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Efforts at Discussing Fertility in Nigeria: Historical Perspectives and Options

Olanrewaju Olaniyan

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FERTILITY IN NIGERIA:
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Efforts at Discussing Fertility in Nigeria: Historical Perspectives and Options

1.0 INTRODUCTION

Nigeria's population is considered to be one of the fastest growing in the world with a growth rate of 2.8 per cent in 2012. The country's population increased from about 88.9 million in 1991 to over 170 million as at 2013, representing about 20% of the population of Africa. It has been argued that this rapidly growing population, if unchecked, can be a source of potential threat not just to the Nigerian economy but to the whole of Africa. The driving force of this population growth rate is the fertility level in the country which has remained consistently high over time. The 2013 Nigerian Demographic and Health Survey (NDHS) puts the total fertility rate in the country at 5.5. The negative effects of high fertility rate to any economy cannot be over-emphasised. At the national level, uncontrolled population growth places extra strain on public infrastructure and government budgets. At the micro/individual level, large family sizes imply large family budgets and, in the face of poverty, this situation could be devastating for the household. Indeed the quality-quantity trade-off theory proposes a choice between large family size and the quality of the household's livelihood. The theory argues that having large families implies compromising on household quality in areas such as education, health, housing, etc. (Becker and Lewis, 1973; Willis, 1973).

Nigeria is at risk of the implications of population escalation given the high level poverty faced by many households in the country. It is even becoming evident that the country will miss many of the targets set by the Millennium Development Goals (MDGs), especially as they concern human capital variables. In Nigeria, the total fertility rate is conditioned by biological, social, and religious

factors, which include high level infant and child mortality, early marriage, early and prolonged child-bearing as well as low use of contraception and high social values placed on child-bearing.

The implication of a growing population can however have numerous advantages if the population growth rate is controlled in line with the per capita income and productivity of a country. The growing population will create a large market for goods and services; this will stimulate demand and investment. A growing population can also increase the labour force of a country leading to high productivity. However, where a large proportion of the population are dependent, it creates a problem of producing enough to take care of this dependent population. Nigeria represents a classic case of population where there is a large dependent population; this, of course, leads to substantial economic lifecycle deficits (Olaniyan *et al*, 2012).

The immediate impact of low fertility, if it is achieved, is the reduction of the number of children in the population and the increment of the share of the population concentrated in the working ages, raising the support ratio and, correspondingly, raising per capita income which can launch the economy into prosperity if the window of opportunity is well harnessed; a phenomenon referred to as the first demographic dividend (Lee and Mason, 2009).

The inability to substantially reduce fertility levels is thus of considerable concern to many policymakers and individuals in the country. Nigeria's high rate of maternal, child and infant mortality present a massive challenge to policymakers and stakeholders at all levels of the Nigerian society. These problems are related to the challenges of high fertility and a low modern contraceptive prevalence rate, which can lead to unintended pregnancies, births

spaced too close together, and high-risk births. In response, Nigerian policymakers at the federal and state levels have become increasingly motivated to renew the commitment to lower maternal and child mortality. Support for reduction on population growth, family planning (FP) and maternal and child health are being discussed openly at governmental and civil society levels; however, the extent of discussion at the family level is still limited.

Despite the discussions that have been held at various levels to reduce fertility, their achievements are yet to be felt. Given the fact that fertility was only reduced by 0.2 from 5.7 in 2008 to 5.5 in 2013, there is the need for an in-depth understanding of fertility issues, the types of discussions that have taken place around them and how the different stakeholders can be engaged to bring about an optimal fertility management. It is noted that governments at all levels in Nigeria have initiated various policies and programmes aimed at reducing fertility in the country. These policies have also been complimented by assistance and programmes by development partners and Non-Governmental Organisations (NGOs). Despite these, the fertility rate appears not to have responded substantially to the initiatives. If fertility is thus to be reduced and population growth rate to be subsequently stemmed in the country, there is the need to understand the state of fertility discussions and actions that have occurred in the country, and then examine areas of gaps that need to be filled and how to design new issues for policy discussions and actions. This is the theme of this paper.

To achieve its objective, the paper utilized a combination of methodologies. First is a comprehensive desk review of past studies in fertility management in Nigeria. The desk reviews is done based on literature search. Three specific search engines were utilized in the literature and the keywords utilized for the search are: Nigeria, Population policy, Fertility, Fertility management, Fertility advocacy and Demographic transition. Key informant

interviews (KII) on fertility management issues in Nigeria were also conducted on key stakeholders.

The key informants utilised include a director in an International NGO who is also a retired professor and a key figure in family planning research, policy and implementation in Nigeria, a researcher who has worked in the area of fertility and fertility management and the director in charge of family planning and reproductive health in a State Ministry of Health. Others include a director of health at the local government level as well as three health personnel working in MCH facility at both primary and secondary health facilities.

This paper proceeds as follows: following the brief introduction are the statement of terms of reference and the methodological approach used. This is followed by the profile of fertility as well as discussions that has taken place around them. Suggested policy issues that will involve and engage stakeholders in the attempt to advocate fertility management were put forward. Some policy implications of the various discussions concluded the discourse.

2.0 FERTILITY PROFILE AND DISCUSSIONS IN NIGERIA

2.1.1 History of Family Planning in Nigeria

The efforts at discussing fertility and family planning issues started in the department of Obstetrics and Gynaecology of the University of Ibadan in collaborations with some concerned people in Lagos in the early 1960s. The first clinic was University College Hospital (UCH) and given that it was not part of the main health concern, the clinics had to operate after 5PM. The issues at the time focused on two types of fertility problems: high fertility and low fertility or infertility. The main aim was to offer opportunity of access to contraceptives to these at-risk people.

The issue of high fertility focused on couples/individuals who had excessive number of children with a view towards assisting them to have the adequate number of desired children. At the other extreme were those who had no children or just one child. These created social, economic and public health issues in a patriarchal society like Nigeria where social and economic status (in the 60s) was particularly measured by the number of children; especially, the number of male children in each household.

Concerning these issues, the UCH embarked on research on the epidemiology of infertility and about new methods of limiting fertility, including introduction of sterilisation, to agreeable women if they already had more than four children, and other types of contraceptive usage. In 1972, laparoscopy was acquired in UCH and was soon deployed. The initial family planning programmes provoked political reactions, including religious objections, revealing disagreements over the appropriate roles of governments and civil society organisations in the provision of these services. There was a hostile position to family planning, with many arguing that it was part of a conspiracy to control the population of some sections of the country to the advantage of others. In fact, in Nigeria these arguments have both religious and tribal leanings.

Birth control in the 1960s was overwhelmingly dominated by sexual abstinence, and even the few planned families, which were relatively small, have mostly been achieved by this means (Caldwell and Ware Source, 1977). The use of modern contraception rose steeply during the 1960s and early 1970s from very low levels, but even by the 1970s the great majority of adult women, even in the urban areas, had never used any means of contraception other than abstinence (Morgan, 1972).

It should also be noted that Ibadan University College Medical Hospital began experimenting with oral contraceptives and IUDs in

the early 1960s and with injections and implants in the late 1960s and early 1970s. At the beginning of the family planning clinics, there was confusion between oral preparations with supposedly contraceptive effect (prepared by herbalists) and hormonal pills; and between some indigenous contraceptive rings (usually worn externally) and IUDs (Caldwell, 1975).

One of the first family planning projects in Nigeria is the Nigerian segment of the Changing African Family Project (Okediji *et al*, 1976). This project which started in the early 1970s gave high priority to the study of changing family planning practices and project. The success of the project led to a contraceptive revolution in Ibadan. Even then, less than one-quarter of all women practicing contraception were doing so; not because they wished to stop having more children; thus, the effectiveness of contraceptive practices would not necessarily be reflected in fertility levels. In many instances, some women who practise contraception 'occasionally' do so with extra-marital sexual partners but not with their spouses. This affected the acceptability of family planning principles in the 1960s which was carried on for a very long time; even now it is still so for some men (Okediji *et al*, 1976).

The real change in family planning services was the arrival of oral contraceptives and IUDs, which probably accounted for half of all contraceptives used by 1973. This was reinforced by the different messages coming from the media and elsewhere and, to a lesser extent, the easy availability of contraceptives commercially as well as from clinics. During this period the importance of the herbalist declined from the provision of perhaps one-fifth of all contraceptive substances to one-twentieth. In absolute numbers, there has been a marked increase, probably greater than in the number of herbalists who specialize in contraception and abortion, for such practitioners report steep rises in demand. A comparison

of the popularity of different methods of birth control in Ibadan and other areas of Nigeria is complicated by the fact that most other studies have reflected patterns associated with particular family planning programmes (Morgan, 1972).

Another birth control method that emerged in the 60s and 70s was abortion. Morgan (1972) submits that abortion was relatively rarely intended to limit family size in Ibadan. Most of the acts of abortion were performed in the early years of the reproductive period to prevent a woman's education or training being cut short by pregnancy, or to avoid bearing a child to a man whom the woman did not wish to marry. More than half of the remainder were intended either to achieve a desired interval between births, or to avoid births where the woman's husband was not the father. Fewer than 10% of all abortions were procured by women who hoped to have no further pregnancies.

The Ibadan family planning clinics (mostly situated in hospitals or maternity centres) concentrated on promoting birth control for family planning amongst high-parity women. By the middle of the 1980s, family planning programmes had become more acceptable in many health clinics beyond UCH, especially from funds from USAID to set up FP clinics in many parts of the country. The decade of the 1980s was a period of revolution as a result of the support of many development partners and under the leadership of the Federal Ministry of Health led by the Honourable Minister of Health, Professor Olikoye Kuti. During the period, family planning was expanded to become a community project; one that was beyond the activities of just medical people - and as such non-medical people became fully involved. Community Health Officers (CHOs) were included to administer family planning and contraceptives. Also, task shifting was entrenched in the activities of the health workers at the primary level with family planning as a major component of the tasks.

It was during this period that the first population policy was formulated in 1988. The implementation of many aspects of the policy, especially the family planning component benefited from external funding and support. However, the political problems of the 1990 stalled progress when a lot of foreign support was lost. However, with the advent of a democratic regime in 1999, several of these support was restored. Also, a revised national population policy, whose implementation had faltered, was launched in 2004

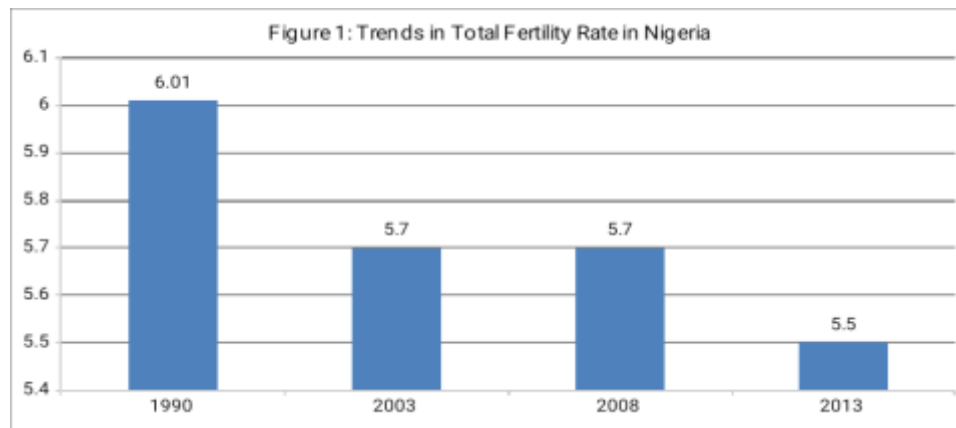
The key success story of the mid 2000s was the budget and release of an initial \$33 million and an additional \$18.5 million for reproductive health and family planning. For the first time in the history of the Federal Ministry of Health, a budget vote head was created for family planning. It is important to note that the history of family planning in Nigeria has been tortuous and bedevilled by many constraints. These include traditional barriers of which religion and the patriarchal nature of the society are key culprits. The low pace of child schooling and female education in the country also had negative effects on fertility decisions in the country. Government(s) and donors have also not done enough in providing financial and capacity-building supports.

2.1.2 Fertility Profile in Nigeria

Fertility transition in Nigeria is regarded to be one of the slowest (Mason *et al*, 2010). Evidence is ripe that fertility rate has remained relatively high among women, implying that effort of policies meant to reduce fertility has had minimal impact as there has been no substantial decline in fertility level since 1950. This is obvious from the fertility reduction of only 0.4 from 1991 to 2013. Fertility only reduced from 6.5 in 1950 to 5.5 in 2013. Although Total Fertility Rate (TFR) increased slightly to 6.6 in 1965 and increased further to 7.3 in 1975, it started declining rather very slowly since then, before finally reaching 6.0 in 1990 and 5.7 in 2008. This slow

decline was due largely to lack of population policy and action during these periods. In the 1960s and 1970s, various governments tacitly encouraged population growth. First, the civil war in the late 1960s and the post-war period of early 1970s made population reduction a politically irrelevant issue to discuss. In addition to this, the oil boom of the early 1970s brought with it substantial economic prosperity with the attendant assumption that the country needs more people to be able to exploit the associated economic prosperity.

Source: Author's construction from NDHS data for various years

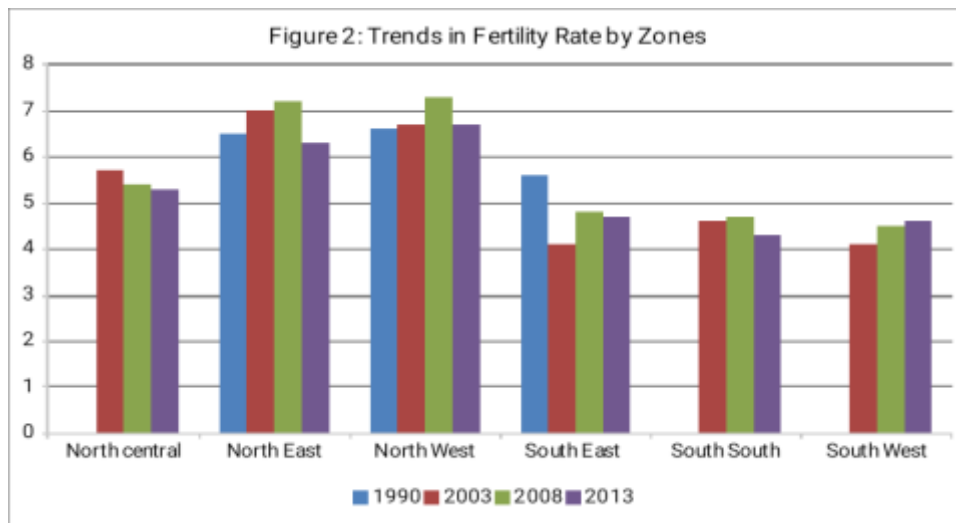


Despite this, there are wide disparities in the total fertility rates in the different geopolitical zones of the country. Fertility rate is highest in the northern part of the country compared to the south. The analysis in Figure 2 shows that fertility reduced in the north-central zone from 5.7 per woman in 2003 to 5.4 in 2008 and further to 5.3 in 2013. The south-east zone also recorded a significant reduction in fertility rate from 5.6 in 1990 to 5.1 in 2003. This, however, increased to 4.8 per woman in 2008 and reduced marginally to 4.7 in 2013. Similar situation prevailed in the south-west where fertility rate reduced from 5.5 in 1990 to 4.1 in 2003. The figure increased to 4.5 in 2008 and further to 4.6 in 2013. All the other zones recorded consistent increase in their fertility rate over

the years. For instance, in the north-east, fertility rate increased from 6.5 per woman in 1990 to 7 in 2003 and 7.2 in 2008. This trend, however, changed in 2013 with a reduction to 6.3. In the North-west zone, fertility rate increased from 6.6 per woman in 1990 to 6.7 in 2003 and 7.3 in 2008. Again the trend changed in 2013 with a reduction to 6.7 per woman. It is observed that, with the exception of the South West Zone, all the other zones recorded a reduction in fertility rate between 2008 and 2013.

Source: Author's construction from NDHS data for various years

Disparities are also noticed according to the age-group of the



women. Table 1 shows the detail information on age-specific trend in total fertility. The total fertility rate between the reproductive ages of 15 and 49 was above five (5) for all the years under consideration. Information from different NDHS for the country shows that total fertility progressively dropped from 5.9 in 2003 to 5.7 in 2008 and further to 5.5 in 2013. This implies that a woman, on the average, gives birth to, at least, five children within this period.

Given the age-specific characteristics, fertility is highest among women within ages 24 to 29, followed by ages 20 to 24, ages 30 and 34 and ages 35 to 44, respectively. Fertility rate is lowest among older women between the ages of 45 and 49. It is important to note that fertility rate among adolescent girls is also high compared to that of women within the ages of 45 to 49. The implication of this fertility profile is that fertility is highest among women during their years of active labour participation. Also, adolescent pregnancy is found to be high.

Age group	Census 1991	NDHS 2003	NDHS 2008	NDHS 2013
15-19	112	126	121	122
20-24	234	229	225	235
25-29	266	274	265	253
30-34	217	244	241	234
35-39	167	168	161	160
40-44	100	72	87	78
45-49	83	18	44	29
TFR 15-49	5.9	5.7	5.7	5.5

Source: NDHS report 2008 and NDHS report (2013)

Having considered the age specific fertility rate, it is important to examine the drivers of fertility by background characteristics. Statistics show variation between various age groups and places of residence. Table 2 below shows the profile of fertility rate across respondent's place of a residence, with respect to variations in the total fertility rate by residence, zone, education, and wealth quintile.

Fertility rate is higher for women from rural areas than those in urban areas. A woman from a rural area on the average will give

birth to six (6) children compared to a woman from an urban region who will give birth to an average of four (4) children.

Table 2: Fertility Rate by Background Characteristics in Nigeria in 2008			
Background characteristics	Total fertility rate	% of Women age 15-45 currently pregnant	Mean number of children ever born to women age 40-49
Residence			
Urban	4.7	9.0	5.7
Rural	6.3	11.3	6.9
Region			
North-central	5.4	10.4	6.4
North-east	7.2	12.6	7.5
North-west	7.3	13.5	7.7
South-east	4.8	8.8	5.8
South-south	4.7	8.5	6.2
South-west	4.5	8.2	5.0
Education			
No education	7.3	12.6	7.3
Primary	6.5	11.6	6.6
Secondary	4.7	8.3	5.1
More than secondary	2.9	8.4	4.1
Wealth quintile			
Lowest	7.1	13.3	7.3
Second	7.0	11.5	7.3
Middle	5.9	10.5	6.7
Fourth	5.0	8.7	6.3
Highest	4.0	8.8	4.8
Total	5.7	10.5	6.5

Source: NDHS report 2008

Variations in the education attainment also play a significant role in shaping the fertility pattern of women in the country (McNirol, 2009). Fertility rate was found to be highest among women with no education, having an average of seven (7) children while fertility rate is lowest among women with more than secondary education, having an average of 2 to 3 children. There are indications that the higher the educational attainment of a woman, the less is her fertility rate. The enhanced level of awareness associated with education on the availability of family planning methods, accessibility, and efficient usage may be responsible for the lower fertility rate among post-secondary educated women. More so, educated women are said to have the highest maternal labour participation as such they have less time for child bearing and child care.

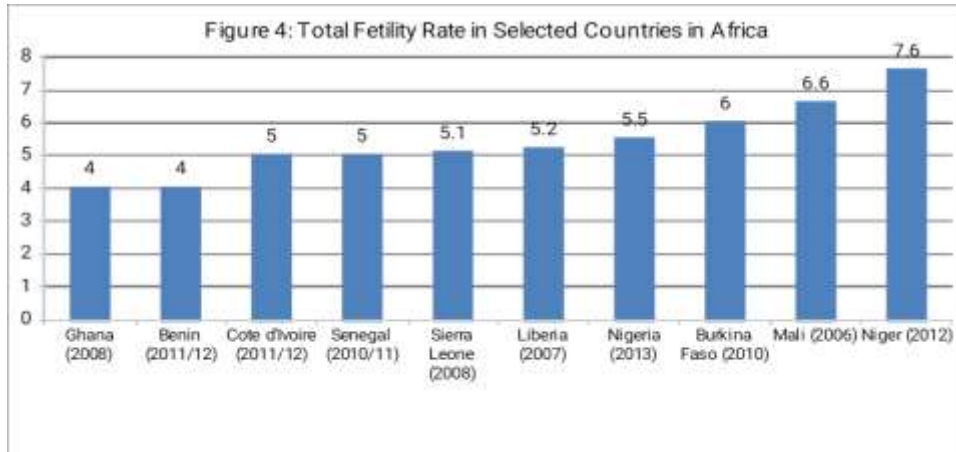
It has been acknowledged that economic status also influences fertility, with evidence to support association between the two (Oduola, 2000; Oyedele, 2013). Fertility rate was found to be highest among women that are poor. On the average, the category of women in the lowest quintile gives birth to seven (7) children compared to rich women with an average of four (4) children. Therefore, the higher the wealth of a woman, the less children she will have during her reproductive years. In a nutshell, residence, region, education and wealth are the major determinants of fertility among women in Nigeria.

2.1.3 Fertility Comparison between Nigeria and Other Countries

Nevertheless, according to the 2011 estimates by the Central Intelligence Agency (CIA), the Total Fertility Rate (TFR) in Nigeria is 4.73, rated 27th in the world and 25th in Africa, immediately after Sudan and Senegal but ahead of Togo, Central Africa Republic and Gabon (in that order) (Akpa and Ikpotokin, 2012). Nigeria is the most populous black nation in the world with a total population of over 140 million people and an annual population growth rate of

3.2%. These statistics are, obviously, indicators of impending population explosion if measures for checks are not considered.

In Figure 4 below is the current fertility rate of Nigeria in comparison to that of her neighbouring countries. The figure was also contracted from the most recent DHS data from each of the countries. The statistics show that Ghana and Benin Republic recorded the lowest fertility rate with an estimated fertility rate of about four (4) children per woman. This is followed by Cote d'Ivoire and Senegal with a fertility rate of about 5.0. Nigeria recorded a relatively high score (5.5 per woman) in terms of fertility with other countries such as Burkina Faso with the fertility rate of 6.0 children per woman. While Niger recorded the highest fertility rate (7.6 per woman), the statistics show that Nigeria requires extra efforts to catch up with other countries such as Ghana and Benin Republic.

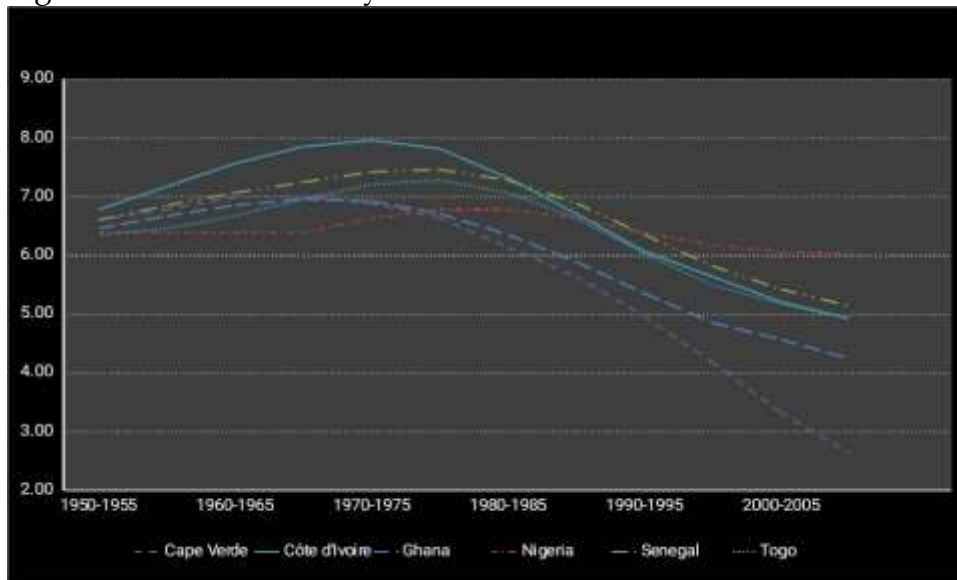


Source: NDHS (2013)

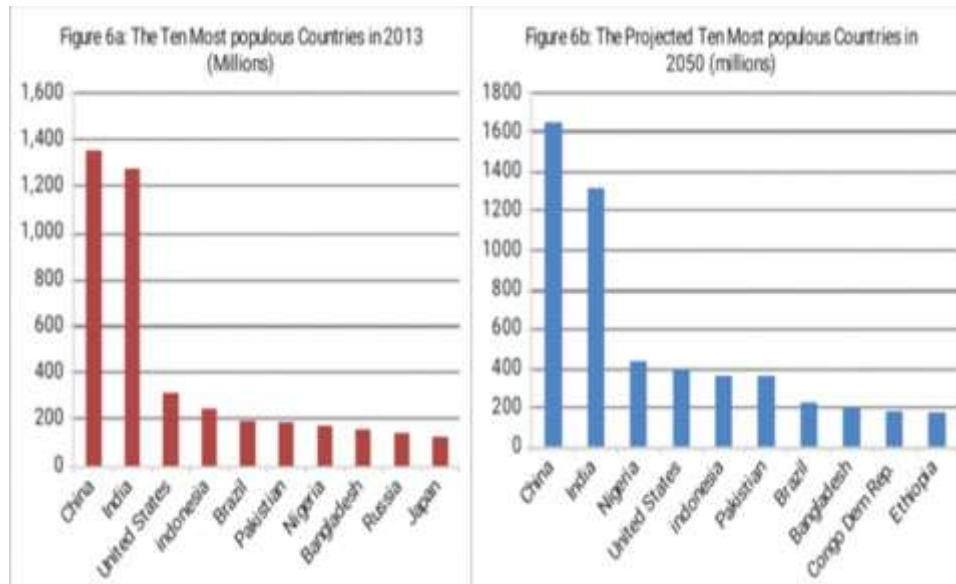
In addition, West Africa has the highest fertility rate in the world, but what is interesting is that many countries that had the same fertility level with Nigeria in 1950 have been able to reduce theirs

rates substantially. Figure 5 presents the profile of fertility rate between 1950 and 2015 for six (6) West African countries. While Cape Verde has made substantial progress over the years, it is only Nigeria's fertility rate that appears to have falter over the same period

Figure 5: Trend in Fertility Rates in Selected Countries



Within the global context, the high fertility rate in Nigeria is projected to impact the total population of the country in the next 16 years. According to the current World Population Data Sheet, Nigeria is currently ranked the seventh most populous country in the world, with a population of 174 million (Figure 6a). However, given the country's fertility rate and population growth rate over the years, the population of the country is projected to more than double by 2050, to reach 400 million people capacity, becoming the third most-populous country in the world (Figure 6b). The picture raises a great concern on the need for a concerted effort to slow down the rate of growth of the country, with fertility reduction as the first point of call.



Source: World Population Data Sheet, 2013

2.2 Fertility Discussions in Nigeria

2.2.1 Population Policies and Programmes Affecting Fertility in Nigeria

Nigeria did not have any explicit population policy until 1988 when the first National Population Policy was formulated. Although Nigeria had prepared elaborate development plans since the 1960s, population issues had not been a key and integral part of the plans. Despite the fact that the second National Development Plan (1970-1974) reported an annual population growth rate of about 2.5% which was considered to be high even then, none of the policymakers and government considered it important enough to lead to a population crisis. Most items of population were encompassed into health policy and programmes such as family planning programmes. Incidentally, the programmes focused

primarily on health of women and children and not necessarily on the reduction of fertility.

However, the rising population growth and its attendant negative effects led to the formulation of the first Nigeria Population Policy, titled the *National Policy on Population for Development, Unity, Progress and Self-Reliance*, in 1988. The population policy was aimed at improving the standard of living of all Nigerians and promoting their wealth, as well as mother and child welfare, by focusing on fertility reduction. The policy thus set targets for fertility and mortality levels, population growth rates, family planning programmes and social amenities while ensuring an equitable distribution of health services mainly in deprived areas of the country. The policy also focused on making family planning services easily affordable, safe and culturally acceptable (Federal Republic of Nigeria, 1988).

One key issue in the policy is a conscious effort by the government to facilitate free choice of family planning methods by making a variety of these methods easily accessible and affordable. This policy was to complement the establishment of family planning clinics, commercial distribution outlets as well as the utilization of existing health facilities and community-based delivery systems to ensure grassroots coverage.

The basic issues of discussions from the 1988 population policy include:

- Female and child education
- Poverty and livelihoods
- Four-child policy
- Reduction on population growth rate, and
- Health and welfare of women and other citizens.

There are divergent views on the success of the 1988 population policy. While some schools of thought argue that it was

unsuccessful due to cultural, religious and financial factors in play, others argue that the policy was partially successful, especially in southern Nigeria where social advancement played an integral role (Adegbola, 2008). Unfortunately, the success was very limited in northern Nigeria due to the region's cultural aversion to family planning, among other factors.

According to Obono (2012), the 1988 population policy had multiple goals which were large and ambitious. The goals include improving living standards and quality of life, promoting health and welfare, reducing the population growth rate, and achieving balanced rural-urban development. It also sought to promote the awareness of population growth and the negative effects on development, provide family planning services and collect data for economic and social development planning.

The third target in the 1988 population policy sought to reduce the number of women bearing more than four children by 50% by 1995 and 80% by 2000. A related target was also stated in point six where the number of children a woman is likely to have during her lifetime was expected to be reduced from 6 to 4 per woman by the year 2000. Available statistics suggest that the government failed in achieving this target. The 2003 NDHS data showed that fertility rate in Nigeria was 5.7 per woman, which is significantly above the four (4) per woman target. It is worth noting that this statistic was recorded in 2003, three years after the target year of 2000. This implies that the policy target of reducing fertility rate to a reasonable level was not successfully achieved. Indeed, the four-child policy was a feasible and acceptable way of effectively checking the population of Nigeria from exploding. Some other countries like Ghana have achieved similar targets with the fertility rate of about four children per woman as far back as 2008.

Achieving a similar feat in Nigeria requires conscious policy efforts with political commitments in the execution of the policy.

There were ten specific policy targets to be achieved by the year 2000 in the 1988 policy. Unfortunately, the targets were not met and the performance left much to be desired. As a response to the shortcomings of the 1988 policy, the 2004 *National Policy on Population for Sustainable Development* was formulated. The 2004 population policy mainly set 2015 as the target point for achieving the goals contained therein. In the 2004 revised population policy, some of the limitations in the previous policy's targets were addressed. The second policy also had 10 specific targets which appear to be more feasible and reasonable to achieve. The year 2015 was mainly used as the target year when most of the policy targets are to be achieved. It is important to assess the performance or progress in terms of achieving the policy targets. It can be said that the policy was designed to go hand-in-hand with the MDGs. The targets of the two population policies for the country to-date are presented in table 3.

1988 Population Policy	2004 Population Policy
<ul style="list-style-type: none"> ▪ To reduce the proportion of women who get married before the age of 18 years by 50% by 1995 and by 80% by the year 2000 ▪ To reduce pregnancy to mothers below 18 years and above 35 years of age by 50% by 1995 and by 90% by the year 2000 ▪ To reduce the proportion of women bearing more than four children by 50% by 1995 and by 80% by the year 2000 ▪ To extend the coverage of family planning services to 50% of women of childbearing age by 1995 and 80% by year 2000 	<ul style="list-style-type: none"> • Achieve a reduction of the national population growth rate to 2% or lower by the year 2015 • Achieve a reduction in total fertility rate of at least 0.6 children every five years • Increase the modern contraceptive prevalence rate by at least 2% per year. • Reduce the infant mortality rate to 35 per 1000 live births by 2015 • Reduce the child mortality rate to 45 per 1000 live births by 2015

<ul style="list-style-type: none"> ▪ To direct a significant proportion of the family planning programme in terms of family life education and appropriate family planning services at all adult males by the year 2000 ▪ To reduce the number of children a woman is likely to have during her lifetime, now over 6, to 4 per woman by 2000 and reduce the present rate of population growth from about 3.3% per year to 2.5% by 1995 and 2.0% by the year 2000 ▪ To reduce infant mortality rate to 50 per 1000 live births by the year 1990 and 30 per 1000 live births by the year 2000 and the crude death rate to 10 per 1000 by 1990 and 8 per 1000 by the year 2000 ▪ To make available suitable family life education, and family planning information and services to all adolescents by the year 2000 to enable them to assume responsible parenthood ▪ To provide 50% of rural communities with basic social amenities by 1990 and 75% by 2000 in order to stimulate and sustain self-reliant development ▪ Family planning services shall be made available to all persons voluntarily wishing to use them. Priority attention shall be given to reaching high-risk clients; for examples, women under 18 or over 35, those with four or more children, those with previous complicated pregnancies of childbirth, or those with chronic illness which increase the health risk of pregnancy. 	<ul style="list-style-type: none"> • Reduce maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 by 2015 • Achieve sustainable basic education as soon as possible prior to the year 2015 • Eliminate the gap between male and female enrolment in secondary schools, and tertiary, vocational and technical education training by 2015 • Eliminate illiteracy by 2020. • Achieve a 25% reduction in HIV/AIDS adult prevalence every five years
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The 2004 policy targets are relatively straightforward and feasible; the efforts required to achieve the targets also require extra push. After almost a decade since the policy targets were introduced, available statistics suggest that there still exists a significant gap between the set target and what had been achieved so far. All the policies in the previous and revised population policy targets are related to controlling population growth, with some being directly related while others are indirectly related.

In the first target, the 2004 population policy sought to achieve a reduction in the population growth rate to 2% by the year 2015. The population growth rate in 2004 as at the time of the formulation of the policy was approximately 2.6%. This figure increased to about approximately 2.7% in 2010. The population growth rate as at 2012 is approximately 2.8, three years away from the end of the policy target. This indicates a significant poor performance in achieving this target. Population growth rate has consistently increased over the years since the inception of the policy target in 2004. With the current trend in performance, it would take major extra efforts to reduce the population growth rate to 2% between 2012 and 2015.

The policy on reducing fertility rate to four (4) children per woman in the 1988 policy targets was revised to reducing total fertility rate by 0.6 per woman every five years. Evaluating this policy shows that again as at 2008, four years after the introduction of the policy, very little progress was made in achieving the target. Total fertility rate from the 2003 NDHS of 5.7 per woman remained the same as at 2008, indicating a zero reduction contrary to the 0.6 per woman proposed by the target. Between 2008 and 2013 (five years' interval), total fertility reduced from 5.7 per woman to 5.5 in 2013. This indicates that fertility rate over the five-year period reduced by 0.2 per woman. While this still falls short of the target of 0.6, it shows an impressive progress towards achieving the target. This

performance suggests that with extra efforts, the target could be achieved in the next five-year period.

Other issues for discussion in the 2004 policy are

- Reduction of population growth rate to 2%
- Reduction in total fertility rate
- Reduction in infant/child and maternal mortality
- Improvement in basic education, and reduction in illiteracy and gender gap

Evidence from DHS survey 2013 suggests that the revised national population policy is far from successful.

2.2.2 Family Planning and Unmet Need for Contraception

Another major issue for discussion is the issue of family planning and contraceptive use. This issue was very well emphasised in the two population policies. About four of the ten policy targets in the 1988 population policy sought to either improve the knowledge of family planning methods or make these services available to women all over the country by the year 2000. The third policy target was directly focused on managing fertility and represents an improved revision of the previous targets that were unspecific and ambiguous on contraceptive use. This target sought to increase the modern contraceptive prevalence rate by at least 2% every year. The statistics on the progress of achieving this target suggest that while some progress has been made, it may not be sufficient.

a. Knowledge of Contraceptives

The knowledge of contraceptive among any groups of people is the starting point for engendering its use by the population. Where awareness is poor, it will be difficult to influence the use. Table 2 below shows the level of knowledge about various contraceptive methods among both women and men (statistics on whether or not respondents have ever heard of any method of contraception or

any modern method of contraception). The statistics were also presented across respondents' place of residence and zones of Nigeria. Figures from the Table further indicate that that knowledge of contraceptive methods was higher among men than women. About 85% and 97% of women and men, respectively, had heard of any method of contraception. Similarly about 83% and 96% percent of women and men, respectively, have ever heard of any modern method of contraception. Further, urban respondents had higher knowledge of contraceptives relative to their rural counterparts. About 95% and 99% of female and male urban respondents had heard of any method of contraception. This was higher compared to about 78% and 96% of female and male respondents in rural areas. Similar trend prevail for the knowledge of modern contraception methods.

In terms of the zonal difference in the knowledge of contraceptives, the statistics show that respondents from the South-South zone recorded the highest level of contraceptive knowledge in Nigeria. Over 97% of both men and women in the South-South zone have heard of any contraception method or modern contraception method. On the other extreme, respondents from the North-East recorded the lowest knowledge of contraception method among both males and female respondents.

b. Contraceptive Use

An important component in fertility management in any country is the use of contraceptives. This is widely accepted as an effective way of controlling population growth from exploding. Figure 3 below shows the use of contraceptive by type in Nigeria. In general, modern contraceptives are recommended as the most effective contraceptive method for family planning. Like many developing countries, Nigeria has made several efforts over the years to improve the use of modern contraceptives. The statistics show that about 15% of currently married women aged between 15 and 49 years used any type of contraception. A positive indication,

however, emerges from the fact that majority of the respondents used modern contraceptives relative to traditional methods of contraception. The use of any method is higher than the use of any modern method as well as any traditional method. About 10% of the respondents used modern contraceptive methods relative to 5% using traditional methods.

Table 4: Knowledge of Contraceptive Methods

	Women		Men	
	Heard of any method	Heard of any modern method	Heard of any method	Heard of any modern method
<i>Residence</i>				
Urban	95.4	95.0	99.4	99.1
Rural	78.4	75.8	95.6	93.7
<i>Zones</i>				
North-Central	78.6	78.0	94.4	92.7
North-East	73.2	70.1	94.1	91.3
North-West	81.1	78.4	97.4	96.0
South-East	95.9	95.4	99.6	99.3
South-South	97.7	97.5	99.7	99.4
South-West	96.4	95.7	98.8	98.4
Total	84.6	82.8	97.0	95.8

Source: NDHS (2013)

Note: Knowledge of contraceptive method is measured as percentage of all respondents, currently married respondents and sexually active unmarried respondents' ages 15 to 49 who know any contraceptive method.

Table 5: Trends in contraceptive use by specific method

	1990	2003	2008	2013
Any method	6.0	12.6	14.6	15.1
Any modern method	3.5	8.2	9.7	9.8
Female sterilization	0.3	0.2	0.4	0.3
Pill	1.2	1.8	1.7	1.8
IUD	0.8	0.7	1	1.1
Injectables	0.7	2	2.6	3.2
Male condom	0.4	1.9	2.4	2.1
LAM		1.4	1.6	0.4
Any traditional method	2.5	4.3	4.9	5.4
Rhythm	2.1	2.1	2.1	2.2
Withdrawal	2	1.3	2	2.5
Folk method	0.6	1.0	0.9	0.7
Not currently using	94.0	87.4	85.4	84.9

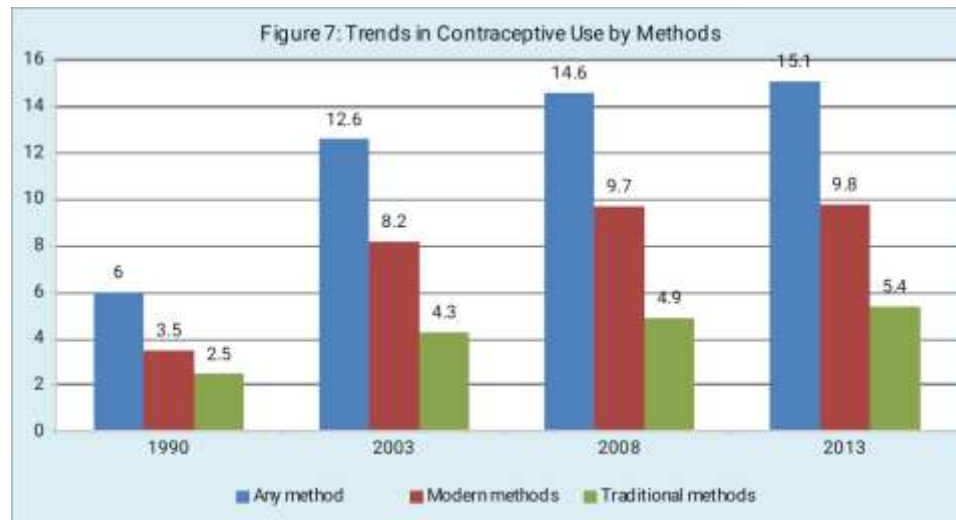
Source: Author's compilation from NDHS data for various years

*LAM = Lactational Amenorrhoea Method

The statistics on the proportion of currently married women in Nigeria not using any form of contraception is staggering and these statistics have only marginally reduced over the years. Although the use of contraceptive is generally very low, there is an increase in usage as the years go by due to increased awareness. In 1990, about 94% of married Nigerian women were not using any form of contraception. This reduced to about 87.4% in 2003 and went further down marginally to about 85.4% in 2008 and further to 84.9%. The statistics suggest there is still a long way to go as far as the use of contraceptives in Nigeria is concerned. This also implies

that there is a need to step up family planning/population control efforts in the country.

In terms of fertility control and management, the trend analysis show that over the years, the use of contraceptives, in general, has increased among married women in their reproductive ages. The proportion of women who used any contraceptive method increased from about 6.0% in 1990 to 12.6% in 2003, 14.6% in 2008 and 15.1% in 2013. Modern contraceptive use also increased significantly over time with about 3.5% of women using modern contraceptives in 1990, 8.2% in 2003 and 9.7% in 2008. This further increased marginally to 9.8% in 2013. The specific type of modern method also varied in terms of usage over time. Injectables and male condoms seem to be the most prevalent modern method used by women in Nigeria to control fertility.



Source: Author's construction from NDHS data for various years

While the use of traditional contraception methods also increased over the years, the rate of increase was not as much as that of modern contraceptive use. Traditional contraceptive increased from 2.5% in 1990 to 4.3 in 2003 among women in Nigeria. This further increased marginally to about 4.9% in 2008 and 5.4% in

2013. This shows a slight progress in the campaign to encourage women to move to the use of modern contraceptive methods which are considered to be more effective.

2.2.3 Education and Fertility

Fertility management is always shaped by education attainment of women and their partners. Many studies have shown that this could be a significant factor for fertility decline in many countries. In many earlier studies, education of adults persistently emerges as the single most powerful predictor of their demographic behaviour. The start of reproductive life (marriage and maternity), childbearing and the use of birth control are strongly associated with schooling. Age at first marriage has been found to rise with education. The publication of results from a survey in Nigeria by Caldwell (1979) showed the schooling of mothers to be a more powerful predictor of child survival than economic characteristics of the family, such as the father's occupation. Cochrane (1979) also buttressed the same stand in an extensive review of the educational/fertility relationship. Thus later researches have upheld mother's schooling as generally having more decisive influence on reproduction than characteristics of the father. According to Isiugo-Abanihe (1994), high level education (secondary and tertiary) exerts stronger positive and highly significant effect on age at marriage; however, women with only primary education tend to marry earlier than those with no schooling at all.

There are evidences that the relationship between education and fertility is more likely to be inverse in urban than in rural areas (see Lawoyin and Onadeko, 1997). Also, in countries with high illiteracy rates, individuals with some education may appear to have higher fertility than those with no education, whereas in countries with low illiteracy rates, individuals tend to have lower fertility.

Discussions on education have centred around enhancing access to basic education as well as emphasising female education. In order to fully exploit the role of education the issue of family life education project was introduced to make sure that young people are well aware of fertility issues and how they affect them.

2.2.4 Stakeholders Engagement and Advocacy

There is the need to create awareness through advocacy drive. Advocacy is the process of managing information and knowledge strategically to change and/or influence policies and practices that affect the lives of people (particularly the disadvantaged). UNFPA's (United Nations Population Fund) 2013 State of the World Population report, focusing on 'Motherhood in Childhood,' x-rayed the alarming rates of girls and young women, mostly in developing countries, who continue to give birth to children while they themselves are still children. Advocacy to reduce fertility can then be termed as an advocacy that is intended to reduce death or disability in groups of people (overall or from a high fertility); one that is not confined to clinical settings. Such advocacy involves the use of information and resources to reduce the occurrence or severity of public health problems.

The language of communication is very important in advocacy and engagement. Using the right tenses and language are needed in order to successfully sell family planning to many communities in the country. It has been found that in many Nigerian communities, the way some population and health terms are phrased can affect the process of engaging individuals and households in such places. Engagement by agencies such as NURHI have shown that terms such as early marriage, family planning, and other maternal health-related topics need to be made more culturally compliant for them to be acceptable in some communities.

For example, languages such as economic (ability to provide good education to few children), health of mother and health of children as well as aesthetic factors (being slim and looking beautiful) represent some positive arguments that can be used to encourage more family planning.

Communications research has also shown that mass media interventions work by stimulating discussion within social networks (including but not limited to discussion between spouses), which then leads to subsequent contraceptive uptake could be additional ways of raising the discussion levels.

2.2.5 Marital Dynamics

It has long been argued that marriages in Nigeria are so closely linked with childbearing that a change in the pattern of marriage necessarily will influence the birth rate, and hence the rate of population growth (Olusanya, 1982). Family setting in rural areas is more of polygamy, in which both women (wives) and children are seen as assets in the production of agricultural products on farms. The other issues involving marital activities and fertility include the following:

- Culture which places higher value on child-bearing as a greater achievement for girls.
- Parents who give out their daughters in marriage at an early age for economic gains or under the guise of protecting her from herself or temptation from others.
- Delayed marriage for reasons of increasing focus on educational/career pursuits. While marriage is being delayed, the other factors listed above combine together to influence sexual activity among young people.

Underscoring the importance of social meanings in high fertility, Izugbara and Ezeh (2010) explored the perceptions of women in north-western Nigeria on high fertility in the region and showed that many women reportedly give birth to many children to prevent divorce and/or plural marriages by their male spouses. This they related to the inheritance structure of Islam, the dominant religion in the North.

Within the marital space, communication about family planning is critical. Inter-spousal communication is a key issue that affects the sustained use of family planning in Nigeria. While a few men, mainly from the north of the country, were of the opinion that the issue of family planning should not be discussed at all within the family, most male and female participants agreed that the use of contraceptives should be a joint decision between husband and wife. Despite this, it was found that the men find it difficult to talk about family planning.

It has been shown in the literature that women's adoption of family planning potentially puts them at risk of adverse outcomes (e.g., as victims of partner violence) when their husbands are opposed to contraception. Apart from spousal discussions, discussion of contraception between wives and their sisters-in-law supports covert contraceptive use and promotes both spousal discussion and overt use. In addition, discussion within social networks also promotes contraceptive use.

2.2.6 Adolescence Reproductive Health

The issue of Adolescence Reproductive Health is shaped by their sexuality. This has implication for fertility in the form of teenage pregnancies. Early age initiation into conjugal unions and parenthood, and consequence to mothers and children, has been a source of concern in Nigeria (Isiugo-Abanihe, 1994). High fertility among adolescence is not peculiar to sub-Saharan African countries, but applies to countries like Brazil as well. According to

Gyepi-Garbrah (1985), about one-third of all fertility in Africa in the 1970s was attributed to adolescent mothers. In addition to this, there are concerns over child marriages. Interestingly, many of these girls are unmarried and this raises the issue of unmet needs for never married young girls who are sexually active.

A number of factors influencing sexual activity among young people have been identified and they include:

- Early onset of sexual maturation and the accompanying natural increase in body secretions (sex hormones) which stimulate sexual urges in adolescent boys and girls.
- Pressure by peer group and adults on young people to engage in sexual relations.
- Increasing socio-economic problems which result in pressures on young people to exchange sex for money.
- Glamorization of sex in the mass media without equally highlighting the associated risks.
- Permissive attitude of society towards premarital sexual relations for boys as part of their predatory sexual socialization.

One major talking point on adolescence reproductive health has to do with teenage pregnancy; this is a universal problem and a result of the fact that teenagers are sexually active. Teenage pregnancy has not only become a public health issue, but also a media focal point; it is a major issue irrespective of the teenager's marital status (Chau-Kuang, 2013). Teenage pregnancy is one of the main reflections of unmet needs for contraceptives. Teenage fertility establishes the pace and level of fertility over a woman's entire reproductive lifespan as women who are married before the age of 18 tend to have more children than those who marry later in life. Early marriage is a basic issue for discussion on the reduction of adolescent fertility. Nigeria is one of the top 21 countries in the

world with the highest rate of women 20 to 24 years old who married before their 18th birthday (Ajala, 2014). This has implications not just for fertility but also because early marriage limits the opportunities for women to advance in their educational attainment or to develop meaningful livelihood skills. The prevalence of early marriage differs by geopolitical zones in Nigeria as teenagers in the core North (the North-East and North-West) still marry for the first time about four years earlier than their counterparts in the Southern part of Nigeria.

Baby factory

Another emerging issue in fertility decision in Nigeria is the baby factory syndrome. Childbearing has always been known to be a private, individual, family or household decision, but in recent times in Nigeria, a commercial dimension has been introduced through the activities of the so-called “baby factory.” A baby factory is a location where women are encouraged or forced to become pregnant and give up their babies for sale (Wikipedia). In another way, baby factories can also be defined as places where women, mostly teenagers, are assembled, get impregnated by some hired males, with the aim of procreating to sell the born babies to infertile couples or for ritual purposes. The arrangement is made in such a way that the teenagers are denied access to their babies. A baby-making factory was first discovered in southeast of Nigeria; it was disguised as an orphanage, with several pregnant teenage girls; they were catered for alongside orphans that had been abandoned by families who considered their pregnancies ‘unwanted.’ At the moment, it seems that Abia and Imo states have the highest number of such illegal homes in the country (see table 4).

Table 6: Some Baby-Making Factory Sites and Activities

State	Location	Number of teenagers	Age range	Amount paid for boys (₦)	Amount paid for girls (₦)	Boys Sold for (₦)	Girls Sold for (₦)
Ogun	9, Sebanjo Crescent, in Akute	8	16 - 25			300,000	300,000
Abia	Umuzue community in Osisioma Ngwa Local Government Area	32	10 - 20	100,000.	80,000	450,000	400,000.
Abia	3, Anyamele Street, Off Nicholas Avenue, in Umungasi Area of Aba	16	17 - 37	15,000 - 20,000	10,000 - 20,000	400,000	300,000
Abia	Double Research Clinic and Laboratory at Iheoji Mgboko in Obingwa LGA	19	NR	NR	NR	NR	NR
Abia	Humaihia	19	15-23	NR	NR	NR	NR
Anambra	Community Children's Home at Umunna Street in Onitsha South LGA	17(25 babies)		NR	NR	NR	NR
Imo	Umuguma in Owerri West LGA	17	13 - 21	NR	NR	NR	NR
Imo	Ahamefula Motherless Babies Home, Umuaka in Njaba Council Area	24	14-19	NR	NR	NR	NR
Imo	Egbu Road, Owerri	16	14 - 19	100,000	100,000	NR	NR
Ondo	Ilu-Titun in Okitipupa council area	24	19 - 25	NR	NR	2,5 million ¹	
Rivers	God's Gift Maternity Hospital at Elemenwo in Obio/Akpor LGA	NR	NR	NR	NR	1.5mill. & 6mill. ²	
Delta	Oko community near the River Niger	5	NR	NR	NR	NR	NR
Akwa Ibom	Uruah LGA	7	18 and 20	70,000	70,000	300,000	450,000
Enugu	Enugu	20	NR	20,000	20,000	300,000	450,000

Note: NR: Not Reported; Source: Compiled from the internet by the author

¹ Represents cost of twin babies. Single boy and girl cost below ₦1 million.

² Include the cost of injection of desperate infertile women with substance to make them appear pregnant, and arrangement for stolen babies for the women.

There are economic, social and illegal reasons why teenagers are involved in baby factories. Some of them get into the business purely driven by the prospect of monetary gain. While the teenagers are paid between N10,000 and N80,000, depending on female or male child delivery, the babies themselves are sold for between N300,000 and N500,000 each to childless couples. And in some cases, they are sold to those requesting them for ritual purposes. UNICEF estimates that no fewer than 10 children are sold daily across Nigeria. While some voluntarily join the baby factory because of poverty crunch and unemployment, many others find solace in these baby factories following the emergence of unwanted pregnancies and rejection by family members. Some become victims out of the acts of kidnapping and being forcefully impregnated, while some are deceived to work in these baby factories; and once they are in, they find it difficult to retreat. The buyers are often couples who are unable to conceive; male children typically attract higher prices than baby girls for both the teenage mothers and the buyers.

The destination of the babies from the baby factories also varies. In some cases, infertile couples buy the babies. This is because the options open to infertile couples is either the procurement of assisted conception or the adoption of children from orphanages; the latter, though still not totally accepted in the society, is gaining some measure of popularity and acceptance nowadays. While the former is exorbitant and not always guaranteed, the latter option for childless couples is fraught with many obstacles. Thus, in the absence of the inadequate right channels of accessing children by couples, commercial initiatives are springing up all over the country to meet this demand.

2.2.6 Abortion Policy

Abortion is often considered as a consequence of lack of effective contraceptive. Abortion is illegal in Nigeria, and the Nigerian abortion law is one of the most restrictive in the world. The law's

main concerns are the need to save lives and preserve physical and mental health; its violation is greatly frowned at, attracting up to seven and 14 years' imprisonments for both the pregnant woman and the abortion provider, respectively. Abortion in Nigeria is governed by two different laws: the Penal Code, Law No. 18 of 1959 in the predominantly Muslim states of Northern Nigeria, and the Criminal Code of 1916 in the largely Christian southern part of the country. However, abortion is presently regarded as a major cause of social and clinical problems in Nigeria (Okonofua and Ilumoka, 1991); apart from that fact that its restriction fuels fertility rate in the country.

The attempt in 1982 to liberalize abortion law in Nigeria through a sponsored bill on "termination of pregnancy" by the Society of Gynaecologists and Obstetricians of Nigeria was scuttled by women groups and religious leaders. Further, the opposition of women's groups and active anti-abortion lobby scuttled the 2007 attempt to reform the country's restrictive abortion law. The fear of the opposing groups was that its passage into law would promote sexual promiscuity. The bill recommended permission for termination of pregnancy on the condition that two physicians certified that the continuation of a pregnancy would involve risk to the life of a pregnant woman, or of injury to her physical and mental health or to any existing children in her family if the pregnancy was terminated. The bill also sought to allow abortion if "there was a substantial risk that the child, if born, would suffer such physical and mental abnormalities as to be seriously handicapped." However, whatever must be done must be within the first 12 weeks of the pregnancy.

Given the prevalence of illegal abortion practice in Nigeria and the implications for public health, discussions about abortion policies and practices are still in the public domain (Olaniyan and Awoyemi 2010).

2.2.7 Poverty Rural Livelihood and Fertility Dynamics

Poverty remains one peculiar challenge facing Nigeria, as there has been a progressive upsurge in its incidence over the years. Poverty rates have been increasing over the years and by 2010, 69% of Nigerians are lining below the poverty line, and mostly affected are the rural people whose major occupation is the agriculture (Table 7). This tends to affect the perception of children in the family as they are viewed as old age insurance. This leads to increased fertility.

The typical schedule of daily activities of a rural dweller in Nigeria starts with resumption on the farm early in the morning and working till the sun goes down (towards evening). This is followed by limited recreation activities involving engagement in one form of light game or the other, as well as 'gisting' or story-telling. Modern recreations which can occupy their leisure time are totally absent in rural areas. Often the heads of households take to sexual activities as a form of recreation, which has implication on their fertility. In addition, there are practices that often reward women with belonging to a privilege group based on the ability to undergo certain number of impregnation and deliveries (as high as ten or more).

The absence of recreation in Nigerian rural areas further compounds the fertility problem. Sexual relationship between couples tends to have become an act of passing time, since there is little or no available recreational engagement or leisure activity.

	1980	1985	1992	1996	2004	2010
National	27.2	46.3	42.7	65.6	54.4	69.0
Urban	17.2	37.8	37.5	58.2	43.2	
Rural	28.3	51.4	46.0	69.3	63.3	

Source: National Bureau of Statistics (NBS)

Most rural families, apart from engaging in agricultural activities, rely heavily on the family's labour supply on the farm. This has greatly encouraged the practise of polygamy and the deliberate procreation of children to support the family farm business as well as provide security for the parents in their old age. Thus, the fertility rate among rural dwellers has been high at over 6, and the size of an average rural family will be big, with little/inadequate resources to cater for their needs, especially education and health. This more or less creates a vicious cycle of poverty among rural dwellers. It is not therefore surprising that rural poverty is more severe in Nigeria when compared with urban poverty. Almost all the varieties of poverty measure indicate rural poverty to be more than one-half fold of urban poverty.

Fertility decline is always associated with economic progress as the theory of quality-quantity trade-off of children holds in virtually all economies. Hence there is the need to improve the general wellbeing of the citizens for a sustainable fertility transition process.

3.0 PROCESS OF ENGAGING STAKEHOLDERS IN THE BID TO ADVOCATE FOR FERTILITY MANAGEMENT

Government Action and Commitment

Population programmes are inherently multidimensional and cut across many government organizations, from education to housing, transportation and others. The various fertility discussions should involve not only religious leaders but also the different government ministries, departments and agencies as much as possible. This should be designed in such a way that every MDA sees the population programme as theirs, or at the very least as compatible with their goals. Each MDA would see the major costs of rapid population increase from his ministry's vantage point. In this wise,

officials should also educate each other about the consequences of population growth; the process allows members of each ministry to find their own reasons for participating actively in the promotion of the family planning programme. Although this situation can be complicated by competition between ministries for a relatively larger share of shrinking government budget; this would call for a coordinating ministry/agency to reconcile these differences.

The commitment by government must be explicit; which means that there must be deliberate government action seeking to reduce fertility. Government must match words with actions by adopting and implementing policies as well as devoting actions necessary to achieve a decline in fertility. In this wise, government action should be a multi sector approach including health, education and legal actions that are explicitly articulated. In achieving this multi-sector approach, programmes must be launched in all sectors to make the environment more conducive to small families. However, education and health policies should be implemented in such a way to explicitly ensure their influence on fertility.

Population Policies

There is the need for a good population policy for the country. The last population policy was formulated in 2004 and is expected to expire in 2015. Now is more than the right time to start the evaluation of the policy and to draft a new one, taking into consideration the failure and successes of the 2004 policy. The new population policy must however be specifically linked to fertility decline.

Policies should be a product of engagement with the communities based on a bottom-up approach. As long as decisions on population policy and decisions relating to fertility are made in Abuja and handed down to the people, they will continue to be defective. For any policy to succeed there must be an element of ownership by the people which the policy is intended to benefit.

Nigeria is made of more than 380 tribes with significantly divergent cultural, traditional and religious beliefs. It may not be farfetched to note that a single straitjacket policy may not be acceptable and work for all. Given that control fertility rate is the objective, the standpoint of thinking that the people at the community level have nothing to offer should be done away with. Useful suggestions abound in the minds of the people, and should be given consideration in an attempt to harvest ideas that can be built up to form a unifying population policy direction for the country. Input from the community level, in addition to enlightenment and creation of awareness of high fertility risks, will convince individual households, communities and the nation at large. Attempts should be made to allow for individual tribes or communities to adapt the general policy to suit the peculiarities of each tribe or community.

Unfortunately the process of policy-making in Nigeria is often fraught with bureaucratic or policy-makers' arrogance; thinking they know more than the people who the policies are designed to capture.

All these different levels of arrogance lead to the acceptance problem by the people that the policies are meant to assist. A sociologist in one of our KII submitted that *"In a country of with about 389 tribes, no population policy can work without input from the people it is meant for. It is purely a case of lack of ownership that is bound to fail. Future population policy attempts should be bottom-up, account for variations in different tribes and allow for adaptation to suit individual community or tribe peculiarity within the larger setting. The community must be engaged, and the outcome should be people oriented."* Another consultant corroborated this submission by stating that *"The problem we have is that of information dissemination, awareness creation: if you are saying fertility is high in Nigeria, the people in the rural*

communities do not even know what you are saying, the message does not get them. All those things are paper work. The real people populating the society, so to say are in these rural communities. Even majority of urban people do not know the reason why they should have fewer children. Government has failed in education the people." A good population policy must therefore be multi-sectoral and include other ancillary policies, including health policies, education, women empowerment and so on.

Women Empowerment Policies

Policies to control fertility in Nigeria must greatly borrow from the factors that explain the low fertility rate and population decline in developed countries. The empowerment of women, resulting in an increase of females in the workforce, has been identified as leading to a decline in birth rates for employed women. The exact opposite, where women are idle, is what applies to most developing countries, including Nigeria. It has been suggested that as female participation in the labour force increases, total fertility rates decrease (Rindfuss and Brewster, 1996). This finding was further confirmed by other studies, among which are Hoem (2000), Lappegard (2000) and Kravdal (2001). In fact, occupied women tend to be less sexually active, which has implication on their fertility. The unemployment situation in the country must be addressed, both among the rural and urban population. The decision to postpone childbirth until a later age is directly linked to women in the labour force. (Bongaarts, 2002; Kravdal, 2001; Lesthaeghe and Moors, 2000).

Health Policies

Where health conditions are poor, high mortality is usually prevalent. When families are not sure of the possible survival of children given birth to, there is every possibility that precaution will be taken by the household to bear children, with mortality replacement intent in view. Parents have fewer children when they have more hope that children will survive into adulthood. The

Nigerian health status is still very poor, especially in the rural area where children are seen as security for old age. Health policy aimed at addressing the poor state of health facilities in the country should be seen and taken as the heart of population control.

Regulation and Control Policies

Many countries have legislated on the maximum number of children allowed a couple. Evidences in literature have proved that they have not been successful in many of these countries. China has implemented a one-child policy over the years and this has led to various problems including high rate of abandonment and infanticide, especially of girl children as well as sex selective abortion accounts. As a result, China has a gender crisis manifested in problematic sex ratio with the ratio of male to female is high as 130 to 100. This translates to 32 million more male than female under the age of 20. The implication is that birth control can lead to serious structural problems in a country like Nigeria with her strong preference for boys. This can be further escalated by corruption, for people who want to circumvent the law would be the beginning of the consequence. Evidence from the key informant interview indicates that government could be overstepping its bounds by attempting to regulate family size. It has been argued that the Nigerian tradition and religious values make birth control a "hard sell" in Nigeria.

Cultural Policies

The varied demographic patterns of different groups also call for a tailored policy. For an effective population policy, the government needs to find ways of incorporating distinct elements of the cultures of respective nationalities and other minority groups, leveraging rather than suppressing the country's cultural diversity

The strength of cultural beliefs in influencing the stronghold that favour high fertility rate is a reality in Nigeria, especially in rural areas. Of great importance is the procurement of efforts at the cultural transformation of the society to change social perceptions of the value of children, ideal family size and acceptance of contraception to influence fertility rates.

The challenge however is that the use of contraceptives as family planning mechanism is frowned at under African traditional and religious values as well as the doctrines of Christianity and Islam. This is coupled with the low level education, urbanization, modernization and economic development hindering the adoption of the complex family planning mechanism for controlling the fertility rate. A consultant on population issues described how difficult it can be if cultural issues are not taken into consideration. According to him, "Where childbearing has been elevated to be criteria (minimum of ten delivered pregnancies) for receiving honour to join privileged club in society, then high fertility is not only the issue, but survival risk is aggravated."

Engagement of Traditional Leaders

One significant asset of the communal setting in Nigeria, especially in rural areas, is the respect and trust which people have in their leaders. Traditional and religious leaders are often called opinion leaders. This can be taken advantage of by using them as gateways to people's hearts so that they can buy into the policy and make it work. They are highly respected by people and they thus have a responsibility to assist young people deal with reality by giving them a consistent set of messages regarding community values such as the right sexual behaviours, responsibility and future planning. Attention should be focused on educating and convincing traditional and religious leaders of the inherent benefit associated with bringing the fertility rate down. When these leaders understand and accept the importance of addressing young people's needs, it becomes easier for them to promote these issues

among members of their community. Opinions of these leaders must be sought on how to engage the people, and they must be adequately involved in the process of sensitizing the people on the need to embrace and comply with relevant fertility-related population policies. These leaders can specifically assist in the areas of:

- Urging acceptance, care, and concern for the lasting interest of their subjects;
- Raising awareness within the community on the merit of cooperating with policy actions to reduce fertility rate as part of the reproductive health concerns;
- Addressing people publicly on the people's health needs and inspiring their support;
- Providing community members support and guidance to explore and affirm their own values within the confine of their health safety;
- Engineering efforts to facilitate access to reproductive health information and services;
- Advocating and organizing substantial reproductive health programmes to reach different segments of the community across different age groups;
- Calling for responsible depiction of sexuality and morality in the mass media;

There is the need for constructive engagement with traditional leaders (sultans, emirs and chiefs) in the country. Many of these traditional leaders wield enormous power and influence in their domains which makes them of critical importance at the local level for the effective implementation of any population policy and/or programme.

Incidentally, the process of gaining the trust of traditional leaders and gatekeepers may require special sensitivity and acknowledgement of their stature in the community, and a nuanced understanding of how to relate with them is of utmost importance.

Engagement of Religious Leaders

Nigerians are very religious people which make faith-inspired organizations very important tools in driving home important population policies and actions. Churches and mosques have often been at the frontline of healthcare in developing countries and have networks in the most remote regions. Their close links to communities provide them with an opportunity to promote behavioural change. However, the introduction of a controversial health intervention (such as family planning) in a religiously conservative community requires careful assessment of the environment and careful planning for its introduction. It should be realised that the process of winning the trust of religious leaders can be difficult and time-consuming but is necessary for opening doors to patriarchal societies. Religious leaders can evangelise population discussions at various religious programmes and ceremonies including wedding, child-naming and funeral ceremonies.

Discussions through Formal Educational System

Given the stronghold of traditional values, many parents and guardians have a great deal of reservation discussing sexuality with their offspring, out of the fear that it may make them promiscuous. While effort is put in place to change this attitude, attention can be shifted to the formal educational system to offer the needed awareness and understanding that can assist women from their early ages to make informed decisions on reproductive activities, while appreciating the merit of keeping a manageable family size both to themselves and the society at large. This thus brings to fore the role of teachers and educational administrators.

Schools should be seen as a point where knowledge and skills that equip students for responsible lifestyles now and for the future are acquired by the young. In this regard, the roles of the school system should be designed to:

- Incorporate students' age-appropriate comprehensive sexuality education into the development of the school curricula. Although life education is now a national project, there is the need for teachers to be adequately trained. A piece of equipment is either limited or, in many cases, not available at all;
- Retrain teachers to handle the teaching of sexual and reproductive health accurately and comfortably;
- Provide practical experiences that reinforce values and group norms against unprotected sexual behaviours;
- Allow for open communication about sexuality and contraception between students and their parents by sensitizing parents on the need to show interest; and
- Emboldening students to discuss sexuality and reproductive health with their parents or guardians, with the aim of exploring further information from parents.

Discussions at the Family Level

There must be an increased level of discussions at the family level. In many cases, discussion of fertility behaviour and population control policies have focused exclusively on the behaviour of the female gender and often target women for change while disregarding the role of the male gender. The content of awareness programs should start focusing on males as they are the confirmed decision-makers. It will be important to educate men about the importance and benefit of a small family size as a tool to health and socio-economic independence.

One major issue is how to develop and enhance spousal communication on population issues. During one of the conducted KIIs, a matron in a state's health facility (in charge of reproductive health) argued that *"One prominent challenge to acceptance of family planning methods is the absence of cooperation from men to their spouses. It is often seen as the problem of women, and not for the couple."* In addition to good spousal communications, there must also be opportunities for encouraging sibling communications. According to responses from a KII-conducted affair for female doctors who are reproductive health specialists, the belief that women should always take responsibility for fertility decline may have its root in the fact that most of the contraceptives are made for women; this aggravates the lukewarm attitude and complacency of men (husbands).

Also, inadequate discussions at the family level can also create problem for the family as noted from a KII conducted for a health educator, State Ministry of Health that *"Secrecy of sexuality, and non-discussion of the subject at nucleus family level, often expose teenagers to risky inquisitiveness that gets a large number of them impregnated with unwanted child."*

Integrated Services

Family planning services should be integrated with other maternal and child health services to make it easier for populations to access a wider range of services. More service delivery points and increased integration of related services have the potential to result in greater continuity of care, better access to services, and fewer missed opportunities to address clients' comprehensive sexual and reproductive health (RH) care needs. This has been practised in the country through many forms. For example, the federal government adopted a policy guiding the integration of RH and HIV/AIDS services in January 2008.

4.0 CONCLUSION

There have been various levels and depth of discussions concerning fertility in Nigeria and this study submits that such discussions between and among various stakeholders should continue. The discussions should include discussions at all governmental levels. This level of discussion must happen at the vertical and horizontal levels. Vertically, all the three tiers of government in Nigeria must discuss the modalities of fertility reduction and improvement in the social sector and welfare of the citizens as these have important implications for the country's population growth. There should also be horizontal discussion between various sectors of the economy. Hence, ministries such as that of education, health, agriculture, economic planning and others must work together at making sure that the proximate and contextual determinants of fertility are attacked from all angles.

Since the initiative on population policy always originates from the government, an important concern will be to enhance political commitments towards these policy targets and ensure that changes in governments do not affect the implementation of the targets. In Nigeria, like many developing countries all over the world, getting governments to commit resources to family planning is usually difficult, especially in situations where new governments do not consider such policies as priority areas. A solution to this situation may be to commit some statutory amounts to the implementation of these policies, irrespective of which government is in power at a particular time. This calls for a revision of the 2004 population policy.

In revising the population policy, an important component should be to make it all-inclusive from the formulation stage to implementation. Policies that will significantly reduce the cost

involved in seeking family planning services should be considered. These components (inclusion and access cost) in the fight against population growth have been explicitly silent in previous policy design and targets. Some individuals are sincerely discouraged from the use of family planning services due to the disbelief of the process and the cost involved. Strategies such as ensuring ownership of the process and subsidizing various modern family planning methods and adopting house-to-house service delivery approach may go a long way in mitigating the problem of cost.

These discussions must definitely involve the development partners who should be encouraged to assist in capacity-building and development as well as complement the funding by government. Such discussions should also include the coordination and collaboration of different programmes by different partners and international NGOs.

One key issue that government must address is the funding problem. Over the years limited funds have been made available by the government. The National Population Commission should be strengthened to perform its function adequately. Before the next Census, a new national policy should be put in place.

There should be continuous discussions at the community level. At this point it is important to involve traditional leaders and gatekeepers to adequately understand the importance of fertility reduction. The discussions should move beyond health issues to include economic and social concerns that are raised by unabated population growth. At this level, the importance of NGOs and CBOs cannot be over-emphasised. They are important in terms of concrete programmes for intervention to ensure behavioural changes. Apart from community leaders, religious leaders are also important advocates using various religious ceremonies and opportunities.

The widespread availability of internet and ICT facilities can also make use of internet-based platforms to discuss relevant fertility issues. This is an area where NGOs and CBOs can develop so that the young population can continue to discuss these issues in real time.

In recent times, experts in family planning policies have called for the integration of family planning services with child immunization services. In this strategy, immunization officers are also trained with basic family planning service skills so that they can provide these services to women after immunizing their children. As it has been well documented in the 2004 population policy, achieving reasonably lower population growth is a multi-sectoral issue that deserves multi-sectoral strategies to achieve. This implies that the successes achieved in the targets directed towards family planning and fertility control are also tied to successes in other sectors such as education, nutrition, agriculture, housing, urbanization, etc. There is the need for the government to improve its efforts in the sectors that have indirect impact on population growth. In the case of women in their reproductive ages, providing family planning methods and encouraging their use may also be complemented with empowering them to make appropriate choices. Efforts should also be directed towards improving women education level, employment, gender equality and fairness.

Another critical issue is with the actual process of implementing the various policy targets. In most cases, policy implementation ignores the people directly concerned with the situation. A grassroots involvement approach should be adopted in the formulation and implementing family planning policies. This may go a long way to raise the progress in achieving the set targets.

One issue that will remain germane is the need to evangelise family planning. This is with the view to change the mindset of people; people should be made to understand that qualitative and not quantitative population is the way to go. The various media that can be explored include radio/TV and other mass communication agencies. Also, religious outlets, especially worshipping time, and during marriages, naming ceremonies, burials, etc., should be explored. There is also the need to make available many service outlets in both public and private sectors. Government(s) must also be prepared to invest in research in (a) new and old methods and (b) communication strategies in order to enhance fertility transition in the country

There is also the need to choose the right language and communication acts that are acceptable to the people. This will differ by geopolitical zones. Family planning programmes should be intensified to improve people's knowledge of contraception and reduce their fear of the different methods available. This will include providing better information about the usage of contraceptives and what side effects to expect once they do adopt a method. In addition, family planning programmes should also provide health education to adolescents (male and female), including information on sexuality, responsible parenthood, sexual behaviour, reproduction, family planning, sexually transmitted diseases and gender roles.

Lastly, economic progress as well as reduction in poverty level remains the key to the development of human beings; this is what will reinforce the fertility transition of the country.

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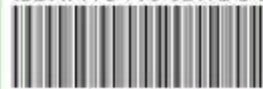
ABOUT CENTRE FOR SUSTAINABLE DEVELOPMENT (CESDEV)

The Centre for Sustainable Development (CESDEV) was established by the University of Ibadan through Senate paper 5386 in May 2010 as a demonstration of the University's commitment to Sustainable Development. It was based on the need to provide intellectual platform for identification of issues germane to sustainable development, critically analyse them, and provide leadership in finding enduring solutions that will enhance sustainable development.

The establishment of CESDEV was sequel to series of events, paramount among which was the winning of a USD 900,000 grant from the MacArthur Foundation to establish the Master's in Development Practice (MDP) Programme. The University of Ibadan was one of the ten original Universities that won the grant in a global competition involving over 70 Universities. Further brainstorming led to defining the composition of the emerging Centre beyond the MDP Programme. It was resolved that a number of development programmes that were "hanging in the balance" be moved to the Centre. The **Centre for Sustainable Development** (CESDEV) thus became a Teaching and Research Centre with a mandate in multi- and inter-disciplinary approach to Sustainability issues affecting not just our continent but the whole universe. The Centre is designed to be a Teaching, Research and Development unit in the University. Presently, CESDEV has the following academic and outreach programmes:

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- ◆ Sustainable Integrated Rural Development in Africa Programme (SIRDA)
- ◆ Climate and Society Programme (CSP)
- ◆ Environmental Protection and Natural Resources Programme (EPNARP)
- ◆ Leadership and Governance Programme (LGP)
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