

A close-up, high-resolution portrait of a young African child, likely a boy, looking slightly to the left of the camera. The child has dark skin, short dark hair, and large, expressive eyes. The lighting is soft, highlighting the texture of the skin and the intensity of the gaze. The background is blurred, focusing attention on the child's face.

# Assessing Progress in Africa toward the Millennium Development Goals

MDG Report 2010

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# Table of Contents

List of Tables . . . . .	iv
List of Figures. . . . .	v
Note to the Reader . . . . .	vii
Foreword . . . . .	ix
Acknowledgments . . . . .	xi
List of Abbreviations. . . . .	xiii
<b>SECTION I: INTRODUCTION . . . . .</b>	<b>1</b>
<b>SECTION II: TRACKING PROGRESS . . . . .</b>	<b>5</b>
Goal 1: Eradicate extreme poverty and hunger . . . . .	5
Goal 2: Achieve universal primary education. . . . .	14
Goal 3: Promote gender equality and empower women. . . . .	21
Goal 4: Reduce child mortality . . . . .	28
Goal 5: Improve maternal health . . . . .	33
Goal 6: Combat HIV, AIDS, malaria, and other major diseases. . . . .	41
Goal 7: Ensure environmental sustainability . . . . .	51
Goal 8: Develop a global partnership for development . . . . .	57
<b>SECTION III: THE ROLE OF GOAL-SPECIFIC AND INSTITUTIONAL INNOVATIONS IN ACCELERATING PROGRESS TOWARD THE MDGs IN AFRICA . . . . .</b>	<b>74</b>
3.1 Goal-specific innovations . . . . .	74
3.2 Broad-based institutional innovations . . . . .	78
<b>SECTION IV: CONCLUSIONS AND AN AGENDA FOR ACTION . . . . .</b>	<b>84</b>
References and Web Resources . . . . .	90
Annex 1: Official list of MDG indicators . . . . .	95
Annex 2: African optimism about the future. . . . .	100
Annex 3: Global Peace Index (GPI) rankings and scores of African countries (2007–2010) . . . . .	101
Annex 4: Global Hunger Index (GHI) for African countries. . . . .	102
Annex 5: Composition of subregional country groupings . . . . .	103

# List of Tables

Table 1:	Percentage change in employment-to-population ratio 1991–2007 for selected African countries . . . . .	9
Table 2:	Enrollment in private primary schools (% of total enrollment and aggregate primary completion rates), 1999 and 2007 . . . . .	19
Table 3:	Contraceptive prevalence rates in Africa, various years (%) . . . . .	38
Table 4:	Adolescent birth rates in Africa, various years (per 1,000 girls aged 15–19 years) . . .	40
Table 5:	Antenatal care coverage in Africa, various years (%) . . . . .	42
Table 6:	Unmet need for family planning in Africa, various years (%) . . . . .	43
Table 7:	Percentage of under-fives sleeping under insecticide-treated nets, 2000–2008 . . . .	47
Table 8:	Net Official Development Assistance, 2008 and 2009 . . . . .	58
Table 9:	ODA to Africa by sector as a percentage of total bilateral commitments, 2004–2008 . . . . .	61
Table 10:	Tariffs imposed by developed countries on African exports of agricultural products, textiles and clothing, 2000, 2007, and 2008 (%) . . . . .	64
Table 11:	OECD Aid for Trade commitments to Africa by sector at constant prices (2008 USD millions) . . . . .	66
Table 12:	Classification of African countries by HIPC status (January 30, 2010) . . . . .	67

# List of Figures

Figure 1a: Growth rate of GDP per person employed, for selected African countries, 1992 and 2008 (%) . . . . .	7
Figure 1b: Change in growth rate of GDP per person employed, 1992–2008 (%) . . . . .	7
Figure 2a: Growth rate of GDP per person employed over time by African subregion, 1992–2008 (%) . . . . .	8
Figure 2b: Change in growth rate of GDP per person employed by African subregion, 1992–2008. . . . .	8
Figure 3: Employment-to-population ratio by African subregion, 1991 and 2007 (%) . . . . .	10
Figure 4: Prevalence of underweight under-five year-olds for selected African countries, 1990–99 and 2000–09 (%) . . . . .	12
Figure 5: Percentage of population undernourished according to WFP/FAO subregional groupings (excluding North Africa), 1990–2006 . . . . .	13
Figure 6: Expenditure on primary education (as % of total educational expenditure) . . . . .	15
Figure 7a: Progress in net enrollment ratio in primary education for selected African countries, 1991, 2005, and 2007 (%) . . . . .	17
Figure 7b: Gap to net enrollment target in primary education for selected African countries, 2007 (%) . . . . .	17
Figure 8: Primary completion rates for selected African countries with data for 1991, 2005, and 2007 (%) . . . . .	18
Figure 9a: Literacy rate of 15–24 year olds, for selected African countries, both sexes, 2007 (%) . . . . .	20
Figure 9b: Literacy rate of 15–24 year olds for selected African countries, disaggregated by gender, 2007 (%) . . . . .	20
Figure 10: Gender parity index in primary education for selected African countries, 1991 and 2007 . . . . .	22
Figure 11: Gender parity index in primary education by African subregion, 1991–2007 . . . . .	23
Figure 12: Gender parity index in secondary education for selected African countries, 1991 and 2007 . . . . .	23
Figure 13: Gender parity index in tertiary education, for selected African countries, 1991 and 2007 . . . . .	24
Figure 14: Share of women in wage employment in the non-agricultural sector, for selected African countries (%) . . . . .	25
Figure 15: Percentage of seats held by women in national parliaments, 1990 and 2009 . . . . .	26
Figure 16: Percentage of women in national parliaments by African subregion, 1990–2009. . . . .	27
Figure 17: Under-five mortality rates for 1990, 2008, and 2015 (target). . . . .	28

Figure 18: Under-five mortality rates in Africa for 1990, 2007, and 2015 (estimated rate and target) . . . . .	29
Figure 19: Causes of under-five mortality in Africa in 2008 . . . . .	30
Figure 20: Under-five mortality rate per 1,000 live births by African subregion, 1990–2007 . . .	31
Figure 21: Under-five mortality rate per 1,000 live births by African subregion, excluding the most populous countries, 1990–2007 . . . . .	31
Figure 22: Progress (% change) in Infant Mortality Rate, 1990–2008 . . . . .	32
Figure 23: Percentage of one-year-old children immunized against measles in 2008 and percentage change between 2000 and 2008 . . . . .	34
Figure 24: Maternal Mortality Ratio (MMR) per 100,000 live births by African subregion, 1980–2008 . . . . .	36
Figure 25: Percentage of births attended by skilled health personnel for selected African countries . . . . .	37
Figure 26: Tuberculosis prevalence rate per 100,000 population by African subregion, 1990–2007 . . . . .	49
Figure 27: Tuberculosis prevalence rate per 100,000 population by African subregion excluding the most populous countries, 1990–2007 . . . . .	49
Figure 28: Tuberculosis mortality rate per 100,000 population by African subregion, 1990–2007 . . . . .	50
Figure 29: Tuberculosis detection rate under DOTS, 1995 and 2007 . . . . .	51
Figure 30a: Percentage of population using an improved drinking water source, 1990–2008 . .	55
Figure 30b: Percentage of population using improved sanitation, 1990–2008 . . . . .	55
Figure 31: Net ODA as a percentage of GNI, 2009 . . . . .	60
Figure 32: ODA received in Small Island Developing States as a proportion of their GNIs, 2000–2008 . . . . .	62
Figure 33: Percentage of imports from Africa, LDCs, and developing market economies admitted free of duty by developed countries, 1996–2007 . . . . .	63
Figure 34: Total debt service as a percentage of exports of goods and services, Africa excluding North Africa, 1990–2011 . . . . .	68
Figure 35: Cellular subscribers per 100 population, 2008 . . . . .	71
Figure 36: Cellular subscribers per 100 population by African subregion, 2000–2008 . . . . .	72
Figure 37: Internet users per 100 population, 2008 . . . . .	73

# Note to the Reader

The 2010 *Assessing Progress toward the MDGs in Africa* report is based on the latest updated and harmonized data from United Nations agencies and OECD statistics databases. UNSD is the official repository of data for assessing progress toward the MDGs. The main reason for using these international sources is that they collect and provide accurate and comparable data on MDG indicators across African countries. The irregularity of surveys/censuses, ages, definitions and methods of production of the indicators may explain the lag between the reporting year and the years of data, which vary from 2006 to 2008. Some of the indicators are new or have been modified since 2007. Some indicators, like CO<sub>2</sub> emissions and ozone depletion in Goal 7, are not relevant or are not quite in line with national priorities. Therefore, some countries use proxies for such indicators which reflect the specificities of their own circumstances and which align more fully with their priorities. Several indicators are dependent on censuses/surveys carried out every 2 or 10 years, so that inter-survey and inter-census periods tend to lead to data gaps. The MDG data are compiled by the Inter-Agency and Expert Group (IAEG) on MDG indicators, with one or more UN agencies being responsible for indicators falling under their area of competency.

UN agencies compile, on a regular basis, data from countries using standardized questionnaires or other mechanisms agreed upon with the latter. Submitted questionnaires are then validated

through a peer review process based on their data collection and processing methodology. They provide estimates, take the responsibility for filling data gaps by estimating missing values, and make adjustments if need be, to ensure global comparability across countries. The OECD also collects data specifically to track aid flows, based on a standard methodology and agreed definitions to ensure comparability of data across donors and recipients. As far as the production of MDG reports at the continental level is concerned, these UN agencies and the OECD provide adequate harmonized and comparable sources of data. However, some countries' official data on particular MDGs were used in this report to better indicate the performances of those countries on those indicators.

MDG data have not always been available on time at the national level. If they exist, they have been subject to problems of inconsistency with international standards. Moreover, data transmission to and estimates made by international agencies – together with the fact that countries do not produce data on MDGs annually – constitute another layer of problems contributing to the observed data gaps. Over the last few years, there have been commendable steps taken by African countries, with the support of international organizations, to obtain data for tracking progress on the MDGs. However, a number of challenges persist relating to the production of data in Africa. The low profile of statistics on the continent is due to a number of obstacles, including: inadequate resources allocated to statistical activities; the lack of institutional capacity; inadequate coordination of statistical activities; and minimal consideration of African specificities in setting up international standards. The African Statistics System (ASS) is therefore expected to further scale up its efforts



toward continental statistical integration to address a continent-wide need for harmonized and quality statistical information. The AUC, ECA, and AfDB have embarked on the development of programs that directly respond to these challenges and improve the statistical capacity of African countries. These include: the Africa Symposium for Statistics Development (ASSD), which is an advocacy framework for censuses; the African Charter on Statistics (ACS), constituting a framework for the coordination of statistical activities in the continent; the Strategy for the Harmonization of Statistics in Africa (SHaSA), which provides guidance on the statistics harmonization process in Africa; and the new initiative on civil registration and vital statistics. Since 2009, the three institutions have also set up a joint mechanism for data collection and validation at the continental level for the production of an African Statistical Yearbook. These initiatives will scale up the availability of data for tracking progress on MDGs in Africa.

Proposed remedies for data gaps and discrepancies include the following measures:

- » African governments need to provide their national statistical systems with adequate and regularized financing to ensure their autonomy and independence in operations, in conformity with the African Charter on Statistics;
- » The joint AUC/ECA/AfDB mechanism for data collection and validation needs to be strengthened;
- » All countries need to strengthen their civil registration and vital statistics production system and conduct on a regular basis their censuses and surveys;
- » All countries should set up a national MDGs data collection mechanism for regular data reporting, validation, storage, and dissemination;
- » Some indicators need to be reexamined to take account of the priorities and specificities of developing countries.

# Foreword

In five years' time, world leaders will assess the progress that has been made in meeting the Millennium Summit commitment to "spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty". That commitment, enunciated in the Millennium Declaration of 2000 and encapsulated in the eight Millennium Development Goals (MDGs), has been the main impetus to advance international development over the last decade.

Mandated by the Assembly of Heads of State and Government of the African Union, the African Union Commission (AUC), the United Nations Economic Commission for Africa (ECA) and the African Development Bank (AfDB) have, over the past five years, jointly produced this annual report on *Assessing Progress in Africa toward the Millennium Development Goals*. This year, the three pan-African institutions have been joined in this effort by the United Nations Development Programme (UNDP).

This year's report shows that, prior to the onset of the food and fuel crises and the global recession, African countries were making steady progress toward attainment of the MDGs. Even though information is not yet available to delineate the precise impact of the three crises on MDG achievement, we know that many African countries were sharply affected by these shocks. However, with support from their international development partners, including the African Development Bank and UNDP, African countries have taken a series of measures aimed at stemming the adverse effects.

According to this report, there has been progress achieved in reducing poverty rates and moving toward the targets of several of the MDGs, even though Africa still has the highest proportion of people living in extreme poverty within the developing world. The advances made are attributed, in part, to improvements in the political, economic, and social landscape across much of the continent.

The emerging picture of Africa in this year's report portrays a continent that has secured progress in key areas such as net primary enrollment, gender parity in primary education, political empowerment of women, access to safe drinking water, and stemming the spread of HIV/AIDS. Antiretroviral treatment is becoming available in a large number of countries and maternal mortality rates are falling in some places. On the economic front, growth has begun to pick up after the global economic and financial crises.

The report draws attention to policy innovations in Africa that are facilitating progress toward attainment of the MDGs. These innovations include new and expanded social protection programs, which were once thought to be unaffordable to most poor countries but are now embraced as important additional interventions to secure progress on key human development indicators. In addition, countries have used the MDGs as a framework for development planning, strengthening coordination and cascading the MDGs to lower tiers of government.

Political support for the MDGs remains strong. For instance, the Assembly of the African Union Heads of State and Government continues to review, on a yearly basis, progress toward the attainment of the MDGs. Moreover, even at the height of the

crisis, budget allocations to MDG-critical sectors did not fall in most African countries. A further indication of the strength of political support can be seen in the establishment in March 2010 of the African Parliamentarians' MDGs Forum.

Nonetheless challenges remain, especially in the area of health. Achieving the goal of "health for all," as embraced in Almaty about 30 years ago, has proven to be difficult. Health in Africa is still not "for all" but rather is characterized by glaring inequities among socioeconomic groups and classes. Progress in achieving the MDGs has therefore been considerably fettered by the slow progress on meeting the health targets.

The adverse impacts of climate change pose a further threat to the sustainability of MDGs achievement. Moreover mitigating climate change presents a significant policy challenge for a region that faces huge energy needs to power its development and industrialization. The continent must have access to the technology and financing that will enable it to meet those energy needs, but in a way that is consistent – to the extent possible – with climate change mitigation.

It is also the case that the global partnership for the MDGs has fallen short of its promise. The Doha Round of trade negotiations, for instance, remains stalled, denying African countries the opportunities

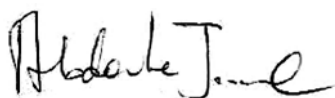
that might emerge from a successful development round. In addition, various international commitments, including those made at Monterrey and Gleneagles, are yet to be fulfilled.

The evidence in this report indicates that actions taken by African governments in concert with their development partners are having a positive impact on the lives of their populations. In this regard, African countries must scale up efforts to meet their own commitments, as expressed in the various decisions of the African Union Assembly of Heads of State and Government. Development partners, too, must fulfill their commitments to development and to the MDGs. We call for these commitments to be renewed and given greater impetus by world leaders when they meet in September 2010 to review progress toward the MDGs. Backed by the evidence presented in this report and elsewhere, it is becoming clear that the challenges that we face in meeting the MDGs in Africa can be overcome through a sustained focus on what works and a stronger international partnership.

We wish to thank all those who have contributed to the preparation of this report. We commend it for the attention and use of leaders, policymakers, and development practitioners who are actively engaged in promoting the achievement of the MDGs in Africa and especially in meeting the agreed targets.



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# List of Abbreviations

AAA	Accra Agenda for Action	ECOWAS	Economic Community of West African States
AAPA-MDGS	Association of African Parliamentarians for the Advancement of the MDGs	EDND	Economic Development and NEPAD Division
ACS	African Charter for Statistics	EFA	Education For All
ACT	Artemisinin-based Combination Therapy	EPA	Economic Partnership Agreement
AfDB	African Development Bank	ESA	Eastern and Southern Africa
AfT	Aid for Trade	EU	European Union
AGRA	Alliance for a Green Revolution in Africa	EUR	Euro
ART	Antiretroviral Therapy	FAO	Food and Agriculture Organization
ASS	African Statistics System	FISP	Farmer Input Support Program
ASSD	Africa Symposium for Statistics Development	GAIN	Global Alliance for Improved Nutrition
AUC	African Union Commission	GAVI	Global Alliance for Vaccines and Immunization
BCI	Bonobo Conservation Initiative	GBP	British Pound Sterling
BIG	Basic Income Grant	GDP	Gross Domestic Product
BPR	Business Process Re-engineering	GHI	Global Hunger Index
BRIGHT	Burkinabe Responses to Improve Girls' Chances to Succeed	GNI	Gross National Income
CAADP	Comprehensive African Agricultural Development Program	GPI	Global Peace Index
CAR	Central African Republic	HIPCs	Heavily Indebted Poor Countries
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa	HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
COMESA	Common Market for Eastern and Southern Africa	IAEG	Inter Agency and Expert Group
CSOs	Civil Society Organizations	IBRD	International Bank for Reconstruction and Development
DAC	Development Assistance Committee (OECD)	ICD	International Classification of Diseases
DFID	Department for International Development (UK)	ICT	Information Communication Technologies
DHS	Demographic and Health Survey	IDA	International Development Association
DOTS	Directly Observed Short-Course Treatment	IFAD	International Fund for Agricultural Development
DRC	Democratic Republic of Congo	IFPRI	International Food Policy Research Institute
DRG	Debt Relief Gain	IGME	Inter-agency Group for Child Mortality Estimation
ECA	United Nations Economic Commission for Africa	IIED	International Institute for Environment and Development
ECCAS	Economic Community of Central African States	IISD	International Institute for Sustainable Development
		IITA	International Institute of Tropical Agriculture

IMF	International Monetary Fund	PNAS	Plan National d'Action Sociale
IMR	Infant Mortality Rate	PPP	Purchasing Power Parity
IPCC	Intergovernmental Panel on Climate Change	PRSP	Poverty Reduction Strategy Paper
		R&D	Research & Development
IPTp	Intermittent Preventive Treatment of malaria during pregnancy	R4D	Research for Development
IRS	Indoor Residual Spraying	RECs	Regional Economic Communities
ITNs	Insecticide-Treated Nets	REDD	Reducing Emissions from Deforestation and Degradation
ITU	International Telecommunication Union	SBAS	Strategic Budget Allocation System
LDCs	Least Developed Countries	SDT	Special and Differentiated Treatment
LEAP	Livelihood Empowerment Against Poverty	SHaSA	Strategy for the Harmonization of Statistics in Africa
LGRP	Local Government Reform Program	SIDS	Small Island Developing State
LLDCs	Landlocked Developing Countries	TB	Tuberculosis
M&E	Monitoring and Evaluation	TFR	Total Fertility Rate
MDGs	Millennium Development Goals	TRIPS	Trade-Related aspects of Intellectual Property Rights
MDRI	Multilateral Debt Relief Initiative		
MDR-TB	Multi-Drug-Resistant Tuberculosis	U5MR	Under-five Mortality Rate
MFPED	Ministry of Finance Planning and Economic Development (Uganda)	UN	United Nations
MIT	Massachusetts Institute of Technology	UNAIDS	Joint United Nations Program on HIV/AIDS
MKUKUTA	Tanzania's National Strategy for Growth and Reduction of Poverty	UNDP	United Nations Development Programme
		UNDP-RBA	United Nations Development Programme – Regional Bureau for Africa
MMR	Maternal Mortality Ratio	UNECA	See ECA
MWE	Ministry of Water and Environment (Uganda)	UNEP	United Nations Environment Program
NAMA	Non Agricultural Market Access	UNESCO	United Nations Educational, Scientific and Cultural Organization
NEPAD	New Partnership for Africa's Development	UNFPA	United Nations Population Fund
NGOs	Non-Governmental Organizations	UNGASS	United Nations General Assembly Special Session
NPCA	NEPAD Planning and Coordinating Agency	UNHQ	United Nations Headquarters
NSOs	National Statistical Offices	UNICEF	United Nations Children's Fund
ODA	Official Development Assistance	UNPD	United Nations Population Division
OECD	Organization for Economic Cooperation and Development	UNSD	United Nations Statistics Division
		USAID	United States Agency for International Development
OSSAP-MDGs	Office of the Senior Special Assistant to the President on MDGs	USD	American Dollars
PAP	Pan African Parliament	VCT	Voluntary Counseling and Testing
PASDEP	Plan for Accelerated and Sustained Development to End Poverty	VPF	Virtual Poverty Fund
		WFP	World Food Program
PEAP	Poverty Eradication Action Plan	WHA	World Health Alliance
PER/MTEF	Public Expenditure Review/Medium Term Expenditure Framework	WHO	World Health Organization
		WHS	World Health Statistics
PMI	President's Malaria Initiative	WSIS	World Summit on the Information Society
PMTCT	Prevention of Mother To Child Transmission	WSSD	World Summit on Sustainable Development
		WTO	World Trade Organization

# SECTION I:

## Introduction

In September 2010, world leaders will once again gather at the New York United Nations Headquarters (UNHQ) to evaluate progress made by countries toward the targets of the United Nations Millennium Development Goals (MDGs), as endorsed at the United Nations Millennium Summit in 2000. This meeting will mark the five-year countdown to the MDGs' target date. The leaders will examine strategies that have worked, as well as those that have failed, and reaffirm their commitment to the goals.

This annual report, mandated by the African Union Assembly of Heads of State and Government, provides an assessment of progress in Africa toward the targets of the MDGs. The assessment is not year-on-year but is rather cumulative. It is based largely on information drawn from the database of the United Nations Statistics Division (UNSD), which is the official repository of data for assessing progress toward the targets of the MDGs. The UNSD database, however, provides information only up to 2007. Consequently, in order to avail the most recent statistics, where possible, data from other international sources such as the World Health Organization's (WHO) World Health Statistics, UNESCO's Education for All (EFA) initiative, UNICEF, and from the World Food Program/Food and Agricultural Organization (WFP/FAO) have been used. This report proposes policy options for consideration and adoption by African governments, their development partners, and African civil society organizations in order to scale up their interventions

to accelerate progress toward achievement of the MDGs by the target date.

Africa is often portrayed as lagging behind on the attainment of the MDGs relative to other global regions. The data used in this report confirm this overall verdict. However, this broad-brush conclusion ignores the significant achievements that individual countries are making on the goals and the scaling-up of opportunities that this provides. This report in part addresses this shortcoming. It not only assesses the overall progress made in the region toward the targets of the MDGs, but also identifies those African countries that have made rapid progress. Further, the report highlights the innovations/interventions that countries have implemented that are responsible for this rapid progress, with the aim of providing lessons and opportunities for peer learning and experience sharing among countries.

Overall, this report shows that most African countries are making steady progress on almost all the MDGs. Most countries have consistently advanced toward all the targets of the MDGs in spite of the recent food, fuel, financial and economic crises. Key areas of progress include a reduction in the proportion of undernourished people on the continent. Ghana, for example, has already met this target and a number of countries along the Atlantic seaboard of the continent are also on track to meet it. The continent is also well positioned, as shown in past reports, to meet the



universal primary education and gender equality and empowerment goals. On the health front, commendable progress has been made in reducing tuberculosis, while the proportion of children sleeping under insecticide-treated bed-nets is increasing in the drive to combat malaria.

Equally commendable is the fact that high-level political commitment to the MDGs has not been eroded by the crises – fuel, food price, financial and economic – that have buffeted the continent in the recent past. African countries have adopted a broad range of policy instruments to minimize the impacts of the financial and economic crises. South Africa, Tunisia, and Morocco drew on their foreign reserves to cushion the shock; Nigeria rescued some of its banks; whilst Uganda, Kenya, and Tanzania raised public expenditure on infrastructure by 20-30 percent to enhance economic growth (AfDB, 2010). Africa's development partners also stepped up their assistance. The G20 agreed to the International Monetary Fund's (IMF) request to raise its capital base. As a consequence, the IMF increased its lending to Africa almost fivefold (World Economic Outlook, 2010a). The World Bank and the African Development Bank also provided countercyclical funding to the region. The World Bank tripled its lending to Africa in 2009 compared to the pre-crisis level, to reach a total of USD 8.25 billion. Of this, USD 7.89 billion was channeled through the International Development Association (IDA), and USD 362 million through the International Bank for Reconstruction and Development (IBRD) (World Bank, 2009a). The African Development Bank (AfDB) developed innovative financing instruments to assist countries to mitigate the adverse impact of the crisis, such as the Emergency Liquidity Facility and the Trade Finance Initiative.

An important element of the success is the significant, wide-ranging institutional innovations that countries have introduced to drive and secure growth and achieve the MDGs. These include: embracing MDGs-based planning; cascading of the MDGs through decentralization to lower tiers of government for improved service delivery; enhanced national policy coordination and harmonization; as well as new sectoral policies, such as an expanded role for social protection. African countries are also increasing the contribution of domestic revenues to their economic growth, although about 12 countries continue to rely on aid for about 85 percent of their annual budgets. Against the backdrop of these African-led initiatives, international support for the MDGs in Africa remains high. All of these initiatives and programs combine to provide a robust platform for accelerating the rate of progress toward the goals in the final quinquennium of the MDGs agenda.

However, the challenges that lie ahead should not be underestimated. The eddies of the global financial and economic crisis are beginning to recede but its impact on African economies and their ability to attain the MDGs will continue to be felt for many years to come. Fiscal revenues declined due to lower commodity prices and the shrinking of the domestic tax base as domestic output contracted. Fiscal balances may improve over time but they are not expected to be strong in the short term because of uncertainty over the pace of recovery in the advanced, industrialized economies. Although recovery in China has been strong, it is unlikely that it alone can drive the recovery in demand for African commodities and thus shore up the fiscal health of the continent's economies. In the interim, countries will acquire more debt and seek more official development

assistance (ODA) to maintain the momentum toward 2015. Dependency ratios will increase due to demographic variables and weak employment growth, making it difficult to reduce headcount poverty. Both of these factors could weaken the rate of progress toward the targets of the MDGs and reverse the gains already made.

Further, global food prices remain well above their average before the 2008 price spike, leaving the poor highly vulnerable to hunger. Oil prices have also been rising, albeit at a slow rate. Budget cuts arising from concern over mounting deficits in advanced industrial economies and the Eurozone debt crisis of 2010 threaten economic recovery and could cause a significant reduction in aid flows to Africa in 2010 and beyond. Climate change presents an additional challenge to African development in general and the achievement of the targets of the MDGs in the region in particular.<sup>1</sup> In spite of the Copenhagen Accord, African countries urgently need to mobilize additional resources to mitigate and adapt to climate change in the years ahead.

With five years remaining to the MDGs' end-date and with the rate of progress on most of the goals slower than desired, it is unlikely that the region as a whole will achieve all of them by 2015, if current trends and the usual way of doing things persist. In some cases, this will not be for lack of effort but due to structural, cultural rigidities in African society. Inadequate financing is also a constraint.

1 This is a front-burner issue for African countries. See in this connection the report of the Third African Ministerial Conference of Ministers of Finance on Financing for Development on the theme: *Climate Change: Financing Opportunities and Challenges to Achieve the MDGs*. See also the Ministerial Statements of ECA Conference of Ministers of Finance for 2007 and 2008.

Nonetheless, most Africans remain optimistic about the future. A recent survey by the Pew Forum on Religion and Public Life (Pew Forum, 2010) revealed that 76 percent of people living in Sub-Saharan Africa believed that their life would be better in five years' time. The same survey revealed that Africans are more optimistic about their future, compared to populations in other regions of the world (see *Annex 2*).

This optimism about the future derives in large measure from the growing prevalence of peace in the region. According to the 2010 Global Peace Index (GPI),<sup>2</sup> although Africa is ranked as the least peaceful region in the world, with an average GPI score of 2.23, it recorded the best rate of progress between 2007 and 2010. Botswana was the most peaceful African country, followed by Tunisia and Mozambique. Four war-torn countries – Somalia, The Sudan, Chad, and the Democratic Republic of Congo (DRC) – continue to occupy the lowest ten positions in the index and each experienced deterioration in their scores. Angola's GPI score improved for the fourth successive year, due to its greater respect for human rights. Meanwhile Sierra Leone, included in the GPI for the first time this year, is the sixth highest-placed Sub-Saharan African country due to its conflict-free status and very light military presence. In North Africa, Algeria and Egypt made significant improvements in the reduction of military expenditure as a percentage of GDP (see *Annex 3*).

African governments and their development partners must capitalize on this optimism and the increasing prevalence of peace in the region. Political

2 Institute for Economics and Peace, <http://www.visionofhumanity.org/wp-content/uploads/2010-GPI-Discussion-Paper.pdf>

stability and peace gains free up financial resources for growth and development, including achievement of the MDGs. Peace also promotes national dialogue and consensus building on important national and international challenges. Pan African institutions such as the African Union Commission (AUC), the United Nations Economic Commission for Africa (ECA), the African Development Bank (AfDB), the Regional Economic Communities (RECs), and UN agencies and funds have a central role to play by contributing to these efforts. However, African governments must also be willing to make difficult choices. In the context of limited financial and human resources and time constraints, they must choose between aiming to achieve all

the goals by the target date or concentrating on a few goals that they consider most critical for their long-term development. Evidence suggests that all the goals can be achieved if efforts, including financing for public sector investments, are scaled up. The choice is for each country to make.

This report is organized as follows. Section 2 assesses progress on each of the eight goals. Section 3 discusses some of the institutional innovations that African countries have adopted, in part, to drive forward the MDG agenda, while Section 4 concludes with recommendations and proposals on the way forward.

# SECTION II: TRACKING PROGRESS

## Goal 1: Eradicate extreme poverty and hunger

### **Target 1A: Halve between 1990 and 2015 the proportion of people whose income is less than USD 1 a day**

There has been great progress in reducing poverty worldwide over the last two decades. This has been largely due to rapid economic growth in Asia, especially China and India. Africa as a region, according to the available evidence, has not contributed significantly to this success. Some countries in Africa are making progress on poverty reduction (Ghana has already met the target) but for the region as a whole, the goal is unlikely to be met without significant additional policy effort and resources. According to the World Bank (2010a), the number of Africans living below the poverty line is likely to increase by the target date. A significant proportion of the poor in Africa are chronically poor. This means that it will require much more effort to lift them out of poverty and keep them out of it. Similarly, a large number of Africa's poor live in fragile states, which have their own special development challenges.

There is considerable debate amongst the international community about the breadth and depth of poverty in Africa and methods of computing them. How many Africans fall below the international poverty line and how fast are they exiting from poverty? This debate has recently been invigorated by a paper entitled "African Poverty

is Falling.....Much Faster than You Think!" by Massachusetts Institute of Technology (MIT) and Columbia University/NBER's Pinkovskiy and Sala-i-Martin, who suggest that poverty in Sub-Saharan Africa is decreasing at a much faster rate than conventional wisdom would imply. They argue that this is because the benefits of growth have been widely distributed across African society as income inequality in Africa has declined since 1995. This suggests that growth has accrued to the poor. Further, they provide evidence that this good news is common to the entire region, and is not limited to countries endowed with natural resources or coastal countries. According to Pinkovskiy and Sala-i-Martin, Africa will be able to achieve the MDG of halving poverty perhaps two years earlier than the target date.

However, the report's findings and conclusions are very controversial, given the methods used. Nonetheless, the general direction of the evidence is not inconsistent with the findings of Chen and Ravallion (2008), who noted that poverty rates in Sub-Saharan Africa fell from 59 percent in 1996 to 51 percent in 2005. However, while Pinkovskiy and Sala-i-Martin concluded that Africa's poverty is falling rapidly and that the continent could meet the poverty target earlier than estimated by many, Chen and Ravallion concluded that it is not declining fast enough to offset the high population growth rate and that Africa is therefore unlikely to reach this goal. Chen and Ravallion point out that the absolute number of poor people in Africa

(excluding North Africa) almost doubled in the period 1981–2005.

The controversy over methods should not obscure the fact that all these authors agree that African poverty is declining. Their conclusions provide a basis for countries to stay the course in their policy choices and to scale up interventions, including aid, to accelerate the rate of progress to meet the poverty target. This needs to be set against the evidence reported on Indicator 1.4 – Growth rate of GDP per person employed – that over 84 percent of the 48 countries for which data are available show positive trends in labor productivity growth rate, with some countries increasing their productivity levels by as much as 38 percentage points. All this lends credence to the argument that African poverty is falling, due in large measure to improvements in governance, the cessation of conflicts in some countries, and the positive growth experience of the past ten years.

International cooperation is essential if Africa is to maintain the positive trend in poverty reduction. In this regard, it is critical that the Doha round of trade negotiations be resumed as soon as possible to enable African countries not only to take advantage of trade to mobilize resources for their development but also to lift millions of people out of poverty. Similarly, developed countries need to fulfill the far-reaching pledges that they made in 2005 to scale up the fight against global poverty. At the Gleneagles Summit, G8 countries<sup>3</sup> agreed to increase aid to Africa and improve aid effectiveness. The commitments made in the Paris Declaration and the Accra Agenda for

Action on aid effectiveness also have to be met. African leaders, for their part, committed to lead their own development by improving governance, upholding the rule of law, and using their resources to fight poverty.

**Target 1B: Achieve full and productive employment and decent work for all, including women and young people**

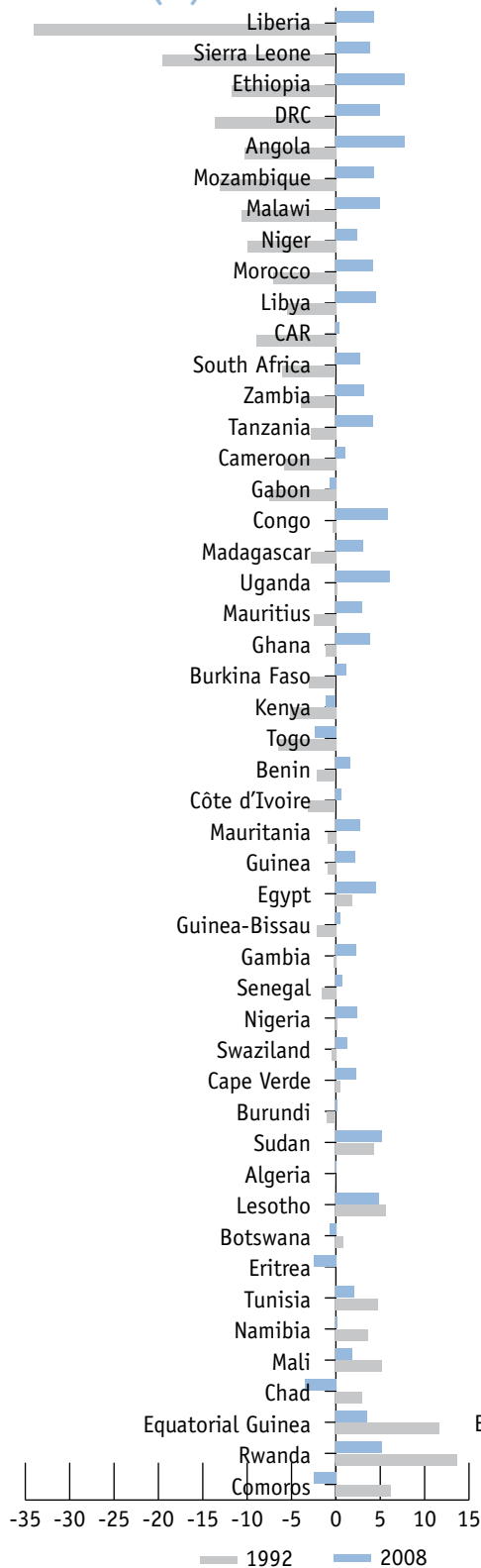
This target, along with its associated indicators, was officially adopted in 2007 and was reported on for the first time in 2009. However, due to revisions to the UNSD data, the progress described in this report may not necessarily be consistent with what was reported last year.

*Indicator 1.4: Growth rate of GDP per person employed*

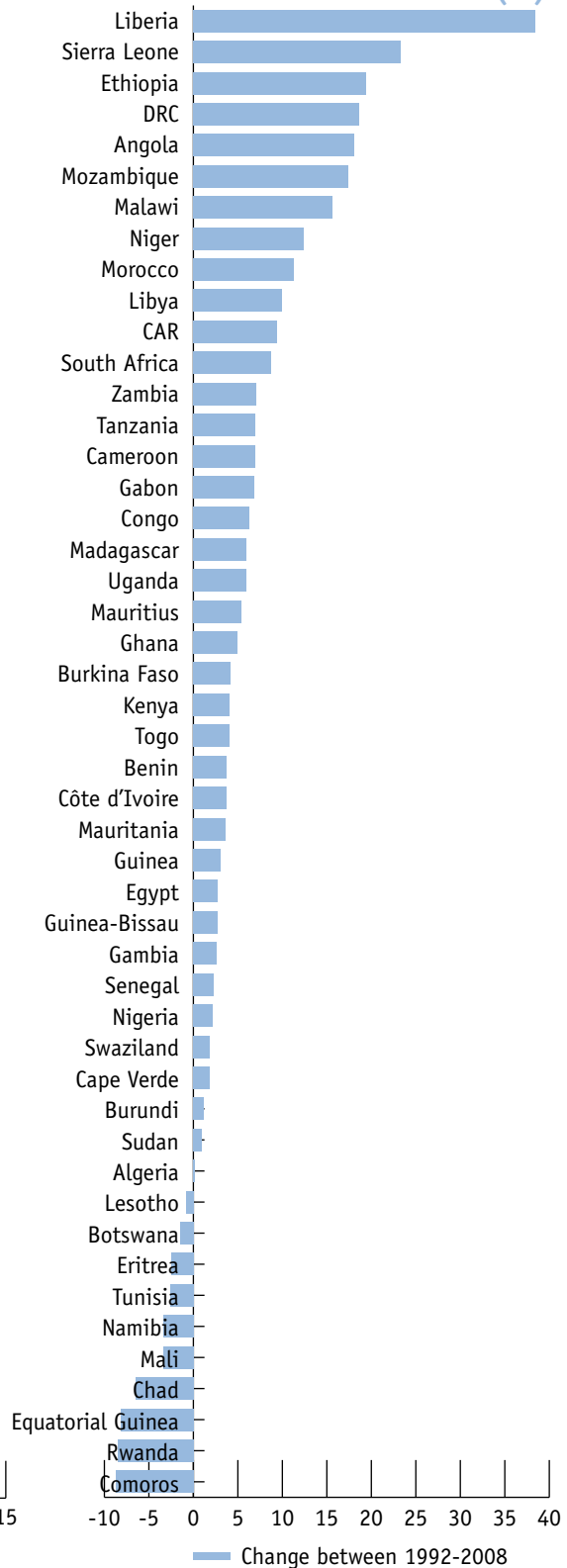
A necessary condition for poverty reduction is output growth per person employed. Sustained labor productivity growth is critical for improving the potential of African economies to reduce poverty. This is achieved by increasing output, demand for labor, and through higher wages and income. The evidence from Africa on the growth rate of GDP per person employed is mixed, as can be seen in *Figure 1*. Labor productivity per person employed has been growing in over 84 percent of the 48 countries for which data are available. Of the countries showing positive trends, Liberia, Sierra Leone, Ethiopia, the Democratic Republic of Congo, Angola, Mozambique, and Malawi were the biggest achievers, as they increased their labor productivity from a very low level in 1992 by some 15 to 38 percentage points by the year 2008. Around 14 countries also showed an increment in labor productivity during the same period of between 5 to 15 percentage points, while another 17 countries witnessed positive changes of

3 Canada, France, Germany, Italy, Japan, Russia, United Kingdom, and the United States of America.

**Figure 1a: Growth rate of GDP per person employed, for selected African countries, 1992 and 2008 (%)**



**Figure 1b: Change in growth rate of GDP per person employed from 1992 to 2008, for selected African countries (%)**



Source: ECA computations based on UNSD data, updated in July 2009. No data for five countries (Djibouti, São Tomé and Príncipe, Seychelles, Somalia and Zimbabwe) from 1992–2008.

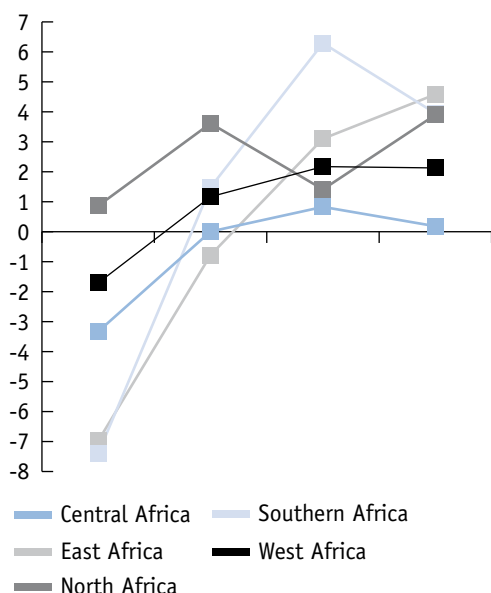
up to 5 percentage points. However, ten countries<sup>4</sup> showed a decline in labor productivity growth rate between 1992 and 2008.

For the year 2008, Malawi, the Democratic Republic of Congo, Rwanda, The Sudan, Congo, Uganda, Ethiopia, and Angola reported the highest labor productivity growth rates (up by 5–8 percent) in Africa, while in Chad, Comoros, Eritrea, Togo, Kenya, Botswana, and Gabon there was a regression. For Liberia and the postconflict countries, there has been a clear recovery in the growth rate of labor productivity. Overall, labor market policies are essential in these postconflict countries to maintain

the positive trend and to reduce poverty through employment, as the lessons emerging from the recent global economic and financial crises indicate.

Collective regional action is essential for improving the growth rate of GDP per person employed. This is because an expansion of intra-regional trade could boost employment opportunities, while the policies adopted by regional economic communities (RECs) – for example convergence criteria – could have a significant impact on domestic output decisions of the private sector in their member countries. For this reason, further analysis of the data by subregion is warranted.

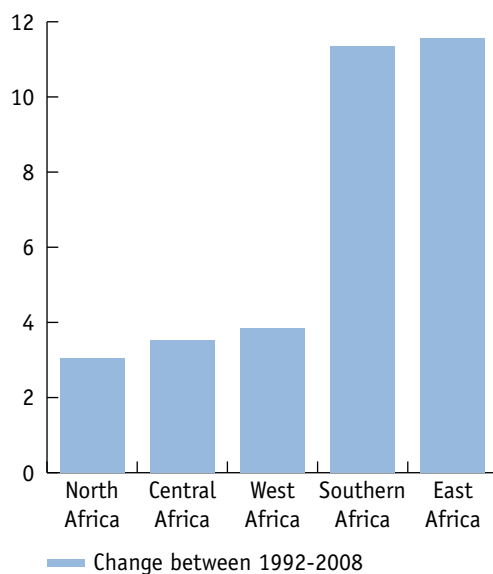
**Figure 2a: Growth rate of GDP per person employed over time by African subregion, 1992–2008 (%)**



Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for five countries (Djibouti, São Tomé and Príncipe, the Seychelles, Somalia, and Zimbabwe) from 1992–2008; no data for Eritrea in 1992. For the composition of the subregional country groupings, see Annex 5.

**Figure 2b: The change in growth rate of GDP per person employed by African subregion, 1992–2008 (%)**



<sup>4</sup> Comoros, Rwanda, Equatorial Guinea, Chad, Mali, Namibia, Tunisia, Eritrea, Botswana, and Lesotho – see Figure 1b.

The evidence suggests that GDP per person employed grew during the period 1992–2008 in all African subregions. This is striking, given that all subregions, except North Africa, had negative labor productivity rates for the base year of 1992 (see *Figure 2a*). The pick-up from 1992 was not sustained beyond 2005, except in the East and North African subregions. It declined in Southern Africa and Central Africa and leveled off in West Africa between 2005 and 2008. In North Africa, the rate declined between 2000 and 2005 and picked up thereafter. For the period 1992–2008, labor productivity growth was significantly greater in East and Southern Africa than in the other subregions (see *Figure 2b*).

*Indicator 1.5: Employment-to-population ratio*

While labor productivity has been growing, the employment-to-population ratio<sup>5</sup> stagnated between 1991 and 2007 in all subregions of the continent.

In fact, it declined in 28 of the 50 countries that provided data, particularly in Mauritania, Tanzania, and Rwanda where the decrease was 13.8, 10.6, and 8.1 percent, respectively. Guinea-Bissau did not register any changes between 1991 and 2007. Algeria, Ethiopia, and Lesotho are noteworthy exceptions to this trend as they increased their employment-to-population ratios by 28.2, 12.2, and 10.8 percent, respectively (see *Table 1*).

*Figure 3* summarizes the performance of Africa's five subregions in creating employment for their people and reducing dependency. In absolute terms, East Africa has the highest employment-to-population ratio while North Africa has the lowest. However, between 1991 and 2007, North Africa and Southern Africa improved on this ratio while West Africa regressed and East and Central Africa largely stagnated.

**Table 1: Percentage change in employment-to-population ratio, 1991–2007 for selected African countries**

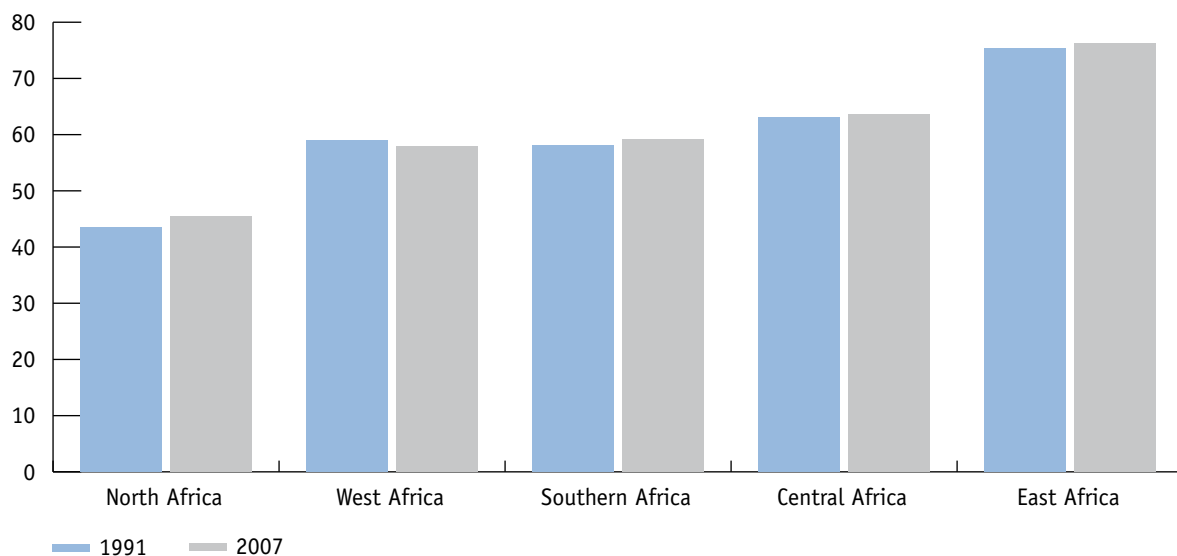
<b>Countries</b>	<b>&gt;5% increase in employment-to-population ratio</b>	<b>Countries</b>	<b>&gt;5% decline in employment-to-population ratio</b>
Algeria	28.2	Mauritania	-13.8
Ethiopia	12.2	Tanzania	-10.6
Lesotho	10.8	Rwanda	-8.1
Zambia	7.0	Swaziland	-6.1
Libya	6.1	Botswana	-5.9
		Ghana	-5.1

Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for three countries (the Seychelles, Congo, and Somalia) from 1991–2007.

<sup>5</sup> Employment-to-population ratio may be defined as the proportion of a country's working age population, aged 15 years and older, who are employed. The ratio therefore stands as a measure of an economy's ability to create jobs (and also of dependency).



**Figure 3: Employment-to-population ratio by African subregion, 1991 and 2007 (%)**

Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for three countries (the Seychelles, Congo, and Somalia) from 1991–2007.

A number of factors may be driving the decline in employment-to-population ratio not only in West Africa but across the region. The large share of the capital-intensive extractive industry in domestic output is one causative factor. Another is the elevated rate of population growth in most countries, as well as the adverse employment effects of the continent's many conflicts. East Africa's relative peace provided a conducive environment for employment growth. Other causative factors include poor labor market and growth policies, the shrinking of the state as an employer, and the lack of economic diversification.

**Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger**

Many African countries have made progress toward meeting this target, although overall in the continent, the number of people who suffer

from hunger has actually increased. Ghana has already met the target, due in large measure to its stable good governance, sound macroeconomic policies, and increased agricultural investments. North African countries have also met the target. Nonetheless, efforts need to be scaled up in the remaining countries to reduce hunger, because of this target's close interaction with the other MDGs, especially in the area of health. International cooperation remains essential in this regard.

International assistance to Africa for meeting this target has been positive. In July 2009, G8 countries, along with leading international organizations, committed USD 20 billion over three years to help farmers boost their productivity. In 2006, the Gates and Rockefeller Foundations provided a USD 150 million grant to the Alliance for a Green Revolution in Africa (AGRA) to catalyze agricultural transformation

in Africa (see *Box 1*). The United Nations High Level Task Force for food security has also played a very important role in driving international efforts to address the food crisis. The Global Alliance for

Improved Nutrition (GAIN), recently established as a result of renewed United Nations General Assembly Special Session (UNGASS) pressure, has received over USD 180 million from donors since 2008.

### Box 1: Sustaining the Green Revolution in Africa

As population growth rates continue to exceed the productive capacity of Africa's current food reserves, agricultural transformation remains a fundamental development challenge, impeding the achievement of the Millennium Development Goals. The emergence of alternative users for agricultural products has resulted in additional pressure on Africa's capacity to feed itself; resulting in many millions of Africans living on the brink of starvation. In response to concerns over food security and low-performance agricultural indicators, African countries and their development partners are stepping-up their efforts to strategically harness the best science and technology available to increase the continent's agricultural productivity. The Alliance for a Green Revolution in Africa (AGRA) is a major outcome of these efforts. AGRA is a coordinated initiative to ensure agricultural development and to promote the importance of indigenous science and technology innovation to sustain the Green Revolution within Africa.

Since its establishment in 2006, with the support of the Bill and Melinda Gates Foundation, AGRA has provided local distributors with adaptable, manageable solutions to develop an efficient, competitive working environment in rural agriculture, effectively improving output. Targeting small-scale farming, AGRA's programs support rural infrastructure, water management systems, and agro-dealer enterprises, as well as facilitating training in efficient farming techniques and the impact of agricultural development on the process of climate change. As women are responsible for the majority of food production in Africa, they maintain a particular focus in AGRA's policy framework.

Investment in innovative agricultural research and development (R&D) to further the capacity of small-scale farming in Africa is critical for achieving sustainable growth in agricultural output. The International Institute of Tropical Agriculture's (IITA) Research for Development (R4D) has made important contributions in this regard. Its research has brought about a series of agricultural innovations in high-yielding and disease-resistant seedlings in many areas such as banana and plantain plantations, cereals and legumes, horticulture and tree plantations. It has also introduced a systemic program of integrated pest management with wide applications in many African countries. Similarly, the Africa Rice Centre has introduced new rice varieties to many African countries, including Guinea, Côte d'Ivoire, Nigeria, and Uganda. The diffusion of this innovation in Guinea resulted in that country producing a record 1.4 million tonnes of rice in 2007, 5 percent higher than its 2006 output. As a consequence, Guinea's domestic rice production was able to cover 70 percent of domestic consumption.

Due to investment in indigenous science and technology, the capacity of local seed varieties and crop outputs has considerably improved. Malian sorghum breeders have released three new hybrid sorghum crops with the capacity to quadruple the harvests of Mali's staple food crop. The grain is drought-resistant and essential to food security.

Sources: <http://www.agra-alliance.org>; <http://www.iita.org>; and <http://www.panapress.com> (*New Rice Varieties Boost African Rice Production*).

Overall, efforts to boost agricultural production are beginning to yield results. Malawi, for example, has succeeded in boosting its agricultural productivity. However, there is little consensus on the cost of ending hunger in Africa. The 2009 World Food Summit on Food Security estimated that USD 44 billion would be required each year to end hunger and achieve food security, while the World Bank has estimated that such interventions in high-burden countries would cost USD 11.8 billion per year.

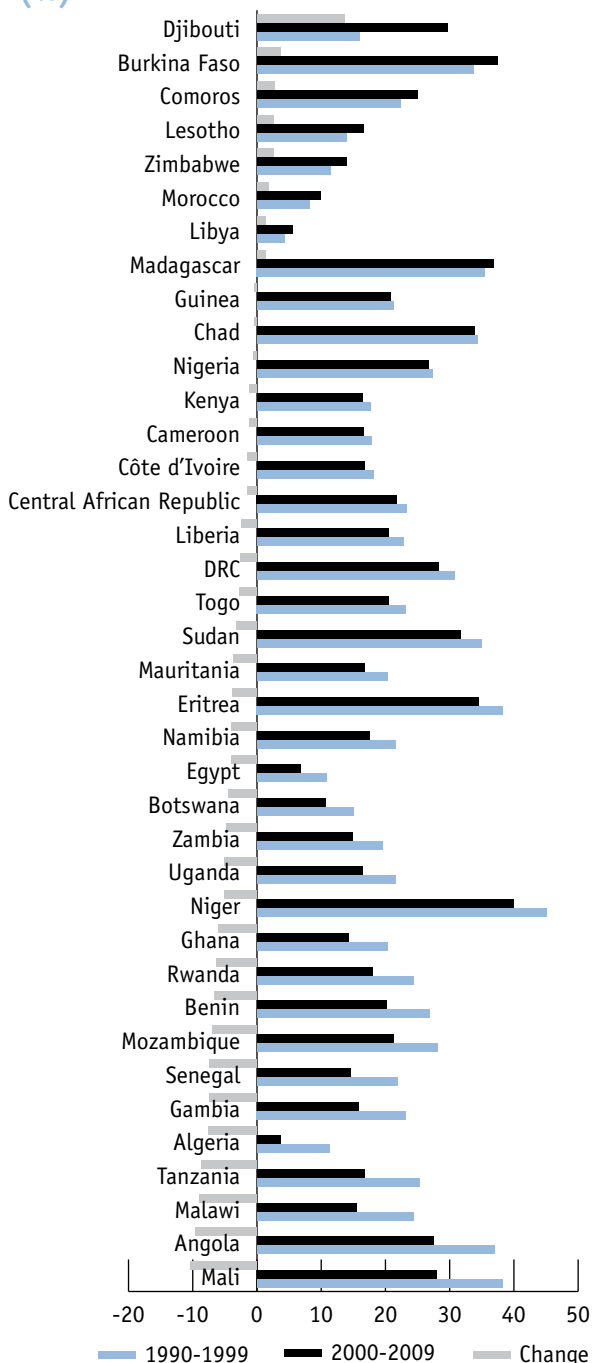
However, the lack of data for the corresponding indicators makes it difficult to monitor progress at individual country levels. The data for this target are drawn from the WHO's World Health Statistics (WHS) 2010 and FAO (2009).

*Indicator 1.8: Prevalence of underweight children under five years of age*

Another measure of food deprivation is the prevalence of underweight children under five years of age falling below minus two (-2) standard deviations (moderate to severe) and minus three (-3) standard deviations (severe) from the median weight-for-age of the reference population. This indicator has the potential to capture the combined effects of acute and chronic malnutrition. As *Figure 4* shows, 30 out of 38 countries with available data<sup>6</sup> reduced the prevalence of underweight children over the period 1990–1999 to 2000–2009, with the rate of progress varying by country. Thirteen countries recorded a reduction of over 5 percentage points for this indicator, while for the remaining 17 countries, the reduction was less than 5 percent. However, in eight countries<sup>7</sup> the prevalence of underweight children increased over the period.

6 The countries without data in Figure 4 are: Burundi, Cameroon, Congo, Equatorial Guinea, Ethiopia, Gabon, Guinea-Bissau, Mauritius, Sierra Leone, Somalia, South Africa, Swaziland, Tunisia, São Tomé and Príncipe, and Cape Verde.

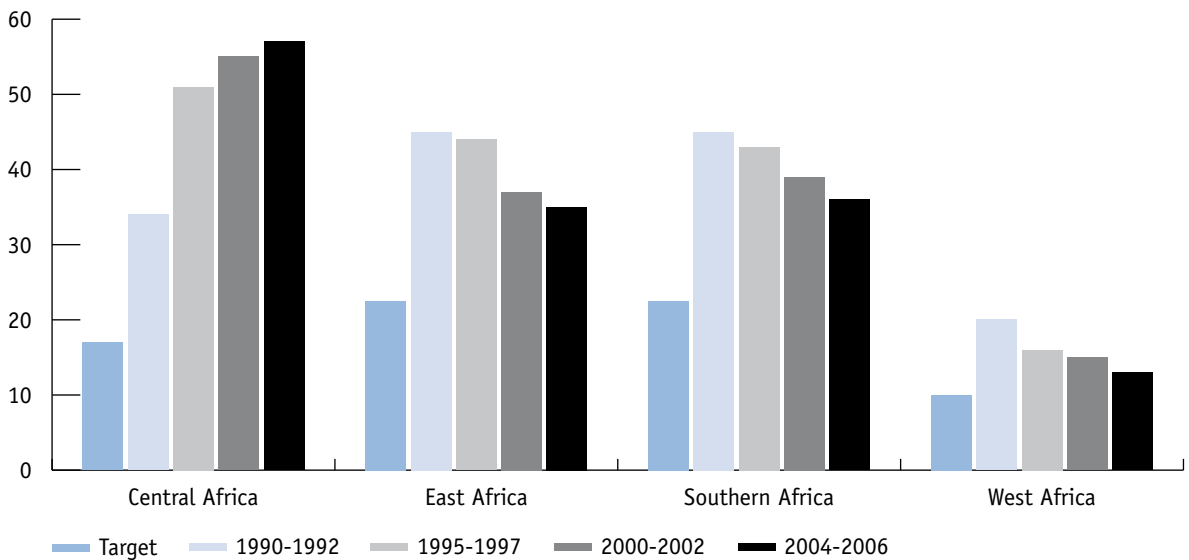
**Figure 4: Prevalence of underweight under-five year-olds for selected African countries, 1990–1999 and 2000–2009 (%)**



Source: ECA computations based on WHS 2010.

Notes: No data for 15 countries for the periods specified.

**Figure 5: Percentage of population undernourished according to WFP/FAO subregional groupings (excluding North Africa), 1990–2006**



Source: ECA computations based on FAO (2009).

Note: North Africa recorded less than 5 percent undernourishment during the entire period.

*Indicator 1.9: The proportion of population below the minimum level of dietary energy consumption*<sup>8</sup> Providing the minimum level of dietary energy consumption continues to represent a challenge to many African countries. The absolute number of undernourished people in the region increased on average from 172.8 million in 1990–1992 to 217.2 million in 2004–2006. However, the proportion of population below the minimum level of dietary energy consumption fell marginally from 34 to 30 percent in Africa excluding North Africa. In North Africa the situation is much better, with less than 5 percent of the population undernourished. As *Figure 5* shows, the proportion of undernourished

population has been falling steadily in all subregions of the continent except Central Africa. West Africa is on track to meet the target of halving the proportion of the undernourished population by the target date if current trends persist. This is largely due to good progress in Nigeria and Ghana. However, the proportion of the undernourished population increased in Liberia, The Gambia, and Sierra Leone (FAO, 2009). Progress in East and Southern Africa has been slow on this indicator, and if current trends continue, these two subregions will fail to meet this target.<sup>9</sup>

7 Djibouti, Burkina Faso, Comoros, Lesotho, Zimbabwe, Morocco, Libya, and Madagascar.

8 The analysis of this indicator is based on FAO (2009).

9 In *Figure 5*, countries are grouped according to WFP/FAO subregional classifications. Accordingly, the DRC contributed to the overall regress in Central Africa and represents 62 percent of the subregion's population. For the composition of subregional groupings used elsewhere in this report, see Annex 5.

Urgent action is required in Central Africa, notably in the Democratic Republic of Congo which accounts for most of the undernourished of this subregion, and also in the Eastern and Southern Africa subregions.

Overall success will depend on a combination of policies – economic, social, and relating to science and technology. As already discussed in Box 1, an African Green Revolution is urgently needed. However, as highlighted by Conway and Waage (2010), for the revolution to succeed, it must develop technologies that will “deliver for relatively small farmers in more diverse, poorly endowed, risk-prone environments.” This will require technologies to be targeted to meet specific needs. Conway and Waage further suggest five broad areas of focus: (i) new crop varieties, (ii) improvements in soil fertility, (iii) more efficient water usage, (iv) better pest, disease and weed control, and (v) cropping and livestock systems that combine the above in ways that bring benefits to both small and large farmers.

## Goal 2: Achieve universal primary education

African countries continue to perform well on most of the education targets. Net primary education enrollment has increased in all countries and the majority of African countries are likely to achieve this goal by the target date. However, the rate of progress made in primary enrollment has not been matched by a commensurate increase in the primary school completion rate. Ensuring a good quality of primary education across many African countries has become a major challenge.

### Target 2A: Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

*Indicator 2.1: Net enrollment in primary education*  
African countries continue to show overall progress in net enrollment in primary education. Of the 27 countries with data for 1991 and 2007 (see Figure 7), seven countries (Ethiopia, Guinea, Malawi, Mali, Madagascar, Mauritania, and Morocco), scored a significant improvement of 30 to 50 percentage

### Box 2: Measuring the state of hunger – the Global Hunger Index

In the context of a composite measure of hunger across regions, the International Food Policy Research Institute (IFPRI) introduced the Global Hunger Index (GHI) by combining three indicators: (i) the proportion of undernourished as a percentage of the total population, (ii) the prevalence of underweight children under the age of five, and (iii) the under-five mortality rate.

Overall, the GHI shows a declining trend in the developing world (see Annex 4). However, the reduction in GHI was uneven across regions. Africa, excluding North Africa, registered the lowest reduction in the hunger index at 13 percent, compared to Latin America and the Caribbean where GHI fell by over 40 percent. Furthermore, nine out of the ten countries worldwide which saw the greatest rise in the GHI over the period 1990–2009 were in Africa (the Democratic Republic of Congo, Burundi, Comoros, Guinea-Bissau, Zimbabwe, Liberia, Sierra Leone, Swaziland, and Zambia). On a more positive note, some African countries improved their GHI by more than ten percentage points (Angola, Ethiopia, Ghana, Malawi, and Mozambique).

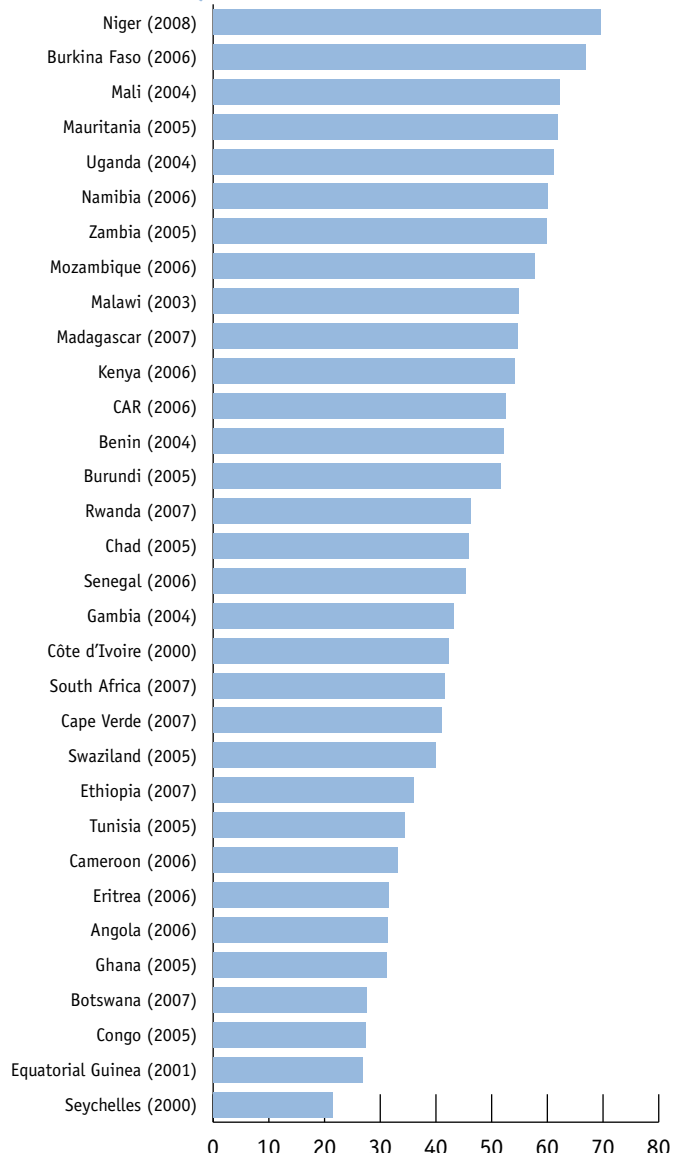
Source: Grebmer et al. (2009).

points. Burkina Faso, Burundi, Djibouti, The Gambia, Ghana, Niger, Rwanda, Senegal, Swaziland, and Togo also succeeded in improving primary net enrollment by some 10 to 30 percentage points during this period. Relative to 2005, there was a marginal regress on this indicator in Algeria, Cape Verde, Eritrea, Malawi, Togo, South Africa, and Tunisia in 2007. This regress could be an artifact of the data and should not raise any significant policy concerns in these countries, especially in Tunisia and Algeria, which boast near 100 percent net enrollment rates.

The Republic of Congo and Equatorial Guinea reveal the sharpest reversal for 2007 relative to 1991 on this indicator. In Congo, net primary enrollment fell from slightly more than 85 percent in 1991 to about 60 percent in 2007, having recovered from a low of 44 percent in 2005. In Equatorial Guinea, the net primary enrollment fell from about 98 percent in 1991 to about 70 percent in 2007. This is a serious concern because as a matter of policy, public education is free and compulsory in both countries. However, very low expenditure on primary education as a share of the total education budget in both countries (see *Figure 6*), combined with civil unrest and conflicts, have resulted in a significant degradation of the educational infrastructure.

Increasing primary education expenditure is critical for raising the primary enrollment rate. This will permit the building of new schools and new classrooms, the hiring of additional teachers, raising teachers' salary, and the provision of school meals and books. These increase the attractiveness of schooling and encourage retention. *Figure 7a* shows that the countries which (according to *Figure 6*) allocate at least 50 percent of their education budget to primary education reported the fastest

**Figure 6: Expenditure on primary education (as % of total educational expenditure)**



Source: UNESCO (2009).

Note: Years in parentheses indicate latest available data.

rate of progress on this target in 2007 relative to 1991. Mauritania, for example, increased its primary enrollment rate from about 38 percent

in 1991 to 81 percent in 2007, Niger from about 28 percent in 1991 to 46 percent in 2007, and Burkina Faso from about 30 percent in 1991 to 53 percent in 2007. These countries show that increasing expenditure on primary education is a necessary condition for accelerating progress toward achievement of this indicator.

Many primary schools impose fees and levies which may have a detrimental impact on the net enrollment rate, especially in the poorer segment of the population.

International aid has played an important role in scaling up expenditure on primary education. There was a considerable focus on education in 2005 by international donors. The UK government, through DFID, committed GBP 8.5 billion on international aid for primary education in the 10 years to 2015, most going to Sub-Saharan Africa and South Asia. To have access to this additional funding, countries were required to prepare well-costed education plans. Many countries did so and most of the countries that reported increased expenditure on primary education received additional funding from this source.

The criterion for achievement on this indicator is that countries reach a net enrollment rate of at least 95 percent. According to this criterion, as of 2007, Algeria, Egypt, Madagascar, Mauritius, São Tomé and Príncipe, Tunisia, and Zambia achieved the target or were less than 5 percentage points adrift, while Morocco, Rwanda, South Africa, and Uganda were some 5 to 10 percentage points off target. Thirteen other countries<sup>10</sup> are also on

track to meet this target provided they maintain the rate of progress they achieved from 1991 to 2007. If current trends persist, about 27 countries will reach the net primary enrollment goal by the target date.

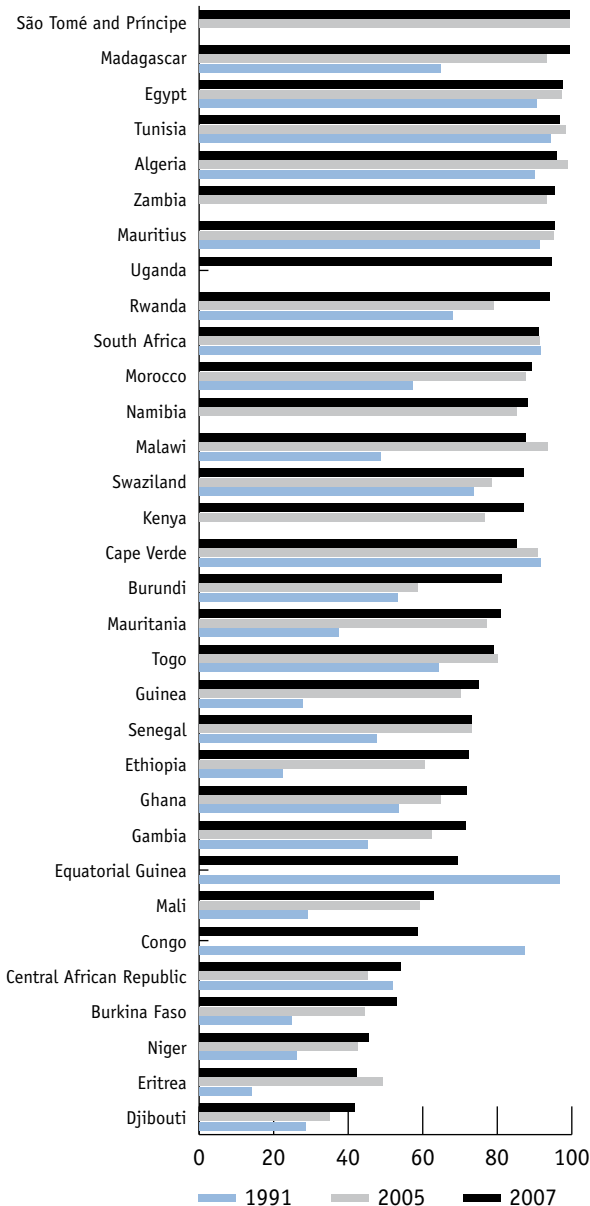
However, a large number of countries are more than 11 percentage points away from the target. In 2007 seven countries (Burkina Faso, Central African Republic, Congo, Djibouti, Eritrea, Mali, and Niger) reported a net primary enrollment rate ranging from 37 to 58 percentage points off-target (see *Figure 7b*). If current trends persist, about 22 countries will fail to reach this target by 2015. Urgent action is therefore required to scale up interventions to improve primary enrollment in these countries, especially in the seven countries recording the least progress. International aid accompanied by increased budgetary allocation to the primary education sector will be essential for success.

#### *Indicator 2.2: Primary completion rate*

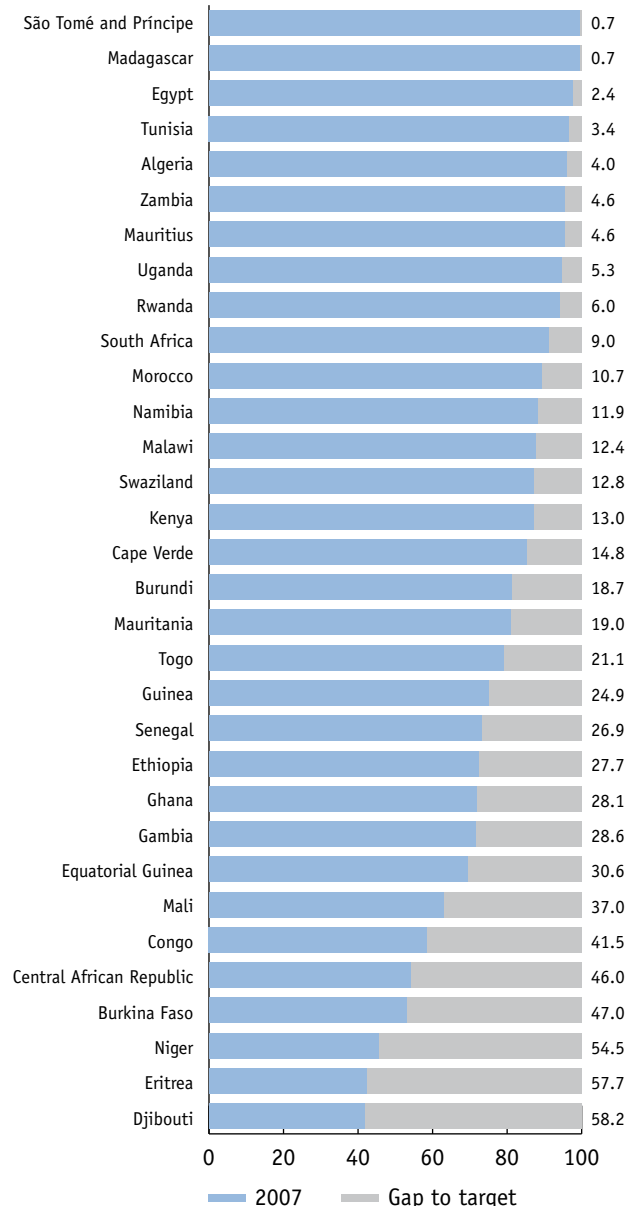
While the news on net primary enrollment is heartening, progress on the primary completion rate remains very slow. Although the completion rate is not an official MDG indicator, it has nonetheless been used as a measure of the quality of the education system. It helps to gauge the success of an education system in curbing dropouts and improving retention, thereby keeping children in school to complete their primary education. Moreover, a scaling-up of investments – both public and private – in the provision of primary education is more clearly justified when the children enrolled at school stay on to complete their studies.

<sup>10</sup> Burundi, Cape Verde, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Malawi, Mauritania, Namibia, Senegal, Swaziland, and Togo.

**Figure 7a: Progress in net enrollment in primary education for selected African countries, 1991, 2005, and 2007 (%)**



**Figure 7b: Gap to net enrollment target in primary education in selected African countries, 2007 (%)**



Source: ECA computations based on UNSD data, updated in July 2009.

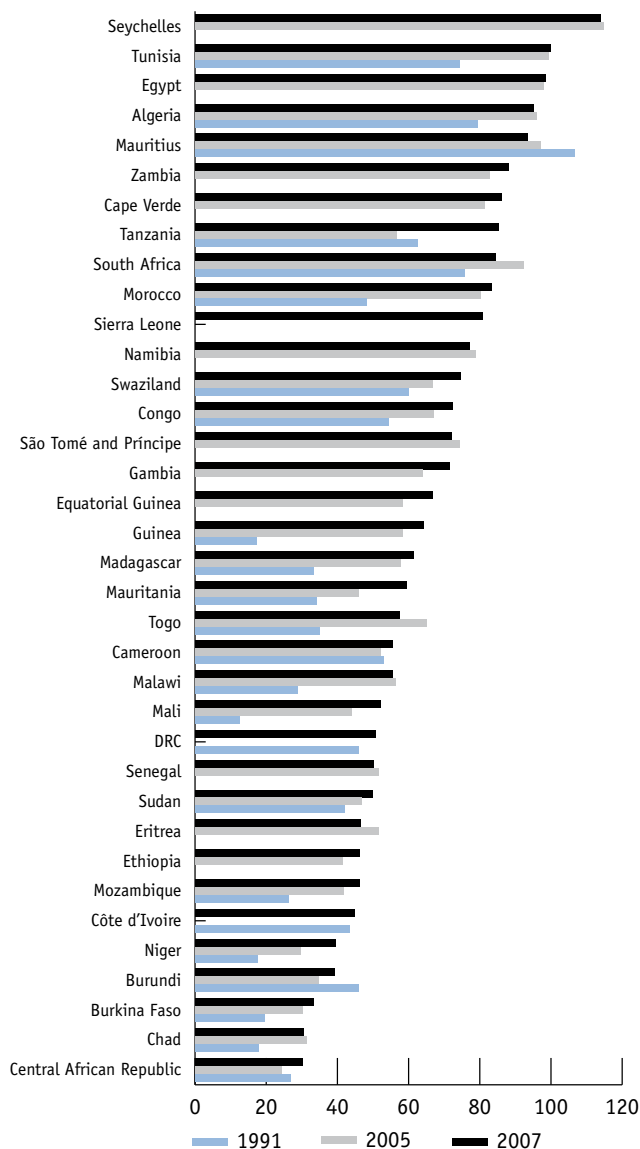
Notes: No data for 26, 24, and 21 countries for the years 1991, 2005, and 2007, respectively.



Figure 8 presents the evidence on the primary completion rate for countries where data are available for 1991, 2005 and 2007. Of the 24 countries listed,<sup>11</sup> 92 percent show a significant improvement in their primary completion rate. Thirty-one percent of these countries had improved within the range of 25 to 47 percentage points while another 30 percent reported improvements of between 10 and 25 percent. The remainder reported an improvement of less than 10 percent. Relative to 1991, Guinea, Morocco, Mauritania, Tunisia, Malawi, Madagascar, Mali, Mozambique, Chad, Madagascar, Tanzania, and Togo have made significant progress in improving their primary completion rates. Mauritius and Burundi were the only countries to register a decline in primary completion rates during the 1991–2007 period of 13 and 6 percent respectively. To gauge more recent progress (2005–2007), Figure 8 shows that Algeria, Chad, Eritrea, Malawi, Mauritius, Namibia, São Tomé and Príncipe, the Seychelles, Senegal, South Africa, and Togo regressed on their primary completion rates, whereas Tanzania improved its primary completion rate by more than 50 percent. Ethiopia, Congo, Zambia, the Central African Republic, Guinea, The Gambia, Swaziland, Mali, Equatorial Guinea, Niger, and Mauritania improved their primary completion rate by between 5 and 13 percentage points over the same period.

It is important to note the growing importance of the private provision of primary education in Africa, even in countries where free primary education is constitutionally guaranteed, and the contribution that this is making to the net primary enrollment

**Figure 8: Primary completion rates for selected African countries with data for 1991, 2005, and 2007 (%)**



Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 29, 20, and 17 countries for the years 1991, 2005, and 2007, respectively.

11 Algeria, Burkina Faso, Burundi, Cameroon, the Central African Republic, Chad, Congo, Côte d'Ivoire, the Democratic Republic of Congo, Guinea, Madagascar, Malawi, Mali, Mauritania, Mauritius, Morocco, Mozambique, Niger, South Africa, The Sudan, Swaziland, Tanzania, Togo, and Tunisia.

**Table 2: Enrollment in private primary schools (% of total enrollment and aggregate primary completion rates), 1999 and 2007**

	1999		2007	
	Enrollment rate**	Completion rate* (private & public)	Enrollment rate**	Completion rate* (private & public)
Mali	22	32.8 (2000)	38	52.2
Togo	36	53.2	42	57.4
Tunisia	0.7	87.9	1	99.9
Tanzania	0.2	56.8	1	85.4
Chad	25	20.1	34	30.4
Egypt	N.A	100	8	98.5
Nigeria	4		5	72.4 (2004)
Mozambique	N.A	14.0	2	46.3
Malawi	N.A	67.2	1	55.4
Morocco	4	53.8	8	83.4
Mauritania	2	52.6 (2000)	9	59.4

Sources: \*UNSD data updated in July 2009; \*\*UNESCO EFA Global Monitoring Report

target. *Table 2* shows the trend in enrollment in private primary schools for a subset of African countries and aggregate (national) primary completion rates.

In the year 2007, the private primary school sector accounted for 42 percent of total primary enrollment in Togo, while in Chad and Mali this sector accounted for over 30 percent. Private provision is growing in countries where in the recent past the government held a monopoly on the provision of education and guaranteed free compulsory primary education. It is clear that enhanced and expanded private provision can be a positive factor for scaling up and accelerating progress on this indicator.

### *Indicator 2.3: Literacy rate of 15–24 year olds*

Progress in youth literacy across African countries (see *Figure 9a*) continues to be commendable and closely tracks progress in those countries with high primary completion rates. In 2007, eight countries<sup>12</sup> were less than five percentage points away from achieving this target, while another four countries were less than ten percentage points away. In contrast, seven out of the 28 countries for which data are available fell short of the target by a wide margin (by 28 to 60 percentage points).

12 São Tomé and Príncipe, South Africa, Tunisia, Mauritius, Gabon, Cape Verde, Zimbabwe, and Libya.

Figure 9: Literacy rate of 15–24 year olds, for selected African countries, 2007 (%)

Figure 9a: Literacy rate, both sexes (%)

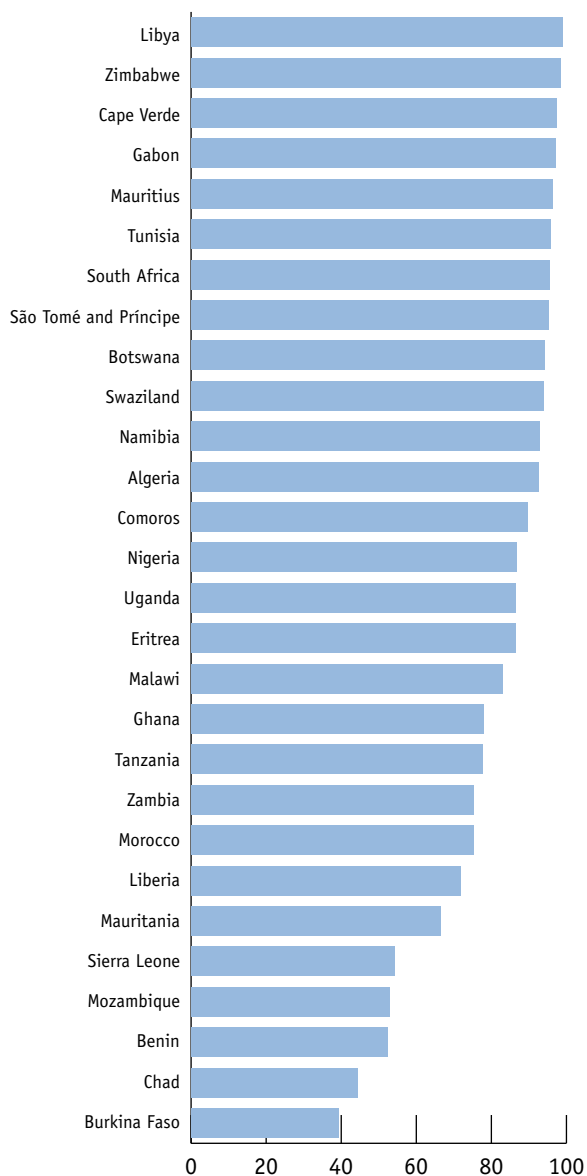
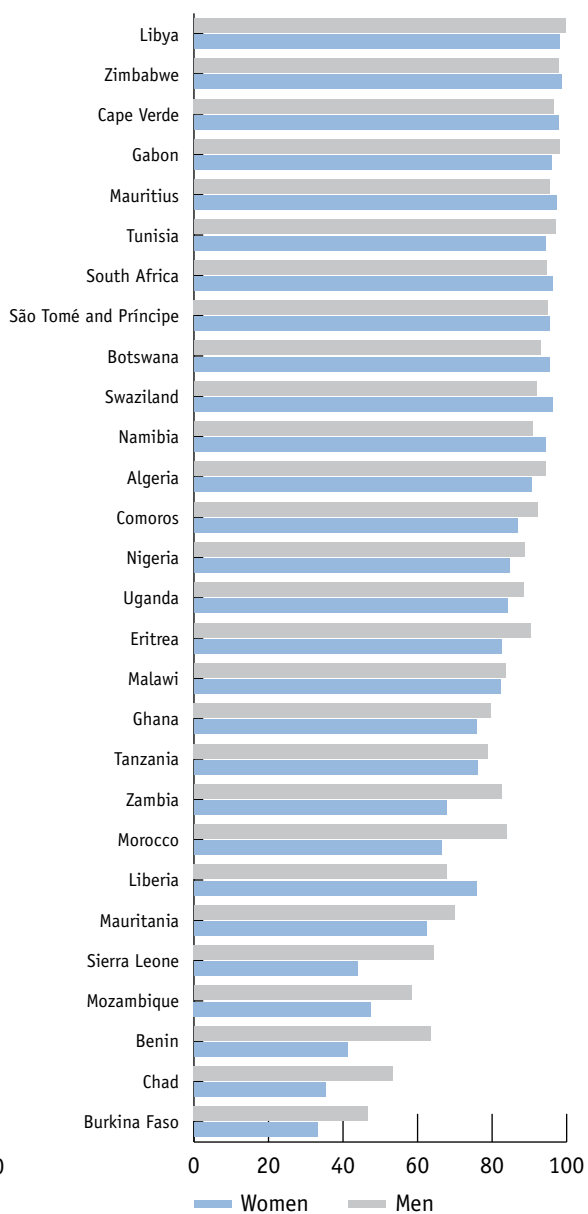


Figure 9b: Literacy rate disaggregated by sex (%)



Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 25 countries in 2007.

Literacy by gender is mixed. Disaggregation of data by sex (see *Figure 9b*) revealed a gap between men and women in literacy rates for 28 countries with available data. Literacy rates in seven countries<sup>13</sup> were 10–22 percentage points higher for men than for women in 2007. A further 12 countries also showed higher literacy rates for the male population, but within the lesser range of 1 to 7.5 percentage points. Although young men are generally more likely to be literate, in a number of countries the situation is reversed, for example in Liberia, Namibia, Swaziland, and Botswana, where the literacy rate is from 2 to 7.7 percentage points higher for women than for men. In Liberia and Namibia, this could be a manifestation of the consequences of conflict, while in Botswana and Swaziland, this could be due to the relative attractiveness of low-skilled mining work in South Africa. While this provides positive evidence on the empowerment of women, the social implications (for crime and violence, including violence against women, and conflict) of a large pool of illiterate young men needs to command significant policy attention. To secure the empowerment of women, it is also important to ensure that men are not disempowered in the process.

### Goal 3: Promote gender equality and empower women

Latest available data indicate that in 2007, African countries showed overall progress in gender equality and the empowerment of women. Gender parity in primary education is likely to be achieved by most countries. Unfortunately, parity decreases in secondary education, and the gap is widest in tertiary education. In primary and

secondary education, the West African countries of The Gambia, Guinea, Mauritania, and Senegal made the greatest progress in achieving gender parity. In tertiary education, although data are scant, North Africa continues to lead the continent, as Tunisia and Algeria have significantly surpassed gender parity, to the extent that they now have more women than men enrolled in universities and colleges. Data remain scant for indicator 3.2, rendering it problematic to track and analyze progress in the share of women in wage employment in the non-agricultural sector.

The year 2009 witnessed a continuing upward trend in the proportion of women in African national parliaments, as was also the case in last year's report. Rwanda, Angola, Mozambique, and South Africa lead the continent on this indicator. Rwanda, which has been the best performer over the past couple of years, increased its share of women parliamentarians by 7.8 percent between 2008 and 2009. Angola, which held elections in September 2008, improved women's representation in its national parliament by 22.8 percent from its last election in September 1992. Similarly, between 1990 and 2009, the share of women in Mozambique's parliament increased by 19.1 percent. Good progress was also made on this indicator in South Africa between 1994 and 2009.

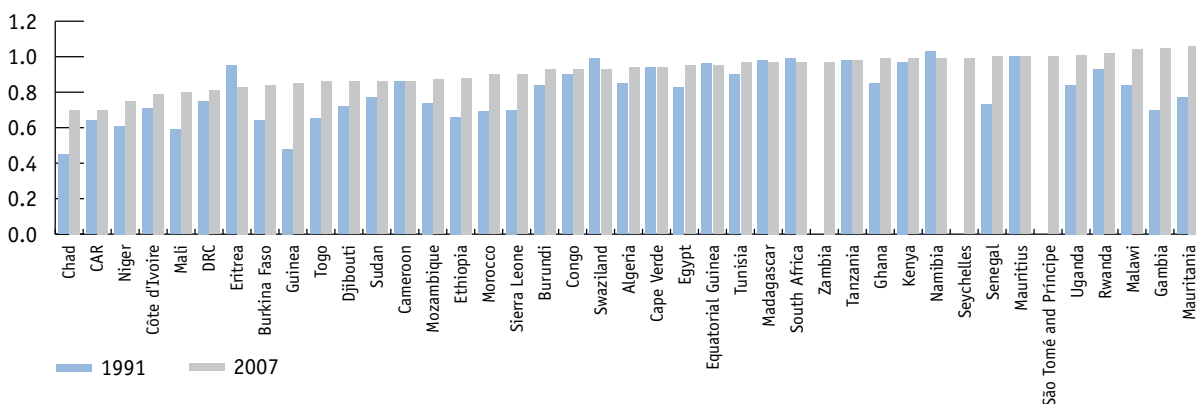
#### **Target 3A: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels of education no later than 2015**

*Indicator 3.1: Ratios of girls to boys in primary, secondary, and tertiary education*

The analysis of the gender parity index at primary education level between 1991 and 2007 (see *Figure 10*) shows that of the 38 countries with

13 Burkina Faso, Chad, Benin, Mozambique, Sierra Leone, Morocco, and Zambia (see *Figure 9b*).

**Figure 10: Gender parity index in primary education for selected African countries, 1991 and 2007**



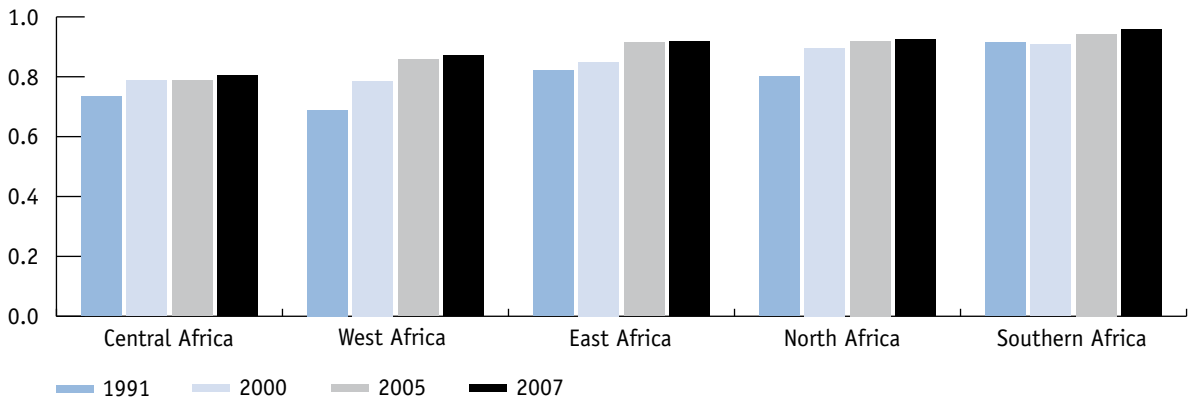
Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 6 countries in 1991 and 12 countries in 2007.

available data, six (Eritrea, Swaziland, South Africa, Namibia, Madagascar, and Equatorial Guinea) have a slightly regressing index. Mauritius is the only country that managed to maintain gender parity for the period 1991–2007. Cameroon, Cape Verde, and Tanzania have not shown any changes in their gender parity levels. The remaining 28 countries have increased gender parity from 0.02 to 0.37 points. Guinea and The Gambia have managed to reduce gender disparity the most, by 0.37 and 0.35 points respectively, closely followed by Senegal and Mauritania. Although data for the baseline year of 1991 are not available, 2007 data reveal that Zambia, Seychelles, and São Tomé and Príncipe have achieved actual or near gender parity in primary schools. In 2007, The Gambia, Malawi, Mauritania, and Rwanda recorded a gender parity level above 1.0 in primary education, indicating that more girls than boys are enrolled in primary schools in these countries. The emerging policy challenge for some countries that have a gender parity index above 1.0 is to increase boys'

enrollment. Overall, if the current trends continue, most African countries will achieve gender parity in primary education by the target date.

While great strides have been made across the continent to achieve gender parity at primary education level, subregional comparison (see *Figure 11*) shows that Southern African countries, though closest to achieving parity, have made the least progress, with Swaziland, South Africa, Namibia, and Madagascar experiencing some regression. West African countries have made the greatest progress on this indicator, with The Gambia, Guinea, Mauritania, and Senegal as the best performers. At the subregional level, North Africa, East Africa, and Central Africa have demonstrated overall progress in achieving gender parity.

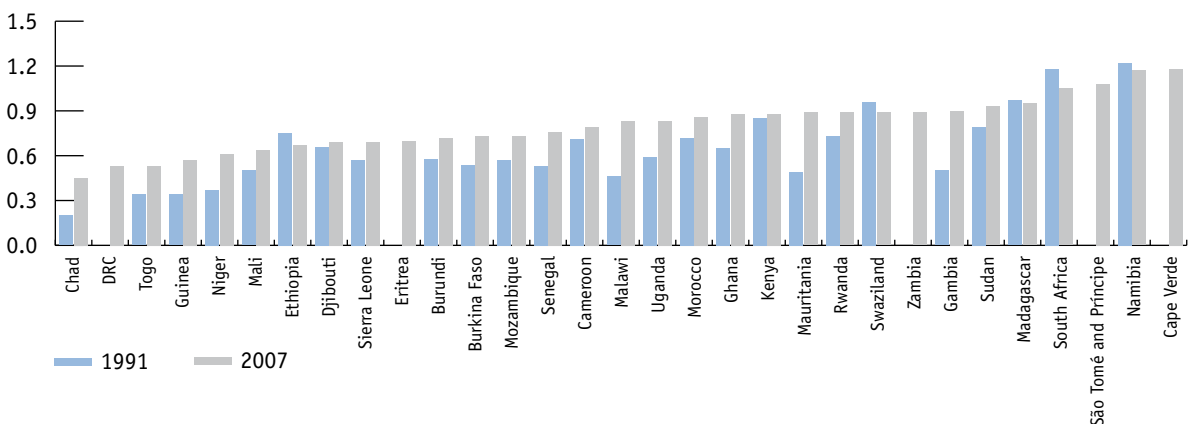
**Figure 11: Gender parity index in primary education by African subregion, 1991–2007**

Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 6 countries in 1991 and 2000, 9 countries in 2005, and 12 countries in 2007.

The analysis of the gender parity index at secondary education level between 1991 and 2007 (see *Figure 12*) shows that of the 26 countries with available data, Ethiopia, Swaziland, Madagascar, South Africa, and Namibia have a regressing index, with South Africa showing the greatest regression

at 0.13 points. The remaining 19 countries reduced gender disparity in the range of 0.03 to 0.4 points. The Gambia and Mauritania have managed to reduce gender disparity the most, by 0.4 points, closely followed by Malawi (0.37). Data for 2007 show that South Africa, Namibia, São Tomé and

**Figure 12: Gender parity index in secondary education for selected African countries, 1991 and 2007**

Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 12 countries in 1991 and 20 countries in 2007.

Príncipe, and Cape Verde have a gender parity level above 1.0 in secondary education, indicating that in these countries, more girls than boys are enrolled in secondary schools. With few African countries having achieved a gender parity index of 0.9 in 2007, if the current trends continue, it is highly unlikely that the continent as a whole will reach this target by 2015.

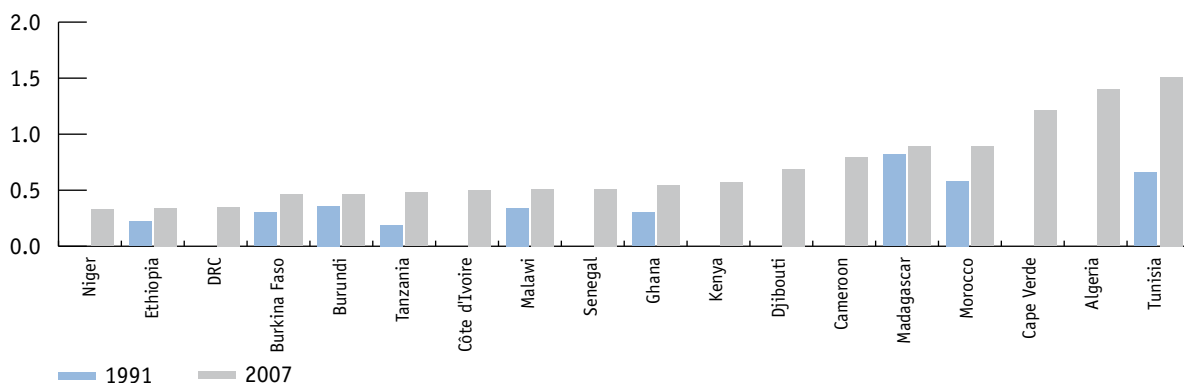
Many African countries fail to report on gender parity at the tertiary level, with only nine countries providing data for both 1991 and 2007 (Burkina Faso, Burundi, Ethiopia, Ghana, Madagascar, Malawi, Morocco, Tanzania, and Tunisia). Data for these nine countries (see *Figure 13*) show that all of them have reduced gender disparity, with Tunisia (0.85) the best performer, followed by Morocco (0.31) and Tanzania (0.29). In 2007, Cape Verde, Algeria, and Tunisia surpassed parity and recorded indices of 1.21, 1.4, and 1.51 respectively. This means that in those countries, women are much more likely than men to access

tertiary level education. With the majority of African countries recording a gender parity index below 0.90 in 2007, and many still struggling to reach a gender parity index of 0.50, it is highly unlikely that African countries will reach this tertiary level target by 2015 if current trends continue.

*Indicator 3.2: Share of women in wage employment in the non-agricultural sector*

This indicator is one area that measures gender equality, but it is difficult to report on due to lack of data. Countries must make an effort to collect gender-disaggregated data. The available information (see *Figure 14*) shows Ethiopia (47 percent), the Central African Republic (47 percent), South Africa (44 percent) and Botswana (44 percent) to be the best performers on this indicator. On the other hand, countries like Senegal (11 percent), Liberia (11 percent), Algeria (15 percent), Libya (16 percent), and Egypt (18 percent) need to exert more effort to increasing women's share in

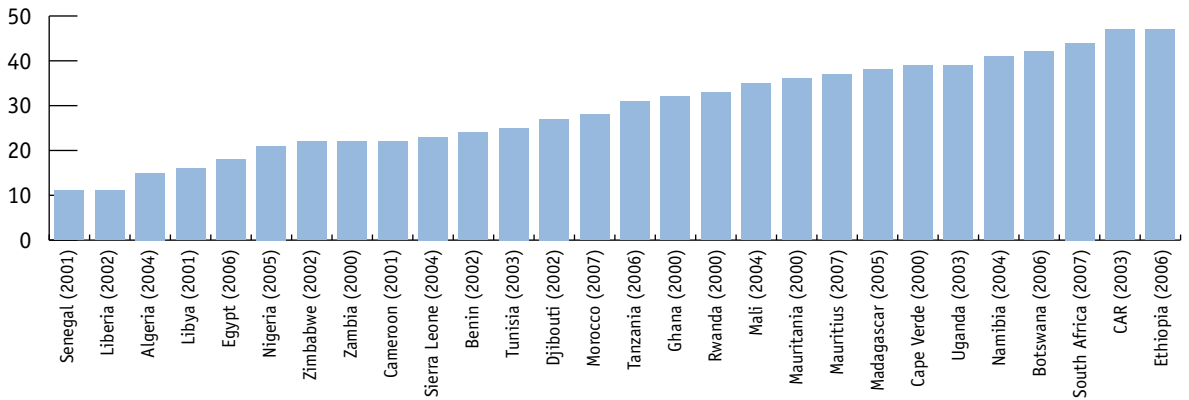
**Figure 13: Gender parity index in tertiary education, for selected African countries, 1991 and 2007**



Source: ECA computations based on UNSD data, updated in July 2009.

Notes: No data for 28 countries in 1991 and for 35 countries in 2007.

**Figure 14: Share of women in wage employment in the non-agricultural sector, for selected African countries (%)**



Source: ECA computations based on UNSD data, updated in July 2009.

Note: Years in parentheses indicate latest available data.

paid employment in the non-agricultural sector. Figure 14 shows countries, in rank order, from the lowest to the highest, depending on year of data availability.

### *Indicator 3.3: Proportion of seats held by women in national parliaments*

Data reporting on this indicator is improving, with all 53 African countries providing data in 2009. Changes in women's representation in national parliaments from the baseline year of 1990 to 2009 have been impressive. Of the 37 African countries with available data for both years (see Figure 15), 31 countries have increased the proportion of parliamentary seats held by women, although six countries (Guinea-Bissau, São Tomé and Príncipe, Congo, Equatorial Guinea, Egypt, and Cameroon) show a regression in that timeframe. As was the case in last year's report, Rwanda proved to be the best performer on this indicator in 2009, with 56.3 percent of its parliamentary seats held by women, followed by South Africa (45.0 percent), Angola (37.3 percent), Mozambique (34.8

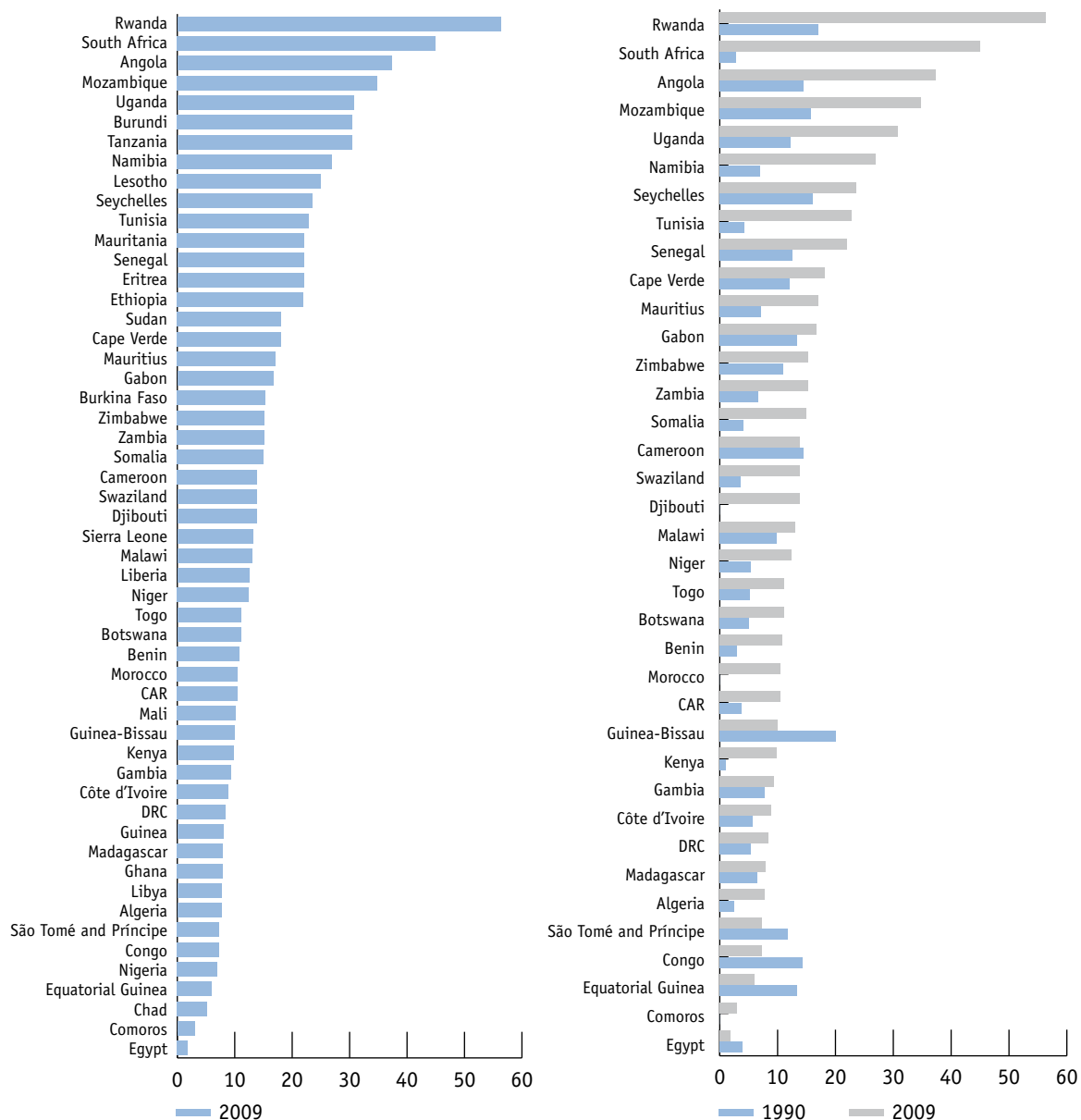
percent), and Uganda (30.7 percent). The remaining 26 countries that show improvements within this time period have less than 30 percent of seats held by women in national parliaments. Seventeen countries registered female participation below 10 percent in 2009.<sup>14</sup> While overall trends for Africa on this indicator are positive, a minimum quota of women parliamentarians needs to be institutionalized, to safeguard the gains made in parliamentary gender parity for the future.

A common characteristic of the four leading countries on this indicator (Rwanda, South Africa, Angola, and Mozambique) is that they have emerged from conflict or civil war. Liberia, the only African country to have ever elected a female Head of State, emerged from a devastating civil war. While some of these countries are no longer considered

14 These countries comprised (lowest ranking first): Egypt, Comoros, Chad, Equatorial Guinea, Nigeria, Congo, São Tomé and Príncipe, Algeria, Libya, Ghana, Madagascar, Guinea, the Democratic Republic of Congo, Côte d'Ivoire, The Gambia, and Kenya.



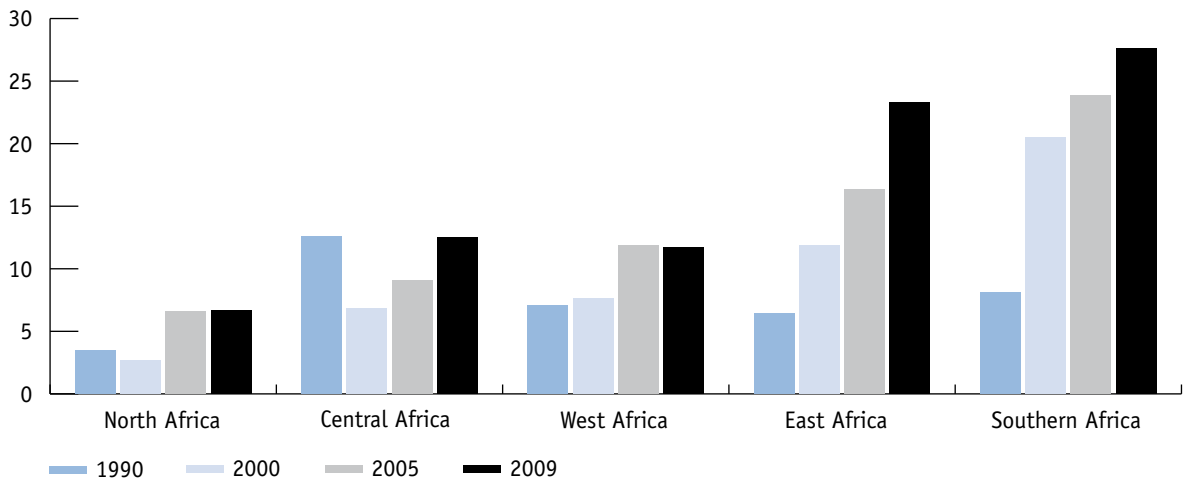
Figure 15: Percentage of seats held by women in national parliaments, 1990 and 2009



Source: ECA computations based on UNSD data, updated in July 2009. No data for 16 countries in 1990. No data for Guinea.<sup>15</sup> The data for South Africa are based on May 2009 election.

<sup>15</sup> The parliament was dissolved following the December 2008 coup.

**Figure 16: Percentage of women in national parliaments, by African subregion, 1990–2009**



Source: ECA computations based on UNSD data as updated in July 2009.

Notes: No data for 16 countries in 1990, 12 countries in 2000, 4 countries in 2005, and 1 country in 2009.

as postconflict or in transition,<sup>16</sup> it appears that conflict environments allow for greater involvement of women in the political sphere. Several possible explanations for this phenomenon exist, one being that in times of severe turmoil, cultural norms and gender-based inequities are set aside for reasons of expediency. Countries in postconflict transition are perhaps more responsive to innovative ideas and donor influence in respect of gender empowerment and equality. Consequently, gender mainstreaming as part of the rebuilding process needs the support of the international community.

<sup>16</sup> The definition of “postconflict” covers the period immediately after conflict, generally lasting about two years. During this period, partnerships with the international community are crucial in supporting or underpinning still fragile ceasefires or peace processes by helping to create conditions for political stability, security, justice and social equity (UNDG/ECHA definition 2004).

*Figure 16* shows that four of the five subregions (Central Africa being the exception) saw overall improvements in the proportion of seats held by women in national parliaments for the period 1990–2009. Southern Africa and East Africa emerged as the best performers in this respect. However, a closer look at the subregional trends shows that improvements were most significant in North, West, East and Southern Africa between 1990 and 2005, while Central Africa saw a sharp decline in the proportion of women holding parliamentary seats over the decade 1990–2000. The period from 2005 to 2009 indicates no progress in North Africa and a slight decline in Western Africa, but improvements in Central, East, and Southern Africa. An overview of subregional trends shows that Southern and East African women are more likely to attain leadership positions than their counterparts in West, Central, and North Africa.

More attention needs to be paid to female representation in national parliaments for this to translate into concrete development outcomes. This is necessary to foster the link between the target and human development indicators, which is the overarching goal of the MDGs.

### Goal 4: Reduce child mortality

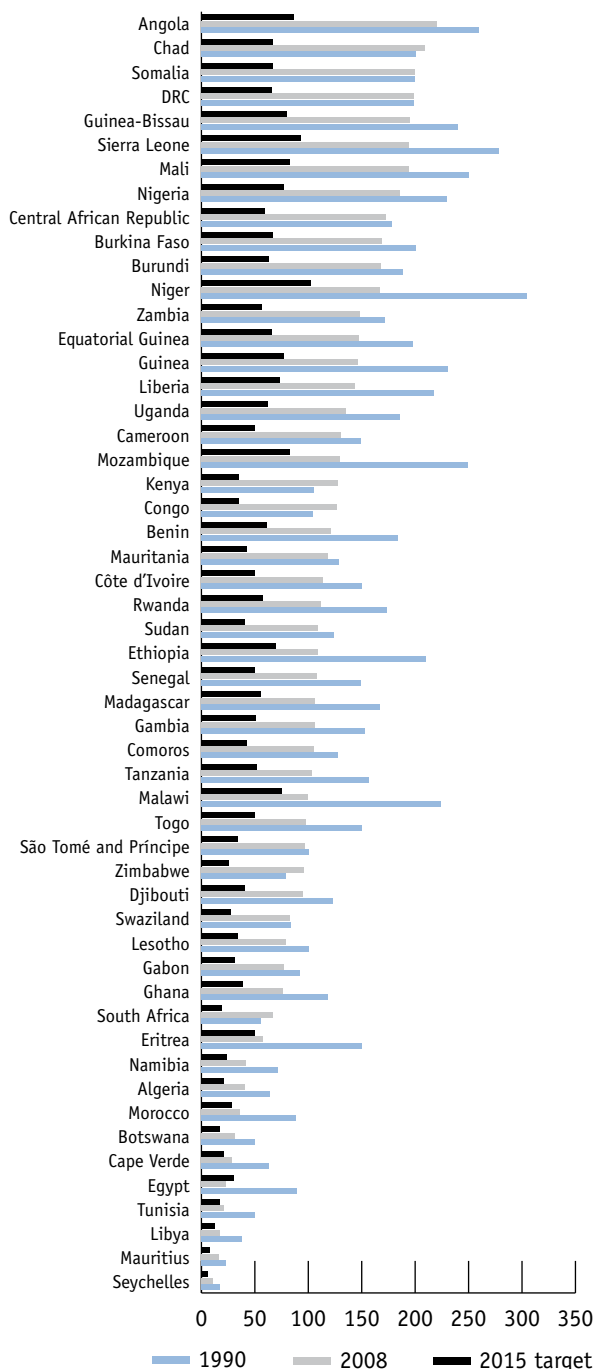
#### Target 4A: Reduce by two-thirds between 1990 and 2015 the under-five mortality rate (U5MR)

Africa continues to show progress, albeit slow, in reducing the under-five mortality ratio. The U5MR declined by 21 percent from 168 deaths per 1,000 live births in 1990 to 132 deaths per 1,000 live births in 2008 (Danzhen et al., 2009). However, the rate of progress being made is insufficient to attain this target at the continental level. Reporting data on this target also presents a challenge. This is because Africa (excluding North Africa) registers the highest percentage (66 percent) of children under-five who are not registered at birth (UNICEF, 2007). African countries should intensify their efforts to establish a credible civil registration system in order to improve the health information system and their ability to monitor progress on this target.

#### Indicator 4.1: Under-five mortality rate (U5MR)

The under-five mortality rate expresses the probability<sup>17</sup> of a child born in a specified year dying before reaching the age of five, subject to the current age-specific mortality rate. Because data on disease incidence and prevalence (viz. morbidity data) are frequently unavailable, mortality rates are instead used to identify vulnerable populations. Measurement difficulties have necessitated

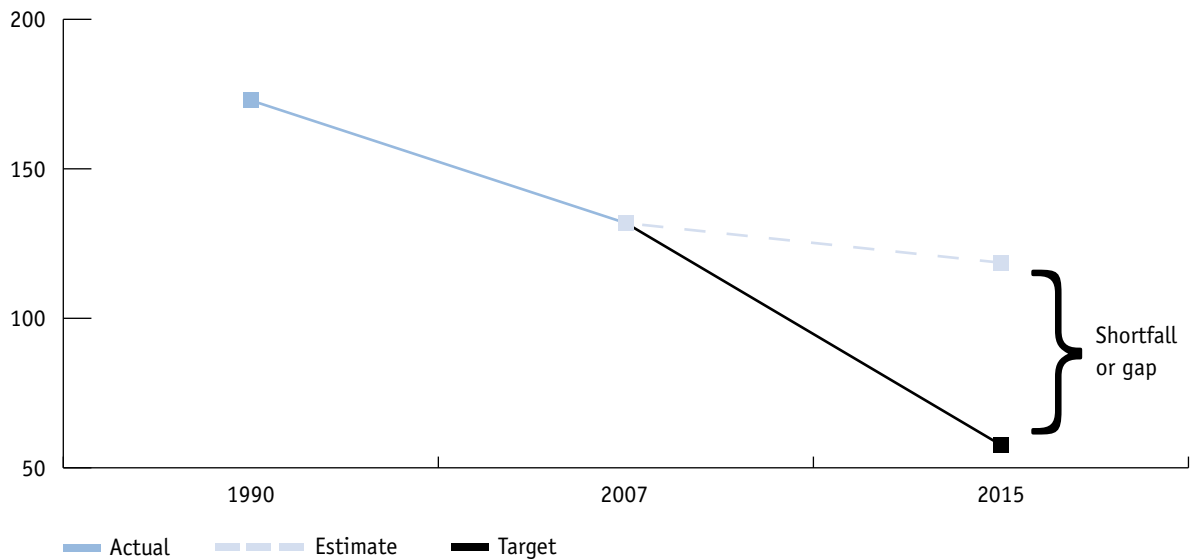
Figure 17: Under-five mortality rates for 1990, 2008, and 2015 (target)



Source: ECA computations based on World Health Statistics, 2010 update.

17 Expressed as a rate per 1,000 live births.

**Figure 18: Under-five mortality rates in Africa for 1990, 2007, and 2015 (estimated rate and target)**



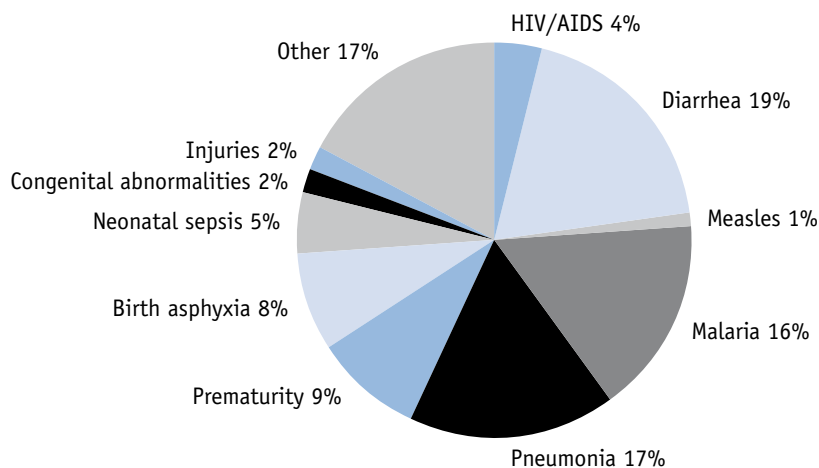
Source: ECA computations based on UNSD data, updated in July 2009.

frequent revisions of the methodology for collecting U5MR data by the Inter-agency Group for Child Mortality Estimation (IGME). Hence the data in this report may not be consistent with what was reported in the past.

*Figure 17* summarizes the under-five mortality rates by country, as well as progress achieved to date. Egypt has already surpassed the target, while Cape Verde, Eritrea, Libya, Mauritius, Morocco, Seychelles, and Tunisia are on track to reduce the U5MR by two-thirds. In countries such as Benin, Equatorial Guinea, Ethiopia, Guinea, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sierra Leone, Togo, and Tanzania, the U5MR has decreased rapidly (by 50 percentage points or

more) from very high initial levels. However, the current rate of progress will be insufficient to reach the target. Progress remains very slow (less than 10 percent) in four countries,<sup>18</sup> while there was no change in the rate in the Democratic Republic of Congo and Somalia between 1990 and 2008. In five countries, namely Chad (4.0 percent), Congo (22.1 percent), Kenya (22 percent), South Africa (19.6 percent) and Zimbabwe (21.5 percent), the U5MR increased between 1990 and 2008.

<sup>18</sup> Mauritania (8.5 percent), São Tomé and Príncipe (4 percent), Central African Republic (2.8 percent), and Swaziland (1.2 percent).

**Figure 19: Causes of under-five mortality in Africa in 2008**

Source: WHO, World Health Statistics 2010.

Note: WHO Africa region excludes Libya, Tunisia, Egypt, Morocco, The Sudan, Djibouti, and Somalia.

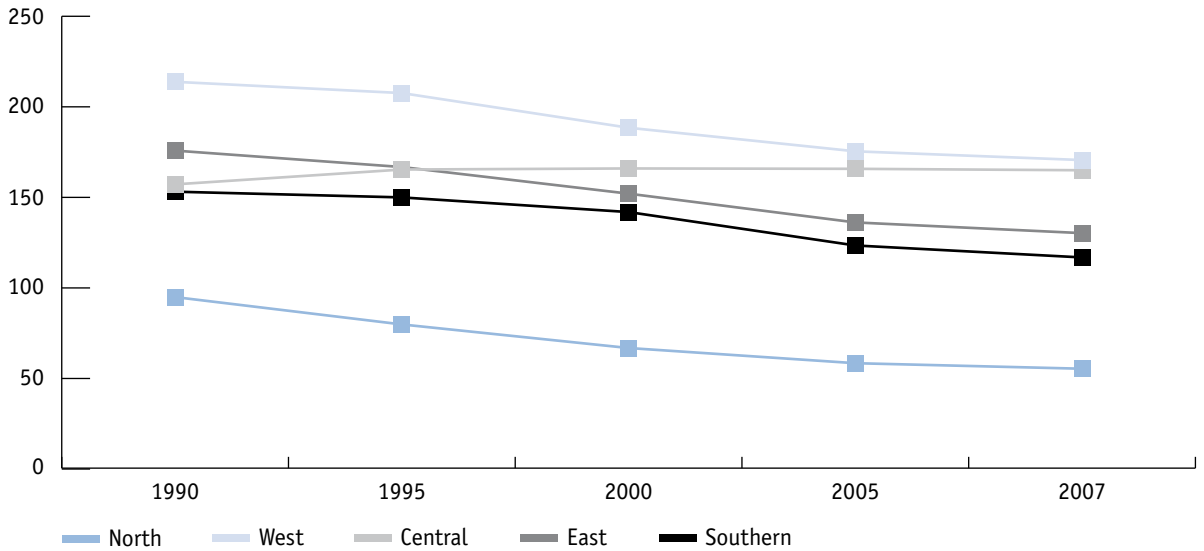
Overall, if the current trends continue, the continent as a whole is unlikely to meet the goal of reducing under-five mortality by the target date of 2015 (see *Figure 18*). Africa, excluding North Africa, still accounts for half of all deaths worldwide of children under the age of five (UN, 2009). This indicates that African countries, excluding North Africa, need to make concerted efforts to achieve this goal and will require strong support from the international community.

According to the latest figures published in the WHO World Health Statistics 2010 report, three major diseases (namely, diarrheal diseases, pneumonia, and malaria) accounted for 52 percent of under-five mortality in Africa in 2008 (see *Figure 19*). This indicates that efforts should focus on the expansion of low-cost, preventative and treatment measures to combat these diseases. Measures could include antibiotics to fight pneumonia, oral rehydration and zinc to combat diarrheal diseases,

insecticide-treated bed nets and effective medicines to prevent and treat malaria.

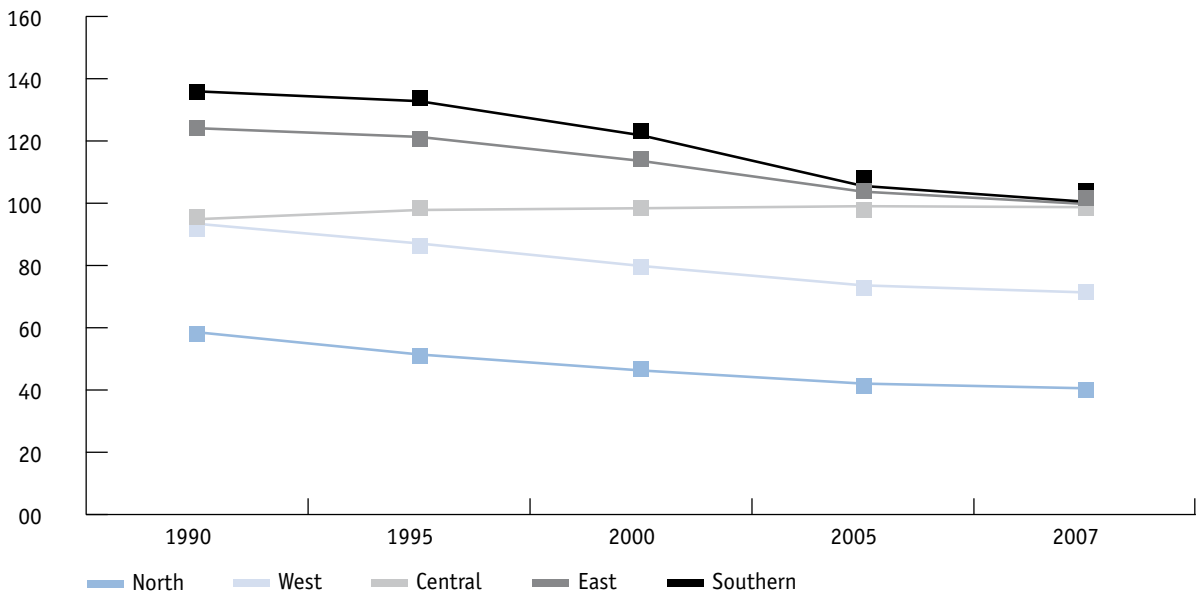
*Figure 20* shows that all subregions except Central Africa have made progress in reducing the under-five mortality rate. North Africa has made the most progress by reducing the U5MR by 42 percent between 1990 and 2007, followed by East Africa (26 percent), Southern Africa (24 percent), and West Africa (20 percent). In Central Africa, the U5MR registered an increase of 5 percent between 1990 and 2007, although there was a leveling-off after 1995. Of all the subregions, West Africa and Central Africa registered the highest U5MR for the year 2007.

**Figure 20: Under-five mortality rate per 1,000 live births by African subregion, 1990–2007**



Source: ECA computations based on UNSD data, updated in July 2009.

**Figure 21: Under-five mortality rate per 1,000 live births by African subregion, excluding the most populous countries, 1990–2007**



Source: ECA computations based on UNSD data, updated in July 2009, excluding the most populous country per subregion: Egypt (North), Nigeria (West), Cameroon (Central), Ethiopia (East), and South Africa (Southern).

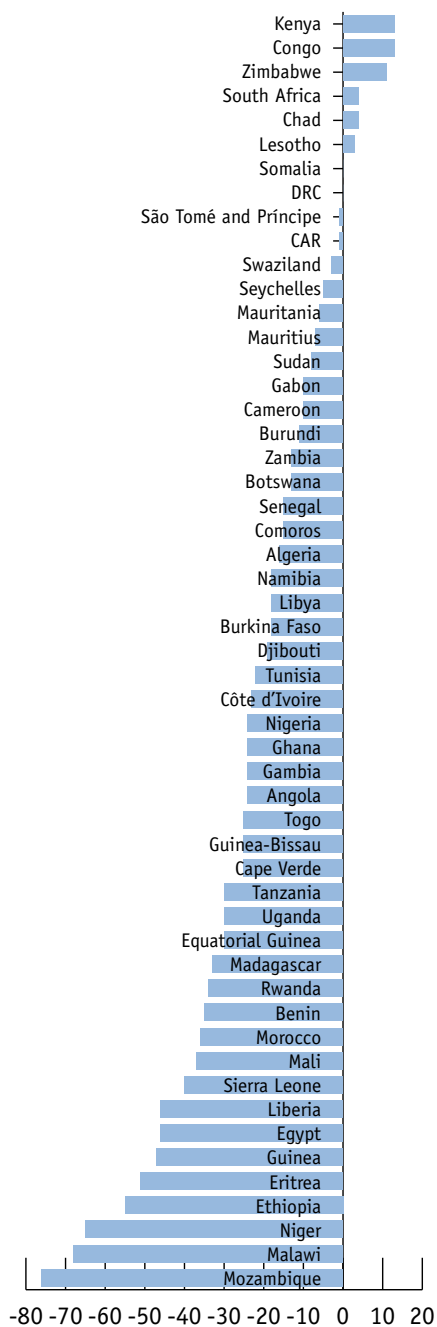
At the subregional level, progress on this indicator depends critically on the efforts being made in the most populous countries within each subregion. Hence, subregional progress rates are highly determined by progress achieved in Nigeria, Egypt, Cameroon, Ethiopia, and South Africa. When these populous countries are taken out of the subregional analysis (see *Figure 21*), the U5MR falls in every subregion, with Southern Africa, East Africa, and Central Africa recording approximately the same ratio (100 mortalities per 1,000 live births) in 2007. North Africa was the best overall subregional performer on this indicator in 2007, followed by West Africa (when Nigeria is excluded from the computations).

#### *Indicator 4.2: Infant Mortality Rate (IMR)*

A critical challenge for Africa is to reduce the number of children who die before reaching their first birthday. The Infant Mortality Rate (IMR) is the number of deaths of infants under one year of age in an indicated year per 1,000 live births in the same year. The IMR measures child survival. It also reflects the social, economic, and environmental conditions in which children (and others in society) live, including their healthcare.

IMR shows a declining trend in most African countries between 1990 and 2008. *Figure 22* reveals significant differences in the rate of progress among countries. The best-performing countries are located on the left hand-side of the figure and the worst-performing countries on the right-hand side. Mozambique recorded the greatest decline in IMR while Kenya was the worst performer, followed by Congo, Zimbabwe, South Africa, Chad, and Lesotho. There was no change in IMR in DRC and Somalia between 1990 and 2008. Of note is the fact that of the six worst-performing countries, two are in Central Africa and three are in Southern Africa. High IMR in Central African countries could be attributed to political

**Figure 22: Progress (% change) in Infant Mortality Rate, 1990–2008**



Source: ECA computations based on World Health Statistics, updated in 2010.

conflict and the prevalence of malaria in the subregion. For example, in Congo and Chad the malaria mortality rate is above the WHO regional average, while in Southern Africa, the high HIV prevalence (above 15 percent) is a determining factor.

Mortality rates at the very early stages of life significantly contributed to the estimated 9.2 million deaths of children under-five around the world in 2007. Around 40 percent of under-five deaths were newborns. In many developing countries, deaths of newborns account for over half of all deaths in infancy, with the vast majority occurring in the first few days of life (UNICEF, 2009). Therefore reducing neonatal deaths is crucial to achieving a reduction in infant mortality. In summary, the slow rate of progress in the region in reducing under-five mortality needs to be addressed urgently.

*Indicator 4.3: Proportion of one-year-old children immunized against measles*

This indicator is defined as the percentage of children under one year of age who have received at least one dose of measles vaccine. This indicator provides a measure of the coverage and quality of the healthcare system in the country. Measles is one of the leading causes of child mortality in developing countries and it is vaccine-preventable. The rates of immunization against measles vary significantly across countries, as can be seen in *Figure 23* below. Thirteen countries reported an immunization rate of 90 percent or above, with only two countries below 50 percent coverage.

Equally important is the rate of progress achieved on measles immunization coverage. This indicates the degree of policy attention being paid to child healthcare. *Figure 23* shows that 16 countries increased their measles immunization coverage by at least 20 percentage points between 2000 and 2008.

These include Niger (46), Congo (45), Angola (38), Cameroon (31), Senegal (29), Nigeria (27), Central African Republic (26), Madagascar (25), Burkina Faso (24), São Tomé and Príncipe (24) Djibouti (23), Sierra Leone (23), Ethiopia (22), Guinea (22), the Democratic Republic of Congo (21), and The Sudan (21). However, nine<sup>19</sup> countries reported a regression in immunization coverage over the same period.

Overall, countries are doing relatively well on this indicator. Most are well above the regional average of 73 percent (WHO, 2010), with only 18 countries falling below it. But vigilance is critical for securing the progress already achieved in order to prevent reversals. In this regard, it is important for African countries and their partners to maintain funding for measles prevention programs.

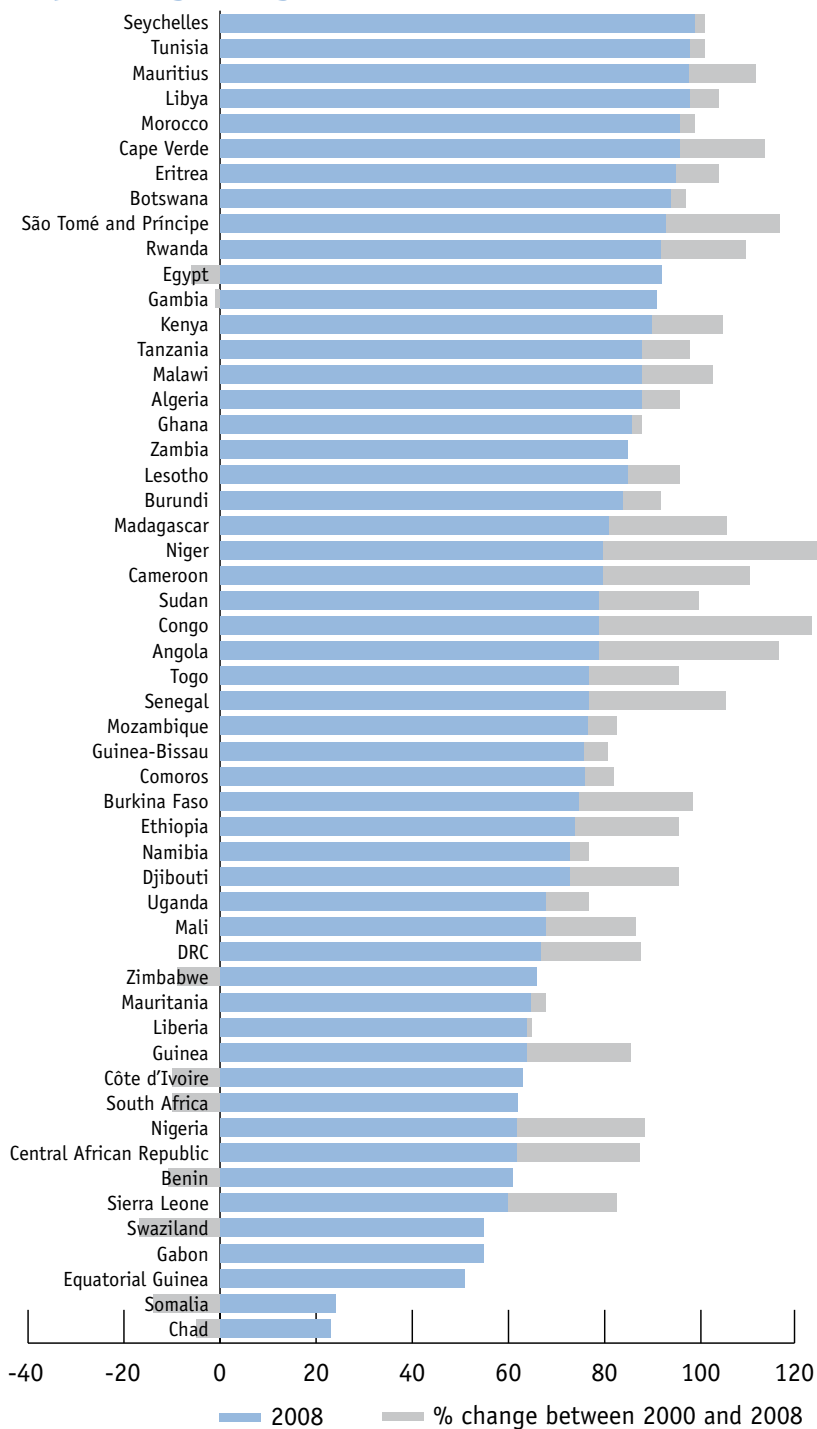
### Goal 5: Improve maternal health

Maternal mortality remains a major challenge for health systems worldwide. Nonetheless, the latest available data give some glimmer of hope for Africa as a region, which registered an overall decline for this indicator between 1980 and 2008. The same data reveal that progress in the continent would have been much more extensive, given an absence of HIV/AIDS (North Africa excepted, since it has a very low HIV/AIDS rate). However, the slow rate of progress is not sufficient to achieve the goal by the target date. The adverse consequences of poor maternal health outcomes are well documented in the literature. The death of a mother during childbirth may shorten the life of the newborn. It may also mean descent into poverty and poor social outcomes for the living children as well as other dependants.

<sup>19</sup> These countries (with percentage regressions) were: The Gambia (-1), Chad (-5), Egypt (-6), Zimbabwe (-9), Côte d'Ivoire (-10), South Africa (-10), Benin (-11), Somalia (-14), and Swaziland (-17).



**Figure 23: Percentage of one-year-old children immunized against measles in 2008 and percentage change, 2000 to 2008**



Source: ECA computations based on World Health Statistics, updated in 2010.

**Target 5A: Reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio (MMR)**

*Indicator 5.1: Maternal Mortality Ratio (MMR)*

The most common measure of maternal health is the Maternal Mortality Ratio (MMR). This is defined as the number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year (expressed per 100,000 live births). It is very difficult to collect data on this indicator. Available data are not comparable across time because of frequent revisions of the methodology. According to UNSD data, there has been a perceptible decline in maternal mortality in Africa.

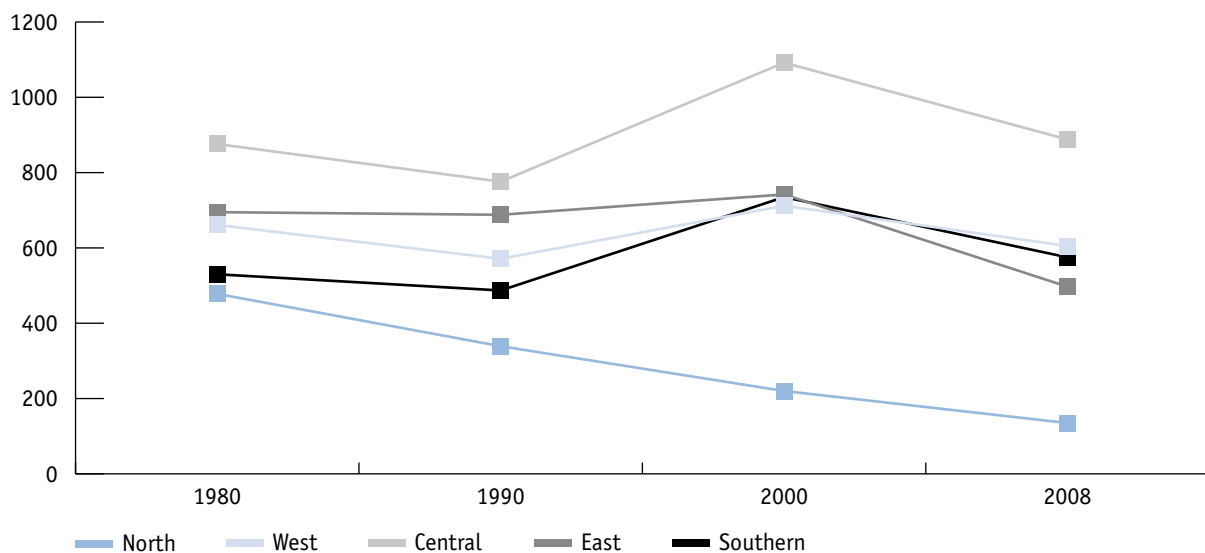
A recent study published in *The Lancet* (Hogan et al., 2010) suggests that the MMR has fallen significantly across the globe, including Africa, by much more than conventional wisdom would suggest. While this finding may be controversial, a number of factors seem to substantiate this claim. First, the average age at first marriage is rising. Second, the average family size is falling. According to the UN (2009), the Total Fertility Rate (TFR) fell from 6.5 to 4.6 between 1970–1975 and 2005–2010. Third, efforts aimed at preventing the spread of HIV and AIDS, including the use of condoms, are also having an impact on pregnancy rates. Fourth, Africa's rising divorce rate may be having a reductive effect on the number of pregnancies that a woman may have during her lifetime, so reducing the risk of death during pregnancy (and the number of women who may face that risk). Rising per capita income, better nutrition, and a rise in the number of girls who complete primary education are other positive factors contributing to improvements for this indicator.

*Figure 24* uses data from the above-cited article in *The Lancet* to explore trends in the MMR across Africa. It shows declining trends across all subregions, although the rate remains high (except in North Africa) in comparison to developed countries. Central Africa, which includes the Democratic Republic of Congo, a country that has been in turmoil for the past eight years, has the highest MMR of all the African subregions, although the ratio declined rapidly from 2000 to 2008 in the subregion as a whole. The MMR is lowest in North Africa, followed by East Africa, Southern, and West Africa.

According to *The Lancet* article, three of the six countries that account for 50 percent of all maternal deaths globally are in Africa – namely, Nigeria, Ethiopia, and the Democratic Republic of Congo. Although the MMR has fallen in both Nigeria and Ethiopia, it needs to fall at a much faster rate for the overall picture to change. In Southern Africa, the high rate of prevalence of HIV is an important contributory factor to the elevated MMR. Indeed, the data suggest an HIV gradient for maternal mortality: the higher the HIV prevalence rate, the higher the MMR. In countries with an HIV prevalence of between 10 and 15, MMR fell by about 20 percent. It fell by about 36 percent in those countries with a reported HIV prevalence rate of between 5 and 10 percent.

While the evidence in *The Lancet* article is open to debate, it nonetheless lends credence to the progress outlined in last year's report, which was based on World Health Organization (WHO) data. According to the WHO 2008 World Health Statistics, the MMR fell in all global regions in 2005 relative to 1990, although Africa accounted for the highest MMR, followed by Oceania. This

**Figure 24: Maternal Mortality Ratio (MMR) per 100,000 live births, by African subregion, 1980–2008**



Source: Hogan et al. (2010) published online April 12, 2010 at [www.thelancet.com](http://www.thelancet.com).

Note: Data weighted by population of each country for the purpose of regional analysis. No data for the Seychelles.

suggests that the current efforts to reduce the high MMR are working but need to be scaled up. Additional resources must be provided to expand access to antiretroviral treatment and to train more midwives. Similarly, countries need to pay urgent attention to reducing inequities in access to healthcare, including maternal care.

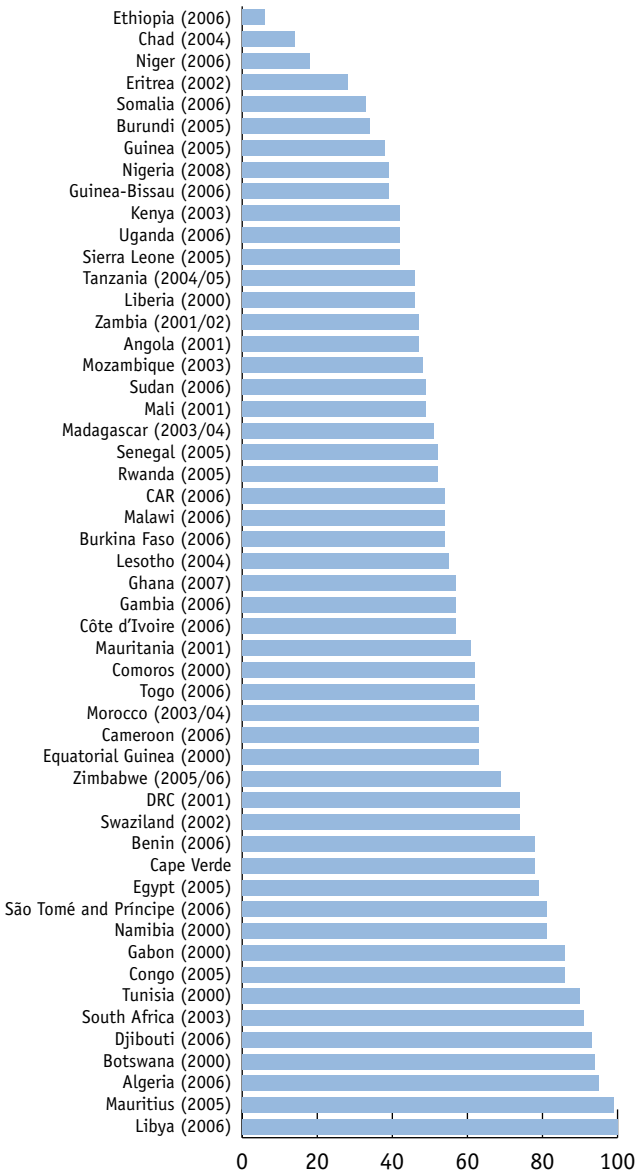
**Indicator 5.2: Proportion of births attended by skilled health personnel**

A key intervention for reducing maternal deaths is to increase the number of skilled health personnel who attend births. Thus, increasing the proportion of births attended by skilled health personnel is a proxy for measuring an improvement in maternal mortality, since most maternal deaths are caused by hemorrhaging, which can be prevented if birth is attended by skilled health

personnel. Although data on this indicator in the UNSD database are inadequate for analysis, 2009 data from the World Health Statistics (WHO, 2010) show significant improvements in many African countries. Of 52 African countries for which data are available (see Figure 25), seven countries reported the proportion of births attended by a skilled health professional to be 90 percent or above. The WHO regional average for Africa (excluding North Africa) is 47 percent, with 38 countries ranking above this average. Nineteen countries recorded fewer than 50 percent of births attended by skilled health personnel, with Ethiopia being the only country to report in single digits.

To accelerate the reduction of maternal mortality in Africa, it is imperative to improve this indicator

**Figure 25: Percentage of births attended by skilled health personnel, for selected African countries**



Source: WHO, World Health Statistics, updated in 2010.

Note: Years in parentheses indicate latest available data. No data available for Seychelles.

in two of Africa's most populous countries, namely Nigeria and Ethiopia. It is also crucial to take regional action to scale up HIV prevention and treatment measures, particularly for those countries that have fallen below the regional average. It would be possible to initiate a program of action between now and 2015 in these countries, as there are proven interventions that work. Additional health personnel could be trained by using existing facilities intensively. It would also be possible to attenuate the rate of out-migration of health workers through a combination of incentives. Further, innovative measures could be introduced to reduce inequities in access to healthcare, and especially to encourage expectant mothers to seek professional care.

Political leadership at national, regional, and continental levels is critical for success in this area. At the country level, there are positive signs that countries are beginning to take action. For example, Nigeria has expanded its national midwifery program and in early 2010 it assigned 2,810 midwives to rural areas. It has also intensified social advocacy in those parts of the country reporting the worst figures.

At the continental level, the African Union is providing much-needed political leadership. In May 2009 it launched at continental, subregional, and national levels its Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) with the slogan, "No Woman should Die while Giving Life." CARMMA focuses on three key areas: (i) positive messaging, (ii) encouraging peer learning and experience sharing in efforts to reduce maternal mortality with a view to replicating successes and avoiding mistakes, and (iii) intensification of actions to reduce maternal and associated infant deaths in Africa. The campaign has been launched

**Table 3: Contraceptive prevalence rates in Africa, various years (%)**

<b>Contraceptive prevalence rate above regional average of 23.7%</b>		<b>Contraceptive prevalence rate below regional average of 23.7%</b>		<b>Countries with no data reported</b>
Mauritius (2002)	75.8	Ghana (2008)	23.5	Libya
Morocco (2003/04)	63.0	DRC (2007)	20.6	Seychelles
Algeria (2006)	61.4	Burundi (2002)	19.7	
Cape Verde (2005)	61.3	Central African Republic (2006)	19.0	
Egypt (2008)	60.3	Djibouti (2006)	17.8	
South Africa (2003)	60.3	Gambia (2001)	17.5	
Tunisia (2006)	60.2	Burkina Faso (2006)	17.4	
Zimbabwe (2005/06)	60.2	Benin (2006)	17.0	
Namibia (2006/07)	55.1	Togo (2006)	16.8	
Swaziland (2006/07)	50.6	Mozambique (2003/04)	16.5	
Botswana (2000)	44.4	Ethiopia (2005)	14.7	
Congo (2005)	44.3	Nigeria (2007)	14.7	
Malawi (2006)	41.7	Somalia (2005/06)	14.6	
Zambia (2007)	40.8	Côte d'Ivoire (2006)	12.9	
Kenya (2003)	39.3	Senegal (2005)	11.8	
Lesotho (2004)	37.3	Liberia (2007)	11.4	
Rwanda (2007/08)	36.4	Niger (2006)	11.2	
Gabon (2000)	32.7	Guinea-Bissau (2006)	10.3	
São Tomé and Príncipe (2000)	29.3	Equatorial Guinea (2000)	10.1	
Cameroon (2006)	29.2	Mauritania (2007)	9.3	
Madagascar (2003/04)	27.1	Guinea (2005)	9.1	
Tanzania (2004/05)	26.4	Mali (2006)	8.2	
Comoros (2000)	25.7	Sierra Leone (2008)	8.2	
Uganda (2006)	23.7	Eritrea (2002)	8.0	
		Sudan (2006)	7.6	
		Angola (2001)	6.2	
		Chad (2004)	2.8	

Source: WHO, World Health Statistics, updated in 2010

Note: Years given in parentheses indicate latest available data.

in Chad, Ethiopia, Ghana, Malawi, Mozambique, Nigeria, Rwanda, Senegal, and Tunisia, with plans to expand coverage to all the 53 AU Member

States. Further, the theme and focus of the July 2010 Summit in Uganda will be on maternal, infant, and child health, as an additional way to

mobilize efforts to accelerate progress on this indicator.

**Target 5B: Achieve universal access to reproductive health by 2015<sup>20</sup>**

Critical to improving maternal health is access to reproductive health. In many parts of the continent, this is a contentious cultural and religious issue. As a consequence, data on access to reproductive health remain scant and of questionable quality and reliability. Nonetheless, recent data from the WHO permit an assessment of progress on contraceptive prevalence rates, adolescent pregnancy rates, antenatal care coverage, and unmet family planning needs. A major limitation of the data is that it is not possible to assess progress relative to 1990.

*Indicator 5.3: Contraceptive prevalence rates for married people*

Progress on contraceptive prevalence for married people in Africa remains low (average 24.4 percent) relative to other regions. *Table 3* summarizes the data for the 53 African countries. It is evident that most African countries are unlikely to achieve the target as only ten countries have reached a contraceptive prevalence rate above 50 percent: Mauritius (75.8), Morocco (63.0), Algeria (61.4), Cape Verde (61.3), Egypt (60.3), South Africa (60.3), Tunisia (60.2), Zimbabwe (60.2), Namibia (55.1), and Swaziland (50.6).

As in previous years, North African countries reported the highest contraceptive prevalence rates, while the West Africa subregion recorded the

lowest. It is noteworthy that the countries reporting the highest percentages of births attended by a skilled health personnel also register the highest contraceptive prevalence rate among married people. This suggests that access to skilled health personnel during pregnancy has a subsequent positive impact on the adoption of contraceptive measures. The social position of married women in society is another constraint, as are religious beliefs, with most surveys indicating that Africa is deeply religious.<sup>21</sup>

*Indicator 5.4: Adolescent birth rates*

Teenage pregnancy, especially among unmarried girls, is a serious social and health problem, with grave inter-generational consequences. Not only are teenage mothers more likely to die during pregnancy, but early motherhood can also limit the life chances of young girls. Similarly, because of inexperience, adolescent mothers are less likely to produce quality care for their newborn, which is a contributory factor to the infant mortality rate.

The goal is to drastically reduce adolescent birth rates, as measured by the fertility rate per 1,000 girls aged 15 to 19. *Table 4* gives details on 50 African countries for which data are available. According to the WHO, the regional average adolescent birth rate in 2009 is 118 births, with 22 countries recording a rate above the average. Four North African countries – Algeria, Libya, Tunisia, and Morocco – report the lowest adolescent birth rates on the continent, putting that subregion's performance well ahead of the rest on this indicator.

20 This target was adopted at the 2005 UN World Summit and mid-term review of progress toward the MDGs and came into effect in 2007, after it had been operationalized by the Inter-agency Expert Group on MDGs indicators.

21 See for example, "Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa". *Pew Forum on Religion and Public Life*, April 2010.

**Table 4: Adolescent birth rates in Africa, various years (per 1,000 girls aged 15–19 years)**

<b>Adolescent fertility rate per 1,000 girls aged 15–19 years below the regional average of 118 births</b>		<b>Adolescent fertility rate per 1,000 girls aged 15–19 above the regional average of 118 births</b>		<b>Countries with no data reported</b>
Algeria (2006)	4	Somalia (2005)	123	Gabon
Libya (2002)	4	DRC (2006)	124	Sudan
Tunisia (2006)	6	Nigeria (2002)	126	Togo
Morocco (2005)	18	Equatorial Guinea (2001)	128	
Djibouti (2000)	27	Burkina Faso (2001)	131	
Egypt (2006)	27	Congo (2003)	132	
Burundi (2001)	30	Central African Republic (2003)	133	
Mauritius (2006)	35	Liberia (2004)	137	
Rwanda (2006)	40	Tanzania (2003)	139	
Botswana (2006)	51	Cameroon (2002)	141	
Seychelles (2006)	54	Sierra Leone (2007)	146	
South Africa (2007)	54	Zambia (2006)	146	
Ghana (2001)	74	Guinea (2003)	153	
Namibia (2004)	74	Madagascar (2001)	154	
Eritrea (2000)	85	Uganda (2004)	159	
Mauritania (2001)	88	Angola (2005)	165	
São Tomé and Príncipe (2001)	91	Guinea-Bissau (2000)	170	
Cape Verde (2003)	92	Malawi (2005)	178	
Comoros (2000)	95	Mozambique (2001)	185	
Lesotho (2003)	98	Mali (2004)	190	
Senegal (2003)	100	Chad (2002)	193	
Zimbabwe (2003)	101	Niger (2004)	199	
Gambia (2000)	104			
Ethiopia (2003)	109			
Côte d'Ivoire (2006)	111			
Swaziland (2004)	111			
Benin (2004)	114			
Kenya (2001)	116			

Source: WHO, World Health Statistics, updated in 2010.

Note: Years given in parentheses indicate latest available information.

The adolescent birth rate is highest in Niger, Chad, Mali, and Mozambique, which are among the poorest countries on the continent. In these countries early marriage is common and the proportion of girls enrolled in school is relatively low. This evidence suggests a very strong association between poverty and high adolescent birth rate and underscores the interconnectivity of many of the MDGs.

*Indicator 5.5: Antenatal care coverage (at least one visit and at least four visits)*

Antenatal care coverage across Africa has seen steady improvement, according to the 2009 MDGs Report (UNECA/AUC/AfDB, 2009). Of the total 53 African countries (see *Table 5*), 18 countries reported a rate of 90 percent and above for at least one visit, while just four countries (Niger, Chad, Ethiopia, and Somalia) reported a rate below 50 percent. Three countries failed to report data on this indicator. In addition, 40 African countries recorded a rate higher than the WHO regional average of 73 percent, while 10 countries fell below this average.

*Indicator 5.6: Unmet need for family planning*

The unmet need for family planning remains one of the most difficult indicators to track. Yet family planning is an essential element of policies and interventions to improve maternal health. In Africa, bridging the unmet need for family planning has been a challenge; furthermore an assessment of progress on this indicator is constrained by inadequate data. Power asymmetry in gender relations is also a factor, as well as restrictive cultural and social norms that limit disclosure of need. Nonetheless, of the total 53 countries (see *Table 6*), 19 reported a rate above the WHO regional average of 24.3 percent, while 17 fell below this

average. Eighteen countries failed to report data on this indicator.

**Goal 6: Combat HIV, AIDS, malaria, and other major diseases**

The diseases of poverty – HIV, AIDS, tuberculosis, malaria, and other related infectious diseases – continue to afflict the continent and fetter improvement in human conditions. Progress is being made in a number of countries but is being constrained inter alia by two major factors: (i) the need for increased financing and (ii) civil/violent conflicts that continue to beset some nations. In 2010, of all the global regions, Africa had the largest number of countries reporting violent conflict within their borders. Conflict means that resources that would otherwise have been directed to tackling these diseases are instead diverted to buying arms.

While their declared commitment to tackling these diseases remains very strong, most countries have yet to meet the pledge that they made in Abuja to allocate at least 15 percent of their annual budgets to the health sector. On the positive side though, the international partnership for health in Africa remains strong. With the assistance of development partners, including non-governmental organizations, additional resources continue to be made available to tackle HIV/AIDS, tuberculosis, malaria, and other related infectious diseases. The key to reducing the burden of these diseases in Africa is economic growth, education, peace, and security.



**Table 5: Antenatal care coverage in Africa, various years (%)**

	Antenatal care coverage (%): at least one visit above regional average of 73%		Antenatal care coverage (%): at least one visit below regional average of 73%		Countries with no data reported
Cape Verde (2005)	98	Mozambique (2008)	89	Eritrea (2002)	Libya
Gambia (2006)	98	Guinea (2007)	88	Mali (2006)	Mauritius
São Tomé and Príncipe (2006)	98	Senegal (2005)	87	Central African Republic (2006)	Seychelles
Botswana (2000)	97	Sierra Leone (2005)	87	Morocco (2003/04)	
Rwanda (2007/08)	96	Congo (2005)	86	Sudan (2006)	
Tunisia (2006)	96	Equatorial Guinea (2000)	86	Nigeria (2008)	
Namibia (2006/07)	95	Burkina Faso (2006)	85	Niger (2006)	
Gabon (2000)	94	Côte d'Ivoire (2006)	85	Chad (2004)	
Uganda (2006)	94	DRC (2007)	85	Ethiopia (2005)	
Zambia (2007)	94	Swaziland (2006/07)	85	Somalia (2006)	
Zimbabwe (2005/06)	94	Benin (2006)	84		
Burundi (2005)	92	Togo (2006)	84		
Djibouti (2006)	92	Cameroon (2006)	82		
Kenya (2003)	92	Angola (2006/07)	80		
Malawi (2006)	92	Madagascar (2003/04)	80		
South Africa (2003)	92	Liberia (2007)	79		
Ghana (2007)	90	Guinea-Bissau (2006)	78		
Lesotho (2004)	90	Tanzania (2007/08)	76		
Algeria (2006)	89	Mauritania (2007)	75		
		Comoros (2004)	75		
		Egypt (2008)	74		

Source: WHO, World Health Statistics, updated in 2010.

Note: Years given in parentheses indicate latest available data.

**Table 6: Unmet need for family planning in Africa, various years (%)**

Unmet need for family planning above regional average of 24.3%		Unmet need for family planning below regional average of 24.3%		Countries with no data reported
Uganda (2006)	40.6	Swaziland (2006/07)	24.0	Algeria
Rwanda (2005)	37.9	Madagascar (2003/04)	23.6	Angola
Liberia (2007)	35.6	Chad (2004)	23.3	Botswana
Ghana (2003)	34.0	Tanzania (2004/05)	21.8	Central African Republic
Ethiopia (2005)	33.8	Guinea (2005)	21.2	Comoros
Mauritania (2000/01)	31.6	Cameroon (2004)	20.2	Côte d'Ivoire
Senegal (2005)	31.6	Mozambique (2003/04)	18.4	Djibouti
Mali (2006)	31.2	Nigeria (2003)	16.9	Equatorial Guinea
Lesotho (2004)	30.9	Cape Verde (2005)	16.7	Gambia
Benin (2006)	29.9	Congo (2005)	16.2	Guinea-Bissau
Burundi (2002)	29.0	Niger (2006)	15.8	Libya
Burkina Faso (2003)	28.8	Zimbabwe (2005/06)	12.8	São Tomé and Príncipe
Gabon (2000)	28.0	Tunisia (2001)	12.1	Seychelles
Malawi (2006)	27.6	Egypt (2005)	10.3	Sierra Leone
Eritrea (2002)	27.0	Morocco (2003/04)	10.0	South Africa
Zambia (2007)	26.5	Namibia (2006/07)	6.7	Somalia
Algeria (2006)	24.6	Mauritius (2002)	3.5	Sudan
Kenya (2003)	24.5			Togo
DRC (2007)	24.4			

Source: WHO, World Health Statistics, updated in 2010.

Note: Years given in parentheses indicate latest available data.

### **Target 6A: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS**

According to UNAIDS, Africa has sustained the progress made in tackling HIV/AIDS. The decrease in HIV prevalence and mortality rates reported in 2007 persists and the HIV/AIDS-related mortality rate has not increased since the last report, but appears to have stabilized. Access to antiretroviral therapy (ART) for HIV patients has expanded in most countries, especially countries at the epicenter of the epidemic. Cumulatively, the number

of adults and children newly infected with HIV decreased by 17.4 percent between 2001 and 2008. Aggressive prevention programs combined with increased access to treatment and behavior change appear to be the main drivers of this improvement. Nonetheless, the number of people living with HIV remains high, in part due to the paradox of success: increased access to treatment is reducing HIV/AIDS mortality and increasing the number of people who are living with AIDS.

This could financially stretch health systems and national economies.

*Indicator 6.1: HIV prevalence among population aged 15–24*

The 15–24 age group is the most sexually active segment of the population. Hence reducing HIV prevalence among this cohort is critical to reversing the spread of the epidemic. As reported in previous editions of this Report, HIV prevalence and mortality rates among this group have been falling. In 2008, the prevalence among this age group in Africa where most HIV patients live (which excludes North Africa) fell to around 5 percent and confirms a declining trend since 2005 (UNAIDS, 2009).

*Indicator 6.2: Condom use for high-risk sex*

One of the indicators used to measure the probability of new HIV infections is condom use for the last high-risk sexual encounter. Despite the high HIV/AIDS prevalence rate, condom use for last high-risk sex encounter remains low. This assessment is however problematic, as most African countries do not report data on this indicator. For example, in 2006, the latest year for which information is available, only 15 African countries reported on this indicator. According to the data they provided, 42 percent of women and 52 percent of men used a condom at the last reported, high-risk sexual encounter. Or to express this differently, men are much more likely to use a condom than are women, which underscores the glaring inequity in gender relations in Africa. Gender inequities continue to affect women's decision-making and risk-taking behaviors. Furthermore, vulnerability to HIV infection is often determined by a combination of physiological and social factors, which may be beyond an individual's choice, for example in cases

of rape or where sex work may be commonplace, or in polygamous marriages.

*Indicator 6.3: Proportion of population aged 15–24 years with comprehensive knowledge of HIV/AIDS*

Comprehensive knowledge of HIV/AIDS and HIV-prevention is improving among young people aged 15–24 years. The UN General Assembly Special Session on HIV/AIDS set the target of comprehensive HIV knowledge at 95 percent by 2010. Most countries will not meet this target, although the decrease in infection rate among young people suggests that comprehensive knowledge is increasing and that it is having the expected impact on behavior. Sex education in schools is seen as a critical intervention in this regard. Providing schoolchildren and adolescents with specific, gender-sensitive and age-appropriate information on HIV prevention is essential, as is equipping them with the problem-solving, negotiation and decision-making skills to put that knowledge into practice.

*Indicator 6.4: Ratio of school attendance of orphans to non-orphans aged 10–14 years*

Progress in achieving the goal of reversing HIV/AIDS is critically dependent on the proportion of orphans aged 10–14 years who attend school. The capacity of education to provide life opportunities and decrease the possible transmission of the disease remains a key element in the integration of HIV orphans in society. Unfortunately, most African countries, for various reasons – including prevention of stigma – do not collect and report data on school attendance of orphans (aged 10–14 years) compared to non-orphans. In countries that do report such data, there has been some improvement for this indicator. Children who lose their mother are less likely to attend school than those who lose their father. And children who are

not enrolled when either parent dies are even less likely to attend school later.

**Target 6B: Achieve by 2010 universal access to treatment for HIV/AIDS for all those who need it**

*Indicator 6.5: Proportion of people with advanced HIV infection who have access to antiretroviral drugs*

As of December 2008, some 3 million Africans (adults and children) were estimated to be receiving antiretroviral therapy (ART), representing 44 percent of the estimated total in need of such services (UNAIDS, AIDS Epidemic Update 2009). Five years earlier, the estimated regional coverage was just 2 percent, so there has been a twenty-fold increase in treatment availability and uptake. This has resulted in a significant decrease in overall AIDS mortality and an estimated gain of 2 million years of life in Africa, excluding North Africa which has very low levels of HIV/AIDS (UN, 2008). Nevertheless, 1.4 million people died of AIDS in the past year alone. Extending treatment to the remaining 4–5 million in Africa who are yet to be reached, and sustaining ART over the longer term, represents a challenge because of the resource costs, especially if patients receiving treatment fail to return to productive employment.

Preliminary evidence from an ongoing cohort study<sup>22</sup> of tea estate workers in Kenya who received ART suggests that this may not present a major challenge, as most of the workers quickly returned to their primary work assignment (picking tea) during the initial 12 months on ART. The study suggests that ART can restore normal functioning quickly among non-formal sector workers in rural areas and prevent precipitous declines in

rural agricultural productivity conditional on two factors: improving access to treatment and ensuring adequate nutritional levels. This reinforces the need for public and private interventions that (i) remove barriers to accessing health services and (ii) improve the nutritional status of HIV patients.

**Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**

*Indicator 6.6: Incidence and death rates associated with malaria*

Malaria continues to represent a major cause of morbidity and mortality in Africa. However, data on malaria incidence and mortality are not consistently reported in the UNSD database. In 2006, the latest year for which data are available, there were an estimated 247 million episodes of malaria worldwide, resulting in 0.88 million deaths. Of these, 91 percent were in Africa and of these deaths, 85 percent were of children under-five years of age. Pregnant women are also particularly vulnerable, being three times more likely to develop serious malaria than other adults during a malaria epidemic (GAVI, 2009).

Poverty is a major cause of death from malaria. The poorest households account for the highest proportion of malaria-related deaths because of poor access to and utilization of healthcare services. This may be due to the cost of such services or to distance from health centers, or both. Political instability in countries such as the Democratic Republic of Congo, Côte d'Ivoire, Chad, and Burundi is a major driver of malaria deaths because it makes it harder to reach groups who might be in urgent need of interventions.

22 Larson et al. (2008).

Nonetheless, there has been a reduction in malaria mortality in a number of countries in the region, including Ethiopia, Mozambique, Rwanda, Zambia, and the Zanzibar region of Tanzania. Insecticide-treated bed nets (ITNs) are a proven intervention against malaria and there has been a major effort both at national and international levels to augment their use in Africa. This has resulted in an increase from 17 percent in 2007 to 31 percent in 2008 in the number of African households with at least one ITN. Artemisinin-based combination therapies (ACTs) are also being more widely applied in the treatment of uncomplicated malaria. In a number of countries, there is an increasing resort to the mapping of weather conditions to target malaria interventions.

Despite these encouraging developments, a lot remains to be done to reduce malaria mortality. In spite of the proven benefits of ITNs, inadequate funding continues to hinder their widespread application. International financing for ITNs in 2007 was USD 0.65 billion, which was far short of the USD 5 billion per annum global estimate to ensure high coverage and maximum impact. Free distribution of ITNs is helping to bridge this funding gap, although there is the risk that it could harm, in the medium to long-term, the development of a mature commercial ITN market. Africa's development partners are also helping to scale up highly effective malaria prevention and treatment programs. For example, the US President's Malaria Initiative (PMI), whose purpose is to "reduce malaria-related deaths by 50 percent in the 15 African countries with a high burden of the disease", is helping to mobilize national governments and other donors to scale up interventions such as ITNs, Indoor Residual Spraying (IRS) with insecticides, Intermittent Preventive

Treatment of malaria during pregnancy (IPTp), and artemisinin-based combination therapy (ACT) for malaria infections (USAID, 2009).

However, external funds are disproportionately concentrated on smaller African countries with lower disease burdens, rather than larger countries with higher malaria cases and deaths. African governments need to devote more resources to malaria prevention and treatment, as they agreed to do at their 2000 and 2006 Summits in Abuja, Nigeria.

*Indicator 6.7: Proportion of children under-five sleeping under insecticide-treated nets (ITNs)*

Malaria remains a major cause of childhood deaths in Africa, with children under five accounting for about 85 percent of all malaria deaths in the continent. The long-term solution to the problem is a malaria vaccine, but its development is proceeding slowly, although some promising candidate vaccines are now at the clinical trial stage. In the short run, in order to reduce childhood deaths from malaria, it is essential to increase the proportion of children under-five who sleep under ITNs. In 2008 (see *Table 7*), the latest year for which data are available, only around 24 percent of under-fives slept under an ITN in Africa.

This is an improvement but still a long way from the World Health Alliance (WHA) target of 80 percent coverage. Sixteen of the 20 countries for which data are available have at least tripled their coverage since 2000. Household ownership of ITNs (used to estimate the proportion of children under-five years of age who sleep under ITN), surpassed 60 percent in Equatorial Guinea, the lowlands of Ethiopia, Gabon, Mali, São Tomé and Príncipe, Senegal, and the Zanzibar region

**Table 7: Proportion of children under-five sleeping under insecticide-treated bed nets, for selected African countries, 2000–2008**

% of under-fives sleeping under ITNs by country (above WHO regional average of 17%)		% of under-fives sleeping under ITNs by country (below WHO regional average of 17%)		Non endemic countries	Countries with no data reported
Madagascar	60	Tanzania	16	Lesotho	Algeria
São Tomé and Príncipe	54	Central African Republic	15	Libya	Botswana
Gambia	49	Cameroon	13	Mauritius	Cape Verde
Equatorial Guinea	42	Burkina Faso	10	Seychelles	Egypt
Zambia	41	Comoros	9	Tunisia	Gabon
Guinea-Bissau	39	Somalia	9		Morocco
Kenya	39	Uganda	9		Namibia
Togo	35	Burundi	8		South Africa
Ethiopia	33	Mozambique	7		
Senegal	31	Niger	7		
Ghana	28	Congo	6		
Sudan	28	Côte d'Ivoire	6		
Mali	27	Democratic Republic of Congo	6		
Sierra Leone	26	Nigeria	6		
Malawi	25	Eritrea	4		
Rwanda	24	Liberia	3		
Benin	20	Zimbabwe	3		
Angola	17	Mauritania	2		
		Chad	1		
		Guinea	1		
		Djibouti	1		
		Swaziland	0		

of Tanzania. However, the distribution of ITNs is hampered by supply constraints.

*Indicator 6.8: Proportion of children under-five with fever who are treated with appropriate anti-malarial drugs*

There has been less progress in treating malaria than in preventing it. Progress in developing a malaria vaccine is the best hope for reducing malarial

incidences, but none presently exists (research on malaria vaccine in Africa is weak). Although treatment among febrile children is moderately high across malaria-endemic regions of Africa, few countries have expanded treatment coverage since 2000. Troublingly, most patients often receive less effective medicines. The number of ACTs distributed at country level slowed in 2006–2008 relative to 2004–2006, due to the low approval

of funds for malaria activities in Rounds Five and Six of the Global Fund.

Preliminary reviews undertaken in ten African countries in 2008 provide some evidence on the two treatment indicators for malaria, namely (i) the proportion of children under-five treated with anti-malarial drugs, and (ii) the proportion of under-fives treated with ACT. The weighted average of the surveyed countries for children under five treated with anti-malarial drugs was 32 percent, and 16 percent for ACT, although the latter was reported in only seven of ten countries surveyed. While these countries may not be representative, nonetheless a message does emerge: treatment of children through anti-malarial drugs and ACT remains low. In 2008, Gabon and Tanzania reached 25 percent and 22 percent of ACT use in children under-five diagnosed with malaria respectively. Only 14 African countries reported distributing enough ACT to treat at least 50 percent of reported malaria cases, whilst five reported distributing sufficient ACT for all malaria cases. As these interventions are known to work, it is crucial that countries scale up the anti-malarial treatment of under-fives who present symptoms of fever. This will significantly reduce child mortality.

*Indicator 6.9: Incidence, prevalence, and death rates associated with tuberculosis*

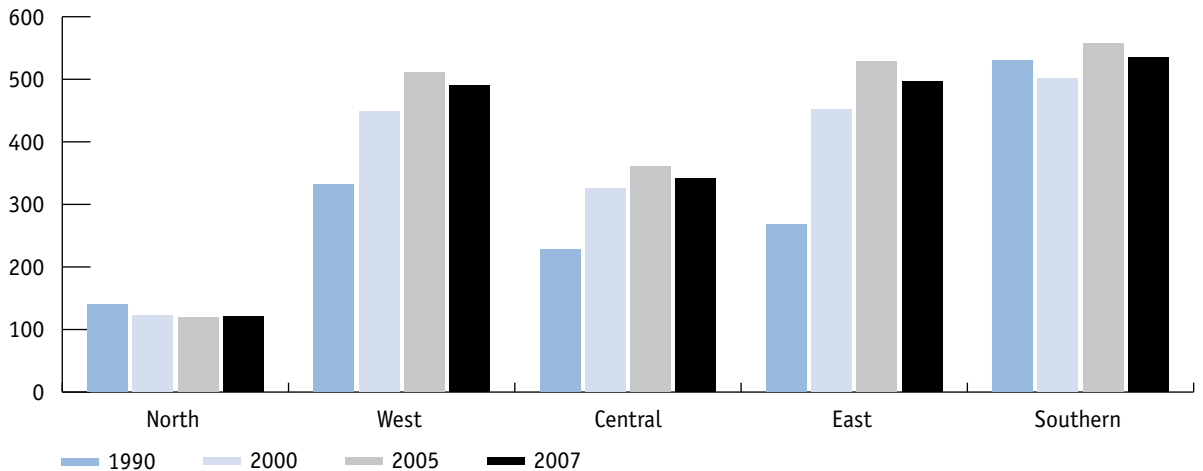
Tuberculosis (TB) remains a significant health risk and major cause of death in Africa, especially in countries with a very high prevalence of HIV/AIDS. Of the 22 countries classified by the WHO as TB high-burden countries, nine are African (the Democratic Republic of Congo, Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zimbabwe). Southern Africa continues to report the highest tuberculosis incidence

rate and North Africa the lowest. Except for North Africa, where the low incidence rate remained unchanged, all subregions of the continent showed a decline, although to varying degrees, in the TB prevalence rate between 2005 and 2007 (see *Figure 26*).

The picture alters though if the most populous country per subregion is excluded from the analysis analysis. In *Figure 27*, Nigeria is excluded from West Africa, Ethiopia from East Africa, Cameroon from Central Africa, Egypt from North Africa, and South Africa from Southern Africa. The overall prevalence rate for example, for West Africa, falls when Nigeria is excluded from the sample, decreasing from about 480 to just under 220 by 2007. In Southern Africa, the regional prevalence rate falls from about 535 in 2007 to around 290 when South Africa is excluded.<sup>23</sup> East Africa excluding Ethiopia recorded the highest TB prevalence rate from 2000 to 2007 of all the subregions; it also registered the largest drop in 2007, relative to 2005. An important factor explaining the declining prevalence rate of TB in Africa could be the increased use of Directly Observed Short-course Treatment (DOTS).

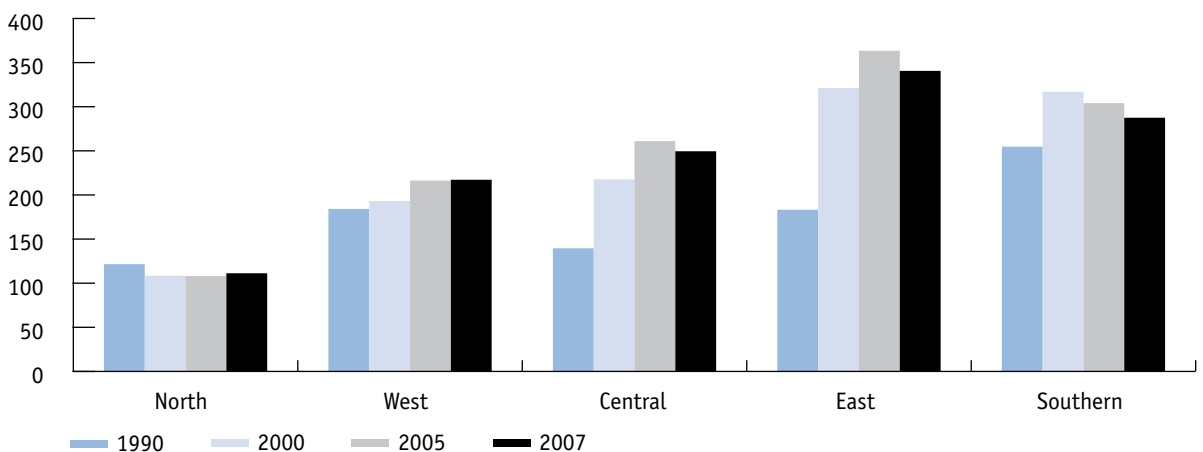
<sup>23</sup> It is possible that these countries have a better TB surveillance and reporting system.

**Figure 26: Tuberculosis prevalence rate per 100,000 population by African subregion, 1990–2007**



Source: ECA computations based on UNSD data.

**Figure 27: Tuberculosis prevalence rate per 100,000 population by African subregion excluding the most populous countries, 1990–2007**



Source: ECA computations based on UNSD data excluding the most populous country per subregion: Egypt (North), Nigeria (West), Cameroon (Central), Ethiopia (East), and South Africa (Southern).



Tuberculosis mortality rates decreased over the period 2005–2007 in Central, East, and Southern Africa, and remained level in North and West Africa, demonstrating a similar trend to prevalence rates (see *Figure 28*). This is partially driven by the increasing success of DOTS. In West Africa, the TB prevalence rate has been rising since 1990 in a number of countries, including Côte d'Ivoire, Senegal, Togo, and Sierra Leone. It declined steadily in Nigeria from 2003 to 2007. In North Africa, the TB prevalence rate increased in Algeria, Mauritania, The Sudan and Tunisia but declined in Egypt and Morocco.

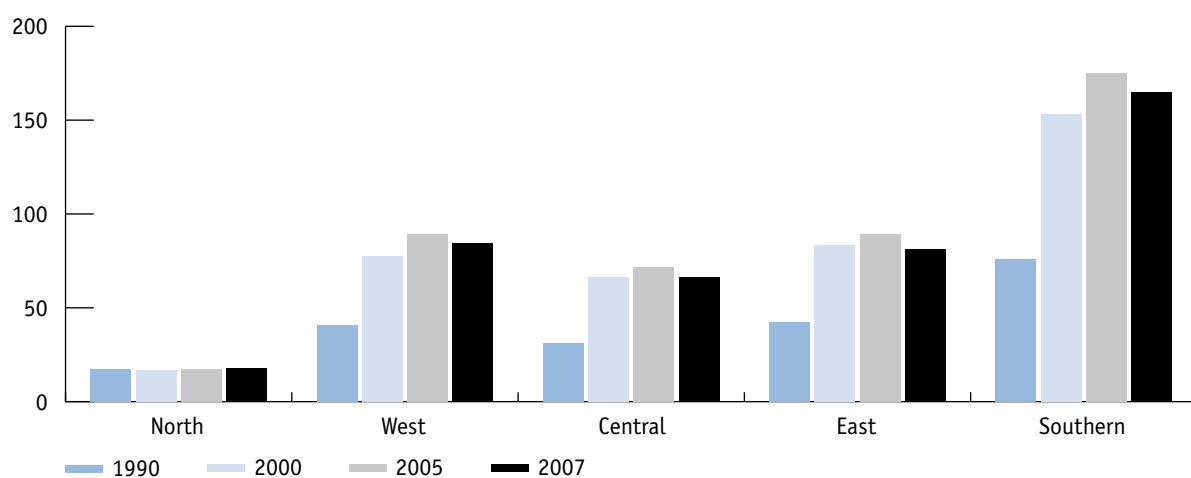
*Indicator 6.10: Proportion of tuberculosis cases detected and cured under directly observed short-course treatment (DOTS)*

To assess the penetration of DOTS, countries monitor the “proportion of tuberculosis cases detected and cured under the directly observed short-course treatment”. The success rate of DOTS increased

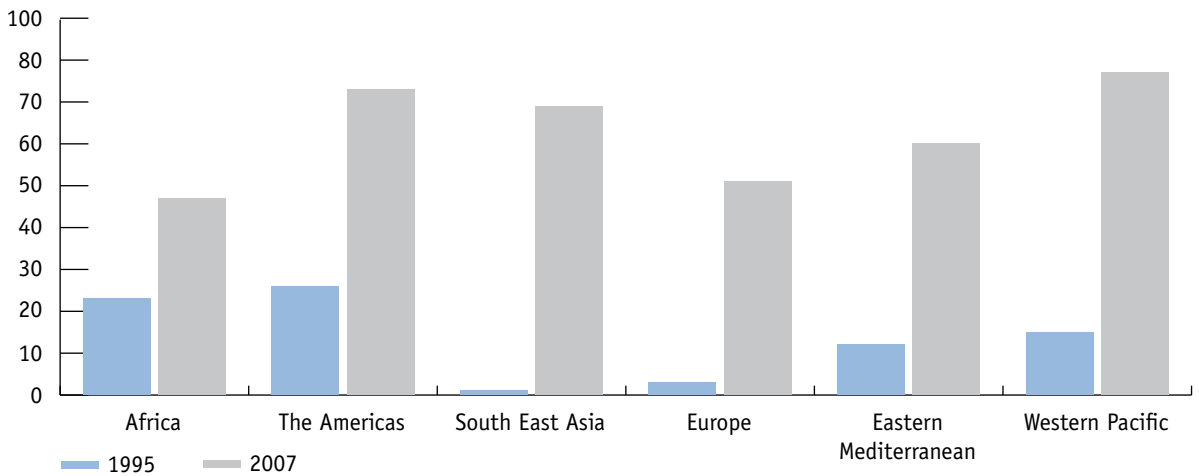
considerably from 1995 to 2007 (see *Figure 29*). Although the target is 85 percent, success in this regard will be 100 percent. DOTS is based on the three I's (Intensified case-finding; Isoniazid prevention therapy; and Infection control), which involves the appropriate diagnosis and registration of each tuberculosis patient followed by standardized, multi-drug treatment. This treatment regime has a demonstrable impact on the TB prevalence rate and on the number of TB-related deaths. Efforts to control TB have been constrained by the emergence of Multi-Drug-Resistant TB (MDR-TB), which is difficult and expensive to treat and fails to respond to first-line drugs. South Africa is among the top five countries with the largest number of cases of MDR-TB (Stop TB Partnership, 2010).

From the evidence presented above, Africa as a region is unlikely to meet the TB targets by 2015. This is largely due to the still high prevalence of

**Figure 28: Tuberculosis mortality rate per 100,000 population by African subregion, 1990–2007**



Source: ECA computations based on UNSD data updated in 2009.

**Figure 29: Tuberculosis detection rate under DOTS, 1995 and 2007 (%)**

Source: World Health Statistics, 2009.

Note: Regions conform to WHO regional groupings.

HIV and rising AIDS-related mortality in some countries. This is a serious challenge that African governments and development partners need to urgently address. African countries should allocate more resources to TB control, consistent with their commitments in the Abuja Declaration on HIV/AIDS, TB and other related infectious diseases. Donors too need to allocate more resources to TB control, since despite an increase in funding, a significant financing gap in this area persists (WHO, 2009b).

### Goal 7: Ensure environmental sustainability

The threat that climate change poses to Africa is resulting in a greater focus on environmental sustainability and the environment MDG. Many of Africa's environmental and natural resources are being degraded at a worrying rate. Rapid economic growth is likely to present African countries with a serious dilemma: whether to concentrate on short-term gains to be made through rapid economic

expansion or whether to lend greater weight to protecting the environment for future generations. An ECA study based on MDG planning in 15 African countries shows that many countries have yet to fully include environmental sustainability in their national development plans. The high-profile debate on climate change appears to be focusing attention toward overall environmental sustainability. Most countries are failing to honor the commitments they made at the World Summit on Sustainable Development (WSSD), including the Environment Initiative of the NEPAD.

#### **Target 7A: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources**

*Indicator 7.1: Proportion of land area covered by forest*

Protected areas are the cornerstone of efforts to conserve the world's species and ecosystems,

as well as a key component in climate change mitigation. Some progress has been registered in this area. For example, in 2007 the DRC government established, in cooperation with the Bonobo Conservation Initiative (BCI), the Sankuru Nature Reserve as a huge protected rainforest covering a total of 30,570 square kilometers. The project will offer certified carbon credits by Reducing Emissions from Deforestation and Degradation (REDD) (UNEP, 2007). Niger is also mainstreaming environmental sustainability into its fiscal strategies. For example, the lumber industry, which was previously a cause of deforestation (since mitigated by the current levy on the transportation of wood traded), provides fiscal revenues for environmental sustainability. Between 40 and 60 percent of collected income is set aside for reforestation programs, while 30 to 50 percent of revenue collected is reinvested in forest planning (UNESCO, 2010).

The level and rate of deforestation, however, continue to present a problem. Between 2000 and 2005, Africa was losing its forests at an annual rate of 4.1 percent, although this was a slight improvement on the 4.4 percentage loss reported for the period 1990–2000. Some loss will be inevitable as Africa grows, virgin forests are brought under cultivation, and new cities and settlements are built. Nonetheless, since forest degradation and deforestation contribute to anthropogenic greenhouse emissions, (accounting for 17.4 percent of emissions in 2004), a reduction in the rate of deforestation could play a key role in mitigating climate change effects. The improvement in protected areas augurs well for the reduction in biodiversity loss, although environmental degradation and rapid urbanization remain serious problems. A key intervention

in this regard could be a more intensive use of land, through increased utilization of fertilizers and high-yield varieties in agriculture, and by multi-storey construction in cities.

*Indicator 7.2: CO<sub>2</sub> emissions, total per capita, and per USD 1 GDP (PPP)*

An important indicator for assessing progress toward environmental sustainability, including climate change, is carbon dioxide emissions per capita, measured in metric tonnes. It is estimated that Africa is likely to experience higher temperatures, changing rainfall patterns, and more extreme weather events than other global regions (IPCC, 2007). On the other hand, Africa is the lowest emitter of carbon dioxide as a global region, producing only 4 percent of greenhouse gas emissions. Carbon dioxide emissions decreased in most African countries between 1990 and 2006, except in Algeria, Botswana, Egypt, Equatorial Guinea, Mauritius, Morocco, Namibia, and the Seychelles, where emissions increased by more than 0.50 metric tonnes. Libya is the highest emitter of CO<sub>2</sub> per capita in Africa, mainly due to gas flaring in its oil fields.

The cost of dealing with the adverse consequences of climate change is likely to hamper progress on the MDGs in Africa. Without rapid economic growth, such expenditure is likely to significantly reduce the resources available for accelerating progress on the MDGs. Estimates of the cost vary. For example, the World Bank estimates that adaptation measures would cost about USD 18.1 billion per year for Africa, excluding North Africa (World Bank, 2009b).

***Indicator 7.3: Consumption of ozone-depleting substances***

The majority of African signatories to the Montreal Protocol<sup>24</sup> have achieved a 97 percent reduction in the consumption of ozone-depleting substances. This extraordinary accomplishment is the result of both the integration of sustainable development principles into national policy frameworks (MDG 7) and the global partnership for development (MDG 8).

To date, parties to the Montreal Protocol have put in place national regulations or legislation to promote effective protection of the ozone layer and sustainable compliance with the Protocol. In addition to funding these critical activities, the Montreal Protocol Multilateral Fund has, over the past 19 years, supported national capacity-building and networking of policymakers, customs officials, and others. Still, challenges remain. Foremost among them is the phasing out of hydrochlorofluorocarbons while avoiding the use of alternatives that carry a high potential for global warming. Other serious issues include the management of existing stocks of ozone-depleting substances (including their destruction) and ensuring that illegal trade does not emerge after key substances are phased out.

***Indicator 7.4: Proportion of fish stocks within safe biological limits***

National action has been taken to limit the impact of fishing and other human activities on exploited fish populations. Nevertheless, the percentage of depleted, fully exploited, or overexploited and

recovering fish species increased from 70 percent in 1995 to 80 percent in 2006. The effect of climate change on all targets and indicators of the MDGs, particularly on Goal 7, is exacerbating the vulnerability of environmental resources in Africa. For example, climate change could alter marine and fresh water ecosystems, affecting the seasonality of certain biological processes, thus disrupting marine and freshwater food webs. This, in turn, has unpredictable consequences for fish stocks. Given the uncertainty of the impact of climate change on resources and ecosystems, a higher level of precaution is required in managing fishery resources.

***Indicator 7.5: Proportion of total water resources used***

About 70 percent of water withdrawn in Africa is for agriculture. When more than 75 percent of river flows are diverted for agricultural, industrial, and municipal purposes, there is simply not enough water left to meet both human demands and environmental flow needs. Physical water scarcity – characterized by severe environmental degradation, declining groundwater, and water allocations – is on the increase. Water withdrawals are highest in arid and semi-arid lands, where they are needed mostly for irrigation and other agricultural purposes, and lowest in tropical countries. In North Africa, an average of 78 percent of renewable water resources are being withdrawn annually. There are a number of African countries that are facing serious water stress. This is further exacerbated by climate change expressed in rainfall cycle variations and extreme weather episodes that contribute to water depletion. Reversing this trend will require more efficient water use, primarily through improved crop varieties and better agronomic practices that lead to higher economic returns and yield more crops with the same volume of water.

<sup>24</sup> The Montreal Protocol of the Vienna Framework Convention on Ozone-degrading Substances, signed in 1996, was the first treaty to set globally quantified emission reduction targets according to a time frame. It was also the first treaty to follow the "Precautionary Principle," whereby governments might adopt mitigation measures even without the benefit of full scientific knowledge.

**Target 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation**

*Indicator 7.8: Proportion of population using an improved drinking water source*

Improved drinking water source is directly linked to an improvement in the health status of African citizens. The slow progress toward the health MDGs is attributed in part to inadequate hygienic conditions, including inadequate access to safe water and improved sanitation.

Most countries for which data are available have shown an improvement in coverage. In 2008, nine countries reached over 90 percent coverage for access to safe drinking water; namely, Botswana, Comoros, Djibouti, Egypt, The Gambia, Mauritius, Namibia, South Africa, and Tunisia. Countries with less than 50 percent coverage comprised (see *Figure 30a*): Somalia, Ethiopia, Madagascar, the Democratic Republic of Congo, Mozambique, Niger, Mauritania, and Sierra Leone. Though there has been some progress, these countries need to scale up their efforts to meet the target.

The urban–rural divide in access to an improved water source continues to pose a policy challenge. Nonetheless, the proportion of rural households with improved access to drinking water sources increased from 54 to 65 percent during the period 1990–2006. In North Africa, during the same time period, there was an improvement of piped water availability from 34 to 63 percent. There was a mere increase of 1 percent in other improved water sources and a significant drop of 36 percent in unimproved water source (UN, 2009a).

*Indicator 7.9: Proportion of population using an improved sanitation facility*

Success in achieving the health MDGs depends in

large measure on improved sanitation. The target is to provide improved sanitation to 63 percent of the region’s population. This requires an improvement for approximately 370 million more people than the estimated 242 million people using such facilities in 2006.

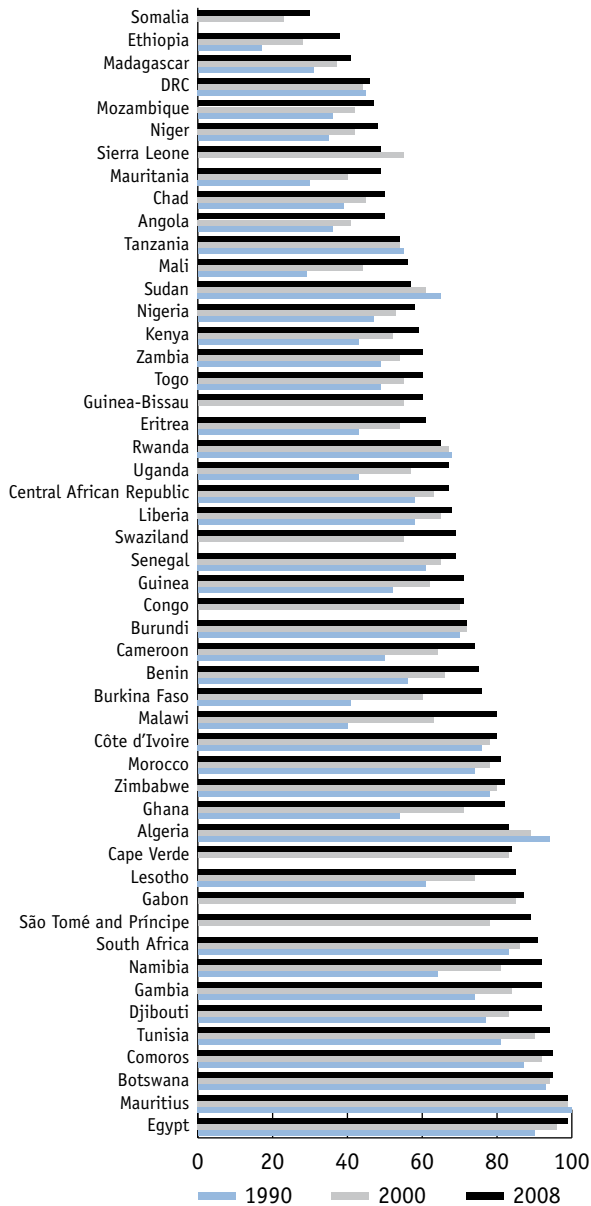
Improvements recorded in this area are still low for a number of countries (see *Figure 30b*). Only four African countries record over 90 percent of their population having access to improved sanitation facilities, namely Algeria, Egypt, Libya, and Mauritius. Many countries fall far below that level. Countries with below 20 percent coverage include: Benin, Burkina Faso, Chad, Eritrea, Ethiopia, Ghana, Guinea, Liberia, Madagascar, Mozambique, Niger, Sierra Leone, and Togo.

Improvements in sanitation largely remain an urban phenomenon. Open defecation is still very common in rural areas and has not been eradicated in many urban areas of the continent. In 2008, excluding North Africa, the percentage of the African population practicing open defecation was 199 million in rural areas and 22 million in urban areas. Simple policy interventions such as public and community toilets and water sources could go a long way toward accelerating improved sanitation. Government commitment and adequate funding in Senegal resulted in an increase in rural sanitation access from 19 to 34 percent between 1990 and 2005. These two features are also evident in the significant progress made in improved rural sanitation in Uganda (see *Box 3*).

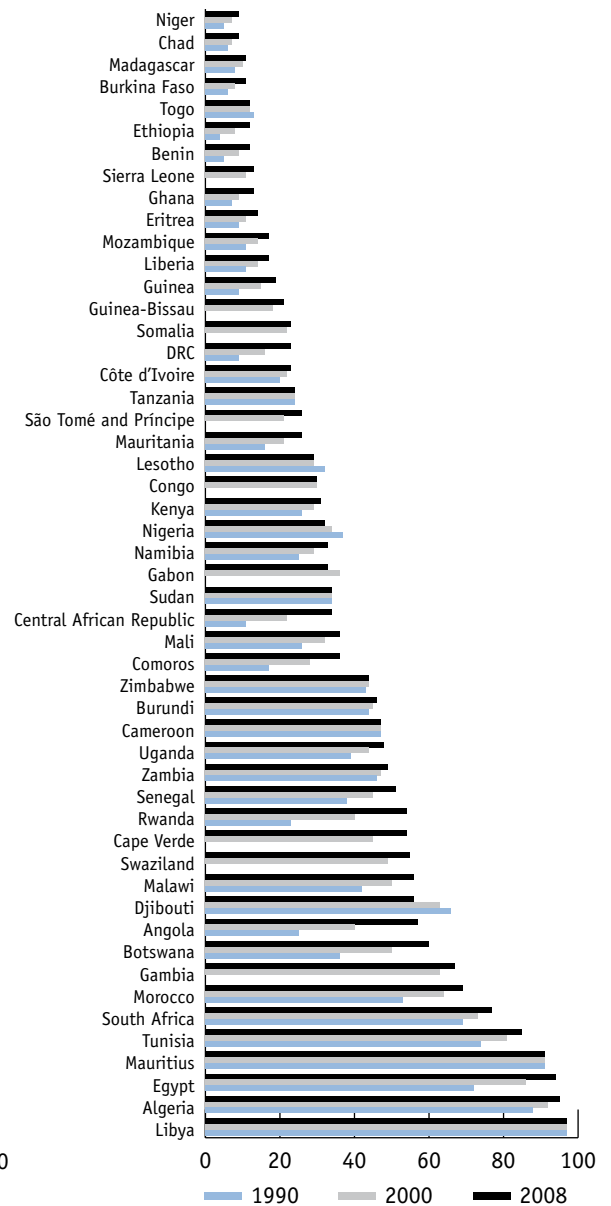
In addition to the rural–urban divide, an important aspect of both improved water and sanitation facilities is the income gradient. In 21

**Figure 30: Percentage of population using an improved drinking water source and improved sanitation, 1990–2008**

**Figure 30a: Percentage of population with improved drinking water source, 1990–2008**



**Figure 30b: Percentage of population with improved sanitation, 1990–2008**



Source: ECA computations based on WHO and UNICEF, updated in 2010.

African countries excluding North Africa, only 16 percent in the poorest quintile have access to improved sanitation, whilst this coverage increases to 79 percent in the richest quintile (UN, 2008). According to an ECA study of 11 African Least Developed Countries (LDCs), countries such as Zambia, Niger, and Rwanda have witnessed a dramatic rise of inequities in access. That development is associated with stronger growth rates among the water and sanitation coverage of wealthier populations, clearly showing that improvements in the water and sanitation sector have failed to reach the poor. However, there are also positive developments in this regard, especially in Uganda and Malawi. Similarities can be observed when looking at geographic inequalities. Another interesting point is that inequalities are much wider for access to sanitation than for water services. This might be associated with higher coverage rates for water services and higher infrastructural costs related to waste management (UNECA, forthcoming).

**Target 7D: By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers**

*Indicator 7.10: Proportion of urban population living in slums*

In Africa, excluding North Africa, the proportion of the population deprived of shelter decreased from 71 to 62 percent between 1990 and 2005. In North Africa, the proportion more than halved from 36 to 15 percent (UN, 2009a). Despite some advances, Africa, excluding North Africa, remains the global region with the highest prevalence of slums. Both slums and urban areas in the region appear to be growing at an equally rapid pace, and the living conditions among impoverished populations are severe, often involving multiple deprivations. Improvements in the lives of slum dwellers in most African countries, excluding North Africa, will therefore require large multisectoral investments. Although general improvements have been made in slums worldwide, the current housing and energy crises may slow progress in the

**Box 3: Sanitation targets, planning, and performance in Uganda**

The Ugandan government has acknowledged the direct impacts of sanitation and basic hygiene on health, education, and poverty reduction in its Poverty Eradication Action Plan (PEAP) (MFPED, 2004). To boost improved sanitation coverage and good hygiene, the government has established national PEAP targets. It has also established an inter-sectoral National Sanitation Working Group to coordinate all sanitation and hygiene promotion efforts, reviewed budget mechanisms and funding flows, and discussed establishing a new national budget line for sanitation and hygiene promotion.

Based on the latest Water and Sanitation Sector Performance Report (MWE, 2008), 62 percent of rural and 74 percent of urban households in Uganda used improved sanitation facilities in 2007/2008. This puts Uganda's rural average of safe sanitation below the country's intermediate target of 64 percent for 2007/2008. This means that rural areas have failed to stay on the trajectory for Uganda's 2015 target of 77 percent safe sanitation coverage. In contrast, urban households achieved their interim target of 74 percent for 2007/2008.

*Source: Uganda Ministry of Health et al. (2009)*

developing regions and, in some cases, reverse positive trends.

### Goal 8: Develop a global partnership for development

The MDGs underscore and are undergirded by international cooperation and global partnership, which are critical for achieving the MDGs. This partnership has remained strong, even at the peak of the crises of 2008–2009. The G20 at their various meetings reaffirmed the importance of global partnership and their commitment to the MDGs<sup>25</sup>. Net Official Development Assistance (ODA) to Africa rose in 2008 in spite of the global financial and economic crisis. However, this was far below the commitment of 0.7 percent of GNI by OECD countries. Africa is likely to be allocated only about USD 12 billion of the USD 25 billion increase envisaged for 2010 at the Gleneagles Summit, due in large part to the underperformance of some European donors who give large shares of ODA to Africa.

An important but under-emphasized component of the global partnership for development, which is critical for African countries, is illicit outflows of resources. In Pittsburgh, the G20 committed to work with the World Bank's Stolen Assets Recovery Program to secure the return of stolen assets to developing countries and support efforts to stem illicit outflows. African countries will gain significantly if this commitment is met in full, as it will provide additional resources for development.

25 In London and Pittsburgh, the G20 reaffirmed their commitment to meet the MDGs and their respective ODA pledges. See [www.g20.org/documents/20091107\\_progress\\_report\\_standrews.pdf](http://www.g20.org/documents/20091107_progress_report_standrews.pdf)

### Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

The WTO negotiations which stalled in 2005 remained stalled in 2009. No progress was made during the year, despite the hope that negotiations might be reopened in the wake of the global economic and financial crisis. This hope was generated by fears of a resurgence of protectionist tendencies (e.g. the "Buy USA" provision in the draft US stimulus bill) and the recognition, based on previous experience, that open markets would be critical for moderating the impact of the crisis (UNECA/AUC, 2010). The international community tried to address these concerns at the various Summits that were convened to agree a response to the crisis. For the purposes of reinvigorating global trade and investment, the G20 pledged USD 250 billion to bolster global trade finance and vowed to refrain from protectionist policies. The World Trade Organization (WTO) was tasked to monitor and report on financial protectionism. Additional resources were approved for the IMF and the G20 committed to bringing the Doha Development Round to a successful and balanced conclusion in 2010.

For Africa, success in the Doha round of trade negotiations will be measured by solid progress in the following distinct areas – agriculture, Non-Agricultural Market Access (NAMA), duty-free and quota-free access for LDCs, Aid-for-Trade and Special and Differentiated Treatment (SDT). The prospects for progress on some of these issues do not appear to be very good.<sup>26</sup>

26 Growing concern in Europe over rising budget deficits could spur action on the issue of agricultural input subsidies. Countries may reduce the amount of subsidies that they give to their farmers.



Table 8: Net Official Development Assistance, 2008 and 2009

	2009*		2008		2009 ODA (USD mn at 2008 prices and exchange rates)**	%
	ODA (USD mn current)	ODA/GNI %	ODA (USD mn current)	ODA/GNI %		
Australia	2,761	0.29	2,954	0.32	2,912	-1.4
Austria	1,146	0.30	1,714	0.43	1,179	-31.2
Belgium	2,601	0.55	2,386	0.48	2,661	11.5
Canada	4,013	0.30	4,795	0.33	4,341	-9.5
Denmark	2,810	0.88	2,803	0.82	2,922	4.2
Finland	1,286	0.54	1,166	0.44	1,319	13.1
France	12,431	0.46	10,908	0.39	12,746	16.9
Germany	11,982	0.35	13,981	0.38	12,297	-12.0
Greece	607	0.19	703	0.21	618	-12.0
Ireland	1,000	0.54	1,328	0.59	1,077	-18.9
Italy	3,314	0.16	4,861	0.22	3,350	-31.1
Japan	9,480	0.18	9,579	0.19	8,556	-10.7
Korea	816	0.10	802	0.09	910	13.5
Luxembourg	403	1.01	415	0.97	423	1.9
Netherlands	6,425	0.82	6,993	0.80	6,675	-4.5
New Zealand	313	0.29	348	0.30	337	-3.2
Norway	4,086	1.06	3,963	0.88	4,650	17.3
Portugal	507	0.23	620	0.27	523	-15.7
Spain	6,571	0.46	6,867	0.45	6,786	-1.2
Sweden	4,546	1.12	4,732	0.98	5,083	7.4
Switzerland	2,305	0.47	2,038	0.44	2,271	11.5
United Kingdom	11,505	0.52	11,500	0.43	13,179	14.6
United States	28,665	0.20	26,842	0.19	28,305	5.4
<b>Total DAC</b>	<b>119,573</b>	<b>0.31</b>	<b>122,296</b>	<b>0.30</b>	<b>123,119</b>	<b>0.7</b>
Average Country Effort		0.48		0.46		
EU Institutions	15,022		14,757		15,412	4.4
DAC-EU countries	67,135	0.44	70,974	0.43	70,838	-0.2
G7 Countries	81,390	0.26	82,465	0.26	82,774	0.4
Non G7 Countries	38,183	0.50	39,831	0.49	40,345	1.3
<b>Non-DAC economies:</b>						
Czech Republic	224	0.12	249	0.12	237	-4.7
Hungary	116	0.09	107	0.08	130	21.7
Iceland	34	0.33	48	0.47	43	-11.7
Poland	343	0.08	372	0.08	422	13.2
Slovak Republic	74	0.08	92	0.10	74	-18.9
Turkey	718	0.12	780	0.11	797	2.1

Source: OECD (2010a). Notes: \* Preliminary data for 2009 \*\* Taking account of both inflation and exchange rate movements

Another area of concern for African countries is the Economic Partnership Agreement (EPA) negotiations with the European Union (EU). Many African countries have signed interim EPAs for the purely strategic reason of protecting their EU markets, in spite of serious reservations. *Pari passu* with the signing of interim agreements by individual countries, progress has also been made by the regional groupings – the Economic Community of West African States (including Mauritania) (ECOWAS), Eastern and Southern Africa (ESA), the Economic Community of Central African States (ECCAS) – in their negotiations. However, contentious issues remain to be resolved, particularly in the areas of services, trade capacity building, and full reciprocity.

The damage inflicted on the global financial system by the crisis prompted the G20 to put in place regulations and reforms aimed at restoring stability to the global economy. These included the establishment of a Financial Stability Board to coordinate and monitor progress in reshaping financial regulatory systems. Funds amounting to USD 2 billion were set aside under the International Development Association's (IDA's) Rapid Social Response Fund to help poor countries deal with the effects of the financial crisis on their economies. In addition, there was a frontloading of the resources of the IDA and the African Development Fund to assist African countries to cope.

*Indicator 8.1: Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' GNI*

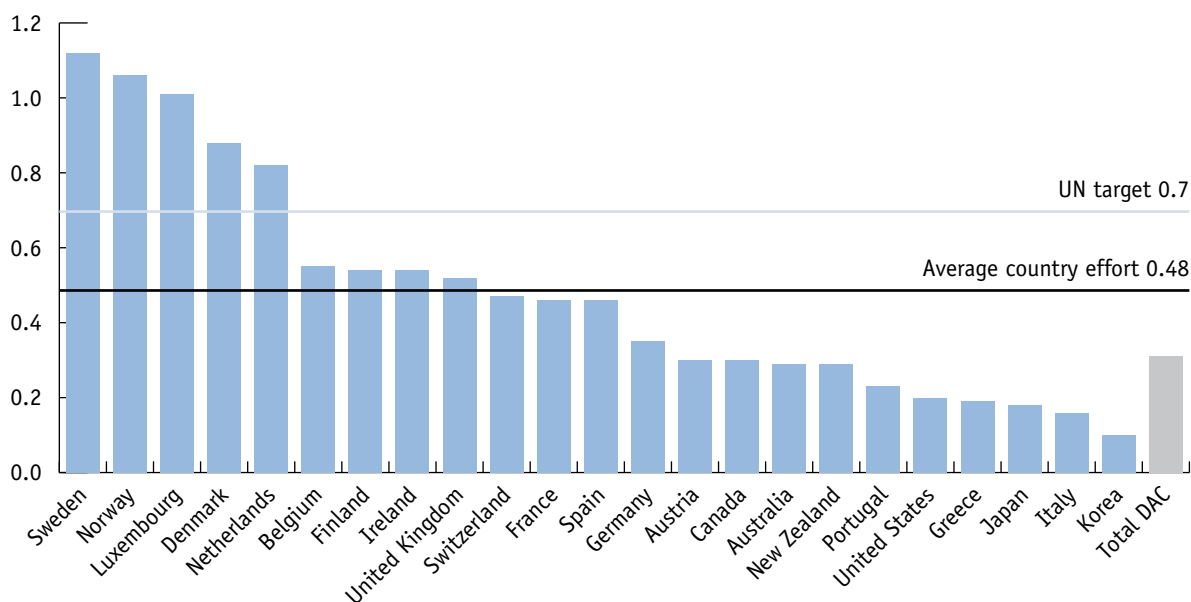
Total ODA from OECD/DAC fell in nominal terms<sup>27</sup> in 2009 relative to 2008 as *Table 8* shows, although

<sup>27</sup> It increased in real terms (2008 prices) by 0.7 percent and by 6.8 percent if debt relief is excluded.

considerable progress has been made in ODA to Africa since 2004 (see *Table 9*). Africa remains the largest recipient of ODA from OECD/DAC relative to other developing regions. Total OECD/DAC ODA in 2009 was 0.31 percent of OECD/DAC gross national income (GNI). In 2009, only five developed countries reached or exceeded the UN target of 0.7 percent of GNI as aid to developing countries (see *Figure 31*). Sweden, Norway, and Luxembourg allocated more than 1 percent of their GNI to ODA in 2009, while Denmark and the Netherlands allocated more than 0.8 percent of GNI.

The European Union accounts for about 55 percent of global aid flows and is the largest provider of ODA to African countries, although its total global aid decreased from EUR 50 billion in 2008 to EUR 49 billion in 2009 due to the contraction of its economies. In fact, the EU spent about EUR 1 trillion on the financial bailout of its banks, which is equivalent to all the ODA delivered since 1960 (Concord/AidWatch, 2010).

According to the OECD/DAC, most of its members will likely achieve the ODA targets that they set for themselves at the 2005 Gleneagles G8 and UN Millennium +5 summits to increase ODA as a proportion of their GNI to a minimum of 0.51 percent by 2010. The OECD projects that overall ODA as a proportion of GNI for the OECD/DAC members in 2010 will be 0.33 percent, instead of the 0.36 percent that was forecast at the Gleneagles Summit. This is a result of the other OECD/DAC members who are unlikely to meet their commitments due to economic difficulties. However, the European Union OECD/DAC members fare much better on their own. Projections are that they will reach 0.48 percent of ODA as a proportion of their GNI in 2010, even though

**Figure 31: Net ODA as a percentage of GNI, 2009**

Source: OECD (2010a).

this falls short of the 0.59 percent that was projected in 2005.<sup>28</sup>

While ODA to Africa has been increasing since 2004, the continent's development partners have not met in full their aid commitments. Further, OECD/DAC ODA to the Least Developed Countries (LDCs), most of which are in Africa, continues to fall short of the 0.15–0.20 percent target commitment set in the Brussels Program of Action (BPoA) in 2001 (UNECA/AUC, 2010).

*Indicator 8.2: Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary healthcare, nutrition, safe water, and sanitation)*

A key area of concern to Africa is the poor state of social services delivery, which greatly impacts the education, gender and health MDGs. In most African countries, basic social services are underfunded. ODA can play an important role in bridging the financing gap. For example, Nigeria agreed to set aside the USD 18 billion it received as debt relief in 2005 to fund the social sector. Annually, it allocates USD 1.0 billion from this fund as additional social sector expenditure. The Office of the Senior Special Assistant to the President on MDGs is responsible for tracking this expenditure.

<sup>28</sup> Source: OECD (2010).

**Table 9: ODA to Africa by sector as a percentage of total bilateral commitments, 2004–2008**

<b>Sector</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
Social	34.7	27.4	28.7	43.7	42.6
Economic	6.4	7.7	4.4	10.0	16.1
Production	5.0	3.9	5.1	6.4	6.5
Multisector	4.5	5.3	3.2	5.1	5.1
General program aid	8.8	5.2	8.0	9.2	8.4
Debt	28.1	36.5	40.8	12.7	7.5
Humanitarian	11.6	11.7	8.7	11.2	12.0
Other	0.9	2.2	1.2	1.7	1.9

Source: OECD (2010a).

The social sector's share of ODA to Africa as a percentage of total bilateral commitments has grown in recent times from a low of 27.4 percent in 2005 to 42.6 percent in 2008 (see *Table 9*). If debt relief were to be excluded, this share would be even larger. This is translating into improved health and education outcomes. For example, ODA has led to an improvement in the delivery of anti-malarial interventions in 15 African countries, resulting in a 50 percent decrease in malaria incidence in those countries. The fundamental challenge to an ODA-supported social sector is long-term sustainability. Overcoming this challenge might require the gradual introduction of user-fees or an increase in taxation – both measures imply significant trade-offs.

One of the indicators of the Paris Declaration is that aid should increasingly be untied. According to the OECD (2009b), there has been gradual progress in the untying of aid. Nonetheless, a significant proportion of ODA to Africa is

tied. Further, aid remains unpredictable and not aligned to national priorities in spite of commitments made in the Paris Declaration on aid effectiveness and the Accra Agenda for Action (AAA). There has been a rise in general and sector budgets, but increasingly, there is a view in some EU countries that aid to Africa should be used in part, not for poverty reduction and development, but to control (African) migration into the EU. Admittedly, uncontrolled migration presents difficulties to host countries. However, tied aid imposes enormous transaction costs on recipient countries and this, along with the non-use of country systems, is an important factor explaining the lack of sustainable development impact of aid, especially in African LDCs.

The Paris Declaration expires this year (2010) and there is a risk that developed countries may not agree to a replacement framework. African countries should strive for a replacement of the Paris Declaration and use the Fourth High-Level Forum

on Aid Effectiveness in Seoul in 2011 to achieve this purpose. Further, African countries should continue to explore other sources of ODA, including through south–south cooperation.

**Target 8C: Address the special needs of Landlocked Developing Countries (LLDCs) and Small Island Developing States (SIDS)**

*Indicator 8.4: ODA received in landlocked developing countries as a proportion of their GNI*

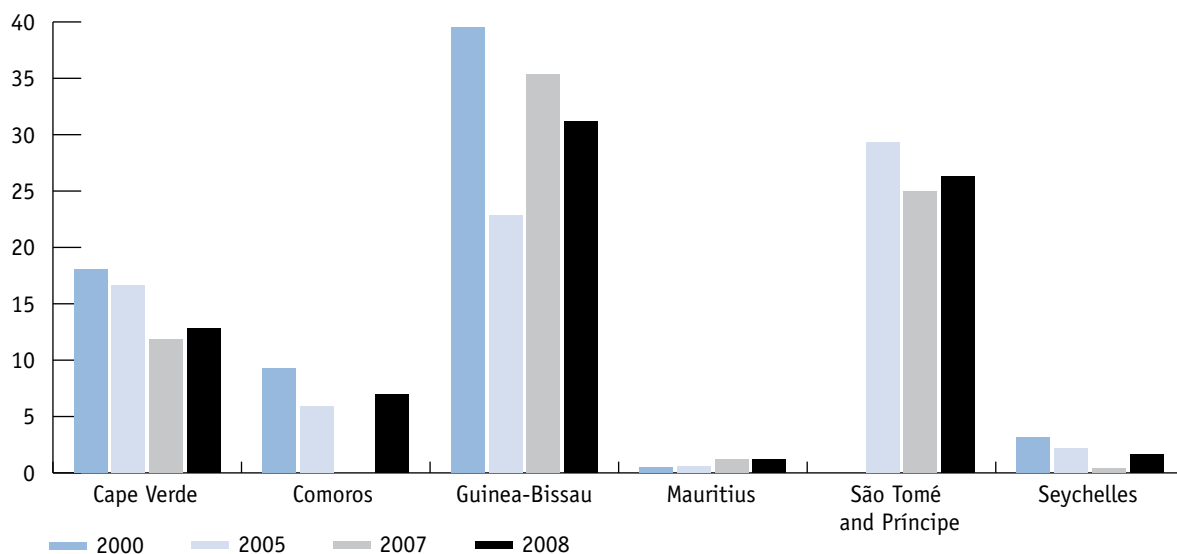
Among African countries, landlocked countries present a special challenge. The MDGs envisage an increase in ODA as a proportion of the gross national income (GNI) of these countries. There are 15 Landlocked Developing Countries (LLDCs) in Africa and most of these also qualify as Least Developed Countries (LDCs). Over two-thirds of these countries are also categorized as Heavily Indebted Poor Countries (HIPCs). ODA received

in African LLDCs as a percentage of their GNI decreased by 4.5 percent between 2007 and 2008. However, a close look at the net ODA received shows that it actually increased in 80 percent of the LLDCs and was mostly directed at health, education, and water (OECD, 2009a). For most of the HIPCs, ODA received as a percentage of their GNI increased from 2005 after the introduction of the Multilateral Debt Relief Initiative (MDRI), suggesting the effectiveness of debt relief in attracting foreign aid.

*Indicator 8.5: ODA received in Small Island Developing States as a proportion of their GNI*

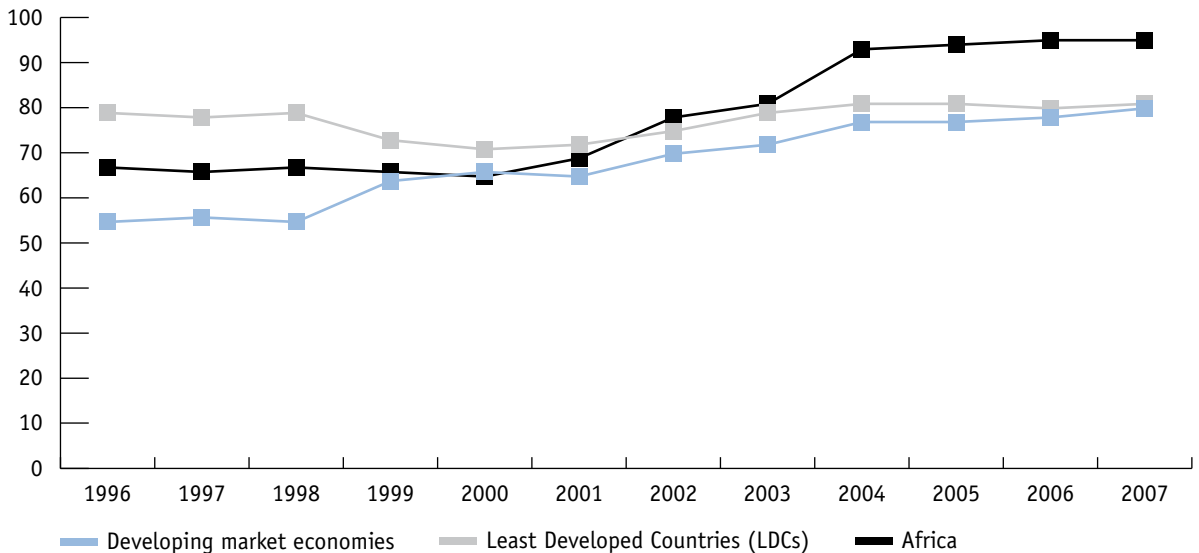
Africa is also home to Small Island Developing States (SIDS). The MDGs envisage an increase in ODA to this group of countries. ODA received by African SIDS as a proportion of their GNI has declined since 2000, although it remains high in

**Figure 32: ODA received in Small Island Developing States as a proportion of their GNIs, 2000–2008 (%)**



Sources: AU computations based on UNSD data, updated in July 2009 and OECD data, updated in February 2010.

**Figure 33: Percentage of imports from Africa, LDCs, and developing market economies admitted free of duty by developed countries, 1996–2007**



Source: ECA computations based on market access indicators by ITC, UNCTAD, and WTO available online at <http://www.mdg-trade.org/38.Graph.aspx>

Guinea-Bissau and São Tomé and Príncipe (see Figure 32). These countries are also HICPs (with Guinea-Bissau yet to receive debt relief under HIPC). Four out of the six African SIDS are also Least Developed Countries (LDCs). The two non-LDC SIDS, Mauritius and Seychelles, have consistently performed better than the rest in terms of economic growth and human development. They have also received lower ODA compared to the other states, implying that they have not had to rely on donor assistance. Nonetheless, ODA to these two countries increased from 2007 to 2008, in line with assistance to other SIDS. The exception was Guinea-Bissau, where ODA as a proportion of GNI decreased slightly, from 35 percent to 31 percent, largely as a reflection of donor unhappiness over the unconstitutional transfer of power and growing political instability in that country.

*Indicator 8.6: Proportion of total developed market economies' imports (by value) from developing and least developed countries, admitted free of duty for all product categories (excluding arms and oil)*

The proportion of total developed market economies' imports (by value) from Africa admitted free of duty for all product categories (excluding arms and oil) rose steadily between 2001 and 2004 but has stagnated since then, as Figure 33 shows. This contrasts sharply with the increasing trend for developing market economies.<sup>29</sup> The possible explanation for this may lie in the fact that duty-free access for LDC exports – the large majority of which are from African countries – has

<sup>29</sup> Duty-free access for developing market economies is due to increased Most Favored Nation (MFN) treatment, which has resulted in the elimination of many tariffs that their exports faced, rather than to preferential access per se.

not been growing. For LDCs, this proportion is not significantly different from its 1996 level. This highlights the special difficulties that LDCs face in trading with the rest of the world.

The EU has delivered on the commitment it made in the 2005 WTO Hong Kong Ministerial Declaration to provide duty-free and quota-free market access for all products from LDCs, 33 of which are African countries. The EU has also provided about EUR 2 billion in trade-related assistance to LDCs.

*Indicator 8.7: Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries*

Average tariffs imposed by developed countries on imports from Africa excluding North Africa, have fallen since 2000 (see Table 10). For agriculture, it fell from 6.2 percent to 5.0 percent, although this has been offset by agricultural subsidies, technical

barriers to trade, and sanitary and phyto-sanitary barriers to trade in Europe and North America. Average tariffs on textiles and clothing have also fallen. The marginal increase in average tariffs for textiles from 2.8 percent in 2007 to 2.9 percent in 2008 is probably due to the reduction in the number of African, Caribbean and Pacific countries entitled to preferential treatment (following the expiry of the Lomé Agreement in 2000 and the Multi-Fiber Agreement in 2005), which has hit countries like Mauritius, which is a sugar and textiles exporter.

Many African countries are unable to take full advantage of the preferential terms of trade given to them and the declining average tariffs imposed by developing countries on their imports. In 2008, the global share of Africa's total trade (exports and imports) was just 3.2 percent, a slight increase from 2.8 percent in 2007 (WTO, 2010). This reflects Africa's limited capacity to trade,

**Table 10: Tariffs imposed by developed countries on African exports of agricultural products, textiles, and clothing in 2000, 2007, and 2008 (%)**

		<b>2000</b>	<b>2007</b>	<b>2008</b>
All DVGs (global)*	Agriculture	9.3	8.3	8.0
	Clothing	10.8	8.3	8.2
	Textiles	6.6	5.1	5.1
North Africa	Agriculture	7.4	7.6	7.3
	Clothing	11.1	6.4	6.2
	Textiles	7.2	4.0	3.9
Sub-Saharan Africa	Agriculture	6.2	6.0	5.0
	Clothing	7.9	1.6	1.6
	Textiles	3.4	2.8	2.9

Sources: WTO-ITC-UNCTAD based on WTO-IDB and UNCTAD-ITC Tariff and Market Access Database (TARMAC).

Note: \*All DVGs = All developing countries, including LDCs.

including weak trade and physical infrastructure, supply-side constraints, and high trade costs arising from inefficient institutions (customs, tax, and product standards).

*Indicator 8.9: Proportion of ODA provided to help build trade capacity*

Aid for Trade (AfT) assists countries to improve their capacity to trade. It encompasses a number of areas, namely technical assistance (advice and expertise to assist countries to deal with the complexities of modern international trade), capacity building on international trade issues, reform of institutions for trade, infrastructure, and trade adjustment costs. Progress on AfT is critical for the success of the Doha Round of trade negotiations.

Commitments have been made by Africa's development partners to assist the region to trade with the rest of the world. *Table 11* summarizes OECD AfT commitments to Africa since 2002 by economic sector. It shows that these commitments increased from USD 8.17 billion in 2002 to USD 14.50 billion in 2008. Looking at the sectoral breakdown, transportation and storage consistently account for more than a third of the AfT commitments to Africa, followed by agriculture and energy. It is important that developed countries honor their AfT commitments. Figures for 2008 confirm that the EU and its Member States have met their target to annually increase Trade-Related Assistance (TRA) by EUR 2 billion (half from the EU and half from EU Member States) by 2010. AfT commitments by the EU and Member States in 2008 have been estimated at EUR 10.4 billion (Council of the European Union, 2010).

Ultimately, African countries need to take full advantage of trade as an engine of growth by

increasing their capacity to trade. They need to dismantle barriers to intra-African trade, and reform their institutions as well as improve productive capacities. This would require significant increases in trade-related infrastructure and the mainstreaming of trade in national development strategies.

**Target 8D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term**

Efforts to deal with the debt problems of African countries continue apace, as the discussion below shows. However, some countries including Uganda are returning to unsustainably high debt levels because of the inadequacy of the debt relief that they have received. Discussions continue about the best methodology for calculating debt sustainability. Resolution of this argument will be critical for a comprehensive solution to the debt problems of developing countries.

*Indicator 8.10: Total number of countries that have reached their HIPC decision points and those that have reached their HIPC completion points (cumulative)*

The HIPC initiative continues to make an impact on reducing the debt burden of countries that qualify for debt relief. Since the last report, the Central African Republic and Congo have reached their post completion point and, therefore, qualify for irrevocable debt relief. *Table 12* summarizes the status of implementation of the HIPC initiative in Africa.

Africa's creditors continue to provide debt relief under the HIPC initiative and the Multilateral Debt Relief Initiative (MDRI). As at end-January 2010, 22 African countries had reached the HIPC post-completion stage; another seven were between their decision and completion points, while just four were



Table 11: OECD Aid for Trade commitments to Africa by sector at constant prices (2008 USD millions)

	2002		2003		2004		2005		2006		2007		2008	
	Total	% share	Total	% share	Total	% share	Total	% share	Total	% share	Total	% share	Total	% share
Transport & Storage	2,245.2	27.5	2,885.3	35.3	2,512.1	31.0	3,026.8	35.0	3,018.0	32.5	4,128.1	36.0	5,545.9	38.3
Communications	166.2	2.0	171.5	2.1	160.1	2.0	75.9	0.9	137.2	1.5	286.8	2.5	114.1	0.8
Energy	1,153.3	14.1	1,168.7	14.3	1,100.6	13.6	1,568.5	18.2	1,214.1	13.1	2,453.0	21.4	2,378.8	16.4
Banking & Financial Services	649.6	8.0	600.5	7.3	825.3	10.2	443.1	5.1	344.0	3.7	420.6	3.7	1,138.2	7.9
Business & Other Services	589.4	7.2	601.4	7.3	338.9	4.2	590.2	6.8	239.4	2.6	464.6	4.1	1,246.4	8.6
Agriculture	1,564.8	19.2	1,729.5	21.1	1,726.1	21.3	1,578.0	18.3	2,231.4	24.0	2,570.4	22.4	2,729.0	18.8
Forestry	129.5	1.6	86.4	1.1	83.7	1.0	161.8	1.9	89.7	1.0	62.7	0.5	229.3	1.6
Fishing	197.4	2.4	155.1	1.9	178.7	2.2	107.4	1.2	79.5	0.9	94.3	0.8	229.2	1.6
Industry	435.6	5.3	264.2	3.2	607.7	7.5	493.0	5.7	715.1	7.7	608.1	5.3	509.0	3.5
Mineral Resources & Mining	461.5	5.6	282.5	3.5	236.4	2.9	168.6	2.0	113.9	1.2	21.4	0.2	73.4	0.5
Trade Policies & Regulations	561.9	6.9	221.7	2.7	324.1	4.0	412.0	4.8	661.1	7.1	346.7	3.0	287.4	2.0
Tourism	16.0	0.0	18.6	0.2	7.1	0.1	16.0	0.2	450.2	4.8	14.2	0.1	16.5	0.1
<b>Total</b>	<b>8,170.3</b>	<b>100</b>	<b>8,185.3</b>	<b>100</b>	<b>8,100.7</b>	<b>100</b>	<b>8,641.2</b>	<b>100</b>	<b>9,293.4</b>	<b>100</b>	<b>11,470.9</b>	<b>100</b>	<b>14,497.2</b>	<b>100</b>

Source: OECD available online at <http://stats.oecd.org>.

**Table 12: Classification of African countries by HIPC status (January 30, 2010)**

<b>Post-Completion-Point Countries (22)</b>		
Benin	Ghana	São Tomé & Príncipe
Burkina Faso	Madagascar	Senegal
Burundi	Malawi	Sierra Leone
Cameroon	Mali	Tanzania
Central African Republic	Mauritania	Uganda
Republic of Congo	Mozambique	Zambia
Ethiopia	Niger	
The Gambia	Rwanda	
<b>Interim Countries (Between Decision and Completion Point) (7)</b>		
Chad	Guinea	Togo
Democratic Republic of Congo	Guinea-Bissau	
Côte d'Ivoire	Liberia	
<b>Pre-Decision Point Countries (4)</b>		
Comoros	Somalia	Sudan
Eritrea		

Source: IMF (2010) <http://www.imf.org/external/np/exr/facts/hipc.htm>.

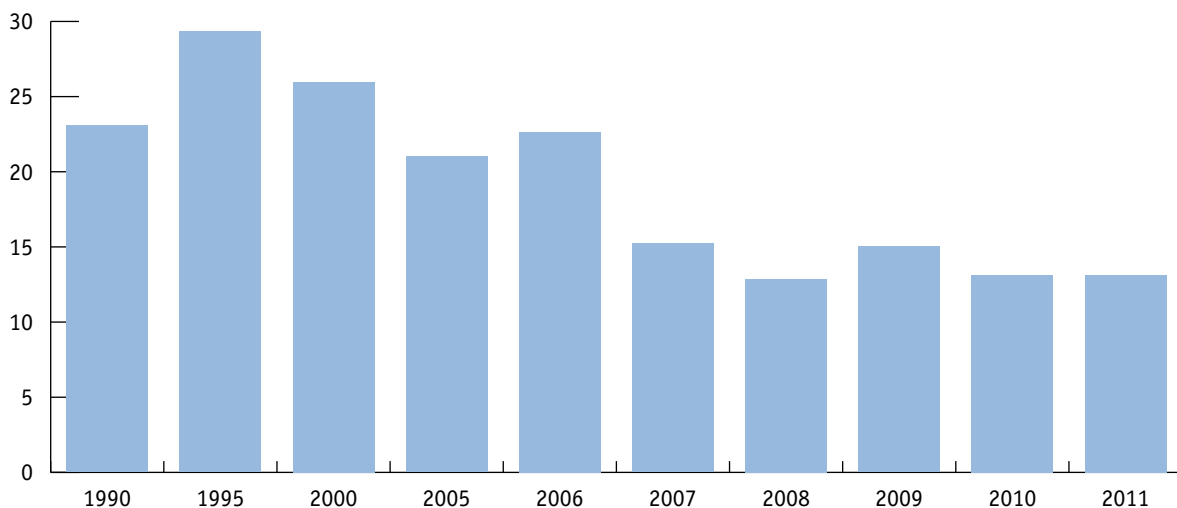
at the pre-decision point stage. Under the MDRI, assistance was delivered to all post-completion countries by March 2009, for a total amount of USD 18.29 billion. The HIPC initiative delivered USD 45.52 billion during the same period. Nonetheless, debt continues to be a constraint on the efforts of African countries to achieve the MDGs because of the insufficiency of the debt relief granted.

*Indicator 8.12: Debt service as a percentage of exports of goods and services*

There was a significant reduction in debt service as a proportion of exports of goods and services

in Africa during the period 2000–2008, falling from 7 percent in 2007 to 4.7 percent in 2008. As *Figure 34* below shows, debt service as a percentage of exports of goods and services for the rest of Africa excluding North Africa declined steadily from close to 29.3 percent in 1995 to 12.8 percent in 2008. The slight increase in 2009 was largely driven by falling exports as a consequence of the global economic crisis and the acquisition of new debt by some countries. This was deemed necessary to maintain fiscal space in the face of declining export revenues and rising development needs.

**Figure 34: Total debt service as a percentage of exports of goods and services, Africa excluding North Africa, 1990–2011**



Source: ECA computations based on IMF, World Economic Outlook Database, April 2010.

The steady progress on this indicator is due in large part to the various debt relief initiatives that began with the HIPC initiative followed by others such as MDRI. Moreover, improved commodity exports of the recent past expanded the capacity of countries to service their debt. But there is significant cross-country variation in debt service as a proportion of exports of goods and services. It increased from 2000 in countries like Comoros, Eritrea, Guinea, and São Tomé and Príncipe. Three of these countries – Comoros, Eritrea and Guinea – have been in conflict and could not prepare their poverty reduction strategy papers (PRSP) in order to benefit from the debt relief initiatives. São Tomé and Príncipe is a post-completion country and its return to debt argues for a review of the methodology for calculating debt sustainability.

**Target 8E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries**

*Indicator 8.13: Proportion of population with access to affordable essential drugs*

This is a very important target for Africa in view of the region's slow progress on the health-related MDGs, as shown in this report. The memory of serious shortages of essential medicines in Africa in the 1990s has receded. Nonetheless, millions of people continue to die needlessly due to poor access to affordable essential drugs. The access problem links to a number of factors – supply gaps, inadequate geographical distribution, and high drug prices.

Progress on improved access to essential drugs is difficult to measure as countries do not routinely collect such data. Evidence from many African countries suggests that there are significant supply

gaps in both the public and non-governmental healthcare provision sectors. The high price of many essential drugs has led to a booming market in many African countries in fake and expired drugs procured mainly from China and India, resulting in many preventable deaths. African governments need to urgently act on fake drugs in concert with their development partners and supplier countries in order to ensure that health gains are not placed in serious jeopardy.

Health insurance schemes and increased public sector expenditure on essential drugs, along with improved geographical distribution of health services, could help to expand access to affordable essential drugs. However, the scope for health insurance is limited in most African countries because it remains largely employment-based. Inequities in access to healthcare are also a contributing factor. Further, African governments are limited in their ability to bridge geographical access to affordable essential drugs due to inadequate human and financial resources. In some countries, user fees still exist for public healthcare services. If patients cannot see a doctor because of user fees, then they are unlikely to get essential drugs at subsidized prices in government hospitals.

The establishment of new pharmaceutical firms in Africa, and the expansion of existing firms' capacity to produce generic drugs, could help to attenuate the supply gap and improve access to affordable essential drugs. However, in this respect the WTO's TRIPS Agreement (Trade-Related Aspects of Intellectual Property Rights) – which established minimum standards for intellectual property rights that WTO members must institute and adhere to through national legislation – presents a problem. Nonetheless, TRIPS does

contain provisions that allow some degree of flexibility and room for countries to accommodate their own patent and intellectual property systems and development needs. However, many African countries have not taken full advantage of these flexibilities due to poor pharmaceutical development policies and inadequate incentives for the private sector to locally produce essential drugs. Cross-border provision of affordable essential drugs (through intra-African trade) is constrained by the lack of adequately harmonized regulatory, certification, and registration systems among African countries.

**Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications**

The benefits of new technologies, especially information and communications, for economic growth and development are incontestable. However, the digital divide that exists between Africa and the rest of the world, and among countries in the African subregions, acts as a major constraint to strategically harnessing the full potential of the Digital Age. To prompt and motivate action on this front, the 14th Ordinary Session of the Assembly of the African Union took as its theme “*Information and Communication Technologies (ICT) in Africa: Challenges and Prospects for Development.*” The Summit underscored the vital role that ICT can play in the development and integration of Africa in terms of infrastructure, culture and economy, and as an essential instrument to advance social, economic, and political development and attainment of the MDGs. A number of African countries have effectively embraced this philosophy (see Box 4).

#### Box 4: Rwanda and Mauritius – ICT pioneers in Africa

Rwanda's ICT policy is based on the premise that ICT is an engine of economic growth. The country aims to become a leader in ICT competitiveness and to serve as an ICT hub in Africa. Rwanda enjoys strong high-level political support nurturing these ambitions. The government has set the science and technology budget at 1.6 percent of GDP, which is comparable with the OECD countries. With a vision of transforming Rwanda into an information and knowledge-based economy, several projects have been launched, including: the building of telecenters; computerization of schools; e-governance; and investment in the Kigali Institute of Science and Technology. These projects form part of the ICT-2020 Policy, which will be implemented through five-year plans, with an emphasis on exploitation, utilization, production, development and delivery of ICT products and services.

Another African country that recognizes the massive contribution that ICT can make to its socioeconomic development is Mauritius, which has a vision of transforming itself into a Cyber Island. The country began ICT formulation, implementation, and physical infrastructure development in the 1990s. The government has engaged in the promotion of ICT in every sphere with a view to steering the country toward full integration in the Information Age. Computerization of the various government agencies started as far back as 1989, with the setting up of the following institutions to oversee the process: National Computer Board, Central Informatics Bureau, State Informatics Limited, and State Informatics Training Center Limited. As a result of this robust policy in the information field, the ICT sector now contributes over 5 percent to GDP, up from less than 1 percent in 2005. Mauritius continues to implement various projects to achieve its vision of becoming a leader in ICT.

Sources: [www.rwandagateway.com](http://www.rwandagateway.com) and [www.gov.mu](http://www.gov.mu).

The lack of a quantifiable target for this indicator makes an assessment of progress difficult if not impossible. The World Summit on the Information Society (WSIS) of 2003 agreed an Action Plan to achieve 10 targets by 2015. Included among these targets were the following: (i) to connect villages with ICTs and establish community access points, (ii) to connect, inter alia, educational establishments (schools, universities), research centers, health centers and hospitals, and government institutions to ICTs; (ii) to ensure that more than half the world's inhabitants have access to ICTs within their reach. Although there is no independent monitoring of Africa's progress toward the WSIS targets, the discussion of access to fixed telephone lines and mobile telephony below suggests that African countries, although

making good progress, are unlikely to meet the WSIS targets by 2015.

#### *Indicator 8.14: Telephone lines per 100 population*

Communication is essential for creating an integrated economic and social space, for building and harnessing social capital, for accessing knowledge, and for economic growth. Fixed telephone lines have played an important role in this regard. The number of fixed telephone lines per 100 population in Africa stagnated between 2006 and 2007. Half of the countries where data were available registered only marginal growth, while the other 50 percent registered either no growth or a decline. In fact, most countries for which data are available registered only modest growth in fixed telephone lines between 1990 and 2007. The

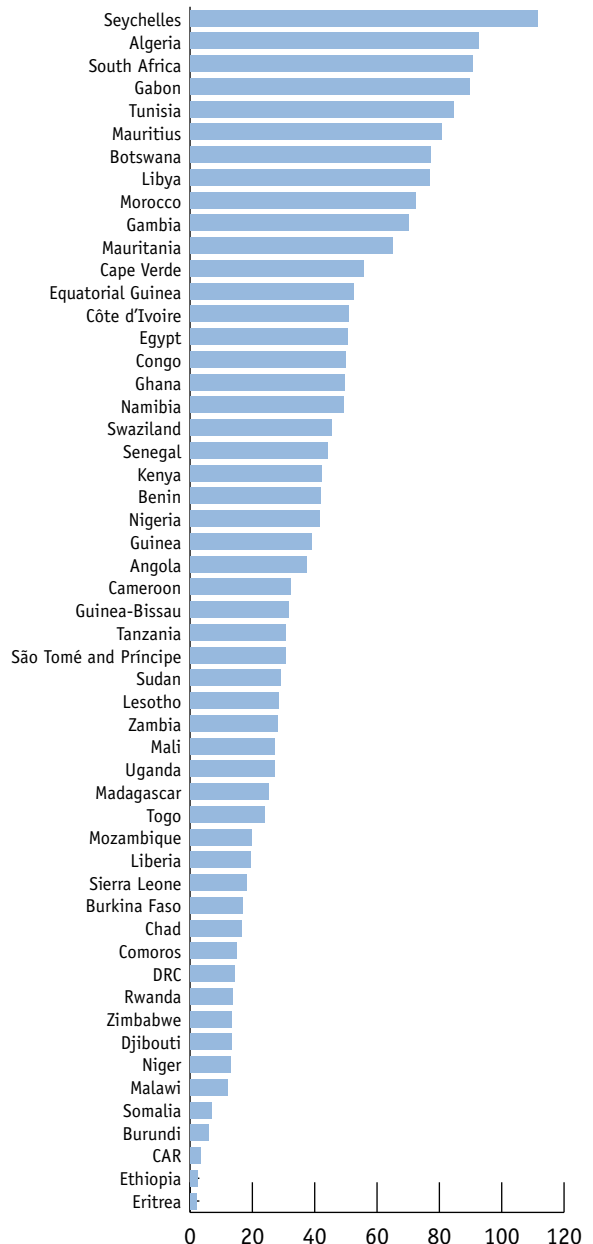
Seychelles and Mauritius are the two countries that have registered impressive growth for this indicator. The slow growth in other countries is largely due to the high cost of fixed-line telephony and the relative attractiveness of mobile telephony, which continues to expand at a very high rate.

**Indicator 8.15: Cellular subscribers per 100 population**

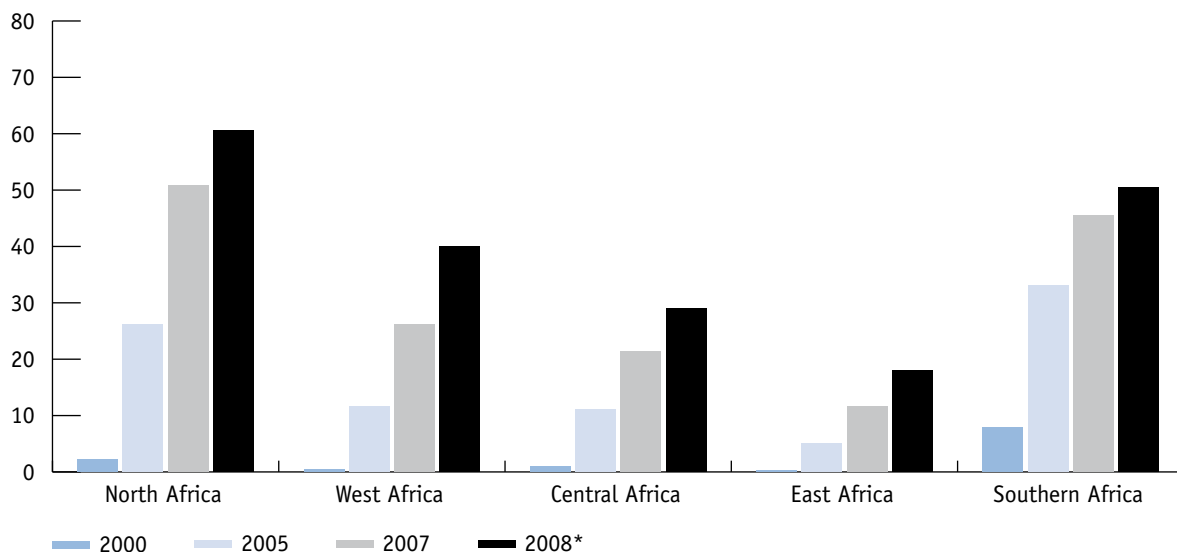
Mobile telephony continues to grow very rapidly on the continent. Cellular subscribers increased between 2006 and 2008 in all African countries. The Seychelles, Algeria, South Africa, Gabon, Tunisia, Mauritius, Botswana, and Libya recorded a cellular subscriber rate of over 75 per 100 population in 2008, while 18 countries had a subscription rate below 25 per 100 population (see Figure 35).

Progress is mixed within and across subregions (see Figure 36), with North Africa registering the most progress and East Africa the least. Within the North African subregion for the year 2008, Algeria recorded 92.7 cellular subscribers per 100 population and Egypt 50.6 cellular subscribers. In East Africa, which is the subregion with the fewest cellular subscribers, in 2008 the Seychelles had the most cellular subscribers (111.5 subscribers per 100 population), while Eritrea and Ethiopia had the least (just 2.2 and 2.4 subscribers per 100 population respectively). However, the Seychelles' robust performance on this indicator is unable to influence the subregional average, due to that country's small population. Conversely, Ethiopia brings down the subregional average due to its large population. Mobile phones are clearly more accessible than fixed-line telephones across the continent.

**Figure 35: Cellular subscribers per 100 population, 2008**



Source: ECA computations based on ITU data, updated in 2009.

**Figure 36: Cellular subscribers per 100 population by African subregion, 2000–2008**

Sources: ECA computations based on UNSD data updated in July 2009 and ITU data updated in 2009.

Notes: No data for Djibouti in 2007. \*ITU data for 2008.

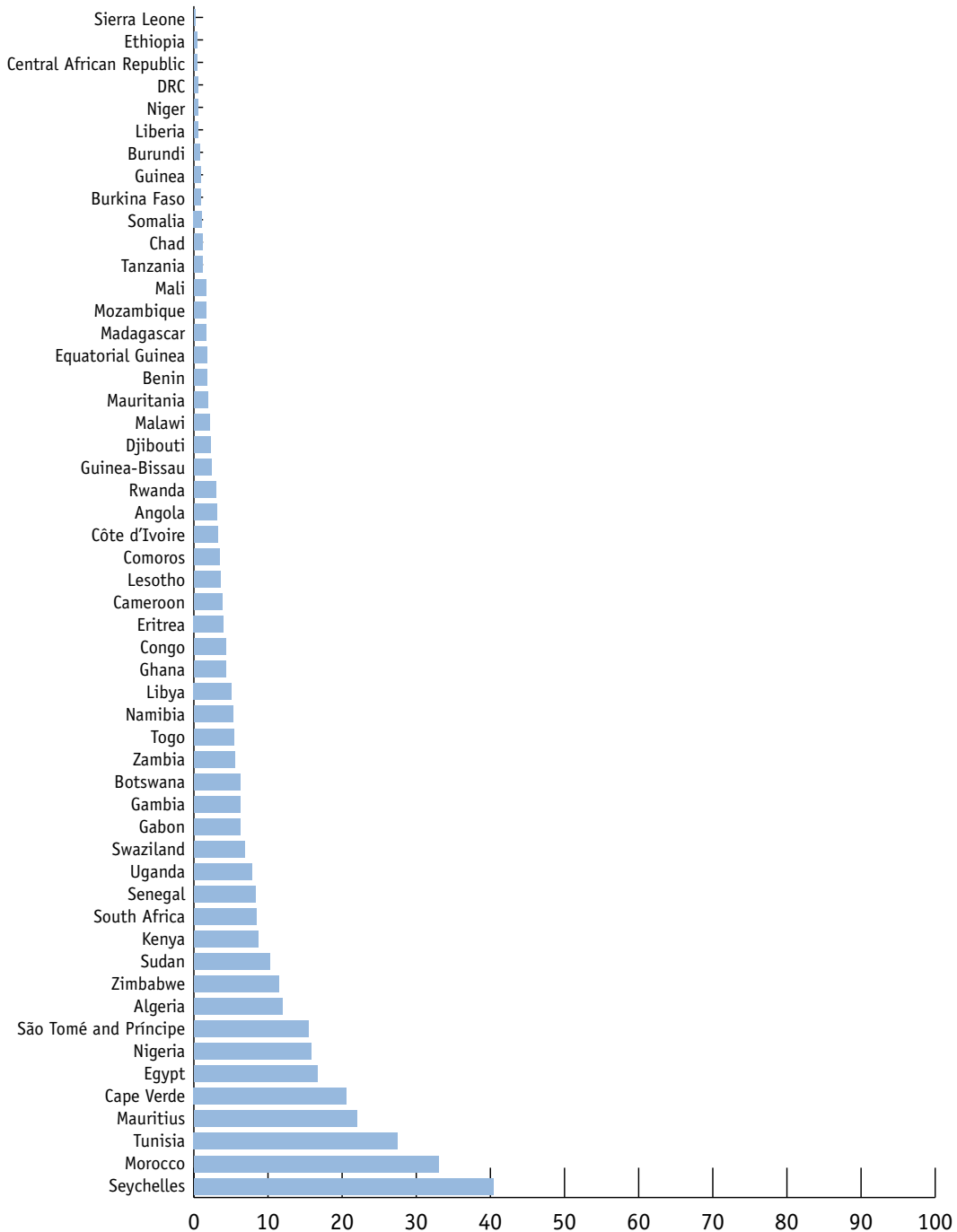
#### *Indicator 8.16: Internet users per 100 population*

The use of the internet in Africa has been increasing since 2000. In 2008, the Seychelles had the highest number of internet users, followed by Morocco, Tunisia, Mauritius, Cape Verde, and Egypt. Internet penetration is lower (less than one per 100 population) in Liberia, Niger, the Democratic Republic of Congo, the Central African Republic, Ethiopia, and Sierra Leone (see *Figure 37*).

Overall, the rate of progress on this target will depend on government policy toward the private sector, including foreign direct investment. Liberalization of the communications sector – as has occurred in countries such as Nigeria, Kenya, and Ghana – is essential for harnessing the benefits of new technologies. Countries need to ensure appropriate regulatory and pricing policies, while maintaining competition.

New technology will also be critical for adapting and mitigating the possible adverse consequences of climate change and harnessing the opportunities that this might present. A proactive policy is required of African governments to ensure that such technologies are available and that their benefits are widely diffused across their countries. To the extent that the WTO's TRIPS Agreement may constrain Africa's ability to use new climate technologies, African countries should, in concert with development partners, argue for the reform of TRIPS. Countries will also need to strengthen their national knowledge and innovation systems to create a large pool of locally qualified and trained people, to help set up and support ICT systems.

Figure 37: Internet users per 100 population, 2008



Source: ECA computations based on ITU data, updated in 2009.



# SECTION III:

## The role of goal-specific and institutional<sup>30</sup> innovations in accelerating progress toward the MDGs in Africa

Much of the discussions on attaining the MDGs in Africa assume the existence of proven interventions, mediating institutions, and practices essential for success. This assumption has in some cases led to an overemphasis on the financing (or resources) gap and an overly narrow focus on the adoption of new models for service delivery, scaling up interventions that work, enhancing aid effectiveness, and better development outcomes. While this focus is not misplaced, it is important to recognize that the institutional and governance context in which MDGs interventions are undertaken also matters.

Today, no one questions the central role that institutions play in economic and social development. The difference between success and failure of many interventions depends on how policies, processes, and relations are structured, organized, and refined. However, African institutions for planning, statistics, policy coordination, and governance, though growing in strength, remain relatively weak to respond effectively to the chal-

lenge of meeting the MDGs. Hence, creating such institutions where they do not exist, and nurturing and deepening them where they do exist, is fundamental to achieving and sustaining the MDGs.

In recognition of the central role that institutional innovation plays in development management, many African countries are now addressing the institutional challenges that are impeding progress on the MDGs. This section discusses the progress made firstly through *goal-specific innovations*, and secondly through *broad-based institutional innovations*.

### 3.1 Goal-specific innovations

This section discusses and highlights the goal-specific innovations that account for the progress on various indicators discussed above. Its purpose is to bring these innovations to a wider audience in the hope that they can be adopted and adapted by countries where they are not already part of the policy portfolio. Some of these innovations predate the MDGs in some countries. Nonetheless, their potential contribution to the achievement of the MDGs has deepened their significance, signaling their potential value in the context of peer

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30 Institutions are much more narrowly defined here as organizations that “implement rules and codes of conduct to achieve desired outcomes”.

learning and experience sharing. Among these innovations are social protection schemes, which are essential to support the vulnerable segments of the population, virtual poverty funds (VPFs), decentralized service provision, innovative funding of the social sector, etc.

### **Innovations for MDG 1:**

#### **Eradicate extreme poverty and hunger**

African countries have adopted a number of innovations or reinforced existing interventions in order to accelerate progress toward achieving MDG 1. A number of governments have increased their support to the agricultural sector. They have addressed difficulties in the agricultural input market and have reaped good results. Zambia introduced the Farmer Input Support Program (FISP) to assist its small-scale farmers. According to government estimates, 500,000 farmers are benefiting from this support. The Zambian government also expanded and intensified extension services to farmers. As a consequence, the country is anticipating a bumper maize harvest in 2010 of 2.7 million tonnes, 48 percent above the 2009 output. Malawi began in 2006 to subsidize the distribution of chemical fertilizers and hybrid maize varieties to its farmers, who responded by substantially increasing output. This has had a positive impact on food prices, household incomes, and should help to reduce malnutrition.

A major development that occurred in the wake of the food crisis of 2007–2008 is the unprecedented increase in the rate, size, and number of acquisitions of large tracks of prime agricultural land by foreign governments, investment banks, pension funds, and other companies. This was seen by many African governments as an innovation that would enable them to expand their fiscal space by

taking advantage of rising food and commodity prices, acquiring new technologies and improving infrastructure, including rural infrastructure. Such acquisitions were also intended to expand employment and raise agricultural productivity, thereby addressing MDG 1. The uptake of this innovation has been staggering. Ethiopia alone has approved 815 foreign-financed agricultural projects since 2007.<sup>31</sup> The government of Djibouti acquired 55,000 hectares of irrigated land from the Government of Malawi in 2009. China signed a contract with the Democratic Republic of Congo to grow 2.8 million hectares of palm oil for bio-fuels. Madagascar and the South Korean company Daewoo came close to finalizing a lease agreement that would have included nearly half of the country's arable land.<sup>32</sup> Tunisia recently adopted a decision to lease its agricultural land to foreign investors. According to a recent report published by the FAO, IIED and IFAD,<sup>33</sup> 2.49 million hectares of land were allocated to foreign investors in five African countries – Ethiopia, Ghana, Madagascar, Mali, and The Sudan – between 2004 and 2009. Although this innovation presents opportunities for accelerating progress on MDG 1, it has also raised concerns about its impact on poor people, who are at risk of losing access to and control of land on which they depend, especially as they have no property rights over such land.<sup>34</sup>

A major innovation in some countries is the Virtual Poverty Fund (VPF). Nigeria and Uganda, for example, have VPFs designed to track MDG-specific

31 <http://www.taipetimes.com/News/editorials/archives/2010/03/12/2003467789>.

32 See von Braun and Meizen-Dick (2009).

33 Cotula et al. (2009).

34 This is a key argument for advocacy for the legal empowerment of the poor.

expenditure. In Nigeria, the VPF, otherwise known as the Debt Relief Gain (DRG), was created using the USD 18 billion debt relief that the country had negotiated with the Paris Club in 2005. This has enabled the country to dedicate USD 1 billion annually to the achievement of the MDGs, focusing on health, education, water and sanitation, environment, energy, housing, women's empowerment, HIV/AIDS, and social safety nets. Lesotho, in addition to public works programs on soil and water conservation and household food security, also provides pensions to senior citizens aged 70 years old or above at a monthly stipend that started at M150 (maloti) per person but since April 2009 has risen to M300 (about USD 40). Swaziland introduced a bursary scheme for orphaned and vulnerable children, thus improving the school enrollment rate for this underprivileged segment. Ghana's social intervention programs, such as the Livelihood Empowerment Against Poverty (LEAP), Capitation Grant, fertilizer subsidy to smallholders, and the school feeding and nutritional supplementary initiatives, are primarily targeted at productivity enhancement. The Central African Republic's Social Insurance Scheme provides the following: old age pensions for men at age 55 and women at age 50; a disability pension; a survivor pension; sickness and maternity; and a family allowance for employees with one or more children.

### **Innovations for MDG 2:**

#### **Achieve universal primary education**

Three key institutional innovations drive the substantial progress made by many African countries on MDG 2: namely, increased resources, alternative educational service models, and the adoption of decentralized systems. Coupled

with a growing emphasis by governments on the centrality of education to the development process, there has been a steady increase in the allocation of public resources to the sector in many countries.

Further, countries such as Nigeria, Ethiopia, and The Gambia have adopted non-traditional models of primary education delivery to boost primary enrollment, educational parity, and adult literacy. Using escrow accounts or special funds, such as the Education Tax Fund in Nigeria and the Girls' Education Trust Fund in The Gambia, these countries have facilitated access to schooling for a large number of children in coastal, pastoral, semi-pastoral and some remote areas beyond the reach of the formal school system. Further, various funds have helped to bridge education financing gaps in many states. Countries like Rwanda have resorted to the intensive use of facilities and teachers through double shifts for lower-grade pupils to cope with a demand that was higher than the rate of expansion.

Many countries have also launched compulsory and free universal primary/basic education (e.g., Benin, the Democratic Republic of Congo, Nigeria, Namibia, Uganda, and Mauritius) and complemented these with additional policies such as School Feeding Programs. Ethiopia introduced in 2005 a productive safety net program, specifically targeting food-insecure and asset-poor households to increase enrollment rates for this group, and to extend the months they spend in school and the time they accord to studies at home. Burkina Faso introduced its BRIGHT (Burkinabe Responses to Improve Girls' Chances to Succeed) program in 2005, and in 2009

launched the second phase of the program. BRIGHT provides daily meals for all children and take-home rations for girls, to reduce the time they spend on household chores and increase the time they allocate to studies at home.

### **Innovations for MDG 3:**

#### **Promote gender equality and empower women**

Political commitment, cultural factors, and advocacy are driving forces to attain MDG 3 on gender empowerment. Political commitment to national gender policies has contributed to appreciable progress on gender parity in education and increased women's participation in decision-making processes (in Rwanda, the Seychelles, Swaziland, and South Africa). Explicit recognition of women's right to land in Tanzania and affirmative actions such as direct land allocation to female-headed households combined with credit assistance to develop such lands in Tanzania, Zambia, and Eritrea have provided some impetus to women's rights and active participation in decision-making processes. A few countries have promulgated legislation dealing with property and inheritance rights of HIV/AIDS orphans and equal inheritance rights for widows/widowers on a country-wide basis (Kenya).<sup>35</sup>

### **Innovations for MDGs 4, 5, and 6:**

#### **Improving health (reducing child and maternal mortality rates and combating HIV, AIDS, malaria, and other major diseases)**

The health MDGs are proving to be the most challenging in Africa. Evidence suggests that countries that demonstrate strong collaboration among government, non-state actors (private

sector and CSOs), and development partners tend to make faster progress on MDGs 4, 5, and 6. For example, São Tomé and Príncipe, the Seychelles, Malawi, Eritrea, and Mauritius leveraged their success through strong collaboration with development partners and committed political leadership. An integrated sector-wide approach, with clearly demarcated roles and responsibilities for each actor, has innovatively and advantageously positioned these countries vis-à-vis the health MDGs. Eritrea and São Tomé and Príncipe as a consequence recorded the fastest reduction in the infant mortality rate in the region.<sup>36</sup> Mali, Togo, and Senegal are on track with respect to the HIV/AIDS target, due to firm leadership, a coordinated multisectoral approach, a strong emphasis on building the capacity of the public sector and CSOs, increased sensitization of the population, the introduction of voluntary anonymous testing and free antiretroviral therapy (ART), and heightened mobilization of international support.

### **Innovations for MDG 7:**

#### **Ensuring environmental sustainability**

Performance on MDG 7 on environmental sustainability is highly uneven across the continent, although limited documentation of good practice does exist. Mauritius offers a very good example for several targets of Goal 7, with substantial reductions in carbon emissions, and almost universal access to safe drinking water and sanitation. In

35 See Augustinus and Deininger (2005) for more information on innovations about women's land ownership in Africa.

36 This was possible in Eritrea through increased access to healthcare services by investing in the reconstruction of destroyed facilities, training for health workers, and increased provision of drugs and equipment, as well as proactive and maximum coverage of immunization against the major killer diseases (UNDP Background document on Eritrea, 2010).

Ghana and Angola, innovative and locally driven pilot projects on safe water and sanitation aim to increase access to these basic facilities in deprived areas.

A number of countries are also applying innovative policies to provide low-cost housing to the poor (e.g., Namibia and South Africa). Land management is receiving some attention in a number of countries. Decentralized land management in Ethiopia has allowed a more flexible approach and a transfer of skills to the local level. Housing schemes for slum dwellers in Namibia is producing tangible benefits for historically disadvantaged groups. Similarly, the partnership between New Rest (an informal settlement in Cape Town) and the City of Cape Town in South Africa uses a phased approach to land ownership and neighborhood management. The scheme is considered to be user-friendly, flexible, affordable, and accommodates local land tenure practices while meeting the needs of the formal system (Kingwell et al., 2006). However, issues relating to carbon emissions are yet to receive commensurate attention.

### 3.2 Broad-based institutional innovations

In addition to the goal-specific innovations discussed above, a number of broad-based institutional innovations have also contributed to the reported progress in Africa toward the MDGs. These innovations are important because the MDGs need to be “whole-of-government and whole-of-society” initiatives. They cut across ministerial, departmental, and agency portfolios. They also cut across jurisdictional boundaries and tiers of government – national, state, provincial, district, and municipal. Strong institutions are essential for deploying all the resources of a state to

achieve the MDGs. The discussion below focuses on some of these broad-based institutional innovations in the areas of: (i) social protection, (ii) MDG-based planning, (iii) decentralization – cascading the MDGs to lower tiers of government, (iv) policy and program coordination, and (v) accountability and results-based performance management.

#### Social Protection<sup>37</sup>

A key innovation for assisting the poor and excluded groups is social protection, which enjoys a long history in many African countries. However, a number of countries scaled back these schemes or curtailed plans to introduce them during the structural adjustment programs of the 1980s. The urgency of meeting the MDGs, combined with the social consequences of the recent food price, fuel, and financial and economic crises, have provided a new impetus for African countries to expand the scope for social protection as an additional instrument to achieve MDG 1 and to safeguard gains already made.

The positive experience of Latin American countries in providing for their poor has informed current efforts in Africa to reintroduce social protection. Consequently, a large number of the “new” social protection schemes have been initiated by donors to demonstrate their applicability in the context of Africa. There has also

37 Social protection as used in this report is “the set of public and private policies and programs undertaken by societies in response to various contingencies to offset the absence or substantial reduction of income from work; to provide assistance for families with children as well as provide people with healthcare and housing” (UN, 2001).

been endogenous growth of social protection as a concept, with the African Union at the forefront of this initiative.<sup>38</sup>

The approach and scope of these schemes vary from country to country. In the Seychelles, protection of the poor and the marginalized is a fundamental right enshrined in the country's Constitution. The diligent implementation of this constitutional requirement explains the absence of abject poverty in that country. Mauritius, Tunisia, Libya, Egypt, and South Africa are all countries with significant social protection systems. South Africa probably has the most extensive social protection in Africa, encompassing a broad spectrum of their disadvantaged population. It provides a raft of assistance, from child support and youth unemployment support to old-age pensions, with a coverage as at March 2009 of over 13 million people.

There are three broad social protection instruments in Africa: (i) contributory social protection instruments (contributory pension schemes, national health insurance schemes, private health insurance schemes, community-based insurance schemes, weather/ agricultural insurance schemes); (ii) non-contributory social protection instruments (conditional cash transfers/ cash for work, fee waivers for health and education, food transfers; unconditional cash/voucher/in-kind transfers, unconditional cash

transfers for poor households, old age pensions, child allowances, disability allowances); and (iii) minimum standards and regulations (minimum wages) to protect the livelihoods of individuals and households.

Many African countries have already designed and implemented social protection and safety net regimes to minimize the impact of the recent crises, and to serve as a pathway out of poverty. Many others are in the process of designing and implementing such schemes. The diverse examples given here show how widespread the adoption of social protection has become in Africa in recent times. Burkina Faso adopted a *Plan National d'Action Sociale* (PNAS) in April 2007 and is now drafting a three-year implementation plan. Cape Verde adopted a National Social Protection Strategy in 2006 and has instituted a social pension scheme. Equatorial Guinea created a Fund for Social Development to support policies in 2005 aimed at improving the well-being of its citizens, and achieving the MDGs. It signed a Memorandum of Understanding with the United States to mutually cooperate in managing the "Social Needs Fund" that it put in place. Ghana in 2008 launched its Livelihood Empowerment against Poverty (LEAP) Program in response to the food price crisis. This was based on the National Social Protection Strategy finalized in 2007. Malawi developed and adopted a Social Protection Policy Framework in 2006, while Namibia introduced the Basic Income Grant (BIG) pilot project, a universal unconditional cash transfer program, in 2007. Nigeria developed and adopted a social protection strategy in 2004. Sierra Leone's Social Safety Net Program was launched in 2007 and aims to reach 16,000 extremely vulnerable households. Senegal's National Social Protection Strategy aims to extend

38 In 2005, the AU drafted the African Union Social Policy Framework. In 2006, the AUC organized the Inter-governmental Conference on Basic Social Protection in Livingstone, Zambia, which resulted in the Livingstone Call for Action. In 2008, the AU organized the first African Union Conference of Ministers in charge of Social Development in Windhoek, which discussed and agreed to submit the Social Policy Framework for approval by AU Heads of State and Government; this was adopted in 2009.

health insurance to 50 percent of the population by 2015 and also establish a system to insure rural populations from the risks of natural disasters. These are the green shoots that will need to be nurtured to fruition.

However, there are risks – the most pressing being fiscal sustainability. The base of African economies is narrow (compared to that of Latin American countries, for example), and therefore may prove inadequate to sustain these schemes once coverage is expanded. Further, social protection schemes could create dependency and potentially distort the labor market by altering the trade-off between leisure and work. For these reasons, governments should be prudent in regard to coverage expansion.

### **MDG-based planning**

Development planning has undergone a surge of popularity, after retreating in the 1980s and 1990s. The return of national development planning was affirmed by world leaders in the Outcome Document of the 2005 United Nations World Summit and Mid-term Review of Progress toward the MDGs. There is an explicit recognition that the MDGs are global aspirations, not national planning targets, and that countries should tailor them in a manner consistent with their own realities. For the MDGs to become planning targets, they have to be endogenized through national development plans and/or poverty reduction strategies<sup>39</sup> and converted into concrete national targets. Since 2005, over 40 African countries have prepared and are implementing MDG-based national development plans and/or strategies. National development

plans are essential to avoid or minimize the risk of a “Kerala conundrum” (see *Box 5*).

Two countries illustrate this trend. In 2005, Tanzania adopted its National Strategy for Growth and Reduction of Poverty (known by its Swahili acronym as MKUKUTA) to provide a development framework for 2005–2010. MKUKUTA forms part of Tanzania’s efforts to deliver on its national Vision 2025, the goals of which are aligned to the MDGs. It is organized around three broad clusters of outcomes: (i) economic growth and reduction of income poverty; (ii) improved quality of life and social well-being, and (iii) improved governance and accountability. Key to the successful implementation of MKUKUTA is government budgeting. The Tanzanian government has linked MKUKUTA to the national budget through its Strategic Budget Allocation System (SBAS). Successful implementation of MKUKUTA has required the strengthening of the Public Expenditure Review/Medium Term Expenditure Framework (PER/MTEF) process to ensure that resource allocations reflect the following three areas of focus: poverty reduction priorities; reforming the monetary and financial sectors to ensure macroeconomic stability and an investment-friendly environment; and initiating programs to scale up access to finance for disadvantaged communities.

Similarly, Ethiopia adopted its Plan for Accelerated and Sustained Development to End Poverty (PASDEP) to guide its strategic framework for poverty eradication for 2005/06 through to 2009/10. PASDEP is outcome-oriented and defines Ethiopia’s overall development strategy and vision to bring about accelerated and sustained development and so reach the status of a middle-income country. This is to be effected through an

39 There was a heated debate in 2005 and 2006 around whether or not the World Bank’s Poverty Reduction Strategy Paper (PRSP) was an appropriate framework for the MDGs. For a summary of this debate, see Nwuke (2006).

### Box 5: Planning for the MDGs – lessons from Kerala in India

Kerala is India's most socially developed state, with many of its human development indices on a par with those of the developed world. In all of India, Kerala's social indicators outshine the rest of the country as it has the highest literacy rate, the highest life expectancy, the lowest infant mortality rate, the lowest school dropout rate, a low population growth rate, and higher life expectancy for women, etc.

However, even though Kerala has attained most of the MDGs, its economy is heavily dependent on tourism and remittances, and unemployment is rife. Social development has not led to economic development, making the sustainability of the state's social programs precarious. For example, Kerala's highly educated and literate workforce is forced to seek employment outside the state.

Economists believe that Kerala is facing a "second-generation problem" of growth, as following massive investments in social development, the state has little money left to capitalize on achievements and take the economy forward.

The Kerala conundrum offers African states an invaluable insight on the need to balance social development programs with economic development measures. Watching how the situation in Kerala unfolds will offer important lessons and best practices to African development experts.

*Source: BBC News (March 17, 2010) "Conundrum of Kerala's struggling economy."*

aggressive program, focusing on the growth of the agricultural and industrial sectors and on private sector development, and by scaling up efforts to achieve the MDGs. To this end, the government has undertaken institutional reforms and intensified the decentralization process. Institutional reforms include strengthening the regulatory framework, simplification of the fiscal system, financial sector reform, reduction of bureaucratic bottlenecks through Business Process Re-engineering (BPR), and the privatization of state entities.

#### **Decentralization: cascading the MDGs to lower tiers of government**

The implementation of MDG interventions has been proven to be more effective when undertaken at the local level. This makes decentralization of governance in terms of administrative and economic responsibilities a key component of recent institutional reforms in Africa. The forms of decentralization vary, ranging from strengthening the

autonomy of federating units (in those countries with federal constitutions), to deepened decentralization of government structures in countries with unitary constitutions, and to fiscal decentralization irrespective of the type of constitution in place. Decentralization is used not only for promoting and advancing national unity in the context of multi-ethnicity but also as a means of remedying "government failure" and of improving the provision of public goods and services to improve citizens' welfare.

The growing emphasis on decentralization in Africa is resulting in significant changes in the economic, administrative, and political landscape in many countries. It is also determining and shaping the modalities of service delivery. In most countries, there is a geographical dimension to achieving the MDGs. For example, within Nigeria, some states are on track to meet most of the targets of the MDGs. Intra-country variations in the rate of progress



can be attenuated by devolving responsibilities to lower tiers of government. According to Gupta et al. (2005), local governments account for almost 70 percent of poverty-reducing spending in some countries, hence empowering them is critical for progress. In Nigeria, subnational governments now account for more than 50 percent of total government expenditure.

In addition to Nigeria, which constitutes the oldest federation in the region, there are at least five other countries with federal constitutions: Ethiopia, Eritrea, Comoros, Somalia, and The Sudan. South Africa has a unique semi-federal system insofar as its constitution mandates significant devolution of powers to the regions and to local governments. Countries such as Kenya and the Democratic Republic of Congo are exploring how best to decentralize in order to “bring development closer to the people” and to assuage political tensions. In the rest of Africa, where decentralization is not constitutionally mandated, subnational jurisdictions such as regional, provincial, urban, and district local governments have been created through legislation.

Countries are exploring how best to enhance the role and contribution of these subnational units to accelerate progress toward achievement of the MDGs. For instance in Tanzania, the adoption of the MKUKUTA development initiative required devolution of power to the local level to achieve better service delivery. This led to the Local Government Reform Program (LGRP) which involved five main areas: (i) political decentralization (strengthening local institutions); (ii) fiscal decentralization (devolving more finances to local governments); (iii) administrative decentralization (restructuring of local government organizations); (iv) service function decentralization (localizing service provision

and management); and (v) changes to central–local relations.

Similarly in Ethiopia, the decentralization of power and authority from federal to regional governments, and from city administrations to zones, has enabled faster and better targeted delivery of essential services at the local levels. This can be seen in an increase in the construction of low-cost housing, new and maintained roads, public health centers, and employment generation schemes, among other outcomes.

### **Policy and program coordination**

In spite of the advantages of decentralization, its implementation is associated with some challenges. Decentralization requires the transfer of administrative and fiscal responsibilities and thus involves a large number of public actors, both local and central. This may give rise to horizontal and vertical coordination problems among agencies and tiers of government, and between public and private sectors. This is all the more likely if there are no systemic, multi-tiered coordination mechanisms in place, or if those mechanisms do not function effectively. In such circumstances, the center tends to retain a greater control over revenue and expenditure decisions. The situation is very different in countries with a federal system of government, where there is a constitutional delineation of responsibilities among tiers of government.

Vertical regulation mechanisms are essential for monitoring and ensuring that different levels of government fulfill their responsibilities and exert appropriate authority. Such mechanisms bring greater clarity to different tiers of government and help to align local policies and interventions to national ones. Such mechanisms also allow

the priorities set out in MDG-consistent national development strategies to be translated into sub-national planning and budgeting. Coordination mechanisms help to build a consensus on current and emerging issues, on the setting of priorities and on shared program execution, and on the monitoring of development outcomes.

A number of countries have introduced mechanisms to coordinate action on the MDGs across ministries and tiers of government. Nigeria, for example, has an MDGs Office in the Presidency, headed by a Senior Special Assistant to the President. The Office (OSSAP), which serves as the Secretariat to the Presidential Committee on MDGs, is charged with funding, tracking, and monitoring MDG-specific interventions to inform annual budget allocations. Each ministry at the federal level has an MDG desk that works very closely with OSSAP-MDGs. The country also has an MDG Committee in the national parliament, as well as the legislature of the 36 states of the Federation. A national Joint Planning Board, with the National Planning Commission as Secretariat, coordinates planning among all 36 states of the Federation, thereby ensuring coherence.

South Africa recently created a National Planning Commission to coordinate the activities of its ministries/departments and agencies. In addition to this, South Africa introduced a horizontal coordination mechanism. The Cabinet Lekgotla, which meets annually to coordinate strategy, charts the plans of action for the following year, and appraises past performance. Similarly, all government ministries/departments are clustered into five groups, comprising: social, economic and employment, justice and security, governance, and administration. This arrangement fosters policy coherence, coordination of plans and strategies, and improved service

delivery. Also in many countries (e.g. Nigeria, Kenya, and Senegal), an MDG desk has been established in critical ministries and departments. These institutional innovations are helping to reduce the transaction costs of MDG-critical interventions, in addition to helping to build a national consensus on the MDGs.

### **Accountability and results-based performance management**

A number of government documents, including national MDG reports, have singled out the need for improvements in absorptive capacity<sup>40</sup> as key factors in achievement of the MDGs. This is necessary to redress problems associated with poor accountability and transparency in the use of public resources. Weak absorptive capacity and wastages have contributed to slow progress. The increasing resort to extra-budgetary and supplementary expenditures suggests weak adherence to budgetary discipline.

Many African countries measure performance based on resources spent rather than on outputs and impact on the target beneficiaries. Results-based management strategies call for the separation of the implementing units from the oversight and monitoring institutions and for the non-involvement of beneficiaries in the monitoring and evaluating (M&E) of MDG programs. The institutionalization of an effective M&E framework will facilitate the process of achieving the MDGs. Evidence suggests that a major factor differentiating high-performing countries from low-performing countries on human development indicators is adherence or otherwise to transparent and accountable governance.

<sup>40</sup> Absorptive capacity in this context is the ability to use additional aid without pronounced inefficiency of public spending and without induced adverse effects.

# SECTION IV:

## Conclusions and an agenda for action

As we come to the end of the first decade of the MDGs and with five years remaining to the target date of 2015, the evidence shows that Africa has made significant progress since 2000. Notable advances have been made in social indicators, such as net primary education enrollment, childhood immunization, stemming the spread of HIV/AIDS and TB, and gender empowerment, including the representation of women in decision-making. However, progress in the key areas of poverty reduction, employment, and most health-related goals remains disappointing.

Nonetheless, the continent is moving in the right direction, albeit at a slow pace when compared to other developing regions. Still high population growth relative to other regions masks some of the progress that the continent has made in improving human development indicators. Further, the development challenges confronting the continent are not necessarily the same as those confronting other regions and require much greater expenditure of resources and efforts in order to overcome them.

The MDGs have created a heightened awareness of Africa's development challenges and a consensus, both domestic and among development partners, on the urgency of tackling them. The institutions to accelerate progress have been created. The goals have facilitated benchmarking and encouraged

cross-country comparisons. Democratic governance, the rule of law, accountability and transparency – key ingredients for development, and widely taken for granted in most parts of the world – are only now beginning to take root in Africa. African economies, long dependent on foreign aid, have been growing, making it possible for countries to expand fiscal space.

Despite these positive developments, challenges remain. Critical among these is the challenge of reducing inequity in access to social services and thus in development outcomes. A high degree of inequity characterizes access to many social services in Africa, including health and education. There is an acute risk of the poor being left behind, since most of the targets are (national) averages. These inequities explain in large measure the region's slow progress in attaining the health MDGs, since there is strong scientific evidence to suggest that more egalitarian societies tend to be healthier.<sup>41</sup> Furthermore, with just five years left to the MDGs' end-date and with the slow rate of progress on most of the goals impeding their achievement, vigorous efforts are required on the part of African governments and their development partners to expand access of the poor and people living in rural areas to social services. However, African

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41 Wilkinson (1995); Wilkinson and Pickett (2007).

governments are faced with a difficult choice. In the context of limited financial and human resources and time constraints, should they aim to achieve all the goals by the target date or to achieve only a few that they consider most critical for their long-term development? The decision is one that each country must make. Governments may need to recalibrate their priorities and identify which MDGs are within reach, given bankable resources, and refocus their efforts on those. However, this is a choice that countries could avoid if Africa's development partners were to recommit and deliver on the pledges that they made to the continent at various G8 Summits, especially the Gleneagles Summit of 2005.

The analysis presented in this report shows that African countries are making progress toward achieving the targets of the MDGs. The direction of human development indicators has significantly and positively shifted since the 1980s and 1990s. The rate of progress is however slower than is required to meet the MDGs. This report thus underscores the urgency for action by African countries, their development partners, and other stakeholders in Africa's development (NGOs, the private sector, CSOs) to scale up efforts to accelerate the rate of progress to achieve the MDGs by the target date. The evidence suggests that the MDGs are achievable if African countries, their governments and people, and their development partners rededicate and recommit themselves to the MDGs. To achieve this, they need to give due consideration to implementing an Agenda for Action.<sup>42</sup>

42 These actions draw on various sources, including the Ministerial Statements of the ECA Conference of African Ministers of Finance, Planning and Economic Development of 2007 and 2008 and various AU Resolutions on the MDGs from 2007 to 2010. The recommendations are also consistent

The Agenda for Action proposed below is not exhaustive. It consists of two parts: (i) broad policies that provide an overall context and that define the environment and (ii) goal-specific interventions that are needed to accelerate progress. The broad actions seek to create an enabling environment for growth, while the specific actions relate in the main to the delivery of services.

## POSSIBLE AGENDA FOR ACTION

### (i) Broad Actions

- » Maintain sound and stable macroeconomic policies;
- » Improve national capacity to monitor and report on the MDGs. This will include strengthening national statistical systems;
- » Strengthen MDG-based planning at all levels (tiers) of government; countries should cascade planning to lower tiers of government and build appropriate MDG-related capacity at those levels;
- » Countries should scale up public sector investments to achieve the MDGs;
- » Countries should promote active private sector, CSO and NGO involvement in efforts to achieve the MDGs;
- » Promote a unified planning framework that provides a strong macroeconomic framework for achieving the MDGs;

with the recommendations of the UN Secretary-General's MDGs Africa Steering Group of 2008.

- » Harness the potential of regional integration, including South–South cooperation.

## **(ii) Goal-specific Interventions**

### *GOAL 1: Eradicate extreme poverty and hunger*

- » Macroeconomic stability is critical for growing the economy and for reducing poverty. In this regard, countries should maintain the macroeconomic policies that have contributed to the positive growth outcomes of the past 10 years;
- » Undertake structural reforms, including reducing job search costs, to promote employment as a pathway out of poverty;
- » Consider the feasibility of social protection for the most vulnerable and disadvantaged to shield them from the adverse social impacts of the global financial crisis, and to secure progress already made toward achievement of the MDGs. However, social protection schemes should be properly costed and designed in such a manner as to ensure intertemporal sustainability;
- » Strategically harness science and technology to boost agricultural productivity;
- » Operationalize the Fertilizer Fund as well as diligently implement the AU's Comprehensive African Agricultural Development Program (CAADP), including setting aside 10 percent of the annual budget for agriculture;
- » Develop rural infrastructure, including rural roads and rural electrification;

- » Consider offering incentives/subsidies to farmers based on country food preferences (as in the case of Kenya and its maize farmers) and nutritional needs;

- » Implement macroeconomic/fiscal policies that ensure sustainable growth and job creation.

### *GOAL 2: Achieve universal primary education*

- » Improve teacher and teaching quality, including creating quality assurance institutions;
- » Create incentives for greater choice in primary education, including encouraging private provision of primary education;
- » Vigorously implement attendance compliance (truancy prevention) in those countries where constitutionally primary education is free and compulsory;
- » Increase funding to repair and upgrade dilapidated primary education infrastructure;
- » Improve incentives for teachers, especially those teaching in rural and marginalized communities;
- » To the extent fiscally possible, introduce measures such as medical care (to reduce absenteeism), free school lunch, special toilets for girls, free books, etc. in order to improve retention rates;
- » Expand access to primary education especially in rural areas; establish national benchmarks for nominal access, such as distance from a primary school;

- » Ensure industrial peace so that frequent industrial action by teachers does not disrupt learning.

**GOAL 3: Promote gender equality and empower women**

- » Promote measures to discourage early marriage of girls through public awareness campaigns and improved retention of girls in school. These measures may include interventions to reduce teen pregnancy and the number of births out-of-wedlock;
  - » Take special and affirmative measures (e.g. absenteeism quotas<sup>43</sup> for girls) to encourage female enrollment in secondary and tertiary institutions;
  - » Introduce measures to discourage gender discrimination in the workplace and address cultural and religious objections to women's employment outside the home;
  - » Take special and affirmative measures – absenteeism quotas – to expand non-agricultural wage employment and the participation of women in decision-making, including political decision-making.
- of antiretrovirals to prevent mother-to-child transmission of HIV; regular anthropometric measurement of children (in order to educate mothers during clinic visits on their children's nutritional needs);
- » Improve general hygiene, sanitation, and access to improved water quality and quantity;
  - » Improve and integrate maternal and child health policies, including the training of midwives;
  - » Improve the quality and size of the healthcare workforce;
  - » Expand access to healthcare and reduce glaring inequities in the utilization of healthcare services by income and by place of residence. A national benchmark such as distance (in miles) to a healthcare facility may be helpful. Aggressively promote the expansion of the non-governmental healthcare provision sector through legal reforms, franchising, etc.
  - » Provide free outpatient visits for children five years old and under;
  - » Undertake research on the major causes of mortality and morbidity among children, including the development of new and improved vaccines and diets;
  - » Strategically harness indigenous knowledge, for example traditional herbs used to prevent and cure diseases such as malaria. Train traditional doctors and midwives on modern diseases and certify them as authorized/com-

**GOAL 4: Reduce child mortality**

- » Improve diagnosis and national health systems;
- » Accelerate access to interventions that are known to work, including insecticide treated bednets, immunization programs, use

43 Absenteeism quotas allow girls to be absent a certain number of days a month without penalty. The aim is to improve dropout rates due to menstruation, and giving care to sick family members, etc.

petent healthcare providers to reduce mortality from unsafe interventions.

#### *GOAL 5: Improve maternal health*

- » Improve obstetric care, especially emergency obstetrics, which should be a high priority in the health sector plans of countries with very high maternal mortality rates;
- » Ensure that all pregnant women have access to clinics and are able to determine their HIV/AIDS status;
- » Ensure antiretrovirals are freely available for all pregnant women and nursing mothers who are HIV positive to prevent mother-to-child-transmission;
- » Ensure access to nutritional foods and advice for HIV-positive pregnant women;
- » Actively promote prenatal care so that underlying causes of maternal mortality such as malaria, obstructed labor, infections, pregnancy-related hypertensive disorders are quickly diagnosed and treated early;
- » Expand access to contraceptive methods for married couples;
- » Build capacity at local level health centers and introduce incentives for the health workers to retain them at the local level. For example, nurses and midwives, as well as counselors and nutritionists to advise women on health issues;
- » Reduce early marriage and promote girls' continued education, particularly at secondary and tertiary levels;

- » Support and promote the African Union Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA);

- » Strategically harness science and technology to improve maternal health outcomes.

#### *GOAL 6: Combat HIV, AIDS, malaria and other major diseases*

- » Continue to promote behavior change through education, communication and advocacy;
- » Promote prevention methods, including safe sex and abstinence;
- » Promote and expand testing, emphasizing Voluntary Counseling and Testing (VCT);
- » Reduce pediatric HIV/AIDS through PMTCT;
- » Promote and expand male circumcision;
- » Expand access to antiretroviral treatment, including free (or subsidized) provision of ART for all;
- » Ensure access to health facilities, trained personnel, and the availability of information;
- » Improve the number and quality of providers;
- » Work to reduce the scope for the global application of minimum standards for intellectual property under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS);
- » Encourage local production of generic HIV drugs, possibly on a subregional basis;

- » Promote research and development of HIV/AIDS, malaria, and TB vaccines.

*GOAL 7: Ensure environmental sustainability*

- » Improve governance and management of natural (environmental) resources, including the granting of rights to communities dependent on the environmental or natural resources;
- » Ensure adequate pricing of environmental and natural resources to ensure that people internalize the cost of the negative externalities that they generate. This could include an aggressive promotion of carbon markets in Africa;
- » Set up reserves/conservation areas and reclaim degraded land;
- » Provide incentives such as lower taxes for organizations that endorse best international practice in relation to environmental sustainability, and for organizations that are taking affirmative action to attenuate the negative impact of human action on the environment;
- » Improve the human habitat and the quality of human settlements through aggressive affordable housing and environmental planning programs;
- » Harness science and technology to advance environmental sustainability;
- » Mainstream environmental sustainability into national development plans and poverty reduction strategies.

*GOAL 8: Support the Global Partnership for Development*

- » Vigorously and faithfully implement the Accra Agenda for Action and the Paris Declaration on aid effectiveness;
- » Developed countries should meet their aid commitments, especially those made at G8 Summits and reaffirmed at subsequent G8 Summits and the G20 London and Pittsburgh Summits;
- » Give greater voice to developing countries in international financial institutions;
- » Promote trade facilitation initiatives (including ports and transportation infrastructure) to promote intra-African trade;
- » Use debt relief for landlocked countries in the region. Extra funds from debt relief could go into developing regional infrastructure and providing other regional public goods;
- » Promote licensing of technologies and access to technologies and innovations already in the public domain to accelerate the transfer of technologies, innovation, and knowledge to developing countries, especially least developed countries (LDCs).



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# Annex 1:

## Official list of MDG indicators

Effective 15 January 2008

### Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
<b>Goal 1: Eradicate extreme poverty and hunger</b>	
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than USD 1 per day	1.1 Proportion of population below USD 1 (PPP) per day <sup>i</sup> 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below USD 1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
<b>Goal 2: Achieve universal primary education</b>	
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrollment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary school 2.3 Literacy rate of 15-24 year-olds, women and men

<sup>i</sup> For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

### Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
<b>Goal 3: Promote gender equality and empower women</b>	
Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
<b>Goal 4: Reduce child mortality</b>	
Target 4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of one-year-old children immunized against measles
<b>Goal 5: Improve maternal health</b>	
Target 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rates for married people 5.4 Adolescent birth rate 5.5 Antenatal care coverage 5.6 Unmet need for family planning
<b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>	
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use for high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

### Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
<b>Goal 7: Ensure environmental sustainability</b>	
Target 7A: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO <sub>2</sub> emissions, total, per capita and per USD1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
Target 7B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums <sup>ii</sup>

ii The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.



### Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
<p><b>Goal 8: Develop a global partnership for development</b></p>	
<p>Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system</p> <p><i>Includes a commitment to good governance, development and poverty reduction – both nationally and internationally</i></p> <p>Target 8B: Address the special needs of the least developed countries</p> <p><i>Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</i></p> <p>Target 8C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p>Target 8D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</p>	<p><i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i></p> <p><b>Official Development Assistance (ODA)</b></p> <p>8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income</p> <p>8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)</p> <p>8.3 Proportion of bilateral ODA of OECD/DAC donors that is untied</p> <p>8.4 ODA received in landlocked developing countries as a proportion of their GNI</p> <p>8.5 ODA received in small island developing States as a proportion of their GNI</p> <p><b>Market access</b></p> <p>8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty</p> <p>8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries</p> <p>8.8 Agricultural support estimate for OECD countries as a percentage of their GDP</p> <p>8.9 Proportion of ODA provided to help build trade capacity</p> <p><b>Debt sustainability</b></p> <p>8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)</p> <p>8.11 Debt relief committed under HIPC and MDRI Initiatives</p> <p>8.12 Debt service as a percentage of exports of goods and services</p>

**Millennium Development Goals (MDGs)**

<b>Goals and Targets (from The Millennium Declaration)</b>	<b>Indicators for Monitoring Progress</b>
Target 8E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

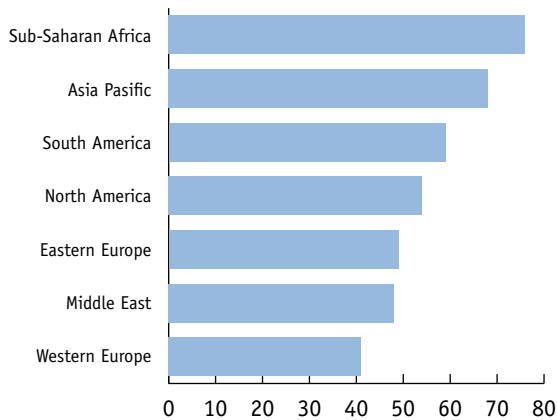
The Millennium Development Goals and targets emanate from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (<http://www.un.org/millennium/declaration/ares552e.htm>) and from further agreement by Member States at the 2005 World Summit (Resolution adopted by the General Assembly – A/RES/60/1, (<http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1>)).

The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries “to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty.”

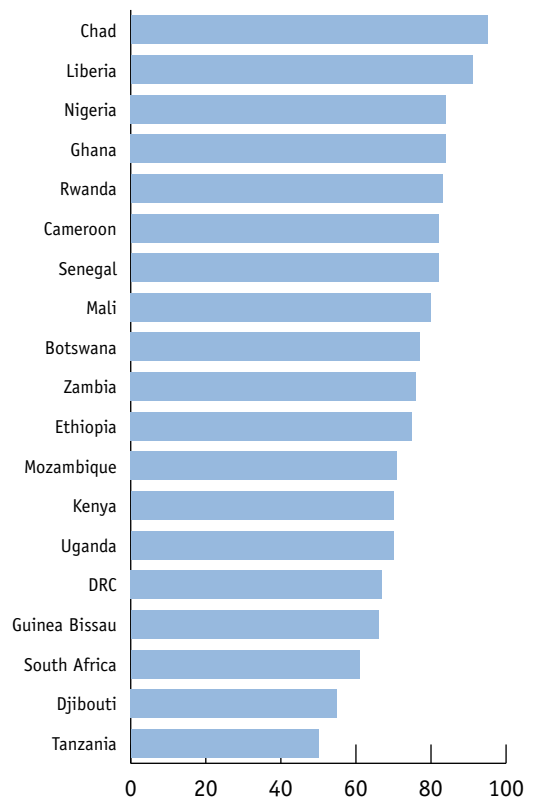
# Annex 2: African optimism about the future

Percentage of people who say their lives will be better in five years' time:

## Median among countries in....

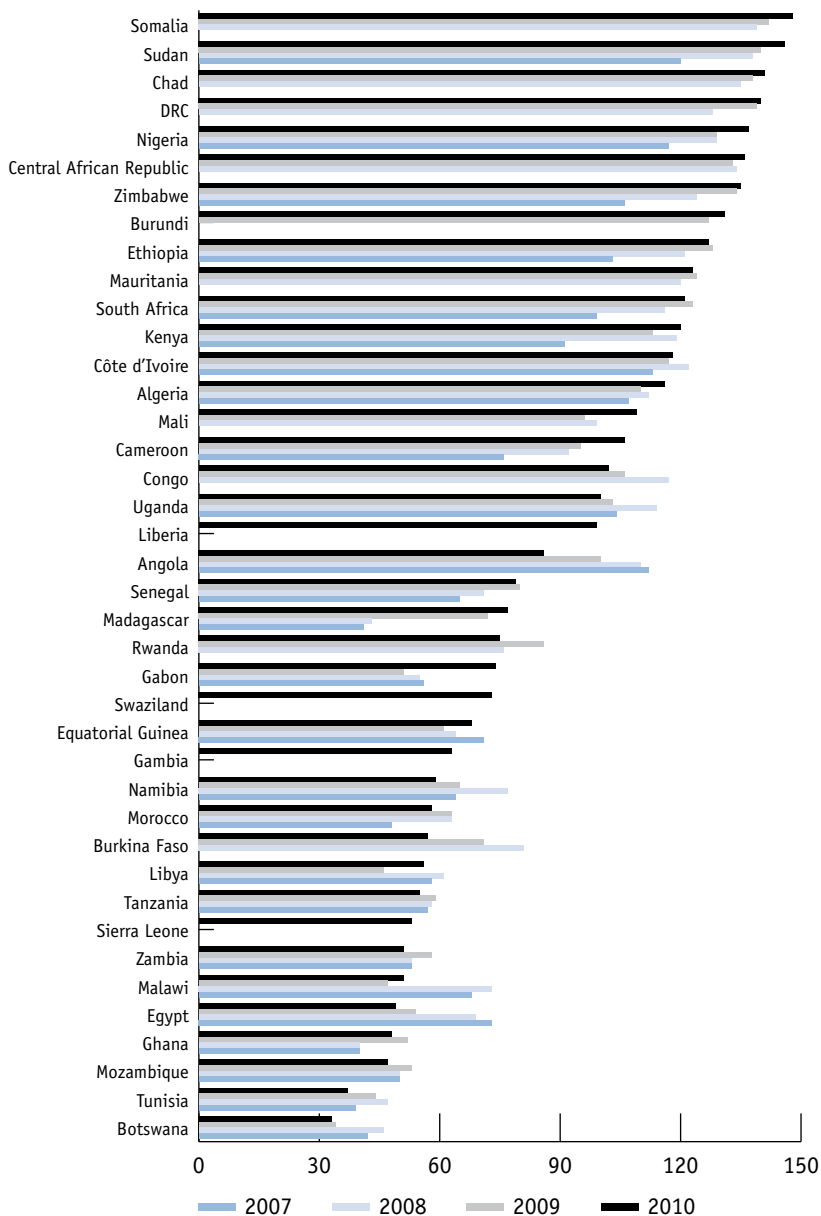


## Among general population in...



Source: WWW.pewforum.org

# Annex 3: Global Peace Index (GPI) rankings and scores of African countries (2007–2010)



Source: <http://www.visionofhumanity.org/gpi-data/#/2010/scor>

# Annex 4:

## Global Hunger Index (GHI) for African countries

Country	1990	2009
Libya	<5	<5
Tunisia	5.1	<5
Algeria	6.3	<5
Egypt	7.1	<5
Morocco	7.3	5.8
Mauritius	7.4	6.7
Gabon	7.7	6.9
South Africa	7.2	7.0
Swaziland	10.9	11.1
Ghana	23.5	11.5
Lesotho	13.0	12.0
Botswana	14.5	12.1
Namibia	19.7	14.4
Côte d'Ivoire	16.0	14.5
Uganda	18.7	14.8
Mauritania	22.1	15.1
Congo	21.0	15.4
Benin	23.9	17.2
Senegal	20.8	17.3
Cameroon	22.0	17.9
Guinea	22.6	18.2
Nigeria	24.4	18.4
Malawi	30.1	18.5
Gambia	18.3	18.9

Country	1990	2009
Mali	24.2	19.5
Sudan	26.3	19.6
Kenya	20.0	20.2
Burkina Faso	21.8	20.4
Zimbabwe	19.2	21.0
Tanzania	22.9	21.1
Djibouti	32.6	22.9
Guinea-Bissau	21.6	23.1
Togo	27.8	23.1
Liberia	23.0	24.6
Angola	41.5	25.3
Mozambique	35.9	25.3
Rwanda	29.6	25.4
Zambia	25.3	25.7
Comoros	22.7	26.9
Central African Republic	30.0	28.1
Madagascar	28.1	28.3
Niger	36.5	28.8
Ethiopia	43.5	30.8
Chad	37.7	31.3
Sierra Leone	33.1	33.8
Eritrea	-	36.5
Burundi	32.2	38.7
Democratic Republic of Congo	25.5	39.1

Source: Grebmer et al. (2009) "2009 Global Hunger Index. The Challenge of Hunger". Deutsche Welthungerhilfe e.v., International Food Policy Research Institute, Concern World Wide.

Note: 1990 GHI is based on the data for 1988-92, and 2009 GHI is based on the data for 2002-07.

# Annex 5:

## Composition of Subregional Country Groupings

The subregional country groupings used in this report are as follows:

### North Africa

Algeria  
Egypt  
Libya  
Mauritania  
Morocco  
Sudan  
Tunisia

### West Africa

Benin  
Burkina Faso  
Cape Verde  
Côte d'Ivoire  
Gambia  
Ghana  
Guinea  
Guinea-Bissau  
Liberia  
Mali  
Niger  
Nigeria  
Senegal  
Sierra Leone  
Togo

### Central Africa

Cameroon  
Central African Republic  
Chad  
Congo  
Equatorial Guinea  
Gabon  
São Tomé and Príncipe

### East Africa

Burundi  
Comoros  
Democratic Republic of Congo  
Djibouti  
Eritrea  
Ethiopia  
Kenya  
Madagascar  
Rwanda  
Seychelles  
Somalia  
Tanzania  
Uganda

### Southern Africa

Angola  
Botswana  
Lesotho  
Malawi  
Mauritius  
Mozambique  
Namibia  
South Africa  
Swaziland  
Zambia  
Zimbabwe











Economic Commission for Africa



African Union



African Development Bank Group



United Nations Development Programme