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Implementation of the DND and the ICPD-PA

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

I. INTRODUCTION

1.1: The context of the assessment

1. This report which has been prepared in the context of the quinquennial review and assessment of the implementation of the ICPD-PA as mandated in the General Assembly Resolution (52/188) of 18th December 1997, focuses on the implementation of ICPD-PA at the ECA regional level making appropriate references to the Dakar/Ngor Declaration (DND). The DND was adopted at the ***Third African Population Conference*** (APC3: Dakar, 1992) with qualitative and quantitative targets covering various aspects of the development planning process. APC3 also established a machinery (i.e. a Follow-up Committee) for continuous monitoring of the implementation of the recommendations of the DND and the subsequent ICPD Program of Action (ICPD-PA)[1] adopted at the International Conference on Population and Development in Cairo, 1994. Table 1 indicates the quantitative targets that were set.

2. To date the Follow-Up Committee has met twice (1994 and 1997) to deliberate on various aspects of implementing the recommendations of the two development frameworks by ECA member States[2]. Additionally, in March 1998 and under the auspices of the African Population Commission, a Seminar on population policies for high level officials of National Population Commissions, among others, also reviewed the progress made in population activities in the region. Two other assessments have earlier been undertaken. In the first[3], a Country Questionnaire was devised to assess the efforts made ECA member states at implementing the KPA recommendations[4]. The second[5], utilized data obtained from direct correspondence with responsible government officials.

3. In assessing the feasibility of meeting the qualitative and quantitative targets contained in the ICPD-PA, the 1995 assessment observed that (i) while some of the targets might be achieved for the region as a whole or by individual member States, most of the targets would be difficult to achieve by the set dates[6]; and (ii) an

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1 The DND was the African common position at the ICPD. In the balance of this report, ICPD-PA will be used to refer to the two development frameworks.

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

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

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

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

6 With respect to the quantitative targets, the assessment compared levels of pertinent population growth components before and after the adoption of the ICPD-PA. For the qualitative targets, the basis was ana analysis of government interventions, perceptions and level of commitment towards meeting the goals and

assessment of what was required was rather difficult owing to uncertainties about future socio-economic conditions in most States as well as the lack of adequate and reliable time series data for trend analysis.

4. The adverse economic conditions in the region since the mid-1980s had considerably affected the quantum of resources available for implementing population programs. And yet, on an annual basis, two thirds of the USD 17 billion estimated for achieving the ICPD-PA goals is expected to be provided by the developing countries. ECA member States are expected to contribute their share through increased budgetary allocation from governments at all levels; a more significant contribution by communities; cost participation by individual beneficiaries of services; and an expansion of NGO and donor support.

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

1.2: Objectives, scope and complexity of the present assessment

6. The factors that either promote or inhibit the implementation of the ICPD-PA recommendations as identified from the earlier assessments have been shared with the member States both during the indicated meetings and through the associated reports which have been published and disseminated. The ultimate test is whether these factors, recommendations and guidelines have been applied towards achieving sustainable development and a higher quality of life for all people.

7. Nonetheless, because long term commitment and concerted action are required, the present assessment, like its predecessors, aims at identifying achievements, best practices and constraints. It draws on a variety of sources including ECA administered country questionnaire as well as regional and sub-regional reports. Among the reports are analyses of lessons learnt as compiled by UNFPA Country Support Teams and two ECA field missions in 12 selected member States to document achievements, best practices and constraints in the implementation of the ICPD-PA recommendations. At the time of preparing this report (i.e. end of August 1998), only 36 completed Country Questionnaires (out of an expected total of 53) had been received. The indicated percentages of the various responses in the Report are based on this number.

8. A careful utilization of these achievements, best practices and constraints should provide some guidelines for the next generation of NPPs in the ECA region. However, this report cautions that although the achievements reflect complex, long-

objectives of the development frameworks.

term processes which include far-reaching changes in attitudes, the building of capacity in many areas and the strengthening of linkages between population and other development activities are often difficult to determine precisely when a particular objective has been attained.

9. The identification and examination of best practices can contribute significantly to the formulation and implementation of effective policies and programmes. Consideration of best practices tends to show how constraints can be overcome and how broad principles (such as *integration* and *mainstreaming*) can be operationalized. Nonetheless, it is essential that best practices evolve over time in light of experiences and changes in needs and that in each case, a "best practice" should be adapted before it is adopted.

10. While implementation of a specific measure, such as dissemination of research findings to policy makers or revision of a law, may constitute a step in the right direction, it may not signify that a key objective has been attained. Moreover, in such key areas as reproductive health (RH) care services; information, education and communication (IEC) activities; and data management, needs are likely to evolve over time. Equally, an assessment of achievements since the adoption of the ICPD-PA necessarily focuses on the adoption and implementation of policies and programmes as distinct from actual changes in social, economic and demographic conditions. Even within some States, there are substantial differences in the extent to which new policies and programmes have been successfully launched and implemented.

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

12. The report is presented in eignt main sections as recommended by the second session of the Follow-up Committee meeting in June 1997 viz reproductive health and reproductive rights; advocacy and IEC strategies; gender, equality, equity, empowerment of women and male involvement; family, youth and adolescents; role of NGOs and the private sector in program implementation; institutional mechanism for implementation, monitoring, evaluation and coordination; resource mobilization for the implementation of population policies and programs; and population and development strategy and policy. For each of these sections, available information on achievements, best practices and constraints are presented. The last section suggests modalities of a way forward.

II. REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

14. The goal of the ICPD-PA is that all countries should make available universal access to a full range of high quality reproductive health (RH) services[7] through the

[7] RH implies that people are able to have a satisfying and safe sex life, are able to reproduce and have the freedom to decide if, when and how often to do so. (ICPD-PA paras 7.2 and 7.3). To have this right, they must have knowledge, skilful services, requisite supplies and financial resources as well as individual empowerment to use all of these.

primary health care (PHC) system[8] no later than the year 2015. Comprehensive RH services include FP information and services, pre and post natal medical care, prevention and management of complications of unsafe abortion including safe abortion services where they are not against the law, treatment of reproductive tract infections and sexually transmitted diseases including HIV/AIDS, active discouragement of harmful practices, and other conditions of the reproductive system including breast and other cancers, prevention and treatment of infertility, and information and counselling on human sexuality, responsible parenthood and RH.

15. Reproductive Rights (RRs) rest on the recognition of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and RH. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence. Excercise of RRs is facilitated by existence of positive laws and procedures as well as personal awareness, education and other resources necessary for implementation.

2.1: Achievements

16. The ECA member States present considerable diversity in their RH/RRs status and services. Availability, quality, utilisation of RH/sexual health (SH) services vary dramatically by type of service among them (see Tables 2, 3, 4 and 5). In all of them, public discussions about and statements made in support of RH, along with updated laws and policies, have provided the requisite open door for implementing RH initiatives as well as a platform for focusing more sharply on critical issues. The primary achievement since Cairo has been the sensitisation of policy makers to ICPD tenets of RRs (including those of adolescents) and of integrated comprehensive RH services. In several States, NGOs have quickly seized this opportunity. Most, however, are still attempting to reform public health services and conduct the retraining of in-service and new staff. Although RH concepts are now much better understood than before by those in leadership positions in the ministries concerned, few States are yet to experience a significant gain in available quality and integrated RH services.

17. Some States report that they have included issues of RRs in their newly adopted national population, RH and FP policies. While 70 per cent of the States indicated they had taken measure to ensure that women and men are aware of their RRs and that they can exercise these rights, fewer had adopted specific policy measures to eliminate FGM. Sex selection does not appear to be a major issue in most States and only one State reports policies enacted to eliminate it. About 87 per cent of the member states have laws setting the legal minimum age at marriage; this varies from 14 in Madagascar and Niger to 21 in Botswana and Rwanda.

18. Most of the States affirm that they were implementing specific components of RH as part of their PHC (see Tables 3 and 4). Virtually all of them have made a considerable effort to expand and improve access to RH services through a variety of channels including the public primary health care (PHC) system, private practitioners, NGO clinics, pharmacies and drug stores, work places, and social marketing and community based distribution (CBD) programmes. Laws previously

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

prohibiting the advertisement or distribution of contraceptives have ***ipso facto*** been superseded in some States and plans to repeal these laws have been formulated in others. In French-speaking countries the 1920 anti-contraceptive law has been repealed. A greater variety of RH services are therefore available especially in urban areas and along major transport routes.

19. According to USA-based DKT International 1997 report, over 26 countries in Africa have social marketing programmes mainly for contraceptives and condoms. Only Egypt and Morocco do not include male condoms in their social marketing programmes. Female condoms are socially marketed in South Africa, Uganda, Zambia and Zimbabwe. While the sale from social marketing decreased between 1996 and 1997 in 5 countries, by far the majority of programmes show increasing sale: Botswana 41%, Cameroon 32%, Ethiopia 45%, Kenya and Mali 65% and Mozambique 155%.

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

21. There is heightened awareness of the need to provide RH services to special groups. In this regard, there are adolescent reproductive health (ARH) projects which offer RH services including peer counselling and IEC in combination with recreation in almost all member States. In some countries, namely Eritrea, Kenya, Uganda, and Botswana there are youth centres targeting out-of-school adolescents. Similarly RH needs of refugees and displaced persons residing in camps and settlements are being addressed with the support of UNFPA, UNHCR and other multilaterals notably in Somali region of Ethiopia, Uganda, Tanzania, Sierra Leone and Kenya.

22. An aspect of RH which is gradually coming out of the socio-cultural closet is the issue of gender violence particularly sexual violence including rape, defilement, wife beating and forms of dangerous traditional practices. Women's professional NGOs have started giving attention to these problems by setting up crisis centres and legal clinics for counselling and research in Uganda, and countries of SARDC.

2.2: Best practices

23. One impact of improved access to RH services is seen in findings from the DHS over the last 15 years, where desired family size has generally decreased. In Kenya for example, women are giving birth to fewer children (about 3 on the average per woman) than they did 15 years earlier, one of the fastest declines in the world. Another notable example of rapid fertility decline is Zimbabwe where, even without the adoption of an explicit population policy, education and lower child mortality have contributed significantly to the reduction of average family size. Examples of best

practices include:

- the establishment of Uganda AIDS Commission within the President's Office ; this indicates Government direct involvement and commitment;

- making high quality non-prescriptive FP commodities affordable to people in spite of a policy of cost recovery as well as promoting the private sector to participate in FP services e.g. in Cameroon;

- Safe motherhood and emergency obstetric care**:** In Uganda, within 6 months of establishing referral mechanisms at the district level, the number of referred cases increased exponentially and maternal mortality rate was drastically reduced;

- FGM - In Uganda, the government initiated a community-based education and sensitisation initiative that focused on influential groups in the community and was able to show that cultural practices can change without necessarily compromising cultural values. Within two years of project implementation, 36 per cent fewer girls and women in the target groups underwent FGM. In addition, clan leaders, elders, and women's groups have agreed to discard FGM. One key factor that was associated with this success was the willingness of community leaders to replace the traditional ceremony with symbolic gift giving, while preserving other aspects of the rite of passage of girls to adulthood;

- CBD programme in Zimbabwe, with about 700 people distributing non-prescriptive contraceptives nation-wide: selected by local communities, the CBDs attend a six-week training course that includes counselling and communication skills, contraceptive counselling and blood pressure measurement;

24. The proportion of public health facilities with recommended stock levels of STD drugs rose from 68 per cent in 1993 to 88 per cent in 1995 in Zimbabwe;

25. Tanzania has decided to channel procurement and distribution of all medical supplies through the Medical Stores Department. Cote d'Ivoire has placed responsibility for procurement and distribution of contraceptives with AIBEF when it realised that contraceptives were three times more expensive if procured through the government pharmacy. In some States, serious consideration is being given to privatising some or all components (e.g., warehousing, transport, clearing, etc.) of the supply system;

26. A number of countries have decided not to embrace all dimensions of RH immediately in view of particular constraints. They have taken on only those activities for which they have some expertise and are encouraging the private sector and NGOs to take on the other dimensions. In Tanzania, the AMREF and UMATI are given responsibility for developing most of the youth RH programmes and of the CBD approaches. The contraceptive supply system in Cote d'Ivoire is entrusted to the AIBEF. The health sector in Lesotho has depended over the years on the facilities provided by the Christian missions;

27. In a number of States (e.g., Botswana, Uganda, Tanzania, Kenya) women's professional associations have published guidelines aimed at assisting women understand the laws that affect them and their families. They have also held

seminars and workshops with political and community leaders to resolve conflicts between customary laws and traditional practices;

28. Some States have been experimenting on cost-sharing approaches including user fees and community participation in the provision of basic infrastructure including volunteer services. In Ghana, it is being proposed that the government should create an endowment fund for such programs such that interest accruing to them can be used for the sustainable funding of at least some of their key components;

29. Some governments have been providing direct financial support to the NGOs in addition to the substantive assistance provided in the form of premises, logistic support, tax and other duty exonerations, training and sponsorship to attend meetings and even detachment of government staff. The AIBEF of Côte d'Ivoire receives substantial funds from the government every year and recently obtained government backing for multilateral funding to expand its services. In Zambia, government subventions are usually budgeted but it takes quite some time and effort for them to be disbursed;

30. Some States have been zoning intervention areas so that each actor of the sector is assigned a specific part of the country. All actors are then expected to abide by the policy guideline and standards of service delivery while adapting their interventions to the local realities of their zones of intervention. This has been the practice in Cameroon where the programs run by the GTZ, the UNFPA, the European Union and the French Cooperation are located in specific provinces or districts within provinces. Tanzania and Lesotho have also worked along identical patterns. Overlapping of interventions is thus avoided and the Ministry of Health does the supervisory work. Occasionally the various actors hold meetings to share their experiences and to examine new strategies. and,

31. A common basket approach for intervening in the health sector has been proposed in Tanzania, Ghana and Côte d'Ivoire under a World Bank initiative. This approach requires that all donor agencies within the sector pool together their resources to allow the governments to decide how best such funds could be used to meet national goals.

2.3: Constraints

32. Faced with a seemingly endless series of competing crises, ministries of health and NGOs involved in health care are finding prioritization both politically and technically difficult. Even within RH itself, conflicting opinions are expressed on whether, for example, HIV/AIDS should be addressed at the preventive or the treatment levels. Questions arise as to the resources that should be dedicated to maternal mortality when the number of deaths is insignificant in comparison to those associated with AIDS. Similar doubts are raised regarding the wisdom of investing in cancer screening. Clearly, available resources do not permit “doing everything well”, but more important the technical bases and the political will to prioritize are still lacking. The deteriorating economic environment affects more than just service provision. Poverty also results in declining school attendance in several States. Many cultural traditions similarly militate against improvement in RH status, and in some cases actually contribute to deterioration.

33. In spite of the fact that many of the critical RH challenges require an IEC solution, there is still a shortfall in funding and a relative shortage of personnel who are adequately trained to produce the quality and quantity of counseling, teaching, mass media, and the other materials required. Additionally, there has been an over reliance on the public sector to conduct requisite IEC activities even in those States where private sector firms might reasonably be expected to provide higher quality, more interesting and more effective products.

34. Although the largest single "captive audience" of young people remain the in-school population, coverage of Population/Family Life Education is still limited in most States to a few pilot schools and the materials presented relating to RH are often too timid to be useful in changing risky behavior. It would also appear that even where more informative materials are in existence, greater impact could be attained if classroom experiences could be supplemented by peer counseling, co-curricular clubs, and other reinforcement mechanisms.

35. Research in several States has served to elucidate cultural obstacles to improving RH, however, little attention has been paid to identification of those mechanisms employed by persons who have found successful ways to communicate about delicate sexual matters in terms which are culturally acceptable. In short, although IEC personnel are learning more about what needs to be communicated, they are hampered by the lack of information on how to communicate it. It is observed that the rural population, precisely the group where cultural barriers may be expected to be most difficult, is the group most marginalized in RH IEC. Since it still constitutes the majority in the various sub-regions, it is imperative that more and better-crafted IEC efforts be directed to them.

36. Most member States are decentralizing their administrations including the RH sector. This has created fear among staff resulting in key project staff of either being laid off or transferred to different services. The new comers into the projects and programmes need some time and training to acquaint themselves with the reorientation process.

37. The inherent comprehensive service delivery approach to RH has caused several operational problems. The activities of these components are usually implemented as vertical programmes with separate management structures including logistics and information systems. Even in service delivery sites with only one provider, separate registers as well as reporting and acquisition forms are kept and separate sites are set within the same health facility to provide specific services of RH components.

38. In order to satisfy the needs for medical supplies for the sector, the range of drugs needs to be broadened; this immediately poses problems of procurement and management. With the current liberalization of the economies of most ECA member States, the formal and informal channels of drug importation and distribution have increased. It is thus not possible to control the quality and ensure the proper handling and conservation of the drugs and the contraceptives. In some of the States, drugs

for the RH sector may be obtained from public and private health institutions, from pharmacies and in generic forms from informal drug peddlers in the streets. It is therefore difficult to guarantee the quality of the drugs and contraceptive methods available to the consumer.

39. Equally, although all the approved FP methods are provided in public sector hospitals, they are not regular due to stock shortages. Safe motherhood services, especially emergency obstetric care, are offered only in very few areas on a pilot project basis. Even these are mostly limited to antenatal care, normal delivery and postnatal care due largely to inadequate number of trained health care providers, lack of equipment and non-functioning referral mechanisms.

40. There are problems as well with the laws and regulations that govern health care workers. In many States, the nurse or midwife is not authorized to prescribe antibiotics and/or administer intravenous fluids; medical assistants are not authorized to treat abortion cases even in remote areas where they are the only available health personnel. More fundamentally, the laws governing abortion are restrictive with limited exceptions. Although the official policy declarations in support of RH and RRs provide advocacy for more action and create awareness among target groups, they have not evolved into enforceable principles protected by legal provisions.

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

42. Laws concerning abortion remain quite restrictive and effectively prohibit the development of safe and effective services for women in most States. In most States abortion is legal only when the life or health of a girl or woman are endangered and in many countries, this must be affirmed by the presence of two senior medical doctors. In only a few States, abortion is permitted following rape or incest. The exception is the Republic of South Africa where abortion on demand has been legalised.

43. In the public sector, very few district or regional government hospitals provide abortion-related services and many health workers do not use manual vacuum aspiration equipment because it is not available to them or they are not trained or legally permitted to do so. In most States still, there are no regulatory barriers to the provision of post-abortion health care services, including counselling, education and contraceptive services. In practice, many of these States report that upward of 25 percent of obstetric and gynaecology hospital and clinic beds are occupied by women needing treatment following abortions and that the deaths of least one-third of all women dying from pregnancy-related causes are due to complications of unsafe

abortion.

44. Although there is increased availability and accessibility to FP, it remains mostly female-centred and supply-side short-term oriented, with pills and injections most often used by women; contraception is practised mostly for birth spacing; and contraceptive methods have gained wide acceptance among younger people. Surgical sterilisation for both males and females remain a method that is inadequately advocated and utilised. The female condom is available in some States through social marketing programmes and in few commercial outlets. Social marketing programmes (in some States) also offer pills, vaginal foam tablets and injectables. Emergency, post-coital contraception is beginning to gain acceptance in the range of choices available to women.

45. In spite of being a priority, safe motherhood and emergency obstetric services are available in very few pilot projects. Safe motherhood services, provided at PHC level are limited to ante natal care, normal delivery and postnatal care. Health centre staff including midwives are not allowed to use forceps, vacuum extractors or to administer oxytocics or intravenous fluids. Eventhough the key to accessibility and cost-effectiveness in safe motherhood is the referral mechanism[9], its non-functioning and lack of fully trained personnel and availability of medical equipment are the norm in most States. The major implementation constraint for adequate referral systems is financial.

46. Most disabled persons are destitute, depending on minimal familial or community support, if any. Their specific needs are hardly ever considered during the design of projects. They are constantly discriminated against in terms of access to social services and employment and very few NGOs have been formed to attend to their specific problems. Some recent censuses have included specific questions on physical disabilities which, hopefully, will lead to more focused projects, programmes and attention to their specific needs.

III. ADVOCACY AND IEC STRATEGIES

47. By definition advocacy aims at changing the status of a policy, strategy or program whereas IEC aims at changing the knowledge base, attitudes, beliefs, values, behavior or norms within individuals[10] or groups of individuals. The ICPD-PA states that greater public knowledge, understanding and commitment are vital to the achievement of its goals and objectives and that increasing such knowledge, understanding and commitment is, therefore, a primary aim. It (I) indicates that members of national legislatures can have a major role to play, especially in enacting

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

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

domestic legislation for implementing the NPPs, allocating appropriate financial resources, ensuring accountability of expenditure and raising public awareness of population issues; (ii) notes that fostering active involvement of elected representatives of the people, particularly parliamentarians and concerned groups and individuals, was a major objective.; and (iii) recommends joint participation of the Government, NGOs, the private sector and the community not only in the dissemination of information but also in the development of IEC/Advocacy strategies.

3.1: ***Achievements***

48. Most ECA member States have not only recognised the need to design and implement advocacy activities but are in fact initiating such activities. In many cases they have undertaken to develop advocacy strategies, often in conjunction with the development of IEC strategies; they have also taken steps to "tool up" for the implementation of advocacy activities, partly through the development of the institutional bases, including coalitions, alliances and consortia.[11]

49. Available evidence from the afore-mentioned ECA field missions to 12 selected member states indicates that advocacy and IEC strategies have been widely used especially by national NGOs to (i) mobilize political commitment and subsequent allocation of resources to address population and development issues; (ii) seek support for the promotion of practices that guarantee protection of women and men from abuse, for programs that prevent and treat STDs, including HIV/AIDS as well as for programs for eliminating traditional harmful practices; and, (iii) create awareness about the type of activities that should be undertaken on these issues at different levels of administration. In particular, IEC strategies have been extensively used to: (i) generate demand for RH services; (ii) enlighten men and women about their RRs and responsible parenthood; (iii) promote safe sexual behaviors; and, (iv) mobilize men to participate in RH programs

50. The various strategies which have been adopted in member States to disseminate information on national population and development issues are presented in Table 6. The data show that the media (newspaper, radio and the television), seminars, workshops and meetings (both formal and informal) are the most widely used means of disseminating information. In 63 per cent of the States, there have been formal presentations of population and development issues to parliament. Table 7 shows the percentages of the States in which IEC/Advocacy strategies have been developed within sectoral programs. Almost all the States have developed IEC/Advocacy strategies for issues concerning adolescents and youth, empowerment of women, FP and RH. Considerable proportions of the States have also developed IEC/Advocacy strategies within other sectoral programs: environment preservation, gender equality and equity (87%); population and development (80%); and, poverty alleviation (77%).

51. The NGOs have not only been involved in the dissemination of information on population and development issues, they have also received information on such issues from government parastatals. There is thus considerable exchange of

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

information between the Government and the NGOs. Table 8 shows a high collaboration between government ministries (Education, Health, Information and Communication, Youth and Culture) and NGOs in the development of IEC/Advocacy strategies. Religious and policy leaders are also involved in about 80 per cent of the States. The general public is involved in two of three States, the private sector in one of two and the community leaders in less than half of the States. Table 9 shows that a significant proportion of the States have mechanisms for coordinating the various IEC/Advocacy components: from 63 per cent for training to 77 per cent for IEC strategy development.

3.2: Best Practices

52. The IEC activities of past UNFPA country and other programs, have contributed immensely to providing policy makers, policy implementers and grassroot actors with the needed information for understanding and explaining the relationship between population issues and development. In the particular domain of RH, some success has been achieved in eradicating misconceptions regarding FP and consolidating the need to promote these services thus paving the way for attitudinal and behavioral change.

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

54. The development of political pluralism along with the extension of civil liberties has created a fertile environment for the creation of NGOs, grassroots and professional associations, pressure groups and other networks for canvassing and advocacy. Once the facts are in hand, one has a wide choice of options to push ideas through so as to advocate policy changes. Most of the States have been conducting such nationally representative sample surveys as the DHS, Household Consumption surveys, Living Standards surveys etc. during intercensal periods. These have been vital for the update and complement of census data on which are based, IEC/Advocacy messages.

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

3.3: Constraints

56. The main constraints are unwillingness of some major players to participate in the design of national IEC/Advocacy strategies; lack of relevant socio-cultural and other data; inability to clearly define the institutional and coordinating mechanisms; inadequate training and supervision of staff; inadequate capacity to produce IEC materials; low motivation among program implementers; and the inability to cover the target population. There are also problems with what processes are to be followed in developing the strategy; how the latter is to be used once developed; who uses it; whether its application should be policed; and who infact, needs the strategy. To a large extent, the data in Tables 6 to 9 amply testify to these constraints. Rarely has the target audience been involved in the formulation, monitoring and evaluation of the impact of IEC and advocacy programs.

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

58. IEC/Advocacy materials have been lacking in variety and specificity, as well as in quality and quantity. Furthermore their wide distribution has been hampered by logistic problems. No functional data banks have been created as yet for the pooling of all the vital population-related data, documentation and other information which could then be easily accessed towards focussed IEC and advocacy messages. Results of most research operations take a long time to be published and are hardly ever given a wide enough dissemination; the raw data files are never easily accessible. In most cases, census data has become obsolete. In Lesotho, the results of the 1996 census are anxiously being awaited before any consistent IEC and other strategies can be developed. Nationally representative surveys like the WFS and DHS have been quite instrumental in the updating of data but they cannot go beyond a certain level of geographical desegregation.

59. A few States like Senegal and Ghana have developed the requisite curricula and pedagogic materials for the teaching of Population and FLE in schools and out of school. Very little thought has yet been given to the training of trainers. A majority of the population, to which IEC messages are destined, is illiterate in States where there is a diversity of ethnic groups and dialects with no other lingua franca. This

requires that the messages be translated into the various dialects and that the appropriate channels be chosen to pass them on. Not only do some States lack the expertise for such translations, but terms such as 'gender', 'RH' etc are new and there are no easy local equivalents for contraceptives and even FP that could appropriately pass on the right meaning.

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

61. More than one third (about 37%) of the member States have never informed their Parliaments about the contents of their population and development issues including national and sectoral policies (Table 6). Although only an insignificant proportion (13%) of these States has not used such other channels as the media, seminars, workshops and meetings to disseminate the information on population and development issues, the non involvement of a sizeable proportion of member States' Parliaments which normally comprise decision makers and professionals as well as the general public (27%); youth and women groups, religious institutions (23%); NGOs (20%); and policy makers and government officials, service providers (13%), is a serious omission.

62. Besides dissemination, more than one fifth (23%) of the member States have not as yet developed a national population IEC/Advocacy strategy purporporting to address poverty alleviation and about one fifth are yet to develop such strategy for the population and development sector (Table 7). Admittedly the corresponding proportions are much lower in the cases of such other sectors as environment preservation and gender equality and equity (13%); RH (10%); and FP (7%). But the message and the implications are clear in terms of effects on the operationalization of population and development activities in these States.

63. Even in sectors where an IEC/Advocacy strategy exists, about half of the member States (47%) do not involve private organizations; about one third (33%) do not involve the general public; and about one fifth (20%) of the policy leaders and of Government institutions (in the case of Ministry of Culture) are not involved in their development (Table 8). Worse still, mechanisms do not exist (Table 9) for the coordination of such population IEC/Advocacy functions as training (37%); message and material development (33%); message dissemination, research and evaluation and information exchange (30%).

IV. GENDER, EQUALITY, EQUITY, EMPOWERMENT OF WOMEN AND MALE INVOLVEMENT

64. The ICPD Programme of Action states that the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself and is essential for the achievement of sustainable development. It recommends that countries should act to empower women and take steps to eliminate inequalities between men and women.

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

66. Complementary objectives and recommendations were incorporated in the Platform for Action which was adopted by the Fourth World Conference on Women that was held in Bejing in September 1995.

4.1: Achievements and best practices

67. Since ICPD, at least 13 countries have requested and implemented training activities in gender, population and development, mostly for high- and mid-level policy makers, programme managers and implementers. The training focused on awareness creation, programme planning from a gender perspective and gender analysis and reflects Governments' increasing commitment to understanding and addressing gender issues in national development planning processes. This is associated with recognition of the centrality of gender issues to achieving population and development goals, the result in good measure of advocacy and sensitization efforts carried out during international and regional meetings and within countries by national and international NGOs as well as other national groups, such as the Network of African Women Ministers and Parliamentarians.

68. Nearly all Member States have taken actions to initiate and or improve gender sensitive data collection, analysis, dissemination and use in education, health and censuses. There is a need to know and understand the underlying causes of gender inequality and equity by using data which highlight gender inequalities and inequities. Measures undertaken to obtain gender-responsive data include: creation of gender statistics units; development of gender-sensitive education management systems, data collection instruments and morbidity and mortality statistics; creation of

documentation centres; and development of gender data analysis and dissemination systems.

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

70. Roughly two-thirds of Member States have initiated gender-focused research in such areas as division of labour, access to income, intra-household control and socio-cultural factors affecting gender equality. Such efforts include gender-focused surveys, demographic surveys with gender modules and studies on poverty, female-headed households and property rights.

71. Most countries are making some efforts which could contribute to the reduction of discrimination against women. About 24 and 21 countries have, respectively, ratified and are implementing the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), a comprehensive, convention extending from public to private spheres, to ensure gender equality in matters of citizenship, education, employment, health care, economic rights, marriage and family relations.

72. Some 25 countries have adopted measures to promote women's participation in decision-making. These measures which facilitate fuller participation of women in decision-making include: creation of women ministries, increase in the number of female ministers and parliamentarians and using the quota system to promote women's participation. For example, in Kenya and Liberia women presented their candidatures for presidential elections in 1997. Also, in some countries women have organized themselves into coalitions or caucuses and have played catalytic roles in conscious-raising and encouraging more women to stand for political elections. In sum, women are empowering themselves and seizing the political initiative to participate in electoral polices.

73. A number of countries, including Mozambique and Uganda, have adopted laws and policies to advance equal participation of women and men in decision-making at all levels. In Burundi, Development Centres have become Gender Development Centres and are producing and disseminating gender-sensitive materials as well as including men in their membership and activities. Post-ICPD women policies have been genderised in Chad, Ethiopia, Liberia, Mauritania and Rwanda. Central Africa Republic, Eritrea, Mauritania, Tanzania, Uganda and Zimbabwe have developed policies on gender and women empowerment.

74. Most Member Sates have created institutional mechanisms to address gender issues at the national and sectoral levels. These mechanisms include Women or Gender Affairs, Ministries, Departments, Councils, Divisions, Desks, Bureaux and Focal Points. These institutional structures and mechanisms are charged with ensuring that all national and sectorial policies and programmes are gender-sensitive

and are responsible for co-ordinating gender issues and activities of women's organisations. Approximately four-fifths of Member States have developed national action plans that address among other things, women empowerment issues. These plans identify areas of discrimination against women. Its main foci are the mobilisation of women, an education micro-plan and implementation of projects that provide equal access to credit, regardless of gender.

75. In an effort to mainstream gender concerns in line ministries, several Governments, including those of Ethiopia, Rwanda and Zimbabwe, have established Gender Focal Points (GFPs) in line ministries. The mandate of the GFP is to serve as a catalyst for gender-responsive planning and programming and to ensure that gender concerns are incorporated into sectoral policies, strategies, projects and activities. The GFP reports to the cabinet minister and collaborates with the ministry or structure that has the primary mandate for co-ordinating gender issues.

76. In Ghana, the Government has formulated a national action plan in consultation with NGOs. The plan identified priority areas, set time-bound targets for monitoring and evaluation and allocated resources for implementation. For 1997-1998, priority areas being addressed are: poverty reduction and access to micro-credit; education of girls; decision-making and public life for women. Mali's action plan covers the years 1996-2000 and allocates resources for women's economic promotion, education, health, environment, civil and human rights and participation in public life.

77. Many States have taken actions to increase women's access to productive resources and technical services. Examples include: provision of credit to women entrepreneurs in Ghana to set up small cottage industries; micro-credit facilities for women entrepreneurs in small businesses in Kenya; establishment of the Family Economic Advancement Programme in Nigeria; income-generating activities in Namibia; and a Women Entrepreneurship Unit providing technical advice, counselling and guidance to women in Mauritius.

78. Other states have taken actions to promote women's participation in the labour force. These measures include: ratification of Employment Equity Bill (South Africa); provision of maternity leave and vocational training and implementation of literacy programmes (Eritrea); inclusion of employment issues in policies and constitutions (Zambia, Uganda); equal-pay-for-equal-work regulations (Zimbabwe and Botswana); provision of credit schemes and education (Ghana); and Affirmative Action Bill and Act (Namibia). Eritrea, South Africa, Mauritius and Botswana have adopted specific legislation to increase and protect women in the labour force.

79. A few States have recognized that men's participation is critical for the attainment of gender equality and equity and women empowerment. Strategies for male participation include: (1) implementation of male promotion IEC and advocacy activities and services; and (2) creation of an enabling environment through implementation of appropriate laws and policies. For example, the ILO has executed about a dozen projects on Population and Family Welfare Education for the labour sector in english-speaking African countries. In Tanzania, one such project increased in contraceptive prevalence rate from 14 to 36 per cent.

80. The data in table 10 indicate that a sizeable proportion of the member States are taking actions towards ensuring gender equality, equity and women empowerment. Rather low proportions of these states are yet to promote women's participation in decision making (17%); to tailor extension and technical services to women producers (13%); and to improve the collection, analysis, dissemination and utilization of gender disaggregated data in education and health (7%).

4.2: Constraints

81. Despite the considerable progress realized since adoption of the Programme of Action, understanding of gender issues and awareness of their implications for reproductive health in general and for well-being in particular remain incomplete. In some countries the tendency remains strong to see issues relating to gender and the need to empower women as matters best left to institutes, departments and even ministries which are largely or even exclusively concerned with those issues. As a result the "mainstreaming" of gender issues remains partial, and as a result it often happens that significant gender issues are neglected in formulating and implementing significant elements of population policies and programmes.

82. A significant barrier to mainstreaming has been weaknesses in its conceptualization of gender as well as the delays and difficulties in developing strategies to operationalize effective integration of gender concerns in the development and implementation of development policies and plans.

83. While many Member States have now adopted gender policies and have modified laws and regulations to eliminate or reduce provisions which discriminate against women, the structures and systems for implementing the new policies and enforcing the new laws are often frail and lack broad support in the community, and the establishment of "guidelines" cannot overcome the lack of commitment and know-how. In many cases attitudes and practices unfavourable to elimination of gender discrimination and disparities remain deeply entrenched and restrict the gains which can be made through changes in policies and laws. Although the importance of male involvement in reproductive health and gender matters has been widely discussed, most Member Countries are still in the process of developing methods and mechanisms for bringing it about and thereby strengthening population programmes.

84. There are several constraints on operational activities. These include inadequate numbers of specialists to train nationals on various aspects of women empowerment, lack of or weaknesses in national IEC and Advocacy strategies focused on women's rights and, in some countries, shortcomings in institutional arrangements for the design and implementation of programmes. In some cases insufficient collaboration between Government departments and NGOs limits programme efficacy as does the weaknesses of links to policies and programmes not specifically focused on issues which relate to gender and/or population.

85. Additionally, to date there are no clear guidelines on programming and mainstreaming of gender into NPPs. Gender issues are still being addressed to predominantly female audiences while male involvement is yet to be evolved. The number of staff in women's Departments and Ministries is inadequate and those

available do not have the necessary training in gender analysis as well as qualitative and quantitative skills for collecting, analyzing, and utilizing the requisite data. Some National Planning Commissions (NPCs) and other data gathering institutions are not even sufficiently trained to collect gender responsive data.

86. The data in Table 10 indicate that only an insignificant proportion of the member States (13%) are yet to put in place needed institutional arrangements for addressing gender issues; about 20 per cent of them are yet to ratify the CEDAW and 30 per cent of them are yet to actually implement measures to effect the latter. Less than one half (47%) of them do not have information on traditional practices and skills, about the same proportion are still to take action towards increasing the age at marriage (43%) while about a third (33%) are yet to focus research efforts on women's division of labour, access to income, control within the household and socio-cultural factors affecting gender equality.

87. Last-but-not-least, gender discrimination and disparities are not only causes of reproductive ill-health but are also results of it. The efficacy of efforts to eliminate gender discrimination and inequity is reduced by reproductive health problems -- from early marriage and early child-bearing to a variety of health problems.

V. FAMILY, YOUTH AND ADOLESCENTS

88. The ICPD-PA draws attention to the special needs of children, adolescents and youth. These needs include social, family and community support, as well as access to education, employment, health, counselling and high-quality reproductive health services. In that connection the ICPD-PA calls upon States to enact and strictly enforce laws against economic exploitation and the physical and mental abuse or neglect of children and to create a socio-economic environment conducive to the elimination of all child marriages.

89. With respect to adolescent sexual and RH issues, which include unwanted pregnancies, unsafe abortion and STDs, the ICPD-PA called for addressing them through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling. The ICPD-PA stresses that States should ensure that programmes and attitudes of health-care providers do not restrict adolescents' access to the services and information they need. These services should safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values, religious beliefs and the rights and duties of parents. States with the support of the international community, should protect and promote the rights of adolescents to RH education, information and care, and greatly reduce the number of adolescent pregnancies.

5.1: Achievements and best practices

90. Most States report that they are implementing policies, programmes and laws favourable to adolescent RH; this includes legislation setting a minimum age at marriage and measures intended to reduce or prevent female genital mutilation

(FGM). More than half of the countries which have adopted development plans indicated that their plans refer to adolescent fertility. Nearly all countries report having formulated strategies relating to children and youth and having developed IEC strategies within their adolescent and youth sectoral programmes.

91. The extent of concern is particularly evident with respect to the girl child. Four-fifths of the countries responding to the questionnaire indicated that actions had been taken to enhance equal opportunities for and legal protection of the girl child.

92. Many different approaches have been used to reach adolescents and win their confidence and support. In some cases the emphasis has been on providing information to adolescents about reproduction, reproductive health, sex and sexual health while in other cases providing RH care services is the only or principal concern.

93. Special programmes have been introduced to meet the needs of adolescents; typically such programmes address either in-school or out-of-school adolescents.

- In Uganda, a Programme for Enhancing Adolescent Reproductive Life, known as PEARL, was launched in four districts in 1995. Designed to help respond to the needs of out-of-school adolescents, PEARL emphasizes: counselling on RH issues; provision of recreation facilities; development and use of IEC materials and messages; conducting research on the impact of culture; parent-child communication; and mobilization of political and community support. An in-school counterpart of PEARL was developed with funding from UNFPA to impart knowledge of RH/life issues to adolescents enroled in school. The formal school program is currently implemented among all pupils in primary and secondary schools.

- In Botswana, a group of individuals came together to form the Botswana Family Welfare Association (BOFWA) to meet the special reproductive needs of adolescents. Two other programmes which address adolescent RH needs are the Peer Approach to Counselling by Teens (PACT) and Education Centre for Adolescent Women (ECAW).

94. With respect to the girl child, most States have adopted measures to enhance girls' opportunities in the areas of access to education and promotion of RH and RRs:

- Eritrea, Ghana and Mauritania have promoted girls' education through sensitisation campaigns and establishment of girl-friendly educational programmes structures, policies and incentives.

- Cote d'Ivoire has provided school equipment to girls at the primary level in the northern regions, where educational levels are rather low.

- Ghana provides fees-waivers, remedial science courses and part-time study facilities.

- In Cameroon, special scholarship programmes are available for girls

studying the sciences at the universities.

95. More than half of the States have taken measures to increase marriage age, including legislative reforms to increase the age of consent to sexual intercourse to 16 years and the minimum age of marriage to 18 years or even 21 years (Table 10). In a few States, legislative and policy measures have been put in place allowing re-entry of pregnant girls into school after delivery; in at least one country a special education programme has been established for girls who dropped out of school due to pregnancy or marriage. Three States have ratified and are implementing the convention on children's rights.

5.2: Constraints

96. Young people in most ECA member States have only limited access to the reproductive health services and information they need to lead healthy sexually active lives; many young people lack the skills and support networks needed to develop healthy social relationships with partners. It is particularly difficult to conduct research on the needs of adolescents because of taboos in some cultures that restrict or prevent explicit recognition and discussion of the sexuality of young adults. Moreover, in some countries the magnitude and extent of harmful traditional practices and their effects are not well known. One traditional attitudes which are conducive to high fertility, gender discrimination and sexual exploitation of girls and women persist and lead to high rates of unwanted pregnancy, unsafe abortion and STDs as well as increases in the incidence of HIV/AIDS among youth and adolescents.

97. There are diverse barriers to the formulation and implementation of comprehensive adolescent RH strategies. Moreover, where new policies have been formulated, they are often at variance with other existing policies and protocols, in good measure because existing internal regulations and other legislation have not been modified in light of the new policies. Besides, many FP agencies and NGOs have sought to "comply" with new recommendations relating to adolescent RH by simply declaring that their service delivery points (SDPs) are "youth friendly" without taking any specific measures to provide the necessary in-service training to their staff.

98. Also, in some States, various groups of parents, religious and even educational authorities have openly objected to the introduction of family life education (FLE) programmes in schools. Yet, despite the common assertion that family life education leads to early sexual activity, the evidence suggests otherwise. Some programmes have shown that "sex education" may in fact contribute to a delay in sexual activity by increasing awareness of the issues and strengthening young persons' social support systems.

99. In general, youth in most ECA member States have not been actively involved in the formulation of programmes that concern them. Moreover, in most cases neither their parents nor other authorities have been fully sensitised to the goals and methods of such programmes. Hence some youth programmes have either failed to attract participants or have been summarily rejected by school, religious or

community authorities or by parents. In most cases, youth do not have an opportunity to participate in the evaluation of the projects which were expected to respond to their needs.

100. In some countries the practice of child marriage is still common and/or premarital cohabitation and childbirth are widely tolerated and practiced. Early entry into unprotected sexual activity before marriage is common in several parts of the Eastern, Central and Western sub-regions. For instance, it is reported that the Masai of Tanzania are rather permissive and encourage sexual activity among youth. The outcome may be the development of debilitating gynaecological complications such as genital fistulae.

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

102. The preference for sons, which still persists in many societies, is another constraint. There is a lack of in-depth socio-cultural studies which could reveal the incidence of such preferences and their consequences for the girl-child. Many discriminatory practices go unnoticed and may have far-reaching consequences for the physical, emotional, psychological and intellectual development of these children. Much remains to be done in order to eliminate stereotypes transmitted by both the media and pedagogic materials in schools.

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

VI: ROLE OF NGOs AND THE PRIVATE SECTOR IN PROGRAMME IMPLEMENTATION

104. The ICPD-PA requests governments and donors to ensure that NGOs and their networks are able to retain their autonomy and strengthen their capacity through regular dialogue and consultations, appropriate training and outreach activities. The governments of nearly all ECA member states have encouraged the formation of NGO "umbrella" or co-ordination organisations to develop guidelines which would help to ensure consistency and collaboration in the implementation of population policies and programmes.

6.1: Achievements and best practices

105. In many countries, policies and practices regarding NGOs are evolving fairly rapidly, often in conjunction with major shifts in development strategies. Among other things, Governments increasingly differentiate among various types of NGOs; this is reflected both in policies adopted with respect to the roles of NGOs and in guidelines relating to their modes of operation.

106. The Governments of nearly all countries have encouraged the formation of NGO "umbrella" or coordination organizations. Such organizations contribute to the establishment of guidelines which facilitate consistency and collaboration in implementing population policies and programmes. Nearly all countries responding to the questionnaire indicated that bodies for coordination of NGO activities had been established, while approximately two-thirds reported having taken steps to support national NGOs dealing with population and development issues. Just over half the countries indicated that they had provided financial assistance to NGOs.

107. The questionnaire on implementation of the ICPD Programme of Action focused attention on five specific categories of non-governmental groups and individuals. These were: local women's groups; youth groups; religious leaders/groups; trade unions; and cooperatives. Significantly, when asked to list "other NGOs involved in reproductive health programmes", the vast majority of countries did so.

108. Countries were asked to indicate whether each of the five categories of groups and individuals had participated in each of five aspects (research; design; implementation; monitoring; evaluation) of each of three types of programmes (reproductive health; family planning; HIV/AIDS).

109. Differences between the three types of programmes were relatively small. In general the category of group which was most likely to have participated in any aspect of a programme was "local women's groups", followed by "youth groups" and "Religious leaders/groups". For most combinations of programmes and categories of group participation in **implementation** was relatively more common than participation in the other aspects of programmes.

110. These results show that various significant elements of civil society -- such as trade unions, religious leaders and women's groups -- are perceived by Governments to participate to a significant extent in selected population activities. The implication appears to be that, in general, more and more diverse elements of civil society are being associated with population activities. However, the responses throw little light on the extent and nature of the role or roles of NGOs in planning, implementing and evaluating population activities.

111. The archetypal form of NGO involvement in provision of reproductive health services remains, presumably, operation of a family planning clinic in an urban environment by a national NGO in association with an international NGO or international federation. However, in practice African countries have secured NGO support for a wide range of programmes which affect reproductive health directly or indirectly.

112. Programmes which focus specifically on one or more reproductive health issues

include programmes to prevent the spread of HIV/AIDS, to deal with the complications of incomplete and/or septic abortions, to train Government and other staff at all levels in prevention, diagnosis and treatment of reproductive health problems and, of course, to make safe, effective and acceptable methods of contraception widely available.

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

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

115. The private sector plays an important role in many African countries in the provision of reproductive health services. In a number of countries policies and strategies relating to the role of the private sector have been modified in a manner consistent with the recommendations of the Programme of Action; these changes appear to have fostered attitudes and practices conducive to greater involvement of the private sector in provision of reproductive health services. Of particular interest is the provision of health care services by private practitioners and private enterprises including pharmacies and clinics, but also important are efforts by a wide range of enterprises and industries to improve the reproductive health of their staff -- and of the dependents of their staff. Examples include provisions for primary health care units in enterprises and on plantations to make available family planning information services and efforts by employers and unions to warn staff, such as truck drivers and laboratory technicians of the dangers of AIDS.

116. Rapid expansion of social marketing of contraceptives may well constitute the single most important change with respect to the role of the private sector in meeting needs for RH information and services. Social marketing corresponds well to the call (by the ICPD-PA) for the private, profit-oriented sector to play an important role in the production and delivery of RH care services and commodities. In a number of States the scale of social marketing operations is impressive and demonstrates their potential. Over 26 countries in Africa have social marketing programmes, mainly for contraceptives and condoms, but the types of commodities made available varies considerably. While the sales from social marketing programmes decreased between 1996 and 1997 in five countries, by far the majority of programmes are increasing - some very rapidly (Botswana 41%), Cameroon (32%), Ethiopia (45%), Kenya and Mali (65%) and Mozambique (155%).

117. In many ECA member States NGOs and the private sector play a large role in

the dissemination of information about population issues and their relationships to major development issues, including gender, poverty and protection of the environment. NGOs and, to a lesser extent, the private sector also play a major role in disseminating information about RH. While many NGOs devote their IEC and Advocacy activities to specific issues, such as prevention of FGM or reducing recourse to induced abortions to terminate unwanted pregnancies, others devote most of their efforts to pursuing such goals as improvements in the status of women, reduction in mortality and prevention of further degradation of the environment.

6.2: Constraints

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

119. Regarding the implementation of FP programmes (Table 11), the proportion of NGOs involved in research activities ranges from 17 per cent of Member States for NGOs involved in co-operative activities to 60 for those working with local women's groups. Regarding the design of FP programme, the corresponding range is from 23 to 63 per cent; for those involved in monitoring, it is 23 to 70 per cent; and for those involved with evaluation activities, it is from 17 to 67 per cent of Member States. The proportions are much lower with respect to RH programmes (Table 12) with a range of 7 to 47 per cent for NGOs involved with research on RH activities; with programme design, it is 17 to 67 per cent; with monitoring, it is 13 to 53 per cent; and with evaluation, it is 13 to 60 per cent. Given the seriousness of the HIV/AIDS pandemic, it is understandable that the corresponding proportions, as shown in Table 13, are somewhat higher.

120. In some cases the contribution of NGOs -- and, more broadly, civil society -- is constrained by lack of sufficient policy and programme guidelines and by inadequate mobilisation of communities and stakeholders by government and managers of population programmes. At times population activities have tended to reflect mainly the orientation and concerns of civil servants and specialists, including researchers. Growing emphasis on decentralisation, devolution of powers, democratisation and empowerment of communities and women increase the importance of securing the involvement of communities and groups in consideration of population issues, policies and programmes.

VII: INSTITUTIONAL MECHANISM FOR IMPLEMENTATION, MONITORING, EVALUATION AND CO-ORDINATION

121. The ICPD-PA (i) specifically recognised the need for demographic, social and economic data for determining priorities, formulating policies and programmes and assessing their impact; (ii) advised governments to strengthen national capacity to carry out sustained and comprehensive programmes to collect, analyse, disseminate and utilise gender-desegregated population and development data; (iii) urged states to set up or enhance national databases to provide information that can be used to measure or assess progress towards the achievement of the goals and objectives of NPPs; (iv) urged them to focus on the determinants and consequences of induced abortion, linkages between women's roles and status and demographic and development processes and interactions among population problems, poverty, patterns of over-consumption and environmental degradation and for governments to strengthen training and research in population and development issues and to ensure wide dissemination of research findings; (v) requested governments to increase the skill level and accountability of managers and others involved in the implementation, monitoring and evaluation of NPPs; and (vi) called upon the international community to assist governments in organising national-level follow-up, including capacity building for project formulation and programme management, and in strengthening co-ordination and evaluation mechanisms.

7.1: Achievements and best practices

122. Several member States are actively pursuing the goal of creating a national population database. Both to facilitate integration of population variables in planning and contribute to the formulation, implementation and evaluation of a wide range of population programmes. Many of these states are currently engaged in planning, launching and/or implementing information systems for health management. The data in Tables 11 through 13 provide evidence that in most member States, research has been launched and/or completed in such areas as RH needs; trends in fertility and mortality and their determinants and consequences; poverty, demographic trends and the status of women; interrelationships between fertility attitudes and behaviour and family structures and values; factors which facilitate and impede integration of RH services in primary health care; harmful traditional practices, including notably female genital cutting; access to RH information and services; determinants of programme impact; and the overall policy environment, which is comprised not only of groups (such as planners and women's rights ac. Many states have established or designated NPCs or inter-departmental or inter-ministerial bodies to over see and monitor implementation of the ICPD-PA. NGO’s are involved in some of these bodies.

123. In many States there are indications that among the measures that have been put in place towards strengthening programme management are (i) establishment and maintenance of policy- and programme-relevant databases; (ii) Use of the logical framework approach; and (iii) preparation of guidelines or, in the case of health care service providers, "protocols" that indicate what course of action staff involved in the development and implementation of NPPs should take.

7.2: Constraints

124. Political instability is a major constraint to programme implementation (Table 14). The frequent changes in government structures and implementing institutions in many States has resulted in high turnover of key personnel and disrupts continuity

within inter-ministerial/sectoral structures. Some States have embarked on decentralisation without the requisite human and material resources required and efficient central co-ordination.

125. In logistics management system, less integration has been achieved due to the diversity of funding mechanisms. In many States, for example, there are separate logistics management systems for contraceptives, sometimes by donor intervention; STD drugs and/or a national essential drugs supply programme. Sometimes, contraceptives are not part of essential drugs list. This has led to separate service delivery strategies which are less compatible with integrated need-based RH/FP and are often involuntarily gender-insensitive.

126. Other constraints are related to the "joint supervision system" in the RH sector. In many States, attempts have been made to harmonise and reduce verticality in supervision. However, most managers are discontented with joint supervision because each supervisor uses a separate checklist and therefore has different tasks and expectations. Often about five supervisors go out together to visit a single health care provider in a peripheral service delivery site. The administration of separate set of questions amounts to harassment of the service provider and dissatisfaction of the supervisors.

127. Information necessary for generating RH indicators is still not routinely gathered in many of the States. The recognition of the utility of population data has not sufficiently permeated leadership and planning communities. Admittedly, Central Statistical Offices in a few of the States have attempted to develop population databases, but they still do not incorporate information and indicators typically outside their purview.

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

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

130. Most States have not conducted a comprehensive needs assessment to accurately identify gaps and issues to be tackled through relevant NPPs. Lack of relevant studies, and in particular lack of policy relevant research and limited know-how on integrating gender issues in data collection, processing, analysis and research, have therefore constituted a great setback for the development of programmes that focus on specific problems facing communities. Many States also lack appropriate indicators for impact measurement as well as for monitoring and evaluation of NPPs.

131. There is also lack of trained personnel in the institutions dealing with population and development activities due partly to the high turnover of trained personnel, the insecure institutional support, the lack of motivation and unattractive remuneration. In addition, the expressions by governments of the need for trained specialists in the population and development sector is not accompanied by comprehensive human capacity needs assessment and human capacity building programmes. The data in Table 14 show that almost one-half of the States have inadequate technical capability to establish population and development interrelationships. It has therefore been difficult for these States to formulate and adopt clearly defined strategies for programme implementation. Programme co-ordination becomes difficult in the absence of clearly defined strategies since each actor tends to act independent of others. Many programme implementers lack the skills to promote the programmes. Lack of diversity in the available expertise at the national level is another important constraint.

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

133. Table 15 shows that co-ordination is a major constraint to programme implementation in the region. In over one-half of the States, there is inadequate cooperation between government and international organisations. Inability to co-ordinate the activities of the foreign partners has also been identified by 60 percent of the States as an impediment to programme implementation. In about half of the states, there is lack of co-operation among the line ministries due largely to the struggle for supremacy and greater share of the resources for population and development projects.

VIII: POPULATION AND DEVELOPMENT STRATEGY AND POLICY

134. The ICPD-PA calls for policies that (i) will ensure equality and equity between men and women and enable the latter to reach their full potential, involve women fully in decision-making and ensure their education; (ii) are sensitive and supportive

of the family; (iii) protect and support potentially vulnerable groups; that ensure effective access to adequate health information and services, especially for underserved and vulnerable groups; (iv) promote a more balanced geographical distribution of population; (v) extend and expand education; (vi) strengthen programme management, including client-oriented management information systems, and mobilise resources for investments in the social sectors; and (vii) integrate NGOs, women's organisations and local community groups into decision-making.

135. Furthermore, it places considerable emphasis on the family, and calls upon Governments to ensure that all social and development policies provide support and protection for families and are fully responsive to the diverse and changing needs of families. It urges governments to formulate policies that are sensitive and supportive of the family and to develop, along with NGOs and concerned community organisations, effective ways of assisting families, and individuals within them, affected by extreme poverty, domestic violence and other acute problems.

8.1: Achievements and best practices

136. Major changes are taking place in the ways in which policies are formulated. In many States the policy formulation process specifically provides for a wide range of concerned individuals and groups (the stakeholders and their representatives) to participate in discussions, information exchange, debates and even decisions regarding national (and sub-national) policies. Good examples are the processes of formulating national population policies in Uganda and Kenya. In Uganda, for instance, religious organisations and their leaders have been involved not only in the formulation of RH activities but also in their implementation. With respect to in-school FLE, consultative and participatory processes are utilised in Tanzania to ensure the relevance and acceptability of curriculum content.

137. A related development is increased emphasis on the relationships between social and health dimensions of well-being and, implementation of population activities, notably those relating to RH information, services and rights. For instance, population policies are increasingly likely to recognise and address such acute problems as the frequency of septic abortion, the impact of female genital mutilation (FGM), the incidence of fistulae, adolescent sexual activity, the spread of the HIV virus and sterility. This corresponds to the emphasis which the Programme of Action placed on alleviating the plight of the poor and other vulnerable groups. In general, the policies and strategies recently adopted by ECA member States place considerable emphasis on reducing gender disparities and discrimination.

138. As is evident from the data in Table 2, a feature of post ICPD-PA population policies and strategies is the emphasis on reduction of maternal mortality. By implication, there is need for improving the data available for measuring maternal mortality, for analysing its immediate and underlying causes and for assessing the efficacy of the policies and programmes. In terms of population data, significant progress has been registered in terms of the numbers of relevant staff trained. Additionally, training has been extended from central statistics offices and population planning units to sectoral ministry planning units. On balance, and in spite of losses of skilled personnel, the region is better staffed to meet population data requirements than before 1994 A major theme of the recent policies is the need to expand "male involvement", both in order to overcome resistance to "FP" and to get men more

actively involved in planning and implementing population activities. Nearly 60 per cent of the States either have implemented or are implementing strategies to increase the role of men in RH.About 79 per cent of them include strategies relating to the family in their policies (Table 2).

139. A significant development following ICPD-PA has been the integration of population concerns in policies and programmes aimed at eliminating gender disparities and discrimination. Equally significant is the inclusion of issues which relate to: the family; refugees and displaced persons; protection of the environment; and, in some cases, poverty alleviation. Table 2 indicates some of such issues and/or strategies. National health policies and programmes have identified RH issues and needs and have foreseen measures to increase access to RH information and services as well as d to improve the quality of care. In the same vein, national social development policies and programmes increasingly recognise the potential contribution of FP information and services to improving the well-being of women and their families and stress the need for effective measures to prevent the spread of HIV/AIDS.

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

141. In sum, in a significant number of member States, the degree of belief in the importance of the population and development nexus especially among central level policy makers and the recognition of the complex interrelationships between population, development, gender, and environment has grown considerably. For instance, there is increased incorporation of population, development and environment relationships into the school curricula. Malawi has introduced such content in all its schools; most other States are at various stages of pilot testing. Population policies are more widely recognized as of national, and not simply as donor driven and are increasingly seen as necessary frameworks to provide legitimacy for new, relatively sensitive population activities (such as provision of services to adolescents). Since such legitimacy requires widespread public acceptance, governments have engaged in considerably more consensus building, especially beyond the national capitals, in favor of the new population policies.

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

such as education, health, energy and infrastructure, which are widely regarded as priorities for government action.

143. About 63 per cent of the States have adopted national economic and social development plans (Table 5). The percentage of the plans, which included specific population variables, ranged widely (Table 6). For the variables *population size* and *population growth, 90 per cent of the States* with plans indicated their inclusion in the development plans, while in the case of the variables *population distribution* and *adolescent fertility,* the proportions were 58 per cent each. Significantly 79 per cent of the States indicated that their development plans took RH into account.

8.2: Constraints

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

145. It is presently difficult to estimate the value of resources which are mobilised domestically for the implementation of population activities.[12]This is largely due to (i) utilisation of the for implementing population activities that are funded under various budget headings such as "primary health career "teacher training, statistics, and "economic planning; (ii) mobilisation of resources at different levels of government by different implementers; (iii) the accounting systems used make it very difficult to impute the value of office premises, equipment and/or common services. Table 16 indicate that 73 per cent of the States increased their spending on RH and FP services, primary health care services and STDs followed by female school enrolment and RH needs for adolescents in that order.

146. At a general level, the overriding contextual factor limiting progress in the PDS sector is an increasingly difficult macro and micro economic environment in which an atmosphere of competing crises prevails and limits resources available for the development and implementation of NPPs. The second such factor is the recurring loss of trained personnel, both to desired improved remuneration and AIDS. The shortage of, qualified personnel has become a greater problem since Cairo because most States are attempting to decentralize their population and development planning functions which are yet to be institutionalized in the capital cities where trained personnel are relatively more available. It remains to be seen whether in States

12UNFPA is collaborating with the Netherlands Interdisciplinary Institute in efforts to collect data on flows of international financial assistance for population activities as well as data on domestic resources, including Government budgetary allocations and expenditures, NGO resource allocations and private sector expenditures for population programmes.

where this is being attempted, decentralization of these functions can work well under current limitations.

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

148. Furthermore, most of the newer policies and development strategies still read as if the primary "demographic enemy" is rapid population growth per se. Policies in those States most afflicted by HIV/AIDS, where rapid population growth may soon give way to dramatically slower growth stemming from increasing mortality, the population policies and development strategies generally do not pay sufficient attention to the emerging demographic threat to development posed by changing age structures and dependency ratios. As a corollary, political support for FP, which was in may cases won on the grounds of the threat of rapid population growth to sustainable development, may be waning, as leaders become aware of slower growth rates at the global level.

149. Provincial and district level planning, in population as well as other development concerns, is still characterized in many States more by the preparation of "shopping lists" than by real planning. Sometimes such plans use population projections, sometimes not, and if they do, they rarely take into account the demographic impact of AIDS. In general, at both central and decentralized levels, the incorporation of population projections into development planning has proven sufficiently challenging; little work has gone into attempting to structure development plans in such a way as to produce desired demographic outcomes. At the peripheral levels, population data required for planning purposes still are not routinely available.

150. Not surprisingly therefore, at the dawn of the 21st Century, a significant proportion of these States still report that several poor technical and institutional capabilities are impeding their development of population policies and implementation strategies. As indicated in Table 2, about one third (37%) of the member States do not have a national economic and social development plan in place. Equally, most States either lack or have rather limited knowledge of the value of socio-economic indicators needed for the formulation, implementation, as well as the monitoring and evaluation of NPPs (see Table 5). Other constraints include (see Table 14) inadequate integration of population variables in development planning (73 % of the member States); low priority for population IEC activities (63%); political instability

and associated high staff turnover (57%); the lack of clearly defined strategies for the implementation of population policies and programs (50%); lack of national technical capabilities to establish population and development interrelationships (47%); and lack of skills for the promotion and implementation of population policies and programs (40%).

151. Besides, economic (Table 17) and financial (Table 18) constraints also militate against the development of effective NPPs. The lead economic factor is the persistence of socio-economic crisis (77%); followed by implementation of adjustment programs (70%); and abandoning of the medium and long term planning in the face of SAPs (43%). The financial ones include difficulty in mobilizing domestic resources for population programs (77%); insufficient external financial resources for population programs (53%); inadequate funding of population activities (50%); and population activities not assigned a budget line in the national budget (27%).

152. The foregoing findings and more (see Table 15) are all related to the process of integrating population variables in development planning. Among the barriers still to be overcome are the intellectual difficulty of defining integration; the lack of a critical mass of needed trained human resources; and the inadequacy of data on the linkages between population and development. There is also the lack of constructive dialogue between the policy makers and the researchers particularly in the area of determining the indicated linkages simultaneously with the development of techniques for modeling the latter.

153. Two main limitations have been identified as accounting for the ineffective operationalization of the IPDP approach. In most explicit population policy documents, the indicated strategies for implementing the policy measures are rather too numerous. In a situation in which the sectoral ministries, charged with the implementation of these strategies, have their specialized functions to perform, they are apparently saddled with a rather heavy additional tasks most of which they do not have the specialized capacity required for delivery.

154. This becomes even more problematic in situations where no single body is charged with the responsibility of coordinating the implementation of the strategies. The data in Table 15 highlight the importance of the factors that seriously constrain the implementation of the ICPD-PA recommendations. These include inadequate cooperation between government and NGO (67% of the member States); low degree of involvement of NGOs as well as women in program formulation, implementation and evaluation (57 - 60%); inadequate cooperation with international organizations (57%); lack of cooperation between the relevant sectoral ministries. There is also the lack of a focus. The strategies identified are usually without a lead sector. By identifying a key sector and selecting a few critical sectors, both of these limitations can be contained especially as the policy document itself is a dynamic document that should be revisited as experience is gained and a critical mass of trained personnel is available.

IX. THE WAY FORWARD

155. A holistic approach to development planning is the common theme of all the series of United Nations Conferences during the 1990s. Notable among these global fora are the 1992 UNCED Summit held in Rio, the 1994 ICPD held in Cairo, the 1995 World Summit for Social Development, the 1995 Beijing Women's Conference and the November 1995 World Food Summit. The message from all these is the need for sustainability. Even before the adoption of the ICPD-PA, there was a gradual shift in development paradigm. The feeling since the mid-1980s has been that unless there is integrated approach to population, environment, agriculture, technological application, etc., the renewable resources (i.e. land, water, air, etc.) of a nation are likely to be misused. When such misuse is combined with mineral depletion (I.e. non-renewable resource), scarcity of resources is bound to result. This underlines the emphasis at UNCED and subsequent United Nations Conferences including ICPD on sustainable development.

156. The ICPD marks a turning point in population policy development for all member States of the United Nations family including those in the ECA region. It has provided the opportunity for reformulation and/or reorientation of previous policies that were devoid of sustainable development considerations. Implementing ICPD-PA recommendations in the areas of RH and RRs; advocacy and IEC strategies,; gender, equality, equity, empowerment of women and male involvement; family, youth and adolescents; role of NGOs and the private sector in programme implementation; institutional mechanism for implementation, monitoring, evaluationa nd coordination; population and development strategy; etc., will require in each ECA member State, *"the evolution of a national consensus on the policy, legal and institutional implications of these concepts and on the action needed to convert them into reality. Not only the governments but also all the actors in civil society have to commit themselves fully and unequivocally to this process"*[13].

157. It will be important for each state *"to learn from success stories, but it will be equally important for them to identify, early on, the problems and constraints that impede progress. Reorienting population policies in order to focus on human rights approach and on the need to provide comprehensive and adequate information and services to individuals and couples will require radical changes at policy, institutional and managerial levels. In countries where family planning services have been organized vertically and run parallel to other health services, efforts at integration would require policy decisions, the retraining of staff and major changes in operational and supervisory structures. In countries where such efforts are under way, bureacratic obstacles and turf problems need to be overcome. …A lack of infrastructure and trained personnel and a serious shortfall of resources remain serious problems in most African countries and will slow down their efforts to realize the commitments they accepted at Cairo unless the international community demonstrates a clear resolve to help them overcome these constraints.full involvement of the NGOs sector, including women's groups, in policy dialogues and*

[13] Singh, J. S., Creating a New Consensus on Population (Earthscan Publications Ltd.: London, 1998).

consultation at all levels, and increasing their participation in advocacy, information and service delivery projects, is not only desirable but necessary. It should be actively sought and promoted to help ensure that the projects respond to the specific needs of individuals and the community on a continuing and flexible basis".

158. This report has assessed the extent to which ECA member states have utilized the ICPD-PA recommendations in the formulation and implementation of their NPPs. Indications are that a significant number of them have done so despite several constraints; albeit the data does not permit precise comparison with the pre-1994 situation. A number of them have also mobilized additional internal resources for the implementation of these NPPs. The following suggestions are intended to eliminate the indicated constraints as well as to enhance and strengthen achievements and best practices.

9.1: Reproductive health and reproductive rights

159. Indications are that contraceptive prevalence has increased in several ECA member States in response to greater availability of services and greater acceptance of the benefits of family planning. However, other RH indicators have either remained static or have deteriorated.

160. In States most afflicted by HIV/AIDS, infant mortality, mortality in the age groups of 20-49, and overall life expectancy have worsened dramatically; maternal mortality has also increased as women weakened by HIV, become more susceptible to infection and death during this period of their reproductive cycle. Efforts to integrate HIV prevention into ongoing RH programmes, which include family planning and maternal child health services, should therefore receive highest priority.

161. Priority should be given, as well to IEC efforts with a view to moving beyond awareness of AIDS to the behavior change required to stem the pandemic. The challenge is to move beyond awareness to behavioral change. Cultural data must be gathered on how to successfully communicate on delicate sexually related matters in the various cultures of the region and this ethno-communication approach should be generally applied in all IEC interventions in the RH sector. The best communications expertise available, in both public and private sectors, should be drawn into efforts to improve RH, particularly to combat AIDS.

162. Of course HIV/AIDS should not be the only RH intervention to receive resources and attention. Other RH services including FP should be extended to underserved groups and improved and their importance for health continually reiterated. The full financial implications of RH services to meet even the most basic needs of adolescents, men and unmarried women have yet to be addressed.. Given the ever-younger ages at infection, youth and adolescents must be provided with the information required to protect their lives. This will entail not only expanding FLE in schools nationwide and supplementing it by peer counseling but also extending the numbers of youth centers enrolled in the effort and making entire national health networks 'friendly" to adolescents and capable of meeting their RH needs. Efforts to sensitize health workers and schoolteachers to make them more receptive and

competent to meet adolescent needs should be evaluated, extended and strengthened where found to be less effective than desired. Equally, detection and treatment of STIs merits greater efforts.

163. Other urgent actions to be taken in the RH sector should include (I) updating and integrating the content of the professional education curriculum and regulations governing licensing and maintenance of standards, including enforcement mechanisms; (ii) easy to use, inexpensive, and accurate approaches to diagnose and treat girls and women with and without symptoms of STDs and RTIs; (iii) integration of all health commodity distribution systems in the public health sector and considerations of privatisation of some or all of their parts; (iv) undertaking studies and research on rates of maternal mortality and morbidity; birth traditions; (v) RH concepts and traditional behaviours; (vi) patterns of sexuality and sexual expression; and, (vii) violence against women both inside and outside familial relationships.

9.2: Advocacy and IEC strategies

164. Because IEC/Advocacy strategies are an essential tool in guiding the implementation of NPPs, approaches to their orientation and development need to be changed. For the future, such strategies would require broad-based partnerships and pro-active consultation; a clearly defined conceptual framework; and coherence with the post ICPD-PA implementation framework. Conceptually, the future IEC/Advocacy strategies should emphasize a logical step by step process starting with the identification of issues through the achievement of outcomes and impact; the importance of research, monitoring and evaluation in informing and guiding each step of the process; and the fact that outcomes and impact rather than outputs should constitute the end result.

9.3: Gender, equality, equity, empowerment of women and male involvement

165. Gender equality is being promoted in many States through changes in laws, rules and regulations and through advocacy of concepts of equality. The need to protect women against sexual and domestic violence is being recognized by an increasing number of States. The incidence of rape, abuse and domestic violence is being reported more widely by the media and there is evidence to show that there is much greater public support than in the past for strong legal and judicial measures to deal with acts of sexual and domestic violence.

166. Whereas in some States laws already exist to deal with such acts of violence and what is needed is more determined and vigorous action on the part of the authorities, in many other States, currently applicable laws will need to be amended. Both the media and civil society organizations (including population NGOs, women's groups and parliamentary organizations) have an extremely important part to play in this context. Given deep rooted traditional attitudes and patterns of male behaviour, the implementation of the Cairo and Beijing recommendations on women's issues and rights must be regarded as a long-term endeavour on the part of enlightened policy

makers and leaders of civil society organizations[14].

167. Efforts should be made to persuade the already convinced policy makers and their subordinates to filter development plans for probable differential gender impacts. Additional advocacy will be necessary, and data to support it should be gathered. The 2000 round of censuses should be designed to gather needed gender-relevant information. Similarly, better techniques for capturing the economic contributions of women and other women's concerns should be built into future research and censuses. Regional workshops to foment such data gathering/analysis/utilization should be supported.

168. The efforts to remove gender stereotypes from school materials and to assure equal treatment of the sexes in the classroom should be strengthened. The broadening of population education/family life education from the pilot stage to entire school systems should be prioritized, and efforts made to include relevant gender and human rights concerns. The demographic content of school materials should be reviewed in order to bring it into line with changing realities including the HIV/AIDS afflicted States.

9.4 Family, Youth and Adolescents

169. More than 50 percent of the African population is under age 25 and about 200 million people belong to the young age group of 10-24 years. Furthermore opportunities for the young people to become productive and fully integrated into society is becoming very much limited. Sexual behaviour of adolescents continues to increase in the midst of the precarious health and socio-economic conditions. Violence against women that constitutes a violation of the basic human rights is still highly prevalent in many African countries.

170. African governments need to exert additional effort to alleviate these problems. In this regard, there is the need to, first of all, formulate policies and programmes that reflect the health development of adolescents based on sound information on the health needs of young people. In this regard, the youth, parents, government authorities, NGOs, and other related civil societies need to be given the opportunity to participate in the formulation and implementation of such policies and programmes. Where appropriate, African governments need to systematically review their national policies and legislation to ensure the rights of adolescents. Adequate provision of information, education and counselling on family planning, maternity and the prevention and control of sexually transmitted diseases which focuses on adolescents' needs is another area of future task. The contribution of relevant line ministries, religious leaders, community leaders, and NGOs is of paramount importance in this regard.

171. Solution to family problems include the socio-economic and cultural context in which they exist. Thus, African governments should develop effective legislation, family policies, services and benefits aimed at strengthening basic family functions,

14 Singh, J. S., op. cit.

taking into account variations on cultural social and religious customs and protecting the basic human rights of family members. Moreover, there is the need to develop social and economic strategies, policies and programmes that address the requirements of families.

9.5: Partnership with the NGOs, the private sector and community participation

172. The 1960s witnessed the emergence of indigenous African NGOs; the 1980s saw their rapid expansion. These NGOs of second generation share the development approach of their Northern counterpart concerning investing in people and promoting participatory grass-roots development[15]. However, given their relative recency, they have had little time as yet to develop a tradition of grassroots' work; they lack their own resources (and depend upon foreign funding) and are still in the process of establishing their legitimacy. With the scope of the development problems and the task of reaching the unserved population in the various countries, the benefits from the activities, scattered and isolated, are simply too minimal.

173. To increase their impact in this regard, the new Indigenous NGOs will need to work more in collaboration with multilateral and bilateral organizations and coordinate their activities with other small organizations and government agencies. There is little evidence that their programmes and projects are replicated by other organizations or the public sector or even have ripple effect where benefits spread beyond the initial target population. The challenge facing them therefore, is to discover and institute an organizational structure and process that combines modern professional management while retaining the comparative advantages, grassroots orientation and the participatory nature of the indigenous NGOs.

9.6: Institutional mechanism for implementation, monitoring, evaluation and coordination

174. Despite gaps, member States are at various stages in terms of having put in place institutional mechanisms for the formulation, implementation, monitoring, evaluation and coordination of their NPPs. For the future, those states at the earlier stages of the integration continuum should undertake study tours to learn from more advanced experiences. States that have not already done so should ensure a career path for their nationals appointed to positions in the various institutional arrangements. This is because if the structures are seen as a set up within the government's civil service structure with established recurrent expenditure and career levels, the implied element of permanency should contribute to effective IPDP.

15 NGOs are classified as first, second and third generation by David Korten (1987). The first generation NGOs focus on delivery of welfare and relief services to the poor and victims of disasters. The second generation strategies stress on local self-reliance rather than satisfying basic needs so that the benefits of their activities to the society would be sustained beyond the period of the NGO's existence. The activities of the third generation NGOs shifted from the mere role of service delivery of the first and second generation to creating a sustainable system of development to increase the capacity of the poor to meet their own needs with the resources they control.

175. The ideal prerequisite for effective institutional arrangement should be a clear specification of the criteria for their selection; the terms of reference per component of the structure and the operating structure and coordination. Towards effective decentralization, some consideration should be given to the creation of population offices in all districts or in a select number of pilot districts manned by trained population experts. These should work with the economists and statisticians to form a unified district planning team as proto-types of the planning organs at the national level.

176. The coordinating body of the NPP should develop necessary mechanisms for horizontal and vertical linkages with local level administrative units and should establish a framework for promoting and fostering effective inter-agency links and elaboration. The coordinating mechanism should ensure that the feedback process from the socio-economic sub-system to the demographic sub-system should be documented and basic data evaluation and monitoring purposes should be provided.

9.7: *Population and development strategy (PDS) and policy*

177. For the future, policies should not only be adopted but also implemented. Consistent with the prevailing development paradigm, the crucial importance of RH for both health and economic reasons should be reasserted as the fact of slowing demographic growth rates becomes more widely known. Since decentralization appears inevitable even in the face of severe shortages of well-trained staff at the periphery, provincial and district levels, capacity building at all levels will be important in population and development programming.

178. The attempt to *integrate population factors* should now take full account of the emerging reformed planning systems. The concept of IPDP was developed in an era when central planning that followed medium-term (5 – 10 years) plans was the norm in the ECA region. Development planning in terms of satisfying basic needs hardly involved the people at the grassroots. Today, central planning is largely down-played and the trend is towards decentralized planning. Hoever, the strategies that aim at reaching the people in their own settings and the methodologies and procedures needed to adapt to the changing development paradigms are yet to be developed in practical terms.[16].

179. Towards ensuring effective integration, the key issues of concern relate to the extent to which existing population policies, can contribute to achieving the objectives of economic growth (i.e. reduction of poverty, unemployment and unequal income distribution); how they can be transformed in order to maximize their contributions to human well being; and how they can be translated into effective programme strategies. These modalities should be considered in evolving future NPPs for ECA member States.

180. For the future, methodologies should be put in place to enable planners to empirically determine the critical socio-economic variables that can be manipulated by policy to trigger off the onset of fertility decline; identify the mechanisms through which such variables will in fact, initiate such onset; and use such identified key variables and

16 UNFPA, `Population policies and development strategies in post-ICPD sub-Saharan Africa`, CSTAA Technical Paper Series, No. 1, December 1996.

mechanisms as bases for deriving key sectors of the population policy[17]. Besides methodological considerations, three major themes that challenge the fundamental premises of current population policies have been suggested[18] namely ethics, human rights and human development; women's empowerment; and reproductive and sexual health19. Together these themes, based on a solid ethical foundation aimed at sustainable human development, should constitute a new approach to population policies development and implementation strategies in the ECA region.

X: CONCLUSION

181. In 1994, representatives from 179 nations adopted by consensus, the ICPD Programme of Action to improve the lives of poor families worldwide, fulfill the unmet needs of couples and individuals, improve the status of women and the health of mothers and children, achieve universal primary education in all States,and increase funding for RH, education and FP and other population and development activities

182. In spite of the many efforts made by member States to implement the relevant recommendations of the DND/ICPD-PA, our assessment highlighted a number of constraining factors that had largely impeded the implementation of the Declaration and the Programme of Action during the five initial years. While some of those difficulties could be resolved at the national level, it must be admitted that a number of them depend on international assistance. African countries, for instance, need the financial support and the technical assistance of bilateral and multilateral donors, international organizations to strengthen their national technical and institutional capacities, to properly integrate population issues in development planning or to boost their IEC activities.

17 One such methodology has been developed. See Ekanem, I. I. And Zewoldi, Y, `Derivation of effective population policy measures from census data: A methodological note`, Forthcoming in African Economic and Social Review.

18 See UNECA, `Population policies, environment and sustainable development in the ECA region` Paper presented at the Nexus Seminar, ECA North African Sub-Regional Development Center, Tangier (Morocco), 26-29 June 1998.

19 Sen, G.; Germain, A.; and Chen, L. C., `Population policies reconsidered: Health, empowerment and human rights` (Harvard University Press: New York, 1994).

Table 1. Quantitative goals and targets in the DND and ICPD-PA

DND				
Reference Countries	Variable	Target Year		
		2000	2005	2010
All African countries	Population Growth Rate (%)	2.5		2.0
	Contraceptive Prevalence Rate (%)	20		40
	Life Expectancy at birth (years)	55		
	Infant Mortality Rate (per 1000 live births)	Less than 50		
	Child Mortality Rate (per 1000 live births)	At most 70		
	Maternal Mortality Rate (per 100000 live births)	At most 1/2 of 1990 level		
ICPD-PA				
Reference Countries	Variable	Target Year		
		2000	2005	2015
All Countries	Access to safe and reliable FP methods and related RH services (%)			100
	Life Expectancy at birth (years)		At least 70	At least 75
	Infant Mortality Rate (per 1000 live births)	50 or 1/3 of 1990 level		less than 35
	Under-Five Mortality Rate (per 1000 live births)	70 or 1/3 of 1990 level		Less than 45
	Maternal Mortality Rate (per 100000 live births)	1/2 of 1990 level		1/2 of 2000 level
	Attainment of primary education			100
Countries with intermediate mortality levels	Infant Mortality Rate (per 1000 live births)		At most 50	
	Under-Five Mortality Rate (per 1000 live births)		At most 60	
	Maternal Mortality Rate (per 100000 live births)		At most 100	At most 60
Countries with highest mortality levels	Maternal Mortality Rate (per 100000 live births)		At most 125	At most 75
	Life Expectancy at birth (years)		At least 65	At least 70

Table 2. Reported implementation of recent strategies, treasures and legislation measures for the implementation of Rh and RRs, by ECA member States

Strategies	% of implementing countries N=36
FP	65.6
Maternal morality	71
Infant mortality	70
Prevention and appropriate treatment of infertility/sub-fertility	53.6
Role of men in sexual and RH	58.1
RH for refugees and/or displaced persons	33.3

Source: Question. 127, Country Questionnaire

Table 3. Percentage distribution of ECA member States implementing selected RH components within their PHC system

RH Component	% of Countries N=30
FP	93.3
Prevention of STDs/HIV/AIDS	96.7
Discouragement of Female Genital Mutilation	60.0
Adolescent RH Information and services	96.7
Prevention of infertility and sub-fertility	80.0
Prevention of Abortion and Management of the Consequences of Abortion	86.7
Safe Motherhood	90.0

Source: See Question. 123, Country Questionnaire

Table 4. Percentage distribution of ECA member States implementing specific policies, plans and legislation affecting accessibility to RH services

Policy, Plan or Legislation	% of Countries N=36
National Policy for the provision of Contraceptives at minimal cost or without charges	
(a) At minimal cost or without charges	96.7
(b) At minimal and without charges	36.7
Policies, programmes and laws favourable to adolescent RH	86.7
Legislation or policy that prohibits provision of FP services to:	
(a) Unmarried persons	0.0
(b) Persons below a given age	16.7
Legislation or policy that prohibits abortion	80.0
Safe pregnancy strategic or operational plan	93.3
National breastfeeding policy and plan	93.3
National strategic plan to control reproductive tract infections and sexually transmitted diseases, including HIV/AIDS	93.3

Source: See Question. 126, Country Questionnaire

Table 5. Percentage distribution of ECA member States implementing policies, plans and programmes protecting RRs

	RRsPolicy, Programme or Legislation	% of Countries N=36
1.	Measures already taken to ensure that men and women are aware of their RRs and can exercise these rights	80.0
2.	Provision to protect the basic rights of HIV positive with reference to:	
	(a) Employment	36.7
	(b) Marriage	33.3
	(c) Travel	33.3
3.	Legislation that sets a legal minimum age at marriage	86.7
4.	Policy measures to eliminate:	
	(a) Female Genital Mutilation	46.7
	(b) Prenatal sex selection	3.3

See Question. 126, Country Questionnaire

Table 6. Reported IEC/Advocacy strategies for disseminating information on population and development issues

	Strategy for disseminating information/Persons to whom information is disseminated	% of all countries that have adopted the strategy N=36
1.	Widespread media reporting (newspaper, radio, television)	86.7
2.	Formal presentation to parliament	63.3
3.	Seminars, workshops and meetings	86.7
4.	Dissemination of related information to:	
	(a) Policy makers and Government officials	86.7
	(b) General Public	73.3
	(c) Service providers	86.7
	(d) NGOs	80.0
	(e) Youth and Women Groups	76.7
	(f) Religious Institutions	76.7

Source: See Question. 138, Country Questionnaire

Table 7. Reported development of IEC/Advocacy Strategies within sectoral programs, ECA member States

	Sectoral Program	% of countries that have developed IEC strategy within program N=36
1.	Population and Development	80.0
2.	Poverty alleviation	76.7
3.	Environment preservation	86.7
4.	Adolescents and youth	93.3
5.	Empowerment of women	93.3
6.	Gender equality and equity	86.7
7.	RH	90.0
8.	FP	93.3

Source: See Question. 139, Country Questionnaire

Table 8 Reported actors in the development and implementation of IEC/Advocacy Strategies, ECA member States

Actor	% of countries in which the actors are found N=36
1. Government institutions:	
(a) Ministry of Information, Communication	86.7
(b) Ministry of Culture	80.0
(c) Ministry of Education	93.3
(d) Ministry of Health	93.3
(e) Ministry of Youth	86.7
2. Non-governmental institutions:	
(a) NGOs dealing with development issues	83.3
(b) NGOs dealing with Women	93.3
(c) NGOs dealing with Youth	93.3
3. Private organizations	53.3
4. General public	66.7
5. Opinion Leaders:	
(a) Religious Leaders	83.3
(b) Policy Leaders	80.0
(c) Civil Society Leaders	46.7

Source: Question. 140, Country Questionnaire

Table 9. Reported coordination of IEC/Advocacy functions ECA member States

IEC/Advocacy Component	% of Countries that have mechanisms to coordinate activity N=36
1. IEC strategy development	76.7
2. Message and material development	66.7
3. Message dissemination	70.0
4. Research and evaluation	70.0
5. Training	63.3
6. Information exchange	70.0

Source: See Question. 141, Country Questionnaire

Table 10. Reported policies, measures and programmes related to the implimenttion of Gender issues, ECA member States

Policies, Measures and Programmes		% of all countries that have taken actions or implemented policies (N=36)
1.	Institutional arrangement for the implementation of the ICPD-PA recommendations put in place	86.7
2.	Ratification and implementation of the Convention on the elimination of all forms of discrimination against women: (a) Ratified (b) Implementing	 80.0 70.0
3.	Actions taken to promote women's full and equal participation in the labour force	93.3
4.	Actions taken to promote women's participation in decision-making	83.3
5.	Actions taken to tailor extension and technical services to women producers	86.7
6.	Actions taken to improve the collection, analysis, dissemination and use of gender-disaggregated data in education and health	93.3
7.	Actions taken to enhance equal opportunities for and legal protection of the girl child	80.0
8.	Strategies or measures adopted to increase age at marriage	56.7
9.	Actions taken to focus research efforts on the division of labour, access to income, control within the household and socio-cultural factors which affect gender equality	66.7
10.	Actions taken to gather information on women's knowledge of traditional practices and skills	53.3
11.	Strategies adopted (including changes in legislation) to ensure empowerment of women	83.3

Source: See Questions. 111 – 122, Country Questionnaire

Table 11. Reported involvement of NGOs in the implementtion of FP programmes, ECA member States

Participation in decision-making about:	% of Countries that reported participation of NGO N=36
1. Research in FP	
(a) Local Women's Groups	60.0
(b) Youth Groups	40.0
(c) Religious Leaders/Groups	43.3
(d) Trade unions	16.7
(e) Cooperatives	16.7
2. Design of FP Programme	
(a) Local Women's Groups	63.3
(b) Youth Groups	56.7
(c) Religious Leaders/Groups	60.0
(d) Trade unions	26.7
(e) Cooperatives	23.3
3. Implementation of FP Programme	
(a) Local Women's Groups	73.3
(b) Youth Groups	73.3
(c) Religious Leaders/Groups	63.3
(d) Trade unions	30.0
(e) Cooperatives	40.0
4. Monitoring of FP Programme	
(a) Local Women's Groups	70.0
(b) Youth Groups	63.3
(c) Religious Leaders/Groups	53.3
(d) Trade unions	23.3
(e) Cooperatives	30.0
5. Evaluation of FP Programme	
(a) Local Women's Groups	66.7
(b) Youth Groups	50.0
(c) Religious Leaders/Groups	50.0
(d) Trade unions	16.7
(e) Cooperatives	20.0

Source: See Question. 130, Country Questionnaire

Table 12. Reported involvement of NGOs in RH Programmes, ECA member States

Participation in decision-making about:		% of Countries that reported participation of NGO N=36
1.	Research in RH	
	(a) Local Women's Groups	46.7
	(b) Youth Groups	46.7
	(c) Religious Leaders/Groups	40.0
	(d) Trade unions	16.7
	(e) Cooperatives	6.7
2.	Design of RH Programme	
	(a) Local Women's Groups	66.7
	(b) Youth Groups	63.3
	(c) Religious Leaders/Groups	56.7
	(d) Trade unions	26.7
	(e) Cooperatives	16.7
3.	Implementation of RH Programme	
	(a) Local Women's Groups	
	(b) Youth Groups	76.7
	(c) Religious Leaders/Groups	73.3
	(d) Trade unions	63.3
	(e) Cooperatives	33.3
		23.3
4.	Monitoring of RH Programme	
	(a) Local Women's Groups	53.3
	(b) Youth Groups	43.3
	(c) Religious Leaders/Groups	40.0
	(d) Trade unions	23.3
	(e) Cooperatives	13.3
5.	Evaluation of RH Programme	
	(a) Local Women's Groups	60.0
	(b) Youth Groups	46.7
	(c) Religious Leaders/Groups	46.7
	(d) Trade unions	56.7
	(e) Cooperatives	13.3

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

Table 13 Reported Involvement of NGOs in the implementation of HIV/AIDS Programmes, ECA member States

Participation in decision-making about:	% of Countries that reported participation of NGO N=36
1. Research in HIV/AIDS	
(a) Local Women's Groups	50.0
(b) Youth Groups	46.7
(c) Religious Leaders/Groups	40.0
(d) Trade unions	23.3
(e) Cooperatives	16.7
2. Design of HIV/AIDS Programme	
(a) Local Women's Groups	76.7
(b) Youth Groups	73.3
(c) Religious Leaders/Groups	60.0
(d) Trade unions	36.7
(e) Cooperatives	33.3
3. Implementation of HIV/AIDS Programme	
(a) Local Women's Groups	80.0
(b) Youth Groups	83.3
(c) Religious Leaders/Groups	70.0
(d) Trade unions	46.7
(e) Cooperatives	50.0
4. Monitoring of HIV/AIDS Programme	
(a) Local Women's Groups	70.0
(b) Youth Groups	60.0
(c) Religious Leaders/Groups	53.3
(d) Trade unions	30.0
(e) Cooperatives	30.0
5. Evaluation of HIV/AIDS Programme	
(a) Local Women's Groups	70.0
(b) Youth Groups	60.0
(c) Religious Leaders/Groups	53.3
(d) Trade unions	26.7
(e) Cooperatives	26.7

Source: See Questions. 132 & 133, Country Questionnaire

Table 14. Reported constraints related to inadequate technical and institutional capabilities re the implementation of the ICPD-PA

Constraining factor	% of countries that reported the factor N=30
1. Lack of national technical capabilities to establish population and development interrelationships within the country	46.7
2. Lack of clearly defined strategies for the implementation of population policies and programmes	50.0
3. Lack of skills for the promotion and implementation of population policies and programmes	40.0
4. Low priority for population IEC activities	63.3
5. Inadequate integration of population variables into development planning	73.3
6. Political instability and high staff turnover that reduce the chances of maintaining one direction in development policy	56.7

Source: See Question. 152, Country Questionnaire

Table 15. Reported constraints related to inadequate coordination of activities re the implementation of the ICPD-PA

Inadequate coordination factor	% of countries that reported the factor N=30
1. Lack of cooperation between the relevant sectoral ministries	53.3
2. Low degree of involvement of women in programme formulation, implementation and evaluation	56.7
3 Low degree of involvement of NGOs in programme formulation, implementation and evaluation	60.0
4. Inadequate cooperation between government and non-governmental organizations	66.7
5. Inadequate cooperation with international organizations	56.7
6. Poor coordination of activities with foreign partners	60.0

Source: See Question. 153, Country Questionnaire

Table 16. Reported trend in Government spending on selected population and development activities since 1994, ECA member States

Population and development activity	Percentage of Countries that Reported that Government Spending was:			
	Maintained	Increased	Decreased	No response
RH and FP Services	6.7	73.3	10.0	10.0
RH needs of adolescents	13.3	56.7	10.0	20.0
Primary health care services	6.7	73.3	10.0	10.0
Sexually transmitted diseases/HIV/AIDS	3.3	73.3	10.0	13.3
Female School enrolment	6.7	70.0	6.7	16.7

Source: See Question. 149, Country Questionnaire

Table 17. Reported Economic Constraints re the implementation of the ICPD-PA

Economic Factor	% of countries that reported the factor N=30
1. Persistence of socio-economic crisis	76.7
2. Implementation of structural adjustment programmes	70.0
3. Abandoning of the medium and long term planning	43.3

Source: See Question. 151, Country Questionnaire

Table 18. Reported financial constraints re the implementation of the ICPD-PA

Financial factor	% of countries that reported the factor N=30
1. Difficulty in mobilizing domestic resources for population programmes	76.7
2. Insufficient external financial resources for population programmes	53.3
3. Inadequate funding of population activities	50.0
4. Population activities not assigned a budget line in the National Budget	26.7

Source: See Question. 154, Country Questionnaire