Population Policy as a Lens to the Drivers of Reproductive Health Outcomes in Africa:
The Cases of Malawi, Nigeria, and Senegal[1]

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Abstract During the 1980s and 1990s, two thirds of sub-Saharan African countries adopted population policies designed to limit population growth (Sullivan 2007). Compared to countries that did not adopt such policies, countries that adopted population policies experienced greater declines in fertility, and received more bilateral funding for population activities (Barrett and Tsui 1999). Analysis of the determinants of, and reactions to, population policies illuminates two *additional* drivers of reproductive health outcomes: 1) a country's relationship with the international community, and 2) a country's relationship with its citizens. To illustrate these drivers, and based on an analysis of 120 interviews with population and reproductive health experts in each country, I present the cases of three countries in sub-Saharan Africa with very different experiences of population policy: Malawi, Nigeria, and Senegal.

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[1] This article is part of a larger book project that examines the relationship between population interventions and HIV/AIDS interventions in sub-Saharan Africa.

INTRODUCTION

During the 1980s and 1990s, two thirds of sub-Saharan African countries adopted national

population policies designed to reduce population growth (Sullivan 2007). These policies

matter for a number of practical reasons, but they also shed light on processes related to

reproductive health more broadly. In terms of the practical reasons, first, countries that

adopted population policies received, on average, more funding from the United States Agency

for International Development (USAID) (Barrett and Tsui 1999). Second, countries with

population policies experienced statistically greater fertility declines between 1987 and 2002

than those without such policies: 21% compared to 14% (author's calculations from World Bank

(2009)). Third, countries with population policies have a greater potential to improve gender

and human rights because the policies motivate discussion of sex, generation and power, and

provide language to groups promoting such rights (Robinson 2009). In addition to these

practical reasons for why population policy matters, in this paper, I argue that population policy

can be used as an analytical tool for understanding broader outcomes related to reproductive

health. To do so, I use interview data and secondary literature from Malawi, Nigeria, and

Senegal.

Specifically, I show that analysis of the determinants of, implementation of, and

reactions to, population policies illuminates two additional drivers of reproductive health

outcomes: 1) a country's relationship with the international community, and 2) a country's

relationship with its citizens. Table 1 shows how the different aspects of the population policy

process (adoption and popular response) each illuminate a driver (relationship with

international community and relationship with citizens) of reproductive health. The cells of the

table provide adjectives describing the nature of the driver within each country, which ultimately impacts the success of reproductive health interventions.

Table 1. Population Policy as a Lens on Drivers of Reproductive Health Outcomes

Population Policy Process →	Adoption	Popular Response
Driver →	Relationship with international community	Relationship with citizens
Malawi	Suspicious	Negative
Nigeria	Contentious	Negative
Senegal	Open	Neutral

Briefly, a country's relationship with the international community matters for reproductive health outcomes because the vast majority of reproductive health services provided in sub-Saharan African countries are funded by international donors. Building good relationships, which includes both the ability to get funding, but also to negotiate with donors about the various policies and programs they prescribe, is crucial to the successful provision of reproductive health care. Characteristics of the relationship with the international community then frequently carry over to the approach taken by the country to the overall intervention, which impacts the success of those interventions. A country's relationship with its citizens also matters for reproductive health outcomes because it determines the popular response to them. Sensitive policies and programs, like those related to reproductive health, will be much more feasible in a country where the government has a neutral or positive relationship with its citizens.

DATA

The primary data for the analysis comes from semi-structured interviews I conducted in the three countries in 2006, 2009, and 2010. I conducted these interviews with individuals from federal ministries, national and local nongovernmental organizations (NGOs), and donor

organizations involved in providing reproductive health and helping to curb the spread of HIV. The goal of these interviews was to elicit local descriptions of governmental and organizational activities in the realms of population, reproductive health, and HIV/AIDS. Almost all respondents were natives of the country in question, and were evenly distributed across the main organization types (government, local NGO, and donor). I conducted 26 interviews with family planning experts in Nigeria and Senegal in 2006, an additional 34 interviews with both family planning and HIV/AIDS experts in Malawi in 2009, and then 59 interviews with HIV/AIDS experts in Nigeria and Senegal in 2010.

To identify respondents, I used snowball sampling techniques, starting with connections from previous fieldwork in Senegal and Nigeria, and from contacts made through NGOs in Malawi. Each interview lasted 45-60 minutes, almost all were conducted at the respondent's place of work, and those in Senegal were conducted in French. Respondents answered the following types of questions:

- What activities does your organization pursue in the realm of family planning and/or HIV, and how have these activities changed over time?
- What are the major challenges to providing services related to family planning and HIV in your country? What have been the major successes?
- What efforts has the government put towards family planning and HIV, and what factors have influenced its commitment or refusal to participate?
- What role have donors played in family planning and HIV interventions?
- What resistance and support has there been from social and religious groups for family planning and HIV interventions?

Interviews were transcribed, and then coded using QDAMiner, a type of qualitative data analysis software.[2]

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[2] This is research in progress, so that only part of the analysis below currently includes quotes from interviews.

COUNTRY'S RELATIONSHIP WITH THE INTERNATIONAL COMMUNITY

The relationships of the three countries with the international community have varied quite greatly. Malawi can be described as having a suspicious relationship, Nigeria a contentious relationship, and Senegal a very open relationship. I describe each of these in turn below with reference to the process of population policy adoption, which brings a country's relationship with international actors into high relief. In other research (Sullivan 2007), I have shown that countries in sub-Saharan Africa adopted population policies for a combination of external and internal reasons. The external reasons relate to relationships with the international community, which provided the impetus to adopt population policies in two forms. The first form was direct pressure from organizations like the World Bank and USAID (Hartmann 1995; Liagin 1996), while the second form was more indirect, in the form of normative pressure to show support for reproductive rights following the 1994 International Conference on Population and Development. The internal reasons relate to the political, social, and cultural characteristics of countries. The countries in sub-Saharan Africa can be thought of as having adopted population policies in two waves: one before the 1994 Cairo Conference, and a second following the conference (Sullivan 2007)[3]. Malawi adopted its population policy at the beginning of the second wave in 1994, while Nigeria and Senegal were vanguards and among the first three African countries to adopt population policies in 1988.

Malawi - Suspicious

Malawi did not adopt a policy until the second wave, in 1994, largely because President-for-Life, Hastings Kamuzu Banda (1964-94), did not see population growth as a problem. Despite

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[3] There were two early adopters of population policy—Kenya in 1967, and Ghana in 1969—that I treat as special cases and exclude from the analysis.

having been trained as a doctor in the US, he went so far as to ban family planning in the 1960s

(Chimbiri 2007; Chimbwete, Watkins and Zulu 2005). Banda exercised a form of authoritarian

rule that emphasized cultural nationalism, particularly respect for hierarchy and authority

(Forster 1994). As a result, he found Western "permissiveness" threatening, and had a very

narrow view of the role of women (Forster 1994). Although he acknowledged the need to

improve women's status, and took concrete steps to promote education and employment for

women, in his worldview they were always subordinate to the male guardians of the family

(Forster 1994; Forster 2001). Given Banda's perspective on both the proper hierarchy of the

family and a negative reaction to all things Western (including slacks on women), it is thus not

surprising that he was against family planning as it threatened both perspectives: it gave

reproductive authority to women, and came almost exclusively from the West.

As donor interest in family planning increased in the 1980s, the Malawian government

remained unwilling to fully endorse family planning, and so implemented a policy in 1982 with a

goal to increase the number of years between births, a so-called "child-spacing" program

(Chimbwete, Watkins and Zulu 2005). Emboldened by the economic downturn that provided

justification for slowing population growth, the international population community continued

to push for a more explicit population policy. In the late 1980s, a National Population Steering

Committee was formed and various meetings and seminars on the topic of population began to

be held (Cohen 2000). In 1992, a number of barriers to access to family planning were

removed, including particularly steep criteria for the use of Depo-Provera: marriage and four

children (Solo, Jacobstein and Malema 2005). Finally, in 1993, a draft population policy was

adopted at the Principal Secretaries Symposium, one month before the referendum on

multiparty elections (Chimbwete, Watkins and Zulu 2005). It was not, however, until Banda left office and a new president, Muluzi, was elected in 1994 that the government formally adopted the national population policy (Chimbwete, Watkins and Zulu 2005).

In President Muluzi's first address to parliament, he mentioned the importance of family planning to development objectives, and in 1995 the budget had a line item for family planning for the first time (Chimbwete, Watkins and Zulu 2005). The adoption of the population policy is best understood as the result of a change in leadership to one desiring to signal to the international community that Malawi had changed and was ready to engage (Chimbwete, Watkins and Zulu 2005).

Nigeria - Contentious

Nigeria adopted a population policy in 1988, in the midst of a period of military rule, economic downturn, and rapid population growth. The World Bank was particularly interested in Nigeria adopting a population policy (Sai and Chester 1990), and at the same time was engaged in negotiations with Nigeria over a relatively unpopular structural adjustment policy. This concurrence of events raises the possibility that General Babangida, the head of state, used the policy as a ploy to keep donors happy. Although there is no direct evidence that he did so, Babangida was well known as a shrewd and savvy politician (Diamond, Kirk-Greene and Oyediran 1997; Forrest 1995; Wright 1998). Nicknamed "Maradona" after the deft Argentinean soccer player (Smith 2007; Wright 1998), he was adroit at pleasing western donors while not overly angering Nigerians (Smith 2007). In particular, he managed negotiations with both the International Monetary Fund and the public about the publically-unpopular, yet potentially lucrative, structural adjustment program in such a way that the 1986 budget looked like it

contained a homemade structural adjustment program, the public felt that it had been consulted, and all parties were left satisfied (Biersteker and Lewis 1997; Dibua 2006; Forrest 1995; Smith 2007). The extent to which he put these skills to use relative to the population policy is unknown, but Babangida's overall shrewdness supports other evidence that the Nigerian government co-opted the population policy to suit its own ends (Sullivan 2007).

The particulars of the population policy, specifically the "ideal" number of children that it put forth, were also a source of contention with the international community (Smith 2003). The external organizations promoting the policy would have undoubtedly preferred a number close to the two children per woman that are required to stabilize population growth. The population policy, however, ultimately came to be seen as a "four-child" per woman policy, in reference to its goal of increasing the percentage of women having just four children. One respondent reported that a journalist dubbed the policy a "four-child" policy, thus making it analogous (in negative ways) to China's one-child policy, while another said that the number four had been chosen because Mrs. Babangida had four children. Other evidence suggests that Babangida himself spoke of "four children is enough" (Caldwell, Orubuloye and Caldwell 1992; Renne 1996). Regardless of the reason why the policy was framed in terms of four children, the number served as a point of contention with donors.

Senegal – Open

Senegal also adopted a population policy in 1988, but without the contention associated with the Nigerian population policy. This lack of contention was mainly the result of Senegal's openness to the international community. Senegal's generally cosmopolitan and outward-oriented perspective can be seen as the result of Dakar's position as a global city and the

former capital of French West Africa. The openness to population policy was also facilitated by the presence of well-respected technocratic specialists.

One of the key specialists involved in the policy's production was Landing Savané, a long-time opposition politician in Senegal as well as a demographer who published *Population: Un Point de Vue Africain* in 1988. As one respondent put it,

> "What's important to me is that the position of the government is prepared by the professoriate. These professionals are demographers, men of science, perfectly aware that you can't deny questions of the impact of elevated demographic growth on development. I think that Senegal played an important role at the beginning of the formulation of population policy [through] the role [of] demographers, like Landing Savané . . . These are the first demographers who played a very important role in the formulation and documentation of the position of the Senegalese government." (Senegal Interview #41)

In addition to Savané, two other academics played an important role in the policy's creation, Abdoulaye Bara Diop, a professor of sociology at the Université Cheikh Anta Diop, and Malick Sow, an economist. Along with Savané, they served as consultants for the population policy. While it is not surprising that the population policy would involve consultants, the fact that respondents explicitly noted the role of science in informing policy, as well as remembered exactly who was involved twenty years later, is indicative of the import placed on scientific knowledge informing government action, and thus a general openness to outside ideas.

RELATIONSHIP WITH CITIZENS

Malawi

Following years of semi-autocratic rule, the Malawian government did not have a good relationship with its citizens around the time of population policy adoption. Moreover, as described above, family planning was seen as a western effort to reduce the size of the Malawian population. Specifically, Malawians interpreted family planning as the combined

efforts of donors and the government to reduce the size of the population of a country that was

constantly in need international aid and emergency support (Kaler 2004). These two factors

combined to create an atmosphere that significantly reduced the likelihood that government

policies or programs could positively impact reproductive health outcomes.

Nigeria

There was a strong negative reaction to the population policy in Nigeria, largely due to the

particular politics of population in Nigeria which interfere with the relationship between

government and citizens. Population is political at both the group and individual levels in

Nigeria. In other words, the size and characteristics of different subgroups, defined by religion,

ethnicity, region, and family have deep political significance because they serve as sources of

identity and resources. As a result, there is competition between regions, individual ethnic

groups, and even states, and much of this competition is framed in terms of whose group is

largest, as large groups are entitled to more resources. At the group level, the rough alignment

between Muslims, the northern region, and military power has been pitted against the similarly

rough alignment between Christians, the southern region, and oil resources (Gordon 2003; Yin

2007). The central government redistributes resources to states based on relative population

size and interunit equality,[4] and although the relative importance of population size in this

equation has declined over time, it has remained a key determinant of revenue distribution

(Suberu 2001). As a result of these distributive rules, and the potential for the creation of a

new state if a minority group becomes large enough, sub-regions and ethnic groups have been

motivated to be, or appear, as large as possible (Gordon 2003; Suberu 2001).

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[4] The level of social development also began to play a role in redistribution algorithms in 1981, and the size and terrain of states were incorporated into these algorithms in 1990 (Suberu 2001).

Individual-level politics of population also exist in Nigeria. Access to resources in Nigeria's political economy depends on patron-client ties, and having more children produces more ties, increasing the odds that some will be beneficial (Pearce 1995; Smith 2004). Having people becomes even more critical in times of political and economic uncertainty (Renne 2003). The importance of "wealth in people" observed in Nigeria is common across African societies and creates powerful incentives for high fertility (cf. the discussion of this topic in Johnson-Hanks (2006)). Indeed, at the time of the policy, the total fertility rate in Nigeria was 6.0 children per woman, and the desired total fertility rate was only slightly less (Federal Office of Statistics and Macro International 1992). The high levels of desired and actual fertility also resulted from economic insecurity, high infant mortality, and the generally low status of women (Dixon-Mueller and Germain 1994; Pearce 1995).

As a result of both group- and individual-level politics of population, the population policy's efforts to *reduce* numbers of people were met with resistance. Specifically, much of the negative reaction to the policy at the time of its passage, as well as respondents' discussion of it, was framed around the issue of four children per woman.   Women's groups did support some parts of the policy, such as its stated commitment to voluntary access to family planning as well as to improving infant and child mortality and the status of women. Nonetheless, women's groups also argued that the policy was discriminatory because fertility goals were expressed *per woman* (rather than per family) and because it enforced patriarchy (Dixon-Mueller 1993; Dixon-Mueller and Germain 1994; Osuide 1988). Christian religious leaders felt that the policy was unfair to Christians and non-polygynous families because it implied that a Muslim man, who could have up to four wives, could also have up to 16 children, whereas a

Christian man could only have four children total. Others objected to the policy because it endorsed contraception and planned fertility in general, and Muslim groups in particular were disappointed that the policy proposed that population and family life education take place outside of the home, a responsibility they felt lay primarily within the family (Dixon-Mueller 1993; Dixon-Mueller and Germain 1994; Osuide 1988).

The particular politics of population in Nigeria thus intervened in the relationship between citizens and state, and complicated the ability of the government to promote behavior change related to reproductive health.

Senegal

There was not much of a response, either positive or negative, to population policy in Senegal. This lack of response seems to have been the result of the planners' message not lining up with the population's desires, but without offending (as in the case of Malawi or Nigeria). Respondents were aware of the disjuncture between the population's desires and those of programmers.

> "Family planning isn't the key issue to people – you can't start with it. Women are preoccupied with things other than family planning." (Senegal Interview #10)

> "When people are dying and you say you have to limit population, it doesn't make sense. The discourse used by programs has not been so good: "You need to have fewer kids so that you can pay for school.' It's much better to tell people that not using family planning will lead to death. Or to use 'child spacing' – it's known already, people understand, and don't have a problem with it. The socioeconomic motivation for family planning didn't work." (Senegal Interview #12)

Furthermore, despite the fact that civil servants working in relevant ministries became progressively more in favor of population policy and family planning as the 1980s wore on, no

president or Minister of Health ever championed it (Wickstrom, Diagne and Smith 2006).

Respondents noted this relative lack of political will.

> "It's a problem of leadership – ministers aren't talking about family planning.
> Family planning is at the midwife level, where there's no power. District chief
> isn't talking about family planning. You have to go to *poste de santé* [the lowest
> level of health care provision] to get family planning . . . Politicians will talk about
> mosquito nets, but not reproductive health. Malaria is well understood, but
> family planning butts up against religious issues." (Senegal Interview #14)

To counter such religious issues, respondents explained, the policy was framed as a *population*

policy, which thus captured much more than contraception or the limitation of births.

Respondents pointed out that Senegal's policy was not "demographic," like that of China or

Anglophone African countries, whose primary goal they perceived to be limiting births. Instead,

it was about child spacing and protecting the health of mother and child. In some regards,

then, Senegalese policymakers achieved a balance between neo-Malthusians and religious

leaders by couching the policy in the language of population, rather than that of family

planning. This bargain can be interpreted as a precursor to the one struck in Cairo six years

later, when family planning was folded into the broader concept of reproductive health to

reach agreement with feminists (Hodgson and Watkins 1997). As one respondent put it:

> "It's only with a global policy that family planning could succeed." (Senegal
> Interview #40)

Although promoting family planning as part of a *population* policy helped make the topic more

palatable, it may also have had negative impacts on the program overall, as it simultaneously

diluted the concept and made goals less clear. The dilution caused by expanding from family

planning to reproductive health was compounded by the concurrent decentralization of health

care overall, which moved family planning further away from its champions at the center

(Wickstrom, Diagne and Smith 2006). (For a larger discussion of a similar outcome, see Luke and Watkins (2002).)

Overall, the population policy was passed without much resistance, indicating not so much that people accepted a national call to slow population growth, but that they ignored it. As a result, matters related to family planning carried on in much the same manner as they had before the policy.

> "For the most part, people at the local level had no idea about population problems. Some of them did not even know that there was a population policy. Even five or six years after the population policy, there were elected officials who didn't know about it." (Senegal Interview #36)

Thus while the relationship between the Senegalese government and citizens was neutral or even positive, other efforts taken to reduce resistance to the population policy prevented it from being particularly focused.

CONCLUSION: IMPACTS ON REPRODUCTIVE HEALTH

The examples from the three countries above describe how population policy can serve as a lens onto the drivers of the success of reproductive health outcomes. In particular, by way of conclusion, I discuss how experience with family planning and population policy has impacted the success of HIV/AIDS outcomes.

In Malawi, with an HIV prevalence rate of 12%, HIV prevention efforts have generally been quite weak, despite large numbers of people infected and dying. This is partially the result of evading the sexual aspect of HIV, the roots of which can be seen in the government's population policy and family planning efforts. The fact that the government began to care about population growth at the same time as HIV/AIDS was leading to increased mortality made its efforts in relationship to HIV all the more suspect (Kaler 2004). Like family planning,

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HIV was also viewed as something dubious that came from abroad (Lwanda 2002). As a result, the acronym for AIDS was given an alternative interpretation: the "American Invention Depriving Sex" (Lwanda 2002). Relatedly, in the mid-1990s, reports still indicated that some Malawians believed that AIDS was invented to frighten people into using condoms to reduce fertility (Forster 2001). While negative reactions to condoms were and are common across Africa, Banda's ban on family planning until 1982 would have certainly provided space for greater skepticism about condom usage. Given this degree of suspicion about population control, when the same actors began talking about AIDS, Malawians saw AIDS as a continuation of those population control efforts: a further concerted effort to eliminate the population (Kaler 2004). Because the same actors also proposed solutions for AIDS, particularly condoms, Malawians were understandably suspicious. As a result, condoms were viewed as dangerous, ineffective, and possibly even the source of AIDS itself. Once treatment for HIV became available around 2003, Malawi became much more proactive in addressing AIDS, and is now hailed as a success story in that antiretroviral coverage is close to fifty percent. But prevention efforts lag behind.

Nigeria's contentious relationship with the international community was smoothed over by a savvy head of state (Babangida) assisted by a charismatic minister of health (Ransome-Kuti) during the population policy era. The relationship with the international community grew even more contentious in the 1990s, as Nigeria entered a period of severe autocracy and lost most international funding for reproductive health. Although funding levels have increased in the 2000s, most of this money is for HIV. Although Nigeria managed to develop a strategic way to address family planning, through emphasis on maternal mortality and calls for nationalism,

they have not been able to do the same with HIV. HIV prevention efforts were completely

neglected in Nigeria during the crucial years of the 1990s, just as the epidemic was gaining

traction but also as Nigeria entered into some of its worst years of authoritarian rule.

Prevention efforts have only gained traction since the return to democracy in 1999 and since

treatment became increasingly available beginning around 2003. Although Nigeria has made

strides in providing treatment, there is still much work to be done in the area of prevention.

Efforts to strategically depoliticize the fact that HIV transmission is primarily through

heterosexual contact—to make HIV about something other than sex—have not worked well,

and there is no charismatic Minister of Health to take that lead. As a result, prevention efforts

have become mired in battles over condoms, themselves fueled by tensions between religious

groups.

Senegal has persistently been open to the international community, and has been

rewarded with significant amounts of funding for family planning as well as HIV/AIDS. Indeed,

Senegal is widely held up by the international community as a success story in the realm of

HIV/AIDS, which is beneficial to the country's image on a number of fronts. Just as with family

planning, Senegal has pursued a technocratic approach to HIV, which has translated into

targeting sex workers, the primary risk group, with condoms and information campaigns.

Senegal was easily able to pursue this path given that prostitution is legal and a plurality of sex

workers are registered. Such a technocratic strategy of focusing on risk groups fares less well in

populations with generalized epidemics, and multiple risk groups who are not so clearly

organized. Although Senegal does not have a generalized epidemic, the prevalence rates

among a less-well-organized population, men who have sex with men (~25%), are troublingly

high and it is not clear that the same tools the government has used before will work with this population.

The experiences in Malawi and Nigeria have left somewhat of a sour taste in the population's mouth regarding population-related interventions. In the case of Malawi, this seems to have been the result of long-standing suspicions about the motivations behind population interventions. In Nigeria, it seems to have been the result of internal religious, ethnic, and regional politics. In Senegal, there was not much of a reaction to the population policy, perhaps because of a high tolerance for technocratic interventions on the part of the government, which suggests that future interventions in the realm of reproductive health may produce positive outcomes.

The analysis of population policy in Malawi, Nigeria, and Senegal presented above indicates that population policy provides a lens through which to look at a variety of relationships, between governments and the international community, and between governments and their citizens, that both impact reproductive health outcomes. The effects relate to population and family planning directly, but also to other sex-related health interventions, such as HIV/AIDS.

BIBLIOGRAPHY

Barrett, Deborah, and Amy Ong Tsui. 1999. "Policy as Symbolic Statement: International Response to National Population Policies." *Social Forces* 78:213-234.

Biersteker, Thomas, and Peter M. Lewis. 1997. "The Rise and Fall of Structural Adjustment in Nigeria." Pp. 303-331 in *Transition Without End*, edited by Larry Diamond, Anthrony Kirk-Greene, and Olyeleye Oyediran. Boulder, CO: Lynne Rienner.

Caldwell, J. C., I. O. Orubuloye, and P. Caldwell. 1992. "Fertility Decline in Africa: A New Type of Transition?" *Population and Development Review* 18:211-242.

Chimbiri, M. Agnes. 2007. "The Condom is an 'intruder' in Marriage: Evidence from Rural Malawi." *Social Science and Medicine* 64:1102-1115.

Chimbwete, Chiweni, Susan Cotts Watkins, and Eliya Msiyaphazi Zulu. 2005. "The Evolution of Population Policies in Kenya and Malawi." *Population Research and Policy Review* 24:85-106.

Cohen, Barney. 2000. "Family Planning Programs, Socioeconomic Characteristics, and Contraceptive Use in Malawi." *World Development* 28:843-860.

Diamond, Larry, Anthrony Kirk-Greene, and Olyeleye Oyediran. 1997. "The Politics of Transition without End." Pp. 1-27 in *Transition without End*, edited by Larry Diamond, Anthony Kirk-Greene, and Oyeleye Oyediran. Boulder, CO: Lynne Rienner.

Dibua, Jeremiah I. 2006. *Modernization and the Crisis of Development in Africa*. Burlington, VT: Ashgate.

Dixon-Mueller, Ruth. 1993. *Population Policy and Women's Rights: Transforming Reproductive Choice*. Westport, CT: Praeger.

Dixon-Mueller, Ruth, and Adrienne Germain. 1994. "Population Policy and Feminist Action in Three Developing Countries." *Supplement to Population and Development Review* 20:197-219.

Federal Office of Statistics and Macro International. 1992. *Nigeria Demographic and Health Survey 1990*. Columbia, MD: Federal Office of Statistics and Macro International.

Forrest, Tom. 1995. *Politics and Economic Development in Nigeria*. Boulder, CO: Westview Press.

Forster, Peter G. 1994. "Culture, Nationalism, and the Invention of Tradition in Malawi." *The Journal of Modern African Studies* 32:477-497.

—. 2001. "AIDS in Malawi: Contemporary Discourse and Cultural Continuities." *African Studies* 60:245 - 261.

Gordon, April A. 2003. *Nigeria's Diverse Peoples*. Santa Barbara, CA: ABC-CLIO.

Hartmann, Betsy. 1995. *Reproductive Rights and Wrongs*. Boston, MA: South End Press.

Hodgson, Dennis, and Susan Cotts Watkins. 1997. "Feminists and Neo-Malthusians: Past and Present Alliances." *Population and Development Review* 23:469-523.

Johnson-Hanks, Jennifer. 2006. *Uncertain Honor: Modern Motherhood in an African Crisis*. Chicago: University of Chicago Press.

Kaler, Amy. 2004. "The Moral Lens of Population Control: Condoms and Controversies in Southern Malawi." *Studies in Family Planning* 35:105-115.

Liagin, Elizabeth. 1996. *Excessive Force: Power, Politics, and Population Control*. Washington, DC: Information Project for Africa, Inc.

Luke, Nancy, and Susan Cotts Watkins. 2002. "Reaction of Developing Country Elites to International Population Policy." *Population and Development Review* 28:707-733.

Lwanda, John. 2002. "*Tikutha*: The Political Culture of the HIV/AIDS Epidemic in Malawi." Pp. 151-165 in *A Democracy of Chameleons: Politics and Culture in the New Malawi*, edited by Harri Englund. Uppsala, Sweden: Nordiska Afrikainstitutet.

Osuide, Simeon O. 1988. "The 1988 Nigerian Population Policy." *Habitat International* 12:119-123.

Pearce, Tola Olu. 1995. "Women's Reproductive Practices and Biomedicine: Cultural Conflicts and Transformations in Nigeria." Pp. 195-208 in *Conceiving the New World Order: The Global Politics of Reproduction*, edited by Faye D. Ginsburg and Rayna Rapp. Berkeley, CA: University of California Press.

Renne, Elisha P. 1996. "Perceptions of Population Policy, Development, and Family Planning Programs in Northern Nigeria." *Studies in Family Planning* 27:127-136.

—. 2003. *Population and Progress in a Yoruba Town*. Ann Arbor: University of Michigan Press.

Robinson, Rachel Sullivan. 2009. "The Positive Impact of Population Policy on Human Rights in Africa." Pp. 157-171 in *Between Life and Death – Governing Populations in the Era of Human Rights*, edited by Sabine Berking and Magdalena Zolkos. Frankfurt: Peter Lang.

Sai, Fred T., and Lauren A. Chester. 1990. "The Role of the World Bank in Shaping Third World Population Policy." Pp. 179-191 in *Population Policy: Contemporary Issues*, edited by Godfrey Roberts. New York: Praeger.

Smith, D. J. 2003. "Patronage, per diems and the "workshop mentality": The practice of family planning programs in southeastern Nigeria." *World Development* 31:703-715.

Smith, Daniel Jordan. 2004. "Contradictions in Nigeria's Fertility Transition: The Burdens and Benefits of Having People." *Population and Development Review* 30:221-238.

—. 2007. *The Culture of Corruption*. Princeton, NJ: Princeton University Press.

Solo, Julie, Roy Jacobstein, and Deliwe Malema. 2005. *Repositioning Family Planning—Malawi Case Study: Choice, Not Chance*. New York: The ACQUIRE Project/EngenderHealth.

Suberu, Rotimi T. . 2001. *Federalism and Ethnic Conflict in Nigeria*. Washington, DC: United States Institute of Peace Press.

Sullivan, Rachel. 2007. "Leveraging the Global Agenda for Progress: Population Policies and Non-Governmental Organizations in Sub-Saharan Africa." in *Graduate Group in Sociology and Demography*. Berkeley, CA: University of California, Berkeley.

Wickstrom, Jane, Abdoulaye Diagne, and Alyson Smith. 2006. *Repositioning Family Planning— Senegal Case Study: Promising Beginnings, Uneven Progress*. New York: EngenderHealth/The ACQUIRE Project.

World Bank. 2009. "World Development Indicators."

Wright, Stephen. 1998. *Nigeria: Struggle for Stability and Status*. Boulder, CO: Westview Press.

Yin, Sandra. 2007. "Objections Surface Over Nigerian Census Results." Washington, DC: Population Reference Bureau.