Independent Assessment of the Implementation of the Programme of Action (POA) of the International Conference on Population and Development (ICPD)

November 2010

INDEPENDENT ASSESSMENT OF THE IMPLEMENTATION OF THE PROGRAMME OF ACTION (POA) OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD)

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Acronyms and Abbreviations

ACAP	African Census Analysis Project
ACHAP	African Comprehensive HIV/AIDS Partnerships
AERC	African Economic Research Consortium
AfDB	African Development Bank
AIDS	Acquired immuno-deficiency syndrome
AIS	AIDS indicator survey
APR	Annual progress report
ART	Anti-retroviral therapy
AU	African Union
AUC	African Union Commission
CAPI	Computer assisted person interview
CDI	Child Development Index
CODESRIA	Council for the Development of Social Science Research in Africa
CPSI	Centre for Public Service Innovation (South Africa)
CSIR	Centre for Scientific and Industrial Research (South Africa)
DAC	Development Assistance Committee (of OECD)
DHS	Demographic and Health Survey
EASTAC	Eastern Africa Statistical Training Centre (Tanzania)
ENEA	National Institute of Applied Economics (Senegal)
FHH	Female-headed households
FHI	Family Health International
G8	Group of Eight
GDP	Gross domestic product
HIPC	Heavily Indebted Poor Countries Initiative
HIV	Human immuno-deficiency virus
IBSA	India-Brazil-South Africa
ICPD	International Conference on Population and Development
ICPD POA	International Conference on Population and Development Programme of Action
IDA	International Development Association
IDMC	Internal Displacement Monitoring Centre
IDP	Internally displaced person
IEC	Information, education and communication
IFORD	Demographic Training and Research Institute/Institut de Formation et de Recherche (Cameroon)
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
JSA	Joint staff assessment
KEI	Key indicators survey
LSMS	Living standards measurement studies
MAPS	Marrakesh Action Plan for Statistics
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MICS	Multiple indicator cluster survey
MIS	Malaria indicators survey
NAPTIP	National Agency for the Prohibition of Traffic in Persons and Other Related Matters (Nigeria)
NGO	Non-government organization
NSDS	National Strategy for the Development of Statistics

OAU	Organization of African Unity
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
OPEC	Organization of Petroleum Exporting Countries
PDA	Personal data assistants
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTC	Prevention of mother-to-child transmission (of HIV)
POA	Programme of Action
PPD	Partners in Population and Development
PRSC	Poverty Reduction Strategy Credit
PSI	Population Services International
REC	Regional economic community
RHS	Reproductive health surveys
RIPS	Regional Institute for Population Studies (Ghana)
SADPA	South African Development Partnership Fund
SITA	State Information Technology Agency (South Africa)
SMS	Short message service
SPA	Service provision assessment survey
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TFR	Total fertility rate
TFSCB	Trust Fund for Statistical Capacity Building
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Foreword

To be provided by UNFPA

Executive Summary

At the United Nations (UN) 1992 Conference on Environment and Development in Rio de Janeiro, Brazil the international community identified population growth as a serious obstacle to sustainable development. Although it did not reach a consensus on actions to address this obstacle, the dialogue at Rio helped produce the historic agreement in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt.

The ICPD defined a comprehensive and ambitious two-decade agenda for meeting human needs, stabilizing global population and promoting sustainable development. It endorsed a new strategy that emphasized the numerous linkages between population and development. The conference's Programme of Action (POA) set out a series of priority issues aimed at empowering women, protecting the environment, and meeting people's basic needs in such areas as education, nutrition and health. The POA also called for the protection and promotion of the rights of adolescents to reproductive health education, information and care provided with privacy, confidentiality, respect and informed consent.

Following the five- and ten-year reviews of the ICPD POA, 2009 – the 15th anniversary of the conference – offered another occasion for countries to reflect on the work done and look forward to the challenges ahead in fully implementing the POA. Country-level reviews, led by the UN Economic Commission for Africa, the African Union Commission (AUC) and the UNFPA, were undertaken in AUC Member States. Besides these, the UNFPA deemed it necessary to commission – for its primary use – this independent assessment in parallel to the ongoing review by Member States.

Objectives of the Independent Assessment

According to the terms of reference, the main objective of this independent assessment was to add value to the country-level reviews by providing critical and objective analysis that contributes to a holistic picture of the status of the implementation of the ICPD POA in sub-Saharan Africa, 15 years on. The assessment was also expected to provide for, and inform, the future direction of UNFPA support to sub-Saharan Africa.[1]

Methodology

To achieve the objectives, the assessment undertook a desk review of both qualitative and quantitative national and international data, supported by interviews with key informants. The document and literature review entailed a comprehensive and analytical perusal of the ICPD POA, the UN Millennium Declaration and Millennium Development Goals, the Maputo Plan of Action on Reproductive and Sexual Health and Rights (or simply Maputo Plan of Action) as well as other population and sustainable development commitments – made at both global and regional levels – since the ICPD in 1994. This phase of the assessment also involved a review of empirical literature that reflected on the overall situation of population and sustainable development, and reproductive health and rights in sub-Saharan Africa. The purpose of this review was to become conversant with the key tenets of the background documents and to determine cross-cutting issues in the documents.

An analytical framework based on the document review was developed, and with this tool the progress made by AUC Member States in the implementation of the ICPD POA was critically reviewed and analysed to provide evidence-based evaluation of the achievements made, major gaps, key challenges, best practices, lessons learned, as well as factors that

[1] Throughout the report sub-Saharan Africa is used interchangeably with "Africa".

facilitated or inhibited progress. Drawing largely from the document and literature review as well as the key informant interviews, issues that have either enhanced or inhibited the advancement of the ICPD POA in sub-Saharan Africa were identified, and forward-thinking strategic recommendations for post-ICPD development agenda in Africa were made.

Key Findings

Perhaps the first thing to note is that for virtually all of the ICPD issues this assessment addressed, governments in sub-Saharan Africa have committed to a range of international, continental or regional declarations and conventions. Significantly, Africa's commitments in many of these areas predate the ICPD by a number of years – education for all, the environment, population planning, etc. Since ICPD, the numerous commitments include the Millennium Development Goals (2000), the Maputo Plan of Action (2006), the Plan of Action on the Family (2004), and the Strategic Framework for Migration Policy in Africa (2006). Among others are African Common Position on Children – Africa Fit for Children (2001), the African Youth Charter (2006), Policy Framework and Plan of Action on Ageing (2003), and the Continental Plan of Action for the African Decade of Persons with Disabilities (1999–2009).

> Governments in sub-Saharan Africa have committed to a range of international, continental or regional declarations and conventions related to virtually all of the ICPD issues this assessment addressed.

Although follow up on these and the many other commitments has been somewhat uneven, at least some progress has been made in most areas. The accomplishments and continuing challenges are summarized below.

Population, Economic Growth and Sustainable Development

Summary of Progress

Most national poverty reduction strategy papers (PRSPs) in sub-Saharan Africa discuss – at least to some extent – general population dynamics in profiling poverty, with reference to population growth and fertility rates, life expectancy, and processes of urbanization. On a number of issues, however, the PRSPs exhibit highly variable thematic coverage – integrated service provision, family planning, adolescent health, unsafe abortion, maternal and child health themes. A number of countries explicitly included a section on population-related issues in the policy content of their PRSPs. Other countries have formulated PRSPs that contain strong examples of effectively integrating other key sexual and reproductive health (SRH) topics, such as gender-based violence and harmful traditional practices.

In the aggregate, there seems to be a sense of improved incorporation of population concerns as countries progressed from first to second generation PRSPs, and as issues such as reproductive health had featured more prominently on the international development agenda, especially post-2006.

Summary of Challenges

- Certain sexual and reproductive health topics remain significantly under-represented. For instance, while youth-related content increased, considerations relating to adolescent health are rather weakly represented in PRSPs.
- Unsafe abortion is also rarely mentioned, despite its continued salience as a cause of maternal mortality in Africa, and the Maputo Plan of Action's explicit called on African Union member states to "enact policies and legal frameworks to reduce incidence of unsafe abortion" and "prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion".

Summary of Recommendations

- Develop guidelines for the preparation of PRSPs or national development plans with provisions supporting sustained progress towards the ICPD POA: UNFPA and other

relevant international and regional agencies should take this action to assist countries with the incorporation of population and/or reproductive health policies and interventions that are specifically related to the POA.

Gender Equality, Equity and Empowerment of Women

Summary of Progress

Many African countries have now enshrined gender equality in their constitutions, promulgated gender-friendly legislation and policies, and put in place national machineries to promote gender equality in fields such as health, education, public sector participation and the economic sector. There have also been notable improvements in girls' primary and secondary school enrolment, female labour force participation, and women's participation in the political arena.

Summary of Challenges

- Implementation of policies on gender equality has tended to be hampered by lack of budgetary commitments.
- Even though many countries' constitutions and statutory law now provide for equality for women, this is often not the reality in practice. Customary and religious laws are usually given precedence in matters of family law, including divorce and inheritance, and provisions that could be considered discriminatory towards women continue under the misapprehension that they are aspects of cultural practices.
- Harmful traditional practices such as female genital mutilation/cutting and child marriages are still common in many parts of sub-Saharan Africa.
- Enrolment in tertiary education remains low and heavily skewed against women.
- The majority of women employed in non-agricultural work are mostly engaged in the informal sector where they are likely to be among the working poor, having low productivity, low earnings and high poverty.
-

There needs to be a shift towards a more inclusive gender approach and away from the misconception that gender equality is a women's project aimed at wresting power and benefits away from men.

Summary of Recommendations

- Implement legal reforms: Governments must take steps to review and reform customary and religious laws in collaboration with stakeholders such as traditional and religious authorities.
- Provide strategic positions for women: It is critical for women to have positions that are central and critical to national processes.
- Enhance the role of men: There needs to be a shift towards a more inclusive gender approach and away from the misconception that gender equality is a women's project aimed at wresting power and benefits away from men.

The Family: Its Roles, Rights, Composition and Structure

Summary of Progress

The post-ICPD period had seen a growing number of African governments designing and implementing national social protection strategies to improve the welfare of different family members. A major post-ICPD landmark in this area is the African Union *Plan of Action on the Family in Africa* adopted in 2004. With its focus on nine priority areas, this Plan of Action is designed to serve as an advocacy instrument for strengthening family units, addressing their needs, improving their general welfare, and enhancing the life chances of family members.

Summary of Challenges

- In many African countries social security programmes of the contributory types apply to salaried workers only.

- Although many countries in the region have some form of family allowance, many of these allowances were means-tested.
- Current socio-economic and demographic transformations in the region are leaving many family members in precarious situations. Among these trends are decreasing fertility, increasing proportion of older persons, weakening intergenerational relations, increasing proportions of female-headed households and rapid urbanization. –
- The AIDS epidemic has had and continues to have far-reaching effects on family by, among other things, creating previously unfamiliar family structures such as skip-generation households, child-headed households and orphans who have no extended family support systems.

Summary of Recommendations

- Develop and implement comprehensive and adequate social protection strategies and programmes: These should address improving the overall understanding of social security; achieving concrete improvements in social security coverage; and raising awareness and mobilizing key actors and partnerships.
- For UNFPA in conjunction with other multilateral agencies and donor countries, facilitate initiatives to improve the welfare of the family: This can take the shape of advocating the inclusion of appropriately designed social protection elements in their support programmes and policy recommendations.
- For African governments, act on commitments: There is need to ensure the effective implementation of the various international and regional commitments aimed at improving the welfare of families and their members.

African governments need to ensure the effective implementation of the various international and regional commitments aimed at improving the welfare of families and their members.

Population Growth and Structure

Summary of Progress

Since the ICPD, sub-Saharan Africa has joined the rest of the world in giving greater attention to the importance of population trends for development, and in emphasizing the eradication of poverty, and the raising of the standard of living by encouraging sustained growth, human resource development and the guarantee of all human rights. Among others, sub-Saharan countries have adopted and some are implementing policies that address the needs of specific sections of the population: children, youth, the elderly and persons with disabilities.

Over the last 15 years, several studies have shown conclusively that fertility decline was under way in most parts of Africa. The key explanatory variables for the declines revolve around increased age at marriage; increased urbanization; increased use of modern contraception, especially condoms in the wake of HIV and AIDS; and the fact that improved education of women appears to have gradually eroded some of the traditional values placed on childbearing.

Summary of Challenges

- The decline in child mortality is much below the average annual rate of 4.3% needed for the region to reach MDG 4 (Reduce Child Mortality) by 2015. Adult mortality in sub-Saharan Africa is also higher than in other parts of the world.
- As a result of the current general mortality trends, sub-Saharan Africa had seen a drop in life expectancy of about 3% over the last two decades.
- Despite the general fertility decline in the region, national total fertility rates in a number of countries have not continue their previous decline.

- Despite having committed themselves to protecting the welfare of children by ratifying various international and regional instruments, countries in the region continued to have the worst Child Development Index (CDI) in the world.
- Young people in the region still face several challenges, including unemployment and underemployment.
- Many older persons in sub-Saharan Africa confront challenges of their own, key among them being the lack of social security.

Summary of Recommendations

It is evident that sub-Saharan Africa is not lacking in commitment to enhance its population growth and structure. What is needed, therefore, is for governments in the region to:

- Work in close collaboration with regional and international partners to transform this commitment into viable actions and enhance the welfare of the different population groups in the region.
- Recognize the large population of youth as an opportunity to revive the region's socio-economic capital.
- Forge partnerships with national and international organizations, including civil society, to develop and implement policies and programmes through which young people can reach or unleash their potential.

Reproductive Rights and Reproductive Health

Summary of Progress

Policies and programmes are in place in many countries to ensure that young people can access sexual and reproductive health services, and several countries have taken steps to implement life skills or sexuality education. In the meantime, contraceptive use in sub-Saharan Africa, though still low by world standards, has risen since the 1990s.

Summary of Challenges

- Unmet need for contraception remains high in most countries of the region; overall 24% of women who say they intend to stop or prevent childbearing are not using any contraception.
- About 92% of women of childbearing age in sub-Saharan Africa live under what may be considered restrictive abortion laws; abortion is still not permitted for any reason in 14 countries, and is allowed to save the life of the mother in only nine.
- Knowledge about HIV and AIDS remains relatively low, and in some countries less than half of young people display comprehensive knowledge of HIV and AIDS.
- Although one of the goals of the ICPD POA was to substantially reduce adolescent childbearing, in many sub-Saharan African countries more than 20% of young women reported that they had been pregnant.

Contraceptive use in sub-Saharan Africa, though still low by world standards, has risen since the 1990s.

Summary of Recommendations

- Invest in skilled human resources, as these constitute a critical area in terms of supporting the achievement of the targets set out in the ICPD POA.
- Focus the research agenda on understanding male perspectives on reproductive health and sexuality.
- Determine the underlying reasons for why limited progress has been made in providing services to young people, and undertake appropriate measures to correct this situation.
- Adopt the 2005 *Continental Policy Framework on Sexual and Reproductive Health and Rights* and integrate sexual and reproductive health services at all levels of the health sector.

Health, Morbidity and Mortality

Summary of Progress Made

African countries and the African Union have, in the recent past, adopted several strategies aimed at improving the health status of people in the African region and to achieve the objectives of the ICPD POA and the MDG targets. These include: the Africa Health Strategy: 2007 – 2015; the Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006); the Continental Policy Framework on Sexual and Reproductive Health and Rights (2005); and the OAU Bamako Declaration "Vision 2010" on Reduction of Maternal and Neo-Natal Mortality, 2001.

Deaths of children under the age of five in sub-Saharan Africa declined from 183 deaths per 1,000 live births to 145 in 2007, as a result of ongoing child survival interventions.

And, as in the rest of the world, under-five mortality in sub-Saharan Africa has declined over the last few years, from 183 deaths per 1,000 live births to 145 in 2007. Several child survival interventions are being implemented and scaled up in many countries of the region, and these are expected to yield further declines in under-five mortality over the next few years. These interventions include immunizations, micronutrient supplementation, insecticide treated bed nets for preventing malaria, and support for mothers for enhanced family care and breastfeeding. Of particular note is that the proportion of one-year-old children who have been immunized against measles increased from 55% in 2000 to 73% in 2007. According to the 2009 United Nations MDG report, sub-Saharan Africa has had the largest reduction in measles deaths between 2000 and 2007.

Moreover, since the ICPD Africa's response to HIV and AIDS – through regional commitments and national policies and programmes – has been decisive and comprehensive. At the regional level, political will among the leadership to address the pandemic and other priority diseases included the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases (2003) and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001). There has, as well, been a rapid scaling-up of antiretroviral therapy (ART) in sub-Saharan Africa in general; the change from no ART to reaching more than a quarter of the population in need of ART in less than a decade has produced significant public health benefits.

Summary of Challenges

- The survival of newborn babies and children less than one year old remains a public health problem for African countries. The majority of deaths are due to infectious diseases, malnutrition, and neo-natal and pregnancy-related conditions.
- Despite its decline, under-five mortality remains the highest in the world.
- Sub-Saharan Africa has made little or no progress in reducing maternal mortality: 920 maternal deaths per 100,000 births in 1990 compared with 900 in 2005. The causes of the high maternal death rates in the region are mainly preventable risk conditions.
- The problem of tuberculosis has intensified in recent years with the increasing HIV-TB co-infection among people living with HIV.
- New health problems, mainly chronic and non-communicable diseases such as diabetes, cancer, hypertension, and cardiovascular diseases, have introduced complicated health care needs.

Summary of Recommendations

- Strengthen primary health care services to meet the treatment needs of the growing population with chronic illnesses (both communicable and non-communicable diseases) in addition to acute illnesses.
- Scale up and integrate fragmented interventions, and ensure access by the poor and marginalized groups to effective, evidence-based interventions.
- With the increased participation of women in the labour force, develop a supportive legislative environment to support women who opt for exclusive breastfeeding in the first six months of their babies' life.

- Increase coverage of bed nets to most population groups that need them, including making them part of maternal and child health programmes, a move that could be a cost-effective intervention for development.

Population Distribution, Migration and Urbanization

Summary of Progress Made

Migration has been making its way steadily towards the top of the continental affairs agenda in recent years. For example, a number of regional blocs have made efforts to facilitate free movements between countries of their regions. In addition, the 2009 Global Trends report by the UN High Commissioner for Refugees shows that the number of refugees in sub-Saharan Africa continued to decline for the ninth consecutive year. And partly as a reflection of economic growth and development, Africa has witnessed rapid urbanization, with urban areas growing at an estimated 3.5% per annum.

Summary of Challenges

- Africa has already lost one-third of its human capital and continues to lose its skilled personnel – particularly from the health sectors – as a result of brain drain.
- Despite the number of sub-Saharan African citizens in the Diaspora, the region has benefited from only 15% of the remittance flow from the developed to the developing countries.
- A new phenomenon of "economic migrants" or "economic refugees" is emerging. To the extent that these types of migrants are not classified as refugees, many of them are vulnerable to constant harassment in host countries.
- Available evidence suggests that human trafficking is on the rise in sub-Saharan Africa, spurred by poverty, armed conflict and instability, as well as traditional practices such as early marriage.
- Durable solutions to the conflict in central Africa and the Great Lakes Region remain out of reach and internal displacement of people continues. In particular displaced persons who have attempted to rebuild their lives are blocked by the absence of stability and food security, as well as development and livelihood opportunities in areas of return. Prospects for reconciliation between communities and for mechanisms to provide compensation for housing, land and property remain dim. Also questionable is the appropriate management of funds meant for returns, compensation and purchase of land
- The rapid urbanization in sub-Saharan Africa is a worrying trend given that it is happening without an accompanying process of industrialization. Cities cannot cope with the influx, and many new city dwellers are vulnerable to diseases like malaria, HIV and AIDS, and those associated with poor sanitation and pollution.

Brain drain has already cost Africa a third of its skilled personnel – with the health sector being the biggest loser.

Summary of Recommendations

- Support the implementation of the key tenets of the African Union *Strategic Framework for Migration Policy in Africa.*
- Strengthen the involvement of the African Diaspora in the developmental issues of the continent.
- Mount a Pan-African effort to educate government officials and the general public on xenophobia and the rights of refugees. In addition, Governments must be encouraged to establish multi-agency working groups to deal with issues of immigrants.
- Develop policies to address the proliferation of informal settlements, urban slums and peri-urban areas and to manage urban settlements effectively.

Population, Development and Education

Summary of Progress

Over the post-ICPD period there has been a gradual increase in primary school enrolment in sub-Saharan Africa, from 61% in 2000, to 68% in 2005 and 74% in 2007. Furthermore, available data also indicate that all regions in sub-Saharan Africa have seen a relative increase in the net enrolments rates of girls at primary education level – nearly 20% between 2000 and 2009. Participation in pre-primary education has also been increasing steadily, and literacy rates rose from 50.6 in 2000 to 62.4 in 2009, an overall increase of more than 11% in less than ten years.

Across Africa there has been a gradual increase in primary school enrolment, from 61% in 2000 to 74% in 2007, plus an 11% increase in overall literacy rates.

Summary of Challenges

- While progress has been made in increasing girls' enrolment in primary education, girls in many countries are still much less likely than boys to attend secondary/high school and college or university. In 2009, just over a quarter – 25.1% – of the region's girls were enrolled in secondary education,, down from 30.7% in 2005.
- While global participation in vocational education was around 16% in 2007, the sub-Saharan African region recorded a mere 6% in 2009.
- Gender disparities vocational education enrolment are highly pronounced in sub-Saharan Africa.
- Despite improvements in enrolment rates, available evidence points to poor quality of primary and secondary education because of such factors as teacher shortages, large and increasing class sizes, under-qualified and poorly paid teachers, and scarce and poor quality learning material.
- The content of the curricula has generally not kept pace with the needs of the labour market, nor has information and communication technology been incorporated as part of schooling.

Summary of Recommendations

- For Member States, rededicate efforts to the realization of the Plan of Action of the AU *Second Decade of Education for Africa (2006-2015)* goals.
- Strengthen the capacity of teacher training colleges, review remuneration of teachers and ensure continuous teacher training.
- Strengthen partnerships between and among local communities, students/parents associations, employers associations, trade unions, development partners, faith-based organizations, and non-government organizations to increase resource mobilization for education in rural and other under-served areas.

Technology, Research and Development

Summary of Progress

Many African countries are making efforts to respond positively to the ICPD POA's call to collect analyse and disseminate relevant and useful population data. There are, as well, various initiatives in place to coordinate and focus resources for the development and use of data.

Summary of Challenges

- Financial and human resources (particularly personnel skilled in technical and research fields) remain inadequate.
- Ability to exploit new technology that could significantly reduce costs associated with large surveys/censuses is lacking.
- There is a general lack of reliable vital registration systems to allow accurate measurement of demographic indicators such as adult mortality.
- Governments in Africa have many pressing issues such as health, food production and education that compete for government funding. Under these conditions, research tends to take a back seat.

Summary of Recommendations

- There should be continued commitment and enhancement of national capacities and mechanisms for the collection, analysis, interpretation, and dissemination of population data.
- Place a high priority on training and development of human resources – this is essential in all processes. In particular, support should be given to countries to build demographic skills around capacity to analyse and interpret census and survey data.
- Develop local research capacity to ensure that research is relevant to local communities' population and reproductive health concerns, and that local policy makers make use of this evidence.
- For African governments, build a national statistical base aimed at polling pertinent data from various sectors of their economies, and to ensure that such data are accessible to policy makers.
- To the extent possible, disaggregate the collection and analysis of all population data by demographic characteristics such as age and sex to assist in effective policy making and planning at local levels.
- Monitor and evaluate the impact of all the programmes and policy implementations and use the feedback to inform the next phases in technology development and research.

The collection and analysis of all population data should be disaggregated by demographic characteristics such as age and sex to aid policy making and planning.

Partnerships and Resource Mobilization

Summary of Progress

The New Partnership for Africa's Development (NEPAD), established in 2002, is notable among partnership efforts. NEPAD is a framework consisting of a set of African-driven development priorities that constitutes the key blueprint for post the ICPD resource mobilization and partnerships in the continent.

Moreover, African countries have been receiving increased support from an array of development partners to implement the ICPD POA. These include multilateral and bilateral partners, UN agencies, and international non-government organizations. For example, the flow of official development aid (ODA) to sub-Saharan Africa has been on the rise; the region remains the largest receipt of ODA, having more than doubled receipts in current US dollars between 2000 and 2007. South-South cooperation has also gained importance as a complement to the "traditional" North-South cooperation.

Furthermore, the potential contribution of the private sector to the formulation and implementation of population policies and programmes is now better understood and more widely recognized in many African countries. In consequence, varied modalities for the participation of the private sector in population activities have emerged. These include social marketing programmes and greater reliance of private practitioners.

Summary of Challenges

- Although developed countries are providing increased ODA to Africa, they lag behind the commitments made in the 2002 Monterrey Conference on Financing and Development and the 2005 Gleneagles Summit.
- Much of the increase in ODA to Africa has been linked to debt relief operations, with only moderate increases in aid for development.
- Despite specific commitments made at the ICPD by the international community to steadily increase financing to programmes in the area of population dynamics (including reproductive health, family planning, maternal health and STI prevention), available evidence indicates that this goal has not been reached.

- Much of the funding to population assistance has gone largely to HIV and AIDS activities, thus leaving insufficient resources for family planning and reproductive health interventions.
- The period 1986–1997 saw a slight increase (from 0.20 to 0.27) in the proportion of ODA earmarked for technical assistance/cooperation. This proportion declined in recent years, however, from 0.25 in 2002 to 0.13 in 2007.
- Development aid derived from South-South cooperation is often a small component of a much bigger development support approach focusing on trade and investment and on peace and security issues. Even so, only 11 sub-Saharan African countries are currently members of the Partners in Population and Development (PPD), a Southern-led, Southern-run inter-government organization that operates through the modality of South-South cooperation in the areas of reproductive health, population and development.

Summary of Recommendations

- Increase both international and domestic allocation of resources to population activities if the targets of the ICPD POA are to be achieved in Africa.
- Sign the Paris Declaration: Those African countries that are not signatories to the Paris Declaration on Aid Effectiveness should be encouraged to consider it. Among other things the Declaration can make it easier for countries to make demands on donor agencies and countries to honour their commitments.
- Join the Partners in Population and Development (PPD). The countries that are not members should consider joining, and be encouraged to do so.

1. Background to the Independent Assessment

Ever since the Bucharest Conference of 1974, the salient relationship among population dynamics, individual wellbeing and sustainable development has been at the centre of the global agenda. Bucharest was the first of a series of world conferences on population held during the last three decades of the 20th century. This wave of global awareness was also witnessed at the Mexico City Population Conference held in 1984, and the United Nations Conference on Environment and Development in Rio de Janeiro, Brazil, in 1992. At the Rio conference the international community identified population growth as a serious obstacle to sustainable development. Although it did not reach a consensus on actions to address this issue, the dialogue at Rio helped produce the historic agreement reached in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt.

The ICPD defined a comprehensive and ambitious two-decade agenda for meeting human needs, stabilizing global population growth and promoting sustainable development. The conference endorsed a new strategy, in fact a new paradigm, that emphasized the numerous linkages between population and development. This strategy abandoned rigid, top-down demographic targets in favour of a rights-based approach that holds that smaller families and a stable population will result from meeting people's basic needs, which include family planning and reproductive health care, basic health care, education, and human rights. The ICPD Programme of Action (ICPD POA) therefore, set out a series of priority issues aimed at empowering women, protecting the environment, and meeting people's basic needs in such areas as education, nutrition, and health. It also called for the protection and promotion of the rights of adolescents to reproductive health education, information and care provided with privacy, confidentiality, respect and informed consent.

ICPD endorsed a new paradigm that emphasized the linkages between population and development in a rights-based approach holding that smaller families and a stable population will result from meeting people's basic needs,

The goals of the ICPD POA were refined and amplified at the fifth-year review of its implementation (ICPD+5) in 1999 when additional *Key Actions* were adopted. These included a new set of benchmarks in four areas: education and literacy; reproductive health care particularly the unmet need for contraception; maternal mortality reductions; and HIV and AIDS. Therefore, following ICPD+5, the key goals of the ICPD POA included:

- Achieving, by 2015, universal access to reproductive health care, including: safe and effective family planning; pre- and post-natal care; essential obstetric care; infertility treatment; and prevention; and management of reproductive tract infections, including sexually transmitted infections (STIs);
- Reducing maternal mortality rates to half the 1990 levels by the year 2000, and by half again by 2015;
- Increasing the presence of skilled attendants at birth to at least 78% by 2005;
- Reducing infant mortality to below 35 deaths per 1,000 live births and under-5 mortality to below 45 deaths per 1,000 live births by 2015;
- Ensuring that 90% of 15–24-year-olds have access to information and services by 2005 to help them avoid HIV infection; and
- Achieving universal access to primary education by 2015, and closing the gender gap in primary and secondary school by 2005.

Given the cross-cutting nature of population issues, the implementation of the ICPD POA and the achievement of its targets will be critical for reaching the Millennium Development Goals (MDGs), which are global targets set by world leaders at the Millennium Summit in

2000. Five of the eight MDGs demonstrate a strong alignment with the ICPD POA. These are:

- MDG 2: Achieve universal primary education.
- MDG 3: Promote gender equality and empower women.
- MDG 4: Reduce child mortality.
- MDG 5: Improve maternal health.
- MDG 6: Combat HIV/AIDS, malaria and other diseases.

Given the cross-cutting nature of population issues, the implementation of the ICPD POA and the achievement of its targets will be critical for reaching the Millennium Development Goals

Two additional MDGs are also closely linked to the ICPD goals and recommendations, although they are not similar in scope and function. These are MDG 1 (eradicate extreme poverty and hunger) and MDG 7 (ensure environmental sustainability). The ICPD POA's recognition of the importance of partnerships in achieving development is also reflected in the last of the MDGs (MDG 8: Develop a global partnership for development).

The close link between the ICPD POA and the MDGs was further affirmed when the 2005 Millennium Project Report on Child and Maternal Health acknowledged that sexual and reproductive health is essential for reaching not only the three health-related MDGs, but also for attaining many of the other goals including reduction of extreme poverty, ensuring educational opportunities and gender equality, and achieving environmental sustainability. The report also strongly recommended that universal access to reproductive health services be added as a target to MDG 5 on improving maternal health.

The 2005 Millennium Project Report on Child and Maternal Health acknowledged that sexual and reproductive health is essential for reaching not only the three health-related MDGs, but also for attaining many of the other goals.

Recognizing that African countries are unlikely to achieve the MDGs without significant improvements in the sexual and reproductive health of their people, the African Union (AU) endorsed the Maputo Plan of Action on Sexual and Reproductive Health and Rights (or simply, the Maputo Plan of Action) in 2006. This Plan of Action sets into motion the Continental Policy Framework on Sexual and Reproductive Health and Rights adopted by AU Heads of State in October 2005 to take Africa forward towards the goal of universal access to comprehensive sexual and reproductive health services by 2015. The Maputo Plan of Action is a short-term plan for the period up to 2010 built on nine action areas:

- Integration of sexual and reproductive health (SRH) services into primary health care;
- Repositioning of family planning;
- Provision of youth-friendly services;
- Unsafe abortion;
- Quality safe motherhood;
- Resource mobilization;
- Commodity security; and
- Monitoring and evaluation.

Most countries in Africa are not on track to reach the MDGs

Recent evaluations of the Maputo Plan of Action indicate that progress in its implementation is below expectations (see, for example, AUC, 2010). By the same token, it is now universally recognized that most countries in Africa are not on track to reach the MDGs as a result of the recent financial and food crises coupled with the rising cost of energy, recurrent challenges and emerging development threats, such as the deepening of poverty and climate change. To this end, given the strong linkage of ICPD POA with the MDGs, it is also unlikely that countries in Africa will reach the ICPD/POA targets set for 2015.

With 2009 marking the 15th anniversary of the ICPD and almost a decade of the MDGs, the year provided another opportunity for countries to reflect on the work done and look forward to the challenges ahead in fully implementing the ICPD POA. Thus, led by the United

Nations Economic Commission for Africa (UNECA), the African Union Commission (AUC) and the UNFPA undertook country-levels reviews of the implementation of the ICPD POA in all AUC Member States. In addition, the UNFPA deemed it necessary to commission – for its primary use – this independent assessment to complement the review done in the AUC Member States.

1.1 Objectives of the Assessment

According to the terms of reference, the main objective of this independent assessment is to add value to the country-level reviews by providing critical and objective analysis that contributes to a holistic picture of the status of the implementation of the ICPD POA in sub-Saharan Africa (among AUC Member Sates) 15 years on. The assessment is also expected to provide for, and inform, the future direction of UNFPA support to sub-Saharan Africa.[2]

The specific objectives are to:

- Undertake an analytical review of the implementation of ICPD POA in Africa over the past 15 years and the Maputo Plan of Action on Reproductive Health since 2007.
- Document country and regional experiences, lessons learnt and best practices related to the implementation of ICPD POA.
- In the context of the Maputo Plan of Action, analyse sub-regional and major country level responses relating to such issues as:
  - Applying a continuum of care approach to the full range of reproductive, maternal, newborn and child health issues;
  - Meeting the needs of young people, especially those at risk;
  - Advancing women's health overall;
  - Adopting life-cycle and preventive approaches for addressing reproductive health challenges; and
  - Involving men in family planning, the promotion of women's health and empowerment, and other related relevant areas.
- Determine the extent to which population dynamics have been incorporated into national development plans and poverty reduction strategies and their impacts.
- Identify key policy and programme priorities that should be considered for the period 2010–2014 as well as for UNFPA's future direction and for the post ICPD development agenda in Africa.

The assessment sought to determine the extent to which population dynamics have been incorporated into national development plans and poverty reduction strategies and their impacts.

The terms of reference further stated that the review was not meant to provide a country-by-country assessment, but, rather, to give a regional picture of progress, gaps, lessons and best practice.

1.2 Methodology

In accordance with the main objective of the assessment and the specific tasks outlined in the terms of reference, the assessment team undertook a desk review of both qualitative and quantitative national and international data related to the key priority areas in the ICPD POA. The overall approach to the assessment, then, involved a document and literature review, development of a conceptual and analytical framework, assessment of progress made, and interviews of key informants. From that evidence, the team was tasked with making recommendations for the way forward. These components of the assessment are described below.

[2] Throughout the report sub-Saharan Africa is used interchangeably with "Africa".

1.2.1 Document and Literature Review

The purpose of this review was to become conversant with the key tenets of the background documents and to determine cross-cutting issues in the documents. The exercise entailed a comprehensive and analytical review of the ICPD POA, the UN Millennium Declaration and Millennium Development Goals, and the Maputo Plan of Action on Reproductive and Sexual Health and Rights (or simply Maputo Plan of Action), as well as other population and sustainable development commitments – made at both global and regional levels – since the ICPD in 1994. This phase of the assessment also involved a review of empirical literature reflecting on the overall situation of population and sustainable development, and reproductive health and rights in sub-Saharan Africa.

1.2.2 Development of a Conceptual and Analytical Framework

Results of the document and literature review formed the basis for an analytical framework to review the progress made by AUC Member States in the implementation of the key dimensions of the ICPD POA. To the extent possible, the alignment of ICPD with the MDGs was the main focus of this phase of the assessment.

1.2.3 Assessment of Progress Made

The analytical framework then guided the assessment of progress made by AUC Member States in the implementation of the ICPD POA. Progress was critically reviewed and analysed to provide evidence-based conclusions on the achievements, major gaps, key challenges, best practices and lessons learnt, as well as factors that facilitated or inhibited progress.

1.2.4 Key Informant Interviews

Where deemed necessary to complement the findings of the desk-top assessment, telephone interviews were conducted with key informants from different parts of sub-Saharan Africa. The informants comprised people working for regional non-government organizations and research institutions, independent researchers, and others working with issues of population, development and reproductive health. Among the organizations whose staff or members were interviewed were JHPIEGO,[3] Centre for Development and Population Activities, Regional Institute for Population Studies (Ghana), and the UNDP Regional Service Centre for Eastern and Southern Africa Others were Union for African Population Studies, MiET-Africa[4] Human Sciences Research Council, Africa Focus and the Global Campaign for Education. To note is that views expressed by the key informants do not necessarily reflect those of the organizations they work for, but are largely drawn from the informants' experiences in their work within the population and development sector.

1.2.5 Making Recommendations

Findings related to the achievements, major gaps, key challenges, best practices and lessons learnt served to document the factors that facilitated or inhibited progress in realizing the goals of the POA. . To the extent possible, quantitative outcome indicators were analysed using internationally comparable data. Where this was not possible, the analyses focused on a thematic review of progress. The results of the review were used to make strategic recommendations for post-ICPD development agenda in Africa.

[3] JHPIEGO is the Johns Hopkins Program for International Education in Gynaecology and Obstetrics, a leading provider of training, information and other support to the reproductive health sector.

[4] MIET Africa is a not-for-profit organization based in South Africa with a strong presence throughout the SADC Region. See www.miet.co.za.

1.3 Structure of the Report

Following this introductory outline of the background and methods used for the assessment, sub-Saharan Africa's implementation of the key priority areas of the ICPD POA is examined within the following ten sections:

- ***Section 2*** *(Population, economic growth and sustainable development)* examines the extent to which population and reproductive health concerns have been integrated into development and poverty reduction strategies.
- ***Section 3*** (*Gender equality, equity and empowerment of women)* examines the extent to which African countries have taken full measures to eliminate all forms of discrimination against and exploitation and abuse of women and the girl-child.
- ***Section 4*** *(The family: Its roles, rights, composition and structure)* examines to what extent African governments have formulated policies that are sensitive and supportive of the family and have created innovative ways to provide more effective assistance to families and vulnerable individuals within them.
- ***Section 5*** *(Population growth and structure)* undertakes an in-depth assessment of trends in population growth and structure, fertility, and mortality. The changes in the welfare of children, youth, older persons and people with disabilities are also explored.
- ***Section 6*** *(Reproductive health and reproductive rights)* addresses questions about the accessibility of reproductive health services within the framework of the ICPD POA and the Maputo Declaration on Reproductive Health and Rights.
- ***Section 7*** (*Health, morbidity and mortality)* conducts an analysis of basic health indicators such as infant and child mortality, maternal mortality, HIV and AIDS, and the quality of health services in sub-Saharan Africa, post ICPD.
- ***Section 8*** *(Population distribution, urbanization and migration)* analyses the patterns and trends of population movement and urbanization in relation to the concerns and strategies outlined in the ICPD POA.
- ***Section 9*** *(Population, development and education)* assesses the relationship of population and education as highlighted in the ICPD POA and the experiences of Africa thus far.
- ***Section 10*** *(Technology, research and development)* investigates the extent to which Africa has invested in the collection and wide dissemination of valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development, implementation, monitoring and evaluation, in line with the ICPD POA.
- ***Section 11*** *(Partnerships and resource mobilization)* examines the existence of effective partnerships between and among African governments, non-government organizations, the private sector and international partners in the implementation of the ICPD POA.

The report concludes with a reference section that outlines all the literary sources used in the assessment. A series of annexes provides supplementary data on poverty reduction strategy papers prepared across sub-Saharan Africa, the availability of social security programmes in the region, various health-related and other surveys undertaken by African countries, and a tabulation of official development assistance to Africa.

2. Population, Economic Growth and Sustainable Development

Interrelationships among population, sustained economic growth and sustainable development, according to the ICPD POA, can be classified into three broad components: (a) integrating population and development strategies, (b) population, sustained economic growth and poverty, and (c) population and environment. At the core of the set of actions associated with these components is the integration of population issues into national poverty reduction strategies and national development plans.

2.1 Africa's Progress towards the Implementation of the ICPD POA

Given the dramatic and widespread adoption of the World Bank's poverty reduction strategy paper (PRSP) approach in sub-Saharan Africa over the last decade, this national strategy framework forms the primary focus of this section. Particular emphasis is given to population dynamics and sexual and reproductive health in line with the Maputo Plan of Action.

> At the core of actions related to sustainable economic growth and development is the integration of population issues into national poverty reduction strategies and national development plans.

2.1.1 Commitment

Since the ICPD many African countries have taken explicit measures to address social and economic challenges so as to attain sustainable development. Such measures include agreeing to commitments outlined in international instruments such as the Declaration and Programme of Action of the Copenhagen World Summit for Social Development (1995); the Declaration and Programme of Action of the Johannesburg World Summit for Sustainable Development (2002); and the Millennium Development Goals (MDGs). Many countries have also ratified regional commitments such as Relaunching Africa's Economic and Social Development: The Cairo Agenda for Action (1995), which reaffirmed the region's commitments to continental sustainable development; and the 2004 Ouagadougou Declaration on Employment and Poverty Alleviation in Africa. The latter's plan of action guides African Union Member States to develop policies on poverty reduction and job creation.

More recently, the first session of the African Union Conference of Ministers in Charge of Social Development, which took place in Windhoek, Namibia, in 2008, adopted three documents dealing specifically with pro-poor empowerment, social protection, human rights and other issues related to an inclusive development. These documents are: the Social Policy Framework for Africa; the African Common Position on Social Integration; and the Windhoek Declaration on Social Development.

2.1.2 Development of National Poverty Reduction Strategy Papers

PRSPs were introduced in late 1999 when the World Bank and International Monetary Fund (IMF) announced that developing countries would be required to complete the papers as a precondition for accessing concessional finance and debt relief in future. Premised on the principles of national ownership, broad-based participation, comprehensiveness, pro-poor policy outcomes and a long-term perspective on poverty reduction, this approach has rapidly become the dominant mechanism for development policy.

In the decade since its introduction, the poverty reduction strategy initiative has tended to concentrate predominantly on countries that are characteristically at the poorer end of the range of countries eligible for concessional lending, more aid dependent, and African (Piron and Evans, 2004). This is indeed evident in the context of sub-Saharan Africa where more than three-quarters of countries (37 out of 47) currently have fully completed PRSPs or interim-PRSPs[5] (see Annex A). At the sub-regional level, half of the countries in Southern Africa have produced full or interim PRSPs, compared with 69% in East Africa, 89% in Central Africa and an extraordinary 100% in West Africa. As PRSPs are supposed to be updated on the basis of a three-year cycle, 18 countries have also made the transition from first to second generation PRSPs, while Uganda was the first country to adopt a third generation PRSP in March 2010.

Of the remaining ten countries, seven (Botswana, Namibia, South Africa, Swaziland, Mauritius, Seychelles, and Gabon) are not eligible for World Bank/IMF supported poverty reduction strategies because of their middle income status (see Annex B). Nonetheless, a number of these countries have independently produced national poverty reduction strategies. In Gabon, for example, the government has begun drafting a poverty reduction strategy paper because of declining social indicators. Among the other three countries, Sudan is currently preparing an interim PRSP, while Somalia and Zimbabwe are eligible for PRSPs but for political considerations have not yet begun the process. Since the emphasis of this section is on the poverty reduction strategy approach, the remainder of the analysis is focused on the 37 countries in the region that have either begun implementing or are finalizing the full PRSP.

2.1.3 Integration of Population Issues

Several studies conducted to date have assessed the integration of population issues (either generally or specific sectors) into World Bank approved national poverty reduction strategies. An early contribution by Sundaram et al. (2004) reviewed the extent to which the poverty reduction strategies that had been finalized at the time had begun to incorporate issues relating to population, reproductive health, adolescent health and development. Specifically, the analysis concentrated on the 21 full PRSPs that had been completed and approved by 31 December 2002, together with the associated documents that are deemed integral to the implementation, monitoring and evaluation of the PRSPs.[6] Of the countries examined, 12 were low-income states in sub-Saharan Africa with broad sub-regional representation. These consisted of five countries in West Africa (Burkina Faso, Gambia, Guinea, Niger, Senegal), four in East Africa (Ethiopia, Rwanda, Tanzania, Uganda) and three in Southern Africa (Malawi, Mozambique, Zambia). All these were first generation PRSPs; there was no coverage from Central Africa at this stage.[7]

In their review, Sundaram and colleagues focused on the population content in the four primary sections of the PRSP documents: participatory process; poverty diagnosis; proposed policies and strategies; and monitoring and evaluation targets. In general, they found that the PRSPs had succeeded in devoting an acceptable amount of attention to

[5] Recognizing that the process of preparing a full PRSP could take more than one year, countries were requested to produce an interim poverty reduction strategy paper (I-PRSP), which was intended to be a short transitional document describing a country's poverty situation and policies and outlining the plan for preparing the full PRSP.

[6] These associated documents included Annual Progress Reports (APRs) prepared by countries that have adopted poverty reduction strategies, Joint Staff Assessments (JSAs) produced by IMF/World Bank staff in response to PRSPs and APRs, and the Poverty Reduction Strategy Credit (PRSC), which is a World Bank lending instrument for annual budget support.

[7] The first full PRSPs in Central Africa were those of Sao Tome and Principe and Cameroon, which were completed early in 2003.

population, reproductive health, and adolescent health and development issues, but that the depth and quality of this coverage differed extensively from country to country.

In terms of the participatory process involved in formulating the PRSPs, the study concluded – on the basis of available information contained in the documents – that there was uneven involvement of principal stakeholder groups with knowledge of key population issues. There was typically better representation of NGOs, the donor community and women relative to youth and professional groups, a finding that has been corroborated in other research.

Turning to the poverty diagnostics section of the PRSPs, which aimed to outline the causes and consequences of poverty at the country level, Sundaram et al. found substantial variation in the quality of population content (see Table 2.1).

Table 2.1: Most common key indicators in poverty diagnoses in full PRSPs, sub-Saharan Africa, 2002

Population	Reproductive health	Adolescent health and development
▪ Life expectancy (18) ▪ % Urban population (11) ▪ Population growth rate (10) ▪ Population size (9) ▪ Human development index (8)	Maternal health and family planning ▪ Maternal mortality rate (16) ▪ Total fertility rate (11) ▪ Antenatal care coverage (various definitions) (8) ▪ Contraceptive prevalence rate (any method) (7) ▪ Births attended by skilled personnel (5) STIs/HIV ▪ HIV prevalence (11) ▪ Knowledge of HIV-related prevention practices (3) ▪ Number of AIDS orphans (2) ▪ Infant and child health ▪ Infant mortality rate (19) ▪ Child mortality rate (16)	▪ HIV infection rate, 15–24-year-olds (2) ▪ HIV infection rate, pregnant 15–24-year-olds (1) ▪ Adolescent fertility rate (1) ▪ % of women with first birth at 12–15 years old (1) ▪ % of women with first pregnancy at <19 year-olds (1) ▪ Unemployment rate, 15–24- year-olds (1)

Source: Sundaram et al. (2004).
Numbers in parentheses indicate the number of countries having this indicator.

Most of the PRSPs (17 of 21) examined had at least a basic discussion of the relationship between poverty and population and/or reproductive health issues. Moreover, many included a number of key population and reproductive health indicators as part of their poverty diagnosis, although these suffered from inconsistent definitions and measurement, as well as being inadequately disaggregated by socio-economic subgroups. On average, the reviewed PRSPs contained a minimum of two reproductive health indicators and one population indicator, with highly circumscribed coverage of adolescent health.

A key shortcoming of the PRSPs was the failure in most instances to specify institutional responsibility, timelines and budgetary requirements for implementation.

With respect to policy content, all PRSPs from sub-Saharan Africa except Uganda's contained at least one policy addressing reproductive health and child health needs, while all countries included policies focused on HIV and other sexually transmitted infections (STIs). There was relative under-coverage of adolescent health and population policies. From a policy implementation perspective, a key shortcoming of the PRSPs was the failure in most instances to specify institutional responsibility, timelines and budgetary requirements for implementation.

Finally, as with poverty diagnosis, the PRSPs did integrate monitoring and evaluation targets that relate to population, reproductive health, infant and child health, and sexually transmitted infections (STIs) including HIV. Again, adolescent health is poorly represented, although all of the strategy documents included at least one reproductive health and child health target (typically maternal and infant mortality rates), while a majority had population-related and STI/HIV targets.

A second noteworthy study on the integration of population issues in national poverty reduction strategies was undertaken by the United States Agency for International Development's (USAID) Health Policy Initiative (Borda 2005, cited in Bhuyan, Borda and Winfrey, 2007). Focusing on the 45 countries that had finalized their full PRSP by 2005, the study entailed an analysis of the extent to which family planning had been effectively incorporated into the content of the documents. Of the 45 national PRSPs considered in the study, 25 were from sub-Saharan African countries (see Table 2.2).

Table 2.2: Extent of family planning content in full PRSPs in sub-Saharan Africa, 2005

Countries with PRSPs that do not mention family planning	Countries with PRSPs that do mention family planning but do not provide programmatic details	Countries with PRSPs that include specific details about family planning, such as financing, logistics, quality of service, and/or awareness raising campaigns
DR Congo Djibouti Lesotho Mali Republic of Congo Sierra Leone Tanzania Uganda Zambia	Benin Burkina Faso Cameroon Cape Verde Chad Ethiopia Gambia Guinea Madagascar Malawi Mozambique Niger Rwanda Senegal	Côte d'Ivoire Ghana
(n=9)	(n=14)	(n=2)

Source: Borda (2005); Bhuyan et al. (2007).

Nine (36%) of these papers did not mention family planning. In a further 14 cases (56%), family planning was mentioned but there was no associated detail in terms of programmatic activities. In only two instances (for Côte d'Ivoire and Ghana, 8%) was discussion of family planning accompanied by an articulation of the programmatic detail, including budgetary estimates, logistics and quality of service. These findings suggest that there exists substantial scope for improving the content of salient reproductive health issues such as family planning in future.

Most of the reviewed PRSPs included population growth as an issue and had stipulated objectives or strategies to deal with it. Nonetheless, in a majority of cases, there were no corresponding policy actions or indicators with which to gauge progress.

A third study prepared by the World Bank (Lakshminarayanan et al., 2007) undertook a rapid, desk-based assessment of population and family planning content in 27 countries with high total fertility rates (TFR≥5) that had completed a PRSP. In its content analysis of the documents, the study placed particular emphasis on population momentum, fertility, population or population growth rate, family planning, contraceptives or contraception, condom use, and reproductive health (family planning within reproductive health). Similar to the Sundaram et al. (2004) findings, the study concluded that most of the reviewed PRSPs included population growth as an issue and had stipulated objectives or strategies to deal

with it. Nonetheless, in a majority of cases, there were no corresponding policy actions or indicators with which to gauge progress. Also corroborating the Borda (2005) evaluation, the study found that:

> Of the 27 PRSPs, 13 (48%) had at least one indicator, five (19%) had at least one policy, five (19%) had both a policy and an indicator, and 13 had neither a policy nor an indicator related to population and family planning. Most PRSPs had an indicator on condom use, but it was included with respect to STD/HIV/AIDS and was unrelated to family planning. None of the PRSPs mentioned population momentum. (Lakshminarayanan et al., 2007: 34)

Since the Sundaram et al. (2004) and Borda (2005) assessments, at least ten additional countries in sub-Saharan Africa have adopted first generation PRSPs, while a further 18 countries have progressed to second generation PRSPs. Other parallel developments that may have influenced the extent and nature of population issues integrated into these more recently produced poverty reduction strategies include:

- The reaffirmation of the Programme of Action during ICPD+10 meetings in 2004.
- The emphasis on sexual and reproductive health rights at the Beijing+10 commemorations in 2005.
- The expansion of Millennium Development Goal 5 (improve maternal health) at the 2006 United Nations General Assembly to include the target of achieving universal access to reproductive health by 2015; and the subsequent adoption in 2007 of the following four progress indicators: adolescent birth rate, antenatal care coverage, unmet need for family planning and contraceptive prevalence rate.
- The signing of the Maputo Plan of Action by heads of state at an African Union meeting in 2006, which commits countries to move towards universal access to comprehensive sexual and reproductive health services by 2015 (African Union Commission, 2006b).
- The increasing need among donors and governments alike to demonstrate progress towards the MDGs and indeed the ICPD POA as 2015 draws nearer (Driscoll and Evans, 2005).

Developments such as these, taken together with the lessons that countries will have gleaned from their own experiences or those of other early PRSP adopters, mean that the nature and outcome of recent rounds of PRSP formulation processes could conceivably be significantly different in character. As such, it is recommended that an updated assessment of the integration of population content in PRSPs in sub-Saharan Africa be undertaken, drawing primarily on the evaluative framework and criteria specified in the reviews discussed in this section in order to maximize comparability of findings and facilitate meaningful trend analysis. This exercise should focus on the most recent generation of PRSP available in each country.

2.1.4 Sexual and Reproductive Health Content of PRSPs

In assessing the extent to which population issues are effectively incorporated into national development frameworks such as PRSPs, an important consideration is the multitude of topics that fall under this umbrella term and the associated need to narrow the analytical scope to specific thematic areas of evaluation. As discussed in the preceding section, several salient developments in the last decade have created an increased emphasis on sexual and reproductive health and brought recognition of the importance of accelerated national level progress in realizing the ICPD goal of “universal access to reproductive health” in order to achieve the MDGs more generally.

In terms of methodology, current review used a combination of the approaches employed by Sundaram et al. (2004), Borda (2005) and Lakshminarayanan et al. (2007). As noted, this last reviewed the PRSP documents and identified the extent to which a set of key population terms were substantively present. More specifically, “the terms were considered to be substantive if they appeared in policy statements or in an indicator”, while they were

designated “insignificant if they appeared only in the background description or for statistical purposes, or if they appeared in goals, objectives, or strategies, but were not subsequently translated into policy or indicators” (Lakshminarayanan et al., 2007: 47). As stated earlier, the seven search terms were: population momentum, fertility, population/population growth rate, family planning, contraceptives/contraception, condom use, and reproductive health (family planning within reproductive health). These were supplemented by findings of a review of the other studies and the Maputo Plan of Action, along with other documentation proposing indicators for global monitoring of progress towards the achievement of universal access to sexual and reproductive health (UNFPA, 1998; WHO, 2004; African Union, 2006a; WHO/UNFPA, 2008).

In their examination of the coverage of population content in specific components of the PRSP process, Sundaram et al. (2004)specifically sought the diagnosis of country-level poverty, proposed policies and strategic interventions, as well as the targets and indicators included in the monitoring and evaluation plan. In their content analysis, they examined: *population level traits* that influence and are influenced by reproductive health and adolescent health and development, such as the rate of population growth, life expectancy, age structure, and level of urbanization; *reproductive health* based on the ICPD definition, which includes access to family planning, safe motherhood programmes, and STI prevention and treatment.; and *adolescent health and development*. In common with Sundaram et al., the present review examines population-related content in the different components of the PRSP documents.

The findings reveal that most of the national PRSPs discuss – at least to some extent – general population dynamics in profiling poverty, with reference to population growth and fertility rates, life expectancy, and urbanization processes. When one focuses more specifically to sexual and reproductive health, however, the PRSP documents continue to exhibit highly variable thematic coverage of integrated service provision, family planning, adolescent health, unsafe abortion, and maternal and child health.

PRSP documents exhibit highly variable thematic coverage of integrated service provision, family planning, adolescent health, unsafe abortion, and maternal and child health.

A number of countries such as The Gambia (2007), Ghana (2006), Mali (2008) and Niger (2007) have explicitly included a section on population-related issues within the policy content of their PRSPs. Other countries have formulated PRSPs that contain strong examples of effective integration of other key sexual and reproductive health topics, such as gender-based violence in Liberia (2008) and Ghana (2005), and harmful traditional practices in Niger, even though the former two cases are weaker in relation to family planning content. In the aggregate, there does seem to be a sense of improved incorporation of population concerns as countries have progressed from first to second generation PRSPs, and as issues such as reproductive health have featured more prominently on the international development agenda, especially since 2006.

In spite of such progress, certain sexual and reproductive health topics remain significantly under-represented. For instance, while youth-related content is increasing, considerations relating to adolescent health are still rather weak. Similarly, unsafe abortion (albeit an admittedly controversial and contested matter) is rarely mentioned, despite its continued salience as a cause of maternal mortality in Africa, and despite the Maputo Plan of Action’s explicit calls on African Union Member States to "enact policies and legal frameworks to reduce incidence of unsafe abortion" and "prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion" (African Union Commission, 2006b:12). Of the 47 country documents examined, only eight referred to abortion, four of which are from West Africa (Côte d’Ivoire, Gambia, Guinea-Bissau and Mali), one from Central Africa (CAR), and three in Southern Africa (Angola, Botswana and Zambia).

There was no mention of abortion from East Africa. The countries that do mention this issue are those that tend to have abortion laws in place, even though they continue to be restrictive in many instances. All in all, the resistance to relaxing laws concerning legalized abortion as a means for reducing maternal mortality continues to be reflected in national poverty strategies, where it remains conspicuously absent even in second and third generation documents.

The targets and indicators associated with the MDGs, especially those related to maternal health (Goal 5), child health (Goal 4), and HIV and AIDS (Goal 6), appear to have been effectively incorporated into these medium-term national development framework documents. There are also encouraging signs on the linkages to other key policy documents, notably national population policies and health plans. Côte d'Ivoire's recently finalized first generation PRSP (2009) includes strong reference to the country's planned population policy and second National Health Development Plan (PNDS 2009–13) in relation to interventions in the health sector. The Gambia's second generation PRSP outlines the challenges faced in meeting the targets included in its national population policy, and also highlights barriers to access and use of reproductive health services. Similarly, Niger's second PRSP also has strong linkages with the government statement on population policy in its discussion on planned actions to control population growth.

2.2 Conclusions and Recommendations

The joint anniversary celebrations in 2009 of 15 years of the ICPD and a decade of the MDGs and PRSP approach served as a timely reminder of what has been achieved in sub-Saharan Africa and the considerable challenges that remain. Given the primacy that the PRSPs and national development plans assumed during the last decade, and the increasing alignment between these framework documents and national-level, medium-term expenditure, it is imperative that greater attention be given to better mainstreaming the ICPD POA objectives, targets and indicators. It could be argued that accelerating the implementation of the POA may, to a considerable degree, be contingent on this activity being accomplished.

Given the importance of PRSPs and national development plans, and the increasing alignment between these framework documents and national-level, medium-term expenditure, it is imperative that greater attention be given to better mainstreaming the ICPD POA objectives, targets and indicators.

While the PRSPs have served to encourage social spending in sectors such as primary education and basic health care, there is a need for family planning and reproductive health care to also receive adequate attention and fiscal priority. The evidence is mixed in this regard. Subsequent development planning processes need to place greater emphasis on family planning, including contraceptive use and addressing unmet need. Although there are some encouraging signs from recent strategies prepared by countries such as Uganda, Rwanda, Ghana and Niger, which have relatively good family planning coverage, this focus needs to be taken up by other countries in the subregion.

Related to this, the provision of integrated sexual and reproductive health services, including emergency obstetric services, antenatal and post-partum care, HIV and AIDS and other STI treatment, and family planning, is an issue that is also significantly under-represented in poverty reduction strategies and should be identified as a priority action for advocacy and policy promotion efforts in coming years. In order to ensure the adequate quality of such integrated services, suitably qualified health professionals will be essential and should be considered as part of the human resource requirements for the effective implementation of national poverty reduction strategies.

With respect to adolescent health and development, the coverage of youth issues in PRSPs has been improving, although youth-friendly sexual and reproductive health services warrant attention. The inclusion of issues such as abstinence and dual protection against unwanted pregnancy and STI/HIV is also inconsistent across the sub-region. So too are other challenges confronting youth in the transition to adulthood, such as access to productive and decent employment.

Finally, on a more technical note, UNFPA together with other relevant international and regional agencies should consider developing a set of guidelines for the preparation of PRSPs or national development plans. The focus of the guidelines would be on how to effectively incorporate population and/or reproductive health policies and interventions that would assist in forging sustained progress towards the ICPD POA. These guidelines would need to be inherently flexible in order to take into account sub-regional heterogeneity, as well as the necessity for periodic updating as new priorities, concerns and development compacts emerge. Given the competing demands, needs and pressures imposed on policy makers and development planners in crafting national poverty reduction strategies and development plans, a guidelines document could serve as an invaluable resource for informing the debates and dialogues involved in the strategy formulation process. It would also ensure that the ICPD Programme of Action increasingly stands alongside the MDGs and national long-term visions as a framework for monitoring and assessing the successes and shortcomings of national PRSPs or development plans in bringing about societal progress.

3. Gender Equality, Equity and Empowerment of Women

Full participation and partnership of both women and men in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household, is requisite (UNFPA, 2004). The ICPD's pronouncement regarding gender equality and participation of both men and women was thus a critical step towards incorporating gender issues into broader development processes. According to the ICPD POA, the empowerment and autonomy of women and the improvement of their political, social, economic and health status constitute a highly important end in itself, which is also key to the achievement of sustainable development. In order to achieve gender equality, equity and empowerment of women, the POA urged governments to, among other things:

- Act to empower women and to take steps to eliminate inequalities between men and women.
- Make greater efforts to sign, promulgate, implement and enforce national laws and international conventions that promote women's rights and gender equality.
- Eliminate all forms of discrimination against the girl-child and the root causes of son preference.
- Promote gender equality in all spheres of life, including family and community life, and encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

The ICPD POA also urged the establishment of mechanisms for women's equal participation and equitable representation at all levels of the political process and public life, and the elimination of discriminatory practices by employers against women to ensure that women can "combine the roles of child-bearing, breast-feeding and child-rearing with participation in the workforce". These goals were taken up and further advanced at the Millennium Summit in 2000, where it was agreed to set a goal to "promote gender equality and empower women" (MDG 3).

3.1 Africa's Progress towards the Implementation of the ICPD POA

Empowering women and achieving gender equality require no less than upturning generations of entrenched concepts. That it must be done is no less certain. The late Mwalimu Julius Nyerere, Tanzania's first president, is said to have observed that just as no one could run a race with one leg tied, no country could develop if half its population were not allowed to contribute fully. This assessment looked at the status of the rights of women under custom and tradition, gender disparities in education, women's participation in political and economic life, and the disproportionate impact of HIV and AIDS on women.

Many African governments have, over the past 15 years, ratified a number of international and regional treaties to promote and protect women's rights and gender equality.

3.1.1 Commitment

In line with the ICPD POA, many African governments have, over the past 15 years, ratified a number of international and regional treaties to promote and protect women's rights and gender equality. Key among these are: the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW); the Beijing Platform of Action; the Nairobi Forward Looking Strategy; the Addis Ababa Declaration on the Dakar African Platform for Action on Women (1995); the Declaration on the African Plan Concerning the Situation of Women in

Africa in the Context of Family Health (1995); the Kampala Declaration and Framework for Action adopted by the African Conference on the Empowerment of Women through Functional Literacy and the Education of the Girl-Child (1996); the Addis Ababa Declaration on Violence against Women (1997); the Plan of Action for Enhancing the Participation of Refugees, Returnees and Internally Displaced Women and Children in Post-Conflict Rehabilitation, Reintegration, Reconstruction and Peace Building (1998); the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003); and the Solemn Declaration on Gender Equality in Africa (2004). These instruments unequivocally commit governments to integrate gender perspectives into legislation, public policies, programmes and projects. Most recently the AU declared 2010–2020 to be the Decade of the African Woman, with various objectives and actions for promoting women's empowerment.

Through a process that cumulatively builds on being signatory to or having ratified key conventions, many African countries have now enshrined gender equality in their constitutions, promulgated gender-friendly legislation and policies, and put in place national machineries with a mandate to promote gender equality in fields such as health, education, public sector participation and the economic sector. A pilot evaluation focusing on 12 countries found that "Although at different stages, all countries under consideration are undertaking reforms in family law to ensure consistency with CEDAW" (UNECA, 2009: 50).

Efforts are also visible in many countries to improve the financial position of women though entrepreneurship programmes and the establishment of women's banks, credit institutions and development funds. Trade policies have been revised to improve women's access to credit and a number of countries have begun land reforms that among things, aim to improve women's access to land (Mukasa, 2008). In Lesotho for, example, the Government enacted the Legal Capacity of Married Persons Act 9 of 2006 which gives women the right to access credit, to be directors of companies, to sue or be sued, as well as to acquire immovable property in their own name. This Act effectively overturns existing requirement for married women to obtain the assistance of their spouses to validly enter into any contracts (Dube, 2008). By the same token, the Abolition of Marital Powers Act of 2005 in Botswana now provides for equality for women. Prior to this legislation, women who were married were regarded as minors and policies in government departments and financial institutions demanded that a married woman obtain the consent of her husband to carry out any transactions and gave the husband all the property rights. Kenya's new constitution, adopted in August 2010, similarly affirms the equality of women in marriage, inheritance and other spheres.

UNECA sums some of the steps taken by specific countries thus:

> The Ministry of Justice of Ghana has…made proposals for new property arrangements between spouses and cohabitees under a Spousal Property Bill (2006). In Madagascar, the Family Law is being revised to ensure that the lawful age of marriage for both sexes is made 18 in substitute for 14 years for girls and 17 years for boys, as provided for in the present Ordinance No. 62-089. Similar to Uganda, Madagascar is also undertaking reforms to ensure that rules pertaining to adultery apply equally to both men and women… Previous legislation permitted a man convicted of adultery to pay a fine, whereas a wife was liable to imprisonment. In addition, the revised Family Code of Ethiopia (2000) contains detailed provisions on common and shared responsibilities of both spouses in relation to the upbringing of their children (UNECA, 2009: 51).

In Benin, Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, South Africa, Tanzania and Uganda, laws and policies against traditional harmful practices have been adopted, and plans are in place to deal with female genital mutilation and cutting (FGM/C), forced marriage, trafficking, virginity testing, and widow inheritance, among many (UNECA, 2009). Tanzania has devoted a national day to providing informing about FGM/C, and the advocacy

around this has seen changes even among people and parents who hitherto supported the practice (UNECA, 2009).

3.1.2 The Rights of Women under Custom and Tradition

Despite the fact that many countries' constitutions and statutory law now provide for equality for women, this is often not the reality on the ground. These provisions most often fail to protect women from discrimination in custom and tradition, and allow for discrimination in personal status codes. For example, the practice of FGM/C still ranges from 71% in Mauritania to almost universal in countries such as Somalia (97.9%), Guinea (95.6), and Mali and Northern Sudan (91.6% and 90%, respectively). The primary roadblock is considered to be lack of attitudinal change (UNECA, 2009; Connell, 2003).

Most countries have set 18 years as the minimum legal age of marriage, but child marriages remain common, with the proportion of girls a situation that undermines the ICPD POA given the strong link between child marriage and vulnerability to HIV infection, pregnancy and childbirth complications, and poor knowledge of and use of basic reproductive health issues and services.

In addition, customary and religious laws are usually given precedence in matters of family law, which include divorce and inheritance, and provisions that could be considered discriminatory towards women are allowed under the misapprehension that they are aspects of cultural practices. While most countries have declared 18 years the minimum legal age of marriage, child marriages remain a common phenomenon in sub-Saharan Africa, with the proportion of girls married before 18 years ranging from 11% to 88% (UNFPA, 2004). In Tanzania, for example, the minimum legal age of marriage is still 15 years for women and 18 for men, and the law even allows for girls aged 14 to marry under "justifiable" circumstances. The family code also allows citizens of African and Asian origin to marry daughters younger than 12 years provided the marriage is not consummated until girls reach this age (UNECA, 2009). This situation undermines the ICPD POA given the wide evidence showing the strong link between child marriage and vulnerability to HIV infection, pregnancy and childbirth complications, and poor knowledge of and use of basic reproductive health issues and services.

It is also noteworthy that in much of sub-Saharan Africa women still obtain land rights chiefly through their husbands as long as the marriage endures, and they often lose those rights when they are divorced or widowed. Gender disparities in rights constrain the sets of choices available to women in many aspects of life and often limit their ability to participate in, or benefit from, development (World Bank, 2001).

3.1.3 Addressing Gender Disparities in Education

MDG 3's focus on education is based on the premise that education is a driving force for economic, social and political development and economic prosperity, and that it creates choices and opportunities for people and communities. Demographic and Health Surveys, for example, have shown that as a woman's education level increases, she is more likely to delay births and to use a modern method of contraception, a relationship that is quite consistent worldwide.

In much of sub-Saharan Africa women still obtain land rights chiefly through their husbands as long as the marriage endures, and they often lose those rights when they are divorced or widowed.

Progress towards achieving parity in education in sub-Saharan Africa can be described as mixed if consideration is given to different levels of education. The female adult literacy rate over the period 1997–2007 for 30 African countries was 56%, as opposed to 70.3% for men, representing a gender gap of 14% points (UNDP, 2009). However, parity has been achieved for primary and, to a greater extent, secondary education (see Table 3.1). This does not necessarily translate into gender equality, however. The absence

of a gender gap does not illuminate the low enrolment and retention rates that continue to characterize education at all levels. Further, it does not reflect some critical gender differences in the education of young girls and boys, including the influence of extended chores on girls' achievement, choice of subjects and prospects of attending school. It also conceals inequities that affect poor and rural households in which girls are particularly at risk of missing out on primary and secondary education (UNICEF, 2009). For example, in spite of gender parity having been achieved in earlier grades, girls in Kenya will drop out as a result of unwanted pregnancy, early marriage, poverty, and HIV and AIDS-related orphanhood (Kenya MDG Report, 2005).

Table 3.1: School attendance ratios in selected countries

Country	Primary school net attendance ratio 2000–2007		Secondary school net attendance ratio 2000–2007	
	Male	Female	Male	Female
Zambia	55	58	17	19
Guinea Bissau	54	53	8	7
Burundi	72	70	8	6
Benin	72	62	40	27
Botswana	83	86	36	44
Cameroon	86	81	45	42
Angola	58	59	22	20
Uganda	83	82	16	15
Kenya	79	79	12	13
Malawi	86	88	27	26
Zimbabwe	91	93	46	43
Lesotho	82	88	16	27
Namibia	91	91	40	53

Adapted from: UNICEF (2009).

Notes: Primary school net attendance ratio: number of children attending primary or secondary school who are of official primary school age, expressed as a percentage of the total number of children of official primary school age. Secondary school net attendance ratio: number of children attending secondary or tertiary school who are of official secondary school age, expressed as a percentage of the total number of children of official secondary school age.

Enrolment in tertiary institutions also remains low and heavily skewed against women. Noting the inequities at various levels of the educational system, some countries have implemented an affirmative action policy in university education. Uganda, for example, gives women 1.5 bonus points for entry into university, a policy that has been credited with a notable increase in female entry into university (UNDP, 2007). Kenya lowered the entry mark for women to public universities, while girls who drop out because of pregnancy are allowed to re-enter and complete their education. In South Africa, as in Kenya, girls who have been or are pregnant can go back into school to proceed with their education.

Several countries have also taken steps at the highest level to ensure the retention of girls in school and promote gender equality in education. Ghana has a special Girls Education Unit under the Ministry of Education. Tanzania has implemented a Community-Based Education for Girls Initiative to encourage public and private investors to build girls' hostels in schools. Uganda has a national strategy on girl-child education that identifies strategies to improve retention including developing gender sensitive materials, providing adequate sanitation for girls and boys in mixed sex schools, and strengthening governing bodies of schools to respond to needs of pupils including girls. Unfortunately, the laws are sometimes not implemented accordingly, as in Madagascar where government school rules stipulate that pregnant girls ought to be expelled (UNECA, 2009).

3.1.4 Participation in Political and Economic Life

An important measure of women's empowerment is their participation in political and economic life. It is argued that as this role increases, women will gain more control over their

own lives, including childbearing choices. In selected countries in Africa the average of both the percentage of seats held in Parliament and the proportion of ministerial positions in 2008 was 17 (UNDP, 2009; UNECA, 2009). In Namibia during 2007, women occupied 27% of seats in parliament. In the East African region, women legislators in both Burundi and Tanzania stand at over 30% and in Uganda at 28% (see Table 3.2). In contrast, Kenyan women account for only 8% of seats in the National Assembly (UNDP, 2005). Mozambique uses a quota system that ensures a minimum 30% representation at all levels.

Table 3.2 Power and decision making in the public sector component values

Share of total (in %)	Sex	Benin	Burkina Faso	Came-roon	Ethiopia	Mada-gascar	Mozam-bique	South Africa	Tanza-nia	Uganda
Members of parliament	F	10.8	15.3	13.9	28.5	10.3	37.2	33.0	30.5	33.2
	M	89.2	84.7	86.1	71.5	89.7	62.8	67.0	69.5	66.8
Cabinet ministers	F	9.1	11.1	10.1	13.0	19.0	25.9	42.8	25.5	20.0
	M	90.9	88.9	89.9	87.0	81.0	74.1	57.2	74.5	80.0
Higher court judges	F	25.5	22.6	22.6	14.5	52.9	30.2	16.7	35.2	15.3
	M	74.5	77.4	77.4	85.5	47.1	69.8	83.3	64.8	84.7
Members of local councils	F	3.2	20.9	25.8	20.7	4.1	28.5	29.1	20.6	41.7
	M	96.8	79.1	84.2	79.3	95.9	71.5	70.9	79.4	58.3
Higher positions in civil service	F	11.1	5.7	17.1	21.1	2.4		16.7	19.3	21.5
	M	88.9	94.3	82.9	78.9	97.6		83.3	80.7	78.5

Source: Adapted from UNECA (2009).

Looking at the percentages in isolation may obscure positive trends in female representation, especially considering that many countries started from a low baseline level. In Kenya, for example, the number of women members of parliament increased from 5 to 18 in 2002/03. As of June 2003, the proportion of women in the judiciary was 36.4%, where most of them are in the rank of the chief magistrate and below (UNDP, 2005). In Uganda's local government, up to one-third of seats on Local Councils, which exist from village to district level, are allocated to women. There is a post of Secretary for Women on each Local Council, and each of the 56 districts has a woman representative in parliament. With regard to central government, the Ministry of Women in Development, now Gender, Labour and Social Development, was created in 1988.

At over 56%, Rwanda is considered to have the highest percentage of women lawmakers in the world. Another remarkable achievement for the continent was the elevation of Ellen Johnsson-Sirleaf in 2005 to become the first woman president in Liberia and on the entire continent.

It is also noteworthy that Rwanda has excelled in terms of representation of women; at over 56%, the country is considered to have the highest percentage of women lawmakers in the world (IPS, 2009). A remarkable achievement for the continent was the elevation of Ellen Johnsson-Sirleaf in 2005 to become the first woman president in Liberia and on the entire continent. Table 3.3 shows some of the key positions previously considered the preserve of men that are currently or recently held by women.

Table 3.3: Key positions held by women in some African states

Country	Positions
Mozambique	Prime Minister; Vice president of the Parliament; Foreign Affairs
Gambia	Vice President
Uganda	Vice President; Finance Minister
Zimbabwe	Vice President
Ethiopia	Deputy Speakers and Chief Whips
South Africa	Deputy President
Nigeria	Ministers of Finance, Drug and Narcotics, Foreign Affairs
Liberia	President; Finance; Foreign Affairs; Trade
Niger	Foreign Affairs
Senegal	Trade

Country	Positions
Ghana	Attorney General; Chief Justice; Trade Minister; Speaker of Parliament

Source: Adapted from UNECA (2009).

Regarding economic life, there has been a steady increase in the labour force participation rate of African women, from 61.9% in 1995 to 63.0% in 2000 and 63.2% in 2003 (International Labour Organization, 2004). This progress does not, however, reflect the dire situation of those women. For example, not only are these levels still much lower than those of men (at 85.3% in 2003) but analysis of a key measure of women's empowerment shows that their share of non-agricultural occupations is about 20% and does not seems to be increasing. In addition, employed women in the region are mostly engaged in the informal sector where they are likely to be among the working poor, having low productivity, low earnings and high poverty. In essence, as informal sector workers many African women generally live and work under harsh conditions that are more commonly associated with shocks such as illness, loss of assets and loss of income. Moreover, they have little or no access to formal risk-coping mechanisms such as insurance, pensions and social assistance, and they generally lack resources to pay for proper housing and education (African Union, 2009).

Women's share of non-agricultural occupations is about 20% and does not seems to be increasing. Many African women generally live and work under harsh conditions that are more commonly associated with shocks such as illness, loss of assets and loss of income.

The increasing participation of women in the labour force means that they have to handle multiple roles. Like their counterparts in many other parts of the world, African women continue to be primarily responsible for the general management of their households and for the care of family and household members, particularly minor children, older persons and the infirm. Having multiple roles does have potential to provide certain resources – such as a better financial situation, greater social integration, improved social support and higher self-esteem – that can be used to promote personal growth and better functioning in other life domains (Hãrenstam and Bejerot, 2001; Oomens et al., 2007). Nevertheless, a wide strand of literature has consistently shown that it can also lead to work-family conflict, defined as "a form of inter-role conflict in which the role pressures from work and family domains are mutually incompatible" (Greenhaus and Beutell, 1985: 77).

Many African women generally live and work under harsh conditions that are more commonly associated with shocks such as illness, loss of assets and loss of income.

Among its many impacts, work-family conflict perpetuates gender inequality and is a major factor contributing to women's disadvantage in the labour market. Such conflict can also prevent the attainment of equal opportunity and treatment for men and women in employment; and constrain women's ability to maximize income-generation opportunities and/or career prospects (International Labour Organization, 2004). It is also well-established and documented that combining personal and occupational roles induces physical and psychosomatic symptoms (such as fatigue, anxiety, migraines, hypertension and depression) among women more than among men (Oomens et al., 2007; Blin, 2008).

Like their counterparts in many other parts of the world, African women continue to be primarily responsible for the general management of their households and for the care of family and household members.

3.1.5 HIV and AIDS

Women in Africa suffer a disproportionately high burden of HIV; 57% of people living with HIV in sub-Saharan Africa are women (Amnesty International, 2004). The gendered nature of HIV epidemiology manifests markedly in young women, who in many countries have HIV prevalence rates several times higher than those of their male counterparts (see Table 3.4). In South Africa, for example, young women are twice as likely to be infected as young men, while in Kenya and Mali the ratio of young women infected to young men infected is as high as 4.5 to 1 (Amnesty International, 2004). This is partly because young women tend to have sexual relations with men older than themselves for exchange purposes or in the well-documented "sugar daddy" phenomenon (Silberschmidt and Rasch, 2001). Many young people are also sexually abused and assaulted, even at ages below 12, and thereby infected with HIV/STI (Kimani, 2007).

The gendered nature of HIV epidemiology manifests markedly in young women, who in many countries have HIV prevalence rates several times higher than those of their male counterparts.

Table 3.4: Number of people infected with HIV in selected countries, 2007

Country	Estimated number of people all ages living with HIV (thousands)	Estimated number of women 15+ living with HIV (thousands)	Estimated number of paediatrics 0–14 living HIV (thousands)	Women as a percentage of infected adults *
Angola	190	110	17	64
Botswana	300	170	15	60
Burundi	110	53	15	56
Cameroon	540	300	45	61
Congo	79	43	6.6	60
Burkina Faso	130	61	10	50
Ethiopia	980	530	92	60
Côte d'Ivoire	480	250	52	58
Gabon	49	27	2.3	58
Lesotho	270	150	12	58
Malawi	930	490	91	58
Mozambique	1,500	810	100	58

Source: Adapted from UNECA (2009).
*Note: This column is calculated by subtracting column three from column one, and generating a fraction.

Other explanations for women's greater vulnerability to HIV infection include marital rape, FGM/C, sexual abuse and exploitation of domestic workers, prostitution and trafficking, and abuse in conflict situations. The role of conflict in the spread of the epidemic is significant. In conflict situations, women suffer rape and other forms of sexual violence that drive the epidemic. Apart from being forced to fight as combatants and being exposed to HIV in the process, the destruction or stalling of services in conflict settings disrupts health care delivery including HIV and AIDS treatment (Amnesty International, 2004). Given that they comprise the majority of people infected, and that they also bear the largest share of caregiving within the epidemic, it follows that conflict situations exacerbate the burden of HIV and AIDS for women.

3.2 Conclusions and Way Forward

Africa has made great strides in terms of gender equity. Countries such as Rwanda and Liberia have in their different ways become exemplary to the entire world. Implementation of policies on equality tends to be hampered by lack of budgetary commitment, however. There also appears to be lack of uniformity in terms of progress within different spheres of the gender equality agenda. For example, while South Africa records high achievements in social aspects (education and representation in legislative bodies, the judiciary, etc.), it simultaneously has high maternal mortality and high female HIV prevalence (UNECA, 2009). What can be done?

3.2.1 Implement Legal Reforms

Very often, gender equality and women's empowerment are driven from a legal platform. Such efforts, while necessary, do not guarantee equality and empowerment. Reluctance of victims and their families to report, limited capacity of law enforcement agents, lack of awareness of rights and obligations afforded under the law, and delays in judicial processes may all militate against the fruition of gender equality efforts (UNECA, 2009). Also contributing is widespread outright flouting of existing laws, such as those against FGM/C, in order to uphold "tradition".

Laws imported wholesale for purposes of equality may also result in accentuated inequalities if local contexts and particularly the working of common law are not taken into account (Kameri-Mbote, 2002; Ozoemana and Hamsungule, 2009). Where countries have multiple legal systems in place, the situation of women may be fraught with uncertainty and may become highly dependent on how the different systems are invoked. Even where countries have "integrated non-discriminatory clauses into their constitutions and other legislative frameworks and proceeded with reforms in marriage, family and property relations, their content, judicial interpretation and operation tend to be hampered by continued operation of customary law and general lack of enforcement" (UNECA, 2009: 1). Governments must therefore take steps to review and reform customary and religious laws in collaboration with stakeholders such as traditional and religious authorities.

3.2.2 Provide Strategic Positions for Women

Morell (2007) states that the "tick the box" approach to gender equality, where emphasis is put on quantitative outputs, results in the equality agenda being placed in the hands of bureaucrats. These individuals may want to present quantitative evidence of gender equality even though they may have little sympathy with the equality agenda. A reliance on percentages or quotas to portray the participation of women in leadership also masks the question of to what extent they are playing a role in influencing the direction of policy. In other words, it is equally critical for women to have positions that are central and critical to national processes. This applies as well to conflict management, resolution and prevention.

Gender equality requires participation of men both as gatekeepers who command resources and as partners.

3.2.3 Enhance the Role of Men

Calls have been made for a shift away from a conception of gender equality as a "women's project" involving wresting power and benefits from men, towards a more inclusive approach. The calls are prompted by several concerns. First, as Connell (2003) has observed, gender equality requires participation of men both as gatekeepers who command resources and as partners. Second, several changes occurring in contemporary society require a shift from regarding men as monolithically powerful and advantaged towards an understanding of the crises that they too encounter in their lives (Chikovore et al., 2002).

Employment patterns, for example, are undergoing significant changes that require a re-evaluation of men's role as provider and controller of the purse strings within families and relationships (Chiuri, 2008). At another level, in countries such as South Africa, young boys are dropping out of school more than their female counterparts (UNECA, 2009), clearly calling for the reconsideration of the view that only girls must be targeted for retention. The "instrumentalist approach" to gender equity and equality – which focuses on enumerating outputs – overlooks nuances of interaction between men and women, and among men themselves, and is generally alienating of men. Still, while acknowledging that men are not all the same, it remains critical

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4. The Family: Its Roles, Rights, Composition and Structure

While there are varied and changing types of family structures in different parts of the world, the family is universally recognized as the fundamental, dominant and natural grouping in society as it is the setting for demographic reproduction, the seat of the first integration of individuals into social life, and the source of emotional and material support essential to the growth and wellbeing of its members (African Union, 2004; Belsey, 2005). As the core of society, the family can be seen in three basic dimensions: as a psycho-biological unit where members – united by the ties of marriage, blood or adoption – are linked together by kinship relations, personal inclinations and emotional bonds; as a social unit where members live together in the same household and share tasks and social functions; and as the basic unit of economic production (African Union, 2004). This recognition of the family as a dynamic unit engaged in an intertwined process of individual and group development underscores the need to ensure its place at the core of society, and to strengthen it as part of the development process.

Many international commitments have responded to this call. The 1990 World Summit on Children, the 1992 Rio Declaration on Environment and Development, the 1992 Agenda 21, and the 1993 Vienna Declaration and Plan of Action all gave special consideration to the family and its role in development. In the same vein, and recognizing the needs and challenges of the family, the ICPD POA urged governments to:

- Develop policies and laws to better support the family, contribute to its stability and take into account its plurality of forms, particularly the growing number of single-parent households;
- Establish social security measures to address the socio-cultural and economic factors underlying the increasing costs of childrearing;
- Promote equality of opportunity for family members, especially the rights of women and children in the family; and
- Ensure that all socio-economic development policies are fully responsive to the diverse and changing needs and rights of families and their members, and provide necessary support and protection, particularly to the most vulnerable families and the most vulnerable family members.

> The recognition of the family as the foundation of individual and group development underscores the need to ensure its place at the core of society, and to strengthen it as part of the development process.

Implicit in the POA is a call for governments to develop social protection policies. Described as “policies and programmes that protect people against risk and vulnerability, mitigate the impact of shocks, and support people from chronic incapacities to secure basic livelihoods” (Adato and Hoddinott, 2008: 1), social protection policies have three major elements, succinctly summarized by RHVP (2007) as:

- *Social legislation,* which provides a legal framework that defines and protects citizens’ rights, and ensures minimum civic standards to safeguard the interest of individuals (e.g., labour laws, health and safety standards);
- *Social insurance,* which are contributory schemes, managed by governments, that provide financial support to participating individuals in times of hardship. Contributions are generally compulsory and are designed to cushion the risks associated with unemployment, ill health, disability, work-related injury and old age; and
- *Social transfers,* which are non-contributory (in the sense that the recipient is not required to pay for them through premiums or specific taxes) social assistance provided

by public or civic bodies to those living in poverty or in danger of falling into poverty (e.g., non-contributory pensions, child benefits, disability allowances).

Social protection schemes have wide-ranging benefits. Among these are promoting access to nutrition, health services and education and protecting the most vulnerable from sinking into poverty. Others are achieving economic growth, assisting in building social cohesion and promoting political stability (Carmona, 2009). With specific regard to the family, social protection can, in the short term, help provide relief to affected families and prevent them from falling into destitution. In the longer term, the promotive and transformational functions of social protection programmes address some of the underlying causes of inter-generational poverty.

4.1 Africa's Progress towards the Implementation of the ICPD POA

The African conceptualization of the family centres around the extended family as an important unit of analysis, and as the basis for the substance of society (Kaseke, 1996). For generations, this type of family structure has been the main source of material, social and emotional support, as well as social security for its members, particularly in times of need and crisis such as unemployment, sickness, old age and bereavement (African Union, 2004). In this regard, the review of progress towards implementing the ICPD POA looks first at social protection programmes and protection for the rights of family members

The African conceptualization of the family centres around the extended family as an important unit of analysis, and as the basis for the substance of society.

4.1.1 Commitment

African governments have long recognized the family as an important unit of society that should be strengthened and protected to enhance its role in political, cultural, and socio-economic development. For example, the 50 African countries represented at the Third African Population Conference held in Dakar, Senegal, in December 1992 adopted the Dakar/Ngor Declaration on Population, Family and Sustainable Development, which among other things called for governments to give due consideration to the rights and responsibilities of all family members, to ensure that measures are put in place to protect the family from socio-economic distress and disintegration, and to integrate family concerns into all development plans. Another example of earlier commitments to improve the welfare of African families is Resolution CM/Res 1466 (LVIII) of the former Organization of African Unity; this resolution urged Member States to lend priority to the observance of the International Year of the Family (1990) as proclaimed by the United Nations.

Post ICPD, a landmark in the continent's efforts to address family concerns was the development and adoption of the African Union *Plan of Action on the Family in Africa* in 2004. With a focus on nine priority areas, the Plan of Action on the Family is meant to serve as an advocacy instrument for strengthening family units, addressing their needs, improving their general welfare and enhancing the life chances of family members. It also aims at guiding African Union Member States in designing, implementing, monitoring and evaluating appropriate national policies and programmes for the family on the basis of their specific requirements and needs.

The AU's *Plan of Action on the Family in Africa* in 2004 stands as a landmark in the continent's efforts to strengthen the family and improve the general welfare and life chances of family members.

Other post-ICPD blueprints that indirectly affect the family, in that they advocate for the promotion of social protection and social security measures, are:

- *The Ouagadougou Declaration and Plan of Action:* Considered the blueprint of the African Union strategy on social development, this declaration has the overall aim of empowering African people, opening opportunities and creating social protection and security for workers by building a people-oriented environment for development and national growth (Taylor, 2008).
- *The Livingstone Call for Action on Social Protection:* Adopted at a meeting – spearheaded by the AU and other stakeholders – held in Livingstone, Zambia, in March 2006 where significant consensus was reached on the need for African governments to strengthen social protection and social transfer interventions; develop costed plans for social protection; engage in capacity building and experience sharing on social protection; adopt comprehensive social protection schemes for older people; and introduce universal social pensions.
- *The Social Policy Framework for Africa:* Agreed at the first ever conference of African ministers in charge of social development in Windhoek, Namibia, in 2008, and adopted by the African Heads of States in Addis Ababa, Ethiopia, in 2009. Among other things the framework includes a series of policy recommendations to help African Union Member States to develop their national social policies to promote human empowerment and development, within the broader framework of social protection. The framework identifies 15 key thematic social issues and others that deserve attention, with "the family" being one of them.

4.1.2 Implementation of Social Protection Programmes

Largely as a result of the foregoing commitments, and the accumulating evidence of the effectiveness of social protection in low-income countries throughout the world, interest in social protection is increasing across Africa. The post-ICPD period has thus seen a growing number of African governments designing and developing national social protection strategies, often in the context of more comprehensive versions of poverty reduction strategy papers (PRSPs) aimed at achieving economic growth, poverty reduction and sustainable development (Adato and Hoddinott, 2008; International Social Security Association, 2008; Niño-Zarazúa et al., 2010). Social protection policies and programme in the continent are variedly configured, however, and far from comprehensive.

Since ICPD many African governments have put in place national social protection strategies aimed at achieving economic growth, poverty reduction and sustainable development.

Annex C illustrates this diversity for 39 sub-Saharan African countries for which relevant data were available in 2009. The most salient points from the annex with implications for the family in Africa are that:

- The focus of many African countries seems to be on social security programmes of the contributory types that apply to salaried workers only. The annex table shows that all the listed sub-Saharan African countries have some form of benefits for old age, disability, work injury, sickness and maternity – all of which derive their finances from three possible sources: a percentage of covered wages or salaries paid by the worker; a percentage of covered payroll paid by the employer; and/or a government contribution (International Social Security Agency Association, 2008). In essence therefore, these benefits are available only to formal sector waged workers, in either the public or private sectors, who are able to contribute to social insurance – and who actually constitute the minority of the economically active population in the region. Informal sector workers, some 72% of all non-agricultural workers in the region (Heyzer, 2006), do not have access to these benefits.

- Given that African men have higher formal employment rates than their female counterparts, and that the majority of women in wage employment are in the informal sector, the predominance of contributory social insurance schemes in the region tends to discriminate against women. Furthermore, this means that in the event of family break-

ups or the death of the husband, affected women are often not entitled to present or future unemployment or pension benefits (Taylor, 2008). Overall, the current social security landscape aggravates aspects of gender bias, which in turn can leave families, particularly those headed by women, vulnerable to poverty and social exclusion.

- Wide-ranging non-contributory social protection provided by the state seems to be rudimentary or absent. For example, provision for unemployment (including for former salaried workers) is generally lacking. Only two countries (Mauritius and South Africa) out of the 39 shown in the table provide compensation for the loss of income resulting from involuntary unemployment.

- Although more than half of the countries reviewed do have some form of family allowance – defined by the International Social Security Agency Association (2008): as programmes or regular cash payment meant to provide additional income for families with young children to meet at least part of the added costs of their support – it is noteworthy that many of these allowances are means-tested. That is, eligibility for benefits is established by measuring individual or family resources against a calculated standard usually based on subsistence needs. It is well-documented, however, that while effective targeting may reduce governments' direct costs for providing relief, there are often errors of exclusion of those who should be receiving the transfer and errors of inclusion of those who should not be receiving it (Kaseke, 2008). An additional limitation of targeting in Africa is that many governments lack administrative capacity, resulting in the means tests and categorical targeting being costly and inefficient in reaching the poorest (Taylor, 2008).

4.1.3 The Rights of Family Members

In terms of implementation of laws, policies and programmes to address the needs and rights of families and their members, many African countries have signed various international and regional commitments to that effect. Key among these are the Beijing Platform for Action**,** the African Union Policy Framework and Plan of Action on Ageing, and the African Union Continental Plan of Action for the African Decade of Persons with Disabilities**.** The effective implementation of these commitments is reflected in, among others, improvements in progress towards gender parity in education as measured by the ratio of girls' to boys' gross enrolment (MDG 3) and increases in paid employment for women from around 23% in 1990 to 29% in 2007, and projected to increase to 33% by 2015 (United Nations, 2009).

The United Nations further shows that sub-Saharan Africa continues to make strides in women's political representation, exemplified by the increase in the proportion of seats they hold in single and lower houses of national parliaments from 9% in 2000 to 18% in 2009. A number of countries have also, post ICPD, amended their statutory laws to provide for equality for women. For example, the Abolition of Marital Powers Act of 2005 in Botswana and the Legal Capacity of Married Persons Act 9 of 2006 in Lesotho (discussed in Section 3 of this report) now give both partners in common law marriage equal powers in the family. The Bill of Rights in Kenya's new constitution also provides for equality in marriage for all parties.

4.2 Current Status of the Family in Africa

Despite the fairly considerable progress in implementing the ICPD POA as it relates to the family, sub-Saharan Africa is currently undergoing fundamental demographic, sociological and economic changes that have the potential for a negative impact on the family (see Bigombe and Khadiagala, 2003, for a comprehensive discussion of these changes). The following subsections succinctly discuss some of these key changes.

4.2.1 Demographic Changes

Among others these include declining fertility and the increasing number of older adults, which will ultimately alter dependency ratios and likely change some family roles.

Decreasing Fertility

It is well-documented that families with lower fertility are better able to invest in the health and education of each child, which in turn can help reduce poverty and stimulate national development. In the context of social protection, however, decreasing fertility (and the eventual smaller families) may have acute implications for the poor. As de Oliveiria (1997) asserts, small families have possibly less ability to cope with multiple or increased demands on their members. That is, members of small families are more likely to be under greater pressure to meet their family duties in situations of unemployment, illness or death than members of larger families. Since a small family has fewer people to rely on, the load has to be distributed among fewer available kin. In Africa this is particularly relevant in the context of the fertility transition that has been under way over the past 15 years, as confirmed by several studies (see for example, Caldwell and Caldwell, 2002; Bigombe and Khadiagala, 2003; Shapiro and Gebreselassie, 2008) and as discussed in more detail in Section 4 of this report.

Ageing

Sub-Saharan Africa has a youthful population that is expected to remain relatively young, at least until 2050 (Caldwell and Caldwell, 2002). At the same time, however, the proportion of older persons (those aged 60 years and above) in the region is clearly increasing and this age group, now estimated to number between 35 million and 40 million, is projected to double by 2050 (Konkolewsky, 2008; Makoni, 2008).

In addition to the usual physical, mental and psychological changes associated with ageing, older people in Africa are further disadvantaged by lack of social security for everyday socio-economic needs. This is aggravated by the growing burden of care through which grandparents – at a time when they themselves should be taken care of – have increasingly taken up the responsibility of caring for the sick, the dying, and the grandchildren orphaned or made vulnerable by HIV and AIDS and other causes (African Union, 2009). Indeed, it is well-documented that apart from children, older people are the other social group most vulnerable to the many socio-economic challenges affecting Africa today, particularly poverty, food insecurity, violence and inadequate social welfare (African Union, 2004).

4.2.2 Sociological Changes

As discussed below, weakened intergenerational relationships, increased age at first marriage and the proportion of female-headed households are among the major sociological changes affecting the family.

Weakened Intergenerational Relations

Traditionally, old age was venerated in Africa, as old people were seen as reservoirs of wisdom; their role was to advise, direct and lead their families and communities. Younger family members, on the other hand, were the main carers of old people. Over the years, however, major economic, cultural, political and demographic changes have disrupted the reciprocal relations between generations. For example, while rural-urban migration has for years been one of the essential mechanisms for job opportunities, social mobility and income transfer in Africa, it has gradually loosened traditional social control mechanisms that regulated reciprocities and responsibilities within families. It has, for example, reduced household sizes and weakened the traditional kinship mode of residential settlement and care by physically separating members of the family who, in traditional African societies, provided primary care and support for older people. It has also resulted in the over-

representation of older persons in rural areas (Aboderin and Kizito, 2010). Consequently, some older people in Africa, the majority of whom do live in rural areas, receive only erratic family care and support from their urban-based children.

A substantial body of literature also provides evidence that although grandmothers have traditionally played a major role in taking care of grandchildren and maintaining multi-generational households during both "regular" and "crisis" times (Ingstad, 1994; Schatz, 2005), this role is now increasing and becoming heavier with the migration of the younger generation to urban areas and the high prevalence of HIV and AIDS that has increased the burden of care as discussed above. Weakened intergenerational relationships are also reflected in families consisting of four or more generations living under one roof, which are becoming increasingly common as lack of employment opportunities in many parts of the region is seeing the younger generation continuing to live longer with their parents than was previously the case. The growing families continue to be a burden for older people who may be forced to sell their meagre assets or to go out for petty jobs in order to raise capital to provide better care for the many who depend on them. This, among other things, can have negative effects on older people's physical, emotional and financial wellbeing.

Increasing Timing of Marriage and Proportion of Female-Headed Households

Despite the diversity across the region, early dominant models of traditional African marriage stressed several key components that included early marriage especially for women, almost universal marriage for both sexes, and prompt remarriage for widowed and divorced women of reproductive age (van de Walle, 1993). Since the 1970s, however, a large part of the continent has experienced significant transformations in nuptiality patterns, reflected mainly in the increase in age at first marriage for women and the increase in the amount of time spent out of marriage during adult years (van de Walle, 1993; Hertrich, 2002). Mokomane (2004) showed that while marriage remains the norm in most African countries no part of Africa has remained totally unaffected by these transformations. The most remarkable changes have been observed in Southern Africa where, for example, the age at first marriage for women increased from 22 years in the 1960s to over 28 years in the late 1990s. Although still relatively low, age at first marriage for women has also increased to around 21 years in East Africa and around 20 years in Central and West Africa (Mokomane, 2004).

Much of Africa has experienced significant transformations in nuptial patterns since the 1970s, mainly in the increase in age at first marriage for women and the increase in the amount of time spent out of marriage during adult years.

Partly because of these nuptiality trends, as well as other factors such as male migration, unpartnered adolescent fertility and family disruption, female-headed households (FHH) have become a discernible pattern of the African social landscape (Bigombe and Khadiagala, 2003). Table 4.1, for example, shows that over 20% of households in the Eastern, Central and Southern African countries for which data are available were headed by women; this was also the case in 5 of the 11 West African countries shown. Although there is often disagreement as to whether FHHs are poorer than male-headed households in terms of income poverty, the pattern in the table has implications for the family in Africa because of the virtually undisputed fact that FHHs are usually disadvantaged in terms of access to land, livestock, credit, education, health care and extension services.

Table 4.1: Percentage of female-headed households, selected sub-Saharan African countries, late 1990s–2000s

Central Africa	Proportion of female-headed households (%)	East Africa	Proportion of female-headed households (%)
Cameroon, 2004	24.0	Eritrea, 2002	46.7
Central Afr. Rep. 1994/95	21.0	Ethiopia, 2005	22.8
Chad, 2004	19.6	Kenya, 2003	31.7
Congo, 2005	23.3	Rwanda, 2005	33.9

Gabon 2000	26.0	Uganda, 2006	29.9
Southern Africa	**Proportion of female-headed households (%)**	**West Africa**	**Proportion of female-headed households (%)**
Lesotho, 2004	37.3	Benin, 2001	20.8
Madagascar, 2003/04	21.7	Burkina Faso, 2003	9.4
Malawi, 2004	24.7	Cote d'Ivoire, 1998/99	14.4
Mozambique, 2003	26.4	Ghana, 2003	33.8
Namibia, 2000	41.5	Guinea, 2005	16.7
South Africa, 1998	41.9	Mali, 2001	11.3
Tanzania, 2004	24.5	Mauritania, 2000/01	29.1
Zambia, 2001/02	22.6	Niger, 2006	18.5
Zimbabwe, 2005/06	37.7	Nigeria, 2003	16.6
		Senegal, 2005	23.1
		Togo, 1998	24.3

Source: Computed from Demographic and Health Surveys data available at www.measuredhs.com

4.2.3 Economic Changes

Poverty – Africa's perennial problem – coupled with high unemployment rates and rapid urbanization are among the negative economic changes affecting the family.

Persistent Poverty

Sub-Saharan Africa's poverty gap index (the proportion of the population living under the poverty line) shows almost no change since the early 1980s, with the distance below the poverty gap line being 36.6 in 1981 and 36.4 in 2005 (Taylor, 2008). Taylor further posits that the simple head-count index illustrates that while the region had 50.8% of its population living on less than US$1.25 a day in 1981, the corresponding figure in 2005 was 50.4%. This high and persistent level of poverty negatively affects families' standard of living and also render them less able to meet basic social needs for their members.

Unemployment

In addition to poverty, sub-Saharan Africa faces a severe and multidimensional problem of unemployment, especially among young people. Although the youth made up only 33% of the labour force, they accounted for 63% of the total unemployed population of sub-Saharan Africa in 2003. Furthermore, at an average 21%, the unemployment rate of young people aged 15–24 years was twice that of the total labour force in 2003.

In terms of gender, female unemployment rates are generally lower than those of males, and as shown earlier, their labour force participation has been increasing over the years. The nature of their employment is up for scrutiny, however. Because of the general underestimation of female unemployment, the gender gap in favour of women in sub-Saharan Africa does not reflect the dire situation of women in the labour force. For example, 84% of women in non-agricultural occupations are employed in the informal sector, compared with 63% of men (Heyzer, 2006). This sector is notorious for its low productivity and low earnings, and the high poverty among its workers. Informal sector workers in Africa generally live and work under harsh conditions that are more commonly associated with shocks such as illness, loss of assets and loss of income. Moreover, the workers have little or no access to formal risk-coping mechanisms such as insurance, pensions and social assistance (African Union, 2009).

Furthermore, and as discussed above, the combination of women's employment and their caring and domestic responsibilities means that many of them experience high levels of work-family conflict. From the family welfare point of view, work-family conflict has been associated with negative impacts on the quality of relations between spouses and increased risk of family dysfunction (Macewen and Barling, 1994; Matthews et al., 1996; Duxbury and Higgins). The conflict can also create difficulties in providing appropriate care for dependent children and the elderly within families.

Urbanization

Although Africa is still very largely rural and agricultural, more than 38% of the region's current population lives in urban areas (2005 estimate), compared with 30% in 1985 and 23% in 1970. Only two cities in the continent had populations exceeding 500,000 in 1970, but by 2005 a total of 37 African cities had populations of more than 1 million . If current trends continue, 48% and 53% of Africa's population will live in urban areas by 2025 and 2030, respectively (African Union, 2009).

This rapid urban population growth has been caused by factors such as perceived prospects of more jobs, access to medical treatment and general attractions of urban life. Many migrants to the cities, however, have discovered that their prospects are not significantly improved by relocation. Consequently, unemployment and underemployment are rampant in every major city in Africa. In addition, without adequate housing facilities, the rapid population growth rate has resulted in poor and crowded housing and infrastructure in urban slums (Bigombe and Khadiagala, 2003; African Union, 2009). Studies from most African cities have also shown that female-headed households are over-represented among the urban poor. Africa's unplanned urban sprawls are populated with unmarried and poor women who face considerable obstacles in overcoming dislocation, migration and deprivation (Bigombe and Khadiagala, 2003).

4.2.4 HIV and AIDS

The livelihoods and family-based support systems in Africa have also been undermined by shocks such the HIV and AIDS epidemic (Taylor, 2008). The AIDS epidemic has had far-reaching effects on the family by creating, among other things, previously unfamiliar family structures such as skip generation households, child-headed households and orphans who have no extended family support systems (Bigombe and Khadiagala, 2003; Taylor, 2008). As a result, there has generally been a progressive disintegration of families, as they become ineffective social and economic units.

4.3 Recommendations

It is evident from the foregoing that despite the various efforts made by African countries to improve the welfare of the family and its members, there are still major challenges. The challenge is to reiterate and renew the ICPD POA's call for countries to develop social protection policies and to improve those that are existing through, for example, better integration of contributory and non-contributory schemes, extending of coverage, and improved governance and administration. This is particularly the case considering the large body of evidence showing that comprehensive social protection is an enabler of family functioning as it contains an *intra-generational* notion of social justice and income redistribution from better-off to low-income families (through taxation) and an *inter-generational* notion of burden shifting, via financing modalities (Köhler, 2009). Box 4.1 provides some evidence of this.

Box 4.1: Examples of the impact of pension plans in Southern Africa

- Non-contributory pensions in South Africa reduce the country's overall poverty gap by 21%, and for households with older people by more than half (54%) while virtually eliminating poverty for households with only older people (a reduction of 98%)
- In Mauritius the share of older people in households below the poverty line is 64% without the non-contributory pension but only 19% with the non-contributory pension
- Old age pensions also help children grow into more productive adults who escape the inter-generational transmission of poverty. Girls in households receiving a non-contributory pension are more likely to attend school, succeed academically and have better health and nutrition indicators than children in similar households that do not receive the grants.

- Predictable and regular pension income provides the income security that households need to manage social risk and invest in the riskier but higher return activities that enable people to break free from poverty.
- Some older people in Namibia, for example, use their pension to invest in livestock and other agricultural activities and to access credit (accepted as collateral) Elsewhere, 21% of the surveyed recipients in Lesotho spent part of their pension creating jobs ranging from general household chores to farm work.
- Pensions support the successful participation of adult household members in labour markets. This impact is significantly greater for women in the poorest households, and positively associated with a reduction in child labour.

Source: Adapted from International Social Security Association (2008).

The specific pathways to achieving comprehensive and adequate social protection differ among authors (see for example, Taylor, 2008; International Social Security Association 2008; Niño-Zarazúa et al., 2010), but all emphasize three key components:

- ***Improve the overall understanding of social security*** by conducting research on extension efforts, documenting best practices worldwide, developing new mechanisms to reach out to workers in the informal economy and creating guidelines for extending basic benefit entitlement.
- ***Achieve concrete improvements in social security coverage*** through technical assistance projects focusing on a diagnosis of unfulfilled needs and ways to meet them. Undertake training and policy discussion with stakeholders, strengthening institutions and social dialogue, formulating action plans, establishing networks of support institutions and individuals, and monitoring and evaluating results
- ***Raise awareness and mobilize key actors and partnerships*** in particular with possible donor countries and agencies to ensure a broad base of support for the implementation of the campaign.

UNFPA, in conjunction with other multilateral agencies and donor countries, can play an important role in facilitating initiatives to improve the welfare of the family by advocating a role for appropriately designed social protection elements in their support programmes and policy recommendations.

In addition to social protection programmes, African governments need to ensure the effective implementation of the various international and regional commitments aimed at improving the welfare of families and their members.

There is an important advocacy role for UNFPA and other development partners in improving the welfare of the family through appropriately designed social protection elements in their support programmes and policy recommendations.

5. Population Growth and Structure

A new strategy emerged from the ICPD, one that emphasized the numerous linkages between population and development, thus abandoning rigid, top-down demographic targets in favour of a rights-based approach holding that smaller families and a stable population will result from meeting people's basic needs. To this end the ICPD POA set out a series of priority issues aimed at facilitating "the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social and environmental goals, while fully respecting human rights" (UNFPA, 2004: 35).

To achieve this, countries were urged to, among other things, aim to reduce high levels of infant, child and maternal mortality so as to lessen the need for high fertility and reduce the occurrence of high-risk births. In terms of population structure, the POA called on governments to promote the welfare and potential of vulnerable population groups such as children and youth, elderly people, indigenous peoples, and persons with disabilities by, for example:

- Giving high priority and attention to all dimensions of the protection, survival and development of children and youth, and making every effort to eliminate the adverse effects of poverty on children and youth;
- Taking into account the increasing numbers and proportions of elderly people at all levels of governments' medium- and long-term socio-economic planning;
- Recognizing the distinct perspective of indigenous people on aspects of population and development; and
- Considering – at all levels – the needs of persons with disabilities in terms of ethical and human rights.

The ICPD strategy abandoned rigid, top-down demographic targets in favour of a rights-based approach holding that smaller families and a stable population will result from meeting people's basic needs.

5.1 Africa's progress towards the implementation of the ICPD POA

Efforts to implement the ICPD POA stem from the priorities spelled out in the ICPD strategy. From population growth and structure, to fertility, mortality, and the welfare of children, African countries are taking measures to comply. Other areas, as described below, include the welfare of young people, older persons and persons with disabilities

5.1.1 Commitment

Historically the main efforts to address concerns about population growth in Africa went into family planning programmes. Following the ICPD, however, the region joined the rest of the world in giving greater attention to the importance of population trends for development, and also emphasizing the eradication of poverty and the raising of the standard of living by encouraging sustained growth, human resource development and the guarantee of all human rights. This perspective has been reflected in continental blueprints such as the African Union Common Position on Human and Social Development in Africa (1994); the African Union Strategic Plan (2004–2007); and the African Union Social Policy Framework for Africa (2008).

5.1.2 Population Growth and Structure

These and other commitments, and the various efforts to address population growth concerns in line with the ICPD POA, have not prevented sub-Saharan Africa from becoming the second most populous region after Asia. As of 2007, the estimated population of the

region was about 784 million people, which translates to about 14% of the world population. More than a third – 35% – of this population lives in West Africa, 43% in East Africa, 15% in Central Africa and only 7% in Southern Africa. With its current population growth rate of 2.7%, which is relatively high compared with those of Asia (1.13%), Latin America (1.24%) and Europe (-0.02%), the sub-Saharan African population is expected to continue growing, and to encompass 17% of the world's population by 2025 and 22% by 2050 (African Union, 2009).

In terms of sub-regions, Southern Africa is likely to reach zero growth rates soon, as a result of the combination of rapid fertility decline and high HIV prevalence. Currently most countries in the sub-region have growth rates at or below 1% per annum: 0.3% in Zimbabwe, 0.9% in Lesotho and 1.0% in South Africa. Island nations in the sub-region also tend to have low population growth rates; with Seychelles' growth rate estimated at 0.47% and that of Mauritius at 0.69%.

Since ICPD, several studies have revealed conclusively that fertility decline is indeed under way in most parts of Africa, although it is still higher than anywhere else in the world.

5.1.3 Fertility

Between the 1960s and 1980s as fertility declined throughout much of the developing world, sub-Saharan Africa was distinguished as the only major region in the world without any indication of an onset of fertility transition (Lesthaeghe, 1989, cited by Shapiro and Gebreselassie, 2008). By the early 1990s, however, it was becoming apparent that fertility in at least a few African countries had started to fall. Over the last 15 years, several studies have revealed conclusively that fertility decline is indeed under way in most parts of Africa, albeit still considerably higher than anywhere in the world (Table 5.1). Caldwell and Caldwell (2002) projected that Southern Africa will likely reach replacement level fertility (2.0 children per woman) by 2040; East and Central Africa by around 2075; and West Africa by 2060.

Table 5.1: Estimated total fertility rates, sub-Saharan Africa, 1995–2010

Subregion	1995–2000	2005–2010
Central Africa	6.5	5.7
East Africa	5.9	5.3
Southern Africa	3.1	2.6
West Africa	5.9	5.3

Source: *World Population Prospects*, 2008.

The key explanatory variables for the region's fertility declines revolve around increased age at marriage; increased urbanization; increased use of modern contraception, especially condoms in the wake of HIV and AIDS; and the fact that improved education of women appears to have gradually eroded some of the traditional value placed on childbearing (Bigombe and Khadiagala, 2003).

Despite the general fertility decline in the region, a stall (where the national TFR has failed to continue its previous decline) has been observed in a number of countries. These countries can be divided into two groups; the first comprises those in which the prior fertility decline had brought the national TFR to 5 or fewer children per women (mid-transition stall). These include Cameroon, Ghana and Kenya. The second group consists of those in which the prior fertility decline was more modest and the national TFR was approximately 5.5 to 6 children per woman (early transition stall). Among these countries are Guinea, Mozambique, Rwanda, Senegal and Tanzania (Shapiro and Gebreselassie, 2008).

5.1.4 Mortality

Relatively improved living conditions and greater availability of health services enabled many African countries to achieve remarkable reductions in infant and child mortality between 1960 and 1990. Since 1990, however, Africa has experienced a general stall in the infant

mortality decline. In the same vein, declines in child mortality rates averaged about 1% in the 1960s, increasing to 2% between 1970 and 1985, but reverting back to 1% from 1985 to 1990. Afterwards, the decline averaged much below 1%, and is currently well below the annual average of 4.3% needed for the sub-Saharan African region to reach MDG 4 by 2015 (United Nations, 2005b).

Of the 40 countries with the highest adult mortality in the world, 37 are found in sub-Saharan Africa.

Adult mortality in sub-Saharan Africa is also higher than in other parts of the world. For example, of the 40 countries with the highest adult mortality in the world, 37 are found in sub-Saharan Africa. Not surprisingly, adult mortality in the region is highest in areas that also have the highest HIV and AIDS prevalence, especially in Southern and East Africa in countries such as South Africa, Zimbabwe, Zambia, and Uganda.

As a result of these general mortality trends, sub-Saharan Africa has experienced a drop in life expectancy of about 3% over the last two decades. Some of the worst affected countries in the region, especially East and Southern Africa, have seen life expectancy fall by as much as 20% (Jamison et al., 2006).

5.1.5 Welfare of Children

Since the ICPD, African countries have committed themselves to protecting the welfare of children by developing and ratifying various regional instruments. Among these are the Tunis Declaration on the follow-up of the Mid-Decade Goals of the Child (1995), the Cairo Declaration and Plan of Action on Children (2001), the African Common Position on Children – Africa Fit for Children (2001), and the Kigali Declaration on Children and HIV/AIDS Prevention (2001). Most recent is the Call for Accelerated Action on the Implementation of the Plan of Action towards Africa Fit for Children (2008). Overall, these instruments reiterate the regions' commitments to the improvement of children's welfare, as outlined in the landmark African Charter in the Rights and Welfare of the Child (1990) and the ICPD POA.

All these commitments have not prevented the countries in the region from recording the worst Child Development Index (CDI) ratings in the world (Africapedia, 2009). The CDI is one of the most commonly used measures of the welfare of children in three areas of child wellbeing: health (measuring the under-five mortality rate), nutrition (the percentage of under-fives who are moderately or severely under weight) and school enrolment (the percentage of primary school-age children who are not enrolled in school). Additionally, sub-Saharan Africa accounted for almost half of all global child deaths in 2007. In the same vein, UNAIDS figures show that nearly 90% of children living with HIV in the world live in sub-Saharan Africa. Furthermore, and as shown earlier, Africa's infant and child mortality rates are the highest in the world. The lives of children in the region are also made precarious by conflict situations in many countries, and by the HIV and AIDS epidemic, which has left many of them orphaned and vulnerable (African Union, 2009).

Sub-Saharan Africa accounted for almost half of all global child deaths in 2007, with the lives of children in the region made even more precarious by conflict situations.

5.1.6 Welfare of Young People

Africa is generally a young continent, with as much as 44% of its population in 2006 being below the age of 15 years, compared with Europe where the population under the age 15 is only 15%. Recognizing the importance of youth participation and involvement in the development of the continent, the African Union Commission Strategic Plan (2004–2007) gave due priority to youth development and empowerment. To give substance to this commitment, the African Union developed the *African Youth Charter* in 2006. This charter aims to ensure the constructive involvement of youth in the development agenda of Africa and their effective participation in

the debates and decision making processes in the development of the continent (African Union Commission, 2006a).

Young people in the region nevertheless face several challenges, including unemployment and underemployment. The few who are working often do so in low-paying, temporary positions where they work long hours under poor conditions often with few, if any, protection (African Union, 2008). Another major problem facing young people in the region is teenage childbearing, which remains a challenge even in countries that have experienced a significant fertility decline. Teenage childbearing is seen as a major inhibitor of children reaching their full potential. It is also noteworthy that while many young Africans are sexually active, consistent condom usage still low among them. In consequence, like their counterparts all over the world, young people in Africa are at special risk of sexually transmitted infections including HIV (Shaw and Aggleton, 2002). It has been estimated that nearly half of all new HIV infections in sub-Saharan Africa occur among 15—24-year-olds (WHO, 2006b).

The *African Youth Charter* in 2006 aims to ensure the constructive involvement of youth in the development agenda of Africa and their effective participation in the debates and decision making processes in the development of the continent.

On the other hand, sub-Saharan's Africa's youth bulge is recognized as an opportunity to revive the region's socio-economic capital. A youth bulge happens when a large cohort of children is born during a period when the total fertility rate was high, followed by a period of sustained decline in fertility. As a result of the fertility decline, a bulge in the working population emerges. Thus, a large number of people support a relatively low number of persons in the dependant young and old ages, a phenomenon known as the demographic dividend (Lee and Mason, 2006). Indeed, it has been suggested that the demographic dividend is partly responsible for the economic miracle of East Asia (estimated contribution to be anything between 25 and 40%). The policies that contributed to East Asia's ability to benefit from the youth bulge include large investment in youth education, broadening of the tax base, labour exchange programmes between countries, and market flexibility.

Sub-Saharan's Africa's "youth bulge" offers an opportunity to revive the region's socio-economic capital.

5.1.7 Welfare of Older Persons

Given the youthful structure of the population of sub-Saharan Africa, just under 5% of the present population in the region is aged 60 years and above (Velkoff and Kowal, 2007). The proportions are small, but the absolute numbers are considerable and are estimated to be slightly more than 38 million, projected to reach between 203 million and 212 million by 2050 (Velkoff and Kowal, 2007). Unlike in most parts of the world where population ageing has been propelled by falling mortality rates, in sub-Saharan Africa, the process of ageing is largely explained by the fertility decline, and in some countries by accompanying emigration of the middle age group, as is the case in Lesotho where many young people migrate to South Africa in search for employment.

Recognizing the emerging importance of the elderly population in Africa, the African Union developed and adopted a *Policy Framework and Plan of Action on Ageing* that intends to guide African Union Member States to develop policies on ageing, embark on resource mobilization, and implement and monitor the implementation of such policies on a regular basis. Many African countries were also party to the landmark 2002 Madrid International Plan of Action on Ageing, which called for the incorporation of ageing into national and global development agendas, and for the right of older persons to an equal share in development resources.

Despite these commitments, many older persons in Africa continue to face several challenges, key among them being the lack of social security. Apart from a few countries – such as Botswana, Lesotho, Mauritius, Namibia and South Africa – that have some form of old age pension, most African countries have poorly developed social security systems, if any at all. As discussed in Section 4, retirement cover in sub-Saharan Africa is generally enjoyed by only a small group of mostly urban-based workers and civil servants. In consequence, the majority of older persons in Africa rely almost entirely on their families for all types of support. However, while extended families were for many years able to adequately support their older members, the institution has of late found it difficult to fulfil this role, largely because of decreasing family sizes, the high AIDS-related mortality rates among the middle aged, the migration of young adults in search for employment, and the growing intergenerational disjuncture that is rapidly emerging in the region.

5.1.8 Persons with Disabilities

Levels of disability in Africa are higher than in many regions of the world, where it is estimated at about 10% of the population. Even so, the causes of disability in Africa are similar to those found in many parts of the world, which include birth defects, ageing, injuries both at home at work and those that are related to motor accidents, which is rapidly becoming a huge portion. In addition, malnutrition, HIV and AIDS, and conflicts are a significant contributor to the high level of disability in Africa. According to the United States Agency for International Development (USAID, 2009), between 350 and 500 people every day are amputated throughout the world because of landmines alone, and a significant number of those amputees are in Africa. A good example is Angola – a country that endured a prolonged civil war lasting for a period of four decades – where an estimated 100,000 people are victims of landmines planted during the war (USAID, 2009).

Despite the African Union declaring 1999–2009 the African Decade of Persons with Disabilities and the development of the *Continental Plan of Action for the African Decade of Persons with Disabilities,* many Africans with disabilities continue to be isolated from society. They are often excluded from school (literacy rates among this group in Africa are estimated to be about 1%), and many resort to begging as their sole means of survival. Overall, persons with disabilities in Africa constitute 20% of the poor in Africa (USAID 2009) – twice their proportion of the overall population.

Calls by emerging civil society organizations in the region demand that governments ensure effective implementation of global and regional commitments towards persons with disabilities, and that they apply a “disability lens” to all aspects of national development plans. For example, in 2008, members of a group calling itself the MDG and Disability Conference, comprising delegates from all over sub-Saharan Africa, met in Nairobi to examine the status of MDGs in respect to the inclusion and mainstreaming of disability in Africa. This group noted with dismay that the MDGs have no specific reference to disability. Thus, they advocated for a specific mechanism to monitor the implementation of international resolutions on disability and the inclusion and prioritization of disability issues.

5.2 Recommendations

It is evident that sub-Saharan Africa is not lacking in commitments to enhance its population growth and structure. What is needed, though, is for governments in the region to work closely with regional and international partners to implement these commitments and enhance the welfare of the different population groups in the region. For example, given the well-documented influence of women’s education and infant and child mortality on fertility, sub-Saharan African countries that seek to avoid stalling and to maintain or accelerate their fertility transitions need to implement policies and programmes to realize increased education of women at all levels, and reduced infant and child mortality (Shapiro and

Gebreselassie, 2008). Shapiro and Gebreselassie also highlight the fact that the stalling of fertility at high levels (4–5 children per woman) may be a reflection of the old age security function of children in Africa, and that in the absence of alternative mechanisms for old age security it may be very difficult to prevent stalling on a wider basis in the region. To this end, the need for African countries to invest in social protection policies as discussed in Section 4 is further underscored.

It has also been shown that that the unique opportunity provided by the youth bulge does not automatically translate into a demographic dividend. Rather, evidence shows that where the youth bulge has benefited society, conscious policy decisions were made to involve young people in all aspects of development and the economy. For instance, some of the policies that assisted East Asia to benefit from the youth bulge were neo-liberal economic policies on tax, labour exchange, trade liberalization, and market flexibility. Otherwise, some social commentators have associated a youth bulge with negative consequences for society. Beehner (2007), for instance, found the youth bulge to be destabilizing for developing countries. Thus to reap the benefits of their youthful populations, African governments should work in partnership with national and international organizations, including civil society, to develop and implement policies and programmes through which young people can unleash their potential. The implementation of the African Youth Charter will be particularly important in this respect.

6. Reproductive Rights and Reproductive Health

Consensus is growing among development partners that reproductive health – defined as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, paragraph 7.2) – is a human right that is not only vital for improving the general health and well-being of populations, but is also central to sustainable development. As UNFPA has pointed out, disease and ill-health weaken the poor by diminishing their personal capacity and their ability to contribute to their households, resulting in lost incomes and lower productivity (UNFPA, 2005). At the macro level, disease and illness burden national budgets, and lost incomes and lower productivity slow economic development. Investments in reproductive health are therefore central for individual and family security through the reduction of morbidity and mortality, which in turn will promote economic growth and improve a country's productivity and development prospects. Other tangible benefits may include promoting social justice by contributing to gender equality and social inclusion (UNFPA, 2005).

Investments in reproductive health are central for individual and family security through the reduction of morbidity and mortality, which in turn will promote economic growth and improve a country's productivity and development prospects.

This link between reproductive health and human development led to the ICPD's urging all countries to "make accessible through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than the year 2015" (ICPD, paragraph 7.6). There was a specific call to pay attention to reproductive rights; family planning; prevention and treatment of sexually transmitted diseases including HIV; improving human sexuality and gender relations; and the reproductive health needs of adolescents.

6.1 Africa's Progress towards the Implementation of the ICPD POA

Although the goal for universal access to reproductive health by 2015, as adopted by consensus in Cairo, was not included as an explicit goal or target among the MDGs, achieving good reproductive health essentially underpins all the goals, especially MDG 1 (*Poverty*), MDG 3 (*Gender equality*), MDG 4 (*Child health*), MDG 5 (*Maternal health*) and MDG 6 (*Combating HIV/AIDS and other diseases*). Given that gender equality, child health and maternal health are covered elsewhere in this report, this section focuses on contraceptive use, termination of pregnancy, adolescents and young people, HIV prevention, childbearing, and – as a cross-cutter – male involvement.

6.1.1 Commitment

African countries have shown their concern for, and willingness to address, reproductive health as outlined in the ICPD POA through such regional commitments as the African Health Strategy (2007–2015) and the Maputo Plan of Action on Sexual and Reproductive Health and Rights. The latter endorsed by the African Union (AU) in 2006 when the regional body recognized that African countries were unlikely to achieve the MDGs without significant improvements in the sexual and reproductive health of their people. The Maputo Plan of Action activates the Continental Policy Framework on Sexual and Reproductive Health and Rights. Adopted by AU Heads of State in October 2005, the framework aimed to take Africa forward towards the goal of universal access to comprehensive sexual and reproductive health services by 2015.

The Maputo POA is a short-term plan for the period up to 2010; it is built on nine action areas: Integration of sexual and reproductive health (SRH) services into primary health care; repositioning family planning; providing youth-friendly services; working to stop unsafe abortion; ensuring quality safe motherhood; mobilizing resources mobilization; securing the commodity chain; and monitoring and evaluating progress in all these areas. The plan is premised on sexual and reproductive health in its fullest context as defined at ICPD (African Union Commission, 2006b).

6.1.2 Contraceptive Use and Unmet Need

Contraceptive use in sub-Saharan Africa has risen since the 1990s, with close to one-half of women in Southern Africa currently using a contraceptive (Population Reference Bureau, 2008). Overall, however, use of a modern method remains low, especially for many countries in Middle and West Africa where it is around 10%. The latter countries also seem to have much higher levels of fertility than others (Population Reference Bureau, 2008).

Unmet need remains high in most countries of the region. Twenty-four per cent of women who intend to stop or delay childbearing are not using any contraceptive (Guttmacher Institute, 2007). Table 6.1 shows the extent of unmet need for selected countries, ranging from 13% and 15% in Zimbabwe and South Africa, respectively, to around 30% in Ghana, Burkina Faso, Malawi and Zambia. Unmet need is estimated to be even higher among adolescent women; 67% of those who are not intending to be pregnant in the next two years are not using any form of contraceptive (Guttmacher Institute, 2010).

Table 6.1: Contraceptive use and unmet need in selected sub-Saharan African countries

	Percentage of married women using contraception		Percentage of women	
Country	**Any method**	**Modern methods**	**With an unplanned pregnancy**	**With an unmet need for family planning**
Burkina Faso	14	9	23	29
Ghana	17	14	40	34
Malawi	42	39	40	28
Nigeria	12	8	15	17
Madagascar	27	17	16	24
Zambia	34	23	40	27
Zimbabwe	60	58	33	13
Cameroon	26	13	22	20
South Africa	60	60	53	15

Source: Adapted from Population Reference Bureau (2008).

Close to half of young men and women reported in various Demographic and Health Surveys that they did not use a condom the last time they had higher-risk sex. However, non-use of condoms seems to be reported more by young women (see Table 6.3). On a positive note, the majority (65%) of Tanzanian women aged 20–49 expressed support for the teaching of condom use in schools (MEASURE DHS and Tanzania Bureau of Statistics, 2005).

6.1.3 Termination of Pregnancy

The Safe Motherhood Conference held in 1987 in Nairobi, Kenya, drew the world's attention to the fact that unsafe abortion causes approximately 13% of all maternal deaths and long-term sexual and reproductive ill-health (Starrs, 2006). It was partly because of this that the ICPD POA urged all governments and relevant intergovernmental and non-governmental organizations to deal with the health impact of unsafe abortion as a major public health concern, and to reduce the recourse to abortion through expanded and improved family planning services, without promoting abortion as a method of family planning.

More than 20 years after the Nairobi Conference and 15 years after the ICPD, unsafe abortion is a continuing pandemic in Africa. About 92% of women of childbearing age live under what may be termed restrictive abortion laws (see Table 6.2); abortion is still not permitted for any reason in 14 countries, and is allowed to save life of the mother in only nine. Even where it is permitted, requirements for one to have a legal abortion prevent many women especially the poor and illiterate from accessing the service. Not surprisingly, 23% of women seeking abortion in Uganda – where it is permitted only to save the life of the mother and for her mental and physical health – reportedly go to traditional providers or some do the procedure themselves.

Table 6.2: The status of abortion in selected African countries

Country	Life	Health	Mental	Rape	Defect	Social	Demand	As of
Angola	1	N	N	N	N	N	N	-
Benin	Y	Y	N	Y	Y	N	N	2007
Botswana	Y	Y	Y	Y	Y	N	N	2007
Burundi	Y	Y	N	N	N	N	N	2007
Cameroon	Y	Y	N	Y	N	N	N	2007
CAR	Y	N	N	N	N	N	N	2007
Zambia	Y	Y	Y	Y	Y	Y	N	2007
Ivory Coast	Y	N	N	N	N	N	N	2007
Gambia	Y	Y	Y	N	N	N	N	2007
Lesotho	Y	N	N	N	N	N	N	2007
Malawi	R	N	N	N	N	N	N	2007
Zimbabwe	Y	Y	N	Y	Y	N	N	2007
Namibia	Y	Y	Y	Y	Y	N	N	2007
Kenya	R	R	R	N	N	N	N	2010
Swaziland	Y	Y	Y	Y	Y	N	N	2007
Senegal	Y	N	N	N	N	N	N	2007
Uganda	Y	Y	Y	N	N	N	N	-
South Africa	2	2	2	2	2	2	1	-

Source: Adapted from www.pregnantpause.org/lex/world02.jsp)

Key to table:

Life: To save life of the mother
Health: To preserve the physical health of the mother
Mental: To preserve the mental health of the mother
Rape: In cases of rape
Defect: When the unborn child has medical problems or defects
Demand: Available on demand, no reason to be given

Y: Legal for this reason
N: Not legal for this reason
1: Legal but only in the first trimester (three months) of pregnancy (exact times vary)
2: Legal, but only in the first two trimesters (six months) of pregnancy (exact times vary)
R: Generally legal but with significant restrictions

Adolescents and young people live in contexts where premarital sexuality is heavily sanctioned. They are denied services and information (Pattman, 2007), and this exposes them to unplanned and unwanted pregnancy, and hence to abortion. For the young people, unplanned pregnancy can lead to anguish and distress. School pupils in Zimbabwe, writing freely about their concerns about life and growing up generally (Chikovore, 2004) wrote very tellingly about the anxiety they had about getting pregnant while in school. The girls were worried about how to tell parents, the violence and threats from the father, the possibility of the man responsible denying, and how to approach health service providers. They made it clear that they would consider abortion, although they worried too about the possibility of death. The young men, who equally feared making a girl pregnant, indicated they might support a girl to secure an abortion, if they did not run away or deny outright. The fact that mothers are blamed or even assaulted within families when a daughter gets pregnant (Chikovore et al., 2003) means that they may assist their daughters to secure abortion. Because women have limited control over household resources, or they want to help conceal a daughter's pregnancy, they may facilitate a clandestine abortion often under unsafe conditions.

Adolescents and young people live in contexts where premarital sexuality is heavily sanctioned, often meaning that are denied services and information, which exposes them to unplanned and unwanted pregnancy, and hence to abortion.

The circumstances leading one to chose to terminate a pregnancy point to a need to relax abortion laws, as a starting point, in addition to making contraception information and services available, and promoting communication and the involvement of men. On the legal front, South Africa has spearheaded the relaxation of abortion laws on the continent, by making abortion available on demand, with only some limitations around the stage of a pregnancy. However, beyond permissive legal contexts, campaigns for norm changes and more targeted efforts at involving men in sexual and reproductive health and rights are required.

6.1.4 Adolescents' and Young People's Reproductive Health

According to the ICPD POA, information and services should help adolescents understand their sexuality and protect them from unwanted pregnancy, STI/HIV and risks of early fertility. Moreover, young men must be educated to respect women's self-determination. Several countries have signalled their commitment to adolescent reproductive health by establishing Commissions, (e.g., Ghana, Tanzania and Uganda) or Committees (e.g., Cameroon) on HIV and AIDS (UNECA, 2009) in addition to having strong civil society engagement. Kenya has an operational National Policy on Adolescent Reproductive Health and Development, ratified in 2004, with a plan of action adopted in 2005.

A potential threat to the ability of young people to exercise and enjoy reproductive health and reproductive rights is the population increase, particularly the growing numbers of young people. This puts pressure on resources including jobs and amenities. At the same time, many young people prefer to live and work in the cities, but end up being, in some respects, worse off than they would be in rural settings. The anonymous living characteristics of urban settings makes it easier for men to evade responsibility for pregnancy and for caring for their children who are not co-resident (Richter et al., 2010). It is important for policy to be aware of these dynamics, and especially of the differences in ability to exercise rights and to access services, not just between urban and rural but also within urban settings.

6.1.5 HIV Prevalence and Knowledge

Unprotected sexual activity – the non-use or inconsistent use of condoms – is young people's primary risk for HIV infection.

Unprotected sexual activity – the non-use or inconsistent use of condoms – is young people's primary risk for HIV infection. Young people have unprotected sex for many reasons, including rape and sexual abuse, poor information, lack of access to services, and peer influence. Young women are more vulnerable to HIV infection than are young men for biological reasons, sexual liaisons with older men (see Section 3 of this report), forced and early marriage, and transactional sex. As a result, young people account for more than half of all new HIV infections in sub-Saharan Africa, where more than 75% of the world's HIV-infected youth live (UNAIDS, 2008). Table 6.3 shows the prevalence of HIV in young people aged 15–24 years. A consistent feature of the HIV and AIDS pandemic is the high prevalence among young women compared with their male counterparts. The table shows that young women are two to five times more likely to be HIV infected than their male counterparts.

Knowledge about HIV and AIDS is still relatively low: In some countries less than half of young people have comprehensive knowledge of HIV and AIDS. In many instances, knowledge about HIV and AIDS seems to be less among young women compared with young men (Table 6.3).

Table 6.3: HIV prevalence, HIV knowledge and condom use in young people age 15-24 in selected countries

Country	HIV Prevalence in young people (aged 15-24 2007)		% who have comprehensive knowledge of HIV, 2002-2007		% who used condom at last higher-risk sex, 2002-2007	
	Male	Female	Male	Female	Male	Female
Zambia	3.6	11.3	37	34	48	38
Chad	2.0	2.8	20	8	25	17
Congo	0.8	2.3	35	26	36	16
Côte d'Ivoire	0.8	2.4	28	18	53	19
Uganda	1.3	3.9	38	32	55	38
Malawi	2.4	8.4	42	42	58	40
Zimbabwe	2.9	7.7	46	44	68	42
Lesotho	5.9	14.9	18	26	53	53
Ethiopia	0.5	1.5	33	20	50	28
Benin	0.9	0.3	35	16	45	28
Namibia	3.4	10.3	62	65	81	64

Source: Adapted from UNECA (2009).

6.1.6 Childbearing

One of the goals of the ICPD POA was to substantially reduce adolescent childbearing. However, in many sub-Saharan African countries more than 20% of young women report that they have been pregnant (Table 6.4).

Table 6.4 Prevalence of teenage pregnancy and child-bearing in selected countries

Country	Percentage of young people pregnant or have had a child
Côte d'Ivoire	31
Liberia	32
Guinea	32
Mali	36
Niger	39
Malawi	34
Mozambique	41
Zambia	32
Central African Republic	36
Burkina Faso	23
Ghana	14
Nigeria	25
Cameroon	28
Zimbabwe	21
Madagascar	34
South Africa	16
Chad	37
Gabon	33

Source: Adapted from Population Reference Bureau (2008).

6.1.7 Male Involvement

As guardians and as partners, men influence family formation, abortion, and adolescents' and young peoples' sexual and reproductive health and rights. Many women embark on clandestine contraceptive use because they fear discussing this subject with their husbands. The husbands may indeed be negative about contraceptive use (Chikovore et al, 2002), or women may wrongfully think their husbands are opposed without communicating with them (Toure, 1996; Castle et al., 1999). Clandestine contraceptive use or the non-use of contraceptives may result in unwanted pregnancy and hence abortion.

Many women embark on clandestine contraceptive use because they fear discussing this subject with their husbands.

Men may have a more direct influence on abortion, however, according to their role and the way they react or are likely to react: as fathers when a daughter becomes pregnant, as a husband

when a wife becomes pregnant from what is believed to be illicit sexual activity, and as partners when they deny responsibility for a pregnancy (Chikovore et al., 2003). Men's behaviour and role during pregnancy may also have an influence on the mental and physical health of the mother (Greene et al., n.d.).

6.2 Challenges, Emerging Issues and Way Forward

Clearly, many challenges continue to confront the actualization of the ICPD's goals of reproductive health and rights for all. Challenges and other emerging issues revolve around the following:

- ***Human resources:*** Health human resources constitute a crucial area in terms of supporting the movement towards achieving the ICPD goals. Attitudes of staff towards contentious issues of unmarried people's sexual and reproductive health and abortion are also critical to address. Similarly, in order to involve men in reproductive health, it is important that measures be put in place to help staff adjust towards embracing a subgroup that had all along been sidelined in service provision.

- ***Male involvement:*** The ICPD POA drive to involve men has not been matched by research to understand how exactly men can or should be involved. A key starting point would be a research agenda that focuses on understanding male perspectives on reproductive health and sexuality. In fact, an understanding of male perspectives has become even more crucial in light of the growing discourse illuminating the contradictions and crises in men's lives, including gender power. As Greene and colleagues point out:

  > Men's sexual and reproductive lives – and the impact of their choices on women and children – do not unfold in a vacuum. Rather, a wide range of societal and individual factors shapes, and often constrains, men's aspirations and behaviors as partners, husbands, fathers and sons. The broader context of men's lives is increasingly characterized by deepening poverty and by rapid social, cultural and economic change. (Greene et al., n.d.: 14)

  Some of the changes occurring in contemporary society may motivate risky behaviour in men, including violence, drug and alcohol abuse, and other forms of self-destructive behaviour, which in turn affect their partners. Ultimately, it is necessary for programmes to understand and deal with relational dynamics and the contexts of men's lives, and not simply focus on teaching men or delivering services (Green et al., n.d.; Chikovore et al., 2002). Such a focus would also emphasize the fact that there are multiple masculinities and different men, therefore providing scope to promote positive forms of masculinity (Greene et al., n.d.).

  Programmes must understand and deal with relational dynamics and the contexts of men's lives, and not simply focus on teaching men or delivering services.

- ***The role of leaders:*** Sexual and reproductive health rights are often misunderstood or misinterpreted by many African leaders. For example, the East African Community (EAC) Council of Health Ministers in March 2008 reportedly refused to sign the EAC Sexual and Reproductive Health and Rights strategy as they felt the rights language would promote homosexuality in the sub-region (Oronje, n.d.). The continued persecution of people who engage in same-sex sexuality in many countries in Africa is a major stumbling block to the realization of reproductive rights on the continent.

- ***Adolescents and young people:*** Several countries have taken steps to implement life skills or sexuality education. Policies and programmes are increasingly being put in place to ensure young people can access services. Even so, young people still have limited

knowledge about HIV, in addition to failing to access services for sexual and reproductive health. Young people still harbour anxieties about approaching service providers for service and information, while service providers also discourage or deny young people seeking services. There is need to understand why limited progress is being made in respect of providing services to young people, and the role of different stakeholders in this. Thus, whilst governments may signal commitment by putting appropriate policies and legal instruments in place, they must go a step further and act as catalysts for a dialogue around the reproductive health and rights situation of young people. The dialogue ought to address the contexts in which young people and adolescents live, and the role of different actors in hampering progress towards meeting young peoples' needs. Given also that many young people drop out of school, it is important to ensure that adequate steps be taken to reach out-of-school youth with life skills education.

7. Health, Morbidity and Mortality

The multidimensional nature of health, and its impacts on the population, mean that good health plays a pivotal role in poverty reduction and development. Therefore, reducing the burden of disease will directly release the potential of people and countries to increase production and productivity, and thus achieve higher economic growth rates as well as improved human and social development (African Union, 2009). The ICPD POA stipulated four themes that required the action of governments to improve the health of their citizens:

- Improvement of primary health care and the health care sector;
- Child survival and health;.
- Women's health and safe motherhood; and
- HIV and AIDS.

These actions relate directly to three of the eight MDGs: MDG 4 (reduction of child mortality); MDG 5 (improvement of maternal health), and MDG 6 (combating HIV/AIDS and malaria).

7.1 Africa's Progress towards the Implementation of the ICPD POA

"Reversing the trends" has become a by-word for many national health sector strategies as countries struggle to meet ICPD and MDG commitments in the face of increasing disease burdens and limited financial and human resources.

Inadequate services, low coverage of available programmes and low numbers of skilled health personnel are responsible for the poor performance of countries towards realizing the ICPD agenda and the health-related MDGs.

7.1.1 Commitment

African countries and the African Union have, in the recent past, adopted several strategies with the aim of improving the health status of people in the Africa region and achieving the objectives of the ICPD POA and the MDG targets. These strategies include:

- Africa Health Strategy: 2007–2015.
- Plan of Action on Violence Prevention in Africa, 2007.
- The Maputo Plan of Action on Sexual and Reproductive Health and Rights, 2006.
- Continental Policy Framework on Sexual and Reproductive Health and Rights, 2005.
- The OAU Bamako Declaration "Vision 2010" on Reduction of Maternal and Neo-Natal Mortality, 2001.

7.1.2 Trends in Health Indicators

Health indicators considered here range from primary health care to infant and child survival and health, including under-five mortality and child immunization. Other issues are women's health and safe motherhood, HIV and AIDS, tuberculosis and malaria, and emerging issues such as non-communicable diseases.

Primary Health Care

Primary health care (PHC) was adopted as the key approach to providing and improving access to various health care services for all following the Alma Ata Conference on primary health care in 1978. The conference specified the key elements of primary health care as health education; sanitation; maternal and child health programmes, including immunization and family planning; prevention of endemic diseases, appropriate treatment of common diseases and injuries; provision of essential drugs; promotion of sound nutrition; and

traditional medicine (United Nations Economic and Social Council, 2010). Singh (2006) observes that in developing regions including Africa (North Africa and sub-Saharan Africa), health systems are generally too weak to support MDG initiatives, and the attainment of sustainable health improvements is dependent on strengthening health systems as a priority.

For most countries, the challenge to deliver on the prevention, detection and treatment of health problems is lack of adequate services, low coverage of available programmes and low numbers of skilled health personnel. The weaknesses are responsible for poor performance of countries towards realizing the ICPD agenda and the health-related MDGs specifically. Currently, the MDGs are perceived as providing the opportunity for African countries to work towards sustainable improvements in health for all, especially for the poor who tend to be excluded by conventional efforts.

Governments are also constrained in providing basic health-care services that are sustainable financially. The political will towards providing support to African countries for addressing public health problems is varied. Interventions for the fight against HIV and AIDS, malaria and tuberculosis have received substantial support from the Global Fund and other bilateral sources of assistance. Similarly, there has been improvement in donor funding to maternal and child health programmes since 2000 (Ruiz-Austria, 2009). But poor integration of programmes within functional institutional frameworks prevents progress in the provision of services on the basis of continuity, and this is true for maternal care.

Infant and Child Survival and Health

One of the most important reflections of a population's health status and general social development is the number of children who die within the first year of life. The ICPD POA identified the following specific targets with regard to child health and survival:

- Countries should strive to reduce their infant and under-5 mortality rates by one-third, or to 50–70 per 1,000 live births, whichever is less, by the year 2000.
- By 2005, countries with intermediate levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-5 mortality rate below 60 deaths per 1,000.
- By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000. Countries with indigenous people should achieve infant and under-5 mortality rates among their indigenous people that are the same as those of the general population.

These goals are complemented by MDG 4, which targets reducing child mortality by two-thirds, from 93 deaths per 1,000 children in 1990 to 31 per 1,000 children in 2015.

Infant Mortality Rate

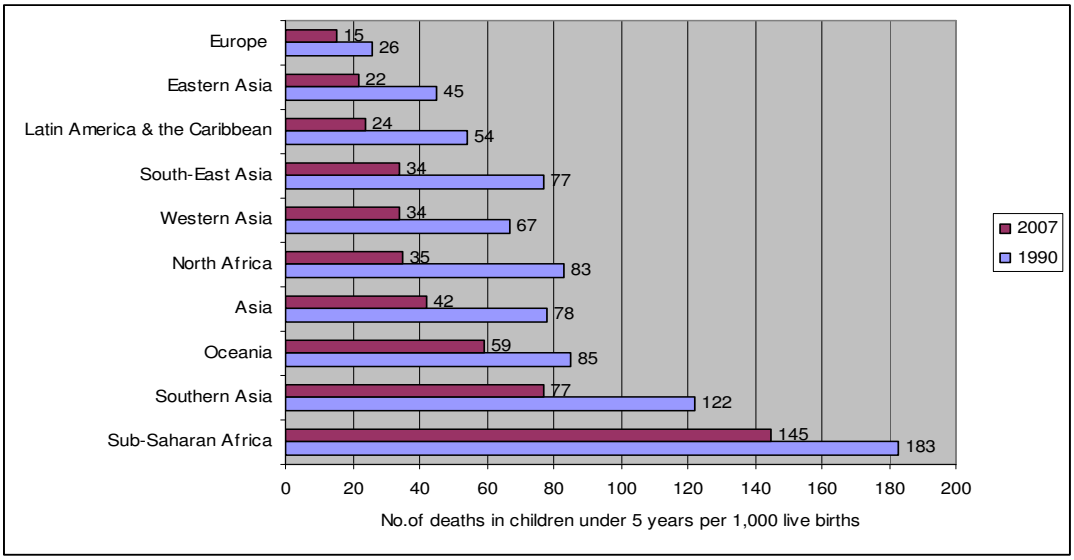
Despite the emphasis, the survival of newborn babies and children less than one year old remains a public health problem for African countries. Using 2006 data, the United Nations Children's Fund (UNICEF) showed that four of the five countries with the highest rates of infant mortality in the world were in sub-Saharan Africa. These were: Sierra Leone, with 270 deaths per 1,000 live births; Angola with 260; Niger with 253; and Liberia with 235. This is in stark contrast with rates in developed countries, such as Sweden and Iceland, which are among the countries with the lowest mortality rates – 3 deaths per 1,000 live births.

The majority of infant deaths have been due to infectious diseases, malnutrition, and neo-natal and pregnancy-related conditions. Increased rates of disease are related to easily preventable and treatable conditions such as disruption of health services, the impact of HIV (despite PMTCT programmes), poor food security, deterioration of infrastructure, and population displacement (Mason, 2008).

Under-Five Mortality

As in the rest of the world, under-5 mortality in sub-Saharan Africa has declined over the last few years, from 183 deaths per 1,000 live births in 1990, to 145 in 2007. These levels, however, remain the highest in the world (Figure 7.1), and according to the United Nations (2009), sub-Saharan Africa now accounts for half of all deaths among children below five years of age globally.

Figure 7.1: Under-5 mortality rate per 1,000 live births, worldwide, 1990–2007



Source: Adapted from United Nations (2009).

Gloomy as the foregoing may be, intensified efforts hold promise (United Nations, 2009). Available evidence shows that in many countries of the region several child survival interventions are being implemented and scaled up and that these are expected to yield further declines in under-5 mortality over the next few years. These interventions include immunizations, wide coverage with ART for PMTCT, micronutrient supplements, insecticide treated bed nets for preventing malaria, and support for mothers for enhanced family care and breastfeeding.

Child Immunization

Immunization against common childhood diseases dramatically reduces morbidity and mortality among children. Thus another indicator of progress in the achievement of MDG 4 is the proportion of one-year-old children who have been immunized against measles. In 2000, this proportion was estimated at 55% for sub-Saharan Africa. By 2007, it was estimated to have increased to 73%, and according to the United Nations (2009), sub-Saharan Africa had the largest reduction in measles deaths between 2000 and 2007.

This progress has been attributed to a combination of improved routine immunization coverage and the provision of a second opportunity for immunization. In South Africa, for example, the Expanded Programme for Immunization has been one of the most successful of the government's commitments to improving children's health, having increased immunization coverage from 63% in 1998 to 84.5% in 2007.

Women's Health and Safe Motherhood

The ICDP POA document called for a reduction in maternal mortality by one-half of the 1990 levels by the year 2000 and a further half by 2015. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by 2015 a rate below 60 per 100,000. Countries with the highest

levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a rate of below 75 per 100,000. Overall, all countries were expected to reduce maternal morbidity and mortality to levels that no longer constitute a public health problem.

Available evidence indicates that sub-Saharan Africa has made little or no progress in terms of reducing maternal mortality: 920 maternal deaths per 100,000 births in 1990 compared with 900 in 2005 (United Nations, 2009). In all, 20 countries in the region have maternal mortality ratios in excess of 1,000 per 100,000 births, and two (Sierra Leone and Rwanda) have ratios above 2,000 Except for Seychelles, Mauritius, Cape Verde, South Africa, Namibia and Mozambique, many other countries have figures above 500. The annual rate of reduction in the region is estimated at 0.1%, making sub-Saharan Africa the region with the slowest reduction rate globally. The African Union (2006) observed that the targeted 85% coverage of births attended by skilled health providers will not be attained by 2015.

The causes of high maternal deaths in sub-Saharan Africa are mainly risk conditions that are preventable. They range from individual factors such as the age at which women begin or stop childbearing, the interval between births, and the total number of lifetime pregnancies. In addition, the structural and economic circumstances in which women live also influence maternal morbidity and mortality. For example, inadequate health infrastructure, human resources constraints, poor access to antenatal care and family planning services, and weak referral systems point to the general weaknesses in most African countries' health systems. Unsafe abortions, maternal sepsis and haemorrhage are important death risks. In sub-Saharan Africa, haemorrhage accounts for 34% of maternal deaths, with hypertension, HIV and AIDS, malaria, and infections also claiming mothers' lives. Pregnant women are at risk of malaria and the associated anaemia that leads to maternal and infant deaths in the endemic regions, most of which are in Africa.

Many causes of the high maternal death rates in sub-Saharan Africa are preventable, including lack of access to health facilities, lack of skilled attendance at delivery, early or late childbearing, the interval between births, and the total number of lifetime pregnancies.

Efforts to increase demand for and provision of reproductive health services in a cost- effective manner will improve the health of women and reduce the proportion of the burden of disease related to maternal morbidity and mortality. Just one of the efforts to link maternal health to development and to provide an evidence base for policy was a major research project funded by the William and Flora Hewlett Foundation and conducted by the African Economic Research Consortium (AERC). The research explored the relationships among reproductive health, economic growth and poverty reduction in sub-Saharan Africa, emphasizing increasing demand and providing cost-effective delivery of reproductive health services. A series of framework papers set out the analytical methodologies (Mwabu and Ajakaiye, 2010), and individual country case studies investigated specific issues in Bénin, Botswana, Cameroon, Congo, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, Mauritius, Mozambique, Nigeria, Senegal, Togo, Uganda and Zambia (refer to AERC, 2010).

HIV and AIDS

The ICPD POA had three main objectives regarding HIV and AIDS:

- To prevent, reduce the spread of and minimize the impact of HIV; to increase awareness of the disastrous consequences of HIV and AIDS and associated fatal diseases; to address the social, economic, gender and racial inequities that increase vulnerability to the disease.
- To ensure that HIV-infected individuals have adequate medical care and are not discriminated against.

- To intensify research on methods to control the HIV and AIDS pandemic and to find an effective treatment for the disease.

To achieve these objectives, the POA urged governments to adopt a multisector approach and to give high priority to information, education and communication (IEC) campaigns in programmes intended to reduce the spread of HIV infection by raising awareness and emphasizing behavioural change.

Since the ICPD, Africa's response to HIV and AIDS – through regional commitments and national policies and programmes – has been decisive and comprehensive. At the regional level, demonstrations of political will among the leadership to address the pandemic and other priority diseases include the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2003) and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001).

To enhance partnerships, coordination of efforts by different role players and use of international support, most of the countries in the region have also implemented at least one of the "Three-Ones" principles: "one overall national authority with a broad-based multi-sector mandate to lead and coordinate the entire response; one agreed HIV and AIDS Action Framework that drives alignment of all partners; and one agreed country-level Monitoring and Evaluation (M&E) system" (UNAIDS, 2007).

There has also been a rapid scaling-up of antiretroviral therapy (ART) in sub-Saharan Africa in general, and the change from having virtually no ART available to reaching more than a quarter of the population in need of ART in less than a decade has produced significant public health benefits (WHO/UNAIDS/UNICEF, 2009). By December 2008 it was estimated that 44% of adults and children (nearly 3 million people) in need of ART in the region were receiving the services. This is compared with five years earlier when the regional treatment coverage was estimated at only 2% (UNAIDS, 2009). The concern, however, is the disparity between adults and children in terms of treatment coverage. Currently, treatment services reach 44% of adults, compared with 35% of children (WHO/UNAIDS/UNICEF, 2009).

Largely as a result of the these and other commitments there is increased level of effort, resources and political commitment to address HIV and AIDS comprehensively. As a result, the 2009 statistics indicate that HIV infection rates in sub-Saharan Africa have stabilized. Some of the positive trends include the increased proportion of pregnant women in the region who received HIV testing, from 43% in 2008 to 51% in 2009 (WHO/UNAIDS/UNICEF, 2009); and increased coverage of HIV infected pregnant women receiving ART for the prevention of mother-to-child HIV transmission (PMTCT) – from 8% in 2005, 21% in 2008 to 24% in 2009. Nonetheless, most of the countries were not "on track"; that is, they had not covered 48% of HIV-positive pregnant women by 2006 (Bryce et al., 2008).

Across Africa there is increased level of effort, resources and political commitment to address HIV and AIDS comprehensively.

Some of the development partners in the region indicate that countries need to be assisted to develop an evidence-based understanding of HIV and the structural determinants such as income inequality, human rights, gender inequality and migration, and this should complement the epidemiological information for which there has been support to generate up-to-date country-specific data

Two main strategies are in place through which the international community catalyses sub-Saharan countries' efforts to expand access to HIV treatment beyond treating opportunistic infections. The first is the "3 by 5" initiative launched by WHO in 2003. The goal was to achieve ART coverage for 3 million people in lower- and middle-income countries by 2005.

This initiative led to governments' prioritizing the scaling-up of HIV treatment by expanding health care infrastructure and mobilizing communities to support this change of course in the fight against HIV and AIDS. For example, there was clear political commitment towards promoting HIV testing and counselling. Although the "3 by 5" goal was not attained within the specified period, the initiative is generally seen as having increased political commitment to the disease.

The second initiative, which overlapped with the "3 by 5", is the "All by 2010", which has the goal to work towards achieving universal access to HIV/AIDS prevention, treatment and care services by 2010. This goal has become part of MDG 6 (set for 2015) with countries targeting midterm coverage of 80%. Clearly, the "All by 2010" is an overly ambitious goal given the current resource constraints globally, but in the same way that "3 by 5" stimulated change, this new global commitment intends to expand efforts to develop and implement cost-effective interventions for providing services that are equitable, accessible, comprehensive and sustainable in the long term. Some of the key improvements in this regard include clinical monitoring of the CD4 count and development of treatment guidelines recommending that treatment be made available to people with HIV if their CD4 count is at 350 cells/mm^3 (WHO, 2009).

Challenges remain, however; they include:

- Poor health literacy about HIV and related interventions such as CD4 count monitoring, PMTCT, HIV drug regimens, breastfeeding by HIV-positive mothers.
- The high number of children who lost parents to AIDS-related deaths means that policy makers should develop long-term, multisector approaches to addressing the situation of orphans and vulnerable children.
- The link between HIV, maternal health and child survival in the region suggests the need to increase raising awareness about the availability of antenatal care and postnatal services for people living with HIV and their children. The services should be family-focused and should include providing information, education and HIV prevention services to adolescents, as well as address the poverty situation of many people affected by HIV.
- Some of the development partners are concerned about slow progress by governments to mainstream HIV/AIDS into national development and population plans, which in most cases are developed without the participation of the stakeholders of the HIV/AIDS sector.
- The narrow focus of HIV/AIDS plans developed by non-health sectors is a challenge. Most non-health responses tend to concentrate on workplace activities and do not address the external aspects of the epidemic. Poor integration of HIV action plans into sectoral plans means that planning, implementation and budgeting run parallel and these are further complicated by lack of support from middle and top management.
- The problem of older people (aged over 50 years) who are aging with HIV or are at risk of HIV infection because they continue to be sexually active is a health, development and human rights issue that is still invisible in the policy agenda.

Tuberculosis and Malaria

The increasing AIDS-related morbidity and mortality in Africa is also partly due to the high rate of tuberculosis (TB), which kills more than a million people on the continent each year, and disproportionately affects the poor and other vulnerable groups, including women, children and the elderly. African Ministers of Health have recognized TB as a crisis that requires urgent and concerted efforts to curtail its spread and save the lives of people it has infected and affected. MDG 6 specifies: *Combat HIV/AIDS, malaria and other diseases*, and sets Target 6.C to *have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.*

The problem of TB has intensified in recent years with the increasing HIV-TB co-infection among people living with HIV. The major concern is the increasing prevalence of multi-drug

resistant TB, which affected 3% of newly infected and 19% of recurring infections in 2007 (United Nations Economic and Social Council, 2010)

Malaria is another major health problem in sub-Saharan Africa. Its highest toll is often noted in pregnant women and very young children in parts where malaria is endemic. In epidemic prone areas, where about 110 million Africans live, the disease tends to affect people of all ages. Malaria exerts high pressure on health services. For example, the disease accounts for at least a third of outpatients, and a quarter of admissions in endemic areas. It also poses a significant cost to workforce productivity. The African Union's Abuja Declaration on Roll Back Malaria (RBM) in Africa in 2000 is one example of the region's commitment to address malaria.

7.1.3 Emerging Health Issues

New health problems, mainly chronic and non-communicable diseases such as diabetes, cancers, hypertension and cardiovascular diseases, have introduced complicated health care needs that require responsive health care systems relevant for prevention, early diagnosis and management of chronic diseases. These features are lacking in most countries' primary health care systems as these systems were designed primarily to respond to acute illnesses. Other emerging health issues in the region include accidental childhood injuries, which have been one of the major causes of child death and disability in the last decade (WHO, 2008), child obesity, and road accidents.

7.2 Recommendations

Central to improving the health of populations on a sustainable basis is the principle of continuum of care. It should be adopted to address the gap in the provision of postnatal services to mothers and newborn babies and children, as well as to adolescents and pregnant women to ensure life-cycle and spatial continuity. A number of strategies are identified as effective in reducing maternal and child death simultaneously. They include strengthening both scheduled and non-scheduled services, home visits and referral services. For example, linkages of services between different levels of care and across home and facility are critical. Critical also to the element of continuum of care is the availability of services for which women are referred. The Child Healthcare Problem Identification Programme in South Africa has gone a long way in identifying the risk factors and causes of child and maternal death by systematically micro analysing (based on the death of each child) the quality of care provided across the various spheres of care – home, clinic, hospital ward – and by various categories of health care providers (Patrick and Stephen, 2005). Other strategies include:

- Strengthening primary health care services as a basis for a district health system, to be responsive to disease prevention and also meet the treatment needs of the growing population with chronic illnesses (both communicable and non-communicable diseases), that is, in addition to acute illnesses.
- Expanding the pool of trained health workers and devising appropriate retention strategies.
- Scaling up and integrating fragmented interventions and ensuring access by the poor and marginalized groups to working interventions. Integration of programmes is critical since in most cases, programmes tend to be oriented towards specific diseases and not comprehensive.
- For governments and their development partners, improving newborn care, and intensifying postnatal care by integrating home- and facility-based health care through referrals.
- Integrating the management of childhood diseases to include causes of death among newborns.

- Increasing the proportion of births attended by skilled health workers from the current 50%.
- Expanding HIV treatment for children younger than six months by adequately trained clinicians with the support of improved interventions including access to proper equipment and intensive care.
- Reviving and promoting community health workers and the home visit approach advocated by WHO/UNICEF as a strategy for preventing neonatal deaths, child abuse and neglect, and accidental child injury; promoting breastfeeding, reproductive health services and early child development, as well as providing support to caregivers.
- With the increased participation of women in the labour force, developing a supportive legislative environment to support women who opt for exclusive breastfeeding in the first six months of their babies' life.
- Increasing coverage of bednets to most population groups that need them, including making them part of maternal and child health programmes will be a cost-effective intervention for development.

Health systems play a critical role in the prevention and treatment of many health problems prevalent in the regions. However, there are specific challenges that governments and their development partners need to address apart from difficult access to services. They include the inability of Health Ministries to provide multisector programmes and full integration of existing services into programmes that are dovetailed to broader continental strategies on health and development. Providing interventions in a vertical manner without integrating services for women, children, adolescents, pregnant women, mothers and children as well as families remains a weakness. Consequently, implementation of programmes remains fragmented and the benefits of various multi-pronged strategies such as home visitations are not optimized for improved health outcomes and continuity of care.

8. Population Distribution, Migration and Urbanization

Migration of human populations is generally recognized as an integral part of the process of socio-economic development. It ensures the mobility of labour and its associated human capital between regions and occupations. In a competitive economy, migration serves as a market adjustment mechanism to bring factor markets in different geographical areas into equilibrium (Byerlee, 1972). The United Nations, the International Organization for Migration (IOM) and the International Labour Organization (ILO) estimate that the number of persons living outside their country of origin has reached 175 million, more than twice the number a generation ago.

Recognizing that the number of migrants worldwide was increasing and that the trend was likely to persist, the ICPD agreed that countries should aim at the following, with regard to population distribution and migration:

- To foster a more balanced spatial distribution of the population;
- To reduce the role of various push factors as they relate to migration flows;
- To enhance the management of urban agglomerations through more participatory and resource-conscious planning and management;
- To offer adequate protection and assistance to persons displaced within their country, and to find the root causes of displacement in view of preventing it and, when appropriate, to facilitate return or resettlement; and
- To put an end to all forms of forced migration.

8.1 Africa's Progress towards the Implementation of the ICPD POA

Important migratory movements, both voluntary and forced, have been part of Africa's experience throughout history and have contributed to the continent's contemporary demographic landscape (African Union, 2006b). Of the 150 million migrants in the world currently, more than 50 million are estimated to be Africans. The United Nations has estimated that over 16 million people in Africa are living in a country other than that of their birth. By the same token, the ILO has estimated that the number of labour migrants in the continent constituted one-fifth of the global total, and that by 2025 one in ten Africans will live and work outside their country of origin.

Throughout history migratory movements, both voluntary and forced, have been an important part of Africa's experience and have contributed to the continent's contemporary demographic landscape.

Some of the issues considered in this context are the emigration of trained professionals to other countries (brain drain) and the impact of funds sent home by people who have settled elsewhere (remittances). Other elements include forced migration and refugees, economic migrants, human trafficking, and internally displaced persons. Urbanization is also a significant concern, with both positive and negative aspects. Migration from rural to urban areas has particularly been the essential mechanism for job opportunities, social mobility and income transfers in the region.

8.1.1 Commitment

Against this background, migration has been making its way steadily towards the top of the continental affairs agenda in recent years, especially and since the ICPD. For example, recognizing the importance of migration and its consequences, a seminar on intra-African migration was held in Cairo in 1995. Participating African Heads of State and Government

made several recommendations on the legal, political, social and administrative aspects of African migration. Their recommendations were endorsed by the Organization of African Unity in 1996.

The major regional post-ICPD blueprint, however, is the Strategic Framework for Migration Policy in Africa (2006). The framework provides the guidelines and principles to assist African governments and the regional economic communities (RECs) in the formulation of their own national and regional migration policies as well as their implementation in accordance with their own priorities and resources. Some of the key recommendations that the framework advances are to:

- Incorporate provisions from ILO Convention No. 97 and No. 143 and the *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* into national legislation.
- Strengthen national laws regulating migration, including through the creation of clear, transparent categories for admission and expulsion, and clear eligibility criteria for protection.
- Identify, to the maximum extent possible, measures to encourage and facilitate voluntary departure and return.
- Strengthen national and inter-state efforts to prevent persons from moving across boundaries for illegal purposes.
- Take steps to ensure that persons migrating internally have adequate access to basic services such as education, health and employment, especially in urban centres with rapidly growing populations of migrants from rural areas.

Other post-ICPD regional commitments to migration and urbanization issues include:

- *Social Policy Framework for Africa:* Endorsed by the African Union in 2009. Among other things this framework highlights the importance of migration in Africa and notes that "the question in Africa should no longer be whether migration is occurring or not, but rather how to manage migration effectively so as to enhance its positive and to reduce its negative impacts" (African Union, 2009: 23).
- *African Common Position on Migration and Development:* Contains a set of recommendation at national, continental and international levels aimed at addressing migration and development issues including migration and development; human resources and the brain drain; remittances; trade; migration and peace; security and stability; migration and human rights; gender; and access to social services.
- *The Maputo Decision on Promoting the Development of Sustainable Cities and Towns (2003):* Adopted by the African Union with the aim of committing its Member States to develop concrete action plans for dealing with the problem of rapid urbanization in Africa.
- The *Ouagadougou Action Plan to Combat Trafficking in Human Beings, Especially Women and Children (2006).* Urges all African countries to develop policies that will result in national plans for combating trafficking of women and children and encourages African countries to collaborate with international agencies in combating this scourge.
- *The 2008 Pact on Security, Stability and Development in the Great Lakes Region (the Great Lakes Pact).* Defines protection measures for IDPs for all causes and in all phases of displacement, and addresses some specific concerns from the experience of internal displacement in the Great Lakes Region, such as protection measures for pastoralists, host communities and families of mixed ethnic identity. Furthermore, it strengthens the legal basis for IDPs to claim their rights, including the rights to access to information, to be consulted about and to participate in decisions that affect their lives, and to receive humanitarian assistance (IMDC, 2010)
- The *Convention for the Protection and Assistance of Internally Displaced Persons in Africa (the Kampala Convention)*. Adopted by the African Union in 2009. This is the first regional instrument in the world to impose legal obligations on states to protect people from arbitrary displacement, to provide protection and assistance to IDPs during displacement.

Regional blocs have also made efforts to facilitate free movement between countries of their regions, with some of these efforts predating ICPD. For example, the Economic Community of West African States (ECOWAS) Treaty formulated in 1975 had an objective of abolishing all obstacles to free movement of people between member states and the goal of granting automatic community citizenship for all nationals of member states. More recently (2005), the Southern African Development Community (SADC) started its own process of integrating the sub-region through the *Protocol on the Facilitation of Movement of Persons*, which aims at easing movements within the community.

Overall, African governments acknowledge the importance of the movement of skilled personnel as an important component of regional cooperation, and the potential positive effects of migration on communities of origin and destination. Despite this and the regional commitment described above, Africa still faces a number of challenges related to migration.

8.1.2 Brain Drain

According to the IOM, Africa has already lost one-third of its human capital and is continuing to lose its skilled personnel at an increasing rate. It is estimated that 20,000 professionals have been leaving the continent annually since 1990, and that there are currently over 300,000 highly qualified Africans in the Diaspora. The impact on Africa's health sector is particularly severe. In effect, African countries are funding the education of their nationals only to see them end up contributing to the growth of developed countries with little or no return on the original investment. To some extent, however, some of the brain drain has been internal to Africa, with the Southern African sub-region being the biggest beneficiary. The flow to the south accelerated after the first South African democratic elections in 1994, and involved a range of people including professionals, business people and informal traders.

Brain drain essentially means that African countries are funding the education of their nationals only to see them end up contributing to the growth of developed countries with little or no return on the original investment.

8.1.3 Remittances

Remittances usually play a large role in connecting migrants with their home countries and in sustaining a number of developing countries. Households that receive these remittances tend to use them to boost consumption and to spend on children's education and family health (UNECA, 2006b). In 2004, remittances to Africa contributed as much as US$14 billion to the African economy, most of which (72%) went to North Africa. Generally, the Middle East is one of the biggest beneficiaries of remittances from the West, and has more than doubled its share recently (Sander and Maimbo 2003). Thus, despite the number of sub-Saharan African citizens in the Diaspora, the region benefits from only 15% of the remittance flow from developed to developing countries (Sander and Maimbo, 2003).

8.1.4 Forced Migration and Refugees

Since the beginning of the millennium Africa has seen a number of conflicts that have resulted in mass movements of people. Many of the refugees were fleeing the Great Lakes conflict and the civil war in Darfur, which resulted in about 2.5 million refugees being forced to leave their home countries. In the aftermath of the Rwandan massacre, 2.1 million refugees fled to neighbouring countries in the Central African region.

On a positive side, however, the 2009 Global Trends Report (UNHCR, 2010) showed that the number of refugees in sub-Saharan Africa continued to decline for the ninth consecutive year: At the end of 2009, there were fewer than 2.1 million refugees compared with more than 3.4 million in 2000. The refugee population then decreased by 1.5% between the start and end of 2009, primarily because of the naturalization of 155,000 Burundian refugees in the United Republic of Tanzania and the successful voluntary repatriation operations to the Democratic Republic of Congo (44,300), Southern Sudan (33,100), Burundi (32,400) and

Rwanda (20,600). Unfortunately, the UNHCR points out that renewed armed conflict and human rights violations in the DRC and Somalia led to new refugee outflows and the movement of 277,000 people primarily to the Republic of Congo (94,000) and Kenya (72,500).

8.1.5 Economic Migrants

In addition to forced migration resulting from political instability, there has been an emergence of a new phenomenon of "economic migrants" or "economic refugees". For example, the Southern African sub-region has seen mass emigration from Zimbabwe as a result of the economic crisis in that country into a number of neighbouring countries, with the biggest proportion heading for South Africa and Botswana. To the extent that economic migrants are not classified as refugees, many of them are vulnerable to constant harassment in host countries. There are, for example, often tensions between host communities and economic migrants, giving rise to social pathologies such as xenophobia and victimization. Indeed, it has been suggested that the flow of economic migrants to South Africa has prompted xenophobic sentiments in the country; in May 2008 about 62 people were reportedly killed in anti-foreigner attacks that spread throughout South Africa.

8.1.6 Human Trafficking

Human trafficking has been described as the illegal trade in human beings for the purposes of commercial sexual exploitation or forced labour: a modern-day form of slavery. A core element of trafficking is that victims are deprived of their will and forced into slavery-like conditions and involuntary servitude. Available evidence suggests that human trafficking is on the rise in sub-Saharan Africa. For example, a study by UNICEF (see Fleck, 2004) found that all 53 countries in the region reported some form of human trafficking, spurred by poverty, armed conflict and instability, as well as traditional practices such as early marriage.

Most victims of human trafficking are women and young girls, many of whom are forced into prostitution and other forms of sexual exploitation, but trafficked men end up working in commercial farms, mines and quarries, or in other dirty and dangerous working conditions.

According to the United Nations Office on Drugs and Crime, most victims of human trafficking are women and young girls, many of whom are forced into prostitution and other forms of sexual exploitation. Trafficked men end up working in commercial farms, mines and quarries, or in other dirty and dangerous working conditions. Boys and girls are trafficked into conditions of child labour, within a diverse group of industries, such as textiles, fishing or agriculture.

A number of sub-Saharan African countries have taken steps to tackle the problem. For example, in 2003 Nigeria set up the National Agency for the Prohibition of Traffic in Persons and Other Related Matters (NAPTIP) to address the scourge of trafficking in persons and its attendant human abuses (NAPTIP, 2010), and in 2006 the joint ECOWAS/ECCAS (Economic Community of Central African States) regional cooperation on human trafficking was signed by 26 countries in West and Central Africa. In South Africa the Prevention and Combating of Trafficking in Persons Bill was presented to parliament in March 2010 and is expected to be passed in due course.

Yet despite the foregoing, efforts to deal with this crime are hampered by the general paucity of data and lack of official statistics in many sub-Saharan African countries, which leaves the specific dimensions of the problem only dimly understood. Additionally, many African governments have yet to ratify the main international instruments outlawing the trade in humans (Fleck, 2004).

8.1.7 Internally Displaced Persons

Internally displaced persons (IDPs) are people who are forced to flee their homes to some other areas within the borders of their own countries. The main feature of internally displaced persons is coercion.

In 1995, significant displaced populations could be found in at least 14 sub-Saharan African countries. Four – Angola, Liberia, Sierra Leone and Sudan – each counted a million or more displaced persons (Sudan was in the lead with 4 million). Three – Mozambique, Rwanda and South Africa – each had about a half million IDPs. Four states – Burundi, Kenya, Somalia and DRC (at the time, Zaire) – counted 200,000 to 400,000 internally displaced. Smaller but significant numbers of persons were displaced in Ghana, Uganda, Nigeria and Algeria (Ayalew, 1999).

The Internal Displacement Monitoring Centre (IDMC) tracks forced internal movements in 21 African countries and in 2009 found that there were an estimated 11.6 million IDPs in these countries, representing more than 40% of the world's total IDP population. As in previous years, Sudan had Africa's largest internally displaced population at about 4.9 million, followed by DRC with 1.9 million and Somalia with 1.5 million.

According to the IDMC, internal displacement in 2009 resulted from ongoing internal armed conflict, generalized violence, human rights violations, and inter-communal tensions that flared up over limited natural resources, including between pastoralists and sedentary farmers, and over political, social and economic advantages. The highest number of new displacements in 2009 was reported in the DRC, with over 1 million new IDPs (the country's highest rate of new displacement since 2004), followed by Sudan with 530,000, Somalia with 400,000 and Ethiopia with an estimated 200,000. New displacements were also reported in CAR, Côte d'Ivoire, Kenya, Nigeria, Senegal and Zimbabwe.

Here again, despite the intentions shown by sub-Saharan African states in supporting the Great Lakes Pact and the Kampala Convention, durable solutions remained out of reach for many IDPs in the region. In particular IDPs' attempts to rebuild their lives remain blocked by the continuing absence of stability and food security, reconciliation between communities, and development and livelihood opportunities in areas of return. Also frequently absent are mechanisms to provide restitution or compensation for housing, land and property, and appropriate management of funds meant for returns, compensation and purchase of land (IDMC, 2010).

8.1.8 Urbanization

Urbanization – one of the domino effects of migration, particularly rural-urban migration – has historically been seen in a positive light as part of modernization, economic growth and development. Today's rapid urbanization, however, especially when the social and physical infrastructure of towns and cities is not being expanded to keep up with expanding influx of migrants, is generally seen as a major problem that is associated with unemployment, unsanitary conditions and strife. Many new city dwellers in the region become vulnerable to diseases like malaria, HIV and AIDS, and those associated with pollution, as well as to violence and exploitation. Thus the rapid urbanization in sub-Saharan Africa (estimated at 3.5% per annum) is a worrying trend given that it is happening without an accompanying process of industrialization. Serious problems related to the diminishing municipal revenue base, poor governance, and growing health and environmental crises also confront many African cities. The situation is exacerbated by the fact that most of the cities are unable to collect revenue from large sections of the residents (Cheru, 2010).

Empirical studies conducted on aspects of African urbanization highlight the dehumanizing impact on family life of the migrant labour system – a situation that often arises when a man

who is the head of the household works in an urban area, even in another country, leaving wives and children in the rural areas. Among other things, this system has had corrosive effects on kinship ties. Women have been forced to undertake the rearing of children alone, and many households lack the stabilizing influence of a father and are thus incapable of providing the support network that is the foundation of family stability (Bigombe and Khadiagala, 2003).

8.2 Recommendations

There is need to adopt and scale up the key tenets of the main migration-related regional instruments. Other areas that need special attention include the following:

- Reviewing the systems and policies that limit the volume of remittances and discourage their use for saving.
- Exploring the role of communication technology, especially mobile phones, which have penetrated the African continent recently, in facilitating easy flow of remittances into Africa. For example, Safaricom[8] in Kenya is already doing this between Kenya and the UK.
- Strengthening the involvement of the African Diaspora in the development issues of the continent.
- Encouraging and facilitating voluntary return of migrants who are outside the continent.
- Making specials efforts to combat xenophobia. Ratification of refugee conventions and passing of legislation are not enough. There is a need for a pan-African effort to provide government officials and the general public with education and attitudinal training on xenophobia and the rights of refugees. In addition, governments must be encouraged to establish multi-agency working groups to deal with issues of immigrants.
- Reviewing policies and practices of African governments that relate to dealing with undocumented migrants, with the aim of enforcing a culture of compliance with human rights.
- Making new efforts to combat international trafficking in and out of Africa.
- Developing policies to address the proliferation of informal settlements, urban slums and peri-urban areas and to effectively manage urban settlements.
- Building partnerships with urban dwellers to improve the management of cities.

[8] Safaricom is a provider of converged communication solutions in Kenya: www.safaricom.co.ke

9. Population, Development and Education

Education is one of the most powerful instruments for reducing poverty and inequality and for laying the foundation for sustained socio-economic development (African Union, 2009). It can help to reduce fertility, morbidity and mortality rates; empower women; improve the quality of the workforce; and promote genuine democracy (UNFPA, 2004). Education is thus a component of well-being and, at the same time, a factor in the development of human well-being through its links with demographic and socio-economic factors.

Education is one of the most powerful instruments for reducing poverty and inequality and for laying the foundation for sustained socio-economic development.

The ICPD POA outlined four main objectives with regard to the development of education for sustainable development:

- Achieving universal access to quality education, in particular to primary and technical education and job training;
- Combating illiteracy and eliminating gender disparities in educational opportunities and support;
- Promoting non-formal education for young people; and
- Introducing and improving the content of the curriculum so as to promote greater responsibility towards, and awareness of, the interrelationships between population and sustainable development; health issues including reproductive health, and gender equity.

In 1999, the United Nations General Assembly Special Session on ICPD+5 examined progress made in implementing the ICPD goals. This session developed a set of key actions for further implementation of the ICPD POA. Those related to education were to:

- Reduce the rate of illiteracy of women and men, at least halving it for women and girls by 2005, compared with the rate in 1990;
- Promote the achievement of functional literacy for adults as well as children in environments where schooling remains unavailable;
- Continue to give high priority in development budgets to investments in education and training; and
- Provide adequately equipped facilities by rehabilitating existing schools and building new ones.

The initial ICPD POA goals and the ICPD+5 Key Actions link very well with MDG 2 (achieve universal primary education), the target of which is to “ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling”. They are also relevant to MDG 3 (promote gender equality and empower women), which aims, among other things, to “eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels by 2015” (United Nations, 2005a).

9.1 Africa’s Progress towards the Implementation of the ICPD POA

Under consideration here are universal access to education, enrolment in primary education, early childhood education, tertiary and vocational training, and adult literacy. Expenditure on education is also assessed as the foundation of capacity to achieve the other aspects.

9.1.1 Commitment

African countries recognized the critical role of education as far back as 1962 when they committed themselves to “Education for all children by 1980” in the Addis Ababa

Declaration. Post ICPD, in 1996 the OAU at its 32nd Ordinary Session of the Assembly of Heads of States and Governments proclaimed 1997–2006 the Decade of Education in Africa. Four priority areas of attention for the Decade were outlined:

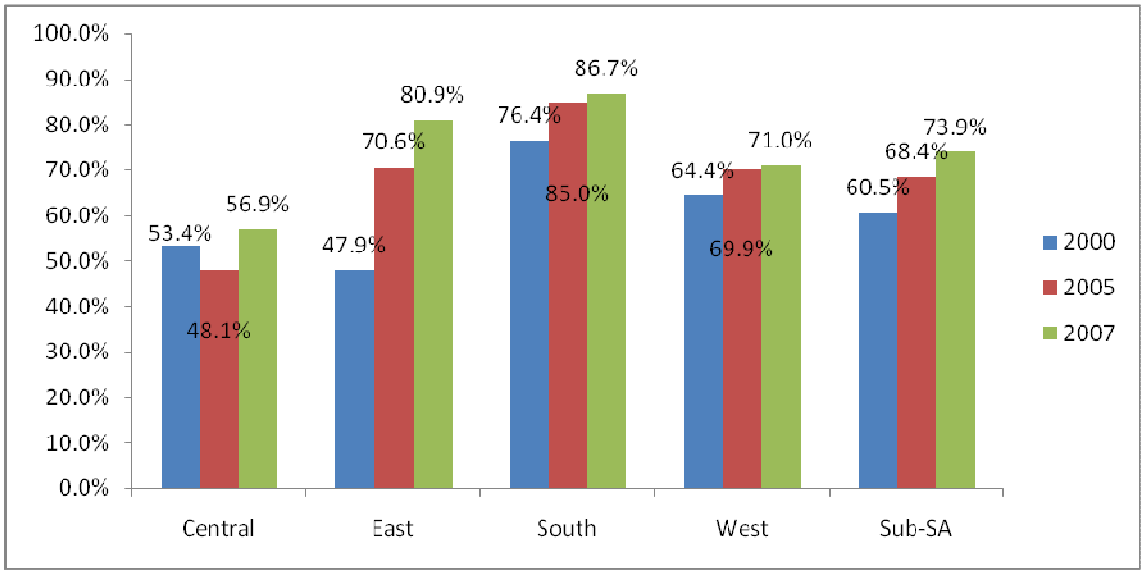
- Equity and access to basic education.
- Quality, relevance and effectiveness of education.
- Complementary learning modalities.
- Capacity building.

An evaluation of the Decade in 2006 revealed that most of the goals set in the Decade Plan of Action had not been achieved. The reasons cited included lack of investment and pervasive conflict, which affected 21 countries in the region during the decade, disrupting education systems and undermining progress. In consequence, a Plan of Action for the Second Decade of Education for Africa (2006–2015) was put in place. The new plan of action focuses on improving the quality of education on offer at all levels as well as making it more widely available.

9.1.2 Universal Access to Education

The ICPD goal on education emphasizes universal access to quality education, particularly primary education. It further stresses the elimination of gender disparities in educational opportunities and support as a critical indicator. Over the last ten years, there has been a gradual increase in primary school enrolment in sub-Saharan Africa, from 61% in 2000 to 68% in 2005 and 74% in 2007 (Figure 9.1).

Figure 9.1: Primary level net enrolment rates (%) by region, sub-Saharan Africa, 2000–2007



Source: World Bank (2010a).

Despite the overall regional progress, some sub-regions and countries are doing better than others and are better poised to meet the goal of universal access to primary education by the targeted date. Southern Africa particularly stands out in this regard, with an average 86.7% net enrolment at primary education in 2007, up from 76.4% in 2000. The country with the lowest rate of enrolment in the region, Lesotho, recorded 72% in 2007. At the other end of the spectrum Mauritius registered a near-universal primary education enrolment of 98.4% in 2007. East Africa is also doing remarkably well in terms of promoting access to primary education. More than two-thirds of children were enrolled in primary education in all countries of the sub region, barring civil strife-torn Eritrea at just 42.6%. Rwanda recorded 97.2% followed by Uganda with 95.4%. West Africa recorded a 71% enrolment rate at

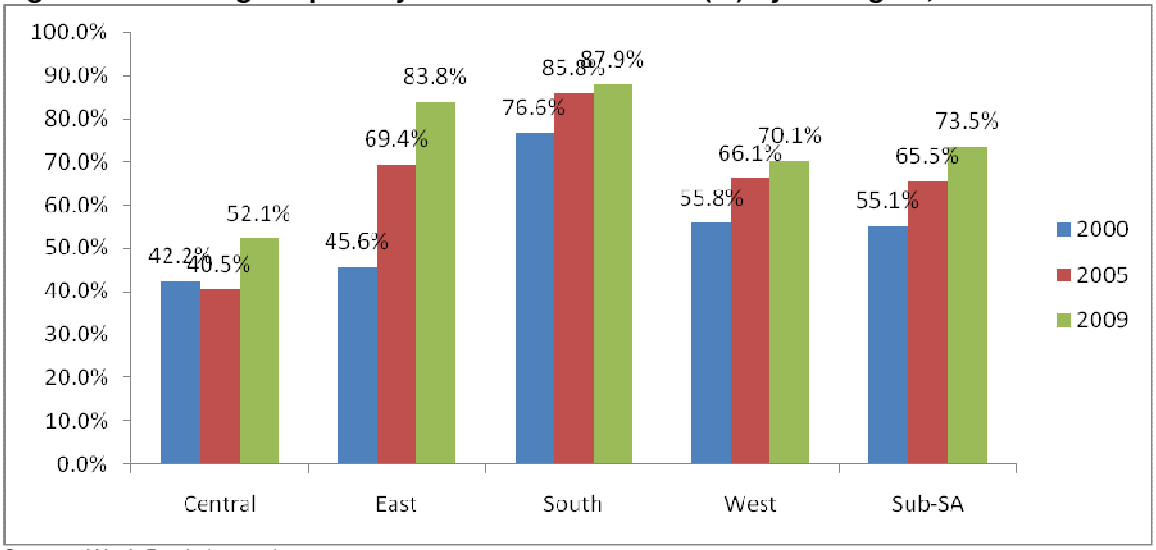
primary education level in 2007. This figure is 2% lower than the regional average of 73.9%. Overall, Central Africa as a sub-region has been the worst performer, with just over half of children enrolled in primary education in 2007.

Clearly emerging patterns are that island countries tend to record better enrolment rates than mainland countries, and countries immersed in or emerging from protracted conflicts have lower rates of enrolment or are unable to furnish the required data, making it difficult to monitor their progress. In a conflict situation the infrastructure often gets destroyed, thus making the provision of quality education a challenge. Moreover, during the war, children are moved from one place to another to avoid confrontations. This further hampers proper provision of educational services, including the lack of personnel, including teachers.

9.1.3 Enrolment in Primary Education

Analysis of World Bank (2010a) data on primary school enrolment in 2009 indicates that all regions in sub-Saharan Africa have seen a relative increase in the net enrolment rates of girls at primary education level. Overall, girls' enrolment rates increased by 18% between 2000 and 2009 (Figure 9.2).

Figure 9.2: Net girls' primary level enrolment rates (%) by subregion, 2000–2009



Source: Work Bank (2010a).

The highest enrolment rates (over 70% net enrolment for girls) have since 2005 been recorded in Southern Africa, where in 2009 the enrolment rate was 87.9%. Since 2005, Southern African countries have recorded more than 70% net enrolment for girls. The highest increase in the enrolment rates in the region took place in East Africa, where 45.6% of primary school age girls were attending school. This figure rose to 83.8% in 2009. Central Africa, on the other hand, recorded the lowest enrolment rates throughout the years under review. The sub-region's average enrolment rates were 42.2%, 40.5% and 52.1% in 2000, 2005 and 2009, respectively. This is an increase of less than 10% from 2000 to 2009. This figure is also lower than the average increase by more than 20% and it trails the highest enrolment figure in sub-Saharan Africa, Southern Africa, by more than a third.

All regions in sub-Saharan Africa have seen a relative increase in the net enrolment rates of girls at primary education level.

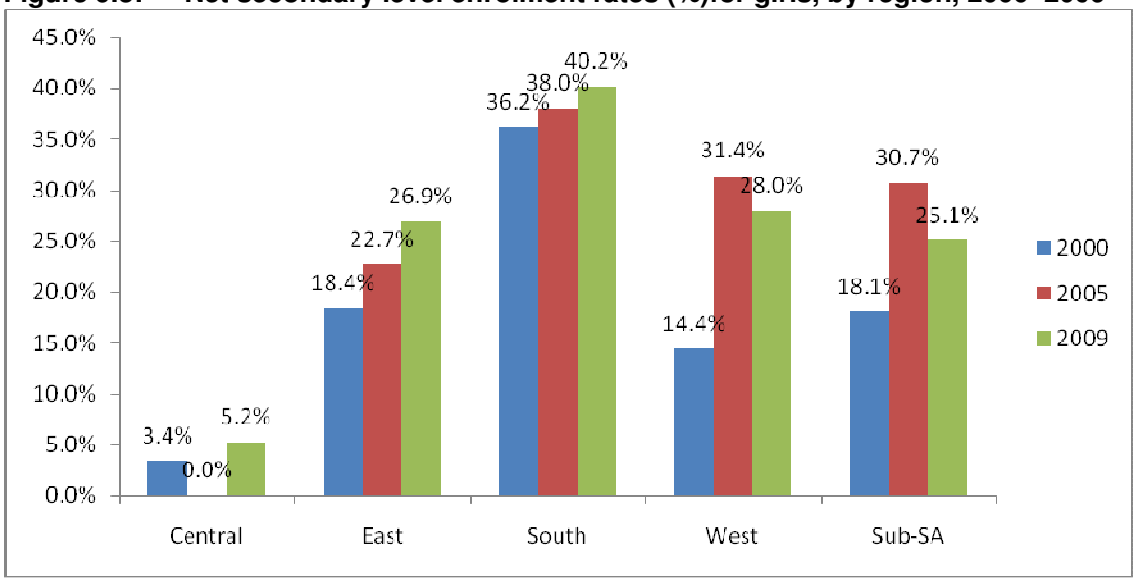
In West Africa some countries have registered more than 80% net enrolment, while some – particularly those engulfed in or emerging from unstable political environments – recorded sub-Saharan Africa's lowest enrolment for girls at the primary education level in 2009. Examples are Guinea-Bissau (43%), Niger (43%) and Côte d'Ivoire (49%).

Not discounting improvements in increasing access to girls, disparities between girls and boys persist in sub-Saharan Africa. In 2000, more of the region's boys than girls were enrolled for primary education, 65.6% and 55.1%, respectively. The situation remained unchanged in 2009 when 78.7% of boys and 73.5% of girls were enrolled in primary education. Significant improvement is seen in the decrease of the gap in enrolment rates between boys and girls: The gap in 2000 was about 9% and by 2009 it was 4%.

Differences between sub-regions are also pronounced. Since 2005, enrolment rates in Southern Africa have remained consistently higher for girls than boys with the gap increasing each year. When differences among countries are analysed, the gap is particularly huge in Malawi, where enrolment for girls and boys was 93.3% and 87.9%, respectively. Madagascar had a more equitable access to primary education, as both girls and boys recorded 98% enrolment rates. Mozambique, on the other hand, had more boys enrolled for primary education than girls, 82.4% and 77.3%, respectively.

Although progress has been made in increasing girls' enrolment in primary education, girls in many countries are much less likely than boys to attend secondary/high school and college or university. Only a quarter of girls were enrolled in secondary education in the region, 25.1% in 2009, down from 30.7% in 2005 (Figure 8.3). Southern African is doing relatively better than other regions, although enrolment is less than half of its girls' population. This is an increase of merely 4% since 2000. Mozambique recorded the lowest girls' enrolment rate in the sub-region, 5.9% in 2009. Mauritius had the highest enrolment figure of 80.9% for girls at the secondary level of education. While West Africa registered the second highest net enrolment for girls in secondary education, only one country (Cape Verde) had more than half (59.7%) of its girls enrolled.

Figure 9.3: Net secondary level enrolment rates (%)for girls, by region, 2000–2009



Source: World Bank (2010a) .

A number of factors explain the low enrolment for girls, For example, girls rather than boys are expected to perform household tasks in addition to their school work. Long distances to schools and lack of transport present a safety challenge to girls, and poor or missing sanitary facilities and teachers who discriminate against or sexually abuse girls also contribute to girls leaving school early.

It is widely recognized that access to education is only part of the solution. The completion of a full course of primary

School expenses, safety, distances to school and conducive learning environments, especially for girls, have a crucial role in maintaining school attendance and ensuring timely completion of the full education cycle.

schooling is necessary to achieve universal primary education. It is noted that while millions of children start school, large numbers eventually drop out (United Nations, 2009; Africafocus, 2010[9]) notes that factors like funds, safety, distance to school and a conducive learning environment, especially for girls, are crucial elements in maintaining school attendance and ensuring timely completion of the full education cycle.

But the shortage of teachers is a worrying factor as well. Many countries in sub-Saharan Africa do not have sufficient teachers. Likewise, there are insufficient school facilities and scholastic materials. This is a direct result of the structural adjustment programmes of the 1980s, which emphasized fiscal austerity at the expense of social services, mainly education, welfare and health. UNESCO (2010) estimates that in the region, 3.8 million teachers will have to be recruited by 2015 if the goal of primary education is to be realized.

9.1.4 Early Childhood Education

Early childhood learning including pre-primary schooling plays a catalyst role in facilitating primary and secondary school enrolment and retention. It is also important for offsetting social-, economic- and language-based disadvantages. A study by UNESCO finds that participation in pre-primary education has been increasing steadily, albeit from a low base (UNESCO, 2010). The study notes that in 2007 some 140 million children were enrolled in pre-primary programmes worldwide, up from 113 million in 1999. The gross enrolment ratio increased from 33% to 41% for the same period. The study further notes that sub-Saharan Africa is one of the regions that recorded the most pronounced increases. For example, in 2008 one in seven children was enrolled in early childhood programmes in the region, compared with one in three for all developing countries (UNESCO, 2010). However, a closer analysis of the regional data reveals differences in terms of coverage. Among countries for which data are available, 17 in sub-Saharan Africa had coverage rates of less than 10%.

The main barrier to pre-primary education is household poverty. Studies suggest that children born into a poor household carry a large handicap when it comes to early childhood care (UNESCO, 2010). Poverty makes access to pre-primary education difficult, especially where facilities are far from their homes. Most importantly, the service is not affordable by the majority, even when facilities are accessible.

9.1.5 Tertiary and Vocational Training

The fundamental purpose of technical and vocational education is to equip people with capabilities that can broaden their opportunities in life, and to prepare youth and young adults for transition from school to work. Technical and vocational education is offered through a bewildering array of institutional arrangements, public and private providers, and financing systems. The most common format is entry in middle school or upper secondary school, or through college courses combining general and vocational learning. Most courses at this level orient students towards labour markets, although some offer a route into tertiary or general education. While global participation in vocational education was around 16% in 2007, the sub-Saharan African region recorded a mere 6% (UNESCO, 2010: 79). The share of the technical and vocational education in secondary enrolment in the 17 sub-Saharan African countries with data was less than 5% for the same period.

Gender disparities in enrolment in vocational education are highly pronounced in sub-Saharan Africa. This is quite evident, for example, in the learnership/apprenticeship data for South Africa, which show a high enrolment by males. According to UNESCO (2010), while girls accounted for 44% of secondary education in the region in 2007, just 39% were in technical and vocational training. A critical point to consider is the type of training for which

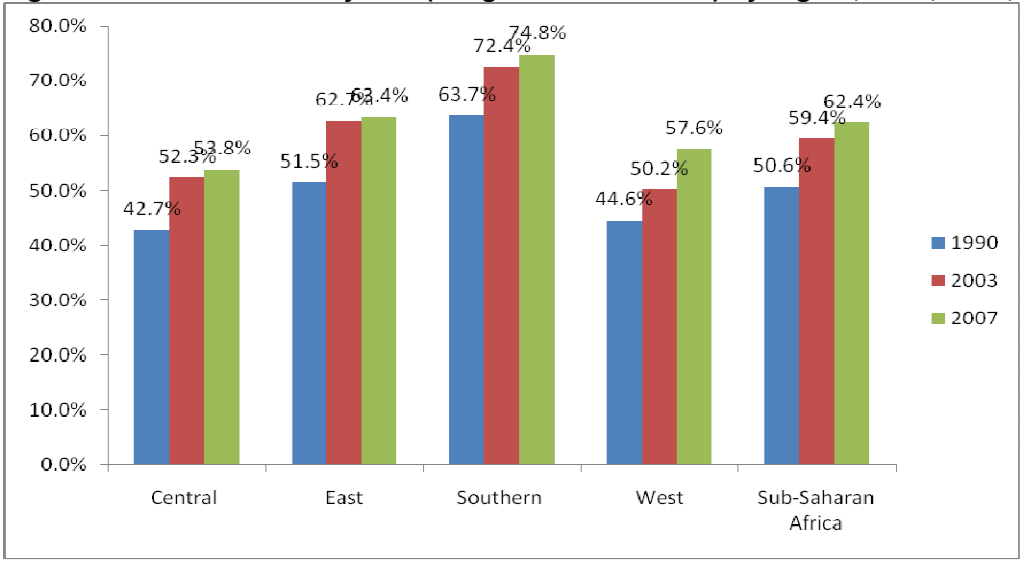
[9] AfricaFocus Bulletin. “Africa: Primary education pays off”. www.africafocus.org/educexp.php Accessed on 30 September 2010.

girls enrol. The temptation is to train girls for traditional "women's" occupations, which are often characterized by low pay. The lack of participation in vocational training by women is exacerbated by their very low rate of enrolment in secondary education. Therefore, strategies aimed at increasing girls' enrolment in technical and vocational education should simultaneously address access to secondary education.

9.1.6 Adult Literacy

Overall, sub-Saharan Africa has done relatively well in addressing the problem of literacy over the past decade. As Figure 9.4 shows, literacy rates increased from 50.6 in 2000 to 62.4 in 2009, an overall increase of more than 11% in just less than ten years.

Figure 9.4 Adult literacy rate (% aged 15 and above) by region, 2000, 2003, 2007



Source: UNDP (2009).

The highest literacy rate has been recorded in Southern Africa where more than three-quarters of the population is fully literate. In this region, Zimbabwe is the country with the highest literacy rate of 90%, followed by Botswana and South Africa with 88% apiece. The country with the lowest literacy rate is Mozambique at 44%.

Central Africa is the only region in which half of the population may not be able to read or write. The literacy rate is particularly lower in Chad, where less than a third of the population is literate. As with school enrolment, the problem may be attributed to conflicts in this country and the sub-region as a whole.

Countries mired in conflict, or those that have recently emerged from conflict, recorded the lowest literacy levels.

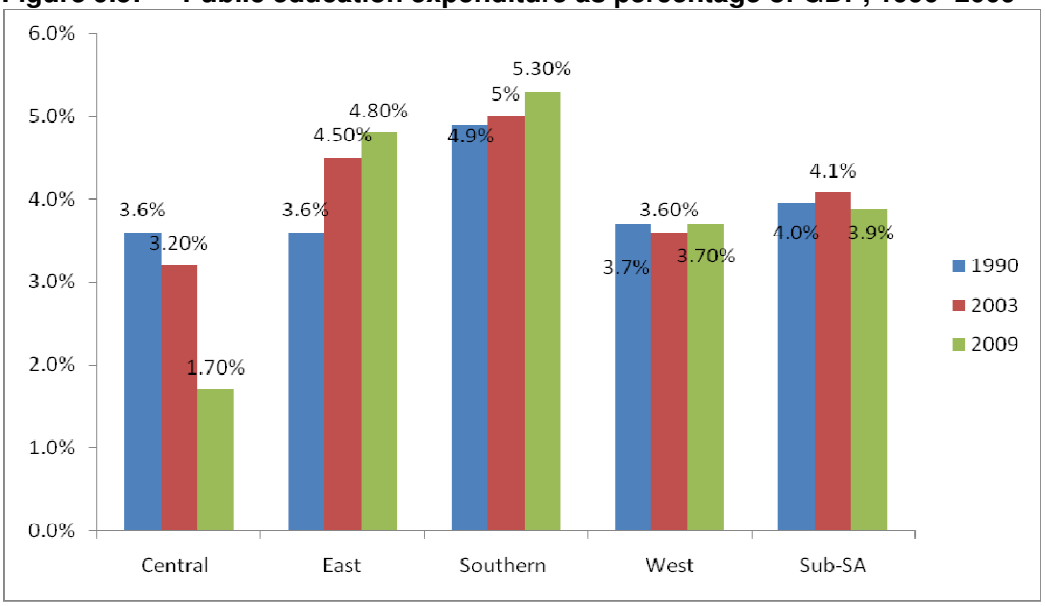
In the same vein, West African countries recorded the lowest level of literacy; Burkina Faso with a 28.7% literacy rate, Niger with 28.7%, Guinea with 29% and Sierra Leone with 38.1%. On the other hand, the politically stable island countries of Cape Verde and the Comoros had high literacy rates of 83.8% and 75.1%, respectively. The regional average for East Africa in 2009 was 62%. Kenya and Uganda had the highest literacy rates in the sub-region of 73%. Ethiopia, where a mere third of the adult population can read or write, had the lowest rate.

9.1.7 Education Expenditure

One of the key indicators of education levels is the amount of money allocated to education programmes as a percentage of the gross domestic product (GDP). For countries of the world to realize the goal of providing universal access to education, the Global Campaign for

Education recommends that they allocate at least 6% of their GDP expenditure to education. Research reveals that most sub-Saharan African countries fall far short of this expectation (Global Campaign for Education, 2010).[10] According to latest figures, sub-Saharan African countries collectively have consistently spent 4% of the GDP on education (Figure 9.5).

Figure 9.5: Public education expenditure as percentage of GDP, 1990–2009



Source: Work Bank (2010a).

The sub-region that spent slightly more on education is Southern Africa with 5% of GDP in 2009. This figure has remained unchanged since 2000. Interestingly, the poverty stricken countries of Lesotho (12.4%) and Swaziland (7.94%) spent more than the natural resources-endowed countries of Angola (2.6%) and South Africa (5.1%).

In East Africa, expenditure on education rose from 3.6% in 1990 to 4.8% in 2009. It is the second highest sub-region in terms of education expenditure as a percentage of the GDP. Burundi and Kenya spent more than 7% of their GDP on education, in 2009 followed by Ethiopia at 5%. Eritrea spent by far the least on education, 2%.

A clear pattern indicates that the West African sub-region falls below Southern and East Africa on this education indicator. West Africa spent less than 4% of GDP on education in 2009. Seychelles and Ghana are the only two West African countries that spent more than 5% of their GDP on education in 2009. The oil rich countries of Equatorial Guinea and Guinea spent 0.6% and 2% of their GDP on education, respectively.

9.2 Conclusion and Recommendations

Overall, sub-Saharan Africa countries have seen improvements in terms of equitable access to primary education and the elimination of illiteracy. There was an overall increase in the net enrolment rates for girls of nearly 20% between 2000 and 2009. Nevertheless, there are variances and some sub-regions have done better than others. Highest enrolment rates were recorded in Southern Africa (87.9% in 2009), with Central Africa having the lowest enrolment for girls in primary education.

[10]Global Campaign for Education. 2010. “Back to school? The worst places in the world to be a school child in 2010”. www.campaignforeducation.org/docs/reports/1goal/1Goal%20School%20Report.pdf Accessed on 30 September 2010.

Although school enrolment figures show a positive trend, it is possible that the goal of universal education by 2015 will be missed. Moreover, while gender disparities are narrowing in many areas, young women and girls still face disadvantages at several levels, from early childhood through to primary and secondary school, and into adulthood. It is imperative for sub-Saharan African countries to intensify their efforts to reach the target of ensuring universal access to primary education, especially by girls. Inequitable access to education has the potential to hamper women's economic and social empowerment, thus keeping them dependent on men for their livelihood. It is also the case that women with more education have fewer but healthier children. Maintaining the status quo will serve to reinforce the entrenched patriarchal relations of domination and subjugation of women. Lack of education will further deny women's opportunity to exercise their rights in relation to sexual and reproductive health, including reducing the risk of HIV infection.

Progress in school participation continues to outstrip progress in learning achievement, implying that the quality of education requires greater attention.

Another area that needs closer examination is the quality of education. The general observation is that there is a widening gap between qualitative and quantitative indicators of progress, since progress in school participation continues to outstrip progress in learning achievement. In addition to looking at the quantity and quality indicators, attention should be paid to age of school entry, because many children enter school late, drop out early and therefore never complete the full cycle.

These findings suggest a number of recommendations that should be taken into account in order to achieve ICPD POA's goals on education. Overall, countries should:

- Rededicate themselves to the realization of the goals articulated in the Plan of Action of the AU *Second Decade of Education for Africa (2006–2015)*.
- Strengthen the capacity of teacher training colleges, review remuneration of teachers and ensure continuous teacher training.
- Strengthen partnerships between and among local communities, students/parents associations, employers associations, trade unions, development partners, faith-based organizations and non-government organizations to increase resource mobilization for education in rural and other under-served areas.
- Increase spending on education; it is clear that most countries in the region spent far less than what is required to meet quality and quantity goals.
- Explore measures for eliminating the burden of school fees, as it excludes many poor children.

Most countries in the region spent far less than what is required to meet quality and quantity goals.

10. Technology, Research and Development

Accurate, reliable, timely and comparable data are essential for setting priorities and monitoring and evaluating population and development programmes. In essence, conducting research ensures that measures used to tackle population and development issues are based on evidence, so that resources supporting these measures are used effectively and efficiently. Also required are improvements in the interaction between researchers and policy makers (over and above the other stakeholders such as communities and the funders of such research). Putting these requisites into practice was the aim of the ICPD POA emphasis on the role of research in achieving its goals. The POA urged countries to strengthen their national capacities to produce valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development, implementation, monitoring and evaluation. Particular attention was called to the importance of data classified by age, sex, ethnicity and geographical units.

> The availability of accurate, reliable, timely and comparable data provides the evidence base for effective planning and evaluation of population and development programmes.

10.1 Africa's Progress towards the Implementation of the ICPD POA

Progress on several interlinked issues is reviewed here, including sources of data and data availability, access and dissemination, as well as the disaggregation of data into usable classifications. New technologies for data gathering and management are also important. Underlying these are initiatives and training programmes in statistical capacity development, reproductive health research, and capacity building for health research generally.

10.1.1 Commitment

There is evidence that many African countries are now making efforts to respond positively to the ICPD POA's call to collect, analyse and disseminate relevant and useful population data. Various initiatives have been put in place to coordinate and focus resources for the development and use of data. Examples include the Global Plan for Statistics or the *Marrakesh Action Plan for Statistics* (MAPS) and the WHO Health Metrics Network. The Marrakesh Action Plan for Statistics was created in 2004 to assist countries in improving their national statistical systems to be able to measure and evaluate national development plans. Among other things, the MAPS recommends that countries develop a *National Strategy for the Development of Statistics* (NSDS), which must be part of the national development processes. The MAPS activities are driven by the World Bank and the Partnership in Statistics for Development in the 21st century, also known as Paris21[11] .

The development of NSDS is funded through the World Bank's STATCAP programme, which administers funding such as the Trust Fund for Statistical Capacity Building (TFSCB). Nigeria, Burkina Faso, Sierra Leone, Ghana and Kenya are some of the sub-Saharan African countries that received funding for the development of their national statistical systems. By the end of 2005, most African countries were involved in the development and implementation of their strategies. A few countries such as Eritrea, Central African Republic, Libya, Seychelles and Somalia were in very early stages of preparing for the development of the strategy and unlike other countries, did not have other strategies in place.

[11] See www.paris21.org

10.1.2 Sources of Data and Data Availability, Access and Dissemination

Most African countries rely on their statistical offices to collect and disseminate different types of data including population statistics. Household surveys and population censuses tend to be good sources of data in this regard, and for reporting progress towards achieving the ICPD POA objectives and other global commitments such as the MDGs. Censuses are large, time-consuming and costly exercises, however, and require extensive investments in financial and human resources. Despite these disadvantages, they are valuable tools because they provide necessary evidence for planning, good governance, strategic decision making and programme implementation.

UNFPA has been in the forefront of supporting and advocating the undertaking of population censuses in developing countries, including sub-Saharan Africa. In consequence, it is estimated that over 200 censuses have been conducted in the sub-Saharan region to date. Only a few of these censuses survived, however, because of poor storage and management (Zuberi and Bangha, 2006). Furthermore, data from the surviving few censuses are not usable because of poor or absent meta data on codes and definitions.

The Statistics Division of the United Nations Department of Economic and Social Affairs initiated a *2010 World Programme on Population and Housing Censuses* that was scheduled to cover the 2005–2014 census periods. The goal of the *World Programme* is for all countries and areas to agree on a set of accepted international principles and recommendations governing the conduct of censuses; to conduct a census during the period 2005–2014; and to disseminate census results in a timely manner. To date, only 15 countries in Africa have completed their 2010 round census. Countries that have planned to undertake 2010 census, are in the process of conducting the census or have not yet started include Angola, Democratic Republic of Congo, Ghana, Madagascar and Zambia.

One of the attempts to preserve African census data has been through the African Census Analysis Project (ACAP). ACAP is a joint initiative of the Population Studies Center, University of Pennsylvania, together with African research and government institutions. ACAP has also fostered collaborative efforts to enhance the utilization of census data at regional levels, including the SADC statistical committee programme on analysis of the 2000 round of census and 2010 rounds of population and housing censuses and the collaboration with the INDEPTH system of surveillance sites.

Countries also collect data through regular Demographic and Health Surveys (DHS) – which are funded by USAID with contributions from other international donors such as UNICEF, UNFPA, WHO and UNAIDS. Implemented by MEASURE DHS, the surveys are aimed at providing nationally representative and internationally comparable data (through a standard questionnaire) on various aspects of population, health and nutrition mainly of women and children in developing countries. The surveys are conducted, on average, every five years. MEASURE DHS performs other surveys, secondary data analysis and specialized studies, including AIDS indicator surveys (AIS), service provision assessment surveys (SPA), qualitative research, key indicators survey (KEI), malaria indicators surveys (MIS), biomarker collection, geographic data collection, and benchmarking surveys. Other major data sources for African countries include reproductive health surveys (RHS), UNICEF's multiple indicator cluster surveys (MICS), the World Health Organization's world health survey and the World Bank's living standards measurement studies (LSMS),

Information sourced from the MEASURE DHS databases shows that only a handful of African countries conduct regular surveys or at least have undertaken more than four standard Demographic and Health Surveys (see Annex D). By the same token, very few countries conduct other supplementary surveys, for instance the service provision assessment (SPA) surveys (Egypt, Kenya, Namibia, Rwanda, Tanzania, Uganda and

Zambia), MICS (Ghana and Mali), and standard AIS (Kenya, Côte d'Ivoire, Mozambique, Tanzania and Uganda).

Some countries, such as Botswana, South Africa and Mauritius, have vast arrays of data and information produced by their statistical offices, government departments and other institutions such as private and public research institutions. The data are held by these institutions, however, and more often than not are not available in the public domain or accessible to potential users. To illustrate this point, a study conducted by the William and Flora Hewlett Foundation in four countries (Ethiopia, Uganda, Ghana and Tanzania) found that data exist but often potential users are not aware of its existence because of a lack of knowledge as well as poor communication and dissemination of information by data producers. Other reasons cited by the study for the lack of accessibility are bureaucracy, physical distance, confidentiality issues and inexperience with data sharing by the producers (Center for Global Development and Population Reference Bureau, 2009).

Other mechanisms exist to support research at national and regional levels. At the national level, for example, many countries have a medical research council (to facilitate skills development, grant opportunities, peer review and collaboration with other colleagues in nationally and internationally). One example is South Africa's Medical Research Council, which plays dual roles as an agency funder (funding of health research in South Africa) and research performer. Another council is the Human Sciences Research Council, which performs social sciences and humanities research. It works closely with other institutions in Africa and the world, such as the Council for the Development of Social Science Research in Africa (CODESRIA), which has headquarters in Dakar, Senegal.

10.1.3 Disaggregated Data

The ICPD+5 progress report indicated that nearly all African Union Member States have taken actions to initiate and/or improve gender sensitive data collection, analysis, dissemination and use in education, health and censuses.[12] The report further highlighted the measures being taken by different countries; these included creation of gender statistics units; development of gender-sensitive education management systems, data collection instruments and morbidity and mortality statistics; and creation of documentation centres. Other measures are collating recurrent publications on gender disaggregated data by concerned ministries, conducting Demographic and Health Surveys, training personnel, and advocating for the use of gender disaggregated data in policy and planning. To date, the countries initially involved in these activities continue to improve their standing on gender equality by implementing measures, programmes, policies and strategies on gender issues. With the assistance of international organizations, there is interest in countries that did not participate five to ten years ago. Major shortcomings still exist, however, in terms of the availability of data disaggregated by age, ethnicity, and region or geographical area.

New technologies likes personal data assistants (PDAs) and computer assisted interviews (CAPI) are now being piloted or used in some African countries to make data collection, analysis and dissemination easier.

10.1.4 New Technologies

Several new technologies are available that can make data collection, analysis and dissemination easier and more effective than it is currently. The initial DHS survey instrument included about 250 questions, a number that has been increasing over the years. It is said that the average female respondent took 45–55 minutes answering interviewers' questions and many interviews now take over 90 minutes to complete. Additional questions to an already long questionnaire/interview contribute to the survey fatigue syndrome and at the same

[12] The report of the Third Meeting of the Follow-up Committee on the Implementation of the Dakar/Ngor Declaration (DND) and the ICPD-PA, 23–25 September 1998, Addis Ababa, Ethiopia.

compromise the quality of the data collected. New technologies such as personal data assistants (PDAs) and computer assisted person interview (CAPI) are now being piloted or used in some African countries to make data collection, analysis and dissemination easier (Box 10.1).

Box 10.1: Examples of remote data collection technology in Africa

The Dokoza System: South Africa
Sponsoring organizations and partners: Dokoza, State Information Technology Agency (SITA), Centre for Public Service Innovation (CPSI), Centre for Scientific and Industrial Research (CSIR), and the Meraka Institute, with the cooperation of South Africa's National Department of Health

Description
Integrating mobile data collection solutions with existing health information systems is essential to advancing patient care. The Dokoza system seeks to meet this need. It is an SMS-based mobile system designed to fast-track and improve critical services for HIV/AIDS and TB patients. Dokoza relies on SIM cards that can be used across networks, which interact with a more complex back-end system that integrates with existing hospital information systems. The integration with existing infrastructure offers the possibility of dramatic improvements to existing patient health information records, and in the 2004 pilot, both doctors and patients found the system to be user-friendly. Challenges encountered during the pilot include the duplication of data entry in instances where paper-based systems already existed, and staff shortages that hampered information collection. Despite the promise of this technology, few new data exist on its impact since the end of the pilot.

Reference sources:
http://www.changemakers.net/node/1014, http://www.dokoza.co.za/content/patent.asp,

EpiHandy: Uganda, Zambia, Burkina Faso
Sponsoring organization: Centre for International Health, Norway

Description Health data collection in the developing world is often hampered by the high costs and inefficiencies of traditional large-scale paper-based surveys. The EpiHandy tool, a mobile health data collection and record access programme enabled by PDAs, helps to mitigate these issues. EpiHandy has been deployed in many countries and by many different organizations since its first release in 2003, and has been used in multiyear studies in Uganda, Zambia and Burkina Faso. In the Uganda study, mobile phones were deployed to participating clinics and Ministry of Health experts trained the local staff on using the open source JavaRosa software to fill and submit medical forms. The data from the forms were transmitted across the standard services available on the local mobile network. EpiHandy has yielded positive results during a five-year assessment in which 14 interviewers collected information on breastfeeding habits and child anthropometry in rural areas of eastern Uganda. Outcomes include greatly reduced data entry errors and broad user acceptance, as well as cost-effectiveness relative to traditional paper-based surveys, increasing the potential for this already successful solution to scale up further.

Reference sources:
http://www.epihandy.com http://www.cih.uib.no/

10.1.5 Initiatives and Training Programmes in Statistical Capacity Development

To be able to understand the importance and value of population and demographic data, it is crucial that proper training be provided to the funders of data collection as well as the people who collect the data. The training programmes should be designed in such a way that they have a long-term perspective. This kind of training approach helps ensure that information is institutionalized and sustained.

There are several training programmes and institutions dedicated to demographic and population studies and statistics in Africa. These include:

- The Regional Institute for Population Studies (RIPS) based in Ghana. The institution offers modules in general theory and methods of demography, with particular reference to the special needs and problems of the African continent.
- The Eastern Africa Statistical Training Centre (EASTAC) in Tanzania, which caters mainly for the African English-speaking countries of Eastern and Southern Africa.
- Demographic Training and Research Institute (Institut de Formation et de Recherche, IFORD) in Cameroon.
- National Institute of Applied Economics (ENEA) in Senegal.

The issue, therefore, is not lack of facilities, but that the institutions present do not produce sufficient numbers of specialists to cater for the entire African continent.

10.1.6 Reproductive Health Research

No country can expect to meet the health requirements of its nation without a robust and functional health system – defined by WHO as a system consisting of all organizations, people and actions whose primary intent is to promote, restore or maintain health (WHO, 2000; 2007a). It is acknowledged that the strengthening of any health system must be preceded by a thorough understanding of the underlying issues that require refining because the challenges facing countries that need assistance with their health systems are not necessarily the same. In this regard, most countries must develop national health plans that guide and provide strategic direction in the construction of strong, effective health systems.

A national health plan is recognized as a right to health feature of health systems. Backman et al. (2008) conducted a study to assess the extent to which the health systems of 194 countries included some features that arise from the right to health. The study indicated that out of the 194 countries assessed, only 13 did not have national health plans in place. Of these 13, two are in sub-Saharan Africa (Eritrea and Lesotho). Twenty-one African countries had done situational analyses, including the four that did not have a national health plan.

10.1.7 Capacity Development for Health Research

The development of trained and skilled personnel in health research to achieve some of the key goals of the ICPD POA is imperative. Nevertheless, largely because of inadequate training facilities (see Box 10.2) and massive brain drain, there are still major shortages of health professionals in Africa. Capacity development is thus an absolute necessity.

Box 10.2: Mapping Africa's advanced public health education capacity – The AfriHealth project

The objective of the study was to present the first map of university-based public health education capacity in Africa. The study recognized the need for qualified and adequate African public health professionals who can provide expertise and leadership for health systems management, transformation and research.

The results showed that 11 out of 53 countries offer at least one or two postgraduate trainings in public health, but 29 of the 53 offer no such training.
Most institutional units delivering postgraduate public health programmes are small and rely on part-time staff for an important part of their establishment.

The study also revealed that there were 493 full-time faculty in public health for the entire continent (854 if part-time staff are included) and only 42 PhD students and 55 MSc students newly enrolled for 2005 (together, these degree holders can be considered to constitute the public health research training capacity on the continent).

The male staff is in the majority (63%), and at the same time males are more qualified than their female counterparts (i.e., 89.2% of male staff had either a master's or doctoral degree. The corresponding percentage of female staff was 71.6%. The study also revealed that there is a shortfall

of senior staff in institutions of public health. The age distribution of staff is skewed towards younger age groups: 15% are aged 35 years or younger, 66% are between 36 and 50 years, and only 19% are older than 51 years of age.

Most programmes offered at institutions are directed towards satisfying national, rather than regional, needs even if they receive students from outside. The main finding of the study was that there is a critical gap in advanced public health education in Africa: 29 countries were without graduate public health training and 11 countries had one institution/programme only.

http://afrihealth.up.ac.za/database/database.htm) , www.cohred.org/AfricaSPH

10.2 Conclusions and Recommendations

Although it is evident from the foregoing that data collection in Africa has improved, the implementation of the POA in this area is not being achieved as recommended or expected. There are several issues that still need to be resolved if African countries are to meet the ICPD POA targets with regard to research development, and it is from these that recommendations are drawn, as discussed below.

10.2.1 Conclusions

Among the barriers to the realization of this aspect of the POA are the following:

- Inadequate financial and human resources (particularly personnel skilled in technical and research fields). Ghana, for example, has the human capital but lacks requisite resources. South Africa, on the other hand, has financial resources but does not have adequate human resources.
- Inability to exploit new technology that can significantly reduce costs associated with large surveys/censuses.
- Various pressing issues confronting governments in Africa, such as health, food production and education, thereby competing for government funding. Under these conditions research takes a back seat.

10.2.2 Recommendations

In the short –term, there is no doubt that most African countries have demographic and other data stored in some form or other. What needs to be done is to use what is available and share it with other users. This approach will assist in identifying existing gaps and will also help to avoid duplication of efforts. And for the long term there should be continued commitment and enhancement of national capacities and mechanisms for the collection, analysis, interpretation and dissemination of population data. Among other things, this calls for implementing vital registration of all births and deaths.

The collection and analysis of all population data should be disaggregated by demographic characteristics such as age and sex to assist in effective policy making and planning at local levels.

Other recommendations include the following:

- To the extent possible, the collection and analysis of all population data should be disaggregated by demographic characteristics such as age and sex to assist in effective policy making and planning at local levels.
- Countries should begin to monitor and evaluate the impact of all the programmes and policy implementations and use the feedback to inform the next stages in technology development and research.
- Training and development of human resources are essential in all processes. In particular, support should be given to countries to build demographic skills around capacity to analyse and interpret census and survey data.

- Local research capacity should be developed to ensure that research is relevant to the population and reproductive health concerns of local communities, and that local policy makers make use of this evidence.
- African countries should aim to have a national statistical base aimed at polling pertinent data from various sectors of their economies, and to ensure the accessibility of such data to policy makers.

11. Partnerships and Resource Mobilization

To ensure effective implementation and achievement of the objectives and goals of the ICPD POA, countries were urged to take action on two fronts. One was to mobilize resources by increasing the commitment to, and stability of, international financial assistance in the field of population and development. The other was to clarify the reciprocal responsibilities among development partners and improve coordination of their efforts. With regard to resource mobilization, the POA urged the international community to strive for the fulfilment of the agreed 0.7% of GNP for overall official development assistance (ODA), and to endeavour to increase the share of funding for population and development programmes commensurate with the scope and goals of the POA.

ICPD aimed to promote partnership among governments, NGOs, community groups and the private sector in the design, implementation, coordination, monitoring and evaluation of programmes relating to population, development and environment.

In order to meet and reinforce social development goals and satisfy previously undertaken intergovernmental commitments, all governments were advised to devote an increased proportion of their public sector expenditures to the social sectors, stressing in particular poverty eradication in the context of sustainable development (ICPD POA 1994; Ch xiii). As for partnerships, the ICPD POA aimed to promote an effective partnership among governments, non-government organizations, local community groups and the private sector in the discussions and decisions on the design, implementation, coordination, monitoring and evaluation of programmes relating to population, development and environment.

It is evident from the foregoing that the ICPD POA is closely related to Millennium Development Goal (MDG) 8 (*Develop a global partnership for development*) in that they both recognize that successful development efforts require appropriate partnerships at the domestic and international levels. Indeed, it has been argued that the achievement of the first seven MDGs depends largely on the establishment of successful global partnerships.

11.1 Africa's Progress towards the Implementation of the ICPD POA

Achievements in this area, as discussed below, have moved on many fronts. Notable among these is the establishment of the New Partnership for Africa's Development (NEPAD). Resource mobilization efforts and the formation of many types of partnerships are also reviewed.

11.1.1 The New Partnership for Africa's Development (NEPAD)

The New Partnership for Africa's Development (NEPAD) – a framework consisting of a set of African-driven development priorities – can be considered *the* key blueprint for resource mobilization and partnerships in the continent post ICPD. Adopted at the 37th Summit of the Organization for African Unity (OAU) in Durban, South Africa, in July 2001, NEPAD is a call for stronger partnership between Africa and the international community, especially the highly industrialized countries "to overcome the development chasm that has widened over centuries of unequal relations" (NEPAD, 2001: 2). NEPAD's primary objectives are to:

- Eradicate poverty;
- Place African countries, both individually and collectively, on a path of sustainable growth and development;

- Halt the marginalization of Africa in the globalization process and enhance its full and beneficial integration into the global economy; and
- Accelerate the empowerment of women.

NEPAD (2001) outlines three key strategies to achieve its objectives:
- The Capital Flows Initiative, which is strongly aligned to the ICPD POA and the MDGs in that it aims to achieve increased domestic resource mobilization; debt relief; ODA reforms; and increased private capital flows.
- The Market Access Initiative, which calls for diversification of production by, among other things, improving the agricultural, mining, manufacturing, tourism and services sectors, as well as the promotion of the private sector.
- Building partnerships, by establishing a new relationship with industrialized countries and multilateral organizations to improve the quality of life of Africa's people.

11.1.2 Resource Mobilization

The three main elements of resource mobilization as recognized by the ICPD POA are: official development assistance; contribution of resources by national governments; and management of external debt. This section reviews Africa's progress in the implementation of these elements.

Aid Flows

For many African countries development aid underpinned by development cooperation is a critical aspect of financing of development. Indeed, AFRODAD (2010) argues that the volume of aid flows as well as the sectors of flow will greatly determine the pace at which development is realized in the continent. To this end it is a positive sign that after a spell of volatility in the 1980s to early 1990s (Akinkugbe and Yinusa, 2009), the flow of ODA to sub-Saharan Africa has been on the rise, and that the region continues to be the largest recipient of ODA, having more than doubled receipts in current US dollars between 2000 and 2007. (See Annex E.)

A number of post-ICPD commitments to increase and mobilize additional development finance play a major role in the pattern shown in Annex E. The *Monterrey Conference on Financing for Development* is a key reference in this regard. This conference – which followed the 2000 Millennium Summit that adopted the MDGs – urged developed countries that had not yet done so to make concrete efforts towards the target of 0.7%. More substantial and Africa-specific commitments were made at the *2005 Gleneagles Summit* where Group of Eight (G8) leaders pledged to increase their budget to assist in clearing the highly indebted poor countries' outstanding debts to the IMF, International Development Association (IDA) and the African Development Fund. G8 summits in 2006 and 2007 reaffirmed earlier commitments regarding ODA to Africa and pledges for the debt cancellation for the continent.

The *Monterrey Conference on Financing for Development* – which followed the 2000 Millennium Summit that adopted the MDGs – urged developed countries to make concrete efforts towards the target of 0.7%.

A number of observations can be made about the trend of aid flows to sub-Saharan Africa:
- Although developed countries are providing increased ODA to Africa, they are lagging behind commitments made in 2002 and 2005. For example, only 5 of the 22 members of the Development Assistance Committee of the Organization for Economic Development (OECD/DAC) had reached their 0.7% commitment in 2007. Overall, therefore, there is a gap between commitment and actuality (United Nations Millennium Project, 2006).
- Much of the increase in ODA to Africa is linked to debt relief operations (notably to Nigeria and the DRC), with only moderate increases in aid for development. Therefore when debt relief is excluded, ODA to Africa has grown only moderately since 2005.

- Despite specific commitments made at the ICPD by the international community to steadily increase financing to programmes in the area of population dynamics (including reproductive health, family planning, maternal health and STI prevention), available evidence shows that this goal has not been reached in Africa, as in other developing countries (UNFPA, 2009). Data from the OECD, for example, show that while funding for population activities increased from the mid-1990s (just after the ICPD) to the late 1990s, it decreased between 1998 and 2003, and has basically stagnated at 2005 levels (OECD, 2010). It is also noteworthy that much of the funding to population assistance goes to HIV and AIDS activities, thus leaving insufficient resources for family planning and reproductive health (UNFPA, 2009).

Much of the increase in ODA to Africa is linked to debt relief operations, with only moderate increases in aid for development.

The period 1986–1997 saw a slight increase (from 0.20 to 0.27) in the proportion of ODA that was earmarked for technical assistance/cooperation. This proportion has declined in recent years, however, from 0.25 in 2002 to 0.13 in 2007 (Akinkugbe and Yinusa, 2009). Among other things this pattern is accentuating Africa's lack of competitiveness in international research and development, including in the collection, analysis and dissemination of population data. It is also pulling highly trained staff out of the continent. As noted earlier, the health sector is particularly affected by the migration of doctors, nurses, pharmacists and social services personnel. Indeed, the desperate shortage of health professionals is the most serious obstacle in Africa's efforts to fight AIDS and support other health programmes. In several countries the brain drain of medical professionals is threatening the very existence of the countries' health services.

To put this in context, the minimum standard set by the WHO to ensure basic health care services is 20 physicians per 100,000 people. Whereas Western countries boast an average of 222 physicians per 100,000 people, 38 countries in sub-Saharan Africa fall short of WHO's minimum standard, with some countries having 5 or fewer physicians per 100,000 people (African Union, 2009). Although this exodus has resulted in significantly increased inflows of remittances to sub-Saharan Africa, which may in some way help in the poverty reduction efforts (Akinkugbe and Yinusa, 2009) it also means that in effect, African countries are using their meagre resources to fund the education of their nationals only to see them end up contributing to the growth of developed countries with little or no return on the original investment (African Union, 2009).

Governments' Contribution of Resources

Available evidence suggests that African countries have generally taken cognisance of the ICPD POA's notion that external financing for the programme needs to be complemented by domestic resources. Despite the constraints in generating the necessary resources to finance their own population programmes, many governments in the region have shown commitment and political will in supporting the ICPD POA through increased financial allocation to relevant sectors. For example, disbursements for population and reproductive health services and activities in the region accounted for 11.6% of all disbursement for the social sector in 2008, up from the 4.0% reported in 2004. In the SADC region, allocations to health, education, housing and social welfare continue to dominate national budgets. As with the pattern of ODA flows, however, the majority of the national resources goes to the fight against HIV and AIDS and related health problems.

Despite their financial constraints, many African governments have shown commitment and political will in supporting the ICPD POA through increased financial allocation to relevant sectors.

Debt Relief

The key post-ICPD initiative for servicing external debts is the Heavily Indebted Poor Countries (HIPC) Initiative introduced in 1996 and followed later by the "enhanced" HIPC

initiative in 1999. Both focused on large-scale debt cancellation as opposed to palliatives such as debt rescheduling and interest rate reduction (Vandemoortele et al., 2003). Largely because of these initiatives – as well as others such as the Multilateral Debt Relief Initiative (MDRI), bilateral debt relief and the pledges made at the 2005 Gleneagles Summit – major progress has been achieved in extending and deepening debt relief in Africa. Under MDRI, for example, the African Development Fund, IDA and the IMF have agreed to provide 100% debt relief on their eligible claims to countries that reach the completion point under the HIPC Initiative. In consequence, the burden of servicing external debt in the region fell from 9% in 2000 to 4% in 2007 (United Nations, 2007). According to this UN publication, as of July 2007, some 18 African countries had reached the HIPC completion point and were thus benefiting through the MDRI. Seven countries were receiving interim relief through the HIPC Initiative, as they were paying significantly reduced debt services, and eight countries met the income and indebtedness criteria (based on data from end 2004) and could be considered for debt relief under the HIPC Initiative.

11.1.3 Partnerships

The patterns of ODA flows and resource mobilization discussed above indicate that African countries have been receiving support from an array of development partners to implement the ICPD POA. As described below, the key affiliations here are with the UN system, multilateral and bilateral partners, non-government organizations, the private sector, and South-South cooperation.

The United Nations Systems

The UN systems, particularly UNFPA, WHO, UNICEF and UNAIDS, are an important source of multilateral support for Africa's efforts to implement the ICPD POA and other similar commitments such as the MDGs. Through the United Nations Development Assistance Framework, UN agencies assist African countries variedly with advocacy, institutional support and technical assistance to implement population and development programmes and projects. The recent (2006) declaration on *Enhancing United Nations–African Union Cooperation* signed by the United Nations and the African Union Commission provides a framework for stronger and more effective cooperation between the UN and the region.

Multilateral and Bilateral Partners

Key multilateral organizations active in the region are European Union institutions, the Global Fund to Fight AIDS, TB and Malaria, and development banks such as the World Bank and the African Development Bank (AfDB). Indeed, UNFPA signed a cooperation agreement with the AfDB in 1992 (revised in 2003) to facilitate collaboration between the two parties in providing assistance to African countries for the formulation, implementation, monitoring and evaluation of population policies, plans and programmes, as well as the integration thereof into national, social and economic development policies plans and programmes. Bilaterally, the United States, France, the United Kingdom, Germany and the Netherlands have been the largest ODA donors to Africa since the 1970s (OECD, 2010).

Philanthropic foundations – many of them based in the United States – are also increasingly providing development assistance. Examples include the Bill & Melinda Gates Foundation, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, the MacArthur Foundation, and the Henry J. Kaiser Family Foundation. Among others are the Ford Foundation, the Children's Investment Fund Foundation, the Wellcome Trust, and the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development (UNFPA, 2008).

Non-Government Organizations

Non-government organizations (NGOs) such as Population Services International (PSI), Family Health International (FHI), and the International Planned Parenthood Federation

(IPPF, especially through the Africa Regional Office) are providing support to population activities in many African countries (UNFPA, 2008). These NGOs are mainly involved in issues related to adolescent reproductive health, HIV and AIDS, safe abortion, and family planning. In many instances the NGOs have introduced and implemented innovative cost-effective approaches and programmes (UNECA, 1998).

Private Sector

The potential contribution of the private sector to the formulation and implementation of population policies and programmes is now better understood and more widely recognized in many African countries. In consequence, varied modalities for the participation of the private sector in population activities have emerged. These include social marketing programmes and greater reliance on private practitioners. Using MDG 8, Target 6 (*in cooperation with the private sector, make available the benefits of new technologies, especially information and communication*) as an illustration, it is evident that the private sector's involvement in the development sector has not only grown, but it has also improved Africans' lives in many ways. According to the United Nations (2009), the use of communication technology such as mobile phones and the Internet in Africa continues to be characterized by uninterrupted growth. For example, in 2004 the continent added almost 15 million new mobile phone subscribers to its subscriber base, a figure equivalent to the number of fixed and mobile telephone subscribers on the continent in 1996, just eight years earlier (Gray, 2004).

Internet usage has also been growing steadily, having increased from 1% to 4% between 2002 and 2009. Using examples from Uganda and South Africa, Gray (2004) reports how these technological advances have positively affected Africans. In South Africa the TB Compliance Service sends text messages (SMS) to remind patients to take their medication, thus decreasing the number of treatment failures. The TRACnet HIV/AIDS Solutions programme in Rwanda also uses cell phone technology to contact Rwandans accessing ARV treatment to collect, store, retrieve and disseminate critical programme, drug and patient information related to HIV and AIDS care and treatment. According to UNICEF, Nigeria[13], mobile phones are also part of a project aimed at the development and implementation of an e-learning system of the Nigerian Family Life and HIV/AIDS Education School Curriculum.

The region has also witnessed growth in the establishment of Public-Private Partnerships (PPPs) that led to successful implementation of some of the ICPD POA, particularly in the area of health. Examples include:

- The African Comprehensive HIV/AIDS Partnerships (ACHAP). This partnership – between the Government of Botswana, Merck & Co., Inc., and the Bill & Melinda Gates Foundation – supports and enhances Botswana's response to HIV and AIDS through a comprehensive approach to prevention, care, treatment and support. When it was established in 2001, the partnership identified and mobilized technical assistance to provide infrastructure, ensure the effective delivery of services, and enhance local capacity through the transfer of managerial, leadership and technical skills to Botswana
- A partnership by Chevron, the Angolan National Health Service and civil society to offer free TB services to employees, contractors and 75% of the 400,000 community members in Cabinda Province where Chevron Angola is located.
- Bhubezi Community Health Centre – a PPP established in 2006 by the US President's Emergency Plan for AIDS Relief (PEPFAR), Virgin Unite, Anglo Coal and the South African Government to provide a one-stop health care centre that brings effective diagnosis and treatment to a poor community in rural South Africa.. Bhubezi serves approximately 70,000 people from 12,000 households in 21 villages. The centre charges

[13] www.unicef.org/nigeria

for basic health care services and provides free diagnosis and treatment for HIV and AIDS, tuberculosis, and malaria.

Other examples in the region include those by Daimler Chrysler South Africa; Infection Disease Institute (Uganda), PEPFAR (Rwanda, and Zambia), and Royal Dutch Shell in Nigeria (see Leaders Forum on Public-Private Partnerships, 2007).

South-South Cooperation

South-South cooperation is increasingly important as a complement to the "traditional" North-South cooperation. South-South cooperation has been specifically expanded between Africa and China, India and Brazil. Chinese aid to Africa, for example, was estimated at about US$ 1 billion in 2007 and was expected to double by end of 2010. This is based on a number of pledges made by China such as cancellation of some loans and debts, increasing of scholarships to African students, and provision of technical assistance mainly in health, education and agriculture (SADC, 2008). The formation of the India-Brazil-South Africa (IBSA) trilateral development initiative is another example of such South-South cooperation in the region. The group was created in June 2003 with its main aims being to promote South-South cooperation and dialogue to achieve common positions on issues of international importance, to explore trade and investment opportunities, to promote international poverty alleviation and social development, the exchange of information, technologies and skills, and to complement each others' competitive strengths into collective synergies.

South Africa is the only country in the region that can regarded as a (an emerging) "donor". The country has a special fund for cooperation with other African countries and regional institutions, the *African Renaissance and International Cooperation Fund* (ARICF) Established in 2000, the fund is a mechanism to foster cooperation with other African countries, promote good governance, prevent and resolve conflict, advance socio-economic development and integration, and provide humanitarian assistance and human resource development. It is managed by South Africa's Department of International Relations in cooperation with the National Treasury. At the national conference of the African National Conference[14] (ANC) in December 2007, the resolution on international relations called for the establishment of a South African Development Partnership Fund (SADPA) and that the Fund should be located in the Department of Foreign Affairs, functioning as the ARICF. The South African Government is still expected to make a final decision on this matter.

11.2 Conclusions and Recommendations

Although partnership in development efforts is often the most effective course of action, the requirements of differing funding and support channels can be costly, complicated and time consuming.

Having several different partners in development efforts is often necessary, and the most effective course of action. However, the different channels through which funding and support flow before they reach the grassroots level can be complicated, expensive and time consuming. This underscores the need for the improvement, to the maximum extent possible, of the delivery and effectiveness of funding and technical support provided by international partners. The Paris Declaration on Aid Effectiveness – the culmination of a series of international efforts to improve aid delivery and achieve predictable, well-aligned programmes and coordinated aid – is therefore an essential complement of efforts to maximize the use of aid flows to the region as it clearly identifies fundamental principles of partnership commitment necessary for success in aid management. However, only about half of sub-Saharan African countries

[14] South Africa's ruling political party.

were signatories to Declaration in 2006 (Tjønneland, 2006). This is a potential impediment to the effective use of ODA flows to the region.

Notwithstanding the progress in reducing debt, there have been arguments, largely from civil society organizations, that debt relief mechanisms have not offered a lasting solution to the fundamental debt problems in Africa. AFRODAD (2010), for example, asserts that not only have the mechanisms been insufficient to support the full attainment of the MDGs, but also that current and future risks such as high food and fuel prices, as well as climate change, make MDRI beneficiaries vulnerable to being ensnared in a new round of unsustainable and unjust debt that will contribute to the re-accumulation of debt. In the same vein, the 2009 MDG report (United Nations, 2009: 51) concludes its discussion of the MDG 8 Target 4 by stating, "while data needed to make a comprehensive assessment are not yet available, debt service to exports ratios of developing countries are likely to deteriorate, especially for those countries that benefited from increased export revenues over that last few years". To this end, AFRODAD advocates stronger debt management policies and strategies including prudent lending by developed countries and responsible borrowing by African countries.

Other observations that can be made include the following:

- Development aid derived from South-South cooperation is often a small component of a much bigger development support approach focusing on trade and investment and on peace and security issues. It is also much focused on project support and – especially in the case of India and China – a strong emphasis on infrastructure. Brazil's aid – delivered through its Agency for Brazilian Cooperation – has a stronger emphasis on technical assistance and human resource development (SADC, 2008). While broadband is rapidly replacing dial-up as the preferred Internet access method in Africa, the service remains relatively expensive in many countries and thus inaccessible to many potential users (United Nations, 2009). This denies a large proportion of the African population the benefits of mobile technology and communication as related to the ICPD POA.
- Many of the PPPs are largely for HIV and AIDS programmes; few if any have been established to scale up the implementation of other population and reproductive health services.

Recommendations

- Both international and domestic allocation of resources to population activities must be increased if the targets of the ICPD POA are to be achieved in Africa.
- Those African countries that are not signatories to the Paris Declaration on Aid Effectiveness should be encouraged to consider it. Among other things the Declaration can make it easier for countries to put demands on donor agencies and countries to honour their commitments.
- Only 11 sub-Saharan African countries are currently members of the Partners in Population and Development (PPD), a Southern-led, Southern-run inter-governmental organization that works through the modality of South-South cooperation in the areas of reproductive health and population and development. The remaining countries should consider joining, and be encouraged to do so.

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Annex A: Coverage of PRSPs in Sub-Saharan Africa (May 2010)

Country [a]	I-PRSP completion[b]	PRSP completion	Second PRSP completion	Third PRSP completion
Southern Africa				
1. Angola	n.a.	Feb-04	n.a	n.a
2. Lesotho	Dec-00	Jul-05	n.a	n.a
3. Malawi	Aug-00	Apr-02	Feb-07	n.a
4. Mozambique	Feb-00	Apr-01	May-06	n.a
5. Zambia	Jul-00	Mar-02	Dec-06	n.a
East Africa				
6. Comoros	Oct-05	n.a	n.a	n.a
7. Djibouti	Jun-01	Mar-04	Apr-08	n.a
8. Eritrea	Apr-04	n.a	n.a	n.a
9. Ethiopia	Nov-00	Jul-02	Sep-06	n.a
10. Kenya	Jul-00	Mar-04	n.a	n.a
11. Madagascar	Nov-00	Jul-03	Feb-07	n.a
12. Rwanda	Nov-00	Jun-02	Sep-07	n.a
13. Tanzania	Mar-00	Oct-00	Jun-05	n.a
14. Uganda	n.a.	Mar-00	May-05	Mar-10
Central Africa				
15. Burundi	Nov-03	Sep-06	n.a	n.a
16. Cameroon	Aug-00	Apr-03	n.a	n.a
17. C.A.R.	Dec-00	Sep-07	n.a	n.a
18. Chad	Jul-00	Jun-03	n.a	n.a
19. Congo, Rep. of	Sep-04	Dec-08	n.a	n.a
20. D.R. Congo	Jun-02	Jun-06	n.a	n.a
21. Equatorial Guinea	n.a.	May-07	n.a	n.a
22. São Tomé & Príncipe	Apr-00	Jan-03	Jan-05	n.a
West Africa				
23. Benin	Jun-00	Dec-02	Apr-07	n.a
24. Burkina Faso	n.a.	May-00	Jul-04	n.a
25. Cape Verde	Jan-02	Sep-04	May-08	n.a
26. Cote d'Ivoire	Jan-02	Jan-09	n.a	n.a
27. The Gambia	Oct-00	Apr-02	Nov-06	n.a
28. Ghana	Jun-00	Feb-03	Jun-06	n.a
29. Guinea	Oct-00	Jan-02	Aug-07	n.a
30. Guinea-Bissau	Sep-00	Sep-06	n.a	n.a
31. Liberia	Jan-07	Apr-08	n.a	n.a
32. Mali	Jul-00	May-02	Dec-06	n.a
33. Niger	Oct-00	Jan-02	Aug-07	n.a
34. Nigeria	n.a.	Dec-05	n.a	n.a
35. Senegal	May-00	May-02	Sep-06	n.a
36. Sierra Leone	Jun-01	Feb-05	n.a	n.a
37. Togo	Mar-08	May-09	n.a	n.a

Notes: [a] Countries are listed alphabetically by subregion. The definitions of region used for the analysis are those used by the African Union. [b] The dates in the table refer to those on the actual documents, rather than dates of publication on the IMF/WB websites.

Annex B: Countries Not Eligible For or Not Having Initiated PRSPs

Country	Classification of economies 2005[a]	Status and nature of national poverty reduction strategy
Southern Africa		
38. Botswana	UMC	National Poverty Reduction Strategy
39. Namibia	LMC	National Poverty Reduction Action Programme (NPRAP 2000); National Development Plan (NDP2, 2001–06)
40. South Africa	UMC	Reconstruction and Development Programme (RDP 1994); Growth, Employment and Redistribution (GEAR 1996); Integrated Sustainable Rural Development Strategy (ISRDS, 2000); Urban Renewal Programme (URP, 2000)
41. Swaziland	LMC	Poverty Reduction Strategy and Action Plan (PRSAP, 2005)
42. Zimbabwe	LIC	The PRSP process has been stalled because of the current political situation in the country.
East Africa		
43. Mauritius	UMC	National Action Plan for Poverty Alleviation (APPA 2001)
44. Seychelles*	UMC	
45. Somalia	LIC	No PRSP process is in place.
46. Sudan	LIC	An I-PRSP is currently being prepared and is expected to be finalized by mid-2006.
Central Africa		
47. Gabon	UMC	Despite a GDP per capita of $6,590, Gabon has the human development index of a poor country, ranking 122nd out of 177 in the 2003 HDI, a fall of four places compared to 2002. Faced with this decline in social indicators, the government has begun drafting a PRSP, despite not being a HIPC country. The final PRSP was expected to be completed in late 2005.
West Africa		

[a] This classification is derived from the 2006 World Development Report. (WDR) Economies are divided among income groups according to 2004 GNI per capita, calculated using the World Bank Atlas method. The groups are: low-income economies (LIC), $825 or less; lower-middle-income economies (LMC), $826–3,255; and upper-middle-income economies (UMC), $3,256–10,065 according to 2004 GNI per capita; Source: WDR 2006

Annex C: Types of Social Security Programmes, Selected African Countries, 2009

Country	Old age, disability & survivors	Sickness and maternity		Work injury	Unemployment	Family allowances
		Cash benefits for both	Cash benefits plus medical care[a]			
Benin	X	b	c	X	d	X
Botswana	e	d	d	X	d	c
Burkina Faso	X	b	X	X	d	X
Burundi	X	d	d	X	d	X
Cameroon	X	b	X	X	d	X
Cape Verde	X	X	X	X	d	X
Central African Republic	X	b	X	X	d	X
Chad	X	b	c	X	d	X
Congo (Brazzaville)	X	b	X	X	d	X
Congo (Kinshasa)	X	d	c	X	d	X
Côte d'Ivoire	X	b	X	X	d	X
Equatorial Guinea	X	X	X	X	d	X
Ethiopia	X	d	d	X	d	d
Gabon	X	b	X	X	d	X
Gambia	X	d	d	X	d	d
Ghana	X	d	c	X	d	d
Guinea	X	X[f]	X	X	d	X
Kenya	X	d	g	X	d	d
Liberia	X	d	d	X	d	d
Madagascar	X	b	X	X	d	X
Malawi	d	d	g	X	d	d
Mali	X	b	X	X	d	X
Mauritania	X	b	X	X	d	X
Mauritius	X	d	g	X	X	X
Niger	X	b	X	X	d	X
Nigeria	X	d	g	X	c	d
Rwanda	X	d	d	X	d	d
Sao Tome and Principe	X	X	c	X	d	d
Senegal	h	B	X	X	d	X
Seychelles	X	X	c	X	c	d
Sierra Leone	X	d	d	X	d	d
South Africa	X[i]	X	c	X	X	X
Sudan	X	d	d	X	d	d
Swaziland	X	d	d	X	d	d
Tanzania	X	b	X	X	d	d
Togo	X	b	c	X	d	X
Uganda	X	d	d	X	d	d
Zambia	X	d	g	X	d	d
Zimbabwe	X	d	g	X	d	d

Source: International Social Security Association *(2009). Social Security Programs Throughout the World: Africa, 2009.* Geneva: International Social Security Association

Key: a. Coverage is provided for medical care, hospitalization, or both.
b. Maternity benefits only.
c. Coverage is provided under other programmes or through social assistance.
d. Has no programme or information is not available.
e. Old age and orphan's benefit only.
f. Maternity benefits are financed under family allowances.
g. Medical benefits only.
i. Old age and disability benefits only, with survivor benefits under unemployment.
X Available in some form.

Annex D: Demographic and Health Surveys and Other Surveys Undertaken by African Countries

	Type of survey and year conducted				
Country	**Standard DHS**	**MIS**	**Standard AIS**	**MICS**	**HIV/MCH SPA**
Angola	-	2006-07	-	-	-
Benin	1996, 2001, 2006	-	-	-	-
Botswana	1988	-	-	-	-
Burkina Faso	1993, 1998-99, 2003, 2010a, b	-	-	-	-
Burundi	1987, 2010a	-	-	-	-
Cameroon	1991, 1998, 2004	-	-	-	-
Cape Verde	2005a	-	-	-	-
Central African Republic	1994-95	-	-	-	-
Chad	1996, 1997	-	-	-	-
Comoros	1996	-	-	-	-
Congo, Republic	2005, 2009a	-	-	-	-
Congo, DR	2007	-	-	-	-
Côte d'Ivoire	1994, 1988-99	-	2005	-	-
Djibouti					
Equatorial Guinea		-	-	-	-
Eritrea	1995c, 2002c	-	-	-	-
Ethiopia	2000, 2005, 2010a, b	-	-	-	-
Gabon	2000	-	-	-	-
The Gambia					
Ghana	1988d, 1993, 1998, 2003, 2008	-	-	2006a, b	-
Guinea	1992, 1999, 2005	-	-	-	-
Guinea Bissau					
Kenya	1989, 1993, 1998, 2003, 2008-09	2010d	-	-	1999, 2010a, 2004-05
Lesotho	2004, 2009a, b		-	-	-
Liberia	1986, 2007	2009	-	-	-
Madagascar	1992, 1997, 2003-04, 2008-09	-	-	-	-
Malawi	1992, 2000, 2004, 2010a, b	-	-	-	-
Mali	1987, 1995-96, 2001, 2006	-	-	2009d	-
Mauritania	2000-01c	-	-		-
Mauritius					
Mozambique	1997, 2003, 2010-11d	-	2009d	-	-
Namibia	1992, 2000, 2006-07	-	-	-	2009d
Niger	1992, 1998, 2006	-	-	-	-
Nigeria	1990, 1999, 2003, 2008	-	-	-	-
Rwanda	1992, 2000, 2005, 2007-08, 2010d	-			2001a, 2007a
Sao Tomé & Principé	2008-09a, b	-	-	-	-
Senegal	1986, 1992-93, 1997, 1999, 2005, 2010d	-	-	-	-
Seychelles					
Sierra Leone	2008	-	-	-	-
Somalia					
South Africa	1998, 2003a, d	-	-	-	-
Sudan	1989-90	-	-	-	-
Swaziland	2006-07	-	-	-	-
Tanzania	1991, 1996, 1999, 2004, 2009-10		2003-04, 2007-08	-	2006
Togo	1988, 1998	-	-	-	-
Uganda	1988-89, 1995, 2000-01, 2006	2009-10d	2004-05c, 2010d	-	2007
Zambia	1992, 1996, 2001-02, 2007	-	-	-	2005a
Zimbabwe	1988, 1994, 1999, 2005-06, 2010d	-	-	-	-

Key: a = Data not available, b = Report not available, c = Restricted data, d = Survey and or analysis of results ongoing.
DHS; MIS = Malaria indicator survey; AIS = AIDS indicator survey; MICS = Multiple indicator cluster survey; SPA = Service provision assessment.

Annex E: ODA to Africa by Recipient Country (US$ Million, 2007 Prices and Exchange Rates, Net ODA Receipts)

Country	Share (%)	1970-79	1980-89	1990-99	2000-08	2005	2006	2007	2008
		Annual averages				Annual amounts			
Algeria	**1.0**	555	366	367	356	398	235	390	294
Angola	**1.5**	47	221	513	521	462	178	246	352
Benin	**1.2**	162	254	347	426	387	409	474	600
Botswana	**0.4**	174	256	151	127	54	74	108	680
Burkina Faso	**2.2**	316	496	577	768	778	951	951	936
Burundi	**1.0**	164	344	270	350	408	446	473	479
Cameroon	**2.9**	431	505	737	1,016	464	1,871	1,908	492
Cape Verde	**0.5**	37	155	165	163	184	153	165	205
Central African Rep	**0.4**	150	291	215	129	100	145	177	242
Chad	**0.9**	243	304	325	334	424	306	354	391
Comoros	**0.1**	68	100	56	36	26	34	44	35
Congo, Dem. Rep.	**5.7**	747	964	400	2,020	1,914	2,190	1,241	1,543
Congo, Rep.	**0.9**	176	220	280	332	1,644	283	119	469
Cote d'Ivoire	**1.3**	351	458	1,160	464	107	272	171	583
Djibouti	**0.3**	117	185	152	101	82	126	112	113
Egypt	**3.9**	4,306	2,982	3,904	1,388	1,107	953	1,107	1,282
Equatorial Guinea	**0.1**	9	53	59	33	44	29	31	35
Eritrea	**0.8**	-	-	136	282	383	137	157	135
Ethiopia	**5.8**	373	1,076	1,249	2,053	2,111	2,102	2,563	3,196
Gabon	**0.1**	144	171	146	42	67	33	51	51
Gambia	**0.2**	50	150	91	75	66	78	73	90
Ghana	**3.3**	305	606	835	1,167	1,269	1,277	1,154	1,237
Guinea	**0.8**	77	331	482	279	219	166	228	300
Guinea-Bissau	**0.3**	56	164	166	113	75	90	122	123
Kenya	**2.5**	559	1,148	939	871	833	1 007	1,323	1,308
Lesotho	**0.3**	109	221	151	98	75	77	129	136
Liberia	**1.0**	86	193	152	335	247	279	698	1,189
Libya	**0.0**	33	16	7	16	27	40	19	57
Madagascar	**2.3**	287	539	571	800	1 024	812	895	794
Malawi	**1.9**	261	428	649	674	645	745	742	882
Mali	**2.1**	351	703	595	756	790	898	1,020	907
Mauritania	**0.9**	335	432	318	318	202	217	342	291
Mauritius	**0.1**	82	104	59	39	35	21	69	102
Mayotte	**0.8**	10	55	135	279	233	377	407	441
Morocco	**2.5**	837	1,317	1,040	871	804	1,152	1,073	1,129
Mozambique	**5.0**	123	852	1,525	1,774	1,467	1,742	1,778	1,907
Namibia	**0.5**	0	22	230	193	140	163	217	197
Niger	**1.5**	381	547	435	513	581	566	542	569
Nigeria	**7.8**	316	150	304	2,769	7,332	12,444	1,956	1,234
Rwanda	**1.7**	250	407	578	599	648	632	722	893
Sao Tome & Principe	**0.1**	7	33	69	43	37	24	36	44
Senegal	**2.3**	465	933	810	809	769	900	872	998
Seychelles	**0.0**	54	46	27	15	16	15	9	11
Sierra Leone	**1.2**	70	170	202	430	383	366	545	358
Somalia	**0.9**	383	933	468	328	269	426	384	727
South Africa	**2.3**	-	-	406	800	777	781	810	1,083
St. Helena	**0.1**	17	42	26	33	26	31	43	69
Sudan	**3.7**	668	1,764	584	1,295	2,030	2,202	2,112	2,289
Swaziland	**0.1**	74	73	62	41	46	37	51	64
Tanzania	**5.7**	783	1,584	1,421	2,024	1,686	1,982	2,820	2,233
Togo	**0.3**	173	265	213	112	94	87	121	310
Tunisia	**1.2**	661	507	326	415	408	480	321	442
Uganda	**4.0**	137	458	975	1 400	1,327	1,675	1 737	1,575
Zambia	**3.3**	313	723	1,109	1 148	1,294	1,542	998	1,035
Zimbabwe	**1.0**	19	520	591	336	418	305	479	594
North of Sahara, regional	**0.4**	**20**	**31**	**52**	**155**	**191**	**161**	**279**	**253**
South of Sahara, regional	**4.3**	**618**	**839**	**833**	**1 514**	**1,448**	**1,705**	**1,694**	**2,609**
Africa, regional	**2.5**	**221**	**686**	**736**	**898**	**848**	**928**	**1,454**	**1,259**
Africa total	**100.0**	**17,760**	**27,392**	**29,384**	**35,279**	**39,924**	**47,358**	**39,122**	**41,849**

Source: OECD (2010).