[COMMITTEE PRINT]

REPORT OF

The Honorable JAMES H. SCHEUER

ON

The Growing Awareness of Population and Health Issues in Africa

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PREPARED BY THE

SUBCOMMITTEE ON DOMESTIC AND INTERNATIONAL SCIENTIFIC PLANNING, ANALYSIS AND COOPERATION

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SCIENCE AND TECHNOLOGY,
Washington, D.C., December 22, 1977.

Hon. OLIN E. TEAGUE,
Chairman, Committee on Science and Technology, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to submit to you this report on the national family planning programs and population concerns in six sub-Saharan nations. The report includes a summary of observations and findings, as well as recommendations for suggested action by the Congress, Government, and private agencies concerned with all phases of international development assistance.

As a member of this committee, I was honored to be invited by you to attend the Intelsat Conference in Nairobi, Kenya, in October 1976. This report grew out of your gracious support as well as the encouragement by Marshall Green, Coordinator of Population Affairs, U.S. Department of State, who urged me to utilize the return leg of my journey for an oversight and review of family planning programs and population issues with U.S. representatives and national leaders in sub-Saharan Africa. This mission took me from Kenya on the east coast of Africa, where the Interpol Conference was held, to Tanzania, Zaire, Nigeria, Ghana, the Ivory Coast, and, finally, Senegal.

Except for the Ivory Coast, all the countries visited by our congressional delegation confront the dilemma of a rapidly growing population that is already outstripping development efforts. We found the situation graver than we anticipated, but not as bleak as the doomsday experts would have us believe.

What we have tried to do is draw on a highly educational trip to prepare a modest report on the African population experience as we saw it, from the viewpoint of its uniqueness as well as the universal truths and unifying concepts that have general application to our assistance efforts to the developing world.

One of the major problems caused by a rapidly growing population is that it is also a young population. In Kenya, one of the fastest growing countries in the world, 46 percent of the people are under 15 years of age. This means ever-increasing numbers of children to be fed, nurtured, and educated; more and more potential young workers to be provided with jobs and land; and before long, large numbers of young couples setting up households and having children of their own.

In his meeting with the House Armed Services Committee in January 1976 in Jakarta, Indonesia's President Suharto told us that the greatest threat to stability in his part of the world is galloping population growth. If his government could not meet the people's basic demands for the minimum essentials of life—schools, housing, health

care, and above all, employment—then unrest, chaos, and revolution were in store for Indonesia.

Development in Africa has proceeded more slowly than in other developing areas, so the problem for most African countries is not yet as critical. At the very least, however, improvement of per capita enjoyment of development in Africa cannot take place unless national leaders implement policies which allow the nations to get a handle on population growth. In some areas of Africa, of course, population growth has exacerbated the food crisis and people are dying by the hundreds of thousands.

Everywhere we went, high-level host country spokesmen told us that more visits and discussions on this concern with their U.S. counterparts would be of great benefit. We submit that assistance to developing countries should enable our representatives abroad to help national policymakers lay out the entire range of their development options in the face of a rapidly growing population, and then help them with distribution, information, management, evaluation, and assessment of family and population planning programs.

When Katherine B. Oettinger, Chief of the Children's Bureau, was appointed our first Deputy Assistant Secretary for Population and Family Planning, she pointed out that "going out to do battle against social ills without making family planning services available is like asking physicians to make their rounds with no antibiotics at their command."

In this same vein I firmly believe that we advance the causes of humanity, peace, and stability by encouraging developing nations to integrate their development and population concerns, and then put together programs and policies that invest wisely in raising the quality of life and averting disaster.

JAMES H. SCHEUER,
Chairman, Subcommittee on Domestic and International Scientific Planning, Analysis and Cooperation.

JUNE 23, 1976.

Hon. JAMES H. SCHEUER,
House of Representatives,
Washington, D.C.

DEAR JIM: In response to your informal suggestion, I am putting down a few personal thoughts—concurred with by Dr. Pinkham—concerning a joint study mission on world population that I believe would be useful and timely for both the executive and legislative branches of our Government.

What are the major adverse effects of current population growth in the countries visited? How serious are these problems, and what are their implications for the United States?

In the countries visited, what measures have proved to be most effective and least effective in coping with excessive population growth? How can successful approaches be widely applied within these countries and more broadly replicated around the world?

The United States is currently providing about 12 times as much food assistance under Public Law 480 as population assistance under the Foreign Assistance Act. Do our assistance programs aggravate the imbalance between food and population? If so, what corrective measure might be taken?

Our AID programs, to the extent possible, should be made to serve population objectives. Is this being done, or are there ways in which our various AID programs could be more effective in that regard?

Aside from the opportunity which such a study mission would provide for examining the above and other questions, the trip would allow us to discuss issues frankly with foreign leaders, enabling us to bolster the efforts of those who are really trying to cope with the population issue, tactfully encouraging others to develop population policies, and, where advisable, getting across suggestions of what they might do to cope with population issues and conditions more effectively.

Moreover, the report prepared as a result of this trip would prove useful to the Congress and the administration in broadening interest and understanding in the United States for international population assistance. Since the trip would come shortly after the November election, it might also have the effect of generating interest with regard to new directions in population policy and programs which the Congress and the executive branch might jointly consider next year.

While I do not suggest the study mission seek publicity, there would necessarily be a great deal of press interest in the countries visited; and press conferences in those countries would afford an opportunity to project the cooperative approach, as well as common concern, of our legislative and executive branches in this and other development issues. Anything said to the press would of course have to be carefully coordinated with local situations.

I am sure you will find everyone here in the executive branch to be fully supportive.

With warm personal regards,
Sincerely yours,

MARSHALL GREEN,
Coordinator of Population Affairs.

CONTENTS

PART I

Acknowledgments

We gratefully acknowledge the assistance of a number of persons without whose cooperation our visit to Africa would have been impossible.

First, special thanks are due to Marshall Green, the outstandingly effective Coordinator of Population Affairs for the Department of State, who encouraged and supported us in undertaking the trip, and to his special assistant, Robert Simmons, whose knowledge and implementation of the considerable logistics involved in getting to and around six sub-Saharan countries made our trip feasible and productive.

We wish to thank the U.S. Ambassadors who made available the services of their embassy staffs, and who gave us a great deal of their time: Ambassadors Anthony Marshall, Kenya; James W. Spain, Tanzania; Walter L. Cutler, Zaire; Donald B. Easum, Nigeria; and O. Rudolph Aggrey, Senegal. We are also grateful to John Linehan, Charge d'Affairs, Ghana, at whose home we stayed, and Ralph E. Lindstrom, Deputy Chief of Mission in Kenya, who was a generous host and counselor. We are aware of the great efforts of our control officers in making so many complicated arrangements under difficult circumstances, and our sincere thanks go to Edward Noziglia, Daniel F. Waterman, Jerry Mitchell, Kris Atchley, Albert L. Glad, Max N. Robinson, and Paul A. Inskeep.

We especially thank the Office of Population, U.S. Agency for International Development, in Washington, D.C., which made many arrangements for us and briefed us for the trip, and its population officers in each country visited—Thomas Lyons, Kenya; Jake Harshbarger, Tanzania; Rob Robinson, Zaire; Ted Morse, Nigeria; Julius Prince, M.D., Ghana; and Max N. Robinson, Senegal—who managed to get our party into remote rural areas so we could see family planning services in action where most of Africa's people live.

Special thanks are also due to Jack Schaefer, Director of our Peace Corps mission in Senegal, who introduced us to several of America's best representatives and who arranged for us to watch them work in the bush providing knowledge, experience, and guidance—a rare and heartwarming occasion of our visit. We found them to be dedicated, caring people. The same is true of people from private nonprofit population agencies: The Pathfinder Fund, International Planned Parenthood Assistance Foundation, Ford Foundation, Family Planning International, and the other groups pioneering in this work.

We appreciate the work of Helen Cohen, student intern, who made the trip at her own expense, maintained our rapidly accumulating library of interesting documents, and assisted in taking notes during

interviews. Our generous thanks also to Cathy Parks, legislative assistant in my congressional office, who assiduously collected the documents essential to broadening our understanding of the problem we were studying.

We also thank Polly Greenberg, a professional in the design and delivery of human service programs and author of books on the subject. Ms. Greenberg worked closely with me at every stage of planning and conducting the interviews, taking copious notes throughout the trip, and immersing herself in the research and drafting of this report. We are grateful to Stewart Mott, Mary Lasker, and the Population Institute for the financial assistance which allowed Ms. Greenberg to travel with us.

We also specially thank Shirley Sirota Rosenberg, a writer/editor with much experience in putting together state-of-the-art reports, who provided editorial assistance in preparing these materials and bringing them to publication. We also thank Leon F. Bouvier, a distinguished demographer and sociologist, and Leonard H. Robinson, Jr., an expert in managing family planning, education/service programs in Africa, who brought their sensitive perceptions to a review of the manuscript.

Finally, and most especially, our deep appreciation to the Government officials at all levels, the African women, the doctors, and the nurses, midwives, and tribal chiefs who gave their time with such ebullient cheer and good humor. All helped us enrich our understanding and sharpen our perceptions, thus enabling us to conduct this survey of population and family planning in six African countries.

We also thank the other people from the U.S. Agency for International Development, with whom we discussed ways to effectively integrate population planning and development programs in their areas of specialization: Alex Dickie, congressional liaison; Barbara Herz, population specialist; Anita Mackie, nutrition and agriculture specialist; Edgar Owens, rural assistance specialist; Merrill M. Shutt, M.D., chief, health delivery system division; and James Weaver, development studies training program.

We hope that our observations, findings, and recommendations will be of interest and use to the Members of the Congress, and the public servants who set assistance programs in motion. And we hope it will be helpful to all those seeking the optimum balance between the Earth's population and the resources of this globe.

JAMES H. SCHEUER,
Member of Congress.

PART II

Summary of Observations and Findings

(1) Despite a slight decline in fertility, substantial increases in life expectancy have advanced population growth in Africa at an astonishing rate in the last quarter century. Statistics are lean, but the best estimates place the current population growth rate at 2.7 to 3.6 percent. Decades will pass before Africa's population reaches replacement levels and size is stabilized. Although large areas of the continent are sparsely populated, the uneven quality of the land and the rapid increase in population means that Africa is racing against time as population growth threatens to outrun socioeconomic development.

(2) There is an astonishing unanimity of opinion among African leaders, from cabinet ministers to village midwives, about the need to contain population growth in the six sub-Saharan African countries we visited. The lessons of Southeast Asia, the Indian subcontinent and, most recently, their neighbor Egypt, have brought home the urgent need to telescope the period between lowered mortality and lowered fertility—a timespan that took a century-and-a-half for the now-developed world after it stood on the threshhold of modernity. Africans want all the help they can get from the developed world so that each of their people will enjoy the improvement in the quality of life that should flow from comprehensive development efforts.

(3) Some opinion leaders in Africa remain to be convinced that this problem is urgent and is at the core of all development efforts. Other decisionmakers have been persuaded by the data, but don't perceive how the problem can be handled through their areas of development expertise.

(4) Not one of the six countries we visited in Africa has had a complete and professional census, and the data for rational, sophisticated development planning are not yet available to scholars and policymakers. However, sample surveys and the experience in other parts of the world indicate that expansion of maternal-child health/family planning (mch/fp) services is a logical next step in national development efforts. Family planning programs delivered within the mch/fp framework can speed the decline in birth rates and diminish the devastating effect of rapid population growth on social, health, economic, education, and other development efforts.

(5) Wherever family planning services are being made available in the six countries we visited, they are inundated with women ready and eager to space their children. In addition, many African experts told us that when couples are reminded that childspacing is part of their cultural and tribal traditions designed to safeguard the health of mother and child, additional numbers become interested in modern

methods of contraception. In many places, the people are ahead of the politicians.

(6) Family planning services in Africa are most successfully introduced when they are made part of the full array of preventive and curative services offered by maternal and child health facilities. As national mch/fp programs evolve and achieve credibility and acceptance, free-standing family planning clinics prove to be more acceptable.

(7) All the countries we visited had started national family planning programs, and in all the countries the logistics of getting supplies and staff to the people is the major impediment to the delivery of family planning to all people who want these services. Facilities for providing maternal and child health care are pitifully few, and the number of delivery points for family planning services are even fewer. Less than 10 percent of women in their childbearing years were being reached in any country we visited, and even current 5-year plans which incorporated family planning services were designed to reach no more than 5 percent.

(8) Voluntary organizations, including religious groups both Catholic and Protestant, play a pivotal role in the spread of family planning services through health facilities, including mission hospitals. Operating with a high level of efficiency that derives from experience and dedication, private agencies pioneer in the establishment of family planning services, conduct programs when Government support can remain only tacit, and supplement and stimulate Government services when a national family planning program gets underway.

(9) In the long run, fertility reduction stems from personal decisions. However, the option to have small families is not real for young couples unless relevant family planning information and services are easily available to them, and incentives to use these services to limit family size are part of the socioeconomic scene, legal framework, and value system in which decisions on family size are made.

(10) Research has isolated some of the socioeconomic factors that apparently speed the change toward preference for smaller families. Historically, better education and more job opportunities for women outside the home have consistently helped speed the preference for the two-child family. Other components of modernization which are correlated with smaller families are decrease in infant deaths, delayed age at marriage, increased years of schooling, and assurance of care in times of disability and during old age.

(11) Information on the benefits and availability of family planning services is not reaching many people in Africa, and the integration of population planning materials in school curriculums at any level is miniscule.

(12) The African chief-of-state classically has total control over the nation he leads. What he chooses to do—the orders he gives, the doors he opens, and the funding he spurs—will determine the course of population planning, including the delivery of family planning services, over the next two decades and, ultimately, the state of development his country achieves.

Recommendations

(1) Congress must legislate and fund a new orientation to development that focuses on helping African leaders bring a better quality of life to all their people through a range of development programs that include all possible appropriate and acceptable policies and programs to contain rapid population growth. A long-term, balanced approach to integrating development assistance with aid for family planning and population planning is essential if the considerable aid the United States gives to Africa is to yield significant results. This new approach to foreign aid will fortify and enhance programs conceived by national leaders in the developing world for development in farming, jobs, housing, education, health, land tenure, et cetera—indeed, any program that affects the quality of individual, family, and national life in Africa.

(2) The excellent U.S. Agency for International Development (USAID) work to date should be expanded through congressional funding and encouragement. This combined development-population effort requires upgrading population concerns within the framework of USAID so that population concerns are taken into account in the planning and implementation stage of all foreign assistance development programs. Some recommended methods for implementing this integrated, interdisciplinary thrust are:

Assigning a population specialist to each USAID section to help experts in all development areas integrate a population component into their programs, where relevant. This population specialist would work cooperatively with other development specialists from USAID, bilateral and international organizations and foundations, and U.S. embassies and, above all, with scholars and decisionmakers in host countries.

Establishing a population policy group in USAID with two major functions: (a) reviewing proposals for assistance in all USAID program areas, with special attention to the need for a population component, and (b) providing assistance to countries requesting technical help in both family planning and population planning.

(3) Preservice and intraining programs should be developed to provide all foreign service staff, including our Ambassadors, with an indepth understanding of population problems in Africa, and the need for population planning that includes broadening the scope and reach of family planning services and building incentives to use these services into other assistance programs where feasible.

(4) Consideration should be given to operating a two-level USAID program: (a) support for population planning and family planning to all countries desiring assistance regardless of USAID criteria (such as Nigeria which has outgrown current eligibility); and (b) an additional tier of support for further mch/fp efforts in countries eligible for USAID.

(5) When requested by individual countries, USAID should be prepared to respond to national leaders when they request assistance in formulating and implementing programs for family planning and population planning in the following areas:

Education and training.—Supporting the work of private population groups, with emphasis on training indigenous key staff.

Helping local institutions train doctors and nurses as family planning supervisors, and training paramedical personnel to provide the entire range of family planning services.

Participating in the design and implementation of a national system of recruiting and providing assistance in paraprofessional training for local people—for example, family planning clients, midwives, tribal chiefs, traditional healers, and pharmacists—who show aptitude for providing family planning information and services.

Assisting universities in strengthening their departments of demography, and supporting advanced training abroad for Africa demographers.

Supporting the establishment of departments of preventive medicine in medical schools and scholarships for overseas medical studies.

Preparing doctors and nurses to train and supervise paraprofessionals in the delivery of family planning services (that is, training the trainers).

Supporting the efforts of appropriate ministries and private organizations to spread the word on family planning, in appropriate languages, through all formal channels—for example, by using radio, television, periodicals, newspaper ads, billboards, posters, and flyers, and distributing materials on the job, in schools, and at health centers.

Participating in designing a family planning network of "each-one-teach-one" so that informal peer-group communications systems are established between satisfied family planners and the nonacceptors.

Supporting the integration of population and family planning concerns in every formal learning situation, from elementary school level through university and teacher-training curriculums.

Service delivery.—Working with appropriate institutions to develop incentives that will bring the medical knowledge and skills, and oversight and review capability of nurses and doctors to a far-flung network of mch/fp clinics, and to develop a system of staggered tours of duty.

Augmenting counterpart training so that Africans develop their own capability to deliver health and family planning services through a network of well-trained paraprofessionals supervised by sophisticated medical and management personnel.

Assisting in the development of a contraceptive manufacturing capability in each African country or region.

Drawing on U.S. marketing expertise to help Africans create a climate and system that permits contraceptives to be available from many sources, including midwives, pharmacies, and village markets, as well as from the medically directed health and family planning services.

Research, planning and evaluation.—Working with host country officials to assess current development objectives in the light of population growth rates. (This process will lay the base for a realistic timetable by which national leaders can establish priorities, evaluate

national capacities to use external technical assistance successfully, and pace development programs.)

Helping create and improve national and private systems of data gathering and sharing.

Supporting major evaluation efforts on the effectiveness of family planning education and services, the extent to which health aides are offering information and services as frequently as they could and should, and the impact of broader population planning activities on birth and death rates and maternal and child health indicators.

Conducting research on the effects of land redistribution on family size.

(6) We should help governments who wish to develop or augment programs that make small families not only feasible but desirable by helping national leaders to build purposefully antinatalist features into public policy and law. Such incentives could cover many areas of socio-economic development including preferential housing, jobs, and tax rates for couples with smaller families. A few other examples are as follows:

Employment and education.—Increasing education and employment opportunities for women.

Agriculture.—Introducing simple, effective farm machinery and tools that decrease the number of hands needed to farm the land, and establish better prices for cash crops so farmers can give up the labor-intensive practice of subsistence farming.

Housing.—Providing more favorable financing to families with fewer children for repair and purchase of homes and giving priority in electrification to rural communities which have brought down their birth rates.

Social security.—Providing medical and old age benefits to reduce dependence on children for support in times of reduced productivity and increased dependence.

(7) In each country, U.S. Ambassadors and other high-level counterparts should encourage the head-of-state to launch more pervasive efforts to move mch/fp ahead rapidly and to make population activities a priority concern of his ministers and scholars. For example:

The Ministred of Education can generate family life curriculums for all students from the earliest grades through graduate school, including teacher-training institutes.

The Ministry of Information can develop awareness of family planning and produce materials that refute the myths about contraceptives for a variety of mass media.

The Ministry of Internal Affairs can prepare for an accurate and regular census.

The universities can develop strong demography and population courses that cut across departments and alert students in all disciplines to pressing population issues.

Scholars can participate vigorously in establishing nonprofit regional institutes in east, central, and west Africa where decision-makers, political leaders, ministers, and tribal chiefs can be oriented to population problems and solutions.

Physicians and lawmakers can work to change attitudes so that it becomes increasingly acceptable to limit family size, and legal and profitable to establish a diversified distribution system of contraceptives.

The Scheuer Congressional delegation traveled from East to West across subSaharan Africa. Of the seven countries visited, only the Ivory Coast had no population problem.

PART III

Introduction

In recent years, enlightened Members of Congress have worked diligently to increase U.S. Agency for International Development (USAID) development assistance to developing countries around the world to help our fellow human beings avoid great suffering. This appears to be the only humane and decent thing to do. Such assistance began in 1948 when the United States, under Executive order, began to extend economic assistance to developing countries. Only in 1967, however, did Congress authorize specific funding for population planning and family planning programs in assistance programs when it directed the USAID, than 6 years old, to include such projects under title X of the Foreign Assistance Act.[1] Even then this aid lagged consistently and strikingly behind assistance for other kinds of programs. Over the years, $22 billion has been extended for all title X programs. Of this amount, only about 3½ percent, or $831 million, has been allocated for population and family planning activities. We in Congress who have shaped the USAID program, have ignored the destructive imbalance that can result when programs affecting population and family planning are not made an integral part of other development efforts.

To a great extent, we have been reluctant to meddle in the sensitive area of reproductive behavior. Nevertheless, it is now becoming inescapably clear that efforts to improve the quality of life in developing countries must take population growth into account. Otherwise, our assistance will avail little. Unless our foreign aid program is recast, any suffering we lessen today may arise to be compounded many times over a generation hence.[2]

The rapid rise in population which startles us today did not come about because people suddenly started having more children. Indeed, the evidence shows that they are having less children. Since the late

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[1] Public Law 90–137.

[2] As might be expected, private organizations—for example, the International Planned Parenthood Federation (IPPF), founded in 1952, and the Pathfinder Fund, active since the inter-World War period—entered the population assistance field long before governmental agencies, which were constrained by internal and external political considerations. The Swedish International Development Authority (SIDA) was the first government agency to offer assistance for population/family planning projects. In 1966–67, the U.N. Fund for Population Activities (UNFPA) was organized. It became a major force in organizing, financing, and coordinating national efforts to slow population growth. UNFPA-funded projects are implemented as appropriate, by other agencies, such as the World Health Organization (WHO) and the U.N. Development Program (UNDP). Many governments contribute to population-related activities by channeling funds through UNFPA.

Population donors active in sub-Saharan Africa include multinational agencies—the World Bank, UNFPA, WHO, UNDP, the Food and Agricultural Organization (FAO), and the International Labor Organization (ILO); USAID, SIDA, and other international development agencies including those of Denmark, Norway, Finland, the Federal Republic of Germany, Canada, Belgium, Japan, the Netherlands, Switzerland, and the United Kingdom; and private associations including IPPF, the Pathfinder Fund, the Population Council, the Ford and Rockefeller Foundations, the Family Planning International Assistance (FPIA), World Neighbors, and various church organizations.

22-303 O - 78 - 2

1950's, birth rates have declined all over the world, dropping as much as 20 to 40 percent in some parts of Southeast Asia, to only slightly in such areas as Africa. In the United States birth rates dropped by 33 percent.

Rather, the rapid increase in population occurred because more babies survive to adulthood and more adults are living longer lives. High mortality rates—once nature's universal answer to impending population pressure—have been brought down somewhat in the developing world by human intervention through powerful medical and technological tools. Having influenced one side of the birth/death balance, forward-looking societies now have the responsibiltiy of controlling fertility so as to restore equilibrium. Such a new ratio implies longer, healthier, and more productive lives.

In October 1976 we visited six African countires—Kenya and Tanzania in east Africa, Zaire and Nigeria in central Africa, Ghana and Senegal in west Africa—and found much about population growth that holds true for the rest of the developing world, as well as much that is uniquely African.

OVERVIEW OF AFRICA'S POPULATION PROBLEMS

Most of Africa has a population that grows at the rate of 2.7 to 3.6 percent or more—if the sparse and murky statistics available can be relied upon, for skilled demographers, experienced data gatherers, and computerized data systems are in short supply.[3] No one knows how many tiny villages remain uncounted and how many unrecorded babies are born at home, where 9 out of 10 mothers still give birth. We were advised privately by demographers in most of the countries we visited that the growth rate is probably higher than what the records show.

The facts of life in Africa are harsh. Infant mortality averages 154 per 1,000, compared to 78 in Latin America and 16 in the United States. In western Africa, the average rate of infant mortality is 175 per 1,000 and only half the babies who survive infancy live to be 5 years old. Between 1950 and 1976, modern techniques of sanitation, preventive health, and medical care enabled Africa's population to raise life expectancy from 30 to about 50 years. Efforts are now being made to increase life expectancy, perhaps eventually matching the 70 years enjoyed in the developed world. As the unnecessarily tragic toll of life in Africa starts to tumble further through the application of additional humanitarian measures, the rate of natural increase (RNI)—the difference between deaths and births—will rise. However, if decreases in death rates are not matched by lower birth rates, Africa will face the kind of explosive population growth that undermines national struggles to create better lives for their citizens.

For example, during the sixties, donor assistance helped food production in developing countries over the world increase by 2.7 percent annually, compared to 2.6 percent in developed countries. But because their populations were growing nearly as fast as food production, the actual gain for each person in the developing countries amounted to only 0.19 percent a year. In developed countries, on the

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[3] Reliable statistics for projecting birth and death rates, and rate of natural increase are not yet available in most African countries. All numbers in this report are the best approximations available to us, but they are not valid for planning purposes.

other hand, per capita food production in the same period rose 1.53 percent annually. Insignificant gains in food production mean that developing nations, in general, and Africa, in particular, cannot improve the current low nutritional status which contributes to major health problems and which has such insidious effect on child development that it threatens the health and strength of the future population.

Governments urge increased production. Farmers work harder, generate more food, and stack it at the roadside for pickup. But, because of pathetically inadequate transport systems, it is never hauled away. Instead, it rots. Even with extraordinarily vast infusions of capital from the developed countries for fertilizer, seed, irrigation know-how, appropriate technology, new crop education, and demonstration at the farmer-by-farmer and village-by-village level, even with massive help with road and railroad building and maintenance, materials, managers and specialists, vehicles, and vehicle operation, even with well-conceived incentive programs to tempt farmers to grow more—it's difficult to see how food production and distribution can be doubled to meet current nutritional needs, and then doubled again to handle a doubled population in over 20 years.

Realistically, there is little credible evidence that the developed world is prepared to invest at this enormously escalated level. Yet the United States has never been indifferent to such crises, and we must search for a role that balances the reasonable expectations of the developing world and our sometimes competing domestic needs and priorities.

Integrating Population and Other Development Concerns

What appropriate actions can the United States take to promote development and wise use of the Earth's resources so that we can enhance and preserve our own quality of life while helping developing nations to cope with the swift onrush of demographic change?

It is the right of each government to decide whether or not its growing population impedes development and, if so, to establish the specifics of a rational population policy. As has always been our policy, the United States should, provide assistance for family planning and population activities only to countries that request it. Underlying these principles of U.S. assistance, however, is the obligation of the United States to promote understanding among host country scholars and policymakers of the critical link between population growth and the success of the development programs we choose to assist. Only then can the developing world request aid for a balanced array of development programs that includes assistance to those population planning programs, including family planning, which evolve as acceptable to their people and which are consistent with their cultural, racial, tribal and political mores.

With only a few exceptions, our own U.S. Embassy and USAID representatives in sub-Saharan Africa are not sufficiently aware of this responsibility or, indeed, that population growth is outrunning development efforts on the continent. We asked the able Ambassadors posted in the six countries we visited if they had ever discussed with chiefs-of-state the connection between exploding population growth and national development programs. Despite the clear indications of a need

for changing values in Africa, not a single one had ever done so. These are the replies we received:

> No; I've never had time—there have always been more urgent things to discuss. I've always had to put it on the back burner.
>
> Well, you see, there isn't a population problem in this country, because there's still a lot of empty land.
>
> It is important, and the time might be right in other African countries, but you must understand that it's different in this country. It's a very sensitive subject. There are tribal factors to take into account. And the men don't want it. And many women are Catholic or Moslem—their religion is against it. Maybe someday, but right now the people are not ready.

At home and abroad, the population problems of developing countries tend to be viewed as distinct from other international concerns. Not only are USAID population officers isolated from the mission people who, like the rest of Americans, have little sophistication about population issues, but they are also frustrated when attempting to integrate population components into the development efforts of their USAID colleagues. Few of the Foreign Service, within and outside USAID, are sufficiently aware of the interrelation between population and development and the broad scope of this relationship. Even within USAID, most of the Agency's population assistance tends to be focused on family planning. Conversely, one health official told us that priority is often given within USAID to delivery of family planning supplies before other health equipment.

The Available Alternatives

When a developing country is unable to furnish its people with enough nourishing food, sufficient sanitation to prevent mass disease immunization against the cripplers and killers avoidable in the developed world, effective treatments for injury and illness, and appropriate education and employment, its leaders have two alternatives:

(1) They can initiate programs to moderate the rate of population growth while augmenting the supply and equitable distribution of vital goods and services, or

(2) They can allow population growth to race ahead, overwhelming the newly developing supply of goods and services, with resultant diminished per capita income, consumption, and living standards, and high death rates.

The logic is inexorable. Equilibrium between births and deaths will be reached, one way or another. The question is, can Africa learn from the experience of other developing areas—most notably seen today in the crises confronting Southeast Asia and the Indian subcontinent—and bring about a decrease in fertility before the continent is caught on a deadly treadmill in a tragic race with time?

The need to improve quality of life in Africa and ward off dsiaster is great. An indispensable precondition to such progress is the need to decelerate the rate of African population growth. A proper solution to the interrelated problems of population and development cannot be undertaken without mature political decision and governmental support. It is imperative that each country in Africa understand the magnitude of the problem now. The situation is alarming and we found that many African policymakers as well as scholars

agree. Fred T. Sai, a leader in Ghanaian demography, sums up this position:

> For sustained action the politicans must be committed. The food and population problems of Africa appear to be incapable of solution in a reasonable time. Let our political and technical leaders come together and dream an impossible dream. A dream that gives them courage to try solutions. It is then and only then that real progress can be made.

The United States, backed by women's and health professionals' groups, has come to favor family planning as a human right, a health measure, an alternative to abortion (perhaps the most widely used birth control method in the world) and a means of reducing the impact of closely spaced pregnancies on maternal and child health. In 1965, when John W. Gardner, Secretary for Health, Education, and Welfare, laid the base for the national family program that was to become embodied in the 1967 social security amendments, he declared the objectives would be to "improve the health of the people, to strengthen the integrity of the family, and to provide families with freedom of choice to determine the spacing and size of their families."

The World Population Plan of Action adopted in 1974 at the third U.N. World Population Conference states that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so," and urges governments to take steps to make these rights reality.

Family planning, in turn, affects population growth by providing the tools for decreasing fertility. Research has shown that other government actions tending to reduce the birth rate, whether or not they were so intended, are policies which reduce child mortality, provide women with alternatives to motherhood through educational and employment opportunities, and assure parents of the benefits expected from children, such as care and security in old age or during disability. Policies that redistribute income will also have a fertility-reducing effect in the long run.

Dearth of Statistics Compounds Problems

A major problem confronting national policymakers in Africa is the lack of statistics necessary for evaluating the implications of population change. Population data in Africa are not systematically collected and published. African nations have only a short history of census taking. Colonial-era counts were incomplete; tallies were frequently made only of the white population or only of taxpayers, and the close link of the census with the head tax discouraged cooperation of the indigenous population with the census takers.

Even the United States with its long census experience must allow for undercounts and errors, and in Africa the logistical and cultural barriers to an accurate count are great. For example, locating villages, households, and nomadic groups is a major task, and maps frequently have to be prepared before the census begins. Getting a nearly simultaneous count is doubly difficult where travel is difficult. If custom decrees that only the head of the household may be interviewed, women and children may be underenumerated. In many cultures which consider it bad luck or impolite to inquire about the number in the family, women tend not to list the children who did not survive the first week of infancy. This leads to underestimates of infant mortality.

Despite such problems, most African countries, with the help of the UN's African census program, have taken censuses in recent years—Ghana in 1970; Kenya in 1969, with another planned for 1979; Senegal in 1976.[1] Tanzania has tentatively scheduled a census for 1978—its last census was in 1967—and Zaire expects to conduct its first census since independence in 1978.

Nigeria's 1973 census showed a population of 79 million, a startling rise over the 55 million obtained 10 years before. However, the 1973 census was later repudiated by all parties involved when it was shown to be in error because of overcounting. The country has gone back to using the admittedly imperfect 1963 count and data from subsequent surveys as the basis for national planning purposes. The Nigerian experience illustrates the vulnerability of census taking where enumeration of the various groups that make up the country is important for political representation and influence.

In sum, reliable statistics for projecting the numbers of current and potential consumers of jobs, education, health care, and other services, are not yet available in most African countries. However, the obvious and rational first step toward population planning is the introduction of family planning services for couples who want to space or limit their children, and family planning information for people who do not yet perceive family planning as a viable option.

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[1] The Senegal count, which has not yet been analyzed, suggests that the population may stand at 5 million, 15 percent higher than was estimated by Senegal's planners on the basis of preliminary surveys.

In the developing world, the broader area of population planning—as distinct from family planning programs per se—may include building socioeconomic incentives into government policy. Other incentives on trial in some countries include preferential housing, schooling, and tax rates for families with only two or three children. Among population planning programs funded in some measure by USAID are development of health and family planning and population policy, investigation into the biochemistry of sterility and fertility, development of demographic data, promotion of education and social science research on the twin issues of population and development, and establishment of adequate manpower and facilities to handle the new disciplines and additional professionals demanded by the population situation.

Population Trends Viewed Historically

The world's experience with rapid population growth is extremely limited, since the phenomenon is relatively new. For millenia, high birth rates exceeded high death rates only slightly. The result was a slow growth in numbers of people. Indeed, the RNI was sometimes even negative. Between 1350 and 1400 A.D. when the Black Death and other devastating epidemics swept through the continent, the population of Europe sank by about 25 percent. By 1900, as man learned to deal better with disease, famine, accidents, and other natural catastrophes, the Earth's population grew to 1.6 billion. By 1970, it had risen to 3.6 billion. At present rates of growth, the demographic outlook calls for today's world population of 4.1 billion to grow to 6.4 billion by century's end, doubling to 8.2 billion shortly before the year 2020—about 40 years from today. The previous doubling took about 50 years; the doubling before that, 110 years.

Doubling time is often used to illustrate the enormity of the population problem. At the annual growth rate of 2 percent now being experienced by the world as a whole, doubling implies an eight-fold increase in numbers of people in just over one century. However, most population experts believe that exponential growth would eventually lead to either a drop in fertility, or mortality would increase as the Earth's support systems give way. In either event, the projection of continued population growth on the basis of the current RNI will prove to be inaccurate.

What is demographically much sounder, and even more dramatic, is the method of population projecting development in 1975 by Tomas Frejka of the Population Council. This method demonstrates the property of momentum that is always present when major changes occur in demographic behavior, and reminds us of the tendency of a moving vehicle to continue its motion long after its brakes are applied. The momentum of population change applies both to rapidly growing and to rapidly declining populations. However, only growing populations are our concern here. Michael S. Teitelbaum, a demographer at Oxford University, explains it well:

> The subtle basis for the momentum of population growth resides in the age structure of a rapidly growing population. Such a population is distinguishable from a slow-growing population by the former's very "young" age structure—i.e., by its large proportion of children and adolescents. In such a country there are many more young people than adults, and as the young enter the reproductive ages there inevitably will be more potential parents. The implications for future growth of this population momentum are often overlooked. Government officials, even some well-versed in economics, often view population growth rates as amenable to the same type of short-term manipulation as other societal rates. Such perceptions are factually incorrect. The momentum of population growth is determined not by government policies but by the inexorable logic of mathematics.

To put it more simply, you can't get immediate results as soon as you turn off the faucet. Certainly you can't reverse the flow of water once it is released from the tap.

Examples of the tremendous effect of population momentum is contained in the following data for four of the countries we visited: Nigeria, Ghana, Kenya, and Tanzania. The results for Zaire and Senegal would be quite similar. Looking at Nigeria, for example, we see that even if women reduced their fertility from an average of seven children to a little over two children in 2000—a totally unrealistic assumption—Nigeria's current population of 65 million would increase to 200 million by 2050, three times the current figure, before it would level off. These are the minimum numbers that Nigeria will have to face.

POPULATION PROJECTIONS FOR FOUR AFRICAN COUNTRIES

	Nigeria's population			Ghana's population		
	Present	2000	2050	Present	2000	2050
If nation reaches NRR 1.0 in the following years: [1]						
1985	65	102.5	134.6	10.6	13.6	17.4
2000	65	129.2	197.8	10.6	16.8	24.8
2025	65	147.8	294.1	10.6	19.1	35.7
	Tanzania's population			Kenya's population		
	Present	2000	2050	Present	2000	2050
If nation reaches NRR 1.0 in the following years: [1]						
1985	15.6	19.7	25.3	13.9	16.7	21.3
2000	15.6	24.4	35.9	13.9	20.7	30.3
2025	15.6	27.5	51.6	13.9	23.4	43.2

[1] NRR (net reproduction rate) of 1.0 means that a woman will live to have 1 female live birth, thus achieving "replacement level fertility." This translates to a little over 2 live births (male and female) per woman for a country's population to replace itself exactly.

Source: Tomas Frejka, 1975, "The Futura of Population Growth" John Wiley.

This calculation assumes that mortality will drop slightly over the next 50 years. The fear is that if fertility shows no signs of declining, death rates will start rising again, and population growth would be curtailed once more by the harsh hand of nature. Neither history nor the data lie, and virtually everyone concerned with the issues agree that Herculean efforts must be made—now.

THE DEMOGRAPHIC TRANSITION

The interim period when death rates fall rapidly while birth rates decline only slowly until a state of low growth or equilibrium is reached is known as the demographic transition. Demographers first charted this period for western and northern Europe, where the over 150 years. In general, most of Europe, Northern America, U.S.S.R., Australia, Japan, and Israel had completed the demographic transition by the mid-20th century.

The demographic transition theory, derived from this history of changing mortality and fertility levels in the Western World, states that some threshold level of socioeconomic modernization precedes mortality and fertility reduction, usually with a time lag for the latter. The theory explicitly holds that modernization is a precondition for such demographic change, although its early proponents cautioned that it is impossible to be precise about the various casual factors.

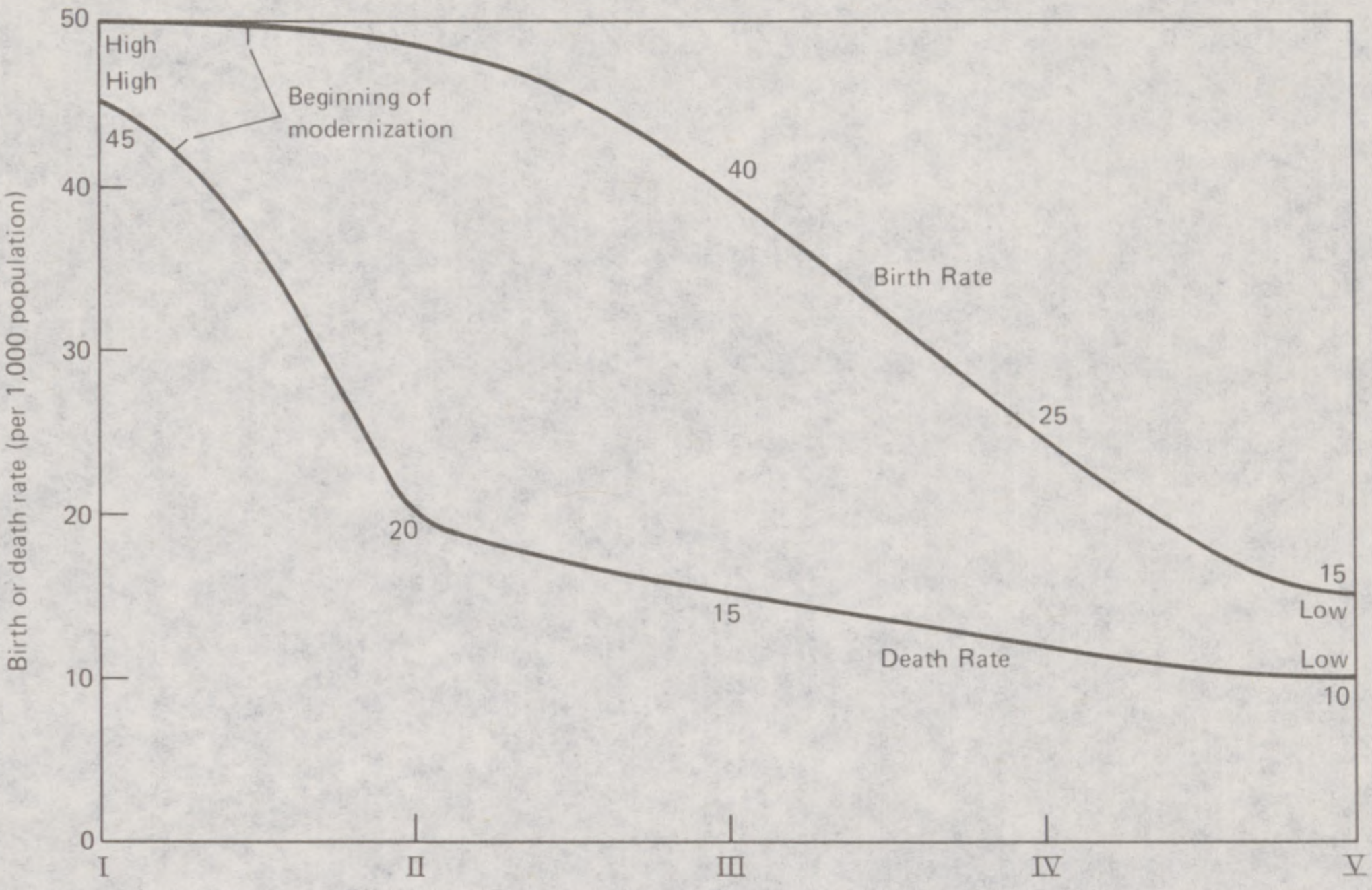
According to Leon F. Bouvier, a demographer with the International Statistical Program Center, U.S. Bureau of Census, the demographic transition is marked by five stages as shown in figure on the following page.

Demographers believe that for about 3 centuries prior to 1900, Africa's population, ravaged by disease and depleted by the slave trade, held steady at about 120 million. In the earlier part of this century, Africa and most of Asia were in stage 1 of the demographic transition. India and many Latin American countries were in stage 2. Most eastern European countries were in stage 3 or stage 4. The United States was about to enter stage 4. A few western European countries, led by France, were on the verge of entering stage 5.

Two-thirds of the countries of the world did not enter stage 2 of the demographic transition until after World War II. For those countries, the period of transition is only 30 years old. Many are in stage 3, and some have even succeeded in entering stage 4.

In African countries, where today's total estimated population is 400 million, mortality has declined somewhat to bring them out of stage 1 but not sufficiently to bring them into stage 3. Here lie some interesting possibilities: Of all areas in the world, Africa has had the most recent experience with steadily increasing population growth rates. Because she is such a latecomer to the demographic transition, and vital statistics remain relatively high, many of her nations may yet be able to go against all classical theory and lower their fertility and mortality simultaneously.

DEMOGRAPHIC TRANSITION



I **High Potential for Population Growth.** BR and DR are high but country is on the verge of modernization. In the early 20th century, Africa and most of Asia were at this stage. No countries remain at this stage today.

II **High Population Growth Rate.** BR remains high while DR begins to drop as a result of modernization (health improvements, more food available, less violence). India and many Latin American countries were at this stage in the early 20th century. Today, most sub-Saharan countries are at this stage.

III **Transitional Population Growth.** DR continues to decline and BR begins to decline. Early in this century, some eastern European countries were at this stage. Today, India and most Latin American countries are at this stage, and some African countries are moving into this stage.

IV **Potential for Decline of Population Growth Rate.** Continuing decline of DR and sharper decline of BR. Early in this century, the United States was about to enter this stage, and some eastern European countries were already in it. Today, Taiwan, South Korea, Puerto Rico, Costa Rica, and the People's Republic of China are at this stage.

V **Incipient Decline of Population Growth Rate.** Low BR and low DR which are almost equal. In the early 20th century, a few western European countries (led by France) were about to enter this stage. Today, western European countries, the United States, Japan, and the U.S.S.R. are at this stage.

How African Leaders View Population Growth

If the projected population picture for Africa is so alarming, why aren't Africa's leaders more concerned?

One answer is that they are concerned.

Many African planners realize that strength does not lie only in numbers. African development-conscious thinkers in each of the countries we visited are far more aware than some of our Embassy and USAID personnel that a huge but sickly and uneducated population has less likelihood of becoming a world power than a small, healthy, educated population. In the past, foresighted African leaders pointed to India, in contrast to Israel and Scandinavia, as an example of this point. Today, the view is rapidly gaining adherents.

Apparently there has been a tremendous turnaround in the last year or two in Africa. Virtually every country on the continent has reversed itself because of the demographic reality facing Africa. The most dramatic example of the growing conflict between population and development is illustrated for Africans by the phenomenon of Egypt's Aswan Dam. Preliminary research indicates that authough this dam has fulfilled most expectations for producing vast amounts of hydroelectric power and millions of acres of irrigated land, per capita gains in energy and arable land are below expectations because of the population increase that took place in the Aswan Dam Valley during the period of construction.

Everywhere I went in Africa, the USAID population official would tell us:

> I am so glad you are here. You are the first Member of Congress who has ever expressed an interest in seeing people here about the population problem. It is essential that you see the Health Minister. I couldn't even have taken you to see him 2 years ago.

In all six countries we visited, family planning is happening, to one degree or another. Ghana and Kenya have explicit policies to limit population growth, with family planning programs forming the initial thrust of this effort. The other countries have all started national family planning programs. Some are of comparatively long standing. Others, such as Senegal, are in the process of refining an elaborately written plan, which USAID is helping them produce.

There are some few black people who see attempts to control exploding population as a wiley plot on the part of the imperialistic Western World to reduce black Africa's population, strength, and world influence. We are reminded that in the late 1960's, when Congress for the first time mandated the availability of family planning information and services in public health, welfare, and poverty programs, some U.S. black leaders accused us of attempted genocide—after decades of voluntary effort by private organizations, including black people's groups, to get our Federal Government to assume this responsibility. However, our travels have taught us that most African

leaders in sub-Sahara Africa hold to the same knowledgeable view articulated in a statement by a black leader from southern Africa to the 1974 Bucharest Conference on World Population:

> Although it might be true that family planning projects are part of the white man's conspiracy to halt Black population growth relative to white in southern Africa, it is doubtful that the white man has much to gain in any population planning programs in independent African States.

Some African leaders see vast empty land and feel that their countries are underpopulated. Like the late Francis O. Okediji, a leading African demographer from Nigeria, they believe that a growing population, with its energy and demands, is a spur to development:

> It is debatable whether many of the small African states possess the critical population size necessary to launch a real program of industrial development. Exploitation of the abundant natural resources—minerals, energy sources, cultivatable land—which most of these countries possess, is often not possible because their populations are too small and scattered to control these resources and use them profitably.

A closely linked argument is that nations need a large pool of potential consumers to absorb local products and encourage growth.

Growth of population may be a source of national pride. When the results of Senegal's census were announced, one newspaper headline read, "We Senegalese are 5 million."

A reaction we repeatedly got from African leaders is that while they agree in the abstract with the proposition that population growth may rank as the most important long-term problem for developing countries, they must concentrate on today's short-term crisis. "Our people have enough to worry about," they told us, "war, famine, and internal struggles just to stay alive each day."

Many heads of state in the newly emerging African nations hesitate to make public proclamations in behalf of controversial programs. Few feel it is safe to advocate family planning publicly and strenuously. Some leaders attack population planning just as they do many other Western-backed programs. Comments a well known Ghanaian political leader:

> It's only rhetoric. After some of our distinguished politicians pound on the table against family planning, they go home to the beds of their contracepting wives.

Actually, it serves no purpose for some African heads of state to make family planning and population planning part of their platforms. When a leader is overthrown—a frequent occurrence in newly emerging, identity-seeking African countries—programs associated with him, especially those bearing his personal imprint, are usually thrown out, too.[1] If a President makes a major issue of family planning, he may expose himself to attack both from within his country and from neighboring nations. At the least, he runs the risk of alienating the average citizen by focusing attention on a particularly sensitive aspect of both a comprehensive family health program and an overall national development plan.

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[1] One indication of how quickly things change is the news, as we go to press with this report, that the Senegalese Health Minister in office during our visit has been ousted and the new family planning program discussed in our country report (section IV) has been halted.

In addition, public political pronouncements in Africa, as elsewhere, may have little connection with actual program development. This can quickly be seen by looking at Kenya, where family planning exists as part of an excellent small scale pilot maternal and child health (MCH) project, but lacks the dynamism to be expected from President Kenyatta's official commitment to child spacing. In contrast, Tanzania's President Nyerere has said less than Kenyatta about family planning, but has moved quietly to encourage a far larger effort to create a family health services system, including contraceptive education and service clinics in all rural areas.

Virtually all African countries are single-party countries, entirely dominated by the head of state. Almost without exception, the head of state can direct that certain programs be carried out and appropriate resources channeled. Therefore, the still slightly sensitive subject of implementing rational population policies through the medium of family planning need never be brought into open debate. Instead, the head of state can quietly open doors to this approach.

It is important to recognize that for many decades no African country need worry that population growth will reach a plateau. "Fertility in developing countries," observes Timothy King, Chief of the Population and Human Resources Division, World Bank, "is well above replacement levels, and the young age structure provides an inbuilt momentum to keep population growth high for several decades after fertility falls to replacement."

Arable Land in Africa Is Limited

In our trip in Africa, we sometimes heard the remark, "We don't have a people problem, we have a land problem." Considering the size of the continent, Africa appears sparsely settled. Most people don't realize that much of Africa's land is fragile. The deceptively lush tropical forest is actually rooted in low-fertility soils and is not a reservoir of agricultural land that can be easily exploited. Where such land is cultivated, a system of shifting cultivation has been developed to protect the land from overuse. A plot is cleared only partially to protect it from the scorching sun, planted with a rapid succession of crops, and then left fallow for long periods of 6 to 20 years to recover fertility. As a result, much land that appears to be unused, is actually in fallow. Attempts to use it more intensively cause degradation of the soil and reduction in crop yields.

Projects to impose temperate-zone agricultural practices—as the Belgians did in 1930 in the region that is now Zaire—lead to crop failure and long-lasting ecological damage. Coastal strips are often saline or swampy; savannahs, of course, are semi-arid; large tracts of some countries will only be habitable when the tsetse fly and other insects are controlled. Bringing such land into cultivation is incredibly capital-intensive.[1]

Despite the superficial comfort of relatively low overall population density statistics, good agricultural land in African countries is already densely settled. Writes Sai:

> It is true that Africa is a vast continent which, in terms of population density, can be considered underpopulated. However when population is related to arable land, the density is quite high. It is difficult to see how this current rate of population growth can be sustained at the same time efforts are made to achieve the ultimate goal of economic and social development.

The Sahel is an illustration of what we believe will happen in much more of Africa in years to come if the population explosion is not contained. It is also a dramatic example of the fuzzy thinking of some donor countries, ourselves included, regarding population and development.

The Sahel is an arid and semiarid strip of land running through west Africa. It cuts across Senegal, Niger, Chad, Mauritania, Gambia, Mali, and Upper Volta. Here, millions of square miles of former farmland have been turned into desert by the overgrazing of nomad flocks. Starting in 1968, rainfall declined across the Sahel and by 1972 this region of west Africa was blighted.

According to pictures by Landsat, a NASA satellite taking multispectral images of the Earth, the decline in rainfall may have been caused by the desertification itself, which changed the reflective char-

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[1] From time to time, people point to what the Israelis have done. The Israelis, however, had the capital from both government and voluntary contributions abroad. The Africans have neither the capital nor the deep, almost irrational commitment of the Israelis to rebuilding the land.

acteristics of the land. (See satellite photos which follow.) As a result, the Sahel's 25 million people faced starvation and malnutrition, disease, and social disruption. Their suffering gained the world's compassion, and a massive relief effort was rapidly mounted and carried through to the end of the drought in 1974.

The Sahel relief effort initiated the substantial involvement of USAID in central and west Africa. The design of our current development programs, primarily in the sectors of livestock and a rain-fed agriculture, followed the perceptions of need which we developed during that period. Although the cost of the drought relief was staggering—almost $1 billion—a monumental human disaster was averted. Even so, tens of thousands of people died, whole populations were displaced, and cattle and farms—the basic wealth of the region—were devastated.

Already at the bottom of the economic scale, the economies of the Sahel are now stagnant, with steady decline in average per capita gross domestic product over the last 15 years. Its population threatens to reach 50 to 60 million by the turn of the century, further aggravating the demands on its ecostructure. The drought forcefully illustrates our contention that within the present agricultural framework, much land in sub-Saharan Africa is not and cannot be used well. Despite past aid, the ability of the Sahel to produce food is declining and its vulnerability to disaster is growing. Many otherwise excellent individual development projects had been funded in the sixties and seventies, but their benefits are not reversing the process of deterioration which precipitated the present crisis. And the cost of aid is growing. We were astonished to learn that population limitation and planning is nowhere mentioned among the project areas of the massive rescue and development program led by USAID at the time of this writing. Should there be another drought, the world will find it difficult to afford another rescue which would cost an estimated $3 billion by 1985.

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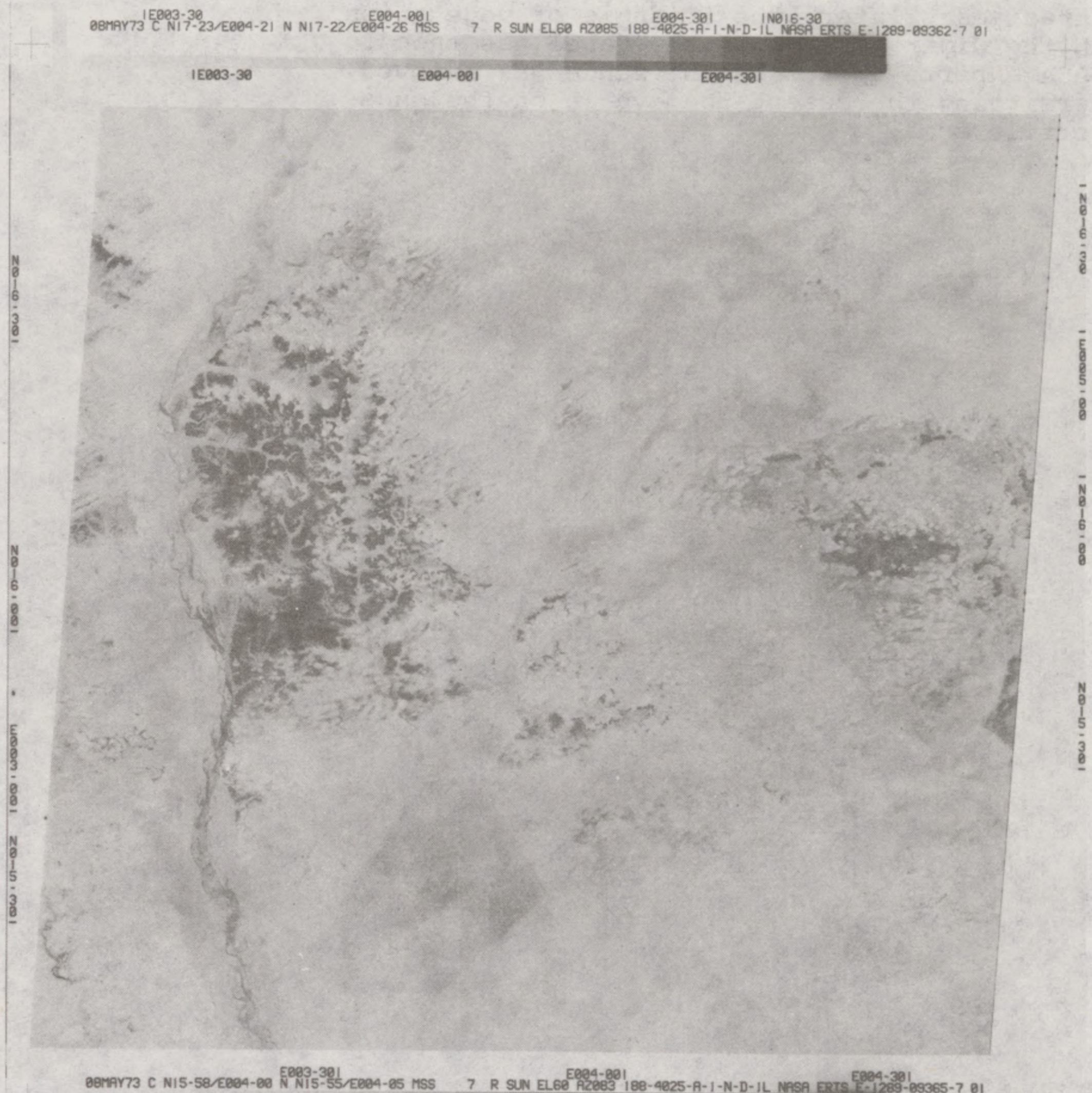
Satellite photo of the Sahel region, Africa, reveals amazing difference between controlled and uncontrolled grazing as seen from space. Darker, diamond-shaped area in the center foreground is a fenced cattle ranch with managed grazing in Niger; it was successfully resisting the process of desertification going on throughout the region as recently as 1973.

A model of the Sahelian dilemma developed under a National Science Foundation grant suggests that in the absence of intervention, the range will not return to pre-1974 drought levels for another century, and that such well-intentioned interventions as veterinary services, breeding programs, and restocking may so overburden the range that total desertification will result.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Three years later, the triangle of vegetation in the Niger portion of the Sahel has faded. NASA experts speculate the fence was removed, permitting the desert to move in on the once fertile area.

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A striking difference in land use management is illustrated along the northern border of the Sinai with Israel. In this recent satellite photo, the more effective Israeli conservation practices, particularly in controlling goat herds in this desert region, are reflected in the darker tone which indicates greater density of vegetation. The demarcation between the replenished area and the one that remains denuded is the armistice line of 1947-48 between Egypt and Israel.

High Fertility No Longer Suits Africa's Needs

In traditional societies, social values and religious customs all come down on the side of high fertility, which for so long has been essential to group survival. African cultures have always viewed childbearing as the ultimate expression of womanhood, and women's status is likely to be measured by the number of children—especially sons—she has produced. Childlessness is a reproach. The typical couple wants an average of six surviving children, and achieves this goal. Typically, woman's work is compatible with childbearing and then childrearing, and cottage industries flourish. In Africa the farm and market women take their infants with them to the fields and marketplace, where the older siblings instruct them in their chores.

When infant mortality is high, large families serve as insurance against the economic and emotional loss of some of the children through early deaths. In Africa, only half the children can be expected to grow to adulthood, provide grandchildren, carry on the family name and traditions, and care for their parents in their old age.

Economics rewards large families in a nonmechanized society. Even the smallest child can help out in traditional farming, housekeeping, and other home industries. The more hands a farmer has to help him, the more land he can cultivate, and the more intensely he can cultivate the land he does have. A weaver's children can work on the time-consuming preparation of the fiber for the loom. Children can earn money on plantations or in labor-intensive factories. Only in highly industrialized societies do children cease to be an economic asset. In societies where social security programs are lacking or are not universal, parents need insurance children to help them in hard times and old age. Unless there are clear indications for African families as to why these values should change, why limit family size?

Apparently, one reason the small family norm has not yet taken hold in Africa is because child survival is still too low. Health care remains so unbelievably inadequate and disease takes such a toll, that prospects are poor for child survivorship to rise as dramatically in Africa as elsewhere in the post-World War II world. Women will not limit the numbers of their children until they are convinced, from near-at-hand experience gained over a sufficient period of time, that their babies will live long enough to grow up to adulthood.

African Women Are Ready

Existing family planning programs in Africa are vastly oversubscribed, as we saw for ourselves.

The African woman has a human elemental need for family planning services, and that need is raw. You don't have to read her human rights to her. A great many African women are ready now to practice modern methods of contraception. They need little motivation, training, or encouragement; they simply have to be shown how.

In Kenya, public health nurse Victoria Lupuwana, said:

> If a mother has one on her right side, one on her left, one on her back, one in her arms, one in her belly, and also suffers from malaria, she is overjoyed if we can help her rest a while from childbirth. We know it is our responsibility to help her. We know how to do it. But we are helpless; we don't have the supplies and support to do it.

Nurse supervisor/trainer in family planning, Machakos district, Beatrice M. Mutna, said:

> Look at them. They are exhausted. Some of the husbands see it, too. We talk to the husbands about helping their wives have better health by going along in this matter. The women suffer so many complications in childbirth. Many men see the advantages of family planning.

In Senegal we mentioned to a host country expert that:

> We've been told African women regard contraception as a Western plot to promote genocide. In your experience, sir, is that true?

He replied:

> Show me the African woman who will tell me that offering her an option to having 13 children, great grief over many of them, illness and early death for herself is "an American imperialist plot."

Esther Mukatha, public health nurse with the National Family Welfare Centre in Kenya, explained:

> It is not against tribal religions. Every tribe has always practiced birth control. There are various traditional methods. Polygamy is common. This keeps down the number of children one wife has. Prolonged nursing with restrictions on intercourse until weaning is another method. And abortion is practiced in every country in Africa. In modern times, these ways of the grandmothers are breaking down. We only remind women of those old practices and ask them if they would like to learn of new scientific methods. There is never a problem—the women accept help. It has to do with building on attitudes that are there already instead of coming at it in a way that offends.

Health incentives are being used extensively to get people involved in spacing children. Without exception, everyone we spoke to emphasized that this is the only way to bring the services into their countries and to their people. By offering family planning where women come for instruction in the basic essentials of sanitation, meal planning, and immunization, policymakers have made childspacing an incidental part of a maternal and child health program, and nobody is appalled.

Dr. E. Tarimo, director of preventive services, Ministry of Health, Kenya remarked that:

> Our rate of child mortality is so high, people would think it ridiculous to talk about limiting family size. Our focus is on reaching children with immunizations. We now reach 55 to 60 percent of all mothers. We want every mother who comes to clinic to get family planning lectures and, if she wants, devices.

"We do not run into resistance among the women in this crowded urban community," Mrs. Anne Bamisaiye stated. She is a sociologist and head of evaluation at the Oguntola Street Family Planning and Maternal Welfare Clinic, Shomolu, Lagos. Another health worker at this clinic explained the secret door strategy. Some women readily accept family planning services if they wait with all women for all services—nutrition, education, cooking, immunization, weighing, et cetera—not in a section of benches set aside specifically for those waiting a turn for family planning. They are then escorted through an unmarked door to the family planning aide between attendance at other classes or receiving immunizations.

In a country with a new family planning program, family planning is naturally and easily integrated with preventive care, because it is just that. In a country where this preventive care approach has been established and the idea of modern contraception has been broadly diffused and accepted, free-standing family planning clinics can be set up. (Conversely, in the United States, free-standing family planning clinics are sometimes the first introduction to preventive care for disadvantaged women.) At the Mamayeno Hospital in Kinshasa, Zaire, we saw a separate free-standing family planning clinic. Women come right in from the street to get their family planning assistance, and leave the same way because it is more convenient. But first, they had to have an initial period of family planning based in the MCH clinic. Similar clinics operated by the Catholic and Protestant churches and the Salvation Army in Kinshasa are greatly oversubscribed.

Harvey Herr, working on contract with the Research Division of the Ministry of Health to build an evaluation capability into the family planning program in Kenya, said:

> A coupon is filled out for each woman who comes in for child spacing services. We ask how far she came. From this we know that many women are walking 4 and 5 miles for family planning. Initially, they usually come for curative or other services for themselves or their children, but they come back just for contraceptive guidance. We keep track of "dropouts"—women who miss an appointment and haven't shown up yet 3 months later—and "inactives"—people who've missed an appointment and haven't come back within 3 months, but have reason, and we know what it is. People are keeping up pretty well.

In Nairobi, Eric R. Krystall, Project Manager of Programmes for Better Family Living, Food and Agriculture Organization of the United Nations, assured us: "The women are sold on child spacing. But we have to get services to them."

The people we saw being served are the people who want family planning. That's a large number of people, and Africa does not have enough facilities for half the women who want to practice modern methods of contraception right now, let alone for those who have yet to be motivated.

Although we didn't see midwives being trained, we saw midwives in action, talking to the men (they make a definite point of involving the

husbands) and women in groups of from 25 to several hundred people, including the village chiefs. Many of the women come to the sessions with babies tied in sacks on their backs. Barely literate herself, the midwife holds the attention of her audience as she discusses the reasons for the techniques of family planning, usually with boisterous good humor. In a sense, she is a government representative; she has been trained at government expense and is paid by the government. But all the people before her are her friends in the village. It is one of their own teaching her own neighbors and friends with total credibility and acceptance.

No stranger to family planning

As in other areas of the world, the Moslem religion has posed no barrier to acceptance of family planning; neither do tribal customs.

As infant survival grows, the economic value of children in rural areas is lessening because the land cannot support the larger families.

Also, some tribal practices are effectively antinatalist. For example, according to tradition, a new mother abstains from sexual relations until her child is weaned or can run, about 2½ years to 3 years of age. During that time, she either moves out of the husband's home and goes back to her parents' home, or a member of her family moves in and sleeps in her room with her—a very good form of birth control.

Indeed, the Ford Foundation has funded a study in Ghana of the impact of urbanization on tribal mores and the resultant rise in fertility rates when young couples get married and move to the city to set up their households—possibly because of the absence of the customary chaperone after the birth of each child. Apparently, this rise in fertility is only temporary. After a few years, when the husband becomes accustomed to living in a money economy and is earning enough cash to support his growing family, he tends to adopt the idea of family planning.

The greatest family planning motivators are the women who have practiced family planning succesfully. Many of them will be employed as outreach personnel when they can say, "See what I have done." Just by living in the village or down the street, these women exert peer group pressure on their neighbors by serving as models. They don't have to say a thing. But the fact is that they do talk, and thus serve as 24-hour ambassadors of family planning.

After a decade or two, when this first group of family planners has proven to their neighbors that they can control their bodies, that they can space their pregnancies 2 or 3 years apart, that they bear only 2 or 3 or 4 children, and not 8 or 9 or 10, that they stay healthier, stronger, more youthful, and more attractive, that their children grow up to be healthier, and that they have a more solid home life supportive of literacy and education, then family planning in Africa will spontaneously take off.

We saw little population education of any kind, other than simple single-page throwaways and an occasional highway billboard or clinic poster such as those shown in this report. Many posters point out the connection between the wisdom of spacing children and spacing seed-

lings; they are seen almost exclusively in the clinics. There should be many more posters around. They should be in the schools and on the job, in stores, in post offices. The concept of limiting family size in order to produce a healthier and a more productive population should be inextricably intertwined with every aspect of education at elementary, secondary, and university levels. Administrators do talk about this need, but they need help in developing curriculums. One role the United States could play is to help them design population information for textbooks in all disciplines, up to and including those used in teacher training. They also need assistance in setting up radio and television programs that are consistent with and sensitive to the religious, political, racial, and tribal mores of each country.

Thomas Lyons, USAID mission population officer in Kenya, told us that family planning is no longer a taboo subject in that country. When preceded by education, women readily accept family planning services. Indeed, the Kenyan Government won't supply family planning education without the availability of services; too many women would want the services and would be disappointed.

Michael Sozi, Regional Director for IPPF in Nairobi explained, "Women are much more advanced on the subject of family planning than their husbands. Many women secretly use contraception."

Seifulazia Leo Milas, Research and Evaluation Officer for IPPF, Raj Naik, Assistant Regional Director, Wilson Okwenje, program officer, and other IPPF officers at the Nairobi meeting, agreed. One of them said, "It is not the women who are not ready."

Can Volunteer Family Planning Slow Down Fertility?

"We are all still learning."

An officer of the Pathfinder Fund, Boston.

Population planning proponents warn against a tendency to equate government actions—that is, enunciation of a national family planning program or opening of model family planning clinics—with progress in reducing national birth rates. In Africa, as in the United States, providing family planning services is basically a preventive health measure, one means to a priority goal shared by all governments: namely, to strengthen their nations by reducing morbidity and mortality.

Establishing family planning programs does not necessarily mean the programs will bring the population growth rate down. The question in Africa is: Now that family planning is coming of age, will the African people turn to modern means of contraception as a reliable way of spacing births? Will they have fewer children?

Opinions differ, and statistical proof of a drop in the birth rate due solely to widespread family planning services is as yet scanty. According to Robert S. MacNamara, President of the World Bank, by 1974, South Korea, Mauritius, Costa Rica, Chile, Trinidad/Tobago, Singapore, Taiwan, and Hong Kong had experienced birth rate declines of over 40 percent in less than 20 years. All these countries have public family planning programs. Other nations with public or large-scale voluntary family planning programs that have seen fertility fall by 20 percent or more in that time are Colombia, Thailand, Turkey, Egypt, the Philippines, Tunisia, Barbados, Panama, Sri Lanka, Fiji, and Malaysia.

FAMILY PLANNING PROGRAMS IN AFRICA

In no case can the effect of family planning on fertility be separated out from the effect of other aspects of modernization. In some cases, fertility decline began even before initiation of large-scale programs. It is obvious that when families are inclined to reduce fertility, the availability of modern contraceptives can help them implement that desire.

Other factors—for example, better health, education, housing, job opportunities—can encourage people to have smaller families, but these require long-term government programs and vast sums of money. Family planning programs, on the other hand, have a direct impact. They can be initiated rapidly and require less in the way of resources.

Joel F. Montague, a health expert who has traveled widely in francophone Africa, is convinced that "a lot of family planning is going on—through polygamy, breastfeeding, and abstinence," and that the outlook for a widespread change to modern methods of birth limitation within the next 25 years is bleak. Others point out that since

African tradition fosters birth limitation, particularly by encouraging that each new child is breastfed as long as possible, the people will naturally adopt sophisticated contraception when introduced within a health setting.

Family planning came later to Africa than the rest of the developing world, so the data are not as definitive as for Asia and Latin America. Egypt, Mauritius, Morocco, Tunisia, and Botswana are the only African nations with plans to reduce the population growth rate through family planning programs integrated into health services. Only two nations, Ghana and Kenya—both were on our itinerary—have population policies which seek to influence growth through government agencies that minister to other needs.

Of the seven African countries with population-related family planning policies, Tunisia, Mauritius, and Egypt have scored apparent successes in achieving birth rate declines. Tunisia's birth rate declined from 46.8 per 1,000 population in 1960 to 30.0 in 1974. The island nation of Mauritius achieved a birth rate of below 25 per 1,000 by 1970, down from 40 per 1,000 in 1958. In Egypt, the birth rate decreased from 43.1 per 1,000 in 1960 to 37.5 by 1975. (Despite this substantial decline, leaders in this country are concerned because the population growth rate is still well over 2 percent.) None of these nations is typical of the countries of mainland sub-Saharan Africa which we visited, and population experts warn against trying to apply the standards and experience of other countries to this part of the vast continent. Many sub-Saharan nations, especially those in francophone Africa [1] where the legal heritage is French, are outright pronatalist. Neither is enough evidence available for an evaluation of the ongoing efforts of private or public agencies in any of the countries we visited, although all had government-sponsored family planning programs. Some were of long standing; others, such as Senegal, who had no program a half-year before, were in the process of refining their plans.

It is generally agreed that at least 5 years must elapse between the initiation of a national family planning program and clear evidence of its impact on fertility. In sub-Saharan Africa, an even longer time may have to pass before the potential effect of family planning programs on population growth can be judged. Many of the successes achieved by model programs in other parts of the world took place in nations that are culturally homogeneous, small in area, and blessed with a communications and health infrastructure. In Africa, distances are vast, infrastructure in rural areas is thin or nonexistent, and numerous cultures and languages make up each country. Those are among the practical difficulties that have to be overcome.

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[1] Francophone countries, including Senegal, have been heavily influenced by French law. Upon independence, every ex-colony of France in Africa adopted statutes providing that all French colonial law in effect prior to independence and not contrary to the constitution remains valid until amended or repealed. Thus, a French law of 1920 forbidding promotion, sale, and distribution of contraception remains on the statute books of francophone African nations. The pronatalism of French legislation stemmed in part from alarm as France became the first European country to undergo a decline in birth rates beginning in the late 18th century. However, fertility decline took place in France despite official alarm at the trend and, before the advent of modern contraceptives, by means of delayed marriage and folk methods of birth control.) In 1974, France enacted legislation to make all contraceptives available without requiring registration by name, without charge, and without parental consent regardless of age for family planning and education financed by the social security system. This action may have some influence in African countries whose laws are based on the French code. Mali has begun an official family planning program and Senegal, as explained in our country report, is moving in that direction.

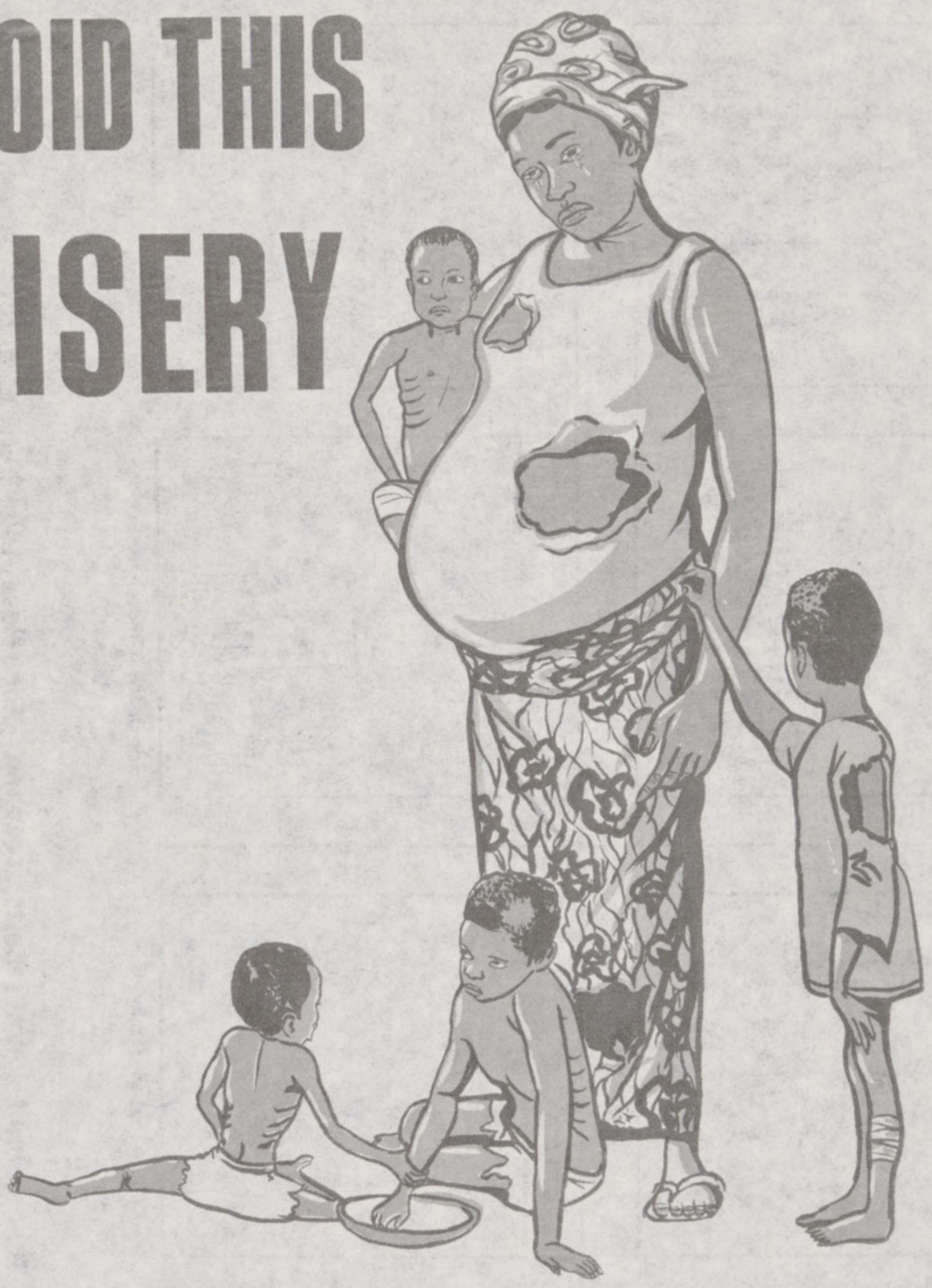
Kenya and Ghana have public family planning programs backed by population policies. Some of these posters displayed in clinics, such as the two which follow, emphasize the changes in family life that planned births can bring. In 1966, Kenya adopted an official program aimed at reducing fertility by voluntary means. Due to lack of the resources necessary for a concentrated effort, the policy largely remained on paper until the initiation, in 1974. of a coordinated family planning program that was to be staffed mainly by Kenyans with multidonor backing. Under this project, funded by UNFPA, USAID, the Federal Republic of Germany, Sweden, and Norway, infrastructure has been built and personnel trained. We visited some of the clinics where actual operations are just getting under way but it will be years before the program's effect on fertility will be felt in Kenya. And when completed, the program will reach less than 5 percent of women in their childbearing years.

Ghana enunciated its population policy in 1969 and has been receiving external assistance for population and family planning programs since then. Nevertheless, it is too early to judge the success of the program, and both birth and death rates in this country remain alarmingly high.

The following posters from Haiti and El Salvador are distributed in two of the developing nations which recently built on the work of voluntary organizations to launch government national family planning programs—Haiti in 1974 and El Salvador in 1975. In Afghanistan, the government works through the clinics of the Afghan Family Guidance Association to provide family planning services to people who need and want them. The AFGA is a semiprivate agency founded in 1968 through the efforts of a few physicians and women.

AVOID THIS

MISERY



Family Planning
better life

PLAN YOUR FAMILY

Contact
Any Family Planning Clinic

Designed and Published by the M.P.U. of the Ghana Family Planning Programme

22-303 O - 78 - 4

Careful planting

A rich harvest

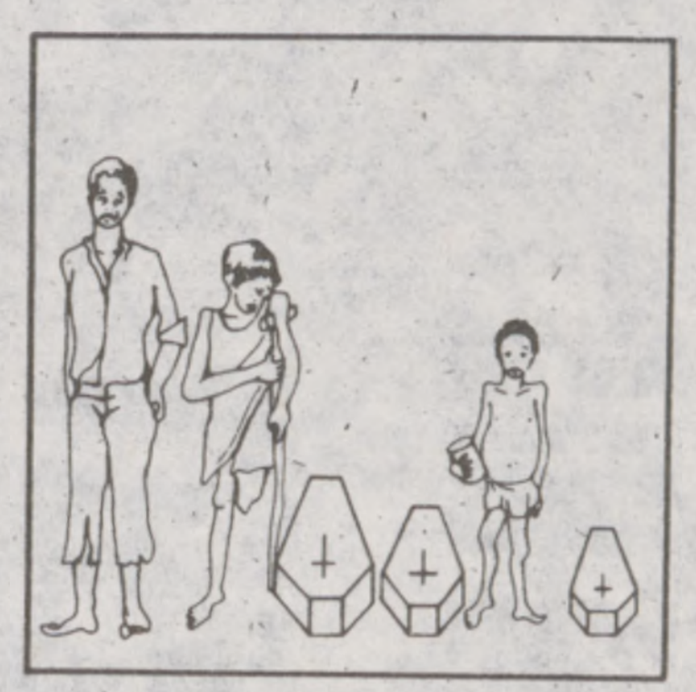
Careless, close planting

A bad harvest

Spaced children

A happy family

Too many children, too close



A wrecked family

Any farmer will tell you this. Don't plant maize seedlings too close together: give them room to grow properly: space them out. Then they will grow tall and strong. Children are the same: Space them out and be proud of your strong and healthy family.

Printed by: D. L. Patel Press (Kenya) Ltd. P. O. Box 9788, Nairobi

More copies: IPPF, P. O. Box 30234, Nairobi, Kenya.

DL—R—380

SPECIAL CONSIDERATIONS

Not only is it difficult to replicate a successful family planning program from one country to another in Africa, but also from one region to another in the same country.[2] Experts who have worked in the field in Africa point to problems with communication and transportation as the great roadblocks to family planning acceptance. In a prepared statement to an IPPF regional council meeting in 1976, Professor Adebaya Adediji, Executive Secretary of the Economic Commission for Africa (ECA), wrote:

> In Africa and in most of the developing countries, one serious handicap to the extension of family planning services is the delivery system, which usually limits the numbers who are able to benefit from these services. It is for this reason that in most of these countries, both for national as well as voluntary programs, services are usually limited to urban areas, since health facilities are concentrated in these areas.

In most parts of the world, including the United States, the startup of a family planning program brings out a wave of customers. In Africa we saw women forming long, patient lines at clinics in the bush. If the scenes we saw in most clinics in Africa are a forerunner, the women there will not be turned off by bureaucratic abrasion. In the city, and probably even more so in the country, we saw them treated gracefully, with understanding and dignity, an approach which should be further enhanced when the clients themselves enter the ranks of the clinic staff in a variety of educational and service paraprofessional roles.

VOLUNTARY ORGANIZATIONS WERE THE PIONEERS

Private population groups deserve a great deal of credit for scouting, spearheading, and piloting the thinking, program development, and demonstrated projects on family planning in all the countries we visited. (A brief description of the national maternal/child health care and family planning programs in each country we visited is contained in part IV of this report.)

The USAID program has also done excellent work, and as world population activities continued to expand in the early seventies existing private agencies stepped up their operations and new agencies entered the field. Multilateral involvement in population programs expanded through the work of the UNFPA and other U.N. agencies and through entry of the World Bank into the population arena. In 1960 private associations conducted programs in 34 countries around the world, compared to government programs in four countries. By 1974 these figures had risen to 112 and 47, respectively.

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[2] For example, a set of flip charts providing information on pre- and post-natal care and family planning that had proven effective in one area of Zaire was a failure when used in a nearby area. Investigation showed that some colors used in the chart had such negative traditional associations that people refused to look at the pictures. A new chart with different colors was acceptable, but with custom-designed efforts, economies of scale in family planning programs are difficult to realize. Similarly, pictorial program materials developed in one African country were unusable in another. Audiences in the second country were so fascinated by the style of dress and appearance of the people they had never met, that they missed the content of the visual aids. This is understandable. The medium can also get in the way of the message for an American audience, as advertising people know. But because of the multiplicity of cultures and poor communication channels in Africa, the chances that an audience will find material offensive or exotic are greatly increased.

This poster from El Salvador reads:

A child is a treasure that needs the protection
of his parents.

Your child needs

Food
Housing
Education
Health
Parental love

Responsible parents have only those children
they want to have.

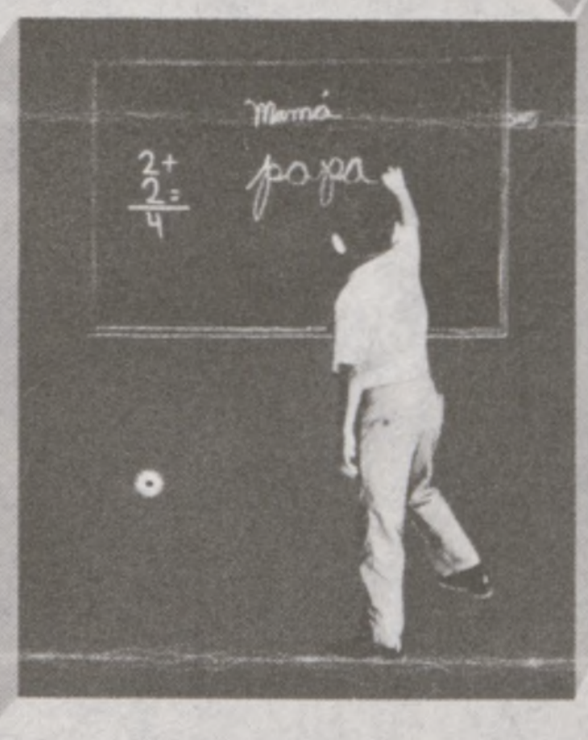
Consult your nearest health center.

UN NIÑO es un TESORO

QUE NECESITA DE LA PROTECCION DE SUS PADRES

Su hijo necesita:

Alimentación
Vivienda
Educación
Salud
Amor paterno

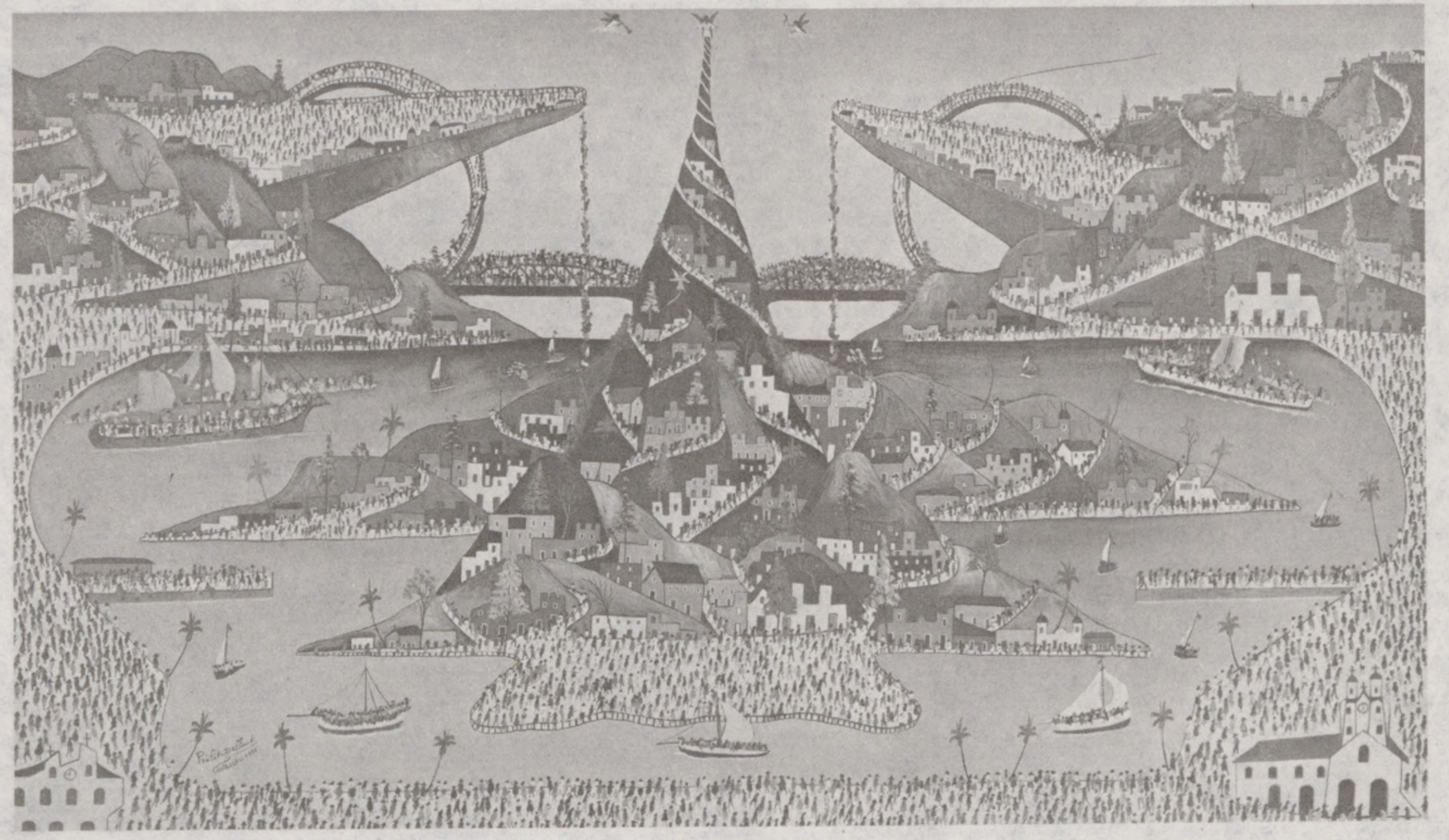


Los padres responsables sólo tienen los hijos que desean tener

Consulte al centro de salud más cercano

npc

"The Human Tide" is the theme of this poster on the need for family planning in the small Caribbean island nation of Haiti.



"Marée Humaine"
by Préfète Duffaut of Haiti

Centre d'Hygiene Familiale
Unitarian Universalist Service Committee
Family Planning International Assistance

In Afghanistan, a poster in the Dari language reads:

Just as the distance between cultivated plants results in more fruit, so the distance between pregnancies guarantees health and happiness for our children.

نشریهٔ انجمن رستمای خانواده
عمل ۱۳۵۳

طوریکه فاصله در نهال شانی ثمر بخش است در ولادت ها
نیز ضامن سلامت وسعادت اطفال مایباشد .

څرنګه چه دنیالګیو ترمنځ فاصله ګټوره ده په همداسې دزیږیدنو ترمنځ
فاصله زمونږ دماشومانو دسلامتی اونیکمرغۍ سبب ګرځی .

As in these and other developing countries, private organizations have often assumed the sole responsibility for initial family planning and related activities in Africa. There are two obvious reasons for this. One, developing countries simply do not have the money or trained manpower to set up such programs. Two, host governments can permit, and even encourage, private groups to carry on sensitive and potentially controversial programs which they would fear to support as official government policy. Thus, from both a political and financial perspective, the vital contribution provided by these early pioneering efforts cannot be overestimated.

The Catholic and Protestant churches in Africa, through their mission hospitals and health services, run innumerable family planning programs on a high level of professionalism and dedication. Far from being an obstacle to spreading the concepts of "child spacing" and "desired births," these religious groups do much to promote them.

In an analysis of the literature on the organization of family planning services, Calman J. Cohen, a politicial scientist with the Interdisciplinary Communications Program (ICP), Smithsonian Institution, observes that some problems have inevitably arisen between private organizations and host governments involving ideology, financing, coordination, and administration. One of the basic errors of some programs has been that planning is not based on indigenous health philosophy but on imposed alien concepts. Some government officials in the new Africa nations have become statistics-oriented to satisfy the demands of international organizations and donor agencies who, quite reasonably, expect a country to prove, by statistics, where it is going. Some recipients have complained of overly strict donor control of aid accompanied by short-term commitments, complex procedures, narrow definition by donors of projects eligible for assistance, nonprovision by donors of funds for general program support and building costs, and problems with foreign experts and advisors.

As host country governments become more involved in population and family planning activities, problems may become more acute. At this stage, the role of private organizations must gradually evolve so that private efforts complement and stimulate government efforts but do not duplicate them. Once a government program is underway, private associations can provide more convenient services for people willing to pay for them, introduce innovative methods, offer specialized family planning services, and meet the increasing demand for services that the government program cannot handle.

MODERN FAMILY PLANNING METHODS

The same kinds of contraceptive methods are used in Africa as in the United States, with the same popularity ratings, advantages, and disadvantages. All the people involved in providing information and services told us that program success depends, in great measure, on the women having a variety of methods from which to choose.

In reviewing the availability of methods in the country programs, we found that where programs offer many family planning methods through a number of distribution channels focusing on the village, more and more women are using contraceptives more efficiently. Reliance on a single contraceptive or a single delivery channel has not yet met with success.

Our research and interviews indicate that the pill appeals to the young woman with few children and easy access to clinics. Some women give the pill to the children to cure illness or to husbands to cure headaches, swallow a month's supply at once to insure month-long protection or forget to take pills. Nonetheless, the pill has apparently averted many a birth. In some countries, health auxiliaries can prescribe and distribute the pill and are trained to follow up in case of side effects.

IUDs are reasonably well accepted, in spite of the rumors that occasionally abound in communities. They require continuous follow-up for possible adverse side effects, but they can be inserted by health aides who have about 2 months training and who have handled at least 30 supervised insertions.

Foam, jellies, and diaphragms are not well accepted—possibly because of a dearth of privacy?—nor are they carefully used. As one lady confided to another: "I do put the diaphragm in every night, but sometimes my man comes in the afternoon." Nevertheless, some families prefer these methods of contraception, and more women can be taught to use them more carefully. "Everything helps," we were reminded.

Condoms are not popular anywhere we went, although the United States supplies them by the carload. As we were told more than once, condoms may be unpopular because it is a contraception for men, and men are not the leading proponents of contraception; its use is associated with prostitution, and it decreases sensitivity.

Tubal ligation has proven surprisingly popular where available. It is generally recommended for people with large families, or people who want no more children. Many African women who feel that they've "already had enough" or "too many" children choose sterilization, as do many women in the United States. With quality training and supervision, we were told, health auxiliaries can perform sterilizations.

The only contraceptive used in Africa that isn't used in the United States is depo provera, an injectable drug now being researched in the United States but not yet approved by our Food and Drug Administration. Offered by local private family planning programs, it is popular in Africa where the syringe is traditionally associated with curing and preventing myriad health problems.

Because of the limited availability of contraceptives and the side effects and other disadvantages of some modern techniques, abortion is widely practiced, legally or illegally, in each country we visited. In Zaire, we were told, "Many people here abhor abortion. For this reason, because we are pro-life and want to avoid killing, we favor prevention through contraception."

In Ghana, we were told:

> We in Africa do not believe in abortion, and we do not want sterilization. We do not want to have happen here what is happening in India: enforced sterilization and abortion, that is, the involuntary control of births. So we must increase family planning information, education, and services—the opportunity for people to voluntarily space their children. We are short of many things in these new, very young African countries. But we do have one valuable commodity: time. If we use our time well to develop systems of maternal/child health services with a family planning component, and to develop curriculum about family life, family health, and family planning for our schools; if we reach with this knowledge and these services into all the rural pockets of our countries, we will never find ourselves where India is today. But we must hurry, or it will be too late. Every hour we have many births.

The Many Ways in Which Rapid Population Growth Impedes Development

With the recent onset of population growth encapsulated in an unprecedented, short period, it has become increasingly urgent for every government to take into account those actions of its policymakers that influence population dynamics, whether or not intended.

No matter how rapid the fertility decline will be when it does occur, some of the now sparsely populated countries will feel the pressure of high population densities growing out of the population momentum. Meanwhile, population growth creates a large dependency burden. Since a rapidly growing population is a very young population, particularly critical issues have to be faced in five development areas: food production, education and training, health care, investment and productivity, and employment.

Food production.—Although total food production in Africa has increased 26 percent in the past quarter century, per capita food production has declined by 8 percent, something that has happened on no other continent. Some African countries that were exporting food only a generation ago are now importing food and expending scarce foreign exchange in the process. Sai points out:

> The need to increase both the quantity and quality of the food produced in Africa is great, but even greater is the need to decelerate the rate of African population growth. A proper solution of these interrelated problems cannot even be undertaken without a mature political decision and governmental support. It is imperative that each country in Africa understand the magnitude of the total food gap and the appalling implications of the protein problem now.

Education and training.—As in most developing areas, education in Africa has a high priority, and school and university enrollments have increased faster than population growth. Nevertheless, the school age population is simply growing so rapidly that schools cannot be built or teachers trained and recruited within the educational budgets available. As a result, says Lester R. Brown, who has written extensively on food resource problems, governments once committed to universal education have quietly abandoned this objective for the foreseeable future. In Kenya, for example, primary education enrollment doubled from 890,000 in 1963 to 1,675,000 in 1972 and rose sharply again in 1974 when free education was introduced and made compulsory for the first 4 years of primary school. Although 75 percent of Kenyan children ages 6–12 are now in the primary grades, about 8 million persons in Kenya are illiterate. A similar pattern holds for other African countries. High population growth rates have meant that the demand for education has frequently gone unsatisfied and that educational targets have not been met.

Education is one of the best investments a nation can make. A literate, trained labor force is necessary for modern economic development. Education, especially of women, is a powerful factor in fertility decline, point out economists William B. McGreevey and Nancy Birds-

all in a 1974 report on "The Determinants of Fertility" for the ICP. Yet if material and human resources are spread thin, it is difficult to lengthen years of schooling, especially for girls. Lack of education can lead to a vicious cycle; high fertility increases the number of children to be educated, hampering educational progress that would help bring fertility levels down.

Health care.—"For hundreds of millions of people, perhaps half of the world's population, health care is unavailable or is a luxury they cannot afford," points out the staff at the Worldwatch Institute. In Africa, where mortality rates are highest in the world, lack of basic health care translates into sickly mothers and infants, high rates of infant and maternal mortality, and the prevalance of such debilitating disease as intestinal parasites, malaria, and schisosomiasis.

In no country we visited did we find a nationwide family health system capable of providing comprehensive health services, which include pre- and post-natal care, nutrition education, immunization, medical treatment, family planning services, and adequate sanitation. The skewed distribution of health facilities is shown in the case of Kenya, where health records are above-average for Africa. Rural areas, where most of the population is concentrated, have only one doctor for every 50,000 people. Although Kenya has twice as many hospital beds as 10 years ago, 90 percent of the women give birth at home. Two hundred forty rural health delivery points have been set up, but an estimated 90 percent of the rural population remains unserved because they have difficulty getting to these points. "Even if the number of doctors in rural areas triples in the next 25 years," observes the staff of Worldwatch Institute, "current rates of population growth would make it impossible to deliver in the countryside even the same level of service that people now receive in * * * Nairobi."

In Senegal, another country on our itinerary, the infant mortality rate is 170 per 1,000 live births, and mortality for ages 0–5 may reach as high as 400–500 per 1,000 births. In other words, half the children in Senegal die before they are five. As in most developing countries, endemic diseases are rampant. Major health problems include general infections and parasites, nutrition deficiency diseases, and complications of pregnancy and childbirth. A large proportion of the high morbidity and mortality rates in the population can be attributed to malnutrition. Lack of nutritional education is partially responsible for diets deficient in calcium, iron, and vitamins A and C, but a real shortage of food and lack of financial resources accounts for much of the problem.

Poor health status is compounded by the lack of environmental sanitation and the contamination of water sources common in sub-Saharan Africa. Rapid population growth undermines efforts to improve public health and nutritional standards.

As in the education sector, investments in health could contribute to eventual fertility reduction. Studies have shown that mothers who have experienced the death of an infant tend to want more children, to have more children, and to space their children more closely than those who have not lost a child. "It is the early experience of child loss that leads women to have larger families," concludes Judith A. Harrington of the Department of Population Planning, University of Michigan, who conducted studies in Ghana, Upper Volta, and Nigeria.

A truly vicious circle prevails in rural Africa, notes the ICP staff. Because of the extreme protein and caloric deficiencies, risk of death increases when a child can no longer depend on breastfeeding and other special attention because of the birth of a sibling. High fertility produces high child mortality which, in turn, stimulates high fertility.

The breaking of such a circle in the poorest region of the world might result, at least for some period, in increased population growth. Increased health brings with it both an increase in fecundity and a decrease in mortality. Despite this short-term effect, reduction of infant mortality, and health improvements in general, are regarded by most development experts as contributing, in the long run, to fertility reduction and slower population growth.

Investment and productivity.—Resources which must be spent to provide the most basic survival needs of a constantly growing population with a high dependency ratio, are diverted from capital investment. In the World Bank report to the recent World Population Conference, King suggests that with slower population growth:

> A lower proportion of investment could go to equipping new workers, thus permitting an increase of capital per worker. This in turn would raise productivity and ultimately (assuming equitable distribution of income) an enhanced standard of living.

An understanding of the relationship between population and investment is still incomplete. To use the World Bank's terminology, economists usually assume that rapid population growth has a negative impact in that it forces widening of investment at the expense of deepening.

Rapid population growth, for example, necessitates a similar widening of public expenditures in such areas as health and education. Yet deepening is desperately needed in developing areas where the shortage of managers and trained manpower is a major constraint on development.

In their need for capital to cover both widening and deepening of investment in the presence of a rapidly growing population, governments may be thrown into a greater reliance on external financing than they would ideally desire. Compounding this problem, is that the relationship between dependency rates and savings rates is inverse. In a simulation of the Indonesian economy, projected to the year 2021, the Indonesian economist Hananto Sigit found that if the government's goal is a specified per capita income, fertility reduction would make the task easier by increasing the amount of private investment available.

More research on this issue is needed, and an International Review Group on Research in Population and Development has recently been formed, under the sponsorship of UNFPA, the World Bank, and the Ford and Rockefeller Foundations to evaluate the state of the art and suggest areas in need of study.

Employment.—The pervasive lack of jobs in Africa is linked with the rapidly growing young labor force which puts additional pressure on agricultural land that may already be fragmented or overutilized.

The result is migration to the already overcrowded cities. Yet because of low capital investment, these young people cannot be accommodated in the nonagricultural sector. So they join the ranks of the unemployed who already make up over 30 percent of the working-age population in some cities.

National development projects that increase the attractiveness and accessibility of the cities can at the same time exacerbate the urban crises of overcrowding and unemployment. Studies in Mexico and Sierra Leone, among other places, have shown that feeder roads intended by planners to help farmers market their crops also turn into convenient routes to the city. This occurs at the same time the government is trying to discourage rural-urban migration, the principal reason for population pressures in the cities. In Kinshasa, Zaire, for example, 10 percent of the urban growth rate is due to migration; only 3 percent comes from a rise in natural increase.

A recent analysis of the situation in Kenya by Shirley Sirota Rosenberg, editor of *Population Dynamics Quarterly*, is descriptive of many other countries:

> It is estimated that 17 percent of Kenya's people are landless, one-fourth of job-seekers are unemployed, half the wage earners make less than 10 Kenya pounds a month, and people of low income are not much better off than people with no income at all.

Absolute numbers of potential workers are destined to rise sharply through the rest of the century, increasing pressures on land and aggravating under-employment and unemployment. High levels of unemployment make it difficult to increase employment of women, although their employment is associated with reduced fertility, in part because it is incompatible with continued childbearing and, in part, because it offers an attractive alternative role for women.

LOGISTICS CANNOT KEEP UP WITH NEEDS

When population rises so rapidly, countries can't improve their quality of life.

African countries do not have enough national planners. They cannot afford to pay for enough national planners from abroad. If they were able to pay them, they still would not accept this foreign invasion, for they want to learn to do things themselves.

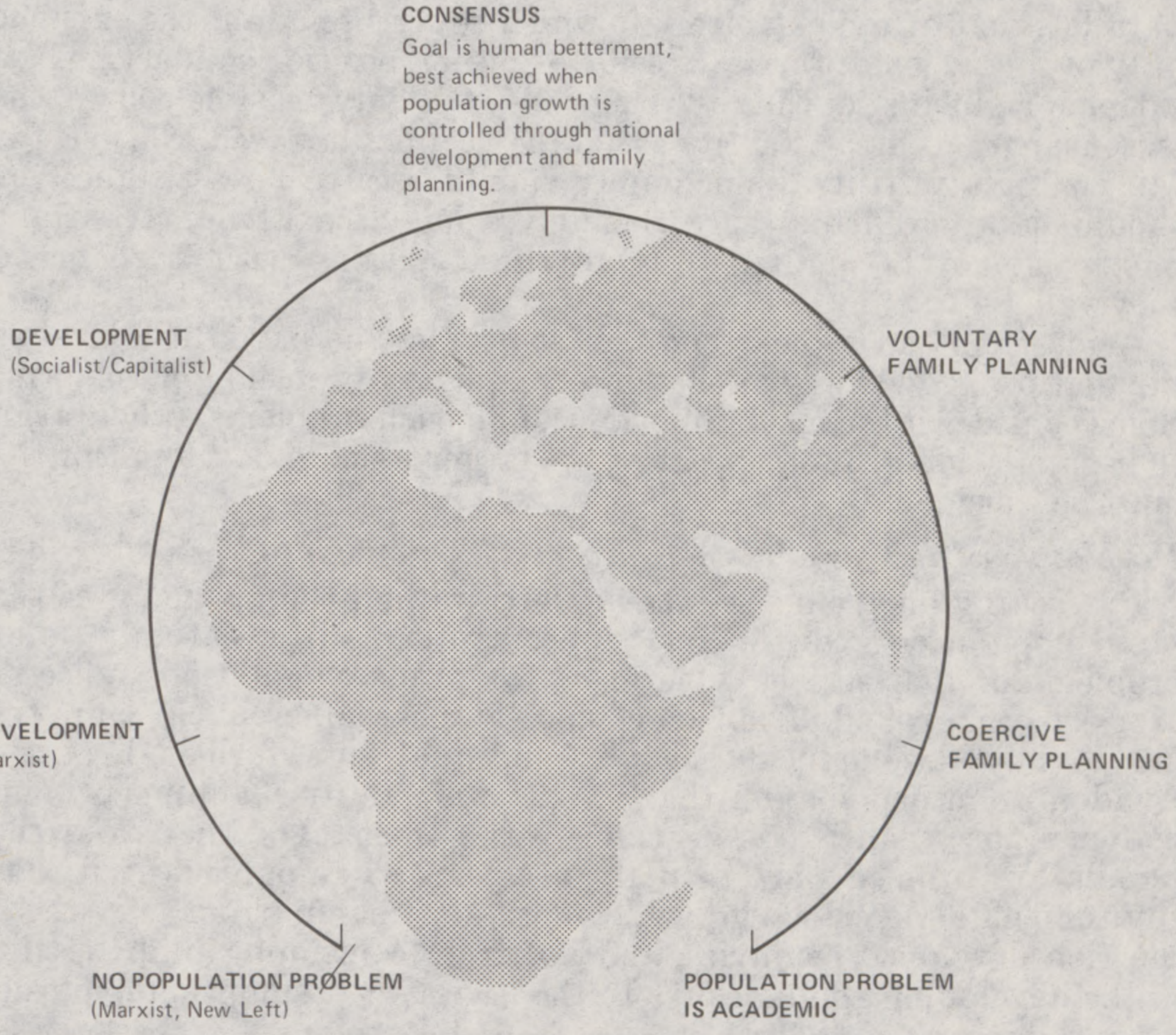
African countries do not have enough operational managers, supervisors, and facilities, or supporting services such as water, electricity, telephones. and photocopy machines. They do not have the in-service and pre-service institutions, curriculums, trainers, and budgets essential for training all the professional and paraprofessional health and education people they need. Neither do they have a transportation system functioning to get these people and their supplies to and from where they are needed.

Even if this part of the economic and social development puzzle were in place, each bravely progressing African nation would be putting all their incredible efforts merely into keeping up with their relentless population growth flowing over and drowning all improvement.

Ideologies Vie For Attention In Population Arena

Humanitarian ethics clearly dictate that developed nations do everything in their power to help developing nations control their population growth. To better understand why this apparently simple imperative becomes so complex in practice, we looked at the major ideologies that compete for attention in the arena of population issues. In the following figure, Bouvier shows how population ideologies may be viewed on a continuum from the political left to the political right. "Admittedly," says Bouvier, "this necessitates some adjusting of our customary definitions." Furthermore, as the figure indicates, the continuum is not along a straight line. As is sometimes the case with extreme positions, the left and right almost merge. At these two extremes are views that insist there is no population problem to be solved.

VARIOUS TYPES OF POPULATION IDEOLOGIES



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The extreme left point of view was put forward at the 1974 World Population Conference in Bucharest by some Marxist participants. The position holds that there can never be a population problem. It is only invented by the capitalists as an excuse for their failures. An extreme left view is captured in the following excerpt from an anonymous pamphlet distributed on the streets of a large U.S. city:

> The world is NOT overpopulated. The world is NOT about to BECOME overpopulated. THE "OVERPOPULATION STORY" IS A BIG LIE: OVERPOPULATION IS NOT THE CAUSE OF CROWDING, STARVATION, SLUMS, INFLATION, CIVIL UNREST, OR OTHER PROBLEMS LIKE THESE.

Also in this group are those who cannot see population growth as ever posing a problem for their countries. Growth is needed for economic reasons, for military reasons, for creating a pool of labor, consumers, et cetera. In addition, some revolutionists argue that population programs are mere palliatives to fundamental social and political contradictions—most notably, inequitable distribution of resources—which will inevitably lead to a just revolution. Thus some Latin American leftists argue that continued rapid growth will keep the population young and, thereby, make revolution much more likely to succeed.

The extreme right takes such a pessimistic view of population problems that they say it is past the time for solution. In a sense, this view parallels that of the extreme left which refuses to admit the existence of a problem. The practical result of either position is inaction. The extreme right insists that a "triage" [1] is the only feasible course, that is, some nations are so far gone that they cannot be saved. Nations that fail to limit fertility immediately should receive no assistance, but should be allowed to starve themselves out of existence. Assistance efforts should be limited only to those nations with a chance of survival.

Aside from the two extremes, most people who have thought about population growth agree that it does pose a problem for mankind. Some consider it the most important of all such problems; others argue that population growth is part of the larger issue of development that must be considered.

Development and population concerns are intertwined

Proceeding on from the extreme left, we find those who agree that rapid population growth, if left uncontrolled, will eventually pose a problem for that society. One group of proposed solutions reflects a Marxist background. The rich countries, these adherents say, are trying to buy development cheaply, and they cite former President Lyndon Johnson's maxim that $5 spent in family planning brings a better return than $100 spent for development. Or, they hold that population problems are actually problems of resource scarcity and environmental deterioration which derive primarily from activities of the rich developed countries, and not from continuing high fertility in the developing countries. Here the cry is, "Consumption explosion

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[1] *Triage*, from the French word meaning sorting or shifting, has a neutral application in commercial grading. As used by population pessimists, however, it refers to a military system for deciding which battle casualties should have priority for first aid in collection stations at the front before their evacuation to hospitals in the rear. Those with the best chances of recovery would be given curative treatment first; those with the worst chances would receive it last, if at all.

rather than population explosion." This kind of thinking was seen among many African representatives to Bucharest, where Nigeria called for a new world economic order. A report in IPPF's special World Population edition of its periodical, *People*, hypothesized that Nigerian leaders may have felt that with an economy that "had picked up and with an assumed population growth rate of 2.5 percent, it was clear that for the forseeable future Nigeria could sustain a satisfactory way of life for its citizens." Senegal's representative was reported as stating, "Africa must choose development today and perhaps the pill tomorrow."

Another developmental view, less Marxist and more capitalist in substance, is that population growth is secondary in urgency to development concerns, but is a problem, nonetheless. Here the predominant view is that developmental assistance is desperately needed—from the United Nations, United States, and other sources. Such aid would lead to better education, less unemployment, a changing role for women, redistribution of income, et cetera—in other words, most of the features of the demographic transition that preceded and probably precipitated fertility decline in the developed world. Only then, it is maintained, will fertility decrease in the developing natons.

Another position, somewhat related, concentrates on health factors. As long as infant mortality remains high, no one can expect families to desire fewer children. Assistance which alleviates this high death rate will indirectly lead to lower fertility.

Those on the right side of the circular continuum maintain that family planning should be enforced by governments so that population growth can be limited. The policies of former Prime Minister Gandhi prior to her downfall reflect this thinking, which is also held by some in the developed countries. It closely resembles the "triage" position. Ironically, as far as we can tell, the People's Republic of China, which at Bucharest voiced the Marxist view on population in principle, has firm antinatalist policies, apparently implemented not only through peer pressure but also through developmental changes, particularly basic and far-reaching changes in women's role.

Voluntary family planning, the best known approach to the problem of population growth, is embraced by USAID. This view argues that only through the availability of contraceptives—preferably at modest or no cost—can population growth be cut down because most women would limit their fertility if they knew how and could afford to do so.

Approach developed at international conference

This leaves the middle of the continuum—the so-called consensus approach which came out of the Bucharest population conference. This view holds that (1) population growth is only one of the detriments to development, and (2) that the population problems cannot be solved simply by making family planning services available to all. Rather, a comprehensive program to curtail population growth must be launched before such societal problems as poverty, disease, illiteracy, and income inequality can be eliminated. In addition to economic aid, such approaches include improved government assistance to health and educational sectors and government attempts to redistribute income where possible.

The population problem which Africa must eventually face is far too awesome to be beset by conflicting ideologies and international alliances. If the quality of life, however defined, is to improve on that continent, population growth must be limited. Further, because of the built-in momentum we discussed earlier, any attempts to curtail growth must begin immediately. In such a situation, any reasonable approach that would lead to a decline in fertility should be made available. Assistance in providing family planning services is required, but we must bear in mind that women and men must somehow be encouraged to desire fewer children as funding for a variety of development assistance comes forth mightily from developed and oil-rich countries and the multilateral agencies.

Many tens of millions of African women are ready to space their children without learning how to read or write, without motivation, orientation, or training, without any altered perception of themselves in jobs outside the home. They must be given the chance now. And tens of millions of others, not yet ready, will follow as they see that smaller families lead to enriched and more satisfying lives for all family members.

We close on a note sounded by the African writer, Takawira Shumba Mafukidze, for the World Population Conference:

> Perhaps the experience of the Sahelian countries where thousands of people have died of drought-induced starvation will influence African thinking on family planning. Most of the children who are dying in the drought-stricken areas are under 6 years old, which means they were conceived and born during the drought. Surely children should be brought into this world to live, and not to die horribly before they mature.

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PART IV

Country Reports

(In order of visit)

KENYA, TANZANIA, ZAIRE, NIGERIA, GHANA, AND SENEGAL

Note.—These brief reports are based on what we learned through questioning many people in each country for brief periods of 2 to 6 days. We emphasize that these are only impressions, not expert findings, and we apologize for any errors incurred in transmitting information or opinions. We hope that insights gained through extensive interviewing, in however short a period, have produced observations, findings, and recommendations which may be of interest and assistance to the Administration, the Congress, and the people we all serve.

KENYA

Key demographic data

Mid-1976 population	million	13.9
Annual growth rate	percent	3.6
1975 urban population	do	11.0
Agricultural labor force	do	8.0
Per capita GNP	U.S. dollars	200
Life expectancy	years	50
People per doctor		16,400
Literacy rate	percent	20–25
Primary and secondary students, ages 5 to 19	do	41

Kenya, a former British colony, is the second and most recent African nation to issue an explicit population policy. It straddles the Equator on the East Coast of Africa, occupying an area just under 225,000 square miles—about the size of Texas and has about 13.9 million people, most of them cultivators and herdsmen. More than half of the country is savannah grassland and semidesert stretching north to Ethiopia. Another fifth, the rolling plains of the south, is the traditional home of Masai, the cattlegrazers. Agricultural wealth is concentrated in the well-watered lowlands bordering Lake Victoria in the west and in the green highland valleys of central Kenya, once the preserve of white settlers. The country's economic mainstays are coffee, tea (Kenya is the largest tea producer in Africa), agricultural and forestry products, minerals, and tourism.

Black Africans make up about 97 percent of the population and are divided into about 40 ethnic groups. The Kikuyu is the largest of these groups, but others are substantial in size. Persons of Indian, Pakistani, Goanese, and European descent live in the interior, and there are some Arabs living along the coast. Most of the population follows traditional religious beliefs, but about 30 percent are Christian and 6 percent are Moslem. Swahili replaced English as the official language in 1974.

National history

Following early periods of Portuguese and Arab control primarily on the coast, most of present day Kenya passed under British influence in 1886. In 1895 the British Government established colonial rule in what was named the East African Protectorate.

In 1903 the first settlers of European descent became large-scale farmers in the highlands by taking land from several native tribes. From the twenties to the forties, European settlers controlled the government and owned extensive farmlands, Indians maintained small trade establishments and worked as lower-level government employees, and black Africans survived mainly as subsistence farmers.

Black African protest, which had begun in the 1920's, reached a peak in the mid-fifties, and the British Government declared a state of emergency, imprisoning many nationalist leaders. After the revolt, Britain

22–303—78——6

increased black African representation in the colony's legislative council until there was a black majority.

Political leadership

Kenya gained independence in 1963 with Jomo Kenyatta, who had been imprisoned during the emergency, as its first prime minister. In 1964, Kenya became a unitary republic and de facto one-party state under the Kenyan African National Union (KANU). Its first and only president, Kenyatta, was born in 1891 and studied at the London School of Economics.

Demographic picture

Kenya has a rate of natural increase of 3.6 percent per year, one of the highest in the world. If current birth and death rates (50–51 births per 1,000 population, 15 deaths per 1,000) were to continue, population would double in 21 years. Almost half (46 percent) of the present population is under 15 years of age.

Nine-tenths of the people are rural dwellers and are concentrated on the 17 percent of the nation's land that is suitable for cultivation. Per capita income is $200 (1974 U.S. dollars).

The shortage of land in Kenya has increased urban migration, bringing crime, housing problems, and unemployment. In 1974 there were 250,000 adults seeking jobs in Kenya. By 1980 this number may be over 900,000.

The new technology based in the cities demands a higher level of skills than the average migrant has, even if he is among the newly educated. In addition, modern management has raised productivity to a point where industry needs capital more than it does labor. Kenya's gross domestic product rose by 6.7 percent between 1968 and 1972, but employment rose by only 4.0 percent.

To cut back on rural-urban migration, the current development plan calls for bringing marginal and grazing land into production, restoring to families the land that is theirs by tradition, and settling farmers on former large landholdings. Labor-intensive schemes are contemplated for raising crops, building roads, irrigating, planting trees, controlling floods, and wildlife husbandry.

Socioeconomic status

The Government has already settled thousands of families on land formerly owned by large-scale European farmers. However, reducing the size of chunks of farm land too far lowers production, accelerates erosion, and causes the land to deteriorate—the beginning of the desertification process. In 1965, Kenya had 1.7 hectares (4.2 acres) of land per person. At the present growth rate, by 1980 each person will have only 1.5 hectares (3.7 acres). In addition, many believe that it will be decades, perhaps as many as 50 years, before Kenya will have the resources to irrigate a substantial portion of its currently nonarable land.

Kenyan women tend to achieve a desired family size of six to seven children. Polygamy is permitted under Islamic law and traditional tribal laws for four main reasons: (1) The more wives, the more children; (2) the more hands in the family, the more food produced;

(3) the more children, the higher a man's status; and (4) the belief, probably erroneous, that there are more women than men in Kenya. Fear of public outcry has curtailed attempts to abolish this practice, although it is becoming less common. The African and Christian Marriage and Divorce Act has abolished the practice of wife inheritance. Under this Act, a widow is no longer bound to cohabit with any relative and is now free to support herself and her children as though she were an unmarried woman.

With the breakdown of polygamy, the Kenyan woman is now increasingly exposed to the risk of pregnancy. However, most women are engaged in some form of economic activity, and both wives and husbands may see family spacing as advantageous, since it frees women to supplement livelihoods. The concept of spacing births also has parallels in traditional practices, which may make it more acceptable. The mother in a polygamous marriage was enjoined to abstain from sexual relations until her 2- or 3-year-old child was weaned.

Population specialists have observed that family size tends to decline as educational level rises. In Kenya, primary education enrollment nearly doubled between 1963 and 1972, rising from 890,000 to 1,676,000. It rose sharply again in 1974, when free education was introduced for the first 4 years of primary schools. (Families still must pay for uniforms and books, and sometimes contribute a small annual fee towards school construction.) Although it is estimated that 75 percent of all children between 6 and 12 years of age are in primary school, a UNESCO study conservatively estimates that about 8 million people—well over half the population—do not know how to read or write. A high illiteracy rate makes it more difficult for a family planning program to succeed and undoubtedly demands different approaches and materials than those which are used in more literate societies.

In turn, slowness to adopt family planning affects the nation's educational efforts; more schools will have to be built and teachers trained and paid to accommodate larger cohorts of school age children.

Population policy

Kenya began limited official action in the population field little more than a decade ago; however, contraceptives had been offered in public clinics since 1952. In 1965, only 2 years after Kenya became independent, the Ministry of Economic Planning and Development expressed interest in the relationship between population and development. The Population Council was asked to study the population growth problem and make recommendations for alleviating it.

In 1967, Kenya announced a national population policy and started the first Government-sponsored family planning program in sub-Saharan Africa. Little progress was made under this plan, which did not quantify demographic goals and was considered by many to be merely a paper policy.

In the early seventies the World Bank was invited to present a plan for action. As a result, a concerted effort to implement Kenya's population policy was written into the country's Third Development Plan, 1974–78. This new and more comprehensive family planning program has the stated—and modest—goal of reducing population growth to 3 percent by 1979 and to 2.8 percent by 1999. The 1979 target is

based on plans to recruit 640,000 family planning acceptors, prevent 150,000 births, lower the birth rate by 5.5 per 1000, and reduce the death rate by 2.5 per 1,000. Funding is estimated at $39.7 million, with the Government providing $14.3 million and outside donors $25.4 million.

The new program builds on the earlier one but endeavors to solve some of the difficulties it encountered, such as lack of high- and mid-level administrators, the need for better coordination of family planning efforts, and the traditional bias toward large families.

The program is administered by the Ministry of Health, placing it on much firmer footing than private projects in some other African countries. The National Family Planning Welfare Center is the Ministry of Health office responsible for implementing and coordinating all maternal child health/family planning activities. It has an administrative section and four divisions: Clinical services, training and information, education, research, and evaluation.

The new population strategy calls for an eightfold increase in mch/fp activities, a stepped-up information campaign, and intensive training of indigenous paramedical and field workers. A significant aspect of this project is the Kenyan Government's understanding that it will be many decades before there will be enough physicians in Kenya to serve all people in all communities. In the meantime, it has concluded that it is wiser to reach people via paraprofessionals than not to reach them at all. The emphasis is on providing sufficient services so that, for the first time, every couple in Kenya has the means to space children voluntarily, for health reasons.

Health and family planning strategy

Maternal and child health activities occupy the center of Kenya's program. The belief is that mothers will bring ill children to a health facility if one is accessible; they will participate in immunization, sanitation, and nutrition education if offered at the same time; and they will accept techniques for sensibly spacing their children when they come to understand, through discussions with field educators, the wisdom of guarding their health and the well-being of each child.

Dr. Marasha Marasha, the Pathfinder Fund's regional representative for sub-Saharan Africa, confirmed the logic of this approach when he told us:

> African women are tired. They are tired of seeing their children die, tired from doing agricultural work, cooking, and having so many children. They are just plain tired. They are grateful for ways of keeping their children alive and well, and of not having more than they can provide for. We start with the 90 percent who want family planning—with the women, not with the politicans.

The 5-year plan calls for developing 400 comprehensive maternal and child health service delivery points (SDPs), open daily, with family planning services as one of six health care components, At present, 212 such service delivery points, many of them at clinics or hospitals, offer daily services. Another 182 clinics are also open and offer mch/fp services, but not on a daily basis. The plan calls for an additional 190 service delivery points to be served by 17 mobile teams fortnightly.

The strategy is to add staff to functioning but understaffed hospitals, clinics or rural dispensaries; increase the range of services provided by dispensaries that now offer only a few of the components

customarily considered part of comprehensive maternal child health care; make services more convenient for clients by offering them daily (many dispensaries are now open only a few days or hours a week); and provide inservice training in family planning education and procedures for all levels of existing health care staff.

Comprehensive maternal child health and family planning services

By the spring of 1976, over 70 field educators had been trained and were on the job. These are recruited from the communities where they will work. Home visiting is a major part of their work and is successful in persuading people to become contraceptive users, probably in part because the workers are members of the community themselves. Their training, which lasts only a few weeks, focuses on giving information and answering questions about the contribution of childspacing to family health and welfare, and about methods of childspacing. Although communication techniques are emphasized, training also includes information about the general population situation in Kenya and Government policy, as well as techniques of gathering and reporting information.

In addition to the government-sponsored activities, the voluntary Family Planning Association of Kenya (FPAK), established in 1961, provides information and education support for the Government program and operates eight clinics to supplement the services of the Ministry of Health. The FPAK staff also provides family planning information to rural areas, trains its own and some Government personnel, and conducts information and publicity campaigns. The city council of Nairobi and Mombassa also provide family planning services, with the Nairobi effort accounting for 15 to 20 percent of the country's total acceptors each year. Private family planning associations have operated in these two cities since 1955.

Although there are now twice as many hospital beds as there were 10 years ago, 90 percent of Kenyan women give birth at home. Even with 240 rural health service delivery points (SDPs), it is estimated that 90 percent of the rural population is still unreached because of the distance and difficulty in walking to the dispensaries. In addition, many rural SDPs suffer from inadequate staff, a desperate shortage of drugs, and vaccine that has gone bad because it was not kept refrigerated.

Such deficiencies of health service and family planning in rural areas are particularly harmful to efforts to reduce population growth, since fertility is much higher in rural areas—an average of 8 children per woman compared to 5 children for urban women.

Kenyan Ministry of Health officials took us on a field trip to Machakos District to see rural health services in action. "We are trying very hard to develop more maternal child health services with a family planning component," said J. D. Makayoto, M.D., Training Division, Maternal and Child Health and Family Planning, Ministry of Health. "The women are waiting, but we haven't enough trained aides to supply them with family planning materials and information."

Machakos Health District Medical Officer P. F. O. Callaghan, M.D., said:

> There's no way we can keep up with the demand. If you cure the sick children mothers bring in, and show them how to control the spacing before the next one comes, they are very receptive.

As we passed wall-to-wall women packed onto benches awaiting their turns with child-spacing aides, Margaret Ithongo, provincial matron for the Eastern Province, commented, "Sometimes they sit all day to be helped."

Modern contraceptive use

Despite such optimistic expressions of Kenyan women's willingness to accept family planning, only one-third of the small number of women who are receiving such information are using contraception. For these women, the pill is by far the preferred method—the choice of 80 percent of the acceptors. It is thought that the pill's popularity is due more to ease in dispensing it than to an adverse reaction to the side effects of the IUD, which is used by only 11 percent of acceptors. It is also thought that depo provera, an injectable contraceptive now chosen by 8 percent of acceptors and distributed by private family planning groups, would be more widely used if it were not restricted to women who want no more children.

Although the willingness of Kenya's opinion leaders to speak out for family planning is impressive, much more could be done. The Ministry of Education is doing little to develop primary and secondary school curriculums that include population concepts.[1] Mass communication materials and techniques designed to motivate and educate toward planning smaller families are minimal. Under various tribal, religious, and state laws, the minimum age at marriage for females is frequently no more than 16. One of the reasons for having a large family in a traditional system—to increase family income—is bolstered by legal provisions allowing children to be bound to masters under apprenticeship contracts, and by the practice of using a great deal of child labor in agriculture, particularly on coffee, tea, and pineapple farms. The custom of bearing many children as insurance against lack of income in old age still prevails and is likely to continue as long as social security is restricted to those who have served in Government or quasi-governmental agencies.

A major effort to increase employment and generate roles for women other than motherhood is not being made. Nor are there programs to reach large numbers of men with family planning education and services. Finally, most development programs do not yet include programs designed to reduce fertility rates.

EXTERNAL ASSISTANCE

The International Planned Parenthood Federation (IPPF) has provided $2.36 million in assistance since 1969. This funding has gone toward activities of the Family Planning Association of Kenya (FPAK), including the operation of eight mobile units serving 90 clinics throughout the country. IPPF also operates the Family Welfare Training Center in Nairobi and maintains a regional office in the same city.

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[1] In the summer of 1976, the family life education program of the National Christian Council for Kenya received its fourth grant from Family Planning International Assistance. The Council is to use its experience in curriculum design, materials production, and in-service training to discuss changes in Kenyan's family life instruction with the Ministry of Education and the recently established National Education Commission. The goal is to design and implement a curriculum in sex education for teacher training colleges as well as for primary and secondary schools.

The Population Council conducted the study on which Kenya's family planning program is based and has provided a total of $225,000 in assistance since 1969. Family Planning International Assistance (FPIA) has provided $454,000 since 1973. Financial support also has come from the Ford Foundation, the Pathfinder Fund, and the Association for Voluntary Sterilization.

The World Bank provided $360,000 for family planning activities in 1974 and 1975 and has pledged loans totaling $12 million in support of the Kenyan program for 1975–79, to be used for construction of nurses' training centers, facilities for training midwives, and similar projects.

The United Nations Fund for Population Activities (UNFPA) made $3.5 million available in 1974 for general support of Kenyan family planning efforts through 1979. Previous UNFPA funding included $794,000 through fiscal 1975. In addition, the U.N. Children's Fund (UNICEF) is providing assistance through its maternal and child health programs.

Between fiscal 1969 and 1975, assistance from USAID totaled $1.93 million; about $329,000 is budgeted for fiscal 1976. Funding has gone toward training of family planning personnel, technical and commodity assistance for the Government program, and technical assistance in demographic studies.

Specific activities have included tests of three different delivery systems in the Special Rural Development Project in Viluga; advisory assistance in preparing information, education, and training materials for the Ministry of Health; production of a prototype family planning calendar; establishment of a major demographic project through a contract with the University of North Carolina; and a regional project to test the potential for commercial marketing of contraceptives.[1]

Among individual countries providing bilateral assistance, the Swedish International Development Authority (SIDA) has provided $2.4 million in the last 19 years for advisory assistance, contraceptives, and support for the education and information activities of the Government program. The Netherlands has supplied $819,000 in the last decade—mainly for a 1968–72 project in Nairobi to provide training for medical officers and a paramedical staff. Since then, The Netherlands has paid the salary of an obstetrician-gynecologist assisting the national family planning program. Denmark has pledged $426,230 to the school for district nurses in Eldoret. The Norwegian Agency for International Development provided $240,000 in 1974 and 1975, mainly for clinic equipment. In addition, it has committed $3.1 million for 1974–77 for the establishment and operation of six rural health training centers and has programed $1.9 million for the building of three demonstration health centers and to cover current expenses of family planning clinics. West Germany provided $498,000 in assistance from 1969 through 1972.

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[1] The extent of the contribution by the commercial sector is not known at present except that doctors and pharmacists do cater to a certain segment of the population. The USAID regional project included sales of condoms though established markets in the Meru District, which has a population of some 500,000. The organization which was started with this grant now sells condoms and foaming tablets for profit in urban areas and on a nonprofit basis (directly and by mail order) in rural areas.

SUMMARY

Alhough Kenya's family planning efforts are advanced compared to other African nations, it is not commensurate with the thrust that should have followed President Kenyetta's announcement of his support. One wonders, therefore, whether the Government has fully realized the magnitude of the population growth problem. According to an estimate made jointly by the United Nations and the Kenyan Ministry of Health, the present population policy means that fertility decline in Kenya will be very slow and replacement level—not to be confused with zero population growth—will not be attained before the year 2040. If this happens, Kenya's current population of about 13.9 million will have soared to about 54 million. Planners must ask whether future resources can support a population of this size under any socioeconomic system or conditions. If there are doubts, the present population policy and family planning programs should be re-examined.

The low-key nature of Kenya's family planning program probably accounts in part for the lack of opposition to it, but, at the same time, the program has failed to reduce the population growth rate significantly. With outside aid, perhaps the present pilot program can be expanded. However, one gets the impression that donor groups, as well as the Kenyan Government, are so involved in developing the pilot project that they have failed to notice how little impact it has on meeting the country's real needs.

Obviously, the first 5 years of any nationwide project are the hardest. Key people, as well as the general population, must be won over. A sensible program must be designed. Institutions must be altered, people trained, paid positions created, and systems launched. Data must be collected and analyzed to obtain information on which to base program improvements and expansion. It is also true that, psychologically, a country can absorb only a certain amount of help at one time.

Despite these difficulties, substantial economies of scale appear attainable. It has cost a great deal to put the system in place; it would cost considerably less per birth averted to expand the program. What has already been spent may simply be money wasted unless the Kenyan Government, the United States, and other donors invest enough additional funds to make the project really count. While Americans often think too big and too fast, making plans that are too small and taking action that is too slow will incur disaster.

KENYA—PEOPLE INTERVIEWED

P.F.O. Callaghan, M.D., Medical Officer, Machakos Health District, Kenya.

Eric Carlson, Acting Director, Division of Financial and Technical Services, U.N Habitat and Human Settlements Foundation, P.O. Box 30552, Nairobi, Kenya.

John J. Eddy, Counselor for Economic Affairs, U.S. Embassy in Kenya.

Jack Edmundson, Vice President, Foundation for Cooperative Housing, 1001 15th Street, N.W., Washington, D.C.

William Neal Goodson, Chief, Housing and Urban Development, USAID, East Africa.

Peter Hall, Ph. D., Kenya Population Project Officer, World Bank, Washington, D.C. and Nairobi, Kenya.

Harvey Herr, Data Access Inc. (contractor), Ministry of Health, Research and Evaluation Division, Nairobi, Kenya.

Jerome Hulehan, General Development Officer, USAID, Kenya.

Margaret Ithongo, Provincial Matron Eastern Province, Kenya.

Curtis Kamman, Counselor for Political Affairs, U.S. Embassy in Kenya.

S. Kanani, Director, Rural Health Services, Ministry of Health, Kenya.

Eric R. Krystall, Project Manager, Programmes for Better Family Living, Food and Agricultural Organization of the United Nations, Box 30470, Nairobi, Kenya.

Donald Larson, Ph. D., Central Bureau of Statistics, Nairobi, Kenya.

Ralph E. Lindstrom, Deputy Chief of Mission, U.S. Embassy in Kenya.

Victoria Lupowana, Public Health Nurse.

Thomas Lyons, USAID Population Officer, Nairobi, Kenya.

Layton F. MacNichol, Regional Housing Officer, USAID, Washington, D.C.

J. D. Makayota, M.D., Ministry of Health, Training Division, Maternal and Child Health/Family Planning, Nairobi, Kenya.

Marasha Marasha, M.D., D. Obs., D.P.H., M.P.H., Regional Representative SubSahara Africa, The Pathfinder Fund, Box 48147, Nairobi, Kenya

Leo Milas Seifulazi, Research and Evaluation Officer, International Planned Parenthood, Nairobi, Kenya.

Father Muhoho, Chief Environmentalist, United Nations, Nairobi, Kenya.

Esther Mukatha, Public Nurse, National Family Welfare Center, Kenya.

Beatrice M. Mutna, Nurse Supervisor/Trainer in Family Planning, Machakos District, Kenya.

Anthony Mwaniki, Chief Demographer, Central Bureau of Statistics, Nairobi, Kenya.

Raj Naik, Assistant Regional Director, International Planned Parenthood, Nairobi, Kenya.

Wilson Okwenje, Program Office, International Planned Parenthood, Nairobi, Kenya.

Mrs. Otete, Director, National Family Welfare Center, Ministry of Health, Nairobi, Kenya.

Robert Peterson, Director, Research and Evaluation, National Family Welfare Center, Ministry of Health, Nairobi, Kenya.

Dale Pfeiffer, Program Officer, USAID, Kenya.

Mike Rugh, Assistant Program Officer, USAID, Kenya.

William Sigler, Director, USAID, Kenya.

Michael Sozi, Regional Director, International Planned Parenthood, Nairobi, Kenya.

Magnus Steinborg, M.D., Program Advisor, National Family Welfare Center, Ministry of Health, Nairobi, Kenya.

Dr. E. Tarimo, Director of Preventive Services, Ministry of Health, Kenya.

Irwin K. Teven, Public Affairs Officer, U.S. Information Service in Kenya.

KENYA—SCHEDULE OF APPOINTMENTS

Monday, September 27, 1976.

Arrived Nairobi, Midday.
2:30 to 5:30—Intelsat Conference.
6:00—Reception for Intelsat Delegation.

Tuesday, September 28, 1976

8:00 a.m.—Intelsat Conference.
9:00 a.m. to noon—Thomas Lysons, USAID Population Officer.
Complete presentation and discussion of the comprehensive MCH/FP Kenyan national plan and program.
1:00 p.m. to 3:00 p.m.—Luncheon, Residence of Edward Noziglia: To discuss appropriate topics with Ambassador Anthony Marshall, and (with reference to Congressman Schener's other projects) David Muhro, Action Executive Director, United Nations Environment Project; Jean Jacques Graisse, Director, Office of External Relations, United Nations Environment Project; Richard Morse, Chief, Operations Unit, United Nations Environment Project.
Joel W. Biller, Deputy Assistant Secretary for Transportation, Telecommunications and Commercial Affairs, Bureau of Economic and Business Affairs, Department of State; John O'Neill, Jr., Director, 0ffice of International Communications Policy, Bureau of Economic and Business Affairs, Department of State.
4:00 p.m. to 6:00 p.m.—Informal conversations about population problems in Kenya.
8:00 p.m.—Dinner with William Fishman, White House Telecommunications specialists.

Wednesday, September 29, 1976.

8:00 a.m.—Marasha Marasha, M.D., M.P.H., Regional Representative SubSahara Africa, The Pathfinder Fund: Presentation and discussion of family planning in the entire region; and Tom Lyons (Greenberg).
Intelsat Conference (Congressman Scheuer).
10:00 a.m.—Michal Sozi and staff, Regional Director, International Planned Parenthood.
11:30 a.m.—Donald Larson, Ph. D., and Anthony Mwaniki, Chief Demographer, Central Bureau of Statistics.
1:00 p.m. to 2:30 p.m.—Lunch with Donald Larson, Anthony Mwaniki and Tom Lyons.
3:00 p.m. to 4:00 p.m.—Intelsat Conference (Cong. Scheuer).
4:30 p.m.—U.S. Embassy Political and Economic Briefing.
6:00 p.m. to 7:30 p.m.—Dr. Marasha.

Thursday, September 30, 1976.

9:00 a.m.—Rather Muhohs, Chief Environmentalist, United Nations.
10:15 a.m.—Intelsat Conference (Cong. Scheuer).
Collected appropriate documents (Greenberg).
12:30 p.m. to 3:00 p.m.—Luncheon. Residence of Thomas Lyons, USAID Population Officer: From the National Family Welfare Center—Ms. Otete, Director; Robert Peterson, Director Research and Evaluation; Dr. Magnus Steinborg, Program Advisor; From

USAID—William Sigler, Director, Kenya; Jerome Hulehan, General Development Officer; Dale Pfeiffer, Program Officer; Mike Rugh, Assistant Program Officer.

3:00 p.m.—USAID: Tom Lyons, Robert Peterson and Harvey Herr (designing a computerized evaluation system for family planning in Kenya with the Ministry of Health).

4:00 p.m.—Mr. Englund, United Nations Development Program Res. Representative.

5:15 p.m.—Intelsat Conference (Cong. Scheuer).

6:45 p.m.—Reception for Intelsat Delegation.

8:00 p.m.—Dinner. Residence of Deputy Chief of Mission Lindstrom to meet Kenyan and Embassy officials relevant to our work.

Friday, October 1, 1976

8:30 a.m. to 1:00 p.m.—Field trip to Machakos District to see hospital with MCH/FP clinics and services, to discuss family planning with staff and Mott people who accompanied us.

1:30 p.m.—S. Kinani, Director Rural Health Services, Ministry of Health, Kenya.

3:00 p.m.—Congresman Scheuer taped an interview at the U.S. Information Service.

5:30 p.m.—Congressman Scheuer television appearance at the International Show.

Saturday, October 2—Sunday, October 3, 1976

Extensive driving to see rural Kenya, City of Narok.

Monday, October 4, 1976

12:30 p.m.—Lunch with housing officials from several organizations to discuss the relationship between housing projects and population growth rate reduction.

2:00 p.m. to 3:00 p.m.—Further discussion about population and development with Embassy counselors.

9:00 p.m.—Eric Krystall, UNFAO, Project Manager, Programmes for Better Family Living.

Tanzania

Key demographic data

Mid-1976 population	million	15.6
Annual growth rate	percent	2.9
1975 urban population	do	7.0
Agricultural labor force	do	90.0
Per capita GNP	U.S. dollars	160
Life expectancy	years	45
People per doctor		26,800
Literacy rate	percent	15–20
Primary and secondary students, ages 5 to 19	do	22

Located in east Africa, the United Republic of Tanzania, at 342,171 square miles, is about the size of Texas and Wyoming combined. We visited Tanzania at a time when the government was charting a nationwide health network which was to include family planning services, and we were excited about the herculean efforts the country is making to upgrade the health status of its people. Jack Harshbarger, USAID population officer in Dar es Salaam, Tanzania's capital, pointed out that at the present pace, by 1981 there will be 2,600 mch/fp aides receiving on-the-job training in providing family planning information and services.

National history

Tanzania comprises mainland—formerly called Tanganyika—and the islands of Zanzibar, Pemba, and Mafia. It is a poor country, one of the 25 least developed in the world, and among the least urbanized.

Over 90 percent of its 15.6 million people live in rural areas and make their living from traditional, often subsistence, agriculture. There are about 120 tribal groups, the largest being the Sukuma and Nyamwesi. About 30 percent of the people are Moslem and 30 percent Christian. Swahili is the common language, but English is also spoken. The country was administered by the British until 1961, first as a League of Nations mandate, later as a U.N. Trust Territory.

Tanzania's economy is based on such agricultural exports as coffee and cotton. Agriculture contributes nearly 40 percent of the gross domestic product. However, this contribution has been declining in recent years. Problems include drought, a poor distribution system, and lack of incentives for farmers to produce.

The Government has taken a socialist path to development. The state controls production and commerce and is trying to transform rural agriculture into a cooperative system. Although Tanzania is nonalined, it is heavily influenced by the Chinese model and stresses rural socialism and self-reliance. The Government's concentration on rural areas can be seen upon arrival in Dar es Salaam, a rundown capital city. Dar has been allowed to deteriorate, since the Government intends to build a new capital city at Dodomo, in the center of the country. Furthermore, Government policy is to emphasize rural, not urban, development.

More than 35 percent of Tanzania's rural population now lives in ujamaa, or development villages, formed to concentrate the scattered rural dwellers. Here, members join in communal farming and general improvements. The leader (Balozi) of the smallest unit is appointed. Such a person can be trained to promote anything for the social and individual good, including family planning.

POLITICAL LEADERSHIP

The ruling party, the Tanganyika African National Union (TANU) is the official party and is interwoven into the Government.

The president of Tanzania is Dr. Julius Nyerere, who was a schoolteacher before going into politics. Nyerere, who has headed the Government since independence, is a much admired African president. A thoughtful pan-Africanist, he is a dedicated support of the liberation effort of southern Africa, and his influence on this issue is so important that any "South African solution" will need his approval to be workable. He has set demanding self-help and decentralization standards for his countrymen. Though he has promoted a socialist approach to all aspects of improvement for his country, he has won much respect for his ability to change ways of doing things that fail to work.

Demographic picture

Tanzania's population is increasing at the annual rate of 2.7 percent. The birth rate is estimated at 46–50 per 1,000 and the death rate at 16–21 per 1,000. At the current rate of increase, the population would virtually double by the year 2000. Because 47 percent of the population has not even reached reproductive age, further increases are clearly in sight, exacerbating the already heavy pressure of population numbers on employment opportunities and public services. Per capita GNP is already low at $160—1974 U.S. dollars.

A high infant mortality rate—160 deaths per 1,000 live births—accompanies the high birth rate. Large numbers of children die of malaria, measles, and other illnesses, and one in four dies before reaching age 5. Thus people continue to have very large families to insure that there will be surviving children.

One of the direct results of population growth is the country's increasing need to import food. Food imports amounted to $150 million in 1974, compared with an annual average of $20 million in the late 1960's. It is estimated that, if population growth continues at the present rate. Tanzania's cultivated area would have to expand 64 percent by 1992 to supply the same amount of food per capita as is grown today.

President Nyerere has often discussed the problem of population growth and the need for family planning. Although the Government does not yet have an official population plan, its commitment to rapid development of rural areas and its attempt to spread the activities and benefits of development throughout its population have had significant implications for Tanzania's health care system, which includes family planning in its maternal and child health network. UMATI—a Swahili word meaning family planning—the official family planning association of Tanzania, is part of TANU. In addition to its other

activities, it sponsors meetings to explain contraception, often confused with castration, to men.

Health care

A review of services when we were there revealed that not all health service centers are open daily. Many are not yet adequately staffed, or do not have the equipment and supplies they need. Of the few that offer mch services, fewer have family planning. The best estimate of the present situation is that eight hospitals, 100 health centers, and 300 dispensaries offer daily clinics.

There is a pressing need for improvements in these basic health units, expansion of the mch/fp aide training program, and solutions to serious drug, material supply, and distribution problems. Only an estimated 40 percent of the 3 million children under age 5 have any contact with mch services, and so far only a bare 1 percent of the country's 3 million women are being reached by family planning services. Of course, there is a difference between women reached and women protected, but reaching is a beginning.

The Government is aware of the need for a widespread network of family planning facilities. At the time of our visit, Tanzanian officials were formulating a national plan for delivering and supervising preventive and curative health services. The organizational chart for a system of comprehensive health services has not yet been approved.

Until a few years ago, Tanzania's health delivery system stressed primary treatment services at fixed facilities and preventive programs operating from mobile units. Problems developed because mothers had to be highly motivated to bring their children all the way to the clinic for preventive services. In addition, these clinics offered only one kind of service—tuberculosis prevention, or an inoculation against sleeping sickness, or family planning. The result was that most mothers passed up preventive services, and family planning received little attention. Due to the lack of vehicle maintenance and repair services for the mobile units, as well as expenses resulting from the international oil crisis, most district mobile teams suffered breakdowns or exhausted their travel budgets early in the fiscal year and were idle after that.

In 1973, the Ministry of Health moved to correct the problem by training multipurpose auxiliaries. A plan was developed to provide enough basic training to enable them to perform a variety of curative and preventive services.[1] Auxiliaries were to be trained in sufficient numbers so that they could be based at all dispensaries and health centers.

Training paraprofessionals

The three kinds of health auxiliaries now being trained for the dispensary team are: (1) Rural medical aides, who function as team leaders after 3 years of training in simple curative and preventive services; (2) Mch aides, who after 18 months of training provide comprehensive mch services;[1] and (3) health auxiliaries, who also receive 18 months of training, and then provide environmental sanitation services as well as specific disease control services. A team made

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[1] We got the impression that prevention is being stressed much more heavily in Tanzania than in Kenya, although Kenya is aiming in that direction. Tanzania seems to be holding curative services at the current spending level, while increasing expenditures for preventive services.

up of these workers, with one or two support staff, provides primary care for an area of 7,000 to 10,000 people. None of these auxiliaries has attended secondary school.

Principal Secretary G. J. Kileo of the Ministry of Health told us that mch/fp aides are being given brief training courses to enable them to dispense all sorts of contraceptives and even insert one IUD "under a physician's guidance and with his approval. We have one physician per 23,000 people. Aides will be trained to do it and will do it if they prove capable."

We drove to several rural areas on two-lane hardtop roads with holes nearly deep enough to swallow the car. At Kerege Dispensary, Bagamoyo, family planning services are available. We were informed,

> We will offer the services, but we don't have our aide yet. We will when we get one from training. The women are ready.

The health center is the first line of referral from the dispensary. It is run by a medical assistant, who has some secondary school education and 3 years of medical training. He is assisted by one or two rural medical aides, several nurse/midwives—primary school plus 3 years of training—several maternal and child health/family planning aides, and support staff. In contrast to a dispensary, a health center has space for 20 to 40 inpatients.

Standardized curriculum and career ladders have been established for each category of auxiliary. Training centers are operating, and more are being built. When we were there, Tanzania had:

One training center for health auxiliaries with an output of 44 per year,

Fourteen training centers for mch/fp aides with an output of 165 per year, and 4 more being built—1 for each region of Tanzania,

Thirteen training centers for rural medical aides, turning out 259 per year,

Six training centers for medical assistants, turning out 171 per year.

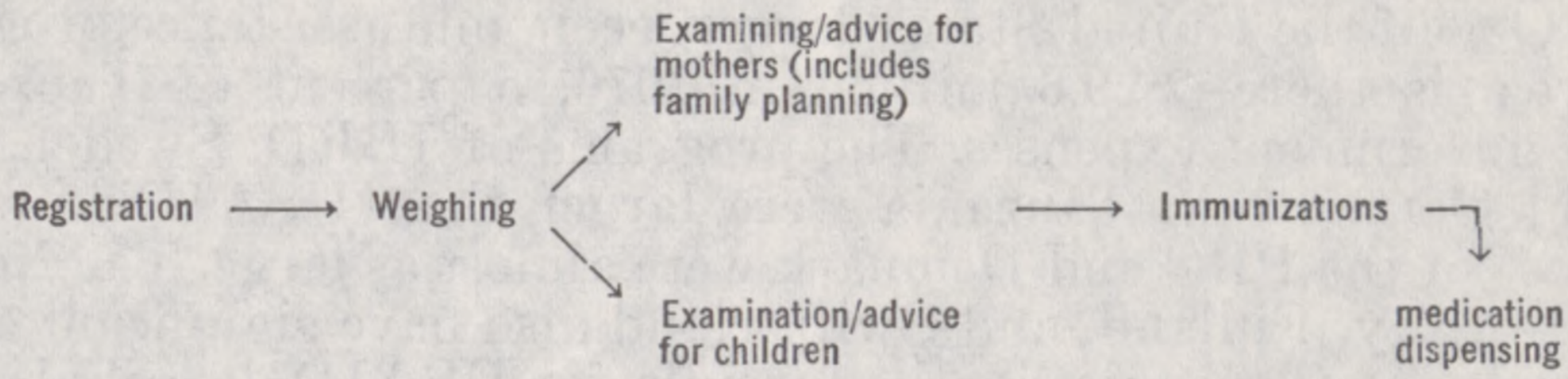
It is expected that by 1980, training centers will be providing 380 health auxiliaries, 450 mch/fp aides, 480 rural medical aides, and 217 medical assistants per year.

To broaden health care delivery, the Government also decided to provide daily preventive and curative services at every dispensary and to require mothers and children to go to the preventive mch unit before seeing higher auxiliaries or obtaining medicine. In this way, the more popular curative services can be diverted, in part, to providing equally important preventive services, including family planning.

Reorganizing health services

Tanzania is using a three-step approach to convert from the old to the new clinic pattern. The first step is to add missing services to single-service facilities, enabling them to provide comprehensive care. Once this has been accomplished, the second step is to add new full-service facilities. The final step is to require women and children coming for outpatient curative treatment to first pass through the mch/fp clinic for treatment of routine problems. This typically takes pressure off the outpatient clinics.

The activities of a combined mch/fp clinic are divided into five basic stations—actually, benches full of women and children awaiting the attention of health auxiliaries working at tables in the open or in separate rooms. We saw all patients progress in this manner:



Both registration and dispensing are done by support staff who have been trained on the job. The mch/fp aide is at the heart of the facility, doing examinations and giving advice.

Dispensaries—we visited two in rural areas—are simpler, and the patient flow pattern is abbreviated. Registration and weighing are combined, as are immunizations and dispensing. In both clinics and dispensaries, health education is given at all stops.

A major problem, but one that Tanzania is tackling effectively, is handling mch equipment and supplies. If each facility is to provide daily, integrated mch/fp clinics and operate reliably enough to build credibility in the community, each must have its own equipment, ability to store vaccines—which must be continuously refrigerated—and other supplies. In much of rural Tanzania, neither electricity nor gas is available. Kerosene refrigerators, mostly supplied by USAID, are being relied upon; at the time of our visit, 820 had arrived and 235 more had been ordered, and these are being distributed to the districts. Temperatures fluctuate, kerosene runs out, and they break. However, Tanzanian health officials and consultants have developed an increasingly successful system of giving one individual at each facility the necessary training and full responsibility for keeping the refrigerator working.

Other equipment in the basic mch/fp kit are a hanging scale for weighing babies and small children, a bathroom-type scale for weighing older children and mothers, a sphygmomanometer, a small kerosene sterilizer, stethoscope, obstetric syringes, and needles.

The program must be able to provide consumable mch/fp supplies to remote rural areas regularly. Establishing and guaranteeing transport of perishables from the airport in Dar es Salaam to each of the 20 regions, from there to regional and district hospitals, and from there to clinics and dispensaries, is still a problem. East African Airways handles much of the transport. Nonperishable supplies go by land transport, which is also difficult because of the condition of Tanzania's roads.

Tanzania, like some of the other developing countries we visited, has had trouble keeping useful clinic records in rural areas. It has now adopted a simple system of individual mch/fp records which mothers keep at home in clear plastic bags supplied by dispensary personnel and bring to the health facility at each visit. Within one-half year of starting this system, only 2 percent of the mothers forgot their cards. Duplicate records are not kept.

EXTERNAL ASSISTANCE

Though the U.S.S.R. is not popular and the United States is attacked in the United Nations and by the press, Tanzania depends primarily on multilateral and bilateral aid for its capital development requirements. One of the United States' largest economic assistance programs in Africa is there—$29.6 million in 1976, 5 percent of Tanzania's central government expenses. The programs of IBRD, Sweden, Canada and Germany in Tanzania were larger than USAID's in 1976, and those of the PRC and Denmark were almost as large. The Netherlands, Norway, Finland, and Switzerland also have significant assistance programs. Tanzania fits the formula for USAID, largely because of its tremendous emphasis on rural development. Zanzibar has been dependent upon the PRC for most of its aid during the past 10 years, but is now beginning to turn West.

USAID is providing about $10 million for a 5-year project for construction of 18 regional training centers and 64 outposts that will provide training for an estimated 2,600 paramedical personnel.

The United Nations Fund for Population Activities (UNFPA) has financed census publications and other projects in the family planning field.

The International Planned Parenthood Federation (IPPF) has provided a total of $1.93 million since 1969 in support of the Family Planning Association of Tanzania (UMATI), which provides family planning advisers, conducts training courses, and provides equipment for more than 100 mch/fp clinics in Tanzania. Over 50 of these clinics are in Government hospitals; the largest and most active are in Dar es Salaam. UMATI also produces family planning literature and radio programs.

The Population Council, with a cumulative input of $324,000 since 1969, has provided demographic assistance, support for a project to analyze census data on migration, and assistance for private agencies in Tanzania.

Other private organizations lending assistance during the past decade include Family Planning International Assistance (FPIA), the Pathfinder Fund, and World Neighbors.

SUMMARY

Tanzania is beginning to think about integrating population planning into other development programs, such as agriculture and employment. While the focus of population planning in Tanzania is often on accommodating larger numbers of people, the Government is intensifying its family planning program, which aims to slow growth of the population.

Family planning as part of the school curriculum received a setback when some sex education materials showing reproductive organs caused a flurry and were banned. Family planning education is now making a slow comeback as an aspect of health and well-being for mothers and children. Achieving universal education by 1978 is a national priority. Even if family planning is not part of the curriculum, universal education may promote smaller families, since more education for women is apparently correlated with lower fertility.

Though Tanzania is consistently unfriendly to the United States in the U.N. and the local government-controlled press, we had the distinct feeling that more technical assistance from us in training paraprofessional trainers and supervisors would be readily accepted, as would aid in purchasing mch/fp kits and for ongoing evaluation. The latter is immensely important. Those of us who have had experience with paraprofessional health workers know what marvelous work they can do. However, some individuals are untrainable, some training is ineffective, and some paraprofessionals do not get much done on the job. Evaluation should be part of any health auxiliary training program so that unsatisfactory aspects of training can be built up and problems straightened out.

The Tanzanian Government has shown that it will turn down aid with too many strings attached, but it will accept aid from any country, regardless of political persuasion, because its needs are so great. If a major U.S. criterion for determining development assistance is whether countries are investing a sizable proportion of their own manpower, funds, and energy in development efforts, then Tanzania is eminently eligible for maternal and child health, family planning, and other population-related assistance from USAID.

TANZANIA—PEOPLE INTERVIEWED

Mr. and Mrs. Sulvano Adel—Mr. Adel is a Senior Economist, Planning Section, Ministry of Health.
Mr. Asman—Scientific Advisor, National Science Research Council.
Mr. and Mrs. Faustin S. Chale—Deputy Director, Information and Research Bureau, Ministry of Foreign Affairs.
A. D. Chidius, M.D.—Director, Manpower and Training, Ministry of Health.
Jake Harshbarger—Maternal Child Health/Family Planning Officer, USAID, Dar es Salaam.
Dr. and Mrs. Henry E. Heidinger—Chief of Party and Chief Advisor to the MCH unit, Preventive Services Division, Ministry of Health.
Dr. Henin—Economist/Demographer, and East Africa Representative for Population Council.
Allan Hoben, Ph. D.—Program and Policy Planning USAID, Washington, D.C.—Anthropologist visiting projects in Tanzania and other African countries.
Doug Hogan, Ph. D.—Economist, University of Dar es Salaam, Tanzania
Dr. Vernon C. Johnson—Director, USAID, Tanzania.
Kerege Dispensary Staff—P.O. Box 29, Bagamoyo, Tanzania.
Principal Secretary G. J. Kileo—Ministry of Health, Tanzania.
Miss J. Z. Kimangono—Senior nurse advisor in the Preventive Medicine Division, Ministry of Health.
Sister Jean Kruith—Mary Mount Sisters, Dar es Salaam, Tanzania.
Herbert Levin—Deputy Chief of Mission, U.S. Embassy, Tanzania.
Mr. and Mrs. F. K. Lwegarulila—Principal Secretary, Ministry of Water Development, Energy and Minerals.
Frederic Mabbott—Public Affairs Officer, U.S. Information Service, Tanzania.
Hugh C. MacDougall—Political Officer, U.S. Embassy, Tanzania.

Nimrod Mandara, M.D.—Medical Director of UMATI.
Prof. A. C. Mascarenhas—Director, Bureau of Resource Assessment and Land Use Planning, University of Dar es Salaam.
Chief and Mrs. Adam Sapi Mkwawa—Speaker, National Assembly.
Mr. Munisi—Documents officer, National Science Research Council.
Dr. James Mwakalukwa—Head of Disease Surveillance Section, Preventive Services, Ministry of Health.
Mr. Mwombe —Executive Secretary, National Scientific Research Council (NSRC).
Dr. Michel Safe—MCH Advisor, MCH Section, Preventive Services, Ministry of Health.
James W. Spam—Ambassador, Tanzania.
E. Tarimo, M.D.—Director, Preventive Services, Ministry of Health.
Linus Unson—Consular Officer, U.S. Embassy, Tanzania.
Mr. Vitanyi—Scientific Advisor, National Science Research Council.
Daniel F. Waterman—Economic Officer, U.S. Embassy, Tanzania.
Miss Ellen Zablan—Senior nurse advisor, Hospital Services Division, Ministry of Health.

TANZANIA—SCHEDULE OF APPOINTMENTS

Tuesday, October 5, 1976

Arrive Dar es Salaam from Kenya, 10:30 a.m.

11:45 a.m.—University of Dar es Salaam, Dr. Henin, Economist/Demographer, East Africa Representative for the Population Council—Population Officer Jake Harshbarger and Economic Officer Daniel Waterman accompanied—Doug Hogan, Ph. D. also present.

1:00 p.m. Congressman Scheuer only: Mr. Mwombela, Executive Secretary of National Scientific Research Council. Waterman accompanied.

Greenberg interviewed Jake Harshbarger, MCH/FP Officer, USAID.

2:00 p.m.—Call on Principal Secretary Kileo, E. Tarimo, M.D. and A. D. Chidius, M.D., Ministry of Health.

3:00 p.m.—Call on Dr. Mandara, medical director of UMATI—Family Planning Association. Harshbarger accompanied.

4:00 p.m.—Briefing at Ambassador's Residence on general economic and political matters. Attended by Ambassador Spain, Mr. Levin, Mr. Mabbat (USIS), Dr. Johnson (USAID), Mr. MacDougall, Mr. Upson, Mr. Waterman, and Dr. Hoben (USAID), Wash., D.C.

5:00 p.m.—Met with interested members of the American Community to discuss current US political and election scene at Ambassador's Residence.

7:30 p.m.—Dinner at home of Population Officer Harshbarger with Tanzanians involved in family planning and related activities.

11:30 p.m.—Interviewed Allan Hoben, Ph. D. at Kilimanjaro Hotel.

Wednesday, October 6, 1976

7:15 a.m.—Continued interviewing Dr. Hoben.

8:30 p.m.—Departed from Bagamoyo, historic town 60 kms (all day trip) north of Dar es Salaam.[1] On way, stopped at two rural dispen-

[1] Bagamoyo means "Here I lay down my heart." It was a terminus for slaves brought from the interior for transport by sea to Zanzibar and thence to the Americas.

saries, Benju and Kerege. In Bagamoyo, visited Maternal and Child Health Aide Training Center, funded by USAID. Regional Medical Health officials, Harshbarger and Dr. Harvey E. Heidinger accompanied. Interviewed Heidinger extensively.

4:00 to 6:30 p.m.—Visited welfare handicraft center. Interviewed Mr. Waterman. Also interviewed Sister Jean Cruith who used to run a family planning clinic.

7:00 to 11:00 p.m.—Dinner at Ambassador's Residence with senior government officials responsible for population and scientific matters.

Zaire

Key demographic data

Mid-1976 population	million	21.7
Annual growth rate	percent	2.3
1975 urban population	do	26.0
Agricultural labor force	do	78.0
Per capita GNP	U.S. dollars	140
Life expectancy	years	44
People per doctor		24,700
Literacy rate	percent	20
Primary and secondary students, ages 5 to 19	do	53

Our visit to Zaire coincided with the publication of an issue of Zaire magazine, similar to our Time magazine, devoted to the national "desirable births" program, and preceded a week-long conference on the subject.

The Republic of Zaire, formerly the Belgian Congo, is the most populous country in central Africa and the largest in sub-Saharan Africa. It is 895,348 square miles in area, as large as the United States east of the Mississippi. The population of about 21.7 million is 80 percent Bantu; about 200 tribes have been identified. As a former Belgian colony, Zaire retains French as its official language. Approximately 700 African languages have been distinguished. About 50 percent of the people are animist and 43 percent Christian, with Catholics accounting for about three-fourths of the Christians. The Government has consolidated all Protestant denominations into the Church of Christ in Zaire. A third Christian group, the Kimbanguist church, is Zairian in origin.

A potentially rich nation, Zaire has much underutilized agricultural land, plentiful deposits of metals, and a huge hydroelectric potential—one of the largest in the world. Its per capita GNP is about $140—1974 U.S. dollars.

National history

The area now known as Zaire was virtually unknown to Europeans until the mid-1870's, when Henry Morton Stanley—of Stanley-Livingston fame—explored it in the name of Belgium's King Leopold II. We were told that King Leopold and, after him the Government of Belgium, ruled more harshly than any other colonial power, permitting the blacks to be trained for only menial work, exploiting the colony's resources for export, demanding severe taxes and bribes, and punishing cruelly for failure to pay.

Political leadership

The colonial power did virtually nothing to help the country prepare for self-government. For example, under colonial rule, only 10 percent of the African children even completed primary school. In 1960, spurred by riots in the previous year in Leopoldville, the

capital—and the wave of decolonization elsewhere in Africa, the Belgian Government reluctantly but precipitously granted independence to the colony, which became the Republic of the Congo, under President Joseph Kasavubu and Premier Patrice Lumumba.

Peaceful independence lasted less than a week; then chaos and civil war erupted. The army mutinied, copper-rich Katanga Province—now Shaba—in the south seceded under the leadership of Moise Tshombe, and public authority broke down. President Kasavubu appealed to the U.N. to restore order; Premier Lumumba asked the U.S.S.R. for help. He was dismissed in 1961, replaced by Cyrille Adoula and murdered in Katanga by political opponents.

U.N. security forces were sent to the Congo in 1960; indeed, in 1961 Dag Hammerskjold lost his life in a plane crash on a peace mission to the troubled area. Order was temporarily restored, the U.N. presence was withdrawn in June 1964, and former secessionist Tshombe became premier. In September, however, rebels set up a "people's republic" in Stanleyville in the northeast section, and almost a year passed before this rebellion was quelled. In 1971, the name of Congo and the Congo River were changed to Zaire, a traditional name derived from the Kikongo word meaning river.

In 1965, Gen. Joseph Desiré Mobutu, who had previously held cabinet posts, seized control of the Government, cancelled the next year's elections, and became President. In 1966, he abolished the office of premier and assumed all legislative powers from Parliament. Under constitutional changes made in 1974, the President is elected for a 5-year term, renewable only once, but this does not apply to President Mobutu who was elected in 1970 to a 7-year term. The constitution of 1967 places all executive power in the Presidency. In 1970 the constitution was amended to make Zaire a one-party state and Mobutu's MPR—Movement Populaire de la Revolution—became the only sanctioned party. In 1972, government and party leadership were merged in the National Executive Council.

Zairianization

Mobutu, who studied at the Institute of Social Studies in Brussels, has set out to make Zaire one of Africa's leading industrial countries and has made conscious efforts to reduce the economic influence of Belgium by promoting investments from other countries. He has achieved some centralization and stabilization by reducing provincial powers, introducing "Mobutism"—Mobutu veneration, and promoting "Zairianization," a movement toward national authenticity. Mobutism is evidenced in a number of ways the President's picture is the only one permitted to hang in public buildings; places connected with events in his life have been named "meditation" places; his face appears on TV coming out of the clouds and surrounded by a halo; and the anniversary of the date he took over is the principal public holiday.

Mobutu ordered the renaming of the cities, as well as the country. Leopoldville became Kinashasa, Stanleyville is now Kisangani, and Elisabethville is Lubumbashi. He changed his own name to Mobutu Sese Seko, and in 1972 all Zairians were ordered to take African names.

Another aspect of Zairianization was the transfer of most commercial and agricultural enterprises from foreign to Zairian owner-

ship. In 1974, the Government ordered large production, distribution, transportation, and construction enterprises to be sold to Zaire citizens. Though at the time of independence Zaire had one of the most highly developed economies of sub-Saharan Africa, it suffered greatly from the political disruption of the 1960's and from a worldwide drop in copper prices in the 1970's. During 1975, Zaire continued to suffer from the effects of its acute financial crisis, exacerbated by inept Zairian management.

Zairianization also entailed a takeover of the well-organized church-run school system and the extensive church-run medical system. During Belgian rule, both Catholic and Protestant churches had been very active in these areas. When Mobutu intervened in these church-sponsored social services, education and medical treatment nearly ground to a halt in Zaire.

Demographic picture

Zaire has a birth rate of 43–48 per 1,000 population and a death rate of 24–25 per 1,000, making a rate of natural increase of about 2.3 percent. If continued, this would double the country's 21.7 million mid-1976 population in 28 years. About 44 percent of the country's population is under age 15, setting the stage for accelerated increases.

Zaire is already suffering some of the repercussions of rapid population growth. A broad-based population pyramid, indicative of an increasingly young population, hinders efforts to improve the present quality of life. The needs of the people are outrunning food production, vital social services are lacking, disease and malnutrition are widespread, and mortality rates, especially among children, are high.

The large number of persons under 15 has placed enormous strains on the country's educational system. Although educational expenditures were doubled in the latter part of the sixties in an effort to keep pace with increased primary and secondary school enrollments, Zaire has not achieved universal primary enrollment. We were informed that about 80 percent of primary school-age children are enrolled in school.

Similarly, though many new jobs have been created in the Kinshasa area in recent years, continued migration to the capital city, combined with the large number of young people entering the labor force each year, have made it impossible to provide employment for everyone. Primarily because of farm-to-city migration, the percentage of the total population living in urban areas increased from 11.1 percent to 17 percent between 1960 and 1971. The population of Kinshasa is increasing at the rate of 13 percent a year—10 percent from migration and 3 percent from natural increase.

Population policy

In the past, Zaire's low population density and untapped wealth, coupled with the Bantu philosophy that the ultimate goal of marriage is reproduction, militated against public support of population programs. However, the overall population problem is generating increasing concern, and national leaders have indicated a growing commitment to curtailing population growth.

The turning point may have been President Mobutu's statement before the National Legislative Council in December 1972, in which he observed that "the control of the evolution of our population will, at the same time, permit control of our national development." He de-

clared that the state should help all citizens in their efforts to avoid unwanted births and pointed out that this policy of "naissances desirables"—desirable births—grew out of concern for the health of the people, particularly mothers and children. The state, he asserted, has a role to play in reducing infant mortality to the absolute minimum, so that a couple who would like to have 5 children will not be "constrained to bear 10 or 15, hoping that at least 5 will survive." The state, said Mobutu, should explain and facilitate the use of contraceptives so that citizens can avoid risky abortions as well as "exploitation by charlatans and unscrupulous fetishists."

Following Mobutu's speech, a National Council for Promotion of the Principle of Desirable Births [1] was created in the Office of the President in February 1973, and Dr. Sabwa Matanda was named president of the new national family planning policymaking organization. Family planning services are offered through the national health system.

At present, few hospitals, health centers, or clinics have been set up outside Kinshasa. The handful of rural government health facilities rarely have drugs, though mission health facilities usually stock them. At the church clinics, the cost of the injectable contraceptive depo provera is about 5 zaires per year, and an IUD is 1 zaire. Ms. Immetje Nieboer, a nurse involved in national family planning, told us:

> Depo is very popular. People are use to shots. They want a needle for every thing from headache to athlete's foot. Contraceptives are free at government clinics but women generally have to pay a bribe to get them. But, it's worth it to some women.

Maternal, child health, and family planning services

The national health plan now being developed calls for a hospital in each district; a health and maternity center staffed by nurses and auxiliaries reporting to the hospital; and a community health clinic staffed by a nurse, several auxiliaries, and some "animateurs"—similar to Kenyan field educator motivators—all of whom report to the health center. An effort is currently being made to revise the nursing school curriculum and to design training programs for animateurs. There are now 18 schools for training registered nurses and 45 schools for training auxiliaries. The total number of graduates is approximately 1,000 per year, but this number will be temporarily reduced as inadequate training institutions are closed and curriculum is overhauled. A considerable amount of schooling after primary school will continue to be required of health personnel.

The Government has a pilot mch/fp program operating in several clinics in Kinshasa under the auspices of Fonds Medical de Coordination (FOMECO). In addition, the national radio education-television production agency is producing radio tapes and films for national distribution.

Our trip included a visit to the Mama Yemo Hospital in Kinshasa, which has a full-blown maternal and child health/family planning program. Although various U.S. officials had told us that Zaire wasn't ready for the concept of family planning, the staff at Mama Yemo led us through tiny rooms packed with women, babies, and demonstrations

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[1] Conseil National Pour La Promotion du Principe des Naissances Desirables.

of contraceptive techniques. We saw similar sights at several satellite mch/fp centers.

The Mama Yemo program is the model for mch/fp clinics which the Government hopes to establish at each planned regional hospital. The program has already been expanded to three outreach mch/fp clinics in the city, with another scheduled to open shortly. It is hoped that these clinics will be models for the operation of mch/fp programs in rural clinics. All existing hospitals and clinics are now encouraged to send available doctors and nurses to Mama Yemo for from 3 to 6 weeks of family planning training.

Unfortunately, it appears unlikely that plans for additional hospitals and rural clinics with family planning components will be implemented in the near future. Zaire's current national health budget for nearly 25 million people is only $20 million, and Mama Yemo Hospital receives $10 million of this sum. "If I had a million dollars," laughed a public health nurse we talked to, "I'd buy contraceptives and quietly sell them in the village market. Women don't demand contraceptives. There is no national demand. But, if contraceptives were easily available, many would buy them."

Dr. Sabwa Matanda, who heads Zaire's family planning program, gave us this summary of his country's efforts:

> Our family planning program is 4 years old. We have reached 10,000 people at one hospital and three outreach clinics associated with it. Another clinic opens next month. We have expanded from 3 days a week to 6. The national plan is to expand outward from this central demonstration. Our objective is an orderly spread. We must gradually reach the women. They are way ahead of the politicians.

EXTERNAL ASSISTANCE

Because of Zaire's central location in Africa and its influence with other African countries, the United States has gone to great lengths to maintain good relations with this nation. Tension between the two countries has existed from time to time; until 2 years ago, Zaire consistently opposed the United States in U.N. actions, and in 1975 the U.S. Ambassador was declared persona non grata in the aftermath of an attempted coup in which Zaire charged CIA involvement.

The U.S. Agency for International Development has provided substantial assistance to Zaire. The agency obligated $1.63 million for population programs in fiscal years 1972 through 1975 and budgeted $593,000 for fiscal 1976. Much of this money has gone toward the Government's pilot project of mch/fp services, including training, information-education work, contraceptive distribution, and development of model clinics.

The United Nations Fund for Population Activities (UNFPA) provided $209,000 between fiscal 1973 and 1975 for a demographic and rural fertility survey and for a civil registration project. Funds also have gone toward strengthening the demographic division of Zaire's Department of Statistics and toward the salary of a professor of demography at the territorial school of Likas.

The Population Council in 1973 provided $40,000 in grant assistance to the University of Zaire for partial support of a Department of Demography. It is now headed by Pere Joseph Boute, a Belgian Jesuit priest who has lived and worked in Zaire for several decades, and is one

of the outstanding intellectual leaders in the family planning field in francophone Africa.

Canada's International Development Research Center granted $99,500 to the Government's National Institute of Statistics for a demographic survey in three major cities and for development of techniques applicable to other African nations.

Limited assistance also has come from the Pathfinder Fund, Family Planning International Assistance (FPIA), and the Mennonite Central Committee.

SUMMARY

Despite the impressive family planning models we saw during our visit to Zaire, we believe that in the absence of major intervention by donor nations and organizations, generations will elapse before family planning services are available throughout the country. A new order of magnitude is demanded by the situation, and we were told by Zairian decisionmakers that assistance at all levels of planning, including implementation of an mch/fp program, would be welcome, as would assistance with promoting pan-African interflow of ideas regarding population and development. It was suggested that an institute for all francophone countries interested in this subject be established in Zaire, and another for anglophone countries elsewhere. As in the other countries we visited, we were told of the key role played by private groups, of some of the problems in government-sponsored programs, and of the need to help both private and public sectors.

ZAIRE—PEOPLE INTERVIEWED

S. Adrien, M.D.—Chief representative, World Health Organization.
Anne Bamisaive—Head evaluation, Oguntola Street.
Joseph Boute, S.J.—Head, Department of Demography, National University of Zaire.
James Conley—U.S. Information Service.
Walter L. Cutler—U.S. Ambassador.
Citoyen Diastouk—Clinical director (church supported) Health and Family Planning Clinic, Yolo-Sud Kinshasa.
Joy Dodson—Public health nurse.
Richard Dodson, Ed. D.—Human Resources Development Adviser for the U.S. Agency for International Development, Kinshasa.
Ines Durana, M.D.—The Rockefeller Foundation.
Mrs. Ralph Galloway, R.N.—Works with the Zairian Protestant Church through the church's medical services organization in developing family health programs including the introduction of family planning services.
William Garvey—Agriculture, USAID.
Colonel John Geraci—Military mission.
Ernest Grigg—Political Counselor, U.S. Embassy.
Vince Havenec—U.S. Information Service.
John E. Kennedy, M.D.—Chief of the Public Health Division of the U.S. Agency for International Development.
Bernard McCullough, M.D.—Chief, Community Health Department, Mama Yemo Hospital, Kinshasa.
Jean McCullock, R.N.—Peace Corps Volunteer (rural).

Sabwa Matanda, M.D.—President of the National Committee for Desired Births, responsible for the implementation of the Government's desired births program. He is on detail from the army where he holds the rank of major.
Clayton Miracle—Chief of the Africa Division of the Office of Population at the Agency for International Development in Washington.
Jerry Mitchell—U.S. Embassy Political Officer, Zaire.
Clay Nettles—Economic counselor, U.S. Embassy.
Immetje Nieboer, R.N.—Public Health Nurse, Organization for Rehabilitation Through Training (ORTT) assisting the Government of Zaire in the development of the Maternal Child Health/Family Planning services in Kinshasa.
Mark Robbins—Health Director, Peace Corps.
Rob Roy Robertson—Population Officer, USAID.
Harland Robinson—U.S. Embassy, Political Counselor.
Bisengimana Rwena—Director of the Presidency, Government of Zaire.
Charles Tanguy—Department of State Inspector.
William Van Pelt, M.D.—Chief of Party for the training team from the Organization for Rehabilitation Training (ORT) which is responsible for the development of the model Maternal Child Health/Family Planning Centers now being established in Kinshasa.
Lannon Walker—DCM, U.S. Embassy.

ZAIRE—SCHEDULE OF APPOINTMENTS

Thursday, October 7

4:30 p.m.—Arrive Kinshasa, Zaire after all day plane trip from Dar es Salaam. Met and briefed by USAID Population Officer. Robertson, and Jerry Mitchell, Political Officer, U.S. Embassy.

Friday, October 8

8:15 a.m.—Breakfast discussion with Mr. Robertson.

9:00 to 12:30—Visit to Mama Yemo Hospital to see the model government MCH/FP clinic Zaire hopes to replicate.

Also visited a church family planning center, Yolo Sud, and a government family planning center, and a model government MCH/FP facility at Barumbu. Discussion with staff (translated) including aides.

Extensive discussion with Pelz, M.D., and Nieboer, R.N.

12:30 p.m.—Lunch with U.S. Embassy Political Counselor, Harlan Robinson.

2:00 p.m.—Meeting with Kennedy, M.D., and Mr. Roberston.

4:30 p.m.—Congressman only: met with Bisengimana Rwema, Director of the Presidency, Government of Zaire.

6:00 p.m.—Reception at residence of DCM Lannon Walker.

Walker reception guest list in honor of Congressman Scheuer:

Mr. and Mrs. Bob Robertson
Mr. and Mrs. William Mashburn
Dr. and Mrs. John A. Kennedy
Mr. and Mrs. Richard Dodson
Mr. and Mrs. Marshall McCallie
Mr. and Mrs. Harlan Robinson
Mr. and Mrs. Ernie Grigg
Mr. and Mrs. Jerry Mitchell
Ambassador and Mrs. Cutler
Mr. Clay Nettles
Mr. and Mrs. Alan Larson
Mr. George Hamilton
Mr. and Mrs. Bert Moore
Ms. Andree Slaughter
Mr. and Mrs. William Garvey
Ms. Nancy Bennett
Ms. Ginny Schrenk
Ms. Bonnie Kuhr
Ms. Sarita Cabanillas
Mr. and Mrs. Ollie Ellison
Mr. and Mrs. Yasar Karaer
Mr. and Mrs. Thomas Randall
Mr. and Mrs. Jim Conley
Mr. and Mrs. Jon Randall
Mr. Stuart Methven
Congressman James Scheuer and Mrs. Scheuer
Ms. Helen Cohen
Mrs. Polly Greenberg
Mr. Charles Tanguy
Mr. and Mrs. Paul Levihn (CIS)
Mr. and Mrs. Larry Devlin
Mr. and Mrs. P. F. Davies
Mr. and Mrs. Thomas King
Dr. and Mrs. William Van Pelt
Mr. and Mrs. William Emmet
Ms. Immetje Nieboer
Rev. and Mrs. Ralph Galloway
Mr. and Mrs. John Keller
Ms. Madeleine Byron
Mr. John W. Schamper
Mr. and Mrs. Dennis J. Marcott
Mrs. Ira Johnson
Ms. Jean Hall
Mr. and Mrs. Gordon Hopman
Maj. and Mrs. John Swenson
Lt. Col. and Mrs. David Beach

Citoyen Commissaire d'Etat Ngwete Kinhela et Citoyenne, Commissar at de la Sante.
Dr. Phaka Mbumba et Citoyenne, Commissariat de la Sante.
Dr. Sabwa A. Matanda et Citoyenne, Hopital Mama Yemo.
Dr. Miatudila Malonga et Citoyenne, Hopital Mama Yemo.
Dr. Ngwala Ndambi et Citoyenne, Hopital Mama Yemo.
Dr. Illunga et Citoyenne, Hopital Mama Yemo.
Citoyen Sokolua Lubanzadio et Citoyenne, USAID.
Pere Boute, UNAZA.
Commissaire d'Etat a la Sante Publique, Ngwete Kindela & Citoyenne.
Professeur Malu wa Kalenga et Citovenne, Commissaire des Sciences Nu leaires. Universite Nationale du Zaire.
Citoyen Bomina et Citoyenne, Department des Affaires Etrangeres.
Citoyen Kashile et Citoyenne, Department des Affaires Etrangeres.
Ambassadeur Bulambo et Citoyenne, Department des Affaires Etrangeres.
Ambassadeur Musobekwa et Citoyenne, Directeur pour la Cooperation Internationale, Dept. des Affaires Etrangeres.
Citoyen Sema P'Fambon et Citoyenne, AZAP.
Mr. and Mrs. Peter Leobarth, African American Labor Center.
Dr. Kalala et Citoyenne, African American Labor Center.
Citoyen Bonkongo Liasa et Citoyenne, National Legislative Council.

Saturday, October 9

7:30 a.m.—Breakfast meeting with Clay Nettles, U.S. Embassy Economics Counselor; Ernest Griggs, Political Counselor; John Gerraci, Military Mission; Bill Garvey, agriculture; James Conley, USIS.

9:30—University of Zaire to talk with Pere Boute, Chairman of Department of Demographic Studies, professor and expert in demography and family planning.

12:00—Luncheon at Ambassador Cutler's residence.

6:00 p.m.—Dinner at Mr. Robertson's home to meet USAID Washington, D.C. Population Specialist Clay Miracle.

Sunday, October 10

12:00—Luncheon, Miss Nieboer, R.N., Participant in designing national plan for MCH/FP.

3:00 p.m.—Second discussion with Pere Boute.

6:15—Political briefing, later dinner, at home of Ernest Grigg.

Monday, October 11

7:00 a.m.—Discussion with Richard Dodson.

9:30—Joy Dodson (Congressman only) Met with the Commissaire d'Etat a l'Environment et La Conservation de la Nature et Tourisme, Citoyenne Lessedjina.

10:00—Interviewed Peace Corps Health Director Mark Robbins.

10:45—Discussion with Sabwa Matanda, M.D., Director, Commissioner of Environment, Conservation and Tourism.

12:30 p.m.—Lunch discussion with Mark Robbins and Peace Corps volunteer Jean McCullock, R.N.

3:00—To airport to go to Lagos, Nigeria.

4:00—(At airport) USIS interview with Vince Havenec.

NIGERIA

Key demographic data

Mid-1976 population	million	64.7
Annual growth rate	percent	2.6
1976 urban population	do	19
Agricultural labor force	do	62
Per capita GNP	U.S. dollars, billion	28
Life expectancy at birth	years	43
People per physician		25,800
Literacy rate	percent	6
Primary and secondary students, ages 6 to 19	do	24

One out of every four Africans comes from Nigeria, a former British colony, a Commonwealth member, and an English-speaking country. With 65 million people, the Federal Republic of Nigeria is Africa's most populous country. It is also one of the largest; with 356,669 square miles, it is about one-third as large again as Texas, or one-tenth the size of all the United States.

Located on the Gulf of Guinea, Nigeria has a coastal area largely composed of a belt of mangrove swamps inersected by small rivers and creeks. A tropical rain forest, extending up to 150 miles inland over gradually rising country, gives way to a savannah plateau that reaches an elevation of 6,000 feet in the east. In the far north, the land is semidesert.

Of the country's 250 tribal groups, the most prominent are the Yoruba (13 million) in the west, the Ibo (7.8 million) in the east, and the Hausa (6.8 million) in the north. Population figures are projections based on the census of 1963 and on subsequent surveys taken since then. The results of the most recent census—taken in 1973—were discarded when all parties concerned agreed that the results were invalid. Although that census, supported by the U.N., was widely hailed as a model effort in technical terms, overreporting was evident. This is blamed on widespread belief that the results would be used for representation and resource allocation purposes. Of the previous censuses, the 1953 count, taken by the colonial administrators, received little cooperation from Africans, partly because colonial enumerations were used for poll-tax purposes. The 1963 census utilized improved methods, but analysis of results led many observers to conclude that the estimated population of 55.6 million was too high.

National history

Nigeria became independent in 1960 after moving toward self-government under successive post-World War II constitutions legislated by the British Government. Coalitions of regionally based parties ruled the country under a parliamentary form of government with local autonomy for the four regions. In January 1966, ethnic and sectional rivalries culminated in a violent coup by army officers, mainly Ibo, who later, in May, abolished the federation and established

22-303—78——8

a unitary government. Meanwhile, resentment against the Ibos had been growing, and the constitutional change was followed by a wave of anti-Ibo riots in the north, fighting within the army, and a countercoup. The army chief of staff, Lt. Col. Yakubu Gowon, assumed control, restored the federal structure, and began to take steps toward settlement of regional differences. More riots against the Ibos broke out, however, and the country slid into civil war not long after Gowon, in May 1967, proposed creation of 12 states (6 in the north; 3 in the former eastern region: Lagos state; and the western and midwestern states) that would replace the four regions. This last-ditch effort to reassure minority groups failed. The eastern region declared itself the independent state of Biafra, and the ensuing war lasted until January 1970, when Biafra, whose wartime sufferings had aroused worldwide concern, surrendered. Gowon then declared a general amnesty and reintegrated the east into the 12-state federation.

Gowon then turned his attention and abilities to the international scene. He served as President of the Organization of African Unity (OAU), 1973–1974, and was instrumental in the formation of the West African Economic Community. In July 1975, while he was out of the country at the OAU conference in Kampola, a bloodless coup brought Gen. Murtala Ramat Mohammed to power. Then in February 1976, shortly before our visit, dissident officers assassinated the general. The coup was crushed the same day, and the supreme military council, currently Nigeria's ruling body, named Lt. Gen. Olusegun Obasanjo head of state.

The 20-member Council which now rules Nigeria asserts that it is conducting a careful step-by-step program to return the country to civilian rule by 1979. Previously, Gowon had put off plans to restore civilian rule, in favor of concentrating on the Third National Development Plan (1975–1980) and making additional administrative changes.

Nigeria is a nonaligned country. The cornerstone of its foreign policy is total African unity and support for black majority rule in southern Africa, and it provided financial, material, and diplomatic support to the MPLA (Popular Movement for the Liberation of Angola) in its fight against South African troops in Angola. Continuing U.S. commercial dealings with South Africa are a cause of disagreement betwen the United States and Nigeria.

Socioeconomic status

Economically, Nigeria has a strong oil industry and by 1975 had become the world's eighth largest petroleum producer. Oil accounted for 90 percent of export value, with cocoa second.

The incredible amount of construction, day and night, that we observed in the capital city, Lagos, is evidence of Nigeria's massive development effort, fueled by oil export earnings. Although "indigenization" of the economy is increasing, Nigeria still desires foreign investment and expertise. The agricultural sector, in which most of the population is employed, is sagging, and Nigeria recently had to import large quantities of grain, dairy products, and sugar. The United States is the third largest supplier of Nigerian imports.

The government's stated goal is to provide better lives for its citizens. Education is the first priority, with universal primary education the immediate objective. Health services, including family planning, have a lower priority. The major barrier between Government policy and its implementation seems to be the insecurity of the national leaders. The Government's chief focus is on retaining control, and controversial decisions, such as extensive commitment to social development or programs to which some powerful factions might object, are avoided.

Demographic Picture

Nigeria's growth rate is estimated at 2.6 to 2.7 percent annually for 1977. Eighty-five percent of the population is rural. The 1977 birth rate was 49 per 1,000 population and the death rate was 23 per 1,000.

The growing pressure of population on resources is already evidenced by a 7-percent decrease in per capita food production over the past quarter century—even though total food production increased—in high rates of unemployment and dependency, and in a general inability of public services to keep up with population growth. Nigeria's abundance of natural resources gives rise to a common national feeling that the country can easily absorb the expected increase in population, and recent high prices for petroleum, of which Nigeria is a chief producer, have strengthened this view. In fact, since 1974, the country has no longer been receiving new grants and loans from USAID, though there is still some money in the "pipeline" and Nigeria also receives some services (training and technical assistance, for example) for which it pays the United States. Between 1954 and 1976 the United States made $367 million available to Nigeria; a number of other countries and agencies have also assisted her.

Family planning policy

Although ambitious official plans have been outlined and private family planning activities have been conducted for more than a decade,[1] the Government has made no firm commitment to curb population growth. Nevertheless, Nigerians who are concerned about the severity of the country's population problems are pleased that family planning is finally being recognized by the Government as a necessary aspect of regular mch services.

"How do the women in Nigeria feel about child spacing through contraception?" we asked a community health nurse. She replied:

> You can get an idea by looking at the number of self-induced abortions in each tribe. Sixty-five to eighty five percent of all women who come to our rural clinics as patients come because of abortion-related complications. When we suggest contraception as a way of avoiding this unhappiness in the future, we meet with gratitude.

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[1] Private family planning services have been offered since 1964 through the Family Planning Council of Nigeria (FPCN), a member of IPPF. In addition to services available through clinics, the FPCN conducts widespread information, education, and communication activities stressing the relationship between small families and family well-being. Its efforts are supported by the universities of Lagos and Ibadan, which have demonstration clinics for student nurses and doctors as part of their curriculums. For example, the Lagos University Teaching Hospital operates a family planning training clinic in Lagos. Here, student nurses, physicians, and paramedics from Nigeria and other countries are trained in family planning and the treatment of infertility.

In May 1975, Nigeria established a National Population Council composed of representatives from Government, private organizations, and academic and research institutions. Envisioned in the second national development plan 1970–74 but authorized only near the end of the plan period, the Council has the mission of advising the Government on formulation of national population policy, coordinating implementation of the policy, securing internal and external assistance for family planning services, and channeling assistance to family planning organizations. The Council has identified issues to be examined in depth, including the need to expand family planning programs—education, motivation, and services—throughout the country.

Nigeria's 1970–74 development plan called for integration of family planning activities into mch programs. Little progress was actually made, but 10 States—Lagos, Western, Kwara, Mid-Western, and several of the Northern States—are reported to be making family planning services available. Under the federal system, health is a concurrent responsibility of the States and the Federal Government.

In the third national development plan 1975–80 in effect at the time of our visit, the Government emphasizes the need to develop basic health services. It has been estimated that with proper reorientation, one-fourth of the population can receive basic health services, including child spacing advice and services, from the existing primary care facilities—dispensaries, maternity clinics, child welfare units, mch centers, outpatient departments, et cetera. New facilities are to provide coverage for an additional 40 percent of the population.

Health care

The basic health services plan is designed to make the best use of a hierarchical network of facilities, a health team approach, and community oriented and mobile activities. At the periphery are health clinics—about 1 per 2,000 population—operated by community health assistants. Every four health clinics are supervised by a primary health center, which is also responsible for the primary care of a population of 10,000. This primary center is staffed by a team made up of, at minimum, a nurse/community nurse/midwife, nursing assistants, nursing aides, and community health assistants. At the next level is a comprehensive health center that supervises four primary health centers with their 16 health clinics; it provides primary care for a population of 50,000 and is linked to and supervises its own four health clinics. A comprehensive health center, together with its complement of primary health centers and health clinics, constitutes a basic health unit, serving a total population of 150,000. Each comprehensive health center would have 1 to 2 doctors and about 40 other health workers.

Under the basic health services plan for 1976 and 1977, planning, training of trainers, reorientation of existing personnel, and construction of new facilities are to take place. The years 1978–80 are to see the massive training of new personnel for basic health services and the opening and operation of an estimated 285 comprehensive health centers, with their primary health centers and health clinics.

As in Kenya and Tanzania, we were told that the problem with the plan is its cost.

Family planning programs

On our visit, we were able to see the early beginnings of public family planning programs in Nigeria. Gabby Williams, M.D., director of the Family Planning Council in Nigeria, told us:

> Contraceptives of most kinds are available across the counter at any chemist's. Family planning is now favored by the Government. When I ran the school system in Lagos, I had a sex education curriculum developed and used. It will probably be used more widely. We have made great progress. I am not aware that family planning programs are running into resistance.

The most notable project is at the Institute of Child Health (ICH) at the University of Lagos. The Institute was founded in 1962 to promote the health of Nigerian children through research into causes, prevention, and treatment of common childhood diseases. This research information is used for health planning and policy recommendations.

Three components of the Institute of Child Health are the sociodemographic unit, the family health nurse clinic, and the family health nurse training program.

The sociodemographic unit is staffed by sociologists, a statistician, and field health workers who visit homes in specified areas to gather basic demographic and health care data, answer questions by families about clinic services and refer families in need of these services, give information about unsafe or harmful conditions which may affect the health of the family, and continue to work with families to determine whether the clinic services are meeting the needs of the community.

In the family health nurse clinic, nurses provide primary health care and counseling to families with children under 6 years old. Other members of the health team—field health workers, midwives, nutritionists, sociologists, social workers, and doctors—help provide combined preventive and curative services, including voluntary child spacing services.

The purposes of this project are to integrate and improve the delivery of preventive and curative health services to the community, and to provide training for all categories of health workers. According to ICH, modifications of the traditional well-baby clinic approach made in the clinic program are as follows: Expanded roles for nurses and auxiliaries in preventive and curative care, emphasizing the health team concept in health care delivery; home-based record system; prepacked drugs; all services available daily, including immunization; integration of child spacing services in comprehensive care of mothers and children; serving a target community; and evaluating the effect of service on that community.

Training in family health services

The family health training program prepares health workers to fulfill an enlarged role in meeting the health care needs of Nigerian families. Their education and experience are used in management of health problems of the whole family. They work in close collaboration with the physician consultant and evaluate the mother's understanding of instruction by followup in clinic and home.

The 4½-month training course, given in Lagos, is designed to meet training requirements for a team of nursing staff in a family health nurse clinic and for senior nurses with administrative, supervisory, and teaching responsibilities in such a clinic. Each Nigerian state may send

a team of health workers to the clinic for training. Upon completion of the course, the team returns to set up a family health clinic and training program in its state.

This train-the-trainers phase of the family health project has received funds from USAID.

We visited the Oguntolu Street Family Health Clinic in Shonulu, Lagos, a demonstration service and training site for the ICH family health project. One of its forerunners was the popular and successful Obaja Street Family Health Clinic, which was eventually turned over to the Lagos City Council. Starting in 1973, the Federal Military Government and USAID agreed to assist ICH in extending the family health concept to other parts of Nigeria. Family health teams were trained, and clinics were subsequently opened in Sokoto (1973), Calabar (1974), and Katsina (1976). Oguntolu Street Family Health Clinic was opened in July 1974 as a demonstration clinic and began providing health care to a defined area in July 1975.

The area served by the clinic is divided into five sections. Each section is assigned two family health nurses at the clinic, as well as two or three health workers and one or two health assistants in the field. These workers exchange information and assist each other in providing health care for the families in their assigned area. Thus a team of health workers is responsible for and knows the families of each section, and the families can also get to know them. Ideally, the system provides the families with continuity of health care. Field staff visit families and issue referral slips for registration to each mother who has a child under 6 years. They explain that the clinic will provide health care for her family, and she is encouraged to bring all her small children for registration, not only when they are ill but also on a regular basis so the child's growth and development can be supervised and immunization provided against certain diseases. Clinic requirements and expectations are explained. The field workers also conduct surveys or studies to help the clinic staff learn more about the community and to evaluate the clinic work.

At the clinic, each family is assigned a family health nurse who sees family members each time they come. Typically, the clinic staff consists of a doctor in overall charge of the clinic, three nursing sisters, eight community nurses who provide primary care, and nine clinic assistants. Eighteen health workers from the ICH socio-demographic unit and seven field health assistants are in the field.

In addition to basic qualifications in nursing and midwifery, all nurses in the family health clinic have had 4½ months of intensive training in primary pediatric and maternal health care, childspacing services, clinic organization and management, and community health. This training is conducted by the educational unit in cooperation with the clinic staff. The educational unit includes a nurse tutor, a health sister, and a consultant nurse educator.

Efficient logistics

At the Oguntolu Clinic we were able to observe the efficient organization that is an important factor in the success of these installations. The registration table is the gateway to the clinic. At this table the concept and procedures of the clinic are explained, women are instructed what to do and what to bring, and a health record is started. A record consists of two treatment cards, one for the child and one for

the mother, and the child's family health card which shows the child's weight, immunizations received, nutrition demonstrations attended, and a list of siblings—living or dead. These cards are put in a polyethylene bag and become a home-based record which the mother brings with her when she visits the clinic or any other health facility. The only patient records kept in the clinic are three small index cards on the mother, the child, and his immunizations. A small fee is collected for the registration. Attendance and registration data are recorded at the weighing table and compiled daily by the clinic assistant.

The mother who comes to the clinic with a referral slip issued by a field worker, goes directly to the registration table. If she has no referral, the field health staff check the master file of eligible families in the target area. If she is included, she is issued a referral slip. If her name is not found, she is told that a field health worker or assistant will visit her at home to issue a referral slip, after which she can be fully registered. If the child is well, he can receive immunizations on the same day without waiting for full registration.

On the family's first visit, child and mother are tested by a trained clinic assistant for their hemoglobin level to screen for anemia. On subsequent visits, the mother posts the home-based record at the weighing table. The "posting box" is designed so the cards fall in order of arrival. If the mother is ill or wants to discuss a problem with the family health nurse, she posts her card separately from the child's.

Children are routinely weighed once a month. The clinic assistant asks the mother to undress the child, weighs him, and records the weight on his treatment card; the nurse charts the weight during the interview.

The family health nurses collect the cards and call the patients from their areas. The nurse checks the mother's bag to see if she has all the things she was told to bring when taking the child to the clinic. These are: Two polyethylene bags—one for clean diapers, one for dirty diapers; cup and spoon for toddler—sharing of feeding utensils is discouraged; covered plastic bowl for babies' feeding utensils—use of bottle is discouraged, and cup and spoon are encouraged even for young infants; standard medicine bottles with plastic cover and stopper—to be exchanged if the mother is to take medicine home.

Personalized services

If the mother does not have the items with her, she may buy them at the clinic. She then follows her nurse into the interviewing cubicle. This stop is one of the most important stations in the clinic.

Each interviewing cubicle contains a nurse's table and chair, a long bench for waiting mothers, a small stool which each patient uses, in turn, and a wall cupboard. Thermometers, otoscopes, stethoscopes, spatulas, and disinfectant solution are on each table for use in the examination procedure. Commonly used drugs are kept in the medicine box and cupboard so the nurse can hand them to the mother as she prescribes them and explains how they are to be used, thus cutting down on waiting time in the clinic. During the first visit, the child is given a thorough examination, and the mother's blood pressure, urine, and general health are checked. It is here that the mother's understanding of her child's problem and treatment is checked and

reinforced. The nurse at this table explains anything about which the mother seems uncertain. Immunizations are recorded in the patient's home-based record and the immunization file card is then stamped with the date of acceptance. The nurse then directs the mother to where she is supposed to go next (for example, BCG tuberculosis immunization table, injection room). If the child or mother is receiving polio vaccine, she pays a fee and is given a receipt.

The nurse at the exit table has several clerical tasks, including recording injections and immunizations for all patients from the family health clinic, the maternity section, and the dispensary. This nurse also reviews all treatment cards to make certain that the standing orders are followed through by staff and a high standard of care is provided.

Health services provided by the clinic include health education—for groups at the clinic, and on a one-to-one basis in homes, and for fathers as well as mothers—in addition to childspacing services and general mch services. A family planning talk is given once a week at the clinic as part of the education program. Mothers are advised of the adverse effect of frequent pregnancies and short birth intervals on family health. The advantages of allowing 3 years between births are stressed, and the mothers are invited to bring their husbands to the clinic for discussion and counseling. During any visit, a mother interested in family planning can receive counseling and select an appropriate contraceptive method. The family health nurse has been trained to provide direct clinical services such as prescribing oral contraceptives and inserting IUD's.

At the moment, though oral contraceptives are sold over the counter without evidence of marriage and without husbands' permission, only doctors and nurses can insert IUD's.

In Nigeria's midwestern state, where the birth rate exceeds 50 per 1,000, repeated childbearing is a major barrier to improving maternal and child health. Here, both actual and ideal family size are reported to average more than seven children, and the infant mortality rate is 112 per 1000 live births. In Ishan division of the midwestern state, which initiated its first organized family planning program in 1969, a multiround survey conducted at 1-year intervals between 1969 and 1972 indicated that, as a result of the program, knowledge of at least one contraceptive method increased from 13 percent to 55 percent, and the proportion of respondents practicing contraception rose from less than 1 percent to 24 percent.

EXTERNAL ASSISTANCE

The International Planned Parenthood Federation (IPPF) has provided $3.5 million since 1969, mainly in support of the activities of the Family Planning Council of Nigeria (FPCN).

USAID budgeted a total of $1.62 million for family planning in Nigeria during 1973–75, primarily for an experimental project to integrate family planning into mch programs and for improvements in preventive and curative medicine for children under 5 years of age. This project, scheduled to end in 1976, was carried out by the Institute of Child Health with assistance from Johns Hopkins University under a USAID contract.

Other USAID assistance in the past decade has included an $84,000 grant to the University of Lagos for an expanded demographic training and research program, $10,000 for training five nurses in family planning, $84,000 under a regional grant to help the Federal Ministry of Health improve its data gathering system, and $114,000 to the University of Michigan to help the University of Ibadan conduct a study of rural-urban migration in Nigeria.

The United Nations Fund for Population Activities (UNFPA) in 1975 approved the outlay of $1.3 million to assist the Government's rural mch/fp program. The estimated equivalent value of the Government's contribution is $3.3 million for a 5½ year period beginning in July 1975. Earlier, UNFPA had provided assistance for the 1973 population census, a law and population study, and other population/family planning projects.

The World Health Organization (WHO) has supplied funds for training and research.

The Population Council has given a total of $1.3 million in assistance, chiefly to improve and maintain demographic and research facilities at the Universities of Ife and Lagos and the Ahmadu Bello University. It also has assisted the rural family planning project at Zuma Memorial Hospital in Urrua, postpartum family planning programs, and a demonstration clinic at Ahmadu Bello University.

The Ford Foundation, which provided a total of $1.1 million in population assistance since 1966, maintains a resident West African adviser in its Lagos office, operates an informal population information service, and has made a number of grants for family planning training and demographic projects.

Family Planning International Assistance (FPIA), with $116,000 in assistance since 1972, has provided support for regional conferences of the Christian Council of Nigeria, the Africa Medical Student's Association, contraceptive supply, and other activities.

The Pathfinder Fund's $194,100 in cumulative assistance has gone toward a female sterilization clinic, a family planning information center and clinic at Enugu, a medical students' conference, and a study of maternal and child health services offered by rural health workers in east-central state. It also has provided contraceptives for family planning acivities in the northeastern state of Nigeria and at Zuma Memorial Hospital.

Other voluntary assistance has come from the Mennonite Central Committee, the Smithsonian Institution, the World Assembly of Youth, World Neighbors, and the Rockefeller Foundation.

In addition, Finland—through the United Nations Children's Fund—has provided $144,000 during 1972–76 for a pediatric training unit at Ahmadu Bello University Medical School.

Apparently, the most successful population research programs in Africa have been those planned in the context of socioeconomic development. Two programs, supported by the Population Council, are located in Nigeria—in the Human Resources Unit, University of Lagos, and the Institute of Manpower, University of Ife. Building on the success of these research programs, the Ford Foundation is planning to organize a forum, coordinated by the University of Ibadan, for interdisciplinary dialog among West African consultants. Development planning in all sectors will be reviewed with an eye toward values ex-

pressed and whether and how population factors have been taken into account. Particular attention will be paid to assessing and strengthening research capabilities. A workshop will then be held at which participants representing different types of researchers and decisionmakers consider the consultant's findings and make recommendations for next steps.

SUMMARY

Since the end of the civil war in 1970, the economic development of Nigeria has progressed rapidly, first in the agricultural sector, and later in the urban areas. The Second National Development Plan (1970–1974) stressed achievement of a "qualitative population policy" through the availability and practice of voluntary family planning. The Government hopes that increased access to contraceptive information and services, integrated into the national health and social welfare programs, will promote widespread childspacing and thereby help raise the quality of life. One critical question is whether the pilot project we saw at the Oguntolu Street Family Health Clinic can be replicated elsewhere.

Their mch/fp system works because of good organization—that is, clinic layout and patient flow. It is heavily loaded with sophisticated medical personnel—M.D.'s, senior nurses, nursing sisters, and nurses—whereas the other countries we visited were relying on health auxiliaries. Will enough nurses and doctors be available to reach remote rural corners of the country? Will the model work well enough without them?

In our opinion, the interdisciplinary research projects in Nigeria are an example of what is meant by USAID, World Bank, and other specialists when they say, "African population problems can only be solved by African leaders with African solutions." It is the type of project the United States should support generously. To tell African leaders what to do would be presumptuous and preposterous. To enable them to learn and decide what to do is useful.

NIGERIA—PEOPLE INTERVIEWED

Olukunle Adegbola, University of Lagos graduate student, doing research on the influence of the extended family on family planning.
Godfrey K. J. Amachree, a leading Lagos lawyer and businessman.
Kris Atchley, Economic Counselor, U.S. Embassy, Lagos, Nigeria.
Gloria Bozeman, Economic Officer, U.S. Embassy.
Robert L. Bruce, Counselor, Political Affairs.
Harry A. Cahill, Economic and Commercial Counselor, U.S. Embassy.
Oliver S. Crosby, Deputy Chief of Mission, U.S. Embassy.
Babs Dada, chief statistician, Lagos State Ministry of Health.
John Darnton, New York Times correspondent.
Ambassador Donald B. Easum, U.S. Embassy.
Melvin Fox, Ford Foundation.
Kurt Jansson, resident representative, United Nations development program.
Ed Knoll, U.S. Information Service.

R. J. Lesthaege, Ph. D. demographic researcher, University of Lagos
Ted Morse, Population Specialist, USAID, Lagos, Nigeria.
H. J. Page, Ph. D., demographic researcher, University of Lagos.
Olikoye Ransome-Kuti, director, Oguntola Street Family Planning and Maternal Welfare Clinic, Shomolu, Lagos.

NIGERIA—SCHEDULE OF APPOINTMENTS

Monday, October 11

6:00 p.m.—Arrived at airport. Briefed by Kris Atchley, Economic Counselor, while driving to Ambassador's residence.

9:00—Briefed by Ambassador Easum at residence.

Tuesday, October 12

9:00 a.m.—Briefing at Embassy.

10:00 to 11:00—Congressmen only.

12:00 noon to 1:00 p.m.—John Darnton, New York Times correspondent.

1:00 to 2:30—Luncheon meeting with appropriate officials.

3:00—"Gabby" Williams, M.D., director, Family Planning Council of Nigeria.

6:00 to 11:00—Dinner at Ambassador's residence with many relevant officials as guests.

Wednesday, October 13

6:00 to 10:00 a.m.—Field trip, Oguntola Street Family Planning and Maternal Welfare Clinic.

11:00—University of Lagos, Medical School Teaching Hospital, Ransome-Kuti, M.D.— chief planner of FP in Nigeria and director of model clinic.

12:30 p.m.—University of Lagos, Dr.'s Lesthaege and Page—demographic researchers—and a graduate student specializing in the effects of the extended family on childspacing.

3:00—Melvin Fox, Ford Foundation.

Ghana

Key demographic data

Mid-1976 population	million	10.6
Annual growth rate	percent	3.0
1975 urban population	do	33.0
Agricultural labor force	do	55.0
Per capita GNP	U.S. dollars	430
Life expectancy	years	48
People per doctor		11,200
Literacy rate	percent	25
Primary and secondary students, ages 5 to 19	do	45

The Republic of Ghana, which in 1969 became the first nation in Africa to issue an explicit population policy, is located on the Gulf of Guinea in West Africa. The country has a land area of over 92,000 square miles, about the size of Indiana and Illinois combined. Its population of 10.6 million is concentrated to a great degree in the coastal area. The major ethnic groups are Akan—44.1 percent of the population; Mole-Dagbani—15.9 percent; Ewe—15 percent; and Ga-Adangbe—8.3 percent. English is the official language, but five African languages are in official use in local areas, and about 75 Sudanic languages are spoken. The population is 43 percent Christian, 12 percent Muslim, and 38 percent animist.

Ghana's rate of natural increase is about 3.0 percent. The birth rate is approximately 45 births per 1000 population; the death rate is approximately 25 per 1000. Because almost 47 percent of Ghana's population is under 15 years of age, a potential exists for continuing population growth which could lead to serious economic, social, and political problems. The present population of 10.6 million is projected to grow to 21.1 million by the year 2000.

Ghana is the world's leading producer of cocoa; its other major products are timber, coconuts, and coffee. The country also has fisheries, and is one of the world's leading producers of industrial diamonds, manganese gold, and bauxite. It has more industry than most African nations.

In spite of the Government's emphasis on austerity and national self-reliance, as well as continuing assistance from western nations, Ghana suffers from severe economic problems. Reports from a number of international agencies confirm famine conditions and food shortages during the last 2 years. Ghanaian and western press have both reported rising deaths from malnutrition-related diseases. However, the military government has refused to publicly acknowledge the existence of a famine although obvious drought conditions exist in the grain-producing northern and upper regions. Failure to acknowledge and request aid despite repeated attempts of various relief organizations has led to an emergency situation. In 1975, the United States did provide drought relief funds through the Foreign Disaster Assistance Act.

The government of the first Prime Minister, Kwame Nkrumah, emphasized increased stability and productivity through a socialist approach. In 1964, Nkrumah made Ghana a single-party state; in 1966, the Ghanaian Army and police, in a coup supported by the people, overthrew his government, dismissed the ministers, and dissolved Nkrumah's Convention People's Party and the National Assembly. The reasons given for the coup were Nkrumah's suppression of individual liberties, his corrupt government, and extravagances which had led the government to near bankruptcy. Nkrumah died in exile in 1972. As promised, the government was returned to civilian authority in 1969, after elections won by Kofi Busia—a former professor of sociology at the University of Ghana—and his Progress Party. However, the new government was unable to stop inflation, and in 1972 a bloodless military coup led to abolition of the Constitution.

Gen. Ignatius K. Acheampong, leader of the coup, is currently head of the state in Ghana. Educated in Catholic schools and at Mons Officers Cadet School in the United Kingdom, he was a school teacher and headmaster before joining the army in 1959. Prior to the coup, he was administrator of Ghana's western region. Gen. Acheampong formed the National Redemption Council, which in 1975 was displaced as the country's highest legislative and administrative authority by a new body, the Supreme Military Council (SMC). Both councils are headed by Acheampong. SMC members are primarily military or police, with a few civilians. All political parties are banned in Ghana, and criticism of the Government by the press is rare. The SMC is ruling the country by decree until a new constitution goes into effect.

The people of Africa's Gold Coast have long been noted for intelligence and enterprise, and Ghana has many educators, lawyers, doctors, and economists, along with a well-trained civil service. Ghana and the central African states get along comfortably.

In 1975, U.S. exports to Ghana totaled $100 million and imports totaled $150 million. The value of imports and exports has been growing steadily since then. There are no major outstanding bilateral issues on which Ghana and the United States are in conflict, although Ghana would like us to sign the International Cocoa Agreement. Since Ghana became independent in 1957, we have had an assistance program principally covering food assistance, rural development, and health.

Family planning programs conducted within the health network preceded the nation's explicit population policy.

Ghana's population policy is concerned not only with controlling high fertility, but also with migration, population distribution, and high mortality. It includes provision of family planning services through the Ghana national family planning program (GNFPP), with the aim of changing the traditional reproductive behavior of Ghanaians. The policy also promotes measures to increase educational and employment opportunities for women and to modify Government benefits such as paid maternity leave so as to prevent their having a pronatalist effect. On paper, at least, the program goes well beyond family planning in its attempts to lower the rate of population growth.

An American had told us that the village chiefs, traditional healers, and local midwives would not permit contraception among the women in their jurisdictions. Perhaps this was where the real resistance would be found. Such assumptions were not borne out by our visit to

Adidome, a village made up mostly of mud huts with thatched roofs, a sprinkling of plastered mud huts with thatched roofs (higher status), and a few plastered mud huts with tin roofs—the fanciest. There we saw a small training session in which a village worker was explaining and demonstrating various contraceptive devices to students who would go on to provide family planning services.

These students were none other than the village chiefs, traditional healers, and local midwives. They appeared enthusiastic, with lots of spontaneous laughter, joshing, and gesturing throughout the session.

A similar attitude was evident in the village courtyard of Kwabenya, where we joined a class of women who were receiving contraceptive instruction with much merriment, boisterous chanting, and ribaldry. This openly earthy and sociable approach contrasted sharply with the Nigerian approach of the unmarked door, yet both approaches to family planning appear effective.

The most interesting health and family planning project we visited in Ghana was the Danfa project, a joint undertaking of the University of Ghana Medical School, the University of California at Los Angeles, and USAID. This research and demonstration program at the Danfa Rural Health Center and satellite clinics is gathering information for use in a nationwide program of rural family health care. In Ghana, only 35 percent of the people receive curative health services; fewer receive preventive care.

The aim of the Danfa project is to improve the health of the rural population and to train host-country doctors, medical students, and other health personnel.

Techniques for providing varying levels of health care and family planning are being tested in four rural areas, and the data obtained are being used to determine which kinds of services would provide optimal cost-effective health and family planning care to the rural population.

The project's administrators attempt to improve methods of child delivery, contraception, and basic maternal/child health care, without interfering with the practices of traditional chiefs, healers, and midwives.

EXTERNAL ASSISTANCE

Ghana's concern with its population problems has attracted external assistance, provided through missions, university projects, private voluntary organizations, and projects supported by international, government and private donors. These sources have a long history of rendering technical assistance and other aid to Ghana in areas other than population.

In addition to the Danfa project, USAID is participating—frequently in cooperation with other organizations—in the following population-related activities in Ghana:

Population program support.—This project is designed to strengthen the national family planning program's capacity to provide family planning services. Continued support is planned in four major areas: planning and management, research and evaluation, contraceptive supply and distribution, and in-service training.

Two prototype demonstration areas are being planned to test the Danfa methodology, using mobile systems and community volunteers. An expanded commercial distribution program is also envisioned.

Management and delivery of rural health services.—The goal of this program, being implemented by the Kaiser Foundation International, is to expand and improve the planning and management of rural health services. USAID is involved in two projects. The first focuses on establishing a planning unit in the Ministry of Health, providing practical training in planning and management, and assisting with formulation of a 5-year plan for health services. The second project proposes to implement effective, low-cost delivery of comprehensive health care and family planning assistance to the poorer rural population. The total grant contribution to these projects is expected to be $6.6 million; $15 million in loans is being considered for health facilities, supplies, and equipment.

World Education, Inc. (WEI).—USAID has made a grant to WEI for a project, in conjunction with a social welfare department, to introduce family planning concepts into adult literacy programs.

University teaching of population dynamics.—The University of Ghana is developing a cadre of Government officials and researchers in anglophone Africa to promote an interdisciplinary approach to population as it relates to national development. USAID funds have been made available for population dynamics teaching, research grants, seminars, fellowships, and curriculum development. At the start of the program, an American resident adviser provided services for 1 year.

African Health Training Institutions Projects (AHTIP).—Through the University of North Carolina, this project promotes integration of family health training into the curriculums of African health training institutions. Support, guidance, and advice are provided by a regional advisor located in Yaounde. In Ghana, the University Medical School and the Nursing School, as well as various Ministry of Health schools for paramedical personnel, are involved. Several seminars on the preparation of programmed learning units have been held in Ghana.

International Conference of Midwives (ICM).—ICM promotes the integration of family planning and related subjects into the curriculums of training schools for midwives. Workshops have been held in Ghana under the guidance of ICM, and annual meetings elsewhere have been attended by Ghanaians. Project activities are being increasingly coordinated with those of AHTIP.

Planned Parenthood Association of Ghana (PPAG).—PPAG, the local affiliate of the International Planned Parenthood Federation (IPFF), operates 38 family planning clinics throughout Ghana and conducts training and information/education programs. It works closely with the secretariat of the Ghana national family planning program and helps provide family planning services in some Ministry of Health clinics.

Christian Council of Ghana (CCG).—CCG receives financial and advisory assistance from Family Planning International Assistance (FPIA), a branch of the Planned Parenthood Federation of America. CCG operates 11 family planning clinics and offers excellent counseling services. Since the FPIA regional adviser for Africa is stationed in Accra, his services are readily available to CCG.

Population Council.—Through a USAID grant, the Council is funding a project at the University of Cape Coast for a demographic sample survey of five or six rural communities in the western region.

Information derived from this survey will be used in national vital events registration and in the collection and analysis of fertility data.

SUMMARY

Although Ghana was the first African nation to establish a population policy, we question whether its activities thus far are leading to nationwide availability of mch and family planning services. The Danfa project was the most sophisticated, multifaceted program we saw in Ghana, or, indeed, in the other five countries we visited. Can it be reproduced on a scale large enough to make a difference? At any rate, the amount of resources devoted to almost every aspect of the health and family planning projects will have to be raised many times over.

GHANA—PEOPLE INTERVIEWED

Prof. Nelson Addo, Director, Population Dynamics Project, University of Legon, Accra.
Stewart Blumenfeld, M.D., UCLA Team, Danfa project.
Prof. E. A. Boateng, Chairman, Environmental Protection Council.
Ambassador E. M. Debrah, Secretary, Supreme Military Council, Accra.
Albert L. Glad, Commercial Attaché, U.S. Embassy, Ghana.
Susan Kessler, M.D., Organization for Rehabilitation and Training.
Nimo Kwasi, M.D., Director, HPM, Research and Planning Unit, Ministry of Health Accra.
John Linehan, Chargé d' Affair, U.S. Embassy.
Richard Morrow, M.D., Chief of Group, Research and Planning Unit, Ministry of Health, Accra.
Ofusu-Amaah, M.D., Head of Community Health and Director, Danfa Project.
Dr. Chukuka Okojo, Director, U.N. Regional Institute, Population Studies, University of Legon, Accra.
Marc Okunnu, Program Officer, Family Planning International.
Julius Prince, M.D., Project Officer, Health, Population and Nutrition, USAID.
Leonard H. Robinson, Jr., Africa Regional Representative, Family Planning International Assistance.
Prof. A. N. Tackie, Executive Chairman, Council for Scientific and Industrial Research, Accra.

We also interviewed Chiefs, Village Elders, midmives, community health nurses, traditional healers, and women on the field trip.

GHANA—SCHEDULE OF APPOINTMENTS

Thursday, October 14

6:00 a.m.—To airport to leave Lagos for Accra.
10:00—Arrived, Accra, Ghana. Briefed by Albert Glad, Embassy Commercial Attaché, and Chargé d'Affairs, U.S. Embassy, John Linehan.
11:00—Briefing at Embassy by staff.
12:00—Luncheon at residence of Chargé; guests included Dr. and Mrs. Prince.

2:00 p.m.—Appointment with Dr. A. N. Tackie, Executive Chairman, Council for Scientific and Industrial Research.

3:30—Meeting with Leonard Robinson and Marc Okunnu, Family Planning International Assistance.

4:30—Research and Planning Unit, Ministry of Health; Richard Morrow, M.D., Chief; Kwasi Nimo, M.D., Director, HPM; and other staff. Also Dr. Prince.

5:30—Appointment, Prof. E. A. Boateng, Chairman, National Environmental Protection Council (Congressman only).

8:00—Dinner at residence of Mr. Armantrout. List of those present:

Mr. William Armantrout, Resident Director, Volta Aluminum Co. Ltd. (VALCO) and Mrs. Armantrout.

Mr. Keith Kerr, Managing Director, Union Carbide Ghana Ltd. and Mrs. Kerr.

Ms. Helen Cohen.

Ambassador E. M. Debrah, Secretary, Supreme Military Council and Mrs. Debrah.

Mr. John A. Linehan, American Chargé d'Affaires and Mrs. Linehan.

Mr. David Egyir, personnel manager, VALCO, and Mrs. Egyir.

Mr. Ralph Graner, Counselor, U.S. Embassy, and Mrs. Graner.

Mr. Larry Lowenstein, purchasing manager, VALCO, and Mrs. Lowenstein.

Mr. William McNulty, manager, Texaco Africa Ltd., and Mrs. McNulty.

Mr. Hal Pearson, plant manager, VALCO and Mrs. Pearson.

Mr. J. V. L. Phillips, resident manager, VALCO, and Mrs. Phillips.

Friday, October 15

7:30 a.m—Visit DANFA project.

1:00 p.m.—Luncheon at residence of Dr. Prince. Dr. Armar, a guest.

2:00—A visit to the Legion (University of Ghana) offices of the Danfa project for a demonstration of activities related to carrying on the field research of the project and attendant electronic data processing.

3:00—Dr. Chukuka Okojo, Director, U.N. Regional Institute for Population Studies, University of Legon, Accra.

4:00—Prof. Nelson Addo, Director, Population Dynamics project, University of Legon, Accra.

6:00 to 8:00—Meeting with the U.S. INTERPOL delegation at the U.S. Ambassador's residence, including:

GUEST LIST

INTERPOL RECEPTION—OCTOBER 15, 1976

AMBASSADOR'S RESIDENCE—6:00 TO 8:00 P.M.

Government of Ghana

Mr. and Mrs. Ernest Ako, Inspector General of Police.
Mr. and Mrs. E. N. Debrah, Secretary of the SMC.
Mr. and Mrs. Smyly Chinery, Deputy Secretary to the SMC (special duties).

Lt. Col. and Mrs. Joseph Akompi, Deputy Secretary to the SMC, (military).
Mr. and Mrs. F. W. Beecham, Deputy Secretary to the SMC, (administration).
Mr. and Mrs. T. K. Leighton, Principal Secretary to the SMC (special duties).
Mr. and Mrs. Edward Buckman, Commissioner for NRC Affairs.
Mr. and Mrs. Joseph Boye, Director of Special Branch.
Mr. and Mrs. Kofi Quanson, Deputy Director of Special Branch.
Mr. and Mrs. George Tieku, Special Branch.
Mr. and Mrs. Kofl Jackson, The Castle Osu.
Lt. Col. and Mrs. Isaac Akuoko, Director of Military Intelligence.
Lt. Col. and Mrs. Prince Twumasi-Ankra, Deputy Director of Military Intelligence.
Mr. and Mrs. Ansah, Deputy Commissioner of Police, Accra Region, GP.
CID Commisioner and Mrs. T. O. Lindsay, CID.
Deputy CID Commissioner Tenkorang and Mrs. Tenkorang.
Mr. and Mrs. E. I. Otoo, Senior Principal Secretary, Ministry of Foreign Affairs.
Mr. and Mrs. H. Sekyl, Senior Principal Secretary, Ministry of Foreign Affairs.
Mr. and Mrs. S. Tetteh, Acting Chief of Protocol, Ministry of Foreign Affairs.
Mr. Joseph Edusel, Deputy Director, Europe and American Division, Ministry of Foreign Affairs.
Mr. and Mrs. A. N. E. Amissah, Court of Appeals.
Mr. and Mrs. J. R. O. Arthur, Deputy Director, CID.
Lt. Col. S. C. K. Kwawu, Provost Marshal, Ghana Armed Forces, Burma Camp.
Lt. Col. and Mrs. J. Owusu, Acting Military Secretary, Ministry of Defense, Burma Camp.
Mr. and Mrs. Paul Boakye-Dattey, Deputy Commissioner, CID.
Mr. J. Y. A. Kwofie, Secretary, I.G.P., and Mrs. Kwofie.
Mr. and Mrs. Abadie, Manager, Ambassador Hotel.
Mr. and Mrs. Kwabena Boateng, Manager, Hotel Continental.

Press

Colonel J. Y. Assaie, Managing Director, Ghana Broadcasting Corp., and Mrs. Assaie.
Mr. Ken Amoah, Ghana Broadcasting Corp.
Mr. K. B. Brown, General Manager, Ghana News Agency and Mrs. Brown.
Mr. Kofi, Managing Director, Graphic Corp., and Mrs. Badu.
Mr. Kwame Gyawu-Kyem, Editor, Ghanysian Times and Mrs. Gwayu-Kyem.
Mr. I. K. Nkrumah, Editor, Daily Graphic and Mrs. Nkrumah.
Alhaji (Major) B. Salifu, Managing Director, New Times Corp.
Mr. A. Kutin-Mensah, Editor in Chief, Spectator and Mrs. Kutin-Mensah.
Mr. Chris Asher, Editor, The Palaver and Mrs. Asher.
Mr. Bediako Asare, Deputy Editor, Ghanysian Times and Mrs. Asare.

Mr. Samuel Kissi-Afari, Echo Publications and Mrs. Kissi-Afari.
Mr. Nicholas Alando, Editorial Chief, the Mirror and Mrs. Alando.

Diplomatic missions and INTERPOL delegations

Ambassador and Mrs. Z. Pecar, Yugoslavia.
Leader and Members of the INTERPOL Delegation, Yugoslavia.
Ambassador and Mrs. A. E. Habibou, Niger.
Leader and Members of the INTERPOL Delegation, Niger.
Mr. and Mrs. N. Neustrup, Charge, Denmark.
Leader and Members of the INTERPOL Delegation, Denmark.
Mr. and Mrs. G. Ballou, Charge, Ivory Coast.
Leader and Members of the INTERPOL Delegation, Ivory Coast.
Ambassador Yang Ke-Ming, China.
Leader and Members of the INTERPOL Delegation, China.
H. E. and Mrs. D. W. Evans, Australia.
Leader and Members of the INTERPOL Delegation, Australia.
Ambassador and Mrs. P. T. Rouamba, Upper Volta.
Leader and Members of the INTERPOL Delegation, Upper Volta.
Ambassador and Mrs. S. A. H. Ashani, Pakistan.
Leader and Members of the INTERPOL Delegation, Pakistan.
Ambassador and Citoyenne Nzekele, Zaire.
Leader and Members of the INTERPOL Delegation, Zaire.
Ambassador and Mrs. J. M. Garcia-Agullo, Spain.
Leader and Members of the INTERPOL Delegation, Spain.
H. E. C. B. Muthamma, India.
Leader and Members of the INTERPOL Delegation, India.
H. E. R. M. Middleton, Canada.
Leader and Members of the INTERPOL Delegation, Canada.
Ambassador and Mrs. G. Motz, Federal Republic of Germany.
Leader and Members of the INTERPOL Delegation, Federal Republic of Germany.
H. E. and Mrs. F. Mills, Britain.
Leader and Members of the INTERPOL Delegation, Britain.
Lt. Col. and Mrs. Charles Crossland, Defense Advisor British High Commission.
Ambassador and Mrs. Murakami, Japan.
Leader and Members of the INTERPOL Delegation, Japan.
Mr. and Mrs. R. Mayor, Charge, Switzerland.
Leader and Members of the INTERPOL Delegation, Switzerland.
Dr. and Mrs. S. Hakeni, Israeli Affairs, Swiss Embassy.
Leader and Members of the INTERPOL Delegation, Israel.
Mrs. I. Nicole, Acting Trade Delegate, Austria.
Leader and Members of the INTERPOL Delegation, Austria.
H. E. J. C. Ferringa, Netherlands.
Leader and Members of the INTERPOL Delegation, Netherlands Antilles.
H. E. Jean Deciry and Mrs. Deciry, France.
Leader and Members of the INTERPOL Delegation, France.

NOTE.—While all delegations attending the INTERPOL conference were invited to the reception, this listing consists of only those delegations the Embassy knew would be attending the conference as of October 13.

Codel Scheuer

Congressman James D. Scheuer.
Miss Helen Cohen.
Mrs. Polly Greenberg.

American business community

Mr. and Mrs. William Armantrous, VALCO.
Mr. and Mrs. Keith Kerr, Union Carbide.
Mr. Walter Cotten, Union Carbide.
Mr. and Mrs. William McNulty, Texaco.
Mr. Robert Vance, Mobil Oil.

U.S. Mission

Chargé and Mrs. John A. Linehan.
Mr. and Mrs. Ralph H. Graner.
Mr. Henry H. Janin.
Lt. Col. and Mrs. Robert Wolff.
Mr. and Mrs. James Haase.
Mr. and Mrs. Robert Hammond.
Mr. Kenneth Brill.
Mr. and Mrs. Albert L. Glad.
Mr. and Mrs. Jarrel Richardson.
Miss Lois Butkus.
Miss Ida Beer.
Mr. and Mrs. Earl T. Eason.
Mr. and Mrs. Clyde Brown.
Mr. and Mrs. Ron Charles.
Mr. and Mrs. Lonnie Washington.
Mr. Larry Fein.
Miss Mary Butler.
Miss Miriam Washington.
Miss Esther Klein.
Mrs. William Callihan.
Mr. and Mrs. Kenneth Bache.
Mr. and Mrs. John Hols.
Mr. and Mrs. Irvin Coker.
Mr. and Mrs. Donald Huth.
Mr. and Mrs. Charles Williams.
Mr. and Mrs. William Rosner.
Mr. and Mrs. Craig Lineburger.
Dr. and Mrs. Lawrence Rockwood.
Mr. and Mrs. William Jackson.
Mr. and Mrs. Samuel Ostertag.
Dr. and Mrs. J. Prince and Miss Prince.
Mrs. Oleen Hess.
Mr. and Mrs. Leonard Robinson.
Miss Kathleen Whittaker.
Miss Elizabeth Martinec.
Mr. and Mrs. Lynn Marshall.
Mr. and Mrs. Roy Anderson.
Mr. and Mrs. Spriggs.

Also:

H. Stuart Knight, Director, Secret Service, Washington.
O. Neil Benson, Chief Postal Inspector, U.S. Postal Service, Washington.
Joseph Blankh, Deputy Director, Civil Aviation Security Service, Federal Aviation Administration, Washington, D.C.
George Corcoran, Assistant Commissioner, U.S. Customs, Washington.
John T. Cusack, Chief, International Operations Division, Drug Enforcement Administration, Washington, D.C.
Eugene Dagg, U.S. Secret Service, Embassy, Paris, France.
John H. Dennis, Director General, Investigation Division, U.S. Customs Service, Washington, D.C.
Henry Falcher, District Director, Immigration and Naturalization Service, Rome, Italy.
Thomas J. Kelley, Assistant Director U.S. Secret Service, Washington. D.C.
Vdja V. Kolombatovic, Chief Liaison Section, FBI, Washington, D.C.
Joseph Le Denmat, U.S. Secret Service, Paris, France.

William McCarter, Internal Revenue Service, American Embassy, Rome, Italy.
Louis B. Sins, U.S. Interpol Chief, Department of Treasury, Washington, D.C.
Robert F. Smith, Deputy Assistant Director, Office of Investigation, Department of Agriculture, Washington, D.C.
Andrew C. Tartaglino, Director, Department of Justice, Washington, D.C.
Glen D. King, Executive Director, International Association of Chiefs of Police.

Senegal

Key demographic data

Mid-1976 population	million	5.1
Annual growth rate	percent	2.8
1975 urban population	do	28.0
Agricultural labor force	do	76.0
Per capita GNP	U.S. dollars	330
Life expectancy	years	44
People per doctor		16,400
Literacy rate	percent	5–10
Primary and secondary students, ages 5 to 19	do	21

We happened to visit the Republic of Senegal at an exciting time in terms of our own interest in national family planning programs. The Ministry of Health had been avoiding expressing a position on family planning, and the Government still sees the population growth rate as acceptable. However, just prior to our visit, the Senegalese Government, working with USAID and other groups, had completed a 3-year comprehensive plan for developing family planning services and training health personnel in delivery of these services.[1]

Senegal is located on the coastal bulge of west Africa, and, with 76,000 square miles, is about the size of South Dakota. At first glance it appears to be heavily French influenced. However, only 21 percent of the men and 2 percent of the women understand French, the official language. Most Senegalese use their own tribal languages. Eighty-six percent of the Senegalese are Moslem; 6 percent are Christians; the remainder are animists.

Despite the sandy, saline, or swampy condition of much of the land, Senegal is primarily an agricultural country, with 76 percent of the population engaged in farming. Peanuts, accounting for 80 percent of total export earnings, are the principal crop; cotton has proven the most successful of the new cash crops being developed to diversify agriculture. Although the industrial sector is still small, Senegal is the most industrialized state of former French West Africa, and urbanization is increasing. Commercial fishing received a substantial boost from a Canadian assistance program and is expanding rapidly. The Senegalese Government encourages the private sector.

National history

What is now Senegal came under the influence of the great Mandingo Empires to the east in the 13th and 14th centuries. French commercial establishments date from the 17th century. During the 19th century, the French gradually took over the interior regions, which they administered first as a protectorate, later as a colony. At present, about 50,000 Europeans, Syrians, and Lebanese live in Senegal, chiefly in the cities.

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[1] As of November 1977, implementation of the plan described in this section has been delayed because of ministerial changes.

About one-sixth of the Senegalese live in the capital city, Dakar, which fronts on the Atlantic Ocean and is the gateway to black Africa for visitors flying in from Europe or the Americas. This city is actually an oasis at the door to the Sahel, the semidesert transitional region that stretches across Senegal, the Gambia, Mauritania, Mali, Niger, Upper Volta, and Chad. The people of the Sahel are undergoing great crisis as a result of land exhaustion.

In 1959, Senegal and the French Sudan merged to become the Federation of Mali; together, they became fully independent from France in 1960. Within a few months, Senegal seceded from the Federation and proclaimed itself an independent republic. Leopold Sedar Senghor, who was elected President in 1960, has been returned to office for consecutive 5-year terms ever since. An attempted coup d'etat in 1962 by the president of the Council of Ministers was put down without bloodshed; Senghor took over his office. In 1974, Senegal adopted a new Constitution.

Political leadership

Viewed as the father of his country, Senghor, born in 1906, is an acknowledged leader of French-speaking Africa and is regarded as a rare combination of politician, intellectual, and statesman. A Catholic, he received his primary education at a mission school. At the University of Paris, which he attended under a French scholarship, Senghor became acquainted with many eminent writers, thinkers, and politicians from France and francophone Africa, and was influenced by black American and West Indian intellectuals. The first African to become qualified to teach in a lycée, he taught in French schools, served in the French army in World War II, and was elected Deputy for Senegal to the French Constituent Assembly. He has published several volumes of poetry.

Between 1956 and 1960, Senghor organized the Union Progressiste Senegalaise (UPS), the political party that led Senegal to independence and that has dominated its political life for almost 20 years. The UPS is a moderate party which advocates a form of socialism based on traditional African communal institutions. Some political opposition is tolerated.

It is generally agreed that Senegal has a wise and successful economic structure and plan. President Senghor has done much to foster regional west African cooperation and African unity in the broader context of international relations. He has a policy of maintaining relations with both East and West. Relations between the United States and Senegal are cordial. The ties of language, history, and habit mean that Senegal does most of its business with France, but trade with the United States is increasing. The United States has provided modest economic and technical assistance. A significant portion of the recent contribution has been in emergency drought assistance, Public Law 480 foodstuffs, and short-term relief and rehabilitation.

Demographic picture

Senegal's population of about 5.1 million in mid–1976 is growing by some 2.5 percent a year. Both the estimated birth rate (46–49 per 1,000 population) and the estimated mortality rate (20–24 per 1,000) are unusually high. Demographic trends are similar to those in other

developing countries; the population is predominantly young, with 43 percent of the people under age 15. Women marry at an early age and polygamy is common. Recent studies have shown that regardless of age or education, the majority have no knowledge of modern contraceptive methods. The population is projected to grow to 9.3 million by the year 2000.

Population growth continues to outstrip the country's social services and resources. Per capita GNP is approximately $330—1974 U.S. dollars annually. Growth in critically important agricultural production was curtailed for most of the decade by the prolonged drought in the Sahel. Though Senegal was not as adversely affected as other countries in the region, the drought was a disastrous situation for an economy based primarily on agriculture.

Life expectancy in Senegal was 44 years in mid-1976. The infant mortality rate is approximately 170 per 1,000 live births, and child mortality through age 5 may be as high as 400–500 per 1,000 births. Coupled with a high maternity mortality of 400–600 per 1,000, these data reveal maternal and child health problems of staggering proportions.

Health status

As in most developing countries, endemic diseases—malnutrition, malaria, tuberculosis, onchoceriasis, schistosomiasis, measles, and gastrointestinal diseases—are widespread in Senegal, especially among children. Other major health problems include general infections and parasites, nutritional deficiencies, and complications of pregnancy and childbirth. Poor health status is compounded by the lack of environmental sanitation, contaminated water sources, and the scarcity of health-care resources common to sub-Saharan Africa.

A large proportion of illness and death among the Senegalese is due to malnutrition. Lack of information on diet is exacerbated by a shortage of food and by insufficient income. The typical diet is high in carbohydrates, low in protein, and deficient in vitamin A, calcium, and iron. There is simply not enough food to meet the needs of the country's population, and those who suffer most are the pregnant women and children under 5.

Health care

At present, most health services and facilities are operated and financed by the Government. Some private health services are conducted by a private insurance program and the Catholic Relief Services, but these do not play a major role in providing health care.

Except for Louga, Senegal's seven other regions have regional hospitals, and Cape Verde, the region in which Dakar is located, has three. However, these facilities are often understaffed. Each hospital is supposed to have a maternity and sick center, but this is not always the case. Nevertheless, we were impressed with the orderliness of the present setup; this encourages one to feel that as facilities expand, all Senegal's people will eventually be served.

The hierarchical health system is similar to that in the People's Republic of China, with patients directed to increasingly sophisticated services when their needs cannot be handled at lower levels of expertise.

The regions are divided into 27 departments or districts, each with at least one medical division. Although each division is supposed to

have a chief physician, many are staffed only by nurses. The medical division is also supposed to contain a primary health care center, a small clinic or hospital, a primary MCH center, a maternity ward, and a dispensary. Rarely, however, are all these resources found in one district.

Each district or department is subdivided into arrondissements, and within the 85 arrondissements are a total of 429 health posts. Health posts are staffed by a state nurse, a sanitarian, an orderly, and a traditional midwife. The health posts provide simple health care and refer complicated medical problems to the medical division level. In addition, some districts are served by a mobile health team.

Senegal suffers from a shortage of medical personnel and the often-encountered imbalance in distribution of such personnel between urban and rural areas. In 1974, 76 percent of the 281 doctors in Senegal practiced in the Dakar/Cape Verde area, where only 19 percent of the population live. There is 1 doctor for every 4,370 people in Dakar. In the rest of Senegal, the average is 1 doctor per 16,400 people, and some districts have only 1 doctor for 150,000 persons. A significant proportion of doctors practicing in the country are expatriates—that is, non-Senegalese—who may soon return to their own countries.

In 1974, 64 percent of the 330 midwives and 35 percent of the 2,459 nurses practiced in the capital area. A similar preponderance of other health personnel in major urban areas leaves most rural areas inadequately served or completely without services. Moreover, those health services available are mostly curative rather than preventive.

Health training institutions consist of a medical school at the University of Dakar which graduates 30 doctors a year of whom only 10 to 12 are Senegalese; a nursing school from which 40 to 50 auxiliary nurses graduate annually; a school for sanitarians that turns out only 10 sanitarians each year; and a training program that graduates 18 midwives per year. On our route was the Medina Maternal and Child Health Center, located along one of the central avenues of Dakar in a heavily populated area. Besides serving about 500 children and 800 pregnant women daily, a key feature of this project is the training and education of professional and auxiliary health workers.

Senegal has virtually no organized family planning services, although a few doctors do provide family planning information and insert IUD's. In Dakar, we visited a rare exception, the Croix Bleue Clinic, a private family planning clinic which was the first such facility in francophone Africa. Madame Whest-Allegre, who runs Croix Bleue, told us, "For years, I have had women of all tribes, all religions. Women travel a long way to come to my clinic, even from other African countries."

Croix Bleue has now established two satellites—one in a Dakar suburb and another in the interior of Senegal—and its staff extends services to other parts of the country.

We understand that, until 1976, the extent of the Government's involvement in family planning was to tolerate the activities of the Croix Bleue Clinic. This changed in spring 1976, when a group of midwives was officially sent to take the family planning course offered by the clinic. At about the same time, the Ministry of Health contacted USAID and the Pathfinder Fund to explore the possibility of further assistance for a national family planning program. In July 1976, Ms.

F. K. Ndiave, a Senegalese, was appointed technical adviser to the Minister of Health and given the task of organizing family planning services; by fall, a detailed comprehensive plan had been worked out and was awaiting approval.

Policy on family planning

Although the country has no formal population policy statement. President Senghor declared in Parliament in 1971 that his government favored family planning. Recent rapid program developments indicate that the Government is working hard on population activities and, before long, can be expected to issue a strong pro-family planning statement based on the need to improve family health. Such a policy will probably be well received in Senegal where complications of pregnancy and childbirth are a major cause of illness and death. Religious belief is not expected to pose a lasting barrier, since family planning is being accepted in other Moslem societies such as Egypt and Tunisia. We asked a midwife who runs a Senegalese maternity and family planning clinic to account for the high rate of contraceptive acceptors despite lack of support from the Moslem leadership. She replied:

Well, I explain to the ladies that taking a life is wrong, but if you just keep a life from going in there, you are killing nothing and doing no harm.

As in other African countries, the Senegalese Government believes it is wisest to offer family planning services as part of an overall health care system. This approach is consistent with Ministry of Health priorities, which emphasize mass medicine rather than individual medicine, preventive rather than curative medicine, and improvements in health education.

The primary purposes of the program are to improve family health, especially of mothers and children, and to lower and stabilize the population growth rate throughout the country by reducing unwanted fertility as well as maternal and infant morbidity and mortality.

Family planning services

Although development of rural health services is also a national health priority, the Government has decided to launch family planning services in urban areas, where the greatest concentrations of people live, and then to expand to rural areas within several years.

A family planning component is to be developed and added to existing curriculum in all health training institutions.

Phase 1 of the planned family planning program will focus on development of services and related program components—staff training, community and patient education, supply and logistics systems, and a basic data collection system—in selected health centers in eight urban areas. Initially, services will be provided in 10 hospitals and 25 maternal and child health centers. Condoms will be distributed from 450 locations. Training in phase 1 will include 1-month programs for 200 midwives and 1-day orientation programs for 800 nurses.

Phase 2 will expand these activities to additional health centers in the cities. In addition, plans will be made to bring services to rural areas. Contraceptive distribution to households and voluntary surgical contraceptive services will also be considered for this phase.

During phase 3, the program will be expanded so that family planning services will be available to all persons who need them, with 60

percent of the primary target population—women ages 15–44—already receiving these services.

Physicians are important in the existing health infrastructure, both in delivery of services and in conducting training programs for other health workers. Therefore, brief technical conferences in family planning, designed in consultation with the director of the Dakar School of Medicine, are planned. They will be offered at times and places convenient for physicians.

Midwives—sage-femmes, or wise women—will be the backbone of the program. Their training will cover not only family planning theory and practice, but also overall administration and management of family planning services, information, counseling, data collection, and supervision of other workers who will assist them in delivering services. Lower-level health workers who assist midwives will be given family planning training that is appropriate to their responsibilities.

Senegalese will participate in designing all aspects of the family planning program, including development of supply and data collection systems.

EXTERNAL ASSISTANCE

The national family planning program is being aided by a number of external sources.

The Pathfinder Fund, which supported the Croix Bleue Clinic for years, is working to develop the capacities of five other clinics, one in Dakar and four nearby, as well as a training center for paramedical personnel. In the past, Pathfinder has supported training of paramedical staff in the United States and assisted a trip by six Senegalese opinion leaders to family planning facilities in Moslem countries in North Africa and the Middle East.

The United Nations Fund for Population Activities (UNFPA) is supporting two demographic projects—analysis and evaluation of the 1975 population census and an investigation of fertility trends.

The Medina mch Center in Dakar will be renovated, and USAID will assist the Government to develop at Medina a model capable of being replicated, with only minor modifications, in other urban mch centers.

The International Planned Parenthood Federation (IPPF) has provided limited assistance to Senegalese projects.

SUMMARY

Senegalese officials believe a national family planning program will be successful because so many births are insurance births or accidental births. Since prevention of accidental births will improve child health care, more children will survive past the age of five. Thus, insurance births will probably become less necessary. Changing attitudes regarding desired family size is a more complex issue. As in each country we visited, Senegal's family planning programs are being developed without the backup of extensive, pervasive public education and incentive systems.

National leaders told us that TV and radio should be helpful in the education effort; television reaches many urban couples, and radio is available to most rural people. Newspapers will be of little use. The daily Le Soleil du Senegal is in French, and Wolof is not yet a fully

written language. Nor are there yet plans for solving the problem of supplying additional and alternative roles for women to replace to some extent their roles as mothers. In Senegal, preference in education and employment is given to males; cultural and religious traditions dictate that girls and women should keep house, raise children, and do agricultural work. However, the movement in the Government's attitudes and action in only 1 year is astonishing and holds promise for more progress.

SENEGAL—PEOPLE INTERVIEWED

U.S. Ambassador O. Rudolph Aggrey, Dakar, Senegal.
Paul Inskeep, Labor Attaché, U.S. Embassy.
Alan McKee, Political Officer, U.S. Embassy, Senegal.
Mme. Fatou Ndiaye, Technical Advisor on Family Planning to the Minister of Health.
Dr. Matar Ndiaye, Minister of Public Health and Social Affairs.
Max N. Robinson, U.S. Embassy.
Jack Schaefer, Peace Corps Director.
Djibril Sene, Delegate General for Scientific Research in the Office of the Prime Minister.
Habib Thiam, Deputy, National Assembly.
Dr. Moustapha Toure, Deputy, National Assembly.
Mme. Whest-Allegre, Director, Clinique Croix Bleue.

SENEGAL—ITINERARY

Monday, October 18, 1976

Arrived Dakar, Senegal at 7:40 p.m. Met by Ambassador O. Rudolph Aggrey, Max N. Robinson—dinner and briefing at Terangra Hotel.

Tuesday, October 19, 1976

8:30 a.m.—Continue country briefing in the office of the Ambassador: Paul Inskeep, Labor.

10:00.—Meeting with Dr. Djibril Sene, Delegate General for Scientific Research; Government of Senegal (Congressman only).

10:00 a.m.—Meeting with Peace Corps Director, Jack Schaefer (Ms. Greenberg only).

12:00 p.m.—Meeting with the Senegalese Minister of Health, Dr. Matar Ndiaye and Mme. Fatou Ndiaye, Technical Counselor for family planning program.

1:30 p.m.—Lunch and discussion with Paul Inskeep.

3:30.—Meeting with Senegalese National Assembly Members, Mr. Habib Thiam and Dr. Moustapha Toure.

8:30.—Dinner and discussion at the Residence of Ambassador and Mrs. O. Rudolph Aggrey.

Wednesday, October 20, 1976

12:00 p.m.—Lunch and discussion, Goree Island.

5:00.—Visit the Clinique Croix Bleue and meet with Mrs. Whest-Allegre.

6:30 to 11:00.—Buffet at Peace Corps Director's residence to meet Peace Corps volunteers from all over Senegal.

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