REPORT ON

THE REVIEW OF THE TWENTY YEARS OF IMPLEMENTATION OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) PROGRAMME OF ACTION (PoA) IN THE SOUTHERN AFRICA DEVELOPMENT COMMUNITY (SADC) REGION

SADC MINISTERS’ CONFERENCE ON

The 20th Anniversary of the ICPD-PoA.

Ministry of Planning and Development
Maputo - Mozambique
In collaboration with
The SADC Secretariat in Gaborone
Botswana (June 2013)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>5</td>
</tr>
<tr>
<td>1. BACKGROUND</td>
<td>6</td>
</tr>
<tr>
<td>2. POPULATION, SUSTAINED ECIONOMIC GROWTH AND SUSTAINABLE DEVELOPMENT</td>
<td>10</td>
</tr>
<tr>
<td>3. POPULATION GROWTH AND STRUCTURE</td>
<td>14</td>
</tr>
<tr>
<td>a. Adolescents and youth</td>
<td></td>
</tr>
<tr>
<td>b. Older persons</td>
<td></td>
</tr>
<tr>
<td>c. Persons with disabilities</td>
<td></td>
</tr>
<tr>
<td>d. Indigenous people</td>
<td></td>
</tr>
<tr>
<td>4. GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN</td>
<td>21</td>
</tr>
<tr>
<td>5. THE FAMILY COMPOSITION AND CHANGING STRUCTURE</td>
<td>23</td>
</tr>
<tr>
<td>6. MATERNAL HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH</td>
<td>26</td>
</tr>
<tr>
<td>7. HIV/AIDS, MALARIA, TB AND OTHER COMMUNICABLE DISEASES</td>
<td>33</td>
</tr>
<tr>
<td>8. POPULATION DISTRIBUTION, URBANIZATION AND INTERNAL MIGRATION</td>
<td>38</td>
</tr>
<tr>
<td>9. INTERNATIONAL MIGRATION AND DEVELOPMENT</td>
<td>40</td>
</tr>
<tr>
<td>10. EDUCATION</td>
<td>44</td>
</tr>
<tr>
<td>11. CRISIS SITUATION AND EMERGENCY PREPAREDNESS</td>
<td>48</td>
</tr>
<tr>
<td>12. RESOURCES MOBILIZATION, PARTNERSHIPS AND COORDINATION</td>
<td>50</td>
</tr>
<tr>
<td>13. MONITORING AND EVALUATION MECHANISMS</td>
<td>52</td>
</tr>
<tr>
<td>14. RESOLUTIONS</td>
<td>64</td>
</tr>
</tbody>
</table>

References: 71
### Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination against Women</td>
</tr>
<tr>
<td>CGE</td>
<td>Commission on Gender Equality</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DHIS</td>
<td>District Health Information System</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Neonatal Care</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>MCP</td>
<td>Multiple Concurrent sexual Partnerships</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NEP</td>
<td>National Electrification Programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>PoA</td>
<td>Programme of Action</td>
</tr>
<tr>
<td>PMCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategic Paper</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>SADHS</td>
<td>South Africa Demographic and Health Survey</td>
</tr>
<tr>
<td>SAFFPAD</td>
<td>Southern African Forum on Population and Development</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
</tr>
<tr>
<td>VETA</td>
<td>Vocational Education Training Authority</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
SADC: Projected Population, 2015-2050

Source: SADC Statistics Yearbook, 2012

Source: SADC Statistics Yearbook 2012 (Based on Table 1.1.12)
INTRODUCTION

The process leading to the production of this ICPD PoA report on progress implementation in 20 years has been coordinated by the Ministry of Planning and Development, Maputo, Mozambique. The process started in March 2013 with a meeting of the Technical Committee and the advance notice to all member States to submit both their completed Questionnaires and ICPD+20 country reports, in accordance with the directives from the United Nations Economic Commission for Africa in Addis Ababa, Ethiopia.

In the end, only 11\(^1\) out of 15 SADC countries responded to the call on submission of country reports, although three of the remaining countries completed and submitted the ICPD PoA Questionnaires. In order to provide information for countries without a report, and in all cases where standardized data in terms of measures and time were lacking, the report utilized data from the SADC Statistics Yearbook 2012 and UN sources. It is the opinion of the coordinating body that the information base for this report is generally credible and reliable.

The Coordinating body, with UNFPA support, appointed an international consultant (Prof. Oladele Arowolo) to facilitate the preparation of this progress report, and present the findings to the Technical team as well as the Ministers’ Conference.

In order to ensure quality of the output, the Technical Committee represented by all SADC countries met in Maputo in April 2013 to consider the Terms of Reference for this exercise and discuss the overall recommendations. On the 26\(^\text{th}\) of June 2013, the Technical Committee met again on the eve of the Ministers’ Meeting, to review Draft report as well as the recommendations.

The Ministers’ Conference on the 20\(^\text{th}\) Anniversary of the ICPD PoA took place on 27 June 2013 at Indy Village Congress Hotel, Maputo, Mozambique. Countries represented at Ministerial level at the Conference were: Mozambique, Namibia and Zambia, other countries were represented by senior officials such as Permanent Secretaries, General and National Directors and other staff members. Also present were UNFPA representatives from the sub-region and other dignitaries. Were absent from this meeting the following countries: Democratic Republic of Congo, Mauritius, Tanzania, Seychelles and Madagascar (not invited).

The Report and the resolutions were discussed by the Conference; and in the absence of any objections to the contents, were unanimously adopted.

\(^1\) By the time this report was completed in June 2013, ICPD PoA progress reports were outstanding for Angola, Zambia, Madagascar and Seychelles.
1. Background of the region (SADC)

Introduction
The Southern African Development Community (SADC)\(^2\) has evolved from the then Southern African Development Co-ordination Conference, which was established in April 1980 for the purpose of working together in the group of Frontline States to advance the political struggle, to a broader group of 15 countries established by Treaty (1992) for the advancement of broader cooperation in pursuit of economic and social development. The ultimate objective of SADC is “to build a Region in which there will be a high degree of harmonisation and rationalisation to enable the pooling of resources to achieve collective self-reliance in order to improve the living standards of the people of the region” (SADC Secretariat).

Political
Fundamental to the existence of SADC is the Treaty signed in Windhoek in 1992, which established Community and provides for protocols that set out the principles and procedures under which Member States are expected to conduct their cooperation in specific areas. The existing Protocols and Memoranda of Understanding (MoUs) have been used to guide SADC in all sectors of cooperation and integration; and, as of August 2002, a total of 20 Protocols have been developed in such areas as transport and communications, water, trade, energy, mining, health, education, and training. By 2012, eleven of these Protocols have entered into force and are being implemented. The SADC Secretariat facilitates the implementation of SADC programmes and activities to meet its objectives and overall goal of poverty eradication and regional integration.

Social and Cultural
The SADC region is made up of peoples with diverse background ethnic, cultural and social characteristics which continue to shape the programmes of national and regional integration within the community. In order to harmonize these differences and promote cooperation and human development, member States of SADC adopted the ‘SADC Social Charter” in August 2003, which commits all member States to adhere to the Human Rights principles within the context of the Universal Declaration of Human Rights, the African Charter on Human and Peoples’ Rights, the Constitution of the ILO and other international instruments.

In response to emerging social development issues in the region, SADC has also adopted a number action plans and declarations which have proved useful in guiding the development and implementation of social policies at national level. The SADC HIV and AIDS Business Plan (2003-2009) is one of such plans developed in response to the challenge of the epidemic in the region.

In recognition of the importance of education and training for the development of the region, the SADC Protocol on Education and Training was adopted in 1997, with the objective to, among others, work towards the reduction and eventual elimination of constraints (including gender

---

\(^2\) The 15 Member States that make up the Southern African development Community (SADC) are Angola, Botswana, Lesotho, Malawi, Mozambique, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe, South Africa, Namibia, Madagascar, Mauritius, Seychelles and the Democratic Republic of Congo (DRC).
discrimination) to better and freer access, by citizens of Member States, to good quality education and training opportunities within the Region.


There is also the SADC Protocol on Gender and Development (2008), which focuses on integration and mainstreaming of gender issues into the SADC Programme of Action considered to be important to the sustainable development of the region. Among others, the Protocol on Gender aims to provide for the empowerment of women, to eliminate discrimination and achieve gender equality by encouraging and harmonizing the development and implementation of gender responsive legislation, policies and programmes and projects in member States. All SADC member States are also supportive of the ICPD PoA (1994) and the Millennium Declaration (2000) and have adopted common strategies for the implementation of these international instruments in addressing social development issues in the region.

**Economic**

From its inception, SADC committed itself to pursuing policies aimed at economic liberalization and economic development. The SADC Regional Indicative Strategic Development Plan is a broad strategic plan for implementing programmes for achieving key milestones that will ensure the realisation of a Monetary Union in SADC. Towards this end, SADC has attained a Free Trade Area (FTA) by 2008; this was followed by the launch of Customs Union by 2010, and the establishment of a SADC central bank by 2016 and eventually a SADC currency by 2018.

In spite of national efforts to achieve the targets of MDG1, it is estimated that about 40% (or 76 million people) of the region’s population is living in extreme poverty, compounded by the imminent humanitarian crisis arising from the acute food shortage in most parts of the region (SADC Secretariat, 2012). Within the Community, unemployment is extremely high (particularly among youth) and has been cited as a major factor in poverty and reduced economic growth; average unemployment rate in the region was 24.9% in 2011; DRC (51%) has about the highest unemployment rate, while Seychelles (1.7%) has the lowest. Unemployment rates hover around 25% in South Africa and Lesotho (25.3%), and above in Swaziland (28.5%). Income inequality also remains a major challenge, both between and within the countries (see Table 1.1).
Future economic growth and development must, therefore, respond effectively to risks emanating from concerns over debt sustainability in the United States and Europe, high oil prices, unemployment, rising food prices and climatic change. In addition, economic activity in the SADC region must contend with risks arising from energy constraints, infrastructural bottlenecks, slow pace of industrialization, high commodity dependence, relatively underdeveloped financial markets, subdued foreign direct investment flows and relatively high costs of doing business.

Among the most daunting challenges being faced by SADC are those related to poverty eradication, HIV/AIDS pandemic, rising trends in inequality (except in Namibia, Lesotho, Malawi and Swaziland - see Table 1.1), sound macroeconomic management, good governance and democracy, as well as globalisation.

**Demographic**

The estimated total population of SADC has increased from about 212 million in 2000 to about 281 million in 2011; close to 60% of the total population resides in the three largest countries – Democratic Republic of Congo (75.3m), South Africa (50.6m) and UR Tanzania (44.5m). SADC population is projected to increase to over half a billion by 2050.

The three demographic factors affecting the region’s population dynamics are fertility, mortality and migration. The level of fertility is still high in quite a number of countries but overall, there has been a declining trend. Similarly, the trend in mortality levels vary widely among member States due largely to the varying impact of AIDS and other underlying causes of death; but the overall mortality trend has been downward since about 2000. The combination of high fertility and declining mortality has been largely responsible for the rapidly increasing population of SADC.

In terms of internal population movements within countries, except for Mauritius, such movements have contributed immensely to the growing urbanization of the population. However, SADC remains a predominantly rural region, largely because agriculture and related occupations are still dominant in the work force. By 2009, only South Africa and Botswana were

### Table 1.1: Trends in Inequality (Gini Coefficient) in SADC, selected years

<table>
<thead>
<tr>
<th>Country</th>
<th>Value</th>
<th>Earliest Year</th>
<th>Value</th>
<th>Latest Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>58.64</td>
<td>2000</td>
<td>Na</td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>53.7</td>
<td>1994</td>
<td>57.3</td>
<td>2003</td>
</tr>
<tr>
<td>DR Congo</td>
<td>na</td>
<td></td>
<td>44.3</td>
<td>2006</td>
</tr>
<tr>
<td>Lesotho</td>
<td>57.94</td>
<td>1993</td>
<td>52.5</td>
<td>2003</td>
</tr>
<tr>
<td>Madagascar</td>
<td>46.12</td>
<td>1993</td>
<td>47.24</td>
<td>2004</td>
</tr>
<tr>
<td>Malawi</td>
<td>50.31</td>
<td>1998</td>
<td>39.02</td>
<td>2004</td>
</tr>
<tr>
<td>Mauritius</td>
<td>39.7</td>
<td>1992</td>
<td>38.8</td>
<td>2007</td>
</tr>
<tr>
<td>Mozambique*</td>
<td>44.9</td>
<td>1996</td>
<td>47.29</td>
<td>2002</td>
</tr>
<tr>
<td>Namibia</td>
<td>70.1</td>
<td>1993</td>
<td>59.71</td>
<td>2010</td>
</tr>
<tr>
<td>Seychelles</td>
<td>na</td>
<td></td>
<td>Na</td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>60.5</td>
<td>1995</td>
<td>48.3</td>
<td>2010</td>
</tr>
<tr>
<td>South Africa</td>
<td>59.33</td>
<td>1993</td>
<td>57.77</td>
<td>2000</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>33.8</td>
<td>1992</td>
<td>34.62</td>
<td>2000</td>
</tr>
<tr>
<td>Zambia</td>
<td>52.61</td>
<td>1993</td>
<td>55</td>
<td>2010</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>50.1</td>
<td>1995</td>
<td>Na</td>
<td></td>
</tr>
</tbody>
</table>

Source: SADC Statistics Yearbook 2012, (Based on Table 3.8). * Official figures for Mozambique: 41.5 (2002/3); 41.4 (2008/9)

---

over 60% urbanized, while Malawi was less than 20% and, except for Angola (58%), most of the other countries fall within the range of between 25% and 40%. International migration has continued to maintain prominence in population dynamics in the region; however, the Community is yet to address its importance in social and economic development through an appropriate policy response, or a Migration Protocol.

Although quite a number of challenges remain, SADC has made remarkable achievements in the continuing implementation of its Sector Programme of Action (SPA) in the areas of regional cooperation and integration, including Trade, Industry, Finance and Investment; Food, Agriculture and Natural resources; Infrastructure and services; Social and Human development and Special Programmes.
2. POPULATION, SUSTAINED ECONOMIC GROWTH AND SUSTAINABLE DEVELOPMENT

POPULATION

2.1 Status and trends

Based on extrapolations from the available data on SADC (2012), it is estimated that the population of sub-region stood at about 185 million in 1994 when the ICPD PoA was adopted by all nations, including the 15 countries of SADC. The latest yearly population estimate for the region is for 2011, which shows a total population of about 281 million, implying that SADC has increased its population by a net addition of about 96 million between 1994 and 2011 (see Figure 2.1 for population trend).

The dynamics of population in the region have been influenced by the demographic factors of fertility, mortality and migration (both internal and international). Indicated by the Total Fertility Rate (TFR), average TFR remains quite high in a number of countries: between 2005 and 2010, average TFR is as low as 1.6 for Mauritius, while the highest is 6.1 for DRC. Although AIDS contributed significantly to the overall mortality rates in SADC during the past decade or so, overall there has been a downward trend in mortality, particularly infant and child mortality levels in the region. The combination of high fertility and declining mortality has been largely responsible for the rapidly increasing population of SADC.

Overall mortality rates and, in particular, infant mortality rates have declined significantly across the SADC for most of the past 20 years; and for most countries the decline seems to have been sustained and is most likely to continue. The current levels are, however, still high especially in Angola and DRC with over 100 infant deaths per 1,000 live births, and in Lesotho, Mozambique and Zambia with over 90 infant deaths per 1,000 live births during the period 2005-2010. In Mauritius, infant mortality rate has decreased from 60.1 per 1,000 live births in 1962 to 12.6 in 2011 and still birth rate has decreased from 65.5 in 1962 to 9.6 in 2011.

Migration has played an important role in population dynamics both at national and regional levels. The effects of migration on the total national population have varied over the years but quite minimal in terms of the overall regional population growth. Between 2005 and 2010, three countries (South Africa, Botswana and Angola) were net recipients of international migrants,
while other countries, to varying degrees experienced a net loss of population due to emigration of their citizens, particularly Zimbabwe.

Figure 2.2 shows the distribution of population among member States: DRC (75.2m), South Africa (50.5m) and Tanzania (44.5m) are by far the major concentrations of population; while Seychelles (.087m), Swaziland 1.06m), Mauritius (1.3m), Botswana (1.84m) and Lesotho (1.9m) are the least populated countries.

![Fig. 2.2: Population ('000) of SADC countries 2011](image)

Source: SADC Statistics Yearbook 2012, based on Tables 1.1.1..

SUSTAINED ECONOMIC GROWTH & SUSTAINABLE DEVELOPMENT

**Economy**

Economic growth in SADC has been steady, averaging about 5.0% from 2003 until 2008 when it declined to 4.0% and further down to 2.3% in 2009. However, in response to improved global economic growth, economic growth in the region expanded by 5.4% in 2010 from 2.3% in 2009, reaching 5.8% by 2011. Official records show that most of the region’s economies registered robust growth, low inflation, sustainable fiscal balances, improvement in current account positions, rising foreign exchange reserves and sustainable public debt levels.

SADC region has many of the most unequal countries in the world, where a small segment of the population is swelling in abundance of wealth while quite a substantial proportion lives in abject poverty. There is general consensus that economic growth is a necessary condition for poverty reduction, but not a sufficient condition; therefore, policies combing the pursuit of economic growth while at the same time reducing income inequality would be much more effective on poverty reduction.

Although some countries in SADC are emerging in the global classification as ‘low-medium’ (Namibia, Botswana, Swaziland), middle-income (Seychelles and Mauritius), with the possible
exception of Seychelles and Mauritius, poverty remains endemic in the majority of the population in SADC countries in general. As revealed in Figure 2.3, nine out of the 15 SADC countries did not attain 0.5 mark on the UNDP Human Development Index in 2011, which has Seychelles, Mauritius, South Africa, Botswana and Madagascar moving to the next level in the global development scale. In many of the countries, poverty is concentrated among groups, which historically have been disadvantaged and those who remain marginalized. Consequently, as the country reports reveal, poverty is disproportionately to be found among rural people, especially those in remote locations and other areas which have been subjected to systematic under-investment; female-headed households; youth; elderly and disabled; and recent migrants to marginalized peri-urban areas.

**Sustainable development**

Apart from poverty reduction strategies common to all SADC countries, member States of Community have also, through policies, programmes and resource inputs, been addressing the challenge of population dynamics and sustainable human development. In recent times the discourse within the global community has centred on how best to integrate the economic, social, and environment components which are the three pillars of sustainable development in order to effectively address existing and emerging challenges including poverty and climate change.

**Box 2.1: Why population matters:** Unsustainable patterns of consumption and production, which erode essential and irreplaceable natural resources, would ultimately undermine the very basis for economic growth and social progress. It is therefore important that the objective to promote social progress, which requires higher economic output, does not jeopardize the sustainability of the environment. Efforts to achieve these balances – which are at the heart of sustainable development strategies – are strongly influenced by population dynamics (UNFPA).

---

4 According to UNDP (2002), sustainable development is the type of development that meets the needs of the present, without limiting the ability of future generations to meet their own needs. Sustainable development calls for the following: partnerships; capacity enhancement; good governance, accountability and transparency; democracy and human rights; environmental protection; peace and political stability.

In consideration of the 15-year review report on the ICPD PoA, the Conference of African Ministers responsible for population endorsed the findings, conclusions and recommendation of the Africa Regional Review of Progress Report and adopted a ‘Commitment Document’ which, among others, urged them to renew efforts to accelerate the implementation of the ICPD PoA taking into account reproductive health, population and gender issues that contribute to achieving the MDGs in their respective countries.

2.2 Actions taken

The SADC system of governance has been based on sector planning with policies and time-bound implementation strategies or programmes. The SADC Policy and Strategy for Environment and Sustainable Development – Towards Equity-led Growth and Sustainable Development in Southern Africa was approved by the Council of Ministers at Maseru in August 1996. The Council also established SADC Environment and Land Management Sector (SADC-ELMS), an outgrowth of the former food, agriculture and natural resources sector of SADCC.

Through effective partnership between stakeholders such as government ministries, international partners, Civil Society Organizations and the Private Sector, SADC member States have formulated policies, legal instruments and programmes for the management and protection of the environment from which the majority of the work force derive livelihoods.

2.3 Achievements

With regard to economic development, SADC countries have made significant progress towards attainment of macroeconomic convergence targets in 2010. The region is poised for further growth, which underscores the need for sustaining sound macroeconomic policies. Most countries have managed to reduce inflation to single digit levels and curtail budget deficits, current accounts and public debt to sustainable levels. Prudent fiscal policies and adroit monetary policies are contributing to general macroeconomic stability and robust growth rates in the region. The region has immense growth potential as evidenced by the availability of natural resources, and vast tracts of arable land. Investment opportunities abound in mining, agriculture, manufacturing, financial services, ICT, tourism and infrastructural development (SADC Secretariat, 2012).

The SADC REEP is a 15-year programme and has made a number of remarkable achievements, including the establishment of strong conceptual foundations for environment and sustainability education that are reported to be regionally robust, and a strong advisory community in the form of ‘a national network representatives’ structure and forum. This network provides a mechanism through which much of the programme’s work can be taken forward in the region into the next 30 or more years.

In line with the overall SADC programming strategy and in response to national objectives, member States have made investments in policies, legislative frameworks and programming to address the challenge of population and the environment.

In its assessment of the progress in addressing the ICPD issues related to population, sustained economic growth and sustainable development, Tanzania has reported that out of the ten ICPD
issues considered, the Country report indicates that by 2012, 50% are behind schedule and 50% are on deficit, meaning that there is not any single issue whose measures to implement it are on schedule. In Botswana, the establishment of community-based Trusts, provision of assistance to NGO’s Fund and forest conservation funding are some of the environmental actions taken. In the past five years, Malawi has also made a lot of progress in integrating population issues in development plans, reducing poverty and achieving economic growth; the country has recently registered significant achievements in economic growth and development, indicated by an average economic growth rate of 7.5%; food self-sufficiency for 80 percent of the households through the Farm Input Subsidy Programme; and infrastructure development such as roads, schools, hospitals and clinics. In Mauritius, apart from success in implementing other environment-related policies and programmes, significant achievements have been made over the past years in the solid waste management sector. South Africa, in promoting sustainable development has implemented, among others, the ‘Extended Public Works Programme 2005, and the Comprehensive Agricultural Support Programme towards increasing access of the population to social services and infrastructural facilities, and poverty reduction in both rural and urban areas. Among others, during the period 2010–2011, Zimbabwe has achieved a 38% reduction in veld fires and 50% reduction in reported poaching crimes during this same period.

2.4 Major challenges/constraints

Southern Africa has been described as a predominantly semi-arid region with high rainfall variability, characterised by frequent droughts and floods; and being one of the most vulnerable regions to climate change because of low levels of adaptive capacity (particularly among rural communities), combined with a high dependence on rain-fed agriculture (IPCC, 2007). In this regard, SADC has long recognized that years of largely unsustainable development in southern Africa have threatened the livelihoods and lives of many people and the economic prospects of most countries continue to be threatened by environmental degradation. The records show that SADC countries now face a formidable series of critical demographic, social, economic, agricultural, energy, technological, and institutional transitions in order to move toward development that is economically, socially, and environmentally sustainable (see Table 2.1).

<table>
<thead>
<tr>
<th>Transition challenge</th>
<th>Development possibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>A demographic transition</td>
<td>toward an optimal size and distribution of population and economic activity in relation to the environment and natural resource base (including the ‘Demographic Dividend’)</td>
</tr>
<tr>
<td>A social transition</td>
<td>toward a more equitable sharing of development opportunities and benefits with priority to the poor majority</td>
</tr>
<tr>
<td>A gender transition</td>
<td>toward expanded rights and participation of women in the development process</td>
</tr>
<tr>
<td>An economic transition</td>
<td>toward equity-led growth with priority to the poor and to protecting the environment and natural resources needed for future development</td>
</tr>
<tr>
<td>An agricultural transition</td>
<td>toward better and sustainable use of land for greater food production and productivity with priority to household and regional food security</td>
</tr>
<tr>
<td>An energy transition</td>
<td>toward more efficient use of and less polluting sources of energy with priority to the accelerated development of renewable sources and affordable</td>
</tr>
</tbody>
</table>

alternatives to fuelwood for the poor majority

<table>
<thead>
<tr>
<th>A technological transition</th>
<th>toward accelerated industrial development with priority to technologies that produce less waste and are more energy and resources efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>An institutional transition</td>
<td>toward new national and regional institutional arrangements with priority to integrating economic, equity and environmental imperatives in planning and decision-making within and among different Ministries and countries</td>
</tr>
<tr>
<td>A governance transition</td>
<td>toward greater public accountability and participation with priority to new sustainable development partnerships among governments, industry and NGOs</td>
</tr>
<tr>
<td>A capacity building transition</td>
<td>toward greater public accountability and participation with priority to accelerated development and use of local know how, technology and expertise</td>
</tr>
<tr>
<td>A development budget transition</td>
<td>from aid dependence to self-reliance</td>
</tr>
<tr>
<td>A peace and security transition</td>
<td>after decades of conflict toward a new era of regional cooperation and integration with priority to the peaceful settlement of disputes and equity-led growth for sustainable development</td>
</tr>
</tbody>
</table>


Nevertheless, SADC is committed to building a new Southern African Development Community (SADC) anchored on the principles on sustainability of environmental resource utilization so as to better manage their multiple transitions and together move toward sustainable development.

"Southern Africa is richly endowed with abundant agricultural, mineral and other resources ... About 70 per cent of the region’s population depend on land [and the environment] for food, income and employment. ...Despite progress and commitment to environmental management, the SADC region continues to experience considerable levels of land degradation, deforestation, loss of biodiversity, inadequate access to clean water and sanitation facilities, and poor urban conditions. It therefore comes as no surprise that SADC places high priority on these and other challenges.”, SADC, (2008) Southern African Environment Outlook. SADC, SARDC, IUCN & UNEP, Gaborone/Harare/Nairobi.

Apart from the population, environment and development challenges facing the SADC region in general, which militate against sustainable development, individual countries also face certain peculiar challenges.

2.5 Future plans (beyond 2014)
The broad based growth opportunities offered by SADC resource base should be complemented by deliberate programmes to bridge infrastructural gaps and ensure reliable and extensive service delivery in health, education, energy, water and sanitation. Therefore, SADC needs to embark upon extensive reforms to unlock productive potential, promote trade and financial sector development, and encourage domestic savings and investment as well as strengthening of institutional capacity to help attract sustained capital flows into the SADC region. Measures should be put in place early to mitigate the possible future effects of sovereign debt crisis and food insecurity\(^7\).

\(^7\) Banco Nacional de Angola, Integrated Paper on Recent Economic Developments in SADC, Prepared for the Committee of Central Bank Governors in SADC, September 2012
When it comes to environment and development issues, SADC strategic frameworks point at a determination to achieve sustainability in future. However, the Secretariat underscores the need to change policy structures necessary to enable the region’s people to learn how to create a sustainable future; the need to strengthen policy making and implementation capacity, at the levels of both institutional and human professional capacity and; the need for inter-disciplinary co-operation and multi-sectoral engagement; as well as multi-levelled engagement and policy coherence at international, regional and nation state levels.

Given the above challenge to action, individual member States have been concerned with developing proposals and policies that will ensure poverty reduction, reduction in income inequality, economic diversification, sustained economic growth, low levels of unemployment and sustainable utilization of environmental resources.
3. POPULATION GROWTH AND STRUCTURE

Status and trends
Within SADC, the observed population trends (Chapter 2) have been influenced largely by the fertility and mortality rates, and to some extent the patterns and trends in internal and international migration. This section focuses on how these demographic factors have played out in the region and their effects on the structure of the population, with reference to: a) Adolescents and youth; b) Older persons; c) Persons with disabilities and; d) Indigenous people.

Population growth

As illustrated in Figure 3.1, the overall growth rate of population in SADC has declined in the past decade from 3.25% in 2001 to 2.4% in 2008, but has picked up a rising trend since then to 2.68% in 2011. If the trend is sustained at 2.68% per annum, SADC would double its population from 281 million (2011) to about 562 million in 26 years (i.e. by 2037).

While declining population growth in developing countries should be welcome as a population parameter (suggesting a downward trend in the levels of fertility and mortality), care must be taken in interpreting the evidence from SADC countries, especially where AIDS mortality has impacted negatively on population growth.

In spite of the ravaging effect of AIDS mortality, especially during the decade between 1998 and 2008, efforts to combat the forces of mortality in the region has borne mixed results, a few of them in the positive direction. A total of 9,936,370 persons have died of AIDS between 1990 and 2009; the trend shows a vigorous rise from 77,903 deaths in 1990 to over half a million in 1999, reaching a peak of 783,636 deaths in 2005. Since then the number of recorded AIDS deaths has declined gradually to 658,030 in year 2009, the latest year for which data are available.

Actions taken, achievements and challenges

Source: SADC Statistics Yearbook 2012 (Based on Table 1.1.2)

---

*Internal migration and urbanization are treated in Chapter 8; International migration is the subject of Chapter 9 of this report.*

---

17
Every SADC country has taken specific actions to address the challenge of population dynamics, particularly fertility and mortality trends. Common to all is the formulation of a national population policy, as already reported in Chapter 2; and in all countries, population policies have been amplified by supporting national poverty reduction strategies and sectoral policies in health, sexual and reproductive health (SRH), HIV/AIDS, education, gender, youth and related sectors. As a first step in addressing the challenge of population dynamics, it is fair to conclude that SADC has provided the guiding principles and member States have responded effectively.

However, both the questionnaires completed and the country reports provided are not as articulate in demonstrating that population programming for policy implementation (including development of Action Plans, integration of population issues into national policies and programmes, and monitoring and evaluation of population programmes) is as important as the policy itself, and that one without the other is mere paper work. While it is not correct to state that countries have not implemented their population policies, it is accurate judgment to conclude that in many cases, attempts to implement national population policies have not been universally backed by National Population Programmes and/or National Action Plans. For illustration, the National Population Unit in Swaziland developed an Action Plan for implementing the National Population Policy; however, this could not be fully operationalized due to financial constraints coupled with limited human resources to monitor the implementation process. As a consequence, there is limited integration of population issues into development policies and plans in Swaziland as elsewhere in the Community. The DRC formulated the national population Policy only in 2007 and has limited human and financial resources to pursue its implementation.

A National Population Programme or National Action Plan for Population Policy Implementation must be conceived and executed in the same way that the national population Policy has been formulated: it must be nationally owned, developed and implemented, together with NGOs and developing partners. The absence of serious attempt at population programming also explains why country reports are scanty on information on population and development integration.

As far as the population sector is concerned in SADC, the major challenge is for each country to address population and development programming in its totality, with particular attention paid to human and institutional capacity building for the integration of population issues into national and sectoral development policies and programmes.

a) Adolescents and Youth

Status and trends
As a matter of principle, all SADC countries are agreed that the young people (children, adolescent and youth) are the future of all nation states, and that their care and nurture through social development, political participation and economic empowerment should not be compromised. In most countries, young people aged 30 years and below make up close to 70% of national populations across the region; therefore any planning strategy must recognize that the bulk of all interventions should address the needs and concerns of this segment of the population. The youth as a group within the young segment constitute a formidable force in terms of current
development efforts and socio-economic challenges faced by member States of SADC. Officially defined by many countries as those aged between 18 and 35 years, the youth constitute about 35% of total national populations. Children below 15 years of age constitute close to 40% of the population of most countries in SADC: Zimbabwe, 42%; Mozambique, 45%; Swaziland, 39.6%.

Across the Community, the youth face generally the same set of problems: high unemployment rates; poor education and skills; pervasive poverty; high vulnerability to sexual and reproductive health issues; poor access to family planning services; early marriage of girls; high rates of HIV and AIDS; high frequency of teenage pregnancies; growing limited involvement in the political process.

The real message of the youth population share in the national population is that they are an integral part of the labour force (15-64); and this segment of the population is poised to grow more rapidly than the overall national population growth in the coming decades. Therefore, every country must strive to tap into the potentials held by the rapidly growing labour force and thereby reap the ‘Demographic Dividend’ through quality education and skills development for the youth, quality RH and general health facilities and services, coupled with a robust labour market capable of absorbing most of the new entrants into the work force.

Actions taken
All SADC countries have a national policy or legal framework that addresses the concerns of the youth. Mauritius created a Youth Service within the Ministry of Education in 1948; but launched the National Youth Policy of Mauritius (2010-2014) only in August 2009, with the objective to ensure that all young men and women are given meaningful opportunities to reach their full potential both as individuals and as active participants in society. The Government of Namibia promulgated the first National Youth Policy in 1993, revised and re-launched in 2012, primarily to address youth issues through the Ministry of Youth National Services, Sport and Culture (MYNSSC). In Tanzania, Government has continued to strengthen the national policy framework for promoting youth development and empowerment with a thrust on skills training and mind-set change that enhance employability, self-employment and productivity.

The Department of Youth and the National Youth Council of Malawi are the institutional authorities responsible for the coordination of youth development strategies, guided and influenced by the Strategic Plan, the Malawi Growth and Development Strategy (MGDS), the African Youth Charter, etc. In South Africa, the Government has ratified international and regional conventions, and is bound by the constitution and various pieces of legislation to implement adolescent and youth rights. Almost all the Government Departments in the country have a duty with the youth programmes; even the Parliament of South Africa has set a number of portfolio committees to deal with several issues that affect adolescents and youth.
The governments of Swaziland, Zimbabwe, Mozambique, DRC and Botswana have all taken the challenge of youth development seriously and adopted policies, legal instruments, international conventions and Treaties, apart from their national constitutional provisions, to ensure youth development, protection, empowerment and their human rights. Botswana, for instance, has established a number of institutional entities, such as the ASRH Technical Advisory Committee (2003); Department of Youth and MYSC Regional Youth Officers (2005), etc, to support programs and strategies that address issues affecting the youth.

Achievements and challenges
Much of the achievements mentioned in the country reports are related to the establishment and strengthening of human capacity and institutional mechanisms for addressing the challenges faced by the youth. Concrete evidence of the impact of policies and programme implementation is scarce, suggesting that the enumerated problems being faced by the youth may have been addressed by policies and programmes but, in most SADC countries, they remain largely unresolved. As shown above, much has been done by national governments in SADC to address the burning issues of youth development, empowerment and human rights; however, achievements so far have been limited, particularly in reducing poverty levels, high unemployment rates and certain reproductive health challenges among the youth in most SADC countries.

For example, in Swaziland, the current official unemployment rate stands at 30%, but it is 50% for the youth and is not expected to decrease soon because of the global downturn and its repercussions on Swaziland’s domestic economy. Although concrete results are in the waiting, Botswana has been implementing policies and legislations that address protection of youth and children against abuse, exploitation and violence. Zimbabwe, like most other SADC countries, also faces the challenge of inadequate funding for all the youth initiatives, including difficulties in accessing loans, HIV and AIDS, youth abject deprivations, unemployment, teenage pregnancy, sexual exploitation, early marriages, illiteracy, and information gaps, youth vulnerability, as well as shortfalls in the provision of reproductive health facilities, information, training and other social services, as well as their inclusive participation in the development process.

Future plans
The objectives of most national youth policies, legislations and supporting programmes are essentially the same; and the position of Swaziland seems to aptly sum up what lies ahead. The government plans to embark upon a comprehensive implementation of the Swaziland National Youth Policy (2009), with the overall goal of creating and ensuring an enabling environment for developing youth to their full potential, socially, mentally, physically, culturally and spiritually, by providing quality education, employment (economic empowerment), to further the aims of sustainable human development and realization of the Demographic Dividend. Action will also be taken to promote adolescents and youth participation in governance, development planning and programming.

b) Older persons

Status and trends
In SADC, the proportion of older persons aged 65+ in the total national population is higher than 5% only in South Africa (5.1%), Mauritius (7.3%) and Seychelles (7.6%). In all the countries in
the region, although a general increasing proportion of older persons in the total population is discernible, a few countries seem to have stagnated at low levels of representation of the elderly in their total population; namely, Angola, DRC, Madagascar, Mozambique and Zambia (see Figure 3.2). Increasing growth in the proportion of the elderly in total national population is a healthy sign; it is evidence of increasing longevity, and declining trends in the vital rates, i.e. fertility and mortality.

![Fig. 3.2: SADC: Percentage of national population aged 65+, 1980-2010](image)

*Source: SADC Statistics Yearbook 2012, based on Table 1.1.4*

**Actions taken, achievements and challenges**

Given that older persons are a growing minority population group in SADC, Governments have become increasingly concerned about their plight and the need to for their protection and social and economic support.

In all SADC countries, the elderly persons benefit from a number of social safety nets (SSNs) that Government has put in place to reduce poverty and provide social protection. Mauritius has one of the most elaborate schemes in support of the elderly in SADC, based on the Government philosophy that “our elderly enjoy a pleasant and active retirement”.

<table>
<thead>
<tr>
<th>Care for the Elderly in Mauritius</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apart from the basic retirement pensions for the elderly, Government has also put in place other facilities and services: Elderly Day Care Centres; Senior Citizens Council; Anti-influenza Vaccination Campaign; Training Programme for Carers; Road Safety Awareness; Protection of the Elderly; Elderly Persons Act 2005; Accommodation for elderly widows (Residence Bois Savon); Domiciliary monthly medical visit; hotel-type recreation centres for the elderly; computer clubs in all Elderly Day Care Centres; International Day of the Elderly; Get Together Programme; Observatory on Ageing; Residential Care Home (Foyer Trochetia); Legal Counselling Programme for Elderly. <em>(Source: Mauritius, Country Report ICPD+20)</em></td>
</tr>
</tbody>
</table>

In spite of the interventions to support the elderly in many countries, some challenges still remain. One challenge that is common to all countries is that the elderly population is poised for long-term growth, and so also the associated demand for social and economic support - basic retirement pension, health care, leisure facilities, security and educational programmes.
Across the SADC, the overriding future consideration seems to be the sustained implementation of the existing policies and legal frameworks designed to support the elderly and give them hope that life is worth the living. For example, South Africa plans to continue to implement its policy for older persons and related legislation and report on its progress. The National Policy on Older Persons in Malawi was approved only in 2012 and an Action Plan on the implementation of the Policy has been drawn for implementation in 2012-16. Therefore, the future lies in a comprehensive implementation of the programme for the elderly in SADC countries.

c) Persons with Disabilities

The occurrence of permanent disability conditions is often found in relatively small proportions in all human populations, including SADC; however, the disability types may vary widely by age, sex or social background.

Status and trends

The country reports show that disability conditions are found in about 3% of the national total population: Botswana has experienced an increasing trend from 2.2% in 1991 to 3.5% (2001), and reported to be higher among males (3.1%) than females (2.8%). In Malawi, 3.8% of the population reported disability conditions, including inability to see, hear, speak and walk. Lesotho’s report indicates that persons with disabilities constituted 2.6% of the total population in 2011, suggesting a decline from 3.7% of disabled persons reported in 2006. Mauritius reported that 60,000 people were living with disabilities in 2011, representing a 47% rise compared to the Census 2000. Currently in South Africa, persons living with disabilities make up 4.0% of the total population, a decline from 5.0% in 2001. Across SADC in general, impairment of sight or hearing, and loss of limb mostly in countries affected by internal conflict, are the most commonly cited disability conditions in the census reports.

Actions taken, achievements and challenges

In general, SADC countries have responded to the challenges faced by people living with disability conditions in practically the same way as done with social problems in the Community; almost every country has enacted legislations, developed relevant policies and established mechanisms considered appropriate to address the problems of relative deprivations faced by those living with disabilities.

In terms of achievements, Tanzania has made significant progress in implementing the ICPD issues on regarding persons with disabilities. It is on schedule in implementing one (9%) of the eleven ICPD issues examined; but it is reported to be deficient in four (36.4%) of the issues – namely developing infrastructure to ensure that persons with disabilities have access; strengthening and extending comprehensive rehabilitation services and programmes for persons with disabilities; promoting equality; and instituting concrete measures and mechanisms for the inclusive participation of older people in the development process.

Given the challenges often faced by people living with disabilities and the generally weak institutional support to their programmes, the task of addressing disabilities in the population is daunting. For illustration, people with disabilities in Malawi were generally excluded from the
mainstream of society, as such they often experience difficulty in accessing fundamental social, political and economic rights; however, Government has recently adopted a policy on equalisation of opportunities to promote their inclusion. In Swaziland, given their impairment and generally poor education, an overwhelming proportion (83.7%) of people with disabilities in the country is reported to be economically inactive; only 12.3% percent of the disabled population are employed. A major problem relates to the non-availability of the requisite infrastructure for disabled people for example, schools.

**d) Indigenous people**

The San are the indigenous people of Namibia, numbering about 38,000, or about 8% of national population. They are marginalised and remain the poorest of the poor. In 2010, the Namibian Cabinet approved a Division for San Development under the Office of the Prime Minister which is an important milestone in promoting the rights of indigenous people/marginalised communities in Namibia. Many NGO’s are supporting Government programmes on indigenous people (e.g. education, human rights and livelihoods); however, the challenge of lifting them up to the national level on all indicators of social, political and economic development remains formidable.

South Africa recognizes five indigenous groupings which are the San and the Nama in the Northern Cape Province; the Korana mainly found in the Northern Cape and Free State Provinces; the Griqua mainly in the Western Cape, Northern Cape and KwaZulu-Natal Provinces; and the Khoi that reside mainly in the Western Cape. Despite the gains made since the end of Apartheid, these people remain in a subordinate, vulnerable and marginalized position. It is difficult to follow and document the population growth, structure and changing dynamics of indigenous people in South Africa as they are currently not treated as a unique and distinct population group.

**4. GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN**

**4.1 Status and trends**

The ICPD PoA urges all Governments to ensure the empowerment and autonomy of women and improvement of their political, social, economic and health status, both as an end in itself and as an essential condition for the achievement of sustainable development (ICPD PoA, 1994: para. 4.1). However, all countries acknowledge the persistence of gender inequalities in favour of men and boys, while noting with alarm the rising trends in gender based violence, particularly rape, abuse and workplace harassment.

Country reports show that gender discrimination has negative consequences on vital rates in the region. While high fertility rate stems mainly from low schooling levels of a large part of the population, particularly in the rural areas, there are gender related factors as well: early age at

---

*Not all countries refer to indigenous population as such, but wherever they exist there are policies and programmes to ensure their integration.*
marriage and pregnancy, and the persistence of gender discriminatory practices that affect marriage and family formation. Maternal mortality has been attributed in part to gender related issues - adolescent pregnancies which contribute about 20% of maternal deaths, and the limited involvement of men in family planning. HIV infections among women outweigh male infections among the youth in SADC, making prevention among girls and young women of particular and urgent concern.

Gender inequality exists in almost all spheres of life in Swaziland: socially, women are regarded as minors; decision-making power is vested in males at family, community and national levels; men take decision on matters relating to sexuality, reproduction, family size, and the adoption of fertility regulation measures.

Information on status and trends regarding gender issues in Botswana, Mozambique, Tanzania and South Africa are scanty; however, in Botswana, the Customary Law and practice have been observed as inhibiting the success of efforts (including Government policies, legal instruments and programmes) to eliminate gender discrimination by continuing the perpetuation of unequal power relations between men and women.

There has been, in Zimbabwe, a decline in the percentage of women who have ever experienced physical violence since the age of 15 from 36% in 2006 to 30% in 2011. The prevalence of physical violence in rural areas remains slightly higher (31%) than in urban areas (28%). The percentage of women who have ever experienced sexual violence slightly increased from 25% in 2005-06 to 27% in 2010-11. In the education sector, gender parity in terms of completion rates at primary school level (no less than 0.97 since 1996) and near gender parity at secondary school level (average of more than 0.91 since 1996) has been achieved. However, disparities still exist at tertiary level where 57% of university students were male in 2011.

Unlike the pattern of gender disparities observed in a number of countries in SADC, Lesotho has higher rates of literacy among girls than boys, a relative advantage has enabled women to compete for employment within the country while, historically, the more poorly educated men have sought employment in South Africa. As a result, women have done well in certain sectors of the economy, including health, education and manufacturing, although often in poorly paid positions; and within Government, in lower and middle ranking positions women predominate over men in many departments.

In Mauritius also, women are reported to be academically more qualified than men, but earn less; they perform more unpaid work compared to men; and while children are taken care of within families, most of the work is done by their mothers. In Zimbabwe, the majority of this employment is concentrated in the micro, small and medium enterprises sector, and is largely informal. Although there is a gender gap and gender-differentiated pattern established from childhood in a variety of leisure, sport and socialising activities in Mauritius, today the country is reported to offer an example of society with a good human development index, where women enjoy a good health status, have access to free education, are economically empowered, as there is a commitment to the ideals of equality, good governance, respect for human rights and social justice.
4.2 Actions taken
The available reports show that nearly every SADC country has developed a Gender Policy and Programme/Action Plan for policy implementation; included gender issues in sectoral policies and Action Plans and; committed to a number declarations and protocols aimed at the full realization of all human rights and fundamental freedoms, including the goal of equality between women and men. These include the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) 1979; the United Nations Millennium Development Goals (MDGs) 2000; the Convention on the Rights of the Child (CRC, 1989); International Conference on Population and Development (ICPD, 1994); Beijing Declaration and Beijing Platform for Action (BPFA, 1995); the SADC Declaration on Gender and Development (1997) and its addendum on The Prevention and Eradication of Violence Against Women and Children (1998) and the UN Security Council Resolution 1325 on Women, Peace and Security (2000).

4.3 Achievements
Many SADC countries have taken the implementation of the SADC Declaration on Gender and Development (1997) and its addendum on The Prevention and Eradication of Violence Against Women and Children (1998), and the achievement of the MDG targets related to gender seriously in their planning and implementation strategies, particularly Primary school enrolment. Representation of women in the decision-making spheres of governance has been on the increase in almost all countries in SADC, and the most recent data show that South Africa is a leader in this, with about 45% of representatives in Parliament as women, followed by Mozambique (39%), Angola (38.6%) and Tanzania (36%). (see Table 4.1).

<table>
<thead>
<tr>
<th>Country</th>
<th>Latest Elections</th>
<th>Total number of seats</th>
<th>No. of seats held by Women</th>
<th>Women as %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>September 2008</td>
<td>220</td>
<td>85</td>
<td>38.64</td>
</tr>
<tr>
<td>Botswana</td>
<td>October 2009</td>
<td>63</td>
<td>5</td>
<td>7.94</td>
</tr>
<tr>
<td>DR Congo</td>
<td>July 2006</td>
<td>500</td>
<td>52</td>
<td>10.40</td>
</tr>
<tr>
<td>Lesotho</td>
<td>February 2007</td>
<td>120</td>
<td>29</td>
<td>24.17</td>
</tr>
<tr>
<td>Madagascar</td>
<td>October 2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>May 2009</td>
<td>192</td>
<td>40</td>
<td>20.83</td>
</tr>
<tr>
<td>Mauritius</td>
<td>May 2010</td>
<td>69</td>
<td>13</td>
<td>18.84</td>
</tr>
<tr>
<td>Mozambique</td>
<td>October 2009</td>
<td>250</td>
<td>98</td>
<td>39.20</td>
</tr>
<tr>
<td>Namibia</td>
<td>November 2009</td>
<td>78</td>
<td>19</td>
<td>24.36</td>
</tr>
<tr>
<td>Seychelles</td>
<td>May 2007</td>
<td>34</td>
<td>8</td>
<td>23.53</td>
</tr>
<tr>
<td>South Africa</td>
<td>April 2009</td>
<td>400</td>
<td>178</td>
<td>44.50</td>
</tr>
<tr>
<td>Swaziland</td>
<td>September 2008</td>
<td>66</td>
<td>9</td>
<td>13.64</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>October 2010</td>
<td>350</td>
<td>126</td>
<td>36.00</td>
</tr>
<tr>
<td>Zambia</td>
<td>September 2006</td>
<td>157</td>
<td>22</td>
<td>14.01</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>March 2008</td>
<td>214</td>
<td>32</td>
<td>14.95</td>
</tr>
<tr>
<td>SADC Total</td>
<td>Oct-10</td>
<td>2969</td>
<td>735</td>
<td>24.76</td>
</tr>
</tbody>
</table>

Source: SADC Statistics Yearbook 2012 (Based on Table 4.3)
Namibia’s report indicates that reported cases of rape, passion killing and domestic violence are on the increase, and that women continue to be under-represented in decision making roles in the country even as women representation in the National Assembly dropped significantly from 30.8% to 26% in 2005. Mozambique has recently put in place a legal framework to address the challenge of gender based violence in the country. In Malawi also, one of the main gender issues is the continuing disparities between men and women, as evident from the political, social and economic spheres; women are still under-represented in decision making from household levels to the highest offices of government. Following the 2004 general elections in Botswana, the percentage of women legislators declined from 18% to 9%; out of the Cabinet of 19 members, five are women and; of the 15 members of the House of Chiefs, three are women. In Zimbabwe, the representation of women in cabinet increased slightly from 14.3% in 2002 to 20% in 2008; ministers from 8.3% in 2002 to 9% in 2008; female Provincial Governors and Resident Ministers is at 20% and has not changed since 2006. Progress has also been witnessed

**Challenges and future plans**

Statistical indicators on gender based violence are most difficult to find in almost all SADC countries; yet the need for intensified efforts to eliminate this resistant challenge cannot be overemphasized. Table 4.2 summarizes three other outstanding gender issues requiring renewed efforts in SADC; namely, high and fluctuating levels of maternal mortality, increasing rates of adolescent fertility and percentage of women in Parliament.

In almost all cases, the challenge is to comprehensively implement the existing gender and related policies, protocols, Conventions and programmes, and enforce the related laws and statutes in the respective countries. That should also define the future plans in all SADC countries.
5. THE FAMILY COMPOSITION AND CHANGING STRUCTURE

1. Status and Trends

The ICPD PoA recognizes the family as the basic unit of society and as such is entitled to receive comprehensive protection and support. In terms of programming for family support, the objectives of the PoA are to: develop policies and laws that better support the family, contribute to its stability and take into account its plurality of forms, particularly the growing number of single-parent households; establish social security measures that address the social, cultural and economic factors behind the increasing costs of child-rearing and; promote equality of opportunity for family members, especially the rights of women and children in the family (ICPD PoA, 1994: 5.2).

Marriage is regarded as the basis of family formation in all SADC countries, but recent trends seem to suggest that the move towards single motherhood is gaining ground, as marriage rates appear to be declining. Similarly, there has been a growing trend towards female-headed households: in Swazi households consist of an average of 4.6 persons, and almost half of households in the country are headed by women. In Malawi also, the average household size is 4.6 persons, with rural households having slightly more members at 4.7 compare to urban households at 4.4 persons; however, in Malawi, 72% of all the households are headed by men, but households headed by women are more likely to be found in the rural areas (30%) than in the urban areas (21%). Like in all other countries, female-headed households are poorer than male-headed households.

In Lesotho, as in many SADC countries the extended family is growing in size and posing a challenge of sustainability; the proportion of families with foster children (children who live within families with neither biological parent), double orphans (children with both parents dead) and single orphans (children with one parent dead) has increased tremendously; in 2011 42% of families in the country contain fostered or orphaned children. The HIV/AIDS accounts for a significant percentage of parental deaths. Botswana has, however, been experiencing significant changes in the family structure and composition over the years, characterized by an increase in the number of households and a decline in the average household size; while the number of households increased by 30% from 1991 to 2011, the average household size has been declining, from 3.7 to 3.9 people per household between 2001 and 2011, suggesting that households and probably families are becoming more nucleated, and moving away from the traditional extended family structure.

The scourge of AIDS in Swaziland has also resulted in a dramatic increase in the number of orphans and vulnerable children in the country; and now, the society seems to be witnessing the emergence of “skip generation” households whereby grandparents are forced to shoulder the burden of caring for orphans. As a consequence, 20% of households are currently headed by an elderly person aged 60 years and over, and a small number of child headed households are also beginning to emerge in the country. There are also indications of child abuse in many SADC countries, sexual abuse and exploitation that involve family members including incest are
rampant; there are other problems of sexual and reproductive health nature such as child marriage, inter-generational sex, multiple-concurrent sexual relationships, and unsafe abortion.

**Actions taken**
The “Strategic Framework and Programme of Action for Comprehensive Care and Support for OVCY affected by HIV and AIDS Conflict and Poverty”, is one of several efforts by the SADC Secretariat to implement the 15-year Regional Indicative Strategic Development Plan (2004). The 15-Year Plan has listed the main forms of vulnerability affecting children and the family in general in SADC as: poverty; HIV and AIDS; natural disasters; conflict; access to education; cross-border migration; lack of Birth Registration. Many country reports include violence against children, child labour and the rising number of orphans and street children, as additional forms of vulnerability affecting children.

All the available ICPD+20 Country reports show that serious efforts have been made by member States to address issues affecting the family, particularly children and the youth through the formulation of national and sectoral policies, National Visions, National Development Plans, legal instruments and programmes, as well as accession to Treaties, Conventions and related international obligations. In particular all national Population and Youth policy documents have provisions for the family, children and youth, in terms of Government strategies and programme targets.

Taken together, these policies, programmes, strategies and international instruments seek to ensure health, education and welfare services of the family, children and youth; prevent all forms of abuse and neglect; provide assistance to children in need and victims of abuse, neglect or abandonment, including orphans; assist families caring for family members with disabilities, and family members living with HIV; support and assist vulnerable families (very poor, victims of humanitarian crisis, drought, etc.) and provide education and skills for the full integration of the family in community and society at large.

**3. Achievements**

Much has been achieved in SADC countries to reduce poverty and increase the access of families to social services and protection, particularly water, health, education, housing, and roads in rural and urban areas.

Botswana has a number of welfare services that offer social protection programs for families and individuals and are accessible to individuals and families who qualify. These services offer food baskets for the needy; home and community based care for the chronically ill; orphan care programme; labour intensive public works; drought relief; and the Orphans and Vulnerable Children program. In Namibia, with Government support, children get evaluated by Medical Officers and families are registered to receive grant of N$200 per month per child, as well as support to disadvantaged families and children victims of abuse and neglect. Apart from basic support to the family of the sort enumerated above, Mauritius provides alternative care, the Foster Care System, and the School Child Protection Club.

Tanzania has also made fairly good progress in implementing the ICPD issues on family and wellbeing of individuals and societies; about 50% of the ten ICPD issues on family and
wellbeing have been accomplished. In Malawi, support to families include a social cash transfers scheme; Public works and farm input subsidy programme; food support to people living with HIV; a Micro Finance Programme, to assist widows, widowers, the elderly, young people and disabled in starting small businesses; support to children victims of abuse and neglect, etc. South Africa’s development programmes are shifting emphasis from individual based targeting to family targeting, and Government considers this paradigm shift as critical to bolstering programmes as individuals are also members of families, and families have their own dynamics and challenges. Family-oriented interventions have been used to promote and strengthen families and individuals within.

As illustrated by Swaziland, some cultural practices have changed over time, but preservation of aspects of tradition and culture in the country or community could also be good for the family. While some of the cultural practices have had a negative effect on gender issues, others have a positive effect, for example, the re-introduction of the Umchwasho traditional chastity rite in 2001, which forbids unmarried girls from falling pregnant, has the effect of reducing HIV infection amongst teenagers.

4. Challenges and future plans

One of the major social and human development challenges facing the SADC region at family level is the increasing vulnerability among children and youth. This is largely due to, among others, growing poverty, the food crisis, the burden of diseases such as the HIV epidemic, Tuberculosis and Malaria.

Most SADC countries have national policies and National Plans of Action (NPAs) that respond to issues related to the family including orphans and vulnerable children10. However, in many cases programme implementation has been hampered by human and institutional capacity shortages, leading to poor access to social services and productive resources by those who need them most, especially rural dwellers and the urban poor.

In South Africa, for example, the major challenges facing the family have social and economic dimensions: they include HIV and AIDS which is directly related to the death of the breadwinners, leading to a dramatic role reversal within families in which children now take on adult responsibilities; children are rearing other children without the developmental and emotional experience to do so.

Some of the challenges faced by programmes and strategies addressing the needs of the family and welfare of individuals in Botswana include lack of qualified staff to address critical areas of family concern, such as poverty and unemployment; HIV/AIDS, the chronically ill and burden of care; declining marriage rates and fertility; protection to single parent families; limited capacity to monitor the impact of policies on the wellbeing of families.

In Namibia, the government is faced with a challenge of the increasing number of street children, mostly orphans and vulnerable, as poverty and unemployment threaten the wellbeing of families and individuals. Service delivery seems to be hampered by staff shortage and this constitutes a

---

negative force in reducing extreme poverty; improving health and nutrition for children; improving access to quality HIV prevention, treatment, care and support, etc.

In terms of future plans, it is clear that institutional and capacity strengthening is critical to the effective implementation of the numerous policies and programmes developed to support the family in SADC countries.
6. MATERNAL HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

1. Status and trends

Maternal Health Services

The health service delivery system in SADC is characterized by public and private partnership, consisting of both formal and informal sectors. In Swaziland for example, the health system is organized in a multi-tier system comprising: i) national referral hospital; ii) regional hospitals; iii) primary health care facilities (clinics and health centres) and outreach sites and; iv) community-based care where care and support is provided by rural health motivators, NGOs, traditional birth attendants and other volunteers. The formal health sector comprises both public and private health service providers including non-Governmental Organizations (NGOs), Faith Based Organizations (FBOs), industry and private practitioners. Of the total health facilities in the country 45% belong to the public sector, 20% are owned by private practitioners, 12% are by industries, 15% by FBOs, 5% by NGOs, and 3% by private nurses.

Botswana has an extensive network of health facilities (hospital, clinics, health posts, mobile stops) spread over the twenty eight (28) health districts. Figure 22 shows the percentage of population residing within 5 km; 5-8 km and 8-15 km of a modern health facility, respectively. Development Partners have been very active in the health sector in Tanzania, particularly in the areas of general and programme support including technical issues. The Partners include a range of international NGOs like Plan International, World Vision, Save the Children, Pact Tanzania, Care International, etc. Their support has been well harmonized with the government plans in the sector at every level.

In Zimbabwe, ANC coverage is generally high even though it has declined from 94% in 1999 to 90% in 2010-11. ANC coverage for adolescents has remained lower than the general one, standing at 86% in 2010-11. The decline in ANC coverage can be attributable to the economic decline of the nation over the years and shortage of skilled public health care workers due to staff attrition over this period. PNC coverage has declined from 30% in 2005-06 to 27% in 2010-11. The percentage of institutional births rose from 69% in 1994 to 72% in 1999 before declining to 68% in 2005-06 and 65% in 2010-11. This decline is attributable to the restrictive user fees that the majority of women could not afford and religious inhibitors. Skilled attendance at birth rose from 69% in 1994 to 73% in 1999 before declining to 66% in 2010-11. In terms of service delivery, 6% of the 252 health facilities which are expected to provide the 7 signal functions satisfied the criteria for basic emergency obstetric and neonatal care (BEmONC) while 7.4% of the 147 hospitals assessed met the standards for comprehensive emergency Obstetric and Neonatal Care (CEmONC). Capacity to provide blood transfusions and caesarean sections(C/S) was found at 29% of the hospitals.

In Swaziland, the health system has been faced by an acute shortage of health staff and high turnover, worsened by migration of skilled health workers to developed countries and the further imbalance of staff levels in favour of the private sector and urban areas within the country. The
negative effect of deficit in the human capacity within the health sector has been compounded by the ever increasing health service demands due to the HIV and Tuberculosis (TB) disease burden.

In Mozambique, since 2004, with a view to improving Maternal and Child Health, special attention continued to be given to increasing the access to and availability of essential services for women and children, with priority to the rural areas, as well as to the development of training actions for Maternal and Child Health care professionals and the distribution of different equipment for childbirth and antenatal care. Thus, 48 graduates received Bachelor’s Degrees in Surgery from the Higher Institute of Health Sciences (ISCISA), with an additional 1,715 graduates in other areas of health.

Most of the SADC countries show a glaring disparity between urban and rural health services and distribution of resources and facilities. For example, in Swaziland, the standards of care in rural and urban health facilities differ, as peripheral health facilities only offer primary care and in cases of complications the patient is referred to the next level; the referral system is still poor, and with any supporting service. Botswana has an extensive network of health facilities (hospital, clinics, health posts, mobile stops) spread over the twenty eight (28) health districts; but overall 84 per cent of the population is within 5 km radius of a modern health facility, but in the rural areas 72%, while virtually all urban residents (96 %,) were within 5 km of a modern health facility.

**Maternal mortality**

The maternal mortality ratio in SADC has been declining but remains high in quite a number of countries (see Figure 6.1). Malawi has one of the highest maternal mortality ratios (MMR) globally, estimated at 984 deaths per 100,000 live births in 2004; 1,120 deaths per 100,000 live births in 2000 and 675 deaths per 100,000 live births in 2010. Adolescent pregnancies contribute about 20% of maternal deaths. Swaziland is one example of countries in SADC with worsening trend in maternal mortality: the Maternal Mortality Ratio (MMR) in the country has increased from 229 per 100,000 live births in 1991 to 589 per 100,000 live births in 2007, in spite of the fact that 79% of women aged 15-49 years made at least four visits to ante-natal clinics during pregnancy. Most maternal deaths are attributed to a three factors: delay in decision making; delay in transport to nearest health facility and; delay in service delivery at health facility level.

Even in South Africa with relatively low MMR, the latest estimate (2008-2010) revealed an increased institutional MMR of 176 maternal deaths per 100 000 live births, compared to 153/100,000 during the previous period (2005-2007). The top three causes of maternal death (non-pregnancy-related infections, obstetric haemorrhage and hypertension) accounted for almost 70% of all maternal deaths in the country. Similarly, MMR has been increasing in recent years in Botswana, and Lesotho, while the high levels have been sustained in Angola, DRC and Madagascar, while Seychelles and Mauritius have consistently maintained low levels of MMR since about 2000.

In Tanzania, maternal mortality ratio estimated at 454 deaths per 100,000 live births (2010) is lower than the previous figure of 578 deaths per 100,000 live births (2004); but it is insufficient progress to meet the MDG 5 targets. Today half of Tanzanian’s births occur in health facilities
and home births are more common in rural areas (56%) than urban areas (17%). With one third of health staff posts being occupied, only 5% of births are assisted by skilled birth attendants and one in five women who require emergency obstetric care actually receive it. Approximately, 35% of Tanzanian women received a postnatal check-up in 2010. In Zimbabwe, Maternal Mortality Ratio has increased over the years from 283/100,000 live births in 1994 to 555/100,000 in 2005-06 and 960 per 100,000 in 2010-11. Infant mortality rate was on a gradual decline from 53/1000 live births in 1994 to 24/100 in 2005-06 before rising to 57/1000 in 2010-11. The rise in maternal and infant mortality can be attributable to the economic challenges faced between 2000 and 2008, and the attendant decline in public health service delivery system.

Reproductive Rights and Reproductive Health

The conventional indicators of reproductive rights and reproductive health in a population include the level and trends of fertility and the determinants (age at marriage, contraceptive prevalence, unmet need for family planning), and mortality (particularly, infant and child mortality) and their determinants.

Fertility

Regarding fertility, country reports and supporting data show clearly that since 1994, the trend has been downward, except that the tempo of decline seems to vary significantly between countries (see Figure 6.2). There are at least 8 countries in the SADC region that reported significant declines in fertility levels, and/or have begun to experience ‘fertility transition’ since about 2010 or long before; namely, Mauritius, Seychelles, South Africa, Botswana, Namibia, Lesotho, Swaziland and Zimbabwe. Indicated by the Total Fertility Rate, these countries vary in tempo of fertility decline and the levels attained, distinguished between Mauritius, Seychelles and South Africa with TFR between 1.6 and 2.6; and the remaining 5 countries at the inception of fertility transition having TFR between 2.9 and 3.4. Among the countries in the transition mode, it is noteworthy that Mauritius had already achieved a low level of fertility even before the ICPD PoA in 1994.
Outside the 8 SADC ‘fertility transition’ countries, the remaining 7 countries have TFRs in the range of between 4.8 (Madagascar) and 6.1 (DRC) by 2010. The TFR in Mozambique was estimated at 5.5 in 2007 and official projection predicts a gradual decline that will move it to 4.8 by 2020. The high fertility rate stems mainly from low schooling levels of a large part of the population, particularly in the rural areas, early marriage and pregnancy and poor knowledge and limited use of the modern contraceptive methods.

CPR in Zimbabwe has increased steadily from 48% in 1994 to 60% in 2006 and currently stands at 59%. Knowledge of modern methods of family planning is near universal, having remained above 98% for both men and women since 1994. This can be attributed to the strong information, education and communication (IEC) services and high literacy rates in the country.

Given the slow rate of fertility decline experienced by these pre-transition countries, the prognosis for future fertility change can hardly be encouraging, unless concerted efforts are made to implement the necessary programmes in support of fertility decline, including education, family planning that involves widespread and effective use of modern methods, and elimination of gender discriminatory practices that affect marriage and family formation.

**Fig. 6.2: SADC countries: Trends in the Total fertility Rates, 1980-2010**

![Graph showing trends in total fertility rates for SADC countries between 1980 and 2010.]

*Source: SADC: Statistics Yearbook 2012, based on Table 1.1.10*

**Mortality**

Available evidence shows three categories of countries with similar mortality patterns. In terms of mortality transition (see Table 6.1), both Mauritius and Seychelles have advanced to low levels of mortality by 2010: Infant Mortality Rate in Mauritius declined from 19.8 to 12.0 per 1,000 live births between 1990 and 2010, while in Seychelles, IMR declined from 13.8 to 11.0 per 1,000 live births during the same period. Except for the past pattern of fluctuations, the recent trends seem to suggest that Namibia and Botswana might soon join the group already in the throes of mortality transition. The second group of countries are defined by very high but
declining infant mortality rates, comprising Angola, Malawi, Mozambique, Tanzania and Zambia, (see Table 6.1); this group is exemplified by Angola with IMR registered at 144.7 per 1,000 live births during 1990-1995 and currently standing at 117.5 (2005-2010). The final category is characterized by fluctuating trends in IMR; at fairly low levels of mortality, IMR has been fluctuating in South Africa, Zimbabwe, and Swaziland; while DRC has experienced fluctuations at a very high level, as opposed to Lesotho defined by an upward but fluctuating trend of IMR. The available census data shows that childhood mortality levels have begun to increase from 2007 after consistently declining during the previous decades. For example in Swaziland, IMR declined from 156 per 1,000 live births in 1976 to 99 in 1986, and to 78 in 1997 but had risen to 107 by 2007; similarly, Under-Five mortality rate declined from 218 in 1976 to 140 in 1986 and to 106 in 1997 but increased to 167 in 2007. The trends in Under-Five mortality rates are shown in Table 6.2.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>144.7</td>
<td>142.1</td>
<td>132.9</td>
<td>117.5</td>
</tr>
<tr>
<td>Botswana</td>
<td>51.6</td>
<td>61.6</td>
<td>60.9</td>
<td>36.2</td>
</tr>
<tr>
<td>DR Congo</td>
<td>113.3</td>
<td>127.7</td>
<td>112.0</td>
<td>116.8</td>
</tr>
<tr>
<td>Lesotho</td>
<td>66.6</td>
<td>74.0</td>
<td>91.0</td>
<td>91.0</td>
</tr>
<tr>
<td>Madagascar</td>
<td>95.6</td>
<td>84.5</td>
<td>74.7</td>
<td>65.2</td>
</tr>
<tr>
<td>Malawi</td>
<td>127.5</td>
<td>111.2</td>
<td>96.5</td>
<td>83.7</td>
</tr>
<tr>
<td>Mauritius</td>
<td>19.8</td>
<td>17.9</td>
<td>15.2</td>
<td>13.8</td>
</tr>
<tr>
<td>Mozambique</td>
<td>134.8</td>
<td>114.6</td>
<td>102.9</td>
<td>88.0*</td>
</tr>
<tr>
<td>Namibia</td>
<td>57.1</td>
<td>53.8</td>
<td>49.4</td>
<td>35.0</td>
</tr>
<tr>
<td>Seychelles</td>
<td>12.8</td>
<td>10.8</td>
<td>11.9</td>
<td>11.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>50.4</td>
<td>56.8</td>
<td>59.1</td>
<td>49.1</td>
</tr>
<tr>
<td>Swaziland</td>
<td>67.2</td>
<td>77.0</td>
<td>82.3</td>
<td>65.7</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>100.2</td>
<td>89.7</td>
<td>74.0</td>
<td>64.8</td>
</tr>
<tr>
<td>Zambia</td>
<td>123.0</td>
<td>107.4</td>
<td>110.0</td>
<td>94.6</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>52.9</td>
<td>63.8</td>
<td>68.9</td>
<td>57.7</td>
</tr>
</tbody>
</table>

Source: SADC Statistics Yearbook 2012, (Based on Table 2.2.1)
* Official figure for 2011 (DHS)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>252.7</td>
<td>245.8</td>
<td>231.3</td>
<td>205.0</td>
</tr>
<tr>
<td>Botswana</td>
<td>70.9</td>
<td>89.1</td>
<td>94.2</td>
<td>53.8</td>
</tr>
<tr>
<td>DR Congo</td>
<td>198.3</td>
<td>214.4</td>
<td>197.7</td>
<td>197.8</td>
</tr>
<tr>
<td>Lesotho</td>
<td>98.5</td>
<td>107.2</td>
<td>113.0</td>
<td>117.0</td>
</tr>
<tr>
<td>Madagascar</td>
<td>154.6</td>
<td>134.4</td>
<td>116.9</td>
<td>100.2</td>
</tr>
<tr>
<td>Malawi</td>
<td>207.8</td>
<td>175.5</td>
<td>145.3</td>
<td>120.9</td>
</tr>
<tr>
<td>Mauritius</td>
<td>21.9</td>
<td>21.8</td>
<td>16.8</td>
<td>16.2</td>
</tr>
<tr>
<td>Mozambique</td>
<td>233.0</td>
<td>200.8</td>
<td>176.9</td>
<td>122.0**</td>
</tr>
<tr>
<td>Namibia</td>
<td>79.5</td>
<td>75.9</td>
<td>72.7</td>
<td>51.6</td>
</tr>
<tr>
<td>Seychelles</td>
<td>2.2</td>
<td>2.2</td>
<td>2.1</td>
<td>1.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>67.6</td>
<td>77.4</td>
<td>86.0</td>
<td>71.7</td>
</tr>
<tr>
<td>Swaziland</td>
<td>95.5</td>
<td>111.6</td>
<td>126.5</td>
<td>101.7</td>
</tr>
<tr>
<td>UR Tanzania</td>
<td>167.1</td>
<td>150.9</td>
<td>124.8</td>
<td>105.8</td>
</tr>
<tr>
<td>Zambia</td>
<td>151.0</td>
<td>183.1</td>
<td>162.0</td>
<td>160.3</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>83.9</td>
<td>102.6</td>
<td>111.8</td>
<td>94.2</td>
</tr>
</tbody>
</table>

Source: SADC Statistics Yearbook 2012, based on Table 2.2.2
** Official figure for 2011 (DHS)

2. Actions taken
At the 2nd Ordinary Session of the Conference of African Ministers of Health, meeting in Gaborone, Botswana, in October 2005, the Continental Policy Framework on Sexual and Reproductive Health and Rights was adopted and subsequently endorsed by AU Heads of State in January 2006. Again, at its special session (18-22 September 2006), the African Union Conference of Ministers of Health in Maputo, Mozambique, adopted the Maputo Plan of Action
for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights. The Maputo Plan of Action seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. About half a decade after the ICPD PoA was unanimously adopted, the Millennium Declaration was adopted by all the member states of the United Nations in September 2000, with MDG4 and MDG 5 targeting improved child mortality and maternal health within the context of Human Rights. A Sexual and Reproductive Health Strategy for the SADC Region (2006-2015) was developed in recognition of the importance of the subject and its role in the development of its countries and the region. The Strategy provides a framework for developing reproductive health policies or for harmonization for countries that do not yet have such policies. It also guides interventions by the SADC member States, and development partners in the region.

At country level, the pattern of policy, legislative and programmatic response to addressing the challenges of Maternal Health Reproductive Rights and reproductive Health across the region is broadly similar. SADC countries have addressed reproductive rights and reproductive health issues through policy and legislative measures, institutional reform and special programs, including: National Development Plan; National Policy on Sexual, Reproductive Health, Child Health and Nutrition; Guidelines on Essential and Emergency Obstetric Care; Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality; Guidelines for completing the Maternal and Perinatal deaths Review; National Standards for Adolescent Friendly Health Services; National Policy on Sexual and Reproductive Health; National HIV/AIDS policy; National Guidelines for HIV Counselling and Testing; PMTCT in RH Programme, etc.

For example in Zimbabwe, the National Reproductive Health (RH) programme is currently being implemented within the framework of the Maputo Plan of Action on Sexual and Reproductive Health and Rights and the African Union Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), as well as the National Maternal and New-born Health Road Map 2007 – 2015 and the National Adolescent Sexual and Reproductive Health Strategy: 2010 – 2015. These policies are also coined to support the national development priorities through focusing on the fourth and fifth Millennium Development Goals (MDG 4 and 5) which are aimed at reducing child mortality and improving maternal health, respectively.

In addition, the existing health institutions have been strengthened in many ways and additional supporting structures, the form of Committees at national and sub-national levels, have been created to promote decentralization and provision of services at regional/provincial level.

3. Achievements
Overall the maternal health, reproductive rights and reproductive health of the population in SADC has improved considerable since the adoption of the ICPD PoA (1994). The health service delivery system in SADC is characterized by public and private partnership, consisting of both formal and informal sectors. The levels and trends already described above indicate some of the demographic outcomes of the combined efforts of Government and private sector in the health and related sectors.
With regard to RH indicators in general, all countries reported having made some progress in achieving national and/or global targets as a result of their respective RH programmes. In terms of programme efforts, most countries indicate having made good progress with regard to putting in place concrete measures of implementation of the ICPD issues on health and sexual and reproductive health, except in respect of access to safe abortion services where South Africa has made notable progress.

Most countries have made progress in the integration of SRH and HIV services, as evident from the reported increase in the Antenatal Care (ANC) coverage; access to Emergency Obstetric care (EMOC); provision of PMTCT services; and ARV prophylaxis. In addition, countries report increased level of knowledge on safe sexual practices especially among young people, and high levels of knowledge and use of modern contraception amongst sexually active women. There also has been expansion of services at maternity waiting homes especially in deep rural areas, and a high proportion of deliveries at health care facilities and births attended by a skilled health professional. Antenatal care coverage and immunization coverage for less than one year of age at public health institutions has increased.

4. Challenges

The available reports show that the gap between policy/strategy formulation and implementation remains the major challenge to demographic transition (the transition from high to generally low levels of fertility and mortality) in the Community. This gap has been attributed by many countries to a number of interrelated factors: weak human capacity and institutional structures; the persistence of gender discrimination; poor funding of population/SRH programmes; over-concentration of health related facilities and services in urban areas; lack of monitoring and evaluation mechanisms; unsustainable input programming strategies that tend to rely largely on external funding.

A few countries have to deal with emerging health and RH issues for which advance preparations have not been made. In Botswana these include the need to recognize and address the health and other needs of sexual minorities; making condoms available to inmates; provision of condoms for prisoners and ARVs to foreigners who are incarcerated in Botswana’s jails. Mauritius considers the relatively high rates of unplanned and unwanted pregnancies and a relatively high rate of adolescent fertility emerging reproductive health issues as a result of socio-economic changes in recent years in the country. In a number of countries (Swaziland, Lesotho, Malawi, Zimbabwe) the health system has been faced by an acute shortage of health staff and high turnover, worsened by migration of skilled health workers to developed countries. Most of the SADC countries show a glaring disparity between urban and rural health services and distribution of resources and facilities.

Future Plans

In order to effectively implement the RH aspects of the ICPD-PoA, member Sates plan to strengthen the capacity of the health system in general and mobilize resources to: promote access to and utilization of quality RH services, including family planning services; improve method mix; target vulnerable groups, youth and hard to reach rural communities and; reduce the unmet need for family planning.
Member States also plan to further reduce maternal morbidity and mortality; child morbidity and mortality; promote HIV/AIDS prevention; strengthen PMTCT programmes and increase access to ARV treatment; monitor and treat TB; reduce gender based violence and; make further improvements in reducing other non-communicable diseases.

7. HIV/AIDS, MALARIA, TB AND OTHER COMMUNICABLE DISEASES

1. Status and trends
HIV/AIDS was identified in most SADC countries in the mid-80s, but there has been a rapid increase in the numbers of adults and children infected with, and dying from HIV and AIDS, with a corresponding adverse impact on the socio-economic development of the region. By 1999, the Community was already faced with a very severe HIV/AIDS epidemic, the extent of which has affected virtually every aspect of the lives of the people in the SADC.

The HIV prevalence reported in SADC national population surveys ranged from 2.7% to 16.2%, and it is clear in many parts of the region where more than one person in every ten aged 15-24 is infected with HIV. As illustrated in Figure 7.1, HIV infections among women outweigh male infections in this youth age cohort, making prevention among girls and young women of particular and urgent concern. Information is still limited for identifying trends in the number of new infections in member States.

The available reports show that the health sector in every member States has over the last two decades provided much of the leadership in the HIV/AIDS response and has advocated a strategy that addresses the HIV/AIDS epidemic through the efforts of health care system, communities, youth, the private and public sector and other stakeholders in society. The adult prevalence trend data suggest modest declines in HIV prevalence for most SADC countries over the last decade. Before then, as illustrated in Figure 7.2, adult prevalence of HIV increased dramatically in most SADC countries until about 1998; between 1998 and 2004 most countries with high prevalence experienced relative stability in trend, and from 2005 a downward trend in HIV in almost all countries seems discernible.
According to the available data, a total of 9,936,370 persons have died of AIDS in SADC between 1990 and 2009. Figures of AIDS deaths are not available by age and sex for SADC, but the trend (illustrated in Figure 7.3), shows a vigorous rise from 77,903 deaths in 1990 to over half a million in 1999, reaching a peak of 783,636 deaths in 2005. Since then the number recorded AIDS deaths has declined gradually to 658,030 in year 2009, the latest year for which data are available (SADC Statistics Yearbook, 2012).

Apart from its direct impact on mortality, AIDS has also negatively affected human longevity across the Community. AIDS related mortality has dramatically reduced life expectancy, notably in Botswana, Lesotho, Swaziland, South Africa, Zambia and Zimbabwe. The average life expectancy for both sexes remain low (less than 50 years) in Angola, DRC and Mozambique; while, in Madagascar, Mauritius and Seychelles, life expectancy has been increasing.

Orphans and vulnerable children
Throughout the Community, the effect of AIDS deaths has been an increasing population of orphans. Regional estimates based on the SADC Epidemic Report’s analysis of country data show that up to a third of children below 18 years in member States have lost one or both of their parents. It has been estimated that about 38% of the total number of orphans in SADC, or 6,390,000 children, has lost parents to HIV and AIDS; and, close to 8% of people living with HIV in the SADC region are under the age of 15.\(^\text{11}\)

**Malaria**

Malaria is not endemic in all SADC countries and, even within particular member States, there are regional differences in prevalence. Malaria is one of the leading causes of morbidity and mortality in Malawi, especially in children under the age of five years and pregnant women. It is also the leading cause of outpatient visits, hospitalization and death. About six million cases are reported every year which represent about 40 percent of the burden of illness in Malawi’s health facilities. Malaria is endemic throughout the year and transmission peaks during rainy season which presents ideal climatic and environmental conditions for the vectors to thrive. During the financial year 2011-2012, there were over 2 million under-five malaria cases in Malawi. Malaria is also an important public health problem in Mozambique, although there has been a reduction in the malaria morbidity and mortality rate in recent years. Malaria contributed to approximately 27% of hospital deaths in 2009.

The burden of malaria has been declining in South Africa; only 4% of the population is at high risk of malaria and 6% at low risk, while 90% live in malaria-free areas. The confirmed malaria cases have decreased from an annual average of 36 360 during 2000–2005 to 6072 cases in 2009 (83% reduction) and reported malaria deaths fell from 127 to 45 (65% decline) in the same period. It is estimated that 32% of the population in Swaziland is at risk of malaria, affecting about 10,000 people annually. The prevalence of clinical trend in malaria deaths in Zimbabwe has declined from 1,200 in 2006 to 451 in 2011; the decline in malaria mortality has been largely attributed to the increased spraying coverage (90% in 2009) and ownership of insecticide treated bed nets (29% in 2010-2011).

**Tuberculosis (TB) and Other Communicable Diseases**

Based on the available evidence, it has been shown that the TB epidemic in the SADC region is driven by the high prevalence of HIV in most Member States (see Figure 7.4). People infected with HIV have a ten times increased risk of developing TB compared to those not infected with HIV. About two thirds of TB patients have a dual TB/HIV infection; the prevalence of TB/HIV co-infection ranges from 3% in some of the low HIV prevalence Member States to about 80% to some of the high prevalence Member States. In addition there is increasing concern about emergence of large numbers of Multi and Extreme Drug Resistant TB cases.\(^\text{12}\)

South Africa has identified TB as the leading cause of death in the country, and has since declared TB as a national crisis; TB accounted for 12.8% of all deaths in 2007, 12.6% in 2008, and 12.0% in 2009. In Lesotho, TB is one of the ten leading causes of morbidity and mortality and a major public health problem; the country has the fourth highest TB infection rate in the


\(^\text{12}\) SADC HIV and AIDS Strategic Framework 2010-2015 (October 2009).
world (637 out of 100,000 people per year), commensurate with the rising rate of HIV infection. There is also the problem of MDR TB and XDR TB. The prevalence of Tuberculosis (TB) in Swaziland has increased from 629 per 100,000 populations in 1990 to 936 per 100,000 populations in 2008 but decreased to 914 per 100,000 in 2009. TB remains among the leading causes of deaths in the country especially among patients that are co-infected with HIV.

Note: Data not available for Mauritius in 2005 and 2010. Source: SADC Statistics Yearbook 2012 (Based on Table 2.2.9)

The TB prevalence rate has declined in Mozambique from 636 cases per 100,000 inhabitants in 2006 to 490 cases per 100,000 cases in 2011. There has also been a reduction in mortality, from 129 deaths per 100,000 inhabitants in 2006 to 47 deaths per 100,000 inhabitants in 2011. While the treatment rate is very close to the established target, detection of cases is still a problem. In Zimbabwe, the notification rate of tuberculosis (new and relapse) continued to rise from 402 per 100,000 in 2000, to 411 per 100,000 people in 2003.

Other communicable diseases
Diarrhoeal and cholera are the most common communicable diseases in the region. In South Africa diarrhoeal diseases account for 3.1% of total deaths – the eighth largest cause of death nationally. Diarrhoeal diseases are the third largest cause of death (11.0% of all deaths) among children under 5 years of age. Diarrhoea as underlying natural cause of death for all ages has increased from 1998 as the 10th leading cause to become the 3rd leading underlying natural cause of death for two consecutive years (2004 -2005). In Zimbabwe, cases of diarrhoea outbreaks have generally been on the increase and now affect both rural and urban areas. The worst cholera outbreaks were recorded in 2008/2009 where 100,000 cases were reported and more than 4,000 deaths occurred giving a case fatality rate of 4% which is higher than the WHO target rate of 1%. Even though there has been a decline in the number of cholera cases since then, to 1,140 in 2011, for example, the case fatality rate has remained stagnant at 4%. In
addition, there have been 1,073 cases of typhoid reported in 2011. Possible reasons for the increase in incidences of diarrhoeal diseases include poor hygienic practices exacerbated by erratic clean water supplies, poor sanitation and contaminated food from unregulated vendors.

2. Actions taken

In response to the rapid increase in HIV/AIDS, the SADC HIV/AIDS Task Force was set up in December 1999 to guide the work of the seven sectors participating in the development and implementation of a multi-sectoral SADC HIV/AIDS Framework for the period 2000 - 2004. Building on the modest achievements under the 2003-2007, a successor plan was developed – the SADC HIV and AIDS framework 2010 – 2015; it establishes strategic objectives and actions of operation for the period and provides guidance to the response to HIV and AIDS in the Community, in the light of the commitment to achieve the MDG 6 and its targets.

Most member States of SADC declared HIV/AIDS as a national emergency and in response formulated relevant policies, established appropriate institutional structures and put together a long-term, phased response to the epidemic, in the form of a number of national strategic plans.

Achievements
Significant achievements have been made in all SADC countries in addressing the challenge of HIV/AIDS, as well as TB, Malaria and other communicable diseases. Most of these achievements are implied in the analysis of status and trends above in which the downward trend in HIV prevalence, AIDS deaths, TB prevalence and malaria incidence have been illustrated in many SADC countries. Besides those indicators, member States have also made significant strides in implementing specific programmes.

For example, Botswana has made significant achievements in HIV/AIDS prevention, treatment and care. Apart from being the first African country to offer free HIV prevention, treatment and care services, Botswana is also one of the first countries that have implemented a comprehensive strategy to respond to the HIV/AIDS epidemic. South Africa has increased male condom distribution and introduced female condom; the number of male condoms distributed by the government rose from 8 million in 1994 to an estimated 376 million in 2006; additional female condom distribution introduced in 1996 led to the distribution of 3.6 million female condoms in 2006. South Africa has also expanded TB control efforts through the Directly Observed Treatment Short course (DOTS) programme adopted as the standard of care for TB in 1995. The government has also scaled-up of the free HIV and AIDS treatment programme since 2003, making South Africa the world’s largest HIV and AIDS treatment programme. Zimbabwe has been experiencing a decline in HIV prevalence since the late 1990s when it peaked at 27.2% before coming down to 14.3% in 2009. The incidence (new cases) of HIV declined from 5.6% in 1993 to 0.4% in 2007. These declines may be attributed to a number of behavioural change interventions, among them sexual partner reduction and increased condom use as well as high mortality due to AIDS-related illnesses.

Challenges and future plans
The reported challenges include: the high HIV prevalence and incidence rate in many countries, and female’s heightened susceptibility to infection; the strong association between HIV/ AIDS

42
and TB; the challenge of encouraging men to accompany their partners when attending antenatal care. There institutional and capacity related challenges as well: the challenge of implementing the various policies and programmes on HIV/AIDS, due to the inadequacy of human, financial and infrastructural resources; weaknesses in communication and dissemination of new policies; lack of multi-sectoral participation in the HIV-prevention response; and lack of monitoring and evaluation and research capacities; limited engagement of males in HIV prevention, especially in Mother-to-child transmission (PMTC) at both policy and programme levels. Regarding malaria, there is the risk of imported malaria by travellers and migrant workers from malaria endemic countries in non-endemic countries and sub-regions.
8. POPULATION DISTRIBUTION, URBANIZATION AND INTERNAL MIGRATION

1. Status and trends
The overall trend in SADC has been towards increasing urbanization of the population in most countries (see Figure 8.1). Two countries seem to be de-urbanizing: the percentage of urban population in Mauritius decreased from about 44.0% in 2000 to 42.8% in 2011; while, in Swaziland the proportion of urban population declined from 23.1% in 1997 to 22.1% in 2007. Elsewhere in the Community, the rate of population growth in urban areas is much higher than the national total. Without discounting the relative contribution by natural increase, urban population growth has largely been spurred largely by net in-migration.

In a few countries, the rapid rate of urbanization has been due to a combination of natural increase, net in-migration and annexation of rural neighbouring settlements. For example, Botswana has experienced rapid urbanization, with urban population increasing from 4% at independence up to 18 per cent in 1981, 46 per cent in 1991 and 52 per cent in 2001; part of this increase in the proportion of urban population is attributable to ‘area reclassification’, where some large hitherto rural villages obtained ‘urban village’ status.

Malawi is the least urbanized country in SADC (less than 20% in 2009), but urbanization, fuelled by rural-urban migration, has been identified as the major factor contributing to land and housing shortages, congestion, crime, HIV and AIDS infection and unemployment in the country. On the other hand, the major contributor to rapid urbanization in Malawi has been rural-urban migration. DRC is only moderately urbanized with 30.4% of the population in urban areas in 2005; the country is reported to be underpopulated with a density of 24 inhabitants in km2 only; in the city-province of Kinshasa, on the other hand, geographic density reaches a high of
577 inhabitants / km², notably because of the concentration of economic and social facilities and opportunities.

With 61% of the total population classified as urban, South Africa is currently the most urbanized country in SADC; the increasing trend towards urbanization has been mainly driven by rural-urban migration; but other forms of internal migration have been observed in the country - step migration and circular migration, as well as intra-metropolitan migration, all of which affect total urban population estimates.

The attraction to urban residence by an increasing number of rural dwellers is the result of several factors common to almost all societies in SADC and beyond: urban places have unusually large concentrations of economic opportunities for wage and self-employment, educational facilities, and other social and infrastructural services and facilities (health, potable water, modern housing, electricity, and the urban ‘bright light’), all of which constitute centripetal forces in the decision to migrate. This explains why urbanization as a process is irreversible.

**Actions taken, achievements and challenges**

Member States have addressed the issues of rural and urban migration and urbanization through their national Population Policies in general; few countries have explicit Urban Policy besides urban/municipal planning legal frameworks.

Worldwide, cities act as the engine room of the economy – making typically disproportionate contributions to the economy. However, it is paradoxical that these cities also represent some of the highest concentrations of poverty in the country, effectively representing the urbanization of poverty. In this regard, SADC countries may need to revisit the existing urban programmes, and appreciate the complexity of modern city management, which demands an integrated and carefully considered rural and planning strategy.

**Box : Internal migration and urbanization in Namibia**

Issues of internal migration and urbanization are addressed by the Ministry of Regional, Local Government, Housing and Rural (MRLGHRD), which is coordinating the implementation of several policies and programmes; these include the Decentralisation Policy and Decentralisation Enabling Act 33 of 2000 as well as the Local Authority Act 23 of 1992 and Regional Council Act 22 of 1992. In order to promote the growth of small or medium raised urban centres, a number centres in the country have been proclaimed as towns through the Local Authority Act 23 of 1992. Decentralisation programme aims to take government services closer to people and promote rural development in order to decrease push factors on urbanisation. Through the Local Authorities, the Build Together Housing Programme is being implemented to ensure land, housing, services and livelihood of urban poor. Similarly, the National Housing Enterprise constructs a number of affordable houses for low income citizens. The MRLGHRD works closely with local and regional authorities in addressing the challenges of urbanisation and internal migration. A number of towns have expanded the boundaries as proactive planning for urban population growth. *(Source: Namibia: Country Report on ICPD+20)*

The integration of city planning and rural development is one approach to addressing the challenge of rapid urbanization and poverty reduction. As shown by Namibia and Botswana, among others, most countries seem to be moving in this direction. In Botswana, government has pursued strategies that promote rural development, as a way to counter the rural-urban migration.
The obvious challenge faced by member States is how to manage the rapid rate of urban population growth, in terms of planning, infrastructure development (transport, water, electricity, waste disposal), provision of the range of social services to the burgeoning urban population, creating access to employment and economic opportunities; reducing poverty, particularly among urban youth, women and the elderly; making the urban environment liveable through containment of crimes and provision of recreational facilities. In short, the challenge is how to integrate human rights principles into urban policies and into municipal governance.
9. INTERNATIONAL MIGRATION AND DEVELOPMENT

1. Status and trends

International migration within SADC has been identified as a significant factor in the social, economic and political integration since the inception of the Community. SADC has a goal of fostering regional socio-economic cooperation and integration, as well as political and security cooperation; yet cross-border movements of the people remain a controversial subject. One of the objectives of the SADC education sector is “to work towards the relaxation and eventual elimination of immigration formalities in order to facilitate freer movement of students and staff within the Region for the specific purposes of study, teaching, research and any other pursuits relating to education and training”\textsuperscript{13}.

Concerns have been expressed about international migration in SADC for several reasons, but importantly because: i) the need to harmonize regional migration policies to ensure free movement of labour across the region; ii) given the high levels of regional economic disparity, many people in countries like South Africa and Botswana worry the free movement of people would inundate them with a flood of migrants from their less developed neighbours; iii) migration of highly skilled individuals within the SADC and overseas often results in shortages of national skilled workers, and is believed to have an adverse effect on overall long-term national economic growth, despite benefits from remittances; iv) emigration of skilled workers has negatively impacted on social services, particularly in the health sector in number of SADC countries. A recent assessment by the International Organization for Migration has observed that informed policy and decision making related to these issues is hampered by lack of quality migration data, making it difficult to assess labour migration in the SADC region\textsuperscript{14}.

In one way or another, every SADC country has been affected by inter-territorial movements of population. Figure 9.1 illustrates net international migration within the Community from 1990 to 2010, extracted from World Data, by the United Nations population Division (2012). The Table shows the patterns and trends in international migration rates\textsuperscript{15} in SADC countries in five-year periods from 1990 to 2010.

\textsuperscript{13} SADC Protocol on Education and Training (1997).
\textsuperscript{14} IOM, IOM, Data Assessment of Labour Migration Statistics in the SADC Region: South Africa, Zambia, Zimbabwe; Prepared for IOM by Dr. Jason P. Schachter June 2009

\textsuperscript{15} Defined as the number of immigrants minus the number of emigrants over a period, divided by the person-years lived by the population of the receiving country over that period. It is expressed as net number of migrants per 1,000 population.
South Africa, because of the high rate of economic growth and overall development, has been the major destination of most international migrants in SADC even before the transformation in 1994. In recent years, apart from regular flows, irregular or undocumented migrants have increased (numbering between 1 and 8 million persons), particularly as a result of internal strife in neighbouring countries, including Mozambicans fleeing civil war in the 1980s and more recently, economic collapse in Zimbabwe. Refugees and asylum seekers, mostly from Zimbabwe, have also increased, from 114 in 2000, to 4,550 in 2003. The international transfer of human capital from South Africa to the developed countries has also increased in recent years and seems to undermine the human capital development efforts in the country.

The effect of geographic location has been the most important factor in the choice of destination of migrants within the Community; South Africa remains the major destination of migrants from Lesotho, Zimbabwe, and Mozambique. In terms of country of residence outside Lesotho, only 0.03% of migrants from Lesotho outside the country were residing in other countries other than South Africa. In 2001, close to 43% of all non-Namibians were from Angola, 12% from South Africa and 9% from Zambia.

An overwhelming majority (89.2%) of the absentees from Swaziland were away in the neighbouring country of South Africa. The second most preferred destination for Swazi absentees in 2007 was also the neighbouring country of Mozambique, which accounted for 4.1% of all absentees. The remaining 6.7% of the absentees are scattered among countries in SADC, Europe, North America, other African countries and the rest of the world.

Sustained economic growth in Botswana since independence has, on the one hand, attracted streams of immigrants into the country; the numbers foreign nationals living in Botswana tripled between 1971 and 1991 from 10,861 to 29,557, and had increased by six-fold to 60,716 by 2001. On the other hand, the rapid economic growth and expanded investment in education and skills development has curbed the need for citizens to migrate to South Africa. In Mauritius, the...
balance of international migration has been outward since the early sixties but the trend has been declining and is expected to continue because of improving economic conditions within the country and more stringent controls in receiving countries.

**Actions taken**

As already noted above, the lack of critical data has hampered informed policy and decision making related to international migration among member States of SADC. Most SADC countries are a signatory to both the 1951 UN Convention relating to the Status of Refugees and the 1969 Organization for African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa. Nevertheless, countries continue to use deportation as means of dealing with irregular migrants. There are also national legislations in member States for dealing with international migration in general: the Immigration Act of 1966 in Botswana; and in Namibia, the Refugee Control and Recognition Act 2 of 1999; Departure from Namibia Regulation Act 4 of 1990; Immigration Control Act 7 of 1993 and Namibian Citizenship Act 14 of 1990. Lesotho has put in place the Anti-Trafficking in Persons Act of 2010; while Malawi Refugee policy and Act. In Mauritius, laws and regulations relating to immigration are governed by the Recruitment of Workers Act 1993, the Non-Citizen (Employment Restriction Act 1970) and the Immigration Act 1973 as amended.

South Africa has a range of Legal instruments, strategies and programmes for international migration and development: The Immigration Act (Act No. 13 of 2002); The Immigration Amendment Act (Act No. 19 of 2004; The White Paper on Population Policy for South Africa (1998); etc. Botswana experienced an increase in the incidences of forgery related to travel documents issued in Botswana, and in response to that problem new travel documents with improved security features to ensure compliance with the Regional and International standards were introduced. In addition, during NDP 10 the computerization of critical functions, such as visas, residence permits, passports and citizenship and the creation of databases for illegal immigrants, to improve service delivery and security of documentation.

2. **Achievements**

In SADC, remittances by migrants (including monetary and “in-kind”) are a major source of household income especially among the poorer segments of the population. According to the IOM (2009), at national level (see Figures 9.2 and 9.3), remittances flows within SADC, particularly from South Africa, are credited for keeping the economy afloat during their current economic turmoil. For illustration, according to World Bank estimates remittance flows out of South Africa exceeded one-billion US$, though much of this also went to Lesotho and Mozambique (World Bank 2008).
Sending money to Lesotho to finance individual household projects remains the main benefits of international migration to the country. The deferred payment scheme where a certain percentage of labour migrants’ salary is transferred to Lesotho and the owner can withdraw such money when in Lesotho has made it easier for Basotho men working in the mining industry to finance household projects in the country.

South Africa has revised some of the punitive measures against irregular migrants, particularly from Zimbabwe. Zimbabweans who had been employment in South Africa prior to 31st May 2010 could now apply for a work permit. Those who run small businesses, including those in the informal sector, were allowed to issue registration with the South African Revenue Service (SARS) or the Companies and Intellectual Property Registration Office (CIPRO) and they would be issued with a business permit for four years.
3. Challenges and future plans
For SADC as a whole, perhaps the major challenge is the development of a Protocol to address the issues of international migration, including standardization of data and measures, and the free movements of persons of SADC origin within the Community. Most countries are without coherent evidence-based Migration Policy, which makes difficult to realize and effectively harness the potential benefits of international migration on economic growth and social cohesion.

Several SADC countries (Malawi, Lesotho, Swaziland, Zimbabwe, etc.) have lost substantial numbers of their skilled personnel, particularly in the health sector to emigration. In South Africa, apart from the burden posed by the continuous streams of regular migrants, irregular migration and asylum seekers have increased by leaps and bounds. In addition, the country is faced with emigration of the skilled work force in large numbers, which has undermined the human capacity building efforts in the country. Influx of undocumented migrants, especially from Zimbabwe is not only a development planning challenge, but also imposes significant costs associated with their deportation, many of who re-enter the country again illegally after deportation, due to the long, porous and unsecured border between the two countries. Namibia has been contending with inadequate infrastructures for offices and staff accommodation at the borders as a means of controlling the influx of refugees and irregular migrants.
10. EDUCATION

1. Status and trends

All SADC member States are committed to achievement of the targets the education MDGs:
Goal 2: Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling; Goal 3: Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.

The prospects of achieving the MDGs on education are bright. The national drive towards universal enrolment and gender parity in Primary School has been successful in almost all SADC countries. By 2011 total primary school net enrolment has exceeded 90% in many countries (since 2000 in Mauritius, Seychelles, South Africa, Zimbabwe and Namibia) and; by 2006 almost all the remaining countries had achieved over 90% net enrollment ratio for both sexes at primary school level. A few countries are still catching up; in the DRC for example, the net enrolment in primary school increased slowly from 51.7 % in 2001 to 55.6 % in 2005, and form 61 % in 2007 to 75 % in 2010. By 2011, at least four countries (Mauritius, Seychelles, Malawi and Madagascar) have almost accomplished universal enrolment ratio (close to 99%) at primary school level.

In terms of gender parity, unlike the countries in Africa, the net enrolment ratio for females in primary school in SADC has been consistently higher than for their male counterparts in almost all SADC countries except Mozambique with 77.3% of females compared to 82.45 of boys enrolled in primary school in 2008. Malawi is also exceptional in another sense; female/male net enrolment ratio was 101:97 in 2011, a trend that has been on since 2006. Even in countries like Botswana where net enrolment ratios are generally high (90%), the implication is that close to 10 per cent of the country’s primary going age population are not attending school, and Government considers this gap particularly worrying. The general indication is that most SADC countries are likely to meet the two MDG targets on education by 2015.

Generally in SADC, dropout rate is higher among girls than boys as the level of education progresses: for example, in Malawi the Gender Parity Index (GPI) for standard 1 was 1.04 while for standard 8 was 0.88 in 2011. In South Africa, the completion rate up to Grade 7 (end of primary school) increased from approximately 88% to 93% between 1995 and 2007, and the completion rate up to Grade 9 (end of compulsory education) increased from 75% to 83%. However, only an average of about 20% continues immediately with Higher Education studies the year after finishing high school.

While the overall enrolment rates at primary level is high and improving in most countries, the same cannot be said about the transition from primary to secondary school. For illustration, in Malawi, the transition from primary to secondary school is generally more favourable to boys than girls; as the level in secondary school progresses, the proportion of boys increases: in Form 1, boys constitute 55% and this increases to 57% in Form 4. The declining participation of girls
has been attributed to pregnancy, and in order to correct this imbalance, most SADC countries now have a school re-admission policy which allows pregnant girls who dropped out of school to be re-admitted to school. The situation in Zimbabwe and Mozambique is different: smaller proportions transit from primary to secondary school, but the proportion of females is higher than that of males, and the rates have been declining.

Botswana has exhibited a progressive transition trend since 2004; the transition rates from junior to senior secondary education increased from 49% in 2004, to 61% and 66% in 2006 and 2008, respectively. The improvement in transition rates is a result of a combination of factors, among which are the expansion of the capacity of some senior secondary schools; construction and commissioning of new schools and the introduction of the ‘double shift’ program, in which there are two streams of students per school.

In Botswana and South Africa, more females than males are enrolled in higher institutions of learning, while in Mozambique, Namibia and Swaziland, the boot is on the other leg, females constitute 37.9%, 31.3% and 45.5%, respectively. In those countries with comparable data, females in higher institutions of learning tend to subscribe more to Education, Humanities/Arts, Health/Welfare and Social Science disciplines than to Agriculture, Science and Engineering fields. Within the Health Sciences in general, more women tend to concentrate in Nursing and Social Work fields than in the other areas of Medical Science. Botswana seems to be addressing this gender imbalance with the opening of its International University of Science and Technology (BIUST) designed to increase access to tertiary education and improve the human capital development, especially in science and technology.

2. Actions taken
While recognizing that each Member State has its own policies for education and training and whilst co-operation and mutual assistance in education and training is desirable and possible, the SADC Protocol on education and training calls for the development and formulation of coherent, comparable, harmonised and eventually standardized policies with regard to the following matters, amongst others: (a) widening provision and access to education and training as well as addressing gender equality and; (b) increasing equitable access, improving the quality and ensuring the relevance of education and training. All member States of SADC have accepted the education and training aspects of the ICPD PoA and MDGs as frameworks for developing their education and training policies and programmes.

In response to country needs and in honor of international agreements, all SADC countries have put in place and been implementing different policies, strategies and programmes within the education sector. Most, if not all, of the national education policies articulate educational issues at primary and tertiary level, technical education level, vocational training and higher education, in line with the national strategic planning framework. In most countries, education programmes have been backed by increasing allocations over the years, confirming the view that SADC countries in general consider education as a top priority area in development. Indeed, more and more countries are extending the benefit of free education, almost universal at primary school level, to secondary school; and in order to deepen human capacity almost all SADC countries have different forms of bursary or students’ loan programme for the promotion of tertiary education.
3. Achievements

In the drive towards regional integration through harmonisation of policies and programmes in the education sector, member States of SADC have made progress in regionally identified areas, including: i) early childhood care and development; ii) curriculum development; iii) gender parity; iv) higher education, technical and vocational education and training. In recent times, SADC has sustained high levels of access to education, equity and gender balance in primary and secondary education.

Perhaps the most fundamental achievement by almost all SADC countries in the field of education has been the expanded access to primary education by both sexes. In this regard, a growing number of SADC countries, with substantial budget allocations, have been implementing policies and programmes that free learners and their parents from the burden of school fees payment, and more and more countries are providing food and transportation to learners in order to widen access and encourage sustained participation.

Since 1976, the Government of Mauritius has been providing free education, from pre-primary to tertiary level; and education is compulsory for boys and girls within the 3 to 16-year age bracket. In addition, free transport has also been provided to all students to curb absenteeism since 2005. Similarly, Botswana enjoys high access to basic education, and free education up to university level; the number of institutions that offer tertiary education has not only increased, but government sponsorship now covers these institutions. In South Africa, the “no fee school policy”, school transport policy and nutrition programme have all contributed to better access to schooling in the country; the percentage of learners who reported that they paid no tuition fees increased from 0.7% in 2002 to 55.6% in 2011. The National Feeding Scheme for Orphans and Vulnerable children in Namibia, the provision of education for the children of refugees, and the introduction of Mobile and satellite schools for marginalized communities have contributed to expanded access to education in the country.

<table>
<thead>
<tr>
<th>Actions to Improve Access to Education among Remote Area Communities (RACs) in Botswana</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Government of Botswana provides boarding schools in the remote areas to cater for students who reside in localities where there are no schools. Through the same program government also supports children from RACs while they are in schools with uniforms, clothes, toiletries, blankets and transport to and from their homes at the beginning and end of school terms. The support also includes care in the hostels through the matrons. This contributes to better completion rates of basic education. The support is also extended to senior secondary schools students and those in vocational and training education. Through the affirmative action RADP assist learners from RACs to get admissions in tertiary institutions by encouraging institutions to use positive discrimination in their admission procedures and use lower cut-off point to admit the RACs learners, because of the fact that their learning environment for primary and secondary education was not conducive as for learners in established villages and urban centers (Source: Country Report – Botswana ICPD + 20).</td>
</tr>
</tbody>
</table>

Different strategies have also been pursued to improve the quality of education. For example in 2010, Zimbabwe provided core textbooks to all children in formal primary school, thereby raising the textbook pupil ratio to 1:1. In order to sustain the participation of girls in school, Malawi has put in place school health and nutrition interventions for the facilitation of access to sanitary facilities by girls; a mother group initiative to ensure that girls’ reproductive health issues in their communities do not prevent girls from accessing education; Construction of girls’ hostels in some selected secondary schools to ensure that girls do not walk long distances to
access secondary education and are protected from socio-economic challenges of learning as day secondary school students and; the 50-50 secondary school selection criteria, which ensures parity in the number of boys and girls selected to start secondary school education.

4. Challenges

Major challenges faced by the education sector in SADC include access by the poorer communities, overall quality of education outcomes, as well as the external and internal efficiency of the education system.

The achievement of universal access to quality education in Zimbabwe is being inhibited by among other factors: poverty, health issues, distance between home and school in some remote areas and shortage of adequate resources. In Tanzania and Namibia, both geographically vast relative to other many countries in the region, the dispersed population distribution in rural and remote areas makes it is resource-expensive to reach all communities in terms of timely distribution of educational resources and facilities.

In terms of the internal and external efficiency of the educational system in SADC, perhaps the best indicator is its relevance to the labour market dynamics. In spite of the great strides attained in spreading the benefits of education in the region, unemployment rates (open and disguised), especially among the youth are unacceptably high in most countries. Botswana is concerned about the quality of education, specifically its relevance and suitability for the country’s development needs, as well as access, especially by the poorest and most of those in remote areas.
11. CRISIS SITUATION AND EMERGENCY PREPAREDNESS

1. Status and trends

Due to climatic change, many SADC countries have become highly susceptible to environmental crisis, sometimes causing severe flooding or prolonged droughts in an unpredictable sequence in the same country. The odd combination of erratic weather, high fuel and input costs, the devastating impact of HIV/AIDS, and a decline in the use of improved agricultural practices and inputs have been cited as contributing factors to the decline in food production and attendant food insecurity in SADC countries.

Early 2011, Lesotho experienced the heaviest rains in decades, resulting not only in loss of agricultural output but also damage to infrastructure: power lines collapsed, roads were severely damaged, bridges and culverts were destroyed. In recent years, droughts, hailstorms, high winds and other natural disasters have similarly caused periods of loss of output. Food shortages have been the core of humanitarian crisis Lesotho has been dealing with; cereal production in 2012 was just a third of the average for the last 10 years.

Swaziland has also been experiencing food insecurity due largely to climatic variability since 2000: before then, the average annual maize production was about 100,000 tons but has since declined to 70,000 tons annually, while torrential rainfall and cold weather in 2012 caused the death of some 8,000 cattle in the country.

In Mozambique, the period from October 2011 to March 2012 was characterised by localised violent wind and intense rain storms, resulting in deaths and displacement of thousands of people; during January and February 2012 Storm Dando and Tropical Cyclone Funso created havoc which affected 108,048 people in the City of Maputo and in the districts, resulting in 44 deaths, 52 injured and the destruction of 19,468 houses; the country was also hit by Tropical Cyclone IRINA, causing destruction of properties.

With the increase in climate variability, an increase in magnitude and frequency of disasters has been witnessed in Malawi. Zimbabwe has also been prone to a plethora of calamities of both natural and human induced nature, including: drought, flooding, tropical cyclones, wind/hail storms, pest infestations, epidemics, zoonotic diseases, human-wildlife conflicts, earthquakes, veldt fires, environmental degradation, landmines, industrial accidents and chemical spillages.

There are social and economic crises as well. In Malawi, civil strife, particularly clashes between demonstrators and police led to loss of lives, damage to property and public infrastructure. In 2008, xenophobic attacks in South Africa led to hundreds of deaths of people from Zimbabwe, Mozambique, Malawi, etc. and rendered many more homeless. Swaziland has identified recent economic trend as a crisis: since 2000, the Swazi economy had been beset by underlying long-term structural weaknesses coupled with the spread of HIV/AIDS, which had slowed GDP growth and the capacity to create employment. Since 2004, the average loss in GDP growth attributable to HIV and AIDS has been around 2 percent per year.
2. **Actions taken and achievements**

Countries have worked in collaboration with UN agencies and local NGOs to define multi sector emergency and recovery response plans to mitigate the impact of recurring crisis of flooding, droughts, food insecurity, vulnerability and related emergencies.

In Mozambique, the Disaster Prevention and Mitigation Master Plan was implemented in order to reduce the impact of natural disasters on the populations and their goods, leading to a reduction in the number of people affected by the natural phenomena. Lesotho has also put in place mechanisms for conducting thorough reviews and overhaul of policies for supporting food security, and re-examining policy in connection with mid-term PRS reviews. Zimbabwe has addressed crisis and emergency situation through the Civil Protection Act Chapter 10.06 of 1989, the Education Act, Defense Act, etc. In the past 5 years Malawi has implemented a number of programmes aimed at improving the livelihoods of people affected by disasters and improving their resilience towards disasters. There are five types of emergencies identified by the Government of Mauritius arising from: cyclone, torrential rain, landslide, Tsunami, or high waves; for each emergency, there are well established mechanisms in place, including the Cyclone Emergency Organization located at the Prime Minister’s Office. South Africa is well-equipped with management and implementation strategies, acts, policies for dealing with crisis situation and emergency preparedness at national, provincial, municipality level.

**Achievements**

The identified coping mechanisms have been quite effective in SADC countries with regard to disasters, whether natural or man-made; such mechanisms in all cases have been supported by the development partners, including the United Nations system and the NGOs. For example in Malawi, with support from development partners, the Government has assisted vulnerable and food insecure people for the past five years except 2009; the country also coordinated the safe repatriation and home settling of 1,617 people displaced by xenophobia in Republic of South Africa in 2008. At national level, South Africa has made considerable progress in providing services, dealing with crisis situations, and saving people from natural and non-natural disasters. Zimbabwe has strengthened the national risk management machineries with the drafting of the strategy for Disaster Risk Mitigation, and the on-going disaster risk assessments to assist in understanding prevailing disaster threats and determining the related mitigating measures.

3. **Challenges and future plans**

Most of the challenges being faced in addressing crisis situations in SADC countries relate the weak institutional structures and implementation capacity, unpredictability of timely budget support by Government, and lack of comprehensive communication and early warning management systems.

In Swaziland, the Government plans to upscale implementation of the Comprehensive Agricultural Sector Policy and the National Food Security Policy, among others, and implement the appropriate policies and programmes which address the underlying factors which impact on the ability of households to provide for their nutritional needs; namely, HIV, unequal gender relations and deepening poverty levels. The major challenge to Malawi’s ability to avert or respond successfully to crisis situations and emergencies is inadequate financial resources.
coupled with low staffing levels. There is also no contingency/preparedness or response plans for man-made disasters hence, response to man-made disasters has been highly uncoordinated. South Africa, although sufficiently prepared for disasters and emergency situations, has identified certain situations where response rate was little delayed due to various factors: in rural and semi-urban areas disaster management offices have encountered some challenges due to lack of resources; sometimes, break of down of communication channels have been causing delay in reaching people about crisis situation.
12. RESOURCES MOBILIZATION, PARTNERSHIPS AND COORDINATION

1. Status and trends
Given that domestic resources provide the largest portion of funds for attaining national development objectives, the PoA suggests that domestic resource mobilization (involving both public and private sectors) should be one of the highest priority areas for focused attention to ensure the timely actions required to meet the objectives of the ICPD PoA. The international community, on its part, is urged to fulfill the agreed target of 0.7 per cent of the gross national product for overall official development assistance (ODA) and endeavour to increase the share of funding for population and development programmes commensurate with the scope and scale of activities required to achieve the objectives and goals of the present Programme of Action.

Actions taken
At the national (domestic) level, the implementation of population programmes addressing both the goals of the ICPD PoA and the MDG has witnessed an increasing budget support to population activities in SADC countries in general. While most countries have an explicit population policy, not as many countries have been able to move forward to developing and implementing a national Population Programme or Action Plan for population policy implementation. In the absence of such a framework, most governments have selectively supported population-related programmes and projects. Most prominent strategy followed has been the creation or strengthening of institutions in support of population activities; namely, National Population Unit, Ministry of Gender, Ministry of Youth, Ministry of Health (including the strengthening of the RH Division), Ministry of Youth, Ministry of Education, Ministry of Home Affairs, etc.

 Achievements
At national level, countries have focused attention on the achievement of both the ICPD PoA and the MDGs, apart from national population targets. The assessments in the preceding sections of this report attest to the achievements attained thus far. However, in terms of domestic resource mobilization, this has been difficult to quantify, largely because countries have not addressed policy implementation through a costed, comprehensive national population programme.

It is, however, commendable that SADC countries have honored partnership with both national and international NGOs in addressing all aspects of the ICPD PoA. Inclusive participation is evident from the process of national population policy (and Action Plan or Programme) development, in which extensive consultations have been held with development partners in the determination of goals, objective, strategies and specific targets. National NGOs with interest and involvement in population issues are in large numbers in all member States, and they have been vigorous in supporting Government efforts in: the promotion of gender issues (female representation in decision-making, gender based violence, teenage marriage, teenage pregnancy, etc.); care for orphans; HIV/AIDS issues; poverty reduction; advocating for youth and development; reproductive health; etc.

At the international level, SADC countries have enjoyed partnership and collaboration with numerous UN and multilateral agencies (UNFPA, WHO, UNICEF, UNAIDS, UNDP, ILO, FAO, UNESCO, WB, IMF, WTO, AfDB), EU, OECD, DFID, WWF, etc.), and bilateral agencies
(USAID, Netherlands, Japan, Oxfam, GTZ, Canada, SIDA, African Comprehensive HIV/AIDS Partnership (ACHAP) etc. In addition, South-South cooperation in the field of population and development has also been growing, especially in the areas of capacity strengthening and information sharing within SADC and AU, among others.

In terms of international support to development in SADC countries in general, the Official Development Inflow (ODI) trends provide a good measure. As illustrated in Figure 12.1, until 2001, ODI to SADC on annual basis was under US$10 billion; it declined between 2001 and 2006, rising thereafter rather sharply to about US$18 billion in 2008, and from US$20 billion in 2010 to US$52 billion in 2011.

![Fig. 12.1: Foreign Direct Investment Inflows in SADC (Millions US$), 1980-2011](image)

Source: SADC Statistics Yearbook 2012 (Based on Table 7.1)

**Challenges and future plans**

Perhaps the weakest point in the delivery of the PoA across SADC has been the transition from framework development (Population Policy) to actual implementation, constrained as it were, by the lack of a comprehensive, nationally agreed Population Programme or Action Plan. In the absence of an action plan for population policy implementation, there is no effective platform comprehensive enough to bring all the actors (national and international) together to mobilize resources, budget for and work together in implementing the various interconnected activities of a population programme. This also implies that advocacy for the integration of population issues into national and sector policies and programmes is non-existent in most SADC member States.

Another related factor has been the weakness of the institutional structure specifically created to facilitate the coordination of activities addressing Population Policy implementation – the National Population Unit (NPU/Secretariat). Most of the NPUs in SADC are located in the National Ministry of Finance/Development Planning, which should be an asset to the NPU in attracting funds and exercising its functions. However, in many cases the NPUs are poorly staffed and resourced and are unable to carry out effectively the task of facilitating the implementation of population policy. In addition, most often, the national coordinating body, which the Policy suggests should be made up of members at Ministerial level, is either not constituted or has been there only in name. Apart from the lack of a higher body to effect the coordination of population activities at national level, there is also the lingering challenge of poor integration of population issues into development policies and plans.
One other major challenge being faced by a few countries in SADC is related to the international economic classification which puts them in the “Lower-Middle Income” or “Middle Income” or “Upper-Middle Income” group; namely, Mauritius, Seychelles, Namibia, Botswana, Lesotho and Swaziland. Such re-classification has limited their chances of receiving donor funding.

All SADC countries face the challenge of effectively bringing the private sector, the engine of national economic growth and development, into the population and development scene. This may have to do with the lack of a comprehensive resource mobilization strategy for population activities across SADC.

All future activities should endeavor to address the above mentioned challenges.
13. MONITORING AND EVALUATION MECHANISMS

1. Status and trends
All the national Population Policy papers in SADC have defined implementation arrangements, which specify the range of collaborating institutions, the overall coordinating body, the role of the National Population Unit (NPU), and the requirements for monitoring and periodic evaluation of the outcomes of policy implementation. Almost every country with a population policy has undertaken a review of the document, after 10 years or so, to update with more recent data and to factor in important emerging issues.

2. Actions taken
Following policy formulation, a number of countries (South Africa, Namibia, Botswana, Swaziland, etc.) have developed a Monitoring and Implementation Plan for the Population Policy. In most other countries, the monitoring and evaluation of population policy outcomes is done within the context of the existing M&E mechanisms that have already been institutionalized in the country. These mechanisms (often referred to as National M&E Frameworks) are used to monitor and evaluate progress achieved in national development at national and sector levels.

3. Achievements
Although actual integration of population issues into development plans is yet to be effectively addressed in many countries through the National development strategic frameworks, countries have been able to factor in some population indicators. Member States often conduct Mid-Term evaluation and final evaluation of their National Development Plans, and from the results, population outcome indicators are identified. Country reports show that the statistical systems have improved over the years with periodic population and housing censuses and special surveys, particularly Demographic and Health Surveys and Demographic Sample Surveys, Impact Surveys, Labour Surveys and Agricultural Censuses. It is also noteworthy, that quite a number of countries have supported the establishment of higher education institutions for training and research in population and development to support population policy implementation. These institutional developments have gone a long way in facilitating monitoring and evaluation processes in the member States.

Every five years since the formulation of ICPD PoA, countries in the region have responded to the call to evaluate and prepare a report on progress achieved in the implementation of the PoA and indirectly in their respective national population policies. In addition, SADC countries since ICPD+15 have organized regional progress review meetings, one in 2009 and this meeting, to assess the progress made individually by member States and collectively as a region in addressing ICPD PoA issues as well as related DGs.

4. Challenges and future plans
The major challenge, as identified by member States, is how to build adequate capacity and provide the necessary budget support to the formulation and implementation of national action plan for Population Policy implementation, and thereby achieve a comprehensive integration of population issues into development policies and plans.

In terms of data on population and development, there is the challenge in many countries of in-depth analysis and reporting of the existing stock in the national databases for policy implementation and evaluation of programmes. The actual implementation of population programme would, therefore, require research based on the available data and generation of updated age/sex disaggregated data to support policy formulation and implementation, and for developing appropriate indicators on a continuing basis.
14. RESOLUTIONS

RESOLUTION BY SADC MEMBER STATES

We, the Ministers responsible for population and development planning in SADC fully re-affirm our commitment to the implementation of the ICPD PoA beyond 2014.

We commit ourselves to:

1. POPULATION, ECONOMIC GROWTH AND SUSTAINABLE DEVELOPMENT

1.1 Scale up investments in research to determine the linkages between population, environment and poverty and to develop and utilize sustainable development strategies and initiatives aimed at reducing territorial inequalities, improving waste management and preventing environmental degradation as key instruments for guiding decision-making and implementation of sustainable development programmes at regional, national and sub-national levels;

1.2 Encourage countries to continue promoting participatory and inclusive consultations with all stakeholders, including CSOs and the private sector, on development planning and implementation processes;

1.3 Strengthen national socioeconomic empowerment systems through inclusive mechanisms and vocational and appropriate skills training in relation to income generation and employment strategies and initiatives, especially for vulnerable groups, women and young people;

1.4 Increase labour productivity, particularly in the agriculture sector, to ensure household food security and enhance the nutritional status of the population, particularly the vulnerable groups;

1.5 Strengthen institutional and technical capacities to develop and use tools and modules for integrating population, development and environment issues and their inter-linkages into development planning, budgeting and implementation processes; and

1.6 Strengthen capacities at regional, national and sub-national levels to generate, analyse and utilize integrated social, economic and environmental quality data and information for development, particularly through conducting surveys.

2 POPULATION GROWTH AND STRUCTURE
2.1 Recognize the role of population dynamics and structure as key determinants of development and integrate these to realize socio-economic and sustainable development outcomes;

2.2 Implement appropriate policies and laws aimed at managing population growth and achieving demographic transition and the realization of the ‘Demographic Dividend’ through support to reproductive health programmes, including voluntary family planning;

2.3 Develop/update and implement policies and programmes that promote the rights of adolescents and young people and accelerate investments in quality education, decent employment opportunities, effective livelihood skills in order to strengthen young people’s individual resilience and create the circumstances for the realization of their full potential;

2.4 Adopt and implement policies and programmes that ensure equal access to various services including health, education, protection and care for the aged persons, indigenous groups and people with disabilities; and

2.5 Develop national programmes/Action Plans, strengthen human and institutional capacities and provide adequate budget for the implementation of national population policies.

3. GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN

3.1 Strengthen human and institutional capacity in support of gender policies and programme implementation;

3.2 Set up and strengthen legal mechanisms/frameworks that protect and promote human rights, including elimination of all forms of gender-based violence;

3.3 Promote equal access to resources and opportunities in all spheres of life including economic empowerment of women and participation in decision making structures;

3.4 Strengthen the implementation of programmes of public education which address issues of gender equity and equality; and

3.5 Strengthen national gender mainstreaming strategies in all sectors and support the continuous generation and utilization of ‘gender statistics’.

4. FAMILY COMPOSITION AND CHANGING STRUCTURE
4.1 Recognise the changing family structures and composition within countries’ socio-cultural contexts and provide adequate social services and protection to emerging families such as those headed by females, children, the elderly and persons living with disabilities;

4.2 Provide training and support services to empower communities to address domestic violence, and HIV and AIDS;

4.3 Establish child and elderly protection units at national and sub-national levels to provide assistance and protection to children and the older persons;

4.4 Eliminate child labour and all forms of child exploitation, abuse and neglect, and provide adequate care for the development and welfare of children; and

4.5 Develop family and related programmes that would address challenges facing emerging families such as female-headed households, child-headed households and elderly-headed households.

5. MATERNAL HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

5.1 Train and retain skilled health personnel especially doctors and midwives;

5.2 Increase universal access to quality, affordable, comprehensive and integrated maternal health, sexual and reproductive health and rights services, including voluntary family planning;

5.3 Increase community social mobilisation to create demand and uptake of reproductive health services especially to the underserved groups, including people with disabilities;

5.4 Increase community awareness on the importance of early attendance of ante-natal care services, with emphasis in the first trimester of pregnancy;

5.5 Increase funding and resource mobilisation in accordance with the Abuja Declaration Programme of Action requesting allocation of 15% of the national budget to the health sector; and
5.6 **Uphold and strengthen** SADC commitments to mother and child health, sexual and reproductive health and rights through the implementation of the Maputo PoA, CARMMA and other national, regional and global agreements.

6. **HIV and AIDS, Malaria, TB & other Communicable Diseases**

   **6.1 Strengthen** mechanisms and resources for more effective implementation of programmes that curb the spread of HIV, reduce HIV/AIDS deaths through appropriate treatment, including PMTCT as well as management of its impact on the economy and its repercussions on society, especially for the most vulnerable;

   **6.2 Enforce** implementation of policies, strategies and programmes to fight against discrimination and stigma against persons living with HIV and/or AIDS;

   **6.3 Strengthen** the Voluntary Counselling and Testing Programmes and encourage medical male circumcision so as to reduce HIV infection rates and cervical cancer;

   **6.4 Reinforce** political commitment, institutional capacity and prioritise awareness raising, for the prevention and treatment of Malaria, especially in areas where it is endemic;

   **6.5 Allocate** adequate resources to facilitate comprehensive and integrated provision of health services that include awareness raising, prevention and treatment of HIV/AIDS, TB, Malaria and other communicable diseases and;

   **6.6 Promote** better integration of family planning and sexual reproductive health in HIV and AIDS services and vice-versa (i.e. promote better integration of HIV and AIDS services into family planning and sexual and reproductive health services).

7. **POPULATION DISTRIBUTION, URBANIZATION AND INTERNAL MIGRATION**

   **7.1 Improve** the management of human settlements, including local and municipal governance through more participatory processes to address urbanisation issues;

   **7.2 Implement** urban plans and accelerate the provision of basic services such as clean water, adequate housing and sanitation system;
7.3 Strengthen capacity and resources for effective rural development and develop alternative points of population concentration in order to stimulate new settlement areas; and

7.4 Strengthen national statistical systems, including civil registration and vital statistics, to generate data and information and appropriate research to better capture and understand internal migration.

8. INTERNATIONAL MIGRATION AND DEVELOPMENT

8.1 Adopt selective migration policies, maximize the benefits and minimize the costs and repercussions of international migration, and manage undocumented migration;

8.2 Formulate and adopt evidence-based migration policies, particularly those aimed at vulnerable groups, especially women and youth; maximize the benefits and minimize the costs and repercussions of international migration and to protect the rights of migrants;

8.3 Strengthen the capacity of the relevant institutions to monitor and manage undocumented migration and strengthen legislation relating to immigration control;

8.4 Develop and implement policies and strategies to eradicate all discriminatory practices against immigrants;

8.5 Support data collection and analysis on migration and standardize measurements at national, regional and international level;

8.6 Develop and implement a SADC Migration Protocol that recognizes and protects the human rights of cross border migrants and discourages irregular migration, taking into account developmental differences between countries in the region, and further noting that international migration could provide an added opportunity for regional integration and;

8.7 Reaffirm the need to address and to promote conditions for cheaper, faster and safer transfers of remittances in both source and recipient countries and, as appropriate, to encourage opportunities for development-oriented investments in recipient countries by beneficiaries that are willing and able to undertake such action.

9. CRISIS SITUATION AND EMERGENCY PREPAREDENESS
9.1 **Strengthen** institutional capacity and ensure adequate financial and human resources to prevent and management of the disasters;

9.2 **Formulate and implement** a strategic plan on emergency preparedness and management of disaster crisis;

9.3 **Encourage** collaboration between SADC countries in sharing information, knowledge and best practice in emergency preparedness and management of disaster crisis; and

9.4 **Foster** collaboration in addressing crisis situations and emergencies within and between SADC Member States, including the establishment of a regional integrated database derived from functioning country databases.

10. **EDUCATION AND DEVELOPMENT**

10.1 **Enhance** the interventions towards quality universal primary education through expansion of educational services and facilities, including the welfare of teachers, provision of free education and school feeding programs, while guaranteeing higher completion rates;

10.2 **Expand** the provision of quality formal (higher education and vocational training) and non-formal education services that address the need for skilled manpower in the labour market and the need for entrepreneurial development with promotion of the additional role of private providers;

10.3 **Improve** the quality of adult literacy education programme and increase the number of adult literacy institutions with involvement of non-public stakeholders;

10.4 **Develop and strengthen** programmes addressing education needs for early childhood education and development; and

10.5 **Strengthen** the school curriculum to include life skills education and comprehensive sexuality education, taking into account country specific contexts, and develop appropriate systems to integrate teenage and young mothers back into the education system.

11. **MONITORING & EVALUATION MECHANISMS**
11.1 Strengthen capacities at regional, national and sub-national levels to produce, analyse, disseminate and utilise disaggregated social, economic, demographic and environmental quality data for development, through strengthening civil registration and vital statistics and conducting special surveys and population and housing censuses, to inform development planning, monitoring and evaluation;

11.2 Develop and implement comprehensive monitoring and evaluation (M & E) frameworks and Action Plans for population and related policies to achieve sustainable development;

11.3 Finalise and adopt population and related policies, strategies and institutional frameworks for the implementation of the ICPD PoA;

11.4 Decentralise the implementation of the ICPD PoA recommendations; and

11.5 Update current indicators and set targets to assess the progress of implementation of ICPD PoA at all levels.

12. RESOURCE MOBILIZATION, PARTNERSHIP AND COORDINATION

12.1 Strengthen strategic working relationships and promote partnerships with government agencies, CBOs, NGOs, the private sector and development partners engaged in population, environment and development issues;

12.2 Develop and implement effective resources mobilization strategies which address technical, human and financial resources needed for implementation of the ICPD PoA;

12.3 Develop and implement effective coordination mechanism to track implementation of the ICPD PoA indicators among different stakeholders engaged in population and development issues;

12.4 Strengthen institutional and human capacity to effectively coordinate implementation of the ICPD PoA;

12.5 Develop innovative capabilities and engage in activities to attract political and private sector active involvement in population and development issues;
12.6 Foster and promote collaboration in sharing experiences on sustainable policy and strategy formulation and implementation and in resource mobilization between SADC countries as well as between South-South and North-South countries, in capacity building, research, exchange of best practices and lessons learnt in the area of population and development.
REFERENCES

- ICPD+20 Country reports: Botswana; Democratic Republic of Congo; Lesotho; Namibia; Malawi; Mauritius; Mozambique; South Africa; Swaziland; United Republic Tanzania and; Zimbabwe.


