

The African population growth and development conundrum



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Socio-economic decadence and degradation

Africans with ages spanning two generations have seen it all happen. They are living witnesses to the prosperity that has presently eluded Africa. They saw the good old days of the 1960s and 1970s vanish, yielding place to the current crisis of growth and development and its attendant deprivation and pauperization of the population. As for those younger Africans born after political independence and therefore into the relative prosperity of the 1960s and 1970s, it has been their unfortunate lot to struggle endlessly to contain the deterioration in their own standards of living. Better equipped with education, knowledge and skills than their parents, they are finding no enabling environment for their progressive participation in meaningful development. They are the victims of unfulfilled expectations.

The acute economic problems and the ever-expanding population create pessimism about the future despite continued internal and external support. And yet for the continent which is rapidly and increasingly sinking into more deprivation and poverty, the urgent arrest of the situation is critical. The world no doubt is getting richer. Life in the affluent societies contrasts sharply with that in the pauperized developing world, particularly in sub-Saharan Africa. Such glaring disparity calls for critical appraisal and redress.

In the light of contemporary developments, it is no longer reasonable to attribute the state of affairs in Africa to either overpopulation or underdevelopment. The unaccomplished or delayed demographic transition and the growing penury in the continent call for a new strategy that will hasten the demographic transformation, satisfy the aspirations of the poor and help mitigate the pressures on the deteriorating environment. At stake is the achievement of sustainable human development which improves living conditions and gradually replenishes resources for the future. This type of development which involves complex interconnected processes of expanding education, health, employment and other basic needs provides the chief ingredient for lasting demographic transition with markedly reduced fertility and mortality (Speth 1994).

Recently, speaking on the importance of social development, the United Nations Secretary-General maintained that there was need to create an economic environment that was favourable to the attainment of social justice. He argued that poverty could not be overcome and greater social integration could not be attained in conditions of economic stagnation or recession (UN 1993a).

Further reinforcing the relevance of links between population and economic development, it was recently reported in UNFPA's *State of the World Population 1992* that in the 1980s, the 41 countries where population was growing more slowly experienced an average income growth of 1.23 per cent per annum while in the other 41 countries with faster population growth, incomes fell by an average of 1.25 per cent per annum, the difference between the two groups being a significant 2.5 per cent per annum. The report recognizes that

the observed relationship may be due to a combination of factors, a major one of which is education which surely aids economic growth, helps to reduce female fertility (Harrison 1994), lowers infant mortality, improves employment prospects of females and generally enhances their status, and raises the earning capacity of family households.

This presentation recognizes the presence all over sub-Saharan Africa of profound social problems — poverty, illiteracy, joblessness, disease, hunger — all connected with the lack of sustainable and integrated demographic, economic and social development. On these are predicated the occurrence of social change and development for population welfare and prosperity. The rate of population growth influences socio-economic development which in turn affects the process of demographic growth.

However, there is no inevitable Malthusian barrier to economic progress (Kelly and McGreevey 1994), as some high-fertility countries such as China and India have been experiencing high rates of per capita income growth. Nevertheless, the African crisis is very much a function of the structure of the African economy and its demographic configuration. Economic considerations apart, 'Africa remains transfixed in a high fertility/high mortality syndrome that scars its society generally' (Kelly and McGreevey 1994). Economically, it is a structure of dependency rather than self-reliance as the continent depends on external agents for the production of what its people need and for its industrial inputs such as capital, technology, skill, and spare parts. There is the dominance of subsistence production and a dependence on undeveloped and unscientific methods leading to low productivity. A catalogue of related causes has been compiled by the United Nations Economic Commission for Africa (ECA) under the distinguished leadership of its former Executive Secretary, Adebayo Adedeji.

The Commission also emphasizes the existence of a large informal sector, the degraded environment, an urban bias in development that permanently impoverishes the rural areas and the presence of weak institutional capacities (ECA 1991). The restrictions imposed by the prevailing social, political and demographic structures are also highlighted. The absence or non-observance of basic human rights and democratic participation has tended to engender dissatisfaction and civil conflict which discourage overseas investment and stifle domestic productivity. The socio-political environment has also nurtured a lack of probity and accountability. The rampant bankruptcy and breakdown of institutions and closing of unprofitable factories are related to the dearth of management and entrepreneurial skills. This occurs in situations where political, social, linguistic and ethnic considerations have led to frequent changes of ego-centred managers and consequently to a lack of the continuity of service and application of experience which are needed for greater efficiency and productivity.

Africa has always been prone to disasters. As well as the devastation caused by violent internecine conflicts, natural disasters have also occurred. Since cultivation technology is old-fashioned and exclusively dependent on rain, food supply has tended to be insufficient for the large family households common in the continent. When there are no rains, drought further reduces the food supply for an already deprived population. On the other hand, excessive rainfall from time to time brings floods which by destroying crops and livestock also aggravate the precarious food situation.

According to the Director-General of the United Nations Food and Agricultural Organization (FAO), sub-Saharan Africa was one place in the developing world where food production in 1993 increased by 3.4 per cent, but it was seriously affected by famine and food insufficiency (FAO 1993). With the decline in food production during the last 20 years, the region has progressively become a net importer of food (Massou 1995). At the 1994 FAO Regional Conference in Botswana, the Director of the Organization in his address pointed out that Africa was the only region in the world where food production per capita decreased

during the last quarter of the century. While 20 per cent of the population of the developing countries suffered from chronic undernutrition, the proportion in sub-Saharan Africa was 37 per cent. Thus while certain regions had access to 3,600 calories daily per capita, in sub-Saharan Africa the figure was no more than 2,100 (*Le Sahel*, 10 November 1994:4).

There are numerous manifestations of Africa's population and development crisis. Many vital issues, such as the crushing and destabilizing debt burden, exacerbate the short-supply of resources to satisfy the development needs of the population. The immensity of the debt problems was recently highlighted in an economic review showing that out of 32 countries in the world which are classified in a recent World Bank publication as severely indebted, 25 are in Africa (Ejimofor 1995).

In the foregoing review, Africa's crisis of development in relation to other major regions of the world was not considered. Table 1 presents some aspects of the relative deprivation in the continent. With the exception of South Asia, the gross national product (GNP) per capita of US\$504 is the lowest, amounting to 19 per cent of that of Latin America and the Caribbean and a mere 2.6 per cent of that of the industrialized countries. As Table 1 further shows, Africa, south of the Sahara, ranks the lowest of all regions in terms of the percentage

Table 1
Relative socio-economic indicators of Africa's well being and survival

Socio-economic indicators	Africa South of the Sahara	Middle East and North Africa	South Asia	East Asia and Pacific	Latin America and Caribbean	Industrialized countries
1. Gross National Product (GNP) per capita (US\$)	504	1,977	313	800	2,648	19,521
2. Primary school enrolment (%)	67	96	86	-	-	-
3. Adult literacy rate (%)	50	57	46	80	85	96
4. GNP per capita Rate of Growth						
(a) 1965-80 (%)	3.0	3.2	1.5	4.8	4.1	2.9
(b) 1980-92 (%)	-0.4	-0.7	3.0	6.5	0.0	2.2
5. Rural population below absolute poverty threshold (%)	62	-	39	17	49	-
6. Population with access to:						
(a) Potable water (%)	42	77	77	66	80	-
(b) Sanitation (%)	36	70	29	27	66	-
(c) Health services (%)	56	82	77	87	74	-

Source: UNICEF 1995:84-85.

of primary school enrolment, adult literacy, rural population below the absolute poverty threshold, and population with access to potable water, sanitation and health services.

Health and sanitary conditions have deteriorated so much that Primary Health Care (PHC) objectives are now not being fully realized. The achievement of health for all by the year 2000 is now unlikely mainly because of the weakness of health infrastructures and inadequate health and sanitation education, as well as weak management of health services delivery. The United Nations appraisal of the World Population Plan of Action made it clear that in attaining the goals related to morbidity and mortality, other regions than Africa have made progress (UN 1989).

The sterility of the demographic transition in Africa

Africa arguably has more population issues and problems to contend with than any other continent or major region of the world. While it is recognized that there are issues stemming from population distribution, internal and international migration, and urbanization, attention is mainly focused here on those which are more directly connected with the retardation of the demographic transition in Africa compared with other major world regions. The delayed transition has implications for the prevailing levels of fertility and mortality, rate of population growth, the emergent population structure and its effect on the provision of basic needs such as education, health, employment, and housing.

The prevailing rapid rate of population growth in Africa continues to be mortality-induced as well as fertility-driven (UN 1993b:8-9). The important question is when Africa will catch up with the developed countries where the demographic transition has advanced significantly. After a brief period of stagnation, the developed countries attained a very low level of population growth of 0.6 per cent per annum during 1980-1993 as shown in Table 1. East Asia as opposed to South Asia has reached the stage of transition to the low levels of growth prevalent in industrialized countries. Indeed, Japan had done so in this century.

Instead of declining, the rate of population growth in sub-Saharan Africa (Table 2) rose from 2.8 per cent per annum in 1965-80 to 3.0 in 1980-93. The latter rate is only marginally higher, by 3.4 per cent, than the rate for North Africa and the Middle East. It is, however, markedly higher by 36.4, 76.5, 42.9 and 500 per cent than the rates for South Asia, East Asia and the Pacific, Latin America and the Caribbean, and the industrialized countries respectively.

There are however indications that population growth rates began to decline in Northern Africa and Southern Africa during 1970-1975. Although relatively still high the recorded growth rate for these two regions was about 2.5 per cent per annum during 1985-1990 (UN 1993b:14-15).

Table 2
Relative demographic indicators of Africa's well-being and survival

Demographic and Socio-economic indicators	Africa South of the Sahara	Middle East and North Africa	South Asia	East Asia and Pacific	Latin America and Caribbean	Industrialized Countries
1. Annual population growth rate						
1965-80(%)	2.8	2.8	2.3	2.2	2.5	0.8
1980-93(%)	3.0	2.9	2.2	1.7	2.1	0.6
2. CBR decline						
1960-1993 (%)	8	26	27	41	38	35
3. CDR decline						
1960-1993 (%)	38	62	48	63	46	0
4. Synthetic Index of Fertility						
	6.4	4.9	4.2	2.5	3.0	1.8
5. Under 5 mortality decline						
1960-1993 (%)	30	71	47	76	69	77
6. Infant mortality decline						
1960-1993 (%)	28	66	40	68	64	75
7. % Urban population						
	31	55	26	31	73	76
8. Expectation of life at birth (1993)						
	51	64	59	68	68	76
9. Increase of expectation of life at birth						
1960-1993 (%)	28	36	28	45	21	10
10. Rate of use of contraceptives (%)						
	12	44	39	74	59	72
11. Annual rate of decline of synthetic fertility						
1960-1980 (%)	0.0	0.9	0.8	3.0	1.8	2.0
1980-1993 (%)	0.3	1.4	1.7	1.8	2.5	0.1

Source: UNICEF 1995.

As already indicated, the prevailing high rate of population growth derives from additions to the population due to high fertility as well as declining mortality. Globally, both variables have been changing. The total fertility rate (TFR) for the world declined from 5.0 during 1950-1955 to 3.3 during 1990-1995. However, the rate in sub-Saharan Africa in 1993 at 6.4 remains the highest in the world. Women in sub-Saharan Africa had 6.4 children during their reproductive lives, while those in industrialized countries had 1.8 children. Women in North Africa and the Middle East had 4.9 children which was still 26.4 per cent less than the rate for women in sub-Saharan Africa.

With total fertility rates of 4.2, 3.0 and 2.5 births per woman, fertility was much lower in South Asia, Latin America and the Caribbean, and East Asia and the Pacific than in sub-Saharan Africa. As shown in Table 2 the annual rates of decline in Africa during 1960-1980 and 1980-1993 were the lowest in all major regions. The rate did not decline during the first period and did so by only 0.3 per cent per annum during the second period 1980-1993 when the annual rates of decline were 1.4 per cent for North Africa, 1.7 for the Middle East, 1.8 for South Asia and the Pacific, and 2.5 for Latin America and the Caribbean. The TFR in the industrialized countries had fallen very low and had long been stabilized at below replacement level. No significant measurable decline occurred during the period. The very small fertility drop in sub-Saharan Africa can also be evaluated from the fact that during 1960-1993 the crude birth rate (CBR), also in Table 2, fell by a mere eight per cent in contrast to declines ranging from 26 to 41 per cent for the other major regions.

This pattern of fertility variation is supported by the fact that sub-Saharan Africa also had the lowest rate of use of contraceptives. This was only 12 per cent as against 39 per cent for South Asia and 59 per cent for Latin America and the Caribbean. The rate of use was remarkably 74 per cent for East Asia and the Pacific, and 72 per cent for the industrialized countries.

For Africa in general, two distinct fertility trends are emerging. One is the declining trend in some of the countries of Northern Africa (Algeria, Egypt, Morocco, and Tunisia) to which should be added the declining trend in Southern Africa (Botswana and South Africa). The second trend is the continuity of the high and constant rate of above six births per woman prevailing in sub-Saharan Africa.

Like fertility, relatively high mortality, even if declining, also distinguishes sub-Saharan Africa from the rest of the major areas of the world. Generally, from a level of 19.7 deaths per 1000 during 1950-1955, the crude death rate (CDR) for the whole world rapidly declined to 9.7 during 1985-1990. Apparently, CDR over the period declined faster than CBR. This is indicated in Table 2 for all major regions, including sub-Saharan Africa where CBR declined by only eight per cent during 1960-1993 while CDR in the same period declined by 38 per cent. In North Africa and the Middle East CBR fell by 26 per cent while CDR fell by 62 per cent. In South Asia CBR declined by 27 per cent and CDR by 48 per cent. This pattern of variation applies to East Asia and the Pacific, and Latin America and the Caribbean. For the industrialized countries, it is even more dramatic because although CBR continued to decline by 35 per cent, CDR had, even by 1960, fallen to the lowest level possible, which led to no further decline at the same level in 1993.

Life expectancy at birth in industrialized countries was 76 years in 1993 and 68 years in both East Asia and the Pacific as well as Latin America and the Caribbean. The lowest level of life expectancy at birth of 51 years was for sub-Saharan Africa. It was 64 for North Africa and the Middle East and 59 years for South Asia. During the period under consideration, 1960-1993, East Asia and the Pacific experienced the most rapid increase of 45 per cent in life expectancy at birth, followed by North Africa and the Middle East with a rise of 36 per cent. In sub-Saharan Africa, the increase was by 28 per cent and for Latin America and the Caribbean, 21 per cent. Since the industrialized countries had already attained a high level of augmentation of life expectancy at birth in 1960, their observed increase of 10 per cent in 1993 could only at that level represent a trimming-off of rough edges.

These regional variations mask the levels of attainment in individual countries. For instance, those with spectacular levels of life expectancy at birth of more than 75 years were in (a) Asia: Japan with the highest level of 78 years; Cyprus, Israel and Hong Kong; (b) Europe: Norway, Italy, France, Spain, Switzerland, Sweden, the Netherlands, Greece and Iceland; (c) North America: Canada and the USA; and (d) Oceania: Australia (UN 1993b:40).

As expected, the improvement in life expectancy at birth has been accomplished by a dramatic decline in the level of infant as well as childhood mortality in the world. The infant mortality rate in 1950-1955 was 155 per 1000 births and this was more than twice as high as the rate in 1985-1990. The rate during this same period (1985-1990) was 15 per 1000 births in the developed region. In the less developed countries, it was 76 per 1000 births. In Africa, it was 103 per 1000, 69 in Asia and 53 in Latin America. Europe recorded 12 per 1000 and North America the lowest, 10 per 1000 births (UN 1993b:42).

Table 2 further illustrates the regional variations in the spectacular decline in infant mortality. During 1960-1993, it declined by 28 per cent in sub-Saharan Africa, 66 per cent in North Africa and the Middle East, 40 per cent in South Asia, 68 per cent in East Asia and the Pacific, and 64 per cent in Latin America and the Caribbean. The highest decline of 75 was recorded in the industrialized countries.

The decline of child mortality followed a similar pattern to the one for infant mortality. During 1960-1993 (see Table 2), the under-five mortality level fell by only 30 per cent in sub-Saharan Africa and 47 per cent in South Asia. The decline of 77 per cent was highest in the industrialized countries followed closely by East Asia and the Pacific region with 76 per cent, North Africa and the Middle East 71 per cent, and Latin America and the Caribbean 69 per cent.

Further illustration of the regional variation in the level of decline in both infant and child mortality in the 30 years, 1960-1993, is given in Table 3. About two-thirds of the countries in sub-Saharan Africa had experienced less than 50 per cent declines in childhood mortality. This was made up of 27 per cent of countries with less than 30 per cent declines

Table 3
Extent of decline of under five mortality and infant mortality rates in the world's major regions, 1960 - 1993

Rate of Decline (%)	Africa		Number of Countries in				Developed Areas		Total	
	N	%	Asia	Latin America & Caribbean	N	%	N	%	N	%
(a) Under Five Mortality										
0 - 29	12	27	5	15	0	0	0	0	17	13
30 - 49	16	36	2	6	0	0	0	0	18	14
50 - 69	12	27	9	26	11	50	7	26	39	21
70 - 89	5	11	15	44	11	50	19	70	50	39
90 +	0	0	3	9	0	0	1	4	4	3
Total	45	100	34	100	22	100	27	100	128 ^a	100
(b) Infant Mortality										
0 - 29	14	31	2	6	0	0	0	0	16	13
30 - 49	18	40	8	24	1	5	0	0	27	21
50 - 69	11	25	6	18	13	59	11	41	41	32
70 - 89	2	4	17	50	8	36	16	59	43	34
90 +	0	0	1	3	0	0	0	0	1	1
Total	45	100	34	100	22	100	27	100	128 ^a	100

Source: UNICEF 1995. Note: ^a Excludes the 17 new states of Eastern Europe for which there were no data to facilitate the comparison.

and 36 per cent with 30-49 per cent declines. In this respect, Asia had 15 per cent of the countries with less than 30 per cent decline, and six per cent with 30-49 per cent decline. As can be seen from Table 3, the Latin American and Caribbean countries, as well as the developed ones, fell outside these categories. Fifty per cent of the Latin American and Caribbean countries experienced 50-69 per cent and 70-89 per cent declines respectively. For the developed areas, 26 per cent of the countries experienced 50-69 per cent declines while 70 per cent experienced 70-89 per cent declines in under-five child mortality.

Sub-Saharan countries performed worse with respect to infant mortality than under-five mortality, 71 per cent experiencing less than 50 per cent decline in infant mortality. Of this, 31 per cent experienced 30-49 per cent decline. More than 50 per cent decline was experienced in 29 per cent of sub-Saharan countries. For Asia, the proportion with more than 50 per cent decline was 71 per cent; for Latin America and the Caribbean countries and for the developed countries, it was 95 per cent. Thus Africa south of the Sahara has a long way to go to attain the levels of decline in the other areas of the developing world and even more so to reach the level in the developed region. It still has to take greater advantage of the low-cost techniques for promoting infant and child survival through better health education, basic sanitation, immunization and general strengthening of the health infrastructure.

Future control of mortality in the continent will be complicated by the emergence of the HIV/AIDS epidemic which has been, particularly in some countries, obstructing resource development and utilization. Not only are the victims relatively young adults in the economically active age group but governments have been compelled to divert general development and health resources to the care of AIDS patients. The World Health Organization maintains that over five million children from now up to the year 2000 will become orphans as a result of losing their mothers or both parents to AIDS. Children are increasingly being forced to pay the price of the AIDS epidemic not only because they lose their parents but also because they generally end up being victims of the disease. In 1993, about 700,000 children were born to seropositive mothers in Africa. The majority of these children who were born with the virus infection risk dying early while those who were not infected will survive as orphans or be condemned to live on their own without family care (Agence France Press 1994).

The reported levels, patterns and variations in the natural dynamics of population growth have also produced variation in population structure with implications for the socio-economic development of the major regions. Two trends have been apparent. The first, occurring in Africa and the rest of the developing world, has been a general 'juvenation' of the population, to borrow an expression from the United Nations. According to this, the proportion of children aged less than 15 years increases while that of the aged generally declines. The second trend, peculiar to the developed countries, has been one of aging, in which the proportion of those aged 65 years and above increases while that of children decreases. With juvenation, the median age of the population tends to decrease while with aging, it tends to increase.

Estimates of median age published by the United Nations show that for Africa the median age in 1960 was a low 18.1 years. It declined to 17.4 years in 1990 and was projected according to the medium variant projection to be 17.5 years in 1995. The median age for Asia was given as 20.9 years in 1960, rising to 23.3 in 1990 and 24.4 in 1995. In East Asia where fertility has been declining, it rose from 22.2 years in 1960 to 26.2 years in 1990 and 28.1 in 1995. In Europe where the transition had already reached an advanced stage, the mean age in 1960 was a relatively high one of 31.6 years rising to 34.9 years in 1990 and 36.0 years in 1995. Thus, the population of sub-Saharan Africa has been the only one with a declining median age as the share of children and youth increased through high fertility and declining mortality.

In order to determine the economic implications of the emergent age structure, whether juvenating or aging, account should be taken of the third component of persons aged 15-64 years who make up the working-age group on which the two other components, the children and the aged, depend for sustenance. This is measured by the dependency ratio.

The dependency ratios associated with the age structure of the major world regions are given in Table 4 for 1960 and 1995. As already demonstrated, the demographic transition has barely started in sub-Saharan Africa. Thus it is, of all the regions, developed and developing, the only place where the total dependency rate increased significantly from 87.9 per 100 active persons to 91.8 per 100 active persons aged 15-64 years. Only a very slight increase was observed for the aged in Africa.

Table 4
Dependency ratios by major regions, 1960-1995

Dependency ratio per 100 active population	Africa	Asia	Europe	Latin America & Caribbean	North America	Oceania	USSR (Former)	World Total
Age Groups								
1960								
0-14	82.3	70.1	39.9	79.0	52.4	55.2	49.4	64.1
65+	5.6	7.3	15.0	6.9	15.2	12.4	10.7	9.2
Total	87.9	77.4	54.9	85.9	67.6	67.6	60.1	73.3
1995								
0-14	85.9	51.8	28.4	55.3	33.2	40.4	39.2	51.8
65+	5.9	8.7	21.1	8.4	19.1	14.7	16.9	10.6
Total	91.8	60.5	49.5	63.7	52.3	55.1	56.1	62.4

Source: United Nations 1993a:258-281.

For the other major regions including Asia and Latin America, significant declines in the dependency burden occurred: in Asia from 77.4 in 1960 to 60.5 in 1995; in Latin America from 85.9 in 1960 to 63.7 in 1995; and in Europe from 54.9 in 1960 to 49.5 in 1995. Similar significant declines can be seen in Table 4 for North America, Oceania and the former USSR. In the developed regions (Europe, North America, Oceania and the USSR), the trend towards aging of the population can be seen from a rise in the dependency ratio of the population aged 65 years or more. For instance, their ratio rose in Europe from 15.0 in 1960 to 21.1 in 1995. That in Africa was 5.6 per 100 in 1960 and 5.9 in 1995.

Progress in population and development policies in sub-Saharan Africa

Ostensibly, policies have been implemented to regulate the relationship between population and development in order to attain improved living conditions. The concern has been that the development has been somehow irregular and perhaps of limited effect. By 1974 only three sub-Saharan countries (Ghana in 1969, Kenya in 1967, and Mauritius in 1958) had adopted an explicit population policy. The number, despite the claim of growing awareness of the importance of population factors in development planning, rose only to six to include Liberia (1987), Niger (1988), and Senegal (1988).

However, in 1988 several countries, Rwanda, Sudan, Togo, Zaire and Zambia, were assessed to be drafting national population policies for national and parliamentary

consideration and adoption.¹ Another 12 countries, Benin, Botswana, Burkina Faso, Cameroon, Chad, Madagascar, Niger, Sierra Leone, Swaziland, Tanzania, Uganda and Zimbabwe, proposed the drafting of population policies (Mosley and Branick 1989).

Nevertheless, the critical question is why no progress has been made in spite of the efforts, even if limited, and indeed in spite of governmental participation and declarations at world population conferences and other politically focused meetings. For example, 44 African governments meeting in Arusha, Tanzania in 1984, preparatory to the Mexico World Population Conference in the same year, recognized the importance of population in development and adopted the Kilimanjaro Programme of Action (ECA 1992). Subsequently in 1992 and preparatory to the Cairo population conference in 1994, they also adopted the Ngor Declaration in Dakar, Senegal (ECA 1992). The follow-up to the decisions of these meetings has not been as effective as expected. They do not appear to have created a real depth of awareness among the masses of ordinary people, only among government officials who may provide political support but do so mainly in a social sphere where the desired innovations cannot reach the consciousness of the masses. A growing awareness among governmental agents is not the same as that among the people (family and social groups as well as individuals) directly affected by the application of various policy options.

Plans are supposed to spell out the details of population and development policies. There have been indications that African governments are increasingly recognizing that population growth has implications for national development (Mosley and Branick 1989). However, in African development plans the methods adopted varied a great deal from the very rudimentary to the most complex. Of the more complex, the highly recommended integrated approach which takes into account the interrelationship between population and development has not been commonly implemented.

Complex projections and models have not been easy to apply in Africa because of the prevailing weak data base and dearth of trained personnel. Some countries have barely described their demographic profile and trends, others have more seriously undertaken some macro and sector analysis, while a few have focused on demonstrating the relationship between population and selected socio-economic factors such as income distribution, education, savings, food and nutrition.

Because of these problems, African countries have been implementing policy measures which are implicit and indirect rather than explicit and direct. These measures sometimes obliquely influence population variables while explicit and direct measures have a direct bearing through well defined goals and strategies (Ohadike 1992).

Scrutiny suggests that in Africa, family planning policies designed to regulate population increase and economic growth have been given greater attention than non-family planning aspects of policy. This may be justified because the contribution of high fertility to population growth is the most critical factor affecting the pace of development. Besides, and specifically in terms of the demographic transition, fertility, by its very nature and resilience and for cultural reasons, has been more resistant than mortality to change and innovation. Births are normally welcome events but deaths though inevitable are occasions for sorrow.

The cultural drag is partly related to the very low use of contraceptives, which already has been shown to be the lowest in the world. This also has to be assessed against the apparent contradiction that 27 sub-Saharan African countries provide support for family planning services mainly for the combined reasons of promoting maternal and child health (MCH) and family health and reducing the levels of fertility and population growth, while some 15 other countries support family planning services for health reasons alone. The overall volume of

¹ In Zambia, the National Commission for Development Planning prepared in 1989 the first National Population Policy which now provides the blueprint for action by NGOs.

support agrees with the survey findings of the United Nations that between 1976 and 1989 more and more governments in Africa were beginning to perceive their fertility and population growth rates as too high (Ohadike 1992). But the successful practice of family planning is a different matter.

The policy on the control of mortality has always had the universal support of African governments and efforts in this direction, even if relatively limited, have been more successful than those in respect of fertility. Primary Health Care programs following the Alma Ata declaration in 1978 have been pursued, although with limited success. Because there have been no major improvements in the ten years after the declaration, WHO launched the Bamako Initiative. This was aimed at strengthening and decentralizing community health service delivery, and taking it, along with financial support and the element of participation, directly to where people live. The success or failure of Primary Health Care was affected by the unanticipated global economic recession which reduced the level of funding; and by the added health complications created by the sudden emergence of HIV/AIDS, the treatment of which has led to the diversion of funds from other areas of health care.

Nevertheless, PHC has led to some achievements in the promotion of health in the region. Indications are that immunization coverage increased from less than 50, to 70 per cent or more in most countries, and MCH services have improved and become more accessible. Also the program on safe motherhood initiatives has gained momentum and the services of Traditional Birth Attendants and Community Health Workers have gained some recognition (WHO 1991). The adoption of the Expanded Programme on Immunization helped to reduce maternal and child deaths while improved sanitation and environmental programs have helped to control the spread of communicable and diarrhoeal diseases. The measures have led to the fall in the level of mortality which has been augmenting the size of the African population.

Since this analysis is focused on the delayed demographic transition in Africa, attention will not be given to population and development policies affecting population movements, distribution and urbanization. However, it is necessary to re-emphasize that an explicit, integrated and multidisciplinary population and development policy should certainly deal with all facets of socio-economic and demographic interrelationships.

The effectiveness of population policies adopted in Africa was hampered by the questionable methods of implementation. This was very much related to the failure by governments to institutionalize the operation of policies to support their sustainability. Implementation involves the translation of policy ideas into action through predetermined strategies and instrumentalities for the satisfaction of basic needs, including the provision of family planning. Essentially, implementation calls for carefully co-ordinated programs of research, which were lacking in many countries.

In many instances, implementation, more than formulation, was neglected or at best poorly executed. Most policies when formulated did not allow for any detailed and serious implementation program including co-ordination. The reasons for this include inadequate infrastructure and information, as well as lack of finance and trained and devoted staff. Implementation in Africa, therefore, relied heavily on external multilateral and bilateral funding and very limited internal financial resources. Political will and commitment to the policies were also lacking as was government funding to reinforce political commitment. This partly explains why policies dating back to the 1960s such as in Kenya and Ghana have had very little effect after so many years of existence.

Co-ordination between the formulating and implementing agencies including NGOs and the private sector was weak or totally lacking as has been shown for Ghana (Omaboe 1991). The involvement of the private sector through the use of more NGO services and through social marketing by the Futures Group was long in coming and the public sector could not afford all the funding and infrastructure requirements. Also implementation of programs did

not reach all segments of the population. Rural areas and males were neglected. The people, as recipients of services, were not adequately involved or informed about the services being provided.

An aspect of the lack of procedures for implementing policies has been the absence of appropriate ways to ensure the inclusion of population variables in the planning process. For the long-term survival, effect and sustainability of programs, adequate instrumentalities are needed in many countries to ensure that program activities continue even when external support has ended. The required mechanism should be created from the start to ensure that projects are implemented as part of the overall normal development programs.

Apart from infrastructure and funding requirements, most African governments have yet to develop the professionals for integration, institutionalization and co-ordination activities. Staff for data collection and analysis have been trained in a number of institutions in and outside the continent but not enough in these vital areas, especially effective integration. Population Planning Units have been created in many countries. It is not clear how effective these are, especially when they appear to be accorded lower priority than other departments concerned with planning. Besides, the units have not usually been located in the ministries with the core responsibility for planning and co-ordinating national development programs. At this time the location and distribution of duties of units have not been equitably organized. Some countries have established population commissions; others have created units, sections or centres. The effect of these bodies has yet to be assessed.

Agenda for renewed action

Economic-demographic interrelationships are the basis of Africa's problem of underdevelopment and the retardation of the demographic transition. Buttressing the demographic and economic forces and ensuring their persistence have been the adventitious results of socio-cultural and traditional factors. The interaction of economic-demographic and socio-cultural forces has been the major correlate of deteriorating general conditions of living and worsening poverty and marginalization, despite the efforts of the national and international communities.

The analysis so far undertaken seems to support the view that Africa with its plethora of economic-demographic problems unequalled anywhere else in the world, requires quick and concerted remedies. Unless the current situation is redressed, the continent will plunge deeper into penury and so take much longer to stabilize its population and go through the demographic transition. The former Director of the WHO Regional Office for Africa, Dr Monekosso, after reciting a list of Africa's woes, concluded that Africa has the image of a continent cursed and condemned to despair (Monekosso 1994).

The situation calls for a total refocusing of demographic and socio-economic development to take sufficient account of the social aspects of development relating to the provision of basic needs including family planning. This will be a difficult task requiring some fundamental re-assessment of priorities and careful control and interpretation of the transformations associated with demographic, economic, and social innovations.

Demographic innovations, especially those affecting fertility, do not operate in isolation. The required transformation is bound by cultural, social and economic imperatives of African life. These imperatives are relevant to the ease of acceptance of change in view of the time it will take for the new behaviour patterns to be accepted and practised. This calls for prudence in introducing change or we will run the risk of either passive acceptance or total rejection. People are concerned more with satisfying immediate mundane needs than with working for long-term advantages which in the end may be more rewarding. Long-term advantages are not easy to comprehend, especially if people are badly deprived. So Africa needs greater

sensitizing to improve the well-being of its people. An agenda for revived action is called for in the demographic, economic and socio-cultural areas.

Demographic revitalization

Other things being equal, the persistent African economic-demographic crisis has been the consequence of declining mortality and high and constant (sometimes rising) fertility. The demographic transition in Africa has barely begun. The decline in mortality has been due to the health technology developed in the West; this especially has led to a slight reduction of infant deaths resulting from better hygiene and sanitation among the better informed and more enlightened mothers. There is, however, room for further significant mortality decline and governments should strive for this as well as for the commencement of fertility decline.

Mortality

Efforts to attain further significant declines in mortality in the region should be made for two main reasons. First, health improvement should continue to be used to improve well-being and survival which will in turn develop human resources and enhance productivity at all levels. Second, available evidence is that in all known transitions that attained the advanced stage, the fall in fertility was accompanied (presumably preceded) by a decline in mortality, especially infant and child mortality. This is illustrated in Table 5 for all the major regions of the world including Africa. The table shows that mortality decline during 1960-1993 was negatively correlated with the level of synthetic fertility in 1993.

Table 5
Results of regression analysis of childhood mortality decline (1960-93) and levels of fertility (1993) in countries by major regions ^a

Region	Infant Mortality			Under-five Mortality		
	B	Beta	P-value	B	Beta	P-value
Gobal	-0.067	-0.725	0.0000	-0.064	-0.690	0.0000
Africa	-0.035	-0.563	0.0001	-0.034	-0.594	0.0275
Asia	-0.037	-0.438	0.0096	-0.032	-0.378	0.0275
Latin America & Caribbean	-0.044	-0.3461	0.0307	-0.045	-0.378	0.0238
Developed countries	-0.038	-0.676	0.0001	-0.032	-0.582	0.0015

^a See Annexe for list of countries

The Latin American and Caribbean region exhibits the weakest association between decline in fertility and decline in child mortality. However, it experienced greater proportionate reduction in fertility per unit decline in either infant (4.4%) or under-five (4.8%) mortality than any other region. In the industrialized countries, there is a fairly strong association between decline in infant mortality and decline in fertility. The association between decline in under-five mortality and decline in fertility is moderate. But the proportionate decline in fertility per unit decline in either infant (3.8%) or under-five (3.2%) mortality is similar to that observed for the Asian region.

Continued reduction of mortality will also mean that the rate of population growth will be accelerated and so precipitate additional problems of socio-economic dependency and human resources development, especially in the areas of education, employment and health. But mortality reduction programs should also be accompanied by a co-ordinated fertility reduction

scheme. In this way, governments can improve health and lower mortality as well as lower fertility and attain lower rates of population growth.

Just as mortality remains relatively high in the region, so also are the majority of countries still in the early phase of the transition to good health. Epidemiological conditions indicate the prevalence of parasitic and communicable diseases as the main killers, especially when they afflict the population in epidemic proportions. Development and strengthening of preventive PHC focused on better living conditions and environmental sanitation, and especially on a clean potable water supply, should be given greater attention than hospital-based chemotherapeutic care. Experience so far with the implementation of the Alma Ata declaration and subsequently the Bamako Initiative underlines the importance of strengthening community-based action and decentralizing PHC to the village and district levels. This provides more cost-effective services and promotes general awareness that good hygiene and sanitation, food and nutrition, water supply, prenatal and MCH care including immunization and rehydration therapy, contribute greatly to reducing sickness, disabilities and death.

The enlightenment and involvement of women in particular, their education, improved status, and legal and economic independence are important factors in heightening awareness and acceptance of PHC services. Governments should continue to strengthen these programs. The role of women in the promotion of good health, especially that of children, is already recognized (Caldwell 1980, 1986). Although some progress is being made to improve the status of women in Africa, more needs to be done to articulate and strengthen women's rights and autonomy.

Two other aspects of decentralization of health services should be stressed. The first is the involvement of traditional birth attendants and community health workers whose services should be integrated into the national health delivery system. The second is promotion of a system of community financial support for health programs and for the delivery of services which will help sustain them. This has been found to be beneficial in rural areas where fees have been imposed for services rendered. While fostering a sense of belonging, responsibility and dignity in community members, it has helped to reduce over-dependence on the central government and external resources. It has also encouraged the continuity of programs and even more importantly it has helped to focus health priorities on the actual needs of the people and not just on preconceived notions and unverified hypotheses.

To move further through the epidemiological transition, African countries should strengthen PHC strategies for all by intensifying social and political action. They should empower the people, particularly women, by providing information, education and communication (IEC) on PHC matters. Health personnel should be better educated and trained to cope with decentralization of services to the villages and districts and the cultural adaptations required. Finally the decentralization and creation of local health centres means reducing the work load imposed on hospitals which should no longer provide PHC but should serve more as referral points to handle complicated cases that local community-based centres may be ill-equipped to handle (Ebin 1994).

Fertility and family planning

The analysis so far has underlined the fact that population places a burden on the resources for the provision of services. It has also shown that to avoid growth due to mortality decline placing a burden on the provision of services, mortality control programs should include fertility regulation. The way to this is through family planning, the practice of which is very low in Africa, indeed the lowest of all the major world regions. The relative absence of family planning has been associated with a high incidence of abortion and unnecessary childbirth

especially among adolescents. Experience in other parts of the world shows that the incidence of abortion is lowest in populations where family planning is widely and effectively practised (UN 1989:26). African countries can take advantage of this and promote greater use of family planning.

A major move in this direction will be to democratize the provision of family planning as a basic need of the population. It should be available to all sections of society especially the largely marginalized groups in the rural areas. Other groups such as males, adolescents and young people who were neglected in the past should be included. The point is not only to increase access but also to improve the quality of family planning services and to offer a wide range of methods so that users have freedom of choice.

To continue to create and strengthen awareness and knowledge of family planning, information through IEC programs should be available to all segments of the population, especially those in rural areas where most of Africa's population lives. Family planning services and information reinforce each other and should be provided together and given equal attention.

Government support, financial, human and material, should be total and make it possible to provide services, essentially from local resources, to all sections of the country. External funding and support are vital and should be pursued but only if it is accepted that such external support supplements the internal support generated by African governments.

As in the case for lowering mortality, the empowerment of women through an all-round support of development programs which enhance their status and reduce the gender gap should be addressed by all governments to promote family planning and lower fertility. Special efforts should be made to facilitate the education and employment of women as well as enabling them to have legal rights to their bodies, land and family property.

The environment in which people live has implications for the promotion of family planning. Socio-cultural forces are as important as socio-economic factors in determining behaviour. In particular, in controlling fertility through family planning consideration needs to be given to ways of dealing with those social and cultural forces which support high fertility in African societies.

Governments should support policy-oriented information gathering, social research, and anthropological studies on the cultural and traditional determinants of fertility behaviour and response to innovations. The results of such investigations should be widely disseminated among relevant users. In addition, support is needed for research into the delivery of family planning services. This would include collection and analysis of data on acceptance and continuation rates, characteristics of participants and methods used. Evaluation of programs, their management and effectiveness would also be necessary.

Existing family planning programs have been poorly managed and this partly accounts for their limited expansion and effect. There is, therefore, the need to install an innovative and effective system of program management in general. Better management will be reflected in the quality of vital routine activities and the development of all forms of available resources. Good management depends very much on the establishment right from the start of sound institutional machinery for a plan of implementation, including monitoring and evaluation. The feedback and results of monitoring and evaluation would be used to redesign the existing program and to carry out further evaluation which should be continuous. Innovative IEC methods for public information campaigns should also be used.

The successful execution of all these activities is contingent on maintaining systematic record-keeping that permits periodic analysis of information to assess the evolution of the program and correct any errors to ensure its continuity. As argued elsewhere, it is vital to install a strategic management system with checks and balances to deal with daily family

planning implementation and to anticipate and handle future contingencies (Ohadike and Adansi 1989).

A viable co-ordination system is an important part of good management of family planning programs. Such co-ordination will be useful in promoting judicious and economical use of resources, and in fostering greater harmony and understanding among donor agencies and operators. To enhance program effectiveness, there should be a clear-cut delineation of areas of responsibility among concerned ministries, organizations and agents to eliminate wasteful competition, duplication and waste of resources. The gap between the formulation of family planning programs and their implementation should be bridged as part of the required process of co-ordination which should again be backed by cultivated professionals not only in family planning but also in general population and development policies.

The creation and strengthening of machinery for overall population policy development, of which family planning is a major factor, can speed up the demographic transition. Such an institutional mechanism should be created from the start and made to work, backed by adequate political will and commitment, and by provision of human, financial and material resources from the national budget. External support by donors should only supplement or complement national effort and should be properly used and accounted for. The machinery should be part of the larger system for total national development of all sectors, and should be sited in or within reach of the national agency or ministry responsible for national development planning.

Socio-economic renewal

The sluggishness of the demographic transition and the associated population and development problems have to be addressed and possibly resolved also through socio-economic changes.

Despite the persistence of a hostile economic environment, African governments should rededicate themselves to sustainable and self-reliant development with less dependence on external aid. If they receive aid, it should be genuine and disinterested, and should be such as to help the country to become more self-reliant. In this respect, all governments should exclude luxuries and work for the social survival of their people through sustainability and self-reliance in the provision of essential basic needs such as education, health, housing, employment and transport. As Speth (1994) notes, 'enduring declines in fertility can only be achieved in the context of high levels of sustainable human development'.

To achieve auto-centred development and sustainability, the level of production of wealth and income has to increase internally to reduce dependence on external sources, donor agencies and benevolent countries. This is the only avenue to self-sufficiency especially in the provision of basic needs.

Reiterating the view espoused in the 1974 Bucharest Conference World Population Plan of Action, the Mexico Conference recommendations in 1984 urged all governments to adopt the integrated planning approach in the formulation of development strategies. This approach, though complex, is still valid and should be used. Government should institutionalize integration through creating units for the formulation of policies. Such units should help with preparing data and information for use in planning. Staff should be instructed on the meaning and implications of integration and should be armed with the appropriate methods to achieve it.

Of all the basic needs, none gives a more sombre image of a dying Africa than the shortage of adequate food. Newspaper stories of Africans dying from drought-induced famine in particular, are common. The occurrence has been cyclical since 1974. Although concerned humanity has admirably rallied to salvage the desperate situation, food insecurity is basically an African problem. The main solution lies in augmenting productivity and production of

staple foods, not cash crops. Rainfed agriculture should be complemented with cultivation based on irrigation and small dams. Wars have hampered agricultural production. Hence countries at war should intensify efforts to restore peace and undertake relief and rehabilitation measures. Immediate danger from starvation in times of scarcity can be arrested by governments installing food security and storage systems. The ultimate goal of international assistance should be to help African countries to achieve self-sufficiency in food production.

Investment in human resources through education invariably enhances economic productivity and hastens the demographic transition by reducing fertility in particular. African governments should therefore invest in the education of their people, male and female alike. In fact, in terms of the demographic transition, greater educational opportunities should be created for girls and women who should also be accorded greater access to jobs and property ownership especially in the traditional setting. Additionally, investment in education for all contributes to reducing preference for large families and for sons over daughters. Education enhances child survival which in the long run contributes to lower fertility in that families forgo having extra children to compensate for possible child deaths. Also providing more education to women helps to raise the age of marriage and the average age of first childbirth, both of which can lower fertility.

For the above and other reasons women's education and participation in the labour force should be vigorously promoted. This should be accompanied by actual elimination of measures in law, tradition and practice which discriminate against women. Countries that have yet to accede to the Convention on the Elimination of All Forms of Discrimination against Women should do so.

The prevalent heavy debt burden which unfortunately is a hindrance to economic development is an affront to the debtors as well as the creditors. Apart from the dead weight imposed by the volume of debt, the interest payments, representing a significant drain of resources from Africa to the rich countries, amounts to over one-third of the already meagre total export earnings of the debtor African countries. Even so, this high proportion does nothing to reduce the total volume of debts which, over the years, has been increasing. African countries should however continue to acknowledge their responsibilities to creditors. They should make efforts to manage their economies more prudently for enhanced productivity in a climate of stability, rule of law, democracy, and respect for both majority and minority rights. In return, the international community should show greater understanding and co-operation to achieve a speedy resolution of the debt burden in general.

In dealing with population, resources and environment, it is important to bear in mind that patterns of consumption of natural and man-made resources affect the environment. African governments are urged to take cognizance of this especially as their large population size leads to depletion of resources, notable deforestation and loss of biodiversity in tropical forests. Sustainable and environmentally sound development is particularly relevant in the large capital cities, which as a result of overcrowding and the breakdown of municipal support services have problems of inadequate sanitation. In some streets there are mountains of domestic household wastes which no one removes.

There is now a deep-seated yearning all over Africa for peace and political stability without which development will be dead as it is in Angola, Rwanda, Burundi, Liberia, Sierra Leone, and Somalia. The need for peace was recently underscored when the African Regional Conference on Women and Development meeting of over 5000 delegates in Dakar from 13 to 23 November 1994 adopted a resolution calling for security and peace to reign and for all warring army factions, OAU, UN, and African governments to work for peace and protection for refugees, women and children.

The position taken by the women at the meeting stresses the need for peace and security in the continent. It is incumbent on African leaders to solve problems arising out of political, social, religious or ethnic differences by dialogue rather than confrontation. Leaders should practise good governance, tolerance and accommodation. They should be accountable and transparent and should eschew all forms of discrimination against any group. A peaceful environment for development will exist if these conditions prevail.

Conclusion

Africa today has great untapped resources but a large proportion of its population suffers from despondency, poverty and deprivation. For the last 35 years or so, despite the volume of assistance from the international community, African countries have not been successful in curing the malaise. This paralysis constitutes the major conundrum of African development. There has been a total evaporation of the development successes of the 1960s and 1970s and a marked decline thereafter, in a world that has been increasingly experiencing unprecedented expansion of wealth. The growing contrast between prosperity in the rich world and misery in Africa south of the Sahara and other developing areas is unhealthy for global survival.

Given that most favourable conditions in the continent are in a state of flux, another riddle is to ascertain if and when Africa in contrast to other developing countries, can possibly attain an advanced stage in the demographic transition. In this respect, it is highly desirable to have a better understanding of why previous population and development policy efforts have yielded no more encouraging results than recorded so far. The continent, through national activities, has participated in the global efforts through conferences, training, funding, IEC activities, planning and development, and yet the transition, both demographic and epidemiological, has been delayed.

Still another riddle is founded on a rather simplistic expectation of the elimination of poverty and inequality in international economic relations through the rich solving the problems of the poor. It is an ethical view, but benevolence is not part of the rationalism of economics. It will take acceptance of the seriousness of these problems for there to be a realization that humanity must sink or swim together. It is now really a matter of altruism and discernment, for the laws of economics appear to have been dead long ago in Africa.

To implement UNDP views on international responsibility and co-operation, Africa will still have to find funds in order to co-operate as required, for example, by the 20:20 proposal for cost sharing in promoting human development. The implementation of the proposal belongs to the future and requires a lot of goodwill, understanding and sacrifice on the part of donors. So far only a handful of rich countries have been able to answer the international call to make available 0.7 per cent of their gross domestic product for overseas development assistance. It is therefore obvious that African development is an extremely difficult problem. For the moment it is a conundrum.

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Annexe**Synthetic Index of Fertility Levels of Countries by Major Regions**

Synthetic Index of Fertility	Countries by Major Regions
(a) AFRICAN COUNTRIES	
1 - 4	Mauritius, Tunis
4 - 5	Lesotho, Algeria, Egypt, Morocco, South Africa
5 - 6	Botswana, Cameroon, Gabon, Ghana, Guinea Bissau, Eritrea, Chad, Zimbabwe
6+	Niger, Angola, Sierra Leone, Mozambique, Guinea, Malawi, Liberia, Mali, Somalia, Ethiopia, Zambia, Mauritania, Nigeria, Zaire, Uganda, Burundi, Central African Republic, Burkina Faso, Tanzania, Madagascar, Benin, Rwanda, Togo, Sudan, Ivory Coast, Congo, Libya, Kenya, Namibia
(b) ASIAN COUNTRIES	
1 - 3	China, Thailand, North Korea, Sri Lanka, South Korea, Israel, Hong Kong, Japan, Singapore
3 - 4	India, Indonesia, Philippines, Vietnam, Malaysia, Lebanon, Kuwait
4 - 5	Cambodia, Bangladesh, Myanmar, Mongolia, Papua New Guinea, United Arab Emirate
5 - 6	Bhutan, Iran, Irak, Jordan
6+	Afghanistan, Laos, Pakistan, Nepal, Yemen, Oman, Syria, Saudi Arabia
(c) LATIN AMERICAN AND CARIBBEAN COUNTRIES	
1 - 4	Brazil, Peru, Equador, Dominican Republic, Mexico, Argentina, Venezuela, Trinidad and Tobago, Uruguay, Panama, Colombia, Chile, Costa Rica, Jamaica, Cuba
4 - 5	El Salvador, Honduras, Paraguay, Haiti, Bolivia
5 - 6	Guatemala, Nigaragua
(d) DEVELOPED COUNTRIES	
1 - 2	Ex-Yugoslavia, Bulgaria, Hungary, Portugal, Greece, Belgium, Spain, France, Australia, Canada, Switzerland, United Kingdom, Austria, Netherlands, Germany, Denmark, Finland, Italy
2 - 3	Albania, Rumania, Poland, U.S.A., New Zealand, Ireland, Sweden
3 - 4	Turkey

Source: UNICEF 1995:74-75