

**Does  
Economic  
Policy Conflict  
with Population  
Policy? A Case  
Study of Reproductive  
Health in Tanzania**

**Lisa Richey**

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## **Contents**

Abstract .....	1
Introduction.....	1
Linking Population Policy with Economic Liberalization.....	2
Donors, Lenders and Population in Tanzania .....	4
Tanzania’s “Success” in Family Planning .....	10
Realities of Reproductive Health in Tanzanian Clinics .....	12
Conclusions: Local Bodies, National Policies and International Actors .....	16
References .....	18

## Abstract

*Population policies have rarely been linked to economic policy, although the promoters of economic liberalization also support the embrace of population policy as important to the economic well being of African states. Using a case study from Tanzania, I argue that population policies with a limited focus on fertility reduction may continue to be successful in the context of post-adjustment African health care systems, but policies that aim for the larger goals of improving women's reproductive health will be severely limited. Tanzania's donors and lenders promoted Neo-Malthusian types of population policies aimed primarily at reducing childbearing as a partial solution to the country's economic crisis. However, in the mid- 1990s, the international discourse on population shifted toward a new dependent variable of "women's reproductive" health. The notion of reproductive health reunites population and development issues in the context of basic health care provision. Improvements in the reproductive health of Tanzanian women will require more than simply the effective provision of contraceptives. This article argues that the challenges of improving reproductive health are not likely to be met without a revitalization of the public health care sector systems in African countries.*

## Introduction

Population policy is not usually considered as one of the instruments of economic liberalization. In fact, the rare work that has linked these two issues together has concluded that structural adjustment policies threaten the goals of population policies (Grown 1994; Palmer 1991). The Tanzania case appears to support many of the predictions about women's reduced access to health care and lowered economic status;<sup>1</sup> however, it does not reflect a decrease in women's use of contraceptives, or an increase in actual or desired fertility. Therefore, I argue that structural adjustment policies are not in conflict with the old Neo-Malthusian policies concerned primarily with increasing family planning use and decreasing fertility, but they are in conflict with the new generation of population policies that focus on women's reproductive health and well-being.

In the following sections, I will review the expected relationship between population policy and liberalization and the relationship between the state, donors and lenders in promoting population policies in the Third World. Then, I will turn to the specifics of National Population Policy for the Tanzania case. In Tanzania, liberalization measures and population policies were actually promoted by the same international interests as appropriate responses to Tanzania's economic crisis. I will describe the "success" of this policy as measured by fertility rates and contraceptives. Then, I will problematize this "success" by analyzing the realities of family planning within Tanzanian clinics. The final section will draw some

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<sup>1</sup> For contributions that speak to the gendered impact of structural adjustment policies in Tanzania see Izumi (1999); Bagachwa (1997); Bryceson (1996); Swantz, and Tripp (1996); Warner (1996); Bienefeld (1995); Lugalla, (1995); Mbilinyi (1994); Tibajuka (1994); Booth, Lugangira, et al. (1993); Maghimbi (1993) and Mbilinyi (1991).

conclusions about the role of local, state and international actors in population policy implementation in liberalized Tanzania. I will argue that population control has been an important part of the bundle of recommendations given to African countries under the rubric of structural adjustment. The resulting retreat of the Tanzanian state from the health sector, coupled with an upsurge in donor interest in population, has led to a public health care system equipped solely to supply contraceptives.

## **Linking Population Policy with Economic Liberalization**

The gendered impact of liberalization stemming from structural adjustment is now well documented in theoretical analyses (Palmer 1992; Elson 1995; Elson 1991) and empirical studies (Gladwin 1991; Afshar and Dennis 1992; Beneria and Feldman 1992; Cagatay, Elson et al. 1995). However, these disparities are rarely linked with the objectives of population policy. Nonetheless, in Third World “development,” many of the major proponents of economic liberalization—individual and institutional—are the same as those advocating population policies, and the countries targeted by these policies are often identical.

The World Bank is clearly a significant institutional actor in promoting economic liberalization, and while the Bank has become a player in health care reform, it is not usually considered to be among the most powerful actors in the population field. The most prominent population actors in the international population arena are the United States Agency for International Development (USAID), the United Nations Fund for Population Activities (UNFPA), the International Planned Parenthood Federation (IPPF), and the Population Council. Yet, perhaps because the Bank is not associated with promoting a population-control agenda, it is able to push for these goals without incurring the same backlash that might be aimed against stronger population actors. Gibbon’s (1991) work in the early 1990s suggests that the Bank has long embraced population control as one of its regulatory measures used in the Third World. The Bank laid out a popularized version of its role in population issues in *Population and Development: Implications for the World Bank* (1994). While the Bank does not stress the existence of a population policy to limit fertility as a prerequisite for its development investments, it does point to the “political acceptability of fertility regulation” as the “most critical issue to address” in poor countries (World Bank 1994, 86). The Bank also notes: “donor influence has to be used judiciously to increase political and public sensitivity to the health and welfare hazards of unrestrained reproduction” (*Ibid.*) The Bank traces projects supporting population activities back as far as 1970 loans to Jamaica for family planning.

Evidence from Williams’ (1995) study of discourses on population, agriculture and environment suggests that the World Bank’s role in problematizing population is similar throughout Africa. He demonstrates that “the basic diagnoses and policy recommendations of all these documents are remarkably consistent with the policies and practices which the World Bank has espoused since its foundations” (1995). Williams shows how the Bank ignores both historical evidence and geographical variation, instead representing all of Africa “as deriving from a generic process engendered by the reproductive and economic activities of numerous

people, activities whose adverse consequences they neither intend nor recognize" (*Ibid.*, 173). The Bank's representation of Africa as a catastrophe of overpopulation, agricultural crisis and environmental degradation, and of Africans as neither understanding nor controlling these processes, calls for the "development" *experts* from outside to cope with the development crises and promote the common good. A detailed examination of the Tanzania case study will clarify the specific ways that economic policy and population policy are intertwined and will substantiate Williams' interpretations of the tone of the World Bank's overall Africa discourse.

The limited literature that speculates on the relationship between population policy and liberalization concludes that structural adjustment, in general, is not congruent with the goals of population policy. It is important to note that population policy here is intended as fertility reduction. Grown (1994) argues that structural adjustment measures should be stopped because they will hurt population objectives by worsening Third World women's economic status. An earlier work focusing specifically on Africa, Palmer (1991) predicted that women in adjusted economies would be constrained into higher fertility and less participation in "market-oriented activities." Palmer explains the relationship between adjustment's effects and continually high levels of fertility when "deterioration of women's economic status, by leading to further uncertainty, locks women even more tightly into survival strategies which emphasize fertility and dependency" (Sadik cited in Palmer 1991, 4). The links between women's status and fertility have been well documented in work such as Oppong (1989) and Youssef (1988). Following these arguments, in adjusted African economies, we would expect to see women wanting to bear more children who can contribute to the household economy, while increasing the mothers' status within their families and communities. In sum, we would expect higher levels of desired fertility in countries that have undergone structural adjustment.

Furthermore, as the factors contributing to a greater desire for high fertility rise, Palmer (1991) and Grown (1994) suggest that women's access to contraception will be reduced. "The increasing poverty of the Third World curtails the ability of governments and individuals to finance population programmes" (Grown 1994, 65). Similarly, Cornia, et al. (Cornia, Jolly et al. 1987) argue that cuts in the health care sector that accompany liberalization result in decreased access to contraceptive and abortion services. However, these authors did not take into consideration that in cases like Tanzania, donors absorb nearly all of the costs of the National Family Planning Programme. The main donors funding the lion's share of the Tanzanian National Population Policy are the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA). Other donors active in the health sector include Denmark, the United Kingdom, the Netherlands, and the World Bank. Therefore, it is critical to consider donor interests and willingness to pay, as well as government financing.

From the few studies on adjustment and population, we would expect that fertility rates would be maintained, if not increased, because women would desire larger families than the previous generation, and family planning services would become increasingly less available for those women who did want them. From this scenario, it would appear that economic and population policies would be in opposition if fertility rates did not decline. In contrast, we have seen a

clear decline in Tanzanian fertility rates as I will elaborate later in the article. Yet, declining fertility alone is not enough to suggest a synergy between the goals of population policy and economic adjustment. In the 21<sup>st</sup> century, population policy has come to mean far more than merely decreasing rates of fertility. The advancements in the international discourse on what a population policy should do call into question whether such policies can be effectively implemented in the context of post-adjustment health care provision. Because population policy is so intensely donor-driven and donor-funded, this international discourse on population shapes the implementation of policies in aid-recipient states such as Tanzania.

Population control through fertility limitation was the mainstay of population policies until the mid-1990s. In 1994, a shift—paradigmatic or rhetorical—took place in the mainstream population and development debates. This radical shift in the official discourse on population came after the International Conference on Population and Development in Cairo (see Hodgson 1997; Sinding and Caldwell 1997; Jain 1998). An international consensus was generated to support changing the goals of population policies from demographic targets and contraceptive goals to improving “women’s reproductive health” (see Lane 1994 for a literature review). Women’s empowerment, reproductive choice, and the overall health of women and their children are now recognized as important arenas for population interventions, both as “development” ends and as a means of creating a conducive environment for choosing lower fertility. Thus, population policy in a post-Cairo environment aims at improving the reproductive health of women, not simply on decreasing their levels of fertility. This new generation of approaches to population policy may find itself at loggerheads with the realities of adjusting economies. State withdrawal from social sector service provision coupled with decreasing resource flows from donor countries to the Third World exacerbates existing conditions of insufficiency. Some have suggested that health care provision serves as the “welfare arm of structural adjustment” and is critical to the process of economic recovery (Kabeer and Raikes 1992). We can not expect that population policies will in fact improve women’s health, choice, and empowerment, when women have no access to health care that is not contraceptives.

In the following discussion, I will demonstrate how population policy has been directly, if subtly, linked to economic liberalization in Tanzania. First, I will introduce the Tanzanian case. Then I will move to an analysis of the history of the population “problem” as it evolved in discussions between the Tanzanian government and the IMF and World Bank.

## **Donors, Lenders and Population in Tanzania**

Tanzania was one of the first countries in sub-Saharan Africa to begin offering contraceptive services in 1959, yet has been one of the last to declare an official population policy in 1992. Interestingly, Tanzania was also one of the most outspoken Third World countries promoting the idea that population was not a major problem for development at the 1974 World Population Conference in Bucharest (see Finkle and Crane 1975). However, in 1992 Tanzania adopted a National Population Policy very similar to that of other Third World countries. This

made a significant statement to the international community and signified an important shift in the way that the Tanzanian state was approaching its population “problem.” Given Tanzania’s reluctance to declare an official population policy that defined its population as a “problem,” why did the government finally agree to do so in 1992?

The Tanzanian state’s approach to population has gradually shifted to become more compatible with the priorities and understandings promoted by its donors and lenders. Historically, the Tanzanian government has maintained a strategically ambiguous stance in its declarations and approaches to population (Richey 1999b). This ambiguity exists in both the document of the National Population Policy itself and in the directives promoted by the state for its implementation. Nonetheless, the aspect of the population policy that is, in effect, given the most priority is family planning. This organization of a family planning program as the main or only implementing arm of population policy related to fertility reduction is typical in population policy implementation (Jain 1998). The family planning sector is most visible because it receives the most attention and funding from international donors, the critical sources of “development” interventions in a time when state-funded health care is rapidly declining in both quantity and quality.<sup>2</sup> The donors’ emphasis on family planning stems from the way that population is understood as a “problem” in a global discourse that emphasizes reducing fertility levels as a prerequisite to “development.” It could be argued that the Tanzanian state, weakened by its dependence on international aid and loans and the conditionalities accompanying its structural adjustment programs, has become more receptive to the agenda of its international donors and lenders in tackling many “development” issues, including population.

Tanzania’s economic history leading it to the negotiating table with the IMF in 1980, and the subsequent signing of an Economic Recovery Programme in 1986 is well-documented elsewhere (see Gibbon 1995). In brief, Tanzania, like many other African countries, found itself at the brink of economic crisis in the late 1970s. It was forced to take on structural adjustment policies which in Tanzania have meant processes like market liberalization, currency devaluation, liberalization of foreign exchange transactions, privatization of key parastatals, tax reform, bank privatization, civil service reform, and elimination of subsidies. By the mid-1990s, liberalized Tanzania embraced a business-friendly market-orientation. Private investments boomed and consumer goods became readily available for those who could afford them.

However, structural adjustment has also resulted in the introduction of user-fees for health care services and rising school fees. Literacy rates have declined from 90 percent in 1986 to some 84 percent in 1992 (other estimates put literacy at only 68 percent in 1991) (Raikes and Gibbon 1996, 291). This is not surprising in light of the results of Rose’s 1995 study of 78

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<sup>2</sup> Kiondo (1995) documents the ongoing “donorisation” of important social services in many areas as one of the main forms of development privatization taking place in contemporary Tanzania.

Third World countries that found education suffering in countries undergoing adjustment policies.<sup>3</sup>

The greatest impact of adjustment on the social sector is its limitation of government deficit funding (Raikes and Gibbon 1996, 291). This has led to falling morale among workers in this sector who are experiencing a drop in their real incomes as a result of adjustment policies (Raikes, A. 1992). Simultaneously, the HIV/AIDS pandemic has placed further demands on the already-fledgling health sector (see for example Baylies and Bujra 2000; Nnko 2000; Setel 1999). Currently, the health care sector is overburdened by increasing numbers of patients who wait longer and longer before seeking treatment, often to find that medicines are not available and staff are engaged in second-economy survival activities.

Statistically speaking, Tanzania is in the midst of an ecological and development crisis, and it is one of the poorest countries in the world (Turshen 1999, 100, 101). Tanzania's state of "projectitis" in the 1980's when there were more than 2000 development projects in the national development budget has been replaced with a new "reformitis" where donor-funded reforms are the focus of development attention (Therkildsen 2000, 62). While donor aid has, for the most part, resumed to Tanzania, it is not at levels comparable to the 1970s. Like the rest of Africa, Tanzania lost some of its geo-political importance to donors with the end of the Cold War, and donor fatigue has set in amongst even Tanzania's staunchest supporters. Still, a recently proclaimed National Population Policy with its recognition of a population "problem" has made Tanzania's population sector an area of growing donor interest.

In the context of years of economic decline and the constraints imposed by structural adjustment policies, the "successes" of the National Family Planning Programme provide an ironic contrast with the failure of state-provided health care. This translates into local clinics that are mere shells without medicines or basic supplies, but where most of the contraceptives being promoted by the family planning program and supplied by donors can be found. The expanded notion of "women's reproductive health" as an objective for donor funding under the population rubric becomes more significant in a context like Tanzania where formal health care needs lying outside the scope of donor-funded projects are not likely to be met at all.

In Tanzania, the contentious history of population issues (see Richey 1999a) required that donors act "judiciously" in promoting calls for a national population policy. During the 1980s, changes began to take place in the perceptions of Tanzanian officials about their population "problem" and appropriate solutions. Of course, this shift did not come out of nowhere. It was embedded in a changed way of thinking about Tanzania's overall approach to development. The formulation of the National Population Policy involved the intersection of government, donors and international organizations. Diverse organizations with different but convergent goals gained influence in Tanzania simultaneously, so while this did not have the

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<sup>3</sup> Rose (1995) found that adjusting countries show a closing of the gender gap in education only because the average male enrollment rate is falling toward the lower average female rate (compared to non-adjusting countries where an increase in averages of both male and female rates has taken place). Also, a slow-down in the increase in average female school enrollment rates, and an absolute decline in female enrollment in many countries (*Ibid.*).

overt intention of a common front organized to bombard the government with anti-natalist propaganda, it did have that outcome.

By the middle 1980s, almost no government funds were available for financing the development or implementation of the National Population Policy. The state acknowledges that “due to these budget difficulties the national population programme is mainly financed by multilateral and bilateral assistance”(United Republic of Tanzania 1994, 28). Therefore, the Tanzanian National Population Policy was, from its inception, a policy that would be dependent on donor funding and shaped by donor interests. Not only were funds unavailable from the state for funding the policy but also the same donors who were promoting population issues were being called upon to fund other aspects of Tanzania’s development budget. There are varying interpretations of what the lack of government contribution signifies. It may be an indicator of insufficient political commitment toward the population issue (as it has been understood at various times by donors and analysts in Tanzania), or it may be that the Tanzanian government is simply being strategic by putting its money into areas where donors are less readily available, given that external funds for population issues may be more easily forthcoming; see Richey (1999b).

Tanzania’s population issues were taken up in the first Paris Club meetings between the state and international lenders. The World Bank statement given at the Consultative Group for Tanzania meeting in June 1986, the first of such meetings since 1977, stated:

*We also expect to initiate studies on longer term issues such as education and training needs in Tanzania, and we will in response to the minister’s [either Msuya, Minister of Finance or Bomani, Minister of Agriculture and Livestock Development] request examine the possibility of support in the population field (World Bank 1986, 3,4).*

The Bank uses careful language to avoid any possible implications that its policies had an impact on the decision of the Tanzanian government to develop a national population policy. However, one informant stated that “Tanzania was forced into a policy by conditionalities which are not written down” because donors want to control population if they are to give aid (Interview 95ND01, 8/25/95).

The World Bank Social Sector Representative at the Dar es Salaam Mission Office stated in an interview with the author that he “could not remember” if the Bank had been involved in any way with the formulation of the National Population Policy, but he did not think that they had been involved (Interview 95DD01, 8/30/95). He also stated that the Bank supports a health and nutrition project worth \$47 million, which includes a “tiny component to support the Population Planning Unit [part of the Planning Ministry responsible for developing and coordinating population policy].” According to the Bank’s own data, the “tiny component” was \$9.5 million (World Bank 1994, 118). He went on to explain that the PPU was supposed to be co-financed by UNFPA, but due to some “mistake of communication,” the Bank is financing the whole thing. The position of the World Bank and IMF on Tanzania’s population “problem” is rarely discussed in official documents, as the Bank is reluctant to be identified

with pushing for a population policy. However, from the documents and records of the Paris Club Meetings, we can observe their stance on these issues.

The Bretton Woods institutions' interpretation of whether or not Tanzania had a population "problem" was initially vague, depending on the context of discussion, but by the late 1980s it was clear that population had begun to be perceived as an impediment to economic development. The 1986 Economic Recovery Programme drafted by the Tanzanian government in collaboration with the World Bank and the IMF stated: "Tanzania is a *relatively thinly-populated country*. There is a place and ample space for large private farms. . . ." (United Republic of Tanzania 1985, 30). However, by the June 1988 report, the Tanzanian government, in conjunction with the IMF and World Bank, attributed the need for cost-sharing to the problem of over-population. The document stated:

*Rehabilitation and development of the [social] sector will also be affected by the expansion of the requirements to the sector given the high rate of population growth. With these problems in mind, the Government is now reviewing how beneficiaries can make a more direct contribution to the financing of such services (United Republic of Tanzania 1988, 8).*

When justifying the potential for private enterprise in agriculture, the country was "thinly populated," but when discussing government provision of social services, Tanzania became "over-populated."

In 1988, the World Bank's report to the Paris Club meeting stated clearly its interest in Tanzania's population "problem:"

*In addition to these key priorities for economic management, there are longer term development challenges which face Tanzania. Among these are the preparation of a population policy, to reduce over time Tanzania's present high rate of population growth, and to take account of its impact on the urban areas and on the provision of social services. The present growth rate of close to 3 1/2 percent per annum imposes an intolerable strain on basic services, on the labour market and on the environment. It needs to be brought down to a manageable level as rapidly as possible (World Bank 1988, 8).*

The World Bank's report to the Paris Club the following year blames deteriorating social services on the population problem and reiterates the need for population control. In this report, the Bank asserts that "Tanzania faces a serious population problem" (World Bank 1989, 20). As a solution, they commend the government's development of a population policy with a strong demographic agenda:

*[T]he Government has developed a national population policy with the objectives of reducing fertility rates by 30 percent by the year 2000. . . reducing the proportion of women marrying before the age of 20, minimum spacing of 2 years between births, and attaining a higher contraceptive prevalence. To achieve these objectives and more, over the coming years it will be necessary for Government and for donors to concentrate*

*efforts on expanding family planning services and provision of contraceptives throughout the country . . . .” (World Bank 1989, 21).*

Here the Bank was clearly spelling out what it wanted in a population policy—specific targets for lowering fertility. Interestingly, in the period between the 1988 and 1989 reports, the population growth rate supposedly had *decreased* (without the help of a population policy) from 3.5% to 2.8%, but this was given no explanation. Such a dramatic drop in rates of growth in one year would be impossible. Of course, a likely scenario is simply that a different source of adjusted data was used; however, it would seem that for the Bank, the “real” population growth rate was a question of expediency, not one of correct data. While I can not prove definitively that Tanzania’s structural adjustment loans were held hostage until a population policy was instituted by the government, this was the case for Egypt (see Kaplan 1976 cited in Morsy 1995, 165 and Kenya, (see Hodgson and Watkins 1997). The Bank’s statements in quotes such as this one suggest that there was more than a casual relationship between the World Bank activities in Tanzania and the preparation of a particular kind of population policy to bring down Tanzania’s population growth rate.

The sudden notice of a population “problem” by its lenders had a significant impact on the Tanzanian state. The government used the population policy to show that it had properly recognized and was dealing with its “problem.” The report prepared by the government for the same consultative group meeting in 1989 responded to the Bank’s abrupt concern with the population “problem,” reassuring the Bretton Woods Establishment that:

*Given the critical role of population-related programmes in overall socio-economic development, the Government has finalized the preparation of a population policy which will be adopted during the ESAP period. The main goals of the national population policy are to reinforce national development, especially human resources development, by putting emphasis on influencing population trends, enhancing population quality, and improving the health and welfare of women and children. More specifically, the population policy will initially concentrate on expanding and strengthening maternal and child health and family planning programmes. . . . (United Republic of Tanzania 1989b, 15).*

A statement given by the Tanzanian Finance Minister at the 1989 Paris Meeting clearly situated population issues within Tanzania’s structural adjustment package: “Population issues will also receive special attention under ERP II” (Msuya 1989, 10). To the displeasure of its donors and lenders, the government engaged in strategic foot-dragging that prolonged the actual adoption of the policy by over a year. By 1991 when the National Population Policy was still not finalized, the report prepared by the government for the consultative group meeting in Paris in June reassured the lenders that: “In population, the Government has prepared and this year will formally adopt and announce its population policy for the 1990s” (United Republic of Tanzania 1991b, 5).

Tanzania’s donors have been similarly interested in promoting fertility reduction through a population policy as a way of dealing with declining social services as the state withdraws.

One example from the Demographic and Health Survey (DHS)<sup>4</sup> conveys the official understanding of the problem of population for development in liberalized Tanzania:

*As in other countries in sub-Saharan Africa, rapid population growth has been associated with poor economic performance. The consequences of rapid population growth are felt acutely and visibly in the public budgets for health, education, and related fields of human resource development. It is obvious that expansion of and improvements in the quality of these services is unlikely to happen without first controlling the rapid population growth (TDHS, 2).*

The donors' interpretation suggests that the rapidly growing population has led to Tanzania's economic problems and, thus, that the population growth must be tackled before expanding or improving the services related to "development." Warwick argued that donors were responsible for a narrow interpretation of the problem of population in the 8 countries of his study. Even though their styles and power vary, "donor influence extends from creating the conditions that lead governments to become aware of a 'population problem,' through defining the organizational forms and dominant emphases of family planning programs, to pressuring for specific results in implementation" (1982, 97). A government official involved in the Tanzanian National Population Policy summed up: "The time element is important—bring the population growth to zero as quickly as possible. Donors think this is urgent and government should be more active and quick" (Interview 95GD01b, 8/13/95).

The link between population policy and adjustment policy was important in bringing the Tanzanian state closer to the position of its donors and lenders. Donors and lenders were able to successfully shift the state's perspective on its population "problem," cumulating in the 1992 declaration of Tanzania's National Population Policy. Barrett and Tsui's quantitative cross-national study, found that the existence of a population policy holds symbolic value for international aid money. They conclude that "[population] policies indicate countries' receptivity to outside assistance, flashing the green light to donor agencies seeking appropriate beneficiaries" (Barrett and Tsui 1999). If a country adopts a population policy, it is 12.5% more likely to receive USAID funding, and of those countries having received funding, adopting a policy increases the countries' expected assistance nearly threefold (*Ibid.*). Given Tanzania's political economy and reliance on donor funding this relationship between population policy and increased donor assistance is particularly important.

## **Tanzania's "Success" in Family Planning**

Contrary to the expectation that population policy implementation would be thwarted in the context of structural adjustment, Tanzanian implementation through its National Family Planning Programme claims a striking level of "success" if policy implementation is assessed

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<sup>4</sup> The DHS, conducted by the Tanzanian Bureau of Statistics and the Washington-based Macro International at the request of and with funding from USAID, is considered by population "experts," along with its companion study the Tanzanian Knowledge, Attitudes and Practices Survey, to be the only reliable source of information about population and family planning in the country.

on narrowly demographic indicators. The population policy was successful in terms of increasing levels of family planning and decreasing the total fertility rate, as I will demonstrate in this section. However, in the next section, I will show that the larger reproductive health goals that are meant to be the centerpiece of the post-Cairo generation of population policies have not been successfully implemented. In fact, by maintaining a focus on population control, the policy is antithetical to improving reproductive health and upholding reproductive rights.

Regarding the demographic accomplishments of the National Family Planning Programme in Tanzania, an independent consultant of the United States Agency for International Development (USAID) was reported to have said about 1993 that “a miracle has been wrought” (United Nations Population Fund 1994c, annex E). Family planning was offered in approximately 90% of Tanzanian health clinics by 1996. During the last decade, Tanzanian family planning use has nearly doubled from 10.4% of married women using contraception in the 1991/92 Demographic and Health Survey (DHS) to 18.4% contracepting by the 1996/97 DHS.<sup>5</sup>

Knowledge of contraception is quite high (in 86% of all couples, both know a modern method of family planning according to the 1996/97 DHS). Also, Hollos and Larsen (1997) and Richey (1999a) found that knowledge about family planning and contraceptive methods was nearly universal among their respondents in three regions of the country. Trends in fertility preferences have shifted during the period of the 1990s, with fewer married women wanting another child ‘soon’ and more wanting no more children (1996/97 DHS). Results from the 1991/92 DHS in comparison to the 1996/97 DHS suggest that there has been a decline in the Tanzanian total fertility rate from 6.25 to 5.82 (1996 DHS). However, this striking fertility decline should be read cautiously when assessing the impact of the National Population Policy. We do not know how much of this fertility decline can be attributed to increased contraceptive use. Another cause of lower fertility rates is infertility—higher in Tanzania than in neighboring countries. Larsen’s (1996) work suggests that higher levels of infertility in some regions may be partly responsible for the appearance of a lower total fertility rate.

In sum, we know that donors have succeeded in funding a national family planning program that has raised awareness, access and use of contraceptives throughout the country. Therefore, the relationship suggested by Grown (1994) and Palmer (1991), that fertility decline could not take place in a structurally-adjusted context does not hold true for the case of Tanzania. In fact, it has been suggested by Larsen (1997), Kamuzora (1993), and my own field research that the economic hardship precipitated by structural adjustment and its related decline in social services may have led to a desire for fewer children. However, it is important to remember that population policy in the post-Cairo environment aims to improve health, not just to reduce numbers. Fertility reduction dependent on economic hardship puts population policy squarely in contrast to economic policy in achieving its goals.

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<sup>5</sup> This may even be an under-representation of women who are using family planning, as Richey (1999a) and Hollos and Larsen (1995) suggest that women may not consider themselves to be using family planning if their method choice is rhythm, condoms or traditional methods.

We know that the total fertility rate is dropping, as it is in many other parts of the Third World. However, it is not clear how much we can attribute Tanzania's fertility decline to contracepting in general, or to the family planning programme specifically. Furthermore, Lloyd, Kaufman, and Hewett (1999) argue that Tanzania still has lower levels of contraceptive use than expected when compared to other African countries with similar levels of educational attainment. However, it is not my point to assess the efficacy of the family planning programme on fertility. Also, I am not conducting any analysis of the relationship between the family planning programme and HIV/AIDS, a topic whose importance clearly merits its own discussion. Instead, I argue that whatever its effect on demographic goals, successful implementation of population policy in the post-Cairo era demands far more than simply decreasing fertility and a policy that gives fertility limitation top priority neglects critical issues in improving women's reproductive health.

## **Realities of Reproductive Health in Tanzanian Clinics**

While the Tanzanian National Population Policy may be considered successful in meeting some of its goals regarding the distribution and use of contraceptives as shown by national level statistics, local level implementation shows that other important needs of women's reproductive health are not being met. In this section, I will describe the context in which the population policy operates. I am using national survey data together with data based on fieldwork conducted in Swahili in 10 clinic sites (equally distributed between urban and rural areas) in Morogoro, Ruvuma and Kilimanjaro Regions of Tanzania. I conducted interviews with family planning service providers and engaged in participant observation at each site. Regions were chosen to represent areas of high, medium and low rates of contraceptive use, and clinic sites were chosen in consultation with district and regional Maternal and Child Health (MCH) coordinators to reflect a variety of service provision scenarios (see Richey 1999a for a detailed discussion of methodology).

In the following discussion, I will elaborate on what may be the most important and yet least analyzed level of population policy implementation—the clinic. Contraceptives are usually provided within an integrated clinic structure designed for family planning and maternal and child health services. This clinic may be situated within different types of health care structures: (1) a dispensary, the smallest type of health facility designed to serve a ward with a population of about 6,000; (2) a health center, with 20-30 beds that is supposed to function as a small hospital; or (3) a hospital, which may be classified as District, Regional or Consulting. Private services are available for a fee from some church-based or NGO providers (such as the Marie Stopes or UMATI [the Tanzanian Family Planning Association]). Still, three-fourths of all family planners obtain their contraceptives from government sources (Bureau of Statistics, Planning Commission et al. 1997a, 53), underscoring the importance of state service provision in women's reproductive health care.

While contraceptives are now readily available at clinic sites, the structures in which they are delivered speak to overall deterioration of the Tanzanian health system. For example, clean

water supply was a problem in all of the clinics where I worked. Even the regional hospitals, which were supposed to have running water from the tap, usually had to rely on buckets of water gathered from a shared water point in the hospital. This was not surprising considering that the matched national data available from the Service Availability Modules show both not only low, but *decreasing*, percentages of government clinics with running water. The percentage of government hospitals in the matched sample with running water was 85% 1991, but dropped to 77% in 1994. For health centers, 53% had running water in 1991, but only 40% had it in 1994. Dispensaries were even less fortunate with only 32% with running water in 1991 and 27% in 1994 (Ngallaba, Bardsley et al. 1994, 7-11).

Blood pressure cuffs that are critical for screening patients who may not be compatible with hormonal contraceptives were available at the regional hospitals, but were conspicuously absent from many other clinics, particularly rural ones. When I asked about them, I was often told the following: “There had been one in the past, but it had broken and had never been replaced.” Lack of proper lighting, particularly for pelvic exams, is a serious problem for inserting intrauterine devices (IUDs) or conducting examinations. The national situation for electricity parallels that for running water. In 1991, 87% of government hospitals in the matched sample had electricity, but in 1994, only 85% had it. For health centers, 24% had electricity in 1991, and 23% in 1994; while in dispensaries, 15% had it in both the 1991 and 1994 samples (Ngallaba, Bardsley et al. 1994, 7-10). National data show that access to electricity *declined* during the 1990s. During one day of clinic observation, I observed service providers attempting to do a pelvic examination for an IUD insertion in a rural health center where there was no electricity and no battery or solar-powered light. In this context, service providers had a difficult time seeing well enough to conduct the exam and were faced with the dilemma of how to cope when the environment itself limited their ability to provide good quality of care. Opening the curtain would violate the client’s right to privacy, as the examining room looked out onto the busy hospital courtyard, so one service provider tried to manipulate the curtain to let in a thin stream of light while the other attempted to perform the examination. After asking for my help, the service providers complained to me that it was difficult to perform even a basic examination under these circumstances.

In my interviews with service providers, supplies were mentioned at every service provision site as a problem—particularly disposable supplies (called “expendables,” although they hardly seem “expendable”) such as sterile gloves and bleach or other solutions for sterilizing instruments. As early as the 1992 National Family Planning Programme Annual Report, the Ministry of Health wrote that “there was in all regions visited, an acute or chronic shortage of expendable supplies especially gloves, antiseptics, cotton wool, gauze, disinfectants and local anesthetic for minilap [female sterilization]” (United Republic of Tanzania 1992, 8). The problem had yet to be resolved by the late 1990s. At one health center, the service providers explained the dilemma of providing quality service when sterilizing solution and gloves are often unavailable:

*There is always a problem with bleach and gloves: they say that bleach is expensive and the government can’t afford it, so usually we just use boiling because if we tell them [clients] to go and buy it they won’t return (Fieldnotes 96GM14, 4/30/96).*

Boiling could provide an alternative method for sterilization; however, boiling water itself presented a problem, as most clinics were without electricity and also lacking in kerosene. At an urban clinic I was told: “If a client needs a procedure done with sterile gloves, such as a pelvic exam or IUD insertion, she has to buy them (Fieldnotes 95GM12, 3/12/96).” The following example from an urban clinic and family planning training site shows the difficulties in providing high quality of care in the absence of basic supplies:

*I observed another client who had come in the day before with an IUD that had slipped out of place. However, she came late in the afternoon (according to the service provider), so they told her to come back today. This time, she forgot to bring her own bleach to sterilize the instruments, so there was a long wait and discussion over what to do. Finally, the older nurse, said to use the small amount of bleach they had remaining in the clinic [from the supplies brought by students during family planning training] and do the removal and reinsertion (Fieldnotes, 95GM12).*

This example shows both the reluctance on the part of service providers to remove the IUD on demand,<sup>6</sup> and the shortage of basic supplies in a popular urban clinic. I was also told at two sites, that if they run out of syringes for injections, clients must buy them from private pharmacies and bring them to the clinic. At another rural clinic a service provider told me:

*We now use setrimide instead of bleach—if someone comes for an IUD and there are no supplies [of setrimide], we give them another method for the time being, and then when the supplies come they can get them*

The same service provider told me that there was no examination bed [they were using a wooden table], flashlight, no blood pressure machine, scissors, screen for privacy of clients, and no kerosene to use for sterilization. It is important to note that this service provider in a rural clinic was aware of the sorts of supplies which would be necessary for upholding a high standard of quality of care, and she tried to innovate whenever possible. Yet the dissonance between the demands of “modern” family planning and the clinic space where she worked was irreconcilable.

One of the most startling contradictions between family planning supplies and those for all other health needs is that contraceptive pills are likely to be the only pills found in state clinics. In clinics where I worked there was either a complete unavailability or frequent stock outs of even the most rudimentary antibiotics. A District Medical Officer explained some of the underlying reasons for the chronic shortage of antibiotics in government clinics. Government dispensaries and health centers rely on kits from the Essential Drugs Programme (EDP) [provided by donors, but in the process of discontinuation in 1996] which are distributed once per month to each site regardless of its catchment size. Sites with larger catchment populations and/or sites where people have more health problems (due to

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<sup>6</sup> According to Yanoshik and Norsigian (1989), “IUDs have been seriously misused in Third World family planning programs” and they detail examples in India and China. I discuss this issue in detail for the Tanzanian case in Richey (1999a).

environment, lifestyle, poverty, etc.) run out of drugs more quickly than other sites. The government is supposed to increase the varieties and quantities of drugs in the kits, but has not done so on account of the worsening economic conditions in the country. Therefore, shortages of antibiotics are chronic in both urban and rural government clinics (Personal correspondence 95GR26, 4/30/98).

A Maternal and Child Health regional coordinator told me that one of the most serious reasons for the high maternal mortality rate is the lack of antibiotics in the hospitals (Interview 95GR28, 9/2/96). In interviews, almost all service providers mentioned a problem with getting basic medicine such as antibiotics for treatment of infections. A rural service provider stated: "If you go to the regional capital for medicine, there isn't any—there are also no trays, scissors, nothing" (Interview 95GM13, 7/8/96). I observed women who are diagnosed with reproductive infections being informed that the clinic had no medicine, and that they were supposed to go to the local pharmacy and buy antibiotics. I often heard women complain that they did not have money to purchase drugs.

Proponents of a "reproductive health" approach to family planning argue that controlling one's fertility entails both preventing unwanted pregnancy and supporting healthy childbearing. Therefore, antibiotics should be an integral part of providing for reproductive health. My understanding is that antibiotics were not considered to be "family planning" supplies under the Tanzanian National Family Planning Programme. If women's reproductive health problems were diagnosed but not treated because of a lack of sufficient medicines, these women were, in effect, forced to continue with infections untreated. Untreated infections can lead to more serious reproductive problems, including infertility. In an interview response, a physician at a regional hospital told me:

*Many women have problems with infertility—far more than in the past—"hali ya maisha" [it is a fact of life] especially for young women. Many come to be treated only after they get complications—before, they treat STDs [sexually-transmitted diseases] themselves, sometimes using traditional medicine (Interview 95GR27, 9/9/96).*

I was told by physicians at both government and NGO hospitals that the number of sick patients who were treating themselves first with traditional, less costly medicine was increasing. Only if that traditional medicine did not work would they come to be treated at the hospital, by which time their condition had often worsened. I was told at many clinics in rural areas and even in urban hospitals that those who were ill would not bother coming to be treated because they knew that the clinics had no medicine. Also, in my interviews with individual women, a majority of users and nonusers of family planning mentioned the cost of health care as one of their most pressing concerns, since the government no longer provides free care and medicines as it did under earlier socialist policies.

The effects of Tanzania's deteriorating health sector on women's reproductive health have been confirmed by national level surveys. As household-based surveys, these are interesting statistics because they would be sensitive to any shift in health-seeking behavior from the public to the private domain, i.e. if women began using private clinics when they found the

government ones lacking. In the interval between Demographic and Health Surveys, the number of visits that women made to receive prenatal care decreased from a median of 5 visits in 1991/92 to only 3.9 visits in 1996/97 (1996/97 DHS, 107). Furthermore, more women are giving birth at home (49.5% compared to 45.5%) and fewer are assisted by any sort of trained personnel (53.1% in 1991/92 compared to 46.7% in 1996/97). Similarly, child health has also suffered, as fewer children with diarrhea were taken to a health facility or provider (59.5% in 1991/92 compared to 56.3% in 1996/97).

As the Tanzanian state withdraws from the health care sector, the only services and supplies that are available without pay at government clinics are family planning. In light of the global discourse on “women’s reproductive health’s” emphasis on “quality of care” received by clients in family planning clinics, Tanzanian clinics are supposed to be brought up to standard for providing family planning services. Most of this “improvement” is predicated on restructuring other clinic activities (if there are any) so that family planning will have its own room. Ideally, clients will be counseled and examined in rooms that guarantee their privacy. USAID funds limited improvements to clinics that will be used as training sites for family planning courses. While these improvements offer “higher morale” for family planning service providers (Interview 95GM24b, 5/15/96), the improvements brought into the clinic by its association with “modern” family planning are often only a coat of paint over crumbling walls. In an ironic twist to the struggle in the 1970s to integrate family planning services into government primary care clinics, in the 1990s there is a failure to integrate any other services into what have become, in effect, family planning clinics.

## **Conclusions: Local Bodies, National Policies and International Actors**

Tanzania’s population policy can be viewed as a “success” if evaluated solely on the basis of fertility reduction goals, but it has, thus far, failed to make significant improvements in women’s reproductive health. Responsibility for the limitations in implementation of a reproductive health agenda rests in the relationship between the Tanzanian state and its international donors and lenders. Population policies, like that of Tanzania, represent a state’s participation in an international community advocating a global and hegemonic discourse on the “problem” of population. However, the role of the state is contingent, shifting from one context to another. The Tanzanian state must negotiate its priorities with those of its donors while struggling to maintain legitimacy as the main provider of basic health care services. Baylies and Bujra (2000) suggest that the old debates about the efficacy of the “developmentalist state” may need to be reopened by the demands that AIDS presents. The defining element of the Tanzanian development landscape is still “post”-structural adjustment. The effects of adjustment policies on various aspects of Tanzanian women’s lives are in need of further empirical documentation. However, my research in family planning clinics suggests that the intended benefits of improved reproductive health are not realizable without a revitalization of Tanzania’s public health care sector.

Donors' success in funding contraceptive provision and in implementing the National Family Planning Programme stands in stark contrast to the rapidly deteriorating health care structures into which these interventions are inserted. "Modern" family planning comes to the clinic with its own set of tools and supplies. These things distinguish it from other less-funded, and therefore, apparently less important, clinic activities.

The weakened position of the Tanzanian state *vis a vis* international donors and lenders as a result of its signing on to structural adjustment policies contributed to the state's willingness to adopt a National Population Policy in 1992. Consequently, donors were amenable to funding the lion's share of the policy's implementation through family planning programs. Family planning, narrowly defined, has shown some successes in liberalized Tanzania. Yet, population policies and adjustment policies in Tanzania have been at odds with one another in the realm of meeting women's reproductive health needs.

Is the state of affairs at the clinic level of policy implementation in Tanzania a deviation from expected outcomes in other parts of Africa? There are strikingly similar population policies in all Third World countries with policies (see Barrett 1995), deriving in no small part from a rather narrow conceptualization by international donors as to what "counts" as a population policy. Analogously, structural adjustment policies have been based on the same neo-liberal principles. Therefore, it is likely that similar points of congruence and discontinuity exist between population policy and economic policy in other "high fertility" "low development" contexts of the Third World.

The post-Cairo shift in the international community's official understanding of population policy provides an important opportunity for states like Tanzania. The notion of "women's reproductive health" as a goal of population policy contributes a new language for the articulation of a more comprehensive approach to population. This much-needed shift from narrowly-demographic priorities to including women's priorities may provide a chance for mobilizing population resources in ways that off-set some of women's structural adjustment losses.

In liberalized Tanzania, the role of the state is to act as an intermediary between the global population discourse promoted by donors and lenders and the local realities of Tanzanian clinics. When the state is unable to set its own agenda, international actors must be held accountable for the impact of their policies at all levels of implementation. Thus, while structural adjustment has not proved to be antithetical to a narrow conceptualization of population policy limited to increasing family planning use and reducing fertility, it has thwarted the policy's intended outcome of meeting reproductive health needs. Population policy and its donors can not operate from a generic global blueprint or assume that family planning services can be discretely implemented within a collapsed health care system. Population policies must take into account the local realities of liberalized Tanzania and shape interventions accordingly if women's reproductive health is their goal.

## References

- Afshar, H. and C. Dennis, Eds. (1992). *Women and Adjustment Policies in the Third World*. London, Macmillian.
- Bagachwa, M. S. D. (1997). The Rural Informal Sector in Tanzania. *Farewell to Farms: De-agrarianisation and Employment in Africa*. D. F. Bryceson and V. Jamal. Leiden, African Studies Centre.
- Barrett, D. and A. O. Tsui (1999). "Policy as Symbolic Statement: International Response to National Population Policies." *Social Forces* 78(1): 213-234.
- Barrett, D. A. (1995). *Reproducing Persons as a Global Concern: The Making of an Institution*. Sociology, Stanford University.
- Baylies, C. and J. Bujra (2000). "Editorial: Special Issue on AIDS." *Review of African Political Economy* (86): 483-486.
- Beneria, L and S. Feldman, eds. (1992). *Unequal Burden: Economic Crises, Persistent Poverty and Women's Work*. Boulder, CO, Westview Press.
- Bienefeld, M. (1995). Structural Adjustment and Tanzania's Peasantry: Assessing the Likely Long-Term Impact. *Structural Adjustment and Rural Labour Markets in Africa*. V. Jamal. Basingstoke and London: St. Martin's Press for ILO.
- Booth, D., F. Lugangira, et al., eds. (1993). *Social, Cultural and Economic Change in Contemporary Tanzania*. Stockholm: SIDA.
- Bryceson, D. F. (1996). Structural Adjustment in Tanzania: Rural Women Farmers' Production Opportunity or Overload? *Changing Rural Structures in Tanzania*. D. Schmied. Munster, LIT.
- Bureau of Statistics, Planning Commission, et al. (1997a). *Tanzania Service Availability Survey 1996*. Dar es Salaam, Tanzania, Bureau of Statistics, Planning Commission.
- Cagatay, N., D. Elson, et al. (1995). "Gender, Adjustment and Macroeconomics." *World Development Special Issue* 23(11).
- Cornia, G., R. Jolly, et al. (1987). *Adjustment with a Human Face*. Oxford and New York, Clarendon Press.
- Elson, D. (1991). Male Bias in Macro-Economics: The Case of Structural Adjustment. *Male Bias in the Development Process*. D. Elson. Manchester: Manchester Univ. Press.
- Elson, D. (1995). "Gender Awareness in Modelling Structural Adjustment." *World Development* 23(11).
- Finkle, J. L. and B. B. Crane (1975). "The Politics of Bucharest: Population, Development and the New International Economic Order." *Population and Development Review* 1(1): 87-114.
- Gibbon, P. (1995). Merchantisation of Production and Privatisation of Development in Post-Ujamaa Tanzania. *Liberalised Development in Tanzania*. P. Gibbon. Uppsala: Nordic Africa Institute: 9-36.
- Gladwin, C. H., Ed. (1991). *Structural Adjustment and African Women Farmers*. Gainesville, FL: Univ. of Florida Press.
- Grown, C. (1994). Structural Adjustment, Demographic Change and Population Policies: Some Preliminary Notes. *The Strategic Silence: Gender and Economic Policy*. I. Bakker. London: Zed Books and the North-South Institute: 61-70.
- Hodgson, D. and S. C. Watkins (1997). "Feminists and Neo-Malthusians: Past and Present Alliances." *Population and Development Review* 23(3): 469-523.
- Izumi, K. (1999). "Liberalisation, Gender, and the Land Question in Sub-Saharan Africa." *Gender and Development* 7(3): 9-18.
- Jain, A., Ed. (1998). *Do Population Policies Matter?: Fertility and Politics in Egypt, India, Kenya, and Mexico*. New York: The Population Council.
- Kabeer, N. and A. Raikes (1992). "Gender and Health: An Introduction." *IDS Bulletin* 23(1): 1-3.
- Kamuzora, C. L. (1993). "Refining the Issues for Realistic Population-Development Policies in Africa." *The African Review* 18: 71-88.
- Kaplan, G. (1976). "An Afternoon with Anwar el-Sadat." *Institutional Investor* August.
- Kiondo, A. S. Z. (1995). When the State Withdraws: Local Development, Politics and Liberalisation in Tanzania. *Liberalised Development in Tanzania*. P. Gibbon. Uppsala: Nordic Africa Institute: 109-176.
- Lane, S. D. (1994). "From Population Control to Reproductive Health: An Emerging Policy Agenda." *Social Science and Medicine* 39(9): 1303-1314.

- Larsen, U. (1997). "Fertility in Tanzania: Do Contraception and Sub-Fertility Matter?" *Population Studies* 51: 213-220.
- Lloyd, C. B., C. E. Kaufman, et al. (1999). *The Spread of Primary Schooling in Sub-Saharan Africa*. New York: The Population Council.
- Lugalla, J. (1995). *Adjustment and Poverty in Tanzania*. Munster: LIT.
- Maghimbi, S. (1993). The Decline of the Economy of the Mountain Zones of Tanzania: A Case Study of Mwanga District. *The Tanzanian Peasantry: An Economy in Crisis*. P. G. Forster and S. Maghimbi. Aldershot, Avebury.
- Mbilinyi, M. (1991). *Big Slavery: Agribusiness and the Crisis in Women's Employment in Tanzania*. Dar es Salaam: Dar es Salaam Univ. Press.
- Mbilinyi, M. (1994). Restructuring Gender and Agriculture in Tanzania. *African Perspectives on Development: Controversies, Dilemmas and Openings*. U. Himmelstrand, K. Kinyanjui and E. Mburugu. New York: St. Martin's Press: 166-182.
- Morsy, S. A. (1995). Deadly Reproduction among Egyptian Women: Maternal Mortality and the Medicalization of Population Control. *Conceiving the New World Order: The Global Politics of Reproduction*. F. D. Ginsburg and R. Rapp. Berkeley: Univ. of California Press: 162-176.
- Msuya, C. D. (1989). Consultative Group for Tanzania, Paris, Dec. 18-20 1989, Statement by C.D. Msuya, Minister for Finance: Programme and Prospects for Economic Recovery.
- Ngallaba, S., P. Bardsley, et al. (1994). The Family Planning Service Environment in Tanzania: A Report Based on the 1991 and 1994 DHS Service Availability Modules, United Republic of Tanzania (Bureau of Statistics) and Carolina Population Centre.
- Oppong, C. (1989). Women's roles and gender issues in family planning in Africa. *Developments in Family Planning Policies and Programmes in Africa*. Logon, Ghana, University of Ghana, Regional Institute for Population Studies: 143-193.
- Palmer, I. (1991). *Gender and Population in the Adjustment of African Economies: Planning for Change*. Geneva: International Labour Office.
- Palmer, I. (1992). *Gender Equity and Economic Efficiency in Adjustment Models*. Dennis, C H. Afshar. London, Macmillan.
- Raikes, A. (1992). "Gender and the Production of Health Care Services: Issues for Women's Roles in Health Development." *IDS Bulletin* 23(1): 19-28.
- Raikes, P. and P. Gibbon (1996). Tanzania, 1986-94. *Limits of Adjustment in Africa: The Effects of Economic Liberalization, 1986-94*. P. Engberg-Pedersen, P. Gibbon, P. Raikes and L. Udsholt. Oxford: James Currey: 215-307.
- Richey, L. A. (1999a). "Development," Gender and Family Planning: Population Politics and the Tanzanian National Population Policy. Ph.D., Dept. of Political Science. Univ. of North Carolina at Chapel Hill.
- Richey, L. A. (1999b). "Family Planning and the Politics of Population in Tanzania: International to Local Discourse." *The Journal of Modern African Studies* 37(3 (Sept.)).
- Sadik, N. (1989). *The State of World Population 1989*. New York: UNFPA.
- Sinding, S. and J. Caldwell (1997). "Where is the International Population Movement Going? Cairo's Legacy;" *Supplement to Health Transition Review* 7.
- Swantz, M. L. and A. M. Tripp (1996). *What Went Right in Tanzania*. Dar es Salaam: Dar es Salaam Univ. Press.
- Therkildsen, O. (2000). "Public Sector Reform in a Poor, Aid-Dependent Country, Tanzania." *Public Administration and Development* 20: 61-71.
- Tibaijuka, A. (1994). "The Cost of Differential Gender Roles in Farms in African Agriculture: A Case Study of Smallholder Banana-Coffee Farms in Kagera Region, Tanzania." *Journal of Agricultural Economics* 45(1): 69-81.
- Turshen, M. (1999). The Ecological Crisis in Tanzania. *Dangerous Intersections: Feminist Perspectives on Population, Environment, and Development*. J. Silliman and Y. King. Cambridge, MA: South End Press: 89-107.
- United Nations Population Fund (1994c). UNFPA Third Country Programme 1992-1996 Mid-Term Review Report. Dar es Salaam: UNFPA.
- United Republic of Tanzania (1985). Tanzania Government Programme for Economic Recovery. Dar es Salaam.

- United Republic of Tanzania (1988). Programme for Economic Recovery: Report Prepared by the Government of Tanzania for the Meeting of the Consultative Group for Tanzania, Paris, July 1988. Dar es Salaam.
- United Republic of Tanzania (1989b). Economic Recovery Programme II 1989/90-1991/92: Report Prepared by the Government of Tanzania for the Meeting of the Consultative Group for Tanzania Paris, December 1989. Dar es Salaam.
- United Republic of Tanzania (1991b). Developments in Policy and Institutional Reforms Since December 1989: Report Prepared by the Government of Tanzania for the Meeting of the Consultative Group for Tanzania Paris, June 1991. Dar es Salaam.
- United Republic of Tanzania (1994). Country Report on Population and Development to the International Conference on Population and Development to be held in Cairo, Egypt Sept. 5-13, 1994. Dar es Salaam.
- United Republic of Tanzania, M. o. H. (1992). National Family Planning Programme Annual Report 1992. Dar es Salaam, Tanzania: MOH.
- Warner, J. M. (1996). *The Effects of Structural Adjustment on Rural Tanzania*, Univ. of Utah.
- Warwick, D. P. (1982). *Bitter Pills: Population Policies and Their Implementation in Eight Developing Countries*. Cambridge: Cambridge Univ. Press.
- Williams, G. (1995). Modernizing Malthus: The World Bank, Population Control and the African Environment. *Power of Development*. J. Crush. New York and London, Routledge: 158-175.
- World Bank (1986). Consultative Group for Tanzania Paris June 10-11, 1986: Statement on World Bank Assistance. Paris: World Bank.
- World Bank (1988). Meeting of Consultative Group for Tanzania: Current Economic Developments and Future Prospects.
- World Bank (1989). Report to the Consultative Group for Tanzania on The Government's Economic and Social Policy Reform Program, The World Bank Southern Africa Department.
- World Bank (1994). Population and Development: Implications for the World Bank. Washington, DC: The World Bank.
- Yanoshik, K. and J. Norsigian (1989). Contraception, Control, and Choice: International Perspectives. *Healing Technology: Feminist Perspectives*. K. S. Ratcliff, M. M. Ferree, G. O. Mellowet al. Ann Arbor: Univ. of Michigan Press: 61-92.
- Youssef, N. (1988). The Interrelationship Between the Division of Labour in the Household, Women's Roles and Their Impact on Fertility. *Women's Role and Population Trends in the Third World*. R. Anker. London: Routledge.