AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE

UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone 517 700 Fax : 517844

EXECUTIVE COUNCIL
Fifth Ordinary Session
23 June – 3 July 2004
Addis Ababa, ETHIOPIA

EX.CL/113(V)a
Original: English

THE STATE OF AFRICA'S POPULATION REPORT-2004

THEME: *POPULATION AND THE POVERTY CHALLENGE*

THE STATE OF AFRICA'S POPULATION REPORT-2004

THEME: POPULATION AND THE POVERTY CHALLENGE

INTRODUCTION

1. The African socio-economic situation has been deteriorating, while the population phenomenon of the continent is characterized by extreme demographic trends. In general, African countries are characterized by high fertility rates as well as high but declining mortality rates; high population growth rates, a high and increasing proportion of the youth and disproportionate spatial distribution. Other population phenomena include high levels reproductive health and migration on displacement of persons, and rapid urbanization.

2. Rapid population growth rates, inadequate access to health and educational services, persistent gender inequality, and violence have contributed to deepening poverty in the continent. This has been compounded by the burden of disease; especially HIV/AIDS and other pandemics, globalisation, unfair international trade policies, inadequate capital and slow technological progress. Well aware of these immense challenges African Leaders collectively decided to intervene in establishing the African Union to spearhead Africa's renaissance in the 21st Century.

3. The African Union is a unique body, which has a comparative advantage over other institutions in the continent. As a regional, socio-economic and political body, the AU has considerable potential to play a greater advocacy role in population and development matters, thereby filling the gap which has existed for many years and by laying the ground not only for implementing Plans/Programmes of Action, but also monitoring and evaluating activities to which AU Member States are signatory. The current African leadership has begun, with a new vigor, to grapple with challenges of war and peace, violence, racism, respect for human dignity, human rights, poverty and freedom from want. Thus, the African dream has been revived at the dawn of the new millennium. Through a most significant initiative, the African Union (AU) and its regional programme framework, the New Partnership for African Development (NEPAD), have emerged as the new path, aiming to achieve greater unity and solidarity among African countries and the peoples of Africa.

4. In this context and because national development is about people the logical questions of development should centre on population issues. For instance issues that need to be addressed revolve around such questions as: whether the size and rate of growth of a country's population is consistent

with relation to the natural resources and the trend in the growth of basic socio-economic sectors including the standard of living. Given the current population growth rates, it is important to know whether the prevailing levels of fertility, mortality and distribution of population are desirable; and whether characteristics of the population are consistent with relation to developments in education, health services, shelter, employment, labor force manpower mix, etc.

5. At the level of regional groupings, the AU will work with the Regional Economic Communities (RECs) to evolve a coordinated and integrated population policies and programmes, which would address critical population issues that transcend national boundaries. These include reproductive health, labour migration, refugees and displaced persons conflicts, natural calamities, environmental degradation, and control of HIV/AIDS.

6. To respond to this concern the African Union in collaboration with UNFPA undertook to prepare Report on the State of Africa's Population with a theme: "Population and the Poverty Challenge". The Report reflects various population aspects in relation to poverty. The Executive Summary which follows, gives general review of the content of the main document which is also available. The Report of the State of Africa's Population 2004 is submitted for information and to be utilized by policy-makers and implementers as reference

EXECUTIVE SUMMARY

On the tenth anniversary of the International Conference on Population and Development (ICPD), the Commission of the African Union reviewed issues relating to Africa's thorniest population and development problems including the impact of population issues on poverty and the HIV/AIDS epidemic, the high levels of infant and maternal morbidity and mortality, the implications of Africa's huge youthful population, and the much talked about and mostly neglected gender factor. The message of the report is that population and development, after all, are about people. Despite decades of debates, decisions and declarations to address these problems, the people of this continent – famed for its strong family ties, community solidarity and traditional hospitality – are being engulfed by them. A common underlying factor in all the problems is the persistent underestimation of the importance of strong reproductive health policies, programmes and services. As a result, families and communities are torn asunder, poverty mires half the population, young people are without direction, far too many women and their infants and small children are allowed to die every year, and earlier progress is being relentlessly eroded. There are some embers of hope to be found in the data and the examples of initiatives that work, favourable policy frameworks in many areas, new structures and mechanisms for moving beyond simply coping to real progress, and a renewed determination by African leaders to rebuild traditional strengths even as they embark on new paths. These embers need to be fanned to full blaze, with proper resource allocations, so that Africa and its people can take their rightful place in the world. In short, it is high time to back the regional and international consensus regarding population and development in Africa with the strongest possible action.

Population Dynamics and Sustainable Development in Africa

The notion of development hinges not only on economic growth, on developments in infrastructure and advances in technology, but also on the continued progress of human capital and its effective use. In other words, economic growth alone is not enough unless it is coupled with social development efforts particularly those directed at the specific needs of the poor. Thus, in essence *sustainable development* is a people centred concept that involves increasing production and consumption without compromising the needs of future generations, enhancing education, health and citizenship rights; reducing inequality; appropriately upgrading and conserving the capital stock including the environment; advancing knowledge; and building durable and efficient institutions. Given the unavoidable linkages between people and development, it is critical to factor population issues into development policies, planning and programmes. The success of national and international efforts will be judged on the extent to which development outcomes enable people to lead fuller and richer lives while safeguarding the future for generations to come.

Population Dynamics

Fertility, mortality and migration form the main set of determinants of population dynamics and influence changes in population age structures. Population density is the second major issue. In mid 2002, Africa's population was estimated at 840 million, constituting 14% of the world population and expected to exceed 1.2 billion by 2025. In terms of density, Africa's overall 28 persons per square kilometre is second only to Asia. High population densities combined with high population growth causes imbalances in land carrying capacity, resulting in pollution of air and water mainly from production process; land degradation and soil erosion; loss of biodiversity; and deforestation. This becomes a major concern when looking at arable land densities.

Age Structure. Africa's population is young, with persons under 15 years constituting 42% of the population in 2000. The working age group, 15–60 years, form about 53.2% of the total, while those 60 years and above make up only about 5%. This gives a median age of 18.4 years, substantially below the corresponding figures for developed and developing countries at 37.4 and 24.3 years, respectively. As populations around the world are tending to age, however, it is estimated that the median age for Africa will increase to 27.4 years by 2050, when those under 15 years will have declined to 28% and the proportion of the elderly will reach 10%. The huge numbers of the very young translate into high dependency ratios, which represent major challenges and responsibilities for families as well as governments in the region. The future impact of high child dependency rates is that there will be little or no savings left for future development, while current and future implications are heavy demands on health, education and employment.

Fertility Levels and Trends. Between 1995 and 2000, the total fertility rate stood at 5.27 children per woman for the region as a whole, which is the highest rate in the world, far exceeding the level of 2.2 children required to replace the population. The implication of high fertility for women is quite serious. First, each pregnancy carries a life-threatening risk for the mother. Second, high fertility often denies women the opportunity to develop their fullest potential and thus be effective participants in the development process. Third, it increases the burden particularly of poor women as family caretakers.

Mortality. Mortality in Africa is also the highest in the world, with a crude death rate (CDR) estimated at 14 per 1,000 (1995–2000); 11 countries in the region had CDRs of 20 and above in 2002. This is due to poor living conditions in the region and prevailing ill health because of infectious and communicable diseases, and more recently the impact of the HIV epidemic. Africa's estimated infant mortality rate (IMR) was 91 per 1,000 live births for the period 1995–2000, and 86 for 2002. Only nine countries had infant mortality rates of 50 and under per 1,000 in 2002. Under-five mortality

rates are still generally very high in Africa, despite being cut in half from 256 to 175 deaths per 1,000 live births between 1960 and 1995. High infant mortality results mainly from inadequate quality of maternal/child care, particularly pre- and post-natal care, including lack of early reporting, malnutrition, and mother-to-child HIV transmission. In terms of maternal mortality, women's lifetime risk of maternal death stands at 1 in 16 for Africa compared with 1 in 110 for Asia, 1 in 160 for Latin America and 1 to 3,500 for North America. Yet maternal mortality and morbidity are preventable through universal access to reproductive health care, including family planning, pre- and post-natal care, and emergency obstetric care.

Life Expectancy. During 1950–2000, *life expectancy at birth* for both sexes ranged from 38 to 51 years in Africa, 41 to 66 years in Asia, and 47 to 65 years in the world. The estimate for Africa for 2002 was 53 years for both sexes. Life expectancy indicators for 1993–2003 show that appreciable increases occurred in Libya, Egypt, Morocco, Tunisia and Benin; substantial declines occurred in Botswana, Lesotho, Namibia, South Africa and Swaziland, likely related to high HIV prevalence.

Migration. Migration has always been a major socio-economic issue in Africa and remains inseparable from African ways of life. A recent phenomenon is the feminization of migrants: Women currently make up half of Africa's migrants, suggesting that traditional social roles have been modified considerably. Among the pertinent migration issues are refugee crises, smuggling of migrant workers and human trafficking**,** which are considered irregular migration. An important sub-set of labour related migration is the "brain drain", involving the emigration of highly skilled persons. Reversal of brain drain is a sectoral priority, and the New Partnership for Africa's Development (NEPAD) has proposed policy measures to mitigate its effect on national economies. All the same, identifying ways to maximize the developmental effects of remittances sent home by those working outside**,** as well as improving remittance transfer mechanisms, is of growing importance in Africa.

Urbanization. Africa has the world's fastest growing urban population, an annual average of 4% over 1995–2000. Currently, 38% of the total population in Africa lives in cities, and by 2030 the proportion is expected to reach 53%. Further, 60.9% of urban populations resided in slums in 2001. Over the next two decades 87% of population growth in Africa will take place in urban areas.

Poverty and Sustainable Development

As is universally acknowledged, half of Africa's people live below the poverty line. The majority of rural people and 41% of urban residents in Africa live in poverty, with inadequate capacity to meet basic needs such as food, housing, education and health. This pervasive poverty is the human face of Africa's failure to generate sustainable development, a process that involves

self-sustaining economic growth, technological change, modernization of institutions, and changes in **attitudes** and values. Besides inadequate capacity to deliver economic growth and painfully slow social development, the main socio-economic issues here include environmental degradation, inadequate investment in human resources development, low agricultural production, food insecurity and the prevailing unequal opportunity for women.

Almost every study, undertaken for whatever type of population and level of disaggregation, shows that the poorest households tend to have the largest number of children. Families with high child/adult ratios are more likely to be poor and unable to afford the required social investment in children. Given a real choice, individual families would choose to have smaller families than their parents did. Health status is another important outcome of, and key input into, sustainable development. Returns to investment on women's education and health are significantly greater than those for men. This is because of the strong interaction among factors such as women's schooling, health, nutritional status and fertility, on one hand, and the synergetic effect of this combination of factors on Africa's future education, health and productivity, on the other.

The Demographic and Socio-Economic Impact of HIV/AIDS in Africa

HIV/AIDS is of vital importance across a spectrum of issues including development, security, food production and life expectancy. AIDS is a development challenge, perhaps the single most important obstacle to social and economic development in sub-Saharan Africa.

Demographic Impact. One pernicious characteristic of HIV/AIDS is that it shrinks life expectancy drastically and greatly influences human demographics. The numbers are well known. Since the epidemic began, some 15 million Africans have died out of the global total of approximately 21.8 million. AIDS has reduced average life expectancy in 11 African countries to 47 years, down from 62 without AIDS. The United Nations Population Division projects the 2015 populations of the 35 most affected African countries to be less by 10% than they would have been without HIV/AIDS. Owing to the large proportion of deaths amongst the youth, and the high vertical transmission (around 30%), the age structure in the most affected countries is expected to change. The typical population pyramid with its wide base of young people tapering gradually to a smaller group of elderly is being transformed to a shrunken base topped by a relatively narrow "chimney" due to lower fertility and high mortality. The implication is a significant reduction of potential future productive capacity.

Socio-economic Impact. HIV/AIDS has impoverished already poor families who lose income earning and yet have to bear expenses for

medical care, expensive funeral costs and support of children left behind. It has left children of ailing parents with increased responsibility for contributing to the household's survival at the expense of their education. The emotional drain of repeated loss of friends and loved ones takes a major psychic toll. Young girls at home bear most of the care-giving burden at the expense of their education and self-promotion, which will negatively affect the prospects for mainstreaming gender into development. Other consequences include increased numbers of women- and child-headed households, and a situation of neglect or abuse of fostered orphans. Grandparents may have to shoulder parental responsibilities, which results in further deterioration in the quality of life of the already poor. The economic impact of the pandemic is manifested in all sectors, including education, health, labour and agriculture. It has affected national budgets and poverty eradication efforts, and may reduce annual per capita economic growth by 1 to 2% in the hardest hit African countries. By 2010, the per capita GDP in some of these countries may drop by 8%, and per capita consumption even more. Pressure on national spending is likely to increase as a result of HIV/AIDS, while national revenues are likely to fall as economies decline. The quality and efficiency of the education and health systems are adversely affected because of increasing morbidity and mortality among infected teachers and health professionals. As AIDS largely affects people in economically productive age groups – 25–45 years of age – it adversely affects the size and productivity of the workforce. The most affected age groups are 20–29 for women and 30–39 for men. The majority of people dying from AIDS are in the prime of their working life. Death is only the ultimate loss. They usually become unproductive for a long time, owing to multiple illnesses, before actually dying. Most deaths occur among the most skilled and experienced workers, whether in blue- or white-collar jobs.

Reproductive Health and HIV/AIDS: Implications and Choices

The relationship between economics and ill health is complex. The main effect on economics is through equity in income distribution and the corresponding poverty reduction. Four factors are of unremitting importance in mortality reduction: income growth, improvement in medical technology, basic education and access to public health services, with important synergies among them. For maternal mortality specifically, one study observes that the relatively high rates in much of the developing world are a consequence of *continued neglect of women's reproductive health*, coupled with a legacy of ineffective programme interventions. Of the 529,000 maternal deaths worldwide, 240,000 (45%) were in SSA. Maternal mortality is less than half the picture because for each mother who dies, more than 20 develop – sometimes severe – maternity-related disabilities.

Status of Reproductive Health

In the African context, pregnancy and childbirth involve significant health risks even for women with no pre-existing health problems. Up to 40% of pregnant women experience pregnancy-related health problems and 15% suffer long-term and life threatening complications. Maternal health problems account for over 2% of the global burden of disease, and almost 3.5% in sub-Saharan Africa (SSA). This does not have to be so. Under optimum conditions, fewer than 10 per 1,000 pregnancies have any problem and, as experience in industrialized countries shows, very few women die.

The economic and social impact of high maternal mortality and morbidity – the cost of neglect – is high. Maternal mortality is a tragic loss occurring at the prime of life and having multiple ramifications. It means the breakdown of the family and loss of a productive force for the community. It means not only the death of the mother, however tragic and unnecessary, it endangers the whole family, children in particular. Yet however tragic maternal death may be, reproductive health does not command the priority attention it merits because it is perceived essentially as a "woman's problem". There are rays of hope. The political and socio-economic context seems to be improving; clear commitments to prioritize reproductive health and HIV/AIDS interventions are emerging. However, if investment and implementation levels are any indication, the commitments are not yet at par with the urgency of these issues.

Some studies of the benefits of reproductive health services indicate that in a typical high-mortality, high-fertility African country, the cost of averting a single unintended birth through family planning is $380, while the estimated saving for government would be $440. Several studies show that every dollar invested in family planning saves $9–32 in different contexts of mortality and fertility and cost per user falls as programmes mature. The cost of averting maternal mortality and morbidity and peri-natal mortality is estimated at $140, while the benefits, though difficult to quantify, are multi-fold. The contributions of improved reproductive health to overall development are high, working through reduction of maternal and child mortality and morbidity, reduced fertility, enhanced contribution to the labour force, and general well-being and quality of life of the family, community and nation.

Complications of unsafe abortion are a major public health problem in Africa. WHO estimates that there are about 5 million unsafe abortions per year in Africa, and this result in 34,000 deaths. As abortion is illegal in nearly all-African countries, almost all induced abortions are done under unsafe conditions, which result in high rate of complications. Safe abortion, in all circumstances where the law allows it, saves a lot of lives. Effective post-abortion care (PAC) maternal mortality by as much as one-fifth in many low-income countries.

Underlying Factors High Maternal Morbidity and Mortality

Access to and use of health services have important implications for reproductive health. However, access to quality health services is limited in most of African countries and utilization of these services is even lower. Among the major factors that contribute to high maternal morbidity and mortality in Africa, include:

- Lack of quality health services and particularly essential and emergency obstetric care –

- Lack of adequate information (which often cases late reporting for ante-natal care) and the capacity and willingness to use and pay for health care.

- Underdevelopment and poverty go beyond low income and limited access to social services to embrace social inferiority, physical weakness, vulnerability, powerlessness and humiliation – all factors that have wide ranging impact on reproductive health.

- Early marriage. risky – pregnancy, premature childbearing, high parity and domestic violence (In Africa an estimated 86,000 women died from intentional injuries in 2000 - The victims are often too young or weak to protect themselves or are kept silent by social conventions or pressure).

- Female genital mutilation (FGM), which is still practiced in 28 countries across sub-Saharan Africa from east to west and concentrated along the Nile Valley, negatively affects women's sexuality and leads to several complications.

Reproductive Health Interventions That Work: Lessons from Africa

Even at the dawn of the 21st century it is not uncommon for women in Africa, when about to give birth, to bid their children farewell. What needs to be done to bring hope and smiles to African mothers is well known: avoid the unwanted/unplanned or too close pregnancy, ensure availability of emergency obstetric care (EOC) with functional referral systems, and take measures to reduce the three delays (delay in deciding to seek appropriate care, in reaching the appropriate facility and in receiving adequate care at the facility). While most complications of pregnancy, labour and delivery cannot be predicted or prevented, they can be treated by skilled EOC. And more women will survive.

Two areas are critical to the reduction of RH-related mortality and morbidity in Africa. The first is ensuring skilled attendance at all levels of health services along with the essential supplies, equipment and infrastructure for maternal and newborn care. The second is

strengthening individual, family and community capacity to improve maternal and newborn health, including outreach from health facility to communities and households, and institutionalizing birth preparedness at community level.

Family planning services comprise another major area. Family planning reduces fertility and hence the lifetime risk of maternal death. Moreover, the use of family planning is liberating and empowering to women and consequently has an important impact on the development of the family and the wider community. African governments have recognized the importance of providing the widest possible range of contraceptive methods. There is need to improve choices through a more balanced mix and for promoting greater acceptance of barrier or dual methods in view of the high prevalence of STI, particularly HIV/AIDS, in Africa. Male participation in the use of preventive methods.

The cost of inaction is high. It is estimated that if reproductive health issues are not addressed effectively, there will be 2.5 million maternal deaths, 7.5 million child deaths and 49 million maternal disabilities in the next ten years in Africa. But even so there is reason for hope. Reproductive health problems are amenable to practical, proven solutions. Most of these have been well articulated in Africa. The estimated annual cost for services (circa 1990) in low-income countries was $90 per case for prenatal and delivery care, $12 for family planning, and $11 for STI. What is required is improved leadership and scaling up successful interventions.

HIV/AIDS

Already at epidemic levels (prevalence of greater than 5%) in over 22 African countries, HIV/AIDS is now the leading cause of death in SSA. Every year there are about 3 million new infections, ominous because the majority of newly infected are adults/youth below 25 years. As is well known, the magnitude and impact of the pandemic is startling particularly in Southern Africa, which is the hardest hit part of the continent; but HIV/AIDS has been progressing in other parts of Africa as well. More females (higher vulnerability) than males are infected (110 to 100 in Africa). The ages of highest prevalence are young men (20–54 years old), women of reproductive age (15–49) and children under five years old**.**

TB is the most important HIV-related disease in resource poor countries. Once the biggest killer of Africans, TB had been brought under control through massive treatment and immunization in the 1970s and 1980s, but has come back with vengeance fuelled by the HIV/AIDS epidemic. Those with immune systems weakened by HIV/AIDS are particularly affected since dormant cases gain expression. The emergence of drug resistant strains is another feature of the resurgence.

The health sector is under siege due to the pandemic, caught between increasing demand for services, and reduced capacity to deliver because of ill health and disease among service providers infected by HIV. In some African countries, HIV/AIDS-related patients occupy more than 50% of beds. Significantly, the increased demand is from younger people who are not normally users of health care. The effects on morale are particularly marked in the health sector, as workloads escalate and stress increases, fuelled by high mortality in children, young adults and colleagues.

The impact of AIDS on education is particularly deep because education is person-intensive. Estimates show that because of HIV/AIDS by the end of the first decade of the twenty-first century there will be fewer children at the primary level by 12–24% in a range of countries in eastern and southern Africa. Some studies show that the level of HIV infection in teachers is higher than in other groups of populations, with some countries losing as many as half of those trained per year.

Threats to the family take several forms, both economic and psychosocial. In Tanzania, a single case of HIV infection cost $2,462–$5,316 (1985 dollars) for treatment and forgone productivity. Coupled with the pre-existing low income and slow growth, the outcome of HIV infection for these households is a further plunge into poverty. This is compounded by the fact that those who die of AIDS are mostly young adults on whom children and the elderly depend, leaving children or grandparents to head the households. In 2000, SSA had 18 million children below 15 years old who were orphans – 70% because of HIV/AIDS. The number is expected to reach 24 million by 2010. The care of these children often falls on the extended family, overstretching their limited and declining resources.

Transmission

HIV/AIDS is a core component of sexual and reproductive health and most transmission of HIV in Africa is through heterosexual sex. Yet, sexuality in Africa, as in most societies, is a taboo subject. There is almost no discussion of sex between parents and children (youth) even in this age of HIV/AIDS, between sexual partners, or among peer groups even in a university setting. The ramifications of the traditional low status of women are such that discussion in an atmosphere of mutual exchange of information – much less any type of negotiation about any aspects such as condom use – is almost impossible.

Patterns of sexual behaviour are determined by complex factors not only of individual morality, personal choice and private decision about risk, but a range of societal factors as well. Though interactions and linkages are not always clear, it is well documented that multiple sexual partners, sex with commercial sex workers and a history of sexually transmitted infections

(STI) constitute high risk factors for sexual transmission. The other major modes of transmission in Africa include blood transfusion, poor quality health services (syringe reuse, lapses in universal precaution, etc.), intravenous drug use – growing in urban areas – and homosexuality. Mother-to-child transmission (MTCT) accounts for 90% of the infection in children, affecting 30–40% of children born to HIV-positive mothers.

Lessons Learnt

Leadership. The role of leadership at all levels, and the importance of political commitment at the highest level, has been amply demonstrated by the success stories of the last decade, for example Uganda. African leaders pledged in the Abuja Declaration to provide direct leadership and established the AIDS Watch Africa Group, made up of heads of states, to follow up this and other commitments. Many leaders are initiating policies, leading councils, speaking out forcefully and often. The commitment and role of religious/spiritual leaders and community leaders is also paramount.

Advocacy and Behaviour Change Communication (BCC). These play an important, crosscutting role in interventions against HIV/AIDS. There are also good examples of appropriate messages and methods of BCC (e.g., peer education among the youth) that have achieved behavioural change. These include efforts to promote safer sex and less risky behaviours, including abstinence, reduction in the number of partners, consistent and correct use of condoms, and avoidance of injectable drug use. Involvement of people living with HIV/AIDS (PLWHAs) has clearly improved the success of interventions even though it is hampered by high levels of denial, fear, rejection and stigmatization. Many African countries have well-established associations of PLWHAs and Greater Involvement of People Living or Affected by HIV/AIDS (GIPA) does commendable work on the international scene.

Prevention, Care and Treatment. Sustainable prevention requires major advances towards sustainable development, reduction of poverty and empowerment of women. Improved understanding and communication methods, among the youth in particular, are starting to bear fruit. The challenge is to adapt them to local circumstances and give correct, appropriate and relevant information. Strengthening voluntary counselling and testing (VCT) should be given due attention African leaders recognize a clear moral obligation to provide whatever care, support and assistance is appropriate or
feasible for individuals infected with or affected by HIV/AIDS, just as for any other disease. Lack or inadequate treatment of HIV-related and opportunistic infections is a major cause of suffering, of early evolution from HIV to AIDS and early death. The benefits of care include the reduction of suffering, the improvement of the quality of life of the individual and society at large, and the likelihood of prolonged economic and social productive activity. The care issue must be seen as multi-sectoral. While the health sector may play a lead role, the participation of all stakeholders at all stages

of the disease and across the continuum of care is important. Community-based and home-based activities are crucial. Involvement of traditional medicine practitioners has proved useful in many communities and could help mitigate some harmful practices (FGM, uvula cutting, scarification, etc.).

Treatment with highly active anti-retroviral therapy (HAART) has changed the face of HIV/AIDS, dramatically improving the survival and quality of life of PLWHAs. All the same, treatment is complex and the drugs are expensive despite dramatic decreases. Generic drugs are available for as low as $350 per year (2002) instead of $10,000 and more a few years ago but the implications for most African countries with annual per capita public health expenditure of around $10 is staggering. Studies are being carried out to develop simpler and cheaper regimens. WHO has launched the "3 by 5" initiative: 3 million who need it (50% of the estimated) receiving ART treatment by 2005. Most arguments for introducing ART in Africa are based on political, ethical and human-rights grounds. There are few studies on economic and service delivery implications. The need for treatment is compelling, but it should not overshadow preventive actions now
or the need for developing new methods – vaccines, microbicides, etc. – for better prevention. Nor should it displace funds from other health activities.

Adolescents and Youth in Africa

Africa's population is young, exuberant and facing dramatically changing life ways and expectations. The youth are not only the future, they are the present, and African societies must come to grips with their changing needs and demands. Their health and development is key to the development of the continent. They require attention not least because there are so many of them. The youthful population in Africa (10–25 years) numbers some 255 million and will reach an estimated 465 million by 2010. It is increasing relative to other age groups because youth is the most fertile section of society: About 75% of teenage girls (15–19) in Africa become mothers, representing 13% of all fertility.

Adolescents' Peculiar Needs

Adolescence as a distinct period of growth is not fully recognized in most African societies, but it is a time of dramatic and rapid change and a period of transition, experimentation and risk taking with adolescents often not able to comprehend the extent of their exposure to risk. Many key social, economic, biological and psychological events that set the stage for adult life occur in adolescence. While most young people pass through this period without major handicaps, a significant number do not. Worldwide, including in Africa, puberty is occurring earlier and age at marriage is rising. Thus, sexually ready (and active) young people stay out of marriage for longer periods – the "bio-social" gap. This phenomenon is new to most

African/traditional communities and poses unfamiliar challenges. Millions of young people face the prospect of incomplete education and the threat of HIV/AIDS compounding traditional problems of early marriage, early pregnancy, etc.

At the same time, more African young people are growing up with fewer opportunities for education, health, recreation and gainful employment that could enable them to realize their full potential as contributors to development than was the case previously, because of the wars, conflicts and socio-economic problems Africa faces. For teenagers, the future can be bleak indeed. In countries with HIV/AIDS prevalence of 15% and over, at least one-third of those now 15 years old will die of AIDS. The risk is over 50% in Botswana, Kenya, South Africa, Zambia and Zimbabwe. This tragic situation could be mitigated by strategies that ensure that children will have a safe, healthy and well-educated childhood establishing the foundation for a productive adult life as contributors to their countries' overall development – rather than grow up as problems robbed of their childhood.

Lack of Opportunity. Poverty and the related problem of limited opportunities and lack of skills and employment are the underpinnings of most of adolescent issues in Africa. The young are the main victims as economic hardships and civil unrest have pushed increasing numbers away from home and into towns and, often, onto the streets, exposing them to abuse and exploitation. The rate of young unemployment is high and increasing – 56% in South Africa – reaching double the rate for adults in most countries, e.g., Algeria, Nigeria. On the other hand, despite laws on child labour, the proportion of children under 14 in the labour force in 1996 was over 40%. It is culturally accepted in Africa for children to work within the family or the community, especially now that family incomes have been eroded by unemployment, stagnant nominal wages, and job losses and/or business failures. Many adolescents work mainly to augment their family incomes, but the region's economic problems and HIV/AIDS often distort this into exploitation and increased vulnerability.

Health Problems. There is growing awareness of the current importance and future implications of adolescent health problems, and the need for a policy and service framework to address them. The whole reproductive health issue, for example, takes a very different dimension in adolescence. Maternal mortality is higher in this group because of the risks of early pregnancy associated with medical, service-related and social factors – including harmful traditional practices, sexuality and gender – that have stronger impact on the young. Although there are indications that age at marriage is increasing in Africa as in other parts of the world, early marriage remains the norm in Africa. Once married, a girl is bound to be pregnant as soon as she reaches puberty – as early as 11 or 12 years of age in some cases. Girls less than 15 years old have 5–7 times greater risk of dying during pregnancy and delivery than those between 20 and 24. Most of these girls face obstructed labour because the birth canal of the girl is too small.

This, under the conditions of lack of trained assisted delivery in Africa, leads to prolonged labour resulting in the death of the child in utero, damage to the birth canal leading to fistula, and even the death of the mother through haemorrhage, uterine rupture and/or exhaustion. The child, if born alive, is often under-weight and has a much higher risk of infant death.

On the other hand, abortion is a major problem among the young, with a third to half of early pregnancies being deliberately aborted. Abortion is illegal in most African countries (only three – Cape Verde, South Africa and Tunisia – allow unrestricted access to abortion), so there is a high risk from these abortions including death or life threatening haemorrhage and infection. Abortion cases are seen from all walks of life – students, out-of-school youth, married women, etc. Poverty, the low availability and accessibility of health services, limited use of contraceptives (even where knowledge is reportedly high), and high peer pressure for sexual experience are often mentioned as the main causes for the prevalence of abortion. Abortions are also often associated with sexual violence, rape, abduction, early marriage and/or dissolution of marriage. Other disease burdens to be noted among young people include: TB, which has always been more prevalent in the young and is now being fuelled by HIV/AIDS, and malaria, which is high risk for the pregnant adolescent girl in particular. Furthermore, diseases such as polio and rheumatic heart disease manifest themselves primarily in the youth but originate in childhood.

However, primary school enrolment is low in most African countries and in 19 SSA countries, less than 30% of the age group is enrolled for secondary education. In Burundi, Central African Republic, Mali and Niger, less than 10% of girls receive at least seven years of schooling. Youth with low levels of education face severely limited prospects for economic self-sufficiency
However, primary school enrolment is low in most African countries and in 19 SSA countries, less than 30% of the age group is enrolled for secondary education. In Burundi, Central African Republic, Mali and Niger, less than 10% of girls receive at least seven years of schooling. Youth with low levels of education face severely limited prospects for economic self-sufficiency

Education

The significance and impact of education on human development is undeniable. However, primary school enrolment is low in most African countries and in 19 SSA countries, less than 30% of the age group is enrolled for secondary education. In Burundi, Central African Republic, Mali and Niger, less than 10% of girls receive at least seven years of schooling. Youth with low levels of education face severely limited prospects for economic self-sufficiency

HIV/AIDS. African policy makers know well the impact of HIV/AIDS on Africa's young people. Three quarters (8.6 million) of the world's youth living with HIV/AIDS are from SSA, with prevalence ranging from 33% in Botswana to 0.3% in Mauritania in 1999. Invariably, HIV prevalence among young girls in Africa is higher than boys. Girls constitute 64% of 15–24-year-olds living with HIV/AIDS. Sexually active youth are at substantial risk particularly when they have multiple sex partners, engage in unprotected sex and, for young women, have older male partners. The highest rate of STI including HIV infection is found among young people 20–24 years old and the next highest among adolescents, 15–19. Young people are particularly vulnerable to HIV/AIDS because of the physiological, psychological, social and economic attributes of adolescence.

Safeguarding Africa's Future through Youth Development

Adolescents' penchant for risk-taking behaviour and susceptibility to peer pressure accentuates their vulnerability. In part, this is because they lack reliable. appropriate and consistent information on sexuality, HIV/AIDS, etc., and how to protect and manage themselves. Some parents still think that sex education encourages sexual experimentation, despite evidence indicating that sex education seems to delay the onset of sexual activity, reduce the number of sexual partners and increase the likelihood of condom use. Studies show that the most important source of information for most African youth is their peers – who too often are simply ill-informed, and thus perpetuate the flow of wrong information.

The silence surrounding sexuality is one of the driving forces for adolescent vulnerability. African leaders have acknowledged adolescents as a discrete group with specific characteristics, problems and needs. There is need now to recognize that interventions for them work best as part of wider sustainable development and poverty reduction programmes. Improved conditions for dialogue and active participation by parents/family, school and, community can be created by providing young people with accurate knowledge and information. It is also important to involve young people, including young PLWHAs in the case of HIV/AIDS, in conceptualizing, planning, implementing and evaluating programmes. Youth welcome the opportunity to participate and their involvement saves costs and ensures ownership, success and sustainability. Peer education, in or out of school, is a key element. In addition, young people need to be equipped with life skills, including skills in friendship formation, communication, self-awareness and confidence, negotiation, tolerance, critical and creative thinking, and coping with emotion and pressure. Programmes should reach out to young people most at risk – orphans, child labourers, street children, drug abusers, etc. – and provide youth friendly services. This has proved important for youth health services in particular.

Implications of Adolescent Programmes for Socio-Economic Development
The economic return from adolescent programmes is difficult to estimate because it is complex, multi-sectoral and multidimensional. The limited research undertaken shows that $1 invested in school-based adolescent education programmes on HIV/AIDS, for example, gave a return of $0.5, $5 and $99 in areas of less than 1%, 1% and 20% HIV prevalence, respectively. Some studies show that the return on $1 invested in adolescent schooling is $3.3 and that on adult education for the young is $19.90. A study in the Caribbean has shown that for early pregnancy, the direct financial cost is $28–$262, depending on locale, and $33–363 per birth annually. While these are considered most certainly an under estimation, the annual cost of averting pregnancy using family planning will be only $17.

Lack of empowerment because of poverty and, for girls, gender inequality and discrimination, is a significant underlying factor. Adolescence could be an important gateway towards achieving equal status for women, eliminating harmful traditional practices, etc., because it is a receptive age for change. However, the opportunity is often lost because of lack of education and social pressure in the guise of early marriage and other traditions.

African states have long recognized the rights of young people in the declaration of the Rights of Children and other international and regional instruments. Most of these rights continue to be ignored, however, because of public neglect and cultural pressure. Delegates at the UN General Assembly on the Special Session on HIV/AIDS (2001), for example, resolved to "reduce by 2005 HIV prevalence among young men and women aged 15–24 in the most affected countries by 25% and by 25% globally by 2010". Today we know that the 2005 target will not be achieved.

It has been said that investing in children and the youth is the best investment a government can make. Returns are reported in agriculture, livestock, and industry and health services. Returns on adolescent sexual and reproductive health investments are high and competitive. Studies show that countries in East Asia were much more successful than SSA in economic development in the 1970s and 1980s because of heavy investment in children and good macroeconomic management in the previous decades. Ultimately, African governments will have to decide whether they can afford the enormous future costs of inaction. If the 21st century is to be African, it will come through the development and full participation of African youth – of both genders.

Gender Issues and Population Dynamics in Africa

Since the post independence era, the lives of African women have undergone profound positive change that were facilitated by national efforts, regional and international instruments that promoted women's empowerment
In this regard, the first treaty designed specifically to address the concerns and rights of women, known as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) or the Women's Convention, came into effect in 1981. It also called for appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations as well as the modification of other culturally based gender biases, however deeply entrenched And in addition to three international conferences between 1975 and 1995 that focused specifically on women. The numerous other UN conferences during the 1990s that revealed the disadvantages faced by women included: the UN World Conference on Environment and Development (UNCED, Rio de Janeiro, 1992); the UN Second World Conference on Human Rights (Vienna, 1993); the International Conference on Population and Development (ICPD, Cairo, 1994); and the World Summit on Social Development (WSSD, Copenhagen, 1995). All these conferences indicated the type of legislation and strategic interventions that ought to be made. Furthermore, they identified core targets that could be used to measure progress towards the empowerment of women. Some of the targets, especially those related to education and health, were brought together in the Millennium Development Goals (MDGs) and subsequently in NEPAD and most poverty reduction strategy papers.

ICPD is noteworthy because it moved the overall objective of population policy from one focused on achieving population targets to people's sexual and reproductive health and rights. Here again, women's empowerment was highlighted as a key determinant of reproductive outcomes. CEDAW was among the first to include the right of reproductive choice. The positive policy environment has clearly contributed to enhanced decision making by women, increasing girl's enrolment in primary education, employment, family planning among many other areas of relative improvement in the status of women.

However, the progress has not gone far enough, however, and the role and condition of the African woman and her impact on social development are often not fully recognized. Development initiatives are often premised on the assumption that women's roles are limited to a simplified version of "housework" and childcare. This despite a large body of studies, mostly facilitated by the initial United Nation's women's conferences held between 1975 and 1995, that revealed women's substantive role in both subsistence agriculture and cash crop production, in both the formal and informal (e.g., local trading) economy. The studies also revealed that the very functioning of the economy depended on what was often dismissed as non-economic "housework".

These time and energy consuming activities geared towards production of services – including cooking and cleaning for family and community members, looking after children and the sick and elderly, and tending to the emotional needs of family and community members – sustain a supply of labour to the economy.

The Feminization of Poverty

The gender dimensions of poverty include such factors as access to common property resources such as forests and rivers, state-provided services, and assets such as health, education, land and equipment. In addition, poverty entails lack of dignity, autonomy and free time. Even within the same household, women and girls may be relatively poorer than other household members even if the household itself does not fall within the defined absolute poverty line. Such forms of gender disparity indicate the links of poverty to inequality in the distribution of resources and income in African societies. The magnitude of the denial of entitlements varies by country, but the overall pattern indicates unequal access to and distribution of resources between men and women as well as women's limited participation in economic and political institutions. Women are also affected by Lack of Infrastructure and Time Poverty. An important element of women's well being is related to the distribution of work and leisure. In all countries where data on women's and men's use of time are available, women work longer hours than men in both rural and urban areas, with the former working much longer hours. The "overtime" is the result of women's reproductive roles in addition to their participation in agricultural and income-generating activities with the lowest returns.

In rural areas, where infrastructural investment is low and environmental degradation is on the increase, women spend long hours fetching water, fuel and fodder. But this backbreaking, time and energy consuming, and unpaid work is not counted as work in systems of national accounts (SNA), and those who perform such unpaid tasks are neither economically rewarded nor socially valued as productive members of society. Women's time poverty is one of the causal factors in girl's low school enrolment and attainment. Time poverty also negatively affects women's and children's health.

Absence of Legal Rights and Legal Literacy. Women are disproportionately poorer because of the absence or non-enforcement of marriage, inheritance, labour and land laws. Even when laws exist, most women are unaware of them. Women lack access to land ownership and use, credit, and other productive resources and their lack of entitlement to these resources limits the returns from their off-farm enterprises. Furthermore, market discrimination against women results in their concentration in low-paying jobs. Even when women are given access to services such as micro-credit, they are often not trained in marketing or other better-paid skills.

Poverty and Women's Health

Poor women carry a disproportionate burden of high fertility. Poverty increases the demand for children. Poor women and men lack education and information that would enable them to make informed choices about reproductive health. Lack of education limits women's access to birth control, and men's and women's willingness to invest in children's education especially girl's education, an investment that makes large families less affordable. Although men have high rates of fertility it is most often women who bear the burden of responsibility for contraception. The growing focus on adolescent sexuality and reproductive health opens a window of opportunity for challenging norms, beliefs and practices related to gender stereotypes and for promoting equal responsibilities in areas such as fertility, prevention of STDs, and the well-being of sexual partners and their children.

The road to maternal death is accelerated by women's subordinate status, discriminatory traditional practices and poor environmental conditions including lack of clean water. These forms of ill health translate into an intergenerational transfer of disadvantages. A mother's poor nutritional status results in low birth weight infants, and there is a 3–10 times greater likelihood of motherless babies dying within two years than children with parents alive. In general, the various dimensions of gender and poverty result in poor childcare, which in turn results in extremely high child mortality and morbidity, both of which result in high fertility and increased poverty.

Feminization of HIV/AIDS

The myriad of disadvantages faced by women has resulted in their carrying a disproportionate burden of the HIV/AIDS pandemic. In many African countries, compared with men, women experience discrimination in their legal status and treatment. This may include diminished rights to hold, inherit or dispose of property, to participate in democratic processes, or to make decisions about marriage or about education of their children. HIV/AIDS is exacerbating the difficulties women face and may make it difficult for them to exercise their rights to property, employment, marital status and security.

Changing Patterns of HIV Transmission. Across the world, the pattern in male/female HIV/AIDS infections is changing. There has been a progressive shift towards heterosexual transmission and increasing infection rates in women. Women are biologically more vulnerable to infection; data from UNAIDS indicate that male-to-female HIV transmission is estimated to be twice as likely as female-to-male. More women than men are dying of AIDS and the age pattern of infection is significantly different for the two sexes. In sub-Saharan Africa women constitute 55% of all HIV infected adults, while teenage girls are infected at a rate five to six times greater than their male counterparts.

The Hidden Face of Powerlessness. A major contributor to the feminization of HIV/AIDS is the lack of economic and social power and hence women's inability to negotiate safer sex. In most societies, women and girls are powerless to abstain from sex or to insist on condom use. They are often coerced into unprotected sex or run the risk of being infected by husbands in societies where it is common for men to have more than one partner. Yet another contributory factor includes inadequate knowledge about AIDS.* Other reasons include insufficient access to HIV prevention services and lack of female controlled HIV prevention methods such as microbicides. Becoming HIV positive often has more economic impact on women than men. Women are likely to lose employment in the formal sector and to suffer social ostracism and expulsion from their homes

Fear of Disclosure. Women are blamed as vectors of the pandemic (to partners and children) even though it is commonly the husband who passes the HIV infection to his wife. She may be labeled promiscuous, and abused, abandoned or even killed. As one study noted the negative consequences of disclosure may be harsher for women than for men, in part because women are more economically and socially vulnerable, and because there is less societal tolerance for women perceived to have multiple sexual partners than for men. Consequently, one of the major causes for the rapid spread of the pandemic is that most of those with the disease do not disclose their HIV serostatus.

Increased Burden of Care and Destitution. As a recent FAO study underscored "HIV/AIDS is not just another problem of health and underdevelopment. It is a unique disease because of its devastating, systemic and cumulative impact". In aggregate terms, the epidemic produces new mechanisms for impoverishment and thus creates new patterns of poverty and livelihood insecurity. The outcome is the emergence of new category of poor people. Women not only are more vulnerable to HIV infection biologically but they also bear the brunt of the social and economic costs of the disease.

The range and depth of women's responsibilities have increased during the era of AIDS. Increased care giving for sick and dying relatives has been added to the existing workload. This has led to the withdrawal of girls and to lesser degree even boys from school, both to save on costs and to add to household labour. As a result, HIV/AIDS is facilitating a further increase in gender disparities. In rural areas where women often account for the majority of the agricultural labour force, especially in food production, care giving has been shown to reduce farm output for family consumption and sale.

Women widowed and children orphaned by HIV/AIDS are stripped of property and assets like cattle and tools and thrown off the farm by relatives of the diseased. In a pilot study of 29 widows living with HIV/AIDS, 90% had property wrangles with in-laws and 88% of those in rural areas were unable to meet their household needs. Being thrown off the farm means homelessness, contributing to women's and their children's destitution. Such a calamity often encourages high-risk behaviour such as unsafe sex for money, housing, food or education, further exacerbating the spread of the pandemic.

Gender and Education

In sub-Saharan Africa unacceptably high numbers of children of school age are not enrolled in school. Of these a disproportionate number are girls. The net primary enrolment in sub-Saharan Africa is 57%, the lowest rate in the world; it is higher in North Africa with 81%. The gender gap gets wider for secondary and tertiary education. Despite the relatively low average, there are a number of countries that have closed the gender gap in secondary level enrolment. By 1999/2000, Algeria, Libya, Tunisia, Lesotho, Namibia, Botswana, Mauritius and Madagascar had closed the gender gap in net education enrolment. In fact, most of these countries, especially the three in Southern African, exhibited a reverse gender gap, where the net enrolment rate of boys was lower.

Literacy Rates

Globally, there are more illiterate young women than men. Available data suggest that there is much more of a gender gap in literacy rates than in school enrolment. The problem is the greatest in sub-Saharan Africa where 35 to 41 countries for which data are available have a ratio of fewer than 100 literate females for every 100 males. Studies have shown the link between women's literacy and demographic outcomes. Demographic and health surveys in a number of African countries show that a 10% increase in female literacy rates reduced child mortality by 10%, but changes in male literacy have little influence

Education as a Route to Empowerment. There is ample evidence in support of education as a route to women's empowerment. Education improves access to knowledge, information and new ideas as well as the ability to use these effectively. A World Bank study on gender and the MDGs argues that eliminating gender disparities in education is one of the most effective development measures that a country can take. When a country educates both its girls and boys, economic productivity tends to rise, maternal and child mortality usually fall, fertility rates decline and the health and educational prospects of the next generation are improved.

Many factors limit girls' enrolment and educational attainment in most SSA countries. These include lack of schools or their location at long distances exposing girls to possible violence and long absences from home; early marriage; mother's heavy workload; household poverty and increasing schooling costs; gender stereotyping in the school curriculum that depicts limited options for girls; violence in schools and teachers gender biased attitudes and women's lack of viable employment. In most countries, women face gender-based inequities in the labour market, such as lower wages, less regular employment and higher level of underemployment than men. Where agriculture is one of the primary means of livelihood, women's share of non-agricultural employment is small.

Opening New Vistas. Many studies have shown that employment outside the home has the potential to reduce women's dependence on others, provide alternative sources of social identity and support; and increase women's desire to delay marriage and space or limit births. The empowering potential of employment depends on a number of other factors. These include a satisfactory and healthy work environment, protection against unemployment in cases of pregnancy and marriage and access to appropriate services, such as childcare. Of equal importance are measures that ensure that women not only have access to income but also control of such income. Likewise, employment becomes more empowering when it provides women access to non-kin support including women's groups, independent sources of information, and services such as credit, marketing and health. Such support and services often facilitate higher use of birth control and significant improvement in child welfare.

The Way Forward

The key challenges to sustainable development in Africa turn on effectively addressing the root causes of poverty, and reversing the spread of HIV/AIDS. Accordingly, the main actions required are:

- Increasing political will for the implementation of plans of action agreed upon regionally and internationally, including those enunciated in ICPD, the Beijing Platform and the Dakar/Ngor Declarations, as well as those adopted at the Social Summit, the World Summit on Sustainable Development and other forums.
- Putting in place effective mechanisms that enforce legislation aiming at gender equity, equality and the empowerment of women including the protecting the property and land tenure rights. Reinforcing positive aspects of African culture while eradicating those that are harmful and those that decelerate the development processes
- Effective implementation of sound poverty reduction strategies and programmes.

- Reversal of environmental degradation and food insecurity. Addressing under-nutrition and chronic malnutrition among particularly pregnant women and children.
- Ensuring universal access to and increasing investment in education and health.
- Reduction of maternal and infant mortality and morbidity as well as communicable infectious diseases.
- Improvement of the availability of up-to-date data by enhancing capacity in data collection to better enable governments to target policies and programmes, strengthen integration of population and development planning, and monitor progress toward goals.

AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE
UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone 517 700 Fax : 517844

EXECUTIVE COUNCIL

Fifth Ordinary Session
25 June – 3 July 2004
Addis Ababa, ETHIOPIA

EX.CL/113(V) b

PROGRESS REPORT ON THE AFRICAN COMMON POSITION ON THE FUTURE OF CHILDREN (2001):

STATE OF AFRICA'S CHILDREN

PROGRESS REPORT ON THE AFRICAN COMMON POSITION ON THE FUTURE OF CHILDREN (2001): STATE OF AFRICA'S CHILDREN

Foreword

A world of promises have been made and obligations assumed to Africa's children. The obligations are reflected in the almost-universally ratified Convention on the Rights of the Child (CRC) and in the African Charter on the Rights and Welfare of the Child (ACRWC). The promises are found in national policies, including National Plans of Action for Children, as well as in the Declarations of the 1990 World Summit for Children, the 1992 Organization of African Unity (OAU) International Conference on Assistance to African Children (ICAAC), the African Common Position of 2001, and the 2002 United Nations Special Session on Children. The promises, and the country goals and targets which took them further, have been largely consistent for the last 15 years. For Africa's renaissance in the 21st Century, the Continent has to invest in its children and youth and ensure that they have a good start in life**.** There is little argument about what needs to be done. It is also clear, from the best examples, what it is possible to achieve. Then there is the separate question of what has been achieved.

This intense focus on children is entirely consistent with the best-known of the international development targets—those encapsulated in the Millennium Development Goals (MDGs) adopted at the 2000 Millennium Summit. In fact, most of the MDGs directly concern children, and all of them directly affect children's futures. The Millennium goals are in turn reflected in the 21 goals and associated targets adopted by the UN Special Session on Children held in 2002 as incorporated in the document World Fit for Children.

At the 72nd Session of the OAU Council of Ministers, Decision CM/Dec. 542(LXXII)Rev.1 was adopted mandating the former OAU Secretary General to develop, , in consultation with relevant partners including the Civil Society Organisations, an African Common Position to present to the UN General Assembly Special Session (UNGASS) on Children. To implement this decision, a Pan-African Forum on the Future of Children was convened, in collaboration with UNICEF and the Egyptian Government, in Cairo, Egypt in May 2001 to consider the Draft African Common Position.

The African Common Position was endorsed by the 74th Session of the OAU Council of Ministers and 37th Assembly of Heads of State and Government in Lusaka, Zambia in July 2001. In Decision CM/Dec. 584 (LXXIV the 74th OAU Council of Ministers mandated the First Lady of

Egypt, Mrs. Suzanne Mubarak to present the African Common Position to the UNGASS on Children and to ensure that the voices of the children of Africa are heard.

During the 2001 Lusaka Summit, the Heads of State and Government also established the African Committee of eleven Experts to coordinate and monitor the implementation of the African Charter on the Rights and Welfare of the Child. In spite of some logistical constraints, the Committee is striving to fulfil that mandate

The endorsement by Heads of State and Government at the Lusaka Assembly signifies that the provisions of the ACP constitute specific OAU/Africa Union commitments against which progress of the state of Africa's children can be measured.

To this end, the ACP mandated the Africa Union (AU), in collaboration with UNICEF and other partners, to undertake regular monitoring of African countries' realization of the goals it lays down, along with the rights enshrined in the ACRWC and the CRC. This report is to include children up to the age of 18, i.e. those commonly regarded as "youth".

The reporting mechanism is envisaged as a major biennial report, The State of Africa's Children and Youth. This will be a substantive, evidence-based analysis of the extent to which children and youth in Africa are realizing the full range of rights laid down in the series of instruments endorsed by African governments, and the extent to which African countries are complying with their obligations under these instruments. It will also evaluate the extent to which donors are living up to the many commitments that they have repeatedly made.

This biennial report will be presented jointly by the AU and UNICEF to the Annual Summit of the AU for consideration. To fulfil obligations, it was jointly decided that a preliminary short report be prepared for this summit. It consists of three parts:

A. a relatively brief overview of the state of Africa's children at this time, synthesizing the latest information and reflecting in-depth research;

B. a special section highlighting three key issues of obvious concern---girls' education, HIV/AIDS and orphans, and malaria;

C. a concluding statement indicating the way forward.

INTRODUCTION.

Significant challenges face Africa if the commitments made to its children and youth by both African governments and the international community have any chance of being met. Generalizations about a continent as diverse as Africa must naturally be cautious. Without question, some modest progress has been witnessed in some sectors of some countries and in many communities. The near-eradication of polio and guinea worm disease, the widespread iodization of salt, the improvement of child-related laws and juvenile justice systems, reforms to health and education systems, sustainable approaches to local clean water management, initiatives to expand access to primary education and dynamic post-conflict recovery - these are all areas where success stories can be found in Africa. Moreover, it is possible to account for these welcome successes: The central factor in virtually every case has not been funding so much as the presence of strong political leadership linked to the mobilization of families and civil society.

On the other hand, many aspects of the record remain troubling. The issues that continue to confront many African states---and which sometimes seem overwhelming-- can readily be identified: deep and widespread poverty, HIV/AIDS, malaria, malnutrition and undernutrition, internal displacement of populations, drought, impaired services, deteriorating infrastructure, low revenues, inferior status of females, denial of problems, corruption, bad governance and its consequences. All these problems and more are exacerbated by violent internal conflicts and compounded in one country after another by political, economic, social and/or cultural issues. As a result, survival remains a continuous struggle for Africans across the continent, with women and children of both sexes facing, as always, the greatest adversity.

While more and more countries now enjoy a fairly stable political situation, a precondition for meeting these pressing challenges, conflicts old and new continue to bedevil all areas of the continent, while several countries have only recently undergone major changes with unpredictable consequences.

Stable government and an end to conflict are the necessary conditions for facing Africa's problems. But they are by no means sufficient by themselves. Stability in government does not necessarily mean good governance. Stability in government does not always translate into sustainable economic growth let alone lead to the introduction of more progressive and just policies. Major constraints, not least the tolerance threshold of international financial institutions, limit the options of all

governments on the continent. Dependence on external forces well beyond the influence of national governments remains striking. The economies of most of Africa are burdened with fiscal deficits and onerous external debts that typically continue to soak up more of the annual budget than do health or education expenditures.

In substantial chunks of the continent, drought, HIV/AIDS and malaria play havoc with government plans. Neither of these are simply natural phenomena; drought is often exacerbated by environmental depredations, while the spread of HIV/AIDS lies completely within human control. The devastation invariably caused by conflicts to physical infrastructure is both costly and difficult to replace or repair; it is always easier and cheaper to destroy than to build. In this sense, conflict can be said to turn an underdeveloped country into an underdeveloping one. Africa has only too many examples of such cases.

There are Africans living comfortably, not to say opulently, everywhere on the continent. Yet almost all African countries are grindingly poor, underdeveloped, constrained by inadequate trained manpower, and burdened by food insecurity. This is life at the routine level. When the routine is broken by a crisis of any kind—drought, flooding, a surge of returning refugees, destructive leadership, armed conflict with its attendant horrors, disease outbreaks---the difficult becomes the intractable.

While all these curses have been inflicted on African countries, the HIV/AIDS pandemic is the most terrifying and disruptive. HIV/AIDS is a disaster for all concerned, but its impact on children is perhaps the most pitiless. Among the growing population of the chronically vulnerable that it creates, requiring recurrent supports of many kinds---female-headed households, elderly-headed households, farmers unable to support themselves let alone cultivate for export--- no group is more vulnerable than the children. This report will return more than once to the mortal challenge of HIV/AIDS.

PART A. THE STATE OF AFRICA'S CHILDREN AND YOUTH: AN OVERVIEW

1. Poverty and deprivation in Africa

According to a May 2004 report by the UN Economic Commission for Africa (ECA), about 300 million people live in poverty in Africa. This number is likely to swell to 400 million or more by 2015. Africa is growing poorer. Poverty levels on the continent have increased by 43 percent over the previous 10 years, with women constituting up to 80 percent of the people living on less than a dollar a

day. This situation has been exacerbated by the unequal distribution of resources between men and women and the rising HIV/AIDS infection rates, especially among women and girls. Given that women provide 70 percent of Africa's food and account for two -thirds of production, the gravity of the problem cannot easily be exaggerated.

The World Bank estimates that African economies need to grow by five percent a year just to keep the present number of Africans living at the poverty level from rising. If the number living in extreme poverty is to be halved by 2015, as called for under the Millennium Development Goals (MDGs), not only would economies need substantial growth of at least seven percent, but incomes would also have to be distributed more equitably. Neither substantial growth nor redistribution is taking place. The ECA calculates that only four of the continent's 53 countries are on track to meet the MDG poverty goal.

2. Child poverty in Africa.

Important new data recently became available on the scale and nature of child poverty in Africa. The October 2003 UNICEF- sponsored study called Child Poverty in the Developing World illuminates many aspects of the subject, much of it bleak and harsh.

Two key categories are used: absolute poverty, i.e. children severely deprived of two or more basic human needs, and severe deprivation, i.e. children suffering from being severely deprived of one or more basic human needs. Seven basic human needs are identified: food, safe drinking water, sanitation facilities, health, shelter, education, access to information.

The findings showed that virtually two/thirds of all children in sub-Saharan Africa, 65%, live in absolute poverty as defined above; in real terms, that totals 207 million African boys and girls. This was the highest rate in the world; South Asia, in 2nd last place, had a rate of 59%. Rural children face significantly higher levels of absolute poverty than urban children, with rates of absolute poverty running as high as 78% in certain rural areas of sub-Saharan Africa countries compared to 25% in urban areas. This should not be read as a satisfactory urban rate, however, since it still means that tens of millions of urban children live in absolute poverty.

As for severe deprivation of basic human needs, the sub-Saharan Africa rate is over 80%. Once again, rural children, at 90%, experience much higher deprivation levels that urban children. In North Africa, where levels of development are generally higher than in sub-Saharan Africa, in this case rural

children are almost as deprived, with a severe deprivation rate of 82%. (This data includes the Middle East.)

Of the 7 indicators of absolute poverty and severe deprivation, sub-Saharan Africa has the highest rates in the world for 4 of them. Well over half of all children in sub-Saharan Africa countries are severely shelter-deprived (198 million) and water-deprived (167 million). Breaking the data down, 73% of rural children in the region and 28% of urban children face severe shelter deprivation, far and away the highest rates in the world. Thirty per cent are severely deprived in terms of education, 27% in terms of health. On three basic human needs, sub-Saharan Africa rates better than South Asia, though the region's numbers are still unacceptable---37% severely deprived of sanitation, 39% of information access, and 18% of food.

As always, generalizations about Africa must be made cautiously. There are significantly different rates of absolute poverty and severe deprivation between urban and rural areas, between boys and girls, between sub-Saharan Africa and North Africa, and among sub-Saharan Africa countries. The lesson is that policies and strategies to reduce absolute poverty and the rate of severe deprivation must carefully take into account local conditions; as Africa has learned to its great cost over the past quarter century, one-size-fits-all solutions are no solutions at all.

3. Evaluations, 2001 and 2004.

a)The World Summit for Children and Plan of Action: The Record.

In recent years, there have been evaluations of the records of donors in meeting their repeated commitments to African development. The findings have been unflattering. With the exception of a handful of northern European countries, the record reveals a consistent, unvarying pattern of failure to live up to obligations freely undertaken. Year after year, conference after conference, declaration after declaration, rich countries pledged to reach certain goals---related to aid, trade, subsidies, investment, debt relief: the usual litany---and just as regularly failed to do so.

What is the African record? All African countries (save Somalia) have ratified the Convention on the Rights of the Child [CRC]. All African countries have adopted the African Charter on the Rights and Welfare of the Child [ACRWC]---the Africanization, as it were, of the CRC, although only 33 have ratified it. At the 1990 World Summit for Children [WSC], a World Declaration was approved and a Plan of Action developed for its implementation. African leaders, among

others, committed themselves to a series of precise goals for the continent's children to be met ten years later; these included reducing the under-5 mortality rate by a stated amount, reducing maternal morality rates, reducing malnutrition, providing universal access to safe drinking water and to sanitary human waste disposal, providing universal access to basic education, reducing adult (and especially female) illiteracy, and protecting children in armed conflicts. These were, it was agreed, achievable goals.

In 2001, the Pan-African Forum on the Future of Children agreed on an African Common Position which was spelled out in detail in a document called Africa Fit for Children. In an annex, the document evaluated the compliance of African governments with the obligations they had solemnly accepted in both the CRC and the ACRWC as well as in the World Summit for Children's Plan of Action. The assessment was chastening. Eleven years after making these commitments, they concluded, "overall, across Africa," the achievable goals had not been achieved. "There have been important gains in some countries and some sectors, but setbacks in many countries in many sectors."

Africa's leaders had also made commitments to a series of national follow-up actions set out in the Plan of Action for Implementing the World Declaration; the evaluation then turned to these. These include preparing national programs of action to implement commitments undertaken, re-examining programs and policies to accord higher priority to the well-being of children, re-examining national budgets with the same objective, and the like. "Once again, the record is disappointing. Substantial progress has been made in some countries and with regard to some issues, but not in other countries with regard to other issues. Overall, the majority of these actions have not been undertaken by African governments, or have been undertaken purely in a nominal way with little or no impact on resource allocation, policymaking or actions with relevance to children."

The overall conclusion was outspoken. "The record of implementing the WSC Plan of Action and achieving the World Declaration goals has been considerably poorer in Africa than in other regions of the world, in marked contrast to the enthusiastic participation of African leaders in the WSC and the alacrity with which African governments acceded to the CRC." The bite of this assessment stung even more since it excluded goals that were dependent on external assistance which, as always, fell far short of commitments. Goals that had been expressly committed to and remained far from attainment included universal free primary education, reducing gender disparities in education, ending harmful traditional practices that harmed females, and reducing child labour and trafficking in children.

What accounted for this disappointing record, Africa Fit For Children asks? Had unforeseen constraints—HIV/AIDS and other pandemics, diseases related to poor hygiene, sanitation and housing, civil strife, natural disasters, falling commodity prices-- made it impossible to realize the goals set out at the WSC? Had lack of political will among the leadership, and/or corruption and poor governance stood in the way of progress? "Were African leaders genuinely committed", it toughly asks, when they made their pledges to implement the goals of the WSC Plan of Action, the ACRWC, and the CRC? Whatever the reasons, the fact remained that the aims of the World Declaration were not close to achievement and the WSC Plan of Action was not implemented in anything remotely like a comprehensive way.

b). Reviewing the Record, 2004.

That was three years ago. Realistically, of course, dramatic changes can hardly be expected in such a short time. Still, it is reasonable to ask whether at least some progress has been made in moving the continent closer to reaching the goals to which its leaders were committed. Has the record of achievement improved in any discernible way in light of the negative assessment of progress in the previous decade? These are the questions to be addressed in the first section of this short report.

Structurally, the report follows the five major areas set out in Africa Fit For Children's Plan of Action. Brief perspectives will be presented on: child well-being, HIV/AIDS, education, protection of children, and children's participation. The conclusions exactly echo those summarized above in 2001. While very modest progress was made in some countries and in some sectors, little progress has been made by many countries and in many sectors. It is true that everywhere on the continent, civil society organizations, NGOs, national governments, sub-regional organization, United Nations agencies and donors have launched endless initiatives meant to meeting goals agreed in these 5 major areas. Entire massive reports are available outlining these efforts, many of which make a real contribution. Success stories pepper the continent.

In North Africa, for example, states have been able to achieve and sustain progress in the rights of children irrespective of their national income. Nutrition and immunization have both improved, contributing to a major reduction of under-five mortality rates and greatly expanding school enrolment, fast-tracking the enrolment of girls. Tunisia, for one, is expected to meet 7 of the 8 MDGs, only the maternal mortality rate remaining in doubt. Further action in the region is actively being planned. In May 2004, a Summit of the League of Arab States, half of

whose 22 members are African, passed a resolution on the Rights of the Child that focuses development efforts on achieving concrete, time-bound targets. The Summit adopted a regional plan aimed at realising global targets for children by 2015. The plan commits member states to design national plans of action that allocate resources to realising minimum standards for the children in the region.

Nevertheless, despite such productive initiatives, the fact remains that no sub-region of the continent is immune from serious challenges. Some, of course, are in far worse shape than others. Of the 175 countries on UNDP's Human Development Index for 2003, the 25 lowest ranked are all in sub-Saharan Africa as are 38 of the bottom 46. An outspoken recent peer review of the Economic Community of West African States (ECOWAS), embracing 15 nations, almost one-third of the membership of the Africa Union, offered its own devastating findings. The ECOWAS region was found to be the worst in the world regarding the state of children, where the rights of children are the least respected, and where the least progress was achieved in attaining the objectives set at the World Summit on Children. As for southern Africa, it faces the world's worst HIV/AIDS situation, with consequences only just beginning to be understood. For too many of Africa children and youth, life is not only brutish, nasty and brief, it is even shorter, nastier, more hopeless and less fulfilling than the lives of their parents. Mere survival is a continuous struggle.

These were not the outcomes anticipated when the CRC, the ACRWC, the World Declaration, and the WSC Plan of Action were all enthusiastically adopted.

4. Implementing the Cairo Declaration's Plan of Action.

Section I. Enhancing Life Chances.

We urge our Governments to take measures to ensure that every child in Africa has a good start in life, to grow and develop in a child-friendly, nurturing environment of love, acceptance, peace, security and dignity. Africa Fit For Children, paragraph 27.

Early childhood development. Authorities agree that children grow up healthier, better adjusted and more intellectually developed if they get a good start early in life. Minimally, investment in the earliest years should ensure a child' survival. Optimally, it ensures that she thrives and is socially, emotionally and cognitively ready for school. The best early childhood development requires many interventions---in health, nutrition, water,

sanitation, psychosocial care, early education and protection---all working together. This is a demanding regimen, and few even of the world's wealthiest countries have implemented it in a comprehensive manner.

Not surprisingly, both the provision of the required supports and their coordination have proved a formidable challenge that few African countries have met effectively. In the first place, for example, if there is no adequate supply of clean water for the community in general, it can hardly be made available for infants and young children. Beyond that, the skills and capacities for delivering such interventions are in dangerously short supply. And finally, whatever agreements may be made at conferences and forums, however many national coordinating mechanisms for early childhood have been developed, in reality the importance of early childhood development has not really been internalized by many African decision-makers. Among too many urgent priorities, it fails to make the grade. In much of the continent, the concept itself is not well known and few examples of integrated structures and programmes exist.

Immunization. Progress achieved in the prevention of preventable diseases through immunisation has been erratic. In many countries immunisation coverage, which often embraces no more than 60% of children, is lower than the 80% that prevailed in the middle of the last decade. Even in the countries of North Africa, many hundreds of thousands of children are not protected from measles. Famine and epidemics such as meningitis, cholera and yellow fever occur frequently, and national capacities to respond to these recurrent emergencies remain generally low with predictable consequences. On the other hand, progress has been made in the control of polio through massive immunisation and the disease can be eradicated in the near future.

While in certain parts of the continent satisfying progress has been made in the area of Immunization Plus, obstacles to strengthening and extending the reach of the routine immunization system still remain. These include shortages of funds, staff shortages and turnover, inconsistency of vaccine supplies, unsafe waste disposal, and the challenge of strengthening district-level planning and monitoring. It is vital to secure supplies at reasonable cost and to ensure that governments and the public understand that these supplies are safe and effective. The introduction of new vaccines will require private sector investment in capacity to meet demand and will create additional financing challenges in the years ahead.

Maternal mortality.

According to the Economic Commission for Africa, as of May 2004 maternal morality in Africa stood at a distressingly high 940 deaths per 100,000 births. This figure obscures truly extreme variations between countries, from Ghana's 214, for example, to Sierra Leone's 1800. Haemorrhage, hypertension and the consequences of illegal and unsafe abortion are among the main causes of maternal morality. Poor women's nutritional and health status, frequent diseases, heavy workload in and out of the home, early, frequent and late pregnancies, limited access to antenatal and obstetrical care are also contributing factors, and these in turn are compounded by the lack of skilled personnel in the health care centres. Death in pregnancy or childbirth is 100 times more likely in sub-Saharan Africa than in high income OECD countries. The continent is far from achieving the Millennium Development Goal (MDG) of reducing by 2015 its 1990 maternal mortality ratio by three-quarters. But Member States, WHO, the AU Commission and other partners are collaborating in efforts to reduce maternal and neonatal morbidity and mortality in Africa**.**

Child mortality. On the one hand, sub-Saharan Africa has made some progress in reducing child mortality. On the other, achieving the Millennium Development Goal of a 2/3 reduction will at the current pace take 150 years longer than the target deadline of 2015. Of the 50 countries world-wide with the highest mortality rates for under-fives, 36 are in Africa. In 1990, the ECOWAS region was burdened with the highest rate in the world. Although in a good number of countries under-5 mortality rates has improved since then, their starting point was so low that only a massive improvement can come close to meeting the target. This is not happening. To the contrary, due to the high prevalence rate of HIV/AIDS among other factors, some countries actually recorded a significant increase of more than 10% in child mortality,

Compared to sub-Saharan Africa, North African states have done well in securing the most basic rights of the child to survival and development, with both under-five mortality and infant mortality reduced dramatically since independence. Still, while North African statistics in these areas now compare well to the world average, they compare extremely poorly to industrialized countries. Among the League of Arab States, half of which are African, half a million children die each year before they are one year old.

Everywhere on the continent there are wide discrepancies in the levels of child mortality. Simply put, children from poor families are the most vulnerable. On average, children from poorer households face twice the risk of dying than

children from richer ones. These figures can hardly be surprising. Child mortality has several direct causes, diseases that are often associated with malnutrition. Acute respiratory infections and diarrhoea are among the primary causes of child mortality and there is no evidence that they are on the decline.

Food security. The Millennium Development Goal is to halve by 2015 the proportion of people who suffer from hunger. At the present rate, sub-Saharan Africa will reach the goal in 2165, one and a half centuries after the target date. In southern Africa, food insecurity is severely exacerbated both by the very high prevalence of HIV/AIDS ---the highest in the world---and poor governance. As a result, the situation of women and children and especially vulnerable communities such as orphans remains dire. In West and Central Africa, the prevalence of child malnutrition is also extremely high, indeed second highest in the world after Central and South Asia. Rates are generally higher in the countries of the Sahel than in other countries in the region. Overall, 10% of all children under 5 suffer from malnutrition and more than a quarter suffer from moderate malnutrition. Almost half of all under-fives are stunted, 17% of them seriously. Seven million children in the Arab states are malnourished.

The failure virtually everywhere on the continent to seriously combat environmental degradation significantly retards the quest for food security.

The link between HIV/AIDS and food insecurity in Africa is not in question. Research unveiled in May 2004 found that HIV/AIDS is having a devastating effect in this area as in so many others. Seven million farmers are estimated to have died from HIV/AIDS across the continent, reducing food production significantly. The disease also robs people of the energy to farm. As well, families reduce their own food intake as the first strategy to cope with the increased financial burden of caring for a sick or dying family member, reducing their own well-being and energy to work or farm effectively.

Health promotion. Many African countries hold Child Health Week campaigns that include not only such activities as measles vaccinations and vitamin A supplementations but also breastfeeding promotion, growth monitoring and bednet distribution. Several donor countries, UN agencies and the Micronutrient Initiative are partners in sponsoring these Child Health Weeks. It should also be pointed out that the fight against micronutrient deficiency has recorded substantial progress, with iodised salt now being consumed by a large proportion of households in many countries of the sub-region.

Section II. Overcoming HIV/AIDS.

Africa must overcome HIV/AIDS in order to fulfil children's rights to survival and development. Africa Fit For Children, paragraph 28.

The HIV/AIDS pandemic has become the main focus for all discussions and all strategies dealing with Africa's development. Reports on every conceivable facet of the pandemic pour out. A seemingly endless array of conferences, workshops and meetings come and go. Every donor government, every international aid agency, countless NGOs large and small, many UN agencies, major private foundations--- the world seems to have embraced the campaign against HIV/AIDS in a million different ways. And yet the pandemic remains largely untamed. Sub-Saharan Africa, with some 10% of the world's population, has 70% of the world's HIV/AIDS cases, 80% of its HIV deaths, and 90% of its HIV orphans.

Tragically, there is little evidence that any of the HIV/AIDS prevention programmes and policies that have been carried out have had any demonstrable success at bringing down rates of HIV transmission. With the exception of Uganda, national policies aimed at AIDS prevention have failed to make an impact in any high prevalence country, and there is no agreement about why Uganda succeeded.

While HIV/AIDS is a major issue for the entire continent, it is especially problematic for sub-Saharan Africa, and within sub-Saharan Africa for southern Africa. Southern Africa has the highest incidence of infection in young people and women in the world. In stark contrast to trends in other regions of the world, children in Southern Africa today can expect to live shorter lives than their grandparents. Within southern Africa, a South Africa survey released in May 2004 reported that more than 700,000 children aged 14 and younger in that country are HIV/-positive. Children, it concludes, run a much greater risk of contracting the disease than previously thought. 5.4% of 2-14 year olds were HIV/AIDS/positive, almost identical to the rate of the total population. But among 2 to 9 year olds, the infection rate was 6.7%. The younger children are believed to have contracted the infection from their mother. The older ones did so through sexual abuse, revealing a terrible truth about the dark side of South African life.

Already twenty years old and with billions of dollars spent tackling the disease, its far-reaching consequences are only beginning to be understood. With most epidemics, there is an assumption that they will one day soon be

conquered, their damage then largely ended. With HIV/AIDS , there is no end in sight, and even should it end in the near future—which it will not---the ramifications will be felt in terms of death, pain and the reversal of many development efforts for generations to come. As the World Health Organization's May 2004 World Health Report points out, the long-term economic and social costs of HIV/AIDS have been seriously underestimated in many countries. Apocalyptic language is uncommon in these reports, yet WHO finds it necessary to warn that some African countries could face actual economic collapse unless the pandemic is brought under control. HIV/AIDS is killing the people who we count on and take for granted to make society work—doctors, teachers, judges, farmers, miners, midwives, police officers, information specialists.

Thirty million people in sub-Saharan Africa are now HIV-positive, almost 60% of them females. In southern Africa, about one-quarter of all adults currently live with the virus, meaning a majority of today's teenagers are more likely than not to contract HIV and die of AIDS during their lifetime. Almost 4 million Africans require anti-retroviral therapy (ARV), which greatly increases life expectancy and normal functioning. It is today accessible to only 3% of those who need it, about 150,000 people. In every area of life, HIV/AIDS is taking its toll: lower agricultural productivity among farmers, teachers dying off as fast as they can be replaced, the poor impoverished even more, government departments watching their already strained capacities nosedive, armies losing healthy troops including those who could be sent on peacekeeping missions, poor public health services deteriorating even more as health professionals themselves become infected. According to a May 2004 projection by a health economist with the United Nations Population Fund, Nigeria, Africa's largest state, will soon see its economy shrink by 20% due to HIV/AIDS. It seems difficult to exaggerate the scope and scale of the disaster.

By contrast, the pandemic remains a minor problem in North African countries, although threats exist for high risk groups. A real challenge, which is widely understood, lies in the mobility of populations between countries and sub-regions. The 2003 Tamanrasset initiative on HIV is an attempt to address this issue, mainly between north Africa and sub-Saharan Africa but between neighbouring north African countries as well.

Progress in a number of areas of combating the pandemic is being made. Funding of AIDS programmes from a growing number of sources is becoming considerably easier, while new, more conveniently packaged and dramatically cheaper ARV drugs are now available. The World Health Organization has launched its "3x5" campaign, to organize treatment for 3 million infected people by 2005; most of those would be in Africa. There is a fear, however, that

funds for combating HIV/AIDS might be diverted from existing international aid budgets, leaving the other critical and needy areas described in this report even more bereft of resources than at present.

Yet in terms of prevention, the best news is also a double-edged sword. Africa knows how to prevent HIV/ transmission. Theoretically, nothing could be simpler. The answer is safe sex---men agreeing to wear condoms. Yet many men who know perfectly well how they contract or spread the virus still refuse to use condoms. In sub-Saharan Africa, the overwhelming responsibility for HIV transmission rests with men who are abusing their position of power over women who mostly are powerless in sexual encounters.

Now a significant gender gap has appeared in the impact of the pandemic. Women are disproportionately affected by HIV/AIDS. Their vulnerability to infection is increasing. In May 2004, the results of a large-scale survey of youth in South Africa found that 77% of young South Africans infected with HIV/AIDS are female; equally distressing, almost two-thirds of them believed they had little or no chance of contracting the virus. Nearly one in four young women aged 20 to 24 was HIV positive, compared to only one in 14 of the men the same age. The gender gap is also reflected programmatically; UNAIDS has stated that females are denied equal access to prevention and treatment initiatives, a pattern that must urgently be reversed.

Large-scale funding from outside Africa should not be seen as a pure panacea. Among other things, many African governments lack the capacity to put large new infusions of funds to effective use. The World Bank's Multi-Country Assistance Programme for HIV/AIDS (MAP) is a case in point. MAP disbursed about $800 million to African countries between 2001 and the middle of 2003, and yet less than 15% of this total had actually been spent.

There is a complementary issue here as well. There will be a temptation, with these new sources of funds, to have outsiders determine the programmes to be funded. Yet if there is anything that has been learned from both the history of development assistance in general and from the experience of HIV/AIDS initiatives in particular, it is the importance of starting with locally-designed programmes, with substantial input from local communities and especially those who are themselves affected by the virus, and slowly taking them to scale, rather than designing grand blueprints from outside.

At the same time, it cannot be repeated too often that the underlying multisectoral issues that lead to HIV/AIDS vulnerability must be acknowledged and confronted. Poverty, conflict, lack of food security, high levels of migration, rapid urbanization, joblessness, low education—

all of these are risk factors for HIV/AIDS, and all of these remain critical challenges for Africa to meet effectively.

Section III. Realizing the Right to Education.

Education is a basic right that allows every child to develop to his or her fullest potential. Africa Fit For Children, paragraph 29.

Education is both the right of all children and a critical tool of development. Girls' education has become a marquee issue among those concerned about schooling, and a special section of this report is devoted to that subject. It is also worth underlining the all-important truth that if the policies required to advance schooling for girls are implemented, boys will be equal beneficiaries. In this section other aspects of education in Africa are highlighted.

Since the 1990 World Education for All Conference in Jomtien, Thailand, universal primary education (UPE) has been a target of all African countries. Eventually, it was understood that the quality of education was as important as the numbers who attended. In its Framework for Action, the World Education Forum in Dakar, Senegal in 2000 committed the world to "Ensuring that by 2015, all children, with special emphasis on girls and children in difficult circumstances, have access to complete free and compulsory primary education of good quality." Across most of Africa, these goals remain elusive at best. Progress in education continues to be disturbingly slow, lagging far behind the rest of the developing world. Many children do not go to school at all. Most do not complete primary school. Few go on to or complete secondary school. And the quality throughout leaves much to be desired. In Nigeria, the most populous African country, the Minister of Education announced in April 2004 that it was simply not feasible to expect the country to meet the 2015 target of Education For All.

Primary education.

A May 2004 report by UNESCO states that in 2001, 106 million African children were in school; if the goal of UPE by 2015 is to met, that figure would swell to 180 million students. To cope, besides a massive increase in facilities, the number of teachers would have to increase at an even greater rate, doubling, tripling or quadrupling depending on the sub-region. Yet even now, in many countries fewer than half of those teaching are qualified to do so.

In fact, primary education performance is very low all across the continent. In many countries, half the children who begin primary

school fail to reach the fifth grade and many fall back into illiteracy. Few pupils in the fourth year of primary education are able to manage the basic knowledge required for this grade. In the many countries suffering from or just emerging from conflict, the school system is invariably one of the serious casualties. Yet even in a number of countries carrying no abnormal burdens, studies that have monitored learning achievements have shown a worrying decrease in the quality of primary education.

In North Africa, recent data show that young people are dissatisfied with the education they receive, finding it bears little relevance to life outside the schoolroom. An initiative to monitor learning achievement shows disappointing results in literacy, numeracy and life skills. The quality of education, the curriculum and the teaching methods used all contribute to the dissatisfaction and poor outcomes.

There are reasons why only a small number of African countries are expected to meet the Millennium Development Goals. Schooling cannot easily keep up with demand as the child population, even given high mortality rates, grows faster than services can be provided; 40% to 50% of the population is under 15 years old, a percentage that is growing. At the same time, especially in southern Africa, the number of deaths due to HIV/AIDS and the rapid increase in the number of orphans and child-headed households create constraints that pose a special challenge to meeting education goals. Most African governments are still charging fees at the primary level despite multiple pledges to the contrary, and despite the well-publicized boom in enrolment in Kenya when fees were dropped. Donor support to education remains well below repeatedly agreed targets even while donors and the international financial institutions emphasize its indispensability. As a result, poverty remains a major impediment to enrolment, retention and completion. In most countries, budget allocations to education remain well below established norms.

Secondary education.

This is a dangerously neglected subject when discussing schooling in Africa. Expectations for secondary schooling, when it is raised at all, are extremely high. Most secondary graduates are expected to be immediately employable at relatively high levels requiring sophisticated skills and considerable expertise. Secondary schools must prepare the best students to be ready for university. Secondary schools are now almost solely responsible in most African countries for inculcating in students a vast world of knowledge not only of a traditional academic nature but also such subjects as peace and conflict resolution, the environment, human rights, sex, drugs and others. By any criteria, a high

quality secondary system attended by a majority of young Africans is critical to the continent's future.

As Africa strives to achieve Universal Primary Education, the flow of learners knocking on the doors of secondary schools keeps growing. Yet secondary education has received little attention in recent years, either in reports and recommendations or in actual education reform. Little of the aid allocated to the education sector is directed at the secondary level. Not enough thought is given to the future of children who complete primary school. Through most of Africa, only a distinct minority of students enter secondary level, and only a distinct minority complete it. Nor is the quality of the graduates, few that there are, adequate. If African capacity-building relies first and foremost on its graduates, the severe deficiencies of secondary school must be seen as a challenge that needs to be tackled immediately.

Illiteracy.

Adult illiteracy is widespread on the continent and there is little evidence of noticeable progress in its reduction. In most sub-Saharan Africa countries, about half of the adult population is illiterate, with the number of illiterate women being twice as high as that of illiterate men. Across North Africa too the percentage of illiterate females is higher than that of males. Disparities between the urban and rural population are also notably wide, in favour as usual of the former.

Section IV. Realizing the Right to Protection.

Protection of children in situations of armed conflict and under foreign occupation is a special imperative. Children caught up in armed conflicts shall be given increased care and protection in order to reduce the devastating impact of war. Africa Fit For Children, paragraph 30.

Legal protection of children outside situations of armed conflict and under foreign occupations is essential. Africa Fit For Children, paragraph 31.

Protection from violence, neglect, abuse and sexual exploitation must be enhanced. Children shall be given increased protection against all forms of violence, abuse and exploitation. Africa Fit For Children, paragraph 32.

Children in conflict.

In virtually all the armed conflicts in Africa, children, both boys and girls, are still recruited or abducted to be used as combatants and/or sex slaves. But women and girls remained the most vulnerable group in such conflicts, just as they are among refugees or the internally displaced. As pointed out in Amnesty International's latest Annual Report, released in May 2004, indiscriminate and massive sexual violence against girls is commonplace in most of these conflicts.

Formal agreements to end conflicts do not necessarily end these violations. Amnesty International investigations found, for example, that despite the signing of a Peace Agreement and the formation of a new Transitional Government of National Unity, the rate of child recruitment actually increased in the Democratic Republic of Congo, particularly in the eastern region of the country.

Young ex-soldiers.

Among the great challenges facing many war-torn African countries is the future of young soldiers once conflicts have ended. For many years, youth militias operating in conflict zones---mostly boys and men but recently including girls and women as well—have offered meaning, excitement, prestige and power, and an escape from grinding poverty, hunger, boredom, poor schools and joblessness. A gun has meant a license to pillage homes, extort money, rape, kill, maim and sow havoc. Today, as Africa and the world welcome the winding down of several ferocious wars, among the challenges facing these fragile states is how to bring the ex-fighters back into the civilian fold.

The numbers are large. They exist wherever there has been conflict and wherever conflicts still rage. In Sierra Leone, 55,000 former fighters have come forth, in Liberia some 50,000 are to be disarmed. The United Nations offers these ex-killers cash incentives and access to education and job training.

But the disarming program has been riddled with difficulties. Donors have given barely a third of the money needed for these operations while gunmen cheerfully accept their cash handouts yet bring with them far fewer guns than were expected. In the northern Liberian city of Gbranga, the disarmament effort produced one weapon for every three self-described ex-fighters. There is widespread speculation that the remaining guns are buried in the bush.

What happens after the handouts run out? With joblessness sky high across almost all of Africa, with opportunities as scarce as aspirations are high, how

can ex-fighters, often uneducated and unskilled in anything but the practices of dirty war, make any kind of living without their guns? The danger is in recreating the very same grievances that led young Africans to be attracted to militias in the first place.

Child trafficking.

Thousands of children, often deprived of education, continue to be victims of child trafficking for economic reasons. West and central Africa seem to be the source of most of the child trafficking on the continent. Trafficked girls are employed for household chores, usually under harsh conditions, or for sexual exploitation. Boys are often used for difficult agricultural and mining jobs, or work as beggars in cities. Some agreements between nations have been signed, aimed at ending the practice, but it will be difficult to eradicate the practice as long as poverty, the major structural cause, persists.

Child labour.

A recent UNICEF survey of households in 25 sub-Saharan Africa countries revealed that 31%, or almost one-third, of all children between 5 and 14 are engaged in the unconditional worst forms of child labor. This is work that should be eliminated entirely for children, involving slavery, trafficking, and forced recruitment for the purposes of armed conflict, prostitution, and pornography. Almost 1 in ten children are engaged in hazardous work, labouring more than 43 hours a week in jobs that jeopardizes their well-being. In these 25 countries, covering almost half the countries in sub-Saharan Africa, there are an estimated 31 million child workers, 24 million child labourers, and 7 million children engaged in hazardous work. Taking into account household chores of more than 4 hours a day, more girls than boys were found to be engaged in hazardous work. In North Africa, too many children do work that is hazardous to their survival, development, health and moral sense. Others grow up in deprivation lacking primary caregivers, and are unregistered, juvenile delinquents, live on the streets, and face domestic violence or abuse.

Female genital mutilation (FGM).

Despite the campaigns being led by some First Ladies, despite the efforts of the Inter-African Committee on Harmful Traditional Practices, despite official prohibitions by some governments and commitments to eradicate the practice, despite the crusades against it by female activists, despite the research revealing the physical pain, long-term side effects, mental anguish, and

sometimes death experienced by girls who have been subjected to FGM, the practice continues to be widespread. It is widely pursued in all ECOWAS countries and in a number of African Arab countries. An 80% to 90% frequency rate is common, though in a few countries a quarter of all girls being forced to undergo this ritual.

In 2003, the Afro-Arab Expert Consultation for the Prevention of Female Genital Mutilation was held in Cairo, with activists from 28 Arab and African countries attending. Participants issued a petition, The Cairo Declaration, calling on all concerned Governments to adopt and implement appropriate laws to eradicate FGM. The Declaration also calls for incorporating information on FGM into the school curriculum and community-based programmes. The Declaration described FGM as an "obsolete tradition not required by religion" and the great challenge as stopping "the transfer of this practice to the next generation". Progress to this end, however, is painfully slow.

Section V. Participation of Children and Youth.

The right of youth and children to participate, and to have their civil rights respected, is stipulated in the African Charter on the Rights and Welfare of Children and The Convention on the Rights of the Children. It should be enforced without delay. Africa Fit For Children, paragraph 33.

Increasingly, and more swiftly than many might have expected, Africa's youth are being heard. But whether they are being listened to is another question.

Young Africans are routinely invited to speak at major meetings and summits and to participate in development programme meetings. The trend to political participation by youth is also growing. Some countries have designated seats for youth representatives in parliament and/or local councils and young people are very much involved in debates on poverty reduction strategies. Many countries have established a Children's Parliament which passes resolutions on issues its members consider relevant. Some schools have created children's governments with cabinet ministers assigned to portfolios of real concern to children and youth. Here the "ministers" often prove to have real power in improving the school environment, since they deal principally with problems off hygiene, health, sports and the like.

Some aid agencies and civil society organizations have taken a lead in promoting youth participation while youth associations themselves are

organizing to have their voices heard. In certain countries, radio broadcasting is both a way for youth to have their opinions expressed and to function as outreach to other young people. A variety of activities are possible using this medium, from youth interviews with government and community leaders to field trips by young people who meet peers, conduct interviews or have discussions with them that are then played on the programme. Being heard on a radio station makes young people, like their elders, feel as if their opinions matter.

But the constraints to meaningful participation by children in the life of the continent and in the decisions that affect their lives remain substantial. Cultural obstacles to allowing young people to have real influence are considerable. Levels of education are low, especially among girls, who often feel---not incorrectly—that their voice and views are unwelcome. Public participation, speaking out at a forum, appearing on the radio---all these require a high degree of self-confidence. School dropouts, those who recognize the mediocrity of their learning, young people who fear no good jobs are waiting for them, all could feel reluctant to become involved.

Yet the potential for youth to play a highly practical and constructive role in development activities is real and significant. Who better to spread the word about the need and means to prevent HIV/AIDS , for example? An army of enthusiastic volunteers is waiting to be mobilized, and indeed to mobilize themselves if they are given the opportunity. This is Africa's greatest underused and still mostly neglected asset, constituting well over half the entire population. On a continent that can afford to waste no precious resource, youth participation would mean not only the fulfilment of their rights; it would also be a meaningful leap forward for the development process.

PART B. SPECIAL ISSUES

Issue 1. GIRLS' EDUCATION.

It has long been understood that development depends on an active role for women in every aspect of society. It is a right for women to participate as equals in business, government, civil society, the professions; and it is also a practical necessity. But in order to equip women to play their crucial roles, they need to be properly prepared. So education too is a right for all children, including girls, and is also a practical necessity.

Yet in most African countries, girls remain disadvantaged when it comes to schooling. Millions never attend at all, millions more drop out long before completion, and far too many fail to receive a quality education. When a girl is

educated, her entire family and community share in the benefits. That is why study after study shows that there is no tool for development more effective than the education of girls. It is well known that there is a direct correlation between educating girls and raising economic productivity, lowering infant and maternal mortality, improving nutrition, promoting health, and preventing the spread of HIV/AIDS. A study of 17 African countries showed that better-educated girls tended to delay having sex and were more likely to require their partners to use condoms.

By the same token, uneducated girls—the many tens of millions of them---are at serious risk of becoming marginalized. They themselves will be less healthy and less skilled, less prepared to participate in the lives of their family, community and nation. They are at greater risk of poverty, HIV/AIDS, sexual exploitation, violence and abuse, and, just as the children of educated women are likely to go to school, so are the children of uneducated women less likely to attend.

For these reasons, education for all and gender parity in education have been a universally acclaimed development goal for the past 15 years. Education itself had been considered a vital factor in development beginning with African independence. Colonialism had let the continent down badly. It was handicap enough that in 1960 fewer than half of children aged 6 to 11 in newly developing countries were enrolled in primary school. But the capacity to run a state in sub-Saharan Africa was severely challenged with only one youth in 20 attending—but by no means necessarily completing---secondary school. Many newly independent nations did make UPE, as it was then called---universal primary education—a priority, and by 1980 primary enrolment in Africa had tripled. But so large was the cohort, and so rapidly did population grow, that millions of children remained school-less, the majority of them girls.

Since the late 1980s at least, the academic evidence and programmatic proof of the efficacy of girls' education was clear. Yet in that same decade, structural adjustment policies were imposed on African countries that made matters even worse. What Africa needed was a massive injection of new funding to allow for a major expansion of high quality education; yet most countries were forced to reduce their per capita spending on schooling. Fees were introduced even at the primary level, effectively deterring most poor children, not least the female ones. Few cared; the question of girls' education was not even on the radar screen.

By 1990, the consequences of structural adjustment had become only too evident. Schooling was re-discovered as one of the keys that opened the door to development. Both the Jomtien Conference and the Education for All

Moment that it seeded recognized the importance of closing the gender gap and of taking special measures to enable girls to go to school and to remain there. Ten years later, at the UN Millennium Summit and the World Education Forum in Dakar, Senegal, schooling for girls moved from the education sector to centre stage.

As the Dakar Forum declared: "The most urgent priority is to ensure access to, and improve the quality of, education for girls and women, and to remove every obstacle that hampers their active participation." This position was strengthened by the knowledge that making schools more gender sensitive and girl-friendly also makes the educational experience more relevant and comfortable for boys as well. So urgent was this issue deemed that, unlike the other Millennium Development Goals, which are targeted for 2015, gender parity in primary and secondary education was to be achieved by 2005.

Unhappily, there seems little chance this accelerated goal will be met. In sub-Saharan Africa, at the current rate of progress it will be not next year, nor even 2015, but well over 100 years from now in 2129 before all children are in school. No other region of the world fares as poorly. Sub-Saharan Africa has the invidious distinction of having both the fewest boys (62%) and the fewest girls (57%) attending primary school. Of 37 countries world-wide where fewer than one quarter of the girls are in secondary school, 30 are in sub-Saharan Africa. Forty-five million children were not enrolled in primary school in 2002.

Sub-Saharan Africa also badly lags the rest of the world in the rate of primary school completion. In the developing world as a whole, completion rates rose during the 1990s from 73 to 81%; in sub-Saharan Africa, while there was some improvement over the decade, barely half of all children complete primary school; at this rate, the level will barely reach 60% by 2015. As for girls, while a number of African countries saw an impressive improvement in girls' enrolment during recent years, the primary school completion rate is characterized by a yawning gap between girls and boys. This means that millions more girls than boys are dropping out each year, behavior the continent can simply not afford. In sub-Saharan Africa, in the face of all the resolutions and declarations to the contrary, the number of girls out of school rose from 20 million in 1990 to 24 million in 2002. With one exception, the countries with the smallest proportion of girls enrolling in secondary school are all in sub-Saharan Africa. In eight sub-Saharan Africa countries, the gross secondary enrolment rate is actually under 10%.

These outcomes, while unsettling, are not entirely surprising. Despite the good intentions and positive rhetoric, education, and girls' education in particular, is not in practice often treated as a priority. Governments with scarce financial

resources and an avalanche of pressing immediate demands –even those that are genuinely committed---find it easy to underfund schooling for yet another day. As a result, too many schools offer few incentives to come and learn. They are overcrowded. They lack desks, notebooks, and teaching aids. Many teachers are poorly trained, unmotivated, and operate in a harsh, authoritarian manner with little regard to making their lessons stimulating. Above and beyond all these deterrents stand school fees. Together with such hidden costs as textbooks and uniforms, plus the opportunity costs associated with the household responsibilities assigned to children, the price of attending school directly impacts the most vulnerable in Africa---the children orphaned by HIV/AIDS, the poor, girls in rural areas.

Beyond that, and beneath the rhetoric, many African societies in fact are characterized still by persistent gender discrimination, however subtle it may be. Equality for women, and equal schooling for girls which permits women's equality in practice, are rights that are often as not honoured in the breach, rather than the observance. It is unlikely that many government officials are broken-hearted if education for girls has to be sacrificed.

As well, despite the apparent universal consensus, the sad truth is that many still fail to recognize how critical to any country's development the contribution of its women, above all its educated women, really is. Much development theory remains so fixated on economic growth and structural adjustment—as unsuccessful as the first has been and destructive the second---as to virtually ignore factors such as gender equality. As a result, while conference-going officials passionately endorse resolutions and declarations putting girls' education first, decision-makers negotiating national budgets too often put it nowhere at all. Somehow or other, they have still not grasped that development is a multisectoral phenomenon. To attempt to foster growth while ignoring education for all and the elimination of disparities between boys and girls is simply self-defeating. And girls' education in particular is not only a catalyst for growth, it leads to positive change on a range of other critical development fronts from health to early childhood care to nutrition, water and sanitation, to the reduction of harmful child labor.

A word on development assistance. If too many African countries have failed to live up to the commitments they made at the Jomtien Conference, and at the World Summit for Children, and at the UN Millennium Summit, so too have the richer countries and the international financial institutions [IFIs]. Donor countries are tireless in pushing poorer countries to expand educational opportunities and have repeatedly made specific pledges to provide extra funds to ensure universal primary education by 2015. Instead, the exact opposite has happened. Not only did total development assistance to sub-

Saharan Africa shrink by 14% during the 1990s, bilateral funding for education has plummeted even further. In 2000, it was fully 30% lower than in 1990. Similarly, the IFIs churn out reports and studies and finance conferences all of which conclude that education, and specifically girls' education, must be one of Africa's sacred priorities. Yet the World Bank's International Development Association loans to education were one-third less at the turn of the millennium than in the first half of the 1990s. At the same time, conditionalities imposed by the IFIs on African governments continue to chip away at the education sector. It is by no means easy to reconcile these contradictions.

Girls' Education

Workshop on investments addresses gender disparities.

In June 2003, UNICEF and the World Bank, with Norwegian support, organized a workshop called "Investment Options in Education for All: Addressing gender and other disparities". Held in Ouagadougou, Burkina Faso, and attended by ministers from 24 countries in west and central Africa, along with senior technical officials, the workshop issued a report in November called Girls' Education: Making Investments Count.

The report begins by recalling that only 59% of children in sub-Saharan Africa attend school, most of them boys, while over a third of students drop out before the 5th grade. Household surveys from 21 African countries carried out by the World Bank revealed that the children who are not in school are usually girls, from poor households, in rural areas. Given scarce resources, the report therefore argues that the priority should be given to poor rural girls. Within this broad category, it recommends investing in the following areas which have the greatest impact in providing a quality education for all:

"Early childhood development and pre-primary education, a positive learning environment that ensures safety and security especially for girls, a learning process that includes teacher training as well as health, nutrition and life skills."

Even students that do remain in school may not learn much. The quality of education is often poor. Supplies of textbooks and instructional materials are typically lacking, an average of 70 children to a classroom is common, and only half the teachers are trained at all. The quality of teaching is the single most important factor in student learning, and far too many teachers in African schools, both the untrained and the poorly trained, have no idea how to make lessons stimulating so that students learn. The school's physical environment is also of great importance. It is becoming understood that the availability of safe water and separate latrine facilities is a major factor in getting children, especially girls, to enter and remain in school.

The report concludes with the drastic statement by a World Bank official that "Development aid to reduce poverty makes no sense if we cannot provide all African children with good quality basic education." It points out that no country in the world has achieved sustainable economic growth without first achieving at least an average of 5 to 6 years of basic education among adults. Since development aid for both poverty reduction and education falls far short of need, the lessons to be learned from the report are clear enough.

Issue 2. HIV/AIDS AND ORPHANS.

There are 15 countries in the world where more than a quarter of a million children aged 0 to 14 years have been orphaned by HIV/AIDS. One is Thailand. The other are all in sub-Saharan Africa. Here the pandemic has already orphaned a generation of children. It now seems set to orphan generations more. Not only are the rights and well-being of these generations of parentless children in great jeopardy, so are the overall development prospects of their countries.

There are an estimated 11 million children under 15 orphaned by HIV/AIDS in sub-Saharan Africa, approaching 90% of the world total. Together they constitute a nation with a far greater population than many African countries. By 2010, their number is expected to be 20 million—nearly twice the 2001 figure-- and between 15% to over 25% of the children in a dozen sub-Saharan Africa countries will have lost one or both parents, mostly to HIV/AIDS. This is a phenomenon unknown before in human history.

Even with a super-human effort to combat the plague, the number of orphans in sub-Saharan Africa will continue to rise for years, simply because of the high proportion of adults already living with HIV/AIDS and the slow progress in expanding access to antiretroviral treatment. Inevitably, many will die, leaving their children parentless. Besides the long lag time between HIV infection and death, it is also a characteristic of HIV/AIDS that if one parent is infected, the probability is that the other is too. Children therefore face the real risk that both their parents could die in relatively short period; they then become "double orphans".

The pandemic has deepened the poverty that already afflicted so much of Africa, worsening a myriad of conditions that were already severe. Orphans are among the most vulnerable to the shock of deprivation. In nearly every sub-Saharan Africa country, extended families have assumed responsibility for more than 90% of orphaned children. Many of these families, however, already pushed to the limit, overwhelmed, increasingly impoverished and unable to provide adequate care even for their own children, can no longer cope when they are obligated to care for orphaned children. An increasing number of families are headed by women and grandparents, while girl-led households are becoming more common. Grandmothers who should be cared for by their children are tending to their dead children's children. All face burdens that are barely manageable. Yet it is precisely those countries that will see the largest increase in orphans over the coming years where the extended or decimated family is already most stretched in caring for orphans.

When an adult falls ill from HIV/AIDS and can no longer work full-time or at all, household incomes plummet. In rural areas, land cultivation suffers, resulting in reduced crop production and lower food availability. The costs of treating illnesses caused by HIV/AIDS also places a huge economic burden on families, as much as four times greater than unaffected households. This extra expenditure is of course particularly onerous since household income has likely declined because of working days lost to the illness. Funeral expenses, often outrageously high, also contribute to the toll exacted by HIV/AIDS. Yet it is precisely such households that end up with orphans.

The consequences of being orphaned are easily intuited. They are disadvantaged in any number of ways, some of them devastating. They are likely to be traumatized from witnessing the illness and death of one or both parents, with no way to deal with or even understand their trauma. They may well have treated their parents, especially their mothers, as they lay dying. They are likely to suffer damage to their cognitive and emotional development. They are likely to be poorer and less healthy than non-orphans. Orphans often lose the support of extended families who determine if they will be allowed to attend school. Orphans losing both parents are even less likely to attend, while girls are victimized more than boys because the burden of caring for sick relatives falls disproportionately on them.

Many orphans end up living on the streets, easy prey for the unscrupulous. They are obvious candidates for the worst forms of child labor. Among girls and young women, being an orphan is a major risk factor for becoming a prostitute in order to earn money. Young girl orphans especially are vulnerable to child rape, a terrible perversion that has become more prevalent on the continent. Orphans may also eat less, which only intensifies their vulnerability.

Children can be cruel to each other. Those whose parents are ill with HIV/AIDS or those who have been orphaned by it face stigma and discrimination. Other children assume—why should they be wiser than adults?-- that if your family is infected, you too have the dread disease. Orphans who move to foster homes may be treated as second-class family members, discriminated against in the allocation of food or in the obligation to work. Children know when they are unloved and excluded, and the psychosocial trauma from family deaths can easily be exacerbated. In these cases, separation from siblings is often another source of anxiety.

It is possible, with an effort commensurate to the challenge, to change possibilities for those already orphaned and for the generation to come. It is not inevitable that orphans should be denied their rights. They too are entitled to,

and could have, the same safe, healthy and well-educated childhood that is envisioned for all Africa's children, establishing the foundation for a productive adult life and their countries' overall development. The world community is on record as supporting this ideal. In 2001, the UN General Assembly Special Session on HIV/AIDS paid special attention to children made vulnerable and/or orphaned by HIV/AIDS, and endorsed a Declaration of Commitment that set specific goals for the subsequent five years.

HIV/AIDS and orphans.

Commitments made at the 2001 UN General Assembly Special Session on HIV/AIDS and reiterated at the Special Session on Children in 2002:

By 2003, affected countries will develop, and by 2005 implement, national policies and strategies to : build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psycho-social support; ensure their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

Urge the international community, particularly donor countries, as well as civil society and the private sector to complement effectively national programs to support programs for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk, and to direct special assistance to sub-Saharan Africa.

By the close of 2003, of the 40 sub-Saharan Africa countries with generalized epidemics (i.e., 1% or higher HIV in the general adult population), only 6, or 15%, had developed a national policy on orphans and other vulnerable children. Eight—20%--were preparing these plans. The remaining 65%, 26 countries, had no national policy in place. It seems unrealistic to expect that by 2005 the large majority of affected sub-Saharan Africa countries will be anywhere close to fulfilling the commitments they made.

In fact, the opposite is true. With a few exceptions, it is evident that governments in sub-Saharan Africa have so far barely responded to the orphan crisis at all. The reasons are not hard to find, and perhaps not even surprising. Most governments can hardly cope with their routine responsibilities, let alone with huge new disasters with no easy solutions. Most governments already suffer from limited capacity; now HIV/AIDS has compounded that serious problem as key public servants are struck down. At the best of times—which these are not—a host of immediate demands compete for ministers' attention and for scarce public resources. Each new call for special funds adds to the level of frustration.

AIDS orphans are a complicated issue for governments. First, many politicians continue to feel uncomfortable dealing with HIV/AIDS in any of its multiple aspects; after all this time and all the research and all the deaths and misery, denial and stigmatization remain all too common. Second, despite the numbers, the orphan crisis is not especially visible, since these millions of children are dispersed over many families and communities where the hardships of individual children are lost to sight. As for orphans who are forced onto the street, it is hard to single them out from the other children who struggle to survive on the streets of most African cities, Finally, and perhaps most significantly, government action has been slow to emerge because, until now, families and communities have shouldered the strain, relieving the pressure on governments and public institutions.

It may also be that even governments with the best will in the world understand that the orphan crisis is not given to easy or rapid solutions. After all, if governments cannot get "ordinary" street children off the street and into good families and good schools, how can they be expected to find a satisfactory way to deal with troubled HIV/AIDS orphans? If so many families that do not support these orphans live on the brink, how can government afford to help a family that has adopted one or more of them? With so few experts in psychosocial counselling, how can this generation of troubled orphans be helped to cope with their traumas?

But being realistic must not mean paralysis. The free basic education that should be public policy for all governments would be a great boon to orphans. So would achieving such elementary goals as the provision of safe drinking water. So would fulfilling a host of commitments that African governments have made and continue to make. Nor are new funds invariably required. There are countless heartening examples throughout Africa of community initiatives to care for and support orphans and vulnerable children. Such efforts can be nurtured, expanded and taken to scale. Local leaders need to be engaged --- everyone from traditional and religious leaders to administrators, prominent

citizens, journalists, civil society activists, teachers. They need to be sensitized to the impact of HIV/AIDS and the circumstances of orphans and other vulnerable children. They need to see that the response demands the mobilization and collective commitment of the entire community. And indeed, working together almost any community can make very significant progress.

As for donor countries who have not become engaged with this issue, they could presumably argue that there are few national programs in sub-Saharan Africa to support, which is only too true. But there are no end of other means to contribute, as they well know. In the spirit of the Convention on the Rights of the Children and the Millennium Development goals and all the other commitments they have made, rich nations must recognize that they have a vital role to play in meeting the challenges of the orphan crisis. They must mobilize increased resources, keep the issue high on the global agenda, provide technical and material support, and ensure that progress towards global goals is monitored. Such monitoring, of course, must encompass their own records in fulfilling commitments solemnly and repeatedly made.

Issue 3. THE SCOURGE OF MALARIA.

Malaria is the biggest killer of young children on the African continent. Although it barely exists in north Africa, malaria is the principal cause of at least one-fifth of all child deaths in Africa, claiming up to one million such lives each year. It also causes severe illness in young children, giving rise to severe anaemia and cerebral complications, both of which can have serious consequences for long-term child survival and, if they do survive, for educational and social development. As a result of overall reductions in child mortality, the proportion of child deaths attributable to malaria in Africa actually rose during the 1980s and 1990s, especially in east and southern Africa. An average of 30% of all outpatient clinic visits and between 20% to 50% of hospital admissions are for malaria, placing a severe burden on fragile national health systems. Pregnant women are also prone to severe and complicated malaria which in turn leads to low birth weight infants, an important factor in determining the survival and development of the child.

As usual, poor people—those with inadequate housing, who live in a rural environment, and who lack access to preventive measures-- are at highest risk of becoming infected with malaria. The rural poor also suffer increased mortality as a result of lack of financial and geographical access to effective treatment. The direct and indirect costs of infection also disproportionately effect poorer households which are less able to afford treatment or the loss of income as a result of illness. Malaria receives far less high profile attention than HIV/AIDS. Yet in general, and with exceptions, the burden of malaria in

Africa continues to worsen, due to a combination of factors that include weak health systems, large population movements, increasing parasite resistance to the cheaper antimalarial drugs, and by no means least, HIV/AIDS itself. There is growing evidence of a destructive interaction between HIV and malaria. They make each other worse. Data from 2003 shows that co-infection of HIV and malaria increases the risk of mother to child transmission by nearly three times.

Roll Back Malaria [RBM].

The RBM Partnership was founded in 1998 by the World Health Organization, UNICEF, the UN Development Programme and the World Bank to tackle the global malaria problem. The goal is to halve the world's malaria burden by 2010. Two years after the founding of RBM, an African malaria summit was convened in Abuja, Nigeria, attended by delegates from forty-four of the fifty malaria- affected countries on the continent plus the RBM founding partners and other key organisations. African Heads of State accepted the goal of halving the malaria mortality rate by 2010 and resolved as well to meet the following commitments by 2005:

- At least 60% of those at risk of malaria, particularly pregnant women and children under five years, will benefit from personal and community protective measures to prevent infection and suffering such as insecticide-treated nets [ITNs] and other interventions that are accessible and affordable.
- At least 60% of those suffering from malaria will have prompt access to and are able to use correct, affordable and appropriate treatment within 24 hours of the onset of symptoms
- At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to intermittent preventive treatment [IPT].
- Reduce or waive taxes and tariffs for mosquito nets and materials, insecticides, antimalarial drugs and other recommended goods and services that are needed for malaria control strategies.

Progress towards these targets will be evaluated at extraordinary meetings of Heads of State and Government in 2005 and 2010. Countries are also required to provide annual reports on implementation of the Abuja Plan of Action.

The period since the launch of RBM in 1998 has seen several important developments in the field of malaria prevention and control. Effective new tools are now available, as the Abuja Summit recognized. ITNs can reduce child mortality by 20%, which can be further reduced by ensuring prompt access to effective antimalarial treatment. Intermittent preventive treatment of malaria during pregnancy can significantly reduce the proportion of low-birth weight infants and maternal morbidity. IPT for infants, linked to the routine immunization schedule, is now on the horizon.

While a multitude of worthwhile and often low-cost initiatives embracing these new tools have been launched, evaluations of their impact do not yet allow for many generalizations. Using the latest data available at the time, however, the 2003 World Malaria Report published by WHO and UNICEF found no country in sub-Saharan Africa that showed a decline of illness due to malaria.

Still, to a greater or lesser extent, all sub-Saharan Africa countries take malaria seriously. The majority, for example, have adopted Insecticide Treated Nets (ITNs) as a key RBM intervention. These nets are a highly effective tool in reducing malaria-related mortality and morbidity. Data from the Africa Malaria Report 2003 indicated that only about 15% of children under five slept under a net and fewer than 2% slept under a net treated with insecticide. However, much of these data relate to surveys carried out in 2001 and some recent country survey data indicate much higher coverage rates. Given the political will, it seems that countries can rapidly scale up ITN coverage, although preliminary evidence suggests that coverage in rural areas may be considerably less extensive than in urban areas

Prompt access to effective treatment and appropriate management of severe disease is vital to reduce malaria-related mortality. In much of Africa, though, access to quality health services is limited both as a result of poor geographic coverage of health facilities and of limited resources at national and household levels. Community-based interventions for home based management of fever are increasingly being introduced in several countries to overcome inadequacies in the formal health services.

Home based management of malaria: Uganda

Uganda is in the process of implementing a strategy to improve the home-based treatment of malaria through the provision of first line antimalarials at community level. The antimalarials are provided as pre-packaged combinations of chloroquine and SP, known as HOMAPAK. Two different packages are provided – a red one containing a treatment dose for a child aged 2 months to 2 years, and a green one containing a treatment dose for a 2-5 year old. HOMAPAKS are distributed free of charge to the user. Although at an early stage, initial results indicate a high acceptance of the principle of home-based malaria treatment at all levels. At community level more than 60% of children receiving HOMAPAKS were seen in the first 24 hours from onset of symptoms.

The 2002 external evaluation recommended that the second phase of RBM should focus on country level actions in order to accelerate progress towards attaining the Abuja targets. Sub-Saharan African countries were divided into four categories reflecting their readiness to go to scale with RBM interventions and based on an assessment of burden of disease, existence of effective partnership mechanisms, implementation readiness (including funding availability, mainly from the Global Fund to Fight AIDS, TB and Malaria [GFATM]), and progress on Abuja targets. As can be seen below, almost half the countries of sub-Saharan Africa are not expected to reach the Abuja targets by 2005.

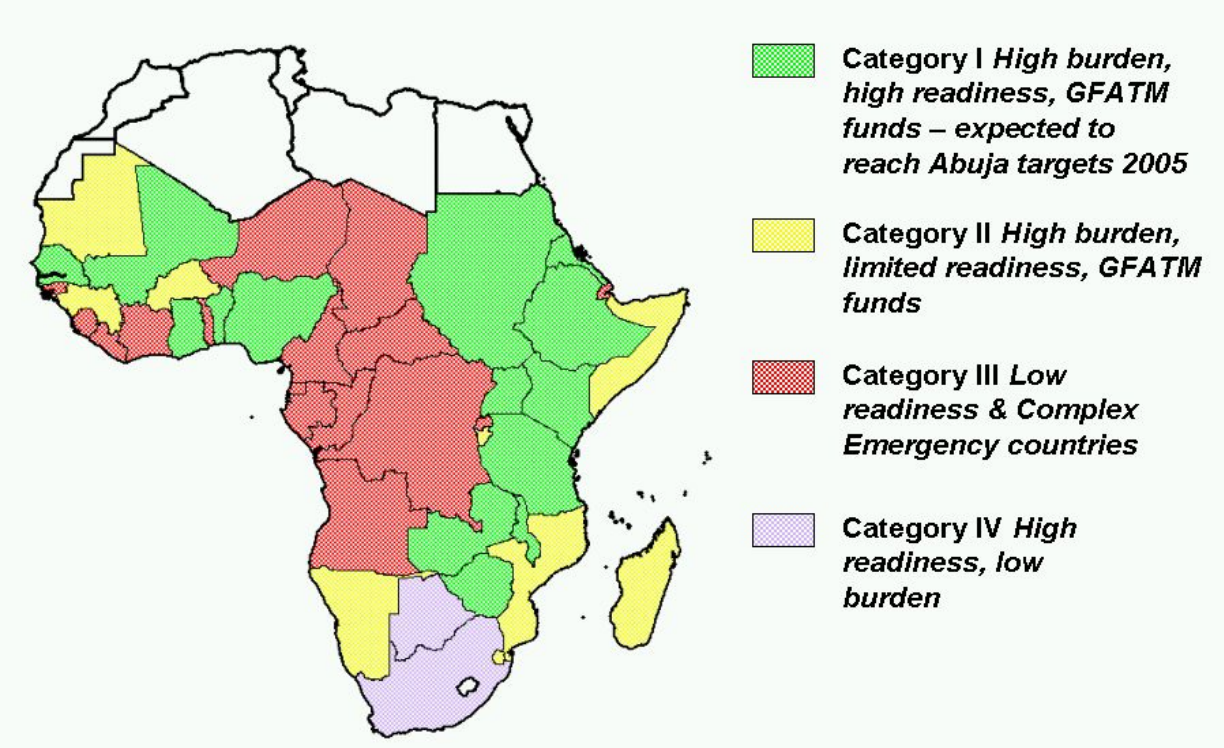

Figure: Categorisation of sub-Saharan African countries for REAPING [Roll Back Malaria Essential Actions, Products, Investments, Gaps]

Financing the malaria rollback.

Tackling malaria effectively requires substantial resources. The Abuja Summit estimated that at least $1 billion would be needed. Spending by African governments on health care is remarkably low---typically less than $15 per person a year, at least 100 times less per capita than most rich countries. Given income levels, the costs of malaria control---drugs, insect-treated nets, insecticide sprays, coils---are relatively high. Yet most of the costs of preventing and treating malaria in Africa today are borne by Africans themselves, even if

this contributes to their greater impoverishment. Their choices are not enviable. Collective action by governments is critical.

The Global Fund to fight AIDS, TB and Malaria (GFATM) was established in 2002 as a funding source to support countries in preventing and controlling these three deadly diseases. The first grant agreement, signed in December 2002, approved funding of $ 2.1 billion. Sixty percent was allocated to Africa, a quarter of it to malaria. Total approved funding for malaria proposals in Africa is $371.6 million over two years, representing a significant financial resource for scaling up RBM interventions. More than US$ 40 million has been disbursed to African countries for malaria to date.

C. THE WAY FORWARD.

The post-Cold War period has evolved into an era where governments are held accountable for their actions. Instead of just mouthing pious platitudes, governments are called upon to make formal commitments to specific goals. They also are asked to have their performance reviewed by their peers. The catch here is the results. If you make commitments, and if your record of fulfilling those commitments is evaluated, and if that record comes up short, it is likely to be a source of some considerable embarrassment. That, of course, is the price of accountability.

What this brief overview of the state of Africa's children reveals is that it is well past time to begin moving beyond commitments to implementation. On indicator after indicator, goal after goal, hope after hope, commitments repeatedly and often enthusiastically made receive little or no follow-up. This is as true for the governments of Africa as for donor governments and organizations. Those who pay the penalty—and it is severe—are the children and youth of Africa, on whose behalf the commitments were made. Unless the fulfilment of commitments is drastically accelerated, the lives of countless millions of African children will remain nasty, brutish and short. In some cases it will get nastier and even shorter.

Innumerable recommendations exist for African leaders to follow. The overriding issue is not knowing how to proceed but having the political will to do so.

But action by Governments alone will not be enough to fulfil the promise of an Africa Fit for Children. While Governments and political leaders are accountable for action and progress, partnerships are needed, with civil society, young people and families. As recognized by the African Common Position (ACP), the participation of young people and children is central to

tackling issues ranging from peace-building to HIV infection. That is why the ACP seeks to bring together "people's movements, youth movements, professional networks, artists, intellectuals, mass media, business community, women groups, religious and traditional leaders, children, the military, adolescents, political leaders as well as civil society organizations in order to advocate for the rights of children and tackle problems affecting them". The private sector too must play a leading role in generating economic opportunities, jobs and taxable surplus for investment in basic services.

This coalition works. Experience demonstrates it. A thousand initiatives that have directly benefited African children and youth have succeeded because of it. Society counts on the contributions of all its members for effective development. If the will exists, the way will be found.

2004

The state of Africa's population Report-2004 theme: Population and the poverty challenge

African Union

African Union