

# The Role of Public Population Institutions on Fertility Outcomes in Sub-Saharan Africa

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**Abstract:** The UN Population Division currently projects the population of Sub-Saharan Africa will reach 4 billion by the end of this century, unless we see a sharp decline in the region's fertility rates. Although the region has embarked on its demographic transition, this process is occurring at a slower rate than in the rest of the developing world and seems to be stalling in several countries. The economic benefits that would follow from an acceleration of the fertility decline are now widely recognized but the SSA leadership is only slowly changing its attitude towards population issues. This paper's discussion of SSA population growth focuses on fertility, and the identification of factors that may lead to fertility decline, with particular attention to the direct influence of public institutions. These are the public institutions dealing with family planning programs or those designed to prepare and implement population policies and/or monitor the demographic dividend. Reviewing the experience of these institutions in the SSA context allows us to suggest ways to strengthen them with the view of accelerating the fertility transition in the region, opening a demographic window of opportunity, and capturing a first demographic dividend.

**Keywords:** Sub-Saharan Africa, Demographic Transition, Public Institutions, Population Policy, Demographic Dividend

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## Introduction

The population of sub-Saharan Africa (SSA) was almost 1bn people in mid-2016 and will more than double by 2050 (Population Reference Bureau, 2016). According to the new population projections (Medium variant) of the UN Population Division (United Nations, 2017), SSA's population could reach 4bn people at the end of this century, unless fertility would decline more sharply in the region in the near future. This rapid demographic increase would translate into a possible quadrupling of the current SSA population in a time span of about three generations.

Nonetheless, the sub-Saharan population has embarked on its demographic transition, i.e., the shift from high to low crude birth rates and crude death rates. However, this process has occurred in SSA at a slower pace than in the rest of the developing world.

In particular, the time-lag between the decline of mortality and the decline of fertility has been longer in SSA than elsewhere, the pace of decline of fertility has been much slower, and protracted fertility stalls have occurred in several countries.

The need to accelerate the fertility transition in SSA has generated discussions among African leaders, policymakers, and development professionals and their development partners. More recently, it has been established that prospects for a fertility decline in SSA might help the region open a demographic window of opportunity and thereafter capture a first demographic dividend (Gribble and Bremner, 2012; May and Turbat, 2017). The prospects of potential economic benefits have brought the important issue of the acceleration of the fertility decline back to the development policy agenda (World Bank Group, 2015; Groth and May, 2017). Yet, the SSA leadership has still to fully endorse the need

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to intervene rapidly on fertility although the attitude of the African leadership vis-à-vis population issues has changed in recent years (May, 2017).

This paper will first outline the main components of sub-Saharan population growth with a focus on fertility. Thereafter, the paper will attempt to identify the factors that may influence fertility outcomes<sup>1</sup> and will pay particular attention to the public population institutions that may influence fertility directly. These are the public institutions dealing with family planning programs or the public institutions designed to prepare and implement population policies and/or monitor the demographic dividend. The paper will also review the experience of public population institutions in the sub-Saharan context. Finally, the paper will discuss the options available to strengthen public population institutions, with the view of accelerating the fertility transition in the region, opening a demographic window of opportunity, and capturing a first demographic dividend.

## Drivers of Rapid Demographic Growth in SSA

The 48 sovereign sub-Saharan countries have experienced very different demographic trajectories, which are linked to a stunning diversity of historical, cultural, ethnic, socioeconomic, and religious settings. However, several common causes can explain the unprecedented population growth that the region has experienced since World War II and will continue to experience during this century (Guengant and May, 2013; United Nations, 2017).

The first driver of rapid demographic growth in SSA rests with the mortality levels (especially infant and child mortality), which have decreased dramatically. This has occurred despite the emergence of major epidemics, such as HIV/AIDS. This survival revolution has been triggered by a number of factors, including major improvements in health sector systems, comprehensive immunization campaigns, supply of nutritional supplements, and widespread distribution of impregnated bed-nets to protect against malaria. Improved sanitation and the supply of clean water have also played a role. As a result, population growth rates have increased because many more people survive and live longer.

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<sup>1</sup> In this paper, fertility outcomes are deemed positive when fertility levels decline.

The second engine of the SSA population growth has been the persistence of very high fertility levels (Bongaarts, 2008, 2017). Sub-Saharan women still have 5 children on average as compared to 6.7 in 1970 (Population Reference Bureau, 2014, 2016). Fertility has declined much more slowly than mortality. The length of time between the decline of mortality and the decline of fertility appears to be longer in SSA than in other developing regions. Indeed, this time-lag is estimated at 10 to 15 years in Asia, but can be twice as long in sub-Saharan Africa (Turbat, 2017). While fertility has decreased, the pace of decline has been slow and the fertility decline has stalled in several countries. Moreover, fertility stalls have often been protracted (Bongaarts, 2006; Bongaarts and Casterline, 2012; Howse, 2015). Overall, the Southern and Eastern Africa sub-regions are more advanced in their fertility transition, but the Western Africa and, particularly, the Central Africa sub-regions are lagging behind (Population Reference Bureau, 2014, 2016).

Third, one should also factor in the role of the youthful age structure, a phenomenon known as the *population momentum*. Because SSA populations are very young (in high fertility countries, close to half the population is below age 15), numerous young people enter or will enter the reproductive age bracket. This will fuel also population growth, in addition to the rapid decrease of mortality levels and the slow erosion of high fertility levels. If SSA countries were to reach replacement fertility level today (i.e., about 2.1 children per woman, depending on mortality levels), their population would still continue to increase steadily (and possibly even double) over the next 70 years or so, due to the effect of the young age structure.

Against the backdrop of the slow demographic and especially fertility transition in the region, leaders and policymakers in sub-Saharan Africa have been keen to accelerate the decline of mortality, thereby triggering a survival revolution. However, sub-Saharan leaders and policymakers have been more reluctant to promote family planning programs to decrease high fertility levels, although they have endorsed family planning and reproductive health for welfare and health reasons (May, 2017).

There is an ongoing debate in sub-Saharan Africa as well as in the international development circles active in Africa as to the need to accelerate the fertility transition in the region. Economists tend to assume that fertility levels will decline automatically when economic outcomes will improve. Proponents of massive education interventions believe that education

alone will be sufficient to trigger a fertility decline. On the contrary, “family planners” posit that fertility declines are a prerequisite to improve socioeconomic conditions (Shapiro, 2015). Furthermore, there is no consensus about the effectiveness of family planning programs. Available evidence shows that reductions in total fertility rates in the range of 0.5 to 1.5 children per woman can be attributed directly to family planning programs, with the actual results being probably closer to the lower end of this range (May, 2012; World Bank Group, 2007).

Nonetheless, rapid fertility decline in sub-Saharan Africa could help countries to open a demographic window of opportunity and capture a first demographic dividend (May and Turbat, 2017). The issue of fertility decline appears therefore to be crucial for SSA countries to reap the potential benefits of such a demographic dividend (Lee and Mason, 2006; see also Turbat, 2017).

At this juncture, however, many SSA countries are still decades away from achieving the women’s health improvements and the contraceptive revolution that are needed to trigger a significant fertility decline, with the goal of reaching between 2 and 3 children per woman (this is viewed as a positive fertility outcome). Whereas the current use of modern contraception is 26 percent in sub-Saharan Africa (Population Reference Bureau, 2016), the contraceptive revolution requires that at least 75 percent of couples use a modern contraceptive method. Reproductive norms are still favoring large families in many African societies, especially in rural areas. Moreover, many countries in SSA do not yet have extensive family planning programs and do not muster the socioeconomic conditions, e.g., improved levels of female literacy and labor participation as well as gender equality and increased female autonomy (May, 2017), which are also necessary to accelerate the fertility decline.

## Factors Impacting Fertility Outcomes

Many factors do impact fertility outcomes. However, the key causes of fertility decline are still not fully understood. As a result, many different theories have been expounded to highlight the assumed causes of fertility decline. Still, there is not yet such a thing as a general theory of fertility decline despite the quest for a global explanation that has been undertaken by

demographers, economists, sociologists, and political scientists alike (see Höhn and Mackensen, 1982).

At this juncture, one can broadly categorize the various fertility decline theories into two major groups. On the one hand, one finds the “adaptation” theories, in which socioeconomic improvements bring lower fertility levels because couples change their reproductive behavior to cope with new realities (e.g., improved survival of children). On the other hand, the “diffusion” theories posit that the spreading of new ideas can bring changes in attitudes about fertility as well as entice couples to lower their desired fertility. Moreover, couples may also want to imitate their peers who have reduced their fertility levels already, and change their fertility aspirations downward as well.

Among the “adaptation” theories, socioeconomic and educational improvements have ranked prominently. Caldwell has proposed an “intergenerational wealth flows” theory of fertility decline, whereby parents want fewer children because children bring less monetary contributions and cost more than in traditional settings. Therefore, the reversal of wealth flows between generations force parents to adapt to new circumstances, namely the children’s decreasing income and the increasing costs of their education. Compulsory mass education comes with an opportunity cost too, precluding children and adolescents to earn money at an earlier age (see Höhn and Mackensen, 1982).

Among the “diffusion” theories, ideational changes—changes of perceptions and attitudes—have been proposed to explain fertility declines. Ideational changes belong to the group of “diffusion” theories, because the ideational process is also based on the spreading or diffusion of new perceptions, new ideas, and new attitudes. Ideational changes have come in handy to explain fertility declines in poor socioeconomic settings (e.g., Ethiopia and Bangladesh; see Cleland and Wilson, 1987).

With respect to fertility declines, a number of additional factors also come into play, which may reinforce or weaken the processes of adaptation and/or diffusion. Some authors have attempted to understand fertility declines within the broader context of socioeconomic improvements and policy interventions (Tsui, 2001). Other researchers have taken into account the role of the political-administrative settings (McNicoll, 1996). Last but not least, a key factor appears to be the desired fertility (the demand for children), which according to Pritchett is the fundamental variable, carrying more

weight than the alleged efficiency of anti-natalist policies (Pritchett, 1994).

In the quest for an explanation of fertility changes, researchers have also examined the role of institutional factors. Institutional factors impacting fertility outcomes have been defined either broadly as a large spectrum of various economic and institutional settings or domains that impinge on fertility (McNicoll, 1980), or more narrowly as administrative steps taken specifically to implement family planning programs and/or population policies.

Analysts of the broadly understood institutional determinants of fertility changes have pursued rather ambitious goals. They have attempted to find a *theory of fertility*, meaning by theory a “coherent body of analysis linking a characterization of society and economy, aggregate or local, to individual fertility decisions and outcomes”. Based on concrete examples or case studies, the ultimate purpose of such analyses was to move “from satisfactory anecdotal explanation of fertility change to social science theory” (McNicoll, 1980). The institutional factors include an array of dimensions (or domains) that may influence fertility outcomes, such as family structures, the cultural environment, the impact of education and the school curricula, as well as the influence of public institutions. McNicoll (1980) depicts the institutions and institutional changes “as more or less stable social or economic arrangements, the form of which depends in part on an underlying logic of transactional attributes”.

Nonetheless, these analyses appear to fall short of formulating a “social science theory”. When these institutional factors are viewed as general settings or domains against which fertility outcomes play out, we believe that they are too broadly defined. As such, they cannot usefully guide the role of public population institutions. Moreover, they do not provide concrete and actionable tools to inform public policies with the view of accelerating the fertility decline and addressing population issues.

We submit here that one should focus on a narrower definition of institutional factors impacting fertility, namely the public sector population institutions that can influence fertility outcomes directly. Such institutions can be the public-sector (governmental) population institutions aimed at dealing with specific population issues, for instance, institutions designed to implement and monitor family planning programs and/or institutions created to formulate population policies. One should also consider institutions

created to monitor the demographic dividend (e.g., demographic dividend “observatories”).

Such narrowly defined population institutions have been reviewed in the literature dealing with family planning programs and population policies. Mauldin and colleagues have attempted to measure family planning programs efforts through a detailed metric of the programs’ perceived strengths or weaknesses, although they have also taken into account other socioeconomic variables (Mauldin et al., 1978). Similarly, the role of national governments has been analyzed with respect to the formulation and implementation of population policies (Demeny, 1975). In this paper, the focus will be on these narrowly defined population institutions.

## **The Experience of Public Population Institutions in SSA**

In order to address their demographic challenges, governments in sub-Saharan Africa have pursued different institutional approaches. They have made efforts to plan for socioeconomic development, implemented family planning programs, and adopted and implemented formal population policies. Such developments have taken place within the context of the creation of new population institutions worldwide in the 1950s, 1960s and beyond (May, 2012). Sub-Saharan governments have established specific population institutions, particularly with respect to family planning programs and national population policies. More recently, they have also considered creating institutions to monitor the demographic dividend (e.g., demographic dividend “observatories”).

Many efforts have been geared at expanding the availability of family planning services in the region. Donors and NGOs, such as the International Planned Parenthood Federation (IPPF), have helped SSA countries to establish national family planning programs. Donors have been most instrumental in Ghana and Kenya, which have developed family planning programs early on (Botswana, South Africa, and Zimbabwe also had early family planning programs). The IPPF, which was established in London in 1952, created a network of national family planning associations in sub-Saharan Africa, which often played the role of pioneer family planning institutions at the country level (1952 was the year India adopted its first population policy; see May, 2012).

Since then, bilateral and multilateral donors have helped SSA countries to initiate, consolidate, and expand family planning programs. One should mention here the major contributions of the US Agency for International Development (USAID), the United Nations Population Fund (UNFPA), and other bilateral development agencies. For example, family planning programs in Ethiopia, Kenya, Rwanda, and Madagascar have benefited from large financial and technical support from USAID. In addition to its multiple interventions across the social sectors in most SSA countries, the World Bank Group has also supported family planning programs in the region. A case in point is the success story of Rwanda, where the World Bank Group funded the expansion of family planning services through its support to the health sector, using the results-based financing mechanism. In addition, the program also received strong support from the Rwandan leadership (Westoff, 2012).

Nonetheless, as compared to other developing regions of the world, donors' support to African family planning activities has been relatively limited overall. Moreover, the HIV/AIDS crisis has diverted funding from family planning programs (Shiffman et al., 2009). Despite efforts to introduce and expand family planning programs in SSA, the measure of unmet need points to a pent-up demand for modern contraceptives (unmet need captures the women who would like to postpone their next birth by two years or stop childbearing altogether but are not using a contraceptive method). Most SSA countries, except in Southern Africa, have unmet need for contraception in the range of 20 to 30 percent of women of reproductive age (Alkema et al., 2013). Contraceptives stock-outs are still too frequent in the region. Family planning programs need also to improve the quality of services and manage a shift to long-term contraceptive methods. Last but not least, African leaders have not, until quite recently, committed their full support to expand family planning programs in the region (May, 2017).

The creation of public population institutions to help prepare and implement comprehensive population policies has been another avenue used by governments, donors, and international NGOs to promote population policies and family planning programs in SSA. *Ad hoc* African population institutions were created within the public administration to deal with population issues through the broader context of socioeconomic development. Population Commissions or Population Secretariats

were routinely anchored in the Ministry of Planning. Occasionally, however, such bodies were located in the Ministry of Finance, the Ministry in charge of the Economy or even the Prime Minister's Office. The role of these institutions was to oversee and coordinate at the national level, all population-related activities from a developmental perspective (May, 2012). Such population institutions were heavily dependent on external funding and often staffed with expatriate experts. Some population institutions have been well-established, like the National Council for Population and Development (NCPD) in Kenya. However, since their creation, many "population planning units" have become lethargic, have been merged with other units (sometimes in other ministries, like recently in Burkina Faso), and/or have disappeared altogether.

Overall, it appears that these public population institutions have not been very effective to promote the formulation and implementation of population policies. In many sub-Saharan countries, these institutions have not received strong support from the highest level of leadership. Indeed, with respect to the strengthening of family planning programs and the implementation of population policies, the lack of genuine leadership support has been a major stumbling block throughout sub-Saharan Africa (May, 2017).

## **Strengthening Public Population Institutions in SSA**

Recently, however, SSA governments' attitudes vis-à-vis family planning, reproductive health, and population policies and programs have changed (see Murunga et al., 2012; May, 2017; Musinguzi, 2017). For various reasons, such as the health of women and children as well as the reproductive rights agenda, the interest of African governments in family planning programs has been somewhat rekindled. Moreover, African leaders and policymakers—along with their development partners—have come to appreciate the role that a more rapid fertility decline could play in opening a demographic window of opportunity and enabling countries to reap a first demographic dividend. To a large extent, this has helped to reposition demographic issues on the overall development agenda in sub-Saharan Africa (May, 2017).

With respect to the supply side of contraceptives, major financial and technical resources have been mustered since 2012 to expand family planning

services in SSA. The impetus was given at the London Summit on Family Planning of July 2012, which convened under the auspices of the Bill & Melinda Gates Foundation and the UK Department for International Development (DfID), along with other donors (a second London Summit on Family Planning was convened in July 2017). The first London Summit launched the Family Planning 2020 (FP2020) Initiative. Out of the 69 focus countries of the FP2020, 39 are in SSA (see [www.familyplanning2020.org](http://www.familyplanning2020.org), accessed on July 7, 2017). There is also a renewed interest in family planning in Western Africa, which has some of the highest fertility levels in the world. The Ouagadougou Partnership, launched in 2011, covers nine countries in Western Africa, i.e., Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo. The partnership is mainly supported by the French Development Agency (AFD), USAID, the French Ministry of Foreign and European Affairs, the Bill & Melinda Gates Foundation, and the William and Flora Hewlett Foundation.

Institutional factors at the national level will play a major role in this global effort, because mature family planning programs need strong management capabilities as well as unflinching political commitment. The logistics of family planning programs cannot be underestimated. Family planning programs in sub-Saharan Africa need steady funding, reliable supply chain mechanisms, and a gradual shift to long-term methods. All this will require strategic decisions as well as the support from the highest level of leadership in every country (the latter still needs strengthening despite a few exceptions). It appears therefore that the institutional strengthening of family planning programs will play a crucial role to foster the necessary expansion of modern contraceptive coverage in the region. As already mentioned, only 26 percent of African women currently use a modern method of contraception (Population Reference Bureau, 2016), which is a far cry from the 75 percent level that would ensure the completion of the contraceptive revolution.

Turning to the public institutions needed to spearhead population policies, it is worth looking at the emergence of population policies in sub-Saharan Africa since the 1980s. By the time the UN International Population Conference gathered in Mexico City in 1984, most SSA countries had started to prepare national population policies. In the 1980s, these policies relied on the framework of the *Kilimanjaro Plan of Action for Africa Population and Self-Reliant Development*, which was prepared at the

Second African Population Conference organized in Arusha, Tanzania, in 1984 (in preparation to the Mexico Conference). The *Dakar/Ngor Declaration on Population, Family and Sustainable Development*, which elaborated on the Kilimanjaro document, was adopted at the Third African Population Conference, held in Dakar, Senegal, in 1992 (Kekovole and Odimegwu, 2014).

The 1994 International Conference on Population and Development (ICPD) held in Cairo in 1994 led to the updating of many African population policies. Given that most sub-Saharan governments were still lukewarm to implement proactive demographic actions to influence marriage and childbearing, the model adopted to prepare national population policies was two-fold. First, the national population policies focused on socioeconomic development and echoed what became known as the “Kilimanjaro Declaration”. These population policies integrated—but sometimes diluted—family planning goals into broader and more acceptable interventions on population and development. Second, population-focused interventions that were aimed at “integrating population into development planning” framed population issues into a more politically correct developmental discourse. As exemplified in most population policies developed at the time, the documents addressed many priorities and covered all sectors, even when remotely related to population and family planning. As no priorities were clearly established, implementation was often disappointing. Occasionally, the adopted policies were only meant to foster economic growth in order to adapt to rapid population growth (May, 2012). Last but not least, because of their emphasis on safe motherhood and child survival, it could be argued that many SSA population policies were pro-natalist documents in disguise.

Against this background, we want to submit that two major changes are required. First, public population institutions will need to be strengthened in order to really manage population policies in the region, including the policies related to capturing a first demographic dividend. Governments will need to hire, and especially retain, competent staff for the population institutions, which must be anchored in high level and powerful ministries. The overall effort will need to be funded and maintained steadfastly over a long period of time (probably several decades). In short, this tall order will require a clear vision, strong political commitment, a competent staff, and steady funding.

Second, the new generation of population policies will need to be much more focused on the goal of accelerating the fertility transition. Today, too many African policymakers, opinion leaders, population specialists, and business planners still believe that education and economic growth alone will trigger a fertility decline. More advocacy will be needed to convey to African leaders the importance of intervening proactively on fertility. Policy documents will also need to be more concrete and action-oriented. In this respect, an example worth replicating is the short and matter-of-fact *Declaration on Population Policy* adopted in Niger in 2007 with four clear-cut objectives on family planning and age at marriage that were to be reached in eight years, along with a comprehensive monitoring and evaluation plan. Such an action-oriented document appears more focused and better designed to tackle the challenge ahead, although its implementation had been rather disappointing as well (Republic of Niger, 2007).

## Conclusions

The total demand for contraception (i.e., actual contraceptive use plus unmet need) remains modest in sub-Saharan Africa. In many SSA countries, the values of this total demand are about two-thirds of what is found currently across the emerging market economies. However, several SSA countries (e.g., Kenya, Malawi, Rwanda, Zimbabwe, and all Southern African countries) have already reached family planning *total demand* levels (not actual levels of use) of 75 percent or more (the level needed to achieve the contraceptive revolution), similar to levels observed in the emerging market economies. As a whole, however, SSA appears to be still decades away from achieving its contraceptive revolution (Guengant and May, 2013).

Today, as mentioned, African leaders and policymakers seem to be more amenable to fertility-reduction programs, a policy shift explained to a large extent by the potential of opening a demographic window of opportunity and capturing a first demographic dividend. Donors have also come back to family planning, as illustrated by the 2012 and 2017 London Summits aimed at expanding family planning services in 69 priority countries, most of them located in sub-Saharan Africa.

Some SSA governments also appear keen to prioritize the acceleration of the fertility decline and revise their population policies accordingly. However,

SSA governments will need more efficient policies to open their demographic window of opportunity and benefit from a first demographic dividend. This will require that demographic issues be given very high priority, be treated at the highest possible level of leadership, and viewed as cross-sectional issues impinging on, and affected by, all development sectors.

To conclude, improved public population institutions will be crucial to foster the extension of family planning programs, implement a new generation of population policies, and monitor the population trends that may be conducive to opening a demographic window of opportunity and capturing a first demographic dividend. To achieve these goals, it must be stressed again that public population institutions in SSA will need to be strengthened. Moreover, a more rigorous evaluation of family planning and population policy interventions will be necessary as well. All of this will require the genuine commitment from African leaders and the unflinching support from the donors' community.

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