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Edited by WOLFGANG GLATZER, SUSANNE VON BELOW
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5. TOWARDS ENHANCING THE QUALITY OF LIFE IN AFRICA

Challenges, Problems, and Prospects

Patrick A. Edewor

Olubisi Onabanjo University, Ago-Iwoye, Nigeria

ABSTRACT

That some countries are rich while others are poor is a well-known fact. While people in the developed countries of Europe and North America, for example, enjoy good water, good food, good housing, clothing, medical facilities and education, those in the less developed countries of Africa suffer without these basics for a decent quality of life. Even though there are spatial inequalities within countries, in the quality of life, the disparity between the industrialized countries and those of Africa is astonishingly wide. Differences in the quality of life are explored by comparing the Gross National Income Purchasing Power Parity Per Capita, life expectancy, literacy, infant and child mortality, access to safe water, and sanitary facilities. The persistently high fertility in the face of declining mortality and the consequent high rate of natural increase in the population of the countries of Africa as well as a high dependency ratio are noted as impediments to the realization of socioeconomic development goals and enhancement of the quality of life of the people. Provision of mass education, changes in the perceived value of children, improved use of modern contraceptives, and reduced fertility amongst others are major steps towards enhancing the quality of life of Africans.

INTRODUCTION

That some countries are rich while others are poor is a well-known fact. While people in the developed countries of Europe and North America, for example, enjoy good water, good food, good housing and clothing, medical facilities and education, those in the less developed countries of Africa suffer without these basics for a decent quality of life. Even though there are spatial inequalities within countries, in the quality of life, the disparity between the industrialized countries and those of Africa is astonishingly wide. Compared with the rest of the world, Africa, particularly Sub-Saharan Africa, remains the world's poorest region with average living standards lagging behind those of other parts of the world (USAID, 2003). As at mid-2002, Africa's population stood at 840 million with Sub-Saharan Africa having a population of 693 million (PRB, 2002). Almost half of this population of Sub-Saharan Africa lives on less than 65 cents a day (USAID, 2003).

At the current annual population growth rate of 2.5 %, reaching the Millennium Development Goal (MDG) of reducing poverty levels in Sub-Saharan Africa by 50 % by 2015 will require a 7 % annual growth rate in Gross Domestic Product (GDP) (USAID, 2003). Africa continues to lag far behind the rest of the world in

investment in its people, particularly in the area of education. The region suffers from an average illiteracy rate of 41 %. With 61 % of boys and 57 % of girls enrolled in primary school, Africa is the only region of the world in which access to education has actually decreased in the last 20 years.

Using different indicators, as we shall soon see, there is ample evidence to show that Africans have very low quality of life, compared with persons from other parts of the world. The health of Africans, for example, remains unacceptable poor by any standard. Continent-wide, the rate of decrease in child mortality has declined in the past decade. For every thousand children born in Africa in 2003, 175 will die before their fifth birthday, compared with 100 in Asia and just 6 in the developed world. A woman's risk of dying from maternal causes is 1 in 15 in Africa, about 10 times higher than in Latin America and over 2000 times higher than in North America. Similarly, unlike other parts of the world, malnutrition rates are actually increasing in Africa (USAID, 2003).

The central thrust of this paper is to examine the challenges, problems and prospects on the path to enhancing the quality of life in Africa. To put the discussion in proper perspective, the paper first attempts a clarification of the concept of quality of life. Thereafter, quality of life indicators are examined and quality of life in Africa is discussed, using selected quality of life indicators. A comparative approach is adopted to bring into focus, how significantly the quality of life in Africa contrasts with those of other parts of the world. The challenges, problems, and prospects of enhancing the quality of life are then discussed before the conclusion.

QUALITY OF LIFE DEFINED

The concept of quality of life has been variously defined. For example, Mendola and Pelligrini (1979) defined quality of life as an "individual's achievement of a satisfactory social situation within the limit of perceived physical capacity". Shin and Johnson (1978) conceived quality of life as "the possession of resources necessary to satisfy individual needs, wants and desires, participation in activities enabling personal development and the satisfactory comparison between oneself and others". On the other hand, Donald (2001) sees quality of life as "a descriptive term that refers to people's emotional, social and physical well being, and their ability to function in the ordinary tasks of living".

A group of researchers (Carr et al., 2001) was interested in knowing whether quality of life is determined by expectation or experience. They observed that "expectation may have a greater impact on quality of life than experience". In their opinion, based on the findings from their study, the perception of quality of life varies between individuals and is dynamic within them. They also noted that quality of life in relation to health is the gap between one's expectation of health and his/her experience of it. Persons with different expectations report a different quality of life even when the same clinical condition is present; and current measures for quality of life do not account for expectation of health.

Quality of life measures subjective experiences. In relation to health, it is not uncommon for patients and professionals to have different perspectives on what constitutes quality of life. These different perspectives pose a difficulty in the assessment of quality of life. Some further examples of varying definitions include the following:

"A measure of the optimum energy or force that endows a person with the power to cope with the full range of challenges encountered in the real world. The term applies to individuals, regardless of illness or handicaps, on the job, at home, or in leisure activities. Quality enrichment methods can include activities that reduce boredom and allow a maximum amount of freedom in choosing and performing various tasks" (Mosby's Medical, Nursing, and Allied Health Dictionary, 1998).

"Health-related quality of life represents the functional effects of an illness and its consequent therapy upon a patient as perceived by the patient" (University of Bergen, 2000).

"Quality of life or well-being is a composite of two components: (I) the ability to perform everyday activities, which reflect physical, psychological, and social well-being; (II) patient satisfaction with levels of functioning and control of disease and/or treatment-related symptoms" (Gotay et al., 1992).

Fallowfield (1993) has argued that quality of life focuses on four main areas; (I) psychological, including anxiety and depression as well as adjustment to illness; (II) social, including social relationships and intimate relationships; (III) occupational; and (IV) physical.

It is important to emphasize that what constitutes the quality of life is, in the final analysis, subjective: It has no right or wrong answer. Perceptions of quality of life may differ among individuals and may vary from place to place with differences in culture and societies. However, although everyone has a different perception of quality of life – a perception which is dynamic, the desire for a better quality of life is what makes us human. Quality of life is what makes us happy. The conventional measure of quality of life is defined in material and quantitative terms, for example, Gross Domestic Product (GDP). This conventional measure has some limitations. These derive from the realization that there is a cost/limit to extreme materialism: (I) destruction of nature; and (II) the fact that human fulfillment goes beyond materialistic needs. A perennial perspective is that there are three facets of quality of life for complete human fulfillment: material, intellectual and spiritual. An ideal measure of quality of life should be dynamic in the sense that it should be indicative of potential development. In addition, it should be accommodative of changing human perceptions of development. It should also take into account, major driving forces of change such as information and communication technologies (Shariffadeen, 2000).

QUALITY OF LIFE INDICATORS

We need some measures to compare differences in quality of life among countries. Evidently, it takes wealth to acquire some of the things needed for a high quality of life, such as good food, housing, and education. The most commonly used measure of a country's wealth is Gross National Product (GNP) per capita. Usually, the higher a country's GNP per capita, the better its quality of life. But owing to the fact that money has different purchasing power in different countries, GNP values are converted to a common value as if there was a common international currency. This is called Purchasing Power Parity (PPP), meaning that all money has the same purchasing power. We can then explore differences in quality of life among countries by comparing GNP PPP per capita.

However, other indicators such as infant and child mortality, availability of medical services and sanitary facilities, prevalence of child malnutrition, life expectancy, literacy and access to safe water may be equally or even more important. In

addition to GNP PPP per capita, these indicators are examined to determine the quality of life in African countries and to compare them with those of the developed countries of the world, thereby bringing into sharp focus how significantly poorer the quality of life is in Africa. Table 1 (see below) shows these quality of life indicators for African countries and some selected developed countries.

QUALITY OF LIFE IN AFRICA

In discussing the quality of life in Africa, we wish to examine the infant mortality rate, the prevalence of child malnutrition, as well as child mortality and life expectancy at birth. In addition, other quality of life indicators discussed include access to sanitation, access to safe water, adult literacy as well as Gross National Income Purchasing Power Parity per capita (GNI PPP per capita).

Infant mortality is becoming widely accepted as the most objective criterion for assessing the overall quality of life across highly diverse societies and cultures (Brockerhoff & Brennan, 1997). Whereas infant mortality is as high as 86 per 1,000 live births in Africa, it is only 6 and 8 per 1,000 live births in North America and Europe respectively. Apart from Reunion, Seychelles, and Mauritius which have achieved low infant mortality rates (8, 10 and 13.7 deaths per 1,000 live births respectively) and Tunisia, Libya, Cape Verde, Egypt and South Africa that have somewhat averagely low infant mortality rates (26, 30, 31, 44 and 45 respectively), others have infant mortality rates of at least 50 deaths per 1000 live births. Infant mortality rates are highest in Sierra Leone (153), Western Sahara (140), Liberia (139) and Mozambique (135 deaths per 1000 live births) (see Table 1). The generally high level of infant mortality in African countries is indicative of the low quality of life in these countries.

Using infant mortality as an indicator, evidence shows that quality of life declines in big and growing cities in developing countries especially those of Africa (Brockerhoff & Brennan, 1997). Infant mortality trends reveal deterioration in places that grow too big and too rapidly. Today's big cities in Africa are not keeping pace with the improvements in child survival throughout the rest of Africa. Since the 1970s, infant mortality has fallen precipitously in towns and villages, with declines ranging from about 14 % in Sub-Saharan Africa to more than 50 % in North Africa and the Middle East. In contrast, the largest cities of Sub-Saharan Africa have experienced less than 5 % decline in infant mortality. Indeed, infant mortality has risen from 73 to 90 deaths per 1,000 live births in cities of tropical Africa containing 50,000 to 1 million people. A similar trend has been observed in countries of North Africa and the Middle East: infant mortality declines much more slowly in the largest cities than in the rural settlements. Consequently, infant mortality rates registered by big cities and small settlements have converged.

The slower decline in infant mortality in big cities is accompanied by low investment in social services for children as well as adults, with big cities having lower rates of school enrollment, poor health care, inadequate nutrition, and other deprivations as compared to smaller settlements. All these reflect less improvement in the overall well-being in big cities. Ironically, the cities are the areas in which high incomes and publicly financed services are presumably concentrated. The poor social conditions of the cities may be connected with the overwhelming effect of

migration inflows and persistent high fertility rates, which have strained the carrying capacity of the cities.

Child malnutrition is prevalent in Africa. Whereas only 1 % of children under 5 years suffer from malnutrition in United States, 33 % of children under 5 years suffer from malnutrition in Sub-Saharan Africa. Of the 44 African countries for which we have data on child malnutrition, only 11 (25 %) have child malnutrition prevalence rates of less than 20 %, mostly in Northern Africa. Prevalence of child malnutrition is as high as 50 % in Niger, 48 % in Ethiopia, and between 35 and 44 % in Nigeria, Burundi, Eritrea, Madagascar, Angola, and Chad. The high prevalence of child malnutrition in Africa is associated with the level of poverty in the region. Northern African countries and countries like Mauritius, Zimbabwe, Gabon and South Africa with relatively lower prevalence rates of child malnutrition have higher Gross National Income Purchasing Power Parity per capita relative to other African countries and child malnutrition is virtually non-existent in the countries of North America and Europe which are much richer.

Whereas the child mortality rate is as low as 7 per 1,000 live births in Canada, 5 in Sweden, 6 in Germany and Italy, and 5 in Switzerland and Spain, Sub-Saharan Africa had a child mortality rate of 151 per 1,000 live births in 1998. USAID (2003) actually reports 175 per 1,000 live births in 2003. While child mortality rates range between 32 per 1,000 live births (Tunisia) and 61 per 1,000 live births (Morocco) in North Africa, Sub-Saharan Africa records much higher child mortality rates with Sierra Leone, Niger, Malawi, Mali, Mozambique, Burkina Faso, Rwanda, and Angola recording over 200 deaths per 1,000 live births, particularly Sierra Leone and Niger in which more than a quarter or as much as a quarter of the children born die before their fifth birthday.

Life expectancy at birth is still low in Africa. Whereas it is 74 years and 80 years for male and female respectively in North America and 70 years and 78 years for male and female respectively in Europe, it is 52 and 54 years respectively in Africa (49 and 50 years respectively in Sub-Saharan Africa) (PRB, 2002). Sub-Saharan Africa's average life expectancy reported by UNAIDS (2002) is 47 years. North Africa records relatively higher life expectancy than Sub-Saharan Africa, with Libya and Tunisia recording life expectancy of over 70 years. Compared with other countries in Sub-Saharan Africa, Reunion, Mauritius and Seychelles (in Eastern Africa) and Cape Verde (in Western Africa) also record relatively higher life expectancy.

Table 1: *Quality of Life in Africa and Selected Developed Countries*

	IMR	CM5	MR5	LEB		AS	AW	AIR		GNI PPP
				♂	♀			♂	♀	
<i>Africa</i>	86	-	-	52	54	-	-	-	-	1,960
<i>Sub-Saharan Africa</i>	91	33	151	49	50	37	45	32	49	1,540
<i>Northern Africa</i>	55	-	-	64	68	-	-	-	-	3,500
Algeria	54	13	40	68	71	-	-	24	46	5,040
Egypt	44	12	59	65	68	11	64	35	58	3,670
Libya	30	5	-	73	77	-	90	-	-	-
Morocco	50	10	61	67	71	40	52	40	66	3,450
Sudan	82	34	-	55	57	22	50	-	-	1,520
Tunisia	26	9	32	70	74	-	-	21	42	6,070
Western Sahara	140	-	-	-	-	-	-	-	-	-
<i>Western Africa</i>	87	-	-	50	51	-	-	-	-	1,030
Benin	85	29	140	53	56	20	50	46	77	980
Burkina Faso	105	33	210	46	47	18	78	68	87	970
Cape Verde	31	-	-	66	72	-	-	-	-	4,760
Côte d'Ivoire	95	21	143	44	47	54	72	47	64	1,500
Gambia	82	17	-	51	55	37	76	-	-	1,620
Ghana	56	27	96	56	59	27	56	22	40	1,910
Guinea	119	24	184	47	48	70	62	-	-	710
Liberia	139	-	-	49	52	-	-	-	-	-
Mali	113	27	218	46	48	31	37	54	69	780
Mauritania	74	23	140	53	55	-	-	48	69	1,630
Niger	123	50	250	45	46	15	53	78	93	740
Nigeria	75	39	119	52	52	36	39	30	48	800
Senegal	68	22	121	52	55	58	50	55	74	1,480
Sierra Leone	153	29	283	38	40	11	34	-	-	480
Togo	80	25	144	53	57	22	-	28	62	1,410
<i>Eastern Africa</i>	97	-	-	47	48	-	-	-	-	880
Burundi	116	38	196	40	41	-	-	45	63	580

Table 1: *Quality of Life in Africa and Selected Developed Countries (continued)*

	IMR	CM5	MR5	LEB		AS	AW	AIR		GNI PPP
				♂	♀			♂	♀	
Comoros	86	-	-	54	59	-	-	-	-	1,590
Djibouti	117	-	-	42	44	-	-	-	-	-
Eritrea	77	44	90	53	58	-	-	34	62	690
Ethiopia	97	48	173	51	53	10	17	58	70	660
Kenya	74	23	124	47	49	77	53	12	27	1,010
Madagascar	96	40	146	53	57	3	29	28	42	820
Malawi	104	30	229	37	38	53	45	27	56	600
Mauritius	13.7	15	-	68	75	100	98	-	-	9,940
Mayotte	75	-	-	57	62	-	-	-	-	-
Mozambique	135	26	213	38	37	21	32	42	73	800
Réunion	8	-	-	70	79	-	-	-	-	-
Rwanda	10	29	205	39	40	-	-	29	43	930
Seychelles	10	-	-	67	73	-	-	-	-	-
Somalia	126	-	-	45	48	-	-	-	-	-
Tanzania	99	31	136	51	53	86	49	17	36	520
Uganda	88	26	170	42	44	57	34	24	46	1,210
Zambia	95	24	192	37	37	23	43	16	31	750
<i>Middle Africa</i>	100	-	-	48	51	-	-	-	-	1,000
Angola	122	35	204	44	47	16	32	-	-	1,180
Cameroon	77	22	150	54	56	40	41	20	33	1,590
Central African Republic	98	23	162	42	46	-	18	43	68	1,160
Chad	103	39	172	49	53	21	24	51	69	870
Congo	72	24	143	49	53	9	47	14	29	570
Democratic Republic of Congo	102	34	141	47	51	-	-	9	53	680
Equatorial Guinea	108	-	-	49	53	-	-	-	-	5,600
Gabon	57	15	-	49	51	76	67	-	-	5,360
São Tomé and Príncipe	50	-	-	64	67	-	-	-	-	-

Table 1: *Quality of Life in Africa and Selected Developed Countries (continued)*

	IMR	CM5	MR5	LEB		AS	AW	AIR		GNI PPP
				♂	♀			♂	♀	
<i>Southern Africa</i>	51		-	50	51	-	-	-	-	8,610
Botswana	60	27	105	39	40	55	70	27	22	7,170
Lesotho	84	16	144	50	52	6	52	29	7	2,590
South Africa	45	9	83	50	52	46	70	15	16	9,160
Swaziland	109	-	-	40	41	-	-	-	-	4,600
<i>North America</i>	6	-		74	80		-	-	-	33,410
Canada	5.3	-	7	76	81	85	100	-	-	27,170
USA	6.6	1	-	74	80	85	90	-	-	34,100
<i>Europe</i>	8	-	-	70	78	-	-	-	-	16,150
Sweden	3.4	-	5	77	82	100	-	-	-	23,970
Germany	4.4	-	6	75	81	100	-	-	-	24,920
<i>World</i>	54	30	75	65	69	47	78	18	32	7,140
<i>Developed Countries</i>	7	-	-	72	79	-	-	-	-	22,060
<i>Less Developed Countries</i>	60	-	-	63	67	-	-	-	-	3,580

Sources: PRB (2002), World Bank (1998), World Bank (2000/2001). IMR=infant mortality rate; CM5=prevalence of child malnutrition in % of children under 5 (1992-98); MR5=mortality rate under age 5 per 1,000 (1998); LEB=life expectancy at birth in years (2002); AS=access to sanitation in % of population (1995); AW=access to safe water in % of population (1995); AIR=adult illiteracy rate in % of population aged 15 and older (1998); GNI PPP=income in purchasing power parities per capita in US\$ (2000).

A major factor that has contributed to the low life expectancy in Africa is the emergence of AIDS. The average life expectancy which is presently 47 years in Sub-Saharan Africa would have been 64 years without AIDS (UNAIDS Report, 2002). In Botswana, life expectancy has dropped to the level of 1950 due to AIDS. At the end of 2001, as much 38.8 % of the population aged 15 to 49 years in this country were with HIV/AIDS. The corresponding figures for Zimbabwe, Swaziland, Lesotho, Namibia, Zambia and South Africa were 33.7 %, 33.4 %, 31.0 %, 22.5 %, 21.5 % and 20.1 % respectively. The HIV/AIDS seropositive prevalence rates in these countries are devastatingly high. Consequently, life expectancy in these countries has declined to very low levels.

Unlike Europe where the populations of most of the countries have 100 % access to sanitation, the story is different in Africa. Only 37 % of the population in Sub-Saharan Africa has access to sanitation. With the exception of Mauritius, Tanzania, Kenya, Gabon and Guinea in which at least 70 % of the populations have access to

sanitation, in the majority of the other countries, less than 40 % of the populations have access to sanitation with only 3 % and 6 % of the population of Madagascar and Lesotho respectively, having access to sanitation.

Similarly, the majority of Africans has no access to safe water. Only 45 % of the population of Sub-Saharan Africa has access to safe water. Aside from Mauritius and Libya in which 98 % and 90 % of the population enjoy access to safe water respectively, in the majority of the other countries, access to safe water is very low with Ethiopia, Central African Republic, Guinea-Bissau, and Chad recording as low as 17 %, 18 %, 23 % and 24 % respectively. The generally low level of access to sanitation and safe water has serious implications for health and well-being of Africans especially when one considers the fact that most tropical diseases are water-borne.

Illiteracy is still as high as 41 % in the African region. Adult illiteracy rate in Sub-Saharan Africa is 32 % for male and 49 % for female. Niger has adult illiteracy rate of 78 % and 93 % for male and female respectively; Burkina Faso, 68 % and 87 % respectively; Ethiopia, 58 % and 70 % respectively; Benin, 46 % and 77 % respectively; and Mozambique, 42 % and 73 % respectively. However, Southern African countries have somewhat lower rates of illiteracy than the rest of the sub-regions in Africa with rates for females which are unusually lower than those for male in Botswana and Lesotho or about equal in Namibia and South Africa. With respect to literacy, the scenario in Africa contrasts sharply with that in Eastern Europe and Southern Europe where illiteracy is virtually non-existent.

Given the fact that it takes wealth to acquire some of the things needed for high quality of life such as good food, housing, and education, let us examine the Gross National Income in Purchasing Power Parity (GNI PPP) per capita in the African region. GNI PPP refers Gross National Income converted to "international" dollars using a purchasing power parity conversion factor. International dollars indicate the amount of goods and services one could buy in the United States with a given amount of money (PRB, 2002). Africa remains the poorest of all the regions of the world. While GNI PPP per capita is US\$ 33,410 in North America and US\$ 16,150 in Europe, it is only US\$ 1,960 in Africa and US\$ 1,540 in Sub-Saharan Africa. GNI PPP per capita is highest in Southern Africa (US\$ 8,610) and lowest in Eastern Africa (US\$ 880) with Western Africa and Middle Africa having about the same (US\$ 1,030 and US\$ 1,000 respectively). Mauritius has the highest GNI PPP per capita (US\$ 9,940), followed by South Africa (US\$ 9,160), Botswana (US\$ 7,170), Namibia (US\$ 6,410) and Tunisia (US\$ 6,070). GNI PPP per capita is US\$ 800 or less in Guinea-Bissau, Mali, Niger, Nigeria, Sierra Leone, Burundi, Ethiopia, Malawi, Mozambique, Tanzania, Zambia, Congo, and Democratic Republic of Congo. These show the extent of poverty in Africa.

ENHANCING THE QUALITY OF LIFE: PROBLEMS AND PROSPECTS

How can the quality of life be enhanced in Africa? What are the problems on the path to enhancing the quality of life? What are the future prospects? To enhance the quality of life, the challenges for quality of life as discussed in the preceding section must be addressed. In other words, infant and child mortality as well as child malnutrition have to be reduced. It goes without saying that a reduction in mortality rates

would automatically increase life expectancy at birth. By the same token, access to sanitation and safe water, literacy and GNI PPP per capita must increase.

To reduce infant and child mortality, there is the need to improve the existing services for the reduction of infant and child mortality. Efforts should be made to ensure increased utilization and coverage of such services. One of the major reasons why fertility is high in Africa is high infant and child mortality. It follows that parents will be more willing to have fewer children if infant and child mortality are reduced. It has been established that infant mortality declines less rapidly in the cities owing to the overwhelming effect of migration inflows and persistently high fertility, which strain the carrying capacity of African cities.

Evidence shows that compared to cities that have grown less than 3 % a year, cities that have grown at rates of more than 5 % annually have higher infant mortality levels, higher by 24 % in countries of North Africa and Asia, 28 % in Latin America, and 42 % in Sub-Saharan Africa (Brockerhoff & Brennan, 1997). These results imply a need for continued efforts to reduce the pace of city growth in African countries.

Life expectancy at birth would increase with a decline in infant and child mortality rates. However, for there to be any appreciable increase in life expectancy, aside from reducing infant and child mortality, the AIDS pandemic has to be effectively controlled. In less than two decades, HIV/AIDS has become a development disaster: Infection rates in Africa have reached alarming proportions, with Botswana (38.8 %), Swaziland (34.4 %) and Lesotho (31.0 %), in Southern Africa as well as Zimbabwe (33.7 %), in Eastern Africa, being the worst affected (UNESCO, 2001; PRB, 2002). These figures represent the prevalence rates among populations aged 15-49 years in these countries.

HIV/AIDS is having negative impact on households, agriculture, firms, education and many other sectors. Women contribute to over 50 % of the food production in Sub-Saharan Africa. Food shortages and malnutrition is one of the consequences of female-headed AIDS affected households. Owing to the fact that the vast majority of people living with HIV/AIDS are between the age of 15 and 49 in the prime of their working life, the epidemic hits productivity mainly through increased absenteeism. Funeral costs are provided by a number of employers and these are rising sharply. As it relates to education, evidence shows that infection and death rates are high among the skilled, trained and educated, draining countries of their intellectual resources and the groups most vital for development. Up to 10 % of teachers are expected to die of AIDS in the worst affected African countries over the next five years (UNESCO, 2001). Without the control of HIV/AIDS, an increase in life expectancy will remain an illusion. Uganda was the first country in Sub-Saharan Africa to curb the spread of HIV with a very comprehensive HIV/AIDS program including awareness and promotion of safer sexual behavior. The rest of Africa, particularly Southern Africa, should emulate Uganda by intensifying efforts or embarking on very vigorous and aggressive HIV/AIDS awareness programs and also promote safer sexual behavior.

Improvement in access to sanitation and safe water does not yet occupy top positions in the development agenda of African countries and these are inevitable in the enhancement of quality of life. Countries like Madagascar and Lesotho in which access to sanitation is extremely low should make this a top priority. The same ap-

plies to Ethiopia, Central African Republic, Guinea-Bissau and Chad in which access to safe water is extremely low.

Given the important role of education in the developmental process, it is disturbing to know that Africa is the only region in the world in which access to education has actually decreased in the last 20 years. It is even more worrisome to know that AIDS is further exacerbating the situation by reducing the supply of experienced teachers by AIDS-related illness and death (Bollinger et al., 1999), causing children to be kept out of school because they are needed at home to care for sick family members or to work on the farm to augment household income or drop out of school because their families can not afford school fees due to reduced household income as a result of AIDS death (*ibid.*). One way to curb the decreasing access to education, therefore, is through curbing AIDS.

CONCLUSION

Continued high population growth rates in Africa undermine the best efforts to improve the quality of life. Although fertility rates continue to decline in some countries, particularly those with relatively higher incomes, fertility rates are still high in most African countries. Consequently, the annual population growth rate is still 2.5 %, the highest in the world. Owing to the high birth rates, the age structure of the populations in Africa is such that there is a preponderance of young persons and consequently, a high dependency ratio, which serves as an impediment to the realization of socioeconomic development goals and enhancement of the quality of life of the people. Contraceptive prevalence rates remain under 15 % in Sub-Saharan Africa, even though the majority of women say they desire fewer children. Even with the devastating effects of the HIV/AIDS pandemic, the population of Sub-Saharan Africa is likely to increase from 693 million at present to about one billion in 2020, further straining the social infrastructure. Provision of mass education, changes in the perceived value of children and improved use of modern contraceptives and reduced fertility, improved access to sanitation and safe water as well as reduction in infant and child mortality are major steps towards enhancing the quality of life of Africans.

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