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DETERMINANTS OF FERTILITY LEVELS IN KAFANCHAN, NIGERIA

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ABSTRACT

This study is an attempt to investigate the general level of fertility in Kafanchan, a town in Kaduna State of Nigeria. The main concern is to examine the individual and group behaviour of the population with specific reference to the prevailing fertility rates.

The paper examines some of socio-cultural factors that relate to fertility history, attitude related to fertility and knowledge and use of contraception.

On the average, fertility in this community is high. A woman experiences a total life time fertility of 7 live-births and least one of the children die in childhood. Marriage is universal and every young man and woman aspires to satisfy this social obligation. The mean age at marriage is 17 years. A lot of importance is attached to having children, for social and cultural reasons. Knowledge and use of contraception is still very low. Government interest in population matters has been mainly restricted to population data collection for the purpose of socio- economic and political planning. These factors have a positive bearing on average family size which is relatively large.

Fertility is high while mortality is low. However, as a measure towards demographic readjustment, a further reduction in the level of mortality may lead to decline in fertility. Some future planning implications of the existing fertility levels are discussed in the light of the current population policy and development planning in the country.

INTRODUCTION

In the 1950s the stagnation of population growth and the prospect of an actual decline, especially in Europe pre ocoupied demographers and economists. They envisaged an attrition of investment opportunities declining growth of income ap-

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palling problems of economic adjustment a petrification of institutions and political disintegration. Gunner Myrdal (1973) therefore argued that democracy, not only as a political form but with all its contents of civic ideals and human life, must either solve this problem or parish. The problem in question was that of contraception the failure of mainkind even to replace itself.

The fears of over-population (maladjustment of population, resources and expectations) which emerged in the 1960s, was first inspired by the obstacles which rapid population growth allegedly posed to social and economic change in the very poor countries. Therefore, some researchers over the years have come to the conclusion that no substantial benefits will result from further growth of the nations populations. According arguments for continued population growth.

Many of the disastrous consequences which were then advanced as the outcome of population stagnation are quite similar to those now attributed to rapid growth. This is not much of a surprise to anyone familiar with the history of population thought. The truth is that people have almost always worries about population since early times and at the root of the problem has always been fertility rates, since population grows exponentially.

This study seeks to determine the general level of fertility in Kafanchan. The main concern is to examine the individual and group behaviour of the population with specific reference to the prevailing fertility rates. The focus is on those aspects of socio-cultural factors that relate to fertility history, attitude related to fertility and knowledge and use contraception.

Field work for this study was carried out in 1985 in Kafanchan, Nigeria and presented as an unpublished M.A. Dissertation in the Department of Geography of Ahmadu Bello University, Zaria in 1986.

DATA AND SOURCE

The data used in this study were from 729 male and female respondents who came from 333 households. A man, his wife/wives and unmarried children living together constitute a household. The sample of 729 was made up of 299 (41.0%) males and 430 (59.0%) females. Information was obtained from respondents by interview, using questionnaires. Only married women (15 years and above) and household heads constituted the respondents for the study. The interview schedule focussed on the following characteristics: general characteristics of the respondents such as sex, age, education, marital status, fertility history and knowledge and use of contraception.

Interviewing was preceded by a geographical survey of the town. At the end of the survey, the town was carved into wards from which the sample was taken. The town was divided into ten wards on the basis of the physical location of the residents population (Fig.1). The ten wards comprise of Bakin Kasuwa, Bakin Rogi, Railway Quarters, Rumoda, Ungwar Fada, Sabon Kaura, Takau, Geraje, Zipkah and Aduwan. Based on this sample frame, 10 percent of the households in each ward was interviewed. A further 10 percent sample of households was taken from every strata. Every 1st, and subsequent 5th household was interviewed accordingly. The

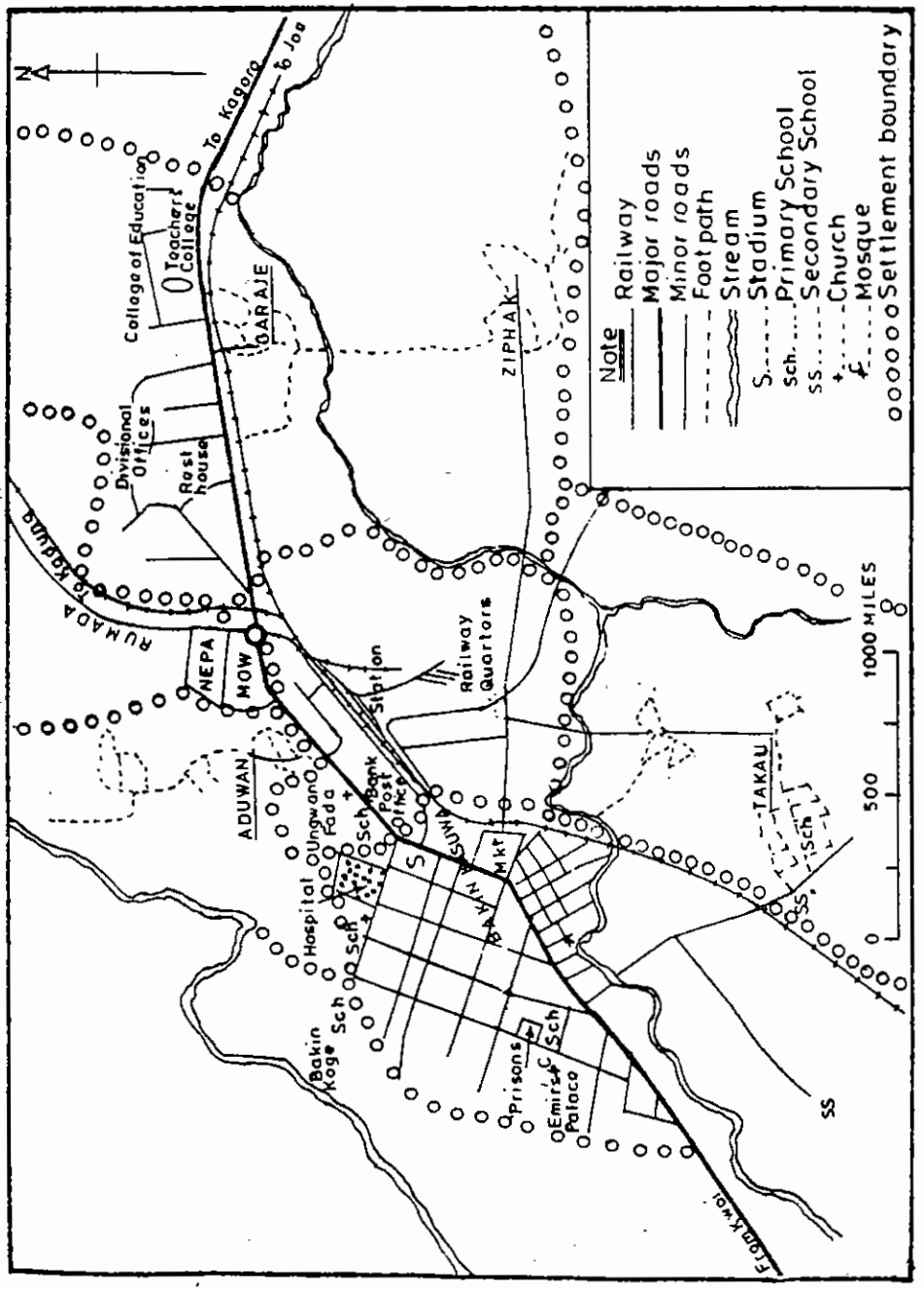

Figure 1. Kafanchan and Its Environs

uneducated respondents was therefore not difficult and common lecal events were used to determine respondents ages.

PREVIOUS STUDIES OF FERTILITY LEVELS

An important phase of the evolution of the birth rate from a high to low level is the emergence of fertility differentials among various strata or groups of the population. These differentials tend to be associated with socio-cultural, economic, residential of ecological, physiological and other related factors.

FERTILITY RATES AND SOCIO-CULTURAL FACTORS

Weeks (1978) noted that in vertually every society, individuals feel pressured to have children although in some societies these pronatalist pressures are stronger than in others. This view is corroborated by Caldwell (1975). He found that there is an abhorence of a family so small that it might mean the extinction of descendants needed to perform the services for their ancestors; in traditional society nearly all parents have social and usually economic gains which increase almost indefinitely with the size of the family. Societies everywhere have developed social institutions to encourage child bearing and reward parenthood in various ways. Chapera (1966) discovered among the Kgatla in South Africa that it is inconceiveable that a married couple should for economic or personal reason deliberately seek to restrict the number of its off-spring. He found several social factors that encourage the Kgatla to desires children. A woman with many children is honoured. Married couples acquire new dignity after the birth of their first child.

Many cultures the world over attach great importance to the act of procreation. In a review of studies in India, Mandelbaum (1974) reports that typically a woman knows of no acceptable alternative role for herself than wife-mother. For all but a relative few, a woman's destiny lies mainly in her procreation; the mark of her success as a person is in her living, thriving children.

In this study in Ghana, Gaisie (1975) found out that the Tallensi-regard the prepetuation of their line descent as of transcendent importance. To the Asante profilic child bearing is honoured. A mother often boasts of her achievement and is given a public ceremony of congratulation. Children often follow rapidly after one another. By contrast barren women are given little or no prestige and are regarded with contempt and malicious pity. Reports about fertility from India, Ghana, Kenya, Indonesia and Nigeria all agree with the above findings.

All the above findings and reports tend to reveal one fact, that socio-cultural factors tend to encourage and perpetuate high fertility among most African communities. There is therefore need to formulate an explanatory theory designed to test, guide and improve knowledge of demographic and cross-cultural frame of reference.

MORTALITY AND ITS EFFECTS ON FERTILITY

Declining mortality is one of the major determinants of population growth. Declining mortality, not rising fertility, is the root cause of current world population growth. Mortality data, therefore are very necessary for projections of population

rates are mentioned; seldom are age specific rates or expectation of life figures given. It is important to find out about infant mortality should be a pre-condition for successful population control. The decline of infant mortality rates in Western countries has been cited as a major cause of the decline of fertility, on the ground that the increase probability of children's survival enabled parents to assure of the desired size of family with a smaller number of births. This factor has been mentioned by many authors among the presumed causes of the fall of Western fertility. Some have treated it as the sole cause (Paurose, 1934; Weeks, 1978; Caldwell, 1976). It would follow that resources directed towards achieving demographic goals would have a high cost effectiveness if invested in mortality central programmes.

But country to the above widely acclaimed effect of mortality on fertility, another school of thought which holds some truth, has opened that, multiple child losses might actually encourage a couple to stop child-bearing rather than risk yet another disappointment. Although this opinion is not widely held, and perhaps seems far-fetched, at least in African context, there is likelihood that it contains some truth which must be established by further investigation.

In conclusion, we can therefore say that child mortality has two possible effects on fertility, the first being increased fertility and the second, reduces fertility.

The fertility issue, especially as it relates to the developing countries of the world, including Nigeria, appears to have been rested finally on the level of economic development as againts public and corporate programmes of family planning. Barry Commoner (1975) convincingly argued that Western industrial nations achieved the third stage of the Demographic Transition of low mortality and low fertility only when economic prosperity occured after the Industrial Revolution period when the socio-economic pressures for high fertility were relevant and couples had more stake in the economy than hitherto. According to him, fertility did not fall because of any orchestrated family planning compaign programme. The implication of this, as supported by the experiences of India and China, is that fertility rates in the developing countries would continue to be high (population explosion) until such a time that significant economic development programmes are implemented to remove emphasis on children as a source of social security and economic asset.

HYPOTHESIS

The study is based on the following assumptions. The first assumption is that women involvement informal education would tend to raise the age at the first marriage. The second assumption is the idea that a rise in age at first marriage may result in lower fertility. The third assumption is the notion that women's education may increase the proportion of contraception users hence may lower fertility. The fourth assumption concerns continuing child bearing i.e. the probability of continuing childbearing is a function of current family sex composition as well as parity.

BACKGROUND TO STUDY AREA

Kafanchan is situated in the southern part of Kaduna State of Nigeria, (Lat. $9^{0}37'$N; Long. $8^{0}21$E), see Figure 2 (inset). By road, Kafanchan is some 104

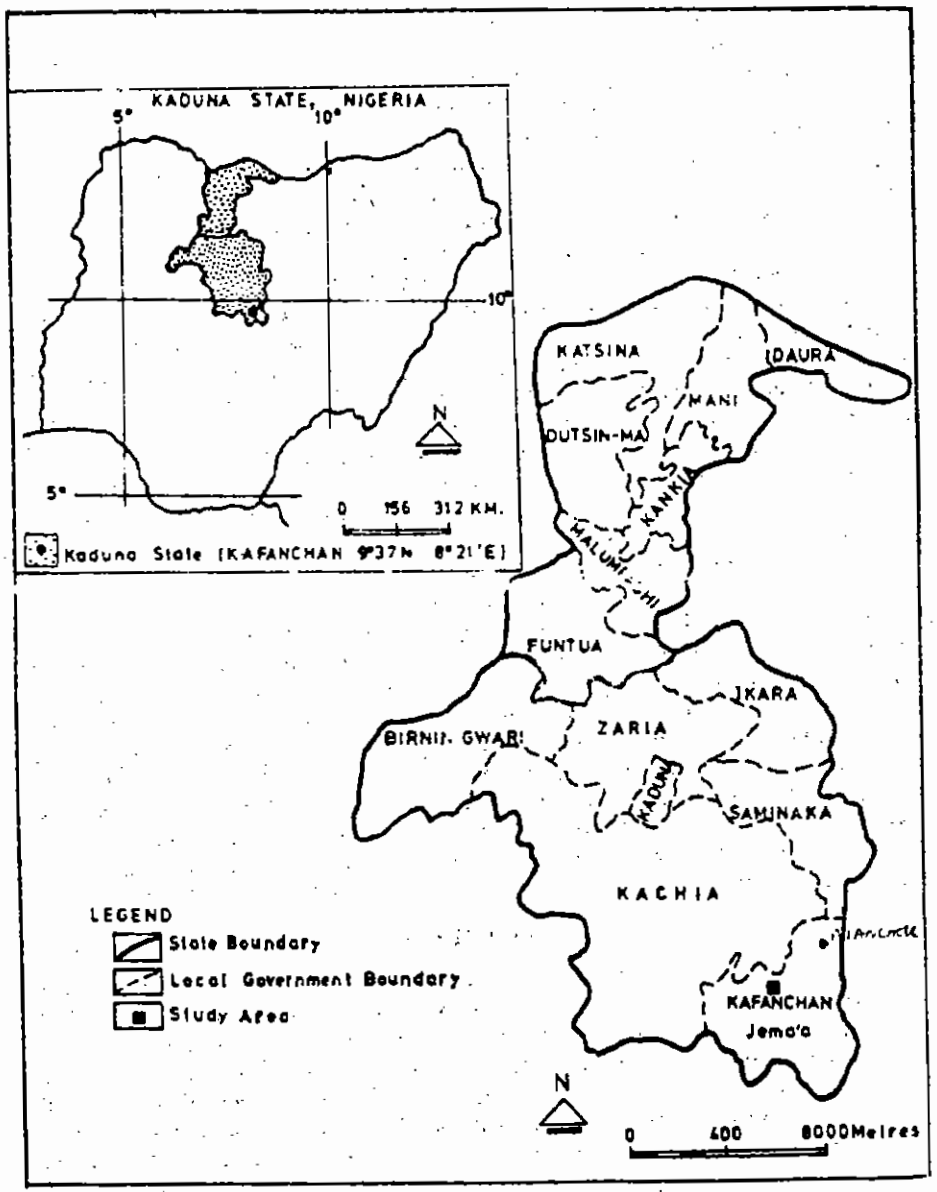

Figure 2. Location of Kafanchan

The main economic activities in Kafanchan include agriculture, with guinea corn, cassava, yams, maize, ginger, cotton, cocoyam, citrus fruits and vegetables dominating. Active agriculture activities are mainly concentrated in the 'peripheral settlements' in Garaje, Takau, Zipkak and Aduwan. In the built up area one can only find small patches of cultivated land mainly devoted to the growths of market-gardening type of crops like vegetables. Transportation is the single most important activity that has been responsible for the growth of the town Kafanchan is a rail way junction linking the eastern and western railway lines from southern to nothern Nigeria. There is a Federal trunk 'A' road linking the town with other Nigerian towns of Kaduna and Jos. The combined effect of these two transport systems has been tremendous, the impact of which is noticeable in the increase in immi gration (rural urban migration) due to case of accesibility.

Commercial activities are assuming increasing importance in the economy of the town especially in the built up area. Here one finds quite a large proportion of the population engaged in trading. Most of the traders are small-scale traders who are mainly engaged in retail activities.

There are a few small-scale industries and these are in the form of bakaries, brick industries and furniture making industries.

The town has two secondary schools a teachers college and a college of education. Increasing number of schools are raising the level of literary. About 36.0% of the respondents had no formal education, 22.0% had either primary or Koranic education and 42.0% had either middle, secondary or post secondary education.

In this community, the people practice the nuclear and extended family systems. Household economic systems is based mostly on the nuclear family and culture here demands the earliest possible marriage and child-bearing. Childlessness is taken seriously. A woman who does not give birth to a child feels very unhappy and husband is forced to marry another wife. Polygamy is common in this society and cuts across all religions be it Christianity, Islam or the Traditional religion.

AGE AT FIRST MARRIAGE

Marriage in this society is taken to include all women who live with their husbands in legally, traditionally or religiously accepted unions, as well as those who live with a male partner in stable consensual unions without the blessings of the law, tradition or religion.

The data in table 1 shows that the age at first marriage of women interviewed has been rising over time. This trend is more evident when the mean ages at first marriage are considered (Fig.3). With the exception of the lowest age group (15-19), age at first marriage tends to decrease generally from a mean of about 19 for those aged 20-24 to 15 and 16 for women aged 45-49 and 40-44 respectively. The smallness of the sample size in the age group 15-19 seem to effects the generally observed pattern of rising age at first marriage over the last 30 years. The implication of this observed rise in age at first marriage is that fertility might decline in future. This will be due to a reduction in the number of total years spent in marital bliss (Caldwell, 1974).

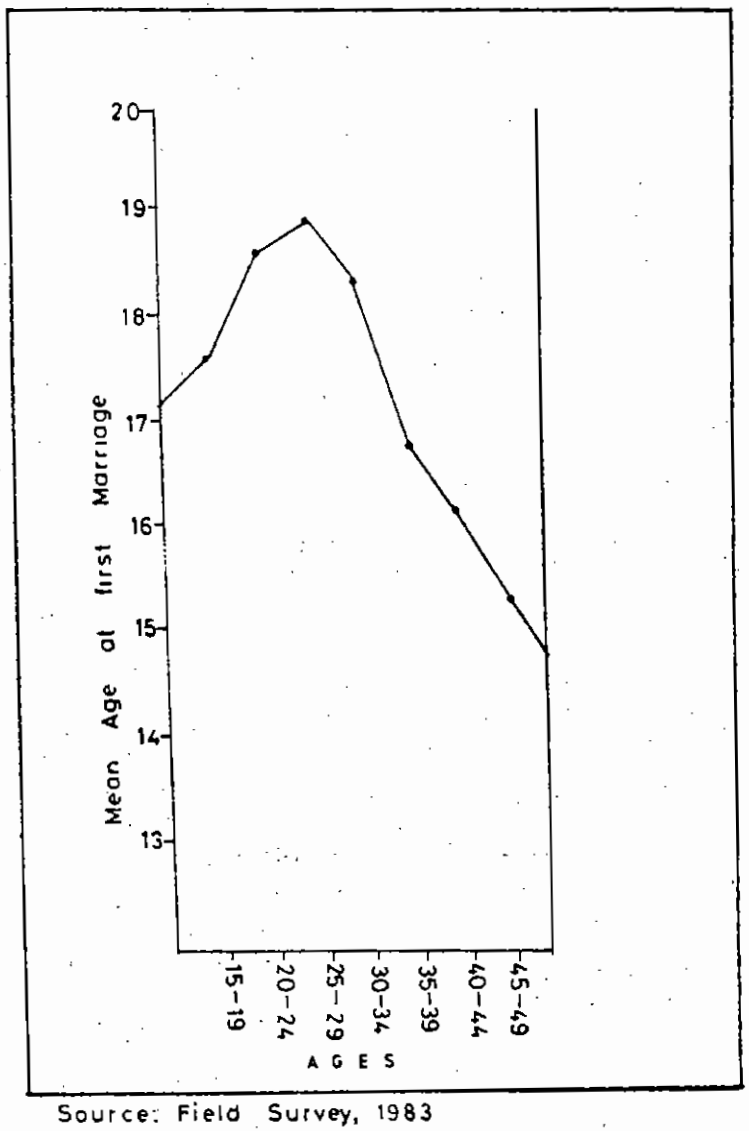

Figure 3. Mean Age at First Marriage According to Age of Women

TABLE 1. PERCENTAGE DISTRIBUTION OF ALL WOMEN AT FIRST MARRIAGE

Age Groups	Age at First Marriage					Mean Age at 1st Marriage
	12-15	16-18	19-21	22-24	25-27	
15-19	20.0	40.0	4.0	0.0	0.0	17.4
20-24	3.5	48.8	31.4	10.3	0.0	18.6
25-29	7.4	41.5	31.9	18.1	2.1	18.9
30-34	17.9	39.3	23.6	7.1	7.1	18.3
35-39	25.8	58.1	3.7	6.5	0.0	16.8
40-44	39.3	46.4	10.7	3.6	0.0	16.8
45-49	56.6	33.3	11.1	0.0	0.0	15.3
Total	18.2	45.6	25.4	9.1	1.7	100.0

Source: Field Survey, 1983.

TABLE 2.MEAN NUMBER OF CHILDREN EVER BORN TO ALL WOMEN BY CURRENT AGE AND AGE AT FIRST MARRIAGE

Age at First Marriage	Current Age							Mean Total
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
15-16	0.8	2.2	3.4	4.5	5.5	5.2	6.3	3.5
17-18	0.5	1.9	3.3	4.4	5.1	5.7	5.4	3.4
19-20	0.4	1.3	3.0	4.3	5.2	5.1	6.2	3.6
21-22	-	0.8	2.0	3.6	4.5	5.4	4.8	3.4
23-24	-	1.1	1.7	3.7	5.4	4.7	5.4	3.2
25+	-	-	1.1	2.7	4.5	4.6	5.7	4.0
Mean Total	0.4	1.7	3.1	4.3	5.1	5.1	5.7	3.5

Source: Field Survey, 1983.

Among women of the same age group, those who married earlier have given birth to more children than those who married later in life. This confirms the positive effect of young age at marriage on achieved fertility. For example, for women aged 25-29, the mean number of children ever born decreases from 3.4 for those married when they were between 21-22 years old. For the women aged 20-24 the mean decreases steadily from 2.2 for those married by the age of 15 to 0.8 for those married between the ages of 21 and 22, a difference of 1.4 children.

FERTILITY LEVELS

A complete maternity history of each woman interviewed was obtained. The findings below are presented for women of all marital status. Table 3 shows the average number of livebirths for women aged 15-49 of all marital conditions. The mean number of children ever born to the women interviewed is 7.1. This figure can be compared with other figures obtained from studies carried out in some other

woman in Kafanchan or Manchok is likely to have about 7 livebirths by the time she completes the childbearing cycle. This rate could be considered relatively high for an urban population. However, given the small size of Kafanchan town and the general low level of urbanism in the community, the data seems empirically valid. The observed pattern is consistant with Ekanem's findings of 7.2 total fertility rate for some urban centers in the former Eastern Nigeria (Ekanem, 1974).

INFANT AND CHILD MORTALITY

Infant mortality is defined here as the death of children under 1 year of age, while child mortality refers to death of children from birth up to ten years. The data, as we have been informed earlier on, is based on retrospective mortality reporting. However, it should be stated that information on mortality was difficult to obtain. As a result, the above data may not be sufficiently accurate because of memory lapse and unwillingness on the part of the respondents to talk freely on mortality.

While the mean number of children ever born to all the women interviewed is 4.6 (Table 3), the mean number of those alive and dead is 3.7 (Table 5) and 0.9 (Table 6) respectively. The difference between total livebirths and living children shows that 19 percent of all the children born by these women had died by the time of the appears to be rather high. The high mortality among young children may be a reason why most women gave birth to more than four, which is the number recommended by the government. The risk of ending up with too few without any children mortality is on a declining trend. This might be attributable to improved medical health care services and general sanitation. The availability of medical facilities is an important determinant of mortality levels. The spectacular decline in mortality in the Third World, among other factors, has been traced to the general improvement in sanitation and advancement of medical knowledge (United Nations, 1953).

TABLE 3. DISTRIBUTION OF LIVEBIRTHS ACCORDING TO AGE GROUPS OF MOTHERS

Age Groups	Sum Number of Livebirths	Number of Respondents	Mean
15-19	6	5	1.2
20-24	170	83	2.1
25-29	392	104	3.8
30-34	341	65	5.2
35-39	268	40	6.7
40-44	281	41	6.9
45-49	262	37	7.1
Total	1720	375	4.6

Source: Field Survey, 1983.

TABLE 4. FEMALE POPULATION OF MANCHOK BY AGE AND LIVEBIRTHS

Age Groups	No. of Women	Live Time Fertility
15-19	4	0.5
20-24	15	1.7
25-29	32	3.2
30-34	27	4.5
35-39	10	5.2
40-44	10	7.2
45-49	8	7.3

Source: Ottong, J.G. The Dynamic of Demographic Change: A case study of Manchok, Kaduna State, in Savanna, Vol. 6, No.1, June 1977.

DESIRED NUMBER OF CHILDREN

Two sets of questions were used for determining fertility preferences. The first deals with the desire for more children, e.g. "Do you want to have another child in addition to the one(s) you already have?" and the second is about the total number of children desired e.g. "If you could chooses exactly the number of children to have in your whole life, how many boys and how many girls would you like to have?"

If a respondent's stated fertility preferences are related in some way to her eventual fertility, then information on fertility preferences should have a predictive value in forecasting the future course of fertility. There is however, a discrepancy between the average desired family size and the total actual fertility as represented by current fertility rates.

In this study, it was found that the total actual fertility of an average woman in Kafanchan of 5.0 as well as the mean desired family size of 6.7 is relatively large. The observed pattern is consistent with Ottong's (1977) findings of 6.0 and 7.0 for current total fertility and desired family size respectively. When we consider the real family size in terms of surviving numbers of children, one finds that the figure is lower (a mean of 3.7, Table 5). The above figures can be compared with the ones in Table 7. The implications of the difference between the tables under considerations for future fertility is obvious; the level is likely to rise for quite some time. The difference between the actual numbers of children and preferred numbers of children is indicated of how aim and achievement differ with respect to completed family size.

TABLE 5. DISTRIBUTION OF LIVING CHILDREN BY AGE GROUPS OF WOMEN

Age Groups	Sum of living Children	Number of Women	Mean
15-19	6	5	1.2
20-24	150	83	1.8
25-29	342	104	3.6
30-34	267	65	4.1
35-39	210	40	5.1
40-44	212	41	5.3
45-49	196	37	5.3
Total	1383	375	3.7

Source: Field Survey, 1983.

TABLE 6. DISTRIBUTION OF DEAD CHILDREN BY AGE GROUPS OF MOTHERS

Age Groups	Sum of Dead Children	Number of Women	Mean
15-19	0	5	0.0
20-24	20	83	0.3
25-29	50	104	0.5
30-34	74	65	1.1
35-39	58	40	1.6
40-44	69	41	1.7
45-49	72	37	1.9
Total	343	375	0.9

Source: Field Survey, 1983.

Table 6 reveals that the younger age groups prefer smaller numbers of children than the older age groups. An average of 5.8 for the age group 20-24 and 8.0 for the age group 45-49. The pattern is that the general level of fertility might be lower than the present level in the distant future.

It may be assumed that the relationship between livebirths and surviving children plays a part in conditioning attitudes towards family size and family planning. When figures of living children for the age groups 20-24 (1.8);30-34 (4.1) and 45-49 (5.0) are measured againts preferred or ideal family sizes of 5.8, 6.7 and 8.0 respectively, it is clear that older women in this society tend to have fewer surviving children than they would prefer. Under these circumstances prospects for family planning are not very bright.

TABLE 7. PREFERRED NUMBER OF CHILDREN ACCORDING TO AGE GROUP OF WOMEN

Age Groups	Total Number of Children Preferred	Number of Women	Mean
15-19	27	5	5.4
20-24	522	83	5.8
25-29	666	104	6.2
30-34	431	65	6.7
35-39	295	40	7.2
40-44	240	41	8.0
45-49	294	37	8.0
Total	2495	375	6.7

Source: Field Survey, 1983.

The data in table 8 shows percentage distribution of women according to age groups by preferred number of children.

It is obvious from the table that smaller percentage (0.8, 2.3 and 9.6 percents) of women preferred 2, 3 and 4 children as their ideal family sizes and the greater majority who indicated these ideal numbers are in the younger age groups of between 20-29.

These figures however, are high and the implication is that fertility will remain high inspite of the fact that the younger generation preferred smaller families as pointed out earlier. In the long run, fertility, though still high may drop to lower levels in the future since a large proportion of the younger generation preferred smaller numbers of children.

TABLE 8. PERCENTAGE DISTRIBUTION OF WOMEN ACCORDING TO AGE GROUPS BY PREFERRED NUMBER OF CHILDREN

Age Groups	Preference Number of Children										Percentage of
of Women	2	3	4	5	6	7	8	9	10	11	Total Sample
15-19	0.0	0.0	2.7	3.1	2.1	0.0	0.0	0.0	0.0	0.0	1.3
20-24	10.0	22.3	27.0	39.0	34.0	20.5	15.5	9.1	0.0	0.0	24.3
25-29	0.0	33.3	37.8	35.9	30.9	28.2	19.7	13.6	13.9	22.2	27.1
30-34	0.0	22.2	18.9	14.1	11.3	10.3	25.4	9.1	22.2	11.1	16.6
35-39	0.0	11.1	5.4	3.1	11.3	20.5	11.3	13.6	13.9	11.1	10.6
40-44	0.0	0.0	5.4	1.6	4.1	12.8	14.7	22.7	22.2	33.3	10.3
45-49	0.0	11.1	2.7	3.1	6.2	7.7	8.5	31.8	27.8	22.2	9.8
Total	0.8	2.3	9.6	16.5	25.1	10.1	18.3	9.3	9.3	2.3	100.0

Source: Field Survey, 1983.

SEX PREFERENCES AND LATER FERTILITY

It is probable that family size preferences are formed with some consideration of preferences about family composition (that is, the sex of children). Table 9 indicates that about 7 percent of the respondents said they preferred a family with

sons and 30 percent undecided. The general pattern of strong son preference appears among all women regardless of age at first cohabitation and parity.

Because of the importance of sex preference for offspring in Nigeria, the probability of continuing childbearing is a function of current family sex composition as well as parity. Women who have more girls than boys are more likely to have another child during the subsequent period, a finding consistent with previous findings from other parts of the country. Although son preference is the prevailing pattern, there are differences in its degree, and also some preference for laughters or for a balanced family composition. These underlying preferences for sex of children in the long run contribute to differences in fertility.

TABLE 9. PERCENTAGE DISTRIBUTION OF WOMEN BY AGE AND SEX PREFERENCE AND AGE

Age	Boys > Girls	Boys = Girls (Balanced)	Boys < Girls	Undecided Left to God
15-19	45.2	30.5	12.2	11.1
20-24	37.0	24.1	15.2	23.7
25-29	39.3	28.1	15.0	28.6
30-34	40.1	19.3	14.1	22.5
35-39	36.3	30.5	15.2	18.0
40-44	52.2	18.1	15.0	14.7
45-49	50.0	20.1	12.8	17.1
Total	34	29	7	30

Source : Survey, 1983.

TABLE 10. PERCENTAGE DISTRIBUTION OF WOMEN BY SEX PREFERENCE AND LIVING CHILDREN

Number of Living Children	Boys	Balanced	Girls	Undecided Left to God
0-1	39	18	15	28
2	39	16	14	31
3	36	23	14	27
4	31	24	16	29
5	32	18	18	32
6+	35	20	20	32

Source : Survey, 1983.

KNOWLEDGE AND USE OF CONTRACEPTION

Information was collected on knowledge, use and the intention to use any of various birth control methods in futrure. Attention is focussed on levels of awareness, knowledge of where to get information, method most frequently used, and

data on the extent of contraceptive knowledge showed that at least 40 percent of the sample has at one time or the other, heard of a contraceptive device as methods of family planning [1]. The most widely recognised methods are the pill, loop or I.U.D. (Intra Uterine Device), rythm and abortion. Table 11 shows that 41 percent knew about the pill, 24 percent recognised the loop and rythm and 22 percent said they have of abortion as a birth control method. Rings on finger, vasectomy and douche methods were least known.

In Kafanchan, there is no organised private or public sponsored family planning programme. This lack of public family planning programme did not necessarily mean that family planning services were unavailable to the population. It is of considerable interest therefore to know that, the contraceptive knowledge and use that exist are considered essentially the result of personal effort on the part of women and their partners. The women practicing contraception claimed to have learned about it first from either friends, personal reading or from the hospital (Table 12).

Analysis of table 12 reveals that 33 percent knew about family planning through discussion with friends and 30 percent through personal reading from books and related literature. 11 percent got their information through Church organised units while 26 percent said they got their knowledge through doctors and nurses in the hospital.

TABLE 11. MARRIED WOMEN WHO HAVE HEARD OF SPECIAL CONTRACEPTION METHOD

Method	Ever Heard	Never Heard	% Ever Heard	% Never Heard
Pill	171	249	40.7	59.3
Loop	103	326	24.0	76.0
Abortion	95	332	22.2	77.8
Douche	17	412	4.0	96.0
Rythm	103	321	24.0	76.0
Withdrawal	43	286	10.0	90.0
Female Sterilization	37	391	8.6	91.4
Vasectomy	15	414	3.5	96.5
Condom	50	379	11.7	88.3
Abstantion	40	386	9.4	90.6
Ring of finger	10	413	2.4	97.6

Source: Field Survey, 1983.

TABLE 12. REPORTED SOURCES OF CONTRACEPTIVE KNOWLEDGE

Knowledge Source	No. of Respondents	Percentage
Friends	51	33.3
Personal reading	45	29.6
Church	17	11.1
Nurse (Hospital)	39	25.9
Total	152	100.0

The use of contraception among the women interviewed is not very high. Only about 30 percent of them had ever used any type of contraception, while about 70 percent have never used any method (Fig. 4). The data on figure 4 also shows that the pill is the most widely used (14 percent); 10 percent of the sample said they have used the loop or I.U.D. The least used method is female sterilization (1.4 percent).

Of those using one form of contraception or the other (Table 13), 74 percent said they were using it for childspacing while 26 percent have used contraception for termination of child bearing for various reasons - such as poor health of the mother, several births through operation (Caesarean birth).

TABLE 13. MAIN REASONS FOR ADOPTING FAMILY PLANNING

Reason for Adoption	No. of Respondents	Percentage
Child spacing	113	74.3
Pregnancy Termination	39	25.7
Total	152	100.0

Source: Field Survey, 1983.

About their intensions for future use (Fig. 5), 33 percent of the sample indicated they will use any of the methods. These were mostly women who were not currently using any method at the time of the interview. This is an indication that the level and demand for family planning services is going to increase. About 25 percent indicated that they will not like to use any device, 16 percent were undecided (don't know) while there were 29 percent non respondents. Table 14 illustrates the percentage of women who have never used any method of contraception according to number of living children and by current age. Use of contraception is lowest amongst women with no living children. The proportion of those who have ever used any method increases from 7 percent for those who have more than 2 living children. Although the level of current use was found to be fairly high among young women, suggesting rather frequent spacing of births, it was generally highest among women in the middle of the reproductive ages - from 25 to 34 years.

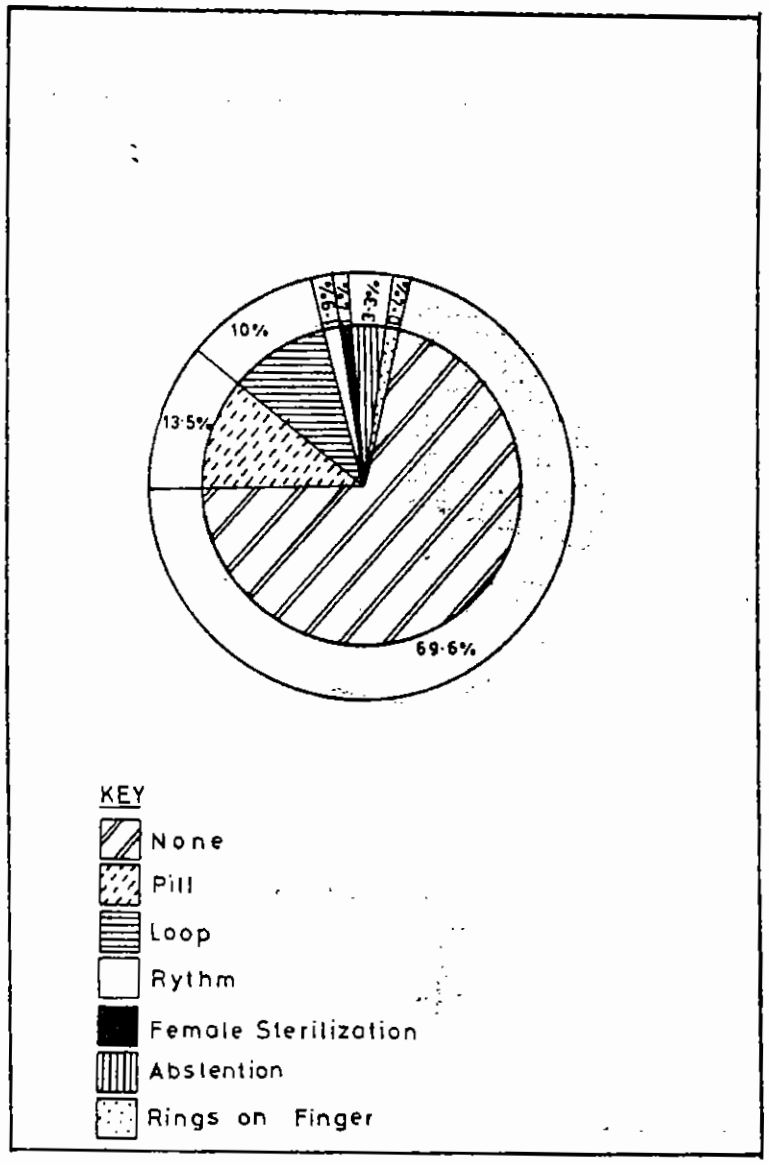

Figure 4. Type of Contraceptive Device Used

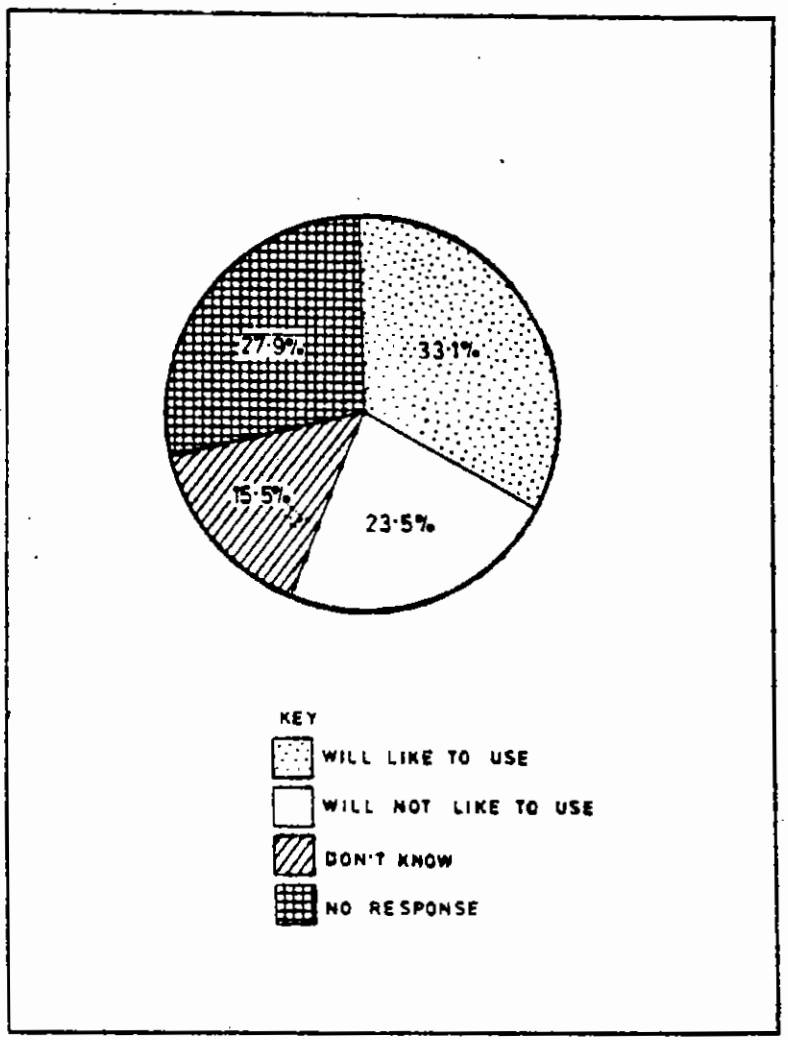

Figure 5. Intention to Use Contraception in Future Among Women who Do not Use any Method at Present

TABLE 14. PERCENTAGE DISTRIBUTION OF WOMEN WHO HAVE USED ANY METHOD OF CONTRACEPTION BY LIVING CHILDREN AND AGE GROUPS

Age Groups	Living Children								Percentage of
(Mothers)	0	1	2	3	4	5	6	7	Age Groups
15-19	-	66.7	33.3	-	-	-	-	-	1.7
20-24	7.7	19.2	26.9	23.1	23.1	-	-	-	14.9
25-29	2.4	4.8	19.0	16.7	16.7	11.9	14.3	14.3	24.0
30-34	2.3	4.7	18.6	16.3	14.0	18.6	16.3	9.3	24.6
35-39	-	4.0	20.0	16.0	20.0	16.0	12.0	12.0	14.3
40-44	-	-	-	13.6	13.6	27.3	31.8	13.6	12.6
45-49	-	-	-	14.3	35.7	28.6	21.4	-	8.0
Total	2.3	6.9	16.5	16.5	18.3	15.4	14.9	9.1	100.0

Source: Field Survey, 1983.

There are several possible reasons for the typical curvilinear relationship between contraceptive use and age (Fig.6). Older women may be less likely to use contraception because of lack of information or because of adherence to traditional norms and religious inhibitions which discourage contraceptive use. Young women may be less subject to the influence of tradition and religion but some may also be poorly informal about contraception.

Demographic variables such as age and family size, affect current contraceptive use, at least in part, although their relationship to a couple's desire to limit family size is not the only reason for using contraception. For example, couples may use contraception in order to ensure adequate spacing between births or be cause the wife is in poor health and wishes for that reason to avoid pregnancy. The foregoing discussion relating to the comparatively wide use of contraception among with small families suggests birth spacing.

Ever-use of contraception varies considerably by the level of education of the women. The proportion of women with secondary or higher education who have ever used contraception (68 percent) is more than double the proportion with primary education and no schooling or illiterates (32 percent) (Table 5). It can also be observed that at all educational levels, the degree of contraceptive usage tends to be highest after the third and fifth child. The discussion on age, parity and education as factors affecting the acceptance of modern methods of birth control should not lead to the conclusion that these are the only factors that can explain and predict fertility behaviour. Other factors like social control, sex preference, personal experience and social status are also of great influence. However, such social phenomena cannot be investigated by a sample survey of this nature and require, instead, intensive research by participation and observation. This form a fertile ground for future research.

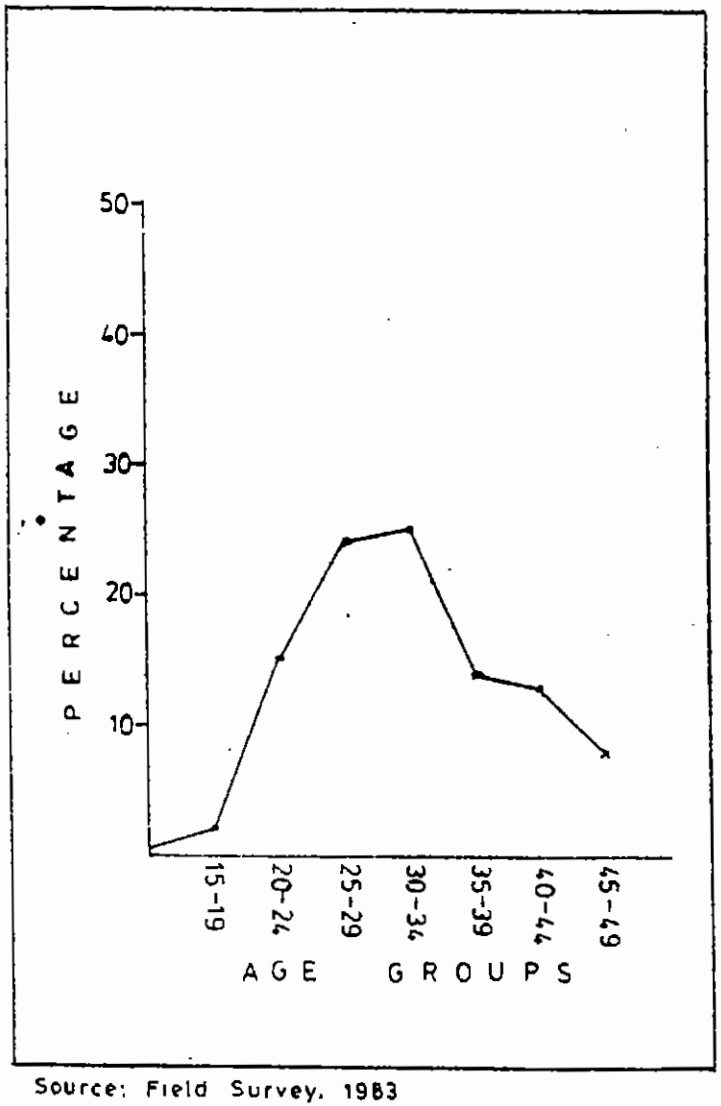

Figure 6. Relationship Between Contraceptive Use and Age Groups of Women

TABLE 15. PERCENTAGE DISTRIBUTION OF WOMEN WHO HAVE EVER USED ANY METHOD OF CONTRACEPTION ACCORDING TO LIVING CHILDREN AND BY EDUCATIONAL LEVELS

Educational Levels	Living Children 0	1	2	3	4	5	6	7	Percentage of Educational Levels
No Schooling	9.5	4.8	4.8	14.3	5.5	19.0	19.0	19.0	13.8
Primary/Koranic	3.6	10.7	14.3	14.3	25.0	14.3	7.1	7.1	18.4
Secondary	4.9	8.2	9.8	27.9	23.0	9.8	6.6	6.6	40.1
Post Secondary	3.6	7.4	22.2	11.1	14.8	29.6	7.4	7.4	17.8
University	6.7	13.3	33.3	20.0	13.3	13.3	-	-	9.9
Percentage of Living Children	5.3	9.2	14.5	19.1	17.8	17.8	13.2	7.9	100.0

Source: Field Survey, 1983.

GOVERNMENT ATTITUDE TO FAMILY PLANNING

Until of recent, 1988, government interest in population matters has been mainly restricted to population data collection for the porpuse of socio-economic and political planning. The Federal Government made its first official stand point on population policy clear in the Second National Development Plan (1970-1974). Even then, this was in a passive and evassive manner. Emphasis was mainly to "protect mothers ..... from repeated and unwanted pregnancies as well as to enable parents to space their children" (Second National Development Plan, 1970). There was no clear stand either in the Third National Development Plan (1975-1980) too as far as family planning is concerned. In the Fourth Development Plan (1981-1985), the government placed emphasis on the regulation of family size by couples on a rather voluntary basis (Fourth National Development Plan, 1981).

In February 1988, the Federal Government pagged the number of children each women can have at four, even though, it should be a maximum of four kids per couple in order that the policy can have the desired effect on population growth rate. Even then, not much has been done in terms of raising the level of awareness through massive compaign and making contraceptives available.

What has always been absent, both in policy and implementation is define effort on the part of the government to promote family planning. Consequently, people continue to desire for large families despite the socio-economic transformation and hardship imposed by the Structural Adjustment Programme (SAP) in the society in the past 3 years (1986-1988).

POLICY OPTIONS

The apparent problem of high fertility levels in many African countries poses a different set challenges for policy intervention. The goals of material and child health-care remain critical in all African countries today as they were in the past in the more advanced countries of the world. But added to them are new societal objectives entailing not simply healthly survival but also a progressively enhanced living standard resulting from a fuller exploitation of national resources.

stress the importance of a longer period of lactation (and thus amenorrhoea) as a means of improving the survival chances of babies. It should also pay attention to improving the knowledge of the women as the critical role of appropriate nutrition. Data from the present study revealed a very low level of family planning knowledge of contraceptive use.

There is need for the expansion of educational opportunities for girls, especially at the secondary level and beyond. This policy can be defended not simply on the grounds that it would keep girls in school to the age where they can better appreciate the importance of sex education and the value of contraception but particularly because it will enhance their capacity for a more economically useful life.

There is to increase resources for family planning programmes both in the public should be provided on a large scale and contraceptive device made more easily available. There should be special benefite for family planning aceptors or couples with small families.

The present permissible age at marriage (from 12 years) should re-examined with a view to legislating a minimum age that is consonance with present aspirations for improved living stand ards. A minimum age of 20-22 years for girls and 25-27 years for boys would appear to be appropriate.

The present ceiling of 4 children per couple as contained in the national population policy, should be pursued vigorously.

Finally, a meaningful population policy should not be based solely on mechanistic means of holding down fertility rate. It should recognize the influence of a powerful social force which leads people voluntarily to restrict the production of children. That social force is the quality of life - a high standard of living, a sense of well-being and of security in the future. It is for this reason that programmes of agricultural, industrial and economic development should be seen equally as part of population policy.

CONCLUSION

In Kafanchan, mortality is declining sharply while fertility has remained stable at very high level. This has resulted in a rapid growth of the population of the town. Excessively rapid growth of population has been increasingly recognised as a proper area for public policy intervention by many governments. The concern is of course, not with demographic growth perse, but rather with its negative implications for the attainability of a wide range of desirable goals in the several other coast of rapid population growth complicate development efforts.

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