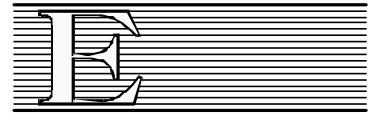




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Implementation of the DND and the ICPD-PA

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## **CONSTRAINTS, BEST PRACTICES AND INSTITUTIONAL CHANGES, INCLUDING PARTNERSHIP WITH THE CIVIL SOCIETY, IN THE IMPLEMENTATION OF THE DND AND ICPD-PA IN AFRICA<sup>1</sup>**

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## **INTRODUCTION**

In line with the recommendations of the ICPD Plan of Action, a follow-up effort has been initiated by the ECA Food Security and Sustainable Development Division to document on the efforts being made by ECA member states to implement the decisions taken during recent major international conferences. In this direction, specific questionnaires were mailed to focal points in each of the member states. This report is based on the analyses of some of the questionnaires relating to the evaluation of the implementation of the Dakar/Ngor Declaration (DND) of 1992 and the Cairo ICPD Plan of Action of 1994 but more especially on information collected from in-country sources in Tanzania, Zambia, Lesotho, Côte d'Ivoire, Ghana, Senegal and to some extent, Cameroon during a short term consultancy.

In view of the fact that most of the recommendations of the DND happened to have been taken up by the ICPD-PA, the framework for this analysis has been the ICPD Programme of Action. For purposes of clarity, the several actions recommended in the various chapters of this document shall be examined under five main themes. Within each thematic area, the main enhancing factors (best practices) shall be examined, followed by major constraints to implementation. Specific examples shall be drawn from the experiences of the countries visited.

## **1. POPULATION AND DEVELOPMENT STRATEGIES**

### **1.1 Policy and Planning**

#### **Best Practices**

- Most countries presently have an explicit Population Policy which has recently been updated (or is in the process of being updated) to incorporate the new orientations of the ICPD-PA on grounds of more reliable and recent data. These policies have guided the formulation of National Population Programmes and Plans of Action, indicating the strategies and activities to be undertaken and the institutions to be involved in their implementation. These programmes are designed to serve as a reference document for all population-related interventions in the country. The UNFPA Country Offices have thus drawn them to design their Country Programmes of Assistance.
- During the course of the formulation of the respective Population policies and programmes and their updating, efforts have been made by respective governments to involve most of the line ministries, Non-governmental Organisations (NGOs), the civil society and local communities in the formulation process. This exercise has brought most of them to better understand the linkages between population dynamics and sustainable development, especially, the importance of incorporating key demographic variables in development planning.

- The Population Policy formulation or reformulation process goes with the identification of the basic institutional framework needed to coordinate its implementation. In most
- cases, this is a new structure with specific functions and wielding ample authority to command respect from the other institutions. It is thus that the National Population Council of Ghana was created in 1993 and attached to the President's Office and the Bureau National de Population (BUNAP) of Côte D'Ivoire was created in 1994 and attached directly to the Cabinet Office of the Ministry of Planning. The Planning Commission in Tanzania is a much more elaborate structure which is taking on both population and economic planning thus making for the synergy that is required for sustainable development. Though a National Population Council is still awaited in Zambia, the Inter-agency Technical Commission on Population with its various inter-sectoral subcommittees is playing an important role in coordination of activities within the sector.
- Efforts have been made, with the assistance of UNFPA Country support teams to further operationalise Country Programmes of Assistance in terms of Logical Frameworks specifying the various activities by strategy and main objective and identifying the key indicators for follow-up and evaluation. It is even possible to identify possible constraining factors to implementation. This should render the implementation and regular follow-up of projects and programmes much easier since almost every activity is foreseen from the outset with the active participation of those who shall eventually be doing the execution and follow-up.

### **Constraints**

- Some of the present population policies were never properly formulated and never went through the requisite channels for adoption. They are therefore not the fruit of popular participation and do not have the weight of law. They do not enjoy the full appropriation by government and key ministries and the public are not conversant with their contents. The population policy document of Lesotho suffers from all these defects because it was designed by a Country Technical Expert working with a few staff of the Population and Manpower Division. None of the procedures for promulgation was ever respected and the final document is largely unknown to the public. In the case of Cameroon, the formulation process was quite elaborate but the final document was promulgated in 1992 rather by the National Population Commission which has never met since then. Under these circumstances, the reformulation process becomes more cumbersome because of the need to first overcome earlier defects before incorporating recent information on levels and trends and the new ICPD orientations.
- Some of the institutional dispositions foreseen for the formulation, follow-up of the implementation of the population policies have either never been created or are presently obsolete and inoperational. The frequent changes in the government structures under the impulse of democratic forces have resulted in the instability of

both key persons and institutions to the extent that continuity can hardly ever be assured within inter-ministerial or inter-sectoral structures. In the case of Cameroon, the original set-up of the National Population Commission can no longer be reconstituted today because some

- key ministries (including the Ministry of Planning which was heading the Commission) have either disappeared through mergers or changed their names, functions and even levels of authority. There now exists the post of Prime Minister and Head of Government who is not part of the Commission. A junior minister has no authority to invite a Minister of State to a meeting of the National Population Commission. In any case, the Interministerial Technical Commission which should have been preparing the key background documents for the convening of such meetings is not operational. In Senegal, the Direction de la Planification et des Ressources Humaines (DPRH) owed its strength to the existence of a Vice Minister in charge of Population and Development but he recently resigned in anticipation of the reconstitution of the political map after the legislative elections of last May. It is not certain whether the same configuration of government shall be maintained but the DPRH shall certainly suffer from such a vacuum and loss of status.
- A number of the newly created coordinating institutions are having much difficulties in playing their roles simply because they have taken up the roles formerly performed by other government services which have a longer experience and more qualified staff both at the central and at regional levels. Most often, the new organs have been placed at a higher level of authority but do not yet have the requisite staff or resources to assume their functions. Under these circumstances, they may experience open criticism and even competition from the other services. It is thus that in Ghana, the NPC is being seen as simply another organ of the ruling PNDC government. Furthermore, the Directorate of Planning is presently launching the implementation of the Poverty Alleviation Programme, which has more substantial funding and shall be intervening in several population-related areas without involving the NPC. We find the same situation in almost every country where a Poverty Alleviation Programme is in place. It is usually the rival and better equipped ministerial department which takes up its execution and hardly ever endeavours to either involve the organ for population coordination or at least to work towards some synergy in their interventions.
- Some of the institutions charged with the coordination of population-related activities are located too far down the administrative hierarchy to command much respect from other institutions which are both better placed and coordinate many more projects and even programmes. In most countries, coordinating institutions have found the Reproductive Health subsector rather unwieldy and often nonchalant largely because it has for long been the target of several donor-supported interventions to the extent that project managers owe more allegiance to funding organizations than to government institutions. In some countries, this subsector is a veritable empire. This situation is quite evident in Ghana, in Senegal

and in Cameroon. In Lesotho, for example, the Division for Population and Manpower Planning (DPMP) in the Ministry of Economic Planning does not have adequate human and material resources for its mandate and has to depend on decisions taken by the Executive Committee made up of Principal Secretaries of line ministries who infrequently attend meetings and from the Lesotho National Population Commission headed by the Prime Minister, but which has never met.

- In spite of the renewed interest in the use of demographic data for development planning, the various line ministries lack the requisite human resource base to fully integrate population variables into their planning procedures. There are some which do not consider them to be pertinent enough. This is usually the case in countries where demographic data is scarce, obsolete and not sufficiently disaggregated to provide the details that can readily be used by non-specialists.
- It is evident that a substantial part of the effort that has so far been made in the area of population policy and planning has depended on donor support, particularly from the UNFPA. In the late 1980s, it funded the creation of Population Planning Units which did the groundwork for the creation of the institutional framework for the formulation and coordination of the implementation of the Population Policy. The substantial funds placed at the disposal of governments brought them to effortlessly create such structures and to come up with Population Policies. The implementation process again received funding but almost all the other structures that no longer benefitted from such funding either phased out or went into slumber. It required more funding from the UNFPA to embark on the revision process to conform with the new ICPD orientations and more funds are being requested for its eventual implementation. The respective governments have not provided ample financial support though some human and material contribution has been evident. Their failure to sustain structures at the end of donor-funding periods and especially to retain the project staff which had acquired substantial experience poses serious questions as to the sustainability and national appropriation of the programmes. There is little evidence to show that most governments would have gone this far without donor support or that they could go further without it. A case in point is the DPRH in Senegal which was adequately equipped with human and material resources up till 1996 while executing the projects of the third UNFPA Country Programme. At the end of the projects, the government could neither retain the project staff nor provide adequate funds for the DPRH to play its role of coordination prompting the UNFPA to again step in before the National Population programmes could be formulated and the sectoral action plans designed. In the near future, the DPRH which is supposed to be executing projects of both the Population and Development Strategies and the IEC/Advocacy subprogrammes shall be out again in search for staff who may require some more training to become functional. Thus experience is never cumulated.

## **1.2 Population Growth and Structure**

**Best Practices**

- With regard to fertility and infant and child mortality the successive WFS and DHS surveys have been able to give a fairly clear idea of both levels and trends without necessarily providing an idea of the population dynamics of the individual countries. In some countries, further analyses have been conducted on these databases to provide a clearer picture of the fertility and mortality situation in the countries. Indeed, there is ample evidence to show that recent programmes and other social interventions have been

inspired by lessons learned from these surveys. The main areas of focus have been to reduce fertility, infant, child and maternal mortality as to improve on the wellbeing of women, children and the family.

- An increasing number of countries is becoming conscious of the consequences of past and present population dynamics on the structure of their populations. With regard to children, nutrition and immunization campaigns are in place. Based on an inventory of the various problems confronting the youth (employment, schooling, access to information and services, delinquency, drug-taking, prostitution, street children, etc.), some countries like Zambia and Tanzania have come up with elaborate Youth Policies and are now in the process of designing action plans while envisaging the creation of Youth Funds to assist youths in creating self-employment. In addition to provision of schooling, youth centers are being created by both the government, private investors and NGOs. Many of the programmes have been designed to make for active youth participation in their implementation thus giving them a sense of ownership of such programmes. The Projet Promotion des Jeunes and the GEEP programme for population and Family Life Education (FLE) through FLE clubs in schools in Senegal are eloquent evidence of youth participation in project implementation.
- Elderly persons, though their numbers have been increasing rapidly, continue to be cared for within the community. In most rural societies, they are still playing their traditional roles as custodians of the culture, decision-makers within families and can still count on the kin and offspring for old age support. As more and more problems facing the elderly becoming evident, a number of NGOs are being created but their impact is still minimal because they lack the funds and have not won ample public support.
- There has been increasing interest lately in making an inventory of the number and characteristics of the disabled persons in various countries through the inclusion of a specific question on physical disabilities during recent censuses. Hopefully, this information shall lead to the elaboration of more focussed and effective projects and programmes to attend to issues relating to specific disabilities. Few programmes exist for the deaf and dumb, the blind, the physically handicapped and the mentally retarded but these are usually small-scale ventures which do not receive much support from public and private funding and some must depend

largely on external donor support.

### **Constraints**

- Not much is known about the exact levels, patterns and trends of maternal mortality in most countries. Usually, current levels are obtained through indirect estimations which cannot provide sufficiently disaggregated information or from hospital records which are often poorly kept and incomplete. In spite of the abundant evidence of cases of maternal morbidity and mortality, very few focussed studies have been conducted (or are being planned) to investigate this phenomenon. Furthermore, the issue of higher male mortality has been taken for granted and no efforts have been made to investigate into gender-specific issues of mortality.
- The youth have not been actively involved in the formulation of programmes that concern them, neither have their parents or other authorities been fully sensitized. Hence some youth programmes have either failed to attract them or have been summarily rejected by either school, religious or community authorities or by their parents. In most cases, the youth do not participate in the evaluation of the projects.
- Where the traditional familial support systems are crumbling, especially in urban areas, the elderly persons are the hardest hit. Only a small proportion of the can lay claim to any existing social security schemes. In the case of Cameroon, the pay-as-you-go system in place was equally victim of the economic crises to the extent that most retired civil servants have been going for several months without their pensions. So far geriatrics is not considered a major dimension of medicine and elderly persons do not benefit from any specific health or social programmes and no efforts are being made to employ their cumulated experience at community level.
- Most disabled persons are destitutes depending on the very little non-expert familial or community support there is. 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 to employment. Very few NGOs have been formed to attend to the specific problems of disabled persons.

### **1.3 Population Distribution, Urbanization and Migration**

#### **Best Practices**

- A majority of African countries has embarked on a process of decentralization of the administration to various degrees with the purpose of giving more political and economic autonomy to the regions. This process brings the administration nearer to the people and enables them participate more closely in the decision-making

process. Some services and facilities which were hitherto available only in the capital cities are offered at the regional capitals which gradually become interior growth poles, thus diverting migration streams from the primate cities. In Ghana, the autonomy of the region has been further enhanced by the advent of democratically elected district assemblies for the 110 districts of the country. The NPC is envisaging to create regional NPC offices with Population and Development Committees in each district assembly. Furthermore, plans are under way to implement an "impact programme approach" in two districts in each region whereby a joint intervention of all the activities of the three current UNFPA subprogrammes shall be made. This should enable the coordinating body to acquire more experience and to build on the synergy necessary for the extension of programme execution over the whole country. Regional specificities can thus be incorporated.

- With decentralization, regional planning commissions are having greater autonomy in the design of regional development models and in setting more realistic investment priorities.
- Some countries have currently received substantial funding from various donor agencies including substantial pledges of government counterpart funding for the execution of five-year poverty alleviation programmes targeted at the rural and sub-urban poor populations. The purpose of these programmes is to increase income levels and particularly improve on the economic welfare of the women, environmental management and to provide institutional support for coordination of interventions. It is thus expected that their implementation shall result in greater access to services, higher productivity, availability of off-farm employment and better overall environmental management and welfare for the poor segments of the population.
- Regional agreements have been signed by countries of the eastern, southern and west African region to facilitate the movement of citizens across their borders. This has gone a long way to enhance regional collaboration and to facilitate the exchange of experiences. It has thus been possible to replicate migration surveys in most of the West African countries and to do other research networking.
- Refugee populations have often been granted some amount of shelter across borders but usually in clearly demarcated areas where they can receive emergency aid. It is only when they have been resident for long that they are provided with educational and other social amenities but hardly with access to land and employment.

### **Constraints**

- In some countries decentralization has remained mere political rhetoric with very little effort on the ground. With the prevailing economic crises and under the stress

of structural adjustment prescriptions, some countries have embarked on decentralization without the requisite political will and the human and material resources to enable autonomous regional autonomy and efficient central coordination. In the end, some regions are far more endowed than others and almost all of them are lacking the critical human capacity base to execute, follow-up and evaluate the various projects and programmes. In Senegal, for example, the few regional staff of the statistical office are programmed to serve in various committees for coordination, to participate in execution of almost all population-related projects including conduct of surveys and to attend several seminars and training courses (in project management, data collection and analyses, IEC etc) during the same period. Yet no specific dispositions are being taken to recruit more staff. In the end, there may be dispersion of energy with a tendency to attach more importance to projects or programmes which have more funds.

- Because of limitations of funds, interventions are usually focussed on only a few of the regions and usually, the choice of such regions is not properly coordinated. Hence some

regions are more endowed while others are totally neglected. In Senegal for example, the Poverty Alleviation Programme and the core interventions of the current UNFPA Country programme shall both focus on five of the ten regions in the country.

- Regional planning has been greatly constrained by the absence or the inadequacy of data. In most cases, the available demographic and social data is obsolete and not sufficiently disaggregated to make for informed project formulation and impact assessment. On the other hand, most of the regions do not have the capabilities to generate their own data or to conduct the socio-cultural research needed to adapt interventions to local realities.
- In most countries, the implementation of SAP has meant the replacement of long-term planning by "integrated" or "strategic" planning whose long term goals are hardly perceptible. In addition, it becomes difficult to coordinate the planning in all the regions in the absence of long-term development plans.
- Apparently, the municipal authorities of most of the large urban areas are ill equipped in terms of the expertise and the financial resources to handle the several challenges that are being posed by the rapid growth of such towns. These include employment, basic education, health services, transportation, security, sanitation, housing, etc. Most of the comprehensive urban development plans need updating.
- Countries like Lesotho have been severely affected by international migration and especially by brain drain toward their larger and more economically viable neighbour - South Africa. The trends have recently shifted from the young male population which was usually employed in the mines to trained personnel in almost any field. Indeed most services in Lesotho are experiencing severe shortages of

staff not because dispositions had not been taken to train them but because of persistent outmigration to South Africa. Entire projects (i.e. training in demography at the University of Lesotho, the DHSI, the 1996 census) have failed to produce expected results because the core staff has migrated. On the other hand, the closure of mines and massive lay-offs have resulted in the return of several unemployed persons and in the reduction of funds repatriated into Lesotho thereby placing many families in conditions of abject poverty.

## **2.REPRODUCTIVE HEALTH/SEXUAL HEALTH /FAMILY PLANNING**

### **2.1 Conceptual Issues and Institutional Changes for Coordination**

#### **Best practices**

- A number of countries have decided not to embrace all the eight dimensions of the RH subprogramme in view of particular constraints. To start off, they have taken on only those activities for which they have some expertise and are encouraging the private sector and NGOs to take on the other dimensions. In Tanzania, the AMREF and

UMATI are being relied upon for the development of most of the youth RH programmes and on UMATI especially for the development of her Community-based Distribution (CBD) approaches. The contraceptive supply system in Côte d'Ivoire has been entrusted into the hands of the Association Ivoirien de Bien-Etre Familial (AIBEF). In general, there exists a fairly favourable atmosphere of collaboration between the government-operated services and the private sector stakeholders and especially the NGOs of the RH sector in most of the countries. This is partly because the latter have a much longer experience and have access to more substantial resources than the government. The health sector in Lesotho has over the years depended on the facilities provided by the christian missions and the government has to thread cautiously when it needs to introduce approaches that may run counter to the ethical dictates of the churches.

- Projects and programmes that now fall under the Reproductive Health (RH) subprogramme have for long been receiving substantial subventions from donor agencies. In response to the ICPD recommendations, this sector has again been receiving the lion's share of donor funding which, if well coordinated, could contribute enormously to the improvement of the health and welfare of african populations.
- In recognition of the fact that governments may not have sufficient funds to sustain the functioning of some of the key projects and programmes, countries have been experimenting on cost-sharing approaches including user fees and community participation in the provision of basic infrastructure including volunteer services. The main problem is that community enthusiasm in such projects often wanes rapidly when the results are not immediately perceptible and when other more

pressing problems beset poor populations. In Ghana, it is being proposed that the government should create an endowment fund for such programmes such that interest accruing to them can be used for the sustainable funding of at least some of their key components.

- Some governments have been providing direct financial support to the NGOs in addition to the substantive assistance provided in the form of premises, logistic support, tax and other duty exonerations, 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 but it takes quite some time and effort for them to be disbursed. Often they come rather late.
- Some countries have proceeded to the zoning of intervention areas such that each actor of the sector is assigned to a specific part of the country. All actors are then expected to abide by the policy guideline and standards of service delivery while adapting their interventions to the local realities of their zones of intervention. This has been the practice in Cameroon where the programmes 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. Overlapping of interventions is thus avoided and the Ministry of Health does the supervisory work. Occasionally the various actors hold meetings to share their experiences and to examine new strategies.

- In an attempt to avoid duplication and dispersion of energies and to ensure a more judicious use of scarce donor funding to meet national objectives in the health sector, a "Health Basket" approach is being proposed in Tanzania, in Ghana and in Côte d'Ivoire under a World Bank initiative. This approach requires that all donor agencies within the sector pool together their resources to allow the national governments to decide how best such funds could be used to meet national goals. Apparently, some of the key donors of the sector are not accepting this proposal in view of their desire to defend their individual interests (which may sometimes not be quite compatible with national interests), the differences in their individual programming cycles and particularly, in their accounting and reporting procedures and also because most of them doubt the probity of national execution of pooled funds.

### **Constraints**

- The concept of Reproductive Health (RH) is rather too broad embracing activities that had hitherto been autonomously carried out by individual departments within the Ministry of Health and even beyond as vertical programmes receiving funding from various donors. The issues that are yet to be settled in most countries are

which of the eight basic activities are to be considered as part of the comprehensive RH subprogramme and which organ shall be responsible for the coordination of the interventions within the subprogramme. The general tendency has been for the Family Planning (FP) programme to assume the leading role on grounds of its wider experience and geographical coverage as well as its ability to adapt by incorporating the other activities into its FP approaches. There is hardly any evidence that the other programmes are accepting a merger under these terms. In Tanzania for example, the Family Planning Union (FPU) is bracing itself to take on this role - even though it has not changed its name yet. However, the terms of the merger with the Safe Motherhood Initiative (SMI) programme, the Expanded Programme of Immunization (EPI) programme and the National AIDS Control Programme (NACP). The current Strategy for Reproductive Health and Child Survival seems to advocate for separate programmes coordinated by the Directorate of Preventive Services at the MOH. The situation in Senegal is rather tense between the Programme National de Planning Familial (PNPF) in charge of the National FP programme which is placed at the level of the cabinet office of the MOH and the Direction de l'Hygiène et de la Santé Publique which is in charge of a vast STD/AIDs programme since 1992 and receives substantial funds from several donor agencies and international NGOs. None of them is prepared to fall under the control of the other. But then a central coordinating body must be designated to coordinate the activities of the subsector and manage the funds allocated by the UNFPA.

- Some countries have rather decided to create new institutions or to rename old ones giving them more functions but this has not brought much improvements in the coordination of activities since the previous programmes of the sector have continued to function almost autonomously and so have the NGOs of the sector. The Bureau Executives de la Santé de la Reproduction of Côte d'Ivoire is a case in point. Since its creation, its denomination and attributions have changed almost every year and none of its appointed directors has ever served for more than 15 months. The various changes at the helm of this institution have implied changes in its pattern of collaboration with the main programmes and NGOs of the sector including the donors. In Zambia, the current health sector reforms have seen the creation of a Central Board of Health which in principle should be the main coordinating body but which presently has neither the human and material means nor the experience to perform such functions. On the other hand, the job uncertainty created by the reforms has almost totally dismembered the Family Planning Unit of the MOH and ruptured the synergy that had hitherto existed between the activities of the actors RH within the sector. At the moment, it is rather uncertain how the activities of the RH subprogramme shall get off the ground.
- A scrupulous evaluation of the performance of the various programmes and projects of this subprogramme in the past years demonstrates that in spite of the enormous resources that have constantly been pumped into them, the overall results have been modest. Trained staff have either not been adequately used or have

lacked the basic tools to work with, the supervision has often fallen short of expectation because of problems of logistics, accessibility and motivation, the system of record keeping and logistics management to aid procurement and supply of vital inputs have been anything but perfect and above all, their impact on the population in terms of changes in behaviour or in general welfare conditions have not been obvious. It is thus that infant child and maternal mortality rates have remained high and are even increasing (in the case of Zambia), HIV/AIDS and STD prevalence levels have been on the increase and there has been no dramatic increases in modern contraceptive prevalence in recent years. Indeed, it becomes questionable whether some of the observed fertility declines can be explained by the slight increases in contraceptive prevalence rates (CPR). Can the decrease of the TFR from 6.4 to 5.5 children per woman in barely five years in Ghana be explained by a 10-14% change in CPR? Such performances can hardly warrant the increase in financial allocations by most donor agencies to this sector and the substantial and abrupt reduction of assistance to the other sectors. The RH subprogramme almost everywhere is found to be absorbing 60-75% of all UNFPA funding for most of the Country Programmes.

- The performance of projects and programmes of the RH sector largely depends on the performance of the entire health sector in a country. Under these circumstances, rehabilitation work or any other aspect of structural or logistic improvements which focus on only the RH facilities within a health institution may not necessarily attract more people. It could be negatively perceived by the rest of the staff and authorities of the institutions.
- At the moment, most of the countries are in the process of conducting rather far-reaching public sector reforms aimed at decentralizing their administrations such as to reduce the functions of the central government institutions. The health sector reforms which are part of this process are also coinciding with the orientations that are envisaged within the projects and programmes of the RH sector in order to obtain a comprehensive subprogramme. An absence of synergy between these two or more processes has created a climate of uncertainty among staff and has even resulted in key project staff either being laid off or transferred to different services. By implication, the new arrivals into the projects and programmes need some time and training to acquaint themselves with the reorientation process within the RH sector. This situation is most perceptible in Zambia. Lesotho still has problems operationalising the Health District concept out of the percent system which has been functioning through 18 Health Service Areas and a Flying doctor unit.
- For the RH subprogramme to function smoothly, the requisite equipment and drugs should be available at all the service delivery points. This requires a functional Health management information system (HMIS) with an efficient Logistics information system (LMIS) which have never properly functioned even within the previous individual programmes as evidenced by the frequent stock-outs and incompatible material supplies. Countries like Tanzania have decided to channel

all procurement and distribution of all medical supplies through the Medical Stores Department. On the other hand Côte d'Ivoire realised that its government pharmacy was most unsuited for the supply of contraceptives which became three times more expensive on arrival. So it has left this dimension of procurement and distribution to the AIBEF which has a longer experience and more international connections. No specific dispositions have been taken for the procurement of medical supplies for the other activities of the RH sector. Ghana has transformed the former Pharmacy Board into a Food and Drugs Authority but the bulk of the contraceptives continue to be supplied by the USAID and the UNFPA. All these approaches have not specifically addressed the issue of estimation of the needs for each intervention.

- Almost all projects and programmes of the RH sector have been launched and executed through donor funding with usually very minimal government counterpart contributions. Such contributions are often expressed in terms of premises, tax exonerations, various other services (water, lights, security, communications) and staff salaries which the projects usually augment as motivation. Over the years, there has been no perceptible increase in such counterpart contributions which on their own can never sustain these projects and programmes. In the end, the project staff are more conversant with procedures for seeking donor funding and managing it than with those needed for advocating for government or other local support. When donor funding for any of such projects or programmes begin to diminish, such staff would rather resign to seek for jobs in other donor-supported programmes or to go abroad than continue to serve with the government. Thus the experience and knowledge base the donor agencies had spent so much to build is never employed to ensure sustainability. The AIDS control

programmes in most countries have fallen victim of this situation.

## **2.2 Reproductive Health of Women**

### **Best Practices**

- Over the past few years there have been significant improvements in levels of knowledge among women about modern contraception with a more precise identification of where they can be obtained. Levels of knowledge among married women, of at least one modern method improved from 72 to 84 per cent between 1992 and 1996 in Tanzania, from 68 to 83 per cent between 1986 and 1997 in Senegal while in Zambia, knowledge was almost universal in 1996. This is the fruit of more aggressive and more focussed and adapted IEC campaigns that have been carried out in many African countries using multimedia approaches. The groundwork of awareness has therefore been laid for eventual change of behaviour if proper advocacy is done and matched by greater accessibility to better quality services.
- There has been significant shifts of government policies from passive acceptance

of FP service delivery to active involvement, sometimes involving the takeover of activities formerly performed by NGOs and the private sector. At the same time, more NGOs are being allowed within the sector and encouraged to open service delivery points in remote areas. A serene climate of collaboration and mutual respect has been found to exist between most governments and the NGOs of the RH sector. To ensure the delivery of better and uniform quality FP services, the various actors have in common agreement drawn up comprehensive packages of equipment that should be available in a service delivery point and designed policy guidelines and standards for FP service delivery. With more efficient supervision, this should render services more attractive and effective.

- The need has been realised to further revise the existing FP training curricula for various levels of staff to include other dimensions of RH and plans have been designed for in-service retraining and pre-service training of more staff. In this direction, efforts have been made to identify and involve key local training institutions in the reformulation of various standard curricula with the view to their greater involvement in training.
- Women are increasingly being recruited into executive positions in the main FP agencies in the various countries. The Director and vice of the FPU in Tanzania are women. The FP programme in Lesotho and the Lesotho Planned Parenthood Association are all women. In both Cameroon, Côte d'Ivoire and Senegal, women have played leading roles in FP programmes and feature prominently in their executives and among affiliate volunteer groupings. This is guarantee that the specific needs of the women are being taken care of.
- A fairly wide method-mix of contraceptive methods is available both through government and private sector channels and most service delivery points endeavour to provide ample information on the possible side effects of the methods. The procurement and distribution systems are becoming more and more experienced such that stock-outs are less frequent. National institutions are no more conversant with the use of the Contraceptive Procurement Table (CPT) and have indicated the need to be closely associated in the contraceptive requirement estimation process.
- Thanks to the efforts of AIDS control programmes and NGOs, awareness levels have are on the increase almost everywhere and people are adopting such preventive measures as reduction in the number of partners, protected sex and screening of blood.
- In the health institutions where comprehensive RH services are being provided by trained staff, the option has been taken to adopt the syndromic approach rather than the more onerous and expensive laboratory testing to diagnose most of the sexually-transmitted infections. Nurses have been authorised to prescribe some common antibiotics for the prevention and treatment of such infections. Referrals

are recommended where complications are identified.

### **Constraints**

- \* In spite of the almost universal levels of knowledge about modern contraception among men and women alike, the contraceptive prevalence rates (CPR) have remained rather low in most countries. There are still serious problems of both physical and financial accessibility. People are aware of services which are not there and when they are available, they may either be expensive or require long waiting hours and other constraining preconditions to obtain them from user-unfriendly service delivery points. Cultural barriers and apprehensions about side effects are still persistent and may require more of advocacy than IEC to overcome them.
- \* The composite nature of the RH subprogramme implies that health staff down to the lowest categories (including CBDs and Community health workers) be provided with ample expertise to identify main RH problems, counsel and provide treatment or refer to the competent reference institutions. This may require several training sessions that may in the end be disruptive to service delivery initially and may also require a sound educational base which is usually not guaranteed at the lowest levels. With regard to reference institutions, there are usually not enough specialists to provide services in the various domains.
- Most african women are hindered from access to information and RH services by their low literacy levels, poverty and generally low social status which reduces them to subordinates who must obtain the authorisation and sponsorship of others in the family go for consultation. In countries like Lesotho and in large urban areas of other countries where female literacy levels are much higher some of these barriers to access may be overcome but the some cultural constraints still persist. In Lesotho, though the long absence of the husband may give greater autonomy to the wife, the influence of the mother-in-law remains overbearing especially in issues relating to RH.
- \* Individual valuation by service providers has often brought them to withhold RH services from some categories of women or to impose preconditions which are not indispensable. The general tendency in Zanzibar is to restrict FP services only to married women and to require the consent of the husband before services can be offered. In such circumstances, the husbands tend to prefer pills whose use they can easily control to long-acting methods. Even in countries like Zambia where official legislation is fairly permissive to abortion (the 1972 Pregnancy Termination Act), women are not aware of the conditionalities and the physicians who have been given the mandate to provide the requisite authorization are reticent. In effect, the Ethics oath to which they are bound forbids abortion and most often, the requisite abortion equipment is not available.

- \* In order to satisfy the needs in medical supplies for the RH sector, the range of drugs needs to be broadened and this immediately poses problems of procurement and management. With the current liberalisation of the economy, the formal and informal channels of drug importation and distribution have increased. It is thus not possible to control the quality and ensure the proper handling and conservation of the drugs and even the contraceptions. In Cameroon, drugs of the RH sector may be obtained from public and private health institutions, from pharmacies and in generic forms from informal drug peddlers in the streets. Condoms are even available from cigarette vendors, in bars, night clubs and in hotels. Under these circumstances it is not possible to guarantee that the quality of drugs and contraceptive methods available to the consumer are of good quality. Most often, consumers resort to automedication or to prescriptions and services offered by untrained persons.
  
- \* Donors and actors of the sector often do not agree on the approaches to be adopted on ethical or policy grounds and this may affect accessibility. In Tanzania, the USAID has consistently been against the training of TBAs under the Safe Motherhood Initiative programme and has consistently opposed the introduction of the use of emergency contraception which is considered as abortion. The Christian churches which operate about half of the health institutions in Lesotho are mostly against the introduction of modern contraception and would prefer the vulgarisation of natural FP approaches. Rumours and suspicion are believed to have significantly affected the acceptance of Depo Provera in Zambia and especially the overall immunization programme in most of Cameroon.
  
- Most AIDS control programmes have been experiencing problems of coordination of the several actors who sprung up during the period when donor funding was easily available. As funds are now scarce most activities are grounded. In addition, popular participation in campaigns to detect an ailment for which there is no cure and which carries so much stigma has waned drastically.
  
- \* Available statistics on HIV/AIDS and even on STDs are either hospital-based or from surveys conducted on unrepresentative samples among high risk populations (prostitutes, drug addicts, transporters). Future trends obtained from applying such results on an epidemiological model are considered in most official circles as unrealistic and alarmist and hence have not significantly influenced behaviour or policy.
  
- \* Despite the services being rendered to address women's RH problems, maternal mortality levels have remained persistently high and have even been found to be increasing in Zambia (649 per 100,000 births in 1996). This has been attributed largely to the fact that many women report for prenatal care too late (during the sixth month), a large proportion of those receiving prenatal care deliver at home unassisted by any trained medical personnel and few report for post-natal care. The

reasons are to be found in their low social status, poverty and dependency, entrenched cultural beliefs, low nutritional status and problems of accessibility.

- \* Female Genital Mutilation (FGM) and other harmful cultural practices against women have continued in spite of a few campaigns that have been carried out in some countries. In effect, the intensity of advocacy has not yet been sufficient to convince the women who practise and accept these practices and the men who encourage them. Further research needs to be conducted into the background justifications for such practices. The 1996 DHS of Tanzania indicated that 81% of the women in Arusha and 68% of those of Dodoma were circumcised while this practice is unknown in other parts of the country. There must therefore be some sound cultural justification for it which makes every women feel obliged to accept it.

## **2.3 Reproductive Health of Adolescents**

### **Best Practices**

- The ages at first marriage and at first birth especially among the young educated and urban women have been found to be increasing consistently even though they are still below 20 years in most countries. This is a positive indicator that more and more young women are starting procreation at a time when they are physiologically mature to give birth.
- A number of initiatives have started in most countries, usually on a pilot bases, which may be considered as best options to adolescent RH health service delivery. The Projet Promotion des Jeunes in Senegal operates five pilot youth counselling centers with multidisciplinary teams composed of a midwife, a psychologist, a social worker, an IEC expert, and some youth in charge of the telephone hotline service. These centers provide several social and entertainment facilities for the youth such that the intentions for visiting them can not be easily determined. Youth who come for counselling and

services do not necessarily have to disclose their identity and those who are too timid can call through the telephone hotline and present their problems with all confidentiality. The center have liaised with other reference centers to which they refer cases that are beyond their competence and such cases are received with confidentiality. The centers have maintained advocacy campaign focussed at parents, religious and administrative authorities and strong IEC programmes for the youth. One of the centers in Pikine, Dakar had handled over 6000 cases over the past two years with the main RH problems being pregnancy, abortion, rape, physical and psychological violence and incest. The AMREF youth project in Tanzania has the same focus. These examples emphasize the fact that adolescent RH is rather holistic and should not be limited to mere provision of services. The YWCA of Zambia has opened Youth Dropping centers in Lusaka which offer a similarly wide range of services and provide temporary shelter and solace for youth

who are victims of domestic or street violence and neglect. With the support of the Irish Volunteer Service, it offers psychosocial counselling in cases of child sexual abuse and operates programmes for street kids in two centers in Lusaka. The Planned Parenthood Association of Ghana has recently opened a 'teen center' with assistance from the Japanese government, where young teenage mothers can have access to RH information and service. It has a skills component which enables such teen mothers to complete their schooling and/or to acquire some professional training.

- Other youth programmes have been focussing on Population and Family life Education (FLE) mainly for youths in school with a few of them targeted at youth out of school in Lesotho. These programmes are based on graded courses according to the age and level of reasoning of the youth. In Ghana, specific classes within a cycle are targeted for such courses such that a child who goes through the whole cycle should have undergone all the courses designed for that cycle. The recommended approach to launch such programmes is to do ample advocacy at the level of the parents, community leaders, religious leaders and among the administrative political and educational authorities before starting off. When they are fully sensitized and made to participate in the conceptualization of the programmes then success can be guaranteed. It is thus that the FLE programme in Zanzibar had to be revised and renamed as a "Moral Ethics" programme and be delivered along with Islamic education as a compromise with the religious authorities. In effect, adolescent RH issues are very complex and need to be handled with much caution. Operational research approaches should enable the redirection of approaches as programmes are being executed.

### **Constraints**

- Early entry unprotected sexual activity long before marriage is still being reported in several parts of Africa. Due to economic hardship and absence of adequate parental protection, many young girls have resorted to sexual adventures and even open prostitution to make ends meet. Under these circumstances, they have a rather weak bargaining position to impose safer practices and end up with various sexually transmitted infections and/or early pregnancies which they often attempt to dispose of

through illegal abortions. Very few health facilities are providing user-friendly RH services for this category of youth who are thus compelled to resort to automedication and other unorthodox means to cure themselves.

- The practice of child or early adolescent marriage still persists among some tribes especially in the Eastern, Central and West African regions. The masai are known to be rather permissive and encourage sexual activity among young children. Among the coastal tribes of Tanzania, it is believed that an old man may gain more years of life if he got married to a very young wife. Some religious groups emphasize on marriage of girls at menarche. Such early exposure may lead to

rather too early pregnancies at a time when the young girls are not yet physiologically mature to deliver children. The outcome may be the development of such debilitating gynecological complications as genital fistulae which maim them for life. Naturally, they are divorced and become destitutes. An attempt to highlight this situation in Tanzania was met with open rejection. Nobody wishes to talk about it. Victims who are admitted in special wards are abandoned by family and friends.

- Some parents, religious and even educational authorities have openly rejected the introduction of FLE programmes in schools on grounds that the child were not ripe enough to be taught sex education and be introduced to contraception. The fear is that the youth may be tempted to go ahead and experiment what they are being taught. Though most of this may be unfounded suspicion reflecting inadequate knowledge of the content of programmes, their apprehensions are genuine.
- The tendency has been for many FP agencies and NGOs to want to comply with the recommendations relating to adolescent RH by simply declaring their service delivery points (SDPs) 'youth friendly' without any specific measures being taken to provide the necessary in-training to acquaint their staff with youth RH services. No further staff recruitments are made to handle those RH issues which had hitherto not been handled by such SDPs.
- Except in Tanzania and to some extent in Senegal, no comprehensive adolescent RH strategies have been designed. Even then, existing internal regulations and other legislation has not yet been specifically modified.
- Most parents do not have the requisite knowledge and skills to provide effective FLE to their children. Education has tremendously differentiated the sources of knowledge and the perceptions of the youths and their parents that they can hardly arrive at any consensus on issues relating to family life.

## **2.4 Reproductive Health of Men**

### **Best Practices**

- In spite of the fact that most of the programmes and services in the RH sector have traditionally focussed on women and children the contraceptive knowledge and use levels are higher among men than women in most of the african countries. This is probably a reflection of their higher educational and income levels which grants them greater access to information and to contraceptives. Perhaps the AIDS scare has also resulted in more men resorting to protected sexual habits. This would then imply that more use is made of them during extraconjugal encounters than at home since the married women are declaring consistently lower levels of use. How much of such practices can therefore be considered as contributing to improvements in RH is the question.

- Most men have been severely affected by the current economic crises. Being the main bread-winners in their households and families, some of them have witnessed significant cuts in the income both in absolute and real terms as many have lost their jobs while prices of most essential goods and services have been escalating inexorably. Under these circumstances, many are rethinking their life options including fertility and other reproductive behaviour such that they now constitute fertile ground for IEC and advocacy campaigns. They are thus more prepared to allow their wives and adolescent children to have access to RH information and services. In Ghana, it was realised that even the Chiefs and other traditional authorities are overlooking entrenched sociocultural norms and practices and are more in favour of cultural adaptation.
  
- A number of innovative approaches to male involvement are currently being executed in a various countries. These include programmes where parents are encouraged to discuss RH issues with their children and where the knowledge gaps between men, women and men are documented to enhance preparation of IEC and advocacy programmes. A parent-peer programme exists in Tanzania where some of the parents are trained to intervene in society to counsel their peers who are objecting to wives or adolescent children having access to RH information and services. Almost all CBD programmes have been employing the services of male CBDs to enhance outreach programmes for men. Industrial programmes have been designed to reach men at their workplaces with services made available either through the company clinics or through CBDs recruited from among the workers. Ghana envisages to increase the male component of its next DHS sample to one-third. It has now developed a 'responsible fatherhood' advocacy programme. The PPAG is currently operating male RH clinics in four urban areas since 1996. These are special days in their regular clinics devoted to male RH issues of males. On such days, a number of specialist medical personnel is available and the attendance has been very encouraging. It has also transformed the 'Daddy's Clubs' which used to venues for macho talk into channels for the introduction and discussion of RH issues, recruitment of male CBDs and provision of FP supplies and resupplies for the members and their wives. The success of this approach had led the creation in 1997 of 'Young Men's Clubs' with similar objectives.
  
- In spite of various efforts to render services more user-friendly, these are still viewed by  
  
the men as programmes for women. Most programmes and NGOs have maintained their former names or acronyms (FPU, AIBEF, ASBEF, LPPA, UMATI, PPAG etc and the same staff (mostly women at the SDPs) as before when they provided services only to women and children. The men naturally are bound to assume a status quo and even suspect any shift of attention towards them. Furthermore, these programmes usually have nothing very new to propose to them in terms of services.

- \* As the economic crisis deepens, some men have been failing in their family responsibilities towards their families such that the very basic RH needs are no longer available to their members. Cases of domestic violence against women and children are on the increase. There are increasing cases of abandoned children and wives and of divorce.
- \* Men are hardly ever prepared to accept responsibility over their sexual acts such that they continue to indulge in unprotected sexual activities both at home and when they have to pay for them out-of-home. Adolescent girls are thus lured out of school and abandoned when pregnant or forced to perform unsafe abortions.
- \* Since it is the men who occupy most of the decision-making and law-enforcement positions in most african countries, they are often insensitive and lukewarm to initiatives which may result in the loss of their traditional prerogatives especially in the area of RH. Law enforcement officers have been found to play down on the gravity of cases of such RH transgressions as rape, incest, abortion etc. where women and children are usually the victims. The YWCA has catalogued several such cases in Zambia from independence to 1995.

## **2.5 Reproductive Health of Special Groups**

### **Best Practices**

- Countries like Tanzania, Zambia and Côte d'Ivoire which have been receiving large refugee populations from their belligerent neighbours have developed special RH programmes within the refugee camps with the collaboration of either the Red Cross or scout movements. Such programmes usually address the specific problems of refugee women who are usually victim of violence and rape. The programmes are not usually elaborate and little supervision is done to ensure quality of service.
- The current National RH strategies for Tanzania are envisaging the incorporation of specific components for the elderly including handling skills, clinical services and provision of the requisite equipment, counselling on care at the level of the family and of the community. There is some alertness to the specific problems of the elderly in the strategies that are being designed for the execution of current UNFPA Country programmes but these are still mere intentions. However some NGOs like the PPAG have already been providing menopausal counselling while the men's clinics handle such elderly male RH problems as continence and prostate cancer.
- \* Refugees often are having more urgent problems which are not related to RH and towards which RH resources may be diverted. Furthermore, their status as destitutes implies that they cannot afford to pay for services. The tendency has thus been to provide only those services which are cheap and oftentimes these are ill adapted to their unstable conditions. In the area of FP they may be requiring

long-acting methods while the programmes may only be affording pills and condoms.

- \* Specialists in the RH problems of the elderly are very scarce in most African countries which have not as yet been considering specialization in geriatrics as a worthwhile option given the relatively small number of elderly persons. Above all, in the absence of viable social security systems, few elderly persons can afford to pay for such specialist services.
- \* Those who provide home or community care for the elderly do not possess the basic skills to easily detect the development of RH problems and often accept them as irreversible symptoms of degeneracy. Consequently, they are unlikely to refer such cases to the health units.
- \* There are very few studies, hence little documentary evidence on which to base the formulation of focussed programme components for either elderly or disabled persons. Thus proposed strategies must start from baseline studies for which the requisite expertise may not be readily available given that it may require essentially qualitative approaches to fully capture the problems faced by such categories of persons.

### **3 GENDER EQUALITY, EMPOWERMENT OF WOMEN & THE FAMILY**

#### **3.1 Empowerment and Status of Women**

##### **Best Practices**

- Thanks to the advocacy that has been carried out during international meetings and within the countries by national and international NGOs and other pressure groups, most african governments have become sensitive to the disparities that are existing between men and women in their societies. This is evidenced by the creation of specific institutional mechanisms to address specific gender issues at the national and sectoral levels. Gender policies and even action plans have been formulated or are in process. In Zambia, a Gender in Development Division (GIDD) has been created at the Cabinet of the President with Gender Desks in the line ministries to ensure that all national policies and programmes are gender-sensitive. A Gender Policy Committee has been created in Lesotho while in Ghana such leading women's groups as the National Council on Women and Development and the 31st December Women's Movement are alert to gender issues. Almost everywhere Ministries of Women's Affairs have taken up gender issues as a priority.
- Most african governments have signed and ratified the international Convention on the Elimination of Discrimination Against Women and the Elimination of Violence against Women and actively sponsored the participation of women in the recent

international fora on women (Dakar, Beijing, Addis Ababa). To some extent, several dispositions are in place to ensure equal opportunities for men and women in terms of access to employment, salaries, parental leave, social security, etc. But the problem is with the implementation.

- More and more efforts are being made to come up with strongly gender-sensitive legislation to protect the disadvantaged elements in some african countries. The Interstate laws in Ghana have been modified to guarantee the right of the spouse and children to property. A Sexual Abuse Act which provides ample protection against violence and various dimensions of sexual exploitation of women is in process in Tanzania. Some educational policies now allow pregnant girls to return to continue schooling after delivery and foresee stiff penalties on those who make them pregnant.
- Women's groups and NGOs have been actively advocating against FGM and other harmful practices against women and children and have been actively involved in projects and programmes for the empowerment of women through greater participation in economic and political life. In this direction, programmes to increase access of women's groups to loans from Women's Development Funds have been put in place with both government and donor funding. Skills development and managerial programmes have been provided while appropriate technology initiatives strive to lighten the burden of work on women. Pressure groups and coalitions have been created in parliaments and within local and sectoral administrations to push through gender-sensitive policies and legislation.
- Female legal practitioners have organised themselves into associations which provide legal advice to women's groups and to individual women on the legal rights of women and even provide free or subsidised services to destitutes. Recent efforts are being made by the FIDA in Lesotho and the ASBEF in Senegal to invite men to their legal sensitization sessions. The YWCA in Zambia went ahead to advocate at the level of the police corps and has succeeded in bringing the police administration to institute gender-sensitive internal codes of conduct and to incorporate gender issues into training programmes at all levels. In Lesotho, the FIDA again organised a workshop for the sensitization of prominent women in some localities towards the standing for elective posts in their constituencies with some positive results since more women candidates participated during the recent legislative elections of May 1998.
- Countries like Tanzania have provided a 15% quota for women in parliament which is not elective. The elected female members only come to add to this fixed quota. Another quota has been introduced for female enrolment into secondary schools. In addition, a

Tanzanian/Canadian programme is in place for the graduate training of women in four main sectors: science and technology, law, gender planning and management and administration. The purpose here is to enhance their access to higher job

positions. In most other countries various scholarship programmes and incentives exist in favour of women and young girls.

### **Constraints**

- \* There exists a persistent confusion between 'gender' and 'female' or 'women's' issues. The tendency has been for previous programmes and strategies of the Integration of Women in Development framework to be simply renamed as gender programmes and strategies. It is thus that the 'Women in Development Division' (WIDD) with its 'Women's Desks' in Zambia have simply swapped 'women' for 'gender' without any further changes in either staff or strategies. Oftentimes, stark feminist undertones can be discerned in the advocacy campaigns that are presently in place. Not only do some of the argumentations lose sight of local realities and sensibilities, they are rather elitist in the sense that they leave out the plight of the largely poor and rural women. The tendency has been to ignore pertinent male issues even in countries like Lesotho where problems of schooling and school drop-out rates have been found to be affecting the boys more than the girls.
  
- \* The low socioeconomic and sociocultural status of women as evidenced by their poverty, illiteracy, status as minors or subordinates has greatly hampered their access to vital information, to land, to property, to credit facilities and to decision-making positions. Most of them are unaware of their basic rights and are constrained by entrenched traditional prescriptions and even modern legislation from asserting them. In the final analyses, most women have come to accept and internalise their plight and status to the extent that no longer perceive them as major issues. It is thus that few of them offer to go for elective positions and even though they usually constitute the majority of the electorate, they prefer to vote for the men. Though women constituted 66% of Zambia's voting population in 1996, only 14 out of the 158 parliamentarians were women. It is largely elderly women who perform FGM and oversee the betrothal of young girls. In the absence of male hegemony in some basotho households the mothers-in-law ensure the respect of norms. African women therefore still are requiring much of conscientisation to be alert to their rights and to discriminatory, degrading and harmful practices against them and to desist from cautioning them and even participating actively in their perpetuation.
  
- \* Incidents of violence against women such as rape, defilement, battery, assault, murder, divorce and separation have been on the increase and such degrading practices as FGM, forced and child marriages, widow cleansing and inheritance have persisted in spite of the several advocacy campaigns and the enactment of legislation to curb such practices.
  
- \* Where dual legal systems exist, the statutory laws and regulations guarantee equal rights and opportunities for both sexes but the customary laws reinforce male

dominance. During implementation traditional values override statutory dispositions and the victims who are usually women and children are given little sympathy.

- \* The policy of quotas and incentives for females poses problems of equity. They may be interpreted as discrimination against men. They may not be sustainable especially if successive administrations do not share the same vision.
  
- \* The culture of male dominance has persisted at the time when the socio-political environment has greatly improved in Africa. The advent of democratic regimes with the resurgence of multipartism and freedom of press and expression have created many opportunities for men and women form parties, associations and other pressure groups to freely express themselves through various communication channel. Yet the proportion of women in political and other decision-making positions has rather been declining in almost every country. The few who are selected do not occupy key departments. In Lesotho for example, where women constitute 53% of the heads of households and predominate in the civil service and the entire formal and informal sectors of the economy, they are still legally considered as minors by both the statutory (Roman Dutch Law) and customary legal systems. Hence they must obtain the permission of their partners to open bank accounts, to enter into contracts, to obtain loans, to acquire landed property and even to undergo a medical operation. Only one cabinet position is held by a woman and men are largely predominant in the parliament. In Cameroon the number of women in both the government and in parliament has equally declined.

### **3.2 The Girl Child**

#### **Best Practices**

- Female participation in education at the primary level has been found to be equal to that of the males. Even in countries where schooling rates have been declining as the result of economic hardships, this equilibrium has been found to prevail. This may be an indication that parents are becoming more conscious of the need to provide equal opportunities for basic education for all their children. Even at the secondary level, the proportion of female students has been increasing over the years.
  
- Some countries have designed programmes with incentives for the education of girls. In Côte d'Ivoire, the government recently intervened to provide school equipment to girls at the primary level in northern regions where educational level are consistently low. Similar programmes are available in Ghana which has gone further to provide fee-waivers, remedial courses in the sciences during holidays and part-time study facilities within the framework of the 1996 Action Plan for Girls' Education. Quotas have since been instituted for the enrolment of girls at the universities and other professional schools. Similar quotas exist at the secondary school level in Tanzania. In other

countries like Cameroon, special scholarship programmes are available for girls studying the sciences at the universities.

### **Constraints**

- \* Female drop-out rates have remained high especially during the transition from one cycle of learning to the other implying that parents are still inclined to investing more on male than female children. As the girls grow up they are orientated towards female roles in the household and the community and expected to go into marriage as early as possible. In Zambia, the equitable enrolment rates at the primary level gradually become skewed in favour of the boys at the higher grades (60 to 40% at Grade IX; 67 to 33% at Grade XII). The disparities are even higher in Tanzania - 62 to 38% at the secondary level and 85 to 15% at the University level.
- \* The culture of son-preference still persists but is not readily admitted in most societies. The requisite in-depth sociocultural studies that could highlight the incidence of such preferences and the consequences on the girl-child are lacking. Consequently, most discriminatory practices go unnoticed and have far-reaching consequences for the physical, emotional, psychological and intellectual development of these children.
- \* Little has been done so far to eliminate stereotypes transmitted by both the media and pedagogic materials in schools. This may be due to the fact that most countries are lacking the requisite expertise to develop their own programmes and materials. It may also imply that such issues are not considered as priority.
- \* Though efforts have been made in some countries to set the official age at first marriage for girls at 18 years in order to ensure that they are fully mature and have acquired some basic training before entering into marriage, the practice of child marriage and early betrothal is still very common. In effect, such legislation can only be enforced for official marriages. Premarital cohabitation and childbirth are not prohibited and indeed are widely practised.
- \* Official legislation in most countries has provided for compulsory child support from parents but the problem remains with the enforcement of such legislation. When marriages break down, the children suffer most because they are unaware of their rights and lack the means to assert such claims.

### **3.3 The Family and its Roles**

#### **Best Practices**

- All African countries have endorsed the main resolution of the DND whereby the family is the basic unit of society which should be strengthened and provided with

comprehensive protection and support.

- Most official policies are sensitive to the marital and family status of individuals in the sense that provision of such amenities as housing, employment health and social security discriminate in favour of married persons.
- Fiscal countries in some countries are offer rebates for persons who are married thus creating incentives for founding families.

### **Constraints**

- \* Few socio-anthropological studies have been done on the family, its forms, structure and roles in african countries. Most often confusion is made by researchers between the household and the family to the extent that household patterns are considered as family patterns. A household can be part of one family and many family units can be found in one household. Most family codes have thus been designed withhold sufficient background information and turn out to be of little relevance to social policy formulation.
- \* Statutory and customary legislation have mostly recognised monogamy and tolerated polygamy but the other forms of unions and family types are not recognised. Hence single parents are restricted access to RH services and housing facilities. Children born out of wedlock have no specific status and rights.
- \* No specific dispositions have been taken to address the case of families of disabled persons. In the case of refugees and displaced populations, efforts are usually made to reconstitute families.

## **4 POPULATION INFORMATION, EDUCATION & COMMUNICATION AND ADVOCACY**

### **Best Practices**

- The IEC activities of past UNFPA country programmes, coupled with IEC programmes of other programmes have contributed immensely to providing policy makers, policy implementers and grassroots actors with the needed information for understanding and explaining the relationship between population issues and development. In the particular domain of RH, some success has been achieved in eradicating misconceptions regarding Family Planning and consolidating the need to promote these services thus paving the way for attitudinal and behavioural change.
- The current trends in the liberalisation 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 countries like Zambia and Tanzania, the institutional structures for the design, implementation and coordination of advocacy and IEC programmes 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 programmes including the materials, messages and appropriate channels.
- 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 push ideas through so as to influence policy.
- Most of the countries 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.
- Some countries such as Senegal and Ghana have been working closely with the RAPID 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. The problem however is with the scarcity of sufficiently disaggregated data and other information at the input level and for the formulation of realistic assumptions.

### **Constraints**

- \* There is persistent confusion between what should be considered as IEC and what is advocacy. Much of this confusion emanates from the ICPD itself which did not clearly draw the line between the two. The UNFPA and other organs which have for long been running IEC programmes have tended to present advocacy as another brand of IEC without clearly highlighting the specificities of each approach. Evidently both depend on identical sources of information, have fairly identical target audiences and employ almost the same channels to pass the message across. That is why most countries have simply renamed their previous IEC programmes.
- \* 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 programmes. This

leaves room for amateurism and may adversely affect programmes.

- Most countries 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 programmes 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 jeopardise the cause for which such messages were designed.

- \* 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 behaviour and attitude issues and for targeting messages at specific audiences. Most of the IEC and advocacy materials are hardly ever pretested and no operational research is foreseen to evaluate their impact.
- \* 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 accessible so as to make for 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. Above all the raw data files are never easily accessible. In most countries, census data has become obsolete and needs to be updated to provide sufficiently disaggregated data down to the district level. In Lesotho, the results of the 1996 census are anxiously being awaited before any consistent IEC and other strategies can be developed. Tanzania, Senegal, Côte d'Ivoire, Cameroon and Ghana are preparing to conduct their next censuses soon. Indeed, nationally representative surveys like the WFS and 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 disaggregation.
- \* IEC and advocacy materials have been lacking in variety and specificity, as well as in quality and quantity. Furthermore their wide distribution has been hampered by logistic problems.
- \* Few countries 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 countries 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 countries lack the expertise for such translations, terms such as 'gender', 'reproductive health' etc are new and loaded while there are no easy local

equivalents for contraceptives and even family planning that could appropriately pass on the right meaning.

- In some countries, 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 programmes 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 programmes 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 at the DPRH in Senegal loses its staff at the end of each project period and must recruit new, inexperienced staff for the next period.
- \* Rarely has the target audience been involved in the formulation, monitoring and evaluation of the impact of IEC and advocacy programmes.

## **5. DATA COLLECTION, CAPACITY BUILDING AND RESOURCE MOBILISATION**

### **5.1 Basic Data Collection, Analyses and Dissemination**

#### **Best Practices**

- Countries with outdated census data are currently preparing to conduct other censuses before the end of the century. Special efforts are being made to update the mapping using GPS techniques such as to eventually dispose of updated sampling frames for future national sample surveys. In some cases, community-based information is being collected at the mapping phase with the view to producing comprehensive village directories. To meet recent realities and orientations, new variables are being introduced and new approaches envisaged. It is thus that Tanzania has included a number of gender-specific questions and intends to address only part of the questionnaire to the whole population and another part shall only be addressed to a 30% sample of the households. Ghana shall be including variables on housing while Senegal is envisaging to include questions on female genital mutilation and emigration and to modify categories of the handicapped within a draft questionnaire which shall be pretested.
- A number of nationally representative sample surveys have been conducted in most countries to gather information on economic activity, living standards and levels of poverty, household consumption and fertility and related issues during the

intercensal periods. Furthermore, other focussed surveys have been conducted to research into specific problem areas identified by the censuses and national surveys. It could thus be said that the knowledge base on population and related issues has continued to improve since 1994.

- Some experience has been accumulated and skills developed in data collection and analyses in countries with stable and well-structured statistical services. Thus, there

exists a critical mass of expertise both at the national and regional levels for the conceptualisation, execution and analyses of research projects and other data collection operations.

### **Constraints**

- \* The data collection and analyses component of population programmes has been the hardest hit in terms of reductions in both international funding and local contributions. It must be admitted that most of the past censuses had been largely sponsored by donor funding and benefitted from substantial external technical assistance with the hope that skill would be transferred. Many of the countries can now execute census and other data collection exercises with minimal external human resource assistance. But the current economic crises have not made it possible 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. This trend is rather too abrupt and unfortunately is affecting a very vital component which has provided the basic framework for other surveys, the baseline data for the formulation of policies and programmes and whose constant update is essential for their follow-up and evaluation. Each census produces an updated sampling frame for intercensal surveys which have been so vital for population programmes. It thus does not sound logical to channel more funds to other components while the core component which provided justification for their existences and provides data for their evaluation is being starved. Indeed, the data collection component should have been considered a transversal component as are gender and IEC.
- \* The time-lapse between data collection and availability of results has remained wide for many censuses and some surveys. The 1984 census data Ghana was long overdue when it was published in 1996. The 1987 census results for Cameroon were only available as from 1991 and some of the programmed reports are not available even today. Up till May 1998 the first results of the 1996 census of Lesotho had not been released. Under these circumstances, various actors have had to depend on population projections and other doubtful population estimates to Lesotho drew much of its data from projections.
- \* The few available socio-anthropological studies are usually very limited in scope

and thus not representative. Such details are indispensable for the deciphering of the persistence of such practices as child marriage, female genital mutilation, polygamy, widow inheritance and widow cleansing, etc. Quantitative research usually describes phenomena which qualitative research must explain in order to guide the formulation of policy and the orientation of implementation strategies.

- There has been practice in countries like Cameroon to consider each census as a project which ends at the publication and dissemination of results. The next census project is then situated in another site with its staff (who may not necessarily come from the

previous project) and materials. In the end, the experience gained is never cumulative. Data files for both the first and second censuses of Cameroon can no longer be retrieved today partly because they had no custodian

## 5.2 Training

### Best Practices

- Various countries are increasingly realizing the need to locally train the staff they need for the successful implementation of population-related projects and programmes. The main teaching and research institutions have constantly been associated in the design of adapted curricula and in the training of staff at various levels. Ghana's Training Action Plan, besides identifying the key institutions (universities and their colleges, GIMPA, RIPS etc) envisages to limit training abroad to short and medium-term courses and to rather bring in trainers of some the courses to the country where they can train more people at comparatively lower cost.

### Constraints

- \* As a result of the increase in the awareness of the pertinence of population issues, actors in almost all the countries have expressed the need to train specialists in the area of population and development. However, no comprehensive human capacity needs assessment studies have been made for training plans to be developed. In spite of the recent UNFPA orientations requiring countries to budget for the training of the nationals at regional training institutions through their Country programmes, no country has foreseen any such training during their current programme periods. The UNFPA Country Offices have either not insisted on this detail or have not been aware of it. This may imply that the various regional training institutions shall not be receiving any more students forthwith except other alternative sources of scholarship funding are found. On the other hand most of the local training institutions provide only medium-level training and have been having problems of staffing.
- \* For the RH sector and even the IEC/advocacy sector to be fully operational in any

country, a large number of staff shall have to be trained or retrained so much so that there may be periods within a year when most of the staff is in for training. In order to have at least two trained service providers per health facility, the Tanzanian authorities have estimated that some 54 courses shall have to be delivered in five years. More staff may be needed in other sectors. Yet the government is bound by structural adjustment dispositions to cut down on employment.