FACILITATING THE DEMOGRAPHIC TRANSITION IN AFRICA:
ISSUES AND CHALLENGES

VOLUME II. CASE STUDIES OF SELECTED ANGLOPHONE COUNTRIES

BOTSWANA
EGYPT
MAURITIUS
NIGERIA

FSSDD
DECEMBER 1997

ECAC
314.116
F1415
c.2
UNITED NATIONS
ECONOMIC COMMISSION FOR AFRICA

FACILITATING THE DEMOGRAPHIC TRANSITION IN AFRICA:
ISSUES AND CHALLENGES

VOLUME II. CASE STUDIES OF SELECTED ANGLOPHONE COUNTRIES

BOTSWANA
EGYPT
MAURITIUS
NIGERIA

FSSDD
DECEMBER 1997
# TABLE OF CONTENTS

## BOTSWANA

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. BACKGROUND</td>
<td>4</td>
</tr>
<tr>
<td>II. POPULATION DYNAMICS</td>
<td>4</td>
</tr>
<tr>
<td>III. POPULATION POLICIES AND STRATEGIES</td>
<td>5</td>
</tr>
<tr>
<td>A. Education</td>
<td>6</td>
</tr>
<tr>
<td>B. Health Care</td>
<td>7</td>
</tr>
<tr>
<td>C. Employment</td>
<td>8</td>
</tr>
<tr>
<td>D. Poverty</td>
<td>9</td>
</tr>
<tr>
<td>E. Gender Considerations</td>
<td>10</td>
</tr>
<tr>
<td>IV. CONCLUSION</td>
<td>10</td>
</tr>
</tbody>
</table>

## EGYPT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. SOCIO-ECONOMIC BACKGROUND</td>
<td>12</td>
</tr>
<tr>
<td>II. POPULATION DYNAMICS</td>
<td>13</td>
</tr>
<tr>
<td>A. Population Size and Growth</td>
<td>13</td>
</tr>
<tr>
<td>B. Fertility Levels and Trends</td>
<td>13</td>
</tr>
<tr>
<td>C. Mortality Levels and Trends</td>
<td>14</td>
</tr>
<tr>
<td>D. Causes of rapid population growth</td>
<td>14</td>
</tr>
<tr>
<td>III. POPULATION POLICIES AND STRATEGIES</td>
<td>16</td>
</tr>
<tr>
<td>IV. CONCLUSION</td>
<td>17</td>
</tr>
</tbody>
</table>

## MAURITIUS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. SOCIO-ECONOMIC BACKGROUND</td>
<td>18</td>
</tr>
<tr>
<td>II. POPULATION DYNAMICS</td>
<td>20</td>
</tr>
<tr>
<td>A. Population Size and Growth</td>
<td>20</td>
</tr>
<tr>
<td>B. Marriage and fertility rates</td>
<td>20</td>
</tr>
<tr>
<td>C. Mortality</td>
<td>21</td>
</tr>
<tr>
<td>III. POPULATION POLICIES AND STRATEGIES</td>
<td>22</td>
</tr>
<tr>
<td>A. Family Planning and Health Care Services</td>
<td></td>
</tr>
<tr>
<td>B. Education</td>
<td>25</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>IV.</td>
<td>CONCLUSION</td>
</tr>
<tr>
<td>NIGERIA</td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td>SOCIO-ECONOMIC BACKGROUND</td>
</tr>
<tr>
<td>A.</td>
<td>Economic Evolution</td>
</tr>
<tr>
<td>B.</td>
<td>Migration and Urbanization</td>
</tr>
<tr>
<td>C.</td>
<td>Education and Literacy</td>
</tr>
<tr>
<td>D.</td>
<td>Health, Water and Sanitation</td>
</tr>
<tr>
<td>II.</td>
<td>POPULATION DYNAMICS AND DETERMINANTS</td>
</tr>
<tr>
<td>A.</td>
<td>Population Size, Structure and Growth</td>
</tr>
<tr>
<td>B.</td>
<td>Fertility Levels, Trends and Determinants</td>
</tr>
<tr>
<td>D.</td>
<td>Mortality Levels, Trends and Determinants</td>
</tr>
<tr>
<td>III.</td>
<td>POPULATION POLICIES AND STRATEGIES</td>
</tr>
<tr>
<td>A.</td>
<td>National Health Policy and Strategy</td>
</tr>
<tr>
<td>B.</td>
<td>Impact of Policies and Strategies on Population Growth</td>
</tr>
<tr>
<td>IV.</td>
<td>CONCLUSION</td>
</tr>
</tbody>
</table>
I. BACKGROUND

Botswana with a size of 582,000 Square Kilometre lies at the centre of Southern African Plateau sharing borders with the Republic of South Africa, Namibia, Zambia and Zimbabwe. 85 percent of the land mass is covered by the Kalahari Desert. The whole country has, therefore, a semi-arid climate with scanty rainfall. The country has in recent years experienced intermittent drought conditions that have been hitting the whole of the Southern belt. The availability of water is the determinant factor influencing the pattern of settlement. Thus, 85 percent of the population live in the Eastern part of Botswana where rainfall is more regular, ground water is available and soil relatively fertile. The semi-arid climate limits the arable land to 5 percent of the total land area which constrains agricultural production.

Botswana is one of the very few African countries that have achieved an impressive economic growth since independence, GDP growth has averaged 6 percent per annum in real term over the whole post independence period. Between 1996 and 1991 its annual rate of growth was 13 percent. Its per capita income increased nine fold over the period making five times over the average of sub-Saharan Africa in 1991. Botswana has continued to enjoy vibrant economy through to 1996. Real Domestic Product 1995/96 is estimated to have grown by 7.0 percent and per Capita income increased by 4.3 percent. The Success of Botswana economy is attributed to a combination of factors including prudent management of its economy, promoting favourable macro-economic policies as well as good earnings from its exports. The economy has been driven by a thriving diamond industry combined with favourable international prices. Added to this is the commitment of the government to stick to its national development plans and reinvesting a significant proportion of its diamond revenues into building social and physical infrastructures throughout the country. The promotion of the principle of democracy has also been one of the attributes that has helped to preserve stability so that there are very few ethnic divisions within the Botswana society. In addition is the maintenance of one working language (Setswana) which seem to have added a unifying factor among the people.

II. POPULATION DYNAMICS

The population of Botswana is rapidly growing: between 1971 and 1991 it increased from 584,644 to 1,326,796 thus between 1971-81 and 1981-91 it increased at the rate of 4.9 percent and 3.5 percent respectively. The high rate of population growth follows declines in infant mortality and the young structure of the population. Based on these trends, it is projected that the population of the country will reach 1.7 million by the year 2001. The population is projected to double in 30 years time.


The country’s population is relatively youthful with the children under 15 years of age constituting 43.6 percent of the total population. The median age is about 19 years which means that the dependence ratio of the population is very high. The above 65 years make up only 5 percent of the entire population. There is equal ratio of male and female both in rural and urban areas.

Botswana’s is unevenly and sparsely populated with the average population density of around 2.6 person per Kilometre. However, there are districts like the Southeastern districts which are most densely populated with population of 87 persons per square kilometres as opposed to the Western districts which remain least populated with densities as low as 0.2-0.8 per square kilometre. Another phenomenon with the country’s population distribution is the high rate of rural to urban drift. The urban population was estimated to be 45.7 percent of total population in 1991 a jump from the 18.2 percent it was in 1981. However some of the seemingly rapid increase is explained by the decision to reclassify the rural villages to urban districts. Nevertheless there are still many factors pulling population to urban areas which include the search for economic opportunities particularly in the face of diminishing returns from agricultural ventures caused by the recurrent drought situation. Labour migration has historically been an important feature in the country’s population profile. Botswana’s migratory patterns has historically been characterized by the labour movement to South African Mines as with most of other South African neighbouring states. However this has been on the decrease in recent years.

Botswana has managed to tremendously reduce its mortality levels between 1991 and 1996 period. Crude death rate declined from 13.7 per 1,000 in 1971 to 11.5 per 1,000 in 1991 and to current levels of 7.7 per 1,000. Infant mortality levels have also dropped from 97.1 to 48.0 during the 1971-91 period and they are currently at 42 per 1,000. Similarly, childhood mortality is down to 32.4 in 1996. Life expectancy rate has risen both for urban and rural population although there is still discrepancies. The urban life expectancy at birth rose from 62.4 years in 1981 to 67.7 years in 1991 whereas, rural life expectancy has improved from 54.9 years to 62.3 years in the same period. The narrowing of gap in life expectancy between rural and urban has been facilitated by the spread of social infrastructures including health care services and schools in the rural areas.

Notwithstanding the overall achievement in mortality reduction, Botswana like many other African countries is now faced with the threat of HIV/AIDS pandemic. The increase in cases infected has rapidly grown to the extent that in 1995 estimates put the figure of around 180,000 people believed to be HIV positive. This represented 13 percent of the over all population and 23 percent of the sexually active population3/1. The added worry is that this figure is rising in spite of the fact that about 80 percent of the population are aware of the disease and there is increased use of preventative measures like condoms.

III. POPULATION POLICIES AND STRATEGIES

Botswana has undergone the first phase of demographic transition as reflected by the declines in infant mortality which is followed by the current rapid increase in its population growth due to youthfulness of its population. The policies employed so far in population...
management including provision of social services, family planning services, child and maternal health care, have all contributed to achieving remarkable results in such a short time. The challenges is for the country to employ strategies and policies that will sustain the progression of transition to lower fertility levels. This implies instituting more self sustaining socio-economic policies to improve the lives of people through better education, health care, increasing employment opportunities, maintaining essential social and physical infrastructures and above all ensuring food security.

The economic success of the country throughout the 1980s combined with the governments unwavering commitment to spread social benefits to a wider spectrum of society has contributed to the reduction of infant mortality. However, to meet the needs of high growing population which now constitute a very young age would obviously put a lot of constrain on the country’s available resources. Against the backdrop of projected decrease in economic growth resulting from extended droughts and the undiversified nature of the economy, there is genuine fear that the government might not be in a position to sustain all the welfare benefits that are currently extended to the society and that poverty will most likely be a serious issue. Already there are a number of problems in the distribution of facilities in some key social sectors as explained below.

A. Education

Education is crucial for increasing productivity of the country’s human resources that will transform the economy into prosperity thus ensuring higher incomes. An informed society is also more likely to appreciate and take personal charge of the various dimensions of population issues. The increased demand for education due to high population momentum is already proving difficult to satisfy. Primary school age population grew at the rate of 4.2 percent in 1991. With the introduction of Universal education, Botswana children are assured free basic education for at least 10 years. Botswana’s comprehensive Education programme consists of special assistance to destitute children and those in remote areas, providing feeding programmes, providing physical infrastructures like classrooms and hostels for remote schools, involving communities in the running of schools and establishing national literacy programmes. With these provisions primary school enrolment has reached 83 percent although with regional differences. The variation is as high as 95 percent in Orapa to as low as 66 percent and 65 percent in Ngamiland South and Kweneng West respectively.

In spite of the remarkable improvement in ensuring greater access to education, there are a number of constraints that have arisen as a result of demographic factors. Rapid population expansion combined with remoteness of some areas make it difficult for the government to provide equitable education to all. Already resources to meet the expanding demand are highly constrained. There is reportedly shortages in facilities including classrooms estimated to be at the ratio of 30 percent nationwide. The number of teachers are also inadequate.

Botswana is one of the few African countries that have historically managed to achieve reasonable gender balance in education. If at all, girls enrolment has in many cases
out numbered that of boys. It is only in recent years that cultural changes have led to putting emphasis in boys education rather than keeping them at the cattle post as has been the case before\textsuperscript{5}. While boys are slowly closing the gap, girls are experiencing the problem of increased incidence of drop out due to teenage pregnancies. Of the 2,168 girls who dropped out of school in 1993, 62 percent were pregnant\textsuperscript{6}. This is a growing problem as it compromises the girls' potential in terms of future job prospects as well as becoming effective partner in development. In addition adult literacy rates show higher ratios for female in most districts except those remote areas like Ghanzi and Kgalagadi\textsuperscript{7}.

B. Health Care

Botswana government has whole heartedly embraced the social goal of Providing health for all and has also accepted the strategy of primary care as a mean of attaining that goal\textsuperscript{8}. Health is interlinked with many other socio-economic factors which include provision of basic facilities like water, shelter, sanitation, education of girls. The government's impressive record of expanding social infrastructures has already brought some positive results as reflected in the reduction of infant mortality. About 90 percent of Botswana live 15 kilometre within reasonably well run health facilities. Nearly 90 percent of the household have access to safe water supply. These data have regional variation due to the sparse nature of the country. The Western parts of the country are not easily serviced with these standard package of health services and have to be reached by mobile stops.

Botswana is said to be undergoing "health transition" which go hand in hand with the demographic transition\textsuperscript{9}. This refers to changes in epidemiology, changes in risk environment and health needs across social and economic classes. This is brought about by the changes in life styles from rural subsistence to urban market oriented that result in changes in their diet, housing, sanitation which reduce incidence of infectious diseases but increases risk of cardiovascular and other chronic diseases. There is also the threat of Botswana entering what the author refers to as "epidemiological poloralisation"\textsuperscript{10} which \textit{inter alia} includes a state of differences in health status within the country whereby there is a high prevalence of infectious diseases, malnutrition and high fertility among the poor. It is the government's role to minimize epidemiological poloralisation. Health care in Botswana is in the hands of not only government but Religious groups, major industries in addition to private sector. The central element in the government's health policy is to conduct a full set of primary health care programme throughout the country in an integrated way. The range

\textsuperscript{5/} Direen Nteta, Janet Hermans and Pavla Jeskova Editors, Poverty and Plenty, The Botswana Society, P. 212.

\textsuperscript{6/} Poverty and Plenty, Op. cit. p.224


\textsuperscript{8/} Poverty and Plenty, op. cit. p. 292


\textsuperscript{10/} Ibid Poverty and Plenty, p. 293.
of health services delivered in the public health system have expanded over the years to include Mother and Child Health including antenatal care, child welfare and growth monitoring, family planning, supervised delivery in addition to immunization, treatment of common disease and disease control, nutritional related activities and mental health. The Ministry of Health is the main provider of the modern contraceptives accounting for 92.2 percent of current users. The services were found to be client friendly for instance Family Services are provided daily at all three levels i.e, hospitals, clinic, health posts. As such 85 percent of the population is within 15 kilometre of one of the health facility.

Such improvement in health services over the years have contributed greatly to the overall quality of life reducing diseases, raising life expectancy and reducing infant mortality. This has obviously been reinforced by other attributes which include universal provision of safe water, education of girl child and improvement in child nutrition. The impact of social policy strategy as manifested in the various services discharged to the public has brought significant results as the social indicators show. Botswana is one of the few African countries with high level of contraceptive use. It rose from 29 percent in 1988 to 32 percent in 1991. The population with access to clean water was 83 percent with rural lagging behind proportionately. Rural access stood at 64 percent in 1994. All water drawn from public stand pipes is free although this is likely to change because there is intention of introducing a user fee.

Botswana is now entering into a stage whereby the health interventions that have worked wonders in the 1980s to reduce infant mortality rates could not bring the same impact into the twenty first century with the rate at which population is growing which is constraining the resources. The rise in HIV/AIDS pandemic is another challenge facing the health status of Botswana which is causing rise in adult morbidity and mortality as well as a source of resurgence of tuberculosis.

C. Employment

Access to employment opportunities is important in improving a household income, ensuring better nutrition, health care, education and the various attributes of qualitative life. Employment opportunities to women in particular have been associated to lowering fertility rates and generally reduce poverty. Although Botswana’s formal employment grew rapidly between 1966 and 1991 with the reduced economic growth of the 1990s, employment faltered slightly in 1992 and 1993. Formal employment rose only by 1.3 percent between 1994 and 1995. The future outlook for employment expansion does not look very bright. The government sector has in the past been responsible for generating much of formal employment but there is limit now to how it can expand given that governments all over are withdrawing from active production and trade. Expansion in the private sector is limited due to the nature of the economy that is heavily dependent on capital intensive mining industry. Agricultural sector traditionally provided most Setswanas with livelihood but its contribution to GDP has continued to go down. While it accounted for 42.7 percent of GDP in 1966 in


1994/95 its share dropped to only 4.1 percent to GDP. The problems in the sector have been the intermittent drought conditions combined with outbreak of cattle lung disease which at one point forced the destruction of 300,000 cattle. Scarcity of arable land is another constraint which all put together with drought conditions make agriculture less viable activity in Botswana. Consequently food import bill for Botswana is quite high.

Employment opportunities are weighted against women the majority of whom are in rural areas. It has been estimated that the majority of economically active people are in rural area and three quarter of whom are women. It is also estimated that females are still in the minority in cash employment although their rate has been increasing over the years. Male cash earners were 3.1 times more than female in 1971 but by 1991 the gap had narrowed to 1.7 times. Women are dominate in Education and clerical jobs while male have benefitted in the increase of government administration jobs which put the majority of women in the lower paid job categories. It has noted that the burden of unemployment is disproportional falling on women and those most affected are the youth between (ages 15-34). Unemployment in Botswana is currently 22 percent of labour force and growing at the rate of 3.5 percent per annum. Because of relatively few job opportunities there is a growing incidence of poverty in the country. 37 percent of Botswana’s households were classified as poor in 1994 and 46 percent incidence of poverty among individuals. Poverty is highest among rural dwellers particularly the Female Headed Households.

D. Poverty

The government has initiated a number of measures designed to address the problem of poverty in general and unemployment in particular. Many of these have been targeted to the rural population since the government emphasis in all the development plans have been to improve the rural sector. some of these programmes are:

i) To put in place a strong drought preparedness scheme whereby famine relief programmes targeting vulnerable groups like women and children are conducted;

ii) A permanent feeding programme called Remote Area Dweller(RAD) for remote people and destitute;

iii) The Financial Assistance Policy(FAP) meant for providing start up capital for establishing small scale business in manufacturing mainly for semi skilled people which has enabled people to establish businesses ranging from flour milling, brick making to welding and baking;

iv) The public works schemes run by the District Councils. These are basically relief and rehabilitation programme to compensate loss of crop through drought in return for labour which involves improving rural infrastructures like roads.
However well meaning these programmes are they have met with some short comings some of which are issues of impact as only few people can be rescued. Others are to do with the management of the programme.

E. Gender Considerations

Botswana has done reasonably well in closing gender balance in various social aspects particularly in education, health and to some degree employment. However, at a closer examination there are still some socio-cultural factors that are preventing women from achieving their full potential and thus enabling them to effectively contribute to the country’s development. Available data show that poverty among women remain an important issue. Female Headed Household (FHH) are among the most vulnerable to poverty. FHH constitute 47 percent of all households and they usually have to survive on lower incomes. It was found that 41 percent of FHH were poor as opposed to 34 percent Male Headed Households (MHH). The majority of poor FHH are concentrated in the rural areas which demonstrates their inability to get into the formal job market. Although when it comes to the very poor, the FHH are not very worse off than the MHH this is due to the relative level of education attained between the two groups. Access to employment in the urban area is another reason that puts many women in poverty bracket.

Legal and cultural constraints have impeded on women’s rights and freedom to acquire property including land, advancing their career opportunities in the commercial sector. Women are also predisposed to a number of preventable health problems that need to be addressed particularly maternal deaths and increased teenage pregnancy. Increased teenage pregnancy is a growing menace to women’s advancement. Teenage account for 18 percent of all births, most of them are not in stable union and would tend to seek illegal abortions thus putting their lives in danger. Teenage account for 28 percent of maternal death in the country. Women’s access to tertiary education has been hindered by low performances. The gender balance in education that has been achieved has been more at the primary levels which has provide less opportunities for women in as far as getting into gainful employment.

IV. CONCLUSION

Botswana has made great strides in improving the key economic and social sectors particularly, education, health, water and roads. All these have contributed to attaining positive demographic indicators i.e reduced infant mortality, increased life expectancy at birth etc. A higher proportion of population have access to education, health services, safe water and sanitation etc.

In spite of this achievement, substantial sector of the population remain poor. Household income and expenditure survey (HIES) of 1993/94 showed that 38 percent of Botswana households were considered poor, although this was an improvement from the previous score of 49 percent. Proportion of households that were considered poor in 1985/86, 18/ For discussion on these see NEMIC paper #3 p. 5 and The Botswana Society, Poverty and Plenty, p. 71.
it is still high. When poverty was considered on the individual basis the figure was even higher. It was 47 percent individuals considered poor, the difference between the household and individual basis is due to the fact that the poor have larger than average households. Looking it from another angle, it was found that the richest 20 percent of the households received 61.2 percent of the total national income whereas the 40 percent of the households received 9.4 percent of the national income. It is apparent that the distribution of the country's income is highly eschewed. It has already been demonstrated that poverty falls disproportional on the rural population and particularly on the Female Headed Households.

The issue of poverty in Botswana is closely related to employment opportunities and this subsequently has influence on how far the country can sustain its achievements so far in population management. Botswana Family Health Survey has already indicated a significant difference in Total fertility rates between the rural and urban areas whereby urban rates averaged 3.8(1987) as opposed to 5.5 for rural area with 5.0 as the national average. Education has also been found to be strongly correlated with fertility rates for women with secondary and higher education had rates of 3.4 against those women who had no schooling or completed just primary education having rates of 5.9 and 4.7 respectively. Education is one axis to better employment opportunities and subsequently contributes to higher incomes and better and assurance to better quality of life.

The people in Botswana, unlike other African countries have to look for gainful employment outside the traditional agriculture because of the harsh physical features of the country that limits the expansion of agriculture. This situation has been a major source of rural to urban migration which is at the rate of 46 percent. The government has a big challenge of creating more formal employment. There is also the problem of physical size of the country where population are so dispersed to remote communities which make it very difficult and expensive to reach and ensure they have access to public services including schools, health care, water etc.

The new Population Policy which was adopted in August 1997, proposes a comprehensive multi-sectoral institutional and organizational arrangement for coordinating and implementing population issues both at the national and local levels. This promise to ensure a sustained monitoring and ensuring the interventions are done timely.

EGYPT

I. SOCIO-ECONOMIC BACKGROUND

Egypt is located in the northeastern corner of the African continent. It occupies around one million square kilometres but most of the territory is constituted by the desert. Although the Egyptian government has adopted a policy of land reclamation and fostering of new settlements in the desert, the majority of Egyptians still live either in the Nile Delta located in the north or in the narrow Nile Valley and this inhabited area is equivalent to only 6% of the total area. The Frontier Governorate which are mostly part of the desert contains 1 percent only of the total population. The population density in the inhabited area is estimated to be above 1,000 persons per square kilometre (EDHS, 1995). However, this figure fluctuates considerably both within and between governorate. For example, the population density in Cairo governorate is said to be above 10,000 persons per square kilometre with some areas exceeding 33,000 people per square km. By contrast, the Suez governorate has only 23 people per square km.

The annual Gross Domestic Product (GDP) per capita was around U.S.$200 in the 1970s but had reached more than U.S.$600 in 1993. It increased more than three times in a span of twenty years or so and at an average annual growth rate of more than 8% which exceeded by far the population growth rate during the same period. Between the 1960s and the 1990s there has been a shift also from agriculture led growth to an industrial led growth. In 1960, agriculture represented 40 percent of GDP but by the 1990s the agricultural sector contributed to less than 20 percent of GDP. On the other hand, the industrial sector which represented around 15 percent in the 1960s has expanded to 22 percent (World Bank, 1995).

Indicators of human development have also improved. They include among others an overall increase in the school enrolment ratio and a decline in the illiteracy rate which is a direct result of higher spending on education. Of particular interest is the way female enrolment rate increased. At the primary level, the female enrolment rate went from 57 percent in 1970 to 92 percent in 1992 while at the secondary level it went from 23 percent in 1970 to 73 percent in 1992 (World Bank, 1995). Moreover, there has been an overall improvement in the basic social services which is reflected in the rise of life expectancy. In 1992, it was estimated at 64.8 years for females and 62.4 years for males (UNDP, 1995).

With a population estimated at more than 63 million in 1996 (UN, 1997), Egypt is the 17th most populous country in the world. Moreover, the Egyptian population is still growing very fast since the population growth rate stood at 2.1% in 1996 though it was much lower than the 2.8% of 1986. Thus, Egypt is still a long way on the road to achieve the demographic transition, but nevertheless the accomplishments of the Family Planning Program are impressive and worth noting. The contraceptive prevalence rate has risen from less that 10% in 1960 to almost 50% today and total fertility has dropped by nearly half in thirty years to reach the level of 3.9 children per woman. However, there are still sharp differences especially between urban and rural areas. In general big cities, like Cairo or Alexandria, are reaching a situation of replacement level fertility while in most rural areas fertility is still high. Socioeconomic and other cultural factors do play also an important role since it has been found that fertility levels are correlated for example to female educational level and others. Fortunately, recent surveys have revealed that there is a high potential
demand for family planning services in high fertility areas, and thus the challenge facing Egyptian authorities is to find appropriate ways to satisfy this demand.

II. POPULATION DYNAMICS

A. Population Size and Growth

The total population of Egypt stood at some 26 million people in 1960 and was above 59 million in 1995. This represents an average annual growth rate of nearly 3.6 percent over the past three decades. As will be seen below, this high population growth rate was a result of a high rate of natural growth of the population.

This natural growth rate is the difference between the crude birth rate and the crude death rate. In Egypt, between 1900 and 1920 the natural growth rate was usually less than 1 percent (it was 0.6 percent in 1920). Between 1920 and 1960 this rate went up as the death rate was declining rapidly while the birth rate was increasing albeit slowly. By 1960, the natural growth rate was 2.7 percent. Then, between the 1960s and the 1970s this rate decreased but resumed its ascension again between the 1970s and the 1980s. In the early 1980s, the rate was at a record high of around 3% per annum. Thereafter, it went down again so that by the late 1980s to the early 1990s it had reached a level of 2.2% (NPC & Options II Project, 1994, p.2). In 1994, the natural growth rate was a little bit less than 2.2% suggesting that in the 1990s it has somewhat stagnated.

This natural growth rate is a major determinant of population growth. Countries achieving or undergoing the process of demographic transition have natural growth rates usually less than 1%. Since the Egyptian natural growth rate has been and is still high, we should expect that its average annual growth of population will be much higher and that its population will continue to grow at a relatively sustained rate in the near future.

B. Fertility Levels and Trends

The rapid growth of population in Egypt is largely a result of the country’s high fertility rate. Between the two World Wars, the birth rate was increasing. Thus, in 1920 the birth rate was 42% but by 1950 it stood at 50%. However, after 1950, fertility rates started to decline until the 1970s when they picked up again. In 1972, the crude birth rate (CBR) was 34.5 births per thousand populations while in 1985 it stood at 39.8 births per thousand. The decline resumed in the later 1980s so that by 1994 the CBR had dropped to 28.6 per thousand populations (CAPMAS, 1995).

The total fertility rate as found in the EDHS (1995) indicates that if fertility rates were to remain at their prevailing level between 1993-1995, the average Egyptian woman would bear 3.6 children during her reproductive life. This is significantly lower to the 7.2 children of 1952 or the five children of the early 1980s but nevertheless it remains high. This is especially true since the rate for rural women is still at 4.2 children while they do represent around 60% of all women.
C. Mortality Levels and Trends

The crude death rate (CDR) had stabilized at 36 deaths per thousand since the early 1900s. It is only after the First World War that the death rate started to fall until it reached eventually the level of 17 deaths per thousand populations in 1960. However, unlike the CBR, the CDR kept a steady decline. Thus, in 1986 it was estimated at 9.2 per thousand and in 1994 at only 6.8 deaths per thousand (CAPMAS, 1995).

Much of the decline was owed to a sharp reduction in the infant deaths. Infant mortality levels decreased from 200 deaths per thousand births in the 1940s to 124 in the late 1970s and were still declining albeit at a slower rate. There is still further scope for reduction of infant death rates since the EDHS (1995) revealed that between 1991-1995, the infant death rate was still at a staggering 63 deaths per thousand births.

D. Causes of rapid population growth

As found in the EDHS survey of 1995 there are several reasons to this problem. Among the most important causes are the relatively low age at first marriage, the little control that women have over the most important aspects of their lives, the high teenage childbearing, the short births intervals, and finally the relatively high family planning and contraception discontinuation. All these factors have an important and in most case an undeniable implication on the demographic composition and growth.

1. Age at first marriage

In general, the age at marriage is still low in Egypt compared to countries undergoing or that are achieving a demographic transition. Though there has been a steady increase in the age at first marriage, the median age at marriage in Egypt is still at only 19.3 years for women between age 25 and 49. This is still low compared for example to the Indian village of Kerala where the age at marriage is more than 23 years or with Sri Lanka where it is more than 24 years old for women. A closer example is the difference between Tunisia and Egypt. In Tunisia, the median age at marriage for women ages 25-29 is 23.2 years while in Egypt it is three years lower (20.2 years). Thus, in general an Egyptian woman is exposed for much longer to the risk of pregnancy than a Tunisian woman.

However, within Egypt itself there are large disparities. In Upper Egypt which is home to 35% of the population, the median age at first marriage for women 25-49 is still at only 17.8 years and for 80 percent of these women in Upper Egypt who happen to live in the rural area the median age at first marriage is only 16.9 years. In rural Lower Egypt which is home to a little more than 50% of the population, the age at marriage is only 18.6 years.

2. Constraints on women over major decisions

Women in Egypt have usually little power over major decisions which concerns the major aspects of their lives. For example, most women did not select their spouses (three out of four women married) and that explains the large differences (especially in age and
education) found between husbands and wives. Moreover, Egyptian women have little autonomy in the decision-making process at the household level. They seldom have the final word on major decisions and these include decisions like seeking medical attention. This situation is compounded by the fact that most women move in with their in-laws right after their marriage.

3. Teenage childbearing

Usually, the latter the first birth the larger the decline of the overall fertility. In Egypt, though the teenage childbearing has decreased substantially, it is still high. The EDHS (1995) report that overall, one in 10 teenagers has given birth or is pregnant with her first child. However, this is a substantial improvement since among women of age 45-49, 47.4% of them had their first birth in their teenage years compared to 28.9% for women aged 20-24 and 7.3% for those aged 15-19 years. The proportion of women who began childbearing in their teenage years rise rapidly throughout the teenage years. Thus, it is less than 1 percent among 15 years-old women and jumps to 9 percent among 17 years old women and 25 percent among 19 years old women. In the overall teenage childbearing, the highest level is reached with teenagers in rural Upper Egypt (18 percent) while the lowest is found in urban areas (7 percent).

4. Short birth intervals

Closely spaced births are common in Egypt. More than a quarter of all non-first births occur within 24 months of a previous birth and in general, younger women tend to have shorter birth intervals. The EDHS (1995) found that the median interval between births is 20 months for women age 15-19. One factor contributing to this short birth interval is the short period of postpartum protection from pregnancy. This protection period is reduced as a consequence of breastfeeding practices, particularly the early introduction of supplemental foods (EDHS, 1995).

5. Trends in family planning use and contraceptive discontinuation

The level of use of contraception and family planning in general is a major determinant of the fertility level and the measurement of the success of the family planning program. The contraceptive prevalence in Egypt is still at only 48 percent (though it represents a substantial increase from the 24 percent of 1980). In urban areas, the prevalence rate is above 50 percent while for example in rural areas of Upper Egypt it is still at 24 percent. The EDHS survey (1995) found that the pace of change was rapid in the 1980s but slowed significantly in the 1990s, and there was no increase in the overall rate of use between 1991 and 1995.

Moreover, the 1995 data of the EDHS indicates also that many users discontinued the use of contraception within 12 months of starting it. Three out of 10 users discontinue the use of contraception within one year of starting it. This discontinuation was found to be usually a result of side effects or health concerns. This discontinuation rate is an indicator that there is a need for a better counselling in the selection of the method to be used and a better follow-up.
III. POPULATION POLICIES AND STRATEGIES

The concerns about high population growth started early in Egypt. The National Charter adopted in the early 1950s indicates that high population growth constitutes a major impediment on the raising of the living standard of the Egyptian people. However, it is only toward the late 1960s that a national family planning program was established with the mandate of reducing fertility. The Ministry of Health spearheaded the action and family planning services were added in over two thousands government hospitals, clinics, health stations and substations. These actions had the support of leading Islamic scholars and thus family planning was introduced in the teaching of Islam. However, it is worth noting that at this stage there was no implication of the private sector.

The first population policy was adopted in the early 1970s and this population policy was accompanied with increased governmental activities related to family planning. In the early 1980s and then again in the mid-1980s, the second and third population policies were adopted respectively. The last and current policy emphasized the seriousness of the population problem and recognized the interaction between population and development.

The National Population Council (NPC) was established in the early 1980s with the mandate to coordinate all efforts in family planning, child welfare and, women’s participation in the labour force and literacy. In the 1990s, following the International Conference on Population and Development (ICPD), a modified population strategy was developed. This new strategy placed a greater emphasis on providing reproductive health services and supporting non-governmental organizations (NGO) in the development of local communities and in the social marketing of contraceptives.

The efforts of the government are reinforced by efforts from NGOs, the Cairo Demographic Centre (CDC) and the International Islamic Centre for Population Studies and Research (IICPSR) of Al-Azhar University. Of particular interest is the Islamic Centre. Its objectives are to conduct population studies and research in the Muslim World and to add credibility to the population information obtained before its dissemination in Muslim countries. In particular, the Centre aims to dispel misconceptions about Islam and certain population policies which can be adopted in the Muslim World. The Centre has a few branches in rural area that provide health services for rural population and which is a base for researches and training in reproductive health.

All these efforts invested in the Egyptian family planning program have not been vain. Contraceptive use in Egypt has doubled in 15 years, from 24 percent in 1980 to 48 percent in 1995. Moreover, knowledge of family planning methods and sources is universal among women in Egypt. Broadcasts of information about family planning have wide coverage to the point that more than eight in 10 ever-married women have heard a family planning message. Family planning use has also a broad support. Thus, nine in 10 married women and eight in 10 married men approve the use of contraceptive methods while seven in 10 currently married women have used a family planning method at some time.
The new stated objective of Egypt is to reach a replacement level fertility (an average of two children per family) by the year 2015. To attain that objective it is expected that the family planning program must reach a contraceptive prevalence rate of 74% and for this to happen, the program must be successful in generating new demand especially in rural areas. Thus, the new program action that has been adopted includes:

i) The broadening of the client’s choice so that the available contraceptive methods meet the desires of couples;

ii) The improvement of the quality of services through additional and improved clinical and counselling training, and enhancement of existing infrastructures;

iii) An increase of the community outreach programs for education and services especially in rural areas;

iv) The development of specific local goals and plans to guide the decentralization process of the family planning program;

v) The support of parallel and complementary social programs for women’s education and employment; and finally

vi) To ensure that adequate and sustained resources are committed to family planning.

IV. CONCLUSION

Since the early 1960s, Egypt has invested a substantial amount of resources on family planning programs. Though the results are impressive, Egypt is still a long way on the road to achieve the demographic transition. This under performance is most probably a consequence of the lagging socioeconomic changes that are yet to happen in most parts of the country especially in rural areas. In big cities like Cairo and Alexandria, the demographic transition is already underway though it is dampened by rural to urban migration. The rural areas, however, are yet to undergo these changes. Thus, for Egypt to achieve successfully the demographic transition, it has to improve the quality of life in general in all areas and this, in return, will boost the impact of the family planning programs.
I. SOCIO-ECONOMIC BACKGROUND

With an area of 1,843 square kilometres, the country of Mauritius consists of the main island of Mauritius and a number of outlying smaller islands, the largest being the island of Rodrigues. It is located at latitude 20 degree south and longitude 58 east, some 800 kilometres from the south-east of Madagascar in the south-west Indian Ocean. Mauritius enjoys a maritime climate, which is tropical in summer and subtropical in winter. The islands are prone to cyclonic depressions almost annually between the months of December and April. The remoteness of the island, its relatively late settlement (17th century) and the specificity of the microclimates had led to the evolution of plant and animal species unique to the island. Besides its limited land resources, the country has a narrow natural resource base, with no mineral resources. Therefore, because of the very high population density, pressure on land resources is tremendous.

Mauritius has reached a fairly good level of economic development among the developing countries. Until a few years ago, agriculture, through sugar cane and tea as main cash crops, has been the main activity of Mauritius when the industry sector expanded to become foreign exchange earner of the country. The island has then evolved from a low-income, agriculture-based economy with a 1970 GNP per capita of about $ 300 to a middle-income diversified economy with a GNP per capita of about $ 3,280 in 1995 (World Bank, 1996. Trends in Developing Economies). Sugar production was predominant in the economy and provided almost 20 per cent of GDP and over half of export earnings. In 1994, the role of the sugar sector was reduced to 6 per cent of GDP and to about 21 of export earnings as result of diversification into manufacturing and tourism.

Mauritius strong performance has been made possible by liberal economic environment, including an open exchange and trade regime, incentives for foreign private investment, strong resource mobilization, conservative public expenditure policies, prudent credit expansion, and good governance (World Bank, 1996).

Gross Domestic Product (GDP) at market prices reached the level of Rs 68,135 million\(^{16}\) (equivalent to about 3,400 M. US$). Over the period of 1992-1995, the Mauritian economy registered an average annual real growth of 5 per cent, which was lower than the average rate of 6 per cent recorded during the period 1990-1992. Excluding the sugar sector which was affected by unfavourable climatic conditions, the average gross rate registered in both periods remained the same.

Per capita income, taken as per capita at current market prices, grew at an average annual rate of around 10 per cent over the period of 1992-1995 to reach Rs 60,404 (about US$ 3020) by 1995, thus confirming the position of Mauritius among the middle-income countries as per the World Bank classification.

The overall performance of agriculture in terms of contribution to GDP is decreasing over the years to be only 9.3 per cent in 1995, reducing its share in total employment to 13.7 open cent for the same year. As for agricultural exports, their contribution to total exports earnings dropped from 32.9 per cent in 1991 to 30.4 per cent in 1994. Although the area under cane as well as employment in the sugar industry continued their downward trends, the sugar sector will remain critical in the foreseeable future especially in view of the favourable treatment afforded to sugar exporters under the Lomé Convention.

The marine environment contributes substantially to the Mauritian national economy through rational exploitation of its living and non-living resources. The living resources comprise fisheries, mangroves, seaweeds and sea grasses and the non-living resources that have been so far exploited include coral sand, coral (liver and fossil) and common salt. Fisheries and marine resources are important contributor to the island economy.

The manufacturing sector is one of the main pillars of the economy. Around 23 per cent of GDP was accounted for by this sector during the period 1992-1995. The manufacturing sector comprises three major sub-sectors: (i) sugar milling, (ii) the EPZ sub-sector, which is primarily concerned with export activities, and (iii) the "Other manufacturing" sub-sector which is mainly geared to the domestic market.

The contribution of the sugar milling sub-sector to the manufacturing sector's value-added declined over time and remained at around 7 per cent during the period 1992-1995. Although the area under cane as well as employment in the sugar industry continued their downward trends, the sugar sector will remain critical in the foreseeable future especially in view of the favourable treatment afforded to sugar exporters under the Lomé Convention.

Industrial output comes primarily from an export processing zone (EPZ) created in 1976, and which around 12 per cent of GDP at factor cost in 1995. However, despite rapid growth over the past decade, the export processing zone has been losing international competitiveness in recent years due to a larger increase in unit labour cost and the availability of lower cost labour in newly industrializing economies.

The "Other manufacturing" sub-sector which consists basically of a variety of activities, such as food processing, assembly of electrical appliances, metal products, plastics and chemicals gained significant importance in the past three years and its share in manufacturing output increased from 41 per cent in 1992 to reach nearly 44 per cent in 1995.

The tourism industry is one of the most dynamic sector of the economy in terms of contribution to GDP, gross foreign exchange earnings and employment creation. Mauritian tourism policy emphasizes low-impact, high-spending approach by promoting an up market profile aimed at increasing expenditure per tourist. Gross tourist receipts amounted to Rs 7, 472 million in 1995 and Restaurant and Hotels sector contributed to 3.8 per cent of GDP. The role of private sector was highly significant to this performance while the necessary framework for promoting Mauritius as a high class tourist resort was provided by Government.

During the period 1992-1995, the trade sector was marked by significant developments. The "wholesale and retail trade" sector averaged a growth rate of 6 per cent over that period and accounted for nearly 13 per cent of GDP.
The "financing, insurance and business services" sector has been promoted as a major source of future growth through the establishment of an Offshore banking centre (1988) and a Freeport (1992). Since the start of the 1990s, the sector progressed with a high average annual real growth rate of 9.6 per cent and contributed around 10 per cent, on average, to GDP during the period 1992-1995.

II. POPULATION DYNAMICS, TRENDS

A. Population Size and Growth

The Mauritian population of is a mixture several races with a majority of Indian origin but also many other people with European, African and Chinese heritage. Creole is by far the most widely spoken language at home but English and French are also spoken indifferently. However, although English is the primary language of very few inhabitants, it is the official language of Mauritius.

The Mauritian performance in the field of demography has been highlighted in many occasions and especially at the International Conference on Population and development (ICPD), held in Egypt in September 1994. Mauritius was also attributed the Population Award (1990) which was a testimony to the country's demographic achievements.

The estimated total population of the Republic of Mauritius as at mid-1995 is 1,122,288 of whom 561,595 (50.04%) were males and 560,693 females (49.96%). With a population density of about 554 persons per square kilometres at the end of 1995, Mauritius is one of the most densely populated nations in the world. The average annual growth rate during the period 1992-1995 was 1.2 per cent. As for the age distribution, the proportion of population under 15 years of age was decreasing over the period 1992-1995 while the economically active group (14-64 years) increased slightly as well as the elderly population group (65 years and above). Fifty six (56) per cent of Mauritians live in rural areas and fourth four (44) in areas classified as urban. Taken into account births, deaths and net migration, the resident population of Mauritius grew at the rate of 1.39 per cent and 1.11 per cent in 1992 and 1994, respectively. (Republic of Mauritius, Ministry of Economic Planning and Development, 1996).

B. Marriage and fertility rates

In the early 1960s Mauritius had one of the highest population growth rates of the world: between 1963 and 1972, fertility rate levels declined from more than six to only slightly above three children per woman which was considered as the most rapid fertility transition in human history. The decline in total fertility rate continued to decline over the past two decades to just over two births per woman in 1991. It seems however that this declined has stopped in the more recent period.

The total fertility rate indicates the number of children women would have in their lifetime if age-specific fertility rates were to continue at their current levels. Table 1 shows a moderate rise in fertility in the second half of the 80s decade (both sources). Fertility behaviours are influenced by some factors such education, religion and Socio-economic index. In this connection, the survey indicates that less educated women have slightly higher
fertility; catholics have higher fertility than Muslims who in turn have higher fertility than Hindus. Finally, women having low Socio-economic index have higher fertility rate.

There has been a very moderate increase in the age at marriage over the past years. At the time of the Survey on Contraceptive Prevalence, fifty per cent of Mauritian women are married by age 21.8 years. In 1997, available information indicates that the age at marriage is estimated to about 24-25 years (ECA mission. 1997).

However, teenage pregnancy was declared to be major cause for concern. According to the 1991 Contraceptive Prevalence Survey undertaken by Government, 9 per cent of first pregnancies were conceived before the women get married for the first time. Since induced abortions are illegal in Mauritius, some pregnancies were either terminated under unhygienic and risky conditions or resulting in births to single parents.

Table 1. Mauritius. Age-Specific fertility Rates and Total Fertility Rate

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Age-Specific Fertility Rates</th>
<th>Vital Statistics</th>
<th>Surveys*</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>0.038</td>
<td>0.045</td>
<td>0.025</td>
</tr>
<tr>
<td>20-24</td>
<td>0.125</td>
<td>0.143</td>
<td>0.113</td>
</tr>
<tr>
<td>25-29</td>
<td>0.121</td>
<td>0.133</td>
<td>0.123</td>
</tr>
<tr>
<td>30-34</td>
<td>0.077</td>
<td>0.080</td>
<td>0.068</td>
</tr>
<tr>
<td>35-39</td>
<td>0.041</td>
<td>0.038</td>
<td>0.048</td>
</tr>
<tr>
<td>40-44</td>
<td>0.014</td>
<td>0.011</td>
<td>0.016</td>
</tr>
<tr>
<td>Tot Fert. rate</td>
<td>2.08</td>
<td>2.24</td>
<td>1.98</td>
</tr>
</tbody>
</table>


C. Mortality

Overall mortality rate has been improving as result of the rapid increase in standards of nutrition, health care and other social services. However certain age groups show signs of some deterioration. It was also observed that heart, hypertensive and cerebrovascular diseases together accounted for more than 40 per cent of deaths during the period 1992-1995. The crude death rate declined from 9.3 per thousand population in 1962 to 6.6 in 1991.

The infant mortality rate (IMR) in Mauritius reached 19.7 in 1995 which partly reflected the poor health status of mothers. As for the under-five mortality rate at 25, it was still considered high for a country which achieved a significant level of human development.
Life expectancy at birth improved considerably over the last two decades. It is as high as 72 years for female and 72 years for male, only a few years less than in most developed countries.

III. POPULATION POLICIES AND STRATEGIES

Mauritius is one of the few countries that have succeeded in managing its population growth. And after the success of family planning and rapid economic growth, Mauritius has become an example in a large international context. Demographic transition in Mauritius has taken place only 34 years as opposed to other classical cases of industrialised countries such as France. Mauritian population grew very fast during the post second World War, following a death rate decrease mostly as a result of eradication of communicable diseases, mainly malaria and increase in birth rates to their highest level ever.

The success of Mauritian population management has been largely attributed to the government’s concern and deep commitment to reduce the rate of population growth, through supportive and extensive health care services, family planning programmes, promotion of basic education particularly among women. Over the last decade, Mauritius’s population has witnessed increase in its per capita income and living standards. Standards of nutrition, health care, and general education exceeded those of most neighbouring countries and are now at the level of the other middle-income countries.

There has not been population policy as such in Mauritius. However, as a follow-up action to the ICPD, a national Population and development Committee (NPDC) was set up in April 1995 by Government with the prime objective of formulating and coordinating population policies and programmes as well as to monitor and evaluate on-going programmes and other population related activities.

Mauritius has been investing significantly in social services with a view to provide its population with higher social standards and increased per capita income. During the past 25 years, the standard-of living of the population improved considerably as a result of the government policy to share equitable the benefits of economic growth.

The social safety mechanisms which have been put in place over the past 15 years include the following:

i) Retirement pension;
ii) Widows pension;
iii) Orphans pension and guardian allowance and;
iv) Invalidity pension and child allowance.

These pensions are earnings-related and depend on the amount of contributions paid.

As shown in table 2, expenditure on community and social services increased from 48.8 per cent in 1992 to 51.7 per cent in 1994. Over the last years, the government has put emphasis on social security. Expenditure on social security and welfare accounted for 15.9 per cent and 16.9 per cent in FY92 and FY94 respectively, followed by expenditure in education which stood at 13.66 per cent and 15.82 respectively.
Table 2. Government Budget Expenditure on Social Sectors, FY92-FY94

<table>
<thead>
<tr>
<th></th>
<th>FY92</th>
<th>FY93</th>
<th>FY94</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>1,670</td>
<td>2,263</td>
<td>2,723</td>
</tr>
<tr>
<td>Health</td>
<td>1,141</td>
<td>1,304</td>
<td>1,404</td>
</tr>
<tr>
<td>Social Security &amp; Welfare</td>
<td>1,943</td>
<td>2,302</td>
<td>2,689</td>
</tr>
<tr>
<td>Housing &amp; Comm Amenities</td>
<td>715</td>
<td>986</td>
<td>1,114</td>
</tr>
<tr>
<td>Recreational, cult. &amp; religious activities</td>
<td>223</td>
<td>220</td>
<td>283</td>
</tr>
<tr>
<td>Rice &amp; Flour Subsidy</td>
<td>240</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total expenditure on Social Services</strong></td>
<td><strong>5,932</strong></td>
<td><strong>7,075</strong></td>
<td><strong>8,213</strong></td>
</tr>
<tr>
<td>Government expenditure</td>
<td>12,157</td>
<td>14,330</td>
<td>15,881</td>
</tr>
<tr>
<td>GDP at Market Price</td>
<td>51,519</td>
<td>58,184</td>
<td>64,225</td>
</tr>
<tr>
<td>Total Social Expenditure as % of Government expenditure</td>
<td>48.8</td>
<td>49.4</td>
<td>51.7</td>
</tr>
<tr>
<td>Social expenditure as % of GDP</td>
<td>11.5</td>
<td>12.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Social Security &amp; Welfare Expenditure as % of Government Expenditure</td>
<td>15.91</td>
<td>16.11</td>
<td>16.9</td>
</tr>
</tbody>
</table>


A. Family Planning and Health Care Services in Mauritius

The issues of controlling population and family planning in Mauritius began as early as after the demographic explosion when malaria was eradicated in 1948. Initially, family planning was slow to develop partly because of the opposition from the Catholic church and vocal Muslims to all contraceptive methods. That is why the Government decided not to be involved in the provision of services and people were left free to take their own decision concerning the number of children they wish to have. In 1957, some NGOs initiated the programmes on family planning but without the government’s intervention. The first family planning clinic was opened in 1957 by the Mauritius Family Planning Association (MPA). Then the Catholic Church started thinking about population issues and proposed use of alternative natural methods of birth control. Thereafter a private organization, Action familial (AF) was formed with the objectives of promoting and teaching natural family planning methods.
In 1964, the Government participated in the whole exercise by subsidizing the NGOs involved and one year later changed its policy, officially endorsing family planning and providing financial as well as material help too both MPA and AF. In 1968, UNFPA joined the team and family planning was integrated into the Ministry of Health programme of activities. Most of the clinics operated by the MPA were under control of the Ministry of Health. Then family planning became the main tools used to tackling demographic problems. By the middle of 1980s the majority of women in union of childbearing age was using contraception and almost all of them had done so at some point.

Intensive population and family life education programmes supported by regular family planning services were launched throughout the country. Family health service points were established throughout the island with a view to providing facilities and advice on FP. Today, family planning services are provided by the Maternal and child Health and Family Division of the Ministry of Health (MOH), the MPA and the AF. The total number of clinics operated by these agencies are presently 222. Methodologies for providing the services includes both home visits and consultation at the centres. There are 5 regional hospitals in the country (one in each region). All public hospitals and community health centres provide free services and medication and they are all located at walking distances from the homesteads. Services provided at the Centres include, besides family planning, immunization, ante and pre-natal care and general consultation. General awareness campaigns are also conducted in educational institutions and places of work particularly at the Export Processing Zones.

The Area health centres (AHC's) and Community Health Centres (CHC's) act as the first point of contact for the primary health care services on a regional basis. In total, there are 26 AHCs and 126 CHCs throughout the country with 4 to 6 CHCs per AHCs. Cases that require specialised care are generally transferred to the district or regional hospitals. In the private sector, two new clinics (nursing homes) were opened during the period 1992-1995, bringing their total number to ten.

The public sector plays a central role as the main provider of health services with the programme of modernisation of health delivery system including upgrading the skills of health personnel, decentralising national disease control programme and improving the infrastructure and facilities of hospitals. Total expenditure by Government and the household sector in 1991/1992 on medical and health care represented about 33 per cent of GDP.

The 1991 Contraceptive Prevalence Survey shows that knowledge of the supplied methods in common use in Mauritius is practically universal, methods of natural family planning (NFP) being lower than that of the supplied methods. Among supplied methods, the diaphragms and Norplant are the least known. Among NFP methods, both the temperature and the calendar methods are more widely known than the symptom-thermal method currently promoted by Action Familial. Knowledge of the various contraceptive methods is somewhat lower among women who have never been in union compared to women who have been in union. All these differences could be due to insufficient information, education and communication.

To day, the rate of contraceptive use in Mauritius could be compared to that in Europe and North America. Women generally use contraception to limit their pregnancies. The two-child family seem to be the norm in Mauritius. However, data from the 1985 Contraceptive Prevalence Survey and that of 1991 show that there was a slight decrease in
overall contraceptive use between 1985 and 1991. This is partly due to a decline in the use of natural methods, particularly the symptom-thermal method. There is also little difference in overall contraceptive use between urban and rural women. In general, there is a greater current use of natural methods in urban areas. Religion does not seem to be a strong determinant of overall contraceptive use.

Various reasons given for stopping use of contraception include the desire to become pregnant or because of side effects or method problems, especially in rural areas. Reluctance from using contraception also was due to the failure of the method mainly the condom and natural methods. Contraceptives are in principle provided free to the users.

B. Education

About 80 per cent of population are educated. Education, particularly of women, has been one of the major population characteristics that could affect fertility behaviours. 75 per cent of women in Mauritius are literate. Education in Mauritius through University is free with a 9 year primary education being compulsory. Generally better education leads to lower fertility. As the cost of rearing and educating children is increasing, families also choose to have fewer children on whom they put their focus on ensuring that their offsprings acquire white collar jobs. It is to be noted that education is not gendered in Mauritius. Everybody has the right to education and besides, families now got conscious about the importance of educating their children. In this regard, the Ministry of education, Science and technology was canvassing parents through NGOs to keep their children in school for the entire primary cycle.

The cost of education in total Government expenditure has been increasing over the years. Its share in the capital budget increased from 7.7 per cent in 1992 to 13.5 per cent in 1994 and to 14.6 per cent in 1995. The government is also providing interest-free loan private pre-primary schools to help them improve their infrastructure.

C. Employment

Employment share credit with education to have contributed to higher living standards of population in Mauritius where the vast majority of people have been benefited of full employment. The total labour force constituted 45.4 per cent of the total population in 1995 as compared to 43.7 per cent in 1992. This increase was due to the change in the age structure of the population and to the increase in the participation of women in economic activities. The promotion of EPZs with labour intensive industries created numerous job opportunities for people and particularly for women. The total Labour Force participation (LFPR) rate rose from 61.8 per cent in 1992 to 62.8 per cent in 1995. Total employment in the economy as estimated at 511,000 in 1995 (about 45.5 per cent of total population). This figure included the 9,795 foreigners working on contract basis in Mauritius. Female labour force participation in Mauritius is as high as 44 per cent and it has been on the rise over the years. Increased labour participation, especially at the women's side affected the traditional child rearing methods and led the couples to review the size of their family. An increasing number of women who previously stayed at home as housewives have joined the labour market, especially in the manufacturing sector. Actually there are 65 000 women working in the EPZ, which constitutes two thirds of the total workers.
D. Social and family welfare

Considerable efforts have been made both by Government and private sector to improve the standard of living of the population and particularly that of the workers and their families. Various welfare schemes provided by Government include social security for the vulnerable groups, family allowance to assist families with three or more children under age 15, the Unemployment Hardship Relief Scheme in view to assist the unemployed heads of households and their dependents. With the rise in life expectancy, additional care was needed for the ageing of the population and the policy was oriented to keeping the elderly in the family units. Several facilities with a view to providing the elderly with recreational opportunities and better welfare have been put in place.

The EPZ Labour Welfare Fund was created to promote the welfare of the workers and their families. The welfare programme which comprises daily care centres, leisure programmes social programmes, IEC activities, export enterprise scholarship scheme, support services for working women, has been strengthened through allocation of interest-free loans under the Household Appliances Scheme to purchase refrigerators, washing machines, rice cookers, gas plates and mixer-grinders without deposit and at prices lower than those prevailing on the market.

IV. CONCLUSION

Mauritius is at a critical juncture in its development. It has reached the stage of temporary success but much still has to be done for the country to enter the newly industrialized economies. In the long run, Mauritius is presumed to face labour shortage as it is already importing from Asian countries and others. The easy acceptance of family planning programmes by the population facilitated the fertility decline. It may be found in the high level of social development and basic education and empowerment of women.

Fertility rate in Mauritius was already below replacement level in the late 1980s but the growth rate of the population was still above 1 per cent per year. Despite the lack of a clear formal population policy, the assumptions are to keep the population at the present level. The Government is also conscious of the problem that the ageing population is going to raise in the long turn.
I. SOCIO-ECONOMIC BACKGROUND

A. Economic Evolution

With a population of 88.5 million (1991 census) and a land area of 923,768 sq. km, Nigeria is the largest country in West Africa. Situated along the coast of West Africa, the country consists of 30 states with Abuja as the Federal capital.

Nigeria is endowed with abundant natural and human resources which if efficiently and rationally managed can not only significantly improve the standard of living of the majority of her people but also transform the country into one of the most advanced countries in Africa. In addition to its abundant and productive land some 30% of which is arable, it possesses major oil and gas deposits, a variety of solid minerals such as coal, tin, columbite and gold and a well laid out industrial base. It also has a dynamic labour force engaged in all fields of economic endeavour and has developed an extensive financial institutional network. Infact, the country can be said to be endowed with all the key ingredients necessary for economic takeoff and sustained growth.

Due, however, to lack of efficient and effective management and recurring political instability, the country has failed to capitalize on these endowments and harness the productive forces to achieve sustained economic development in all sectors of the economy.

In the 1960s and early 1970s, the Nigerian economy was primarily agricultural, contributing to over 70% of the Gross Domestic Product (GDP). With the discovery of oil, agriculture was given a back seat and the role of the sector in terms of its contribution to GDP has declined since the mid-1970s. Between 1992 and 1994, the contribution of agriculture including crop production, livestock, forestry and fisheries to GDP stabilized at 38% before increasing to 39.5% in 1995 and 1996. The petroleum and gas sector contribution has also declined continuously from 13.4% in 1992 to 12.6% in 1994 and 13.1% in 1996. In 1996, wholesale and retail trade accounted for 11% of GDP, financial institutions 9.9%, other industries 9.3% while other services accounted for the remaining 7.6% of GDP which in 1986 stood at N106.87 bn at constant 1984 factor cost. GNP per capita has declined from US$640 in 1986 to US$250 in 1989 and around US$240 in 1994-1997.

After a period of oil boom during which Nigeria had a positive balance of payments, the country began to borrow extensively from the international market from 1983. By the end of December 1992, her external debt which had reached US$46.6bn in 1988, had been reduced to US$27.56bn. Budget deficits have however, increased from N17.5bn (7.9% of...
GDP) in 1988 to ₦43.8bn in 1992 (69.8% of GDP) while the economic growth rate which was 4.2% between 1965 and 1980 declined to around -5.3% in the late 1980s and 1990s. By mid-1995, the rate of inflation had risen to 72% from 5.3% during 1980 and 1984, 46% in 1992 and 65% in 1994. According to the 1997 World Development Report, Nigeria had a GNP per capita of $260 in 1995 and 28.9% of the population lived on less than $1 a day between 1981 and 1995. In order to arrest the continuing decline in the economy and get the country out of the deep economic crisis into which it had been plunged into, the Government introduced a structural Adjustment Programme (SAP) in September 1986.

The agricultural sector however continues to play an important role in food security and employment generation. The major food crops grown in the country are maize, millet, cassava, yam, and rice. The major export crops and foreign exchange earners are cocoa, groundnuts, cotton, rubber and palm oil. Data on trends in the food profile of Nigeria show that agricultural production including crops, livestock and fish products increased from 40.8 million mt in 1992 to 74.2 million mt in 1996. During the same period, agricultural exports declined from 292,400 mt to 224,000 mt while imports of agricultural products doubled from 1.8 million mt to 3.6 million mt as a result of increased demand.

The agriculture sector also employs about 70% of the country's labour force in a country where unemployment is one of the major problems. However, the unemployment rate which was 3.5% in 1992 (4.8% for urban and 3.0% for rural areas) is estimated to have averaged at 2.8% in 1996 (4.4% for urban and 2.4% for rural). Unemployment among men is lower (2.25%) than among women (2.74%). Apart from rural-urban and gender variations, unemployment rates also varied with the level of education and between age groups and among states. By June 1996, the rate of unemployment was highest among the age group (48%) followed by the age group 15-24 years (43%).

The main objective of the SAP introduced in 1986 was to diversify the economy's production base in order to reduce its dependency on the oil sector, reduce imports, achieve fiscal viability, direct investment into productive sectors, improve public sector efficiency and enhance private sector potential. In essence, the goal was to lay down the basis for sustainable, non-inflationary growth. In the sections that follow, an attempt is made to examine other socio-economic developments in Nigeria within the context of the demographic transition which the country is believed to be passing through. In this connection data on some relevant socio-economic and demographic indicators are provided in Table 1.

It is important to stress that in a country as vast and heterogeneous as Nigeria, with inequalities in resources and levels of development among its 30 states, a global assessment of these developments is bound to hide disparities between and among states and Local Government Areas. However, efforts will be made to highlight these differences to the extent possible.

---

B. Migration and Urbanization

Although historically, there has been steady migration across the country for various reasons, internal movements of persons from rural to urban areas represent the most important and problematic of these migrations.


Problems of rapid urbanization resulting from mass exodus of rural youths to urban centres are well known. They include urban congestion, homelessness, crime, prostitution, excessive pressure on the grossly inadequate social infrastructure and high unemployment.

Among the measures taken by the Nigerian government to stem the tide of mass exodus of rural youths to urban centres was the establishment of farm institutes and farm settlements in the 1960s and 1970s to train young school leavers for self-employment in the agricultural sector in rural areas. A similar and more recent scheme is the "school on wheels" scheme designed to train rural youths in various skills so that they can be self-employed in their rural areas. Available information seems to suggest that all the schemes met with very little success as the school leavers deserted the schemes and still migrated to the cities in preference to urban environments and non-agricultural employment.

International migration on the other hand, is considered insignificant. Since the period of the oil boom, there has not been any significant influx of migrants into the country. Fragmentary administrative data and the results of censuses of neighbouring countries, however, show that there has been some temporary and permanent out-migration of Nigerians over the last decade owing particularly to the current economic recession.

C. Education and Literacy

The current educational system in Nigeria is based on the national policy on education adopted in 1976 which aimed at providing compulsory, universal and free primary education to all Nigerians. The revised policies of 1981 and 1988 provided progressively increasing access to females. Pre-primary education covers children from ages 0-5, primary school from ages 6-11 and secondary school from ages 12-17.

According to data from the National Household Survey of 1995/96\textsuperscript{25} the enrolment rate for children of pre-primary school age was 11\% with 10.5\% of boys being enrolled as against 11.8\% of girls. The enrolment rate for primary school age children at the country level was 65.5\%. In this age group, boys had a higher enrolment rate (66.8\%) compared to 63.9\% for girls. For children of secondary school age, 74.0\% of boys were enrolled as

\textsuperscript{24} World Bank: World Development Reports, 1993 (p.299) and 1997 (pp.230,231)

against 71.7% of girls bringing the national total enrolment of this age group to 72.9%. Disparities in school enrolment exist also between the age groups 6-11 and 12-17.

The literacy rate in 1995/96 for the whole country for all adults 15 years and above was 48.9%. There was a noticeable disparity between the literacy rate for men and women. 55.8% of men were literate compared to 42.3% of women. There were wide variations in the literacy rate between the states. These ranged from 5.3% in Jigawa State to 77% in Edo State. The literacy rate among young adults (15-29 years) was about 65.4% at the country level with men having a higher literacy rate (76.8%) than women (56.8%). There were also wide variations between the states with Sokoto State having the lowest rate of 10.1% compared to Imo State with 100% in this age group26.

Apart from primary and secondary education, Federal and State Governments provide technical and vocational training through polytechnics, colleges of technology and colleges of education or teachers' training colleges. In 1995, there were about 37 polytechnics and colleges of technology in the country with an enrolment of 67,716 students in 1987/88, up from 42,381 in 1980/81. Higher education is provided through 4 sub-degree colleges and 20 federal and 8 state universities. Total enrolment in universities more than doubled during the 10 years between 1980 and 1990 having risen from 77,791 in 1980/81 to 162,059 in 1987/88 and 180,811 in 199027.

D. Health, Water and Sanitation

According to the World Development Report for 1997, about 40% of the population had access to health care in 1980 and 67% 1993. The Federal Ministry of Health, however, estimates that about 35-40 per cent of the total population has access to modern medical facilities and services. The recent census data show wide disparities between urban and rural areas: between 1991 and 1997, 80% of the urban population had access to health services compared to 53%-55% of rural women.

As in many African countries, health services and facilities have tended to be urban-based with little attention given to the rural communities. Emphasis has until recently also been given to hospital-based curative medicine with an almost neglect of preventive medicine. Although considerable progress has been made in the provision of health services, general mobility especially among women and children is still said to be high.

About 47% of children aged less than 1 year were not immunized in the country. However, about 6.4% of all children in the country were said to have completed their doses of which 3.1% were males and 3.3% were females28.

Census data show that over 27% of households in the country used well water while 10% used boreholes. About 9% of all households are thought to have got their water supply through vendors. About 24% used pipe borne water within their households while 30% used

---

26 FOS; Ibid.
other sources of water such as streams, ponds and similar sources. Of course wide variations exist in access to various sources of water among states. The use of pipe borne water was highest in Edo state (84%) and lowest in Kogi State (0.8%)\(^{29}\) According to Federal Ministry of Health sources, about 58% and 22% of the urban and rural population have access to safe water supply.

As regards toilet facilities, only 9% of the population used modern w/c facilities. The use of these facilities was highest in Lagos state while the system was virtually non-existent in Sokoto State. The majority of the Nigerian population (about 61%) however, used pit toilet while 1% used the pail system. The remaining 29% used other systems\(^{30}\).

Similar data also show that only 16% of the population used modern refuse disposal methods such as government bins. This method was used the most in Lagos state and not used at all in such states as Akwa-Ibom, Edo, Jigawa, Katsina etc. Over 50% disposed of their refuse within compounds while 33% disposed theirs in the bush and dung hills\(^{31}\).

The high percentage of the population disposing their refuse in compounds and using other systems of human waste disposal is a reflection of the poor sanitation situation in the country.

II. POPULATION DYNAMICS AND DETERMINANTS

A. Population Size, Structure and Growth

Data from the 1991 national census gave a provisional population figure of 88.512 million. The national demographic health survey of 1990 also gave a crude birth rate of 39 per 1000 population and a crude death rate of 13 per 1000. Based on these figures the natural growth rate of the Nigerian population was estimated at 2.8% annually. With this growth rate, the population was projected to reach 104.6 million in 1997. However, since Nigeria is a vast country, population density is fairly sparse (about 100 persons per sq.km.) although there are large population concentrations in the south-western, south-eastern and north central areas of the country.

At the national level, the sex distribution is fairly balanced although there has been a slight increase in the number of males over females. Males out number females by 100 men to 98.7 women. At the state level, the men/women sex ratio is low in 14 states where it lies between 98.91 in Benue and 87.90 in Enugu; and fairly balanced in 6 states where there are as many males as females as in Adamawa, Cross River, Edo, Kebbi, Kwara and Plateau. In the remaining 11 states there is clearly a preponderance of males in the population. In these states there are between 101 and 110 males to every 100 females\(^{32}\). It is difficult to explain the variation in the sex ratio. It could be due to the high mortality suffered by women from excessive child birth or possibly from data quality.

\(^{29}\) FOS 1996: Ibid. p.3.
\(^{30}\) FOS 1996: Ibid. p.3.
\(^{31}\) FOS 1996: Ibid. p.3.
Data on the distribution of the population by age show that children aged 0-14 years accounted for 43.4% of the total population while the elderly (those aged 60 years and over) were only 4.6% of the population. In the 0-14 years age group, boys and girls accounted for 23.5% and 19.9% respectively while in the men also outnumbered women in the age group of the elderly\textsuperscript{33}. According to UNFPA\textsuperscript{34}, the age groups 0-14, 15-64 and 65+ comprised 48%, 47.7% and 4.3% respectively of the total population. The adolescent age group (10-19 years) accounted for 22% of the total population. The above information suggests that the Nigerian population structure is broad-based although data from the 1990 National Demographic Health Survey (NDHS) suggest that the base of the pyramid has narrowed with the population below 5 years being less than those in the 5-9 age group. Also there is a high percentage of the dependency age group (0-14) and a fairly critical mass of adolescents (22%).

B. Fertility Levels, Trends and Determinants

Early marriages are still a common practice in many parts of the country. Over three quarters (86.7%) of mothers married before the age of 18 although only about 0.5% of the women population in the country married before the age of 15. In 1994/95, 60.9%, 38.2%, 1.2% and 1% of babies were born by mothers in the age groups 15-19, 35-49, and 49 and above respectively\textsuperscript{35}. About 8.3% of women ever married were found to be pregnant. 46.9% of the pregnant women were registered with the clinics. The crude birth rate for the country was 14.69 per 1000. The total fertility rate (TFR) is still high and fell only slightly from 6 in 1991 and 1994 to 5 during the period 1995 and 1997. In the North and North-West Zones of the country, fertility rates are still 6.0 and 6.3 respectively. There are considerable differentials in the fertility levels according to residence, region and educational attainment. The crude birth rate fell only slightly from 48 per 1000 in 1991 to 39 per 1000 during the period 1994 to 1997.

Various factors account for the high fertility rates observed in Nigeria. The use of contraception is still fairly limited. Only 6% of married women actually use contraceptives. About 3.5% of these women use a modern method and 2.5% use a traditional method. These levels although high when compared to a decade ago when only 1% used contraception, are nevertheless quite low. Periodic abstinence (rhythm method), the pill, IUD and injection are the most popular methods among married couples. Knowledge of contraception remains low with less than half of all women age 15-49 knowing any method. Available data also show that more than 50% of women using modern contraceptives are on pills, injection, condom and IUD. Diaphragm, foaming tablets jelly and sterilization are the least used methods. Women with more education and those in urban areas are far more likely to be using contraception. The Contraceptive Prevalent Rate (CPR) of 20% shows that there is a large proportion of currently married women whose demand for family planning has not been met. Survey data indicate that many women who know contraceptive methods do not know where to get supplies.

\textsuperscript{34} UNFPA 1995; Op.Cit pp 11-12.
\textsuperscript{35} FOS 1996; Op.Cit, p.15.
Another factor leading to high fertility is that the vast majority of births are wanted. The desire for childbearing is still strong particularly in the rural areas. This is due to tradition and religion. High infant mortality in many parts of the country is also a reason for the high demand for children. Economic franchisement of women in the South as a result of better education, etc impacts on lower fertility rates. In the north women, continue to follow traditional patterns of life and marry early at median age 15. Half of all women are married by age 17 and half have become mothers by age 20. Some Traditions, cultures and religions also forbid the use of contraception and other family planning devices. This gives rise to high fertility. Also, most women especially in rural areas live in conditions of disenchantment and disfranchisement and cannot make their own decisions on family planning.

C. Mortality Levels, Trends and Determinants

There appear to be errors in the data provided in the quarterly report\(^\text{16}\) by the Federal Office of Statistics on the mortality situation especially regarding the crude death rate (CDR) at the national and state levels. According to the report, about 19.3% of the children ever born in the country die. The CDR for the country was 1.74 per 1000 with wide disparities across states. Sokoto, Imo, Katsina and River had crude death rate above 4 while Abia, Akwa-Ibom, Cross River, Delta, Edo, Kano, Kebbi, Kwara, Lagos, Niger, Ogun and Ondo states were said to have reported 0.00 CDR. In the 12 months before the last survey, the distribution of deaths by age-groups at death showed 0.06% between 1-4 years, 0.08% between 5-59 years and 0.03% were 60 years and over.

Data provided by the UNFPA appear more realistic. The data show that the crude death rate per 1000 has stabilized at 12 since 1994 after falling from 16 in 1991. Infant mortality is also high although it fell from 85 per 1000 in 1991 and 1994 to 70 in 1995, 1996 and 1997. Maternal mortality rate has remained stable at 10 per 1000 since 1995 after falling from 15 in 1991 and 1994.

Many factors contribute to the childhood mortality levels provided above. Among these is under-nutrition. According to NDHS data\(^\text{17}\), 43% of the children under 5 are chronically undernourished especially in rural areas and in the northern parts of the country. Also despite the strides made in health care, preventive and curative health services have not yet reached many women and children. Mothers receive no ante-natal care for one-third of births and over 60% of all babies are born at home. Only one-third of births are assisted by doctors and trained nurses or midwives; one-third of infants are never vaccinated and only 30% are fully immunized against childhood diseases. Lack of knowledge by many mothers as to the proper time to introduce various supplementary foods to breastfeeding babies within the first two months of life often jeopardises their nutritional status and increases the risk of infection.

\(^{16}\) FOS 1996; Ibid. p.15.
III. POPULATION POLICIES AND STRATEGIES

The high rate of population growth in Nigeria and its adverse effect on national development and individual welfare have been issues of great concern to the various governments in Nigeria since independence. Thus, in 1988 the government formulated and launched the National Policy on Population. The policy is based on the belief that every couple and individual has the right to decide fully on the number and spacing of their children, and the right to information, education and the means to exercise such rights. The specific objectives of the policy are to:

i) Improve the living standards and the quality of life of the people of the country;

ii) Promote their health and welfare, especially through preventing premature death and illness among the high risk groups;

iii) Achieve lower population growth rates through reduction of birth rates by voluntary fertility regulation methods that are compatible with the attainment of economic and social goals of the nation;

iv) Achieve a more even distribution of population between urban and rural areas.

Targets were also set for the implementation of this policy. They include extending the coverage of family planning service to 50% of women of childbearing age by 1995 and 80% by the year 2000; reducing the proportion of women who get married before the age of 18 years by 50% by 1995 and 80% by the year 2000, etc.

Government accordingly formulated and is vigorously pursuing a number of strategies aimed at achieving the above objectives. These are:

i) Establishing fertility regulation and management programmes which make services and facilities accessible and affordable to couples and individuals who want to regulate their fertility;

ii) Integrating family planning services into the Primary health Care Programme;

iii) Providing necessary and adequate population information and education to young people, couples and individuals in order to promote responsible parenthood and to enable them to understand the value of moderate-sized families and the importance of spacing children; and

iv) Improving rural living conditions through effective implementation of integrated rural development programmes.

A. National Health Policy and Strategy

Since aspects of the population policy and strategies are integrated into the National Health Plan, it is important to outline, albeit briefly, the National Health Policy and Strategy to achieve health for all. Primary health care (PHC) remains the cornerstone of the National Health Policy. Focused on the Local Government Area (LGA) level, the PHC has made notable achievements including the promotion of a community health system and has increased awareness and knowledge about disease control interventions such as the National Programme on Immunization (NPI).

A Country Plan of Action for Implementing a Minimum District Health-far-All Package (1995-2000) has also been developed. This package consists of the following thirteen components with their budget estimates\(^{i)}\): child survival, safe motherhood, productive life years, basic immunization coverage, family planning and essential drugs coverage. Other components are Adult health, literacy, household food security, water supplies and sanitation, HIV/AIDS, emergency preparedness and response, health education and health financing. Non-governmental agencies, private practitioners as well as the health facilities of private companies provide an inter-linkage between the secondary and tertiary public health care facilities at the Federal, State and LGA levels.

The above notwithstanding, the MCH/FP strategy has had serious limitations in terms of scope, coverage and sometimes quality of service. Contraceptive supply has been most irregular and unreliable with occasional depletion of stocks since supplies are dependent exclusively on donor sources. Family planning services used to be provided virtually free of charge in public MCH/FP clinics but due to difficulties of supplies, cost recovery is now being introduced by government in family planning service centres.

B. Impact of Policies and Strategies on Population Growth

In the 1981-1985 Fourth National Development Plan, government made a commitment to provide adequate and effective primary health care that is promotive, protective, preventive, restorative and rehabilitative to 80% of the population by 1985 and to extend same to the entire population within the available resources by the year 2000. Maternal and child care which encompasses family planning, immunisation against major infectious diseases, education regarding the prevention and control of health problems, and environmental sanitation to secure a quality of environment adequate for the health and wellbeing of all Nigerians has received particular emphasis. Unlike past practices where health care was directed at urban centres where hospitals were built, efforts are being made to bring health care as close as possible to people in rural areas.

Inspite of the shortcomings identified earlier in the health care system, these efforts have resulted in noticeable improvements in the range of available health care facilities and in the services being provided. These improvements have been reflected in a decline and subsequent stability in the infant and maternal mortality rates and the crude death rate. Government efforts have been supplemented by those of non-governmental agencies such as the UNFPA and the International Planned Parenthood Federation (IPPF) through its Nigerian

affiliate, the Planned Parenthood Federation of Nigeria (PPFN) which operates family planning clinics in all the states.

The impact of these efforts are reflected in the improved knowledge and wider use of contraception and other family planning services. The difference between approval of contraception and knowledge of modern methods in urban areas is very small and has narrowed down considerably by region and educational attainment. In rural areas, more than 80% of those approving contraception know any method. According to UNFPA, this general increase in knowledge of any family planning method is traceable to the Public Service announcement broadcasts undertaken nationally on radio and television by the PPFN between June and November 1992. The CPR for all age groups is about 20% for all methods and 10.8% for modern methods.

IV. CONCLUSION

Nigeria is a vast country endowed with abundant natural and human resources which, had they been efficiently managed in the national interest, could have made the country one of the most developed nations in Africa. Nevertheless, the country has made much progress in many areas including education, health and population activities. As with other large countries, regional and rural-urban and gender variations are bound to exist in socio-economic progress. Economic and social policies pursued by various governments since independence have aimed at narrowing these variations especially gender differences in education and employment and promoting the demographic transition.

Political and economic empowerment of women has been a major weapon in promoting the transition. Concerned national institutions in collaboration with UNIFEM and other organizations have worked towards increasing women’s awareness of the need to participate in politics, the need to understand the law and their rights and participate in lawmaking. The empowerment of women through educating them, equipping them for global trade, developing and diffusing appropriate technologies for their use and providing them with sustainable livelihoods give women an alternative to the number of children as social security. The media and other forms of communication have also been used to enlighten women on their rights including their rights to family planning services.

Due however, to difficulties of contraceptive supplies, cost recovery is now being introduced by government in family planning service centres for family planning services which had hitherto been offered fairly free of charge. This policy should, however, be viewed positively under current conditions of diminished donor resources in that it seeks to ensure continuous supplies of the relevant facilities and services. Health and population policies and strategies have made positive impacts on the major indicators of the demographic transition.

The age distribution and sex composition of the population are some of the characteristics of the Nigerian population with implications for the demographic transition and socio-economic development in the next millennium. The population of Nigeria is still extremely young with high dependency ratios typical of those found in many other African countries. This and the high potential of the population for growth, the critical mass of adolescents in the population, the high proportion of females among them, the high risk of these groups from pre-mature sexuality and fertility all represent both challenges and
opportunities to planners, programmers, parents and indeed the nation as a whole for the
demographic transition and socio-economic development of the country. The provision of
reproductive health services and education, how to structure the society to deal with aids and
other epidemics, manpower development and utilization, employment creation and provision
of social services are some of the critical areas which future policies will need to address.

Data provided by the various surveys undertaken in Nigeria during the last decade or
so appear to show that Nigeria is experiencing the demographic transition, albeit delayed.
The issue of paramount interest to policy and decision makers is whether the fertility decline
is real or whether there has been an under-count of births in the years preceding particularly
the 1990 survey and if so, whether other behaviours had changed to a degree that would be
commensurate with a decline in fertility. While some evidence suggests that there has been
an underestimation of births, data on such proximate determinants of fertility such as the
mean number of children ever born, the median birth interval length, the age at first birth,
etc appear to be inconclusive especially given the wide variations between states and regions.
Changes in such socio-economic factors such as cost of living, cost of medical treatment, life
expectancy at birth etc will be some other important determinants of the direction and
sustainability of the transition. The answer as to whether the demographic transition is
sustainable must therefore await further investigation and analysis.

Signals emanating from the behaviour of the population make it difficult to predict
the direction of the transition. Economic difficulties in maintaining large families as a result
of the economic crisis is forcing people to change traditional beliefs in large family sizes and
the traditional system of African extended family that hitherto had led to high fertility rates.
At the same time, the desire for childbearing is still strong in Nigeria particularly in the
rural areas. If and when the prevailing economic pressures disappear in future, are people
likely to revert to previous traditional patterns of behaviour leading to high fertility?
However, crisis or no crisis, there is a strong view that the levels of fertility and
contraception use are not likely to change until there is a drop in desired family size and until
the idea of reproductive choice is widely accepted.