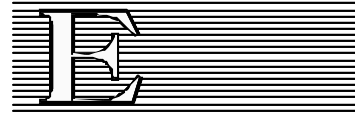

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IN COLLABORATION WITH UNFPA

AFRICAN EXPERIENCES ON THE IMPLEMENTATION OF THE DAKAR/NGOR DECLARATION AND THE PROGRAMME OF ACTION OF THE INTERNATONAL CONFERENCE ON POPULATION AND DEVELOPMENT:

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ANNEXE 53

SOME ACRONYMNS

ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
APC3	Third African Population Conference
BOFWA	Botswana Family Welfare Association
CBD	Community-Based Distribution
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CST	Country Support Team
CSTAA	Country Support Team, Addis Ababa
DHS	Demographic Health Survey
DND	Dakar Ngor Declaration
ECA	Economic Commission for Africa
ECAW	Education Center for Adolescent Women
EU	European Union
FGM	Female Genital Mutilation
FP	Family Planning
FWCW	Fourth World Conference on Women
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
ICPD-PA	Program of Action adopted at ICPD
IEC	Information, Education and Communication
ILO	International Labor Organization
IPDP	Integrated Population and Development Planning
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine Device
KPA	Kilimandjaro Program of Action
MCH/FP	Maternal and Child Health/Family Planning
MIS	Management Information System
NGOs	Non-Governmental Organization
NPCs	National Population Councils
NPPs	National Population Programs
PDS	Population and Development Strategy
PEARL	Programme for Enhancing Adolescent Reproductive Life
PHC	Primary Health Care
POP/FLE	Population/Family Life Education
RH	Reproductive Health
RRs	Reproductive Rights
RTIs	Reproductive Tract Infections
SDPs	Service Delivery Points

STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted infection
TBAs	Traditional Birth Attendants
TFR	Total fertility Rate
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization
WFS	World Fertility Survey

FOREWARD

1. The ICPD marks a turning point in population policy development for all member States of the United Nations family. It has provided the opportunity for reformulation and/or reorientation of previous policies that were devoid of sustainable development considerations. Implementing ICPD-PA recommendations in various thematic areas will require in each ECA member State, "the evolution of a national consensus on the policy, legal and institutional implications of the concepts and on the action needed to convert them into reality. Not only the governments but also all the actors in civil society have to commit themselves fully and unequivocally to this process"1.

2. This report which has been prepared in the context of the quinquennial review and assessment of the implementation of the ICPD-PA as mandated in the General Assembly Resolution (52/188) of 18th December 1997, assesses the extent to which ECA member States have utilized the DND and the ICPD-PA recommendations in the formulation and implementation of their NPPs. Indications are that a significant number of them have done so despite several constraints. A number of them have also mobilized additional internal resources for the implementation of these NPPs.

3. It will be important for each ECA member State to learn from success stories, but it will be equally important for each of them to identify, early on, the problems and constraints that impede progress. The lack of infrastructure and trained personnel and a serious shortfall of resources remain serious problems in most of these States and will slow down efforts to realize the commitments accepted at Cairo unless the international community demonstrates a clear resolve to help them overcome these constraints. The full involvement of the NGOs sector, including women's groups, in policy dialogues and consultation at all levels, and increasing their participation in advocacy, information and service delivery projects, is not only desirable but necessary. The identification and examination of best practices can contribute significantly to the formulation and implementation of effective policies and programmes. Consideration of best practices tends to show how constraints can be overcome and how broad principles (such as integration and mainstreaming) can be operationalized.

4. Nonetheless, it is essential that best practices evolve over time in light of experiences and changes in needs and that in each case, a best practice should be adapted before it is adopted. While implementation of a specific measure, such as dissemination of research findings to policy makers or revision of a law, may constitute a step in the right direction, it may not signify that a key objective has been attained. Moreover, in such key areas as reproductive health (RH) care services; information, education and communication (IEC) activities; and data management, needs are likely to evolve over time. Equally, an assessment of achievements since the adoption of the ICPD-PA necessarily focuses on the adoption and implementation of policies and programmes as distinct from actual changes in social, economic and demographic conditions. Even within some States, there are substantial

1 Singh, J. S., Creating a New Consensus on population (Earthscan Publications Ltd.: London, 1998)

differences in the extent to which new policies and programmes have been successfully launched and implemented.

5. Accordingly, given the diversity of ECA member States, generalisations and conclusions about their achievements and best practices since the adoption of the two development frameworks are necessarily approximative and should be considered tentative; albeit it remains true that many of the member States are moving in the same direction to tackle such problems as high maternal mortality, the spread of HIV/AIDS and insufficient access to reproductive health information and services, among others.

6. The report draws on a variety of sources including ECA administered Country Questionnaire as well as regional and sub-regional reports. Among the reports are analyses of lessons learnt as compiled by UNFPA Country Support Teams and two ECA field missions in 12 selected member States to document achievements, best practices and constraints in the implementation of the ICPD-PA recommendations. At the time of preparing this report (i.e. end of October 1998), only 41 completed Country Questionnaires (out of an expected total of 53) had been received. The indicated percentages of the various responses in the Report are based on this number. The content is in three parts.

7. In the first, some background information is provided on the demographic dynamics, socio-economic dimensions, population and development interrelationships and policies and programmes in the ECA region. The second part is in two sections. The first section presents a report of the third meeting of the Follow-up Committee (FUC.3) held from 23 to 25 September 1998 in Addis Ababa (Ethiopia) to assess the achievements, best practices and constraints experienced by ECA member States while implementing the recommendations of the DND and the ICPD-PA. The second section presents the main recommendations of FUC.3. The third part contains the report of such implementation in the following thematic areas[2]: reproductive health and reproductive rights; family, youth and adolescents; gender equality, equity, empowerment of women and male involvement; role of NGOs and the private sector in programme evaluation and coordination; population development strategy, policy and institutional mechanisms for implementation, monitoring, evaluation and coordination; and advocacy and IEC strategies.

2 The report incorporates the observations and comments made by the third meeting of the Follow-up Committee (FUC3). It was also enriched by the inclusion of the findings from analyses of (i) additional questionnaires received after the FUC3; (ii) open-ended questions in the completed questionnaires; and (iii) UNFPA Country Questionnaire on ***"Inquiry of the country level experience since ICPD".***

PART ONE

BACKGROUND TO THE ASSESSMENT

PREAMBLE

1. The human development situation in Africa as measured by different indicators points to a rather low standard of living for the people of the region. According to the UNDP's Human Development Index (HDI), 37 out of 48 countries categorized as "low human development" are in Africa3; and 54 per cent of the African population are estimated to live in absolute poverty. In addition, the associated low income, underemployment, illiteracy, malnutrition, poor health, low status of women and the deteriorating environmental conditions coexist with high levels of fertility, mortality and morbidity in the continent.

2. In this section, an overview of the population dynamics, the socio-economic dimensions, the population and development situation as well as the policies and programmes is presented.

POPULATION DYNAMICS

Population size and growth

3. The African population increased from 320 million in 1965 to 778 million in 1998 representing an annual increment of 13.9 million people. About 634 million persons are expected to be added to the regional population during the 2000-2025 period. The regional share of the total world population is expected to increase from about 13.1 per cent in 1998 to about 18.1 per cent by 2025 (i.e. 5per cent increase) as against relatively slight changes in the other two major developing regions: Latin America with a change from 8.4 per cent to 8.6 per cent (i.e. only 0.2per cent increase) and Asia from 60.5 per cent to 59.5per cent (i.e. 0.5per cent decrease).

4. According to the medium variant projections of the United Nations, the annual population growth rate in Africa will decline from 2.6 per cent in 1995-2000 to 1.98 per cent in 2020-2025. At the current population growth rate, Africa is expected to double its 1998 population size by the year 2025. This makes Africa the only major area that is projected to have more than twice its current population size by 2050 when the population is projected to reach 2.05 billion[4].

5. At the sub-regional level, indications are that population growth rates will have declined significantly by 2025 particularly for the northern and southern sub-regions which are expected to exhibit annual population growth rates below 1.5 per cent. At the country level, only seven countries have moderate population growth rates of between 1 and 2 per cent during the 1995-2000 period; sixteen countries have high growth rates of between 2 and 2.5 per cent;

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3 UNDP, Human Development Report 1997, New York, 1997.

4 United Nations, World Population prospects: the 1996 Revision (United Nations: New York, 1998).

and thirty eight countries have very high population growth rates of more than 2.5 per cent[5].

Fertility

6. Africa has also the highest fertility rate in the world with a total fertility rate (TFR) estimated at 5.31 children per woman (1995-2000). This level which was typical for Asia and Latin America and the Caribbean in the early 1970s, is a result of early and near universal marriage; and a rather low age at marriage (although the regional median age for marriage is rising). Other causal factors include a rather stretched age pattern of fertility and the low contraceptive prevalence rates (CPRs). About 36 per cent of lifetime fertility occurs either early (12per cent between ages 15 and 20) or late in the child bearing period (24per cent between ages 35 and 50). Teenage fertility is high in Middle Africa (206 births per 100 women), Western Africa (158 births per 1000 women) and Eastern Africa (145 births per 1000 women). At the country level, Guinea (241 births per 1000 women), Angola (236 births per 1000 women) and Liberia (230 births per 1000 women) register the highest teenage fertility during the 1990-95 period. The CPR among women of child bearing age is below 15 per cent in most countries although some countries in the northern and southern sub-regions register relatively higher prevalence rate 6.

6. Although the TFR level in Africa is expected to decline to 3.28 children per woman by the year 2025, there are differences in levels and trends at the sub-regional level. For example, during the 1995-2000 period, Eastern, Middle, Western, Southern and Northern Africa each has an estimated TFR of 6.05, 6.01, 5.95, 3.92 and 3.67 children per woman, respectively. During the decade 1980-2000 period, Northern Africa experienced the sharpest fertility reduction among all world regions: the TFR decreased by 1.88 births per woman or by more than a third. Fertility decline for the other sub-regions ranged from modest in East Africa (12per cent) to marginal in Western Africa (2per cent). Conversely, the current TFR in Southern Africa is much lower at 3.9 births per woman reflecting a 20 per cent decline since 1980-1985. Fertility decline has not started in a number of countries; the highest TFR level (above 7.0 children per woman) is found in Ethiopia, Niger, Somalia, and Uganda with exceptions being Botswana, Kenya, and Zimbabwe where fertility has declined by 26, 22 and 18 per cent respectively in the period between World Fertility Survey (WFS) and Demographic and Health Survey (DHS).

Mortality

8. Mortality rates in Africa, although declining, are high relative to those in other developing regions. The crude death rate (CDR) for the region is estimated at 12.9 per thousand population in 1995-2000 as compared to 8.5 for other

5 Ibid.

6 For example, among currently married women aged 15-49 years in Botswana, Egypt, Namibia, Morocco, South Africa, Tunisia and Zimbabwe, CPS ranged between 28.9 and 49.8 percent for the 1988-1993 survey years. Other countries with high CPRs are Kenya (33 per cent) and Mauritius (75 per cent) and those with the lowest prevalence rate (for the same period) are Nigeria (6 per cent) and Mauritania (4 per cent).

developing regions. The region has also the highest level of infant mortality rate (IMR) with 86 infant deaths per 1000 live births in 1995-2000. Variations of IMR among the sub-regions are wide: Eastern Africa, has the highest IMR of 99 while Southern Africa has an IMR of 50 (just about half that of Eastern Africa). Africa also exhibits the highest child mortality (145 deaths per 1000 children born alive during the first five years of life) in the world. The child mortality varies between 164 in Eastern and Western Africa to 86 and 87 in Northern Africa and in Southern Africa, respectively.

9. Since the 1950–55 period, the estimate of life expectancy at birth for the region has increased by 16 years. However, the current level of life expectancy of 54 years is very low compared to 63.6 years for the less developing regions. There are also marked variations in the levels of life expectancy at birth; the highest in Northern Africa (64.6 years) and the lowest in Eastern Africa (49 years). At the country level, Sierra Leone, Liberia and Rwanda have 37.5, 41.4 and 42.1 years of life expectancy at birth in 1995-2000 respectively, thus qualifying as countries with the lowest life expectancy at birth in the world. Maternal mortality in the region still remains the highest in the world; in the early 1990s about 40 percent of the maternal deaths in the world have occurred in Africa. The high prevalence of HIV/AIDS among the young and the working age group has brought about significant demographic, social and economic impact in these countries. According to WHO estimates, as at 1994, about 16 million adults and 1.5 million children were living with HIV/AIDS worldwide; of the adults, 10.6 million were in Africa[7]. Twenty-four countries in Africa had reached the adult seroprevalence rate of 2 per cent in 1994.

Urbanization

10. The two distinguishing characteristics of urbanization in Africa are the low proportion of urban population and the high rate of urban population growth. The urban proportion was 18 per cent in 1960 (34 per cent for the world) and by 1985 the proportion had increased to 30 per cent (41 per cent for the world)[8]. By the year 2000, the proportion is expected to be 38 per cent in Africa and 47 per cent for the world. By 1960–65, the average annual urban growth rate for Africa was 4.9 per cent, compared with 3.1 per cent for the world, 3.7 percent for Asia and 4.4 for Latin America and the Caribbean. During 1995–2000, the urban growth rate is 4.2 per cent per annum for Africa, 2.3 per cent for the world, 3.0 per cent for Asia and 2.1 per cent for Latin America and the Caribbean. Thus, Africa maintains its position as the region with the fastest growing urban population among world's major regions.

SOCIO-ECONOMIC DIMENSIONS

The economy

7 WHO, 1995, Ibid.

8 United Nations, World Urbanization Prospects: The 1996 Revision, New York, 1998

11. Since the early 1970s, Africa has been in an economic crisis. However, the situation has improved since 1995 to the extent that most countries of the region enjoy economic expansion due to primarily internal macroeconomic reforms, improved domestic policy environment, the relatively favourable external conditions and, in some cases, increased political stability. The gross domestic product (GDP) in the region grew by 2.3 percent in 1995 compared to 2.1 percent and 0.7 percent in 1993 and 1994, respectively. Some countries even showed as high as 6 to 7 percent growth rates in their economy[9]. Hence, in the mid 1990s, GDP growth rate was higher than population growth rate in 19 African countries[10]. Similar improvements were also registered in the political and social spheres. Thus, such economic, political, and social developments did form a basis for a growing hope that with a continued reform, Africa had a distinct opportunity to meet basic human needs and sharply reduce poverty in an environment of economic growth. However, the hope from all these was soon shattered as these improvements could not be sustained in the face of drought, social unrest, civil strife or political crisis which continued to disrupt production and other economic activities and impede reforms in various countries.

12. As at now, the food situation remains a serious source of concern in many countries. According to an FAO report, the continent experienced a food deficit of 19.6 million metric tonnes in cereals in 1995 for which commercial food imports and food aid were needed[11]. Moreover, currently Africa accounts for 44 of the 88 countries classified as low-income food deficit countries. Food shortages are more severe in drought-affected areas especially in the Sahel region where food production grows at rates lower than the population growth rate.

13. The external debt and debt-servicing obligations of Africa continues to pose a major threat to economic recovery. Reports from the World Bank and various national sources indicate that Africa's total external debt reached $322 billion in 1995, growing by about 4 per cent over the $310 billion recorded in 1994 and representing 70 per cent of the regional GDP and 250 per cent of exports. The share of multilateral debt in the long term outstanding debt of Sub-Saharan Africa has risen from 13 per cent in 1980 to 24 per cent in 1990 and 31 per cent in 1995. The capacity of these countries to service their debt has not improved despite several efforts made by the concerned governments. The share of the region in aggregate world trade continues to fall steadily from 5 per cent in 1980 to 3.1 per cent in 1990 and 2.3 per cent in 1995. Net flows of official development assistance (ODA) to Africa also declined from $25 billion in 1992 to $21.5 billion in 1993, to reach the level of $23.5 billion in 1994.

Education

14. Although literacy rate showed slight improvement in the majority of African countries over the last three decades, it is still the lowest in the world. For population aged 15 years and above, it changed from 40 in 1980 to 56 in 1995 as compared to 70 and 77 for the world for the same periods[12].

9 Burkina Faso (6%), Côte d'Ivoire (6.6%), Ghana (6.9%), Kenya (6.1%), Malawi (6.2%), Mali (6.0%) and Togo (6.7%).

10 ECA, Report on the Economic and Social Situation in Africa (E/ECA/CM.22/4), 1996

11 FAO, Food Requirements and population Growth, Rome, 1996.

12 UNESCO, Statistical Yearbook 1995 (UNESCO: Paris, 1996).

15. In 1980, there were 159 million adult illiterates in Africa as compared to 179 million in 1995. In the near future, the number of adult illiterates in Sub-Saharan Africa is expected to rise because of the continuing influence of low school participation rates in circumstances of high population growth rates. UNESCO also estimates that there will be 12 countries with adult literacy rate below 50 percent by the year 2000. While there has been substantial progress in reducing male/female disparities in illiteracy, the gender differential remains pronounced in Africa. In 1995, for example, literacy rate for men was higher than that of women in 46 countries[13]. Considering that education for women is particularly important for its proven multiplier effects on the development process, the gap between the male and female literacy rates indicate the society's underdevelopment. UNESCO data reveal that increase in gross enrolment ratio in Sub-Saharan Africa between 1970 and 1990 more than doubled from 7 percent to 17.5 percent. However, the gross enrolment ratio was still very low compared to other regions of the world.

Health

16. A large majority of the population, particularly those in rural areas of Africa, still lack health services. Coverage for sanitation is particularly worse in those areas. On the other hand, according to data from the World Bank, almost the entire population of Egypt, Mauritius, Tunisia and about two-thirds of the population in Nigeria and Morocco have access to health care[14]. In those countries with greater access to health services and to safe water and sanitation, infant and under-five mortality rates were reduced.

17. Rapid urbanisation associated with the spread of slums and squatter settlements in many cities force millions of the dwellers to live in overcrowded and unhygienic conditions. Such settlements are breeding grounds for infectious, respiratory as well as contagious diseases as they have acute shortage of clean water and adequate sanitation. Lack of adequate and safe water and sanitation are the two major underlying causes of mortality and morbidity in rural and urban slums where millions of the poor live in developing countries[15]. In addition to shortage of water and sanitation, the pressure of fast growing population engenders acute shortage of food, energy, housing and sheer space in urban areas. Urban concentrations of impoverished people tend to exert parasitic impact on their resource support zones in the hinterlands, contributing, for example, to accelerating deforestation through unsustainable demand for fuel-wood.

Employment

18. In the past, some African countries had registered impressive rates of economic growth through expansion of commodity and mineral exports and some degree of industrialisation. But, because the pattern of development was capital intensive and import oriented, the registered economic growth did not generate

13 UNESCO, 1995, Ibid.

14 World Bank, Development in practice, a new agenda for women's health and nutrition, Washington, D.C., 1997

15 WHO, Water supply and sanitation collaborative council; UNICEF, Water supply and sanitation sector monitoring report 1996: sector status as of 31 December 1994, Geneva, 1996.

adequate employment opportunities. The projected GDP growth in the late 1990s for Sub-Saharan Africa is not either expected to generate employment rise at a rate of more than 2 per cent annually while the labour force is growing at annual rate of 3 to 3.5 per cent. Projections indicate that the economies of the region would need to grow at a rate between 4 to 6 per cent per annum to meet the employment needs of new entrants to the labour force[16]. This is equivalent to creation of 10 million additional jobs in the public sector every year, a task very difficult for the majority of African countries.

19. Unemployment has been high in African countries. Available studies indicate that in the early 1990s, unemployment rate in the region was about 15per cent and the rate was much higher in urban areas, 23 per cent[17]. Furthermore, those studies indicate that the number of unemployed persons in urban areas is growing by about 10 percent annually. The flow of the surplus labour from rural to urban areas to escape poverty has contributed to the urban employment problem. The bulk of this labour force ended up being underemployed in low productive activities in the informal sector or openly unemployed.

20. Lack of economic growth has acted as a constraint on the growth of productive employment which in turn has contributed to keeping households below the poverty level. The incidence of absolute poverty is expected to increase from 48 per cent in 1990 to 50per cent in 2000. The high rate of urbanisation is believed to exacerbate the incidence of urban poverty in the continent.

POPULATION AND DEVELOPMENT

Population and food security

21. Food security issues are a great concern to African countries as a result of several factors including high population growth, drought, declining soil fertility, inappropriate agricultural technology, social conflicts and civil wars. Despite some improvements in the food supply situation recorded after 1970s in several African countries, many others failed to make progress and some even experienced outright reversals; consequently, their dependence on food imports grew steadily. Based on the estimates/projections provided by IMPACT, about 158 million metric tons of grains/cereals will be needed to feed the population in Sub-Saharan Africa[18]. Of this amount, 83,5 per cent would be covered by domestic production implying that food imports, particularly cereals will be a significant burden on the African economies. Imports of cereals in the region are projected to increase at the rate of 3.5 per cent per year, from 9 million tons in 1990 to about 27 million tons in 2020.

22. Per caput food production index has also fallen from 112 in 1970 to 101 in 1980, 98.4 in 1990 and 95.2 in 1995. About 40 percent of the total African population, some 250 million people, largely children and women, face mounting

16 ILO, African Employment Report 1995 Geneva, 1995

17 ILO/JASPA , African Employment Report, 1990 Addis Ababa., 1990.

18 IFPRI, Global Food Projections to 2020: Implications for Investment , 1995.

problems of poverty and malnutrition. Unlike Asia and Latin America, Africa has been unable to improve its coverage rate of energy requirements by its food supplies[19]. Initiatives undertaken by countries to combat famine and malnutrition both individually and collectively in the short, medium and long term have, by and large, have failed. Population pressure on land is also very strong particularly in those places where population densities have increased by 66 percent over a 20 years period; consequently, cultivated land per capita has declined significantly.

Population and environment

23. Poor agricultural productivity in Africa is worsened by existing poor macro-economic performance, neglect of rural development, reduced and uncertain levels of rainfall, armed conflicts and civil strife, natural disasters, inadequate land tenure, lack of women's right to land and inappropriate technologies used in all areas of the food chain. But above all, population pressure is the main cause of natural resources degradation in Africa. Because the large majority of the African population live in rural areas and are poor, they derive their livelihood mainly from the exploitation of natural resources; they cultivate fragile soils and clear forest-land for food production, irrespective of the sustainability of the natural resources.

24. Environmental degradation reinforces the links between poverty and fertility. The problem of environmental degradation hits hardest at those least capable of withstanding it, the poorest of the poor. Moreover, degradation of land resources reduces rural women's productivity and the opportunity cost of their labour time. For example, degradation of tree cover, range and drinking water resources can increase the time cost of fuel-wood gathering, livestock pasturing and water fetching, activities that children can undertake, and that consequently increase their value to parents. Since these links are potentially strongest in areas where fertility is already high, they tend not to decrease fertility rates, but to make fertility reduction harder to achieve. This leads to a vicious circle whereby population increase leads to environmental degradation and reduction of agricultural productivity that in turn favours high fertility rates.

Gender and population

25. The extreme demand put on women in carrying out the multi-faceted roles of reproduction and production is well documented. It has been estimated that in many African countries women might be working 12-13 hours a week more than men[20]. The incidence of greater working hours has even increased recently among the poorest women who must make ends meet providing their families with nutritional requirement, water and fuel supply. It means that women and children, particularly girl children in rural areas, have to spend more hours on household chores, walking greater distances in search of fuel wood or water. This has many implications in terms of the time taken away from other productive activities. Besides, the burden of trying to balance the multiplicity of tasks with rudimentary technologies, not only compromises women's health but the nutritional pattern of

19 FAO, Food Requirements and Population Growth, Rome, 1996.

20 Adepoju, A. and Oppong, C. (eds.), Gender, Work and Population in Sub-Saharan Africa, 1996.

the household[21]. A direct consequence of the mother's health and nutrition is related to the survival of an infant. The multiple demands on women's time and the need to use children labour also prompt women to maintain high fertility.

POLICIES AND PROGRAMMES

26. Because of the increasing level of awareness of the negative implications of population growth on development, a number of African countries have formulated population policies and programmes to reduce fertility and hence population growth rates. Some of these policies are based on the right of individuals and couples to decide fully on the number and spacing of their births and the right to information, education and communication and to the means to exercise these rights.

27. Furthermore, many countries have established institutional mechanisms to oversee the implementation of the population policies and programmes at different levels of the hierarchy. Besides institutional structures, some governments have configured population programmes, instituted legal frameworks, increased financial resources allocated to population related programmes and also demonstrated willingness to facilitate the complimentary activities of NGOs, the private sector and the civil societies.

28. Government efforts have been supplemented by IGOs, bilateral donors, NGOs, the private sector, and the civil societies. The recognition and facilitation of the work of NGOs, the civil societies and the private sector by the governments have greatly assisted governments to deal with the design, implementation, monitoring and evaluation of the national population policies and programmes.

29. However, despite the heroic efforts made by governments and supplemented by IGOs, bilateral donors, NGOs, the private sector, and the civil societies many African countries have found it difficult to adopt and implement population policies and programmes in line with the DND and ICPD.PA. There are many constraining factors for the setback. The precarious and fragil nature of the political and economic conditions are among the constraining factors.

30. It is in this context that the Follow-up Committee established by the Third African Population Conference (Dakar, 1992) has been monitoring the implementation of the DND and the ICPD-PA which highlighted matters of quality of life. The Third Meeting of the Follow-up Committee held in September 1998 was convened as the Africa Regional input reviewing the progress made five years following the ICPD.

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21 Ibid.

PART TWO

ASSESSMENT OF AFRICAN EXPERIENCES ON THE IMPLEMENTATION OF DND AND ICPD-PA

INTRODUCTION

1. The Follow-Up Committee met in 1994 and 1997 to deliberate on various aspects of implementing the recommendations of the DND and the ICPD-PA by ECA member States[22]. In March 1998 and under the auspices of the African Population Commission, a Seminar on population policies for high level officials of National Population Commissions, among others, also reviewed the progress made in population activities in the region. Two other assessments have earlier been undertaken. In the first[23], a Country Questionnaire was devised to assess the efforts made by ECA member States at implementing the KPA recommendations[24]; the second[25], utilized data obtained from direct correspondence with responsible government officials.

2. In assessing the feasibility of meeting the qualitative and quantitative targets contained in the ICPD-PA, the 1995 assessment observed that (i) while some of the targets might be achieved for the region as a whole or by individual member States, most of the targets would be difficult to achieve by the set dates[26]; and (ii) the requirements towards attaining the set targets are rather difficult to meet owing to uncertainties about future socio-economic conditions in most States as well as the lack of adequate and reliable time series data for trend analysis.

3. The 1996 assessment was more positive; it indicated that these States were responding explicitly and deliberately to specific provisions of the two development frameworks. In terms of impact, it noted that attitudes of some of the States towards the adoption of population policies were evolving rapidly and that larger, stronger and more varied national population programs (NPPs) were being developed based on the recommendations of the ICPD-PA.

4. The factors that either promote or inhibit the implementation of the ICPD-PA recommendations as identified from the earlier assessments have been shared with the member States both during the indicated meetings and through the associated reports which have been published and disseminated. The ultimate test is whether these factors, recommendations and guidelines have been applied towards achieving sustainable development and a higher quality of life for all people. Nonetheless, because long term commitment and concerted action are required, the present assessment, like its predecessors, aims at identifying achievements, best practices and constraints.

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22 For details see Report of the first meeting of the Follow-up committee on the implementation of the DND and the ICPD-PA, 24-25 March 1994, ECA/POP/APC.3/FC.1/94/3; and Report of the second meeting of the follow-up committee on the implementation of the DND and the ICPD-PA, 13-14 June 1997, FSSDD/APC.3/FC.2/97/6.

23 For details, see Report of Experts and NGOs Workshop on the implementation of the DND and ICPD.PA, Abidjan, 6-9 June 1995 (UNECA: Addis Ababa, 1995), pp. 119-152.

24 The Kilimanjaro programme of Action (KPA) was adopted at ***The Second African Population Conference*** (APC2: Arusha, 1984).

25 For details, see ***Progress report on the implementation of the DND and the ICPD.PA***, Paper presented to the ninth session of the Conference of African Planners, Statisticians, Population and Information Scientists, 11-16 March 1996, E/ECA/PSPI.9/5.

26 With respect to the quantitative targets, the assessment compared levels of pertinent population growth com ponents and/or their derivatives before and after the adoption of the ICPD-PA. For the qualitative targets, the basis was an analysis of government interventions, perceptions and level of commitment towards meeting the goals and objectives of the development frameworks.

REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

5. ***The goal of the ICPD-PA is that the recommendations relating to reproductive health (RH) and reproductive rights (RRs) should be viewed in the broader context of the need to provide basic health services and fulfil overall socio-economic development needs of all the people. In this regard, the ICPD-PA calls on all member States of the United Nations family to make available universal access to a full range of high quality RH services[27] through their primary health care (PHC) system[28] no later than the year 2015. Equally, according to the ICPD-PA, RRs rest on the recognition of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and RH. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence.***

Achievements and best practices

6. The ECA member States present considerable diversity in their RH/RRs status and services. Indications are that virtually all of them have made considerable effort to expand and improve access to RH services through a variety of channels including the public primary health care (PHC) system, private practitioners, NGO clinics, pharmacies and drug stores, work places, and social marketing and CBD programmes. Availability, quality, utilisation of RH/sexual health (SH) services vary dramatically by type of service among them (see Tables 1, 2, 3 and 4). The primary achievement since Cairo has been the sensitisation of policy makers to ICPD tenets of RRs (including those of adolescents) and of integrated comprehensive RH services. Although RH concepts are now much better understood than before by those in leadership positions in the ministries concerned, few States are yet to experience a significant gain in the quality of available integrated RH services.

7. Towards the development and implementation of their RH programme strategy, Burkina Faso, Burundi, Côte d'Ivoire, Guinea, Niger, Sao Tome and Principe, Senegal, Tanzania and Togo have integrated family planning and safe motherhood in their PHC system. Other related actions include the use of team approach in both intra and inter-sectoral collaboration; prevention of STDs and HIV/AIDS; integration of RH in the NDP (Algeria, Botswana, Cape-Verde and Lesotho); training of service providers (including integration of family health issues) on how to offer integrated services (Ethiopia, Lesotho, Kenya, Malawi);

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27 RH implies that people are able to have a satisfying and safe sex life, are able to reproduce and have the freedom to decide if, when and how often to do so (ICPD-PA paras 7.2 and 7.3). To have this right, they must have knowledge, skilful services, requisite supplies and financial resources as well as individual empowerment to use all of these. Comprehensive RH services include FP information and services, pre and post natal medical care, prevention and management of complications of unsafe abortion including safe abortion services where they are not against the law, treatment of reproductive tract infections and sexually transmitted diseases including HIV/AIDS, active discouragement of harmful practices, and other conditions of the reproductive system including breast and other cancers, prevention and treatment of infertility, and information and counselling on human sexuality, responsible parenthood and RH.

28 PHC refers to the kind of care that is provided at the first point of contact with the health care system; its drive has been to provide a network of basic health services that are available and accessible to everyone. The earlier PHC focus on disease is now evolving into a focus on the individual within a social, cultural context with as much emphasis on the context as on the individual.

and introduction of RH in the "minimum package of activities" to improve health services in rural areas (Mali, Rwanda).

8. Policies and programmes that have been adopted as well as laws that have been enacted that are favorable to adolescent RH include the establishment of centers for counselling on FP/RH and service delivery to young people (Burkina Faso, Cape Verde, Central Republic of Africa, Guinea, Lesotho, Malawi); formulation of Action Plan on adolescent RH (Burkina Faso); increasing accessibility to health facilities for commodities and services (Botswana, Cape Verde, Ghana); formulation and implementation of RH Strategy and/or Youth Development Policy (Burkina Faso, Central African Republic, Guinea, Sao-Tome and Principe, Tanzania, Togo and Uganda) ; amendment of the penal code and abolishment of the 1920 French law on abortion (Ethiopia, Guinea) ; and removal of spousal consent for supply of contraceptives/sterilization (Ghana, Kenya).

9. Recent measures/strategies adopted in the area of maternal mortality include mainly the formulation and/or implementation of safe motherhood strategy to reduce maternal mortality, expanding of coverage and improving quality of primary health care through IEC, better referral services, provision of emergency obstetric care, training of lower cadre of health staff and Traditional Birth Attendants (TBAs) in life saving skills and building more health facilities in remote areas. Those in the area of infant mortality include the continuation of the national immunization campaign to eradicate major diseases of childhood (Algeria, Burkina Faso, Burundi, Congo, Eritrea, Gambia, Ghana, Lesotho, Mali, Senegal, Malawi); promotion of breast feeding (Burkina Faso, Burundi, Malawi, Mali, Morocco); adoption of the WHO/UNICEF approach for an integrated management of childhood illness (Eritrea, 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 diarrheal diseases (Ghana); and free health care for pregnant mothers and children under the age of 6 (South Africa).

10. There is heightened awareness of the need to provide RH services to special groups. In this regard, there are adolescent reproductive health (ARH) projects which offer RH services including peer counselling and IEC in combination with recreation in almost all member States. In some States (e.g. Eritrea, Kenya, Uganda and Botswana) there are youth centres that target out-of-school adolescents. Women's professional NGOs have set up crisis centres and legal clinics for counselling and research (e.g. Uganda and countries of SADC) to deal with issues of gender violence particularly sexual violence including rape, defilement, wife beating and forms of dangerous traditional practices.

11. Recent strategies/measures taken towards appropriate treatment of infertility and/sub-fertility in most cases include the provision of RH services ; setting-up of infertility clinics; and attachment to FP clinics (Ghana) and to Universities (Algeria and Central African Republic). Health education campaigns have also been developed and/or implemented to prevent STDs or harmful traditional practices (Central African Republic, Ethiopia, Kenya, Niger, and Togo).

12. Strategies/measures taken to enhance the role of men in sexual and reproductive health include sensitization and awareness campaigns for involvement of males in FP services and their positive behavior change in RH

issues; targeting men for RH facilities services (Botswana, Cape Verde, Central African Republic, Ethiopia, Ghana, Kenya, Lesotho, Namibia, Senegal, Uganda); and man to man motivation sessions (Algeria, Malawi, Mali); integration of men's health in the "Minimum Package of Activities" (Benin). Strategies/measures adopted to provide RH services for refugees or displaced persons include the provision of services to refugees at their respective camps, usually with the assistance of UN agencies (Algeria, Côte d'Ivoire, Guinea, Kenya, Mali, Rwanda, Senegal, Tanzania, Uganda and Zambia).

13. In no other area of RH are the activities of government, private sector, NGOs, community-based organisations, households and individuals as pronounced as in the prevention and management of HIV/AIDS, a momentum which was created by the Joint UN Special Programme on AIDS (UNAIDS) as early as 1986/87. Increasingly, National AIDS Control Programmes, with support from UNAIDS and others, have promoted multi-sectoral approaches to AIDS control. Government and NGOs have organised workshops and undertaken sensitisation activities to promote sexual behaviours that reduce risks for contracting STDs and HIV. There are clubs and programmes comprising youth, men and women of people living with AIDS as well as annual public rallies, walks and marches to publicise the HIV/AIDS preventive and curative interventions. In some States, laboratory and health facilities are increasingly well equipped for the prevention and treatment of STDs.

14. There are several examples of best practices. There is the establishment of Uganda AIDS Commission within the President's Office indicating government direct involvement and commitment as well as of safe motherhood and emergency obstetric care (again in Uganda) which has led to drastic reductions in maternal mortality rates. There is also the initiation of a community-based education and sensitisation initiative (in Uganda) that focuses on influential groups in the community and has led to a 36 per cent reduction in the number of girls and women that have undergone FGM.

15. The establishment of a CBD programme in Zimbabwe with about 700 people distributing non-prescriptive contraceptives nation-wide has led to an increase in the recommended stock levels of STD drugs from 68 per cent in 1993 to 88 per cent in 1995. The decision to channel procurement and distribution of all medical supplies through the Medical Stores Department (as in Tanzania) and to place responsibility for procurement and distribution of contraceptives with AIBEF (as in Côte d'Ivoire) have resulted in cheaper contraceptives than when procured through the government pharmacies.

16. A number of States have also decided against embracing all dimensions of RH but to take on only those activities for which they have some expertise and to encourage the private sector and NGOs to take on the other dimensions. In Tanzania, the AMREF and UMATI are given responsibility for developing most of the youth RH programmes and of the CBD approaches. As mentioned earlier, the contraceptive supply system in Côte d'Ivoire is entrusted to the AIBEF. The health sector in Lesotho has depended over the years on the facilities provided by the Christian missions.

17. Guidelines have been published by women's professional associations (e.g. Botswana, Uganda, Tanzania, Kenya) aimed at assisting the women to understand the laws that affect them and their families. Equally, seminars and workshops have been organized with political and community leaders to resolve conflicts between customary laws and traditional practices. Direct financial support have been provided by some member State Governments to the NGOs

in addition to the substantive assistance provided in the form of premises, logistic support, tax and other duty exemptions, training and sponsorship to attend meetings and even detachment of government staff. The AIBEF of Côte d'Ivoire receives substantial funds from the government every year and recently obtained government backing for multilateral funding to expand its services. In Zambia, government subventions are usually budgeted.

18. In some States, the intervention areas have been zoned so that each actor of the sector is assigned a specific part of the state. All actors are then expected to abide by the policy guidelines and standards of service delivery while adapting their interventions to the local realities of their zones of intervention (e.g. in Cameroon where the programs run by the GTZ, the UNFPA, the European Union and the French Cooperation are located in specific provinces or districts within provinces; Tanzania and Lesotho have also worked along identical patterns). This practice has eliminated overlapping of interventions and occasionally the various actors hold meetings to share their experiences and to examine new strategies.

19. Almost all member States but particularly Botswana, Democratic Republic of Congo, Gambia and Ghana have reported sensitizing all concerned target groups about their RRs through IEC campaigns, seminars, workshops, posters, radio-drama or publications. FLE has also been introduced into school curriculum in some cases in order to ensure that men and women are aware of and can exercise their RRs (Botswana, Ghana, Gambia, Democratic Republic of Congo, Kenya, Lesotho, Morocco).

Constraints

20. Faced with a seemingly endless series of competing crises, Ministries of Health and NGOs involved in health care are finding prioritization both politically and technically difficult. Even within RH itself, conflicting opinions are expressed on whether, for example, HIV/AIDS should be addressed at the preventive or the treatment level. Clearly, available resources do not permit “doing everything well”, but more important, the technical bases and the political will to prioritize are still lacking. In spite of the fact that many of the critical RH challenges require an IEC solution, there is still a shortfall in funding and a relative shortage of personnel who are adequately trained to produce the quality and quantity of counseling, teaching, mass media, and the other materials required.

21. The inherent comprehensive service delivery approach to RH has caused several operational problems. The activities of these components are usually implemented as vertical programmes with separate management structures including logistics and information systems. Even in service delivery sites with only one provider, separate registers as well as reporting and acquisition forms are kept and separate sites are set within the same health facility to provide specific services of RH components. Equally, although all the approved FP methods are provided in public sector hospitals, they are not regular due to stock shortages. Safe motherhood services, especially emergency obstetric care, are offered only in very few areas on a pilot project basis. Even these are mostly limited to antenatal care, normal delivery and

postnatal care due largely to inadequate number of trained health care providers, lack of equipment and non-functioning referral mechanisms.

22. Only donor-supported RH and RRs components (e.g. in-service training) are being addressed; the management and service delivery practices are not integrated. Despite the apparent increased knowledge, attitudes and skills on RH issues, the compartmentalization between these aspects has persisted. For instance, either different service providers are trained for different component intervention or the same provider is trained in all the components on separate occasions to learn separate logistic mechanisms and IEC practices. The content of education received by service providers as well as the regulations governing licensing and maintenance of standards have lagged considerably behind social and health developments of most States. There is also lack of knowledge about constitutional provisions and health workers depend on ***hear-say*** rather than ***informed behaviour***; this obstructs individual freedom of choice of RH services and quality of care.

23. Laws concerning abortion remain quite restrictive and effectively prohibit the development of safe and effective services for women in most States. Abortion is legal only when the life or health of a girl or woman is endangered and in many States, this must be affirmed by the presence of two senior medical doctors. Abortion is permitted following rape or incest in only a few States. The exception is the Republic of South Africa where abortion on demand has been legalised. In the public sector, very few district or regional government hospitals provide abortion-related services and many health workers do not use manual vacuum aspiration equipment because it is either not available or they are not trained or they are not legally permitted to do so.

24. Although there is increased availability and accessibility to FP, it remains mostly female-centred and supply-side short-term oriented. Pills and injections are most often used by women and contraception is practised mostly for birth spacing. Surgical sterilisation for both males and females are inadequately utilised. The female condom is available in some States through social marketing programmes and in few commercial outlets. Social marketing programmes (in some States) also offer pills, vaginal foam tablets and injectables.

25. In spite of being a priority, safe motherhood and emergency obstetric services are available in very few pilot projects. Safe motherhood services, provided at PHC level are limited to ante natal care, normal delivery and postnatal care. Health centre staff including midwives are not allowed to use forceps, vacuum extractors or to administer oxytocics or intravenous fluids. Even though the key to accessibility and cost-effectiveness in safe motherhood is the referral mechanism[29], its non-functioning, lack of fully trained personnel and non-availability of medical equipment are the norm in most States. The major implementation constraint for adequate referral systems is insufficient finances.

[29] The three key elements of a safe motherhood and emergency obstetric care mechanism are communication and transport from the patient's home to the required health facility; appropriately equipped service delivery sites; and competent health provider(s).

26. Most member States are decentralizing their administrations including the RH sector. This has created fear among staff resulting in key project staff of either being laid off or transferred to different services. The new comers into the projects and programmes need some time and training to acquaint themselves with the reorientation process. There are problems as well with the laws and regulations that govern health care workers.

27. The ECA region contains about 30 per cent of the world's refugees and more than 50 per cent of the world's internally displaced people[30]. In a ***Memorandum of Understanding*** signed between the High Commissioner of UNHCR and the Executive Director of UNFPA in 1995, the two agencies agreed to work together in helping member States address the RH needs of both groups of people. However, the practical side of the accord has to depend on the awareness of and support by member States. More importantly, member States are to address the root causes of internal displacement and processes that create refugees. Africa hosts a large size of disabled persons as a result of diseases, accidents and more importantly, wars, and civil conflicts. Most disabled persons are destitute and depend on minimal familial or community support, if any. Their specific needs are hardly ever considered during the design of projects. They are constantly discriminated against in terms of access to social services and employment and very few NGOs have been formed to attend to their specific problems.

FAMILY, YOUTH AND ADOLESCENTS

28. **The DND calls on ECA member States to take due account of the rights and responsibilities of all family members and ensure that measures that protect the family from socio-economic distress and disintegration are taken into account in accordance with family well-being and health requirements (bearing in mind the survival strategies designed by the families themselves); provide couples and individuals with the facilities and resources for deciding the size of their families and integrate family concerns in all development plans, policies and programmes; and encourage analytical studies on demographic processes within the family cycle so as to better identify the determinants of small family size.**

29. **The ICPD-PA addresses the roles, rights, composition and structure of the family (chapter 5). Accordingly, the objectives of the ICPD.PA are to develop policies and laws that better support the family; contribute to its stability and take account of its plurality of forms particularly the growing number of single parent households; establish social security measures that address the social, cultural and economic factors behind the increasing costs of child-bearing; and, promote equality of opportunity for family members especially the rights of women and children.**

30. **On youths and adolescents, the DND and ICPD-PA draw attention to the special needs of children, adolescents and youth including social,**

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[30] See Roberta Cohen and Francis Deng, "Masses in Flight" in **Global crisis of internal displacement** (Brookings Institute, 1998), chap. 2; See also **The State of World's Refugees: a humanitarian agenda** (UNHCR, 1991), page 2.

family and community support, as well as access to education, employment, health, counselling and high-quality reproductive health services. Accordingly, they call upon member States to enact and strictly enforce laws against economic exploitation and the physical and mental abuse or neglect of children and to create a socio-economic environment conducive to the elimination of all child marriages. On unwanted pregnancies, unsafe abortion and STDs, they urge member States to ensure that programmes and attitudes of health care providers do not restrict adolescence's access to the services and information they need. They stress that these services should safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values, religious beliefs and the rights and duties of parents.

Achievements and best practices

31. Although population programme activities in most of the member States had not paid specific attention to the family, the measures taken for the improvement of the quality of life for various components of the population may have positively impacted on the family. For instance, about 84 percent of the member States have taken action to promote equal opportunities and legal protection for the girl child; about half of them have enacted laws and formulated policies and adopted strategies favorable to adolescent. A rich mixture of diverse approaches to reach youth and adolescents and to win their trust has developed including the enhancement of girls' opportunities with respect to access to education; the provision of information, especially on their menstruation process and sexual/RH issues as well as on health and other basic social services.

32. About 85 per cent of the responding member States have put in place measures to increase age of consent to sexual intercourse to 16 years and minimum age at marriage to 18 years and some to 21 years. Virtually all member States have formulated IEC strategies relating to children, youth and adolescents in their sectoral programs. In some cases the emphasis has been on providing information to adolescents about reproduction, reproductive health, sex and sexual health while in other cases providing RH care services is the only or principal concern.

33. Special programmes either in-school or out-of-school have been introduced to meet the needs of adolescents. For example, in Uganda, a Programme for Enhancing Adolescent Reproductive Life (PEARL) was launched in four districts in 1995 to help respond to the needs of out-of-school adolescents. PEARL emphasises counselling on RH issues; provision of recreation facilities; development and use of IEC materials and messages; conducting research on the impact of culture; parent-child communication; and mobilization of political and community support.

34. An in-school counterpart of PEARL was developed with funding from UNFPA to impart knowledge of RH/life issues to adolescents enroled in school. In Botswana, a group of individuals came together to form the Botswana Family Welfare Association (BOFWA) to meet the special reproductive needs of adolescents. Two other programmes which address adolescent RH needs are the Peer Approach to Counselling by Teens (PACT) and Education Centre for Adolescent Women (ECAW).

35. In a few States, legislative and policy measures have been put in place allowing re-entry of pregnant girls into school after delivery. In at least one member State, a special education programme has been established for girls who dropped out of school due to pregnancy or marriage. Three States have ratified and are implementing the convention on children's rights. With respect to the girl child, most States have adopted measures to enhance girls' opportunities in the areas of access to education and promotion of RH and RRs. Eritrea, Ghana and Mauritania have promoted girls' education through sensitisation campaigns and establishment of girl-friendly educational programmes structures, policies and incentives. Côte d'Ivoire has provided school equipment to girls at the primary level in the northern regions, where educational levels are rather low. Ghana provides fees-waivers, remedial science courses and part-time study facilities. In Cameroon, special scholarship programmes are available for girls studying the sciences at the universities.

Constraints

36. Statutory and customary legislation have mostly recognised monogamy and tolerated polygamy, but other forms of unions and family types are not well recognised. Hence single parents may not have full access to RH services and to housing facilities. In some cases the rights of children born out of wedlock may not be clear. This is particularly likely where governments have not systematically reviewed national policies and legislation to determine what are the rights of such children.

37. The preference for sons, which still persists in many societies, is another constraint. There is a lack of in-depth socio-cultural studies which could reveal the incidence of such preferences and their 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 these children. Much remains to be done in order to eliminate stereotypes transmitted by both the media and pedagogic materials in schools.

38. Special groups such as the disabled and the elderly may also require special attention. To date, few States have addressed the needs of families of disabled persons. Where traditional family support systems are weakening, notably in urban areas, elderly persons may find it very difficult to satisfy their basic needs, especially as only a small proportion of them can lay claim to any social security benefits.

39. Regarding the youth and adolescents, it is particularly difficult to conduct research on their needs because of taboos in some cultures that restrict or prevent explicit recognition and discussion of the sexuality of young adults. Moreover, in some member States, the magnitude and extent of harmful traditional practices and their effects are not well known. Traditional attitudes which are conducive to high fertility, gender discrimination and sexual exploitation of girls and women persist and lead to high rates of unwanted pregnancy, unsafe abortion and STDs as well as increases in the incidence of HIV/AIDS among youth and adolescents. For instance, it is reported that the Masai of Tanzania are rather permissive and encourage sexual activity among youth. The outcome may be the development of debilitating gynaecological complications such as genital fistulae.

40. There are diverse barriers to the formulation and implementation of comprehensive adolescent RH strategies. Where new policies have been formulated, they are often at variance with other existing policies and protocols. Many FP agencies and NGOs have sought to "comply" with new recommendations relating to adolescent RH by simply declaring that their service delivery points (SDPs) are "youth friendly". But they have not adopted any specific measures to provide the necessary in-service training to their staff. In some States, various groups of parents, religious and even educational authorities have openly objected to the introduction of FLE programmes in schools.

41. Accordingly, the young people in most ECA member States have only limited access to the RH services and information they need to lead healthy sexually active lives. Many of them also lack the skills and support networks needed to develop healthy social relationships with their sexual partners. In general, the youth in most of the States have not been actively involved in the formulation of programmes that concern them. In some cases neither their parents nor other authorities have been fully sensitised to the goals and methods of such programmes.

GENDER EQUALITY, EQUITY, EMPOWERMENT OF WOMEN AND MALE INVOLVEMENT

42. ***According to the ICPD-PA, the empowerment and autonomy of women and the improvement of their political, social, economic and health status are important ends in themselves in addition to being essential for the achievement of sustainable development. It called on member State Governments to take actions purporting to empower women and eliminate inequalities between men and women.***

Achievements and best practices

43. Since ICPD, several ECA member States have requested and implemented training activities in gender, population and development, mostly for high- and mid-level policy makers, programme managers and implementers. This not only reflects ECA member States governments' increasing commitment to

understanding and addressing gender issues in national development planning processes but is an indication of their recognition of the centrality of gender issues to achieving sustainable development.

44. Nearly all member States have taken actions to initiate and/or improve gender sensitive data collection, analysis, dissemination and use in education, health and censuses. The measures being undertaken in this regard include creation of gender statistics units; development of gender-sensitive education management systems, data collection instruments and morbidity and mortality statistics; creation of documentation centres; collection of recurrent publications on gender disaggregated data by concerned Ministries (Algeria, Burkina Faso, Botswana, Côte d'Ivoire, Democratic Republic of Congo, Mauritius, Namibia, South Africa); conducting Demographic and Health Surveys (Benin, Central African Republic, Guinea, Senegal); training personnel; and advocating for the use of gender disaggregated data in policy and planning (Kenya).

45. Other actions taken to gather information on women's knowledge of traditional practices and skills include undertaking surveys on traditional practices (Ethiopia, Ghana). Specific studies have been carried out on FGM (Gambia, Guinea), adolescent motherhood (Malawi), women's status and women in development (Mali, Algeria, Comoros), traditional contraceptive methods (Senegal) and women's knowledge of traditional food (Zambia). South Africa reported the creation of a Journal focussing on culture, traditions and gender. Togo reported the creation of a data base on modern and traditional laws related to the family.

46. The Population Census in Tanzania illustrates the manner in which some data collection, planning, implementation and analysis activities are being genderized in a few member States. The genderization of the census exercise started with gender-based assumptions and basis for the census. It continued with the development of gender sensitive questionnaires and a gender-focused analysis plan. Genderization of the census exercise is to continue with recruitment of staff, training of enumerators, implementation and data analysis.

47. About 71 per cent of the reporting member States have initiated gender-focused research in such areas as division of labour, access to income, intra-household control and socio-cultural factors affecting gender equality. Such efforts include gender-focused surveys, demographic surveys with gender modules and studies on poverty, female-headed households and property rights. Actions taken to focus research efforts on the division of labour, income access, control within the household and socio-cultural factors which affect gender equality include specific studies and research on women's workload; women's involvement in enterpreneurship; women's rights and baseline of women in development; violence against women; marriage and fertility rights; women's lands rights; FGM; surveys focussing on income an wealth of the household level by gender.

48. Equally, based on research findings from studies, strategies have also been developed by member States to increase age at marriage. The actual measures in this regard mostly include informing and educating the community leaders,

parents and the public at large about the disadvantages of early marriage; encouraging girls to go to school and to remain there at least up to the end of their secondary school; as well as enacting and enforcing legislation concerning the minimum age at marriage (Cape Verde, Central Republic of Africa, Ethiopia, Gambia, Ghana, Mauritius, Nigeria).

49. Most member States are taking steps to reduce discrimination against women. Significant proportions of them have respectively, ratified and are implementing the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[31]. An equally significant proportion of them have adopted measures to promote women's participation in decision-making. The latter measures include the creation of women ministries, increase in the number of female ministers and parliamentarians and using the quota system to promote women's participation. A number of member States, including Mozambique and Uganda, have adopted laws and policies purporting to advance equal participation of women and men in decision-making at all levels.

50. Women are empowering themselves and are taking the initiative to participate in electoral policies. For example, in Kenya and Liberia women presented their candidatures for Presidential elections in 1997. In some other States women have organized themselves into coalitions or caucuses and have played catalytic roles in encouraging more women to compete in political elections. In Burundi, Development Centres have become Gender Development Centres and are producing and disseminating gender-sensitive materials and have included men in their membership and activities.

51. Over 90 per cent of the reporting member States (including Chad, Central African Republic, Eritrea, Ethiopia, Liberia, Mauritania and Rwanda, Mauritania, Tanzania, Uganda and Zimbabwe) have developed national action plans that address among other things, women empowerment issues. These plans identify areas of discrimination against women. Among other things, these plans advocate the enrolment of all school age girls as well as the readmission of such girls who dropped out of school due to pregnancy (Kenya). Their main foci are the mobilisation of women; the development of an education micro-plan; and implementation of projects that provide equal access to credit, regardless of gender.

52. Ghana has ratified the universal treaty on the rights of the child (1994); has increased advocacy and sensitization at political and grassroots levels on the needs and benefits of girl child education; has raised the quota of girls in higher educational institutions; and has adopted measures to encourage more girls and women to opt for science and mathematics in schools. Additionally, in consultation with NGOs, the government has formulated a national action plan which has identified priority areas, set time-bound targets for monitoring and evaluation and allocated resources for implementation. For 1997-1998, the priority areas being addressed are poverty reduction and access to micro-credit; education of girls; decision-making and public life for women.

31 CEDAW is a comprehensive convention extending from public to private spheres to ensure gender equality in matters of citizenship, education, employment, health care, economic rights, marriage and family relations.

53. Cameroon has made primary school attendance for girls obligatory. Côte d'Ivoire has fixed the goal to increase the overall schooling rate to 90 per cent by 2000; has reduced the rate of illiteracy from about 57 per cent to 30 per cent in four years; and has adopted measures to distribute books and construct boarding schools for girls. Kenya has instructed its provincial administration to ensure that girl child marriages are eliminated from areas where the practice is still prevalent. Mali's action plan covers the years 1996-2000 and allocates resources for women's economic promotion, education, health, environment, civil and human rights and participation in public life. Nigeria has designed programmes to increase female enrolment into primary school and more girls' schools are being established in the northern region. South Africa has established a gender equity task team to review practices within the Department of Education and within schools that negatively influence the participation of girls and women in formal education.

54. Various actions have been taken to promote women's equal participation in the labour force. These measures include ratification of Employment Equity Bill (South Africa); provision of maternity leave and vocational training and implementation of literacy programmes (Eritrea); inclusion of employment issues in policies and constitutions (Zambia, Uganda); equal-pay-for-equal-work regulations (Zimbabwe and Botswana); provision of credit schemes and education (Ghana); and Affirmative Action Bill and Act (Namibia); Botswana, Eritrea, Mauritius and South Africa have adopted specific legislation to increase and protect women in the labour force. Besides, many States have taken actions to increase women's access to productive resources and technical services including the establishment of the family economic advancement programme in Nigeria; an enterpreneurship unit providing technical advice, counselling and guidance to women in Mauritius.

55. Equally various steps have been taken to tailor extension of technical services to women producers including providing services, equipment and funding to assist their income generating activities (Burkina Faso, Benin, Cape Verde, Central African Republic, Côte d'Ivoire, Madagascar, Mauritius, Morocco, Namibia and Togo); organizing training seminars on techniques of management for women's associations and groups (Burundi, Central African Republic, Mauritania, Niger, Rwanda); developing specific programmes for women (Gambia); providing micro-credit to women entrepreneurs to set up small and cottage industries (Central African Republic, Ghana, Rwanda, Sao Tome and Principe, Senegal); setting up women's banking to give credit facilities to women in business (Ghana, Mauritius); implementing appropriate technology projects to ensure that existing and new technologies are genderized (Guinea, Kenya, Sao Tome and Principe); and encouraging the formation of women farmer clubs (Malawi, Democratic Republic of Congo).

56. In an effort to mainstream gender concerns in line ministries, several governments, including those of Ethiopia, Rwanda and Zimbabwe, have established Gender Focal Points (GFPs) in line ministries. The mandate of the GFP is to serve as a catalyst for gender-responsive planning and programming and to ensure that gender concerns are incorporated into sectoral policies,

strategies, projects and activities. The GFP reports to the cabinet minister and collaborates with the ministry or structure that has the primary mandate for co-ordinating gender issues

57. A few States have recognised that men's participation is critical for the attainment of gender equality and equity and women empowerment. Strategies for male participation include implementation of male promotion IEC and advocacy activities and services; and creation of an enabling environment through implementation of appropriate laws and policies. For example, the ILO has executed about a dozen projects on Population and Family Welfare Education for the labour sector in English-speaking African countries. In Tanzania, one such project increased contraceptive prevalence rate from 14 to 36 per cent.

58. Côte d'Ivoire, Gabon, Kenya, Morocco and Nigeria are reinforcing political will and are pursuing decentralized implementation of NPPs. Kenya has initiated special education and information programmes to expand the resource base for population programmes by encouraging the private sector and the local communities to be actively involved in initiating, implementing and financing the programmes. The concerned Department (i.e. NCPD) is designing packages that would enhance the capacities of the institutions to deal with integration of population into development planning at all levels. In Morocco the decentralization policy, the reactivation of the NPC's role as the coordinator of the country's NPP and the coordination of the various sectors and advocacy are among the measures being put in place to ensure that population issues is central to governmental priorities. In Nigeria there are concerns with the rapid population growth and its consequences on poverty and economic development, the needs to revise the National Population Policy and to integrate population factors into development planning, among others. In Seychelles and Mauritius concerns are being raised about the phenomenon of aging.

59. The data in Table 5 indicate that a sizeable proportion of the member States are taking actions towards ensuring gender equality, equity and women empowerment. Only a few member States are yet to promote women's participation in decision making (8 per cent); to tailor extension and technical services to women producers (13per cent); and to improve the collection, analysis, dissemination and utilization of gender disaggregated data in education and health (3per cent).

Constraints

60. Despite the considerable progress realized since the ICPD-PA, understanding of gender issues and awareness of their implications for RH in general and for well-being in particular remain incomplete. As a result the "mainstreaming" of gender issues remains partial, and significant gender issues are neglected in formulating and implementing NPPs. A significant barrier to mainstreaming has been weaknesses in the conceptualization of gender as well as the delays and difficulties in developing strategies to operationalize effective integration of gender concerns in the development and implementation of

development policies and plans. While many member States have now adopted gender policies and have modified laws and regulations to eliminate or reduce provisions which discriminate against women, the structures and systems for implementing the new policies and enforcing the new laws are often frail and lack broad support in the community.

61. In many cases attitudes and practices unfavourable to elimination of gender discrimination and disparities remain deeply entrenched and restrict the gains which can be made through changes in policies and laws. Although the importance of male involvement in RH and gender matters has been widely discussed, most member States are still in the process of developing methods and mechanisms for bringing it about and thereby strengthening population programmes.

62. There are several constraints as well on operational activities. These include inadequate numbers of specialists to train nationals on various aspects of women empowerment; lack of or weaknesses in national IEC and advocacy strategies focused on women's rights; and in some States, shortcomings in institutional arrangements for the design and implementation of programmes. In some cases, insufficient collaboration between Government departments and NGOs limits programme efficacy as does the weaknesses of links to policies and programmes not specifically focused on issues which relate to gender and/or population. The number of staff in women's Departments and Ministries is inadequate and those available do not have the necessary training in gender analysis as well as qualitative and quantitative skills for collecting, analyzing, and utilizing the requisite data. Some NPCs and other data gathering institutions are not even sufficiently trained to collect gender responsive data.

63. The data in Table 5 indicate that from the responding countries, 10 per cent the member States are yet to put in place needed institutional arrangements for addressing gender issues; about 10 per cent of them are yet to ratify the CEDAW and 20 per cent of them are yet to actually implement measures to effect the latter. Moreover, 38 per cent of them do not have information on traditional practices and skills, 51 per cent are still to take action towards increasing the age at marriage while about 29per cent are yet to focus research efforts on women's division of labour, access to income, control within the household and socio-cultural factors affecting gender equality.

ROLE OF NGOs AND THE PRIVATE SECTOR IN PROGRAMME IMPLEMENTATION

64. ***The ICPD-PA requests governments and donors to ensure that NGOs and their networks retain their autonomy and strengthen their capacity through regular dialogue and consultations, appropriate training and outreach activities.***

Achievements and best practices

65. In many ECA member States, policies and practices regarding NGOs are evolving fairly rapidly, often in conjunction with major shifts in development strategies. Among other things, governments are increasingly differentiating among various types of NGOs both in the policies being adopted with respect to their roles and in the guidelines relating to their modes of operation.

66. NGOs have played important roles in closely related areas. For instance, in many States they play a key role in organizing and operating programmes which seek to inform adolescents about the risks associated with early and unprotected sex, about their options and about the advantages of avoiding risky behaviour. In a similar manner NGOs are playing important roles in meeting the needs of other hard-to-reach groups, including refugees, prostitutes and persons in remote rural areas.

67. In a number of States, NGOs are playing important roles in introducing and disseminating relatively innovative approaches. Such approaches include provision of post-abortion counselling; establishment of "one-stop" clinics; providing for substantial community participation in management of service facilities; involving males in activities and responding to their needs; adoption of cost-recovery measures; and promotion of early detection and treatment of cancers of the reproductive system.

68. The Governments of nearly all member States have encouraged the formation of NGO "umbrella" or coordination organizations. Depending on the member State, the name of such umbrella NGO could be either National Council of NGOs, National Forum of NGOs, National NGOs Coalition, National Association of NGOs, Network of NGOs or Federation of NGOs. In some States the coordinating body is a Ministry or a Department (Algeria, Burundi, Central African Republic, Côte d'Ivoire, Ethiopia, Gambia, Gabon, Madagascar, Niger, Rwanda, Togo, Uganda).

69. Such organizations contribute to the establishment of guidelines which facilitate consistency and collaboration in implementing population policies and programmes. Nearly all States responding to the Country Questionnaire indicated that bodies for coordination of NGO activities had been established, while approximately two-thirds reported having taken steps to support national NGOs dealing with population and development issues. Just over half the States have indicated that they had provided financial assistance to NGOs.

70. Recent measures and/or strategies adopted to support national NGOs dealing with population and development issues comprise (in most member States) the promotion of effective partnership between government and NGOs involved in population activities particularly in project/programme design; monitoring, and evaluation including contractual relations between government and NGOs (Algeria, Benin, Cape Verde, Guinea, Morocco, Mauritania, Nigeria); facilitation and funding of NGOs activities (Botswana, Côte d'Ivoire, Lesotho, Mali); adoption of new laws on NGOs (Madagascar, Benin, Kenya, Mali, Mauritania); integration of NGOs representatives in NPCs (Sao-Tome and Principe).

71. The private sector is playing an important role in many ECA member States in the provision of RH services. In a number of them policies and strategies relating to the role of the private sector have been modified in a manner consistent with the recommendations of the ICPD-PA. These changes are fostering attitudes and practices that are conducive to greater involvement of the private sector in the provision of RH services.

72. Actions taken by member States to involve the private sector in the implementation of NPPs include identification by National Health Services of private sector as stakeholders in the implementation of population policies and programmes (Algeria, Cape Verde, Comoros, Côte d'Ivoire, Ghana, Zambia); invitation to the private sector to participate in population related activities such as workshops, meetings, seminars, youth programmes, population day celebration, conduct of population census (Gambia, Botswana, Democratic Republic of Congo, Kenya, Madagascar, Mali, Mauritius) ; representation of the private sector in the NPCs (Ghana, SaoTome and Principe); provision of contraceptive to the private sector free of charge or at subsidized costs (Kenya, Niger, Morocco, Togo).

73. Rapid expansion of social marketing of contraceptives may well constitute the single most important change with respect to the role of the private sector in meeting needs for RH information and services. Social marketing corresponds well to the call (by the ICPD-PA) for the private, profit-oriented sector to play an important role in the production and delivery of RH care services and commodities.

74. In a number of States the scale of social marketing operations is impressive and demonstrates their potential. Over 26 of them have social marketing programmes, mainly for contraceptives and condoms, but the types of commodities made available vary considerably. While the sales from social marketing programmes decreased between 1996 and 1997 in five States, by far the majority of programmes are increasing - some very rapidly Botswana (41per cent), Cameroon (32per cent), Ethiopia (45per cent), Kenya and Mali (65per cent) and Mozambique (155per cent).

Constraints

75. The extent of collaboration among NGOs, the private sector and governments varies from one member State to another. Collaboration is impeded by many factors including, in some cases, lack of a specific modus operandi for such interaction, disagreement as to priorities, different styles and even, occasionally, rivalries. This is significant since some NGOs have accumulated significant experience in implementing various types of population programmes, especially in the areas of RH and advocacy. In some cases insufficient collaboration may have resulted in underutilization of local expertise and/or experience and in failure to take advantage of the comparative advantages of different types of institutions.

76. Increasingly, there is growing emphasis on decentralization, devolution of powers, democratisation and empowerment of communities, groups and women in the consideration of population issues, policies and programmes. And yet in some cases, the contribution of NGOs and more broadly, civil society, is constrained by lack of sufficient policy and programme guidelines as well as inadequate mobilisation of communities and stakeholders by government and managers of population programmes. At other times, population activities have tended to reflect mainly the orientation and concerns of civil servants and specialists including researchers as against those to be directly affected by such activities.

77. Regarding the implementation of FP programmes (Table 6), the proportion of NGOs involved in research activities ranges from 22 per cent of member States for NGOs involved in co-operative activities to 65 for those working with local women's groups. Regarding the design of FP programme, the corresponding range is from 32 to 75 per cent; for those involved in monitoring, it is 35 to 76 per cent; and for those involved with evaluation activities, it is from 21 to 69 per cent. The proportions are much lower with respect to RH programmes (Table 7) with a range of 9 to 58 per cent for NGOs involved with research on RH activities; with programme design, it is 21 to 76 per cent; with monitoring, it is 17 to 67 per cent; and with evaluation, it is 17 to 60 per cent. Given the seriousness of the HIV/AIDS pandemic, it is understandable that the corresponding proportions, as shown in Table 8, are somewhat higher.

POPULATION POLICY AND DEVELOPMENT STRATEGIES/ INSTITUTIONAL MECHANISMS

78. The ICPD-PA calls for the development of population policies that (i) will ensure equality and equity between men and women and enable the latter to reach their full potential; (ii) involve women fully in decision-making and ensure their education; (iii) are sensitive and supportive of the family; (iv) protect and support potentially vulnerable groups; that ensure effective access to adequate health information and services, especially for underserved and vulnerable groups; (v) promote a more balanced geographical distribution of population; (vi) extend and expand education; (vii) strengthen programme management, including client-oriented management information systems, and mobilise resources for investments in the social sectors; and (viii) integrate NGOs, women's organisations and local community groups into decision-making.

79. The ICPD-PA (i) specifically recognized the need for demographic, social and economic data for determining priorities, formulating policies and programmes and assessing their impact; (ii) advised governments to strengthen national capacity to carry out sustained and comprehensive programmes to collect, analyse, disseminate and utilise gender-desegregated population and development data; (iii) urged states to set up or enhance national databases to provide information that can be used to measure or assess progress towards the achievement of the goals and objectives of NPPs; (iv) urged them to focus on the determinants and consequences of induced abortion, linkages between women's roles and status and demographic and development processes and

interactions among population problems, poverty, patterns of over-consumption and environmental degradation and for governments to strengthen training and research in population and development issues and to ensure wide dissemination of research findings; (v) requested governments to increase the skill level and accountability of managers and others involved in the implementation, monitoring and evaluation of NPPs; and (vi) called upon the international community to assist governments in organising national-level follow-up, including capacity building for project formulation and programme management, and in strengthening co-ordination and evaluation mechanisms.

Achievements and best practices

80. Major changes are taking place in the ways in which policies are formulated. In many ECA member States the policy formulation process specifically provides for a wide range of concerned individuals and groups (the stakeholders and their representatives) to participate in discussions, information exchange, debates and even decisions regarding national and sub-national policies.

81. A major theme of the recent policies is the need to expand "male involvement", both in order to overcome resistance to "FP" and to get men more actively involved in planning and implementing population activities. A significant development following ICPD-PA has been the integration of population concerns in policies and programmes aimed at eliminating gender disparities and discrimination. Equally significant is the inclusion of issues which relate to the family; refugees and displaced persons; protection of the environment; and, in some cases, poverty alleviation.

82. National health policies and programmes have identified RH issues and needs and have foreseen measures to increase access to RH information and services as well as to improve the quality of care. In the same vein, national social development policies and programmes increasingly recognise the potential contribution of FP information and services to improving the well-being of women and their families and stress the need for effective measures to prevent the spread of HIV/AIDS (Table 1).

83. Education policies and programmes in many of the States are addressing the needs of young persons for accurate and complete information about RH, RRs and the importance of responsible behaviour. They also recognise that the youth should receive balanced and relatively thorough information about the causes and consequences of high fertility, high mortality and rapid urbanisation. In many of the States, the Ministry of Education curriculum specialists and decision-makers are increasingly consulting community leaders, teachers and parents' associations in order to secure support and consent for introduction of family life subjects in the school programme.

84. In sum, in a significant number of member States, 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, gender, and environment has grown considerably. For instance, there is increased incorporation of population, development and environment relationships into the school curricula. Malawi has introduced such content in all its schools; most other States are at various stages of pilot testing. Population policies are more widely recognized as of national, and not simply as donor driven and are increasingly seen as necessary frameworks to provide legitimacy for new, relatively sensitive population activities such as provision of services to adolescents.

85. With regard to population/development planning, member States are only now beginning to grapple with the challenges of responding to the demise of medium to long term central development planning and of the units to geographic and sectoral decentralization. Achievements include training of significant numbers of planners in sectoral and sub-national planning units, of improvements in some States in using population data in short term sectoral planning and of the increased utilization of gender desegregated data, much of which existed previously but remained unused, in assessing the status of women. Many States prepare "framework", "perspective" or "rolling" development plans or programmes; these plans often focus on sectors, such as education, health, energy and infrastructure, which are widely regarded as priorities for government action.

86. Several member States are actively pursuing the goal of creating a national population database both to facilitate integration of population variables in planning and contribute to the formulation, implementation and evaluation of a wide range of population programmes. Many of these states are currently engaged in planning, launching and/or implementing information systems for health management. Many states have established or designated NPCs or inter-departmental or inter-ministerial bodies to over see and monitor implementation of the ICPD-PA. NGO's are involved in some of these bodies.

87. Table 11 indicates that 77 per cent of the States increased their spending on each of RH and FP services, primary health care services, STDs and female school enrolment followed by RH needs for adolescents (64 per cent). In most member States, research has been launched and/or completed in such areas as RH needs; trends in fertility and mortality and their determinants and consequences; poverty, demographic trends and the status of women; interrelationships between fertility attitudes and behaviour and family structures and values; factors which facilitate and impede integration of RH services in primary health care; harmful traditional practices; determinants of programme impact; and the overall policy environment.

Constraints

88. At a general level, the overriding contextual factor limiting progress in the PDS sector is an increasingly difficult macro and micro economic environment in which an atmosphere of competing crises prevails and limits resources available

for the development and implementation of NPPs. The second such factor is the recurring loss of trained personnel, both to desired improved remuneration and AIDS. The shortage of, qualified personnel has become a greater problem since Cairo because most States are attempting to decentralize their population and development planning functions which are yet to be institutionalized in the capital cities where trained personnel are relatively more available. It remains to be seen whether in States where this is being attempted, decentralization of these functions can work well under current limitations.

89. There are more technical constraints. NPPs in the post ICPD era are expected to be conceptually more people centered; institutionally aimed at establishing NPCs with vertical and horizontal linkages capable of instituting effective decentralization; and strategically and operationally based on relevance, effectiveness and sustainability of population and development activities. Besides, they should include core activities as advocacy, assessment of capacity at national and sub-national levels, mobilization of resources and various forms of support. Additionally, they should be integrated in the overall socio-economic framework and provide support for research, analysis, monitoring and evaluation of the implementation. But with the indicated new desiderata for NPPs, prioritizing among objectives and monitoring compliance have become much more complicated than in the pre-ICPD period.

90. Most of the member States either lack or have rather limited knowledge of the value of socio-economic indicators needed for the formulation, implementation, as well as the monitoring and evaluation of NPPs. Other constraints include (see Table 9) inadequate integration of population variables in development planning (77 per cent of the member States); low priority for population IEC activities (62per cent); the lack of clearly defined strategies for the implementation of population policies and programs (56per cent); lack of national technical capabilities to establish population and development interrelationships (50per cent); and lack of skills for the promotion and implementation of population policies and programs (39per cent).

91. Besides, political instability and associated high staff turnover (58per cent) is a major constraint to programme implementation. The frequent changes in government structures and implementing institutions in many States has resulted in high turnover of key personnel and disrupts continuity within inter-ministerial/sectoral structures. Some States have embarked on decentralisation without the requisite human and material resources required and efficient central co-ordination. Economic and financial constraints also militate against the development of effective NPPs (see Table 12). The lead economic factor is implementation of adjustment programs (78per cent) followed by the persistence of socio-economic crisis (76per cent); and abandoning of the medium and long term planning in the face of SAPs (51per cent). The financial ones include difficulty in mobilizing domestic resources for population programs (81per cent); insufficient external financial resources for population programs (55per cent); inadequate funding of population activities (55per cent); and population activities not assigned a budget line in the national budget (39per cent).

92. International organisations have played a significant role in assisting the population and development programmes of ECA member States. The implications of the heavy dependence on external funding of population and development activities are more than evident. Inability of Governments to provide counterpart funding or direct population and development activities on their terms has led to the slow progress in the formulation and implementation of NPPs. For instance, most AIDS control programmes have been experiencing problems of co-ordination among the several actors who sprung up during the period when donor funding was easily available. As funds became scarce, most of the activities got grounded. There has also been lack of capacity or inability to utilise all the funds provided by development partners.

93. It is presently difficult to estimate the value of resources which are mobilised domestically for the implementation of population activities.[32]This is largely due to (i) utilisation of the resources for implementing population activities that are funded under various budget headings such as "primary health career”, "teacher training”, “statistics”, and "economic planning”; (ii) mobilisation of resources at different levels of government by different implementers; (iii) the accounting systems used make it very difficult to impute the value of office premises, equipment and/or common services.

94. The data collection and analysis component of population programmes has been the hardest hit in terms of reductions in both international funding and local contributions. Most past censuses had been largely donor funded. The current economic crises have made it difficult for governments to be providing the funds required to conduct censuses. In view of competing needs, governments have given rather low priority to other data collection and research operations. At the same time, donor agencies have almost unilaterally reduced or withdrawn funding for censuses.

95. This trend is rather too abrupt and unfortunately is affecting the availability of baseline data required for the formulation of policies and programmes as well as their follow-up and evaluation. In most States, census and survey data have become obsolete and need to be updated to provide sufficiently desegregated data by gender; no functional data banks have been created as yet so as to pool all the vital population-related data, documentation and other information. Indeed, nationally representative surveys like the World Fertility Survey (WFS) and Demographic and Health Survey (DHS) have been quite instrumental in the updating of data and in the highlighting of fertility, morbidity and other related behaviour but they cannot go beyond a certain level of geographical desegregation.

96. The foregoing findings are all related to the process of integrating population variables in development planning. Among the barriers still to be overcome are the intellectual difficulty of defining integration; the lack of a critical mass of needed trained human resources; and the inadequacy of data on the

32UNFPA is collaborating with the Netherlands Interdisciplinary Institute in efforts to collect data on flows of international financial assistance for population activities as well as data on domestic resources, including Government budgetary allocations and expenditures, NGO resource allocations and private sector expenditures for population programmes.

linkages between population and development. There is also the lack of constructive dialogue between the policy makers and the researchers particularly in the area of determining the indicated linkages simultaneously with the development of techniques for modeling the latter.

97. Two main limitations have been identified as accounting for the ineffective operationalization of the IPDP approach. In most explicit population policy documents, the indicated strategies for implementing the policy measures are rather too numerous. In a situation in which the sectoral ministries, charged with the implementation of these strategies, have their specialized functions to perform, they are apparently saddled with a rather heavy additional tasks, most of which they do not have the specialized capacity required for delivery. This becomes even more problematic in situations where no single body is charged with the responsibility of coordinating the implementation of the strategies. There is also the lack of a focus. The strategies identified are usually without a lead sector. By identifying a key sector and selecting a few critical sectors, both of these limitations can be contained especially as the policy document itself is a dynamic document that should be revisited as experience is gained and a critical mass of trained personnel is available.

98. Population and development units in some States have been created to take over the functions that were formerly performed by other government ministries. Unfortunately some of these units are not staffed with adequately trained and experienced personnel; accordingly many of them cannot function effectively. This problem is compounded in some cases by the fact that some of the institutions charged with the co-ordination of population-related activities are sometimes located too far down the administrative hierarchy and as such hardly command the respect of better placed line-ministries that should have collaborated with them in the implementation of the population and development programmes.

99. The data in Table 9 show that almost one-half of the States have inadequate technical capability to establish population and development interrelationships. It has therefore been difficult for these States to formulate and adopt clearly defined strategies for programme implementation. Programme co-ordination becomes difficult in the absence of clearly defined strategies since each actor tends to act independently of others. Many programme implementers lack the skills to promote the programmes. Lack of diversity in the available expertise at the national level is another important constraint.

100. The data in Table 10 highlight the importance of the factors that seriously constrain the implementation of the ICPD-PA recommendations. These include inadequate cooperation between government and NGO (63per cent of the member States); low degree of involvement of women in program formulation, implementation and evaluation as well as NGOs (56 - 68per cent); inadequate cooperation with international organizations (63 per cent); and lack of cooperation between the relevant sectoral ministries (56 per cent). In many of the States, there is lack of co-operation among the line ministries due largely to the struggle for supremacy and greater share of the resources for population and development projects. Table 10 also shows that co-ordination is a major

constraint to programme implementation in the region. Inability to co-ordinate the activities of the foreign partners has also been identified by 69 percent of the States as an impediment to programme implementation.

ADVOCACY AND IEC STRATEGIES

101. By definition advocacy aims at changing the status of a policy, strategy or program whereas IEC aims at changing the knowledge base, attitudes, beliefs, values, behavior or norms within individuals[33] or groups of individuals. The ICPD-PA states that greater public knowledge, understanding and commitment are vital to the achievement of its goals and objectives and that increasing such knowledge, understanding and commitment is, therefore, a primary aim. It (i) indicates that members of national legislatures can have a major role to play, especially in enacting domestic legislation for implementing the NPPs, allocating appropriate financial resources, ensuring accountability of expenditure and raising public awareness of population issues; (ii) notes that fostering active involvement of elected representatives of the people, particularly parliamentarians and concerned groups and individuals, was a major objective; and (iii) recommends joint participation of the Government, NGOs, the private sector and the community not only in the dissemination of information but also in the development of IEC/Advocacy strategies.

Achievements and best practices

102. Most ECA member States have not only recognised the need to design and implement advocacy activities but are in fact initiating such activities. In many cases they have developed advocacy strategies, often in conjunction with IEC strategies. They have also developed advocacy activities34.

103. Available evidence indicates that advocacy and IEC strategies have been widely used especially by national NGOs to mobilize political commitment and subsequent allocation of resources to address population and development issues; seek support for the promotion of practices that guarantee protection of women and men from abuse, for programs that prevent and treat STDs, including HIV/AIDS as well as for programs for eliminating traditional harmful practices; and create awareness about the type of activities that should be undertaken on these issues at different levels of administration. In particular, IEC strategies have been extensively used to generate demand for RH services;

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[33] ***Advocacy*** implies undertaking research to clarify issues and strategic directions; providing adequate and appropriate information and education to all interested parties; building partnerships, alliances and coalitions; and mobilizing these partners that are interested in the issue being advocated for; dialoguing and negotiating with individuals and organizations with contrary views and positions; and networking with groups of similar persuasion elsewhere to learn from their experiences. ***IEC interventions*** are designed to change knowledge, attitudes, beliefs, values, behavior or norms within individuals or groups of individuals. See Lessons Learnt by UNFPA/CSTAA, 1993-1996, February 1997.

34Although "advocacy" and "IEC" differ markedly in goals, their methods may be quite similar.

enlighten men and women about their RRs and responsible parenthood; promote safe sexual behaviors; and mobilize men to participate in RH programs

104. The various strategies which have been adopted in member States to disseminate information on national population and development issues are presented in Table 14. The data show that the media (newspaper, radio and the television), seminars, workshops and meetings (both formal and informal) are the most widely used means of disseminating information. In 62 per cent of the States, there have been formal presentations of population and development issues to Parliament. Table 15 shows the percentages of the States in which IEC/Advocacy strategies have been developed within sectoral programs. Almost all the States have developed IEC/Advocacy strategies for issues concerning adolescents and youth, empowerment of women, FP and RH. Considerable proportions of the States have also developed IEC/Advocacy strategies within other sectoral programs: environment preservation, gender equality and equity (85per cent); population and development (81per cent); and, poverty alleviation (72per cent).

105. The NGOs have not only been involved in the dissemination of information on population and development issues, they have also received information on such issues from government parastatals. There is thus considerable exchange of information between the Government and the NGOs. Table 16 shows a high collaboration between government ministries (Education, Health, Information and Communication, Youth and Culture) and NGOs in the development of IEC/Advocacy strategies. Religious and policy leaders are also involved in about 84 per cent of the States. The general public is involved in 71 per cent of the States, the private sector in 54 and the civil society leaders in about half of the States. Table 17 shows that a significant proportion of the States have mechanisms for coordinating the various IEC/Advocacy components: from 64 per cent for training to 77 per cent for IEC strategy development.

106. The current trends in the liberalization of the socio-political environment have seen the emergence of several media channels (electronic and print media, community-based media) with the private sector playing an important role. A wider choice therefore exists for the dissemination of information and for interaction with various target populations. In States like Tanzania and Zambia, the institutional structures for the design, implementation and coordination of advocacy and IEC programs are already in place. The Planning Commission in Tanzania and the Inter-agency Technical Committee on Population have components which are focal points for the harmonization of IEC programs including the materials, messages and appropriate channels.

107. The development of political pluralism along with the extension of civil liberties has created a fertile environment for the creation of NGOs, grassroots and professional associations, pressure groups and other networks for canvassing and advocacy. Once the facts are in hand, one has a wide choice of options to push ideas through so as to advocate policy changes. Most of the States have been conducting such nationally representative sample surveys as the DHS, Household Consumption surveys, Living Standards surveys etc. during

intercensal periods. These have been vital for the update and complement of census data on which are based, IEC/Advocacy messages.

108. Some States such as Ghana and Senegal have been working closely with the RAPID[35] project to develop population profiles and to simulate population projections in relation to various resources and overall development in order to create awareness among decision-makers and opinion-leaders at national and regional levels. The use of such models which require basic data inputs and assumptions with differing scenarios displayed on screens, maps and charts have been found to create more immediate impact among government and traditional authorities than several pages of data and literature.

Constraints

109. The main constraints are unwillingness of some major players to participate in the design of national IEC/Advocacy strategies; lack of relevant socio-cultural and other data; inability to clearly define the institutional and coordinating mechanisms; inadequate training and supervision of staff; inadequate capacity to produce IEC materials; low motivation among program implementers; and the inability to cover the target population. There are also problems with what processes are to be followed in developing the strategy; how the latter is to be used once developed; who uses it; whether its application should be policed; and who infact, needs the strategy. To a large extent, the data in Tables 14 to 17 amply testify to these constraints. Rarely has the target audience been involved in the formulation, monitoring and evaluation of the impact of IEC and advocacy programs.

110. There is an insufficient number of trained IEC personnel to provide the technical capacity for the management, message development, strategy development and the monitoring and evaluation of the impact of IEC and advocacy programs. This leaves room for amateurism and may adversely affect programs. Most States have not designed comprehensive national IEC strategies as yet and have not designated any particular institutional framework for the coordination of IEC and advocacy activities. As a consequence, several IEC programs are ongoing which sometimes pass on contradictory and ill-adapted messages to identical target populations. This creates confusion and suspicion among the population and may even jeopardize the cause for which such messages were designed. Besides, almost everywhere, there is an absence of socio-cultural research-based information or of a research agenda for the in-depth assessment and interpretation of behavior and attitude issues and for targeting messages at specific audiences. Most of the IEC and advocacy materials are hardly ever pre-tested and no operational research is foreseen to evaluate their impact.

111. IEC/Advocacy materials have been lacking in variety and specificity, as well as in quality and quantity. Furthermore their wide distribution has been

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35 Resources for the awareness of population impacts on development (RAPID) model was developed during the 1970s by the Futures Group of USAID to generate the required awareness for the policy implications of the country's population growth components and changes on the nation's economic and social objectives.

hampered by logistic problems. No functional data banks have been created as yet for the pooling of all the vital population-related data, documentation and other information which could then be easily accessed towards focussed IEC and advocacy messages. Results of most research operations take a long time to be published and are hardly ever given a wide enough dissemination; the raw data files are never easily accessible. In most cases, census data has become obsolete. In Lesotho, the results of the 1996 census are anxiously being awaited before any consistent IEC and other strategies can be developed.

112. A few States like Senegal and Ghana have developed the requisite curricula and pedagogic materials for the teaching of Population and FLE in schools and out of school. Very little thought has yet been given to the training of trainers. A majority of the population, to which IEC messages are destined, is illiterate in States where there is a diversity of ethnic groups and dialects with no other lingua franca. This requires that the messages be translated into the various dialects and that the appropriate channels be chosen to pass them on. Not only do some States lack the expertise for such translations, but terms such as 'gender', 'RH' etc are new and there are no easy local equivalents for contraceptives and even FP that could appropriately pass on the right meaning.

113. In some States, the cost of radio and television spots and even newspaper space are so prohibitive that most of the actors are compelled to condense their messages to the extent that they are no longer easily understood. Most IEC programs have been executed with donor funding as specific projects with project staff and materials. Though the governments have been able to provide some logistic support through their media and staff, they are often never prepared to recruit the project staff at the end of the projects or to at least provide subventions for the sustenance of such programs during transition periods from one funding cycle to the other. As a consequence, experience is never cumulative and materials are not properly conserved. The UNICOM II project in Senegal loses its staff at the end of each project period and must recruit new, inexperienced staff for the next period.

114. More than one third (about 38per cent) of the member States have never informed their Parliaments about the contents of their population and development issues including national and sectoral policies (Table 14). Although only 17per cent of the States has not used such other channels as the media, seminars, workshops and meetings to disseminate the information on population and development issues, the non involvement of a sizeable proportion of member States' Parliaments which normally comprise decision makers and professionals as well as the general public (26per cent); youth and women groups, religious institutions (20per cent); NGOs (16per cent); and policy makers and government officials, as well as service providers (10per cent), is a serious omission.

115. Besides dissemination, more than one fourth (28per cent) of the member States have not as yet developed a national population IEC/Advocacy strategy purporting to address poverty alleviation and about one fifth are yet to develop such strategy for the population and development sector (Table 15). Admittedly the corresponding proportions are much lower in the cases of such other sectors

as environment preservation (22 percent); gender equality and equity (15per cent); RH (8per cent); and FP (7per cent). But the message and the implications are clear in terms of effects on the operationalization of population and development activities in these States.

116. Even in sectors where an IEC/Advocacy strategy exists, about half of the member States (46per cent) do not involve private organizations; about one third (30per cent) do not involve the general public; and about one fifth (16per cent) of the policy leaders and of Government institutions (in the case of Ministry of Culture) are not involved in their development (Table 16). Worse still, mechanisms do not exist (Table 17) for the coordination of such population IEC/Advocacy functions as training (36per cent); message and material development (31per cent); message dissemination(28 per cent); research and evaluation (32 per cent); and information exchange (34per cent).

PART THREE

RECOMMENDATIONS FOR THE WAY FORWARD ON POPULATION AND DEVELOPMENT IN AFRICA FOR THE 21ST CENTURY

The Third meeting of the Follow-up Committee on the Implementation of DND and ICPD-PA, held in Addis Ababa, Ethiopia, from 23-25 September 1998 with the participation of 22 member States as well as representatives of UN agencies and organizations, NGOs and other members of the international community adopted the following recommendations aimed at further implementation of the DND and the ICPD-PA.

Reproductive health and reproductive rights

The goal of the ICPD-PA is that the recommendations relating to reproductive health (RH) and reproductive rights (RRs) should be viewed in the broader context of the need to provide basic health services and fulfil over all socio-economic development needs of all the people. In this regard, the ICPD-PA calls on all member States of the United Nations family to make available universal access to a full range of high quality RH services[36] through their primary health care (PHC) system[37] no later than the year 2015. Equally, according to the ICPD-PA, RRs rest on the recognition of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and RH. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence. Accordingly, the meeting recommended that:

1. Further advocacy campaigns aimed at governments and the private sector should be undertaken in order to obtain more resources for RH. Cost recovery was also mentioned as a partial solution. However, the limited purchasing power of the majority of the population in most countries was noted; it was recommended that service fees should not constitute an obstacle to obtaining services for the poorer population.

2. All possible modalities to extend accessibility to RH services should be employed. Depending on national circumstances, this may include deployment of mobile service units, use of community-based agents and the construction of new health units, where possible, particularly in under-served areas. Existing facilities should be improved and/or enhanced.

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36 RH implies that people are able to have a satisfying and safe sex life, are able to reproduce and have the freedom to decide if, when and how often to do so (ICPD-PA paras 7.2 and 7.3). To have this right, they must have knowledge, skilful services, requisite supplies and financial resources as well as individual empowerment to use all of these. Comprehensive RH services include FP information and services, pre and post natal medical care, prevention and management of complications of unsafe abortion including safe abortion services where they are not against the law, treatment of reproductive tract infections and sexually transmitted diseases including HIV/AIDS, active discouragement of harmful practices, and other conditions of the reproductive system including breast and other cancers, prevention and treatment of infertility, and inf ormation and counselling on human sexuality, responsible parenthood and RH.

37 PHC refers to the kind of care that is provided at the first point of contact with the health care system; its drive has been to provide a network of basic health services that are available and accessible to everyone. The earlier PHC focus on disease is now evolving into a focus on the individual within a social, cultural context with as much emphasis on the context as on the individual.

3. An incremental approach to developing integrated RH/FP/SH services should be adopted which implies starting with those elements most responsive to national health priorities such as the HIV/AIDS prevention in order to eventually integrate all components of RH in the primary health care system.

4. Quality reproductive health services should be made accessible, including through the private sector. This would reduce the "patient load" burden on the public sector.

5. Parliamentarians, women's groups, other professional societies and NGOs should publicize and promote reproductive rights.

6. In the integration of RH services, HIV prevention and related services such as treatment of sexually transmitted infections should be prioritized. However, each country would need to make its own decisions about the distribution of relatively scarce financial/human resources among such RH components as HIV prevention, STI treatment, FP, safe motherhood interventions, etc.

7. Priority should be given to programmes aimed at reaching children and adolescents with the information and services necessary to avoid infection. Approaches to reach the young both in and outside schools should be emphasized.

8. In addition to funding for HIV prevention, donors should continue to invest in the search for effective vaccines and cures.

9. Accessibility to counseling and safe abortion, where legal, should be improved and treatment for abortion complications provided.

Family, youth and adolescents

The DND calls on ECA member States to take due account of the rights and responsibilities of all family members and ensure that measures that protect the family from socio-economic distress and distintegration are taken into account in accordance with family well-being and health requirements (bearing in mind the survival strategies designed by the families themselves); provide couples and individuals with the facilities and resources for deciding the size of their families and integrate family concerns in all development plans, policies and programmes; and encourage analytical studies on demographic processes within the family cycle so as to better identify the determinants of small family size.

The ICPD-PA addresses the roles, rights, composition and structure of the family (chapter 5). Accordingly, the ICPD-PA urges governments to develop policies and laws that better support the family; contribute to its stability and take account of its plurality of forms particularly the growing number of single parent households; establish social security measures that address the social, cultural and economic factors behind the increasing costs of child-bearing; and, promote equality of opportunity for family members especially the rights of women and children.

On youths and adolescents, the DND and ICPD-PA draw attention to the special needs of children, adolescents and youth including social, family and community support, as well as access to education, employment, health, counselling and high-quality reproductive health services. Accordingly, they call upon member States to enact and strictly enforce laws against economic exploitation and the physical and mental abuse or neglect of children and to create a socio-economic environment conducive to the elimination of all child marriages. On unwanted pregnancies, unsafe abortion and STDs, they urge member States to ensure that programmes and attitudes of health care providers do not restrict adolescence's access to the services and information they need. They stress that these services should safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values, religious beliefs and the rights and duties of parents. Accordingly, the meeting recommended that:

10. The promotion and implementation of socio-cultural research agenda that will lead to the formulation of appropriate policies and the design of effective and targeted interventions should be intensified.

11. Databases should be established to be used in classifying the different needs of children, youth and adolescent and designing appropriate research to address the gap.

12. Research should be expanded to identify the needs of parents, the sources of information of the youth and positive cultural values.

13. Parents, programmes implementers, teachers and young people should be targeted for training in gender issues that will ensure effective and sustainable gender equality and equity.

14. IEC/Advocacy messages should be expressed in the context of health and developmental issues taking into account positive socio-cultural values.

15. IEC/Advocacy programmes should be linked to service delivery systems that are accessible and responsive to adolescent needs.

16. Inter-generational communication skills should be developed for the sensitization, education and/or training of parents to address the needs of adolescents.

17. HIV/AIDS education, fertility and family planning education should be effectively linked.

18. Life skills education should be incorporated in the IEC programmes in order to ensure positive behavioural change among the youth.

19. Adolescent RH programmes should be linked with income generation and employment schemes.

20. A body/forum should be created in countries to address various personal problems of adolescents. In addition, programmes addressing post crisis

situations of adolescents should be designed and effectively implemented.

21. Country-level mechanisms should be created which will ensure the enforcement of various policies related to adolescents.

22. Life-enhancing family stability in which all members of the family (children, the aged and the disabled) have opportunities in life should be promoted.

23. The issues of the aged with respect to poverty should be addressed, particularly, on how this group is affected by HIV/AIDS when they take on the roles of the deceased members of the family.

24. The impact of political instability on the family i.e., the refugee situation and internal displacement should be assessed.

25. All public and private health facilities should be made adolescent friendly and better able to meet the special RH needs of this age group.

26. Youth involvement in formulating, implementation, monitoring and evaluation of programmes should be actively promoted to ensure the successful achievement of adolescent and development.

Gender equality, equity, empowerment of women and male involvement

According to the ICPD PA, the empowerment and autonomy of women and the improvement of their political, social, economic and health status are important ends in themselves in addition to being essential for the achievement of sustainable development. It called on member State Governments to take actions purporting to empower women and eliminate inequalities between men and women. Accordingly the meeting recommended that

27. Countries which have not done so, are urged to ratify and implement the CEDAW convention. Those that have already ratified, should ensure effective implementation of the Convention.

28. The role of the family in inculcating new gender values should be promoted and strengthened.

29. Studies should be commissioned into the current state of the family in African society taking into account the various transformations it has undergone in order to ensure family stability and other life-enhancing strategies.

30. More research studies should be commissioned on gender issues such as the image of women portrayed in the media and school curricula; violence in the family; discrimination against girls education; socio-cultural barrier to women's employment.

31. Mechanisms should be established and programmes developed for strengthening positive socio-cultural practices and eliminating negative and harmful practices.

32. Countries should give priority to the special needs and requirements of rural women in gender programmes.

33. Countries should ensure that the school curriculum and materials are made gender sensitive.

34. Countries should constantly exchange experience on all aspects of gender programmes; and

35. Countries should raise the level of formal education of females and males, where necessary, as a means and an end to tackle gender concerns.

Role of NGOs and the Private Sector in Programme Implementation

The ICPD-PA requests governments and donors to ensure that NGOs and their networks retain their autonomy and strengthen their capacity through regular dialogue and consultations, appropriate training and outreach activities. The Third Follow-up Committee Meeting also noted the increasing and important role played by the civil society and the private sector. Accordingly, the meeting recommended that:

36. National dialogues should be organized on the roles of NGOs and on their obligation to take account of national priorities, policies and sensitivities.

37. The legal, fiscal and regulatory frameworks in which NGOs implement programmes should be clarified on the basis of open and thorough discussions.

38. Country-level coordination mechanisms should be developed which are acceptable both to Governments and to NGOs.

39. Governments and NGOs should take advantage of their potential complementarity with respect to mobilizing resources – both domestically and internationally.

40. Agreement should be reached among the parties concerned on the roles of the private sector in strengthening population policies and programmes.

41. In order to encourage private enterprises and health care providers to contribute to implementations of population polices and programmes, clear and conducive legal fiscal and regulatory frameworks should be established.

42. Drawing attention to examples of private sector contributions to population programmes would indicate the scope in many countries for the private sector to complement activities implemented by Government.

43. The private sector, civil society and Government should collaborate in order to develop and implement new approaches to the mobilization of resources for population programmes, including the full range of reproductive health activities.

44. Transparency should involve not only finance but also programme concerns. It should be understood as an issue of cost effectiveness.

45. In order to ensure transparency and accountability, communities should be empowered to participate in monitoring NGO programmes.

46. National capacity building should include NGOs and the private sector.

47. Sustainability of programmes run by NGOs should be borne in mind. Hence, counterparts should always be sought before starting such programmes, particularly with regard to those run by international NGOs.

48. Governments and key elements of civil society should consult regularly – not only on special occasions.

49. Information and points of view regarding population policies and programmes should be exchanged on a regular basis between Governments on the one hand and elements of civil society on the other.

50. A wide range of contacts between Government and diverse elements of civil society should be encouraged. These should take place at different levels of government, involve different technical specialties and take different forms.

51. Participation of civil society in population matters should not be limited to discussions of broad principles but should extend to considerations of population policies and programmes.

Population development strategies, policies and institutional mechanisms

The ICPD-PA calls for the development of population policies that (i) will ensure equality and equity between men and women and enable the latter to reach their full potential; (ii) involve women fully in decision-making and ensure their education; (iii) are sensitive and supportive of the family; (iv) protect and support potentially vulnerable groups; that ensure effective access to adequate health information and services, especially for underserved and vulnerable groups; (v) promote a more balanced geographical distribution of population; (vi) extend and expand education; (vii) strengthen programme management, including client-oriented management information systems, and mobilise resources for investments in the social sectors; and (viii) integrate NGOs, women's organisations and local community groups into decision-making.

The ICPD-PA (i) specifically recognized the need for demographic, social and economic data for determining priorities, formulating policies and programmes and assessing their impact; (ii) advised governments to strengthen national capacity to carry out sustained and comprehensive programmes to collect, analyze, disseminate and utilise gender-desegregated population and development data; (iii) urged states to set up or enhance national databases to provide information that can be used to measure or assess progress towards the achievement of the goals and objectives of NPPs; (iv) urged them to focus on the determinants and

consequences of induced abortion, linkages between women's roles and status and demographic and development processes and interactions among population problems, poverty, patterns of over-consumption and environmental degradation and for governments to strengthen training and research in population and development issues and to ensure wide dissemination of research findings; (v) requested governments to increase the skill level and accountability of managers and others involved in the implementation, monitoring and evaluation of NPPs; and (vi) called upon the international community to assist governments in organizing national-level follow-up, including capacity building for project formulation and programme management, and in strengthening co-ordination and evaluation mechanisms. Accordingly, the meeting recommended that:

52. Policies adopted should have clearly defined objectives and strategies in order to be effectively implemented. Those member States that have not adopted population policies are urged to do so.

53. Integrated approach to population, environment, agriculture, technology etc., should be promoted in order to realize sustainable development;

54. The commitment of all actors in a society, the strengthening of the legislative action in population and development, strengthening of the institutional mechanisms and availability of services should be considered important factors for the successful implementation of population and development programmes.

55. Full involvement of the population at grass roots level and the NGO sector, including women’s groups should be promoted at all levels of policy formulation and programme implementation.

56. Population policies should pay sufficient attention to the emerging demographic threats such as HIV/AIDS, impacts of wars and civil strife, etc.; the emerging reformed planning systems should be taken into account when integrating population factors into development plans; emphasis should also be given to capacity building at all levels and ways should be sought in order to minimize the problem of high turnover of staff; required population data as well as other socioeconomic indicators should be made available routinely and timely.

57. With a view to developing long-term vision and perspective on development issues, member States are urged to undertake appropriate analysis and research. Based on the results of such analysis and research they are further urged to integrate population and other relevant variables into over-arching development strategies. Full use of national expertise and greater reliance more on national resources are also strongly recommended.

58. Member States should ensure that coordination mechanisms have the authority and resources they require in order to carry out satisfactory their mandates.

59. The modalities of South-South cooperation should be encouraged and promoted in the context of greater exchange of information, research and training between and among the countries of the region. Institutional mechanisms such

as, Partners in Population and Development should be given all possible support in this context.

60. Governments should have mechanisms for coordinating the policy formulation process as well as the implementation, monitoring and evaluation of projects and programmes.

61. Governments should clearly specify the mandate and the coordination mechanism of each institution.

62. Appropriate modalities for the monitoring and evaluation of the projects and programmes before or at the design stage should be established.

63. An appropriate budgetary allocation for the monitoring and evaluation processes at national and/or regional levels should be provided.

64. A network of database for periodic monitoring and evaluation of the projects and programmes should be established.

65. Governments should strengthen national capacities for research, data collection and analysis. In this connection, all research findings should be published and disseminated.

66. Governments should optimize their utilization of national regional training and research centres.

67. Efficient methods of recording in the civil registration systems and harmonizing such systems should be established.

68. Institutional mechanisms for implementation, monitoring and coordinating of population and development activities should be placed at the highest level possible within the governmental hierarchy with a view to ensuring effective implementation of their mandates.

69. Regional Training Institutions should: (i) continuously update training curricula to incorporate emerging issues and needs of member States, (ii) endeavour to reinforce closer collaboration between themselves and national training institutions to transfer skills and experience; and, (iii) diversify their funding sources and market their products in order to ensure their sustainability.

70. Member States should define training orientations for national, sub-regional and regional levels. Moreover, training in population should be assessed on the basis of projected personnel requirements and in light of the specific priorities and circumstances of the countries concerned.

71. The roles of national, sub-regional and regional training institutions should be determined in light of their comparative advantages and with a view to realizing the best possible synergy between these institutions. This would ensure collaboration and avoid competition. Further attention should be given to articulating a comprehensive and integrated network of regional training centers.

72. In order to ensure sustainability of sub-regional and regional institutions member States are urged to fulfil their financial obligations on a regular and continuous basis.

Advocacy and IEC Strategies

By definition advocacy aims at changing the status of a policy, strategy or programme whereas IEC aims at changing the knowledge base, attitudes, beliefs, values, behavior or norms within individuals[38] or groups of individuals. The ICPD-PA states that greater public knowledge, understanding and commitment are vital to the achievement of its goals and objectives and that increasing such knowledge, understanding and commitment is, therefore, a primary aim. It (I) indicates that members of national legislatures can have a major role to play, especially in enacting domestic legislation for implementing the NPPs, allocating appropriate financial resources, ensuring accountability of expenditure and raising public awareness of population issues; (ii) notes that fostering active involvement of elected representatives of the people, particularly parliamentarians and concerned groups and individuals, was a major objective.; and (iii) recommends joint participation of the Government, NGOs, the private sector and the community not only in the dissemination of information but also in the development of IEC/Advocacy strategies. Accordingly, the Committee recommended that:

73. Broad-based partnerships and pro-active consultation between government and NGOs, NGOs and NGOs, Donors and NGOs, and Government and Donors should be developed.

74. Resources from public, private-sector, civil society and donors should be mobilized for sustainability of advocacy and IEC programmes.

75. Conceptually, the future IEC/Advocacy strategies should emphasize logical step by step process namely: needs assessment through organized research, design, development including pretesting, development of implementation strategy, programme implementation, evaluation, expansion and replication.

76. Evaluation mechanism to measure IEC and advocacy outcome and impact should be established.

77. Qualitative and quantitative data for development of indicators for IEC and advocacy should be collected, processed and disseminated timely.

78. International Organisations should support capacity building in the area of evaluation of communication programmes and activities.

79. Government should ensure that advocacy and IEC support the paradigm shift as outlined in the Programme of Action--to go beyond reproductive health

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[38] ***Advocacy*** implies undertaking research to clarify issues and strategic directions; providing adequate and appropriate information and education to all interested parties; building partnerships, alliances and coalitions; and mobilizing these partners that are interested in the issue being advocated for; dialoguing and negotiating with individuals and organizations with contrary views and positions; and networking with groups of similar persuasion elsewhere to learn from their experiences. ***IEC interventions*** are designed to change knowledge, attitudes, beliefs, values, behavior or norms within individuals or groups of individuals. See Lessons Learnt by UNFPA/CSTAA, 1993-1996, February 1997.

and include other development and environmental issues.

80. Network of communicators in Africa region through which there will be increased sharing of information and support materials should be established.

81. Sub-regional and Regional Institutions should include advocacy and gender dimensions in their training and research programmes.

82. Those concerned with IEC/Advocacy programmes are urged to ensure that appropriate research is undertaken for the development of IEC/Advocacy messages, with the full involvement and participation of all stakeholders and adequate attention to their social and cultural sensitivities.

ANNEXE

Table 1: Reported implementation of recent strategies, measures and legislation of RH and RRs, by ECA member States

Strategies/Measures/legislation	Rate of Implementation (%)	No. of Total Responses
Family planning	65.8	38
Maternal morality	67.6	37
Infant mortality	63.9	36
Prevention and appropriate treatment of infertility/sub-fertility	50.0	34
Role of men in sexual and reproductive health	55.3	38
Reproductive health for refugees and/or displaced persons	29.4	34

Source: Question. 127, Country Questionnaire

Table 2. Percentage distribution of ECA member States implementing selected RH components within their PHC system

Reproductive Health Components		Rate of Implementation (%)	No. of Total Responses
1.	Family Planning	100	39
2.	Prevention of STDs/HIV/AIDS	100	40
3.	Discouragement of Female Genital Mutilation	67.3	31
4.	Adolescent Reproductive Health Information and services	97.5	40
5.	Prevention of infertility and sub-fertility	79.5	39
6.	Prevention of Abortion and Management of the Consequences of Abortion	97.2	36
7.	Safe Motherhood	100	38

Source: See Question. 123, Country Questionnaire

Table 3. Percentage distribution of ECA member States implementing specific policies, plans and legislation affecting accessibility to RH services

Policies,/Plans/Legislation		Rate of Implementation (%)	No. of Total Responses
1.	National Policy for the provision of Contraceptives at minimal cost or without charges		
	(a) At minimal cost or without charges	92.9	28
	(b) At minimal and without charges	90.3	31
2.	Policies, programmes and laws favourable to adolescent reproductive health	78.9	38
3.	Legislation or policy that prohibits provision of family planning services to:		
	(a) Unmarried persons	0.0	39
	(b) Persons below a given age	13.9	36
4.	Legislation or policy that prohibits abortion	87.5	40
5.	Safe pregnancy strategic or operational plan	90.0	40
6.	National breastfeeding policy and plan	92.5	40
7.	National strategic plan to control reproductive tract infections and sexually transmitted diseases, including HIV/AIDS	100	39

Source: See Question. 126, Country Questionnaire

Table 4. Percentage distribution of ECA member States implementing policies, plans and programmes protecting RRs

	Policies/Plans/Programmes	Rate of Implementation (%)	No. of Total Responses
1.	Measures already taken to ensure that men and women are aware of their reproductive rights and can exercise these rights	79.5	39
2.	Provision to protect the basic rights of HIV positive with reference to:		
	(a) Employment	38.7	39
	(b) Marriage	34.4	32
	(c) Travel	34.4	32
3.	Legislation that sets a legal minimum age at marriage	84.6	39
4.	Policy measures to eliminate:		
	(a) Female Genital Mutilation	50.0	28
	(b) Prenatal sex selection	6.1	33

See Question. 125, Country Questionnaire

Table 5. Percentage distribution of ECA member States implementing policies, measures and programmes related to Gender issues

	Policies/Measures/ Programmes	Rate of Implementation (%)	No. of Total Responses
1.	Institutional arrangement for the implementation of the ICPD-PA recommendations put in place	89.7	39
2.	Ratification and implementation of the Convention on the elimination of all forms of discrimination against women:		
	(a) Ratified	89.7	39
	(b) Implementing	79.4	34
3.	Actions taken to promote women's full and equal participation in the labour force	94.9	39
4.	Actions taken to promote women's participation in decision-making	91.7	36
5.	Actions taken to tailor extension and technic al services to women producers	87.2	39
6.	Actions taken to improve the collection, analysis, dissemination and use of gender-disaggregated data in education and health	97.3	37
7.	Actions taken to enhance equal opportunities for and legal protection of the girl child	84.2	38
8.	Strategies or measures adopted to increase age at marriage	48.7	39
9.	Actions taken to focus research efforts on the division of labour, access to income, control within the household and socio-cultural factors which affect gender equality	71.1	38
10.	Actions taken to gather information on women's knowledge of traditional practices and skills	61.8	34
11.	Strategies adopted (including changes in legislation) to ensure empowerment of women	86.5	39

Source: See Questions. 111 – 122, Country Questionnaire

Table 6. Reported involvement of NGOs in the implementation of FP programmes,, ECA member States

NGO involvement in FP	Rate of Involvement of NGOs	No. of Total Responses
1. Research in Family Planning		
(a) Local Women's Groups	64.7	34
(b) Youth Groups	53.1	32
(c) Religious Leaders/Groups	54.8	31
(d) Trade unions	20.7	29
(e) Cooperatives	22.2	27
2. Design of Family Planning Programme		
(a) Local Women's Groups	75.0	32
(b) Youth Groups	64.7	34
(c) Religious Leaders/Groups	64.5	31
(d) Trade unions	34.5	29
(e) Cooperatives	32.1	28
3. Implementation of Family Planning Programme		
(a) Local Women's Groups	81.1	37
(b) Youth Groups	78.9	38
(c) Religious Leaders/Groups	68.6	35
(d) Trade unions	36.7	30
(e) Cooperatives	40.6	32
4. Monitoring of Family Planning Programme		
(a) Local Women's Groups	75.7	37
(b) Youth Groups	70.3	37
(c) Religious Leaders/Groups	60.0	35
(d) Trade unions	30.0	30
(e) Cooperatives	34.5	29
5. Evaluation of Family Planning Programme		
(a) Local Women's Groups	69.4	36
(b) Youth Groups	58.3	36
(c) Religious Leaders/Groups	54.5	33
(d) Trade unions	24.1	29
(e) Cooperatives	21.4	28

Source: See Question. 130, Country Questionnaire

Table 7. Reported involvement of NGOs in RH Programmes, ECA member States

NGO Involvement in RH	Rate of Involvement of NGOs	No. of Total Responses
1. Research in Reproductive Health		
(a) Local Women's Groups	58.1	31
(b) Youth Groups	52.9	34
(c) Religious Leaders/Groups	56.3	32
(d) Trade unions	17.2	29
(e) Cooperatives	8.7	23
2. Design of Reproductive Health Programme		
(a) Local Women's Groups	75.8	33
(b) Youth Groups	65.7	35
(c) Religious Leaders/Groups	68.8	32
(d) Trade unions	27.6	29
(e) Cooperatives	20.8	24
3. Implementation of Reproductive Health Programme		
(a) Local Women's Groups	86.1	36
(b) Youth Groups	81.1	37
(c) Religious Leaders/Groups	76.5	34
(d) Trade unions	35.7	28
(e) Cooperatives	28.0	25
4. Monitoring of Reproductive Health Programme		
(a) Local Women's Groups	66.7	33
(b) Youth Groups	55.9	34
(c) Religious Leaders/Groups	61.3	31
(d) Trade unions	25.0	28
(e) Cooperatives	16.7	24
5. Evaluation of Reproductive Health Programme		
(a) Local Women's Groups	60.0	34
(b) Youth Groups	57.6	33
(c) Religious Leaders/Groups	63.3	30
(d) Trade unions	21.4	28
(e) Cooperatives	17.4	23

Source: See Questions. 130, and 131, Country Questionnaire

Table 8 Reported Involvement of NGOs in the implementation of HIV/AIDS Programmes, ECA member States

NGO involvement in HIV/AIDS	Rate of Involvement of NGOs	No. of Total Responses
1. Research in HIV/AIDS		
(a) Local Women's Groups	55.6	36
(b) Youth Groups	54.1	37
(c) Religious Leaders/Groups	50.0	34
(d) Trade unions	32.1	28
(e) Cooperatives	21.4	28
2. Design of HIV/AIDS Programme		
(a) Local Women's Groups	80.0	35
(b) Youth Groups	80.6	36
(c) Religious Leaders/Groups	73.5	34
(d) Trade unions	44.4	27
(e) Cooperatives	39.3	28
3. Implementation of HIV/AIDS Programme		
(a) Local Women's Groups	83.3	36
(b) Youth Groups	87.2	39
(c) Religious Leaders/Groups	80.0	35
(d) Trade unions	54.8	31
(e) Cooperatives	53.3	30
4. Monitoring of HIV/AIDS Programme		
(a) Local Women's Groups	75.0	36
(b) Youth Groups	68.4	38
(c) Religious Leaders/Groups	65.7	35
(d) Trade unions	37.9	29
(e) Cooperatives	35.7	28
5. Evaluation of HIV/AIDS Programme		
(a) Local Women's Groups	74.3	35
(b) Youth Groups	64.9	37
(c) Religious Leaders/Groups	66.7	33
(d) Trade unions	35.7	28
(e) Cooperatives	34.6	26

Source: See Questions. 132 & 133, Country Questionnaire

Table 9. Reported constraints related to inadequate technical and institutional capabilities re the implementation of the DND and ICPD-PA

Constraints on Implementation		Countries that reported specified constraints	
		percentage	No. of total responses
1.	Lack of national technical capabilities to establish population and development interrelationships within the country	50.0	40
2.	Lack of clearly defined strategies for the implementation of population policies and programmes	56.4	39
3.	Lack of skills for the promotion and implementation of population policies and programmes	38.5	39
4.	Low priority for population IEC activities	61.5	39
5.	Inadequate integration of population variables into development planning	76.9	39
6.	Political instability and high staff turnover that reduce the chances of maintaining one direction in development policy	57.9	38

Source: See Question. 152, Country Questionnaire

Table 10. Reported constraints related to inadequate coordination of activities re the implementation of the DND and ICPD-PA

Constraints on Implementation	Countries that reported specified constraints	
	percentage	No. of total responses
1. Lack of cooperation between the relevant sectoral ministries	56.4	39
2. Low degree of involvement of women in programme formulation, implementation and evaluation	56.4	39
3 Low degree of involvement of NGOs in programme formulation, implementation and evaluation	68.4	38
4. Inadequate cooperation between government and non-governmental organizations	63.2	38
5. Inadequate cooperation with international organizations	55.6	36
6. Poor coordination of activities with foreign partners	69.4	36

Source: See Question. 153, Country Questionnaire

Table 11. Reported trend in Government spending on selected population and development activities since 1994, ECA member States

Areas of Government expenditure	Percentage of Countries that Reported that Government Spending was:					
	Maintained		Increased		Decreased	
	%	N	%	N	%	N
Reproductive health and family planning Services	14.7	34	76.5	34	8.8	34
Reproductive health needs of adolescents	25.0	28	64.3	28	10.7	28
Primary health care services	14.7	34	76.5	34	8.8	34
Sexually transmitted diseases/HIV/AIDS	12.9	31	77.4	31	9.7	31
Female School enrolment	13.3	30	76.7	30	10.0	30

Source: See Question. 149, Country Questionnaire; N/B: N= No. of Total Responses.

Table 12. Reported Economic Constraints re the implementation of the DND and ICPD-PA

Economic Constraints	Countries that reported specified constraints	
	percentage	No. of the responses
1. Persistence of socio-economic crisis	76.3	38
2. Implementation of structural adjustment programmes	77.8	36
3. Abandoning of the medium and long term planning	51.4	37

Source: See Question. 151, Country Questionnaire

Table 13. Reported financial constraints re the implementation of the DND and ICPD-PA

Financial Constraints		Countries that reported specified constraints	
		percentage	No. of the responses
1.	Difficulty in mobilizing domestic resources for population programmes	80.5	41
2.	Insufficient external financial resources for population programmes	55.0	40
3.	Inadequate funding of population activities	55.0	40
4.	Population activities not assigned a budget line in the National Budget	38.9	36

Source: See Question. 154, Country Questionnaire

Table 14. Reported IEC/Advocacy strategies adopted for disseminating information on population and development issues

IEC/Advocacy Strategies		Rate of Adoption (%)	No. of Total Responses
1.	Widespread media reporting (newspaper, radio, television)	82.5	40
2.	Formal presentation to parliament	61.5	39
3.	Seminars, workshops and meetings	92.1	38
4.	Dissemination of related information to:		
	(a) Policy makers and Government officials	89.7	39
	(b) General Public	75.7	37
	(c) Service providers	89.7	39
	(d) NGOs	84.2	38
	(e) Youth and Women Groups	79.5	39
	(f) Religious Institutions	77.8	36

Source: See Question. 138, Country Questionnaire

Table 15. Reported development of IEC/Advocacy Strategies within sectoral programs, ECA member States

IEC/Advocacy Strategies		Rate of Development (%)	No. of Total Responses
1.	Population and Development	80.5	41
2.	Poverty alleviation	71.8	39
3.	Environment preservation	78.0	41
4.	People's participation	71.1	38
5.	Adolescents and youth	90.2	41
6.	Empowerment of women	87.8	41
7.	Gender equality and equity	84.6	39
8.	Reproductive health	92.3	39
9.	Family planning	92.5	40

Source: See Question. 139, Country Questionnaire

Table 16. Reported actors in the development and implementation of IEC/Advocacy Strategies, ECA member States

Implementors of IEC/Advocacy		Countries in which actors are found	
		percentage	No. of the responses
1.	Government institutions:		
	(a) Ministry of Information, Communication	91.9	37
	(b) Ministry of Culture	83.8	37
	(c) Ministry of Education	94.9	39
	(d) Ministry of Health	94.9	39
	(e) Ministry of Youth	86.5	37
2.	Non-governmental institutions:		
	(a) NGOs dealing with development issues	81.6	38
	(b) NGOs dealing with Women	92.3	39
	(c) NGOs dealing with Youth	92.1	38
3.	Private organizations	54.3	35
4.	General public	70.6	34
5.	Opinion Leaders:		
	(a) Religious Leaders	84.2	38
	(b) Policy Leaders	78.4	37
	(c) Civil Society Leaders	56.3	32

Source: Question. 140, Country Questionnaire

Table 17. Reported coordination of IEC/Advocacy functions, ECA member States

Coordination of IEC/Advocacy functions		Rate of Coordination	No. of Total Responses
1.	IEC strategy development	76.9	39
2.	Message and material development	69.2	39
3.	Message dissemination	71.8	39
4.	Research and evaluation	68.4	38
5.	Training	64.1	39
6.	Information exchange	65.8	38

Source: See Question. 141, Country Questionnaire