

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)

EXECUTIVE SUMMARY



United Nations Economic
Commission for Africa



United Nations Population Fund



African Union Commission



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ECA
Addis Ababa
October 2009

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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).

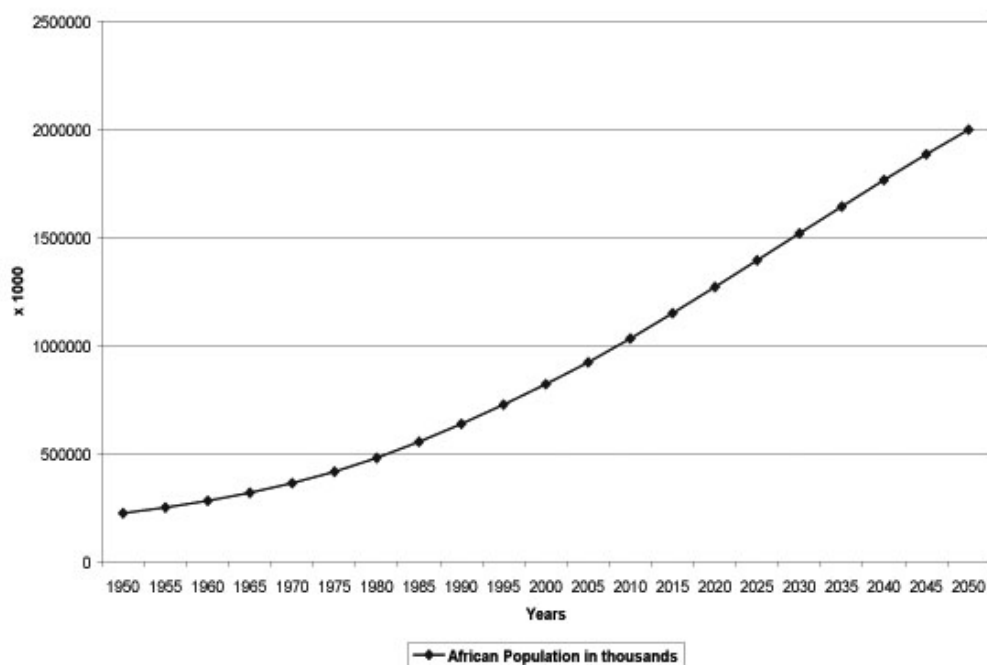
I- Poverty, population and sustainable development

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 dif-

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 commitment 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 per cent), 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, 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 Report, 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 monitoring 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 (GTFM), 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 specifically 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.

14- 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.

14.1 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;

14.2 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.

14.6 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.

I4.10 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.

I4.11 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.

I4.12 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.

I4.13 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.

