



# UNFPA

AFRICA  
IMPACT



**Helping Mothers Live**

Special on CARMMA

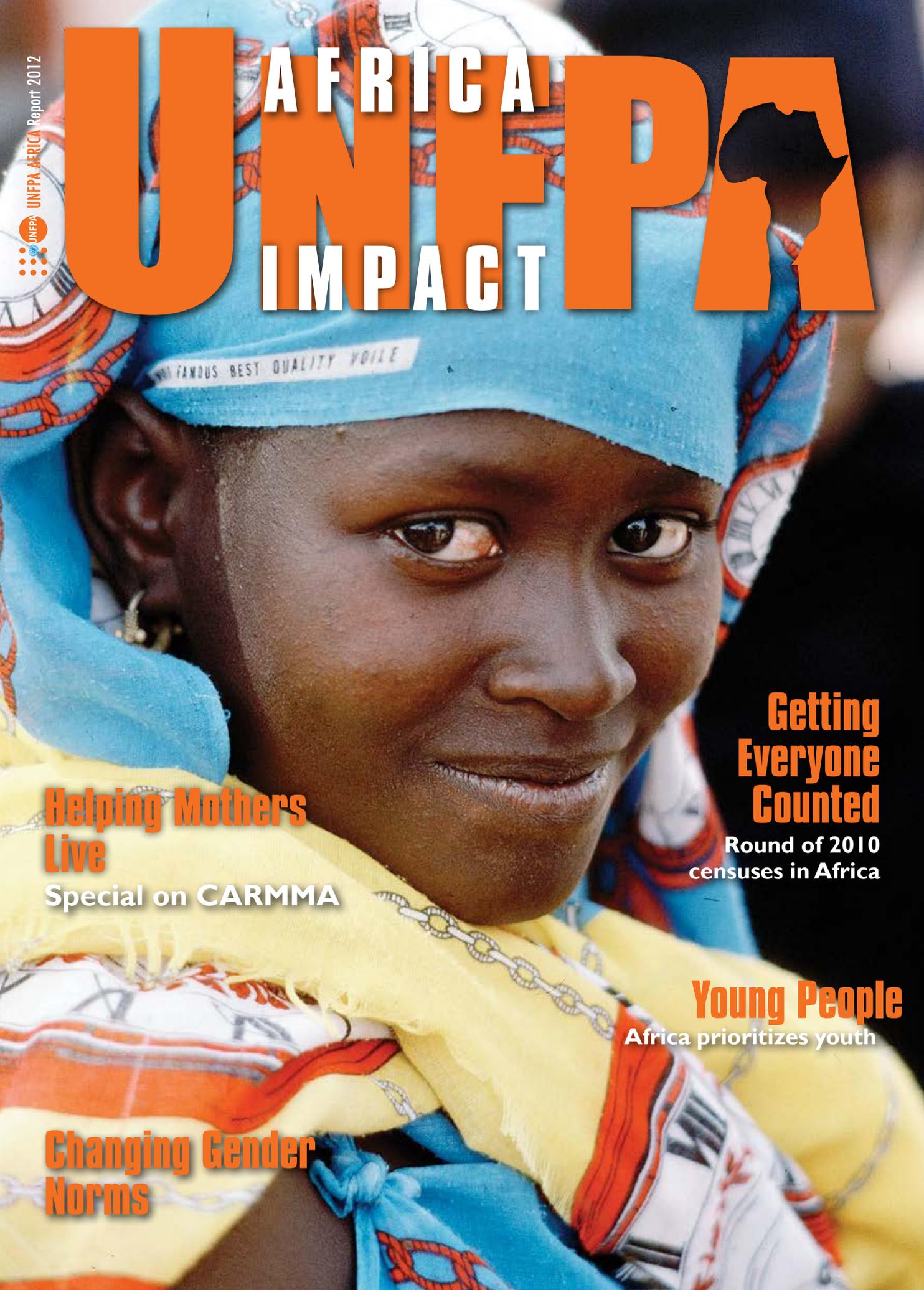
**Getting Everyone Counted**

Round of 2010 censuses in Africa

**Young People**

Africa prioritizes youth

**Changing Gender Norms**

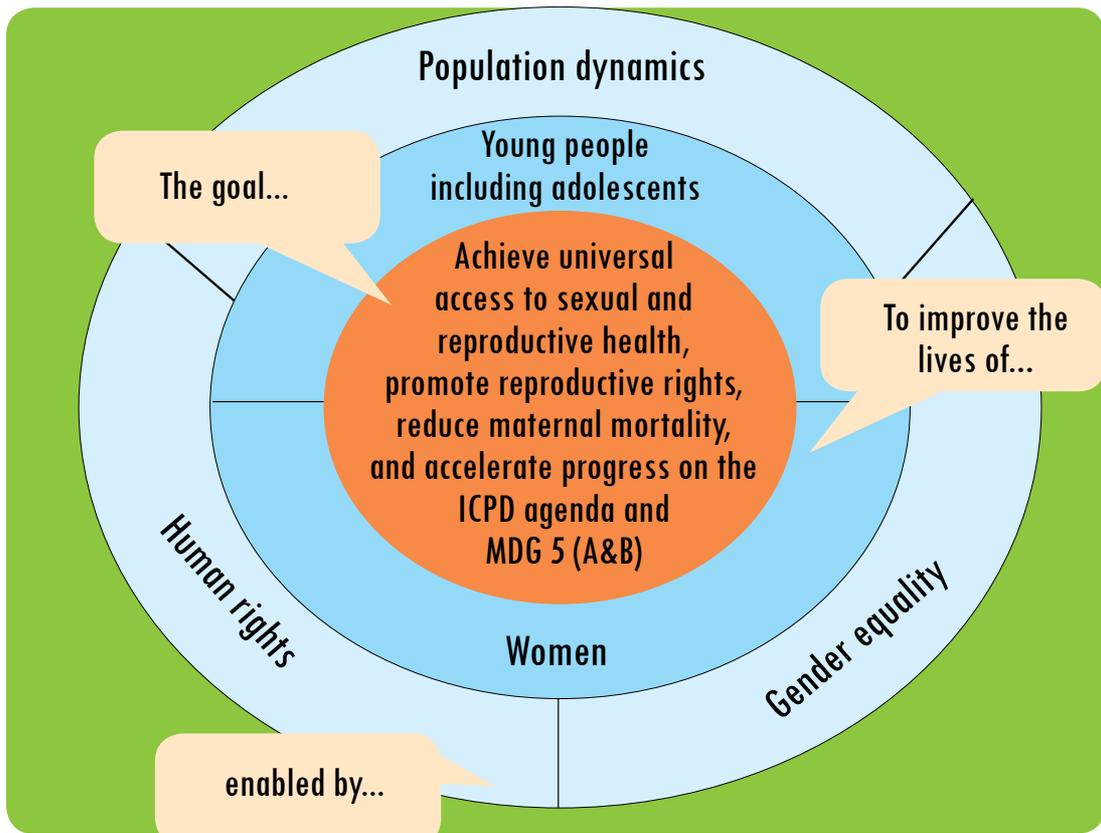




*Dr. Babatunde Osotimehin*  
Executive Director  
United Nations Population Fund, UNFPA

*Delivering a world  
where every pregnancy  
is wanted, every  
childbirth is safe, and  
every young person's  
potential is fulfilled.*

## UNFPA strategic focus



# UNFPA in Africa



**Regional  
Office  
Johannesburg**

**Headquarters**



## UNFPA

The United Nations Population Fund's goal is to achieve universal access to sexual and reproductive health (including family planning), promote reproductive rights, reduce maternal mortality and accelerate progress on the International Conference on Population and Development (ICPD) Agenda and Millennium Development Goal 5 (A and B) in order to empower and improve the lives of underserved populations, especially women and young people (including adolescents), enabled by an understanding of population dynamics, human rights and gender equality, and driven by country needs and tailored to the country context.



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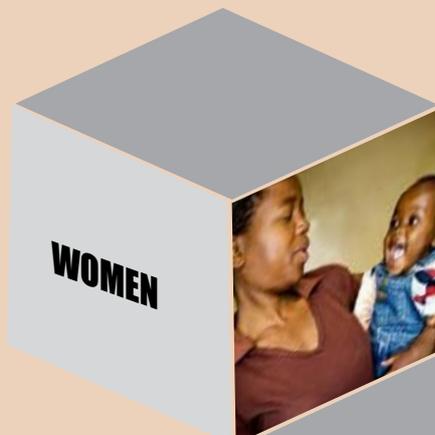
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# The focus of our work



## Helping mothers live

UNFPA helps governments to deliver sexual and reproductive health care throughout a woman's life cycle. We advocate for the right of all people to voluntarily decide the number and timing of their children. We support programmes that ensure reliable supplies, improve access and affordability, and promote the acceptance and utilization of family planning services. We also promote maternal health, which includes good care for pregnant women and safe childbirth, to safeguard the lives of mothers and their newborn babies.

## Empowering youth

UNFPA's four key strategies for empowering young people and protecting them from sexual and reproductive health problems, including HIV, include incorporating youth issues into national development and poverty reduction strategies, expanding access to gender-sensitive sexual and reproductive health education that encourages the development of life skills, promoting a core package of health services and commodities for young people, and encouraging youth leadership and effective participation in policy dialogue and quality programming.

## Getting everyone counted

If a country is to see to its people's needs, the government needs a full set of facts and figures to understand the population dynamics, chart the trends and plan for the future. This allows it to build sound policies and generate political will to appropriately address the nation's needs – now and in the future. UNFPA assists countries in every aspect of this task, from developing capacity in data collection, analysis and utilization, to participating in national, regional and global policy dialogue. It includes migration, ageing, climate change and urbanization.

## HIV prevention

As a co-sponsor of UNAIDS, we focus on HIV prevention among young people, women and marginalized groups, including sex workers. We support comprehensive programming for male and female condoms. We advocate for the linking and integration of sexual and reproductive health and HIV policies, programmes and services.

## Changing gender norms

UNFPA tackles four elements of gender inequality and violations of rights – girls' education, women's economic empowerment, women's political participation and the balancing of reproductive and productive roles.

## Providing humanitarian assistance

Within the interagency response to disasters, UNFPA takes the lead in providing supplies and services to promote reproductive health, emphasizing the special needs and vulnerabilities of women and young people. Both groups can figure prominently in rebuilding communities. UNFPA supports various data collection activities in humanitarian situations to provide detailed information for planning and rapid health assessments to allow for appropriate, effective and efficient relief. We also assist stricken communities as they move beyond the acute crisis stage and enter the reconstruction phase.

# The challenges in sub-Saharan Africa

**55 per cent**

of all pregnancy-related deaths worldwide occur in Africa. On average, more than five women die per 1000 live births.

**22** More than million

Africans are living with HIV, 61 per cent of them women. Young people accounted for 40 per cent of all new infections among people aged 15–49 years in 2009. Almost 3000 youth are infected daily.

## Deaths of women from maternal causes each year



**10 per cent**

of people have access to condoms in West and Central Africa.

### In sub-Saharan Africa

$\frac{1}{4}$  of women aged 15 to 49 who are married or in union and have expressed the desire to use contraceptives do not have access to them.

Sub-Saharan Africa has **11,8** million internally displaced people and **2,1** million refugees (2010)

**54 per cent**

of the region's 46 countries has undertaken national population and housing censuses. Ensuring the collection and analysis of, and access to, data needs to be a top priority in the coming decade.

**92** million

girls aged 10 years and above have undergone Female Genital Mutilation (estimation).

**3** million

girls in the region are at risk for Female Genital Mutilation annually.

# How we are changing the picture



- Maternal mortality in Africa has reduced by **41 per cent** between 1990 and 2010.
- The proportion of women in sub-Saharan Africa who received skilled assistance during delivery rose from **41 per cent** in 1990 to **46 per cent** in 2008.
- **25** African countries have conducted their censuses to date.
- The African Youth Charter has been adopted and ratified by more than 28 countries. It became a legally binding document after ratification by 16 Member States.

- A **25 per cent** reduction in HIV prevalence among young people aged **15–24** has been recorded in **15** out of the **21** countries most affected by HIV and **13** of these are in sub-Saharan Africa. This has been attributed to declining new infections and changing sexual behaviour patterns.<sup>1</sup>
- The risk of Mother-to-Child Transmission of HIV (PMTCT) has been reduced from nearly **40 per cent** to under **5 per cent**
- To date more than **2000** communities in Africa have publicly declared their abandonment of FGM



Bunmi Makinwa, Africa Regional Director

“  
**The Executive Director’s new strategic direction for the organization has confirmed our priorities – that of MDG 5, maternal health and maternal mortality reduction.**”

**What are the priorities for UNFPA’s Africa Regional Office?** At our first Regional Planning Meeting in 2009, we decided to focus on five priority areas.

**Firstly, we sought to become Africa’s foremost organization on maternal health.** The reason we chose this focus is that MDG 5, which includes maternal health, lags the furthest behind and the performance of most African countries is poorest on this front. Our primary aim is to help countries in sub-Saharan Africa reduce their maternal death rates.

**Our second priority is population development and census taking.** We are the only agency that assists governments and organizations with census taking for population development. Yet at one stage we were falling behind in this task. By 2009, most African governments were no longer calling on us to help them in this matter, so we decided to reassert ourselves to become the primary agency on population and censuses. The task of enumeration is critical for governments because without data and information, they cannot make policy decisions. Some in the organization didn’t quite understand the need for this focus and they asked about also prioritizing gender, HIV and youth. Yet all of these issues are included in the priority areas, especially when it comes to maternal health. For instance, maternal mortality was increasing because of HIV and AIDS and women’s relegated position in many communities. So if we choose to focus on maternal health and maternal mortality, we will be tackling all of these issues simultaneously.

If we help countries carry out successful census surveys to collect a full set of population data, we will know how many young people there are in order to take their needs into account. We will know what the current situation is with HIV and AIDS, and what still needs to be done about it. We will know where women are vulnerable and need assistance, thanks to data that show whether women are engaged economically, whether they are being educated, and whether girls are staying in school. Population data provide that kind of information, so by being involved in census taking we will target our development priorities.

**Our third priority area is to improve on our management and leadership in the region.** This means that the people

# Act always, for women and youth

who are leading and managing us should be stronger in their roles than they were at that time.

**Fourthly, we seek to be an agency that is critical to UN reform.** We intend to take it seriously and to partner with other agencies in this aim. The whole world is going into the mode of ‘Delivering as One’.

**Our fifth priority area is to work on operational issues that have become problematic.** This includes the National Execution (NEX) Audit Management System and Operating Fund Accounts (OFAs). We hadn’t had a qualified audit but we knew that if we didn’t deal with the issues promptly, we could soon run into difficulties. We took the matter seriously and I am pleased to tell you that we have made significant progress in each of the files. Even today, they remain our priorities.

The Executive Director’s new strategic direction for the organization has confirmed our priorities – that of MDG 5, maternal health and maternal mortality reduction.

**The world population reached 7 billion in 2011. How has the UNFPA Africa Regional Office integrated this new milestone into its action plan?** As the Africa Regional Office for UNFPA, the question for us is, what contribution has Africa made to that milestone figure? Africa is the region with the fastest growing populations, and this has implications for the world as well as for Africa.

**The number 7 billion hides some very important issues. Is the world getting richer or poorer?**

When you consider wealth indicators, it is evident that there has been substantial wealth creation – yet when you look at poverty levels, it is also true that more people are becoming poor today. Unfortunately, much of the increase in poverty is occurring in Africa. Take maternal deaths, for instance. While there have been some improvements in this respect, including in sub-Saharan Africa, up until about four years ago the sub-continent’s maternal death rates were rising substantially. Fortunately the rates are mostly stabilizing now and, in some countries, declining.

So the number 7 billion is a way to look at where the world is today in terms of its ability to take care of its people. It’s not merely a question of whether the world population is 5 or 10 billion – what is important is that we take the numbers and break them down and ask ourselves, as UNFPA, “How can we help countries and governments overcome problems relating to their population figures?”

At UNFPA, we use numbers as data to bring these issues to the attention of governments through advocacy. When you can provide people with the numbers as evidence of what you are talking about, they form a better understanding of the matter at hand.

# Helping mothers live: Maternal Health

Africa has the highest maternal death rate, but the good news is that it is declining. In 1990 the rate in developed regions was 20 maternal deaths per 100,000 live births, while in sub-Saharan Africa the rate was 920 deaths per 100,000 live births. This figure has dropped by 41 per cent from 1990 to 2010, to 500 deaths per 100,000 live births.

The use of modern contraception is low. Only 17 per cent of married women of reproductive age use a modern contraceptive, even though a far higher proportion than this wants to avoid becoming pregnant at some stage. In Africa, no less than 39 per cent of pregnancies are unwanted (2008 figures). In West and Central Africa, less than 10 per cent of women use any modern contraceptive method. This means they can't choose when they have children, the spacing between children, or how many children they have.

# Extent of maternal mortality in Africa

There were around 158,000 maternal deaths in sub-Saharan Africa in 2010, while 16 countries in the region had maternal death rates of over 500 per 100,000 live births. Only Cape Verde, Mauritius, São Tomé & Príncipe and Seychelles had below 100 deaths per 100,000 live births.

## Number of deaths Rate per 100,000 live births

UNFPA AFRICA



# CARMMA: Campaign for Accelerated Reduction of Maternal Mortality in Africa

To date, 37 African countries have launched CARMMA

## Ensuring Africa's future today

### What is CARMMA?

The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was initiated by the African Union Commission (AUC) to renew and intensify implementation of the Maputo Plan of Action for Reduction of Maternal Mortality in Africa and for the attainment of MDG 5.

### Why is CARMMA necessary?

In 2010, more than 287,000 women died from pregnancy and delivery-related complications worldwide. Around half of these deaths occur in Africa. The high number of deaths due to childbearing is tragic because with proper care, most of them could have been avoided. MDG 5 recommends that maternal deaths must be reduced by 75 per cent in most African countries by 2015, when compared with the figures for 1990. This is a daunting challenge. African women also face an increased threat to their health due to the recent global financial crisis. Specific action that targets this issue is therefore crucial to achieve the desired results. That is why this major initiative has been put in place to tackle Africa's high maternal death rate.

### What are the causes of maternal deaths in Africa?

Firstly, there are three critical delays in accessing health care. The first delay happens with the decision to access health services, due to obstacles like gender inequality and cultural traditions. For instance, a pregnant woman may need permission from her husband or another male relative before she can seek medical treatment. The second delay in getting to health facilities is due to a lack of health facilities in rural areas, poor road networks and poor transportation to the facilities. The third delay in accessing quality health care at health facilities is due to a lack of skilled birth attendants, and a lack of Emergency Obstetric and Newborn Care (EmONC). Other causes of maternal deaths are bleeding in pregnancy and labour, obstructed labour, eclampsia and infections such as sepsis; poverty – inability of pregnant women to pay for the

cost of health services; illiteracy, lack of awareness and cultural beliefs.

### What is the added value of CARMMA?

Building ongoing best practices; generating and providing data on maternal and newborn deaths; mobilizing political commitment and support of key stakeholders and communities for additional resources and involvements; and accelerating actions to reduce maternal and associated infant mortality.

### Who are the champions and partners of CARMMA?

The AUC and national governments; birth attendants, community health workers, nurses, midwives and doctors; UN agencies (WHO, WFP, UNICEF, FAO, UNAIDS, UNIFEM, UNFPA) and The World Bank; bilateral partners (USAID, DFID); civil society organizations (IPPF, RMNCH Coalition, White Ribbon Alliance, Save the Children Fund); academia, community and religious leaders, professional associations, artists, the media, and the private sector.

### What progress has been made to date?

CARMMA has made tremendous progress due to rising political commitment following its launch in 2009. By early 2012, 37 countries had launched CARMMA. In many of the countries, the national champions of CARMMA or the national authorities have committed to follow-up activities to intensify the reduction of maternal mortality in their countries. For instance, the governments of Malawi, Chad, Zambia, Rwanda, Sierra Leone, Ghana and Nigeria took a decision to launch CARMMA in all districts or states. Malawi and Sierra Leone have chosen to adopt district hospitals for health system strengthening in partnership with the private sector, while Swaziland has instituted maternal mortality monitoring indicators. Chad used the launch of CARMMA to coincide with the Campaign to End Violence Against Women, and also to mobilize funding for maternal mortality reduction through pledges, while Sierra Leone and Nigeria are now providing free medical services for pregnant mothers and infants.

African Union, the United Nations (WHO, WFP, UNICEF, FAO, UNAIDS, UNIFEM, UNFPA), The World Bank, bilateral donors (USAID, DFID), academia and civil society (e.g. IPPF, White Ribbon Alliance)

South Africa

2012

Botswana, Liberia, Democratic Republic of Congo, Gabon, Tanzania, Equatorial Guinea, Burundi, Burkina Faso, Tunisia and Niger.

2011

Ethiopia, Sierra Leone, Central African Republic, Uganda, Cameroon, Mauritania, Lesotho, Zambia, Zimbabwe, Guinea Bissau, Senegal, Gambia, Eritrea, Angola, Togo, Benin, Congo Brazzaville and Kenya.

2010

Mozambique, Malawi, Rwanda, Nigeria, Swaziland, Ghana, Namibia and Chad.

2009

Côte d'Ivoire

Egypt

Mali

Sudan



## Interview with Sierra Leone's President Ernest Bai Koroma

### CARMMA in Sierra Leone: leading with change

1. You have initiated the first step towards health care reform in Sierra Leone – free health care for pregnant women and children under five. What has inspired you to make this a priority?

I have derived my inspiration from this set of people because they constitute a very high percentage of the total population. They are the ones who use medical services the most. They frequent our hospitals and I believe they are the most vulnerable group; that is why I have singled them out as the group that we should address first in terms of providing free services.

2. The Ministry of Health and Sanitation has worked closely with Government stakeholders and development partners, using the Strategic Health Plan as a guiding document to set priority interventions. What are the priorities that guided you to launch this free health service?

Our priority has been to substantially increase our financing of the health sector, because we believe that targets have been set. For instance, we have to adhere to the Abuja Declaration and to be quite honest, we have not been doing so. This is one of the areas where we are intervening. Another area of intervention is the provision of sufficient drugs and equipment. Now, for this programme to succeed, we have to ensure that drugs are made available at all of our health centres and that the equipment required to treat the people who qualify for this programme is available, because if we don't have the necessary drugs and equipment, then it will make nonsense of the whole programme.

We also know that for the programme to succeed, we have to increase the number of health workers and we need to keep them motivated. We have to train them well because there is going to be a surge in the number of people who come for treatment. We need to ensure we have the commensurate number of health workers who are well equipped, in terms of expertise and motivation, to do the work. Over and above this, we have to ensure that we coordinate our activities within the health sector because it is only when these are effectively coordinated, including coordinating and monitoring the supply system, that our interventions will succeed overall.

3. Can the beneficiaries go to any hospital to get treated for free?

For now, we will limit our activities to Government hospitals. However, the Government is in talks with faith-based



Sierra Leone's Head of State, Ernest Bai Koroma

“Let me seize this opportunity to thank UNFPA for the support provided to us during the preparatory work for the programme, for supporting us throughout our inspections and for providing great support almost immediately.”

organizations so that we can map out a strategy on how they can add to the provision of this service.

4. The state of the roads in the districts makes health care inaccessible for the more remote communities, where reproductive health issues tend to be very high. What steps are being taken to improve the roads or to construct roads to the more remote villages?

We know this matter will limit service provision. This is why we are trying to connect the main communities to each other and especially connect them to the district headquarters, where the referral hospitals are located. A lot of work is required in this respect but I can assure you that we are looking at it from a holistic point of view. That is why road infrastructure development is part of the overall programme.

5. Does this also apply to the upgrading or renovating of the health facilities that have been in disrepair since the end of the war?

Yes, it does. I am happy that I undertook a visit to our hospitals, because it gave me an opportunity to do a first-hand assessment of them. We have just constructed three new hospitals, and a good number of the existing hospitals need rehabilitation. But as a start to the programme, we have ensured that the basics are provided. We can now be sure that we have what it takes to launch the programme. A process has begun to rehabilitate at least six hospitals, and we will continue until most of the hospitals are able to serve the purpose for which they were intended.

6. CARMMA, the campaign to reduce maternal death rates, which in Sierra Leone is a very high 857 deaths per 100,000 births, was launched by her Excellency, Madam Sia Koroma. Did this campaign enhance publicity for the launch of your free health care service initiative?

This has been the main publicity behind the free health care service programme. We will encourage her to do more of that kind of publicity and also encourage other groups to join a nationwide publicity campaign. We need to ensure that the message reaches the people.

Let me seize this opportunity to thank UNFPA for the support provided to us during the preparatory work for the programme, for supporting us throughout our inspections and for providing great support almost immediately. We look forward to working with you.

# African countries' commitment to UNSG's global strategy

**In September 2010, UN Secretary-General (UNSG) Ban Ki-moon launched a Global Strategy for Women's and Children's Health to accelerate the achievement of MDGs 4 and 5 by 2015. CARMMA is a conducive platform to mobilize commitment and support for this strategy. The graphic below shows African countries' level of commitment.**

COUNTRY	COMMITMENTS												OTHER COUNTRY-SPECIFIC ACTIVITIES	
	Policy	Law	Budget	Human resources	Free services	Contraception / family planning	Health facility	PMTCT	Vaccination	HIV	Schools	Births assisted by skilled personnel		
Benin	■	■	■		■	■		■		■				
Burkina Faso		■		■	■						■			
Burundi			■	■		■		■			■	■		Reduce percentage of underweight children
Cameroon			■	■	■	■		■	■	■	■			HIS
Chad	■		■	■	■	■				■	■	■	■	
CAR	■		■		■	■			■	■	■		■	
Comoros		■			■									Reduce percentage of underweight children
Congo				■	■			■						Observatory to investigate deaths linked to pregnancy
Cote d'Ivoire														
DRC	■		■		■	■		■	■	■			■	ITN
Djibouti*			■	■		■		■	■	■			■	Mobile health services; malnutrition
Ethiopia				■	■									
Gambia			■		■	■		■	■				■	
Ghana					■	■			■					ITN
Guinea			■	■	■			■	■					
Guinea-Bissau			■	■		■		■					■	Health mutual and state fund; reduce percentage of underweight children
Kenya				■										
Lesotho	■		■		■	■			■					
Liberia			■	■	■			■	■					
Madagascar			■		■	■			■				■	Youth-friendly facilities; maternal death audit
Malawi				■	■									
Mali				■	■									Integrated management of childhood illnesses
Mauritania			■	■		■		■	■		■	■		Integrated management of childhood illnesses
Mozambique						■		■	■		■		■	
Niger	■	■	■	■	■	■							■	
Nigeria			■	■				■						
Rwanda			■	■				■						
Sao Tome et Principe			■			■		■					■	
Senegal			■	■	■	■							■	Create a national directorate for maternal, neonatal and child health (MNCH)
Sierra Leone				■	■									Develop a health compact
South Sudan	■		■		■	■			■		■	■	■	
Sudan*			■	■	■								■	
Tanzania			■	■	■	■		■	■		■		■	
Togo						■								
Uganda						■		■	■	■				
Zambia			■			■								
Zimbabwe			■		■									Audit system

\*Not included in sub-Saharan Africa

## Cameroon: enabling more women to deliver safely

The maternal death rate is high in Cameroon because in critical regions only 11 per cent of deliveries occur in a health facility, due to the high costs involved. The strategy of pre-positioning obstetric and Caesarean kits, set up in 2011 in 10 health districts with a very low health facility delivery rate, is an innovative mechanism initiated by UNFPA and the French debt relief and development initiative, C2D, to increase financial access and ensure quality services for pregnant women. Before the strategy was introduced, hospitals often detained women who didn't pay their delivery-related bills. The cost of a safe delivery or Caesarean section is now regulated and has been reduced by half, and flexible schemes of payment are in place. The cost of the kits includes a motivation premium for health personnel or facilities assisting with the delivery. Finally, the pre-packaged kits ensure that the critical drugs and supplies required to perform a safe delivery are available when needed. Six months after the start of the pre-positioning of these kits, deliveries in health facilities rose by 50 per cent. By reducing the cost of delivery and allowing flexibility in payment, the strategy has made it possible for the poorest and most vulnerable women to have access to sexual and reproductive health services, contributing to the reduction in maternal deaths and morbidity.

*“When I came to the health centre for the delivery, I had complications and they told me that I will have a Caesarean. My husband didn't have money and we wanted to leave the health centre. Then the nurse told us that I will have my operation and we could pay later. I had my operation, thanks God. We are going to reimburse this money because the nurse told us that if we don't pay it back, another woman in the same situation could die because of a drug stock shortage.”*

## Huge drop in maternal mortality in the Republic of Congo



Official figures showed that the number of women dying in the Congo from pregnancy and childbirth-related complications has declined from a high of 1100 per 100,000 live births in 2002 (a peak following civil unrest) to 300 deaths per 100,000 live births in 2010. These figures relate to public structures only and were supplied by the National Survey Centre on Maternal Deaths. The graph below shows the positive trend observed in recent years in maternal health:

Deaths per live births



### More... Malawi:

The training of 120 Health Surveillance Assistants and 1,300 core group members conducted in UNFPA's five focus districts has contributed to an increase in pregnant women who receive antenatal care from a skilled provider from **93 per cent (DHS 2004)** to **95 per cent (DHS 2010)**

and births delivered in a health facility

**from 57 per cent to 73 per cent** respectively.

In the five focus districts the Health Information Management System reports showed an increase of **3 per cent** for pregnant women receiving antenatal care.



# Progress on family planning in Africa



Two young mothers receive contraception at a clinic in an outlying district of Antananarivo during an Implanon campaign in Madagascar in July 2011.

“ The use of modern contraception tripled over a ten-year period – from 9.7 per cent (1997) to 29.2 per cent (2008–2009) – beating the government’s ambitious goal. ”

## Madagascar: tripling contraceptive use in 10 years

Madagascar is a striking success story of how to improve family planning and reproductive health despite facing severe difficulties. The use of modern contraception tripled over a ten-year period – from 9.7 per cent (1997) to 29.2 per cent (2008–2009) – beating the government’s ambitious goal of a contraceptive use rate of 28 per cent by 2009.

### What was key to this success?

How did it manage to achieve such tremendous results despite the country’s high rate of poverty, a largely rural population, transport difficulties due to poor infrastructure, and the political crisis of 2009?

This is a story of a government turning its words and written commitments into action to help its people. It is also an example of how successful programmes can be continued even during times of crisis and conflict.

### Working together to reach national goals

Many players were involved and supported the

Government’s efforts, from international and local NGOs to donors, such as UNFPA and USAID. These groups worked together, taking advantage of each organization’s comparative advantage, to achieve national goals.

At the heart of the programme’s success was the importance of ensuring access to a reliable supply of contraceptives, condoms, medicines and equipment for obstetric and maternal health care; the prevention, diagnosis and management of reproductive tract infections and sexually transmitted infections (STIs); and contraceptive supplies including male and female condoms.

This shows UNFPA’s Global Programme to Enhance Reproductive Health Commodity Security in action at the country level. UNFPA began implementing the five-year programme in Madagascar in 2007. It provided a structure for moving beyond ad hoc responses to a more predictable, planned and sustainable approach for securing essential supplies and ensuring their use.

**At the heart of the programme’s success was the importance of ensuring access to a reliable supply of contraceptives, condoms, medicines and equipment.**



#### Uganda:

UNFPA procured **62 per cent** of total commodities (contraceptives and condoms for family planning and STI/HIV prevention) for Uganda **for 2011**.

Uganda registered an increase in the contraceptive prevalence rate (CPR)

**from 24 per cent (DHS 2006) to 38.2 per cent** (National Panel Survey 2010/11).

# The benefits of investing in family planning

In sub-Saharan Africa, only 17 per cent of married women of reproductive age use a modern contraceptive, even though a far higher proportion wants to avoid becoming pregnant soon or ever. Thirty-nine per cent of pregnancies in the region are unwanted, ranging from 30 per cent in West Africa to 59 per cent in Southern Africa. Disparities among and within countries are pronounced. Women who are young or poor, have little education or live in rural areas, find it especially difficult to obtain the services they need to have planned and healthy pregnancies and deliveries.

The benefits of meeting women's family planning and maternal and newborn health care needs would be dramatic and would include saving as many as 750,000 lives annually.

## Unmet need for services

Modern family planning services include counselling, provision of contraceptives and follow-up.

In 2008, about 60 per cent of women aged 15–49 in the region who wanted to avoid a pregnancy were either not using family planning or were using a traditional method. These women accounted for 91 per cent of unwanted pregnancies.

## Cost of services

• In sub-Saharan Africa, the cost of providing family planning services to women who currently use modern methods is \$290 million. The cost of providing current levels of maternal and newborn care is \$1.5 billion. Current levels of care, however, fall well short of recommended

standards and result in 158,000 maternal deaths a year (2010).

- Providing modern contraceptives to all women who need them would increase the cost of family planning services to nearly \$2.4 billion annually. But it would substantially reduce the number of unwanted pregnancies, thereby making improvements in maternal and newborn care more affordable.

- Providing all pregnant women with the recommended standards of maternal and newborn care would cost US\$8.1 billion if investments were made simultaneously in modern family planning – \$2.7 billion less than such care would cost without improvements in family planning.

- Thus, the total for both sets of services would be \$10.5 billion – a five-fold increase on current spending, which reflects the urgent need to increase the availability and quality of services.

## Direct health benefits

Meeting women's needs for modern family planning and the recommended standards of maternal and newborn care would result in major immediate health benefits:

- Unwanted pregnancies would drop by 77 per cent, from 17 million to 4 million annually.
- Unsafe abortions would decline from 5.2 million to 1.2 million (assuming no change in abortion laws; data not shown), and the number of women needing medical care for complications of these unsafe procedures would decline from 2.2 million to 500,000.
- Roughly 750,000 lives would be saved annually – 200,000 among women (a 69 per



cent decline in maternal mortality) and 550,000 among newborns (a 45 per cent decline in newborn deaths).

- The number of healthy years of life lost because of disability and premature deaths among women and their newborns would decline by nearly two thirds, from 61 million to 22 million disability-adjusted life years (DALYs) lost.
- Providing these services as part of an integrated package is easier for users and is generally more cost-effective than stand-alone approaches.
- Providing modern contraceptives to all women who need them more than pays for itself, saving \$1.30 in the cost of maternal and newborn care for each dollar invested.
- The average cost of saving a healthy year of life, or DALY, would be \$149, which compares favourably with interventions to prevent or treat cholera, HIV and AIDS, and tuberculosis.
- Greater use of condoms would reduce the

transmission of HIV and other sexually transmitted infections, thereby helping to curb the AIDS pandemic. Greater integration of HIV prevention, family planning and maternal health services would be even more cost-effective – for example, by helping HIV-infected women avoid unwanted pregnancies and helping pregnant women living with HIV protect their babies' health.

- Reducing unplanned births would save on public-sector spending for education, health, water, sanitation and other services and would reduce pressure on scarce natural resources, making social and economic development goals easier to achieve.
- Reducing unwanted pregnancies, particularly among adolescents, would improve educational and employment opportunities for women, which, in turn, would contribute to gains in gender equity, women's status, productivity, family savings, poverty reduction and economic growth.

### Cost and Benefits of Services

Cost of services, pregnancy outcomes and deaths, according to use of family planning and maternal and newborn health services, Sub-Saharan Africa, 2008

	Current levels of service use	100% of needs met for services
<b>Cost of services (2008 US\$; in millions)</b>		
Family planning services	\$290	\$2,380
Maternal and newborn care*	\$1,460	\$8,100
<b>Total</b>	<b>\$1,750</b>	<b>\$10,480</b>
<b>Pregnancy outcomes (in 000s)</b>		
<b>Intended</b>		
Births and miscarriages	26,950	26,950
<b>Unintended</b>		
Births and miscarriages	11,730	2,750
Induced abortions	5,310	1,240
<b>Total</b>	<b>43,990</b>	<b>30,940</b>
<b>Deaths</b>		
Maternal	290,000	90,000
Newborn	1,220,000	670,000
<b>Total</b>	<b>1,510,000</b>	<b>760,000</b>

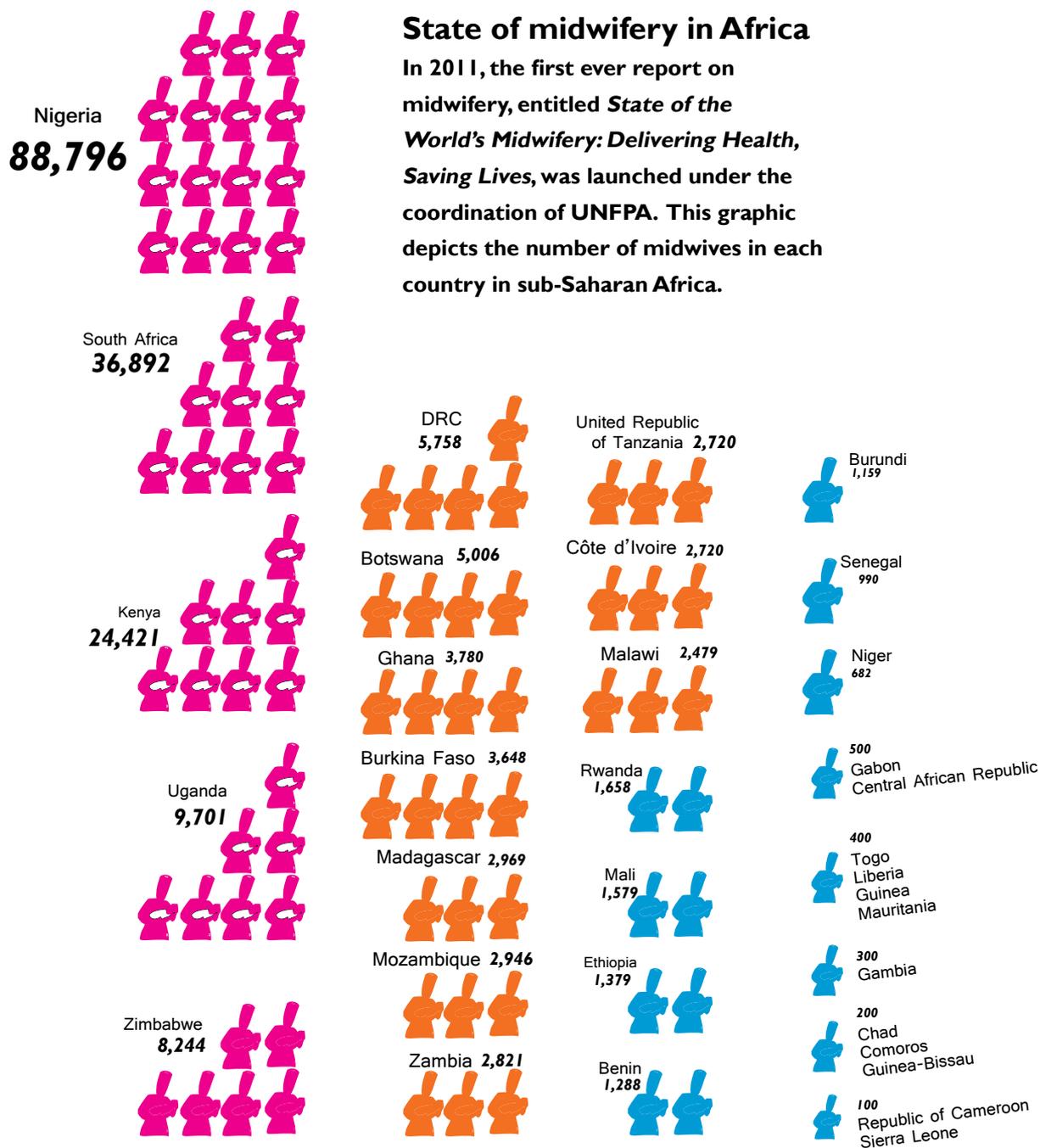
\*Without simultaneous investment in family planning services, improved maternal and newborn health care would cost \$10.8 billion.

“**Providing all pregnant women with the recommended standards of maternal and newborn care would cost \$8.1 billion if investments were made simultaneously in modern family planning - \$2.7 billion less than such care would cost without improvements in family planning.**”

The information reported in this article is for 2008 (except where indicated otherwise) and is based on special tabulations of data from Singh S et al., 'Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health,' New York: Guttmacher Institute and United Nations Population Fund, 2009.

According to the United Nations Statistics Division's regional definition, sub-Saharan Africa includes East Africa (Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mayotte, Mozambique, Réunion, Rwanda, Seychelles, Somalia, Tanzania, Uganda, Zambia and Zimbabwe), Middle Africa (Angola, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, and São Tomé and Príncipe), Southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland), West Africa (Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Saint Helena, Senegal, Sierra Leone and Togo) and Sudan in North Africa.

# Training of midwives



In Uganda, UNFPA advocated with Uganda Nurses and Midwifery Council (UNMC) and produced a draft Amendment Bill of the 1996 Nurses and Midwifery Act as well as developed a draft framework/strategy for regionalizing licensing and registration of midwives.



## Midwives in Ghana overcome barriers to giving birth in facilities

**“The midwives help me and encourage me. I have had my baby and I have my life as well.”**

In Ghana, 350 women die in childbirth for every 100,000 live births. Trained midwives working in the community offer cost-effective and high quality health care. This is why UNFPA and the International Confederation of Midwives (ICM) launched a joint programme in 2008 to invest in midwifery as the key solution to dealing with maternal mortality. In addition to caring for pregnant women, their services encompass family planning, HIV prevention and treatment, newborn care, child health and dealing with violence against women.

Yet working as a midwife is not easy, as Alizetta Mahama explains: “At times there is just one midwife available and you end up doing six, eight, even ten deliveries alone. We just get on and do it. As a midwife, you have to understand your client’s problems. You need to have time to let her express herself.” As she attends to a patient, she asks:

“How many children do you have?”

“Two – this is my third,” the woman replies.

“Did you deliver the other two by yourself?”

“Yes.”

Alizetta’s patient has never experienced a hospital delivery before, probably because of the hospital fees. Since the Ghanaian Government introduced free delivery services in hospitals in 2003, the number of women delivering in a health facility has increased by 11 per cent. The effect on women’s ability to deliver safely is very evident. “The midwives help me and encourage me. I have had my baby and I have my life as well,” said a

patient who has just delivered safely.

“It is very important to have midwives in the country and if we get more of them, the country is going to be a very healthy one.”

In urban areas, 82 per cent of women now deliver in health facilities. In rural areas, however, the average is just 41 per cent.

After training at Bolgatanga Midwifery School, Hajia Mary Issaka works as a midwife in a rural area. Full of initiative, she took it upon herself to find out why women were not choosing to deliver at a health facility.

“It is possible for a midwife to save lives but to do so, you need to know the problems of that community, such as why women don’t attend the clinic and why they don’t use our facilities.

“I delivered a woman’s baby. If she didn’t have my telephone number in her card, she could have lost her life. She would have died in the house. Because she delivered her baby alive, she told other women in the community to deliver in the health centre. Now they come to the health facility and see the difference we make. We are getting women who have had bad experiences [in childbirth] to form a support group. The role of the midwife is important because you are saving two lives,” she says.

In the nine months prior to her arrival at the facility only three deliveries took place. In her first four months there Hajia performed 62 deliveries, a figure she is proud of. She sees the difference her work makes. “I am hoping that in the future, we will have zero maternal deaths in the district.”

Somaliland: When she retired, a midwife in Somaliland used her retirement benefits to build a hospital where she began training a new cadre of midwives, including community-based practitioners. Her selfless action had a breathtaking effect. The maternal mortality rate in Somaliland dropped from 1400 per 100,000 live births to 400 over 10 years, at least in part due to the deployment of the midwives she has trained.



In Africa, 37 countries have been identified as having a substantial burden of obstetric fistula, resulting in a high number of maternal deaths and injuries. UNFPA and its partners launched the global Campaign to End Fistula in 2003 as an attempt to redress the unacceptable and neglected human rights and equity dimensions of obstetric fistula. Since the campaign started, UNFPA has helped more than 20,000 women and girls to access fistula treatment and care.

## Using mobile phones to fight fistula in Tanzania

Across Africa, cell phones are rapidly pushing the boundaries of what's possible. From an isolated rural village, a business owner can make a bank deposit through her phone, a farmer can access current crop prices, and an expectant mother can learn about antenatal care. And now, in Tanzania, cell phones offer a chance of treatment for women living with obstetric fistula – a painful and often ostracizing condition that follows prolonged and obstructed childbirth and causes chronic incontinence and even paralysis. The country's largest provider of fistula surgery, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) is revolutionizing the fight against fistula through mobile phone technology to make services more available to women living with the condition. The goal is to facilitate transportation for fistula

**An estimated 3,700 new cases of obstetric fistula occur in Tanzania every year, but only about 1,000 get treated.**

patients seeking treatment, so that more women can access surgery. According to UNFPA, an estimated 3,700 new cases of obstetric fistula occur in Tanzania every year, but only about 1,000 get treated. "Sadly, most women living with the condition do not know that treatment is available or they just can't afford it," explains CCBRT's Chief Executive Officer, Erwin Telemans, who is also responsible for the mobile phone initiative. At their hospital in Dar es Salaam, CCBRT provides fistula surgery free of charge, but until recently, the high cost of transportation and accommodation prevented fistula survivors in remote villages from seeking treatment.

Since late 2009, however, the non-governmental organization (NGO) began using Vodafone's mobile banking system M-PESA – M for 'mobile' and PESA for 'money' in Swahili – to help patients overcome transportation costs. Supported by UNFPA, the institution embarked on a pilot project using M-PESA to send money to fistula survivors so that they can travel to the hospital in Dar es Salaam for their repair surgery. The money, which is provided

by the project, is sent by CCBRT via SMS to fistula volunteer ambassadors, who may be former patients, health workers, or NGO staff, to identify and refer women suffering from fistula for treatment. "The ambassador called the CCBRT hospital, received the money for the tickets, and then he got us the bus tickets," says a 20-year-old fistula patient in Mbeya. "There were six of us, so we took a bus from Mbeya to Mbongo, where there was a CCBRT driver waiting to pick us up."

The ambassadors can retrieve the money at the local Vodafone M-PESA agent and buy bus tickets for the patients. When the patient arrives at the hospital, the ambassador receives a small incentive.

Since the start of the project, the fistula ambassadors' network has expanded to all regions of the country and the number of women who have been able to access fistula surgery increased by 65 per cent. In 2010, 54 ambassadors referred 129 women for fistula repair via M-PESA.

According to the latest UN statistics, Tanzania is one of 11 countries that together account for 65 per cent of all maternal deaths worldwide. Every fourth woman who dies during pregnancy in Tanzania is a teenager – more than half of all girls in the country are pregnant before they turn 19 years. Adding to this stark reality, nearly half of all births in Tanzania do not take place in a health facility. Even when the woman reaches a hospital in time, the facilities are often ill-equipped or under-staffed and cannot provide the care they needed, particularly if there are complications. Basic emergency obstetric and neonatal care is available in about 5 per cent of Tanzania's health centres.

**Since the start of the project, the fistula ambassadors' network has expanded to all regions of the country and the number of women who have been able to access fistula surgery increased by 65 per cent.**



**In Malawi  
in 2011 a total of**

**178** fistula patients were mobilized, treated and reintegrated into the community with their dignity restored.

**In Angola**

**117** cases were treated in 2011.

# Adolescents and Youth

The region's population is youthful, with children below the age of 15 making up about 41.2 per cent of the total population, according to the most recent estimates. Together, children and youths aged 30 and under make up over 70 per cent of the total population (UN, World Population Prospects – 2008 Revision). Young people account for 1.7 million new HIV infections.

UNFPA is supporting governments and their people in the development and implementation of policies, action plans and programmes that address and protect the sexual and reproductive health of young people, including HIV prevention.

# African Youth Charter

**8 Member States** have ratified the Charter.

**9 Member States** have signed the Charter.

**6 Member States** are yet to sign and ratify it.

In a major milestone, the African Youth Charter was developed in 2005 as a legal framework of action for African youth. The Charter was approved in May 2006 by African Ministers in charge of youth, and endorsed by the African Union Heads of State in July 2006. The Charter provides guidance for youth development policies and programmes at the national level. The Charter also highlights the rights, responsibilities and duties of young people and draws from various international agreements and commitments.

The process of developing the Charter was participatory, taking into account the voices of young people from all over the continent and the Diaspora. UNFPA assisted with finalizing the details of the Charter and aiding its adoption. UNFPA also partnered with the African Union Commission's Youth Department, ministries of youth, and the AfriYAN youth network to help popularize it and get it ratified by Member States. To date, at least 28 African countries have ratified the Charter. It took

effect as a legally binding document after being ratified by the first 16 Member States in 2009.

The significance of the Charter is that African governments commit themselves to undertaking critical actions to improve the status of young people in their countries. These actions include ensuring that issues affecting young people are adequately addressed within the framework of national youth policy and youth development programmes, such as employment, sustainable livelihoods, education, health (including sexual and reproductive health and HIV prevention), youth participation, national youth policies, peace and security, law enforcement, youth in the Diaspora and youth with disabilities. The African Union's Action Plan for the Decade of Youth (2009–2018) was also developed with UNFPA support and aims to implement the Charter through strategic actions that will allow Africa to achieve its human resources and development goals.

## Empowering youth through Youth Volunteer Corps

### Meaningful participation and contribution through youth service

The African Union Youth Volunteer Corps (AUYVC) is a continental youth development programme that recruits and works with youth volunteers in all African Union Member States. AUYVC promotes volunteering to provide young people with work experience across cultures while contributing to Africa's efforts to meet its human development targets and goals. The programme brings volunteers together to share knowledge, skills, creativity, leadership skills and the democratic processes and concepts necessary for building a more integrated continent and, by implication, strengthen Africa's relevance in the globalized world. UNFPA has provided technical support across the continent through its country offices, and also provided financial support for the programme. The AUYVC Programme is in line with the African Youth Charter and the decision of the African Union Heads of States and governments to set up a continental volunteer initiative.

## Teaching Madagascar's youth about STIs

### Empowering young people through youth-friendly services

A youth centre run by Fiakaviana Sambatra (FISA) in Madagascar has become instrumental in empowering young people to seek sexual and reproductive health services. Prior to the opening of the centre, unmarried young people seeking contraceptive advice or services were often turned away from primary health care centres. This meant they were unable to take control of their sexual and reproductive health and were exposed to unwanted pregnancies, unsafe abortion and sexually transmitted infections (STIs), including HIV. FISA is the country's leading non-governmental organization promoting and providing sexual and

reproductive health services to expand youth-friendly services for Malagasy youth. UNFPA partners with FISA and the Ministry of Health as part of UNFPA's strategy for Madagascar. The project trained service providers and offered information and services, through the centre as well as outreach by peer educators. It included advocacy for adolescent sexual and reproductive health information, services and rights in the community, creating an enabling environment for youth.

***“Young people are no longer scared to ask us for condoms.”***  
Service provider

### Key achievements

- Understanding of STIs in the community increased from 44 per cent of young people surveyed at the start of the project to 97 per cent of young people surveyed at the end of the project.
- There was an increased preference for modern contraception methods among young people at the end of the project as opposed to the use of the rhythm/calendar method, which was their preference at the beginning of the project.
- Primary health care centres in the commune now refer unmarried young people to the youth centre for services and advice.
- An increased number of young people were utilizing the youth-friendly service.

parents' attitudes towards young people's sexuality and to get their feedback. This was used to develop a partnership strategy with parents, formalizing and approving both the educational and extra-curricular activities of the youth centre. The parents were critical to the community's acceptance of the youth centre.

***“My mother told me I should come and spend time here in the afternoon.”***  
Youth centre user

### Involving the parents

During the mid-term evaluation, it was recommended that parental involvement would contribute to the success of the project. A workshop was organized to better understand

### Fostering community ownership

Young peer educators use the centre as their base while conducting outreach activities in the community – usually without remuneration. Given the government's prioritization of adolescent sexual and reproductive health and community support, the youth centre may become integrated with government facilities providing information and services to young people, with special focus on dual methods of contraception.



In Uganda,

UNFPA supported the development of guidelines and standards on provision of youth-friendly services in reproductive health and the establishment of youth-friendly corners in

**8** secondary schools and **4** health facilities in **2011.**



In 2011 the world reached a population of 7 billion people. This poses many challenges – and countless opportunities to make a positive difference. Everyone has a responsibility to make a world of 7 billion a better place for all. 7 Billion Actions, established by UNFPA, inspires change that will make a difference by highlighting positive actions by individuals and organizations around the world. By mid 2012, almost a thousand people had shared their stories (see <http://7billionactions.org/>) of how they have made a difference. Here are some of them.

## Africa – Nigeria – Abuja

### Urbanization: Planning for growth



**Divine Freeman**

### I am the voice of digital creativity 4m Africa

I am looking forward to an Africa where every young person is digitally literate, information literate, a digital skills master & a digital content creator because I know that Africa is a strategic part of the 7 billion world, and if it plays low in this ongoing global digital revolution, the whole world of 7 billion will be affected.

That is why my team & I at Zillion Digital Institute are labouring daily, organizing free Digital Boot Camps for Secondary Students, Undergraduates and SMEs, equipping them with necessary skills & knowledge to become intelligent consumers & active contributors.

## North America – United States – Denver

### Poverty and inequality



**Annie Elble**

### I am needing Africa more than Africa needs me

While in grad school, I lived in Swaziland & worked in a paediatric HIV clinic. I had the mentality that I was going to give & teach – what I didn't know was that I would actually learn so much more! The Swazi's selflessness is truly inspiring; they have nothing & still manage to give with gracefulness & joy. I learned from the orphans to fill my heart with peace & love & never take a single thing for granted. Since returning to the States years ago, my friend Kait & I started a nonprofit to help address the needs of Swazi orphans in partnership with local African NGOs: Give Hope Fight Poverty.



### I am Julie Imafidon-Bedan

I am working for UNFPA in Bangui, Central African Republic.

I joined this organization because I am convinced that together we can make a better world. When I see how the actions of the organization are impacting lives: giving joy to ladies with fistula, making the youth understand that their future depends on the choices they are making today, and enabling women to deliver their babies in well-equipped facilities, I am proud of being part of the organization.

Together we can make life better for our 7 billion neighbours.

## Africa – Cameroon

### Young people



**Victor Ndonng**

### I am a young ICT entrepreneur

The Internet is my employer. Since the connection of my country to the Internet in 1997, my professional and social life revolves around the Internet. I believe the Internet is a real development tool for developing countries. With the Internet, I'm self-employed and help fight against poverty and unemployment. In recent months, I have formed the Cameroon Chapter of an international organization named Internet Society to educate and encourage other young Cameroonians to become the next generation of leaders using the Internet and make the Internet accessible for everyone.

Watoto ([www.watoto.com](http://www.watoto.com)) is committed to making a world of 7 billion people a better place for orphans and vulnerable children in Africa. Currently, more than 2,400 children and 2,100 HIV+ women in Uganda are living quality lives through our holistic programmes.

We are excited to join UNFPA and the 7 Billion Actions campaign to mark this milestone in history.

## Africa – Uganda

### Reproductive health and rights



**Sister Anne**

### I am a nurse

I'm a nurse working in the maternity ward at the Moroto Referral Hospital in Karamoja, Uganda.

I was the first nurse on my ward to be trained by Marie Stopes Uganda to insert and remove IUDs and contraceptive implants.

I know that these family planning services are important in combating the high unmet need for contraception and the unacceptable maternal mortality rates that persist in this part of Uganda.

## Africa – Malawi – Wimbe

### Environment



**William Kamkwamba**

### I harness the wind

An inspiring story of a young man in Africa who used the only resources available to him to build a windmill and elevate the lives and spirits of those in his community. William Kamkwamba's achievements with wind energy should serve as a model of what one person, with an inspired idea, can do to tackle the crises we face.

## Africa – Uganda – Kampala

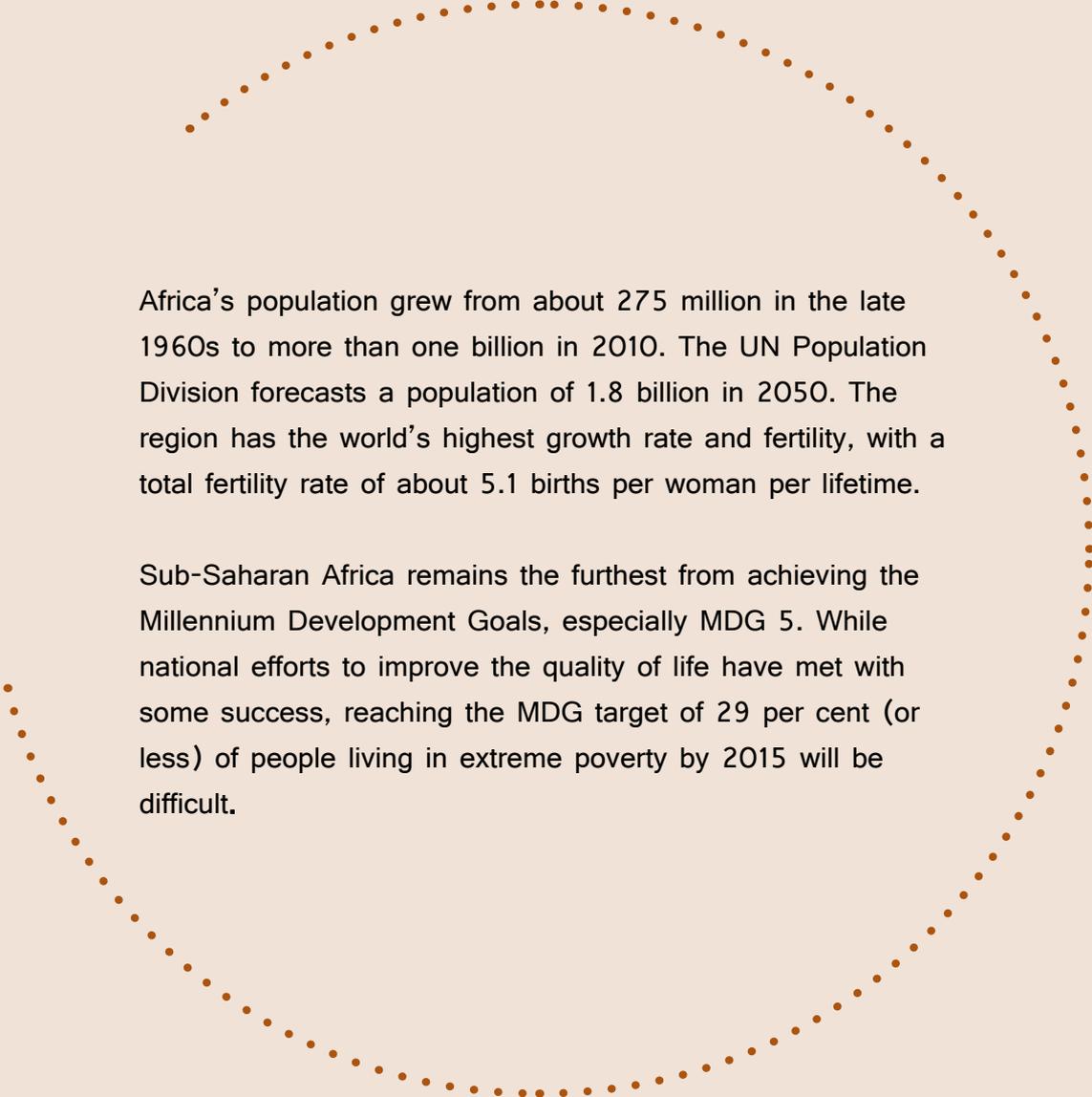
### Women and girls



**Esther Agwang**

### I am a Communications Officer

# Getting everyone counted: Population Dynamics



Africa's population grew from about 275 million in the late 1960s to more than one billion in 2010. The UN Population Division forecasts a population of 1.8 billion in 2050. The region has the world's highest growth rate and fertility, with a total fertility rate of about 5.1 births per woman per lifetime.

Sub-Saharan Africa remains the furthest from achieving the Millennium Development Goals, especially MDG 5. While national efforts to improve the quality of life have met with some success, reaching the MDG target of 29 per cent (or less) of people living in extreme poverty by 2015 will be difficult.

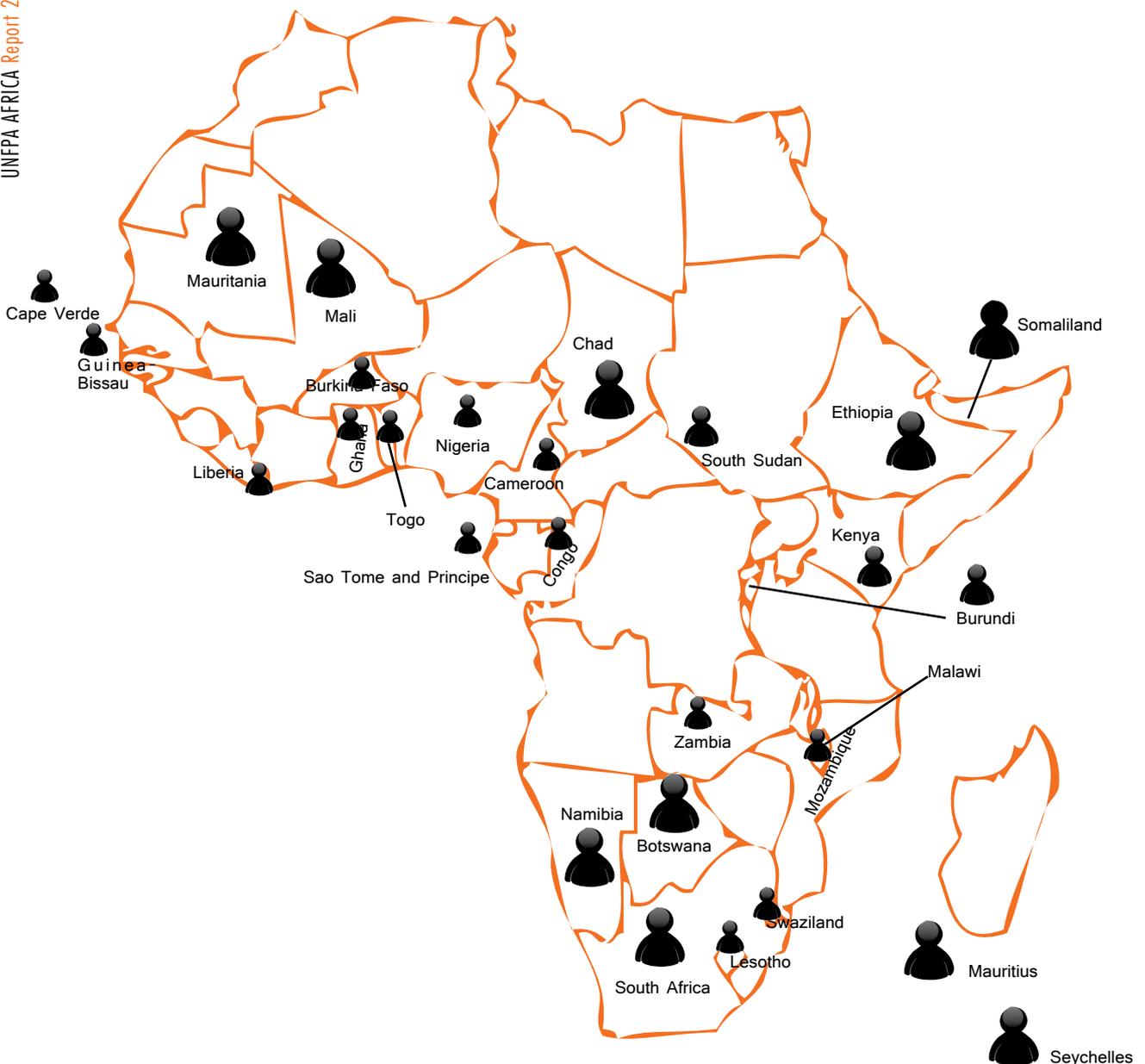
# Round of 2010 censuses in Africa

\*The region's population increased from 906 million in 2005 to 1.1 billion in 2010.

\*To date, 27 countries in sub-Saharan Africa have conducted their 2010 round of censuses, as shown below.

**Ensuring everyone counts  
requires counting everyone!**

UNFPA AFRICA Report 2012



# Chad's census a successful undertaking



It's been almost two decades since Chad's first – and last – census was completed in 1993. Provisional results are now in for the country's second census, carried out in 2009. It presents a clearer picture of the country's population, providing information that policymakers need for planning health and education systems, roads, water tanks and boreholes. "The Government needs detailed information on the country's population to better focus its strategic options," said Hamida Alladji Ahmat, Director General of the Ministry of Economy and Planning. "The census is an opportunity to get such information."

***"UNFPA was more than a technical partner. Its involvement was so keen that it has been designated by the community of census partners to ensure technical follow-up and manage a large part of the financing."***

Significant human, material and logistical resources were mobilized for Chad's second population and housing census. More than 20,000 staff, along with 4X4 vehicles, motorcycles and various other means of transportation, were involved. GPSs (global positioning systems) were used to map the entire country. Mobile telephones in areas without network accessibility also played an important role in the success of the operation. However, the process took longer than anticipated and the cost of the exercise was close to \$30 million, which was 50 per cent higher than the initial estimate. Conducting a census is a major undertaking for any country; it is especially challenging for a country such as Chad, with its diverse, multilingual population, its vast expanse of roadless areas, its refugee camps housing nearly 300,000 people displaced by conflict in Sudan, the difficulty of recruiting enumerators with the requisite skills, overlapping administrative boundaries, lack of resources and political infighting. Rebel incursions in Ndjamena, the capital city, in April 2007 and in February 2008 also delayed the process and dampened the enthusiasm of partners. The World

Bank, for instance, ended its support. During this time, however, UNFPA continued to advocate for the completion of the census. "UNFPA was more than a technical partner. Its involvement was so keen that it has been designated by the community of census partners to ensure technical follow-up and manage a large part of the financing," said Mr. Ousmane Matar Breme, Minister of Economy and Planning, early in 2009.

The Fund assisted in the preparation of technical documents, training of staff and procurement of vehicles, while helping to mobilize support from other partners. Major external donors included the European Union, Swiss Cooperation, UNDP, UNICEF and the United States Government. However, the Government of Chad shouldered 60 per cent of the costs, a commitment that was viewed favourably by the other donors.

In addition to helping policymakers plan for the future, a census has political implications. In the case of Chad, new information will facilitate country redistricting and the allocation of Parliament seats on an objective basis.

Interview with  
Marilyn Aniwa of UAPS

## Providing evidence to enhance quality of life



Marilyn Aniwa  
Executive Director, UAPS

*To address population growth and poverty in the region, UNFPA's Regional Programme for 2008–2011 aimed to strengthen the capacity of regional institutions to integrate population, gender issues, and sexual and reproductive health into national and regional development efforts and to advocate for the funding required to address them. This was done through partnerships with renowned institutions such as the Union for African Population Studies (UAPS).*

UAPS promotes the generation of research evidence, strengthens research capacity and advances the use of population-related scientific evidence in development policies and programmes in Africa.

### How do you characterize Africa's development?

It is characterized by challenges and opportunities. Africa has the fastest growing population in the world (by 2050, it may be home to more than 20 per cent of the world's population); the youngest population in the world, with a related demand for services (education, health, housing and employment); the slowest economic development (though some countries have an average annual growth rate of 8 per cent and above); mismanagement of meagre resources; and high levels of poverty.

With regard to opportunities, the youthful nature of Africa's population represents a dividend that could be adequately harnessed, as it has been done

in Asia. It represents an opportunity to educate and train more scientists and experts. However, there is a need for appropriate policies and investments for this demographic dividend to be tapped.

### What is the role of research and academic institutions?

The role of research is to provide evidence for policy formulation, implementation, monitoring and evaluation. However, most research in Africa is not taken

seriously by policymakers, and not used to improve the quality of life in Africa. The role of academic institutions is to train and build the capacity of young research scientists for the continent.

They serve as the link between evidence-based research and policy. Many of these institutions have not been able to deliver on this, mainly due to a reduction in funding support and the inability of national governments to provide the needed resources.

### What is UNFPA's role?

This is to ensure that the focus on population and development is brought back to the table.

UNFPA should be the galvanizing

force between evidence-based research and policy implementation. This can be achieved through programmes between academic and research institutions, regional bodies and groups such as the African Union, the New Partnership for Africa's Development (NEPAD), the Pan-African Parliament, governments and policymakers. UNFPA could also help raise financial support by introducing these institutions to organizations such as the African Development Bank, the African Capacity Building Foundation and other UN bodies.

UNFPA's strong points are that it has national and regional offices across the continent working in population and development. It can obtain evidence-based research in any subject area it so wishes. And it could call on the African Development Bank to support post-graduate training for young scientists in selected institutions across the continent.

**UNFPA's strong points are that it has national and regional offices across the continent working in population and development. And it can obtain evidence-based research in any subject area it so wishes.**

**The role of research is to provide evidence for policy formulation, implementation, monitoring and evaluation. However, most research in Africa is not taken seriously by policymakers, and not used to improve the quality of life of African populations.**

# Changing Gender Norms

The African Union has adopted a gender policy as a framework for promoting women's empowerment, especially in its Member States. It has also put in place further legal frameworks and policies, which guide national governments in developing related policies and programmes.

Most countries in Africa have now put in place legislative measures to promote gender equality. In politics, steady increases are being seen in women's participation and representation in most African countries.

Rwanda leads the world in the share of female Members of Parliament, at 57 per cent. The first democratically elected female Head of State in Africa was inaugurated in Liberia in 2006, and female parliamentary representation exceeds 30 per cent in Mozambique, Namibia, South Africa and several other African countries. Yet when it comes to women being empowered to seek good reproductive health, Africa has a long way to go. Changing gender norms is one way of empowering women, girls and young people to exercise their sexual and reproductive health and rights.

# Schools of Husbands in Niger

## Teaching men to improve women's health

In the shady village square, some 40 men aged between 25 and 50 years gather around their spokesperson. "For four years, we have been criss-crossing the villages night and day to promote family planning, visits to the health centre, antenatal visits, childbirth at the maternity health centres and vaccination," the spokesman says. He speaks for one of four Schools of Husbands in the Bandé Rural Community, with a population of 62,844 inhabitants, and one of the oldest of the 137 Schools of Husbands operating in the Zinder region in East Niger.

Zinder region has alarming maternal health indicators compared to Niger's Health Development Plan. According to the Zinder Regional Health Department's 2007 report, the rate of childbirths assisted by skilled birth attendants

was only 28.5 per cent and the contraceptive prevalence rate was a mere 8.5 per cent. As a result, UNFPA Niger conducted a survey in 2007 of obstacles to the utilization of reproductive health services by women. It identified the power structures and behaviour of the men as one of the main impediments.

To tackle this challenge, a strategy of increasing the involvement of men in the promotion of reproductive health was adopted and with it, the 'School of Husbands' initiative was launched. It provides a space for the exchange of information, analyses of reproductive health obstacles, a search for responses adapted to the local context, and action. It is equally an opportunity for strengthening husbands' capacities.

## An innovative strategy that yields results

The results obtained in just three years are remarkable. A change in behaviour was observed among the men, characterised by discussions between couples, an awareness of the importance of women's health and greater consideration of women's opinions and needs.

***"Since the establishment of the Schools of Husbands, visits to the integrated health centre and the utilization of contraceptive methods have increased."***

## Family planning and prenatal visits tripled

Reproductive health indicators have improved. On average, the use of family planning and prenatal consultations tripled, while the number of childbirths attended by skilled health personnel doubled in the areas concerned. According to figures from the Head of the Bandé Integrated Health Centre, the rate of antenatal visits rose from 28.6 per cent in 2006 to 87.3 per cent in 2010. "Since the establishment of the Schools of Husbands, visits to the integrated health centre and the utilization of contraceptive methods have increased," the Head of Bandé Canton ("Chef de Canton"), Yahya Louché, said.



## Funding is key to success

The Schools of Husbands have been supported by the authorities, including the region's Governor and traditional and religious leaders, with the Sultan of Zinder at the forefront. This is one of the keys to its success. According to Yacine Diallo, UNFPA Representative in Niger, the initiative is now known beyond the borders of

Niger. At the Conference on Population, Development and Family Planning in Francophone West Africa in Ouagadougou in February 2011, several countries that learned of the initiative at a presentation by UNFPA expressed their desire to replicate the schools to help boost the demand for family planning services.

## Use of contraception rises substantially

The country's contraceptive prevalence rate rose from 5 per cent in 2006 to 16 per cent in 2009. This success can be attributed to countrywide community mobilization using Schools of Husbands, community radio

programmes, community activities, the involvement of men and religious and traditional leaders, and greater security of reproductive health products.

# Cutting out Female Genital Mutilation



UNFPA AFRICA Report 2012

**“UNFPA has supported community organizations that promote alternative rites of passage ceremonies as a positive marker of initiating girls into adulthood.”**

## Working to speed up abandonment of the practice

Female genital mutilation/cutting (FGM/C) has been a chronic human rights and reproductive health concern in the region. UNFPA has actively promoted legislation to end the practice in countries where it continues and to support existing legal frameworks.

However, governments are unable to monitor FGM/C as this practice is usually underreported, particularly in remote locations. In recent years, UNFPA has advocated for specific actions to eliminate FGM/C,

including the need to work with communities, and religious and cultural leaders.

UNFPA supports efforts to end this harmful cultural practice without disrupting its positive underlying social purpose of marking the transition into adulthood. In Kenya, for example, UNFPA has supported community organizations that promote alternative rites of passage ceremonies as a positive marker of initiating girls to adulthood.

## UNFPA and UNICEF initiative with governments

The Joint Programme on Female Genital Mutilation/Cutting is being carried out in 17 African countries – Burkina Faso, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Senegal, Mauritania, Mali, Djibouti, Egypt, Somalia, Sudan and Uganda. Launched in 2007, the innovative aspect of this programme is that two UN agencies work together under the leadership of national governments, supporting community-based and national activities

identified as leading to positive social change.

The programme's main orientation is to support and accelerate efforts already underway through ongoing programmes and to not operate as a stand-alone initiative. The joint programme, funded by Norwegian Agency for Development Cooperation (NORAD), addresses FGM/C from a human rights perspective with cultural sensitivity, using a combination of strategies appropriate to specific contexts.

**In Ethiopia,**  
the prevalence of FGM/C has fallen  
from **80 per cent** to **74 per cent**

**and in Kenya**  
from **32 per cent** to **27 per cent.**

In 2011,

**197**

communities declared they were abandoning FGM/C in Guinea.

And in Gambia, **131**  
communities abandoned  
FGM/C.

In 2011, the Parliament of Guinea-Bissau approved a draft law to prohibit FGM/C in the country. The practice affects about half of Bissau-Guinean women. The new law includes sanctions of up to five years in prison for performing the practice on girls.



# Addressing girls' vulnerability in Ethiopia

“  
**The study showed that adolescent girls aged 10 to 14 in the programme intervention area were nearly three times more likely to be in school compared to girls in the control area.**  
 ”



Credit: UN Photo/Eskinder Debebe

***In the Amhara region of northern Ethiopia, the rate of child marriage is among the highest in the world. Half of all girls are married before their fifteenth birthday.***

A 2004 survey carried out by the Ministry of Youth and Sports and the Population Council on more than 1800 adolescent girls and boys in two districts found that a considerable number of girls were already married, and most felt they married too early. Most did not know their husbands beforehand, and their sexual initiation was a result of force. Many of these marital unions are unstable; many girls flee to urban areas to escape early marriage.

Another survey carried out in the slum areas of Addis Ababa showed that a considerable number of female migrants came to the city to escape early marriage, most of them ending up as child domestic workers or sex workers.

## Education to delay early marriage

In 2005, UNFPA launched a programme, *Berhane Hewan*, meaning 'Light for Eve', in the rural Amhara Region to promote education and delay marriage in rural Ethiopia. It organized adolescent girls aged 10 to 19 into groups led by female mentors and supported them to stay in school or convened groups outside of school, including non-formal education and livelihoods skills. It arranged community-wide conversations on early marriage and reproductive health issues affecting girls. In addition, economic incentives were provided to the adolescent girls who did not get married during the life of the programme to encourage families to allow their daughters to participate in girls' groups. A parallel programme (*Biruh Tesfa*, or 'Bright Future') being run for vulnerable adolescent girls in Addis Ababa is

designed to assist out-of-school girls by creating safe spaces in which they can build support networks with other girls as well as relationships with supportive adults.

## The impact of the programmes

An impact evaluation after two years by the Population Council in 2008 among adolescent girls in the pilot site, as well as comparable girls in a control site, found that significantly fewer girls in the experimental area had married during early adolescence (ages 10–14) compared to girls of a similar age in the control site. Moreover, married girls living in the project site were nearly three times more likely to use family planning methods than those living in the control sites.

## Results of the programmes

Younger adolescent girls in the programme intervention area were nearly three times more likely to be in school compared to girls in the control area. The girls in the same age group in the programme intervention area were 90 per cent less likely to be married compared to girls in the control site.

Moreover, compared to girls in the control site, girls in the programme site demonstrated improved knowledge on HIV, sexually transmitted infections and family planning methods. After the completion of the pilot phase the programme has been scaled up to 36 sites in 12 localities. Around 10,000 girls are now participating in the programme.

More importantly, the regional Government is preparing to scale up the programme, which has now been incorporated into a Government programme. A budget is being allocated for this and Government structures are to be used.

# HIV Prevention

Over 22 million Africans are living with HIV. In contrast to other regions, the majority of people (61 per cent) living with HIV are women. Young people account for 40 per cent of all new HIV infections among people aged 15 to 49 years (2009 figures).

Today, more than 1 in 20 people between 15–49 years is HIV-positive – the worst rate across the globe. In the past decade more women have been infected than men, in a trend of increasing feminization of HIV and AIDS. HIV prevalence among women aged 15–49 is 6 per cent while for men within the same age group, it is 3.9 per cent.

# HIV prevalence declines in Zimbabwean districts

Concurrent partner numbers decline

## The challenge of HIV and AIDS in Zimbabwe

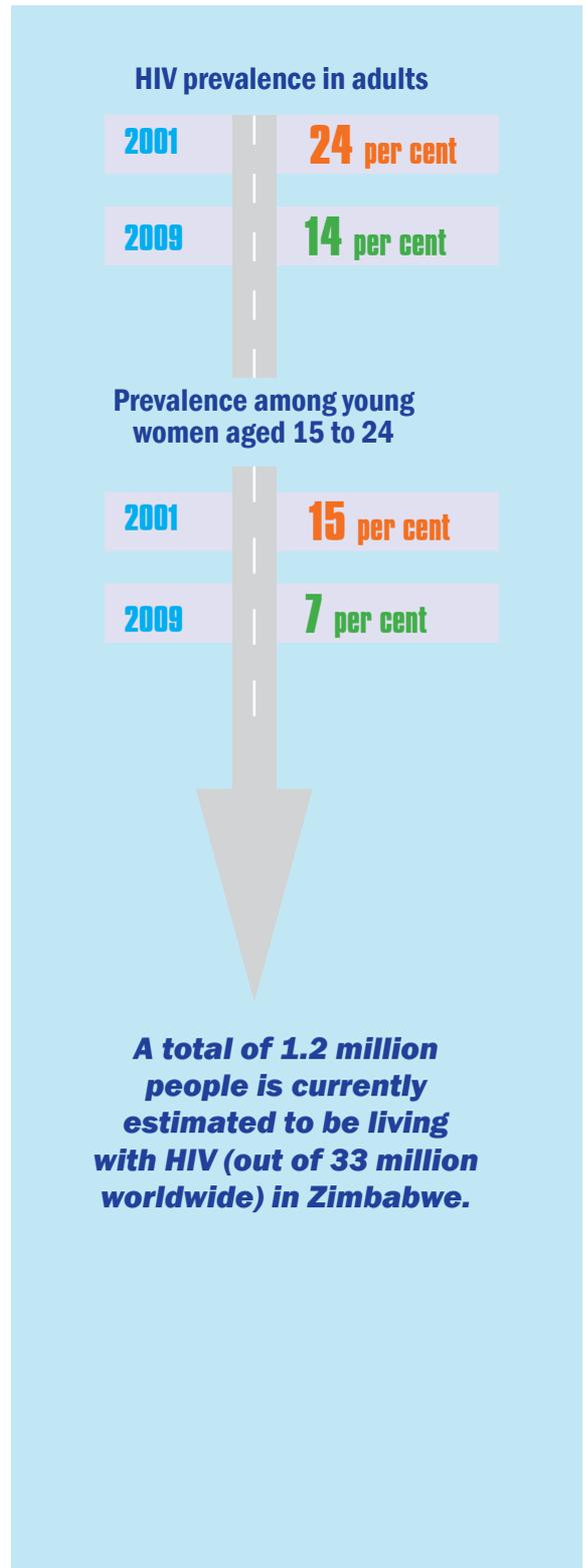
Zimbabwe has shown the most significant decline in the HIV epidemic in Southern Africa. In six years, adult HIV prevalence in the country dropped from 23.7 per cent to 14.3 per cent (2001–2009). This is a result of the combined effects of behaviour change interventions, including sexual partner number reduction, increased condom use and the impact of HIV-related mortality.

A decline was also recorded in HIV prevalence in young women aged 15 to 24 years, from 14.7 per cent in 2001 to 6.9 per cent in 2009. However, Zimbabwe's HIV prevalence is still high and more needs to be done to prevent new HIV infections. A total of 1.2 million people are currently estimated to be living with HIV (out of 33 million worldwide). In 2010 alone, there were an estimated 47,000 new infections in the 15–49 age group and 14,000 new infections among children.

Zimbabwe's epidemic is generalized, with the virus spreading through sexual contact (over 75 per cent of new infections annually) and mother-to-child transmission (over 20 per cent of new infections annually). The epidemic is largely being maintained by multiple concurrent relationships, low levels of male circumcision, transmission of the virus within stable

## Targeting behaviour change

In collaboration with key national and international partners, UNFPA supports decentralized behaviour change promotion in all 62 districts in Zimbabwe, ongoing comprehensive condom programming within a scaled-up male circumcision programme, and HIV prevention among key affected populations.





Between 2007 and 2011, a UNFPA-supported HIV prevention behaviour change programme achieved more than 17.6 million exposures to interpersonal communications and reached 649,000 people through an evidence-informed community course.

Studies show that HIV prevalence among pregnant women aged 15–24 declined from 14.8 per cent to 12 per cent between 2006 and 2009 in the initial focus districts of the programme. This decline was 24 per cent more pronounced than in other districts, where HIV prevalence in young pregnant women remained stable over the same period. This difference would translate into 39,000 to 42,000 HIV infections averted at a cost of around US\$285 per averted HIV infection, model projections suggest, – a figure that compares favourably to the lifetime cost of treatment and of other prevention interventions.

### Comments from participants:

- “I have since stopped engaging in risky behaviour and have become a role model. My relationship with my wife has improved and has become less quarrelsome. I gained knowledge that condoms are not only for sex workers and have started using them with my wife.”
- “These days we go for even four months without a funeral whereas previously we used to have up to five funerals a month.”

### Scaling up to reach more people

The UNFPA-supported programme has been scaled up nationally in Zimbabwe with Global Fund support.

The management of the programme was handed over to the National AIDS Council in January 2012, with UNFPA continuing to provide technical support. The current Expanded Support Programme (ESP)/European Union (EU) support is coming to an end; however, UNFPA, sister UN agencies, the Government and funding partners are in the process of developing follow-up funding mechanisms for integrating HIV and other health-related priorities.

# Sex work and HIV in Rwanda

The most up-to-date epidemiological data and analyses suggest that sex workers are particularly important in the dynamics of Rwanda's HIV epidemic.

## The extent of the problem

While the prevalence of HIV among Rwanda's general population is an estimated 3 per cent, a recent nationwide survey showed that the prevalence among female sex workers was 51 per cent (95 per cent confidence interval (CI): 48 per cent - 54 per cent). The prevalence increased with age, from 35 per cent among 15-19 year olds to 63 per cent of those over 40 years. The highest prevalence of 57 per cent was found in Kigali City.

According to the 2010 Behaviour Surveillance Survey, 66 per cent of female sex workers reported that their most frequent clients were married men, 21 per cent that they were widowers, and 13 per cent that they were single people. By occupation, students represented the largest

group of clients for female sex workers (29 per cent), followed by houseboys and hair dressers (18 per cent). Only 33 per cent of female sex workers reported having consistently used condoms during commercial sex.

A modelling exercise carried out by RBC-IHDPC (an organization comprising former National AIDS Control Commission (NACC) and Measure Evaluation) in 2009 showed that at least 9 per cent of new HIV infections in Rwanda occurred in female sex workers, although the percentage could be as high as 46 per cent. Clients of female sex workers are estimated to account for 9 to 11 per cent of new HIV infections. Therefore, even at the lowest end of the scale, sex workers and their clients are likely to represent at least 18 per cent of new infections.

## UNFPA'S approach as a solution

Coordination mechanism committees were put in place in five UNFPA-supported districts, and in three districts in Kigali town.

An orientation session was conducted for this group on 'knowing your epidemic' and 'knowing your response'. An assessment was carried out to estimate the number of sex workers in all eight districts. This was conducted mainly by young, active sex workers themselves.

## What the programme has achieved

- The number of sex workers in the UNFPA-supported districts has been estimated and is known.
- The size estimation exercise increased the district authorities' awareness of the magnitude of the sex worker problem in their respective districts.
- The sex workers that were identified are organized into groups, making it easy to provide services to them.
- The coordination of the sex work programme is owned by the sex workers and by the district authorities.

Ministry of Health, Biological and Behavior Surveillance Survey among Female Commercial Sex Workers, Rwanda, December 2010

Asimwe, A., Koleros, A., Chapman, J. Understanding the dynamics of the HIV epidemic in Rwanda: Modeling the expected distribution of new HIV infections by exposure group. s.l.: RBC-IHDPC, Measure Evaluation, 2009.



In Uganda in  
**2011**

about

**25,000**  
young people

**10,000**  
members of the  
general population

including

**2000**  
couples

and over

**1500**  
sex workers

were reached with SRH/HIV services in target districts.

# Developing a national EMTCT plan in Rwanda



The Government of Rwanda has developed a national strategic plan for the elimination of mother-to-child transmission (EMTCT) of HIV by 2015, in collaboration with its partners in the fight against HIV.

After the First Lady of Rwanda, Jeannette Kagame, launched the national EMTCT initiative in May 2011, the Rwanda Biomedical Center (RBC) and partners in the prevention of mother-to-child transmission (PMTCT) saw the need to develop a national plan to provide a framework to accelerate the implementation of the EMTCT.

The strategic plan took three months to be developed, from December 2011 to February 2012. The process was led by the HIV clinical prevention unit of the RBC, which actively involved the Technical Working Groups for clinical prevention, district health workers, and networks of People Living with HIV (PLHIV), among others.

The development of the strategic plan had four stages, as follows.

## Establishment of technical working sub-groups

Firstly, four technical working sub-groups were set up in July 2011 to look into the performance of PMTCT, including its achievements, gaps and challenges, and to outline priority interventions and key indicators for EMTCT. RBC and its partners then carried out a gap analysis for the PMTCT programme.

## Comprehensive bottleneck analysis of the PMTCT programme

Secondly, a full assessment of the current PMTCT programme was undertaken in November and December 2011 to better understand and evaluate programme performance as well as to identify and address any challenges, gaps and bottlenecks. It also aimed to provide evidence-based strategic guidance for priority interventions to achieve the goal of elimination.

## Meeting to develop the national EMTCT strategy

Thirdly, several consultative meetings were organized with members of the Technical Working Groups to identify priority programme areas for accelerated EMTCT programme implementation. RBC organized a strategic planning workshop in December 2011 to share the findings of the analysis with partners and district health workers and to carry out an analysis of evidence-based bottlenecks for the PMTCT programme, as well as to define key outcomes and outputs for the EMTCT strategic framework. Over 40 participants from the Institute of HIV and Disease Prevention and Control (IHDP), RBC, Technical Working Group members, district health workers, and representatives from other governmental institutions attended the workshop.

Finally, networks of women and girls living with HIV were consulted at a meeting, to ensure that PLHIV networks contributed to the development of the EMTCT strategy. This was organized by IHDP and UNAIDS. More than 25 network members attended. The next stage is to develop an EMTCT plan in all 30 districts, which will be endorsed by the district authorities.

# Special Report

## UNFPA in Humanitarian Settings

In times of upheaval and conflicts, pregnancy-related deaths and sexual violence soar. Reproductive health and obstetric services often become unavailable. Young people become more vulnerable to HIV infection and sexual exploitation. Too often, the special needs of women and young people are overlooked in humanitarian emergencies.

Africa is plagued by many humanitarian crises. In 2010, sub-Saharan Africa had 2.1 million refugees and almost 12 million internally displaced people, mostly due to conflicts.

More than 12 million people have been affected by drought in the Horn of Africa. Heavy seasonal rainfall has had a devastating effect on Madagascar, Mozambique, Zambia, Zimbabwe, Angola, Nigeria, Ghana, Gambia and Senegal. In 2010, 1.5 million people were affected by floods in West and Central Africa; in Southern Africa more than 708,000 people were affected by storms and floods.

Extreme drought, especially in desert countries, has resulted in food insecurity in Niger (more than 7.2 million people were affected in 2009), Ethiopia, Somalia, Kenya and Lesotho.

# A refugee's journey to Dadaab (Kenya)



UNFPA AFRICA REPORT 2017

**Today, Fatuma can access emergency antenatal care services at Hagadera clinic, a facility run by the International Rescue Committee, a UNFPA partner.**

When Fatuma Ali and her husband began their trek from Somalia to Kenya with their four children, they knew the journey would be torturous. But it was one that they had to take.

Pregnant with her fifth child, Fatuma could no longer tolerate life in Somalia – a ravaging famine on top of one of the world's most enduring conflicts. Yet the punishing 17-day journey through the sandy desert into Kenya injured her feet.

"I am pregnant and I needed food. I needed to go to the hospital. I couldn't get all of these in Somalia because hospitals don't work and there is no food – only war and hunger. We heard people say we could be helped here in Dadaab and we decided to come. At one time I could not walk because my feet were swollen and had sores," she says.

With a population of more than 500,000, Dadaab in northern Kenya is the world's largest refugee camp. In July, about 1500 Somalis arrived at the camp every day. Outside her family's makeshift tent, Fatuma narrates her story of endurance. At times she even smiles as she recounts her ordeal.

"Every time we came across the police in Kenya, they threatened to take us back to Somalia. I was afraid because I had heard stories of women and girls being raped on their way to Dadaab. I thought I would die on the journey because I was so hungry. My children were even hungrier and my husband and I took turns in carrying them on our backs," she says.

Today, Fatuma can access emergency antenatal care services at Hagadera clinic, a facility run by the International Rescue Committee, a partner of UNFPA. In addition, Fatuma has been able to get advice on reproductive health whenever she visits Hagadera clinic.

UNFPA has provided IRC and other partners with emergency reproductive health supplies to meet the needs of approximately 600,000 people in the area. Fatuma and almost 4,000 women have received UNFPA's hygiene kits, which include soap and sanitary towels.

"I have been going to the clinic here in Hagadera and I am given treatment. I know I will be able to deliver my child alive and healthy," she says.

Staring into the skies as she ponders the future, Fatuma says she would want to plan her family so that she is able to care for them with the little resources she has. "I don't know how long I will be here but I know I don't want to give birth here. I will not be able to care for all my children because my husband doesn't have a source of income. We rely on relief food. But I am not the problem – men are the problem because they want many children to guard against calamities," she adds.

Her story is one of endurance as famine continues to ravage Somalia, pushing many families into refugee camps where they seek help. Through its local partners in Kenya, Somalia, Ethiopia and Djibouti, UNFPA is providing supplies, including reproductive health care kits, to hospitals, primary health care facilities and communities. Clean delivery kits are distributed to the most vulnerable pregnant women among the affected communities for safe deliveries.

UNFPA has also trained midwives and other health workers and provided them with the necessary medical supplies for improved quality care.

# Did you know?



UNFPA AFRICA Report 2012

## MOZAMBIQUE

The Geração Biz Programme produced brochures in Braille to reach visually disabled young people with much needed information about sexual and reproductive health and HIV prevention in appropriate language.

‘Bancada Feminina’ (‘Female Stand’) is a successful UNFPA initiative to help inform girls and women in Mozambique about their sexual and reproductive health and rights. It provides girls and women with a comfortable space to talk about their sexual and reproductive health problems and experiences, and to learn about their rights.

## ETHIOPIA

UNFPA created a multi-donor pooled fund for the purpose of receiving contributions to support the 2007 National Population and Housing Census in Ethiopia. As a result, nearly \$20 million was mobilized by UN agencies (UNDP, UNICEF and UNFPA) and other development partners (DFID, Italian Cooperation and JICA). The entire census operation cost about \$72 million. The Government of Ethiopia covered nearly 70 per cent of this while development partners such as DFID, Italian Cooperation, UNICEF, UNDP and JICA made up the shortfall.

## SENEGAL

The Bajenu Gox Initiative is President Abdoulaye Wade’s community-based health worker programme, which trains women to be leaders in reproductive health. The name of the initiative is a reference to the deep tradition of solidarity between young women and older women, known as *bajenu gox*. The initiative uses grandmothers and mothers-in-law to promote good maternal and newborn health practices in each village.

# Spreading UNFPA's messages through music



## 7 Milliards Chad's message of hope

This song was composed by popular Chadian singer Sultan for the 7 Billion campaign. It aims to sensitize its audience on gender issues, promoting schooling for girls and raising awareness on the fight against gender-based violence.



## 8 Goals For Africa

The song, 8 Goals For Africa, is part of an awareness and advocacy campaign developed by the UN System in South Africa on the eight MDGs. It was recorded by eight African artists from across the continent as an inspirational message.



## La femme enceinte A song for Cameroon

La Femme Enceinte (Pregnant Women) is a call for everyone to unite and act against maternal deaths. This includes raising awareness of the issue of early pregnancies, the importance of spacing births, the three delays as obstacles to maternal health, and the need to get to a health centre to seek appropriate, qualified care.



## 7 Billion Song Developing Tanzania's youth

Produced and performed by Tanzania House of Talent (THT), a Dar es Salaam-based youth group, this song was translated from Swahili to promote the 7 Billion campaign. THT develops Tanzanian youth by guiding them in music production and giving them a platform for performing live music.



About 150 staff participated in the Africa Regional Consultation Meeting. The Executive Director, Dr. Babatunde Osotimehin, attended on the final day.

## Looking ahead

# Africa Regional Consultation Meeting

Johannesburg, South Africa, March 2012

After devising a new Business Plan and revising the organization's Strategic Plan in 2011, it was timely for UNFPA Africa to consult its country offices on how to forge a new way forward, translating these documents into action on the ground at country level.

For four days in March 2012, more than 150 staff members met in Johannesburg to debate and discuss the key challenges currently facing UNFPA Africa. They came from all 46 sub-Saharan African countries, headquarters in New York and other regions to renew the organization's commitment to improving the lives of women and youth.

The Consultation built on the strategic outcomes of UNFPA's Senior Management Meeting with UNFPA Representatives in Jordan in December 2011. Under the theme, 'Accountability for Results', the aim of the Consultation was to refocus the region's approach to reproductive and maternal health, and support the investment in and empowerment of youth and adolescents.

The goals of the Consultation were met. These were to develop a common understanding and commitment at the regional level towards advancing the implementation of the new vision and directions of the organization; and to help identify operational mechanisms for implementation at the regional and country levels, to ensure higher levels of programme effectiveness and efficiency.

In Africa there is an urgent need to reduce maternal deaths and achieve universal access to reproductive health. It is UNFPA's joint duty to prevent these deaths and improve women's access to health care services, especially sexual and reproductive health, including family planning.

Africa's future development and prosperity depend on investments in young people's health, education and opportunities. It is imperative to empower them to reach their full potential and contribute to the development of their communities and nations.

### **To address the challenges and seize all opportunities, four key actions were highlighted:**

- Increase UNFPA Africa's personal commitment to results, in line with the new Business Plan and the revised Strategic Plan;
- Translate into concrete actions the new vision of 'country focus' and provide adequate support for programme delivery in countries;
- Improve communication, in line with the new Communication Strategy;
- Demonstrate leadership in the areas of women's health and young people.

# UNFPA Strategic Plan (2012–2013)

## Management Results Framework

- 1 Enhanced programme effectiveness through strengthened results-based and evidence-based programming
- 2 Strengthened stewardship of resources through improved efficiency and risk management
- 3 Appropriately staffed UNFPA with high-performing professionals fulfilling its mission
- 4 Secured broad-based and stable funding to meet the Strategic Plan resource requirements

## Development Results Framework

- 1 Population dynamics and its interlinkages with the needs of young people (including adolescents), sexual and reproductive health (including family planning), gender equality and poverty reduction addressed in national and sectoral development plans and strategies
- 2 Increased access to and utilization of quality maternal and newborn health services
- 3 Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions
- 4 Increased access to and utilization of quality HIV and STI prevention services especially for young people (including adolescents) and other key populations at risk
- 5 Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy
- 6 Improved access to SRH services and sexuality education for young people (including adolescents)
- 7 Improved data availability and analysis around population dynamics, SRH (including family planning) and gender equality



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