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Five-Year Review of the Addis Ababa Declaration on Population and Development (AADPD)

August 2018

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Acronyms

AADPD	Addis Ababa Declaration on Population and Development
AADPD OG	Addis Ababa Declaration on Population and Development-Operational Guide for monitoring and evaluation
ADB	African Development Bank
AFD	Agence Française de Développement
AFIDEP	African Institute for Development Policy
AIDS	Acquired Immune Deficiency Syndrome
APF	African Parliamentary Forum on population and development
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AUC	African Union Commission
BEAM	Basic Assistance Education Module
CAP	Common African Position
CFA	Colonies Françaises d'Afrique (francs)
CNC	Comité National de Coordination
CPR	Contraceptive Prevalence Rate
CREFAT	Centre de Recherche en Economie et Finances Appliquées de Thiès
CREG	Consortium Régional pour la Récherche en Economie Générationnelle
CRVS	Civil Registration and Vital Statistics

DD	Demographic Dividend
DHIS	District Health Information System
DHS	Demographic and Health Surveys
DOTS	Directly Observed Therapy Strategy
DR	Democratic Republic
DRC	Democratic Republic of Congo
EAC	East African Community
ECA	Economic Commission for Africa
ECOWAS	Economic Community of West African States
EDD	Demographic Dividend Team
ESA	Eastern and Southern Africa
ESARO	East and Southern Africa Regional Office
FGM	Female Genital Mutilations
FP	Family Planning
FRANET	Francophone Network
GBV	Gender Based Violence
GDP	Gross Domestic Product
GIMAC	Gender Is My Agenda Campaign

GTP	Growth and Transformation Plan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HPP	Health Policy Project
HSSP	Health Sector Strategic Plan
ICI	Initiatives Conseil International
ICPD	International Conference on Population and Development
IDEA	Informing Decisionmakers to Act
IDRC	International Development Research Center
ILO	International Labor Organization
IRD	Institut de Recherche pour le Développement
ITN	Insecticide Treated bed Nets
IUDF	Integrated Urban Development Framework
IUSSP	International Union for the Scientific Studies of the Population
LFP	Labor Force Participation
LISER	Luxembourg Institute of Socio-Economic Research
MDG	Millennium Development Goals
MIC	Multiple Indicator Cluster Survey

MOGE	Ministry of General Education
MPI	Multidimensional Poverty Index
NAMATA	Nairobi Metropolitan Area Transport Authority
NCD	Non-Communicable Diseases (or NCDs)
NDP	National Development Plan
NDPII	National Development Plan-2
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
NGP	National Gender Policy
NHI	National Health Insurance
NHIF	National Hospital Insurance Fund
NPPSD	National Policy on Population and Sustainable Development
NSA	Namibia Statistics Agency
NSDS	National Statistical Development Strategy of Ethiopia
NSNP	National Social Safety Network Programme of Kenya
NSP	National HIV and AIDS Strategic Plan of Malawi
NTA	National Transfer Account
OAP	Old Age Pension

OGME	Operational Guide for Monitoring and Evaluation
ONIP	National Population Identification Structure
OPHI	Oxford Poverty and Human Development Initiative
PDC	Population and Development Coordination
PHC	Primary Health Care
PND	Plan National de Développement du Congo
PNDES	National Program of Economic and Social Development Plan (of Guinea)
PNPS	National Social Security Policy (of Madagascar)
PR	Présidence de la République
PRB	Population Reference Bureau
SD	Schooling Dividend
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SP-CNC CRVS	Sécrétariat Permanent du Comité National de Coordination du système d'état civil
SPLUMA	Spatial Planning and Land Use Management Act
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Reproductive Rights
SRMNIA	National Strategic Plan for Maternal, Newborn, Adolescent and Youth Health

SSA	Sub-Saharan Africa
STC	Specialized Technical Committee
STC-HPDC	Specialized Technical Committee on Health, Population and Drug Control
STIs	Sexually Transmitted Infections
SWEDD	Sahel Women's Empowerment and Demographic Dividend
SYP	Safeguarding Young People
TB	Tuberculosis
TFR	Total Fertility Rate
TVET	Technical and Vocational Education and Training
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Population Division
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESA	United Nations Economic and Social Affairs

UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGA	United Nations Genal Assembly
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNPAF	United Nations Partnership Framework
UNPD	United Nations Population Division
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
WAEMU	Western Africa Economic and Monetary Union
WCARO	Western and Central Africa Regional Office
WHO	World Health Organization
ZPRP	Zanzibar Poverty Reduction Plan

Executive Summary

1. The AADPD +5 Review

1. The Addis Ababa Declaration on Population and Development (AADPD) was adopted by African Ministers at the Africa Regional Conference on Population and Development held in Addis Ababa from October 3-4, 2013, and endorsed by African Heads of State at the African Union Executive Council in 2014. This declaration provides region-specific guidance on population and development in Africa, and guidelines for the full implementation of the International Conference on Population and Development (ICPD) beyond 2014 in Africa.
2. The Declaration comprises a total of 88 priority measures (commitments) grouped under six pillars: Dignity and Equality; Health; Place and Mobility; Governance; Data and Statistics; Partnership and International Cooperation. In making the AADPD commitments, the Ministers viewed the demographic dividend as an important dimension of the AADPD agenda, and one of the key pathways from AADPD to sustainable development. With its human rights framing, the AADPD can serve as a standard for policies and programs that empower women and young people and uphold their rights.
3. The Review aims to assess and report on progress in implementing the commitments contained in the Declaration, with a view toward highlighting the gains, gaps, best practices and challenges as depicted by the data and evidenced from a policy perspective. This review highlights evidence-based recommendations that can accelerate progress on implementation at the national and continental level, thus moving African countries toward the vision of the AADPD and the realization of the Demographic Dividend and ultimately sustainable development in line with Agenda 2063 and the 2030 Agenda.
4. The AADPD Operational Guide for Monitoring and Evaluation was adopted during the second meeting of the Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC-2) held in Addis Ababa, Ethiopia, on March 23-24, 2017. It is the substantive basis of the review. It follows the dual approach of “micro-monitoring” (i.e., the tracking the implementation of individual commitments) and “macro-evaluation” (i.e., assessment of progress on policies and the demographic dividend).
5. Data for this review come from two main sources. The quantitative component uses data from several sources, including national Demographic and Health Surveys (DHS), the United Nations Population Division (UNPD), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF),

the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute of Statistics, the International Labor Organization (ILO), and the World Bank. The desk review covers AADPD plus five national review reports[1], policy documents and program reports at the continental and regional levels, and peer-reviewed and grey literature.

2. Major Population and Development Trends

Life Expectancy and Declining Mortality

6. There has been a steady decline in infant and under-five mortality and a gain in life expectancy since the 1960s as a consequence of progress in public health measures and medical technology. Life expectancy has increased from 51.7 years in 1990-1995 to 62.4 years in 2015-2020, corresponding to a 10.7-year gain. For Africa as a whole, infant mortality declined from 102 per 1,000 live births in 1990-1995 to 57 per 1,000 live births in 2015-2020. The same trend is observed for under-five mortality, which has decreased from 167 per 1,000 live births to 87 per 1,000 live births. Two distinctive regional patterns have emerged: a) high infant and under-five mortality in Western and Central Africa (respectively 72 and 113 per 1,000 live births in Central Africa; 70 and 111 per 1,000 live births in Western Africa); b) low infant and under-five mortality in Northern Africa (respectively 28 and 37 per 1,000 live births). Another dimension of improved health conditions is that life expectancy at older ages is increasing. On average, life expectancy in Africa at 60 years has increased by two years from 15 in 1990-1995 to 17 years in 2015-2020.

Overall Population Growth

7. Over the period from 1980-2020, Africa has been facing a rapid population growth as compared to other regions in the world. According to UN population projections, after a peak in 1980-85 (2.8%), the growth rate declined to 2.5% in 2000-2005, and then was estimated at 2.6% for the period 2015-2020. Despite a projected decline, population growth of the continent will still be the highest in the world in 2050. According to the medium variant of the 2017 revisions of the United Nations population

[1] Preparations for the Five-Year Review of the Addis Ababa Declaration in Africa commenced in 2016, with the development of the Addis Ababa Operational Guide and its Monitoring and Evaluation Framework, subsequently endorsed by the STC-HPDC-2 at the recommendation of the APEC in 2017. In early 2018, national review processes were held in AU Members States. These processes, which assessed the extent of national level implementation of the commitments in the Declaration, culminated in nationally validated review reports highlighting progress, gains, gaps and challenges over the 2013-2018 five-year period.

prospects, the growth rate of the African population will decline to 1.8% in 2050 (compared to 0.56% worldwide). This high average growth masks regional disparities, with higher rates of population growth in Central, Western and Eastern Africa (respectively 3.0, 2.7, and 2.7 in 2015-2020) and lower population growth in Northern and Southern Africa (respectively 1.8, and 1.3 in 2015-2020).

Changing Age Structure

8. Unlike mortality, **fertility** has been declining at a slower pace: within a period of 30 years from 1990-1995 to 2010-2015, the Total Fertility Rate (TFR) moved from 5.7 (compared to 3. worldwide) to 4.7 (compared 2.5 worldwide). While the proportional declines for the continent and the world are similar over the period, what is striking across regions is the level of fertility at the 1990-1995 starting point. Fertility levels remain very high in Central and Western Africa (respectively 5.9 and 5.5 in 2010-2015), while in Eastern Africa the fertility decline over the last two decades is comparable to the continental average (4.9 in 2010-2015). In contrast, Southern Africa and Northern Africa started with lower levels of fertility, and these continue to fall slowly (respectively 2.6 and 3.3 in 2010-2015), although more recently (2005-2010), fertility rates in Northern Africa have been rising. Noteworthy is the widened gap between the poorest and the richest in 15 countries out of the 23 countries with available data. This raises the issue of equitable participation in the demographic dividend across the different economic strata of the population.
9. On average, about one in three people in Africa is aged 10-24. This relative share of **adolescents and youth** in the total population remains more or less stable over the 1990-2030 period for the entire continent and in Western, Eastern, and Central Africa, which are the regions with the highest fertility levels. The number of 10 - 24 year-olds on the continent however, is expected to rise from 200 million in 1990 to 530 million in 2030. The youth age group of 15-24 represents 19% of the African population, and by 2030 the number of youths in Africa will increase by 45 percent, from 230 million in 2015 to 335 million in 2030, according to the medium variant of the World Population Prospects 2017 revision.
10. With successes in fertility decline and improved life expectancy, the associated rise in the proportion of **older people** (65 years and older) is set to be an emerging population phenomenon for the continent. While the proportion of the elderly will remain relatively low in Western, Eastern, and Central Africa (between 3.0 and 3.5%), in the North and Southern subregions where the demographic transition is well advanced, there will be almost a doubling of the proportion of older people (from 3.9% and 3.4% in 1990, respectively, to 7.5% and 6.4% in 2030, respectively). This increasing trend

points to the need for increasing policy focus on their well-being and living conditions as highlighted by the AADPD.

11. Africa's population dynamics has resulted in a large proportion of children. This increasing share of the younger age categories of the population is less apparent in the projected age pyramid for the period 2025-2030 for the continent, as well as for Western, Eastern, and Central Africa. However, the change is very clear in Southern Africa and Northern Africa, two regions where the fertility transition is well advanced, and in which a "window of opportunity" for the demographic dividend is currently underway.

Urbanization

12. Africa is undergoing rapid urbanization and is set to be the fastest urbanizing region in the coming decades. While in the 1990s only a third of Africa's population was urban (31 percent), by 2035, about half of Africa's population is projected to be living in urban areas. Urbanization has been attributed to four drivers, namely: international migration; natural growth, or the difference between mortality and fertility rates; net rural-urban migration; and reclassification of rural to urban areas.

Migration

13. Projections for net migration in Africa for the period from 1990 to 2030 have been in favor of emigration. This is largely driven by the pattern seen in Western Africa where there was a negative migration balance between 1990 and 1995, which became more negative thereafter. The expectation is that migration flows will stabilize at -0.3 for Africa and -0.4 for Western Africa, on average around 2020. Apart from the period between 1995 and 2000 where Eastern Africa was a recipient of migrants, the region has had, and is expected to continue to have, a negative migration balance.

3. Progress and Challenges on AADPD's Commitments

3.1. Dignity and Equality

Poverty and Inequality

14. Most African countries face poverty and human-rights challenges. In parallel, several countries are making progress through the development of poverty-reduction plans and creation of human rights councils. Overall, between 1995-2000 and 2010-2017, the proportion of people living on less than USD 1.90 per day and the Multidimensional Poverty Index (MPI) has declined in all countries except in South Africa, in Côte d'Ivoire and in the

Republic of Congo.. In 24 countries the percentage of the population living on less than USD 1.90 a day at 2011 international prices has decreased except in ten countries (Comoros, Djibouti, Madagascar, and Mauritius in Eastern Africa; Benin, Côte d'Ivoire, and Guinea-Bissau in Western Africa; Cameroon and Central African Republic in Central Africa; and Zambia in Southern Africa) where the proportion has increased according to the indicator. The MPI has decreased by more than 10 percentage points in four countries (16 in Senegal, 13 in Rwanda, 12 in Guinea, and 10 in Liberia), whereas it has increased by 4 percentage points in the Republic of Congo and Côte d'Ivoire, and by less than one percentage point in South Africa and Namibia. During the second period (2010-2016), two countries with the highest MPI are from Western Africa (Niger: 58.4 and Burkina Faso: 50.8), whereas Egypt (1.6) and South Africa (4.1) have the lowest MPI during the same period.

15. Efforts are needed to reach disadvantaged groups, especially older people, adolescents and youth, the unemployed, people living with HIV and AIDS and people with disabilities, in both urban and rural areas. Some countries have developed and implemented national strategic plans to improve the living conditions of people living with disabilities. In 2016, 90% of people living with disabilities in Cabo Verde were covered by a social protection system. Since 2015, the Zimbabwe government assumed full responsibility for funding vulnerable children under the Basic Assistance Education Module (BEAM). Kenya has established a National Social Safety Network Programme (NSNP) aiming to guarantee minimum income protection ("safety net") for particularly poor and vulnerable groups. Between 2013-14 and 2015-16, the number of beneficiary households of the Kenyan government's four principal cash transfer programs increased from 522,000 to 829,000.

Gender Inequality

16. A number of countries have developed gender-responsive policies though gender equality and women's empowerment are still a concern in Africa. Gender parity in primary education is almost achieved (equal or higher than 0.95 in both rural and urban areas during the last study period (2010-2017)). Gender disparities have narrowed at the primary and secondary school levels. Findings show national commitments to increase women's parliamentary representation. However, indicators of progress revealed absence of regional patterns.

Regardless of the region, the proportion of women in parliament varies by country. With 41.8% of women representation, Senegal is the only country out of fourteen in Western Africa where women representation in the parliament is higher than 30%. In Northern Africa, only Tunisia (out six countries) has a figure of more than 30%. In Central Africa, two countries (Burundi and Cameroon) out of eight have more than 30%. Five countries (Angola,, Mozambique, South Africa, Eswatini, and Zimbabwe) out of ten in Southern Africa have more than 30% while six countries in Eastern Africa (Ethiopia, Kenya, Rwanda, Sudan, Tanzania, and Uganda,) out of fourteen have more than 30% women in the parliament.

Child Nutrition and Mortality

17. African countries have made significant progress in improving child survival through the development and implementation of strategic health plans to strengthen health systems and promote family planning using integration between health service (maternal, child, infant and neonatal health services) models. Botswana has established an under-five Nutrition Surveillance and Growth Monitoring program to track the growth of children and subsequently determine their nutritional status, and mothers or caregivers take children to clinics every month for weight monitoring. In addition, the Vulnerable Group Feeding Programme in the Ministry of Health and Wellness is distributing supplementary food to the under-five population. The prevalence of stunting has decreased in all countries except Nigeria and Benin in Western Africa. In Western Africa, the prevalence of stunting varies from 17% in Senegal to 48% in Nigeria in 2010-2017. During the same period, the prevalence of stunting is low in Zimbabwe (27%) and high in Mozambique (43%) in SouthernAfrica; and ranges from 16% (Gabon) to 40% (Chad) in Central Africa. Though under-five mortality has declined in general, it remains high in Central Africa (113 deaths per thousand live births) compared to Northern Africa (37 deaths per thousand live births) in 2010/2017.

Women's Rights and Gender-Based Violence

18. Over the last decade, African countries have promoted policies fighting gender-based violence and harmful practices, particularly female genital mutilation, and early, child or forced marriages. Twenty-four African countries have laws banning FGM practices. However, efforts are still needed to ensure implementation and to address plural legal systems where

these exist. The proportion of women (15-49) who have undergone female genital mutilation decreased in all the selected countries, except in Nigeria where it increased from 19% to 25%, and Guinea where it increased from 96% to 97%. A pronounced drop was noted in Kenya (from 32% to 21%) and Ethiopia (from 74% to 65%) in Eastern Africa. In Western Africa, the decrease in the proportion of women who have undergone female genital mutilation ranges from 0.2 percentage point in Mali to 10 percentage points in Benin. The large majority of women in Burkina Faso, Egypt, Ethiopia, Guinea and Mali.have undergone female genital mutilation. Notably, the proportion of women who reported sexual violence decreased in all selected countries except in Malawi and Cameroon.

Universal Access to Quality Education for All

19. Overall, the proportion of children who completed primary school increased in the majority of countries. The greatest changes in the proportion of children who completed primary school was recorded in Seychelles (73 percentage points), which increased from 54% (2000/2005) to above 100% (2010/2017). During the most recent period, the indicator varied from 38% in Chad to 126% in Seychelles. The high proportion of children who completed secondary school (above 100%) was observed in Seychelles over the study period; while the lowest proportion of students who completed secondary school was observed in Niger (7% in 2000/2005) and in the Central African Republic (10% in 2010/2017). The majority of countries (30 out of 42) have achieved gender parity (girl/boy parity equal or higher than 0.95) in primary school completion except in twelve countries (Chad, Democratic Republic of Congo, Djibouti, Ethiopia, Equatorial Guinea, Malawi, Niger, Nigeria, Tanzania, Togo, Zimbabwe and Zambia, and) where the indicator is below 0.95.

Welfare and Longevity, Healthy Ageing, and Lifelong Learning for Older People

20. Some African countries have developed policies to support and strengthen the capacity of organizations for people with disabilities to ensure a common advocacy approach toward the promotion of their rights (commitments 23, 25 and 26). Though life expectancy has increased across all regions, life expectancy is higher in Northern Africa (71) and lower in Western Africa (55). Lack of data does not allow an assessment of progress regarding healthy aging as well as equity in health among elders.

3.2. Health

Sexual and Reproductive Health and Rights:

Family Planning and Unmet Need

21. The unmet need for family planning remains high on the African continent. Although it is reducing in many African countries, such as Rwanda (-20 percentage points), Ethiopia, Lesotho, Mali and Kenya (12-13 percentage points), a few countries recorded an increase in unmet need over time. These include Nigeria (+10 percentage points), Mauritius (+9%), Guinea (+6%), Benin (+5%), and Mozambique (+4%). Eastern and Southern African countries appear to have made the greatest progress, not just with unmet need, but also the proportion of demand for family planning satisfied by modern methods, and the prevalence of modern contraceptive use.

22. Modern contraceptive use increased in almost all countries across the subregions. Of the 44 countries studied, 20 countries recorded an increase in modern contraceptive prevalence rate (CPR) from 9-10 percentage points (e.g., Ghana, Guinea-Bissau, São Tomé and Principe,) to 25-30 percentage points (, Ethiopia, Kenya, Lesotho, Malawi, Eswatini,), and even 30 percentage points (Rwanda). Most of these countries are in Southern and Eastern Africa.

Adolescent Sexual and Reproductive Health

23. The adolescent fertility rate is generally high on the continent, but it decreased in all countries between 2005 and 2016, with the exception of three of the Northern African countries (Algeria, Egypt and Tunisia) where the levels are very low. The proportion of women aged 20-24 who were married by age 18 remains high in Africa, varying from 30% (e.g., in Zimbabwe) to more than 50% (e.g., in Burkina Faso, Guinea and Mali), and even 67% (in Chad). It has declined over time by 10 percentage points or more in Gabon, Guinea, Tanzania, Uganda and Zambia. The proportion of women ages 20-24 who gave birth before the age 18 years on the other hand has changed only minimally over the last few years. Eleven countries exhibit a percentage of births before age 18 ranging from 30% (Côte d'Ivoire, Malawi, Nigeria, and Zambia) to 40% (Guinea and Mozambique), to even 51% in Chad. The lowest percentage of births before 18 was reported in Rwanda and Egypt (at 6-7%).

Maternal Mortality

24. Progress, though minimal, has been made in further reducing preventable maternal deaths. During the decade 2005-2015, maternal mortality decline was highest (between 40% and 53%) in Botswana, Ethiopia, Rwanda, Tanzania and Zambia. In 2015, 18 African countries had maternal mortality

exceeding 550 deaths per 100,000 live births, all of which are in the Western and Central Africa region, with the exception of South Sudan, Somalia, Malawi and Mauritania.

25. Access to skilled attendants at birth is one of the most critical interventions to reduce maternal mortality. Nine countries recorded an increase in skilled birth attendance ranging from 25-35 percentage points (Niger, Ghana, Guinea, Djibouti, Malawi and Uganda) to 42% (Burkina Faso) and 52% (Burundi and Rwanda). On the other hand, Togo and Tunisia showed a decline in skilled birth attendance of 16 percentage points. Access has been, and remains universal in Mauritius, and is near universal in Algeria, South Africa, Seychelles and Botswana (97-99%). Eleven other countries exhibit rates between 85% and 95%.

HIV and AIDS, STIs and Other Infectious Diseases

26. Comparing prevalence rates in 2005 to 2016, progress in combating the HIV pandemic appears to be modest but widespread, except in a few countries (Sierra Leone, Lesotho, South Africa, Angola and Equatorial Guinea) where the epidemic appears to be worsening. Southern and Eastern Africa were the worst hit by this epidemic and continue to have comparatively high prevalence rates. The 2016 prevalence rate reaches 25% or higher in Eswatini and Lesotho and stands in the range of 12%-22% in Mozambique, Zambia, Zimbabwe, Namibia, South Africa and Botswana.

27. Alongside efforts to combat HIV, countries are also taking steps to fight sexually transmitted infections (STIs). For example, South Africa is implementing a program that equips teachers with ways to impart knowledge on STIs, HIV and AIDS and TB to young people, and Burkina Faso launched its 2016-2020 National Strategic Framework for the Fight Against HIV, AIDS and STIs.

Noncommunicable Diseases

28. The changing patterns of morbidity and mortality that define the epidemiologic transition in Africa have produced what is widely described as the “dual burden of disease,” a combination of both the so-called “diseases of poverty”—communicable, maternal, perinatal, and nutritional—as well as noncommunicable diseases (NCDs). In 2000, seven in 10 deaths on the continent were due to communicable, maternal, perinatal and nutritional conditions, but the burden of diseases due to these causes reduced by about 1% annually over a 16-year period, estimated at 56% in 2016. Over the same period, deaths due to NCDs and injuries increased from 23% and 7% in 2000 to 34% and 10% in 2016 respectively.

Health Systems Strengthening

29. Access to health insurance is generally very poor on the African continent. Although the time points differ slightly. Ghana and Rwanda appear to be making good progress with regard to the percentage of the population covered by social insurance programs.

30. Many African countries have a low health budget, much lower than stipulated in the Abuja Declaration, and this is one of the reasons for the slower than expected progress in reducing preventable maternal deaths. Putting the right, strategic investments and mechanisms in place to holistically strengthen health systems and ensure universal access to sexual and reproductive health and rights by providing universal access to modern contraceptives, skilled birth attendance, including emergency obstetric and neonatal care to address preventable maternal deaths, and other crucial health services, including for adolescents and youth, will ultimately improve maternal, child and adolescent health indices, and ultimately improve population health, accelerate progress on the demographic dividend, and provide governments the space and clear focus to tackle other pressing population and development issues.

3.3. Place and Mobility

Living Conditions of People in Urban and Peri-Urban Areas

31. A large proportion of the population in African urban areas resides in slums. However, a number of countries have curbed the proportion of their urban population living in slums between 2005 and 2014. These include Angola (reduction of 31 percentage points), and Sierra Leone, Rwanda, Tanzania, Nigeria, Uganda and Niger (reduction between 12 and 21 percentage points). In Lesotho, and to a lesser extent in Burkina Faso and Zimbabwe, the proportion of slum dwellers has increased over time. In 2014, of the 39 countries studied, more than half of urban dwellers were living in slums in 27 countries.

Access to basic services

32. Where data are available, it is evident that only minimal progress has been made on the continent with regard to access to safely managed drinking water. Of the countries for which data are available, the greatest progress was recorded in Tunisia, and the least in Nigeria and Uganda.

33. Huge disparities in access to electricity across and within African subregions, with West and East African countries bearing the greatest burden. Of the countries studied, 17 recorded an increase in access to electricity between 20 and 35 percentage points. In 2016, access to electricity was universal

or almost universal in all Northern African countries (Algeria, Egypt, Libya, Morocco and Tunisia) as well as in Mauritius and Seychelles. By contrast, in Burundi, Chad, South Sudan, Malawi, Central African Republic and Guinea-Bissau, electricity was accessed by only between 8% and 15% of the population.

3.4. Governance

34. In recent years, governance has progressed in Africa. Several countries have established the "Demographic Dividend Team" (EDD), including Chad, Ghana and Senegal, among others. In Ghana and São Tomé, population dynamics were integrated into the national poverty reduction program; whereas Gambia created the population and development commission and established a functional Directorate of Local Governance in the Ministry of Lands and Regional Government.

35. The Botswana National Action Plan on the ICPD Beyond 2014 Framework is designed to domesticate the new ICPD framework on population and development beyond 2014 and is built on five thematic pillars: dignity and human rights; health; place and mobility; governance and accountability; and sustainability. A persistent challenge in many African countries is the gap between conception of policies and their implementation. Several countries have created National Population Commissions or National Population Councils which aim to integrate population and development as well as to fight corruption. Likewise, though the culture of monitoring and evaluation is emerging in the implementation of population and development plans, policies and programs, several countries face challenges in human and organizational capacities, and limitations with regard to disaggregated data for monitoring and evaluation.

3.5. Data and Statistics

36. A key lesson from the review of the AADPD is the data limitations to inform a good number of development indicators outlined in the Operational Guide. Where the information exists, it is not necessarily up to date and there is the issue of aggregation at the regional or continental levels. In many countries, there is a need for more regular data collection on timely issues (such as gender-based violence, access to social services for migrants and people with disabilities, people in fragile and humanitarian contexts) and a lack of data and statistics to estimate the magnitude and factors associated. Overall, several African countries recognized the importance of data to improve governance and achieve the goals of Agenda 2063 and the sustainable development goals and have made commitments to support data-collection processes.

3.6. Partnerships and International Cooperation

37. Most countries are taking steps toward strengthening partnerships and international cooperation, though a few challenges continue to hinder their progress. Kenya has continued to play its rightful role in fast tracking East African Community (EAC) integration through the full implementation of the provisions of all common instruments. Challenges faced by Ghana include financial constraints, lack of participation in decision making by beneficiaries of NGO projects and programs, use of NGOs for political and personal gain.

4. Macro-Level Review of AADPD Progress

4.1. Political Commitments and Stakeholder Mobilization on the Demographic Dividend

38. There has been an increase in scientific literature on the prospects and conditions for harnessing the demographic dividend in Africa using different methodological approaches, particularly during the period of the five-year implementation of the AADPD (2013-2108).

39. Among AU member States, there has been growing recognition of the importance of the demographic dividend for Africa's sustainable development, and its implications for poverty reduction and inclusive growth are well understood. Furthermore, the awareness around the kinds of national level strategic investments that are a prerequisite for the demographic transition and ultimately the DD is increasing— investments in family planning and universal access to sexual and reproductive health and rights, strengthening health systems, quality education and skills development, empowerment of women and young people, addressing child marriage and other harmful practices, reducing adolescent fertility and keeping girls in school, creating employment and entrepreneurship opportunities. Indeed, many countries have developed and are rolling out DD national action plans.

40. Subsequent to the 2013 African Regional Conference on Population and Development that yielded the Addis Ababa Declaration, the theme of which was "Harnessing the Demographic Dividend: The Future We Want for Africa," at the continental level, there has been an increase in political will and commitment, with numerous high-level meetings aimed at ensuring that the continent reaps the benefits of the DD. These include the AUC/ECA Joint Conferences of Ministers of Finance, Planning and Economic Development, the African Union High Level Committee of Heads of State and Governments on the Post-2015 Development Agenda which launched the Common African Position (CAP) in 2014, the AU Specialized Technical Committee (STC) on Health, Population and Drug Control

(2015), the AU Heads of State and Government High-Level Event on DD in margins of the 70th General Assembly, and the Second General Assembly of the Forum of African Parliamentarians on Population and Development (APF) in 2014. The African Union "Agenda 2063" (The Africa We Want) also addresses the DD, and specifically in 2017, the AU Heads of State and Government devoted the year to "Harnessing the Demographic Dividend through investments in Youth." Ahead of this, the Heads of State requested the expedited implementation of a continental initiative on the DD, as well as a DD Roadmap with concrete actions to be undertaken in 2017 and beyond. It is important to note that the action points in the Roadmap are in line with the AADPD commitments and need to be fully implemented in line with accelerated implementation of the AADPD commitments.

41. The African Union, in collaboration with the Economic Commission for Africa (ECA), the African Development Bank (ADB), the New Partnership for Africa's Development (NEPAD) Coordination and Planning Agency, the United Nations Population Fund (UNFPA), the World Bank, as well as other International entities, is supporting countries to roll out national DD strategies and action plans in line with the Roadmap and the AADPD. Further DD national profiles have been developed for a majority of countries on the continent.

4.2. Evidence on the Demographic Dividend on the Continent

42. The National Transfer Accounts (NTA) applied to countries of the ECOWAS, show an important economic dependence to younger ages. Indeed, the deficit increases with age from birth, but reaches its highest level at age 17, and thereafter declines. The highest life cycle deficit is observed in the 0-30 age group and lowest for 63 years old and over. The trend in the economic support ratio (number of actual workers over the number of actual consumers) in the ECOWAS zone, based on the low fertility scenario, shows an increase in the first demographic dividend with a slope greater than the other two scenarios (high fertility and intermediate fertility scenarios). The support ratio increases until reaching its maximum around the year 2040. From 2045, it approaches a declining phase. The increasing phase is a situation where the population structure can raise GDP per capita if appropriate actions are taken by the countries. Conversely, the declining phase implies that the population structure will no longer be a potential but rather a constraint for economic growth.

43. Demographic Dividend modeling for various countries using the DemDiv model show better economic outcomes when an integrated investment approach is used for both demographic outcomes such as population growth and dependency burden, and for economic outcomes such as GDP and

employment gap: in some settings the GDP per capita was multiplied by a factor of ten between the "business as usual" hypothesis and the more integrated hypothesis.

44. Many African countries, particularly in Northern and Southern Africa where the demographic transition is well advanced, have already experienced education gains in terms of allocations per child ("Schooling Dividend") during the period 1995 - 2010, due to the change in age structure. In the other regions (Central, Western and Eastern Africa), a good number of countries have also done so. This Schooling Dividend has been possible not only because of the changing age structure, but also due to the benefits of economic performance over the period, and more political commitment to education. The prospect of the future earnings of a schooling dividend, based on the optimistic assumption (low fertility and 8% of the GDP allocated to education), shows that by 2035 (with 2010 as the baseline), the multiplying factor will range from 1.3 to 34.7 (In Northern Africa), from 0.3 to 3.1 (In Southern Africa), from 1.6 to 93.3 (In Central Africa), from 1.2 to 6.1 (In Western Africa), and -0.1 to 15.6 (In Eastern Africa).

4.3. AADPD Related Policy Change and Institutional Arrangements

45. Between 2005 and 2015, the number of countries that have adopted a policy to lower population growth increased from 35 to 42, and there were six additional countries (from 39 to 45) that have adopted a policy to lower fertility. In nine additional countries (from 44 to 53), the government provides direct support to family planning.

46. Considering the set of six key maternal health policies[2], by 2015, more than half of all African countries (30) have adopted all 6 specific policies, while an additional 15 countries have adopted all these policies, except to expand access to safe abortion care, including post-abortion care.

47. Between 2005 and 2015, the number of countries that have adopted a policy to lower documented immigration dropped from 13 to 7, while 12 additional countries (from 11 to 23) have adopted a policy to maintain documented immigration.

5. Recommendations

[2]These policies relate to: 1) Expanded coverage of comprehensive prenatal care; 2) Expanded coverage of obstetric care; 3) Expanded coverage of essential postpartum and newborn care; 4) Expanded access to effective contraception; 5) Expanded access to safe abortion care, including post-abortion care; and 6) Expanded recruitment and/or training of skilled birth attendants

48. The elimination of preventable maternal mortality must be a priority focus for all governments, ensuring access of all women of reproductive age to skilled care before, during and after delivery, at health facilities of all levels, including emergency and neonatal care services at secondary and tertiary health centers accessible to all women regardless of income, wealth, location, level of education, disability or other status. Ensuring that no woman dies while giving birth must be a central development priority in all African countries and contexts including fragile and humanitarian contexts.
49. Governments should work with all stakeholders to ensure the empowerment of women and girls, enact laws, policies and develop programs that guarantee women's equitable access to resources (land, credits, inheritance…), to leadership opportunities including in the private sector, and to political office. Governments must address through various effective means the elimination of gender-based violence and other harmful practices that constrain the rights and impact negatively on the well-being and opportunities of women and girls, including child marriage and female genital mutilation.
50. Governments should promote universal access to health services throughout the life course. To ensure that higher level policies on sexual and reproductive health and rights are appropriately implemented at the community level, it is important to improve the capacity of target communities to understand and demand responsive, timely and accountable services. In doing so, awareness of family planning and sexual and reproductive health must be raised not only among all women of childbearing age, but also among families and community leaders whose commitment to change is crucial. This is a prerequisite for reaping the demographic dividend.
51. There is a need for increased resources to accelerate progress toward universal access to prevention, treatment, care, and monitoring and evaluation in all STI/HIV/AIDS programs, including STI surveillance, in order to protect the health of populations and prevent resurgence and the deadly consequences. It is recommended that governments make the necessary efforts to contribute substantially and sustainably to the funding of HIV and AIDS-related activities.
52. Governments should develop or revise policies and enact legislation that protect young peoples' rights to the highest attainable standard of services, particularly in terms of universal access to quality education—ensuring functional literacy, numeracy, and other skills, guaranteeing that African adolescents and youth can compete favorably on a global stage, providing quality health services including sexual and reproductive health, treatment and prevention of sexually transmitted infections

and HIV, including through access to comprehensive sex education in and out of school, and gainful and productive employment and entrepreneurship opportunities.

53. Education policies should cover primary, secondary and tertiary education, with a special focus on girls' education, re-integration of pregnant adolescents and young mothers into schools, children from poorest families, children from rural areas, the displaced and refugees, young people living with disabilities, out-of-school children, and remove barriers to education. In particular, they should promote education sensitization campaigns and strengthen capacity of relevant institutions and organizations to adopt participative advocacy approaches toward the promotion of women's and girls' rights, including their rights to education at all levels.
54. Countries should promote social and financial inclusion of vulnerable segments of the population (older people, youth, the unemployed, people living with HIV and AIDS, people with disabilities, people in humanitarian settings, in both urban and rural area) through overcoming gender inequality, fighting illiteracy, facilitating access to basic infrastructure and services, including the use of mobile technology to improve targeting and expanding access and reach for the poorest.
55. Governments should develop, strengthen and implement effective healthcare and pension programs for the elderly. The models should be built on a country-specific context to ensure sustainability.
56. Countries should develop policies to address migration issues. Governments should provide technical and financial resources to build the capacity of relevant state agencies to incorporate migration issues into the design of their strategic plans. Conducive legal and regulatory frameworks (fiscal, monetary and investment policies) should be developed. There should be proper monitoring mechanisms in place to help take stock of the flow of migrants in and out of countries.
57. Government should improve good governance practices, particularly foster strong and equitable institutions that ensure the fulfillment of the rights of all, leaving "no one behind" and "reaching the furthest behind first." Greater government commitment is needed not only in terms of the drafting of laws and policy documents, but also in ensuring these laws and policies are widely known and are implemented. There is a need for greater coordination of the activities undertaken on the ground by the various stakeholders.
58. Governments should develop strong national statistical systems that ensure the regular collection of data and timely provision of the results. There is a need for strengthening not only in national statistical offices but also in sectoral statistical, monitoring and evaluation divisions. The

implementation of a specific monitoring and evaluation system or mechanism for the AADPD at the country level, and using a standard continental model, will improve subsequent reviews of the AADPD.

59. In terms of partnership, it is recommended that strategies be implemented to maximize the benefits of South-South cooperation. Government coordination mechanisms with development partners, including civil society organizations, should be instituted. Governments should engage civil society, traditional authorities, religious bodies and the media in national development to improve participatory governance and deliver on the needs of the people in order to enhance the well-being of populations.

60. Governments should take measures to improve the business environment and ensure a more diversified and dynamic economic sector that creates decent jobs for youth and women. Macroeconomic instability should be addressed through restoring fiscal discipline, sustainability and reducing fiscal deficits, improving the quality and composition of public expenditures, and reducing financial sector vulnerability. Development partners should be encouraged to channel support through the national budget, and to implement a reporting mechanism of their interventions to reduce the risk or incidence of project support duplication.

61. The review also identified a number of good programmes that are recommended for expansion and scaling up such as existing initiatives such as the Sahel Women's Empowerment and Demographic Dividend (SWEDD), which aims to support the realization of the demographic dividend through girls and women' empowerment.

62. Due to the unique geographical setting and population size, the small island developing states (SIDS) are particularly more vulnerable to the impact of climate change and natural disasters, and for this reason they need special attention to build resilience to natural disasters, economic resilience, sustainable health services, fighting inequalities, promoting gender equality and human capital development. Furthermore, support is also needed in the area of disaggregated data collection to inform policy choices and monitor progress.

63. The above recommendations are geared toward accelerating implementation to achieve progress, however in order to yield a maximum impact, there is a crucial need to find sustainable solutions to the increasing insecurity in many settings of the continent, which is becoming a major threat to social and economic progress. Political and social unrest, radicalization and terrorism are increasingly creating an unsafe environment for populations and basic services providers. A concerted, comprehensive and sustainable solution is needed to ensure accelerated implementation of population and development policies and programs will realize their objectives in line with the

commitments of the AADPD, Agenda 2063 and the 2030 Agenda and its Sustainable Development Goals.

64. In support of accelerated efforts to fully implement the commitments outlined in the AADPD, the Africa Union Commission, UNECA and UNFPA will continue to facilitate the generation of timely, high-quality knowledge, support advocacy and policy dialogue processes, support implementation of relevant programs, develop institutional capacities, and foster partnerships and coordination, including South-South and triangular cooperation and provide other substantive support as needed at the national level toward the further implementation of these commitments, including for the realization of the demographic dividend.

65. The findings and recommendations of the AADPD plus five continental review report, alongside the outcomes of the 2018 Ministerial Review on the Implementation of the Addis Ababa Declaration on Population and Development deliberations, will inform the global review of the ICPD at the 52nd Session of the Commission on Population and Development in 2019, the 2019 UNECA Africa Regional Forum on Sustainable Development, and the 2019 United Nations Economic and Social Council High-Level Political Forum on Sustainable Development. To better integrate the review and follow-up of the ICPD in Africa with the 2030 Agenda on Sustainable Development, future review cycles of the Addis Ababa Declaration will be aligned with SDG review cycles to take place every four instead of five years. Furthermore, the AADPD plus five continental review report and accompanying STC Decision will be submitted to the AU Assembly through the Office of the AU Secretary General.

Chapter 1: The Addis Ababa Declaration on Population and Development

The Addis Ababa Declaration on Population and Development (AADPD), a key framework for addressing population and development issues in Africa, was adopted by African Ministers at the Africa Regional Conference on Population and Development held in Addis Ababa from October 3-4, 2013, and also endorsed by the African Union executive council in 2014. It provided region-specific guidance on population and development, and guidelines for the full implementation of the International Conference on Population and Development (ICPD) beyond 2014 in Africa.

1.1 Genesis of the AADPD

The journey began with the 1994 ICPD, which brought about a paradigm shift of development that led to a focus on improved quality of life and the protection and fulfillment of human rights, including sexual and reproductive health and reproductive rights (SRHR) for all, especially women and adolescents. Endorsed by 179 governments, the Program of Action that emanated from the conference provided a comprehensive framework on the interrelationship between population, sustained economic growth and sustainable development, and advances in education, economic status and empowerment of women [3]. During the ICPD+5 review, the United Nations (UN) General Assembly held a special session in 1999 during which key actions were adopted that served to affirm the ICPD goals and to provide a set of benchmarks that would be used to monitor progress toward achieving them, and to ensure continued relevance [4]. These goals were deemed essential to meet the Millennium Development Goals (MDGs) and later, the Sustainable Development Goals (SDGs). Similar reviews took place in 2004 (ICPD+10) and 2009 (ICPD+15). The core principles underlying the formulation of the SDGs included that they should be action-oriented, aspirational and easy to communicate; they should be global, yet locally relevant; they

[3] UNECA, UNFPA, AUC. 2009. Africa Regional Review Report. ICPD and the MDGs: Working as One. Fifteen-Year Review of the Implementation of the ICPD PoA in Africa – ICPD at 15 (1994 – 2009). Addis Ababa, 2009

[4] UNFPA 2004. Program of Action. Adopted at the International Conference on population and Development, Cairo, 5-13 September 1994. ISBN 0-89714-696-4

should include economic, social and environmentally sustainable development; and they should be integrated into the UN development agenda beyond 2015.

The "leaving no one behind" framework for action stresses the inclusiveness of the SDGs and brings equality and non-discrimination to the forefront of the implementation of the SDGs. This is a carefully articulated framework to address the gross and rising inequalities in today's world that could threaten the work of the United Nations' system [9]. In committing to AADPD, African Member States adhered to the "leave no one behind" principle, recognizing that the commitments should be met for all nations and people, and for all segments of society. Key to this principle, which goes beyond mere non-discrimination, is the ("reaching the furthest behind first") prioritization and fast-tracking of actions for the poorest and most vulnerable groups including children, youth, people with disabilities, people living with HIV, older people, indigenous peoples, refugees, internally displaced people and migrants [5,6].

At the 2013 Africa Regional Conference on Population and Development (ARCPD), the ICPD beyond 2014 review stressed the need to refocus and respond to "new and emerging challenges relevant to population and development and to the changing development environment." These new development challenges included (but were not limited to): 1) growing inequality in both earnings and wealth; 2) far more diverse demographic trends and a youth bulge; 3) migration and rapid urbanization unfolding in many countries; 4) explosion in access to information; and 5) increasing climate change and humanitarian threats, with effect on population mobility and dynamics and the potential to undermine development. The review reiterated the inspiration of the 1994 Program of Action by emphasizing the need to invest in dignity and the human rights and capabilities of all. These rights included ensuring the equal rights of women and young people, including adolescent girls, and were guided by a comprehensive definition of sexual and reproductive health and rights, as preconditions for building resilient societies with the capacity

[5]UNESA. 2016. Leaving No One Behind: The Imperative of Inclusive Development. Report on the World Social Situation 2016. New York.

[6]UN 2017. Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development. New York

for long-term economic growth, sustainability and well-being in the face of social and environmental change [7,8].

At the 2013 ARCPD organized by the United Nations Economic Commission for Africa (UNECA) and the African Union Commission (AUC), with support from the United Nations Population Fund (UNFPA), the African Ministers adopted the Addis Ababa Declaration on Population and Development beyond 2014. The declaration reaffirmed the region's commitment to the ICPD Program of Action beyond 2014 as the framework for addressing issues of population and development. The theme of the ARCPD "Harnessing the Demographic Dividend: The Future We Want for Africa" was selected. Its rich set of commitments and indicators were designed to simultaneously support Africa's efforts to harness a demographic dividend (DD), advance human rights and meet sustainable development goals. The declaration "reaffirms and consolidates past commitments in the area of population and development" [9]. The AADPD, due to its timing and priority, significantly influenced the Agenda 2063 and the Agenda 2030 through the Common African Position on Post 2015 and resulted in the strong overlap of the three frameworks [10]. Importantly, it was officially endorsed by African Heads of State and Governments at the African Union Summit, and Member States have committed to undertake periodic reviews to assess progress on population and development commitments [11].

[7]UNFPA 2016. FOUNDATIONS for the FUTURE: Building Quality Human Capital for Economic Transformation and Sustainable Development in the Context of the Istanbul Program of Action - A Review of Progress toward the Implementation of the Istanbul Program of Action for the Least Developed Countries. New York

[8]UN 2014. Framework of Actions for the follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014: Report of the Secretary-General. New York

[9]UNFPA. 2018. Operational Guide for Implementing and Monitoring of The Addis Ababa Declaration on Population and Development Beyond 2014. New York

[10]AUC. 2013. Decision on the Regional Conference on Population and Development Beyond 2014. Addis Ababa, Ethiopia, 30 September - 4 October 2013. Doc. Ex.Cl/814(XXIV)

[11]UNECA, AUC & UNFPA. 2013. African Regional Conference on Population and Development: Addis Ababa Declaration on Population and Development in Africa beyond 2014

1.2 Content of the AADPD

The declaration comprises a total of 88 priority measures (commitments) grouped under six pillars: Dignity and Equality; Health; Place and Mobility; Governance; Data and Statistics; Partnership and International Cooperation [4].

1.2.1 Six Interrelated Pillars

Dignity and Equality: The assurance of dignity and human rights are basic to any development agenda that aims to improve the well-being of people. This equality in dignity and rights of human beings has been affirmed in the Universal Declaration of Human Rights, as well as in international, regional and national agreements [4]. In recognition of the importance of this, AADPD includes 29 commitments to promote human rights, dignity and equality; eradicate extreme poverty; address gender equality and promote women's empowerment [5].

Health: Sexual and reproductive health and rights are essential for women and girls, as well as boys and men, and central to sustainable human development. Although the burden of disease has shifted toward noncommunicable diseases and injuries, sub-Saharan Africa continue to struggle with largely preventable communicable, maternal, nutritional and neonatal diseases. However, in order to achieve universal access to health, a holistic approach toward strengthening health systems is essential [4]. To move the health agenda forward, African Ministers made 17 commitments to strengthen health care systems in order to address issues of universal and equitable access, as well as the shortage of resources. The resulting rights-based approach to health care delivery would include community participation, preventive care, treatment of communicable and noncommunicable diseases in a supportive environment, as well as universal access to rights-based sexual and reproductive health services [5].

Place and Mobility: Place and mobility bring together social and spatial contexts. They link population dynamics to the concepts of dignity and sustainable development [4]. In recognition of the role of population dynamics and the resulting change in age structure in influencing prospects for human development, inclusive economic growth, and sustainable development, the African Ministers made 19 commitments related to place and mobility. They committed to

facilitate the free movement of people within and across geographies, in accordance with the adoption of selective migration policies that protect vulnerable groups, especially women and youth, while protecting the rights of migrants and citizens alike [5].

Governance: Global leadership that is accountable is of essence in ensuring the implementation and attainment of development goals [4]. In recognition of the fact that responsive governance should be accountable, participatory, transparent, and follow the rule of law, the African Ministers made five commitments to comprehensively respond to population and development issues by effectively integrating population dynamics into development planning, while ensuring effective coordination of all efforts, across sectors, and instituting appropriate monitoring and evaluation mechanisms [5].

Data and Statistics: The Ministers recognized the existence of gaps in policy-relevant data in many African countries, as well as the lack of complete civil registration systems in these settings. In view of this, they made seven commitments to strengthen national capacity to undertake research and analysis that would provide population-based data for action; establish civil registration systems from community to national levels; undertake research to inform policy; and conduct regular national censuses in keeping with international standards [5].

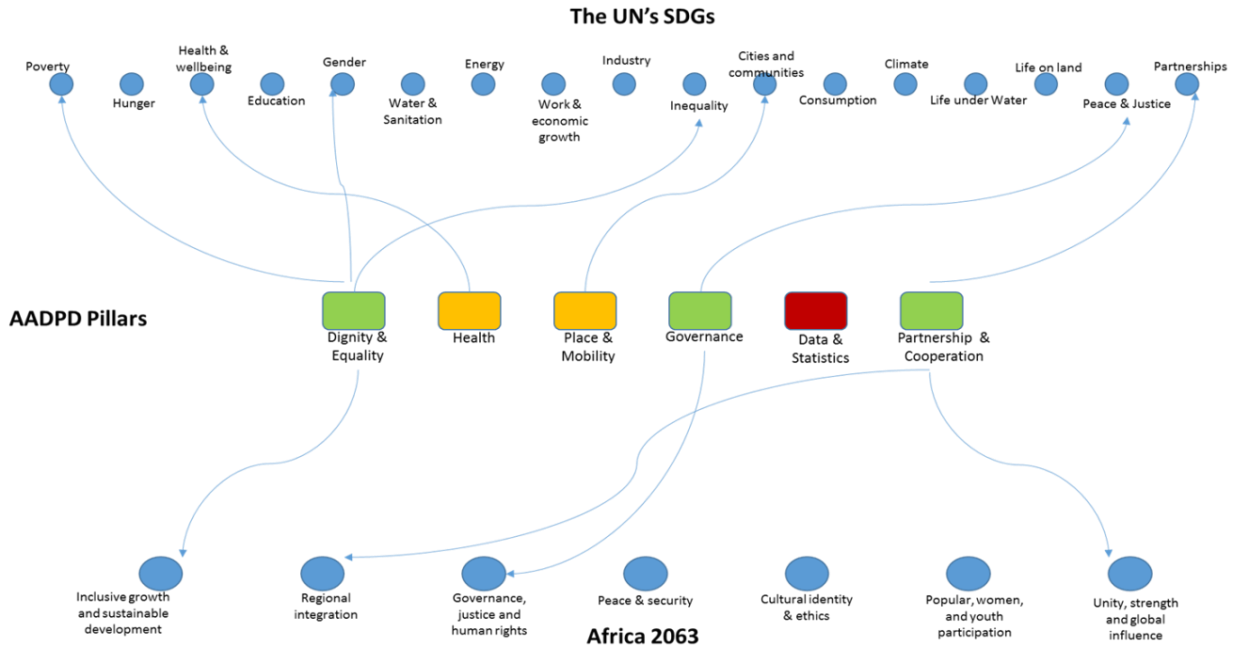
International Cooperation and Partnership: In recognition of the importance of partnering with stakeholders and bringing the international community together, the Ministers made 11 commitments directed at strengthening partnerships in all matters related to population and development programs. Such partnerships would involve working with civil society, nongovernmental organizations and youth, and strengthening partnerships with the private sector.

1.2.2 AADPD and the Sustainable Development Goals (SDGs)

The signatories of the AADPD recognized that the full implementation of ICPD's Program of Action is integrally linked to global efforts to eradicate extreme poverty and ensure sustainable development [4]. Indeed, the AADPD commitments overlap substantially with the UN's agenda for sustainable development, with nearly 80% of the AADPD commitments connected to SDGs,

as shown in Figure 1. Only one of the AADPD's six pillars (data and statistics) does not connect directly with a major pillar in the UN's SDGs, though SDG targets 17.18 and 17.19 advocate for the need to strengthen capacities for generating good quality disaggregated data [3,[12]].

Figure 1. AADPD, the sustainable development goals and the agenda 2063



1.2.3 AADPD and the AU Agenda 2063

The seven aspirations in the "Africa We Want" (Agenda 2063) also overlap with the AADPD's six pillars, as seen in Figure 1, with both agendas intentionally emphasizing sustainable development through integration, good governance, respect for human rights, equity, equality, and strong international partnerships and collaboration. The 50-year Agenda 2063 has goals influenced by four factors: 1) 12 flagship projects; 2) Near-term National and Regional Economic Communities (RECs) development priorities; 3) Continental frameworks; and 4) Agenda 2063 results framework, containing seven aspirations, 20 goals, and 39 priority areas. These priority areas, goals and aspirations will make it possible to reach the African Union vision of "an integrated,

[12]UN. 2015. Transforming Our World: the 2030 Agenda for Sustainable Development. New York

prosperous and peaceful Africa, driven by its own citizens, representing a dynamic force in the international arena" [13].

1.2.4 AADPD and the Demographic Dividend

In making the AADPD commitments, the Ministers viewed the demographic dividend as an important dimension of the AADPD agenda, and one of the key pathways from AADPD to sustainable development [4,14]. Indeed, not only would 20% of the AADPD commitments advance the region's prospects of reaping a dividend, the AADPD can further extend the impact of demographic change by supporting the development of a more equitable fertility transition. With its emphasis on the economic, service, and reproductive needs of the most vulnerable populations, efforts by governments to fulfill the AADPD commitments could reduce the growing socioeconomic gap in fertility in most African countries [15,16]. The reduction in gender gaps in education due to increased enrollment of girls in primary school in African countries is an important development gain in recent decades, but much more needs to be done to ensure that girls stay in school and complete higher education. Given that education is considered a human right, ensuring gender equality in education will lead to further empowerment of girls and women, an element critical for propelling them out of poverty. Moreover, education is likely to empower women and girls, and to address the longstanding, desired large family size recorded in many African countries, bringing about a push to the stalled fertility transition, as educated women tend to favor smaller families.

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[13] AUC. 2015. Agenda 2063 - The Africa We Want: A Shared Strategic Framework for Inclusive Growth and Sustainable Development. First Ten-Year Implementation Plan 2014-2023.

[14] AUC. 2017. AU Roadmap on Harnessing the Demographic Dividend through Investments in Youth - In response to AU Assembly Decision (Assembly/AU/Dec.601 (XXVI) on the 2017 theme of the year. Addis Ababa.

[15] Shapiro D. and Tambashe B.O. 2002. Fertility transition in urban and rural sub-Saharan Africa: preliminary evidence of a three-stage process. Journal of African Policy Studies, 8(2-3):105–130.

[16] Eloundou-Enyegue P, Giroux S. and Tenikue M. (forthcoming). African Transitions and Fertility Inequality. A Demographic Kuznets Hypothesis. Population and Development Review.

With its human rights framing, the AADPD can serve as a standard for policies and programs that could result in a dividend in a manner that empowers and does not constrain the choices of women and young people. The AADPD and the demographic dividend both rest on the connection between population and socioeconomic development. On the one hand, the AADPD is the key programmatic framework for addressing population and development issues in Africa, having been endorsed by African Heads of State at the 2014 AU Heads of State Summit. On the other hand, the demographic dividend is a dominant contemporary theory about the possible influences of demographic change on socioeconomic development. The connections between the two thus bear reinforcing [4].

Chapter 2: Methodological Approach of the Review

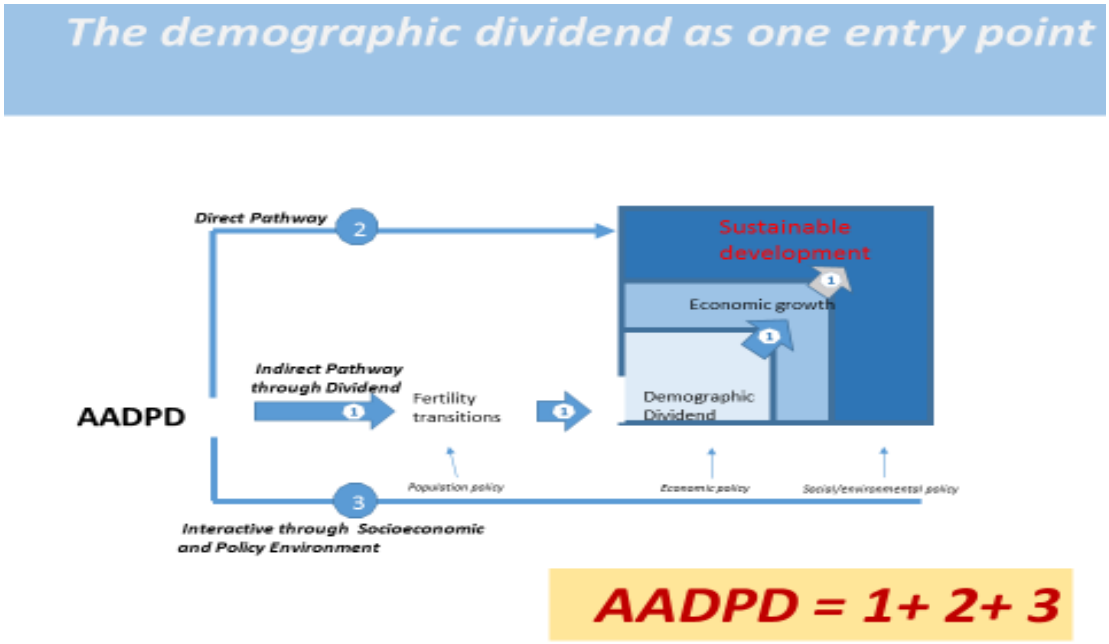
Monitoring and evaluation are an important part of the implementation of the Addis Ababa Declaration on Population and Development (AADPD). This section reports on the review methodology. Overall, this study relies on the AADPD Operational Guide and Monitoring and Evaluation Framework , adopted by African Ministers at the Second Specialized Technical Committee on Health, Population and Drug Control in March 2017.

2.1 Review Framework

This review focused on the two dimensions described in the AADPD Operational Guide and Monitoring and Evaluation Framework (AADPD Operational Guide, 2017): "the "macro-evaluation" and the "micro-monitoring." The macro-evaluation focuses on the full set of 88 commitments contained in the AADPD declaration, rather than individual commitments. The micro-monitoring consists of tracking the implementation of each individual commitment. As the AADPD commitments are expressed in richly detailed text, it requires a conversion of each commitment into a succinct and reliable indicator." (AADPD Operational Guide, 2017). For each pillar described in chapter 1, the AADPD Operational Guide for Monitoring and Evaluation manual provides indicators. Appendix 4.1 (chapter 4) lists selected indicators for each substantive pillar (Dignity & Equity, Health, Place & Mobility) and commitments, based on data availability.

Underpinned by human rights and building on a human rights-based theoretical approach to the demographic dividend, the commitments in the AADPD are linked to the 2063 and 2030 Agendas. The AADPD contributes to the achievement of sustainable development through supporting population policies that advance healthy fertility transitions; economic policies that help the conversion of low-age dependency rates into savings and investment; and social and environmental policies that help distribute the benefits of growth (Figure 2.1).(AADPD Operational Guide 2017)

Figure 2.1 Pathways from the AADPD to sustainable development



Source: AADPD Operational Guide (2017: 23)

2.2 Data Sources and Analysis Methods

2.2.1 Data Sources

Data for this review come from two main sources. The quantitative component uses data from several sources, including national Demographic and Health Surveys (DHS), the United Nations Population Division (UNPD), UNICEF, the World Health Organization (WHO), the UNESCO Institute of Statistics, the International Labor Organization (ILO), and the World Bank. The desk review covers AADPD+5 national reports, policy documents and program reports at the continental and regional levels, and peer-reviewed and grey literature. Throughout the report, for consistency, we use the names and grouping of countries as defined by African Union Commission (AUC).

The DHS data provide the large majority of information on health and gender, including the total fertility rate, prevalence of modern contraception, under-five mortality, female genital mutilation, categorized by place of residence and wealth quintile. We selected all African

countries where at least one DHS has been conducted between 2000 and 2005, and between 2010 and 2016. Table 2.1 lists the 26 countries with DHS data included in this study.

Table 2.1 Eligible countries according to DHS data

Country	TFR	First	Last
Western Africa			
Benin	4.9	2001	2011-12
Burkina Faso	6.0	2003	2010
Côte d'Ivoire	5.0	1998-99	2011-12
Ghana	4.2	2003	2014
Guinea	5.1	2005	2012
Mali	6.1	2001	2012-13
Niger	7.6	1998	2012
Nigeria	5.5	2003	2013
Senegal	4.7	2005	2016
Togo	4.8	1998	2013-14
Central Africa			
Cameroon	5.1	2004	2011
Chad	6.4	2004	2014-15
Congo	5.1	2005	2011-12
Gabon	4.1	2000	2012
Eastern Africa			
Ethiopia	4.6	2005	2016
Kenya	3.9	2003	2014
Rwanda	4.2	2000	2014-15
Tanzania	5.2	2004-05	2015-16
Uganda	5.4	2000-01	2016
Southern Africa			
Lesotho	3.3	2004	2014
Malawi	4.4	2004	2015-16
Mozambique	5.9	2003	2011
Namibia	3.6	2000	2013
Zambia	5.3	2001-02	2013-14
Zimbabwe	4.0	2005-06	2015
Northern Africa			
Egypt	3.5	2003	2014

The selected countries are representative of all African regions: Northern, Eastern, Western, Central and Southern. In addition, these countries are at different stages of their demographic

transition and have different socioeconomic profiles. The demographic data encompassing the distribution of the population by age, dependency ratio and life expectancy are from the United Nations Population Division (UNPD), while the poverty, education, employment and governance data are generally from the World Bank, UNDP, UNESCO, and ILO databases. Furthermore, the UNPD provides data on population policies (https://esa.un.org/poppolicy).

For the analysis of major population and development trends (described in chapter 3), a longer period is covered (1990-1995 to 2025-2030). For the performance analysis of the AADPD's commitments, the period covered is 2000-2005 (which coincides with the beginning of the MDGs) to 2015-2020.

In addition to quantitative data, the review will leverage qualitative data to explain the trends in quantitative indicators. Data from the UN database on World Population Policies (https://esa.un.org/PopPolicy/about_database.aspx) and national reports of the AADPD review are utilized. The review also draws from reports and declarations from regional political meetings on the demographic dividend, using key findings from the work undertaken by academic and policy organizations on the continent. This evidence on the DD includes the work of the Francophone Network (FRANET) on the "Economic Dividend" and the "Schooling Dividend" in 47 countries, the work of the Centre de Recherche en Economie et Finances Appliquées de Thiès (CREFAT) based on the National Transfers Accounts (NTA) approach in 23 Western and Central African countries, and the findings from the work of the African Institute for Development Policies (AFIDEP) based on the application of the DemDiv models in Eastern and Southern Africa.

2.2.2 Data Analysis Methods

The review relies on two major data analysis methods depending on the nature of the data. After using descriptive statistics techniques to provide trend analysis based on quantitative data, especially the level of indicators and track changes over time, we apply content analysis to summarize information from published documents to contextualize the quantitative analysis. Depending on data availability, and using the impact and process indicators specified in the

Operational Guide in some cases, the report will analyze performance trends with regard to fulfillment of AADPD commitments and their overall impact at the continent level as well as at the five subregional levels (Central, Western, Eastern, Southern, and Northern Africa).

2.3 Limitations of the Methodological Approach

This five-year review of the AADPD has two major limitations. Firstly, the short time period under review makes it harder to report on impact indicators in terms of performance, given the relative inertia of social and demographic phenomena (e.g., child mortality, changes in age structure, fertility decline, etc., take some time to show markedly variations). For this reason, the period of analysis goes further back, beyond that of the implementation of the AADPD (2013-2018) so as to assess key population and development trends as highlighted by the AADPD. Secondly, limited availability of data for some commitments makes analysis at the regional and continental levels difficult. For instance, out of 85 indicators of pillar 1 (Dignity and Equality), only 15 indicators could be documented. In addition, among these 15 indicators, information at both the continental and regional levels is available for only two commitments.

Chapter 3: Major Population and Development Trends in Africa

As highlighted by a number of regional and international agendas and reviews, integrating population in development planning, and particularly investing in quality human capital, is a pre-condition for realizing the full potential of a demographic dividend, and therefore achieving the ambitions of the 2030 Agenda and its Sustainable Development Goals. This integration ought to be done within a context of rapid demographic, economic, and social changes by promoting human rights and creating an enabling environment for children, adolescents, youth, and women to fulfill their rights to access quality education, sexual and reproductive services, and decent employment.

The Addis Ababa Declaration on Population and Development (AADPD) has recognized "the critical inter-linkages between population,sustained economic growth and sustainable development and their central importance to addressing the challenges and priorities of the region especially in improving the quality of life of all people, particularly children, adolescents, girls, youth, women, older people, groups marginalized on the basis of culture or history or indigenous people, people with disabilities, migrants, refugees, and the displaced; in eradicating poverty and social inequities; achieving universal primary and secondary education; achieving gender equality and women's empowerment; improving maternal and child health; promoting reproductive health and rights; combating sexually transmitted diseases including HIV and AIDS; and eliminating gender-based violence as well as all forms of discrimination"[17].

The 2030 Agenda for Sustainable Development, on the other hand, provides that "we will strive to provide children and youth with a nurturing environment for the full realization of their rights and capabilities, helping our countries to reap the demographic dividend including through safe schools and cohesive communities and families"[18] , and further states that "we will also take account of population trends and projections in our national, rural and urban development

[17]UNECA, AUC & UNFPA. 2013. African Regional Conference on Population and Development: Addis Ababa Declaration on Population and Development in Africa beyond 2014. Pp 1-2

[18]UN. 2015. Transforming our world: the 2030 Agenda for Sustainable Development. Para 34

strategies and policies."[19] In the same vein, the Istanbul Program of Action calls for the need to "incorporate into their national development strategies and policies human resource development and planning for population dynamics."[20]

This chapter starts by highlighting the progress in health improvement and life expectancy (section 1) and then population growth (section 2). In the third section, the changing age structure, a key dimension of the demographic dividend, is discussed, including issues such as diverse fertility patterns on the continent, the youth bulge, the aging population, and dependency ratios. In subsequent sections 4 and 5, urbanization and migration are discussed.

3.1. Life Expectancy and Declining Mortality

As Figure 3.1 shows, there has been a 10.7 year gain in life expectancy, from 51.7 years in 1990-1995 to 62.4 years in 2015-2020, as a consequence of progress in public health measures and medical technology (particularly through the spread of vaccination, medicine, access to safe water, etc.). Regional differences in life expectancy are narrowing even though Northern Africa stands out from the other regions at a much higher level, and while Eastern and Southern Africa have comparable levels. For example, the life expectancy gap between the highest performing region and the lowest performing region dropped from 17 years in 1990-1995 (64.6 years in Northern Africa vs 47.6 years in Eastern Africa) to 15.2 years in 2015-2020 (72.1 years in Northern Africa vs 56.9 years in Western Africa). The narrowing of the gap in life expectancy is even more dramatic between Southern Africa and Eastern Africa, with a decline from 14.3 years in 1990-1995 (61.9 years vs 47.6 years) to -0.5 years in 2015-2020 (63.5 years vs 64.0 years) (See Table Appendix 3.1).

As a result of improved health conditions, infant and under-five child mortality are decreasing, though the levels are still high when compared to other regions in the world (Figures 3.2a & 3.2b). For Africa as a whole, infant mortality declined from 102 per 1,000 live births in 1990-1995 to 57

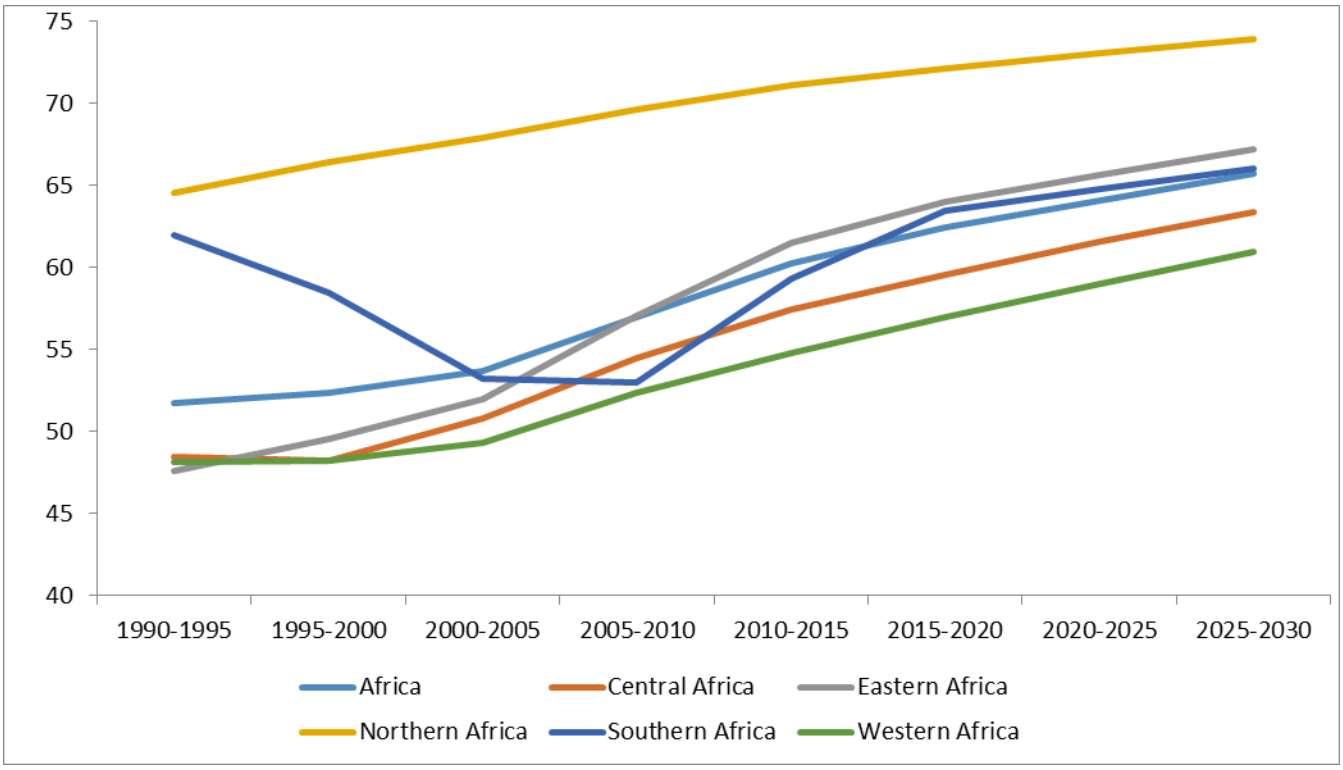
[19]UN. 2015. Transforming our world: the 2030 Agenda for Sustainable Development. Para 25

[20]Istanbul Program of Action for Least Developed Countries for the Decade 2011-2020, Population and Primary Health. Para 2(c)

per 1,000 live births in 1995-2020. The other regions exhibit much lower rates at 31 per 1,000 live births in Asia, 21 per 1,000 live births in Oceania, and 19 per 1,000 live births in Latin America and the Caribbean (See Table Appendix 3.2.a). The same trend is observed for under-five mortality over the same period. It decreased in Africa from 167 per 1,000 live births to 87 per 1,000 live births, while the figures for the other regions are much lower (See Table Appendix 3.2b). Four regional patterns emerge: at the two extremes are a pattern of high infant and under-five mortality in Western and Central Africa, and low infant and under-five mortality in Northern Africa. Between these two is Eastern Africa with an average level of infant and child mortality comparable to that of the continent as a whole, and Southern Africa which, after a period of increased mortality due to the HIV-AIDS pandemic, has a declining infant and under-five mortality since the period 2005-2010.

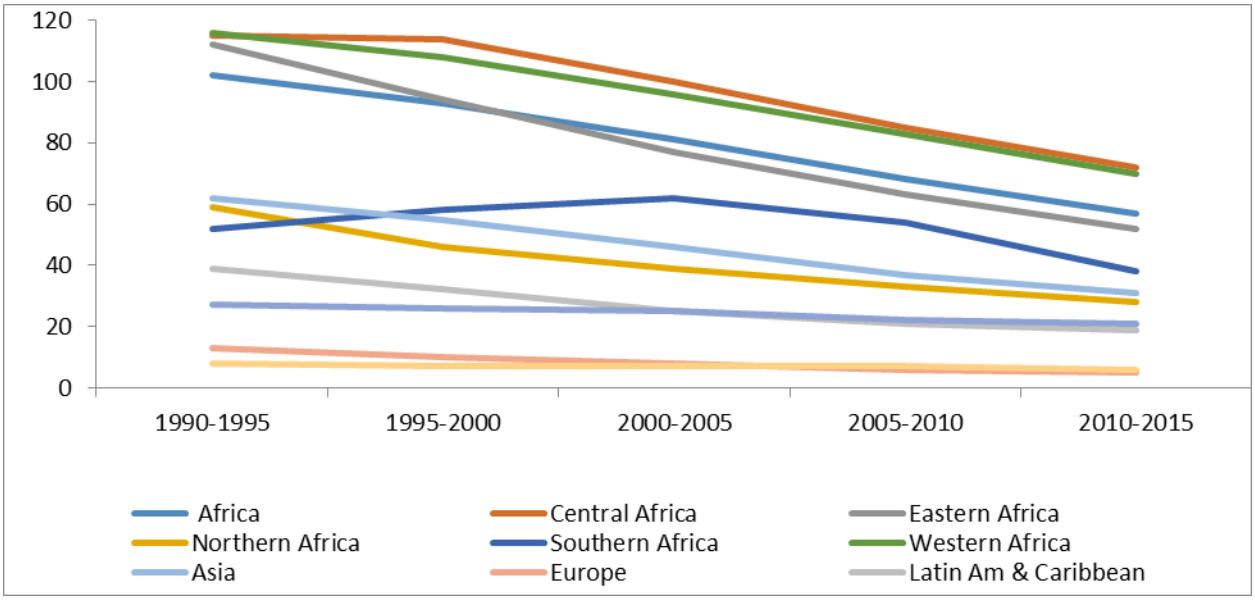
Another dimension of improved health conditions is that life expectancy at older ages is increasing. On average, life expectancy in Africa at 60 years has increased by two years over a 30-year period (from 15 in 1990-95 to 17 years in 2020-2025). Here again, there are regional variations, with the higher increase in life expectancy at older age in Northern Africa and lower increases in Western Africa (figure 3.3).

Figure 3.1: Trends in life expectancy of Africa and its five subregions (1990 – 2030)



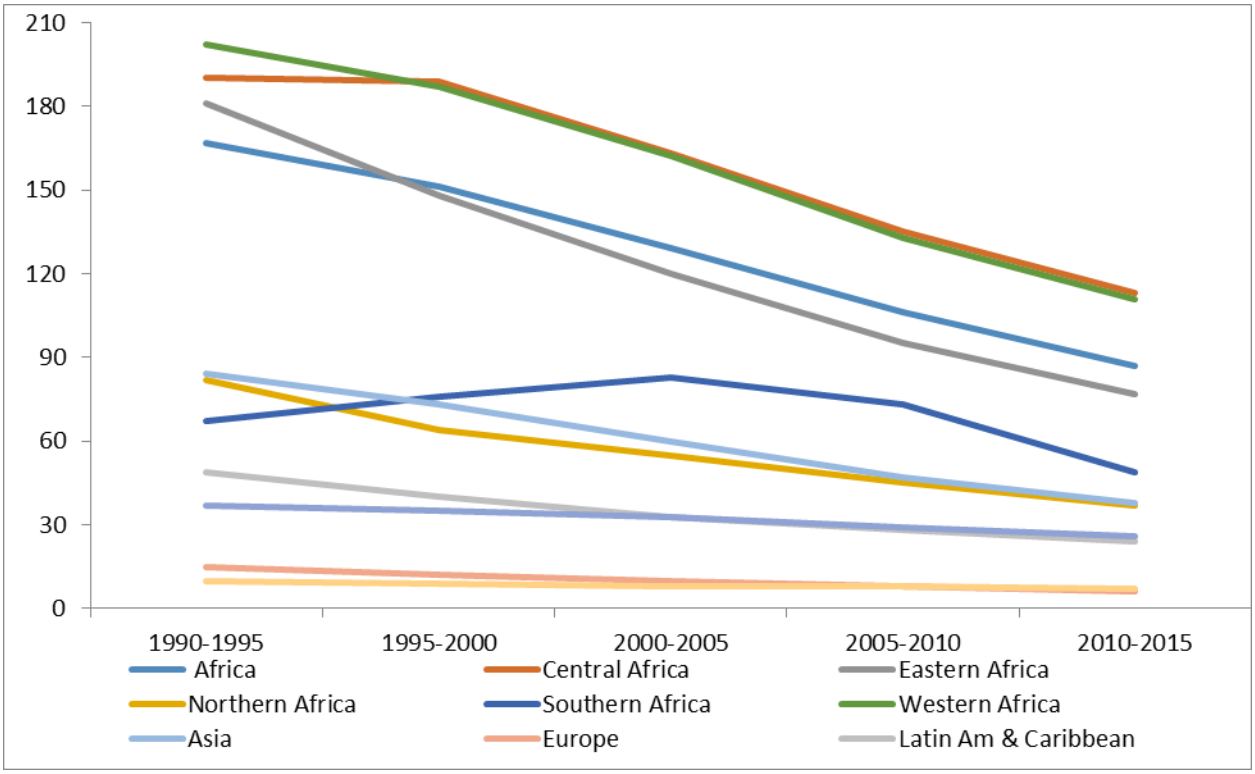
Data source: World Population Prospects 2017/United Nations Population Division

Figure 3.2a: Trends in infant mortality in Africa and other regions of the world (1990 – 2015)



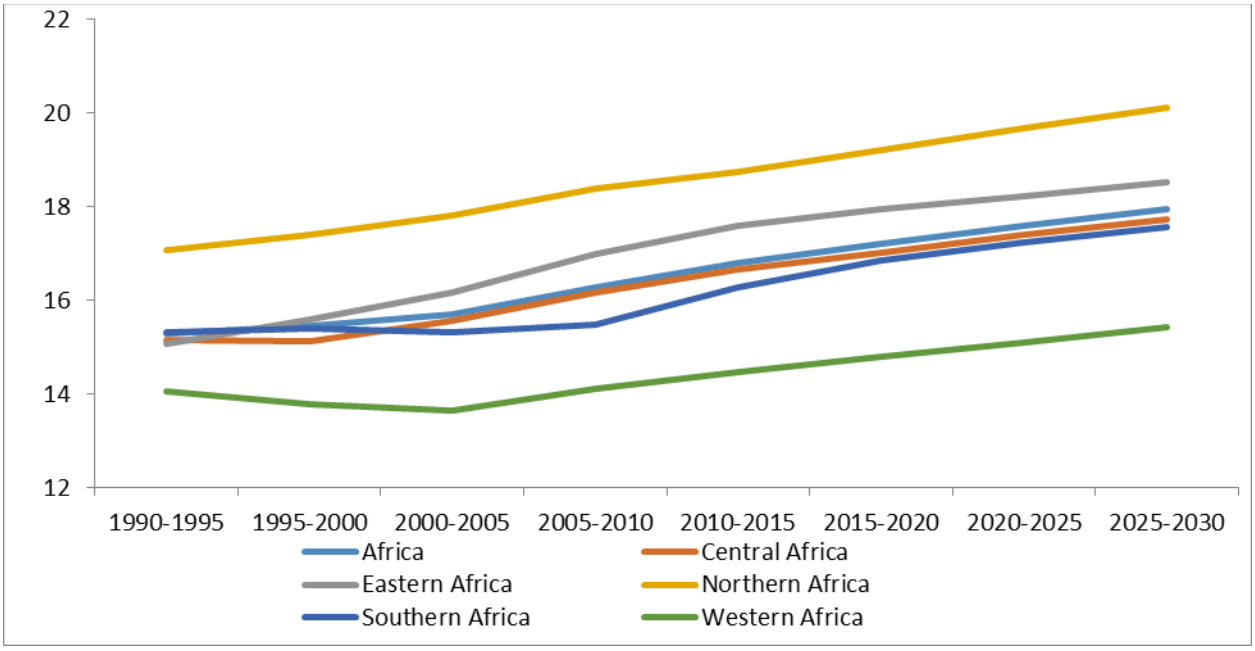
Data source: World Population Prospects 2017/United Nations Population Division

Figure 3.2b: Trends in under-five mortality for the continent and other regions of the world (1990 – 2015)



Data source: World Population Prospects 2017/United Nations Population Division

Figure 3.3: Life expectancy at age 60 in Africa and its five subregions for 1990 –2030



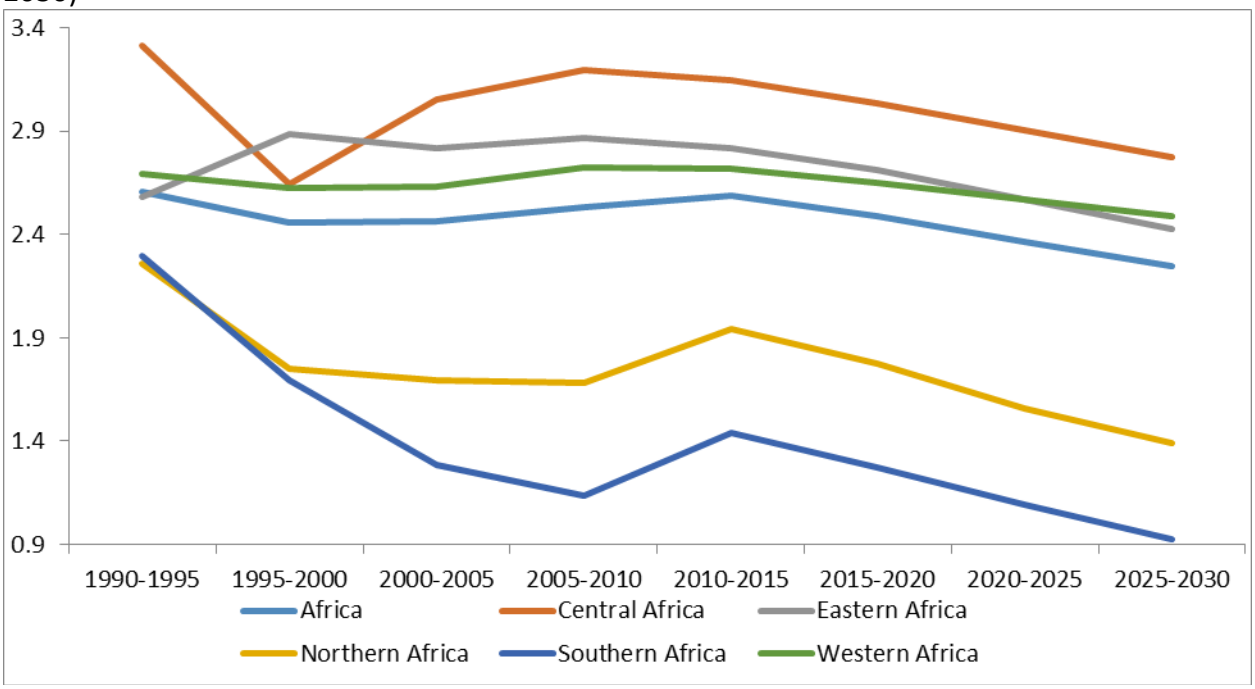
Source: World Population Prospects 2017/United Nations Population Division

3.2. Overall Population Growth

The African continent has been facing one of the crucial moments of its demographic dynamics, characterized by a rapid population growth. According to UN population projections, after a peak in 1980-85 (2.82%), the growth rate declined to 2.46% in 2000-2005, and then was estimated at 2.59% for the period 2015-2020. This high average growth masks regional disparities, with higher rates of population growth in Central, Western and Eastern Africa, and lower population growth in Northern and Southern Africa (Figure 3.4).

Despite a projected decline in the rate of growth, population growth on the continent will still be the highest in the world in 2050. According to the medium variant of the 2017 revisions of the United Nations population prospects, the growth rate of the African population will decline to 1.79% in 2050 (compared to 0.56% worldwide). Notwithstanding this downward trend, the population of the continent is projected to reach almost 2.5 billion in 2050. For a projected world population of 9.8 billion, this means one in every four people in the world will be based in Africa by 2050. A key demographic trait accompanying this population growth is the changing age structure of the population.

Figure 3.4: Trends in population growth rates for the continent and its five subregions (1990 – 2030)



Data source: World Population Prospects 2017/United Nations Population Division

3.3. Changing Age Structure

Changing age structure, which is central to the demographic dividend, is a consequence of the demographic transition which, itself, is the process of fertility decline consecutive to improving health and decreasing mortality. The drivers of this demographic change are well known and documented in the scientific literature. The decline in infant and child mortality is the result of improvement in health systems and success in increasing child survival through immunization and drug discovery to fight against infectious diseases. The drivers of fertility decline are generally classified into two broad categories: indirect or intermediate determinants (i.e., socioeconomic, environmental and psychosocial factors) and direct or proximate determinants, including age of entry in first union, the use of contraception, sterility, induced abortion, and temporary postpartum infecundability.

In the early stages of the demographic transition, as it is still the case in many rural settings of the continent, high fertility is the consequence of a desire for a large family. In more traditional

agrarian communities, couples are still inclined to desire many children to help in family production and as a security in old age. In addition, high infant mortality forces parents to have more children to protect themselves against losses and expect that some will live to adulthood. As infant mortality declines, high fertility results in rapid population growth and growing numbers of children, and soon youth, in the population. The decline in fertility occurs with increasing urbanization and education (especially women's education), accessibility of modern contraception, changes in the economy, and declining mortality. Couples begin to realize their desire for a lower number of births by using family planning services. The resulting decrease in children causes a "youth bulge," in which the cohort of youth is larger than the following cohort of children. Social and economic development improve as a result the changes in age structure which result in an expansion in the i cohort of youth and in the increase in investments to improve education , job creation and entrepreneurial opportunities.

Therefore, as highlighted by the AADPD and the Framework of Actions for the Follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014, promoting the sexual and reproductive health and rights of couples, empowering women through education (beyond primary level), and particularly ensuring that they have access to quality family planning services are crucial to obtaining a significant shift in the demographic trend and setting the path toward the process for capturing a demographic dividend. The 3E (Empower, Educate, Employ) framework to reap the demographic dividend, developed by the Global Agenda Council on the Demographic Dividend (World Economic Forum, 2015) and also emphasized in the 2016 UNFPA report "Foundations for the Future," can be considered the unifying idea to ensure that all the people can take advantage of the full set of opportunities offered and then realize their aspirations and contribute to countries' development.

3.3.1. Fertility Patterns

Unlike mortality, fertility in Africa has been declining at a slower pace: within a period of 30 years from 1990-1995 to 2010-2015, the Total Fertility Rate (TFR) moved from 5.72 (compared to 3.02 worldwide) to 4.72 (compared 2.52 worldwide). While the proportional declines for the continent and the world are similar over the period, what is striking across regions is the level of fertility at the 1990-1995 starting point. Fertility levels remain very high in Central and Western Africa, while

in Eastern Africa the fertility decline over the last two decades is comparable to the continental average. In contrast, Southern Africa and Northern Africa started with lower levels of fertility, and these continue to fall slowly, although more recently (2005-2010), fertility rates in Northern Africa have been rising (Figure 3.5).

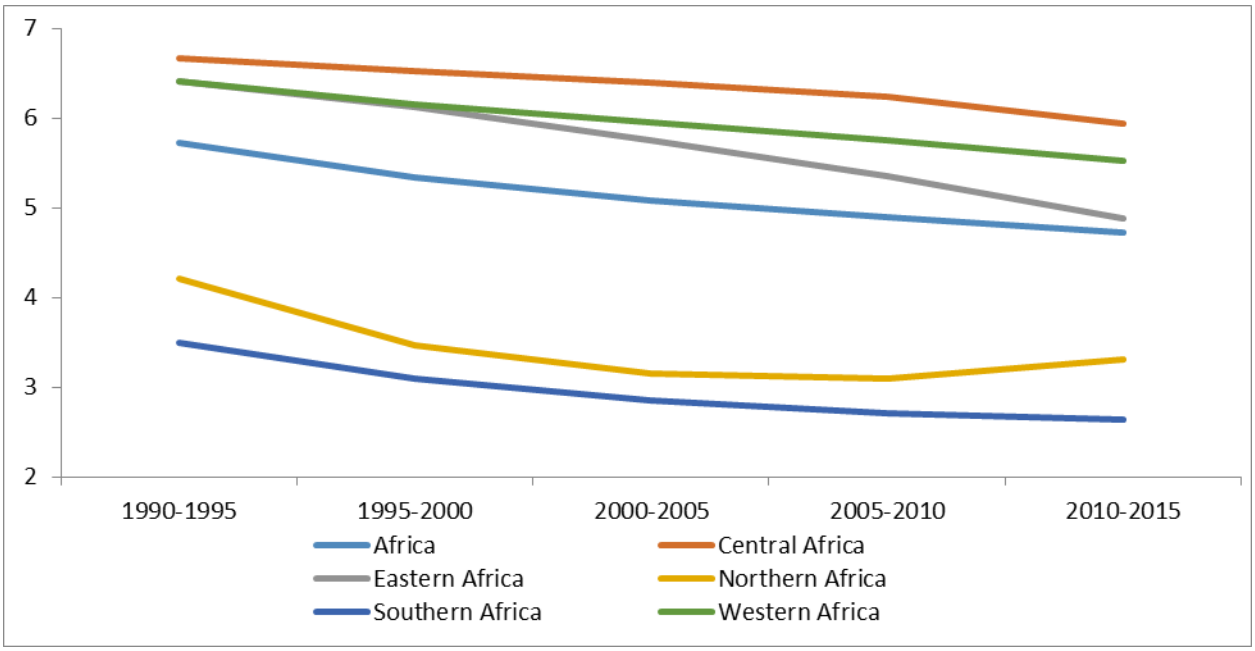
The associated factors to these fertility trends have been highlighted again recently by many authors[21]. These factors include the country level of development, the urbanization rate, the educational level (particularly women's education), women's participation in the labor market and their access to resources and the decision sphere, and the political commitment in terms of population policy.

Using available data for two periods of time (1995 – 2000 and 2010 – 2017), Figure 3.6 shows that in all countries and for the two periods, the TFR is higher in rural areas compared to urban areas. While there is a consistently lower urban fertility compared to rural fertility, the trends in TFR don't show any clear pattern of a declining fertility gap between urban and rural areas. The comparison of the rural/urban fertility ratio of the two periods[22] shows that for the nine countries of Western Africa, the rural/urban gap has decreased in only four countries (Togo, Ghana, Burkina Faso and Benin). Of the eight Eastern African countries, only Kenya recorded a declining rural/urban fertility gap. Egypt also exhibits a narrowed rural/urban TFR gap. It is worth noting that during this period there was a significant shift in the population from rural to urban areas, so many more people fall into the urban group in the second time period compared to the first.

[21]E.g., Bongaarts, 2016; Guengant, 2017, Kobiané and Bougma, 2017, Beninguisse and Manitchoko, 1997; Issaka Maga and Guengant, 2017

[22]If the rural/urban TFR ratio of second period is smaller than the one for first period, it means the fertility gap between the urban and the rural populations has narrowed. On the contrary, if it is higher, it means the gap has increased. The magnitude of the gap between the two periods is difficult to see in Figure 3.7.

Figure 3.5: Trends in Total Fertility Rates (TFRs) in Africa and its five subregions (1990 – 2015)



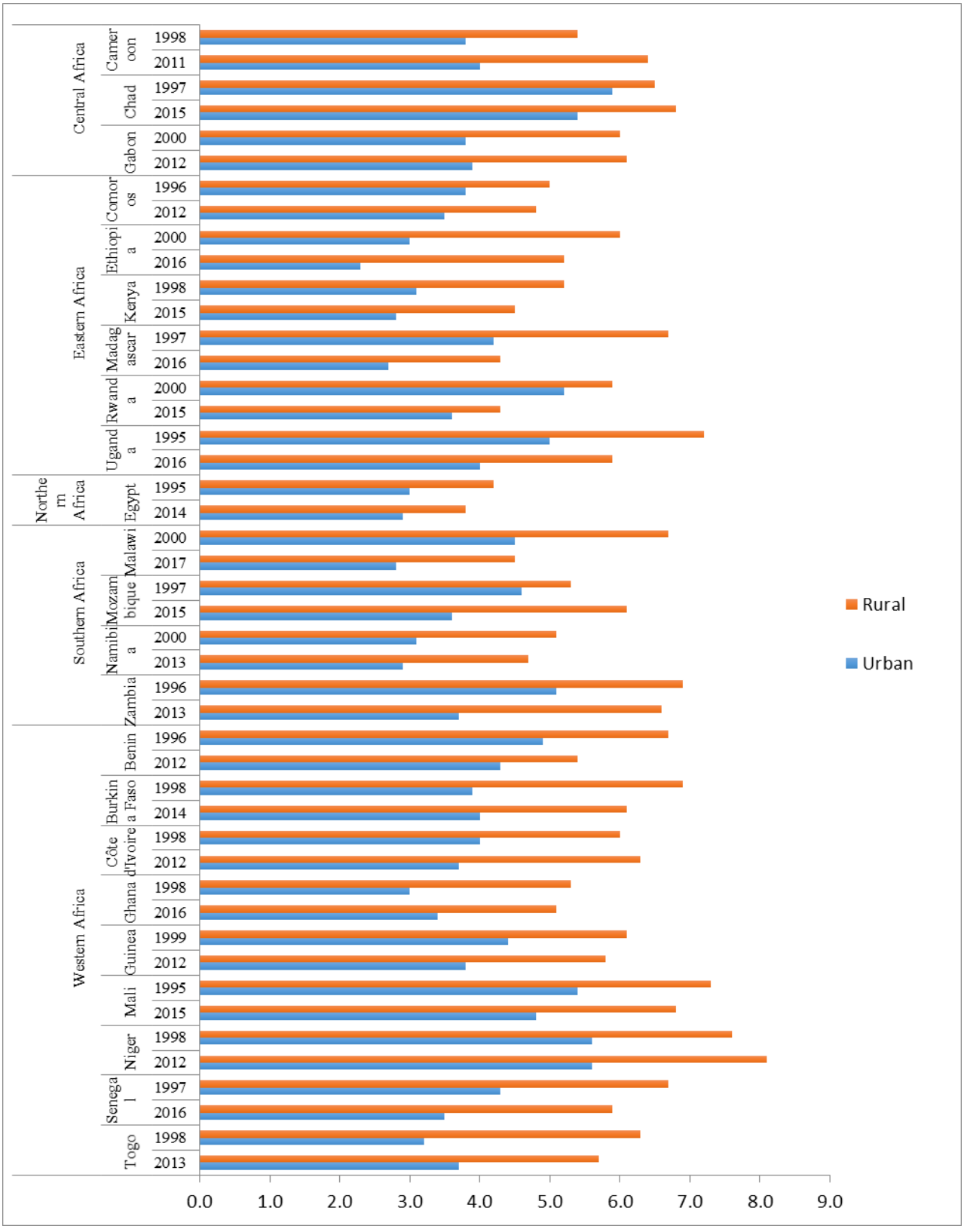
Data source: World Population Prospects 2017/United Nations Population Division

The way a demographic dividend will be equitably shared between the different social strata of the population will depend on fertility transition patterns across these strata. If the decline in fertility is not equitably shared, that is, if all groups do not contribute in a balanced way to the fertility decline, then it is difficult to expect that the benefits of the demographic dividend will be equitably shared[23]. Using the same data source and periods as before, Figure 3.7 presents the TFR of the poorest and the richest over the two periods of time. Table 3.1 gives the actual values of the relative and absolute fertility gaps between the richest and the poorest. There is widening of the relative gap, which is the poorest (quintile 1) / richest (quintile 5) TFR ratio in 15 countries (out the 23 countries covered), 12 of which also recorded a widening of the absolute gap (quintile 1 TFR – quintile 5 TFR). Of the nine countries of Western Africa, there has been an increase of the relative fertility gap in four countries (Burkina Faso, Guinea, Mali and Senegal), and an increase of the absolute gap in two of these countries (Guinea and Mali). In Eastern Africa, half of the eight countries (Ethiopia, Kenya, Rwanda and Uganda) experienced an increase in both the absolute and the relative TFR gaps. Noticeably, four countries in the Southern Africa region (Malawi,

[23]AADPD Operational Guide (2013), Eloundou-Enyegue *et al.* (2017).

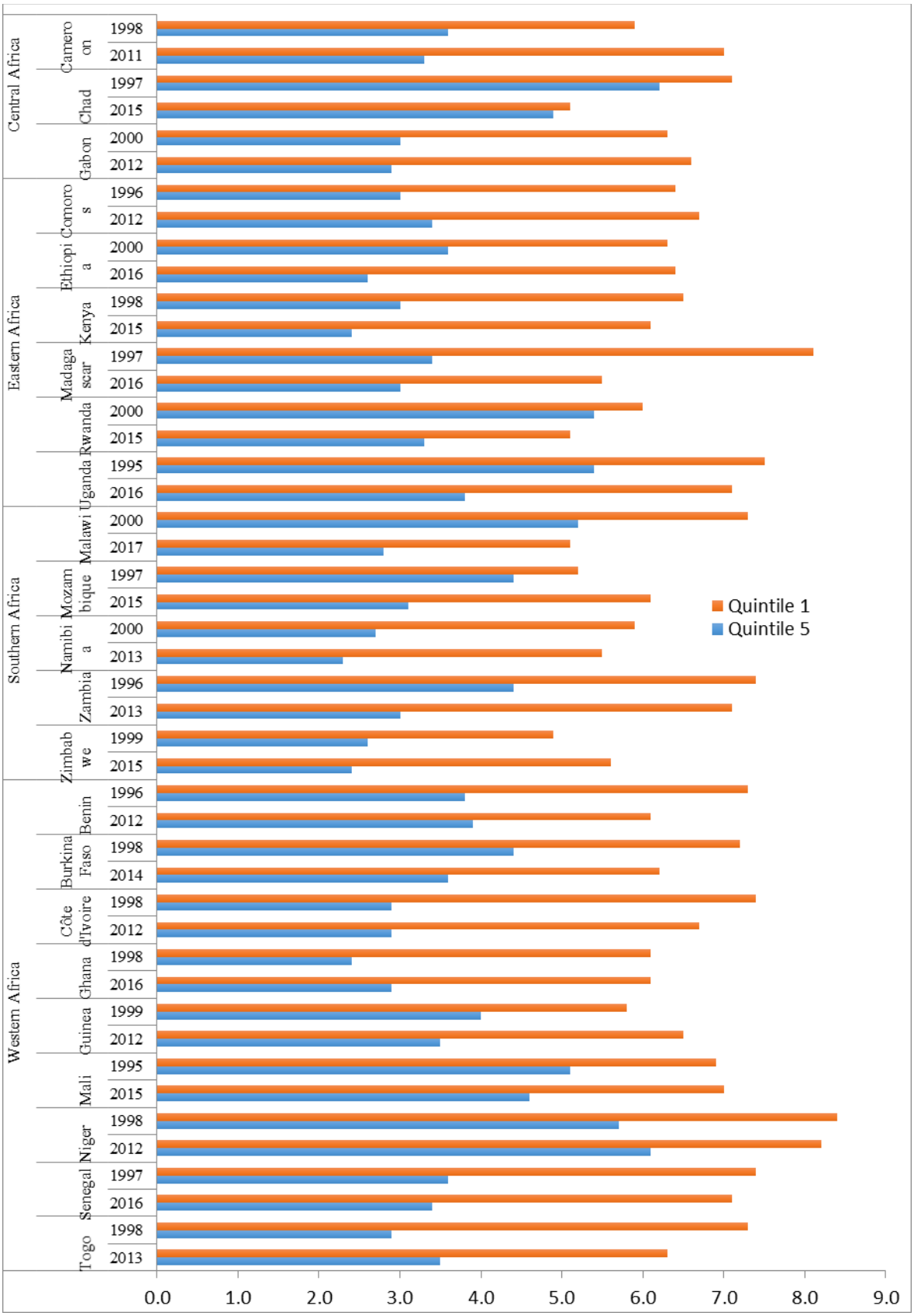
Mozambique, Zambia and Zimbabwe) recorded a widening of both the relative and the absolute TFR gaps, while the fifth (Namibia) exhibited an increase in the relative gap only. Finally, in Central Africa, two countries (Cameroon and Gabon) recorded widening relative and absolute TFR gaps between the richest and the poorest. Only in Chad did the TFR gap narrow over time. Overall, these trends raise a concern about equitable fertility transition and the prospects of a demographic dividend.

Figure 3.6: Trends in TFR by place of residence (periods 1995-2000 and 2010-2017)



Source: STATcompiler/The Demographic and Health Surveys

Figure 3.7: Trends in TFR of the poorest (quintile 1) and the richest (quintile 5)


Central Africa
Cameroon
1998
2011
Chad
1997
2015
Gabon
2000
2012
Eastern Africa
Comoros
1996
2012
Ethiopia
2000
2016
Kenya
1998
2015
Madagascar
1997
2016
Rwanda
2000
2015
Uganda
1995
2016
Southern Africa
Malawi
2000
2017
Mozambique
1997
2015
Namibia
2000
2013
Zambia
1996
2013
Zimbabwe
1999
2015
Western Africa
Benin
1996
2012
Burkina Faso
1998
2014
Côte dIvoire
1998
2012
Ghana
1998
2016
Guinea
1999
2012
Mali
1995
2015
Niger
1998
2012
Senegal
1997
2016
Togo
1998
2013
Quintile 1
Quintile 5
0.0
1.0
2.0
3.0
4.0
5.0
6.0
7.0
8.0
9.0

Source: STATcompiler/The Demographic and Health Surveys

Table 3.1: Trends in relative and absolute TFR gaps between the poorest (quintile 1) and the wealthiest (quintile 5)

Region	Country	Relative gap: Q1 TFR/Q5 TFR		Absolute gap: Q1 TFR-Q5 TFR	
		Period 1	Period 2	Period 1	Period 2
Central Africa	Cameroon	1.64	2.12	2.3	3.7
	Chad	1.15	1.04	0.9	0.2
	Gabon	2.10	2.28	3.3	3.7
Eastern Africa	Comoros	2.13	1.97	3.4	3.3
	Ethiopia	1.75	2.46	2.7	3.8
	Kenya	2.17	2.54	3.5	3.7
	Madagascar	2.38	1.83	4.7	2.5
	Rwanda	1.11	1.55	0.6	1.8
	Uganda	1.39	1.87	2.1	3.3
Southern Africa	Malawi	1.40	1.82	2.1	2.3
	Mozambique	1.18	1.97	0.8	3.0
	Namibia	2.19	2.39	3.2	3.2
	Zambia	1.68	2.37	3.0	4.1
	Zimbabwe	1.88	2.33	2.3	3.2
Western Africa	Benin	1.92	1.56	3.5	2.2
	Burkina Faso	1.64	1.72	2.8	2.6
	Côte d'Ivoire	2.55	2.31	4.5	3.8
	Ghana	2.54	2.10	3.7	3.2
	Guinea	1.45	1.86	1.8	3.0
	Mali	1.35	1.52	1.8	2.4
	Niger	1.47	1.34	2.7	2.1
	Senegal	2.06	2.09	3.8	3.7
	Togo	2.52	1.80	4.4	2.8

Source: STATcompiler/The Demographic and Health Surveys, authors' calculations
Note: Instances of the widening gap between the poorest and the wealthiest are highlighted in yellow.

3.3.2. Adolescents and Youth

On average, about one in three people in Africa is aged 10-24. This relative share of adolescents and youth in the total population remains more or less stable over the 1990-2030 period for the entire continent and in Western, Eastern, and Central Africa, which are the regions with the

highest fertility levels (Figure 3.8a). By contrast, in Southern and Northern Africa, after a decline between 2010 and 2020, the trend indicates a rise in the proportion of adolescents and youth from 2025 (particularly in Northern Africa).

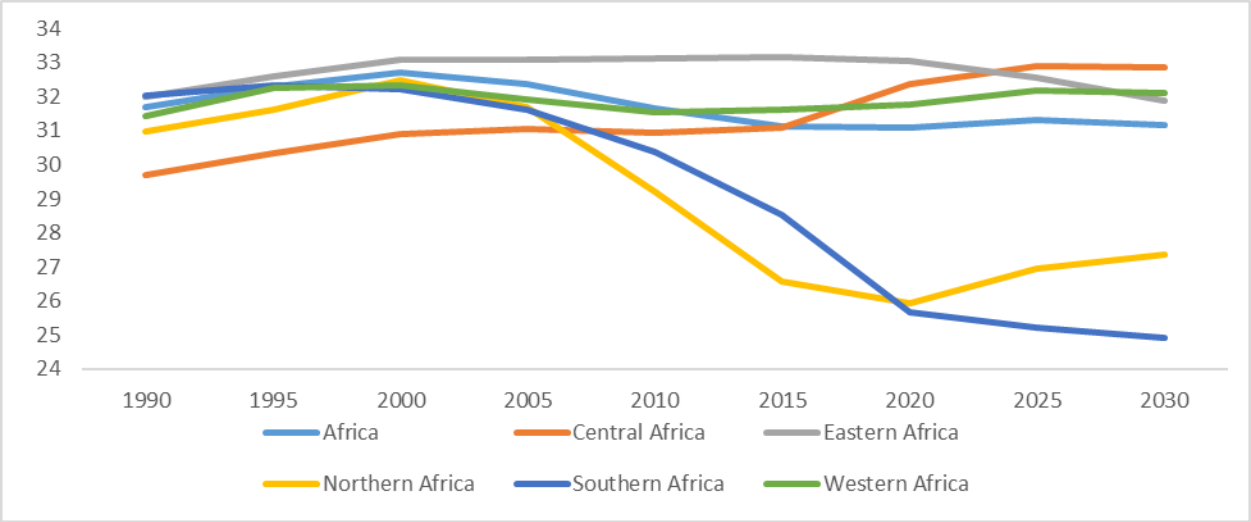
While the share of the 10-24 age group remains relatively stable over the 40-year period of 1990 to 2030, the absolute number of adolescents and young people is rising significantly (Figure 3.8b). The number of 10-24 year-olds on the continent has risen from 200 million in 1990 to 530 million in 2030; nearly a three-fold rise over a period of just 40 years. Regions with high birth rates (notably Western and Eastern Africa) are those that will experience a significant change in the number of adolescents and young people.

If we consider the youth age group of 15-24, according to the United Nations 2017 World Population Prospects, they represent 19% of the African population. By 2030, the target date for the sustainable development goals, the number of youth in Africa will increase by 45 percent, from 230 million in 2015 to 335 million in 2030, according to the medium variant of the World Population Prospects 2017 revision.

As highlighted by the Framework of Actions for the Follow-up to the Program of Action of the International Conference of Population and Development Beyond 2014 (Section C on adolescents and youth), the importance of adolescents and youth to the development agenda is not only because of their numbers, but rather the crucial necessity to fulfill their rights, empower them, and to respond to their needs in terms of health (including sexual and reproductive health and rights), education, and employment linked to the opportunity to transform this youth bulge into a positive driver to reap the demographic dividend[24].

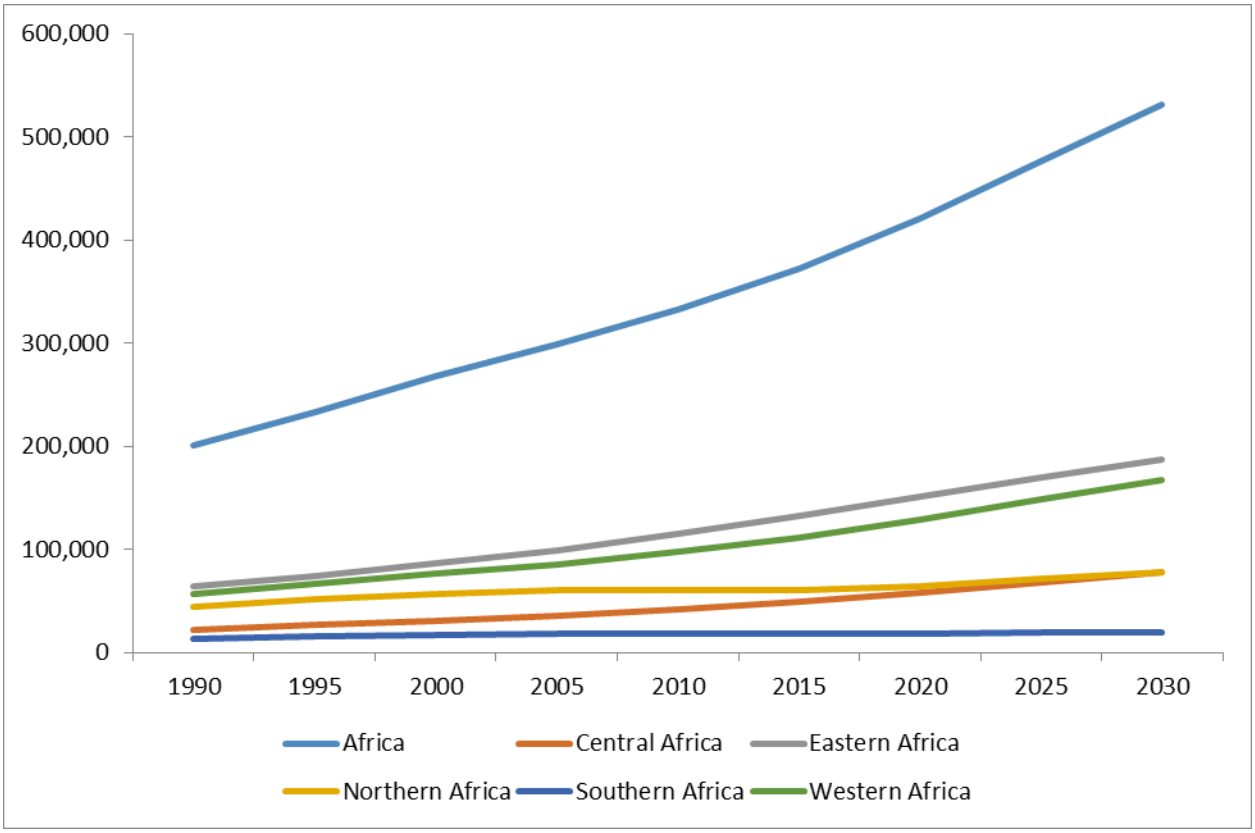
[24]UN 2014. Framework of Actions for the follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014: Report of the Secretary-General. New York

Figure 3.8a: Percentage of 10 - 24 year-olds for Africa and its five subregions (1990-2030)



Data source: World Population Prospects 2017/United Nations Population Division

Figure 3.8b: Numbers (in 1,000) of 10 - 24 year-olds for Africa and its five subregions (1990-2030)



Data source: World Population Prospects 2017/United Nations Population Division

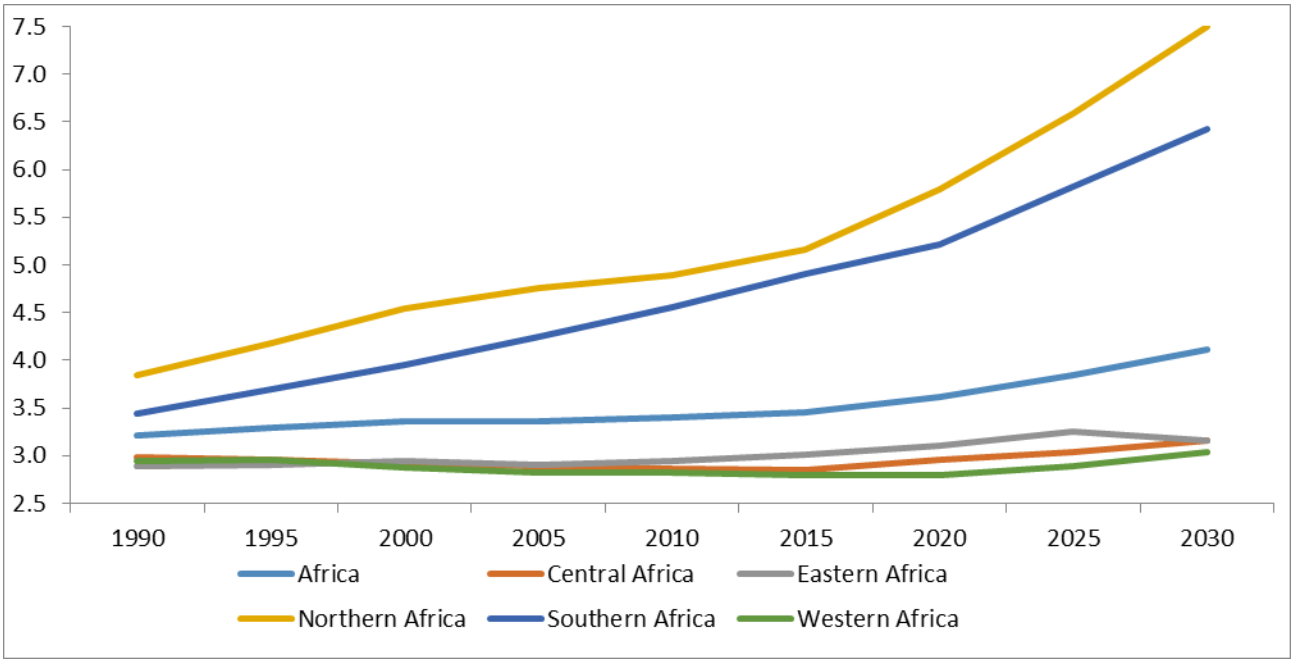
3.3.3. Older People

With successes in fertility decline and improved life expectancy, the associated rise in the proportion of older people (65 years and older) is set to be an emerging population issue for the continent. As shown in Figure 3.9, while the proportion of the elderly will increase at a slow pace in Western, Eastern, and Central Africa (between 3 and 3.5% over the period), for Northern and Southern Africa, where the demographic transition is well advanced, there will be almost a doubling of the proportion of those 65 years and older (respectively from 3.9% and 3.4% in 1990 to 7.5% and 6.4% in 2030). Even within individual subregions, the proportion of the elderly varies widely by country, from less than 4% to 15% of the population[25]. In Africa as a whole, the proportion of older females exceeds that of older males by an average of 0.7 percentage points.

This increasing trend in the proportion of older people points to the need for increasing policy focus on their well-being and living conditions as highlighted by the AADPD (e.g., healthy aging, lifelong learning, access to old-age-pension, etc.).

[25]UN Department of Economic and Social Affairs Population Division. Population Facts, 2016/1. Available at www.unpopulation.org.

Figure 3.9: Trends in percentage of population aged 65+ for Africa and its five subregions (1990 – 2030)

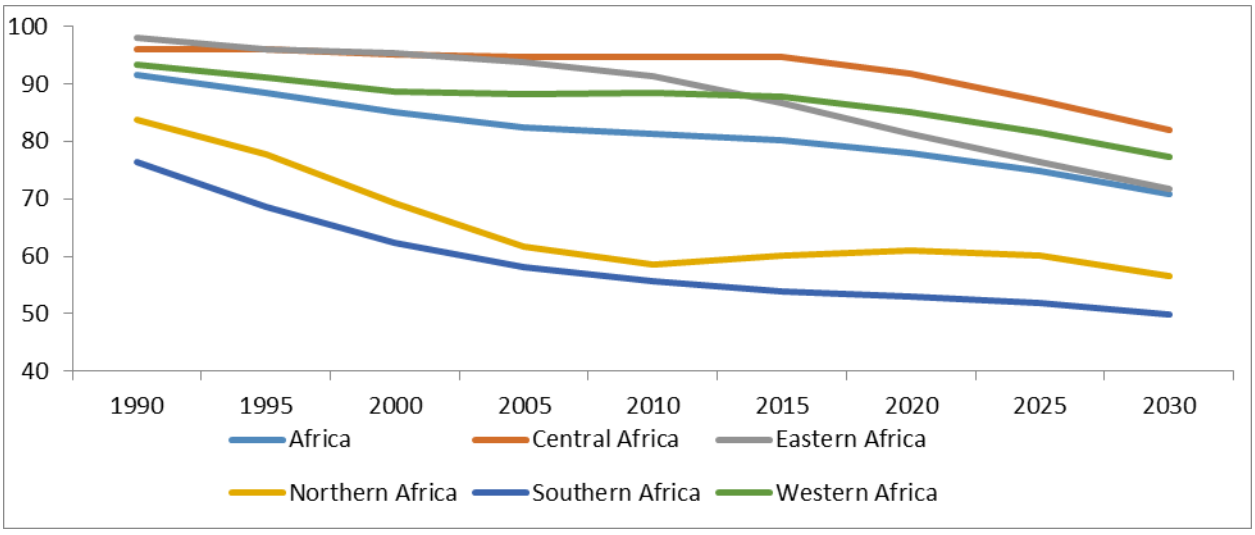


Data source: World Population Prospects 2017/United Nations Population Division

3.3.4 Dependency Ratios and Population Pyramids

The population dynamics of the continent described below, characterized by a reduction in mortality (particularly infant mortality) and continually high fertility rates, has resulted in a large proportion of children (population under 15 years) as highlighted by the broad-based pyramids. This phenomenon is particular to the continent as a whole, and to Western, Eastern, and Central Africa, where fertility levels are the highest (Figures 3.11a, 3.11b, 3.11c, and 3.11d). This increasing share of the younger age categories of the population is less apparent in the projected age pyramid for the period 2025-2030 for the continent, as well as for Western, Eastern, and Central Africa. However, the change is very clear in Southern Africa and Northern Africa, two regions where the fertility transition is well advanced (Figures 3.11e & 3.11f).

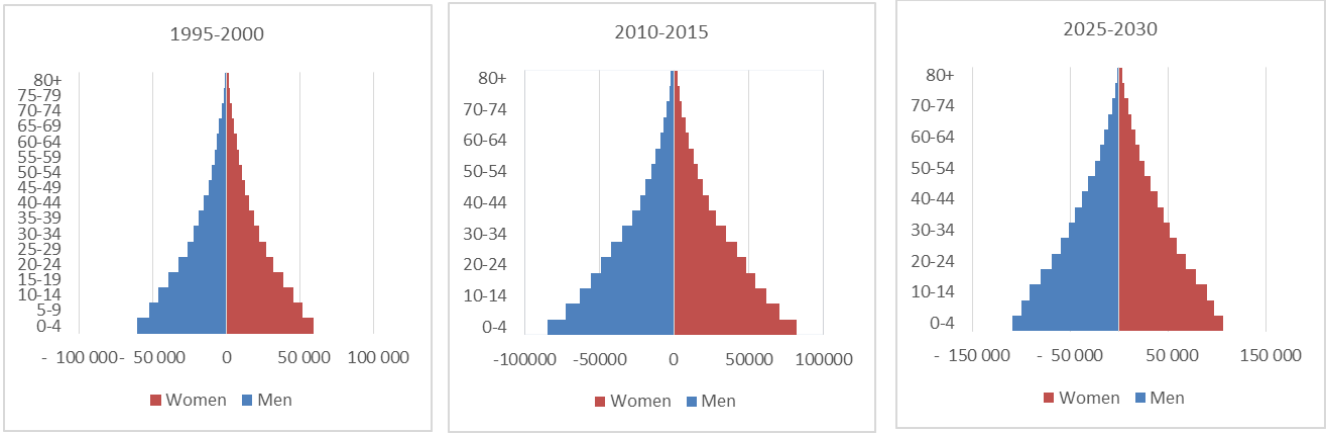
Figure 3.10: Trends in dependency ratios for the continent and 5 subregions (1990 – 2030)



Data source: World Population Prospects 2017/United Nations Population Division

Declining fertility will also provide the continent with a "window of opportunity" since the proportion of the working-age population will be historically high. This window of opportunity is currently underway in two of the five regions (Northern and Southern Africa) (Figure 3.10). Therefore, if the adolescents and youth of today are provided with appropriate learning and work opportunities, they will be well equipped to enter the labor market and contribute to economic growth and development[26].

Figure 3.11: Changing age pyramids (1995-2000, 2010-2015, and 2025-2030)
3.11a: Africa



[26]UN 2014. Framework of Actions for the follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014: Report of the Secretary-General. New York

3.11b: Western Africa

3.11b: Eastern Africa

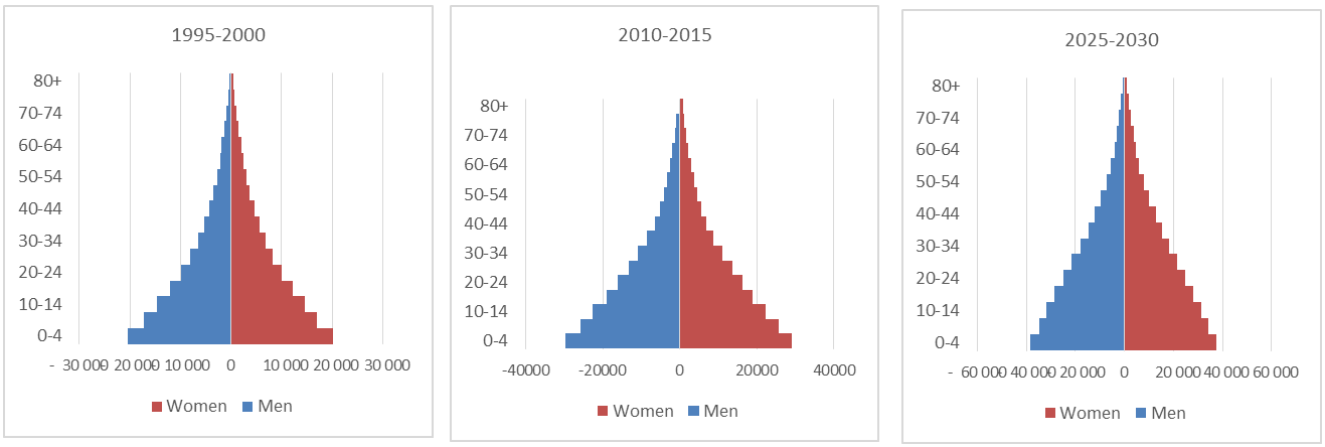
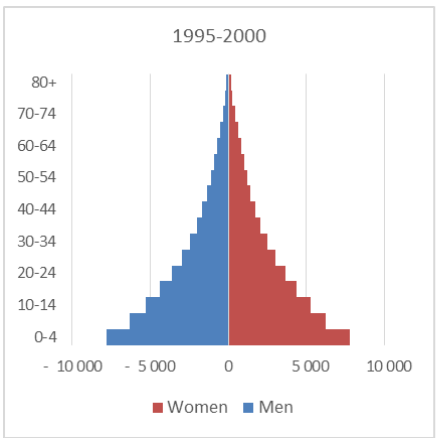
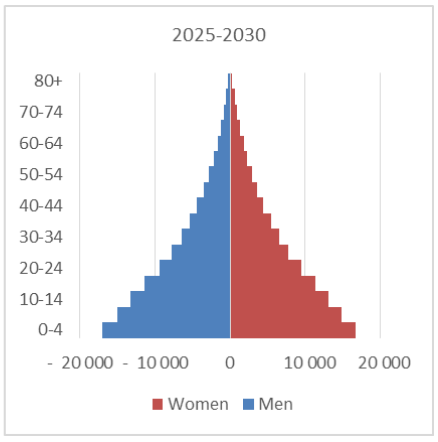


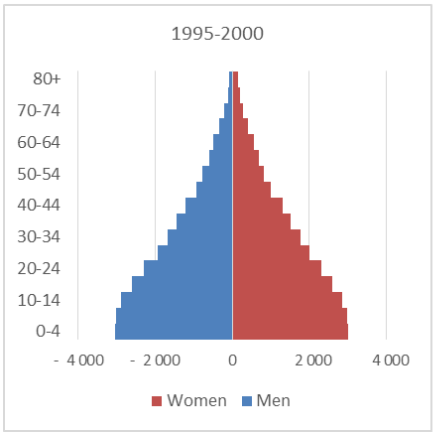
Figure 3.11: Changing age pyramids (1995-2000, 2010-2015, and 2025-2030), *cont.*

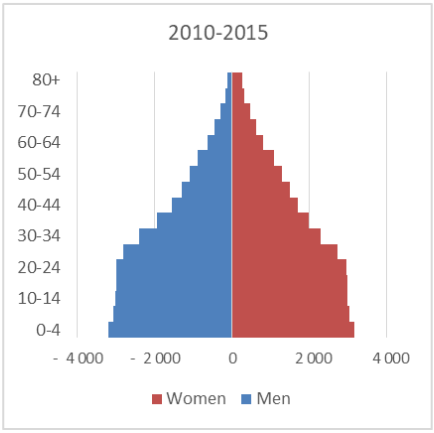
3.11d: Central Africa

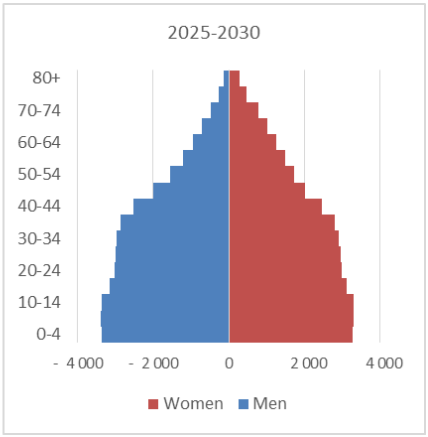




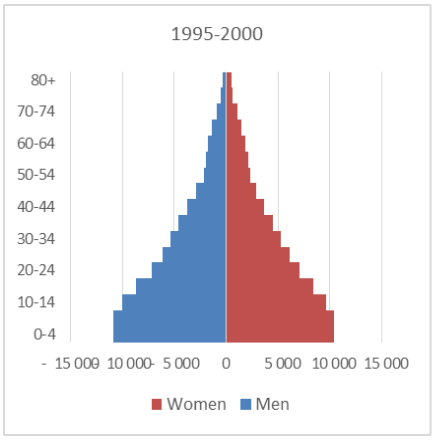
3.11e: Southern Africa

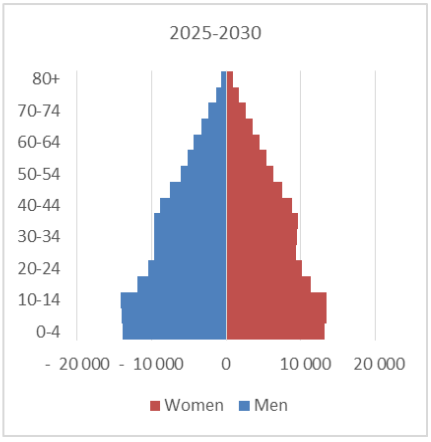






3.11f: Northern Africa



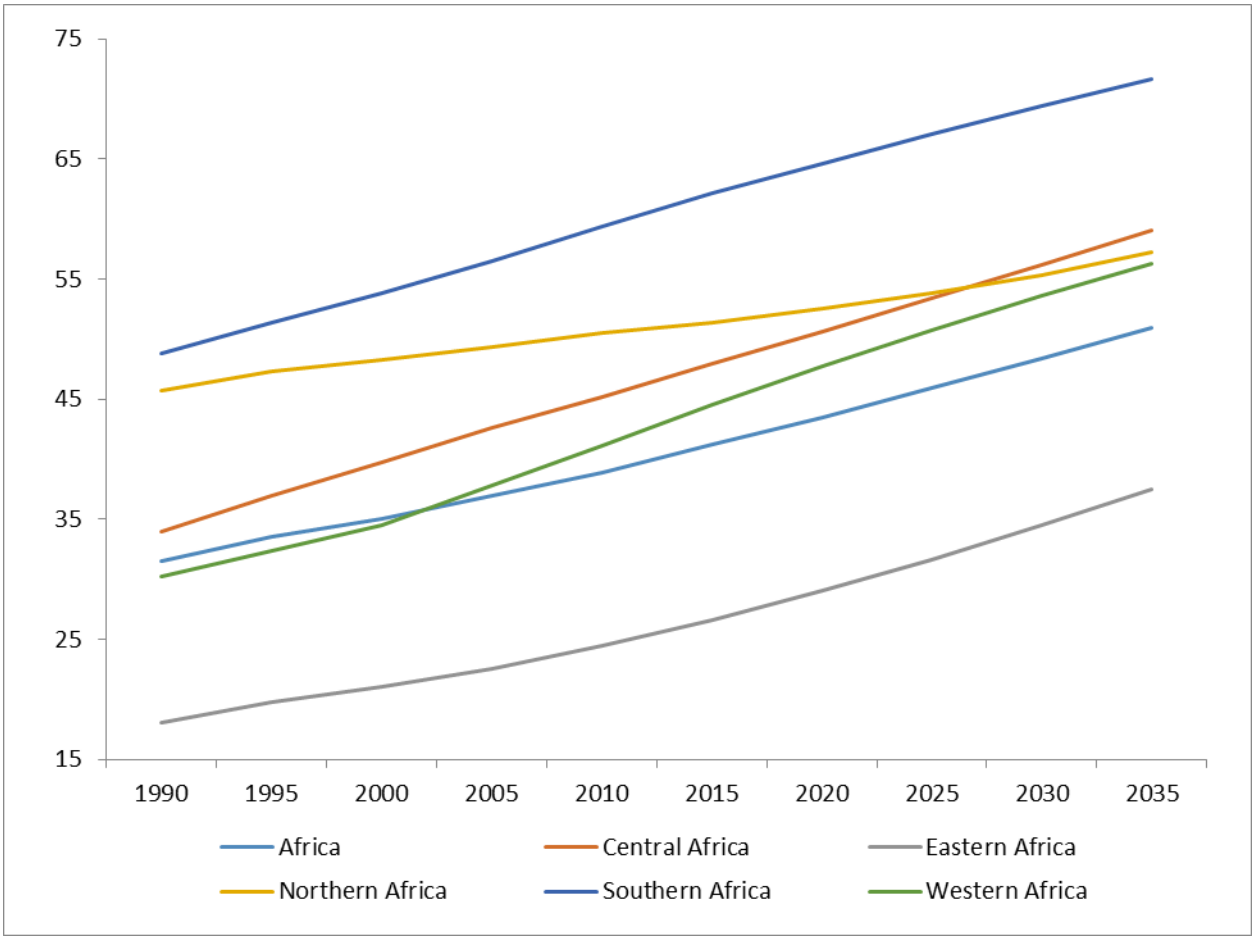


Data source: World Population Prospects 2017/United Nations Population Division

3.4. Urbanization

Africa is undergoing rapid urbanization and is set to be the fastest urbanizing region in the coming decades. While in the 1990s only a third of Africa's population was urban (31 percent), by 2035 about half of Africa's population is projected to be living in urban areas (see Figure 3.12). The percentage of people residing in urban areas has been increasing by approximately two percentage points every five years since 1990. Moreover, it is projected that this rate of increase will continue until 2035, and possibly beyond[27].

Figure 3.12. Percentage of population residing in urban areas



Source: World Population Prospects 2017/United Nations Population Division

[27]UNDESA, 2018. World Urbanization Prospects: The 2018 Revision

Although urbanization on the African continent is ubiquitous, it is occurring at different paces in different places. In each of the five regions, the percent of the population residing in urban areas has increased and is expected to continue to increase by between one and three percentage points every five years. The difference is in the percentage of the population residing in urban areas in 1990. Eastern Africa was the least urbanized at 18% in 1990, but this percentage is expected to double by 2035. On the other hand, Southern Africa starts off as the most urbanized region on the continent, at 49% in 1990, but is expected to have less dramatic increase in the percentage of the population residing in urban areas by 2035.

Urbanization has been attributed to four drivers, namely: international migration; natural growth, or the difference between mortality and fertility rates; net rural-urban migration; and reclassification of rural to urban areas[28,29]. Africa's rapid urban growth is both an opportunity and a challenge. The continent's rapid urbanization can lead to economic growth, transformation, and poverty reduction. Alternatively, it can lead to increased inequality, urban poverty, and the proliferation of slums characterized by lack of basic services, substandard housing, overcrowded dwellings, unhealthy living conditions and hazardous locations, poverty and social exclusion[30]. What appears as urban growth in Figure 3.12 is likely due to the rise in slum development, with a resultant shrinkage of the green environment in urban spaces. Individuals and families who reside in these urban slums are at high risk of suffering from the consequences of climate change such as flooding, landslides and heat waves due to their living conditions (poor waste disposal, poor drainage, overcrowding, poor ventilation, no cooling systems, etc.), but the governments in low- and middle-income countries do little to prevent these potential disasters. There is an

[28]UNECA, 2017. Economic Report on Africa 2017: Urbanization and Industrialization for Africa's Transformation

[29]UNFPA, 2016. FOUNDATIONS for the FUTURE: Building Quality Human Capital for Economic Transformation and Sustainable Development in the Context of the Istanbul Program of Action - A Review of Progress toward the Implementation of the Istanbul Program of Action for the Least Developed Countries. New York

[30]UN HABITAT, 2003. The Challenge of Slums. Global Report on Human Settlements

urgent need for urban governments to adapt to climate change so as to minimize the potential deleterious effects to their vulnerable populations[31].

3.5. Migration

3.5.1 Regional and International Migration

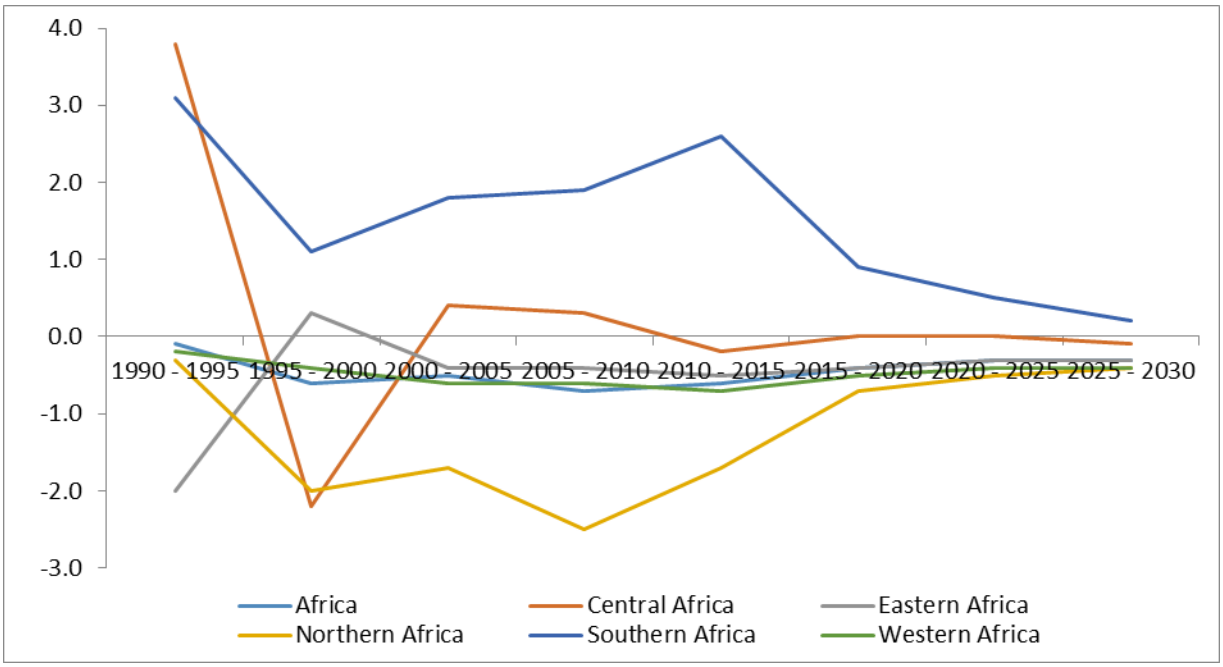
The phenomenon whereby international migrants move toward wealthier, more developed nations is global. Even though seven in 10 global migrants move to high-income countries, only three in 10 migrants from the least developed countries move to high-income countries. Notably, these migrants from the least developed countries are more likely to live in low- and middle-income countries. Thus, internal and cyclical migration may be as important as international migration, which often gets the spotlight. In general, people migrate for similar reasons: (1) in search of greener pastures, employment or education opportunities; (2) for family formation or unity; and (3) to flee from natural or man-made disasters[32].

As shown in Figure 3.13, projections for net migration in Africa for the period from 1990 to 2030 have been in favor of emigration. This is largely driven by the pattern seen in Western Africa where there was a negative migration balance between 1990 and 1995, which became more negative thereafter. The migrant flow out of the region is currently slowing.

Figure 3.13. Net migration rate (per 1,000 population)

[31]United Nations Expert Group Meeting on Population Distribution, Urbanization, Internal Migration and Development, Population Division, Department of Economic and Social Affairs, 2008. UN/POP/EGM-URB/2008/16

[32]UN, 2014. Framework of Actions for the Follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014. Report of the Secretary General



Source: World Population Prospects 2017/United Nations Population Division

The expectation is that migration flows will stabilize at -0.3 for Africa and -0.4 for Western Africa, on average around 2020. Apart from the period between 1995 and 2000 where Eastern Africa was a recipient of migrants, the region has had, and is expected to continue to have, a negative migration balance. The pattern in Central Africa has been less clear, with this region being both a recipient of migrants and a contributor to regional and international migration over the last several decades. It appears a balance has been reached now, but the trend is expected to tip more toward emigration by 2025[33]. Southern Africa has consistently been a recipient of migrants since before 1990, and it is expected to continue to receive migrants until 2030 and beyond, even though the migrant flow appears to be slowing.

3.5.2. National Migration

People leave the places they call home for reasons such as violence, conflict, persecution, disaster and environmental change. Although people who are displaced internally often do not get the spotlight, their experiences in many ways are similar to those of regional and international migrants, and they need financial, social, physical and psychological support.

[33]UNDESA, 2017. World Population Prospects: The 2017 Revision

Chapter 4: Progress and Challenges on AAPDP Commitments

This chapter follows the micro-monitoring approach, as defined in the AADPD Operational Guide for Monitoring and Evaluation (OGME). Its ambition is not to review progress on each of the 88 commitments of the AADPD. Such an exercise for a continental review would have been a tedious initiative, and, as mentioned in the methodology (chapter 2), the unavailability of data for various indicators poses additional challenges. Therefore, for each of the substantive pillars (Dignity and Equity, Health, Place and Mobility), the approach adopted was to group the different commitments under specific sub-themes and then assess the progress on each of the sub-themes through a few selected indicators. Appendix 4.1 in the appendices summarizes for each of three pillars, the sub-themes identified, the commitments that are covered under each sub-theme, and the indicators analyzed.

The analysis of the performance covers the period from 2000-2005 to 2010-2017, which not only covers the implementation period of the five years of the AADPD (2013-2017) but also includes the launch and the end of the Millennium Development Goals (MDGs). The micro-monitoring presented in this chapter also draws from the AADPD national reports, those that were available toward the end of the review. The AADPD reports were distributed among the consultants and their support team, and members of the Technical Oversight Committee set up for the AADPD+5 review, and synthesized between August 8-21, as they became available. The review guide prepared for the synthesis had a focus on policy change and progress in implementation, key findings, and recommendations.

For each sub-theme of the three substantive pillars, this chapter describes progress on the target indicators for which data exist, and, drawing from syntheses of AADPD national reports, sheds light on major implementation successes and challenges, best practices, and policy change. The synthesis of national reports are also used to highlight progress on the three other pillars (Governance, Data and Statistics, and Partnerships and International Cooperation). As shown in Appendix 4.2, 49 AADPD national report syntheses were available by the time this review was completed. It is worth noting that many achievements cited in national reports were not dated. For the sake of this review, only achievements realized since 2013 were selected.

4.1 Dignity and Equality

This section reports progress made in the realization of human rights and the fight against poverty that enables people to fully participate in society and benefit from social, economic and technological advancement.

4.1.1 Poverty and Inequality

The sub-theme Poverty and Inequality covers commitments 1 (Dignity and equality in all economic and social development sectors) and 2 (Eradication of extreme poverty that targets disadvantaged groups).

a. Progress on indicators

Three indicators are used to analyze progress in terms of poverty and inequalities: the percentage of the population living on less than USD 1.90 a day at 2011 international prices, which provides the proportion of the poor; the Multidimensional Poverty Index (MPI) which measures multiple deprivations at the household level in education, health and standard of living[34]; and the Gini coefficient which measures inequality in wealth.

Progress has been made toward reducing poverty across African subregions. Indeed, in 24 countries the percentage of the population living on less than USD 1.90 a day at 2011 international prices has decreased. But in ten countries (Comoros, Djibouti, Madagascar, and Mauritius in Eastern Africa; Benin, Côte d'Ivoire, and Guinea-Bissau in Western Africa; Cameroon and Central African Republic in Central Africa; and Zambia in Southern Africa), the percentage of the population living on less than USD 1.90 a day at 2011 international prices has increased (Figure 4.1.1).

The trend of the MPI supports what has been observed with the percentage of the population living on less than USD 1.90 a day. Overall, as highlighted by Figure 4.1.2, the MPI has declined in all countries except in Côte d'Ivoire, the Republic of Congo, Namibia, and South Africa. The MPI has decreased by more than 10 percentage points in four countries (16 in Senegal, 13 in Rwanda,

[34] Alkire and Santos (2010)

12 in Guinea, and 10 in Liberia), whereas it has increased by 4 percentage points in the Republic of Congo and Côte d'Ivoire, and by less than one percentage point in South Africa and Namibia (Table 4.1.2 in appendix). The situation of the Republic of Congo and Côte d'Ivoire can be explained to some extent by the political and social troubles they have experienced over the given period.

The MPI is generally higher in Western Africa countries as compared to the other subregions. Indeed, among the ten highest value of the MPI in the second period, seven are from Western Africa. When the first period is considered, six out of the ten highest value of the MPI are observed in countries of Western Africa (Table 4.1.2 in appendix).

The Gini coefficient measures wealth and/or income inequality. The value of the indicator varies from 0 (perfect income or wealth equality) to 1 (perfect income or wealth inequality). Figure 4.1.3 reports mixed trends in the Gini coefficient between 2000/2005 and 2010/2017. Overall, the Gini coefficient is below 50% except in five countries out six in Southern Africa countries during the second period, one country in Western Africa, one country in Eastern Africa, and one country in Central Africa. In nineteen countries out of thirty-five, inequality in wealth has decreased. On the contrary, in sixteen countries, inequality in wealth has widened or stalled: eight countries out of fourteen in Western Africa, three out of five in Southern Africa, one out of three in Northern Africa, three out of six in Eastern Africa, and one out of six in Central Africa.

The biggest increase in the Gini coefficient (more than ten percentage points) was observed in Guinea Bissau (from 36% in 2000/2005 to 51% in 2010/2017), and in Central African Republic (from 43.6% in 2000/2005 to 56.2% in 2010/2017). By contrast, the indicator dropped from 44.4% to 34.3% during the same period in Niger, and from 55.9% to 43. (ten percentage points).

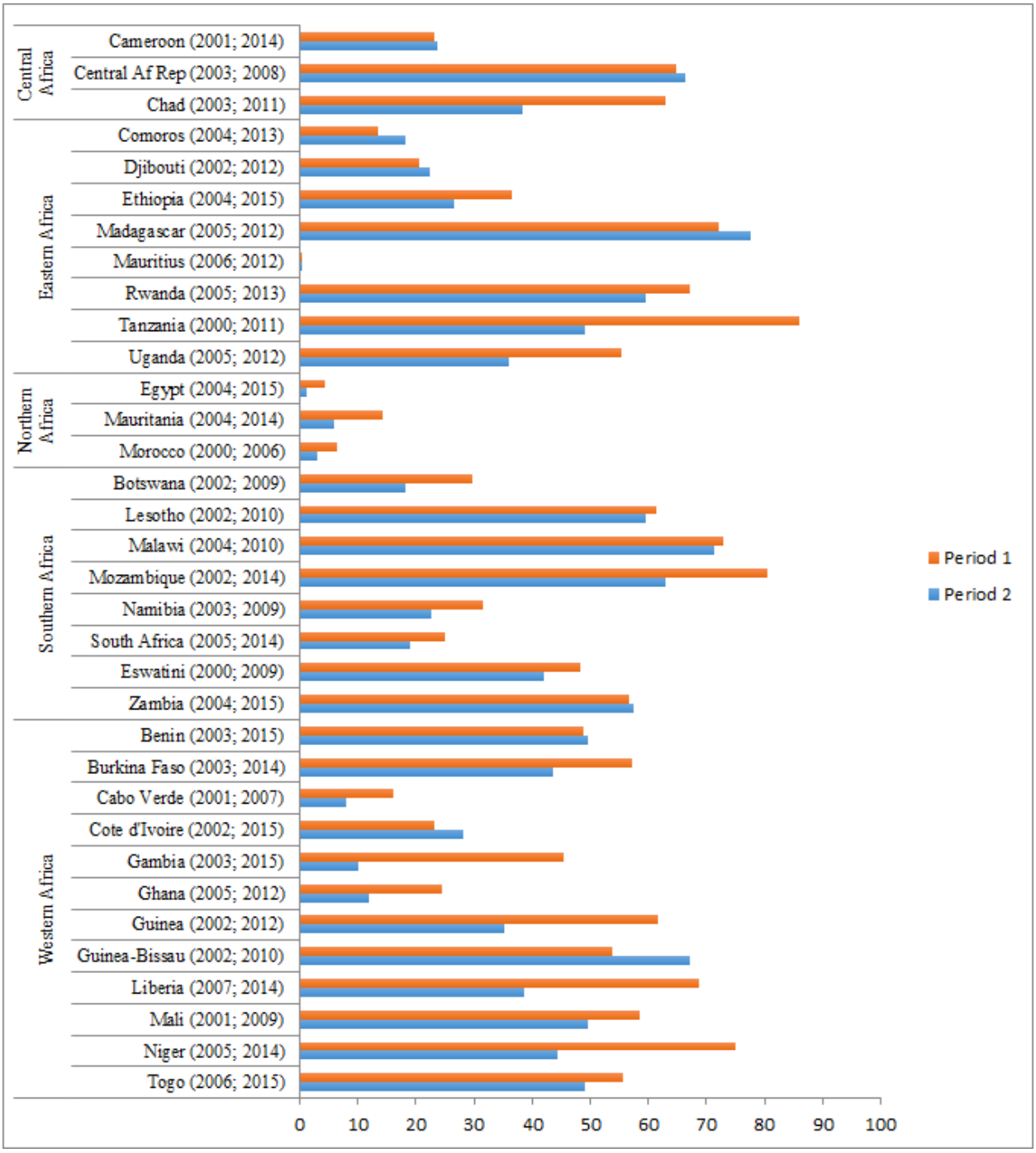
b. Implementation: Examples of Policies, Best Practices and Challenges

Most countries have created human rights councils and developed strategic plans for social and economic development. For instance, Algeria and Togo adopted human rights laws in 2016; Guinea and Togo released a National Social Protection Policy in 2014. Efforts are needed to integrate people living with disabilities into the social and economic development. Cabo Verde

has developed and implemented a strategic plan to improve the living conditions of people with disability: in 2016, 90% of people living with disabilities were covered with social protection system. Egypt has adopted policies to integrate people with specific disabilities within the school system and to equip public accommodations. Gabon ratified in 2014 the convention to abolish death penalty, and a convention related to the rights of people living with disabilities. In 2016, 1,221 primary and secondary schools in Burkina Faso had facilities for children living with disabilities. Since 2015, the Zimbabwe government assumed full responsibility for funding vulnerable children under the Basic Assistance Education Module (BEAM).

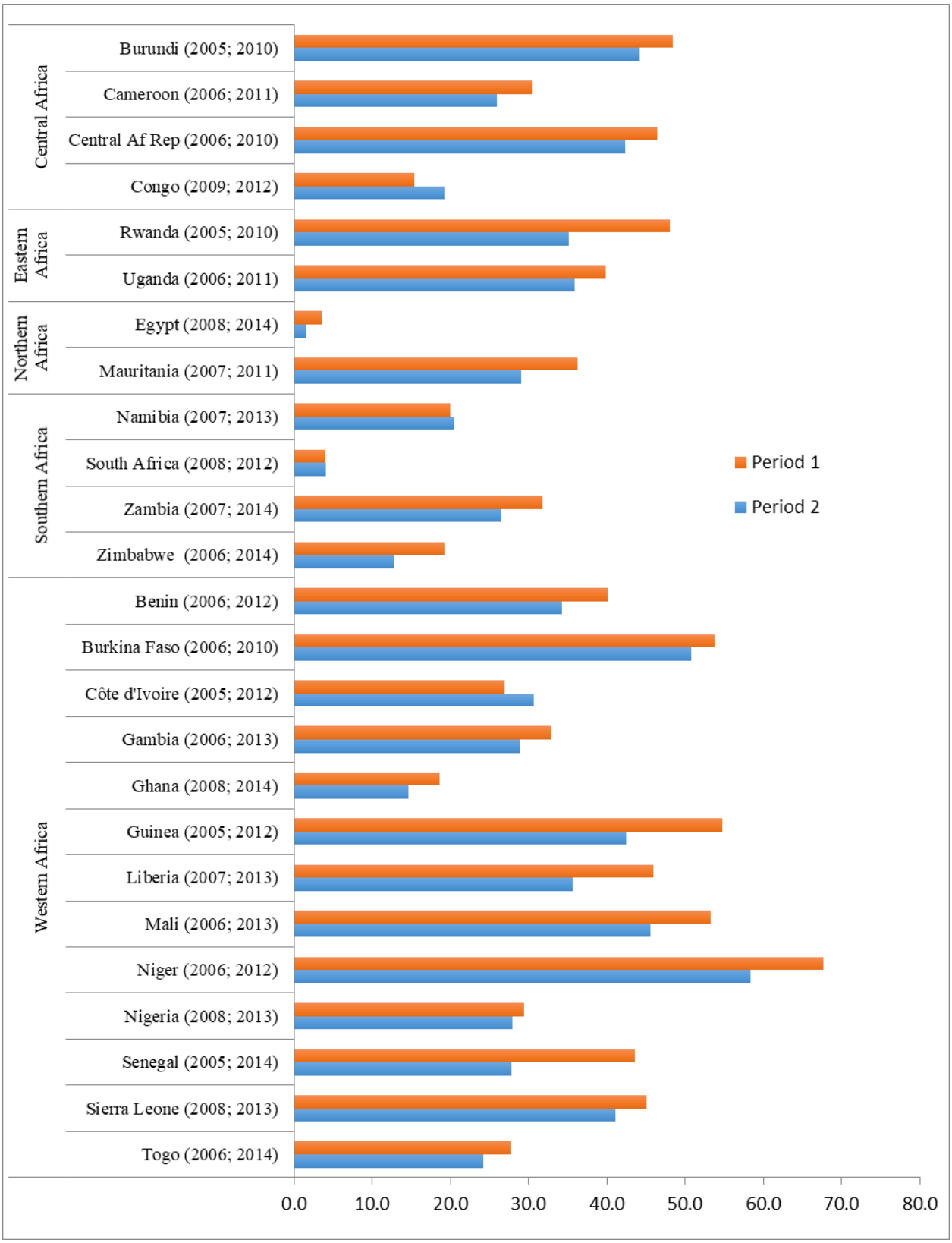
The large majority of African countries have developed a strategic plan to reduce poverty. The government of Sudan is implementing comprehensive macroeconomic and social policies for poverty alleviation, including cash transfers to poor families, social protection networks and mechanisms, social solidarity programs, microfinance and small-scale enterprises, provision of low-cost housing and free health services to the poor, and involvement of community-based-organizations in addressing poverty at the levels of the States and localities. In Eswatini, the proportion of households with access to safe drinking water and sanitation has increased from 40% in 1997 to 67% in 2010 and to 71% in 2013. In Gabon, social protection programs' share of the total budget increased from 1.24% in 2015 to 2.08% in 2018; while the health budget rose from 3.83% in 2014 to 5.94% in 2018. Kenya has established a National Safety Net Program (NSNP) aiming to guarantee minimum income protection ("safety net") for particularly poor and vulnerable groups. Between 2013-14 and 2015-16, the number of beneficiary households of the Kenyan government's four principal cash transfer programs increased from 522,000 to 829,000.

Figure 4.1.1 Percentage of the population living on less than USD 1.90 a day



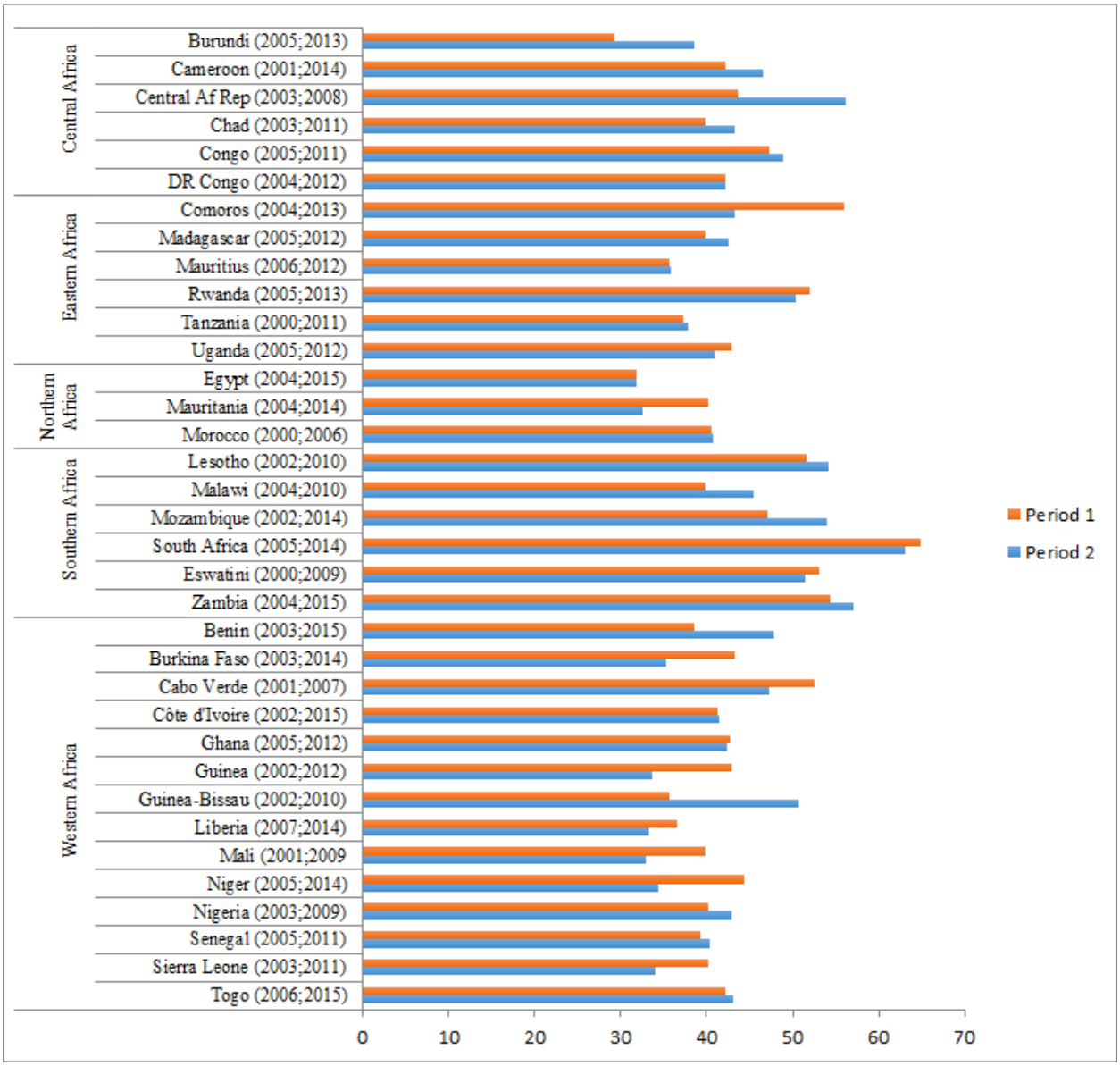
Source: World Development Indicators Database/World Bank

Figure 4.1.2. Multidimensional Poverty Index.



Source: Global Multidimensional Poverty Index dataset/UNDP

Figure 4.1.3 Gini coefficient



Source: World Development Indicators Database/World Bank

4.1.2 Gender Inequality: Promoting Women and Youth Empowerment

Gender inequality refers to unequal treatment, perceptions of roles in the society of individuals wholly or partly due to their gender.

a. Progress on Indicators

Three indicators measure gender inequality: parity in education enrollment; proportion of females participating in household decisions for large purchases; and women's parliamentary representation. These indicators cover commitments 3-9. Figure 4.1.4 shows that gender disparities have narrowed at the primary and secondary school levels, except in Eswatini and South Africa where it has increased by 0.1.

Considering the last study period (2010/2017), the gender disparities in primary and secondary education remain relatively high in Central Africa (0.7-1.0), and low in Southern Africa (0.9-1.1). Central African Republic and Chad have the highest gender parity indicators (0.7) compared to Lesotho (1.1).

Overall, Figure 4.1.5 reveals progress in narrowing gender parity in education in the countries considered, except a few cases (in rural Guinea and Uganda, in urban Kenya, Ethiopia and Congo, in urban and rural Malawi, Lesotho, and Rwanda). Except in Nigeria, Mali, Guinea, and Benin, all located in Western Africa, gender parity in primary education is almost achieved overall (equal or higher than 0.95 in both rural and urban areas during the last study period).

Analysis of female participation in household decisions for large purchases, their own health, and movement (Figure 4.1.6) shows low progress in three Sahel countries in Western Africa (Burkina Faso, Mali, and Senegal). Progress has been notable (more than ten percentage points) in all four countries studied in Southern Africa, in three countries out of five in Eastern Africa (Kenya, Rwanda, and Ethiopia), in Benin and Nigeria in Western Africa, and in Egypt (Northern Africa) (Appendix 4.1.6).

Considering women's parliamentary representation, Figure 4.1.7 shows an absence of regional differences. Regardless of region, the proportion of women in parliament varies by country. With 41.8% of women representation, Senegal is the only country out of fourteen in Western Africa where women representation is higher than 30%. In Northern Africa, only Tunisia out of six countries has more than 30%. In Central Africa, two countries (Burundi and Cameroon) out of eight have more than 30%. Five countries (Zimbabwe, Mozambique, South Africa, Eswatini, and Angola) out of ten in Southern Africa have more than 30% while six countries (Rwanda, Tanzania,

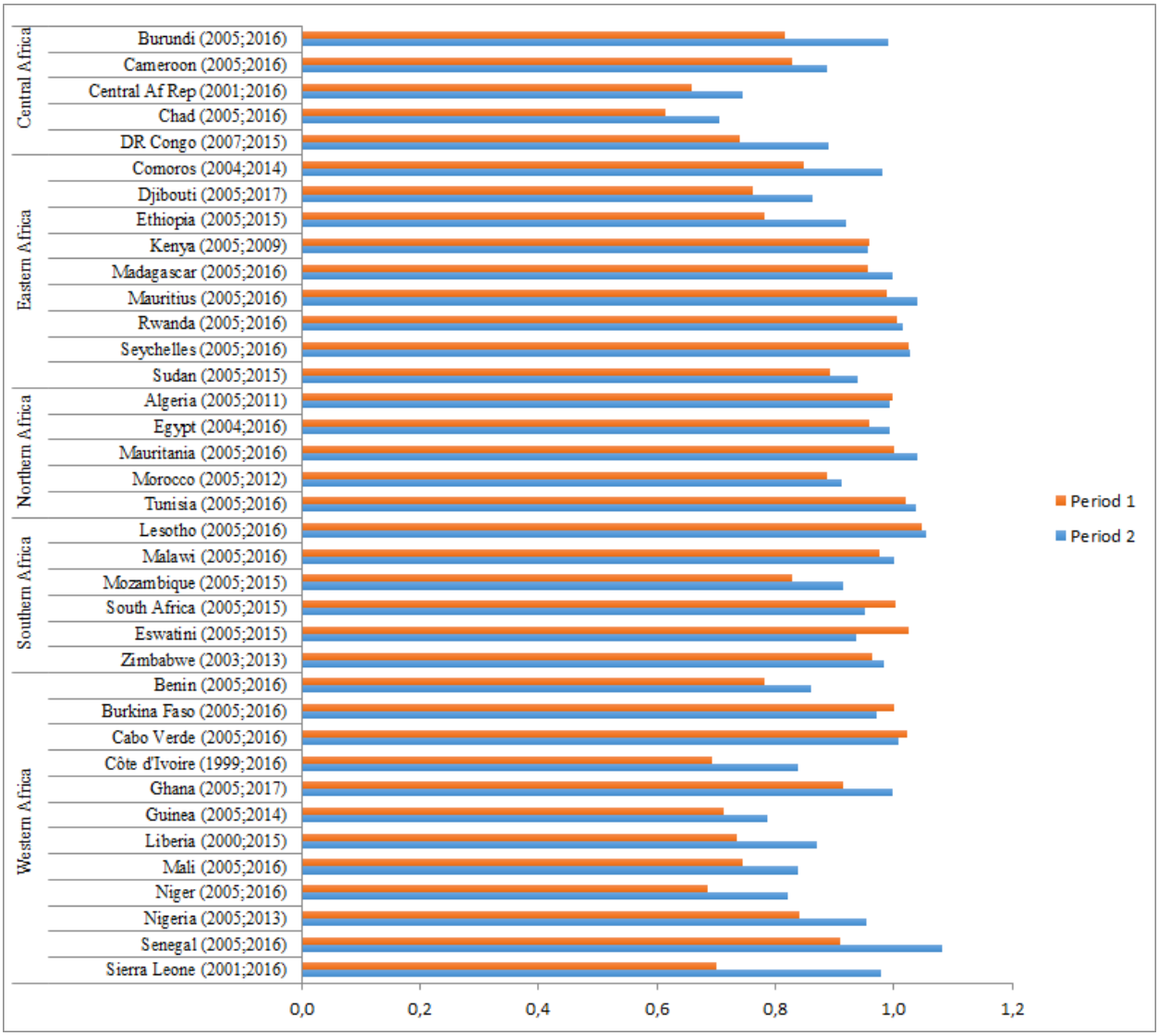
Sudan, Uganda, Ethiopia, and Kenya) out of fourteen have more than 30% women in the parliament. These findings suggest a need for efforts in women's empowerment.

b. Implementation: Examples of Policies, Best Practices and Challenges

A number of countries have made progress in the development and implementation of gender-based policies, though gender equality and women's empowerment. The Algerian government has developed plans and a strategy to promote gender parity and fight inequality. The Algeria 2016 constitution recommends promotion of gender parity in access to employment and encourages the advancement of women to management positions in public administrations and private firms. In 2018, Sierra Leone launched the Women's Leadership Training Institute advocating for gender parity in all spheres of life. After the 2010 election in Burundi, women represented 32% of parliamentarians at the National Assembly, 46% at the Senate, 34% in municipalities, 20% in the "collines," and 43% of all ministers. In Mozambique, 38.9% of women were elected at the National Assembly in 2015. In Egypt, available data show absence of gender bias in the average monthly earning for female (EGP 853) compared to male (EGP 884). However, gender inequality was noticed for unemployment in 2018: unemployment rate was estimated at 8.2% for males compared to 22.1% for females.

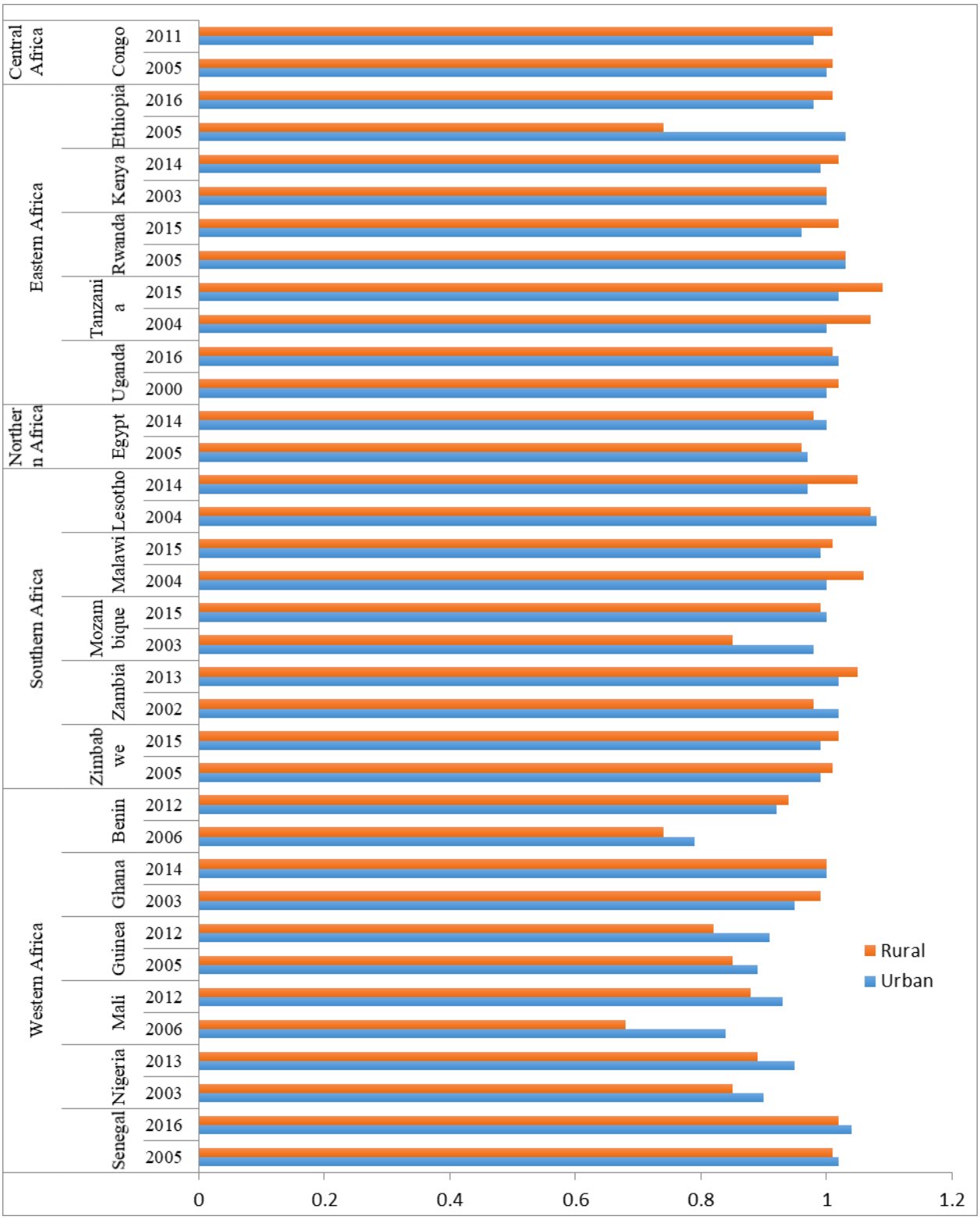
In 2017, Namibia was recognized for its legal and policy frameworks aimed at promoting women's rights. The "Gender Is My Agenda Campaign" (GIMAC) steering committee and the country's head of state accepted the award in January 2018 during the AU Summit. Already in 2014, Namibia ranked among the top tier of countries on the Gender Development Index. However, across all ages, women are more likely to be unemployed in Namibia than men. In Comoros, in the framework of "Emerging Comoros in time of peace and in time of crisis," and to fulfill its commitments with regard to the MDGs and the Agenda 2063, a national strategy to fight GBV was drafted to serve as the benchmark for all actors working in the area of GBV. The government also signed a 2017-2019 roadmap which serves as the legal framework for coordination of actions to fight GBV. In 2013, it also adhered to the Abidjan Declaration on Gender Equality and Women Autonomy in the context of the MDGs.

Figure 4.1.4 Trend in gender disparities (Girl/Boy) at primary and secondary school levels [label (period 1, Period 2 was not visible; Not corrected]



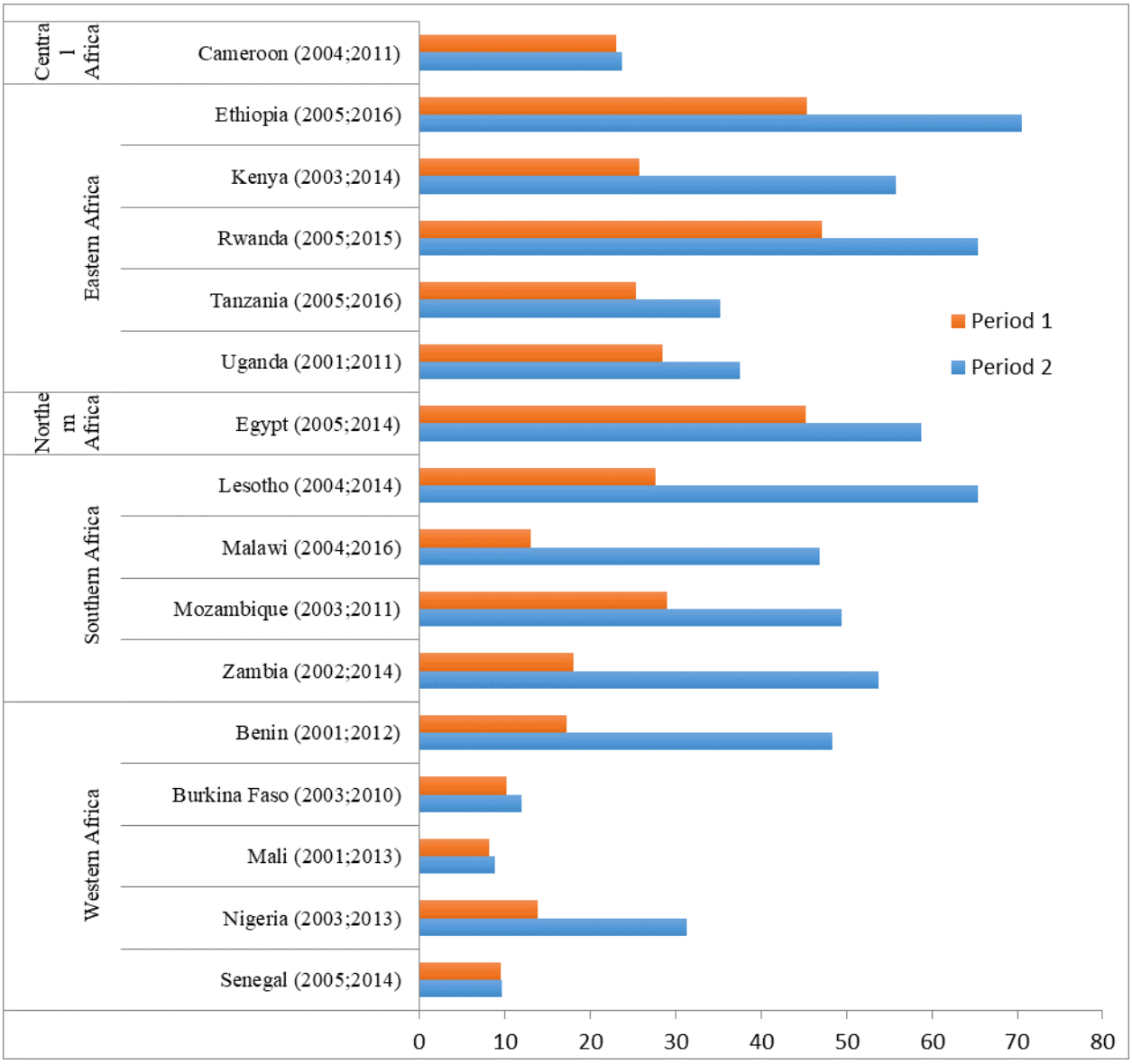
Source: World Development Indicators Database/World Bank

Figure 4.1.5. Gender parity in primary education by residence



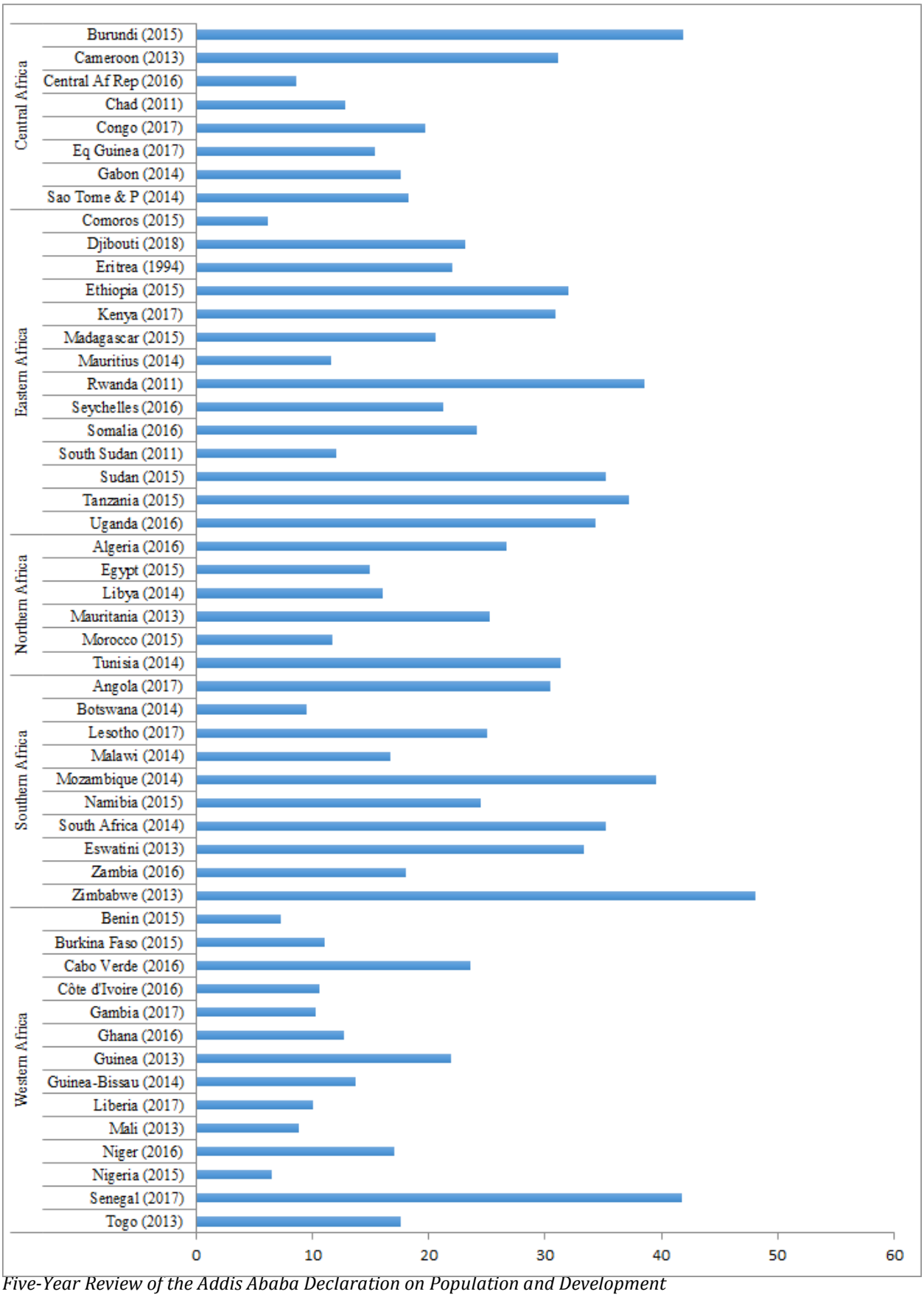
Source: STATcompiler/The Demographic and Health Surveys

Figure 4.1.6 Proportion of women who have a say in household decisions for large purchases, their own health, and movement



Source: STATcompiler/The Demographic and Health Surveys.

Figure 4.1.7. Women's parliamentary representation


Central Africa
Burundi (2015)
Cameroon (2013)
Central Af Rep (2016)
Chad (2011)
Congo (2017)
Eq Guinea (2017)
Gabon (2014)
Sao Tome & P (2014)
Eastern Africa
Comoros (2015)
Djibouti (2018)
Eritrea (1994)
Ethiopia (2015)
Kenya (2017)
Madagascar (2015)
Mauritius (2014)
Rwanda (2011)
Seychelles (2016)
Somalia (2016)
South Sudan (2011)
Sudan (2015)
Tanzania (2015)
Uganda (2016)
Northern Africa
Algeria (2016)
Egypt (2015)
Libya (2014)
Mauritania (2013)
Morocco (2015)
Tunisia (2014)
Southern Africa
Angola (2017)
Botswana (2014)
Lesotho (2017)
Malawi (2014)
Mozambique (2014)
Namibia (2015)
South Africa (2014)
Eswatini (2013)
Zambia (2016)
Zimbabwe (2013)
Western Africa
Benin (2015)
Burkina Faso (2015)
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Senegal (2017)
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Source: Archive of statistical data of the Inter-Parliamentary Union 2018

4.1.3 Child Nutrition and Mortality

This sub-theme covers commitment 10 to address the needs of all girls, boys and children with disabilities, with regard to their rights to health, nutrition and education at all levels. It describes trends in children's nutrition and survival status using prevalence of stunting among children aged less than five years and under-five mortality.

a. Progress on Indicators

Figure 4.1.8 shows the prevalence of stunting in 2000/2005 and 2010/2017. Overall, the prevalence of stunting has decreased in all countries except Nigeria and Benin in Western Africa. Analysis by region shows that the prevalence of stunting varies from 17% in Senegal to 48% in Nigeria. In Eastern Africa, the prevalence of stunting is low in Zimbabwe (27%) and high in Mozambique (43%). Figure 4.7 also shows that in Central Africa, stunting is low in Gabon (16%) compared to Chad (40%).

Overall, child mortality rates dropped over the study period. However, contrary to the proportion of stunting, Figure 4.1.9 shows significant regional differences in child mortality. Under-five mortality was high in Central Africa (113 deaths per thousand live births) compared to Northern Africa (37 deaths per thousand live births) in 2010/2015. A Sahrawi Republic's report entitled "Indicadores de Salud 2016-2017" shows that infant mortality in refugee camps rose slightly from 20.0 per 1,000 live births in 2016 to 21.8 per live births in 2017.

b. Implementation: Examples of Policies, Best Practices and Challenges

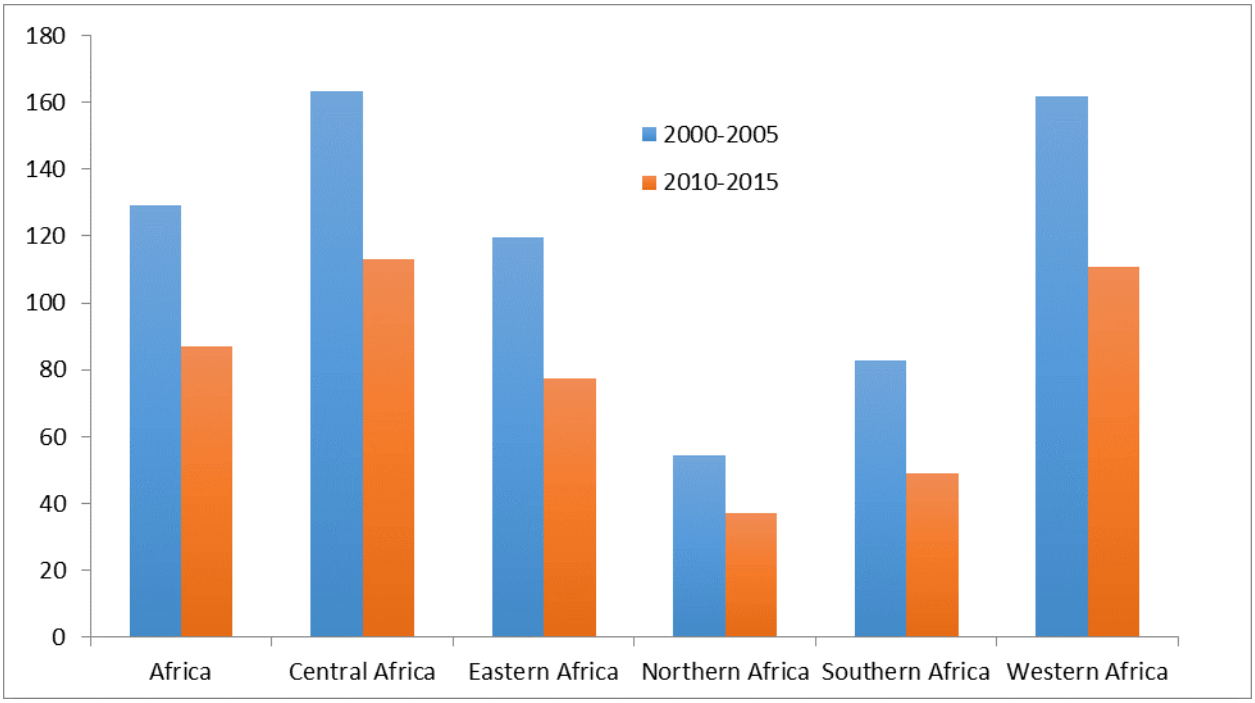
African countries have made significant progress in improving child survival through the development and implementation of strategic health plans. These plans aim to strengthen health systems and promote family planning using integration between health service (maternal, child, infant and neonatal health services) models. For example, the Guinean government drafted the Guinea Vision 2040 document, including the National Economic and Social Development Plan (2016-2020), the National Health Strategic Plan Development (2015-2024), the Strategic Plan for

the Health and Development of Adolescents and Youth 2015-2019 and a National Strategic Plan for Maternal, Newborn, Adolescent and Youth Health (SRMNIA) 2016-2020. The budget of the Guinean MoH increased by 18% between 2011 and 2015. Sierra Leone has launched a National Food and Nutrition Security Policy 2012 -2016, which aims to improve the nutrition status of the population especially infants and young children. Zimbabwe has adopted the Child Survival Strategy (2016-2020), Adolescent and Young People Sexual and Reproductive Health Strategy (2016-2020), and the Newborn Care Guidelines to reduce under-five mortality.

Botswana established an under-five Nutrition Surveillance and Growth Monitoring to track the growth of children and subsequently determine their nutritional status, and mothers/caregivers are required to take children to clinics every month for weight monitoring. In addition, the Vulnerable Group Feeding Programme in the Ministry of Health and Wellness is distributing supplementary food to under-five children and other vulnerable groups, including pregnant and lactating women.

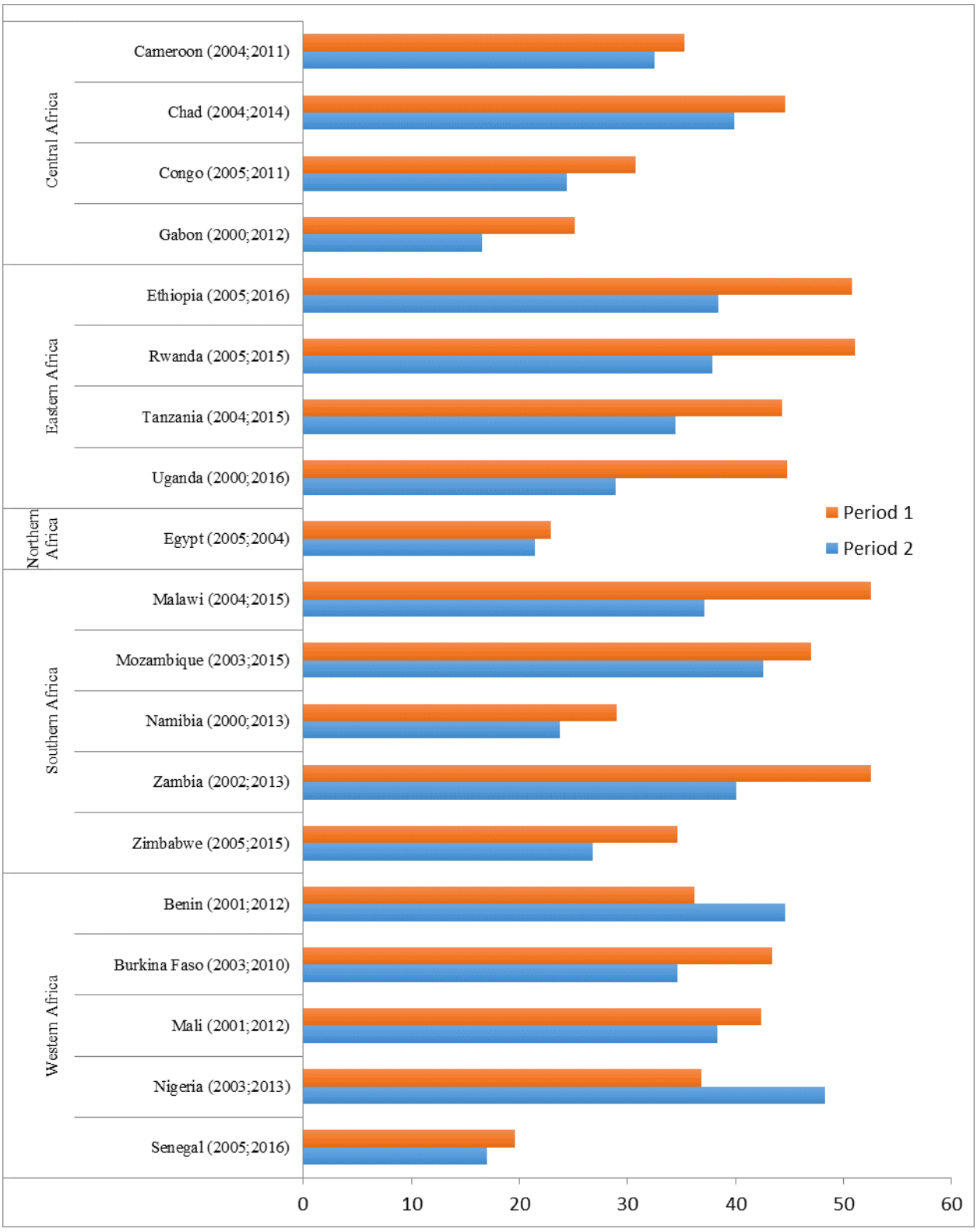
While in the Northern African region and majority of Southern African countries, child malnutrition and mortality are becoming low, efforts are needed to improve child nutrition status and survival in Central, Western and Eastern regions using integrated approaches (education-food security-access to basic socioeconomic services).

Figure 4.1.8: Under-five child mortality of the continent and the 5 regions for 2000-2005 and 2010-2015



Source: World Population Prospects 2017/United Nations Population Division.

Figure 4.1.9. Prevalence of stunting among children under five years



Source: STATcompiler/The Demographic and Health Surveys

4.1.4 Women's Rights and Gender-Based Violence

The AADPD aims to protect the dignity and rights of women and girls by eliminating all harmful practices and gender-based violence (commitments 15 and 16).

a. Progress on Indicators

This section analyzes trends in the proportion of women who have undergone female genital mutilation (commitment 15) and the proportion of ever-partnered women and girls >15 ever subjected to physical, sexual, or psychological violence by their current or former partner in the last 12 months (Commitment 16). Table 4.1.1 and Figure 4.1.10 report the proportion of women (age 15-49) who have undergone female genital mutilation over the study period.

Table 4.1.1 Proportion of women (15-49) who have undergone female genital mutilation

Region	Country	2000-2005	2010-2017	Change (%)
Central Africa	Chad	44.9	38.4	-6.5
Eastern Africa	Ethiopia	74.3	65.2	-9.1
	Kenya	32.2	21.0	-11.2
Northern Africa	Egypt	95.8	92.3	-3.5
Western Africa	Benin	16.8	7.3	-9.5
	Burkina Faso	76.6	75.8	-0.8
	Côte d'Ivoire	41.7	38.2	-3.5
	Guinea	*95.6*	*96.9*	*1.3*
	Mali	91.6	91.4	-0.2
	Nigeria	*19.0*	*24.8*	*5.8*
	Senegal	28.2	22.7	-5.5

Source: STATcompiler/The Demographic and Health Surveys

Overall, the proportion of women (15-49) who have undergone female genital mutilation decreased in all the selected countries except in Nigeria where it increased from 19% to 25% and Guinea where it increased from 96% to 97%. The drop is more pronounced in Kenya (from 32% to 21%) and Ethiopia (from 74% to 65%) in Eastern Africa. In Western Africa, the decrease in the proportion of women who have undergone female genital mutilation ranges from -0.2% in Mali to -10% in Benin. It is worth noting that the large majority of women in Egypt, Guinea, Mali, Burkina Faso and Ethiopia have undergone female genital mutilation.

While there is a slight decline in the number of women subjected to the harmful practice of female genital mutilation (FGM), the cumulative number is still high. Globally, more than 200 million women have undergone female genital mutilation. In 30 countries where the practice of FGM is prevalent, more than 20 million girls and women were subjected to FGM at the hands of a health provider (doctor, nurse) in what is called FGM Medicalisation. Three (3) countries in Africa account for more than 90% of these cases – over 18 million. It is estimated that 50 million girls aged 0 – 14[35] will be at risk of undergoing FGM by 2030 , if efforts are not accelerated.

Over the most recent period (2010/2017), the proportion of ever-partnered women and girls >15 ever subjected to physical, sexual, or psychological violence by current or former partner in the last 12 months was high in Cameroon (43%) and low in Rwanda (27%). Figure 4.12 shows that the proportion of women who reported sexual violence decreased in all selected countries except in Malawi and Cameroon. The indicator ranged from 9.4% (Zimbabwe) to 12.1% (Kenya) in 2000/2005. During the most recent period, the indicator was higher in Malawi (14%) compared to Zimbabwe, Rwanda, Kenya and Cameroon (less than 10%).

b. Implementation: Examples of Policies, Best Practices and Challenges

Since 2013, the number of countries that have made budget allocations to support the implementation of their policy to eliminate female genital mutilation has increased from six to 13[36]countries. Twenty-four African countries have laws in place banning the practice of FGM[37]. Two countries, Egypt and Uganda, have amended their laws to toughen penalties. However, only 6 countries in Africa are enforcing their legislation. Efforts to develop capacity to detect, investigate and prosecute cases of FGM remains low. Cross border, initiatives are critical to eliminating FGM. To address disparities in FGM laws among neighboring countries, interventions

[35]UNFPA (https://www.unfpa.org/female-genital-mutilation)

[1] UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Performance Analysis Phase II

36 UNFPA-UNICEF JP on FGM

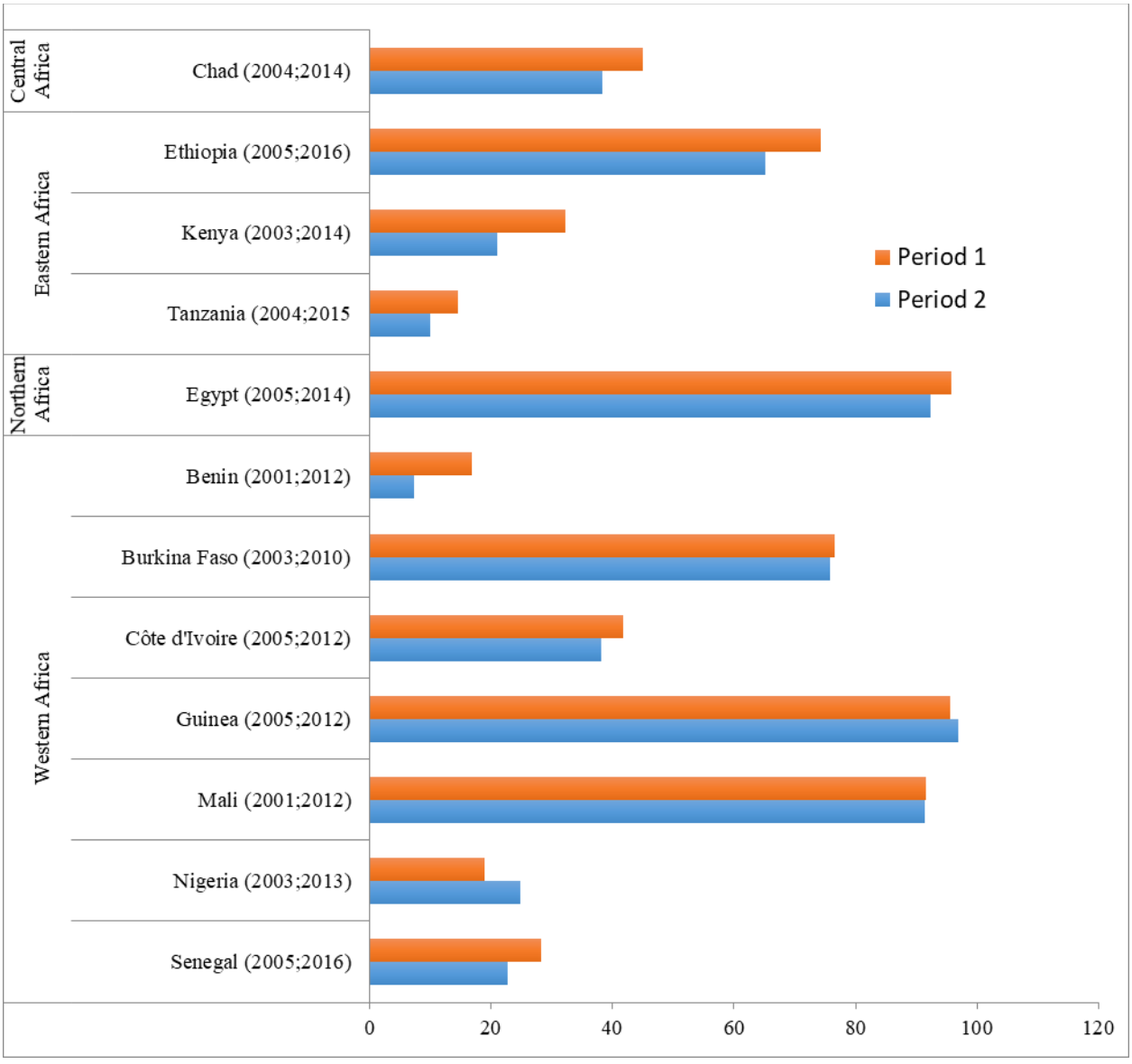
[37] UNFPA Female Genital Mutilation Database, 2012

have included policy collaboration and communications. About 16 countries have a national coordination and action plans in place. Over the last decade, African countries have promoted policies to end gender-based violence, particularly female genital mutilation, and child marriage. Since 2015, Liberia is implementing a National Action Plan on Gender-Based Violence or SGBV program. The country also adopted a National Gender Policy or NGP (revised from 2017-2022) program; and the End Child Marriage Strategy (2016-2020). Nigeria established a National Strategic Plan to End Child Marriage. The Uganda 2016 GBV Policy and Action Plan is part of the government's efforts to address gender inequalities particularly as it relates to GBV and the male engagement strategy. In 2017, Chad adopted a National Gender Policy, including the National Strategy to Combat Gender-Based Violence (Decree No. 2035 / PR / 2017). In September 2016, Madagascar released the 2017-2021 National Strategy Plan to Combat Gender-Based Violence. Furthermore, the minimum age for marriage among both sexes has been standardized (18 years) under the new age of marriage law.

In Ethiopia, a three-year National Strategy on Prevention and Response to Sexual and Gender-Based Violence (2017-2019) was updated in close collaboration with UN agencies, and international and national nongovernmental organizations. Central African Republic National Commission of Human Rights Law No. 026 / PR / 2017 of December 30, 2017, combats rape, early marriage and gender-based violence in international, regional, subregional and national standards, raising awareness of preventive measures or recommendations for appropriate sanctions against co-perpetrators and accomplices. The South Africa 2016 government found that Maiden Bursaries and virginity testing and Ukutwala (traditional marriage) as cultural practices were unconstitutional and violated women's rights to equality, dignity and privacy. The International Criminal Tribunal for Rwanda declared rape as a means of perpetrating genocide, which participates in protecting women from GBV. Consequently, the proportion of women who reported ever experienced violence since age 15 has declined from 41.2% in 2010 to 34.5% in 2014, while the percentage of those who were violated in the past 12 months has decreased from 19.4% in 2005 to 13.6% in 2014. However, implementation of laws protecting women varies by place of residence. In 2015, the prevalence of FGM in Mauritania was estimated at 79% in rural area compared to 55% in urban areas. Therefore, efforts are still needed to reach zero

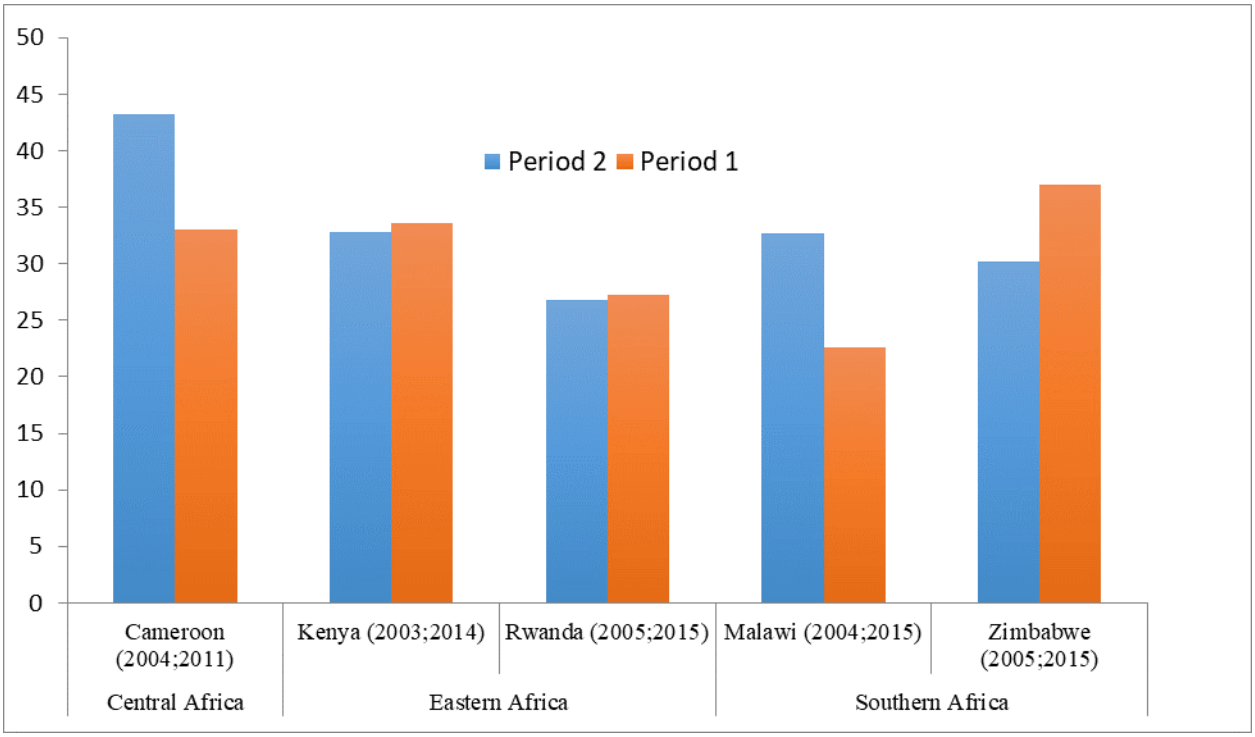
discrimination and harmful treatment. The Cameroon 2016 Penal Code penalizes forced marriage and early marriage by 5-10 years in jail and a fine of 25,000 - 1 million CFA Francs.

Figure 4.1.10 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation



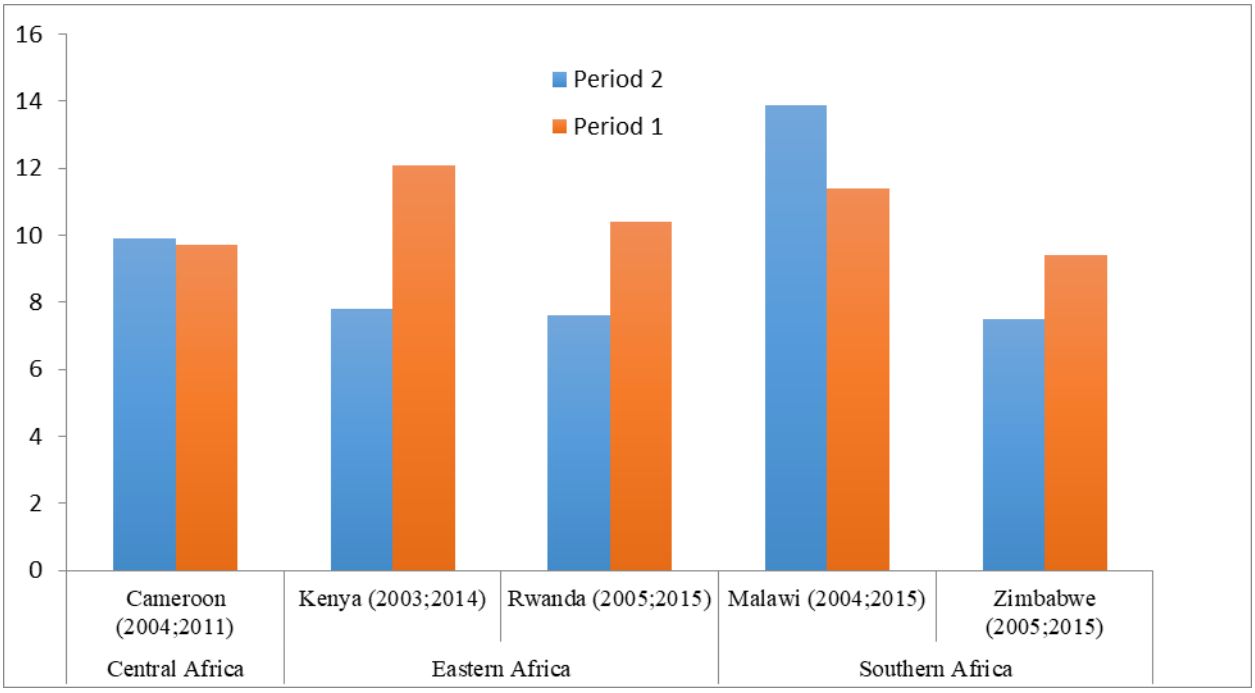
Source: STATcompiler/The Demographic and Health Surveys

Figure 4.1.11 Proportion of ever-partnered women and girls >15 subjected to physical, sexual, or psychological violence by current or former partners in the last 12 months



Source: STATcompiler/The Demographic and Health Surveys

Figure 4.1.12: Proportion of women and girls subjected to sexual violence



Source: STATcompiler/The Demographic and Health Surveys

4.1.5 Universal Access to Quality Education for All

Quality education is the best guarantee for promoting sustainable economic and social development and attaining the Sustainable Development Goals. The AADPD 19th commitment aimed to provide universal access to affordable, quality, comprehensive education and skills development, in a safe and participatory environment, at all levels of education, as well as free elementary education, in order to adequately respond to labor market needs.

a. Progress on Indicators

Figure 4.1.13a reports the proportion of children who completed primary school over the study period in 43 countries. Overall, the proportion of children who completed primary school increased in the majority of countries.

The greatest changes in the proportion of children who completed primary school was recorded in Seychelles (73%). In 2000/2005, the proportion of children who completed primary school ranged from 26% in Central African Republic to 104% in Tunisia. During the most recent period, the indicator varied from 38% in Chad to 126% in Seychelles. Figure 4.1.13a shows that the proportion of children who completed primary school declined in eight countries (Uganda, Eritrea, Zambia, Equatorial Guinea, Tunisia, Nigeria, Namibia and South Africa).

Considering secondary school completion, Figure 4.1.13b reports lower school completion rates compared to primary school. The highest proportion of children who completed secondary school (above 100%) was observed in Seychelles over the study period. The lowest proportion of students who completed secondary school was observed in Niger (7% in 2000/2005) and in Central African Republic (10% in 2010/2017) (Appendix 4.1.13b). The highest increase in the percent of children completing secondary school is observed in São Tomé (39%), while negative change is observed in Namibia (-1.6%), Liberia (-1.0%) and in Gambia (-3.2%).

Figure 4.1.14a displays the trend in gender parity in primary school completion. Overall, the gender gap in primary school completion has decreased over the period, except in six countries which have already achieved gender parity in the first period (Côte d'Ivoire, Algeria, Seychelles,

Rwanda, Mauritius, and Comoros). A majority of countries (30 out of 42) have achieved or almost achieved gender parity (girl/boy parity equal or higher than 0.95) (Appendix 4.1.14a). In twelve countries (Togo, Nigeria, Niger, Zimbabwe, Zambia, Malawi, Tanzania, Ethiopia, Djibouti, Equatorial Guinea, DR Congo, and Chad), gender parity in primary school completion rate has not been achieved yet (girl/boy parity less than 0.95), when considering the recent period.

Figure 4.1.14b displays the trend in gender parity in secondary school completion. Gender parity has improved over the period, except in Central African Republic, Eswatini, and Cabo Verde. The two latter countries have already achieved gender parity in secondary school completion rate during the first period (Appendix 4.1.14b). Overall, gender parity in secondary school completion are lower compared to primary school completion. In addition, considering the recent period (2010-2017), nineteen countries out of the forty-two have not achieved gender parity in secondary school completion (Appendix 4.1.14b).

b. Implementation: Examples of Policies, Best Practices and Challenges

Overall, African countries have made impressive improvement in schooling, especially for girls. In Egypt, the total enrollment rate in pre-university education 2015/2016 was estimated at 80.0% for males and 80.9% for females. In Angola, the gender ratio in primary education increased from 0.98 in 2011 to 0.997 in 2014. The indicator improved from 0.93 in 2011 to 0.987 in 2014 for secondary education. Mauritius has free access to education for all. Gender parity in education is 100% at the primary level in 2013.

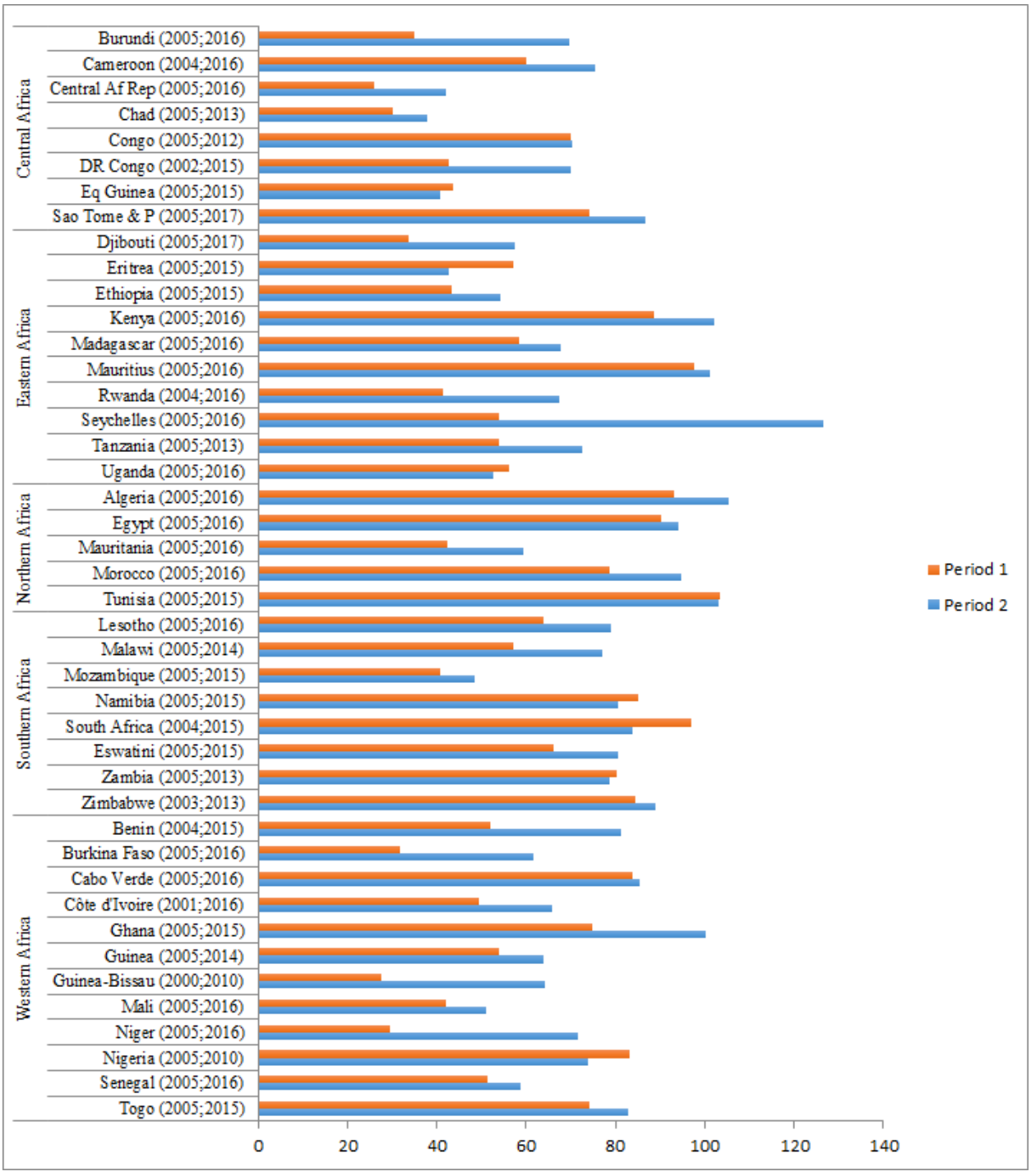
The schooling gap that remains most significant is the gap between the poorest and wealthiest households and the gap between rural and urban areas. In the Democratic Republic of the Congo, primary school attainment was estimated at 48% among children living in the poorest households compared to 99% for those living in the wealthiest households in 2012. In Equatorial Guinea, 100% of professional and technical training centers are located in urban areas.

Against this background, and in the efforts to fight discrimination in access to education, countries have developed and implemented policies and programs to reach education goals. For instance, the Benin 2018-2023 Sectoral Plan for Education; 2016-2021 Government Action Plan;

and the 2015-2030 SDG seek to facilitate universal access to education. The Tanzania 2018-2021 National Education Strategic Plan aims to ensure equitable access to education. In Burkina Faso, the percentage allocated to the education sector in the national budget increased from 17.5% in 2014 to 21.5% in 2017. The proportion of girls completing the primary education cycle increased from 53.7% in 2012 to 64.3% in 2017. The proportion of girls completing secondary education increased from 10.5% in 2012 to 13.6% in 2017. The South Africa government provides a fee-free initiative for first-year University students from low income earning families with annual household income below R350 000 (USD 25,172.30). Zambia's Ministry of General Education (MOGE) has put in place the Re-entry Policy to allow girls that fall pregnant while in school to go back to school. The proportion of girls that went back to school after taking leave due to pregnancies increased from 45.1% in 2014 to 55.6% in 2017.

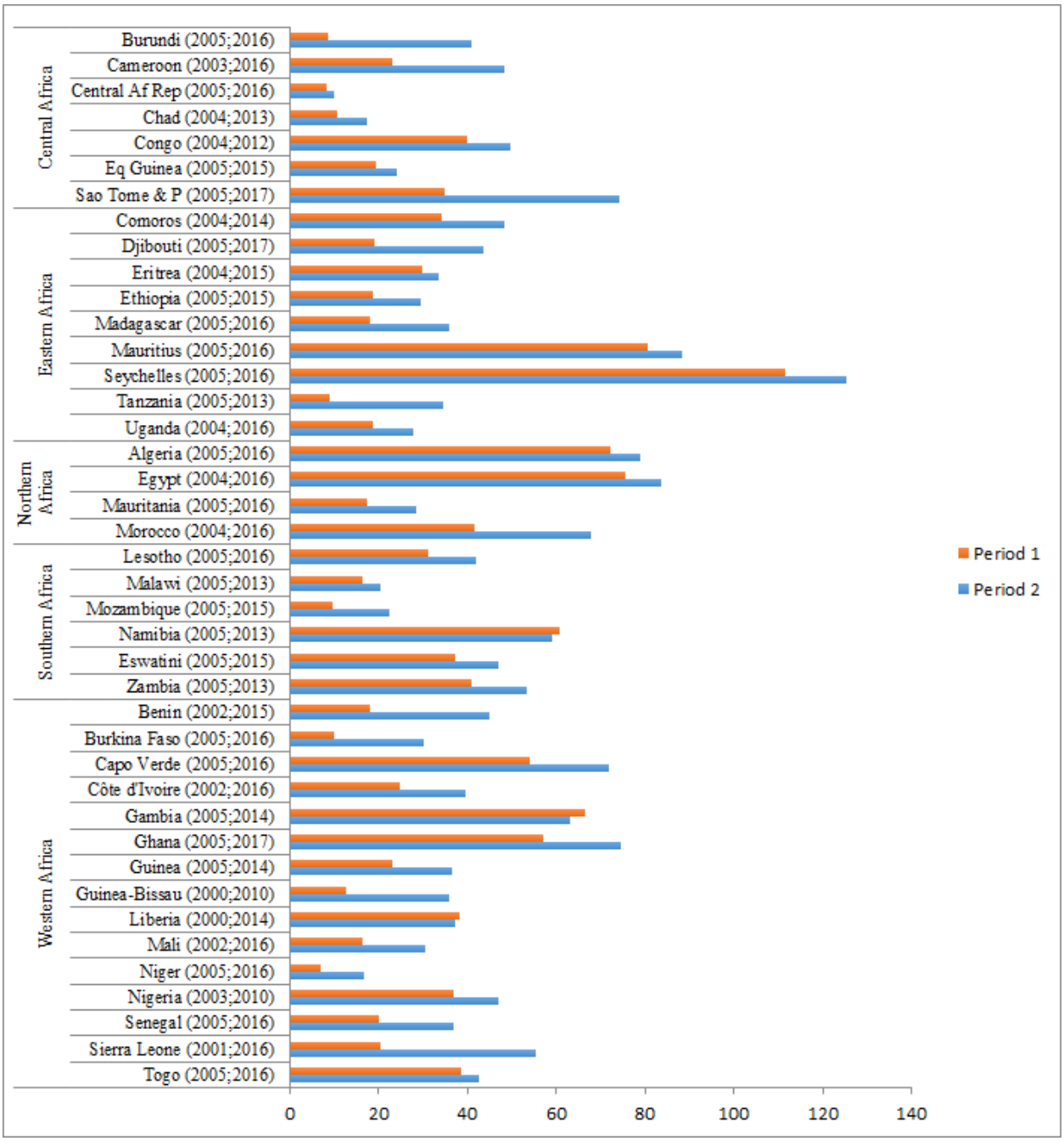
In Namibia, education expenditures increased from 6.0% of GDP in 2007/08 to 9.2% in 2014/15. The goals of the Ministry of Education, Arts and Culture include improving access to quality, inclusive education and promoting lifelong learning. To address the inequities in education and to ensure that all learners benefit equally, universal primary education and universal secondary education were introduced in 2013 and 2016, respectively. The government also provides study loans to students at tertiary institutions and the promotion of vocational training in the country through the Namibia Student Financial Assistance Fund.

Figure 4.1.13a: Percent of children completing primary school



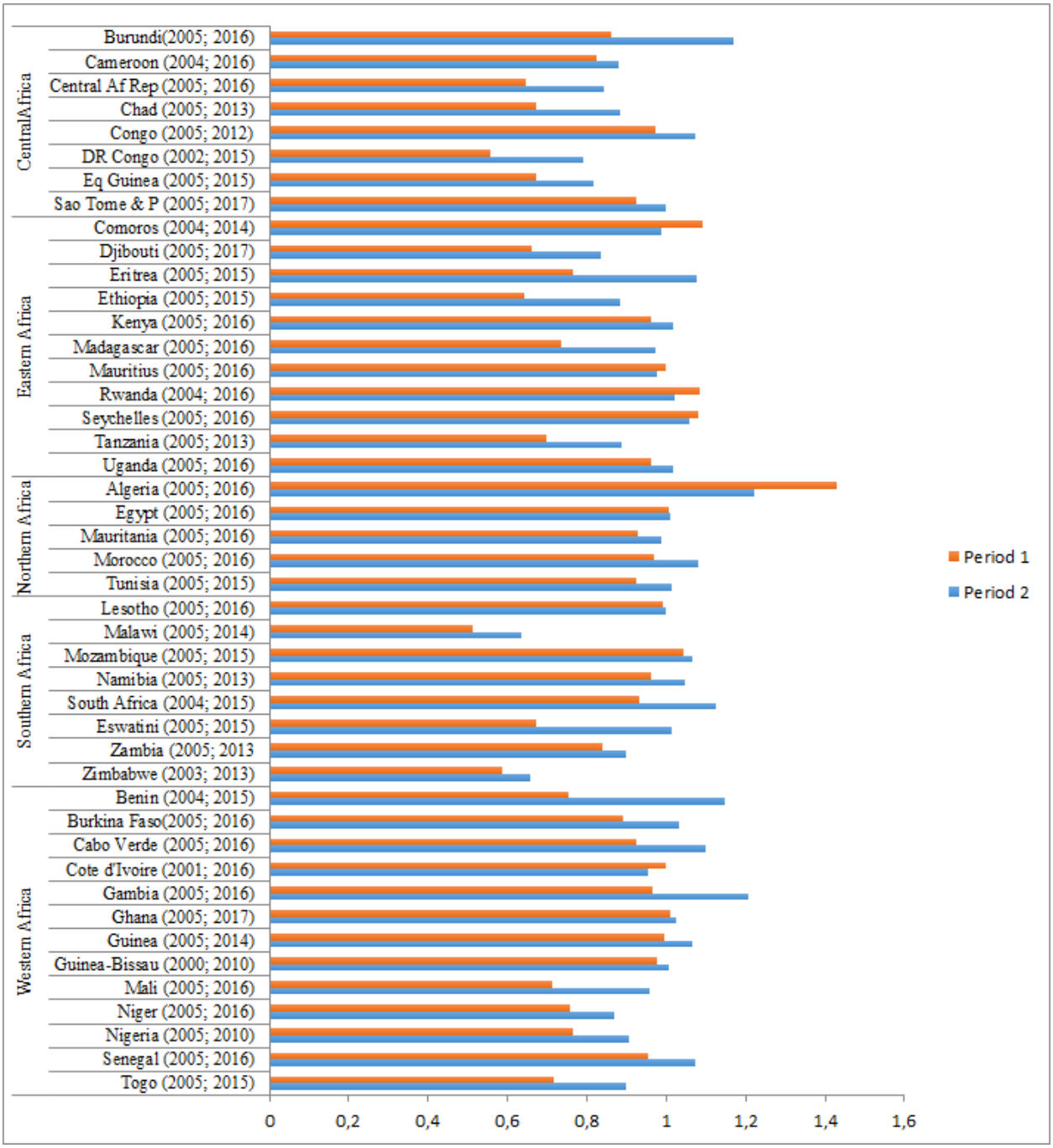
Source: World Development Indicators Database/World Bank

Figure 4.1.13b Percent of children completing secondary school



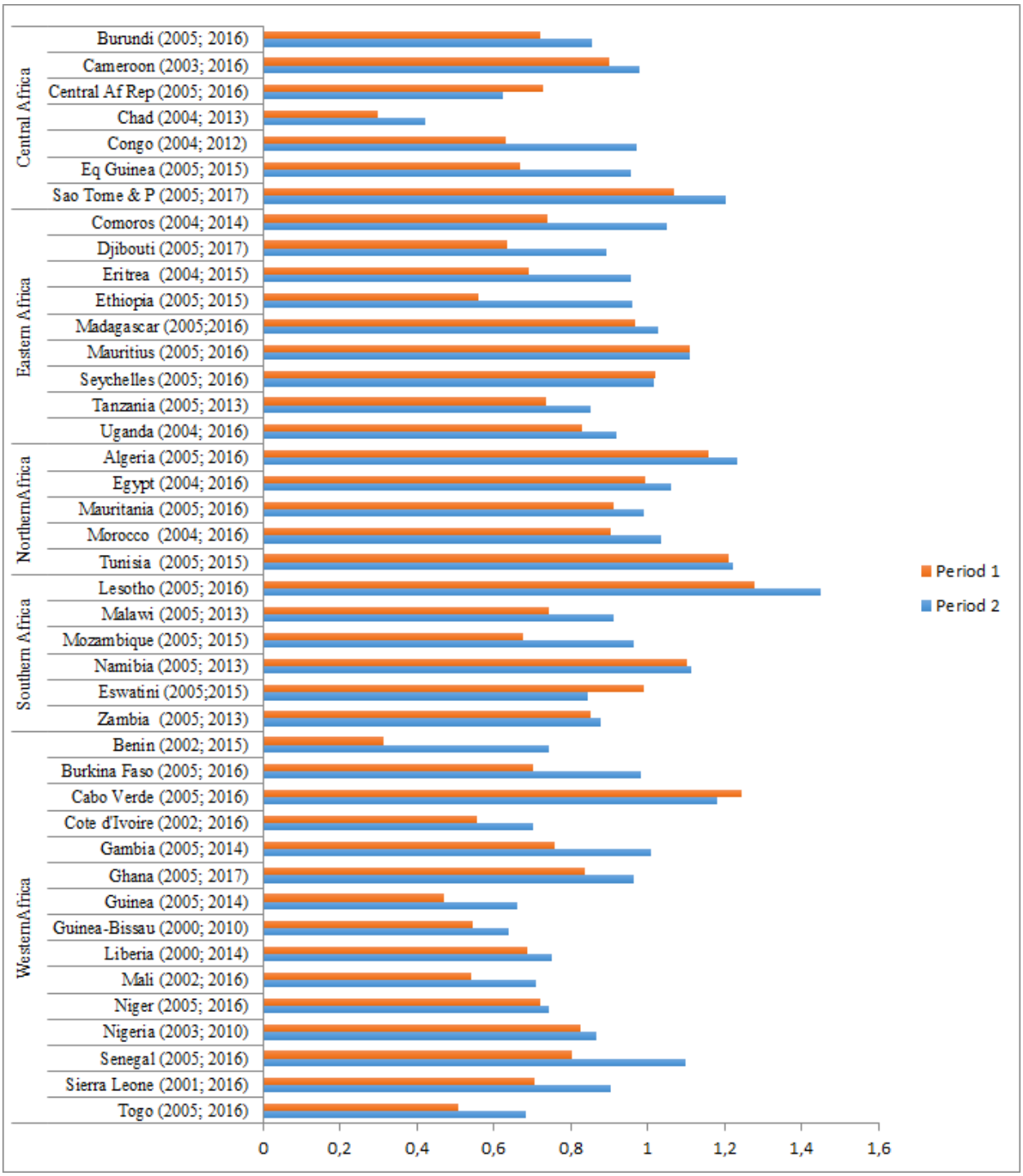
Source: World Development Indicators Database/World Bank

Figure 4.1.14a: Gender parity in primary school completion



Source: World Development Indicators Database/World Bank

Figure 4.1.14b: Gender parity in secondary school completion



Source: World Development Indicators Database/World Bank

4.1.6 Welfare and Longevity, Healthy Aging, and Lifelong Learning for Older People

This sub-theme covers commitments 23 (improve welfare and longevity), 25 (promote healthy aging for older people), and 26 (lifelong learning and integration of older people).

a. Progress on Indicators

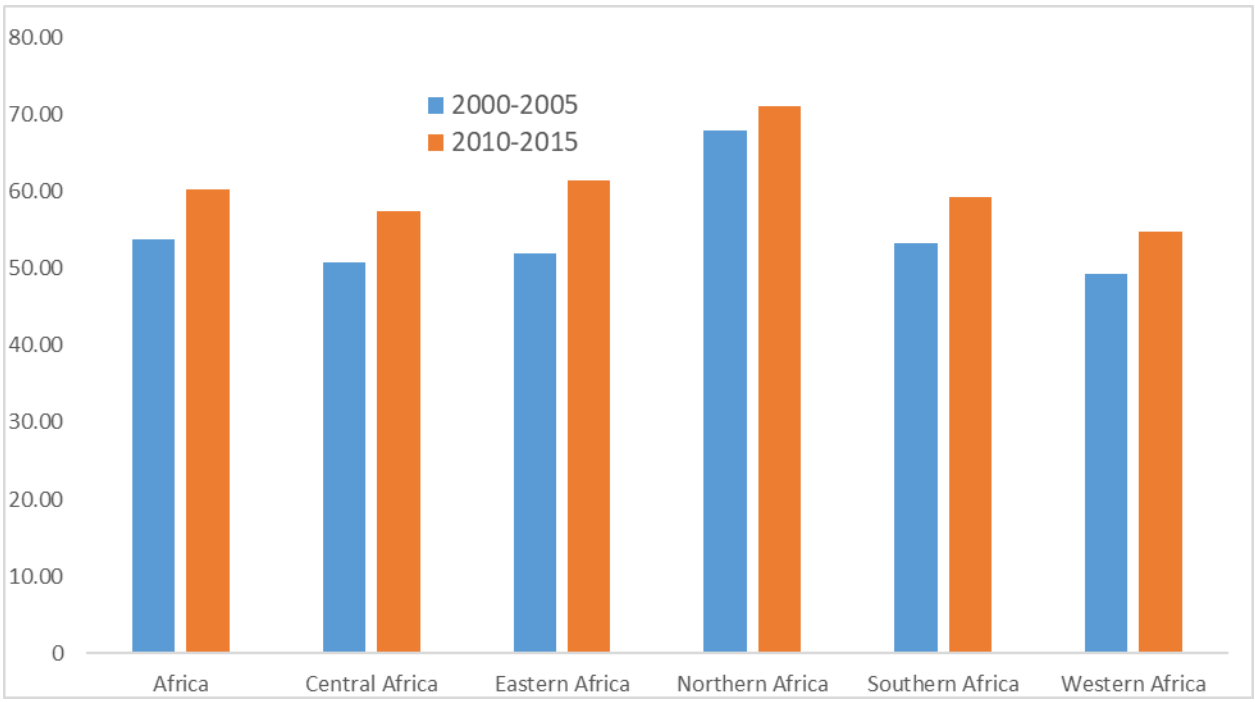
In 2016, the average life expectancy at birth of the global population was 72 years. Figure 4.15 displays the life expectancy of five African regions from 2000/2005 to 2010/2015. Overall life expectancy increased in Africa (from 54 to 60 years) and in all regions. Analysis by region reveals that life expectancy is higher in Northern Africa (71 years) and lower in Western Africa (55 years) during the most recent period.

b. Implementation: Examples of Policies, Best Practices and Challenges

In Africa, older people are often discriminated against within families and services, and this discrimination is often underpinned by the legal system and government policies. Burkina Faso adopted the law protecting and promoting the rights of the elderly in October 2016. Lesotho's Policy for Older People was developed in 2014 and National Strategic Plan for Older People in 2017 to enhance the economic participation of the elderly.

Some countries have developed policies to support and strengthen the capacity of organizations for people with disabilities to ensure a common advocacy approach toward the promotion of their rights. Madagascar adopted the 2015-2019 National Plan for Inclusion of People Living with Disabilities, the National Social Security Policy (PNPS) including disability, and the National Program for Decent Work for the same period. Algeria ratified the International Convention on the Rights of Persons with Disabilities in 2014.

Figure 4.1.15 Life expectancy by African region in 2000/2005 and 2010/2015



Source: World Population Prospects 2017/United Nations Population Division

4.2 Health

4.2.1 Sexual and Reproductive Health and Rights

a. Progress on Indicators

The unmet need for family planning remains high on the African continent. Although it is reducing in many African countries, a few countries (out of the 29 covered in Figure 4.2.1) recorded an increase in unmet need over time. These include Nigeria (+10 percentage points), Mauritius (+9 percentage points), Guinea (+6 percentage points), Benin (+5 percentage points), and Mozambique (+4 percentage points), as shown in Appendix 4.2.1. At the other extreme, the sharper declines are recorded in Rwanda (-20 percentage points) and in Ethiopia, Lesotho, Mali and Kenya (12-13 percentage points). Of the ten countries with unmet need for family planning of 25% or higher in the second data period, seven are from the Western and Central African regions.

In general, progress in family planning uptake has been made in Africa in the last few years, as modern contraceptive use increased in almost all countries across the subregions. Of the 44 countries shown in Figure 4.2.2, 20 countries recorded an increase in modern contraceptive

prevalence rate (CPR) between 9-10 percentage points (e.g., Ghana, São Tomé and Principe, Guinea-Bissau) to 25-30 percentage points (Zambia, Ethiopia, Lesotho, Eswatini, Kenya, Malawi), and even 30 percentage points (Rwanda). Most of these countries are in Southern and Eastern Africa. As shown in Figure 4.2.2, modern CPR remains low in Western and Central Africa, with values of 5% in Chad and 7-12% in Benin, Central African Republic, the Democratic Republic of the Congo, Equatorial Guinea, Guinea, the Gambia, , Nigeria, , and . At the other end of the spectrum, leading countries in the Northern, Eastern and Southern Africa exhibit modern CPR between 45-50% (e.g., Zambia, Rwanda, Algeria and Tunisia) and 60-65% (e.g., Lesotho, Kenya and Eswatini).

In general, the percentage of the demand for family planning satisfied by modern methods has increased over time in Africa, with the exception of Senegal (-14 percentage points), Nigeria (-8 percentage points), and to a lesser degree, Mali (-3 percentage points). In the most recent period of observation, the percentage of the demand for family planning satisfied by modern methods ranged from about 18-25% (in Senegal, Ghana, South Africa, Mozambique and Guinea) to 75% or higher in countries with low CPR such as Chad, Burkina Faso, Mali, Ethiopia and Benin (See Figure 4.2.3).

b. Implementation: Examples of Policies, Best Practices and Challenges

Central Africa: The Democratic Republic of the Congo has developed a National Strategic Plan for family planning with a multisectoral vision (2014-2020), which aims to contribute to the improvement of the well-being of the population by 2020. Since 2012, the government has created a budget line for the purchase of reproductive health commodities, including contraceptives. For the first time, Cameroon set up an operational family planning regime for the period 2014-2020. São Tomé and Principe's 2017-2021 National Development Health plan contains 17 sub-programs including Maternal and Neonatal Health and Sexual Reproductive and Family Planning programs. Equatorial Guinea drafted a Sexual and Reproductive Health bill in 2016, which is in the process of being adopted. However, some countries still face challenges with regard to ensuring the right policies are in place to meet the need for family planning

services. Challenges in Gabon include the absence of family planning policies that recognize the right of couples to make reproductive decisions freely.

Eastern Africa: In Rwanda, the 2018-2024 Health Sector Strategic Plan prioritizes universal access to contraceptive information and services by scaling up postpartum family planning information, ensuring availability of commodities at all health facilities and expanding social marketing of modern contraceptives. While the Ethiopian government has made a concerted effort to end female genital mutilation, an estimated 23.8 million Ethiopian girls and women are subjected to female genital mutilation. The practice also has considerable support from women with less than secondary education, who subject their daughters to it more than their more educated counterparts. In Mauritius, the 2018 Sexual and Reproductive Health plan of action is in line with the 2007 National Sexual and Reproductive Health policy.

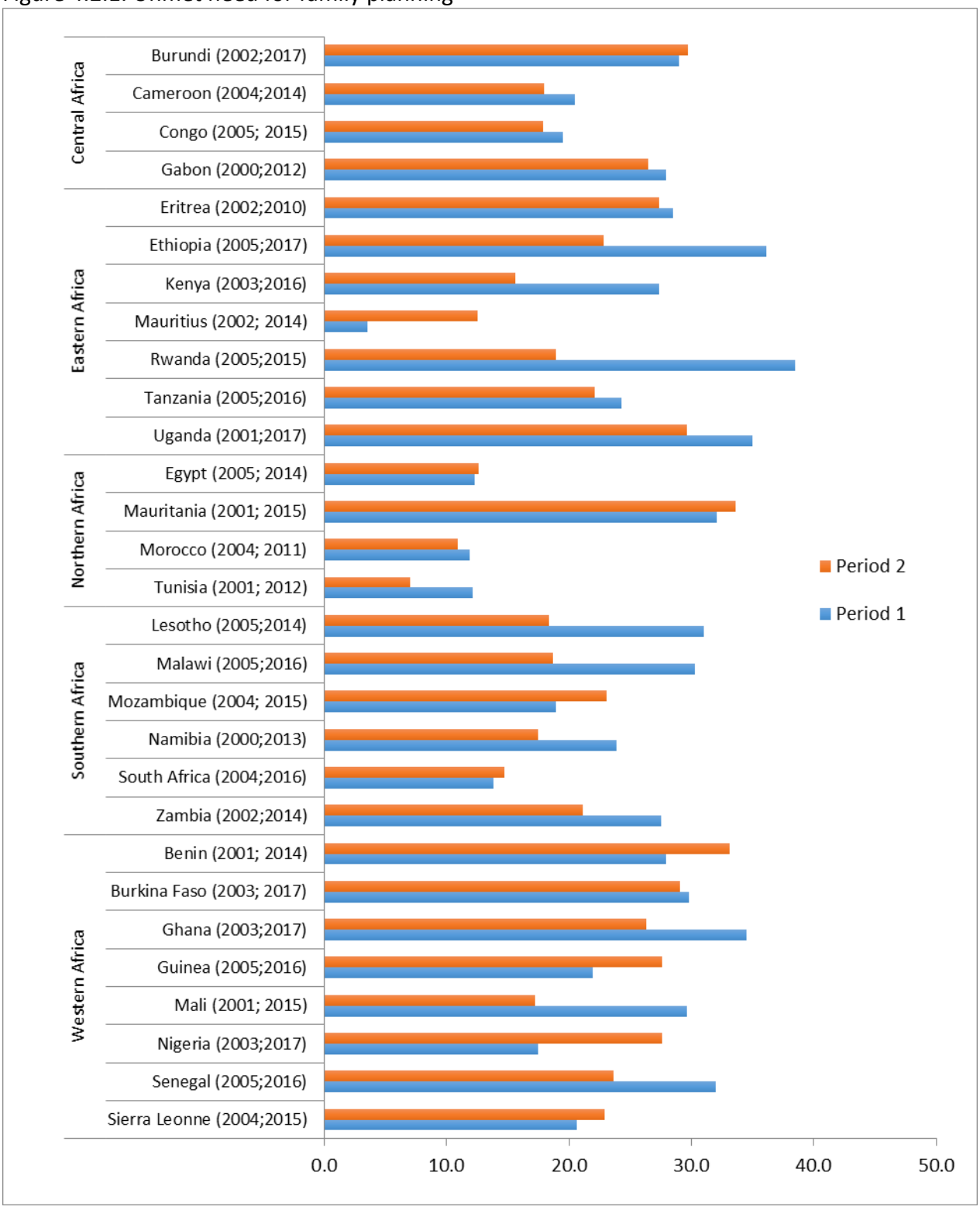
Northern Africa: Progress may be forthcoming in Algeria where use of modern contraception appears to have stalled at 49%. In 2017, the Directorate of Population developed a roadmap aimed at consolidating the National Family Planning Program, which is expected to improve modern contraceptive use rates in the near future. Egypt's Reproductive and Family Health Program ensures freedom of choice for families to decide on the number of children they wish to have. Moreover, the country has a 2015-2030 National Strategy for Reproductive Health, which seeks to ensure the right of all citizens to obtain universal access to quality reproductive health information and services by 2030.

Southern Africa: Following a successful pilot project from 2011 to 2014, Botswana adopted the Sexual and Reproductive Health and Rights (SRHR)-HIV Linkages and Integration services approach, which is currently being rolled out nationwide. In 2013, Malawi Parliamentarians approved the first national funding for family planning commodities. The government allocated 26 million Malawi Kwacha (USD 80,000) for family planning commodities as part of its 2013/14 national budget—the first time that such an allocation would be made from domestic funds. However, disapproving attitudes of health providers is considered to be an important contributor to Malawi's high unmet need for family planning (40%) among unmarried, sexually active women.

Zimbabwe has created an enabling policy and legislative framework to enhance the attainment of sexual and reproductive health as shown by the existence, implementation and periodic review of a number of policies, strategies and guidelines, including the National Family Planning Strategy (2016 – 2020), and the National Family Planning Costed Implementation Plan (2016 – 2020).

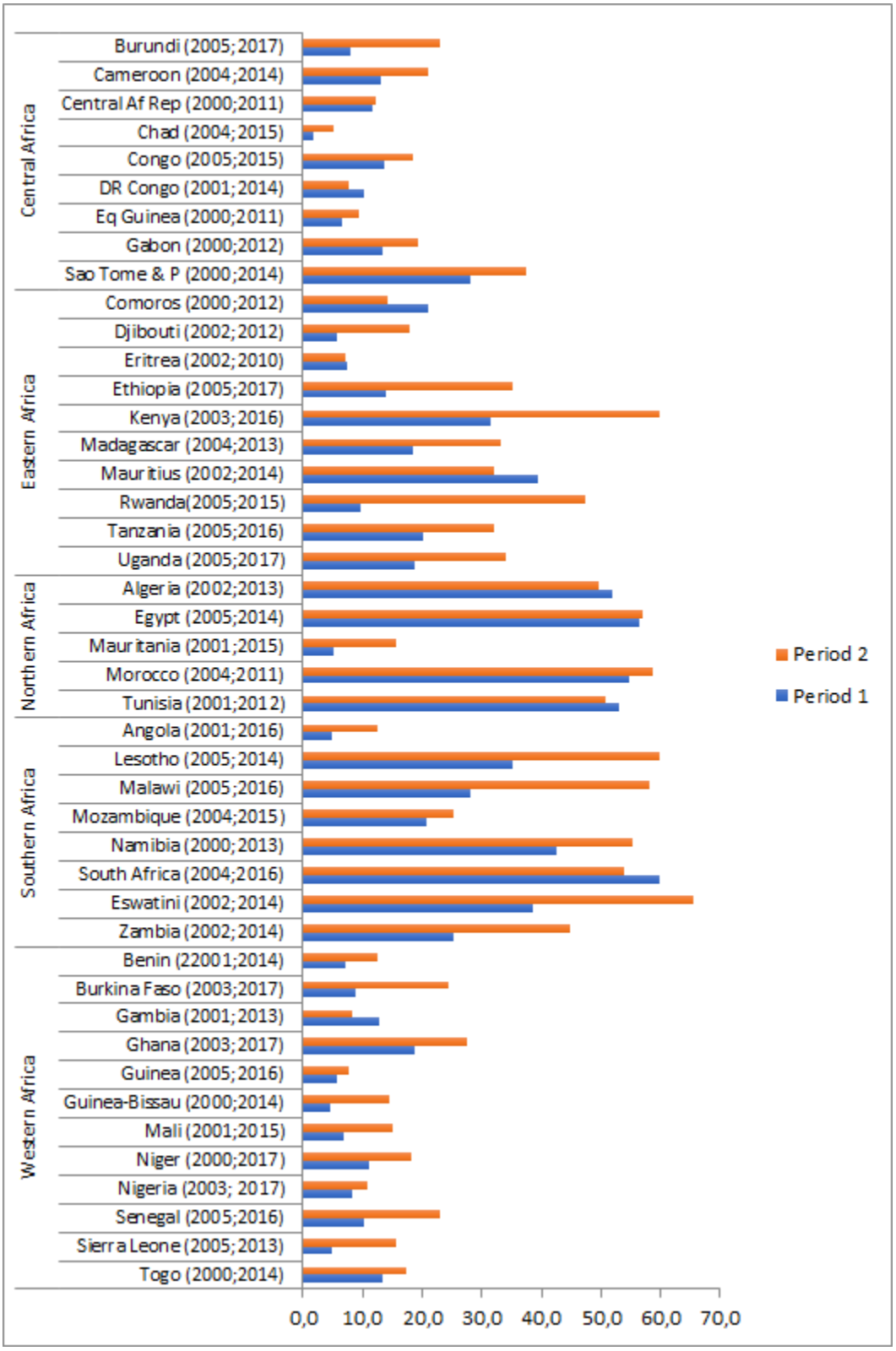
Western Africa: Nigeria developed a National Family Planning Communication Plan to guide the implementation of Family Planning Communication Programs from 2017 to 2020. The plan has its basis in the National Policy on the Health and Development of Adolescents and Young People in Nigeria and the National Youth Policy and their respective implementation frameworks. Burkina Faso's remarkable improvement in contraceptive prevalence rate and reduction in unmet need for family planning will likely be sustained due to government interest, as evidenced by the development of a National Plan to Accelerate Family Planning (2017-2020). Niger also has a plan to reposition family planning in the country (2013-2020).

Figure 4.2.1. Unmet need for family planning



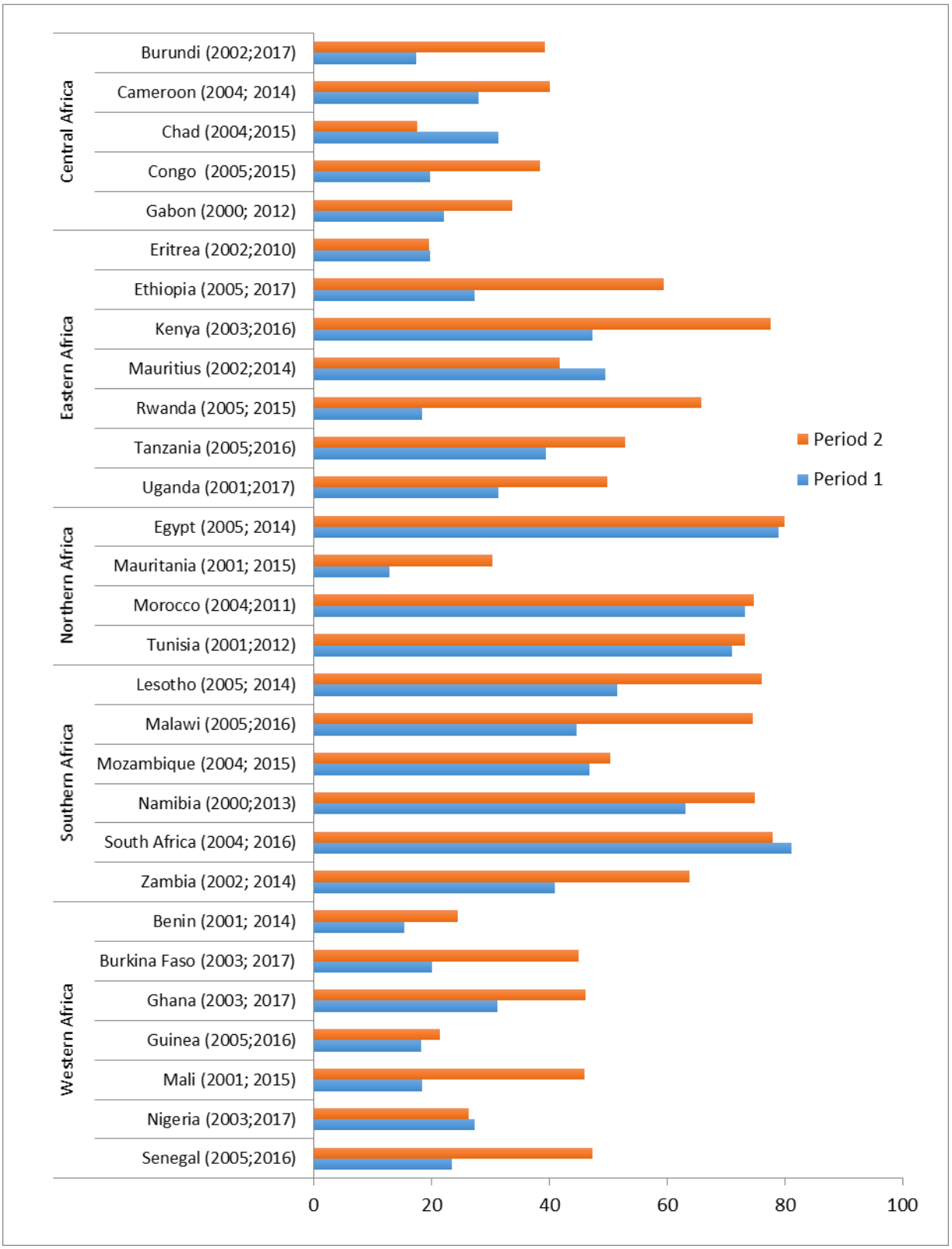
Source: World Development Indicators Database/World Bank

Figure 4.2.2 Modern contraceptive use



Source: World Development Indicators Database/World Bank

Figure 4.2.3. Demand for family planning satisfied by modern methods



Source: World Development Indicators Database/World Bank

4.2.2. Adolescent Sexual and Reproductive Health

a. Progress on Indicators

Adolescent fertility rate is generally high on the continent, but it decreased in all countries between 2005 and 2016, with the exception of three of the Northern African countries (Algeria, Egypt and Tunisia) where the levels are very low (See Figure 4.2.4). The proportion of **women aged 20-24 who were married by age 18** declined over time by 10 percentage points or more in Uganda, Gabon, Guinea, Zambia and Tanzania. In the remaining countries listed in Figure 4.2.5, the decline was minimal. In the last period for which data exist, early marriage remains a matter of concern in Africa, with 17 countries out of the 24 in Figure 4.2.5 recording a percentage of women aged 20-24 who were married by age 18 which varies from 30% (e.g., Zimbabwe) to more than 50% (e.g., Burkina Faso, Guinea and Mali), and even 67% (Chad).

In Africa, the proportion of women ages 20-24 who gave birth before the age 18 years has changed only minimally over the last few years. Only in Mali and Uganda was the decline noticeable at 12 percentage points and 9 percentage points, respectively (see Figure 4.2.6). Eleven countries (out of 28) exhibit a percentage of births before age 18 ranging from 30% (Nigeria, Côte d'Ivoire, Malawi and Zambia) to 40% (Mozambique and Guinea), to even 51% in Chad. The lowest percentage of births before 18 was reported in Rwanda and Egypt (at 6-7%). In many African countries, a large proportion of adolescent childbearing takes place within marriage. Apart from early marriage, other causes of the high adolescent fertility observed include early sexual debut and sexual violence. Nationally representative survey reports suggest that fertility is correlated with education, economic well-being and location. Young women with no formal education, those who come from households in the lowest quintile, and those who reside in rural areas tend to report early childbearing, reflected as higher adolescent fertility rates from these subpopulations[38].

[38]UNFPA. Adolescents and Youth Report: West and Central Africa. WCARO, 2018

b. Implementation: Examples of Policies, Best Practices and Challenges

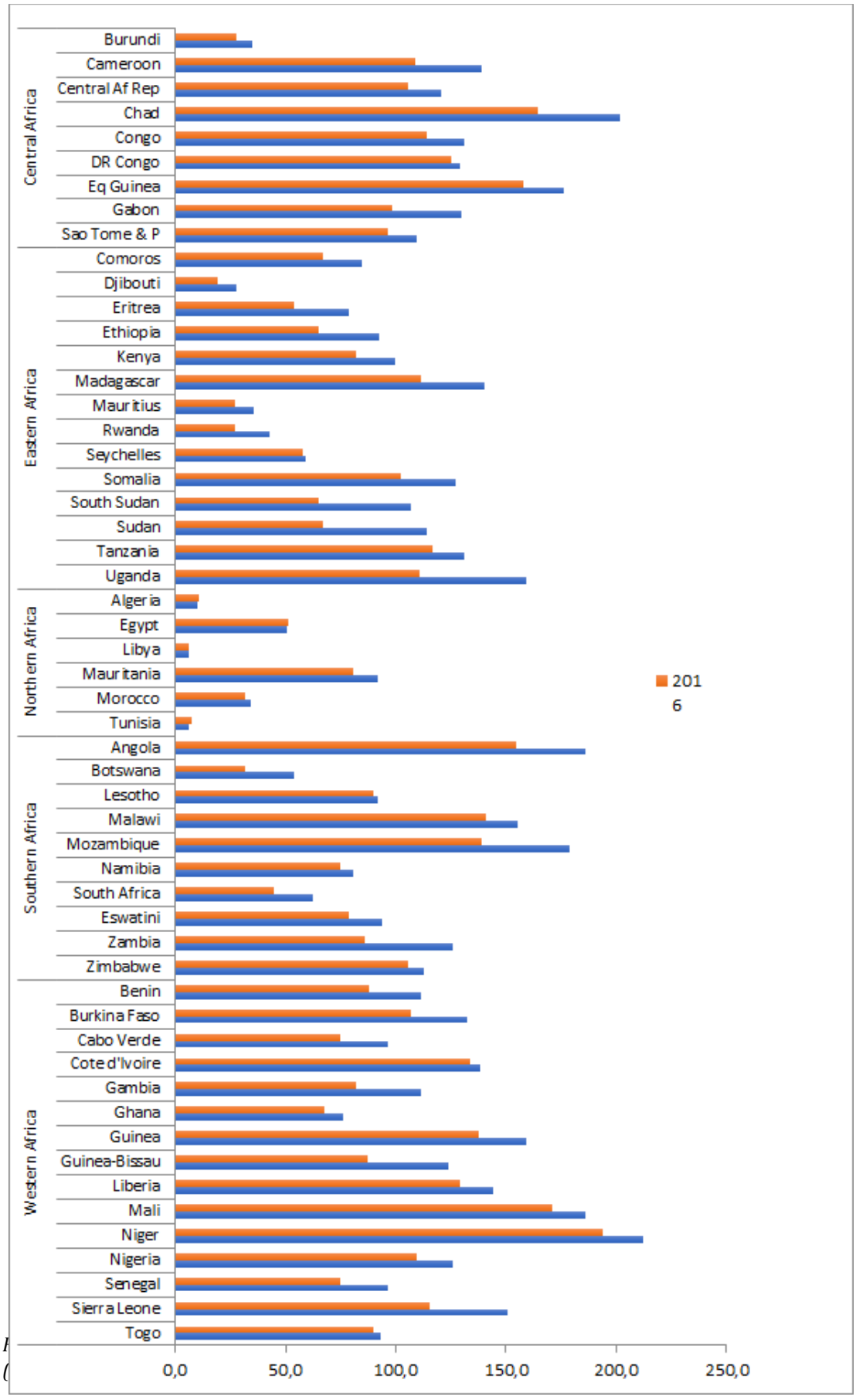
Central Africa: Chad continues to be one of the ten African countries most affected by child marriage, coming second after Niger, and bold policies on adolescent sexual and reproductive health are needed to curb the phenomenon. On the other hand, Gabon's 2017-2021 Health Development Plan prioritizes adolescent SRH. Similarly, in 2013, to address adolescent and teenage pregnancy, the government of Cameroon launched a program to provide adolescents with ''*Calculator 28''* a tool designed to help understand the menstrual cycle.

Eastern Africa: Madagascar's National Youth Policy was updated in 2015 to include children aged 10 years old and the role of youth associations. Madagascar adopted the 2018-2020 Adolescent and Youth Reproductive Health National Strategic Plan aimed at increasing availability, accessibility and use of quality sexual and reproductive health services. A law on family planning and facilitating access to contraceptive methods was adopted and promulgated in January 2018.

In **Southern Africa**, Zambia developed a comprehensive sexuality education curriculum for out-of-school youth in 2015. In Lesotho, the Safeguarding Young People (SYP) program was launched in 2014 to scale up sexual and reproductive health services for young people.

Western Africa: Sierra Leone's National Population Policy, revised in 2017, addresses the sexual and reproductive health of various vulnerable groups such as sterile, sub-fertile young people and the physically challenged. Paragraph 6.5 of the policy addresses the need for having a variety of contraceptive methods to allow free choice to users. In 2014, Ghana's Ministry of Gender, Children, and Social Protection (MoGCSP) created an Ending Child Marriage Unit, which intervenes in communities to address child, early and forced marriage, and in 2016 launched the 2017-2026 National Strategic Framework for Ending Child Marriage. Furthermore, The Ghanaian government, through the National Population Council and with support from UNFPA, developed the National Comprehensive Sexuality Education Guidelines in 2017 to guide the delivery of age-specific and culturally appropriate sexual and reproductive health information to young people.

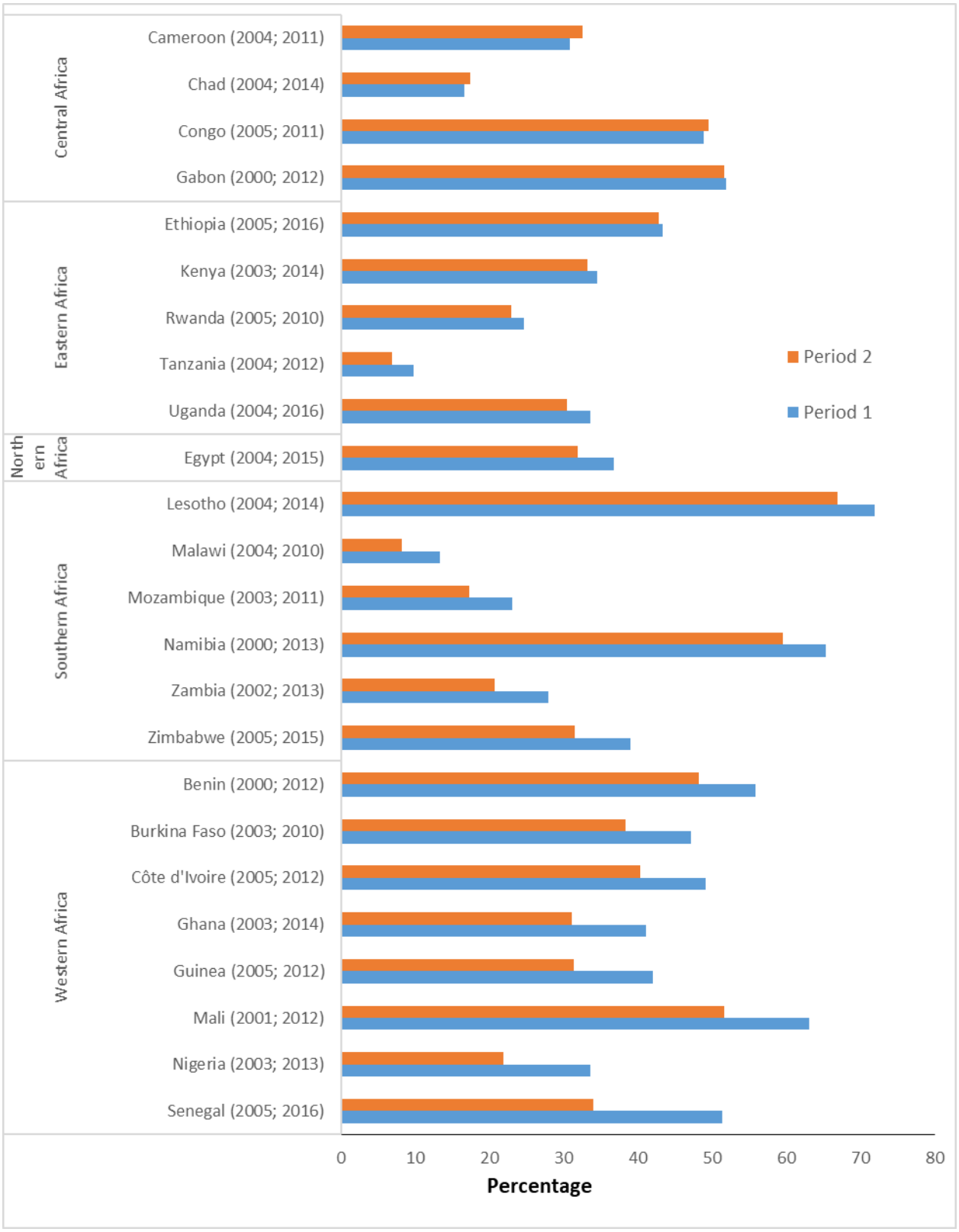
Figure 4.2.4 Adolescent fertility


Central Africa
Burundi
Cameroon
Central Af Rep
Chad
Congo
DR Congo
Eq Guinea
Gabon
Sao Tome & P
Eastern Africa
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Madagascar
Mauritius
Rwanda
Seychelles
Somalia
South Sudan
Sudan
Tanzania
Uganda
Northern Africa
Algeria
Egypt
Libya
Mauritania
Morocco
Tunisia
Southern Africa
Angola
Botswana
Lesotho
Malawi
Mozambique
Namibia
South Africa
Eswatini
Zambia
Zimbabwe
Western Africa
Benin
Burkina Faso
Cabo Verde
Cote d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2016
0,0
50,0
100,0
150,0
200,0
250,0

F
(

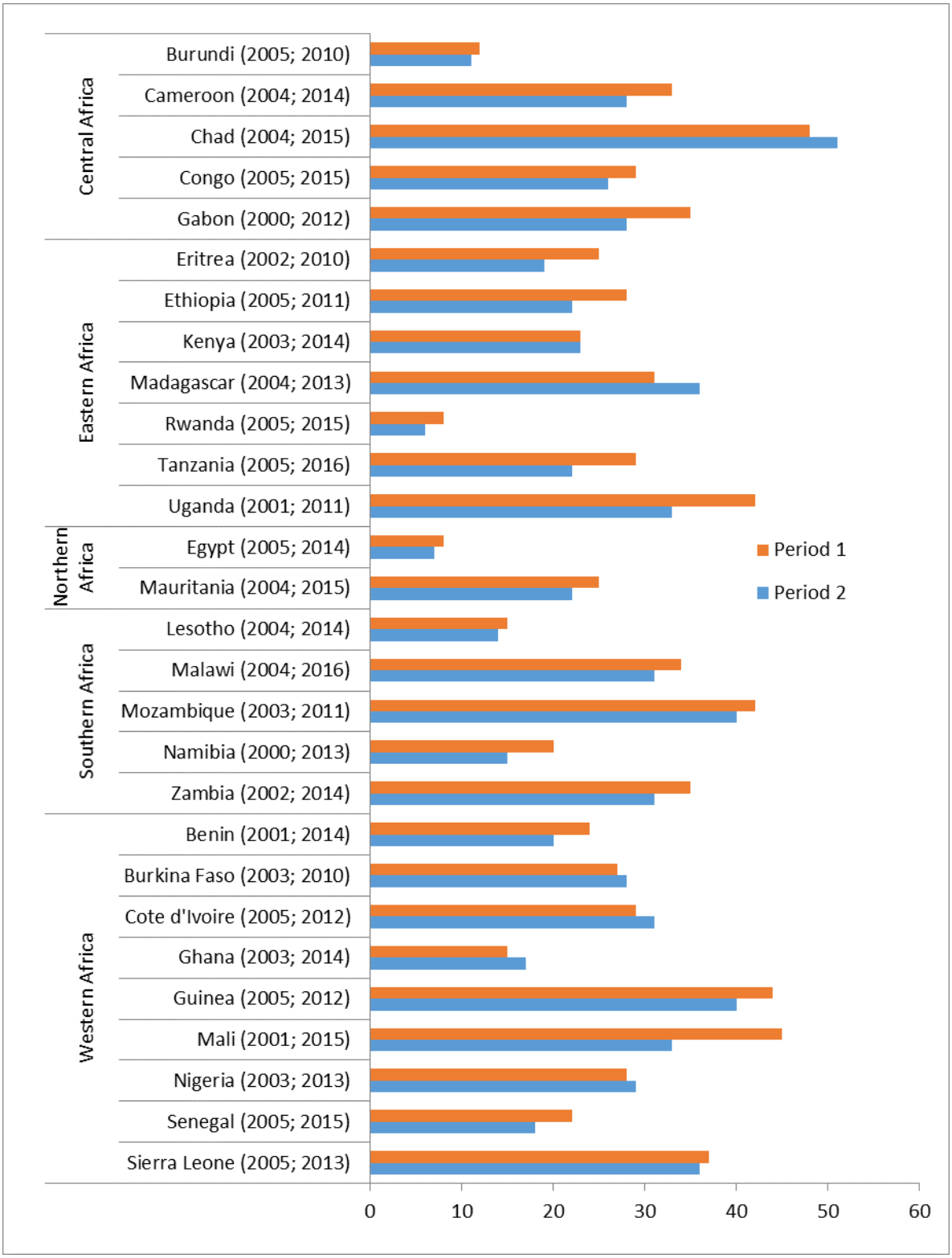
Source: World Population Prospects 2017/United Nations Population Division

Figure 4.2.5: Percentage of women aged 20-24 who were married or in a union before age 18



Source: STATcompiler/The Demographic and Health Surveys

Figure 4.2.6 Percentage of women aged 20-24 who gave birth before age 18



Source: Maternal and Newborn Health Coverage Database/UNICEF

4.2.3 Maternal Mortality

a. Progress on Indicators

Maternal deaths are decreasing across the continent, though progress is slow. During the decade 2005-2015, maternal mortality decline was highest (between 40% and 53%) in Botswana, Ethiopia, Rwanda, Tanzania and Zambia. In 2015, 18 African countries had a maternal mortality exceeding 550 deaths per 100,000 live births, all of which are in the Western and Central Africa region, with the exception of South Sudan, Somalia, Malawi and Mauritania (see Figure 4.2.7).

In general, significant progress has been made in access to skilled attendants at birth for the majority of African countries with available data, as shown in Figure 4.2.8. Nine countries recorded an increase in skilled birth attendance ranging from 25-35 percentage points (Niger, Ghana, Guinea, Djibouti, Malawi and Uganda) to 42 percentage points (Burkina Faso) and 52 percentage points (Burundi and Rwanda). On the other hand, Togo and Tunisia showed a decline in skilled birth attendance of 16 percentage points. Access has been, and remains universal in Mauritius, and is near universal in Algeria, South Africa, Seychelles and Botswana (97-99%). Eleven other countries exhibit rates between 85% and 95%.

Disparities in the proportion of births attended by skilled personnel are widespread on the African continent. Although to different degrees, all countries show some wealth disparities in access to skilled birth attendants at both time points. Judging by the change in the absolute gap between the richest and the poorest, improvement in skilled birth attendance has been largely equitable, except in Togo, Niger, Cameroon, Guinea-Bissau and Central African Republic, where the absolute gap rose by 11-18 percentage points. Ethiopia, Eritrea and Kenya can also be classified in this category (See Appendix 4.2.9).

The Sahrawi Republic's report (Indicadores de Salud 2016-2017) shows that maternal mortality in refugee camps increased from 226.0 per 100,000 live births in 2016 to 253.4 per 100,000 live births in 2017. During the same period, skilled birth attendance in the general population improved from 78% to 89%.

b. Implementation: Examples of Policies, Best Practices and Challenges

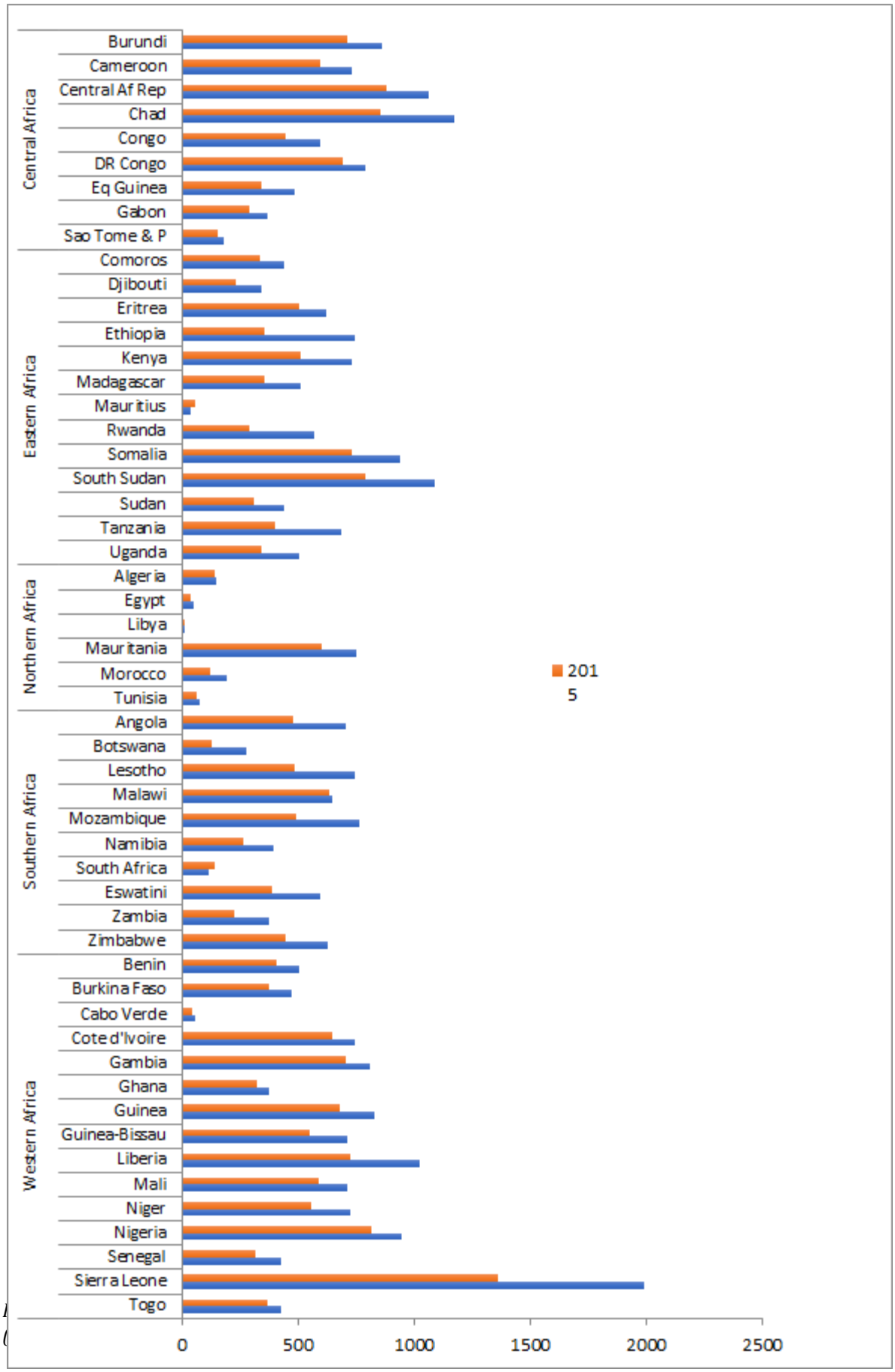
Central Africa: Although the reasons for the progress observed in reducing maternal mortality are multifactorial and differ by country, one important intervention by the government of Chad was the distribution of 300 ambulances nationally between 2013 and 2016.

Eastern Africa: The Tanzanian government developed the 2016-2010 National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in the country. Somalia has set a target in the National Development Plan (NDP 2017-2019) to reduce maternal mortality ratio to 600 deaths per 100,000 live births by 2019, and progress is being made toward this goal. In Comoros, factors that hinder efforts to improve maternal health include poverty, especially among women; prohibitive costs of certain drugs and services; poor attitudes of health facility staff toward women; a weak referral system; and suboptimal quantity and quality of human resources for health.

Southern Africa: According to the 2013/14 Zambian DHS, 0.5 percent of women reported ever experiencing symptoms consistent with fistula. Over the past five years, UNFPA's work on prevention and treatment of fistula in Zambia has resulted in the successful repair of 310 (in 2017) fistula survivors during the fistula repair camps conducted nationwide.

Western Africa: The government of Liberia, with support from development partners has increased and improved sexual and reproductive health services, with more than a 30% increase in the number of health facilities providing sexual and reproductive health services since 2014. In 2013, the government of Côte d'Ivoire launched a Campaign for the acceleration of the reduction of maternal deaths.

Figure 4.2.7 Maternal Mortality Ratio


Central Africa
Burundi
Cameroon
Central Af Rep
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Congo
DR Congo
Eq Guinea
Gabon
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Djibouti
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Ethiopia
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Sudan
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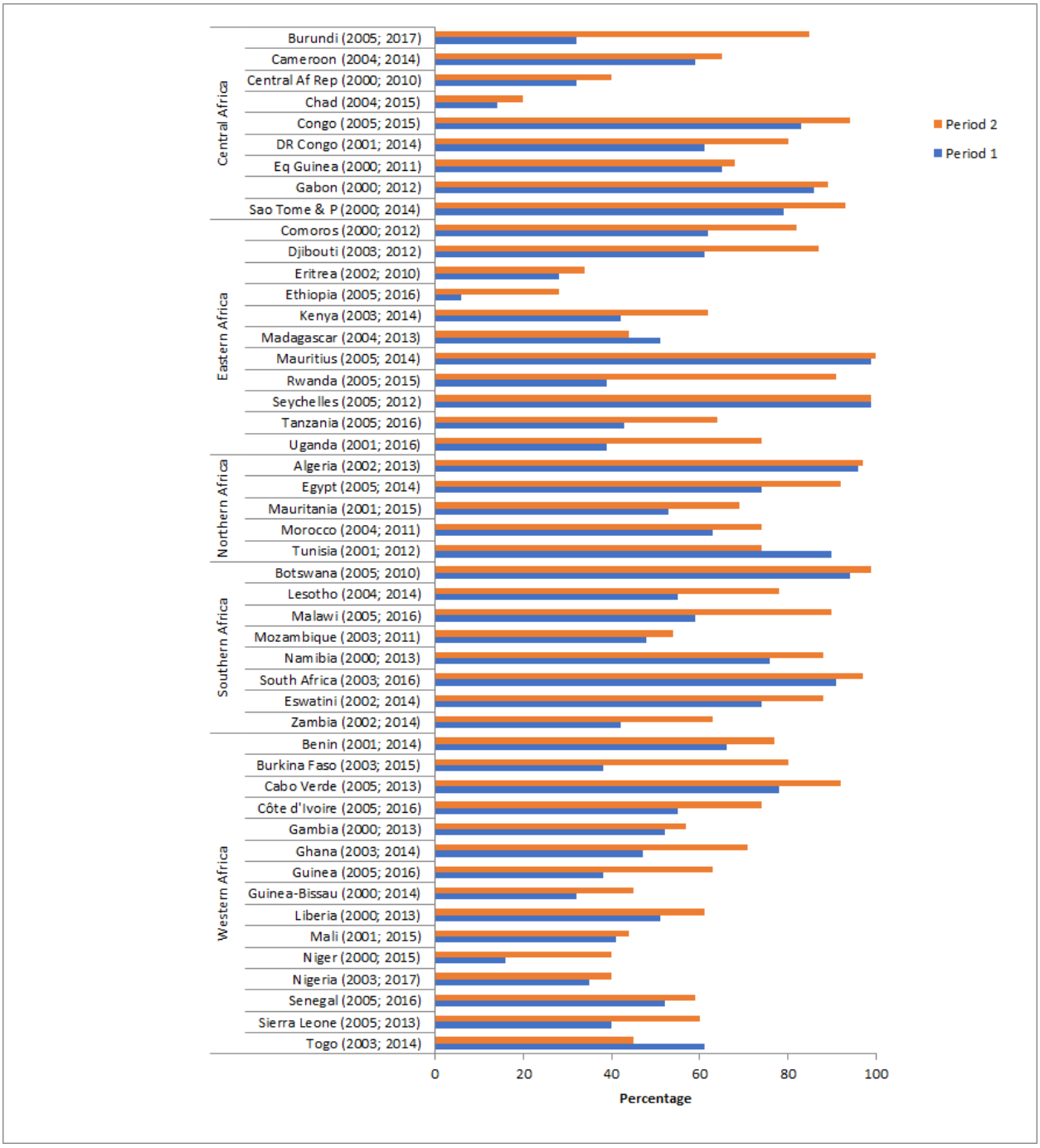
Western Africa
Benin
Burkina Faso
Cabo Verde
Cote d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
201
5
0
500
1000
1500
2000
2500

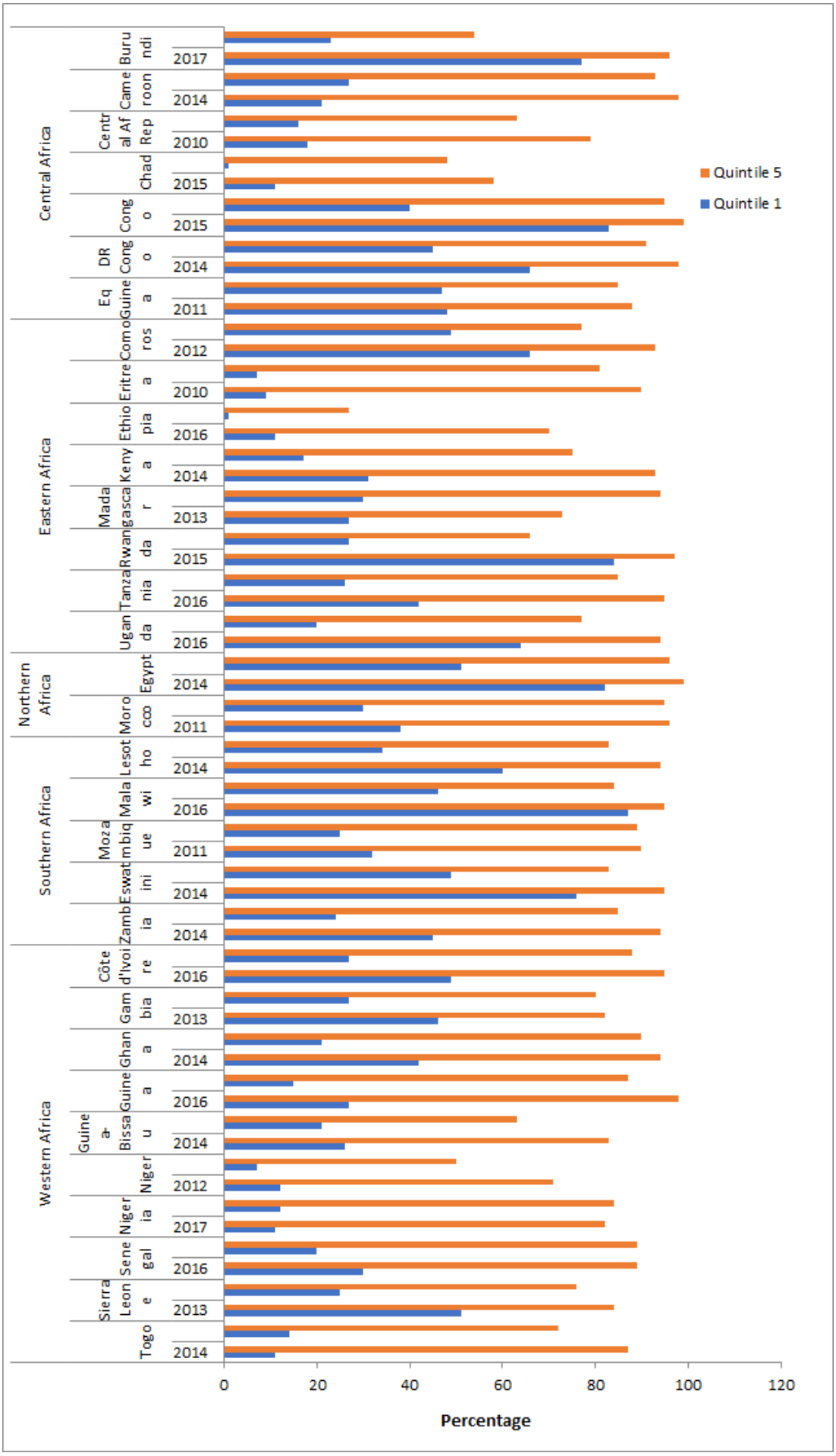
Source: World Development Indicators Database/World Bank

Figure 4.2.8. Proportion of births attended by skilled personnel



Source: Maternal and Newborn Health Coverage Database/UNICEF

Figure 4.2.9. Proportion of births attended by skilled personnel by wealth quintile


Central Africa
Burundi
2017
Cameroon
2014
Central Af Rep
2010
Chad
2015
Congo
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DR Congo
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Eq Guinea
2011
Eastern Africa
Comoros
2012
Eritrea
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Ethiopia
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Kenya
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Rwanda
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Tanzania
2016
Uganda
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Northern Africa
Egypt
2014
Morocco
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Southern Africa
Lesotho
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Malawi
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Eswatini
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Western Africa
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Gambia
2013
Ghana
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Guinea
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Guinea-Bissau
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Niger
2012
Nigeria
2017
Senegal
2016
Sierra Leone
2013
Togo
2014
Quintile 5
Quintile 1
0
20
40
60
80
100
120
Percentage

Source: Maternal and Newborn Health Coverage Database/UNICEF

4.2.4 HIV and AIDS, Malaria and Other Infectious Diseases

a. Progress on indicators

HIV prevalence is highest in Southern African countries and lowest in Northern and Western African countries. With very low prevalence rates, the HIV epidemic is almost nonexistent in many Northern African countries, as well as in Comoros, Madagascar and Somalia. Comparing prevalence rates in 2005 to 2016, progress appears to be modest but widespread, except in a few countries (Sierra Leone, Lesotho, South Africa, Angola and Equatorial Guinea) where the epidemic appears to be worsening (See Figure 4.2.10).

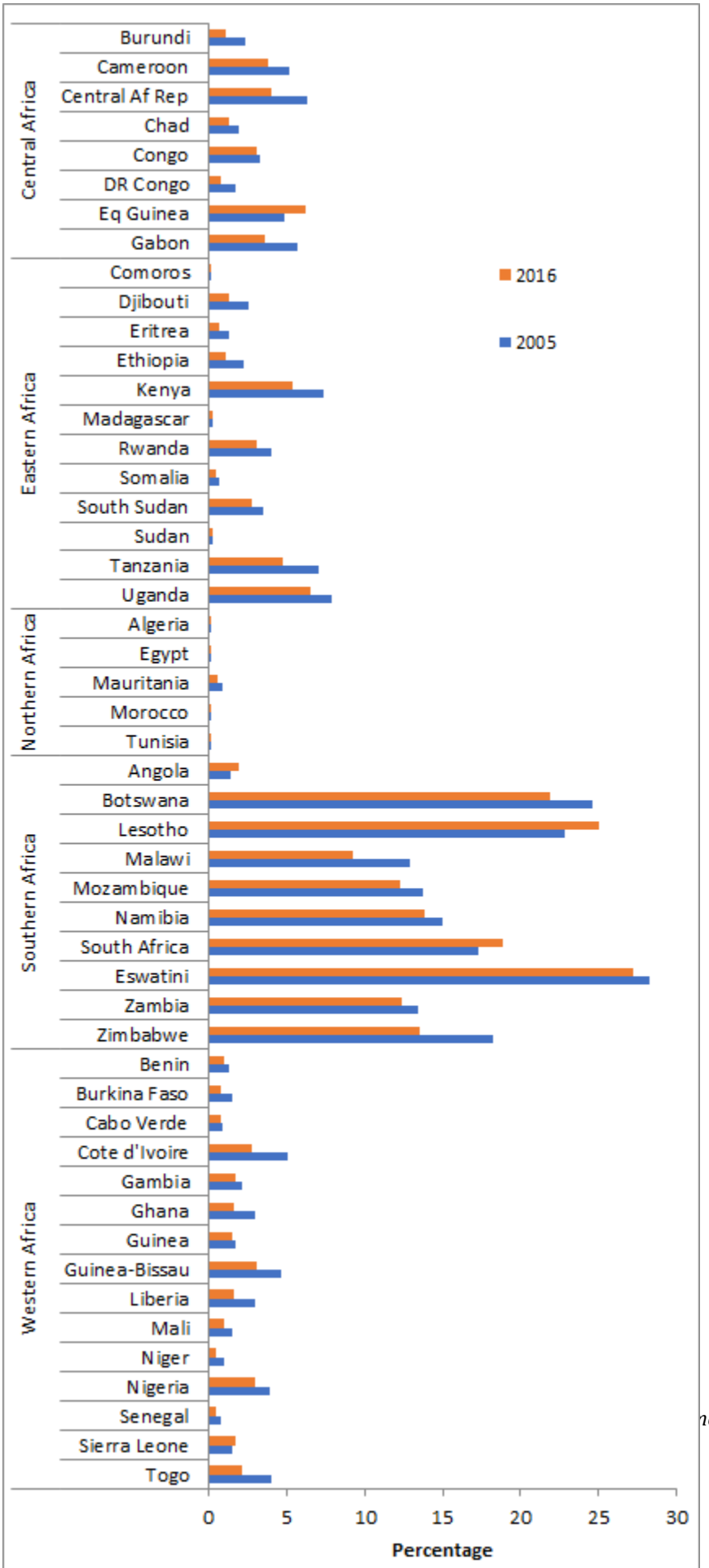
b. Implementation: Examples of Policies, Best Practices and Challenges

In **Central Africa,** the Central African Republic adopted in 2016 the HIV/AIDS B+ option, which entails providing treatment to all mothers who are seropositive, in order to protect their newborns. In **Eastern Africa**, Sudan has in recent times been putting in measures to combat malaria, bilharzias and other communicable diseases, as well as establishing health information databases. In **Northern Africa**, in a historic decision for Egypt and the region, a court in Cairo ruled in February 2016 that people living with HIV cannot be dismissed from work because of their HIV status.

Southern Africa: In 2015, Malawi developed the 2015-2020 National HIV and AIDS Strategic Plan (NSP) which provides a new framework for the implementation of HIV programs that align with UNAIDS' 90-90-90 targets. One year earlier, it developed the 2015-2020 HIV Prevention Strategy that focused on delivering behavior change interventions. In 2016, Botswana launched the "Treat All Strategy" which promotes Universal Health Coverage to ensure that all citizens who test positive for HIV are able to receive treatment. The South African government, for its part, launched the Comprehensive Sexuality Education Policy at the 8th AIDS Conference in July 2017. This policy equips teachers with ways to impart knowledge on STIs, HIV and AIDS and TB to young people. Eswatini also has a TB National Strategic Plan (2015-2019) and the

government is working on the challenges associated with the adoption of the Directly Observed Therapy Strategy (DOTS).

Figure 4.2.10 Prevalence of HIV


Central Africa
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Djibouti
Eritrea
Ethiopia
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Uganda
Northern Africa
Algeria
Egypt
Mauritania
Morocco
Tunisia
Southern Africa
Angola
Botswana
Lesotho
Malawi
Mozambique
Namibia
South Africa
Eswatini
Zambia
Zimbabwe
Western Africa
Benin
Burkina Faso
Cabo Verde
Cote d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2016
2005
0
5
10
15
20
25
30
Percentage

nent

Source: World Development Indicators Database/World Bank

Western Africa: Although HIV rates are already low in the Republic of Benin, the government's continued commitment is evidenced by the 2018 HIV/AIDS Strategic Plan. The Republic of Benin has enacted the 2018-2022 National Strategic Plan Against Malaria and the 2017 Strategic Plan for Malaria. Ghana, for its part, has formulated a National HIV and AIDS Strategic Plan 2016-2020 (NSP), a five-year strategic document designed to fast-track the country's effort toward ending AIDS by 2030.

Eastern Africa: In Comoros, the 2015-2019 strategic plan follows global strategies to reach the 90-90-90 objective. It ultimately aims to eradicate AIDS by 2030.

4.2.5 Burden of Noncommunicable Diseases

a. Progress on Indicators

The changing patterns of morbidity and mortality that define the epidemiologic transition in Africa have produced what is widely described as the "dual burden of disease." Poverty, which is rampant in Africa, presents several risk factors for development of NCDs, such as low birth weight, poor nutrition in childhood, and exposure to second-hand smoke[39]. Additionally, the "globalization of unhealthy behaviors" like smoking, harmful alcohol use, inactivity and overeating/poor nutrition are important risk factors for NCDs[40]. Concomitantly, morbidity and mortality at earlier ages as a result of the so-called "diseases of poverty"—communicable, maternal, perinatal and nutritional conditions continue to ravage Africa, disproportionally affecting the poor. Those who are sick, as well as those who care for them, lose productive work days and spend more on health care, bringing about an economic toll on families and nations[4].

In 2000, seven in 10 deaths on the continent were due to communicable, maternal, perinatal and nutritional conditions, but the burden of diseases due to these causes reduced by about 1%

[39]Bloom DE et al., 2011. The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum.

[40]Resnick MD et al., 2012. Seizing the opportunities of adolescent health. Lancet 379(9826): 1564-7

annually over a 16-year period, estimated at 56% in 2016[41] (See Figure 4.2.11). Over the same period of time, causes of death due to noncommunicable diseases and injuries have steadily increased. Consequently, Africa continues to grapple with this "dual burden of disease" where deaths due to preventable communicable diseases are still rampant while deaths due to NCDs and injuries continue to rise, largely due to changing lifestyles and better capacity to make correct diagnoses. Deaths due to NCDs and injuries have increased from 23% and 7% in 2000 to 34% and 10% in 2016 respectively.

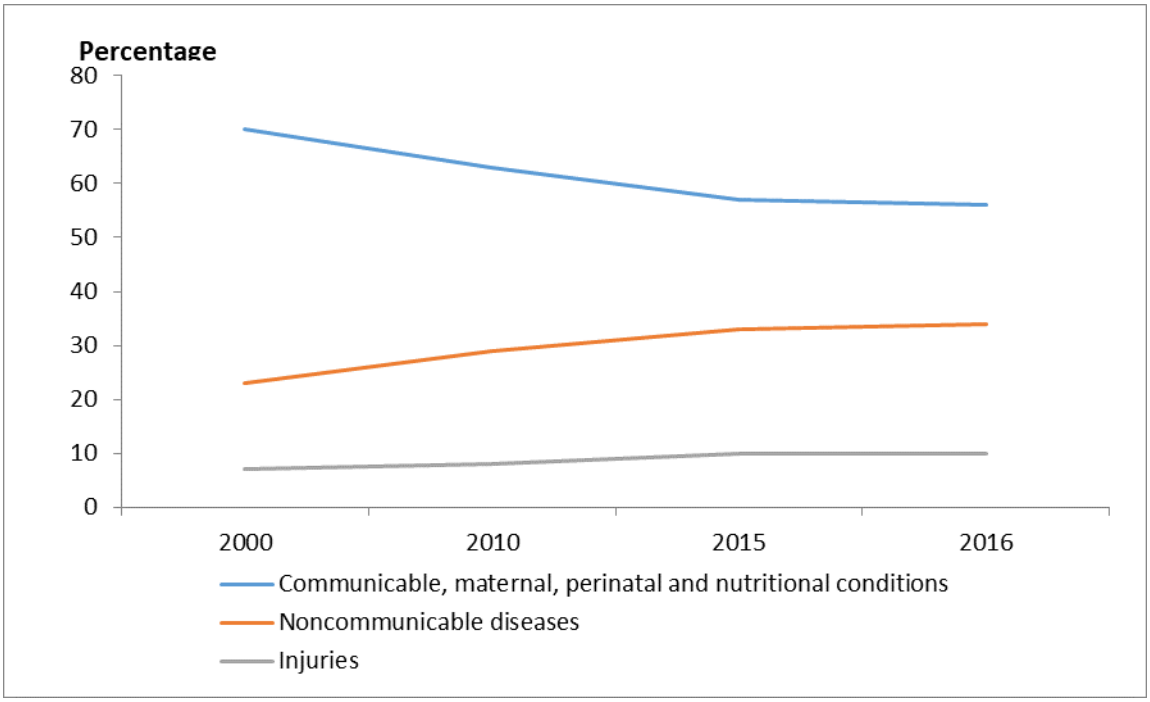
NCDs are an important cause of death in many African countries. In 2015, 12 countries had age-specific NCD mortality rates of 750 per 100,000 population or higher. These include Sierra Leone (mortality rate of 1,026 per 100,000 population), Côte d'Ivoire (949 per 100,000 population), Angola (830 per 100,000), Mali, Togo, and Egypt. Mortality due to NCDs appears low in Central African countries compared to other African subregions (See Figure 4.2.12).

b. Implementation: Examples of Policies, Best Practices and Challenges

The Republic of Benin has put in place the 2017-2022 National Response Plan to NCDs, as well as the 2012-2016 and 2016-2020 NCD plans. Burkina Faso is also actively fighting the war against NCDs with the development of an Integrated Strategic Plan for the Fight Against Noncommunicable Diseases (2016-2020), the Emergency Plan for the Acceleration of the Response to HIV (2017-2018), the Plan to Eliminate Mother-to-Child Transmission (2017-2020) and the National Strategic Framework for the Fight Against HIV, AIDS and STIs (2016-2020). In Namibia, the 2017 United Nations Common Country Assessment showed that diabetes accounted for 4% of all mortality in Namibia in 2012, while injuries contribute 10% to mortality in 2012. Deaths from self-harm, road injuries and interpersonal violence peak in males aged 20 to 24 and collectively account for almost 50 percent of all deaths in this age group. Mental, neurological and substance abuse disorders have been observed to be on the rise. An increase in overweight and obesity rates has also been observed.

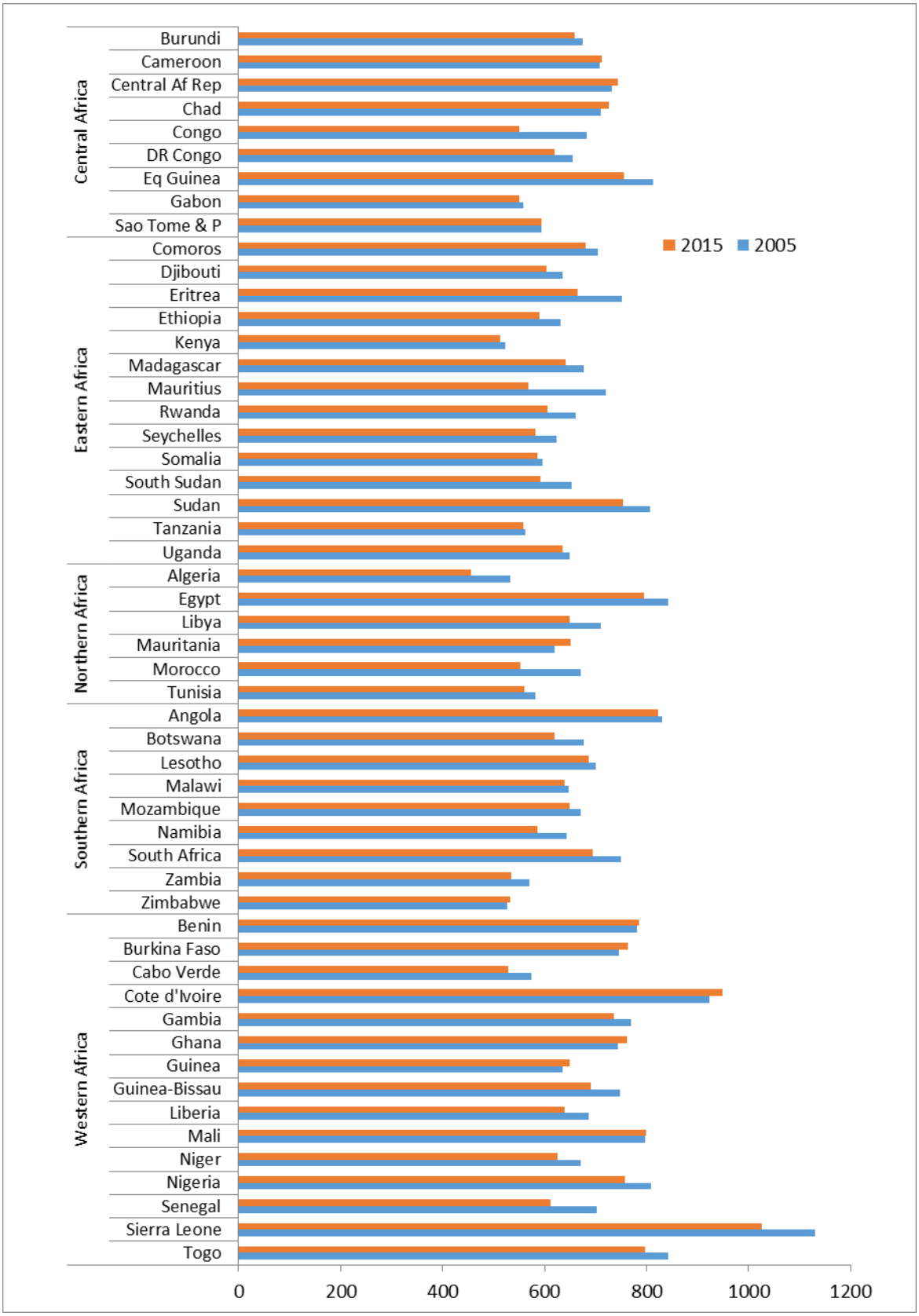
[41]WHO, 2018. Causes of deaths WHO African Region. Available at: http://www.who.int/gho/mortality_burden_disease/causes_death/region/en/

Figure 4.2.11. Causes of deaths - WHO Africa Region



Source: Global Health Observatory data repository/WHO

Figure 4.2.12. Age-standardized NCD mortality rate (per 100,000 population)


Central Africa
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Burkina Faso
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Cote d'Ivoire
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Guinea
Guinea-Bissau
Liberia
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2015
2005
0
200
400
600
800
1000
1200

Source: Global Health Observatory data repository/WHO

4.2.6 Health Systems Strengthening

a. Progress on Indicators

Access to health insurance is generally very poor on the African continent. Although the time points differ slightly, only Ghana and Rwanda appear to be making good progress with regard to the percentage of the population covered by social insurance programs as shown in Table 4.2.2. The progress in Nigeria and Tanzania was modest, but there was no change in the percent of the population covered by social insurance programs between the two time periods highlighted in DR Congo, Malawi, Niger and Uganda. The situation in Côte d'Ivoire is quite concerning, as the population covered by social insurance programs experienced a precipitous drop, comparing 2002 to 2015.

Table 4.2.2. Coverage of social insurance programs[1] (% of population) in selected African countries

	Period 1	Period 2
Côte d'Ivoire (2002; 2015)	20.6	7.9
DR Congo (2004; 2012)	1.5	1.6
Ghana (2005; 2012)	4.0	59.5
Malawi (2004; 2013)	1.0	1.0
Niger (2011; 2014)	1.4	1.4
Nigeria (2012; 2015)	1.2	2.7
Rwanda (2005; 2013)	0.8	10.8
Tanzania (2010; 2014)	1.0	1.3
Uganda (2005; 2012)	1.0	0.9

Source: World Development Indicators Database/World Bank

[1]Percentage of population participating in programs that provide old-age contributory pensions (including survivors and disability) and social security and health insurance benefits (including occupational injury benefits, paid sick leave, maternity and other social insurance). Estimates include both direct and indirect beneficiaries.

b. Implementation: Examples of Policies, Best Practices and Challenges

Central Africa: In Burundi, the government's efforts to increase the share of the state budget devoted to health (to 13%) – i.e., close to the level recommended by the Abuja Declaration (15%) – will also contribute to improved sexual and reproductive health outcomes.

Eastern Africa: In Kenya, health insurance coverage has improved from 17.1% in 2013 to about 25% in 2017, while out-of-pocket expenditure has declined from about 83% to 75% of the population. The membership in NHIF rose by 11.1% from 6.1 million in 2015/2016 to 6.8 million in 2016/2017. Moreover, the Kenyan government increased its budgetary allocation from 5.5 percent in 2013/14 to 7.7 percent in 2015/16. Rwanda has attained the Abuja declaration of allocating 15% of the government budget allocated to health and has established a functional and affordable health insurance system for households. Somalia has developed a Health Sector Strategic Plan II (HSSP) for the period 2017-2021, which includes a Midwifery Strategy, a Human Resources Strategy, and HIV/AIDS Strategy.

Northern Africa: Egypt's new health insurance system is set to fully cover 100% of citizens with quality health care by 2030. It aims to achieve equitable and universal health coverage, including financial risk protection and access to quality essential health services, with an increased level of health financing, starting in 2016/2017.

Southern Africa: The South African government's aim to achieve Universal Health Coverage (UHC) led to the introduction of the National Health Insurance (NHI) in 2011, followed in 2015 by a first White Paper, and in 2017 by a second White Paper. Currently, South Africa is dealing with the pragmatics of bringing the NHI concept into reality, as it continues to strengthen its health systems. However, these efforts have been deemed unsuccessful by some. Critics mention South Africa's institutionalized socioeconomic inequalities and express concern that the government may not be able to sustainably fund the NHI. Zambia also has a 2018 National Health Insurance Act. In Namibia, the total government health expenditure in 2012/2013 amounted to 13% of the total general government expenditure. During the 2014/15 fiscal year, the government of Namibia made the most substantial contribution to health spending by contributing 64%.

Western Africa: In Nigeria, Universal Health Coverage was enshrined in the constitution as captured in the National Health Act 2015, which holds the government accountable for ensuring that all citizens have access to affordable and quality healthcare. In the Gambia, there is ongoing progress in the revitalization of the primary health care and scaling up (from 634 PHC villages in 2015 to 810 in 2018) for equitable and universal access to a comprehensive range of health care services. Mali has developed a 10-year national health and social development plan (2014-2023) that will help to further strengthen the existing health system. The government of Niger's desire to implement the right to health of all citizens is reflected in their 2017-2021 Health Development Plan.

4.3 Place and Mobility

4.3.1. Migration and Internal Displacement

a. Net Migration

Migration across international borders can be a factor of economic and social development, through increased global productivity of labor. It can also promote investment and higher standards of living in countries of origin through remittances sent by migrants to families and communities[42]. Figure 4.3.1 shows the net migration rates for the periods 1995-2000 and 2010-2015. Net migration rate is defined as the number of immigrants minus the number of emigrants over a period, divided by the person-years lived by the population of the receiving country over that period. It is expressed as average annual net number of migrants per 1,000 population.

Data in Figure 4.3.1 have been truncated for the sake of presentation (see Appendix Table 4.3.1 for the actual values). As can be seen, a large majority of African countries are net senders of migrants. In the latest period 2010-2015, these include Central African Republic (-17.6, from +1.4 in 1995-2000), Libya (-14.0, -2.2 in 1995-2000), Eritrea (-6.9), and Sao Tome & Principe (-6.0). At the other end of the scale, a few countries have been countries net receivers of migrants in both periods under review. These include Equatorial Guinea (+16.9, up from +12.5), Gabon (+9.6, up from +1.7), South Sudan (+7.7, down from 13.2), South Africa (3.0, up from +1.4), Mauritania (+2.1, up from +1.0), and Chad (+1.5, down from +1.8).

b. Refugees & Internal Displacement

The continent is affected by a number of conflicts with over 9.3 million forcibly displaced persons made up of 6,880,747 internally displaced and 2,475,518 refugees. There are over 800,000 refugees in Ethiopia, 3,200,000 IDPs in Sudan, 1.69 million IDPs in South Sudan and an estimated 1.1 million IDPs in Somalia. In addition, extreme climate-related hazards are now regularly occurring in Africa: drought in the Sahel, severe water scarcity, more frequent and extreme El Nino events and severe storms affect population in the continent but more data and assessment needs to be done to protect the population.

4.3.2 Living Conditions of People in Urban and Peri-Urban Areas, Displaced People and Migrants

a. Progress on Indicators

An important measure of living conditions is the proportion of the urban population living in slum households (i.e., a group of individuals living under the same roof lacking one or more of the following: access to improved water, access to improved sanitation, sufficient living area, and durability of housing). As Figure 4.3.1 shows, a large proportion of the population in urban African cities reside in slums. A number of countries have significantly curbed the proportion of their urban population living in slums between 2005 and 2014. These include Angola (reduction of 31 percentage points), and Sierra Leone, Rwanda, Tanzania, Nigeria, Uganda and Niger (reduction between 12 and 21 percentage points). In Lesotho, and to a lesser extent in Burkina Faso and Zimbabwe, the proportion of slum dwellers has increased over time. In 2014, of the 39 countries listed in Figure 4.3.1, more than half of urban dwellers were living in slums in 27 countries.

Displacement of populations in Africa has been usually referred to as a humanitarian and protection concern, but it is also fast becoming a developmental and public health issue of great concern. In the first half of 2017, there were more than 2.7 million new displacements across 29 African countries, largely due to conflict and violence. The countries that bear the greatest brunt include DR Congo, Ethiopia, Central African Republic, South Sudan and The Gambia[43]. Behind the numbers lie the blighted lives of people forced to leave their homes, often at a moment's notice and in the most traumatic of circumstances. Women and girls are often the most vulnerable to the devastating consequences of displacement and are subjected to multiple and intersecting forms of discrimination, violence and deprivation of rights. Gender-based violence tends to exacerbate where family and community protection structures have broken down, and this is often the case during displacement, often to the detriment of women and girls.

[42] United Nations, Department of Economic and Social Affairs, Population Division. 2017. World Population Prospects: The 2017 Revision, Volume II: Demographic Profiles (ST/ESA/SER.A/400)
[43]

Drivers of migration include urbanization, poor governance, environmental degradation, water scarcity, food insecurity and climate change, are key underlying causes of irregular migration within and from Africa.

The Kampala Convention for the protection and assistance of Internally Displaced persons (IDPs) of 2009, highlights the specific needs of separated and unaccompanied children, female heads of household, expectant mothers, mothers with young children, the elderly and the disabled. It highlights that steps must be taken to protect displaced people against causes of displacement like; sexual and gender-based violence, harmful practices, recruitment of children as well as human trafficking and smuggling

b. Implementation: Examples of Policies, Best Practices and Challenges

Central Africa: Forced migration is often triggered by local events within the political milieu of a country. However, once people leave, getting them to return home following an improvement in the situation can prove challenging. For example, in Burundi, the crises experienced during the 2015 election period provoked the movement of waves of refugees from the country to neighboring countries. Some countries, such as Gabon, continue to face challenges related to migration. One reason relates to the fact it lacks a migration policy that would allow the country to reap the benefits of international migration and handle illegal migration.

Eastern Africa: To address urbanization, the government of Madagascar developed a roadmap on migrant workforce policy, in 2017. Likewise, Ethiopia has several policies and legislations related to migration, but the country more recently developed the Growth and Transformation Plan (GTP I (2011 – 2015) and GTP II (2016-2020). Since December 2014, UNHCR has been supporting a pilot project to facilitate the return of Somali refugees to selected destinations in the Juba Valley. Returning refugees were given cash grants and core relief items to use during

the journey home. Upon return in Somalia, they were provided with reintegration assistance, comprising cash grants, food and community-based support.

Northern Africa: The Egyptian State Ministry for Migration and Welfare was established in September 2015 to manage and care for the affairs of Egyptians residing outside the geographical borders of Egypt. One of the main principles and directions for achieving sustainable habitat development according to Egypt's Vision 2030 is to prioritize the poorer sections of the population and disadvantaged rural areas when developing policies, plans for habitat development and housing. About 10% of Egypt's total population (as counted in the country's 2017 census) is living abroad, according to the Ministry of Foreign Affairs.

Southern Africa: The South African government initiated the Spatial Planning and Land Use Management Act (SPLUMA) of 2013 and Integrated Urban Development Framework (IUDF) of 2014 to provide a framework for spatial planning, land-use and urbanization management. Unfortunately, South Africa lacks data on migration, including inadequate data on the important relationship between remittances, migration and poverty alleviation, as well as little information on emigration, especially the drivers of migration among young people. This lack of migration data hampers the integration of migration into the country's development plans. Zimbabwe adopted a Diaspora Policy in 2016 in order to provide a conducive environment for diaspora engagement and participation in national development processes. Zimbabwe's action plan (2016-2019) also helps to address mixed and irregular migration. The Ministry of Home Affairs and Internal Security in Malawi also developed a comprehensive National Migration and Citizenship Policy in 2015. The Zambian Ministry of Home Affairs, in collaboration with UNHCR introduced biometric registration in 2017, making it easier to track and manage asylum caseloads.

Western Africa: Between the post-election crisis of 2010 and 31 December 2017, nearly 26,748 Ivorian refugees have voluntarily returned to Côte d'Ivoire. Approximately 8,900 were spontaneous returns and 69,142 were assisted by UNHCR. Women represent 54% of assisted returnees, 60% were minors, girls and boys. In 2016, Sierra Leone's Ministry of Labor and Social Security formulated a National Labor Migration Policy under three domains: a) good governance

of labor migration; b) the protection of the rights of migrant workers; and c) harnessing labor migration for development. The Sierra Leonean Ministry of Labor and Social Security launched a labor policy in 2018 to address irregular migration, and to foster integration/re-integration of migrants. The Liberia Immigration Service, which recognizes migration as an instrument of mutual development was also established in 2016. Ghana, on the other hand, launched a National Migration Policy in April 2016 to provide guidelines for migration governance in the country. However, the challenges of mainstreaming migration into development planning in Ghana include lack of expertise in some government agencies and inadequate financial resources to address the complex linkages between migration and development. Niger is making progressive moves to address public health issues related to migration. For instance, it adopted a Law No. 2015-36 on illegal traffic of migrants in 2015. In 2018, the country also adopted a strategy to combat irregular migration. The country's 2017-2021 report explicitly mentioned the will of the government to combat migratory flows and irregular transit through the north of the country. Niger is also currently developing a National Migration Policy document.

Figure 4.3.1. Net migration rate (per 1,000 population)

		1995-2000	2010-2015
Western Africa	Togo	3.5	-0.3
	Sierra Leone	-6.8	-0.6
	Senegal	-4.5	-1.4
	Nigeria	-0.2	-0.4
	Niger	0.5	-0.3
	Mali	-2.8	-3.7
	Guinea-Bissau	-9.9	-1.2
	Guinea	-5.9	-4.4
	Ghana	-1.3	-0.4
	Gambia	-4.6	-1.5
	Côte d'Ivoire	2.3	0.6
	Cabo Verde	-2.6	-4.3

	Burkina Faso	-2.5	-1.5
	Benin	-0.1	-0.9
Southern Africa	Zimbabwe	-3.7	-3.3
	Zambia	1.6	-0.5
	South Africa	1.4	3.0
	Namibia	4.0	-0.1
	Mozambique	-0.6	-0.2
	Malawi	-0.7	-0.4
	Lesotho	-8.2	-2.4
	Eswatini	-2.4	-1.0
	Botswana	3.0	1.4
	Angola	-1.7	0.7
Northern Africa	Tunisia	-0.8	-1.2
	Sahrawi Republic	21.4	1.1
	Morocco	-4.0	-1.8
	Mauritania	1.0	2.1
	Libya	-2.2	-14.0
	Egypt	-0.6	-0.6
	Algeria	-1.1	-0.8
Eastern Africa	Uganda	-0.4	-0.8
	Tanzania	-1.3	-0.8
	Sudan	-4.9	-3.2
	South Sudan	13.2	7.7
	Somalia	-2.4	-3.5
	Seychelles	-0.3	-4.8
	Rwanda	34.7	-1.4
	Mauritius	-1.5	-1.9
	Madagascar	-0.1	-0.1
	Kenya	-0.1	-0.2
	Ethiopia	-0.5	-0.1
	Eritrea	-4.3	-6.9
	Djibouti	3.0	1.4
	Comoros	-2.4	-2.7
Central Africa	Sao Tome & P	-12.5	-6.0
	Gabon	1.7	9.6
	Equat Guinea	12.5	16.9
	DR Congo	-4.5	0.0
	Congo	3.3	-2.6

	Chad	1.8	1.5
	Central African Republic	1.4	-17.6
	Cameroon	-0.7	-0.3
	Burundi	-14.4	-1.5

Note: Data is truncated for the sake of presentation

Source: United Nations, Population Division

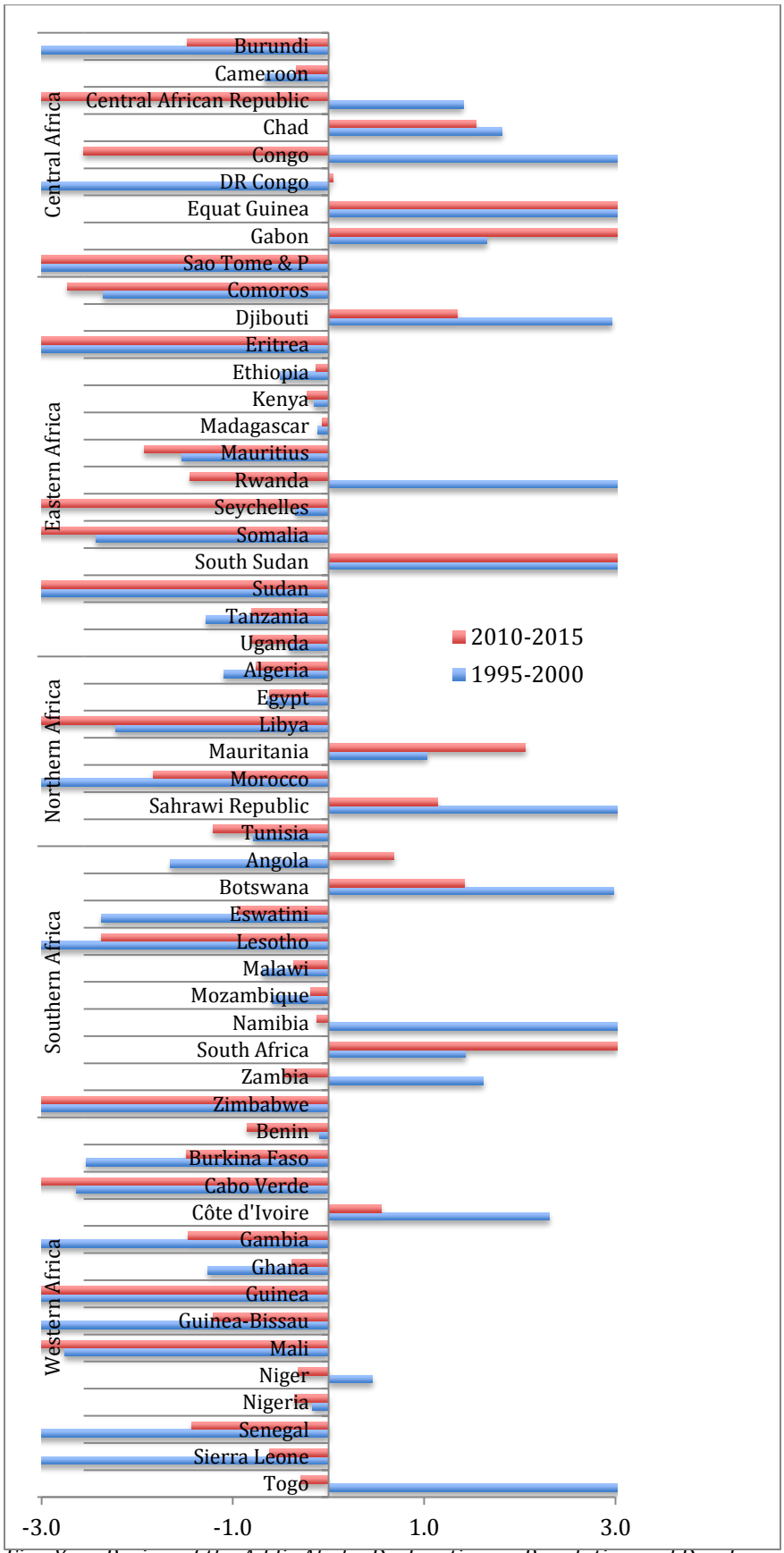
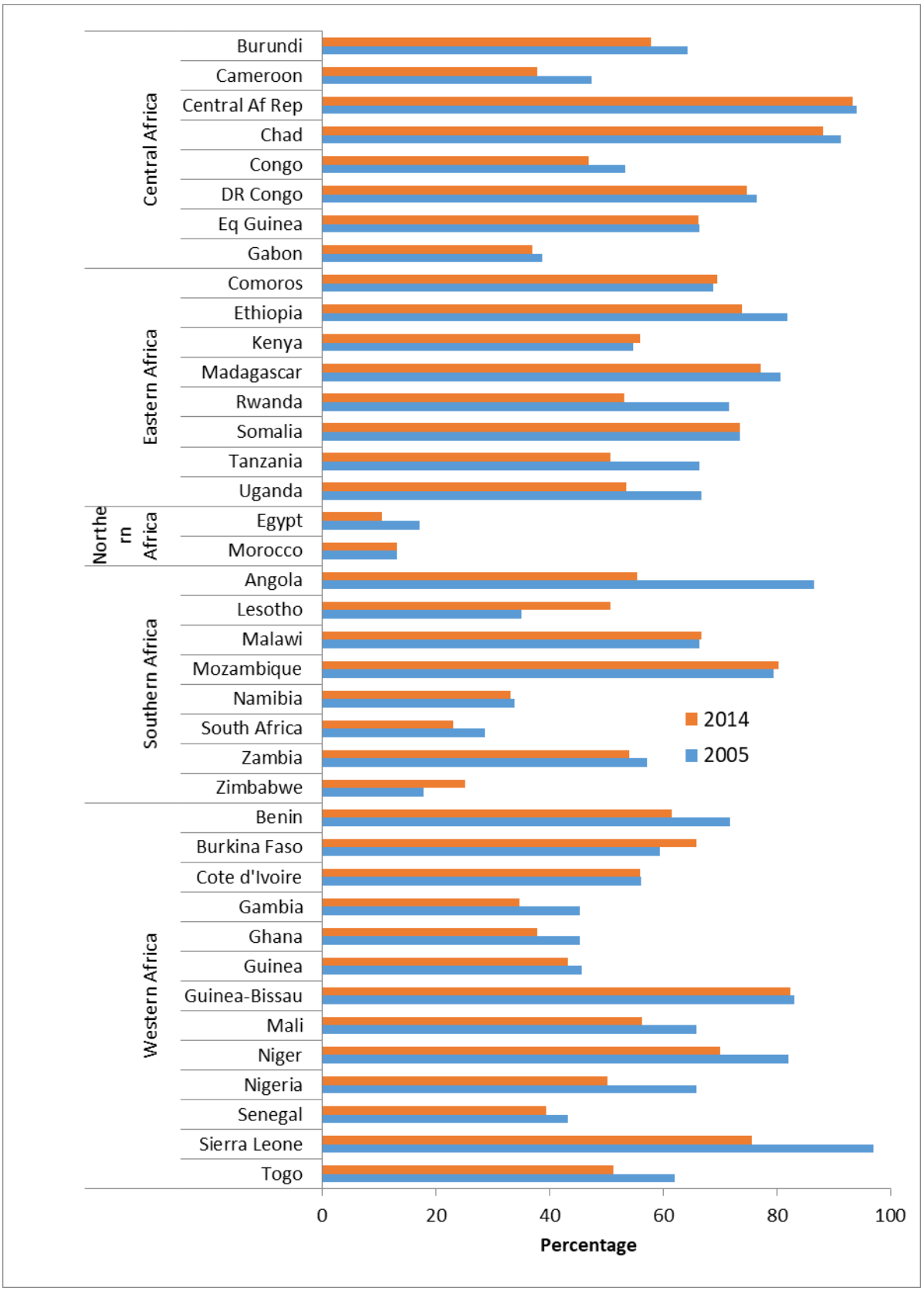

Central Africa
Eastern Africa
Northern Africa
Southern Africa
Western Africa
Burundi
Cameroon
Central African Republic
Chad
Congo
DR Congo
Equat Guinea
Gabon
Sao Tome & P
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Madagascar
Mauritius
Rwanda
Seychelles
Somalia
South Sudan
Sudan
Tanzania
Uganda
Algeria
Egypt
Libya
Mauritania
Morocco
Sahrawi Republic
Tunisia
Angola
Botswana
Eswatini
Lesotho
Malawi
Mozambique
Namibia
South Africa
Zambia
Zimbabwe
Benin
Burkina Faso
Cabo Verde
Côte d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2010-2015
1995-2000
-3.0
-1.0
1.0
3.0

Figure 4.3.2. Percentage of population living in slums


Central Africa
Burundi
Cameroon
Central Af Rep
Chad
Congo
DR Congo
Eq Guinea
Gabon
Eastern Africa
Comoros
Ethiopia
Kenya
Madagascar
Rwanda
Somalia
Tanzania
Uganda
Northern Africa
Egypt
Morocco
Southern Africa
Angola
Lesotho
Malawi
Mozambique
Namibia
South Africa
Zambia
Zimbabwe
Western Africa
Benin
Burkina Faso
Cote d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2014
2005
0
20
40
60
80
100
Percentage

Source: UN HABITAT, retrieved from the United Nations MGD database

4.3.2 Access to Services

a. Progress on Indicators

Access to safely managed drinking water services is lower in Sub-Saharan Africa than most regions of the world. However, there is noticeable progress, comparing 2005 to 2015, with more people reporting access to safely managed drinking water services. Of the countries highlighted for which data are available, the greatest progress was recorded in Tunisia, and the least in Nigeria and Uganda (see Figure 4.3.2). It is worthy to note that Tunisia achieved an expansion of 30 percentage points in access to safe drinking water, from 63% in 2005 to 93% in 2015. The progress was modest in all other countries listed in Figure 4.3.2.

Figure 4.3.3 shows huge disparities in access to electricity across and within African subregions, with Western and Eastern African countries bearing the greatest burden. Of the countries reported in the Figure, 17 recorded an increase in access to electricity between 20 and 35 percentage points. These include Kenya (+34%), Ethiopia and Eswatini (+30%). In 2016, access to electricity was universal or almost universal in all Northern African countries (Algeria, Egypt, Libya, Morocco and Tunisia) and well as in Mauritius and Seychelles. By contrast, in Burundi, Chad, South Sudan, Malawi, Central African Republic and Guinea-Bissau, electricity was accessed by only between 8% and 15% of the population.

b. Implementation: Examples of Policies, Best Practices and Challenges

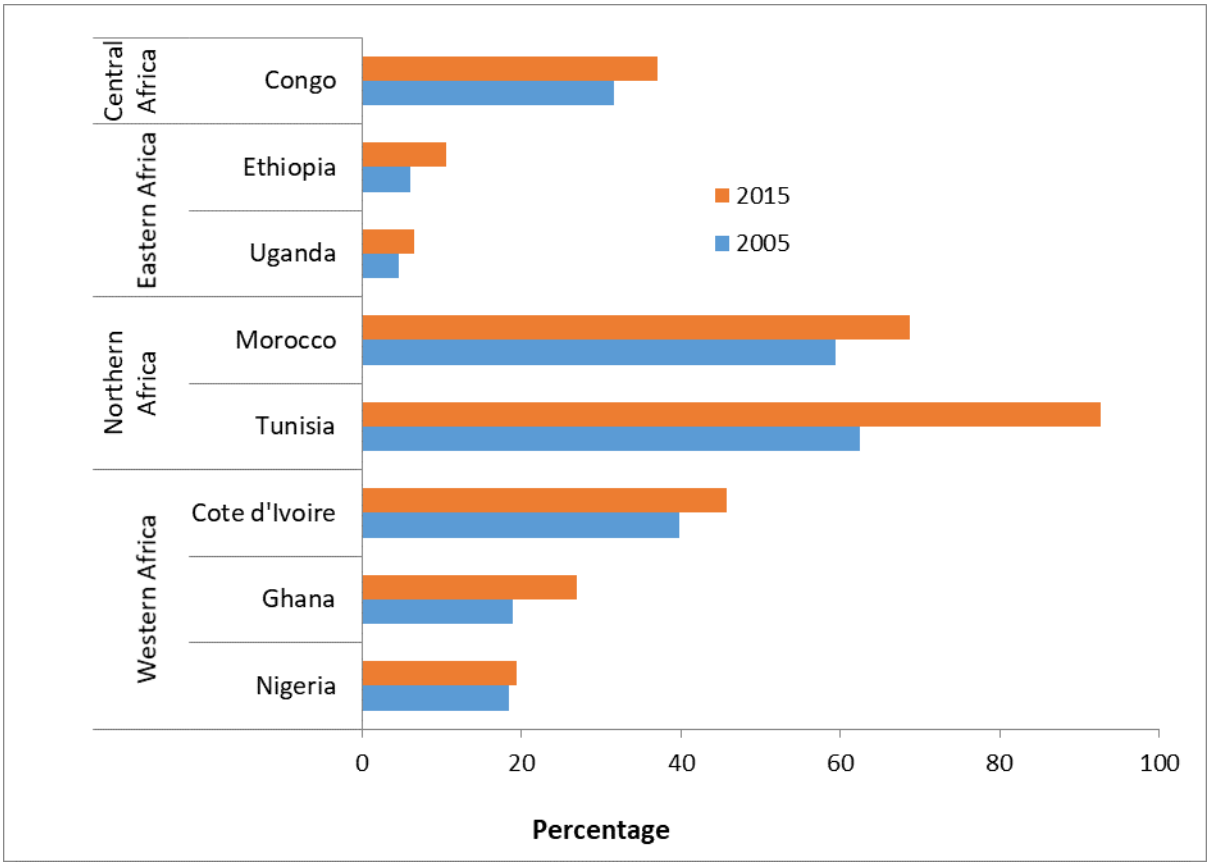
Northern Africa: The Egyptian government is adopting city planning that ensures access to health and social services to all by strengthening national and regional development planning. In 2017, 99.7% and 96.7% of urban populations had access to electricity and safe drinking water respectively, while 66.2% were connected to the sewage system.

Eastern Africa: Kenya has an extensive road network of 161,400 Kilometers. The length of roads under bitumen increased from 13,100 kilometers. The Nairobi Metropolitan Area Transport Authority (NAMATA) was created in 2017 to deal with traffic congestion within the Nairobi

metropolitan area. The Authority is expected to formulate a sustainable integrated public transport strategy based on the development of a sustainable urban mobility plan.

Western Africa: In Guinea, even though there is no migration policy, the 2016-2020 National Program of Economic and Social Development (PNDES) provides information on how to improve access to basic services (clean water, safe sanitation, electricity) in rural areas.

Figure 4.3.2. **People using safely managed drinking water services**

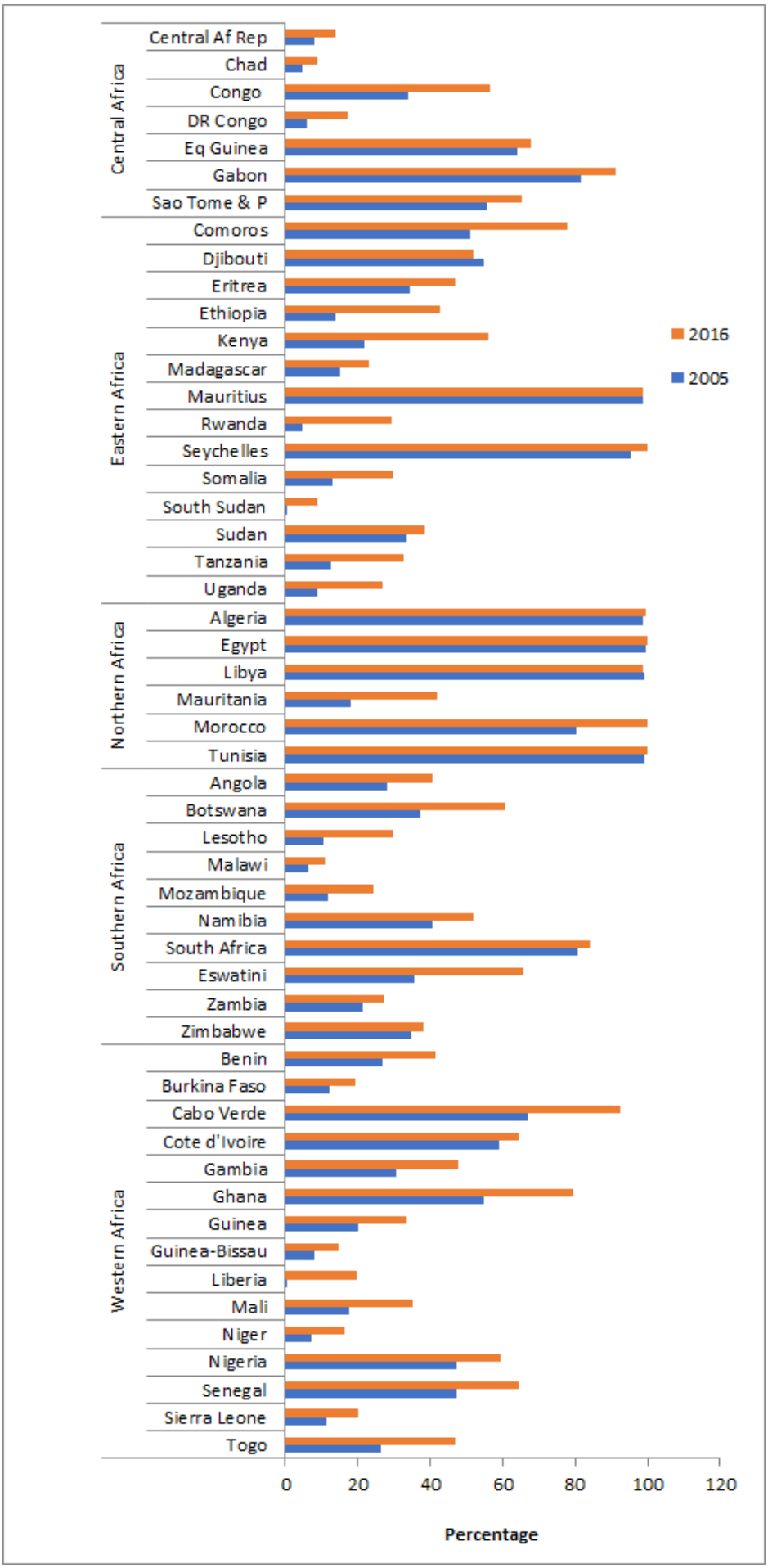


Source: WHO/UNICEF

4.3.3 Other Commitments

Burkina Faso has made progress in the environment and climate change, in the following ways: Launch of the project "ecosystem-based adaptation" in 2015; promotion of Jatropha Curcas as a sustainable biofuel in Burkina Faso since 2015. The part of renewable energies (solar, biomass, etc.) in the total energy production reached 14.3% in 2016.

Figure 4.3.3. Percentage of People with access to electricity


Central Africa
Central Af Rep
Chad
Congo
DR Congo
Eq Guinea
Gabon
Sao Tome & P
Eastern Africa
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Madagascar
Mauritius
Rwanda
Seychelles
Somalia
South Sudan
Sudan
Tanzania
Uganda
Northern Africa
Algeria
Egypt
Libya
Mauritania
Morocco
Tunisia
Southern Africa
Angola
Botswana
Lesotho
Malawi
Mozambique
Namibia
South Africa
Eswatini
Zambia
Zimbabwe
Western Africa
Benin
Burkina Faso
Cabo Verde
Cote d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Niger
Nigeria
Senegal
Sierra Leone
Togo
2016
2005
0
20
40
60
80
100
120
Percentage

Source: World Development Indicators Database/World Bank

4.4 Governance

In recent years, the governance debate has progressed in Africa. A culture of monitoring and evaluation is emerging in the implementation of population and development plans, policies and programs, but the weakness in human and organizational capacities, and the lack of disaggregated data, often limit monitoring and evaluation mechanisms. Several countries have established the "Demographic Dividend Team" (EDD), including Chad, Ghana, and Senegal, among others.

Algeria launched the Campaign against Corruption in April 2015 and developed the 2017-2030 National Plan for the Environment and Sustainable Development considering populations affected by climate change. The country has also developed a 2030 National Climate Plan 2030. Burundi has developed a prospective policy document called "Burundi vision 2025" prioritizing demographic variables. However, more political commitment is needed to develop a culture of monitoring and evaluation. Mobilization of resources for periodic collection of data to monitor public policies should also be prioritized. Chad, for instance, has insufficient availability of statistical data on governance and an inefficient monitoring of development actions. It joined the African Peer Review Mechanism in January 2013. Although countries have developed plans to integrate population indicators to the development plan, efforts are needed in generating data, including data on governance as well as a monitoring and evaluation plan of governance and development. Information from the large majority of countries reveals the need for institutionalization of public policy evaluation and accountability in all sectors (public and private) and at all levels from local to central. In an effort to strengthen the integration of population dynamics in development planning, Angola established the National Population Council, while the Zambian government created the Ministry of National Development Planning in 2016. In Ghana and São Tomé, population dynamics were integrated into the national poverty reduction program; whereas Gambia created the Population and Development Commission and established an operational Directorate of Local Governance in the Ministry of Lands and Regional Government.

The Botswana National Action Plan on the ICPD Beyond 2014 Framework is the first one after the introduction of the new framework for the next 20 years. The action plan is designed to domesticate the new ICPD Framework on Population and Development beyond 2014 and is built on five thematic pillars: dignity and human rights; health; place and mobility; governance and accountability; and sustainability. The country's Population and Development Coordination (PDC) section in the Ministry of Finance and Economic Development coordinates government and nongovernmental organizations dealing with population and development issues.

One of weakness of African countries is the gap between conception of policies and their implementation. Several countries have created a National Population Commission or National Population Council, which aim to integrate population and development. However, these structures are not operational. There is a crucial and urgent need to move from policy documents development and revision to more concrete actions for the improvement of people well-being.

4.5 Data and Statistics

Overall, several African countries recognized the importance of data to improve governance and achieve the sustainable development goals, and have made commitments to develop and support data-collection processes. However, the data systems, particularly data use remains largely poor in many countries, because of a weak statistics culture, and insufficient investments in data collection and analysis. The Civil registration and vital statistics particularly death, marriage and divorce registrations are weak in the majority of countries. The marriage and death registration could show evidence of the potential gender inequalities in terms of inheritance laws/norms, property and asset ownership laws/norms, etc.

In South Sudan, for instance, civil registration and vital statistics data are limited, and the birth registration system is operational only in few urban areas. Countries often rely on data from surveys because administrative sources, including civil registration and vital statistics and administrative data systems face several challenges. Census operations are not happening on a regular basis. Many countries have postponed the census because of lack of resources and crises.

Algeria has a better data system compared to other countries. The country has organized censuses at regular intervals: 1967, 1978, 1987, 1998, and 2008. The next census is planned for 2018/2019. Civil registration systems are equally well-developed, and several surveys, including MIC, have been conducted. The country is developing a new data systems platform integrating various government sectors and services. Tunisia has data and statistics policies, including a youth database. Madagascar has established a National Coordinating Committee in charge of the improvement of civil registration systems and vital statistics (SP-CNC CRVS). In Mauritania, birth registration increased from 58.8% in 2011 to 65.6% in 2015. Senegal has conducted several surveys, including yearly demographic and health surveys. In Sierra Leone, the National Civil Registration Act of February 2016 imposes compulsory registration of citizens. Furthermore, the country is conducting regularly censuses: 1963, 1974, 1985, 2004, and 2015. Likewise, since 1956, Eswatini has been conducting regular censuses on a ten-year basis for which the most recent was undertaken in 2017. Tanzania is preparing monitoring and evaluation policies and programs such as the 2025 Tanzania Development Vision and the Zanzibar Poverty Reduction Plan (ZPRP), in addition to regular censuses. In February 2018, Togo established a National Civil Status Observatory. It also defined the responsibilities of the National Institute of Statistics and Economic and Demographic Studies in 2015.

The Uganda 2040 Vision and Second National Development Plan (NDPII) recognizes the importance of addressing population challenges and harnessing the demographic dividend (defined under part 1 of this report). It aims to harmonize and consolidate the law on registration of people; provide for registration of individuals; establish a national identification register; establish a national registration and identification authority; and provide for the issuance of national identification cards and alien identification cards, as well as other related matters. The Ethiopian National Statistical Development Strategy (NSDS) was initially designed for five years 2010/11 – 2014/15, and it has been revised for another five years (2016-2020). Likewise, the São Tomé and Principe strategy for development of statistics 2017-2021 aims to support the development of institutional capacity. In 2017, 95% of births were registered. In the

The Namibia Statistics Policy was published in 2014 and guides the Namibia Statistics Agency (NSA) on the production of statistics that are relevant, comprehensive, timely, trustworthy,

accessible and focused on meeting the needs of government, research institutions, business and the public at large. The first NSA Strategic Plan ended in March 2017, culminating in the development of the new Strategic Plan covering the period 2017/18–2021/22.

4.6 Partnerships and International Cooperation

Eastern Africa: In Ethiopia in 2013, the country made history by releasing its first ever "Foreign Affairs and National Policy and Strategy of the Federal Democratic Republic of Ethiopia," a document that clearly defined the country's foreign policy and diplomacy. Kenya, on the other hand, has continued to play its rightful role in fast-tracking the East African Community (EAC) integration through the full implementation of the provisions of all common instruments.

Northern Africa: During Egypt's 2017 population census, there was broad cooperation and collaboration between the government and CSOs. Furthermore, the private sector was included in the consultations, and representatives of the private sector were made members of the high-level steering committee.

Western Africa: Senegal continues to strengthen partnerships with civil society organizations and other national and international networks in order to advance population and development matters.

In Ghana, challenges to international cooperation and partnerships include financial constraints, lack of transportation and communication infrastructure in rural areas, lack of storage facilities in rural communities, a weak national economy, control of local NGOs by parent NGOs, tensions between State institutions and NGOs, lack of participation in decision-making by beneficiaries of NGO projects and programs, use of NGOs for political and personal gain. Mali is still grappling with forging lasting international partnerships. In 2017, Mali was ranked 146th place out of 189 countries with regard to business facilities.

Southern Africa: In Namibia, the United Nations Country Team (UNCT) has used the United Nations Partnership Framework (UNPAF) as the vehicle for strategic partnership and resource planning over the years, the most recent one covering the period 2014–2018. Through UNPAF, UNCT seeks to focus on supporting the development of capacities of national institutions;

fostering multidisciplinary approaches to development; strengthening knowledge generation and management; promoting standards, norms and accountability mechanisms; and providing high-quality technical expertise and policy advice.

Appendix 4.1. Commitments by theme - Substantive Pillars

Pillar/Theme	**Commitments**	**Indicators of focus**
1. Dignity and Equality	**1-30**	
1.1. Poverty and Inequality	1 & 2	– % population living on less than USD 1.90 a day – Multidimensional Poverty Index (MPI) measures – Gini coefficient
1.2. Gender inequality: Promoting women and youth empowerment	3, 4, 5, 6, 7, 8 & 9	– Gender disparities at primary and secondary school levels – % women who have a say in household decisions – Women's parliamentary representation
1.3. Child nutrition and mortality	10	– Prevalence of stunting among children under 5 – Child mortality
1.4. Women's rights and gender-based violence	13, 14, 15 & 16	– % Women (15-49) who have undergone FMG – % Ever-partnered women and girls >15 ever subjected to physical, sexual or psychological violence – % women and girls subjected to sexual violence
1.5. Universal access to quality education for all	11, 12, 19 & 20	– % children completing primary school – % children completing secondary school – Gender parity in enrollment and primary and secondary school completion

1.6. Welfare and longevity, healthy aging, and lifelong learning for older people	23, 25, & 26,	– Life expectancy
1.7. Other Commitments	17, 18, 21, 22, 24, 27, 28 & 29	
2. Health	**30-46**	
2.1. Sexual and reproductive health rights	34, 35, 36, 41, 42, 45 & 46	– Unmet need for family planning – Demand for family planning satisfied by modern methods – Modern contraceptive use
2.2. Adolescent sexual and reproductive health	38, 40, 42 & 44	– Adolescent fertility – % women 20-24 married or in a union before age 18 – Percentage of women aged 20-24 who gave birth before age 18
2.3. Maternal mortality	37, 38 & 39	– Maternal Mortality Ratio – % births attended by skilled personnel
2.4. HIV and AIDS, malaria and other infectious diseases	33 & 43	– Prevalence of HIV
2.5. Burden of noncommunicable diseases	30	– Causes of deaths – Mortality rate of noncommunicable diseases
2.6. Health systems strengthening	30, 31 & 32	– Coverage of social insurance programs
3. Place and Mobility	**47-65**	
3.1. Living conditions of people in urban and peri-urban areas	47, 52, 53 & 54	– % population living in slums
3.2. Access to services	57, 58 & 66	– % People with access to electricity
3.3. Other commitments	48, 49, 50, 51, 55, 56, 59, 60, 61, 62, 63, 64 & 65	None (readily available)

Appendix 4.2. Available AADPD National Report Syntheses (as of Aug 22, 2018)

Region	Country
Central Africa [9 countries in total]	1. Burundi 2. Cameroon 3. Chad 4. Central Af Rep 5. Congo 6. DR Congo 7. Eq Guinea 8. Gabon 9. São Tomé & P.
Eastern Africa [11 countries in total]	1. Comoros 2. Ethiopia 3. Kenya 4. Madagascar 5. Mauritius 6. Rwanda 7. Somalia 8. South Sudan 9. Sudan 10. Tanzania 11. Uganda
Northern Africa [5 countries in total]	1. Algeria 2. Egypt 3. Mauritania 4. Sahrawi Republic[44] 5. Tunisia
Southern Africa [10 countries in total]	1. Angola 2. Botswana 3. Lesotho 4. Malawi 5. Mozambique 6. Namibia 7. South Africa 8. Eswatini 9. Zambia 10. Zimbabwe
Western Africa [14 countries in total]	1. Benin 2. Burkina Faso 3. Cabo Verde 4. Côte d'Ivoire 5. Gambia 6. Ghana 7. Guinea 8. Liberia 9. Mali 10. Niger 11. Nigeria 12. Senegal 13. Sierra Leone 14. Togo
Total (n=55) [45]	**49**

[44] A 9-slide PowerPoint presentation entitled "Indicadores de Salud 2016-2017"

[45] The six (6) reports not included in the review are from Djibouti, Eritrea, and Seychelles (Eastern Africa); Libya and Morocco (Northern Africa); and Guinea-Bissau (Western Africa)

Chapter 5: Macro-Level Review of AADPD Progress

5.1 AADPD Achievements and the Demographic Dividend

5.1.1 Stakeholder Mobilization around the DD on the Continent

During the five-year AADPD implementation period (2013 – 2018), there has been an increasing amount of scientific literature on the prospects and the conditions for the African continent to harness the demographic dividend[46]. To foster the leadership of African research institutions[47] on this timely topic of the demographic dividend, the UNFPA Technical Division organized a "Regional Leadership Summit on African Demographic Dividend" in Abuja (Nigeria) from March 7-9, 2016.

The demographic dividend has been a major focus of UNFPA over the past years. In collaboration with other regional organizations, UNFPA has organized a series of meetings, and worked with research institutions (e.g., CREFAT, AFIDEP) to generate evidence on the demographic dividend[48]. UNICEF, with its focus mandate on children and adolescents has also contributed to the discourse, and particularly with regard to drivers (e.g., girls' education, or obstacles (child marriage, FGM, early pregnancy, school drop out). The East-West Center's National Transfer Account (NTA) project in collaboration with the Center of Economics and Demography of Aging

[46]Examples of publications include: Canning, D., Raja, S.; Yazbeck, A. S. (2015), *Africa's Demographic Transition: Dividend or Disaster?* Africa Development Forum ; Groth, Hans, May, John F. (Eds.) (2017), *Africa's Population: In Search of a Demographic Dividend*, Springer; Dramani L, Oga I (2017), "*Understanding demographic dividends in Africa: the NTA Approach*," *Journal of Demographic Economics*, Volume 83(1), pp 2832 – 2847; Tenikue, M. Yao S. K., Mouté C. et Zinvi D.D. F. (2018), *Le Dividende Démographique en Afrique. Premiers signes et estimation par la méthode de décomposition,* Réseau FRANET/IUSSP*;* Eloundou-Enyegue P. *et al.* (Forthcoming)*, Le dividende scolaire en Afrique,* Réseau FRANET/IUSSP*.*

[47] Some research institutions and networks have been active over the past years in the production of evidence on the DD on the continent: the Francophone Network (FRANET) organized around IFORD (Cameroon) and ISSP (Burkina Faso) with the technical support of the Cornell University has started its work on the DD in 2013; CREFAT with its support to SWEDD countries (since 2015), AFIDEP, with its technical support to countries in East and Southern Africa (since 2014).

[48] See AFIDEP and UNFPA (2015). *Synthesis Report on The Demographic Dividend in Africa.*

at the University of California Berkeley has conducted a series of studies in seven African countries. The project is supported by the U.S. National Institute on Aging, the Bill and Melinda Gates Foundation, the International Development Research Center (IDRC), the United Nations Population Division, UNFPA, and the European Science Foundation. The Francophone Network (FRANET), set up by the International Union for the Scientific Studies of the Population (IUSSP) with support from the Hewlett Foundation, has conducted a series of studies on the demographic dividend since 2013. The World Bank has been very active on the demographic dividend agenda, and a few years ago, in collaboration with UNFPA, and in partnership of the Bill and Melinda Gates Foundation, it launched the Sahel Women's Empowerment and Demographic Dividend (SWEDD) project which covers five countries. USAID initiatives include, among others, the work from the Population Reference Bureau (PRB) under the IDEA project in popularizing the demographic dividend agenda through advocacy materials. They also include the DemDiv software developed by the Futures Group under the Health Policy Project (HPP). The Institut de Recherche pour le Développement (IRD), The Initiatives Conseil International (ICI) and the Agence Française de Développement (AFD) have also conducted a series of studies in the West Africa Economic and Monetary Union (WAEMU). The Hewlett Packard Foundation and the Bill and Melinda Gates Foundation have supported PRB and the Bill and Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins University on the development of a knowledge sharing platform on the demographic dividend.

At the continental level, there have also been commitments from various regional bodies, including the African Union Commission (AUC), the United Nations Economic Commission for Africa (UNECA), and the African Development Bank (ADB). In collaboration with other institutions, they have organized various high-level meetings in marge of AU Summits and UNGA with the Head of States for increased awareness around the demographic dividend and to ensure stronger political commitments, which was culminated with the elaboration of the AU DD roadmap-"harnessing the demographic dividend through investments in youth".

The AU roadmap has been launch in the majority of countries and the demographic dividend has been integrated into the national development plan and strategies across Africa .

5.1.2 Political Commitments on DD at the Regional and Continental Levels

There has been an increasing commitment at various high-level meetings, and from a range of stakeholders, to ensure that the continent reaps the benefits of the demographic dividend. These include:

- The African Union "Agenda 2063" set up on the 50th anniversary of the AU with a central focus of leveraging the youth bulge to capture the demographic dividend and facilitate the emergence of Africa in the next 50 years. The Agenda 2063 stresses that failure to harness the demographic dividend is one of the main threats to realizing the "Africa We Want."
- AUC/ECA Joint Conference of Ministers of Finance, Planning and Economic Development in 2013, 2015 and 2016.

African Regional Conference on Population and Development: ICPD beyond 2014 (Addis Ababa, Sept. 30 – Oct. 2, 2013) "Harnessing the Demographic Dividend: The Future We Want for Africa."

- African Union (AU) High-Level Committee of Heads of State and Governments on the Post-2015 Development Agenda launched the Common African Position (CAP) and adopted the N'Djamena Declaration on the CAP, Ndjamena, February 28, 2014.AU Specialized Technical Committee (STC) on Health, Population and Drug Control, 2015
- AU Heads of State and Government High-Level Event on demographic dividend during UNGA 70
- Second General Assembly of the Forum of African Parliamentarians on Population and Development (APF) in Abidjan, 16-19 March 2014
- 28th AU Summit (Addis Ababa, 22-31 January 2017) on "Harnessing the Demographic Dividend through investments in Youth."
- The ECOWAS Parliamentarians' Declaration at the regional conference on "Adequate Financing of Health and Demographic Dividend," Ouagadougou, July 22, 2017.
- The Regional Forum on "The Role of Religious and Traditional Leaders for Capturing the Demographic Dividend," Ouagadougou, July 24-26, 2018.

5.1.3 Summary of Evidence on DD

This sub-section provides the key findings of the synthesis of evidence on the demographic dividend in Africa. Further details can be found in Appendix 5.1.

a) Demographic Dividend Profiles in Western and Central Africa using National Transfer Accounts (NTA)

With support from UNFPA West and Central Africa Regional Office (WCARO), the Research Center for Economics and Applied Finance (CREFAT)[49] conducted a series of studies on the demographic dividend in Western and Central Africa, following which 19 countries produced their demographic dividend profile[50].

The objective of the work is to estimate the economic gains from the changing age structure according to different fertility trend scenarios. By determining the trend in the economic support ratio (number of actual workers over the number of actual consumers), it is possible to understand the timing of the opening of the window of opportunity of the demographic dividend and its policy implications. The current review summarizes the work conducted in the 15 ECOWAS (Economic Community of West African States) countries.

Main Findings

The aggregate consumption of ECOWAS is estimated at USD 486.15 billion in 2014. Individuals aged 0-30 years have a consumption level of 308.80 billion, which accounts for 64% of the total consumption. The relatively high share of this consumption is the consequence of the size of the

[49] CREFAT is a research center created in 2012 at the University of Thiès in Senegal. It is composed of 5 divisions of research, including i) Finance and development; ii) Social and Economic Policies; iii) Applied Economics; iv) Industrial Economy; v) Generational Economy and Regional Integration.

[50] Benin, Burkina Faso, Cabo Verde, Cameroon, Central African Republic, Côte d'Ivoire, Gabon, Ghana, Guinea, Guinea Bissau, Equatorial Guinea, Mali, Mauritania, Niger, Nigeria, São Tomé and Principe, Senegal, Chad, and Togo.

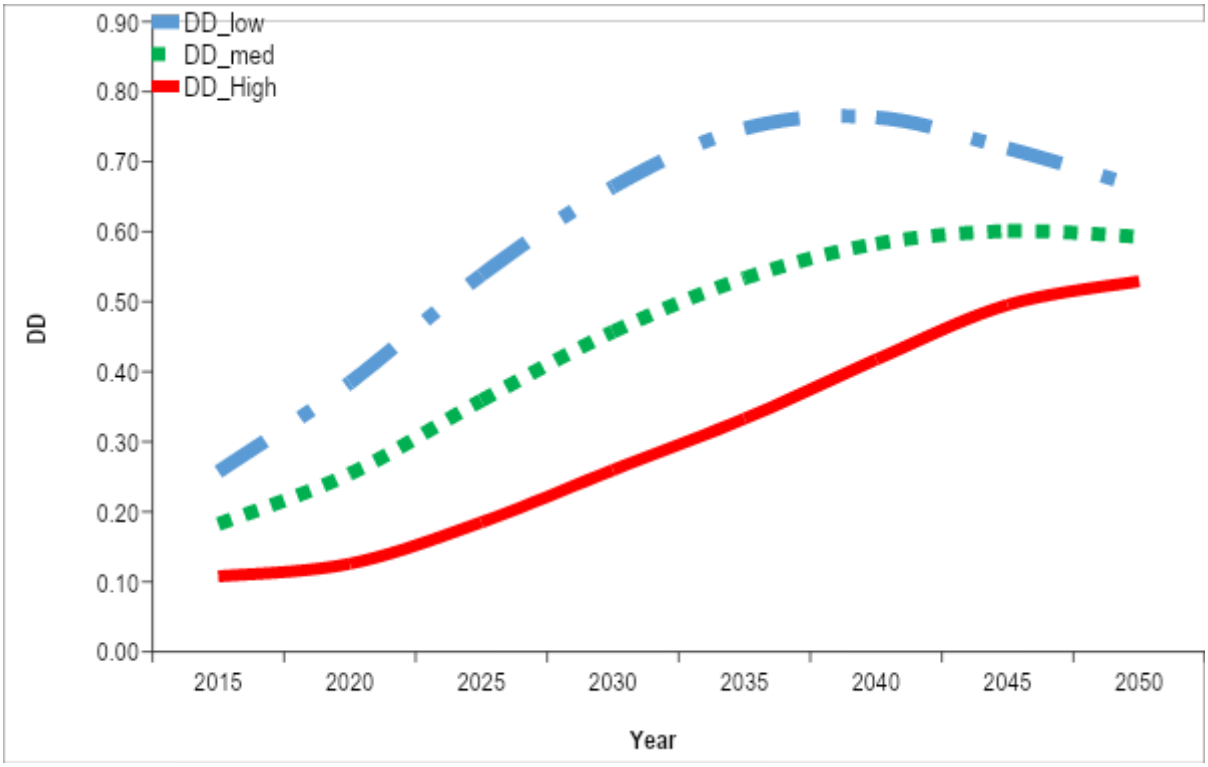
population of this age group (73% of the total population of ECOWAS). Aggregate consumption of adults aged 31-62 years is estimated at USD 154.21 billion (32% of total consumption). For people over 62 years, the share of their consumption represents only 5% of the total (amounting to USD 23.14 billion). At birth, children have an aggregate consumption of 8.59 billion. This consumption increases with age and reaches its maximum value of 11.58 billion at the age of 17 years. It then gradually decreases from 18 years and falls to less than 0.10 billion among those aged 80 years or older.

In terms of aggregate labor income, the related figure rises from USD 0.02 billion for 5year-olds to USD 9.6 billion for 41 years old and falls thereafter. It stabilizes below USD 0.10 billion for each age over 80 years. The labor income generated by all individuals aged 0-30 years old amounts to USD 55.16 billion, which represents 18% of total labor income. Thus, with a consumption of USD 308.80 billion, the 0-30 age group has a deficit of USD 253.64 billion. Seniors (63 years and over) also have a deficit of USD 8.87 billion, which is much lower than that of children and young people. In addition, the aggregate deficit profile (Figure 5.1.3b in Appendix 5.1), shows that, of all ages, 17-year-olds have the largest aggregate deficit. Indeed, the deficit increases with age from birth, but reaches its highest level at age 17 with a value of USD 10.97 billion, and thereafter the deficit enters a phase of decline.

Figure 5.1.1 gives the prospects for the DD in the ECOWAS region according to the three fertility trend scenarios of the Population Division of the United Nations (CREG-CREFAT, 2017). With the low fertility scenario (curve in blue), there is an increase in the first demographic dividend with a slope greater than the other two curves. The curve thus increases rapidly until reaching its maximum value (0.76) around the year 2040. From 2045, it approaches a declining phase. The first phase is a situation where the population structure can raise GDP per capita if appropriate actions are taken by the countries. These actions must be carried out intensively over the period in order to reap the maximum benefit and overcome the difficulties of the next phase. Indeed, this decline in the first demographic dividend after 2045 reveals that the population structure will no longer be a potential but rather a constraint for economic growth. But this should be

controlled if, for example, workers once retired have the resources from their savings to meet their expenses which could lead to the second demographic dividend.

Figure 5.1.1. Prospects for the DD in the ECOWAS region according to the three fertility trend scenarios of the Population Division of the United Nations



Source: CREG-CREFAT (2017).

Policy Implications

The opening of the window since 2002 reflects the need to adapt the policies already implemented and invest in the drivers of the demographic dividend, namely, education with appropriate skills, health, including access to sexual and reproductive health and family planning, women and girls' empowerment and the labor market with decent job, etc. The priority given to women, education and youth in the ECOWAS 2020 Vision is welcome and needs to be strengthened and extended to other key sectors. More specifically:

- Given the high population growth of the region, which modifies the supply of labor and employment, and leads to a high dependency ratio, it is necessary to have an education

system that is adapted to the needs of the labor market and set up a business incentive environment.

- Conduct a study in each member country to identify prospects for a better match between education/training and the needs of the national economies. Such a study should provide recommendations to guide investments in education/training and identify economic sectors that create employment.
- Empower young people to fully participate in economic life in all sectors, as this is essential for building strong economies, achieving sustainable development goals, and improving their quality of life. Create jobs for young people and provide resources for women, as these will have significant implications for the development and acceleration of economic growth.
- Encourage and promote the empowerment of women through the promotion of income-generating activities, raise awareness on gender equality in business, engage companies within the same economic branch to undertake a reflection on the skills needed.
- Implement targeted actions for the control of fertility (family planning, elimination of child marriage, FGM, improvement of girls' education).

b) Demographic Dividend Profiles in Eastern and Southern Africa Using the NTA and the DemDiv Model

DemDiv is a projection model of the demographic dividend potential and the identification of the policy and sectoral investments needed to reap the maximum benefit[51]. With the technical support of AFIDEP[52] and financial support from UNFPA, countries in the Eastern and Southern Africa (ESA) region have developed national demographic dividend profiles at a time when

[51] DemDiv was created by the Health Policy Project, with support from USAID. See Morelan *et al.* (2014).

[52] The African Institute for Development Policy (AFIDEP) is an African-led, regional nonprofit policy think tank established in 2010 to help bridge the gaps between research, policy and practice in development efforts in Africa. It analyzes, synthesizes, and translates evidence (i.e., data and research) and uses it to generate or strengthen political commitment, inform resource allocation, program design and implementation. The aim is to contribute to the realization of sustainable development by enabling the formulation of sound policies and program interventions.

countries are embracing the post-2015 Sustainable Development Goals. Countries within the ESA region that have been supported in developing their national profiles are about to embark on the preparation of their national development plans and, also, in other cases, their long-term development strategy. The key question that has not been examined in depth is how each country's population age structure would affect its development trajectory to become a prosperous middle-income or a high middle-income country, depending on where the country is currently.

The primary objectives of the proposed study are to assess the country's prospects for harnessing the demographic dividend and to demonstrate priority policy and program options that the country should adopt to optimize its dividend in the light of its development aspirations. The specific objectives of the study are to:

i. Review the countries' demographic and economic opportunities and challenges, and assess their implications for the attainment of their development aspirations;
ii. Assess the prospects for harnessing the demographic dividend in each country using the DemDiv Model or NTA model based on the total fertility rates and availability and quality of data; and
iii. Demonstrate policy options for optimizing the demographic dividend that can be earned in a country.

Main Findings and Policy Implications

The use of the NTA in four Southern Africa countries (Botswana, Namibia, Eswatini, and Zimbabwe) shows lifecycle patterns similar to those observed in Western Africa where consumption is quite high at the young ages, while labor income peaks in the 30s and 40s[53]. Based on the trend in the rate of change of the support ratio, all four countries were already harnessing the first demographic dividend by 1990, but at a different pace and magnitude. The study also shows that the estimated potential cumulative increase in living standards from the first demographic dividend between 1990 and 2060, and using the medium fertility variant of the UN

[53] Onyango *et al. (*2018)

population projections, amount to 41%, 36%, 33% and 32% respectively for Eswatini, Botswana, Namibia, and Zimbabwe.[54]

Demographic Dividend modeling using DemDiv for various countries in general show better economic outcomes when an integrated investment approach is used for both demographic outcomes such as population growth and dependency burden, and for economic outcomes such as GDP and employment gap. For example, the DD study in Uganda[55] shows that using the more integrated policy investment in all pillars as envisioned in Uganda's Vision 2040, the GDP per capita will attain USD 9,567 by 2040 as compared to USD 927 for the "business as usual" hypothesis.[56]

Table 5.1.1 summaries the policy implications of the DD evidence in Eastern and Southern Africa.

Table 5.1.1. The Demographic Dividend (DD) status and actionable policy recommendations for ESA region

DD Stage	Countries	Policy Priority	Recommendations
Pre-dividend Fertility levels above 4; rapid population growth, high dependency ratios, however, are expected to decline when children reach working age.	Angola, Burundi, Comoros, Democratic Republic of the Congo, Eritrea, Madagascar, Malawi, Mozambique, South Sudan, Tanzania, Uganda, Zambia	- Improve human capital to reduce fertility	- Improve maternal and child health - Expand education - Not leave girls behind - Empower women - Expand comprehensive FP services
Early-dividend Fertility rates fallen below 4 and the working-age share of the population is likely rising.	Botswana, Ethiopia, Kenya, Lesotho, Namibia, Rwanda, South Africa, Eswatini, Zimbabwe	- Accelerate job creation - Create productive jobs for the growing	- Invest in human capital, including technical and vocational education and training (TVET)

[54] Onyango *et al.*(2018)
[55] NPA and UNFPA (2014) quoted by AFIDEP and UNFPA (2015).
[56] AFIDEP and UNFPA (2015)

		share of the population in working age to reap the first DD	- Reduce barriers to female labor force participation (LFP) - Strengthen conditions conducive to savings and job creation
Late-dividend Fertility rates are typically above replacement levels of 2.1, but fertility continues to decline. Even though they have shrinking working-age shares, their overall age structures are still favorable for the first DD.	Mauritius and Seychelles	- Sustain productivity growth - Create conditions necessary to reap the second DD - Prepare for aging	- Continue mobilization of savings for productive investment - Ensure that public policies encourage LFP for both sexes - Design cost-effective systems for welfare vulnerable elderly

Source: Countries DD reports supported by AFIDEP and UNFPA-ESARO

c) Schooling Dividend

Since 2013, the FRANET network[57] has focused its research on different facets of the demographic dividend, including the Schooling Dividend (SD) using decomposition methods[58]. The objective of the work on the Schooling Dividend (SD) is to evaluate what has been the contribution of the decline in fertility and the change in age structure, in terms of gain in education using a retrospective approach over the period 1995-2010.

The effect of fertility decline on schooling operates through the change in age structure[59]. This process is gradual and includes four major steps. First, the decline in fertility induces a change in

[57]The Francophone Network (FRANET) was set up in 2009 by the International Union for the Scientific Study of the Population (IUSSP) with the support of the Hewlett Foundation, to reinforce capacity building of researchers and research institutions in Francophone Africa.

[58] Eloundou-Enyegue, P. *et al.* (Forthcoming)*, Le dividende scolaire en Afrique,* Réseau FRANET/IUSSP.

[59] Mason and Lee (2005), Bloom and Canning (2008), Eloundou-Enyegue *et al.*(2013).

the age structure. Second, the change in age structure reduces economic dependence. The third step establishes the link between the reduction of economic dependence and the resources allocated per person of school age. Finally, the resources allocated to education are reflected in secondary schooling. The investigation into the future earnings of a schooling dividend is based on the combination of population projections with the different fertility scenarios of the United Nations, and assumptions about past trends in the share of the education budget in the national income. A total of 39 countries were covered in the study (see Appendix 5.1 for the list of countries).

Main Findings:

Since the demographic transition is well advanced in Northern and Southern Africa, the beginning of the window of opportunity started earlier in many countries in these two regions. In Northern Africa, four out of six countries have passed all the stages for the production of the schooling dividend, while in Southern Africa, all five countries studied have successfully completed all the stages. Half of the eight countries in Central Africa, seven out of eight in Western Africa, and seven out 11 in Eastern Africa, have validated all the stages of the schooling dividend process.

In terms of schooling dividend, in Northern Africa in general (for five countries out of the six), the change in age structure is the main source of variation in public allocation per child. The effect of political commitment on education remains relatively low. The same pattern is observed in Southern Africa where in four out of five countries, the demographic factor is the main source of explanation for the observed gains in the allocation per child. In Central Africa, in general, the demographic factor and the economic performance are the sources of the gains observed in terms of allocations per child. Political commitment to education tends to have a negligible effect. In Western Africa, the schooling dividend is partly due to the effect of the change in age structure and political commitment to education. Finally, in the majority of Eastern African countries, economic performance is the main source of the change in public allocation per child over the period, at the expense of the demographic factor and political commitment.

Based on the optimistic assumption and year 2010 as the baseline, the expected gains by 2035 in Northern Africa will be multiplied by a factor ranging from about 1.3 (Libya) to 34.7 (Sudan) as

compared to a factor ranging between -0.1 (Egypt) to 6 (Sudan) under the pessimistic assumption. In Southern Africa, the gains by 2035 will be ranging from 0.3 (Lesotho) to 3.1 (South Africa) under the optimistic assumption, as opposed to -0.8 (Lesotho) to -0.3 (South Africa) under the pessimistic hypothesis. In Central Africa, the expected earnings multiplier under the optimistic assumption ranges from 1.6 (Gabon) to 93.3 (Equatorial Guinea), as opposed to -0.5 (Gabon) to 17.3 (Equatorial Guinea) under the pessimistic assumption. In Western Africa, the gains will be multiplied by a factor of about 1.2 (Côte d'Ivoire) to 6.1 (Cabo Verde) under the optimistic assumption and, on the other hand, this factor will range from -0.6 (Côte d'Ivoire) to 0.4 (Cabo Verde), under the pessimistic assumption. In Eastern Africa, expected public endowments per child will be multiplied by a factor ranging from -0.1 (Burundi) to 15.6 (Ethiopia), under the optimistic assumption. However, under the pessimistic assumption, this factor will be ranging from -0.8 (Burundi) to 2.1 (Ethiopia).

Policy Implications:

The policy implications vary from one region to the other and can be summarized as follows (see Appendix 5.1 for more details):

- Set up policies to boost change in age structure;
- Reorient reproductive health policies to address unmet need for family planning and promote and raise awareness of family planning;
- Take measures to increase the budget allocated to education to at least 8% of national income;
- Improve the supply of education using the resources already generated;
- Strengthen employment policies by improving the work conditions of employees, and by developing in-service training programs;
- Take additional measures to continue boosting economic performance;
- Improve the supply and quality of employment with the aim of developing skills to increase productivity and per capita income;
- Reform the education sector to better match training with the needs of the labor market;

- Develop effective strategies for the professional integration of young people and self-employment in growth sectors;
- Continue efforts to improve school enrollment and retention (at least at the secondary level).

5.1.4 From Evidence to Action

During the 72nd Session of the United Nations General Assembly in September 2017, a side event was organized on "Demographic Dividend Roadmap for Africa: Moving from Commitment to Action." In all the regions of the continent and across countries, there continues to be more and more strong buy-in of the demographic dividend roadmap. Below we present a few examples:

a) In Western and Central Africa

Nineteen countries have produced their NTA demographic dividend profile; seven out of these (Burkina Faso, Cabo Verde, Côte d'Ivoire, Mauritania, Niger, Senegal, and Togo) have integrated the results of the demographic dividend profile into their development plans; and Ghana has integrated demographic dividend strategic priority areas of the AU Demographic Dividend Roadmap into the guidelines for sectorial and local government development plans. In addition, a demographic dividend observatory was set up in six countries in Western Africa. At the core of these observatories, a demographic dividend monitoring index is implemented and followed up. Between 2015 and 2017, 17 country teams were trained to measure the demographic dividend and 17 have a national demographic dividend technical team.

b) In Eastern and Southern Africa

Zambia's 7th National Development Plan was informed by the 2015 demographic dividend study. Namibia has also integrated the findings of the demographic dividend studies into its 4th National Development Plan. Rwanda developed its National Demographic Dividend Profile beginning in March 2017 and the final report was published and disseminated by the government in December 2017. The findings and key recommendations from the Rwanda profile have been integrated into Rwanda's National Strategy for Transformation, 2017-2024. Findings of the national DD profile have also been incorporated into the development of the Rwanda Health

Sector Strategy, 2018 -2024. In Malawi, the National DD profile has also informed several national processes and plans, including the Malawi Medium-Term Plan, and the Malawi Growth and Development Strategy III. Kenya developed its DD Roadmap in 2017 in response to an AU decision that member states should develop their DD roadmaps and operationalize their own DD agenda. In Zambia, the 7th National Development Plan (2017-2021) has adopted the DD framework in its strategic goals.[60]

5.2 AADPD Related Policy Change and Institutional Arrangements

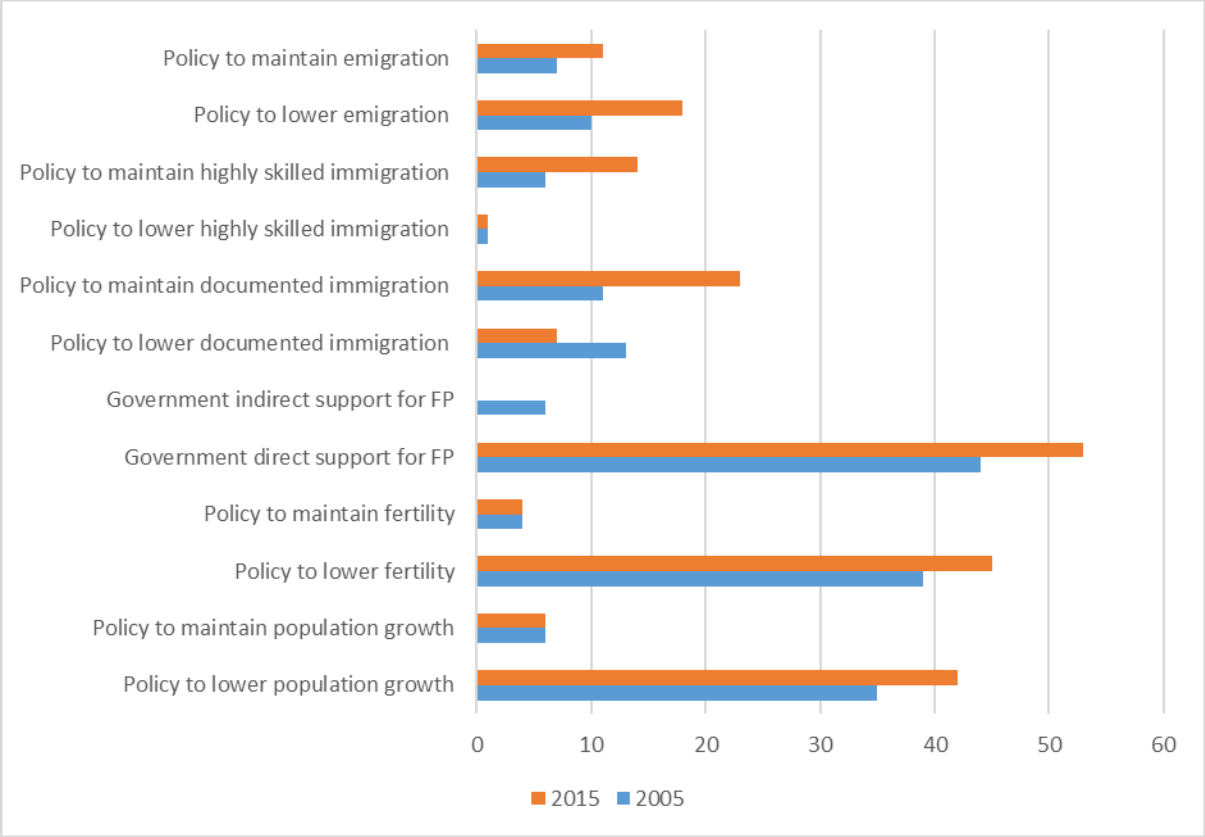
This section uses data from the 2015 update of the United Nations World Population Policies Database. The database shows governments' views and policies on population size and growth, population age structure, fertility, reproductive health and family planning, health and mortality, spatial distribution, and internal and international migration[61]. Data for the years 2005 and 2015 were downloaded, and relevant variables collected at both periods were converted into Excel and tabulated.

5.2.1 Overview of Advances in AADPD Related Policy Change

Figure 5.2.1 Number of African countries with specific population policies

[60] Alhassan *et al.* (no date), *Operationalizing the Demographic Dividend into Development Planning Processes: case studies from four countries in the East and Southern Africa Region.*

[61] World Population Policies: https://esa.un.org/poppolicy/about_database.aspx



Family planning appears to be of great importance to many African countries as their respective governments provided direct support in over 50 countries in 2015, showing visible progress compared to the 2005 report. Moreover, those who formerly offered indirect support in 2005 have shifted to providing more direct support in 2015. While the number of African countries with policies to maintain fertility and population growth has not changed in the 10-year period of interest, more countries have developed policies to lower fertility and population growth.

In recognition of the magnitude and consequences of population displacement, and the need for a collaboration approach in addressing migration crisis, Heads of State and Government representatives adopted in October 2018, Rwanda, the Common African Position (CAP) on Global Compact for Safe, Orderly and Regular Migration, which builds on existing reports such as "Making Migration Work for All" and fosters international cooperation among stakeholders .

The adoption of a CAP was guided by the fact that human mobility and free movement of all persons within the continent constitute one of the pillars of an integrated Africa as envisioned in

the Ouagadougou Action Plan to Combat Trafficking in Human Beings, Especially Women and Children, the Abuja Treaty establishing the African Economic Community (1991), the Protocol on the Free Movement of Person Continental Free Trade Agreement and the Agenda 2063 on the Africa we Want.

At national level more African countries have developed specific policies to either maintain or lower emigration, comparing 2005 and 2015. On the other hand, over the same time period, while more countries have policies to maintain documented immigration, fewer countries have policies to lower documented immigration. The number of countries with policies to lower highly skilled immigration is small, and has not changed over time, while twice as many countries now have policies to maintain highly skilled immigration, comparing 2005 to 2015.

5.2.2 Maternal and Newborn Health

Table 5.2.1. Specific policy measures adopted by governments in the past five years to reduce the number of newborn and maternal deaths (2015) [n = 54].

Combination of policies adopted	Number of countries	Policy
1,2,3,4	4	1. Expanded coverage of comprehensive prenatal care 2. Expanded coverage of obstetric care 3. Expanded coverage of essential postpartum and newborn care 4. Expanded access to effective contraception 5. Expanded access to safe abortion care, including post-abortion care 6. Expanded recruitment and/or training of skilled birth attendants
1,2,3,4,5	2	
1,2,3,4,5,6	30	
1,2,3,4,6	15	
1,3,4,6	1	
2,3,4,6	1	
6	1	
Total	54	

Although contraceptive use on the continent is comparatively low at 36%, almost all African governments provide direct support for family planning. However, despite government support, unmet need remains high and gaps persist in women's and girls' access to family planning. Women and girls who do not use family planning often resort to unsafe abortion where abortion laws are restrictive. Africa has the highest burden of unsafe abortions, estimated at 80 per

100,000 live births, and in 2015, 91% of African countries indicated that unsafe abortion was a major concern [62].

African governments are committed to addressing newborn and maternal mortality as they all have at least one policy in place. Over half of all African countries have adopted all six specific policies shown in Table 5.2.1 above in order to reduce the number of new born and maternal deaths. An additional one quarter of African countries has adopted all these policies, except to expand access to safe abortion care, including post-abortion care. Only one country, Libya, has chosen to adopt only one policy, to expand recruitment and/or training of skilled birth attendants, and only two countries (Central African Republic and Libya) lack policies to expand coverage of comprehensive prenatal care.

Certain countries have policies that restrict access to contraceptive services. For instance, both Mauritius and Seychelles require a minimum age to access contraceptive services, as well as parental consent for minors. Cabo Verde has a policy on access to SRH services for adolescents age 14 years or older, without parental consent. Additionally, Egypt and Morocco require that women who access these services be married [1].

Forty-five of the 55 African countries have adopted specific policies to improve the coverage of their birth registration. UNICEF's work on improving birth registration in Africa suggests that integrating birth registration with immunization (e.g., in Senegal); maternal health services; social assistance (cash transfer programs in Kenya, South Africa and Zimbabwe); and engaging those working in the education sector and faith-based organizations (as in Ghana and Senegal) have proven to be effective [63].

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[62] UNESA, 2017. Reproductive Health Policies 2017. Available at: http://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf)

[63] UNICEF, 2017. A Snapshot of Civil Registration in Sub-Saharan Africa. Available at: https://data.unicef.org/wp-content/uploads/2017/12/Civil-Registration-web-version-v2.pdf

5.2.3 Adolescent Sexual and Reproductive Health

Adolescent birth rates remain high in many African countries, estimated at 100 or more per 1000 women aged 15 to 19, often due to early marriage [1]. In order to improve the sexual and reproductive health of adolescents, 32 of 55 African countries have adopted all three policies listed in Table 5.2.2, and 98% of African countries (with Libya as the exception) have policies addressing at least one of these measures. The most prevalent of these policies is the expansion of secondary school enrollment/retention, adopted by 94% of these countries (with exceptions being Seychelles, Libya and Tunisia).

Table 5.2.2. Specific policy measures adopted by governments in the past five years related to improving sexual and reproductive health of adolescents (2015) [n = 54]

Combination of policies adopted	Number of countries	Policy
1	1	1. Raised and/or enforced minimum age at marriage 2. Expanded secondary school enrollment/retention 3. Provided school-based sexuality education
1,2	9	
1,2,3	32	
2	3	
2,3	7	
3	1	
None	1	
Total	54	

5.2.4 Older People

Table 5.2.3. Specific policy measures adopted by governments in the past five years to address population aging (2015) [n = 55]

Combination of policies adopted	Number of countries	Policy
1	3	1. Raised the minimum retirement age 2. Raised social security contributions of workers 3. Introduced or enhanced non-contributory old-age pensions 4. Promoted private savings schemes for retirement
1,2	2	
1,2,3,4	1	
1,2,4	1	
2	4	
2,4	1	
3	2	

3,4	2	
4	4	
No data	3	
None	31	
Total	54	

In Africa, it is estimated that there were 12.9 people aged 20-64 for each person aged 65 or above in 2017 [64]. This is much more than has been estimated for other regions as the ratio is 7.4 for Asia, 7.3 for Latin America and the Caribbean, 4.6 for Oceania, 3.8 for North America, and 3.3 for Europe. These numbers may explain, at least in part, why fewer than half of the 54 African countries have adopted any policy to address population aging, despite the projected rise in the number of older people. Only one country has adopted all four of the policies in Table 5.2.3, while the most prevalent policy adopted is raising the social security contributions of workers.

In sub-Saharan African countries, there are four broad types of pensions: (i) non-contributory pensions or transfers in old-age assistance which may be universal, pensions-tested or otherwise means-tested; (ii) mandatory contributory pension schemes; (iii) voluntary, regulated occupational or personal pension savings and insurance arrangements; and (iv) other informal voluntary savings arrangements and household assets, savings or transfers to support the elderly[65].

Zoom on the Western and Central Africa Region. A few countries have made significant efforts toward mainstreaming aging issues into their national policies (WCARO Aging Report, 20xx).

- **Cabo Verde**: Pensão Social Mínima (Minimum Social Pension), consolidated scheme in 2006
- **Côte d'Ivoire**: Approved bill on tax exemption for pensions and increased pensions by 8 percent in 2014.

[64]UNDESA, 2017. *World Population Prospects: The 2017 Revision, Volume I: Comprehensive Tables: page xxix*

[65] Dorfman, M (2015). Pension Patterns in Sub-Saharan Africa. Social Protection and Labor Discussion Paper No. 1503. Available at: http://documents.worldbank.org/curated/en/743801468190183781/pdf/98131-NWP-1503-PUBLIC-Box385180B-Pension-Matters-Africa.pdf

- **Ghana**: 1) Formulation of gender policy on aging women to redress inequity in customary laws rooted in male inheritance of land and other productive resources; 2) Introduction of free medical services for people 70 and older; 3) Establishment of an Advisory Committee on Aging, responsible for preparing the bill on aging; and 4) Ghana National Social Protection Policy launched in December 2015, which contains: a) access to basic essential care for all; b) minimum income security for older people that are supported in terms of programs that affords them a meaningful livelihood; and c) preparation of Bill on the Aged
- **Nigeria**: Interventions on aging are being addressed under the 2004 National Policy on Population and Sustainable Development (NPPSD). Four out of 36 states have introduced State Social Welfare Schemes for the elderly. There are pilot non-contributory elderly assistance arrangements in 2 states: Ekiti State Social Security Scheme (2011) and Osun Elderly Persons Welfare Scheme (2012) [66].
- **Senegal**: Innovative policy options have been taken for the benefit of the elderly: 1) the family grant program; 2) the program of universal health coverage; and 3) the Plan SESAME, a nationwide comprehensive scheme of universal free healthcare for all residents aged 60 and older. It was projected that that in 2017, the health insurance coverage would increase from 20 to 75% with a focus on the older people.
- **Togo**: Several actions have been toward integration of aging issues into the: 1) National Population Policy (1998), 2) Poverty Reduction Strategy (2008-2012); 3) Social Protection Policy in 2012; 4) Strategy for Accelerated Growth and Promotion of Employment (2013 - 2017).

In Eastern and Southern Africa, several non-contributory elderly assistance arrangements and pilot schemes exist as listed below[5].

- Botswana: State Old Age Pension (1996)
- Lesotho: Old Age Pension (2004)
- Mauritius: Basic Retirement Pension (became universal in 1958)
- Mozambique: Basic Social Subsidy Program (1992)

[66]Dorfman for WB group, 2015

- Namibia: Old Age Pension (OAP); (became universal in 1992)
- Seychelles: Old Age Pension (Social Security Fund) (1979)
- South Africa: Older Persons Grant (became universal in 1944; full parity achieved in 1996)
- Eswatini: Old Age Grant (2005)

Pilot schemes

- Kenya: Older Persons Cash Transfer (2006/2007)
- Uganda: Senior Citizens Grant (2011)
- Zambia: Social Cash Transfer Program, Katete (2007)

In Northern Africa, several countries are keen to upgrade existing laws or formulate new ones targeting aging people (Ageing in the Arab Region, 2017). For example, **in Egypt**, health insurance provisions that cover the very poor and vulnerable older people have been initiated; directives addressing mobility and accessibility within public premises were issued; and tax directives and exemptions from transportation fees, tourist visits fees and other financial exemptions were issued. More generally, the policy instruments for aging adopted in the regions are the following:

- Egypt: Public Strategy for Older People Care (2010)
- Libya: National Strategy for Active and Healthy Ageing and Older People Care (2009)
- Morocco: National Plan of Action on Ageing (under development)
- Sudan: National Policy for the Care of the Older People (2009)
- Tunisia: Decennial (2003 – 2012) Plan of Action for Older People (2004)

5.2.5 Population Distribution

Table 5.2.4. Specific policy measures adopted by governments in the past five years to influence the spatial population distribution (2015) [n = 54]

Combination of policies adopted	Number of countries	Policy
1	19	1. Reduction of migration from rural to urban areas 2. Decentralization of large urban centers to smaller urban, suburban or rural areas 3. Relocation out of environmentally fragile or threatened areas
1,2	19	
1,2,3	4	
1,3	3	
2	1	
No data	2	

None	6	
Total	54	

Many African countries have defined long-term national visions and plans that include urban policies and strategies (Economic Report on Africa, 2017). Below are policy frameworks in selected countries.

- Republic of Congo: Urban policy incorporated in the Plan National de Développement (PND) 2012– 2016
- Côte d'Ivoire: Urban policy incorporated in the National Development Plan (NDP) 2016–2020
- Ethiopia**:** National Urban Policy (1995); Ethiopian Urban Development Policy (2013)
- Nigeria: National Urban Development Policy 1992 (updated 2012)
- Rwanda: National Urbanization Policy; Urbanization and Rural Settlement Sector Strategic Plan (2012/13–2017/18)
- South Africa: Integrated Urban Development Framework (IUDF); IUDF Implementation Plan 2016–2019; National Spatial Development Perspective

As shown in Table 5.2.4, only 4 of 54 countries (7.4%) have adopted all three policies outlined. The most prevalent of these policies, adopted by 45 of 54 (83.3%) countries is the reduction of migration from rural to urban areas.

5.2.6 Rural Development

Africa's urban population has been growing at unprecedented rates for decades, largely due to natural increase and reclassification of settlements into urban areas, thus the prediction by many of an urbanized future for Africa[67]. According to the United Nations Economic Report on Africa 2017, "Africa's urban population is likely to triple by 2050, with Africa and Asia accounting for nearly 90% of the world's urban population growth." Moreover, some of Africa's small and medium-sized cities are likely to experience major growth by 2030.

[67]Awumbila M (2017). Drivers of Migration and Urbanization in Africa: Key Trends and Issues. United Nations Expert Group Meeting on Sustainable Cities, Human Mobility and International Migration, UN/POP/EGN/2017/12.

Despite these projections, none of the governments of the 54 African countries has adopted the decentralization of large urban centers to smaller urban, suburban or rural areas in order to promote rural development. However, 76% of African countries have adopted policies to reduce migration from rural to urban areas, as well as to relocate out of environmentally fragile or threatened areas. More specifically, all African countries for which data are available have policies to develop rural infrastructure and facilities. Moreover, 77% have policies to provide incentives to establish or retain industries in rural areas[68].

[68]UNDESA, 2016. Policies on Spatial Distribution and Urbanization: Data Booklet (ST/ESA/SER.A/394

Chapter 6: Conclusions and Recommendations

6.1 AADPD and the Demographic Dividend

The main lesson from the review suggests that Africa can reap the benefits of a demographic dividend if the adequate policies are put in place now to ensure the fulfillment of the rights of all people, particularly in terms of youth and women empowerment, sexual and reproductive health, quality education and access to employment, and "leaving no one behind."

To ensure an equitable fertility decline across all socioeconomic groups in countries and achieve the desired changing age structure, a precondition to reap the demographic dividend, there is a need to strengthen and develop efficient policies in health, education, youth and women empowerment, and employment. The priority given to these dimensions of development will depend on the stage where countries and regions stand in terms of their population dynamics.

Recommendations:

All the African countries should domesticate the DD Road Map to assess and better coordinate policies options to harness the demographic dividend through investment in youth, education with appropriate skills, women and girls' empowerment and affordable health care provision and services and good governance.

To realize the dividend countries should:

- Ensure the implementation of comprehensive strategies for the youth which include sexual and reproductive health and rights (SRHR).
- Enhance context-specific age-appropriate comprehensive education on sexual and reproductive health for adolescents.
- Improve reach of education policies to reach children from poorest families, children from rural areas, the displaced and refugees, children with disabilities, out-of-school children, and remove barriers to education.

- Promote youth participation in society, women's empowerment, and implement policies to prevent gender-based violence and harmful practices.
- Implement policies to improve youth employment that include clear guidance and concrete measures on how to equip young people with education, skills and training for the marketplace; reduce youth unemployment and under-employment.
- improve the business environment and ensure a more diversified and dynamic economic sector that creates decent jobs for youth and women.
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6.2. Pillar-Specific Recommendations

6.2.1. Dignity and Equality

Poverty and Inequality

The development and implementation of poverty-reduction strategic plans have contributed to the reduction of the proportion of people living with less than USD 1.90 per day and the Multidimensional Poverty Index (MPI) however in many countries in the level of inequalities persist. In order to further reduce poverty and inequality, countries should Promote economic, social and financial inclusion of the vulnerable segments of the population (older people, youth, the unemployed, people living with HIV and AIDS, internally displaced persons and refugees, and people with disabilities, in both urban and rural areas) overcoming gender inequalities; fighting illiteracy; facilitating access to basic infrastructure and services.

Women's right and G***ender Inequality***

Despite some progress has been observed regarding access to education,little progress has been recorded in regards of women's empowerment (female participation in the formal labor market; women's household decision-making power for large purchases; their own health, including sexual and reproductive health, especially in Western and Central Africa). Most African countries

continue to lag behind the rest of the world in women's participation in developmentand the role and position of women and girls in society. This manifests itself in gender-based violence; harmful practices such as female genital mutilation (FGM); high levels of child marriage and adolescent pregnancy; low participation in household decision-making; poor access to sexual and reproductive health services; high levels of maternal mortality especially among adolescent girls, etc. In order to reduce gender inequalities countries should promote women's empowerment, develop programmes and enact laws that ensure women's access to resources, and contribute to ending gender based violence (GBV) and other harmful practices such as female genital mutilation (FGM).

Child Nutrition and Mortality

Reducing all forms of malnutrition, including stunting, is central to end extreme poverty and promote child survival. Progress in reducing stunting among under-five children has been low in Africa. In order to achieve progress against the AADPD and the United Nations' 2030 Sustainable Development Goals, countries should scale up a set of high-impact nutrition-specific interventions that focus in the first 1000 days andmprove food security, the capacity of caregivers in child health and nutrition as well asimproving the household environment (access to water, sanitation, etc.).

Universal Access to Quality Education for All

Most countries have made significant progress to reach educational goals for primary and secondary education , However, efforts are needed to ensure gender equality in school attendance and completion, especially in rural areas, improve access to special education for disabled children and young people, and promote quality education beyond primary school and

develop Technical and Vocational Education Training (TVET) to improve the skill match with the skills required in the labour market.

Welfare and Longevity, Healthy Aging, and Lifelong Learning for Older People

The overall increase in life expectancy suggests that the number of older people is growing in Africa. Though some countries have developed policies to promote their rights, countries are less equipped to take care of older people, since greater emphasis is now increasingly put on designing policies to reap the 2nd demographic dividend. In the context of social disorganization (deterioration in African traditional patterns of family), African governments should develop, strengthen and implement effective healthcare and pensions programs for the elderly. The models for such programs should be built on a country's specific context so as to ensure sustainability.

6.2.2. Health

Sexual and Reproductive Health and Rights

Given its direct impact on population health and development, it is recommended that sexual and reproductive health and rights be prioritized and included in national and sectorial development plans. SRH policies and service packages should integrate primary health care (PHC) packages and support services for victims of gender-based violence. Men's and boys' engagement in sexual and reproductive health should be improved particularly to ensure that girls and women are empowered and have choices regarding their own sexual and reproductive health. Improving the availability of family planning products and services is of particular importance, and a commodity security strategy and service implementation plan for family planning should be advocated for at the national level in order to make reproductive health products and commodities available in even the most remote regions. There must be a focus on improving and scaling up adolescent and youth-friendly SRH services in line with international standards and norms.

To ensure that intelligent and ambitious policies on sexual and reproductive health and rights are appropriately implemented at the community level, it is important to empower target communities to better express their needs and to demand quality, accessibility and affordable sexual and reproductive health care and services. In doing so, awareness on family planning and sexual and reproductive health must be raised not only among all women of childbearing age, but also among families and community leaders whose commitment to change is crucial. NGOs, community-based organizations and civil society organizations must be supported in raising capacity to deliver rights-based SRH services and information using these community actors. A social marketing strategy to increase access to and utilization of family planning products, commodities and services should be instituted.

At the hospital and clinic level, the capacity of both public and private institutions in providing SRH care should be prioritized. The capacity in fistula prevention, treatment and rehabilitation should also be prioritized in hospitals and clinics. Fistula repair sites should be increased and decentralized to better meet the needs of fistula patients. These efforts at the hospital and clinic levels should be guided by an obstetric fistula elimination strategy and comprehensive management guidelines.

Adolescent Sexual and Reproductive Health

Universal access to SRHR and family planning must be expanded in order to improve access to comprehensive sex education and adolescent- and youth-friendly services for young people. It is recommended that adolescent sexual and reproductive health be integrated into all existing reproductive-health-related trainings, monitoring and research opportunities as well as the provision of an enhanced context-specific and age-appropriate comprehensive education o sexula and reproducitive health for adolescents. Young people should be included in decision-making and leadership positions at all levels, including at service delivery points and program design, to ensure that integration of ASRH initiatives and services respond to the needs of adolescents, and youth laws and policies must be revised to ensure that they do not function as barriers to adolescents and youth access and uptake of SRH services.

Investing in strategies that keep girls in school longer and provide them with skills and qualifications and decent work opportunities will also contribute to improved sexual and reproductive health for girls, women and families. In addition, there must be supportive strategies to allow pregnant girls to continue schooling.

Maternal Mortality

The reduction of maternal, infant and child mortality must be prioritized in national development plans. To meet the needs of women in hospitals and clinics, more health professionals should be trained as midwives, and procedures and guidelines for childbirth should be standardized and widely understood by health staff. To encourage retention of staff trained in midwifery and maternal health procedures and guidelines, recruitment and deployment need to be revised and adapted to the national context for enrollment in training institutions.

HIV and AIDS

Policy measures to halt and reverse the HIV and AIDS pandemic should be reprioritized to receive increased attention. There is a need for increased resources to accelerate progress toward universal access to prevention, treatment, care, and monitoring and evaluation in all STI/HIV/AIDS programs in order to achieve larger targets and goals. It is recommended that governments make the necessary efforts to contribute substantially to the funding of HIV- and AIDS-related activities to achieve the HIV/AIDS treatment target of 90-90-90 in order to contain and eradicate the AIDS epidemic. Continuous uninterrupted ARVs, test kits and other supplies must be ensured, along with appropriate services. In making the utilization of these additional government resources most effective and efficient, HIV services should be strengthened and integrated with other sexual and reproductive health services.

Malaria and Other Infectious Diseases

It is recommended that malaria case detection and treatment protocols and guidelines be recognized at the national level, and that health facilities and clinics be supported which conform

to these national protocols and guidelines. In malaria prevention vector control initiatives ,health education, community ownership of and utilization of insecticide-treated bed nets (ITN) should be emphasized.

Data and information systems should conform to appropriately record malaria information. In some countries, development of a National Malaria Repository is recommended if not already existing.

Access to high impact prevention interventions for malaria control and elimination and set programmatic and impact targets should be expanded. This should include better focus on key locations, intensifying key interventions and sustaining prevention funding while addressing human rights through improved focus (geographic and population focus).

Countries need to ensure timely access to appropriate, effective diagnosis, treatment care and support for malaria and other infectious diseases through improved focus (geographic and population focus), starting with high burden areas;

Provide uninterrupted availability of quality assured and affordable malaria medicines and commodities. This can be achieved through the promotion of local production of pharmaceuticals, harmonisation of regulatory standards and practices and measures to support the implementation of adequate procurement and supply-chain management.

Noncommunicable Diseases

Governments should develop data management policies and implementation strategies on noncommunicable diseases for evidence-based decision making. It is recommended that health systems need to integrate interventions for the prevention of NCDs into primary health care, referral services, human resources and monitoring systems. Furthermore there should be enhanced capacity to establish cross-sectoral partnerships for the prevention and control of NCDs as well as domestic financing and public private partnership.

Health System Strengthening

Overall, universal health coverage, including ensuring universal access to SRHR service packages in the continuum of care, should be prioritized among countries. Access to high-quality care, especially for the poor and extremely poor, must be improved and expanded. The design and financing of universal health coverage and long-term care must include interventions that have the greatest influence on healthy ageing trajectories and include investments in integrated health and social care for older people. It is recommended that additional resources be provided for human resources for health, equipment, medications and supplies. Political commitments expressed by declarations, official documents and the mobilization of resources should be operationalized, and various interventions should be coordinated to address the complexity of management procedures and improve efficiency.

Health services may be decentralized to enable regions and districts to take full control of the provision of infrastructure, logistics and other resources to support health care delivery at local levels. Service providers should be recruited within the local zones for training and assigned to manage them to ensure ownership, loyalty, effectiveness and efficiency. National funding and alternative sources of financing universal health care and social protection systems should be explored to address the challenges identified.

Human resources for health is of particular importance. The number of qualified health workers should be increased according to demand, and health worker capacity should be reinforced through training and support. Health professionals production can be improved through equitable distribution of national funds and retention packages to motivate them to continue to provide quality health services.

It is recommended that resources for health systems also be dedicated to the collection and management of health information in order to scale up evidence based interventions and preventions. HMIS and DHIS platforms, as well as E-Systems, must be fully developed and adequately rolled out for data collection, analysis, and utilization of the data for informed decision-making.

6.2.3. Place and Mobility

Migration Policies

It is recommended that countries develop policies to address migration issues in line with the global and regional frameworks including the Global Compact for safe, orderly and regular migration and the Migration Policy Framework for Africa and its Ten-year Plan. Governments should provide technical and financial resources to build the capacity of relevant State agencies to incorporate migration and spatial issues into the design of their strategic plans.

They should intensify efforts towards good governance, poverty eradication and job creation particularly for the youth through effective implementation of Agendas 2063 and 2030. In order to economically transform rural areas and manage rural-urban migration, development policies should also aim at promoting healthy, prosperous and inhabitable rural areas through improved agricultural productivity, for rural populations to enjoy improved living standards.

Conducive legal and regulatory frameworks (fiscal, monetary and investment policies) should be developed. Priority should also be given to conflict prevention and peacebuilding, combat terrorism and prevent forced displacement. The rights of smuggled and trafficked migrants must be protected regardless of their migration status in compliance with international law. Countries must ensure that immigrants and refugees have access to health and education services, including sexual and reproductive health and rights (SRH&R), while protecting the health of host populations.

Enhanced communication and monitoring and evaluation strategies will also be required to ensure effective mainstreaming of migration issues into development planning agendas. Furthermore, there should be better coordination among the institutions that deal with migration.

Migration Information

There is currently a paucity of data on the magnitude and extent of migration internally and internationally. Information systems and vital statistics are important in managing migration. Therefore, there should be proper monitoring mechanisms in place to help take stock of the flow of migrants in and out of countries. Included in these monitoring mechanisms are the proper development and management of a civil and vital registration system to capture relevant statistics.

Labor Force Regulation and Support

Appropriate policies should be formulated to regulate the participation of immigrants in the labor force, as well as to tap the skills and investment potentials of individuals. In order to reduce the incidence and prevalence of brain drain, working conditions and salaries for professionals should be improved.

6.2.4. Governance

Institutionalize the independent **evaluation of public policies**, combat corruption, promote law enforcement and accountability.

There is a need to improve good governance practices, particularly in terms of fostering strong and equitable institutions that ensure the fulfillment of the rights of all, "leaving no one behind."

There should also be greater commitment from governments not only in terms of enacting laws and developing policy documents, but also ensuring that these laws and policies are broadly disseminated and implemented.

The absence of a "culture of evaluation" and the urgent need to put in place systematic monitoring and evaluation system for the different policies has been highlighted in national

reviews. Some national reports highlighted the need for increased awareness of AADPD and the need to set up specific Information Systems for the Monitoring of the AADPD at the country level.

The need for greater coordination of the activities undertaken on the ground by the various stakeholders was highlighted in a good number of national reports reports, especially as it relates to coordination mechanisms on population issues. There is also a need to strengthen the coordination function of key agencies at country level, including national population councils, to ensure better coordination of population issues and the encouragement of sharing across sectors for effective decision-making.

It is also important that governments and various stakeholders work together to increase the active participation of women, youth and persons with disabilities in society through empowerment initiatives that are aimed at increasing their participation in decision making within society. In this regard, it is important to encourage and support their access to credit and other economic resources.

Additionally, governments need to prioritize domestic resource mobilization to ensure that population activities are funded locally. There is also the need to ensure continued capacity building of policy makers to improve their understanding of complex issues related to population and development.

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6.2.5. Data and Statistics

- Speed up assessments, and develop and implement plans for civil registration and vital statistics systems, ensure the regular collection of data and timely provision of results, promote electronic data collection and revise the "Pan-African Development Information System'.
- There is a need for all Member States to fast-track the implementation of the decision of the 30th Session of the Assembly of the Union held in January 2018 to allocate 0.15% of national budget to statistical activities including the development of National Strategies for the Development of Statistics (NSDS), undertaking of 2020 round of censuses and regular surveys, the improvement of administrative data and Civil Registration and Vital Statistics (CRVS) and geo-spatial data, etc.

- There is a need for member states to implement the Revised Strategy for the Harmonization of Statistics in Africa (SHaSA 2) in order to build sustainable National Statistics Institutions and well-coordinated National Statistics Systems to produce quality statistics to ensure evidence based decision-making, better planning, monitoring and evaluation of Africa's population and development agendas
- There is a need to establish and strengthen partnerships between national statistics institutions, line ministries, and non-state actors including private sector, Civil Society Organizations (CSOs), academia, media, etc. to improve the production and the use of statistics for decision making and ensure transparency and accountability at all levels;

- Design and implement strategies to maximize the benefits of South-South cooperation to strengthen national capacities on data collection and analysis.

A key lesson from the review of the AADPD is the lack of data to inform a good number of the indicators in the operational guide. When the data exist, they are not necessarily up to date and there is an issue of their aggregation at the regional or continental levels.

In many countries, there is a need for more regular data collection on timely issues (such as gender-based violence, access to social services for migrants and people with disabilities, people in humanitarian situations, etc.) that lack data and statistics to estimate the magnitude and associated factors.

With the trend toward decentralization in many countries, there is an increasing need for the design and the monitoring of the implementation of local development policies in the provision of data and statistics at smaller geographical and administrative levels.

6.2.6 Partnerships and International Cooperation

It is recommended that strategies be implemented to maximize the benefits of South-South cooperation, particularly in building national capacities in the areas of health care provision and education.

Government coordination mechanisms with development partners, including civil society organizations, should be instituted. Governments should engage civil society, traditional authorities, religious bodies and the media in national development to improve governance and enhance the well-being of populations. There is also the need to emphasize the importance of public-private partnerships is addressing various population issues at country level. This could be beneficial in advancing innovative solutions in certain areas such as health services delivery, data collection, disaster and risk management.

Furthermore, macroeconomic instability should be addressed through restoring fiscal discipline, sustainability and reducing fiscal deficits, improving the quality and composition of public expenditures, and reducing financial sector vulnerability. Development partners should be encouraged to channel support through the national budget, and to implement a reporting mechanism of their interventions to reduce incidences of project support duplication.

In support of accelerated efforts to fully implement the commitments outlined in the AADPD, The Africa Union, UNECA and UNFPA will continue to facilitate the generation of timely, high quality knowledge, support for advocacy and policy dialogue, support for implementation of relevant programs, develop institutional capacities, and foster partnerships and coordination, including South-South and triangular cooperation and provide other substantive support as needed at the national level toward the further implementation of these commitments, including for the realization of the demographic dividend.

The findings and recommendations of the AADPD plus five continental review report, alongside the outcomes of the 2018 Ministerial Review on the Implementation of the Addis Ababa Declaration on Population and Development Beyond 2014 deliberations, will inform the global review of the ICPD at the 52nd Session of the Commission on Population and Development in 2019, the 2019 UNECA Regional Forum on Sustainable Development, and the 2019 United

Nations Economic and Social Council High-Level Political Forum on Sustainable Development. To better integrate the review and follow-up of the ICPD in Africa with the 2030 Agenda on Sustainable Development, future review cycles of the Addis Ababa Declaration will be aligned with SDG review cycles to take place every four instead of five years. Furthermore, the AADPD plus five continental review report and accompanying STC Decision will be submitted to the AU Assembly through the Office of the AU Secretary General.

Appendix 5.1. Summary of Evidence on Demographic Dividend In Africa

Over the past years there has been increasing scientific evidence on the conditions and gains of the DD in Africa, using different methodological perspectives. This appendix summarizes the approaches used, the main findings of the research, and the policy implications.

Three methodological approaches have been used in the scientific literature to account for the demographic dividend on the continent: National Transfer Accounts (NTA), the DemDiv model, and the decomposition method. The first two methods have been widely used at the national level by several countries from Western, Central, Eastern, and Southern Africa to produce their demographic dividend profile and include policy implications in national development plans.

The National Transfer Accounts (NTA) match macroeconomic outcomes to age-specific economic behavior related to work, consumption, public and private transfers, and saving. The framework is the basis for age-specific economic accounts and has been used extensively to model the macroeconomic implications of demographic change.[69] At the heart of the NTA is the concept of the economic support ratio, that is, the ratio between the number of actual producers and the number of actual consumers. To maintain its standard of living, the workforce must mobilize sufficient resources to fulfill three critical responsibilities: (i) provide for its own material needs, (ii) finance public and private transfers to children and older persons, and (iii) save sufficient resources to finance its own needs at retirement age. The economic support ratio therefore measures the effect of the age structure on the ability of the population to contribute to current production. The demographic dividend is obtained through the rate of growth of the support ratio, which is a function of the population age structure and the life cycle deficit (comparison of consumption and income profile by age group). It is then assumed that a country enters its window of opportunity to benefit from a demographic dividend when the economic support ratio begins to increase and, all other things being equal, the income per consumer also increases. Then, from the different hypotheses of future changes in fertility, different scenarios for the evolution of the economic support ratio can be projected as well as their political implications.

DemDiv is a projection model of the demographic dividend potential and the identification of the policy and sectoral investments needed to reap the maximum benefit.[70] The software is structured in two integrated parts that project the demographic and economic changes. It is a model based on scenario specification that estimates future gains in terms of demographic dividend, according to the combination of different sectoral policy choices in terms of investment in family planning, health, education, economy and governance. With its focus on policy choices and how it impacts socio economic development, DemDiv is an advocacy tool sometimes used in

[69] Lee and Mason (2007); Lee and Mason (2011); Lee, Mason *et al.* (2014); Dramani (2016).
[70] DemDiv was created by the Health Policy Project, with support from USAID. See Morelan *et al.* (2014).

combination with NTA profiles in order to produce estimates of the demographic dividend, measured in terms of GDP per capita.[71]

Decomposition methods are utilized to see, over a retrospective period, what the contributory part of the change in the population age structure has been in the demographic dividend which a country has benefited from. Then, combined with the different population projection assumptions, these methods make it possible to assess the gains over a future time period as compared to a reference year. While NTA and DemDiv focus on the economic gains of the demographic dividend (measured by GDP per capita with DemDiv), the use of decomposition can help reveal other social impacts of the change in age structure, such as the *schooling dividend*. Decomposition methods consider as the threshold of the opening of the demographic window of opportunity, the moment when the demographic dependency ratio falls below 0.80, which corresponds to 45% of the dependent population (0-14 years + 65 years and +) and 55% of the active population (aged 15-64).[72] However, after this stage, these methods consider the actual dependency ratio (the ratio of the dependent population and the actual active population age group employed). Since they use different indicators to account for dependency, decomposition and NTA yield different entry times in terms of window of opportunity. But beyond these differences, it is important to emphasize that these methods concur in terms of policy implications and strategic investments.

d) Demographic Dividend Profiles in Western Africa Using the National Transfer Accounts (NTA)

With the support of the UNFPA West and Central Africa Regional Office (WCARO), the Research Center for Economics and Applied Finance (CREFAT)[73] conducted a series of studies on the DD in

[71] AFIDEP and CREFAT (2016).

[72] According to the UN Population Division, quoted by Hakkert (2007, p. 5), the window of opportunity is defined as the "period when the proportion of children and youth under 15 years falls below 30% and the proportion of people 65 years and older is still below 15%."

[73] CREFAT is a research center created in 2012 at the University of Thiès in Senegal. It is composed of 5 divisions of research, including i) Finance and Development; ii) Social and Economic

Western and Central Africa. Nineteen (19) countries in the region have produced their demographic dividend profile.[74] The current review summarizes the work conducted in the ECOWAS (Economic Community of West African States) zone, which accounts for 15 countries.

- *Main Findings*

We start by presenting economic dependence within ECOWAS region. By multiplying the average consumption and labor income profiles by the size of the different age groups, it is possible to obtain aggregate consumption and income profiles and then to analyze the economic cycle at the macro or regional level. Figures 5.1.3a and 5.1.3b below present the aggregate profiles of consumption and labor income and the resulting life cycle deficit.

Based on CREG-CREFAT (2017) research, the aggregate consumption of ECOWAS is estimated at USD 486.15 billion in 2014. Individuals aged 0-30 years have a consumption level of 308.80 billion, which accounts for 64% of the total consumption. The relatively high share of this consumption is the consequence of the size of this age group, which represents 73% of the total population of ECOWAS. Aggregate consumption of adults aged 31-62 years is 154.21 billion (32% of total consumption). For people over 62 years, the share of their consumption represents only 5% of the total (an amount of 23.14 billion). At birth, children have an aggregate consumption of 8.59 billion. This consumption increases with age and reaches its maximum value of 11.58 billion at the age of 17 years. It gradually decreases from 18 years and falls to less than 0.10 billion over 80 years.

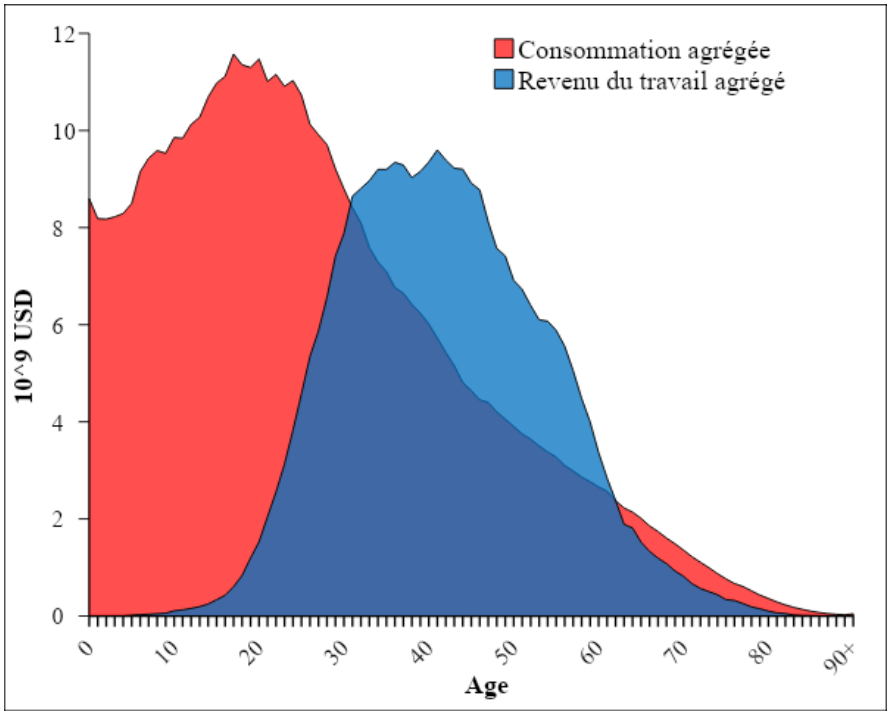
In terms of aggregate labor income, it rises from USD 0.02 billion for 5 year-olds to USD 9.6 billion for 41 year-olds and falls thereafter. It stabilizes below USD 0.10 billion for each age over 80 years. The labor income generated by all individuals aged 0-30 years amounts to USD 55.16 billion, which represents 18% of total labor income. Thus, with a consumption of USD 308.80 billion, the 0-30 age group has a deficit of USD 253.64 billion. Seniors (63 years and over) also

Policies; iii) Applied Economics; iv) Industrial Economy; v) Generational Economy and Regional Integration.

[74] Benin, Burkina Faso, Cabo Verde, Cameroun, Central African Republic, Côte d'Ivoire, Gabon, Ghana, Guinea, Guinea Bissau, Equatorial Guinea, Mali, Mauritania, Niger, Nigeria, São Tomé and Principe, Senegal, Chad, and Togo.

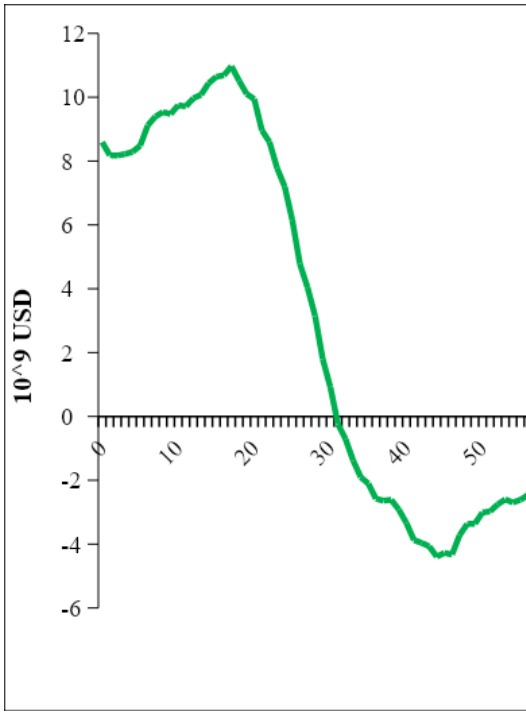
have a deficit of USD 8.87 billion, which is much lower than that of children and young people. In addition, the aggregate deficit profile, shown in Figure 5.1.3, shows that, of all ages, 17 year-olds have the largest aggregate deficit. Indeed, the deficit increases with age from birth, but reaches its highest level at age 17 with a value of USD 10.97 billion USD, and thereafter the deficit enters a phase of decline.

Figure 5.1.3a Aggregate consumption and income profiles of ECOWAS, in 2014



Source: CREG-CREFAT (2017).

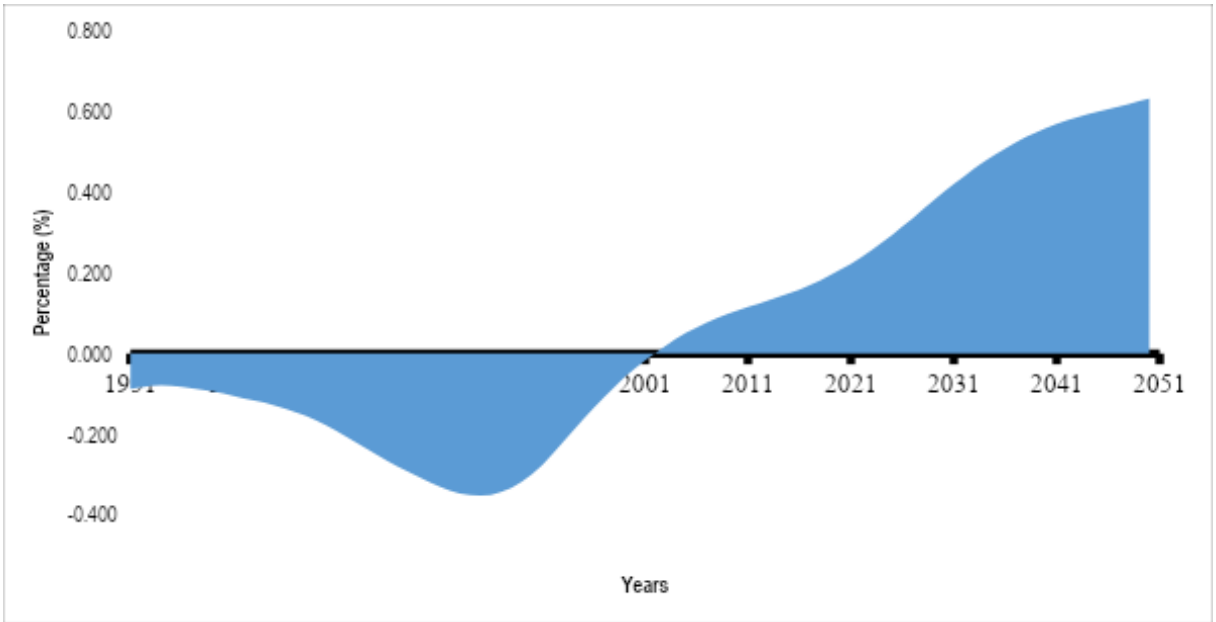
Figure 5.1.3b: Aggregate life cycle deficit 2014



Source: CREG-CREFAT (2017).

Given the current pattern of the economic dependence, how can the ECOWAS countries benefit from the future prospects of the economic support ratio? According to figure 5.1.4, the opening of the demographic dividend window of opportunity in the region corresponds to the year 2002, when the growth rate of the support ratio becomes positive. The window will last until 2050 spreading over 48 years.

Figure 5.1.4. Level of Demographic Dividend in the ECOWAS region

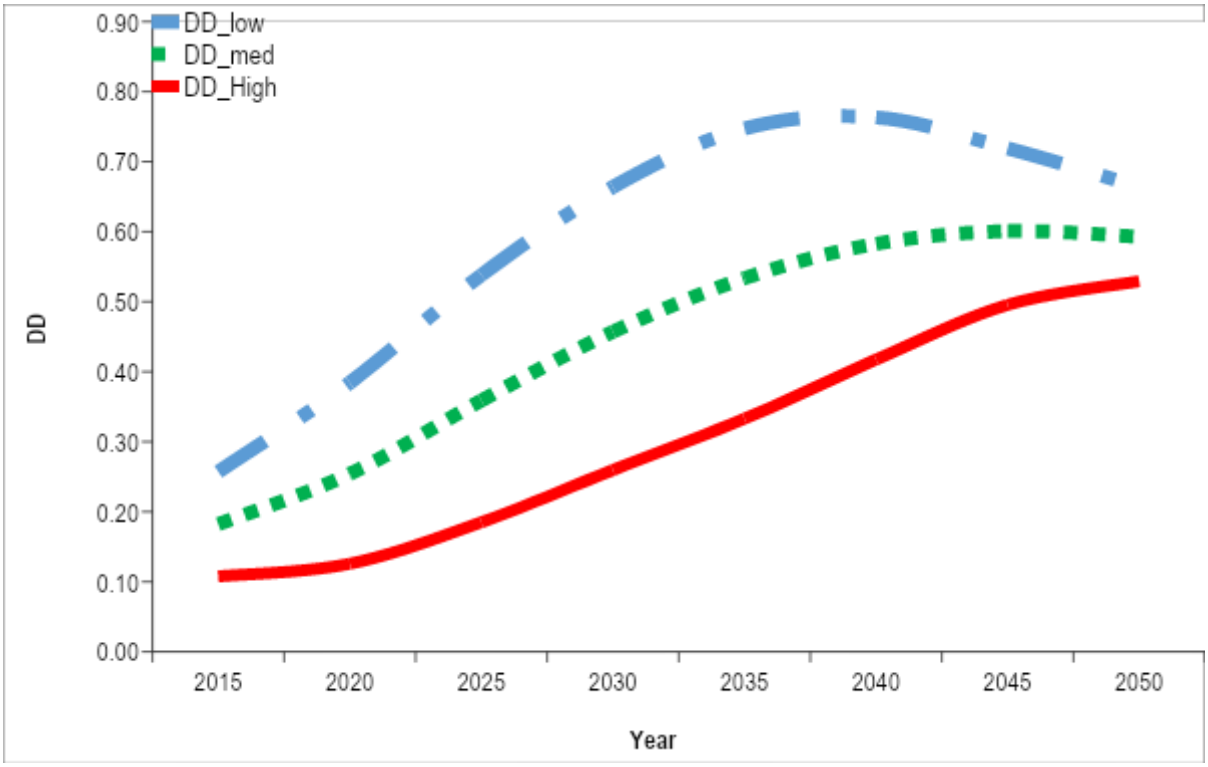


Source: CREG-CREFAT (2017).

Figure 5.1.5 provides the prospects for the DD in the ECOWAS region according to the three fertility trend scenarios of the Population Division of the United Nations (CREG-CREFAT, 2017).

The first scenario based on the high fertility assumption (red curve) takes three different phases of evolution. The evolution of the support ratio is slow over the 2015-2020 and 2045-2050 periods. On the other hand, the curve is growing faster between 2020 and 2045, and at a constant pace. The rate and level of change in the growth rate of the economic support ratio is much lower than the other scenarios because of a higher dependent population (the majority of which is composed of young individuals). In such a scenario, development priorities turn to demographic expenses such as the construction of schools, health centers, etc., rather than investments in economic wealth-creating sectors. Thus, in such a situation, there is a minority of people working as compared to a majority of dependent people, and this constitutes a burden and limits economic growth perspectives in the subregion.

Figure 5.1.5. Results of the DD prospects in ECOWAS using the NTA methodology



Source: CREG-CREFAT (2017).

The curve related to the second scenario is in green. The change in the age structure of the population is less challenging than the first scenario but still less appropriate as compared to low fertility scenario. Growth is more accelerated and peaks in 2045 (0.6% growth rate of support ratio). Between 2040 and 2045, the rate slows and stagnates and then declines thereafter. The 2015-2040 period is therefore an opportunity to boost growth. Indeed, with this assumption, after a while, the first demographic dividend will stabilize and then begin a fall (after 2050), a consequence of the gradual but massive entry into the age group of the working populations with less employment opportunity for children. To anticipate this situation, during the growth phase of the first demographic dividend, governments should carry out specific actions including investing in human capital and job creation for the maximum generation of wealth.

With the low fertility scenario (curve in blue), there is an increase in the first demographic dividend with a slope greater than the other two curves. The curve thus increases more quickly until reaching its maximum value (0.76) around the year 2040. From 2045, it approaches a declining phase. The first phase is a situation where the population structure can raise GDP per capita if appropriate actions are taken by the countries in question. These actions must be carried out intensively over the period in order to reap the maximum benefit to overcome the difficulties of the next phase. Indeed, this decline in the first demographic dividend after 2045 reveals that the population structure will no longer be a potential but rather a constraint for economic growth. But this should be controlled if, for example, workers once retired have the resources from their savings to meet their expenses, which, in turn, could lead to the second demographic dividend.

- *Policy Implications*

The opening of the window since 2002 reflects the need to adapt the policies already implemented and invest in the drivers of the demographic dividend, namely, education, health, the labor market, etc. The priority given to women's education and youth in the ECOWAS 2020 Vision is welcomed and need to be strengthened and extend to other key sectors. More specifically:

- Given the high population growth of the region, which modifies the supply of labor and employment and leads to a high dependency ratio, it is necessary to have an education system that is adapted to the needs of the labor market and to foster a business incentive environment.
- Conduct a study in each member country to identify prospects for a better match between education / training and the needs of the national economy. Such a study should provide recommendations to guide investments in education / training and identify economic sectors that create employment.
- Empowering young people to fully participate in economic life in all sectors is essential to building strong economies, achieving sustainable development goals, and improving their

quality of life. Creating jobs for young people and providing resources for women has significant implications for the development and acceleration of economic growth.

- Encourage and promote the empowerment of women through the promotion of income-generating activities, raise awareness on gender equality in business, engage companies within the same economic branch to undertake a reflection on skills required.
- Implement targeted actions for the control of fertility (family planning, reduction of child marriage, improvement of girls' education).

e) Demographic Dividend Profiles in Eastern and Southern Africa using the NTA and the DemDiv model

With the technical support of AFIDEP[75] and financial support from UNFPA, the countries of the Eastern and Southern Africa region have developed national DD profiles at a time when countries are domesticating the post-2015 Sustainable Development Goals (Table 5.1.3). Countries within the ESA region that have been supported in developing their national profiles were about to embark on the preparation of their national development plans and also, in other cases, their long-term development strategy. The key question that had not been examined in depth is how each country's population age-structure would affect its development trajectory to become a prosperous middle-income country or high middle-income countries depending on where the country is currently.

[75] The African Institute for Development Policy (AFIDEP) is an African-led, regional non-profit policy think tank established in 2010 to help bridge the gaps between research, policy and practice in development efforts in Africa. It analyzes, synthesizes, and translates evidence (i.e., data and research) and uses it to generate or strengthen political commitment, inform resource allocation, program design and implementation. The aim is to contribute to the realization of sustainable development by enabling the formulation of sound policies and program interventions.

Table 5.1.3. The summary of DD studies within the region by methodology applied

Country assessment, Desk review	Demo-socioeconomic projections & scenarios - Comprehensive Analytical Report	DemDiv Model	National Transfer Accounting (NTA)
Ethiopia (2014), Kenya (2014), Mozambique (2014), Rwanda (2015)	Burundi (2014), Democratic Republic of Congo (2014)	Kenya (2013) Ethiopia (2014), Malawi (2015), Mozambique (2015) Uganda (2014) Zambia (2015) Rwanda (2017) Angola (Ongoing) Tanzania (Ongoing)	South Africa (2013) Botswana, (2017) Eswatini (2017) Namibia (2017) Zimbabwe (2017)

The modeling of the potential demographic dividend which African countries can harness was carried out under different policy scenarios which are listed below.

Scenario 1: Business as Usual:

- Modest investments in family planning, education, and economic reforms
- Slow progress in economic development and demographic transition

Scenario 2: Economic Emphasis:

- Maximize economic competitiveness to the benchmark countries
- Modest investments in family planning and education

Scenario 3: Combined model:

- Maximize economic competitiveness to the level envisaged in benchmark countries
- Simultaneous prioritization of education and family planning

- *Main Findings and Policy implications*

The use of the NTA in four Southern Africa countries (Botswana, Namibia, Eswatini, and Zimbabwe) shows lifecycle patterns similar to those observed in Western Africa, where

consumption is quite high at the young ages, while labor income peaks in the 30s and 40s.[76] Based on the trend in the rate of change of the support ratio, all four countries were already harnessing the first demographic dividend by 1990, but at a different pace and magnitude. The study also shows that the estimated potential cumulative increase in living standards from the first demographic dividend between 1990 and 2060, and, using the medium fertility variant of the UN population projections, amounts to 41%, 36%, 33% and 32% respectively for Eswatini, Botswana, Namibia, and Zimbabwe.[77]

Demographic Dividend modeling using DemDiv for various countries in general show better economic outcomes when an integrated investment approach is used for both demographic outcomes such as population growth and dependency burden, and for economic outcomes such as GDP and employment gap. For example, the DD study in Uganda[78] shows that using the more integrated policy investment in all pillars as envisioned in Uganda's Vision 2040, the GDP per capita will reach USD 9,567 by 2040 as compared to USD 927 for the "business as usual" hypothesis.[79]

[76] Onyango *et al.* (2018)
[77] Onyango *et al.* (2018)
[78] NPA and UNFPA (2014) quoted by AFIDEP and UNFPA (2015).
[79] AFIDEP and UNFPA (2015)

Table 5.1.1 summarizes the policy implications of the DD evidence in Eastern and Southern Africa.

The DD status and actionable policy recommendations for ESA region

DD Stage	Countries	Policy Priority	Recommendations
Pre-dividend Fertility levels above 4; rapid population growth, high dependency ratios, however, these are expected to decline when children reach working age.	Angola, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Madagascar, Malawi, Mozambique, South Sudan, Tanzania, Uganda, Zambia	Improve human capital to reduce fertility	Improve maternal and child health Expand education; No girls left behind; Empower women; Expand comprehensive FP services.
Early-Dividend Fertility rates have fallen below 4 and the working-age share of the population is likely rising.	Botswana, Ethiopia, Kenya, Lesotho, Namibia, Rwanda, South Africa, Eswatini, Zimbabwe	Accelerate job creation; Create productive jobs for the growing share of the population in working age to reap the first DD.	Invest in human capital, including technical and vocational education and training (TVET); Reduce barriers to female labor force participation (LFP); Strengthen conditions conducive to savings and job creation
Late-Dividend Fertility rates are typically above replacement levels of 2.1, but fertility continues to decline. Even though they have shrinking working-age shares, their overall age structures are still favorable for the first DD.	Mauritius and Seychelles	Sustain productivity growth; Create the necessary conditions to reap the second DD; Prepare for aging.	Continue mobilization of savings for productive investment; Ensure that public policies encourage LFP for both sexes; Design cost-effective systems for welfare-vulnerable elderly;

Source: Countries DD reports supported by AFIDEP and UNFPA-ESARO

f) Schooling Dividend

Since 2013, the FRANET network[80] has focused its research on different facets of the DD, including the Schooling Dividend (SD), using decomposition methods.[81]

The effect of fertility decline on schooling operates through the change in age structure.[82] This process is gradual and includes four major steps (Figure 5.1.1). First, the decline in fertility induces a change in the age structure. Second, the change in age structure reduces economic dependence. The third step establishes the link between the reduction of economic dependence and the resources allocated per person of school age. Finally, the resources allocated to education are reflected in education outcomes.

The data used are from the 2012 World Development Indicators, the World Population Prospects, and the UNESCO Institute of Statistics. The retrospective period covered is 1990-2010 and target year for the future schooling gains is 2035. Table 5.1.1 provides the countries covered in the study (total of 39 countries)

[80]The Francophone Network (FRANET) was set up in 2009 by the International Union for the Scientific Study of the Population (IUSSP), with the support of the Hewlett Foundation, to reinforce capacity building of researchers and research institutions in Francophone Africa.

[81] Eloundou-Enyegue, P. *et al.* (Forthcoming)*, Le dividende scolaire en Afrique,* Réseau FraNet/IUSSP.

[82] Mason and Lee (2005), Bloom and Canning (2008), Eloundou-Enyegue *et al.*(2013).

Table 5.1.1. Countries covered by subregion for the analysis of the Schooling Dividend

ions	**ies**
rn Africa	, Egypt, Libya, Morocco, Sudan, Tunisia (6)
rn Africa	ana, Lesotho, Namibia, South Africa, Eswatini, Mozambique (6)
l Africa	, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon (8)
rn Africa	Burkina Faso, Cabo Verde, Gambia, Côte d'Ivoire, Mali, Mauritania, Senegal, Togo (9)
n Africa	di, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius,, Rwanda, Tanzania, Uganda (10)
umber of countries	39

● *Main Findings*

 Northern Africa

The beginning of the window of opportunity varies from 1983 (Tunisia) to 2013 (Sudan). In this subregion, 4 out of 6 countries have passed all the stages for the production of the schooling dividend. Only two countries (Sudan and Libya) have stalled at stages 3 and 4. The average earnings per child observed over the 1995-2010 period varies from -USD 3.9 (Sudan) to USD 3 841.4 (Libya). In general (for 5 countries out of the 6), the change in age structure is the main source of variation in public allocations per child. The effect of political commitment in education remains low. Prospects for future earnings show a steady increase in allocations per child based on the optimistic assumption. Under this assumption, by 2035, the expected gains for the countries of this region will be multiplied by a factor ranging from about 1.3 (Libya) to 34.7 (Sudan) as compared to the value observed in 2010. However, under the pessimistic assumption, the factor will range between -0.1 (Egypt) to 6 (Sudan).

 Southern Africa

The window of opportunity in this subregion varies from 1980 (South Africa) to 2006 (Eswatini). All five countries studied in this subregion have successfully completed all the stages for the production of the schooling dividend. Over the period 1995-2010, the schooling dividend earned

by countries in this subregion ranges from USD 257.9 (Lesotho) to USD 1,895.3 (Botswana). In 4 out of 5 countries, the demographic factor is the main source for explaining the observed gains in the allocations per child. In the particular case of South Africa, the effect of the political commitment for education is counterbalanced by the observed positive change in public allocations per child, following a decrease in the share of the budget allocated to education in the period 1995-2010. Under the optimistic assumption, the expected gains by 2035 as compared to 2010 will be multiplied by a factor ranging from 0.3 (Lesotho) to 3.1 (South Africa). This multiplicative factor varies from -0.8 (Lesotho) to -0.3 (South Africa) under the pessimistic hypothesis.

 Central Africa

In this subregion, the opening of the window of opportunity is between 2005 (Equatorial Guinea) to 2031 (Angola). Half of the 8 countries (Angola, Cameroon, Chad and Gabon) have validated all the stages of the schooling dividend process. However, in some countries of the subregion (Central African Republic, Congo, Democratic Republic of Congo and Equatorial Guinea), the shift from declining fertility to changing age structure, then from the reduction of dependents persons into additional resources and converting these resources into schooling gains, remain problematic. The estimated gains in public allocations per child range from of - USD 187.6 (Congo) to USD 545.9 (Equatorial Guinea) over the period 1995-2010, and only two countries have a deficit (Central African Republic and Congo). In general, the demographic factor and the economic performance are the sources of the gains observed over the study period. Political commitment to education tends to have a negligible effect. The expected earnings multiplier for this subregion by 2035 under the optimistic assumption ranges from 1.6 (Gabon) to 93.3 (Equatorial Guinea). However, under the pessimistic assumption, this multiplying factor varies from -0.5 (Gabon) to 17.3 (Equatorial Guinea).

 Western Africa

For this subregion (9 countries covered), the best time to start capitalizing on the schooling dividend is between 2005 (Cabo Verde) and 2035 (Mali). Overall, all stages of the schooling dividend production have been validated by 8 countries. Côte d'Ivoire remains the only country

that has stalled at the stages of transformation of the demographic dependent ratio to increase resources available per child, and then the conversion of the resources per child in the schooling dividend. This situation of Côte d'Ivoire can be related to the political and social instability the country which has experienced in that period. Resources per child earned over the 1995-2010 period range from the lowest of - USD 2.7 (Côte d'Ivoire) to the highest of USD 372.7 (Cabo Verde). This schooling dividend is partly due to the effect of the change in age structure and political commitment to education. The expected gains by 2035 relative to 2010 will be multiplied by a factor of about 1.2 (Côte d'Ivoire) to 6.1 (Cabo Verde), under the optimistic assumption. On the other hand, by 2035 this factor will range from -0.6 (Côte d'Ivoire) to 0.4 (Cabo Verde), under the pessimistic assumption.

- Eastern Africa

In this subregion, the opening of the window of opportunity is between 2004 (Eritrea) and 2028 (Uganda). However, the opportunity for Mauritius has already been in effect since 1975 and will remain so until 2035. The stages of the production of the schooling dividend have been validated entirely by 7 countries out of 11. For the other 4 countries, all stages are problematic, specifically the capitalization of the reduction in the number of dependents to the availability of resources, as well as their conversion into education gains. The public allocations per child accumulated over the 1995-2010 period range from USD -4.7 (Eritrea) to USD 823.3 (Mauritius). In the majority of cases, economic performance is the main source of the change in public allocations per child over the period, to the detriment of the demographic factor and political commitment. By 2035, expected public allocations per child will be multiplied by a factor ranging from -0.1 (Burundi) to 15.6 (Ethiopia), relative to 2010, under the optimistic assumption. However, under the pessimistic assumption, this factor will be in the range -0.8 (Burundi) to 2.1 (Ethiopia).

- *Policy implications*

Table 5.1.2 summarizes the policy implications of the findings on the Schooling Dividend.

Table 5.1.2. Policy implications of the findings on the Schooling Dividend

Subregions	Policy implications
rn Africa	- Take measures to increase the budget allocated to education to at least 8% of national income; - Make efforts to boost change in the age structure.
rn Africa	- Take measures to increase the budget allocated to education to at least 8% of national income; - Make efforts to boost change in the age structure.
l Africa	- Take measures to increase the budget allocated to education to at least 8% of national income; - Make efforts to continue to boost economic performance; - Strengthen employment policies by improving the working conditions of employees, and by developing in-service training programs; - Improve the supply of education using the resources already generated.
rn Africa	- Revise reproductive health policies to address unmet needs in family planning; - Reinforce the commitment to education by increasing the percentage of the national revenue allocated to education by more than 8%; - Continue efforts to boost the change in age structure through education; - Make efforts to continue to boost economic performance; - Strengthen employment policies by improving the working conditions of the employees, developing in-service training programs, and creating decent jobs; - Improve the supply of education using the resources already generated.
n Africa	- Revise reproductive health policies to address unmet needs in family planning; - Reinforce the commitment to education by increasing the percentage of the national revenue allocated to education by more than 8%; - Continue efforts to boost the change in age structure through education;

	- Make efforts to continue to boost economic performance; - Strengthen employment policies by improving the working conditions of the employees, developing in-service training programs, and creating decent jobs; ove the supply of education using the resources already generated.

Source: FRANET's work on Schooling Dividend

Appendix 3.1. Trends in life expectancy of Africa and its five subregions (1990 – 2030)

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015	2015-2020	2020-2025	2025-2030
Africa	51.7	52.3	53.7	57.0	60.2	62.4	64.1	65.7
Central Africa	48.5	48.2	50.8	54.4	57.4	59.6	61.5	63.4
Eastern Africa	47.6	49.6	52.0	57.0	61.5	64.0	65.6	67.2
Northern Africa	64.6	66.4	67.9	69.6	71.1	72.1	73.1	73.9
Southern Africa	61.9	58.5	53.2	53.0	59.3	63.5	64.8	66.0
Western Africa	48.1	48.2	49.3	52.3	54.7	56.9	59.0	60.9

Source: United Nations

Appendix 3.2a. Trends in infant mortality in Africa and other regions of the world (1990 – 2015)

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015
Africa	102	93	81	68	57
Central Africa	115	114	100	85	72
Eastern Africa	112	94	77	63	52
Northern Africa	59	46	39	33	28
Southern Africa	52	58	62	54	38
Western Africa	116	108	96	83	70
Asia	62	55	46	37	31
Europe	13	10	8	6	5
Latin Am & Caribbean	39	32	25	21	19
North America	8	7	7	7	6
Oceania	27	26	25	22	21

Source: United Nations

Appendix 3.2b. Trends in under-five mortality of the continent and other regions of the world (1990 – 2015)

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015
Africa	167	151	129	106	87
Central Africa	190	189	163	135	113
Eastern Africa	181	148	120	95	77
Northern Africa	82	64	55	45	37
Southern Africa	67	76	83	73	49
Western Africa	202	187	162	133	111
Asia	84	73	60	47	38
Europe	15	12	10	8	6
Latin Am & Caribbean	49	40	33	28	24
North America	10	9	8	8	7
Oceania	37	35	33	29	26

Source: United Nations

Appendix 3.3. Life expectancy at age 60 in Africa and its five subregions for 1990 –2030

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015	2015-2020	2020-2025	2025-2030
Africa	15.3	15.4	15.7	16.3	16.8	17.2	17.6	18.0
Central Africa	15.1	15.1	15.6	16.2	16.7	17.0	17.4	17.7
Eastern Africa	15.1	15.6	16.2	17.0	17.6	17.9	18.2	18.5
Northern Africa	17.1	17.4	17.8	18.4	18.7	19.2	19.7	20.1
Southern Africa	15.3	15.4	15.3	15.5	16.3	16.9	17.2	17.6
Western Africa	14.0	13.8	13.7	14.1	14.5	14.8	15.1	15.4

Source: United Nations

Appendix 3.4. Trends in population growth rates in Africa and its five subregions (1990 – 2030)

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015	2015-2020	2020-2025	2025-2030
Africa	2.6	2.5	2.5	2.5	2.6	2.5	2.4	2.3
Central Africa	3.3	2.6	3.1	3.2	3.1	3.0	2.9	2.8
Eastern Africa	2.6	2.9	2.8	2.9	2.8	2.7	2.6	2.4
Northern Africa	2.3	1.7	1.7	1.7	1.9	1.8	1.6	1.4
Southern Africa	2.3	1.7	1.3	1.1	1.4	1.3	1.1	0.9
Western Africa	2.7	2.6	2.6	2.7	2.7	2.7	2.6	2.5

Source: United Nations

Appendix 3.5. Trends in Total Fertility Rates (TFRs) in Africa and its five subregions (1990 – 2015)

	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015	2015-2020	2020-2025	2025-2030
Africa	5.7	5.3	5.1	4.9	4.7	4.4	4.2	3.9
Central Africa	6.7	6.5	6.4	6.2	5.9	5.5	5.1	4.7
Eastern Africa	6.4	6.1	5.8	5.3	4.9	4.5	4.1	3.8
Northern Africa	4.2	3.5	3.2	3.1	3.3	3.1	2.9	2.8
Southern Africa	3.5	3.1	2.9	2.7	2.6	2.5	2.4	2.3
Western Africa	6.4	6.2	6.0	5.8	5.5	5.2	4.9	4.6

Source: United Nations

Appendix 3.6. Trends in TFR by place of residence (periods 1995-2000 and 2010-2017)

Region	Country	Year	Value	
			Urban	Rural
Central Africa	Cameroon	2011	4.0	6.4
		1998	3.8	5.4
	Chad	2015	5.4	6.8
		1997	5.9	6.5
	Gabon	2012	3.9	6.1
		2000	3.8	6.0
Eastern Africa	Comoros	2012	3.5	4.8
		1996	3.8	5.0
	Ethiopia	2016	2.3	5.2
		2000	3.0	6.0
	Kenya	2015	2.8	4.5
		1998	3.1	5.2
	Madagascar	2016	2.7	4.3
		1997	4.2	6.7
	Rwanda	2015	3.6	4.3
		2000	5.2	5.9
	Uganda	2016	4.0	5.9
		1995	5.0	7.2
Northern Africa	Egypt	2014	2.9	3.8
		1995	3.0	4.2
Southern Africa	Malawi	2017	2.8	4.5
		2000	4.5	6.7
	Mozambique	2015	3.6	6.1
		1997	4.6	5.3
	Namibia	2013	2.9	4.7
		2000	3.1	5.1
	Zambia	2013	3.7	6.6
		1996	5.1	6.9
Western Africa	Benin	2012	4.3	5.4
		1996	4.9	6.7
	Burkina Faso	2014	4.0	6.1
		1998	3.9	6.9
	Côte d'Ivoire	2012	3.7	6.3
		1998	4.0	6.0
	Ghana	2016	3.4	5.1
		1998	3.0	5.3
	Guinea	2012	3.8	5.8
		1999	4.4	6.1
	Mali	2015	4.8	6.8
		1995	5.4	7.3
	Niger	2012	5.6	8.1
		1998	5.6	7.6

	Senegal	2016	3.5	5.9
		1997	4.3	6.7
	Togo	2013	3.7	5.7
		1998	3.2	6.3

Source: The DHS Program of USAID

Appendix 3.7. Trends in TFR of the poorest (quintile 1) and the richest (quintile 5)

Region	Country	Year	Quintile 5	Quintile 1
Central Africa	Cameroon	2011	3.3	7
		1998	3.6	5.9
	Chad	2015	4.9	5.1
		1997	6.2	7.1
	Gabon	2012	2.9	6.6
		2000	3	6.3
Eastern Africa	Comoros	2012	3.4	6.7
		1996	3	6.4
	Ethiopia	2016	2.6	6.4
		2000	3.6	6.3
	Kenya	2015	2.4	6.1
		1998	3	6.5
	Madagascar	2016	3	5.5
		1997	3.4	8.1
	Rwanda	2015	3.3	5.1
		2000	5.4	6
	Uganda	2016	3.8	7.1
		1995	5.4	7.5
Southern Africa	Malawi	2017	2.8	5.1
		2000	5.2	7.3
	Mozambique	2015	3.1	6.1
		1997	4.4	5.2
	Namibia	2013	2.3	5.5
		2000	2.7	5.9
	Zambia	2013	3	7.1
		1996	4.4	7.4
	Zimbabwe	2015	2.4	5.6
		1999	2.6	4.9
Western Africa	Benin	2012	3.9	6.1
		1996	3.8	7.3
	Burkina Faso	2014	3.6	6.2
		1998	4.4	7.2
	Côte d'Ivoire	2012	2.9	6.7
		1998	2.9	7.4
	Ghana	2016	2.9	6.1
		1998	2.4	6.1
	Guinea	2012	3.5	6.5

		1999	4	5.8
	Mali	2015	4.6	7
		1995	5.1	6.9
	Niger	2012	6.1	8.2
		1998	5.7	8.4
	Senegal	2016	3.4	7.1
		1997	3.6	7.4
	Togo	2013	3.5	6.3
		1998	2.9	7.3

Source: The DHS Program of USAID

Appendix 3.8a. Percentage of 10 - 24 year-olds for Africa and its five subregions (1990-2030)

	1990	1995	2000	2005	2010	2015	2020	2025	2030
Africa	31.7	32.3	32.7	32.4	31.7	31.1	31.1	31.3	31.1
Central Africa	29.7	30.3	30.9	31.0	30.9	31.1	32.4	32.9	32.9
Eastern Africa	32.0	32.6	33.1	33.1	33.1	33.1	33.0	32.6	31.9
Northern Africa	31.0	31.6	32.5	31.7	29.2	26.6	25.9	26.9	27.4
Southern Africa	32.0	32.3	32.2	31.6	30.4	28.5	25.7	25.2	24.9
Western Africa	31.4	32.2	32.3	31.9	31.6	31.6	31.8	32.2	32.1

Source: United Nations

Appendix 3.8b. Total number (in 1,000s) of 10 - 24 year-olds for Africa and its five subregions (1990-2030)

	1990	1995	2000	2005	2010	2015	2020	2025	2030
Africa	201,036	233,462	267,300	299,248	332,260	371,670	420,329	476,559	530,641
Central Africa	22,185	26,564	30,725	35,818	41,665	48,878	57,896	68,076	78,157
Eastern Africa	63,570	73,677	86,371	99,438	114,869	132,409	151,123	169,320	187,161
Northern Africa	44,828	51,111	57,198	60,620	60,699	60,781	63,834	71,674	78,058
Southern Africa	13,718	15,522	16,837	17,623	17,914	18,094	18,352	18,972	19,591
Western Africa	56,734	66,588	76,170	85,749	97,113	111,508	129,125	148,518	167,675

Source: United Nations

Appendix 3.9. Trends in percentage of population aged 65+ for Africa and its five subregions (1990 – 2030)

	1990	1995	2000	2005	2010	2015	2020	2025	2030
Africa	3.2	3.3	3.4	3.4	3.4	3.5	3.6	3.8	4.1
Central Africa	3.0	3.0	2.9	2.9	2.9	2.8	3.0	3.0	3.2
Eastern Africa	2.9	2.9	2.9	2.9	2.9	3.0	3.1	3.2	3.2
Northern Africa	3.8	4.2	4.5	4.8	4.9	5.2	5.8	6.6	7.5
Southern Africa	3.4	3.7	4.0	4.2	4.6	4.9	5.2	5.8	6.4
Western Africa	2.9	3.0	2.9	2.8	2.8	2.8	2.8	2.9	3.0

Source: United Nations

Appendix 3.10. Trends in dependency ratios for Africa and its five subregions (1990 – 2030)

	1990	1995	2000	2005	2010	2015	2020	2025	2030
Africa	91.6	88.4	85.0	82.5	81.2	80.2	78.0	74.7	70.8
Central Africa	96.0	96.0	95.0	94.6	94.7	94.5	91.8	87.0	82.0
Eastern Africa	98.0	96.1	95.4	93.7	91.2	86.5	81.3	76.3	71.7
Northern Africa	83.8	77.8	69.3	61.7	58.5	60.1	61.1	60.2	56.5
Southern Africa	76.3	68.6	62.5	58.2	55.7	53.9	53.0	51.9	49.8
Western Africa	93.4	91.0	88.7	88.2	88.4	87.7	85.2	81.4	77.4

Source: United Nations

Appendix 3.11a. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Africa

	1995-2000			**2010-2015**			**2025-2030**		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-4	60,534	59,159	119,693	84,618	82,269	166,887	109,167	105,884	215,051
5-9	52,622	51,559	104,181	72,398	70,809	143,207	99,829	97,097	196,926
10-14	46,170	45,317	91,487	62,977	61,691	124,669	91,586	89,156	180,742
15-19	39,078	38,566	77,644	55,426	54,633	110,059	80,151	78,388	158,538
20-24	32,156	32,175	64,331	48,865	48,668	97,533	69,134	68,145	137,279
25-29	26,393	26,913	53,306	41,980	42,293	84,273	59,364	58,887	118,250
30-34	22,194	22,544	44,738	34,752	35,035	69,787	51,470	51,520	102,990
35-39	18,512	18,871	37,383	28,117	28,563	56,680	45,055	45,453	90,508

40-44	15,206	15,549	30,755	22,730	23,499	46,229	38,444	39,159	77,603
45-49	12,193	12,685	24,878	18,815	19,546	38,362	31,364	32,119	63,483
50-54	9,795	10,453	20,248	15,307	16,219	31,526	24,748	25,846	50,595
55-59	8,031	8,730	16,761	12,127	13,083	25,210	19,302	20,838	40,140
60-64	6,533	7,211	13,744	9,194	10,196	19,390	15,073	16,653	31,727
65-69	4,787	5,490	10,277	6,676	7,732	14,408	11,176	12,849	24,025
70-74	3,161	3,776	6,937	4,615	5,590	10,205	7,600	9,094	16,695
75-79	1,780	2,222	4,002	2,828	3,619	6,447	4,408	5,625	10,033
80+	1,043	1,514	2,557	1,881	2,695	4,576	2,103	2,947	5,050

Source: United Nations

Appendix 3.11b. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Central Africa

	1995-2000			**2010-2015**			**2025-2030**		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-4	7,818	7,765	15,583	12,167	12,012	24,179	17,039	16,749	33,788
5-9	6,286	6,271	12,556	9,849	9,789	19,638	14,994	14,803	29,797
10-14	5,260	5,253	10,513	8,123	8,107	16,230	13,290	13,150	26,440
15-19	4,393	4,392	8,785	6,886	6,879	13,764	11,407	11,345	22,752
20-24	3,622	3,643	7,266	5,831	5,840	11,671	9,440	9,444	18,884
25-29	2,971	3,016	5,987	4,864	4,886	9,750	7,737	7,780	15,517
30-34	2,447	2,504	4,951	3,998	4,022	8,020	6,473	6,513	12,986
35-39	2,012	2,075	4,087	3,231	3,261	6,492	5,390	5,444	10,834
40-44	1,670	1,739	3,410	2,593	2,640	5,233	4,409	4,475	8,884
45-49	1,339	1,420	2,759	2,083	2,156	4,238	3,548	3,626	7,174
50-54	1,104	1,205	2,309	1,660	1,757	3,417	2,800	2,895	5,696
55-59	892	1,005	1,897	1,322	1,436	2,758	2,176	2,295	4,471
60-64	690	810	1,500	995	1,116	2,112	1,657	1,803	3,460
65-69	501	619	1,120	739	865	1,603	1,207	1,364	2,571
70-74	329	426	754	500	615	1,115	826	975	1,801
75-79	184	253	437	290	380	670	483	601	1,084
80+	109	172	281	184	277	461	238	319	556

Source: United Nations

Appendix 3.11c. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Eastern Africa

	1995-2000	**2010-2015**	**2025-2030**

Age	Men	Women	Total	Men	Women	Total	Men	Women	Total
0-4	20,418	20,179	40,597	29,768	29,198	58,965	38,416	37,571	75,987
5-9	17,208	17,068	34,276	25,896	25,648	51,544	34,920	34,310	69,231
10-14	14,702	14,624	29,326	22,520	22,284	44,804	31,733	31,209	62,942
15-19	12,131	12,192	24,323	18,947	18,947	37,895	28,456	28,120	56,577
20-24	9,957	10,072	20,029	15,983	16,187	32,170	24,902	24,899	49,801
25-29	7,991	8,333	16,323	13,344	13,712	27,055	21,399	21,472	42,870
30-34	6,487	6,814	13,300	10,777	11,015	21,792	17,727	18,048	35,774
35-39	5,322	5,664	10,986	8,574	8,734	17,308	14,742	15,223	29,964
40-44	4,318	4,583	8,902	6,551	6,907	13,458	12,118	12,714	24,832
45-49	3,459	3,748	7,207	5,106	5,582	10,688	9,575	10,038	19,613
50-54	2,758	3,003	5,761	4,076	4,605	8,681	7,407	7,817	15,225
55-59	2,204	2,413	4,617	3,232	3,701	6,933	5,487	6,074	11,561
60-64	1,824	1,998	3,823	2,522	2,946	5,468	4,091	4,761	8,852
65-69	1,292	1,465	2,757	1,872	2,217	4,088	3,030	3,697	6,727
70-74	892	1,014	1,906	1,309	1,554	2,863	2,104	2,647	4,752
75-79	549	593	1,141	853	1,032	1,885	1,308	1,716	3,024
80+	334	414	748	615	775	1,390	665	910	1,575

Source: United Nations

Appendix 3.11d. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Northern Africa

	1995-2000			2010-2015			2025-2030		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-4	10,915	10,435	21,350	12,274	11,691	23,965	13,927	13,281	27,208
5-9	10,911	10,444	21,355	10,887	10,379	21,266	14,087	13,439	27,526
10-14	10,064	9,658	19,722	10,216	9,773	19,988	14,192	13,511	27,703
15-19	8,722	8,378	17,100	10,413	10,018	20,430	11,942	11,416	23,358
20-24	7,207	7,081	14,288	10,254	10,026	20,280	10,499	10,113	20,612
25-29	6,151	6,154	12,305	9,142	9,154	18,296	9,607	9,394	19,001
30-34	5,404	5,314	10,718	7,694	7,805	15,499	9,667	9,552	19,219
35-39	4,609	4,490	9,098	6,368	6,563	12,932	9,626	9,592	19,218
40-44	3,777	3,657	7,434	5,623	5,756	11,380	8,801	8,841	17,642
45-49	2,897	2,918	5,815	5,029	4,974	10,003	7,525	7,586	15,111
50-54	2,172	2,325	4,497	4,219	4,173	8,392	6,124	6,327	12,452
55-59	1,964	2,107	4,072	3,353	3,328	6,682	5,175	5,420	10,595
60-64	1,732	1,870	3,603	2,458	2,570	5,027	4,341	4,511	8,852
65-69	1,345	1,507	2,852	1,723	1,946	3,668	3,357	3,579	6,936
70-74	884	1,055	1,939	1,320	1,580	2,900	2,364	2,595	4,959
75-79	493	646	1,139	884	1,132	2,016	1,368	1,656	3,024
80+	323	504	827	645	942	1,586	672	931	1,603

Source: United Nations

Appendix 3.11e. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Southern Africa

	1995-200			2010-2015			2025-2030		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-4	3,045	2,997	6,042	3,210	3,151	6,361	3,356	3,280	6,636
5-9	3,011	2,982	5,994	3,062	3,021	6,083	3,384	3,318	6,702
10-14	2,881	2,862	5,743	3,011	2,977	5,988	3,360	3,307	6,666
15-19	2,594	2,590	5,184	3,002	2,969	5,971	3,159	3,122	6,280
20-24	2,283	2,312	4,595	2,999	2,956	5,955	3,025	3,001	6,025
25-29	1,942	2,014	3,956	2,803	2,718	5,521	2,995	2,963	5,958
30-34	1,674	1,762	3,436	2,391	2,297	4,688	2,964	2,917	5,881
35-39	1,433	1,525	2,958	1,950	1,971	3,921	2,858	2,804	5,662
40-44	1,212	1,306	2,518	1,557	1,702	3,259	2,523	2,467	4,991
45-49	923	990	1,913	1,302	1,492	2,795	2,008	2,014	4,022
50-54	764	832	1,596	1,091	1,292	2,383	1,562	1,724	3,286
55-59	608	688	1,296	893	1,084	1,977	1,208	1,490	2,698
60-64	480	551	1,031	637	789	1,427	943	1,266	2,210
65-69	336	418	754	461	619	1,080	704	1,032	1,736
70-74	207	292	499	295	455	751	476	778	1,254
75-79	112	191	302	170	303	473	255	480	735
80+	68	150	218	114	270	384	123	284	408

Source: United Nations

Appendix 3.11f. Total population (in 1,000s) by age (1995-2000, 2010-2015, 2025-2030) for Western Africa

	1995-2000			2010-2015			2025-2030		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-4	18,337	17,784	36,121	27,200	26,217	53,416	36,430	35,003	71,433
5-9	15,206	14,794	29,999	22,704	21,972	44,676	32,444	31,227	63,671
10-14	13,263	12,920	26,183	19,108	18,550	37,658	29,012	27,979	56,991
15-19	11,238	11,014	22,252	16,178	15,820	31,998	25,187	24,384	49,571
20-24	9,087	9,066	18,153	13,798	13,659	27,457	21,268	20,687	41,955
25-29	7,338	7,396	14,734	11,827	11,824	23,651	17,625	17,279	34,904
30-34	6,182	6,150	12,333	9,892	9,896	19,788	14,639	14,490	29,129
35-39	5,135	5,118	10,254	7,993	8,034	16,027	12,439	12,391	24,830
40-44	4,227	4,263	8,491	6,405	6,494	12,899	10,592	10,662	21,254
45-49	3,576	3,609	7,185	5,294	5,343	10,637	8,708	8,855	17,564
50-54	2,996	3,089	6,085	4,261	4,393	8,654	6,854	7,083	13,937
55-59	2,363	2,516	4,879	3,327	3,534	6,860	5,256	5,560	10,815
60-64	1,806	1,981	3,787	2,581	2,775	5,356	4,041	4,312	8,353
65-69	1,313	1,481	2,794	1,882	2,087	3,969	2,879	3,176	6,055
70-74	849	989	1,838	1,191	1,386	2,577	1,830	2,099	3,929
75-79	443	539	982	631	772	1,404	994	1,172	2,166
80+	209	275	485	324	430	754	404	503	907

Source: United Nations

Appendix 3.12. Percentage of population residing in urban areas

	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035
Africa	31.5	33.5	35.0	36.9	38.9	41.2	43.5	45.9	48.4	50.9
Central Africa	34.0	36.9	39.7	42.6	45.2	47.9	50.6	53.4	56.2	59.0
Eastern Africa	18.0	19.7	21.0	22.5	24.4	26.6	29.0	31.6	34.5	37.5
Northern Africa	45.7	47.3	48.3	49.3	50.5	51.4	52.5	53.8	55.3	57.2
Southern Africa	48.8	51.4	53.8	56.5	59.4	62.1	64.6	67.1	69.4	71.6
Western Africa	30.2	32.3	34.5	37.8	41.1	44.5	47.7	50.7	53.6	56.3

Source: United Nations

Appendix 3.13. Net migration rate (per 1.000 population)

	1990 - 1995	1995 - 2000	2000 - 2005	2005 - 2010	2010 - 2015	2015 - 2020	2020 - 2025	2025 - 2030
Africa	-0.1	-0.6	-0.5	-0.7	-0.6	-0.4	-0.3	-0.3
Central Africa	3.8	-2.2	0.4	0.3	-0.2	0.0	0.0	-0.1
Eastern Africa	-2.0	0.3	-0.4	-0.4	-0.5	-0.4	-0.3	-0.3
Northern Africa	-0.3	-2.0	-1.7	-2.5	-1.7	-0.7	-0.5	-0.4
Southern Africa	3.1	1.1	1.8	1.9	2.6	0.9	0.5	0.2
Western Africa	-0.2	-0.4	-0.6	-0.6	-0.7	-0.5	-0.4	-0.4

Source: United Nations

Appendix 4.1.1. Percentage of the population living on less than USD 1.90 a day

Region	Country	Period 1	Period 2
Central Africa	Cameroon (2001; 2014)	23.1	23.8
	Central Af Rep (2003; 2008)	64.8	66.3
	Chad (2003; 2011)	62.9	38.4
Eastern Africa	Comoros (2004; 2013)	13.5	18.1
	Djibouti (2002; 2012)	20.6	22.5
	Ethiopia (2004; 2015)	36.4	26.7
	Madagascar (2005; 2012)	72	77.6
	Mauritius (2006; 2012)	0.4	0.5
	Rwanda (2005; 2013)	67.2	59.5
	Tanzania (2000; 2011)	86	49.1
	Uganda (2005; 2012)	55.4	35.9
Northern Africa	Egypt (2004; 2015)	4.4	1.3
	Mauritania (2004; 2014)	14.4	6
	Morocco (2000; 2006)	6.3	3.1
Southern Africa	Botswana (2002; 2009)	29.8	18.2
	Lesotho (2002; 2010)	61.3	59.6

	Malawi (2004; 2010)	72.8	71.4
	Mozambique (2002; 2014)	80.6	62.9
	Namibia (2003; 2009)	31.5	22.6
	South Africa (2005; 2014)	25	18.9
	Eswatini (2000; 2009)	48.4	42
	Zambia (2004; 2015)	56.7	57.5
Western Africa	Benin (2003; 2015)	48.8	49.6
	Burkina Faso (2003; 2014)	57.3	43.7
	Cabo Verde (2001; 2007)	16	8.1
	Côte d'Ivoire (2002; 2015)	23.2	28.2
	Gambia (2003; 2015)	45.3	10.1
	Ghana (2005; 2012)	24.5	12
	Guinea (2002; 2012)	61.6	35.3
	Guinea-Bissau (2002; 2010)	53.9	67.1
	Liberia (2007; 2014)	68.6	38.6
	Mali (2001; 2009)	58.5	49.7
	Niger (2005; 2014)	74.9	44.5
	Togo (2006; 2015)	55.6	49.2

Source: World Bank

Appendix 4.1.2. Multidimensional poverty index

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2010)	48.5	44.2
	Cameroon (2006; 2011)	30.4	26.0
	Central Af Rep (2006; 2010)	46.4	42.4
	Congo (2009; 2012)	15.4	19.2
Eastern Africa	Rwanda (2005; 2010)	48.1	35.2
	Uganda (2006; 2011)	39.9	35.9
Northern Africa	Egypt (2008; 2014)	3.6	1.6
	Mauritania (2007; 2011)	36.3	29.1
Southern Africa	Namibia (2007; 2013)	20.0	20.5
	South Africa (2008; 2012)	3.9	4.1
	Zambia (2007; 2014)	31.8	26.4
	Zimbabwe (2006; 2014)	19.3	12.8
Western Africa	Benin (2006; 2012)	40.1	34.3
	Burkina Faso (2006; 2010)	53.8	50.8
	Côte d'Ivoire (2005; 2012)	26.9	30.7
	Gambia (2006; 2013)	32.9	28.9
	Ghana (2008; 2014)	18.6	14.7
	Guinea (2005; 2012)	54.8	42.5

	Liberia (2007; 2013)	45.9	35.6
	Mali (2006; 2013)	53.3	45.6
	Niger (2006; 2012)	67.7	58.4
	Nigeria (2008; 2013)	29.4	27.9
	Senegal (2005; 2014)	43.6	27.8
	Sierra Leone (2008; 2013)	45.1	41.1
	Togo (2006; 2014)	27.7	24.2

Source: UNDP

Appendix 4.1.3. Gini coefficient

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2013)	29.3	38.6
	Cameroon (2001; 2014)	42.1	46.6
	Central Af Rep (2003; 2008)	43.6	56.2
	Chad (2003; 2011)	39.8	43.3
	Congo (2005; 2011)	47.3	48.9
	DR Congo (2004; 2012)	42.2	42.1
Eastern Africa	Comoros (2004; 2013)	55.9	43.3
	Madagascar (2005; 2012)	39.9	42.6
	Mauritius (2006; 2012)	35.7	35.8
	Rwanda (2005; 2013)	52	50.4
	Tanzania (2000; 2011)	37.3	37.8
	Uganda (2005; 2012)	42.9	41
Northern Africa	Egypt (2004; 2015)	31.8	31.8
	Mauritania (2004; 2014)	40.2	32.6
	Morocco (2000; 2006)	40.6	40.7
Southern Africa	Lesotho (2002; 2010)	51.6	54.2
	Malawi (2004; 2010)	39.9	45.5
	Mozambique (2002; 2014)	47	54
	South Africa (2005; 2014)	64.8	63
	Eswatini (2000; 2009)	53.1	51.5
	Zambia (2004; 2015)	54.3	57.1
Western Africa	Benin (2003; 2015)	38.6	47.8
	Burkina Faso (2003; 2014)	43.3	35.3
	Cabo Verde (2001; 2007)	52.5	47.2
	Côte d'Ivoire (2002; 2015)	41.3	41.5
	Ghana (2005; 2012)	42.8	42.4
	Guinea (2002; 2012)	43	33.7

	Guinea-Bissau (2002; 2010)	35.6	50.7
	Liberia (2007; 2014)	36.5	33.3
	Mali (2001; 2009	39.9	33
	Niger (2005; 2014)	44.4	34.3
	Nigeria (2003; 2009)	40.1	43
	Senegal (2005; 2011)	39.2	40.3
	Sierra Leone (2003; 2011)	40.2	34
	Togo (2006; 2015)	42.2	43.1

Source: World Bank

Appendix 4.1.4. Gender parity in enrollment in primary and secondary school

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005;2016)	0.8	1.0
	Cameroon (2005;2016)	0.8	0.9
	Central Af Rep (2001;2016)	0.7	0.7
	Chad (2005;2016)	0.6	0.7
	DR Congo (2007;2015)	0.7	0.9
Eastern Africa	Comoros (2004;2014)	0.8	1.0
	Djibouti (2005;2017)	0.8	0.9
	Ethiopia (2005;2015)	0.8	0.9
	Kenya (2005;2009)	1.0	1.0
	Madagascar (2005;2016)	1.0	1.0
	Mauritius (2005;2016)	1.0	1.0
	Rwanda (2005;2016)	1.0	1.0
	Seychelles (2005;2016)	1.0	1.0
	Sudan (2005;2015)	0.9	0.9
Northern Africa	Algeria (2005;2011)	1.0	1.0
	Egypt (2004;2016)	1.0	1.0
	Mauritania (2005;2016)	1.0	1.0
	Morocco (2005;2012)	0.9	0.9
	Tunisia (2005;2016)	1.0	1.0
Southern Africa	Lesotho (2005;2016)	1.0	1.1
	Malawi (2005;2016)	1.0	1.0
	Mozambique (2005;2015)	0.8	0.9
	South Africa (2005;2015)	1.0	1.0
	Eswatini (2005;2015)	1.0	0.9
	Zimbabwe (2003;2013)	1.0	1.0
Western Africa	Benin (2005;2016)	0.8	0.9
	Burkina Faso (2005;2016)	1.0	1.0
	Cabo Verde (2005;2016)	1.0	1.0
	Côte d'Ivoire (1999;2016)	0.7	0.8
	Ghana (2005;2017)	0.9	1.0
	Guinea (2005;2014)	0.7	0.8
	Liberia (2000;2015)	0.7	0.9
	Mali (2005;2016)	0.7	0.8
	Niger (2005;2016)	0.7	0.8
	Nigeria (2005;2013)	0.8	1.0
	Senegal (2005;2016)	0.9	1.1
	Sierra Leone (2001;2016)	0.7	1.0

Source: World Bank

Appendix 4.1.5. Gender parity in education (primary) by residence

Region	Country	Year	Rural	Urban
Central Africa	Congo	2005	1.0	1.0
		2011	1.0	1.0
Eastern Africa	Ethiopia	2005	0.7	1.0
		2016	1.0	1.0
	Kenya	2003	1.0	1.0
		2014	1.0	1.0
	Rwanda	2005	1.0	1.0
		2015	1.0	1.0
	Tanzania	2004	1.1	1.0
		2015	1.1	1.0
	Uganda	2000	1.0	1.0
		2016	1.0	1.0
Northern Africa	Egypt	2005	1.0	1.0
		2014	1.0	1.0
Southern Africa	Lesotho	2004	1.1	1.1
		2014	1.1	1.0
	Malawi	2004	1.1	1.0
		2015	1.0	1.0
	Mozambique	2003	0.9	1.0
		2015	1.0	1.0
	Zambia	2002	1.0	1.0
		2013	1.1	1.0
	Zimbabwe	2005	1.0	1.0
		2015	1.0	1.0
Western Africa	Benin	2006	0.7	0.8
		2012	0.9	0.9
	Ghana	2003	1.0	1.0
		2014	1.0	1.0
	Guinea	2005	0.9	0.9
		2012	0.8	0.9
	Mali	2006	0.7	0.8
		2012	0.9	0.9
	Nigeria	2003	0.9	0.9
		2013	0.9	1.0
	Senegal	2005	1.0	1.0
		2016	1.0	1.0

Source: The DHS Program of USAID

Appendix 4.1.6. Proportion of women who have a say in household decisions for large purchases, their own health, and movement

Region	Country	Period 1	Period 2
Central Africa	Cameroon (2004;2011)	23.1	23.7
Eastern Africa	Ethiopia (2005;2016)	45.4	70.6
	Kenya (2003;2014)	25.7	55.8
	Rwanda (2005;2015)	47.1	65.4
	Tanzania (2005;2016)	25.4	35.2
	Uganda (2001;2011)	28.5	37.5
Northern Africa	Egypt (2005;2014)	45.2	58.8
Southern Africa	Lesotho (2004;2014)	27.6	65.4
	Malawi (2004;2016)	13.1	46.9
	Mozambique (2003;2011)	29	49.4
	Zambia (2002;2014)	18	53.8
Western Africa	Benin (2001;2012)	17.2	48.3
	Burkina Faso (2003;2010)	10.2	12
	Mali (2001;2013)	8.2	8.9
	Nigeria (2003;2013)	13.9	31.3
	Senegal (2005;2014)	9.5	9.7

Source: The DHS Program of USAID

Appendix 4.1.7. Women's parliamentary representation

Region	Country	Value	Region	Country	Value
Central Africa	Burundi (2015)	41.9	Southern Africa	Angola (2017)	30.5
	Cameroon (2013)	31.1		Botswana (2014)	9.5
	Central Af Rep (2016)	8.6		Lesotho (2017)	25
	Chad (2011)	12.8		Malawi (2014)	16.7
	Congo (2017)	19.7		Mozambique 2014)	39.6
	Eq Guinea (2017)	15.3		Namibia (2015)	24.4
	Gabon (2014)	17.6		South Africa (2014)	35.2
	São Tomé & P (2014)	18.2		Eswatini (2013)	33.3
Eastern Africa	Comoros (2015)	6.1		Zambia (2016)	18
	Djibouti (2018)	23.1		Zimbabwe (2013)	48.1
	Eritrea (1994)	22	Western Africa	Benin (2015)	7.2
	Ethiopia (2015)	32		Burkina Faso (2015)	11
	Kenya (2017)	30.9		Cabo Verde (2016)	23.6
	Madagascar (2015)	20.6		Côte d'Ivoire (2016)	10.6
	Mauritius (2014)	11.6		Gambia (2017)	10.3
	Rwanda (2011)	38.5		Ghana (2016)	12.7
	Seychelles (2016)	21.2		Guinea (2013)	21.9
	Somalia (2016)	24.1		Guinea-Bissau (2014)	13.7
	South Sudan (2011)	12		Liberia (2017)	10
	Sudan (2015)	35.2		Mali (2013)	8.8
	Tanzania (2015)	37.2		Niger (2016)	17
	Uganda (2016)	34.3		Nigeria (2015)	6.5
Northern Africa	Algeria (2016)	26.7		Senegal (2017)	41.8
	Egypt (2015)	14.9		Togo (2013)	17.6
	Libya (2014)	16			
	Mauritania (2013)	25.2			
	Morocco (2015)	11.7			
	Tunisia (2014)	31.3			

Source: Archive of statistical data of Inter-Parliamentary Union

Appendix 4.1.8. Prevalence of stunting among children under five years of age

Region	Country	Period 1	Period 2
Central Africa	Cameroon (2004;2011)	35.3	32.5
	Chad (2004;2014)	44.6	39.9
	Congo (2005;2011)	30.8	24.4
	Gabon (2000;2012)	25.1	16.5
Eastern Africa	Ethiopia (2005;2016)	50.8	38.4
	Rwanda (2005;2015)	51.1	37.9
	Tanzania (2004;2015)	44.3	34.4
	Uganda (2000;2016)	44.8	28.9
Northern Africa	Egypt (2005;2004)	22.9	21.4
Southern Africa	Malawi (2004;2015)	52.5	37.1
	Mozambique (2003;2015)	47	42.6
	Namibia (2000;2013)	29	23.7
	Zambia (2002;2013)	52.5	40.1
	Zimbabwe (2005;2015)	34.6	26.8
Western Africa	Benin (2001;2012)	36.2	44.6
	Burkina Faso (2003;2010)	43.4	34.6
	Mali (2001;2012)	42.4	38.3
	Nigeria (2003;2013)	36.8	48.3
	Senegal (2005;2016)	19.6	17

Source: The DHS Program of USAID

Appendix 4.1.9 Under-five child mortality for Africa and it five subregions for 2000-2005 and 2010-2015

	2010-2015	2000-2005
Africa	87	129
Central Africa	113	163
Eastern Africa	77	120
Northern Africa	37	55
Southern Africa	49	83
Western Africa	111	162

Source: United Nations

Appendix 4.1.10. Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting

Region	Country	Period 1	Period 2
Central Africa	Chad (2004;2014)	44.9	38.4
Eastern Africa	Ethiopia (2005;2016)	74.3	65.2
	Kenya (2003;2014)	32.2	21
	Tanzania (2004;2015	14.6	10
Northern Africa	Egypt (2005;2014)	95.8	92.3
Western Africa	Benin (2001;2012)	16.8	7.3
	Burkina Faso (2003;2010)	76.6	75.8
	Côte d'Ivoire (2005;2012)	41.7	38.2
	Guinea (2005;2012)	95.6	96.9
	Mali (2001;2012)	91.6	91.4
	Nigeria (2003;2013)	19	24.8
	Senegal (2005;2016)	28.2	22.7

Source: The DHS Program of USAID

Appendix 4.1.11. Proportion of ever-partnered women and girls >15 subjected to physical, sexual, or psychological violence by current or former partners in the last 12 months

Region	Country	2000-2005	2010-2017
Central Africa	Cameroon (2004;2011)	33	43.2
Eastern Africa	Kenya (2003;2014)	33.6	32.8
	Rwanda (2005;2015)	27.3	26.8
Southern Africa	Malawi (2004;2015)	22.6	32.7
	Zimbabwe (2005;2015)	37	30.2

Source: The DHS Program of USAID

Appendix 4.1.12. Proportion of women and girls subjected to sexual violence

Region	Country	2000-2005	2010-2017
Central Africa	Cameroon (2004;2011)	9.7	9.9
Eastern Africa	Kenya (2003;2014)	12.1	7.8
	Rwanda (2005;2015)	10.4	7.6
Southern Africa	Malawi (2004;2015)	11.4	13.9
	Zimbabwe (2005;2015)	9.4	7.5

Source: The DHS Program of USAID

Appendix 4.1.13a. Percentage of children completing primary school

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005;2016)	34.9	69.8
	Cameroon (2004;2016)	60.0	75.4
	Central Af Rep (2005;2016)	25.9	42.2
	Chad (2005;2013)	30.2	37.9
	Congo (2005;2012)	70.0	70.3
	DR Congo (2002;2015)	42.7	70.0
	Eq Guinea (2005;2015)	43.6	40.6
	São Tomé & P (2005;2017)	74.1	86.7
Eastern Africa	Djibouti (2005;2017)	33.6	57.5
	Eritrea (2005;2015)	57.2	42.5
	Ethiopia (2005;2015)	43.3	54.3
	Kenya (2005;2016)	88.5	102.0
	Madagascar (2005;2016)	58.3	67.6
	Mauritius (2005;2016)	97.5	101.1
	Rwanda (2004;2016)	41.5	67.3
	Seychelles (2005;2016)	54.0	126.5
	Tanzania (2005;2013)	54.0	72.4
	Uganda (2005;2016)	56.0	52.6
Northern Africa	Algeria (2005;2016)	93.2	105.4
	Egypt (2005;2016)	90.3	93.9
	Mauritania (2005;2016)	42.4	59.3
	Morocco (2005;2016)	78.6	94.8
	Tunisia (2005;2015)	103.5	103.2
Southern Africa	Lesotho (2005;2016)	64.0	78.9
	Malawi (2005;2014)	57.2	76.9
	Mozambique (2005;2015)	40.6	48.4
	Namibia (2005;2015)	85.0	80.6
	South Africa (2004;2015)	97.1	83.7
	Eswatini (2005;2015)	66.1	80.6
	Zambia (2005;2013)	80.3	78.7
	Zimbabwe (2003;2013)	84.4	88.9
Western Africa	Benin (2004;2015)	51.9	81.1
	Burkina Faso (2005;2016)	31.7	61.7
	Cabo Verde (2005;2016)	83.9	85.3
	Côte d'Ivoire (2001;2016)	49.3	65.9

	Ghana (2005;2015)	74.9	100.2
	Guinea (2005;2014)	54.0	63.8
	Guinea-Bissau (2000;2010)	27.4	64.3
	Mali (2005;2016)	42.2	51.0
	Niger (2005;2016)	29.4	71.6
	Nigeria (2005;2010)	83.1	73.8
	Senegal (2005;2016)	51.5	58.9
	Togo (2005;2015)	74.2	82.9

Source: World Bank

Appendix 4.1.13b. Percentage of children completing secondary school

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005;2016)	8.6	41.0
	Cameroon (2003;2016)	23.0	48.5
	Central Af Rep (2005;2016)	8.4	10.0
	Chad (2004;2013)	10.7	17.5
	Congo (2004;2012)	40.0	49.7
	Eq Guinea (2005;2015)	19.6	24.0
	São Tomé & P (2005;2017)	34.9	74.2
Eastern Africa	Comoros (2004;2014)	34.4	48.3
	Djibouti (2005;2017)	19.0	43.5
	Eritrea (2004;2015)	29.7	33.7
	Ethiopia (2005;2015)	18.8	29.6
	Madagascar (2005;2016)	18.2	36.0
	Mauritius (2005;2016)	80.5	88.5
	Seychelles (2005;2016)	111.6	125.2
	Tanzania (2005;2013)	9.1	34.5
	Uganda (2004;2016)	18.7	27.8
Northern Africa	Algeria (2005;2016)	72.3	79.1
	Egypt (2004;2016)	75.4	83.6
	Mauritania (2005;2016)	17.6	28.4
	Morocco (2004;2016)	41.5	67.8
Southern Africa	Lesotho (2005;2016)	31.3	42.0
	Malawi (2005;2013)	16.4	20.3
	Mozambique (2005;2015)	9.6	22.5
	Namibia (2005;2013)	60.8	59.2
	Eswatini (2005;2015)	37.2	47.0
	Zambia (2005;2013)	40.8	53.4
Western Africa	Benin (2002;2015)	18.0	45.1
	Burkina Faso (2005;2016)	9.9	30.1
	Cabo Verde (2005;2016)	54.1	71.9
	Côte d'Ivoire (2002;2016)	24.9	39.5
	Gambia (2005;2014)	66.4	63.2
	Ghana (2005;2017)	57.0	74.7
	Guinea (2005;2014)	23.1	36.5
	Guinea-Bissau (2000;2010)	12.8	36.1
	Liberia (2000;2014)	38.3	37.3
	Mali (2002;2016)	16.6	30.6

	Niger (2005;2016)	7.1	16.9
	Nigeria (2003;2010)	37.0	47.0
	Senegal (2005;2016)	20.1	36.9
	Sierra Leone (2001;2016)	20.4	55.4
	Togo (2005;2016)	38.7	42.5

Source: World Bank

Appendix 4.1.14a: Gender parity in primary school completion

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2016)	0.9	1.2
	Cameroon (2004; 2016)	0.8	0.9
	Central Af Rep (2005; 2016)	0.6	0.8
	Chad (2005; 2013)	0.7	0.9
	Congo (2005; 2012)	1.0	1.1
	DR Congo (2002; 2015)	0.6	0.8
	Eq Guinea (2005; 2015)	0.7	0.8
	São Tomé & P (2005; 2017)	0.9	1.0
Eastern Africa	Comoros (2004; 2014)	1.1	1.0
	Djibouti (2005; 2017)	0.7	0.8
	Eritrea (2005; 2015)	0.8	1.1
	Ethiopia (2005; 2015)	0.6	0.9
	Kenya (2005; 2016)	1.0	1.0
	Madagascar (2005; 2016)	0.7	1.0
	Mauritius (2005; 2016)	1.0	1.0
	Rwanda (2004; 2016)	1.1	1.0
	Seychelles (2005; 2016)	1.1	1.1
	Tanzania (2005; 2013)	0.7	0.9
	Uganda (2005; 2016)	1.0	1.0
Northern Africa	Algeria (2005; 2016)	1.4	1.2
	Egypt (2005; 2016)	1.0	1.0
	Mauritania (2005; 2016)	0.9	1.0
	Morocco (2005; 2016)	1.0	1.1
	Tunisia (2005; 2015)	0.9	1.0
Southern Africa	Lesotho (2005; 2016)	1.0	1.0
	Malawi (2005; 2014)	0.5	0.6
	Mozambique (2005; 2015)	1.0	1.1
	Namibia (2005; 2013)	1.0	1.0
	South Africa (2004; 2015)	0.9	1.1
	Eswatini (2005; 2015)	0.7	1.0
	Zambia (2005; 2013	0.8	0.9
	Zimbabwe (2003; 2013)	0.6	0.7
Western Africa	Benin (2004; 2015)	0.8	1.1
	Burkina Faso (2005; 2016)	0.9	1.0
	Cabo Verde (2005; 2016)	0.9	1.1
	Côte d'Ivoire (2001; 2016)	1.0	1.0
	Gambia (2005; 2016)	1.0	1.2
	Ghana (2005; 2017)	1.0	1.0
	Guinea (2005; 2014)	1.0	1.1
	Guinea-Bissau (2000; 2010)	1.0	1.0
	Mali (2005; 2016)	0.7	1.0

	Niger (2005; 2016)	0.8	0.9
	Nigeria (2005; 2010)	0.8	0.9
	Senegal (2005; 2016)	1.0	1.1
	Togo (2005; 2015)	0.7	0.9

Source: World Bank

Appendix 4.1.14b: Gender parity in secondary school completion

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2016)	0.7	0.9
	Cameroon (2003; 2016)	0.9	1.0
	Central Af Rep (2005; 2016)	0.7	0.6
	Chad (2004; 2013)	0.3	0.4
	Congo (2004; 2012)	0.6	1.0
	Eq Guinea (2005; 2015)	0.7	1.0
	São Tomé & P (2005; 2017)	1.1	1.2
Eastern Africa	Comoros (2004; 2014)	0.7	1.1
	Djibouti (2005; 2017)	0.6	0.9
	Eritrea (2004; 2015)	0.7	1.0
	Ethiopia (2005; 2015)	0.6	1.0
	Madagascar (2005; 2016)	1.0	1.0
	Mauritius (2005; 2016)	1.1	1.1
	Seychelles (2005; 2016)	1.0	1.0
	Tanzania (2005; 2013)	0.7	0.9
	Uganda (2004; 2016)	0.8	0.9
Northern Africa	Algeria (2005; 2016)	1.2	1.2
	Egypt (2004; 2016)	1.0	1.1
	Mauritania (2005; 2016)	0.9	1.0
	Morocco (2004; 2016)	0.9	1.0
	Tunisia (2005; 2015)	1.2	1.2
Southern Africa	Lesotho (2005; 2016)	1.3	1.4
	Malawi (2005; 2013)	0.7	0.9
	Mozambique (2005; 2015)	0.7	1.0
	Namibia (2005; 2013)	1.1	1.1
	Eswatini (2005; 2015)	1.0	0.8
	Zambia (2005; 2013)	0.9	0.9
Western Africa	Benin (2002; 2015)	0.3	0.7
	Burkina Faso (2005; 2016)	0.7	1.0
	Cabo Verde (2005; 2016)	1.2	1.2
	Côte d'Ivoire (2002; 2016)	0.6	0.7
	Gambia (2005; 2014)	0.8	1.0
	Ghana (2005; 2017)	0.8	1.0
	Guinea (2005; 2014)	0.5	0.7

	Guinea-Bissau (2000; 2010)	0.5	0.6
	Liberia (2000; 2014)	0.7	0.8
	Mali (2002; 2016)	0.5	0.7
	Niger (2005; 2016)	0.7	0.7
	Nigeria (2003; 2010)	0.8	0.9
	Senegal (2005; 2016)	0.8	1.1
	Sierra Leone (2001; 2016)	0.7	0.9
	Togo (2005; 2016)	0.5	0.7

Source: World Bank

Appendix 4.1.15. Life expectancy for the continent and its five subregions for 2000-2005 and 2010-2015

	2000-2005	**2010-2015**
Africa	53.66	60.23
Central Africa	50.79	57.43
Eastern Africa	51.98	61.45
Northern Africa	67.92	71.08
Southern Africa	53.20	59.30
Western Africa	49.30	54.74

Source: United Nations

Appendix 4.2.1. Unmet need for family planning (% of married women ages 15-49)

Region	Country	Period 1	Period 2
Central Africa	Burundi (2002;2017)	29.0	29.7
	Cameroon (2004;2014)	20.5	18.0
	Congo (2005; 2015)	19.5	17.9
	Gabon (2000;2012)	27.9	26.5
Eastern Africa	Eritrea (2002;2010)	28.5	27.4
	Ethiopia (2005;2017)	36.1	22.8
	Kenya (2003;2016)	27.4	15.6
	Mauritius (2002; 2014)	3.5	12.5
	Rwanda (2005;2015)	38.5	18.9
	Tanzania (2005;2016)	24.3	22.1
	Uganda (2001;2017)	35.0	29.6
Northern Africa	Egypt (2005; 2014)	12.3	12.6
	Mauritania (2001; 2015)	32.1	33.6
	Morocco (2004; 2011)	11.9	10.9
	Tunisia (2001; 2012)	12.1	7.0
Southern Africa	Lesotho (2005;2014)	31.0	18.4
	Malawi (2005;2016)	30.3	18.7
	Mozambique (2004; 2015)	18.9	23.1
	Namibia (2000;2013)	23.9	17.5
	South Africa (2004;2016)	13.8	14.7
	Zambia (2002;2014)	27.5	21.1
Western Africa	Benin (2001; 2014)	27.9	33.1
	Burkina Faso (2003; 2017)	29.8	29.1
	Ghana (2003;2017)	34.5	26.3
	Guinea (2005;2016)	21.9	27.6
	Mali (2001; 2015)	29.6	17.2
	Nigeria (2003;2017)	17.5	27.6
	Senegal (2005;2016)	32.0	23.6
	Sierra Leonne (2004;2015)	20.6	22.9

Source: World Bank

Appendix 4.2.2: Demand for family planning satisfied by modern methods (% of married women with demand for FP)

Region	Country	Period 1	Period 2
Central Africa	Burundi (2002;2017)	17.5	39.3
	Cameroon (2004; 2014)	28.1	40.1
	Chad (2004;2015)	31.4	17.6
	Congo (2005;2015)	19.8	38.5
	Gabon (2000; 2012)	22.1	33.7
Eastern Africa	Eritrea (2002;2010)	19.9	19.6
	Ethiopia (2005; 2017)	27.4	59.4
	Kenya (2003;2016)	47.3	77.6
	Mauritius (2002;2014)	49.6	41.9
	Rwanda (2005; 2015)	18.4	65.8
	Tanzania (2005;2016)	39.5	52.9
	Uganda (2001;2017)	31.5	49.9
Northern Africa	Egypt (2005; 2014)	79.0	80.0
	Mauritania (2001; 2015)	12.9	30.4
	Morocco (2004;2011)	73.2	74.8
	Tunisia (2001;2012)	71.1	73.2
Southern Africa	Lesotho (2005; 2014)	51.5	76.1
	Malawi (2005;2016)	44.7	74.6
	Mozambique (2004; 2015)	46.8	50.4
	Namibia (2000;2013)	63.1	75.0
	South Africa (2004; 2016)	81.1	77.9
	Zambia (2002; 2014)	41.0	63.8
Western Africa	Benin (2001; 2014)	15.4	24.5
	Burkina Faso (2003; 2017)	20.1	45.0
	Ghana (2003; 2017)	31.3	46.2
	Guinea (2005;2016)	18.3	21.5
	Mali (2001; 2015)	18.5	46.0
	Nigeria (2003;2017)	27.4	26.3
	Senegal (2005;2016)	23.5	47.4

Source: World Bank

Appendix 4.2.3 Modern contraceptive use (%)

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005;2017)	7.9	22.9
	Cameroon (2004;2014)	13.1	21.0
	Central Af Rep (2000;2011)	11.7	12.1
	Chad (2004;2015)	1.7	5.0
	Congo (2005;2015)	13.7	18.5
	DR Congo (2001;2014)	10.2	7.8
	Eq Guinea (2000;2011)	6.5	9.5
	Gabon (2000;2012)	13.4	19.4
	São Tomé & P (2000;2014)	28.0	37.4
Eastern Africa	Comoros (2000;2012)	20.9	14.2
	Djibouti (2002;2012)	5.8	18.0
	Eritrea (2002;2010)	7.3	7.0
	Ethiopia (2005;2017)	13.9	35.2
	Kenya (2003;2016)	31.5	59.9
	Madagascar (2004;2013)	18.3	33.3
	Mauritius (2002;2014)	39.3	32.0
	Rwanda (2005;2015)	9.7	47.5
	Tanzania (2005;2016)	20.0	32.0
	Uganda (2005;2017)	18.7	33.9
Northern Africa	Algeria (2002;2013)	51.8	49.5
	Egypt (2005;2014)	56.5	56.9
	Mauritania (2001;2015)	5.1	15.6
	Morocco (2004;2011)	54.8	58.6
	Tunisia (2001;2012)	53.1	50.9
Southern Africa	Angola (2001;2016)	4.8	12.5
	Lesotho (2005;2014)	35.2	59.8
	Malawi (2005;2016)	28.1	58.1
	Mozambique (2004;2015)	20.8	25.3
	Namibia (2000;2013)	42.6	55.3
	South Africa (2004;2016)	59.8	54.0
	Eswatini (2002;2014)	38.6	65.5
	Zambia (2002;2014)	25.3	44.8
Western Africa	Benin (22001;2014)	7.2	12.5
	Burkina Faso (2003;2017)	8.7	24.5
	Gambia (2001;2013)	12.7	8.1
	Ghana (2003;2017)	18.7	27.4
	Guinea (2005;2016)	5.7	7.8
	Guinea-Bissau (2000;2014)	4.5	14.4
	Mali (2001;2015)	6.9	15.1
	Niger (2000;2017)	11.2	18.1
	Nigeria (2003; 2017)	8.2	10.8

	Senegal (2005;2016)	10.3	23.1
	Sierra Leone (2005;2013)	4.9	15.6
	Togo (2000;2014)	13.3	17.3

Source: World Bank

Appendix 4.2.4. Adolescent Fertility Rate (births per 1,000 women ages 15-19)

Region	Country	2005	2016
Central Africa	Burundi	34.6	27.4
	Cameroon	139.1	108.8
	Central Af Rep	120.4	105.8
	Chad	201.5	164.5
	Congo	131.3	114.1
	DR Congo	129.0	125.2
	Eq Guinea	176.3	157.9
	Gabon	129.6	98.5
	São Tomé & P	109.3	96.3
Eastern Africa	Comoros	84.6	67.2
	Djibouti	27.6	19.4
	Eritrea	78.6	53.5
	Ethiopia	92.2	64.9
	Kenya	99.9	81.8
	Madagascar	140.4	111.7
	Mauritius	35.5	26.9
	Rwanda	42.9	26.8
	Seychelles	59.1	57.8
	Somalia	127.2	102.2
	South Sudan	107.0	65.2
	Sudan	114.2	67.2
	Tanzania	131.1	116.6
	Uganda	159.0	110.5
Northern Africa	Algeria	9.7	10.4
	Egypt	50.2	51.0
	Libya	6.2	5.7
	Mauritania	91.7	80.5
	Morocco	34.5	31.7
	Tunisia	6.3	7.6
Southern Africa	Angola	185.9	154.5
	Botswana	53.5	31.7
	Lesotho	92.0	89.7
	Malawi	154.9	141.0
	Mozambique	179.1	138.9
	Namibia	80.6	75.0
	South Africa	62.6	44.4
	Eswatini	93.7	78.5
	Zambia	125.8	86.0
	Zimbabwe	112.8	105.8
Western Africa	Benin	111.5	88.1
	Burkina Faso	132.6	106.5
	Cabo Verde	96.3	74.7
	Côte d'Ivoire	138.0	133.4

	Gambia	111.2	81.9
	Ghana	76.0	67.6
	Guinea	159.3	137.4
	Guinea-Bissau	123.9	87.2
	Liberia	144.1	128.8
	Mali	185.8	171.1
	Niger	212.0	194.0
	Nigeria	126.0	109.3
	Senegal	96.4	74.9
	Sierra Leone	150.6	115.6
	Togo	93.1	89.6

Source: World Bank

Appendix 4.2.5a: Percentage of women aged 20-24 who were married or in a union before age 15

Region	**Country**	**Period 1**	**Period 2**
Central Africa	Cameroon (2004; 2011)	16.5	13.4
	Chad (2004; 2014)	34.5	29.7
	Congo (2005; 2011)	5.9	6.1
	Gabon (2000; 2012)	10.8	5.6
Eastern Africa	Ethiopia (2005; 2016)	23.9	14.1
	Kenya (2003; 2014)	3.8	4.4
	Rwanda (2005; 2015)	1.1	0.4
	Tanzania (2004; 2015)	6.4	5.2
	Uganda (2004; 2016)	16.6	7.3
Northern Africa	Egypt (2004; 2015)	2.5	2.0
Southern Africa	Lesotho (2004; 2014)	2.5	1.0
	Malawi (2004; 2015)	10.7	9.0
	Mozambique (2003; 2015)	18.3	16.8
	Zambia (2002; 2013)	7.8	5.9
	Zimbabwe (2005; 2015)	4.6	3.7
Western Africa	Benin (2001; 2012)	7.5	10.5
	Burkina Faso (2003; 2010)	5.2	10.2
	Côte d'Ivoire (2005; 2012)	8.2	9.8
	Ghana (2003; 2014)	5.9	4.9
	Guinea (2005; 2012)	19.8	21.3
	Mali (2001; 2012)	24.5	22.8
	Nigeria (2003; 2013)	18.8	17.3
	Senegal (2005; 2016)	9.7	7.9

Source: The DHS Program of USAID

Appendix 4.2.5b: Percentage of women aged 20-24 who were married or in a union before age 18

Region	Country	Period 1	Period 2
Central Africa	Cameroon (2004; 2011)	47.2	38.4
	Chad (2004; 2014)	72.0	66.9
	Congo (2005; 2011)	30.8	32.6
	Gabon (2000; 2012)	33.6	21.9
Eastern Africa	Ethiopia (2005; 2016)	49.2	40.3
	Kenya (2003; 2014)	24.6	22.9
	Rwanda (2005; 2010)	13.3	8.1
	Tanzania (2004; 2012)	41.1	31.1
	Uganda (2004; 2016)	51.4	34.0
Northern Africa	Egypt (2004; 2015)	16.6	17.4
Southern Africa	Lesotho (2004; 2014)	23.0	17.3
	Malawi (2004; 2010)	48.9	49.6
	Mozambique (2003; 2011)	55.9	48.2
	Namibia (2000; 2013)	9.8	6.9
	Zambia (2002; 2013)	42.1	31.4
	Zimbabwe (2005; 2015)	33.6	30.5
Western Africa	Benin (2000; 2012)	36.7	31.9
	Burkina Faso (2003; 2010)	51.9	51.6
	Côte d'Ivoire (2005; 2012)	34.5	33.2
	Ghana (2003; 2014)	27.9	20.7
	Guinea (2005; 2012)	63.1	51.7
	Mali (2001; 2012)	65.4	59.6
	Nigeria (2003; 2013)	43.3	42.8
	Senegal (2005; 2016)	39.0	31.5

Source: The DHS Program of USAID

Appendix 4.2.6. Percentage of women aged 20-24 who gave birth before age 18

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2010)	11	12
	Cameroon (2004; 2014)	28	33
	Chad (2004; 2015)	51	48
	Congo (2005; 2015)	26	29
	Gabon (2000; 2012)	28	35
Eastern Africa	Eritrea (2002; 2010)	19	25
	Ethiopia (2005; 2011)	22	28
	Kenya (2003; 2014)	23	23
	Madagascar (2004; 2013)	36	31
	Rwanda (2005; 2015)	6	8
	Tanzania (2005; 2016)	22	29
	Uganda (2001; 2011)	33	42
Northern Africa	Egypt (2005; 2014)	7	8
	Mauritania (2004; 2015)	22	25
Southern Africa	Lesotho (2004; 2014)	14	15
	Malawi (2004; 2016)	31	34
	Mozambique (2003; 2011)	40	42
	Namibia (2000; 2013)	15	20
	Zambia (2002; 2014)	31	35
Western Africa	Benin (2001; 2014)	20	24
	Burkina Faso (2003; 2010)	28	27
	Côte d'Ivoire (2005; 2012)	31	29
	Ghana (2003; 2014)	17	15
	Guinea (2005; 2012)	40	44
	Mali (2001; 2015)	33	45
	Nigeria (2003; 2013)	29	28
	Senegal (2005; 2015)	18	22
	Sierra Leone (2005; 2013)	36	37

Source: UNICEF - Maternal and Newborn Health Coverage Database

Appendix 4.2.7. Maternal Mortality Ratio (per 100,000 live births)

Region	Country	2005	2015
Central Africa	Burundi	863	712
	Cameroon	729	596
	Central Af Rep	1060	882
	Chad	1170	856
	Congo	596	442
	DR Congo	787	693
	Eq Guinea	483	342
	Gabon	370	291
	São Tomé & P	181	156
Eastern Africa	Comoros	436	335
	Djibouti	341	229
	Eritrea	619	501
	Ethiopia	743	353
	Kenya	728	510
	Madagascar	508	353
	Mauritius	39	53
	Rwanda	567	290
	Somalia	939	732
	South Sudan	1090	789
	Sudan	440	311
	Tanzania	687	398
	Uganda	504	343
Northern Africa	Algeria	148	140
	Egypt	52	33
	Libya	11	9
	Mauritania	750	602
	Morocco	190	121
	Tunisia	74	62
Southern Africa	Angola	705	477
	Botswana	276	129
	Lesotho	746	487
	Malawi	648	634
	Mozambique	762	489
	Namibia	390	265
	South Africa	112	138
	Eswatini	595	389
	Zambia	372	224
	Zimbabwe	629	443
Western Africa	Benin	502	405
	Burkina Faso	468	371
	Cabo Verde	54	42
	Côte d'Ivoire	742	645

	Gambia	807	706
	Ghana	376	319
	Guinea	831	679
	Guinea-Bissau	714	549
	Liberia	1020	725
	Mali	714	587
	Niger	723	553
	Nigeria	946	814
	Senegal	427	315
	Sierra Leone	1990	1360
	Togo	427	368

Source: World Bank

Appendix 4.2.8: Proportion of births attended by skilled personnel

Region	Country	Period 1	Period 2
Central Africa	Burundi (2005; 2017)	32	85
	Cameroon (2004; 2014)	59	65
	Central Af Rep (2000; 2010)	32	40
	Chad (2004; 2015)	14	20
	Congo (2005; 2015)	83	94
	DR Congo (2001; 2014)	61	80
	Eq Guinea (2000; 2011)	65	68
	Gabon (2000; 2012)	86	89
	São Tomé & P (2000; 2014)	79	93
Eastern Africa	Comoros (2000; 2012)	62	82
	Djibouti (2003; 2012)	61	87
	Eritrea (2002; 2010)	28	34
	Ethiopia (2005; 2016)	6	28
	Kenya (2003; 2014)	42	62
	Madagascar (2004; 2013)	51	44
	Mauritius (2005; 2014)	99	100
	Rwanda (2005; 2015)	39	91
	Seychelles (2005; 2012)	99	99
	Tanzania (2005; 2016)	43	64
	Uganda (2001; 2016)	39	74
Northern Africa	Algeria (2002; 2013)	96	97
	Egypt (2005; 2014)	74	92
	Mauritania (2001; 2015)	53	69
	Morocco (2004; 2011)	63	74
	Tunisia (2001; 2012)	90	74
Southern Africa	Botswana (2005; 2010)	94	99
	Lesotho (2004; 2014)	55	78
	Malawi (2005; 2016)	59	90
	Mozambique (2003; 2011)	48	54
	Namibia (2000; 2013)	76	88
	South Africa (2003; 2016)	91	97
	Eswatini (2002; 2014)	74	88
	Zambia (2002; 2014)	42	63
Western Africa	Benin (2001; 2014)	66	77
	Burkina Faso (2003; 2015)	38	80
	Cabo Verde (2005; 2013)	78	92
	Côte d'Ivoire (2005; 2016)	55	74
	Gambia (2000; 2013)	52	57
	Ghana (2003; 2014)	47	71
	Guinea (2005; 2016)	38	63
	Guinea-Bissau (2000; 2014)	32	45
	Liberia (2000; 2013)	51	61

	Mali (2001; 2015)	41	44
	Niger (2000; 2015)	16	40
	Nigeria (2003; 2017)	35	40
	Senegal (2005; 2016)	52	59
	Sierra Leone (2005; 2013)	40	60
	Togo (2003; 2014)	61	45

Source: UNICEF - Maternal and Newborn Health Coverage Database

Appendix 4.2.9: Proportion of births attended by skilled personnel by wealth quintile

Region	**Country**	**Year**	**Quintile 1**	**Quintile 5**
Central Africa	Burundi	2017	77	96
		2005	23	54
	Cameroon	2014	21	98
		2004	27	93
	Central Af Rep	2010	18	79
		2000	16	63
	Chad	2015	11	58
		2004	1	48
	Congo	2015	83	99
		2005	40	95
	DR Congo	2014	66	98
		2001	45	91
	Eq Guinea	2011	48	88
		2000	47	85
Eastern Africa	Comoros	2012	66	93
		2000	49	77
	Eritrea	2010	9	90
		2002	7	81
	Ethiopia	2016	11	70
		2005	1	27
	Kenya	2014	31	93
		2003	17	75
	Madagascar	2013	27	73
		2004	30	94
	Rwanda	2015	84	97
		2005	27	66
	Tanzania	2016	42	95
		2005	26	85
	Uganda	2016	64	94
		2001	20	77
Northern Africa	Egypt	2014	82	99
		2005	51	96
	Morocco	2011	38	96

		2004	30	95
Southern Africa	Lesotho	2014	60	94
		2004	34	83
	Malawi	2016	87	95
		2004	46	84
	Mozambique	2011	32	90
		2003	25	89
	Eswatini	2014	76	95
		2000	49	83
	Zambia	2014	45	94
		1999	24	85
Western Africa	Côte d'Ivoire	2016	49	95
		2005	27	88
	Gambia	2013	46	82
		2000	27	80
	Ghana	2014	42	94
		2003	21	90
	Guinea	2016	27	98
		2005	15	87
	Guinea-Bissau	2014	26	83
		2000	21	63
	Niger	2012	12	71
		2000	7	50
	Nigeria	2017	11	82
		2003	12	84
	Senegal	2016	30	89
		2005	20	89
	Sierra Leone	2013	51	84
		2005	25	76
	Togo	2014	11	87
		2000	14	72

Source: UNICEF - Maternal and Newborn Health Coverage Database

Appendix 4.2.10 Prevalence of HIV (%)

Region	Country	2005	2016
Central Africa	Burundi	2.3	1.1
	Cameroon	5.1	3.8
	Central Af Rep	6.3	4
	Chad	1.9	1.3
	Congo	3.3	3.1
	DR Congo	1.7	0.7
	Eq Guinea	4.8	6.2
	Gabon	5.7	3.6
Eastern Africa	Comoros	0.1	0.1
	Djibouti	2.5	1.3
	Eritrea	1.3	0.6
	Ethiopia	2.2	1.1
	Kenya	7.4	5.4
	Madagascar	0.2	0.2
	Rwanda	4	3.1
	Somalia	0.6	0.4
	South Sudan	3.5	2.7
	Sudan	0.2	0.2
	Tanzania	7	4.7
	Uganda	7.9	6.5
Northern Africa	Algeria	0.1	0.1
	Egypt	0.1	0.1
	Mauritania	0.9	0.5
	Morocco	0.1	0.1
	Tunisia	0.1	0.1
Southern Africa	Angola	1.4	1.9
	Botswana	24.6	21.9
	Lesotho	22.8	25
	Malawi	12.9	9.2
	Mozambique	13.7	12.3
	Namibia	15	13.8
	South Africa	17.3	18.9
	Eswatini	28.3	27.2
	Zambia	13.4	12.4
	Zimbabwe	18.2	13.5
Western Africa	Benin	1.3	1
	Burkina Faso	1.5	0.8
	Cabo Verde	0.9	0.8
	Côte d'Ivoire	5	2.7
	Gambia	2.1	1.7
	Ghana	2.9	1.6
	Guinea	1.7	1.5
	Guinea-Bissau	4.6	3.1

	Liberia	2.9	1.6
	Mali	1.5	1
	Niger	1	0.4
	Nigeria	3.9	2.9
	Senegal	0.8	0.4
	Sierra Leone	1.5	1.7
	Togo	4	2.1

Source: UNAIDS

Appendix 4.2.11 Cause of death - WHO Africa Region Appendix

Cause of death - WHO Africa Region	**2000**	**2010**	**2015**	**2016**
Communicable, maternal, perinatal and nutritional conditions	70.0	63.0	57.0	56.0
Noncommunicable diseases	23.0	29.0	33.0	34.0
Injuries	7.0	8.0	10.0	10.0
	100.0	100.0	100.0	100.0

Source: WHO

Appendix 4.2.12: Age-standardized noncommunicable diseases mortality rate (per 100,000 population)

Region	**Country**	**2005**	**2015**
Central Africa	Burundi	673.8	659.0
	Cameroon	708.2	712.8
	Central Af Rep	730.9	743.5
	Chad	710.0	726.9
	Congo	683.5	550.9
	DR Congo	655.9	618.9
	Eq Guinea	813.4	755.0
	Gabon	558.7	550.9
	São Tomé & P	593.8	594.6
Eastern Africa	Comoros	703.4	680.8
	Djibouti	635.2	604.2
	Eritrea	751.9	665.6
	Ethiopia	630.8	589.4
	Kenya	523.0	513.3
	Madagascar	677.5	642.1
	Mauritius	720.4	567.8
	Rwanda	660.0	606.5
	Seychelles	623.7	581.0

	Somalia	595.0	585.1
	South Sudan	652.8	591.9
	Sudan	806.7	752.7
	Tanzania	561.4	558.4
	Uganda	649.4	636.2
Northern Africa	Algeria	532.0	456.6
	Egypt	843.1	794.2
	Libya	709.3	648.9
	Mauritania	618.5	650.6
	Morocco	670.7	551.6
	Tunisia	582.9	561.0
Southern Africa	Angola	830.1	823.1
	Botswana	677.1	620.3
	Lesotho	700.5	686.3
	Malawi	648.0	639.5
	Mozambique	670.9	650.0
	Namibia	643.4	586.5
	South Africa	749.6	694.6
	Zambia	571.1	535.2
	Zimbabwe	526.8	532.8
Western Africa	Benin	780.6	784.2
	Burkina Faso	744.8	764.0
	Cabo Verde	574.2	528.4
	Côte d'Ivoire	922.8	948.9
	Gambia	768.9	736.2
	Ghana	743.4	761.5
	Guinea	635.4	649.6
	Guinea-Bissau	747.9	690.5
	Liberia	687.4	639.8
	Mali	797.1	798.7
	Niger	670.1	624.4
	Nigeria	808.7	756.7
	Senegal	701.8	612.1
	Sierra Leone	1130.0	1026.0
	Togo	842.0	797.0

Source: WHO - Global Health Observatory data repository

Appendix 4.3.1: Percentage of population living in slums

Region	Country	2005	2014
Central Africa	Burundi	64.3	57.9
	Cameroon	47.4	37.8
	Central Af Rep	94.1	93.3
	Chad	91.3	88.2
	Congo	53.4	46.9
	DR Congo	76.4	74.8
	Eq Guinea	66.3	66.2
	Gabon	38.7	37
Eastern Africa	Comoros	68.9	69.6
	Ethiopia	81.8	73.9
	Kenya	54.8	56
	Madagascar	80.6	77.2
	Rwanda	71.6	53.2
	Somalia	73.5	73.6
	Tanzania	66.4	50.7
	Uganda	66.7	53.6
Northern Africa	Egypt	17.1	10.6
	Morocco	13.1	13.1
Southern Africa	Angola	86.5	55.5
	Lesotho	35.1	50.8
	Malawi	66.4	66.7
	Mozambique	79.5	80.3
	Namibia	33.9	33.2
	South Africa	28.7	23
	Zambia	57.2	54
	Zimbabwe	17.9	25.1
Western Africa	Benin	71.8	61.5
	Burkina Faso	59.5	65.8
	Côte d'Ivoire	56.2	56
	Gambia	45.4	34.8
	Ghana	45.4	37.9
	Guinea	45.7	43.3
	Guinea-Bissau	83.1	82.3
	Mali	65.9	56.3
	Niger	82.1	70.1
	Nigeria	65.8	50.2
	Senegal	43.3	39.4
	Sierra Leone	97	75.6
	Togo	62.1	51.2

Source: UN HABITAT

Appendix 4.3.2. Percentage of population using safely managed drinking water services

Region	Country	2005	2015
Central Africa	Congo	31.6	37.0
Eastern Africa	Ethiopia	6.1	10.5
	Uganda	4.6	6.4
Northern Africa	Morocco	59.4	68.8
	Tunisia	62.5	92.7
Western Africa	Côte d'Ivoire	39.7	45.8
	Ghana	19.0	26.9
	Nigeria	18.5	19.4

Source: WHO/UNICEF

Appendix 4.3.3. Percentage of population with access to electricity

Region	Country	2005	2016
Central Africa	Burundi	3.2	7.6
	Cameroon	47.3	60.1
	Central Af Rep	7.9	14.0
	Chad	4.4	8.8
	Congo	33.8	56.6
	DR Congo	6.0	17.2
	Eq Guinea	63.8	67.9
	Gabon	81.6	91.4
	São Tomé & P	55.7	65.4
Eastern Africa	Comoros	51.2	77.8
	Djibouti	55.0	51.8
	Eritrea	34.3	46.7
	Ethiopia	14.0	42.9
	Kenya	21.7	56.0
	Madagascar	15.1	22.9
	Mauritius	98.8	98.8
	Rwanda	4.8	29.4
	Seychelles	95.6	100.0
	Somalia	12.8	29.9
	South Sudan	0.0	9.0
	Sudan	33.3	38.5
	Tanzania	12.7	32.8
	Uganda	8.9	26.7
Northern Africa	Algeria	98.8	99.4
	Egypt	99.4	100.0
	Libya	98.9	98.5
	Mauritania	18.2	41.7
	Morocco	80.2	100.0
	Tunisia	99.3	100.0

Southern Africa	Angola	28.1	40.5
	Botswana	37.4	60.7
	Lesotho	10.3	29.7
	Malawi	6.5	11.0
	Mozambique	11.9	24.2
	Namibia	40.4	51.8
	South Africa	80.9	84.2
	Eswatini	35.5	65.8
	Zambia	21.3	27.2
	Zimbabwe	34.7	38.2
Western Africa	Benin	26.8	41.4
	Burkina Faso	12.0	19.2
	Cabo Verde	67.0	92.6
	Côte d'Ivoire	58.9	64.3
	Gambia	30.5	47.8
	Ghana	54.7	79.3
	Guinea	20.2	33.5
	Guinea-Bissau	8.0	14.7
	Liberia	0.0	19.8
	Mali	17.7	35.1
	Niger	7.1	16.2
	Nigeria	47.3	59.3
	Senegal	47.1	64.5
	Sierra Leone	11.3	20.3
	Togo	26.5	46.9

Source: World Bank

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