VIEWPOINT

Why Not Use Nigeria’s Agricultural Extension System to Increase Access to Family Planning?

By Folarin Olowu

The development literature is full of controversies on the best methods for achieving many desired objectives, but one of the longest-running debates concerns vertical programs versus horizontal (integrated) programs, especially in the health sector. By the 1970s, development planning focused not only on economic growth, but also on equity and intersectoral linkages. Early attempts at integrated rural projects generally failed, though, because these efforts were too ambitious and complex, were not locally rooted and were therefore not supported by local institutions. In addition, benefits often did not flow to the poorest farmers, or the efforts often were not sustainable.

This was unfortunate, given the clear need for integrated projects of community development. One seminal work reported that “the leaders of the community were asked to state in order of their priorities what they considered their health needs. [They responded]: Hospitals, water, good roads, latrines, improved farming, schools and transport.” One participant in a 1973 symposium commented that “people asked for medicine to cure their pain, sanitation for their environment, food for those who are badly fed, education for their dysfunctional or incapacitating ignorance, and mobility to give them progress—no less than a comprehensive life program.”

Since then, integrated rural development projects have sought to address the many needs of local populations—such as water, agriculture, education, nutrition, employment and health. In these settings, extension workers are often generalists in orientation, and may even serve as multipurpose development workers. Agricultural projects in particular have successfully incorporated poverty and gender concerns (besides other sectoral concerns, such as health) into their design and implementation.

In Nigeria, agriculture has worked in the interests of health care and in alliance with health care delivery in its broadest sense since colonial times. Early agricultural projects, such as the home gardening projects conducted in the Western Region, focused on improving health and nutritional status. This has been true in other countries as well: In the Philippines, farmers are used as family planning motivators, and the status of these farmer-motivators has been further increased by mass media information, education and communication campaigns.

These examples suggest that farming communities in developing countries accept receiving linked agricultural and health messages from the same source. Policymakers and agriculture specialists’ misapprehensions that rural populations are too traditional, fatalistic and conservative have often excluded farming communities from mainstream development efforts, yet such communities often hold the key to success of national development efforts in health or in agriculture. Means need to be found to bring members of the rural sector into the mainstream of development.

In particular, innovative strategies are needed if the objectives of Nigeria’s national population policy are to be achieved. The major problems are the rural-urban disparity in population size and growth rates, as well as in access to modern family planning services. About 70% of Nigeria’s people live in rural areas, and agriculture is the major occupation, accounting for 60% of employed Nigerians. The total fertility rate is also higher in rural areas, so there are many more rural births than there are urban births.

Since contraceptive prevalence will not rise appreciably in Nigeria until family planning services are extended throughout the rural sector, a strong and innovative effort must be made to achieve this. Launching such an effort will be a challenge for researchers and policymakers in Nigeria. Nigerians in Delta State and Rivers State, the riverine areas of the country, and those in the rocky and hilly areas of Plateau, Ondo and Kogi states, where the bulk of the rural population resides, find access to health and family planning services difficult. Because of the terrain, they are an underserved and hard-to-reach target group for family planning. Access problems are compounded by the high cost of providing health services, as well as by manpower shortages.

The challenge, then, is to extend family planning services in rural areas such as Delta State and Plateau State. What is needed is an appropriate but cost-effective method of raising family planning awareness and distributing contraceptive commodities in these areas.

Proposal for Integration

The International Planned Parenthood Federation has been involved in the integration of health and social services since about 1974, when its management and planning committee urged family planning agencies to integrate family planning with rural development, food and nutrition, and education and training programs, in whatever mix best served the needs of their particular country or community.

It was 20 years ago that a World Bank review and a United Nations Population Fund (UNFPA) mission both focused on Kenya, recommended that extension agents from other sectors, such as agriculture, cooperative development, social services and labor, be trained to carry and integrate family planning messages, however they were appropriate and relevant to their extension work. The State of the World Population 1994 observes that “the
integration of family planning into other services both in the health and broader community and development sectors is known to enhance the choices of women and their families.16

Nigeria has a well-developed agriculture extension system. It operates as part of the agricultural development projects—state departments of agricultural extension that were excised from the Ministry of Agriculture and set up as separate organizations under a project supported by The World Bank. Each Nigerian state has one, and today they represent the most effective and far-reaching rural extension system in Nigeria. Unlike the health extension system, the agricultural extension system has agents in all rural areas of the country. Thus, wider coverage of family planning services might be achieved by means of this system, using agricultural extension agents.

The many similarities between the functions of agricultural extension workers and those of the community health extension workers employed by the ministry of health should aid integration. Both are low-cost personnel working at the grassroots level. Moreover, agriculture students, graduates and extension agents already have a background in the biological, life and health sciences, training that is very suitable for family planning motivation through information, education and communication.

Furthermore, the linkages between health and agriculture in Nigeria are well-recognized and institutionalized. For example, at the local government level in the primary health care system, agricultural extension workers sit on the village and district primary health care development committees, and members from the agricultural sector are also in the state and zonal primary health care committee.17

In addition, in the course of their professional training, agricultural extension agents have been imbued with the tenets of community mobilization and participation. Agricultural extension activity involves the continuous introduction of new technology, with accompanying behavior and social changes. This same attitudinal change plays a role in family planning acceptance. Moreover, agricultural technology is spread by outreach and extension, just like contraceptive technology.

Thus, it might be feasible to integrate health and agricultural projects and services in Nigeria, by using agricultural extension agents for family planning motivation, outreach and commodities distribution. Under the training and visitation system of agriculture extension,18 extension agents receive regular training on seasonally relevant topics and then go to villages on a strict schedule to advise groups of farmers on the agricultural techniques the agents mastered in the training period. Such a system of training and scheduled visiting is ideal for the community-based distribution of contraceptives.19

It is not new to have extension agents represent multisectoral interests and carry such messages. The Food and Agriculture Organization and the UNFPA have been assisting a similar project in Yemen since 1993. Also, in some settings, the integration of family planning services has been accomplished under a multisectoral strategy where family planning has been added to social and development programs.20 Yet no such approach has been attempted in Nigeria.

How Might It Be Accomplished?

A Test Project

Although improved communication and increased services to the rural community are important, these goals must be accomplished in a cost-effective manner. How this is to be done constitutes a challenge in terms of manpower mix, as well as institutional and intersectoral collaboration between health and agriculture. It also raises a number of questions: What levels of agricultural staff will initiate the extension agents into family planning activities, carry out their training, monitoring and supervision, and sustain the program? What types of extension agents will prove most appropriate and effective?

I propose the establishment of a project to test whether family planning information, motivation and service provision can be integrated into the work of agricultural extension agents. The project could be executed in selected communities in two local government areas of Delta State—Ndokwa East and Burutu—and two such areas of Plateau State—Bassa and Pankshin. (Communities would have to agree to participate in the project before it was instituted; where possible, they would be encouraged to provide lower-level paraprofessionals.) Such a project would be expected to attain the following objectives:

• Demonstrate that the above aims could be achieved in a cost-effective and sustainable manner.
• Show that family planning outreach can be introduced effectively into the curriculum of agriculture undergraduates in the faculty of agriculture at Delta State University, Anwai Campus, and at the Federal University of Agriculture in Makurdi.

• Assess the most cost-effective manpower mix for agriculture extension workers.
• Assess the effectiveness of female agriculture extension workers for both agricultural and health work.
• Show that more efficient agricultural extension and health services can increase the productivity of rural farmers.
• Establish centers for health and agricultural linkages at Delta State University and the Federal University of Agriculture as specialized research centers to propagate this type of research and collaboration.

Collaboration and Evaluation

Not only is such a project technically, institutionally and socioeconomically viable, a rare opportunity presents itself in Delta and Plateau States to launch just this sort of innovative project. The institutions that would collaborate in this effort share a unique degree of institutional and personal rapport and collaboration. The project would also benefit from ongoing UNFPA-assisted reproductive health and family planning programs that can provide it with training in family life education and furnish contraceptive commodities and technical and support staff.

The project could be executed by the maternal and child health and family planning units of the ministries of health in Delta and Plateau states, which would provide training in family planning information, education and communication and in commodities distribution for extension agents. The Delta and Plateau states agricultural development projects, along with the faculties of agriculture at Delta State University and the Federal University of Agriculture and the national youth service programs in those states, would supply extension agents and other levels of professional and paraprofessional personnel needed to achieve the project’s objectives.

If 50% of the project’s extension agents were female, the gender sensitivity of the program could be tested, by comparing male and female extension agents’ output and their effectiveness in meeting the needs of women farmers in these rural communities.

The latter is of particular importance, given that women farmers do not benefit as much as men from agricultural extension services. Women often lack access to such programs; for example, a 1992 study examining the readiness of rural female cassava farmers in Ondo State, Nigeria, to participate in extension education showed that they preferred extension courses to be scheduled in the evening,21 but that most occurred during the day. Thus, agricultural
extension agents’ awareness of the needs of women farmers must be increased.

The project described here will shed light on manpower problems and issues like appropriate manpower mixes, the characteristics of extension agents and the effects of their training, motivation and sex on their work in the agricultural and health sectors. It may also show the need for village-level paraprofessional extension agents.

The results from the project would be evaluated to determine how different levels of agricultural extension agents can best combine their agriculture and family planning work, and how well they achieve specific agricultural and family planning targets. A cost-effectiveness study of the different manpower types used in the project might be done using an appropriate statistical technique. The financial and cost data needed for this could easily be obtained from the project itself and from the agricultural development projects.

Possible Constraints

One of the main concerns about using agricultural extension agents is the potential for abuse of contraceptive technology. This problem is likely to be minimal, though, since extension agents already handle drugs and vaccines in their agricultural work, and share many of the same values and ethical concerns as workers in the family planning field.

The national agricultural establishment might refuse to join such a collaborative project, out of fear that agricultural extension work might be diluted or from concern about the sensitivity of delivering family planning–related messages. Or members of the health sector might argue that resources to be used in training agricultural extension workers to do family planning outreach could be better spent strengthening the health extension system.

In addition, the agricultural extension system itself is currently donor-dependent, and so its long-term sustainability is uncertain. The ability and the commitment of the Nigerian government to continue with such projects after World Bank disengagement is by no means certain.

Conclusion

The UNFPA (in its Programme Review and Strategy Development Report for Nigeria in 1991) and an International Fund for Agricultural Development mission to riverine areas of Nigeria support the kind of health-agriculture linkage proposed here. Moreover, the latter organization (a United Nations–linked fund supported largely by the Organization of Petroleum-Exporting Countries) recommended that in riverine areas, family planning activities could easily be combined with the development of small-scale fisheries, farming and social development activities.

Nigeria’s focus is on slowing its population growth rate, reducing its current high rates of maternal and infant mortality and improving the health and quality of life of its population—particularly its women and children. The provision of comprehensive family planning services is a major strategy for achieving the aims of the national population policy.

Using agricultural extension agents would help expand reproductive care choices and would represent an innovative intersectoral strategy for Nigeria. A pilot project to determine the most effective method of using different combinations of agriculture extension agents to promote the use of family planning services is most justifiable and overdue.

References

22. M. Berger, V. Delancey and A. Mellencam, 1994, op. cit. (see reference 5).