25-49	57.7	50.4	59.1	2.9	5.9	5.5	16.9	17.9	16.6

NA: Not Applicable
a: Omitted because less than 50 per cent of the women in the age group x to x+4 were first married by age x

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992)

Both teenage pregnancy and pregnancy after age 35 increased by 14 and 22 per cent respectively.

Nuptiality

The deferment of initiation of childbearing in the period between 1981 and 1999 noted earlier was related to marriage. The policy targeted a reduction of the proportion of women who get married before age 18 years by 50 per cent in 1995 and by 80 per cent by 2000. The age pattern of marriage displayed in Table 5 gives some evidence of a trend towards delayed marriage up to 1999. Columns 2 to 4 of the table show that the proportion of women who were married before age 18 declined in all age categories between 1990 and 1999. The magnitude of the decline decreased with the age group, except the 45-49 age category. Thus, the greatest decline of 24 per cent (from 51.9 to 39.6) in the period 1990 to 1999 occurred among the 20 to 24 age category while the least decline of 3 per cent (from 57.6 to 56.1) occurred in the 40-44 age category. Furthermore, the percentage of teenagers who were never married rose from 61.4 in 1990 to 72.5 in 1999, an increase of 18 per cent (columns 5-7). Larger increases occurred among the older cohorts with the 20-24 and 25-29 age categories recording a rise of 68 and 65 per cent respectively. Added substantiation for the trend toward delayed age at marriage is found in the median age at first marriage shown in columns 8 to 10.

The average age at first marriage increased among all the age categories between 1990 and 1999. For all women, the average age of marriage in 1990 was 17.1 years, but by 1999 the age had risen to 18.3 years with wide differences between rural (17) and urban (19) areas. The time trend also indicates that older cohorts married at even younger ages than recent cohorts. Among the 20 to 24 cohort, the median age at marriage increased from 17.8 years in 1990 to 19.6 years in 1999, an increase of 10 per cent while among the 25-29 age group, the increase was only 8 per cent and among 30-34 age group, only 9 per cent. In other words, the median age at first marriage among women in their 20s was higher than among those in their 30s and 40s. Thus, in 1999, the median

age at first marriage among the 20-24, 30-34 and 40-44 was 19.9, 17.7 and 17.2 respectively.

By 2003, however, there had been a reversal in the pattern of marriage. A comparison of column 4 with columns 3 and 2 reveals that, on the one hand, the percentage of women who were married by age 18 had increased among all age categories between 1990 and 1999; on the other hand, the proportion of women who were married by age 18 were lower in 2003 than in 1990 among the 15-34 age range but higher for women above age 35. This pattern is identical with the pattern exhibited by the median age at marriage (Columns 8-10). There was a decrease in the median age at first marriage in all age groups between 1999 and 2003 but the median age was higher in 2003 than in 1990 for women in the 15-34 age category. However, for all age groups, the median age of first marriage was marginally higher in 2003 than in 1990, thus indicating that some gain was still retained.

It follows from the foregoing that although the magnitude and pace of the decline in teenage marriage were not as extensive as the policy envisaged, the pattern of the fall indicated above shows a gradual movement away from early marriage to that of delayed age at first marriage. Of course, the pace of the movement was slowed down after 1999 with the suspension of the implementation of the NPP. Nonetheless, this trend implies a later initiation into childbearing, a shorter reproductive period and a longer span between each generation thus reducing population momentum. It also implies that an increasing number of women were spacing their births or stopping childbearing earlier than their predecessors. The means by which this practice could be achieved effectively is the adoption of family planning techniques.

Family planning

The policy envisages extending the coverage of family planning service to 50 per cent of women of childbearing age by 1995 and 80 per cent by 2000. These targets were clearly over-ambitious given the prevailing circumstances in the country. First, the acceptance of contraceptive was very low in the 1980s. According to the National Population Bureau (1984), in 1981/82 only 6.2 per cent of women exposed to the risk of childbearing were using any contraceptive. Of these women, only 0.7 per cent was using a modern method. Raising the level of modern contraceptive use from less than one per cent to 50 per cent within a decade required a very significant cultural change and massive importation and use of contraceptives.

Second, although education, urbanization and modernization were changing the cultural milieu, the erosion of traditional support for high fertility was too slow to make the required impact on the contraceptive prevalence rate. Polygyny which, according to Lesthaeghe (1989) and Caldwell *et al* (1992), is an important promoter of high fertility was still common. Polygyny declined only marginally from 41 per cent in 1990 to 36 percent in 1999. It remained at the same level (36 per cent) in 2003. This fall of only 12 per cent could not pull the skin off a rice pudding. What was worse, most men had 'outside wives' who were usually unknown to their wives. Thus, some women who claimed that they were in monogamous union were actually in polygynous union. Furthermore, about three quarters of women (77 per cent in 1999 and 73 per cent in 2003) who already had four living children wanted more children. Indeed, the mean number of children women considered as ideal increased from 5.8 in 1990 to 6.2 in 1999 and to 6.7 in 2003. Rather surprisingly, the increases were also recorded among young women between 15 and 29, an indication that Nigerians still considered the number of children as giving them security and safety.

Table 6. Percentage distribution of current users of modern contraceptive methods by most recent source of supply, 1990-2003

Source of supply	All modern methods		
	1990	1999	2003
Public sector	36.7	42.9	22.8
Government hospital	25.9	23.0	13.1
Government health center	10.0	12.2	6.5
Family planning clinic	na	6.5	2.4
Mobile clinic	na	0.3	na
Community health worker	na	0.7	0.8
Other public	5.2*	0.3	0.1
Private medical sector	47.2	42.9	57.7
Private hospital/clinic/health center	13.2	10.0	7.5
Pharmacy/patent medicine store	29.0	31.5	48.8
Private doctor	2.2	0.8	1.0
Private mobile clinic	na	0.2	na
Private community health worker	na	0.2	0.1
Other private medical	2.6**	0.3	0.2
Other private	8.8	8.4	14.3
Shop	na	2.1	2.5
Church	5.0	0.4	na
Friends/relatives	3.7	4.2	11.8
Non-governmental organization	na	0.2	na
Others not listed above	na	1.5	0.3
Don't know/missing	na	5.8	4.9

na = information not available
* Includes Government doctors (0.9) and PPFN (4.3)
** Includes private market (1.3) and private place of work (1.3)

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992)

Third, the launching of the policy was not accompanied by a national program on the supply of contraceptives by the FGN. As pointed out earlier, procurement of contraceptives was not included in the first phase of the NPP subprojects. Instead, the NPP relied on contraceptives procured by bilateral agencies and various development partners, particularly, UNFPA and USAID. The unwillingness of Government to commit substantial resources to the procurement of contraceptives in the early days of NPP is reflected in Table 6. In 1990, the private sector was the main provider of modern contraceptive services, covering 47.2 per cent of users. This proportion should actually be 51.5 per cent because the Planned Parenthood Federation of Nigeria which accounted for 4.3 per cent and which was wrongly classified as a government outfit was a non-governmental organization which should be classified with the private not-for-profit sector, although it received some token subvention from the FMOH. The major sources of private sector contraceptives were pharmacy/patent medicine stores (29 per cent), private hospitals/clinics/health centers (13.2 per cent) and private doctors (2.2 per cent). The pharmacy/patent medicine store is the typical ubiquitous neighborhood store at easy reach of users. The pharmacy, which is usually the major source of method for first users, provided both

the privacy needed by people who did not want to be seen as using contraceptives and quick service as the commodity was purchased across the counter without a customer having to queue up. By contrast, the public sector, which provided counseling and ensured continuity, accounted for only 36.7 per cent (32.5 per cent if the share of PPFN is removed), with government hospitals supplying 25.9 per cent. Most of the clientele were women who received maternal care in the hospitals and who were advised, as part of post-natal care, to use contraceptives after the delivery of their babies. Government health centers accounted for 10.0 per cent of supplies. They were primary health care centers run by Local Government Administrations. They were the main providers of services in rural areas and to many low-income people in urban areas.

By 1999, however, there was an almost even split between the public and the private sectors, with each of them supplying 42.9 per cent of all modern contraceptives in the country. The new pattern of distribution was a reflection of Government's response to the challenge posed by the withdrawal of assistance to the FGN in the wake of the sanctions imposed on the country. Within the private sector, the pharmacy group increased its share to 31.5 per cent at the expense of the private hospital group and the private doctor, the share of which declined to 10 per cent and 0.8 per cent respectively. Within the public sector, the share of contraceptives supplied by Government hospitals declined to 23 per cent while the share of PHC increased to 12.2 per cent. A new entrant to the public sector was Family Planning Clinics (FPC) which accounted for 6.5 per cent of the total supply of contraceptives. The shift to PHC and FPC, the patrons of which included single women as well as men of all ages and marital status, was important as it indicated the widening of the clientele of the public sector.

The trend towards increasing share of public supply of contraceptives was drastically reversed in 2003, three years after the directive to streamline population activities in the country. The public sector share decreased to 22.8 per cent, almost half of its share in 1999. The largest declines were in the PHC and FPC which fell to 13.1 and 6.5 respectively, thus losing 47 per cent and 63 per cent of their 1999 share respectively. The share of government hospitals fell by 43 per cent to 13.1 per cent of all supplies. By contrast, the private medical sector increased its share of supply to 57.7 per cent while the share of 'other private' rose to 14.3 per cent (from 8.4 in 1999). The biggest gainer was the pharmacy group which now accounted for almost half of the total supply of contraceptives (48.8%).

The pattern of contraceptive mix shows a clear specialization among the various service providers. Table 7 reveals that while the private sector (made up of both the private medical sector which is profit-oriented and the not-for-profit 'other private' sector which consists of church, NGOs and friends) was the major provider of oral contraceptive methods, serving approximately 68 per cent of current users in 1990, the public sector was the important source of IUD, accounting for 61 per cent of the market share in 1990. The private sector also had a larger market share of condoms and injectables, providing two thirds of all the condoms and about half of the injectables used in 1990.

By 1999, there had been a slight change in the source of each type of commodity. The private sector remained the principal supplier of pills and condoms, accounting for 64.9 and 78.1 per cent respectively. The public sector, by 1999, not only retained its foremost position in the supply of IUD, accounting for about three quarters of all supplies, but it also became the dominant supplier of injectables providing 68.6 per cent of the supply. In other words, the public sector had its share of the market for IUD and injectables increased by 22 per cent and 53 per cent respectively. The effect of the slowing down of population activities following the 2000 Presidential directive is reflected in the pattern of supply of contraceptive commodities in 2003. Although the public sector retained its preeminence position in the supply of IUD, its share had slipped to 65.5 per cent. It had lost its leadership in the supply of injectables, furnishing only 48.4 per cent of the

supply, a decline of 29 per cent. Its share of pills also declined from 29.1 per cent in 1999 to 18.6 in 2003. By contrast, the private sector not only retained its traditional leadership in the supply of pills and condoms, providing 79.5 per cent and 88.3 per cent of the supply respectively, but also inched up its market share in both injectables where its supply was at par with the public sector and the IUD, 32.5 per cent of which it supplied.

Table 7. Percentage distribution of contraceptive users by source of method, 1990-2003

Institution and type of method	1990	1999	2003
Public Sector			
Pill	29.0	29.1	18.6
IUD	61.0	74.4	(65.5)
Injectables	44.9	68.6	48.4
Condom	13.4	12.9	4.1
All modern methods	36.7	42.9	22.8
Private Medical Sector			
Pill	62.1	53.1	74.0
IUD	20.0	19.5	(32.5)
Injectables	48.5	27.0	48.0
Condom	(54.9)	62.7	59.2
All modern methods	47.2	42.9	57.7
Other private			
Pill	5.9	11.8	5.5
IUD	11.1	1.6	(0.0)
Injectables	3.0	1.9	1.0
Condom	(11.7)	15.4	29.1
All modern methods	8.8	8.4	14.3

( ) Figures in brackets are based on 25-49 unweighted cases

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992)

What are the implications of the changing patterns of supply of the contraceptive commodities for the implementation of the policy? First, the increasing dominance of the private sector where prices of commodities were higher than in the public sector where prices were subsidized could restrict access to contraceptives to those who could pay. Although, excessive costs do not seem, as yet, to be barriers to use of contraceptive, ability to pay for service may soon become important. In a country where 69.2 per cent of the population were living in poverty in 1996/1997 (World Bank, 1996; CBN, 1997) and where, according to the 2001 UNDP Human Development Report, absolute poverty has been exacerbated since 1997, the procurement of unsubsidized contraceptives would not be a priority of a significant segment of the populace. Thus, the majority of the population might find it extremely difficult to satisfy their demand for contraceptives, a commodity whose demand is inelastic (10). Second, the commodities provided mainly by the private sector were those that could be obtained easily across the counter at the pharmacy 'down the street' while those in which the public sector predominated were costly, more permanent, more effective and require technical service which was provided by professionals in government hospitals where subsidized services were available. There was bound to be a potentially relatively high demand for the latter type of contraceptives for as long as they were provided free or at heavily subsidized price at the point of delivery. The number of married women, the group who made the most use of government family planning facilities, was

increasing at a time the services were declining. Consequently, the demand of these women could

Table 8. Percentage distribution of current contraceptive users by method, 1990-2003

	All women			Currently married women		
	1990	1999	2003	1990	1999	2003
Any method	7.5	15.7	13.3	6.0	15.3	12.6
Any modern method	3.8	8.9	8.9	3.5	8.6	8.2
Pill	1.4	2.6	2.0	1.2	2.4	1.8
IUD	0.7	1.7	0.6	0.8	2.0	0.7
Injectables	0.7	1.9	1.6	0.7	2.4	2.0
Condom	0.5	2.3	3.4	0.4	1.2	1.9
Tubal ligation (female sterilization)	0.2	0.2	0.2	0.3	0.3	0.2
Diaphragm/foam/jelly	0.2	0.1	3.0	0.1	0.2	-
Implants	-	0.0	-	-	0.1	-
Others	-	-	1.1*	-	-	1.5**
Any traditional method	3.8	5.8	4.4	2.5	5.8	4.3

* Includes lactational amenorrhea method (1.0) and emergency contraception (0.1)
** Includes lactational amenorrhea method (1.4) and emergency contraception (0.1)

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992)

not be satisfied since it was most unlikely that they would be able to pay for private sector services. In a robust economy, the declining role of the public sector in the supply of these effective commodities would have been a welcome development. Unfortunately, the poverty level in Nigeria was, and is, still very high. Third, since the bulk of the contraceptives supplied by the private sector were procured from the pharmacy group, a large proportion of users obtained contraceptive services without proper counseling and information critical for selection of an appropriate method and its use, including continuity and effectiveness

It is not a surprise, therefore, that although there has been some increase in the use of contraceptives over the years, the contraceptive prevalence rate is far below the target set by the policy, especially if attention is concentrated on the modern methods of contraceptives which the policy targeted and which are critical for fertility control because of their effectiveness. As Table 8 shows, only 8.6 per cent of currently married women were using modern method of contraceptives in 1999. Although this percentage was an improvement on the 1990 proportion of 3.5 per cent, it was only a drop in the ocean. What was worse, the proportion had declined to 8.2 per cent by 2003.

The situation was slightly different among all women. While the proportion of users among them increased from 3.8 per cent in 1990 to 8.9 percent in 1999, the proportion remained unchanged at 8.9 per cent in 2003 (11). There have also been some changes in the method mix. In 1990, the majority of married women using contraceptives depended on pills (1.2 per cent). By 1999, they relied on both pills and injectables (2.4 per cent each). IUD had also become important to them, it being used by 2.0 per cent. By 2003, married women using contraceptives relied on injectables (2 per cent), condoms (1.9 per cent) and pills (1.8 per cent). Among all women, the pill, being used by 1.4 per cent of them, was the most preferred. It was followed by IUD and injectables (0.7 per cent each). In 1999, the pill retained its position as the most preferred, accounting for 2.6 per cent of women. It was followed by condoms (2.3 per cent), injectables (1.9 per cent) and IUD (1.7 per cent). By 2003, all these methods had been supplanted by condom, diaphragm/foam/jelly and

Table 9. Selected indicators of attitudes towards family planning among Nigerian men, 1999 and 2003

Indicator	Percentage of:			
	All men		Currently married men	
	1999	2003	1999	2003
Knowledge of contraceptive methods				
Any method	82.3	90.2	83.4	90.0
Any modern method	78.7	89.5	77.9	88.9
Any traditional method	61.7	59.2	68.7	68.9
Source of information about family planning				
Both radio and television	37.9		na	na
Radio alone	22.9		na	na
Television alone	2.3		na	na
Neither	36.0		na	na
Acceptability of television and radio information				
Not acceptable	23.5		na	na
Acceptable	61.8		na	na
Unsure	13.9		na	na
Ever use of family planning methods				
Any method	39.8	33.8	45.1	35.6
Any modern method	25.1	25.1	24.5	23.2
Any traditional method	17.2	22.4	34.8	27.5
Future use of contraception				
Intend to use in the next 12 months	na	na	11.8	na
Intend to use later	na	na	10.1	na
Unsure as to timing or intention	na	na	15.7	na
Do not intend to use	na	na	56.8	na
Reason for not intending to use contraceptive				
Desire for more children	na	na	37.5	na
Opposition on religious grounds	na	na	21.8	na
Opposition on moral grounds	na	na	13.1	na
Lack of knowledge	na	na	9.0	na
Other reasons	na	na	18.6	na
Desire for more children after (i)having four living children/ (ii) all parity				
Have another sooner or later	na	na	65.5/71.0	na
Undecided	na	na	5.8/5.7	na
Want no more	na	na	21.8/18.7	na
Other reasons	na	na	7.0/4.9	na
Mean ideal number of children for				
Men who already have four children	8.8	9.3	8.9	9.4
All men with completed parity	7.8	8.6	9.3	10.6

na = information not available

SOURCES: NPC (Nigeria) and ORC Macro (2004); NPC [Nigeria] (2000); Federal Office of Statistics [Nigeria] (1992)

pills, accounting for 3.4, 3.0 and 2.0 per cent respectively. However, throughout the period covered by this study, contraceptive prevalence varied widely among regions, and among educational and residential subgroups of women. In general, the rates were higher in the south, in urban areas and among the more educated women. Also, during the period, the near absence of surgical contraception is noteworthy. The proportion of women undergoing a tubal ligation was 0.2 per cent among all women and 0.3 per cent among married women. In countries which have achieved substantial reduction in fertility, such a method, directed at family limitation, is usually part and parcel of the family planning strategy (Brambila, 1998).

Male involvement in fertility reduction

In realization of the need to involve men in the family planning effort, the policy proposed "to direct a significant proportion of the family planning program in terms of the family life education and appropriate family planning service to all adult males by 2000" (Federal Republic of Nigeria, 1988 : 14). The extent to which this objective was met could be assessed by the forces that shape male reproductive orientation and behavior. The indicators of some of these forces which have been extracted from the various NDHS data are listed separately for all men and for currently married men in Table 9. The nonavailability of data for some indicators does not allow for temporal comparison in a few cases.

The table shows that most Nigerian men know about family planning methods. Among all men, the proportion who knew any modern method increased from 78.7 per cent in 1999 to 89.5 percent in 2003. Among the married men, the corresponding percentages were 77.9 and 88.9 respectively. The media played a major role as sources of information for this knowledge. In 1999, the proportion of men (37.9 per cent) who were exposed to radio and television messages was slightly higher than that of men who were exposed to neither (36.0 per cent). Although 22.9

percent of men were exposed to radio alone, only 2.3 per cent were exposed to television alone. In the 2003 survey, the results of which were not included in Table 9 because of the different format in which they were presented in the NDHS tabulation, men were asked if they had heard or seen family planning messages on the radio or television, read a family planning message in a newspaper, magazine, poster, or leaflet, or heard a family planning message through traditional folk media during the months preceding the survey. The results show that only 41 per cent of men were not exposed to family planning messages from any source during the months preceding the survey. There were significant differences in exposure to different media. Radio remained the most common source of family planning messages for men (55.9 per cent). Posters/leaflets/brochures, as a group, constituted the next most common source, with 32.1 per cent having read a family planning message in them. It is closely followed by television in which 32.0 per cent of men had seen a message. About 21.9 per cent had read a family planning message in a newspaper or magazine while 11.2 per cent had heard a message from a town crier or a mobile public announcement. Table 9 shows that the dissemination of messages concerning family planning through television and radio was highly acceptable to most of those men exposed to the electronic media. However, 23.5 per cent of men found such media messages unacceptable while 13.9 per cent were unsure of their views.

Surprisingly, exposure to family planning knowledge did not seem to affect men's attitude to the use of contraceptives. Only 25 per cent of all men ever used a modern method of contraceptives. The proportion was less among currently married men, being 24.5 per cent in 1999 and 23.2 per cent in 2003. The proportion currently using contraceptives was lower for both married men and all men, being 14.1 and 14.2 per cent respectively in 1999. The disposition to contraceptive use by currently married nonusers of contraception to future use was low. Only 21.9 per cent of them

planned to use family planning in the future, while 56.8 per cent of them did not intend to use family planning. The major reasons for not intending to use contraceptives are desire for more children (37.5 per cent) and opposition to contraception on either religious or moral grounds. The inclination of men to fertility was still high. In 1999, about 71 per cent of them wanted more children and two thirds of men who already had four living children wanted to have more children sooner or later. The average number of children married men considered as ideal increased from 9.3 in 1999 to 10.6 in 2003. For all men who already had four living children, the mean ideal family size increased from 8.8 to 9.3 between 1999 and 2003.

All in all, although the first part of the objective that targeted the male population was met, that of the second (and by far the more critical) part of the objective was not met. A large percentage of men were exposed to contraceptive methods through family life education propagated by the media. However, their knowledge of the methods was neither reflected in their fertility behavior nor in their demand for family planning services. What is worse, their attitude to a large family size has not changed from the traditional posture while very few of those who are nonusers of contraceptives want to use in future. This attitude is not necessarily a rejection of the policy but a reflection of the contradiction in the posture of Nigerians to family size. As Smith (2004) points out in his study of the Igbo of Eastern Nigeria, the Igbos relish large family size even though they subscribe to the idea of four children enunciated in the policy. This ambivalent attitude of Nigerians to fertility is of concern to policy makers and needs to be addressed in implementing the new policy. The implementation of the new policy will, indeed, benefit from the experience gained in implementing the 1988 policy. It is to a consideration of this experience that attention is now turned.

Lessons Learned from the Implementation of the Policy

One of the disadvantages of the implementers of the NPP was that as the pioneers in the implementation of a program as complex as the NPP, the only experience they could learn from was their own. The implementers of the newly adopted policy have the advantage of drawing on the experience of their predecessors. One of the most important lessons emanating from the implementation of the NPP is the need for the decentralization of, not only social, economic and political space, but also of population policy strategy. The over-concentration of political and economic power in the Federal Government with wide fiscal jurisdiction is too much of a temptation for various religious, ethnic and regional groups, in the zero-sum instinct of Nigerian politics, to desire to control the center and thus avoid marginalization or escape from the hegemonic tendencies of particular ethnic groups. This incentive to take hold of the center, in turn, encourages every group to crave for a large population, and consequently makes nonsense of any fertility regulation program. The solution to this fundamental Nigerian problem is a complete overhaul of the federal system by replacing the current pseudo-federalism with true federalism so that political and economic power is returned to the federating units. This measure will create a sense of belonging to, and genuine social inclusion in, the Nigerian federation, make the center less attractive and reduce the tendency to desire large populations for political advantage.

With respect to population policy strategy, decentralization does not imply that the Federal Government should leave each state or community to formulate its own policy, even though each community is at different stage of erosion of traditional supports for high fertility. A population policy, like all other government policies, must have a national outlook. What decentralization implies is that, regarding the program designed for the implementation of the policy, each State and each Local Government Authority should have its own implementation strategy tailored to its own environment but within the broad guidelines provided by the Federal Government. The Federal authority, recognizing the diversity of local approaches to program implementation, should confine its role to those uniquely appropriate to it, namely, training of personnel, provision

of supplies and equipment, diffusion of information through its nation-wide media network, general supervision and provision of leadership consistent with the constitution. With regards to the latter, the Federal Government should spearhead constitutional and legislative measures that would make population growth in a state generate negative consequences for the state. Such measures were suggested by Adegbola (1982) in connection with the tendency of Nigerians to inflate census figures. A measure that stipulates that each state should contribute into the Federation Account according to the size of its population would nudge each state into adopting measures that would encourage monogamy and small family size as well as increase demand for contraceptives, which demand the Federal authorities must be prepared to meet.

A second lesson inheres in the design of the policy itself. A policy should have only a few focused goals and specific, measurable and achievable objectives. Overly optimistic objectives or targets (as there were in the NPP) can damage the credibility of the program among functionaries who are unwittingly given a virtually impossible task and whose morale may collapse. The inability of the NPP to achieve its targets, most of which are unrealistic within the time frame set, could also result in a loss of interest on the part of the Government and development partners. Furthermore, as part of its leadership role, the Federal Government should encourage the lower tiers of government to design implementation strategies that have performance indicators for monitoring progress made and for periodic reordering of priorities. Identifying performance indicators at the onset is critical for program monitoring and evaluation. Annual output targets and performance indicators for monitoring the NPP were neither in the World Bank Staff Appraisal Report nor in the Development Credit Agreement. They had to be developed after the commencement of project implementation.

A third lesson has to do with the institutional arrangement put in place for the program. The NPP was packaged as a multisectoral program involving the Federal Ministry of Education, the Federal Ministry of Information and National Orientation, two institutions in the Presidency and three departments and a parastatal in the Federal Ministry of Health. The function for the integration and coordination of the programs in the various participating ministries was assigned to two institutions in the Federal Ministry of Health. Thus, the responsibility for the political leadership and overall control was shared by two regulatory bodies, one established by law and the other a creation of the FMOH. Moreover, project management responsibility shared by two functionaries, a department of a Ministry and a parastatal of Government did not function well to suit effective project implementation. While the Department was answerable to one body, the Agency was answerable to another, thereby making project implementation and coordination very difficult. The flaw in this organizational arrangement is most evident if we reflect on the confusion that comes about when two captains are put in charge of a ship. Obviously, a population program, by its nature, involves interministerial and intersectoral collaboration. However, organizationally, there should be only one supervisory authority capable of commanding the respect of all stakeholders. Furthermore, the management structure should be simple and explicit, detailing the roles and specific responsibilities of each institution to be involved in the implementation so as to avoid conflict among bureaucracies over who is to do what.

A fourth lesson is the need to integrate the various facets of developmental and demographic programs into a coherent and mutually reinforcing whole since the very essence of population policy is the promotion of social and economic development. Hence, there is the need to promote population policy simultaneously with other government policies. Indeed. a population policy, as a major vehicle of social engineering, must be seen within the context of several other broader government policies - economic, social (particularly health and education) and cultural - which are supportive of population policy. Social policy that emphasizes educating women is bound to have effect on fertility (Caldwell, 1982). The same is true of social policy that addresses health

issues. The Federal Ministry of Health has produced several national policies on different aspects of health, each of which is bound to have implications for fertility and mortality levels (13). An example of these policies is the 1988 National Health Care Policy which was revised in 2004. As noted earlier, the bedrock of the policy is the Primary Health Care (PHC) program (Federal Ministry of Health, 1988). The provision of maternal and child health services was one of the nine dimensions of PHC and family planning was to be an integral part of each MCH clinic. Even though the expectations of the PHC program were not fully realized, especially with respect to availability of contraceptives, the policy is bound to have effects on fertility through its impact on mothers who received ante- and post-natal care and through improvement in child health.

Also, economic policy is capable of having impact on fertility. The National Economic Empowerment and Development Strategy (NEEDS) is the blueprint for sustainable development recently adopted by the Federal Government (Federal Republic of Nigeria, 2004). It is designed to bring about fundamental changes in the way things were hitherto done by promoting private enterprise, reforming the civil service and advancing changes in societal arrangement. It addresses the welfare, health, employment, political power for women, physical security and empowerment of the Nigerian people. Each state as well as each Local Government Administration also has its State Economic Empowerment and Development Strategy (SEEDS) or the Local Economic Empowerment and Development Strategy (LEEDS). Even though there is no specific attempt in these documents to address high fertility rates, the execution of this economic policy is bound to have effects on fertility. Indeed, the NPP was designed for integration into Government Rolling Plans (which are drawn up from perspective plans like the NEEDS) and other population related projects or policies and was implemented as such. However, it could not go the whole hog. Some CAs tended to implement projects of some donors vertically without integration into the Rolling Plans. Yet, all its components, irrespective of source of fund, must be integrated with other programs for effectiveness.

The fifth lesson has to do with the creation of demand for family planning services, particularly in the Northern parts of the country. The NPP assumed that the demand for family planning services in Nigeria was not only large but was also uniformly spread throughout the country. Consequently, more attention was given to the reproductive health subprojects than to the IEC subprojects, the former consuming about 70 per cent of PAF disbursements to the implementing agencies. The rationale for this lopsided pattern of disbursement lies not only in the fact that medical equipments are expensive, but also in the fact that focusing on reproductive health provided maximum gains and minimum strains. While measures that promote maternal and child health are easily acceptable to the populace, programs, like the IEC subprojects, which are to build up "motivation" by seeking to change the behavior of individuals and the value system of societies, are much more difficult sell to the people. According to Ness (1971), the task is made extremely arduous in a plural society where value systems are not only divergent but may also be antithetical. In such a society, value-oriented programs often induce strains in the polity by laying bare and amplifying the normative distinctiveness within the society. In the particular case of Nigeria, it is believed that, in general, the value systems of the peoples of Southern Nigeria are functional for modernization while those of their counterparts in Northern Nigeria are dysfunctional. Consequently, programs that focus on value change tend to appear as prescription for Northern values to change in the direction of Southern values, a situation that touches the sensitivity of Northerners who consider some manifestations of modernization as either immoral or irreligious. How does one deal with a value system that not only promotes polygyny, early marriage and large family size but also back it up with religious injunction? The foregoing is not to deny recognition to the modest achievement of the IEC subprojects; but to emphasize the fact that in a country as complex as Nigeria, a population program should devote a good deal of energy to activities directed at changing the value system that is patently pronatalist. The objective should be to bring about behavioral change that will influence and drum up demand for

family planning contraceptives.

The sixth lesson is the need for government financial commitment to the program. There are two aspects to this commitment. One is that allocation for population activities should not only be included in the annual budget of government, it must also be released in full and on time. Counterpart funds for NPP were included in the budget of the FMOH and were released to the Ministry by the Federal Ministry of Finance for onward transmission to the NPP. The Ministry often preferred to spend a substantial part of the NPP fund on what it regarded as core health projects (such as hospital services, disease control, essential drugs and pharmaceutics, public health etc), pointing out that the NPP already had access to donor funds. While assistance can be welcome from donor agencies, such assistance should only complement government efforts which should actually be the major engine propelling implementation. The other aspect is the quantum of the resources in the budget available to each component of the population program. In an environment where geography, particularly regional-language-ethnic grouping, exerts a strong influence on fertility behavior, substantial financial resources should be allocated for massive value reorientation activities tailored to meet the peculiar needs of each group. By the same token, adequate allocation should be made, not only for the procurement of contraceptives to meet the demand to be generated, but also for the efficient execution of the contraceptive logistic management system.

Finally, there is the need for a strong, sustained and broad-based political commitment to the policy. The NPP launched advocacy blitz soon after the 1993 National Council of Health meeting. The effort could not enhance support for the program at the state level, especially in the Northern parts of the country. Intensive advocacy should be mounted at the state level to get the State Governors, the government leaders as well as the top and middle level bureaucrats committed to the policy. At the Federal level where the NPP was able to give greater visibility to the national population and development agenda, there is need to sustain the awareness on the link between population and development already created in both the Executive and the Legislative branches of government. The effort should be extended to the political party hierarchy. It will be a big step forward if each political party can be persuaded to have a commitment to family planning in their platforms or manifestoes.

Conclusion

The decision to have a population policy in Nigeria came largely from a realization of the adverse impact of population growth on the welfare of the citizenry. The major source of the impetus for the decision was the Federal Ministry of Health, particularly the incumbent Minister in the Ministry, Prof. Olikoye Ransome-Kuti, who initiated and doggedly pursued the project. He had a definite vision for the population policy and received the strong support of President Ibrahim Babangida despite opposition from doubters of such a policy within and without his cabinet. Kuti succeeded in moving the government (if not the people) from an unconcerned, pronatalist, anti-family planning political and cultural posture to a highly concerned, strongly pro-population program position and ensured that the decision to adopt a policy was followed by effective executive actions. A Department of Population Activities was created to oversee the implementation of the policy in accordance with Section 6.2 of the policy document (Federal Republic of Nigeria, 1988: 26-27). With the cooperation of development partners, particularly, the World Bank, the Department drew up a highly innovative program of action for the forceful execution of the policy. More importantly, the Federal Ministry of Health sought and obtained very large amount of external funds from the World Bank for the execution of the program. In line with the Credit Agreement with the World Bank, it created the Population Activities Fund Agency not only to manage the Population Activities Fund, but also to source for resources on a permanent basis for continuous execution of the program.

With the stage thus set for a successful implementation of the policy, one is struck by the very modest success achieved by, and the inevitable failure of, the policy during the period under review. Among the major successes must be mentioned the nearly universal awareness of the feasibility of family limitation through human intervention. The launching of the policy in each state of the Federation familiarized the people with the notion that "the Government has advised that four children are ideal'. The answers given by the respondents Caldwell et al (1992) studied in Western Nigeria and those Smith (2004) studied in Eastern Nigeria on the number of children they would want to have give credence to the fact that the "four is enough" notion had caught up with the Nigerian populace. Answering a question at a recent Senate ministerial confirmation hearing, Alhaji Shamsudeen Usman said that the Senator who asked for the number of his children should know that he (Usman) had 'broken' the Government guideline by having more than four children (12). This answer shows how the policy has popularized government's legitimation of having four children as well as the practice of family planning that would make it possible to achieve the target of four children. It is not unlikely that if, in future, the Government mentions any number of children in its policy, that number may be seen as the ideal to aim at. If the stop-at-four rule had been strictly adhered to, the fertility level would have been drastically reduced.

Also remarkable is the effect of the policy on the pattern of fertility trend. Frank and McNicoll (1987) have suggested that the simultaneity of apparent vigor in family planning program effort on the one hand and onset of decline in fertility on the other says nothing about causal linkage. But the evidence presented here shows that the NPP had an important impact on the pattern of not only fertility but also its determinants. It is not a mere coincidence that the period of active program implementation witnessed a decline in fertility, an increase in age at first marriage, a decline in the proportion of females marrying before age 18 and an increase in contraceptive prevalence rate while the period that implementation was halted coincided with reversal of all the gains made by the policy. Although there is no doubt that the program effort lost some momentum as a result of the government directive, a basis has been laid for appreciable vigor in subsequent attempt at policy implementation. This is because the directive that resulted in the halting of program implementation was not a product of shallowness of government commitment to the goal of fertility reduction but arose from genuine effort at streamlining population activities in the country for better performance.

The failure of the policy is due largely to the exigencies in the design of the National Population Program and the implementation strategy put in place for the execution of the program. First, as pointed above, the management structure designed for the implementation of the policy gave room for conflict. Secondly, the opening of floodgates of financial resources to the project was a very substantial factor in bringing about interagency rivalry to compound the intra-agency competition. A fierce contest for the control of the machinery for the implementation of the policy ensued between the Federal Ministry of Health which coordinated the preparation of the policy and the National Population Commission which is located in the Presidency and on which the 1999 Constitution confers the function of advising the President on population matters.

Thirdly, the design of the program put emphasis on process rather than on immediate outcome, on the intermediate consumers of its services rather than the final consumers. Thus, the program was oriented towards the immediate provision of goods and institution building, The supply of goods was logical as a foundation on which to build provision of family planning services to end-users. The strengthening of institutional capacity was also rational as it provided the wherewithal needed for policy implementation and accorded credibility to officials who would be in the vanguard of program execution. Even in this area, the design was deficient because initially, it depended on supply of contraceptives by donor agencies. It was not until 1995 that the FMOH

made provision for the procurement and supply of contraceptives to the NPP.

Perhaps the most critical problem facing the government in the implementation of a population policy in Nigeria is how to deal with the issue of "two Nigerias"- the North and the South. While the political, economic and cultural landscape in the North still encourages high fertility and thus makes nonsense of government policy, the mechanisms that encourage policy implementation are actively at work in the South. While social forces put powerful pressure on southerners to accept program measures to limit their fertility, the value system in the north still favor high fertility. The continued practical advantage of a large population in order to secure advantage in parliamentary representation and in the share of the nation's resources encourages the Northern elites to ignore policy implementation despite the fact that large family size is a major factor in the high level of poverty in the region.

The identification of the problems of program implementation has limited value unless the learned lessons impart greater determination of the upper echelons of government, the bureaucracy and the political class in the nation to program efforts in the future. It should also pay particular attention to the direction of other state policies so that it is situated within the broad economic and social priorities of the nation. Government has put in place reform agenda that include economic, social and administrative reforms. The population sector, together with political governance that will address the role of population size in allocation of resources and power, should be included in the reform agenda. Such a bold step is necessary if Nigeria is to cover lost ground in its match to fertility transition and catch up with other fast developing nations.

Notes

1. Although the Council was not established during the Plan period, it was eventually set up in 1975 with the additional function of securing internal and external assistance for family planning and channeling such assistance to appropriate organizations in the country.

2. In June 1980, at its 27th session, the Governing Council of the United Nations Development Program (UNDP) approved UNFPA assistance in the amount of $1.2 million over a five-year period, to support a population policy formulation and development planning component of its 1981-1986 assistance of $17.3 million to Nigeria. See UNDP, 1980.

3. The three-tier planning system comprises the perspective plan, the rolling plan and the annual budget. The perspective plan covers a 15-20 year period and is the pivot upon which the medium term rolling plan rotates just as the rolling plan is the fulcrum on which the annual budget revolves. The rolling plan ensures that planned projects which are completed within a budget year are rolled out of the budget while those which are not completed are rolled over to the next budget. See Nigeria, 1990.

4. The Structural Adjustment Program was officially abandoned in 1994. It was held responsible for most of the economic ills of the country, including the debasement of the national currency, the naira, the high rate of inflation, the crippling of the domestic industry, high interest rates, high unemployment and the spread of poverty. (See Moser, Rogers and van Til. 1997)

5. Targets were also set for important issues worthy of concern other than population dynamics. In recognition of the fact that population dynamics are influenced by a host of social, cultural and economic factors, one of the targets set by the policy is "to provide 50 per cent of rural communities with basic social amenities by 1990 and 75 per cent by 2000 in order to stimulate and sustain self-reliant development." See Federal Republic Nigeria, 1988: 14.

5. Religious riots have a long pedigree in post-civil-war Nigeria. They had variously been used to advance political, economic and social goals by fundamentalist Muslim sects. Some of the sects, such as the Maitatsine, Izala, the Shi'ite and most recently, the Talibans, demanded, among others, purist Islam based on the Sharia law, the eradication of heretical innovations and establishment of an Islamic state. Such demands make some state governments, especially in the North, to be apprehensive about pursuing population programs that these fundamentalists regard as "heretic innovation". This was the context in which riots against the hosting of Miss World beauty pageant in November 2002 should be seen.

7. The Nigerian health system is structured along three tiers of the primary, secondary and tertiary levels of care. The Primary Health Care (PHC) is largely the responsibility of Local Governments with the support of State Ministries of Health and within the overall National Health Policy. Secondary Health Care (SHC) which provides specialized services to patients referred from the primary health care level is the obligation of State Governments. Both the Federal Government and the State Governments are in charge of Tertiary Health Care (THC) which consists of highly specialized services provided by teaching hospitals and other specialist hospitals for specific diseases. In addition, the Federal Government is responsible for the overall policy formulation, coordination, and adherence to internationally recognized standards (Federal Ministry of Health, 1988). .

8. The World Bank adopted the state-by-state approach in the development and implementation

of the first few projects it funded in the Health Sector. The Sokoto and Imo projects were state-level health projects which incorporated population and family planning objectives within wider health projects that emphasized strengthening of PHC. The state-by-state strategy was changed when the Bank realized that the approach would be a much slower response to health and population problems than a direct nation-wide approach (Baldwin, 1992: 43).

9. Several officers, including one drawn from each of the subprojects, two each from DCDPA and PAFA and others from other Ministries were approved to attend the International Conference on Population and Development in Cairo in 1994. All of them except two were not able to attend the conference as a result of the decision of the country not to participate fully in the conference (See Federal Ministry of Health, 1994).

10. The people who need contraceptives most are the poor, majority of who are concentrated in the North. Mustapha (2006) quotes the World Bank and the Federal Office of Statistics as suggesting that one-third of Nigeria's poor are concentrated in the three northwest states of Kaduna, Kano and Sokoto. It is thus obvious that in the northern parts of the country where fertility rates are highest and where the need for contraceptive use is most urgent some incentives including subsidized price of contraceptives is desirable.

11. A recent national study of 2001 respondents aged 15 to 49 years shows that the usage rate of modern contraceptive methods was only 10.1 per cent. See Oye-Adeniran et al (2005).

12. See the Hansard of the Senate of the Federal Republic of Nigeria, July 17, 2007.

13. Some of the other policies that have population import are the National Breastfeeding Policy 1994; Maternal and Child Health Policy 1994; National Adolescent Health Policy 1995; National Health Insurance Scheme 1999; National Reproductive Health Policy 2001 (revised in 2004); National Policy on Food and Nutrition 2001; National Policy on HIV/AIDS 2003; National Immunization Policy 2003; National Policy on Malaria Control 2005; National Child Health Policy and Strategic Framework 2005; National Strategic Framework and Plan for VVF Education in Nigeria 2005; National Guidelines on Micronutrient Deficiency in Nigeria 2005; National Guidelines and Strategies for Malaria Prevention and Control During Pregnancy 2005 and National Child Policy 2006.

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