Chapter 6

Leaving No-One Out: Investing in People

Summary

Strong and sustained progress in human development requires fundamental change. That change will happen only if women and men are at the centre of the action. The world has made inspiring commitments, including Education for All and the UNGASS Declaration of Commitment on HIV and AIDS. Delivering on these commitments is fundamental to meeting the MDGs. But that should not be through yet more competing initiatives. Sustained advance requires financing that aligns behind national health and education systems and is harmonised with and complementary to other assistance. Effective use of the large new resource flows will require careful attention to mechanisms for delivering and monitoring results, and accountability to the poor communities that are being served.

Practical actions include:

- Providing the funding for all boys and girls in sub-Saharan Africa to receive free basic education that equips them with skills for contemporary Africa. Secondary, higher, vocational education, adult learning, and teacher training should receive appropriate emphasis within the overall education system;
- Strengthening health systems in Africa so all can obtain basic health care. This will involve major investment in human resources, in sexual and reproductive health services, in the development of new medicines, as well as supporting the removal of user fees. Through coherent, integrated strategies, this approach could effectively eliminate diseases that devastate poor people, such as tuberculosis and malaria and other parasites;
- Delivering the UNGASS Declaration of Commitment on [illegible]
- SaiGruas vihurute iac pbhhdau7ute 7b pba7uadt 7b o9b7tpa7 orphans and vulnerable children, through providing predictable financing streams for national social protection strategies;
- Meeting the G8 Water Action Plan commitments through increased funding for the Africa Water Vision to reduce by 75 per cent the number of people without access to safe water and basic sanitation by 2015, monitoring progress in 2007.

Of all the issues addressed in this Report, the health, education and inclusion challenges are the most demanding in terms of resources. We recommend that these resources be provided in predictable, long-term streams, with a carefully sequenced steady increase in step with improvements in African governments' capacity to deliver effective services.

1 Human security encompasses men and women's ambition to be free from want, fear, illness and ignorance and to have the freedom to take control of their lives[1]. To achieve this, human development seeks to expand the opportunities available to individuals to help them shape their own lives and fufil their potential with dignity. Human development has intrinsic value. People have a right to it. But it is also a public good – that is, it has value to others. And it is essential for the economic and political development of society as a whole. Health, education and social protection are productive investments not only for the individual but also in the basic capital of a state – its people and particularly the children and youth that are its future. Social justice demands that we work together to deliver these basic rights.

2 The challenges are immense. If we continue as we are, the Millennium Development Goals (MDGs) for halving poverty, for universal primary education and for the elimination of avoidable infant deaths in sub-Saharan Africa will not be delivered in 2015 but between 100 and 150 years late[2]. In 2004, AIDS killed over two million people in sub-Saharan Africa with more than three million infected in that year alone[3]. We are not yet through the peak of the crisis. Three out of four of the young people living with HIV and AIDS are women in sub-Saharan Africa. Meanwhile, health and education systems have been run down through years of neglect and there are huge deficits in doctors, nurses and teachers. Staying healthy is particularly expensive for the poor, with a third of their monthly expenditure going on malaria treatment alone[4].

3 Real progress in human development requires fundamental change. The world has signed up to exciting commitments, including the MDGs, Education for All in 2000 and the Declaration of Commitment on HIV and AIDS at the United Nations General Assembly in 2001. And they must be delivered. But not through new initiatives. Rather, through financing that supports coherent country-led strategies for strengthening health and education systems. Donor funding has been short term, volatile and largely tied to using people and products from donor countries. Single-issue initiatives have led to the setting up of parallel systems in competition with each other, further undermining government capacity. In fragile states, the co-ordination of assistance is even more essential. Whilst we call for substantial new financing, we also call for it to be predictable and over longer time frames. We call for these investments to be increased in a carefully sequenced way, to ensure that government capacity to absorb funding and deliver outcomes is progressively built up. Above all, we call for investment that comes in behind national commitments to improve services, supporting African leadership and based on genuine partnerships between governments, civil society and the international community.

4 But there is much more to do, and African governments must continue to demonstrate their commitment to deliver quality services. Unless the incentives work to improve outcomes – better education, greater health – increased funding will have little impact. Making services accountable to communities either through their participation in design and delivery or through politicians is essential to improve the quality of those services and the effectiveness of investments. And through disaggregated monitoring, governments must also manage for results, to further increase effectiveness and ensure the inclusion of the poorest people in services. But the allocation of resources must be in response to need and the potential to deliver returns – not just based on past performance or previous aid relationships. Chapter 4 covers issues of accountability, transparency and the capacity to deliver services in more detail.

5 This chapter sets out the bold and urgent actions required by the international community to effect real change – along with the reforms that must be undertaken by African governments. First are the actions to support Africa's new vision for education, with skills that are relevant and provision that is inclusive for girls and boys. The case is made for ensuring support is equitably balanced across the sector, from primary to

secondary and higher, including adult learning, vocational and teacher training. Actions to strengthen higher education are covered in Chapter 4. Second are the actions required to strengthen health systems and eliminate preventable diseases. An essential part of this is the harmonisation and integration of initiatives behind coherent national strategies. Third are the actions to ensure three out of four households have water and sanitation by 2015, through integrating efforts behind single national strategies and behind single river basin strategies. The urgent response required for HIV and AIDS is highlighted throughout the report, but fourth are the core actions to ensure that the campaign against HIV and AIDS is coherent and comprehensive. This requires donors to work together behind African leadership to ensure full support for locally owned strategies appropriate to gender and power relationships. Fifth are the additional actions that are required to tackle exclusion and vulnerability – interrupting these interlocking cycles to enable families and communities to protect orphans and vulnerable children. These interventions should also reduce inequalities between groups, and so lessen one of the sources of political instability and conflict. Again, achieving greater inclusion is also explored in other chapters. Protecting the rights of women and children and recognising the far-reaching impacts of the HIV and AIDS pandemic is the foundation of this analysis.

6.1 Education and skills for contemporary Africa

6 Education is a fundamental human right[5]. It is a means to the fulfilment of an individual. It is the transfer of values from one generation to the next. It is also critical for economic growth and healthy populations. Countries which are not on track to meet the gender parity MDG target in education (and nearly half of those are in Africa) will have child mortality rates one and a half per cent worse than countries with better education systems, and they will also have two and a half per cent more underweight children[6]. A World Bank study in seventeen sub-Saharan African countries shows a clear correlation between education and lower HIV and AIDS infection rates[7]. Education should clearly play a powerful role in preventing HIV and AIDS. Providing girls with one extra year of education has been estimated to boost their eventual wages by ten to 20 per cent[8]. All these benefits increase as children, and especially girls, complete more years of schooling and progress to higher levels of education[9]. The case for education is overwhelming – both in terms of fulfilling human security and as an investment with very high returns.

7 Education for All (EFA) is the title of one of the most exciting pledges that the international community has ever made[10]. At the World Education Forum in Dakar, Senegal in 2000, the assembled nations committed themselves to providing free and compulsory primary education for every child in the world and halving adult literacy by 2015[11]. Gender disparities in primary and secondary education were to be eliminated by 2005[12]. The quality of education was to be improved, as was early childcare and learning and life skills for young people. Countries from across the world also pledged 'no countries seriously committed to education for all will be thwarted in their achievement of this goal by lack of resources'[13]. In 2002, the 'Fast Track Initiative' (FTI)[14] was launched as one way to mobilise the resources to make good this promise. FTI is a partnership of donors and low-income countries that have made mutual commitments to accelerate progress in primary education. It provides a practical framework, not only for harmonising donor funds in support of African governments' own education strategies, but for agreeing what constitutes success in the delivery of results.

6.1.1 Time to deliver

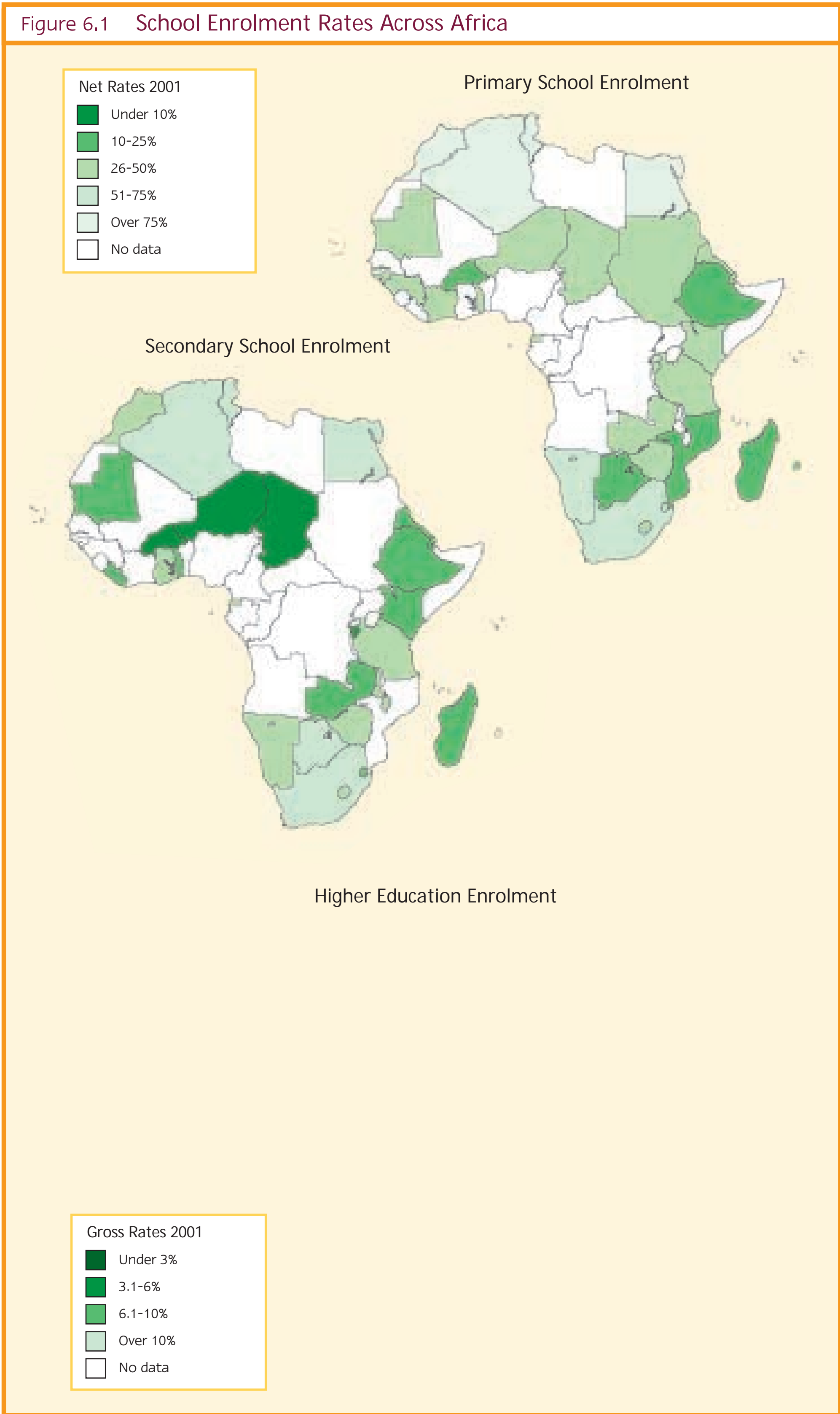
8 Six areas require priority action by the international community in strong partnership with African governments and non-state actors: planning and balancing resources better

across the whole education sector – from primary to secondary and higher, and including adult and vocational education; delivering on existing aid commitments with better international leadership and co-ordination of aid; gender equality; teacher training and retention; community involvement and developing curricula relevant for today's challenges.

Investing resources better across the whole education sector

9 Progress in primary education is being made in some of the poorest countries such as Burkina Faso, Benin and Eritrea[15]; with overall numbers of children in primary school in sub-Saharan Africa increasing by 48 per cent between 1990 and 2001[16]. But attaining universal enrolment has been patchy (see Figure 6.1). Rural areas tend to fare worst[17] and particular groups, such as girls, disabled children and orphans are marginalised. Certain strategies are very successful, such as removing primary school user fees, which can

Figure 6.1 School Enrolment Rates Across Africa



Source: Global Monitoring Report, UNESCO, 2004.

mere third of this to sub-Saharan Africa[26]. Estimates for funding universal primary education in Africa vary greatly. The World Bank estimates that for 33 sub-Saharan African countries, an additional US$1.9 billion is required[27], but this figure does not take into account the needs of the other 15 countries, nor the more comprehensive interventions to improve quality that we are recommending below – including education that is 'girl friendly', that systematically addresses HIV and AIDS, that invests in teachers, that develops relevant curricula and that covers the agenda beyond primary. For secondary alone, a conservative estimate is US$2.3 billion annually[28].

14 We estimate, therefore, that the shortfall to achieve an equitable balance in education provision in sub-Saharan Africa is US$7 to 8 billion each year, but that this should be provided in a steady measured increase, focusing on getting the basic structure right first, such as sufficient teachers and equitable provision, and governments' capacity to deliver effective outcomes. Recommendation: Donors and African governments should meet their commitments to Education for All, ensuring that every child in Africa goes to school. Donors should provide an additional US$7 to 8 billion per year as African governments develop comprehensive national plans to deliver quality education. This would bring spending on the education sector to an average six per cent of GDP in each country[29]. This would be enough to strengthen education systems comprehensively and enable all children to have a basic education with half progressing to secondary. Part of this funding will go through the FTI – US$1.4 billion is required this year for countries that have approved plans ready for immediate implementation. Funds will need to increase incrementally as the expansion of the FTI to other sub-Saharan Africa countries is rapidly pushed through[30], as agreed at the EFA annual meeting in 2004, and supported by the UN Millennium Project. Some of these countries have plans awaiting endorsement, but others need additional support, especially countries with insufficient donor funding[31], countries affected by conflict and those countries with large education disparities but which lack good governance structures[32]. The right to education should be recognised even in fragile states. The balance of overall funding will be through national budgets.

15 This will only be effective with strong leadership and action by African governments. Funding will therefore be dependent on comprehensive education plans to ensure investment is equitably balanced and sequenced across the sector. The emphasis given to each part of the sector plan will depend upon the current situation in individual countries[33]. The plans should have a focus on managing for results – capturing information to evaluate what works and allocating resources appropriately. The plans would be linked to poverty reduction strategies, would prioritise basic education, and ensure a strong focus on girls throughout. Governments must also build mechanisms to increase accountability to communities, discussed further below.

16 Likewise, strong action by donors is crucial. Donor funding must align with national priorities[34] through partnerships with African governments. Investments must also be flexible to be more effective. As discussed in Chapter 4, donors must provide predictable and sustainable funding to allow governments to invest in long-term plans and recurrent costs such as teachers' salaries.

17 But that is still not enough. To make the investment effective, the international community must improve its co-ordination under stronger leadership from UNESCO and the FTI to avoid duplication of activities through clearer delineation of roles. The FTI should also increase African representation in its working groups and planning and review processes.

Gender equality

18 Education is as much a right for girls as it is for boys. And the impacts of education on development discussed earlier are stronger when girls are educated. In particular, girls' education provides an opportunity to reduce the spread of HIV and AIDS – it was considered

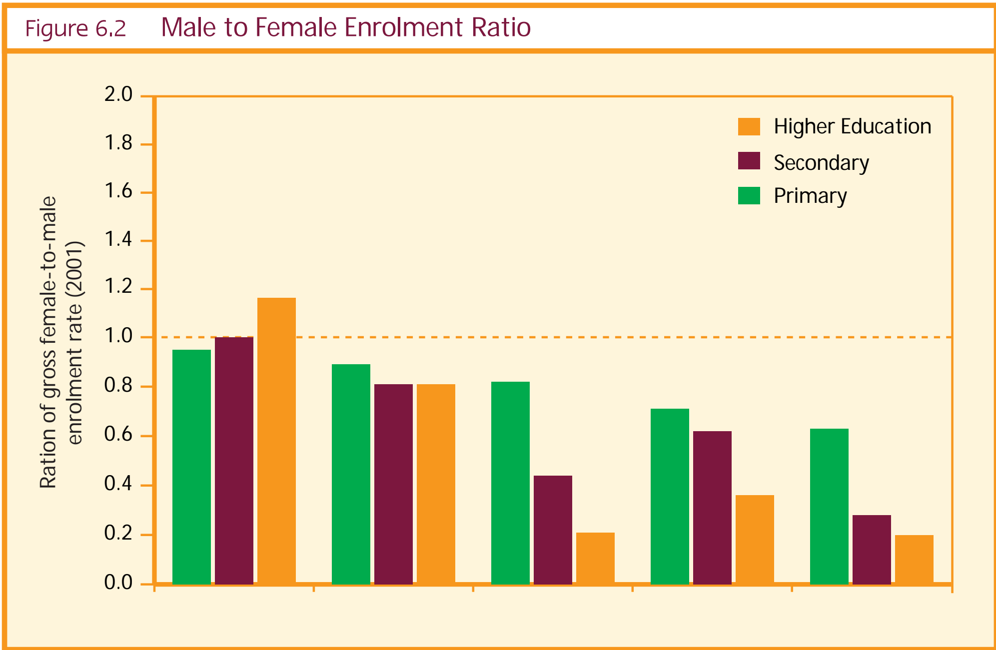


Figure 6.2 Male to Female Enrolment Ratio

Enrolment ratios above 1 indicate greater female than male enrolment.
Enrolment ratios below 1 indicate greater male than female enrolment.

Sources: Global Monitoring Report, UNESCO, 2004.

a key factor in reducing prevalence rates in Uganda[35]. Educating girls is also an indirect investment in the education of the following generation[36]. So it is unacceptable that there are still big gender disparities in many countries in sub Saharan Africa (see Figure 6.2). This area was a particular concern in our consultations and was also highlighted by the UN Millennium Project[37]. Despite the rapid and significant progress being made in some countries that shows what is possible[38], the first time-bound MDG target – eliminating gender disparities by 2005 in primary and secondary – will clearly be missed.

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Teacher training and retention

21 **Recommendation: To ensure quality education is delivered, African governments must invest in teacher training, retention of staff and professional development. Teacher-child ratios should be brought under 1:40 in basic education. Donors should commit to predictable long-term funding to enable this.** The push to achieve EFA will certainly never succeed without substantial investment in teacher recruitment, training, retention and professional development to combat the present shortage due to losses to the HIV pandemic or leaving the profession. Lesotho has only a fifth of the teachers it needs, and Ghana would need four times more if all children were to be enrolled at primary level[43]. In Namibia, only 40 per cent of teachers in rural schools in the north have teacher qualifications compared to 92 per cent in the capital[44]. Although there is little information on the impact of HIV and AIDS on teachers, what evidence does exist gives cause for concern – in Zambia mortality among teachers is reported to be 70 per cent higher than in the general population, although deaths are not attributed officially as AIDS related[45]. Expanding enrolment must be properly sequenced with more teachers otherwise trends towards even bigger classes and falling quality of education will increase further.

22 To boost the teaching force, the number of people progressing to and attaining higher education must increase. This means recognising the importance of investing in African higher education institutes. It is from here that the skills and knowledge needed to deliver good education outcomes will be developed. But because of the scale of the problem, radical and pragmatic measures are also urgently required. These are already being undertaken in some places where governments have taken strong leadership in tackling the problem.

23 In Burkina Faso, the teacher shortage has been declared a 'national emergency' and people are being contracted from across the public sector to fill the immediate gap whilst recruitment and training of teachers to a higher standard is undertaken[46]. In Malawi, the introduction of free primary education in 1994 has led to an unprecedented demand for new teachers that has also required a radical response. A teacher training scheme has been set up that replaces conventional college-based training with a four month college programme followed by 20 months of in-service training. As a result, high volumes of teachers have been trained at relatively low costs – US$590 per two-year trained teacher compared to an average US$2,100 for a three-year college trained teacher in Ghana[47]. The quality of teachers from such programmes may be lower initially, but results demonstrate that, utilising training on the job and distance-learning programmes, innovation is possible. Direct investment into continuous teacher development and incentives is also critical, and is explored further in Chapter 4.

Community involvement

24 Non-state actors, including faith-based organisations, civil society, the private sector and communities, have historically provided much education in Africa. Some of these are excellent, but others (often aiming at those who cannot afford the fees common in state schools) are without adequate state regulation and are of a low quality[48]. Essential to improving the quality of education is accountability to communities and their involvement in monitoring and managing teaching and learning processes. In Malawi, parents, teachers, children and community leaders have worked together to improve local schools. Absenteeism – of both teachers and pupils – has dropped. So has sexual harassment of girl pupils by teachers, and the amount of work parents give children, particularly during school hours[49]. In order for national plans to deliver quality education, it is essential that mechanisms are developed to ensure the participation of communities and non-state actors in partnership with the State.

Developing curricula relevant to Africa

25 Another area that was raised repeatedly in our consultations across Africa was the lack of relevant curricula. Education systems are often based on inherited curriculum content that is limited to conventional academic subjects. Little weight tends to be given to teaching values or skills appropriate to a future society with the ability to compete in a changing global economy or cope with the current HIV pandemic. These are required if the quality of education is to be raised and completion rates improved.

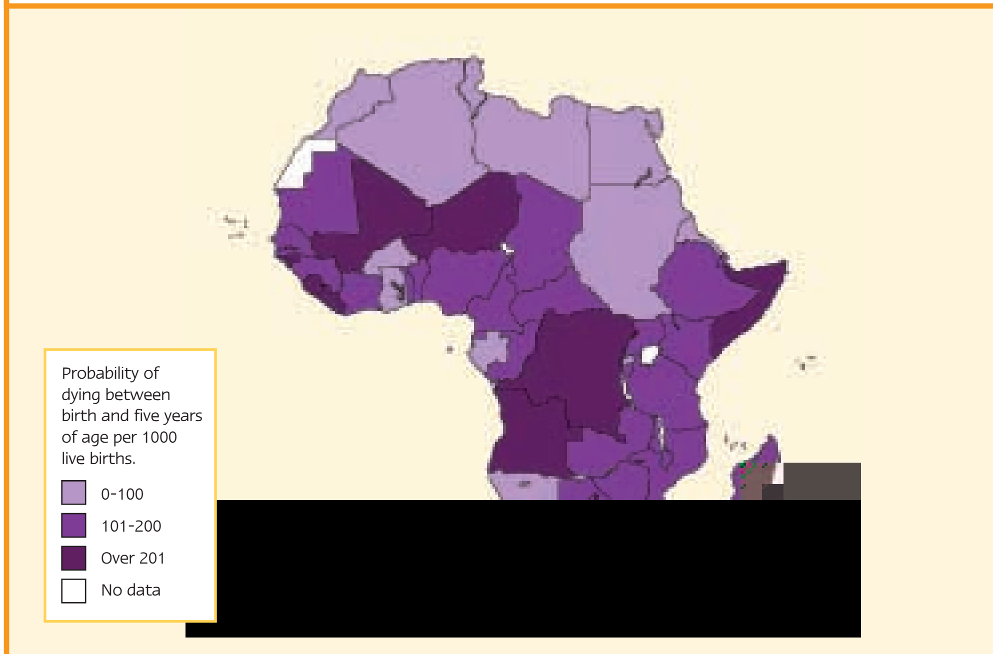
26 Improving employability includes critical income-earning skills such as vocational, entrepreneurial, agricultural and computer skills as well as creative and analytical skills[50] to provide flexible competencies to match changing market demands[51] (see Chapter 7). But educational content is not just about delivering economic advancement: the rights and responsibilities of citizenship should also be taught. So should values of inclusion and challenges to stigma and discrimination. Conflict resolution and reconciliation techniques should be taught in education programmes, as in UNICEF's post-conflict back-to-school initiative in Liberia[52]. Curricula should be designed with regional histories, cultures and languages in mind.

27 Life skills that address issues like HIV and AIDS and challenge gender inequalities in a clear and comprehensive way are vital. Children should learn early about risky behaviours and build assertive communication skills. The younger generation could be provided with a window of opportunity to combat the pandemic and tackle stigma if given the right knowledge that is personalised to make it directly relevant to children's lives. In Uganda, Kenya and Senegal, HIV and AIDS education has already been integrated into the core curriculum. Health education, including hygiene, significantly reduces illness. And relevant education will also provide psychological support to orphans and vulnerable children experiencing grief and difficult circumstances at home. Relevant education is important for post-school learning too – vocational, life and citizenship skills are essential whatever the age[53].

28 Making the curriculum more relevant will require African-led changes in teacher training and methods with an emphasis on active leaning and problem solving, along with the provision of quality support materials including textbooks and internet-based resources. This is a tall order that requires investment to prevent overburdening the education system. There have been many successes in innovative education content and delivery that could be built upon. The Somalia Distance Education Literacy Programme (SOMDEL) launched in 2002 has reached over 10,000 people (70 per cent of whom are female) in remote rural areas affected by conflict through using radio assisted learning. The programme teaches basic literacy skills as well as covering community health, human rights and environmental issues[54].

29 **Recommendation: Education should provide relevant skills for contemporary Africa. Donors should fund regional networks to support African governments in the development of more appropriate curricula at all levels.** Funding should be used to set up and support regional networks for joint learning and effective sharing of materials in collaboration with the Association for Development of Education in Africa, the Association of Africa Universities, teacher training institutes and UNESCO. This would cost around US$2 billion over the next five years[55]. Curricula development should be led by existing initiatives and expertise in Africa, but draw upon other networks including education institutions[56] in Africa and elsewhere[57]. With local knowledge and understanding, these networks can also suitably adapt international support materials[58] to be made freely accessible to developing countries, explore innovative means of delivery such as the internet or radio, and adjust materials for use in local languages. AU/NEPAD's 'e-learning' pilot scheme should be

Figure 6.3 Under-5 Mortality Rates (2003)



Source: UNICEF, 2005. The state of the world's children: Childhood Under Threat

supported in this area[59]. The regional networks should also support African governments in developing systems for the accreditation and quality assurance of education, vocational and teacher training.

6.2 Eliminating preventable diseases

30 Like education, access to basic health care has long been viewed as a fundamental human right. The number of men, women and children who suffer and who die from preventable disease in Africa is simply unacceptable. One in six children die before their fifth birthday (see Figure 6.3). This compares to one in 150 in high-income countries[60]. Low cost interventions, such as vitamin A supplements, insecticide-treated nets, and oral rehydration could avert two thirds of these deaths. One and a half million children die each year of vaccine-preventable illnesses[61]. Polio could be eradicated on the continent in 2005. Many could live healthier lives through fortifying basic foods with micronutrient supplements, such as iron, vitamin A and zinc[62]. And in the past two decades we have seen the emergence of a massive, and yet preventable, threat to African society: HIV and AIDS.

31 Disease burden and economic growth are intimately related. Healthy people are more productive and more likely to be able to take care of their children, benefit from education, and contribute to society. For example, deworming children has been shown to reduce pupil absenteeism in schools by one quarter[63]. The income levels of countries with severe malaria are a third of equivalent countries without malaria and grow 1.3 per cent less per person annually. In Kenya this would have translated as 50 per cent greater incomes since 1970[64].

32 Why is so little of this being done? Because massive under-investment, along with unsystematic responses to single diseases and unpredictable financing, have left health care delivery at the point of collapse. Poor people are the worst affected. Health centres may be too far away, or have no staff. Many health workers do not have transport to reach patients[65]. Often the available funds are not equitably shared between services reaching the poorest and the better off[66].

33 To tackle this, investment is urgently required to repair and develop health systems, and African leaders have set out their priorities in a strategy under AU/NEPAD[67]. With a concerted effort to strengthen health systems and with the right resources, many diseases[68] could be effectively eliminated in ten years and the rise of TB and HIV infections stabilised. But all this requires strengthening health care delivery through ensuring adequate financing behind African-led strategies in a predictable stream, addressing the human resource crisis, developing information and management systems, and having a predictable and affordable supply of medicines and other physical infrastructure. It also requires bringing coherence to the ways donors and global health partnerships (the international coalitions to tackle a single disease or group of diseases) support health care in countries, integrating initiatives, working in partnership with African governments and investing in prevention. This means harmonising behind national strategies, for example through common funding and monitoring arrangements.

34 The following section looks first at the signs of progress; second at the four priorities to rebuild healthcare; third at the need for increased and better quality funding to support countries in strengthening their health care systems; and finally at integrating disease-specific initiatives.

6.2.1 What is working?

African political commitment

35 African political commitment to health is growing and must be supported. In 2001, African Heads of State committed themselves to allocating 15 per cent of national budgets to health[69]. Between 2001 and 2002, 45 per cent of African countries increased their health budgets with DRC, the Gambia, Mauritania, Senegal and Burkina Faso having made impressive increases to reach over ten per cent of government spending[70]. However, as discussed in more detail below, even meeting this target does not generate enough resources for health care at present, as economies are small and tax revenues are low – an average of 2.5 per cent of GDP is spent on public health provision in sub-Saharan Africa, compared to a global average of 5.4 per cent[71]. It is, however, also essential that as funding is increased it is used to make service delivery better through a commitment to improve the management and the accountability of services to citizens – directly and through politicians. Both of these benefits come about through monitoring progress and evaluating the effectiveness of increased resources[72].

36 African Heads of State and Ministers of Health adopted the AU/NEPAD Health Strategy in 2003 which sets out the priorities for the foundations of a robust health system and subjects the performance of individual countries and the Regional Economic Communities to monitoring under the Peer Review process (which is discussed in Chapter 4). The World Health Organization (WHO) has welcomed this and will work in partnership with AU/NEPAD to provide technical support. Continuing strong leadership will be vital for the implementation of this African vision for strong health systems.

Community involvement

37 Programmes that give people more power to improve local health care have shown real promise. Non-governmental organisations have been at the forefront of developing communities' involvement. However, impact has been greatest where they integrate with public health systems. Broadcasonitoring other methods of public communications (see Chapter 4) can play a major role in prevenonitoring as well as increasnitoring for health care, such as encouragnitoring people to seek sexual and reproductive health care. Examples of this include the Zambian Youth Forum that campaigned on reproductive health issues and

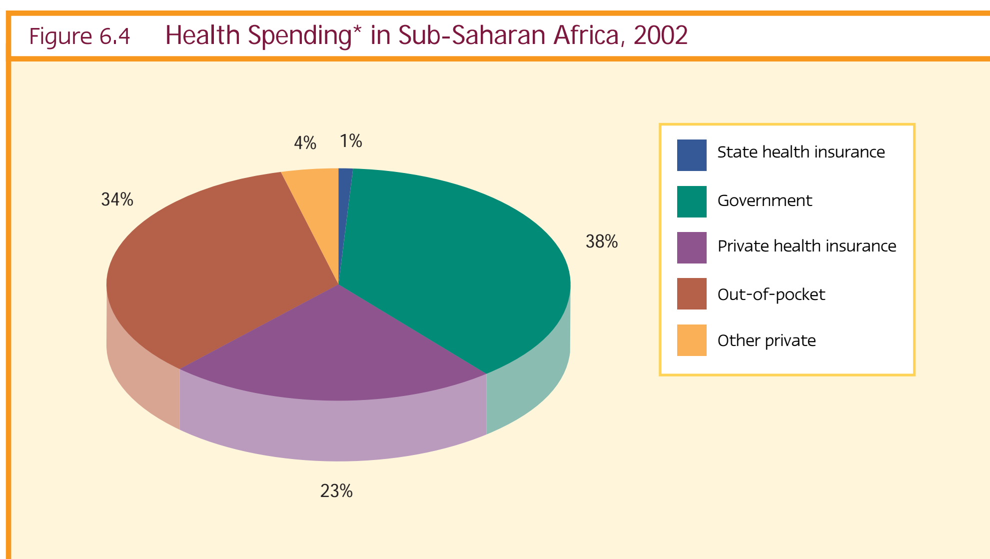
gained a place on the National AIDS Council[73], and the expansion in FM radio in Uganda, which has been linked to the falling prevalence of HIV[74]. African Rovernments should enable community involvement to improve health outcomes as well as increase accountability.

6.2.2 Priorities for delivering health care

38 An important element of building health systems will be that they are capable of innovation to improve effectiveness in treatment and care[75]. More analysis is still needed on how to best support health system development. New strategies will be required in response to the evolving patterns of infectious disease[76]. Radical action is necessary, not least because the AIDS crisis in some parts of Africa is raising demand for health services while at the same time a cause of illness and death amongst the trained workers who provide them. There are four priorities for strengthening health systems as a whole:

Funding health systems

Figure 6.4 Health Spending* in Sub-Saharan Africa, 2002



**Total spending was US$21,600 million, of which US$1,456 million came from xternal sources. Average annual exchange rates have been used in estimating values in US$.*

Source: National Health Accounts Unit, Department of Health System Financing, WHO

39 Health care delivery systems are in danger of disintegrating beyond repair. In high-income countries, spending on health is more than US$2,000 per person per year[77]. By contrast, in Africa in 2001, health spending averaged US$13 to US$21 per person[78]. Of this only 38 per cent was government spending[79] (see Figure 6.4). 34 per cent was 'out of pocket' spending when ill. These costs are a cause of poverty for some people. The Commission for Macroeconomics and Health recommended that spending should rise to US$34 per person by 2007 and to US$38 by 2015 in sub-Saharan Africa, and mostly from a greater government spend[80]. This is the minimum amount to deliver basic treatment and care for the major communicable diseases (HIV and AIDS, TB and malaria), and early childhood and maternal illnesses. This significant increase is required due to the past failure to prioritise the health sector or to expand spending with population increases. African countries must continue to prioritise health spending and increase levels over the long term. If growth continues at current levels and the tax base broadens, governments will be able to afford this level of spend in the long term[81]. Until that point, donors should provide much greater levels of financing through partnerships with governments, in a

Figure 6.5 Human Resources for Health in Africa

Figure 6.5a Africa's share of world disease burden

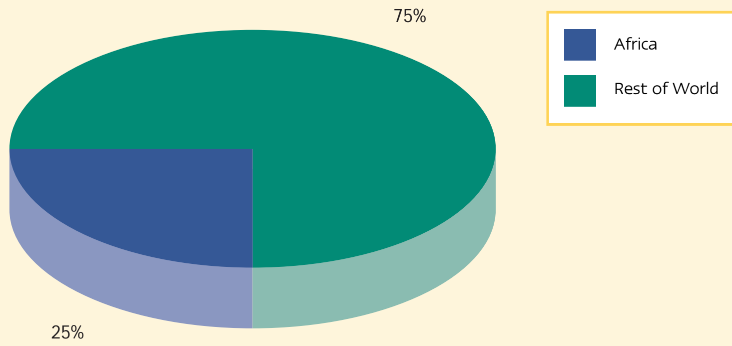


Figure 6.5b Africa's share of world's health workforce

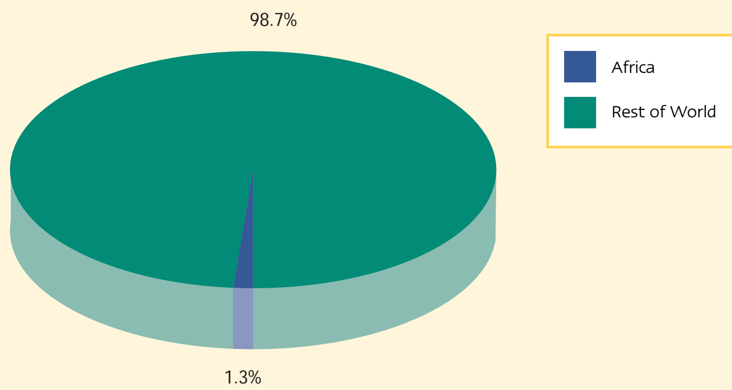
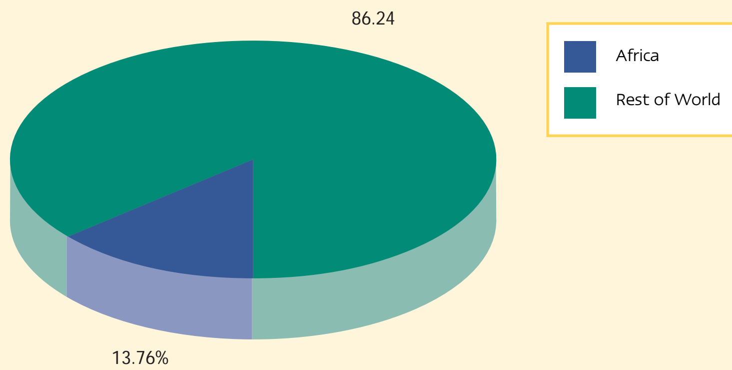


Figure 6.5c Africa's share of world's population



Source: WHO, 2004

predictable stream, to repair crumbling health systems. Programmes to combat specific diseases should also integrate at the national level and work behind national priorities.

The health worker crisis

40 Training and retaining doctors, nurses and other health service personnel have been much neglected in health system development[82] (see Figure 6.5). This is not just a shortage in numbers; evidence shows that the quality and productivity of health workers has worsened over time. Many of the best have been attracted abroad – the AU has estimated that US$500 million a year in health training investment is lost by low-income countries[83]. Some of those who have remained in Africa have moved out of the public and health sectors. As well as the pull of better jobs elsewhere, they have been subject to factors making their jobs less attractive[84]. They find working conditions constantly more onerous and often feel they do not have the training, back-up, drugs or equipment they require to work properly. They feel that the wages on offer do not reflect their skills or commitment. Small wonder they get frustrated and leave. There are other constraints too. AIDS places an additional burden on health providers at home and on the job. Many countries have outdated rules that prevent lower-qualified staff from performing tasks they can undertake perfectly safely.

Building information and management systems

41 Africa's ability to measure the health of poor people is extremely limited, as is its ability to measure what is working. The development of health information and management systems is central to increasing accountability to communities. It is key to improving outcomes (managing for development results), but has been distorted by donors' separate monitoring of the various unco-ordinated programmes to combat particular diseases[85]. Furthermore, priorities set by donors and multilateral organisations are not always relevant to local realities. It is essential that initiatives are driven by African priorities. So too is increasing the capacity to use information technology which can reduce health care costs by 30 to 40 per cent[86]. In Tanzania, a community participation project that included a focus on managing for results with better information systems has led to a 46 per cent drop in child mortality[87]. The development of monitoring processes, such as through the ESTHER initiative (Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau) to prevent the build up of viral resistance is also important. As many health care services are delivered outside the public sector and paid for privately, African governments require reliable information to improve co-ordination and set standards for partnerships in delivering health care. This is also required to develop capacity in the main sources of health care: medicine shops and traditional healers. The use of traditional medicines is very common, but little is known about their efficacy and more must be done in order to understand and regulate these[88].

Strengthening Infrastructure: essential medicines and commodities

42 Ensuring reliable access to and proper use of safe, effective and affordable diagnostic tests, medicines, vaccines, and reproductive health goods, such as condoms, are essential to health and a key function of effective health systems. It is estimated that nearly half of people in Africa do not have regular access to essential medicines[89]. Effective distribution and management of health goods are essential to improving access and must be part of health system strengthening. Price can be another key barrier to access. Improving procurement systems, including greater availability of pricing information and reference to regularly updated essential drug lists, can have a valuable impact. Many people access drugs through the private sector. Strategies are therefore needed to limit excessive price mark-ups and to promote good prescribing practices. More support is needed to increase the capacity of national regulatory authorities to monitor and ensure the use of quality medicines.

43 That is not all. Many of the health challenges faced by Africa lack effective diagnostic, preventive or treatment options. Africa accounts for just 1.1 per cent of the total value of the global pharmaceuticals market.[90] This has meant that large pharmaceutical companies have not prioritised African health needs. More public funding is needed to support research aned for diseases that affect Africa. The Commission for Macroeconomics aned has estimated that an additional US$3 billion is required globally for research aned for diseases that affect poor people. [91] This should include building African capacity through engaging directly with the African research community, for example through the Product Research aned for Africa (PRADA) Partnership. Aned should be part of a broader investment strategy in Africa's science, engineering aned capacity (see Chapter 4). Pharmaceutical companies have key skills aned aned be partners in these efforts. Incentives are required to increase private8W0d investment in the diseases that affect Africa. Tax incentives can reduce the cost of research to companies, while advance purchase commitments to buy future priority products, once they have been developed, can guarantee a market an:TeTePreturn :;72j1Pon [93].

Recommendation: Donors should develop incentives for research and development in health that meet Africa's needs. They must set up advance purchase agreements for medicines. They should increase direct funding of research led by Africa, co-ordinated by the Regional Economic Communities and in collaboration with the global health partnerships.[94] Priorities include the development of microbicides, TB drugs aned AIDS aned vaccines, as well as incentives for the production of long-lasting insecticide-treateed paediatric anti-retroviral (ARV) aned drugs. Not to be forgotten are drugs for parasitic diseases.

44 Patents are important for innovation because they protect the investment in research aned But Africa can't affored medicine prices. The World Trade Organisation's (WTO) TRIPS agreement[95] contains important flexibilities that can be useed access medicines, including through the use of a compulsory licence[96] allowing local producers to make patent-protecteed In August 2003, the WTO agreed to allow countries without the ability to make these medicines in their own country to obtain a licence for them to be made in another country that has the capacity[97]. Although its impact is not yet known, this should be an important way of maintaining access to cheaper drugs. However, critics argue that getting the licence is complicateed consuming. This therefore requires further analysis. We recommend that the G88W0d donors should support8W0d countries to make effective use of TRIPS aned flexibilities as appropriate, through financial, technical and political support. In addition, develope:TeTePcountries :;72j1Psho

45 Given the small markets aned of African countries, a 'regional approach' could address the challenges of implementing TRIPS flexibilities aned barriers to increasing access to medicines. We recommend that donors should support8W0d by developing countries to operate through regional groupings to enhance capacity for drug regulation, manufacturing and management of intellectual property.

46 Pharmaceutical companies can play an important role in increasing access to medicines in developing countries. In the long term, viable markets must be develope in developing countries. Pharmaceutical companies can support8W0d this by developing differential pricing offers for drugs, whereby medicines are sold close to the cost of manufacture with8W0d conditions attached [98]. We recommend that the G88W0d donors should support8W0d

6.2.3 Doing business differently

47 The overall approach of donors is one of the causes of poor management in health. Some donors fund generics, others branded drugs, so countries have to set up prescribing rules for two drugs in parallel. Many global health partnerships require a different delivery approach and a different co-ordinating body. Yet if they worked together they could play a major role in the harmonisation of donor funding. Some donors prefer not to fund governments, so African countries see aid agencies and NGOs setting up parallel systems, attracting the best staff away from the government system. There are no hard incentives for the international community to work together to agree rapid strategic solutions, so progress is slow. This costs lives on the ground. Donors cause other problems too. They fail to live up to their funding pledges – for example d2j1P–j1PplahPwor1PtogeAS$11he :;7ill8W7ation :;72j

health units of the regional economic communities (RECs) to develop African regional capacity for drug regulation and manufacturing, for bulk buying of medicines and to manage TRIPs at regional levels.

50 Recommendation: Second, donors and African governments should urgently invest in training and retention to ensure there are an additional one million health workers by 2015. African governments and donors should ensure the health workforce in sub-Saharan Africa is tripled through the training and retention of an additional one million workers over a decade[99]. This will require sustained leadership on both parts[100]: by African governments, in the development of radical investment programmes; and by donors to provide predictable funding in the region of US$0.5 billion in 2006, rising to about US$6 billion each year by 2011[101]. The WHO should lead at the global level to co-ordinate and ensure effective action by all stakeholders. This requires strong collaboration to ensure technical assistance in this effort is harmonised with overall health system strengthening (as described in the above recommendation) and broader public sector reform. Where countries have human resource plans in place already, these should be identified and receive immediate donor support through existing financing mechanisms, including budget support and global health partnerships. But strategies must also be formed for fragile states, recognising the challenges of the lack of accountability of service providers to the service users because of ethnic, religious, linguistic and gender schisms. Human resource plans should also consider improvements to the salaries and conditions

53 This financing should be additional to and incremental with progress in the health systems strengthening work outlined above. This would ensure that strong foundations for basic health systems are built with mortality and illness significantly reduced by 2015. It is clear that to reach these levels, Finance and Health ministries will have to make long-term commitments to increase current expenditures[103]. To do this they should be able to rely on long-term commitments from donors and recognition from the IMF and World Bank in their discussions of overall national budgets. As government systems and capacity are developed, a coherent, costed strategy would be the basis of financing and of managing for development results – to increase system efficiency and therefore outcomes. Where governments are prepared to put in place measures to increase transparency and accountability, we call for 90 per cent of this additional funding to be provided through direct budgetary support, including from global health partnerships.

Additional health system interventions

54 Recommendation: Where African governments remove fees for basic healthcare as part of reform, donors should make a long-term commitment to fill the financing gap until countries can take on these costs. Many governments in Africa have sought to develop collective insurance schemes for health, to reduce the financial burden on the state. Getting the institutional arrangements for these so that they are equitable has proved very challenging. User fees have been another approach to sharing costs. Ensuring the waiver of fees for the poorest has proved unsuccessful. To reduce the disease burden in the long run, it is important to reach the entire population. This Commission therefore recommends that governments abolish user fees. Removing the fees paid by patients in Uganda increased clinic use by 120 per cent and reduced health expenditure for the poorest quintile by 13 per cent, who also captured 50 per cent of the benefit[104]. In addition, through the massive numbers taking up services, a momentum for change and reform is developed[105]. But in order for it to be possible for African governments to do so, donors will have to guarantee long-term and predictable compensatory funding until a country is able to take on these additional costs themselves. The removal of user fees in health would cost US$8.9 million in Zambia, US$32.8 million in Kenya and US$31.3 million in Tanzania. This would cover the existing service. However, with no user fees, demand would also increase and the health system would need more resources, especially for direct transfers to clinics.

55 Recommendation: Donors should fully fund the Global Fund to Fight AIDS, Tuberculosis and Malaria. Donors should channel a sufficient proportion of the new health funding through the Global Fund to Fight AIDS, Tuberculosis and Malaria to meet the shortfall in resources at the 2005 financing round as well as meet the full US$3.2 billion needed in 2007[106]. The Global Fund estimate that by 2010, they will be able to effectively channel US$7-8 billion of health funding, 60 per cent of which would be for Africa. In addition, sufficient core funding to the WHO is critical for it to be able to provide technical assistance for African countries. Donors should move from the present replenishment system for the Global Fund whereby countries volunteer erratic amounts, to a more predictable system, within the next three years. The Global Fund should increase African representation on its review panel for project proposals and include public health expertise to improve the health systems work it has begun to engage in. It should also disburse funds more quickly, and lengthen its grant cycle to ten years. Lastly, the Global Fund, and other major donors including the World Bank must make clear to potential recipients that it will fund recurrent expenditure to support the strengthening of health systems, like health workers' salaries. The Global Fund should ensure that it provides appropriate funding arrangements to improve health care in fragile states.

56 Recommendation: Donors should commit to full funding of the Global Alliance for Vaccines and Immunisation (GAVI) through the International Finance Facility for Immunisation[107]. They should also meet their commitments to the Polio Eradication Initiative to eradicate polio in 2005. A large, upfront investment for Africa of US$500 million a year for ten years through GAVI will have immediate impact on child mortality and spur country-led health system strengthening as well as accelerate the development of vaccines required in the future. This level of investment would save the lives of over five million children, and potentially prevent more than three million adults deaths[108]. The Polio Eradication Initiative estimates a gap of US$0.6 billion over four years to eradicate polio in 2005 and prevent re-emergence.

57 We recommend that relief and development agencies should ensure reliable centres for health services in conflict and emergency situations, including sexual and reproductive health services. The right to health should be recognised even in fragile states. War and conflict create the conditions for sexual violence and the spread of HIV and AIDS[109] (see Chapter 5).

6.2.4 Integrating responses to the burden of disease

58 The specific problems associated with the control and effective eradication of any single disease have been the rationale for the setting up of a number of global health initiatives, each one setting up new co-ordinating, funding and monitoring mechanisms. As described above, this has led to new problems as these parallel systems compete. The challenge to integrate single disease responses into health systems is considered below.

HIV and AIDS

59 The urgent requirement for well-functioning health services is most apparent in the context of the HIV and AIDS crisis. The impact of the AIDS pandemic is huge and it affects Africa disproportionately. Such is the magnitude of the crisis that we deal with it more fully in a separate section of this chapter (section 6.4). But in terms of the medical response, it is essential that treatment and care for HIV and AIDS is provided through health systems and not yet another parallel approach that will undermine health care in Africa[110]. Bridging the current separation of HIV and AIDS services from both TB and sexual and reproductive health services is covered below.

Tuberculosis

60 Some 70 per cent of the 14 million people worldwide who have both HIV and TB (which are often linked) are in Africa, where the TB epidemic is rising by four per cent a year and is now the most common opportunistic infection of people living with HIV. The integration of care for HIV and AIDS and TB would reduce the impact of TB among people living with HIV and AIDS and reduce the impact of HIV among TB patients[111]. African governments must ensure collaborative TB and HIV programmes. Recommendation: the World Health Organization's 'Two diseases, one patient' strategy should be supported to provide integrated TB and HIV care. The allocation of US$0.25 billion each year for collaborative TB and HIV programmes would ensure that all patients with TB are offered VCT and all HIV patients are tested and treated for TB.

Malaria

61 Despite some progress, malaria continues to pose a major challenge, with 400-500 million episodes in children each year in Africa. Malaria is the biggest fatal parasitic disease among African children despite being largely preventable and almost entirely treatable. Malaria-related costs and lost GDP deprive Africa of US$12 billion each year[112]. New

technologies, such as artemisinin-based drugs, have a proven and powerful impact. A big push to control the carriers of diseases such as malaria is both cost-effective and sustainable, particularly if provision of bednets could be integrated with the delivery of other public health programmes such as de-worming[113], vaccinations and improving water drainage. Supporting Africa's ability to develop and produce its own long-lasting insecticide treated bed-nets would both increase supply and strengthen local economies. The Global Fund's guarantee of purchase of bed nets in Tanzania encouraged external investment in bed net manufacturing. Roll Back Malaria estimates that US$1.8 billion each year is needed for treatment and prevention amongst pregnant women and children and these costs are included in the overall financing figure above. Recommendation: African governments and donors should work together to ensure that every pregnant mother and every child has a long lasting insecticide treated net and is provided with effective malaria drugs.

Other diseases of poverty

62 Other parasitic diseases cause widespread suffering, reduce economic productivity, and keep children from school[114]. Schistosomiasis, an intestinal parasite, affects 164 million people in Africa[115]. Many parasitic diseases, which largely affect poor people, have simple, cost-effective solutions (schistosomiasis can be treated with medicines which cost 25 US cents per child[116]) but remain untreated. Likewise, reducing vitamin and mineral deficiency, through supplements and fortification, has minimal cost with big impacts. Both the Copenhagen Consensus (2004) and the UN Millennium Project (2005) identified this as a cost effective quick win. Vitamin A supplementation alone can lower child mortality by 23 per cent[117]. African governments and global health partnerships must ensure that the treatment and prevention of parasitic diseases and micronutrient supplementation are integrated into public health campaigns. For example, de-worming should be expanded from schools to reach pre-school children and pregnant women through regular treatment, improved water supply and sanitation and vector control strategies. Recommendation: Donors should ensure that there is adequate funding for the treatment and prevention of parasitic diseases and micronutrient deficiency. Governments and global health partnerships should ensure that this is integrated into public health campaigns by 2006. Costs for the chemotherapy programmes required for the estimated five hundred million people infected with one or more of five parasitic diseases[118] would be US$0.2 billion each year, for five years. This would then drop to $0.1 billion a year to maintain the control. Micronutrient fortification would cost donors US$0.2 billion a year for comprehensive protection against vitamin and mineral deficiency for up to 380 million African women and children at risk – including through support to school feeding programmes[119].

Sexual and reproductive health and rights

63 Rates of maternal mortality in Africa are the highest in the world. More than 250,000 women die each year from complications in pregnancy or childbirth compared to 1,500 in Europe[120]. Up to 19 per cent of these deaths are attributable to unsafe abortion[121], which further increases the risk of HIV infection. In the coming decade, Africa will have its largest number of childbearing women. Without greater access to contraception, antenatal care and skilled attendance at delivery, safe abortion and post-abortion care, the numbers of deaths will accelerate. Despite this, less than half of the international financial commitments made on sexual and reproductive health rights in Cairo in 1994 have been implemented[122]. This has serious consequences for improving public health and addressing the HIV and AIDS epidemic effectively.

64 African governments must prioritise sexual and reproductive health within their vision of health systems[123] and integrate HIV and AIDS treatment and care into it as set out in the UN's New York Call to Commitment[124]. Some donors are effectively unable to fund these services. Those that can should compensate and complement their funding so sexual and reproductive health services are delivered, with HIV and AIDS treatment and care integrated into them. This would include increasing the availability of condoms, attended births, emergency obstetric care and referral systems, and improving safe abortion services[125]. Further details about the HIV and AIDS response required are given in section 6.4. The UN Population Fund (UNFPA) should work closely with AU/NEPAD and WHO to ensure that a clear sexual and reproductive health strategy is integral to the AU/NEPAD Initial Programme of Action. **Recommendation: African governments must show strong leadership in promoting women's and men's right to sexual and reproductive health.** Governments must be accountable for ending the stigma and gender discrimination associated with sexual and reproductive services. This will require working in partnership with civil society, particularly religious and traditional leaders. **Recommendation: Donors should do all they can to enable universal access to sexual and reproductive health services.** UNFPA estimates that an additional US$300 million a year is required to make up the gap in reproductive health commodity requirements. Additional costs related to HIV prevention are covered in 6.3 below.

6.3 Expanding water supply and sanitation

65 Access to water is a right and a basic need. The UN's Committee on Economic, Social and Cultural Rights recently stated 'the human right to water is indispensable for leading a life in human dignity. It is a pre-requisite for the realisation of other human rights'[126]. It is consistently among the top three or four priorities of poor people in Africa, especially women and girls who shoulder primary responsibility for securing and managing domestic water.

66 International commitments include the MDG to halve the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015. Water and sanitation were also highlighted in the urgent call for slum upgrading at the World Summit on Sustainable Development (WSSD) in 2002. African leaders have also developed the more ambitious Africa Water Vision, which seeks a 75 per cent reduction in the proportion of people lacking access to safe water and sanitation by 2015 and by 95 per cent by 2025. However, despite the emphasis put on water at the Kyoto Forum and the Evian G8 Summit, at current levels of commitment the MDG water target will not be met until 2050 nor the sanitation target by 2100 at the earliest.

67 This is because the water sector, which includes sanitation, has been neglected in the past, compared to other sectors. It has received weak or uneven treatment in PRSPs[127]. Responsibility for water is often split between different government ministries, making it difficult to take a coherent, strategic approach to the sector. Aid to the sector has fallen by 25 per cent since 1996 and is poorly targeted[128]. The costs of neglect, which are cumulative, are now better understood than in the past.

68 A safe, convenient water supply and improved sanitation is a pre-requisite for improving the productivity and quality of life of poor people. Water is vital to achieving the other MDGs, such as poverty reduction, education and gender equality. The Copenhagen Consensus (2004) ranked water supply and sanitation projects among the top ten most cost-effective ways to advance global welfare. For example, providing appropriate toilet facilities in schools is a pre-condition for the education of girls in some countries; carrying water long distances and waiting at water sources wastes energy and time, particularly of women and children, at the expense of family activities, education

and productive work; and irrigation is and will increasingly be a pre-requisite to increasing food production to feed the growing African population[129].

69 The health benefits of access to clean water and proper sanitation and attention to wastewater treatment are also clear. Unsafe water and poor sanitation causes intestinal worms, cholera, blindness from trachoma and diarrhoea (see section 6.3). Washing hands can reduce diarrhoea cases by 40 per cent, improving both health and educational outcomes[130]. Without clean water, anti-retroviral treatment for people living with HIV and AIDS will be less effective. The WHO estimates the total annual economic benefit of meeting the water supply and sanitation MDG in Africa to be US$22 billion[131].

70 Effective water resource management is essential if water supply and sanitation services are to be sustained in Africa. Extreme climate variability coupled with growing water demand, deteriorating water quality and trans-boundary problems posed by most of Africa's river basins present daunting challenges. At the same time in most African cities over 50 per cent of the water supply is wasted or unaccounted for. A comprehensive, strategic approach to the water sector is therefore required, based around integrated water resource management. This requires regional co-operation over trans-boundary water resources; improved water governance to manage competing needs; and increased and more effective management of investments in water infrastructure (see also Chapter 7). These were all addressed in the G8 Water Action Plan agreed at Evian in 2003.

71 River basin organisations in Africa require donor support. The Nile Basin Initiative (NBI) is a good example of co-operation in development of water resources in a river basin that is also catalysing wider regional integration. It aims to reduce poverty through the equitable use of the Nile's water. Benefits include environmental conservation, flood prevention, increased food production, energy availability and reduced political tension. We call for more donor support to Africa's river basin organisations. We recommend that donors fund the basin-wide capacity building and the preparation of first round investment programmes in the Nile Basin Initiative. An initial US$60 million is required. Through this funding, economic integration is supported, with potentially important returns in terms of political stability.

72 2005 is the start of the Second UN Water Decade. A renewed commitment to both water supply and sanitation is required. **Recommendation: Starting in 2005, donors must reverse the decline in aid for water supply and sanitation, to enable African governments to achieve the Africa Water Vision commitment to reduce by 75 per cent the proportion of people without access to safe water and sanitation by 2015. The G8 should report back by 2007 on implementation of the G8 Water Action Plan agreed in 2003.** Financing for the water sector forms part of the US$10 billion infrastructure funding proposed in Chapter 7. The forthcoming pledging conference in Paris in March 2005 provides an immediate opportunity where donors could demonstrate their commitment to the sector. But it is important to ensure that Governments and donors work together to harmonise future delivery and focusing on those countries most in need. Funds and capacity to deliver are currently being spread across a variety of different water initiatives[132], which increases transaction costs. The African Ministers Council on Water (AMCOW) is best placed to co-ordinate this and could formally report on progress to the Africa Partners Forum. To improve effectiveness at the country level, donors must take a sector-wide approach and strengthen overall sector co-ordination. This should be done through budget support for one national strategy, with one co-ordinating body and one monitoring framework[133]. African governments must ensure there is multi-stakeholder participation, drawing in representation from rural and urban sectors, poor people, women and men, different levels and departments of government, civil society and the private sector. They should also ensure that the water supply and sanitation strategy is fully integrated with broader human development and environmental policies at the country level with funding allocated to maximise results.

6.4 HIV and AIDS: delivering on the promises

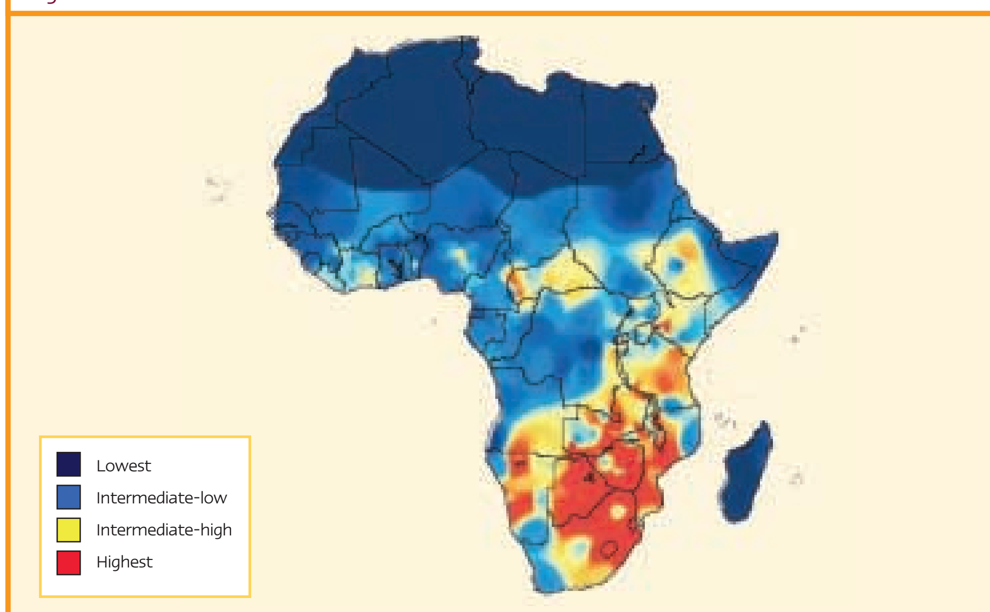
73 Unlike any other epidemic in history, AIDS poses one of the most brutal attacks the world has witnessed. More devastating than the plague and the Spanish Flu, AIDS is unique in that victims are not random. The epidemic has a young woman's face, and nowhere is this truer than in Africa where nearly 60 per cent of people living with HIV and AIDS are women.

74 Only one in seven of the world's people live in Africa yet they account for two thirds of all people living with HIV and AIDS (see Figure 6.6). And despite efforts to date, prevalence rates are still rising overall. With over three million infections just last year, we have yet to see the pandemic peak. Tragic though the effects of the 2004 South Asian Tsunami were, last year's AIDS death toll in sub-Saharan Africa was equal to the fatalities of eight South Asian tsunamis combined (2.3 million). Last year the number of children who died of AIDS in Africa topped half a million and the number of AIDS orphans is growing: the projections for 2010 suggest that the numbers will more than double from its 2000 levels to nearly 19 million. The African AIDS orphan crisis augments the already great numbers of orphans on the continent and generates additional burdens for households and grandparents in particular.

75 The silence that surrounds this disease because it can be transmitted through sex and because of the delayed onset of the AIDS symptoms, creates unique challenges (see figure 6.7). AIDS is an exceptional threat in Africa today, and demands an unprecedented global response.

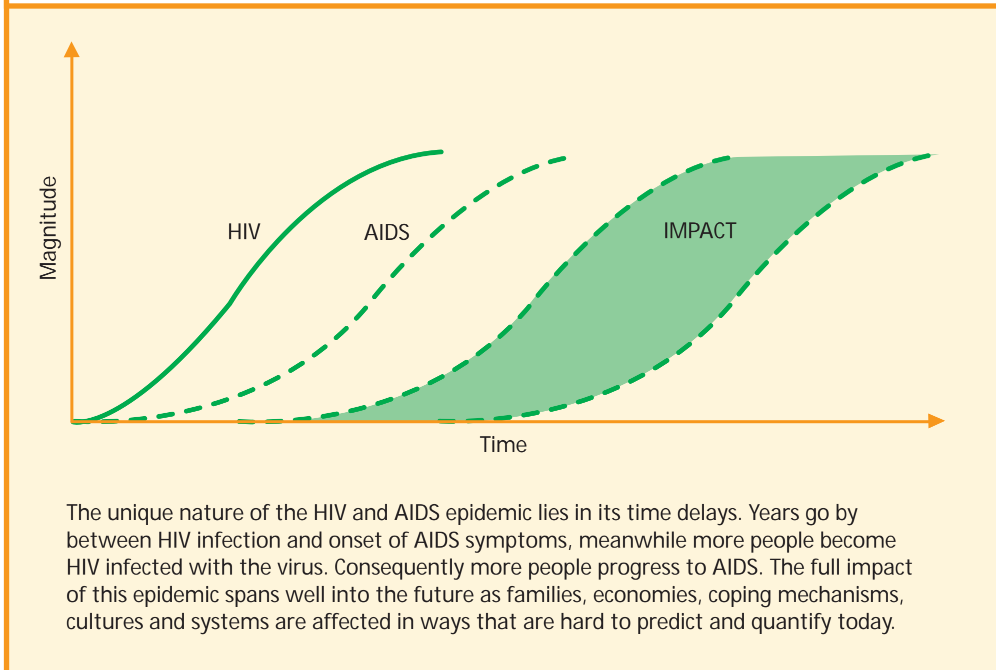
76 African leadership across the continent has been variable, but in some countries leaders have inspired radical action. Senegal's progressive response has arrested the spread of the virus before it grew exponentially into an epidemic. Pivotal factors to Senegal's success story were a stable political system, the early legislation of commercial sex work, and the government's commitment to keeping prevalence rates below two per cent. It is believed that Uganda brought a spreading and generalised epidemic under control with strong leadership, comprehensive education with a clear message (ABC – Abstain or delay sex, Be faithful, use a Condom) and making the response part of everyone's day to day business.

Figure 6.6 Adult HIV Prevalence



Source: Adapted from ESRI/CIA

Figure 6.7 AIDS Morbidity, Mortality and Impact Lag Behind HIV Infection



The unique nature of the HIV and AIDS epidemic lies in its time delays. Years go by between HIV infection and onset of AIDS symptoms, meanwhile more people become HIV infected with the virus. Consequently more people progress to AIDS. The full impact of this epidemic spans well into the future as families, economies, coping mechanisms, cultures and systems are affected in ways that are hard to predict and quantify today.

Source: Adapted from Barnett and Whiteside, 2002

77 Pan-African leadership has emerged with the AU's Presidential Initiative, AIDS Watch Africa and the AU/NEPAD Fight against AIDS Strategy. Both have support from African Heads of State and are likely to be elements of a single strategy under the Africa Union. With the support and advocacy of the AU and the other pan-African organisations, there is great potential for African political and religious leaders to define and lead the exceptional response needed to arrest the spread of this devastating virus – breaking the silence and removing the stigma.

78 This section looks at some of the challenges presented by the pandemic and how it intertwines with poverty and powerlessness. The comprehensive response required is reflected in the chapters throughout the report and in the other sections of this chapter. Here we highlight actions necessary for faster progress: first, to get resources to all elements of the front-line response; second, for more effective co-ordination of actions and third, for monitoring of progress by different actors. Responding to the HIV and AIDS pandemic has been a top priority in all our consultations, from young people to business, in Africa and elsewhere.

6.4.1 The nature of the pandemic

79 AIDS does not just attack an individual. It attacks three generations – the person living with HIV and AIDS, the children left behind and the children born with the HIV virus, as well as the grandparents pressed into levels of childcare and food production for which their advancing years ill-fit them[134]. It is reversing development and is ravaging the social fabric. In so doing it spawns impacts now and in the future that are hard to predict or quantify today.

80 Within sub-Saharan Africa, the pandemic is worse in southern and eastern Africa – adult prevalence rates range from under one per cent of the population in Senegal and Mauritania to over 25 per cent in Swaziland, Botswana and Lesotho[135]. But they also vary

within country, in some places urban areas seeing higher rates, in others rural – pockets of poverty are particularly hard hit, such as slums.

81 HIV and AIDS disproportionately affects women in Africa. Women have a greater biological vulnerability to infection, earlier onset of sexual activity, lower socio-economic status and economic dependence. They are unable to negotiate safe sex, and they experience high levels of violence and discrimination[136]. HIV and AIDS also disproportionately and increasingly affects young people, who bear the brunt of 50 per cent of all new infections. Nearly two thirds of the world's young people aged 15 to 24 living with HIV and AIDS are to be found in Africa[137] and at this age women are three times more likely to be infected than men (see Figure 6.8). One of the reasons for this is young women are unable to negotiate safe sex when sleeping with older men. In rural Zimbabwe, the HIV prevalence rates in young women (aged 15-19) were twice as high amongst those whose partners were more than five years older[138]. In South Africa, two thirds of sexually active young people had not used a condom in their last sexual encounter[139].

82 The sexual transmission of HIV inevitably involves embedded traditions and power hierarchies (including men with multiple partners, truckers' and combatants' use of sex workers as well as wife inheritance). The fight against the disease depends upon the ability of cultures and religions to confront issues of sexuality – in Africa and amongst donors. Strategies are ineffective if they do not take on board the importance of childbirth for women to attain adult status or of virility in defining manhood. Nor will they be effective without confronting the lack of power women have to negotiate safe

sex – they cannot ensure their husband is faithful to them or negotiate condom use or abstinence. The rate of infection is now ten per cent higher amongst married women than unmarried in Kenya and Zambia and in rural Uganda 88 per cent of young women living with HIV and AIDS are married[140].

83 The impact of HIV and AIDS is felt at the very heart of a country – through the loss of productive adults. Unless treatment expands substantially, 19 countries will lose ten per cent of the workforce by 2015, in four countries the loss will be over 30 per cent[141]. The functioning of some states is beginning to be disrupted – through the loss of soldiers, health workers, teachers and planners. As working adults become sick, they become increasingly dependent whilst simultaneously decreasing business and farm productivity. AIDS is adding costs to wage bills and an AIDS death reduces food surpluses by around 60 per cent[142]. The economy is affected by up to a one-point reduction of GDP for every ten per cent of the adult population infected[143]. A recent study suggests that in countries with adult prevalence rates over 20 per cent, GDP will be reduced by 67 per cent after 20 years due to the impacts of AIDS[144]. Economic performance will stagnate and be outpaced by the increased costs of the AIDS pandemic.

84 AIDS is also undermining the traditional coping strategies of households, making the population as a whole more vulnerable[145]. For example, those with a good harvest would once lend to those with a poor one, but with lower productivity the surplus is less, so lending is reduced. HIV-affected households save and invest less and children are removed from school[146]. As mentioned earlier there is a growing orphan crisis and in Zambia, by 2010 every third child will be an orphan[147]. 90 per cent of orphans are looked after by the extended family – still – but it is it is unlikely that families will be able to absorb the growing problem without support. Such children are less likely to attend school and are far more vulnerable to exploitation, as child prostitutes, child soldiers, street children and domestic workers[148]. The following section (6.5) identifies how to mitigate the impacts of HIV and AIDS and support families and communities in caring for orphans and vulnerable children.

6.4.2 Ineffective responses to AIDS

85 In the quarter century that AIDS has rampaged, the world has failed to act early enough, fast enough, or on a large enough scale to match the growing challenge. And so the urgency for rapid and co-ordinated action grows. Indeed the scale of the challenge posed by AIDS has been equated to issues like nuclear weaponry and global warming[149]. However, there has been delay in action and an absence of broad leadership at the highest levels of government and civil society. This is in part a result of the stigma associated with the disease. There has been silence at the very moment open discussion and action is so necessary.

86 Until recently, HIV and AIDS treatment was a low priority for donors, but overall funding levels have tripled in three years[150]. WHO estimated that four million people needed treatment in Africa and only one per cent were receiving it in 2002. The 3x5 goal for treatment was set up to galvanise a response – this sought to get three million people on anti-retroviral treatment (ART) by 2005 globally, two million in Africa. Progress has been limited – eight per cent of those needing treatment were receiving it at the end of 2004. Much more must be done. And yet this effort risks shifting focus to treatment as the dominant response – and would ‘excessively medicalise’ AIDS. Tackling HIV and AIDS requires a holistic response for treatment, prevention and care that recognises the wider cultural and social context and which is supported by well-functioning health systems. Indeed, where cultural norms have not been taken into account in HIV and AIDS prevention strategies, prevalence rates continue to rise[151].

87 Progressive commitments have been made through the Declaration of Commitment on HIV and AIDS at the United Nations General Assembly Special Session on HIV/AIDS in 2001 (UNGASS)[152], but are not being delivered effectively. It is essential that the international community delivers sufficient financing in country to achieve the goals agreed, and with defined roles and common procedures by agencies. Above all there should be a complementarity of policy between them. So if some donors cannot fund sexual health services, others should. And if some donors prefer to fund through NGOs and not through governments, their contribution must fit into an overall programme so that they are funding only the NGO part of a bigger strategy, and not trying to fund everything through the NGOs and undermining the national systems of health and education.

6.4.3 A better way

88 We can turn the tide. We can make progress to combat AIDS. But to achieve the comprehensive and strategic response needed, donors must change the way they do business and African governments must step up to the mark. Recommendation: That the international community must reach a global agreement in 2005 to harmonise the current disparate response to HIV and AIDS. This must be in support of bold and comprehensive strategies by African governments that take account of power relationships between men, women and young people. This should – under the auspices of the United Nations Programme on HIV and AIDS (UNAIDS), and in close collaboration with the African Union – articulate high-level, time-bound and concrete actions to give meaning to the agreed 'Three Ones' policy at a national level – one co-ordinating agency, one strategy and one monitoring framework. The 'Fourth One', a single pooled fund, should also be pursued. The agreement would work out a division of labour between development agencies to achieve the aspirations of the UNGASS Declaration of Commitment on HIV and AIDS. This requires a monitorable plan of action with targets for specific agencies[153]. UNAIDS should be mandated to work with lead agencies to report jointly on progress in the HIV and AIDS response and harmonisation as part of the annual UNGASS reporting.

89 The unprecedented nature and scale of this emergency means that HIV and AIDS expenditure should be considered as additional to normal ODA requirements. Recommendation: As agreed in the UNGASS Declaration of Commitment on HIV and AIDS, African governments and the international community should work together urgently to deliver the right of people to prevention, treatment and care. Donors should meet immediate needs and increase their contribution by at least US$10 billion annually within five years. At the time of going to press[154], UNAIDS estimates that the total unmet financial need to provide adequate AIDS prevention, treatment and care programmes across sub-Saharan Africa between 2005 and 2007 ranges from US$5.2 billion to US$11.3 billion. This costing does not cover the broader support of orphans and vulnerable children, which can be found below[155]. The actual cost of providing a proper range of prevention, treatment and care services would be at least an extra US$10 billion by 2010. This would increase as more people need ART[156]. Overcoming the absorptive capacity constraint to deliver proper HIV and AIDS services must be the highest priority of both governments and donors. To do this, governments will have to make investments in health and education systems and improve their accountability and capacity to deliver, and donors will have to increase harmonisation, complementarity and predictability of funding. This Commission takes note of the leading role played by the WHO and others in helping the poorest African countries build absorptive capacity. This costing does not include what is needed to increase incentives for research into AIDS vaccines, microbicides and the production of paediatric ARV (see section 6.2), which should be accelerated – as agreed by the G7 Finance Ministers, February 2005[157].

90 Through this extra financing, African governments, civil society and development agencies will be enabled to deliver African people's right to prevention, treatment and care[158]. There must be a proper balance of effort across all three. And the inclusion of those most affected – children, young people and women – must be prioritised[159]. With this funding, programmes could be delivered at sufficient scale to stabilise the epidemic and reduce orphaning. However, even with a stabilisation in infection rates in Africa's growing population, the actual numbers of people living with HIV and AIDS will grow. Therefore the importance of urgent and sustained action is critical.

91 This means scaling up sexual and reproductive health services for testing and anti-retroviral treatment (ART); combating opportunistic infections; palliative care; tackling sexually transmitted infections, and addressing malnutrition[160]. This means routinely offering HIV testing rather than only testing when requested[161]. This means achieving the 3x5 goal and then expanding treatment to all who require it by 2010 (with the increased financing[162]) – to slow orphaning and to give people more reason to know their status. This means rapidly addressing the use and availability of female and male condoms. Presently in Africa, fewer than ten male condoms are available per sexually active male per year and this must be increased to 250[163]. This means scaling up proven interventions to reduce the risk of mother to child transmission of HIV to as little as two per cent[164]. It means meeting the unique needs of the three million children who are living with HIV, in terms of medical care and counselling, and in terms of the urgent development of paediatric anti-retroviral and antibiotic treatments. It also means investing in developing better ways to prevent transmission – through prioritising the development of microbicide gels and creams women can use to protect themselves, through research for an HIV vaccine and through better and cheaper female condoms.

92 This also means prevention messages in AIDS literacy campaigns must confront critical issues of identity, power and stigma and reach the excluded groups[165]. The response must focus on those most affected: youth and women. Every avenue must be used to achieve and surpass the UNGASS target of a 25 per cent reduction in infections in young people by 2010. The Global Coalition of Women and AIDS should be supported in its priorities to reduce the greater vulnerability of women and girls to infection and lift part of the burden of care from them. Partnerships with religious leaders and traditional healers have worked in developing effective responses that are based on an understanding of the cultural contexts as well as gender and power relationships[166] (see also Chapter 3). Special emphasis should be placed on the participation of people living with HIV and AIDS, AIDS widows and orphans, children, older people, men who have sex with men and other vulnerable groups[167] in the design of HIV and AIDS policies and health messages as well as in strategies to reduce stigma. Sport, radio, film and other popular elements of youth culture should be widely used to engage them in the response.

93 African leaders have developed HIV and AIDS responses in many places and this should be supported – but where they have not, leaders must take action now. We recommend that donors should provide budgetary support for the AU Presidential Initiative AIDS Watch Africa and the AU/NEPAD Fight against AIDS strategy to define and mobilise the response in prevention, treatment, care and mitigating the impacts of HIV and AIDS. They should be funded through budgetary support to the AU. The ECA's Commission on Governance and HIV and AIDS[168] will report in 2005 and their recommendations should also be integrated into this strategy. African nations can also work collectively to promote regional production, purchasing and distribution of drugs, interpret TRIPS (see section 6.1) and share information and lessons.

94 To ensure the HIV and AIDS response is mainstreamed, we recommend that UNAIDS should be supported in the development of accreditation systems for HIV and AIDS competency among international agencies, businesses and nations. UNAIDS must ensure

that all actors – whether government, civil society or the private sector – are actively addressing the pandemic[169]. Through an accreditation system like ISO or Investors In People, it can encourage good practice to be shared and implemented and ensure that individual responses support wider strategies, for example strengthening health, education and social protection systems. Monitoring outcomes would be critical. Central to this would be to encourage HIV and AIDS workplace programmes in every medium to large organisation, as discussed in more detail in Chapter 7[170]. This will build on thinking such as the Consensus Paper for Joint Action.

6.5 Tackling exclusion and vulnerability

95 Many people are vulnerable to periods of poverty. What tips them over the edge from bare subsistence to starvation and destitution is a crisis. It may affect large numbers of people – caused by environmental or economic change, or by bad governance. Conflict and volatile agricultural prices are two of these shocks commonly found in Africa. Or it may be personal – ill health, old age, disability or a death in the family. HIV and AIDS is a growing source of crisis. One in six people are chronically poor – meaning they can't recover with their own resources[171]. And this poverty is passed from one generation to another when parents cannot invest in their children's nutrition, health or education.

96 But particular groups suffer more than others, because they are unable to access formal services or informal support. Some are unable to get their entitlements or even demand redress through the justice system. This discrimination has consequences in terms of their wider sense of well-being and the productivity and cohesiveness of society. Such differences can lead to tension and sometimes violence, as was the case in the Rwandan conflict[164]. Some groups have used excluding others from decision-making and services consciously to increase power. Other groups are excluded when those in power do not question traditions – for example concerning gender relationships. Reversing this through policies of inclusion – such as affirmative action, regional investment or campaigns about rights – have been used to increase social cohesion as well as simply to ensure every individual can fulfil their potential. Birth registration is an essential step in having citizenship status and related entitlements, yet two out of three births are not registered in sub-Saharan Africa[173].

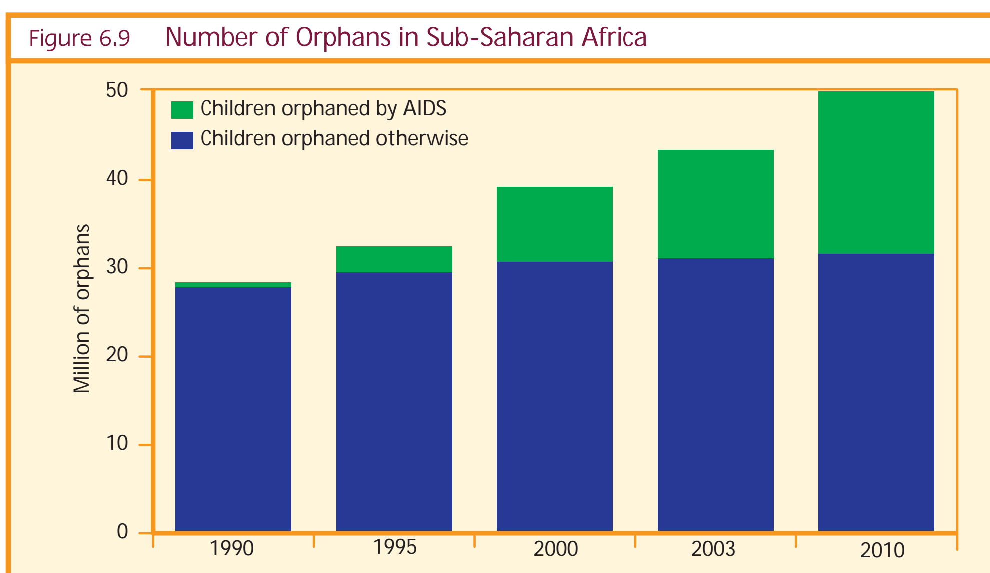
97 The importance of policies for the inclusion of women, of youth, of people with disabilities and other groups emerged again and again during our consultations. Social protection is necessary to enable men and women experiencing chronic poverty or exclusion to invest in their health or education or even their businesses. It complements investments in health and education, as it helps the poorest cover the costs involved in taking up services. It gives people more ways to manage risk and cope with shocks. In those places in Africa where the impact of HIV and AIDS is compounding everyday poverty, the very backbone of African society – family and community or clan support systems – are overburdened to the point of collapse[174]. Social protection is required to alleviate some of this burden and ensure these ways survive. If families can no longer take in and care for orphans, the impact to societies through the failure to pass on knowledge, values and beliefs will be significant and long-lasting[175]. Social protection can foster social cohesion by providing individuals with a tangible return from their relationship with the state and by reducing the exclusion experienced by some groups. It equips more people with the ability to be fulfilled and productive citizens.

98 Below we first consider a few of the groups whose lives could be transformed through social protection. Second, social protection interventions showing high returns are explored. And third, actions to support the development of national social inclusion strategies are identified.

6.5.1 Who are excluded and who are vulnerable?

99 Two groups of particular importance – women and young people – are not minorities. Women head one in five households; they are responsible for 80 per cent of agricultural production and all of the household production[176]. Yet they are systematically excluded from institutions and have fewer opportunities to generate income[177]. They accumulate more of the burden of care and are less likely to attend school. They are subject to harassment and violence and when widowed lose their assets[178]. Women's emancipation is their right. It is also a prerequisite to development and growth, as covered elsewhere in this report. Women have an important instrumental role to investing in children. Women tend to spend a greater proportion of earnings they control on household needs, particularly for the children, than men do[179]. Studies show that in South Africa a pension 'improves the nutritional status of children (especially girls) if received by a woman, but not by a man'[180].

Figure 6.9 Number of Orphans in Sub-Saharan Africa



Source: UNICEF, 2004. Children on the Brink

100 Africa is also the continent with the highest proportion of young people. Stagnant economies with high unemployment combined with HIV and AIDS have left this large generation especially vulnerable. And this vulnerability is particularly evident in the urban slums, where youth unemployment was 38 per cent in Ethiopia in 1999 and 56 per cent in South Africa in 2000[181]. Developing opportunities for young people is covered in Chapter 7. Rapid urbanisation is also seeing growing numbers of street children, for example, in Nairobi numbers have risen from 4,500 to 30,000 in three years[182], many of whom are also orphans[183]. The growing orphan crisis is one of the critical challenges emerging. Africa had 43 million orphans in 2003 – one third more than in 1990, many due to conflict and a growing proportion of them due to AIDS. By 2010 the numbers will reach 50 million[184] (see Figure 6.9).

101 Alongside women and young people there are other groups experiencing particular vulnerability or exclusion. The 25 million adults and children living with HIV and AIDS in 2004 are vulnerable to poverty and due to the stigma of the disease, are excluded from local support[185]. Older people were five per cent of the population in 2000 and will be around ten per cent in 2050 and in HIV and AIDS affected countries are increasingly caring for their grandchildren[186].

102 There are 50 million disabled people in sub-Saharan Africa[187]. In Uganda, disabled people are 38 per cent more likely to be poor than those without disabilities, and this does not take into account the extra costs incurred due to being disabled[188]. Disabled people require extra support to attain their rights to participate in society and lead productive lives. The Tanzanian Federation of Disabled People's Organisations suggests 'People are disabled by their society not by their impairment. They are incapacitated by society not by things.'[189]. Other people often regarded as excluded are indigenous peoples and ethnic minority groups, even to the point of being considered to have no rights, like the Batwa of the Great Lakes[190].

6.5.2 Social protection interventions

103 The costs of pre-emptive social protection are less than the costs of responding after a crisis. For example, in Zambia US$19 million a year is needed to provide cash grants nationwide for the largely elderly carers of vulnerable children. Including administrative costs, this is a total of US$100 per household annually, which compares favourably with the US$250 per household that would be needed to provide food aid of less value than the US$6 per month[191]. If a family's assets are shielded by social protection rather than eroded during a shock, a household is able to return to productive activity more quickly once the crisis has passed. Otherwise, many coping mechanisms have long-term consequences – because they involve choosing low risk and low return enterprises, or selling productive assets, cutting food to levels which bring malnutrition and staying away from schools and clinics on grounds of cost[192]. In Uganda, Kenya, Tanzania and Malawi, the poorest choose low risk crops that are from three to six times less productive than those chosen by the more secure[193].

104 Whilst some types of social protection are not expensive, others can place pressure on public finances and therefore require careful consideration – there are massive trade-offs between different options and the implications of each need to be understood and debated. Having said this, even those requiring more resources are proving to be very cost-effective, as in the long term they reduce costs and increase growth. They deserve more attention than they have been given in past analyses of development in Africa. This has never been more so than in light of the HIV and AIDS pandemic, where special attention is needed to alleviate the burden of care from women and ensure orphans and vulnerable children receive proper support.

105 Each country has to take the lead in developing their own mix of interventions for their context but there are five categories of social protection which, when supporting constructive family and community strategies[194], can be effective.

Protecting Rights

106 Protecting people's rights can transform their lives and enable them to take up opportunities and lessen the impact of HIV and AIDS. Improving women and children's rights over property on being widowed or orphaned would reduce destitution and therefore also reduce their migration into slums and into prostitution. In Namibia just under half of all widows lost cattle and farm equipment in disputes with their in-laws after the death of their husband[195]. In many sub-Saharan African countries, widows lose all rights to cultivate their husband's land[196]. Property rights would also give women more control over the means of production (Chapter 7). Rwanda is at the forefront of realising inheritance rights for women[197].

107 There is greater progress when strengthened legislation is combined with awareness campaigns, legal assistance and legal aid[198]. Violence against women is all too common. South Africa is making significant advances through, for example, enforcing laws where a teacher who sexually abuses a girl is sacked. Simplifying the registration of births, combined

with campaigns to register people retrospectively, would ensure all men and women are able to demand their entitlements as citizens. The decriminalisation of sex work would assist with HIV prevention, detection and treatment[199].

Springboards

108 Schemes to assist poor people into employment work well when the entitlements to them are clear. These might include programmes that guarantee a number of days employment in infrastructure development, at a rate marginally lower than the market. An example of this from India is the Maharashtra Employment Guarantee Scheme, which also provides a crèche, allowing women to participate on equal terms with the men[200]. Schemes that build up people's skills increase their employability. Schemes can also be used to strengthen community institutions such as in Mali[201] and increase awareness of rights or HIV risks, as in Zambia[202]. In Senegal, street children are supported to assess their own education and employment requirements[203]. Entry into employment is also covered in Chapter 7.

Cash transfers

109 Childcare grants, disability allowances, pensions, and other direct transfers of cash can be used even in countries with poor infrastructure, little capacity to deliver services or no interest in reform. The childcare grants in Zambia mentioned above provide US$6 a month to the largely elderly carers of vulnerable children, have increased attendance at school to 90 per cent and improved nutrition[204]. Childcare grants conditional on school and health clinic attendance, such as PROGRESA, Bolsa Escola and PETI, have had dramatic impacts in Latin America – increasing school attendance, reducing illness and malnutrition[205]. Social pensions (universal and non-contributory) have increased investment in children's education and nutrition in Namibia and South Africa, where around a third of pensions are spent on grandchildren's education. Without pensions, the gap between the poorest and the poverty line in South Africa would be 81 per cent greater[206].

Consumption transfers

110 Basic health and education can be made free. So can school meals. The removal of health and primary school fees has been shown (in sections 6.1 and 6.2) to increase numbers of poor people taking up services. In education for example, removing primary fees can almost double the attendance of the poorest girls[207]. School feeding with take home rations – using locally bought produce[208] – increase attendance of girls and boys, improve their nutrition and meets the right of the child to food. The fortification of food and its marketing would reduce illness amongst women and children (see section 6.2). Food supplements for people living with HIV and AIDS are also an important element of their care.

Community support

111 Schemes to involve communities in the protection and empowerment of vulnerable families have been very effective across Africa. These might entail practical care, information about entitlements or psychosocial support to orphans[209]. 'Vulnerable children committees' in Tanzania and Uganda galvanise community support for vulnerable children and their families. In Kenya and Ethiopia, community groups worked with religious and traditional leaders to campaign successfully for eliminating violence against women. In Kenya and Uganda, community volunteers support families in crisis to identify wider support networks.

6.5.3 Building strategies against exclusion and vulnerability

112 All of these mechanisms – as well as the basic provision of health and education covered in the sections above – increase investment in a household's assets. They reduce

vulnerability and exclusion by interrupting the processes that drive people into poverty and exclude them from the economy, politics or society. Objectives of these strategies might be to mitigate the impacts of HIV and AIDS, reduce conflict and lessen vulnerability to economic or natural shocks – this is also covered in Chapters 5, 7, 8 and 9.

113 These interventions have received less attention in Africa than Asia or Latin America. Each country has to develop its own strategy for social inclusion and work on this has begun. African and European parliamentarians have, through the Cape Town Declaration (September, 2004), committed to advocate for interventions to protect orphans and other children made vulnerable by HIV and AIDS[210]. Tanzania, Uganda and Ghana have already undertaken thorough analyses of vulnerability and exclusion in their countries and this is now being fed into the design of national poverty reduction strategies and other policies. 16 countries in Africa have also developed national orphans and vulnerable children strategies. Many local authorities have community strategies to ensure care for orphans. This African leadership must be supported. A review of service delivery in conflict and post conflict countries highlights the requirement for these types of disaggregated analyses in fragile states too. The solutions can be very simple – such as positioning toilets in refugee camps or slums in central well-lit areas to reduce the abuse of girls.

114 But donors to date have tended to fund short-term, small-scale and – frequently complex – social protection projects, often in reaction to a disaster. For social protection to have real impact such projects must be at scale and therefore simple. They must be high impact and therefore bold. African governments require predictable, long-term support from donors in order to take on these types of recurrent costs.

115 There has to be better co-ordination with clear agreement on roles within Africa and internationally. The AU, its programme NEPAD and ECA all have initiatives in this area, particularly on gender relations. UNDP might be well placed to take the lead in co-ordination of international agencies, such as UNICEF, ILO, WB, UN HABITAT, and through their poverty trust fund, could support financing where countries do not have sufficient bilateral support.

116 **Recommendation: Donors should support the African Union's NEPAD programme to develop a rights and inclusion framework and support countries to develop social protection strategies by 2007.** As so little has been done in the area of social protection in Africa to date, this is the first priority. Through a grant of US$2 million as seed money, experience and understanding in Africa would be gathered to inform the development of social protection strategies, linked to the national poverty reduction strategies. In collaboration with other pan-African institutions, such as the Social Affairs Commission of the AU and the ECA's African Gender and Development Institute, AU/NEPAD will develop a rights and inclusion framework drawing on other relevant analysis and good practice[211]. AU/NEPAD will lead the development of a common position of what is required to reach the MDGs in Africa in 2005 – including social protection interventions. Working in collaboration with relevant international agencies, AU/NEPAD will then support African countries to undertake analysis of vulnerability and exclusion and develop national inclusion strategies, piloting approaches as necessary to refine simple, bold interventions that work. Existing national orphans and vulnerable children strategies should be situated within this work.

117 **Recommendation: African governments should develop social protection strategies for orphans and vulnerable children, supporting their extended families and communities. Donors should commit to long-term, predictable funding of these strategies with US$2 billion a year immediately, rising to US$5 to 6 billion a year by 2015.** Following the recommendation above, donors should fund these national social protection strategies, as long as they are credible. These strategies must include clear mechanisms for transferring resources to households and communities to support

child protection, with clear entitlements and processes to ensure transparency and accountability to communities. National strategies should also be structured so that funding would increase incrementally with evidence of the effectiveness of delivery as well as efficiency – to develop the confidence of governments as well as donors. Donors' financing should be provided both bilaterally through a common pool and multilaterally through the poverty trust fund of UNDP to support fragile states and others who have insufficient donor support. Agencies must work in co-ordination to ensure harmonised action in social protection behind national strategies – using the AU/NEPAD rights and inclusion framework for common monitoring.

118 We are recommending an initial US$2 billion a year by 2007, rising to five to six billion a year by 2015 as it is not our view that funding of this magnitude could be used effectively immediately. These are indicative amounts and funding should increase with evidence of the outcomes achieved and of the impacts that would be attained with additional resources. The potential outcomes from the types of bold, simple interventions suggested above could include 40 million cash grants of US$6 a month for child support and people with disabilities, which would cost US$3 billion a year. This would lead to better nutrition, less illness and greater uptake of educational services[212]. UNICEF estimates that with US$1.7 billion a year, the five million most vulnerable children in Africa would be provided with all basic services – health, education, food as well as psychosocial and community support[213]. For US$4.4 billion, UNICEF estimates that all 15 million children who have been identified as an orphan or about to be orphaned and are in need could be supported. A top priority in 2005 is the additional first US$500 million to increase these services gradually[214]. Also required immediately are long term commitments for the 16 national orphans and vulnerable children plans already developed, costing US$30 to 40 million each year on average. These plans are likely to be an underestimate of what is needed, but are an important starting point. Recommendation: Donors and African governments should endorse and realise the UN Framework for the Protection, Care and Support of Orphans and Vulnerable Children.

119 Recommendation: Donors and African governments should provide direct budgetary support to pan-African organisations to support their work in protecting women and children's rights. African governments must honour the progressive and exciting commitments made in the African Heads of State Solemn Declaration on Gender, which includes the implementation of the Convention for the Elimination of Discrimination Against Women. African civil society and governments have also identified specific actions at the Beijing+10 in Africa meeting, 2004. Donors and African Governments should provide financial and other support to the Gender and Development Directorate of the AU, to AU/NEPAD and to the African Gender and Development Centre of the Economic Commission for Africa.

6.6 Conclusion

120 The well-being and development of all individuals has intrinsic value. The Millennium Declaration set out the international community's firm commitment to work together to realise the right to a basic standard of living for all. Progress is measured through a number of goals including to ensure primary education for all, eliminate gender disparity and empower women, halve the numbers of people without access to clean water, reduce maternal and child mortality and halt and begin to reverse the spread of HIV. These goals will not be met without strengthening and resourcing government systems to deliver basic services. The actions set out in this chapter require significant extra resources. But to use these effectively a fundamental change in how donors and African governments work together is needed.

121 This chapter has six recurring themes. First, African governments must develop coherent strategies that integrate different initiatives and resources to maximise impact.

Second, donors and global partnerships must harmonise and co-ordinate their procedures, to lighten the administrative load for African governments and avoid duplication. Third, donors and global partnerships must provide predictable, long-term funding, ideally pooled through budgetary support. Fourth, one agreed monitoring framework is required that allows African governments to improve delivery as well as enabling both governments and donors to see what impact they get for their money. Fifth, a considered but strong increase in funding is necessary, sequenced to ensure the foundations of governments' systems are strengthened and increasing as resource effectiveness is demonstrated. Finally is the overarching requirement to ensure accountability to poor people.

122 Development will not happen without equipping women and vulnerable groups with the capacity to reduce their poverty and participate fully in society, in politics and in the economy. Much is known about which reforms work and when – but innovation is still needed as well as extra effort to ensure that services reach the poorest and excluded.

123 The recommendations made in this chapter would have far reaching effects:

124 In education, a total annual increase of US$7 to 8 billion each year for all the recommendations, would enable all children in sub-Saharan Africa – boys and girls – to complete a basic education, equipping them with the skills for contemporary life. Half of these children would also go on to attain secondary education. And higher and vocational education, adult learning and teacher training would receive appropriate support within the overall education system (higher education is covered in Chapter 4). As a result of this investment across the sector, not only would the education and gender MDGs be attained, and the ability to achieve other MDGs improved, but also the commitments for the broader and more progressive Education For All agenda would be met.

125 The outcomes from the bold programme of action in health would be substantial. For the additional US$20 billion a year, free access to broad-based health systems would be in place by 2015 and would meet 60 to 70 per cent of the Child and 70 to 80 per cent of the Maternal Mortality MDGs, and are absolute requirements for meeting the MDGs for tuberculosis, malaria and HIV and AIDS treatment and care[215]. The lives of five million children would be saved through immunisation, with a further three million deaths among adults prevented. 500 million people would live free from the threat of parasitic disease. All African men and women would obtain the family planning and reproductive health commodities they need. Scientists would accelerate the search for vaccines for both malaria and HIV and AIDS. Polio would be eradicated in 2005. All of these goals are possible if donors provide predictable, long-term financing and if African governments deliver coherent integrated strategies.

126 The outcome of reversing the decline in aid for water supply and sanitation would also be substantial. Chapter 7 sets out recommendations to support the closing of the infrastructure finance gap in Africa. By 2015, this would enable access to water supply and sanitation services for 75 million people. By providing sufficient funding to meet the MDG on water supply and sanitation in Africa, 173 million cases of diarrhoea would be avoided each year, 456 million productive days would be gained annually, US$1.6 billion of treatment costs would be averted each year and 99 billion school days would be gained[216].

127 Through at least an additional US$10 billion annually for HIV and AIDS by 2010, real advances would be made in the delivery of the UNGASS Declaration of Commitment on HIV and AIDS – realising the right of African people to prevention, treatment and care services. The pandemic would be stabilising, 25 per cent of infections in young people having been prevented. All in need of treatment would receive it, with paediatric ART available to the three million children living with HIV and AIDS. The delay in orphaning would reduce the predicted levels of orphans by five per cent. But in addition to the resources, donors and international agencies would have harmonised and worked in complementarity to ensure all aspects of a national AIDS strategy was properly supported. And African governments would

have developed strategies to integrate the HIV and AIDS response into the delivery of health, education and social protection systems, with prevention messages appropriate to and challenging of gender and power relationships.

128 Through the social protection interventions, the lives of women and children would be transformed through property and inheritance rights and protection against violence. The five million most vulnerable children and another 40 million chronically poor households caring for orphans and other vulnerable children would be supported through community programmes and cash grants, perhaps conditional on school and health clinic attendance. For the US$5 to 6 billion, the interlocking cycles of poverty and exclusion trapping millions would be interrupted, preventing the transfer of poverty from parent to child and mitigating the far reaching impacts of AIDS and conflict.

Recommendations on Leaving No-One Out: Investing in People

There is no substitute for the large increase in resources that are required to reverse years of chronic under-investment in education, health and social protection.

Effective use of these large new resource flows will require comprehensive plans for delivery and for monitoring results. To this end, African governments must continue to strengthen governance and ensure the participation of ordinary people and local communities in decisions on development. For its part, the international community must deliver what it has promised. Both African governments and international donors must ensure that opportunities are available to all.

Education

- Donors and African governments should meet their commitments to achieve Education for All, ensuring that every child in Africa goes to school. Donors should provide an additional US$7-8 billion per year as African governments develop comprehensive national plans to deliver quality education.
  - In their national plans African governments must identify measures to get girls as well as boys into school with proper allocation of resources. Donors should meet these additional costs.
  - African governments should undertake to remove school fees for basic education, and donors should fund this until countries can afford these costs themselves.
  - To ensure that high quality education is delivered, African governments must invest in teacher training, retention of staff and professional development. Teacher/child ratios should be brought to under 1:40 in basic education. Donors should commit to predictable long-term funding to enable this.
  - Education should provide relevant skills for contemporary Africa. Donors should fund regional networks to support African governments in the development of more appropriate curricula at all levels.

Health

- African governments should invest in rebuilding systems to deliver public health services. Donors should provide US$7 billion over five years for this, behind the Health Strategy and Initial Programme of Action of the African Union's NEPAD Programme.
- Donors and African governments should urgently invest in training and retention to ensure there are an additional one million health workers by 2015.
- African governments should meet their commitment to allocate 15 per cent of annual budgets to health and put in place strategies for the effective delivery of health services. Donors should increase their funding to support these strategies, making up the shortfall, from an additional US$10 billion annually immediately and rising to US$20 billion annually by 2015. The assistance should go predominantly through national budgets.
  - Where African governments remove fees for basic healthcare as part of reform, donors should make a long-term commitment to fill the financing gap until countries can take on these costs.

- Donors should fully fund the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Donors should commit to full funding of the Global Alliance for Vaccines and Immunisation (GAVI) through the International Financing Facility for Immunisation. They should also meet their commitments to the Polio Eradication Initiative to eradicate polio in 2005.
- The World Health Organization's 'Two diseases, one patient' strategy should be supported to provide integrated TB and HIV care.
- African governments and donors should work together to ensure that every pregnant mother and every child has a long-lasting insecticide-treated net and is provided with effective malaria drugs.
- Donors should ensure that there is adequate funding for the treatment and prevention of parasitic diseases and micronutrient deficiency. Governments and global health partnerships should ensure that this is integrated into public health campaigns by 2006.
- African governments must show strong leadership in promoting women's and men's right to sexual and reproductive health. Donors should do all they can to enable universal access to sexual and reproductive health services.
- Donors should develop incentives for research and development in health that meet Africa's needs. They must set up advance purchase agreements for medicines. They should increase direct funding of research led by Africa, coordinated by the Regional Economic Communities and in collaboration with the global health partnerships.

Water and sanitation

- Starting in 2005, donors must reverse the decline in aid for water supply and sanitation, to enable African governments to achieve the Africa Water Vision commitment to reduce by 75 per cent the proportion of people without access to safe water and sanitation by 2015. The G8 should report back by 2007 on implementation of the G8 Water Action Plan agreed in 2003.

HIV and AIDS

- The international community must reach a global agreement in 2005 to harmonise the current disparate response to HIV and AIDS. This must be in support of bold and comprehensive strategies by African governments that take account of power relationships between men, women and young people.
- As agreed in the UNGASS Declaration of Commitment on HIV and AIDS, African governments and the international community should work together urgently to deliver the right of people to prevention, treatment and care. Donors should meet the immediate needs and increase their contribution by at least US$10 billion annually within five years.

Protecting the most vulnerable

- African governments should develop social protection strategies for orphans and vulnerable children, by supporting their extended families and communities. Donors should commit to long-term, predictable funding of these strategies with US$2 billion a year immediately, rising to US$5 to 6 billion a year by 2015.

- Donors should support the African Union's NEPAD Programme to develop a rights and inclusion framework and support countries to develop social protection strategies by 2007.
- Donors and African governments should endorse and implement the UN Framework for the Protection, Care and Support of the Orphans and Vulnerable Children.
- Donors and African governments should provide direct budgetary support to pan-African organisations to support their work in protecting women and children's rights.