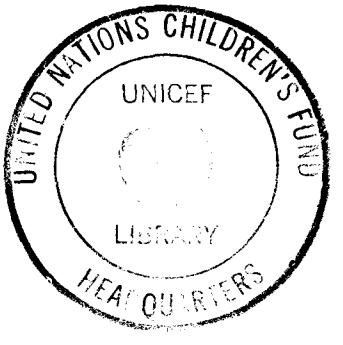
Challenges for Children and Women in the 1990s

Eastern and Southern Africa in Profile



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Foreword

In October 1990, UNICEF's Eastern and Southern Africa Regional Office (ESARO) brought a number of specialists to Masinga Lodge (in Masinga, Kenya) to analyse child survival, protection and development data with a view to identifying new trends and issues emerging in the region. The specialists included P. Anyang' Nyong'o, A.B. Ayako, L. Dirasse and K.M. Mwarania as well as K.E. Fleming, M. Elias, J. Maeda and G. Martin from UNICEF's Regional Office. Several participants joined A. Fleuret and R. Morgan, who were unable to attend the meetings, in submitting papers. For two days, the participants reviewed health, nutrition, education, economic and demographic indicators and identified emerging trends and issues for Eastern and Southern Africa. These trends and issues were loosely grouped under the headings poverty, women's and children's health, household food security, women's development, urbanization, children in especially difficult circumstances and conflicts and wars.

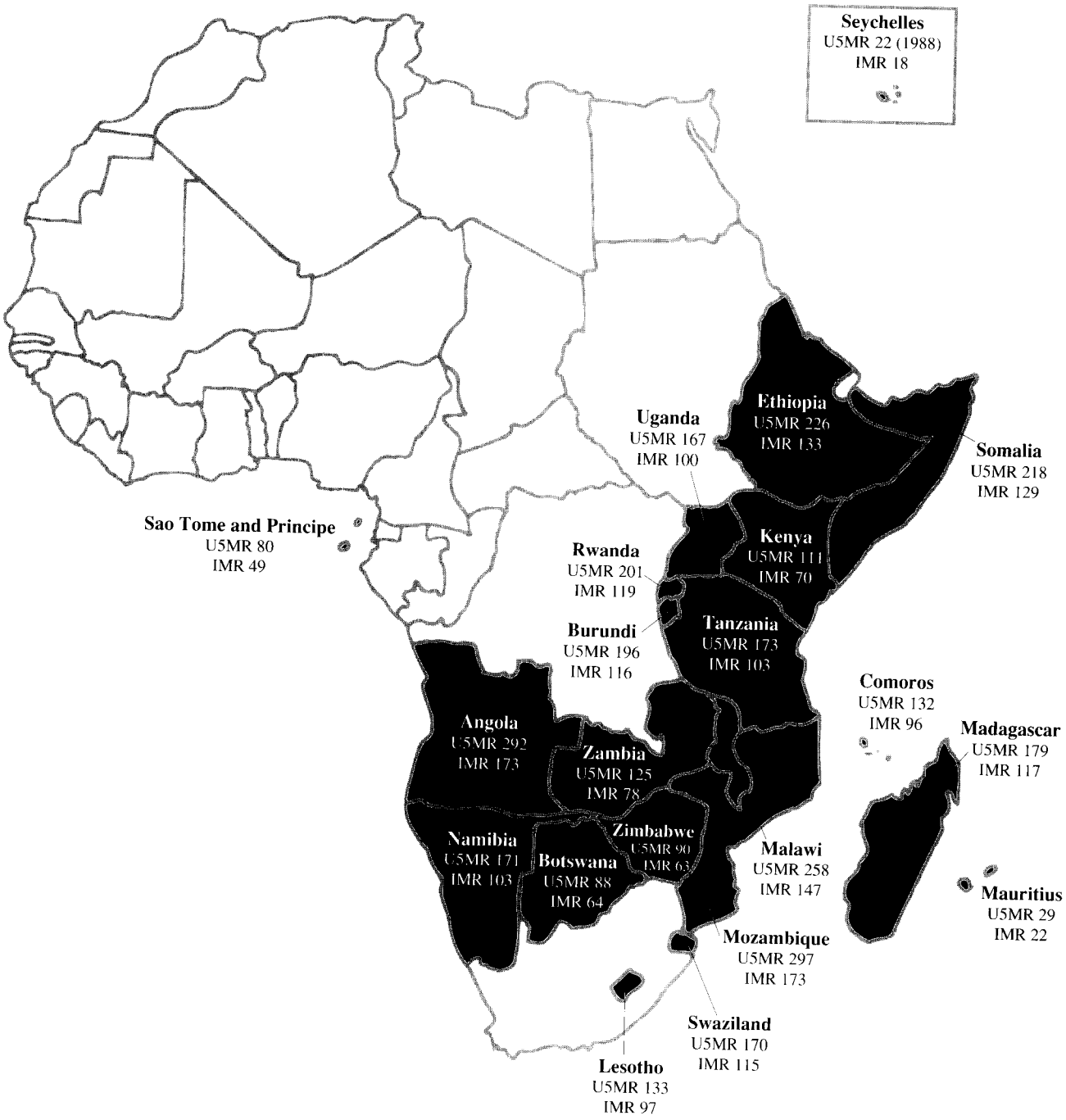
The Masinga meeting established the parameters of a regional profile of children and women in Eastern and Southern Africa. J.C.M. Zutt, who attended the Masinga meeting, was retained to draft and publish this profile. His first draft, which included a strengthened statistical annex and incorporated a large amount of his own research, was submitted in December 1990 to the senior officers of UNICEF ESARO for their review. His second draft, seeking comments from UNICEF headquarters and from UNICEF country offices in Eastern and Southern Africa, was distributed to participants in the Regional Planning and Management Team meeting in January 1991. In June 1991, Mr Zutt completed the final draft of the profile, which now includes chapters on UNICEF's new nutrition strategy and on its new directions in education.

This profile is intended to alert UNICEF country offices to emerging issues in their countries, to establish ESAR's thematic and programmatic priorities and to assist UNICEF Representatives, Senior Officers as well as Headquarters colleagues, in their advocacy for Eastern and Southern Africa's needs. ESARO hopes both to update the profile regularly and to include data and analysis from all of sub-Saharan Africa in subsequent editions. These hopes will require the participation of UNICEF's West and Central African Regional Office (WCARO) as well as other institutions in the region. Such an initiative is especially important in light of the World Summit for Children and the Goals for the Year 2000 as it will enable UNICEF and its partners to monitor their progress. While each chapter suggests a number of "UNICEF Initiatives", these are not exclusive instructions but suggestions for the whole development community. UNICEF recognizes that the enormity of Africa's development needs will be met only with the full participation of Africa's governments, their development partners and—above all—Africa's people.

To the Representatives and Assistant Representatives of ESAR's twenty one countries go my heartfelt thanks for their support to this book. It was they who, as members of UNICEF's Eastern and Southern Africa Regional Planning and Management Team, agreed to identify the most important data sets which they would gather and make available to the Regional Office for broad comparisons and the identification of trends. Their comments on the various drafts and suggestions on topics to highlight strengthened the document. Our colleagues in New York's Africa Section, especially its Chief, Marta Mauras, encouraged us to carry on with the project recognizing its timeliness for UNICEF's now declared priority for Africa. My Regional staff likewise deserve praise, especially Justin Maeda and Kate Fleming. Many others have helped—too many to be listed here. To all, our thanks for their involvement and for proving once again that a collegial or participatory process among colleagues aiming at common goals yields impressive results.

Mary Racelis

UNICEF
Eastern and Southern Africa



Note: U5MR and IMR 1989.

Introduction

This profile of the situation of children and women in Eastern and Southern Africa (ESA) attempts to identify and analyse trends and issues emerging in ESA and having particular significance for UNICEF activities. It will be the first in an intermittent series of such profiles. This profile and its successors will monitor key CSPD, health, nutrition, education, demographic and economic indicators to alert UNICEF country offices in ESA to emerging issues in their countries, establish the thematic and programmatic priorities for UNICEF's Eastern and Southern Africa Regional Office (ESARO) and provide an advocacy tool for UNICEF as well as for other groups which are actively involved in human development in the region.

In this first profile, the issues identified and analysed include poverty, women's and children's health, nutrition, education, women's development, urbanization, children in especially difficult circumstances and conflicts and wars. Although many of these subjects have perennial importance for UNICEF, they are included in this profile chiefly because they present extraordinary challenges after a decade of almost universal decline in ESA. There has been no attempt to cover every programme area, but this should not be taken to denigrate the importance of those programme areas which have been omitted. For instance, water and sanitation and the control of diarrhoeal diseases are reviewed lightly, not because they are unimportant but because the issues presented in each of these areas have not changed significantly in the recent past.

Economic Overview

Emerging trends and issues have been identified against a background of major reversals in ESA during the 1980s. The extraordinary "openness" of ESA economies to external shocks has resulted in unprecedented economic decline for most of the region's countries. Over the 1980s, only four of seventeen ESA countries enjoyed positive annual GNP per capita growth rates. For the remaining thirteen countries, falling commodity prices (resulting in lower export earnings) and rising interest rates (resulting in higher debt service obligations) sharply reduced their sustainable ability to purchase manufacturing imports, thus putting a brake on economic growth. The large and rapid increase in oil prices in 1990 was especially disruptive to ESA economies. At the same time, while many ESA countries implemented painful structural adjustment programmes in the hope of additional lending, external financial flows to sub-Saharan Africa—far from increasing—actually fell for most of the 1980s (from $36.5b in 1982 to $23.5b in 1988). Growing unemployment and falling per capita consumption have accompanied sharp declines in social spending for most of the 1980s, and if these trends continue, poverty will reach a higher concentration in sub-Saharan Africa than in any other part of the developing world by the year 2000.

Poverty

The World Bank estimates that 16% of the developing world's poor people lived in sub-Saharan Africa in 1985. Holding the number of poor at this level, according to the Bank, would require an average annual GDP growth rate of 5.5%. But with sub-Saharan Africa achieving a 0.3% growth rate for 1980-86, such robust positive growth is unlikely. Even the Bank, on optimistic assumptions, believes that the achievable annual GDP growth rate will not exceed 3.7% for sub-Saharan Africa in the 1990s, bringing that region's share of the developing world's poor to 30% by the year 2000. Hence, fighting poverty will be the principal preoccupation of the 1990s in Africa.

Beyond generalities, little is known about Africa's poor people. We know that the poor have high dependency ratios; that they generally lack access to land, livestock, credit and social services; that they achieve low returns from the sale of their primary asset, labour; and that the bulk of their income is spent on (food) consumption. To survive, the poor will respond to their situation with various strategies designed to reduce risk

(e.g. growing low-yielding but highly-resilient crops), to increase household incomes (e.g. deploying child labour) and to stretch household resources (e.g. concentrating food expenditures on cheap sources of calories). But most of our knowledge of the poor's problems—and their solutions to these problems—is general, outdated and derivative. To fight poverty effectively in the 1990s, the development community must learn more.

Health

While the 1980s witnessed some remarkable achievements in health in ESA, much remains to be done. Only eleven ESA countries reached the UCI 1990 target of 75% DPT3 coverage for infants and only eleven countries reported ORT use rates exceeding 15% in 1987. As a consequence, measles, diarrhoea and neonatal tetanus—together with malaria and acute respiratory infections—continue to cause more than 70% of infant and young child deaths in ESA. At the same time, the AIDS pandemic is projected to kill as many as 2.7 million children and 2.9 million women in ten East and Central African countries in the 1990s. Besides reversing recent gains in infant and child mortality rates, AIDS will shift the productive burden increasingly to those who are least able to shoulder it—the young and the old—and it will orphan as many as 5.5 million children. Moreover, after a decade of austerity, the human and financial capacity of African governments to sustain immunization levels or to maintain current levels of access to health services (let alone expand to meet the growing threats of malaria and AIDS) is far from certain.

Much work also remains to be done in the area of girls' and women's health. In Europe—where women suffer little discrimination in health care or nutrition—there are about 105 women to 100 men, but in sub-Saharan Africa there are only 102. Assuming that there are no significant physical differences between Africans and Europeans, these statistics indicate an excess mortality of 3.2 million women in ESA alone, providing strong evidence that girls and women suffer from neglect and unequal access to health care and nutrition. At the same time, inflated maternal mortality rates indicate that maternal health has not been a priority in ESA in the past. As a few basic principles can reduce both maternal and child mortality rates sharply, there is an opportunity for improvement in this area.

While health care improvements have brought crude death rates down to 5-20 per 1,000 population for all ESA countries, crude birth rates continue to range from 41-56 per 1,000 population (except in Mauritius and Seychelles). With many ESA countries thereby doubling their populations every twenty years, human demands may soon exceed the sustainable yield of Africa's fragile ecosystem, leading in some places to total and irreversible ecological collapse. To achieve sustainable health in many parts of ESA, there is now an urgent need to reduce birth rates in order to ease population pressures: the failure to act will soon result in high numbers of environmental refugees who will depend indefinitely on emergency relief to fend off painful and unnecessary deaths.

Nutrition

Following the remarkable successes of the Joint WHO/UNICEF Nutrition Support Programme—which in Iringa, Tanzania reduced severe malnutrition in young children from 6.3% to 1.8% and moderate malnutrition from 56% to 38%— UNICEF has adopted a new nutrition strategy. Under this new strategy, nutrition is analysed and addressed as the focal outcome for child survival and development of a complex (and particular) sequence of social processes identified in a new conceptual framework. In particular the immediate causes of malnutrition and death are identified as disease and dietary inadequacies while the underlying causes are identified as insufficient household food security, inadequate maternal and child care and insufficient health services and an unhealthy environment. To improve nutrition, thstrategy advocates a multisectoral programme of actions based on ongoing analysis and assessment informed by a community-based nutrition-monitoring system.

Although household food insecurity remains a serious concern both because many ESA households continue to be food insecure and because the effort required to obtain or sustain food security continues to be great, the new conceptual framework shows that household food security is not the sole determinant of nutrition levels. Only when household food security is joined with adequate maternal and child care as well as with the availability of basic health services and a healthy environment do we approach a sufficient condition for good nutrition. It is an objective of the new strategy to alert health and nutrition workers to the equal importance of these other determinants of nutrition.

Education

Just as every child has the right to adequate health care and nutrition for survival, so every child has the right to a basic education which will enable her to develop her potential; to live in dignity, earning her living and managing her household; and to participate fully in the life of her community. But education not only satisfies a basic human need; it is also—*par excellence*—a capacity-building activity which sustains and accelerates human development. For these reasons, a chief goal for the year 2000 is universal access to and achievement in primary education. Universal primary education will have been achieved only if a

large majority of children by the age of 11 or 12 habitually acquire the essential learning tools of literacy and numeracy as well as the skills and knowledge which are immediately relevant to their particular needs, interests and problems.

In ESA, where governments continue to operate under severe financial constraints, it will not be possible in the near term to provide a high-quality formal education to all children. Hence the primary challenge to this region is not only to articulate a minimum package of skills and knowledge which all children should acquire but also to identify and develop flexible programme delivery systems which will complement the primary school system. The effort to achieve universal primary education in ESA is certain to require greater use of the "third channel", which consists of radio, newsprint and all other instruments for communicating knowledge and information which will help people to live fuller and healthier lives. At the same time, to improve the quality and relevance of primary education, it will be necessary to improve community involvement in education and to develop regionally-sensitive indicators of learning achievement.

Women

Although women do the bulk of the essential work in ESA—including as much as 80% of the farming—they are marginalized socially, politically and economically at every level. Despite overwhelming anecdotal evidence of widespread and deeply entrenched gender discrimination in ESA, there has been little effort to collect gender-disaggregated data on critical social and economic indicators. Hence the full extent of women's marginalization remains a matter for speculation.

Nonetheless, basic outlines are clear. Women in food insecure households typically take less (or less nutritious) food for themselves than for their male counterparts. Women typically obtain fewer years of schooling than men and as a consequence they are more frequently illiterate. As workers and producers, they have less access to credit, to extension services or to vocational training, and even when they achieve job parity they generally fail to achieve equal pay or equal benefits. Gender discrimination is particularly painful for female heads of households, who labour under higher dependency ratios with less command over resources than male heads of households. While there were modest gains in the reduction of gender disparities in the 1980s, these gains may be eroded in the 1990s if women continue to bear the brunt of structural adjustment.

Urbanization

Although Africa is still primarily a rural continent, urban populations have grown very rapidly in the last thirty years. The bulk of the increase has come from migration, as people move into the cities to enjoy the higher (subsidized) standard of living available there. Since most cities in Africa developed not as industrial centres but as administrative centres for colonial rulers, they are unable to provide work to the flood of migrants now flowing into them. At the same time, the extension of basic services has not been rapid enough to reach all of the urban poor, particularly as incremental improvements in services also attract greater in-migration. Hence the poverty profile in Africa is increasingly shifting from the rural to the urban areas.

Without adequate urban planning, including a substantial devolution of fiscal and administrative power from the central government to the cities, basic services will fail to reach many of these migrants, leaving them crowded in the peri-urban areas and exposed to higher risks of disease and death. Since local and national governments are facing severe fiscal restraints, to ease the plight of Africa's poor, it will be necessary both to promote self-reliant strategies for the construction of housing and the extension and maintenance of infrastructure. Moreover, to provide a long-term solution to Africa's urban crisis, it will also be necessary to build a productive base for the large urban centres. This in turn will require considerable reconstruction of most ESA national economies.

Children in Especially Difficult Circumstances

As many as 20% of the children in ESA are exposed to circumstances which deny their most basic human rights. Children often work to add to their families' incomes and to learn responsible behaviour. But work becomes exploitative when it retards the child's growth, exposes him to environmental hazards, entails prolonged separations from his family, restricts his access to basic health and education or interferes with his psychological or emotional well-being. In ESA, children's work is often structurally necessitated, but such work need never to be exploitative. To accommodate the needs of working children, working conditions can be improved, family connections can be supported and strengthened and schooling can be made more flexible.

Abused and neglected children are growing in number in ESA, but cost-effective interventions to address this problem are still far to seek. Since the high-cost professional assistance which is prevalent in the developed world is not feasible in Africa, prevention and treatment will rely heavily on legislation, family support and community education and mobilization. Africa's ability to respond to the needs of HIV-infected children and AIDS orphans is similarly limited: the emphasis must be on containing the spread of HIV and developing community-based and culturally-

acceptable care-giving systems, both for AIDS victims and for AIDS orphans.

Conflicts and Wars

In the war- and drought-affected countries of the Horn and of Southern Africa, children have most seriously and continuously been deprived of their basic human rights. In the SADCC countries, South African military violence together with the destruction of essential services and the disruption of relief and commercial supplies has claimed the lives of more than 1.25 million children between 1980 and 1990—with twelve children dying every hour in Angola and Mozambique alone. But, with recent reforms in South Africa, the prospects for peace are better than at any time since 1975. In the Horn of Africa, by contrast, peace appears to be more distant than ever. Violent civil wars complicated by widespread poverty, abrupt climatic changes and over-exploited ecosystems, continue to ravage people's lives in Sudan, Somalia and Ethiopia. The recent overthrows of the Barre and Mengistu governments have brought sharply divisive ethnic rivalries to the surface in both Somalia and Ethiopia just as record food deficits have put more than fourteen million people in the Horn at risk of starvation.

Children exposed to armed conflict and natural disaster suffer from sheer deprivation, from lack of access to basic resources, from anxiety and loneliness and helplessness, from unrelieved stress over long periods and from despair at an uncertain and unpromising future. Frequently they are separated from their families and displaced from their homes and their communities. Even if children escape physical wounds, war-related psychological trauma—particularly for the child soldier—may extend over decades. In the absence of the best and only permanent solution—the end of war and disaster—UNICEF and its partners must focus on reunifying families, demobilizing children and securing children's access to basic services. In brief, interventions should aim to protect the services and institutions directed to children's needs and to secure the compliance of governments and rebel forces with international humanitarian laws.

Economic Growth and Human Development

Of all developing regions, Africa continues to make the poorest showing on most basic indicators. Africa has the highest infant mortality rates and the lowest literacy and life expectancy rates. Extremely poor economic performance provides a partial explanation for these facts, but it is not the whole explanation. As UNDP's human development index shows clearly, countries with high GNP per capita can have low life achievements and, conversely, countries with low GNP per capita can nonetheless convert their limited resources into real (albeit modest) increases in human development.

Economic growth is necessary for human development but it is not sufficient. Growth is not directly linked with improving people's lives and in many cases is it not the most efficient way to make such improvements. It is necessary to focus not merely on increasing the sum total of national income but also on managing and distributing this income effectively. Economic growth should benefit all members of society: all social groups should have access to basic services; deprived groups should benefit from special services as long as their deprivation continues; and group disparities must be lowered and where possible eliminated. In ESA, even at current depressed levels of growth, there remains untapped potential for gains in human development. In particular, government spending can be made more efficient both by reordering priorities across sectors (e.g. away from military spending and towards social spending) and by reallocating spending within sectors (e.g. favouring preventive health care rather than curative care or primary education rather than tertiary education). At the same time, the commitment of African leaders to popular participation in development (as evidenced in the Arusha Charter of 1990) positively recognizes both that people are Africa's greatest resource and that Africans will continue to be the principal and the most dynamic agents of development on the African continent.

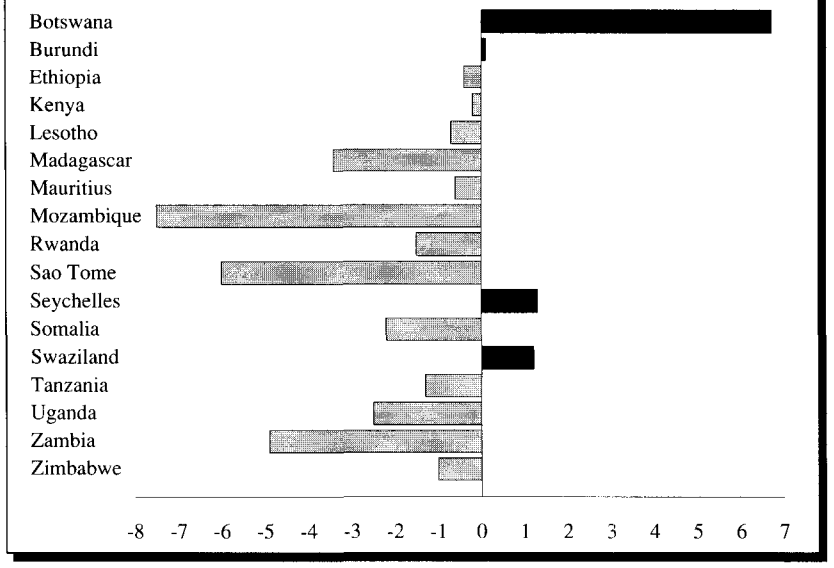
It is false that economic growth and human development are mutually exclusive goals. On the contrary, human development is a necessary component of sustained long-term economic growth. The high returns to education—particularly in the East Asian countries—provide abundant evidence for this truth. Human development aims in the first instance to bring people to their full potential. It attempts both to enlarge people's choices and to raise their level of achievements. At a minimum, people should be able to be educated, to live long and healthy lives and to possess the resources necessary for attaining a decent standard of living. Where development efforts fail to attain this minimum—where a person's potential has not been even minimally actualized—there is a permanent loss. This profile is a contribution to the continuing struggle to reduce and at last eliminate such losses.

1 Economic Overview

For most of the past decade, Eastern and Southern Africa suffered further economic decline. Although there were significant recoveries in some indicators after 1986 and although the region generally performed better than sub-Saharan Africa taken together, the overall trend for 1980-88 remained negative[1]. In Africa as a whole, per capita output fell from $752 in 1980 to $641 in 1987, per capita consumption fell by 20% over 1980-88, and capital formation fell from 21% to 15.6% of GNP over the same period (probably insufficient even to maintain existing capital stock) (Africa Recovery 3-1-2 1989: 31). In most ESA countries, GNP per capita declined as population growth rates consistently outpaced GNP growth rates, with Mozambique, Sao Tome and Principe, Zambia and Madagascar suffering the biggest losses. Gross domestic investment fell for many ESA countries, albeit less than the annual average for sub-Saharan Africa (-7.3%), with Malawi (-8.3%), Mozambique (-6.6%) and Zambia (-4.5%) recording the largest declines and only Burundi, Rwanda and Mauritius recording significant growth. The prices of several key commodities in ESA—tea, coffee, cocoa, cotton, sugar and copper—fell by an average of 3-12% per annum over 1978-1989 (UNCTAD 1990: 122). Export and import volumes declined for about half of ESA countries over 1980-88, despite general recoveries after 1986, with the worst overall performances recorded in Somalia (exports -9.7%, imports -4.1%) and Zambia (exports -3.7%, imports -4.8%). By 1988, gross international reserves had fallen to less than 1.5 months of import coverage for about half of ESA countries. At the same time, the region's terms of trade fell for much of the period 1980-88 (8.0% for all of sub-Saharan Africa).

Today, eleven of the twenty-one ESA countries are "debt-distressed" (Burundi, Comoros, Kenya, Madagascar, Malawi, Mozambique, Sao Tome and Principe, Somalia, Tanzania, Uganda and Zambia) (Killick 1989: 6) and twelve are LLDCs (Botswana, Burundi, Comoros, Ethiopia, Lesotho, Malawi, Mozambique, Rwanda, Sao Tome and Principe, Somalia, Tanzania and Uganda) (Guillaumont 1990: 6). The strongest performers in the region (excepting Mauritius and the diamond-producing enclave economy of Botswana) are stationary economies: the weakest are declining. Zambia and Sao Tome and Principe, middle-income countries in the 1970s, became low-income countries in the 1980s. As early as 1986, the World Bank said of Africa: "For the first time since World War II, a whole region has suffered retrogression over a generation" (World Bank 1986: 9). While some improvements have been observed since the Bank made this statement, "donor fatigue", the legacy of the Gulf War and an on-going world-wide recession strongly suggest that an overall negative trend will reassert itself in the region's immediate future.

Figure 1.1
GNP per Capita Annual Growth Rate (1980-88)



A negative economic trend dominated sub-Saharan Africa in the 1980s, but recovery is possible

Declining Terms of Trade

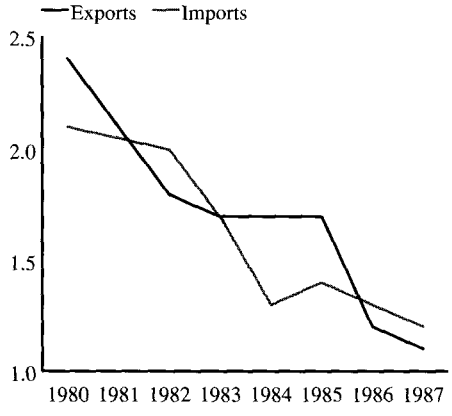
Possibly the chief cause of Africa's unprecedented decline is the extraordinary "openness" of the region's economies to external shocks. As small commodity- and trade-dependent economies, they are "price-takers" with extraordinary vulnerability to

Table 1.1
Terms of Trade for Selected ESA Countries (1980=100)

Country	1980	1981	1982	1983	1984	1985	1986	1987
Angola	100	98	96	94	96	92	62	56
Botswana	100	98	98	98	97	97	100	101
Burundi	100	82	92	90	101	99	117	73
Ethiopia	100	84	90	92	102	98	113	87
Kenya	100	92	90	94	104	93	114	90
Lesotho	100	97	96	96	90	98	84	83
Madagascar	100	87	94	95	100	103	109	83
Malawi	100	94	93	95	97	86	88	81
Mauritius	100	91	81	86	88	77	99	98
Rwanda	100	86	92	91	101	101	133	82
Seychelles	100	104	99	100	111	100	58	66
Somalia	100	91	92	97	93	90	80	88
Tanzania	100	85	88	91	96	91	102	90
Uganda	100	81	89	89	100	96	116	67
Zambia	100	80	71	78	70	72	71	79
Zimbabwe	100	92	87	95	96	89	88	91

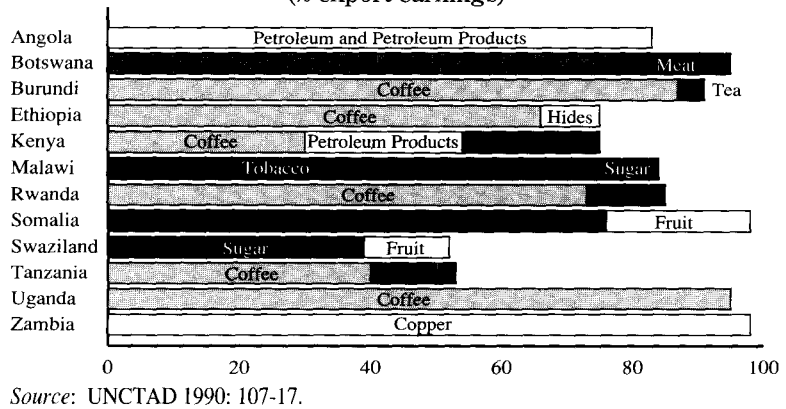
Source: UNDP-World Bank 1989: 49.

Figure 1.2
Sub-Saharan Africa's Share of World Trade (%)



Source: UNCTAD 1990.

Figure 1.3
Commodity Dependency of Selected ESA Countries (% export earnings)



Source: UNCTAD 1990: 107-17.

the influence of international market conditions (Fleming 1990: 3). ESA economies are also extremely sensitive to fluctuations in the weather, with heavy losses from natural disasters (floods and droughts) occurring frequently. The terms of trade for Africa have been disastrous on both sides, as import prices continue to rise and export prices continue to fall. Depressed trade levels are reducing government revenues and weakening governments' abilities to achieve a balance in their trade and fiscal accounts. At the same time, world trade in manufactures continues to grow much more quickly than trade in commodities, dooming Africa to a smaller and smaller share of world trade, at least in the short- to medium-term. When export earnings largely determine the sustainable ability of countries to purchase imports, and when growth is highly dependent on imports (of capital, raw materials, spare parts and key consumption goods), declining export earnings put a sharp brake on economic growth (Ibid.: 3-4). This is precisely the situation in ESA, where severe import strangulation has sharply reduced the level of productivity (i.e. actual capacity utilization) as well as the level of investment (i.e. potential capacity growth).

Export Earnings: For eleven ESA countries (Angola, Botswana, Burundi, Ethiopia, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Somalia, Uganda and Zambia), more than three-fifths of export earnings come from a single commodity. Five other countries (Comoros, Kenya, Malawi, Swaziland and Tanzania) are extremely vulnerable to the market performance of two commodities. The price trends for many of these commodities in the period 1978-89 have been negative[2], with tea and copper declining steadily since 1962. Commodity prices have also been highly unstable (with deviations from the trend in several cases averaging 15-25% per annum (UNCTAD 1990: 122)), seriously disrupting economic planning. At the same time, Africa has been unable to maintain (much less increase) its share of the world market in many of these commodities[3] as infrastructure deteriorated, export volumes fell (often as a consequence of drought), new suppliers and new products (especially synthetic substitutes) entered the market and anti-export biases (e.g. overvalued exchange rates, low producer prices and protection of import-substituting industries) dominated domestic policies (Fleming 1990: 5-8, 11, 23). With no foreseeable improvement in commodity prices (particularly as Africa's export markets enter a recession), with consumer resistance to price stabilization mechanisms, with costly non-tariff barriers confronting some products (e.g. textiles) and high tariff barriers for many processed ones

(e.g. chocolate, fruit juices, coffee and tea extracts), it is hard to see how commodity production will support a durable recovery in Africa.

The Gulf Crisis: The Gulf crisis, which may have been the single largest external influence on ESA economies in 1990, clearly demonstrates the region's vulnerability to large and rapid fluctuations in import costs. The increase in oil prices to an average of $28.50 a barrel in the second half of 1990 added $10 a barrel to the average price prevailing in the first half of that year. Excepting oil-rich Angola, which enjoyed a windfall from higher oil prices, ESA was severely stretched financially, as lack of local oil production combined with sharp reductions in the prices of key exports (especially coffee and copper) and higher shipping costs for goods moving through the war-affected Suez Canal. At the same time, long-term concessional contracts with Iraq and Kuwait (where they existed) were forcibly disrupted, while Mozambique lost its non-hard-currency contract for petroleum imports from the Soviet Union (a contract which formerly saved it $140m a year). Where ESA countries were unable to afford long-term purchase contracts, they were forced to purchase oil on the spot market at prices reaching $40 a barrel. Such economic disruptions—pervasive, unpredictable and uncontrollable—threaten to erode fragile growth in economic and food production as well as recent gains in the extension of basic services and the reduction of morbidity and mortality rates. An increase of a third in external aid earmarked for import purposes might have absorbed the region's additional oil expenses—but this failed to materialize as donor countries struggled with the oil crisis themselves or sent assistance to oil-, trade- or remittance-losing economies such as Egypt, Jordan, Turkey and the Philippines. Unfortunately, the end of the Gulf War is also unlikely to return Africa to its *status quo ante*, as the rich oil-producing states of Kuwait and Saudi Arabia curtail aid grants to pay the costs of war and reconstruction and as Eastern Europe's requests for aid, credit and investment receive a more sympathetic ear from donors with cultural and historical ties to that region.

Declining Foreign Exchange Reserves

External financial flows—Africa's other major source of foreign exchange—are also falling. Many countries in ESA are aid-dependent. In 1988, official development assistance (ODA) as a percentage of GNP reached 57% for Mozambique and 46% for Somalia, exceeded 20% for Malawi, Tanzania and Zambia and exceeded 10% for Botswana, Burundi, Ethiopia, Lesotho, Madagascar and Rwanda. For at least ten ESA countries, ODA in 1988 was a more important source of foreign exchange than exports, being about 850% of exports in Mozambique, 750% in Somalia and 250% in both Ethiopia and Tanzania (World Bank 1990: 216-17). Unfortunately, taking ODA (about 75% of the total), private lending, foreign direct investment and officially guaranteed export credits together, external financial flows to sub-Saharan Africa fell (in constant dollars) from $36.5b in 1982—admittedly a peak year—to $23.5b in 1988 (UNCTAD 1990: 139). Moreover, while total transfers from the World Bank and the IMF to sub-Saharan Africa have remained positive throughout the 1980s, they declined by 60% to 75% over the decade, with positive net resource flows from sub-Saharan Africa to the IMF totalling $4.0b for 1984-90 (Helleiner 1991: 31, 37). Thus, ironically, the international financial institutions (IFIs) are contributing to the problems of underfunding which continually plague the adjustment programmes they themselves prescribe. Finally, even when aid flows are relatively healthy, they are frequently misdirected or inappropriately

Table 1.2
Annual Indices of Free Market Prices of Selected Primary Commodities (1980=100)

Commodity	1981	1982	1983	1984	1985	1986	1987	1988
Cocoa	79.8	66.9	81.4	92.0	86.6	79.5	76.7	61.1
Coffee	76.6	83.3	84.9	93.7	88.6	113.0	71.2	76.4
Copper	82.6	71.9	76.4	65.8	64.7	63.8	80.0	117.5
Cotton	89.7	77.4	89.8	86.4	63.9	51.2	79.8	67.8
Sugar	58.9	29.3	29.5	18.2	14.2	21.2	23.6	35.6
Tea	90.6	86.7	104.3	155.2	89.0	86.6	76.5	80.3

Source: UNCTAD 1988: 46-47.

Figure 1.4
Average Monthly Oil Prices ($ per barrel)

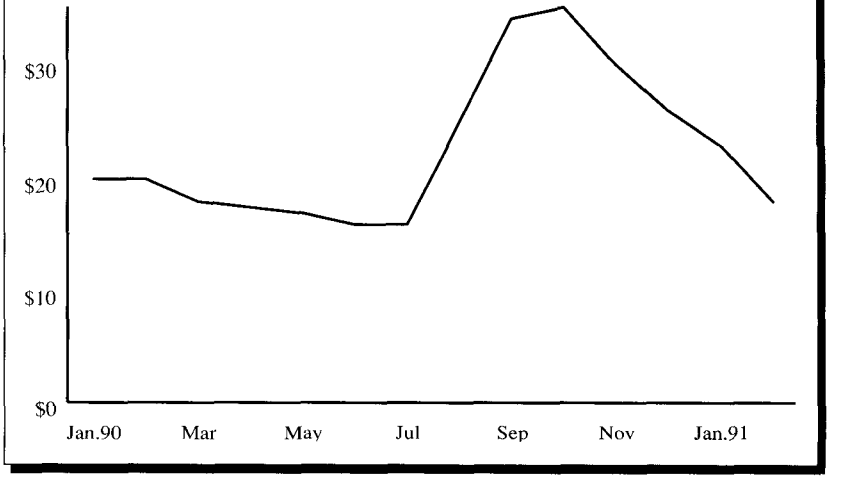


Table 1.3
ODA as a Percentage of Donor GNP

Country	1970	1980	1990
Norway	0.33	0.90	1.04
Sweden	0.41	0.85	0.97
Netherlands	0.60	0.90	0.94
Denmark	0.40	0.72	0.94
Canada	0.41	0.47	0.44
Australia	0.59	0.52	0.38
Japan	0.23	0.27	0.32
United Kingdom	0.42	0.43	0.31
United States	0.31	0.24	0.15

Source: UNDP 1991: 53.

conditioned. Aid may go to relief or to commercial and strategic projects rather than to development. It may be tied to the recipient's purchase of goods and services from the donor country or it may be tagged for capital installations rather than recurrent costs even though health and education sectors in Africa make intensive use of recurrent resources.

Debt Crisis: A growing need for foreign exchange to finance external debt has also contributed to sub-Saharan Africa's severe import strangulation. ESA's debt load is in some ways less burdensome than the load of the heavily indebted "Baker" countries. The combined debt of the ESA countries totals about $40b (compared to $480b held by the Baker countries) and over 80% of this debt is public or publicly-guaranteed long-term debt, mostly owed to official creditors which can address debt-servicing problems with direct political solutions. Moreover, although total debt-to-export ratios in ESA are frequently higher than in the Baker countries (with eight countries over 600%), debt service ratios (though growing faster in Africa) continue to be lower, chiefly as a consequence of reschedulings on concessional terms (low interest rates, long maturities and high grant elements). Nonetheless, for many ESA countries, actual interest and principal payments on external debt continue to consume a high percentage of export earnings (e.g. Madagascar (39% in 1988), Ethiopia (37.4%), Burundi (25.1%) and Zimbabwe (24.8%)) or of ODA grants (e.g. Kenya (47%), Madagascar (50%)) (World Bank 1990: 126, 224-25).

Unfortunately, large-scale borrowing in the 1970s did not yield sufficient returns to avoid these rising debt ratios. Many external factors contributed to these insufficient returns, including weak commodity markets, rising import prices, real reductions in net capital flows and dramatic increases in world interest rates. But domestic policy errors must share some of the blame. In a false reaction to the commodity boom of 1975-77, African governments failed to practice countercyclical management; instead they increased external borrowing and raised spending to unsustainable levels, thereby aggravating the economic imbalance which resulted from the external shocks of 1978-80. In addition, export credits in some cases were used to raise consumption instead of investment, and poor fiscal discipline as well as price and capital market distortions brought very low public-sector investment returns (Killick 1989: 3). ESA has also laboured under over-extended and inefficient state machineries; unproductive and rent-seeking central bureaucracies; low social cohesion leading to political instability; inadequate policy analysis, design and management; overstaffed, poorly trained and poorly motivated civil services; and political cultures, characterised by nepotism, tribalism and corruption, which are not responsive to the people and which discount public accountability and transparency in the use of public funds (Mwarania 1990: 4). However accumulated, the resulting debt "overhang" has been devastating in ESA, diverting scarce financial resources to non-productive uses, absorbing the time and energy of key economic and financial planners in successive (and expensive) rescheduling exercises and creating a strong disincentive to undertake politically unpopular adjustment programmes whose chief beneficiaries are perceived to be foreign creditors (Fleming 1990: 9-10). Moreover, as ESA countries have struggled to service their debts to maintain creditworthiness, there have been disproportionate cuts in discretionary areas of government spending, with economic services and social services suffering the most.

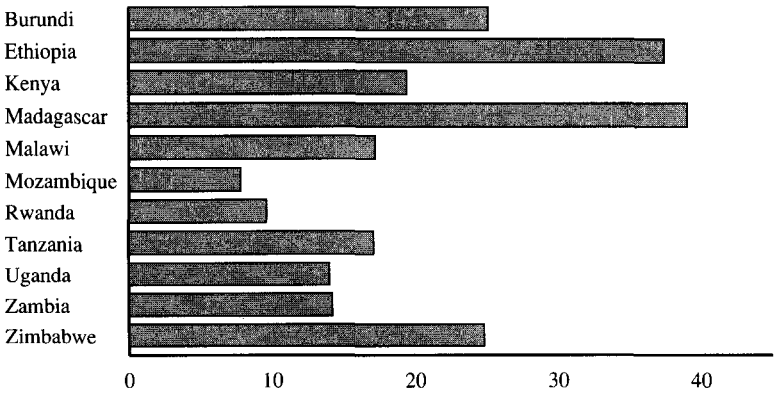
Box 1.1
International Aid

Although most donor countries have agreed to allocate at least 0.7% of GNP to official development assistance, only four countries—Norway, Sweden, Netherlands and Denmark—have met this target. Moreover, only two donor countries—Netherlands and Denmark—allocate more than 0.1% of GNP to priority areas in human development such as basic education, primary health care, family planning or rural water supply. With military assistance an important aspect of U.S. foreign policy, U.S. allocations to human development (0.012% of GNP in 1989) are especially low. It is often said that aid in the form of balance of payments support releases government spending for other (i.e. development) purposes, but this is frequently not the case. Since many ESA countries are heavily aid-dependent, donor priorities tend to "flow through" government spending allocations to become development priorities. For example, in Burundi, Ethiopia, Somalia and Uganda aid provides from 35% to 56% of total expenditure in health and education. Hence, donors must target their assistance more responsibly (UNDP 1991: 53-57).

Debt Relief Initiatives: It is far to seek an end to the debt problem in ESA. Immediate relief to the debtor countries would come only by reducing interest rates or cancelling a significant percentage of contracted debt service—two of the three options approved in the Paris Club in September 1988—but creditor governments for the most part have declined to follow this route. Alternative initiatives are having little positive impact. Disbursements under the IMF's Enhanced Structural Adjustment Facility and the Bank's Special Program of Assistance for Africa have been very low; total debt cancellations (about $3b to date) have left debt service obligations largely unchanged, since most of the cancelled loans had very soft terms; Paris Club agreements lengthening grace and maturity periods—the popular third option approved in the Paris Club—have actually increased total debt by capitalizing interest and increased debt service by charging market rates on this capitalized debt (Killick 1989: 4-5). At the same time, it is highly unlikely that the region will grow out of its debt, at least in the medium term. Starting from a very low base with declining incomes, low savings rates, small tax revenues, deteriorating infrastructures, narrow industrial capacities, low labour and capital productivities, high population growth rates and uniquely high dependencies on commodity trade and imported capital, it is unlikely that Africa will secure significant trade surpluses anytime soon (Ibid.: 5). Meanwhile, debt-related uncertainties discourage new investment and therefore delay the economic restructuring which is necessary for these economies to recover.

Some prospects for substantial debt relief do exist. Three debt relief proposals have been floated in the last year. The most generous is the Trinidad proposal which the finance ministers of the Commonwealth nations (led by John Major) made in September 1990. Under the Trinidad terms, two-thirds of the total eligible debt stock would be cancelled at once, with the repayment period on the remaining stock extended from 14 to 24 years and with interest payments capitalized for an initial five year period. A second proposal, made by Jan Pronk (Development Minister of the Netherlands) in September 1990, would forgive all bilateral official debt to the poorest of the severely debt-distressed countries. A third proposal, made by the Fraser Expert Group in its report entitled *Africa's Commodity Problems* (UNCTAD 1990), would place a 3-10 year moratorium on all bilateral official debt servicing with rescheduling on IDA terms (Helleiner 1991: 11-12). Against this background, countries

Figure 1.5
Debt Service as a Percentage of Exports (1988)



participating in the Western Economic Summit meetings may soon offer terms which are at least as generous as those recently offered to Poland (a one-off 50% cancellation of official debt) on the condition that eligible countries introduce or maintain IMF-approved adjustment programmes.

Unfortunately, even the Poland terms would provide inadequate debt relief to Africa, for two reasons. First, any reduction in the debt stock is likely to be limited to bilateral official debt only. As a consequence, the impact on African financial flows will be less than might be expected. Although Africa is paying only about one-half of its debt service at present, one-third of these payments go to the World Bank and the IMF (Helleiner 1991: 31), which have so far refused to discuss debt

Table 1.4
Net Flows of IMF Credit+
(years ending April 30)
(SDRs millions)

Country	1988	1989	1990
Angola	—	—	33.06
Burundi	0.00	12.81	8.54
Ethiopia	-8.80	-6.47	-18.45
Kenya	-27.35	9.79	-14.03
Lesotho	—	3.02	4.53
Madagascar	3.48	-28.04	-12.26
Malawi	-15.15	-0.25	0.30
Mauritius	-22.80	-32.27	-31.19
Mozambique	30.50	12.20	0.00
Sao Tome	0.01	—	0.80
Somalia	-1.63	-8.50	-1.22
Swaziland	-4.50	-1.10	—
Tanzania	31.88	32.10	13.93
Uganda	-3.18	17.21	-6.13
Zimbabwe	-90.40	-41.77	-25.11
TOTAL	-101.58	-31.27	-47.23

+ Excluding charges

Source: Helleiner 1991: 38.

Table 1.5
Military Expenditures

Country	Arms Imports ($ millions) (1987)	Ratio of ODA to Military Expenditure (1989/86)
Angola	1,600	—
Burundi	20	4.71
Ethiopia	1,000	1.42
Kenya	10	9.70
Madagascar	30	6.41
Malawi	0	12.98
Mozambique	120	7.00
Rwanda	0	6.07
Somalia	20	10.31
Tanzania	110	7.36
Uganda	40	2.11
Zambia	0	5.61
Zimbabwe	80	0.88

Source: UNDP 1991: 156-57.

relief on any terms. (Both organizations have explicitly rejected the Trinidad terms.) Hence payments to the multilateral IFIs will continue to be a significant drain on African economies. Second, several governments which have agreed to significant reductions in the total debt stock owed to them propose to take the savings resulting to debtor countries off their aid budgets: the net result will be less or no additional resource transfers to the debtors. This of course utterly defeats the purpose of debt relief, which is supposed to improve external flows into import-strangled economies so that existing capital stock can be rehabilitated and utilized fully and so that production can be restructured to favour tradeable goods and services. Additional resources must be a part of any debt relief package.

Table 1.6
Manufacturing Earnings per employee

	Annual growth rate			Index 1980 = 100		
Country	1970-80	1980-87	Country	1985	1986	1987
Botswana	12.6	-4.5*	Botswana	85	—	—
Burundi	-7.8	—	Burundi	—	—	—
Ethiopia	-4.7	-0.1	Ethiopia	85	96	105
Kenya	-3.4	-2.3*	Kenya	79	83	87
Madagascar	-0.9	-10.3*	Madagascar	66	—	—
Malawi	—	1.6	Malawi	115	—	—
Mauritius	1.8	-1.8	Mauritius	84	86	94
Somalia	-5.1	—	Somalia	—	—	—
Tanzania	—	-12.7*	Tanzania	51	42	—
Zambia	-3.2	—	Zambia	—	—	—
Zimbabwe	1.6	-0.4	Zimbabwe	105	104	103

* For years other than those specified.

Source: World Bank 1990: 190-1.

Weapons Imports: Finally, and most sinisterly, vital foreign exchange has also been siphoned out of ESA economies to pay for military expansions, particularly arms imports. Between 1975 and 1988, the quantity and quality of weapons in sub-Saharan Africa rose sharply, with the number of tanks and military aircraft doubling and with nineteen countries purchasing missile systems. When military spending is combined with external debt service, the nonproductive share of government expenditures exceeded 40% for seven ESA countries in 1987 (Angola (40% on military spending alone (Green 1990b)), Ethiopia (54.4%), Kenya (45.7%), Tanzania (46.6%), Uganda (58%), Zambia (40.6%) and Zimbabwe (46%)) (Deger 1990: 16). These figures probably understate the facts, since they do not include expenditures for internal security or for debt servicing on arms imports. Even so, they leave little for other government outlays, let alone for critical productive imports (since both debt and arms import expenses are typically costed to the foreign exchange account).

Structural Adjustment

Although African governments were relatively optimistic about prospects for growth in the late 1970s, a deep macroeconomic crisis beginning in the early 1980s forced them to suspend long-term planning to concentrate on short-term crisis management. Faced with rapidly declining economies, African governments were forced one by one to accept structural adjustment programmes in order to attract desperately needed foreign capital.

Approved Programmes: The architects of these adjustment programmes were chiefly the IMF and the World Bank. The IMF initially ascribed the cause of Africa's economic crisis to temporary macroeconomic disturbances which could be cured by a reduction in domestic absorption. Hence, it encouraged countries to devalue their currencies, restrict domestic credit and reduce government expenditures. While these initiatives did restrain demand and produce temporary improvements in the current account of the balance of payments of some countries (chiefly through import contraction), by 1983 it was clear that they had induced a meagre export response. The World Bank took a different tack, viewing micro-economic distortions—price controls, competition barriers, factor mobility restrictions—as the chief cause of Africa's economic malaise. Its solution was to restore market forces, chiefly by reducing government involvement in the productive sectors of the economy. Thus the Bank urged governments to privatize parastatals, reduce the size of the public sector.

establish incentive prices in controlled sectors, liberalize trade and exchange controls and rewrite investment codes to attract private foreign investment. To its credit, the Bank realized that macroeconomic health is a prerequisite to investment project viability, so (unlike the Fund) it also gave some attention to macroeconomic imbalances and external shocks. But until recently it ignored the individual hardships which its programmes created.

Programme Inadequacies: In the early 1990s, it is widely agreed that structural adjustment programmes have been inadequate and that their positive returns—when they appear at all—have been extremely fragile. Although there is a consensus in Washington (including **inter alia** the Bank, the IMF, the U.S. Treasury and the Institute for International Economics) that structural adjustment programmes, if fully implemented, will regenerate growth and reduce poverty, it is probable that such improvements result chiefly from improved financial flows rather than from policy reform (Helleiner 1991: 18-19). (Contrast the experiences of underfunded Zambia and well-funded Ghana.) In any case, continual policy reforms are likely to undermine stability and policy credibility and so generate lower marginal returns (Ibid.: 22-23). Moreover, the "successes" in Africa are generally the least persuasive. Ghana's adjustment-induced "economic miracle" seems to have evaporated in 1990 without changing domestic investment or foreign private investment patterns—the real test for adjustment success.

Reflecting IMF and World Bank prescriptions, adjustment programmes usually include three components: (i) contracting demand, (ii) liberalizing trade and financial markets and (iii) restructuring incentives to favour tradeable goods. The first two are realized by deflationary policies (eliminating subsidies, restricting credit, lowering tariffs and cutting government services) which directly reduce the living standards of the poor (e.g. by increasing food and food import prices and reducing access to high-quality services) and which produce an immediate contraction of the non-tradeables sector, forcing many people out of work. The third component, which is expected to ensure that redundant labourers are reemployed in an expanded tradeables sector, requires a much longer period of reorganization and investment, opening a large gap between initial economic decline and subsequent improvement. Hence adjustment immediately entails negative growth and welfare losses, whatever positive impact it may have in the long run (Fleming 1990: 34-36). High levels of external financing would ease the demand contraction which adjustment requires in the short term, but such levels have not been realized in ESA.

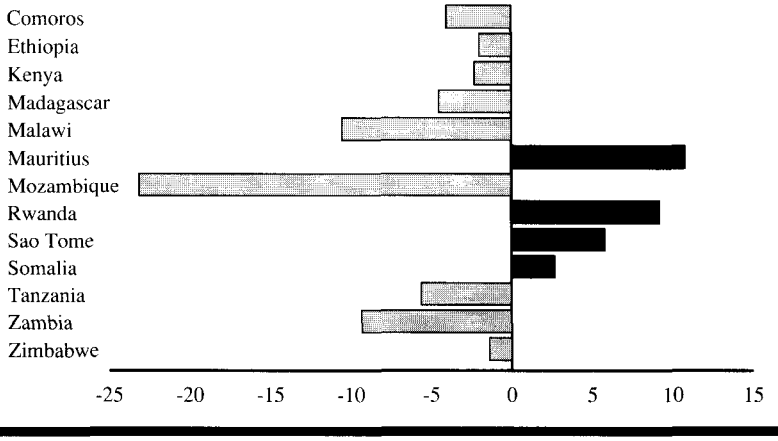
Box 1.2
Zimbabwe's Mixed Experience with Adjustment

Zimbabwe's adjustment efforts have appeared to be successful. Agricultural policies favoured smallholders with targeted credit, marketing and supplies, increasing their share of marketed production from 10% in 1980 to 38% in 1985. Government reallocations from 1980 to 1987 increased health and education expenditures from 21% to 26% of GDP by reducing defense expenditures from 25% to 14% of GDP. But even with a relatively diversified economy within the SADCC community, Zimbabwe has encountered substantial setbacks. Extended services and increased production in the agricultural sector have not benefitted everyone in that sector, but have accrued to a (sizeable) minority. Trade liberalization and a new investment code were introduced in 1990 and price controls on all but five essential products were removed, leading to 16% inflation and nation-wide strikes. Like other countries pressed into austerity programmes, Zimbabwe is being forced to deploy strategies such as community participation, subsidization by "sin" taxes (on alcohol and tobacco) and limited cost recovery to contain the threat of economic regression.

At the same time, currency devaluations sharply reduce the real price of labour, the principal non-tradeable good in ESA and the primary asset of most poor people: hence even those wage earners who escape unemployment may be adversely affected. This consequence also impedes the success of the adjustment programme more generally. By lowering further wages which are already very low, adjustment may result in increased malnutrition, illness, absenteeism and lower performance, which will have a strong negative effect on productive output. But it is production which adjustment is expected first and foremost to improve (Guillaumont 1990: 9-10).

In fact, adjustment has brought immediate hardships, but promised benefits continue to be illusory. Growth rates have been much

Figure 1.6
Gross Domestic Investment, Annual Growth Rate (1980-87)



Box 1.3
Zambia's Adjustment Plight

Zambia stopped all loan repayments to the IMF and the World Bank in May 1987 when it rejected IFI-imposed economic reforms. But growing debt and deteriorating economic conditions forced the government to reopen negotiations with the IFIs in 1989. In March 1991 Zambia cleared its $300m arrears to the Bank and undertook initiatives designed ultimately to clear its $1b arrears to the IMF. Yet Zambia's most recent structural adjustment package has not yet brought significant economic gains. The devaluation of the kwacha by two-thirds in 1983-87 and two attempts to withdraw a crucial food subsidy (1987 and 1990) led to rioting and an attempted coup in July 1990, forcing the government to restore the subsidy. Inflation runs at about 120% and a weak maize harvest in 1990 has brought acute food shortages in 1991. A drop in nutritional levels and a rise in child mortality rates in Zambia seem likely.

lower than expected. However "strong" their prescriptions, adjustment programmes have hardly adjusted institutional structures at all. It is now very clear that any necessary institutional reforms will require not merely short- and medium-term "adjustments" but long-term tranformations which must replace (and be sheltered from) these. It is also very clear that achieving macroeconomic balance is not a sufficient condition for creating sustainable growth (although it may be a necessary condition). A decade of adjustment programmes in Africa, which have displaced large amounts of labour and imposed severe hardships on vulnerable groups, has failed almost completely to generate enough investment in agriculture and manufacturing to restore growth. It is also very clear that all members of society do not automatically share in economic growth. Even when it occurs, growth does not simply "trickle down" to the poor. Indeed, the connections between growth (on one hand) and employment, income distribution, purchasing power and human development (on the other) are complex, indirect and often contradictory: hence economic engineering needs careful study to determine its impact on the poor. Adjustment is at best a means to human development; at worst, taken as an end in itself, it is an impediment to it.

Programme Adjustments: Since the mid-1980s (and UNICEF's publication of *Adjustment with a Human Face*), there has emerged a general consensus that adjustment programmes should consist in more expansionary macro policies designed to sustain investment, production and welfare levels over a lengthened adjustment period. Such policies should be supported by greater access to finance—either through increased aid or decreased debt service. Meso policies redirecting credit, taxation, government spending, foreign exchange and international aid must protect the interests of the poor, who should have "first call" on the resources necessary to sustain their highly vulnerable income, health and welfare levels. Governments must maintain and expand the delivery of basic goods and services to the poor, particularly in the transitional period before restructuring in the productive sectors achieves increased output and higher income levels. The equity and efficiency of the social sector should be improved by directing expenditures away from high-cost services which do not satisfy basic needs to low-cost basic services targeted on the poor.

At the same time, adjustment programmes may need to include compensatory programmes which protect the poor directly. It is encouraging that the Bank now admits this need, although discouraging that it still fails to consider how its free-market adjustment policies make these market interferences necessary. At present, the Bank seems content merely to graft a few compensatory measures onto orthodox adjustment programmes which it holds otherwise to be basically sound. Such an approach is obviously inadequate: caring for the poor is an adjustment issue just as much as it is a government issue.

Table 1.7
Index of Real Expenditure Per Capita (Industrial Countries=100)

Country	All Food	Meat	Dairy, oils	Cereals, bread	Health services	Education services
Botswana	29	27	13	117	10	48
Ethiopia	7	5	4	26	3	10
Kenya	17	5	11	69	4	39
Madagascar	25	25	5	93	0	22
Malawi	19	10	3	100	1	12
Tanzania	13	6	3	47	2	21
Zambia	17	15	8	41	3	15
Zimbabwe	14	12	10	42	4	20

Source: UNDP 1991: 134-35.

Eastern and Southern Africa in Crisis

Africa has suffered through a decade of unprecedented economic decline. GNP per capita declined for all but five ESA countries over 1980-88; declining export earnings contended with increasing import prices and increasing debt service obligations; orthodox adjustment packages produced few (if any) macroeconomic improvements, particularly as external assistance declined throughout the decade. Unfortunately, few of these factors will change even under the most optimistic assumptions. The cumulative effect on human welfare in ESA has been devastating. Poverty has spread and deepened. Large-scale rural-to-urban migration has overwhelmed basic

urban services. Women, Africa's primary providers, have struggled to maintain consumption levels in an eroding balance between incomes and prices. Women's and children's health has declined sharply as reduced resources have entailed greater work responsibilities and as AIDS has spread rapidly throughout their communities. The number of children in especially difficult circumstances—street children, working children, displaced children, children who are neglected or abused, children who have been orphaned by AIDS, children exposed to war or drought or famine—seems to have grown enormously. Eastern and Southern Africa's countries today are at a critical juncture. With substantial debt relief or increased external financing, they may be able to restructure their economies and mitigate the developing tragedy. Without it, they will decline further and further, dooming millions of women and children to endless poverty and painful, needless deaths.

Table 1.8
Net External Transfers to sub-Saharan Africa ($ U.S. millions)

Source	1980	1983	1984	1985	1986	1987	1988	1989	1990+
IMF	730	879	-41	-434	-954	-863	-462	-728	-532
IDA	403	593	722	802	1306	1570	1569	1574	—
IBRD	72	270	305	31	33	-75	-725	-391	—
IMF/IDA/IBRD	1205	1742	986	399	385	632	382	455	—
Multilateral*	707	664	442	487	650	709	672	607	—
Bilateral*	1657	2295	1925	472	1210	1194	630	945	430
Private**	2818	270	-1667	-2648	-1132	-213	-434	-428	-1818
Total Debt-Related	5657	4092	1727	-856	2067	3185	1712	2307	657
Total (incl. grants, FDI)	5843	6606	4460	3213	6163	7626	7973	9420	—

\+ Projected
* Excluding grants
** Publicly guaranteed and unguaranteed, excl. FDI.
Source: Helliener 1991: 37.

UNICEF Initiatives

In this context, UNICEF must continue to advocate for (international and domestic) economic reforms which will promote participation of the poor in an expanding economy. To increase and stabilize commodity export earnings, such facilities as price stabilization agreements, commodity-linked bonds or compensatory financing for commodity producers should be developed. In addition, import restraint measures in the developed countries (e.g. quotas, tariffs, anti-dumping rules) should be structured in a manner which will not impede Africa's economic diversification. In particular, tariffs on processed African products should be eliminated and high internal sales taxes on African products in the developed world should be sharply reduced (UNCTAD 1990: 82-85).

The development community must improve efforts to attract and maintain high ODA levels, which are decreasing at present just as the need for external funding is increasing. All development partners—including the Bank and the Fund—agree that structural adjustment programmes are certain to fail unless adequate levels of financing are forthcoming. To give these programmes a fighting chance, it will be necessary either to increase ODA levels absolutely or to reallocate ODA to basic services (e.g. primary health care, family planning, primary education, rural water and sanitation) to protect and improve the well-being of the worst-off.

In the area of debt relief, there are several priorities for low-income debt-distressed Africa (Helleiner 1991: 12-15; Killick 1989: 6-7: UNCTAD 1990: 93-94): (i) Cancel all official bilateral debt. Since a large part of Africa's total debt is owed to official creditors, the decision to cancel it is essentially a political one which will have little impact on the international financial system. (ii) Refinance all World Bank and IMF debt on highly concessional (e.g. IDA) terms. (iii) Cancel at least one-third of export credit debt (a heavy burden as it mostly carries commercial terms) or reschedule it on highly concessional (e.g. IDA) terms. (iv) Reschedule all debt service due during an entire ESAF programme period (i.e. three years) to reduce rescheduling burdens. (v) Meet arrears to the IMF with new lending financed (e.g.) by drawing down a third of the IMF's gold reserve. (vi) Enable commercial debt reduction on the terms of the Brady Plan. (vii) Link debt service to commodity export prices or limit debt service to a fixed percentage of (selected) foreign exchange earnings (e.g. Zambia's self-selected 10%).

While trade liberalization may be a useful goal in Africa's development, trade restrictions may be necessary in the medium term—as in China, Sri Lanka and South Korea—to protect intensive import substitution efforts and thus to build up an industrial base. Even the World Bank admits that trade liberalization will bring little profit to Africa in the short-run as existing trade preferences would be lost, tariffs against (unprocessed) commodities are already low and demand for these commodities is largely insensitive to price (World Bank 1990: 124). At the same time, for long-term economic growth, it seems inevitable that the region—indeed the continent—will need to move towards economic integration. Many ESA countries are small, landlocked and resource-poor economies (Burundi, Lesotho, Rwanda, Swaziland, Uganda) which have unviable markets and which are unlikely candidates

To ease ESA's economic crisis, international efforts must concentrate on increasing ODA, stabilizing commodity earnings and providing effective debt relief

ESA countries must also expand agricultural production and move towards greater economic integration

for private investment-led growth. Although full-blooded common markets are clearly out of reach in the short-term, incremental movement towards that goal (e.g. reducing tariffs, removing import quotas, reaching regional food security arrangements) is possible and should be encouraged. The 1991 OAU Summit endorsement of an African Economic Community evidences high-level political commitment to greater economic integration.

The region's agricultural (commodity) production should also be expanded. Although the share of agriculture in GDP typically declines as development progresses, for African countries it remains the dominant sector and the principal source of foreign exchange. At least in the medium term agriculture must be the centrepiece of any viable development strategy. Yet, at present, Africa is not exploiting its agricultural sector as fully as it might. Productivity is low, production techniques are uncompetitive, government policies are misguided, linkages to international markets are poor and infrastructure (especially transport) is collapsing: hence African countries are failing to hold onto their world market shares. Moreover, there is unexploited potential in domestic processing, which will permit countries to capture more value-added and at the same time to diversify into new product varieties, to develop more effective cooperation between producers and consumers and to stimulate intra-African trade and cooperation. All efforts to strengthen Africa's agricultural base and increase domestic processing should be encouraged.

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1. Unless otherwise indicated, all data included in the text of this report come from the statistical annex. All data in this paragraph are taken from the World Bank 1990

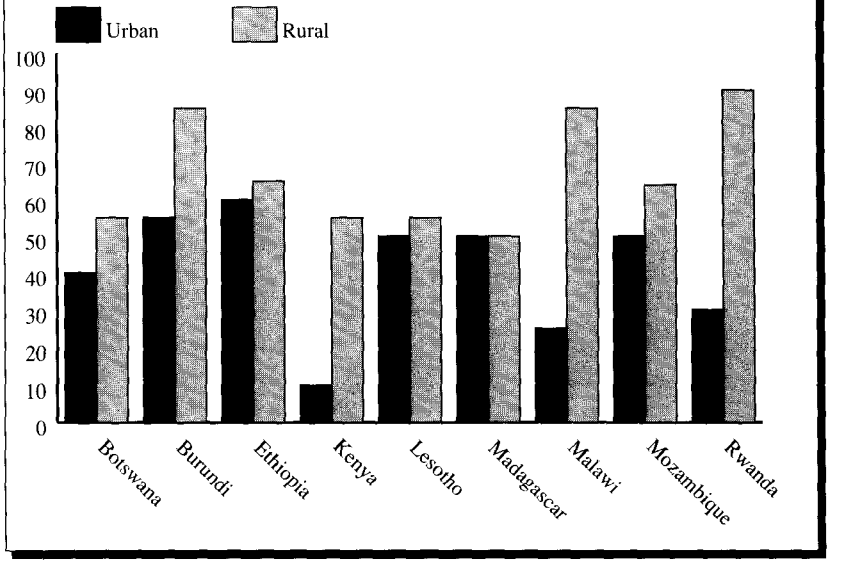
2. For example, cocoa (-6.7), coffee (-3.3), copper (-3.7), cotton (-4.5), sugar (-12.4) and tea (-3.1). (Price trend is calculated as the annual average rate of change of price, in constant dollars, measured as a percentage.) UNCTAD 1990: 122.

3. Between 1970 and 1987, Africa's share of the coffee market fell from 33.6% to 19.9%, cotton from 11.0% to 7.9%, cocoa from 72.6% to 58.7% and copper from 18.0% to 12.6%. UNCTAD 1990: 120.

2 Poverty

Although large numbers of people in ESA are poor, there are few data which indicate the extent or the depth of their poverty, let alone distinguish the chronically poor, the transient poor or the newly poor (victims of structural adjustment). We know that poverty affects more women than men—but we cannot quantify this disparity accurately. We suspect that poverty and environmental degradation are linked, but we know few details about these linkages. As a consequence, interventions often miss their mark, benefiting some of the needy at the expense of others. Our scant knowledge at present is extrapolated from household surveys or from aggregate statistics on income, population and consumption, but these data are inadequate. Local studies cannot be generalized without a loss in accuracy while economic statistics, besides being fragmented and inconsistent in ESA, reveal little about the sub-groups of the poor or about welfare dimensions such as health, education, social equality or self-respect.

Figure 2.1
Population in Absolute Poverty (Urban/Rural) (%)



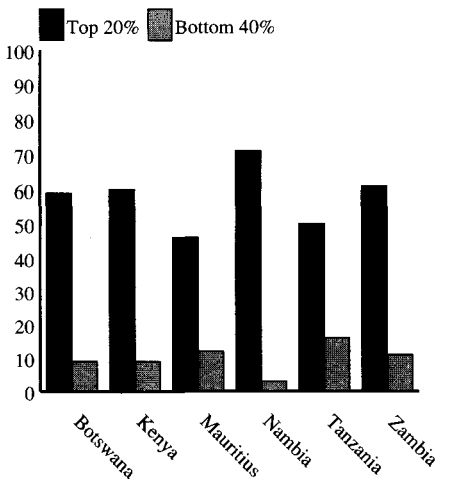
Poverty Indicators

The Standard Indicators: There are two standard indicators of absolute poverty. The first is the "headcount index", which gives the percentage of people living below the poverty line but says nothing about how far below the line these people are. The second is the "poverty gap", which gives the percentage transfer of aggregate consumption necessary to lift the poor above the poverty line. These indicators, besides being crude (possibly ***over***stating poverty, since most subsistence agriculture does not enter market calculations), are incomplete both with respect to specific countries in ESA and (*a fortiori*) with respect to the region as a whole.

The World Bank tentatively offers some poverty statistics for sub-Saharan Africa. Working with two categories—the "extremely poor" (incomes under $275) and the "poor" (under $370)—the Bank estimates that sub-Saharan Africa has 120 million extremely poor people (30% of the total population), and 180 million poor people (45% of the total). A 4% transfer of aggregate consumption would be needed to lift the extremely poor out of poverty while an 11% transfer would be needed to eliminate poverty altogether. These statistics compare unfavourably with the poverty indicators for all developing countries, where the headcount index is 18% extremely poor and 33% poor and the poverty gap 1% for the extremely poor and 3% for the poor (World Bank 1990: 29). Although data for sub-Saharan Africa are notoriously unreliable, the World Bank estimates that consumption per capita stagnated between 1965-85 and that, even if income distribution did not worsen, population growth has added about 55m poor people to the region.

The Human Development Index: UNDP, attempting to capture more than a single dimension of human life in its human development index, measures human development as a composite of three basic variables—life expectancy at birth, educational attainment (measured as a function of both adult literacy and average mean years of schooling) and real GDP per capita (in purchasing power parity (PPP) dollars and allowing for diminishing returns

Figure 2.2
Household Income Shares (%)



+ For Namibia, Estimate Top 5% and Bottom 55%, UN Statistical Office, 1989.

to income) (UNDP 1991: 15). These three variables, besides reflecting intrinsic values, are good proxy measures for other important human development variables (e.g. health and nutrition) and clearly present GNP growth as necessary but not sufficient for human development. But, as with other data, they conceal disparities and do not capture all dimensions of human development, with complex values such as political freedom and personal security (to name two) left out. The human development index (HDI) in 1991 ranges from Sierra Leone, the lowest at 0.048 (with 42 years life expectancy, 13% adult literacy, 0.8 mean years of schooling and PPP$1030 GDP per capita), to Japan, the highest at 0.993 (with 78.6 years life expectancy, 99% literacy, 10.4 mean years of schooling and PPP$13,650 GDP per capita). African countries, with the lowest income figures, literacy rates and life expectancy figures, consistently show the highest degree of poverty on this index. Most fall below 0.500, excepting only Botswana, Mauritius and Seychelles in ESA.

These statistics give an extremely crude picture of the region's poverty. But, both because poverty is understudied generally and because the region's database is very poor, it is difficult to supplement them with other meaningful data. In ESA, there are no consistent inter-temporal data on a wide variety of key poverty indicators, including wages, unemployment and underemployment, prices of main staple foods, persons per habitable room, the Gini coefficient, land concentration ratios and household income shares. At the same time, UNICEF's cluster of welfare indicators (mortality rates, life expectancy, nutritional status, access to health care) often rely on projections and are computed on a national basis, thereby concealing large disparities between various sub-groups of the population—rural and urban, male and female, rich and poor. One expects that the poor, concentrated among females and in the rural areas, will fall one or more standard deviations below reported national figures. More detailed studies focusing directly on the poor and permitting the distinction of sub-groups within the poor (e.g. personal histories, income sources, spatial distribution, access to productive assets, expenditure and consumption patterns) are scarce to nonexistent.

A Profile of the Poor

To compile a poverty profile for ESA, it is necessary to extrapolate from village or household surveys or from general data gathered from international sources. Of these methods, the first provides sufficient detail for planning effective interventions, but it is also extremely limited. For example, household surveys in Tanzania show that in the period 1969-83 urban wages fell about 65% in total, while rural living standards fell 2.5% per year on average. At the same time, a 43% decline in private consumption per person forced many Tanzanians to shift their food purchases from high cost sources of protein (meat, cheese and vegetables) to low cost sources of calories (beans and starches) (World Bank 1990: 42). These data have various implications for nutritional status, the cost of structural adjustment and the relative well-being of rural and urban dwellers: but the poverty profile which emerges cannot be readily transferred to other regions of Tanzania, let alone to other countries in ESA. Hence it is possible only to report general international observations relating to the poor. These observations will be falsifying insofar as poor people in different regions will exhibit different behaviours and construct different coping mechanisms. Nonetheless, rough correspondences in situation may be presumed to entail rough correspondence in reaction, so the exercise is not entirely vain.

High Dependency Ratios: The poor typically have higher dependency ratios than their richer neighbors. Having a large family may be a rational response to poverty, as children will both relieve adults of some domestic tasks (freeing them for wage labour) and care for their parents in old age. Moreover, in countries where children frequently fail to survive infancy, parents will overshoot their desired family size. Because they have large families, poor women frequently bear too many children spaced too close together, to the detriment of their own health and the health of the children. Since children are brought into poor families in part to provide

labour, child poverty is often self-perpetuating. Child labour (sometimes with debt bondage and often with long hours in unsafe and unhealthy conditions) typically comes at the expense of schooling even though schooling is a critical prerequisite for higher productivity and human development.

Little Access to Land, Livestock, Credit or Social Services: Typically, the poor have unproductive assets or no assets at all. The rural poor—who are the bulk of the poor in ESA—are frequently landless, having access to land (if at all) through personal tenancies which provide no security against risk and no guarantees of continued access or else through common tenancies which encourage over-utilization and long-term soil depletion. Others who do own land often own small amounts of unproductive land which they are unable to improve because they lack access to credit (World Bank 1990: 31-32). Pastoral populations, by contrast, are vulnerable to fluctuations in access to livestock: where environmental stresses force herders to reduce herd sizes (especially of cattle, a less hardy animal than the goat yet a more important food source), household food security deteriorates rapidly. Particularly intransigent problems confront the rural poor (whether herders or farmers) who are forced by their circumstances (lack of skills or productive assets) into "downslope" migration to desert areas with limited agricultural potential. In these areas, overfarming, overgrazing and deforestation are rapidly accelerating environmental degradation which further reduces the long-term potential of the land (Ibid.: 71-72).

The poor rarely have access to institutional forms of credit, chiefly because transaction costs and non-payment risks are higher. The World Bank estimates that only 5% of farms in Africa have access to government-subsidized credit, with most of this benefit probably going to nonpoor farmers (Ibid.: 66). At the same time, innovative informal sources of credit (e.g. savings clubs, mobile bankers and rotating associations) have reached few of the poor. Hence, the poor are generally unable to accumulate assets, or improve the return on assets (e.g. through acquiring new skills or using hybrid seeds and fertilizers), or protect consumption levels during economic downturns.

Geographical remoteness often correlates with poverty. Where governments are able to provide social services, these are less likely to reach those areas where the poor live and, even when they do, the poor are often effectively excluded because they are mystified by complex bureaucratic demands or because they simply do not know that such services exist. Since social services typically reach the nonpoor before the poor, the extent of the poor's participation is loosely indicated by how much (if at all) take-up rates exceed the percentage of the nonpoor (World Bank 1990: 42). In 1988, for example, 50% of Madagascar's population were nonpoor while 56% had access to health services, 18% had access to safe water, 97% of school-age children were enrolled in primary school and immunization rates ranged from 35% (measles) to 62% (tuberculosis): hence (crudely) the poor are benefitting extremely little from health services and immunization programmes and not at all from water projects. On the same hypothesis, the poor will suffer first from the declining primary school enrolment rates observed in the region (about 6% on average through 1980-85).

Low Returns on Labour: Most of the urban poor are employed in the informal sector—consisting chiefly of small, illegal or unregistered shops and factories. (Between 1980 and 1985, about 75% of Africa's new labourers entered the informal sector, with only 6% entering the formal sector.) Frequently they are self-employed (trading, selling services, working as casual labourers in simple construction or manufacturing). The most desperate are thieves, beggars and prostitutes (Ibid.: 34). Because the poor generally lack both vocational training and adequate numeracy and literacy skills, it is difficult for them to move into the formal sector, where incomes are higher and job security is greater. Hence, their incomes tend to remain low and insecure.

The poor typically have larger families than the rich, yet they have fewer productive assets and they attain lower returns on their labour

The sale of labour is often an important source of income even for rural dwellers. Poor farmers and pastoralists are not self-sufficient, but need money for clothes, blankets, cooking oil and some nonfarm food stuffs (not to mention schooling and health care): hence they often work seasonally as craftsmen, traders and wage labourers (Ibid.:

Table 2.1
Do Social Services Reach the Poor in ESA?

	Kenya 1988	Madagascar 1988	Zimbabwe 1987
Nonpoor in population	66%	50%	58%
Access to health services	42%	56%	71%
Access to safe water	28%	18%	52%
Primary school enrolment	96%	97%	133%
Immunization rates			
Tuberculosis	90%	62%	86%
DPT	77%	40%	77%
Poliomyletis	78%	38%	77%
Measles	65%	35%	77%

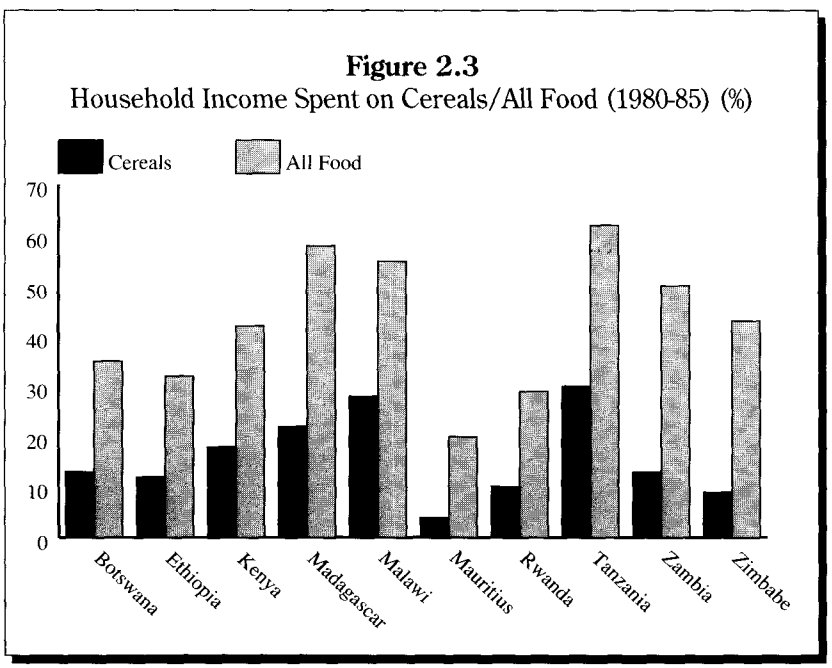
33). Informal sector work—which is typically part-time and traditional, requiring few skills and little capital and producing items intended for household use or for sale in the local market (Ibid.)—also offers poor returns. Moreover, the demand for off-farm produce (clothes, baskets, household furnishings) varies directly with the health of the primary farming sector, so income from these industries increases when the poor farmer needs it least and declines when he needs it most.

The poor remain extremely vulnerable to seasonal fluctuations. During the dry season, the search for water may add hours to a woman's daily chores; during the rainy season, water may become contaminated with pollutants or disease-carrying bacteria; during the harvest, heavy work may coincide with low food supplies and high food prices. (In Lesotho, the "hungry period" has caused 7% losses of body weight (Ibid.: 36), which can be permanently damaging to the young, the old and the infirm). Survival strategies can do very little to mitigate many of these hardships.

The poor frequently spend the bulk of their income on food

Consumption Patterns: The poor spend the bulk of their income on consumption and more than half of this is usually food consumption. Data indicate that, for 1980-85, households in Madagascar, Malawi, Tanzania and Zambia on average spent at least half of their income on food, but these aggregated data obviously understate the percentage of total income the poor spend on food. It is widely believed that the distribution of consumption also tends to favour males and working adults over females and children (Ibid.: 37). At the same time, it is believed household expenditures on education (ranging from 2% to 9% in ESA) tend to favour boys over girls. (Low female primary and secondary school enrolment rates lend some support to this belief.)

Figure 2.3
Household Income Spent on Cereals/All Food (1980-85) (%)



Survival Strategies of the Poor

Risk-Averting Strategies: Asset-poor households will insure against adverse contingencies, whether these are expected (e.g. climatic and seasonal changes) or unexpected (e.g. wars, natural disasters, declining terms of trade, structural adjustment programmes), with a number of survival strategies. In rural areas, especially where rural nonfarm employment is limited, farmers will intercrop and grow low-yielding but highly-resilient crops to reduce the risk of crop failure. In urban areas, where there is heavy reliance on wage incomes, households will coordinate their labour by placing household members in different labour markets (e.g. urban-rural, formal-informal, manufacturing-service). At the same time, both rural and urban households will save and dissave income to smooth consumption patterns (Ibid.: 36). Of course, less poor households whose members are better educated and in their prime years will typically fare better than other poor households (e.g. female-headed households containing many young children). Nonetheless, abrupt or prolonged adversities will in many cases render these strategies insufficient to sustain consumption levels for poor households, forcing them to employ more desperate survival strategies to cope with their worsening situation. These strategies include increasing household income and stretching existing resources.

Increasing Household Incomes: Poor households will try to increase their income initially by producing more (especially food) or by supplying more labour to the market (e.g. increasing the number of hours worked or the number of persons working (typically adding women and children to the labour force)). Where these options are unavailable, the household may be forced to increase indebtedness (e.g. at local shops) or to borrow petty amounts of food or money from friends and relatives (who typically have little to spare), thus "sharing" their poverty. In extreme circumstances, the household may be forced to sell its assets (including, if necessary, productive assets such as land, tools, cattle)—often at extremely low prices (as other households are forced to sell at the same time) and generally undermining the household's prospects for future recovery (Cornia 1988: 94-98).

Stretching Household Resources: To stretch out existing resources, poor households may begin to prepare food in common (permitting bulk purchases and economies of

scale in cooking as well as freeing some household members for child care or for income-generating work). If matters do not improve, they will change their consumption patterns by removing non-basic items or (if matters worsen) basic items such as fuel, rent or protein-rich foods or (if absolutely necessary) basic foods. Where food expenditures are already concentrated on cheap sources of calories, adverse contingencies may force household members to skip meals altogether (Ibid.: 98-100). Often it is the female members of the household who suffer the largest nutritional deprivations, grossly undermining their ability subsequently to recover productive lives.

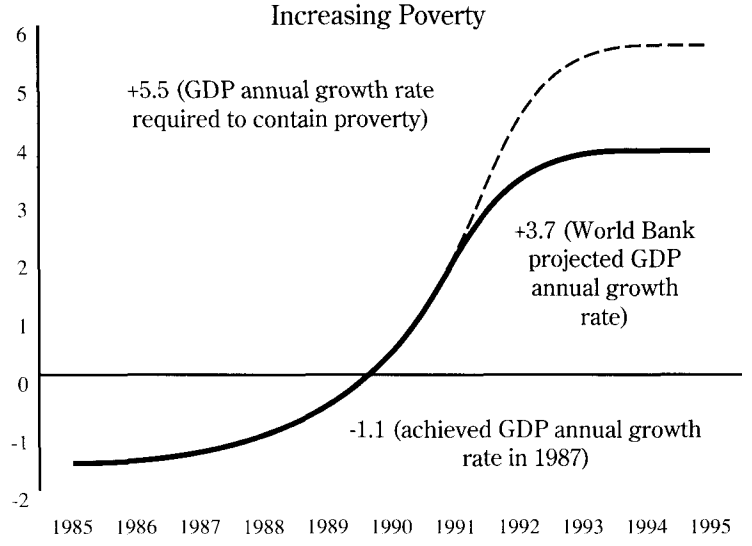
Deploying these strategies may involve changes in family structure or location. Thus several families may be brought into one household, or children may be sent to live with wealthier relatives, or, under severe conditions, family members may migrate to more promising localities (e.g. Ethiopia in the 1983-84 drought). These migrations will be temporary and male-dominated at first (effectively forcing women to become heads of households largely dependent on unstable remittances) but may finally involve the permanent migration of whole families (usually rural to rural or rural to urban) (Ibid.: 101-102).

Poverty-Reducing Strategies

The World Bank: The World Bank projects that sub-Saharan Africa, because of low economic growth and rapid population increases, will have 30% of the developing world's poor by the year 2000 (as opposed to 16% in 1985) (Ibid.: 5). Holding the number of poor at its 1985 level, on the Bank's estimate, would require an average annual GDP growth rate of 5.5% (Ibid.: 5, 140), or an economic about-face of 6.6% from the *negative* 1.1% growth rate attained in 1987. Even the Bank believes that the achievable growth rate for sub-Saharan Africa will be no more than 3.7% (which is still higher than the average growth achieved over the past fifteen years). Hence, on the Bank's own optimistic assumptions, poverty will increase sharply in ESA over the next decade.

In its World Development Report for 1990, the Bank recommends a two-part strategy for attacking poverty in developing countries: (i) promote labour-intensive growth to bring a greater number of persons into income-generating activities in the market-place and (ii) improve the delivery of basic services, especially education, family planning and primary health care, to stimulate the development of human capital and to enhance the ability of Africa's poor to deploy their primary asset—their labour (Ibid.: 138). The Bank suggests that its soft loan arm IDA will view more favourably countries following this strategy (Ibid.: 4). To achieve labour-intensive growth, its first objective, the Bank recommends restoring market incentives, improving institutions and physical infrastructure, providing strong public support for agriculture and taxing agricultural output only moderately. To ensure that the poor share in this growth, the Bank agrees that the poor should have greater access to land, credit, (rural) infrastructure and (farm) technology. At the same time, to accomplish its second objective, the Bank admits that countries should provide targeted resource transfers for those people who cannot share in market-led growth and safety nets for those who share in it but remain vulnerable. Besides subsidizing health and education programmes for the poor, government expenditures may include cash transfers or public employment schemes (e.g. Botswana), well-targeted food subsidies or food ration schemes (e.g. Tanzania's supplementary feeding programme in Iringa province) as well as income support or other forms of income insurance, possibly extending traditional community support systems. In this way, the Bank expects governments to catch people who remain outside the market or who are inadequately cared for within the market (Ibid.: 3, 51, 138).

Figure 2.4
Increasing Poverty



Source: World Bank 1990: 140.

Social spending efficiently directed to the poor is a critical component of successful poverty reduction

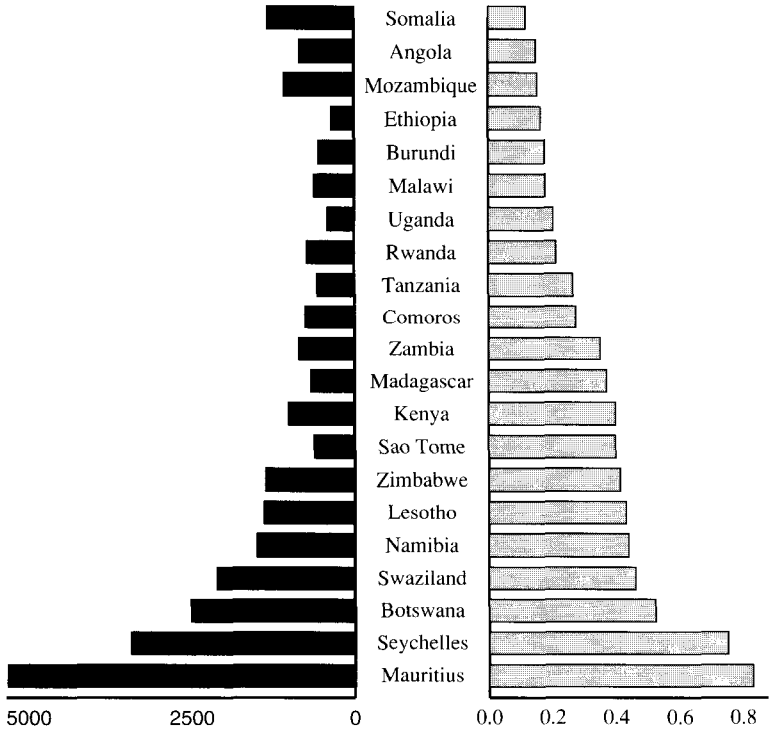
UNDP: In its Human Development Reports, UNDP seeks progress in human development less from regulated market forces and more from efficient social spending than the Bank. Offering Tanzania and Zambia as evidence, UNDP argued in its 1990 Report that African governments which are strongly committed to social progress can improve human development levels even with moderate economic growth. How this growth

Box 2.1
Efficiency in Government Spending on Education

Post-secondary education frequently consumes 15-20% of a government's education budget even though it benefits only 2% of the population directly and achieves a social return of only 13% (compared to 26% for primary school and 17% for secondary school) (World Bank 1990: 79-80). This inefficient expenditure should be redirected to primary and secondary education, both to increase enrolment and completion rates and to reduce repetition rates. Reallocation is particularly critical now, as the World Bank estimates conservatively that achieving universal primary school enrolment in sub-Saharan Africa by the year 2000 will require an 85% increase in the share of GDP allocated to primary education (from 1.41% (1985) to 2.53%) (Ibid.: 87). This calculation forecasts an annual increase of 3.4% in the population aged 6-11 as well as an optimistic GDP annual growth rate of 3.7%: if economic performance is weakers, a larger increase will be necessary.

is distributed is the critical matter. In brief, government expenditures can be made more efficient by redirecting them away from non-productive sectors (e.g. military spending, debt service) towards essential social sectors and also by restructuring allocations within each social sector to favour basic and community services (e.g. preventive health care and primary education) over non-basic services which are generally enjoyed by privileged people who can afford to meet some of their costs (UNDP 1990: 4, 43). Although economic growth is necessary to sustain human development in the long term, human development progress can be protected from short term setbacks (e.g. recessions and natural disasters) through programmes targeted on the most vulnerable. By reducing morbidity and mortality rates and buying large improvements in human capital, these government expenditures have generated a higher social rate of return and benefitted the poor equally with the rich.

Figure 2.5
Real GDP per capita and the HDI



Source: UNDP 1991: 119-21.

Popular Participation in Development: One of the most encouraging strategies for reducing poverty in Africa is popular participation. Recognizing that development aims primarily to improve people's lives and that people are the principal agents of development, African leaders have committed themselves to human-centred and participatory development. This commitment, which is codified in the African Charter for Popular Participation in Development, focuses not only on identifying and meeting people's needs (e.g. for health care, basic education and secure employment), but also on encouraging people's active participation in these endeavours. Particularly in this period of structural adjustment, popular consensus and commitment and solidarity are the necessary foundation for self-reliant and self-sustaining development in Africa. The Charter commits African leaders to creating a political environment which will free people's skills, energies and creativities for development as well as allow people to take full charge of their destinies. In adopting the Charter at the 1990 OAU Summit, African leaders agreed to decentralize their governments, to promote political accountability, to empower the people (especially women) and to guarantee freedoms of opinion, expression and association. This democratization of development constitutes a bright new initiative for Africa's poor.

UNICEF Initiatives

In order to reduce poverty, UNICEF should continue to advocate for the poor's improved access to land. This may be achieved by expanding tenancy, managing the exploitation of common lands, replacing collapsed traditional land tenure with clear individual titles or strengthening traditional land tenure where it still works to the benefit of the extended family (e.g. Rwanda) (Ibid.: 64-65). Where downslope migration is common, it will be necessary to promote migration to more fertile and less unstable areas, to improve farming and grazing techniques, to inculcate soil and moisture conservation (e.g. using

contour cultivation and vegetative barriers), to provide off-farm income-generating opportunities and to secure land tenancies to discourage farmers from taking short-term gains (Ibid.: 71-73).

Advocacy for improved access to credit is also necessary to enable the poor to purchase crucial inputs (e.g. hybrid seeds, fertilizer). This may involve mobile bankers, rotating associations (e.g. Ghana) or group lending (e.g. Zimbabwe's Agricultural Finance Corporation) or group savings programmes (e.g. Zimbabwe's Saving Development Foundation)). Finally, there will need to be improved access to infrastructure (especially rural roads, irrigation schemes, water and electricity) and to technology (hardier crop varieties and appropriate chemical inputs), which will improve agricultural productivity by improving yields and market linkages (Ibid.: 69-71).

Since many of the poor in ESA are subsistence farmers, bringing technologies to small-scale rain-fed farms is especially important. This, unfortunately, does not always occur. In Malawi, only 5% of smallholders have adopted a hardy and high-yield maize specially adapted to the area, chiefly because agricultural support schemes favour large farming estates in the tobacco sector. By contrast, two-thirds of Kenya's small holders had adopted hybrid maize within ten years of its introduction in 1963, and post-independence Zimbabwe, by partially dismantling an agricultural policy which had favoured largeholders, has promoted smallholder maize and cotton production. Growth in the farming sector also fuels growth in the nonfarming sector by creating demands for agricultural inputs (as well as consumer goods and services), improved transport, processing and marketing.

In addition, UNICEF—together with UNDP and the World Bank—should continue to advocate the redirection and restructuring of public expenditures to favour social services targeted on the poor. On UNDP's view, scarce financial resources bring greater social returns when they are directed to training paramedical personnel rather than doctors, financing preventive health care programmes rather than expensive hospital-based curative care, supporting vocational training rather than general education, servicing poor neighborhoods rather than wealthy suburbs and improving informal sector activities rather than formal sector ones (UNDP 1990: 4). Aiming for universal primary school enrolment is critical, both because the social returns to education have proved to be very high (in terms of increased productivity, decreased malnutrition, decreased morbidity and decreased fertility) and because education disproportionately helps the poor by increasing the return to their primary asset, labour.

Finally, UNICEF must be sensitive to political realities as African countries begin to initiate reform, replacing closed and authoritarian political structures with open and pluralistic ones. Such reform will provide UNICEF with an opportunity to form new alliances and to expand its range of partners. Africa's renewed attention to people-centred development requires UNICEF both to ensure that its own programmes have human

Box 2.2
Social Spending Priorities

In its Human Development Report 1991 UNDP analyses public spending with four ratios:

(i) the public expenditure ratio—the percentage of national income allocated to public spending;

(ii) the social allocation ratio—the percentage of public spending allocated to social services (e.g. education, health, welfare, housing, social security, water and and sanitation);

(iii) the social priority ratio—the percentage of social spending allocated to human priority concerns (e.g. basic education, primary health care, rural water supply); and

(iv) the human expenditure ratio—the percentage of national income devoted to human priority concerns (a product of the first three ratios) (UNDP 1991: 39).

UNDP suggests that the optimal course for developing countries would keep the public expenditure ratio moderate (about 25%), with much of this (about 40%) allocated to social services and most of this (50% or more) devoted to social priority areas. This would result in a human expenditure ratio of 5%. By contrast, high public spending with low social priorities would be extremely counter-productive, as the public sector would dominate the economy but fail to benefit most of the population.

	Human Expenditure Ratio	Public Expenditure Ratio	Social Allocation Ratio	Social Priority Ratio
Zimbabwe	12.7	52	49	50
Botswana	7.7	51	37	41
Mauritius	3.1	27	40	29
Tanzania	2.4	29	15	55

Source:UNDP 1991: 41.

In ESA, Zimbabwe and Botswana have exemplary human expenditure ratios (12.7% and 7.7% respectively), but Tanzania—with a fairly high public expenditure ratio but a low social allocation ratio—devotes only a small percentage of GNP to human priority concerns (2.4%), leaving much room for improvement. Although high—but socially unproductive—public expenditure may result from debt servicing (which ESA governments cannot control), it will also frequently result from military spending, prestige projects or loss-making parastatals. Hence there may be ample opportunity to redirect unproductive spending to social services.

development at their centre and to persuade other donors to convert their verbal commitments to human development into effective programmes. The nearly universal desire to promote popular participation in development gives UNICEF and its partners a fresh chance to tackle poverty and to build a Movement for Children in Africa.

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1. UNDP is also modifying the HDI to highlight gender disparities, income distribution and changes in human development over time, but these modifications remain rudimentary for the present. At the same time, in its Human Development Report 1991, the agency presented a human freedom index (HFI) ranking 88 countries according to the number of personal, social and political freedoms which their citizens enjoyed in 1985. Sweden and Denmark, where citizens can enjoy 38 out of 40 key freedoms, rank at the top of the list. Of the seven ESA countries included in the HFI, Botswana ranks highest (26 out of 40) with the remainder--Ethiopia, Kenya, Mozambique, Tanzania, Zambia and Zimbabwe--all ranked at or below 10 out of 40.

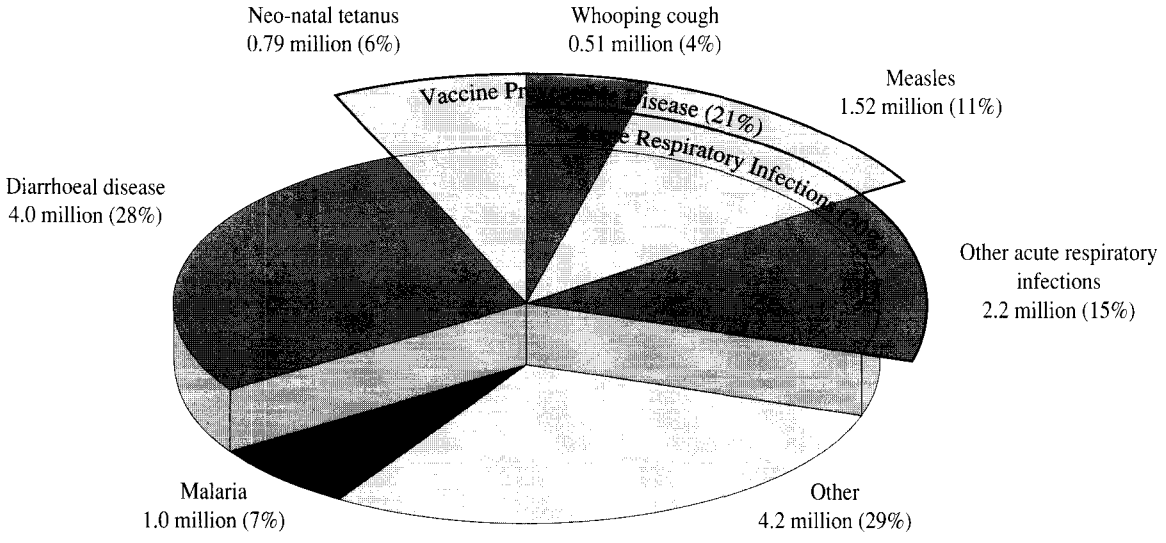
3 Children's and Women's Health

At present, UNICEF-assisted programmes of cooperation have as their primary objectives child survival, protection and development. This broad mandate translates into a variety of programmes focused on children's nutrition, immunization, growth monitoring, basic education, primary health care, water and sanitation, the control of diarrhoeal diseases and early childhood development. Women's development comes into UNICEF-assisted programmes both indirectly, as women are mothers and caretakers of children, and directly, as women's health and well-being is a basic development concern. In any case, there is a close link between women's development and children's development, with ample evidence demonstrating that improving women's health and well-being improves the health and well-being of children. For example, women's knowledge of nutrition improves children's diets; women's access to credit and incomes contributes to better household nutrition and basic welfare; improvements in the health of pregnant and lactating women reduce the incidence of low birth weight (which retards infant development) and also protect babies from birth trauma, tetanus and neonatal asphyxia.

Children's Health

Malaria, measles, diarrhoea, neonatal tetanus and acute respiratory infections continue to cause more than 70% of infant and young child deaths in ESA. Fewer deaths have been attributed to measles, diarrhoea and neonatal tetanus as immunization and oral rehydration therapy coverage rates have increased, but relatively more deaths have been attributed to malaria and malnutrition—both as a direct cause and as an important contributing factor. Perinatal and neonatal deaths now constitute about 40% of infant deaths. Tragically, infections and low birth weight—conditions

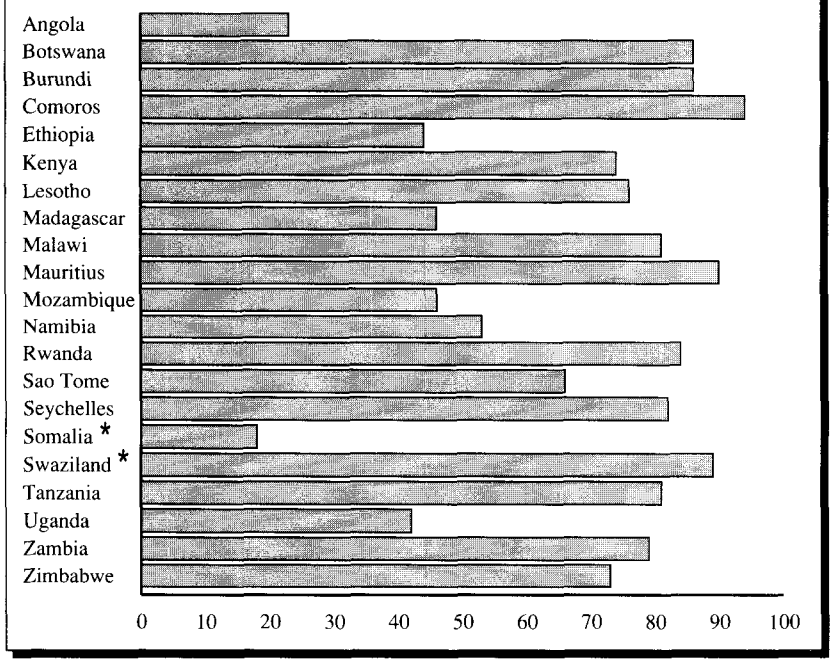
Figure 3.1
Causes of Child Deaths World-Wide



* For purposes of this chart, one cause has been allocated for each child death.

Source: UNICEF 1990e: 17.

Figure 3.2
DPT3 Coverage in ESA (1989*, 1990) (%)



which could be prevented through improvements in maternal status and health care (especially the TT vaccine and hygienic delivery methods)—cause the 20% to 40% of infant deaths which occur in the first two months of life. Finally, and perhaps most disturbingly, perinatal transmission of HIV/AIDS, which causes 80% of infected newborns to die before the age of two, is spreading rapidly in many parts of Central Africa and threatens to erase recent gains in the reduction of child mortality rates.

The paucity of health data continues to impede effective health planning

The paucity of health data in the region continues to be a major constraint, as it remains difficult to assess situations and measure the effectiveness of interventions. For most ESA countries we are unable to obtain accurate measures of access to health care (including essential drugs) or to safe water or to adequate sanitation, whether in urban or rural areas. We are also unable to obtain reliable data on maternal mortality or trained assistance during pregnancy or birth. At the same time, there are considerable statistical disparaties within countries (e.g. infant mortality rates in Kenya range from 35 to about 100 per 1,000 live births) which national averages conceal. Community-based indicators would give a more complex and more accurate picture of ESA countries, which are frequently heterogenous, with a small highly privileged upper class enjoying modern and efficient services, an emerging middle class having some (limited) access to these services and a large and growing class of people living in absolute poverty with little or no access to these services.

Universal Child Immunization (UCI) 1990: Recent data (April 1991) show that eleven ESA countries achieved the UCI 1990 target of 75% DPT3 coverage for infants. Of the ten which did not achieve it, Kenya (at 74%) and Zimbabwe (at 73%) are very close, while Angola, Ethiopia, Mozambique, Namibia, Somalia and Uganda are war-affected. To improve these results, a lot of work remains to be done. First, national UCI is still several years away in Madagascar and in the war-affected countries (with present UCI achievements limited to national and provincial capitals and other conflict-free populations) and will require increased training, costly equipment, large-scale social mobilization and generally improved health services. Only Sao Tome and Principe, with national DPT3 coverage between 60-70%, is close to attaining UCI 1990 goals. Secondly, 75% coverage, where it has been achieved, is not sufficient to prevent outbreaks of neonatal tetanus or measles—the largest killer among the vaccine-preventable diseases as well as a major cause of malnutrition, illness and vitamin A loss: 90% coverage for measles and nearly 100% coverage for tetanus will be required. Thirdly, sustaining UCI 1990 coverage levels presents an enormous challenge. Countries which have recently achieved a spectacular rise in immunization levels may slip to pre-campaign levels in the next two to three years as economies weaken further and as donor and political commitment to UCI declines. Cost analyses will be necessary to reduce wastage, lower vaccine costs and (more generally) contain costs. Technical and managerial support will also be needed. Fourthly, immunizing new-borns against neonatal tetanus through vaccinating mothers remains relatively neglected in ESA, with TT coverage stagnating and controversy continuing in some countries over the question whether all women or only pregnant women should receive the vaccine.

Additional vaccines may soon be introduced into the Expanded Programme for Immunization (EPI). A likely candidate is the Hepatitis B vaccine, which has recently become affordable to poorer economies and may attract donor funds to countries where the disease has a high rate of incidence. The introduction of the High Title Edmonson-Zaghreb measles vaccine, which can be administered at six months, may boost measles coverage rates significantly in countries with high drop-out rates between BCG and measles. Vaccines against various types of respiratory infection and various causes of diarrhoea are being developed and anti-malarial and anti-HIV vaccines are receiving a large amount of attention (though both remain at least several years away). If these become available, they will certainly be integrated into the immunization programme.

Control of Diarrhoeal Diseases (CDD): As diarrhoeal diseases remain among the five most common causes of child illness and death in our region—as well as a major cause (if not **the** major cause) of malnutrition—all countries in the region have national control programmes in place. The primary focus must be informing parents (who are the first line of defense against all childhood illnesses) of appropriate coping methods, including continued feeding and oral rehydration therapy. While access to oral rehydration salts has increased, their proper use is still low. At the same time, the use of home fluids continues to be high, encouraging further research into appropriate home fluids and weaning foods for improved case management. Several countries (Botswana, Comoros, Uganda, Zambia and Zimbabwe) are beginning to link CDD programmes with hygeniene, water and sanitation programmes. As in the case of UCI, technical, managerial and financial sustainability of past successes will be critical in the African context.

Acute Respiratory Infections (ARI): Acute respiratory infections feature among the most common reasons for out-patient care and are the major cause of death in Lesotho and Zimbabwe. Since children with pneumonia die very quickly, early diagnosis and treatment are critical. Alerting parents to its symptoms and harms is again a vital step. Community health workers must be trained to distinguish pneumonia from other illnesses, to administer antibiotics promptly and correctly and to refer critical cases to appropriate back-up medical services. The introduction of cotrimoxazole pre-packs to community health workers should improve access to necessary antibiotics significantly, helping to decrease incidence and severity. At the same time, immunization against measles and whooping cough will help to reduce the incidence of pneumonia by as much as 25%.

Integrating Child Survival, Protection and Development (CSPD): Basic CSPD strategies (including EPI, CDD, ARI and growth monitoring) should be better integrated at the health centre level. Many of the year 2000 goals adopted at the World Summit for Children depend on low-cost technologies (vaccines, antibiotics, growth charts, anti-malarials, iron tablets, vitamin A supplements, oral rehydration salts) and knowledge (about birth spacing, pre-natal care, immunization, breast-feeding, weaning, preventing and attending to common illnesses) which can be most effectively and economically delivered through community health workers. At the same time, since UCI has enjoyed stronger support and greater access to resources (e.g. vehicles, training, supervision) than the other components of CSPD, UCI may be the appropriate entry point for resources more efficiently used to support an integrated CSPD programme.

Table 3.1
ORT Use Rates (1987) (%)

0-5%	6-15%	16-45%
Madagascar	Angola	Botswana
Mauritius	Comoros	Burundi
Rwanda	Malawi	Ethiopia
Uganda	Mozambique	Kenya
Zimbabwe	Somalia	Lesotho
	Tanzania	Sao Tome
		Zambia

As ESA countries achieve high immunization levels, the CSPD health focus will shift from vaccination to disease control. Reliable health information systems (including sentinel site surveillance) will be needed to monitor and respond to the outbreak of diseases, especially neonatal tetanus and poliomyelitis (which ESA governments aim to eliminate by 1995 and 2000 respectively) and measles (which will tend increasingly to break out among older non-vaccinated populations).

Women's Health

Although it is clear that African women play a multitude of roles—mothers, care-givers, producers, household managers, community organizers—which (directly and indirectly) have an impact on children's health and well-being, UNICEF still has difficulty addressing these many responsibilties in multisectoral programmes that promote women's well-being. At the conceptual level there is a strong consensus that these interlocking and pervasive responsibilities cannot be compartmentalized but must be treated holistically. Yet, in the context of country programmes, women's development is often treated as an isolated, separate issue. Rather than undertaking a series of sporadic interventions focusing for the most part on women's roles as mothers, UNICEF should maintain a continuous focus on women's health and well-being, scoring early improvements in the health and status of the girl child and sustaining them through women's mothering, nurturing and beyond. Obtaining equal treatment for girls is the key to securing equal treatment for women.

The Girl Child: This multisectoral concern with women as women and also as mothers and caregivers should translate into a continuous effort to remove disparities in the treatment of the boy child and the girl child. Often boys have first call on family and community resources (UNICEF 1990b: 7),

There have been remarkable achievements in child immunization and the control of diarrhoeal diseases, but much work remains to be done

Eradicating gender discrimination among children will prevent its entrenchment among adults

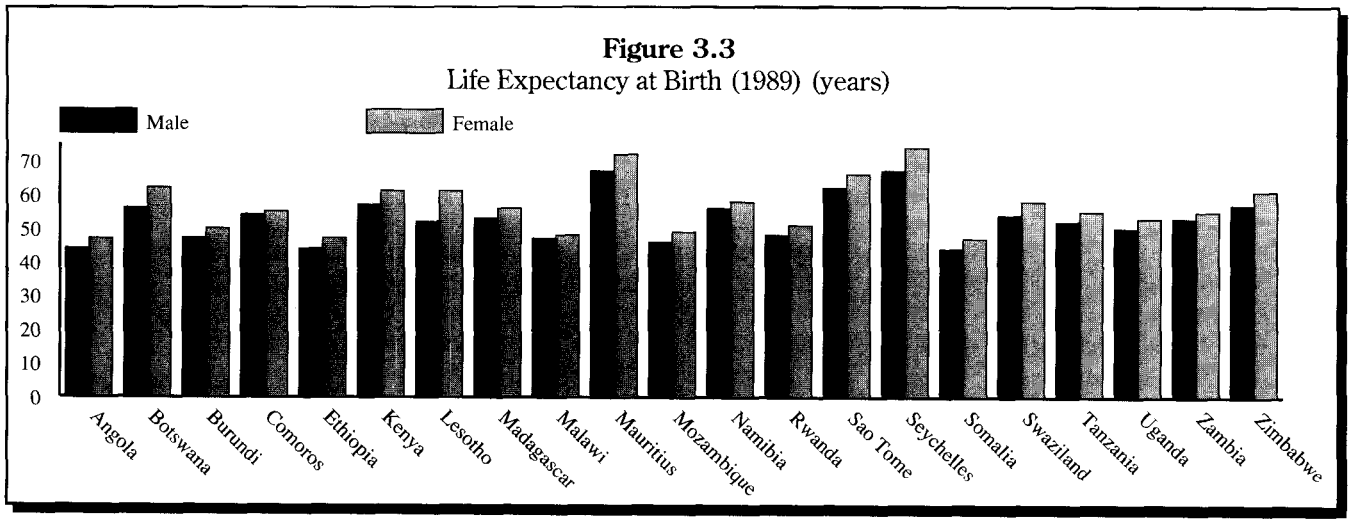
and it is plain that gender-discriminating treatment in childhood will result in deeply entrenched gender-discriminating attitudes in adulthood (UNICEF 1990c: 207). Many of these discriminatory attitudes have a negative effect on girls' and women's health. Although data are scarce in the region, there is reason to believe that infant and child mortality rates for girls are higher than or equal to the rates for boys, although the rates for girls are consistently **lower** in developed countries (Ibid.: 208). Since women often sacrifice their own nutritional needs for the sake of male family members, there is reason to fear that girls' diets are sacrificed to boys' diets, leaving girls without enough food of adequate nutritional quality for a healthy and productive life. This gender bias may emerge very early, as girls are breast-fed for a shorter period and weaned earlier than boys. As a result girls will be less able than boys to resist disease or to recover from it. At the same time, it is believed that immunization rates for girls are lower than for boys and that girls die in greater percentages not only from preventable diseases but also from malaria, diarrhoea and acute respiratory infections (Ibid.).

Since aggregated data mask these critical disparities, high priority must be given to collecting gender-specific data on all key child survival and development indicators, health indicators and nutrition indicators. Significant disparities must be revealed and highlighted. To remove them, health sector programmes should include affirmative action for the benefit of the girl child. Particular attention should be given to harmful traditional practices such as female circumcision and infibulation, which must be legally and practically abolished. Health education programmes, including family planning services, should reach out to the girl child to increase the control which she has over her own health and well-being. Parents must be alerted to the importance of providing adequate nutritional diets to their girl children.

On a broader front, popular attitudes concerning the girl child's socio-economic status—which have a significant detrimental effect on her physical and emotional health as a child and a woman—must be changed. Where the girl child is culturally undervalued (e.g. where her marriage requires payment of a dowry, making her an economic liability), she will have fewer rights and entitlements than her brothers, she will receive less education and she will be forced to work longer hours inside or outside the home. Frequently, she will be married early to reduce her cost to the family. (In Kenya, for instance, 53.2% of females, but only 5.2% of males, were married between the ages of 15 and 19 in 1982 (UNICEF 1990: 209).) There is reason to suppose that this disparity will have grown in AIDS-affected regions, as girls who have avoided perinatal HIV transmission and who are not yet sexually active will be particularly prized as wives and mothers, despite their very young age.

Early marriage will generally mean early pregnancy, with its many attendant hazards both for the young mother and for her child. Girls under fifteen may face five times the risk of death in pregnancy or childbirth which women aged 20-24 years face, and the risk remains twice as high for girls between fifteen and nineteen (UNICEF 1990c: 210). Her child is more likely to suffer from low birth weight and so more likely to die in the perinatal period or to suffer from stunting and from poor mental development in the critical first two years of life (when the brain attains 80% of its adult size). For these young mothers and their children, expanded health education is critical, with particular emphasis on contraceptive knowledge, birth spacing, and

Figure 3.3
Life Expectancy at Birth (1989) (years)



other safe motherhood practices. At the same time, families must be encouraged to treat the girl child more equitably, and early marriages should be strongly discouraged. A legislated minimum age of marriage would help considerably.

Safe Motherhood: Maternal mortality rates (MMR) remain very high in ESA, although reported figures vary widely according to source and year (reflecting the fact that maternal health has not been a priority issue in the past). The conditions leading to female morbidity and mortality include malnutrition, intercurrent infections, sexually transmitted diseases and pregnancy-related complications (especially anaemia, toxaemia, infection, haemorrhage, obstructed labour and septic abortions). In ESA these are complicated by teenage pregnancy, taboos and other harmful traditional practices which are deeply rooted in socio-cultural attitudes towards girls and women.

A few basic principles can reduce maternal and child morbidity and mortality rates sharply. Most maternal deaths occur to women who space births less than two years apart, or give birth more than four times, or give birth when they are younger than 18 or older than 35 (UNICEF 1991: 18, 20). UNICEF estimates that spacing births at least two years apart would alone reduce child deaths by 20% and maternal deaths by 30% as well as decrease child malnutrition significantly (Ibid.: 20). At the same time, pregnant women should receive adequate rest and nutrition to preserve their strength and to prevent the birth of low birth weight babies. In addition, there must be adequate prenatal care to screen pregnant women for anaemia and high blood pressure (both major killers), to innoculate mother and child against tetanus and to identify high-risk cases for referral to a hospital or a maternal waiting home. All births must be attended by trained personnel to ensure clean deliveries and to address possible complications or emergencies. Many of these basic principles are at present not known or not followed in the Eastern and Southern Africa region.

Indiscriminating Killers

Two killers which disproportionately affect pregnant women and children under five are spreading rapidly throughout the region: malaria and AIDS. UNICEF Tanzania estimates that, by the year 2000, malaria and AIDS will account for as much as 60% of all child deaths in that country. Controlling these two killers has emerged recently as the principal health challenge in ESA.

Malaria: Malaria may be the most serious tropical disease in Africa. Of the 8.3 million cases of malaria reported to WHO in 1988, 3.3 million were from sub-Saharan Africa (WHO 1990: 11). WHO believes that these numbers substantially underrepresent the global incidence of clinical malaria, which it estimates at about 110 million cases annually (Ibid.). WHO also reports that more than 25% of malaria deaths occur in children under five and that malaria causes about 10% of the deaths in children under fourteen (Ibid.: 13).

Table 3.2
Hazardous Births in ESA

Country	MMR	% Births Attended
Ethiopia (1985)	2000	14
Somalia (1985)	1100	2
Madagascar (1989)	378	62
Namibia (1989)	370	—
Comoros (1989)	370	24
Swaziland (1986)	340	50
Tanzania (1986)	340	74
Malawi (1989)	320	60
Mozambique (1988)	280	25
Uganda (1987)	265	45
Lesotho (1985)	220	28
Rwanda (1980)	210	5
Botswana (1989)	200	76

These statistics are borne out in several ESA countries (Comoros, Kenya, Tanzania, Uganda) where malaria or malaria-related diarrhoea is among the top three causes of infant and child deaths (see UNICEF Annual Reports 1990). At the same time, malaria in pregnant women is a major cause of high fever and severe anaemia which may lead to the death of the feotus or to low birth weight infants. The incidence of malaria in adults, besides decreasing health and productivity levels severely, can be a major cause of death (15% of admitted cases to health clinics in Tanzania). Recently, there has been a recrudescence of malaria in Southern Africa (due perhaps to the extension of agriculature into areas of potentially high transmission or to the occurrence of heavy rains (WHO 1990: 15)), with chloroquine-resistant malaria spreading in Malawi and with recent malaria epidemics breaking out in Botswana, Zambia and northern Namibia. In addition, resistance to "second-line" drugs (e.g. sulfadoxine-pyrimethamine) is increasingly frequent (Ibid.: 13). Only Madagascar has successfully fought malaria, reducing malaria-related mortality levels by 35% through chloroquine distribution, social mobilization, increased environmental sanitation and indoor spraying in high-plateau malaria areas.

Over 25% of malaria deaths occur in children under five

Several ESA countries are developing or improving national anti-malaria programmes (Malawi, Tanzania, Zimbabwe) although some of the most heavily infected countries (Kenya and Uganda) have not yet made major

Table 3.3
AIDS Cases per 100,000 Population

Country	Cumulative cases 1987	Cumulative cases 1989	Annual growth rate 1989
Malawi	11.8	84.1	37.0
Uganda	21.7	75.6	31.8
Zaire	7.3	35.2	18.6
Kenya	6.3	30.2	12.1
Tanzania	6.8	26.3	8.8

Source:UNICEF Malawi Annual Report 1990: 33.

interventions. The basic strategy typically includes the following items. (i) Improve diagnosis, treatment and access to treatment. This may involve training health care workers to recognize malaria symptoms at earlier stages and alerting them to seasonal fluctuations in its incidence (Botswana). It will also require the development and provision of second-line anti-malarials to combat chloroquine failure, especially in Zanzibar, Malawi, Mozambique and northern Botswana, as well as expanded use of chemotherapy for symptomatic cases. (ii) Retard the malaria incidence rate through the use of anti-malarial tablets and insecticide-impregnated netting (which can be produced locally by women in small-scale businesses, e.g. Kenya's pilot community-based malaria programme in Kisumu district). (iii) Promote malaria-focused information in the health education component of primary and secondary school curricula as well as in community outreach programmes focused on the control of diarrhoeal diseases (as in Malawi) or on the improvement of water and sanitation. (iv) Manage the environment to control and ultimately to reduce mosquito breeding. This will usually require a recurrent spraying campaign—which will in turn require improved transportation links.

To assist countries in their efforts to control malaria, UNICEF can provide supplies for vector control (Mozambique), recommended drugs (e.g. anti-anaemia drugs as well as chloroquine and other chemotherapentic drugs) for treatments, technical assistance (e.g. basic equipment for insectories and for diagnostic laboratories (Namibia)) and in-service training of field workers (Mozambique). Research into preventive strategies and basic treatments should be improved and expanded. Insecticides used in vector control projects must be tested for their health and environmental side effects.

AIDS: A recent study of the impact of HIV/AIDS in ten Central and East Africa countries—including Burundi, Kenya, Malawi, Rwanda, Tanzania, Uganda and Zambia—estimates that the disease will add 1.4 to 2.7 million child deaths to those countries in the 1990s (Preble 1990: 675). This will bring under five mortality rates from 158 per 1,000 live births in 1990 up to as much as 189 in 1999 instead of down to 132 as previously projected (Ibid.: 675, 679). During the same period, AIDS will kill 1.5 to 2.9 million women in their childbearing years, leaving 3.1 to 5.5 million AIDS orphans (6 to 11% of children under fifteen) (Ibid.: 671, 675). In 1989, Malawi recorded the highest incidence of HIV/AIDS in the world (84 cases per 100,000 population) as well as the highest annual growth rate (37 per 100,000), with one study finding more than 20% of antenatal patients in Blantyre and Lilongwe to be HIV-positive. In Uganda's rural Rakai district, over 25,000 children under 18 (12.8%) are reported to be orphans (Hunter 1990: 684), with AIDS as the most likely explanation. In all ten countries, urban seroprevalence rates (ranging from 4.0 to 22.9% in 1988, with a median rate of 8.1%) are consistently higher than rural rates (with a median rate of 2.3%). While perinatal transmission has created significant concentrations of HIV/AIDS in the 0-5 age group (16% of Kenya's cases), the disease is most heavily concentrated in the sexually active population aged 15 to 44—men and women in the prime of life, whose deaths force the productive burden increasingly on the young and old.

The primary victims of HIV/AIDS are women in their childbearing years, who are infected 1.3 to two times as often as men (Burundi, Kenya). Some estimates place the actual number of HIV-infected women at 1,500 per 100,000 in sub-Saharan Africa (UNICEF 1990d: 12). Since there is a 25-40% chance that HIV-infected women will pass on the virus during pregnancy or childbirth, these statistics sketch the outlines of a devastating tragedy. Children born with AIDS are born to die. About the sixth month, the HIV-infected newborn begins to show symptoms of the disease (fever, weightloss, respiratory infection, loss of appetite, chronic

Table 3.4
HIV-Infection in Pregnant Women (%)

City	1986	1987	1988	1989
Blantyre, Malawi	4.2	11.7	—	—
Bujumbura, Burundi	16.0	—	—	20.0
Kampala, Uganda	14.0	—	—	24.0
Kigali, Rwanda	18.1	—	—	30.0

Source: UNICEF 1990d: 11.

diarrhoea). No longer able to absorb nutrients effectively, its growth falters or regresses. Lacking mature natural defences to sickness, it succumbs to the disease swiftly. Nearly half of HIV-positive newborns die before the age of two and 80% die before the age of five (Ibid.: 7).

The newborn's illness and death—if it is diagnosed correctly—may be the first intimation to its mother that she too has AIDS. As a woman, she will have less access to advanced health care than a man. Ill herself, she is less able to care for her children. Her home deteriorates; her skills and knowledge atrophy. Her children will soon be orphaned—leading them to premature illness or death, or to a cramped life on the streets or in an orphanage, or to adoption into a family which may neglect, alienate, overwork or undereducate them. In the more fortunate cases, the children's grandparents, having buried the daughter they expected to care for them, will assume the burden of raising these motherless children (Hunter 1990: 681). (In Rakai, 43% of guardians are over 50 years of age (Ibid.: 685)). In less fortunate cases, fourteen or fifteen year old children will be forced to become heads of households, supporting their siblings through casual labour and cultivation. Providing food, clothing and shelter become daily struggles; love and affection are luxuries. At the same time, young girls who have missed perinatal HIV transmission and are not yet sexually active will be increasingly pressed to become the mates of men seeking to avoid the AIDS scourge. Early pregnancy, with its many risks both for the young mother and her child, frequently follows.

AIDS in children always kills. There is no cure and no vaccine. A few new drugs (e.g. AZT) retard the progress of the disease, or treat painful and debilitating symptoms, but these may have toxic side-effects and are in any case unaffordable to ESA countries. Since there is nothing that can be done to save a child who is born with the virus, efforts to combat AIDS in children must concentrate on preventing perinatal transmission. Thus a major way to prevent HIV infection in children is to contain the spread of HIV in women: saving mothers is the key to saving children (Preble 1990: 677). This will require a fundamental change in attitudes and in behaviour.

UNICEF's AIDS programmes—which can be fairly readily integrated into its primary health care activities—focus on two objectives: (i) preventing HIV transmission in every way possible and (ii) improving the personal and social environments of people living with HIV or AIDS, especially AIDS orphans (UNICEF 1990d: 21). A greater effort must be made to spread correct information about the disease (through health education, poster publication, community seminars, etc.), to combat ignorance, to shake people out of fatalistic complacency and to help people to protect themselves from HIV transmission. If HIV/AIDS is not understood, parents will lose confidence in other effective health interventions (such as breastfeeding, immunization and rehydration therapy) which, because they have little positive impact on HIV-infected children, may seem ineffective all around. Alternatively, parents may assume that a sick child has AIDS and seek no help even for preventable illnesses (Hunter 1990). A special effort must be made to reach teens before they become sexually active. To give the attack on AIDS the widest possible front, there should be extensive coverage of AIDS in training programs for nurses, paramedics, community health workers, traditional birth attendants and primary and secondary school teachers.

Women—the principal victims of AIDS—must be granted more control over their sexual lives. At present, women in the traditional environments of ESA seldom make use of prophylactics, especially barrier prophylactics effective in the combat against AIDS, because they are expensive and rarely available and because they require the informed participation of their sexual partners. Family planning services and STD prevention and control programmes must be extended into all communities. Advertisements such as "love carefully" and "live positively with AIDS" (TASO) will need to be reiterated continually and with sensitivity, not just by

In the next decade, AIDS will cause as many as 2.7 million child deaths in Central and East Africa

Figure 3.4
Infant Mortality Rates

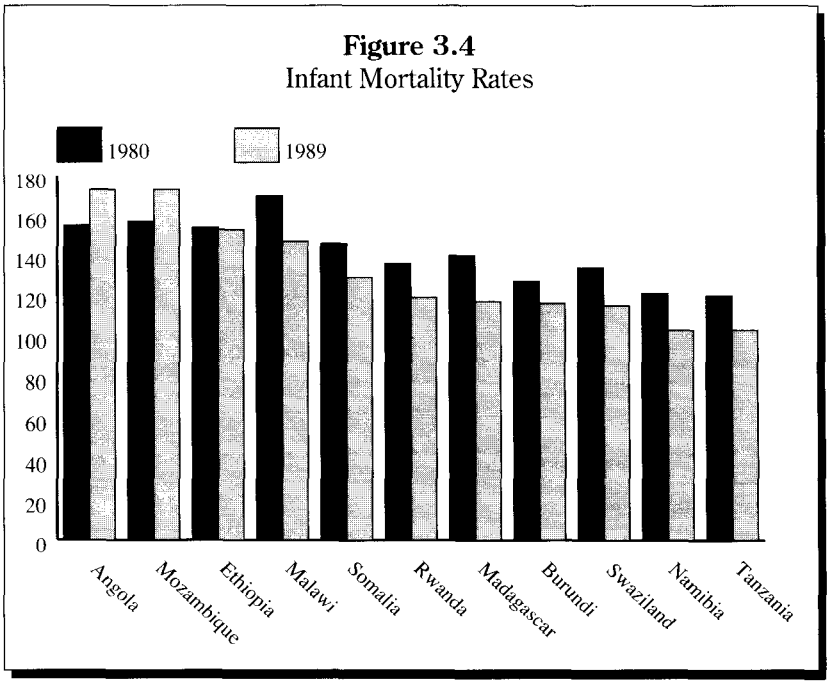


Table 3.5
Food Import Dependency Ratio

Country	1979-81	1984-86
Botswana	65.8	79.5
Burundi	2.1	2.4
Kenya	10.2	12.8
Lesotho	46.9	59.2
Madagascar	8.6	7.0
Malawi	3.3	1.8
Mauritius	76.0	63.6
Rwanda	1.6	4.0
Somalia	33.6	26.4
Tanzania	4.7	4.9
Uganda	2.2	1.0
Zambia	22.1	14.1
Zimbabwe	4.2	7.6

Source: UNDP 1990: 150-51.

organizations such as UNICEF but also by the regular media, educators, community leaders, elders and priests, theatre groups, etc. To maintain confidence in immunization programmes, hospitals and clinics must routinely sterilize blood, blood products, and hypodermic needles to ensure that they are HIV-free.

Perhaps most important, and most difficult to achieve, HIV-carriers and their families must be given proper care and counselling. With austerity measures choking government expenditures, it will be extremely difficult for African governments to expand basic health services to confront the growing AIDS crisis. (Against the $2-$10 per person which the governments of developing countries spend on health care, a $1 ELISA test to determine HIV-positivity is already extravagant.) Home care for AIDS patients must become a real alternative to institutional care in overcrowded and underfunded hospitals. At the same time, community-based and culturally-acceptable caregiving systems are urgently needed for AIDS orphans, whose sheer numbers threaten to overwhelm institutional and non-institutional care-givers extremely rapidly. (It is estimated that between 400,000 and 1.2 million children in Uganda are orphans, with AIDS being the largest cause.) In all care-giving environments, HIV/AIDS-related technologies developed for adult cases must be adapted to pediatric cases.

Table 3.6
Some Demographic Indicators (1989)

Country	Fertility rate	Population growth rate (1980-88)	Food prod. per capita (1980=100)
Angola	6.4	2.6	80
Botswana	7.1	3.6	69
Burundi	6.8	2.8	88
Comoros	6.6	3.1	97
Ethiopia	6.9	1.8	91
Kenya	6.7	4.1	103
Lesotho	5.8	2.8	72
Madagascar	6.6	3.1	92
Malawi	7.6	3.2	86
Mauritius	1.9	1.5	94
Mozambique	6.4	2.6	82
Namibia	6.1	3.1	92
Rwanda	8.2	3.4	72
Seychelles	3.4	0.6	—
Somalia	6.6	3.5	97
Swaziland	6.5	3.4	—
Tanzania	7.1	3.7	90
Uganda	7.3	3.4	85
Zambia	7.2	3.9	96
Zimbabwe	5.7	3.1	94

Sustainable Health

Although crude death rates have fallen to 5-20 per 1,000 population for all ESA countries, crude birth rates continue to range from 41-56 per 1,000 population (excepting Mauritius and Seychelles), bringing population growth rates over 3% per annum on average. At this rate, ESA countries will double their populations every twenty years, with devastating effects not only on service delivery but also on local environments as human demands exceed the sustainable yield of fragile ecosystems (King 1990: 664). Although reducing infant and child death rates is necessary for reducing birth rates, it is not sufficient. Along with vertical interventions (such as immunization and oral rehydration) designed specifically to reduce death rates, parallel horizontal interventions (such as empowering women, improving access to family planning services and increasing social and economic returns) are needed specifically to reduce birth rates. This is particularly true as long as child mortality rates remain above 100 per 1,000 live births—apparently the critical threshold for triggering a strong and persistant fall in fertility rates (UNICEF 1990e: 43). If such programmes are not successfully and concurrently implemented, an unstable period characterized by low death rates and high birth rates will trap increasing populations in poorly serviced communities and rapidly deteriorating environments. The ultimate outcome—as a region winds down to total ecological collapse—will be indefinite dependency on emergency relief, higher numbers of environmental refugees and (after a period of initial decline) increasing death rates (Ibid.).

Bringing social and economic gains to Africans, which is of course the primary and most ambitious goal of development, would be most effective in reducing fertility rates.

There appears to be a correlation between urbanization, modernization and improved standards of living, as children are no longer needed to help in agricultural work or expected to care for their elderly parents. Moreover, changes in lifestyle and expectation lead people to have fewer children whom they can rear more ably (UNICEF 1990e: 37). Unfortunately, serious constraints prevent rapid socio-economic growth in ESA, widening the gap between falling death rates and falling birth rates and causing the unprecedented population explosion which we are now witnessing.

Improving the social and economic status of women—in itself an important goal—would also be especially effective in reducing fertility rates. Women who have a fairly wide range of economic opportunities, who have full control over their lives (including their sexual lives) and who are educated (particularly in health and nutrition and family planning) are less likely to allow fate to dictate the number of children they will bear. Based on *World Fertility Study* findings, UNICEF reports that if women in developing countries were permitted to determine the size of their own families, they would have two fewer children on average, reducing population growth rates by about 30% (UNICEF 1990e: 47).

At the same time, family planning services should be extended to meet the demand already existing. Although less than 15% of the population in ESA uses some form of contraception, the majority—partly because declining infant and child death rates have made family size predictable and controllable—recognize that family planning is possible and that appropriate family planning can have a huge impact on their physical and mental well-being. (That the demand for contraception is often met by an unlicensed abortionist—leading to 20-30% of all maternal deaths—is tragic proof of this.) Exclusive breastfeeding for the first four to six months of a child's life is critical: besides providing cheap, safe, hygienic and complete nourishment to the child, it is also an effective (albeit not foolproof) natural contraceptive.

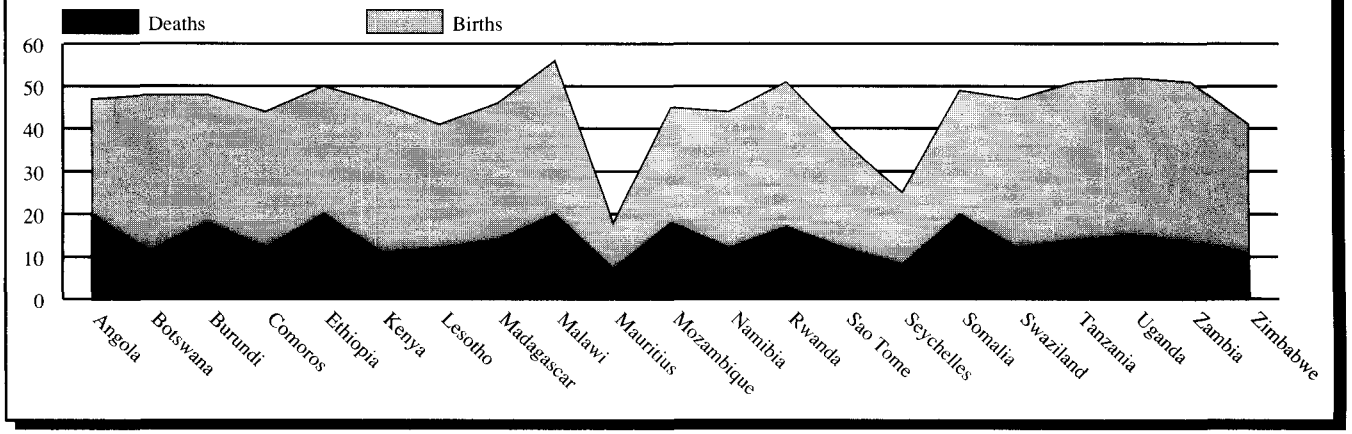
Unless more intensive efforts are made to reduce birth rates, population pressures in many parts of ESA will lead to irreversible and destructive changes to the environment. As population growth forces more and more Africans to substitute intensive for extensive agriculture (which permitted land to replenish itself naturally through a fallow period), formerly fertile land will be leeched of its

Table 3.7
Food Aid in Cereals
(1,000 metric tons)

Country	1981-82	1984-85	1987-88
Angola	74.5	83.7	100.7
Botswana	6.5	38.5	51.3
Burundi	9.0	17.1	4.3
Ethiopia	189.7	868.9	825.3
Kenya	127.2	339.8	118.8
Lesotho	34.2	70.8	49.6
Madagascar	87.1	98.1	75.8
Malawi	2.0	5.4	102.8
Mauritius	42.5	9.2	31.5
Mozambique	148.5	377.8	466.3
Rwanda	12.6	34.5	7.1
Somalia	185.9	247.9	152.4
Tanzania	307.5	124.7	71.5
Uganda	48.5	30.2	29.3
Zambia	100.0	116.3	140.4
Zimbabwe	—	131.3	13.9
TOTAL	1375.7	2594.2	2241.0

Source: UNDP-World Bank 1989: 158.

Figure 3.5
Births and Deaths (per 1,000 population)



nutrients to the point where its carrying capacity will fall far below population levels (UNDP 1990: 5,7). As a consequence, food imports will become increasingly regular (e.g. Ethiopia) and drought cycles will become increasingly common. It is vital for the region that human demands do not exceed the sustainable yield of the environment: birth rates must be lowered quickly, before communities are forced in the quest for survival to destroy their ecosystems.

UNICEF Initiatives

With diarrhoea, immunizable diseases and acute respiratory infections causing more than 70% of the child deaths in ESA, UNICEF priorities for the 1980s will continue into the 1990s. It remains a major challenge both to raise immunization levels (to 75% coverage for DPT3 and poliomyelitis, 90% coverage for measles and 100% coverage for tetanus) for *all* ESA countries and to sustain these levels beyond the decade. At the same time, current CDD and ARI programmes should be improved and extended, with special emphasis on alerting parents to the symptoms and harms of respiratory infections and to the proper use of oral rehydration salts. Since many of the year 2000 CSPD goals depend on health education and low-cost technologies delivered most efficiently and economically through community health workers, UNICEF and allied organizations should extend and strengthen community health centres throughout ESA.

The health of the girl child must receive special consideration in the 1990s, both because gender discrimination has an unacceptably negative impact on girls' health (and therefore on women's health) and because women's health has a direct impact on children's health. Gender-specific data on all key CSPD, health and nutrition indicators will be required, both to assess the extent of gender disparities and to evaluate programmes designed to remove them. At the same time, UNICEF must maintain a focus on women's health *per se*: the relative neglect of maternal health in ESA (where maternal mortality rates continue to range from 19 to 2,000 per 100,000 live births) is particularly shocking.

Obvious additional priorities in ESA include the control of malaria and HIV/AIDS. With malaria epidemics continuing in East Africa and re-emerging in Southern Africa, national anti-malaria programmes urgently require strengthening, with emphasis both on prevention (through education and vector control) and on treatment (through effective diagnosis and increased access to first- and second-line anti-malarials). As the AIDS scourge will not succumb to any known treatment, AIDS prevention (chiefly through health education) is critical in the heavily infected Central and East African countries. At the same time, with particular reference to UNICEF, greater efforts must be made to improve the personal and social environments of the growing numbers of AIDS orphans.

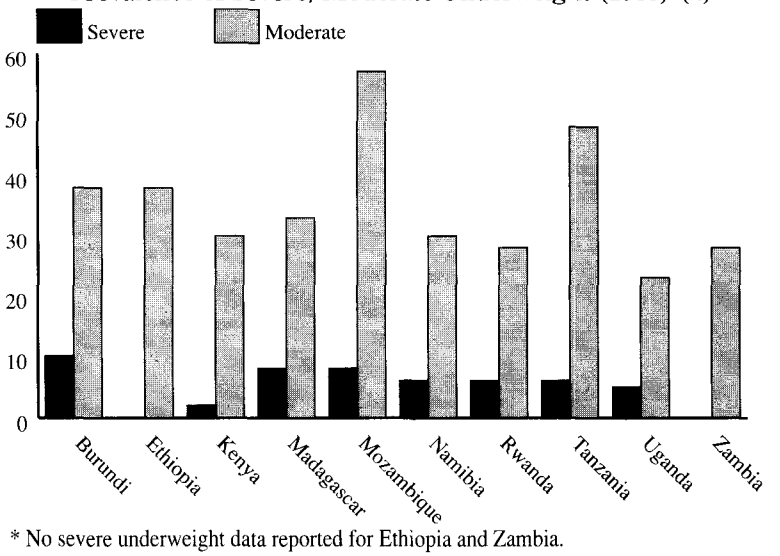
While many UNICEF interventions aim laudably to reduce death rates, growing population pressures on fragile ESA environments indicate that parallel efforts to reduce birth rates are also— critically— necessary. A failure to reduce fertility rates (by empowering women, improving access to family planning and increasing social and economic returns) will lead ultimately to complete ecological collapse, indefinite dependency on emergency relief, large refugee populations and—ironically—higher death rates. The movement towards this disaster must be arrested now.

4 Nutrition

Nutrition goals for the year 2000 present an enormous challenge in ESA. These goals include reducing low birth weight to less than 10%, reducing child malnutrition to one-half of 1990 levels, reducing iron-deficiency anaemia in women of childbearing age to two-thirds of 1990 levels and eliminating both iodine deficiency diseases and vitamin A deficiency and its consequences. Over 1980-88, protein energy malnutrition affected more than 3 in 10 children nationally in Burundi, Ethiopia, Kenya, Madagascar, Mozambique, Namibia and Tanzania, with perhaps 5 in 10 children affected in the poorest areas. Besides contributing to repeated severe infections, malnutrition now ranks among the five major causes of child deaths in ESA. Excepting Angola, stunting (ranging from 7% to 70% over the 1980s) is more common than wasting (ranging from 1% to 64%), indicating that chronic malnutrition is a larger problem than acute malnutrition. Unfortunately, nutrition surveillence data are fragmentary or non-existent in much of ESA, making it difficult (if not impossible) to assess the extent of nutritional deficiencies and the effectiveness of recommended interventions.

This is especially true for micronutrient deficiency disorders, which are not routinely monitored in ESA. Anaemia—an important underlying cause of child deaths—is widespread in children and women (especially pregnant women, who have higher iron and folic acid requirements), particularly in Tanzania. Iron prophylactics are rarely available in health facilities and, when they are available, women often fail to take them regularly. Vitamin A deficiency—a common cause of blindness in children and an underlying cause of death in children suffering acute infections such as pneumonia and measles—is also widespread. Vitamin A tablets should be made more readily available in areas known to have deficiencies and, as a long-term preventive measure, people in these areas should be encouraged to produce and consume vitamin A rich foods (dark, brightly coloured fruits and vegetables). Moderate to severe iodine deficiencies occur in Ethiopia, Kenya, Malawi, Tanzania, Zambia and Zimbabwe (with ten other countries mildly affected), leading to increased infant deaths as well as physical and neurological disorders in children and adults. Each of the moderately-to severely-affected countries, except Zambia, have implemented national programmes to eliminate IDD, with iodised salt now produced in Ethiopia, Kenya and Tanzania. In addition, Malawi and Tanzania are distributing iodised oil in highly endemic areas.

Figure 4.1
Prevalence of Severe/Moderate Underweight (1989) (%)



* No severe underweight data reported for Ethiopia and Zambia.

A neglected area is protein energy malnutrition in women. Most national nutritional surveys exclude women of childbearing age, despite estimates that women in ESA typically gain no more than 4 kgs during pregnancy (as opposed to 10 kgs for women in developed countries). Although more than half of the births in ESA occur at home and newborns are seldom weighed, available data indicate that (over 1980-88) 13% to 20% of the children born in Angola, Burundi, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Swaziland, Tanzania, Zambia and Zimbabwe had low birth weights, greatly enlarging their exposure to perinatal and neonatal morbidity and mortality. As WHO's low birth weight scale becomes more

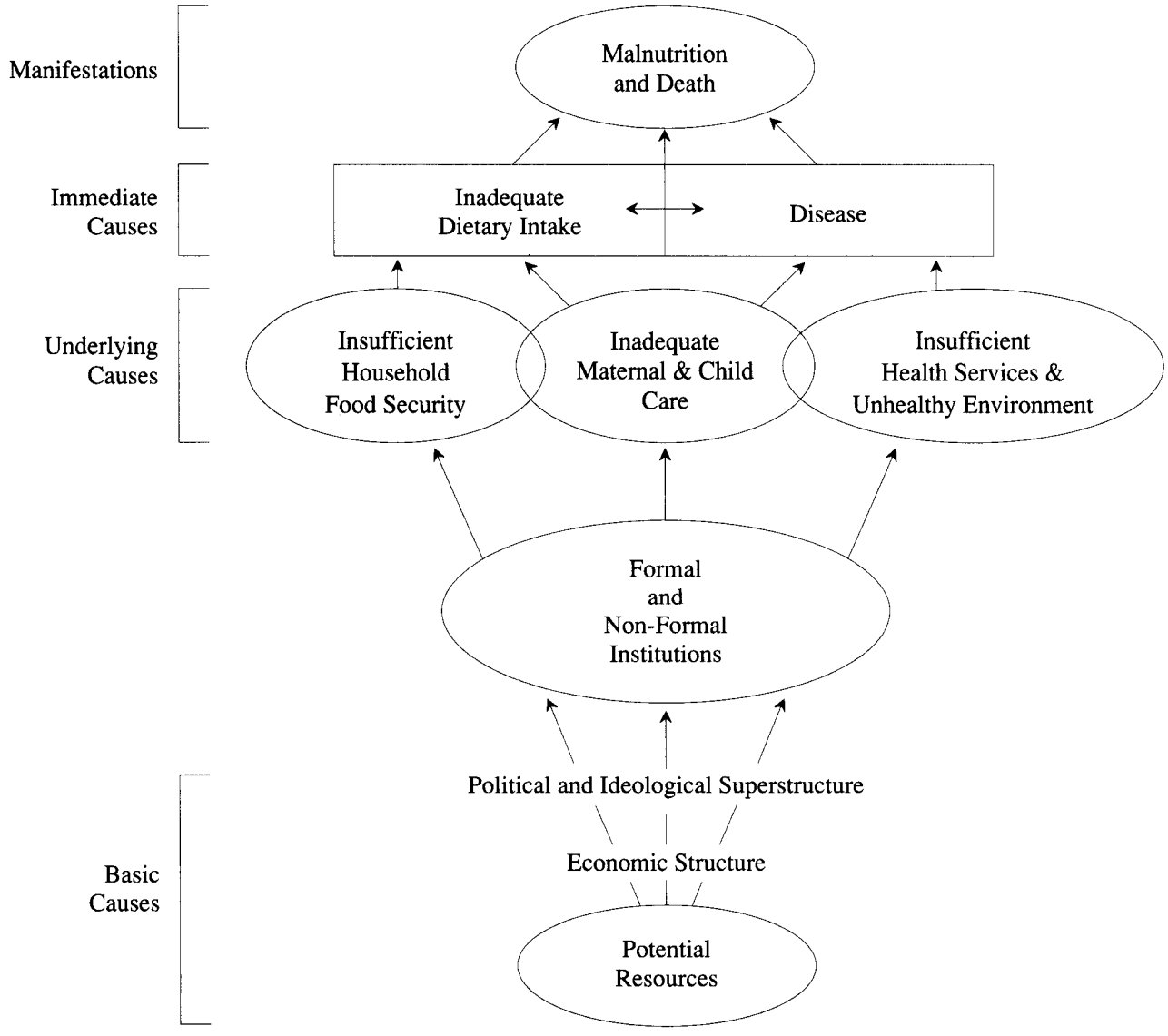
readily available to trained birth attendants, it should be possible to identify and to start special care for low birth weight babies immediately.

The New UNICEF Nutrition Strategy

In April 1990 the UNICEF Executive Board approved a new nutrition strategy designed in part to achieve the 1990s goals. This strategy draws on experience gained in the Joint WHO/ UNICEF Nutrition Support Programme (JNSP). The Iringa Nutrition Programme in Tanzania, which began in 1983, has been the most successful model, reducing severe malnutrition in young children from 6.3% to 1.8%, and moderate malnutrition from 56% to 38%, in 168 participating villages. The new nutrition strategy differs from previous strategies in three ways. (i) It views good nutrition as a basic human right rather than as a utilitarian investment in human capital. (ii) It views nutrition, not as a sectoral activity, but as the manifestation of a sequence of multisectoral social processes. (iii) It is community-based, focusing on the people whose nutritional status is at issue and participating in the coping strategies which they themselves develop as a response to their nutritional problems. By exploiting local skills and mobilizing local resources, UNICEF hopes to promote self-reliance and sustainability in nutrition.

Conceptual Framework: In the conceptual framework of the new strategy, nutrition is analysed and addressed as the outcome of a complex and particular sequence

Box 4.1
Causes of Malnutrition and Death



of social processes (UNICEF 1990a: 19-22). The most immediate causes of malnutrition and death are identified as dietary inadequacies and disease (particularly infectious disease). These conditions are themselves the consequence of insufficient household food security, inadequate maternal and child care, and insufficient health services and an unhealthy environment. These three problem clusters are collectively the underlying causes of malnutrition and they are in turn the consequence of certain basic or structural features of the social, political and economic environment. That is, the potential resources of a country are exploited through particular formal and informal institutions operating within a particular economic structure and a particular political and ideological superstructure. Such constraints collectively are the basic or structural causes of malnutrition.

On this analysis, household food security is clearly shown to be a necessary, but not a sufficient, condition for good nutrition. Hence the conventional coupling of household food security and nutrition, by suggesting an identification of these two concepts, is misleading (Ibid.: 19, 20). It detracts attention from other equally important causes of malnutrition and obscures the processional framework which is most appropriate to understanding nutrition. Only when household food security is joined with adequate maternal and child care—the least studied of these underlying causes—as well as the availability of basic health services and a healthy environment do we approach a sufficient condition for good nutrition.

The "Triple A" Approach: UNICEF's new nutrition strategy advocates a multi-sectoral analytical approach which attempts to use nutrition as a focal indicator of the processes assisting or obstructing child survival, protection and development. Rather than implementing a predetermined package of monofocal technical interventions, ongoing *assessment* and *analysis* undertaken in a community-based nutrition-monitoring system will permit an evolutionary engineering of *actions* (at the household, community, district and national levels) appropriate to local and changing conditions. In this approach, it is critical that people in poor communities take an active part in the regular monitoring and analysis of nutritional status. Merely by measuring four anthropometric indicators (age, sex, weight, height) and mapping them against a universal norm—a task easily mastered—people would be alerted to the gravity of the nutritional problems affecting their own children. By analysing the data collected—through use of the conceptual framework—the linkages between different factors contributing to malnutrition would be clarified. A parallel study of the community's resources, focusing on who controls these resources at what levels, would empower people to act positively to reduce malnutrition. In ESA, malnutrition often results from improper breastfeeding practices (e.g. premature supplementation or weaning), infrequent feeding with bulky contaminated foods, repeated infections and parasitic infestations and household food insecurity (particularly in the 15-46% of ESA households which are female-headed). At the more basic level, decreased food production, rapid urbanization and prolonged periods of structural adjustment are contributing factors.

Nutrition strategies will contain various component actions, addressing manifestations and immediate causes, or underlying causes, or structural causes of malnutrition. Breast-feeding (which also promotes birth spacing, mother's health and well-being and control of diarrhoeal diseases) will continue to have a prominent role. To address the manifestations and immediate causes of malnutrition, there may need to be greater access to oral rehydration therapy, direct feeding programmes, life-saving drugs (e.g. antibiotics and anti-malarials) or micronutrients (e.g. iron supplements) and, for severely malnourished children, institutionalized care. The underlying causes of malnutrition will yield to attaining UCI objectives, ensuring household food security, improving maternal and child care, expanding access to high-quality primary health care and extending health education and family planning services. At a higher level, improved

Box 4.2
The Triple-A Cycle

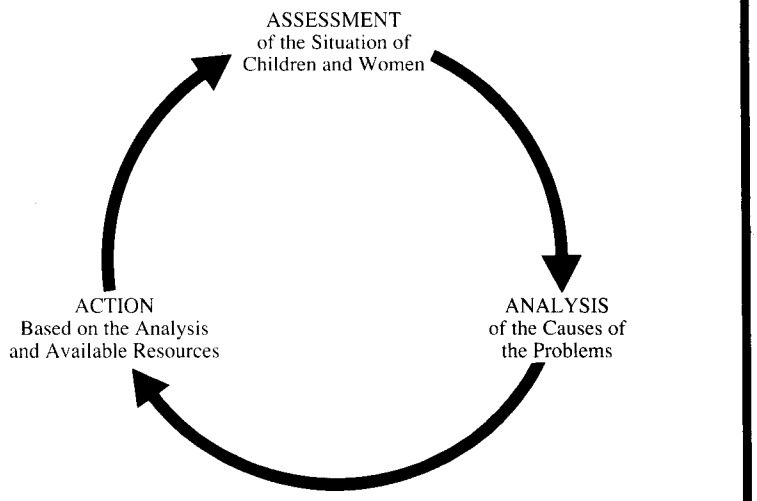


Table 4.1
Babies with Low Birth Weight (%)

	1985	1987
Angola	17	24
Burundi	14	14
Ethiopia	13	—
Kenya	13	11
Lesotho	11	—
Malawi	10	20
Mozambique	15	20
Rwanda	17	17
Swaziland	15	—
Tanzania	14	14
Zimbabwe	15	15

situation analyses, policy planning, technological development and advocacy will help to alter structural causes. The particular mix of component actions will be tailored to the local situation.

Household Food Security

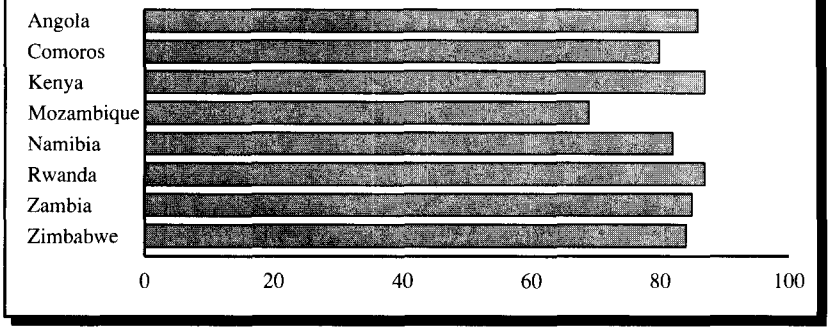
Of the three primary causes underlying malnutrition, household food security has been the most studied. Household food security concerns the capacity of a domestic unit at all times to provide its members with food of sufficient quantity and quality to support them in healthy and productive lives. Even though household food security is only one of three causes underlying malnutrition, it is a serious problem in ESA because many households continue to be food *in*secure and because the effort to obtain or sustain food security continues to require the enormous utilization of (human, economic and organizational) resources, compromising their use for other vital components of good nutrition

Different groups of people will confront different food security issues. Subsistence farmers and small market-oriented farmers are generally more able than other groups to maintain food security, because they often benefit from adjustment policies (e.g. agricultural price increases) and because they are relatively insulated from decreasing real incomes. Rural households can minimize their exposure to food insecurity through mixed cropping, plot dispersal and fragmentation, locally-developed crop adaptations, and multiple labour recruitment and deployment mechanisms (Fleuret 1990: 22). When agricultural development reduces crop diversity, rural households often produce "minor" crops or keep household gardens to hold down the risk of food insecurity (Ibid.: 12). For the same reason, most rural households supplement food income with cash income derived from various sources (the sale of crops, crafts, livestock, wild produce, casual or seasonal or full-time labour). At present there is little known about how these income-generating activities are integrated into rural household economies (e.g. for investment or immediate comsumption) or what value they have in comparison to farming activities. For example, wage employment—especially urban wage employment in the informal sector—may be more remunerative than is generally believed (Ibid.: 16).)

Nonetheless, some threats to household food security in the rural areas are especially intractable. These include drought, floods, epidemic disease, banditry, military activities, and violent political change. In Angola, Mozambique, Ethiopia and Somalia, war has disrupted rural production patterns, severely limiting household food security. Pastoralists—in Botswana, Kenya, Namibia, Somalia, Tanzania and Uganda—are heavily affected, as large herds of mixed animals are their primary or only defense to natural and man-made disaster. In countries with predictable bimodal or unimodal (e.g. Zambia) rainfall patterns, there may be sharp seasonal fluctuations in household food security as people suffer through a hungry period just before the annual harvest, when food stocks are low, food prices high, and work demands especially heavy (Ibid.: 24; World Bank 1990). Where growing populations have exceeded agricultural carrying capacity, as in some regions of Botswana, Burundi, Kenya, Madagascar, Rwanda and Tanzania, farmers may be forced to migrate "downslope" to marginal environments which are then overutilized, resulting in the long-term depletion of land resources through erosion and deforestation (Fleuret 1990: 22-23). Finally, even where highly productive land is available in abundance, inappropriate technologies, dilapidated infrastructure, misguided pricing policies, the lack of extension services and shortages and delays in critical inputs (seeds, fertilizers) frequently threaten or destroy household food security.

Structural adjustment policies, particularly

Figure 4.2
Daily per capita Calorie Intake (1987) (% requirements)



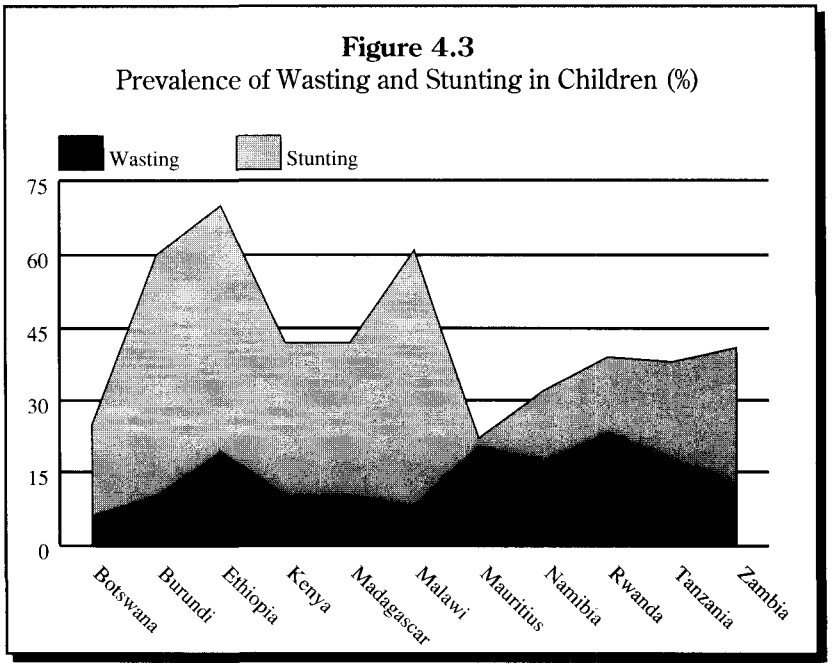
where they have included price increases for basic foodstuffs purchased by poor wage-earning households, have had a mixed impact on household food security in ESA. In Tanzania improved market efficiency has increased farm incomes and also increased urban household food security (Amani 1988) but in Malawi market liberalization has decreased the food security of small farmers who cannot escape prohibitive land constraints (Kaluwa 1988). In any case, it seems that stabilization and adjustment programmes have generally eroded the food security of poor wage-earning households. Low-income wage labourers in the urban areas—including public employees with static incomes in highly inflationary economies such as Mozambique, Tanzania and Uganda—have experienced rapid declines in real incomes over most of the 1980s, significantly reducing their ability to purchase adequate quantities of high protein foods. Within this group, labourers in the expanding tradeables sector may have been relatively sheltered from the negative impact of adjustment. By contrast, self-employed labourers in the informal sector, with little access to credit, training or technical assistance, have been especially vulnerable. As food consumption is positively correlated with income levels, the poorest are hit hardest, forced to shift from protein-rich foods to cheaper carbohydrates or to reduce the number of meals eaten. Severe cases resulted in urban-to-rural migration or reduced urban-to-rural remittances (with some reverse flows). To maintain the food security of poor wage labourers, structural adjustment should focus on maximizing their real incomes rather than on maximizing agricultural output.

It is worth noting that macroeconomic growth—the objective of structural adjustment—even when it is combined with aggressively redistributive government policies may not suffice to relieve household food insecurity. This is Botswana's experience. Although Botswana has put its export earnings (chiefly earned in the mining sector) to good use, offsetting income reduction in periods of drought with supplementary food distributions and income-generating public works programmes (Quinn 1988: 3-27), rural family incomes net of transfers from the state have not improved except in the few families which have gained formal employment or maintained substantial cattle herds (Morgan 1990: 6). That is, growth plus redistribution improve household food security only artificially; they do not lift human development to a permanently higher level. By contrast, Zimbabwe's emphasis on inward investment—strengthening communal farming initiatives and improving the delivery of services in the rural areas—may have created a broader and more robust household economy. But a shortage of the foreign exchange needed to purchase productive inputs (e.g. fertilizer), to sustain the manufacture of consumer products, and to improve crucial transportation and marketing systems threatens these gains as well.

UNICEF Initiatives

To implement the new nutrition strategy, UNICEF must support the "triple A" approach at local, sub-national and national levels, giving special attention to the resources utilized and required for food security. Nutrition strategists must strive to identify actions and interventions which are appropriate to the specific environment (powers, causes, resources). Where nutritional strategies have not been fully incorporated into primary health care services, this should be done: in particular the links between essential services such as immunization and the control of diarrhoeal diseases should be widely and visibly publicized to spread knowledge and encourage social mobilization focused on nutrition. Impact data should be collected and published systematically to enable continual reassessment of programmes. At the political level, UNICEF should increase its advocacy efforts aimed at formal and non-formal institutions, both at the national and the sub-national levels (e.g. through leadership training and training in programme design and evaluation), with special attention to the structural factors which affect the use and control of resources. It will also be necessary for UNICEF to identify strategic allies and to assess local institutional capacities in order to determine where the weaknesses lie and how to repair them. In the African context, it remains premature to expect governments to

Figure 4.3
Prevalence of Wasting and Stunting in Children (%)



undertake and sustain development efforts without external aid: hence donor-directed advocacy focused on nutrition will remain a priority matter.

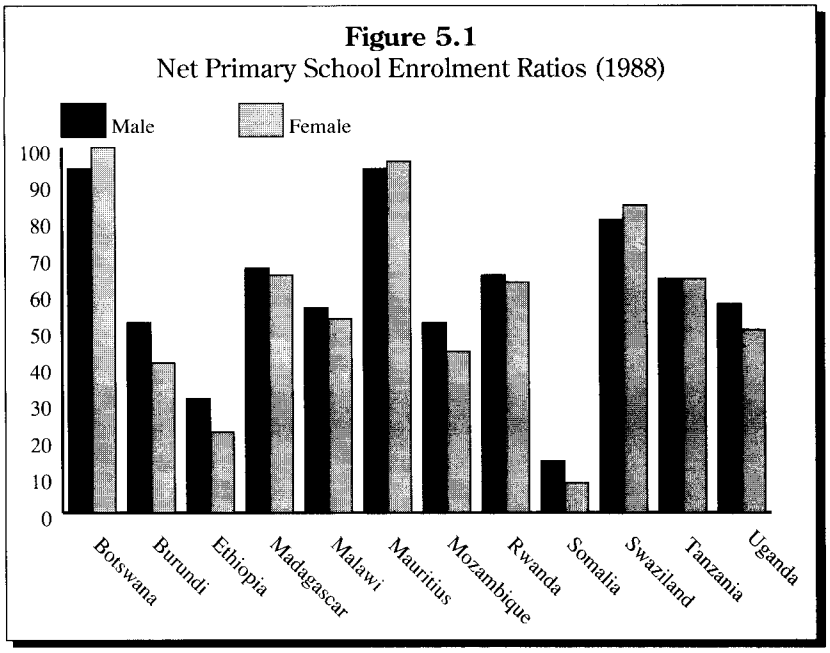
To enhance household food security, a number of specific strategies may be employed. Since women grow as much as 80% of the food grown in ESA, most of these strategies aim to improve the position of women farmers. First, smallholders should have access to agricultural credit and inputs, on a timely basis and in amounts both adequate and affordable (Fleuret 1990: 6). Second, women should have rights to land ownership or to secure use access, enabling them to enhance their own incomes in areas where individual farms are subsistence-based and male-dominated. Third, the maintenance of home gardens, which are typically undertaken by women both to increase food production and to raise their incomes, should be further encouraged. Fourth, agricultural extension services (directed specifically to women as well as men) should be used to encourage crop diversity, to improve the yields of "minor" crops and to expand the use and development of locally-adapted crop varieties (Ibid.: 7). Fifth, the availability of off-farm employment should be increased, particularly as traditional disaster response mechanisms (such as food and livestock exchange systems) break down, forcing people as part of their provisioning strategy to supplement food production and collection with wage employment. Sixth, the constraints on women's time occasioned by seasonal labour demands or by "enabling" tasks such as fuel and water collection should be reduced, particularly as development projects themselves frequently require women's participation. Seventh, supra-household institutions (e.g. schools, churches, local administrative structures) should be strengthened, as they may enhance social support, credit availability, infrastructure building, or labour mobilization.

5 Education

In the 1980s, UNICEF's efforts concentrated on child survival; in the 1990s, they will concentrate increasingly on child development.[1] Universal primary education will be a large part of this concentration. Education is a basic human need: through education, people acquire the knowledge and skills which they require to survive, to continue learning, to live dignified lives and to participate in their communities and their nations. Education is also instrumental to meeting other needs, such as shelter, health care, adequate nutrition and safe drinking water. Finally, education is—*par excellence*—a capacity-building activity which sustains and accelerates development: it empowers women; it improves income distribution; it prepares skilled workers to manage capital, technology, services and administration; it increases the productivity of the poor's primary asset, labour; and it enables people to understand and address major social issues (such as democratization, national unity and social cohesion) by spreading common mores, languages and ideologies. Capacity-building remains a major challenge in Africa as African development continues to rely on about 100,000 resident experts spending $6b a year. Yet sustainable development will not occur unless human institutional capacity "takes" in Africa. The newly industrialized countries of East Asia provide ample evidence of the high returns which accrue to sensible investments in education.

The World Conference on Education for All (Jomtien) has created a new global environment for basic education. The need for a new approach was critical after a decade which saw the share of donor aid allocated to education decline from 17% to 10%. Jomtien identified four key goals for education for the year 2000: (i) Universal access to and completion of primary education. (ii) Reduction of the adult illiteracy rate by one-half of 1990 levels, emphasizing female literacy sufficiently to effect a significant reduction in disparity. (iii) A significant expansion of early childhood development activities, emphasizing appropriate low-cost family- and community-based interventions in resource-poor countries. (iv) Exploitation of all avaliable instruments of information, communication and social action—the so-called "third channel"—to help individuals and families to acquire the minimum basic learning which is necessary for better living (UNICEF 1990c: 153).

Figure 5.1
Net Primary School Enrolment Ratios (1988)



In addition to these major goals, several other thrusts give form to the new vision in education. A major objective is the reduction of disparities, especially those affecting girls and women, but also those affecting children and adults who are marginalized (e.g. nomads, minorities, disabled persons, displaced persons, street children and working children). With educational achievements apparently deteriorating across Africa, there is also a new focus on *learning*: by establishing minimum levels of learning achievement and measuring student learning on a continual basis, it will be possible to assess the impact of expanded opportunities in basic education. In addition, the new vision incorporates a desire to broaden the means and scope of basic education. Since universal access to quality primary schools is not feasible in the

Table 5.1
Adult Literacy Rates (15 years and older) (1990 estimated)

Country	Male	Female
Angola	56	28
Botswana	84	65
Burundi	61	40
Kenya	80	58
Madagascar	88	73
Mozambique	45	21
Rwanda	64	37
Somalia	36	14
Uganda	62	35
Zambia	81	65
Zimbabwe	74	60

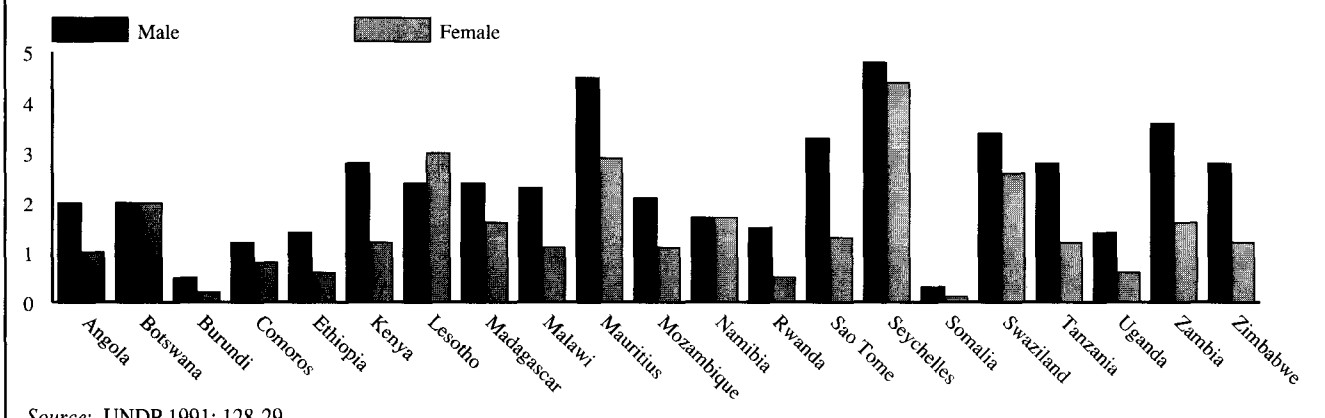
foreseeable future in ESA, various flexible, complementary and alternative delivery systems for primary education will need to be developed. Finally there must be renewed efforts to enhance the environment for learning: in particular, there must be desks and seats, chalkboards, textbooks, pencils and exercise books as well as dynamic teachers' support programmes to make teachers—the critical link in primary education—as effective as possible. Making the new vision a reality in ESA—an ambitious but not an impossible goal—will require greater efficiency, improved training and motivation, widespread commitment to education for all and widespread participation in the design and implementation of basic education programmes.

Basic Education

ESA countries inherited from non-indigenous sources a variety of educational systems which may have met the colonialists' needs but which have been largely inappropriate for post-independence development. This external model is often irrelevant to the actual needs, interests and problems of today's participants in the learning process: it serves at most a thin veneer of Africa's population. Partly for this reason, Jomtien has shifted the focus to basic education and altered our understanding of it. On the new view, basic education forms the learning foundation for **all** citizens, imparting to learners not only the essential learning tools of literacy, numeracy and scientific outlook which are traditionally emphasized but also, with equal emphasis, the skills and knowledge (e.g., about child care, nutrition, food security, basic health and hygiene, environmental protection, conflict resolution, tolerance of (cultural and religious) diversity) which are immediately relevant to their particular needs, interests and problems. Inculcating a minimum common level of basic learning should enable learners to survive; to continue learning; to live in dignity raising their families, earning their livings and managing their households; as well as to participate in their communities and their governments.

What constitutes this core curriculum will vary from one country—and even from one culture—to the next since a relevant and integrated core curriculum must be community-based and community-oriented, focusing on living and on solving problems in a particular context which is made concrete in the learning process. The articulated package of minimum skills and knowledge should be dynamic, reflecting regional and ethnic differences (where possible) and changing over time as the needs of the nation change. For some ESA countries (e.g. Ethiopia), defining the core curriculum will require a sensitive accommodation of conflicting language and value systems existing within the same polity. The language problem is

Figure 5.2
Mean Years of Schooling (25 years or older) (1980)



Source: UNDP 1991: 128-29.

highly political and, at some point (e.g. in providing higher education or government services), it requires a political solution. At the same time, young children should be educated in their native language, both to ensure that learning takes place and that the learning process reflects the histories and the thought processes of the children's communities (UNICEF 1990c: 171).

Basic education, where it is imparted to children through primary education or to adults through literacy classes and continuing non-formal education, of course does not establish the upper limit of the education for all initiative. At the minimum, basic education is meant to ensure that all people possess the learning tools which are necessary to give them a fair start in life. Basic education must be relevant to the local and immediate environment, but it need not to preclude relevance in the longer term to a changing environment. At the same time, what constitutes the learning minimum will be raised incrementally as learning spreads and as budgetary constraints are eased. Finally, for many individuals, the learning minimum will serve as a foundation for continued and self-sustained learning at higher levels (UNICEF 1990c: 155).

Table 5.2
Government Expenditure on Education (1987)

Country	% of Total Expenditure			% of Education Expenditure		
	Defense	Health	Education	Primary	Secondary	Tertiary
Angola	34	6	15	—	—	—
Burundi	16	4	16	—	—	—
Ethiopia	36	5	15	53	28	13
Kenya	8	5	19	62	17	13
Madagascar	10	5	17	—	—	—
Malawi	7	7	11	47	13	21
Mozambique	35	5	10	—	—	—
Somalia	12	1	1	—	—	—
Tanzania	16	6	8	59	23	14
Uganda	26	2	15	20	61	13
Zimbabwe	14	6	20	56	29	9

Primary Education

As Universal Child Immunization was the focal goal for health in the 1990s, attracting a critical mass of interest and resources and spawning achievements in the set of goals clustered around it, so primary education will be the "cutting edge" in the education for all initiative (UNICEF 1990c: 155). This is because primary education is the chief means to meeting the learning needs of children in their formative years; it provides a foundation for further life-long learning; it offers the best long-term strategy for eliminating illiteracy; and, insofar as it fails or succeeds, it determines whether youths and adults will proceed to higher education and employment or else to alternative, equivalent programmes in literacy, technical or managerial training. It has been clearly demonstrated that a completed primary education has a positive effect on poverty alleviation and economic and social development. In brief, a country cannot have a strong educational system or a well-managed economy if its primary education is weak.

A divisive issue in African primary education concerns the trade-off between access and quality. This trade-off appears to be unavoidable at least in the short-term, while extreme resource scarcities continue to determine the limits of possibility. A refusal to choose between quality and access means, in effect, that the quality of education will continue to decline as school systems with fixed operating budgets continue to enroll greater numbers of students. Greater numbers of students will achieve lesser levels of

Table 5.3
Repeaters by Grade (%)

Country	Year	1		2		3		4		5		6	
		T	F	T	F	T	F	T	F	T	F	T	F
Burundi	1984	12	12	13	13	10	10	16	17	22	24	27	30
Ethiopia	1981	17	19	11	13	9	10	8	10	8	10	9	12
Kenya	1981	15	14	13	12	11	11	12	13	13	13	15	16
Malawi	1984	17	17	16	16	13	13	9	10	4	4	11	12
Mozambique	1985	24	24	24	25	22	23	23	25				
Rwanda	1985	18	18	13	12	12	11	11	10	9	8	8	8
Tanzania	1982	3	3	3	3	3	2	0	0	0	0	0	0
Uganda	1982	11	11	10	10	11	11	10	11	11	11	14	14
Zambia	1981	0	0	0	0	0	0	2	2	1	1	1	1
Zimbabwe	1984	1	1	1	1	1	1	1	0	0	0	0	0

T Total F Female

Source: UNESCO Statistical Yearbook 1987.

Table 5.4
Primary-Secondary Progression Rates in Kenya (1980-1986)

Year	Students Completing Primary Level	Students Entering Secondary Level	Progression Rate (%)
1980	351,407	112,405	39.9
1981	328,498	123,460	35.1
1982	371,525	129,602	39.5
1983	385,300	139,614	37.6
1984	452,983	150,475	39.1
1985	360,100	—	—
1986	—	163,256	45.3

Source: Kenya Ministry of Education

learning. Although political realities will not permit educators to ignore access altogether, it seems clear that the short-term emphasis in Africa must be on improving quality, for only high quality education will be useful education. Low quality, by reinforcing negative perceptions about the usefulness of education, reinforces low demand and low motivation of children and parents, particularly among disadvantaged groups.

Of course, improving quality will require significant expenditures beyond merely building classrooms and training teachers. Schools will need to have a minimum package of essential teaching and learning tools (e.g. seats and desks, blackboards and chalk, textbooks for students and teachers, exercise books and pencils, etc.). At the same time, it will be necessary to restore teachers' morale and motivation (e.g. by providing housing, in-service training, programmed materials and interactive radio instruction). There must be an effective, experiential interaction between teachers and students in the the school setting, even if it is only for three or four hours each day. Learning must be active and participatory, with students learning from their teachers and from one another.

Early childhood development, because it links naturally with primary education, will be an area of special concern to UNICEF. Language skills, intelligence, personality and social behaviour are largely determined by the age of four or five. At the same time, good health and nutrition and creative stimulation during childhood are key determinants of school progress, social responsiveness and economic productivity (UNICEF 1990c: 162). Early childhood development programmes addressing this critical period before primary education will help to make primary education more effective, improving mobilization, lessening disparities among children, reducing drop-out and repetition rates and therefore also reducing "streetism" and delinquency. In resource-poor ESA countries, such programmes will need to rely heavily on cost-effective community-based interventions, using donated labour, locally available materials and facilities and parents and para-professionals rather than full professionals. Such programmes should also be intersectoral concerns, involving not only the ministry of education but also other ministries in other social sectors. (Disadvantaged children, in particular, may need school breakfasts or lunches, micronutrient supplementation, parasite treatment and visual and auditory screening.) In fact, early childhood development programmes can be harmonious additions to existing health and nutrition activities in integrated programmes (Ibid.: 165).

Table 5.5
Dropout Rate in Ovambo Primary Schools, Namibia

Year	Standard	Number of Students	% of Sub A Cohort
1983	Sub A	43,663	100.0
1984	Sub B	27,672	61.1
1985	Std 1	24,165	55.3
1986	Std 2	23,479	53.8
1987	Std 3	19,274	44.2
1988	Std 4	18,321	41.1

Source: UNICEF Namibia 1991.

Programme Delivery

With their present lack of resources and (in many instances) lack of relevance, primary schools will not be able to provide education for all in the African setting. Target populations will not have access to the schools or they will reject them as irrelevant. Hence, to meet the Jomtien goals of universal access and universal achievement in primary education, non-formal multi-channeled delivery systems which combine flexibility and improvisation will be necessary to address the learning needs of children. Fortunately, primary education is not the exclusive province of the formal primary school system (the first channel)—alternative delivery systems are also possible and many successful examples exist. Such delivery systems include non-formal but organized schooling (the second channel) as well as any other communicative source which has the potential for educational impact (the third channel).

Formal Education: Formal education makes use of the hierarchically structured and chronologically graded educational system which is commonplace in the developed world. For most of today's children in low income countries, primary education is the only formal education which they can

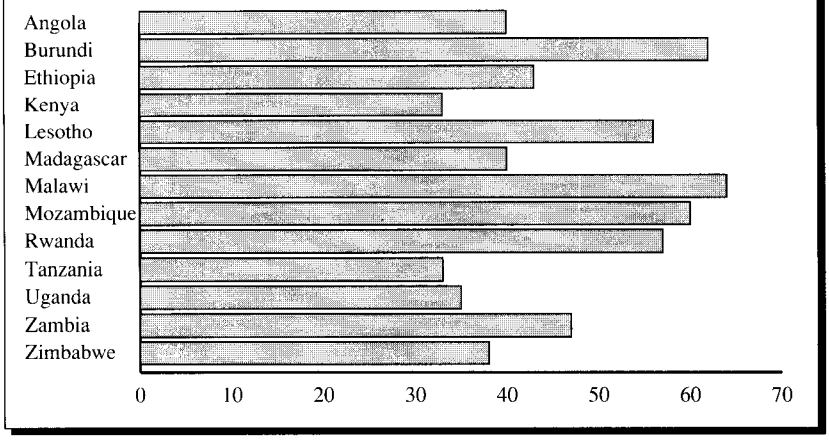
hope to achieve. Happily, the technology for constructing and running an efficient and effective primary school is widely known and available. Unhappily, formal education will not be universally available or universally accepted in Africa in the foreseeable future. There are many reasons for this pessimistic prognosis, including inaccessibility, household poverty, gender discrimination (creating disincentives for female education), demands for child labour (e.g for grazing, petty trade, child-rearing, water and firewood collection), socio-political disadvantage stemming from (e.g.) marginal language groupings or nomadic lifestyles and negative perceptions of the usefulness of literacy (e.g. for providing employment after training). Hence non-formal and informal delivery systems will become necessary.

Non-Formal Education: Non-formal education attempts to catch those children who miss the formal system. It has some structure, but unlike formal education, it is quite flexible, with its curriculum and its teaching methods oriented to the needs, interests and problems of the learners. Non-formal education may cover the same subjects as formal schooling or it may cater to specialist interests (e.g. in health, nutrition, economic activity or self-government) of particular sub-groups (e.g. farmers, craftsman, entrepreneurs).

The most highly prized virtue of non-formal education is its flexibility. Non-formal education will admit students of all ages and provide instruction at unusual times and in unusual (but convenient) places, employing creative teaching methodologies and evaluative exercises (e.g. both routinely and on request). It can also create a curriculum which is tailored to the needs of the learners, thereby ensuring relevancy to their lives. Hence, non-formal education can be targeted on precisely those people who are most likely to miss the formal education system: school drop-outs, adults (especially women), street children, working children and other disadvantaged groups. At the same time, by using local resources and local teaching abilities (e.g. from teachers, volunteers and government officials), non-formal education generally involves lower unit costs.

To exploit fully the potential for non-formal education, it will be necessary to train primary school teachers and other resource people in the community in a different approach to teaching. The community, which is the natural setting for non-formal education, may need improvements such as libraries, resource centres and electrification (e.g. with bio-gas or solar energy). To impart a sense of ownership and ensure high levels of participation, the curriculum and supporting

Figure 5.3
Pupil/Teacher Ratio at the Primary Level



educational materials must be developed with the community's participation and must reflect their priorities and interests (even if this implies a high degree of non-standardization). The non-formal educational system must maintain an action-oriented and intersectoral approach to preserve its strength and attractiveness, but at the same time, it should facilitate entry into formal education—which is not its competitor but its complement—for those learners who have the ability and the inclination. (Bangladesh; Colombia)

Informal Education (The Third Channel): The "third channel" refers to all possible instruments for communicating knowledge and information which will help people to live fuller and healthier lives. What people learn through their daily experiences and interactions with their social and economic environments is learned through the third channel. For the pre-schooler, learning from his mother's activities, it is experientially the first means to learning. For the adult, attending her church or mosque, imitating a role-model, visiting a library, reading a newspaper or listening to the radio, joining a self-help group

Figure 5.4
Children Completing Primary Level (% of First Grade)

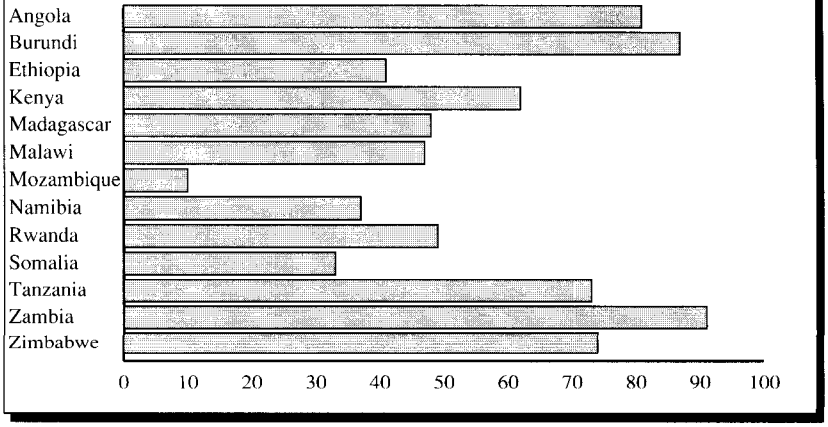


Table 5.6
The Media in Eastern and Southern Africa (1988)

	Newspapers*	Radios+	Televisions+
Angola	—	50	6
Burundi	4	56	—
Ethiopia	1	193	2
Kenya	—	91	6
Madagascar	6	196	9
Malawi	3	242	—
Mozambique	5	39	1
Namibia	10	125	11
Rwanda	—	57	—
Somalia	—	40	—
Tanzania	7	20	1
Uganda	—	99	6
Zambia	11	74	15
Zimbabwe	26	85	22

* Circulation per 1,000 people
\+ Per 1,000 people

or a service club, or taking part in a cultural tradition (whether it be song, dance or drama), it may be the most important—and often the only—source of life-long education.

The third channel has several advantages over formal and non-formal education. In harnessing the immense power of the radio and the newspaper and other mass media, informal education can be more cost-effective and it can have a more extensive outreach, continuing at all times and in all places to contact people of all ages. It is more likely to reach those groups which will be marginalized by the first two channels (especially women and children in especially difficult circumstances). Although it is often passive, it can be made active through imaginative and intelligent programming. Moreover, the third channel can be used both to impart educational material directly and to mobilize people to participate in primary education.

Universal access to primary education is a meaningful goal only if it includes universal achievement

While education through the third channel is already a common phenomenon, more can be done to exploit the third channel to its full potential. This includes both identifying community needs and interests and alerting media employees (e.g. print and radio journalists) to their educational role. Essential information must be identified and packaged for promulgation through the third channel in a manner which is both instructive and entertaining. In many instances, this will require additional training and instruction for persons working within the third channel.

Table 5.7
Public Current Expenditure per student in sub-Saharan Africa (U.S.$)

Year	Primary Level	Secondary Level	Tertiary Level
1970	27	195	1705
1975	49	251	2469
1980	70	296	3521
1987	54	195	2043

Source: UNESCO 1990: 25.

Learning Achievement

The Jomtien education goals for the year 2000 include universal access to primary education as well as significant increases in adult literacy and numeracy rates. Universal access to primary education is a meaningful goal only if it includes universal achievement: that is, only if a large majority (e.g. 80%) of children by the age of 11 or 12 achieve a basic level of literacy, numeracy and life skills (UNICEF 1990c: 156). Jomtien seeks not only increased access, but also relevancy, higher quality, improved efficiency and raised achievement. Hence if we are to monitor our progress towards achieving the Jomtien goals, we need indicators which measure what children (and adults) are actually **learning**. This requires continued assessment of the performance of learners (against their peers) and of educational systems and institutions (against an objective norm). For Jomtien, the second sort of assessment is critical. Moreover, if we can measure learning, then we can also assess different learning settings for their effectiveness and efficiency in the African context. Particularly in this period of tremendous fiscal constraint, education spending must become more efficient. Unfortunately, our customary educational indicators (e.g. enrolment rates, completion rates, pupil to teacher ratios, norm-referenced National Examinations) are inadequate proxies for these purposes, because they tell us very little about students' actual achievements. There is an urgent need to overcome this obstacle.

Although learning achievement will not be measured accurately in ESA for some time, there are many easily collected indicators at least for formal education which can provide a crude picture of learning achievement in the short-term. For measuring access, these include net enrolment, attendance and completion rates for grade one as well as the number of the grade one cohort entering and completing the final year of the primary cycle and, finally, literacy and numeracy results at the end of cycle (assessed by means of school surveys or household surveys). For measuring quality, readily available indicators include repetition rates by year, dropout rates by year, the number of textbooks per subject per class

and the number of exercise books per pupil. It will be useful, for assessing efficiency, to record unit costs per student as well as gross and net enrolment rates and the average number of years taken to complete the primary cycle. Finally, achievements in formal education can be assessed, again crudely, by recording the number of students who complete the primary cycle and who pass the national section of the primary cycle exam. Wherever possible, data should of course be disaggregated to reveal (*inter alia*) male/female and rural/urban disparities.

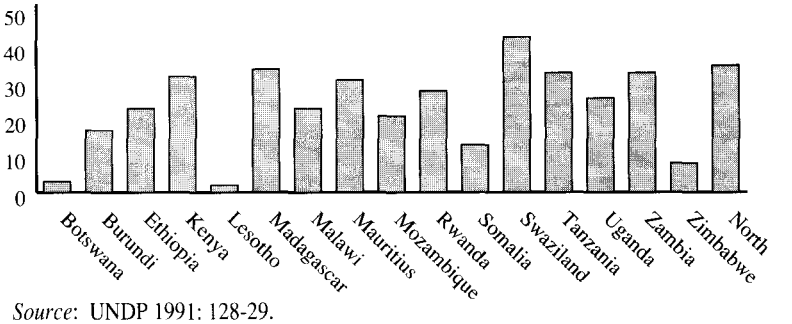
The flexibility of non-formal education, which is its strength, also makes it relatively intractable to measurement. Nonetheless, besides recording participation rates, it should be possible to measure the minimum learning achievement which will form the common core of all formal and non-formal education in a particular context. Participation and learning indicators which are crude, but easy to collect, include literacy and numeracy rates (both for children and for adults over 15), the number of literacy classes, the number of students enrolled in literacy classes, the number of students completing these classes and, finally, the unit costs per student.

Jomtien's core sponsors are developing new education indicators in a variety of areas with a view to complete revision. Indicators on participation in literacy training and in non-formal education are in the province of UNDP while UNESCO, UNICEF and the World Bank are developing technical support packages to help countries (e.g.) with sampling community needs and interests, designing examinations and devising assessment systems. Attempts to measure learning achievement with easily collected statistical indicators which will be comparable across countries are on-going but far from completion: while reading comprehension and mathematical and scientific ability may be relatively tractable to evaluation, it will remain difficult to assess students' command of essential life skills, as these will vary from region to region. Nonetheless, a thorough revision of all statistical education indicators should become available in the education decade.

UNICEF Initiatives

With its limited funds, UNICEF must exploit its comparative advantage within the Jomtien alliance to make a critical difference in education in ESA. With its institutional strength and its large field presence, UNICEF will probably have the greatest impact as a catalyst. Although emphases will vary from country to country, UNICEF priorities in the education for all initiative include (i) early childhood development, (ii) primary education (the cutting edge), (iii) non-formal education (particularly as the mother educates her child), (iv) meeting the learning needs of girls and women, (v) measuring learning achievement, (vi) capacity building and (vii) exploiting the third channel.

Figure 5.5
Science Graduates as a Percentage of Total Graduates (1986-88)



Source: UNDP 1991: 128-29.

To be effective, UNICEF will need to enhance its credibility in the education field. This will require, in the end, completing a critically-important education project effectively, efficiently, and in a timely fashion. Advertising this success will help to attract financial assistance and win political commitment which will be crucial to long-term success. For this purpose, UNICEF with its government partners must complete rigorous country-specific situation analyses from which programme responses will flow logically. The analytical work must be fresh, specific and innovative rather than dated, general and derivative (as it often has been). Conventional **and** unconventional data (e.g. from sample surveys) should be gathered with a view to eradicating discrepancies and other misinformation.

It is also necessary to understand how the various components of a country's education system interrelate and constitute a fully integrated unit. A thorough sector assessment will permit sectoral programming which connects donors (e.g. the World Bank, the EC and the bilaterals) with projects congenial to

Table 5.8
Scientists and Technicians (1980-88)

Country	(per 1,000 people)
Botswana	1.2
Kenya	2.5
Mauritius	24.3
Rwanda	0.2
Zambia	4.4
Industrial Countries	139.3

Source: UNDP 1991: 128-29.

Table 5.9
Pass Rates in Kenya's Secondary Schools 1983 (%)

Type of School	Enrolment	Pass				Fail
		Div.I	Div.2	Div.3	Div.4	
Govt maintained	48,001	8.0	22.4	33.4	25.5	10.7
Govt assisted	13,565	1.9	11.0	25.7	32.4	29.2
Unaided (Harambee)	40,133	1.2	7.1	22.8	34.2	34.7
Private candidates	6,510	0.1	8.0	8.3	47.5	43.3

Source: Kenya Ministry of Education

their interests and which will advance a whole sub-sector instead of merely one discrete portion of it. In addition, gaps in the education alliance may be made clear, giving UNICEF opportunities to channel its limited resources to projects which will have maximum effect. If we fail to understand the education cultures in ESA or if we fail to capture them fully, education programmes addressing misconceived priorities will have no real impact in Africa.

Education for all will also require an extensive mobilization of resources. Within UNICEF, education spending is projected to rise from 8-9% of total spending at present to 15% by 1995 and to 25% by 2000. To ensure that students do not lack textbooks, exercise books, and other materials needed to support the expansion and quality improvements required to achieve basic education, UNICEF estimates that the international community will need to pledge about $5 per pupil over this decade (UNICEF 1990c: 159). At the same time, reforms within ESA countries may help to improve access to education. Marginal expenses (for uniforms, books, materials) which often make formal education too costly for the poor can be eliminated or subsidized. Reducing repetition rates and making class sizes more efficient can help to achieve greater cost-effectiveness within the present school structure. Finally, government spending can be rationalized to favour primary education (with its relatively low costs and high social returns) over secondary or tertiary education (e.g. especially in Uganda).

Table 5.10
Public Recurrent Expenditure for Education in Zambia (%)

	1970	1975	1980	1985	1986
PRIMARY SCHOOLS					
Personal Emoluments	78.0	84.3	92.2	95.6	96.5
Teaching Materials	22.0	9.8	2.8	1.7	.0
General Expenses	.0	5.8	5.0	2.6	3.5
SECONDARY SCHOOLS					
Personal Emoluments	55.5	64.3	64.8	51.0	57.0
Teaching Materials	.0	5.4	4.6	8.8	.0
Boarding Costs	44.5	22.4	22.5	35.1	37.8
General Expenses	.0	7.9	8.2	5.0	5.2

Source: Kelly 1987

UNICEF will also need to renew and strengthen its partnerships with governments, NGOs, communities, the media and the private sector. A country-level EFA Task Force may be appropriate (as in Zambia). Since the emphasis on learning requires equal emphasis on enabling children to learn, education for all in Africa demands a multisectoral partnership supporting programmes which will improve children's health and nutrition as well as children's educational opportunities. UNICEF must make special efforts must to maintain strong ties with the Jomtien core sponsors UNESCO, UNDP and the World Bank. Since the Bank is projected to double its lending to education to $1.5b per annum by 1993 (with about $420m alloted for basic education), it will be a very significant partner.

Finally, UNICEF should help to promote community involvement in efforts to improve the quality and relevance of primary education (e.g. by encouraging the community to manage and monitor performance in its schools, to identify subjects and teaching methods which reflect community priorities and motivate school attendance, and to support teachers (e.g. with housing, land and (student) labour)). Integrating gender awareness as well as health and environment issues into the new curricula are obvious UNICEF concerns. In addition, UNICEF can help to produce low cost instructional materials for pupils and teachers; to rationalize the procurement of school supplies; and to provide in-service training for teachers, tutors and headmasters (focusing especially on the latter as the key managers and supervisors in primary schooling).

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