

# ICPD/15

International Conference on  
Population and Development

## Africa Regional Review Report

# ICPD and the MDGs: Working as One

Fifteen-Year Review of the Implementation of the  
ICPD PoA in Africa – ICPD at 15 (1994 – 2009)

### MAIN REPORT



United Nations Economic  
Commission for Africa



United Nations Population Fund



African Union Commission





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ICPD PoA in Africa – ICPD at 15 (1994 – 2009)

### **MAIN REPORT**

ECA/ACGS/HSD/ICPD/RP/2009

ECA  
Addis Ababa  
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# Table of contents

<b>Acronyms and abbreviations.....</b>	<b>v</b>
<b>Foreword.....</b>	<b>vii</b>
<b>Acknowledgements.....</b>	<b>ix</b>
<b>Executive Summary.....</b>	<b>i</b>
<b>Part 1 Review Process .....</b>	<b>37</b>
<b>Part 2 Review Results .....</b>	<b>47</b>
Section 1 Poverty, Population, Environment and Sustainable Development.....	49
Section 2 Gender Equality, Equity, and Empowerment of Women.....	65
Section 3 The Family, its role, rights, composition and structure .....	79
Section 4 Children and Youth .....	85
Section 5 Reproductive Rights and Reproductive Health.....	97
Section 6 HIV/AIDS, Malaria, Tuberculosis and other Communicable Diseases .....	119
Section 7 Population Distribution, Urbanization and Internal Migration .....	131
Section 8 International Migration .....	143
Section 9 Crisis Situation and Emergency Preparedness .....	149
Section 10 Population and Development Data.....	157
Section 11 Resource Mobilization, Partnerships and Coordination .....	165
Section 12 Monitoring and Evaluation Mechanisms .....	171
Section 13 Factors Affecting Implementation of the ICPD PoA and MDGs .....	177
<b>Part 3 Recommendations and Way Forward .....</b>	<b>183</b>
<b>References.....</b>	<b>191</b>
<b>Annexes.....</b>	<b>194</b>



# Acronyms and abbreviations

ADB	African Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-retroviral Therapy
ARH	Adolescent Reproductive Health
AU	African Union
CBO	Community-Based Organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DHIS	District Health Information System
DRC	Democratic Republic of the Congo
FBO	Faith-Based Organization
GDP	Gross Domestic Product
GBV	Gender-Based Violence
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IDMC	Inter-departmental Disaster Management Committee
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IOM	International Organization for Migration
MCH	Maternal and Child Health
MCP	Multiple Concurrent sexual Partnerships
MDG	Millennium Development Goals

MMR	Maternal Mortality Ratio
NEP	National Electrification Programme
NGO	Non-governmental Organization
NHS	National Health System
NPA	National Programme of Action
NYC	National Youth Commission
NYS	National Youth Service
ODA	Official Development Assistance
PoA	Programme of Action
RDP	Reconstruction and Development Programme
SADHS	South Africa Demographic and Health Survey
STD	Sexually-Transmitted Disease
STIs	Sexually-Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization
YDN	Youth Development Network



# Foreword

The International Conference on Population and Development (ICPD) held in Cairo in 1994 adopted a twenty-year Programme of Action (ICPD-PoA). The ICPD was preceded by the 1992 Dakar/Ngor Declaration (DND) on Population, Family and Sustainable Development and both are milestones in advancing population and development in Africa. DND formed the basis of Africa's common position submitted to ICPD (1994) while ICPD-PoA provides a comprehensive framework on issues of interrelationship between population, sustained economic growth and sustainable development, and advances in education, economic status and empowerment of women. DND and ICPD-PoA have since guided the implementation of health, population, environment and related development policies in Africa. The implementation of the recommendations of ICPD-PoA is the "sovereign right of each country, in line with national laws and development priorities". The ICPD-PoA also calls on the regional institutions, including the United Nations system, to play an active role in the implementation of the Programme of Action.

In Africa, the United Nations Economic Commission for Africa (ECA) is mandated by the General Assembly of the United Nations to follow up on the implementation of the Dakar-Ngor Declaration and Programme of Action of ICPD. In collaboration with UNFPA, and in close consultation with African governments, the African Union Commission (AUC), the African Population Commission (APC) and the African Development Bank (AfDB), ECA implemented this mandate by carrying out ICPD reviews at five-year intervals in 1999 and 2004. The 1999 review identified some key priority areas for action, with emphasis on education and literacy; reproductive health care and unmet need for contraception; maternal mortality reduction; and HIV/AIDS. In this regard the 1999 Report stressed the need for addressing general health, education, income generation and employment, reducing infant and maternal mortality, and HIV/AIDS and sexually transmitted infections. Issues such as the family, refugees, the role of the aged in society, political and social instability, interrelationship between the role of the NGOs, private sector and civil society, information, education, communication materials and advocacy strategies were those that needed adequate attention.

The ICPD review in 2004 demonstrated that countries had made significant progress in adopting and implementing a reproductive health approach; strengthening efforts to improve gender equality, equity and women's empowerment; addressing adolescent reproductive health; forging new partnerships with civil society and the private sector and promoting integration of population dynamics and trends into development planning and policymaking. However, the outcomes showed that major challenges to the full implementation of the Cairo agenda still remained.

This year, as we mark the fifteenth anniversary of the adoption of ICPD, ECA and its partners (AU and UNFPA) undertook a fifteen-year review of the implementation of DND and ICPD-PoA in Africa in the context of the MDGs. The review work included collecting data from Member States, and analyzing it to develop this publication; ICPD and the MDGs: Working as one.

The report reveals the tremendous work done thus far by the African Union, UN Agencies and Member States to formulate policies, develop appropriate legal frameworks and adopt relevant international instruments to achieve the objectives of ICPD-PoA and the MDGs. Many countries have set up new institutions, strengthened existing ones and designed national and sectoral programmes and plans to address the various dimensions of population. However, several countries are yet to give explicit consideration to population planning and design a specific action plan or programme to address policy implementation. Overall, the review notes the wide gap existing in most African countries between population-related policies and actual implementation.

Barely five years to the end of the ICPD and MDG programme cycles (2014 and 2015 respectively), the prognosis for achieving the ICPD objectives and MDG targets points to the need for greater commitment and effort. While national conditions may vary, the outcome of this review suggests that significant difference could be made through renewed focus by all countries on population and development issues, based on a human rights approach. This would be in the areas of health and reproductive health, education, skills development and productive employment, human resources and institutional capacity and finance, with emphasis on domestic resource mobilization. All stakeholders in Africa and partners have a role to play in scaling up efforts to tackle these challenges, especially by improving implementation through capacity-building and increasing resources allocated to this crucial area of development.

We hope that government decision-makers, intergovernmental organizations, bilateral and multi-lateral development partners, non-governmental organizations, academia and the general public will find this publication valuable and timely for achieving the goals and objectives of ICPD PoA and the MDGs.

**Abdoulie Janneh**

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# Executive Summary

## Introduction

### 1.1 Background

Year 2009 marks the 15th anniversary of the 1994 Cairo International Conference on Population and Development (ICPD), and the 17th anniversary of the 1992 Dakar/Ngor Declaration (DND) on Population, Family and Sustainable Development. The ICPD adopted a 20-year Programme of Action (PoA) with a broad mandate on interrelationships between population, sustained economic growth and sustainable development, and advances in the education, economic status and empowerment of women.

In September 2000, about half a decade after the ICPD PoA, all Member States of the United Nations adopted the Millennium Declaration. It commits the world to put in place, measures necessary to attain peace, security and development in the world, and to implement strategies that will accelerate the development of poorer countries within the framework of the ICPD PoA.

Related to these global initiatives, the African Union (AU) put in place a continental framework for sustainable development - the New Partnership for Africa's Development (NEPAD). This vision and strategic framework for Africa's renewal is designed to address the current challenges facing the African continent. These include issues such as escalating poverty levels, underdevelopment, and the continued marginalization of Africa.

### 1.2 Past progress monitoring (ICPD+5 and ICPD+10)

The first five-year review (1999) revealed a heavy focus on reproductive health and reproductive rights, with little emphasis on general health, education, income generation and employment, reducing infant and maternal mortality, and Human Immuno-deficiency Virus / Acquired Immuno-deficiency Syndrome (HIV/AIDS) and sexually-transmitted infections (STIs). The review also indicated inadequate treatment of the family, refugees, the role of aged persons in society, political and social instability, interrelationship between the role of NGOs, private sector and civil society, as well as information, education, communication and advocacy strategies.

The ICPD PoA at 10 review by ECA (2004) showed that countries made significant progress in:

- a. Adopting and implementing a reproductive health and reproductive rights approach;
- b. Strengthening efforts to improve gender equality, equity and the empowerment of women;
- c. Addressing adolescent reproductive health;
- d. Forging new partnerships with civil society and the private sector; and
- e. Promoting the integration of population dynamics and trends into development planning and policymaking.

However, the outcomes also show major challenges to the full implementation of the Cairo Agenda. These include the need for a more effective focus on HIV/AIDS, and to incorporate culturally-sensitive approaches into programming and strengthen data collection and analysis systems. In addition, both the 1999 and 2004 reviews underplayed the role of research in programme implementation.

### **1.3 ICPD +15 Regional Review**

The ICPD+15 review process consisted of technical tools to compile qualitative and quantitative data and information from countries, and institutional arrangements to provide overall policy and technical guidance. The technical tools, prepared in August 2008, and distributed to all African countries, consisted of the following: i) Main questionnaire; ii) Appendix I of the main questionnaire; iii) Country reports; iv) Appendix I of the country report and; v) Appendix II of the country report. Forty-three out of 53 countries sent responses to the five review tools. This gives an impressive response rate of 81 per cent, and reflects the commitment of countries to the ICPD as well as to addressing population and development issues in Africa. However, while all countries were expected to submit all five tools, there was considerable variance in their submissions.

The ICPD + 15 Report addresses 13 thematic areas of the ICPD PoA, including the relevant MDGs. These include:

- a. Poverty, population and sustainable development;
- b. Sexual and Reproductive Health and Reproductive Rights;
- c. Gender equality, equity and empowerment of women;
- d. The Family, its Role, Rights, Composition and Structure;
- e. Children and Youth
- f. HIV/AIDS, Malaria, TB and other communicable diseases;
- g. Population distribution, urbanization and internal migration;
- h. International migration;
- i. Crisis situation and population consequences;
- j. Resource mobilization, partnerships and coordination;
- k. Population data and research; and
- l. Monitoring and evaluation mechanisms.

The last section of the report deal with factors affecting ICPD PoA and MDG implementation in Africa, and recommendations based on the analysis of evaluation findings.

## *The challenge ahead*

This review is the last in the series before the end of the ICPD programme evaluation in 2014. It is, therefore, necessary to reflect on the progress made, the challenges encountered and, based on these, provide strategic guidance to programme implementation for the five years remaining. Analysis of the review tools submitted by member States indicates that they have made considerable efforts to address the ICPD PoA objectives on all themes, as well as the related MDGs. However, given the limited resources and efforts in governance, challenges remain in many African nations in areas such as human and institutional capacity, financial investments in population programme management and political commitment. It is apparent that most of the ICPD PoA and MDG objectives are not likely to be achieved by 2014/2015 unless member States commit themselves to renewed efforts in programme implementation.

African countries have made remarkable achievements in the ICPD PoA and MDG objectives in terms of policy formulation, development of appropriate legal frameworks, and adoption of relevant international instruments. These include those derived from African Union (AU) initiatives since the 1992 Dakar/Ngor Declaration. Many countries have also moved forward to set up new institutions and strengthen existing ones; and have also designed national and sectoral programmes and plans to address the various dimensions of population – poverty, gender, youth, access to health and reproductive health services, family planning, education, housing, transport, communication, data, research, etc. However, many countries have still not given explicit consideration to population planning. In such countries, while population policy may be explicit, there is no action plan or programme specifically designed to address policy implementation. Overall, the review notes the wide gap that exists in most African countries, between population-related policies and their actual implementation.

Barely five years to the end of the ICPD and MDG programme cycles (2014 and 2015, respectively), the prognosis for achieving the objectives of the ICPD and the targets of the MDGs is generally not reassuring. Time is limited and population issues are generally difficult to turn around in the short term. However, strategic or targeted planning, coupled with commitment, could still achieve much within a short time. While national conditions vary, the outcome of this review suggests that renewed focus by all countries on the following population and development issues, based on a Human Rights approach, could galvanize Africa's lackluster move toward 2015:

- a. Health and reproductive health, including maternal mortality and family planning and HIV/AIDS;
- b. Gender and development;
- c. Youth (education, skills development and productive employment); and
- d. Resources (human and institutional capacity, finance, with an emphasis on domestic resource mobilization).

## **I- Poverty, population and sustainable development**

### **I.1 Population Trends**

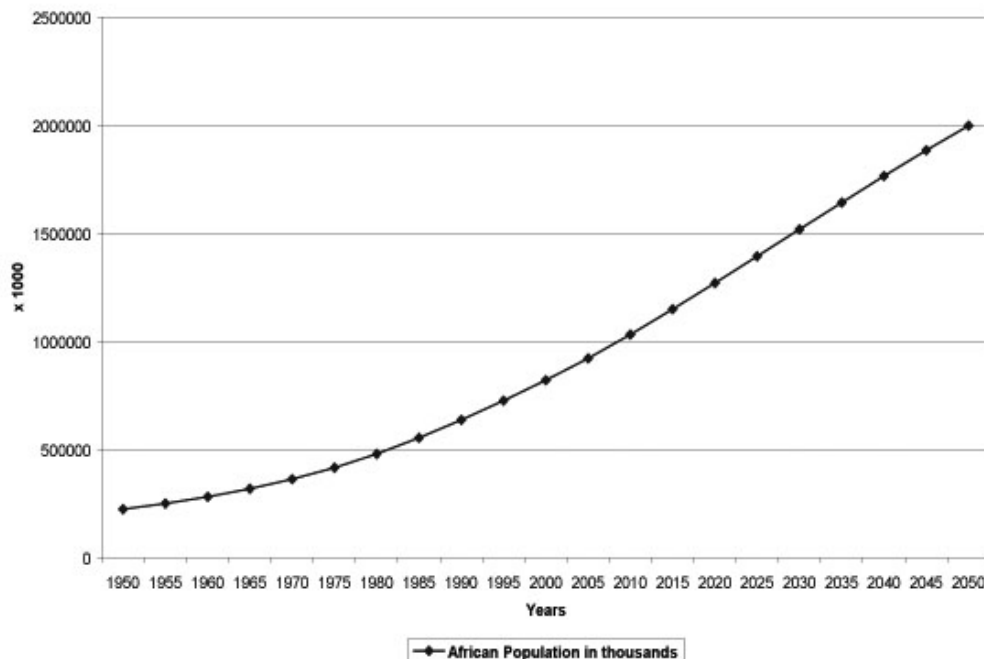
The most recent population estimate of Africa by the United Nations Population Funds (UNFPA)



stood at 987 million in 2008, a figure derived from an average annual population growth rate of 2.3 per cent, from 2005 to 2010. Earlier estimates show that during the 1990 – 2000 decade, Africa’s population increased from 622.4 million to 795.7 million, an addition of 173.3 million (28.4 per cent) in 10 years. The population of Africa will more than double in the next four decades to nearly two billion by 2050 (see Figure 1).

Life expectancy at birth in Africa in general has shown a slow but steady rise from 39 years in the 1950 -1955 period to 54 years in 2005-2010. During the same period, the North African countries, experienced, a higher average life expectancy from 43 years to 68 years. The impact of AIDS mortality is felt most severely in the Southern African sub-region, where the average life expectancy rose to 61 years during 1990-1995, but subsequently declined to 51.6 years for the 2005-2010 period. This represents a significant reversal of gains in health. Tunisia exhibited the highest life expectancy in Africa during the reference period - rising from 41.4 years to 73.89 years, while Swaziland typifies the Southern African experience, with an increase from 41.4 years (1950-1955) to 60.7 years (1990-1995), and thereafter dropping to 45.8 years (2005-2010).

**Figure 1 Projection of African Population 1950-2050**



While AIDS-related deaths are reported to be increasing in some countries, the prevailing pre-transition fertility level, estimated at 4.63 for Africa in 2008, is the major driver of the continent’s high rate of population growth. In most countries, the increase in population size has been as a result of high and constant fertility, coupled with high, but declining mortality over the same period. In addition to HIV/AIDS, the main causes of high mortality in Africa include, weak health systems; pervasive poverty; the low status of women on the continent; prevalence of infectious diseases such as tuberculosis and malaria; the exodus of medical personnel to overseas destinations; limited financial support to address health challenges, and poor infrastructure in most countries.



The population of most African countries continues to be youthful, with children and young people below age 15 constituting about 40 per cent of the total population. The most recent estimates show that children under age 15 account for 41.2 per cent of the population. Taken together, children and youth aged 30 and under, constitute over 70 per cent of the continent's total population (UN, World Population Prospects – 2008 Revision). By 2050, there will be a larger workforce with a declining proportion of children to support. This will create a window of opportunity for increased production and socio-economic development, referred to as the “demographic dividend”. Although this period will last for several years, the window will eventually close when the workforce ages and relatively fewer workers have to support increasing numbers of older people; a pattern currently evident in Europe. This scenario calls for sustained efforts on the continent to address the needs of young people.

Although their current proportion is low, it is expected that by 2050 the aged will constitute 10 per cent of the continent's population. Since they are very vulnerable and could be critically affected by challenges such as climate change, food insecurity and emerging health concerns, their needs must be clearly integrated into development policies and programmes.

## **1.2 Trends in the incidence of poverty**

Apart from the demographic trap, compared with other regions of the world, Africa suffers disproportionately from poverty and deprivation. Worldwide, about 20 per cent of the population survives on less than a dollar a day. In Africa, the problem of poverty is much deeper and far more widespread than in other major regions. Half the population of Africa lives in extreme poverty and one-third in hunger. In addition, about one sixth of children die before age five – the same as a decade ago. In previously war-torn countries like Angola, DRC, Eritrea, Ethiopia, Liberia, the Sudan, Rwanda, Burundi, Somalia, and Sierra Leone, current levels of poverty and hunger have stagnated and, in some, even worsened. Food security has deteriorated in Africa since 1970. The proportion of the malnourished population has remained within the 33 to 35 per cent range in Sub-Saharan Africa, with over 70 per cent of the food insecure population in the continent living in rural areas.

The most recent Human Development Report (2008), however, shows some dramatic positive changes in Africa's human development landscape. The number of African countries ranked as ‘Medium’ human development countries increased from 16 in 2004 to 23 in 2008. Algeria, Botswana, Cameroon, Comoros, Egypt, Equatorial Guinea, Gabon, Ghana, Mauritius, Morocco, Namibia, Sao Tome and Principe, South Africa, the Sudan and Swaziland have been in that category since 2004, and are now joined by the Congo, Djibouti, Kenya, Madagascar, Mauritania, Senegal and the United Republic of Tanzania. Unfortunately, at the bottom, are the ‘Low’ human development countries, all of which (except for three in Asia) are in Sub-Saharan Africa.

## **1.3 Policies and Programmes**

Poverty reduction is a national priority, and all countries in Africa continued to heighten their actions and policies to address it through a wide range of strategies. The country reports indicate that most countries are putting relevant policies and programmes in place to improve the quality of life. The most popular strategy for addressing poverty is the Poverty Reduction Strategy Papers (PRSPs).

Many countries are also implementing poverty reduction programmes under other titles. Some countries have undertaken national long-term perspective studies to provide a "vision" for the formulation of poverty reduction and development interventions. These include, Malawi, Nigeria, South Africa - Vision 2014; the United Republic of Tanzania, Benin, Sierra Leone - Vision 2025; Namibia - Vision 2030 and Ghana - Vision 2035. Other countries, such as South Africa reported a refocusing of expenditure on potentially poverty-alleviating programmes aimed at reducing poverty and socio-economic inequalities, including provision of infrastructure and social services.

## **1.4 Summary of Challenges and Constraints**

These include the following:

- a. Global financial crisis, energy deficits, food crisis, and general ability to adapt to climatic change;
- b. Heavy dependence or over-reliance on the donor community for social protection, poverty reduction, and development interventions exists in all but a few countries;
- c. Inability to implement national plans and international consensus, for instance, the Johannesburg Declaration on Sustainable Development, Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health Rights and Continental Policy Framework, Abuja Declaration on HIV/AIDS, and Tuberculosis and other Related Infectious Diseases;
- d. Limited involvement and investment of the local private sector in social development, particularly in social protection;
- e. Lack of community participation and involvement in ICPD PoA activities; and
- f. A continued high total fertility rate, increase in population size, and high dependency ratio in the face of weak economic performance; both of which are believed to be major factors diluting gains made in poverty reduction in most countries.

## **2- Reproductive rights and reproductive health**

### **2.1 Introduction**

ICPD PoA seeks to promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal mortality and reduce the differences observed between developing and developed countries and within countries, and to greatly reduce the number of deaths and morbidity from unsafe abortion. The relevant MDG is Goal 5, "Reduction by three-quarters, between 1990 and 2015, of the maternal mortality rate". Related maternal and child health indicators include the Maternal Mortality Ratio, Infant Mortality Rate and Under-five Mortality Rate.

### **2.2 Maternal Mortality**

Among the world's major regions, Africa has the highest maternal mortality records. Globally, there were 529,000 maternal deaths per year, 48 per cent of which occurred in Africa (WHO, UNICEF, and UNFPA, 2003). For each maternal death, it is estimated that there are 30 to 50 morbidities, including temporary and chronic conditions (UNFPA, 2004). In the developed regions of the world,

the maternal mortality ratio was as low as 20 per 100,000 live births, while in sub-Saharan Africa, the ratio was 920. More recent estimates of maternal mortality ratios indicate that the condition might be deteriorating in many African countries, with some having maternal mortality ratios in excess of 1,500 per 100,000 live births (Angola, Malawi, the Niger, Sierra Leone, and the United Republic of Tanzania). The worst case is the record of 2,000 per 100,000 in Sierra Leone.

Of concern in some countries, is the reported fluctuating trend in maternal mortality ratios. An example is Namibia, which shows a rising trend in the ratio, from 227 in 1992 to 271 in 2000 and further to 449 in 2006. South Africa's maternal mortality also increased for a while from 64 in 1999 to 78 in 2001, but dropped to 73.1 in 2002. Similarly, Ghana's maternal mortality declined from 250 in 1999 to 186 in 2006, only to rise again to 230 in 2007. One of the most dramatic increases recorded may be that of the Sudan, which went from 509 in 1999 to 1,107 in 2007. This is in contrast to Mauritius and Seychelles, which, not surprisingly, given their strong health infrastructure and management capacity, reported very low levels of maternal mortality.

There is no doubt that pregnancy-related deaths can be considerably minimized in Africa. The health risks of mothers are greatly reduced with the increase in the proportion of babies delivered under supervision of health professionals. All countries recognized that efforts focused on the provision of antenatal care; ensuring skilled attendance at birth; basic postnatal and newborn care, improving access to basic and comprehensive emergency obstetric and newborn care; providing quality family planning service; and ensuring post-abortion care are important to improving maternal and newborn health in Africa.

Therefore, the provision of Maternal and Child Health (MCH) services within the framework of Primary Health Care (PHC) was recognized by all the countries as fundamental to making Reproductive Health services available at the grassroots. The countries reported expansion in primary health care delivery services although disparities between the rural and urban areas and between regional and provincial areas still persist. The United Republic of Tanzania country report indicated that the Primary Health Sector Programme (2007-2017) serves as the framework for providing the road map for implementation of maternal and child health programmes aimed at achieving MDGs 4 and 5. Morocco is implementing a National Plan of Action on Health for the period 2006-2015, which has a strong component for reduction of infant mortality and improvement of child health.

The available data show clearly that, for some countries, only a small but increasing proportion of babies are delivered in health facilities or with the assistance of skilled health personnel. Postnatal care is also important to the health of mothers, as many maternal deaths occur shortly (48 hours) after delivery, because of limited access to maternal health services and poor quality services. In addition, postnatal care is extremely low in most SSA countries. Complications arising from unsafe abortions also contribute significantly to maternal mortality in the continent; but hard data are difficult to find. In addition, poverty reduces access to balanced nutrition, a factor critical to the health and survival of the child. Effective family planning programmes could go a long way in reducing fertility and reducing the risk of high overall maternal mortality in the population. In addition, the widespread practice of female genital mutilation in many African countries also often has negative effects on women's health.

## 2.3 Child Mortality

Regional patterns show that North and Southern Africa have the lowest level of infant mortality; with infant mortality rates over 80 per 1,000 live births in East Africa, and over 100 per 1,000 live births in Central and West Africa. Trends over time indicate that North Africa has had a pattern of low and consistently declining infant and under-five mortality rates since 1990. East Africa mirrors the African pattern of a gradual decline in child mortality. Both West and Southern Africa have experienced fluctuations in child mortality, although the overall levels are higher in West Africa than in Southern Africa. Some high child mortality countries have also been experiencing consistent decline, while for others, the rates declined up to the early 1990s, only to take an upward turn, largely due to the effect of AIDS.

The achievement of MDG 4, “Reduce child mortality“ was judged as very likely by countries, such as Burundi, Kenya, Mauritius, the Niger and Seychelles. This is likely related to the implementation of programmes which offer free medical services for children under the age of five. For Seychelles and Mauritius, child mortality is already very low, in 2007 infant mortality was 10.6 per 1,000 live births in Seychelles. For Benin, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland, and the United Republic of Tanzania, the achievement of this goal is likely, due to the successful implementation of child health programmes. These include expanded coverage for immunization that has led to a decrease in child mortality rates in these countries.

## 2.4 Policies and Programme Achievements

Significant steps have been taken in most countries to integrate population issues into existing policies and plans. However, implementation of these programmes has been very poor. Most countries reported reviewing policies and legislations, and designing plans and programmes that take into consideration, the recommendations of continental policies such as the African Health Strategy and the Maputo Plan of Action on sexual and reproductive health. Twenty-eight countries have formulated plans and programmes to this effect; 27 countries have embarked upon advocacy and awareness creation, while 22 have been building consensus and partnerships to adapt the African Health Strategy 2007-2015.

The provision of MCH services within the framework of Primary Health Care was recognized by all countries as fundamental to making reproductive health services available at the grassroots. Though the countries reported expansions in primary health care delivery services; disparities persist between the rural and urban areas as well as between regional and provincial areas.

In 2007, the overall modern contraceptive prevalence rate was about 20 per cent for Africa. Only in Southern Africa did that rate exceed 50 per cent, followed by North Africa (44 %); East Africa (17 %); and West and Central Africa (less than 10 %). Without a widespread adoption of modern methods of family planning and reduction in the magnitude of unmet family planning needs, it will be difficult, if not impossible, to achieve a significant reduction in maternal and child mortality, as well as achieve the fertility transition threshold critical to the reaping of the demographic dividend.

Overall, 40 per cent of the countries doubt the possibility of achieving improved maternal health by 2015. In terms of the targets, 50 per cent expressed their hope that the maternal mortality ratio could be reduced by three quarters by 2015; however, only 35.5 per cent are optimistic about providing universal access to reproductive health for their population by 2015.

In many parts of the world, including developed countries, abortion is a sensitive RH subject. Whether legally permitted or illegal, however, the practice of abortion is universal. The ICPD Programme of Action (POA) drew attention to the health consequences of unsafe abortion for women, and called for actions to address this critical public health issue (United Nations 1994). It notes further that abortion care should be an integral part of primary health care, and that in circumstances where abortion is not against the law, such abortion should be safe. The United Nations ICPD + 5 report renewed the call on health systems in circumstances where abortion was not illegal, to train and equip health-service providers and to take other measures to ensure that such abortion was safe and accessible (United Nations 1999).

## **2.5 Summary of Challenges**

The challenges include the following:

- a. Despite high policy commitment at the continental and country levels, the disconnect between policies and action often leaves a gap that must be filled; and
- b. If significant progress is to be made in the years ahead, discriminatory social/cultural values that prevent women and men from accessing SRH services should be vigorously challenged.

# **3- Gender equality, equity and empowerment of women**

## **3.1 Introduction**

In many developing regions, including Africa, ethnicity, class, religion and politics continue to define gender relations in favour of men. Gender relations shape women's access to resources and their work opportunities; frame the limits of what a woman may undertake at work, in the family or in public life; help determine male behaviour, responsibilities and entitlements; affect social and economic functioning at all levels; and influence relationships between spouses, children and parents, managers and employees, and community members. It is against this background that ICPD PoA set its objectives, including achievement of equality and equity based on harmonious partnership between men and women so as to enable men and women realize their full potential. Corresponding to these objectives are: MDG 3 which aims to promote gender equality and empower women; and MDG 2 which is to achieve universal primary education.

At the continental level, the African Union adopted in 2009, a Gender Policy (REV 2/Feb 10, 2009) as a framework to promote a gender-responsive environment and practices and strengthen commitments for the realization of gender equality and women's empowerment, especially in its member States.

## 3.2 Policies, Programmes and Institutional Arrangements

With the support of development partners, AU has developed a number of legal frameworks and policies to support gender equity, equality and the empowerment of women. These include the Solemn Declaration on Women's Rights, the Protocol on Human and Peoples' Rights and the Rights of Women, and the Continental Gender Policy. These frameworks have been instrumental in guiding national governments in developing policies and programmes in this regard.

Most countries in Africa have put legislative measures in place to ensure that gender equality, equity and women's empowerment goes beyond the mere equality of persons before the law enshrined in national constitutions. Specific legislation such as the National Civil Society law (2007) of the Sudan; the Legal Capacity of Married Persons Act 2006; the 2006 Constitution of DRC and 2006 nationality code of Morocco have all been enacted to address gender equality, equity and women's empowerment concerns. Some countries, including Gabon, Sao Tome and Principe, and Senegal, have also enacted special laws regarding the sexual and reproductive rights and health of women and men.

Country reports reveal that wide-ranging institutional arrangements have been put in place to facilitate gender mainstreaming and promote women's advancement in African countries. Benin, Gabon, Ghana, Ethiopia, Nigeria, Namibia, Mozambique, and the United Republic of Tanzania, reported that specific ministries, with decentralised outfits at the subnational level, have been created, with the mandate of mainstreaming gender concerns and promoting women's empowerment.

## 3.3 ICPD PoA Implementation and Achievements

The country reports of Ethiopia, Gabon, Ghana, Madagascar, Malawi, Senegal, and Sierra Leone indicated that programmes are being implemented to reduce maternal mortality. Although male involvement was regarded as critical to the achievement of RH objectives, efforts were primarily focused on women – mostly on maternal mortality reduction. Also, socio-cultural norms and practices combine with the power dynamics within households, to keep women vulnerable to maternal morbidity and mortality, and sexually transmitted diseases (STDs and HIV).

The country reports indicated a steady increase in women's political participation and representation in key decision-making organs in almost all African countries. In the legislature, Rwanda holds a global record of 57 per cent female membership of Parliament. The first democratically elected female Head of State in Africa was inaugurated in Liberia in 2006. In Mozambique, Namibia, South Africa, and several other African countries, female representation exceed 30 per cent. Currently, South Africa's Parliament ranks 10th out of 130 world-wide in terms of women's advancement in governance. In Uganda, the proportion of women MPs increased from 25 per cent in 2003 to 29.2 per cent in 2007. Through proactive empowerment actions, legislation and effective advocacy, 51 per cent of persons in decision-making positions in the public sector in Mauritius are women. By contrast, in Morocco, women constitute only 20.6 per cent of ministers and 10.5 per cent of parliamentarians.



Although the illiteracy rate among women is decreasing and gender disparities are narrowing, in many countries, these problems still persist. According to 2007 UNESCO Sources, in Chad, for instance, the female literacy rate is 12.8 per cent, while for men, it is 40.8 per cent. In four other countries, less than 20 per cent of all women are literate: the Niger (15.1 %), Mali (15.9 %), Burkina Faso (16.6 %), and Guinea (18.1 %). In Uganda, girls' enrolment improved from 47 per cent in 1997 to 50 per cent in 2005. In Morocco, enrolment for both sexes at both primary and secondary levels is nearly equal, with girls accounting for 47 per cent of enrolment. Nevertheless, as in other countries, disparities exist at subnational levels.

From 1990 to 2006, female employees in non-agricultural wage employment in SSA increased from 25 to 31 per cent. In North Africa, the proportion remained at 21 per cent during this period. Female unemployment rates are also higher than male rates in North Africa, but lower in the rest of Africa. In 2007, women in Morocco accounted for only 20.7 per cent of salaried workers, compared to 79.3 per cent for men. Moreover, only 13.8 per cent of women, compared to 86.2 per cent of men in Morocco are self-employed. Also of note is the fact that, although the share of South Africa's women in wage employment in the non-agricultural sector is said to have increased, large disparities in wages earned by women and men still persist.

The reports generally show that cultural and traditional practices continue to influence decision-making and the participation of men and women at the family and household level. However, many countries (such as Botswana, Lesotho, Senegal, South Africa, etc.) have programmes designed to encourage men's participation in family life and reproductive health matters, including gender-based violence (GBV) prevention. The Ugandan country report reveals that the proportion of women who take sole decisions regarding use of their earnings decreased from 59.6 per cent in 2001 to 54.6 per cent in 2006, irrespective of their levels of education, age, and rural-urban location.

Gender-based violence was identified as a critical problem that manifests itself in various forms across the continent; these include psychological, emotional and sexual abuse within families and communities. The country report for Ethiopia also shows that RH problems, particularly among the country's young women, could be linked to certain harmful traditional practices such as early marriage, abduction, female genital mutilation/cutting (FGM), gender inequalities, sexual coercion, rape, and deprivations such as lack of access to user-friendly sexual and reproductive health services. In the Sudan, early marriage is also very common, especially in rural areas where 12 per cent of girls are married before age 15, and 27 per cent marry before age 18. The Central African Republic (CAR), the Congo, and Sierra Leone all cited armed conflict as a major factor that aggravates the occurrence of sexual violence against women and girls. According to the Uganda country report, the 2006 Demographic and Health Survey (DHS) results show that 70 per cent of women have experienced either physical or sexual violence, with about 29 per cent having experienced both physical and sexual violence. The Sudan report indicated the prevalence of FGM/C at 70 per cent in Northern Sudan and that 53.6 per cent of women who have ever married still intended to carry out the operation on their daughters. South Africa's country report indicates that many teenagers do not want to become pregnant at an early age, but are significantly more likely to have experienced forced sexual initiation and physical abuse from their partners.

Nigeria, Ghana, Senegal, Madagascar, Democratic Republic of the Congo (DRC), the United Republic of Tanzania, Gabon and Sierra Leone reported various actions taken to protect the girl child including the ratification of various international conventions and the enactment of national legal frameworks. Specifically, Nigeria passed the Child Rights Acts in 2003 and the United Republic of Tanzania has revised its labour law to prohibit employment of children less than 14 years of age. In order to address the incidence of early marriage, Sierra Leone passed the 2008 Marriage Act which increased the minimum legal age at marriage to 18 years.

### **3.4 Achieving the MDGs**

An overwhelming 90 per cent of responding countries indicate the likelihood of achieving the goal of universal primary education, as well as the related MDG 2 target 2a, to “Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling”. In response to the question on prospects of achieving MDG 3, most African countries (76.7 %) expressed this likelihood; but fewer countries (66.7 %) are optimistic about meeting the target by 2015.

Mauritius, Seychelles, and Tunisia indicated that they have almost achieved MDG 3-Target 1, “Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015”. For the Gambia, Lesotho, Morocco, Senegal, Sierra Leone, and Tunisia, the chances of achieving this target were judged as very likely in view of the policies and programmes being implemented and the related results already achieved.

Countries like Burundi, Comoros, Guinea, Kenya, Madagascar, Sao Tome & Principe, Swaziland, the United Republic of Tanzania and Uganda, as a result of suitable policies and programmes which are yielding positive results, will likely achieve the target. Due to universal access to education, at both primary and secondary levels in Uganda, the ratio of girls to boys in primary schools in 2006 was 0.96 while that for the secondary level increased from 0.83 in 2001 to 0.84 in 2006. The target is judged as unlikely to be met by the Sudan, the Niger and CAR whereas a result of various factors, the disparities in primary and secondary school enrolment have either not improved as desired or actually deteriorated.

### **3.5 Commitment to International Agreements**

The country reports indicated that the AU Solemn Declaration on Gender Equality in Africa and the African Charter on Human and Peoples’ Rights were adapted through policy and legislative reviews, reform of institutions and formulation of plans and programmes. The countries reported that other instruments such as the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Millennium Development Goals and Targets had been used to garner resources and exert efforts to address gender concerns.

All the countries indicated that, in addition to the ratification of CEDAW, they have prepared at least one country status report on the convention’s implementation. All the 39 responding countries have ratified CEDAW, 35 are implementing it, while 32 countries say they are reporting on its implementation. Some countries that did not take any action attributed it to lack of political com-



mitment and weak institutional capacity. Only two countries stated that CEDAW and its adaptation at the country level was not a national priority.

### **3.6 Summary of Major challenges and constraints**

Although most countries reported making progress, they continue to face challenges that limit the achievement of set goals. Some of these are listed below:

- a. While gender-related policies and legislations abound, translation of these policies into programmes, enforcement of the legislations and sustained implementation of the programmes, remain a major challenge to addressing gender concerns in most countries;
- b. The HIV/AIDS burden on the continent still rests heavily on women and girls; and
- c. Socio-cultural norms and traditional practices continue to hamper the achievement of gender equality, equity and women empowerment goals in all the countries.

## **4. The family, its role, rights, composition and structure**

### **4.1 Introduction**

In Africa, the family is recognized as an important unit of society and development and plays a key role in the production, reproduction economic and social functions of its members. The 1992 Dakar Ngor Declaration recognized the family as an essential component of the economic and social fabric, which requires the pursuit of appropriate strategies, adapted to family services. In July 2004, African Heads of State and Government adopted the “Plan of Action on the Family in Africa”. This policy instrument called for actions to improve the quality of life of the family in Africa in nine priority areas. These include, poverty alleviation, rights to social services such as education; family health; reproductive health; and families with special needs; promoting environmental sustainability, particularly in the areas of environment, water and sanitation, nutrition and food security, adequate shelter, and land ownership. The 1994 ICPD PoA also urged governments to develop policies and laws to support the family and contribute to its stability; establish social security measures to address the social, cultural and economic factors behind the increasing cost of child rearing, and promote equal opportunity for family members.

### **4.2 Family Situation**

The situation of the family in Africa continues to be seriously impacted by many factors, including conflict and instability, poor governance and deteriorating human rights, all of which jeopardize the stability and welfare of the family. Such situations have strained family relations and have led to the spread of violence and crime among family members. The food, energy and financial crisis have worsened poverty levels in Africa. This notwithstanding, the impact of poverty on the structure and formation of the African families is not very well understood, owing to the paucity of research. In terms of Health and population, research indicates that rapid urbanization and increased use of modern contraceptive methods were responsible for the decline in fertility in the last three decades. In general, fertility in Africa declined mostly in urban areas and remained higher in rural areas where traditional social institutions and values continued to dominate family lifestyles. The gravity of the health and

demographic situation, including as a result of diseases like HIV/AIDS, is reflected in the increasing number of orphans and widowed women, and high school dropout rates, especially among girls.

### 4.3 Implementing ICPD PoA

Results from the ICPD at 15 Review questionnaire indicate that countries have put strategies in place in housing (26 countries), work (24 countries) education (33 countries) social security (29 countries), and inheritance (26 countries), and ageing (31 countries). The actions undertaken since 2004 cover family members, particularly those living with HIV/AIDS, the aged, disabled, unemployed, widowed, and persons affected by natural disasters (see Tables 3.1 and 3.2 in Chapter 3). The country reports provide more detailed information on actions taken by countries, including policies to address family welfare in areas such as social security, education, health, and housing. Benin, Malawi, Mauritius, Nigeria, Mozambique, Seychelles, Sierra Leone, and South Africa have policies, laws and other institutional frameworks to address family needs, and programme to support vulnerable family members, including AIDS orphans, people with disabilities and the elderly. The family which received special attention in post conflict countries, were Angola, Liberia, Mozambique, and Sierra Leone.

### 4.4 Summary of Challenges

These actions and achievements notwithstanding, the reports indicate a low adaptation of the AUC Plan of Action on the Family in Africa. Implementation of existing legal codes and regulations aimed at improving family welfare is also lacklustre. When macroeconomic policies are implemented, their consequences and impacts on the various categories of families are often overlooked. It is therefore necessary to accelerate the implementation of family laws, policies and strategies, and conduct research to inform decision-making so as to integrate family concerns into the development process, as envisaged by the ICPD PoA.

## 5. Children and youth

### 5.1 Introduction

The ICPD PoA urges governments to, among other actions: a) Give high priority and attention to all dimensions of the protection, survival and development of children and the youth; b) Take effective steps to address the neglect, and all types of exploitation and abuse of children, adolescents and the youth and; c) Enact and strictly enforce laws against economic exploitation, physical and mental abuse and neglect of children. In the same spirit as the ICPD PoA, the African Youth Charter, provides a guide and obliges African Union Commission (AUC) member States to mobilize resources and facilitate implementation of programmes on youth employment, youth rights, gender balance, advocacy, education and skills training, health, peace and security, culture, sporting and recreation with meaningful participation by the youth. The *Convention on the Rights of the Child* (Art. 24) affirms that children have the right to attain the highest standards of health and to health care, including family planning education and services.

## 5.2 Situation Analysis

### 5.2.1 Children

UNICEF's State of Africa's Children 2008 Report clearly indicates that Africa south of the Sahara is the most difficult region in the world for a child to survive until age five. Three countries – the Democratic Republic of the Congo, Ethiopia and Nigeria – were reported to account for more than 43 per cent of total under-five deaths in all of Africa.

### 5.2.2 Youth

The population of Africa is predominantly youthful, with children and young people below age 15 constituting over 40 per cent of the total population. The Country reports indicated that the challenges faced by youth and adolescents in all countries are very similar. These include a high level of open unemployment, drug and substance abuse, and exposure to RH and related problems, such as STIs/HIV/AIDS, early marriage and early pregnancy and birth complications, and unsafe abortion. Just like many other countries, the Sudan and Malawi indicated that most reported cases of HIV infection involved young people. The 2006 Sentinel Survey of Namibia revealed that an estimated 10.2 per cent of the 15-19 year old and 16.4 per cent of the 20-24 year old pregnant women are infected with HIV. In South Africa, the highest HIV prevalence rate of 33.7 per cent in 2008 was predicted for women aged 27 years.

The Mauritius country report indicated that in 2007, 10.6 per cent of all live births in Mauritius were to women aged 15-19, with teenage pregnancy and abortion and its complications, on the rise. For CAR, over half of teenagers (15-19 years) lived in conjugal union in 2006, and about 20.4 per cent of the women were married before the age of fifteen.

According to the country reports, the enormity of the challenge posed by problems facing young people has led to the introduction of policies and programmes aimed at youth socio-economic empowerment, including decentralized structures at subregional level, for the coordination of youth issues. In African countries such as Malawi, Senegal, Ghana, Nigeria, the United Republic of Tanzania, and Mozambique, youth development strategies and programmes also focused on the promotion of healthy lifestyles including Sexual and Reproductive Health (SRH) among young people. In addition to the formulation of the National Youth Policy in 2004, Ethiopia reported the mainstreaming of youth issues into the Plan for Accelerated and Sustained Development to end Poverty (PASDEP), covering the period 2006-2010. Projects aimed at promoting youth employment as a strategy for poverty reduction are being implemented in Senegal, Benin and Lesotho to create an enabling national environment for the promotion of youth employment and enterprise development.

The country reports indicate that steps were being taken by the countries to promote the participation of young people in decision-making, including the political process. In Mozambique, Uganda and the United Republic of Tanzania, for example, special provisions are in place for youth participation in the political process at both subnational and at the national level.

All countries reported having a number of strategies in place to address adolescent sexual and reproductive health. Tackling adolescent reproductive health issues through specific programmes for youth both, in and out of school forms a major part of the efforts made by DRC, Gabon, Ghana Lesotho, Mauritius, Nigeria, Senegal. The United Republic of Tanzania, and Uganda, HIV/AIDS prevention programmes in Benin, Namibia, South Africa, the United Republic of Tanzania, and Uganda have also been used to specifically target girls and boys to assist them in making choices that would protect themselves from infection.

### **5.3 Achievements**

West Africa reports show that although progress has been reported for the region, it still accounted for more than 40 per cent of Africa's child deaths in 2006, followed by East Africa (30 per cent), Central Africa (18 per cent), Southern Africa (8 Percent), and North Africa (2 per cent).

As a result of actions taken in some countries such as Uganda, the high incidence of teenage pregnancy has been reduced considerably. In Ghana, adolescent contraceptive use has increased; and as in other countries, adolescents have become more knowledgeable about reproductive health issues. In conflict and post-conflict countries such as DRC and Sierra Leone, the implementation of special programmes has resulted in rehabilitation and reintegration of child and youth ex-combatants into society.

On the whole, these efforts are constrained by insufficient resources. This limits programme implementation to either small pilot schemes or ones located in selected districts only. Special groups such as very young married girls and youth with disabilities have also been very difficult to reach with services due to socio-cultural and logistics constraints. Generally, poverty, unemployment and limited access to productive economic opportunities and gender discrimination in all spheres of life, especially for the girl child, continue to act as major challenges to the provision of services to children and young people.

### **5.4 Summary of Challenges**

According to the UNICEF 2008 Report, the way forward for addressing the needs of children, in sub-Saharan Africa especially, is to radically transform health systems in each country by focusing on key strategic areas including: (a) Strengthening health systems through community partnerships, to foster local ownership of child survival efforts; (b) Establishing the continuum of care across time and location to connect essential maternal, newborn and child health services through the pregnancy, childbirth, postnatal and newborn periods into childhood and provide integrated services to adolescent girls and; (c) Strengthening health systems with results-based strategies, and unified programmes and partnerships.

For the youth, research shows that in terms of demographic dividend, much of Africa will experience gains well past 2040. Therefore, there is a need to take adequate steps, including education and skills development programme, fostering a flexible labour market, and using gender-sensitive planning to ensure that Africa is effectively positioned to realize its benefits.

## 6- HIV/AIDS, Malaria, TB and other communicable diseases

### 6.1 Introduction

The ICPD PoA objective regarding HIV/AIDS and STDs is to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women. To accelerate the realization of the ICPD PoA for HIV/AIDS and STDs, the Millennium Declaration in 2000 set two targets for Goal 6, “Combat HIV/AIDS, malaria and other diseases”. These targets are: (a) Have halted by 2015, and begun to reverse, the spread of HIV/AIDS and; (b) Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.

### 6.2 Patterns and trends

Available data indicates that HIV prevalence among female adults (aged 15-49) is highest in Southern Africa and lowest in North Africa. All the countries with a female adult prevalence rate of 25 per cent and above (2005) are in Southern Africa: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. Except for Central African Republic, Southern African countries like Mozambique and Malawi also fall within the 10 to 20 per cent prevalence range.. By contrast, several North and West African countries, have all maintained a very low, adult female HIV prevalence rate of about one per cent or less. These include Algeria, Egypt, Madagascar, Mauritania, Mauritius, Morocco, Somalia, and Senegal.

In view of the devastating impact of the HIV/AIDS pandemic, most countries reported having taken steps to provide an enabling environment for combating the disease, so as to reduce its prevalence and impact. Related actions included policies and legislation formulation and setting up coordinating institutions at both national and subnational levels. The country reports also indicate that National Multi-Sectoral HIV/AIDS Programmes and strategic plans were being implemented as comprehensive country-specific prevention, care and impact mitigation responses to the epidemic. In recognition of the close relationship between SRH, STI and HIV/AIDS, most of the countries, such as Lesotho, Malawi, Mauritius, Nigeria, and Uganda have also taken steps, such as development of policy, technical guidelines, formulation of protocols as well as reform of service delivery mechanisms, with the aim of integrating HIV/AIDS into RH programmes and services.

Responses to the ICPD at 15 inquiry indicate that Tuberculosis (TB) is acknowledged as a major public health problem in all countries, especially those with high HIV/AIDS prevalence. The country reports also revealed that national TB control programmes and strategic plans were in place in almost all countries. These are principally focused on raising awareness among the people and improving TB case detection and cure.

Malaria was acknowledged by most countries as the number one cause of morbidity and mortality for all ages. Most countries, including Ethiopia, Malawi, Mozambique, Sudan, and Tanzania reported having in place a Roll Back Malaria (RBM) and other strategic programmes aimed at improving malaria case

management, especially for vulnerable groups such as children and pregnant women, and vector control through the use of insecticide-treated bednets (ITNs). As a result of the high prevalence and impact of malaria, especially within the sub-Saharan countries, specific programmes aimed at vector control, distribution of mosquito nets and diagnostics and treatment are being implemented to reduce the effects of the disease.

### **6.3 Policies and Programme Achievements**

The AUC has put numerous regional commitments in place, namely, the African Health Strategy; Maputo Plan of Action on SRH; the Abuja Declaration on Universal Access to Prevention of HIV, Malaria and TB; and the Abuja Call to Universal Access to Treatment, Care and Support. Through these continental actions, African countries scaled up efforts to combat the HIV/AIDS pandemic. Over the years, mechanisms have been put in place for improved surveillance of infectious diseases, including malaria and TB. These have guided the adoption of interventions to reduce the prevalence of these diseases. There has also been a big push for evidence-based research for the management of HIV/AIDS programmes, such as the case for male circumcision and whether it contributes to reduction in the spread of the virus. HIV/AIDS-related drugs have also been made affordable and available to more people in need. Innovative health care financing, including free care, has been instituted in countries like Kenya, and Mauritius, and free extension services in countries like Ethiopia.

According to the ICPD Country reports MDG 6: “Combat HIV/AIDS, malaria and other diseases”, was judged as likely to be achieved by about one-third of the countries. Thirty per cent indicated that they are unlikely to achieve target 1 of MDG 6, “Have halted by 2015, and begun to reverse, the spread of HIV/AIDS”. About the same proportion of responding countries (28.6 per cent) consider it unlikely that they will achieve Target 2 of MDG 6, “Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases”.

### **6.4 Summary of Challenges**

Despite progress being made, the country reports indicate that linkages between the different types of programmes are inherently weak; for instance, between HIV/AIDS and RH. In Uganda and Morocco, this problem has weakened the synergy and harmonization of interventions. Reports indicate that there is also limited translation of increased knowledge of HIV/AIDS into positive behavioural change, particularly in terms of adoption of safe sex practices, including the effective and continuous use of condoms. Poverty, stigma, religion and socio-cultural factors continue to be key factors that exacerbate the spread of HIV/AIDS on the continent. Country reports further indicated that although women and girls were the most affected by HIV/AIDS, they are still the least served. This is mainly due to inadequate mainstreaming of gender into HIV/AIDS service provision. Conflict situations that destroy health infrastructure and create forced population movements have also served as a major challenge to programme interventions in the countries affected; as has the role of conflicts in fuelling gender-based violence and the vulnerability of women to the risk of STI and HIV infection.



## 7- Population distribution, urbanization and internal migration

### 7.1 Introduction

In addition to focusing on population distribution and sustainable development, population growth in large urban agglomerations, and internally displaced persons, the ICPD PoA also sets objectives for addressing population and environmental challenges. These ICPD PoA objectives are clearly linked to MDG 7, Ensure sustained environmental sustainability and its related targets: (a) “Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources”; (b) “Halve, by 2015, the proportion of people without sustainable access to safe drinking water”; and, (c) “By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers”. Addressing population distribution, urbanization and internal migration issues is important for achieving sustainable development as they have implications for achieving all the MDGs.

### 7.2 Situation analysis

ICPD at 15 inquiries reveal that governments are concerned with population distribution and rapid urbanization because countries have experienced significant changes in population size, distribution, urbanization and internal migration. Data on regional distribution indicates that Eastern Africa, with 315.8 million (31 per cent), has the largest population; closely followed by Western Africa with 29.5 per cent; Northern Africa 19.7 per cent; Middle Africa 11.9 per cent and Southern Africa 5.7 per cent. The most recent estimates of world population (UN, 2008) show that the average population density for the whole world is 50.8 persons per sq km. Compared with 23.3 for the developed countries, and 68.4 for the less-developed areas of the world, Africa, with a density of 34.1 persons per sq km, is relatively sparsely populated. However, pockets of high population density are found in the coastal areas of the Gulf of Guinea, the coastal areas of the Indian Ocean and the Mediterranean Sea, and around the Great Lakes (Lake Victoria, Lake Tanganyika and Lake Chad).

Subregional variations also exist with the highest densities recorded for Eastern Africa (51 per sq km), followed by 49 in Western Africa, and then Northern Africa with 25, Southern 22 and Middle Africa at 19 inhabitants per sq km. Very high population densities are also recorded for the capital cities of most African countries. This is exemplified by Mozambique with a population density of 25 inhabitants per sq km for the country as a whole, but with 3,663 inhabitants per sq km for Maputo city; Ethiopia with an overall population density of 68 inhabitants for the whole country and 5,609 inhabitants and for Addis Ababa; and Sierra Leone with a national density of 69 persons per sq km compared to 9,426 for Freetown. In response to the ICPD at 15 inquiry, all countries considered rapid urbanization, high population density and rural exodus as major challenges to their development efforts.

Many regard the 21st century as a unique period in human history, when the growth of cities worldwide and urbanization will be a dominant influence on social and economic development. Currently, more than half of the world’s population lives in towns and cities. This is expected to reach

4.9 billion people by 2030. For Africa, it is expected that from 2005 to 2010, high urban growth rates will be recorded for countries such as Burundi (6.8 per cent), Liberia (5.7 per cent), Eritrea (5.4 per cent), Malawi (5.2 per cent), DRC (5.1 per cent) and Burkina Faso (5.0 per cent). This has wide-ranging implications, with eight out of the 15 countries for which over half of the urban population lives below the poverty line, being located in Africa (i.e. Angola, Chad, Madagascar, Malawi, Mozambique, the Niger, Sierra Leone and Zambia). The demographic profile of cities in Africa is characterized by a marked youth bulge, particularly notable in slum areas. This demographic scenario has wider implications for the urban sector to provide the lead in the country's development.

Africa is one of the continents with a larger proportion of its urban populations in coastal zones. This reflects both its colonial heritage, and the fact that 12 per cent of the urban population on the continent live in the low elevation coastal zones (LECZ), most likely to be affected by a rise in sea levels. Rapidly growing cities in Africa provide challenges and opportunities for socio-cultural change and development. In addition, continuous interaction of urbanites with rural dwellers could contribute to diffusion of social change agents across the continent. However, marginalization, accompanied by identity crises and feelings of frustration, especially among the poor, has fuelled violence and insecurity in Africa's urban areas.

Although, the use of skilled birth attendants and improved access to emergency obstetric care have helped reduce maternal mortality in urban areas, poor urban women are less likely to deliver with a skilled birth attendant. Also, the risk and prevalence of HIV/AIDS has been found to be higher in urban areas than in surrounding rural areas. It is reported that the 14 major metropolitan areas East and Southern Africa account for 25 per cent of total HIV prevalence, with more than million inhabitants in each area. In West and Central Africa, 25 major cities account for 20 to 25 per cent of the epidemic in this subregion.

### **7.3 Summary of Challenges**

Although, the country reports indicated a growing concern about the urban phenomenon, policy makers have often overlooked the crux of the challenge by neglecting the needs of the urban poor and discouraging internal migration. However, compelling evidence points to the positive role that urbanization can play in social and economic development. Cities, especially in the slums areas, have been identified as the potential battle fronts for achieving the MDGs. African countries should thus reconsider giving due priority to urbanization and population movement and distribution, as a key aspect of their development strategies. Specific strategies to be adopted or scaled up should include integrating population distribution, urbanization, internal migration issues into policies and programmes for poverty reduction and development in both rural and urban areas. This would create an enabling environment for all categories of people to improve their livelihoods in both rural and urban areas, and enable countries to capitalize on the demographic dividend in both urban and rural areas by creating opportunities for young people.



## 8. International migration

### 8.1 Introduction

Acknowledging the important role played by international migration in development, the PoA called for cooperation and dialogue between sending and receiving countries, in order to maximize its benefits for development. The ICPD PoA calls on governments in receiving and sending countries to address the issue of documented and undocumented migrants, as well as refugees, asylum-seekers and internationally displaced persons. International migration is not one of the specified goals of the Millennium Declaration. However, it is widely acknowledged that every MDG is linked directly or indirectly to migration. Indeed, after analyzing the relationship between MDGs and international migration, UNFPA (2006) reached the conclusion that international migration both facilitates and constrains the realization of the MDGs.

The developmental benefits of international migration are numerous and very well documented. Migration provides skilled and unskilled labour for development in the receiving countries. In return, the sending countries receive remittances, through both formal and informal means. Migration also facilitates trade, investment and the transfer and exchange of knowledge, skills and technology between sending and receiving countries. The developmental role of international migration in Africa extends to other important areas such as addressing poverty and providing cash flows through formal and informal channels to meet health, education, housing and other social needs. The human rights linked to migration streams in Africa are also equally important.

### 8.2 Status and Patterns of International Migration

The most recent international migration data on Africa show that, the major recipient countries are Liberia, Burundi, Equatorial Guinea, Western Sahara, South Africa, and to a lesser extent, Botswana, the Gambia and Sierra Leone. These countries show net international migration rates ranging from 4 to 20 per 1,000 people. On the other side are the major sending countries that show significant negative migration rates. They include, Cape Verde, Comoros, the Congo, Guinea, Lesotho, Mali, Morocco, Sao Tome and Principe, and Zimbabwe, with net migration rates ranging from -11 to -3 per 1,000 population. For about 17 countries, net international migration is zero; with the net values being small or insignificant for the remaining African countries.

In Africa as a whole, international migration grew from about 16.5 million in 2000 to about 17 million in 2005 - a half-million increase in five years. With an annual exponential growth rate of 0.7 per cent, international migration in Africa in 2009 is estimated at around 22.6 million. Though slow, this general picture masks a variable picture, as the status and trends of international migration vary significantly from country to country. Countries with the highest stock (274,000 or more international migrants in 2005) are shown in Figure 8.1, Chapter 8. These 21 countries together host 82.6 per cent of the continent's total stock of international migrants. The great majority of the international migrants come from neighbouring countries.

Development in Africa is increasingly attracting labour from other continents, particularly Asia.

Labour from India, China, and the Philippines are increasingly engaged in the mining, energy, and construction sectors. The rapidly growing economic and political relations between African countries and China and India attest to this trend.

The 'brain drain' is a large emigration of skilled workers from Africa to countries outside the continent, as well as intra-continental migration of skilled workers from one African country to another. The great majority of countries reported their concern about the brain drain and its impact on development. Most countries report the migration of talented and skilled Africans to Europe, USA, Australia, and the Gulf States, as being a particular drain on scarce human resources. Similarly, there has been considerable movement of skilled workers between African countries and their immediate neighbouring countries as the target destinations. The brain drain is reported to impact directly on specific sectors such as health and education. The indication from country reports is that there will continue to be a shortage of skilled workers, particularly in the health sector, as well as an oversupply of unskilled labour in many African countries.

Generally, undocumented migration is high in the Southern, Western and Northern Africa regions. Countries that host large numbers of undocumented migrants are Botswana, the Libyan Arab Jamahiriya, Senegal, South Africa, and the Sudan. Although the abolition of visas came into effect in 2005 under the Southern African Development Community (SADC) protocol that established free trade, based on free circulation of goods and people, countries in the Southern Africa region have reported an increasing trend of undocumented migrants in their countries. The great majority of undocumented migrants in the Republic of South Africa are from Mozambique and Zimbabwe. The remaining few are from countries as far as Ethiopia, Nigeria, and Somalia.

Return migration is a pattern that is gaining momentum in many African countries. Africa is experiencing two main patterns of return migration: return of refugees to their home countries resulting primarily from the end of conflict, and return of skilled and professional migrants from outside the continent. This latter trend is emerging with the financial crisis that has engulfed the receiving economies. Some countries have documented an increasing trend of the return of their nationals living abroad; Ghanaians, Nigerians, Sudanese, etc. who have been working abroad for years, are now returning to their home countries.

### **8.3 Policy response**

African countries have adopted different measures to address international migration concerns, including promotion of the return migration of skilled workers, encouraging investments from Diaspora communities, customs and tax exemptions, etc. Due to the social pressure arising from xenophobic attitudes in South Africa, the local government there has been forced to adopt restrictive measures, including repatriation or deportation of undocumented immigrants. In response to related attacks, some countries have taken measures to protect their nationals by facilitating their return to their countries of origin.

To date, 16 out of 40 countries have ratified the Conventions and Protocols on the Protection of the Rights of All Migrant Workers and Members of their Families. Eleven of these countries are already implementing these conventions and protocols. In addition, out of the 40 responding countries, 19 indicated that they had ratified, while 14 of them are implementing the Convention against Trans-national Organized

Crime and its supplementary protocols (the Protocol against the Smuggling of Migrants by Land, Sea and Air and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children).

Generally, countries expressed their concern about certain aspects of international migration, particularly, the problem of 'brain drain', refugee movements, pressures being exerted by migrants on local resources and negative ecological footprints left by migrants. In response, the continent's, sub-regional blocs should consider adopting migration protocols to facilitate international migration, while minimizing the disadvantages of migration to both the sending and receiving countries.

## **9- Crisis situation and emergency preparedness**

### **9.1 Introduction**

The ICPD PoA called on all governments to adopt collective measures to alleviate the suffering of children affected by armed conflicts and other disasters, and to provide assistance for the rehabilitation of children who become victims of these conflicts and disasters. It further calls on all countries to address the causes of conflicts and displacement; establish the necessary mechanisms to protect and assist refugees and internally displaced persons; institute measures to provide services for internally displaced persons and refugees, including basic health-care, reproductive health services and family planning; and make efforts in line with existing conventions and charters to find lasting solutions to problems affecting refugees and internally-displaced persons. Although there is no MDG or target on conflict or crisis situations, the fact that the Millennium Declaration emphasizes peace, harmony and fulfilment of human rights, as a precondition for sustainable development makes resolution of conflicts and emergency preparedness and interventions fundamental bedrocks for achieving the MDGs. Indeed, at the Millennium Summit, the General Assembly resolved to put in place the measures needed to attain peace, security and development in the world.

### **9.2 Crisis Situation in Africa**

Nearly one-third of African countries are currently experiencing a crisis or have experienced one within the past year. In the Horn of Africa, ongoing drought, compounded by the soaring food and fuel prices and widespread poverty have generated humanitarian emergencies in various countries. Due to protracted conflict in the Great Lakes Region, millions of people have been displaced within their national borders or are living as refugees in neighbouring countries. In the Sahel region, prolonged drought, attributable to climate change, is causing desertification, loss of farm lands and poor yields. It is also an area dotted by conflicts, which are major contributors to food insecurity and persistent poverty. For Southern Africa, heavy rains in 2007/2008 caused flooding in Zambia, Zimbabwe and Mozambique. As a result, nearly 90,000 people were affected by floods, including some 72,000 in Mozambique and 8,000 in Zimbabwe. Other flash points are the Central African Republic, Guinea-Bissau, the Mano River Basin in West Africa, the Niger Delta, and Southern Sudan.

This state of affairs has eroded livelihoods, exacerbated poverty, generated millions of displaced people and refugees, and left many people, especially women and children, vulnerable to disease, human rights violations, and high-risk occupations. According to the Commission on Africa Re-

port, the continent has by far the highest level of forced displacements in the world, consisting of 13 million internally-displaced persons (IDPs) and 3.5 million refugees, more than twice the absolute number in Asia.

The United Nations High Commission for Refugees (UNHCR) reports that in 2008, a 28 per cent increase in the number of individuals applying for asylum or refugee status was recorded principally because of: (a) The dramatic number of asylum applications in South Africa; and, (b) The significantly higher number of people from certain nations, in particular Afghans, Eritreans, Somalis, and Zimbabweans who sought international protection during the year.

### **9.3 Emergency Preparedness**

The country reports show that international conventions and protocols relating to crisis, refugees and displaced persons have provided frameworks for disaster and crisis management and implementation of emergency programme in collaboration with development partners. Responses to the ICPD at 15 inquiry show that the frameworks have been adapted for advocacy and awareness raising; formulation of national plans and programmes; and building consensus and partnerships on post-conflict related matters.

The country reports further indicate that the factors responsible for refugee movements in the responding countries are principally man-made. Responses indicate that armed conflicts that led to political instability and economic problems, were the main drivers of refugee outflows in Africa. This is followed closely by poor governance and failed development policies and strategies. These factors were identified as being highly responsible for the refugee problem on the continent rather than environmental factors. Moreover, governments in Africa have formulated policies and promulgated legislation to facilitate crisis and disasters management, as well as address the various humanitarian challenges in Africa. Governments are also creating an enabling environment for local and international NGOs to support displaced persons and refugees, by, for instance, granting special concessions and privileges, and allocating resources to these NGOs.

### **9.4 Summary of Challenges**

In addressing the different types of humanitarian problems in the continent, African countries continue to face various challenges. These include:

- a. The shortage of financial and skilled human resources to effectively and swiftly respond to disasters;
- b. Lack of national policy provisions on asylum seekers and refugees;
- c. Rapid population growth and its impact on the environment;
- d. Proliferation of small arms as a threat to peace and security;
- e. Weak democratic institutions; and,
- f. Limited adherence to good governance principles.

Governments and their development partners should thus establish mechanisms for conflict moni-

toring and resolution, including the promotion of good governance, peace security, reconciliation and human rights, and the adoption of sustainable post-conflict reconstruction at both the regional and country levels. It is also very important for governments to mainstream disaster-preparedness strategies into policies and programmes, including provision of reproductive health information and services to refugees, asylum seekers and IDPs.

## **10- Population and development data**

### **10.1 Introduction**

According to the ICPD PoA, it is important to have valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development, implementation, monitoring and evaluation. The Programme of Action places emphasis on research as the veritable source of medical, socio-economic and demographic data for policy formulation, programme development, monitoring and evaluation. ICPD PoA urges governments to strengthen their national capacity to carry out sustained and comprehensive programmes for research on population and development, and to collect, analyse, disseminate and utilize population and development data. Given its direct relevance to programme management, the need to develop training and research capacity in the population and development field cannot be overemphasized.

### **10.2 Population Data**

The population and housing census is the major source of population data for policy formulation, planning and programme management in African countries. Additional population and socio-economic data sets are commonly obtained from official records, operations research, and *ad hoc* sample surveys. Estimates of vital rates (fertility and mortality) are conventionally derived from vital registration statistics. Where a reliable registration system is not in operation, as is the case in most countries in Africa, it may be possible to derive indirect estimates from sample surveys or population census data. Official statistics being routinely collected by ministries, agencies and religious bodies can also be analysed and the estimates of demographic characteristics derived used for population planning.

However, data of the type described above are very expensive to collect, manage and disseminate. UNFPA has assisted many African countries undertake population and housing censuses, supplemented by Demographic and Health Surveys. These data sets have proved invaluable in assisting countries to formulate population, health and other social policies and programmes, as well as monitor their implementation. Increasingly, governments in Africa have been taking up the responsibility of generating development data. The use of DevInfo for data storage and management is also gaining popularity.

In response to new data requirements in the post-ICPD era, new strategies have been developed and implemented in African countries. These include, but are not limited to, the production and management of data in support of development programmes at national and subnational levels, along with the creation and maintenance of databases and integrated management information systems (IMIS).

### 10.3 Population research

Since the launch of the ICPD PoA in 1994, there has not been a comprehensive evaluation of the role of research in achieving the objectives of the programme in Africa. Research orientation and research capacity are two critical, related issues for ICPD PoA implementation in Africa.

Prior to the Cairo Conference, a substantial proportion of funds for population research and population activities originated from foreign sources and was focused on fertility and family planning. A "Cairo Plus Five" publication by the Population Reference Bureau and Population Council, New York (1999) is also quite revealing. Out of the 172 listings, 120, or over 54 per cent, relate to reproductive health issues; 11 per cent to population and environment and four per cent to migration. Again, as before, the keen interest by foreign agencies in population research in Africa seems to be focused on reproductive health.

In the preface to its 2001 resolution on population and development research, the *Southern African Minister's Conference on Population and Development* (SAMCP&D) notes that:

"Member States are at various stages of preparing population research agenda. Whilst awaiting the research on international migration, networking on population research should be encouraged. The SADC region will continue to follow up on modalities for undertaking resource mobilization and institutional identification for undertaking the research and studies".

This also underscores the need to undertake an inventory of research on population and development in Africa, as well as identify research gaps, and provide a basis for formulating a continental research agenda with subregional/subnational orientations.

The situation with the human and institutional research capacity in African countries, may be summed up as follows: (a) Research capacity is weak and requires the training of high-level human resources in all the relevant areas; (b) Research institutions require adequate funding by government, local agencies and supporting partners to ensure that research activities are relevant to local/national or regional needs; and (c) National governments need to be adequately informed about the significance of research and thereby provide policy and financial support that will deliberately orient or re-orient research and researchers in support of national needs and priorities.

### 10.4 Summary of Challenges

The challenges include the following:

- a. Through much of Africa, registration of vital events (births, deaths, marriages) has been neglected or largely incomplete in spite of the administrative, statistical and legal significance of vital statistics;
- b. Although many countries have conducted national population and housing censuses, due to capacity limitations, such data remain underutilized;
- c. Data for policy and planning in many areas are deficient or unavailable (e.g. incidence of



- HIV, AIDS mortality, maternal mortality, neonatal mortality, etc.);
- d. Although it is recognized that research is critical to development, in many countries research capacity is weak due to poor funding and limited institutional support;
  - e. There is need for collaboration among researchers to determine a research agenda for ICPD PoA, as well as the MDGs, and to mobilize resources, exchange ideas and provide direction for development-oriented research for Africa; and
  - f. There is a need to put available research information at national and regional levels into good use.

## **II- Resource mobilization, partnerships and coordination**

### **II.1 Introduction**

In recognition of the magnitude of resources required to implement the ICPD PoA in each country, and in consideration of resource limitation, particularly in African countries, the programme urged the international community to strive for the fulfilment of the agreed target of 0.7 per cent of GNP for overall official development assistance (ODA) and to endeavour to increase the share of funding for population and development programmes in order to scale up activities required to achieve the objectives and goals of the Programme of Action. The ICPD PoA further recommended that governments should devote an increasing proportion of public-sector expenditure to the social sector, within the context of addressing poverty eradication and sustainable development concerns. In terms of partnership, the PoA calls for strong collaboration between government, international organizations and non-governmental organizations in the implementation of the recommended action. The PoA also seeks to improve and strengthen mutual commitments to policy dialogue, as well as coordination of population and development programmes and activities at the national, continental and international levels.

### **II.2 Resource mobilization**

In line with the Paris Declaration on aid effectiveness, most countries have taken steps to put improved financial management systems for the utilization of external assistance in place. Most African countries signed and committed to implement continental or regional policy frameworks, such as the Abuja Treaty calling on States to allocate 15 per cent of their national budget to the health sector. Reports available do not provide an insight into the extent to which African governments have honoured promises made at continental meetings. Therefore it is important to introduce mechanisms to closely monitor the implementation of treaties and other binding instruments to make sure that countries live up to their commitments and are accountable to their people.

The country reports indicate that the major focus areas for resource mobilization to support ICPD interventions in almost all the countries comprise: reproductive health, including family planning, statistics and data systems (particularly population and housing censuses and DHS); HIV/AIDS; gender issues; advocacy and awareness-raising; and poverty reduction. In terms of resources for implementing national population programmes, countries indicate that most domestic resources are contributed by the Government. Funding from external sources in support of national population programmes in Africa in 2004 came from five major development partners: UNFPA, Islamic Development Bank (IDB), the UK

Department for International Development (DFID), International Development Association (IDA) and the African Development Bank (AfDB). Other major partners began to show interest from 2005 to 2007, namely: the Global Fund to Fight AIDS, Tuberculosis and Malaria (GTAfM), the Global Alliance for Vaccines and Immunizations (GAVI), UNICEF, WHO, the World Bank and the European Union and Commission. As shown in Table 10.2 in Chapter 10, the partners provided support in the form of finance and/or technical assistance. Such support, particularly, technical assistance, has proved quite critical to programme implementation.

The ICPD + 15 inquiry wanted to know the extent to which governments gave specific budget allocations to reproductive health in the distribution of resources among sub-programmes. Most countries that responded confirm that special provision had been made for RH issues in their latest national budgets on population. Countries also indicate that certain financial support mechanisms such as charging a fee for service, waiving fees for poor families, and establishing community insurance had been introduced. In most countries, there is hardly any component of the national population programme for which there are no budget provisions. These provisions are reflected either through components of the National Health Strategy; the National RH Strategy; or in both.

### 11.3 Partners and Co-ordination

NEPAD is considered as the continent's blueprint for partnership. It was supplemented by a Declaration on Democracy, Political, Economic and Corporate Governance at the Durban AU summit held in 2002. This Declaration also committed participating states to establish an African Peer Review Mechanism (APRM) to promote adherence to and fulfilment of its commitments. The APRM is a voluntary mechanism open to any AU country, and as of January 2009, the following 28 countries had become signatories to the APRM Memorandum of Understanding (MOU): Algeria, Angola, Benin, Burkina Faso, Cameroon, Djibouti, Republic of the Congo, Egypt, Ethiopia, Ghana, Kenya, Gabon, Lesotho, Malawi, Mali, Mauritius, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Sierra Leone, the Sudan, the United Republic of Tanzania, Togo, Uganda, and Zambia.

The country reports indicated that all governments are working with a range of development and co-operating partners in the implementation of ICPD Goals. The United Nations Development Assistance Framework (UNDAF) provides a strategic modality for ensuring that interventions supported by United Nations agencies, including UNFPA, UNDP, UNICEF, WHO, the World Bank, the United Nations Joint Programmes on AIDS (UNAIDS), the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and UNHCR are in line with the development objectives of the governments. In addition to these UN agencies, a range of international organizations and donor agencies such as DFID, the United States Agency for International Development (USAID), EU, Danish International Development Assistance (DANIDA), *Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)*, Swedish International Development Agency (Sida), International Planned Parenthood Federation (IPPF), CARE, Marie Stopes, and a host of others, including local NGOs, are operating in almost all the countries. This presents both an advantage and a challenge, especially with regard to coordination of efforts.



## 11.4 Progress in achieving the MDGs

MDG 8 is “Develop a global partnership for development”. While no country reported that this goal would very likely be met, some countries, including Benin, Burundi, Eritrea, Kenya, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, and Tanzania indicated that there was improved collaboration with their development partners which could make MDG 8 likely to be achieved by 2015. Other countries, such as Sudan and Swaziland, indicated that achievement of this goal was unlikely. For Sudan, the relationship between the government and the international community was not conducive to this type of cooperation; and for Swaziland, the country is currently experiencing a decline in foreign direct investments.

MDG8 Target 4 is to “Deal comprehensively with the debt problems of developing countries through national and international measures to make debt sustainable in the long term”. Many countries, including Burundi, Eritrea, Kenya, Morocco, Sao Tome, Seychelles, Swaziland, the United Republic of Tanzania, and Uganda, indicated putting measures in place to ensure debt sustainability, and are therefore likely to achieve this target.

The achievement of MDG8 Target 5, “In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries”, is deemed as likely by Eritrea, Kenya, Morocco, the Niger, Sao Tome, Seychelles and the United Republic of Tanzania because of efforts already being made to improve the management of supply systems for essential drugs and to foster strong collaboration between government and various international pharmaceutical institutions and foundations.

MDG8 Target 6, “In cooperation with the private sector, make available the benefits of new technologies, especially information and communication” was judged as very likely to be achieved by the Sudan, as a result of an expansion in mobile phone usage; and by Zimbabwe where the number of people with access to computers is reported to have increased from 13 per cent in 2000 to 77 per cent in 2008. For Eritrea, Kenya, Morocco, Niger, Seychelles, and Tanzania, the goal was judged as likely to be achieved because of efforts being made to adopt ICTs for the development of various sectors of the society.

## 11.5 Summary of Challenges and Constraints

The challenges and constraints include the following:

- a. Scaling up action to achieve the MDG objectives will require extra money as well as new approaches; this is why the United Nations proposed the 20/20 Initiative [UNDP et. al., 1998];
- b. Official Development Assistance (ODA) and debt relief will be indispensable, especially for the least developed and low-income countries; however, the current global financial crisis may mean further reduction in ODA flows to these countries;
- c. Debt servicing by many countries also constitutes a negative force in ICPD PoA implementation;
- d. For Africa, the main problem seems to be the overdependence on external resources, and

- the low level of domestic resource mobilization, particularly the private sector, in support of population activities; and
- e. With respect to external assistance, the problems facing Africa seem to be three-fold: (i) Delay in delivery of promises by development partners; (ii) Conditionalities attached to most development assistance and; (iii) Poor management of donor money.

A recent meeting in Cairo (June 2009) of African Experts to discuss Fiscal Policy for Domestic Resource Mobilization was most appropriate. At the meeting, Mr. Abdoulie Janneh, United Nations Under-Secretary-General and ECA Executive Secretary said: “While seeking to obtain as much external financial support as it can get, Africa must also look inward to the policy options available to increase domestic resources for development”. With regard to the ICPD PoA and MDG programmes in the continent, the next five years should focus much more on the private sector in its domestic resource mobilization drive.

## 12- Monitoring and evaluation mechanisms

### 12.1 Introduction

The ICPD PoA encourages Governments to monitor progress towards the attainment of the goals and objectives set forth in the Programme of Action and calls for valid, reliable, timely, culturally relevant and internationally comparable data to be available for policy and programme development, implementation, monitoring and evaluation.

Monitoring of the MDGs has been taking place globally through the annual reports of the United Nations Secretary-General to the General Assembly, and through periodic country reporting. MDG monitoring focuses on two interrelated issues; monitoring *MDG outcomes* (degree of ‘Human Rights Standards’ achieved); and monitoring *MDG process* (the extent to which progress has been made without compromising ‘Human Rights Principles’). This underscores the fact that the process of human development is as important as the outcome.

At the continental level NEPAD provides the vision and framework for monitoring development process in Africa. It identifies democracy, human rights and good governance as the core challenges for moving the continent forward (ECA, 2005). The MOU on the African Peer Review Mechanism provides a framework for the good governance report cards of the AU member States voluntary assessment and for identifying best practices and lessons learned to be disseminated and emulated. The APRM membership currently represents 652.7 million people – an equivalent of 74 per cent of the total African population. Although the mechanism faces financial, capacity, procedural, operational, and political challenges at the national and continental levels, the APRM Report 2007, maintains that the APRM has served as a means of showcasing Africa’s innovative thinking in governance. The ECA’s African Governance Report, published in 2005 and 2009, has also served as a major mechanism for monitoring governance and accountability in African countries.

### 12.2 Past evaluations

ECA, with the assistance of other partners, especially UNFPA, has conducted two evaluations specifi-

cally related to ICPD PoA implementation in Africa: ICPD at 5 in 1999 and ICPD at 10 in 2004. To support the implementation, management, monitoring, and evaluation of population-related policies and programmes, African governments have established special bodies (commissions, councils or committees) often composed of high-level officials, parliamentarians or private individuals. At the same time, sector-specific strategies are also in place with frameworks to monitor and report on set targets, for example, in the health or education sectors. The inquiry revealed that these institutions and frameworks were often weak and incapable of carrying out their mandates without donor support.

### 12.3 ICPD + 15

Response to the ICPD at 15 inquiries indicate that in most countries integrated mechanisms ranging from the Monitoring and Evaluation Unit at a Central Ministry; Monitoring and Evaluation Units in various Sectoral Ministries and Centralized M&E Framework for monitoring Poverty Reduction Strategies (PRS) and National Development Strategies (NDS) located outside a government ministry are in place for monitoring development strategies including the MDGs and national development strategies such as the PRSPs. The countries indicate that they are monitoring and evaluating key ICPD issues through mechanisms established to coordinate and monitor national development programmes and projects; including the Medium Term Expenditure Framework (MTEF).

With the assistance of UNDP and sister agencies like UNICEF and UNFPA, countries have set up and institutionalized DevInfo databases and Integrated Management Information Systems to facilitate the storage of data for monitoring national development objectives and facilitating national MDG reporting.

African countries have therefore called for sustained efforts to harmonize monitoring and reporting frameworks acceptable to both government and development partners. However, this has yet to be established in almost all countries. There also remains a need to strengthen institutions, mobilize resources, and sustain capacities for the large data and information systems required as a tool to support a vibrant monitoring and evaluation mechanism at the country level.

### 12.4 Summary of Challenges

Countries generally monitor the MDGs from two interrelated dimensions; namely, *MDG outcomes* and monitoring *MDG process*. The same applies to the monitoring of ICPD PoA indicators - which have been established as development outcomes. However, as noted by UNDP (2000), although human development thinking has always insisted on the importance of the development process, many human development approaches and tools focus more on measuring outcomes of social arrangements, and are less sensitive to evaluating the processes needed to achieve these outcomes. This underscores the need to ensure that the monitoring tools developed achieve a balance between the two types of measurement.

ECA has undertaken two governance evaluations in Africa (Governance Report I, 2005; Governance Report II, 2009). Future evaluations of both ICPD PoA and the MDGs will also need to take on the challenge of developing effective process evaluation criteria and indicators as well.

## **13- Factors affecting the implementation of ICPD PoA & MDGs**

### **13.1 Introduction**

Accounts of ICPD at 15 implementation presented in various sections of the report indicate that the process has been facilitated or inhibited by a range of factors. These fall into four categories: (i) Availability of resources; (ii) Political commitment; (iii) Policy and institutional reforms; and, (iv) Programme implementation and management.

### **13.2 Facilitating factors**

The inquiry indicates that governments continue to show commitment to addressing population, gender and RH concerns. Thus a broad range of policy and institutional reforms listed and discussed in the preceding sections of this report attest to the commitment of African Governments and their partners to achieving the objectives of the ICPD PoA objectives, as well as the MDGs. In almost all countries that reported, new institutions have been built, older ones restructured, human and institutional capacities have been strengthened, and databases established for policy formulation and programme management, including monitoring and evaluation.

### **13.3 Inhibiting factors**

The inquiry also shows, however, that countries are being affected by external financial problems such as the debt burden, decrease in ODA and insufficient access to international markets. They are therefore unable to mobilize sufficient external financial resources for population programmes. Also, countries were faced by the challenge of inadequate government funding of population activities in the face of competing national problems and it was difficult to mobilize resources from other domestic sources for population programmes.

Moreover, a set of socio-cultural factors were identified as inhibiting factors to implementation of population and reproductive health-related policies and programmes in various countries. About 70 per cent of responding countries identified the existence of unfavourable socio-cultural, norms, values and practices as a major challenge to their effort. In particular, women's socio-economic status and vulnerability were identified by 68 per cent of the responding countries as key factors that continue to impede ICPD PoA implementation in Africa. The inquiry results further show that in at least 40 per cent of responding countries, coordination is a challenge to its implementation. Another finding is that countries face internal problems ensuring cooperation between sectoral ministries, and the low level of involvement of stakeholder groups, such as women, civil society and NGOs. The countries also cited inadequate cooperation of international organizations, including donors, as a notable challenge in this process.

Reports of MDG Needs Assessments conducted in Africa also underscore these constraints, and point to the fact that the countries do not have the magnitude of resources needed to achieve the MDGs by 2015, especially in the face of dwindling overseas development assistance. The persistence of poverty in most of the countries despite decades of investments, the demographic trap, pervasive

inequality, and the burden of diseases, also cast a heavy shadow of doubt on the feasibility of achieving the MDGs by 2015. Additional problems that will affect the achievement of these internationally agreed goals include: economic stagnation; limited human capacity in key sectors such as health; insecurity and political instability engendered by civil conflict; limited transparency and accountability; gender inequality; and, environmental degradation.

## **I4- Recommendations**

Overall, progress in implementing both the ICPD PoA and the MDGs in most African countries has been unequal, but generally slow. Considerable efforts have been made in the formulation of national policies and the adoption of continental, as well as global conventions and agreements in virtually all areas of population, poverty reduction and sustainable development, complemented by national programmes. However, the extent of work in integrated population and development planning is rather limited. Indeed, only a few countries have taken steps to develop Action Plans to implement their population policies. Taken together, there appears to be a wide gap between population and development programming and implementation. To a large extent this explains the rather slow progress made by most African countries in implementing the ICPD PoA and the MDGs.

### **Recommendations**

Accelerating efforts for meeting the ICPD goals would require addressing the challenges within the socio-economic context of each nation. In this respect, the following recommendations are made for the acceleration of efforts for the achievement of the ICPD goals, as well as other development frameworks including the MDGs.

#### **I4.1 Poverty, Population and Sustainable Development**

These include the following:

- a. Accelerate efforts to promote peace and good governance and to resolve conflicts on the continent;
- b. Support strategies for addressing widespread poverty especially in rural areas and among vulnerable groups; and
- c. Put measures in place to address the shortage of critical human resource sectors that are key to the achievement of ICPD goals and the MDGs;

#### **I4.2 Reproductive Rights and Reproductive Health**

These include the following:

- a. Make adequately skilled personnel and resources available to provide quality integrated services, including emergency obstetric services, STIs treatment and family planning in all communities;
- b. Address adequately sexual and reproductive health needs of men, and design interventions for the enhanced participation in the provision of RH and family planning information and service; and

- c. Strengthen partnerships and efforts for the accelerated reduction of maternal morbidity and mortality;

### **I4.3 Gender Equality, Equity and Empowerment of Women**

These include the following:

- a. Strengthen the implementation/enforcement of policies, laws and programmes that address gender equality, equity and the empowerment of women including those related to the implementation of the Beijing Platform of Action, CEDAW and the elimination of violence against women;
- b. Strengthen institutional capacities for the systematic and consistent mainstreaming and implementation of gender concerns into policies, laws, programmes, budgets and plans;
- c. Take necessary measures and programmes to address the gender dimension of HIV and AIDS and related reproductive health problems.

### **I4.4 The family, its roles, rights, composition and structure**

This will include:

- a. The family, particularly family welfare and stability, should be given adequate consideration in the formulation and implementation of national development plans and strategies.

### **I4.5 Children and Youth**

These include the following:

- a. Ensure the increased enrolment of children especially girls at all levels of the education system, taking steps to foster retention of girls at the secondary and post-secondary levels;
- b. Put measures in place to address challenges related to young people's vulnerabilities and empowerment by ensuring that adolescent sexual and reproductive health concerns are well integrated into other interventions such as education/skills development, gainful employment and participation in decision-making;
- c. Sustain implementation of expanded programmes for immunization to achieve and maintain universal immunization and improved health for children and their mothers; and
- d. Provide for the needs of children and young people in particularly difficult circumstances, especially street children and those affected by wars and conflicts.

### **I4.6 HIV and AIDS, TB and Other Communicable Diseases**

These include the following:

- a. Promote actions to achieve behavioural change in favour of practising safe sex, especially the use of condoms;

- b. Strengthen actions aimed at empowering women and hence reducing HIV prevalence among young women;
- c. Train various categories of health workers in order to scale up access to counselling, testing and post-test services;
- d. Ensure care and support for persons affected by HIV/AIDS including orphans, other vulnerable children and the elderly;
- e. Strengthen the prevention of mother to child transmission (PMCT) of HIV/AIDS within the framework of maternal and child health care programmes;
- f. Reinforce strategies to roll out the provision of antiretroviral therapy to all health facilities; and
- g. Strengthen institutional and human capacity for expanded delivery of services to reduce the impact of Malaria, TB and other infectious diseases in all communities.

## **14.7 Population Distribution, Internal Migration and Urbanization**

These will:

- a. Ensure that due attention is given to urban planning and the expansion of social and economic services and infrastructures in urban centres especially satellite towns;
- b. Promote investment in rural areas to create employment opportunities for the rural labour force, thereby slowing down rural to urban migration; and
- c. Create opportunities for young people to capitalize on the demographic dividend in both urban and rural areas.

## **14.8 International migration**

These will:

- a. Implement policies and programmes to encourage Diaspora communities to invest and support development programmes in their countries of origin;
- b. Continue to build human capacities in especially key sectors such as health implement measures and incentives for retention of skilled professionals return of skilled migrants; and
- c. Implement programmes to uphold the rights of internal and international migrants, especially refugees and displaced persons, in line with laid down conventions.

## **14.9 Crisis Situation and Emergency Preparedness**

These will:

- a. Establish mechanisms for monitoring and resolution of conflicts, including the promotion of good governance, peace, security, reconciliation and human rights; and
- b. Mainstream disaster preparedness, including the provision of reproductive health information and services to refugees and IDPs into programme planning and response to emergencies.



## **14.10 Population and development data**

These will:

- a. Ensure the establishment and continuous update of integrated databases containing disaggregated socio-demographic and economic data for development programme formulation monitoring and evaluation;
- b. Establish and sustain the effective functioning of national vital registration system (registration of vital events of births, deaths, marriages) given the administrative, statistical and legal significance of vital statistics;
- c. Data collected through national population and housing censuses and special surveys should be analysed and used for development planning;
- d. Given the importance of research for development, countries should strengthen research capacity through increased funding and institutional support.

## **14.11 Resource Mobilization, Partnerships and Coordination**

These will:

- a. Increase technical and financial commitment of governments and development partners for the implementation of the MDGs and the ICPD Programme of Action; and
- b. Encourage the private sector to provide support for population and reproductive health programmes.

## **14.12 Monitoring and Evaluation Mechanisms**

These will:

- a. Adopt a harmonized coordination and monitoring framework for development strategies including PRSPs and the MDGs; and
- b. Strengthen the coordination, monitoring and reporting mechanisms of governments on MDGs and ICPD-related interventions.

## **14.13 Factors affecting implementation of the ICPD PoA/MDGs**

These will include:

- a. Good governance (political and economic) is an essential pre-condition for sustainable development and therefore an imperative for any future meaningful implementation of the ICPD PoA and MDGs;
- b. Human institutional capacity in the population and development sector should be improved for population programme design and management; and
- c. Population issues should be integrated into national development policies and programmes.

Part I  
**Review Process**





# I. Review process

## I.1 Background

Year 2009 marks the 15<sup>th</sup> anniversary of the International Conference on Population and Development (ICPD), and the 17<sup>th</sup> anniversary of the Dakar/Ngor Declaration (DND) on Population, Family and Sustainable Development. These two events are milestones in the history of population and development in Africa. The DND, which was adopted by the African countries in 1992, formed the basis of Africa's common position at the ICPD in 1994.

The ICPD adopted a twenty-year Programme of Action (PoA) with a broad mandate on interrelationships between population, sustained economic growth and sustainable development, and advances in education, economic status and empowerment of women. The DND and the ICPD-PoA have since guided the formulation and implementation of programs in reproductive health and rights, population and development, gender, and related national policies in Africa.

Among the objectives and goals of the ICPD PoA are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health (UN, 1994). These objectives are intricately linked to the MDGs.

Barely half a decade after the ICPD PoA, the world reached a consensus in New York at the Millennium Summit (2000) that the eradication of human poverty requires fundamental change of development strategies within the framework of the ICPD PoA. The Millennium Declaration (2000) reviewed and reiterated the human rights clauses of the UN agreements since 1990, and identified, with focus on Africa and other poor regions of the world, eight quantifiable, time-bound goals, that could accelerate development and eradicate poverty. The Summit, represented by 190 countries in the world, unanimously adopted the Declaration and Member States committed themselves to implementing this new framework in their respective countries (UN, 2000).

The United Nations Seminar on the relevance of population aspects for the achievement of the MDGs (2004) agreed that to a large extent, the MDGs that came out of the United Nations Millennium Summit of September 2000 further strengthens the implementation of the Cairo Programme of Action by

coming up with a limited set of time-bound quantitative targets that put women, men, and children at the centre of local and national efforts to reduce poverty and to spur social and economic development. The Seminar noted that countries agreed during the 2004 annual session of the Commission on Population and Development that the ICPD-PoA makes “an essential contribution to the achievement of internationally agreed development goals, including those contained in the United Nations Millennium Declaration.” The Seminar concluded that:

- a. The strong linkages that exist between MDGs and the ICPD entail that their goals and priorities are all about improving the welfare of Africa’s population and beyond;
- b. Their overarching goals try to focus the resources and efforts of both the rich and poor countries on achieving concrete improvements in people’s lives by reducing extreme poverty and hunger, and acknowledging the importance of putting the well-being of individuals, gender equality and human rights at the centre of social and economic development and;
- c. In the case of Africa, MDGs and the ICPD-PoA have an especially important role – they share the common goal of ending Africa’s most pressing problems such as the region’s perennial poverty trap, curtailing the spread of HIV/AIDS, lowering the disease burden for societies and unleashing Africa’s potential through more gender inclusive educational and development programmes and ensuring environmental sustainability. [United Nations, ECA, 2004).

Undoubtedly, the implementation of the recommendations of the PoA is the “sovereign right of each country, consistent with national laws and development priorities” (ICPD PoA). However, recognizing that Governments are not expected to meet the goals and objectives single-handedly, the PoA calls for partnership at all levels. The significance of the ICPD will depend on the willingness of Governments, local communities, the NGOs, and the international community to own its recommendations and turn them into actions. In this vein, the PoA identified the following five follow-up functions:

- a. Building strong political support at all levels for population and development;
- b. Resource mobilization;
- c. Coordination and mutual accountability of efforts to implement the PoA;
- d. Problem solving and sharing of experience within and between countries; and
- e. Monitoring and reporting of progress in the implementation of the PoA

The ICPD PoA calls on regional commissions and United Nations organizations functioning at the regional level to play an active role in the implementation of its action. In Africa, ECA is mandated by the United Nations General Assembly to follow up the implementation of the DND and PoA. In collaboration with UNFPA and in close consultation with African Governments, AUC, APC and AfDB, ECA implemented this mandate by carrying out regional reviews at five-year intervals in 1999 and 2004.

## **1.2 ICPD+5 Review**

Within the framework of the global assessment of the ICPD PoA, ECA undertook a five-year re-

gional review of the extent to which member States had implemented the PoA in Africa. The review, which was partly based on survey responses from 41 countries, revealed that remarkable progress was made by some countries in areas such as access to reproductive health services, integrating family planning and safe motherhood into primary health care systems, developing national action plans designed to empower women, and addressing emerging issues such as HIV/AIDS and sexual and reproductive needs of adolescents.

The five-year review revealed heavy focus on reproductive health and reproductive rights, with little emphasis on general health, education, income generation and employment, reducing infant and maternal mortality, and HIV/AIDS and sexually-transmitted infections. Also, the review indicated inadequate treatment of the family, refugees, the role of the elderly in society, political and social instability, interrelationship between the role of NGOs, private sector and civil society, and IEC and advocacy strategies.

### **1.3 ICPD+10 Review**

The ICPD+10 Review aimed at addressing the gaps mentioned above. This review, which marked the mid-point for the ICPD-PoA, offered an opportunity to look forward and to reflect on the diversity of the goals, and demonstrated how their achievement would promote progress toward the MDG goals and targets.

At the global level, the 37<sup>th</sup> Session of the United Nations Commission on Population and Development, held in 2004, carried out a comprehensive review of progress in the preceding ten years on all aspects of the ICPD PoA. This meeting was built on the previous annual sessions of the Commission, held since 1994, which reviewed the implementation of specific chapters of the PoA. The Commission's 2004 review culminated in the official reaffirmation of the ICPD PoA and Key Actions, and a reiteration that Governments in every region should continue to commit themselves, at the highest political level, to achieving the ICPD goals and objectives.

At the regional level, the review conducted by ECA emphasized full ownership of the ICPD PoA by African countries. In Dakar in 2004 governments re-affirmed their commitment to full implementation of the ICPD PoA, and adopted the Dakar Declaration. They signed a Ministerial Statement in which they decided to intensify efforts in key areas aimed at building on progress made in achieving the goals of the Dakar/Ngor Declaration and the ICPD PoA. This regional review and the Dakar Declaration underscored the relevance of the ICPD goals. Its findings show that much progress has been made in advancing these goals. However, the progress was not uniform across the region and all thematic areas.

Overall, the outcomes of the ICPD+10 review demonstrated significant progress made by countries in adopting and pursuing a reproductive health and reproductive rights approach; in strengthening efforts to improve gender equality, equity and the empowerment of women; in addressing adolescent reproductive health; in forging new partnerships with civil society and the private sector; and in promoting the integration of population dynamics and trends into development planning and policymaking. However, the outcomes also show major challenges to the full implementation of the Cairo agenda. These challenges include addressing HIV/AIDS more effectively, incorporating

culturally sensitive approaches into programming and strengthening data collection and analysis systems. Among the main policy findings and conclusions that emerged from the ICPD+10 review, three are worth mentioning:

- a. Reaffirmation across the globe of the ICPD PoA and the Key Actions;
- b. Universal recognition that the effective implementation of the PoA requires government ownership and commitment of financial resources; and
- c. Acknowledgement that full implementation of the Cairo agenda is essential to achievement of the MDGs.

These three policy findings are the central theses of the ICPD+15 review. Research is essential for informing the regional review. Therefore it is important to make a note on population and development research at this juncture.

## **I.4 ICPD +15 Regional Review**

The Sixth Ordinary Session of the General Assembly of APC held in Johannesburg in 2007 requested the ECA and AUC to jointly coordinate the 15-year review of the DND and ICPD PoA. In collaboration with UNFPA and in close partnership with AUC, ECA embarked on this activity in 2008. Unlike the previous reviews, the ICPD+15 review comes at a time when the financial, energy and food crises impact negatively on development in Africa. The consequences of these crises to social development and to achievement of the ICPD and MDGs goals and targets are of major concern to the African countries. Therefore, this regional review takes cognizance of this concern and highlights the importance of country ownership and integration of the ICPD PoA and the MDGs in national development plans and strategies.

The main objective of the ICPD+15 review in Africa is to provide regional analyses of the progress in the implementation of the DND and ICPD PoA. This includes documentation of experiences in the implementation of the DND/ICPD PoA, and identification of successes, best practices, lessons learned and constraints and limitations encountered. More specifically, the regional review aims to achieve the following:

- a. Link implementation of the ICPD goals and objectives to the achievement of the MDGs in Africa;
- b. Identify the facilitating and inhibiting factors regarding implementation of the DND/ICPD goals and targets; especially in relation to the MDGs;
- c. Document lessons learned and best practices in policy and programme interventions facilitating social change and demographic transition in African countries; and
- d. Identify future activities to accelerate further implementation of the DND/ICPD PoA to support achievement of the MDGs in the coming years.

## **I.5 Why focus on the MDGs?**

The DND/ICPD PoA and the MDGs are interrelated frameworks for gauging development progress in Africa. All countries in the continent committed themselves to the implementation of the DND/



ICPD PoA, and to achieving the MDGs. African Leaders confirmed this commitment and emphasized that “For Africa, the MDGs are too important to fail”. The achievement of these goals is critical for the continent to claim the 21st century for its people and to become an important and reasonable partner in the global economy. Africa’s agenda must be made more MDGs-friendly” (AUC). Still lagging behind other regions of the world on the achievement of the MDGs, the situation in Africa inspired the United Nations Secretary-General to launch the MDG Africa Steering Group as a global initiative to mobilize the international system’s support to achieve the goals and targets.

Indeed, the intricate linkages of the ICPD-PoA to the MDGs framework are globally and regionally acknowledged. Mid-way through implementing the 20-year ICPD PoA, UNFPA re-emphasized the significance of population issues in the current efforts to end poverty and meet the MDGs. The report notes that efforts to end poverty and meet the MDGs by 2015 will depend on success in implementing all actions identified in the ICPD PoA, particularly promoting women’s rights, providing universal access to comprehensive reproductive health services, and ensuring that development plans and policies take population trends into account are key [State of World Population – The Cairo Consensus at Ten: Population, Reproductive Health and the Global Efforts to End Poverty 2004]. Therefore, special attention in the ICPD+15 review is given to the following cluster of essential needs for MDG progress in Africa:

- a. Apply a continuum-of-care approach to the full range of reproductive, maternal, newborn and child health concerns;
- b. Focus appropriate attention on the needs of young people, especially those at risk;
- c. Advance women’s health;
- d. Focus on effective approaches for comprehensive reproductive health progress;
- e. Involve men in the promotion of women’s health and empowerment; and
- f. Incorporate demographic analyses in plans for social development and poverty reduction.

This regional review report pays special attention to issues covered in the MDGs as well as to emerging issues such as energy, food and financial crises, climate change, international migration, ageing and disability. However, progress monitoring is a challenging endeavor, particularly in Africa where there is paucity of time series data and research, and lack of documentation of success and failure stories, and best practices.

## **1.6 The challenge of progress monitoring**

The task of reviewing progress is problematic in this special case where the ICPD and MDGs are considered to work as one. There are two problems with MDGs (as well as ICPD PoA) progress monitoring. First, MDGs progress reviews are commonly based on aggregate national indicators, and the average values computed for the targets mask significant internal variations within each country; hence with the MDG indicators, it is difficult to monitor progress among vulnerable groups, which include rural population, women, marginalized urban poor, the unemployed and under-employed, youth, orphans, people living with disability, the elderly, internally displaced persons and refugees.

**Second**, the global efforts to track progress have focused largely, if not exclusively, on the MDG outcomes (based on human rights standards), neglecting the process, which addresses human rights

principles. Yet, the process of human development is as important as the outcome. However, as noted by UNDP (2000), although human development thinking has always insisted on the importance of the process of development, many of the tools developed by the human development approach measure the outcome of social arrangements in a way insensitive to how those outcomes were achieved.

To be sure, the Millennium Declaration opens in Article I with statements on fundamental values and principles which all nations must cherish, including: freedom, equality, solidarity, tolerance, respect for nature and shared responsibility. Article V focuses on human rights, democracy and good governance. The idea is that achievement of MDGs should be done within the context of adherence to human rights principles - equality and non-discrimination; inclusive participation; transparency; accountability; the rule of law; sustainability; freedom of the media; harmony and tolerance.

Several of the recommendations put forward for African countries at ICPD + 10 also emphasize the need to adhere to human rights principles as countries implement their national population and development programmes. Countries are urged to, among others: practice good corporate and political governance and improve the pace of the democratic process; uphold the reproductive rights of women and adolescents; ensure that policies, strategic plans and all aspects of programming and implementation of reproductive and sexual health services respect all human rights, including the right to development; uphold the Universal Declaration of Human Rights as it relates to both international and internal migrants; promote good governance [ECA, 2004].

In essence, ICPD PoA and MDGs were founded upon human rights principles; and as such, if national efforts to achieve the MDGs or ICPD goals are being reviewed, so also should the process by which the achievements were realized. The same goes for NEPAD, a Vision and Strategic Framework for Africa's Renewal, which is also based on human rights principles and linked to the MDGs.

## **1.7 ICPD+15 review process**

The ICPD+15 review is a regional participatory process that is based on country ownership of the review inputs and sharing of the review achievements. This process involved the African countries which diligently responded to the technical review tools through preparation of country reports and filling of questionnaires as contributions to the regional review process. Also, it involved the AUC and the UNFPA as strategic ECA partners. The three agencies worked together and provided policy guidance and resources (financial and human). Close collaboration has been established between these partners to ensure consensus and common understanding of the ICPD + 15 review process. This has formalized the relationship and roles of the AUC, ECA and the UNFPA through exchange of views and ideas, and close follow up of the review process. Indeed the success of the ICPD+15 process in Africa is attributed to the participation of countries and to the effective partnership of the AUC, ECA and UNFPA.

The review process consisted of technical tools for the compilation of qualitative and quantitative data and information from countries, and institutional arrangements to provide overall policy and

technical guidance. The technical tools were prepared in August 2008 and distributed to all countries in Africa: (a) Main questionnaire ; (b) Appendix I of the main questionnaire; (c) Country reports ; (d) Appendix I of the country report and; (e) Appendix II of the country report.

These five tools were useful not only in the collection of information, but also in engaging governments in the ICPD+15 review process. They generated positive reactions from countries, some of which wrote to request further information so that they could start engaging their partners in the review process. Some of the countries organized national workshops, meetings and seminars on these tools. Contacts with governments, through ECA subregional offices, constant engagement with UNFPA Liaison Office to the ECA and AU, and UNFPA country offices were vital in following the conduct of the review in the countries.

Due to late arrival of the review tools in French-speaking countries, the deadline for submission of the five tools mentioned above was eventually shifted to 15 January 2009 for the questionnaires; and, 30 January 2009 for the Country Report. However, countries continued to send their reports and responses at the time when the analyses of data and preparations of this report had reached an advanced stage.

With regard to the institutional arrangements, a steering committee was established of Addis Ababa-based membership representing AUC, ECA, UNFPA, AfDB, UNICEF, UNDP, ILO and IOM. Its main objective is to provide overall guidance to the entire review process, to ensure that the tasks are completed and set objectives achieved according to plan, and to prepare for and convene a regional expert groups meeting and ministerial conference on the ICPD+15 review in Africa. Also, ECA established an internal technical committee to provide technical advice and support, and to ensure the preparation of the ICPD+15 review report was within corporate standards and procedures. The technical committee played the role of capturing ICPD-relevant information from ECA divisions and SROs.

## **1.8 Response to the tools**

Responses to the five review tools aforementioned were received from 43 out of 53 countries. This gives an impressive response rate of 81 per cent and reflects the commitment of countries to the ICPD and to addressing population and development issues in Africa. All countries were expected to submit all five tools. Unfortunately, that did not happen, and the countries varied significantly in their submissions of the five review tools. Of the 43 countries that responded, 11 submitted all five tools (Benin, Burundi, Ethiopia, Malawi, Mauritius, Mozambique, Namibia, Sao Tome and Principe, Seychelles, Sierra Leone, the Sudan, and the United Republic of Tanzania), eight countries submitted four tools, nine countries submitted three tools, five countries submitted two tools and seven countries submitted only one tool (See map 1). Ten countries did not respond to any of the five tools (Angola, Republic of the Congo, Djibouti, Equatorial Guinea, Guinea-Bissau, the Libyan Arab Jamahiriya, Mali, Rwanda, Somalia and Zambia). Table 1 in the annex shows the distribution of country responses to the five review tools and table 2 shows each country's responses to the five review tools.



Part 2  
**Review Results**





# Section I

## I. Poverty, Population, Environment and Sustainable Development

### I.1 Introduction

One of the objectives of the ICPD PoA is to fully integrate population concerns into development strategies, planning, decision-making and resource allocation at all levels and in all regions, with the goal of meeting the needs, and improving the quality of life, of present and future generations. This will lead to the promotion of social justice and poverty eradication through sustained economic growth in the context of sustainable development. Another objective with regard to population, sustained economic growth and poverty, the PoA objective is to raise the quality of life for all people through appropriate population and development policies and programmes aimed at poverty eradication, and achieving economic growth. Consistent with Agenda 21, the PoA objectives relating to population and environment, are to: (a) ensure that population, environmental and poverty eradication factors are integrated in sustainable development policies, plans and programmes; and, (b) reduce both unsustainable consumption and production patterns as well as negative impacts of demographic factors on the environment in order to meet the needs of current generations without compromising the ability of future generations to meet their own needs.

To achieve these objectives, the ICPD called on governments to take actions to integrate population into sustained economic growth and sustainable development. Most of the actions focus on integrating population issues into the formulation, implementation, monitoring and evaluation of all policies and programmes; establishing the requisite internal institutional mechanisms; strengthening political commitment to integrate population in development strategies and plans; reducing and eliminating unsustainable patterns of production and consumption; giving priority to human resources development; and, promoting appropriate demographic policies. The PoA also calls for actions to eliminate inequities; facilitate job creation; integrate population factors into environmental assessment; and, formulate and implement population policies and programmes, which contribute to achieving poverty eradication and sustainable development goals.

Taken together, these actions indicate a paradigm shift away from perceiving population as a macro-



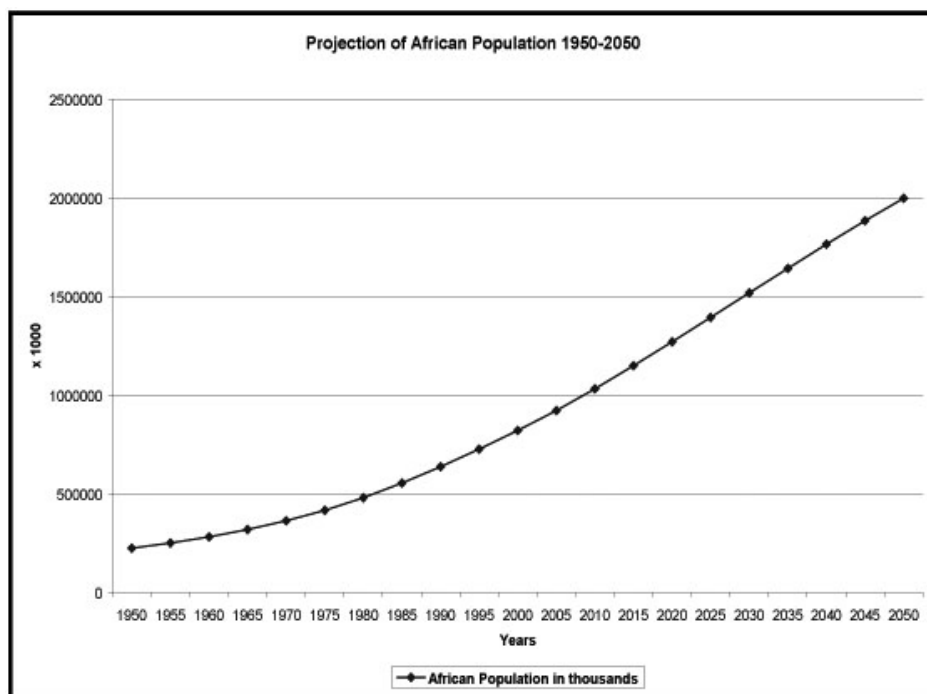
economic variable for planning and policy formulation to a rights-based approach, in which the well being of individuals become paramount. The ICPD Goals are linked to the MDGs as contained in the Millennium Declaration of September 2000 and further agreement by Member States at the 2005 World Summit. Therefore the implementation of the ICPD PoA will contribute to achieving the MDGs.

## 1.2 Population Trends

The most recent estimate of the population of Africa by UNFPA puts the size at 987 million in 2008, derived from an average annual population growth rate of 2.3 per cent from 2005 to 2010. Earlier estimates show that during the 1990 – 2000 decade, the population of Africa increased from 622.4 million to 795.7 million, an addition of 173.3 million in 10 years. As shown in Figure 1.1, the population of Africa will more than double in the next four decades, increasing to nearly 2 billion by 2050.

While AIDS-related deaths are reported to be increasing in some countries, the prevailing pre-transition fertility level, estimated at 4.63 for Africa in 2008, is the major driver of the high rate of population growth in the continent. In most countries the increase in population size has been as a result of high and constant fertility coupled with high but declining mortality over the same period. Niger with TFR of 7.16 has the highest level of fertility in Africa, closely followed by Guinea-Bissau 7.04, Burundi 6.8 and the DRC 6.7; other African countries with TFR of 6 or higher are Somalia, Liberia, Mali and Sierra Leone. On the other hand, in countries like Mauritius, Tunisia, Morocco, Algeria and, to some extent, South Africa, the demographic transition is well underway with these countries experiencing decreases in total fertility rate from over 3.0 in 1999 to 2.5 or below in 2008.

**Figure 1.1** Trend in population size

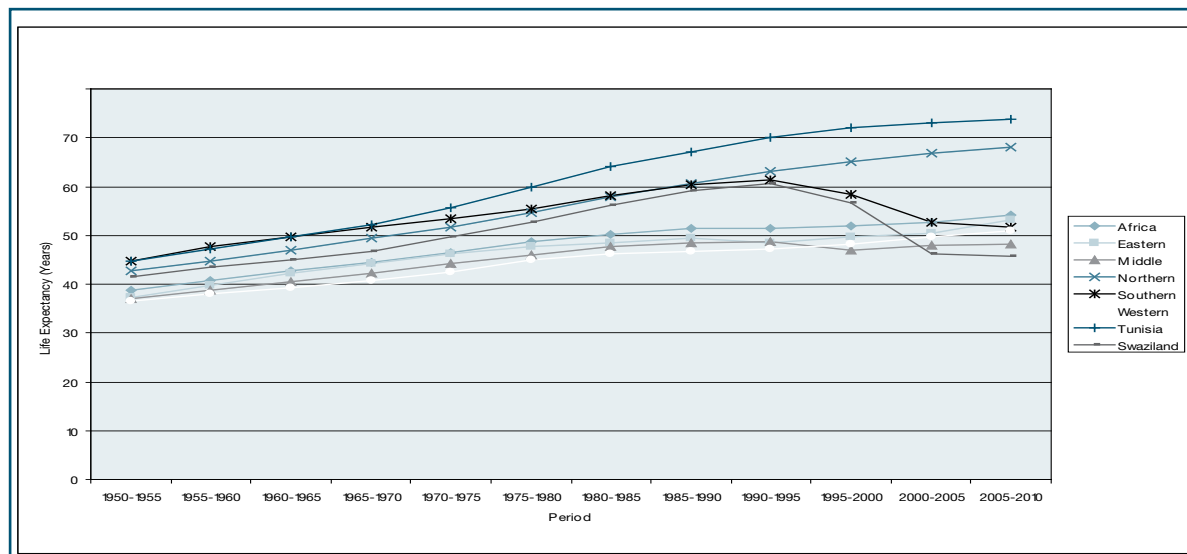


Source: AUC, State of Africa Population 2008 Report

Indicated by life expectancy at birth, Africa in general has shown a slow but steady increase from 39 years in the 1950 -1955 period to 54 years in 2005-2010, as shown in Figure 2.1. Higher average life expectancy is experienced by Northern African countries, rising from 43 years to 68 years during the same period. The impact of AIDS mortality is felt most severely in the Southern African sub-region where average life expectancy rose to 61 years during 1990-1995 but subsequently declined to 51.6 years during the 2005-2010 period. Tunisia has exhibited the highest life expectancy in Africa during the period in reference, from 41.4 years to 73.89 years, while Swaziland typifies the Southern African experience; from 41.4 years (1950-1955) rising to 60.7 years (1990-1995) and thereafter dropping to 45.8 years (2005-2010).

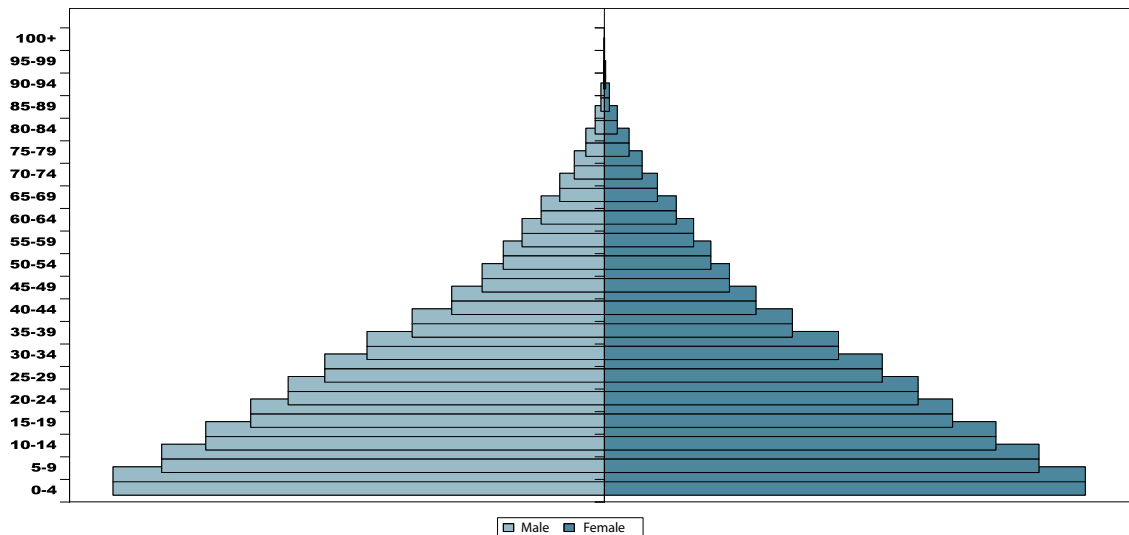
In addition to HIV/AIDS the main causes of the high mortality in Africa include; weak health systems, pervasive poverty; the low status of women on the continent; prevalence of infectious diseases such as tuberculosis and malaria; the exodus of medical personnel to overseas destinations; limited financial support to address health challenges, and poor infrastructure in most African countries.

**Figure 2.1 Trends in Life Expectancy at Birth in Africa, Regions and Selected Countries, 1950-2010**



Source: UN 2009, World Population Prospects - the 2008 Revision

**Figure 2.1a Age sex pyramid for Africa for 2015**

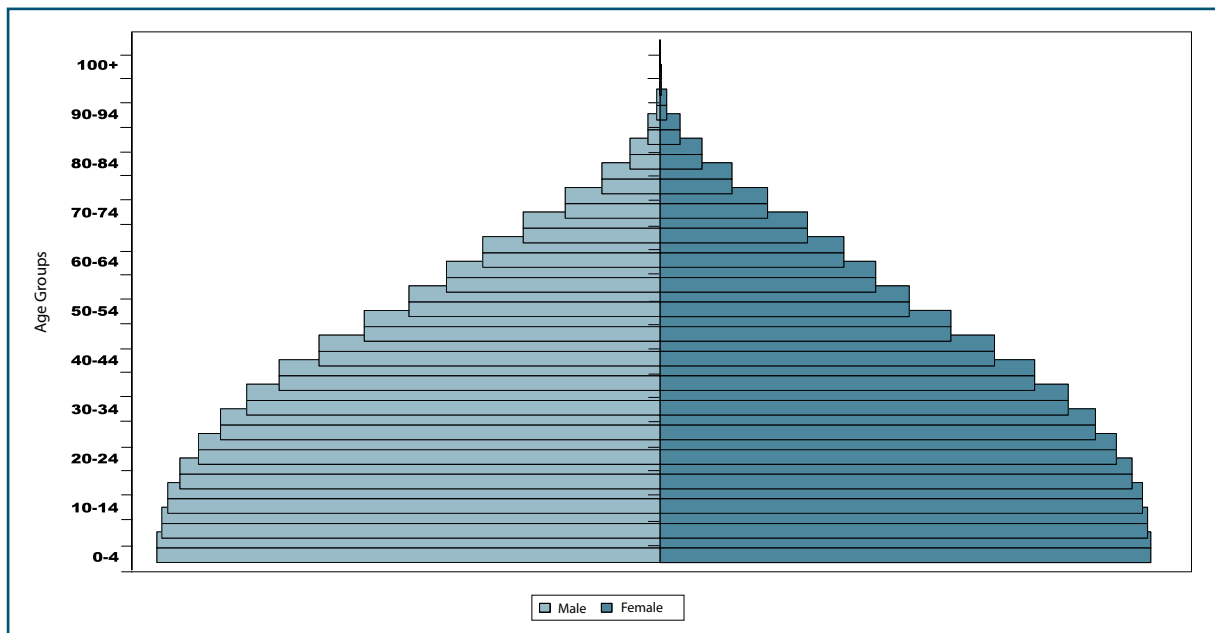


Source: AUC, State of Africa Population 2008 Report

The population of most African countries continues to be youthful, with children and young people below age 15 constituting about 40 per cent of the total population. The most recent estimates show that children under age 15 constitute 41.2 per cent of the population. Projections indicate a slight decline to 40.3 per cent by 2010. When children and youth aged 30 and below are taken together, they constitute over 70 per cent of the total population of the continent (UN, World Population Prospects – 2008 Revision).

Comparing the population pyramids for the projected population for Africa for 2015 (see Figure 2.1a) and 2050 (see Figure 2.1b), it is clear that the continent is expected to have more working-age adults by 2050 than presently. By 2050, there will be a larger workforce with declining proportion of children to support, which will create a window of opportunity for increased production and socio-economic development. This window of opportunity has been referred to as the “demographic dividend”. Although this period lasts for several years, the window eventually closes when the workforce ages and relatively fewer workers have to support increasing numbers of older people, as is currently evident in Europe. This scenario calls for, among others, sustained efforts on the continent to address the needs of young people.

**Figure 2.1b Age sex pyramid for Africa for 2050**



Source: AUC, State of Africa Population 2008 Report

Also, the two pyramids show that the category of the aged is becoming more and more visible. Although their current proportion is low, it is expected that by 2050 the aged will constitute 10 % of the continent's population. Since they are very vulnerable and could be critically affected by challenges such as climate change, food insecurity and emerging health concerns; their needs must be clearly integrated into development policies and programmes.

The other demographic trend that has emerged in Africa, and perhaps other developing regions, in recent years is the increasing urbanization of the population. It is estimated that Africa was 39 per cent urbanized in 2007, lower than the world average of 50 per cent. However, future high growth rates of urban population are expected to occur in the developing regions of the world, particularly Africa, with an estimated annual urban growth rate of 3.2 from 2005 to 2010. Details on population distribution and urbanization are addressed in Section 7 of this report.

### **1.3 Trends in the incidence of poverty**

Apart from the demographic trap, when compared with other regions of the world, Africa suffers disproportionately from poverty and deprivation. Worldwide, about 20 % of the population survives on less than \$1 a day; in Africa the problem of poverty is much deeper and far more widespread than in other major regions.

UNDP review (2003) of progress towards the achievement of MDGs in different nations of the world concludes that Sub-Saharan Africa (SSA) and South Asia both face enormous poverty. However, unlike South Asia, SSA is left behind due to socio-economic stagnation.

Half of Africa's population live in extreme poverty and one-third in hunger. Also, about one-sixth of children die before age five – the same as a decade ago. In the previously war-torn countries, current levels of poverty and hunger stagnated and in some, even worsened. The 2006 UN MDG Report indicated that despite progress to reduce global poverty, SSA along with Southern Asia, are the two regions where millions are affected by chronic hunger. Food security has worsened in Africa since 1970. While the proportion of malnourished population has remained within the 33 to 35 per cent range in SSA, this implies a dramatic increase in the numbers malnourished due to population growth. Over 70 per cent of the food insecure population in the continent lives in the rural areas.

The most recent Human Development Report (2008) shows some dramatic changes in the human development landscape for Africa. The report presents new calculations which show that three African countries; Libyan Arab Jamahiriya, Mauritius, and Seychelles are now in the ranks of 'High' human development countries. It should be indicated that Seychelles has been in that category since 2004.

The ranks of 'Medium' human development countries also showed an increase in the number of African countries from 16 in 2004 to 23 in 2008. At the bottom are the 'Low' human development countries, all of them except for three countries in Asia, are in Sub-Saharan Africa.

Individual country reports on ICPD+15 provide a better insight into the dimensions of poverty, policy and programme response, achievements made so far and prognosis for the future. For instance, in Ghana, while there has been a decline in poverty levels, from 51.7 per cent in 1992 to 36.4 per cent in 2006, the phenomenon is still high especially in rural areas. The same can be said for the United Republic of Tanzania where one-third of its population live below the poverty line, mostly in rural areas, and with 18.4 per cent of households living below the food poverty line and 37 per cent below the basic needs poverty line. In Mozambique, about 54 per cent of the population live in absolute poverty, with 80 per cent of them in rural areas. In Benin, the 2002 Census results also indicate that 59 per cent of the people in rural areas are poor compared to 18 per cent in the urban areas.

The country reports of Gabon, Lesotho, Sao Tome and Principe and South Africa indicate that poverty continues to be a disproportionately female phenomenon, with consistently higher poverty head-count rates for female-headed households. Occasionally, as in Senegal, poverty among female-headed households declined faster than in male-headed households.

In the Democratic Republic of the Congo, it is estimated that 81 per cent of the population, especially in the urban areas, live below the absolute poverty line. On the other hand, countries such as Namibia, Mauritius and Morocco have made tremendous strides to reduce poverty. The results of two Namibia Household Income and Expenditure Surveys (NHIES) conducted in 1993/94 and 2003/04 show that the incidence of extreme poverty among households declined from 9 per cent in 1993/94 to 4 per cent in 2003/04. In Mauritius, the percentage of the population currently living in absolute poverty is estimated at less than one per cent while in Morocco the percentage of poor people (with income less than 1US\$ per person per day) has been reduced from 3.5 per cent in 1990 to 0.6 per cent in 2007. The country report indicates that since 2001, about 1.7 million Moroccans have been lifted out of poverty.

Poverty head count index in Ethiopia for the period 2004/05 is lower by 12 per cent as compared to the level in 1999/00 and much of the decline in poverty at national level is attributed to a decline in rural poverty. For Uganda, the greatest improvement in poverty reduction was more in rural areas (by 8.5 percentage points) compared to urban areas (by 0.7 percentage points). On the other hand, the country report for Lesotho indicated that poverty indicators for urban areas actually experienced an increase of one percentage point (for Maseru) and 3 to 6 per cent for other urban areas.

## **1.4 Population and the environment**

The complex interaction between population and the environment pose serious challenges to development efforts. Unmatched by adequate investment, especially in the social sector, the growing size of Africa's population has implications for natural resource use and improvement in the quality of life now and for future generations. In 2002, UNEP indicated that 61 per cent of the human settlements south of the Sahara Desert are on ecologically vulnerable areas. According to Sayer, Harcourt and Collins (1992), the linkages among rapid population growth, agricultural stagnation and environmental stress in SSA shows that these phenomena are mutually reinforcing. Rapid population growth is regarded as the principal exogenous factor which contributes to the increase in environmental stress and agricultural stagnation.

In Malawi for instance, fuelwood provides 93 per cent of the energy source for the population, putting enormous pressure on the forest cover in the country. The same can be said for other countries where rapid population growth has led to increased demand for natural resources including fuelwood, which in turn, has exacerbated deforestation. Also, mining activities in some countries have contributed to land degradation and pollution of streams and rivers. In Morocco, desertification is estimated to be affecting 92 per cent of the land area (Morocco Country Report).

Environmental stress is expected to trigger movements of people from environmentally-depleted ecosystems on the continent to other zones including urban centres. This will generate what is being referred to as "environmental refugees".

## **1.5 Impacts of the financial crisis**

According to UNFPA (2009), deceleration of economic growth, deterioration of finances (including national revenue, aid, foreign direct investment, and remittances), high levels of poverty, and limited institutional and fiscal capacity to cope are all contributing to emerging and developing economy vulnerability to the current financial crisis. According to World Bank estimates, a one per cent decline in economic growth will push about 20 million people into extreme poverty. Economic growth is projected to slowdown in Africa, but more modestly than in other regions. This is because of Africa's relatively weak integration into the global financial system.

A recent analysis by ECA (2009) has reached a similar conclusion: the financial crisis and the recession are likely to contribute to lower economic growth as a result of declining global commodity demand, the negative effects on other important export sectors such as tourism and non-traditional agriculture. The report also notes other indirect effects of the financial crisis, including falling ODA as well as lower FDI and remittance flows.

Increased poverty; indebtedness; forgoing schooling in light of economic hardship, particularly girls; and limited access to health services will clearly affect the achievement of the goals of the ICPD PoA and indeed the MDGs. Vulnerability to the financial crisis depends on a country's institutional and fiscal capacity to cope and absorb increased spending directed toward mitigating the worst effects of shocks on the poor.

In the light of the financial crisis therefore, increased poverty will constitute the major danger for Africa and its people. This crisis is therefore expected to affect Africa's capacity to cater for the needs of the poor and vulnerable including women and girls. The continent's ability to attend to the demands of the various protracted humanitarian emergencies on the continent will be severely affected. Countries grappling with chronic food insecurity, HIV/AIDS, and lack of access to basic social services are also expected to be rendered even more vulnerable. Also, the likelihood for conflict between displaced populations and host communities will increase under economic strain.

## **1.6 Implementation of the PoA**

The PoA notes that there is general agreement on the persistence of widespread poverty and serious social and gender inequities and the significant influence these have on demographic factors such as population growth, structure and distribution. It also notes that poverty and social inequalities in societies are in turn influenced by demographic factors. Regarding sustainable development it is also noted that unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and to environmental degradation. The action proposed is to integrate population concerns fully into development strategies and into all aspects of development planning at all levels, while the sustained economic growth that results will help meet the needs and improve the quality of life of present and future generations, as well as promote social justice and help eradicate poverty.

### *Poverty Reduction Strategies*

Poverty reduction is a national priority and all countries in Africa continued to heighten their actions and policies to address it through a wide range of strategies. The country reports indicate that most countries are putting in place relevant policies and programmes aimed at improving the quality of life of the people. The most popular strategy for addressing poverty is the Poverty Reduction Strategy Papers (PRSPs). The reports indicate that in addition to the focus on poverty reduction, the strategies include some specific country concerns such as HIV and AIDS (Malawi - MGDS 2006) and post conflict recovery (Sierra Leone PRSP 2005-2007).

In some countries, national long-term perspective studies were also undertaken and have provided a 'vision' for the formulation of poverty reduction and development interventions. These included: Malawi, Nigeria, South Africa - Vision 2014; the United Republic of Tanzania, Benin, Sierra Leone - Vision 2025; Namibia Vision 2030 and Ghana - Vision 2035.

Other countries like South Africa reported a refocusing of expenditure on potentially poverty-alleviating programmes aimed at reducing poverty and socio-economic inequalities, including provision of infrastructure and social services. Also, these programmes aim at creating employment-gen-



erating growth with a focus on economic opportunities for young people and women. Mauritius indicated putting in place structures and a Trust Fund with the objective of eradicating absolute poverty in the country within seven to 10 years.

### *Integration of MDGs and Population Concerns in NDS/PRSP*

About 33 out of 40 reporting countries have mainstreamed the MDGs, including population and reproductive health concerns, into PRSPs, National Health Strategies and National Reproductive Health Strategies as appropriate. Three goals; Child Mortality; Maternal Health; and, HIV/AIDS, malaria and other diseases; were mainstreamed by almost 68 per cent of the responding countries into all the three strategies.

Also, population policies were revised in the Sudan (2002) Nigeria (2005), the United Republic of Tanzania (2006), Botswana (2007), Benin (2006) and, Uganda (2008) to take on board emerging issues including MDG concerns. In addition, 25 countries modified their population policies to reflect more seriously some emerging issues such as poverty, population and environment; gender equality, equity and empowerment of women; gender-based violence; the family; children and youth; reproductive rights and reproductive health; family planning; HIV/AIDS; population distribution; urbanization and Internal and international migration.

In some countries, structures have been put in place to coordinate the implementation of the population policy at both national and subnational levels. In other countries (Sierra Leone and the CAR), national population policies have not been reviewed although mechanisms continue to exist for coordinating the implementation and review of the policies. Nigeria formulated a National Economic Empowerment Development Strategy (NEEDS) in 2004, from which state level initiatives, SEEDS, were formulated to integrate MDGs and population concerns into the various state development strategies.

Most countries reported having articulated population and reproductive health issues in current NDS/PRS and budgeted for in related programme activities. Population and reproductive health concerns often are addressed in NDS/PRSPs. Least often addressed are Reproductive Health and Reproductive Rights, Ante-natal, safe delivery and post-partum care, Emergency obstetric care, Supply and distribution of RH Commodities, Child health care, Adolescent Reproductive health, Family planning, Youth capacity building, Gender equality, equity and empowerment of women, Gender-Based Violence, Human rights, Population distribution urbanization & internal migration, International Migration, Statistical Systems and Data Quality, Housing/shelter, Environmental concerns, Preparedness and mitigation of Emergencies and Crises. Where addressed, they are most often included in budgets. The largest gaps between implementation and allocation are in human rights, population distribution and movement and housing/shelter.

### *Addressing environmental challenges*

The country reports showed that countries are taking steps to implement policies aimed at addressing the challenges of population growth and environmental degradation. In Ghana the revised national population policy, the National Environmental Policy, the 1990 Environmental Action Plan

and the 1999 Environmental Assessment Regulations provide the framework for incorporation of population and environmental management goals into overall national development plan.

Seychelles gives serious consideration to environmental issues, being a small island developing state with a fragile environment and limited natural resources. Emphasis is placed on the protection and conservation of environmental assets. The first EMPS, 1990-2000, was successfully implemented with over 51 projects; the second EMPS is considered special as it makes provision to find the right balance between population (including gender) and environment.

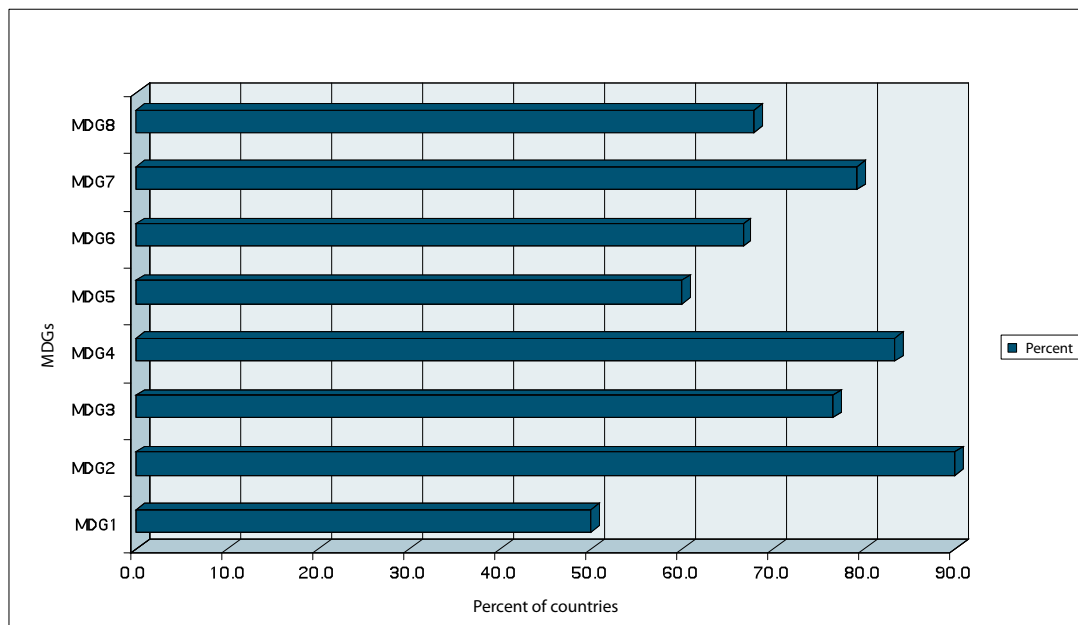
In Morocco, national plans for the prevention of desertification; protection of water basins; and, for soil conservation are being implemented to mitigate the effects of environmental challenges in various parts of the country.

## 1.7 Reduction of Poverty and Eradication of Hunger

### *Achieving the Millennium Development Goals and Targets*

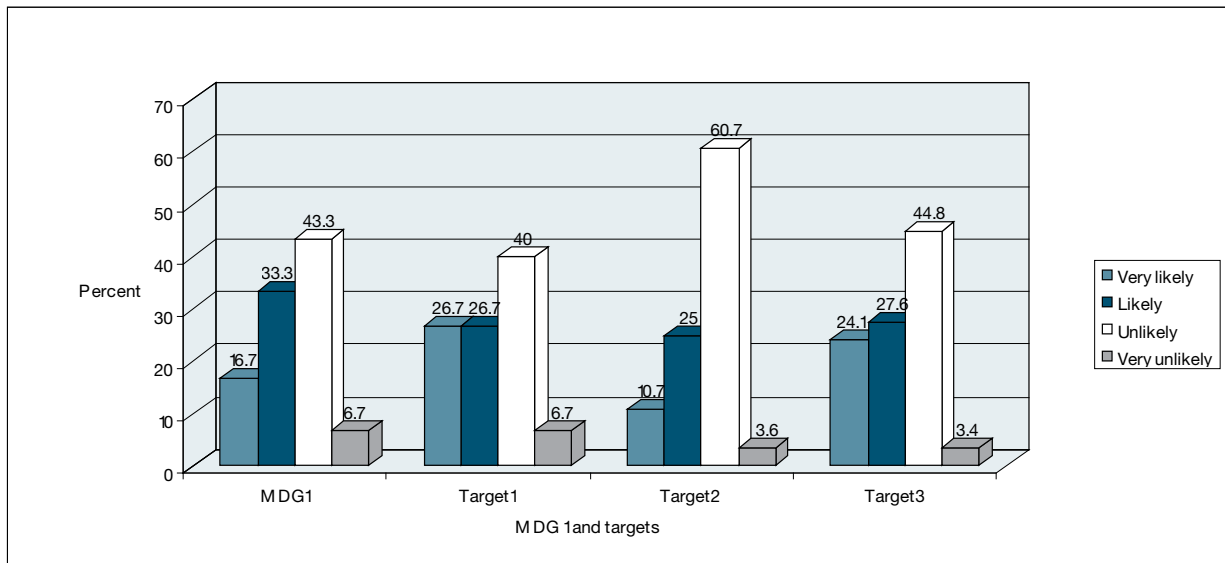
Figure 1.1 summarizes the responses to the likelihood of achieving the MDGs by the responding countries. Most countries are optimistic about achieving MDG2, MDG4 and MDG7; less than half of the countries are optimistic about extreme poverty and hunger eradication (MDG1) by 2015.

**Figure 1.1 Likelihood of achieving the MDGs in Africa**



Taken together, African countries seem to be more optimistic about poverty eradication during the MDG cycle than the available data suggest. In response to the question on the likelihood of eradication of extreme poverty and hunger by 2015, half of the responding countries indicate such likelihood; indeed, about 17 of them are very positive that extreme poverty and hunger would be a thing of the past by 2015.

**Figure 2.2 Likelihood of African countries achieving MDG1 and the targets by 2015**



When it comes to specific MDG 1 targets, the responses seem to be even more optimistic except for target 2 (achieve full and productive employment and decent work for all, including women and young people) where 64.3 per cent of the responding countries are pessimistic about the prospects of achieving the target (see Figure 2.2).

The ICPD at 15 survey results and analysis of country reports show that although poverty is reported to be declining in most countries, the phenomenon still remains endemic and its incidence severe among certain sections of society.

Both the ICPD PoA and the MDGs emphasize poverty eradication as a key objective for raising the quality of life for all people. Goal 1 of the MDGs focuses on eradication of extreme poverty and hunger and has three targets: to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day; to achieve full and productive employment and decent work for all, including women and young people; and to halve, between 1990 and 2015, the proportion of people who suffer from hunger.

In relation to **MDG 1**; which is set to eradicate extreme poverty and hunger, very few countries including Seychelles, Madagascar and Tunisia indicated that they are very likely to attain MDG 1 by eradicating extreme poverty and hunger by 2015. The countries point out that ongoing policies and programmes have resulted in reduced poverty levels and less vulnerability to hunger. In Tunisia, for instance, poverty levels have reduced from 6.7 per cent in 1990 to 3.8 per cent in 2005. In the case of Seychelles, it was reported that extreme poverty and hunger are nonexistent.

In the cases of Mozambique, Mauritius, Benin and Burundi, poverty was declining at such a rate that they are likely to achieve the Goal through their current poverty reduction programmes. In the case of Mozambique for instance, poverty has declined from 69.4 per cent in 1997 to 54.1 per cent in 2003 and is further expected to reduce to 45 per cent by the end of 2009.

By their own assessments, most of the countries indicated that they were not likely to attain this goal. In some countries like Kenya and the United Republic of Tanzania, poverty levels have been falling but the rate of decline is judged insufficient for the attainment of the goal. In other countries like the Sudan, Guinea, Sao Tome and Senegal, unfavourable macro-economic conditions will make the goal unattainable. In the case of Swaziland, intermittent droughts and high HIV /AIDS prevalence have made it impossible to increase food productivity and reduce poverty. Information from other countries such as the Gambia indicated that the situation has worsened with poverty levels increasing from 30 per cent in 1990 to 58 per cent in 2007. In the CAR, poverty levels also increased from 62.5 per cent in 1992 to 67 per cent in 2003.

**MDG 1-Target 1:** Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day. All countries in North Africa, with the exception of the Sudan, indicated that they have already achieved this target. In Tunisia for instance, only 0.4 per cent of the population had incomes below 1\$ a day. Also the island states of Mauritius and Seychelles indicated that this target has already been achieved. In the case of Mauritius, the proportion of the population living below \$1 a day was reported to be less than one per cent. By their own assessment, Madagascar and Uganda indicated that the poverty situation is improving as a result of current programmes, making it likely for them to achieve this target. Data on Uganda shows that poverty has declined from 56 per cent in 1990 to 31 per cent in 2006.

For Kenya, Zimbabwe, Lesotho, Swaziland, Guinea, the CAR, Comoros and the Niger, the achievement of this goal is judged unlikely. While the proportion of people living on less than \$1 a day is still very high in most of these countries, the situation has actually worsened in others. In Swaziland, a majority of the 69 per cent of the population living below the poverty line became vulnerable to hunger when poor rainfall resulted in low productivity of maize, causing a hike in maize prices. The percentage of people living below the poverty line in Guinea increased from 49.2 per cent in 2002 to 53.6 in 2005. The situation is worst in Zimbabwe, where the percentage of people living below the poverty line increased from 55 per cent in 1995 to 72 per cent in 2003.

**MDG 1-Target 2:** Achieve full and productive employment and decent work for all, including women and young people. This was rated as very likely in Seychelles; with an unemployment rate of 7.2 per cent in 2007, and programmes being implemented to provide more women and young people with skills and opportunities for self employment.

Mauritius, Swaziland and Kenya indicated that they were likely to achieve the target. In the case of Mauritius, the unemployment rate was only 8 per cent with efforts being made to further improve on the situation. In the case of Kenya and Swaziland, although employment levels were higher, some efforts are being made to create jobs and provide loans for women and youth to start income-generating ventures. Despite some economic difficulties and the impact of the global economic downturn, Tunisia has been able to maintain the unemployment rate around 14 per cent since 2004.

For most of the countries, including the Sudan, Lesotho, the United Republic of Tanzania, Zimbabwe, Uganda, Sao Tome, the CAR and Comoros, the achievement of this Target was unlikely and for Comoros it was judged as very unlikely, because of the high unemployment rate. As a result of the closure of the mines in South Africa, most of the Basotho mineworkers were retrenched, worsen-

ing the unemployment situation in Lesotho. In Zimbabwe, due to the deteriorating macroeconomic environment, unemployment rates have increased. The level of unemployment in Uganda was in fact judged as higher than reported because the phenomenon is largely disguised.

**MDG 1-Target 3:** Halve, between 1990 and 2015, the proportion of people who suffer from hunger. Egypt, Mauritius, Seychelles, Morocco and Tunisia indicate that they were very likely to achieve this. The countries indicating that the goal was likely to be achieved include Madagascar, Sierra Leone, the Comoros and the United Republic of Tanzania. The Comoros and the United Republic of Tanzania indicated that the percentage of underweight underfives and the percentage of stunted children below age five have been steadily declining.

The target was unlikely to be achieved in the Niger, the CAR, Kenya, Sao Tome and Principe, Uganda, Lesotho, Swaziland and Zimbabwe because of worsening food insecurity, drought and a deteriorating macro-economic environment. High population density and consequent defragmentation of arable land in Burundi was cited as a key challenge to the achievement of food security in the country.

## 1.8 Environmental Sustainability

**MDGs Goal 7** is set to ensure environmental sustainability. Country reports on environmental issues point to a growing recognition of environmental factors in population and development in national development. However, the countries face enormous challenges. Only Seychelles indicated that the country is very likely to achieve the goal of environmental sustainability.

Benin, Burundi, Kenya, Sao Tome, Senegal, Sierra Leone and the United Republic of Tanzania claimed that the goal is likely to be achieved because of increased cooperation between all partners on matters relating to environmental sustainability; and, integration of environmental concerns into development policies, plans and programmes.

For other countries the goal is unlikely to be achieved because most indicators are showing a worsening environmental situation despite government efforts.

**MDG 7-Target 1:** Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

While Egypt reports integration of the principles of sustainable development into country policies and programmes and reversal of the loss of environmental resources, Seychelles, Kenya and Tunisia indicate that the target would very like be achieved. These countries reported that they had put in place various policies, plans and programmes into which they had integrated environmental sustainability principles.

Burundi, Mauritius, Morocco, the Niger, Sao Tome, the United Republic of Tanzania and Zimbabwe give environmental concerns due consideration in the formulation and implementation of development programmes.

However, the target seems unlikely for Comoros, Guinea, Sierra Leone and the Sudan. This is because of slow implementation of their plans.

**MDG 7-Target 2:** Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss. The second target of MDG7: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss is judged as likely to be achieved by Comoros, Burundi, Kenya, Sao Tome, Seychelles, the Sudan and the United Republic of Tanzania. The claims stem from the fact that diverse environmental policies, legislations and programmes are being implemented and there is growing attention and action on environmental issues in these countries.

As a result of poverty and increase in population, the demand for fuel wood is reported to be very high in most countries. For Guinea, the Niger, Sierra Leone, Swaziland, Uganda and Zimbabwe the countries are faced with various challenges that make the achievement of the target unlikely, even though various environmentally friendly policies, legislations and programmes have been put in place. Farming and mining practices are also cited as contributing to environmental degradation and loss of biodiversity.

**MDG 7-Target 3:** Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

This target was judged very likely to be achieved by the Gambia, Mauritius and Uganda where a very high proportion of the population were reported to have access to safe drinking water and improved sanitation facilities. In the Gambia and Mauritius access to safe water and sanitation has been attained by more than 80 % of the population. In Uganda such levels have been reached in urban areas and overall progress has been rapid.

Other countries, including Burundi, Comoros, Lesotho, Morocco, the Niger, Sao Tome, Swaziland, Senegal, and the United Republic of Tanzania indicated that the goal was likely to be achieved, because access to safe drinking water and sanitation have improved considerably in these countries as a result of the various policies and programmes that are being implemented.

However in the case of Guinea, Kenya, Sierra Leone, the Sudan and Zimbabwe the lack of appropriate policies and programmes, sustained actions, and adequate resources make the goal unlikely to be achieved by 2015.

## **1.9 Commitment to Continental level Policies and Strategies**

This New Partnership for Africa's Development (NEPAD) is an articulated long term vision of African leaders, to eradicate poverty and promote sustainable development as well as ensure the continent's visibility in a globalizing world. It is therefore an instrument for fostering a new partnership between Africa and the international community. The Action Programme of NEPAD provides the continent's top priorities for eradicating poverty and hunger; accelerating the pace of economic growth; placing Africa and individual African countries solidly in the global arena; halting the marginalization of Africa in the world social and economic orders; empowering women and other socially disadvantaged groups; and building the requisite infrastructure for sustainable development.

In addition to subscribing to the objectives and principles of NEPAD as AU member States, countries such as Nigeria, the United Republic of Tanzania and Sierra Leone indicated reviewing policies and

legislation; setting up coordination and monitoring mechanisms; and raising awareness on the various NEPAD themes among relevant stakeholders. The responses show that the continental framework has been mostly used for building consensus and partnerships and for advocacy and raising awareness. Fewer than half the countries have reviewed policies, changed legislation, formulated plans, reformed institutions or improved services.

According to the African Peer Review Mechanism (APRM) Newsletter January 2009, 28 countries have so far voluntarily acceded to the APRM (see details under Monitoring and Evaluation Section of this report). The United Republic of Tanzania Country Report indicated that the government has used the APRM to put in place a number of good governance initiatives based on the APRM findings and recommendations.

## **1.10 Challenges and constraints**

The challenges that Africa face in reducing poverty and promoting sustainable development include the following:

### *Global challenges*

- Global financial crisis, energy deficits, food crisis and the general inability to adapt to climatic changes;
- In nearly all the countries, there is heavy dependence or over reliance on the donor community for social protection, poverty reduction and development interventions;
- Inability to implement international consensus, e.g., the Johannesburg Declaration, Maputo Plan of Action and Abuja Declaration; and
- Limited implementation of the Paris Declaration for aid effectiveness; aid effectiveness thus remains weak in many countries.

### *Regional Challenges*

- Sub-regional and regional integration efforts are very slow and limited;
- Good governance and enforcement of human rights is weak;
- The burden of diseases like HIV, AIDS, Malaria, TB and diabetes, limits Africa's potential for growth and development; and
- High population growth in most countries challenges economic capacity and demand resource allocations for services.

### *National Challenges*

- Limited involvement and investment of the local private sector in social development particularly in social protection; and
- Low levels of corporate social responsibility by local private sector.



## Community Challenges

### *Lack of community participation and involvement in ICPD PoA activities.*

Continued high total fertility rate, increase in population size and high dependency ratio in the face of weak economic performance are believed to be major factors in diluting gains made at poverty reduction in most of the countries including Benin, Uganda, the United Republic of Tanzania, Ethiopia and Nigeria. In Ethiopia, the population momentum results in an annual increase in population of more than two million persons per annum. This growth in population is creating pressure on arable land, leading to environmental degradation and ecological imbalances particularly in the northern and central highlands.

The ICPD at 15 country reports explain some of these challenges in specific country contexts. In Namibia, Malawi and Lesotho the needs to divert resources to social protection and other interventions aimed at overcoming the effects of the HIV and AIDS pandemic pose challenges. The Lesotho country report indicated that the GDP of Lesotho will be reduced by almost a third as a result of HIV and AIDS.

The reduction in oil revenue, has affected Gabon's capacity to fund poverty and social protection programmes. For the CAR, the unfavourable terms of international trade and the enormous debt burden pose great challenges to poverty reduction and development efforts.

Namibia, Ethiopia and Senegal cite their vulnerability to environmental degradation and natural disasters as major challenges to poverty reduction and sustainable development. In Ethiopia, the United Republic of Tanzania and Senegal, low productivity, especially in the agricultural sector, makes the challenge of poverty reduction very daunting

In the Sudan, the risk of continued armed conflict and human insecurity in Darfur or conflicts flaring up again in other volatile regions over land, pasture and water are regarded as major threats to poverty reduction and sustainable development efforts. Civil conflict in Northern Uganda and insecurity in the CAR and the DRC were cited as major factors underlying deteriorating economic situations.

Limited capacity for integrating population and environmental management concerns into development processes, including poverty reduction strategies and inadequate funding for programmes that adopt an integrated approach to managing environmental resources. Most municipal authorities are overwhelmed by sanitation and waste management problems, which continue to be major environmental and health hazards to urban dwellers.



# Section 2

## 2. Gender Equality, Equity, and Empowerment of Women

### 2.1 Introduction

In many developing areas, including Africa, ethnicity, class, religion and politics continue to define gender relations in favour of men. Gender relations shape women's access to resources and their work opportunities; frame the limits of what a woman may undertake at work, in the family or in public life; frame male behaviour, responsibilities and entitlements; affect social and economic functioning at all levels; and influence relationships between spouses, children and parents, managers and employees, and community members.

It is against this background that the ICPD PoA set its objectives; namely, (a) to achieve equality and equity based on harmonious partnership between men and women and enable women to realize their full potential; (b) to ensure the enhancement of women's contributions to sustainable development through their full involvement in policy and decision-making processes at all stages and participation in all aspects of production, employment, income-generating activities, education, health, science and technology, sports, culture and population-related activities and other areas, as active decision makers, participants and beneficiaries and; (c) to ensure that all women, as well as men, are provided with the requisite education to meet their basic human needs and to exercise their human rights.

ICPD PoA urges all countries to take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and girls. In addition, development interventions should take better account of the multiple demands on women's time, with greater investments made in measures to lessen the burden of domestic responsibilities, and with attention to laws, programmes and policies which will enable employees of both sexes to harmonize their family and work responsibilities (ICPD PoA 1994; Ch. 4).

The ICPD PoA has called on countries to achieve equality and equity based on partnership between men and women; promote women's contribution to sustainable development through their full involvement in decision-making processes at all levels; ensure that all women, as well as men, are pro-

vided with the education necessary for them to meet their basic human needs and to exercise their human rights; pay special attention to the needs of the girl child; and promote gender equality in all spheres of life, including family and community life.

The Millennium Declaration set a similar goal in MDG 2 which is to achieve universal primary education. Its target is to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. MDG 3 is set to promote gender equality and empowerment of women. Its target is to eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.

As one evidence of its commitment to gender and development in the continent, the African Union (AU) adopted its Gender Policy in 2009 (REV 2/Feb 10, 2009). The stated goal of the policy is to adopt a rights-based approach to development through evidence-based decision-making and the use of gender-disaggregated data and performance indicators for the achievement of gender equality and women's empowerment in Africa. The AU Gender Policy seeks to promote a gender responsive environment and practices and to undertake commitments linked to the realization of gender equality and women's empowerment in member States at the international, continental, regional and national level.

The Consultative Act of the Africa Union Article 4(L) stipulates that the Union will function in accordance with the principle of gender equality, by which it is hoped that all AU organs address equality in policies and programmes. At the Regional Economic Commissions (REC) level, member States have elaborated Gender Policies and adopted Gender Declarations, Action Plans and Frameworks, strategic plans, gender audits and gender analysis tools which guide gender mainstreaming, programming and budgeting.

The African ministers responsible for population and development recognized, in Dakar in 2004, continuing gender inequalities and gender-based violence. They called for strengthening institutional mechanisms for gender mainstreaming in population policies and poverty reduction strategies, to develop programme to support gender equality, equity and the empowerment of women and eliminate discrimination against women and girls.

The country reports indicate that African states are showing commitment by taking actions to promote gender equality and empowerment of women in line with the MDGs and the ICPD recommendations. In all, only 23.3 per cent of the countries indicate that they are unlikely to meet the MDG on promotion of gender equality and empowerment of women. In terms of achieving the MDG3 target to eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015, about one-third of responding countries are pessimistic.

## **2.2 Policies, legislative measures, Programmes/Plans and Institutional Arrangements**

The reports indicate that African countries continue to take action to address gender concerns through policy and legislative measures, institutional reforms and special programmes. The Af-

frican Union, with the support of development partners, has developed a number of legal frameworks and policies in support of gender equity, equality and empowerment of women. These frameworks have been instrumental in guiding national governments in developing policies and programmes in this regard. These include, for example, the Solemn Declaration on Women's Rights, the Protocol on Human and Peoples' Rights on the Rights of Women, and the Continental Gender Policy.

Most African countries have adopted national policies to support the empowerment of women and discourage discriminatory practices. These national gender policies derive inspiration and guidance from the regional and international frameworks on gender and development. For example, the Government of Namibia adopted the National Gender Policy in 1997, aimed at redressing gender imbalances in all spheres.

### *2.2.1 Legislative measures*

Most countries in the Africa region have put in place legislative measures to ensure gender equality and equity and empowerment of women in addition to equality of persons before the law, as enshrined in the national constitutions. Some of these laws make provision for gender equality in job opportunities, career advancement and promotion, remuneration and other conditions of service. The Government of Lesotho established a Law Reform Commission in 1997 to review laws that were discriminatory, in conflict with the Constitution or outdated; resulting in the enactment of two important pieces of legislation namely, the Sexual Offences Act 2003 and the Legal Capacity of Married Persons Act 2006.

Many countries have adopted legislation in support of women's empowerment for the promotion of gender parity and national development. For example, in South Africa, multiple legislative actions have been taken in the area of employment, violence and discrimination.

An increasing number of countries have made legal provisions to ensure gender equality in political participation. Examples include the political parties law of 2007 and the Election law the 2008 in the Sudan which sets aside 25 per cent of elected positions for women and Lesotho's Local Government Act of 1997 as amended in 2004, which ensured that 30 per cent of community council seats were earmarked for competition between women only during local government elections.

The country reports show that governments have adopted legal provisions to combat aspects of violence against women in South Africa, Namibia, the United Republic of Tanzania and Ghana.

Countries like Gabon and Sao Tome and Principe have also enacted special laws on sexual and reproductive rights and health of women and men.

### *Institutional Arrangements*

The country reports revealed that wide-ranging institutional arrangements have been put in place to facilitate gender mainstreaming and promote the advancement of women in African countries.

Most of the countries like Nigeria, Gabon, Benin, Mozambique, Ghana, Ethiopia, Namibia and the United Republic of Tanzania reported that specific ministries are in place, with decentralized outfits at subnational levels, charged with mainstreaming gender concerns and promoting the empowerment of women. Some have adopted multiple and coordinated institutional structures. The most common modality is a specific Ministry for Gender (27) followed by Gender units in multiple ministries (23), Parliamentary committees and decentralized gender office (22 each). Least common are Commissions, Councils or Bureaus for gender.

Most countries are seeking to promote economic participation, including opportunities in institutions and agencies, promote women's participation in politics and the protection of their rights and the improvement of gender-disaggregated data. Targeting women in extension and technical services and researching resource control issues and the division of labour in the household are least common.

The second Ghana Poverty Reduction Strategy addresses gender concerns through various agricultural and commercial programmes. Also, Ethiopia's Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) contains measures aimed at increasing girl's and women's access to education; improving water supply and sanitation; provision of health services; and, adapting agricultural training to the needs of women. Gender issues are also being mainstreamed into various development programmes, projects and activities in Malawi. Similarly, the PRSPs of various countries for example Nigeria, the Sudan, Benin and Senegal have specific activities aimed at addressing gender concerns in the various countries.

Sectorally, efforts are also being made to integrate gender issues in specific initiatives. In Ghana for example, the Commission on Human Rights and Administrative Justice (CHRAJ) and the Legal Aid Board are providing services to protect the rights of women. In Malawi, gender concerns are being integrated in eight priority areas namely Institutional Strengthening; Education; Health; HIV and AIDS; Agriculture, food and nutrition security; Natural resources and environment; Poverty and economic empowerment and Governance and human rights.

## **2.3 Implementation of ICPD PoA**

### **2.3.1 Gender and Reproductive Health (RH)**

The country reports indicate that although male involvement was regarded as critical to the achievement of RH objectives, efforts were primarily focused on women – mostly on maternal mortality reduction. In Gabon, Sierra Leone, Malawi and Ethiopia programmes are being implemented to reduce maternal mortality. Specific measures have been put in place in Senegal and Madagascar to exempt women from paying for Caesarean services as well as for the treatment of obstetric fistulas. For example, in Ghana, clinical skills and health education protocols have been developed for training physicians, midwives and public health technicians. In countries like Ethiopia, Senegal, and Ghana, community-based health programmes exist which have special aspects that focus on women's health.

In spite of the observed trend in many African countries towards improvement in the status of women, when it comes to decision-making regarding RH issues, due to traditional and socio-cultural norms and practices, added to power dynamics within the household, women still do not enjoy equal rights.

This contributes to their vulnerability to sexually transmitted diseases (STIs and HIV), maternal morbidity and mortality.

### *2.3.2 Political participation*

When it comes to decision-making, women, in many African countries, are hardly involved due to their limited access to education and the persistence of discriminatory cultural and traditional practices. The SADC Declaration on Gender and Development, to which Lesotho is a signatory, calls for at least 30 per cent representation of women at political and decision-making levels by 2005. In an attempt to achieve this, the Local Government Act of 1997 was amended in 2004 to ensure that 30 per cent of the community councils were earmarked for competition between women only in the 2005 Local Government Elections. Lesotho's implementation has raised women's share of councillors to 58 per cent of the total.

Constitutional reforms throughout Africa have guaranteed equal opportunities for women and men to participate at all levels of political process, including election to the highest office. Since the ICPD PoA in 1994, Africa has recorded increasing elections of women to high political and administrative office; today Africa has one woman Head of State, and a few Vice-Presidents.

The country reports indicated that, there has been a steady increase in women's political participation and representation in key decision-making organs in almost all African countries. Affirmative action has been used to promote women's participation in politics at all levels. In the legislature, Rwanda holds a global record of 57 per cent female membership of parliament. In Mozambique, South Africa and Namibia female representation exceeds 30 per cent and South Africa has already surpassed the SADC Declaration on Gender and Development.

Currently, South Africa's Parliament is ranked 10th out of 130 world-wide in terms of women's advancement in governance. A recent study shows that women constitute 19.8 per cent of executive managers and 10.7 per cent of directors of the 372 companies surveyed. These figures are an improvement on the 2008 comparable figures of 14.7 per cent and 7.1 per cent respectively. However, considering that 41.3 per cent of the working population is female, these figures still leave much room for improvement.

In Uganda, the proportion of women MPs increased from 25 per cent in 2003 to 29.2 per cent in 2007. In Local Government Councils, the share of women leaders/Councillors has also grown from six per cent in 1990 to 45 per cent in 2007. In South Africa, about a third of Members of Parliament and 43 per cent of the Cabinet are women. In Mauritius, although women currently hold only nine per cent of ministerial level positions and occupy 17 per cent of parliamentary seats, they account for 51 per cent of persons in decision-making positions in the public sector. This has been achieved through empowerment legislation and effective advocacy.

In Morocco, women constitute 20.6 per cent of ministers and 10.5 per cent of parliamentarians. In the DRC, only 2 per cent of senators and 8 per cent of deputies are women. A similar situation exists in Sao Tome and Principe where women account for only 7 per cent of persons in decision-making positions. In spite of some progress in improving the political representation of women, the majority of women

in the Sudan are still outside the political and decision-making process with only 19.7 per cent in the national assembly and 6.8 per cent serving as federal ministers.

Despite some notable improvements in the proportion of women in political decision-making, men still dominate senior executive and managerial positions where crucial decisions are made. For instance, only 21 per cent of women are in managerial executive positions in the public service in Uganda. With 41 per cent, the situation is slightly better in South Africa but still leaves room for improvement. In Morocco, while women have a strong presence at university level, there are fewer of them in decision-making positions, especially in the public sector.

### 2.3.3 Gender and Education

A major objective of the ICPD PoA on gender and education is to achieve universal access to quality education, with particular priority to primary and technical education and job training, to combat illiteracy and eliminate gender disparities in access to, retention in, and support for, education.

Overall, illiteracy rates among women are decreasing and gender disparity is narrowing. However, in many countries illiteracy rate among women remains high and disparities between men and women persist. According to 2007 UNESCO sources, in Chad, the female literacy rate is 12.8 per cent and the male literacy rate 40.8 per cent. In four more countries, fewer than 20 per cent of all women are literate: the Niger (15.1 per cent), Mali (15.9 per cent), Burkina Faso (16.6 per cent), and Guinea (18.1 per cent).

One of the key areas of inequality in all the African countries is education. Thus, governments acknowledge that literacy and educational attainment are critical factors in the empowerment of women. The country reports indicated that although gender disparities in enrolment and literacy are narrowing in every country, more remains to be done to ensure equality between the sexes in terms of educational progress.

In Uganda, for instance, girls' share of enrolment improved from 47 per cent in 1997 to 50 per cent in 2005. In the case of Ethiopia, the Gross Enrolment Rate (GER) for girls at the primary level increased from 53.8 per cent in 2002/03 to 85.1 per cent in 2006/07, while the same rate for boys increased from 74.6 to 98.0 during the same period. In 2006/07 secondary level GER for girls was 28.6 per cent compared to 45.7 per cent for boys.

In the United Republic of Tanzania also, although the gap between male and female enrolment rates at primary school level has considerably narrowed, it widens progressively and becomes more pronounced at the secondary and tertiary levels. In 2006, about 48 per cent of the students enrolled in Form I were female (a near gender balance at entry). However, after Form IV, there is a substantial drop in the enrolment of girls to about 30 per cent at the tertiary level. The scenario is different in Southern Africa while in Lesotho for example, more girls enrolled in schools than boys. Also the country report for South Africa indicated that although at primary school level, the ratio of girls to boys has remained consistently close to 1 from 1999 to 2006, at the secondary school level, the picture is reversed with more girls than boys enrolled throughout the same period.



In Morocco, enrolment for both sexes at primary and secondary levels are nearly equal, with girls accounting for 47 per cent of enrolment. However, like other countries, disparities exist at subnational levels where in 2007, the gross enrolment rate for girls 12-14 years in rural areas was 43 per cent compared to a national average of 75 per cent. The country reports for Ethiopia indicate that disabled women and girls are more disadvantaged than their male counterparts and that disabled girls, particularly the visually impaired, miss out early childhood education. In the case of the Sudan, primary school completion rate in 2006 for disadvantaged girls, especially those from poor households was 2.1 per cent.

The disparity in school enrolment between boys and girls increases as the level of education rises in all African countries except in Lesotho, Namibia and South Africa where female enrolment increases with rising level of education, with the result that tertiary education is dominated by females. By 2001, most African countries had achieved a male/female ratio of 1:0.8 at the primary school level. At the secondary school level, the ratio drops to about 1:0.6. Worse still, at the tertiary level, for every one female student there are as many as three males. The major facilitating factor for the progress in primary enrolment in most African countries is the decision to make primary education a prime development objective.

### *2.3.4 Gender and economic empowerment*

In terms of economic empowerment, the country reports show that although women's participation in economic activities has increased, gender differentials still exist, with majority of women working in rural agriculture, informal sectors and low-paying jobs. Women are more likely to be among the working poor and without any protection.

From 1990 to 2006, women employees in non-agricultural wage employment in SSA increased from 25% to 31%; but in Northern Africa, the proportion remained at 21% during the period. Female unemployment rates are higher than male rates in North Africa but lower in the rest of Africa. In 2007, women in Morocco accounted for only 20.7 per cent of salaried employees compared to 79.3 per cent for men. Although the share of South African women in wage employment in the non-agricultural sector is said to have increased, large disparities in wages earned by women and men still persist. About 56 per cent of women have a monthly wage lower than 1,000 ZAR (South African Rands) compared to 35 per cent for men. Only 13.8 per cent of women compared to 86.2 per cent of men in Morocco are self-employed.

The country report for Ethiopia indicated that 42 per cent of rural women (aged 10 years and above) are economically active mostly in the agricultural sector. Also, 65 per cent of persons engaged in informal sector activities are women mainly engaged in small businesses such as street vending that required limited funding and management skills. According to the country report for the Sudan, women's participation in economic activities is increasing, with their contribution to household income amounting to about 41 per cent. However, the majority of the women work in rural areas in very low-paying jobs and have little control over household income and spending decisions. In Northern Sudan, women constitute 78 per cent of the rural labour force and 85 per cent of the workforce in the informal/private sector. Also, women in the Central African Republic account for two-thirds of the agricultural labour force.

In 2006, more female-headed households in Uganda depended on transfers as a source of income than male-headed households. Additionally, while more women than men depended on wage earnings, an overwhelming percentage of more men than women derived their incomes from household enterprises. Due to their dominance in the informal sector, women are the principal beneficiaries of microfinance facilities in for example, the DRC, Morocco and Benin where they constitute two-thirds of all beneficiaries. In Benin, a special Ministry in charge of microfinance was created in 2006.

### *2.3.5 Male responsibilities and participation*

The PoA recommends that programmes should be developed to enable men to take responsibility for their sexual and reproductive behaviour and social and family roles. The review of employment policies and legislations, sensitization and advocacy campaigns on men supporting women were reported to be the strategies adopted to promote equal participation of men and women at the family and household levels.

The reports generally show that cultural and traditional practices continue to influence decision making and the participation of men and women at the family and household level. However, many countries (such as South Africa, Botswana, Lesotho and Senegal) have programmes which are designed to encourage the participation of men in family life and reproductive health matters, including GBV prevention. The Ugandan country report reveals that the proportion of women who take sole decision regarding the use of their earnings decreased from 59.6 per cent in 2001 to 54.6 per cent in 2006, irrespective of levels of education, age, and rural-urban location. The report, however, noted an increase in joint decision making from 25 per cent to 32 per cent which could signal improved gender relations. The United Republic of Tanzania country report shows that women more likely to be employed in subsistence agriculture and home-making.

Activities to increase the participation of men and address their responsibilities most often deal with reproductive health issues and advocacy for male support and sensitization. The issues least addressed often have to do with resource control within families.

### *2.3.6 Gender and the Environment*

Women's role in environmental management is critical to sustainable development. This is because women play a major role in the collection, consumption and preservation of all natural resources, particularly water and fuel-wood for domestic use. Improved access to potable water will cut down on the amount of time women use in fetching this vital domestic need and improve their contribution to development.

Ethiopia for instance, indicated that gender issues have been mainstreamed into development strategies that include environmental protection and sustainable use of natural resources actions.

### *2.3.7 Gender-Based Violence (GBV)*

The literature uses this as an umbrella term for any harm that is perpetrated against a person's will,



as a result of power imbalances that exploit distinctions between males and females, among males, and among females. Gender-based violence could take various forms: domestic violence; early and forced marriage; wife inheritance, property ownership, child custody; arbitrary incarceration of women and children; female genital mutilation; sexual harassment and assault.

The effects of GBV are also numerous and include post traumatic stress disorders, direct economic costs related to treatment and legal services, loss of income and productivity, contracting HIV and STIs, and ultimately death. One important initiative by South Africa for HIV/AIDS prevention is the introduction of post exposure prophylaxis against HIV infections for women who are victims and survivors of rape and violence.

ICPD PoA recognizes that the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. Gender-based violence is a negative force in the empowerment of women. Therefore, Governments are, among other things, urged to eliminate violence against women.

While acknowledging that the causes of GBV varied among countries, all reports found it to be rooted in unequal power relations between women and men, exacerbated by customary norms and practices. Armed conflict was cited by the CAR, the Congo and Sierra Leone as a major factor that aggravates the occurrence, especially, of sexual violence against women and girls. The ICPD PoA urges all to take the necessary action to eliminate all forms of violence against women and girls.

GBV was a critical problem in that it manifests itself in various forms across the continent, including psychological, emotional and sexual abuse within families and communities. Specific forms cited by the countries include wife battering, sexual harassment, trafficking in especially women and young girls, female genital cutting, property grabbing, especially from widows, and rape/defilement.

According to the Uganda country report, the 2006 DHS results show that 70 per cent of the women have experienced either physical or sexual violence with about 29 per cent having experienced both physical and sexual violence. The Sudan report indicated that the prevalence of Female Genital Mutilation/Cutting (FGM/C) was 70 per cent in Northern Sudan and that 53.6 per cent of married women still intended to carry out the operation on their daughters. South Africa's country report indicates that many teenagers do not want to become pregnant at an early age, but are significantly more likely to have experienced forced sexual initiation and physical abuse at the hands of their partners. The report notes that these factors have dire consequences, i.e., the high levels of teenage pregnancy reflect a pattern of sexual activity that puts teenagers at risk of HIV and other sexually transmitted diseases.

Actions that were taken by the countries to address gender-based violence include, formulation and implementation of policy and legal frameworks; provision of services for victims (including clinical services for rape victims); and implementation of training, counselling, IEC and advocacy programmes. Few countries have established national committees or bodies in GBV or instituted legal reforms to address women's control over their incomes and property.

### 2.3.8 Protecting the Girl Child

The specific objectives of the ICPD PoA on the protection of the girl child are: to eliminate all forms of discrimination against the girl child and the root causes of son preference; to increase public awareness on the value of the girl child, and concurrently, to strengthen the girl child's self-image, self-esteem and status and to improve the welfare of the girl child, especially in terms of health, nutrition and education.

To achieve these objectives, ICPD PoA urges Governments, among others, to develop an integrated approach to the special nutritional, general and reproductive health, education and social needs of girls and young women; to strictly enforce laws to ensure that marriage is entered into only with the free and full consent of the intending spouses; to prohibit female genital mutilation wherever it exists, and to take the necessary measures to prevent infanticide, prenatal sex selection, trafficking in girl children and use of girls in prostitution and pornography.

The countries reported various actions for the protection of the girl child. These include, ratifying various international conventions and national legal frameworks to protect the rights of the girl child against traditional harmful practices (FGM, "Trokosi", etc), sexual violence, forced and early marriage, abduction, expulsion from school due to pregnancy, as reported by the DRC, Gabon Madagascar Nigeria, Senegal, Sierra Leone, and the United Republic of Tanzania. Specifically, Nigeria passed the Child Rights Acts in 2003 and the United Republic of Tanzania has revised its labour law to prohibit employment of children under 14 years of age.

In order to address the incidence of early marriage, Sierra Leone passed the 2008 Marriage Act which increased the minimum legal age at marriage to 18 years. Also, subsidies were provided for books, uniforms and school charges in the northern and eastern provinces which had the lowest enrolment rates in Sierra Leone, to improve the enrolment and retention of girls at especially the secondary level.

The greatest attention has been given to educational access, with slightly declining focus at higher levels. Attention is also given to prevention of trafficking and exploitation. Prevention of FGM, addressing early marriage and ensuring medical care for girls get the least attention in that order. However, the institutional arrangements to monitor and report on progress, have only been made in a bare majority of countries.

## 2.4 Achieving the MDGs

MDG 2 is set to achieve universal primary education. Its target is to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. While MDG 3 is set to promote gender equality and empowerment of women; its target is to eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.

Given the levels of achievement reported by the countries, it is understandable why African nations feel confident about achieving MDG 2 and its target by 2015. An overwhelming 90 per cent

of responding countries indicate the likelihood of achieving the goal of universal primary education as well as the target of ensuring that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. In response to the question on prospects of achieving MDG 3, most African countries (76.7 %) expressed the likelihood; but fewer countries (66.7 %) are optimistic about meeting the target by 2015. As already noted, the major facilitating factor for the progress in primary enrolment in most African countries is the decision to make primary education a prime development objective.

Countries such as Burundi, Kenya, Mauritius, the Niger, Sao Tome, Senegal, Seychelles, Sierra Leone, Swaziland, the United Republic of Tanzania and Zimbabwe indicated that the goal was likely to be achieved because of the enabling legal, policy and institutional environments that have been put in place. In most of these countries, there has been a gradual improvement in women representation in Parliament and Cabinet; and increased participation of women in wage employment especially in non-agricultural sectors.

This notwithstanding, some countries like Kenya, Mauritius and Seychelles indicated that the goal will only be achieved if issues such as availability of adequate financial resources, managing implementation bottlenecks, political will and support are properly addressed.

Based on the rate of progress and the high gender disparities in many sectors, countries such as Benin, Guinea and the Sudan indicated that the goal was unlikely to be achieved.

**MDG 3-Target 1:** Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015. Mauritius, Tunisia and Seychelles indicated that they have almost achieved this. For the Gambia, Lesotho, Morocco, Senegal and Sierra Leone the chances of achieving this target were judged as very likely in view of the policies and programmes being implemented and the results already achieved. In the Gambia, the target as it relates to primary level education is said to have been achieved and progress is being made towards the achievement of the target for the secondary level. In Lesotho, although the enrolment of girls has been higher than for boys, the Household Budget survey of 2002/03 showed the gap narrowing.

In other countries like Burundi, Comoros, Guinea, Kenya, Madagascar, Sao Tome, Swaziland, the United Republic of Tanzania and Uganda, suitable policies and programmes which are yielding positive results have made the target likely to be achieved. In Swaziland, there are more girls than boys enrolled. In tertiary education there are more boys than girls but the gap is slowly closing. The ratio of girls to boys in primary schools in the United Republic of Tanzania reached 0.98 in 2005, and for the secondary level the ratio increased from 0.84 in 2000 to 0.87 in 2005. Due to universal access to education at both primary and secondary levels in Uganda, the ratio of girls to boys in primary schools in 2006 was 0.96 while that for the secondary level increased from 0.83 in 2001 to 0.84 in 2006.

The target is judged as unlikely by the Sudan, the Niger and Central African Republic, where as a result of various factors, the disparities in primary and secondary school enrolment have either not improved as desired or have actually deteriorated.

## **2.5 Commitment to international Agreements**

### *2.5.1 Convention on Elimination of all forms of Discrimination against Women (CEDAW) and other international instruments*

As already noted, the AU Gender Policy seeks to promote a gender responsive environment and practices and undertake commitments linked to the realization of gender equality and women's empowerment in Member States at the international, continental, regional and national levels.

All the countries reported that they were signatory to various international instruments on gender including CEDAW; the Beijing Platform of Action; and Security Council Resolutions SC/1325 on the impact of war on women, and women's contributions to conflict resolution and sustainable peace, and SC/1820 aimed at discouraging acts of sexual violence against civilians in conflict zones.

All the countries indicated that in addition to the ratification of CEDAW, they have prepared at least one country status report on the implementation of the convention. All 39 of the responding countries have ratified CEDAW, 35 are implementing it, while 32 indicate that they are reporting on its implementation. The few countries that had yet to take any of the actions explained their situation in terms of lack of policy commitment and weak institutional capacity. Only two countries stated that CEDAW and its adaptation at the country level was not a national priority.

Uganda, for instance, indicated that it has prepared six CEDAW country status reports and made progress on most of the 16 Articles of CEDAW, especially in the area of constitutional reforms. On the other hand, although Nigeria had ratified the convention, it was yet to integrate it in the laws of the country. In Lesotho, the convention had been ratified with reservations on certain sections that had constitutional implications regarding customary laws, the church and chieftaincy. Lesotho was also party to the SADC Addendum on the Prevention and Eradication of Violence against Women and Children signed in 1997. In the United Republic of Tanzania, the ratification of CEDAW had meant amendment of the Constitution in 2000 and 2004.

### *2.5.2 Commitment to Continental Level Policies and Strategies*

The country reports indicated that the AU Solemn Declaration on the Rights of Women and the African Charter on Human and Peoples' Rights were adapted through policy and legislative reviews, reform of institutions and formulation of plans and programmes. Also other instruments such as the CEDAW and the Millennium Development Goals and Targets have been used to garner resources and exert efforts to address gender concerns in the various countries.

## **2.6 Achievements**

On gender equality, equity and empowerment of women, countries reported intensified efforts to put in place relevant policies, legislations and programmes, including PRSPs. Achievements reported relate to the following:

- a. Specific laws and programmes are in place to combat various aspects of violence against women;
- b. Governments have taken actions to increase the participation of women in the labour force;
- c. The important role women play as custodians of the environment is increasingly recognized at national and regional levels;
- d. National institutions have been reformed and in most cases specific ministries were established with the mandate of mainstreaming gender concerns and promoting the economic empowerment of women;
- e. Efforts have been intensified to provide for the special reproductive health needs of both men and women including implementation of special programmes to reduce maternal mortality;
- f. There is a steady increase in women's participation in politics and in key decision making organs in most African countries;
- g. School enrolment rates for girls have improved and disparities between enrolment rates for boys and girls, especially at the primary level, have narrowed; and
- h. Specific actions have been taken in most countries, including enactment of laws and design of programmes targeted at protecting the rights of and catering for the needs of the girl child.

## 2.7 Major challenges and constraints

These will include:

- a. Although there is a proliferation of gender-related policies and legislations, the translation of the policies into programmes and the enforcement of the legislations remain an important challenge to addressing gender concerns in most countries;
- b. The HIV/AIDS burden on the continent still heavily rests on women and girls;
- c. Gender programmes continue to be under-funded and target donor pilot projects, with limited coverage and results;
- d. Even though there is an increase in the participation of women in decision-making and economic activities, they continue to be employed in subsistence agriculture, domestic or low- paid jobs in the formal sector;
- e. Limited capacity of existing institutions to coordinate the implementation of gender sensitive policies and strategies continue to be a serious constraint to integrating gender and reproductive health issues into sectoral and national programmes;
- f. Socio-cultural norms and traditional practices continue to make the achievement of gender equality, equity and women empowerment goals difficult in all the countries;
- g. Armed conflicts have contributed greatly to aggravating gender-based violence perpetrated against women and girls on the continent;
- h. Protection systems and mechanisms for countering sexual and gender-based violence (SGBV) remain limited and preventive measures weak; and
- i. While gender gaps are closing in many countries, concerns are being expressed about the quality of education.



# Section 3

## **3. The Family, its role, rights, composition and structure**

### **3.1 Introduction**

Enshrined in the laws and constitutions of all countries in Africa, the family is recognized as an important unit of society and development. It plays a key role in the production, reproduction economic and social functions of its members. The family in Africa provides social and emotional support to the elderly, the youth, children and women, particularly when they face crisis such as unemployment, sickness, poverty, old-age, and bereavement. The role of the family in providing care and support to its members, particularly during difficult times, is very well recognized throughout the continent.

The family has been of major concern to African ministers and leaders. In 1992, the DND recognized the family as an essential component of the economic and social fabric, which requires the pursuit of appropriate strategies, adapted to family services. It called for integrating the family into the regional and national development policy agenda, and recommended for governments to take action on the rights and responsibilities of all family members and ensure that measures that protect the family from socio-economic distress and disintegration are taken into account in accordance with family well-being and health requirements, bearing in mind the survival strategies designed by the families themselves, The DND further called on governments to provide couples and individuals with facilities and resources for deciding the size of their families.

The ICPD PoA urged governments to develop policies and laws to support the family and contribute to its stability; establish social security measures to address the social, cultural and economic factors behind the increasing cost of child rearing, and promote equal opportunity for family members. Also, the ICPD PoA urged governments to ensure that social and economic development policies are responsive to the needs and rights of families and individual members. According to the ICPD+10 review undertaken in 2004, implementation of family programmes and legal rights remain ineffective in Africa. The review points to relative weak and disperse attention given by countries to family concerns. Also, the review highlighted paucity of data and policy research on the family as an important constraint to which governments must direct attention and provide support to improve on the implementation of family policies.

### **3.2 Analyses of the current situation**

The situation of the family in Africa continues to be seriously impacted by a wide range of factors including conflict and instability, poor governance and deteriorating human rights, jeopardizing the stability and welfare of the family. Civil wars and internal conflicts have led to the displacement of families and their members, increase in widowhood, teenage pregnancies, homelessness,



and street children, particularly in slums around and inside capital cities in Africa. Such situations have strained family relations and led to rampant violence and crime among family members. Undoubtedly, the recent food, energy and financial crises seriously impacted on family welfare in Africa. Data and research are needed to study these impacts and to provide relevant policies and actions.

Generally, poverty is reflected in scarcity in the means of living and worsening economic conditions. When the family is poor its members live under social tension that often results in fragmentation of the family structure and inability of its members to form new family and household units. Scarce means of survival is reflected in inadequate and overcrowded housing and other living conditions that compromise the capacity of the family to nurture children and to support their education in schools.

In terms of health and population, research indicates that rapid urbanization and the increasing use of modern contraceptive methods are responsible for the decline in fertility that occurred over the last three decades. However, fertility in Africa declined mostly in urban areas and remained high in rural areas, where traditional social institutions and values continued to dominate family life styles. High prevalence of malaria, tuberculosis, and HIV/AIDS have stalled mortality and health transitions and, in many cases, eroded the gains in life expectancy that were achieved after independence.

The repercussions on the family of the health and demographic situations mentioned above are reflected in the increasing number of orphans and widowed women, and high school drop-out rates, especially among girls. For example, results from a survey of 771 AIDS-affected households in three South African provinces indicate that 40 % of primary caregivers “took time off work or school to care for an ill HIV-infected family member. Almost 10 % of the households removed a girl from school compared with 5 % for boys”. In Sub-Saharan Africa, “12 million children have lost one or both parents to AIDS. By 2010, this number is expected to climb to more than 18 million.” (UNAIDS 2004).

### **3.3 Action Taken**

In July 2004, the Heads of State and Government in Africa adopted the “Plan of Action on the Family in Africa”. This policy instrument called for actions to improve the quality of life of the family in Africa in nine priority areas that cover poverty alleviation, rights to social services such as education, family health, reproductive health, and families with special needs, promoting environmental sustainability particularly in the areas of the environment, water and sanitation, nutrition and food security, adequate shelter, and land ownership. The Plan of Action emphasized the need for actions to establish institutional mechanisms to promote the rights, duties and responsibilities of the family, and to develop and promote a legislative framework for protecting the family and its members. It pinpointed the need for actions to strengthen family relationships and to control major diseases such as HIV/AIDS, malaria and tuberculosis. An important precondition for the achievement of these activities is peace and security. In this regard, the Plan of Action called for the promotion of stability and for minimization or elimination of the negative impacts of wars, crimes and conflict on the family.



While the Dakar/Ngor declaration broadly covered the family in development in Africa, the AU plan of action identified important priority areas for action. Also, it emphasized the role of member States, civil society organizations, RECs, the AU and the regional and international community in the implementation of the policy and in its follow up, evaluation and monitoring.

Results from the main questionnaire indicate that the countries do have strategies and have undertaken measures in the areas of housing (26 countries), work (24 countries) education (33 countries) social security (29 countries), and inheritance (26 countries) and ageing (31 countries). The actions undertaken since 2004 cover family members, particularly those who are living with HIV/AIDS, the aged, disabled, unemployed, widowed, and persons affected by natural disasters (see table 3.1 and 3.2). The low country response to adaptation of the Plan of Action on the Family in Africa emphasizes the need for strategies to accelerate country implementation and monitoring of regional policy frameworks agreed on at the level of the African Union.

The country reports provide more detailed information on the actions taken by countries, including policies to address family welfare in areas such as social security, education, health, and housing. Benin, Seychelles, Mozambique, Sierra Leone and Mauritius have policies, laws and other institutional frameworks to address the needs of the family, and programmes to support vulnerable family members including AIDS orphans, people with disabilities and the elderly.

The family received special attention in post-conflict countries such as Angola Liberia, Mozambique and Sierra Leone. The government in Sierra Leone, for example, scaled up the social security scheme (NASSIT), which was established in 2002 with various facilities on pensions, support to survivors, payment of gratuity, etc. to benefit the family. In 2007, it enacted a law on inheritance and devolution of property to surviving females. Incentives were provided for girls who excelled in school. The main objective of such incentives is to keep girls longer in school and to empower them and ultimately improve their status. Nigeria adopted a similar policy for promoting girl child education to “enable them to mature both physically and intellectually to take informed decisions”, and as a strategy to prevent early marriage (Nigeria Country Report).

The government of Sierra Leone embarked on low-cost housing schemes, and continued to provide support to homes for old people and disabled persons. In Sierra Leone, the establishment of the National Commission for War-Affected Children (NaCWAC) in 2001 provided a platform for ensuring that the needs of war- affected families and children are taken into consideration at all levels of national planning.

**Table 3.1**      **Actions taken to promote family welfare (N=40)**

Areas for Family-related Strategies/ Measures/Actions	
Housing	26
Work	24
Health	32
Social security	29
Education	33
Inheritance and distribution of property	26
Addressing the concerns of Aging	31
Other	5

**Table 3.2**      **Actions taken to assist the following family members (N=40)**

Category of Vulnerable Family Members	Response
Extremely poor	29
People living with HIV/AIDS	35
Unemployment	23
Aged	30
Refugees and displaced persons	24
Widows	20
Disabled	28
Persons affected by natural disasters (including droughts and floods)	30
Other	7

Seychelles, which is classified as a middle income country, provides an interesting example of effective social welfare systems that afford adequate living standards for the people with special emphasis on the less fortunate, ensuring that they do not live in poverty. The range of benefits and services provided that directly or indirectly benefit the country's families include old-age pensions, medical benefits and special assistance programmes for disadvantaged groups, such as the chronically ill, and the physically and mentally challenged. Types of benefits that are directly beneficial to families range from sickness to maternity benefits.

The Seychelles government provides free health and education services as well as social housing. School enrolment from primary to secondary is 100 per cent. All deliveries take place in hospitals. Government policies ensure that every Seychellois gets access to free healthcare services and that every child has access to free education from age three and half to 16 years. Furthermore, every family has its own home, bought either through its own means or under the Housing Loan Fund. Families may also live in houses or flats and pay monthly rent.

Mauritius provides a good example of a decentralized family welfare network. The government established a Family Welfare Unit (FWU) in 2003 and formulated a National Policy Paper on the Family in 2006. The FWU is linked to a network of six regional offices known as Family Support Bureaux (FSBx) to offer services to all family members through the Family Counseling Service. This network

provides holistic and decentralized services whereby “staff of the Family Counseling Service, Family Protection Unit and Child Development Unit work within the same premises, with a view to minimizing further trauma to victims of violence” (Mauritius Country Report). The government implemented several other programmes, such as the “Marriage Enrichment Programme”, “Pre-Marital Counseling” and “Men as Partners Programme.” The “Marriage Enrichment Programme” aims at strengthening and promoting understanding and respect between married couples. Pre-Marital Counseling aims at sensitizing unmarried/engaged couples for a more stable married life as well as to prepare couples to cope with marital conflicts. The “Men as Partners Programme”, lays emphasis on men’s responsibility and increased participation within the family, from a gender perspective (Mauritius Country Report). All these programs will strengthen family cohesion and increase male participation within the family.

Benin’s country report indicated that a special Ministry of Family and Children was set up in 2005 to provide government leadership in coordinating efforts to address the needs of the family. The promulgation of the family code in Benin in 2004, the enactment of the Social Protection Law, no.4/2007 in Mozambique, the review of the inheritance law in Sierra Leone in 2007 are all aimed at providing the legal and enabling environment for addressing the needs of members of the family, including children, the elderly and people with disabilities.

In Mozambique, a National Action Plan for the Elderly (2006-2011) is being implemented to provide for the needs of the elderly, especially those in extreme poverty. A similar plan was adopted in Benin in 2007 to address the needs of old people. Micro projects are also being implemented in Mozambique, Sierra Leone, and Mauritius to improve the living conditions of people living with disabilities. The country reports indicated that the national AIDS programmes were providing care for AIDS Orphans. Also, with the support of international agencies, programmes are being implemented to improve the living conditions of street children.

In Malawi, a pilot cash transfer scheme has been implemented since 2006. This scheme delivers monthly cash grants to extremely poor families in the pilot area, as well as to labor-constrained (households with no adult fit for work or with a dependency ratio of more than 3). According to Malawi’s country report, by 2008 about 11,650 households received cash transfers. The members benefiting from cash transfers include orphans and other vulnerable children, the elderly and people with disabilities. The future plan is to scale up this programme to reach 260,000 and then to 390,000 households. This is expected to reduce ultra poverty by about 10 to 15 per cent, from a current level of 22.4 per cent.

The Republic of South Africa adopted a reconstruction and development programme as a strategy to the needs of the black majority in terms of housing, education, water, sanitation, etc. About 1.8 million houses were built from 1994 to 2005, on State-provided land and with State subsidies. During the same period, the State transferred an additional 413,006 housing units to low- income families. Education policies focused on increasing inequalities by race, gender and other social groups. The government adopted a two-pronged social security system that covers social assistance and social insurance. The social grants play a vital role in reducing poverty and promoting social development. Social security is estimated to reduce the poverty gap in South Africa by about 49 per cent.

### 3.4 Challenges and constraints

African countries face some common challenges and constraints relating to the integration of the family in development plans and activities. Though legal codes and regulations directly linked to the welfare of the family and its members exist, they are often not implemented.

Though countries have experienced slow, and sometimes deteriorating social conditions, the repercussions and impacts of such conditions on the values, norms and cultures, and the structure and composition of the family often are not researched. Without information and policy research on how society changes and organizes and reorganizes itself in families and communities of different forms and functions, development will remain a grossly deficient process.

Though recognized by laws and constitutions, the family is grossly neglected in the formulation and implementation of national development plans and strategies. Success and failure of development activities directly impact on the survival and stability of the family and its members. When macroeconomic policies are implemented, their consequences and impacts on the families are often neglected. For example, labour retrenchment policies were implemented under the structural adjustment programmes, and without serious consideration of the impacts of these policies on the welfare and stability of the family. The poverty reduction strategies, which came in the wake of the structural adjustment programmes, also failed to count for the social and economic damage inflicted on families in Africa.

Integrating the family in development remains a challenge for most of the countries in Africa. Development policies and strategies must integrate the family and its changing structure and roles, particularly in the design and implementation of economic and social services. Family-sensitive development policies and strategies are important for social integration endorsed at the Social Summit in 1995.

# Section 4

## 4. Children and Youth

### 4.1 Introduction

The objectives of the ICPD PoA regarding children and youth are: (a) to promote the health, well-being and potential of all children, adolescents and youth as representing the world's future human resources; (b) to meet the special needs of adolescents and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process, and access to education, health, counselling and high quality reproductive health services and; (c) to encourage children, adolescents and youth, particularly young women, to continue their education in order to equip them for a better life, to increase their human potential, to help prevent early marriage and high-risk child-bearing and to reduce associated mortality and morbidity.

The *Convention on the Rights of the Child* (Art. 24) affirms that children have the right to attain the highest standards of health and health care, including family planning education and services. In this regard, the United Nations committee monitors the implementation of the Convention elaborated (2003): “States Parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and prevention and treatment of STIs. In addition, States Parties should ensure access to appropriate information regardless of marital status, and prior consent from parents or guardians.”

Governments are, therefore, among others, urged to: (a) give high priority and attention to all dimensions of the protection, survival and development of children and youth; (b) take effective steps to address the neglect, as well as all types of exploitation and abuse of children, adolescents and youth and; (c) enact and strictly enforce laws against economic exploitation, physical and mental abuse or neglect of children.

In the same spirit as the ICPD PoA, the African Youth Charter, to which African countries are committed, also focuses on the promotion of youth capacity development and employment among others. Under the Charter, Member States are obliged and guided to mobilize resources and facilitate the

implementation of programmes on youth employment, youth rights, gender balance, advocacy, education and skills training, health, peace and security, culture, sporting and recreation through meaningful youth participation.

## 4.2 The situation of children and youth

### 4.2.1 Children

Table 4.1 shows that for the five countries lying mostly north of the Sahara (Algeria, Egypt, the Libyan Arab Jamahiriya, Morocco and Tunisia) the average under-five mortality rate was estimated to have decreased from 82 per 1,000 live births in 1990 to 35 per 1,000 live births in 2006; and were rated to be 'on track' for achieving MDG 4. On the other hand, under-five mortality rate decreased from 187 per 1,000 live births to 160 per 1,000 live births for Sub Sahara Africa, was rated as 'insufficient progress'. In two subregions; Southern Africa and Central Africa, "no progress" was registered. In these regions, under-five mortality actually increased from 125 per 1,000 live births to 146 per 1,000 live births for Southern Africa and 187 per 1,000 live births to 193 per 1,000 live births for Central Africa. The UNICEF Report clearly indicates that Africa South of the Sahara is the most difficult region in the world for a child to survive in until age five. Three countries – the Democratic Republic of the Congo, Ethiopia and Nigeria – were reported to account for more than 43 per cent of total under-five deaths in all of Africa.

**Table 4.1 Progress in Reducing Child mortality by Region**

Region	Under 5 Mortality Rate		Average Annual Rate of Reduction*		Progress Towards the MDG Target
	1990	2006	Observed	Required	
	1990	2006	1990-2006	2007-2015	
Sub-Saharan Africa	187	160	1.0	10.5	Insufficient Progress
East Africa	171	123	2.1	8.5	Insufficient Progress
Southern Africa	125	146	-1.0	13.9	No Progress
Central Africa**	187	193	-0.2	12.6	No Progress
West Africa	215	183	1.0	10.4	Insufficient Progress
North Africa	82	35	5.3	2.8	On Track
Developing country	103	79	1.7	9.3	Insufficient Progress
World	93	72	1.6	9.4	Insufficient Progress

\*A negative Average Annual Rate of Increase indicates an increase in the under-five mortality rate in that region since 1990

\*\* Including Djibouti and the Sudan

Source: Adapted from Figure 1.2 - Progress in Reducing Child Mortality by Region; UNICEF (2008); *The State of Africa's Children Report 2008*, Page 4

Although progress has been reported for West Africa, that subregion still accounted for more than 40 per cent of Africa's child deaths in 2006 followed by Eastern Africa (30 per cent) Central Africa (18 per cent), Southern Africa (8 Percent) and North Africa (2 per cent). According to the report, the following seven key gains have been made in child survival within sub-Saharan Africa:

- a. Rapid progress in child survival in several Sub-Saharan African countries since 1990;
- b. A remarkable reduction in measles deaths among children from 2000 to 2006;
- c. Advances in malaria prevention and treatment;
- d. Increased access to antiretroviral treatment for HIV-positive mothers and children;
- e. Rising rates of exclusive breastfeeding up to six months;
- f. Expanded distribution and use of micronutrient supplementation; and
- g. A growing consensus on the framework and strategies required to accelerate progress.

The way forward for Sub-Saharan Africa especially, according to the UNICEF report, is to radically transform the health systems in each of the countries with focus on such strategic priorities as:

- a. Strengthening health systems through community partnerships to, among other things, foster local ownership of child survival efforts;
- b. Establishing the continuum of care across time and location to connect essential maternal, newborn and child health services through pregnancy, childbirth, postnatal and newborn periods and into childhood and the provision of integrated services to adolescent girls; and
- c. Strengthening health systems with results-based strategies, and unified programmes and partnerships.

#### 4.2.2 Youth

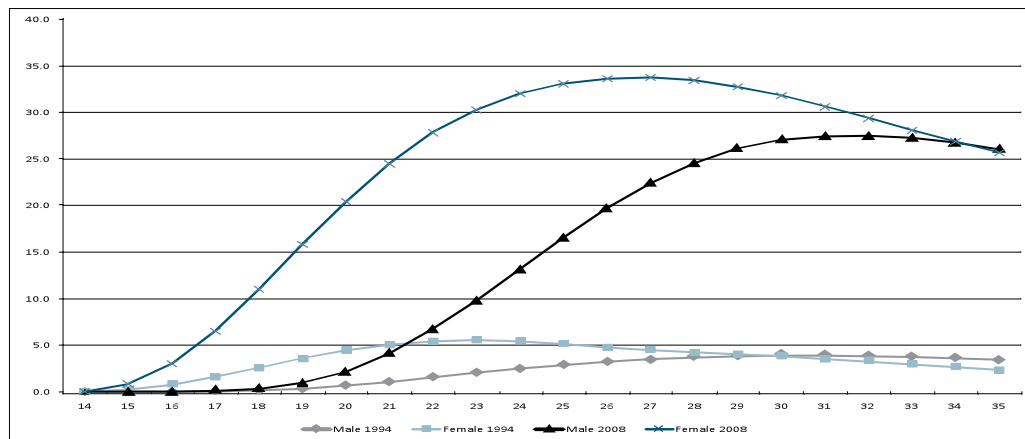
As already noted in Section One of this report, the population of Africa is predominantly youthful in character, with children and young people below age 15 constituting over 40 per cent of the total population. The most recent estimates show that children under 15 years of age constitute 41.2 per cent of the population of Africa, and projections indicate a slight decline to 40.3 per cent by 2010. When children and young people 30 years and below are taken together, they make up over 70 per cent of the total population of the continent (UN, World Population Prospects – 2008 Revision). This implies that national development planning efforts in the continent must necessarily focus on young people.

Different countries apply their own definitions of youth. Whichever is adopted, though, they constitute a significant proportion of the population. The challenges faced by the youth and adolescents in all the countries are very similar and include high open unemployment, drug and substance abuse, and exposure to RH and related problems such as STIs/HIV/AIDS, early marriage, early pregnancy, birth complications, and unsafe abortion.

Like most other countries, the Sudan and Malawi indicated that most of the reported cases of HIV infection were among young people. The 2004 Lesotho Demographic and Health survey revealed that one in nine persons aged 15-24 years is HIV positive. The HIV sentinel surveillance reports reveal that for persons aged 15-19, HIV prevalence increased from 5.3 in 2004 to 11.7 in 2005 compared to 19.2 (2004) and 25.5 (2005) for age group 20-24 respectively. The 2006 Sentinel survey of Namibia revealed that an estimated 10.2 per cent of the 15-19 year old and 16.4 per cent of the 20-24 year old pregnant women are infected with HIV. In South Africa, the highest HIV prevalence rate of 33.7 per cent in 2008 was predicted for women aged 27 years. Women in South Africa, as elsewhere on the continent, are more likely to be affected at a younger age than men (see Figure 4.1).



**Fig. 4.1 HIV prevalence among youth in South Africa, by age and sex, 1994 and 2008**



Source: South Africa ICPD + 15 Country Report

The Mauritius country report indicated that in 2007, 10.6 per cent of all live births in Mauritius were to women aged 15-19 and that teenage pregnancy as well as abortion and its complications are on the rise. A similar situation occurred in South Africa where by the age of 19 years, 35 per cent of all teenage girls have been pregnant or had a child. In 2006, over half of teenagers (15-19 years) in Central Africa Republic lived in conjugal union. About 20.4 per cent of women were married before age 15.

In Uganda, although the incidence of teenage pregnancy is declining, it is still considered to be high at 25 per cent in 2006. The Malawi country report indicated that in 2005, about 22 per cent of maternal deaths occurred among young girls. According to data for 2003, only 13.9 per cent of the girls and 22.7 per cent of boys. In Sao Tome and Principe used a condom in their first sexual encounter. Also, data for the same year indicated that 37.5 per cent of girls admitted to having had an abortion.

The incidence of unemployment was regarded as very high among young people. In South Africa, youths were reported to comprise about 70 per cent of the unemployed - with the phenomena highest among the 25 to 29 age group.

### 4.3 Policies and laws

In recognition of the enormity of the challenge posed by problems faced by young people, the Governments reported putting in place policies and programmes aimed at the socio-economic empowerment and participation of young people in the society.

Having regard to the magnitude of the problems faced by the youth and adolescents of the country, the Government of Ethiopia issued the National Youth Policy of Ethiopia in 2004, with the goal of encouraging the active participation of the youth in the social, cultural and economic life of the country. The policy addresses issues ranging from HIV/AIDS to environmental protection and social services. The Government has developed the Multi-sectoral Youth Development Strategic Plan,



and two Youth Sector Development Programmes, the first of which covers the PASDEP period of 2006-2010.

National youth policies and other sectoral policies and legal provisions which address youth issues were reported to be in place in Mozambique, Lesotho, South Africa, Sierra Leone, the Sudan, Uganda, Benin, Madagascar and Sao Tome and Principe to empower youths to participate in the social, economic, cultural and political life of their countries.

Tanzania's National Employment Policy 2008 and The Employment and Labour Relations Act 2004 (cap. 366) show commitment to the implementation of continental-level strategies. The United Republic of Tanzania addresses the needs of children (under 14 years) through (a) enforcement of laws against trafficking and economic exploitation of children, (b) ensuring equal educational opportunities for boys and girls at every level, (c) protection and care for street children and orphans, particularly those who are affected by HIV/AIDS, (d) provision of assistance for rehabilitation of children affected by armed conflicts and other emergencies/disasters. The country has also enacted The Children and Young Persons Act (Cap. 13) which, among other things, protects young persons (between the ages of 15 and 24) against violence.

Mozambique formulated the National Youth Policy (re. Article 12 of the CAJ) (PNJ), which guides the approach to and treatment of youth issues in the national context, with the aim of approaching and giving due attention to the needs of the Mozambican youth, particularly with regard to access to education and other basic social services. Zimbabwe also ratified and adopted the African Youth Charter in 2008, in which member States are obliged and guided, among others, to mobilize resources and facilitate the implementation of programmes on youth capacity development and employment.

In Malawi, Government has revised the 1996 National Youth Policy, whose goal is to develop the full potential of the youth and promote their active participation in national development. Other development frameworks and policies that have been adopted to contribute to youth empowerment are Malawi Growth and Development Strategy (MGDS), National Gender Policy, Reproductive Health Policy and HIV and AIDS Policy.

In Mauritius, Government promulgated the National Youth Policy (2000) to improve the life skills of young people and empower them to make informed choices for SRH; consolidate counselling services for SRH at secondary and tertiary level institutions; build the capacity of the youth, promote networking with agencies involved in ASRH activities, and set up structures for youth activities and health services.

Cognizant of the role of youth in development and their vulnerabilities, the Government of Namibia promulgated the first National Youth Policy of Namibia in 1993; the policy has since been reviewed. The goals of the youth policy are to empower the youth, foster proper upbringing of young women and men to become responsible citizens, and enable young men and women to initiate actions which promote their own development and that of their communities and the broader society. The strategic areas identified for programme intervention are education, health, employment creation and economic participation.

The Seychelles Constitution promotes non-discrimination and gives "every person equal protection of the law, including the enjoyment of the rights and freedoms contained in the Charter, without discrimination on any grounds, except as is necessary in a democratic society" (Article 27). The Children's Act of 1982 was amended in 1991 and 1998, with the central purpose of protecting children.

#### 4.4 Institutional Arrangements

Almost all reporting countries indicated the existence of either a ministerial department or a commission for coordination of youth issues at the national and subnational levels. For example, the establishment of the National Youth Commission (NYC) through the enactment of the National Youth Commission Act (No. 19 of 1996) provided a key framework for addressing the concerns of young people in South Africa. It also represents a major commitment by government to treat the needs of this sector in a serious and comprehensive manner. The Commission's main objectives are to coordinate and develop a national youth policy that is sensitive to the needs and aspirations of the youth.

In Namibia, the Ministry of Youth, National Service, Sport and Culture (MYNSSC) is responsible for youth affairs, as well as the overall coordination of policy and youth-oriented programme implementation, monitoring, review and evaluation. In Seychelles, the National Council for Children and the Social Services Division in the Ministry of Health and Social Development play important roles in advancing the interest of children.

In the United Republic of Tanzania, youth training centres and institutions like Vocational Education Training Authority (VETA), Folk Development College (FDC), College of Business Education and Small Industries Development Organization (SIDO) facilitate vocational training. The Government is also using existing institutions to promote entrepreneurship for example, the Faculty of Commerce and Management at the University of Dar es Salaam, *The Higher Education Student's Loan Board Act* (cap. 178) of the United Republic of Tanzania facilitates access to higher education even those who have limited ability to pay, and *The National Economic Empowerment Act 2004*, (Cap. 386) *The Business Activities Registration Act 2007*, provides among other things the promotion of wealth creation and decision-making processes by youth and other stakeholders.

In 2005, Zimbabwe established a full-fledged Ministry for the Youth, which is now the Ministry of Youth Development, Indigenization and Empowerment. In addition, the Zimbabwe Youth Council facilitates youth participation through registration and capacity building of young people's organizations and the coordination of the Children's Parliament.

#### 4.5 Programmes and Plans

In Malawi, Senegal, Ghana, Nigeria, the United Republic of Tanzania, Mozambique, and other African countries, youth development strategies and programmes also focused on promotion of healthy life including SRH among young people. In addition to the formulation of the National Youth Policy in 2004, Ethiopia reported the mainstreaming of youth issues into the PASDEP covering the period of 2006-2010. Key interventions include, vocational and technical training; provision of adolescent reproductive health services; small-scale enterprises, development and provision of credits and

marketing services for young people. The Government is promoting entrepreneurship and establishment of micro and small-scale enterprises by a team of youth by providing credits, premises, and marketing services. The youth are also provided with vocational and technical training in masonry, carpentry, electricity and plumbing and are encouraged to form guilds in their fields of training. They are also encouraged to engage in construction of houses, primary schools and health posts.

A National Youth Strategy (NYS) launched in 2008 is being implemented in the Sudan to address the issues and challenges faced by young people and enhance opportunities for their involvement in decision-making; the Youth Commission has been instrumental in coordinating the development of a national youth policy and the implementation of programmes for the empowerment of young people. In Sierra Leone, the 2004 Education Act and the Sababu Education Programme were platforms on which the post-war education sector was rehabilitated and made functional. Special programmes were also put in place for the rehabilitation and reintegration of child and youth ex-combatants into the society.

Through its Ministry of Labour, the Government of Mozambique designed the Employment and Vocational Training Strategy (EEFP), which will guide labour governance actions in the period 2006 – 2015. This Strategy attempts to promote employment growth and the development of a 'post-employment' economy; the promotion of increase in demand for labour; the strengthening of employability of the labour force, and improvement of the regulatory framework for the development of the private sector.

In South Africa, most of the initiatives developed by the Government to address poor skills and high unemployment among the youth in the country seem to be largely relevant to the backlog of the poorly educated and unemployed. These include the Skill Development Act, the National Youth Service (NYS) and the Youth Entrepreneurship programme. The Skills Development Act is aimed at developing the overall skills base in the country and provides guidance to the Learnership programme which integrates theoretical learning with workplace experience. On its part, the NYS programme is intended to increase the quality and scope of government service delivery by harnessing the potential of young people, while increasing their employability through skills training. NYS is administered by five different agencies and other government departments. The Youth Entrepreneur scheme, largely driven by the Umsobomvu Youth Fund, is a government finance agency created for youth skills development and employment creation.

The Malawi Government has laid out strategies and programmes aimed at promoting youth development in the following areas: participation of the youth in the formulation, implementation and review of policies has been institutionalised; creation of more educational and training opportunities for the youth at all levels; re-orientation and encouragement of the youth to participate in development activities; promotion of healthy life among the youth through the provision of appropriate awareness in Family Life Education including SRH and provision of adequate recreational and sporting facilities for the youth in communities and schools.

## 4.6 Youth Empowerment

All the countries reported implementing strategies to empower young people through training, productive employment in various sectors of the economy and youth participation in decision-making through leadership development.

In terms of addressing the concerns of children and youth, very little effort is made to provide assistance for rehabilitation of child victims of armed conflict and other emergencies or disasters. On the other hand, vigorous efforts are being made to stop the trafficking and economic exploitation of children, provide equal educational opportunities for boys and girls, as well as technical and vocational training for young people generally.

The country reports indicated that steps were being taken to promote the participation of young people in decision-making including the political process in the different countries. In Mozambique, Uganda and the United Republic of Tanzania, for example, special provisions are in place for youth participation in the political process in the subnational councils and at the national level.

## 4.7 Youth training and employment

Despite a high level of enrolment in education institutions in South Africa and massive government and private investments in that sector, the economy faces a critical shortage of skills in engineering, science and technology as well as finance and management. In Namibia, the current third National Development Programme is designed to equip young people with educational skills required by the labour market. Likewise, Mozambique is promoting vocational training to build the capacity of young people and to make them employable.

Unemployment among the youth in Ethiopia is said to be high. To this end, PASDEP is being implemented in the country to build human capital through education and training, and the provision of employable skills along with a public works scheme for the unemployed youth. In the rural areas, young people are being provided with farming plots and grazing lands for income generation. In the United Republic of Tanzania, like in most countries, inadequate skills, limited access to finance, lack of collateral and business experience are the main challenges to youth employability and productivity. As a result, the Government has enacted the Higher Education Student's Loan Board Act (cap. 178) to facilitate access to higher education especially for those who have limited ability to pay. Also the National Economic Empowerment Act 2004, (Cap. 386) and the Business Activities Registration Act 2007 are in place to promote wealth creation and participation in decision-making for young people. Efforts are also being made to encourage women to train 'non-traditional subjects such as electricity, mechanics, masonry, carpentry and welding.

The results of the 2007 Labour Survey in South Africa indicate that blacks have much higher unemployment rates than other racial groups. These high rates of unemployment could be attributed to various socio-economic factors like extended schooling years and lack of funds. Projects aimed at promoting youth employment as a strategy for poverty reduction are being implemented in Senegal, Benin and Lesotho to create an enabling national environment for the promotion of youth em-

ployment and enterprise development. Microfinance services are being extended to young people to help them setup micro businesses and become self-employed in Benin and Senegal.

In the United Republic of Tanzania, the National Employment Policy 2008 and the Employment and Labour Relations Act 2004 (cap. 366) provide for strategies and statutory requirements for addressing youth unemployment and empowerment. Also, the Youth Development Policy of 2007 and the National Youth Employment Action Plan (NYEAP) (2008) are designed to promote the participation of young people in the social, political and economic development of the society.

#### **4.8 Adolescent Sexual and Reproductive Health**

A number of strategies were reported to be place in all countries for addressing adolescent sexual and reproductive health. The formulation of the 2006 National Adolescent Health Policy; the adoption of the Sexual Offences Act; and, the formulation of the Guidelines for the Management of Survivors of Sexual Abuse are considered to have contributed significantly to addressing adolescent SRH issues in Lesotho. Addressing adolescent reproductive health problems through specific strategies forms a major part of the efforts made by Ghana, Uganda, the United Republic of Tanzania and DRC to improve the quality of life in the country. In Ghana, the use of contraceptives by adolescents is reported to have increased in the last decade from about 4.8 per cent in 1993 to 16.1 per cent in 2003, with adolescents gradually becoming more knowledgeable about reproductive health issues, as more programmes are being targeted to reach them. In Senegal, a pilot programme which integrated sexual reproductive health into services provided at least, two schools with medical health centres, was reported to have contributed to the improvement of access to SRH services by adolescents in Dakar.

A Population and Family Life Education programme focusing on life skills development, training of peer educators and counsellors, peer counselling and support, dissemination of information on reproductive health and HIV/AIDS is being implemented for both in and out of school youth in most countries including, Ghana, Nigeria, Mauritius, Uganda, Gabon and Senegal.

In Seychelles, the Youth Health Centre was created in 1994 under the umbrella of the Ministry of Health and Social Development to offer youth friendly reproductive health services. In 2006, the Department of Health decentralised its services to target the youth population in certain districts, and in 2007, started distribution of condoms, IEC materials and VCT testing on site in those centres and through outreach programmes.

HIV/AIDS promotional activities in South Africa, Uganda, Benin, Namibia and the United Republic of Tanzania have been used to specifically target girls and boys to assist them make choices that would protect them from infection. In these and other countries, programmes are also being implemented to offer reproductive and sexual health information and services to the youth. In the DRC, the national programme on adolescent health designed in 2003 is being implemented to provide HIV and family planning counselling and post abortion care services and to raise awareness on sexual and reproductive health among in and out of school youth.

## 4.9 Commitment to Continental Level Policies and Strategies

Some countries, including, Nigeria, Uganda, the United Republic of Tanzania, Gabon and Senegal indicated that the Africa Youth Charter provided a framework for the review of policies, formulation of legislation and advocacy on youth empowerment.

Actions taken to adapt the African Youth Charter by countries revolve mostly around advocacy and awareness creation, formulation of Action Plans or Programmes, and service delivery improvement to empower youth. Not many countries take the formulation or review of legislation on health service delivery for the youth seriously.

## 4.10 Achievements

In almost all the countries in Africa, Youth Policies, programmes and legislations are in place to empower young people, harness their potentials and promote their participation in national development.

As a result, youth issues are being mainstreamed into poverty and development strategies in all the countries. Projects aimed at promoting youth employment as a strategy for poverty reduction are being implemented in Senegal, Benin and Lesotho to create an enabling national environment for the promotion of youth employment and enterprise development. Microfinance services are being extended to young people to enable them to set up microbusinesses and be self-employed in Benin, and Senegal.

In countries like Uganda, while the incidence of teenage pregnancy remains high, it has been considerably reduced. In Ghana, the use of contraceptives by adolescents is reported to have risen and adolescents have become more knowledgeable about reproductive health issues. A project which integrates sexual reproductive health into school medical health services has helped to improve access to SRH services among adolescents in Senegal. HIV/AIDS promotional activities in South Africa, Uganda, Benin, Namibia and the United Republic of Tanzania have specifically target girls and boys to assist them to make choices that would protect them from infection.

Also, the implementation of universal primary education programmes has increased girl enrolment in schools across the continent. In conflict and post conflict countries like Sierra Leone and DRC, the implementation of special programmes has resulted in the rehabilitation and reintegration of ex-combatant children and youth into the society.

## 4.11 Major challenges and constraints

Research shows that in terms of demographic dividend, the three major developed regions of the world have already peaked (in 2000), while Asia and Latin America have until 2020 to enjoy a rising percentage of the population in the labour force. Sub-Saharan Africa is the extreme case—if fertility continues to fall it will experience gains well past 2040. According to their assessment, beginning in 1950, East Asian countries moved quickly through falling fertility rates that resulted in a change in the percentage of their populations in the working age group. Their dividend opportunity rose



quickly during the next fifty years. It is peaking just now and will fade steadily as their populations age. Their window of opportunity is beginning to close.

Sub-Saharan Africa, on the other hand, is just now starting to enter its window, under the assumption of declining fertility rates over the next several decades. Should those declines occur and the governments involved institute effective education and skills development programmes, flexible labour markets and gender-sensitive planning as their counterparts have in East Asia, the dividends may become real rather than potential.

#### **4.12 Challenge of implementation**

In Malawi, Madagascar, DRC and Ghana, insufficient resources have confined the implementation of programmes to small pilot schemes or to selected districts only. Often, donor resources are tied to specific projects having a limited life span. In Lesotho, Benin and Malawi, the severe shortages of health workers and the logistics make it difficult to reach remote areas.

Youth Friendly Reproductive Health Services are limited in scope in all the countries. In Malawi, Nigeria, Ghana and Namibia, services targeting special groups such as out-of-school youth, very young married girls and youth with disabilities have been very difficult to reach with services.

The country reports of South Africa, Malawi, Namibia, Ethiopia, and CAR cite poverty, unemployment and limited access to productive economic opportunities and gender discrimination in all spheres of life especially for the girl child, as major factors that exacerbate the vulnerability of young people to high-risk-behaviour and reproductive and sexual health problems.

All the countries cited the existence of cultural values and belief systems as factors that hinder the rights of young people and perpetuate discriminatory practices especially against young girls. Cultural factors were said by most factors that make young girls susceptible to school dropout, early marriage and early child birth.





# Section 5

## 5. Reproductive Rights and Reproductive Health

### 5.1 Introduction

ICPD PoA urges all countries to strive to make reproductive health accessible through the primary health-care system to all individuals of appropriate age, as soon as possible, and no later than 2015. Such care should include, in family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood" (ICPD PoA 1994; Ch. vii). ICPD PoA further urges all governments and health systems to establish, expand or adjust programmes to meet the reproductive and sexual health needs of men and women (including adolescents), to respect rights to privacy and confidentiality, and to ensure that attitudes of health care providers do not restrict adolescents' access to information and services.

Millennium Declaration Goal 5 is: "Improve maternal health". It has two targets, which are: (a) reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; and (b) achieve, by 2015, universal access to reproductive health. Indicators for monitoring include the maternal mortality ratio, proportion of births attended by skilled health personnel, and modern contraceptive prevalence rate.

Reproductive rights involve the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law and; the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

### 5.2 Reproductive Rights

All the countries have come to recognise the need to uphold the Sexual and Reproductive rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.

The country reports of Nigeria, Seychelles and the United Republic of Tanzania indicated that these rights were being addressed within the scope of national laws and policies and programmes have been formulated taking these rights into consideration. South Africa's country report indicates that the country has developed legal instruments aimed at safeguarding the sexual and reproductive rights of all its citizens; noting that the Bill of Rights contained in Chapter 2 of the 1996 Constitution of the Republic of South Africa enshrines the rights of people in the country and affirms the democratic values of human dignity, equality and freedom. Regarding Act No. 92 of 1996, South Africa has taken a bold step to address the thorny issue of teenage pregnancy and the right to choose.

In most countries also, there is a discernible move to provide services to special groups such as men, the youth and the disabled.

### **5.3 Trends in Reproductive Health Indicators**

Reproductive health (RH) is defined as a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Based on this definition, RH implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. The RH definition therefore implies two rights: a) the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning as well as other legitimate methods of their choice for the regulation of fertility and; b) the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and which provide couples with the best chance of having healthy infants. (ICPD PoA, 1994, para 7.2). The extent to which couples are able to exercise their reproductive rights largely determines the reproductive health status of the population. Poverty, lack of education and information, poor access to health and related social services, compromise the health of women and their children, and negatively impact on the reproductive health status of the population.

Maternal and child health indicators include the Maternal Mortality Ratio, Infant Mortality Rate and Under-five Mortality Rate.

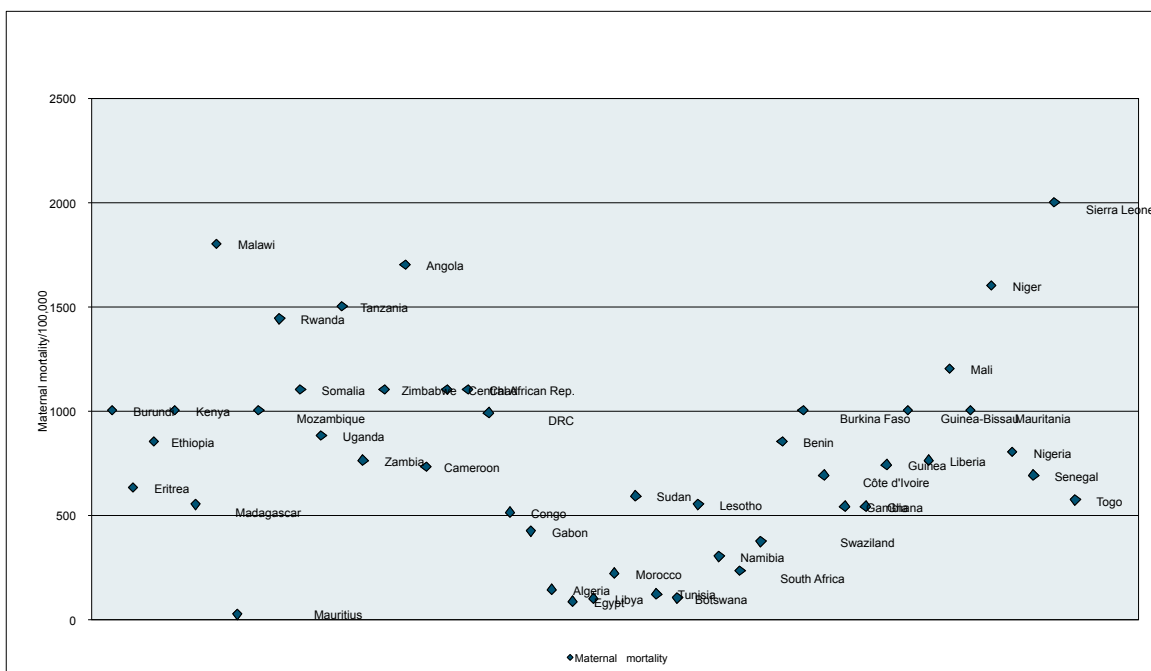
### **5.4 Maternal mortality**

Among major regions of the world, Africa records the highest rate of maternal mortality. Of 529,000 maternal deaths occurring annually, 48 per cent took place in Africa (WHO, UNICEF and UNFPA, 2003). For each maternal death, there were 30 to 50 morbidities, including temporary and chronic conditions (UNFPA, 2004). In the developed regions of the world, the maternal mortality ratio was as low as 20 per 100,000 live births; but in sub-Saharan Africa, the ratio was 920. More recent estimates of maternal mortality ratios (UNFPA, 2007) indicate that the condition might be deteriorating in a number of African countries several of which have maternal mortality ratios exceeding 1,500 per 100,000 live births (Sierra Leone, Malawi, Angola and Niger). The worst case is the record of 2,000 by Sierra Leone, not surprising, given the generally high level of maternal mortality in West Africa. Most of the countries in the lower distribution bracket are Southern and North African

countries having maternal mortality ratios under 100 per 100,000 live births (Libya, Egypt, Tunisia, Algeria, Morocco, South Africa, Namibia and Botswana).

Of concern are the fluctuating trends in maternal mortality ratios; for instance in Namibia, where the ratio seems to be rising from 227 in 1992 to 271 in 2000 and to 449 in 2006. South Africa's maternal mortality also increased for a while from 64 in 1999 to 78 in 2001, but dropped to 73.1 in 2002. Similarly, Ghana's maternal mortality declined from 250 in 1999 to 186 in 2006 but picked up again to 230 in 2007. Perhaps one of the most dramatic increases yet recorded is that of the Sudan - from 509 in 1999 to 1,107 in 2007. Given their strong health infrastructure and management capacity, both Mauritius and Seychelles reported justifiably low levels of maternal mortality,

**Figure 5.1 Maternal mortality ratios (per 100,000 live births) in African countries (2007)**



Data source: UNFPA, State of World Population 2007

There is no doubt that pregnancy-related deaths can be considerably minimized in Africa. The health risks of mothers are greatly reduced when more babies are delivered under the supervision of health professionals. All the countries recognized that efforts focusing on the provision of antenatal care; ensuring skilled attendance at birth; improving access to Basic and Comprehensive emergency obstetric and newborn care; providing quality family planning services; ensuring basic postnatal and newborn care; and, providing post-abortion care are important to improving maternal and newborn health in Africa.

Therefore, the provision of Maternal and Child Health (MCH) services within the framework of Primary Health Care (PHC) were recognized by all the countries as fundamental to making RH

services available at the grassroots. While countries reported expansions in primary health care delivery services, disparities persist between the rural and urban areas as well between regions and provinces. The United Republic of Tanzania country report indicated that the Primary Health Sector Programme (2007-2017) serves as the framework for providing the road map for implementation of the maternal and child health programmes aimed at achieving MDGs 4 and 5. In Morocco a National Plan of Action on Health which has a strong component for the reduction of infant mortality and the improvement of child health is being implemented for the period 2006-2015.

Available data clearly show that for some countries a small but increasing proportion of babies are delivered in health facilities or with the assistance of skilled health personnel. In Ethiopia, only 5.6 per cent of deliveries in 2000 were with the assistance of skilled health personnel, with the percentage increasing slightly in 2005 to 6.0 per cent. Based on the latest records reported, African countries with lower than 50 per cent of skilled health personnel-assisted deliveries include Niger, Burundi, Ghana, the Sudan, the United Republic of Tanzania and Kenya. The list could have been much longer but many countries did not provide information on the subject. Quite a number of African countries have shown appreciable increases in the proportion of women with access to skilled health personnel at the time of delivery; these include: Morocco, Egypt, Senegal, Swaziland, Sao Tome and Principe and Mauritania.

The country report for Malawi indicates that there is inadequate accessibility by the community to maternal and neonatal health (MNH) services due to distance, transportation and cultural practices. The proportion of births attended by skilled health personnel is shown to have declined from 55.6 per cent in 2000 to 54.0 per cent in 2006. In a few countries, skilled attendance at deliveries is near universal. These countries are, Mauritius (95.0 per cent in 2007), and Sao Tome and Principe (94.6 per cent in 2007). In Seychelles, according to the country report, most deliveries are conducted in hospitals and 100 per cent of births are attended by health care professionals.

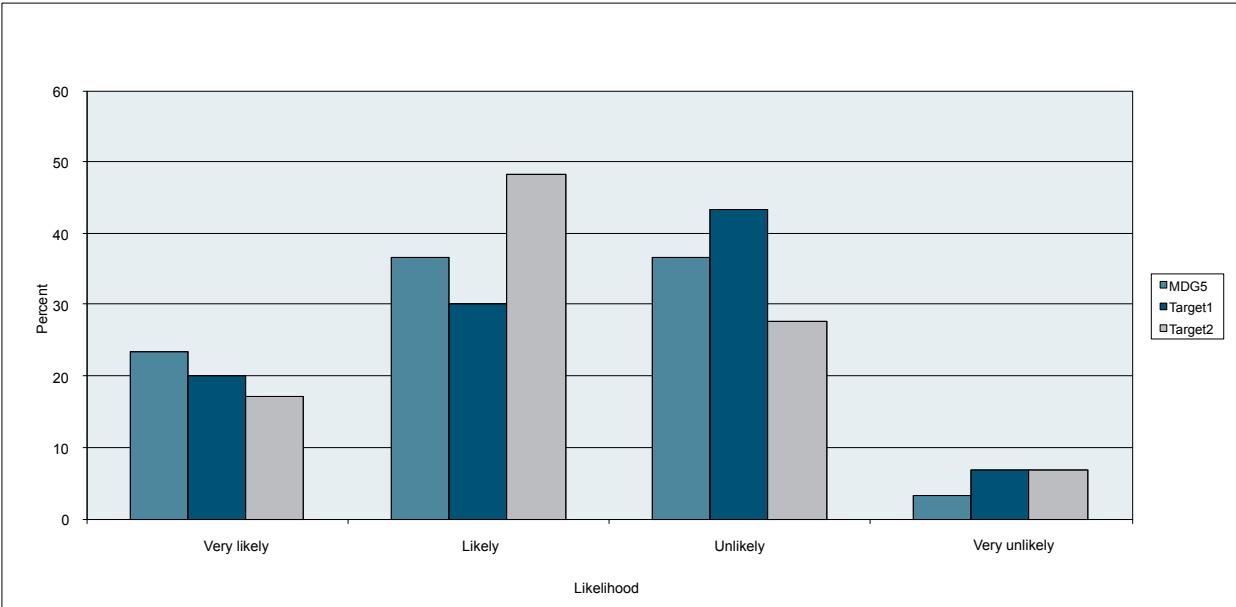
Postnatal care is also important to the health of mothers, as a large proportion of maternal deaths occurs shortly (48 hours) after delivery because of limited access to maternal health services and poor quality of existing services. In addition, postnatal care is extremely low in most SSA countries. Complications arising from unsafe abortions also contribute significantly to maternal mortality in the continent, but hard data are difficult to find. In addition, poverty reduces access to and balanced nutrition, a factor that is critical to the health and survival of the child. Effective family planning programmes could go a long way in reducing fertility and thereby reducing the risk of high overall maternal mortality in the population. In addition, the widespread practice of female genital mutilation in many African countries could also have negative effects on the health of women. Provision of Maternal and Child Health (MCH) services within the framework of Primary Health Care (PHC) was thus recognized by all the countries as fundamental to making RH services available at the grassroots.

The main sexual reproductive health issues being addressed by the countries include; (a) Maternal, Infant and Child Health; (b) Adolescent Reproductive health; (c) family planning; Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIs) including HIV/AIDS; (d) Prevention and management of complications of abortion; (e) harmful traditional practices including FGM.

Based on the questionnaires returned by governments in the ICPD+15 inquiry, the achievement of MDG 5, Improved maternal health, was judged to be very likely in Seychelles, where health care services are free and all health centres provide maternal, child and family planning as well as a full range of other services. Currently, pregnant mothers have access to a full range of reproductive health services at the antenatal, childbirth and postnatal stages. Skilled attendance at birth is rated as almost 100 per cent.

Overall, 40 per cent of countries are in doubt about the possibility of achieving improved maternal health by 2015. In terms of the targets, 50 per cent expressed the hope that the maternal mortality ratio could be reduced by three quarters by 2015; moreover, about 60 per cent are optimistic about providing universal access to reproductive health for their population by 2015.

**Figure 5.a Likelihood of achieving MDGs and targets in Africa**



The goal is deemed likely to be achieved in Benin, Burundi, Kenya and Sao Tome and Principe where improved maternal and child health programmes are being implemented to reduce maternal morbidity and MMR.

For Guinea, Senegal, the Sudan, Swaziland, the United Republic of Tanzania and Zimbabwe the Goal is rated as unlikely to be achieved even though priority is given to improving maternal health. In countries like the United Republic of Tanzania, Guinea and Senegal, maternal mortality levels are said to be unacceptably high - an indication of an equally high prevalence of maternal morbidity. In Zimbabwe, a worsening trend is said to exist, with fewer women giving birth at health centres and a low proportion of deliveries assisted by skilled health personnel. The situation is also exacerbated by the high prevalence of HIV/AIDS. In Swaziland, the health system is faced with a shortage of skilled nurse-midwives and doctors to provide maternal care services.

With high MMR and poor health and other related infrastructure, the goal is judged by Niger as very unlikely to be achieved.

**MDG 5 -Target 1:** Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

This Target is reported to have been already achieved by Mauritius where the MMR is said to have been kept at a very low level of 36 deaths per 100,000 live births; and by Seychelles where the average death recorded for the period 2000 to 2007 was only one.

For Kenya and Madagascar, this Target was reported as very likely to be achieved because of the existence of a road map that is focused on the reduction of maternal and infant mortalities and which has received increased donor funding.

Burundi, Morocco, Mozambique, Sao Tome and Principe, Sierra Leone and Tunisia indicated that the target was likely to be achieved because of improvements in the provision of maternal health services, including increased contraceptive prevalence rates. In Mozambique, MMR has declined from 408 per 100,000 live births in 2003 to 340 per 100,000 live births in 2008.

In the case of countries such as CAR, the Gambia, Guinea, Lesotho, Swaziland, the United Republic of Tanzania, Uganda and Zimbabwe, the achievement of the goal was rated as unlikely because MMRs have remained high, and in countries like the United Republic of Tanzania, the ratio actually increased from 529 in 1996 to 578 in 2004/05. Available information for CAR indicates that MMR more than doubled from 648 deaths per 100,000 live births in 1988 to 1,355 deaths per 100,000 live births in 2003. Although in Uganda, MMR declined from 523 in 1990 to 435 in 2006 the achievement of the target is judged to be unlikely because of inadequate resources to strengthen health delivery systems and the prevalence of high maternal malnutrition.

**MDG 5 - Target 2:** Achieve, by 2015, universal access to reproductive health

Madagascar, Sao Tome and Principe and Seychelles indicated that the second Target of MDG 5: Achieve, by 2015, universal access to reproductive health, was very likely to be achieved because they were implementing programmes that focused on expanding the availability of RH services. In Seychelles, reproductive health services were already included in the package of free health services provided to the people and health centres offer maternal and child health, family planning as well as a broad range of other services to promote the well being of women.

Countries such as Burundi, Guinea, Mauritius, Kenya, Lesotho, Morocco, the Niger and Sierra Leone indicated that the target was likely to be achieved because of programmes being implemented to improve access to RH information and services. Already, reproductive health services are free of user costs and almost all births are attended by health professionals in Burundi and the Comoros. Also, efforts are being made to expand the coverage of basic and comprehensive obstetric care services.

In the case of other countries, including the United Republic of Tanzania, Swaziland, Guinea, Uganda and CAR, the achievement of the target was rated as unlikely because, although several pro-



grammes were currently being implemented, the countries were faced by challenges which made the achievement of the goals very difficult. For instance, in the case of Swaziland and CAR, the prevalence of high poverty and unemployment rates and cultural barriers cause the people to adopt poor health care behaviours which are inimical to the achievement of the target. In line with these and other factors, the United Republic of Tanzania and Uganda specifically point out that less than 50 per cent of births are attended by skilled personnel. CAR also specifically points to the effects of armed conflict which makes it difficult to expand services to affected areas. .

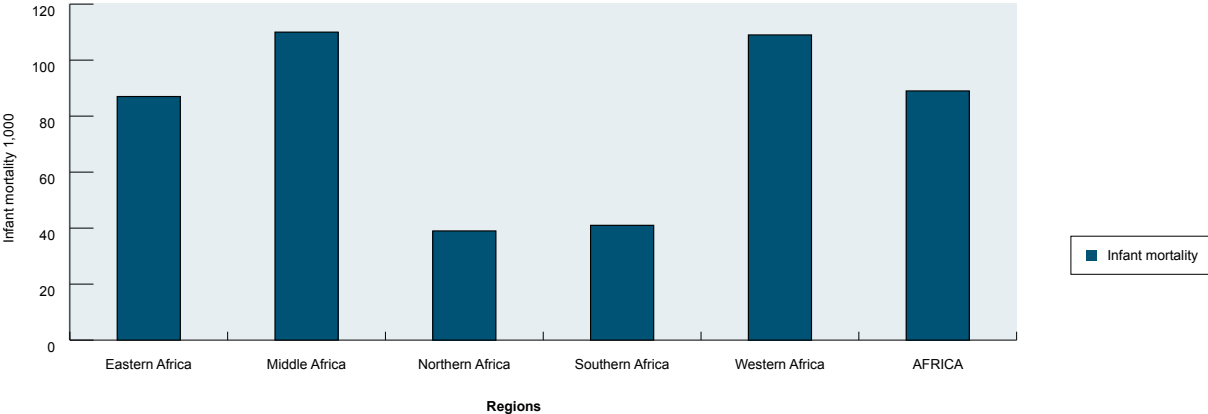
The target was judged as very unlikely to be achieved by countries such as the Sudan and Zimbabwe because of lack of resources and the requisite health delivery system.

### 5.5 Child mortality

Two indicators of child mortality, which are MDG 4 indicators, are considered, namely, infant mortality rate and under-five mortality rate. Country reports show high but variable patterns on each of the two measures of child mortality with high child mortality countries experiencing a gradual decline. another group of countries experiencing initially high but declining child mortality only to go through a period of mortality increase due largely to AIDS; and a third category comprising countries that enjoy relatively low and consistently declining child mortality.

Figures 5.1, 5.2 and 5.3 sum up the emerging regional child mortality patterns in Africa based on the most recent estimates and projection (UNFPA 2007; UN, 2008). Regional patterns indicate that North and Southern Africa show the lowest level of infant mortality Infant mortality rates are over 80 per 1,000 live births in East Africa, and over100 per 1,000 live births in Central Africa and West Africa (see figure 5.1).

**Figure 5.1 Infant mortality rates in Africa and major regions (2007)**

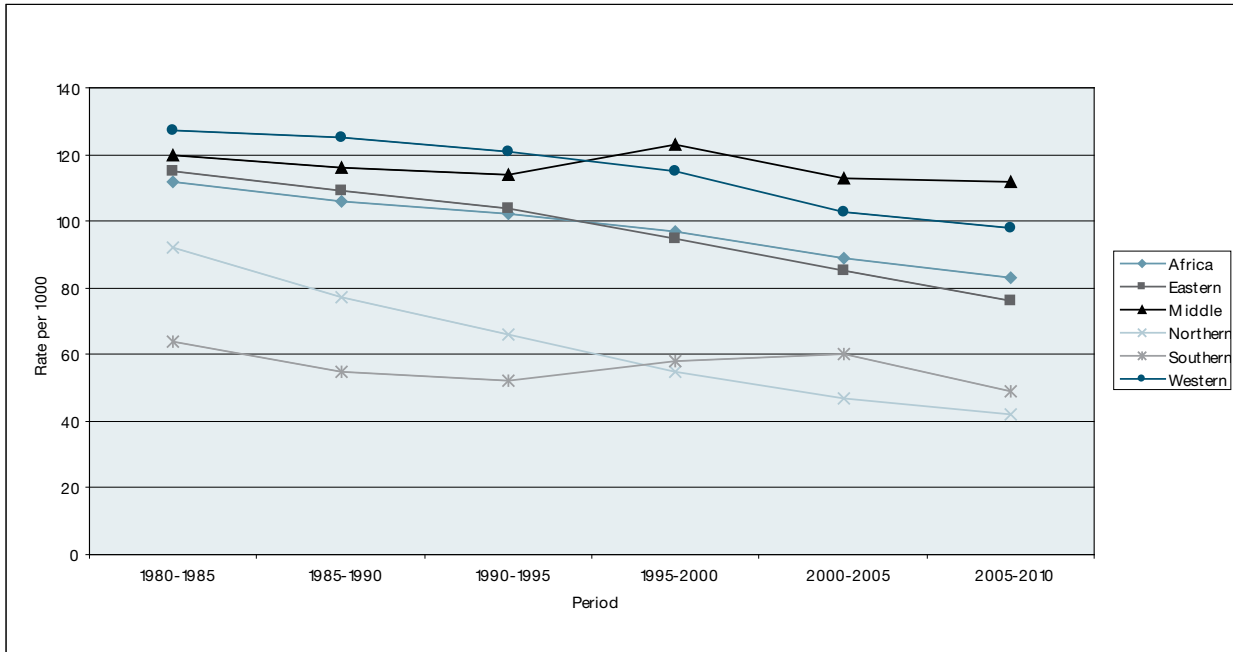


Source: UNFPA, State of World Population 2007

In terms of trends over time, North Africa has had a pattern of low and consistently declining infant and under-five mortality rates since 1990. Although high, East Africa mirrors the African pattern of

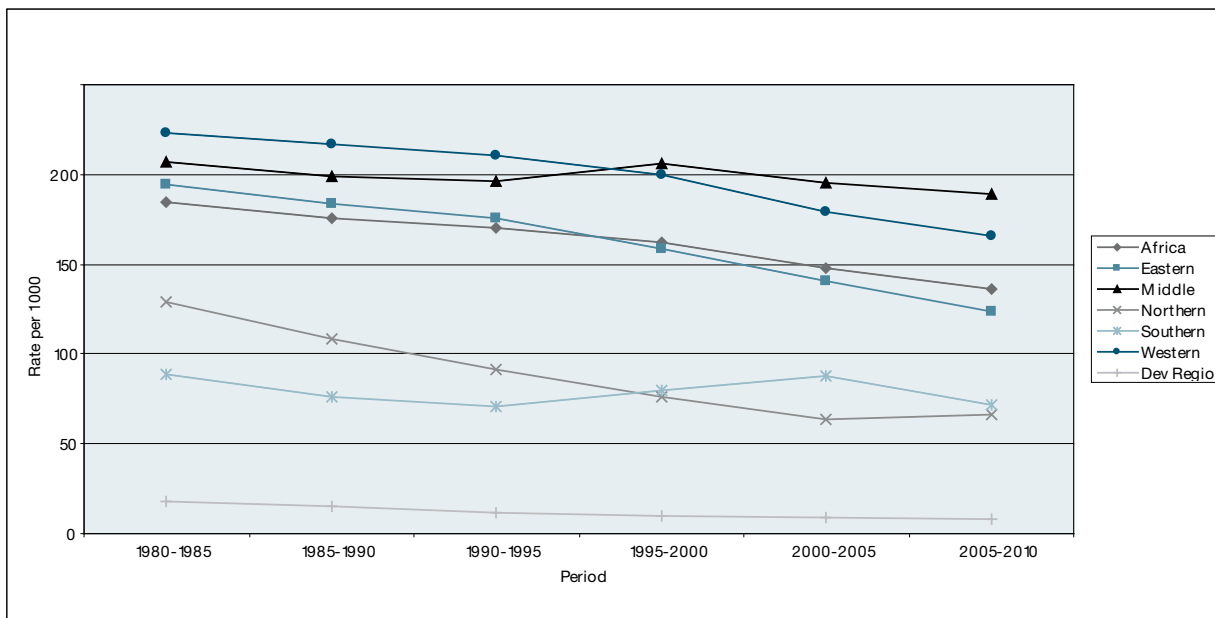
gradual child mortality declines. Both West Africa and Southern Africa have experienced fluctuations in child mortality of the sort described above, though the overall levels are higher in the West than in the Southern sub-region (see figures 5.2 and 5.3).

**Figure 5.2 Infant mortality rates for Africa and regions, 2008**



Source: UN 2009, World Population Prospects - the 2008 Revision

**Figure 5.3 Under-five mortality rates for Africa and regions, 2008**



Source: UN 2009, World Population Prospects - the 2008 Revision

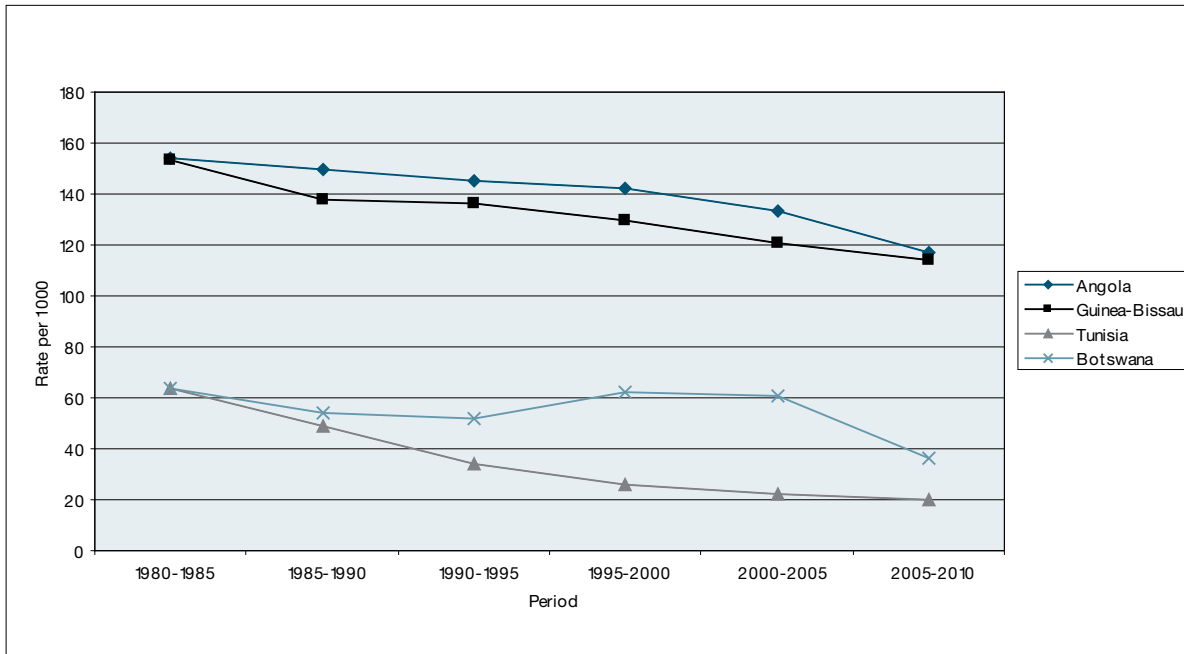
Some high child mortality countries have been experiencing consistent decline. Infant mortality in Ethiopia has declined from 97 per 1,000 in 2000 to 77 in 2005, and the same goes for under-five mortality rate, from 166 per 1,000 to 123 per 1,000 during the same period. Malawi infant mortality rate reduced from 104 per 1,000 live births to 76 per 1,000 live births from 2000 to 2004; In the United Republic of Tanzania, infant mortality declined from 99.1 in 1999 to 68.0 in 2004/05; under-five mortality declined from 147 to 112 in same period. In Nigeria, the infant mortality rate stood at 93.93 deaths per 1,000 live births in 2008, and in Benin infant mortality rate had reduced to 67 per 1,000 live births by 2006.

Estimates of infant and child mortality in South Africa show that infant and child mortality decreased until the early 1990s and then started to increase. For the period 1983-1987, the infant mortality rate was estimated at 50.7 per 1,000 live births and this decreased to 39.2 for the period 1988-92 and increased to 45.4 for the period 1993-98. The probability of dying before age five also shows a similar trend. These estimates are consistent with the high prevalence of HIV observed among ANC attendees. The same increasing trend was observed for both infant mortality and under-five mortality from 2001 to 2004.

Infant mortality increased from 28.8 per 1,000 live births in 2001 to 38.1 per 1,000 live births in 2004. Similarly, the under five mortality rate increased from 39.6 in 2001 to 52.8 in 2004. Also in Burundi, the infant mortality rate increased from 94 per 1,000 in 1999 to 101.5 per 1,000 in 2004, but declined to 97.5 per 1,000 in 2007. Although quite high, the infant mortality rate has declined in DRC from 126 per 1,000 live births in 2001 to 98 per 1,000 in 2007. In Lesotho, the infant mortality rate (IMR) is also estimated to have increased, as a result of the impact of HIV/AIDS, from 81 deaths per 1,000 live births 2001 increasing to 91 deaths per 1,000 live births in 2004. The Sudan

has also been going through a heightened child mortality profile. The infant mortality rate increased from 68 per 1,000 in 1999 to 81 per 1,000 in 2007, while the under-five mortality rate rose from 104 per 1,000 to 112 per 1,000 during the same period. The same goes for Senegal where infant mortality fluctuated from 70 in 1999 to 79.4 in 2004 and 75.9 per 1,000 in 2007.

**Figure 5.4 Infant mortality rates for selected African countries, 2008**

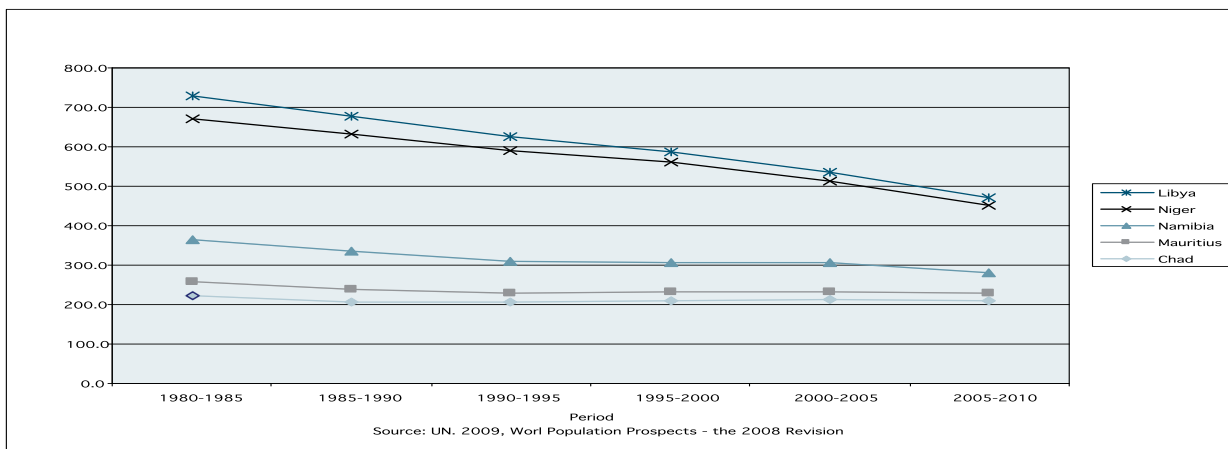


Source: UN 2009, World Population Prospects - the 2008 Revision

Ghana has also experienced fluctuation in child mortality rates: infant mortality rate rose from 56.7 per 1,000 in 1999 to 64 per 1,000 in 2004 and then declined to 62.2 per 1,000 in 2007; under-five mortality followed the same pattern, increasing from 107.6 per 1,000 in 1999 to 110 in 2004 and then dropping to 97 per 1,000 in 2007.

Mauritius has experienced consistent decline in infant mortality from 60.1 per 1,000 live births in 1962 to a low of 15.3 per 1,000 live births in 2007. Also, some low mortality countries like Egypt and Morocco have experienced consistent child mortality declines; infant mortality declined in Egypt from 48 per 1,000 in 1998 to 33 in 2005, and in Morocco from 57 per 1,000 in 1991 to 42.8 per 1,000 in 2004. The decline in the infant mortality rate in Seychelles is remarkable, standing at 10.6 per 1,000 in 2007.

**Figure 5.5 Under-five mortality rates for selected African countries, 2008**



*Source:* UN 2009, World Population Prospects - the 2008 Revision

The achievement of MDG 4 (Reduce child mortality) was judged to be very likely by countries like Burundi, Kenya, Mauritius, the Niger and Seychelles because of positive results achieved from implementing programmes which offer free medical services for children under the age of five. In the case of Seychelles and Mauritius, child mortality was already said to be very low - in 2007, infant mortality in Seychelles was 10.6 per 1,000 births.

For Benin, Sao Tome and Principe, Senegal, Sierra Leone, Swaziland and the United Republic of Tanzania, the achievement of the goal is said to be likely because of the successful implementation of child health programmes including expanded coverage for immunization which has led to a decrease in child mortality rates in these countries. For instance in Guinea, infant mortality declined from 98 per 1,000 in 1999 to 91 per 1,000 in 2005. In Senegal, the percentage of births for which the mothers made four or more antenatal visits more than doubled from 17 per cent in 1997 to 40 per cent in 2005. Also the percentage of births which took place in a health centre increased from 48 per cent in 1997 to 62 per cent in 2005. In Swaziland, the scaling up of Prevention of Mother to Child Transmission (PMTCT) efforts has greatly reduced infant mortality rates.

The Goal is unlikely to be achieved in countries like the Sudan and Zimbabwe where, for lack of resources and facilities, the situation is actually deteriorating.

**MDG 4 - Target 1:** Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

This target was judged as very likely to be achieved by Burundi, Kenya, Madagascar, Mauritius, Morocco, the Niger, Seychelles and Tunisia because of results already achieved in reducing under-five mortality. Under-five mortality rates have already been reduced to a low level in Mauritius and Seychelles where immunization coverage is as high as 95 per cent. In Kenya, Morocco, Madagascar, the Niger, Burundi and Tunisia improved health programmes, including road maps for the reduction of the maternal and infant mortality are in place to provide quality services for children under the age of five. Thus, Tunisia reported that under-five mortality rate decreased from 37.7 per cent in 1990 to 18.4 per cent in 2008 which makes it very likely to achieve the target.

Other countries including the Comoros, the Gambia, Guinea, Mozambique, Sao Tome and Principe, Sierra Leone, Swaziland, the United Republic of Tanzania and Uganda indicated that the target was likely to be achieved because under-five mortality rates were declining. In Mozambique, the under-five mortality rate declined from 219 per 1,000 in 1999 to 178 per 1,000 in 2004 and further down to 140 per 1,000 in 2007. For Swaziland, the increase in the number of health services providing PMTCT services from 10 per cent in 2004 to 71 per cent in 2006 will contribute to the reduction of infant mortality in the country. Also, the Comoros has succeeded in reducing under-five mortality from 104 per 1,000 live births for 1996 to 74 per 1,000 live births for 2000.

For CAR, the Sudan and Zimbabwe the achievement of the target was rated as unlikely because of deteriorating health services and lack of resources. In the Sudan for instance, only 5 per cent of the national budget is allocated to the health sector, of which the provision of curative health services takes most of the budget. In CAR, the situation has actually deteriorated; with infant mortality rate having increased from 97 per 1,000 for 1995 to 106 per 1,000 for 2006.

## **5.6 Other Reproductive Health Issues**

Other reproductive health issues of concern to some countries like Ethiopia, Mauritius, Malawi and the Sudan include reproductive health cancers; geriatrics and reproductive health problems associated with menopause and andropause, vesico-vaginal fistula and infertility. In most of the countries, there is a move towards providing services to special groups such as men, the youth and the disabled.

To address these issues, quite a number of countries reported to have incorporated reproductive health issues into existing strategies at the country level including the National Reproductive Health Strategy; National Health Strategy and the National Development Strategy (PRSP/NDS).

In 38 out of 40 responding countries, RH information and services were being made available to all those who needed them, while child-bearing and use of family planning methods were voluntary within the scope of national laws.

## **5.7 Policies, Strategies and Frameworks**

The country reports indicated that at least, 34 countries have integrated Maternal Health, and Reproductive Health issues into existing strategies including the national development or poverty reduction strategies, the sectoral health strategy, and national reproductive health strategies.

For instance, the National Health System (NHS, 2004-2009) of South Africa and the National Reproductive Health Strategy for the Sudan (NRHS, 2007-2011) were adopted to accelerate efforts to meet national and international goals and targets.

The Government of Namibia, in its current development programme (NDP3, 2007-2012), aims to make quality health service accessible and affordable to all through the following strategies: making quality health care accessible, affordable and equitable, prioritizing improved access to health care and health facilities in previously under-served regions, and targeting more resources towards the poor in rural and urban areas.

Significant steps have been taken in most countries to integrate population issues into existing policies and plans. The Poverty Eradication Action Plan (PEAP) of Uganda and the PRSP of Nigeria have both incorporated reproductive health priorities focused on increasing access to Emergency Obstetric Care (EmOC), providing family planning, antenatal care and adolescent reproductive health services. In Mauritius and Seychelles, reproductive health and maternal and child health services are integrated into the general health services and are provided to ensure that health care services are accessible to all, based on need and not ability to pay. The Health Extension Program in Ethiopia is being implemented to strengthen the link between communities and higher-level health services.

National Population Policies have been modified in Uganda, and Lesotho to explicitly take emerging RH issues into consideration. Also, specific Reproductive Health policies, guidelines and protocols for service delivery have been put in place in most countries. These include the Adolescent RH Policy (2006) in Lesotho and a National RH policy in Sierra Leone, which paved the way for the establishment of a reproductive and child health directorate within the ministry of Health in 2007; the national SRH Policy (2007) and related strategic plan National Sexual and Reproductive Health Strategy and Plan of Action (2009-2015) in Mauritius which particularly takes into consideration the integration of STI and HIV/AIDS within the SRH Services.

In general, components of reproductive health programmes (e.g., EOC, SBA, access to FP, FP for young people, FLE in schools and reduction of harmful practices) are more often mentioned in sectoral plans than in overall national development strategies.

National Road Maps have been developed as a strategy to focus attention on maternal and newborn mortality. The adoption of these was noted in the country reports of Malawi, Namibia and Lesotho. Other comprehensive plans were cited by Mozambique, Nigeria and DRC.

In the United Republic of Tanzania, various legislations were adopted in support of Maternal and Newborn Care, Reproductive Health Commodity Security (RHCS) (Chapters 152, 151, 219, 311); Infant and Child Health (Chapters 13, 180); Management of complications arising from abortion; elimination of harmful traditional practices including female genital mutilation (Cap. 325) and Sexually transmitted infections (Cap. 96 -The infectious diseases Act).

Consistent with the greater attention given to the issue recently, most countries do not believe that there are adequate human resources for RH. Furthermore, most countries appreciate the utility of an explicit RH policy, strategy and/or programme, and see its inclusion in minimum service packages to be valuable.

In Lesotho, the 2002 Sexual Offence Act and the 2006 Married Persons Equality Act have been passed to provide an enabling environment for improved reproductive health services delivery. In Benin, law n° 2003-04 was passed to legislate on specific reproduction health concerns. Also, the inheritance right of every child is provided for under law N° 2002-07 of August 2004.

On RH commodity security, most countries report that strategies are in place to address the problem. Lesotho, Nigeria, Sierra Leone, the United Republic of Tanzania and Benin have formulated



and adopted the reproductive health commodity security (RHCS) plan and set up a national system for planning the distribution of drugs. The system is supported by both the government and donors, who provide services for the forecasting, procurement and distribution of RH drugs and supplies.

The Global Programme of Reproductive Health Commodity Security is being implemented in many African countries. Mozambique and Ethiopia ensured that there was no contraceptive stock out in 2008. More than 95 per cent of people in Sao Tome and Principe are less than a half hour's walk away from a health centre offering reproductive health services and no centre is reported to have run out of reproductive health commodity stock since 1995.

Breastfeeding is promoted in each country in a number of ways. Nigeria adopted a breast feeding policy in 1999 in support of maternal, infant and child health. In South Africa, the policy on universal access to primary health care, introduced in 1994, paved the way for effective health care delivery programmes that have had a major impact on the South African population. There has been a demonstrable increase in women's access to reproductive health care services in the country.

## **5.8 RH services for Adolescents**

Out of the total population of 923 million in Africa (2005), 480.5 million or about 52.1 per cent are under 20 years of age. Those aged between 10 and 19 years constitute about 20.7 per cent of the total population. As a result of the special circumstances they find themselves in, young people in Africa remain vulnerable to teenage pregnancies, unsafe abortion, HIV/AIDS and STI infections. Much has already been reported on adolescent RH issues in Africa under Section 4 (Children and Youth) of this report. The strategies adopted by African countries to resolve adolescent RH problems include access to friendly RH services, integration of RH and life planning skills into formal education and training skills for youth, and prevention of HIV/AIDS and other sexually-transmitted diseases among adolescents.

Action taken by some countries to address adolescent reproductive health issues includes the, formulation of the Youth Reproductive Health Policy (2007) in Ethiopia and the operationalization of mobile brigades to reach young people with Sexual and Reproductive Health services ("Geração BIZ" in Mozambique).

In the United Republic of Tanzania, specific reproductive health services catering for the needs of adolescents and youth are being provided through the framework of the National Population Policy (2006). In Malawi, standards and tools for monitoring Youth Friendly Health Services (YFHS) are being implemented to ensure adequate RH services for young people. In Namibia, the first National Youth Policy was promulgated in 1993 and has since been reviewed. The goals of the youth policy are, among others, to empower the youth and to foster proper upbringing of young women and men to become responsible citizens. The strategic areas identified for programme intervention are education, health (including reproductive health), employment creation and economic participation. Some countries have also taken steps to address the special needs of so-called "difficult-to-reach youth". Such special interventions cover very young girls (10-13 years), adolescent married girls and urban and rural youth.

## 5.9 Male Participation

As important gatekeepers for ensuring increased utilization of RH services in Africa, the needs of men and their participation in the process is very crucial for the achievement of results, especially at the community level. For this reason, most countries have been making efforts to involve men in the provision of RH services.

Specific actions mentioned in the country reports include the establishment of a male clinic at the Lesotho Planned Parenthood Association (LPPA) which offers RH services for men, inclusive of circumcision, and is being used by an appreciable number of men. Also in Lesotho, male support groups are playing important roles in improving antenatal care clinic attendance and raising community awareness on issues such as prevention of HIV transmission from mothers to their infants (PMTCT). In Nigeria and other countries, efforts include raising awareness on the importance of the involvement men in RH service delivery.

## 5.10 RH Needs for Special Groups

Since 2004, some governments in Africa have initiated strategies to address the specific reproductive health needs of vulnerable groups such as people with disabilities, refugees and internally displaced persons (IDPs), migrants, people living with HIV, rural people who are difficult to reach and the poor.

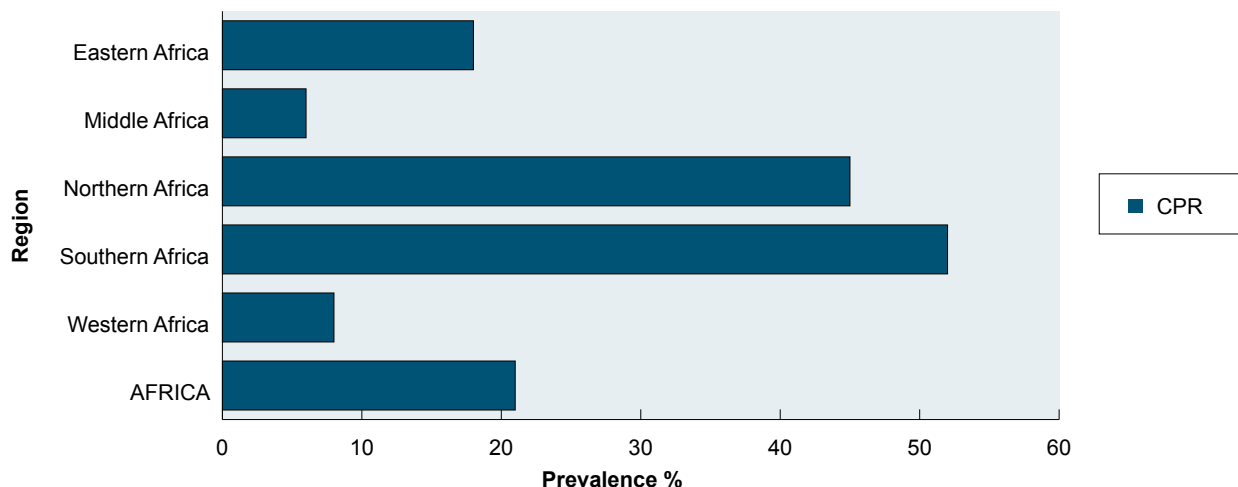
Notable actions taken include the establishment of Health Extension Programmes tailored to the needs of pastoralist communities in Ethiopia, which include mobile health services that provide outreach services and establish new satellite health posts. This has provided an entry point for the provision of reproductive health services in these communities. In the case of the United Republic of Tanzania, legal reforms have encouraged partners to support elderly people and people with disabilities by addressing their access to SRH services.

The National Commission for Refugees was set up in Benin to address the needs of refugees in 2005. Through the commission, family planning and reproductive health services are provided to Togolese refugees who are principally based at Agamè.

## 5.11 Family Planning

The goal of ICPD for family planning is to achieve universal access to a full range of safe and reliable family planning methods through the primary health care system by 2015. However, while modern contraceptive prevalence rates (CPR) are improving, they still are very low. As illustrated by Figure 5.6, overall modern contraceptive prevalence was about 20 per cent for Africa. In 2007, only in Southern Africa did that rate exceed 50 per cent, followed by North Africa (44 %); East Africa (17 %), West and Central Africa (under 10 %). Without a widespread adoption of modern methods of family planning, it will be difficult, if not impossible, to reach the fertility transition threshold critical to reaping the demographic dividend.

**Figure 5.6: Contraceptive (modern) prevalence rate in Africa and major regions, 2007**



Source: UNFPA, State of World Population 2007

Only two countries reported CPR higher than 50 per cent. These are Egypt (57 per cent in 2007) and Morocco (63 % in 2004). Extremely low CPRs (below 10 %) are reported by Mauritania (9.3 % in 2008), Nigeria (8.9 % in 2003), the Niger (8.3 % in 2007), the Sudan (7.6 % in 2007), Burundi (7.0 % in 2007), Benin (6.2 % in 2006), and DRC (5.8 % in 2007).

The remaining 12 African countries with information reported CPRs between 10 and 47 per cent: Namibia (47.0 % in 2006), Sao Tome and Principe (47.0 % in 2007), Mauritius (40.0 % in 2004), Malawi (38.4 % in 2006), Swaziland (36.3 % in 2007), Kenya (32.0 % in 2003), the United Republic of Tanzania (18.0 % in 2008), Mozambique (17.0 % in 2003), Ethiopia (13.9 %), Ghana (13.6 % in 2006), the Gambia (13.4 % in 2007), Cameroon (12.0 % in 2007) and Senegal (10.3 % in 2004).

In Namibia, 98 per cent of all women reported knowledge about contraceptive methods (DHS, 2006-2007). However, only 66 per cent currently use a modern method of contraception. It is also reported that the unmet need for family planning in the country has declined from 5 per cent in 2000 to 3 per cent in 2006-2007. By 1998, knowledge of modern contraceptives among women in South Africa was almost universal. The percentage of married women who knew of a modern method of contraception was 98 in 1998 but surprisingly the 2003 DHS results suggest a possible decline to 95.7. Modern contraceptive prevalence in South Africa was estimated at 60 per cent in 1994, up from 55 per cent in 1990. Current contraceptive use remained constant at around 50 per cent for all women between 1998 and 2003, whilst among married women, the percentage currently using any modern method increased from 55.1 in 1998 to 60.3 in 2003. Like other countries, these prevalence levels are highly correlated with education, place of residence and economic status.

Indeed, the unmet need for family planning among married women in the United Republic of Tanzania is 22 per cent, while about 38 per cent of women of reproductive age are in need of family planning services in the Sudan. The case is the same for Ethiopia where in 1995, the contraceptive

prevalence rate among married women was 14.7 per cent, while the unmet need for contraception was 34 per cent. The scenario is even worse in DRC, CAR and Sierra Leone, where the contraceptive prevalence rates were only 4 per cent, 4.4 per cent and 6.7 per cent respectively. With an increase to 47 per cent in the contraceptive prevalence rate in Namibia in 2006, the unmet need for family planning is said to have decreased to 7 per cent for the same year. While the 2006 Uganda Demographic and Health Survey reported that only one in four married women was using a family planning method in Uganda, contraceptive prevalence is reported to have increased in Morocco from 42 per cent in 1992 to 63 per cent in 2004.

Ensuring that the unmet needs for family planning services are satisfied will significantly reduce reproductive health challenges and lower total fertility rates in most countries. The Uganda Country Report confirms that reducing the unmet needs by 50 per cent would reduce the total fertility rate (TFR) for the country to four children per woman, while satisfying all of the unmet needs would reduce the TFR to 2.9.

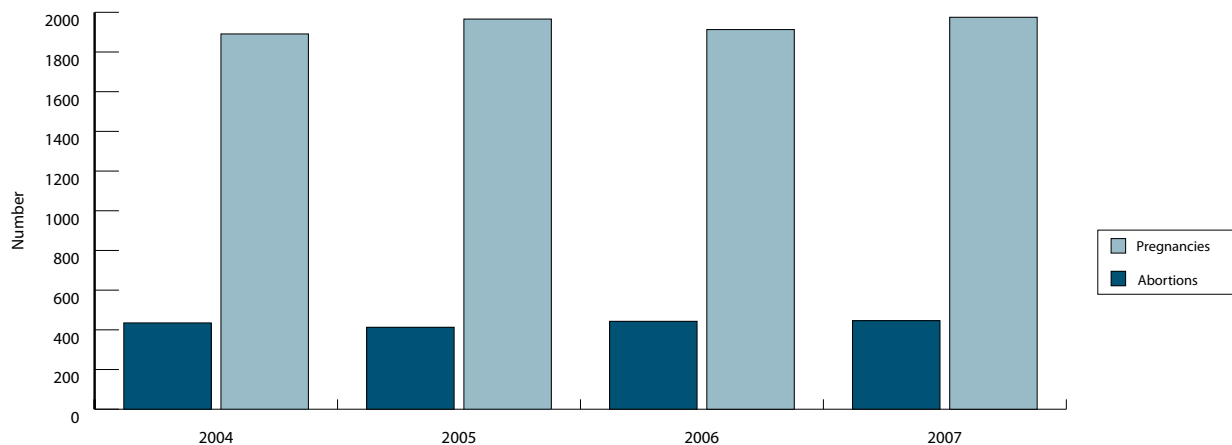
Efforts being made in Nigeria to improve availability and access to family planning services include the development of a five-year (2003-2007) Reproductive Health Commodity Security Strategy (RHCS) to improve the low contraceptive prevalence rate. Lesotho has taken steps to make health and family planning services free even at the health centre level. As in many other countries, community-based distributors (CBDs) were trained in family planning service delivery in Lesotho.

## 5.12 Abortion

In many parts of the world, including developed countries, abortion is a sensitive RH subject. Nevertheless, the practice of abortion is universal, whether legal or illegal. The ICPD Programme of Action (POA) drew attention to the health consequences for women of unsafe abortion and called for action to address this critical public health issue (United Nations 1994). It notes further that abortion care should be an integral part of primary health care, and that in circumstances where it is not against the law, abortion should be safe. The UN ICPD + 5 report renewed the call on health systems in pro-choice countries to train and equip health service providers and take other measures to ensure that abortion facilities were safe and accessible. (United Nations 1999).

The relevant MDG to this call is MDG5, “Improve maternal health,” which is set to reduce maternal mortality by 75 per cent from 1990 to 2015, with a target of achieving universal access to reproductive health care by the end of the MDG cycle. It has been argued that MDG 5 can be met only if unsafe abortion is effectively addressed. Research reports show that unsafe abortion accounts for approximately 13 per cent of global deaths from complications of pregnancy and childbirth, and a much higher proportion in many developing countries (WHO 2007). Estimates indicate that globally, some 66,500 women die each year from unsafe abortion. Worldwide, adolescents and women younger than 24 years account for almost 46 per cent of deaths related to unsafe abortion (WHO 2007). In many African countries, abortion is regarded as sensitive and abortion laws are generally very restrictive. This explains why the toll of unsafe abortion is especially high in sub-Saharan Africa.

**Figure 5.7 Abortions as compared to pregnancies in Seychelles, 2004-2007**



Source: ICPD+15 Seychelles Country Report

In Seychelles, there was a 2-per cent increase in the number of all abortions from 2004 to 2007 (see figure 5.7). During the same period, pregnancies increased by 4 per cent. Terminations of pregnancies carried out under the Termination of Pregnancy Act of 1994 appear to be decreasing. Over the past four years, concern has been raised over the number of illegal abortions.

In South Africa, the 1998 National Confidential Enquiry into maternal deaths revealed that self-induced abortions were a contributing factor in 30% of abortion-related deaths. Since 1997, the number of terminations has increased steadily; a total of 216,718 pregnancies had been terminated during the first four years since the Act was passed, with a 7.2% decrease in the incidence of severe morbidity associated with this procedure. The proportion of pregnancy terminations involving young women under 18 years also increased from 6.4 per cent in 1998 to 12.8 per cent in 2004. In Senegal, abortion contributed to 3.6 per cent of maternal deaths in 2005. Most countries have also developed and are implementing guidelines on the provision of post-abortion care services.

### 5.13 Sexually Transmitted Infections (STIs)

According to the Seychelles Country Report, 13 per cent of all reported cases of STIs in 2007 were of youth aged 15-19. Women are still the most vulnerable group being affected by STIs, especially those aged 20-29 years (31.6%), with cervicitis being the main culprit. In Lesotho, STIs were reported to be among the top ten causes of frequent Out-Patient Department (OPD) consultations at health facilities in 2006.

**Measures taken against STIs.** In Nigeria the action taken on this RH issue was the issuance of policy guidelines on the syndromic management of STIs in primary health care facilities. In South Africa, it is estimated that 11 million STI cases occur annually. Although the basis of this finding separates STIs and HIV, the epidemiological and biological evidence is that STIs are co-factors in

the transmission of HIV, which means that controlling STIs has become a high priority for South Africa. It is one of the main strategies for HIV control. In 2001, 2.8% of pregnant women in South Africa who visited public maternal health facilities had syphilis infections. While this is a source for concern, this figure represents a declining trend. The syphilis prevalence trend has shown a steady decline over the last several years, from 11.2% in 1997 to 2.8% in 2001. In addition to their health consequences, STIs signify the extent of unprotected sex. This could have implications on the possible spread of HIV in the society. Actions being taken by most countries include the syndromic management of STIs in primary health care facilities, in line with set policy guidelines.

#### **5.14 Harmful Traditional Practices**

In most of the countries, the RH problems of women, particularly young girls, originate mainly from harmful traditional practices such as early marriage, abduction, female genital mutilation (FGM), sexual coercion and rape.

The country report for Ethiopia shows that the RH problems of women in the country, particularly the young ones, could be linked to certain harmful traditional practices such as early marriage, abduction, female genital mutilation (FGM), gender inequalities, sexual coercion, rape, and deprivations, particularly lack of access to user-friendly sexual and reproductive health services. The incidence of obstetric fistula among young girls in the country is twice as much when compared to other women of reproductive age. In the Sudan, early marriage is also very common; especially in rural areas where 12 per cent of girls are married before age 15 and 27 per cent marry before age 18.

Although most countries reported raising awareness, with some adopting legislative measures against female genital mutilation and even outlawing the practice, (Nigeria and the United Republic of Tanzania), and others formulating a national strategy for combating FGM (Sudan), the practice still persists. Specific laws have been passed to address HIV/AIDS. Other laws were also enacted in Senegal in 1999 against FGM (Law n°2005-31).

#### **5.15 Reproductive Organ Cancers**

Countries indicated that reproductive organ cancers (ROCs) are among reproductive health concerns which need to be duly addressed. In Ethiopia for instance, studies reveal that cervical cancer is the major cause of deaths from cancer among women (NRHS, 2006). The same can be said for other countries including Lesotho where it is most prevalent among women ranging between 40 and 49 years.

Cancers of all types are the second leading cause of death in Seychelles and, is a matter of central concern for the Ministry of Health and Social Development. In males, cancer of the lungs, oral cavity and pharynx have been the leading causes of death while cancer of the breast, cervix, uterus and ovary has been prominent in females. While the incidence of cervical cancer now appears to have been stabilised (due to cervical screening programmes), the incidence of breast cancer is on the increase from 10 in 2004 to 26 cases in 2007. The average number of pap smears performed in

all the centres is between 500 and 520 per month. In Seychelles, the incidence of cervical cancer is said to have stabilised, due to the availability of screening services in all primary health care centres.

## 5.16 Implementation of Continental Policies

Most countries reported reviewing policies and legislations, and designing plans and programme, taking into consideration the recommendations of continental policies on sexual and reproductive health. These include, the African Health Strategy and the Maputo Plan of Action. Twenty-eight countries have formulated plans and programmes to this effect; 27 countries have embarked on advocacy and awareness creation, while 22 countries have been building consensus and partnerships to adapt the African Health Strategy 2007-2015.

The United Republic of Tanzania specifically indicated that the enactment and review of existing laws such as the Medical Practitioners and Dentists Act (Cap. 152), Nurses and Midwives Registration Act (Cap. 325), and The Sexual Offences Special Provision Act (Cap. 101) was in line with these continental and other international guidelines. Other countries reported having taken similar actions.

## 5.17 Challenges and opportunities

The experience from 15 years of implementing ICPD PoA in Africa offers governments challenges and opportunities which, if carefully examined, could contribute immensely to more successful outcomes during the rest of the PoA cycle.

### *Challenges:*

- a. Despite the high commitment at the continental and country level, there is a disconnect between policy and action, which often leaves a gap that must be filled;
- b. Discriminatory social and cultural values that prevent women and men from accessing SRH services should be vigorously challenged, if significant progress is to be made in the years ahead;

### *Opportunities:*

- a. A certain level of awareness has already been created due to basic education and because of the policies within countries. Countries could capitalize on this awareness by providing the necessary reproductive health infrastructure and services, particularly to under-served people;
- b. Commitment of the AU and Regional intergovernmental bodies should be used as an opportunity to drive the RH agenda;
- c. Support for HIV in the region can be used as an opportunity for strengthening health systems, including RH;
- d. Debt reduction modalities could be used as opportunities for countries to strengthen SRH programmes;
- e. Community involvement and participation is an opportunity in RH programs. Working



- with more stakeholders than the usual number would help in advocacy and implementation of the SRH program;
- f. There is a more conducive environment for RH than 15 years ago;
- g. There has been an increase in innovative health care financing. Free health care for all is being adopted in Kenya, Mauritius, South Africa, Namibia; and Ethiopia has free extension services like in;
- h. Increased donor support and the Paris Declaration to ensure coordination and harmonization of resources for HIV have also in a way facilitated RH services.

Overall, countries reported making considerable achievements in the health sector. These include: the expansion of RH services at community level; a broad range of reproductive health related policies, legislations, strategies and road maps and tools are in place in almost all countries; provision of basic and emergency obstetric care services are being scaled up; training of skilled attendants at birth including midwives and; reducing maternal, child and infant mortality rates in some countries.

#### *Lessons learnt*

- i. More attention has been given to young people;
- ii. Task shifting in human resources, like in the United Republic of Tanzania, to ensure maternal survival;
- iii. Commitment at high level in countries have led to financial commitments for RH in Rwanda for instance;
- iv. Attention has been given to gender- based violence issues like FGM and fistula work in Ethiopia;
- v. Community involvement in RH has increased in some countries;
- vi. Involvement and partnerships with parliamentarians enriched RH programs; there is a parliamentary network on population and development for example in Uganda, Benin and Senegal;
- vii. Diversion of attention to HIV has taken away some attention from SRH; need to reposition and pay more attention to SRH;
- viii. There has been more debate on the use of Traditional Birth Attendants (TBAs).

#### *Major constraints*

Despite the reported success stories, most countries continue to face some of the following challenges to the achievement of reproductive rights and reproductive health goals, including:

- a. Weak health management information systems and lack of data, which impact negatively on programme execution;
- b. The analytical comparison of the issues cannot be reflected well because of the limitations of data;
- c. Human resource shortages, technical capacity, inadequate budgeting for RH, limited involvement of communities, weak health systems and lack of RH linkages with other health-related issues like HIV;
- d. Countries in conflict are worse off in delivering RH services to the people;
- e. Conditional and tied AID impact coordination;

- f. RH and family planning commodities are mostly provided by donors, whose source of funding could be unreliable and subject to disruption;
- g. The RH needs of special groups, such as young people, men, the elderly, pastoralists, disabled persons, migrants and displaced persons are yet to be fully mainstreamed into national strategies;
- h. In some countries, infrastructural facilities such as roads, electricity and communication systems pose serious limitations to the expansion of RH services;
- i. In Southern Africa, the high prevalence of HIV continues to erode gains made in reducing maternal and child health indicators;
- j. High illiteracy levels and prevalence of socio-cultural practices continue to affect the status of especially women and young people and efforts to deliver RH services.

# Section 6

## 6. HIV/AIDS, Malaria, Tuberculosis and other Communicable Diseases

### 6.1 Introduction

The objective of ICPD PoA regarding HIV/AIDS and sexually transmitted diseases is to prevent, reduce the incidence of, and provide treatment for sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women. The PoA urges Governments within their reproductive health programmes to increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. In addition, Governments should ensure that information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, become integral components of all reproductive and sexual health services.

In order to accelerate the realization of the ICPD PoA for HIV/AIDS and sexually transmitted diseases, the Millennium Declaration in 2000 set Goal 6 to “Combat HIV/AIDS, malaria and other diseases”; with two targets: a) Have halted by 2015, and begun to reverse, the spread of HIV/AIDS and; b) Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.

The ICPD+5 set a bench mark for governments to reduce HIV infection rates globally by 25 per cent by 2010. The pandemic is recognized by most governments as one of the major development challenges facing the continent. It is fuelled by various factors including poverty, low level of literacy, traditional practices, gender disparities and population movement, including rural-urban migration. Africa is also burdened by Malaria, TB and other communicable diseases.

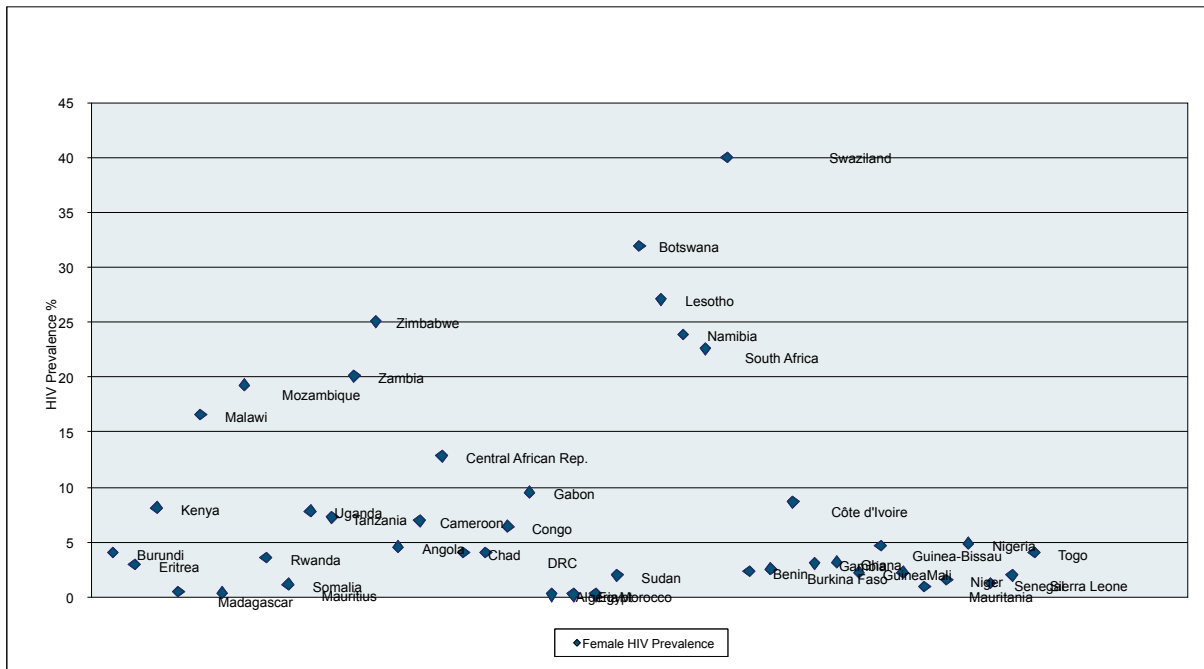
### 6.2 HIV/AIDS situation and trends

The most recent UNAIDS data on HIV/AIDS were from surveillance system reports and model estimates in the 2005 reference year. The data show male-female differences, with consistently higher figures for females than males, reflecting psychological and social vulnerability to the illness, as well as the effect of age differences between sexual partners.

Regional trends suggest that prevalence of HIV among female adults (ages 15-49) is highest in Southern Africa and lowest in North Africa. All the countries with female adult prevalence rates exceeding 25 per cent (2005) are in Southern Africa: Swaziland, Botswana, Lesotho, Zimbabwe, Namibia, South Africa and Zambia. Except for the Central African Republic, countries in the 10-20

per cent prevalence range are also in Southern Africa, namely, Mozambique and Malawi. By contrast, it is noteworthy that quite a number of African countries, mostly from the North and West, have retained a very low adult female HIV prevalence rate not exceeding 1 per cent. These countries are, Algeria, Egypt, Morocco, Mauritius, Madagascar, Somalia, Mauritania and Senegal. Equally noteworthy is the fact that, except for Cote d'Ivoire, with a prevalence rate of 8.5 per cent, no West African country exceeds 5 per cent.

### Female HIV Prevalence in African countries, 2007



Source: UNFPA, State of World Population 2007

The country reports indicate that average adult HIV prevalence is high in most countries. The prevalence rate, though declining, were high in countries such as Lesotho (23.2 % in 2007); Namibia (19.9 % in 2006), Malawi (12 % in 2006) and Mozambique (16 % in 2007). In South Africa, approximately 5.5 million people were estimated to be living with HIV in 2005, with about 18.8 per cent of the adult population (15-49 year olds) affected. The prevalence rate for the same age group for the United Republic of Tanzania was estimated at 8.7 per cent in 2005/2006. In Uganda, the period 1992 to 2002 was characterized by significant declines in HIV/AIDS prevalence which stabilised at 6 per cent, but is currently on an upward trend.

HIV/AIDS prevalence varies by demographic and socio-economic characteristics. In terms of sex and age, the rates for ages 15-39 and 45-49 are higher for females than males but for the rest of the age groups, the rates for males are higher. For the young group aged 15-19, the rate for females is nine times higher than for males. This trend has remained almost the same since the early 1990s.

HIV prevalence is reported to be 4.5 per cent for DRC in 2004; and 2.7 for Ghana in 2005. With a

prevalence rate of 1.6 per cent in 2002, the Sudan was judged to be the country most severely affected by HIV/AIDS in North Africa and the Middle East. In Morocco, HIV prevalence remains very low and stable at 0.08 per cent in 2007, although it has been detected to be higher among special groups such as sex workers (2.5 %) and male prisoners (0.6 %). Even with a six-fold increase in reported new cases of HIV from 2002 to 2007 in Mauritius, the HIV prevalence rate among pregnant women screened at government antenatal care clinics was estimated as 0.38 per cent for 2007.

The country reports indicated that exposure to HIV in all the countries was mainly through heterosexuals and females, who continue to be more infected compared to men. In Uganda for example, the HIV prevalence rate for young people aged 15-19 years in 2008 shows the rate for females to be 9 times higher than for males. The reports indicated that there were Knowledge gaps and misconceptions on the prevention, transmission and treatment of HIV and AIDS in most countries. For instance, only 53 per cent of the population in the Sudan were aware of HIV being sexually transmitted and only 40 per cent of the population in DRC had knowledge of actions to take to prevent HIV transmission.

### **6.3 Policies and legislative frameworks**

In view of the devastating impact of HIV/AIDS, most countries reported putting in place relevant policies and legislations to provide the enabling environment for combating the disease. In Ethiopia, the Strategic Framework for National Response was formulated in 2002 to provide the basis for a multi-sectoral response to the epidemic. Following an in-depth review of the national response in 2005, an updated National AIDS Policy, a National Strategic Plan for 2006-2011 and the National Monitoring and Evaluation Plan was approved by the Government of Lesotho in December 2006. Also, several sector-specific policies have been developed in line with the National HIV and AIDS Policy recommendations. Prominent among the policies approved are the 2006 National Orphan and Vulnerable Children Policy and the 2006 Blood Transfusion Policy and the 2006 HIV Testing and Counselling Policy.

Most countries have adopted measures and strategies relating to HIV/AIDS issues, as part of the national prevention and treatment strategy. In 2006, Lesotho amended the Labour Code Act so as to prohibit pre-employment testing, testing during employment, to ensure confidentiality and banned discrimination in employment. In addition, national guidelines for the implementation of HIV workplace programmes have been developed (UNAIDS, 2008). In Benin, Law 2005.31 of April 2006 was approved to provide for the right to information and treatment and ensure medical and employment ethics regarding HIV/AIDS. The Central African Republic reported the adoption of a law for the prevention of the discrimination against people living with HIV and AIDS.

Policy and legal frameworks were also reported to be in place in DRC, Senegal, Nigeria, Ghana, Uganda, Sierra Leone and Mozambique.

### **6.4 Programmes and Plans**

The country reports of Benin, CAR, DRC, Morocco, Mozambique, Madagascar, Mauritius, Malawi, Lesotho, Ethiopia, Ghana, Namibia, Nigeria, the United Republic of Tanzania, South Afri-

ca, Senegal, Sao Tome and Principe, Sierra Leone, the Sudan and Uganda indicated that National Multi-Sectoral HIV/AIDS Programmes and strategic plans, mostly with similar content, were being implemented as comprehensive country specific prevention, care and impact mitigation responses to the epidemic.

The programmes in all the countries focus mainly on strategies such as awareness raising and advocacy, blood transfusion safety; voluntary counselling and testing; availability of condom and use, targeted intervention for vulnerable groups such as PLWAs and orphans and vulnerable children; prevention of mother to child transmission (PMTCT); provision of Post Exposure Prophylaxis (PEP), and provision of antiretroviral therapy.

In recognition of the close relationship between SRH, STI and HIV/AIDS, most of the countries, such as Mauritius, Nigeria, Lesotho, Uganda and Malawi have taken steps to integrate HIV/AIDS and RH in policies and programmes. The steps include policy, technical guidelines and protocol formulation and reform of service delivery mechanisms.

The few countries that have yet to integrate HIV/AIDS and RH issues in their policies and programmes, most often blame it on lack of resources. Other reasons include low level of policy commitment and human capacity and constraints imposed by customs and traditions.

## **6.5 Institutional Arrangements**

The institutional and management framework which guides the national response to the HIV/AIDS epidemic varies from country to country. Key examples reported include a decentralized mechanism, for example in Lesotho, Ethiopia, Mauritius, Nigeria and the United Republic of Tanzania. These include National AIDS Councils, mostly chaired by the Head of State, with decentralized structures in all Ministries, Departments and Agencies (MDAs) and at subnational levels. The “3 ones” have seen National AIDS commissions become nearly universal (37) with most having decentralized subnational units (30). This multi-sectoral approach has reduced dedicated single issue ministries while facilitating Ministerial and Parliamentary committees.

It was reported that in most of these outfits, people living with HIV/AIDS (PLWA) are encouraged to play active roles in HIV/AIDS advocacy and prevention. There has also been an increasing number of CSOs supporting the National Response. Interventions and activities are being strengthened at district, ward and community levels. Private sector organizations, civil society groups and community-based associations were also incorporated into the mechanism to develop and implement policies and programmes for the management of HIV/AIDS. Development partners were cited as key sources of financial and technical support for the national response programmes.

## **6.6 Tuberculosis**

Tuberculosis (TB) was acknowledged as a major public health problem in all the countries. Since the advent of HIV/AIDS in Malawi, the country had observed a steady increase in TB cases from 5,000 in 1985 to 26,000 cases in 2007. The incidence of TB in South Africa was estimated as 718 per 100,000 people in 2004, with an increase of 8.5 per cent per year. In Uganda, TB remains endemic,

especially among HIV/AIDS infected people. TB cases have been reported to rise by 8 per cent since 1994. In Namibia, the disease is most prevalent among people between the ages of 25 and 34 years, which is also the age group most affected by HIV/AIDS. Other countries reported different levels of prevalence. For example Ghana (180 cases per 100,000 people per annum) and Morocco (85 cases per 100 000 people per annum).

The country reports also revealed that almost all the countries had national TB control programmes and strategic plans, which principally focused on raising awareness among the population and improving on TB case detection and cure. In countries with high HIV prevalence rates, special efforts are being made to reach vulnerable population who are co-infected with HIV and TB. Malawi, for example, reported the formulation of a policy for the control of TB in its prisons.

## 6.7 Malaria

Malaria was acknowledged by most countries as the leading cause of morbidity and mortality. In Malawi, it accounts for 18 per cent of all inpatient deaths and in the United Republic of Tanzania it was the leading cause of admission among inpatients in 2007 of which 30 per cent were children aged under five years. According to the Malaria Indicator Survey (MIS), in October 2005, the prevalence of malaria among children under the age of 5 years, ranged between 0.4 per cent and 15.5 per cent and between 3.7 per cent and 10.3 per cent for pregnant women, with the prevalence reported to be much higher in rural than in urban areas.

In all the countries, malaria continues to top the list of diseases. For example, Ghana (44 % of cases managed in out-patient departments of hospitals and clinics); Uganda (52 % of outpatient and 30 % in-patient admissions; and, Gabon (leading cause for hospital admission for over 40 % of children 0 to 5 years and 71 % of pregnant women). The Sudan country report indicated that the prevalence of malaria ranged from 0.4 per cent to 15.5 per cent for children under the age of 5 years and from 3.7 per cent to 10.3 per cent for pregnant women. Malaria was also reported to be responsible for about 3,360 deaths in 2007 in Mozambique and was also reported as the leading cause of illness and death among under-five children, and the third leading cause among adults in Namibia. In Gabon, it is one of the leading causes of death in children between 0 and 5 years.

An abnormal malaria prevalence was reported for the highlands of Ethiopia in 1988 and 1991-1992. From 2005 to 2006, malaria was the leading cause of morbidity and mortality in the country. Malaria prevalence in some parts of the country was attributed to global warming. The same situation was reported for South Africa where Malaria is said to have been on the increase since 1995, with more cases being reported each year. The situation is attributed to climatic conditions (temperature and rainfall), as well as to the influx of migrants from neighbouring countries. In Mauritius, localised outbreaks of malaria due to the influx of visitors from malaria endemic countries puts the country at risk of imported malaria cases.

As a result of the high prevalence and impact of malaria, especially in sub-Saharan countries, specific programmes, aimed at vector control, through the, distribution of mosquito nets, and diagnostics and treatment are being implemented to reduce the effects of the disease.



Most of the countries, including Ethiopia, Malawi, the United Republic of Tanzania, the Sudan, and Mozambique reported having in place a Roll Back Malaria (RBM) and other strategic programmes that include vector control through the use of ITNs, to improve malaria case management, especially for vulnerable groups such as children and pregnant women. In this regard, Malawi has made remarkable efforts in the past few years (see figure 6.1).

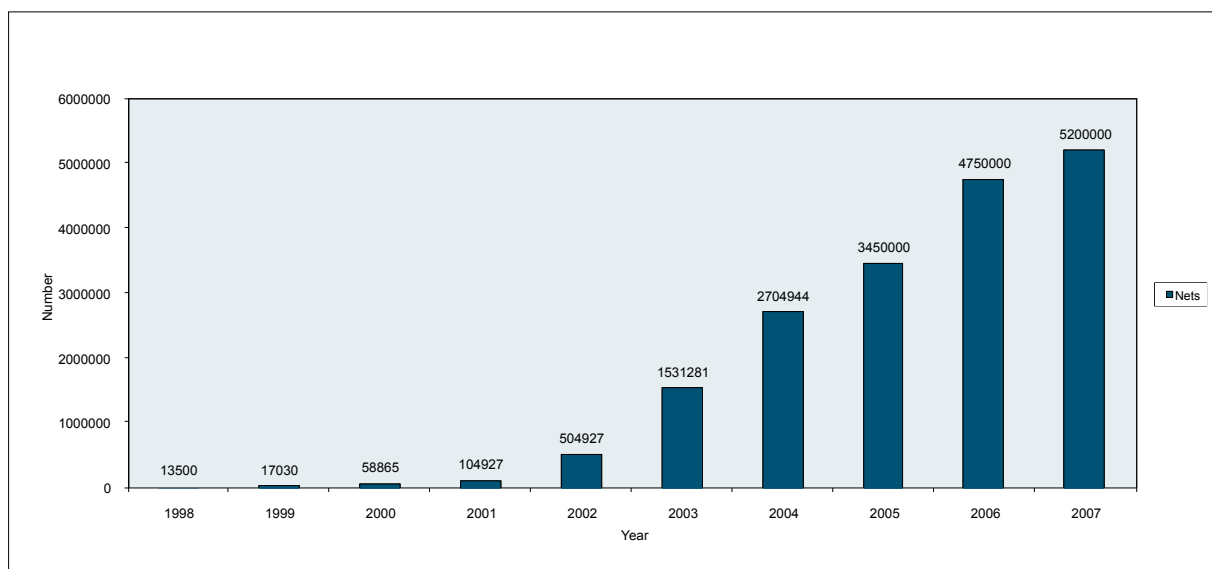
In some countries such as Mauritius and Ethiopia, the programmes also focus on epidemic preparedness, prevention and control.

## 6.8 Other Communicable Diseases

Evidence shows that STIs are co-factors in the transmission of HIV, which means that controlling STIs has become a high priority. In addition to their health consequences, STIs prevalence could signify the extent of unprotected sex and hence have implications on the possible spread of HIV. Actions being taken by most countries include the syndromic management of STIs in primary health care facilities in line with set policy guidelines.

According to the Country report of Seychelles, 13 per cent of all reported cases of STIs in 2007 were of youth aged 15-19. In Lesotho, STIs were reported to be among the top ten causes of frequent Out-Patient Department (OPD) consultations at health facilities in 2006.

**Figure 6.1 Mosquito Net Distribution in Malawi (1998-2007)**



Source: ICPD+15 Malawi Country Report, 2008

It is estimated that 11 million STI cases occur annually in South Africa. Controlling STIs has become a high priority for South Africa and this is one of the main strategies for HIV control in the country. In 2001, 2.8 per cent of pregnant women in South Africa who visited public maternal health facilities had syphilis infections. Though still a concern, this figure represents a declining

trend. The syphilis prevalence trend has shown a steady decline over the last several years, from 11.2 per cent in 1997 to 2.8 per cent in 2001.

## 6.9 Commitments to Continental Policies and Strategies

African countries have shown their concern for and willingness to combat the HIV/AIDS pandemic through numerous regional commitments, namely, the African Health Strategy; the Maputo Plan of Action on SRH; the Abuja Declaration on Universal Access to Prevention of HIV, Malaria and TB; the Abuja Call to Universal Access to Treatment, Care and Support; the CARMMA Initiative, and Review of the implementation of Primary Health Care (PHC) in Ouagadougou.

In line with continental policies such as the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa, some countries such as Benin, Nigeria, South Africa, the United Republic of Tanzania and Senegal have adopted strategies in resource mobilization, building partnerships, especially at the country level and reforming their institutions to ensure effective implementation of reproductive health, HIV/AIDS, STIs, TB and Malaria programmes. Many countries have reviewed national policies or legislations, raised awareness through advocacy and improved RH service delivery in response to the Abuja Call.

## 6.10 Achieving the MDGs

MDG 6: is set to “Combat HIV/AIDS, malaria and other diseases”. In terms of the prospects of achieving MDG6, about one-third of the countries are not optimistic; 30 per cent confirm that they are unlikely to achieve target 1 of MDG6 (Have halted by 2015, and begun to reverse, the spread of HIV/AIDS), and about the same proportion of responding countries (28.6 %) consider it unlikely that Target 2 of MDG6 could be achieved, - (to “have halted by 2015, and begun to reverse the incidence of malaria and other major diseases”).

Combating HIV/AIDS, malaria and other diseases was judged as likely to be achieved by Benin, Burundi, the Gambia, Madagascar, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone and Zimbabwe, because the prevalence rates for most of the diseases, including HIV/AIDS, Malaria, TB and Leprosy were reported to be stabilizing in most of the countries.

Kenya, Senegal, the Sudan, Swaziland and the United Republic of Tanzania indicated that they were unlikely to achieve this goal, especially for HIV/AIDS. This is because of the reversal of progress already made in Kenya and Swaziland and the very slow rate of decline in HIV prevalence recorded in the United Republic of Tanzania.

### **MDG 6-Target 1:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS

The goal was judged as very likely to be achieved by Mozambique, Sierra Leone and Tunisia. The HIV prevalence rate has stabilized at 16 per cent in Mozambique and at 1.5 per cent in Sierra Leone over the past five years. In the case of Tunisia, the rate of prevalence remained steady at 0.7 persons per 100,000 inhabitants.

Countries such as Egypt, the Gambia, Mauritius, Seychelles, Lesotho, Zimbabwe, Morocco, the Niger, Sao Tome and Principe and CAR indicate that the target is likely to be achieved, because policies, strategies and programmes that are being implemented have yielded positive results. In Lesotho for instance, the reported AIDS cases and new HIV infections among ages 5 to 14 is said to be very low. In the case of Zimbabwe, HIV/AIDS prevalence is reported to have declined from 19.9 per cent in 2000 to 12.5 per cent in 2008.

The achievement of this target has been rated as unlikely by the Comoros, Burundi, Guinea, Kenya, Swaziland and Uganda because of difficulties in sustaining a decline in HIV prevalence rate in these countries. In Uganda, there was a drastic reduction in the HIV prevalence rate, among persons 15 to 49 years old, from 30 per cent in 1990 to 6.1 per cent in 2000. This achievement experienced a slight reversal with the HIV prevalence rate increasing to 6.2 per cent in 2004 and 6.4 per cent in 2006. The circumstances are similar in other countries like Burundi, the Comoros and Kenya, where risky behaviour patterns persist and continue to fuel the spread of HIV among the population. The Comoros indicates that, while knowledge about a method of HIV transmission was reported to be as high as 90 per cent, the percentage of 15 to 24 years olds using condoms during their last high risk sex was only 20 per cent.

For lack of coordination and synergy within the health sector across the country, the Sudan indicates that the achievement of this target is very unlikely.

**MDG 6-Target 2:** Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

This Target is very likely to be achieved by Mauritius, Seychelles and Tunisia which reported that they had instituted mechanisms for free access to ART for all persons infected by HIV. In the case of the Gambia, a series of interventions are said to be in place to ensure that people living with HIV who have fulfilled the eligibility criteria, do get free access to ART.

With national HIV/AIDS strategies and programmes being implemented in countries like CAR, the Comoros, Egypt, Lesotho, the Niger, the Sudan, Sao Tome and Principe, Sierra Leone, Uganda and Zimbabwe, the achievement of this target was said to be likely. Increasing access to ART by PLWAs is an important objective of all of these national programmes which are being fully funded by governments and their partners. In countries like Uganda, the commencement of the manufacture of ARVs is said to ensure constant supply and reduced cost of the therapy.

The achievement of the target was said to be unlikely for Burundi, Guinea, Kenya and Swaziland because of the need for a well structured system for the distribution of drugs and the provision of home-based care. In Swaziland, only 26.5 per cent of people needing the drugs in 2007, had access to ARVs.

**MDG 6-Target 3:** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Mauritius, Morocco and Seychelles, where malaria is rampant, indicated that this goal has already been achieved because of the absence of malaria and the low prevalence of other major diseases like TB.

National strategies and programmes on Malaria, TB and Leprosy are being implemented by most countries, including CAR, the Comoros, Guinea, Sao Tome and Principe, Senegal, Swaziland, the United Republic of Tanzania and Zimbabwe, to reduce the prevalence of these diseases. As a result, this target is judged as likely to be achieved by these countries. In Swaziland for instance, the incidence of clinical malaria has been reduced from 4.1 per 1,000 persons in 2000 to 2.2 per 1,000 persons in 2006. In Sao Tome and Principe, the number of under-five children diagnosed with malaria was said to have been reduced by 70 per cent from 2005 to 2006.

In the case of countries like Burundi, Kenya, the Niger, Sierra Leone and the Sudan, the target was unlikely to be achieved because of lack of resources and the required supportive environment to address the root causes and hence reverse the incidence of some of the diseases.

## **6.1.1 Achievements**

The country reports show that the policies and programmes that are being implemented by the countries have provided an improved framework for the coordination of national response strategies under a single strategic plan, often with one monitoring and evaluation plan. Ethiopia and Uganda indicated that this framework has made it easier to harmonize the activities of partners even at the subnational level.

All the countries reported significant expansion at subnational levels, with the establishment of sites to ensure that ART, HIV Counselling and Testing (HCT) and Prevention of Mother to Child Transmission (PMTCT) services reach more people. Also, strategies for serving PLWAs, including orphans and vulnerable children, have been improved and strengthened in most countries, including the United Republic of Tanzania, Uganda, South Africa, Madagascar and Senegal.

Over the years, mechanisms have been put in place for improved surveillance of infectious diseases including malaria and TB. This has guided the adoption of interventions to reduce the prevalence of the diseases. The distribution of Long Lasting Impregnated Nets (LLIN) to millions of households on the continent has contributed to a significant reduction in deaths due to malaria in most of the countries in Sub-Saharan Africa. Also, high success rates of treatment of TB patients, in line with WHO standards, was reported by most countries, including Ethiopia, the United Republic of Tanzania, Nigeria, Uganda and Malawi.

In general, the following achievements are also worth recording as they relate to HIV/AIDS programme management in countries across Africa:

- i. There has been a big push for evidence-based research for the management of HIV/AIDS programmes, such as the case for male circumcision and evidence that it contributes to reduction in the spread of the virus;

- ii. The case has also been made for incidence data rather than prevalence so that policy makers and those involved in HIV programming could have a better picture of the dynamics of the epidemic;
- iii. There has been a general push for increased resource allocation for HIV prevention, as treatment is not cost effective;
- iv. There is a certain level of awareness, and increased basic education because of the country policies;
- v. Discriminatory social cultural values that restrict the access of women and men to preventative SRH services have been identified and continue to be condemned;
- vi. Affordable HIV/AIDS drugs have been made available to more people in need;
- vii. There has been an increase in innovative health care financing, including free care for all in countries like Kenya and Mauritius, and free extension services in Ethiopia. Also, increased donor support and the Paris Declaration to ensure the coordination and harmonization of resources for HIV have also facilitated RH services somewhat.

## 6.12 Challenges and constraints

One of the main challenges to the national HIV/AIDS, Malaria and TB interventions, as cited by the country reports, was the weak linkages between components and entities of the programmes. Ethiopia for instance, indicated that there were still inherent weaknesses in the linkage between HIV and RH services. In Uganda and Morocco, as a result of the weak linkages there was less synergy and harmonization of interventions. Also, Uganda, Gabon, DRC and Sao Tome and Principe indicated that the existence of numerous vertical interventions and partners was a serious challenge to the governments' limited resources for coordinating efforts, especially at sub national levels. The situation was exacerbated by the weak human capacity in the health sector as indicated by Malawi, Lesotho and South Africa. Inadequate funding levels were also affecting the implementation of strategies in most of the countries. For example, in the United Republic of Tanzania, the challenge is to mobilize the US\$100 million needed from external sources annually for HIV/AIDS interventions. The financial burden for HIV and AIDS interventions in Lesotho, Ghana, Madagascar, Gabon, DRC, Sao Tome and Principe, CAR, South Africa and Uganda is unsustainable without external assistance.

In CAR, Malawi, South Africa and Mozambique, the limited translation of increased knowledge of HIV/AIDS into positive behaviour, such as adopting safe sex practices, including the effective and continuous use of condoms, was cited as a contributory factor to the high prevalence of the disease. The stigma attached to HIV/AIDS in Ghanaian society makes it difficult for people living with the disease to disclose their HIV-positive status. In Benin, Madagascar, Gabon, CAR and Morocco religions and socio-cultural factors were major barriers to especially HIV/AIDS programme interventions. In almost all the countries, poverty was cited as a major factor that pushes marginalized groups into practices that make them susceptible to HIV/AIDS infection. Namibia, South Africa, Benin and Uganda reported that although women and girls were the most affected by HIV/AIDS, they were least served, due mainly to inadequate gender mainstreaming in the provision of HIV/AIDS services.

In CAR and DRC, the fluid conflict situation has destroyed health infrastructure and continues to create waves of population movements, causing a major challenge to programme interventions. Also, the conflict situation on the continent has fuelled an increase in gender-based violence, and heightened the risk of STI and HIV/AIDS prevalence in most of the affected countries.

Based on country reports and related research evidence, the challenges facing the implementation of the ICPD PoA as well as related MDG targets for HIV/AIDS in Africa can be summarized as follows:

### *Challenges*

- a. Despite the high commitments by national Governments at continental and country levels, there is a disconnect between the policies in place and actual implementation;
- b. Lack of absorptive capacity and accountability of funds have led to reduced flow of resources;
- c. Limited data on use of HIV/AIDS services by males;
- d. Silent approach for patent rights from countries where HIV/AIDS pandemic is not widespread;
- e. There are so many paradigm shifts in HIV/AIDS; clinical and operational research is very dynamic. Messages are inconsistent and conflicting, which often lead to difficulties in policy formulation and programme implementation in almost every area of HIV, including Syndromic management of STI, microbicides, HIV vaccines, adherence to treatment and PMTCT;
- f. There are still some laws in countries that criminalize HIV/AIDS;
- g. Donor conditionality often sets a limit to programme management in terms of flexibility;
- h. Stigma and discrimination against people with HIV/AIDS is still widespread and poses a challenge to management.

### *Opportunities*

- a. Commitment of AU and regional intergovernmental bodies should be used as an opportunity to drive RH agenda;
- b. Support for HIV in the region should be used as an opportunity to strengthen health systems, including RH;
- c. Use of debt relief modalities could be an opportunity to strengthen HIV programmes;
- d. Health systems should take advantage of integrating RH into primary health care and link to HIV prevention and treatment of AIDS;
- e. NEPAD programmes could be used to elevate HIV/AIDS if there are adequate human resources;
- f. Community involvement and participation is useful in RH programmes. Working with more stakeholders than the usual number would help in advocacy and implementation of SRH programmes.





# Section 7

## 7. Population Distribution, Urbanization and Internal Migration

### 7.1 Introduction

The ICPD PoA focused on the following three broad areas: population distribution, urbanization and internal migration, with set objectives for countries to work towards: a) population distribution and sustainable development; b) population growth in large urban agglomerations; and c) Internally displaced persons. Related broad objectives are to:

- a. Foster a more balanced spatial distribution of the population by promoting, in an integrated manner, the equitable and ecologically sustainable development of major sending and receiving areas, with particular emphasis on the promotion of economic, social and gender equity, based on respect for human rights, especially the right to development;
- b. Reduce the role of the various push factors as they relate to migration flows;
- c. Enhance the management of urban agglomerations through more participatory and resource-conscious planning and management, review and revise the policies and mechanisms that contribute to the excessive concentration of population in large cities; and improve the security and quality of life of both rural and urban low-income residents;
- d. Offer adequate protection and assistance to displaced persons within their country, particularly women, children and the elderly, who are the most vulnerable, and find solutions to the root causes of their displacement in view of preventing it: and, when appropriate, facilitate return or resettlement; and
- e. Put an end to all forms of forced migration, including ‘ethnic cleansing’.

Directly related to these are the following ICPD PoA objectives set out for addressing population and environmental challenges: (a) ensure that population, environmental and poverty eradication factors are integrated into sustainable development policies, plans and programmes and; (b) reduce unsustainable consumption and production patterns and the negative impacts of demographic factors on the environment, in order to meet the needs of current generations without compromising the ability of future generations to meet their own needs.

These ICPD PoA objectives are clearly linked to Millennium Development Goal 7: “Ensure environmental sustainability” and its related targets; i) Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources; ii) Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation; and, iii) By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers. Indeed, addressing population distribution, urbanization and internal migration issues for the attainment of sustainable development does have, a bearing on the achievement of all the MDGs.

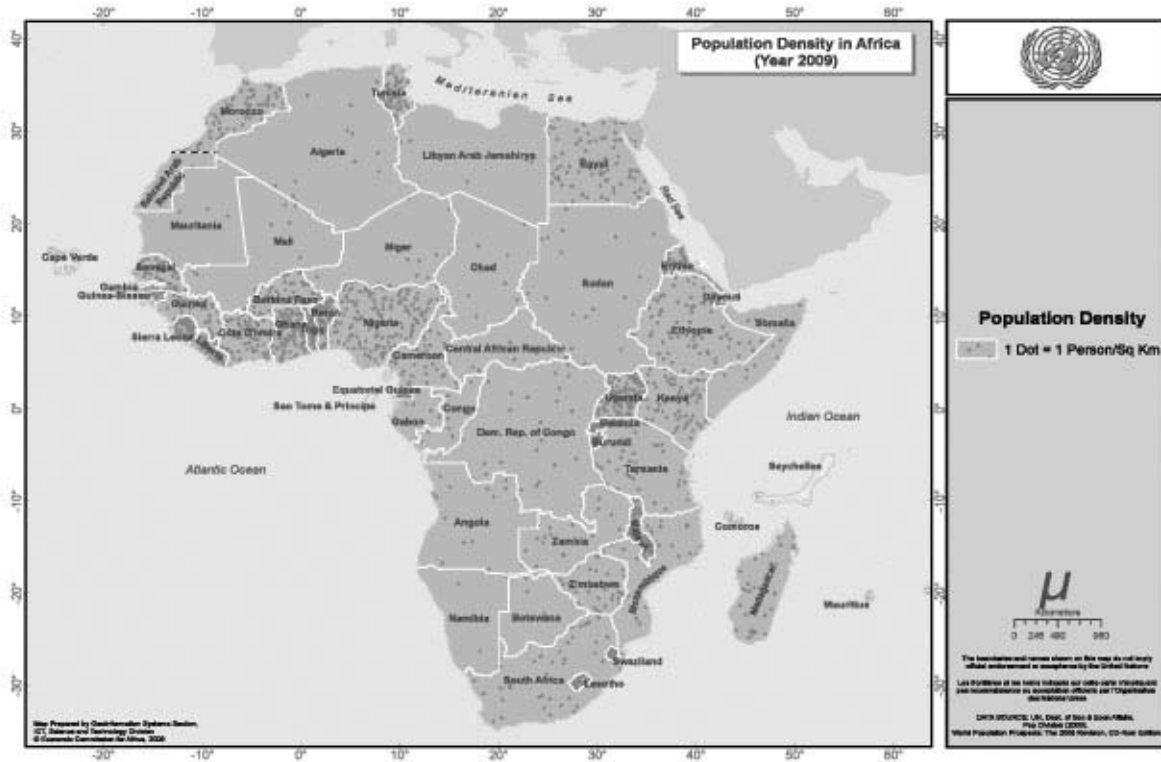
## **7.2 Implementing the ICPD PoA**

In the next four decades, three highly populous nations are expected to emerge; namely Nigeria with a projected population increase from 151.6 million (2008) to 288.7 million (2050); followed by Ethiopia from 85.2 million (2005) to 183.4 million (2050); and Egypt from 76.8 million (2008) to 121.2 million (2050). While most African countries are likely to more than double their population numbers by 2050, the most dramatic growth may occur in Uganda. Fuelled by a high growth rate of 3.2 per cent per annum, the country’s population will triple during this interval from 31.9 million in 2008 to 92.9 million in 2050. Unless these high rates of national population growth are matched by equally rapid social and economic development, many African countries are likely to be entangled in a demographic trap and pervasive poverty. The responses provided by African countries through the ICPD at 15 Review Tool indicate that the governments are concerned with population distribution and rapid urbanization. The countries have experienced significant changes in population size, distribution, urbanization and internal migration.

## **7.3 Population distribution and density**

The distribution of population in Africa is presented in Map 7.1, based on the most recent estimates (UN, 2008). In terms of regional distribution, Eastern Africa with 315.8 million (31%) has the largest population, closely followed by Western Africa with 29.5 per cent; Northern Africa 19.7 per cent; Middle Africa 11.9 per cent and Southern Africa 5.7 per cent. The most dramatic increases in population are expected to occur in Eastern Africa, with a projected population of 692.9 million in 2050, followed by Western Africa, 617 million and Middle Africa 312.7 million. The slowest regional population growth is being experienced in Southern Africa, estimated at 0.6 per cent per annum, which will push the total population size from 56 million in 2008 to 65 million by 2050.

**Map 7.1 Population Density in Africa, 2009**



**Source:** Prepared by UNECA using data from World Population Prospects; 2008 Revision, UN Department of UN Social and Economic Affairs, Population Division, 2009

The most recent estimates of world population and the regions (UN, 2008) shows that the average population density for the whole world is 50.8 persons per sq km. Compared with 23.3 for the developed countries and 68.4 for the less-developed areas of the world, Africa, with a density of 34.1 persons per sq km can be considered to be relatively sparsely populated. It must be understood that much of the land area is arid or semi-arid land not suitable for agriculture. Other indicators, e.g. population per hectare of arable land, tell a different story; it dramatically changes many countries from sparsely populated to disastrously crowded. In addition, even the arithmetic density is expected to more than double within the next forty years.

Map 7.1 shows that there are many areas on the continent with far more than average density, indicating that the population of Africa is not evenly distributed. The map shows notable regional and territorial variations in population distribution on the continent with pockets of high population densities in areas such as the the Gulf of Guinea coast, the coastal areas of the Indian Ocean and the Mediterranean Sea and around the Great Lakes Region - Lake Victoria, Lake Tanganyika and Lake Chad.

In terms of subregions, the highest densities are recorded for Eastern Africa (51 per sq km), followed by Western 49, Northern 25, Southern 22 and Middle Africa with 19 persons per sq km.

High density countries include Mauritius - 632 persons per sq km, Rwanda - 380, Burundi - 290, Seychelles - 185, Sao Tome and Principe - 169, Nigeria - 168, the Gambia - 151, Uganda - 136, Cape Verde - 125 and Togo - 119. In almost every country on the continent, variations in subnational population densities exist, with greater population concentrations in more developed regions and districts such as capital cities, coastal areas and ecologically favourable zones. In landlocked countries like Uganda, Botswana, Swaziland and Burkina Faso, the population is concentrated in and around the capital cities and major towns. The coastal zones in countries such as South Africa, Algeria, Morocco and Nigeria are witnessing rapid population increase. Also, the country reports provide some interesting variation in the patterns of population distribution in Africa. For example, the population of Ethiopia is increasingly concentrating in the highlands as, “nearly half of the population lives at altitudes of 2200 meters and more above sea level” (Ethiopia Country Report). This is in sharp contrast to Lesotho where the “population is shifting from high lands to low lands” with almost two-thirds of the population now residing in the lowlands” (Lesotho Country Report).

Another interesting phenomenon is the very high population densities in the capital cities, as exemplified by Mozambique with a population density of 25 inhabitants per km<sup>2</sup> for the country as a whole, and 3,663 inhabitants per km<sup>2</sup> for Maputo city; Ethiopia with an overall population density of 68 persons per km<sup>2</sup> and 5,609 persons for the whole country and for Addis Ababa, respectively; and Sierra Leone with national density of 69 persons per km<sup>2</sup> compared to 9,426 per km<sup>2</sup> for Freetown.

This variation in the population distribution patterns is due to differences in economic and social opportunities, including modes of production and environmental conditions within ecological zones. In Ethiopia for instance, tarred roads, water projects, electricity and social services are relatively concentrated in the highlands but in the case of Lesotho, these facilities are concentrated in the lowlands. In almost all the African countries, the national capitals have more functional social and economic amenities than other areas.

Indeed, all countries considered population distribution, internal migration and urbanization as priority areas of concern. In addition to rapid urbanization, high population density and rural exodus were major challenges faced by most countries. Indeed, countries considered rapid urbanization (33), population density (28) and rural exodus (27) as priority areas of concern; fewer countries were concerned about low densities in parts of the country.

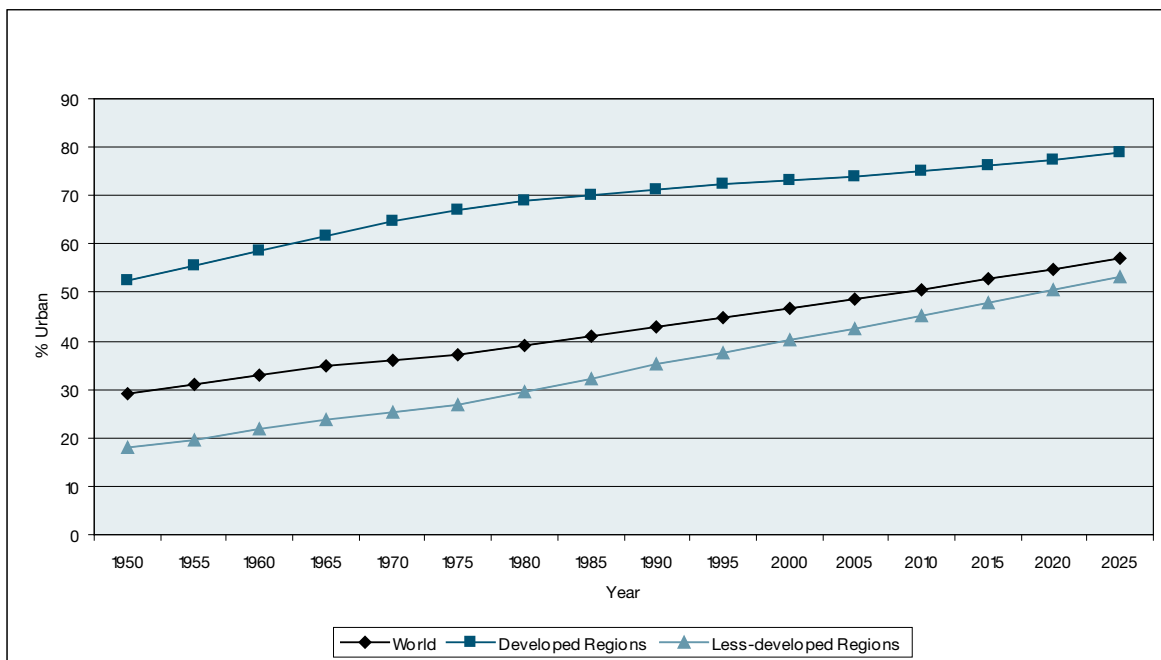
Although the average population density is not a sensitive indicator of the relationship between population and natural resources for survival, it is indicative of the possible extent of pressure on the environment. The consequence is that in some of these countries, the pressure is already being felt negatively in the agricultural sector, particularly in disputes over grazing and crop lands, reduced fallow period, overgrazing, desertification, soil erosion and general degradation of the ecological environment. The Uganda ICPD at 15 Country Report explains that “population distribution is a key factor in development as it often involves matching of people with available resources. People tend to concentrate in areas with reasonable resources and opportunities, and flee from areas of hardship and scarcity”.

## 7.4 Urbanization

Research has revealed that the 21<sup>st</sup> century will be marked by the growth of cities worldwide and urbanization will be a dominant influence on social and economic development.

By 2008, more than half of the world's population lived in towns and cities. This population is expected to reach 4.9 billion by 2030. Figure 7.2 shows that about 50 per cent of the world's population lived in urban areas in 2007; this will increase to 60.8% in 2030.

**Figure 7.2 World Urbanization Trends, 1960-2030**



*Source:* UNFPA, State of World Population 2007; United Nations, World Urbanization Prospects, 2003, Revision, Table II.5

The State of World Population 2007 report (UNFPA, 2007) indicates that this trend will be particularly notable in Africa and Asia. It is projected that from 2000 to 2030, Africa's urban population will grow from 294 million to 742 million persons. As shown in table 7.2, Africa had an urbanization level of 39 per cent in 2005 and is expected to sustain the highest rate of urban growth in the world at 3.2 per cent.

**Table 7.2 Demographic Indicators of Urbanization, World and Major Regions**

	Total Population (in Millions) (millions, 2007)	% Urban 2007	Urban growth rate (%, 2005-2010)
World	6,615.90	50.0	2.0
Developed Regions	1,217.50	75.0	0.5
LDCs	5,398.40	44.0	2.5
Africa	945.30	39.0	3.2
Asia	3,995.70	41.0	2.4
Arab States	335.00	56.0	2.8
Europe	727.70	72.0	0.1
Latin America/Caribbean	576.50	78.0	1.7
Northern America	336.80	81.0	1.3
Oceania	33.90	71.0	1.3
Russian Federation	141.90	73.0	-0.6

Source: UNFPA, State of World Population, 2007, New York.

It is expected that during the period 2005-2010, high urban growth rates will be recorded for countries such as Burundi (6.8%), Liberia (5.7%), Eritrea (5.4%), Malawi (5.2%), DRC (5.1) and Burkina Faso (5.0%). Also, during the same period, quite a number of African countries, including Ethiopia, Kenya, Mozambique, Rwanda, Somalia, Uganda, the United Republic of Tanzania, Angola, Chad, the Sudan, Benin, Mali, Niger and Togo will have urban growth rates in excess of 4.0 per cent per annum. Apart from a few countries that will have urban growth rates below 2.0 per cent per annum, all other African countries will fall within the 2.0-3.9 per cent urban growth rate bracket. It is expected that in all countries, the annual growth rate of the urban population will be much higher than the total population.

It is important to point out that the size and growth of urban areas is not uniform in each country. This is particularly evident in highly populated countries like Egypt, Ethiopia, the the Sudan, Nigeria, Morocco, Republic of South Africa, the United Republic of Tanzania, Lesotho and Kenya. In South Africa, for example, the size and level of urbanization varies considerably by province. The apex of the urban scene is the large metropolitan areas comprising Pretoria, Johannesburg and Vereeniging. Next come the two metropolitan areas of Durban and Cape Town. In Lesotho, lowland urban centres, particularly those where textile factories are located, are growing faster than highland urban centres.

The UNFPA State of World Population 2007 Report indicates that out of 15 countries with over half of the urban population below the poverty line, eight; namely Angola, Chad, Madagascar, Malawi, Mozambique, Niger, Sierra Leone and Zambia are in Africa. The report emphasized that many other countries would be included if their poverty lines made allowance for the real costs of non-food necessities in urban areas.

Rapidly growing urban centres in sub-Saharan Africa have 72 per cent of the urban population living in slum conditions with access to poor amenities and services. In sub-Saharan Africa, rural

population is worse off for reproductive health services than the urban population. However, in urban areas, poor urbanites, especially slum dwellers, are exposed to higher levels of reproductive health risks than other urban women. Higher skilled attendance at birth and improved access to emergency obstetric care explain why maternal mortality is generally lower in urban areas. However, poor urban women are less likely to deliver with a skilled birth attendant. The UNFPA State of World Population 2007 Report points out that, only 10 to 20 per cent of women deliver with skilled health personnel in the slums of Kenya, Mali, Rwanda and Uganda, compared to between 68 and 86 per cent in non-slum urban areas. In urban settings, the risk and prevalence of HIV/AIDS is higher than in surrounding rural areas. It is reported that 25 per cent of the total HIV epidemic in East and Southern Africa is concentrated in 14 major metropolitan areas with more than one million inhabitants each. In West and Central Africa, 25 major cities account for 20 to 25 per cent of the epidemic in this subregion.

Rapid urbanization in Africa offers both challenges and opportunities for socio-cultural change and development. Furthermore, continuous interaction of urbanites with rural dwellers could contribute to a diffusion of social change agents across the continent. However, marginalization, accompanied by crises of identity and feelings of frustration, especially among the poor, has fuelled violence and insecurity in Africa's urban areas. This is especially so in cities like Lagos, Nairobi, Johannesburg and Pretoria, where individual, community and national safety has become a major concern.

Although urbanization has a multiplier effect on women's socio-economic status, they are more likely to find employment in the informal sector in Africa. While urban women may enjoy freedoms to a certain extent, they are also likely to be affected by various forms of gender-based violence in the home and on the streets of big towns. In slum areas, they are less likely to obtain good-quality services and will be overburdened by chores. Published sources cited by the UNFPA State of the World Population 2007 Report indicate that partial time-use study covering 10 sites in East Africa found that the waiting time for water increased from 28 minutes a day in 1967 to 92 minutes in 1997. The report further indicates that the physical and time burdens come not so much from long distances from the source of supply, but from the large numbers who have to use the same source. Most often, the physical burden and time loss caused by these chores are borne predominantly by women and girls.

Urbanization increases girls' access to education and promotes cultural acceptance of their right to education. However in Africa, they are often taken out of school to help with household work or be married off. In sub-Saharan African countries like Benin, Côte d'Ivoire, Guinea and Mali, only half the school-age girls are registered in urban schools. In most others, between 20 and 30 per cent of girls in slums are out of school.

The demographic profile of cities in Africa is characterized by a marked youth budge, which is particularly large in slum populations. This demographic scenario has wider implications for the urban sector to provide the lead in the development of the country. It is expected that urban areas in Africa will first experience the demographic transition before the rural areas, and will thus be better placed to take advantage of the ensuing demographic bonus, if appropriate investment is made in urban youth education and empowerment.



Rapid urban growth, combined with the impact of climate variability and change, is predicted to have severe consequences on environmental health in the tropics, affecting urban livelihoods in Africa. Sources cited by the UNFPA State of World Population 2007 Report points to the alarming prospects of rise in sea levels caused by climate change and its potential consequences for coastal urban areas. The report indicates that Africa is one of the continents with larger proportions of their urban populations in coastal zones, reflecting its colonial heritage. Twelve per cent of the urban population on the continent live in the low elevation coastal zones (LECZ) that are most likely to be affected by rising sea levels.

Although urban centres are notorious for acute poverty, slum growth and a considerable measure of social disruption, the process of urbanization in Africa is inevitable and totally irreversible. Also, African urban centres will continue to be predominantly composed of small towns and will continue to be centres of nearly all major economic, social, demographic and environmental transformations. They will therefore have a tremendous influence on economic growth and sustainable development, poverty reduction and population stabilization. More importantly, they will continue to be composed largely of poor people. Indeed, as population structures change, the needs of young people, especially, will increasingly have to be addressed.

The ICPD at 15 Country Reports show that African countries are concerned about rapid urbanization because of its association with several issues such as, sprawling slums, urban poverty, crime and increasing use of drugs, high pressure on social services and infrastructure, particularly health, housing, education and transportation, and high urban unemployment. The Uganda ICPD at 15 Country Report summarizes this disposition in the following way:

“A serious problem arising out of this urbanization trend is that the resultant increase in the urban population is not matched with growth and development in basic physical infrastructure in the urban areas such as housing, social amenities, management and other skills development. This gap has led to social evils like overcrowding, spread of squatter settlements, dilapidated housing, poor sanitation, urban unemployment, increased pressure on existing social services and general poor urban management”.

However, policy makers have often neglected the crux of the challenge by neglecting the needs of the urban poor and by discouraging internal migration. Neglecting the poor has only resulted in the growth of slums and exacerbated urban squalor. In the case of migration, compelling evidence indicates that urban growth is mostly the result of natural increase rather than migration. Attempts to control rural-urban migration infringe on individual rights and hold back overall development. They are difficult to enforce and usually ineffective and have never worked.

## **7.5 Internal migration**

Internal migration is a major force in the distribution and re-distribution of population in Africa, and an important factor in the increasing urbanization on the continent. However, available evidence continues to suggest that natural increase, rather than net migration, is a major factor in accelerated urbanization in many countries. This emerging trend is confirmed in Ghana and South Africa. The Ghana Country report indicates that based on the results of the 2000 Population and

Housing Census, the contribution of migration to urbanization during the period 1960 -1970 was 54.5 per cent, declining to 25 per cent from 1970 to 1984, and increasing slightly during the period 1984-2000 to 37.4 per cent. South Africa's report shows that while rural to urban migration is, and will continue to be, a strong driver of urbanization, it is natural increase rather than migration that is the major source of urban population growth in the country.

National reports from other countries, on the other hand, show the predominance of rural-urban migration in the dynamics of urbanization on the continent. In Namibia for example, the rapid rate of urban population growth is attributed largely to waves of migration from rural to urban areas, following independence, and which is still being sustained by the lure of urban employment and modern city life by rural residents. In the United Republic of Tanzania also, the population growth rates in urban areas are reported to be more than double that of the rural areas because of rural – urban migration. In Mozambique, Government has expressed concern about the “rural exodus”, a phenomenon which jeopardizes the future of the rural economy. The report noted that: “one of the most preoccupying aspects of the rural exodus is the ‘flight’ of the few professionals and youths with labour skills that are in high demand in their places of origin”. Also, in Lesotho, while internal migration has shifted from the highlands districts to the lowlands districts, the major recipients are Maseru and Leribe urban areas.

In general, the dominant pattern of internal migration in African countries is from rural to urban areas, particularly, the capital cities and large urban commercial and industrial centres. Urban-to-urban population movements are also noticeable in parts of Africa. In the Sudan, the dominant pattern of movement (1993) was from urban to urban areas (37.5 % of total movers); followed by 30.5 per cent who moved from rural to urban areas, although there was also significant movement from rural to rural areas. While rural-urban migration has been dominant in Malawi, the elevation of Mzuzu Municipality to city status increased urban to urban movements.

In Uganda, while rural-urban migration is predominant, social strife, especially in the Northern region, and to a lesser extent, the Eastern region, has forced people from villages to internally displaced people's camps, which were mainly located in urban areas, while other people fled farther afield to neighbouring districts, especially the urban areas. In the West African Sahel region, recurring droughts exacerbate vulnerability and conflicts are a constant threat to the livelihoods of the people.

Rapid urbanization also indicates that rural areas are losing human capital and resources to urban centers. In such a case, rural development becomes a real challenge as does the supply of labour for agriculture and food production for most African countries. In fact many countries are experiencing an “internal brain drain”, especially from the rural areas, as indicated by the Mozambique ICPD at 15 Country Report.

## **7.6 Actions taken by Governments**

Although most of the countries reported that they do not have specific policies regarding population distribution, urbanization and internal migration, they took a wide range of actions to address many of the challenges relating to these issues. These actions include establishing the National

Policy Framework for Regional Development, and Urban Development Policy Strategy, mobilizing international resources for the development of urban infrastructure, inducing agricultural productivity and raising income of farmers, and training in non-farm jobs, as a policy measure to retain rural labour. Decentralizing administrative systems and allocating resources to subregional levels were highly favoured strategies for addressing population distribution concerns.

Most of the countries were taking steps to promote rural development as part of the overall national strategy of addressing population distribution concerns. Again, decentralization of administrative systems was favoured by over 90 per cent of the countries. Other highly favoured actions include ensuring access to credit facilities, resource allocation to subnational level institutions and establishing income-generating projects in rural areas.

Specifically, the Government of Malawi has taken some measures to address the issue of rural-urban migration through the Malawi Growth Development Strategy (MGDs) by promoting decentralization and democratization. Some of the strategies include, labour intensive projects, training in non-farm jobs, improvement of rural transport and communication systems and social services; decentralization of administrative systems and establishment of income-generating projects; and improved access to land and land tenure, water, credit facilities and policies.

The most commonly cited cause of internal migration in Seychelles, especially to Mahé, is housing. In order to address this situation, Government initiated the Ile Perseverance Housing Project.

No country in Africa was adopting a policy to maintain the current levels of migration into cities. Rather the overwhelming focus of the countries was to implement decentralisation and other development strategies that would ensure that people are retained in rural areas. For instance, to curb the rural exodus to neighbouring countries and to urban centres, in September 2007, the Government of Mozambique adopted a Rural Development Strategy (EDR), based on administrative decentralization and allocation of resources to the subregional levels, including the promotion and expansion of self-employment, job opportunities and economic activities in rural areas (Ministry of Planning and Development, 2007).

In Ghana, the Ministry of Local Government and Rural Development and the District/Municipal and Metropolitan Assemblies play a role in ensuring effective rural development, as a way of slowing down rural-urban migration. To this end, rural development and poverty reduction funds were set up, as were other donor-supported initiatives. In Ethiopia, in order to retain the rural labour force in productive employment, the Government initiated various activities to encourage agricultural productivity and raise farmer incomes.

For countries without any policies or measures to address population distribution concerns, the commonly cited reasons include limited human and financial resources, the fact that population distribution is not on the priority list and the fear of civil disturbance. In these countries there is therefore a lack of political commitment to address population distribution concerns.

## 7.7 Achieving the MDGs

The UNFPA State of the World Population 2007 Report notes that the battle to reach the Millennium Development Goal of halving extreme poverty by 2015 will be waged in the world's slums. The report indicates that cities have the potential to reduce poverty but this potential is often neglected to the detriment of the urban dwellers and the development of the country. It is in this respect that African countries should reconsider urban management and development strategies in the light of compelling evidence pointing at the positive role urbanization can play in social and economic development. As the main hubs of economic growth in most countries accounting for a disproportionately high share of national population and economic production, cities have greater potential than rural areas for reducing poverty. To meet the needs of growing urban populations, governments could promote urban and rural development, thereby contributing to the achievement of the Millennium Development Goals (MDGs).

The **MDG 7-Target 4**: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers is not applicable to any country because no country on the continent has at least 100 million slum dwellers. However, efforts are being made to address the needs of slum dwellers in most African countries. For instance, according to South Africa's MDGs Monitoring Report (2005), the percentage of urban slum households declined from 32 per cent in 1996 to 28 per cent in 2001 while the percentage of the urban population living in slums declined from 27 per cent to 25 per cent.



# Section 8

## 8. International Migration

### 8.1 Introduction

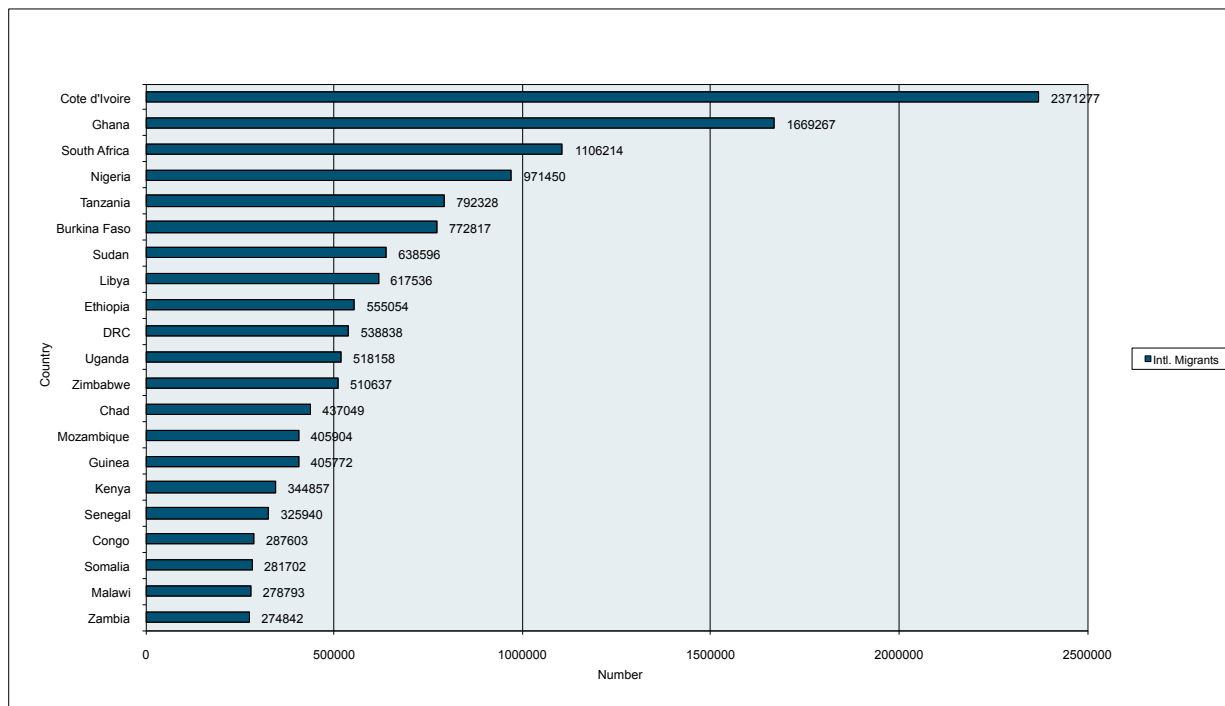
The ICPD PoA recognizes the importance of International Migration in development and hence calls on governments in receiving and sending countries to take actions relating to documented and undocumented migrants, refugees, asylum-seekers and internationally displaced persons. Respect for the human rights of migrants and their families received special emphases in the PoA. Governments are urged to introduce effective sanctions against those who organize and exploit undocumented migration and those who engage in human trafficking.

International migration is not one of the specified goals of the Millennium Declaration. However, it is widely acknowledged that every MDG has some linkage, direct or indirect with migration. Indeed, after analyzing the relationship between MDGs and international migration, UNFPA (2006) reached the conclusion that international migration facilitates and constrains the realization of the Millennium Development Goals. Since there are no relevant MDG targets to monitor, this chapter will not discuss MDGs in relation to international migration.

### 8.2 Status and patterns of international migration

For the purpose of this review, data on international migration were compiled from national reports and responses to a core questionnaire received from countries as part of the ICPD at 15 Africa regional review process. In Africa as a whole, international migration grew from about 16.5 million in 2000 to about 17 million in 2005 - half-million increase in 5 years. With an annual exponential growth rate of 0.7 per cent, international migration in Africa in 2009 is estimated at around 22.6 million. The status and trends of international migration significantly vary from country to country. Countries with the highest stock (274,000 or more international migrants in 2005) are shown in figure 8.1 below. These 21 countries together host 82.6 per cent of the total stock of international migrants on the continent.

**Figure 8.1 Countries with 274,000 or more international migrants in 2005**



The great majority of international migrants are from neighbouring countries. International migrants in Cote d’Ivoire, for example, are mostly from Burkina Faso, Mali, Liberia and other neighbouring countries. Immigration to Uganda is predominantly from neighbouring countries: The Sudan, DRC, Rwanda, Kenya, the United Republic of Tanzania and Burundi (See table 8.1). Most migrants to the Republic of South Africa are also from neighbouring countries.

**Table 8.1 Distribution of Recent Immigrants by Sex and Country of Origin(%): Uganda, 2008**

Country of origin	Per cent share of immigrants		
	Male	Female	Total
Sudan	39.3	37.4	38.3
DR Congo	18.5	21.5	20.1
Rwanda	16.5	16.3	16.4
Kenya	8.5	10.9	9.7
Tanzania	6.8	6.6	6.7
Burundi	5.0	3.5	4.2
Other African countries	1.0	0.8	0.9
Rest of the World	4.7	2.9	3.8
Total	100	100	100

Source: Uganda Country Report



The international migration patterns are linked to engagement in a wide range of economic and other activities. Malawi, for example, reports a “total of 416 foreign professionals working in Malawi during the 2000-2002 period (Ministry of Labour and Social Development, 2005). Most of the labour immigrants were managers, followed by religious establishment workers. Some Malawians have come home fleeing xenophobic attacks in South Africa.” (Malawi Country Report).

Neighbouring countries provide labour to work in some important sectors such as agriculture, mining and construction. Historically, the mining sector in South Africa, Botswana and the United Republic of Tanzania, is known for attracting labour from Mozambique, Malawi, Lesotho, Zambia and Zimbabwe. However, these countries reported a decline in the trend of migration to the mining sector. Lesotho, Malawi and Mozambique reported a decline in the migration of their nationals for work in the mines in South Africa for several reasons. Among the reasons for the decline are:

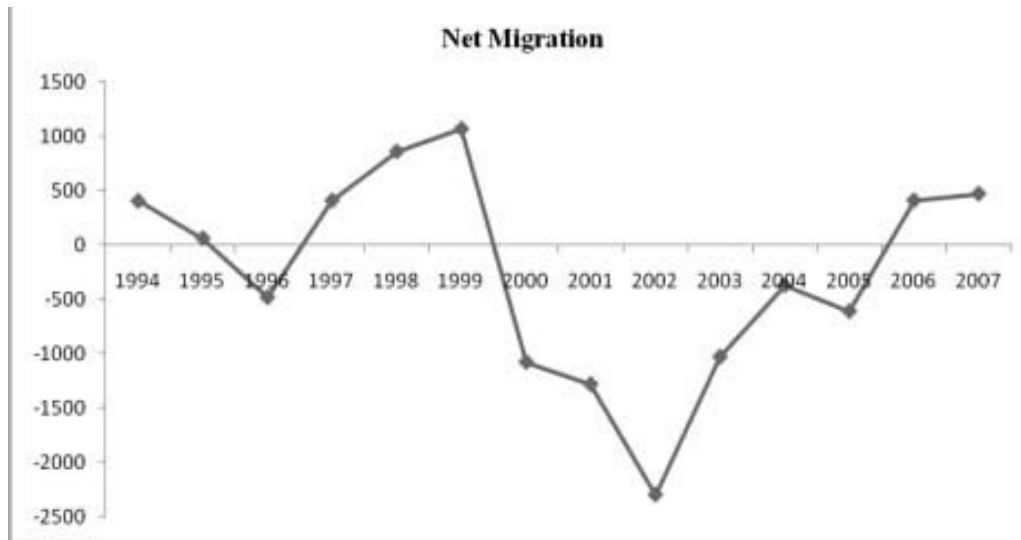
- a. New immigration laws in South Africa which set quotas for the number of foreign workers which each company may employ, in an attempt to promote employment for South African workers;
- b. Shutting down of some gold mines whose reserves have been exhausted;
- c. Aging of the mining labour force; and
- d. High mortality rates as a result of HIV/AIDS and other causes.

Development in Africa is increasingly attracting labour from other continents, particularly Asia. Labour from India, China and the Philippines are increasingly engaged in the mining, energy and construction sectors. In the Sudan, for example, residency permits to foreigners continued to rise steadily from 31,686 in 2000 to 53,449 in 2007. In the first half of 2008, about 8,298 visas were issued for work in the Sudan. The majority (4,028 or 48.5%) of these visas were issued for professional and highly skilled positions such as engineers (Sudan Country Report).

There were 8,000 foreign workers in Seychelles at the beginning of 2008. Seychelles gives expatriate workers short as well as long-term permits and employment contracts. The short-term contract is usually in the professional and construction areas. In the last five years (2003-2008), investment in tourism development has escalated into the construction of numerous five star hotels, with an influx of construction workers from Asian countries, to make up for the lack of local construction workers (Seychelles Country Report).

Figure 8.2 shows that from 2000, until recently, international migration in the Seychelles has been characterized mainly by net out-migration, which has the tendency to keep the rate of population growth very low.

**Figure 8.2 Net Migration in Seychelles: 1994-2007**



### 8.3 Emigration from Africa: 'Brain Drain'

The great majority of countries reported concern on the brain drain and its impacts on development. Most countries report particularly the migration of talented and skilled Africans to Europe, USA, Australia, and the Gulf States, as a drain to the scarce human resources. The brain drain is reported to impact directly on specific sectors such as health and education.

Malawi, for example, has experienced emigration of its professionals and skills to other countries in Southern Africa and to developed countries (UK, USA and Australia). Between 2000 and 2005 alone, over 300 nurses migrated to Europe. As a result of introducing incentives and localization policies, the number of professionals in the health sector migrating abroad has considerably reduced. The incentives include improvements in the general working conditions of health workers (Source: Malawi Country Report).

Emigration tended to be underestimated. From 1989 to 1997, about 233,000 South Africans emigrated to the UK, USA, Canada, Australia and New Zealand. Official statistics revealed that 82,811 people had left during this period. According to the OECD (2006), 47.9 per cent of the 342,947 migrants who lived in OECD countries were highly skilled. Their migration thus left serious social, economic and political consequences in its wake.

The South Africa report indicates that there will continue to be a shortage of skilled workers as well as an oversupply of unskilled labour, which will continue to affect the South African economy and impact on the country's global competitiveness.

### 8.4 Return migration

Return migration is a pattern that is gaining momentum in many countries in Africa. Africa is

experiencing two main patterns of return migration: return of refugees to their home countries resulting primarily from end of conflict, and return of skilled and professional migrants from outside the continent, a trend that is emerging with the financial crisis that has engulfed the economies of receiving countries. Some countries document an increasing trend of return of their nationals living abroad. Indeed, Ghanaians, Nigerians, Sudanese and other Africans who worked abroad for years are now returning home.

Return migration is partly due to deliberate government policies to encourage their nationals abroad to return and invest in their home countries. Such policies include incentive packages of exemptions from customs and land for housing, connecting professional and skilled migrants to relevant institutions at home, etc. In some countries, specific action was taken to amend legislation and design and implement programmes to ensure that returning migrants are integrated into the receiving communities. The following provides excerpts from the country reports on actions taken by some governments:

### *Ethiopia*

The Government has taken certain measures to link up international migrants with higher education institutions to enable them to transfer knowledge and skills. Various incentives were given to return-migrants to invest in the country; returnees are allowed to bring personal effects without paying taxes and thousands have benefited from the scheme. The Diaspora communities are encouraged and provided with information and support to be involved in investment activities (Source: Ethiopia Country Report).

### *Lesotho*

Brain drain, particularly of health professionals, has become a serious problem. This is even more problematic given that Lesotho has the third highest HIV prevalence in the world. The government is committed to creating conducive working conditions in order to attract Basotho working outside Lesotho to come back home. Nurses, in particular, are being encouraged to return home, owing to the shortage of health professionals - a situation aggravated by the high prevalence of HIV and AIDS in Lesotho (Source: Lesotho Country Report).

### *Malawi*

Emigration of various professionals to other countries creates a shortage of skilled and experienced human resources required in various sectors of the Malawi economy. To address the problem, the Malawi government has taken a number of measures aimed at improving the working conditions in the country to make them competitive and attractive. From the mid 2000s, the government has implemented sound economic and investment policies, which have improved the performance of the economy and boosted investment by local and foreign investors. Actions have also been taken to curb the emigration of professionals in specific sectors. For example, in the health sector, the Malawi government, in collaboration with DFID has introduced some incentives to encourage health workers to remain in the country (Source: Malawi Country Report).

## 8.5 Undocumented Migration

Several countries referred to undocumented migration as a major problem, though statistics on this pattern of international migration are scanty. Also, there is paucity of policy research on this pattern of migration mainly because of lack of resources.

Generally, undocumented migration is high in the Southern, West and North Africa regions. Countries that host large numbers of undocumented migrants are the Republic of South Africa, Botswana, Morocco, Senegal, Libya and the Sudan. Although the abolition of visas came into effect in 2005 under the SADC protocol establishing free trade based on free circulation of goods and people, countries in the Southern Africa region reported an increasing trend of undocumented migrants in their countries. The great majority of undocumented migrants in the Republic of South Africa are from Mozambique and Zimbabwe. The remaining few are from countries as far as Ethiopia, Nigeria and Somalia.

The presence of undocumented Mozambican and Zimbabwean immigrants in South Africa, as well as those from other countries in the region, has caused concerns in South Africa and it has lately had a xenophobic effect. An increasing number of South Africans consider immigrants from other parts of Africa as a threat to their future economic well-being and as being responsible for the increase in violent crimes in South Africa especially in 2008.

Some governments provide good lessons of experience for addressing the issue of undocumented migration. The United Republic of Tanzania and Ethiopia, for example, are addressing the problem by providing relevant information on the related risks, and building capacities in the area of migration management.

Regarding ratification and Implementation of Conventions and Protocols on the Rights of All Migrant Workers and Members of their Families, 16 out of 40 countries have ratified, while 11 of them are already implementing. Out of the 40 responding countries, 19 indicated that they have ratified and 14 of them are implementing the Convention against Trans-national Organized Crime and its supplementary protocols (the Protocol against the Smuggling of Migrants by Land, Sea and Air and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. The countries reported that they have adopted measures aimed at addressing the challenges of international migration. Such measures include formulation or review of policies, institutional re-structuring; development of appropriate programmes; advocacy and partnerships.

# Section 9

## 9. Crisis Situation and Emergency Preparedness

### 9.1 Introduction

The ICPD POA called on all Governments to adopt collective measures to alleviate the suffering of children in armed conflicts and other disasters, and provide assistance for the rehabilitation of children who become victims of those conflicts and disasters. It further requires countries to: (a) offer adequate protection and assistance to persons displaced within their country, particularly women, children and the elderly, who are the most vulnerable, and to find solutions to the root causes of their displacement in view of preventing it and, when appropriate, to facilitate return or resettlement; and (b) put an end to all forms of forced migration, including 'ethnic cleansing'. Specifically relating to refugees, asylum-seekers and displaced persons, the ICPD PoA calls on countries to: (a) reduce pressures leading to refugee movements and displacement by combating their root causes at all levels and undertaking related preventive action; (b) find and implement durable solutions to the plight of refugees and displaced persons; (c) ensure effective protection of and assistance to refugee populations, with particular attention to the needs and physical security of refugee women and refugee children; (d) prevent the erosion of the institution of asylum; and (e) provide adequate health, education and social services for refugees and displaced persons.

The programme of action calls on all countries to take actions to; address the causes of conflicts and displacement; establish the necessary mechanisms to protect and assist refugees and internally displaced persons; institute measures to provide services for internally displaced persons and refugees, including basic health-care, reproductive health services and family planning; and make efforts in line with existing conventions and charters to find lasting solutions to problems related to refugees and internally displaced persons.

Although there is no Millennium Development Goal or target on conflicts or crisis situations, the fact that the Millennium Declaration emphasizes peace, harmony and fulfilment of human rights as a precondition for sustainable development makes resolution of conflicts and emergency preparedness and interventions fundamental bedrocks for achieving the MDGs. Indeed, at the Millennium Summit, the

General Assembly resolved to put in place measures aimed at attaining peace, security and development in the world.

## 9.2 Crisis situations in African countries

The Country Reports indicated that natural and man-made disasters have affected almost all the countries in Africa. While natural disasters, which emanate from environmental catastrophes, are the most frequent crisis experienced by the countries, a very significant number of countries have experienced internal and external conflicts.

The WHO health action in crisis website, accessed on Friday, 3 June 2009, provided a list of countries which were judged to be currently experiencing a crisis or have experienced one within the past year. Out of the 32 countries on the list, 47 per cent are in Africa. The website maintains that in the Horn of Africa, persistent drought, compounded by soaring food and fuel prices, general poverty and intermittent conflict in some areas, are having a serious impact on food security, water availability and nutrition. In line with these assertions, the ICPD at 15 Country Report for Ethiopia maintains that environmental degradation, including deforestation, continues to expose farm and grazing lands to massive erosion; and that the occurrences of cyclical drought and flooding have caused displacement of a sizeable population people in different regions of the country.

(<http://www.who.int/hac/crises/international/hoafrika/en/index.html>)

With respect to the Great Lakes Region, information on the website indicates that over six million people are displaced within their national borders or as refugees in neighbouring countries. The situation has exacerbated poverty and eroded livelihoods and left many people, especially women and children, vulnerable to disease, human rights violations, and high-risk occupations. The situation of women and girls is especially appalling because their rights are systematically violated through rape, abduction, forced prostitution and coercive conscription. In the Sahel, prolonged drought attributable to climate change, is a major cause of desertification, loss of farm lands and poor yields. This, in an area dotted by conflicts, is a major contributing factor to food insecurity and persistent poverty. For Southern Africa, heavy rains in 2007/2008 caused flooding in Zambia, Zimbabwe and Mozambique. As a result, nearly 90,000 people were affected by floods, including some 72,000 in Mozambique, 8,000 in Zimbabwe and about a thousand in Zambia.

According to the ICPD at 15 country reports, a number of natural disasters, including floods and drought have affected large communities in Malawi. In Lesotho, the government has declared a drought crisis situation because of the critical food shortages caused by the phenomenon since 2002. Also, snow and strong windstorms affecting parts of the country have destroyed lives and livelihoods. Earthquakes, storms and floods are major causes of natural disasters in Mozambique often leading to loss of lives and destroying social infrastructure and private property. Cyclones are also a major cause of environmental disasters in Mauritius.

Concerning conflicts on the continent, the International Crisis Group website gives a synopsis of the various conflicts that have occurred in Africa. It points out that in West Africa a “regional civil war” in the Mano River Basin, caused by weak States and economic collapse and fuelled by regional war lords and mercenaries, engulfed Liberia, Sierra Leone, Cote d’Ivoire and Guinea in the 1990s.

As a result, these countries continue to face enormous challenges in reconstructing their economies and institutions, and rebuilding societies ravaged by a decade of civil violence. The International Crisis Group also maintains that in Guinea, strikes by public workers, unrest in the security sector and significant governance failures were forerunners to a military coup in late 2008 that has ushered in a new period of political uncertainty. Other flash points in the region include Nigeria where despite 10 years of civilian rule, the country is still beset with problems of localized and short-lived but vicious communal fighting and the persistent problem in the Niger Delta. The assassination of the head of the military followed by the brutal killing of the Head of State in Guinea-Bissau were attributable to decades of economic and institutional decay, weakening of State machinery, and use of the country as a transit point for drug trafficking. For the Horn of Africa, the International Crisis Group reports protracted crises in the Sudan and Somalia, internal and cross-border dynamics in Ethiopia and Eritrea, and the situation in Kenya following the eruption of political violence in December 2007. Although the conflicts in Burundi and Rwanda have died down, Central Africa is still described as unstable, with numerous violent wars raging in the DRC, Uganda, the CAR and Chad. The Darfur crisis in the Sudan has displaced an estimated two million people and there are about 200,000 Chadian refugees sheltering in the west of Sudan.

In Nigeria, ethnic and religious conflicts, drought in the Northern part of the country, and floods in various regions resulted in population displacements. Largely as a result of the environmental conditions, Namibia is highly susceptible to different forms of natural disasters, including droughts, bush fires and floods in some regions. South Africa faces increasing levels of disaster risk including a wide range of weather hazards such as drought, cyclones and severe storms. Floods and droughts in different ecological zones and waves of earthquakes in Uganda are the major natural disasters that constantly occur in the country.

Armed conflicts and political instability were cited as major causes of population displacements and humanitarian crises in Sierra Leone, CAR, DRC, South Sudan, Northern Uganda and parts of Nigeria. In DRC, more than three million people have been displaced, with women and children subjected to rape, abduction and forced labour.

According to the Commission on Africa Report, the continent has by far the highest level of forced displacement in the world, consisting of 13 million internally displaced persons (IDPs) and 3.5 million refugees, more than twice the absolute number in Asia. In addition to natural disasters and environmental problems, armed conflicts and forced resettlements were cited as responsible for internal displacement. The lack of economic and social opportunities was cited by more responding countries (42 %) than any other factor as the most pervasive cause of internal displacement.

UNHCR (2009) estimates that Africa (excluding North Africa) was host to 20 per cent of the world's refugee population in 2008. The region has experienced a decline in the number of refugees for the eighth consecutive year, such that by the end of 2008, there were 2.1 million refugees compared to more than 3.4 million in 2000. From the beginning to the end of 2008, there was a 7 per cent decrease in the refugee population due primarily to successful voluntary repatriation operations to Burundi, South Sudan, the Democratic Republic of the Congo and Angola. However, there were renewed armed conflicts and volatile situations in the Central African Republic, Chad, the Democratic Republic of Congo, Somalia and the Sudan which led to refugee outflows of almost 210,000



people, primarily to Kenya, Uganda, Cameroon and Chad. With more than 3,300,000 refugees, Chad was ranked the major refugee hosting country in Africa and sixth in the world at the end of 2008.

According to the UNHCR global report, all 25 countries with the highest number of refugees per 1USD GDP per capita are developing countries, including 15 Least Developed Countries. While the first on the list was Pakistan with 733 refugees per 1 USD GDP (PPP) per capita, African countries constituted 6 out of the ten countries with the highest refugees per GDP. The countries included, the Democratic Republic of Congo (with 496 refugees per 1 USD GDP (PPP) per capita); the United Republic of Tanzania (262); Chad (230); Kenya, (211); Uganda (144); and, Ethiopia (98). The relative impact of hosting refugees in these countries becomes evident when compared with the first developed country on the list - Germany at 26th place with 16 refugees per 1USD GDP (PPP) per capita.

The ICPD at 15 country reports indicate that, the factors that are responsible for refugee movements are manmade. Armed conflicts, followed by political instability and economic problems were the main drivers of refugee outflows in Africa. This points overwhelmingly to poor governance and failed development policies and strategies than to environmental factors as the major cause of the refugee problem on the continent.

### **9.3 Actions taken**

The country reports indicated that governments in Africa have formulated policies and promulgated legislations aimed at facilitating the management of crisis and disasters on the continent. Tanzania, Lesotho and Uganda have formulated national disaster management policies and plans as frameworks for disaster mitigation and preparedness. Specific environmental policies were reported to be in place in Ethiopia and Namibia for addressing environmental concerns and facilitating the management of natural resources. In Gabon, a policy is also in place for managing and mitigating disasters relating to the exploitation of crude oil.

The Disaster Relief Coordination Act No. 9 of 1990 in the United Republic of Tanzania, the Disaster Management Act 1997 in Lesotho and the Disaster Management Act No. 57 of 2002 in South Africa are examples of legislations that have been promulgated by African governments to provide for integrated and co-ordinated disaster surveillance and management.

In order to facilitate the management of disasters in the country, the Government of South Africa promulgated the Disaster Management Act, 2002 (Act No. 57 of 2002) on 15 January 2003. The Act provides for: i) an integrated and coordinated disaster risk management policy that focuses on preventing; ii) or reducing the risk of disasters, mitigating the severity of disasters, preparedness, rapid and effective response to disasters, and post-disaster recovery; iii) the establishment of national, provincial and municipal disaster management centres; iv) disaster risk management volunteers matters relating to these issues. Since the drought of 1992/1993, the Government of Namibia has formulated national policies, plans and strategies to address disasters in the country, including: the Disaster Plan by the Emergency Management Unit in the Office of the Prime Minister; the National Drought Policy and Strategy developed by the Ministry of Agriculture, Water and Rural Develop-

ment; the Emergency Action Plan, the Environmental Impact Assessment Policy, and the Environmental Management and Assessment Bill by the Ministry of Environment and Tourism. Also, in response to the recurrent droughts and food crisis, Lesotho passed the Disaster Management Act 1997, developed the National Disaster Management Plan and the Disaster Management Manual, and established a Disaster Management Fund to push the disaster agenda forward.

As noted in the national report for the Sudan, the Darfur crisis has had a devastating impact on the people of the Sudan. The civil war has displaced about 2 million people in Darfur, with 200,000 refugees sheltering in Chad. This has caused severe hardship in the lives of several hundreds of thousands of conflict-affected people. With about 30 to 40 per cent of the affected population unable to access any form of assistance, the Government of the Sudan issued as many as 29 Presidential decrees related to humanitarian work in Darfur, which finally culminated in the establishment in 2006 of a Tripartite Joint Technical Committee (TJTC) consisting of the government, UNOCHA, and INGO, to manage the crisis.

#### **9.4 Institutional arrangements**

A wide range of institutions have been established in most countries for the coordination, management and maintenance of disaster preparedness. Examples include the National Environmental Council of Ethiopia; and, the Cyclone Emergency Organization and the Central Cyclone Committee in Mauritius. In the United Republic of Tanzania, the National Disaster Relief Committee (TANDREC), with decentralised structures even at the village level, is responsible for developing and maintaining a national disaster preparedness and management system. Similarly, the National Disaster Management Organization (NADMO) in place in Ghana, the Disaster Management Authority (DMA) in Lesotho; the National Emergency Operation Centre (CENOE) in Mozambique; the Regional Emergency Management Units (REMUs) in Namibia; and the National Emergency Management Agency (NEMA) in Nigeria have all been put in place by the respective governments to principally manage disasters and similar emergencies.

In the Sudan, a Tripartite Joint Technical Committee (TJTC) with membership drawn from the government and development partners was established in 2006 to provide policy direction for humanitarian work, especially in conflict affected regions. In Mozambique, the Government approved the establishment of the National Operative Emergency Centre (CENOE), under the leadership of the National Institute for Disaster Management (INGC), as a platform for the Management and Coordination of emergence operations. And in Nigeria, the National Emergency Management Agency (NEMA) provides relief materials and shelter to displaced persons and manages disasters as they occur.

In a number of countries, government has also facilitated the efforts of local and international NGOs in support of displaced persons and refugees. The main actions include granting special concessions and privileges and resource allocations to the NGOs.

#### **9.5 Programmes and Plans**

The country reports indicated that programmes were being implemented to manage various types

of crises and disasters on the continent. In Lesotho, components of crisis response programmes that have been implemented include an integrated disease surveillance response, management of severe malnutrition, and provision of equipment for emergency obstetric care services. In Senegal, similar activities are being implemented as part of the National Program for the Prevention and Reduction of Risks and Management of Natural Disasters which has been integrated into the national poverty reduction strategy for the period 2005 to 2010.

In Mozambique and Mauritius, programmes are in place to forecast the occurrence of cyclones and raise public awareness about natural disasters. In Namibia, the focus of the Emergency Management Unit has mainly been on the provision of relief to victims of drought during the period 1992 to 1996 and those of floods in northern Namibia in 2008. Since the occurrence of these natural disasters seem to be an annual event, the country has put in place district flood contingency plans to coordinate, monitor and evaluate disaster relief activities in flood-prone districts.

Countries have adopted various measures such as protection, public education, provision of health (including reproductive health) services, resettlement and rehabilitation to assist internally displaced persons.

In particular, South Africa has implemented programmes, with the assistance of the international community, to provide aid to thousands of people affected and displaced by the xenophobic violence. In Ghana and Senegal, efforts are being intensified in partnership with ECOWAS member states to rid the subregion of small arms. Ghana has also played a leading role in resolving conflict situations in Liberia, Sierra Leone and Cote d'Ivoire. In Nigeria, relief materials were provided to persons affected by the 2004 Yelwa crisis in Plateau State. Also in 2007, the people displaced following the ruling of the International court of Justice to cede Bakassi to Cameroon, were camped at Ikang in Cross Rivers State, where NEMA attended to their basic needs. The services provided to the displaced persons included reproductive health and family planning services.

Refugees tend to present social, economic and political challenges everywhere. It is therefore not surprising that many governments are reticent about what to do with them. Regarding refugee-specific policies in African countries, 13 out of 40 countries have no policy. The policies that exist are aimed at reducing the flow of refugees.

In the last two decades, the United Republic of Tanzania has been home to refugees mainly from the Great Lakes Region (Rwanda, Burundi and Democratic Republic of the Congo) for whom the government has provided adequate protection, basic education and training and basic health services including RH and family planning. With the support of its development partners, Ghana, Benin, Sierra Leone, Liberia and CAR established a number of refugee camps for victims of armed conflict within the West African subregion, where refugees were provided with basic services such as education and skills training. Also, reproductive health services, including family planning, HIV prevention and GBV counselling services were provided for displaced persons and refugees. In DRC, Sierra Leone, Uganda and CAR, the main focus of programmes is to provide relief for victims of armed conflict and to put in place measures to promote peace and resolve conflicts.

The UNHCR reports that during 2008, at least 839,000 individual applications for asylum or refugee status were submitted to Governments or UNHCR offices in 154 countries constituting a 28 per cent increase compared to the previous year. The two reasons advanced for this are i) the dramatic number of asylum applications in South Africa, and ii) the significantly high number of people from certain nations, in particular Afghans, Eritreans, Somalis and Zimbabweans who sought international protection during the year.

Although Europe remained the primary destination for individual asylum-seekers, Africa ranked second, with South Africa accounting for roughly one-quarter of global applications, and the main destination of new asylum-seekers worldwide.

By nationality, four countries out of the top five highest number of new individual asylum claims were from Africa; Zimbabwe, Eritrea, Somalia and the Democratic Republic of the Congo (UNHCR 2009). While nine out of 10 Zimbabwean asylum claims were lodged in South Africa alone, two-thirds of all new Eritrean asylum claims were lodged in the Sudan and Ethiopia; and almost half of all Somali requests were submitted in Ethiopia and South Africa. Also, even though asylum-seekers from the Democratic Republic of the Congo sought protection in more than 80 countries, eight out of 10 requested refugee status on the African continent, notably in South Africa and Uganda.

The pattern of responses to the question of policy on asylum seekers shows that most countries do not have policy provisions on the phenomenon. This may present a challenge in addressing the needs and human rights of asylum seekers.

## **9.6 Commitments to Continental Policies and Strategies**

The country reports show that international conventions and protocols relating to crisis, refugees and displaced persons have provided frameworks for disaster and crisis management and implementation of emergency program in collaboration with development partners. The actions taken to adapt the African Post-Conflict Resolution Policy Framework at the country level included using the framework for advocacy and raising awareness; followed by formulation of plans and programmes and building consensus and partnerships on post-conflict related matters.

## **9.7 Achievements**

The country reports indicated that most governments have put in place policies, promulgated legislations and established institutional mechanisms for the management of crisis and disasters.

Also, the reports indicated that various programmes are being implemented to manage the numerous crisis and disaster challenges faced by African governments, including natural disasters and wars and civil conflicts. It is important to note that the programme strategies as reported by Nigeria, Ghana, the United Republic of Tanzania, DRC, Benin, Sierra Leone and CAR included the provision of reproductive health services, including family planning; HIV prevention; and GBV counselling services. Early warning systems, mostly for natural disasters were in place in Ethiopia, Mozambique, Lesotho, Malawi and Namibia to facilitate a swift response to emergencies including epidemic outbreaks.

It was also revealed that partnership forums with membership drawn from stakeholders including the civil society, Non-Governmental Organizations, United Nations Agencies and Government line Ministries were in place in almost all the countries which have been very proactive in provision of humanitarian assistance, conflict resolution, and disaster mitigation. In South Africa for instance, the response by local and international organizations to the May 2008 xenophobic attacks was decisive. United Nations agencies, including OCHA, UNICEF, WHO, UNFPA and UNHCR, and the International Red Cross and Red Crescent Societies assisted through provision of tents, coordination of expertise, repatriation services and health service related assessments.

## **9.8 Challenges and Constraints**

The country reports indicate that the main challenges to humanitarian disaster management and mitigation efforts include the following:

- a. There is shortage of skilled human resources to respond to disasters in an effective and swift manner and secondly access to training in disaster management and mitigation is often limited in most countries.
- b. Rapid population growth, in Ethiopia for instance, is a key contributor to biodiversity loss and land degradation, and therefore an inherent challenge to disaster mitigation and management.
- c. The lack of adequate financial resources to address, manage and prevent crisis makes most of the countries very vulnerable and dependent on donor support for disaster mitigation.
- d. In conflict zones such as West Africa and the Great Lakes Region, the proliferation of small arms poses a threat to peace and security.
- e. Climate change predictions for Africa are such that the spectre of emergencies will be exacerbated beyond the coping capacity of most, if not all the countries, especially in sub-Saharan Africa.
- f. Weak democratic institutions and limited adherence to good governance principles continue to undermine efforts to establish peace and protect human rights on the continent.

# Section 10

## 10. Population and Development Data

### 10.1 Introduction

According to the ICPD PoA, it is important to have valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development, implementation, monitoring and evaluation. Emphasis is thus placed on research (biomedical and social) as the veritable source of medical, socio-economic and demographic data. ICPD PoA urges Governments to strengthen their national capacity to carry out sustained and comprehensive programmes to collect, analyse, disseminate and utilize population and development data. The need to develop training and research capacity in the field of population and development cannot be overemphasized given its direct relevance to programme management.

Indeed, the ICPD PoA is explicit on the role of research in the national drive towards the achievement of the ICPD objectives. In particular, research is required; (i) to assist in the design of programmes, activities and services to improve quality of life and meet the needs of individuals and population groups; (ii) for policy formulation and programmes implementation, monitoring and evaluation, and; (iii) for improved understanding of varying socio-cultural contexts of human behaviour and their implication for policy and programme response.

Given the significance of research in facilitating progress towards ICPD goals, the PoA urges governments, intergovernmental organizations, funding agencies, and research organizations to; (i) promote socio-cultural and economic research on relevant population, environment and development policies and programmes; (ii) make provisions for operations research, evaluation research, and other applied social science research, the results of which should be fed into the decision-making process, and (iii) improve the quality, timeliness and accessibility of data on various aspects of population and development. Therefore, the focus of research should be as wide as possible, depending on national circumstances, but wide enough to encompass the ICPD definition of the subject of population and development. [United Nations, Programme of Action at the ICPD, Cairo, Sept. 1994].

## 10.2 Population Data

### 10.2.1 Needed data for policy and plan

Planning without a reliable data set is mere idle speculation. This is particularly true of integrated population and development planning which requires data on the various facets of the social, economic and demographic characteristics of the population. Being an integral part of the development planning process, the formulation of a national population policy calls for a clear statement of the population problem, the goal and objectives of the policy, target setting, and specification of means of achieving policy objectives. Evidently, a body of demographic data, as well as information on the social, economic and cultural characteristics of the population will be required in order to develop an appropriate policy framework.

In order to understand the dynamics of the population in relation to social and economic development, it is necessary to have data on population size, growth rate, age and sex composition, rural and urban distribution, regional distribution and density, labour force by occupation and industry. Reliable data on fertility, mortality and migration are also required as inputs into the demographic estimates and projections which constitute basic elements for human resource analysis, for sectors such as health, education and employment. Without these data sets, it will be difficult to answer in concrete terms the question: what is the population problem?

In order to relate population characteristics to the features of the economy and society, additional data will be needed on the social and economic conditions in the country. Macroeconomic data are needed to provide estimates of economic performance; GDP, Per Capita GDP, income distribution, annual rate of growth of GDP, Gross Domestic Investment and Gross National Savings. There is need for data on social indicators as well; namely, health, nutrition status, water, sanitation, literacy, school enrolment, teacher/pupil ratio, housing, employment, status of women, youth, etc.

It is hardly possible to integrate population issues into national development frameworks or to institutionalize practices of results-based planning, monitoring and evaluation (PM&E) of socio-economic development processes or good governance without coherent and updated quality data and information. In African countries, the data collected and the population-based information available have been crucial for national, sub-national and sectoral policies and plans, for development frameworks at all levels and for tracking progress towards the MDGs and ICPD goals.

### 10.2.2 Data sources

The census of population and housing is the major source of population data for policy formulation, planning and programme management in African countries. Apart from population and housing censuses, population and socio-economic data sets are commonly obtained from official records, operations research, and ad hoc sample surveys. Estimates of vital rates (fertility and mortality) are conventionally derived from vital registration statistics, but where a reliable registration system is not in operation (as in many countries of Africa, Asia and Latin America), indirect estimates may be derived from sample surveys or population census data. Official statistics being routinely collected



by ministries, agencies and religious bodies can also be analysed and estimates of demographic characteristics derived can be used for population planning.

The point should be made that data of the sort described above are very expensive to collect, manage and disseminate. In the past, UNFPA assisted many African countries to undertake population and housing censuses supplemented by Demographic and Health Surveys. These data sets have proved most invaluable in assisting countries to formulate population, health and other social policies and programmes, as well as monitor their implementation. Increasingly, Governments in Africa have been taking up the responsibility of generating development data, and the use of DevInfo for data storage and management is gaining popularity.

As part of the institutional framework and mechanism of data production in African countries, the National Statistical System (NSS) is generally constituted of the National Council of Statistics (NCS), the National Statistics Offices or National Institute of Statistics (NSO/NIS), and producers of sectoral statistics such as Agriculture, Health, Education and Central Bank. The NCS is the highest organ for the coordination of the NSS. The use of appropriate mechanisms and arrangements for data production at national level is fundamental for qualitative and quantitative periodical assessment of progress in implementing development frameworks at country level as well as agreed commitments on aid effectiveness.

Although census is a unique source of data especially for planning at the sub national level, monitoring of good governance, accountability and effective decentralization, the production of population and development data in countries also relies on the conduct of various household surveys, notably demographic and health surveys (DHS), multiple-indicator cluster surveys (MICS), migration surveys, employment surveys, agricultural surveys, expenditure and income surveys, living standard measurement study surveys (LSMS), core welfare indicator questionnaire (CWIQ), and routine service-based data such as civil registration/ vital statistics, health management information system (HMIS), education/ school information system, behavioural surveillance system, etc.

In response to new data requirements in the post-ICPD era, new strategies have been developed and implemented in African countries, including but not limited to, the production and management of data in support of development programmes at national and sub-national levels along with the creation and maintenance of databases and integrated management information systems (IMIS).

## **10.3 Population research**

### *10.3.1 Role of population research*

Since the launch of the ICPD PoA in 1994, there has not been a systematic evaluation of the role of research in achieving the objectives of the programme in Africa. Two issues critical to research for ICPD PoA implementation in Africa are research orientation and research capacity. Research is needed to consolidate the range of information available, identify gaps in knowledge and provide additional information as basis for decision-making and policy formulation. As background

to further research work, there is need to undertake a thorough inventory of demographic and related socioeconomic data and an assessment of their quality and gaps.

Policy studies are also required on the socio-economic determinants of demographic variables and conversely on the implications of population factors for socio-economic policies and processes. Such policy studies are very valuable in providing information for the development of appropriate methodologies, or models, which will serve the purpose of ensuring the coherence and compatibility of population and development objectives, and facilitate cost-benefit analysis of alternative measures for rational decision-making.

Research is needed on the relative contributions of the “proximate” determinants of fertility on the country’s fertility configurations. These are biological determinants or factors such as length of the female reproductive period, female age at marriage, frequency of intercourse, natural sterility, pathological sterility, and use of contraception (Bongaarts, J. , 1978). In addition, research is required on the role of social, psychological, economic and environmental factors in the variations in fertility, which often tend to affect the success of certain programme measures, particularly family planning.

Detailed investigations are needed on the factors associated with gestation and parturition, as well as environmental influences on child survival. Opinion studies will also be needed to understand the range of opinions on population issues, or perceptions of population problems in the country, including the dynamics of contraceptive adoption. Research efforts should also address a broad range of other topics with emphasis on those associated with human resources such as health, nutrition, education, manpower, employment, roles of women, youth and the disabled. The research capacity in African countries would need to be strengthened considerably to undertake these and related works.

### *10.3.2 Orientation of research*

Earlier assessment of research orientation in population and development in sub-Saharan Africa indicated a narrow focus on fertility and family planning (Mabogunje and Arowolo, 1978). Almost two decades later, a ‘Cairo Plus Five’ publication by the Population Reference Bureau and Population Council, New York (1999), was also quite revealing; out of the 172 listings 120, or over 54 per cent, related to reproductive health issues; 11 per cent on population and environment and 4 per cent on migration. Again, as before, the overwhelming interest of foreign agencies in population research in Africa seems to be in the area of reproductive health.

In terms of ‘guide to research’ on the Cairo Consensus, there is no general direction for Africa. There is no doubt that a large number of research materials on various population and development issues with focus on Africa or parts thereof have accumulated. At the 2007 Conference of the Population Association of Africa in Arusha, the United Republic of Tanzania, over 400 research papers were submitted for presentation by African scholars although analysis of such is not available. Under the circumstance, the researcher is left to wonder which areas constitute research gaps on the population of Africa with reference to ICPD PoA.

In the preface to its 2001 resolution on population and development research, the Southern African Ministerial Conference on Population and Development (SAMCP&D) notes that: “member States are at various stages of preparing population research agenda. Whilst awaiting the research on international migration, networking on population research should be encouraged. The SADC region will continue to follow up on modalities for undertaking resource mobilization and institutional identification for undertaking the research and studies”. This also underscores the need to undertake an inventory of research on population and development in Africa, identify research gaps and provide basis for formulating a continental research agenda with subregional/subnational orientations.

### *10.3.3 Research capacity*

The Government of South Africa and UNFPA commissioned an evaluation of Training and Research Programmes in Population Studies in South African Universities in 2004. The main objective of the evaluation, according to the report, was to review the Training and Research Programmes in Population Studies in South African Universities as well as to assess the capacity of these programmes in terms of human resources, infrastructural facilities and financial support.

The evaluation report concluded that capacity to carry out the programmes in most universities is woefully limited and fragmented and outside assistance is critical to effective implementation of some of the programmes. According to the report, the need to strengthen the research capacity of the universities, through partnerships and consortiums, cannot be overemphasized. The report thereby recommended that a system of incentives should be designed and provided to encourage universities across the historical divide, in order to enable them to undertake cooperative action in building research capacity.

“The capacity for conducting research is closely related to staff provisions and the local university’s infrastructure and resources. Accordingly, volume of research output still reflects divisions created by apartheid in terms of which historically white universities were better endowed with staff, funding and facilities and historically black universities were disadvantaged in these respects. This differential pattern survived into the post-apartheid period and would require deliberate and systematic interventions to create a more equitable system.” [Gaisie and Groenewald, 2004, unpublished manuscript].

The situation with research capacity in other African countries, both human and institutional, may be different from the above picture of South Africa, but the fundamentals are the same; namely, i) research (in the field of population and development, or any field) requires the training of high-level human resources in all the relevant areas; ii) research institutions require adequate funding by government, local agencies and supporting partners in order to ensure that research activities are relevant to local/national or regional needs; iii) national governments need to be adequately informed about the significance of research and thereby provide policy and financial support that will deliberately orient or re-orient research and researchers in support of national needs and priorities (Arowolo, 2006).

## 10.4 Implementing the ICPD PoA

In addition to the human capacity-building efforts, countries also indicated their support to institutional strengthening. These included surveys and research and establishment of centres for population studies.

The responses to the question on establishment and management of databases were encouraging; many countries have established population databases and related information systems for the monitoring of ICPD PoA activities and progress in the achievement of the MDGs. The databases and information systems established are reported to cover national and subnational areas, as well as the sectors of the economy. In terms of accessibility, these systems were reported as having international reach, obviously through national or sector websites.

Apart from other uses, the ICPD+15 inquiry sought information on the extent to which the databases and information systems were used for humanitarian and contingency planning. In response, countries indicated that the systems were used to support rapid assessments, registration of internally displaced persons, and generation of information from the data sets analysed.

Twenty five countries have set up multi-sectoral coordinating bodies to monitor the implementation of ICPD PoA and MDGs; 10 of such bodies have conducted annual surveys to generate data and information on progress achieved. In addition, desk officers were reported as having been appointed by 20 countries to oversee programme implementation in the relevant sectors.

Analysis of the responses to the ICPD +15 questions has not provided insight into the issues about population research in Africa to which attention has been drawn in the earlier sections of this chapter. Future inquiries of this nature (ICPD + 20) should take up this challenge and play up the role of research in development in Africa, with focus on the contributions of population research to the achievement of ICPD PoA and the MDGs.

## 10.5 Challenges and Lessons Learned

Until 1995, although substantial amounts of data were gathered in African countries, their analysis was delayed and the results produced from the data were often not disseminated timely. Analysis and utilization seldom received enough attention. Data quality control was also one of the major concerns about the production of statistical information in the whole of sub-Saharan Africa. Quality control mechanisms were barely established in the gathering and analyzing of data, thereby leading to results from data of doubtful quality. Producers of data seldom consulted with the users and beneficiaries, leading to the production of data in a non-user-friendly form or of non-user-oriented end outputs that sometimes necessitated further processing at additional costs.

More recently, for instance with regard to the 2000 and 2010 Rounds of Population and Housing Censuses (PHCs), i.e. those planned to occur during the periods 1995-2004 and 2005-2014 respectively, funding remains the main challenge. While all the African countries are engaged or due to engage in the 2010 Round of PHCs, during the period 2005-2014, some of them (Angola, Chad, Democratic Republic of Congo, Madagascar and Togo) have not conducted a census for more than two decades due to war, internal conflict and/or political unrests. Except Botswana, Mauritius, Sey-

chelles and South Africa, where the government funded the total census budget, most countries in the continent continue to rely on donor financial support. Unfortunately most countries will be adversely affected by the global financial crisis, which will compel them to take austerity measures in making strides to address development challenges.

The constraints and lessons learned are mainly related to resource mobilization, the lack of skilled human resources to conduct the censuses without at least some assistance, the long delay in the availability of the census results and thematic analysis reports and, the underutilization of census results and products. The collaboration between national statistics offices (NSOs) and African training and research institutions is still another domain to be strengthened for capacity building and requisite expertise for census taking, human resources development for sustainability of quality census work in Africa. The latter constitutes the most important factor for the successful implementation of data collection, processing, analysis and utilization in African countries. Other challenges are:

- a. Through much of Africa, registration of vital events (births, deaths, marriages) has been neglected or largely incomplete in spite of the administrative, statistical and legal significance of vital statistics.
- b. Although many countries have conducted national population and housing censuses due to capacity limitations, such data remain underutilized.
- c. Data for policy and planning in many areas are deficient or unavailable (incidence of HIV, AIDS mortality, maternal mortality, neonatal mortality, etc.).
- d. Although it is recognized that research is critical to development, in many countries research capacity is weak due to poor funding and limited institutional support.
- e. There is need for collaboration among researchers to determine a research agenda for ICPD PoA as well as MDGs, mobilize resources, exchange ideas and provide an orientation for development-oriented research in the continent.
- f. There is a need to put into good use the available research information at national and regional levels.



# Section II

## II. Resource Mobilization, Partnerships and Coordination

### II.1 Introduction

In recognition of the magnitude of resources that would be required to implement the ICPD PoA in each country, and having regard to resource limitation particularly in African countries, the programme urged the international community to strive for the fulfilment of the agreed target of 0.7 per cent of GNP for overall official development assistance (ODA) and endeavour to increase the share of funding for population and development programmes commensurate with the scope and scale of activities required to achieve the objectives and goals of the Programme of Action. The ICPD PoA further recommended that governments should devote increasing proportion of public-sector expenditure to the social sector, within the context of addressing poverty eradication and sustainable development concerns. In the area of partnerships, the PoA calls for strong collaboration between the government, international organizations and non-governmental organizations in the implementation of the recommended actions. Also, the PoA seeks to improve and strengthen mutual commitments to policy dialogue and coordination of population and development programmes and activities at the national, continental and international levels.

In the Millennium Declaration, the United Nations General Assembly resolved to “support the consolidation of democracy in Africa and assist Africans in their struggle for lasting peace, poverty eradication and sustainable development, thereby bringing Africa into the mainstream of the world economy”.

For Africa, the main problem seems to be the overdependence on external resources and the low level of domestic resource mobilization. It underlines the indefensible attitude of resignation by many national governments to a dependency status. In a rapidly globalizing world of keen competition for resources and unfair play of market forces, it is amazing that African governments seem to be looking for solutions to their manifold problems from outside, notably from bilateral and multilateral agencies. With respect to external assistance, the problems facing Africa seem to be three-fold: (i) delay in delivery of promises by development partners; (ii) conditionalities attached to most development assistance; and (iii) poor management of donor money.



## 11.2 Implementing the ICPD PoA

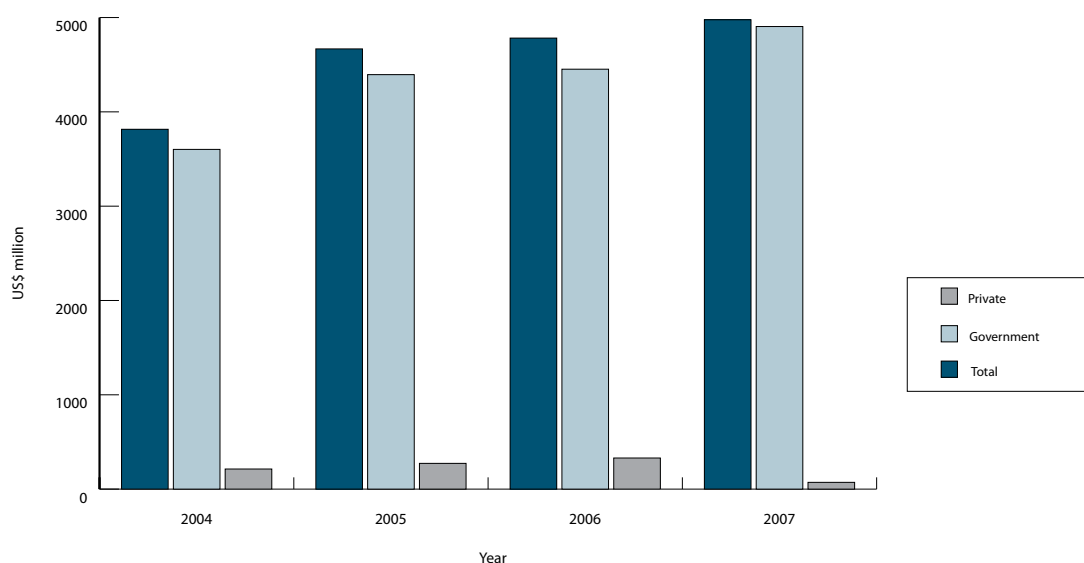
### 11.2.1 Resource Mobilization

In line with the Paris Declaration on aid effectiveness, most countries have taken steps to put in place improved financial management systems for the utilization of external assistance. In Ethiopia, a wide range of institutional and structural reforms have been instituted to enhance the transparency of government expenditure management. Also, steps are being taken to harmonize and coordinate the activities of development partners for the achievement of concrete development results. This process, also being adopted in the United Republic of Tanzania and other countries, is making foreign resource inflows, especially for poverty reduction, more predictable. The country reports indicate that public sector investment in Malawi, Lesotho, Gabon, DRC and Morocco has increased, as a show of commitment to the achievement of the MDGs. In Uganda, government funding of the social sector was reported to be around 30 per cent currently.

Most African countries signed and committed to implement continental or regional policy frameworks such as the Abuja Treaty, calling on States to allocate 15% of their national budget to the health sector. Reports available do not provide an insight into the extent to which African Governments have honoured promises made at continental meetings. It is therefore important to introduce mechanisms to closely monitor the implementation of treaties and other binding instruments to make sure that countries live up to their commitments and are accountable to their people.

The country reports indicate that the major areas of focus for resource mobilization to support ICPD interventions include, Reproductive Health including Family Planning, Statistics and Data Systems (particularly Population and Housing Census and Demographic and Health Survey), HIV/AIDS, Gender issues, Advocacy and Awareness Raising and Poverty Reduction. In terms of resources for implementing national population programmes, countries indicate that most of the domestic resources are contributed by the Government. The distribution is illustrated in figure 11.1.

**Figure 11.1 Africa: Sources of financial resources for population**



The results of the ICPD at 15 inquiry indicates that in 2004, the total amount mobilized from internal sources was US\$3,815 million, with Governments contributing US\$3,602 million or 94.4 per cent of the total. This means that a mere 5.6 per cent was mobilized from the private sector. In 2005 and 2006, private sector contributions seemed to increase slightly to 6.9 per cent in both years; but this dropped significantly to 1.4 per cent in 2007.

Funding from external sources in support of national population programmes in Africa in 2004 came from five major development partners; namely, UNFPA, IDB, DFID, IDA and AfDB. Other major partners began to show interest from 2005 to 2007, namely; GTAFM, GAVI, UNICEF, WHO, World Bank and the European Union and Commission. The country reports indicate that the partners provided support in form of finance and/or technical assistance. Such support, particularly technical assistance has proved quite critical to programme implementation.

The ICPD + 15 inquiry wanted to know the extent to which reproductive health was given specific budget allocations in the distribution of resources among sub-programmes. Most of the countries that responded confirmed that indeed, special provision was made for RH issues in the latest national budgets. Countries also indicated that financial support mechanisms put in place include charging service fees, waiving fees for poor families, and community insurance. In most of the countries, almost all components of the national population programme have budget provisions. These provisions are also reflected in components of the National Health Strategy and the National RH Strategy.

### *11.2.2 Partnership and Coordination*

NEPAD was considered to be the continent's blueprint for partnership. It was supplemented with a Declaration on Democracy, Political, Economic and Corporate Governance at the Durban AU summit held in 2002. This Declaration also committed participating States to establish an African Peer Review Mechanism (APRM) to promote adherence to and fulfilment of its commitments. The APRM is a voluntary mechanism open to any AU country, and as of July 2006, the following 25 countries had formally joined the APRM by signing its MOU: Algeria, Angola, Benin, Burkina Faso, Cameroon, Republic of the Congo, Egypt, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritius, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, the Sudan, the United Republic of Tanzania, Uganda and Zambia.

The country reports indicated that all the governments are working with development and co-operating partners in the implementation of ICPD Goals. The United Nations Development Assistance Framework (UNDAF) provides a strategic modality for ensuring that interventions supported by United Nations agencies, including UNFPA, UNDP, UNICEF, WHO, the World Bank, UNAIDS, UNOCHA and UNHCR are in line with the development objectives of the governments. In addition to the United Nations agencies, a range of international organizations and donor agencies such as the UK Department for International Development (DFID), the United States Agency for International Development (USAID), European Union (EU), Danish International Development Assistance (DANIDA), the United Kingdom's Department for International Development (DFID), the German Technical Cooperation Agency (Deutsche Gesellschaft für Technische Zusammenarbeit or GTZ), the Swedish International Development Agency (SIDA), the International Planned

Parenthood Federation (IPPF), CARE International, Marie Stopes, and a host of others, including local NGOs, are operating in almost all the countries.

This presents both an advantage and a challenge, especially for coordination of efforts. In Senegal, as in most other countries, the complexity of dealing with a multitude of partners, including more than 19 specialized institutions of the United Nations, ten multilateral and financial donors and about thirty bilateral donors presents coordination challenges to the government. In view of such challenges, Senegal, the United Republic of Tanzania, Uganda, the Sudan, Ghana and Mozambique have set up partnership forums as the basis for guiding development cooperation and enhancing aid effectiveness.

### 11.3 Progress in Achieving the MDGs

MDG 8 is set to develop a global partnership for development. Although no country reported that this goal would very likely be met, Benin, Burundi, Eritrea, Kenya, Sao Tome and Principe, Senegal, Sierra Leone, Seychelles and the United Republic of Tanzania indicated that improved collaboration with their development partners could enhance the likelihood of achieving MDG 8 by 2015. Other countries such as the Sudan and Swaziland indicated that this goal, was unlikely to be achieved because in the case of the Sudan the relationship between the government and the international community was less conducive; and for Swaziland, the country is currently experiencing a decline in Foreign Direct Investment.

**MDG8-Target 4:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term. Many countries, including Burundi, Eritrea, Kenya, Morocco, Sao Tome and Principe, Seychelles, Swaziland, the United Republic of Tanzania and Uganda reported having introduced measures to ensure debt sustainability, thereby making achievement of this target likely. The measures include, sound microeconomic policies for Seychelles, and negotiating flexible debt repayment and cancellation as appropriate for Kenya, Swaziland, the United Republic of Tanzania and Uganda. Although some countries, including the Gambia, the Niger, Sierra Leone and Zimbabwe were implementing macroeconomic policies in line with HIPC completion point agreement, the poor performance of these economies, especially in the face of the global economic crisis, makes debt sustainability very difficult. Therefore, this target was unlikely to be achieved.

**MDG8-Target 5:** In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries. The achievement of this target is deemed as likely by Eritrea, Kenya, Morocco, the Niger, Sao Tome and Principe, Seychelles and the United Republic of Tanzania because of efforts already being made to improve the management of supply systems for essential drugs and fostering strong collaboration between Government and various international pharmaceutical institutions and foundations. In Seychelles for example, all the citizens were reported to have free access to essential drugs in all government health centres. For countries like Madagascar, Sierra Leone, the Sudan and Zimbabwe, this target is judged as unlikely to be achieved because of financial and infrastructural constraints.

**MDG8-Target 6:** In cooperation with the private sector, make available the benefits of new technologies, especially information and communications. The sixth target of MDG 8 was judged as very likely to be achieved by the Sudan, as a result of an expansion in mobile phone usage; and Zimbabwe where the number of people with access to computers is reported to have increased from 13 per cent in 2000 to 77 per cent in 2008. For Seychelles, Kenya, the United Republic of Tanzania, Eritrea, Morocco and the Niger the goal was judged as likely to be achieved because of efforts being made to adopt ICTs for the development of various sectors of the society. In Kenya and the United Republic of Tanzania for example, the government has collaborated with the private sector to improve on the information and communication sector. Seychelles reported continuing to upgrade its ICT systems to compare favourably with that of the international community. The target is judged as unlikely to be achieved in some countries including Sierra Leone and Sao Tome and Principe because of poor infrastructure and limited availability of some ICTs. In Sao Tome and Principe for example, there are only 1.7 users of internet per 100 inhabitants.

## 11.4 Challenges and Constraints

There is no doubt that scaling up action to achieve the MDG objectives will require extra money as well as new approaches. This is why the United Nations proposed the 20/20 Initiative [UNDP et al., 1998]. The proposal embodies the principle of shared responsibility for the MDGs by encouraging developing countries to allocate about 20 per cent of their national budget to basic social services; and developed countries to devote about 20 per cent of their development assistance to the same services. However, observers have noted that instead of a "20/20" deal, the reality comes closer to a "12/12" ratio [UNICEF and UNDP, 1998]. This implies that donor countries were allocating on average, about 10-12 per cent of their aid budget to support social services. Governments in developing countries, for their part, were spending on average the same amount on social services.

In this regard, official development assistance (ODA) and debt relief will be indispensable, especially for the least developed and low-income countries, most of which are in Africa. A steady decline in ODA characterized the 1990s, when the relative aid effort fell by one-third; dropping from 0.33 per cent of the combined gross national income of developed countries in 1990 to 0.22 per cent in 2000 [OECD/DAC, 2001]. Official development assistance is most likely to decline further in 2009 and 2010, as a fall-out from the global economic recession.

Debt servicing by many countries also constitutes a negative force in the ICPD PoA implementation. In sub-Saharan Africa, governments have spent twice the amount to meet their financial commitment to external creditors than to meet their social obligation to the people. Debt servicing often absorbs between one-third and one-half of the national budget—making macroeconomic stability an elusive goal. The Heavily Indebted Poor Countries initiative (HIPC) is a first attempt to resolve the debt problem comprehensively, but its implementation is painfully slow, while declining commodity prices are making it increasingly ineffective [UNICEF and UNDP, 1998].

One other serious constraint against the realization of the ICPD PoA in many African countries is bad governance. Many States have openly expressed the political will to pursue the achievement of the MDGs as well as the ICPD PoA but seem to lack the political conviction to do so through good governance and respect for human rights. NEPAD identifies democracy, human rights and good governance as the core challenges for moving the continent forward (ECA, 2005). Regrettably, not all the countries in the continent have as yet acceded to the NEPAD peer review mechanism.

# Section 12

## 12. Monitoring and Evaluation Mechanisms

### 12.1 Introduction

The ICPD PoA encourages governments to monitor progress towards the achievement of the goals and objectives set forth in the Programme of Action. Such monitoring requires accurate and reliable data for policy and programme development, implementation, monitoring and evaluation. In order to account for progress made in the implementation of ICPD PoA, Governments are urged to take a lead role in coordinating the implementation, monitoring and evaluation of follow-up actions.

Regarding the monitoring of the MDGs, actions have been taking place globally, through the annual reports of the United Nations Secretary General to the General Assembly, and through periodic country reporting – based on which, regional analysis has also been conducted. Monitoring the MDGs is generally from two interrelated dimensions; namely, monitoring *MDG outcomes* (degree of ‘Human Rights Standards’ achieved); and monitoring *MDG process* (the extent to which progress has been made without compromising ‘Human Rights Principles’). However, as noted by UNDP (2000), although human development thinking has always insisted on the importance of the process of development, the human development approach and tools focus more on measuring the outcome of social arrangements than on evaluating the processes. This underscores the fact that the process of human development is as important as the outcome. Figure 12.1 shows the list of Millennium Declaration goals (MDGs) and the MDG process indicators (Human Rights principles) which countries should focus on in future evaluations of human development interventions.

**Figure 12.1 Millennium Declaration (MD) Process and Selected Goals (MDGs)**

MDG Outcome	MDG Process
Eradicate extreme poverty and hunger	Good governance
Achieve universal primary education	Equality
Promote gender equality and empower women	Inclusive participation
Reduce child mortality	Transparency
Improve maternal health	Accountability
Combat HIV/AIDS, malaria and other diseases	The rule of law
Ensure environmental sustainability	Sustainability
Develop a global partnership for development	Freedom

*Based on UN Millennium Declaration 2000*

For monitoring the MDGs, two types of indicators are generally used: (i) those internationally compiled; and (ii) those deriving from national sources. At the global level, reporting on indicators is based on data compiled by international organizations and agencies such as UNDP, WHO, UNFPA, UNICEF and the various Divisions of the United Nations, among others. On the other hand, country reporting is based on indicators compiled from national sources, mostly the national statistical system; with the Ministry responsible for statistics/planning given the responsibility for MDG monitoring. The challenge of harmonizing indicators from international partners and governments remains daunting in most countries.

For Africa, NEPAD is particularly important because it is the vision and strategic framework for Africa's renewal. It focuses on eradicating poverty and hunger; accelerating the pace of economic growth; placing Africa and individual African countries solidly in the global arena; halting the marginalization of Africa in the world social and economic orders; empowering women and other socially disadvantaged groups, and building the requisite infrastructure for sustainable development. NEPAD identifies democracy, human rights and good governance as the core challenges for moving the continent forward (ECA, 2005). In 2003, the Sixth Summit of the Heads of State and Government Implementation Committee (HSGIC) of the New Partnership for Africa's Development (NEPAD) adopted the Memorandum of Understanding (MOU) on the African Peer Review Mechanism (APRM). The Mechanism is an instrument voluntarily acceded to by Member States of the African Union (AU) as a self-monitoring initiative for good governance. The aim is to disseminate best practices and recommend the rectification of underlying deficiencies in governance and socioeconomic development processes among AU Member States.

Although the mechanism is fraught with financial, capacity, procedural, operational and political challenges at the national and continental levels, the APRM Report 2007 maintains that it has served as a means of showcasing Africa's innovative thinking in governance. According to a recent APRM Report (2009), twenty-eight countries have so far voluntarily acceded to the APRM. These are: Algeria, Angola, Benin, Burkina Faso, Cameroon, Djibouti, Egypt, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritius, Mozambique, Nigeria, Republic of Congo, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, the Sudan, the United Republic of Tan-



zania, Togo, Uganda and Zambia. The membership of the APRM is currently 652.7 million – an equivalent of 74 per cent of Africa’s total population.

ECA conducted a monitoring study on governance practices in 27 African countries, through national research institutions. The study sampled opinions from over 50,000 households and 2,000 experts. The findings were published in the African Governance Report (2005). The study is considered to be the first major Africa-driven study of its kind. The study aims, among others to (i) conduct an empirical analysis of citizens’ perceptions of the state of governance in their countries, (ii) identify the major capacity deficits in governance practices and institutions, and (iii) recommend best practices and solutions to address them.

Specifically relating to the implementation of the ICPD PoA in Africa, two evaluations have been undertaken; ICPD at 5 in 1999 and ICPD at 10 in 2004 both carried out by ECA with the assistance of other partners, especially the UNFPA. In Part I of this report, the outcomes of these evaluations have been briefly discussed and will not be repeated here.

## **12.2 Institutional framework for M&E**

The Country reports indicate that rather than have a separate mechanism, the implementation of the ICPD Programme of Action is part of an integrated mechanism for monitoring national development programmes, including the PRSPs and the MDGs. The general practice has been that in each country, specific institutions or Government Departments are given the mandate to conduct programme monitoring and prepare evaluation reports at given periods, based on agreed standards. Table 12.2 indicates that the most popular institutional arrangement across the continent is the Monitoring and Evaluation Unit in a Central Ministry; which focuses mainly on monitoring results and the impact achieved, accountability and resource use, and, quality product/service delivery. Countries also reported the existence of Monitoring and Evaluation Units in various sector ministries and Centralized M&E Framework for Monitoring PRS and NDS located outside a government ministry.

**Table 12.2 Institutional framework for Monitoring and Evaluation (N=40)**

Institutional Arrangement	Functions, including issues monitored	
Centralised M&E Framework for Monitoring PRS and NDS located outside a government ministry	<ul style="list-style-type: none"> <li>i. Policy and Legislative Compliance 9</li> <li>ii. Quality of Product/service delivered 9</li> <li>iii. Geographic Coverage/reach 9</li> <li>iv. Accountability and resource use 8</li> <li>v. Results and Impact achieved 8</li> <li>vi. Other (specify); _____ 1</li> </ul>	
Monitoring and Evaluation Unit in a Central Ministry	<ul style="list-style-type: none"> <li>i. Policy and Legislative Compliance 20</li> <li>ii. Quality of product/service delivered 20</li> <li>iii. Geographic coverage/reach 17</li> <li>iv. Accountability and resource use 21</li> <li>v. Results and Impact achieved 23</li> <li>vi. Other (specify); _____ 2</li> </ul>	
Monitoring and Evaluation Units in various Sector Ministries	<ul style="list-style-type: none"> <li>i. Policy and Legislative Compliance 15</li> <li>ii. Quality of Product/service delivered 16</li> <li>iii. Geographic coverage/reach 14</li> <li>iv. Accountability and resource use 16</li> <li>v. Results and Impact achieved 16</li> <li>vi. Other (specify); _____ 1</li> </ul>	
Others (specify); _____	<ul style="list-style-type: none"> <li>i. Policy and Legislative Compliance 1</li> <li>ii. Quality of product/service delivered 1</li> <li>iii. Geographic coverage/reach</li> <li>iv. Accountability and resource use</li> <li>Results and Impact achieved</li> <li>vi. Other (specify); _____</li> </ul>	

In some countries, for instance the United Republic of Tanzania, the national development strategy is aligned with internationally agreed goals including the MDGs. As a result, most of the ICPD issues are monitored under broad NSGRP cluster objectives. Other countries like Malawi have also developed impact indicators for assessing the implementation of the national population policy objectives which were aligned with the ICPD and MGDs. In both cases, the major sources of data for the monitoring and evaluation of the national development programme has been the decennial censuses and national surveys. In 2006, the poverty monitoring system that was adopted for monitoring 2001-2004 PRS for the United Republic of Tanzania, was integrated into the National Strategy for Growth and Reduction of Poverty (NSGRP). The new monitoring System aims at enhancing the result based outcomes of the NSGRP and integrating the MDGs and other internationally agreed development objectives such as the ICPD Programme of Action into the national development planning system. Since population concerns are well integrated important the PASDEP of Ethiopia, key ICPD issues are monitored and evaluated through the mechanisms established to coordinate and monitor national development programmes and projects. Similar frameworks are adopted in Gabon, CAR, Nigeria, Ghana, Namibia, where key population and

RH objectives are included in the national M&E system such as the Medium Term Expenditure Framework (MTEF) and other sector specific monitoring mechanisms.

In 2006 South Africa agreed with the UN agencies to adopt a single monitoring and evaluation of the UNDAF within which ICPD issues and the goals of the Population Policy are integrated. The multi-sectoral long-term National Quarter Century 2007-2031 Strategy and the related Five-Year Strategic Plan (2007-2011) for the Sudan provides the framework for monitoring population and poverty reduction targets.

Most countries have included RH, HIV/AIDS and gender issues into the monitoring and evaluation for the MTEF. However, migration (especially international migration) issues are the least integrated into the MTEF process.

In almost all the countries, databases are being managed to facilitate the monitoring of development programmes including PRSPs. With the assistance of the UNDP and other UN agencies, Namibia, Uganda, Gabon, Lesotho and other countries have institutionalized DevInfo databases and Integrated Management Information Systems (IMIS) to facilitate the storage of data for monitoring of national development objectives and to facilitate national MDG reporting. In Namibia, the population and development database is being managed by the Central Bureau of Statistics (CBS) in the NPCCS in conjunction with sectoral data storage systems such as the Health Information System in the Ministry of Health and Social Services.

Apart from Government institutions, countries have also established special bodies (Commission, Council, Committee, etc) comprising high-level officials, parliamentarians or private individuals to support population and related policy implementation and programme management, including monitoring and evaluation. In Namibia, in order to facilitate the monitoring and coordination of population activities in the country, appropriate structures were created soon after the promulgation of the National Population Policy for Sustainable Human Development 1997. These include (i) National Advisory Committee to advise Cabinet and the President on policy issues; (ii) Inter-Agency Technical Committee on Population (IATCP) to coordinate the implementation of population policy; (iii) Population Unit (now a sub-Division in the Division of Poverty Reduction and Human Resource Planning in NPCCS), to serve as Secretariat to IATCP. In countries such as the Sudan, Nigeria, Senegal, Ghana, Uganda and Malawi, national population commissions, units or councils (as the case may be) are charged with the responsibility of coordinating the monitoring of and evaluation of population related policies and programmes.

At the same time, sector-specific strategies are also in place in countries like Uganda, with frameworks to report on set targets for the Health Sector Strategic Plan (HSSP), for instance. Ghana reports that, donor-funded projects have in-built monitoring and evaluation and reporting requirements such as quarterly, half yearly or yearly progress reports and mid-term/mid-project and end-of- project evaluations. Most countries indicated that reproductive health and gender issues have been included in national and sectoral strategies for monitoring and evaluation.

In summary, the facilitating factors are that, (i) Monitoring and Evaluation institutions are in place in most countries, and (ii) countries have established databases using DevInfo technology for the monitoring the development the PRSPs, MDGs and the ICPD PoA.

### **12.3 Challenges and Constraints**

The major challenges include:

- a. A harmonized monitoring and reporting framework acceptable to both government and development partners is yet to be established in almost all the countries. The existence of donor M&E systems, which tend to operate alongside the national M&E system, is not uncommon on the continent;
- b. Managing elaborate data and information systems require a strong and efficient institutional structure and adequate human capacity which are often lacking in most of the countries.

# Section 13

## 13. Factors Affecting Implementation of the ICPD PoA and MDGs

### 13.1 Introduction

ICPD PoA acknowledges that the achievement of set objectives depends on actions taken by a broad range of actors, especially at the country level. It emphasizes that strong and committed leadership, especially by national governments, is necessary for the achievement of socio-economic development, especially human resource development, gender equality and equity and meeting the health, and in particular, the reproductive health needs of the population. In addition, donors, non-governmental organizations (NGOs), and the private sector are acknowledged as partners in the formulation and implementation of national policies and programmes. Also, a broad range of civil society and community organizations, including members of national legislatures, women's groups, traditional leaders and local governments are expected to play major roles in the implementation of the ICPD Programme of Action.

### 13.2 The Challenge of ICPD PoA Implementation

From the accounts of ICPD PoA implementation presented in the previous sections of this report, it is easy to identify the factors that have facilitated or inhibited the implementation processes in African countries since 1994. Four categories of facilitating/inhibiting factors can be identified: (a) availability of resources; (b) political commitment; (c) policy and institutional reforms; and, (d) programme implementation and management. Countries indicated that economic and financial problems continue to impede the implementation of the ICPD PoA on the continent. Between 40 and 50 per cent of the responding countries reported that they were affected by external financial problems including the debt burden, decrease in ODA and insufficient access to international markets. Added to this, 27 out of 40 (73 %) responding countries cited insufficient external financial resources mobilized for population programmes as a very major constraint. Also, nearly the same proportion of responding countries faced the challenge of inadequate government funding of population activities – a factor underpinned by the fact that nearly two-thirds of the responding countries faced competing national problems. About 68 per cent of the responding countries also indicated that they had difficulties in mobilizing other domestic resources for population programmes.

It is clear that population interventions do not attract budget provisions in the National Development Plan and are not adequately supported by external sources. It would therefore be easy to discountenance any population activity in the process of plan implementation due to lack of funds. The same applies to the MDGs; adequate funding is required but this is generally not the case in many African countries.

Apart from the above economic and financial constraints, countries identified a set of socio-cultural factors which inhibited programme implementation in their respective countries. This includes the existence of unfavourable socio-cultural, norms, values and practices (70 %), and in particular, women's socio-economic status and vulnerability (about 68 %). These key factors continue to impede the implementation of the ICPD PoA in Africa.

### **13.3 Facilitating and Inhibiting factors**

#### *13.3.1 Political commitment*

To date, most African countries have explicit population and related policies in place, and in some cases, these policies have been reviewed in recognition of certain emerging population issues and in line with the national ICPD and MDGs. It can therefore be said that African countries do acknowledge the importance of population factors in development and are committed to undertaking the necessary processes for integrating population and development issues (including gender, Reproductive Health and HIV/AIDS) into development policies and plans. This commitment and show of political will are also underlined by the fact that African countries continue to be committed to periodic reporting of progress in implementing their ICPD PoA.

However, the existence of commitment and political will can hardly be generalized to all the countries. In the current ICPD+15 review process, only 40 out of 53 African countries returned completed questionnaires; worse still, only 23 submitted their country reports (see annex table 1). About 43 per cent of the responding countries reported that low political commitment was a constraining factor to the implementation of the ICPD PoA.

The level of compliance with ECA guidance on this process has already been discussed and well illustrated in Part One of this report. Indeed, this report should serve to encourage all non-reporting Governments to align their development programmes with the ICPD PoA and MDG frameworks, as implementation of ICPD PoA and the MDGs are critical to sustainable development. The process further promotes sharing of lessons learned and country experiences with a view to accelerating achievement of the desired results.

#### *13.3.2 Policy and Institutional Reforms*

The catalogue of policy and institutional reforms listed and discussed in the preceding sections of this report attest to the commitment of African Governments to achieving the objectives of the ICPD PoA as well as the MDGs. In almost all countries that reported, new institutions have been built, older ones restructured, human and institutional capacities have been strengthened, and databases established for policy formulation and programme management, including monitoring and evaluation.

Effective management of population and related development programmes requires, among others, strong institutions, allocation of adequate financial resources and deployment of relevant skills. The formulation of policies on population (sometimes including Reproductive Health, Gender and HIV/AIDS) in many African countries has been a facilitating factor in the implementation of the ICPD PoA as well as the MDGs. Also, availability of population and development data, (accumulated over the past years through population and housing censuses and a series of Demographic and Health surveys, among others) has, in many ways, contributed to the formulation of evidence-based policies and programmes.

This report reveals that some African countries with sound population policies are yet to develop programmes or Action Plans for policy implementation. The Action Plan or population programme are supposed to provide a common platform for all population actors to work together, and it supports the work of the National Population Unit or Department in facilitating coordination of population activities in the country. Therefore, in the absence of a comprehensive national programme or Action Plan, resource mobilization, partnership alliance, policy implementation and coordination are inhibited in many ways.

The challenge of coordination is indicated by the fact that in 40 per cent of the responding countries coordination was a challenge to the implementation of the ICPD PoA. Such countries faced internal problems relating to ensuring cooperation between sector ministries; and the low level involvement of stakeholder groups such as women, civil society and NGOs. Added to this, inadequate cooperation and coordination with, and among international organizations, including donors, was cited as challenges to the implementation of the ICPD PoA.

Perhaps what needs to be addressed in the years ahead is the quality and adequacy of these interventions. Many countries continue to face institutional and technical problems in implementing the ICPD PoA. About 60 per cent of the responding countries experienced a high staff turnover which impeded their ability to maintain direction in policy development; half of the responding countries lacked the national technical capabilities needed to integrate population and sustainable development issues into national development frameworks.

Regarding human resources, many of the Population Units were being managed by one or two officers with no clear career path and little prospect of moving up the ladder. Worse still, in many others, the population unit did not feature at the regional or provincial level of governance where population activities were supposed to be most intense.

The lack of institutionalization of population-related research for ICPD PoA and MDG management also affects the achievement of development objectives. Most countries continued to face challenges in the areas of data for M&E and demonstration of impact, as well as in clearly defining strategies for the implementation of population policies and programmes. In this respect, it is important to underscore the importance of coordinated research at national, subnational and regional levels to address peculiar population problems, inform policies and the design of appropriate programmes.

In its 15<sup>th</sup> anniversary, the implementation of the ICPD PoA is still inhibited by the existence or lack of certain laws and policies. According to Table 13.5, at least one-third of the responding countries



indicated the absence of clearly defined laws and policies on minimum age at marriage, availability of contraceptives, reproductive rights, HIV/AIDS and adolescent reproductive health as inhibiting factors to the implementation of ICPD PoA. Thus, 14 out of 40 (35 %) of the responding countries indicated that there is lack of clearly defined laws and policies on integrating reproductive health into the primary health system. Given the existence of such policy and legislative gaps, what is needed is a strong advocacy campaign for the laws and policies to be formulated or reviewed, to provide the enabling environment for actions to be taken to address these population and RH challenges.

## **13.4 Challenge of Achieving the MDGs**

### *13.4.1 MDGs needs assessment*

According to the Millennium Project, Millennium Development Goals Needs Assessment Methodology (September 2004), developing countries are encouraged to undertake MDG Needs Assessment in order to support the alignment of national development policies and programmes with the MDGs. To this end, low-income or developing country governments are advised to follow a four-stage planning process involving: i) MDG needs assessment to determine the cost for achieving the MDG targets by 2015; ii) development of MDG-based long-term (10 years) development plan; iii) formulation of a medium-term (3-5 years) plan and; iv) ensuring that both the long and medium term plans include a public sector management strategy focusing on transparency, accountability and results-based management. As more countries adopt this methodology, the challenge and commitment to achieve the MDGs is becoming very apparent.

In early 2004, Ethiopia was chosen by the UN Millennium Project as one of the eight MDG pilot countries in the world to undertake analysis of what it would take to meet the MDGs by 2015. Sectoral MDGs Needs Assessments were carried out in Ethiopia (2004) to cover Education, Health, Water/ Sanitation, Rural Development, Urban Development, HIV/AIDS, Gender, Population and Private Sector, Trade and Infrastructure. The individual sectoral assessments have been integrated into a synthesized report (Ethiopia: MDGs Needs Assessment Report, 2005) which informed the formulation of the second SDPRP, now Plan for Accelerated and Sustained Development to End Poverty (PASDEP), 2006-2010.

The assessments made thus far show that Ethiopia, and indeed the other countries, do not have the requisite resources to achieve these goals by 2015. Indeed, the UNDP and World Bank estimate that an additional US\$40 to US\$60 billion is needed to provide such resources to needy countries. If OECD donor countries would meet their development assistance target of 0.7 per cent of gross national income, then US\$195 billion could be added to the US\$58 billion total aid in 2002. According to The Reality of Aid 2004 Report, it is projected that the United Republic of Tanzania, for instance, will require very high per capita levels of average investment and external finance to meet the MDGs. The projected figures are equivalent to aggregate investment of US\$4 billion per year and external finance of US\$2.3 billion per year. In the case of Uganda, the projection is that the country will need to spend an average US\$3 billion per year to meet the goals. More than half of these investments will likely need to be financed externally, requiring an average of US\$1.6 billion (or US\$50 per capita) annually from 2005 through 2015.

### *13.4.2 Are the MDGs achievable in Africa?*

According to Arowolo & Kasse in a 2005 report prepared for the AU in anticipation of the 2005 Millennium Summit, there are enormous development problems facing almost all African countries which militate against making appreciable progress in meeting the objectives of the MDGs. In Africa, notes the report, the persistence of poverty in most of the countries, despite decades of investments, the demographic trap, pervasive inequality, and the burden of disease all cast a shadow of doubt over the feasibility of achieving the MDGs by 2015. There are problems of economic stagnation and rising levels of unemployment and under-employment in most countries. The key root causes of poverty, which need to be addressed by the MDGs, are the interplay of the burden of disease, inadequate access to quality education and health services, insecurity and political instability, engendered by civil conflict, insufficient investment in human capacity development which in turn minimizes productivity, inequality between men and women in resource accessibility and distribution, environmental degradation and the demographic trap. There are also external factors contributing to poverty in Africa; these include the debt burden, declining flow of ODA, now worsened by the spreading global recession, and unfavourable terms of trade.

The report also notes that there are institutional and human capacity constraints as well, exacerbated by years of emigration of thousands of highly qualified professionals in all fields of specialization from Africa to Europe and North America. This has led to the poor quality of the labour force available, technological backwardness and limited productivity. In addition, there are issues of governance – transparency, accountability and commitment – which undermine the management of human, material and financial resources with the result that most Africans suffer from hunger in the midst of plenty. Moreover, agriculture remains the predominant occupation of the labour force, and for decades the technology of production in many countries has remained primitive, with the result that productivity is low and invariably at the mercy of climatic conditions. Other factors inhibiting economic development include poor infrastructure, particularly in rural areas, limited economic diversification, and unfavourable pricing of raw materials in foreign trade. The report concludes that all these challenges make it difficult to produce an optimistic scenario on poverty eradication and the achievement of the MDGs in much of Africa by 2015. Contrary to this, many countries in Africa continue to express optimism about the response to the 2008 ECA ICPD at 15 survey and the likelihood of achieving the MDGs - just as was the case for the global summit in 2005.



# Part 3

## **Recommendations and Way Forward**





# Recommendations and Way Forward

## 1. Introduction

The country reports show that ICPD goals are still valid, and all the countries in Africa are making efforts to achieve them, especially within the context of achieving the MDGs and national poverty reduction strategies. The reports further indicate that while some progress has been made in the implementation of the ICPD-PoA in each of the thematic areas, African countries continue to face challenges which will affect their achievement of the ICPD goals and indeed the MDGs.

## 2. Recommendations

Accelerating efforts for meeting the ICPD goals would require addressing the challenges within the socioeconomic context of each nation. In this respect, the following recommendations are made for the acceleration of efforts for the achievement of the ICPD goals, as well as other development frameworks including the MDGs:

### 2.1 Poverty, Population and Sustainable Development

- a. Foster stronger links between the ICPD goals and the MDGs and NEPAD and the formulation, implementation and monitoring of sustainable development interventions, including PRSPs;
- b. Ensure the establishment and continuous update of integrated databases containing disaggregated socio-demographic and economic data for development programme formulation monitoring and evaluation;
- c. Adopt strategies that promote a better understanding and adaptation of social and cultural issues for the achievement of development goals;
- d. Accelerate efforts to promote peace and good governance and resolve conflicts on the continent;
- e. Support strategies for addressing widespread poverty especially in rural areas and among marginalised groups;
- f. Increase investment in the social sectors, especially health and improve human capital and capacity building for sustainable management of natural resources;
- g. Adopt appropriate and cost effective technologies to improve agricultural and industrial productivity to enhance the competitiveness of African economies and to further reduce poverty;
- h. Ensure balance between population and available resources with special focus on alleviating

- environmental degradation and overburdening of services;
- i. Put in place measures to address the shortage of critical human resource sectors that are key to the achievement of ICPD goals and the MDGs. Governments and their development partners are urged to intensify investment in social development and increase community participation and ownership, and promote fair distribution of national and community resources and benefits;
  - j. There should be recommitment and re-emphasis in environmental protection and adaptation;
  - k. African governments should show more commitment to provide mechanisms for enforcing social accountability on the continent;
  - l. There is need to strengthen the institutional capacities of national central statistical offices in Africa for collecting and managing data, especially on social issues.

## 2.2 Reproductive Rights and Reproductive Health

- a. Urgent steps must be taken to address the causes of the unmet family planning need across the continent;
- b. Private sector partnerships should be sourced to provide family planning information and services especially in hard to reach communities;
- c. Provide adequate essential drugs, commodities and supplies, and put in place a functional referral system for the provision of basic health, especially maternal, child and neonatal health services;
- d. Adequately skilled personnel should be available to provide quality integrated services including emergency obstetric services, STI treatment and family planning in all communities;
- e. Adequately address sexual and reproductive health needs of men, and design interventions for enhanced participation in the provision of RH and family planning information and service;
- f. Address the challenges posed by local customs, beliefs and practices to the promotion of reproductive rights and reproductive health of especially women and adolescents;
- g. Strengthen partnerships and efforts for the accelerated reduction of maternal morbidity and mortality;
- h. Establish appropriate mechanisms to optimize and mobilize internal and external resources to implement SRH services and for HIV/AIDS programmes;
- i. Strengthen governments' and national bodies' capacity to provide leadership in determining country priorities vis-à-vis funding to improve coordination and harmonization of implementation of SRH and HIV/AIDS programmes;
- j. Support comprehensive integration of SRH, including re-positioning of family planning and accelerate linkage of SRH and HIV/AIDS;
- k. Strengthen and/or establish regional and country-level mechanisms for accelerating access to SRH and HIV prevention, treatment, care and support services;
- l. Strengthen health systems, including infrastructure, health management information systems, human resources for health, EmOC and SRH commodity and supplies and HIV treatment and management;
- m. Support and promote evidence-driven SRH and HIV programming based on operational research;



- n. Promote rights-based approach to encourage the access and use of SRH information and services and access to HIV prevention, treatment and care services;
- o. Adopt protocols and legislation to protect and ensure access to SRH and HIV services during crisis and post-conflict situations.

## **2.3 Gender Equality, Equity and Empowerment of Women**

- a. Strengthen the implementation/enforcement of policies, laws and programmes that address gender equality, equity and the empowerment of women including those related to the implementation of Beijing Platform of Action, CEDAW and elimination of violence against women;
- b. Strengthen the implementation/enforcement of policies, laws and programmes on the prevention of violence against women and strengthen protection mechanism for survivors of SGBV;
- c. Strengthen institutional capacities for the systematic and consistent mainstreaming and implementation of gender concerns into policies, laws, programmes, budgets and plans;
- d. Take necessary measures and programmes to address the gender dimension of HIV and AIDS and related reproductive health problems;
- e. Strengthen databases by investing in research, gender analysis and budgeting to support planning, implementation and monitoring of evidence-based gender related policies and programmes at both national and sub national levels;
- f. Strengthen partnerships and networks with multi-sectoral approach involving women's organization, community participation, faith-based organizations, traditional leaders, youth groups and professional associations-- to promote gender equality and ensure women's empowerment ;
- g. Scale up innovative male involvement approaches in family reproductive health and life, and promote gender equality, equity and women's empowerment including women's access to reproductive health, family life information and services;
- h. Strengthen the implementation of policies, laws and programmes for improving girls' access to education and marketable skills including their retention at all levels of the formal and informal educational systems;
- i. Sustain actions that would ensure behaviour change, in view of socio-cultural barriers that hinder women's assertion of their reproductive health rights;
- j. Build the capacity of women and access to employment opportunities, income generation activities, business management skills, protection mechanisms, and increased participation in economic development.

## **2.4 The family, its roles, rights, composition and structure**

- a. The family, particularly with regard to family welfare and stability, should be given adequate consideration in the formulation and implementation of national development plans and strategies;
- b. The family should be integrated into development policies and programmes at all levels of governance.

## 2.5 Children and Youth

- a. Ensure the increased enrolment of children, especially girls, at all levels of the education system, taking steps to foster retention of girls at the secondary and post-secondary levels;
- b. Put in place measures to address challenges of young people's vulnerabilities and empowerment by ensuring that adolescent sexual and reproductive health concerns are well integrated into other interventions such as education/skills development, gainful employment and participation in decision-making;
- c. Sustain implementation of expanded programmes on immunization in order to achieve and maintain universal immunization and improved health for children and their mothers;
- d. Provide for the needs of children and young people in especially difficult circumstances, especially street children and those affected by wars and conflicts;
- e. Sustain the sensitisation of young people on the problems of sexuality, alcoholism and drug use;
- f. Implement programmes to protect children and young people against all forms of abuse, including trafficking, prostitution, exploitation and violence.

## 2.6 HIV and AIDS, TB and Other Communicable Diseases

1. Promote actions to achieve behavioural change through safe sex practices , especially condom use ;
2. Strengthen actions aimed at empowering women and hence reducing HIV prevalence among young women;
3. Train various categories of health workers in order to scale up access to counselling, testing and post-test services;
4. Support epidemiological surveillance and research on HIV/AIDS, malaria and TB for improved service provision and impact mitigation;
5. Ensure care and support for persons affected by HIV/AIDS including orphans, other vulnerable children and the elderly;
6. Strengthen the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS within the framework of maternal and child health care programmes;
7. Reinforce strategies to roll out the provision of antiretroviral therapy to all health facilities;
8. Intensify efforts to integrate HIV and AIDS service provision and sexual and reproductive health interventions;
9. Strengthen institutional and human capacity for expanded delivery of services to reduce the impact of Malaria, TB and other infectious diseases in all communities;
10. Strengthen health systems including infrastructure, health management information systems, Human resources for health, EmOC and SRH commodity and supplies;
11. Strengthen monitoring and evaluation to help in the final review of ICPD;
12. Laws (criminalization) should not be a deterrent to HIV prevention and treatment;
13. HIV needs in conflict or post-conflict crises and difficult to reach population;
14. Need to address HIV across all age levels, with emphasis on young people;
15. Support a regional mechanism for accelerating HIV prevention;
16. Appropriate mechanism for mobilizing internal and external resources to implement for SRH programmes;

17. Ensure that commitments on SRH are implemented by continuing to engage in advocacy at all levels to enlist the commitment of leaders, politically and financially, and through community mobilization for decision-making and involvement;
18. Support comprehensive integration of SRH, including the repositioning of family planning and linkage of SRH and HIV/AIDS;
19. The use of a Rights-based approach to encourage access and use of SRH information and services (refer to a continental policy framework);
20. Adopt protocols and legislation to protect and guarantee the delivery of SRH care during crisis and post-conflict situations;
21. Programme design should be informed and driven by evidence-based operational research;
22. Improve on coordination and harmonization and empower governments and national bodies to implement RH programmes.

## **2.7 Population Distribution, Internal Migration and Urbanization**

- a. Ensure that due attention is given to urban planning and the expansion of social and economic services and infrastructures in urban centres, especially satellite towns;
- b. Promote investment in rural areas to create employment opportunities for the rural labour force to slowdown rural to urban migration;
- c. Foster partnerships with civil society organizations, private sector and communities for development of urban and rural areas;
- d. Design and implement policies and strategies for migrants to support the development of their rural communities;
- e. Set up data and information systems at national and local levels to support the design and management of urban and rural development programmes;
- f. Integrate population distribution, urbanization, and internal migration issues in policies and programmes for poverty reduction and development in both rural and urban areas;
- g. Create an enabling environment for women, young people and the aged for improved livelihoods in both rural and urban development;
- h. Create opportunities for young people to capitalize on the demographic dividend in both urban and rural areas;
- i. Promote strategies that facilitate access to markets by rural communities;
- j. Strengthen capacities of communities and municipalities for urban management.

## **2.8 International Migration**

- a. Implement policies and programmes to encourage Diaspora communities to invest and support development programmes in their countries of origin;
- b. Continue to build human capacities in key sectors such as health; implement measures and incentives for retention of skilled professionals and return of skilled migrants;
- c. Implement programmes to uphold the rights of internal and international migrants, especially refugees and displaced persons, in line with laid down conventions;
- d. Develop and implement comprehensive civic education programme on the rights and responsibilities of both migrants and their host communities to prevent the occurrence of xenophobia;

- e. Put in place a system for documenting and conducting research on international migration.

## **2.9 Crisis Situation and Emergency Preparedness**

- a. Establish mechanisms for monitoring and resolution of conflicts, including the promotion of good governance, peace security, reconciliation and human rights;
- b. Mainstream disaster preparedness, including the provision of reproductive health information and services to refugees and IDPs, into programme planning and response to emergencies;
- c. Promote improved farming practices including prevention of soil erosion, sustainable grazing practices and the use of drought-resistant crops to promote adaptability to change in climatic conditions;
- d. Adopt sustainable post-conflict reconstruction initiatives to effectively address the resettlement and reintegration needs of refugees and internally displaced persons, including returnees.

## **2.10 Population and Development Data**

- a. There is the need to establish a national vital registration system (registration of vital events like births, deaths and marriages) given the administrative, statistical and legal significance of vital statistics;
- b. Data collected through the national census of population and housing should be analysed and used for development planning;
- c. Given the importance of research for development, countries should strengthen research capacity through increased funding and institutional support;
- d. There is the need for collaboration among researchers to determine a research agenda for ICPD PoA as well as MDGs, mobilize resources, exchange ideas and provide an orientation for development-oriented research in the continent.;
- e. There is a need to put into good use the available research information at national and regional levels;
- f. In order to meet comprehensive data requirements for broad social and economic planning at national and subnational levels, governments in are urged to make firm commitments and provide leadership by integrating censuses into their overall development programmes;
- g. The use of appropriate census technology such as geographic information system (GIS) and Redatam-based Integrated Management Information Systems (IMIS) should be encouraged;
- h. Future inquiries of this nature (ICPD at 20) should play up the role of research in development in Africa, with focus on the contributions of population research to the achievement of ICPD PoA and the MDGs.

## **2.11 Resource Mobilization, Partnerships and Coordination**

- a. Increase technical and financial commitment of governments and development partners for the implementation of the MDGs and ICPD Programme of Action;

- b. Encourage the private sector to provide support for population and reproductive health programmes;
- c. Build institutional and human capacities for enhanced resource mobilization and contract negotiation skills within government agencies;
- d. Put in place national strategies, including partnership and coordination mechanisms, for better interaction between governments and all stakeholders, including NGOs and civil society for internal and external resource mobilization and monitoring of resource use, in support of population and reproductive health issues.

## 2.12 Monitoring and Evaluation Mechanisms

- a. Adopt harmonized coordination and monitoring frameworks for development strategies, including PRSPs and the MDGs;
- b. Strengthen the coordination, monitoring and reporting mechanisms of governments on MDGs and ICPD-related interventions;
- c. Ensure the availability of reliable, relevant and timely statistics and indicators for effective management and monitoring of programmes;
- d. Monitoring of progress in achieving the ICPD PoA and MDGs should take into consideration the outcomes as well as the process of development, particularly governance.

## 2.13 Factors Affecting Implementation of the ICPD PoA/MDGs

- a. Good governance (political and economic) is an essential pre-condition for sustainable development and therefore an imperative for any future meaningful implementation of the ICPD PoA and MDGs;
- b. Human institutional capacity in the population and development sector should be improved for population programme design and management;
- c. Population issues should be integrated into national development policies and programmes;
- d. Appropriate institutional structures should be established and existing ones strengthened for the coordination of population activities, including aid coordination;
- e. Governments should provide adequate budget for population programme implementation.

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## Annexes

**Table.I Country Responses to the 5 Review Tools\*\***

No	Country	ICPD+15 Review Tools					
		Any Tool	Main Questionnaire	Appendix-I of the Main Questionnaire	Country Report	Appendix-I of the Country Report	Appendix-II of the Country Report
1	Algeria	✓	✓				
2	Angola						
3	Benin	✓	✓	✓	✓	✓	✓
4	Botswana	✓	✓				
5	Burkina Faso	✓	✓	✓		✓	
6	Burundi	✓	✓	✓	✓	✓	✓
7	Cameron	✓	✓			✓	✓
8	Cape Verde	✓	✓				
9	Central African Republic	✓		✓	✓		
10	Chad	✓	✓				
11	Comoros	✓	✓	✓			✓
12	DRC	✓	✓		✓	✓	✓
13	Congo, Republic of						
14	Cote d'Ivoire	✓	✓				
15	Djibouti						
16	Egypt	✓	✓	✓		✓	✓
17	Equatorial Guinea						

No	Country	ICPD+15 Review Tools					
		Any Tool	Main Questionnaire	Appendix-I of the Main Questionnaire	Country Report	Appendix-I of the Country Report	Appendix-II of the Country Report
18	Eritrea	✓		✓			
19	Ethiopia	✓	✓	✓	✓	✓	✓
20	Gabon	✓	✓		✓		
21	Gambia	✓	✓	✓		✓	
22	Ghana	✓			✓	✓	
23	Guinea	✓	✓	✓			✓
24	Guinea-Bissau						
25	Kenya	✓	✓	✓		✓	✓
26	Lesotho	✓	✓	✓	✓	✓	✓
27	Liberia	✓	✓				
28	Libya						
29	Madagascar	✓	✓	✓	✓		✓
30	Malawi	✓	✓	✓	✓	✓	✓
31	Mali						
32	Mauritania	✓	✓	✓		✓	
33	Mauritius	✓	✓	✓	✓	✓	✓
34	Morocco	✓	✓	✓	✓	✓	
35	Mozambique	✓	✓	✓	✓	✓	✓
36	Namibia	✓	✓	✓	✓	✓	✓
37	Niger	✓	✓	✓		✓	✓
38	Nigeria	✓	✓	✓	✓	✓	✓
39	Rwanda						
40	Sao Tome and Principe	✓	✓	✓	✓	✓	✓
41	Senegal	✓	✓	✓	✓	✓	
42	Seychelles	✓	✓	✓	✓	✓	✓
43	Sierra Leone	✓	✓	✓	✓	✓	✓
44	Somalia						
45	South Africa	✓	✓		✓		✓
46	Sudan	✓	✓	✓	✓	✓	✓
47	Swaziland	✓	✓	✓		✓	✓
48	Tanzania	✓	✓	✓	✓	✓	✓
49	Togo	✓	✓	✓		✓	
50	Tunisia	✓	✓	✓			
51	Uganda	✓	✓	✓	✓	✓	
52	Zambia						
53	Zimbabwe	✓	✓	✓			
	Total Responding Countries	43	40	32	23	28	24

\*\* *Please note:* Country submissions received after the deadline are not included

## *Main questionnaire*

A total of 40 countries submitted the main questionnaire. The purpose of the main questionnaire is to serve as a tool for collecting quantitative and qualitative data from countries in Africa. The questionnaire focused on the themes included in the DND and ICPD-PoA; the goals and objectives, and the achievements of the ICPD and MDG targets on reproductive health, etc. Each theme is structured in such a way as to capture qualitative and quantitative data and information on actions, programmes and institutional arrangements undertaken by country since 2004. Also, the questionnaire covers country implementation of related global and regional policy frameworks, such as CEDAW, AU Plan of Action and Africa's Position on the Family, and African Youth Charter. It was officially distributed to all countries in Africa through email, fax, UNFPA country offices and with a note verbal to the embassies in Ethiopia. ECA and UNFPA followed up and supported the countries to respond, and to use the tools for organizing national workshops and seminars on the ICPD+15.

## *Appendix-I of the main questionnaire*

This appendix questionnaire focused on the MDGs and the prospects of their achievement at country level. The questions in this Appendix require selection of only one answer to each question ( "Very Likely" or "Likely" or "Unlikely" or "Very Unlikely"). Good quality responses were received from 32 countries.

## *Country Reports*

Guidelines were prepared and sent to all countries for the preparation of their reports. The main purpose of the guidelines is to capture qualitative data on lessons of experience, for example, and to standardize the country reports around the ICPD PoA and its themes. For each of the thematic topics the report must include analyses of the status and trends (for major priority issues), actions taken (institutional arrangements, policies, strategies, programmes implemented and other matters relating to supportive environment), achievements with special focus on concrete results, lessons learned and best practices, and major challenges/constraints. Also, countries were requested to provide relevant recommendations for scaling up ICPD related interventions. Reports were received from 23 countries.

## *Appendix-I of the Country Report*

This appendix is a tool for collecting data on 49 ICPD related-indicators covering poverty and employment, population size and structure, fertility, mortality, education, reproductive health, family planning, HIV/AIDS, and gender. Its main purpose is to monitor the trend of ICPD indicators for 1999, 2004 and 2007. Responses were received from 28 countries.

## *Appendix –II of the country report*

This tool is for collecting information from countries on the relevant actions taken and the results/outcomes achieved in implementing activities related to the Ministerial Declaration in Dakar in 2004, bearing in mind that the reporting timeframe is from 2004 to 2008. The action areas include integration of population in development, poverty eradication, reproductive health and reproductive rights,

HIV/AIDS maternal and infant mortality and morbidity, gender equality, equity and empowerment of women, violence against women, adolescent and youth, families, migration, refugees and displaced persons, data for development, and resource mobilization and partnership. Responses to this tool were received from 24 countries.

## Quality of the data and information

The ICPD+15 review tools mentioned above have been used to collect both qualitative and quantitative data and information from countries. The main questionnaire and annex I to the main questionnaire contain open and close-ended questions. The country reports provide substantive text and analyses frequently supported with tables, graphs and indicators. Appendix I to the country report contains close-ended questions while appendix II consists of open ended questions.

Most of the countries followed the guidelines and provided valuable qualitative and quantitative information. Generally, the reports provided more qualitative and in-depth information than the questionnaire. They include texts on lessons from experience and best practices, as well as information on indicators and the population profile. The country reports have been synthesized and integrated into this regional review report.

A total of 560 pages of text received from the countries covers analyses of the ICPD PoA themes. Under each theme, a great majority of the countries prepared analyses of levels and trends, and the actions and policies undertaken during the period since 2004. However, these reports are not without some limitations. Frequently, countries refer to the period before 2004, and some of them even referred to the era before the ICPD in 1994. Also, there is frequent reference to data from old censuses and surveys. Some of the sections in the country reports were short and in bullet point format. Overall, these limitations are insignificant in comparison to the voluminous knowledge and information base compiled for the regional review report. The country reports are frequently quoted and in many cases tables and graphs copied in this review.

The main questionnaire and the appendix questionnaires provide data and information as described above. Complete responses to all questions in all sections of the questionnaire were received from 31 countries. The remaining countries did not respond to at least one full section of the questionnaire, while others skipped many questions in each section of the questionnaire. Some countries did not respond adequately to the interrelated questions. Obviously, parts of the data were erratic and incomplete, therefore, some data cleaning and corrections were done. Data problems were solved either by using the concept of the open-ended questions, responses of the specified questions or by using responses of the subsequent or preceding questions (if the questions are interrelated). Some responses were also missed either because the response was “No” or because the respondents did not want to answer the questions. These kinds of responses were also solved according to the trends of the countries.

With regard to appendix I of the questionnaire, some data problems were encountered. For example, some countries didn't respond to the Goals of the MDGs but, they responded to the targets. In this case, the average or most frequent responses of targets of the specific Goal are used to substitute for the missing ones. Only one country did not use the tool properly, and has therefore been excluded from analyses.

The numeric and non-numeric responses to the close-ended and open-ended questions were processed using SPSS software (Version 15). Coding manuals and standard templates were prepared and used for data entry. The coding manuals were used to translate the questionnaire responses to codes, minimize response and data errors, and to facilitate the response entering process. The coding manual covers the following three major sections:

- a. Identification codes section, which consists of two variables: Name and subregion, location of the country on the continent;
- b. Response codes section, which contains 1133 variables covering 14 ICPD themes;
- c. Appendix code section, which consists of 26 variables covering the MDGs.

A supplementary manual has been prepared and used for coding the “other” responses in the core questionnaire. These are statements mostly in English. “Free online translator” was used to translate the responses received in French and Portuguese into English.

Based on the coding manuals, three data entry templates were prepared; the first template is for entry of data from the core questionnaire. The second template is for entry of data collected through Appendix-I of the main questionnaire. The third template is for entry of data in Appendix-I of the country report. This template covers 149 variables including quantitative/numeric data related to some ICPD indicators, like growth rate of GDP per person employed, total population, age dependency ratio, crude birth rate, maternal mortality rate, etc.

Answers to the open-ended questions are basically in the form of short/long statements. Therefore, these statements in the main questionnaire, Appendix 1 of the main questionnaire, and Appendix II of the country report have been processed separately. This involved several related steps that include designing of formats for organizing information using MS Word Document, editing and finalizing the formats, collecting and organizing the unstructured responses, entering information into the designed formats, translating responses from French and Portuguese into English, editing and finalizing the responses to produce final results.

Overall, the quality of data and information collected using questionnaire method is good. In spite of the lengthy nature of the questionnaires, the great majority of the countries answered most of the questions. However, some countries did not follow the instructions for responding to open-ended questions, while others did not respond at all to some basic questions. Generally, the responses to the annexes are much better than the main questionnaire; probably because they are shorter. In some cases, the responses were confusing as some countries provided two or more answers to the same question. For example, for the questions on MDGs the countries were expected to select only one answer, one country selected several answers. Responses from some countries have been excluded due to problems of this nature, and sometimes for leaving the questions unanswered. One country did not correctly fill out the information for annex II of the country report; it was therefore rejected. Also, responses for annex I of the country report from three countries were rejected because of data problems and missing information.