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SECOND MEETING OF THE SPECIALISED TECHNICAL COMMITTEE ON HEALTH POPULATION AND DRUG CONTROL (STC-HPDC-2)
ADDIS ABABA, ETHIOPIA
20-24 MARCH 2017

STC/EXP/HPDC/2

THEME:- ***"*Youth, Health and Development: Overcoming the Challenges towards harnessing the Demographic Dividend*"***

Paper on the theme «Youth, Health and Development: Overcoming the Challenges towards harnessing the Demographic Dividend » of the Second Meeting of the African Union Specialized Technical Committee on Health, Population and Drug Control, Addis Ababa, Ethiopia, 20-24 March 2017

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Introduction

1. Africa is the world's most youthful continent and home to 226 million people aged 15 to 24 (UN, 2015)[1]. By 2045, this population is expected to double and Africa will be home to 1 in 5 of the world's youth. The rising youth population has incredible potential – they are increasingly better educated then youth cohorts in the past, and there is unprecedented opportunity for economic development and social cohesion if the talents of the youth can be harnessed.

2. The AU Heads of State and Government devoted the 2017 theme of the year on ***"Harnessing the Demographic Dividend through Investments in Youth***". The theme is accompanied by a roadmap with key deliverables and milestones that would guide Member States and Regional Economic Communities (RECs) on concrete actions to be undertaken in 2017 and beyond. The decision of the Heads of State and Government comes at a critical time as the investments made in the youth will have a telling impact on the nature of implementation and success of the Agenda 2063 and 2030 Agenda for Sustainable Development.

3. The 2017 AU Roadmap on "***Harnessing the Demographic Dividend through Investments in Youth"*** focuses on the four key pillars of the demographic dividend: Health and Wellbeing; Employment and Entrepreneurship; Education and Skills Development and Empowerment and Governance with an aim to create an enabling environment for the youth of Africa to have a sustainable future.

4. The theme of the Second Meeting of the Specialized Technical Committee on Health, Population and Drug Control, on «Youth, Health and Development: Overcoming the Challenges towards harnessing the Demographic Dividend » is developed cognizant of the theme of the year and the role the STC-HPDC-2 plays towards realizing the continental initiatives called upon to reap Africa's demographic divided.

5. It should also be recalled that during the last STC-HPDC-1 in April 2015, Ministers emphasized the need for the inclusion of the demographic dividend for Africa's transformation and inclusive development, mindful of its cross cutting nature. To that effect, the Meeting of Experts of the AU Specialized Technical Committee on Health, Population and Drug Control should ensure that key health, population and drug control related challenges are outlined and a concrete way forward recommended regarding interventions and investments needed for the implementation of the 2017 AU Roadmap at national and regional levels.

[1] Population Facts. No 2015/1. UNDESA, 2015

Opinions of Young People

6. Young people are acquiring university education at a much younger age, by the average age of 25 years those seeking university education would have acquired at least a first degree, most of whom would have received education from a government institution.
7. Anecdotal reports suggest that while the education received by the majority prepared them for their employment, a significant number needed to receive retraining to acquire the skills needed to be fit -for -purpose for the job market. Further more it is suggested that of those who do get jobs, less than the majority, feel that they are contributing to national development. Many further suggest that given the opportunity they would have made different educational choices in order to be fit -for -purpose and be better prepared for the job market.
8. With regards to health and the Sexual Reproductive Health(SRH) of Young People in particular, young people suggest that while they do receive information while in school, only about half of them would discuss their sexual and reproductive health concerns with their parents and of these with their mother or sibling in particular. The other half rely on the internet, media and friends for information land guidance as to how to address their SRH concerns. A significant number of these turned to the internet or social media for their primary SRH information Majority feel that comprehensive access to sexual education and services was important to allow them to make the right choices, and that it is government responsibility through education to provide this education.

2017 AU Road Map

9. Under the health and wellbeing pillar of the 2017 AU Roadmap, the following key investments are deemed necessary to achieve Africa's development goals;

    - Access to sexual and reproductive health and rights;
    - Prevention of infectious diseases, immunization, improving nutrition and strengthening interventions around the neonatal period;
    - Access to family planning services;
    - Reduction of maternal and child mortality;
    - Reduction of the prevalence of sexually transmitted infections;
    - Changing the socio-cultural practices that inhibit access to health and wellbeing, particularly harmful practices such as child marriage and female genital mutilation (FGM).

10. The realization of Africa's development goals calls for systematic and strategic investments in health in order to facilitate harnessing of the demographic dividend. It also requires a change in socio-cultural norms, including with regard to the roles and responsibilities of women and men, boys and girls.

Socio-cultural norms

11. There are a number of interlocking social and cultural factors, reinforced by restrictive laws and policies, which can impede access to services and information. **Young** people who are most vulnerable to sexual and reproductive ill health are often those who are denied access to SRH services. Young people face many significant sexual reproductive health challenges such as limited access to youth friendly services including information on growth, sexuality and family planning. This has led youth into risky sexual behaviors resulting to high STI and HIV prevalence, early pregnancy and vulnerability to delivery complications resulting in high rates of death and disability

12. Socio-cultural factors underpin negative gender inequities in the home and wider community, leading to disparities in access to, and quality of health, educational, financial and other services. Traditional practices such as early, forced and child marriages contributing to teenage pregnancy, maternal mortality, obstetric fistula, etc. on the continent. Unmarried adolescent girls are routinely denied or have limited access to SRH services even though they are vulnerable to violence and sexual abuse, and the consequences of early sexual experiences including unwanted pregnancy and STIs.

13. Societal gender norms tend to make **young** women and **young** girls in particular passive, – making them vulnerable in different ways to SRH problems, and inhibiting access to services. **Young** women who are financially, materially or socially dependent on men may have limited power to exercise control in relationships, such as negotiating the use of condoms during sex. Social expectations about how young women women should behave can place young women in subordinate roles and increase their risk of being sexually assaulted, contracting STIs and having unwanted pregnancies, and also limit their access to SRH services.

14. Cultural practices contribute to the utilization level of sexual reproductive health services in societies. Child marriage and gender disparities are among the social-cultural barriers to SRH rights. There is a need of integrating youth friendly services in health facilities and advocate for behavior change at community level. Furthermore, health facilities that do not have skilled service providers on sexual reproductive health rights, privacy, confidentiality, equipments and that have negative attitudes from service providers discourage youth participation in SRHR services. In addition, accountability mechanisms need to be put in place to ensure an acceptable quality of services.

Investments for the way forward to harnesses the Demographic Dividend

15. Integrating reproductive health, family planning and STI/HIV prevention and treatment services is critical for achieving universal access to health care services. Integration requires that health care workers can provide an appropriate comprehensive package of services. Linking STI/HIV with SRH services improves access to HIV/STI services for young women who might otherwise not visit them because of issues of stigma. It also improves access to reproductive health services for people living with HIV and AIDS.

16. Integrating services into mainstream existing primary health care facilities makes them more accessible for non-traditional users of family planning services such as men and adolescents. Additionally, incorporating SRH services into public facilities provides greater

potential for scaling up services and maintaining them on a long-term basis as networks are already in place across countries. Successful integration necessitates political commitment towards providing a comprehensive package of primary health care services and technical and financial support towards achieving this. Many attempts to integrate SRH services have encountered problems at the programme and service level. These include difficulties in: allocating and coordinating responsibilities; ensuring effective communication between staff in programmes and training staff with appropriate skills to meet a broader range of demands.

17. Many **young** Africans are unable to access mainstream SRH services or programmes for reasons of poverty, language, disability and geographical inaccessibility; or are denied access because of stigma, discrimination or restrictive laws and policies. Overcoming inequalities in access requires that the SRH needs of marginalized people are identified, and interventions are targeted towards meeting their needs in a culturally considerate manner.

18. Identifying groups that have unmet needs for SRH services can be difficult because there are often a number of simultaneous factors that prevent access. Also, targeting services towards specific groups can be difficult because people may not identify themselves as belonging to these groups. Actively involving marginalized groups in decision making processes at all levels, and providing them with the opportunity to hold service providers and policy makers accountable for discriminatory practices, corruption or poor quality services, helps to redress inequalities in access to SRH services and ensure that they are acceptable and appropriate. Representation in the planning processes for SRH services of marginalized groups including adolescents, the elderly and the very poor, can also strengthen participation and accountability.

19. To achieve universal access, it is essential that SRH services are affordable even for the poorest people in societies. Developing partnerships between government agencies, the private sector and non-governmental organizations through public-private partnerships or contracts can help sustain facilities and improve access for all.

Growing drug use among the youth as an impediment to harnessing the demographic dividend

20. Youth, by its very nature and essence, has a propensity to experiment, to discover the unknown, and to challenge established norms. 'We recognize that, while tangible progress has been achieved in some fields, the world drug problem continues to present challenges to the health, safety and well-being of all humanity, and we resolve to reinforce our national and international efforts and further increase international cooperation to face those challenges. We express deep concern at the high price paid by society and by individuals and their families as a result of the world drug problem'.[2]

21. Under Prevention of drug abuse, the UNGASS 2016 Outcome Document calls 'to take effective and practical primary prevention measures that protect people, in particular children and youth, from drug use initiation by providing them with accurate information about the risks of drug abuse, by promoting skills and

(https://documents-ddsny.un.org/doc/ UNDOC/GEN/ N16/110/24/PDF/ N1611024.pdf).[2]

opportunities to choose healthy lifestyles and develop supportive parenting and healthy social environments and by ensuring equal access to education and vocational training'; and 'Increase the availability, coverage and quality of scientific evidence-based prevention measures and tools that target relevant age and risk groups in multiple settings, reaching youth in school as well as out of school, among others, through drug abuse prevention programmes and public awareness-raising campaigns, including by using the Internet, social media and other online platforms, develop and implement prevention curricula and early intervention programmes for use in the education system at all levels, as well as in vocational training…'.

22. It is clear that in order to unleash the full potential of the African youth, it is imperative for AU Member States working in collaboration with Civil Society Organizations to act to shield and protect their youth from the ills of drug use and its manifold consequences.

23. The nexus between injecting drug use, blood borne viral infections such as HIV and Hepatitis B and C, are well established. Injecting drug use has been documented in at least 34 countries in Africa and the prevalence of HIV and Hepatitis is significantly higher among people who inject drugs compared to the general population. Young people are disproportionately affected by HIV and the twin threat of injecting drug use and HIV has to well controlled to protect their health and well-being.

24. The higher prevalence of mental health among drug users, their involvement in crime leading to imprisonment have well documented in several countries on the continent. All of these factors, unchecked, will deprive countries and the continent of the possibility of harnessing their full social capital, thereby impinging negatively on development.

25. The challenges to effective drug use prevention are compounded by the emerging body of scientific evidence casting a new light on the genesis of drug use and implications for prevention science. Science tells us that the brain of the young person attains maturity at 20-24 years of age and that the maturation process starts at the back of the brain (occipital region and amygdala) and gradually moves to the front (prefrontal cortex). Science also tells us that the brains of adolescents are 'wired' differently than those of adults. Because the prefrontal cortex is one of the last areas of the brain to mature, adolescents tend to use areas of the brain involved with emotions when making decisions, reflecting a 'gut' reaction instead of a reasoned one. Young people are more likely to think, act and react relying predominantly on the hind brain for decision-making. In adults, it the prefrontal cortex, involved in reasoning and judgement, which are stimulated for decision-making.

26. Drugs used by the pregnant woman pass the placental barrier and reach the foetus. The unborn child starts to 'use drugs' in the uterus. This has a huge impact

on the development of their nervous system, resulting with a multitude of problems and lower Intelligence Quotient compared to children of their corresponding age-groups.

The need for drug policy evaluation and reform in Africa

27. The widespread criminalisation of drug use means that young people caught using or possessing drugs are often left with criminal records which can lead to their exclusion from education or employment – increasing their vulnerability to health, social and economic problems. At the same time, criminalisation has clearly been infective in dealing with the various drug-related issues facing young people in Africa today. Policies across multiple sectors should be formulated with consideration to the factors which have an impact on young people and other vulnerable groups who use drugs. Laws prescribing the incarceration or forced detention of people who use drugs should be repealed and made more proportionate, and must differentiate between personal use and intent to supply – i.e. via indicative quantity thresholds, as well as an assessment of all evidence available on a case-by-case basis (removing any minimum sentences, for example). At the recent UN General Assembly Special Session (UNGASS) on the world drug problem in April 2016, all UN member states also agreed to "Encourage the development, adoption and implementation… of alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature".[3]

The need for stronger harm reduction responses in africa

28. African governments should first and foremost acknowledge that drug use is a health and social issue, and not a criminal one. This includes committing to the provision of evidence-based, cost-effective harm reduction services. Harm reduction strategies are those which aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs.[4] The strategies that can be included under this banner are well-documented and well-evidenced,[5] and include:
    - Needle and syringe programmes
    - Opioid substitution therapy
    - Route transition interventions (i.e. to encourage moves away from injection to oral administration)
    - The provision of, or referrals to, basic health services and social support

29. These strategies help to engage young people who use drugs, reduce the spread of infectious diseases, and prevent other harms such as overdose. Accordingly,

[3] UN General Assembly (2016), *S-30/1: Our joint commitment to effectively addressing and countering the world drug problem,* http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/S-30/1

[4] https://www.hri.global/what-is-harm-reduction

[5] WHO, UNODC, UNAIDS (2012), Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision, http://www.who.int/hiv/pub/idu/targets_universal_access/en/

this approach is expanding across Africa, with positive experiences in Kenya, Tanzania, South Africa, Mauritius, Senegal and Morocco among others. However, even where services exist they are frequently designed for adults, and may not even be legally allowed to provide services to young people. These barriers must be lifted to ensure the protection of young people who use drugs. These services require political commitment, but also funding. Research has demonstrated that there is enormous public health gains to be made through the potential rebalancing of national drug control budgets, allocating a small portion of the drug law enforcement spend towards public health instead. Redirecting just 2.5% of this funding would result in a 65% reduction in HIV-related deaths and a 78% reduction in new HIV infections by 2030.[6]

The need for drug Drug education and to utilise existing available technology

30. There is virtually no meaningful education on psychoactive drugs available to young people in Africa. However, Mobile phone penetration in Africa has grown from 1% in 2000 to 54% in 2012.[7] Young people are the largest group using cell phones and their software applications. In South Africa, 72% of those between the ages of 15 and 24 have cell phones.[8] In Kenya, key findings of a study revealed that over 60% of respondents among the Bottom of the Pyramid (BoP) owned a mobile phone. A general rule of thumb is worth considering when planning for new initiatives that will introduce and/or utilize information and communications technologies: 'The best technology is often the one you already have, know how to (and do) use, and can afford. In many places around the world, this technology is the mobile phone'. The idea is to take advantage of and leverage existing technologies before committing to introduce new ones, *especially in a resource-constrained environment'.*[9]

31. Low-cost smartphones, decreasing cost of airtime and the internet, excellent penetration of phone service coverage and internet even in rural settings, and high smartphone usage by young people for voice, SMS and data, have opened new and exciting avenues for drug use prevention for young people where youth creativity can be tapped for maximal coverage and impact.

The need for research on drug-related issues

32. Incentives should be provided, such as calls and funding programs, to direct research towards the gaps in knowledge about youth and drug-related issues:
33. Develop cross-culturally validated research instruments to investigate drug use and determinants of good health in the youth.

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[6] HRI (2016), *Global State of Harm Reduction 2016*, https://www.hri.global/contents/1739

[7] Deloitte's report The Sub-Saharan Africa Mobile Observatory

[8] UN Children's Fund, UNICEF

[9] (http://blogs.worldbank.org/edutech/category/tags/mobile-phones/Trucano, M. 24.7.2015).

- Build the evidence for youth-focused harm reduction practices in Africa
- Identify economic loses due to drug-related issues and offences among young people

Policy Implications for and Recommended Investments by AU Member States with regard to Drug Control

a) Upstream at the Policy and Strategic Level:

- Rethinking drug use prevention for young people holistically and investing in strengthening social protection nets for young people to contribute to mitigating the overall drug problem by:

(i) Recognizing that drug use is a health matter and not a crime;

(ii) Investing in quality education infrastructure and teachers training; (Note: The more time young people spend in classrooms with a good environment conducive to learning, the less time they are likely to spend in idleness and to engage in uncivil behaviour including drug use or alcohol abuse).

(iii) Investing in affordable health services, including mental health services;

(iv) Investing in building and strengthening the competencies of young people and infusing civics education in core school curriculum starting from the primary level;

(v) Educating all young girls and women not to use drugs and to consume alcohol responsibly and all pregnant women not to use drugs and alcohol during pregnancy;

(vi) Investing in evidence-informed Drug Use Disorders Treatment and scaling up services;

b) Mid-stream and Down-stream at the Implementation Level

- Mobilizing and capitalizing on the intrinsic strengths of the African family and communities network to enhance their protective factors to insulate young people from drug use and build their resilience;

- Helping communities to re-invent themselves for greater cohesiveness and to create a more resilient protective social fabric;

- Training young peer educators in drug use prevention (for young people by young people);

- Establishing a cost-effective data collection mechanism for drugs (e.g. The National Drug Observatory Model) so that the drug situation is regularly monitored and policies and strategies are developed and implemented based on evidence.

34. General recommendation: AU Member States to invest in cost-effective drug use prevention, SRHR services information, HIV/AIDS education, and other prevention programmes using new communication technologies, especially mobile

smartphones, to vehicle preventive information and messages to youth through SMS, Facebook, Twitter and other apps. AU Member States may consider engaging with the private sector, namely the mobile phone and internet companies, and solicit their sponsorship through a corporate responsibility scheme to run such programmes at no or minimal cost.