



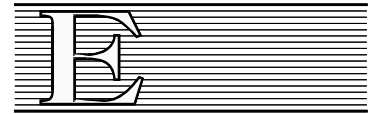
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Declaration and the Programme of Action of the International Conference on
Population and Development – ICPD+10

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LIST OF ACRONYMS

ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APC3	Third African Population Conference
AMCEN	African Ministerial Conference on Environment
ART	Antiretroviral Triple Therapy
ARV	Antiretroviral
ARH	Adolescent reproductive health
ASRH	Adolescent and sexual reproductive Health
AU	African Union
BCC	Behavior Change Communication
CAR	Central African Republic
CEDAW	Convention on the Elimination of Discrimination Against Women
CHGA	Commission on HIV and Governance in Africa
CEMAC	Central African Economic and Monetary Community
COMESA	Common Market for Eastern and Southern Africa
CSO	Civil Society Organization
DRC	Democratic Republic of Congo
DND	Dakar-Ngor Declaration
EAC	East African Community
ECA	Economic Commission for Africa
ECOWAS	Economic Community Of West African States
EU	European Union
FAO	Food Agricultural Organization
FGC	Female Genital Cutting
FGC	Female genital mutilation
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
HIPC	Highly Indebted Poor Countries
ICPD	International Conference on Population and Development
ICPD-PoA	International Conference on Population and Development Programme of Action
IDPs	Internally displaced persons
IGAD	Intergovernmental Authority on Development
IEC	Information, Education and Communication
IGOs	International Governmental Organizations
IOM	International Organization for Migration
KPA	Kilimanjaro Programme of Action
MCH	Maternal and Child Health

MDGs	Millennium Development Goals
MTCT	Mother-to-child Transmission
NEPAD	New Partnership for Africa's Development
NDP	National Development Plan
NGOs	Non-Governmental Organizations
NPP	National Population Programme
NIDI	Netherlands Interdisciplinary Demographic Institute
NPC	National Population Commission
OAU	Organization of African Unity
ODA	Official Development Assistance
OVC	Orphaned and Vulnerable Children
PEDA.	Population, environment, development and agriculture model
PHC	Primary Health Care
PMTCT	Preventing Mother-To-Child Transmission
PRSP	Poverty Reduction Strategy Paper
PLWHA	People living with AIDS
RECs	Regional Economic Commissions
RH	Reproductive Health
RIACSO	Regional Inter-Agency Coordination Support Office for the Special Envoy for Humanitarian Needs in Southern Africa
RRs	Reproductive Rights
STI	Sexual Transmitted Infections
SADC	Southern African Development Community
SSA	Sub-Saharan Africa
STP	Sao Tome and Principe
SRH	Sexual and reproductive health
SWAPS	Sector-Wide Approaches
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization
WSSD	World Summit for Social Development

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EXECUTIVE SUMMARY

The third African population conference adopted the Dakar/Ngor Declaration (DND) as the African regional input into the International Conference on Population and Development (ICPD). In turn, the latter adopted a 20-year Programme of Action for implementing the ICPD recommendations. Both the DND and ICPD-PoA are landmarks in the field of population and development planning. Following the adoption of the ICPD-PoA, a joint regional ECA/OAU/ADB workshop of experts and NGOs was organized (6-9 June, 1995) to provide a framework for use by ECA member States to monitor and evaluate the implementation of the ICPD-PoA recommendations. The 9th session of the ECA Conference of African Planners, Statisticians, Demographers and Information Scientists (11-16 March, 1996), in reporting on the progress made in such implementation, noted that ECA member States were responding explicitly and deliberately to specific provisions of both population and development frameworks.

At the global level, a subsequent comprehensive 5-year review of the ICPD-PoA by the UNGASS (July, 1999), adopted a set of Key Actions for further implementation of the ICPD-PoA recommendations. Within the framework of the global assessment, the ECA also undertook a 5-year assessment of the extent to which its member States had utilized the recommendations from both population and development frameworks in the development of their national population programmes. On the one hand, the ICPD+5 review provided growing evidence that the ICPD-PoA is practical and realistic. It revealed remarkable progress made by some ECA member States in areas such as improving access to reproductive health services, integrating family planning and safe motherhood into primary health care systems, and developing national action plans designed to empower women; and underscored the importance and urgency of addressing emerging issues such as HIV/AIDS, and sexual and reproductive health needs of adolescents. On the other hand, the review pointed to disparities that still remained in such areas as attitudes and practices unfavorable to the elimination of gender discrimination.

In terms of coverage, the ICPD+5 review revealed the heavy focus on reproductive health and reproductive rights with little emphasis on general health and adolescent development issues such as education, income generation and employment, the need to also highlight the importance of reducing infant and maternal mortality, HIV/AIDS and sexually transmitted infections, the inadequate treatment of the “family”, “refugees”, “the role of the aged in society”, “political and social instability”, “the interrelationships between the roles of NGOs, the private sector and civil society”, and “IEC and advocacy strategies”.

Towards addressing these gaps in coverage as well as accommodating emerging new issues, this ICPD+10 review of further progress made by ECA member States in implementing the ICPD-PoA recommendations, covers the nine sectors of population, poverty, environment and sustainable development; gender equality, equity and empowerment of women; the role, rights, composition and structure of the family; children and youth; reproductive rights and reproductive health; HIV/AIDS; population distribution, urbanization and migration; crisis situation and population consequences; and resource mobilization for the implementation of

population policies. A total of 43 out of the 53 ECA member States responded to the 2003 ECA ICPD+10 survey as against 41 at ICPD+5.

The report comprises three parts - the first provides a context for the review; the second presents a statistical and qualitative summary of the responses of the ECA member States to a wide array of issues addressed in a structured questionnaire, a narrative from twenty submitted country reports, and several other relevant documents including the UNFPA Field Inquiry Report (2003); and the third part outlines the major recommendations. For each of the nine sectors reviewed in the second part, relevant key issues raised by ICPD-PoA are highlighted as a prelude to assessing the progress made by the member States in implementing the recommendations.

Population, Poverty and the Environment

The review notes that partly as a result of an increasing population, the ECA region is still riddled with complex and inter-related socio-economic development challenges. Towards achieving the ICPD-PoA recommendations within the context of contemporary poverty alleviation efforts as well as the goals of other critical developmental frameworks (e.g. the MDGs and NEPAD), the progress made by ECA member States in each of the nine sectors, is outlined as a prelude to making some recommendations for the way forward.

Analysis of data from various sources testifies to the changes taking place in the ways in which population policies are being formulated and implemented in the region. Despite gaps, ECA member States are making notable progress in implementing actions proposed in ICPD-PoA. Population issues are being addressed to a better extent within the context of poverty, environment, and decentralization of the planning process. While about 25 per cent of developing States had taken action(s) to integrate population concerns into their development plans as at ICPD, 78 per cent did so at ICPD+5. The corresponding proportion as at ICPD+10 is 96 per cent, a marked improvement particularly for SSA with 71 per cent.

However, there is still need for improved data quality for monitoring progress in implementing the ICPD-PoA recommendations as well as the targets of MDGs and NEPAD. The main problems have been difficulties in adapting global standards to national situations and mobilizing financial resources. There are also technical and institutional limitations, poor coordination among government departments, NGOs, the civil society, the private sector and external partners, inadequate political will relative to use of available human and institutional capacity. Besides, there is the question of how real is the apparent progress being made with population policy development in the region relative to achieving the main goal of ICPD-PoA, MDG and NEPAD namely the alleviation of poverty among the various populations. In order to achieve the ICPD goals on sustainable development, ECA member States would need to address these and other related constraints which go beyond the scope of this review. In particular, they need to:

- strengthen databases required for formulating, monitoring and evaluating population and development policies, strategies and programmes;
- increase investment in social sector services in order to improve human capital;
- increase productivity;

- practice good corporate and political governance and improve the pace of the democratic process;
- strengthen intra-Africa trade and enhance Africa's competitive edge in the context of globalization and;
- match population growth rates with available resources in order to alleviate the burden on national budgets and environmental degradation.

Gender Equality, Equity and Empowerment of Women

From the findings, all 43 responding States have taken actions to ensure gender equality and empowerment of women. Among these are the promotion of women's full and equal participation in the economy, improvement in the collection, dissemination and utilization of gender-disaggregated data in all sectors, ensuring that educational institutions provide equal access to women, the protection of the girl child against harmful practices, tailoring extension and technical services to women producers, focusing research efforts on division of labor, and control over resources within the household. Measures to protect the rights of girls and women as well as to address gender-based violence are among the best practices that have been identified for this sector.

However, there are difficulties with efforts being made to change attitudes towards gender issues due to socio-cultural barriers, unequal educational opportunities for women, lack of specialized gender experts with skills in gender analysis and clear guidelines for mainstreaming gender into population policies and programmes, inadequate and reliable time series data for trend analysis, ineffective advocacy strategies for promoting women's rights, and insufficient staff in government departments and ministries dealing with women's concerns, among others. In order to achieve the ICPD goals on gender equality, equity and women's empowerment, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- ensure the effective implementation of policies and laws and effective functioning of institutions now in place to promote gender equality, equity and the empowerment of women;
- conduct vigorous research to ensure effective advocacy and IEC that focus on such gender issues as the division of labor and resource control within the household;
- invest in the collection of gender-disaggregated data and conduct systematic studies upon which to build effective behavior change communication programmes within a cultural context and;
- ensure that countries that have not ratified CEDAW are urged to do so, and those that have already ratified CEDAW should ensure effective implementation of all its goals.

The Family: it's Role, Rights, Composition and Structure

The situation as regards family welfare is changing with the development of policy frameworks in an increasing number of member States, particularly with the introduction of special family-sensitive policies, measures and programmes, appropriate mechanisms to assist families, the ageing issue, inheritance and the sharing of property.

The vicious cycle of poverty and associated high levels of fertility are major constraints in achieving acceptable standards of living for the majority of families in the region. Family instability, violence and sexual exploitation have followed the breakdown of traditional support networks. High levels of rural-urban migration have diminished the level of support to the elderly from able-bodied men and women. Decreasing social sector spending including pension incomes has curtailed efforts needed to address the needs of the family in such areas as food security, education, and reproductive health services. In order to achieve the ICPD goals on the roles, rights, composition and structure of families, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- put in place policies that place a social safety net for families affected by HIV/AIDS and;
- ensure that policy, legal and institutional frameworks being developed are accompanied by appropriate implementation mechanisms; comprehensive social welfare/security policies and programmes are put in place; and the social, economic, and labor implications of HIV/AIDS on families are assessed to develop appropriate intervention mechanisms.

Children and Youth

Information from the various sources confirm that virtually all responding member States have adopted a mix of policies, strategies and measures aimed at meeting the needs of children and youth. Among the Key Actions taken are the provision of equal educational opportunities to children and youths; putting in place provisions to protect street children and orphans, enact laws against child exploitation.

However, against a backdrop of war and civil unrest in many parts of the region, the worsening conditions of health, education, employment and human rights have inhibited the welfare and other life opportunities of children and youth. Poverty also has a profound influence on the vulnerability of children and youth to ill health including worsening reproductive health conditions and reduced socio-economic and political advancement. In order to achieve the ICPD goals on children and youth, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- work with partners to strengthen youth-friendly services and broad-based community initiatives for youth in order to influence young people's decisions regarding their reproductive and sexual health, and other socio-economic conditions;
- support advocacy groups that target children and youth to undertake continuous advocacy among political leaders and religious leaders, policymakers, parents and guardians for the introduction and reinforcement of positive children and youth reproductive health policies.

Reproductive Rights and Reproductive Health

Since ICPD, ECA member States have adopted policies and programmes and enacted laws favorable to adolescent reproductive health. They have established centers for counseling on family planning, reproductive health, and service delivery to young people. Some member States have amended the penal code and abolished the 1920 French law on abortion. There has been increased accessibility to health facilities for commodities and services as well as expansion of coverage and improved quality of primary health care through IEC, better referral services, provision of emergency obstetric care, training of lower cadre health staff in life saving skills, building more health facilities in remote areas, and formulating safe motherhood strategies. National immunization campaigns are continuing and breastfeeding is being promoted. Adolescent reproductive health projects have been developed offering peer counseling and IEC in combination with recreation, youth centers targeting out-of-school adolescents have been set up, women's professional NGOs have set up crisis centers and legal clinics for counseling and research to deal with issues of gender violence, and measures have been taken to enhance the role of men in sexual and reproductive health.

Several challenges persist however. These include financial and human resource limitations, the HIV/AIDS pandemic, difficulty in addressing culturally sensitive issues, and inadequate provision of emergency obstetric care, among others. In order to achieve the ICPD goals on reproductive health and reproductive rights, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- continue making efforts towards ensuring that the health of women and children is central in all development plans at the national, provincial, district, and community levels;
- ensure that all primary health care facilities have adequate skilled staff and are fully equipped and prepared to offer quality integrated reproductive health services, including emergency obstetrics services, family planning, STIs/HIV/AIDS testing, counseling and treatment services and adolescent RH information and services;
- uphold the reproductive rights of women and adolescents especially the right to appropriate information on how to prevent unwanted pregnancies, STIs/HIV/AIDS and other infectious diseases;
- ensure that policies, strategic plans and all aspects of programming and implementation of reproductive and sexual health services respect all human rights, including the right to development and that such services meet health needs over the life cycle;
- ensure that health sector reforms are promoted across the region to ensure the provision of adequate quality services and;
- ensure that regional and international organizations and the private sector work together to promote the health of women and children.

HIV/AIDS

ECA member States have developed a range of measures and strategies to confront the pandemic. Behavioral surveillance is increasing to supplement epidemiological surveillance in tracking progression of the epidemic and the impact of interventions. There is increased

HIV/AIDS awareness in diverse communities. Diverse HIV prevention efforts have been put in place particularly for the youths aged 15-24. Voluntary counseling and testing services are being expanded throughout the region particularly in SSA. Condoms are readily available; services for preventing mother-to-child transmission (PMTCT) of HIV are being provided; PMTCT services have been made available in pilot sites in urban areas; community care and support programmes for orphans and vulnerable children are being developed particularly in southern and eastern sub-regions; care and support for PLWHA is increasing with considerable expansion in home care services, primarily through NGOs and faith-based organizations; partnerships have intensified, capacity building efforts have expanded, and resource mobilization within and from outside the region has grown significantly.

The main constraints have been insufficient human, financial and material resources, political realization of the sectoral and development impacts of AIDS, AIDS-related attrition in all sectors where prevalence is high, and the difficult economic and sometimes political environment in many States. Stigma and discrimination remain widespread, and openness about the epidemic, while increasing, remains limited. Entrenched gender inequality remains a major factor behind the spread of the disease as do socio-economic inequality, high mobility, instability and conflict. The link between HIV/AIDS and poverty is complex, but the existence of widespread poverty and economic inequality directly and indirectly contribute to HIV transmission and impede care and support. Despite the recent strengthening of political leadership and the prioritizing of AIDS on the international and national development agendas, greater commitment is still needed. In order to achieve the ICPD goals on HIV/AIDS, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- develop strategic efforts to reduce the risk environments for HIV transmission, notably poverty, gender inequality, social instability and conflict;
- address the epidemic needs in an integrated way within broader development frameworks and initiatives, and with a strong human rights base needed to address HIV prevention, care and support and impact mitigation;
- increase political commitment and resource mobilization both within countries and from external sources, including critical capacity building;
- scale up access to treatment services throughout the continent;
- intensify efforts to address stigma and discrimination, and increase openness around HIV/AIDS and;
- ensure greater male and female condom promotion and provision, as well as abstinence.

Population Distribution, Urbanization and Migration

To the extent that conflicts and poverty constitute important root causes of mass migration and forced displacement in much of the region, activities aimed at preventing and managing conflict, promoting good governance and the rule of law, and eradicating poverty are critical to ensuring the future success of national and regional migration management policies. Ongoing initiatives under NEPAD and other poverty reduction strategies developed by member States such as PRSPs are promoting decentralization and democratization.

A significant proportion of responding States have adopted a mix of strategies and measures to promote rural development. Popular strategies include labor intensive projects, training in non-farm jobs, improvement of rural transport and communication systems and social services, decentralization of administrative systems and establishment of income generating projects, improved access to land and land tenure, access to water, access to credit facilities as well as policies that encourage the establishment of production and marketing co-operatives.

The main drawbacks to implementing these efforts are lack of relevant and up to date data and research findings to formulate population and urbanization policies; inadequate capacity in areas such as urban management, local development, management of poverty and health, linking the consequences of economic, political and social policies with population distribution and internal migration; absence of sustainable regional development strategies, including small scale non-farming projects; and poor institutionalization of good political and financial governance. In order to achieve the ICPD goals on population distribution, urbanization and migration, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- uphold the Universal Declaration of Human Rights as it relates to both international and internal migrants;
- ensure the success of population distribution policies and strategies through measures that address the pervasive manifestations of internal migration and uncontrolled urbanization and;
- ensure the implementation of effective decentralization policies and strategies to reduce the concentration of urban populations into primate cities.

Crisis Situation and Population Consequences

In response to the influx of internally displaced persons and refugees, ECA member State governments have adopted various remedial measures and strategies. Over 70 per cent of the responding States have provided protection and assistance to these groups. Member States also provide basic health services and education, programme of rehabilitation, vocational training, adequate capacity preparedness, and employment opportunities. To guarantee basic human rights, adequate protection and assistance to displaced persons within their borders, 49 ECA member States have ratified the 1951 Geneva Convention relating to the status of refugees. In addition to ratifying this global protocol, 11 of the responding States are also signatories to either a regional (OAU/AU) or a sub-regional (e.g. SADC, ECOWAS) protocol on refugees and displaced persons.

High levels of poverty, wide disparities in income distribution in the region, and the increasing impoverishment, provide fertile ground for political and civil unrest. Inadequate food security, agriculture and employment policies, coupled with weak early warning systems for prediction of natural and/or man-made disasters also constitute impediments to effective crisis management. HIV/AIDS has a decisive influence on the capability of communities to give adequate responses to humanitarian crisis. It is also both cause and consequence of the humanitarian crisis. Financial and logistical constraints often undermine the efforts of regional bodies to quickly respond to crisis situations. The easy circulation and trade of illegal small arms across borders and within States constitute an important threat to peace and security. Weak

democratic institutions and insufficiency and/or lack of good governance continue to undermine the efforts to prevent crisis situations. In order to achieve the ICPD goals on crisis situation and population consequences, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- promote good governance;
- increase institutional and material preparedness to face the cyclic droughts and other natural disasters including appropriate data for management of emergencies;
- promote the integration of culture for peace into formal and non-formal education programmes and;
- enhance the provision of sexual and RH information and services to refugees and internally displaced persons.

Resource Mobilization for the Implementation of Population Policies and Programmes

According to data from NIDI, about 91 per cent of the 53 ECA member States have increased their domestic resources for the implementation of population and reproductive health programmes particularly in the southern and northern sub-regions since ICPD. The 1994-1995 period witnessed some growth in external and internal resources mobilized for population and RH programmes, followed by a period of declining funding, which seems to be reversing since the year 2000. Most of the increase comprises government funding. Few States (13 per cent) have cooperated with international organizations to increase their domestic resources. A few more have seen an increase in private sector/NGO funding, in human resource provision, and in investment to improve infrastructure.

The United Nations World Summit for Social Development, held in Copenhagen in 1995 introduced the 20/20 formula that encouraged both donor and recipient States to allocate at least 20 per cent of their funding and budgets respectively, to the health and social services sectors. As a result, countries like Uganda report having exceeded this percentage since the 1994/95 fiscal year. Funding for STIs, including HIV/AIDS has increased steadily since 1995, from 9 per cent of total population assistance to 39 per cent in 2001 consistent with the spread of the HIV/AIDS pandemic, especially in SSA. NGO sources have become the preferred channel of distribution of external funding.

In addition to financial constraints, insufficient technical and human resources are among the most prevalent constraints noted regarding the difficulties to implementing the DND/ICPD-PoA recommendations. Other obstacles may be linked to very low prices of export commodities, constraints necessitated by previous and on-going structural adjustment programmes, and increasingly by socio-political instability. They include insufficient domestic resources, weak technical/managerial capacity, lack of resource mobilization mechanisms, crisis and conflicts, and insufficient international assistance. In order to achieve the ICPD goals on resource mobilization for implementation of population policies and programmes, ECA member States would need to deal with these and other related constraints. In particular, they need to:

- develop standardized methodologies/tools to accurately monitor internal and external resource flows within the various components of population/RH programmes and among the different actors;
- ensure the full participation of key actors of population/RH programmes in development processes within strategic programming frameworks, especially the United Nations Development Assistance Framework (UNDAF) and PRSPs, as a way to leverage more funds for population/RH activities and;
- ensure that national technical and managerial capacities are enhanced, especially in advocacy, establishment of various resource mobilization mechanisms, communication/negotiation skills, and implementation, monitoring and evaluation of resource mobilization plans.

PART I

CONTEXT AND MODALITIES FOR THE ICPD+10 REVIEW

INTRODUCTION

1. The International Conference on Population and Development (ICPD) held in Cairo in September 1994 was a landmark in the population and development field. At this conference, 179 countries adopted a 20-year Programme of Action (PoA) whose overarching goals emphasized the integral linkages between population and development as well as focusing on meeting the needs of women and men rather than on achieving specific demographic targets. Prior to the adoption of the ICPD-PoA, four global and three African regional population conferences had been organized¹. The thrust of the ICPD was to consolidate achievements in fostering contemporary understanding of the integral linkages between population and development from these conferences.

2. This report is a mid-term review of the progress made by ECA member State governments in implementing the ICPD-PoA recommendations. The associated constraints, sub-regional differences and modalities for further implementation are also highlighted. In terms of scope, following these introductory remarks aimed at providing a context for the review, Part II presents a statistical and qualitative summary of the responses of the ECA member State Governments to a wide array of issues addressed in a structured questionnaire administered by the ECA, information provided in national reports, and data from the 2003 UNFPA Field Inquiry.. In Part III, the major recommendations are presented.

Third African Population Conference

3. As part of preparations for the ICPD, the Third African Regional Population Conference (APC3: Dakar, 1992) reviewed the efforts made by ECA member States to implement the recommendations of the Kilimanjaro Programme of Action (KPA) on population and self-reliant development; adopted the Dakar/Ngor Declaration (DND) on population, family and sustainable development specifying conditions for ensuring sustainable relationship between population, environment and development; and urged ECA member State governments to accelerate the rate of such implementation. APC3 also established a Follow-up Committee as machinery for continuous monitoring of the implementation of the DND/ICPD-PoA recommendations (ECAQ 1994).

Workshop of Experts and NGOs

4. A regional ECA/OAU/ADB Workshop of Experts and NGOs was jointly organized (Abidjan: 6-9 June, 1995) to evolve a framework for monitoring and evaluating the implementation of national population programmes (NPPs) using the DND and the ICPD-PoA recommendations. The workshop observed that (i) while some of the targets contained in the DND/ICPD-PoA might be achieved either by individual States or for the region as a whole, most of them would be difficult to achieve by the set dates; and (ii) implementation of the recommendations would be constrained by uncertainties about the future socio-economic conditions and inadequate data in most ECA member States (ECA 1995). Accordingly, the

¹ The 4 global conferences refer to Rome (1954), Belgrade (1965), Bucharest (1974) and Mexico City (1984). The 3 regional conferences refer to Accra (1971), Arusha (1984) and Dakar (1992).

workshop called on the member States to intensify efforts and commitment with the implementation; set reasonable targets; and collect reliable time series data. It also urged the international community to accord greater attention in assisting the States with the implementation.

Conference of African Planners, Statisticians, Demographers and Information Specialists

5. At the 9th session of the Conference of African Planners, Statisticians, Demographers and Information Specialists (11-16 March, 1996), a progress report on the implementation of the DND/ICPD-PoA recommendations was more positive (ECA 1996). It was noted that ECA member States were responding explicitly and deliberately to specific provisions of both population and development frameworks. In terms of impact, the conference observed that attitudes towards the adoption of population policies were evolving rapidly in some States with larger, stronger and more varied NPPs being developed based on the principles of the DND and ICPD-PoA. Increased willingness to view the adoption of a national population policy as a legitimate and logical course of action on the part of the governments was emerging; the case for providing better family planning services to a larger proportion of the population was being based on welfare and health arguments; and policy documents tended to link population with gender issues. Considerable uneven implementation of the DND/ICPD-PoA recommendations was however revealed particularly among States in the eastern and Anglophone western sub-regions as well as States in the southern sub-region while efforts by States in the Sahel and Franco-phone western sub-region were rather scanty.

ICPD+5

6. At the global level, a comprehensive 5-year review and appraisal of the ICPD-PoA, undertaken by the 21st Session of the UN General Assembly (UNGASS: July, 1999), adopted a set of Key Actions for further implementation of the ICPD-PoA in the areas of population and development concerns; gender equality, equity and empowerment of women; reproductive rights and reproductive health; partnerships, collaborations, and resource mobilization.

7. Within the framework of the global assessment, the ECA, based on an analysis of 41 responses (out of 53 member States) to a structured questionnaire (1998), undertook a 5-year assessment of the extent to which its member States had utilized the DND/ICPD-PoA recommendations in the formulation and implementation of their NPPs in the six key sectors of reproductive health and reproductive rights; gender equality, equity, empowerment, and male involvement; role of NGOs and the private sector; population policy and development strategies/institutional mechanisms; and advocacy/IEC strategies (ECA 1998). For each of these sectors, the assessment outlined achievements, best practices and constraints.

8. On the one hand, the ICPD+5 review provided growing evidence that the ICPD-PoA is practical and realistic; underscored the importance and urgency of addressing emerging issues such as HIV/AIDS, and the sexual and reproductive health needs of adolescents. The review also revealed remarkable progress made by some ECA member States in areas such as improving access to reproductive health services, integrating family planning and safe motherhood into

primary health care systems, and developing national action plans designed to empower women. At the time, population policies were more widely recognized as integral parts of the national development planning strategies rather than as donor driven activities. Besides, they were seen as necessary frameworks to provide legitimacy for new and relatively sensitive development activities. Since such legitimacy requires widespread public acceptance, governments had engaged in considerably more consensus building in favor of the new population policies. The degree of belief in the importance of the population and development nexus especially among central level policy makers and the recognition of the complex interrelationships between population, development, and environment had grown considerably. Equally, there had been increased incorporation of population, development and environment relationships into the school curricula.

9. On the other hand, the review pointed to disparities that still remained in such areas as attitudes and practices unfavorable to the elimination of gender discrimination. For example, with regard to population and development planning, member States were by 1999 still grappling with the challenges of responding to the demise of medium to long term central development planning and decentralization (ECA 1998). Some States still had limited access to reproductive health services and information needed to lead healthy sexually active lives.

10. The major socio-cultural constraints (e.g. low literacy rates, local traditional customs, unfavorable cultural practices) to implementing these recommendations are shown in Annex I, Table 1. Other identified constraints included low degree of commitment by politicians and religious leaders, economic and financial constraints such as difficulty of mobilizing domestic resources for population programmes (Annex I, Table 2), lack of institutional and technical capacities (Annex I: Table 3), lack of cooperation between relevant sectoral ministries (Annex I: Table 4), legal and policy constraints (Annex I: Table 5).

11. Based on the gaps identified by the ICPD+5 review, the UNGASS then agreed on a new set of benchmarks for implementing the ICPD-PoA recommendations in the areas of education and literacy, reproductive health care and unmet needs for contraception, maternal mortality reduction, and HIV/AIDS (see Annex II).

Lessons from the series of Reviews

12. The foregoing interim reviews have provided an enabling environment for ECA member States to learn from success stories while identifying, early on, the problems and constraints that impede progress alongside sensitizing the respective governments to the gaps in their practice of population and development planning. The ultimate concern has been the extent to which these factors, recommendations and guidelines have been applied towards achieving sustainable development and hence, a higher quality of life for the populations in the various States.

13. The factors that have either promoted or inhibited the implementation of the ICPD-PoA recommendations as identified from these earlier assessments have been shared with the States both during the indicated meetings and through the associated reports that have been published

and disseminated. While the identification and examination of best practices can contribute significantly to the formulation and implementation of effective policies and programmes, consideration of *'best practices'* in a way, demonstrates how constraints can be overcome as well as how broad principles such as *"integration"* and *'mainstreaming'* can be operationalized. Accordingly, ECA member States have been cautioned (as at ICPD+5) that while it is essential that they evolve *'best practices'* overtime in light of experiences and changes in needs, in each case, a *'best practice'* should be adapted before it is adopted. By capitalizing on such facilitating factors and/or addressing the constraints in the future activities of concerned development partners, considerable progress could be made towards attaining the goal of harmonizing economic and population growth rates in the member States.

14. However, in addition to the problems identified earlier as at the ICPD+5, in terms of coverage, the review also revealed the heavy focus (by the member States) on reproductive health and reproductive rights with little emphasis on general health and adolescent development issues such as education, income generation and employment. Further concerns were expressed about the need to also highlight the importance of reducing infant and maternal mortality, HIV/AIDS and sexually transmitted infections (STIs) and to increase life expectancy; the inadequate treatment of the "family", "refugees", "the role of the aged in society", "political and social instability", "the interrelationships between the roles of NGOs, the private sector and civil society", "IEC and advocacy strategies".

15. Towards addressing these gaps in coverage as well as accommodating emerging issues, this mid-term review of the implementation of the DND/ICPD-PoA recommendations in the ECA region covers the following areas: population, poverty, environment and sustainable development; gender equality, equity and empowerment of women; the role, rights, composition and structure of the family; children and youth; reproductive rights and reproductive health; HIV/AIDS; population distribution, urbanization and migration; crisis situation and population consequences; resource mobilization for the implementation of population policies and the factors affecting national implementation of the DND/ICPD-PoA recommendations and the ICPD+5 Key Actions.

16. Data from a variety of sources are used for the present review. Among these are the ECA 2003 ICPD+10 Survey, National reports on population and development, data from the 2003 UNFPA Field Inquiry, Reports of the Follow-up Committee on the implementation of the DND/ICPD-PoA, Reports of working group meetings, Member States' experiences with the implementation of the DND, Reports of the first and second meetings of the Committee on Sustainable Development, Report of the workshop on women's reproductive health and household food security in region. Regarding the ECA ICPD+10 survey, a structured questionnaire was used and it covered the ten sectors mentioned above. Similar questions were canvassed in the ECA 1998 survey for the ICPD+5 review in the five sectors of poverty, population, environment and sustainable development; gender equality, equity and empowerment of women; reproductive rights and reproductive health; and HIV/AIDS; resource mobilization; and factors that impede implementation of the DND/ICPD-PoA recommendations.

17. A total of 43 out of the 53 ECA member States responded to the 2003 ECA ICPD+10 survey (see Annex I: Tables 6 and 7) as against 41 as at ICPD+5. In addition to completing the

ICPD+10 survey, African countries were also required to submit detailed country reports. A total of 20 member States submitted these national reports (see Annex I: Table 8).

PART II

**TEN-YEAR REVIEW (ICPD+ 10) OF ECA MEMBER STATES' EXPERIENCES WITH
IMPLEMENTING THE ICPD-PoA**

CHAPTER ONE

POPULATION, POVERTY, ENVIRONMENT, AND SUSTAINABLE DEVELOPMENT

18. Available population estimates and projections suggest that the regional population increased from 622.4 million in 1990 to 795.7 million in 2000 and is projected to increase to 1.084 billion by 2015 and to 1.292 billion by 2025 (UN 2003). The associated growth rate declined from 2.6 per cent in 1990-1995 to 2.2 per cent in 2000-2005 and is projected to decline further to 1.9 per cent by 2010-2015 due partly to changes in fertility and the increase in HIV/AIDS related mortality.

19. Deriving from these estimates and projections and other factors, indications are that, the region still faces complex and inter-related socio-economic development challenges. The 25 States with the lowest score on the UNDP human development index are all in the region (UNDP 2003). The number of chronically under-nourished people increased from 89 million in 1969-71 to 126 million in 1979-81, 164 million in 1990-92, and 180 million in 1995-97. Due largely to persistent droughts in several parts of the region, food insecurity is expected to accelerate substantially in the face of inadequacies in the agricultural systems, the impact of HIV/AIDS, wars and civil strife. By 2010, it is estimated that 1 out of every 3 persons in sub-Saharan Africa (SSA) could be food insecure as against 1 in 8 in South Asia and 1 in 20 in East Asia (FAO 2001). These adverse socio-economic indicators imply that the ECA region has not experienced significant economic growth since the ICPD.

20. Whereas the proportion of the population that subsists on less than \$1 a day has been reduced by a third in East Asia, there has been a sustained increase in Latin America, South Asia and sub-Saharan Africa (SSA) (Fleshman 2003). This situation appears inconsistent with the marked recognition of population factors in the development of poverty reduction strategy papers (PRSPs). With all the focus to date on poverty reduction within the PRSP framework, a declining trend in the indicated proportion would have been more realistic. The relevance of this framework in this context is that the country-led PRSPs are, among others, comprehensive road maps designed to provide a framework for domestic policies, programmes and development assistance. On the one hand, they constitute a key requirement to qualify for debt relief, access to concessional World Bank/IMF support and a critical factor in bilateral and multilateral donor support. On the other hand, they set the basis for more comprehensive coordination among donors and international agencies, promoting participatory processes in combating poverty and hunger, and in aiming for more equitable and sustainable development.

21. Against this background, the ICPD-PoA called on member States of the United Nations family to (i) integrate population issues into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development; (ii) introduce the necessary internal institutional mechanisms and enabling environments to ensure that population factors are appropriately addressed within the decision making and administrative processes of all relevant government agencies responsible for socio-economic and environmental policies and programmes; and (iii) formulate and implement population policies and programmes in support

of the objectives and actions agreed upon during the Rio Declaration on Environment and Development (Agenda 21) and other international meetings.

22. The subsequent Millennium Summit held in New York in September 2000 set the Millennium Development Goals (MDGs) that included two specific targets for the eradication of extreme poverty and hunger and for ensuring environmental sustainability. These included a 50 per cent reduction in the proportion of people whose income is less than \$1 a day and the proportion of people who suffer from hunger between 1990 and 2015; reducing by two thirds the under-five mortality rate between 1990 and 2015; integrating the principles of sustainable development into country policies and programmes; and reversing the loss of environmental resources.

Progress towards achieving ICPD-PoA goals

23. In the ECA survey, member States were requested to provide information on the status of their national population programme (NPP). Specifically, information was sought on adoption of a population policy and/or modification of an existing one. For States with a policy, the foci were on the institutional arrangements put in place for coordination, recent strategies to integrate population, environment and agricultural issues, and formulation of a poverty reduction strategy paper (PRSP). The responses to these concerns support the changes taking place in the ways in which population policies are being formulated and implemented in the region.

24. Towards assessing the progress made by ECA member States pursuant to achieving the ICPD-PoA goals in this sector, what follows is first, a review of the responses to the indicated concerns and second, highlights of some evaluation considerations in such progress focusing on the actual process of policy development as against the associated ideal *modus operandi*. The intent here is to identify some gaps (if any) in the policy development experiences of ECA member States. If these gaps are addressed, the process of integrating population factors in the various national development plans should be enhanced.

25. As at mid-2003, with the exception of Libya and Western Sahara, all the other 5 States in the northern sub-region (Algeria, Egypt, Morocco, Sudan and Tunisia) had adopted an explicit population policy as an integral part of their national development programme (NDP). About 20 of the 47 ECA member States that comprise SSA, had similarly adopted a population policy before ICPD; 14 more States had adopted policies following ICPD, and 9 States were at various stages of the policy development process. All 47 States had either established or are establishing fairly complex systems for formulating comprehensive population policies covering demographic, social, economic and environmental issues with objectives, targets and strategies similar to those recommended by the ICPD-PoA.

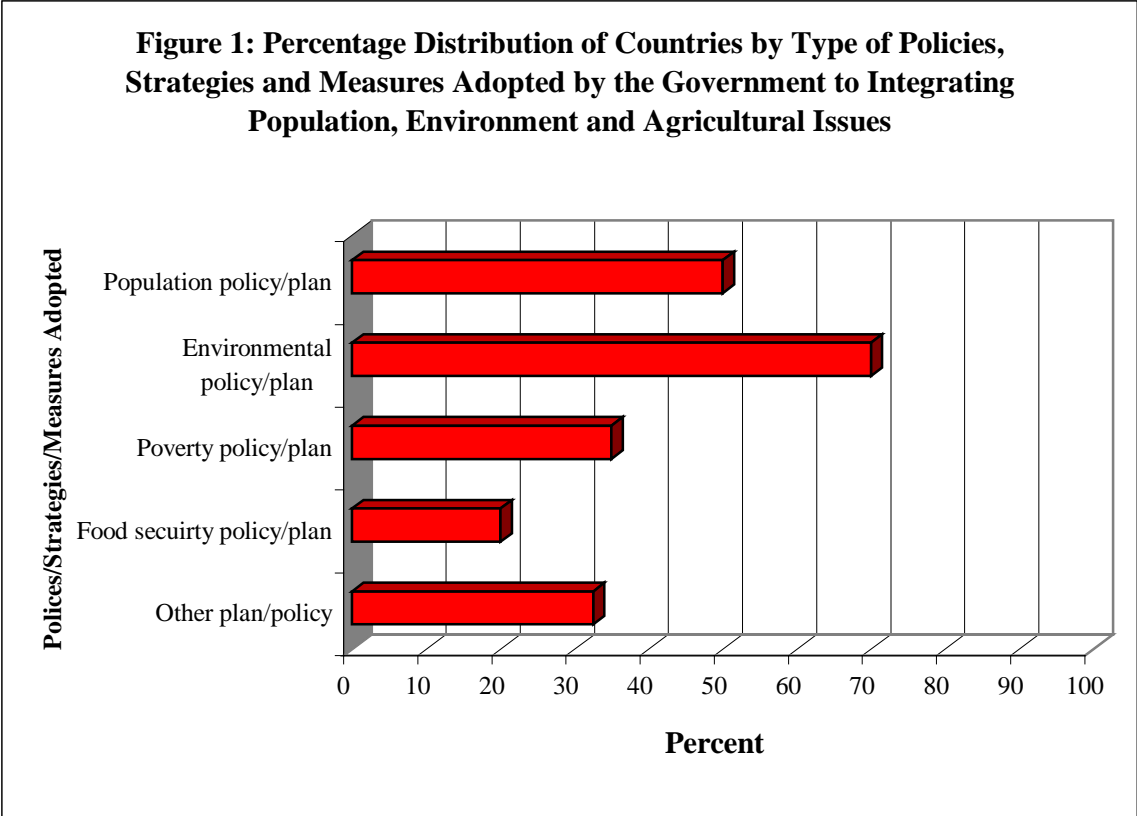
26. Altogether 20 of the responding States had modified existing policies consistent with ICPD-PoA and ICPD+5 Key Actions particularly in the areas of gender, health, HIV/AIDS; children and youth; family; and conflict management (see Annex I: Table 9). The proportion of States that effected these modifications was highest in the western sub-region and least in the central sub-region. In terms of typology, about 70 per cent of the responding States had adopted environmental policies as against 50 per cent with population policies, 35 per cent with poverty

alleviation policies, and 20 per cent with food security policies (see Figure 1). A total of 40 responding States (93 percent) have adopted policies, strategies and measures purporting to integrate population, environment and agricultural issues (see Annex I: Table 10). In addition to adopting national population policies, 37 of the responding member States have also formulated Poverty Reduction Strategy Papers (PRSPs). These PRSPs cover a wide range of areas such as sustainable development, population and employment, population distribution and migration, HIV/AIDS and population, education and housing (see Annex I: Table 11).

27. Among the 5 Lusophone States in the region, Angola and Sao Tome and Principe are yet to develop a population policy. Cape Verde, Guinea Bissau and Mozambique have done so following ICPD. The 20 States that comprise Francophone SSA are relatively at the initial stages of the policy development process; 6 of them (Burundi, CAR, Congo (Brazzaville), Democratic Republic of Congo, Equatorial Guinea, and Gabon) are still in the process of formulating an explicit population policy; 8 others (Cameroon, Chad, Guinea Conakry, Madagascar, Mali, Niger, Rwanda and Senegal) developed a policy before ICPD; and 4 (Benin, Cote D'Ivoire, Mauritania and Togo) after ICPD. The Anglophone SSA States are much more advanced in population policy development. Baring Swaziland that is still in the process of formulating an explicit population policy, 12 Anglophone States including 7 revisions following ICPD (Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Sierra Leone, Tanzania, Zambia) had formulated a policy before ICPD while 4 (Botswana, Namibia, South Africa, Zimbabwe) had done so following ICPD.

28. To ensure the successful coordination and follow-up of the implementation of NPPs, a significant proportion of the responding member States (41 States or 95%) acknowledged putting in place various institutional arrangements. In 12 countries, these arrangements were at the ministerial/parliamentary committee level and in 31 countries these institutional arrangements are also at the national population council or population commission level.

29. To effectively monitor and assess the linkages between population, agriculture and environment and their impact on sustainable development, 33 out of 43 countries have put in place the necessary institutional arrangements. In 17 of the States, these institutions have been established at the national, inter-ministerial or government department level. Fourteen States have established national environmental units or authorities. Towards strengthening these institutional frameworks, 17 States have also incorporated NGOs and other groups in these institutions.



30. Since ICPD, political discourse in the form of vigorous public debates has played a key role in promoting the implementation of the ICPD-PoA recommendations at the national and community levels. ECA member States have made commitments to adopt appropriate policies and legislative measures in various international meetings. There has been increased awareness, consensus, and social mobilization on population issues as well as increased resource and political commitments in implementing the ICPD-PoA recommendations. Social and cultural norms, traditions, legal frameworks, policies and programmes are being changed to ensure that population; reproductive and sexual health, HIV/AIDS and gender issues are addressed in national development strategies, plans and programmes (UNFPA 2003c). Cases in point and/or best practices in this context are Benin, Cote D'Ivoire, Guinea Bissau, Mali and Senegal (western sub-region); Congo (central sub-region); Ethiopia and Eritrea (eastern sub-region), Egypt (northern sub-region), and Madagascar (southern sub-region) (see Box 2.1).

Box 2.1: Best Practices in population policy and programme formulation.

Benin, Cote D'Ivoire, Congo, Ethiopia, Guinea Bissau, Madagascar, Mali, Senegal - points of access to RH information are provided locally; village-level computer centers have been established.

Egypt - a mass media campaign advocating gender equity and rights for girls used to create public opinion towards restricting early marriage; issuance of estimated age certificates for young girls by village-based health units legalized

Ethiopia - Grass root community associations (e.g. Idir, Maheber) and **Zimbabwe** - hair salon discussions and mobile road shows used to increase population access to information on RH and RRs, HIV/AIDS and gender issues.

Eritrea - a range of social and economic development actions taken to eliminate FGC. Actions focusing on women empowerment (e.g. girls' education; special attention to women in adult literacy programmes; legalizing ownership and inheritance of land and other properties by women; IEC programmes) implemented to redress harmful traditional practices.

Source: UNFPA 2003 Field Inquiry Report

31. Partnership with civil society organizations (CSOs) has also facilitated formulation and implementation of national population programmes (NPPs) through national forums and associations (UNFPA 2003c). More than 35 per cent of member States in SSA have partnered with CSOs in developing parliamentary caucuses to advocate population issues. CSOs have also been used to provide RH information, services and commodities. The priority sectors in this partnership are population and RH within the respective member States. For example, in Ghana, the National Population Commission (NPC) has representatives from CSOs and has involved the latter in decision making processes at the community, regional, and national levels. A national coalition of CSOs has been established to foster closer collaboration in the fields of population and RH; quarterly programme team meetings share ideas and exchange experiences on the management of population and RH activities; parliamentary caucuses are used for lobbying and advocacy efforts; advocacy programs targeting traditional, religious, key political and community leaders have been developed forming a strong programme partnership in the promotion of population/RH issues nation-wide. In Angola, provincial committees on population and development coordinate provincial population programmes in conjunction with provincial family planning and youth councils. Ethiopia has created regional population offices that interface with regional health offices. Kenya has used CSOs to sponsor a number of media sensitization campaigns and outreach to youths; these include HIV/AIDS awareness campaigns (AIDS Day), adverts in mass and electronic media, youth variety shows and World Population Day. In Botswana, there is a parliamentary committee on HIV/AIDS with CSO representation (UNFPA 2003c).

32. Ninety per cent of the ECA member States have increased domestic resources for population and RH programmes with 60 per cent of them reporting that their governments utilize cost recovery mechanisms. In Burundi, CSOs are active in lobbying private sector firms to deal with HIV/AIDS amongst their employees and are successful in getting many firms to take into account the health needs of their staff. In Nigeria, the government has set up both a “CSO Forum” based in the Department of Community and Population Activities (Federal Ministry of Health) to coordinate government and CSO activities in relation to RH; and a “Private sector Forum” co-chaired by the President, Shell Nigeria, and MTN Nigeria to focus on prevention of HIV/AIDS. The government has also initiated an extensive social marketing campaign for condoms and other contraceptive commodities entitled “Society for Family Health”. In Zimbabwe, the government has held parliamentarian workshops on advocacy, policy dialogue and development (UNFPA 2003c).

33. In effect, despite gaps, indications are that in the face of the demographic realities and their implications for the socio-economic development of the region, ECA member States are making notable progress in implementing actions proposed in ICPD-PoA. Population issues are being addressed to a better extent within the context of poverty, environment, and decentralization of the planning process. Actions are being taken on specific issues of population ageing and mechanisms are being developed for monitoring and measuring progress made in achieving the quantitative goals of ICPD-PoA. Adoption of specific measures and the formulation of specific population distribution, urbanization and migration policies are most common in the ECA region at 69 per cent. As at ICPD, about 25 per cent of developing countries had taken action to integrate population concerns into their development plans (IPDP), 78 per cent did so as at ICPD+5 (1999). A further increase of 18 per cent was achieved by 2004

(totaling 96 per cent); this represents a marked improvement particularly for SSA with 71 per cent (UNFPA 2003c).

Constraints

34. The State of the environment in the region has been influenced by rapid population growth, increasing and chronic poverty, inappropriate agricultural production methods, unfavorable terms of international trade, the debt burden, the impact of drought and other natural disasters. Rapid population growth intensifies environmental degradation, as is evident in many States experiencing declining soil fertility and rapid depletion of forest and water resources. The negative synergy occasioned by declining agricultural productivity and related food insecurity, rapid population growth and environmental degradation, is among the development constraints in the region.

35. A pertinent concern of this report is the extent to which the indicated progress being made with population policy development in the region is real in terms of achieving the ICPD-PoA, MDGs and NEPADs main goal of alleviating poverty among the various populations? The very process of developing the policies and the associated “ideal modus operandi” as well as the difficulties encountered, should shed some light on this question. The process of population policy development is a difficult one. This is partly because new ideas gain acceptance slowly; opinions and attitudes need to change before a policy can be reformed or effectively implemented. In many ECA member States, there are customs and traditions that make reform difficult. Consequently, legal and policy reforms should be viewed within the context of the complex mosaic of tradition, ethnic rivalries, customs and religious practices in the region. Therefore the key factors to be considered in population policy development should include a broad consensus on the importance and need for a policy; dynamic and committed leadership; interested private organizations and institutions; local political support from powerful groups; the availability of clear and convincing evidence, finance, and personnel/physical resources to carry out policy and implement programme. .

36. The experience however, in most States, has been a partial implementation of elements of the national population programme (NPP). This makes it difficult to monitor progress let alone evaluate performance or ascertain programme impact. A project designed to address one or a few elements of a national population policy (e.g. population and development strategy, adolescents and youths, population distribution and migration, RH, etc.) is only an aspect of the NPP. The existence of a number of population activities in the various sectors is not proof of the existence of a national population program.

37. Many State Governments often have not had sufficient time for the realization of the need for a population policy to diffuse into the national consciousness (UNFPA 1994; Farooq and Pernia 1990). Possibly due to data limitations and technical capacity, in some cases implementation action plans are formulated only after considerable time lag following the adoption of the policy. Some of the policies do not have enough data at the time of formulation and therefore the goals, objectives, targets, and strategies are frequently unrealistic requiring revision shortly following the promulgation of the policy draft into law.

38. Taken together, for some States, population policy objectives are often neither matched by clear implementation strategies nor are the associated operational mechanisms clearly specified. Ideally, the process through which a population policy is accepted at the political level and exerts an impact on the development process of a country should comprise the three processes of formulation (i.e. the articulation of overall national population and development goals); planning (i.e. the elaboration of strategies and measures for the incorporation of population factors into its program formulation and resource allocation activities); and implementation (i.e. the translation of the policy into action through programs and projects). The evolution of an integrated population and development planning (IPDP) is a long and slow process due to the lags involved between the recognition of the problem and learning and actual application of the methodology..

39. A key step in formulating the population policy should comprise research on the correlates of population growth. A related step should be to investigate the pertinence of such correlates for the State as well as the mechanisms through which the correlates operate. It is important that the findings from such research should indicate what the government should do to effect change. Accordingly, possible research areas should include the preparation of estimates and projections of the State's socio-economic and demographic levels and trends; ascertaining the nature and strength of the demographic and development interactions; and conducting various forms of policy analysis.

40. Based on the foregoing, although significant progress has been made by ECA member States in undertaking several censuses and surveys with the assistance of UNFPA and other donors, there is need for improved data quality for monitoring progress in implementing ICPD-PoA, MDGs and NEPADs' targets. Efforts such as those undertaken by the Southern African Development Community (SADC) to harmonize the 2000 round of population censuses are a good best practice in this area. As discussed at ICPD+5, the main problems have been difficulties in adapting global standards to national situations and mobilizing financial resources in the implementation of various international conventions. There are, also technical and institutional limitations, poor coordination among government departments, NGOs, the civil society, the private sector and external partners, as well as inadequate political will related to the use of available human and institutional capacity. These factors also constrain policy development in the sectors discussed in the subsequent chapters.

CHAPTER TWO

GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN

41. During the 1990s, global conferences sought to reshape a vision of women's lives. In Cairo, in 1994, the ICPD built on this assertion and placed women's rights, empowerment and health including reproductive health, at the center of population and sustainable policies and programmes. For development to be effective, it must understand and respond to gender-based differences and power relations (UNFPA 2003c).

42. Accordingly, the ICPD-PoA recommended that member States (i) establish mechanisms for women's equal and equitable participation and representation at all levels of political processes and public life; (ii) promote the fulfillment of women's potential through education and skill development; (iii) eliminate all practices that discriminate against women at all levels of society; (iv) eliminate violence against women and all forms of exploitation; (v) improve women's ability to earn income and achieve economic self-reliance; (vi) implement laws, regulations and other measures to enable women participate in economically gainful employment; (vii) ensure that women can buy, hold and sell property and land, obtain credit and negotiate contracts in their name and exercise their legal rights to inheritance; (viii) ensure equitable representation of both sexes in managerial, policy making and implementation levels; (ix) develop an integrated approach to address the health, education and special needs of girls; and (x) promote equal participation of women and men in all areas of family and household responsibilities.

43. The Millennium Development Goals (MDGs) also call for the promotion of gender equality, women's empowerment and to eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels of education no later than 2015.

Progress towards achieving ICPD-PoA goals

44. Evidence reviewed as at ICPD+5 towards promoting gender equity and economic empowerment, revealed that some ECA member States (e.g. Algeria, Eritrea, Kenya) had enacted/enforced legislation and revised/adjusted national policies purporting to abolish gender discrimination, inequalities and harmful practices (UNFPA 2003c). For instance, Ethiopia, Eritrea, Guinea-Bissau and Uganda had enacted new laws and revised the penal, civil codes and constitutions to ensure women's equal rights and access to economic resources. The national development plans formulated in Senegal, Seychelles, Uganda were not only gender-responsive but were aimed at developing infrastructure and services for control of resources and equal access to employment, markets, trade, business services and information.

45. Many of the States (e.g. Algeria, Tanzania, Tunisia) acknowledged that they had collected, analyzed, disseminated and utilized gender sensitive data and had undertaken gender-focused research in the areas of division of labor, access to income, intra-household control and socio-cultural factors affecting gender equality. Botswana, Ghana, Eritrea, Namibia, South Africa, Uganda, Zambia, and Zimbabwe promoted females' participation in the labor force. This

included the provision of maternity leave, vocational training, and implementation of literacy programmes. Institutional mechanisms (e.g. women commissions, councils, associations, cooperatives and family centers) were established in Ethiopia, Rwanda and Zimbabwe, as were gender focal points in line ministries to address gender issues. Credit for income generating activities and technical advice to female entrepreneurs, were provided in Ghana, Kenya, Namibia, Nigeria, Mauritius.

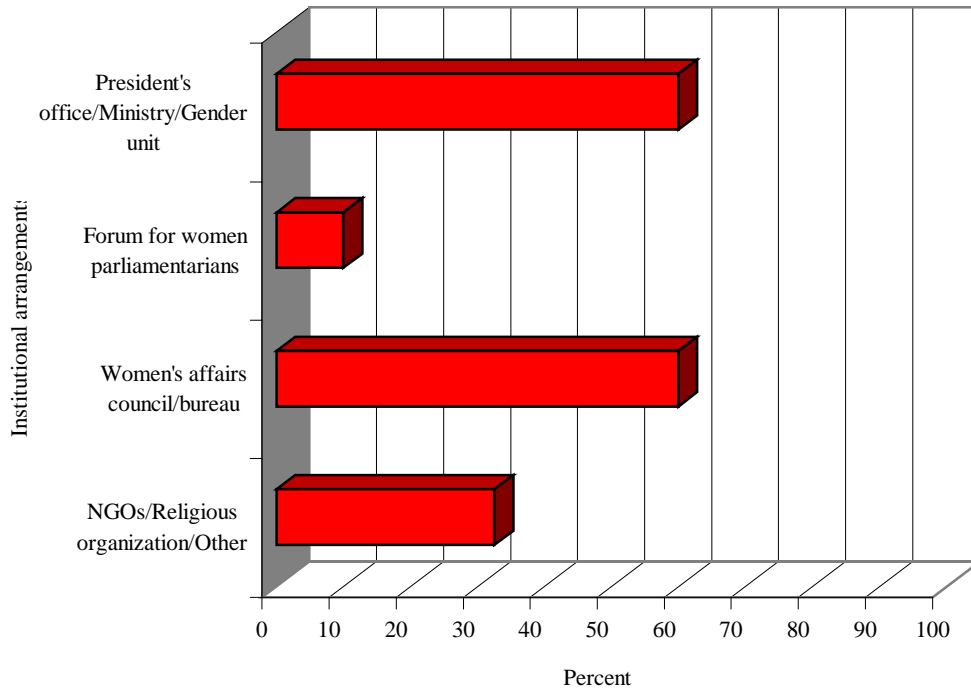
46. Programs for improving girls' education were also developed in Egypt, Senegal and Uganda. Training activities in gender focusing on the creation of awareness, gender sensitive programming and gender analysis were provided. The United Nations Convention on Elimination of all Discrimination Against Women (CEDAW) was ratified by 41 States and was being implemented by 31 States; the latter focused on the creation of women's ministries, increasing number of female ministers and parliamentarians, using the quota system to promote women's participation, among others. Considerable improvement was recorded about women wielding decision-making power and participation in parliaments, local government councils, and statutory commissions.

47. The sector on gender equality, equity and empowerment of women in the ECA ICPD+10 survey solicited information on institutional arrangements put in place to implement the relevant ICPD-PoA and ICPD+5 Key Actions as well as on ratification of CEDAW, protection of the girl child, elimination of harmful practices, and male involvement.

48. Results from the ECA ICPD+10 survey reveal that 41 of the responding States have put in place institutional arrangements for the successful implementation of the ICPD-PoA recommendations related to gender (see Figure 2 and Annex I: Table 12). A total of 24 States reported having institutionalized these arrangements at the level of the President's Office. Gender focal points have also been established in line ministries in Burundi, Cote d'Ivoire, Ethiopia, Mali, Rwanda, Senegal, South Africa, and Zimbabwe. Another 24 States have made similar arrangements at the women's affairs or women's Bureau level (e.g. in Angola, Mali and Niger). Only 4 States have established parliamentary committees on gender issues.

49. All 43 responding States confirm having taken actions to ensure gender equality and empowerment of women. Among such actions, the most popular (42 States) was the promotion of women's full and equal participation in the economy (see Figure 3 and Annex I: Table 13). Other popular actions taken were improvement in the collection, dissemination and utilization of gender-disaggregated data in all sectors; ensuring that educational institutions provide equal access for women; the protection of the girl child against harmful practices; tailoring extension and technical services to women producers; focusing research efforts on division of labor; and control over resources within the household. Among some of the best practices identified in women empowerment are measures to protect the rights of girls and women as well as to address gender-based violence (see Box 2.2).

Figure 2: Percentage Distribution of Countries by the Institutional Arrangements Put in Place for the Implementation of DND/ICPD Recommendations and ICPD+5 Key Actions Related to Gender Issues



50. Towards addressing the gender gap, 40 of the responding States (93 per cent) have adopted strategies and measures to ensure access by the girl child to educational opportunities at the primary school level. At the secondary and tertiary levels, 88 and 84 per cent of the responding governments have respectively adopted measures to ensure that girls have such access. Concerning the promotion of gender equity and women empowerment, 74 per cent of the States have adopted a policy mix that includes promoting the full and equal participation of women in the economy, protecting girls against harmful practices such as female genital cutting (FGC), early marriage and childbearing. A significant proportion of these States have raised the minimum legal age at marriage to 18 years, some to 21 years.

Box 2.2: Best practices in Women empowerment

Measures suggested for protecting girls/women rights - the establishment of national commissions, constitutional provisions, formulation of policies on gender discrimination, ratification of UN Conventions, implementation of the Beijing Platform, legislation on women's rights, development of national action plans on gender mainstreaming, identification of IEC/Advocacy programme on gender.

Measures for addressing gender-based violence - adoption of legal and legislative policies authorizing implementation and enforcement, training, IEC and advocacy strategies to raise awareness of the problem and counter GBV prevalence; institutional mechanisms to monitor and report on GBV prevalence; providing gender-sensitive training for government officials; creating new programmes that promote women's rights. Indications are that the extensiveness and intensity of required actions are not adequate in the face of the pervasiveness of the GBV practice.

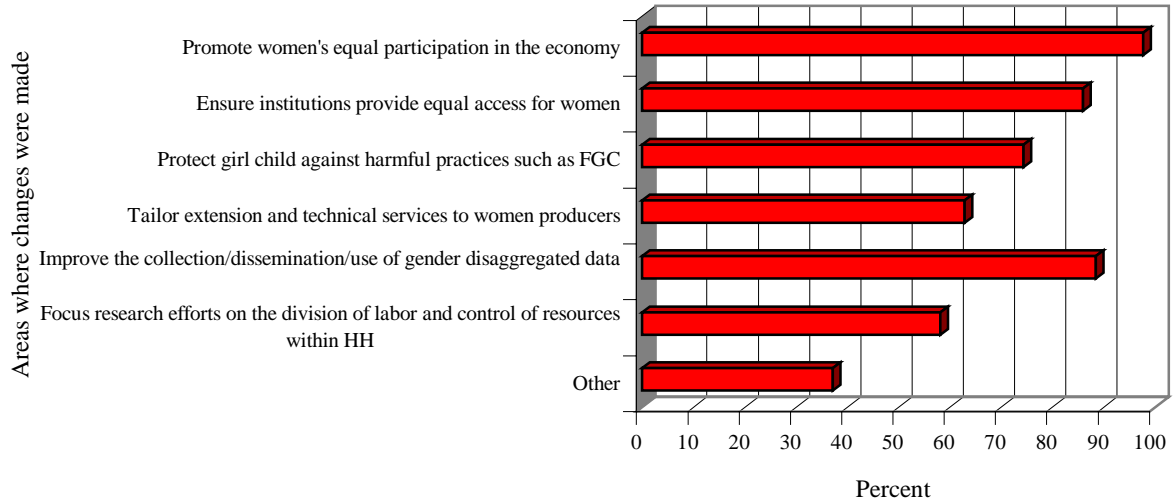
Specific Measures - closing the gender gap in education is an important policy challenge particularly in SSA with wide gender differentials in primary level enrollment. Actions include development and revision of textbooks and curricula to incorporate gender equality concerns; introduction of laws for paternity leave (**Cape Verde, DRC, Guinea Conakry, Uganda**); establishment of male only RH clinics (**Ghana, Guinea Bissau, Kenya, Sierra Leone, Tunisia, Uganda**) and national Commission on women; inclusion of/increase in the participation of women in governance; incentives to poor families to send girls to school; promotion of male contraceptive methods; IEC/Advocacy on men's RH involvement

Gabon – regular organization of sensitization seminars for government administrators on gender and equity; the UN Gabon organized (2001) information session for Cabinet members on gender issues that is presided by the Prime Minister.

Sierra Leone – government (with NGOs) has conducted sensitization and advocacy programmes (including development of telephone help lines linked to a Family Support Unit within the Police Force) on GBV issues.

Source: UNFPA 2003 Field Inquiry Report

Figure 3: Percentage Distribution of Countries by Actions Taken by Government to Ensure Gender Equality and Empowerment of Women



51. Equally, all 43 responding States have taken necessary actions to prevent and control sexually transmitted infections (STIs) including HIV/AIDS. About 95 per cent of these States have targeted men in an effort to prevent unwanted and high-risk pregnancies as well as gender based violence; others have put in place legislative measures. For example, South Africa has adopted Child Maintenance/Financial Responsibility Acts while Ethiopia has enacted a Family Violence Act. However, only 23 States have adopted measures aimed at promoting shared control of family income.

52. Furthermore, forty-two countries (98 per cent) have taken specific actions to promote women's full participation in the economy. For example, Zambia and Eritrea have instituted legislation stipulating equal pay for equal work and non-discrimination. Efforts are underway to give better visibility to women's contribution to national accounts in a number of States. Women's participation in political and administrative areas has also increased considerably in States like Botswana, Seychelles, and Tanzania. The number of women in parliament, government, and in other key positions has been increasing in several member States as a result of affirmative action policies. However, in a number of States (e.g. Swaziland), women still do not have the right to own land and to obtain credit without their husband's consent.

53. For instance, Cape Verde set aside a minimum of 35 per cent of decision-making positions for women. Rwanda has also recently increased the quota of parliamentary seats and cabinet positions allocated to women. Other States that have adopted some form of affirmative action programmes include Eritrea, Mali, Morocco, Niger, South Africa, Tanzania, Uganda, and Zimbabwe. Together, these efforts serve to facilitate the process of gender mainstreaming in all sectors. Actions have also been taken to eliminate negative female stereotypes in the media as well as in educational materials. Steps have also been taken to prevent inhuman practices such as the trafficking of female children, use of girls in prostitution, and pornography.

Constraints

54. The marginalization of women regarding inheritance and property sharing at divorce or death of the spouse is a common problem in the region. In a majority of cases, women are denied the right to inherit and/or share property equitably. Towards addressing the ICPD-PoA provisions in this regard, 38 of the responding States indicate that they have instituted the necessary measures to ensure equal rights of men and women in inheritance and property sharing; in 33 of these (e.g. South Africa), issues dealing with inheritance and property sharing are covered by the constitution.

55. Despite paying attention to the needs of the girl child, the gender gap in primary education has only been eliminated in a few States such as Kenya, Madagascar, Namibia, Tanzania, South Africa, Zambia and Zimbabwe. The gender gap in primary and secondary education still persists in States like Benin, Burkina Faso, Central African Republic, Guinea Conakry, Mali, Senegal and Togo (Lloyd et al. 2000).

56. Both in national and sectoral programmes, the adoption and institutionalization of a gender perspective require application of gender analysis in formulating policies and programmes. The absence of a proper understanding of mainstreaming and the lack of technical capacity for gender analysis, and the design, implementation and monitoring of programmes preclude the adequate integration of gender in programmes. Weak mechanisms to monitor gender equality and equity imply inadequate tracking and closure of the gender gap. Operational guidelines need to be developed for use in orienting programme implementation; streamline gender mainstreaming (a technical process that involves gender gap analysis, policy analysis for gender sensitivity, incorporation of gender concerns in policy pronouncements and their implementation mechanisms, monitoring and evaluation using gender sensitive indicators) as its tenets remain ambiguous and nebulous (UNFPA 2003c).

57. About 86 per cent of the responding States have taken measures that ensure free and full consent to marriage of intending spouses. However, widow inheritance continues to be practiced in States like Ethiopia, Malawi, and Zambia. Most States have launched IEC campaigns aimed at educating their populations about the dangers of such practices. Efforts aimed at promoting girl's education are also being used to raise the minimum age at marriage in about 23 per cent of the responding States. These States also report taking various actions to promote equal participation of men and women in all areas of family and household responsibilities. These measures include IEC campaigns in 40 States, changes in employment legislation (27 States) as well as instituting family leave for men and women (5 States).

58. Limited or no access to credit, institutional constraints, lack of access to and control over productive resources such as land, and low levels of educational and entrepreneurial skills have also been difficult to overcome. In several States, a multiplicity of parallel legal systems (civil law, customary law; legal systems applicable to particular religious communities or ethnic groups) is obscuring recognition of the rights of women especially regarding land ownership rights and rights within the family. Despite the adoption of CEDAW, domestic violence is still a problem in many parts of the region and in conditions of war and political strife, instances of violence against women are common.

59. Other factors that have hindered progress in gender equality, equity and empowerment of women include the ad hoc development of gender programmes lacking long-term goals to mainstream gender into all development sectors; difficulty of changing attitudes and behaviors towards gender issues due to socio-cultural barriers; unequal educational opportunities for men and women, especially at higher and vocational levels; lack of specialized gender experts with skills in gender analysis; lack of reliable time series data for trend analysis, ineffective advocacy strategies for promoting women's rights; lack of clear guidelines for mainstreaming gender into population policies and programmes; and inadequate staff in departments and ministries dealing with women's concerns. Finally, fiscal crises, civil strife, political instability and widespread poverty in many States have hampered efforts to include women on equal terms with men in the market place.

CHAPTER THREE

THE FAMILY: ITS ROLE, RIGHTS, COMPOSITION AND STRUCTURE

60. The family is a basic unit of society. The socialization of children and transition from childhood through adulthood are special responsibilities of families and communities. Despite inroads due to modernization, the role of customary norms in the process of socializing and educating children and young people has not been displaced and/or replaced. The attainment of several MDGs depends as well, on the viability of the family as the primary production and consumption unit providing social welfare and security for its members who could not be absorbed by either the public or the private sector. In particular, in a situation where social insurance systems are not in place as in most ECA member States, the aged and the sick, orphans and disabled people receive care and support from members of the family.

61. A combination of poverty, social unrest, HIV/AIDS, social barriers, among others, threatens the welfare and quality of family life in the region. Increased absolute poverty renders families less able to meet basic social needs of family members. This minimizes the possibilities of members planning their lives including planning the size of their families. With the current level of social unrest, the region hosts about 30 per cent of the world's refugees and over 50 per cent of internally displaced persons. This promotes instability in the families and erodes the social safety net from the social network of extended families and in turn, renders most families vulnerable. Threatened by social unrest, families have difficulty promoting life-enhancing stability in which the quality of life of all members is improved. Besides, there are social barriers to implementing programmes. Some member States openly object to and obstruct efforts to introduce family life education in schools. Even where this is not the case, there is little involvement of the youth and adolescents within families in formulating programmes that concern them.

62. With urbanization, an increasing proportion of the population is migrating (seasonally or permanently) from rural to urban areas. Family structures are increasingly being distorted by AIDS-related morbidity and mortality particularly in the southern and eastern sub-regions, rising divorce rates, increased migration, and the effects of conflicts. This has resulted in increased proportions of female-headed households and the number of street children. The extended family is facing challenges and changes in the care-giving patterns. Child labor in the informal sector and parental work outside the home are also reducing the time available for childcare. Together, these developments signal a gradual and sustained breakdown of the family unit in the region. In the midst of all these developments, there is a characteristic preference for sons in most traditional settings creating an environment in which girls have few opportunities within families. This compounds female low self-esteem and promotes traditions preferring males "because they make it". And yet there has been little or no socio-cultural research on the dynamics of the resulting vicious cycle and on how to break this vicious cycle. Conducting research on the needs of adolescents within families and the extent to which these needs are being met, is difficult due to taboos and entrenched traditional practices some of which are harmful.

63. Accordingly, the ICPD-PoA urges ECA member States to (i) develop policies and laws to support the family, (ii) establish social security measures that address the social, cultural and economic factors behind the increasing costs of childrearing; (iii) promote equality of opportunity for family members; (iv) increase income generating opportunities for all adult members of families while formulating socio-economic development policies and programmes; (v) institute measures to eliminate all forms of coercion in policies and programmes related to marriage, other unions and family formation; (vi) adopt and enforce measures that eliminate child labor and female genital cutting (FGC); (vii) formulate family friendly policies in housing, employment, health, social security and education; (viii) give greater attention to poor families particularly those victimized by war, drought, famine, natural disasters and racial or ethnic violence and discrimination; and (ix) assist single-parent families, as well as attend to widows and orphans.

Progress towards the achievement of ICPD

64. As indicated in Part I, population programmes in most ECA member States did not pay specific attention to the family as at ICPD+5. At the time, largely the international community gave attention. A case in point was the adoption (1995) of a “Declaration on the African Plan of Action concerning the situation of women in the context of family health” by the former Organization of African Unity (OAU). The OAU (now African Union) subsequently adopted the Algiers’ Resolution (1999) requesting its member States to pay particular attention to the needs of the family. Some of the measures taken by the member States to improve the quality of life for various population sub-groups (e.g. girl child, youths, adolescents) have impacted positively on the family. The African Union is now committed to developing an African common position on the family within the framework of its 10th Anniversary of the International Year of the Family to be observed later in 2004.

65. Given the indicated developments affecting the welfare of the family as an institution within the region, the ECA ICPD+10 survey specifically solicited information on policy frameworks in member States that address family welfare including special family-sensitive policies, measures and programmes, appropriate mechanisms to assist families, the ageing issue, inheritance and the sharing of property, and the well-being of families. The findings from the survey support, in a way, the relative lack of attention by member States to family concerns. Barely half of the responding member States (22 States) have adopted a policy framework to address the welfare of the family. States in the western sub-region led the other four sub-regions in formulating such policies.

66. Of the 22 States, 12 developed such a policy framework before ICPD; only 5 did so post ICPD; and 10 had modified existing frameworks. Family sensitive policies have been formulated in areas such as housing (24 States), work (24 States), health (36 States), social security (32 States), and education (37 States) (see Annex I: Table 14). Only Sudan cited food security as a family-sensitive measure that its government had adopted. Figure 4 highlights these special family-sensitive policies, measures and programmes adopted.

67. Lack of communication between spouses and between parents and children often tends to reduce equality between family members. Not surprising therefore, some member States have

launched educational programmes in areas such as enhancing parental roles (31 States), parental skills (26 States) and child development (38 States). Several other States have initiated income generating programmes and credit schemes. Botswana and Eritrea, for example, responded to the twin problems of insufficient income and growing demand for housing by adopting policy schemes that integrate poverty alleviation and housing specifically targeted at low-income female-headed households, and orphaned children, respectively.

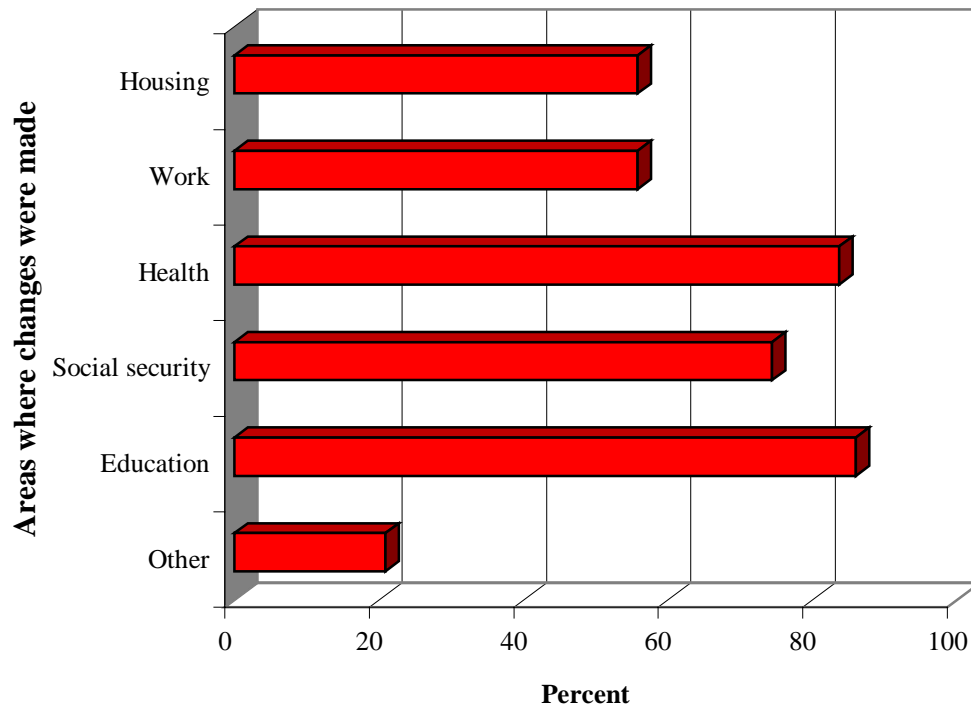
68. In terms of mechanisms put in place by the governments to assist affected families, the responses indicate that such mechanisms targeted the main development problems of the region namely extreme poverty and HIV/AIDS. Between 60 and 75 per cent of the States in each sub-region report putting in place similar mechanisms with the exception of the central and eastern sub-regions with only 33 per cent of the States. Rwanda, for example, has adopted a national policy aimed particularly at redressing the negative impact of the 1994 genocide.

69. Some consideration was also given in these family-sensitive policies and programmes to the welfare of the elderly. Although 32 States expressed concern regarding population ageing, only 10 of them have provided social security or pension schemes to the elderly; none of these 10 States was in the northern sub-region while four each were in the southern and western sub-regions and one each in the eastern and central sub-regions. Institutional care has been provided in 15 States (8 in the western, 3 in the northern, 2 in the eastern and 1 each in the southern and central sub-regions). A number of States (29) have also taken steps to develop the required capacities for monitoring the impact of social and economic decisions and actions on the well-being of families, the status of women and the abilities of families to meet their basic needs. In 13 States such monitoring capacities have been developed at the government department level or women's bureau. A few other States (10) have instituted household and poverty assessment surveys for monitoring these critical issues on a regular basis.

70. There is however considerable variation in the adopted policies. In South Africa the elderly receive social security benefits; in the Seychelles, they receive housing and other forms of old age support; Tunisia has formulated a legal framework to provide homes for divorced or widowed women and has established solidarity funds and associations to assist families in times of difficulty.

71. Regarding measures to guide inheritance and property sharing in the event of divorce or death, a significant proportion (38) of the responding States acknowledged putting them in place; 33 of these also acknowledged using constitutional protection/legal act as the inheritance measure.

Figure 4. Percentage Distribution of Countries by Special Family-Sensitive Policies, Measures and Programmes Adopted by Governments



Constraints

72. As noted earlier in this chapter, the vicious cycle of poverty and associated high levels of fertility are major constraints in achieving an acceptable standard of living for the majority of African families. These constraints stretch the ability of extended families to help other crisis-afflicted family members often resulting in affected children joining the ever-increasing number of street children. Children from broken family backgrounds are also more vulnerable to various forms of abuse such as trafficking and sexual exploitation. Family instability, violence and sexual exploitation have equally followed the breakdown of traditional family support networks.

73. High levels of rural-urban migration have diminished the level of support to the elderly from able-bodied men and women. Unfortunately these elderly people are shouldering the burden of caring for the increasing number of HIV/AIDS and war orphans. Decreasing social sector spending, including pension incomes has curtailed efforts needed to address the needs of the family in areas such as food security, education, and reproductive health services. Inaccessible and poor quality sexual and reproductive health services also undermine human security at the family level.

74. The scarcity of focused research on the family and data constrains affect policy development. While many States have put in place legal frameworks to ensure equal rights for family members regardless of gender, implementation is still not effective. Preference for sons still persists in many societies. There is a need for studies to investigate this phenomenon and the consequences for the girl child. Many discriminatory practices go unnoticed and may have far-reaching consequences for the physical, emotional, psychological and intellectual development of children. Improvement in the quality of family life in the region has also been hampered by the debilitating debt burden and declining foreign development assistance, falling prices for agricultural products and raw materials, market protectionism and farm subsidies in western markets, structural adjustment programmes, and the lopsided process of globalization.

CHAPTER FOUR

CHILDREN AND YOUTH

75. The social, economic and cultural importance of children to African families and communities is well documented. Because more than 50 per cent of the total regional population comprises children and youth, the ICPD-PoA acknowledges their potential both for the socio-economic development of the region as well as their special needs comprising social, family, community support, access to education, employment, counseling, and high-quality reproductive health services.

76. Accordingly, the ICPD-PoA provides a framework within which the development and life preservation aspirations of African families and communities for their young populations can be realized. In practice, the PoA urges ECA member States to (i) design programmes and support mechanisms that promote the full participation and involvement of adolescents and youth in gender-sensitive sexual and reproductive health programmes; (ii) ensure that health care services and health care providers do not restrict adolescents' access to the services and information they need in order to greatly reduce unwanted pregnancies, unsafe abortions and STIs, including HIV/AIDS; (iii) develop culturally sensitive information, education and communication (IEC), and advocacy programmes with the full participation of the youth and parents; (iv) enact and enforce laws protecting children from economic exploitation, and physical and mental abuse; (v) create an enabling environment to eliminate child labor and marriage; and (vi) empower young men and women to address gender inequities.

77. In this context, the thrust of the ICPD-PoA is that reproductive health services should safeguard the rights of adolescents to privacy and informed consent, while respecting cultural values and the rights and responsibilities of parents. Together, these will foster responsible and informed decisions as well as choices regarding the sexual and reproductive health needs of adolescents. The MDG goals also recognize the need for member States of the UN family to pursue substantial reductions in child and maternal mortality, ensure universal primary education for all children and to eliminate gender disparities at all levels of education.

Progress towards achieving the ICPD-PoA recommendations

78. Consistent with the foregoing ICPD-PoA tenets, findings from the 2003 UNFPA Field Inquiry indicate that ECA member States have instituted historically significant policies, legal and legislative, programmatic and strategic measures; and to the extent that resources are available, the communities have also been embracing the changes through culturally acceptable channels (UNFPA 2003c). Put differently, at the macro level, the most important and ongoing achievement brought about by ICPD-PoA has been in ensuring the right of adolescents to reproductive health. The participation of youths in programmes is often recognized both as a dynamic force of change and as key to programme success.

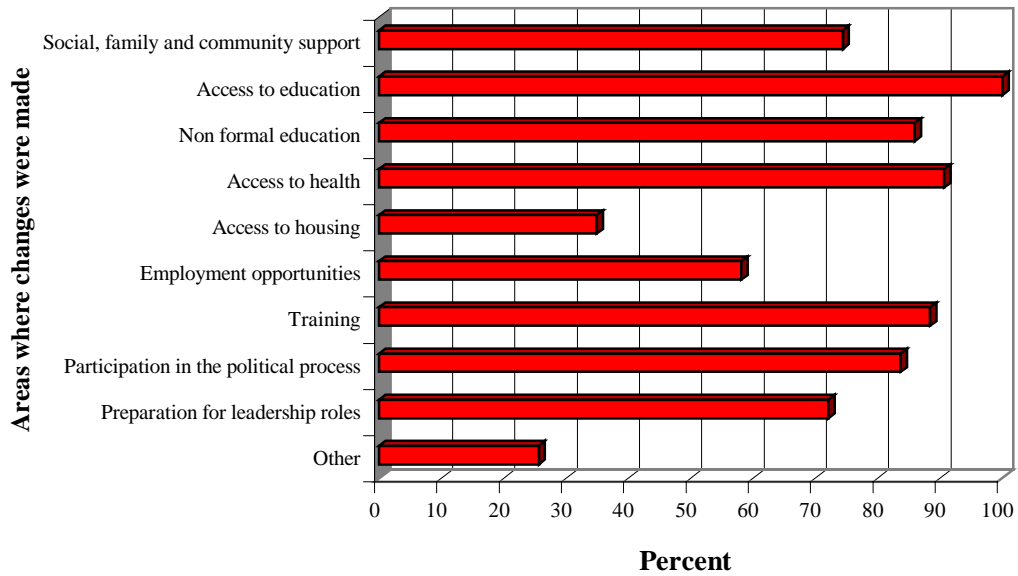
79. Compared to the situation as at ICPD+5, the ECA region has recorded a spectacular increase from 38 to 66 per cent in measures being put in place by member States to protect the reproductive rights and to meet the sexual and reproductive health and development needs of adolescents and youths through national programmes. However, the dismal economic situation of most of the States and the flat support from the international community has affected the strengthening of adolescent and youth programmes. Despite these drawbacks, UNFPA's 2003 Field Inquiry shows that 98 per cent of ECA member States have included issues pertaining to sexual and reproductive health and life skills development in their school curricula. They have also adopted IEC/Advocacy as an important tool to accompany adolescent sexual and reproductive health (ASRH) programmes for out-of-school youths (UNFPA 2003c).

80. At a micro level, the ECA ICPD+10 survey sought to determine the extent to which each of its member States has adopted measures consistent with international conventions on the rights of the child and to address pertinent ASRH including adolescent fertility issues. The findings confirm that member States have adopted policies, strategies and measures on children's rights. In terms of key actions taken by these States, 41 among the responding States have provided equal educational opportunity to children and youths; 38 States have put in place provisions to protect street children and another 37 to protect orphans; and 36 States have enacted laws against child exploitation.

81. In addition, all responding member States have adopted a mix of special measures and programmes aimed at meeting the needs of the children and youth (see Annex I: Table 15). For instance, 39 States have provided access to health; 38 States have made provisions to train them; and 37 States have provided non-formal education facilities (see Figure 5 for these and other actions).

82. The adoption and implementation of youth and adolescent sexual and reproductive health programmes differs across sub-regions. Half of the States in the northern sub-region offer access to youth friendly services, compared to 8 States in the eastern sub-region, 7 States in the southern sub-region, 12 States in the western sub-region, and 5 States in central sub-region. In the particular case of preparing the youths for leadership roles, 31 member States have launched programmes designed to meet this objective. In South Africa, Sierra Leone and Senegal, satellite clinics accessible to large youth populations have been established in schools or strategic locations.

Figure 5: Percentage Distribution of Countries by Special Measures or Programmes Adopted by the Government in Order to Meet the Needs of Children and the Youth



83. In particular, 35 (81 per cent) of the responding member States acknowledge providing youth friendly RH services. Innovative measures in this regard include using hotlines and promotion of youth-focused NGOs to deepen youth participation in the design and implementation ASRH programmes. Notwithstanding the competing priorities that face governments, most States plan for youth development in a holistic manner providing as part of ASRH package a mixture of formal education and vocational training programmes. Of these, adolescent prevention and control of sexually transmitted infections (STIs), including HIV/AIDS is, by far, the most popular strategy or measure adopted by the States (98 per cent) to address ASRH issues (see Annex I: Table 16). In this regard, the 2003 UNFPA Field Inquiry further reveals that NGOs and youth associations have been playing a critical role often in non-clinical settings, providing services, counseling in HIV/AIDS prevention, SRH and adolescent development issues and concerns. Increasingly as well, specific programmes are being formulated to address the special needs of the girl-child. Examples are found in Cote d'Ivoire, Lesotho, and Uganda within the context of their HIV/AIDS programmes for out-of-school youth.

84. Adolescent fertility issues have also raised considerable concern in the region since the 1990s, resulting in the adoption of a mix of measures and strategies including changes in legislation. Thirty-seven of the responding States (86 per cent) have enacted laws and put in place measures that either prevent high risk child bearing or educational programmes that favor life planning skills; 84 per cent of them have taken similar action to reduce mortality and morbidity associated with early childbearing; 79 per cent have done so either to ease access to contraception for adolescents regardless of their marital status or prevent early marriages; 72 per cent have similar actions aimed at eliminating discrimination against young pregnant women (see Annex I: Table 17). A growing number of States (e.g. Burkina Faso, Ghana, Senegal, and Uganda) have also enacted laws to eliminate female genital cutting (FGC) and other practices harmful to the RH of girls. A number of others (Kenya, Senegal, Sierra Leone, South Africa, Tanzania, and Zambia) have adopted policies and measures that allow the readmission of pregnant girls into school after delivery.

Constraints

85. A number of traditional values, beliefs and practices that are harmful to the RH and RRs of children and youth constrain the implementation of the ICPD-PoA recommendations. While many cultures and traditions help to socialize children and youth, the persistence of taboos in some, by limiting or preventing explicit recognition and discussion of sexuality among young adults, militate against such efforts. Traditional attitudes that are conducive to high fertility, gender discrimination and sexual exploitation of girls and women still persist in some States often leading to high rates of unwanted pregnancy, unsafe abortion and STIs (including HIV/AIDS). In Ethiopia and Chad, local cultures favor early marriages leading to early pregnancy and childbirth. Early motherhood has resulted in high incidence of obstetric fistula that carries a heavy social stigma and shortens a girl's education and employment opportunities and ultimately increases poverty.

86. In general, the youth in most of the States have not been actively involved in the formulation of programmes affecting them. In some cases parents, community leaders and government officials have not been fully sensitized about the goals and methods of such programmes. A major challenge in attaining the MDG target of universal education for children and youth relates to reducing school non-attendance and dropping out, particularly among children from poor families. Although a number of States have strategies or measures to reach school drop-outs, the coverage and dimension of such interventions is not known.

87. There is also inadequate knowledge of the magnitude and extent of harmful traditional practices and their effects on youth. Very little progress has been made in conducting socio-cultural research or situational analysis to identify the needs of children, youth and adolescents and the effects of traditional practices on their reproductive health and overall well-being.. Even in States where youth-friendly RH services have been set up, the service providers are still largely trained to deal with adults, and are not sensitized on the special needs of youth. School curricula related to RH and RRs may be developed, but good instructors and quality educational material to ensure quality in the education are still lacking.

88. The resource constraint has forced programmes to shelve strategies that distinguish between the realities and the needs of young people based on sex and gender. Another challenge has been the lack of knowledge of local mores and culture and hence, appropriate strategy in the multi-cultural and ethnic setting of the region for reaching unmarried adolescents, and young people that are not in organized/formal settings particularly in the rural areas.

89. Overall, against a backdrop of war and civil unrest in many parts of region, the worsening conditions of health, education, employment and human rights and needs of children and youth have inhibited their welfare and other life opportunities. Poverty also has a profound influence on the vulnerability of children and youth to ill health including worsening RH conditions and reduced socio-economic and political advancement.

CHAPTER FIVE

REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

90. A major goal of ICPD-PoA is that recommendations relating to reproductive health (RH) and reproductive rights (RRs) should be viewed in the broader context of providing basic health services and fulfilling the overall socio-economic development needs of the populations in the various member States of the UN family (ECA 1998). Operationally, this translates into making available universal access to a full range of high quality RH services through the primary health care (PHC) systems. Reproductive rights on the other hand, recognize the right of all couples and individuals to decide freely and responsibly, the number, spacing and timing of their children, to have the information and means to do so, and to make decisions concerning reproduction free from discrimination, coercion and violence.

Progress towards achieving ICPD-PoA goals

91. Given the primacy of RH issues within the ICPD-PoA, indications are that as at ICPD+5 and towards the development and implementation of RH strategies, ECA member States had (i) adopted policies and programmes and enacted laws that were (at the time) favorable to adolescent reproductive health (ARH) including the establishment of centers for counseling on family planning and RH and service delivery to young people; (ii) amended the penal code and abolished the 1920 French law on abortion (some States); (iii) formulated action plans on ARH as well as RH strategy and/or youth development policy; and (iv) increased accessibility to health facilities for commodities and services.

92. Towards reducing maternal mortality, member States had expanded coverage and improved the quality of PHC through IEC, better referral services, provision of emergency obstetric care, training of lower cadre health staff in life saving skills, built more health facilities in remote areas, and formulated safe motherhood strategies. In the area of infant mortality, national immunization campaigns were continued, breastfeeding was promoted as was the WHO/UNICEF approach for an integrated management of childhood illness, nutrition policies were formulated, free treatment for malnutrition and diarrhea related diseases was provided, and free health care was given to pregnant mothers and children aged under 6.

93. Regarding the provision of RH services to special groups, ARH projects had been developed in many States offering peer counseling and IEC in combination with recreation, youth centers targeting out-of-school adolescents had been set up, women's professional NGOs had set up crisis centers and legal clinics for counseling and research to deal with issues of gender violence, and measures had been taken to enhance the role of men in sexual and reproductive health, including sensitization and awareness campaigns for involvement of males in FP services. The ICPD+5 review report provides other details of achievements in the delivery of RH services since Cairo.

94. The ICPD+5 review revealed that available resources did not permit “doing everything well” in terms of implementing the ICPD-PoA recommendations particularly in the core RH/RRs sector. More importantly, the technical base and the political will to prioritize were lacking. The deteriorating economic situation that has continued to date, affected more than just service provision. Many cultural traditions also militated against improvement in RH status and in some cases, actually contributed to deterioration in the quality of services provided.

95. The pertinent question then is, has the pre-1999 scenario changed significantly in the last five years and if so, in what direction and with what impact? Towards this end, the RH section of the ECA ICPD+10 survey was quite comprehensive and sought information on (i) actions by member States to integrate RH into their primary health care (PHC) system; (ii) measures adopted in the RH areas of family planning, role of men; maternal and infant mortality; abortion; female genital cutting; breastfeeding; infertility; STIs; and (iii) partnerships in population and RH programmes. Box 2.3 presents a synopsis of the regional situation in terms of what can be regarded as “best practices” since ICPD+5 based on findings from the UNFPA 2003 Field Inquiry focusing not only on general issues but also on primary health care and family planning.

96. Consistent with the UNFPA Field Inquiry findings, results from the ECA ICPD+10 survey indicate that improvements in RH status and services that prevailed prior to ICPD+5 have continued to date. Available information from the ECA ICPD+5 and ICPD+10 surveys suggests increases in the proportion of member States that have adopted recent strategies in the RH areas of family planning (22 per cent increase), maternal mortality (30 per cent increase), infant mortality (34 per cent increase) and role of men (33 per cent increase).

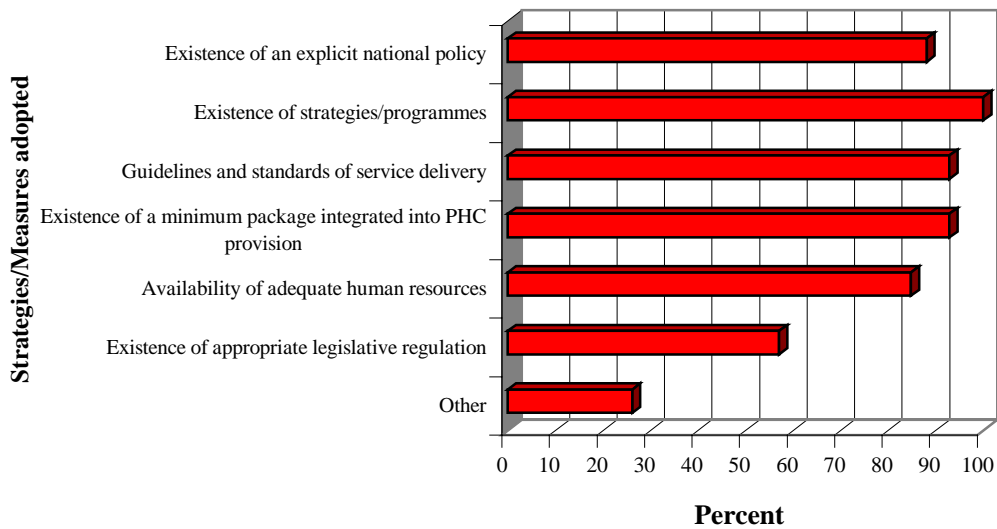
97. Virtually all the responding States to the ECA ICPD+10 survey (42 States) acknowledge integrating RH services into their PHC system at various levels (see Figure 6 and Annex I: Table 18). Explicit strategies or programmes exist in 42 States while guidelines and standards of service delivery and existence of minimum package are found in 39 States), explicit population policy (37 States) and adequate human resources (23 States).

98. Towards continued improved access to RH services, member States have reported that they have adopted several strategies and measures and have made legislative changes in the RH areas of maternal/infant mortality and STIs (42 States); breastfeeding (40 States), family planning, role of men, abortion (38 States), treatment of infertility (34 States) and FGC (23 States). In addition to these actions and/or achievements, UNFPA has since 2001, provided global and country level leadership for achieving RH commodity security. Many States have accepted the need to ensure RH commodity security and are putting implementation strategies in place. In spite of these efforts and as the following developments imply the availability and accessibility of services to a majority of people in the various States particularly in the rural areas remains a major challenge in the region (UNFPA 2003c).

99. Contraceptive use remains low in the region. Twenty per cent of currently married women (ages 15-49) are using modern contraceptive methods. This proportion is lower in middle and western Africa (4.8 and 7.9 per cent respectively) than in the northern and southern sub-regions (41.9 and 51.4 per cent respectively) (UN 2004). The number of member States adopting specific RH strategies and programmes varies from 31 (72 per cent) in the case of “access to

confidentiality and privacy of RH services” to 42 (98 per cent) in the case of “adolescent prevention and control of HIV/AIDS and other STIs”. However, fewer States (23) have adequate human resources or appropriate legislative regulations to help integrate RH services into their PHC provision. Across the region, 5 States in the northern sub-region have adequate resources, as against 6 in the western, 5 in the eastern, 4 in the southern, and 3 in the central sub-region.

Figure 6. Percentage Distribution of Countries by how RH has been Integrated into PHC Provision at Various Levels of Policy and Legislative Implementation



100. A significant number of the responding States (38) have made concerted efforts to ensure male participation in sexual and reproductive health. These are somewhat unevenly distributed across the region with 13 in the western sub-region, 9 in the eastern, 7 in the southern, 5 in the central and 4 in the northern sub-region. Actions purporting to ensure increased male involvement comprise stepping up advocacy (36 States), sensitization (37 States), easing access to male sensitive services (30 States). However, only 11 of the States have IEC campaigns targeting men and addressing issues of male involvement and responsibility in family planning, maternal health and other RH services.

101. Female genital cutting (FGC) is a practice that exists mainly in SSA and is a major concern for the region. In a number of member States, there appears to be a heightened awareness of the need to eliminate the practice. Twenty-three of the 43 responding States have taken the necessary steps to effect elimination. Fifteen States have adopted legislative measures to deal with the problem; another 22 have stepped up sensitization campaigns to eradicate the practice; 10 others in the southern and central sub-regions acknowledge not practicing it. Other measures include the use of IEC campaigns against FGC in schools as well as providing alternative sources of income to FGC practitioners as an inducement to stopping their practice.

102. All 43 responding governments have stepped up STI prevention and treatment sensitization campaigns; 42 of them have adopted measures to improve access to STI prevention, detection and treatment; only two States however, have launched IEC campaigns focusing on STI prevention in schools. Given the fact that there are resource limitations, many States have adopted the syndromic approach to STI detection and treatment. STIs/HIV prevention and treatment interventions have been extended to the army, police and armed militias (Benin, Sierra Leone, Democratic Republic of Congo).

103. Given the magnitude of the various RH problems, many member State governments have adopted measures to promote partnership with the private sector, local NGOs, civil society, as well as educational and youth institutions. Forty-one States have formed partnerships with national NGOs; and 39 governments have formed partnerships with international NGOs and CSOs (see Annex I: Table 19). These partnerships have benefited RH programmes in several ways including additional financial assistance and human resources needed to implement programmes more successfully. Partnerships have also been established to coordinate administrative regulations. Mechanisms to coordinate the activities of public and other partners have also been established in 39 States. In addition, high level political commitment has been demonstrated where Ministers and Heads of Governments have made public Statements in support of family planning and HIV prevention (Ghana, Mali, Uganda).

104. Both the ICPD+5 Key Actions and the MDGs have identified the proportion of births attended by a professionally trained and skilled attendant as a critical indicator for monitoring the quality of maternal services and progress towards achieving the critical goal of maternal mortality reduction. For 1995, WHO estimates that only 47 per cent of deliveries in the region were attended by skilled personnel compared to an average of 77 per cent and 99 per cent respectively for Europe and North America. Figures for the ECA region in particular, mask a great deal of inter- and intra- State variations as well as sub-regional variations ranging from 6

and 8 per cent respectively in Eritrea, Ethiopia, to 36 per cent in Nigeria and 46 per cent in Egypt, and 97 per cent in Mauritius (WHO 2001). Adolescent childbearing significantly contributes to the risk of dying. About 50 per cent of women in the region have their first pregnancy by the age of 19. This increases their lifetime risk of maternal death estimated at 1:14 for the region as against 1:1300 in Europe as well as the risk of developing debilitating morbidities such as obstetric fistulae. UNFPA (2003b) estimates that each year some 50,000 to 100,000 women sustain an obstetric fistula worldwide.

105. The inclusion of quantitative targets that have to be met by 2015 in respect of maternal mortality has heightened the awareness of governments (in the region) to the need to provide reproductive health services. Forty-two responding States have taken appropriate measures to reduce maternal mortality. These include the provision of emergency obstetric care (41 States or 95 per cent), neonatal care (95 per cent) and assisted delivery services (98 per cent). A significant number of governments have thus been spurred to make stronger political commitments towards tackling the problem of high levels of maternal mortality and morbidity. Several States (88 per cent) have taken recent measures designed to manage complications arising from abortion. Whereas virtually all the reporting States in the eastern and southern sub-regions report such measures, only 4 northern, 11 western, and 5 central States did so. The most common measures include the provision of care to women experiencing complicated abortions (38 States) as well as offering post abortion counseling (32 States). Thirty-five States have adopted measures aimed at preventing and/or reducing the incidence of unsafe abortions. On the whole, the quality of emergency obstetric care has improved through training, provision of equipment and supplies, and by putting in place communication and transport systems.

106. Regarding reductions in infant mortality, forty-two States provide neonatal care, integrated care of infant morbidity, and extended immunization programmes. In a few other States nutrition campaigns have also been launched. Other measures include the continuation of the national immunization campaign to eradicate major diseases of childhood (Algeria, Burkina Faso, Burundi, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Mali, Lesotho, Senegal, Malawi); promotion of breast feeding (Burkina Faso, Burundi, Ethiopia, Malawi, Mali, Morocco); adoption of the WHO/UNICEF approach for an integrated management of childhood illnesses (Eritrea, Ethiopia, Gambia, Kenya, Mali, Morocco, Togo); formulation and implementation of a nutrition policy (Algeria, Burkina Faso, Cape, Verde, Central African Republic, Gambia, Malawi, Senegal); free treatment for malnutrition and diarrhea diseases (Ghana); and free health care for pregnant mothers and children under the age of five (South Africa).

Box 2.3: Best practices in RH and RRs since ICPD+5

Generally, many States have upgraded their RH facilities. *Ghana* scaled up the provision of antenatal, prenatal and postnatal care at all levels. *Benin and Guinea Conakry* have emphasized recruitment of additional personnel. **South Africa** has provided additional resources for training healthcare workers and deployment of additional staff. In **Botswana** 90 per cent of the population now lives within 15 kilometers of a health care facility. *Mozambique* has introduced procedures for accreditation of facilities to improve quality of RH services. In *Mauritius* opening hours for health facilities have been extended to make services more accessible.

Integrating RH services into the PHC system – all SSA States have integrated a minimum package of RH services into their PHC. *South Africa* has introduced “one-stop service centers” leading to inclusion of RH services in such centers. *Cote D’Ivoire and Zimbabwe* have included essential obstetric care in their PHC services. *Liberia, Mozambique and Zimbabwe* have included STI and HIV/AIDS prevention in their PHC services.

On family planning, most SSA States have available a range of contraceptives (injectables, IUDs, implants, male condoms, female condoms (available in two thirds of SSA States). Condom use is widely promoted in *Chad, Ghana, Guinea Conakry, Liberia, Seychelles, Swaziland, Tanzania*.

Nearly 70 per cent of SSA States have logistics management systems or procurement plans in place provided largely (100 per cent) by external assistance excepting in Botswana, where the government provides all RH commodities.

Many member States including *Angola, Benin, Burundi, Cameroon, Chad, Cote d’Ivoire, Guinea Conakry, Kenya, Lesotho, Liberia, Mozambique, Namibia, Niger, Senegal, Swaziland, Zambia* have introduced **training in essential obstetric care**; many others have taken measures towards early treatment of malaria and provision of vitamin A supplements. *Egypt* has experienced a significant decline in maternal and infant mortality; still others have improved data collection and record keeping for monitoring purposes. *Angola and Namibia* have introduced measures to improve maternal mortality audits alongside introducing a system for data collection, information flows and the feed back on maternal deaths. In *Zimbabwe* an inquiry/audit meeting is conducted into every prenatal and maternal death at all levels of the health system. *South Africa* published a report in 2003 on a confidential inquiry into maternal deaths with the aim of using its findings to reduce maternal mortality; *Swaziland* has undertaken a similar inquiry. Lessons from *Egypt and Zimbabwe* indicate that maternal mortality can be reduced significantly over the course of a decade.

Most SSA States (*Botswana, Ghana, Mozambique*) provide training in the use of manual vacuum aspiration (MVA) particularly for health workers (including mid-wives).

Source: UNFPA 2003 Field Inquiry Report

107. A significant number of States (40) have also adopted strategies and measures to promote breastfeeding to promote birth spacing. In States such as Ghana and Botswana, these measures include sensitizing women to the importance of intensive breastfeeding, providing guidelines to HIV positive mothers as well as launching programmes aimed at preventing mother-to-child transmission of HIV. Baby friendly hospitals have also been established in some States.

Constraints

108. Despite the aforementioned success stories, several challenges still persist in the realization of the ICPD-PoA goals relating to reproductive rights and reproductive health. The inability of States to prioritize and re-allocate scarce resources to ensure that funds are available for the provision of adequate RH services especially in the context of HIV/AIDS and other developmental challenges is a major constraint. In addition, possible synergies between measures taken to address HIV/AIDS and reproductive health have not been utilized. Financial and human resource limitations as well as cultural obstacles also inhibit the provision of RH services. This is further compounded by the fact that the limited resources available are largely donor dependent.

109. The HIV/AIDS epidemic in many ECA member States, especially among young women and the youth is a well-recognized development challenge that continues to erode gains already realized. There is difficulty with addressing culturally sensitive issues such as early pregnancy and early motherhood, unsafe abortion, very low acceptance and use of family planning methods, female genital cutting, and gender violence. In spite of increased availability and accessibility to family planning, it remains mostly female-centered and supply-side short-term oriented. The situation is compounded by critical resource shortfalls necessary for ensuring RH commodity security. Emergency obstetric care is only provided in a few areas and on a pilot basis and safe motherhood services are largely unavailable to the majority of the population.

110. Additionally, securing effective partnerships between the public, private, non-governmental organizations and donor community has remained problematic. Access to health care is generally low in most SSA States and access to reproductive health services is even lower. There is also a large unmet need for family planning and other reproductive health services, but resources for reproductive health commodities and for putting in place effective logistic systems remain scarce. Monitoring progress or the lack of it towards the achievement of goals and targets, is hampered by the lack appropriate data.

CHAPTER SIX

HIV/AIDS

111. The ICPD-PoA integrated the HIV/AIDS pandemic into reproductive health and rights but did not set specific benchmarks. At ICPD+5, a new benchmark was established calling on “Governments, with assistance from UNAIDS and donors, to ensure that by 2005, at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Additionally, services should include access to preventive methods such as female and male condoms, voluntary testing, counseling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005, prevalence in this age group is reduced globally, and by 25 per cent in the most affected States, and that by 2010 prevalence in this age group is reduced globally by 25 per cent” (UN 2000: para 70).

112. ICPD+5 further called on governments, in partnership with UNAIDS and with communities to (i) develop and implement national policies and action plans; (ii) enact legislation and measures to prevent discrimination against people with HIV/AIDS and against vulnerable groups, including women and young people; (iii) improve care and support including home-based care; (iv) take steps to mitigate the impact of AIDS; (v) give high priority to STI prevention and treatment; and (vi) integrate STI and HIV/AIDS prevention and services into reproductive services and primary health care.

113. The MDGs established yardsticks for measuring progress towards combating the spread of HIV/AIDS, malaria and other diseases (Goal # 6). The hope is for member States to halt and reverse the spread of HIV/AIDS by 2015. At the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, 189 member States also adopted the Declaration of Commitment on HIV/AIDS, reflecting the global consensus on a comprehensive framework for action to achieve the MDG HIV/AIDS target. This action includes carefully monitoring the achievement of concrete, time-bound targets, and emphasizes the importance of working in partnership.

Progress towards achieving ICPD-PoA goals

114. Understandably, virtually all the ECA member State governments were not associated with the HIV/AIDS epidemic early in its spread. This situation changed dramatically during the early 1990s. Twenty-five out of the 50 ECA member States that submitted national reports to ICPD (1994) acknowledged putting in place (largely within Ministries of Health), a national level programme, task force or committee to deal with the pandemic. The establishment of UNAIDS in 1996 to coordinate the UN response has been a significant factor for international, regional and national support to governments and development partners on HIV/AIDS. Efforts at these various levels are often supported and complemented by those of NGOs, religious groups, civil society and people living with HIV/AIDS (PLWHA) as well as donors. High-level

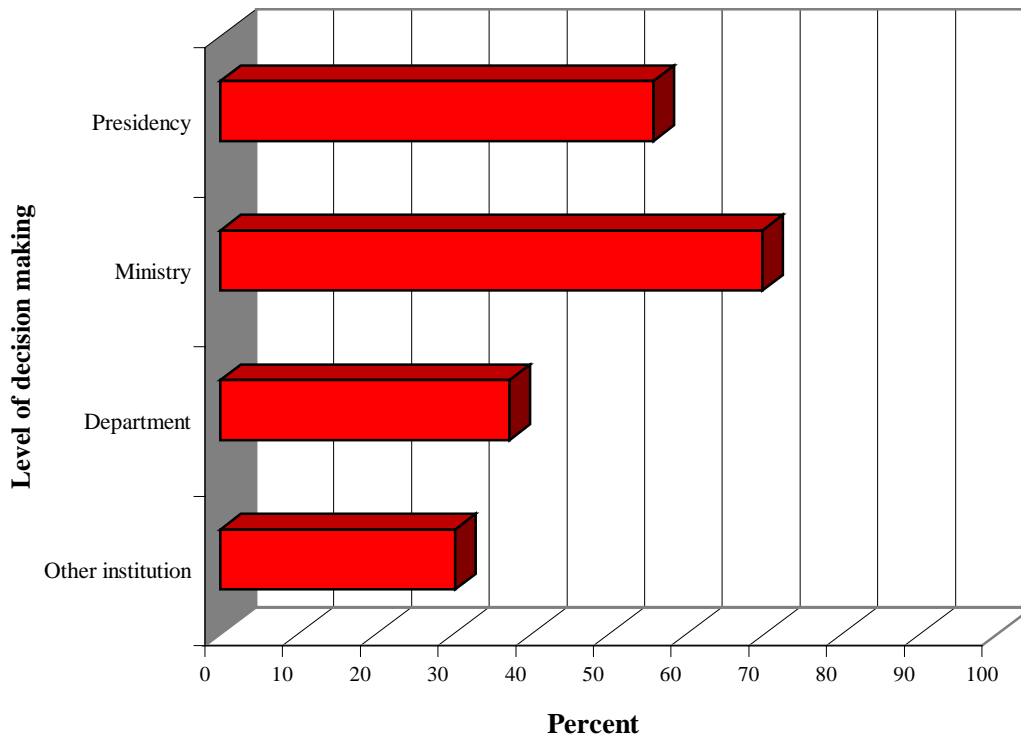
institutional frameworks have been widely established since ICPD+5 to coordinate the national response.

115. As at ICPD, anti-retroviral (ARV) regimens were not available; their expansion to reach the poor nations is not only a recent phenomenon but has depended heavily on intensive international and national advocacy, negotiation, and improved/cheaper medication. Beginning in 2001 and consistent with the WHO/UNAIDS commitment to treat 3 million people (the majority living in SSA) with ARV drugs by 2005, the treatment of PLWHA had included the provision of ARV regimens on a pilot basis. UNAIDS (2003a) had estimated that in 2003 only 50,000 out of 4+ million people in the ECA region that needed ARVs had access to the drug. Efforts to expand the provision of ARV drugs are underway in States such as Botswana, Congo, Kenya, Nigeria, Senegal, Sierra Leone and South Africa albeit, only Botswana has a national programme. Difficulties remain with infrastructure requirements and staff training among other concerns.

116. The ECA ICPD+10 survey was equally comprehensive with respect to the solicited information on the HIV/AIDS pandemic. The foci included the multi-sectoral framework put in place by governments to address it; the level of decision-making within government structure at which the body responsible for HIV/AIDS was located; the measures and strategies adopted towards its prevention and treatment; integration into the PHC system and RH programmes and services.

117. The responses demonstrate increased political commitment on the part of the ECA Heads of State and Governments. Virtually all the responding States (42) confirmed establishing a unit within the government structure to coordinate HIV/AIDS-related efforts. In 24 of these cases, the unit was located in the President's office as the President's Task team; 30 of the States had established AIDS Councils, Commissions or Desks at the ministerial level. Some of these structures had been extended to government departments in 16 States. Usually, these top-level bodies link with NGOs, the private sector and civil society including networks of PLWHA. As noted in the preceding section on RH services, Uganda's AIDS Commission has played a significant role in the management and reversal of the pandemic's spread. In Togo and Ghana, the President chairs the AIDS Commission. Burundi and Côte d'Ivoire have created special anti-AIDS ministries (see Figure 7 and Annex I: Table 20).

Figure 7: Percentage Distribution of Countries by Where the Body Responsible for HIV/AIDS Issues is Located in the Government Structure



118. The wide array of measures and strategies adopted by ECA member States as part of their overall national HIV/AIDS prevention and treatment strategy, is presented in Annex I: Table 21. Progress in this area includes:

119. Behavioral surveillance is increasing to supplement epidemiological surveillance in tracking progression of the epidemic and the impact of interventions.

120. Improved epidemiological surveillance techniques are increasing the standardization and reliability of data.

121. There is increased HIV awareness in diverse communities of many States.

122. Diverse HIV prevention efforts such as HIV awareness, delayed sexual debut, and condom use have been put in place particularly for the youths aged 15-24.

123. Voluntary counseling and testing (VCT) services that were rare in 1994 are being expanded throughout SSA.

124. Eighteen responding member States have integrated HIV/AIDS into PHC provision; 93 per cent of these have taken extra steps to integrate HIV/AIDS into RH programmes and services.

125. Condoms are readily available; 42 responding States have increased the availability of condoms over the past decade.

126. Services for preventing mother-to-child transmission (PMTCT) of HIV is provided in many States since ARV drugs are becoming increasingly affordable and available.

127. Although much remains to be done, many States have PMTCT services in pilot sites in urban areas and plan to scale up their efforts as funds, facilities, commodities and staff training make it possible.

128. Community care and support programmes for orphans and vulnerable children (OVC) are being developed particularly in southern and eastern sub-regions..

129. Care and support for PLWHA is increasing with considerable expansion in home care services primarily through NGOs and faith-based organizations.

130. Over half the States have adopted policies to prevent discrimination against PLWHA.

131. Despite some resistance, reducing stigma and discrimination and increasing openness are widely accepted as critical to effective HIV prevention and care.

132. Partnerships have intensified, capacity building efforts have expanded, and resource mobilization within and from outside the region has grown significantly.

133. In the last few years, new funding sources have included the Global Fund to fight AIDS, Tuberculosis and Malaria; the World Bank Multi-Country AIDS Programme; UNAIDS core and co-sponsor funding and other multi-lateral and bi-lateral funding; private sector contributions; and increased national and other commitments. At the African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases held in Abuja, Nigeria in 2000, African Heads of State and Governments pledged to allocate at least 15 per cent of their national annual budgets to improving the health sector. They also agreed to mobilize the required human, material and financial resources for HIV prevention, provide care and support, and strengthen effective partnerships to achieve these goals. A commission on HIV and Governance in Africa (CHGA) had also been established at the UNECA. As an “Activist Commission”, CHGA does not intend to have distinct research and implementation phases. Rather, it intends to ensure that advocacy and policy engagement are mounted in parallel with research.

Constraints

134. The SSA region is host to 70 per cent of PLWHA worldwide cases (i.e. about 30 million out of 42 million for the entire world). In the hardest-hit southern and eastern sub-regions, the epidemic has reversed the unprecedented achievement made since World War II in reducing infant, child, and adult mortality. Infant and adult mortality rates have been rising sharply in eastern and southern sub-regions as a result of the pandemic. Based on data for 14 States from the 1990 UNFPA Field Inquiry, HIV prevalence rate estimates ranged of 0 – 10 per cent for the population aged 15-24.

135. According to UNAIDS (2002) estimates, the prevalence rate (at the end of 2001) in adults aged 15-49 in the western sub-region ranged from 1.6 to 11.8 per cent as against 0.1 to 2.6 per cent in the northern sub-region, 3.6 to 12.9 in the central sub-region, and 2.8 to 15 per cent in the southern sub-region. According to WHO estimates, whereas 10.6 million PLWHA adults lived in SSA in 1994, there were about 30 million (adults and children) by 2003 with 3.5 million new infections in 2002 alone (UNAIDS/WHO 2002). The high HIV prevalence rate has reduced life expectancy in the hardest-hit States, particularly for women who are typically infected young; changed dependency ratios with over 11 million children orphaned; and has raised infant, child and adult mortality.

136. There are no indications that ECA member States, excepting Uganda, will meet the ICPD+5 goal for 2005 of 25 per cent reduced prevalence in the 15-24 age group. Given the demographic impact of HIV/AIDS, socio-economic impacts are increasingly felt, especially in sectors with highly trained workforce (e.g. health, education, governance). Uniformed forces face particularly high HIV prevalence with the risk of reducing national security. The pandemic thus has health, development and security concerns.

137. The difficulty with generalization about the progress made in controlling HIV/AIDS in the region is that while in Senegal and in a few sub-populations (e.g. among young women in Lusaka and some high-prevalence areas of South Africa), HIV incidence appears to be declining, in sub-regions with slow epidemic progression, HIV prevalence is rising, particularly in certain population groups such as sex workers and uniformed forces. Therefore, it appears ICPD+5 benchmarks will not be attained by 2005 except in very few States and sub-populations.

138. The main constraints have been insufficient human, financial and material resources, political realization of the sectoral and development impacts of AIDS, AIDS-related attrition in all sectors where prevalence is high, and the difficult economic and sometimes political environment in many States. Stigma and discrimination remain widespread, and openness about the epidemic, while increasing, remains limited. Entrenched gender inequality remains a major factor as do socio-economic inequality, high mobility, instability and conflict. The link between HIV/AIDS and poverty is complex, but the existence of widespread poverty and economic inequality directly and indirectly contribute to HIV transmission and impede care and support. Despite the recent strengthening of political leadership and the prioritizing of AIDS on the international and national development agendas, greater commitment is still essential. For example, despite the Abuja commitment to spend 15 per cent of GDP on health, UNFPA (2003a) noted that, by 2003, the percentage expenditures on health ranged from 0.4 to 8.0 of GDP, with considerable variation in each geographical sub-region.

139. Several positive HIV preventive strategies (e.g. STI prevention and treatment; peer education, advocacy, BCC, socio-cultural and other strategies for awareness, attitude and behavior change; male and female condom use; male circumcision; voluntary counseling and testing and PMTCT) have been identified and are being utilized. At the cultural level, many risky practices have also been identified. Effective HIV prevention efforts have not been sufficiently scaled up, however, and remain patchy and limited in scope and impact (UNAIDS 2003a). HIV awareness is insufficient in some States, although it has increased significantly since 1994.

140. Individual behavior change approaches to HIV prevention have limited impact if the majority of people live in high-risk environments most of their lives. The main factors that impact on the risk environment in many ECA member States include:

141. Gender inequality: with girls and women having lower levels of education; less economic self-sufficiency and weaker legal rights than males; gender-based violence; cultural norms that accord them lower status and place them at risk. The ratio of female to male HIV infection increases annually; it was about 58 per cent in 2002 (UNAIDS 2003a). Sex work remains one of the few economic options for many impoverished women and girls, and sex workers are vital to reach in HIV prevention in all States.

142. Cultural values and practices such as adolescent initiation ceremonies that involve sex, sexual cleansing of widows, inheritance of wives, female genital cutting, and dry sex increase HIV transmission risks.

143. Poverty and inequality: the overall economic performance in many States over the past decade has been poor. Even when GDP has increased, this has not necessarily translated into more equitable distribution of wealth or more secure livelihoods for the majority. Continued economic insecurity, particularly for women, helps drive the epidemic.

144. Mobility: the movements of individuals or families in search of employment, internal population displacement and refugee status, all tend to increase vulnerability to HIV infection.

Social customs and controls break down, women are driven increasingly into transactional sex, reproductive and other health services and condom access and use decline; young people are particularly at risk of exploitation including sexual abuse.

145. Conflict and post-conflict situations: social controls break down most severely in times of war; this increases chances of widespread rape and minimum access to STI treatment or condoms to reduce infection risks.

CHAPTER SEVEN

POPULATION DISTRIBUTION, URBANIZATION AND MIGRATION

146. Many cities in the ECA region are facing major challenges in the provision of basic services (housing, transport and sewage disposal facilities) due largely to rapid population growth, increased insecurity, scarce foreign investment, and economic mismanagement. The highest levels of urbanization in the region are found in the northern and southern sub-regions where over half of the total population live in urban agglomerations. In contrast, only about a quarter of the total population in the eastern sub-region lives in urban areas. Although the latter sub-region is among the least urbanized regions of the world, its urban population grew by 5.8 per cent annually during the 1950-2000 period. The western sub-region is also experiencing one of the highest urban population growth rates in Africa at 5.3 per cent per annum.

147. On the other hand, some States in the central and eastern sub-region (Gabon and Djibouti) offer the extreme situation where two urban centers account for over 80 per cent of the total population living in urban areas. In the absence of sustained economic growth and political stability, the projected population increase of these cities (1990-2015) suggests possible worsening of urban agglomeration. There is also concern with the proliferation of 'urban-villages' (UN 2001). Indications however, are that some of these cities have become the prime locations of infectious diseases, notably tuberculosis and HIV/AIDS. Overall, in SSA, where about 80 per cent of all AIDS deaths have occurred, HIV infection is much higher in cities than in rural areas and in some places, by as much as a factor of four to one.

148. Towards the formulation of effective population distribution policies in these States, the ICPD-PoA called on Governments to (i) undertake research on the factors, trends and characteristics of internal and international migration as well as the geographical distribution of the population; (ii) improve management and delivery of services for the growing urban agglomerations and put in place enabling legislative and administrative instruments and adequate financial resources to meet the needs of all citizens; (iii) implement international instruments for protecting and respecting human rights; and (iv) address the causes of internal displacement, including environmental degradation, natural disasters, armed conflict and forced resettlement, and establish mechanisms to protect and assist displaced persons.

Progress towards achieving ICPD-PoA goals

149. To the extent that conflicts and poverty constitute important root causes of mass migration and forced displacement in much of the region, activities aimed at preventing and managing conflict, promoting good governance and the rule of law, and eradicating poverty are critical to ensuring the future success of national and regional migration management policies. The success of such policies would depend on the effectiveness of sound political and economic governance as reflected in the New Partnership for African Development (NEPAD). Ongoing initiatives under NEPAD and other poverty reduction strategies developed by member States such as PRSPs are promoting decentralization and democratization.

150. These initiatives are critical if equity is to be achieved in the distribution of national resources. Most urbanization and migration related issues are integral components of national population programmes highlighted in previous sections of this report. However, their effective implementation has been hampered by factors such as weak coordination, monitoring and evaluation mechanisms, changes in the planning frameworks, and complexity of NPPs. Towards creating alternatives to rural out migration, improving the livelihoods of the rural poor, and addressing the characteristic population mal-distribution, the ECA ICPD+10 survey solicited information on the explicit policies, strategies and measures that governments have adopted such as in-migration policies into large cities, promotion of rural development, implementation of international conventions, and reintegration of returning nationals.

Governments in 38 responding States acknowledge adopting a mix of strategies and measures, including changes in legislation to promote rural development in the formulation and implementation of development programmes (see Annex I: Tables 22 and 23). Some of the most popular strategies that have been adopted include labor intensive projects (27 States), training in non-farm jobs (32 States), improvement of rural transport and communication systems and social services (31 States), decentralization of administrative systems (35 States) and establishment of income generating projects (35 States). An equally significant number of States (28) have adopted strategies designed to address and improve access to land and land tenure, access to water (31 States), access to credit facilities (33 States) as well as policies that encourage the establishment of production and marketing co-operatives (31 States). To reduce urban bias and immigration into urban areas, Zambia and Zimbabwe had also adopted explicit policies encouraging the growth of medium and small-sized towns as well as resettlement towns and growth points.

151. Regional economic integration is a vehicle for economic development, which requires the free and flexible movement of capital as well as of labor. ECOWAS, SADC, EAC, IGAD among others are actively engaged in harmonizing custom procedures, tariff barriers and facilitating the free movement of people within the regional economic communities through the adoption of standard travel/immigration documents, for instance. By implementing the 2000 Round Censuses, many member States are building their socio-economic database, including data related to population movements and basic household amenities.

152. Much of these efforts have been undertaken with the support of UN Agencies, through regional and sub-regional initiatives. They include initiatives such as the Sustainable Cities Programme, and Water for African Cities and Urban Governance in the ECA region. Recently, the African Ministerial Conference on Environment (AMCEN) adopted the NEPAD Environment Action Plan that was endorsed by the Maputo AU Summit in 2003. At the latter, Heads of State and Governments also endorsed the piloting of NEPAD Sustainable Cities as a mechanism of improving, through competition, the quality of life in the various cities of the region.

Constraints

153. Although rural-urban migration is one of the key components behind the rapid growth of urban areas in the region, less than half of the responding States (20) had adopted strategies

aimed at addressing the characteristic population mal-distribution; only 14 of these are designed to achieve a balanced spatial distribution; 10 are designed to modify migration flows into large cities and towns. A small number of States (7) have adopted such other measures as development of secondary and intermediate towns (see Figure 8). Among the few States that had adopted some form of migration policy, seven were explicit policies designed to decrease immigration into metropolitan areas. Only Sudan had adopted an explicit policy seeking to increase immigration into its metropolitan areas. A few other States desired to decrease out migration from large cities while seven other States had adopted policies intended to maintain the current levels of in-migration into metropolitan areas.

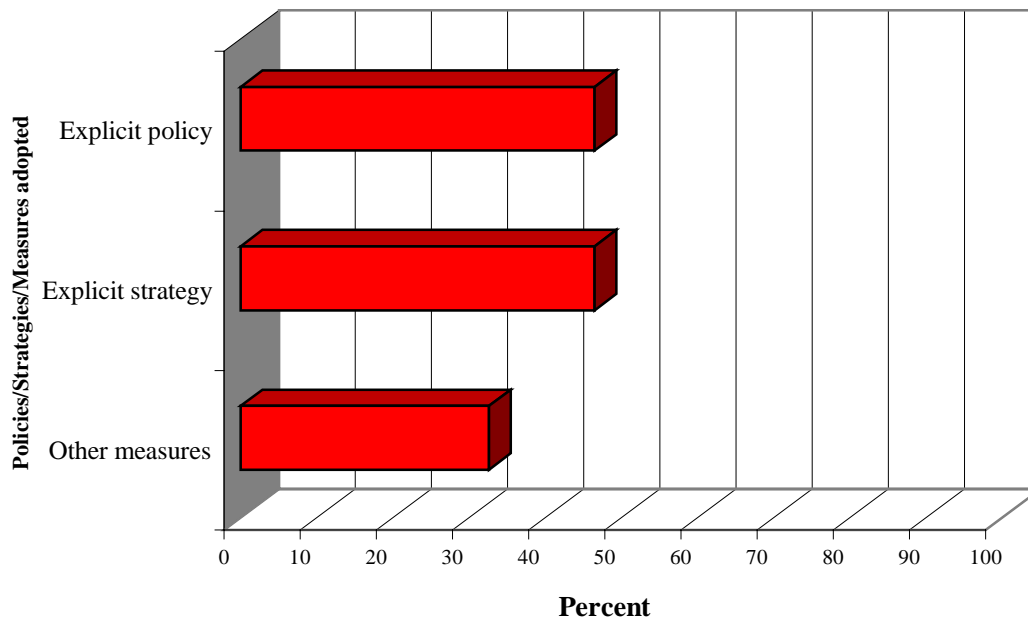
154. It is also noteworthy that only 21 responding States had ratified the 1990 International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families. An even smaller number of States (8) are implementing the recommendations of this international instrument. In this regard, the AU and the NEPAD have adopted basic human rights as a guiding principle and are moving toward the implementation of instruments protecting refugees and Internally Displaced Persons (IDPs). However, internal and international conflicts continue to exacerbate the conflict situation thereby increasing the number of internally displaced persons.

155. Regarding the reintegration of returning nationals, a growing number of governments (28) have taken various measures and strategies including changes in legislation to ensure their successful reintegration. In 21 States, reintegration involves devising ways that allow returning nationals to effectively use their skills in the domestic labor market. Some States offer incentives such as customs and tax breaks to returning nationals while others such as South Africa promote the voluntary return of qualified nationals. A few others offer resettlement assistance or dual citizenship privileges. However, Africa's struggling economies, conflicts and lack of good governance continue to drive its few highly trained workers to migrate to western countries in search of better employment opportunities.

156. NEPAD's commitment to reversing the brain drain has become a focus of the human resource development strategy of enhancing the productivity of growth of ECA member States. However, despite many collaborative AU/IOM initiatives in reversing the African brain drain, success is still illusive.

157. Other challenges include (i) lack of relevant and up to date data and research findings to foster population and urbanization policies; (ii) inadequate capacity in areas such as urban management, local development, management of urban poverty and health, linking the consequences of economic, political and social policies with population distribution and internal migration; (iii) absence of sustainable regional development strategies, including small scale non-farming projects and poor planning of cities, and (iv) poor institutionalization of good political and financial governance.

Figure 8: Percentage Distribution of Countries by Explicit Policies, Strategies, Measures Adopted by Governments to Modify Population Distributions



CHAPTER EIGHT

CRISIS SITUATION AND POPULATION CONSEQUENCES

158. The ECA region has witnessed numerous conflict situations for several decades. These conflicts have taken a toll on the welfare of the population in the various States. Long-term authoritarian rule, denial of citizens' human rights and lack of popular participation in politics and governance are major causes of these conflicts. Other causes are internal conflicts that rapidly escalate into crises, humanitarian disasters and State collapse (e.g. Liberia, Rwanda, Sierra Leone and Somalia); and lingering border disputes between States (e.g. Cameroon and Nigeria; Eritrea and Ethiopia).

159. In 1993, there were 6.4 million refugees and 88,000 internally displaced persons (IDPs) in the region (UNHCR 2003). The situation worsened in 1994 when the number of refugees rose to 6.8 million with 2 million IDPs and 3.1 million returnees. These estimates suggest that whereas the annual increase in the number of refugees in the region was only 6 per cent over the 1993/1994 period, the corresponding increase in the number of IDPs was almost 2,200 per cent. Of the 8 largest refugee displacements in the world in the 1990s, five (Rwanda, Somalia, Burundi, Liberia and Sierra Leone) were in the ECA region. By 2000, the number of refugees had gone down to 3.6 million refugees (a 47 per cent decrease), while the numbers of IDPs and returnees dropped to 1.4 million (a 30 per cent decrease) and 279,400 (a 91 per cent decrease) respectively.

160. Twenty-seven States have experienced a situation of crisis as a result of conflict arising from neighboring States. Crisis situations occur all over the continent, but some regions are harder hit than others. Twelve out of 13 responding States in the western sub-region, 9 out of 10 in the eastern sub-region, and 7 out of 8 in the southern sub-region report that they have experienced one kind of crisis/conflict or natural disaster since 1994. In contrast, only 3 of the 6 responding States in the northern sub-region and 4 of the 6 in the central sub-region report having experienced similar conflicts or crises.

161. Other causes of the refugee crisis include poverty (15 States), environmental degradation (15 States) and natural disasters (13 States). Six States report forced settlements as a cause of internal displacement. Currently 18 States (Angola, Burundi, Congo, CAR, Democratic Republic of Congo, Eritrea, Ethiopia, Cote d'Ivoire, Guinea, Guinea Bissau, Liberia, Sierra Leone, Swaziland, Lesotho, Malawi, Mozambique, Zambia and Zimbabwe) are either in active armed conflicts, post-conflicts or experiencing other forms of humanitarian crisis, including food shortages. Additionally, the Sahelian States of Niger, Mali, Mauritania and Cape Verde continue to experience cyclical drought situations.

162. The population and development consequences of these various humanitarian crises are enormous. Conflicts invariably disrupt access to basic necessities, and lead to forced displacement of people as they flee in search of security, food and shelter. They involve not only the States directly concerned but also the neighboring ones as well as the whole sub-region(s) as

exemplified by the Burundi, Cote d'Ivoire, Liberia, and Rwanda conflicts. The consequences range from security issues, environmental degradation, increase in migrations and mortality especially for mothers, infants and children as well as in reproductive health problems. Armed conflicts and civil strife typically spiral into wider humanitarian crises as civilians are targeted or trapped in the crossfire, driven from their homes, and left to face hunger and disease. Vulnerable groups such as women, children and the elderly bear the brunt of these conflicts, as families are destroyed. They are exposed not only to physical and psychological trauma but also to other forms of socio-economic stress. There is also the emergence of the child-soldier phenomenon, an important scourge that is destroying youths in the region.

163. Towards addressing the root causes of movements of refugees and displaced persons, the ICPD-PoA encourages Governments and the international community to (i) take appropriate measures, particularly with respect to conflict resolution, the promotion of peace and reconciliation and human rights; (ii) reduce pressures leading to refugee movements and displacement of persons; (iii) find and implement durable solutions to the plight of refugees and displaced persons; (iv) ensure effective protection of and assistance to refugee population, with particular attention to the needs and physical security of refugee women and refugee children; (v) prevent the erosion of the institution of asylum; (vi) provide adequate health, education and social services for refugees and displaced persons; (vii) integrate refugee and returnee assistance and rehabilitation programmes into development planning, with due attention to gender equity. In particular, the ICPD-PoA encourages States to become parties to the 1951 Convention and 1967 protocol relating to the status of refugees and to put in place effective asylum procedures.

Progress towards achieving ICPD-PoA goals

164. In response to these crisis situations, ECA member States have taken various steps to improve crisis prevention and crisis management mechanisms through Pan African institutions such as the AU and sub-regional organizations such as ECOWAS, SADC, IGAD, and COMESA. In addition NEPAD explicitly incorporates the promotion of democracy and the rule of law as a development objective. The second AU-Civil Society Conference held in June 2002, adopted the concept of civil society participation as strategy for conflict prevention. The AU summit in July 2002 in Durban, South Africa witnessed the creation of the Peace and Security Council of the AU with a mandate to promote collective security and enhance early warning systems. The Protocol of Peace and Security drafted at the Durban summit also proposed the creation of an African Standby Force that could intervene in conflict situations at the behest of the AU and conduct post conflict disarmament and demobilization.

165. In recent years, six southern African States (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) have experienced severe humanitarian crisis affecting over 14 million people. The crisis involved critical food shortages caused by adverse weather conditions, poor economic policies and the HIV pandemic. In response to this humanitarian crisis, various agencies including WFP, FAO, UNFPA, UNICEF, among others, established the Regional Inter-Agency Coordination and Support Office for the Special Envoy for Humanitarian Needs in Southern Africa (RIASCO), to assist the regional governments to address the crisis. RIASCO assists in vulnerability assessments including the establishment of the Southern African

Humanitarian Information Management Systems and measures to enhance strategic planning and fund raising.

166. The ECA sub-regional organizations, in line with the AU orientations and in agreement with United Nations recommendations, are playing a variety of important roles in peacekeeping missions. The AU played the leading role in the peace process in the Comoros civil war, Ethiopia-Eritrea war. ECOWAS took a leading role to resolve armed conflicts in Sierra Leone, Liberia, Guinea, Guinea-Bissau, and Côte d'Ivoire. Equally, CEMAC, IGAD and SADC have taken leading roles in resolving conflicts in Burundi, Central African Republic, the DRC, Sudan and Somalia.

167. Towards a comprehensive assessment of these issues, the ECA ICPD+10 survey solicited information on the experiences of member States with situations of crisis, conflict, natural disasters, refugees, internally displaced persons alongside the government measures and strategies purporting to address them. Over 80 per cent of the responding States (35) acknowledged experiencing one form of crisis, conflict or natural disaster since ICPD. Of these, 27 (77 per cent) had experienced conflict/crisis in neighboring countries, 24 (69 per cent) had experienced drought, 23 (66 per cent) had experienced internal conflict/crisis, and 22 (63 per cent) had experienced flood. Consequent on a combination of these emergencies, over 70 per cent of the responding member States (31) confirmed having an influx of refugees; another 60 per cent had experienced an influx of internally displaced persons (IDPs). Among the causal factors for both of these situations (i.e. refugees and IDPs) are armed conflicts, forced settlement, poverty, environmental degradation, and natural disasters.

168. In response to the influx of internally displaced persons and refugees, responding member State governments have adopted various remedial measures and strategies. Over 70 per cent of them provide protection and assistance to these groups including basic health services, basic education, programme of rehabilitation, vocational training, adequate capacity preparedness, and employment opportunities. The contribution of NGOs and IGOs in assisting displaced persons and refugees has been growing in various parts of the region. Towards improving the working environment of these NGOs and IGOs, governments in 34 of the responding States (almost 80 per cent) have put in place measures to facilitate the work of these groups including the establishment and/or designation of a ministry to handle refugee issues. However, only 5 States have created government ministries to handle refugee issues. An additional 4 States provide land and security to refugees.

To guarantee basic human rights, adequate protection and assistance to displaced persons within their borders, 49 ECA member States have ratified the 1951 Geneva Convention Relating to the Status of Refugees, including 28 of the responding States (UNHCR 2003). In addition to ratifying this global protocol, 11 of the responding States are also signatories to either a regional (OAU/AU) or a sub-regional (e.g. SADC, ECOWAS) protocol on refugees and displaced persons. As regards the current policies towards entry of refugees or asylum seekers, 19 governments do not have any type of policy in place; only two (Benin and Sudan) have policies designed to halt the flow of these groups; another 5 States have policies aimed at reducing the flow.

Constraints

169. High levels of poverty, wide disparities in income distribution in the region, and the increasing impoverishment, provide fertile ground for political and civil unrest. Inadequate food security, agriculture and employment policies, coupled with weak early warning systems for prediction of natural and/or man-made disasters also constitute impediments to effective crisis management. HIV/AIDS has a decisive influence on the capability of communities to give adequate responses to humanitarian crisis. It is also both cause and consequence of the humanitarian crisis. Financial and logistical constraints often undermine the efforts of regional bodies to quickly respond to crisis situation. The easy circulation and trade of illegal small arms across borders and within States constitute an important threat to peace and security. Weak democratic institutions and insufficiency and/or lack of good governance continue to undermine the efforts to prevent crisis situations.

CHAPTER NINE

RESOURCE MOBILIZATION FOR THE IMPLEMENTATION OF POPULATION POLICIES AND PROGRAMMES

170. The ICPD-PoA calls on Governments to devote an increased share of domestic resources to population and development programmes that expand and improve the quality of reproductive health care, including family planning and STIs/HIV/AIDS prevention efforts. It urges the international community to effectively mobilize significant additional funds required for implementation (USD 5.7 billion in 2000 and USD 6.1 billion in 2005) (UN 1996).

Progress towards achieving DND/ICPD goals

171. The ICPD+5 review revealed that most States had embarked on the process of resource mobilization soon after the Cairo conference. Data on domestic resource flows generated from 61 country reports in 1996, show that States in Asia and the Pacific led other regions in mobilizing domestic resources (USD 5.1 billion) for population and RH programmes followed by Latin America and the Caribbean (USD 1.02 billion). However, only smaller amounts were mobilized in Western Asia and northern African sub-region (USD 260 million) and SSA (USD 196 million) (UNFPA 2003d).. Unfortunately, the “translation of commitment to ICPD goals into commensurate levels of donor funding has not been forthcoming” (UN 2000).

172. According to data collected from the 2003 UNFPA Field Inquiry, since ICPD, out of 52 responding States, 43 (91 per cent) have increased their domestic resources for the implementation of population and reproductive health programmes. The greatest proportion in this respect is recorded in the southern and northern sub-regions (100 per cent of the States) followed by those in the eastern sub-region (85 per cent), western sub-region (73 per cent) and the central sub-region (71 per cent). The largest increase in all sub-regions is made up of government funding (69 per cent of the States). Few responding States (13 per cent) cooperated with international organizations to increase their domestic resources; a few others (6 per cent) had an increase in private sector/NGO funding, in human resource provision (6 per cent) and in investment to improve infrastructure (4 per cent). In terms of increased government resources, the southern sub-region has the greatest proportion of States (91 per cent) that have committed a larger share of their domestic resources towards the implementation of population and reproductive health programmes, followed by the northern and eastern sub-regions with 83 and 77 per cent of the States respectively. The western sub-region presents a relatively smaller proportion compared to the other sub-regions with just 53 per cent of States reporting having increased domestic funding. As regards the central sub-region, less than half the States (43 per cent) have increased their domestic resources for the implementation of population and public health programmes.

173. These differences in the increase of Governments’ domestic resources across the sub-regions are also noted between States within a sub-region and depend on level of socio-economic development as well as socio-political priorities of the State. An example is Senegal, where the government increased its budgetary allocation to the social sector and particularly the health

sector, allowing the development of a national programme for health and social development where the State contributed 54 per cent of the budget, and the international community contributed 30.5 per cent. The same trend is observed in Benin where the government's contribution to population programmes has regularly increased since 1994. Even in a war-torn country like Sierra Leone, since ICPD+5, additional resources provided by the government for population programmes, though still insufficient, increased by 66.7 per cent in two years, from USD 15,000 in 2002 to USD 25,000 in 2003.

174. The generally positive trends recorded by UNFPA are consistent with those from the national reports provided by 20 ECA member States. In the latter, the significant increase in domestic funding was concentrated between 1998 and 2002. For example, Ethiopia has more than tripled its contribution from USD 4.5 million in 1999 to USD 15.1 million in 2002, while Algeria's domestic resource increased from USD 10 million in 1999 to USD 15 million in 2003. The United Nations World Summit for Social Development, held in Copenhagen in 1995 introduced the 20/20 formula that encouraged both donor and recipient States to allocate at least 20 per cent of their funding and budgets respectively, to the health and social services sectors. Uganda reports having exceeded this percentage since the 1994/95 fiscal year.

175. Many ECA member States (82 per cent) have also mobilized international assistance for the implementation of population and reproductive health programmes (UN 2000). The northern sub-region States have profited the most from the international assistance; all of them (100 per cent) have such experience followed by the western sub-region (87 per cent) and eastern sub-region (77 per cent). The increase in international assistance is relatively weaker in the central sub-region (43 per cent) and the southern sub-region (36 per cent). The main contributors to the increase in international assistance in ECA member States are developed countries, international organizations, private foundations and NGOs. Among the major international community donors in this regard are UNFPA, UNDP, UNICEF, WHO, and UNAIDS; albeit the UNFPA is by far the lead donor in this area. Other important contributors are private foundations like MacArthur, Rockefeller, Bill Gates, Turner, Ford and Development Banks including the ADB and the World Bank, the European Union (EU), international NGOs, and many developed countries through bilateral cooperation.

176. Overall, since ICPD and more recently ICPD+5, some positive trends have been observed. The 1994-1995 period witnessed some growth in external and internal resources mobilized for population and RH programmes; thereafter there was a period of declining funding. Since 2000, this decline seems to be reversing especially for ECA member States where domestic resources have increased. Nevertheless, the majority of ECA member States (79 per cent) consider that their needs to meet the ICPD goals exceed by far, the available resources (UN 2000).

177. States receiving debt alleviation under the Highly Indebted Poor Country (HIPC) initiative are witnessing the released resources being channeled into the health and social services sectors. For instance, the temporary debt alleviation obtained by Benin before the implementation of its PRSP allowed it to carry forward an amount of USD 53.5 million from 2000 to 2002 for its social sector and may receive an additional USD 125 million in the next 5 years, which will also be invested in the social sector.

178. According to data collected by the Netherlands Interdisciplinary Demographic Institute (NIDI), external population assistance to SSA amounted to USD 2.5 billion in 1994 and USD 6.5 billion in 2001, while the Western Asia and Northern Africa sub-region received about USD 511 million in 1994 and USD 1.1 billion in 2001 (www.nidi.nl/resflows). SSA received by far the greatest regional assistance, followed by Asia and the Pacific, Latin America and the Caribbean, Western Asia and North Africa, and Eastern and Southern Europe. Worldwide, a total of 39 per cent of all population assistance in 2001 was expended on STIs, including HIV/AIDS activities; 30 per cent on family planning services; 24 per cent on basic reproductive health services; and only 8 per cent on basic research, data and population and development policy analysis.

179. Funding for STIs, including HIV/AIDS has increased steadily since 1995, from 9 per cent of total population assistance to 39 per cent in 2001 in the face of the spread of the HIV/AIDS pandemic, especially in SSA. NGO sources have become the preferred channel of distribution of external funding. In SSA, while 18 per cent of external population funding was channeled through NGOs in 1991, this proportion increased to 39 in 1994 and 63 in 2001. In the same region, the percentage of funds channeled through bilateral cooperation decreased from 44 per cent in 1991, 36 per cent in 1994 and 19 per cent in 2001. A similar trend was observed with regard to multilateral assistance; its contribution declined consistently from 37 per cent in 1991, 25 per cent in 1994, to 18 per cent in 2001 (www.nidi.nl/resflows).

Constraints

180. In addition to financial constraints, insufficient technical and human resources are among the most prevalent constraints noted in the country reports submitted to ECA and the data collected from the UNFPA Field Inquiry (2003) regarding the difficulties of implementing the ICPD-PoA recommendations. Other obstacles are very low export commodity prices, constraints associated with structural adjustment programmes, and socio-political instability.

181. As just noted, since ICPD, in the majority of States, the increase in domestic resources for population and reproductive health programmes has mainly come from government sources. In 77 per cent of the ECA member States, there has been no increase in private sector/NGO funding. The increase in government domestic resources has not been accompanied by an increase in human resource provisions in 77 per cent of the responding States, an increase in investment to improve infrastructure in 79 per cent of States, and co-operation with international organizations in 69 per cent of the States. Domestic funding from sources other than the government (e.g. national NGOs and the private sector) has also not increased sufficiently. Thus, contrary to the recommendations of ICPD, the majority of the States still depend on international assistance for implementation of the ICPD-PoA recommendations.

182. There are also insufficient financial management capacity for resource allocation, tracking and reporting on the use of funds, lack of resource coordination mechanisms, and difficulties in absorption of the funds allocated because of the complexity of withdrawal and management procedures. This could translate into limited capacity to actually spend available funds. Several States that still depend on costly expatriate technical assistance note a weak technical capacity for the implementation of some projects and programmes.

183. In 79 per cent of the States responding to the UNFPA Filed Inquiry (2003), the need exceeds the level of resources available, particularly in the northern sub-region (100 per cent of States), followed by the western sub-region (82 per cent), the eastern sub-region (80 per cent) and the southern sub-region (67 per cent). Fifty per cent of the States in the central sub-region report that available resources meet the need; this is rather surprising because these States have the lowest increase in domestic resource mobilization and also have the lowest increase in international assistance.

184. While the strategic role of resource mobilization cannot be ignored to ensure the effective implementation of the ICPD-PoA recommendations and ICPD+5 Key Actions, it is surprising that only 60 per cent of the States have put in place, a national strategy and mechanisms for resource mobilization. The formal drafting of a national resource mobilization strategy does not guarantee that funds are actually mobilized; implementation and monitoring/evaluation of the strategy are equally necessary and important components.

185. The political instability and the situations of war in some States (Chad, Angola, Côte d'Ivoire, DRC) have had disastrous consequences on the social and economic infrastructures, the safety of the citizens and the State authority. This leads to mistrust by the development partners and a decrease in international assistance in many cases. For example, because of the war in DRC, multilateral assistance was reduced from USD 276.2 million in 1996, USD 144.0 million in 1997, and USD 77.6 million in 1998. The same situation is also noted in Côte d'Ivoire, Togo, Angola and Burundi.

186. The increase in international assistance is insufficient because the latter has come under severe pressure. A major obstacle to increasing resource mobilization in line with ICPD resource goals has been the downward trend in Official Development Assistance (ODA). The ODA for the ECA region declined from USD 17.4 billion in 1998, USD 15.9 billion in 1999, and USD 15.6 billion in 2000 due largely to budgetary constraints from donor States and the diversion of limited resources to humanitarian and peacekeeping efforts. In 2001, it rose to USD 16.2 billion (ADB 2002). There has been also a loss of confidence in some States as to the efficacy of development aid.

PART III
THE WAY FORWARD

CHAPTER TEN

MAJOR RECOMMENDATIONS AND THE WAY FORWARD

187. Population, Poverty and the Environment

Towards addressing the vicious cycle of poverty resulting from the negative effects of the linkages between population, environment and agriculture, ECA member State governments should:

- strengthen databases required for effective formulation and implementation, including monitoring and evaluation of population and development policies, strategies and programmes;
- foster balanced population and economic growth rates thereby alleviating the burden on national budgets and environmental degradation;
- increase investment in social sector services to improve human capital and productivity;
- practice good corporate and political governance and accelerate the democratic process and;
- strengthen intra-Africa trade. This will enhance the region's competitive edge in the context of globalization.

188. Gender Equality, Equity and Empowerment of Women

Towards enhancing gender equality, equity, and women's empowerment, member State governments should:

- invest in the collection of gender-disaggregated data and conduct systematic studies upon which to build effective behavior change and communication programmes within a cultural context;
- base effective advocacy and IEC on rigorous research that focuses on such gender-related issues as the division of labor and resource control within the household;
- ensure the effective implementation of policies, laws and functioning of institutions that are now in place to promote gender equality, equity and the empowerment of women; and effective implementation of all CEDAW goals;
- promote and strengthen the role of the family focusing on inculcating positive gender values;
- establish mechanisms and programmes developed for strengthening positive socio-cultural practices and eliminate negative and harmful practices and;
- make effort to reach women with capacity building interventions such as agricultural extension services, credit facilities, increasing the number of women in wage employment in the non-agricultural sector, and ensure that gender disparities in primary, secondary and tertiary levels are eliminated.

189. Family it's Role, Rights, Composition and Structure

To ensure the role of the family as a basic unit of society, member State governments should:

- develop policies and laws to support and promote equality of opportunity for family members;
- empower the family to continue to care for its old, sick, and disabled members;
- establish social security measures that underline the increasing costs of childrearing;
- increase income generating opportunities for all adult members of economically active families;
- put in place comprehensive social welfare and security policies and practices including sexual and RH services and adequate care and support strategies;
- enhance multi-sectoral cooperation and new partnerships to promote family welfare, quality of life and security, particularly with regard to vulnerable families, such as female and child headed households and;
- assess the social, economic, and labor implications of HIV/AIDS on families and devise appropriate intervention mechanisms.

190. Children and Youth

Given the potential of children and youth for socio-economic development, governments and partners should:

- strengthen youth-friendly services and broad-based community initiatives for youth (e.g. IEC, youth mobilization, community-based service delivery in SRH);
- support socio-cultural research and utilize the findings to identify factors contributing to reproductive health problems towards appropriate interventions;
- encourage advocacy groups targeting children and youth to undertake continuous advocacy among political and religious leaders, policymakers, parents and guardians towards enacting positive children and youth RH policies;
- strengthen youth-friendly services to ensure that health workers respect youth's confidentiality;
- target parents, teachers and young people for training in gender issues to ensure effective and sustainable gender equality and equity;
- ensure that behavior change communication, IEC, and advocacy messages are expressed in the context of health and developmental issues taking into account positive socio-cultural values, and life skills education are incorporated in IEC programmes to foster positive behavioral change among the youth.

191. Reproductive Rights and Reproductive Health

Towards ensuring the centrality of the health of women and children in all development plans at the national, provincial, district, and community levels, member States should:

- ensure that all PHC facilities have adequate skilled staff, are fully equipped, and prepared to offer quality integrated RH services such as emergency obstetric services, family planning, STIs treatment and ASRH;

- strengthen curative policies to ensure that a wide range of RH services are available, promoted, and necessary supportive guidelines are in place and utilized within the health delivery system;
- provide additional resources to support the training of health staff, ensure a sustainable RH referral system, and provide essential drugs, commodities and supplies;
- ensure equitable distribution of facilities and skilled personnel;
- conduct relevant research, particularly operations research and utilize results to monitor progress towards achievement of relevant goals and targets;
- uphold the RRs of women and adolescents especially the right to appropriate information on how to prevent unwanted pregnancies, STIs and other infectious diseases.

Governments, NGOs and civil society organizations should:

- develop partnerships to design and implement strategies to improve the social, economic and living conditions for women, and address unfavorable cultural conditions affecting the status of women;
- ensure that policies, strategic plans and all aspects of programming and implementation of SRH services respect all human rights, including the right to development and that such services meet health needs over the life cycle;

Regional and international organizations as well as the private sector should:

- work together to promote the health of women and children;
- develop and implement proactive and innovative strategies in securing and utilizing private partnership collaboration for the provision of appropriate services and;
- promote health sector reforms across the region to ensure the provision of adequate quality services.

192. HIV/AIDS

Member State Governments should:

- make effort to reduce the risk environments for HIV transmission (poverty, gender inequality, social instability and conflict);
- make budget allocations to all sectors towards HIV prevention, AIDS care and impact mitigation;
- address the epidemic in an integrated way within broader population and development frameworks and initiatives and with a strong human rights base;
- ensure increased political commitment and build capacity;
- ensure greater promotion and provision of male and female condoms; improved data collection, analysis, interpretation and dissemination to influence policy and programmes in different sectors; and the provision of access to treatment services region-wide;
- intensify efforts in addressing stigma and discrimination around HIV/AIDS;
- target pregnant women and their partners for HIV prevention and PMTCT;

- identify, through research, risky sexual practices and promote safer ones and;
- provide extensive and long-term support and HIV prevention to orphans and the elderly.

193. Population Distribution, Urbanization and Migration

Member State governments should:

- work towards eradicating poverty and addressing most of the pervasive manifestations of internal migration and uncontrolled urbanization;
- uphold the Universal Declaration of Human Rights as it relates to both international and internal migrants;
- ensure the implementation of effective decentralization policies and strategies towards reducing urban agglomerations;
- integrate interventions within the framework of NEPAD and the MDGs and;
- implement effective policies and strategies to address problems associated with rapid urbanization and the growth of squatter settlements.

194. Crisis Situation and Population Consequences

Member State governments should:

- address the root causes of refugees and displaced persons through conflict resolution, the promotion of peace and reconciliation, human rights and good governance;
- increase institutional preparedness to deal with cyclical droughts and other natural disasters;
- promote the integration of culture for peace into formal and non-formal education programmes, and appropriate technologies to improve sustained food production and food security;
- enhance the provision of SRH information and services to refugees and internally displaced persons and;
- encourage regional organizations, civil society, NGOs, and universities to undertake in-depth research on the causes and consequences of humanitarian crises.

195. Resource Mobilization for the Implementation of Population Policies and Programmes.

Member State governments should:

- ensure that national technical and managerial capacities are enhanced in advocacy, resource mobilization mechanisms, communication/negotiation skills, and monitoring and evaluation of resource mobilization plans, and the full participation of key actors of population/RH programmes in the development process of strategic frameworks, especially UNDAF and PRSPs;

- develop standardized methodologies/tools to accurately monitor internal and external resource flows within the various components of population and RH programmes and among the different actors;
- establish clear and conducive legal, fiscal and regulatory frameworks in order to encourage private enterprises and health care providers to contribute to the implementation of population policies and programmes and;
- involve NGOs in mobilizing resources- both domestically and internationally.

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ANNEX I STATISTICAL TABLES

Table 1. Percentage distribution of countries by types of socio-cultural constraints that have impeded the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions

Type of constraint	<i>Sub-Region</i>					No constraints	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Low degree of commitment by politicians	4.7 (2)	14.0 (6)	2.3 (1)	14.0 (6)	11.6 (5)	41.9 (18)	11.6 (5)	100	46.5 (20)
Low degree of commitment by religious leaders	2.3 (1)	16.3 (7)	7.0 (3)	23.3 (10)	9.3 (4)	32.6 (14)	9.3 (4)	100	58.1 (25)
Low literacy rate of people	9.3 (4)	20.9 (9)	9.3 (4)	27.9 (12)	7.0 (3)	20.9 (9)	4.7 (2)	100	74.4 (32)
Low status of women	4.7 (2)	20.9 (9)	11.6 (5)	25.6 (11)	4.7 (2)	23.3 (10)	9.3 (4)	100	67.4 (29)
Local traditions and customs	7.0 (3)	20.9 (9)	7.0 (3)	27.9 (12)	11.6 (5)	16.3 (7)	9.3 (4)	100	74.4 (32)
Religious beliefs	7.0 (3)	20.9 (9)	7.0 (3)	20.9 (9)	9.3 (4)	25.6 (11)	9.3 (4)	100	65.1 (28)
Unfavorable socio-cultural practices	7.0 (3)	20.9 (9)	9.3 (4)	27.9 (12)	11.6 (5)	16.3 (7)	7.0 (3)	100	76.7 (33)
Other constraints	0.0 (0)	2.3 (1)	4.7 (2)	2.3 (1)	0.0 (0)	90.7 (39)	0.0 (0)	100	9.3 (4)

Note: Number of countries reported in parentheses

Table 2. Percentage distribution of countries by type of economic and financial constraints that have impeded the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions

Type of constraint	<i>Sub-Region</i>					No constraints	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Persistence of socio-economic crisis	7.0 (3)	18.6 (8)	11.6 (5)	25.6 (11)	14.0 (6)	16.3 (7)	7.0 (3)	100	76.7 (33)
Debt burden	7.0 (3)	16.3 (7)	14.0 (6)	25.6 (11)	14.0 (6)	14.0 (6)	9.3 (4)	100	76.7 (33)
Decrease of official development assistance	7.0 (3)	18.6 (8)	11.6 (5)	20.3 (10)	11.6 (5)	18.6 (8)	9.3 (4)	100	72.1 (31)
Lack of/insufficient access to international trade market	7.0 (3)	14.0 (6)	11.6 (5)	20.9 (8)	9.3 (4)	23.3 (10)	14.0 (6)	100	62.8 (27)
Inadequate government funding of population activities	9.3 (4)	20.9 (9)	9.3 (4)	27.9 (11)	11.6 (5)	16.3 (7)	4.7 (2)	100	79.1 (34)
Difficulty in mobilizing other domestic resources	14.0 (6)	20.9 (9)	11.6 (5)	30.2 (13)	11.6 (5)	7.0 (3)	4.7 (2)	100	88.4 (38)
Insufficient external financial resources	9.3 (4)	23.3 (10)	11.6 (5)	23.3 (9)	11.6 (5)	16.3 (7)	4.7 (2)	100	79.1 (34)
Others	0.0 (0)	0.0 (0)	2.3 (1)	9.3 (4)	0.0 (0)	88.4 (38)	0.0 (0)	100	11.6 (5)

Note: Number of countries reported in parentheses

Table 3. Percentage distribution of countries by type of institutional and technical constraints that have impeded the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions

Type of constraint	<i>Sub-Region</i>					No constraints	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Political instability and absence of good governance	0.0 (0)	16.3 (7)	2.3 (1)	14.0 (6)	11.6 (5)	46.5 (20)	9.3 (4)	100	44.2 (19)
Lack of national technical capabilities	2.3 (1)	14.0 (6)	14.0 (6)	14.0 (6)	7.0 (3)	37.2 (16)	11.6 (5)	100	51.2 (22)
Lack of clearly defined strategies	4.7 (2)	18.6 (8)	7.0 (3)	14.0 (6)	2.3 (1)	51.2 (22)	2.3 (1)	100	46.5 (20)
Lack of skills	4.7 (2)	18.6 (8)	9.3 (4)	7.0 (3)	7.0 (3)	44.2 (19)	9.3 (4)	100	46.5 (20)
Inadequate integration of population variables in development planning	4.7 (2)	18.6 (8)	16.3 (7)	20.9 (9)	11.6 (5)	23.3 (10)	4.7 (2)	100	72.1 (31)
High staff turnover	4.7 (2)	20.9 (9)	14.0 (6)	23.3 (10)	9.3 (4)	20.9 (9)	7.0 (3)	100	72.1 (31)
Others	2.3 (1)	0.0 (0)	2.3 (1)	4.7 (2)	2.3 (1)	88.4 (38)	0.0 (0)	100	11.6 (5)

Note: Number of countries reported in parentheses

Table 4. Percentage distribution of countries by type of inadequate coordination constraints that have impeded the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions

Type of constraint	<i>Sub-Region</i>					No constraints	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Lack of cooperation between relevant sectoral ministries	4.7 (2)	14.0 (6)	7.0 (3)	25.6 (11)	9.3 (4)	39.5 (17)	0.0 (0)	100	60.5 (26)
Low degree of involvement of women in programme formulation, implementation and evaluation	4.7 (2)	18.6 (8)	4.7 (2)	18.6 (8)	4.7 (2)	46.5 (20)	2.3 (1)	100	51.2 (22)
Low degree of involvement of NGOs in national policy formulation, implementation and evaluation	7.0 (3)	9.3 (4)	4.7 (2)	14.0 (6)	4.7 (2)	55.8 (24)	4.7 (2)	100	39.5 (17)
Inadequate cooperation between governmental and NGOs in programme formulation, implementation and evaluation	7.0 (3)	18.6 (8)	4.7 (2)	18.6 (8)	11.6 (5)	32.6 (14)	7.0 (3)	100	60.5 (26)
Inadequate cooperation and coordination with international organizations and donors	7.0 (3)	4.7 (2)	7.0 (3)	16.3 (7)	11.6 (5)	46.5 (20)	7.0 (3)	100	46.5 (20)
Others	0.0 (0)	0.0 (0)	0.0 (0)	2.3 (1)	0.0 (0)	97.7 (42)	0.0 (0)	100	2.3 (1)

Note: Number of countries reported in parentheses

Table 5. Percentage distribution of countries by type of legal/policy constraints on various subjects that have impeded the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions

Type of constraint	<i>Sub-Region</i>					No constraints	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Integration of RH into the PH system	2.3 (1)	2.3 (1)	2.3 (1)	7.0 (3)	2.3 (1)	69.8 (30)	14.0 (6)	100	16.3 (7)
Marriage and the family	0.0 (0)	4.7 (2)	7.0 (3)	14.0 (6)	7.0 (3)	53.5 (23)	14.0 (6)	100	32.6 (14)
Minimum age at marriage	0.0 (0)	9.3 (4)	2.3 (1)	9.3 (4)	7.0 (3)	62.8 (27)	9.3 (4)	100	27.9 (12)
Registration of births, deaths and marriages	2.3 (1)	14.0 (6)	9.3 (4)	18.6 (8)	7.0 (3)	41.9 (18)	7.0 (3)	100	51.2 (22)
The production, sale and distribution of contraceptives	2.3 (1)	2.3 (1)	4.7 (2)	11.6 (5)	4.7 (2)	62.8 (27)	11.6 (5)	100	25.6 (11)
Increase of a variety of contraceptives available to individuals and couples	0.0 (0)	2.3 (1)	4.7 (2)	11.6 (5)	2.3 (1)	62.8 (27)	16.3 (7)	100	20.9 (9)
Abortion	0.0 (0)	16.3 (7)	7.0 (3)	16.3 (7)	2.3 (1)	48.8 (21)	9.3 (4)	100	41.9 (18)
Sterilization	0.0 (0)	2.3 (1)	7.0 (3)	16.3 (7)	2.3 (1)	58.1 (25)	14.0 (6)	100	27.9 (12)
Reproductive rights	2.3 (1)	9.3 (4)	4.7 (2)	16.3 (7)	2.3 (1)	55.8 (24)	9.3 (4)	100	34.9 (15)
HIV/AIDS	0.0 (0)	4.7 (2)	4.7 (2)	9.3 (4)	0.0 (0)	69.8 (30)	11.9 (5)	100	18.6 (8)
Adolescent RH	4.7 (2)	11.6 (5)	4.7 (2)	14.0 (6)	2.3 (1)	53.5 (23)	9.3 (4)	100	37.2 (16)
Standards of environmental hygiene	2.3 (1)	9.3 (4)	7.0 (3)	14.0 (6)	7.0 (3)	48.8 (21)	11.6 (5)	100	39.5 (17)
Pollution and waste management	4.7 (2)	7.0 (3)	4.7 (2)	16.3 (7)	7.0 (3)	46.5 (20)	14.0 (6)	100	39.5 (17)
Access to housing	0.0 (0)	9.3 (4)	7.0 (3)	16.3 (7)	9.3 (4)	44.2 (19)	14.0 (6)	100	41.9 (18)
Others	14.0 (6)	23.3 (10)	19.0 (8)	30.2 (13)	14.0 (6)	0.0 (0)	0.0 (0)	100	100 (43)

Note: Number of countries reported in parentheses

Table 6. Countries that responded to the ECA ICPD+10 Questionnaire*

1. Algeria	
2. Angola	29. Niger
3. Benin	30. Nigeria
4. Botswana	31. Rwanda
5. Burkina Faso	32. Sao Tome and Principe
6. Burundi	33. Senegal
7. Cameroon	34. Seychelles
8. Cape Verde	35. Sierra Leone
9. Central African Republic	36. South Africa
10. Chad	37. Sudan
11. Comoros	38. The Gambia
12. Congo	39. Togo
13. Cote d'Ivoire	40. Tunisia
14. Democratic People's Republic of Congo	41. Uganda
15. Egypt	42. Zambia
16. Eritrea	43. Zimbabwe
17. Ethiopia	
18. Gabon	
19. Ghana	
20. Guinea	
21. Kenya	
22. Lesotho	
23. Libya	
24. Madagascar	
25. Malawi	
26. mali	
27. Mauritius	
28. Morocco	

*The following countries did not respond to the ECA Questionnaire: Djibouti, Equatorial-Guinea, Guinea-Bissau, Liberia, Mauritania, Mozambique, Namibia, Swaziland, Somalia and Tanzania.

Table 7. Response Rates by Sub-Region

	Replies	Number of Countries	Response Rate (percentage)
Africa	43	53	81
Eastern Africa	10	13	77
Middle Africa	6	7	86
Northern Africa	6	7	86
Southern Africa	8	11	73
Western Africa	13	15	87

Table 8. Countries that submitted the ECA-ICPD+10 country report

1. Angola
2. Benin
3. Botswana
4. Burundi
5. Central African Republic
6. Cote d'Ivoire
7. Eritrea
8. Ethiopia
9. Kenya
10. Lesotho
11. Rwanda
12. Sao Tome & Principe
13. Senegal
14. Seychelles
15. Sierra Leone
16. South Africa
17. Tanzania *
18. Togo
19. Uganda
20. Zimbabwe

* All the above countries except Tanzania also responded to the ECA ICPD+10 Questionnaire

Table 9. Percentage distribution of countries by type of modifications made to their national population policy

Areas where changes were made	<i>Sub-Region</i>					No changes made	Not Stated	Total Per cent (N=20)	All countries
	Northern	Eastern	Southern	Western	Central				
Poverty, population, environment and sustainable development	15.0 (3)	10.0 (2)	15.0 (3)	30.0 (6)	10.0 (2)	20.0 (4)	0.0 (0)	100	80.0 (16)
Gender equality, equity and empowerment of women	15.0 (3)	15.0 (3)	20.0 (4)	35.0 (7)	10.0 (2)	5.0 (1)	0.0 (0)	100	95.0 (19)
The family, its roles, rights, composition and structure	15.0 (3)	15.0 (3)	10.0 (2)	30.0 (6)	5.0 (1)	25.0 (5)	0.0 (0)	100	75.0 (15)
Children and youth	15.0 (3)	15.0 (3)	20.0 (4)	30.0 (6)	10.0 (2)	10.0 (2)	0.0 (0)	100	90.0 (18)
Reproductive rights and reproductive health	15.0 (3)	15.0 (3)	20.0 (4)	35.0 (7)	10.0 (2)	5.0 (1)	0.0 (0)	100	95.0 (19)
HIV/AIDS	15.0 (3)	15.0 (3)	20.0 (4)	35.0 (7)	10.0 (2)	5.0 (1)	0.0 (0)	100	95.0 (19)
Population distribution, urbanization and migration	20.0 (4)	10.0 (2)	10.0 (2)	30.0 (6)	10.0 (2)	20.0 (4)	0.0 (0)	100	80.0 (16)
Crisis situation and population consequences	15.0 (3)	5.0 (1)	5.0 (1)	20.0 (4)	5.0 (1)	45.0 (9)	5.0 (1)	100	50.0 (10)
Other	5.0 (1)	10.0 (2)	10.0 (2)	5.0 (1)	0.0 (0)	70.0 (14)	0.0 (0)	100	30.0 (6)

Note: Number of countries reported in parentheses

Table 10. Percentage distribution of countries by type of policies, strategies and measures adopted by the Government to integrating population, environment and agricultural issues

Policies/Strategies/Measures adopted	<i>Sub-Region</i>					None adopted	Not Stated	Total Per cent (N=40)	All countries
	Northern	Eastern	Southern	Western	Central				
Population policy/plan	7.5 (3)	7.5 (3)	5.0 (2)	15.0 (6)	15.0 (6)	0.0 (0)	50.0 (20)	100	50.0 (20)
Environmental plan/policy	10.0 (4)	17.5 (7)	12.5 (5)	25.0 (10)	5.0 (2)	0.0 (0)	30.0 (12)	100	70.0 (28)
Poverty plan/policy	2.5 (1)	7.5 (3)	2.5 (1)	15.0 (6)	7.5 (3)	0.0 (0)	65.0 (26)	100	35.0 (14)
Food security plan/policy	0.0 (0)	7.5 (3)	0.0 (0)	10.0 (4)	2.5 (1)	0.0 (0)	80.0 (32)	100	20.0 (8)
Other	2.5 (1)	10.0 (4)	5.0 (2)	10.0 (4)	5.0 (2)	0.0 (0)	67.5 (27)	100	32.5 (13)

Note: Number of countries reported in parentheses

Table 11. Percentage distribution of countries by themes included in Poverty Reduction Strategy Papers

Areas where changes were made	<i>Sub-Region</i>					None	Not Stated	Total Per cent (N=37)	All countries
	Northern	Eastern	Southern	Western	Central				
Sustainable development	8.1 (3)	24.3 (9)	13.5 (5)	27.0 (10)	13.5 (5)	8.1 (3)	5.4 (2)	100	86.5 (32)
Population and employment	8.1 (3)	18.9 (7)	16.2 (6)	27.0 (10)	13.5 (5)	5.4 (2)	10.8 (4)	100	83.8 (31)
Population and education	8.1 (3)	21.6 (8)	16.2 (6)	29.7 (11)	13.5 (5)	2.7 (1)	8.1 (3)	100	89.2 (33)
Population and housing	8.1 (3)	10.8 (4)	10.8 (4)	27.0 (10)	8.1 (3)	21.6 (8)	13.5 (5)	100	64.9 (24)
Population and environment	8.1 (3)	18.9 (7)	18.9 (7)	27.0 (10)	13.5 (5)	0.0 (0)	13.5 (5)	100	86.5 (32)
Population and food security	8.1 (3)	21.6 (8)	16.2 (6)	27.0 (10)	13.5 (5)	2.7 (1)	10.8 (4)	100	86.5 (32)
Population distribution and migration	8.1 (3)	16.2 (6)	10.8 (4)	18.9 (7)	8.1 (3)	21.6 (8)	16.2 (6)	100	62.2 (23)
Reproductive rights	8.1 (3)	13.5 (5)	10.8 (4)	24.3 (9)	10.8 (4)	18.9 (7)	13.5 (5)	100	67.6 (25)
Reproductive health	8.1 (3)	24.3 (9)	16.2 (6)	32.4 (12)	10.8 (4)	2.7 (1)	5.4 (2)	100	91.9 (34)
HIV/AIDS	8.1 (3)	24.3 (9)	18.9 (7)	32.4 (12)	13.5 (5)	0.0 (0)	2.7 (1)	100	97.3 (36)
Gender equality, equity and empowerment of women	8.1 (3)	18.9 (7)	16.2 (6)	29.7 (11)	13.5 (5)	2.7 (1)	10.8 (4)	100	86.5 (32)
Meeting the needs of the youth	8.1 (3)	16.2 (6)	18.9 (7)	24.3 (9)	10.8 (4)	5.4 (2)	16.2 (6)	100	78.4 (29)
Girl's education	8.1 (3)	21.6 (8)	16.2 (6)	27.0 (10)	13.5 (5)	5.4 (2)	8.1 (3)	100	86.5 (32)
Human rights	8.1 (3)	21.6 (8)	13.5 (5)	27.0 (10)	8.1 (3)	5.4 (2)	16.2 (6)	100	78.4 (29)
Other	5.4 (2)	10.8 (4)	2.7 (1)	5.4 (2)	8.1 (3)	0.0 (0)	67.6 (25)	100	32.4 (12)

Note: Number of countries reported in parentheses

Table 12. Percentage distribution of countries by location of various institutional arrangements put in place for the implementation of the DND/ICPD recommendations and the ICPD+5 Key Actions related to gender issues

Policies/Strategies/Measures adopted	<i>Sub-Region</i>					None	Not Stated	Total Per cent (N=41)	All countries
	Northern	Eastern	Southern	Western	Central				
President's office/ministry/gender unit	5.0 (2)	12.5 (5)	15.0 (6)	15.0 (6)	12.5 (5)	0.0 (0)	40.0	100	60.0 (24)
Forum for women parliamentarians	0.0 (0)	7.5 (3)	0.0 (0)	2.5 (1)	0.0 (0)	0.0 (0)	90.0	100	10.0 (4)
Women's affairs council/bureau	12.5 (5)	10.0 (4)	7.5 (3)	22.5 (9)	7.5 (3)	0.0 (0)	40.0	100	60.0 (24)
NGOs/religious organization/other	5.0 (2)	10.0 (4)	0.0 (0)	12.5 (5)	5.0 (2)	0.0 (0)	66.5	100	32.5 (13)

Note: Number of countries reported in parentheses

Table 13. Percentage distributions of countries by actions taken by Government to ensure gender equality and empowerment of women

Areas where changes were made	<i>Sub-Region</i>					No actions taken	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Promote women's full and equal participation in the economy	14.0 (6)	20.9 (9)	18.6 (8)	30.2 (13)	14.0 (6)	2.3 (1)	0.0 (0)	100	97.7 (42)
Ensure that institutions provide equal access for women	14.0 (6)	16.3 (7)	18.6 (8)	23.3 (10)	14.0 (6)	4.7 (2)	9.3 (4)	100	86.0 (37)
Protect girl child against harmful practices such as FGC	11.6 (5)	14.0 (6)	11.6 (5)	23.3 (10)	14.0 (6)	14.0 (6)	11.6 (5)	100	74.4 (32)
Tailor extension and technical services to women producers	9.3 (4)	11.6 (5)	14.0 (6)	18.6 (8)	9.3 (4)	16.3 (7)	20.9 (9)	100	62.8 (27)
Improve the collection, dissemination and use of gender-disaggregated data in all sectors	11.6 (5)	20.9 (9)	18.6 (8)	23.3 (10)	14.0 (6)	7.0 (3)	4.7 (2)	100	88.4 (38)
Focus research efforts on the division of labor and on access and control over resources within the household	9.3 (4)	9.3 (4)	11.6 (5)	20.9 (9)	7.0 (3)	23.3 (10)	8.6 (8)	100	58.1 (25)
Other	7.0 (3)	11.6 (5)	7.0 (3)	9.3 (4)	2.3 (1)	62.8 (27)	0.0 (0)	100	37.2 (16)

Note: Number of countries reported in parentheses

Table 14. Percentage distribution of countries by special family-sensitive policies, measures and programmes adopted by the Government in various areas

Areas where changes were made	<i>Sub-Region</i>					No policies adopted	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Housing	11.6 (5)	9.3 (4)	14.0 (6)	18.6 (8)	2.3 (1)	37.2 (16)	7.0 (3)	100	55.8 (24)
Work	11.6 (5)	9.3 (4)	11.6 (5)	18.6 (8)	4.7 (2)	37.2 (16)	7.0 (3)	100	55.8 (24)
Health	14.0 (6)	18.6 (8)	16.3 (7)	25.6 (11)	9.3 (4)	14.0 (6)	2.3 (1)	100	83.7 (36)
Social security	14.0 (6)	9.3 (4)	16.3 (7)	23.3 (10)	11.6 (5)	20.9 (9)	4.7 (2)	100	74.4 (32)
Education	14.0 (6)	16.3 (7)	14.0 (6)	30.2 (13)	11.6 (5)	9.3 (4)	4.7 (2)	100	86.0 (37)
Other	4.7 (2)	9.3 (4)	0.0 (0)	4.7 (2)	2.3 (1)	79.1 (34)	0.0 (0)	100	20.9 (9)

Note: Number of countries reported in parentheses

Table 15. Percentage distribution of countries by special measures or programmes adopted by the Government in order to meet the needs of children and the youth

Areas where changes were made	<i>Sub-Region</i>					No measures adopted	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Social, family and community support	14.0 (6)	14.0 (6)	14.0 (6)	25.6 (11)	7.0 (3)	16.3 (7)	9.3 (4)	100	74.4 (32)
Access to education	14.0 (6)	23.3 (10)	18.6 (8)	30.2 (13)	14.0 (6)	0.0 (0)	0.0 (0)	100	100 (43)
Non formal education	14.0 (6)	18.6 (8)	14.0 (6)	27.9 (12)	11.6 (5)	4.7 (2)	9.3 (4)	100	86.0 (37)
Access to health	14.0 (6)	23.3 (10)	16.3 (7)	27.9 (12)	9.3 (4)	7.0 (3)	2.3 (1)	100	90.7 (39)
Access to housing	9.3 (4)	7.0 (3)	9.3 (4)	7.0 (3)	2.3 (1)	44.2 (19)	20.9 (9)	100	34.9 (15)
Employment opportunities	11.6 (5)	7.0 (3)	14.0 (6)	23.3 (10)	2.3 (1)	25.6 (11)	16.3 (7)	100	58.1 (25)
Training	14.0 (6)	16.3 (7)	16.3 (7)	30.2 (13)	11.6 (5)	7.0 (3)	4.7 (2)	100	88.4 (38)
Participation in the political process	14.0 (6)	16.3 (7)	16.3 (7)	27.9 (12)	9.3 (4)	7.0 (3)	9.3 (4)	100	83.7 (36)
Preparation for leadership roles	14.0 (6)	14.0 (6)	16.3 (7)	20.9 (9)	7.0 (3)	14.0 (6)	14.0 (6)	100	72.1 (31)
Other	4.7 (2)	7.0 (3)	4.7 (2)	4.7 (2)	4.7 (2)	74.4 (32)	0.0 (0)	100	25.6 (11)

Note: Number of countries reported in parentheses

Table 16. Percentage distribution countries by strategies or measures, including changes in legislation adopted by the Government to address adolescent sexual and reproductive health issues

Strategies/Measures adopted	<u>Sub-Region</u>					No measures adopted	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Access to youth friendly RH services	7.0 (3)	18.6 (8)	16.3 (7)	27.9 (12)	11.6 (5)	11.6 (5)	7.0 (3)	100	81.4 (35)
Access to confidentiality and privacy of RH services	7.0 (3)	16.3 (7)	14.0 (6)	23.3 (10)	11.6 (5)	16.3 (7)	11.6 (5)	100	72.1 (31)
Access to counseling and high quality RH services	9.3 (4)	20.9 (9)	14.0 (6)	30.2 (13)	11.6 (5)	7.0 (3)	7.0 (3)	100	86.0 (37)
Incorporation of RH into formal, non formal and vocational training	9.3 (4)	18.6 (8)	14.0 (6)	25.6 (11)	9.3 (4)	14.0 (6)	9.3 (4)	100	76.7 (33)
Sex and health education	9.3 (4)	23.3 (10)	16.3 (7)	27.9 (12)	11.6 (5)	4.7 (2)	7.0 (3)	100	88.4 (38)
Adolescent prevention and control of HIV/AIDS and other STIs	14.0 (6)	23.3 (10)	16.3 (7)	30.2 (13)	14.0 (6)	0.0 (0)	2.3 (1)	100	97.7 (42)
Other	4.7 (2)	9.3 (4)	7.0 (3)	11.6 (5)	2.3 (1)	65.1 (28)	0.0 (0)	100	34.9 (15)

Note: Number of countries reported in parentheses

Table 17. Percentage distributions of countries by strategies or measures, including changes in legislation adopted by the Government to address adolescent fertility issues

Strategies/Measures adopted	<i>Sub-Region</i>					No measures adopted	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Access to contraception regardless of marital status	9.3 (4)	16.3 (7)	14.0 (6)	25.6 (11)	14.0 (6)	9.3 (4)	11.6 (5)	100	79.1 (34)
Prevention of early marriages	11.6 (5)	20.9 (9)	14.0 (6)	23.3 (10)	9.3 (4)	9.3 (4)	11.6 (5)	100	79.1 (34)
Prevention of high risk childbearing	11.6 (5)	18.6 (8)	16.3 (7)	27.9 (12)	11.6 (5)	7.0 (3)	7.0 (3)	100	86.0 (37)
Reduction of mortality and morbidity associated with early childbearing	11.6 (5)	16.3 (7)	16.3 (7)	27.9 (12)	11.6 (5)	4.7 (2)	11.6 (5)	100	83.7 (36)
Discrimination against young pregnant women	9.3 (4)	11.6 (5)	16.3 (7)	23.3 (10)	11.6 (5)	16.3 (7)	11.6 (5)	100	72.1 (31)
Educational programmes in favor of life planning skills	11.6 (5)	18.6 (8)	16.3 (7)	27.9 (12)	11.6 (5)	4.7 (2)	9.3 (4)	100	86.0 (37)
Other	0.0 (0)	9.3 (4)	7.0 (3)	7.0 (3)	0.0 (0)	76.7 (33)	0.0 (0)	100	23.3 (10)

Note: Number of countries reported in parentheses

Table 18. Percentage distribution of countries by how reproductive health has been integrated into primary health care provision at various levels of policy and legislative implementation

Strategies/Measures adopted	<i>Sub-Region</i>					No measures adopted	Not Stated	Total Per cent (N=42)	All countries
	Northern	Eastern	Southern	Western	Central				
Existence of an explicit national policy	14.3 (6)	21.4 (10)	19.0 (8)	26.2 (11)	7.1 (3)	9.5 (4)	2.3 (1)	100	88.1 (37)
Existence of strategies or programmes	14.3 (6)	23.8 (10)	19.0 (8)	31.0 (13)	11.9 (5)	0.0 (0)	0.0 (0)	100	100 (42)
Guidelines and standards of service delivery	14.3 (6)	21.4 (9)	19.0 (8)	28.6 (12)	9.5 (4)	4.8 (2)	2.4 (1)	100	92.9 (39)
Existence of a minimum package integrated into PHC provision	14.3 (6)	21.4 (9)	16.7 (7)	31.0 (13)	9.5 (4)	4.8 (2)	2.4 (1)	100	92.9 (39)
Availability of adequate human resources	11.9 (5)	11.9 (5)	9.5 (4)	14.3 (6)	7.1 (3)	40.5 (17)	4.8 (2)	100	84.8 (23)
Existence of appropriate legislative regulation	11.9 (5)	4.8 (2)	19.0 (8)	14.3 (6)	7.1 (3)	31.0 (13)	11.9 (5)	100	57.1 (24)
Other	7.1 (3)	4.8 (2)	4.8 (2)	7.1 (3)	2.4 (1)	73.8 (31)	0.0 (0)	100	26.2 (11)

Note: Number of countries reported in parentheses

Table 19. Percentage distribution of countries that have established partnerships in population and reproductive health

Type of Partner	<i>Sub-Region</i>					No Partner	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
National NGOs	14.0 (6)	23.3 (10)	18.6 (8)	30.2 (13)	9.3 (4)	2.3 (1)	2.3 (1)	100	95.3 (41)
International NGOs	11.6 (5)	23.3 (10)	18.6 (8)	27.9 (12)	9.3 (4)	4.7 (2)	4.7 (2)	100	90.7 (39)
Civil society	11.6 (5)	23.3 (10)	18.6 (8)	27.9 (12)	9.3 (4)	2.3 (1)	7.0 (3)	100	90.7 (39)
Private sector	11.6 (5)	23.3 (10)	18.6 (8)	25.6 (11)	7.0 (3)	9.3 (4)	4.7 (2)	100	86.0 (37)
Other	4.7 (2)	4.7 (2)	4.7 (2)	4.7 (2)	2.3 (1)	79.1 (34)	0.0 (0)	100	20.9 (9)

Note: Number of countries reported in parentheses

Table 20. Percentage distribution of countries by location of the body responsible for HIV/AIDS issues is located in the Government structure

Level of decision making	<i>Sub-Region</i>					No AIDS body	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Presidency	2.3 (1)	14.0 (6)	14.0 (6)	20.9 (9)	4.7 (2)	34.9 (15)	9.3 (4)	100	55.8 (24)
Ministry	9.3 (4)	16.3 (7)	14.0 (6)	16.3 (7)	14.0 (6)	7.0 (3)	23.3 (10)	100	69.8 (30)
Department	9.3 (4)	7.0 (3)	7.0 (3)	4.7 (2)	9.3 (4)	25.6 (11)	37.2 (16)	100	37.2 (16)
Other institution	2.3 (1)	7.0 (3)	9.3 (4)	7.0 (3)	4.7 (2)	25.6 (11)	44.2 (19)	100	30.2 (13)

Note: Number of countries reported in parentheses

Table 21. Percentage distribution of countries by measures and strategies, including changes in legislation that Governments have adopted as part of HIV/AIDS prevention and treatment strategies

Measures and strategies adopted	<i>Sub-Region</i>					No changes made	Not Stated	Total Per cent (N=42)	All countries
	Northern	Eastern	Southern	Western	Central				
Counseling and voluntary testing	11.9 (5)	23.8 (10)	19.0 (8)	31.0 (13)	11.9 (5)	2.4 (1)	0.0 (0)	100	97.6 (41)
Condom availability and use	14.3 (6)	23.8 (10)	19.0 (8)	31.0 (13)	11.9 (5)	0.0 (0)	0.0 (0)	100	100 (42)
Targeted intervention to most vulnerable groups	11.9 (5)	23.8 (10)	19.0 (8)	31.0 (13)	11.9 (5)	2.4 (1)	0.0 (0)	100	97.6 (41)
Prevention of mother to child transmission	11.9 (5)	21.4 (9)	19.0 (8)	31.0 (13)	11.9 (5)	4.8 (2)	0.0 (0)	100	95.2 (40)
Behavior change communication	14.3 (6)	23.8 (10)	19.0 (8)	28.6 (12)	9.5 (4)	0.0 (0)	4.8 (2)	100	95.2 (40)
Strengthening capacity of service providers	14.3 6	21.4 9	19.0 8	31.0 13	11.9 5	0.0 0	2.4 1	100	97.6 41
Medical, psychological and social care to HIV/AIDS victims	11.9 (5)	21.4 (9)	16.7 (7)	31.0 (13)	11.9 (5)	7.1 (3)	0.0 (0)	100	92.9 (39)
STIs management	14.3 (6)	23.8 (10)	16.7 (7)	31.0 (13)	11.9 (5)	0.0 (0)	2.4 (1)	100	97.6 (41)
Abstinence	11.9 (5)	19.0 (8)	19.0 (8)	28.6 (12)	9.5 (4)	7.1 (3)	4.8 (2)	100	88.1 (37)
Advocacy	9.5 (4)	23.8 (10)	16.7 (7)	31.0 (13)	11.9 (5)	2.4 (1)	4.8 (2)	100	92.9 (39)
Home based care	4.8 (2)	19.0 (8)	16.7 (7)	26.2 (11)	7.1 (3)	23.8 (10)	2.4 (1)	100	73.8 (31)
Other	4.8 (2)	9.5 (4)	4.8 (2)	16.7 (7)	4.8 (2)	59.5 (25)	0.0 (0)	100	40.5 (17)

Note: Number of countries reported in parentheses

Table 22. Percentage distribution of countries by explicit policies, strategies and measures adopted by Governments to modify population distribution

Policies/Strategies/Measures adopted	<i>Sub-Region</i>					No policies adopted	Not Stated	Total Per cent (N=43)	All countries
	Northern	Eastern	Southern	Western	Central				
Explicit policy	9.3 (4)	9.3 (4)	7.0 (3)	20.9 (9)	0.0 (0)	51.2 (22)	2.3 (1)	100	46.5 (20)
Explicit strategy	9.3 (4)	7.0 (3)	7.0 (3)	20.9 (9)	2.3 (1)	48.8 (21)	4.7 (2)	100	46.5 (20)
Other Measures	7.0 (3)	7.0 (3)	7.0 (3)	9.3 (4)	2.3 (1)	51.2 (22)	16.3 (7)	100	32.6 (14)

Note: Number of countries reported in parentheses

Table 23. Percentage distribution of countries by measures and strategies, including changes in legislation that Governments have adopted to promote rural development in the formulation and implementation of development programmes

Measures and strategies adopted	<i>Sub-Region</i>					No measures adopted	Not Stated	Total Per cent (N=38)	All countries
	Northern	Eastern	Southern	Western	Central				
Adoption of labor intensive projects	10.5 (4)	18.4 (7)	15.8 (6)	21.1 (8)	5.3 (2)	21.1 (8)	7.9 (3)	100	71.1 (27)
Training in non farming job for youth	13.2 (5)	18.4 (7)	13.2 (5)	26.3 (10)	13.2 (5)	7.9 (3)	7.9 (3)	100	84.2 (32)
Improvement of rural transport and communication systems and social service	15.8 (6)	18.4 (7)	15.8 (6)	23.7 (9)	7.9 (3)	5.3 (2)	13.2 (5)	100	81.6 (31)
Decentralization of administrative systems	15.8 (6)	21.1 (8)	15.8 (6)	31.6 (12)	7.9 (3)	5.3 (2)	2.6 (1)	100	92.1 (35)
Establishment of income generating projects	13.2 (5)	18.4 (7)	15.8 (6)	31.6 (12)	13.2 (5)	0.0 (0)	7.9 (3)	100	92.1 (35)
Access to ownership and use of land	13.2 (5)	21.1 (8)	13.2 (5)	18.4 (7)	7.9 (3)	10.5 (4)	15.8 (6)	100	73.7 (28)
Access to water resources for family units	13.2 (5)	18.4 (7)	15.8 (6)	23.7 (9)	10.5 (4)	5.3 (2)	13.2 (5)	100	81.6 (31)
Facilitate establishment of credit	10.5 (4)	21.1 (8)	15.8 (6)	28.9 (11)	10.5 (4)	5.3 (2)	7.9 (3)	100	86.8 (33)
Facilitate establishment of production and marketing co-operatives	15.8 (6)	10.5 (4)	15.8 (6)	26.3 (10)	13.2 (5)	7.9 (3)	10.5 (4)	100	81.6 (31)
Other	5.3 (2)	2.6 (1)	5.3 (2)	2.6 (1)	5.3 (2)	78.9 (30)	0.0 (0)	100	21.1 (8)

Note: Number of countries reported in parentheses

ANNEX II:

ICPD+5 Key Actions

Education and literacy

196. "Governments and civil society, with the assistance of the international community, should, as quickly as possible, and in any case before 2015, meet the Conference's goal of achieving universal access to primary education; eliminate the gender gap in primary and secondary education by 2005; and strive to ensure that by 2010 the net primary school enrolment ratio for children of both sexes will be at least 90 per cent, compared with an estimated 85 per cent in 2000." [para. 34]

197. "Governments, in particular of developing countries, with the assistance of the international community, should: ... Reduce the rate of illiteracy of women and men, at least halving it for women and girls by 2005, compared with the rate in 1990." [para. 35 (c)]

Reproductive health care and unmet need for contraception

198. "... Governments should strive to ensure that by 2015 all primary healthcare and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods (such as male and female condoms and microbicides if available) to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services, and by 2010, 80 per cent of them should be able to offer such services." [para. 53]

199. "Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2015. In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients." [para. 58]

Maternal mortality reduction

200. "By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent, and by 2015, 90 per cent." [para. 64"]

HIV/AIDS

201. Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have

access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent." [para. 70].