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NIGERIA'S 2004 NATIONAL POLICY ON POPULATION FOR SUSTAINABLE DEVELOPMENT



Implementation Assessment Report

This publication was prepared by staff from the National Population Commission of Nigeria and the Health Policy Project.

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ABBREVIATIONS

BCC	Behaviour Change Communication
FMOH	Federal Ministry of Health
FP	family planning
HPP	Health Policy Project
ICPD	International Conference on Population and Development
LGA	local government area
MCPR	modern contraceptive prevalence rate
MDA	ministry, department, or agency
M&E	monitoring and evaluation
NC	North Central Zone
NE	North East Zone
NPMC	National Population Management Council
NPopC	National Population Commission of Nigeria
NPP	National Policy on Population for Sustainable Development
NW	North West Zone
PAG	Population Advisory Group
PIAT	Policy Implementation Assessment Tool
PTWG	Population Technical Working Group
SE	South East Zone
SS	South South Zone
TFR	total fertility rate

EXECUTIVE SUMMARY

In 2005, Nigeria adopted the National Policy on Population for Sustainable Development (2004), the second such strategy in the nation's history. The policy has a 2015 end date for most targets, and aims to improve standards of living and quality of life for Nigeria's people by addressing the complex interrelationships between population and development. As a result, specific interventions for health,¹ the environment, education, social-cultural barriers and legal support, and statistics (among others) were identified as key to Nigeria's sustainable development. To drive implementation, the Strategic Plan for the National Population Policy for Sustainable Development was launched in 2008, specifying activities, responsible agencies, and resources required to implement the policy.

Continued rapid population growth, high maternal and infant mortality, and poor school enrolment and achievement called its implementation into question and cemented the need for review and revision. In 2013, the National Population Commission and the Population Technical Working Group—with support from the USAID-funded Health Policy Project—developed a roadmap to guide the policy's implementation assessment and its revision.

The implementation assessment was conducted using an adapted version of the USAID-funded Health Policy Initiative's Policy Implementation Assessment Tool and carried out by the National Population Commission and the Health Policy Project. Researchers collected input from eligible implementers (ministries, departments, and agencies, donors, and civil society groups) at the national level and in four states on the policy's formulation, content, and dissemination; the execution of implementation activities overall, and across specific sectors; enabling environment; resource mobilisation; monitoring and evaluation; and overall progress and on-the-ground impacts.

The findings reveal that the 2004 population policy addressed the prevailing development issues of the time, but was not effectively implemented at national, state, and local government area levels. As a result, the policy targets were not achieved and there are few perceived improvements in the health and well-being of Nigerians today among selected respondents. According to interviews and focus group discussions, several factors presented obstacles to the policy's implementation, including

- Limited content knowledge—including roles and responsibilities—among intended implementers, due to 1) poor institutional memory of the policy formulation era and proceedings and 2) inadequate dissemination of the policy itself; this has led to actual and perceived non-implementation
- Declining policy content relevance in light of new and emerging population and development issues such as conflict- or insecurity-induced migration and displacement
- Limited relevance to subnational levels due to national focus of policy targets
- A weak enabling environment, characterised by pervasive cultural/religious practices, gender norms, and poverty
- Changes in policy/programmatic priorities—and weakened institutional memory—as a result of shifts in administration/government, coupled with limited integration of the policy within new national development efforts

¹ Interventions include reproductive and sexual health, family planning and fertility management, women's health and safe motherhood, child health and survival, HIV/AIDS, and male reproductive health.

- Limited political will for population activities among policymakers, influencers, and community/religious/traditional leaders overall, linked to insufficient dissemination and sensitisation activities
- Lack of leadership on policy implementation by delegated institutions
- Weak capacity among implementers in the areas of service delivery, advocacy and social mobilisation, and monitoring and evaluation across all sectors
- Lack of resources for the implementation of activities, characterised by delayed or nonexistent release of funds

Based on the assessment of key findings, several factors should be prioritised during the revision and implementation process of the forthcoming population policy:

- Deepen engagement with ministries, departments and agencies, civil society, and the private sector at national, state *and* local government area levels during policy formulation. This will build buy-in and institutional memory, and generate political will among a larger share of implementers, influencers, and policymakers for future population and development issues.
- Execute comprehensive *and* ongoing policy dissemination and awareness-raising activities at all administrative levels, leveraging social media, radio jingles in native languages, and town hall meetings to sensitise policymakers, implementers, traditional/religious leaders, and intended beneficiaries.
- Harmonise the policy—or use the policy as the anchor for harmonisation—with existing and new development initiatives.
- Revise content for maximum relevance to existing and emerging population and development issues in Nigeria, while ensuring that goals and targets are disaggregated to zonal or state level.
- Create an enabling environment for population policy implementation, with special attention to adopting and enforcing international charters that address social-cultural barriers (e.g., son preference, early marriage) to health and education.
- Generate political will through continuous sensitisation of policymakers and influencers (particularly in northern Nigeria) on population-development linkages and the benefits of smaller families.
- Build capacity around 1) advocacy and social mobilisation for family life education and population-environment-development linkages; 2) integration of population variables into planning; 3) monitoring and evaluation of programmes; 4) and high-quality service delivery in rural and underserved areas.
- Increase public sector funding for intended implementers, including those working outside of direct service delivery
- Improve public sector funding for health, education, and other population policy programmatic areas through budget advocacy at state and local government area levels. Ensure that all implementers, including non-service delivery agencies, have funding for population activities like behaviour change communication, advocacy and social mobilisation, research promotion, and coordination/collaboration.

INTRODUCTION

With a current population exceeding 170 million, the Federal Republic of Nigeria is the seventh-largest country in the world and the most populous in Africa. Despite the introduction of policies and programmes over the last 30 years to address Nigeria's rapid population growth and the challenges it poses for development, the country is projected to become the third-largest nation in the world by mid-century (United Nations Population Division, 2015). These continuing demographic trends—coupled with emerging national priorities and new international development frameworks—created the need to assess the implementation of Nigeria's 2004 Policy on Population for Sustainable Development (henceforth NPP, or the policy). Results from the assessment are intended to guide the formulation of a revised policy and the approaches needed to realise its goals and objectives.

Background

Population policy landscape prior to 2004

Concerns about the negative development impacts of Nigeria's population size and rate of increase trace back to the population conferences held across Africa in the 1960s and 1970s (Murray, 1966). The 1984 conference in Arusha, Tanzania—precursor to the second International Conference on Population in Mexico City that same year—provided the framework for the design and implementation of population policies and programmes in Africa (United Nations Population Information Network, n.d.). In response, the government of Nigeria formulated the nation's first population policy in 1988, titled the National Policy on Population for Development, Unity, Progress and Self Reliance.

The policy aspired to achieve reductions in fertility (four children per woman by 2000), the proportion of early marriages, the population growth rate, and infant mortality by expanding coverage of family planning (FP) services and family life education across the country. After the policy's launch, an implementation workplan was developed by the public sector, civil society, and development partners. Despite attempts to disseminate and adapt the workplan to local conditions (Mbamaonyekwu, 2002), insufficient resources, poor coordination among lead agencies and service providers, and a lack of political will derailed implementation (Adekunle and Otolorin, 2000). By its end date, the policy had failed to achieve its aspirations.

The emergence of new national population concerns, combined with shifting international development consensus—particularly the 1994 International Conference on Population and Development (ICPD)—created an urgent need to revise the 1988 policy. In 2000, President Olusegun Obasanjo issued a mandate to streamline population management nationally. A committee of representatives from the National Population Commission (NPopC), Federal Ministry of Health (FMOH), National Planning Commission, and other stakeholders endowed NPopC with the mandate to both review population policy and coordinate and monitor all population management activities. However, management responsibilities were not transferred until 2003. As a result, population management was disjointed, with responsibilities divided across multiple agencies, including the Population Activities Fund Agency, the Population Information and Communications Bureau, the FMOH's Department of Community Development and Population Activities, among others. Due to these unresolved issues around structures for population management, development partners/implementers—including the POLICY Project (predecessor to HPI and HPP) and UNFPA—supported NPP creation through the Department of Community Development and Population Activities. During a week-long meeting for 32 mid- to senior-level population management stakeholders in 2001, attendees supported the government in both reviewing the 1998 policy and drafting a revised policy. Due to protracted management issues, the NPP was not launched until 2005. Compared to its predecessor, the policy embedded the rights-based tenets and narrative of ICPD and

addressed a more comprehensive range of health, rights, and human development issues and interventions, representing a clear paradigm shift.

NPP goals, targets, and strategies

The overall goal of the NPP is to improve the quality of life and standard of living of Nigeria's people by 2015. The policy recognises the complex linkages between demographics, social and economic development, and environmental factors by addressing direct population management issues in addition to broad health, education, and resource management concerns. The policy outlines six specific goals, nine supporting policy objectives, and 10 targets at the national level to drive implementation (see Table 1). However, the policy does not identify specific indicators to measure progress towards each target.

Table 1: NPP Targets

Demographic	Reduce national population growth rate to 2 percent or lower by 2015
	Reduce total fertility rate by at least 0.6 children every five years
Health	Increase modern contraceptive prevalence rate by at least 2 percent per year
	Reduce the infant mortality rate to 35 per 1,000 live births by 2015
	Reduce the child mortality rate to 45 per 1,000 live births by 2015
	Reduce the maternal mortality rate to 125 per 100,000 live births by 2010, and 75 by 2015
	Achieve 25 percent reduction in HIV adult prevalence every five years
Education	Eliminate gap between men and women in enrolment in secondary, tertiary, vocational, and technical education and training by 2015
	Eliminate illiteracy by 2020
	Achieve sustainable universal basic education as soon as possible prior to the year 2015

The NPP includes implementation strategies across nine thematic areas required to achieve sustainable development in Nigeria:

1. **Health:** reproductive and sexual health, family planning and fertility management, women's health and safe motherhood, child health and survival, HIV/AIDS, male reproductive health
2. **Environment:** population, development, and environmental interrelationships
3. **Education:** population and family life education, basic education and literacy
4. **Communication:** behaviour change communication (BCC), advocacy, and leadership commitment
5. **Population dynamics:** population distribution, urbanisation and migration, population with special needs (e.g., nomads, the elderly, persons with disabilities, refugees and displaced persons)
6. **Youth and adolescents:** adolescents and young people
7. **Social-cultural barriers and legal support**
8. **Population and development planning:** integration of population variables into development planning, integration of reproductive health concerns into sectoral programmes and activities
9. **Population statistics:** data collection and analysis; and monitoring, evaluation, and research

Within each thematic area, implementation strategies include advocacy and social mobilisation, establishing/strengthening social services, ensuring adequate resource mobilisation, and monitoring and evaluation. Institutional leadership is assigned to three multisectoral bodies: 1) the National Council on Population Management (NCPM), newly formed under the NPP and designated with overall management of the policy's implementation; 2) the Population Advisory Group (PAG) at federal and state levels, which holds coordination functions along with NPopC; and 3) the Population Technical Working Group (PTWG), which is responsible for providing direction and guidance on operational strategies for the achievement of the multisectoral agenda (state and federal levels).

The implementation strategies themselves were intended to be executed by a multisectoral group of actors across ministries, departments, and agencies (MDAs); the private sector; civil society; and communities. Roles were identified for every relevant MDA (e.g., ministries of finance, health, education, agriculture and rural development, environment, etc.), the Office of the Presidency and National Assembly, and civil society.

To ensure full implementation and operationalise the policy, a separate but aligned Strategic Plan for the National Population Policy for Sustainable Development (henceforth, the strategic plan) was launched in 2008. The strategic plan outlines key activities, indicators, responsible actors/agencies, resources required, and timeframes for each of the policy's nine thematic areas, in addition to gender and interagency collaboration.

Health and education outcomes under NPP

Eleven years after the launch of the NPP, Nigeria has experienced limited improvements in the health and education of its population (see Table 2: Gaps in NPP National Targets). However, the policy environment for population issues, including health and education, has seen much progress in recent years, creating opportunities for positive change in outcomes moving forward.

Nigeria's population has continued to grow rapidly over this time, reaching an estimated 188.9 million in 2015 (NPopC, 2009). This represents an increase of more than 46 million people since the NPP was formulated. Nigeria's population growth rate—an estimated 3.2 percent per annum—is high and fails to meet the policy's first target (NPopC, 2009).

Large family sizes are the single most important driver of Nigeria's population growth rate. Since the policy was enacted, the total fertility rate (TFR)—or the average number of children a woman would have throughout her lifetime—decreased by just 0.2 children, from 5.7 to 5.5 children per woman in 10 years (2003–2013) (NPopC and ICF International, 2014). This slight decadal decline is far less than the policy's aspirational decrease (0.6 per five years), which would have produced a fertility rate of 4.38 by 2015. As expected, the TFR decline at the zonal level was also minimal, with some variation by region (see Annex A). The greatest decline in childbearing occurred in the North East (NE) zone, where TFR decreased by 0.7 points (from 7.0 in 2003 to 6.3 in 2013). Contrary to national trends, the South East (SE) and South West (SW) zones experienced slight increases in childbearing over this time (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014).

Table 2: Gaps in NPP National Targets

	2015 GOAL	2013/2014	GAP
Reduce national population growth rate to 2 percent or lower by 2015 ^a	≤2%	3.2%	1.2 percentage points
TFR declines by at least 0.6 children every 5 years ^b	4.38	5.5	1.12 children
Increase mCPR by at least 2 percentage points per year ^b	30.2	9.8	20.4 percentage points
Reduce the infant mortality rate to 35 per 1,000 live births by 2015 ^b	35	69	34 deaths per 1,000 live births
Reduce the child mortality rate to 45 per 1,000 live births by 2015 ^b	45	64	19 deaths per 1,000 live births
Reduce maternal mortality ratio to 75 per 100,000 live births by 2015 ^b	75	576 ^a	501 deaths per 100,000 live births
Achieve 25 percent reduction in HIV adult prevalence every five years ^c	2.67%	3%	.33 percentage points
Eliminate gap between men and women in school enrolment by 2015 ^{b,1}			
Gender Parity Index (Secondary) ²	1	0.86	0.14
Eliminate illiteracy by 2020 (literacy rate, those who did not complete primary education) ^b			
Female	100%*	53.1%	46.9 percentage points
Male	100%*	75.2%	24.8 percentage points
Achieve sustainable universal basic education prior to the year 2015 (net attendance ratio) ^b			
Primary	100%	59.1%	40.9 percentage points
Secondary	100%	48.8%	51.2 percent points

Note: 2015 goal values for TFR and mCPR computed based on desired level of improvement/decline stated in targets.

^a NPopC, 2009

^b NPopC and ICF International, 2014

^c Federal Ministry of Health, 2013

^c WHO, UNFPA, The World Bank, and the United Nations Population Division (2005 estimate for maternal mortality ratio)

* Refers to 2020 target

¹ Secondary, tertiary, vocational, and technical education and training

² A score of 1 indicates parity between the sexes. A score between 0 and 1 indicates disparity in favor of males.

Nigeria's levels and trends in fertility can be attributed, in part, to low modern contraceptive uptake. According to the NPP targets, the modern contraceptive prevalence rate (mCPR) among married women should have reached at least 30.2 percent by 2015 (see Table 2). At the national level, however, mCPR increased to just 9.8 percent, representing a 1.6 percentage point increase over the 11-year NPP period (NPopC and ICF International, 2014). Nearly all zones experienced a similarly modest improvement in mCPR. The SE zone experienced the greatest improvement in modern method uptake: an increase from 13.8–16.4 percent (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014). Despite this limited progress in outcomes, the policy environment for family planning has improved significantly since the launch of the NPP. In 2011, the Nigerian government committed to providing contraceptive commodities at no cost to states. In 2014, the government approved the national Family Planning Blueprint and the Task-Shifting and Task-Sharing Policy for Essential Health Care Services, both of which hold positive implications for FP programming moving forward.

Beyond their devastating effects on the household, survival, and longevity, infant and child mortality also affect fertility levels over time; as infant mortality decreases, parents have fewer children to reach their desired family sizes. In addition to the NPP, Nigeria issued the Revised National Health Policy in 2004 to improve access to primary, secondary, and tertiary healthcare services to reduce under-five mortality, maternal mortality, the spread of HIV, and the burden of malaria and other major diseases (NPopC and ICF International, 2014). Despite this level of policy commitment, infant and child mortality rates far exceed the targets set by the NPP (69 and 64 deaths per 1,000 live births, respectively). At the subnational level, none of the zones reached the national target for infant mortality rate; however, South South (SS), SW, and North Central (NC) have surpassed the target set for child mortality rates (35, 31, and 36 deaths per 1000 live births, respectively) (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014).

Frequent childbearing poses dangers to maternal health and survival. In Nigeria, the maternal mortality ratio remains high at 576 maternal deaths per 100,000 live births, exceeding the 2015 target seven-fold (NPopC and ICF International, 2014). Unlike the other health targets, Nigeria has made positive strides towards reducing adult HIV prevalence; despite not reaching the target, HIV prevalence decreased by 40 percent (from 5 to 3 percent nationally) between 2003 and 2013. This trend holds across nearly all zones, excluding SW, where HIV prevalence has increased by 0.5 percentage points (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014).

Nigeria has prioritised interventions to increase access to and gender equity of secondary, tertiary, vocational, and technical education nationwide. For example, incentives for the education of female children (e.g., the Girl Education Programme) have proven effective in northern Nigerian states where school enrolment, retention, and completion rates for girls were significantly lower than for male children. Although the NPP target has not been fully achieved, access and equity have improved over time, with the national Gender Parity Index for secondary enrolment increasing from 0.77 in 2003 to 0.86 in 2014 (NPopC and ICF International, 2014).²

Despite Nigeria's 2004 Universal Basic Education Act, which provides free and compulsory basic education to all, 40 percent of the school-age population was not attending primary education by 2013, representing a failure to reach the NPP's target. Even more alarming, over half of all eligible children in the North West (NW) and NE zones do not attend primary school (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014). Among those who do not enrol or complete primary education, the literacy rate for women and men has increased by just 4.9 and 7.2 percentage points, respectively, between 2003 and 2013. Similar trends exist at the zonal level; despite slight improvements in the literacy

² A GPI of 1 indicates parity between the sexes. A GPI that varies between 0 and 1 typically means a disparity in favor of males, whereas a GPI greater than 1 indicates a disparity in favor of females.

rate, the NW, NE, and NC zones are far from reaching their goal to eliminate illiteracy (NPopC and ORC Macro, 2004; NPopC and ICF International, 2014). Based on these trends, an increase to full literacy by 2020 per the target goal is unlikely without further interventions.

Purpose of the Implementation Assessment

Three key factors motivated the revision of the NPP: 1) a desire to identify and overcome the persistent challenges inhibiting full implementation; 2) recognition of new and emerging population concerns across the country that require policy action; and 3) the changing international development landscape and a desire to harmonise national policy with the Sustainable Development Goals, successor to the Millennium Development Goals. In 2013, a roadmap was developed to guide the policy's review and revision. As the first phase, an implementation assessment was mandated to identify progress, challenges at different levels, and key recommendations for policy formulation.

Methodology

The NPP implementation assessment was led by NPopC, in coordination with HPP. The review process was clearly defined, based on internally accepted best practices, consultative, and anchored on an adapted approach from the Health Policy Initiative's Policy Implementation Assessment Tool (PIAT) (Bhuyan et al., 2010). The assessment was guided by the PIAT and retrospectively examined the adequacy of the policy's content, implementation strategies, and dissemination; the enabling environment; availability of resources; and the extent of monitoring and evaluation (among other implementing modalities).

Review process

The review process was characterised by six phases.

Formation of the National Review Secretariat and Core Team: In March 2015, the National Review Secretariat was formed to provide overall strategic leadership and guidance on the assessment. The secretariat was based at NPopC headquarters in Abuja and consisted of the Director-General, select Honorable Federal Commissioners, NPopC Directors, Population Management Unit project staff,³ a review consultant—who coordinated all implementation assessment activities—and HPP. In addition, a core team was inaugurated in May 2015, composed of a cross-section of multisectoral stakeholders from the country's PTWG. The core team was convened to provide technical guidance on the review process, assessment methodology, interview tools, and data collection. The review process spanned a period of six months.

Consensus reached on review roadmap and scope of fieldwork: The secretariat convened a series of meetings to identify the scope of review activities, timelines, and budget. They decided to conduct the review at the national level and in six states intended to represent Nigeria's geopolitical zones—four of which are included in this assessment.⁴ State selection was purposive, based on knowledge of state dynamics and expectations of the number of potential eligible interviewees.

Interview guides developed, adapted, and pretested: Under the core team's leadership, the PIAT was adapted into one interview guide for all MDAs and civil society actors charged with implementation under the NPP. The tool was first implemented in Edo and Enugu states, where it was observed that residual knowledge was weak among persons eligible to be interviewed. It was concluded that the rapid appraisal methodology would be ineffective on its own. As a result, additional short interview guides

³ The Population Management Unit is one of six units and eight departments conducting technical and operations work at the Commission's headquarters in Abuja.

⁴ See limitations section.

were developed to retrieve information on the implementation of activities across each policy sector as outlined in the strategic plan.

Key informants identified and interviewed: A research team, comprised of members of the Population Management Unit and the review consultant, was formed to undertake national and state-level interviews and focus group discussion. The team identified all key informants via expert sampling (purposive), selecting informed designated implementers. In the case of interviewees, the research team identified implementer institutions/organisations at the national and state level; each institution head was asked to select/nominate an informed member for interview. Focus group discussion (FGD) participants were identified directly by the research team, also on the basis of their direct experience with implementation. The research team conducted interviews and facilitated six FGDs at the national and state level between May and August 2015.

The core and sectoral interview guides were administered to 71 key informants at the national and zonal/state levels (Lagos, Kaduna, Nasarawa, and Gombe): 14 participants from the national level, 18 from Lagos, 14 from Kaduna, 15 from Nasarawa, and 10 from Gombe. National participants represented a wide range of MDAs, including the Federal Ministry of Youth Development, National Bureau of Statistics, FMOH, the Federal Ministry of Finance, civil society, and donors. State participants represented a range of MDAs, CSOs, and universities.

Secondary data collected: Impact-level data, drawn largely from the Demographic and Health Surveys, was gathered and analysed to elucidate the extent to which NPP targets were achieved.

Data entry and analysis: Data was collected by the research team, and quality checks were performed by NPopC data clerks at headquarters during the process of transcription. Each state/zone was initially coded separately, after which a master file with consolidated interview outcomes was developed. The research team analysed qualitative responses from both the interviews and FGDs to identify recurring themes reflective of the predominant and dispersive opinions.

Questionnaires

Three questionnaires were used throughout the review process. For the informant interviews, one core questionnaire was adapted from the PIAT. The protocol consisted of Likert-like ranking questions whereby informants rated specific aspects of implementation, as well as open-ended questions to elicit key informants' experience. The protocol was organised around seven dimensions of policy implementation:

1. The policy: formulation, content, and dissemination
2. The implementation plan: formulation, content and dissemination
3. Social, political, and economic context
4. Stakeholder involvement in implementation
5. Resource mobilisation
6. Monitoring progress and results
7. Overall assessment

In addition to completing the core questionnaire, each individual informant assessed the level of achievement for activities outlined in the 2008 strategic plan. With guidance from the core team, seven shorter sectoral interview questionnaires were developed: health, education, population planning and statistics, agriculture, environment, gender, and social-cultural barriers. Questions on cross-cutting thematic areas from the policy⁵ were integrated across the sectoral questionnaires. Each respondent was

⁵ Communication, population dynamics, youth and adolescents, population statistics and inter-agency cooperation

asked questions from the relevant sectoral tool, which again consisted of Likert-like ranking and open-ended questions. Finally, an FGD guide served as the basis for small group consultations in Nigeria's six geopolitical zones.

Limitations

The goal of the assessment was to gauge the extent of NPP implementation as informed by a small, purposive sample of implementers. As a result of this research choice, the findings are not representative of the general population, each geopolitical zone, or the entire body of intended NPP implementers.

The initial assumption underlying the assessment was that interviewees would possess strong prior knowledge of and familiarity with the policy. It was soon evident that dissemination of the policy was so poor—coupled with staff reassignments and retirement—that too few persons met this eligibility criterion. To overcome this limitation, skip patterns were developed so that only respondents with some level of NPP knowledge answered in-depth questions on the policy and the strategic plan's content and implementation.

The initial adapted PIAT core tool was implemented in Edo and Enugu states. The questionnaire was extensive and featured many in-depth questions across all phases of implementation. Informants overwhelmingly provided “don't know” and “missing” responses, but demonstrated a good level of knowledge around the implementation of specific health, education, environment, and other interventions. This demonstrated that while certain aspects of the NPP may be implemented, respondents are not linking those activities to the policy itself. As a result, the core tool was shortened and the sector-specific questionnaires on specific activities and tasks outlined in the strategic plan were developed. Given the extent to which the previous core tool deviated from the revised version, respondent input from Edo and Enugu states have not been included in this assessment.

While the sectoral tool created an opportunity to better assess the policy's impact on programmatic implementation, it simultaneously narrowed the number of informants eligible to respond in each sector (e.g., only a respondent with a position in the education sector would be eligible to respond to the education sector questionnaire). Thus, the sample size of national- and state-level respondents by sector was small compared to the core tool. The research team accounted for this by aggregating sectoral responses across geographic zones in the areas of advocacy, BCC, capacity building, and monitoring and evaluation. These categories aligned with implementation activities in the national strategic plan. The number of participants (four in total) from the agriculture sector proved too small to consider in the overall analysis.

Missing answers were not included in the final analysis presented in this paper. However, informant responses of “don't know” are factored into the final analysis.

KEY FINDINGS

The Policy: Formulation, Content, and Dissemination

The first section of the core interview guide assessed whether the foundation for effective implementation of the NPP was in place—namely, the content of the NPP, the process of its formulation, and the extent of its dissemination.

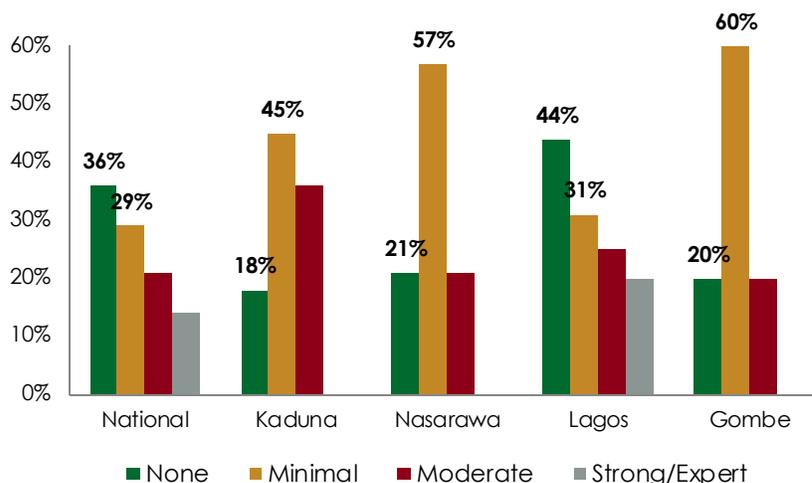
Adequacy of content

The vast majority of respondents (85%, or 58/68) had heard of the NPP prior to interviews, but nearly two-thirds had never read any part of the policy itself, demonstrating a lack of familiarity with much of its content. Unsurprisingly, three-quarters of interviewees rated themselves as having little to no NPP content knowledge, with some variation by zone (see Figure 1).

Among those with some content knowledge, there was consensus that the policy's goals and objectives tackle important issues related to population and development. However, respondents recognised a number of emerging issues on the national stage and recommended that these be addressed in a revised policy: 1) insecurity- or conflict-induced migration and displacement; 2) dearth of birth/death registration; 3) needs of the elderly; 4) more emphasis on education, care, and work opportunities for out-of-school youth/adolescents to deter radicalisation; 4) emergency and disaster response; 5) unemployment; and 6) newborn health.

Respondents also revealed that despite policy targets being appropriately specific, measureable, attainable, relevant, and time-bound (or SMART) at the national level, the revised policy would benefit from the inclusion of zonal-level targets to better motivate and monitor progress. Overwhelmingly, 74 percent of interviewees believed that the goals, objectives, and targets were not achievable within the 2004–2015 timeframe given the low capacity—due to little or no skills building—of implementers to execute.

Figure 1: Ratings of Policy Content Knowledge (n=65)

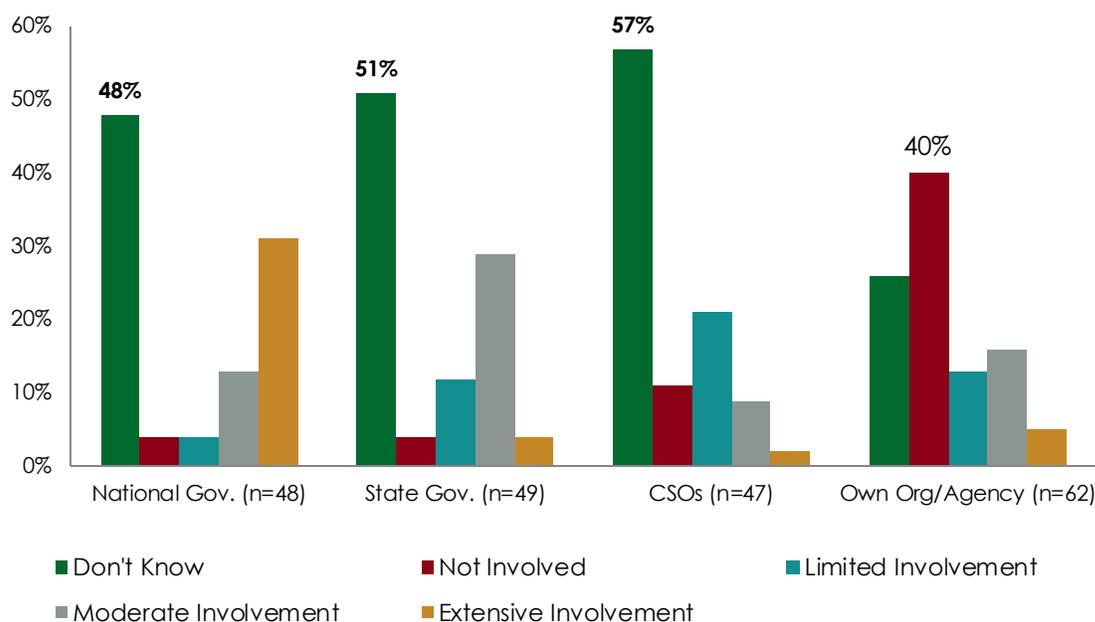


*SouthSouth and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Policy formulation

Despite an inclusive partner-supported FMOH effort to review and revise the 1998 policy, resulting in the draft NPP in 2001, interviews and FGDs with implementers reveal a severe lack of knowledge about the NPP's formulation process.

Due to reassignment, turnover, and retirement, half of the interviewees did not know the extent to which the government and civil society were involved in policy formulation (see Figure 2), demonstrating poor institutional memory across MDAs and organisations since the policy's introduction. When asked about their own MDA/organisation and its involvement with the formulation process, the largest share of respondents reported no involvement. Both interviewees and FGD participants stressed the importance of a broad, inclusive consultation process for the next policy. This would include policy drafting forums with national, state, and local government area (LGA) representatives and beneficiaries to facilitate a citizen-driven or bottom-up approach.

Figure 2: Perceived Stakeholder Involvement During NPP Formulation

*South South and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Policy dissemination

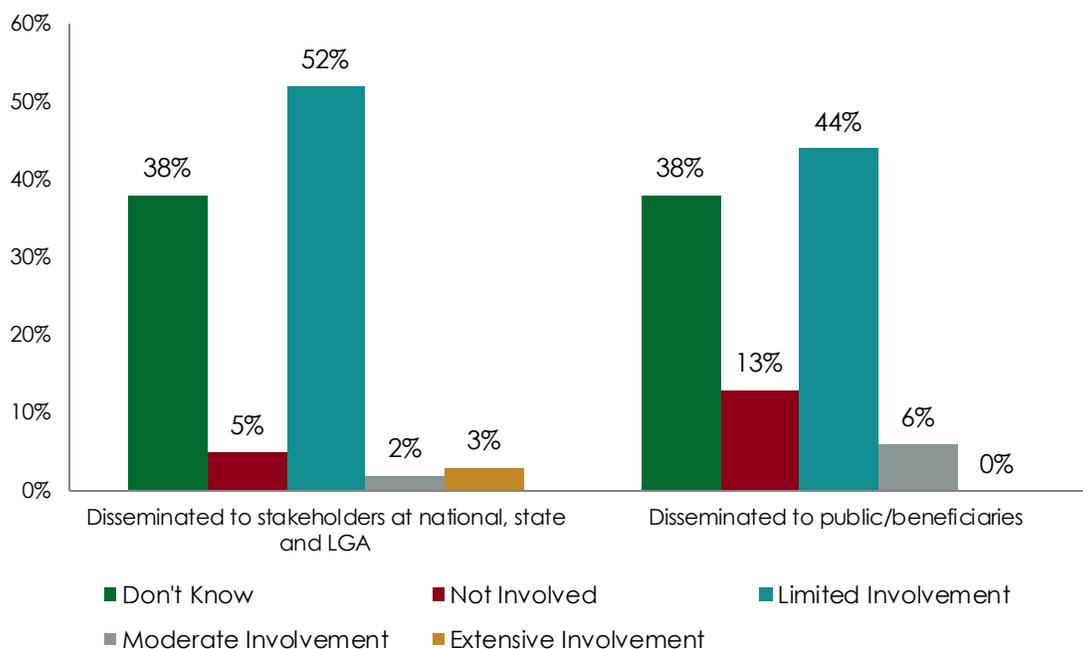
More than half of all interviewees viewed the dissemination process as weak and limited (see Figure 3). According to FGDs, there was only one wave of NPP dissemination in 2005, including a launch event. Respondents believed that dissemination did not trickle down to local levels. Continuous/ongoing dissemination at the national, state, and LGA levels was identified as a key strategy for successful policy awareness-raising. Respondents identified several additional courses of action that should be practiced under the revised policy for improved dissemination:

"... traditional rulers and local leaders should know of the policy and even the Sustainable Development Goals, they should go hand in hand, this policy should reach the LGA, even the Ward level ..."

~FGD participant in Gombe state

1. Disseminate hard and electronic copies of the policy to all MDAs across all three tiers of government, as well as to research institutions and places of higher learning for teaching purposes
2. Train a cadre of content experts (e.g., select staff based in NPopC field offices to be responsible for engaging stakeholders on policy implementation and evaluation)
3. Launch an awareness-raising campaign—inclusive of channels/mediums like radio jingles in native languages, social media campaigns, town hall meetings/forums, and town criers—to reach policymakers, implementers, and intended beneficiaries with the policy's key messages
4. Involve traditional, religious, and other local community leaders in dissemination—individuals who are a gateway for behaviour change

Figure 3: Perceived Extent of Dissemination



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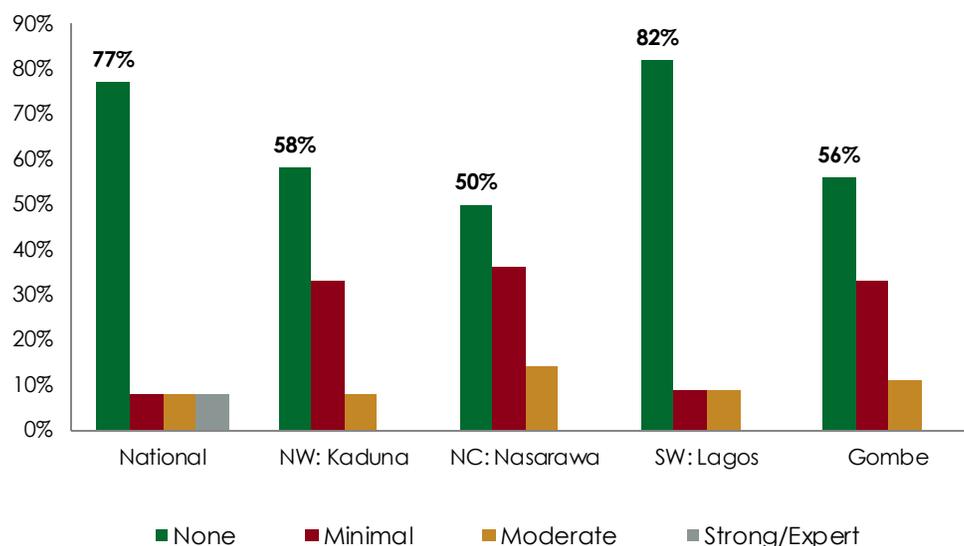
*South South and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

The Implementation Plan

The 2008 Strategic Plan for the National Population Policy for Sustainable Development was designed to provide the operational framework for the implementation of the NPP. Similar to the policy itself, involvement in formulation and dissemination—and by extension, knowledge of the plan’s content—are crucial for successful implementation.

As with the NPP, interviews reveal a lack of knowledge about the plan’s formulation process; in most cases, interviewees with some content knowledge did not know who was involved in writing the plan, and believed that the government and other actors were not extensively involved. Most interviewees agreed that the plan’s dissemination was extremely limited.

As a result of poor stakeholder engagement in policy formulation and weak dissemination, the vast majority of interviewees (62%) across geographic zones had not heard of the document prior to the interview. Two-thirds of interviewees believed they had no knowledge of the plan’s content (see Figure 4). Among those with some content knowledge, interviews and discussions showed that the plan’s content corresponded well to the policy itself.

Figure 4: Perceived Knowledge of Strategic Plan Content (n=59)

*SouthSouth and SouthEast zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Social, Political, and Economic Context

Social, political, and economic factors influence policy processes and can either facilitate or hinder implementation. Respondents reported almost exclusively on those factors that impeded implementation over the preceding 11 years.

Social factors

- **Cultural practices and gender norms** were believed to be among the most pervasive challenges to the implementation of the NPP. According to respondents, Nigeria's patriarchal structure creates behavioural expectations for both men and women, expectations not aligned with the tenets of the NPP. For instance, female children are perceived to hold a lower value than their male counterparts, negatively impacting their school enrolment and completion. Respondents also observed that Nigeria failed to incorporate the tenets of the Convention on the Elimination of all Forms of Discrimination Against Women within municipal law, slowing the pace of women's empowerment and the overall reversal of harmful practices and norms.
- **Religious practices or beliefs** have constrained health-seeking behaviour at all levels, and have had a detrimental effect on data collection. According to some respondents, religious-based objections to open discussion about sex have prevented children from participating in family life education, where otherwise available. Religious objections continue to negatively impact women's use of contraception, exposing them to unwanted fertility, risky pregnancies/births, and unsafe abortions. Data collection efforts have also been negatively affected by religious practices like purdah, which limit physical contraceptive access to the female members of households.

Political factors

- **Lack of political will** for the policy's implementation is evident in the limited financial resources available to programmes (FP, advocacy and research on social-cultural barriers, advocacy and

research on gender, education programmes, etc.). Respondents believed that policymakers and influencers have little motivation to execute population activities, or to act as champions in the public domain. This is driven in part by misinformation; respondents believed that influencers/policymakers do not fully understand or appreciate population-development linkages. **Misinformation (intentional or unintentional)** offered by politicians and opinion/community leaders has negatively impacted the uptake of health services. According to some respondents, political and religious leaders in northern Nigeria misinformed constituents about the safety of immunisations, resulting in massive rejection of polio vaccinations. Mixed messages are also problematic.

- **Frequent changes of government and poor harmonisation across development efforts** have a direct bearing on the policy's implementation. Since the NPP's launch, changes in government have meant shifts in priorities, which lead to fragmented or discontinued programming and policy support. At the time of the NPP's institutionalisation, the federal government developed the National Economic Empowerment Development Strategy (NEEDS I, and later NEEDS II) as Nigeria's poverty alleviation blueprint, aligned with the Millennium Development Goals. This blueprint diverted resources away from population activities. Following the 2007 elections and change in administration, the new president ushered in drastic changes, discarding NEEDS in favour of the Yar Adua Seven Point Agenda. Much of the momentum around the NPP was lost.

Economic factors

- The **politicising of population counts** has also negatively impacted implementation of the NPP. Nigeria's census figures determine seats in the House of Representatives (apportioned based on population), civil servant hiring, and—most importantly—the distribution of federal funds to the state level. This creates a perverse incentive to manipulate and inflate population figures (e.g., census pits northern states against southern) to gain larger state-level budget allocations.
- **Insufficient domestic funding**—linked to the lack of political will—from federal and state governments has affected the continuity and reach of NPP programmes. These have been plagued by low or nonexistent allocations (e.g., vital registration, census, etc.), delayed releases, or inadequate expenditures, with adverse impacts on development outcomes.
- **Widespread poverty** in Nigeria creates reliance on remittances from children to parents (and the elderly), limiting access to educational opportunities for children, increasing risky behaviours, and creating an incentive for larger family sizes overall. Poverty and related cost barriers have also had a detrimental effect on access to health services such as delivery care, newborn care, HIV prevention and treatment, and family planning.

"During the Obasanjo regime, population became a political issue, and some states census figures were bloated for resource allocation..."

~FGD participant in Lagos state

Stakeholder Involvement in Implementation

According to the NPP’s implementation activities and strategic plan, multisectoral stakeholders—particularly national and state-level MDAs—are charged with implementation.⁶ Each MDA (along with civil society organisations) is assigned specific activities and programmes. Knowing and understanding these responsibilities is a prerequisite for successful implementation and accountability.

Only half of all respondents had heard of the three lead agencies charged with NPP strategic direction, guidance, and oversight (the NCPM, the PAG, and the PTWG), pointing to a lack of visibility and coordination over the policy timeframe. Sixty percent of interviewees identified NPopC as the lead agency. While this represents strong consensus and a vote of confidence around this agency’s visibility on population issues, the remaining share of respondents cited the FMOH, the National Bureau of Statistics, the Federal Ministry of Education, and the National Planning Commission as lead institutions—demonstrating some level of confusion, as well as potentially fragmented NPopC leadership. More than half of interviewees (56 percent, or 30/ 54) stated no knowledge of the roles and responsibilities of other designated implementers.

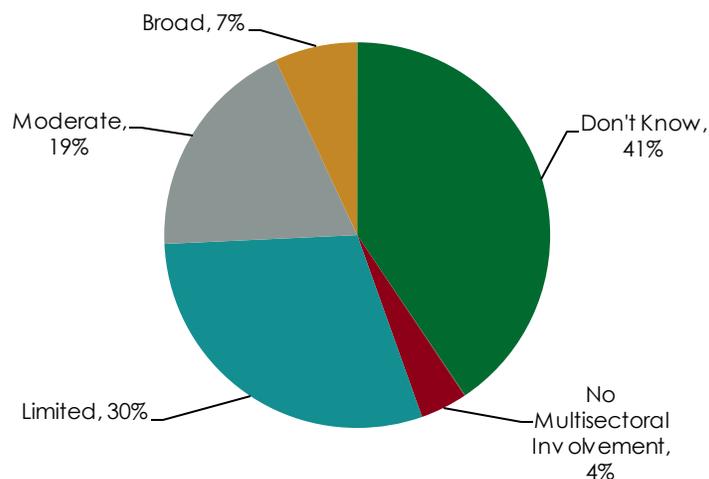
Despite recognising that their own MDA/organisation was responsible for implementing *some* part of the policy, two-thirds of interviewees were not aware of their specific roles and responsibilities under the NPP. The majority (52 percent) believe they are only partly meeting their responsibilities. Respondents also indicated that they had received no training or capacity building overtly linked to implementing the policy. Areas in which training is needed and desired include

- Training/information on the concept and content of the policy itself, as well as the role of implementers
- Basic demography and population issues
- Data analysis and mapping
- Best-practices in sensitising intended beneficiaries on the policy
- Gender-mainstreaming
- Monitoring and evaluation

The majority of interviewees did not know the extent of multisectoral involvement in policy implementation (Figure 5). An additional 30 percent, the second-largest share of respondents, believed multisectoral involvement to be limited. There is a lack of clarity over whether other stakeholders (e.g., the private sector) are involved in implementing the policy, as well as whether CSOs are advocating for the policy’s implementation.

⁶ These stakeholders include NPopC, FMOH, Federal Ministry of Information, National Primary Health Care Development Agency, Federal Ministry of Women Affairs, Federal Ministry of Education, Universal Basic Education Commission, National Bureau of Statistics, National Planning Commission, and others.

Figure 5: Perceptions on the Extent of Multisectoral Government Involvement in Implementation (n=27)



*SouthSouth and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Implementation of Activities

To evaluate the extent to which specific activities were achieved—as defined by the policy and strategic plan—key institutional informants ranked tasks relevant to their sub-sector on a scale: “don’t know,” “not achieved at all,” “partly achieved,” “moderately achieved,” and “fully achieved.”

Health

Health sector participants reported good progress on generating buy-in and mobilising policymakers and religious/traditional leaders on matters of health; 58 and 65 percent of respondents, respectively, cited moderate or full achievement of mobilisation. There was less consensus around advocacy for funding health programmes, with approximately half of respondents reporting that such activities were only partly achieved. Over 60 percent of respondents, on average, believed that activities related to BCC had been moderately or fully achieved. Across health activities, the lowest rankings were reported for monitoring and evaluation (M&E); over 50 percent of respondents believed that implementation reviews and updates to policies and programmes were only partly achieved.

According to respondents working in the health sector, a number of factors acted as key challenges to successful NPP implementation over the last 11 years:

- Inadequate government funding, particularly at subnational levels (e.g., delayed release of funds)
- Dependence on donors for programming, and poor coordination of donor activities leading to inefficient redundancies (data gathering, M&E, etc.)
- Insufficient human resources for health, particularly well-trained personnel
- Insufficient commodities and supplies, particularly for family planning and maternal health
- Poor and delayed health management and information systems

Based on respondent feedback, three areas require additional attention, both now and under a new/revised policy. First, improved public sector funding and accountability is required to address poor budgetary

allocations, and the delayed or nonexistent release and disbursement of funds at federal, state, and LGA levels. Scaling up government health insurance—specifically the Community Based Social Health Insurance Programme—is one way to overcome clients’ cost barriers to health. Respondents also stressed the importance of setting up a reliable performance-based financing structure, both to motivate service providers and to ensure adequacy of funds. Second, the public and private sectors must tackle high attrition and increase the number of trained health personnel—particularly at local levels—deployed to areas with poor coverage (e.g., provide incentives to work in hard to reach areas). Finally, respondents pointed to several new health initiatives that will require attention in the coming years, including combating stigma and discrimination against people living with HIV/AIDS.

Education

Compared to advocacy and social mobilisation for universal basic education, respondents observed less progress towards building support for family life education at all levels, particularly among religious/traditional leaders (around 50 percent believed that this was only partly achieved). Teachers are not adequately trained in the provision of family life education (38 percent of respondents claimed “partly achieved”), and programmes are not monitored or evaluated, unlike programmes for universal basic education.

According to respondents working in education, five factors hindered successful implementation of universal basic education and family life education under the 2004 NPP:

1. Inadequate funding, including for basic education, which is largely dependent on state resources
2. Poor supervision and monitoring and evaluation of programmes, particularly population and family life education
3. Inadequate school infrastructure and facilities
4. Shortages in well-trained personnel
5. Cultural and traditional norms, which negatively affect girls’ enrolment and school attendance

Several existing and emerging areas require additional attention now and under a revised policy:

- Revise curricula in higher education institutions and strengthen curricula for trade subjects
- Build capacity of teachers, particularly in the area of population and family life education
- Focus efforts on improving access to education for girls and vulnerable groups, including nomads, Almajiri, and the disabled
- Improve government and donor harmonisation of education programmes via more frequent coordination meetings (e.g., quarterly meetings of the Joint Consultative Council on Education)

Population planning and statistics

Half of all participants from the population and planning sectors cited either moderate or full achievement of activities to develop advocacy materials/strategies for planners on the integration of population variables into development planning. Over half of respondents believed that capacity for the integration of population into development planning was weak. Activities around strengthening infrastructure for effective population data collection were reported as partly achieved, and there was little consensus as to whether an M&E framework for population data collection was created and implemented.

According to interviewees, the key factor that has hindered successful implementation of population planning and statistics under the 2004 NPP—and that requires further attention in coming years—is insufficient funding. Key population planning activities, like the census and vital registration, do not receive their required funding. When allocations are made, slow or nonexistent releases plague activities.

There is also insufficient funding for M&E, research, and data analysis and dissemination. Ongoing advocacy to the national government for adequate funding is a key intervention moving forward.

Environment

Across the environment sector, respondents overwhelmingly stated that activities had been only partly achieved. Eighty percent of respondents believed that development of an integrated population-development-environment framework had only been partly achieved, and that sensitisation tasks had proven insufficient. Nearly 90 percent of respondents believed that training of staff from other MDAs on the importance of environmental linkages issues had been not at all, or partly, achieved. An M&E framework for linkage issues has not been created, and further research exploring the interrelationship has received insufficient attention over the past 11 years.

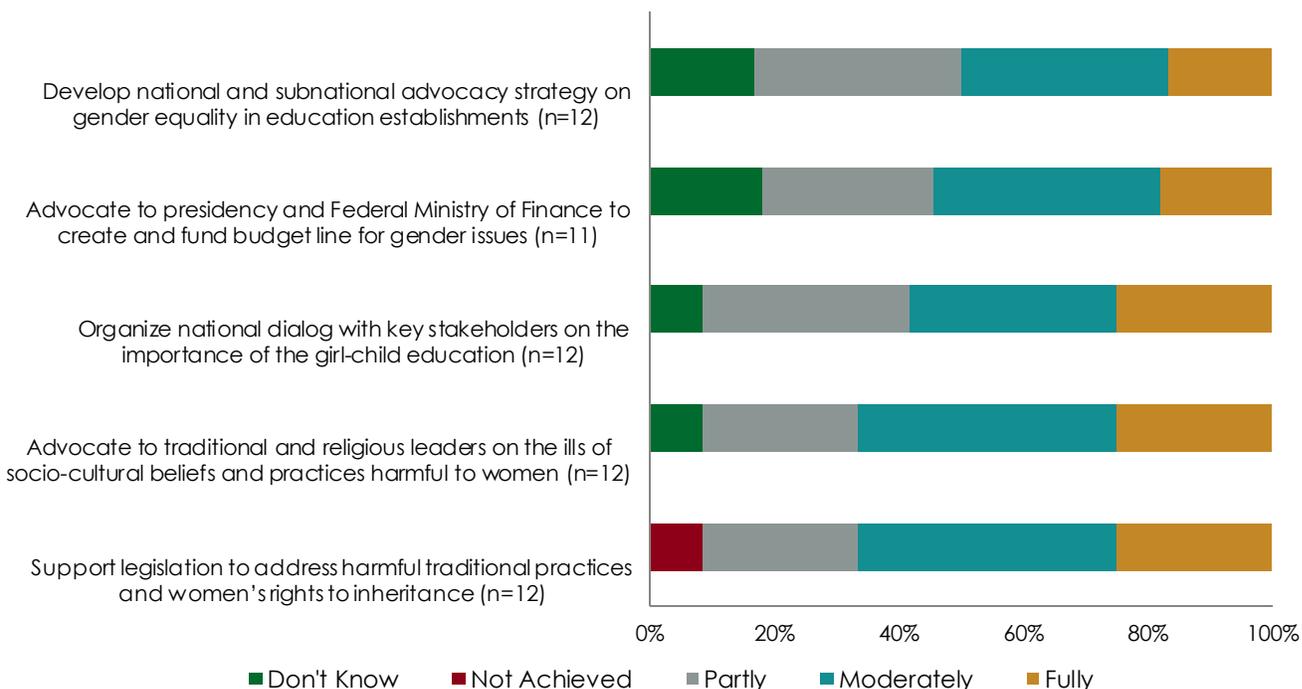
One key challenge facing the environment sector is the lack of interest and poor appreciation of population-development-environment linkages at the highest governing levels. In addition, respondents believed that actors/advocates in the sector were poorly organised and coordinated. As a result, the sector faces poor funding for awareness-raising/sensitisation activities.

Respondents felt that several key activities should be prioritised over the coming years to bring awareness and support to linkage issues, and to address emerging environmental concerns:

- Establish government structures to mitigate and adapt to climate change and environmental degradation, with consideration given to desertification, gully erosion and flooding, and the regulation of infrastructure development (e.g., stemming illegal development, ensuring the use of proper building materials, etc.). This includes buying into the Great Green Wall Initiative and establishing a National Environmental Standards and Regulations Enforcement Agency, in addition to state environmental protection agencies.
- Strengthen the implementation of water and sanitation regulatory and management policies.
- Increase funding for research on population-development-environment linkages.

Gender

Overall, respondents believed that advocacy activities around gender had been at least partly or moderately achieved (see Figure 6); there was more consensus for moderate achievement of legislation creation and advocacy to traditional leaders relative to other activities. Similarly, respondents believed that BCC activities—including the production and dissemination of materials that promote gender equality—had been moderately achieved. Respondents were most likely to think that little progress had been made towards the implementation of various capacity-building and institutional strengthening activities, as well as M&E.

Figure 6: Perceptions on Achievement of Gender Advocacy and Social Mobilisation

*SouthSouth and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Three factors have hindered successful implementation of the policy's gender activities:

1. Continued cultural and religious resistance to gender equality and the empowerment of women and girls
2. Low or nonexistent political will, which affects levels of funding for gender equity programmes
3. Low levels of awareness on the intrinsic importance and benefits offered by women's empowerment, including positive impacts on child survival, maternal health, and the economy

Social-cultural sector

Overwhelmingly, respondents from the social-cultural sector reported partial progress for activities across all thematic strategies. Half of all respondents believed that advocacy for the domestication of international charters that address issues of social-cultural barriers on health had been partially achieved, while 59 percent believed that there had been little capacity building on the enforcement of legislation. Media campaigns to build awareness on harmful traditional practices were also perceived as lacking, as were any related M&E frameworks.

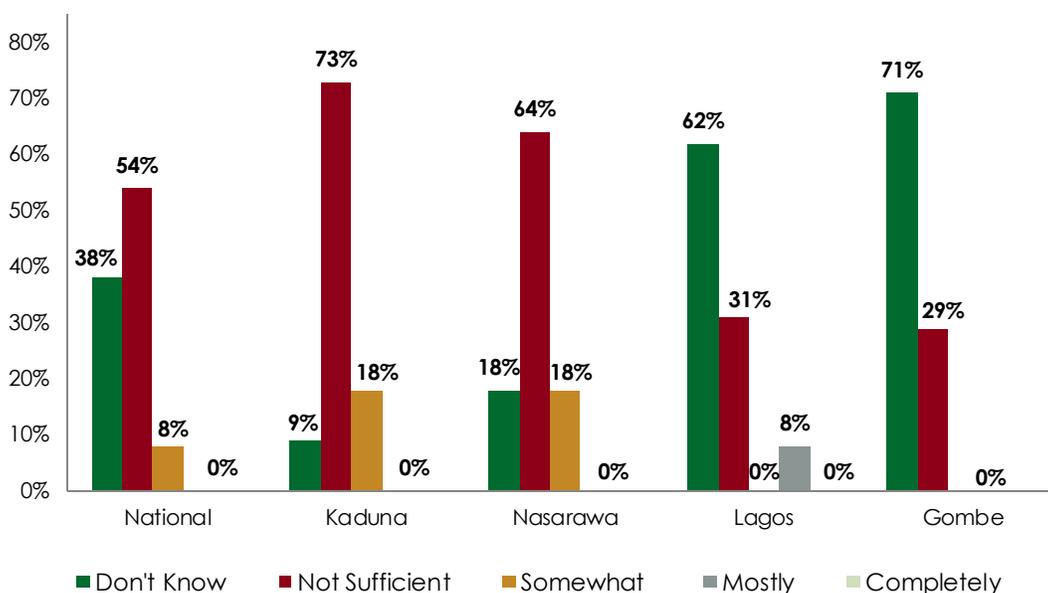
Respondents cited two key issues that negatively affect the elimination of cultural practices harmful to health and well-being, both of which require further attention: 1) lack of political will to adapt, implement, and enforce international consensus, charters, declarations, and treaties that address issues of social-cultural barriers, to include limited funding; and 2) insufficient awareness-raising campaigns to shed light on the pervasiveness and negative consequences of harmful practices.

Resource Mobilisation

Effective implementation requires planning and mobilisation of sufficient resources. Once strategies are determined and costed—like those in the NPP and the strategic plan—financial, human, and material resources required to effectively implement the policy must be mobilised.

Ultimately, the vast majority of interviewees did not know whether any mechanism was in place to ensure funding for implementing the policy. However, most cited the national government and donors as the main funders of their discrete programmatic activities. With such heavy reliance on the national government, over half of interviewees believed that the resources they receive for carrying out any activities demarcated by the policy are inadequate (see Figure 7). The most significant challenges to adequate funding include the lack of budget lines for services and delayed or nonexistent releases, causing some organisations to become donor-dependent in the absence of domestic alternatives.

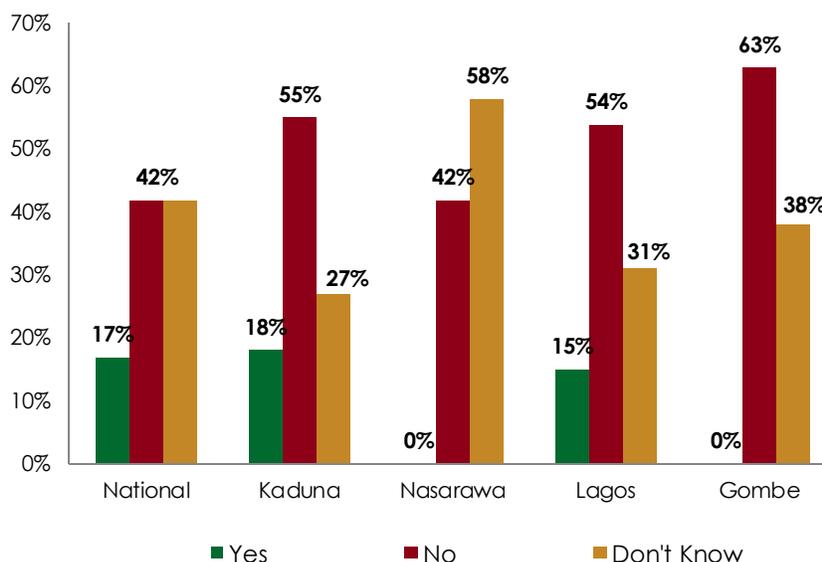
Figure 7: Ratings on the Extent to Which Resources Available Are Sufficient (n=55)



*SouthSouth and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Monitoring Progress and Results

Monitoring and evaluation is important for tracking progress towards the implementation of activities and achievement of results. Most interviewees believed NPopC to be the key institution responsible for monitoring the implementation of the policy. There was general confusion about whether interviewees' organisations were responsible for reporting on progress or accomplishments under the policy: 38 percent of interviewees did not know whether they were responsible for reporting, followed by 37 percent of interviewees who said they were not required to report. However, the vast majority of MDAs/organisations reported no feedback on how the policy has been implemented over time.

Figure 8: Extent to Which Feedback on Policy Implementation is Received (n=56)

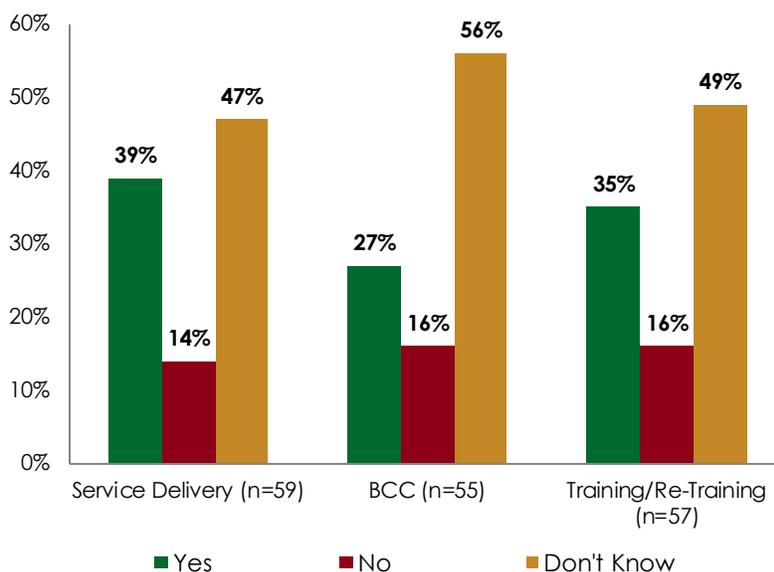
*South South and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Overall Assessment

Overall, two-thirds of interviewees thought that the NPP was only partly implemented, but little consensus existed as to whether there are observable positive changes on the ground. Forty-three percent of respondents believed that positive changes were evident, while 40 percent did not know.

When examining the components of service delivery, BCC, and training/retraining of staff/personnel, there was also little consensus as to whether there had been observable improvements (see Figure 9). The positive changes noted most frequently resulted from improved service delivery, to include higher acceptance of contraceptives, lower HIV prevalence, and improvements in school enrolment.

Figure 9: Perception on Observable Positive Changes



*South South and South East zones (Edo and Enugu) not represented due to lack of comparable data (see limitations section)

Coordination is a key pillar of the NPP and a crucial strategy for successful implementation, but the majority of respondents (46 percent, or 26/57 respondents) did not know the extent to which it was effective. Despite the strategic plan—a clear framework that defines the responsibilities of implementing agencies and requires coordination—23 percent of respondents believed that coordination was somewhat effective, while only 16 percent of respondents (9/57) found it to be mostly or very effective.

The majority of interviewees (69 percent, or 35/51 respondents) believed that some additional policy action—like the issuance of a law or operational guidelines, directives, norms, or standards—would facilitate implementation of the policy. Interviewees suggested results-oriented funding and the issuance and enforcement of clear operational guidelines at all levels.

DISCUSSION OF KEY FINDINGS

Key findings from the assessment reveal that, despite a detailed policy and implementation strategies, the NPP has not been successfully implemented. Additionally, there have been limited perceived improvements in the overall health and wellbeing of Nigerians.

The most severe challenge to implementation is the lack of awareness of—and in-depth knowledge on—the policy and strategic plan at national, state, and LGA levels. This is attributed to poor institutional memory and to weak dissemination. With little to no individual or institutional knowledge of the NPP, stakeholders are limited in their ability to evaluate the extent of implementation (leading to, for example, the preponderance of “don’t know” responses using the core questionnaire). This dearth of knowledge among implementers has a direct bearing on the execution (or lack thereof) of assigned activities. Limited stakeholder involvement in policy formulation and dissemination also represents a missed opportunity to generate buy-in and political will among policymakers, implementers, religious/traditional leaders, and even citizens—a necessary step in Nigeria given the prevalence of harmful cultural practices and entrenched gender norms at all levels.

Another challenge to implementation is the lack of leadership at the highest levels. Despite leadership roles and responsibilities being clearly defined in the policy and strategic plan, only half of the implementers interviewed had ever heard of the NCPM, the PAG, and the PTWG, implying a lack of strategic guidance and coordination over the policy timeframe. Moreover, the vast majority of respondents never received feedback on policy implementation, information that should have been provided by each MDA/implementer, and then analysed and disseminated by NPopC.

Respondents overwhelmingly believed there was insufficient public sector funding for carrying out NPP activities. Across health, education, population planning and statistics, environment, gender, and social-cultural barriers, the majority of respondents cited funding shortfalls due to delayed or nonexistent releases as the biggest impediment to the implementation of activities. In part, this was attributed to low political will for population activities overall. Importantly, even NPopC—charged with the mandate of population management—has inadequate domestic resources for key population activities, like carrying out the census. On the client end, poverty (financial barriers) and the lack of universal healthcare limit access to services.

Pervasive cultural practices and gender norms such as son preference and early marriage continue to propagate a system in which women suffer discrimination in all spheres of life, creating a poor enabling environment for the policy. These factors drive lifetime childbearing and discourage the uptake of contraceptives, fuelling unintended pregnancies, high-risk births, and (ultimately) maternal, infant, and child mortality—all counter to the goals and tenets of the NPP.

Respondents also observed low capacity for providing high-quality services and administering family life education programmes. Low capacity in advocacy, as reported by respondents, was seen as a barrier to building political will among policymakers, and contributes to the dearth of resources across sectors. It also represents a missed opportunity for generating buy-in for the policy and supporting programmes among traditional/religious leaders, who could serve as key influencers and community mobilisers. Finally, respondents across all sectors cited capacity gaps in the area of monitoring and evaluation, revealing that structures do not exist for review, reporting, and revision as they relate to policies and programmes.

RECOMMENDATIONS

Based on the review of key findings, the following core recommendations should guide the revision of Nigeria's population policy:

1. **Revise the NPP with a focus on broad multisectoral stakeholder engagement in the formulation stage.**

Broad stakeholder engagement during the policy formulation process is crucial for generating buy-in, ownership, and institutional memory—components lacking under the NPP. The forthcoming policy revision should therefore be based on broad stakeholder consultations at national and state levels, and should include all MDAs, parastatals, mobilisers/influencers (e.g., traditional and religious leaders), and beneficiaries.

2. **Revise content for maximum relevance to existing and emerging issues in Nigeria, national development priorities, and international development frameworks.**

- a) The forthcoming policy should be revised to include the following key issues, as identified by respondents: conflict-/insecurity-induced migration and displacement; access to education for girls and vulnerable groups; desertification, gully erosion and flooding, and the regulation of infrastructure development; the importance of collecting vital statistics; the needs of the elderly; education, care, and work opportunities for out-of-school youth/adolescents; emergency and disaster response; and newborn health.
- b) To drive implementation, policy targets should be relevant and measurable at both national and state levels. End-year dates should be uniform across all targets.
- c) The forthcoming policy should identify indicators in order to monitor and evaluate progress towards each target, based on available data/metrics at national and state levels.
- d) Due to a weak enabling environment across Nigeria, a policy revision should retain a strong focus on ameliorating factors that deter implementation, including entrenched gender norms, son preference, and early marriage.
- e) Ensure alignment/harmonisation with other national development policies and international development frameworks, such as the forthcoming Sustainable Development Goals. Aligned policies are stronger than those that stand alone. With improved harmonisation, there is decreased risk of drastic shifts in priorities and funding levels with changes in administration, and more accountability imposed by international standards and practices.
- f) To motivate programmatic action, issue relevant operational guidelines, directives, norms, or standards concurrently with the policy.
- g) Establish a motivating yet realistic timeframe for the achievement of goals.

3. **Create and implement a nationwide policy dissemination strategy.**

- a) Distribute the policy (e.g., hard and electronic copy dissemination) to *all* MDAs and designated implementers at national, state, *and* LGA levels. Per the feedback of respondents, it is critical that implementers are sensitised on the content of the policy, particularly on their roles and responsibilities. Suggested mechanisms include state-level dissemination meetings and forums, during which the policy can be presented and discussed in depth.
- b) Distribute the policy after each election cycle, and sensitise new government officials about the policy's content and roles and responsibilities.

- c) Policy dissemination should also reach institutions of higher learning to promote continued research on demography and development, as well as integration of the policy into curricula.
 - d) Influencers, including traditional, religious, and other local community leaders (including prominent grassroots CSOs), should be included as dissemination targets. These individuals are a gateway to social mobilisation and community behaviour change.
 - e) As part of the dissemination strategy, the government should launch an awareness-raising campaign—including channels/mediums such as radio jingles in native languages, social media campaigns, town hall meetings/forums, and town criers—to reach intended beneficiaries and others with the policy's key messages. This is critical for combatting entrenched norms while broadening ownership and accountability.
 - f) Train a cadre of policy content experts, housed at the state level, to facilitate engagement with implementers on an ongoing basis.
- 4. Tackle gaps in capacity.**
- a) Beyond the dissemination process, provide targeted training to implementers on the concepts and content of a revised policy, as well as basic population and development issues.
 - b) Provide training to implementers on best practices in social mobilisation in family life education and population-development-environment linkages.
 - c) Train implementers on advocacy to higher levels of government for generating policy support and increased funding (e.g., budget advocacy).
 - d) Train implementers on M&E, to include review of dated policies and evaluation of existing programmes.
 - e) Train and retrain health providers in high-quality service provision across health sub-sectors, ensuring access for rural and vulnerable populations.
- 5. Address coordination challenges and strengthen leadership for policy implementation.**
- a) A revised policy should include clear leadership designations. One factor to consider may be consolidation of responsibilities under fewer head agencies/bodies.
 - b) Sensitise key government officials at the highest levels on demography and development to build buy-in for the policy and engender leadership (e.g., regular meetings of the NCPM).
 - c) Empower NPopC to execute its population management mandate by providing more domestic resources to fulfil designated responsibilities.
 - d) Intended beneficiaries should be empowered with knowledge on implementer roles and responsibilities (e.g., through the dissemination process) to hold agencies to account.
- 6. Increase available domestic resources for policy implementation.**
- a) Advocate to the federal and state governments to increase resources available for intended public sector implementers, including MDAs, to facilitate meetings for information sharing, coordination, and the execution of activities. Continuous and sustainable funding of implementers is crucial for overcoming resource constraints, generating buy-in, and building institutional memory.
 - b) Advocate to state governments and LGAs to increase resources available for health, education, environment, gender, and all other sectors of a revised policy. This could include advocating for 1) budget lines and releases; 2) buy-in for the Community Based Social Health Insurance Scheme and other National Health Insurance Scheme programmes; and 3) leveraging new resources emerging from the National Health Act.

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- c) Build the capacity of local stakeholders to monitor national, state, and LGA budgets, and track government expenditures to ensure adherence to commitments.

ANNEX A: TRENDS IN NPP INDICATORS

	National		South South		South East		South West		North West		North East		North Central	
	2003	2014	2003	2014	2003	2014	2003	2014	2003	2014	2003	2014	2003	2014
Reduce national population growth rate to 2 percent or lower by 2015 ^a	3.2	3.2												
Reduce TFR by at least .6 children every 5 years ^b	5.7	5.5	4.6	4.3	4.1	4.7	4.1	4.6	6.7	6.7	7	6.3	5.7	5.3
Increase mCPR by at least 2 percentage points per year ^b	8.2	9.8	13.8	16.4	13	11	23.1	24.9	3.3	3.6	3	2.7	10.3	12.4
Reduce the infant mortality rate to 35 per 1,000 live births by 2015 ^b	100	69	120	58	66	82	69	61	114	89	125	77	103	66
Reduce the child mortality rate to 45 per 1,000 live births by 2015 ^b	112	64	63	35	40	54	47	31	176	105	154	90	70	36
Reduce MMR to 125 per 100,000 live births by 2010 and 75 by 2015	740 ^c	576 ^b												
Achieve 25 percent reduction in HIV adult prevalence every five years ^c	5	3	5.8	5.5	4.2	1.8	2.3	2.8	2.7	3.2	5.8	3.5	7	3.4
Eliminate gap between men and women in school enrolment by 2015 ^{b,1}														
Gender Parity Index (Secondary) ²	0.77	0.86	1	0.93	1.11	0.99	0.85	1.03	0.36	0.63	0.55	0.66	0.61	0.90
Eliminate illiteracy by 2020 (literacy rate among those not having completed primary education) ^b														
Female	48.2	53.1	75	81	85.6	84.2	79.1	82	20.9	25.8	25.6	28.3	43.4	54.3
Male	72.5	75.2	80.5	93.1	92.9	91.2	93	88.8	55.7	62.2	59.9	51	75.2	82.3
Achieve sustainable universal basic education prior to the year 2015 (net attendance ratio) ^b														
Primary	60.1	59.1	82.2	74.9	80.2	81.4	82.8	70	41.7	47.2	44.4	44.2	70.2	68

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Secondary	35.1	48.8	51.5	65.4	48.5	69.6	61	68.1	14.7	32.5	19.1	28.5	37.7	54.5
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Sources:

Note: 2015 goal values for TFR and mCPR computed based on desired level of improvement/decline stated in targets.

^a NPopC, 2009

^b NPopC and ORC Macro, 2004 and NPopC and ICF International, 2014

^c Federal Ministry of Health, 2013

^c WHO, UNFPA, The World Bank, and the United Nations Population Division (2005 estimate for maternal mortality ratio)

* Refers to 2020 target

¹ Secondary, tertiary, vocational & technical education and training

² Score of 1 indicates parity between the sexes. A score between 0 and 1 indicates disparity in favour of males

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