MDG Report 2012

Assessing Progress in Africa toward the Millennium Development Goals

Emerging perspectives from Africa on the post-2015 development agenda

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In line with the Decision of July 2005 Assembly/AU/Dec 78(v), this report was jointly prepared by AUC, UNECA, AfDB and UNDP. It has been presented and endorsed by the 19th Ordinary Session of the Assembly of Heads of State and Government of the African Union held in July 2012 in Addis Ababa, Ethiopia for submission to the General Assembly in September 2012 in response to the Resolution 55/162.

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Foreword

This year's report has been written against the backdrop of continued rapid economic growth in Africa, uprisings and transitions in North Africa, the festering sovereign debt crisis in the eurozone, the United Nations Conference on Sustainable Development (Rio+20), and the beginning of consultations on the post-2015 development agenda.

The findings of this year's report confirm that steady economic growth and improvements in poverty reduction on the continent continue to have a positive impact on MDG progress. Africa has sustained progress toward several MDGs and is on track to achieve the targets of: universal primary education; gender parity at all levels of education; lower HIV/AIDS prevalence among 15-24 year olds; increased proportion of the population with access to antiretroviral drugs; and increased proportion of seats held by women in national parliament by 2015.

Even so, the report acknowledges that more needs to be done to address inequalities, including between women and men. It highlights the need to address the sub-standard quality and unequal distribution of social services between rural and urban areas. It suggests active steps to ensure that economic growth translates into new and adequate employment opportunities for Africa's youthful and rapidly growing population, and social protection systems which grow the resilience and capabilities of poor and vulnerable households. The report urges policymakers to put greater emphasis on improving the quality of social services and ensuring that investments yield improved outcomes for the poor. Expanding access and improving the quality of social services are both imperative for MDG progress. A balance must be struck to move both objectives forward.

The report observes that high rates of population growth can strain countries' ability to deliver vital public services and undercut progress. Africa needs to turn this dynamic on its head, to exploit a 'demographic dividend' which can help drive growth, innovation, and provide a clear competitive advantage. To do this the countries of Africa must invest in their greatest asset, their people - in particular, their growing number of young people - ensuring that they can be the productive, innovative, and engaged citizens who will help accelerate MDG progress and achieve sustainable human development.

Assessments of Africa's progress must be anchored in timely and reliable data, and objective and effective monitoring and evaluation systems. Thus, African countries, with the support of development partners, should continue to strengthen the statistical monitoring and evaluation capacities needed to track MDG progress.

It is imperative that the lessons from Africa's MDGs experience inform the Rio+20 negotiations and drive the post-2015 development agenda. Cognizant of the importance of ensuring that Africa's priorities and development aspirations feature substantively in the negotiations on Internationally Agreed Development Goals, this year's report highlights the inclusive and consultative process planned around formulation of the post-2015 development agenda. It points to a consensus emerging from wide-ranging and on-going consultations with African stakeholders on the need

to invest in human and institutional capacities and technological innovation as critical drivers of sustainable development. It notes the agreement on the need for the post-2015 agenda to be transformative, inclusive, and sustainable, anchored in principles of equality and framed by a commitment to deliver quality social services.

We wish to thank all those who have contributed to the preparation of this report. We commend the authors for taking into account the views and experiences of the many leaders, policymakers, and development practitioners working daily to advance and achieve the MDGs in Africa.

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The report was prepared under the general direction of Abdalla Hamdok (UNECA Deputy Executive Secretary), Dr. Maxwell Mkwezalamba (AUC Commissioner for Economic Affairs), Professor Mthuli Ncube (AfDB Chief Economist and Vice President), and Mr. Tegegnework Gettu, United Nations (UN) Assistant Secretary-General and Director of UNDP–RBA. The Chairperson of the AUC, Dr. Jean Ping, the UN Under-Secretary-General and Executive Secretary of UNECA, Mr. Abdoulie Janneh, the President of the African Development Bank Group, Dr. Donald Kaberuka, and Helen Clark, Administrator UNDP and Chair of the UN Development Group, provided general guidance.

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Teshome Yohannes, Charles Ndungu, Menkir Girma and Ferdos Issa of the Publications and Conference Management Services (PCMS) Division of UNECA, led by Etienne Kabou, handled the design and printing of the report. The final report was edited by Communications Development Incorporated's Bruce Ross-Larson and Jack Harlow. The Report was translated into French by Prime Productions and was proof-read and edited by Adla Kosseim. The ECA Information and Communications Service (ICS), led by Adeyinka Adeyemi and supported by Mercy Wambui and Aloysuis Fomenky, provided invaluable assistance in media outreach, dissemination and policy advocacy around the report.

A note on data

This year's *Assessing Progress in Africa towards the Millennium Development Goals* is based on the latest updated and harmonized data from United Nations Statistics Division (UNSD) – the official repository of data for assessing progress towards the MDGs. It also uses data from United Nations agencies, the World Bank, and statistical databases of the Organisation for Economic Co-operation and Development (OECD). The main reason for using these international sources is that they collect and provide accurate and comparable data on MDG indicators across Africa. 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.

United Nations agencies regularly compile data from countries using standardized questionnaires or other mechanisms agreed on with those countries. Submitted questionnaires are then validated through a peer review process based on the data collection and processing methods. The agencies provide estimates, take the responsibility for filling data gaps by estimating missing values and make adjustments (if needed) 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 among donors and recipients. As far as the production of MDG reports at the continental level is concerned, these United Nations agencies and the OECD provide harmonized and comparable sources of data. However, some countries' national data on particular MDGs were used in this report.

Over the last few years, African countries have taken commendable steps, with the support of international organizations, to obtain data for tracking MDG progress. The AUC, UNECA, and AfDB have embarked on the development of programmes that directly respond to these challenges and improve African countries' statistical capacity. They include the Africa Symposium for Statistics Development, an advocacy framework for censuses; the African Charter on Statistics, constituting a framework for the coordination of statistical activities in the continent; the Strategy for the Harmonization of Statistics in Africa, which provides guidance on harmonizing statistics; and a new initiative on civil registration and vital statistics. Since 2009, the three Africa-wide institutions have also set up a joint mechanism for continental data collection and validation for producing an *African Statistical Yearbook*. These initiatives will scale up the availability of data for tracking MDG progress in Africa.

Acronyms and abbreviations

AfDB	African Development Bank
AfT	Aid for Trade
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
AUC	African Union Commission
CAR	Central African Republic
CO_2	Carbon Dioxide
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
DRC	Democratic Republic of Congo
EDND	Economic Development and NEPAD Division
EU	European Union
GDP	Gross Domestic Product
GNI	Gross National Income
HCFC	Hydro-chlorofluorocarbon
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
ICT	Information and Communications Technology
IFPRI	International Food Policy Research Institute
ILO	International Labour Organization
ITN	Insecticide-treated Net
LDC	Least Developed Country
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NEPAD	New Partnership for Africa's Development
NORAD	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
ODS	Ozone-depleting Substances
OECD	Organisation for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PPP	Purchasing Power Parity
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNDP–RBA	United Nations Development Programme–Regional Bureau for Africa
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGEI	United Nations Girls' Education Initiative
UNICEF	United Nations Children's Fund
UNSD	United Nations Statistics Division
USAID	United States Agency for International Development
WDI	World Development Indicators
WHO	World Health Organization

The "$" symbol refers to United States dollars unless otherwise specified.

Section I: Overview

With less than three years before the Millennium Development Goals (MDGs) target date of 2015, development practitioners, including agencies of the United Nations (UN), are already initiating consultations aimed at defining the contours of the post-2015 development agenda.

The United Nations Economic Commission for Africa (UNECA), with the African Union Commission (AUC) and the United Nations Development Programme–Regional Bureau for Africa (UNDP–RBA) organized a regional workshop in Accra, Ghana, in November 2011 to engage policymakers on dialogue on the issue. Also, the five regional commissions of the UN are drafting a report on the post-2015 development agenda, entitled *Beyond 2015: A Future UN Development Agenda.* It is expected to provide the main elements of a global development agenda from a regional perspective.

In parallel, the UN Department of Economic and Social Affairs and UNDP are co-leading the UN system-wide consultations for the post-2015 development agenda, with support from all UN agencies and in consultation with relevant stakeholders. The Overseas Development Institute of the United Kingdom, with UNDP, held consultations on the same issue in Cairo, Egypt, in October 2011.

Given the importance of the post-2015 agenda – particularly for Africa – this year's *Assessing Progress in Africa towards the Millennium Development Goals* identifies that agenda as an area of focus. The discussion synthesizes the findings of the Africa region-wide consultations, led by UNECA, AUC and UNDP–RBA, which aim to articulate an African common position on the post-2015 development agenda. The consensus is for and "MDGs plus" option that reflects emerging global issues, such as climate change, and takes into account development enablers and outcomes. Enablers encompass factors such as institutional capacity that facilitate development while outcomes include priorities such as reduced poverty and improved health.

Any meaningful discussion of Africa's priorities after 2015 must, however, be grounded in Africa's experiences and lessons learnt with the MDGs. A review of earlier reports in this series suggests that the quality of social service delivery, inequality, unemployment (particularly among youths), vulnerability to shocks, economic, social and environmental sustainability of performance and inclusive growth are recurrent challenges in Africa and, consequently, should inform the post-2015 agenda.

The quality of service delivery remains a particular concern, despite good progress on social indicators, particularly for net primary school enrolment. Poor completion rates, lack of qualified teachers, doctors and skilled birth attendants, and weak education and health infrastructure are a few examples of poor quality. It is therefore important for policymakers to ensure that social services meet minimum standards of quality.

This series of reports has consistently revealed that Africa's aggregate performance on the MDGs

masks wide income, gender and spatial inequalities in accessing social services. Left unchecked, these trends are likely to lead to social tensions and unravel progress made on the MDGs. Hence it is imperative that policymakers design and implement policies that address inequalities, promote social cohesion and sustain Africa's progress on the MDGs.

This year's report also underscores the poor capacity of Africa's recent rapid growth to commensurately boost jobs and reduce poverty. Contributing to this pattern is the dependence by several African countries on primary commodity exports and capital-intensive extractive industries, which have few or no linkages with other sectors of the economy. Collectively, these factors create and reinforce the "enclave" structure of these countries, which undermines their capacity to translate economic growth into strong job growth and poverty reduction.

The MDG experience is characterized by large and persistent variations in performance across sub-regional, national and sub-national jurisdictions. Sub-regionally, North Africa still outperforms on most MDGs, and may provide opportunities for sharing experience with other sub-regions (given differences in contexts, of course). Nationally, variations in performance often reflect differences in initial conditions. Sub-national variations, though, tend to be marked by gender and spatial disparities in outcomes.

The past decade has laid bare the vulnerabilities of countries to socio-economic and climate-related shocks – as seen in the global financial crisis, sharp increases in food prices, the intensity and frequency of natural hazards and recurrent conflicts. The post-2015 agenda must seek to promote African resilience by addressing associated vulnerabilities. Economic activity should reflect efforts to adapt to and mitigate the effects of climate change, as well as to move towards a low-carbon growth path.

These broad outlines find expression in this year's *Assessing Progress in Africa towards the Millennium Development Goals*, and offer a perspective on the continent's development priorities for the post-2015 development agenda.

Table 1 Africa's MDGs performance at a glance, 2012

Goals and Targets (from the Millennium Declaration)	Status	Remarks
Goal 1: Eradicate extreme poverty and hunger	Off track	• $1.25-a-day poverty in Africa (excluding North Africa) declined from 56.5% to 47.5% during 1990–2008
Goal 2: Achieve universal primary education	On track: net enrolment	• Average enrolment exceeds 80% • Issues of quality remain • Most countries are not expected to meet the completion target
Goal 3: Promote gender equality and empower women	On track	• Good progress at primary level but weak parity at secondary and tertiary levels of education • High representation in parliament
Goal 4: Reduce child mortality	Off track	• Declining, but slowly
Goal 5: Improve maternal health	Off track	• Declining, but slowly
Goal 6: Combat HIV/AIDS, malaria and other diseases	Off track	• HIV/AIDS on the decline, especially in Southern Africa, due to behavioural change and access to antiretroviral therapy
Goal 7: Ensure environmental sustainability	On track: improved water supply	• Few countries have reforestation plans • Emissions minimal for most countries with little increase • Most countries reduced consumption of ozone-depleting substances by more than 50%

Source: Computations from UNSD, accessed December 2011.

Africa's recent MDG performance

Africa's progress on the MDGs is gaining momentum. The continent continues to make steady progress on most of the goals. And even though it is unlikely to achieve all the targets by 2015, the rate of progress on several indicators – including primary school enrolment, gender parity in primary school enrolment, the proportion of seats held by women in national parliament, HIV/AIDS prevalence rates and the share of women in non-agricultural wage employment – is accelerating (table 1). Indeed, in some cases Africa exceeds regions such as South-eastern Asia, Latin America and the Caribbean, and Western Asia. This is both remarkable and commendable, though complacency must not be allowed creep in.

Poverty is declining slowly and decent jobs are hard to find

Both the rate of poverty and the absolute number of poor in Africa declined during 1990–2008. Excluding North Africa, the rate of poverty in Africa fell from 56.5 per cent to 47.5 per cent, driven in part by strong economic growth of the past decade and a decline in the proportion of workers below the poverty line ($1.25 a day). Nevertheless, decent jobs are at a premium in Africa as the majority of jobs are in the informal sector, which generally has

low incomes, low productivity and poor working conditions. Vulnerable employment accounts for some 70 per cent of employment growth – and is largely overrepresented by women.

Food price increases are a barrier to reducing malnutrition

The proportion of children under five who are malnourished in Africa (excluding North Africa) declined only marginally, between 1990 and 2009, despite a reduction in the poverty rate. Contributing to the sluggish decline was the continued escalation in food prices, which has invariably had an adverse impact, particularly on the food budgets of lower-income groups. Girls and rural dwellers are the most affected.

More children are in primary school, but retaining them requires more effort

Net primary enrolment in most African countries shows tremendous gains, with ratios exceeding 90 per cent in several countries. Completion rates, however, have seen little progress, and are as low as 33 per cent in some countries. Predictably, dropout rates are higher among girls than boys. Teacher absenteeism, late age entry by children in primary school cycles, poor health and nutritional status of pupils, financial constraints, distance to school and quality of educational facilities are some of the factors affecting educational quality and completion rates.

Gender parity and women's empowerment – a glass half full

African countries have made significant strides in promoting gender parity in primary education. But they need to do more at secondary and tertiary levels to fully exploit women's intellectual capacities. And although gender parity in paid non-agricultural employment is observed in the services sector (where women usually outnumber men), the reverse is true for higher-paying industrial jobs, which may stoke gender wage disparities because wages differ across sectors, skills and occupations. In politics, Africa needs to move beyond women's participation to improving their capacity for contributing to development discussions and outcomes.

Lagging health indicators

Performance on health indicators such as infant, under-five and maternal mortality is still improving but not fast enough to achieve the goals. Immunization coverage, in contrast, has expanded rapidly and only two countries record less than 50 per cent coverage.

Access to contraceptives is reducing maternal deaths

Progress in reducing maternal deaths stems largely from declining fertility rates, helped by greater access to contraceptives. Yet almost one in four women in Africa who wish to space or delay their next pregnancy cannot do so because of lack of access to contraceptives, failure to empower women to use contraceptives and a mismatch between the types of contraceptives desired and those provided.

Funding cuts threaten progress on the HIV/AIDS front

Africa appears to be starting to win the battle against HIV/AIDS. This is evidenced by a fall in the prevalence rate (particularly among women), a steep decline in the regional rate of new infections (the incidence rate), a reduction in the number of AIDS-related deaths and a drop in mother-to-child transmission of HIV/AIDS. Behavioural change

and access to antiretroviral therapy (ART) have underpinned the HIV/AIDS turnaround in Africa. Sustaining access to ART in an uncertain funding environment will, however, present a challenge to the countries most affected by the disease. Indeed, the announced cancellation of Round 11 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) could lead to reversals in other vertical funding schemes.[1]

Malaria-related deaths are down but access to effective drugs is limited

Malaria mortality rates in Africa have declined by more than a third since 2000 owing to increased prevention and control measures. But the most effective treatment regimens – artemisinin-based combination therapies – still account for only a tiny portion of total treatment.

Environmental challenges persist

Poor sanitation, limited access to improved drinking water sources and declining forest cover are among the most pressing environmental challenges facing the continent – and climate change is likely to make them worse. But more positively, carbon dioxide (CO_2) emissions have stabilized in most African countries, and the majority of countries have lowered their consumption of ozone-depleting substances. Furthermore, twenty-seven countries have listed improvements in the share of protected terrestrial and marine areas.

1 Programmes that target resources at specific health problems.

Official development assistance is important, but diversifying the assistance portfolio is crucial

Official development assistance (ODA) in Africa's development is important, but African policymakers are urged to diversify their portfolio of such funding so as to maximize the volume of resources and minimize exposure to funding shocks. In addition, promoting African products' access to global markets provides an opportunity for growing out of aid. Trade is vital for Africa's development, and the continued growth of Aid for Trade (AfT) commitments, which are growing faster than ODA, are welcomed. Still, AfT's concentration in a few countries is a concern that requires an immediate remedy.

Informing the post-2015 agenda

Accelerating progress to achieve the MDGs will require an integrated approach that takes into account the inter-linkages among goals and indicators. Yet it is not enough to reach the MDGs–progress must be kept up after that to make a difference to the lives of ordinary people. That momentum will require policymakers to ensure equal access to basic social services without compromising such services' quality. Sustainability also hinges on the capacity of African countries to continue providing critical services such as ART and other essential drugs, even without vertical funds. Ultimately, African countries will have to transform their economies in ways that not only support rapid and inclusive growth but also generate enough domestic resources to offset shortfalls in external financing.

Section II: Tracking progress

Goal 1: Eradicate extreme poverty and hunger

Although Africa has experienced rapid economic growth in the past decade, this has not translated into commensurate reductions in poverty and hunger. Nor is the growth rich in jobs.

The slow pace of poverty reduction has been linked to inadequate and inconsistent growth, high population growth, low growth elasticity of poverty[2] and persistently high levels of gender and geographical inequalities. Indeed, the burden of poverty in the continent is disproportionately borne by women and rural dwellers.

Reducing poverty is not only an end in itself. It is also a means to accelerate progress for the rest of the MDGs. For instance, raising people's purchasing power (especially women's) often has large positive effects on families' education and health decisions: people who live above the poverty line and have stable jobs are more capable of educating their children, of facilitating access to basic medical services and of contributing to decisions that affect their lives and livelihoods – and those of their children (box 1.1). Progress on this indicator has positive knock-on effects that create a virtuous circle between Goal 1 and other MDGs.[3]

Box 1.1 The importance of early nourishment

Well-nourished children have strong immune systems which reduce their chances of dying prematurely from communicable diseases. Infants who are undernourished in the first 36 months of lives can suffer irreparable damage to their physical and mental development, debilitating them throughout their life. Malnutrition affects children's cognitive learning, educational performance and even status in life.

When they eventually reach adulthood, such individuals are likely to give birth to another generation of low-birth-weight babies.

Source: Victora et al. (2008).

2 The growth elasticity of poverty measures the reduction in poverty associated with a unit increase in growth. The higher the growth elasticity the greater the effects of growth on poverty reduction.

3 As will be seen throughout this report, the outcomes of one MDG frequently affect those of others.

Target 1A: Halve between 1990 and 2015 the proportion of people whose income is less than $1.25 a day

Indicator 1.1: Proportion of people living below $1.25 (PPP)[4] a day

Poverty is on a slow decline in Africa and is unlikely to meet the target

Based on the World Bank's poverty estimates for 2008, the developing world was very close to reaching the global target of halving income poverty by 2015. Despite the deleterious effects of the triple crises of fuel, food and finance, the overall share of the developing world's population living on less than $1.25 a day in 2008 was 22 per cent, just about 0.4 percentage points above the 2015 target of 21.6 per cent. This translates into 1.29 billion people in 2008 who lived on less than $1.25 a day, compared with 1.91 billion in 1990. This is the first time, since 1981, that both the poverty rate and the number of poor in all six regions of the developing world declined at the same time. This success can be linked to the dramatic progress in populous countries like China, Indonesia and Brazil.[5]

Like the other regions, Africa also experienced a decline in the poverty rate as well as the absolute number of poor people. However, its rate of decline in poverty is too slow to achieve the target by 2015. For instance, the proportion of people living on less than $1.25 a day in Africa (excluding North Africa) decreased marginally from 56.5 per cent in 1990 to 52.3 per cent in 2005 and further to 47.5 per cent in 2008. Only East Asia and the Pacific, and the Middle East and North Africa have reached the target (figure 1.1).

Africa (excluding North Africa) made the least progress in reducing poverty. It is about 41 per cent off the 2015 target, versus 25 per cent in South Asia and 6.1 per cent in Latin America. Taking an annual average, poverty declined by only 0.5 per cent in Africa (excluding North Africa) from 1990 to 2008, but by 2.3 per cent in East Asia and the Pacific and by about 1.0 per cent in South Asia. The difference in economic growth elasticity of poverty among the three regions explains the regional disparities in performance on this indicator. (See table 1.2 below and the accompanying discussion).

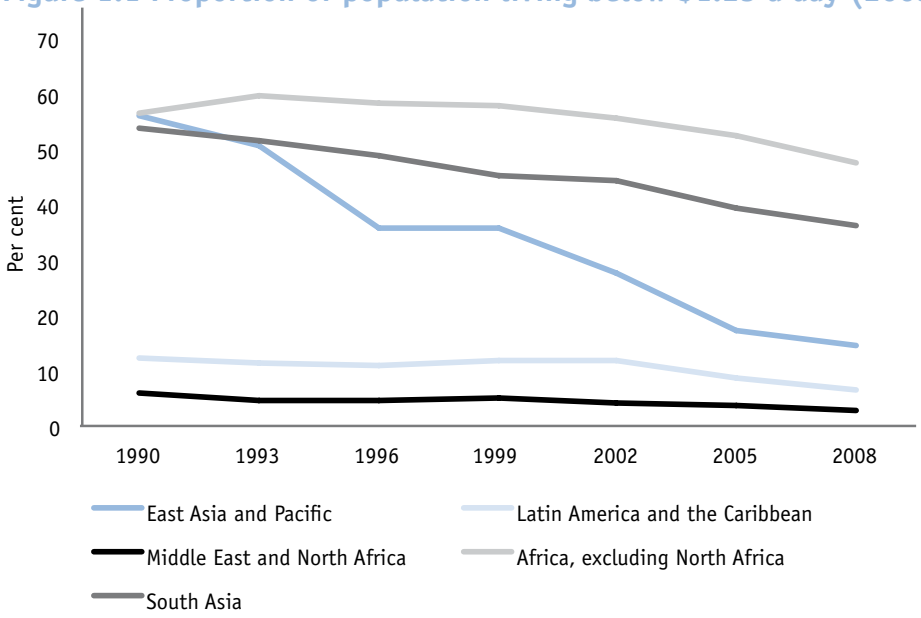
In contrast with the past trend where the number of people in extreme poverty (below $1.25 a day) has increased considerably in Africa (excluding North Africa) from 289 million (1990) to 394 million (2005), the trend was reversed by 2008. The number of people living below that threshold fell by about 9.0 million. Compared with the $1.00 per day poverty line, the fall was substantial – about 32 million people moved out of extreme poverty (figure 1.2). However, about 3.2 million people fell below the $2.00-a-day poverty line, suggesting vulnerability between the $1.25 and $2.00-a-day lines.

This new poverty dimension hits some of the middle class that plays a critical role in Africa's growth process, and confirms the finding from AfDB (2011) that, although Africa's middle class

4 Purchasing power parity.

5 These countries reached the income poverty target for 2015 in 2008: China (from 60.2 per cent in 1990 to 13.1 per cent in 2008), Indonesia (from 54.3 per cent in 1990 to 22.6 per cent in 2008) and Brazil (from 13.7 per cent in 1990 to 6.0 per cent in 2008). Compiled from World Bank, http://data.worldbank.org/indicator/SI.POV.DDAY?page=4,(updated February 2012).

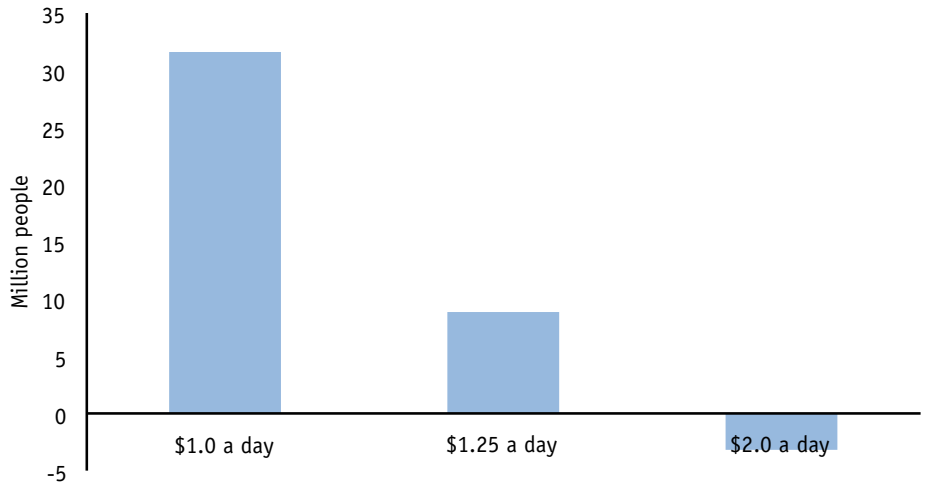
Figure 1.1 Proportion of population living below $1.25 a day (2005 PPP), 1990–2008



Source: Compiled from World Bank, http://data.worldbank.org/indicator/SI.POV.DDAY?page=4, updated February 2012.

has grown over the past 30 years, some segments remain vulnerable. Addressing the insecurity of this class should remain an important policy focus for African governments.

Figure 1.2 People in Africa (excluding North Africa) are moving out of poverty but vulnerability is higher among the middle class, 1990–2008



Source: Compiled from World Bank, http://data.worldbank.org/indicator/SI.POV.DDAY?page=4, updated February 2012.

The current pace of poverty reduction is too slow for the continent to achieve this goal by 2015, although it is faster than historical trends. Extreme poverty for Africa (excluding North Africa) is forecast at 35.8 per cent in 2015 against the previous forecast of 38 per cent (UN, 2011).

Recent national poverty data are scant. Of 25 countries with recent data on this indicator from international organizations, 20 countries show improvement.[6] Tunisia, Egypt, Cameroon and Guinea have achieved the target while Senegal, Gambia, Swaziland, Uganda and Mauritania are very close to halving extreme poverty, at about 5 percentage points from the 2015 target (figure 1.3). Ghana, South Africa, Mali and Niger are about 10 percentage points away. Five countries (Côte d'Ivoire, Kenya, Madagascar, Nigeria and Morocco) regressed on this indicator.

Key drivers behind progress in some countries include narrowing inequality, falling fertility, increasing wage employment, rising livestock production (box 1.2) and improving access to social protection (box 1.3). Rwanda's performance, for example, was made possible by the past decade's growth, which showed resilience in the face of the triple crises. This performance is repeated in the impressive growth of per capita income in many countries. For instance, 24 of 53 countries more than doubled their per capita income from 1990 to 2010, led by Equatorial Guinea, Angola, Nigeria, Cape Verde, Egypt, South Africa and Mauritius.[7] These countries (except Cape Verde) are resource-rich countries – an indication that most of them benefited from the commodity boom of the past decade (World Bank, 2011a).

Poverty in Africa is concentrated in rural areas and affects men and women differently

Poverty in Africa is spatial, with a higher prevalence of rural poverty. All 37 countries with data for this indicator exhibit a wide disparity between urban and rural poverty. Rural poverty is at least three times as high as urban poverty in Morocco, Egypt, Ghana, Zambia, Cameroon, Cape Verde and Rwanda (figure 1.4).

The deplorable state of rural infrastructure, paucity of rural livelihoods and youth employment, limited access to high-quality education and high rates of child labour are key drivers of rural poverty (FAO, IFAD and ILO, 2010). Policies for integrated rural development remain crucial to addressing this imbalance. Rwanda (see box 1.3) and Ethiopia (box 1.4) show what can be done.

The second insight is that many countries have "feminized" poverty: relative to men, women are disproportionately affected in some countries including, in descending order, Egypt, Cameroon, Morocco, Kenya, Cape Verde, South Africa, Guinea and Madagascar (figure 1.5).

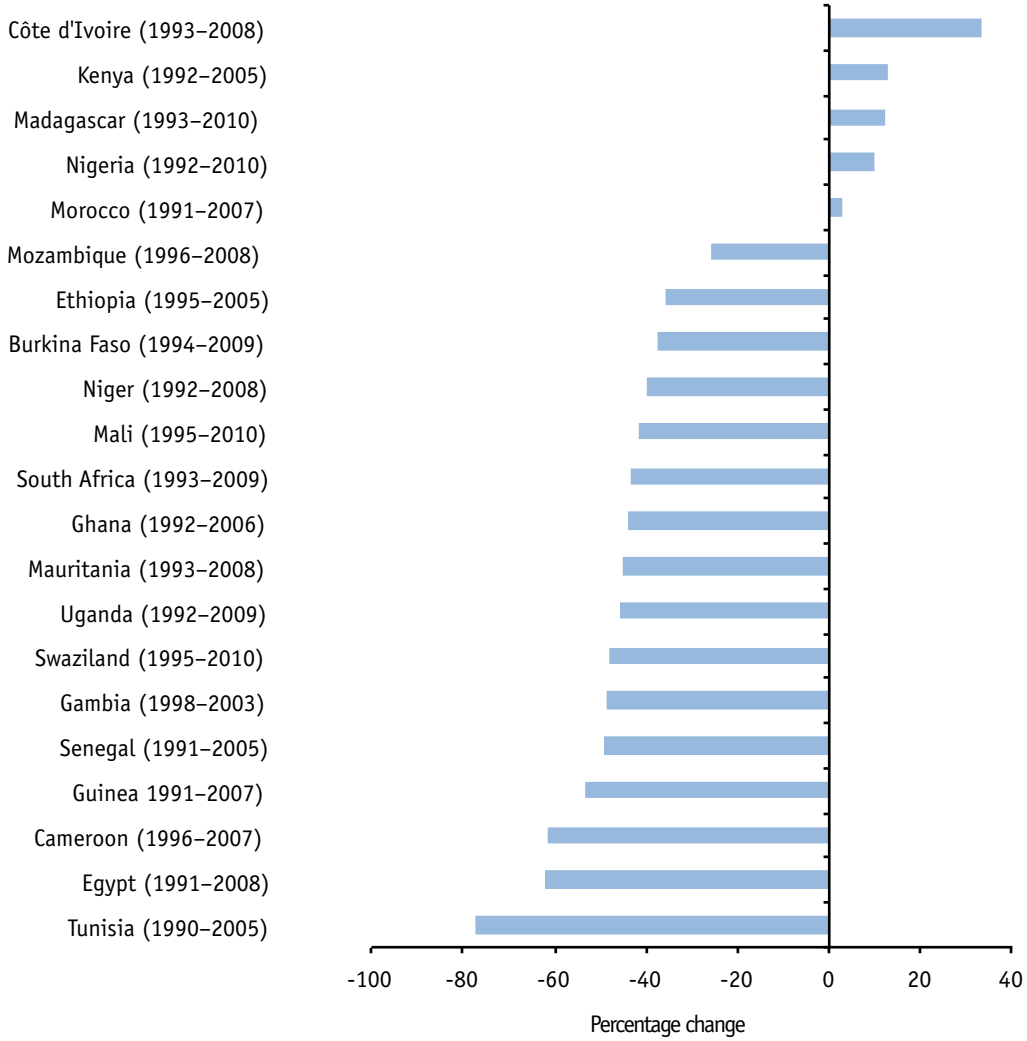
Poverty is declining slowly in Africa

Several factors may account for this. Women's work in the home often prevents them from having wage employment. And when they do earn wages,

6 Some of the countries have just conducted national poverty surveys with new estimates. For instance, evidence from Rwanda's 2010/11 household survey reveals that the incidence of poverty fell by about 12 percentage points between 2005/6 and 2010/11 from 56.7 per cent to 44.9 per cent.

7 Authors' computations from World Bank, http://data.worldbank.org/data-catalog/gender-statistic, updated April 2011.

Figure 1.3 Change in the share of people living below $1.25 a day, various years, 1990–2010



Sources: Compiled from World Bank Database, http://data.worldbank.org/indicator/SI.POV.DDAY and http://data.worldbank.org/data-catalog/gender-statistics, updated February 2012.

Box 1.2 Livestock farming helps to reduce rural poverty in Burkina Faso

Burkina Faso cut poverty by 37.3 per cent from 1994 to 2009, aided by livestock farming. This initiative is also contributing to food security and human development in rural areas. In 2007/08, income from livestock covered 56 per cent of households' food needs, 42 per cent of their health expenses and 16 per cent of children's educational costs. Evidence from Government of Burkina Faso and UNDP (2011) shows a high, inverse correlation between rural poverty and livestock activity.

In addition, the livestock sector has helped to accelerate economic growth and stabilize the economy. In 2009, it contributed 18.8 per cent of total national income and 14.2 per cent of exports. The sector's performance is, however, impeded by bottlenecks, primarily difficulties in accessing the following: capital and pastoral resources (including finance, animal, grazing land and other livestock infrastructure); inputs including livestock feed and veterinary services; and appropriate support and advice (such as extension services). Also, livestock receives inadequate budgetary allocation, and is over-reliant on foreign resources.

UNDP has therefore worked with the government to develop an MDG acceleration framework on food security. A priority action plan has been developed on food security, with an emphasis on increasing livestock productivity and facilitating access to livestock products and their use.

The government has also introduced an Operational Action Plan of the National Livestock Policy (2010–2015). A simulation analysis reveals that if the current bottlenecks are eased, the plan could raise economic growth by about 1.0 per cent a year and generate sharp rises in rural household incomes, helping to reduce the incidence of poverty by at least 25 per cent by 2015.

Sources: Ministère de l'Economie et des Finances et Système des Nations Unies Burkina Faso (2010); Government of Burkina Faso and UNDP (2011).

their work tends to be undervalued. Women work mostly in low-wage jobs and in poor conditions. Restricted access to economic resources and lack of education are also important in feminizing poverty.

Ethiopia and the Central African Republic (CAR) have a more gender-balanced distribution of poverty. Further still, poverty is biased against men in most East African countries (Tanzania, Uganda, Rwanda and Burundi). This calls for a comprehensive action to achieve poverty reduction with better targeting of identified vulnerable groups.

Why is poverty declining so slowly in Africa? Several factors account for the slow progress on poverty reduction – economic, demographic and social. Political instability and conflict also undermine progress in many African countries. Some of the critical factors are highlighted below.

Insufficient and inconsistent economic growth

The size and consistency of growth required for significant poverty reduction are yet to be fully realized. Africa on average needed to grow at around 7 per cent a year for countries to halve the proportion of people living below the poverty line between 1998 and 2015 (UNECA, 1999). But in 2000–2010 average growth – aggregate and per capita – fell short of the required rate in each African sub-region (table 1.1). (The widest shortfalls were in East and West Africa.)

Box 1.3 Rwanda accelerates poverty reduction by reducing inequality, widening social protection and improving access to credit

Over the past five years, Rwanda has translated its economic growth into poverty reduction country-wide because growth has been inclusive and accompanied by falling inequality – unlike the previous five years.

In that earlier period (2000/01 to 2005/06), income growth was higher among richer groups, especially at the top, whereas in the second period (2006–2011) growth benefited lower-income groups. More technically, the ratio of the 90th percentile of consumption to the 10th fell between 2005/06 and 2010/11. It had increased sharply in the previous half decade, when inequality (measured by the Gini coefficient) worsened from 0.51 to 0.52.

The inclusive second-period growth narrowed income inequality to 0.49, lower than in 2000/1. All provinces (apart from Northern Province) shared in the growth's inclusiveness as their inequality narrowed – in short, most of the population shared in the benefits of growth.

Other factors reducing poverty include:

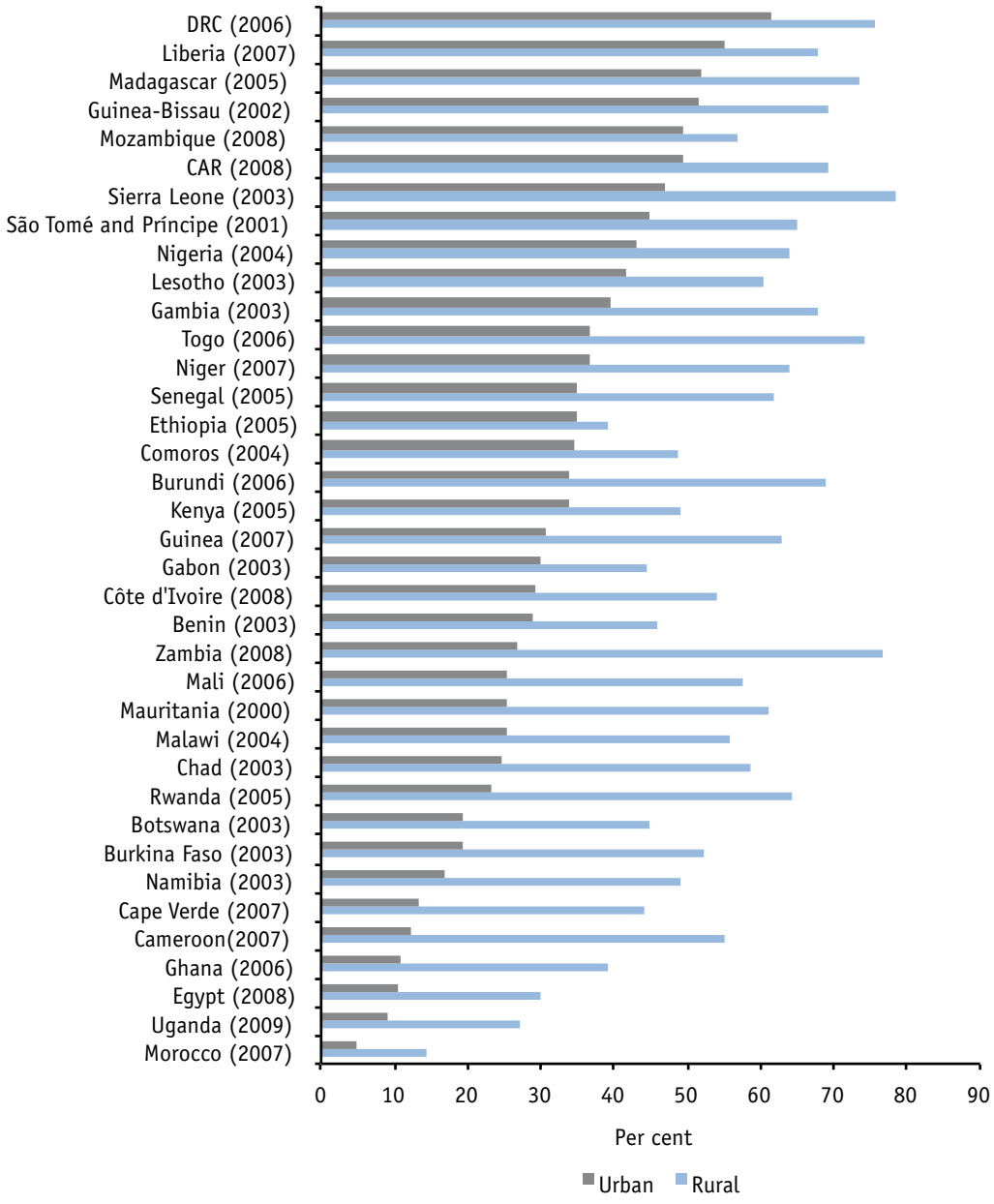
- greater access to electricity of domestic dwellings (6.5 per cent more households used electricity for lighting in 2006–2011);
- a rise in the share of households' agricultural output marketed across regions from 22 per cent in 2006 to 27 per cent in 2011;[1]
- participation in social protection, such as the Ubudehe scheme, the Rural Sector Support Project and the Vision 2020 Umurenge Programme Direct Support, in which 8 per cent, 5 per cent and 1 per cent of households benefited (according to the Third Integrated Household Living Conditions Survey); and
- better access to credit (although access is biased toward urban households, Kigali and Eastern Provinces improved strongly).

Still, the government could focus more on addressing rural poverty, especially by improving farmers' living conditions. It should also improve the coverage and efficiency of social protection. And access to credit – still biased against rural households – requires further deepening.

1. The rate increases with income quintile: the poorest quintile sells only 15 per cent of its harvest, the second-poorest 19 per cent and the fourth 25 per cent.

Sources: NISR (2011); NISR and UNDP (2007).

Figure 1.4 Rural poverty remains high and pervasive in Africa



Source: Compiled from World Bank, http://data.worldbank.org/indicator/SI.POV.RUHC, accessed February 2012.

Note: The poverty definition is based on household consumption per adult equivalent member (including food and non-food items), adjusted for differences in prices faced by households between regions, between months of the year and allowing for inflation between one survey round and the next. The extreme poverty line covers food costs only.

Box 1.4 Ethiopia's rapid poverty reduction is accompanied by rising inequality in rural areas and regional disparities

With its development partners, the government is pursuing the overall development objective of broad and sustained economic growth that will rapidly reduce poverty and inequality. This objective forms an integral part of the Economic Reform Program, which strongly supports approaches to design and carry out welfare-enhancing programmes and to build the government's analytical capacity for monitoring and evaluating poverty-reduction moves.

The proportion of people in Ethiopia living below the poverty line fell from 45.5 per cent in 1995/96 to 29.6 per cent in 2010/11, a decline of about one third. Over the period 1995 and 2011, poverty is declining at an annual average of 2.32 per cent as against 0.5 per cent for Africa (excluding North Africa). With appreciable progress like this, Ethiopia is just about 7 percentage points from the 2015 target, and will reach it if it maintains this trend.

Between 1995 and 2011, Ethiopia reduced poverty in rural and urban areas by 36.0 and 22.8 per cent, respectively. Rural poverty fell faster during 1995–2005, urban poverty during 2006–2011.

The decline in rural poverty, especially in 1995–2005, stems from a wide range of pro-poor programmes in rural areas, such as expansion of improved agricultural technologies, expansion of agricultural extension services, commercialization of smallholder farming agriculture, rural infrastructural development and access to social protection programmes, especially those relating to productive safety net programmes and provision of credit.

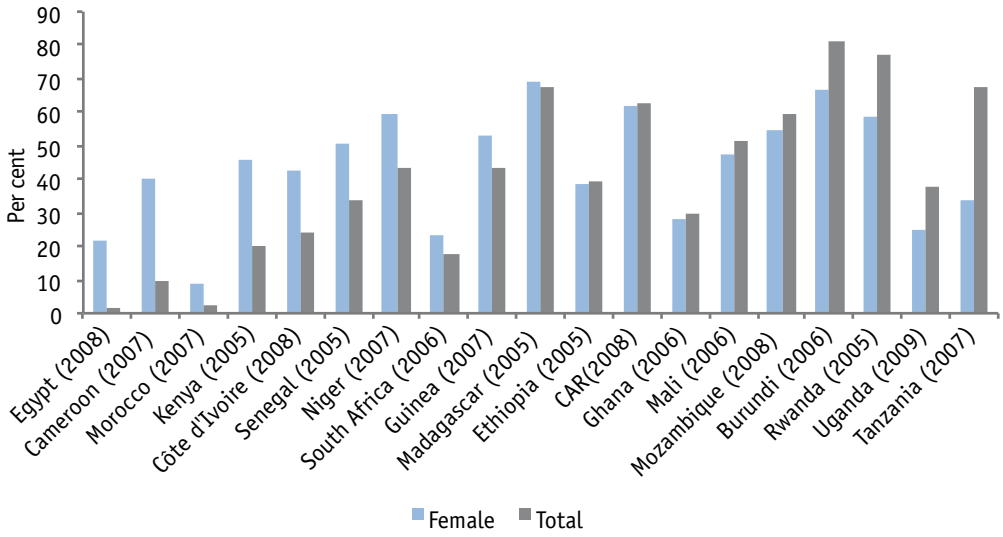
The progress on urban poverty reduction, especially in 2006–2011, was linked to government efforts to create a favourable environment for private investment, create jobs and distribute subsidized basic food to the urban poor during high inflation.

Although the poverty headcount ratio and poverty gaps are declining, a widening poverty gap between rural and urban areas since 2006 and a rising poverty severity index are issues for urgent policy consideration. Widening inequality in rural areas is also a concern: the Gini coefficient rose from 0.26 to 0.27 there but fell from 0.44 to 0.37 in urban areas during 2006–2011. The poverty disparity among regions also requires policy and programme attention.

On the data front, future household income and consumption expenditure surveys, as well as the associated poverty analysis, should address the absence of gender-disaggregated data in Ethiopia's poverty analysis.

Source: Federal Republic of Ethiopia (2012).

Figure 1.5 Poverty is higher among women in many countries



Sources: Compiled from World Bank, http://data.worldbank.org/indicator/SI.POV.DDAY and http://data.worldbank.org/data-catalog/gender-statistics, updated April 2011.

Due to over-dependence on primary commodities, growth in Africa over the past decade has been non-inclusive and volatile. The standard deviation of growth (a measure of growth volatility) in each African sub-region during 2000–2010 was higher than the global average of 1.98 – that is, African growth was more volatile. Indeed, of the 19 countries that met or surpassed the required growth rate, only six did so for more than three consecutive years. Increasing the rate of growth, and then sustaining it, is vital for reducing poverty quickly in Africa.

High population growth

High population growth seriously weakens the link between economic growth and poverty reduction. It also strains the provision of vital public services, particularly education and health, exacerbating the huge pressures on public spending that Africa faces owing to its distinct challenges, such as pervasive malaria and HIV/AIDS. Addressing high population growth is fundamental to raising Africa's low human capital and to securing faster poverty reduction. Indeed, larger household size is a significant determinant of poverty in numerous African countries, including Kenya, Mauritania, Uganda and Nigeria.[8]

But poverty itself adds to population growth, because poverty and its determinants (such as subsistence agriculture, little education, child fostering, the subordinate position of women) tend to perpetuate high fertility (Odusola et al., 1997). Reducing the continent's high population growth

8 See Geda et al. (2005) for Kenya, Coulombe and McKay (1996) for Mauritania, Deininger and Okidi (2003) for Tanzania and Odusola et al. (1997) for Nigeria.

Table 1.1 Estimated annual GDP growth required to meet the poverty reduction target, and actual growth attained, 2000–2010 (%)

African sub-region	Required per capita growth[a] (%)	Actual per capita growth[b], 2000–2010 (%)	Required aggregate growtha (%)	Actual aggregate growth, 2000–2010b (%)	Standard deviation of growth
North	3.60	3.09	5.60	4.91	2.06
West	4.71	2.66	7.61	5.31	2.64
Central	3.90	2.15	6.70	4.67	4.30
East	5.40	2.89	8.12	5.72	3.52
Southern	3.80	2.58	6.20	4.58	3.68
Total average (excluding North Africa)	4.19 (4.39)	2.79 (2.71)	6.79 (7.16)	5.22 (5.30)	3.00 (3.26)

Source: Authors' computations.

a. UNECA (1999).

b. World Bank (2011a).

is important to addressing poverty – as seen in Rwanda in recent times (NISR, 2011).

Strengthening the links between growth and poverty reduction

One of the reasons why appreciable economic growth has not translated into steep poverty reduction is the relatively low responsiveness of poverty reduction to growth – the growth elasticity of poverty. That absolute value of elasticity has increased in some countries since the 1990s, implying that economic growth has had an increasingly positive effect on poverty reduction. For instance, the growth elasticity of poverty rose from 1.75 in 1990–1996 to about 3.0 in 2000–2007 in Tunisia; from about 1.0 to about 2.0 in Mauritania; and from about 0.9 to about 2.0 in Ethiopia. Yet it was still less than 1.0 during 2000–2007 in many countries, including Burkina Faso and Zambia (Fosu, 2011).

The average growth elasticity of poverty in Africa (absolute value) of 1.82 is less (sometimes far less) than in other regions (table 1.2). In East Africa and Southern Africa it is less than half that of Latin America and the Caribbean. Its weighted average for resource-rich countries, defined as countries with an average ratio of resource rents to GDP during the past decade of over 15 per cent, is 1.16.[9] This elasticity is lower than any of the regional averages and highlights the weak links between the resource sector and the wider economy in these countries.[10]

The low growth elasticity of poverty marks a weak connection between growing sectors of the economy and the sectors where the poor work, as well as spatial disparities between areas with strong

9 Only Burundi, Congo, DRC, Gabon, Liberia and Nigeria meet these criteria for which elasticity data are available.

10 See Fosu (2011) for the required growth rates of real GDP and population, and economic growth elasticity of poverty for Africa to halve poverty between 2010 and 2025.

Table 1.2 Growth and inequality elasticities of poverty

	Elasticities	
	Growth	**Inequality**
North Africa	-2.93	4.34
West Africa	-1.67	1.76
Central Africa	-1.76	2.08
East Africa	-1.39	1.36
Southern Africa	-1.39	1.45
Africa (excluding North Africa)	-1.51	1.56
Africa	-1.82	2.16
East Asia and Pacific	-2.48	3.49
Eastern Europe and Western Asia	-4.22	6.85
Latin America and the Caribbean	-3.08	5.00
Middle East and Central Asia	-2.75	3.91
South Asia	-2.10	2.68

Source: Fosu (2011).

growth and areas where the poor live. A multitude of interconnected factors influence the response of poverty reduction to economic growth, but the growth elasticity in Africa is underpinned by the absence of a diversified economy, poor access to credit and insurance, low human and physical capital and weak systems of social protection.

Most African countries still rely heavily on extractive sectors for export, such as solid minerals and fuel, and these sectors have only weak connections to the wider economy – they lack forward and backward linkages to sectors where the poor are employed. High mineral and fuel-commodity prices have driven growth in many of the African countries that have recorded the fastest growth, such as Equatorial Guinea and Nigeria, and minerals and fuel accounted for the largest share of African exports during 1996–2008 (AfDB, OECD and UNECA, 2010).

Rural areas' limited access to modern infrastructure, such as good roads, electricity and telecommunications, has also reduced the potential contribution of growth. Thus the large rural population, lacking adequate access to physical and social infrastructure, is a major impediment to reducing poverty and inequality. To take an example, one study has shown that Ugandan communities more than 10 kilometres from the nearest municipality are more likely to have a higher incidence of poverty than people living in municipalities (Deininger and Okidi, 2003). It also found that households living in urban areas or with access to electricity were significantly more likely to escape poverty, indicating the importance of infrastructure to a

household's growth opportunities. Access to credit, insurance and social protection also strengthens the linkage between growth and poverty reduction. Thus improving rural access to infrastructure as well as credit, health and educational services, which have generally lagged behind economic growth rates, should be given priority.

The strengthening of the relationship between growth and poverty reduction in Africa has implications for the annual rate of GDP growth required to halve the proportion of the population living on less than $1.25 (Fosu, 2011).Regions with a higher growth elasticity of poverty and slower population growth usually require slower GDP growth to reach the target by 2025.

For instance, during 2010–2025, North Africa (the African region with the highest growth elasticity of poverty) requires 2.95 per cent annual growth (table 1.3). East and West Africa, with the highest population growth rates, require 5.90 per cent and 5.96 per cent annual GDP growth. Southern Africa in contrast, with the lowest growth elasticity of poverty, requires 5.60 per cent GDP growth a year to halve poverty.

An important caveat to the estimates in table 1.3 is that higher growth will be required if, over the period, inequality increases and the growth elasticity of poverty decreases. The latter may reflect greater divergence in growth and poverty reduction among countries.

Wide inequality undermines efforts to reduce poverty

The responsiveness of poverty to economic growth is also weakened by wide economic inequality in Africa. Initial inequality significantly reduces the gains from growth that accrue to the poor (Ravallion, 2001; Fosu, 2011), although equally it reduces the adverse impact on the poor from economic contraction (Ravallion, 1997). While the inequality elasticity of poverty in Africa is the lowest of any region worldwide (see table 1.2), a percentage

Table 1.3 Annual GDP growth required to halve poverty between 2010 and 2025

Africa Region	Required per capita GDP growth (%)	Population growth (%)	Required aggregate GDP growth (%)	Growth elasticity of poverty
North	1.39	1.56	2.95	-2.93
West	3.41	2.55	5.96	-1.67
Central	2.83	2.46	5.29	-1.76
East	3.19	2.71	5.90	-1.39
Southern	3.55	2.05	5.60	-1.39
Total average (excluding North Africa)	2.60 (3.31)	2.31 (2.52)	5.21 (5.84)	-1.82 (-1.51)

Note: The period is 15 years to allow time comparability with the estimated rate computed by UNECA (1999).

Sources: Fosu (2011); authors' computations based on World Bank (2011a).

change in inequality has a more significant impact on poverty than a percentage change in growth.

Inequality in the distribution of assets, such as land, as well as the use of public services, such as education and health, hinders poverty reduction in much of Africa. Inequalities in access to education are particularly wide in several West African countries, including Benin, Burkina Faso and Mali, while in Kenya, Malawi and Tanzania the differences are quite small (Gauci and Gueye, 2003). Disparities in educational access reflect lack of physical access (particularly in rural areas where the poor tend to be concentrated) and the direct and indirect costs associated with educating a child. All these factors contribute to higher dropout rates.

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

Employment is projected to grow but higher productivity is key to decent jobs

The world is still grappling with the effects of the global financial crisis on employment generation. The world's average annual employment growth of 1.1 per cent in the post-crisis (2008–2011) years was below the pre-crisis (2002–2007) average of 1.8 per cent, and is projected to stay below pre-crisis rates in 2012–2016 (table 1.4).

Africa's employment growth over the next half decade is expected to exceed the global average. Improvements in the business climate in some Africa countries and the drive for African markets by both the emerging and Western countries are expected to create employment opportunities in the region. However, labour productivity is expected to decline over 2014–2016.

Table 1.4 Africa has potential for generating jobs but its productivity growth is too low

Groupings	Average annual employment growth (%)				Average annual labour productivity growth (%)			
	2002–2007	2008–2011	2012–2013	2014–2016	2002–2007	2008–2011	2012–2013	2014–2016
World	1.8	1.1	1.4	1.3	2.5	1.6	2.6	3.2
Developed economies and EU	1.0	-0.3	0.4	0.6	1.4	0.5	1.5	2
CSEE (non-EU) and CIS	1.1	0.8	0.5	0.3	6.1	1.1	3.5	4.0
East Asia	1.2	0.6	0.6	0.3	8.6	7.8	7.5	8.1
South-east Asia and the Pacific	1.8	1.9	1.6	1.4	4.1	2.6	3.5	4.0
South Asia	2.2	1.0	2.0	1.9	5.4	6.1	4.8	5.4
Latin America	2.5	1.9	1.8	1.7	1.4	1.0	1.7	1.8
Middle East	4.5	3.2	2.8	2.5	0.9	0.9	1.2	2.0
North Africa	3.4	2.0	2.2	2.3	1.4	1.8	0.8	2.8
Africa (excluding North Africa)	3.1	2.8	3	3	2.5	1.5	2.3	1.9

Source: ILO (2012).

Note: CIS = Commonwealth of Independent States; CSEE = Central and South-eastern Europe; EU = European Union.

Indicator 1.4: Growth rate of GDP per person employed

Labour productivity is central to sustaining economic growth, improving livelihoods and reducing poverty and inequality. Factors that drive it include investment in capital (such as machinery and equipment), better organizational capacity, revitalization of physical and institutional infrastructure, gains in health and skills of workers ("human capital") and the generation of new technology.

Yet labour productivity growth is low in Africa compared with East Asia, South-east Asia and the Pacific, and South Asia (figure 1.6 and see table 1.4). In North Africa, it was only one quarter of that in East Asia during 2008–2011, and in Africa (excluding North Africa) less than a fifth. Worse, North Africa's labour productivity growth is expected to fall in 2012 and 2013, largely owing to political upheavals, but it is set to rise in the medium term.

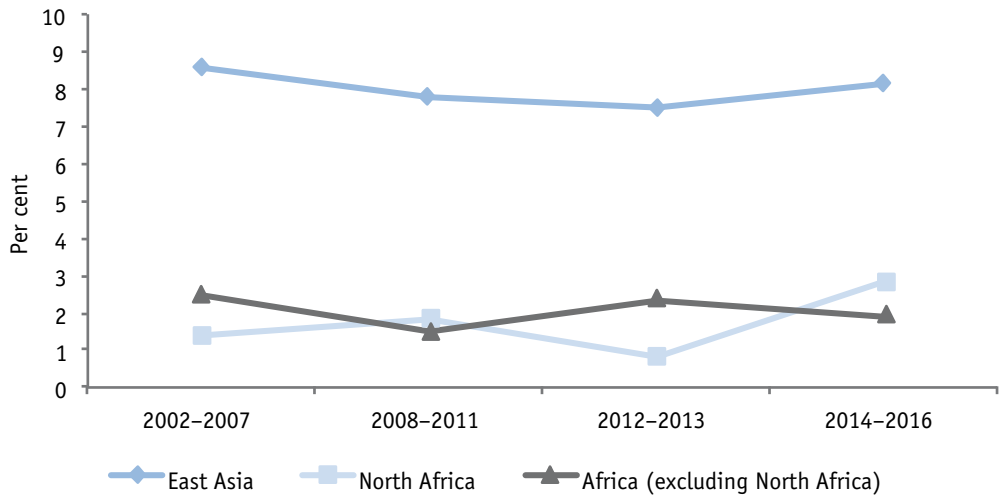
In Africa (excluding North Africa), labour productivity growth decelerated in the aftermath of the global crisis, and is expected to decline slightly over the long term. The decline is predicated on governments' increased creation of short-term, low-skilled jobs to diffuse tensions that may arise from high youth unemployment rates.

Indicator 1.5: Employment-to-population ratio

Global employment-to-population ratios declined (but not homogenously) in all global regions during 2002–2011. But in Africa (excluding North Africa), the ratio increased by 1.5 per cent over the period – female employment accounting for four fifths of the gain. In North Africa the increase was higher at 2.4 per cent, with women accounting for three fifths (ILO, 2012).

North Africa's employment-to-population ratio stood at 43.6 per cent in 2011, against a global average of 60.3 per cent that year. Agriculture and

Figure 1.6 Average annual labour productivity growth



Source: Authors' computations on ILO (2011 and 2012): data for 2002–2007 are actual, 2008–2011 are estimates; and post-2011 are forecasts.

services accounted for 28.4 per cent and close to 50 per cent, respectively, of total employment. In both sectors, poor conditions of service and low salaries predominate. The business environment in North Africa is not conducive to creating small and medium-sized enterprises, and labour market institutions are not fully developed.

At an estimated 64.7 per cent in 2011, the rest of Africa has a higher ratio than North Africa (and the global average), but there, too, many of the jobs are vulnerable. Indeed, manufacturing employment accounts for a mere 8.5 per cent of the total (ILO, 2012).

African governments have launched a raft of initiatives to generate jobs, ranging from creating business-friendly macroeconomic and regulatory environments for the private sector to establishing public works programmes for tackling chronic employment. Although often having a negligible impact on the poverty headcount, such programmes can help reduce the depth of poverty among participating households (box 1.5).

Some new approaches to youth unemployment – building on experience – link social protection to acquiring skills and creating synergy with other MDGs (box 1.6).

Indicator 1.6: Proportion of employed people living below $1.25 a day

Worldwide, the number of working poor (employed persons earning less than $1.25 a day) has fallen to 435 million – a drop of 233 million since 2000 and 38 million since 2007. This decrease has been heavily influenced by a rapid decline in the working poor in China and in East Asia generally (figure 1.7).

Box 1.5 Lessons from African public works programmes

A review by the Overseas Development Institute of nearly 170 public works programmes in Africa (excluding North Africa) provides some lessons on how to use such programmes to accelerate poverty reduction.

Most of the public works were largely donor funded (83 per cent), predominantly food for work (60 per cent), and divided equally between those whose primary objective was the provision of safety nets or social protection among households, and those using infrastructure construction and rehabilitation to promote aggregate job creation. Only 4 per cent of the programmes were for income insurance.

The gross wage from a public works programme represented a significant share of total household income in most countries among participating households. In Malawi and Ethiopia, however, the transfer was insufficient to meet household consumption needs and in South Africa it was too little to close the poverty gap. Most programmes had a negligible impact on reducing headcount poverty, although they helped to cut the depth of poverty among participating households. Tight targeting was important.

The review revealed a policy misalignment. For instance, programmes offering short-term employment and aiming to provide social protection or promoting graduation out of chronic poverty might not have been as effective as intended if they did not guarantee employment.

Source: McCord and Slater (2009).

In Africa, the situation has improved but the number of working poor is still high. They accounted for 39.1 per cent of total employment in Africa (excluding North Africa) in 2011, a decline of 15.7 percentage points between 2000 and 2010 that stems from two main factors. First, the moderately good economic growth of the last decade has, plausibly, pushed wages above the international poverty line. Second, affirmative action has upgraded the conditions of the working poor. Examples include Algeria's employment policy and South Africa's New Growth Path, which introduced measures to tackle poverty and inequality through social transfers. Many other countries raised national minimum wages during 2008–2011, such as Algeria, Angola, Cameroon, Mauritania, Nigeria and Tanzania.

North Africa has also shown a drop in the share of the working poor, although from a much lower initial level, and the situation there compares well with East Asia. African governments give greater priority to addressing unemployment than reducing the number of working poor, however, and policy attention on the working poor is still critical for accelerating poverty reduction.

Indicator 1.7: Proportion of own-account and contributing family workers in total employment

Global vulnerable employment was estimated at 1.52 billion in 2011. Although East Asia managed to cut the absolute number of people in vulnerable employment by 40 million after 2007, the

Box 1.6 Oyo State Government's (Nigeria) youth employment scheme is creating synergy with other MDGs

The Youth Empowerment Scheme of Oyo State, Nigeria, is generating jobs for youths and aiming to create synergy with other MDGs. Established in July 2011, the overall goal is twofold.

First, it aims to generate 20,000 jobs annually in agriculture, public works, health and education, and environmental services. Second, it seeks to build capacity in life-skills, including cognitive and entrepreneurial skills, supported by seed money to build a critical mass of small entrepreneurs for the state.

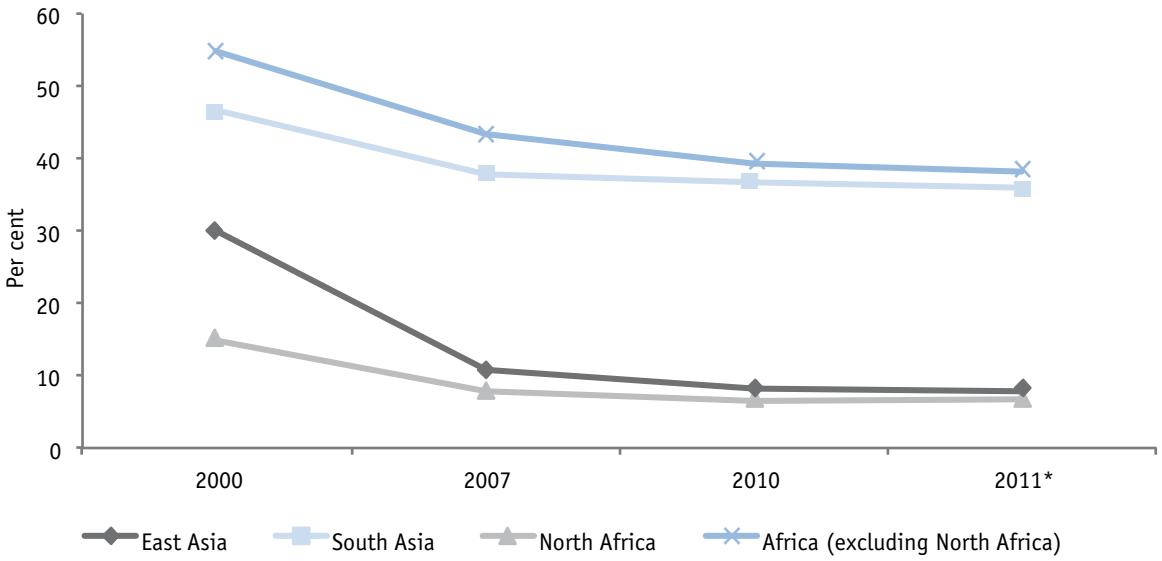
In less than a year, it has created 20,000 jobs in different sectors: 5,000 in agriculture and related activities, 3,000 as traffic control officers and 2,500 as environmental officers. The rest were in information and communications technology, automobile repairs, welding, laboratory technology and music.

The scheme has re-activated eight farm settlements, providing a platform for agricultural production and processing (the settlements were abandoned about two decades ago). Deploying young people into agriculture has started to yield good results as the aged farmers are now being gradually replaced. Elsewhere, chronic traffic congestion in the state capital is being eased and the environmental officers are helping to enforce good sanitation and a clean environment.

The main challenge is sustaining the project and scaling it up, as well as replicating it in other states of the country.

Source: Oyo State Government of Nigeria (2012).

Figure 1.7 Share of working poor in total employment



* = estimates.

Source: Authors' computations from ILO (2012).

figure increased in Africa (excluding North Africa) by 22 million.

In Africa, the informal sector has been the main driver of job creation – vulnerable work accounted for 70 per cent of job growth during 2007–2011. Four out of ten employed people in North Africa in 2011 were in vulnerable employment. In Africa (excluding North Africa), vulnerable employment was 76.6 per cent, although this marks a decrease of 3.8 percentage points in the last decade.

The vulnerable employment figures are disproportionately driven by women and youths. In North Africa men are less likely (32.2 per cent) to be employed in vulnerable jobs than women (55.1 per cent). For the rest of Africa, the probability is far higher that a woman (84 per cent) or man (70 per cent) is vulnerably employed. The dominance of the informal sector and the few (or missing) social protection systems partly explain the high proportion of vulnerable workers in Africa (excluding North Africa). This is particularly evident with youth employment (ILO, 2010c).

Youth employment is becoming a matter of concern

Youth employment has been particularly vulnerable to the global economic situation. In 2011, 74.8 million youths were unemployed, an increase of more than 4 million since 2007. Young people are worldwide three times as likely to be unemployed and could be a cause of political instability. Youth unemployment is higher in Africa than in East or South Asia (ILO, 2012).

In the African continent, North Africa has by far the highest youth unemployment rate, which has hardly budged over the last decade (figure 1.8). Unemployment there affects women and youths

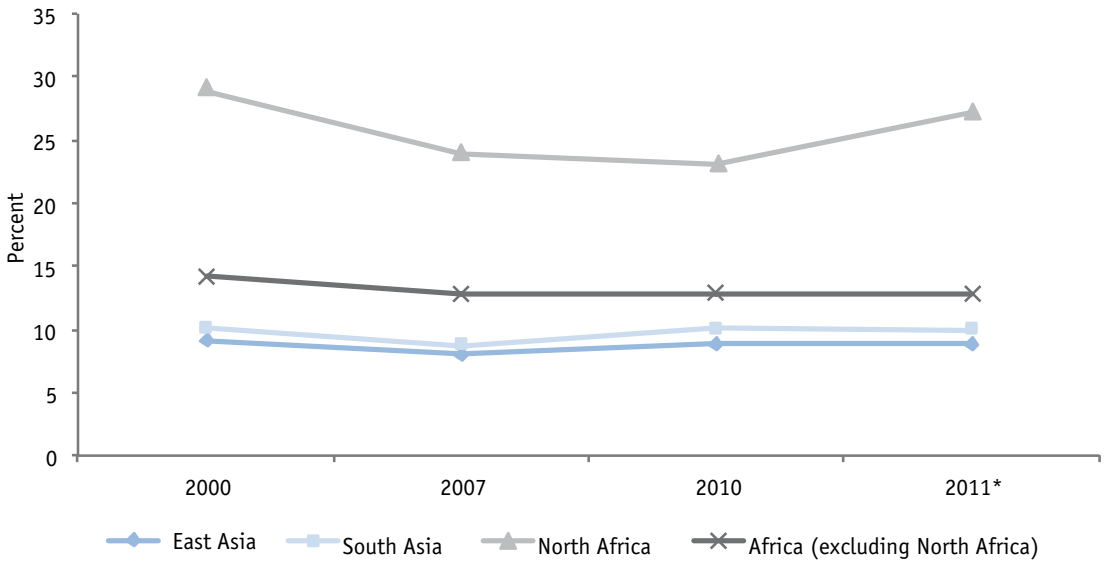
heavily. The lethargic growth in the formal job market leads these two most vulnerable groups to be overrepresented in the informal sector.

Unemployment among youths is lower in Africa (excluding North Africa) but employed youths are overrepresented among the working poor. In Burundi and Liberia, for instance, more than 85 per cent of employed youths are working poor (but the differences between adult and youth working poverty rates are small).

Distinct from North Africa, the informal labour market in the rest of Africa provides a cushion – albeit vulnerable – for job-seeking youths and women. Youths, though, often find it harder to secure formal work than adults, owing to their short work experience and limited professional networks. Hence, even when they find work, it tends to be characterized by low wages, poor working conditions and few opportunities for skills development. The upshot is higher working poverty rates for young people than adults in the large majority of Central, East, Southern and West African countries (ILO, 2012). Women face similar challenges because of their lower education and cultural marginalization from labour market networks.

Labour market demand and supply determine job market opportunities. Improving job opportunities will therefore require efforts to enhance the competitiveness of the labour force and create an enabling environment for domestic and foreign investment. Infrastructure development that stimulates private investment, especially for electricity, roads and water, is vital for creating employment in rural and urban areas. Strengthening managerial capacities and facilitating access to affordable credit by micro and small enterprises are vital for

Figure 1.8 Youth unemployment trends, 2000–2011



Source: Authors' computations based on ILO (2012).

the survival and growth of local businesses, as well as overall economic growth. Special programmes for developing the skills of young entrepreneurs in the various sectors are therefore needed for sustained income and employment generation.

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

Progress on this target is slow. The 2011 Global Hunger Index from the International Food Policy Research Institute (IFPRI) shows an improvement of 18 per cent during 1990–2011 in Africa (excluding North Africa), compared with 25 per cent in South-east Asia and 39 per cent in North Africa.[11]

The regional aggregate masks wide country variations, from the largest improvements in Ghana, Mauritania, Angola and Congo versus a sharp worsening in the Democratic Republic of Congo (DRC) (figure 1.9). The trend in Central, East, Southern and West Africa stagnated between 1990 and 1996, improved slightly in 2001 and then declined more markedly in 2011 (IFPRI et al., 2011).

The proportion of people who are malnourished has stabilized at 16 per cent of the population, implying that nutritional advances have not matched declines in poverty. Increases in international food prices, which are still higher than before the global crisis, are partly to blame (FAO, 2010; UN, 2011). They have had an adverse effect on income and other poverty correlates.

For example, food-price increases render poor consumers more vulnerable to poverty, because food represents a large share of their spending. Similarly, volatility in food prices (large price swings) have large effects on real incomes of smallholding farmers. Thus even short episodes of high prices for consumers or low prices for farmers can cause productive assets – land and livestock, for example – to be sold at low prices, leading to potential poverty traps. In addition, small farmers are less likely to invest in measures to raise productivity when price changes are unpredictable. For net food consumers, price increases can give rise to coping mechanisms that defer educational and health spending by households, lowering welfare and long-term development.

Indicator1.8: Prevalence of underweight children under five years of age

In developing regions, the proportion of children under age five who are underweight declined from 30 per cent to 23 per cent during 1990–2009. All global regions with comparable trend data made progress, and Eastern Asia, Latin America and the Caribbean, and the Caucasus and Central Asia have reached or nearly reached the MDG target. South-eastern Asia and North Africa are on track.

Africa (excluding North Africa) has not improved enough to ensure that it will meet the target by 2015. Central, East, Southern and West Africa improved slightly from 27 per cent to 22 per cent between 1990 and 2009, yet the aggregate figures mask cross-country and gender disparities (figure 1.10), as well as rural–urban gaps.

Malnutrition of children has negative spill overs on other MDGs, and therefore requires assertive

11 The index is a multidimensional statistical tool that combines three equally weighted indicators: the proportion of the undernourished as a share of the population; the prevalence of underweight children under the age of five; and the mortality rate of children under the age of five.

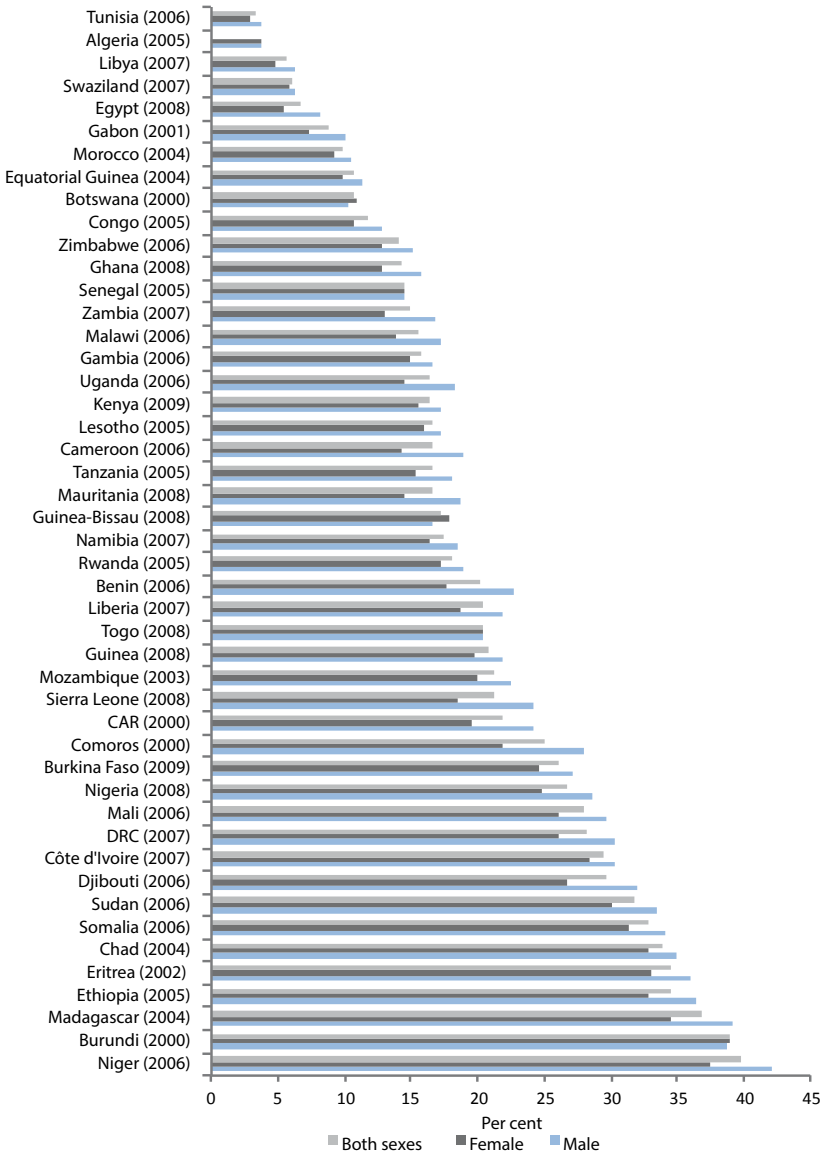
Figure 1.9 Progress in reducing the Global Hunger Index, 1990–2011

Source: Authors' computations from IFPRI et al. (2011).

Note: A negative number represents progress.

national policies (box 1.7). It is also an underlying cause of more than a third of under-five deaths and more than 20 per cent of maternal deaths (UNICEF, 2011b).

Figure 1.10 Prevalence of underweight among under-five-year-olds



Source: Authors' computations from WHO (2011).

Box 1.7 Responding to the wider impacts of malnutrition

Adequate nutrition is central to achieving many MDG targets. Well-nourished children have strong immune systems and are less likely to die prematurely from communicable diseases. Infants who are undernourished in the first 1,000 days of life can suffer irreparable damage to their physical and mental development, handicapping them for life (Victora et al., 2008). Malnutrition affects children's cognitive learning and educational performance and status in life. On reaching adulthood, they are likely to give birth to another generation of low-birth-weight babies.

Malnourished mothers are at greater risk than healthy mothers of dying during childbirth and of giving birth to underweight, stunted and wasted children with less chance of surviving infancy than well-nourished infants.

To any society, the cost of preventing malnutrition is far lower than the cost of managing its side-effects. National policies should therefore be targeted at better nutritional outcomes. Many countries have launched national programmes, including community-based activities that have started to yield results. The Global Alliance for Improved Nutrition is active in, for example, Côte d'Ivoire, Egypt, Ethiopia, Ghana, Kenya, Niger, Nigeria, Mali, Morocco, Senegal, South Africa and Uganda.

Lessons from most of these countries underline the importance of national ownership, adequate and predictable funding from government, solid governance of nutritional programmes, decentralized programming and close teamwork with development partners.

Sources: UNDP Regional Bureau for Africa (forthcoming) and Victora et al. (2008).

Conclusions

Progress on reducing income poverty has been encouraging across the continent. Many countries have made substantial progress, even if disparities exist within and among countries – for example, the dominance of rural poverty and the feminized nature of poverty should be given greater attention. Although Africa has strong potential to generate jobs over the medium term, addressing youth unemployment and increasing labour productivity are daunting challenges. Progress on malnutrition is slow, hence the need to accelerate efforts to meet this target by 2015.

Specific policies to promote inclusive growth, with a particular focus on agriculture and the informal sector, have the potential to increase the growth elasticity of poverty. Lessons from countries like Ethiopia and Rwanda show the importance of reducing inequality to facilitate a rapid decline in income poverty.

Policies to address population growth and to promote social protection are also vital for reducing poverty, as are national employment strategies that involve key stakeholders. Actions to expand jobs and labour productivity should focus on widening access to complementary inputs such as machinery and equipment, strengthening the business environment in which private firms can thrive, boosting the quantity and quality of physical and institutional infrastructure, and improving working conditions.

Food security requires short- and long-term strategies and interventions. In the short term, these should focus on improving nutritional outcomes

(including via comprehensive national nutritional programmes that ensure access to health clinic services), on promoting home visits by health workers and on facilitating distribution of therapeutic food supplements to vulnerable groups, especially children and women.

Long-term policies and strategies should be institutionalized to promote better use of fertilizers and wider access to drought and disease-resistant seedlings, encourage all-season farming, give farmers market information, and provide credit and assisted insurance to farmers nationally, as instruments to bring into full operation the African Union's Comprehensive Africa Agricultural Development Programme.

Goal 2: Achieve universal primary education

Education is a crucial element of human development, and progress towards this goal will heavily influence that towards other MDGs. Primary education is the basis for high-quality skills development in numeracy and literacy, which are critical for skills development in scientific and technological education. Higher levels of education for girls and women have strong positive impacts on their employment and earning potential, as well as their ability to contribute to society's development. Educated women tend to have fewer children and healthier families, which contributes to improved child and maternal health, higher immunization rates, good family nutrition, and the next generation's schooling attainment (World Bank, 2001). Education for girls and boys is also a preventive weapon against HIV/AIDS.

For primary education to move towards its potential, however, a minimum threshold of five or six years of schooling is needed. This potential would be boosted if primary school completion were followed by secondary education.

Many African countries are on track to achieve this goal. Some have progressed on net enrolment, with most countries reaching 90 per cent. Gross enrolment ratios – not an MDG indicator but often used to measure universal primary education – improved from 76 per cent in 1990 to 102 per cent in 2010, and 28 of 36 countries with data have a gross enrolment ratio of at least 90 per cent.

Completion rates, however, are less satisfying, and some countries still have rates as low as 33 per cent. Youth literacy has seen progress, notably the number of countries with youth literacy rates of 95 per cent and above. Still, overall progress towards the target is slow, and marked by gender inequity as women's literacy rates remain lower than men's.

Free and compulsory primary education has been introduced in many countries, imposing stress on educational facilities (classrooms, facilities and teachers), affecting the quality of education and raising dropout rates. However, with more resources allocated to primary and secondary education, stronger governance of school systems, better teaching and curricula, and current educational reforms, the continent will be able to consolidate its progress.

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 enrolment in primary education

African countries continue progressing on primary school enrolment

The aggregate net primary school enrolment for Africa rose from 64 per cent in 2000 to 84 per cent in 2009. Most African countries have made

steady progress and are on track to meet the target for net enrolment in primary education by 2015. Of the 35 African countries with data for 2009, 17 had net enrolment ratios above 90 per cent. Algeria, Burundi, Egypt, São Tomé and Príncipe, Tanzania, Togo and Tunisia have already reached or exceeded the minimum target to achieve 95 per cent net enrolment by 2015.

Ten countries have made considerable strides to improve their net enrolment ratios by more than 20 percentage points between 1999 and 2009 (table 2.1). It is heartening that some of the fragile states, such as Burundi, and non-resource rich countries, including Madagascar, Rwanda, São Tomé and Príncipe, and Tanzania have achieved or are nearing the goal of universal primary education. Seven countries registered increases in primary school enrolment ratios of 10–20 percentage points.

However, countries such as Djibouti and Eritrea still have very low net enrolment (figure 2.1). The Eritrean government has in fact invested heavily in education, expanding access across the country. It is promoting a new class of trained youths who have disciplined minds and skills to act as teachers and to address the educational deficit,

Table 2.1 Net enrolment changes in primary education, 1999–2009

Gains of 20 percentage points or more		Gains of 1–20 percentage points		Declines	
Burundi	63.0	Senegal	19.9	Gambia	-1.2
Tanzania	47.3	Morocco	19.5	South Africa	-7.0
Ethiopia	46.8	Djibouti	17.0	Malawi	-7.5
Mozambique	38.3	Ghana	16.0	Cape Verde	-16.6
Mali	32.2	Lesotho	15.9		
Guinea	30.5	Mauritania	14.1		
Burkina Faso	29.2	São Tomé and Príncipe	10.2		
Niger	28.1	Togo	8.8		
Zambia	22.7	Egypt	7.6		
Kenya	20.3	Tunisia	3.9		
		Mauritius	3.5		
		Eritrea	3.5		
		Algeria	3.1		
		Namibia	1.2		
		Côte d'Ivoire	0.9		

Source: Computations from UNSD, accessed December 2011.

especially at the primary level. The government has established some eight colleges at tertiary level quickly, with new curricula, appropriate to immediate national needs

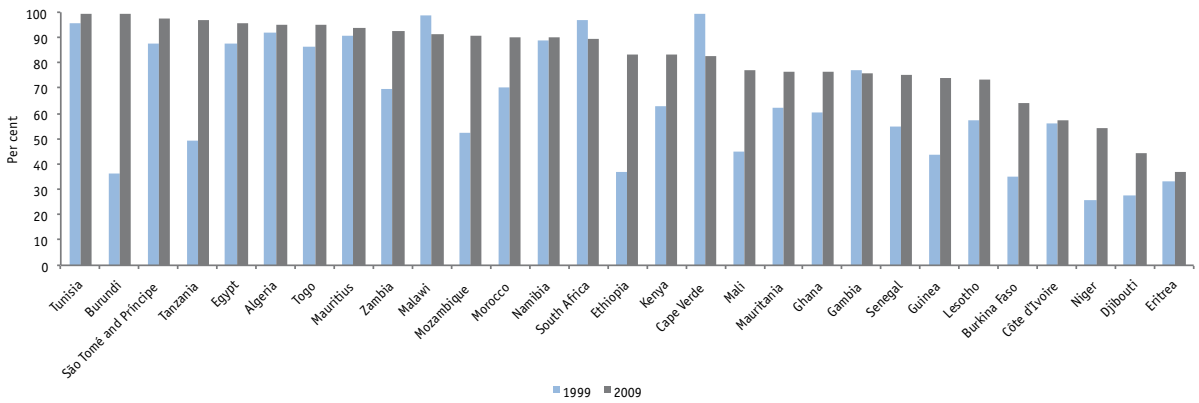
The steep gains in primary school enrolment may be linked to several factors. Beyond those discussed in box 2.1, the introduction of free and compulsory education in most countries has been a major driver (Riddell, 2003; Vavrus and Moshi, 2009). In Zambia, for instance, free primary education launched in 1994 lifted enrolment by over half from 1.9 million in 1993/4 to 3.2 million in 1994/5; net enrolment rose from 58 per cent for both boys and girls before free primary education to 73 per cent for girls and 67.9 per cent for boys in 1996.In Kenya, its introduction in 2003 raised gross enrolment from 87.6 per cent in 2002 to 104 per cent in 2003/4,and net enrolment from 46.7 per cent in 1999/2000 to 80.7 per cent in 2001 (Riddell, 2003).

Some countries may not achieve the target by 2015

A few countries have suffered notable reversals in net enrolment in primary education, including Cape Verde, Malawi, South Africa and Gambia (see table 2.1). These stem from too few qualified teachers, inadequate educational infrastructure and poor school management. In Malawi, for example, a shortage of qualified primary school teachers, weak physical infrastructure and sub-par school management by school committees are some of the bottlenecks. In Cape Verde, lack of trained teachers is the main problem.

Eighteen countries are more than 10 percentage points away from hitting the target by 2015. Among these, seven show large deviations from the target, with net primary enrolment ratios 33–63 percentage points off target in 2009 (figure 2.2). These countries need to introduce policies to address their binding constraints.

Figure 2.1 Net enrolment in primary education, 1999 and 2009



Source: Computations from UNSD, accessed December 2011.

Box 2.1 Good policy spurs rapid educational advances

Countries have their own slightly different, but ultimately similar, ways of encouraging education.

Some, like Namibia, have enshrined compulsory education in their constitution and have established educational policies and programmes to enforce compulsory primary education. Mauritius imposes penalties on parents who do not send their children to primary school. Rwanda is introducing a nine-year cycle of basic education.

Universal primary or basic education has produced encouraging results in Nigeria and Zambia, among others. The Seychelles has eliminated all forms of educational discrimination (including against disabled people). Increased budgetary allocations, a primary education development plan and capitation grants are driving progress in Tanzania.

In short, a good policy environment can create momentum for rapid progress.

Source: UNDP–RBA (2010).

Indicator 2.2: Primary completion rate

Completion rates are low but some countries show real progress

Some countries have made tremendous progress in boosting their primary completion rates – although most countries are unlikely to meet the target for completing a full course of primary school. The primary completion rate is a measure of the quality of the educational system. It also helps to gauge the success of that system in curbing dropouts and improving retention, thus keeping children in school to complete their primary education.

Only six countries (the first six from the left in figure 2.3) recorded primary completion rates of 90 per cent and above in 2009. From 1999 to 2009, seven countries recorded huge gains of more than 30 percentage points (first column of table 2.2). Apart from Madagascar, Tanzania and São Tomé and Príncipe, they started from a very low primary completion rate (of below 30 per cent). This implies that such improvements may have been due to radical policy shifts to address matters. However, precisely because they started from a low base they are unlikely to reach the target.

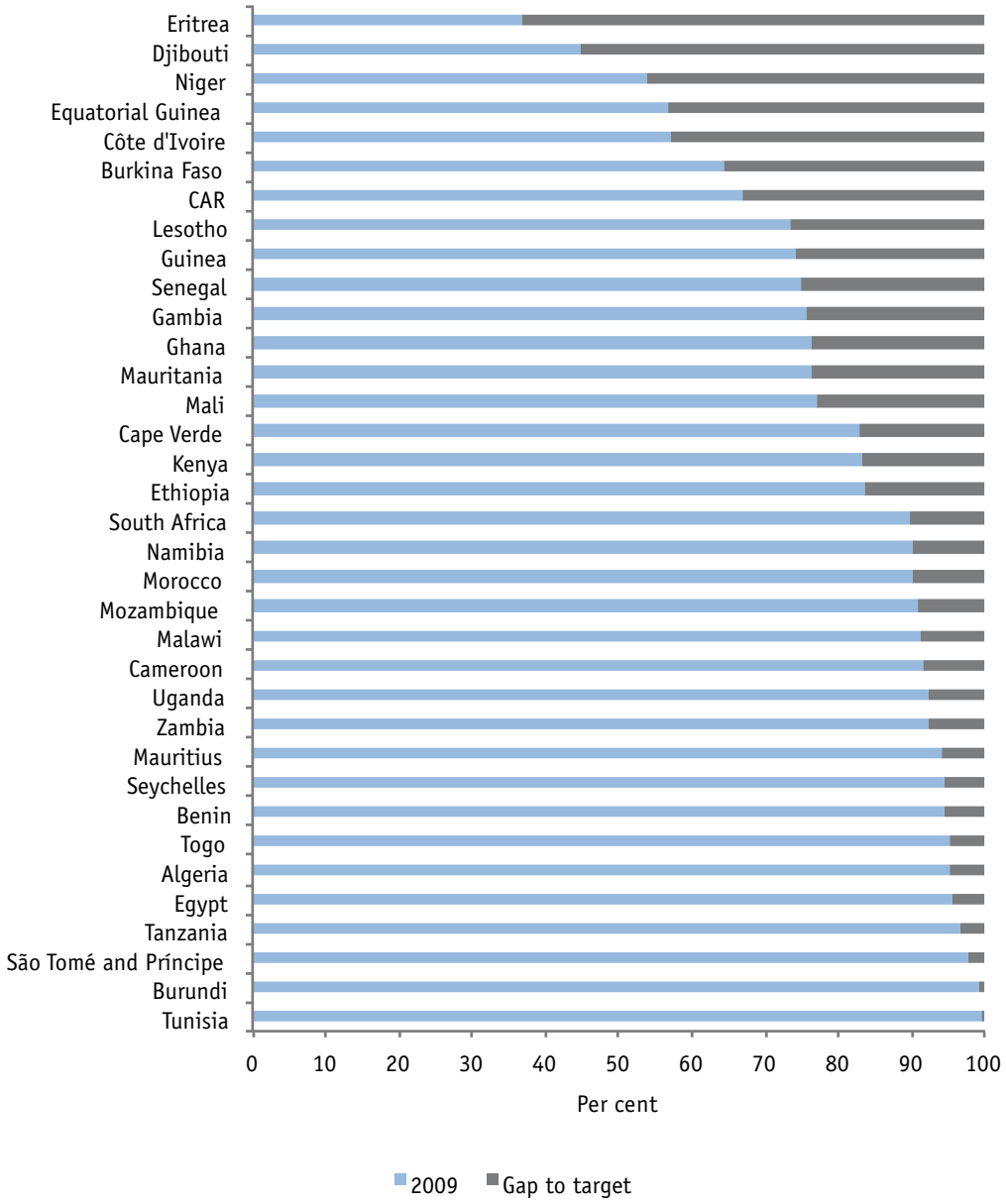
Another seven countries (Burkina Faso, Chad, Côte d'Ivoire, Djibouti, Eritrea, Equatorial Guinea and Niger) can be classified as seriously off track because their completion rates in 2009 were below 50 per cent and on current trends their rates may not even exceed that by 2015.

Most of these countries have very high dropout rates – of the 20 countries in the world with the worst dropout rates, 16 are from Africa, with Chad having the dubious distinction of heading the group.[12] Addressing the dropout rate in primary school has become a major challenge for the continent – boxes 2.1 and 2.2 illustrate some approaches.

Several factors account for low completion rates in primary school. Sabates et al. (2010) classifies them into three groups: individual factors such as poor health or malnutrition status of pupils; household situation (including child labour and

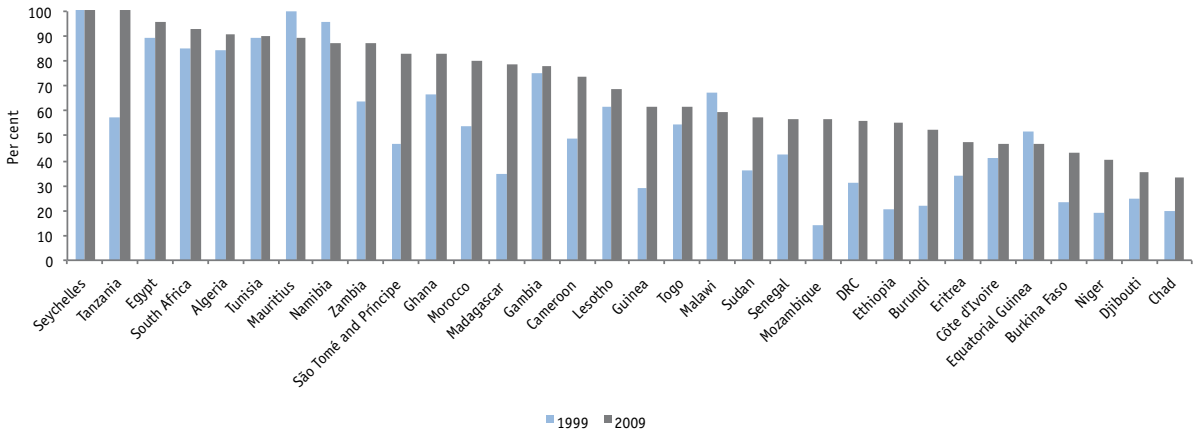
12 Encyclopaedia of the Nations (2001–2008), www.nationsencyclopedia.com/WorldStats/Edu-primary-drop-out-rate.html.

Figure 2.2 Gap to net enrolment target in primary education, selected African countries, 2009



Source: Computations from UNSD, accessed December 2011.

Figure 2.3 Primary completion rate for selected African countries, 1999 and 2009



Source: Computations from UNSD, accessed December 2011.

Table 2.2 Changes in primary completion rate, 1999–2009

Gains of 20 percentage points or more		Gains of 1–20 percentage points		Declines	
Tanzania	45.1	Burkina Faso	19.8	Equatorial Guinea	-5.2
Madagascar	44.0	Ghana	16.2	Malawi	-8.0
Mozambique	42.6	Senegal	14.3	Namibia	-8.4
São Tomé and Príncipe	36.8	Eritrea	13.5	Mauritius	-10.5
Ethiopia	34.5	Chad	13.4		
Guinea	32.7	Djibouti	10.9		
Burundi	30.2	South Africa	8.2		
Morocco	26.6	Lesotho	7.5		
DRC	25.0	Egypt	6.6		
Cameroon	24.8	Togo	6.5		
Zambia	23.1	Algeria	5.9		
Niger	21.5	Côte d'Ivoire	5.2		
Sudan	21.4	Gambia	2.7		
		Tunisia	0.5		

Source: Computations from UNSD, accessed December 2011.

Box 2.2 Keeping children in primary school – Tanzania's reforms

Primary education reforms in Tanzania followed three approaches.

First, the government adopted a political and budgetary focus on universal primary education and completion rates, and used the decentralized local government system to realize this focus. It began by mapping, as much as possible, all primary education facilities and identifying all school-aged children (including tracking down those out of school). This information was useful in gauging the scope of the nation's educational resource needs. The government then instituted a policy of compulsory enrolment of all children from seven years and up, including over-aged children who were out of school.

Second, education was devolved to the regions, with a community approach to education starting from villages.

Third, to tackle inefficiencies in the system, children were enrolled at the right official age of entry in primary school. At the same time, the government brought in quality-improvement measures, such as child-friendly teaching and learning skills for teachers; flexible learning hours; abolition of corporal punishment and of compulsory school uniforms; wider availability of textbooks; school health measures, such as improved access to water and sanitation facilities in school; and school meals in drought-prone areas.

Those children found to be overage and out of school were accommodated through a condensed curriculum of three years equivalent, rather than the traditional seven years. (This proved to be more beneficial to young children in the classroom.) Other forms of education were introduced for these children – complementary, and not an alternative to the formal system.

Source: Sabates et al. (2010).

poverty); and school factors such as teacher absenteeism, school location and poor educational provision. For countries to improve their primary completion rate, they need to design and implement policies and programmes that encourage pupils to stay in school.

More effort is needed to keep girls in school

Educating girls produces many socio-economic gains that benefit the whole of society. These include greater economic productivity, higher family incomes, delayed marriages, reduced fertility, and improved health and survival rates for infants and children.

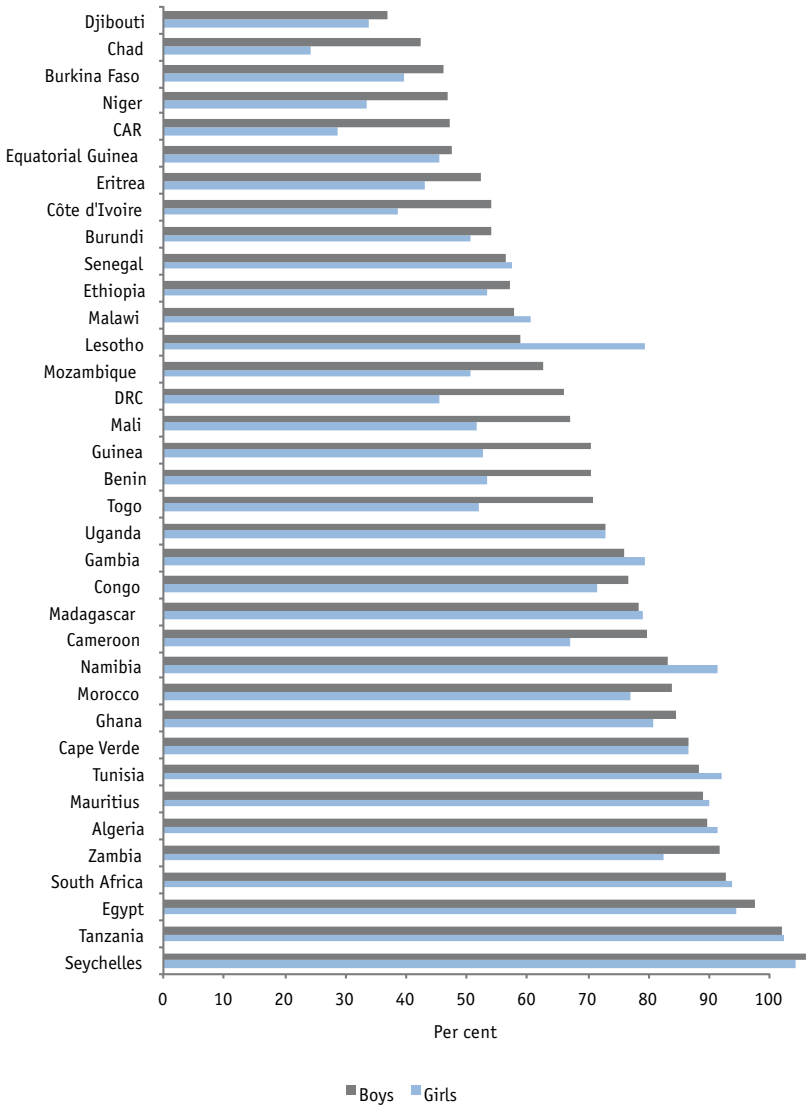
Still, more girls drop out of school than boys, leading to their lower primary school completion rates. In 24 of 36 countries with data, completion rates for boys are higher than for girls, and of those 24, 11 are higher by about 10 percentage points (figure 2.4).[13]

To improve primary school completion rates for girls, some countries have introduced policies that focus on girls' education. In Zambia, for example, the government has launched a Programme for Advancement of Girls' Education (box 3.1 below).

To improve school completion rates, particularly for girls, governments need to secure greater balance between policies and interventions that focus on

13 Algeria, Benin, Cameroon, CAR, Chad, DRC, Côte d'Ivoire, Gambia, Guinea, Mali and Mozambique.

Figure 2.4 Primary completion rate disaggregated by sex, selected African countries, 2009



Source: Computations from UNSD, accessed December 2011.

improving educational access and gender parity in enrolment, and those that address retention and achievement – the quality and relevance of education. An educational system that meets minimum standards of quality and that is relevant to the labour market needs of a community or country not only contributes to improved enrolment and retention, but also helps to ensure that boys and girls are able to fully realize the benefits of education (USAID, 2008). Globally, responding to gender equity concerns, the UN launched the United Nations Girls' Education Initiative (box 2.3).

Indicator 2.3: Literacy rate of 15–24-year-olds, women and men

Youth literacy is on the rise but gender disparities persist

Literate individuals are better *"able to access other education and employment opportunities and, collectively, literate societies are better geared to meet development challenges" (*Carr-Hill, Frostell and Pessoa, 2008).Youth literacy rates are generally rising in African countries, and very few had literacy rates below 50 per cent in 2005–2009.

The number of countries with very high youth literacy rates also rose strongly – 10 of 39 countries with data had rates of 95 per cent or more in 2009 (figure 2.5). Despite these rising trends, progress towards the MDG target appears slow, and an equal concern is the gender inequity in literacy rates, as women still lag behind.

During 2000–2009, 15 countries lifted their youth literacy rates. Gambia and Guinea-Bissau showed strong gains of 13 percentage points and 11 percentage points, respectively. Senegal also recorded a healthy gain, from 49 per cent in 2002 to 65 per cent in 2009. Niger recorded a steep increase in youth literacy from 14 per cent to 36 per cent between 2001 and 2005. Niger's efforts to improve literacy and non-formal education through a major multi-year plan have stimulated the interest of development partners such as UNDP, AfDB and the World Bank.

Some countries, however, saw only marginal gains in youth literacy rates – some others even recorded declines. Madagascar's youth literacy rate, for example, fell from 71.1 per cent in 2000 to 64.9 per cent in 2009.

The pattern for youth literacy rates between sexes remains the same, with male rates surpassing those of females in 24 of 37 countries with data for 2009

Box 2.3 Providing educational opportunities for girls

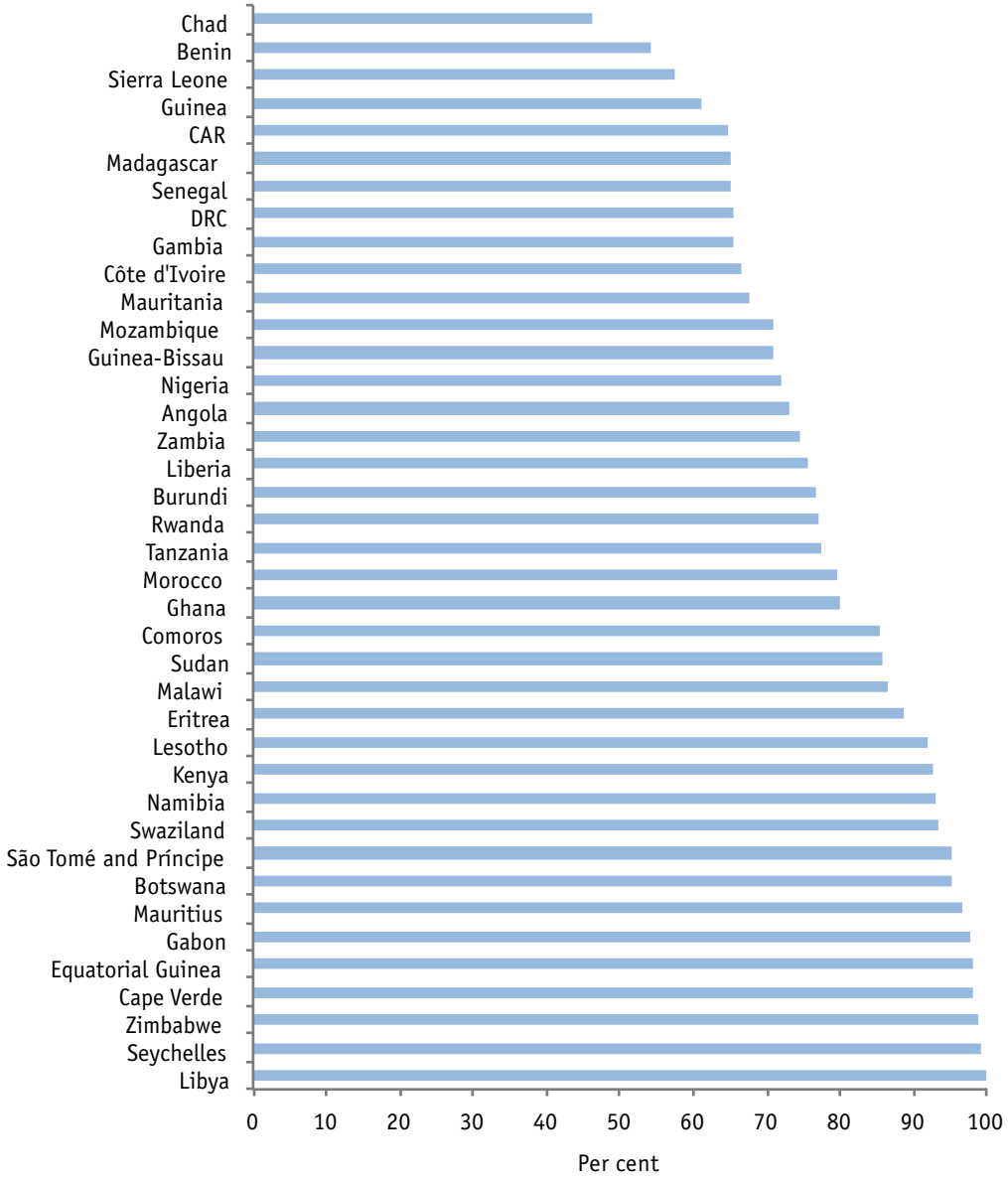
The United Nations Girls' Education Initiative (UNGEI) was launched in 2000. It originated in the widespread realization that millions of girls were still unable to fulfil their right to education, despite almost universal endorsement of this right. When UNGEI was launched, more than half the children out of school were girls – and despite progress in many countries, that still holds true.

UNGEI – in Africa, based on local experience and best practices, including the African Girls' Education Initiative – promotes girls' education and works for gender equality in education through a network of partners. The initiative works specifically to eliminate barriers that keep girls out of school. UNGEI envisages a world where all girls and boys are empowered through high-quality education to realize their full potential, leading to true equality between the sexes. Its work is driven in particular by MDGs 2 and 3.

Since 2008, UNGEI has prepared an annual gender review of the Education for All Global Monitoring Report. Its objective is to examine the strengths and gaps that emerge from monitoring Education for All goals from a gender perspective, and to inform advocacy messages on education and gender equality in key thematic areas for governments, development partners and civil society.

Source: UNGEI (2012).

Figure 2.5 Literacy rate, both sexes, 2009



Source: Computations from UNSD, accessed December 2011.

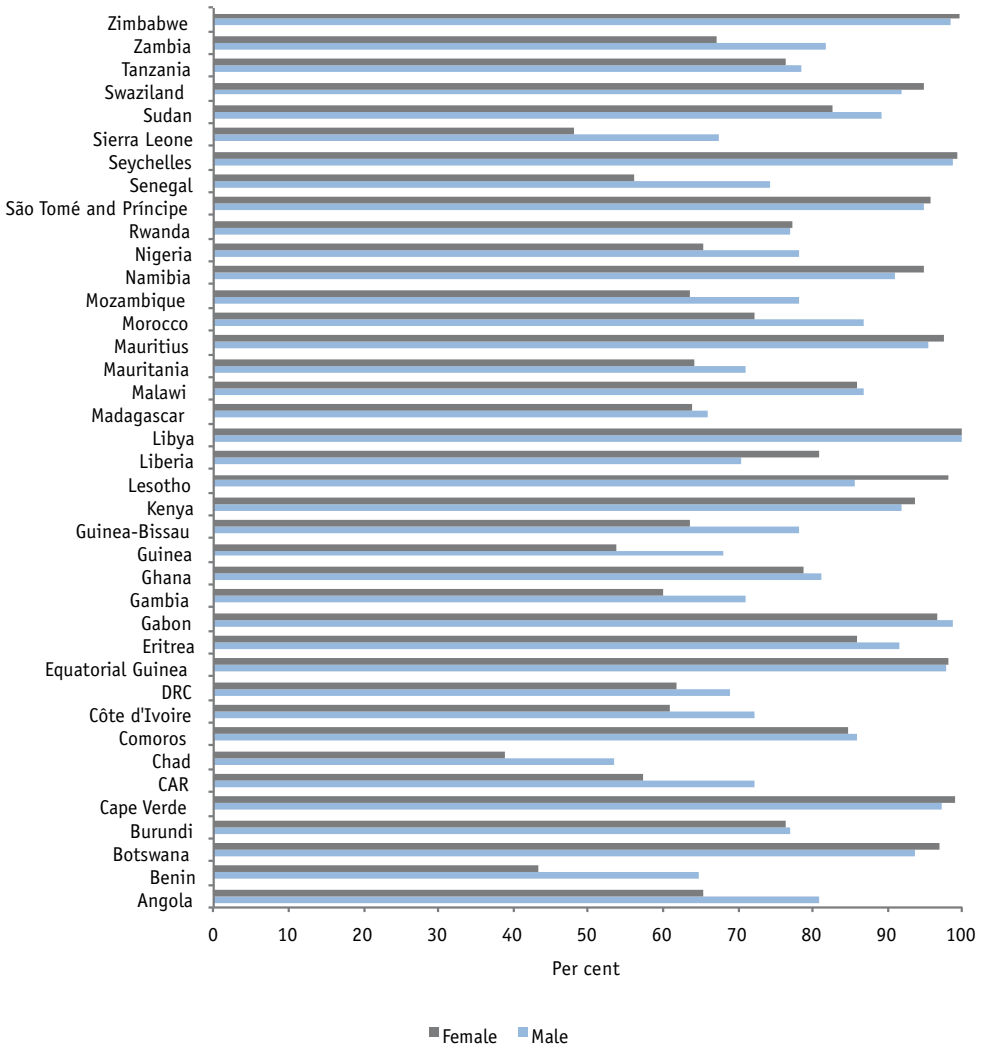
(figure 2.6). Female literacy rates surpass those of males in the remaining 13 countries, generally in countries where youth literacy rates are high. This pattern may reflect policies to improve youth literacy rates among women particularly.

To promote the improvement of literacy in countries facing critical literacy challenges UNESCO has developed a framework known as the Literacy Initiative for Empowerment. The framework has been put into place for implementing the UN Literacy

Decade (2003–2012).A number of countries are using the provisions of the framework to improve literacy rates. For example, so far five countries (Mali, Morocco, Niger, Nigeria and Senegal) have carried out in-depth situation analyses to identify strategic areas for making a difference in literacy efforts, which includes developing national action plans as well as implementing annual work plans (UNESCO, 2008).

Improving literacy is beyond the responsibility of governments alone. It is important for other stakeholders and partners to be fully involved if progress towards this target is to be seen by 2015. Civil society has always been a crucial partner in youth

Figure 2.6 Youth literacy rate by sex, 2009



Source: Computations from UNSD, accessed December 2011.

and adult literacy, designing flexible programmes for specific groups among communities, lobbying for the interests of vulnerable populations and monitoring performance. The private sector has a particular interest in an educated workforce and has developed workplace literacy and skills programmes. Involving parent–teacher associations in school management also contributes to progress, and universities and research institutions can offer an evidence base for analysing performance, bottlenecks and practical solutions.

Conclusions

The continent is generally on track for this target but challenges of increasing completion rates, reducing dropout rates, improving the quality of education and bridging the gender gap in school need urgent attention. Off-track countries could learn from countries that have strongly advanced towards this target. In looking beyond the MDGs, countries must focus on education beyond the primary level in order to meet the demands of changing economies.

As well as increasing budgetary allocations for primary and secondary education, authorities need to improve governance of the educational system, including managing resources efficiently. It is equally important to institute appropriate educational reforms. For example, policies that aim to improve educational quality and relevance through curricular and pedagogical reforms can go a long way in improving completion rates.

Governments also need to tackle school dropouts through policy measures that raise school retention rates, such as providing micro-enterprise support for poor households as well as improving child health and nutrition. They should also work with stakeholders (including civil society organizations, parent–teacher associations, the private sector and academia) in designing and pursuing policies and programmes that improve youth literacy rates.

Goal 3: Promote gender equality and empower women

Improving gender equality and empowering women are pathways to making sustainable human development and to achieving other MDGs (especially accelerating maternal and child health care, improving education and reducing poverty and hunger).

Gender equality increases people's abilities – women's and men's – to be educated and healthy, have voice and influence, take advantage of opportunities and make informed choices. These abilities are vital for societal and national transformation and development. Achieving this goal sets the climate for realizing all other MDGs – again creating a virtuous circle for sustainable human development.

Empowering women and girls is central to promoting quick and equitable economic growth and long-term stability. For instance, facilitating poor women's access to productive and financial resources, while promoting gender equality in the household and in society more widely, also generates large development pay-offs. Expanding women's opportunity in public works, agriculture, finance and elsewhere accelerates economic growth, helping to mitigate the effects of economic shocks and natural disasters. World Bank (2011b) shows that countries that invest in promoting the social and economic status of women tend to have lower poverty rates – an extra year of secondary schooling for girls can increase their future wages by 10–20 per cent.

Women's empowerment shows a dynamic relationship with most other MDGs. When women are more educated they also, for example, delay marriage and pregnancies, leading to lower likelihood of maternal and child death during childbirth, and a greater probability that children will be strong enough to attend school and survive into adulthood. More educated mothers have the skills to compete for high-skilled and well-paid jobs and will therefore be in a better position to feed, care for and educate their children. Empowering women and girls through education also enables them to be involved in decisions at all levels, from the household through to local and national levels, and influence the allocation of resources in a gender-sensitive manner. This contributes to higher productivity, which increases economic growth and resources (in the form of taxes and additional incomes) to finance investments in social services. Consider it another virtuous circle.

The cost to society of not investing in gender equality and female empowerment can be heavy. Over 2005–2015, wide gender gaps in education at primary and secondary levels were estimated to reduce economic growth by 0.4 percentage points annually, increase birth rates by about one child per woman, increase child deaths by 32 per year (per 1,000 live births) and raise by 2.5 percentage points the prevalence of underweight children (Abu-Ghaida and Klasen, 2004).

Progress on this goal is encouraging. Many countries are making notable performance – especially on gender parity in primary school education and number of seats held by women in parliament – but promoting women in paid employment outside agriculture is still a challenge. Cultural practices (including inequitable inheritance practices, early marriage and household power dynamics), few economic opportunities for women and too little political will still impede progress. For sustained advances, cultural transformation aimed at addressing the negative perception in society to gender equality and women's empowerment is imperative.

Policy changes should be directed at addressing discrimination against girls and women in educational systems, encouraging greater participation of women in productive and remunerative economic activities and increasing women's voice in making decisions at all levels of society. Economic and social policies that respond better to the needs of men and women – including affirmative action strategies, the reform of customary laws that discriminate against women and girls, and more human and financial resources to enforce and implement such laws – are crucial for meeting this goal. And countries with educational disparities against boys should address that issue.

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

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

The primary school ratio is still generally improving

The ratio of girls to boys enrolled in primary school[14] continues to improve in many African countries. Of 42 countries with comparable data between 1990/91 and 2009, 29 scored higher than 0.9 (90 girls compared with 100 boys), while three and eight countries scored 1.0 and slightly higher than 1.0, respectively.[15] Countries like Lesotho and Mauritius have been addressing the imbalance against boys in primary school enrolment since 2004 and 2000, respectively.

UNESCO (2012) provides more recent progress data. Of 50 countries in Africa having data, 31 countries have a gender parity index in primary school enrolment of less than 1.0 (that is, girls' enrolment is less than boys'), 16 countries have an index of 1.0 (boys' enrolment is equal to girls'), and in two countries girls' enrolment is higher than boys' (figure 3.1.)

Guinea, Benin and Chad made the most progress from 1990/91 to 2009 with proportional changes ranging from 79.2 per cent to 55.6 per cent (figure 3.2). Guinea provides a good example of promoting parity among regions and among

14 Also known as the gender parity index in primary school enrolment.

15 Scores above 1.0 indicate disparity against boys.

Figure 3.1 Gender parity index in primary school enrolment

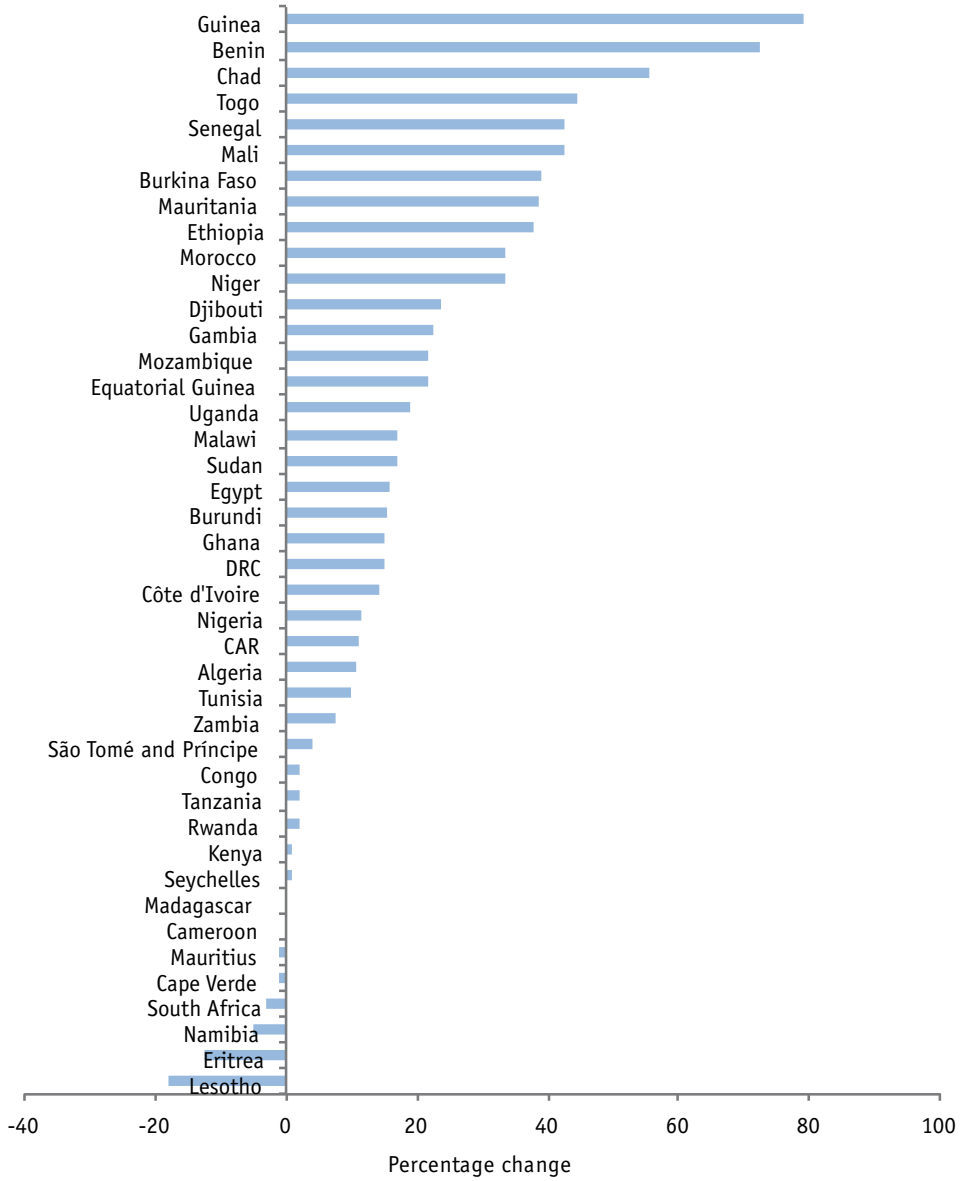
Source: UNESCO (2012).

towns, an approach that has yielded solid results in narrowing gender gaps (AfDB et al., 2011). Eight countries, including Mali, Togo and Senegal, improved gender parity in primary school enrolment by 30–49 per cent, and four countries grew by 20–29 per cent.

Seven countries progressed little or not at all and six recorded apparent regression. But declines in Lesotho, Namibia and Mauritius should not be interpreted this way – they stem from efforts to reverse the imbalance against boys. Eritrea has, though, consistently regressed since 1991, and Cape Verde since 2000. South Africa has stagnated since 2003.

Africa's performance over time, relative to other regions of the world, is promising but there is room for improvement. The rate at which it has addressed the gender gap in primary school enrolment is faster than South-eastern Asia, Latin America and the Caribbean, and Western Asia

Figure 3.2 Change in gender parity index in primary school enrolment, 1991–2009



Source: Computations from UNSD, accessed December 2011.

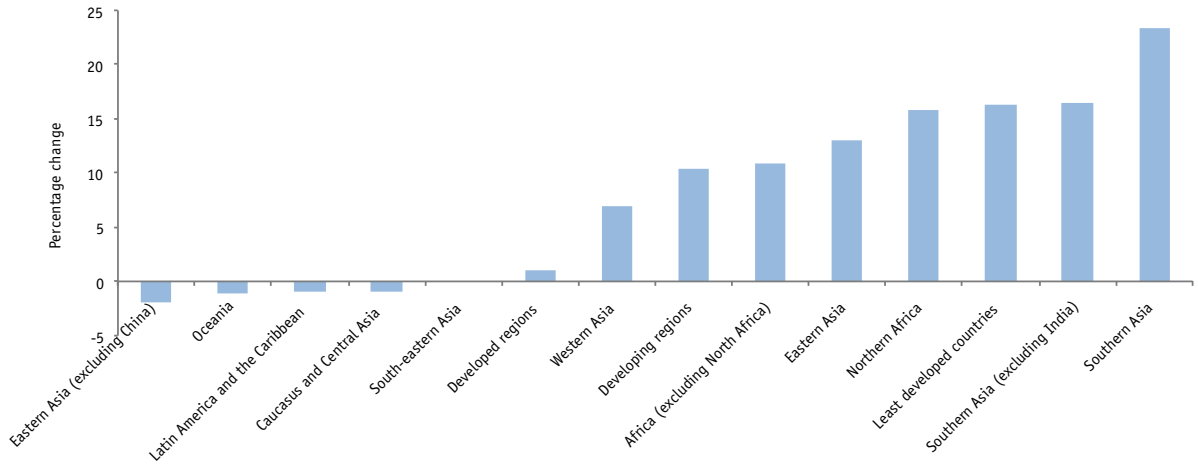
Note: The trend in Lesotho, Mauritius and Namibia is based on effort to balance the gender gap in favour of boys.

(figure 3.3).[16] The continent has, however, performed below the average of the group of least developed countries[17] and Southern Asia.

16 Developed regions have achieved, and are sustaining, gender parity in primary school enrolment.

17 Africa has the majority of such countries – 33 of 48 (UN-OHRLLS, n.d.).

Figure 3.3 Regional change in gender parity in primary school enrolment, 1991–2009



Source: Compiled from UN (2011).

Many countries have secured positive trends from strong advocacy for girls' education, promotion of girl-friendly schools and scholarships for girls. Impediments to progress are too often multidimensional – as seen in Zambia (box 3.1), bottlenecks are at three different levels: among families, patrimonial attitudes prevail; in school, sexual harassment and inadequate girl-friendly sanitation are concerns; and nationally, commitment from the political leadership is still weak.

UN (2011) shows that household income and wealth are important in explaining gender parity in primary education. The gender index is higher among high-income groups and lower among children from low-income groups. Commitment to education, such as the proportion of the national budget devoted to education at all levels and the number of years of compulsory education, are important drivers. Yet in many African countries the quality of education remains low, and as seen earlier, high repetition rates are a manifestation of this.

Advances are less clear for the secondary school ratio

The data lacunae on gender parity in secondary enrolment make it hard to conduct a full analysis and so conclude whether the target will be achieved. In 2009, data were only available for 30 countries and eight of them had surpassed the index of 1.0 (the top eight in figure 3.4). Lesotho, Cape Verde and São Tomé and Príncipe, however, actually need to step up efforts to reverse the trend of disparity against boys in secondary school enrolment. Egypt and Rwanda are very close to achieving gender parity in secondary school. Seven countries scored between 0.8 and 0.94, and the remaining 13 countries less than 0.8.

Ten countries recorded a more than 25 per cent increase in gender parity in secondary school enrolment between 1991 and 2009 – Guinea, Niger and Chad led the performance. Thirteen improved by 1.0–24.9 per cent. Seychelles stagnated (table 3.1). Two of the six countries (Kenya and Madagascar) regressed on the index while four countries

Box 3.1 Zambia has gender parity in primary school enrolment – but must overcome obstacles to sustain progress

The ratio of girls to boys in primary school enrolment rose from 0.90 in 1990 to 0.97 in 2008. As a continuation of this trend, the UNESCO's 2011 *World Atlas of Gender Equality in Education* ranked Zambia one of the countries with parity in primary school enrolment.

The Programme for Advancement of Girls' Education, introduced in 1994, is a major driver of progress. Supported by UNICEF, the Canadian International Development Agency and the Norwegian Agency for Development Cooperation, this Ministry of Education initiative aimed to empower girls and women to fully participate in the nation's economic and social development.

The programme has focused on policy development, capacity building, gender sensitization, material development and research. In addition, it has introduced single-sex classes, strengthened parent–teacher associations, increased the number of women in educational management, introduced girl-friendly curricula, brought in education grants for vulnerable children, and launched advocacy programmes at the community level for girls' education.

Despite these efforts, inequality has persisted. Among families, patriarchal attitudes and beliefs still have major implications for girls' education – the boy rather than the girl is more likely to remain enrolled in school. Thus creating a conducive family environment is vital to keeping girls in school. At school, sexual harassment of girls and provision of adequate sanitation facilities for girls remain priorities.

Provinces with large urban populations outperform those with mainly rural populations. And nationally, a major bottleneck is the lack of institutional commitment and capacity to implement policies on gender equality, particularly in the provinces. Strong commitment from political and traditional leaders is now critical for consolidating progress.

Sources: Mumba (2002); Ministry of Finance and National Planning and UNDP (2011).

(Lesotho, Mauritius, South Africa and São Tomé and Príncipe) reduced the disparity against boys in secondary school enrolment – South Africa, for example, by 11.0 per cent.

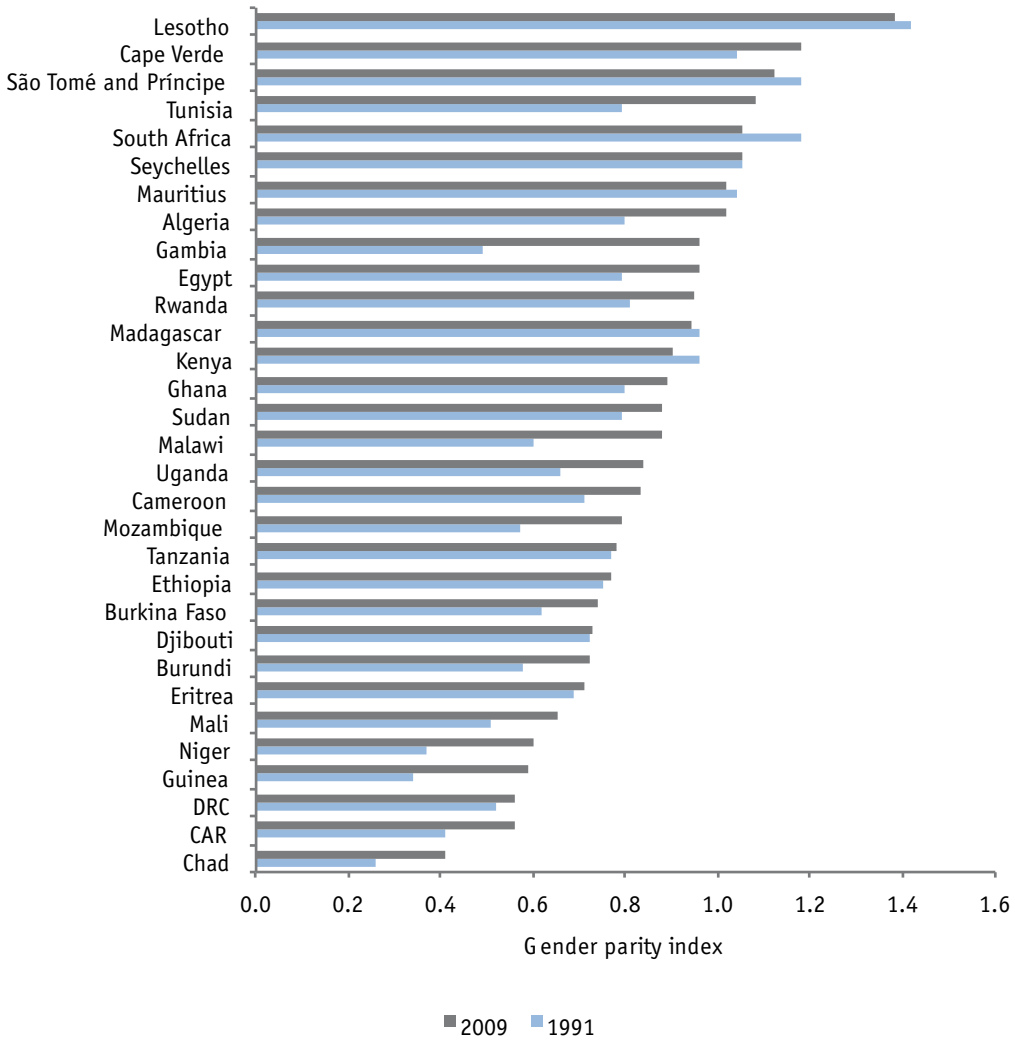
Drop-out rates higher for girls in most African countries

In Africa, the school life expectancy[18] (from primary to secondary school) is higher for boys than girls. Between 1998 and 2009, in Africa (excluding North Africa), the school life expectancy rose from 5.7 years to 8.0 years for girls and from 6.3 years to 8.5 years for boys. Regionally, Africa (excluding North Africa) made the fastest improvement on the gender parity index in school life expectancy during the period, although this was partly because it was – and is – furthest behind (figure 3.5). Six countries achieved parity in school life expectancy – Cape Verde, Lesotho, Malawi, Rwanda, Mauritius and São Tomé and Príncipe. Gambia and Senegal achieved near parity while CAR and Chad had a less than parity index of 0.7.

UNESCO (2012) suggests that girls who transited from primary to secondary school tend to perform better in their studies than boys. This perhaps

18 The average number of years of instruction that a boy or girl entering the system can expect to receive from primary to secondary school. The benchmark is 12 years. Fewer years of schooling indicate a low completion rate or high dropout rate.

Figure 3.4 Gender parity index in secondary school enrolment, 1991 and 2009



Source: Computations from UNSD, accessed December 2011.

Note: Not all countries have 1991 as the reference year. It is 1999 for Burkina Faso, Chad, DRC, Djibouti, Eritrea, Ghana, Kenya, Seychelles and Uganda; 2001 for Cape Verde; 2003 for São Tomé and Príncipe; and 2005 for Madagascar.

accounts for the higher rise in women's participation in tertiary education in many African countries, especially in high-income countries where female students outnumber male students.

In addition to the bottlenecks identified at primary school level, other reasons why access to secondary education can be hard for girls include high repetition and dropout rates. Repetition rates are an indication of the internal inefficiencies of educational systems. Repetition is an important

Table 3.1 Change in gender parity index in secondary education, 1991–2009

Countries with gains of 25% or more		Countries with gains of 0–25%		Countries with declines	
Guinea	73.53	Burundi	24.14	Mauritius	-1.92
Niger	62.61	Egypt	21.52	Madagascar	-2.08
Chad	57.69	Burkina Faso	19.35	Lesotho	-2.82
Malawi	46.67	Rwanda	17.28	São Tomé and Príncipe	-5.08
Mozambique	38.60	Cameroon	16.90	Kenya	-6.25
Tunisia	36.71	Cape Verde	13.46	South Africa	-11.02
CAR	36.59	Sudan	11.39		
Algeria	27.50	Ghana	11.25		
Mali	27.45	DRC	7.69		
Uganda	27.27	Eritrea	2.90		
		Ethiopia	2.67		
		Djibouti	1.39		
		Tanzania	1.30		

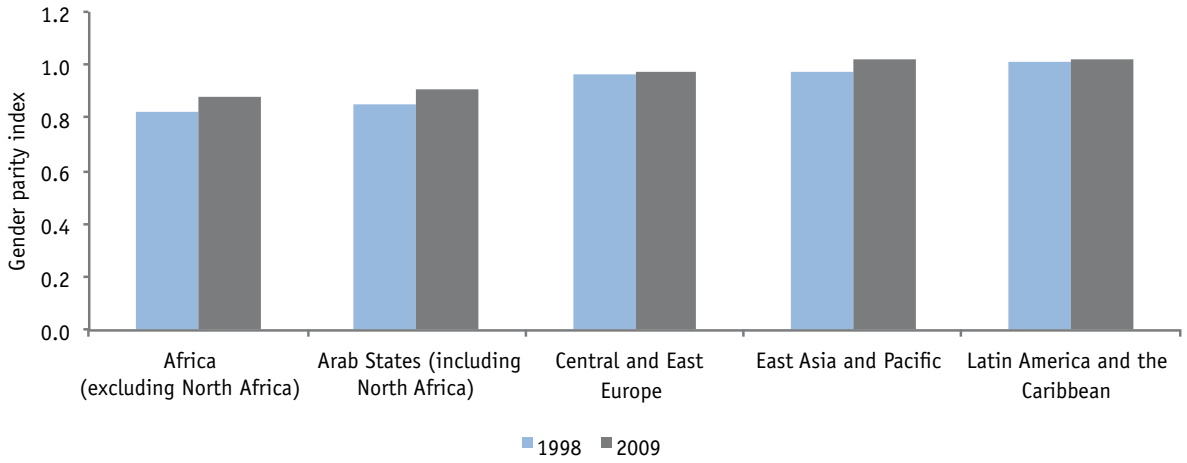
Source: Computations from UNSD, accessed December 2011.

Note: Not all countries have 1991 as the reference year. It is 1999 for Burkina Faso, Chad, DRC, Djibouti, Eritrea, Ghana, Kenya, Seychelles and Uganda; 2001 for Cape Verde; 2003 for São Tomé and Príncipe; and 2005 for Madagascar.

determinant of whether a child enrolled in school will stay in school to complete primary and secondary school. Cultural attitudes and practices that promote early marriage, the seclusion of girls, and the education of boys rather than girls continue to present formidable barriers to gender parity (World Bank, 2010).

Many factors account for girls' high dropout rates in secondary education (Government of Zambia and UNDP, 2011; UNESCO, 2012). First, cultural practices in families and society more widely impose constraints on girls' secondary education. They include domestic responsibilities (chores, care of younger siblings and sick family members), which often reduce girls' time and concentration on studies and related academic work; preference to send boys to school; and pressure on girls for early marriage. Second, vulnerability to violence, in and out of educational settings, and to HIV/AIDS and other diseases is a major constraint. Third, many countries have not developed girl-responsive secondary schools that address issues of sexual harassment from teachers and boys, that ensure an adequate representation of female teachers to serve as role models for girls or that promote gender-sensitive sanitation facilities in most schools. Finally is the perception that, in some countries, the benefits of education do not always translate into jobs. The rising trend of unemployment is also

Figure 3.5 Africa made the fastest progress on the gender parity index for school life expectancy, but still trails



Source: Authors' compilation from UNESCO Institute of Statistics, http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=185.

reducing the value of education to girls in many African societies.

The ratio for tertiary education shows uninspiring gains

Progress on the gender parity index for tertiary education is slow, but very few countries have data for 2009. Out of the 21 countries with such data, three countries (Algeria, Cape Verde and Tunisia) had a gender parity index of more than 1.0, while the index for four countries (Chad, Congo, Eritrea and Niger) was extremely low, at 0.17–0.34 (table 3.2). The best improvement during 1991–2009 was in CAR, Mali, Mauritania and Tunisia. Djibouti, Chad and Congo regressed. Based on the tardy progress, Africa will not achieve gender parity in tertiary education by 2015.

Although progress on tertiary gender parity remains low, tertiary female enrolment has grown almost twice as fast as men's over the last four decades in Africa, made possible by factors such as greater social mobility of girls and women, enhanced income potential and international pressure to narrow the gender gap. High national per capita income has a correlation with low gender disparity in secondary school, and women are more likely to pursue tertiary education in countries with relatively high incomes – and less likely to do so in low-income countries. But low economic and job opportunities tend to discourage tertiary education for women and men.

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

This indicator measures how much an economy diversifies livelihoods from agriculture and informal activities. It is premised on the emerging reality that wage employment is a key element of improving household well-being. Monitoring progress is problematic, though, owing to paucity

Table 3.2 Tertiary enrolment parity and percentage change in gender parity index in tertiary education

Parity index in 2009		Percentage change, 1991–2009	
Chad	0.17	Djibouti	-34.29
Congo	0.21	Chad	-5.56
Eritrea	0.32	Congo	-4.55
Niger	0.34	Madagascar	9.76
Mali	0.41	Niger	13.33
Mauritania	0.41	Cameroon	23.44
CAR	0.43	Senegal	26.09
Burkina Faso	0.49	Cape Verde	29.59
Senegal	0.58	Kenya	29.63
Ghana	0.62	Algeria	33.33
Djibouti	0.69	Morocco	51.72
Kenya	0.70	Rwanda	56.25
Rwanda	0.75	Burkina Faso	63.33
Cameroon	0.79	Eritrea	100.00
Uganda	0.80	Ghana	106.67
Morocco	0.88	Uganda	110.53
Madagascar	0.90	Tunisia	131.82
São Tomé and Príncipe	0.93	Mauritania	141.18
Cape Verde	1.27	Mali	156.25
Algeria	1.44	CAR	186.67
Tunisia	1.53		

Source: Computations from UNSD, accessed December 2011.

Note: The reference year ranges from 1991 to 2006 (1999 for Djibouti and Eritrea, 2000 for Chad and Kenya, 2001 for Rwanda, 2002 for Cameroon, 2003 for Niger, 2004 for Algeria and 2006 for Senegal. Others are 1991.

of information – very few countries have recent data for this indicator.

African women's employment in the non-agricultural wage employment is low relative to other regions of the world (UN, 2011). In 2009, the share stood at 18.8 per cent in North Africa and 32.6 per cent in the rest of Africa compared with 43.0 per cent in Latin America and the Caribbean and 41.7 per cent in Eastern Asia. Africa (excluding North Africa) is, however, doing relatively well in its rate of change, second only to Southern Asia (figure 3.6). North Africa regressed.

Cultural impediments are key to this low trend. As in many other African countries, evidence from Mozambique shows that women's labour market participation and access to particular jobs are constrained and shaped by the relations of power within existing "patriarchal bargains" – that is, when women negotiate with either their husbands or fathers) (Oya and Sender, 2009). ILO (2010a) also points out male breadwinner bias as another bottleneck. Box 3.2 provides international perspectives on factors propagating women's concentration in poorly paid and vulnerable jobs.

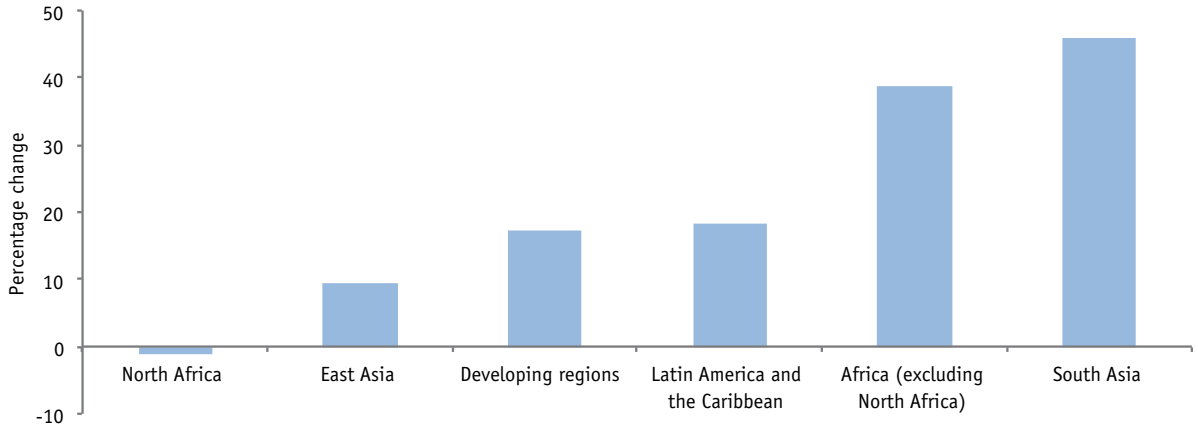
Beyond limited economic opportunities, these factors drive women into informal activities – the most important source of employment for women in Africa (excluding North Africa). This is supported by Arbache (2010), who finds that, in most African countries, women are almost twice as likely as men to be in the informal sector and about half as likely to have a public or private formal job.

Trading activities provide about 60 per cent of non-agricultural self-employment for women (UN Women, 2010). In Senegal, for instance, sustainable forestry generates about $12.5 million a year, with women driving one third of this performance. In Madagascar, women's membership in microfinance networks increased from 15 per cent in 1999 to 45 per cent in 2006 (World Bank, 2011b).

While low-wage, vulnerable employment often presents itself as a first step towards better paid work, especially for young workers and women, it can also become a trap from which workers find it hard to extricate themselves, largely owing to a lack of opportunities for developing skills. With low productivity, insecurity of income and poor working conditions, such employment mainly serves as a coping mechanism during periods of minimal jobs. However, its capacity to take people out of poverty is limited. Efforts should therefore be directed at enhancing the sector's productivity and improving its working conditions.

Women's share of employment varies by production sector. It is higher than men's in services; the converse holds for industry. In North Africa, female

Figure 3.6 Change in share of women in wage employment outside agriculture, 1990–2009



Source: Compiled from UN (2011).

Box 3.2 Factors propagating women's concentration in vulnerable employment

There have been several explanations for why women are more often in vulnerable employment. Based on experience across the world, they can be grouped into four strands.

Women's work may be undervalued because women's economic lives follow different patterns from men's. Several factors account for low valuation: low valuation of skills and status (mothers and caregivers), the assumption that women are second earners (male partners' wages constitute a large share of household income), women's concentration in low-paying firms or low value-added industries in the secondary labour market, and a perception that women's lives follow different patterns from men's, which therefore pushes them to poorly remunerated forms of work.

Women tend to have a lower reservation wage than men. This is often reflected in gender bias in eligibility rules for unemployment benefits and social protection, insufficient maternity protection and gender inequality in dependence on family income, especially during childbearing. These factors weaken women's wage-bargaining position.

Gender bias in wage-setting institutions weakens women's pay prospects. Female-dominated sectors and occupations are shaped by lack of collective bargaining power, weakening their pay prospects. Even where they do have such power, collective bargaining in such sectors often secures only lower national minimum wages.

Women are often disadvantaged by independent workplace practices. This is propagated by such practices as employers' ability to pay different wages by the gender composition of the workplace, the often-monopolistic power of employers, barriers to women's mobility and outsourcing of low-skill activities.

Sources: Authors' compilation from Grimshaw (2010) and ILO (2010b).

industrial employment declined from 2000 to 2011 (figure 3.7). The wide disparity in the female–male employment ratio in industry and services could be an indication of greater job opportunities in services relative to other sectors of the economy.[19]

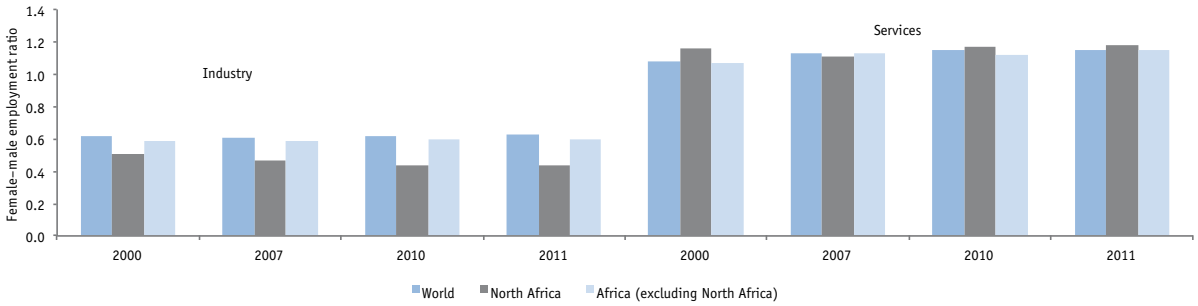
Only 31 countries have comparable data on the share of women in wage employment outside agriculture since 2000. Of these, Ethiopia, CAR, Botswana and South Africa have the highest ratios, Senegal, Liberia, Algeria and Libya the lowest (figure 3.8). One way for national statistical authorities to step up efforts to generate regular and consistent data on this indicator would be to integrate gender wage employment into national household surveys.

Gender wage disparities persist in many African countries, even for similar work (figure 3.9). Although many countries have adopted minimum wage policies, very few have explicit policies designed to counter female wage discrimination – it should take centre stage.

There seems to be an inverse relationship between the share of female non-agriculture wage employment and growth of incomes/salaries. A correlation analysis between non-agriculture wage employment and growth of per capita income on

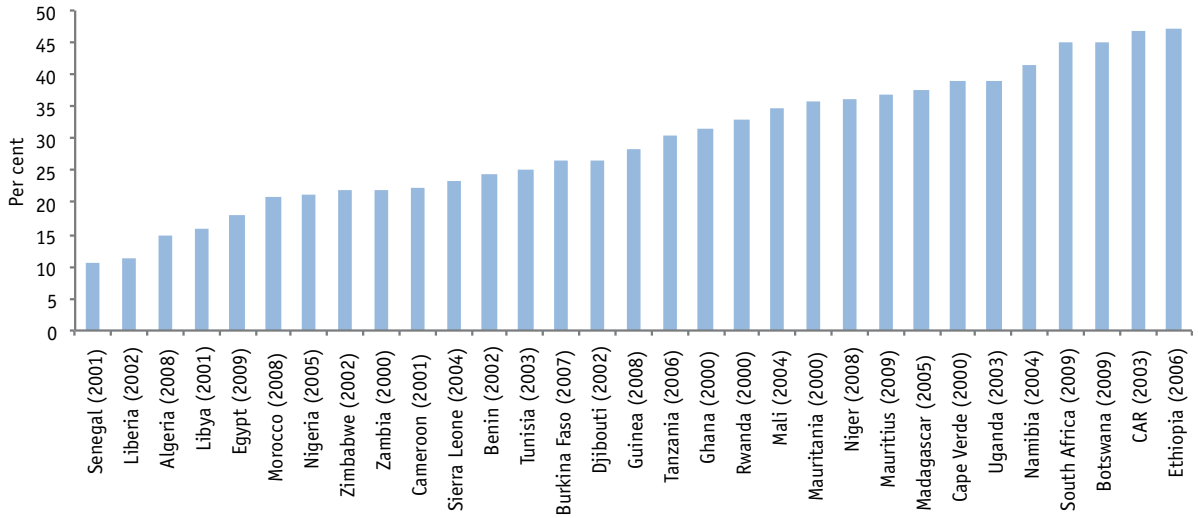
19 This could possibly be due to women's limited skills and gender discrimination in industrial jobs, making services the last option.

Figure 3.7 Female–male employment ratio, industry and services, 2000s



Source: Authors' calculations based on ILO (2012).

Figure 3.8 Share of women in wage employment outside agriculture, 2000–2010



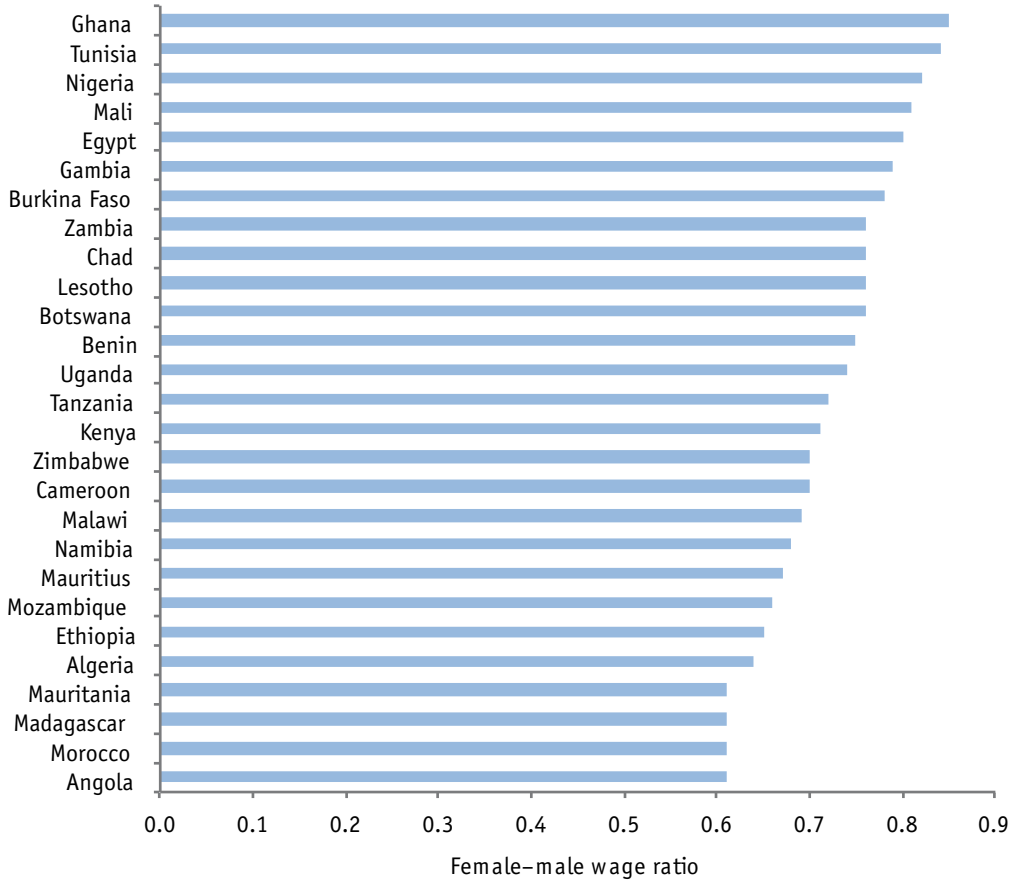
Source: Computations from UNSD, accessed December 2011.

the one hand, and the female–male wage ratio on the other, reveals correlation coefficients of -0.068 and -0.210, respectively.[20] Although the coefficient is low, it suggests the need for governments to ensure that women do not lose out in job markets as wages become more equal between men and women and as per capita income grows.

Arbache (2010) identifies three key factors in explaining the dynamics of women's participation in job markets in Africa: limited job opportunities; differences in education; and power dynamics in households. The research finds little evidence to support labour market discrimination against

20 A correlation coefficient provides a predictive relationship between two variables or factors. A positive correlation index shows that as one variable or factor increases, the second variable also rises. When it is negative, it implies an inverse relationship – for example, a rise in the female–male wage ratio (for similar work) reduces the share of women in non-agricultural employment.

Figure 3.9 Female–male wage ratio for similar work, 2007



Source: Compiled from World Bank, http://data.worldbank.org/data-catalog/gender-statistic, updated April 2011.

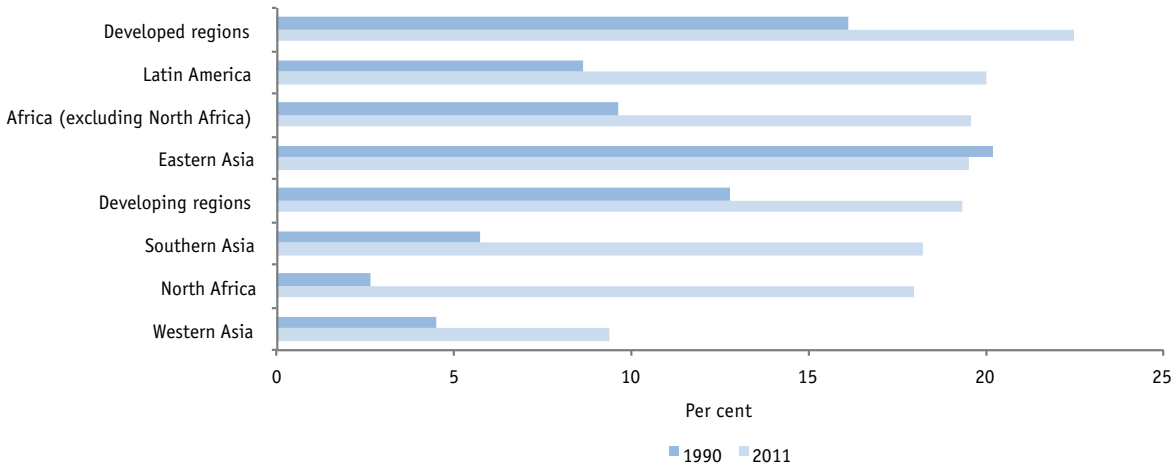
women. Nonetheless, gender disparities in labour market participation tend to be higher in countries with fewer job opportunities. Promoting women's employment outside agriculture will require generating productive and decent jobs, improving labour market functioning, creating job opportunities for women (including enabling women to access higher skilled jobs), subsidizing social services to enable more women to have more time to participate in remunerative economic activities, and addressing cultural practices that discriminate against girls' education or that create imbalances in household power dynamics.

Indicator 3.3: Proportion of seats held by women in national parliament

Steady progress by most countries

Africa is making steady progress on this indicator relative to other developing regions. Its rate in 2011 was surpassed only by Latin America and developed regions (figure 3.10). North Africa showed the fastest growth among regions from 1990 to

Figure 3.10 Proportion of seats held by women in national parliament, 1990 and 2011



Source: Compiled from UN (2011).

2011. The adoption of legal frameworks that guarantee seats for women in the national parliament (as in Egypt, Rwanda, South Africa and Uganda) was one key driver. Political parties, too, have a strong role to play in accelerating and deepening gender inclusiveness in politics at local, regional and national levels.

What is the performance at country level? Data for the proportion of women in national parliaments are available for 53 countries.[21] Progress is positive, but with extreme outliers. For instance, seven countries have reached the target of 30 per cent women in the national parliament – Rwanda, South Africa, Mozambique, Angola, Tanzania, Burundi and Uganda. Three countries are very close to reaching the target: Ethiopia, Tunisia and Sudan (table 3.3). Countries with the fastest growth after 1990 (at over 500 per cent) include Morocco, Mauritania, South Africa, Ethiopia, Kenya and Tunisia (figure 3.11). Forty-four countries had made progress by 2011.

Yet 15 countries still have fewer than 10 per cent of women in the national legislature. Countries that regressed are Niger, Chad, Guinea Bissau, Congo, Equatorial Guinea, Ghana, Cameroon and Comoros.

An important driver of progress is the adoption of legal frameworks for a minimum number of women representatives in parliament. Progress in Uganda, for example, has been helped by the provision for 69 women representatives in the national parliament – about 22 per cent of the total. Women can also participate in the 215 seats allocated for members directly elected to represent constituencies and be among the 25 representatives of Special Interest Groups (Electoral Commission, 2006). Recent gains in Egypt and Mauritania, too, can be attributed to legal provisions. Mauritania

21 The reference year varies, with a default of 1990. Otherwise, it is 1997 for Burkina Faso, Chad, Eritrea, Ethiopia, Lesotho, Liberia, Mali, Mauritania, Sierra Leone and Tanzania; 1998 for Ghana; 1999 for Burundi; 2001 for Nigeria; and 2006 for Libya. For Guinea it is between 1997 and 2008 – the constitution is suspended. The date point ended in 2010 for Niger and CAR. Computations from UNSD, accessed December 2011.

Table 3.3 Proportion of seats held by women in national parliament, 2011

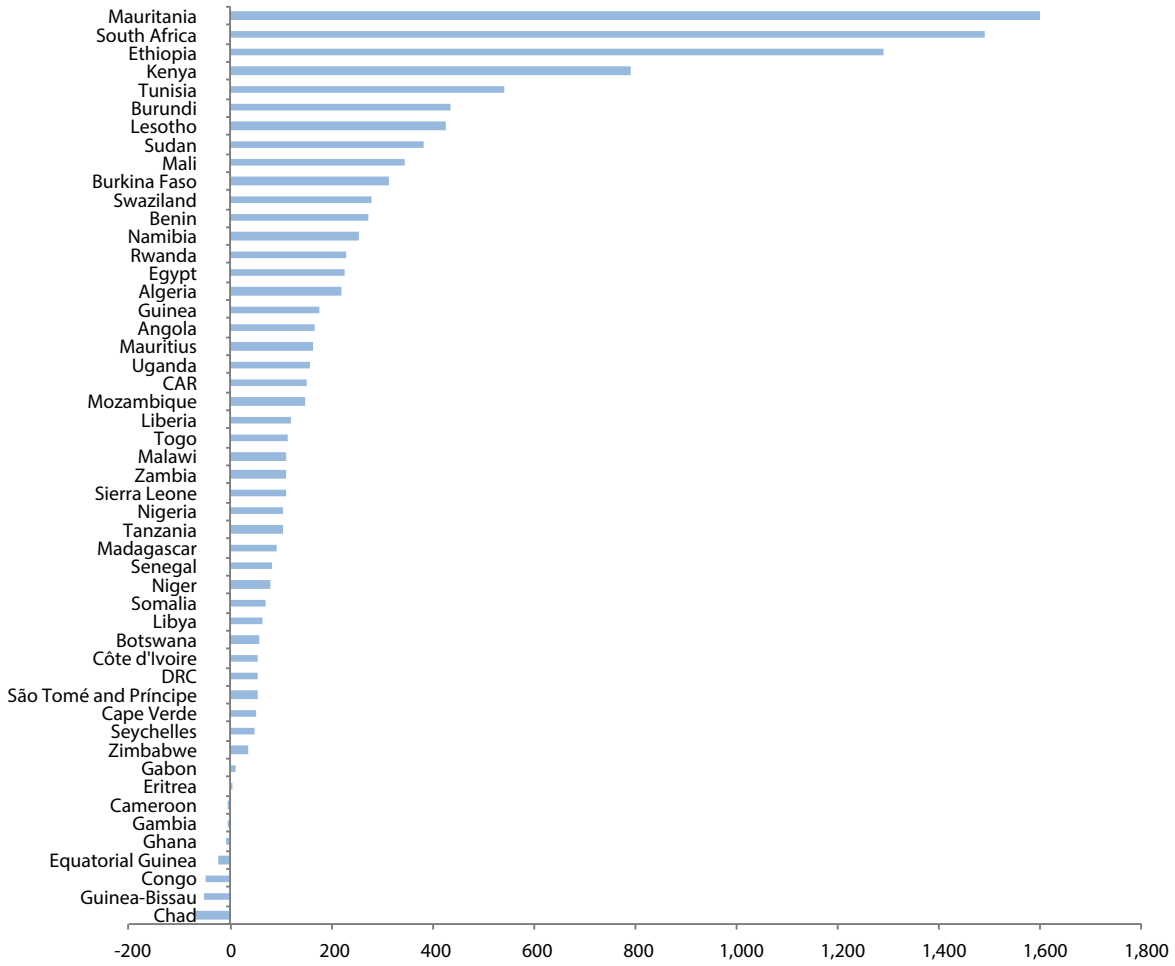
Countries with 30% or more of women in national parliament		Countries with between 20% and 30% of women in national parliament		Countries with between 10% and 20% of women in national parliament		Countries with between 10% or fewer of women in national parliament	
Uganda	31.3	Malawi	20.8	Equatorial Guinea	10	Comoros	3
Burundi	32.1	Eritrea	22	Guinea-Bissau	10	Chad	5.2
Tanzania	36.0	Mauritania	22.1	Mali	10.2	Somalia	6.8
Angola	38.6	Senegal	22.7	Morocco	10.5	Nigeria	7
Mozambique	39.2	Seychelles	23.5	Benin	10.8	Congo	7.3
South Africa	44.5	Lesotho	24.2	Togo	11.1	Gambia	7.5
Rwanda	56.3	Namibia	24.4	Liberia	12.5	Algeria	7.7
		Sudan	25.6	Madagascar	12.5	Libya	7.7
		Tunisia	27.6	Egypt	12.7	Botswana	7.9
		Ethiopia	27.8	Sierra Leone	13.2	Ghana	8.3
				Swaziland	13.6	DRC	8.4
				Djibouti	13.8	Côte d'Ivoire	8.9
				Cameroon	13.9	CAR	9.6
				Zambia	14	Niger	9.7
				Gabon	14.7	Kenya	9.8
				Zimbabwe	15		
				Burkina Faso	15.3		
				Cape Verde	18.1		
				São Tomé and Príncipe	18.2		
				Mauritius	18.8		
				Guinea	19.3		

Source: Computations from UNSD, accessed December 2011.

provides a good case for affirmative action and how to address cultural impediments to progress (box 3.3).

Although political participation (as measured by the seats held by women in national parliaments) in many African countries is comparable to elsewhere in the world, there is scope for strengthening their political empowerment (as measured by the ratio of women to men in ministerial positions and the ratio of women to men in parliamentary positions).

Figure 3.11 Change in proportion of seats held by women in national parliament



Source: Computations from UNSD, accessed December 2011.

Five African countries rank among the best 30 countries globally on political empowerment – South Africa, Mozambique, Angola, Uganda and Tanzania. (Egypt and Algeria are among the lowest ranked in Africa – WEF, 2011). Similarly, three of these countries also rank among the best 30 countries on the Global Gender Gap Index: the top five African countries are Lesotho, South Africa, Burundi, Mozambique and Uganda.[22] (Chad, Mali, Côte d'Ivoire, Morocco, Benin, Egypt and Algeria are among the worst countries on that index.) Southern African countries generally rank better than countries from, for example, North and West Africa.

22 This index examines the gap between men and women in four critical areas of empowerment: economic participation and opportunity, educational attainment, health and survival and political empowerment (WEF, 2011).

Box 3.3 Mauritania made the most rapid progress in women participation in politics in Africa between 1990 and 2010, yet the need to address emerging impediments is obvious

The July 2006 act that mandated a minimum quota of 20 per cent women's representation in municipal and legislative bodies ushered in a new era in the Mauritanian political landscape for women. The proportion of seats held by women in the national parliament reached 18 per cent in 2007, up from nothing in 1992 and 4 per cent in 2003.

Yet the most significant progress was local. In the 2007 municipal council elections, 1,120 seats out of 3,688 seats were held by women – about 30 per cent – against 18 per cent of national parliamentary seats. Only three women (out of 27) are ministers, however.

The transformation can be linked particularly to the lobbying role of women leaders from political parties and civil society, which led to the quota. A broad-based media campaign that included the production of a documentary, TV and radio programmes (to raise awareness of the importance of women in politics) also contributed.

Although an important milestone, the quota is not an end for women's empowerment in Mauritania. Many of the elected and appointed female politicians are not used to speaking out or making decisions publicly and are still finding it challenging to advocate for issues that will advance gender equality and women's empowerment.

Breaking cultural barriers and training women to be good leaders on how to lobby for change and to take the lead in political decisions are important for consolidating current successes – and moving forward. For the transformation to have an overarching impact on society, quotas should be extended to public services and the judiciary, without compromising merit.

Sources: Islamic Republic of Mauritania and UNDP (2010); NDI (2007); WLP (2008).

Conclusions

Performance on this goal is encouraging. Some countries have made excellent progress, although the initial low level of some of the indicators in the 1990s is the major impediment to faster advances relative to other regions of the world. Paucity of data makes measurement problematic.

For sustained gains, it is important to focus on cultural practices that hold back women's empowerment. Examples from North Africa show that cultural transformation can be achieved – Egypt, Sudan and Tunisia with political empowerment and Algeria and Tunisia with gender parity in secondary education. With determined advocacy on such empowerment's importance in face of the need to transform cultural impediments, it is possible to create awareness that girls and women are able to perform the same tasks as boys and men. In similar vein, policy changes should address factors that discourage women from attending and completing a full course of education – confronting factors that promote early marriage, the seclusion of girls and the education of boys rather than girls – and should promote women's participation in productive economic activity and politics.

Boosting women's participation in wage employment requires a range of measures to improve conditions and widen their opportunities in the labour market. Specifically, efforts to eliminate all socio-cultural impediments to girls' education and increase women's access to productive and financial resources (such as legally guaranteeing land rights for both men and women) are vital to enhancing women's wage employment. On the data front, national statistical institutions need to strengthen their capacity to generate and analyse regular gender-disaggregated labour market statistics, as a basis for gender-sensitive policymaking.

Deliberate efforts at enhancing the status of women through involving and committing the top political class are vital. Beyond allocating resources – financial and social capital – explicitly passing and enforcing laws are pivotal steps. Indeed, affirmative actions and explicit constitutional provisions for dealing with gender-based discrimination have advanced women's positions in Ethiopia, Mozambique, Rwanda, South Africa, Tanzania and Uganda. But such actions are a means to achieve gender equality and women's empowerment, not an end. To link gender equality to sustained development, Africa should go beyond participation to "capacitation".

Finally, in the political realm, efforts are needed to break the socio-cultural impediments that hinder women's political participation through training and advocacy on how women can enhance their leadership role and contribute fully to public debate and policy decisions.

Goal 4: Reduce child mortality

Child mortality is deeply interlocked with all the other MDGs: extreme poverty, gender inequalities in education, inadequate sexual health education for girls and women, the spread of HIV/AIDS and other diseases, and non-sustainable environmental practices. Each one is a major contributor to poor and dangerous living conditions for children.

The world has made substantial progress towards MDG 4. The latest figures for under-five mortality from the UN Inter-agency Group for Child Mortality Estimation show a 35 per cent decline in the global rate, from 88 deaths per 1,000 live births in 1990 to 57 in 2010. The number of children under five dying each year worldwide declined from more than 12 million in 1990 to 7.6 million in 2010, although the falls are uneven across regions.

Of the 26 countries worldwide with under-five mortality rates above 100 deaths per 1,000 live births in 2010, 24 are in Africa. Nevertheless, Africa (excluding North Africa) doubled its average rate of reduction in child mortality from 1.2 per cent a year in 1990–2000 to 2.4 per cent in 2000–2010. Madagascar, Malawi, Eritrea, Liberia, Niger and Tanzania are the best performing countries, with falls of at least 50 per cent in 1990–2010 (UNSD, 2011). The overall rate of decline is not enough, however, for Africa to meet the goal by 2015, and under-five mortality remains alarmingly high in the continent.

Still, it is possible to accelerate the rate of decline by further expanding interventions that target the main causes of death as well as the most vulnerable newborn and children. Thus efforts need to be intensified in reducing neonatal mortality (deaths during the first 28 days of life), because the rate of decline in neonatal mortality is generally slower than that among older children. According to UN (2011), children from rural and remote areas, as well as those who are marginalized, vulnerable and living in the poorest households, are still at a disadvantage. Scaling up health services and addressing the challenges that hinder their use, as well as prioritizing prevention and treatment of childhood illnesses, improved nutrition, immunization coverage, and water and sanitation are important to promoting universal access to services and reducing health inequalities.

Well-functioning health systems require a robust health management information system that can provide evidence for prioritizing these interventions. Producing accurate estimates of child mortality remains a considerable challenge owing to the lack of fully functioning vital registration systems that accurately record all births and deaths in most African countries, especially those with deep cultural issues surrounding child mortality. Along this line, African countries have supported the African Programme on Accelerated Improvement of Civil Registration and Vital Statistics and related regional medium-term plans. The programme requires greater support, however, to produce high-quality statistics for monitoring progress on health-related targets.

Target 4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicator 4.1: Under-five mortality rate

Four diseases kill half of all children under five

The four main global killers of children under-five are pneumonia (18 per cent), diarrhoeal diseases (15 per cent), pre-term birth complications (12 per cent) and birth asphyxia (9 per cent). Malnutrition is an underlying cause in more than a third of under-five deaths.

Malaria is still a major cause of child mortality in Africa (excluding North Africa), causing about 16 per cent of under-five deaths (UNICEF, 2011b). Special efforts to control pneumonia, diarrhoea, malaria and malnutrition, with effective comprehensive interventions reaching the most vulnerable and marginalized children, could save the lives of millions of children.

Neonatal mortality is of particular interest both because the health interventions needed to address the major causes of such deaths generally differ from those for other under-five deaths, and because the proportion of neonatal under-five deaths is rising (as under-five mortality declines). This increase is due to lack of highly cost-effective interventions, such as early post-natal home visits and case management of neonatal infections that are feasible even at community level and that are linked to preventive and curative interventions for mothers and for babies (UNICEF, 2011b).

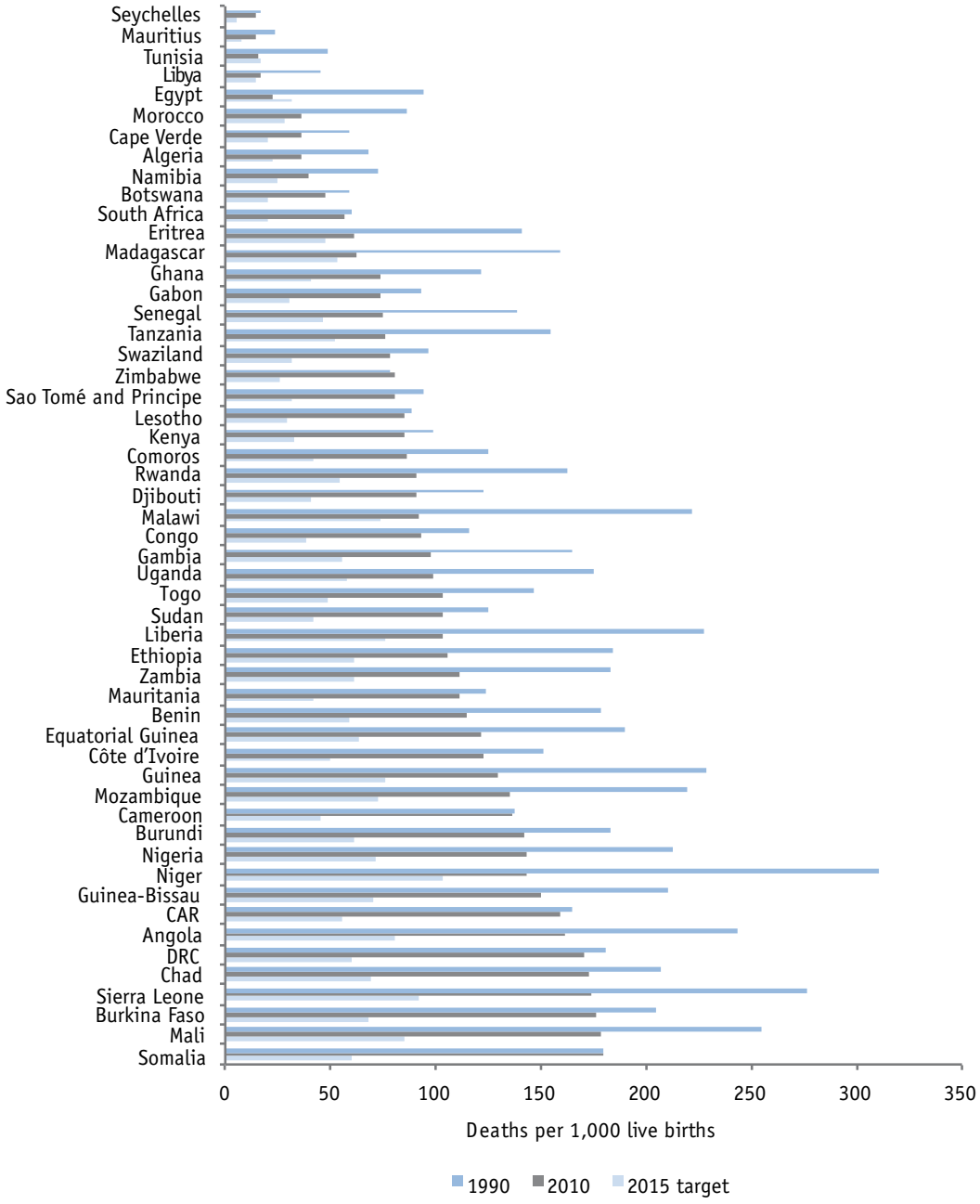
Significant progress in under-five mortality by African countries has been registered (figure 4.1), although continental progress is slow. Egypt has already surpassed the target, and Tunisia has achieved it. The top five on-track countries are Libya, Mauritius, Morocco, Seychelles and Madagascar.

In contrast, Somalia, DRC, Burkina Faso, Chad and CAR are far from reaching the target. Progress is very slow in Cameron, CAR, Lesotho, South Africa and DRC (a less than 10 per cent improvement in the period). The slow progress in Southern Africa can be attributed to the high prevalence of HIV/AIDS in the sub-region; that in Central Africa to the relatively high prevalence of malaria there (appendix 2).

In Zimbabwe, under-five mortality rose slightly between 1990 and 2010. The country's unprecedented economic decline saw spiralling inflation, deteriorating physical structures and, in 2008, the inability of the public sector to deliver basic social services. The country has faced severe public human resource capacity constraints, in health particularly. The consequences were further reflected in a major outbreak of cholera in 2008–2009 and an outbreak of measles in 2009–2010. The rise in child mortality is also attributed to the direct and indirect impacts of the HIV/AIDS epidemic and the concomitant rise in poverty owing to economic difficulties (Ministry of Labour and Social Services of Zimbabwe and UNDP, 2010).

In Africa (excluding North Africa), diarrhoea, malaria and pneumonia are responsible for more than half the deaths of children under five, and malnutrition is an underlying cause of a third of these. Children from rural and the poorest households are still at a disadvantage.

Figure 4.1 Progress in reducing the under-five mortality rate, 1990, 2010 and 2015 target



Source: Computations from UNSD, accessed December 2011.

The continent as a whole is unlikely to meet the under-five mortality target on current trends. Intensified efforts by African governments and their development partners, with full community participation, are crucial to scale up interventions to reduce the rate. Highly cost-effective interventions are feasible even among communities, and most of them can be linked to preventive and curative interventions for mothers and babies.

Under-five mortality is higher in Africa (excluding North Africa) than in other regions (figure 4.2). The average annual rate of reduction was only 1.8 per cent during 1990–2010, for a 30 per cent decline.

Africa (excluding North Africa) contributed the largest proportion of global under-five deaths in the world, followed by Southern Asia, in 2010. The rest of the world accounted for only 18 per cent. In Africa (excluding North Africa), one in around eight children die before the age of five (121 deaths per 1,000 live births), nearly twice the average in developing countries overall and more than 17 times the average in developed countries.

These unacceptably high rates in Africa (excluding North Africa) and in Southern Asia have held back global progress. But there is increasing evidence that MDG 4 can be achieved if high priority is given to targeting the major killers of children such as pneumonia, diarrhoea, malaria and malnutrition, using preventative and curative interventions (UNICEF, 2011b).

Although slow, under-five mortality shows a declining trend in all African regions (figure 4.3). North Africa showed the most progress at 49 per cent followed by Southern Africa (35 per cent) and West Africa (34 per cent). Their progress is attributed to innovative approaches to delivering interventions in areas with poor access to health, increased immunization, exclusive breast-feeding, vitamin and mineral supplementation, stronger malaria prevention and treatment, improvements in water and sanitation, and fighting pneumonia and diarrhoeal disease – the two biggest killers of children.

Progress is slowest in Central Africa, attributable to the high prevalence of malaria. West Africa and Central Africa had the highest under-five mortality rates in 2010.

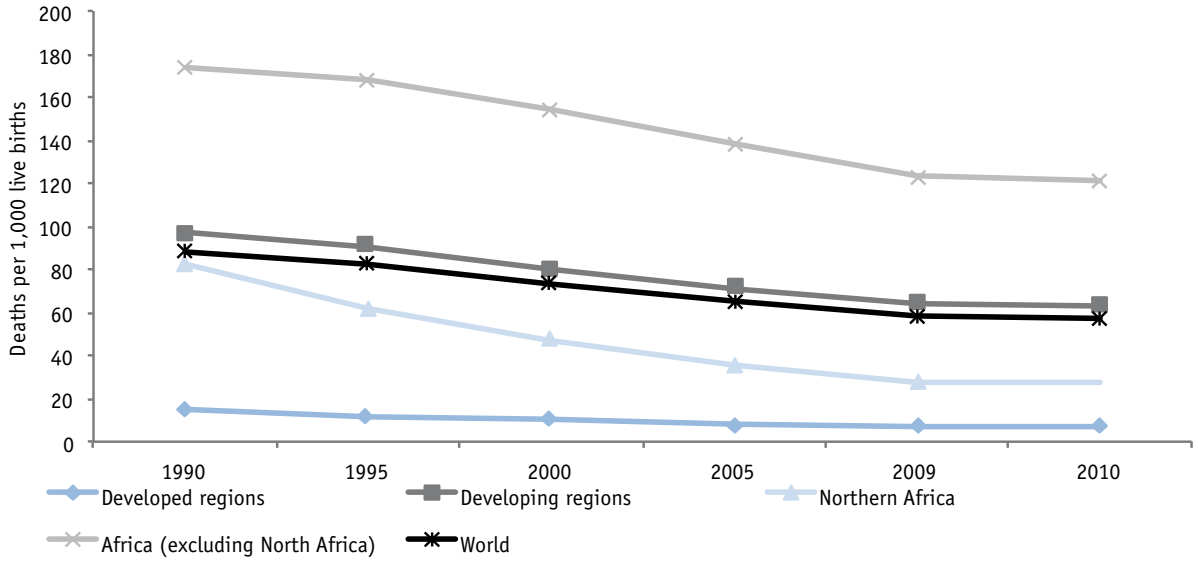
Indicator 4.2: Infant mortality rate

Progress in infant mortality is driven by improved immunization

The infant mortality rate is the number of deaths of young children under one year of age per 1,000 live births in a given year. This rate is often used as an indicator of the health status of a country. Globally, more than 40 per cent of under-five deaths occur within the first month of life, and over 70 per cent in the first year. Interventions in that first month have a direct bearing on children surviving to their first birthday.

The continent registered a reduction of the infant mortality rate from 99 deaths per 1,000 live births in 1990 to 71 in 2010 – a 28.3 per cent fall. All African countries (bar Somalia) saw declines, of 1–72 per cent. The eight best performing countries, all of which lowered their rates by at least 50 per cent in the period, were Egypt, Tunisia, Libya, Malawi, Madagascar, Morocco, Eritrea and Liberia (table 4.1).

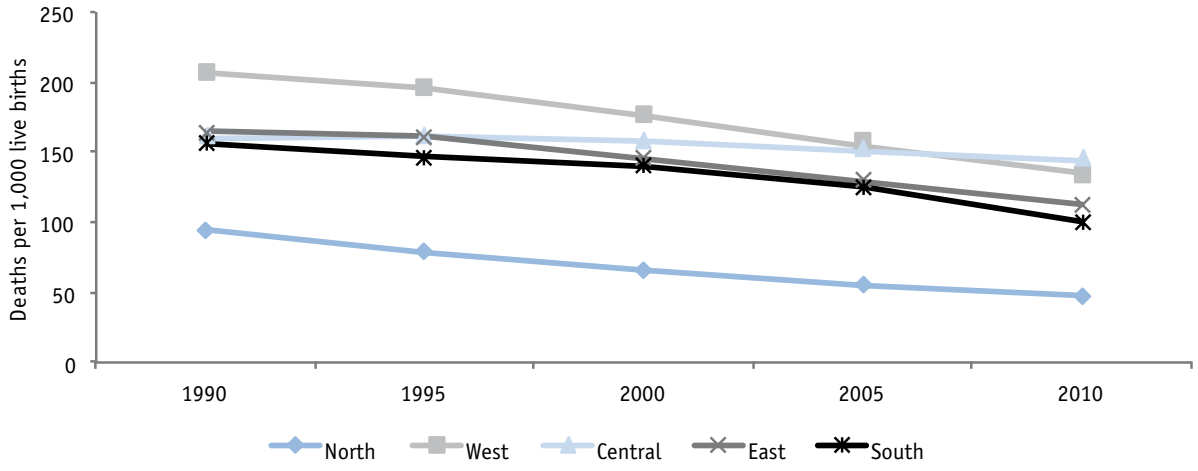
Figure 4.2 Under-five mortality by region, 1990–2010



Source: Compiled from UNICEF (2011b).

Twenty-three countries recorded a 25–50 per cent reduction, and 15 countries a fall of 10–25 per cent. Burkina Faso, Cameroon, CAR, DRC, Lesotho, Mauritania, Somalia and Zimbabwe were the worst performing countries, with less than 10 per cent reductions.

Figure 4.3 Under-five mortality by African sub-region, 1990–2010



Source: Computations from UNSD, accessed December 2011.

Note: The data are weighted by population aged 0–4.

Table 4.1 Reductions in infant mortality, 1990–2010

At least 50%		25–50%		10–25%		Less than 10%	
Egypt	72.1	Tanzania	47.4	Mali	24.4	Lesotho	9.7
Tunisia	64.1	Niger	44.7	Togo	24.1	Burkina Faso	9.7
Libya	60.6	Algeria	43.6	Djibouti	23.2	Mauritania	6.3
Malawi	55.7	Namibia	40.8	Botswana	21.7	DRC	4.3
Madagascar	55.7	Uganda	40.6	Swaziland	21.4	CAR	3.6
Morocco	55.2	Rwanda	40.4	Gabon	20.6	Zimbabwe	1.9
Eritrea	51.7	Guinea	40.0	Burundi	20.0	Cameroon	1.2
Liberia	51.0	Ethiopia	38.7	Côte d'Ivoire	18.1	Somalia	0.0
		Mauritius	38.1	Congo	17.6		
		Mozambique	37.0	Sudan	15.4		
		Cape Verde	37.0	Seychelles	14.3		
		Zambia	36.7	Kenya	14.1		
		Ghana	35.1	São Tomé and Príncipe	13.1		
		Angola	31.9	South Africa	12.8		
		Benin	31.8	Chad	12.4		
		Equatorial Guinea	31.4				
		Nigeria	30.2				
		Sierra Leone	29.6				
		Senegal	28.6				
		Comoros	28.4				
		Gambia	26.9				
		Guinea-Bissau	26.4				

Source: Computations from UNSD, accessed December 2011.

The four countries with the highest rates of infant mortality (above 100 deaths per 1,000 live births) in 2010 were Sierra Leone (114), DRC (112), Somalia (108) and CAR (106) – all countries either in conflict or recovering after conflict.

The relatively successful progress in infant mortality may be attributed to focused interventions, such as free immunization campaigns. Much more, though, needs to be done to reach the target. In particular, efforts to reduce neonatal mortality need to be increased as the rate of decline for that age group is slower (19.5 per cent during 1990–2010) than for older children.

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

Immunization is improving but equity needs more work

Measles is a viral respiratory infection that attacks the immune system. It is highly contagious, and children who are not immunized may suffer from the disease when exposed. Unvaccinated children under the age of five are most at risk (UNICEF, 2011c).

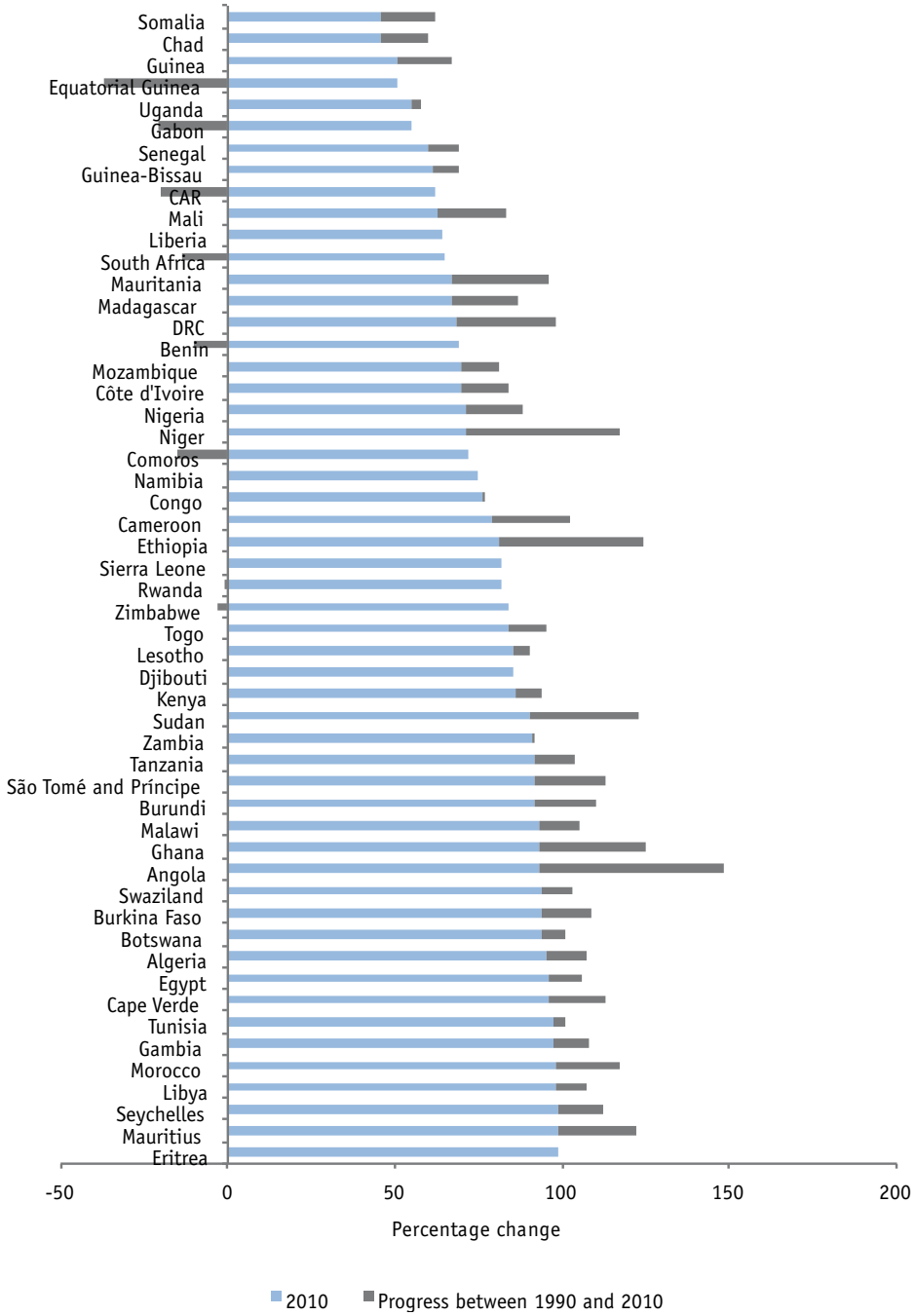
In an effort to stem preventable loss of life among children, African countries have made huge efforts to immunize children against measles. Coverage has increased in most African countries, but rates vary widely (figure 4.4).

Twenty-one countries registered immunization rates above 90 per cent in 2010. Only two countries (Chad and Somalia) reported coverage below 50 per cent. Seven countries showed slight declines in coverage during 1990–2010.[23] Most of these countries also performed poorly in reducing under-five mortality. The top five performing countries – expanding their measles immunization coverage by at least 30 percentage points between 1990 and 2010 – were Angola, Niger, Ethiopia, Sudan and Ghana.

Many of the poorest, most marginalized children, especially in hard-to-reach areas, have been left behind, however. Attaining the 2015 goal requires wider measles immunization coverage in countries with weak health infrastructure, sustained high-quality campaigns and full implementation of the measles control strategy in Africa.

23 Comoros, Benin, South Africa, Zimbabwe, CAR, Gabon and Equatorial Guinea.

Figure 4.4 Proportion of one-year-old children immunized against measles in 2010 and percentage change, 1990–2010



Source: WHO (2011d).

Note: No data for Eritrea, Liberia, Namibia and Sierra Leone in 1990.

Conclusions

Most African countries have registered large gains on all the MDG 4 indicators, although the continental rate of progress is too slow to achieve the goal by 2015. And despite steady progress in reducing under-five deaths, children from rural and poorer households remain disproportionately affected.

As most child deaths are preventable or treatable, African countries should revitalize a comprehensive and integrated effort against the main diseases that cause child mortality, such as measles, pneumonia, diarrhoea, malaria and HIV/AIDS. Accelerating the decline in under-five mortality is possible by expanding interventions that target the main causes of death and the most vulnerable newborn babies and children. Empowering women, removing financial and social barriers to accessing basic services, launching innovations that make the supply of critical services more available to the poor and increasing local accountability of health systems are all policy interventions that will allow health systems to improve equity and reduce mortality.

Goal 5: Improve maternal health

Maternal health is still a grave concern for most of Africa. The continent's average maternal mortality ratio (MMR) was 590 deaths per 100,000 live births in 2008. This means that, in 2008, a woman in Africa died as a result of pregnancy or childbirth every 2.5 minutes – 24 an hour, 576 a day, and 210,223 a year (UN, 2011).[24]

The link between other MDGs and maternal mortality is important in identifying drivers of trends and policy responses. Gender parity in education and women's empowerment have a positive effect on fertility and access to health information. Similarly, poorer women are disproportionately affected by higher mortality rates owing to lower access and use of health services. Malaria, HIV and AIDS, TB and other health threats in pregnant women are important factors in driving MMR.

Maternal mortality is a result of a multitude of factors, including too few health services and providers, poor infrastructure and transport, and low empowerment of women. Some of the primary causes are haemorrhage, sepsis, hypertensive disorders, unsafe abortion and prolonged or obstructed labour. These complications can often be managed with a health system that provides skilled personnel and facilities to handle emergencies and post-partum care. Thus access to and use of health services focused on childbearing becomes vital (UN, 2011).

For years, governments and policymakers have recognized that the number of maternal deaths in Africa is unacceptable. They have put forward numerous strategies, yet maternal mortality remains disproportionately high, and has decreased by an average of only 1.6 per cent a year across the continent. Some international initiatives, such as the UN Secretary General's Global Strategy on Women's and Children's Health, continental initiatives such as the African Union's Campaign on Accelerated Reduction of Maternal Mortality in Africa as well as the Maputo Plan of Action, besides other national and local projects and programmes, have raised awareness and increased financing for maternal health.

No new comprehensive data for maternal health indicators have appeared since 2008, presenting a conundrum. Without proper data, countries cannot fully know what interventions are most effective and where to concentrate financial and programme efforts. Looking at data in new ways while examining best practices and key challenges can, though, assist policymakers in understanding how to focus efforts to accelerate progress towards MDG 5.

24 Calculations are based on UNSD data for the MMR in Africa in 2008 and UNICEF data on Africa's total birth rate that year (35,631,000 live births).

Target 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 5.1: Maternal Mortality Ratio (MMR)

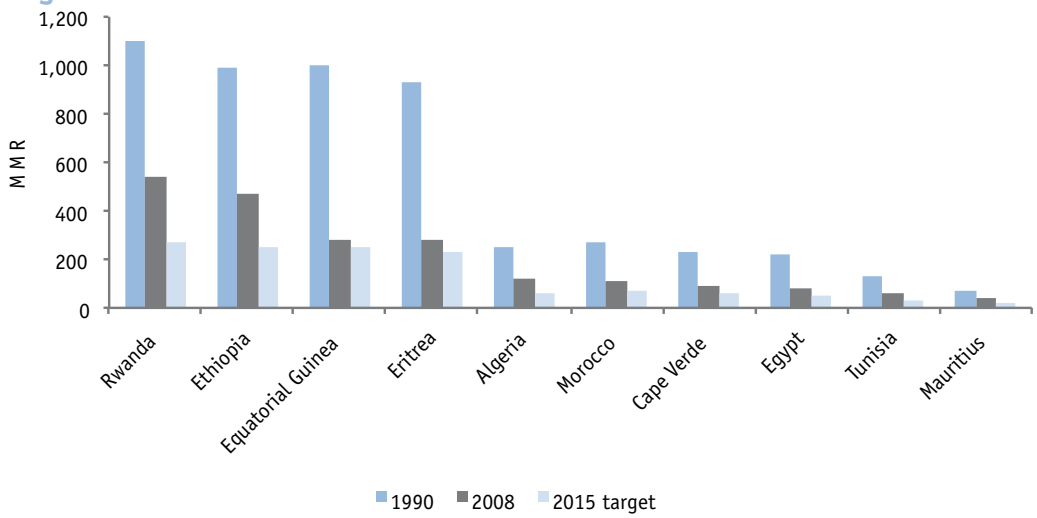
Some countries in Africa are close to achieving MDG 5

An article published by *The Lancet* in 2010 showed that maternal mortality is declining, even in Africa. This is in line with UN data which shows that many African countries in fact recorded large declines in maternal mortality during 1990–2008: Equatorial Guinea, Eritrea, Egypt, Morocco, Cape Verde, Tunisia, Ethiopia, Algeria, Rwanda and Mauritius all saw a more than 50 per cent reduction, and are thus close to achieving MDG 5 (figure 5.1).

What did these countries do to achieve such a reduction in MMR? First, most of them greatly improved the proportion of women giving birth with a skilled health attendant. They did this mainly through policy interventions that focused on improving access through means such as transport to referral health institutions, increased information about contraception and better supply of health attendants. Equatorial Guinea – the closest to achieving MDG 5 with a 72 per cent reduction in maternal mortality during 1990–2008 – improved the proportion of births attended by a skilled personnel from 5 per cent in 1994 to 64.6 per cent in 2000. (New data being collected in that country will probably show further progress since 2000.) Egypt, Morocco and Rwanda (box 5.1) also have steep gains in the share of births with a skilled health attendant, and are among the best performers in reducing maternal mortality.

The best performers also share high economic growth rates. Equatorial Guinea has seen rapid growth over the past 20 years, and Egypt, Morocco and Cape Verde have had sustained

Figure 5.1 Best performing countries on maternal health, MMR, 1990, 2008 and 2015 target



Source: Computations from UNSD, accessed December 2011

Box 5.1 Political commitment and well-planned interventions fast-track Rwanda's progress towards MDG 5

While African countries in conflict or post-conflict suffer from a loss of critical infrastructure and health services, leading to high levels of maternal mortality, these countries are also presented with an opportunity to focus efforts on maternal and child health in the most cost effective ways. Rwanda is a good example of a country arising from conflict that has seen concrete results from its investments in maternal and child health.

After the 1994 genocide and years of conflict, Rwanda had an extremely high MMR of 1,400 deaths per 100,000 live births in 1995, then the highest in Africa. Less than one third of births were attended by a skilled health worker, only 13.7 per cent of women used contraceptives and just 10 per cent of women had the recommended four antenatal visits. Through strong political will and solid planning of maternal health financing and interventions, Rwanda cut its MMR to 540 in 2008. Estimates from Health Management Information Systems put Rwanda's MMR at 383 in 2010, a near three-quarter reduction since 1995.

The Ministry of Health has fast-tracked progress towards MDG 5 in several ways. First, by institutionalizing audits of maternal deaths, it can better identify when, where and how maternal deaths throughout the country occurred. Through this initiative, 256 maternal deaths in 2009 and 221 in 2010 were audited, and recommendations were formulated to avoid similar deaths in the future. The ministry sees this approach as one of the most effective ways to avoid further preventable deaths and focus on maternal health interventions.

Another initiative, the RapidSMS service launched in 2010, equips health providers to track expectant mothers and to provide antenatal care and delivery advice via short messaging services (SMS). Between March and May 2010, 432 community health workers were trained in RapidSMS, and tracked 14,000 pregnancies. During the period, they reported 583 births, 115 risks during pregnancy and no maternal or child deaths. This service also increased the share of women receiving antenatal visits: nearly 100 per cent of Rwandan women have at least one, and the proportion with at least four has more than doubled since 1995.

Last, Rwanda has placed a strong focus on increasing women's access to and use of contraceptives. Community health workers have been trained to provide condoms, pills and injectables, and the government has made a reduction in the total fertility rate a maternal health goal, alongside the MDGs. As a result, 36.4 per cent of women now use contraceptives, and the total fertility rate fell from 6.1 to 5.5 during 2005–2007 (UNSD, 2011).

Sources: UN Rwanda (2011); UNFPA Rwanda (2011).

growth, making them some of the best performing economies in Africa. Thus their decline in the MMR was partly achieved through ensuring that policy interventions were delivered at a sufficient scale and quality to have a major impact. Key supply- and demand-side determinants of persistent high maternal mortality were targeted and financial resources allocated to this end (World Bank, 2009).

Other countries, especially those heavily affected by HIV/AIDS, and those in conflict or post conflict, have made little progress or have regressed since 1990

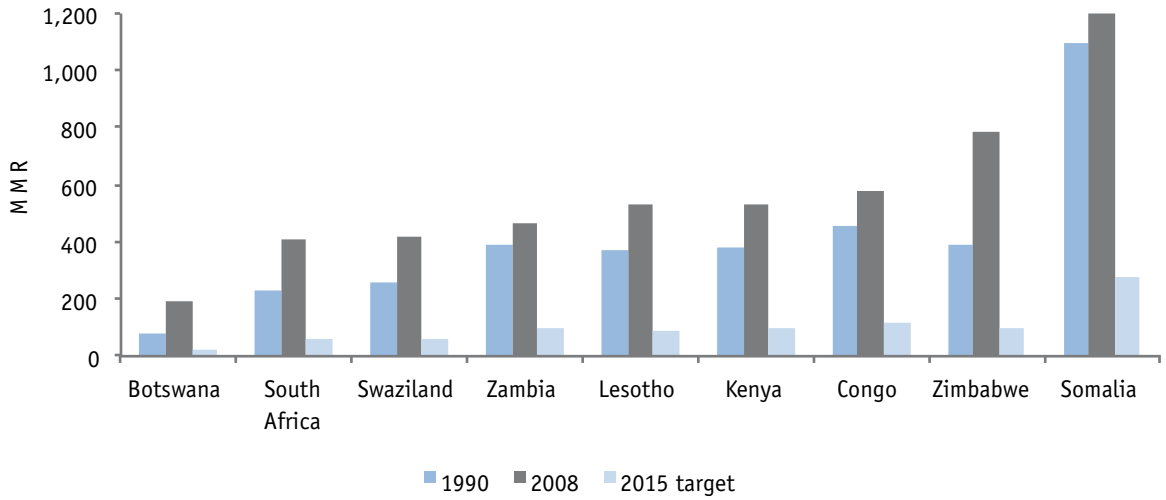
Some countries have made no progress (Gabon and Namibia) or have in fact regressed: nine countries have seen an increase in their MMR since 1990 (figure 5.2).[25] In particular, Botswana and Zimbabwe's MMR more than doubled from 1990 to 2008 (UN, 2011).

Most of these countries are experiencing HIV/AIDS epidemics, which puts women more at risk of dying as a result of childbirth. HIV can kill mothers directly through, for example, anaemia, postpartum haemorrhage and puerperal sepsis, as well as indirectly through opportunistic infections, pneumonia, TB and malaria. Thus testing women of the reproductive age group, especially when they are pregnant, is essential to secure the proper treatment and adequate medical precautions during delivery. This will ensure safer childbearing as well as lower risk of mother-to-child transmission of HIV/AIDS.

Yet maternal mortality is not only a problem in countries with high rates of HIV/AIDS. Conflict and political instability also affect it. All eight countries with the highest MMRs in 2008 were in conflict or were post conflict.[26] Preliminary estimates of maternal mortality in South Sudan in 2011 were reported to be 2,054 deaths per 100,000 live births, the highest in the world (UNICEF, 2011a).

The high likelihood of a woman dying as a result of pregnancy or childbirth in conflict-afflicted countries is illustrative of the importance of functional infrastructure and services – not only of health institutions, but of other infrastructure as well. Roads, transport and communication are crucial

Figure 5.2 Regressing countries on maternal health, MMR, 1990, 2008 and 2015 target



Source: Computations from UNSD, accessed December 2011.

25 Botswana, Congo, Kenya, Lesotho, Somalia, South Africa, Swaziland, Zambia and Zimbabwe.

26 Burundi, CAR, Chad, DRC, Guinea-Bissau, Liberia, Sierra Leone and Somalia.

for mothers to access life-saving care. Countries affected by conflict require a rebuilding of key institutions and infrastructure in a broad range of sectors, including health, as well as training for medical professionals.

Indicator 5.2: Proportion of births attended by skilled health personnel

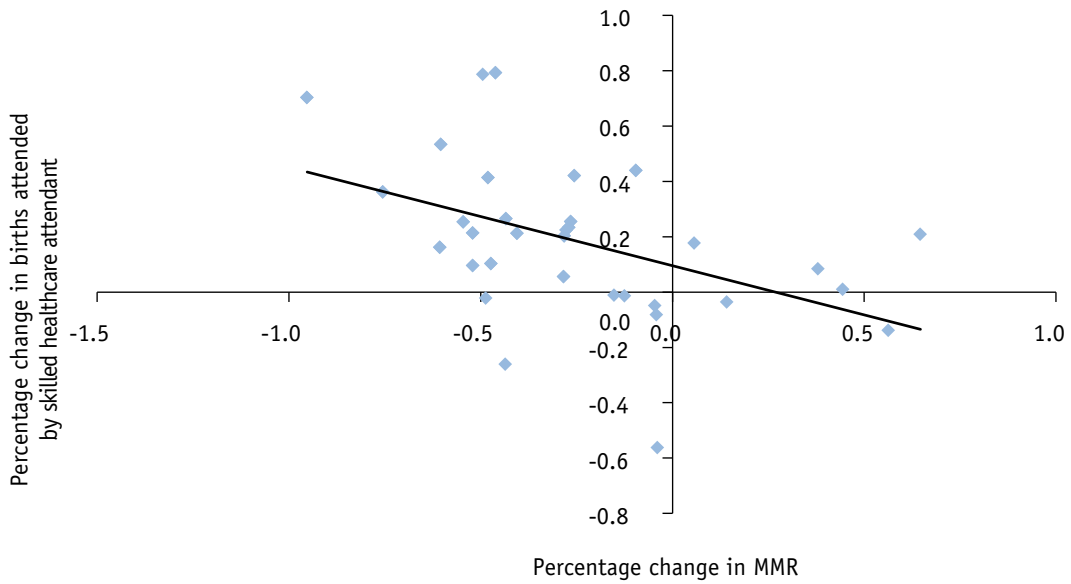
Delivering with the assistance of a skilled health attendant is one of the best ways to ensure survival of mother and child

Pregnancy-related deaths can, without doubt, be cut heavily in Africa. The health risks of both mothers and babies are greatly reduced with an increase in the proportion of babies delivered under the supervision of health professionals. It is well recognized that efforts focused on providing antenatal care, ensuring skilled health attendance at birth, improving access to basic and comprehensive emergency obstetric and newborn care, and providing basic post-natal and newborn care, are essential components for improving maternal health. The provision of maternal and reproductive health services within the framework of primary health care is fundamental to making such services available to all.

An analysis of the data for 1995–2008 bears out the fact that the percentage increase in the proportion of births with a skilled health attendant is correlated with the percentage decrease in the MMR (figure 5.3). In sum, a 1 per cent increase in this proportion is associated with a 0.21 per cent decline in maternal mortality.

Several countries illustrate this relationship. Equatorial Guinea increased the proportion of women

Figure 5.3 Correlation between % change in proportion of births with a skilled health attendant and % change in MMR, 1995–2008



Source: Computations from UNSD, accessed December 2011.

giving birth with a skilled attendant from 5 per cent to 64.6 per cent in six years, almost a 10 percentage point increase every year. Morocco, Rwanda, Egypt, Angola and Niger all more than doubled this proportion during 1990–2008, and all these countries are performing relatively well in reducing maternal mortality.

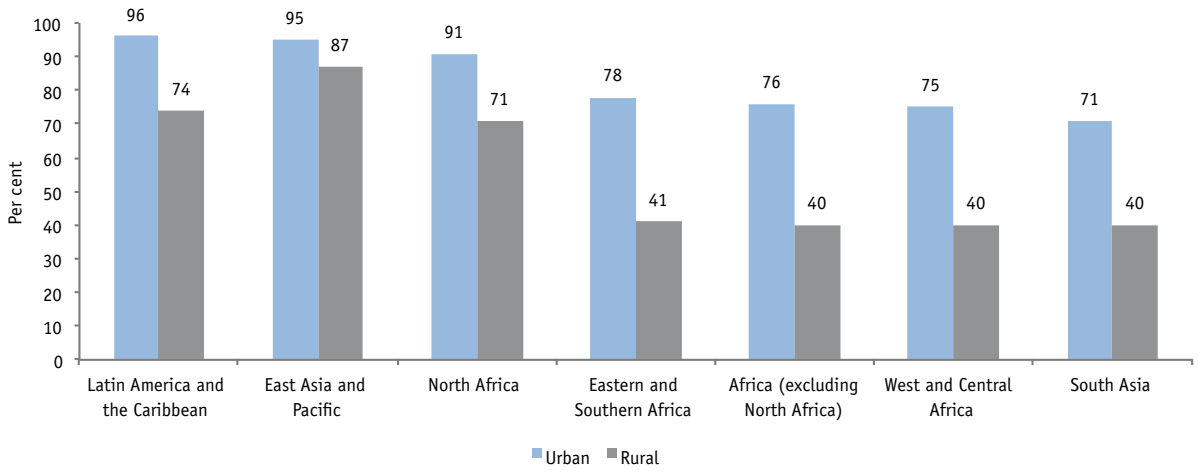
Likewise, countries that have performed poorly in reducing the MMR have shown little progress in increasing the proportion of deliveries with skilled birth attendants. Zimbabwe saw a steep fall in this proportion from 69.2 per cent in 1994 to only 60 per cent in 2008; and that year, 790 out of 100,000 births resulted in maternal death – more than twice the rate of 1990. The deteriorating capacity of the health system in Zimbabwe partly contributed to this regression – for example, 80 per cent of public midwifery posts are vacant. In addition, only 5.4 per cent of pregnant women knew their HIV status before pregnancy, and just 34 per cent of pregnant women were tested for HIV during pregnancy.

Spatial and income inequalities remain a challenge for increasing access to skilled birth attendants

Comparing MMR performance among countries is only part of the story. Vast inequalities exist within countries as well, and access to skilled birth attendants highlights the gaps between urban and rural women, and between high- and low-income women.

The world's widest urban–rural gaps are in Africa (excluding North Africa) where women in urban areas are almost twice as likely as those in rural areas to deliver with a skilled health attendant, and where 80 per cent of those in the highest income quintile deliver this way against only 24 per cent for the lowest quintile (figure 5.4).

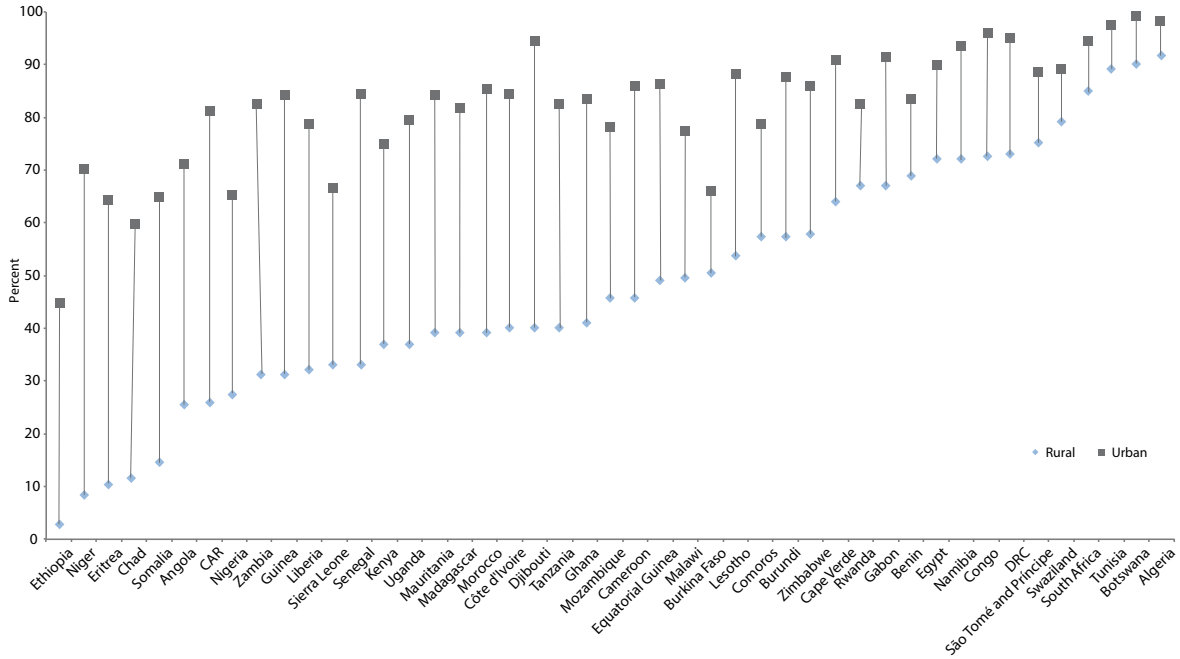
Figure 5.4 Share of births with a skilled health attendant by region, urban versus rural, 2006–2010



Source: Compiled from www.childinfo.org.

Note: No data for Libya, Sudan and South Sudan.

Figure 5.5 Share of women giving birth with a skilled health attendant in Africa, urban versus rural



Source: Compiled from www.childinfo.org, accessed March 2012.

By country, Niger, CAR and Djibouti have the biggest urban–rural divide (figure 5.5). In Niger, 71 per cent of urban women deliver with a skilled health attendant versus only 8 per cent in rural areas. Tunisia, Botswana and South Africa are the most equal on this measure, with a less than 10 percentage point difference.

Income inequalities are bigger than urban–rural gaps in accessing skilled health care

African women in the richest quintile are more than three times as likely to give birth with a skilled health attendant as women in the poorest (figure 5.6). West and Central Africa have the largest sub-regional inequality. Nationally, Nigeria has the biggest gap: 86 per cent versus 8 per cent. Cameroon, Mauritania, Sudan (North and South), Eritrea and Ghana have more than a 70 percentage point difference between the two quintiles.

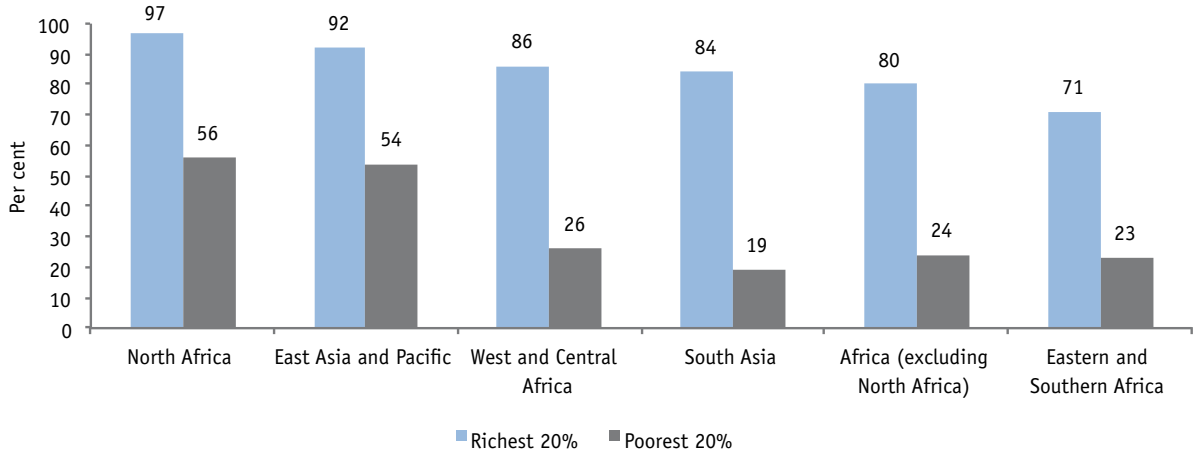
Burkina Faso has a relatively equal proportion of women across all wealth quintiles for this indicator: 56 per cent in the lowest and 65 per cent in the highest. Algeria and São Tomé and Príncipe also have a fairly equal distributions across income groups.[27]

Access, cost and demand for services explain inequalities within countries

The spatial and wealth gaps demonstrate key challenges to increasing the share of women giving birth with a skilled health attendant.

27 www.childinfo.org, accessed March 2012.

Figure 5.6 Share of births with a skilled health attendant by wealth quintile, 2006–2010



Source: Compiled from www.childinfo.org, accessed March 2012.

Note: Data are weighted averages.

First, they highlight the need to increase availability of trained and skilled providers in rural areas. Furthermore, these providers need access to essential drugs, supplies, equipment and emergency obstetric care. Increasing the number of trained and skilled birth attendants requires a revitalization of the midwifery profession, and a commitment from governments to provide adequate funding and training. Some countries have implemented programmes to improve services in rural areas. In Nigeria, for example, where the most women in an African country die from giving birth, and where there are vast inequalities between urban and rural women and between wealth quintiles, the Midwives Service Scheme requires midwives to undertake a compulsory year of community service in rural and underserved areas. From the launch of the scheme in 2009 to July 2010, 2,622 midwives had been deployed to primary health facilities in rural areas (WHO et al., 2012).

A second key challenge is meeting the cost of giving birth with a skilled health care attendant. Not only does delivery away from home cost money for transport and health care, but entails an opportunity cost. Women may have to leave home and travel for hours, sometimes days, to the nearest clinic, where they are not even sure if they will receive timely or adequate care. They must arrange for care of children, and ensure that other house duties will be taken care of. Only if countries can reduce the direct and opportunity costs of such delivery, including free maternal health care as in Malawi, Rwanda and Sierra Leone, will rural and low-income women be able to access skilled assistance for delivering their babies. Similarly, introducing social protection is a crucial part of removing cost barriers and decreasing maternal mortality (Africa MDG Report 2011).

Lastly, the spatial and wealth gaps illustrate the importance of empowering women with the

knowledge and power to decide on her delivery. Indeed, women who are better able to decide where they give birth are more likely to deliver with the assistance of a skilled health attendant. Beyond this, cultural barriers often keep down these rates of delivery in rural areas and among lower income groups. There may be a higher distrust of health care attendants and greater reliance on family or community members, as well as a lack of knowledge or belief in the benefits of skilled attendance. Thus such cultural barriers need to be dismantled. Improving girls' education, providing women with more economic opportunities and reinvigorating community awareness campaigns are just a few of the ways to give rural and poor women more say in their childbearing conditions.

Target 5B: Achieve universal access to reproductive health by 2015

Indicator 5.3: Contraceptive prevalence rates for married people, and Indicator 5.6: Unmet need for family planning

Access to contraceptives reduces the risk of maternal death

Access to reproductive health services, including family planning, and maternal mortality are two sides of the same coin. UNFPA (2009) estimates that one in three maternal deaths could be avoided if all women had access to contraceptive services. When women are better able to control when and how many children to have, the health outcomes of both mother and child improve greatly. Indeed, almost one in four women in Africa who want to space or delay their next pregnancy seem not to be using contraceptives (UN, 2011).

Unfortunately, as data on contraceptive prevalence and on unmet need are scarce, comparative analysis between these indicators and maternal mortality is difficult. It is self-evident, though, that fewer pregnancies will lead to fewer maternal deaths. Indeed, the total number of maternal deaths is calculated as the product of the number of women of reproductive age, the general fertility rate, and the MMR. Because the number of women of reproductive age is steadily increasing and the MMR is declining only slightly, African countries have seen the total number of maternal deaths fall largely owing to declining fertility rates.

In fact, UNFPA (2009) shows that reduced fertility accounts for 53 per cent of the fall in the number of maternal deaths. It is thus imperative for African countries to make a real effort to lift the population's access to contraceptives, as well as provide the information for effective use.

Vast family-planning disparities exist between countries

The contraceptive prevalence rate (CPR) for married people in Africa averages 29.3 per cent, but with huge disparities. Chad had a CPR of less than 3 per cent in 2004 and Mauritius 75.8 per cent in 2002 – one of the highest in the world (UNSD, 2011). Countries with particularly low CPRs are mostly in conflict or are post conflict (table 5.1), again illustrating the importance of health infrastructure.

Countries with high CPRs are almost all in North Africa or Southern Africa. Those in North Africa are performing well across all maternal health variables. The high CPRs in Southern Africa may well be attributable to increased condom use as a response to the HIV/AIDS epidemic.

Table 5.1 Contraceptive Prevalence Rate (CPR), various years

Below 10%		10–15%		15–30%		30–50%		Above 50%	
Mauritania (2007)	9.3	Ethiopia (2005)	14.7	Cameroon (2006)	29.2	Lesotho (2009)	47.0	Mauritius (2002)	75.8
Burundi (2006)	9.1	Somalia (2006)	14.6	Comoros (2000)	25.7	Kenya (2009)	45.5	Morocco (2004)	63.0
Guinea (2005)	9.1	Nigeria (2008)	14.6	Uganda (2006)	23.7	Libya (1995)	45.2	Algeria (2006)	61.4
Mali (2006)	8.2	Guinea-Bissau (2010)	14.0	Ghana (2008)	23.5	Botswana (2000)	44.4	Cape Verde (2005)	61.3
Sierra Leone (2008)	8.2	Côte d'Ivoire (2006)	12.9	CAR (2006)	19.0	Congo (2005)	44.3	Egypt (2008)	60.3
Eritrea (2002)	8.0	Senegal (2005)	11.8	DRC (2010)	18.0	Malawi (2006)	41.0	Tunisia (2006)	60.2
Sudan (2006)	7.6	Liberia (2007)	11.4	Djibouti (2006)	17.8	Zambia (2007)	40.8	Zimbabwe (2006)	60.2
Angola (2001)	6.2	Niger (2006)	11.2	Gambia (2001)	17.5	Madagascar (2009)	39.9	South Africa (2004)	59.9
Chad (2004)	2.8	Equatorial Guinea (2000)	10.1	Burkina Faso (2006)	17.4	São Tomé and Príncipe (2009)	38.4	Namibia (2007)	55.1
				Benin (2006)	17.0	Rwanda (2008)	36.4	Swaziland (2007)	50.6
				Togo (2006)	16.8	Tanzania (2010)	34.4		
				Mozambique (2004)	16.5	Gabon (2000)	32.7		

Source: Computations from UNSD, accessed December 2011.

Note: Reference years are shown in parentheses.

Changing attitudes towards family planning

Use of contraceptives is changing across the continent: CPRs have risen slightly from 21 per cent in the early 1990s to 29 per cent in recent years. Yet the proportion of women with an unmet need[28] for family planning has not changed, staying at around 25 per cent (UN, 2011).

The slight rise in the continental CPR masks a wide range of increases among countries. Niger, Zambia, Mozambique, Ethiopia, Malawi, Sierra Leone, Tanzania and Guinea have seen their CPRs more than triple over the past 20 years (UNSD, 2011). This is partly due to interventions that targeted increased access to family planning services, improved awareness of the benefits of family planning and enabled women to space or limit births.

That said, although more African women are using contraceptives, the provision of such services to

28 Unmet need is defined as the percentage of currently married women aged 15–49 who want to stop having children or to postpone the next pregnancy for at least two years, but who are not using contraception.

all who demand it is not met (UN, 2011). All else being equal, an increase in the CPR should see an equal decrease in unmet need, but that need is not declining in Africa – and in many countries is even increasing. On the positive side, this means that more women wish to space or limit births, indicating increased awareness of the benefits of family planning, and perhaps greater gender equality and women's empowerment. Unfortunately, this desire is not being met for two main reasons.

First, the wealth effect is important in contraceptive use, for short- and long-term purposes. Whereas certain countries have increased their CPRs, access may be skewed toward higher income levels. Creanga et al. (2011), for example, found that wealth-related inequalities, measured as the concentration index of met need to limit childbearing, were highest in Namibia, Mozambique and Ethiopia and lowest in Ghana and Malawi. There is also the wealth-related inequality in the met need for contraception to space births, which was found to be highest in Ethiopia and lowest in Malawi, Namibia and Zambia.

Second, adequate empowerment for women to choose to use contraceptives is critical. In other words, contraceptives may be available, and women may wish to space or limit births, but owing to cultural, economic or social factors, they do not use available methods of family planning. Furthermore, there may be a mismatch between the types of contraceptives desired and provided. Women may have access to short-acting contraceptives, such as condoms or the oral contraceptive pill, when they may actually desire long-acting or permanent methods, such as an intra-uterine device or sterilization.

Thus while countries are moving their CPRs in the right direction, they must take a closer look at the barriers to accessing the correct types of contraceptives, and why the unmet need is not decreasing. In Egypt, for example, removing barriers to family planning was a key component of the country's maternal health campaign. Despite having a family planning programme in place since the 1960s, the CPR remained relatively low and the unmet need for family planning high. Through a unique campaign put in place by the government in the early 1990s, women in rural areas throughout the country were trained and paid by the government to act as advocates for family planning, alongside a widespread television and radio campaign.

Through these initiatives, Egypt addressed certain cultural barriers to contraceptive use, more than halving the unmet need for contraceptives from 19.8 per cent in 1992 to 9.2 per cent in 2008, as more women used family planning services. Egypt was the best performer in Africa for the unmet need indicator. The country's maternal mortality decreased from 220 to 82 deaths per 100,000 live births over the same period.

Indicator 5.4: Adolescent birth rate

Adolescent birth rates in Africa stay high

Girls aged 15–19 are twice as likely to die during childbirth as women 20 years and above. Unsafe abortion because of unwanted pregnancy is also common among adolescents. Complications from pregnancy or childbirth contribute up to 30 per cent of maternal mortality, and are the leading cause of death among girls in this age group (UNFPA, 2009). Thus reducing adolescent birth rates and making post-abortion care available and

accessible are imperative for African countries to reduce maternal mortality.

For countries with the most recent data, an average of 101.3 women aged 15–19 give birth per 1,000 women, meaning that over 10 per cent of African women will have given birth by age 20. This number does not take into account the large proportion of young women who do not carry their pregnancy to term owing to miscarriage or abortion.

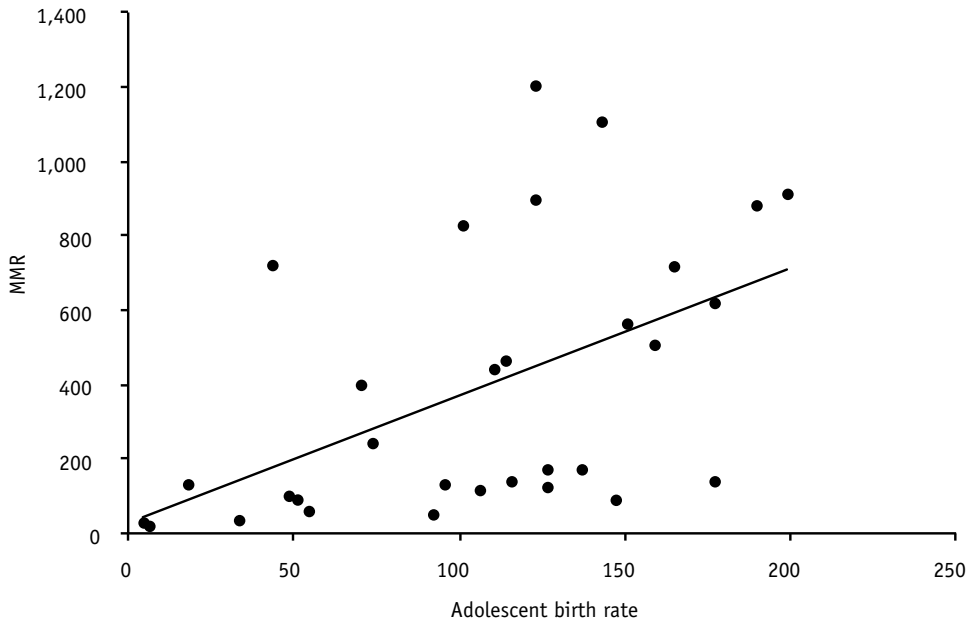
Africa's adolescent birth rate has remained fairly stagnant over the past two decades, showing only a 3.6 per cent decrease from an average of 105 per 1,000 women in the early 1990s (UN, 2011).

The link between adolescent birth rates and the MMR is clear (figure 5.7), although not causal. The higher the adolescent birth rate, the higher the MMR.

North African countries, namely Libya, Algeria, Tunisia and Morocco, are the best performers in adolescent birth rates in Africa, and all have adolescent birth rates far below the global average.

Niger, Chad and Mali have the highest adolescent birth rates, at 199, 193 and 190 per 1,000 births. This means that nearly 20 per cent of women in these countries will give birth before the age of 20. Cultural factors there, namely early marriage and the low importance placed on female education,

Figure 5.7 Correlation between adolescent birth rates and MMR, 2005–2008



Source: Computations from UNSD, accessed December 2011.

Note: The figure illustrates the correlation among countries with data points for both the adolescent birth rate and the MMR for the same year.

are partly responsible for early births. These three countries also have high maternal mortality.

Reducing adolescent birth rates and improving health outcomes for adolescent mothers

Numerous policy interventions are needed to lower adolescent birth rates, and to address the health risks associated with adolescent pregnancy. WHO recommends a three-tiered continuum of care that starts among individuals and extends to the health system.

At the individual, family and community level, it is vital to improve the knowledge, education, experience, income and empowerment of young girls. Those who have access to education, especially beyond primary school, are far more likely to delay marriage and childbearing. Adolescent mothers must also be provided with life skills and sexual education to increase their independence, mobility, self-esteem and ability to take decisions. Furthermore, families and communities generally must be aware of complications associated with adolescent pregnancy in order to ensure good pregnancy outcomes if a young woman becomes pregnant. With better awareness at this level, adolescents are less likely to get pregnant and are more likely to survive if they do.

At the outpatient and clinical care level, adolescents must be provided with an early start to antenatal care with options for whether they wish to continue the pregnancy. Making abortion safer is a critical component on improving the health outcome for pregnant adolescents. In addition, adolescent mothers are especially susceptible to anaemia, low birth weight, sexually transmitted diseases and malaria, and thus these risks must be properly screened for and managed.

Finally, countries must address adolescent pregnancy at a higher level with a more conducive legal and policy environment that empowers young women, decreasing the amount of adolescents who get pregnant, and improving the health outcomes for those who do. Formulating and enforcing laws on child marriage, improving access to education and economic opportunities for women, and providing adequate financing for maternal health are some of the ways in which governments can address the issue of adolescent pregnancy (WHO, 2008).

Indicator 5.5: Antenatal care coverage

Women who receive regular antenatal care are far more likely to give birth with a skilled health attendant and are better able to recognize the signs of complications before, during and after delivery. Yet antenatal care coverage in Africa remains very low. Overall, about 79 per cent of pregnant African women attend at least one antenatal check-up, but fewer than half of pregnant women in Africa attend the recommended four. And these rates mask huge disparities. Although nearly half of all countries show that over 90 per cent of women make at least one antenatal visit, in countries where maternal mortality is the biggest problem, such as Somalia, Ethiopia, Chad and Niger, fewer than half the women make even one antenatal visit.

Maternal survival increases significantly with four or more antenatal check-ups

Although the majority of women in African attend at least one antenatal check-up, the correlation with maternal mortality increases significantly with four or more visits (figures 5.8 and 5.9). Attending the WHO-recommended four antenatal care visits has the strongest correlation with reducing the MMR of all the other maternal health variables

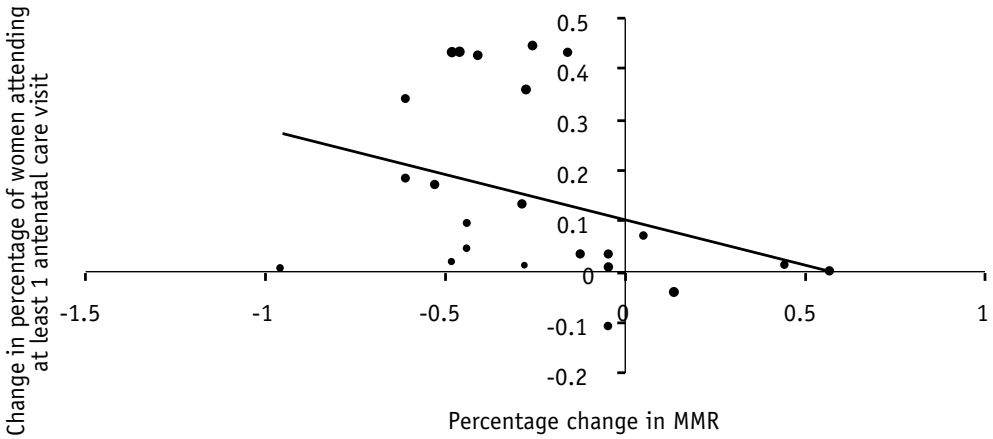
assessed. The correlation between antenatal visits and MMR increases with the number of visits.

Regular contact with skilled health personnel during pregnancy is imperative for the health and well-being of the mother and infant. Antenatal care allows for detection and management of conditions such as hypertension, sexually transmitted diseases and HIV/AIDS as well as malaria, while promoting immunization and nutrition supplements, prevention of mother-to-child transmission of HIV/AIDS and birth preparedness. The antenatal period is also an opportunity for women to get information on future birth spacing or limiting, an important factor in improving mother and child survival.

What is preventing African women from attending the recommended four visits? In many countries, the quality of care is poor, and although the first antenatal check-up is free, women must pay out of pocket for subsequent visits. It is therefore imperative for countries to provide at least four, free, high-quality antenatal check-ups to pregnant women. Women may also not have enough information on the importance of multiple antenatal check-ups, and so health providers must urge women to return for check-ups, and provide incentives for women to do so. If more women can attend the recommended four check-ups, Africa will undoubtedly see a steep fall in maternal mortality.

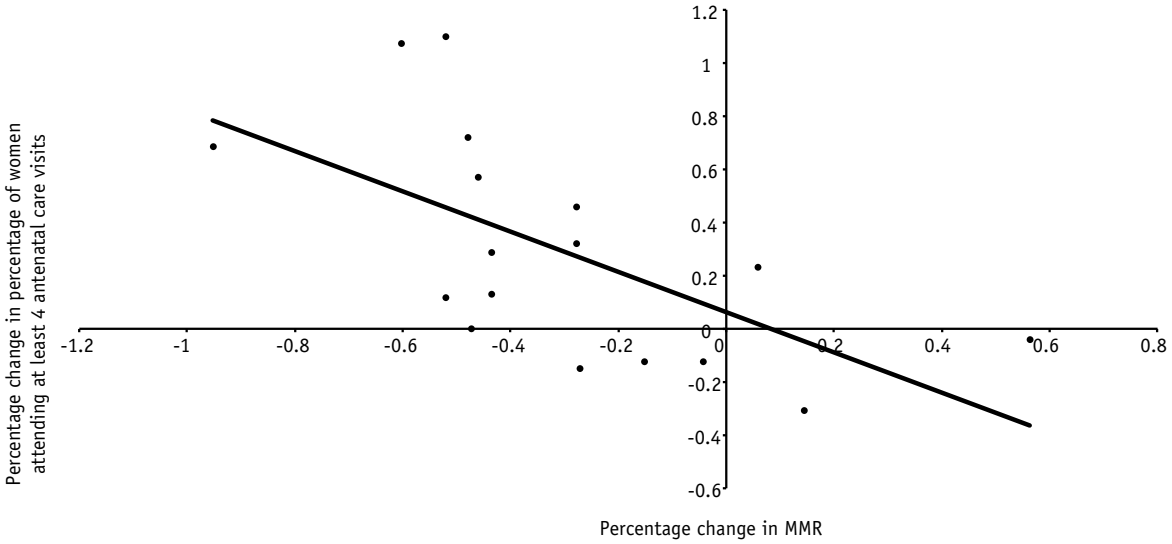
Post-natal care – health services provided in the first six weeks after birth – although not measured as part of the MDGs is also essential to the health of mothers and newborns. The first day after birth is the time of highest risk for both mother and baby, and half of all post-natal deaths occur in the first week after birth. WHO estimates that every year in Africa, at least 125,000 women and 870,000 newborns die during that first week, largely owing to limited access to, and poor quality of, maternal services.

Figure 5.8 Correlation between change in percentage of women attending at least one antenatal check-up and percentage change in MMR, 1995–2008



Source: Computations from UNSD, accessed December 2011.

Figure 5.9 Correlation between change in percentage of women attending at least four antenatal check-ups and percentage change in MMR, 1995–2008



Source: Computations from UNSD, accessed December 2011.

On average, 18 million African women do not give birth in a health facility every year, making it hard to plan for and implement post-natal services (WHO, 2006). Thus, beyond increasing the number of women who attend antenatal care services and who give birth with a skilled health attendant, countries must improve the availability and quality of post-natal services.

Conclusions

Africa as a whole continues to make slow progress towards MDG 5, despite international, continental and national initiatives aimed at improving maternal health. Efforts to decrease maternal mortality cannot be undertaken in isolation, as it is closely linked to other maternal health indicators, as well as other MDGs.

The inadequate access to and use of skilled birth attendants and inequity by location and income are serious impediments to reducing national MMRs. The use of contraception to space or limit births is an important factor in the continent's high MMR. Furthermore, reducing poverty, improving education, boosting employment and empowering women, as well as fighting HIV/AIDS, TB and malaria will all have positive effects on maternal mortality. Better maternal health will have residual effects on child health and the economic well-being of individuals, families and communities.

MDG 5 provides a good framework for monitoring maternal health, but countries must look beyond the indicators and consider critical issues such as maternal morbidity, post-natal care and fertility rates to comprehensively address maternal health. With an international spotlight on maternal health in Africa, now is the time for governments and policymakers to put into place concrete actions so that no woman must fear death while giving birth.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Africa's progress in the fight against HIV/AIDS, TB and malaria is being sustained – even stepped up. This is noteworthy as there are worrying signs of regress in other developed and developing regions of the world, particularly for HIV/AIDS. The number of people in Africa living with HIV has increased owing to improved coverage of antiretroviral therapy (ART). Infections, too have fallen: the decrease in young women's prevalence (15–24 years) is particularly encouraging.

The fight against malaria is seeing major advances. Increases in funding and attention to malaria control have led to a 20 per cent global decline in the number of malaria deaths in 2000–2009. Africa (excluding North Africa) made a large contribution to this steep drop through critical interventions such as greater use of insecticide-treated nets (ITNs) and artemisinin-based combination therapies, as well as adequate financing.

The *Global Plan to Stop TB* is also bearing fruit. Improved ART coverage and the decline in HIV infection rates have also reduced TB infections, given the opportunistic nature of the disease.

The Global Fund, the Abuja Declaration, Stop TB, the African Leaders' Malaria Alliance, and an update of the Roll Back Malaria partnership in June 2011 are just a few of the international and regional initiatives that show the high level of political commitment to tackle these diseases. These vertical funds – programmes that target resources at specific health problems, and deliver direct and measurable results – are among the reasons for the outcomes in tackling these three diseases.

In July 2011, following the reduction in HIV prevalence rates and the increase in access to ART, the UN General Assembly set bold new targets[29] with the aim of achieving faster, smarter and better results in the fight against HIV/AIDS, namely through implementing the Global Plan for Elimination of HIV infection in Children and Keeping Mothers Alive (UNAIDS 2011a).[30]

Although HIV prevalence data have been regularly updated, the same is not true for data related to behaviour and knowledge on HIV. Indeed, there has not been an update since the 2011 *Assessing progress in Africa towards the MDGs* report on condom use for high-risk sex, the proportion of population aged 15–24 years with comprehensive knowledge of HIV/AIDS or the ratio of school attendance of orphans to school attendance of non-orphans aged 10–14 years. The main reason is that most data are collected in irregular surveys, and the data-collection cycles vary by country (UNECA et al., 2011).

29 In its Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS.

30 The Global Plan identified 22 priority countries – India and 21 African countries (Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe).

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

Pronounced declines in HIV/AIDS

Africa (excluding North Africa) remains the region most heavily affected by HIV. Although it is home to only 12 per cent of the global population, it accounted for about 68 per cent of all people living with HIV in 2010. The region also accounted for 70 per cent of new HIV infections in 2010, although it showed a notable decline in the rate of new infections. The epidemic remained stable in Western and Central Europe, was increasing in North America, East Asia, Eastern Europe and Central Asia, and was declining in South-east Asia (table 6.1).

More people than ever are living with HIV, largely due to greater access to treatment. In Africa, the number of people dying of AIDS-related causes fell to 1.9 million in 2010, down from a peak of 2.2 million in the mid-2000s. Annual new HIV infections fell by 21 per cent between 1997 and 2010.

The number of new HIV infections (the incidence) in Africa (excluding North Africa) has dropped by more than 21 per cent, down to 1.9 million, from an estimated 2.6 million at the peak of the epidemic in 1997. HIV has fallen in 21 African countries, the continent most affected by the AIDS epidemic. Declines have been steep, particularly in countries with the highest number of infected people, including Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe. The decrease in the incidence is particularly noteworthy in South Africa, which remains the country with the highest number of infected people in the world; the annual HIV incidence in the country, though still high, dropped by a third during 2001–2009, from 2.4 per cent to 1.5 per cent.

The epidemic remains most severe in Southern Africa, followed by East Africa, Central Africa and West Africa. One third of all people living with HIV globally resided in 10 countries in Southern Africa.[31] North Africa is still the sub-region least affected by HIV/AIDS. The epidemic is becoming generalized in countries like Djibouti and South Sudan, where it has so far been concentrated among high-risk groups.

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

Recent estimates by UNAIDS show that HIV prevalence declined among young people (aged 15–24 years) in at least 21 of 24 African countries with a national HIV prevalence of 1 per cent or more. The drop in HIV prevalence was statistically significant in sentinel sites in Botswana, Burkina Faso, Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Namibia, Tanzania, Togo and Zimbabwe. Four of those countries (Botswana, Malawi, Tanzania and Zimbabwe) also had statistically significant declines in the general population, according to results from population-based surveys. In addition, a statistically significant decline in prevalence in the general population was observed in Lesotho, South Africa and Zambia (UNAIDS 2011).

Declining HIV infection and prevalence among young women

Particularly interesting is the fall in HIV incidence among young women. From 2001 to 2010, HIV incidence among adult women in Africa (excluding

31 Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

North Africa) has declined from 0.72 per cent to 0.49 per cent, while adult HIV incidence declined considerably during the same period in several of the priority countries (including Botswana, Côte d'Ivoire, Namibia and Zimbabwe) where they fell by at least 50 per cent. Furthermore, young women's prevalence decreased from 5.2 per cent to 3.3 per cent during 2001–2010 (table 6.1), partly driven by improved education for girls, which may be the single most effective preventive weapon against HIV/AIDS (World Bank, 2002).This also augurs well for positive effects on other indicators such as TB incidence and mother-to-child transmission of HIV/AIDS.

The increase in ART has also been driven by a request for HIV screening of all TB patients by many countries, allowing swift treatment while ensuring anonymity and voluntary screening. This led to an increase in the proportion of TB patients screened for HIV from 11 per cent in 2005 to 59 per cent in 2010. The proportion of HIV-positive TB patients accessing ART rose from 29 per cent to 42 per cent in the same period (WHO, 2011a).

One in every 10 African women becomes a mother before the age of 19. Hence the declining prevalence of HIV infections among young women is likely to result in a steep decline in mother-to-child transmission. This trend is likely to improve further as more women take advantage of voluntary HIV testing. In 2010, an estimated 35 per cent of pregnant women in low- and middle-income countries (most of them in Africa) took an HIV test, compared with 8 per cent in 2005 and 26 per cent in 2009.

Indicator 6.2: Condom use at last high-risk sex

Condom use is on the rise in high-prevalence countries, but geographical and gender disparities persist

No new data have appeared since the previous 2011 report. Condom use during high-risk sex is still low among young people (15–24 years of

Table 6.1 Regional HIV/AIDS statistics, 2001 and 2010

	Adults and children living with HIV (millions)		Adults and children newly infected with HIV (millions)		Adult prevalence (%)		Adult and child deaths due to AIDS (millions)		Young people (15–24) prevalence (%), male		Young people (15–24) prevalence (%), female	
	2001	2010	2001	2010	2001	2010	2001	2010	2001	2010	2001	2010
Africa excluding North Africa	20.5	22.9	2.2	1.9	5.9	5.0	1.4	1.2	2.0	1.4	5.2	3.3
South East Asia	3.8	4.0	0.380	0.270	0.3	0.3	0.23	0.250	0.2	0.1	0.1	0.2
East Asia	0.380	0.790	0.074	0.088	<0.1	0.1	0.024	0.056	<0.1	<0.1	<0.1	<0.1
Eastern Europe and Central Asia	0.630	1.5	0.030	0.160	0.2	0.9	0.01	0.090	0.1	0.1	0.1	0.1
Western and Central Europe	0.630	0.840	0.030	0.030	0.2	0.2	0.1	0.0099	0.1	0.1	0.1	0.1
North America	0.980	1.3	0.049	0.058	0.5	0.6	0.019	0.020	0.3	0.3	0.2	0.2

Source: UNAIDS (2011b).

age) in developing regions. From the latest survey data, ranging from 2005 to 2009, fewer than half of young men and just over a third of young women used condoms during their last high-risk sexual activity in Africa (excluding North Africa) (UN, 2011). The scant information shows that high-prevalence countries have improved condom use, but large intra- and inter-country disparities persist. In Zimbabwe, for instance, an estimated 68 per cent of young men used condoms versus 42 per cent of young women. Similar to other health services, the gender gap is exacerbated by income and locational inequities – condom use is much less common among young people in poorer households and those living in rural areas (UNAIDS, 2011b).

The use of condoms in high-risk sex situations is based also on the knowledge of HIV transmission and prevention. Although data are scant, population-based surveys in selected African countries(excluding North Africa) indicate that the proportion of young people who know that using condoms can reduce the chances of getting HIV ranges from about 50 per cent to almost 90 per cent, although with a geographical and gender bias (as seen in other MDGs). In almost all the countries, young women are less likely than men to have such knowledge. Youths in rural areas are also less likely to know about prevention (UNAIDS, 2011b).

In some countries with generalized epidemics, a combination of behaviour changes (including reduction in number of sexual partners), increases in condom use and delayed age of first sex have reduced new infections. In urban Zimbabwe, for example, a huge decline in HIV incidence, from an extremely high peak of almost 6 per cent in 1991 to less than 1 per cent in 2010, paced encouraging changes in sexual behaviour among young people, including a reduction of the proportion of young men with multiple partners and an increase in the proportion of young people claiming to have used a condom the last time they had high-risk sex. Similarly, the percentage of young men and women who have had sex before their 15th birthday fell significantly in eight of the 18 countries with sufficient data (UNAIDS, 2011).

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

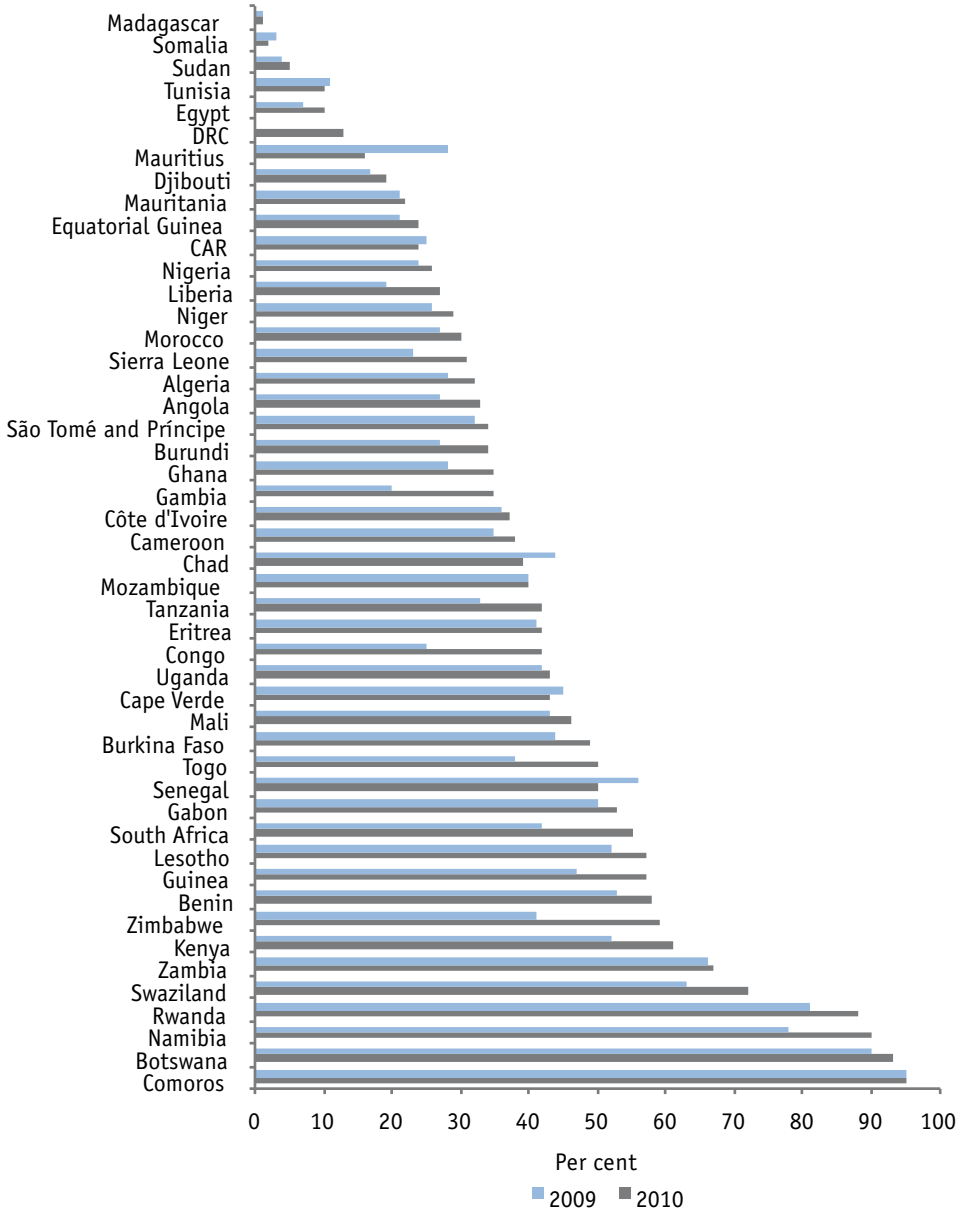
Indicator 6.5: Proportion of population with advanced HIV infection with access to antiretroviral drugs

Improved access to treatment is a winning strategy

Universal access to treatment for HIV/AIDS (defined as 80 per cent or greater coverage) shows crucial progress. Worldwide, the most dramatic increases in ART coverage have been made in Africa (excluding North Africa), with a 20 per cent increase from 2009 to 2010 alone (UNAIDS 2011b). In low- and middle-income countries, 47 per cent of the 14.2 million eligible people living with HIV were on ART at the end of 2010, up from 39 per cent a year earlier. Universal access to treatment has been achieved in Botswana, Comoros, Namibia, South Africa and Swaziland (>95 per cent), Lesotho (89 per cent), and perhaps Zambia (70–80 per cent) (figure 6.1).

UNAIDS estimates that access to HIV/AIDS treatment has averted 2.5 million AIDS deaths between 1995 and 2010 in low- and middle-income

Figure 6.1 Estimated ART coverage, 2009 and 2010



Source: UNAIDS (2011b).

countries globally, mostly through falling mother-to-child transmission (UNAIDS, 2011b).

Mother-to-child transmission is declining

Eliminating mother-to-child transmission of HIV/AIDS is challenging because it requires agencies to identify nearly all pregnant women living with

HIV. The rate of such transmission is estimated to have declined from 35 per cent in 2001 to 29 per cent in 2009 and to 26 per cent in 2010. It is also estimated that more than 350,000 new infections among children have been averted since 1995 owing to the provision of antiretroviral prophylaxis to HIV-positive pregnant women (UNAIDS, 2011b).

Coverage of HIV testing and counselling services – a key factor in reducing this mode of transmission – has risen in almost all sub-regions, including East and Southern Africa (where HIV testing coverage rose from 52 per cent to 61 per cent from 2009 to 2010). Among the 21 priority countries in Africa, coverage of HIV testing and counselling services exceeded 90 per cent in Botswana, South Africa, Zambia and Zimbabwe in 2010. Another five countries have reached more than 80 per cent coverage: Kenya, Mozambique, Namibia, Swaziland and Tanzania. Against this, fewer than 20 per cent of pregnant women living with HIV were identified in Chad, DRC and Nigeria.

Coverage of HIV testing and counselling services across Africa's sub-regions usually reflects the severity of the HIV/AIDS epidemic: in 2010 it was lowest at 4 per cent in North Africa, stood at 18 per cent in West and Central Africa, but reached 64 per cent in East and Southern Africa.

Although the most effective strategy for preventing paediatric HIV infections and mortality is blocking mother-to-child transmission, infant antiretroviral prophylaxis coverage remains a concern. Coverage varies hugely among sub-regions, from West and Central Africa's 14 per cent in 2010 to East and Southern Africa's 55 per cent in 2009/10 (box 6.1), up from 41 per cent in 2005.

Efforts towards infant antiretroviral prophylaxis are stagnating, however: one year from 2009 to 2010 recorded only a 21 per cent increase in Africa (excluding North Africa), again with variations among sub-regions. Coverage increased in East and Southern Africa by 26 per cent and an estimated 337,000 children were receiving ART there in 2010, but in West and Central Africa coverage grew at a mere 9 per cent, giving just 9,000 more children the therapy.

Many AIDS-related deaths among HIV-infected children can also be avoided through timely provision of care and treatment, and although such services for HIV-exposed and HIV-infected children are expanding in Africa, they remain inadequate.

National plans should leverage opportunities to strengthen synergies with existing programmes for HIV, maternal health, newborn and child health, family planning, orphans and vulnerable children, and treatment literacy. HIV prevention and treatment for mothers and children is more than a single intervention at one point in time in the perinatal period. It should be seen as an opportunity for a longer continuum of engagement in care with other essential health services, without loss of focus on HIV. This would allow powerful synergies across the MDGs, helping to achieve the health-and gender-related targets.

HIV treatment can boost prevention

One area for synergy in the fight against HIV/AIDS is the impact of HIV treatment on prevention, and there are early signs that this increase in access to treatment is contributing to the rapid decline in new HIV infections. UNAIDS suggests that the number of new HIV infections is 30–50 per cent lower than it would have been without universal

Box 6.1 Preventing mother-to-child transmission – success in Botswana

Botswana has anchored the MDGs within its national development plan, allowing the country to set its own priorities and to design and implement strategies most appropriate for achieving them. National ownership and relevance for a wider audience have been the guiding principles. Targets have to be relevant to local circumstances and reflect national commitment.

The country has a successful prevention of mother-to-child transmission programme. By September 2009, over 90 per cent of HIV-infected pregnant women had received services under the programme. Mother-to-child transmission of HIV had been reduced from 20–40 per cent in 2001 to around 4 per cent in 2008/09.

The government plans to ensure access to highly active antiretroviral therapy (HAART) for all pregnant women infected with HIV, which should reduce mother-to-child transmission further, to under 1 per cent.

Source: Ministry of Finance and Development Planning of Botswana and UN (2010).

access to treatment for eligible people living with HIV. However, this finding should not distract attention from preventing transmission of new infections. Combining treatment with prevention has implications for resources that all governments should be ready to accept (UNAIDS 2011b).

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

Political commitment is a driving factor in reducing malaria and TB. Commitment made by heads of state at African summits covers bolstering institutional responses, strengthening health systems, forging partnerships, mainstreaming health in development plans, mobilizing financial resources and investing in research and development. Forging partnerships and mobilizing resources have been very successful, and to a lesser degree institutional responses.

Malaria is preventable and curable, but the world in 2010 saw over 200 million cases and 650,000 deaths. Most deaths worldwide still occur among children in Africa. Positively, malaria mortality has fallen by more than 33 per cent in the continent since 2000 – much faster than the global rate of 25 per cent – stemming mainly from stronger prevention and control measures.

Because TB is the most common opportunistic infection, controlling its epidemic is closely linked to controlling the HIV epidemic. The number of new cases of TB has fallen and TB prevalence was lower in 2010 than in 2005 in all Africa's sub-regions.

Indicator 6.6: Incidence and death rates associated with malaria

Control strategies and funding are crucial

Malaria control shows broadly two positive developments. The first is the reported reduction of global incidence and death rates: the annual number of cases dropped slightly from 233 million in 2000 to 216 million in 2010, of which 174 million (81 per cent) were in Africa, while deaths fell from 985,000 to about 655,000 in 2010, 86 per cent of which were among children under five. The second is that international funding has continued to rise, reaching $2 billion in 2011.

Eight African countries showed a fall of at least half in confirmed cases (or malaria admissions) and in deaths in recent years (Algeria, Botswana, Cape Verde, Namibia, Rwanda, São Tomé and Príncipe, South Africa and Swaziland). Eritrea, Ethiopia, Senegal and Zambia showed reductions of 25–50 per cent. In all countries, the decreases were associated with intense malaria control interventions.

Increases in malaria cases in Rwanda and in São Tomé and Príncipe in 2009 (two countries that had previously reported reductions) are being reversed after intensification of control measures. This highlights the need to build systems for effective surveillance of malaria and to rigorously maintain control programmes even when cases have been reduced substantially. The increase in cases and deaths in Zambia in 2009 has yet to be reversed (WHO, 2011b).

In 2010, 27 countries in Africa adopted the WHO recommendation to provide ITNs for all people at risk for malaria – not only pregnant women and children – and 35 per cent of children under five at risk slept under an ITN. The number of people protected by ITNs in Africa increased from 10 million in 2005 to 78 million in 2010. Malaria programme reviews were conducted in 23 African countries. Updated strategic plans, targeting universal access, were developed in 15 countries (WHO, 2011b).[32]

Issues with vertical health funds

The encouraging increase in funding is threatened by the Global Fund's announcement in November 2011 that Round 11 of funding is to be cancelled for 2012–2016, which could lead to reversals in other vertical funding programmes. This raises issues for sustaining vertical health funding, particularly given declines in development partners' funding owing to the global financial crisis.

There is a need for African countries to reduce heavy reliance on vertical funding by exploring alternative sources, and by better harmonizing support from other major global health initiatives and bodies such as the Department for International Development, the World Bank's Booster Program and the Bill & Melinda Gates Foundation.

Another drawback of vertical funding is that it contributes little to capacity building in Africa, and so external finance should be flanked by domestic resources and public–private partnerships to strengthen health systems.

Malaria constitutes 22 per cent of all childhood deaths and its disease burden[33] is estimated at about 1.3 per cent of GDP in countries with high disease rates (WHO, 2011b). The high burden of TB a few years ago meant a loss in productivity of an estimated 4–7 per cent of GDP (AUC et al., 2004). Thus adequately addressing vertical funding has positive repercussions not only for the health of African populations and health systems in general, but socio-economic development more widely.

32 Benin, Botswana, Burkina Faso, Kenya, Malawi, Mozambique, Namibia, Niger, Rwanda, Senegal, South Africa, Tanzania, Togo, Uganda and Zambia.

33 A statistical measure indicating loss of years of healthy life through disabling disease in a specified population, as measured in disability-adjusted life years.

Indicator 6.7: Proportion of children under five sleeping under insecticide-treated bednets

ITNs have helped to lower under-five malaria incidence

Thanks to increased funding, the share of households owning at least one ITN in Africa (excluding North Africa) is estimated to have risen from 3 per cent in 2000 to 50 per cent in 2011, and many children under five are using them (figure 6.2). The proportion of exposed people protected by indoor residual spraying rose from less than 5 per cent in 2000 to 11 per cent in 2010.

After recent studies identified long-lasting insecticidal nets and indoor residual spraying as the two most powerful means of avoiding malaria infections, WHO now recommends an emphasis on both long-lasting nets and indoor residual spraying rather than just ITNs.

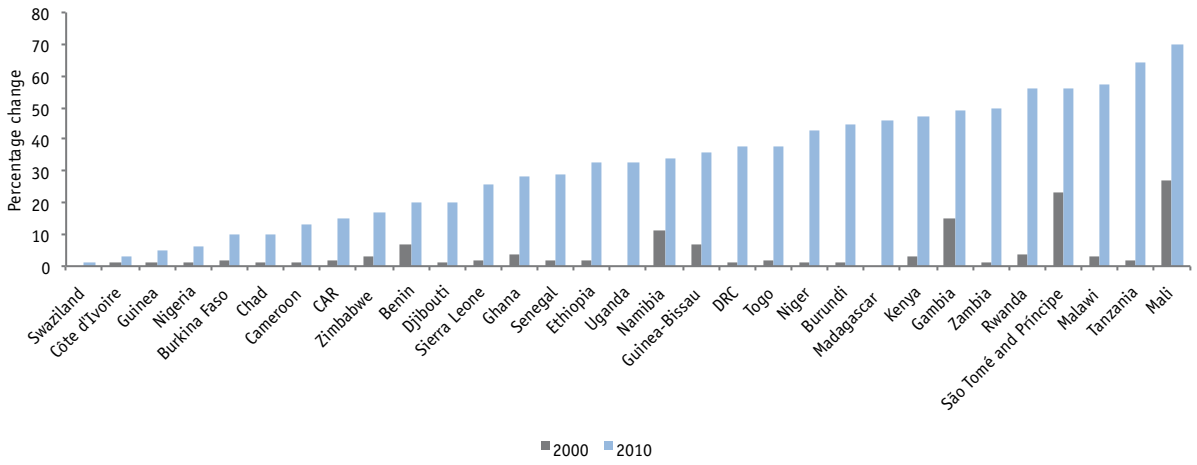
Indicator 6.8: Proportion of children under five with fever who are treated with appropriate antimalarial drugs

Inequities still mark malaria treatment

Surveys in many African countries show that the number people receiving antimalarial medicines is increasing, as well as the proportion of reported suspected cases receiving a parasitological test (35 per cent), with the largest increase among the world's regions seen in Africa (excluding North Africa) (WHO, 2011b). This progress needs to be sustained to achieve the malaria control targets. Furthermore, inequity in access and use of these medicines needs to be addressed, because populations from rural areas and poorer backgrounds still receive fewer antimalarial drugs than those from urban and richer backgrounds (UNICEF, 2011b).

Detailed analysis of antimalarial treatment shows that artemisinin-based combination therapies still

Figure 6.2 Change in share of children under-five sleeping under insecticide-treated bednets, circa 2000 and 2010



Source: UNICEF Global Database, June 2011.

Note: The country data were collected through various surveys and in various years.

account for only a tiny (but rising) share of total treatment in Africa, even though it is a more effective treatment for the disease than chloroquinine and/or single therapy treatment (WHO, 2011b).

Indicator 6.9 Incidence, prevalence and death rate associated with TB

TB is usually curable. More than 90 per cent of people with drug-susceptible TB can be cured in six months using combinations of first-line drugs. Treatment of multidrug-resistant TB – there are around 0.5 million cases each year globally – is more challenging, requiring the use of second-line drugs that are more costly, cause more severe side effects and must be taken for up to two years. Cure rates for multidrug-resistant TB are also lower, usually 50–70 per cent (WHO, 2011a).

WHO continues to support the rolling out of the Stop TB strategy in Africa. Thirty-six eligible African countries have been supported to access high-quality first-line anti-TB medicines through the Global TB Drug Facility. Twenty-four countries have accessed quality-assured second-line anti-TB medicines through the WHO Green Light Committee mechanism. To assess the burden of drug-resistant TB, 13 countries have completed countrywide TB drug resistance surveys.[34]

WHO has set targets for all countries to achieve at least a 70 per cent case detection rate and an 85 per cent treatment success rate. The continent is still short of these targets but many countries have made real progress. By 2010, 15 countries had reached the targeted case detection rate;[35] by 2008, 20 had achieved the targeted treatment success rate (Global TB Report, 2010);[36] and eight had reached both targets by 2010 (WHO, 2011a).[37]

Tackling HIV has a positive impact on TB infections

HIV and TB show a strong association. Evidence from Figure 6.3 suggests that countries with high HIV prevalence always have very high incidence of TB. Over 10 per cent of TB cases are HIV positive. In 2009, TB accounted for one in four deaths among HIV-positive people. Thus TB control largely follows the same path as that for HIV (WHO, 2011a).

TB control is starting to bear fruit in Africa. After a peak in 2005, prevalence rates by 2010 had fallen in all sub-regions, and were lower than in 1990 in all sub-regions except two (figure 6.4). Southern Africa is still the sub-region most affected by TB. The number of new infections is stable in North Africa, which remains the least affected sub-region.

Egypt, Tunisia, Mauritius, Seychelles and Libya had the lowest prevalence in 2010, and Sierra Leone, Togo, Djibouti, South Africa and Swaziland, the highest. Namibia, Botswana, Uganda, Rwanda and Mali recorded the biggest reduction in prevalence after 1990 (WHO, 2011a).

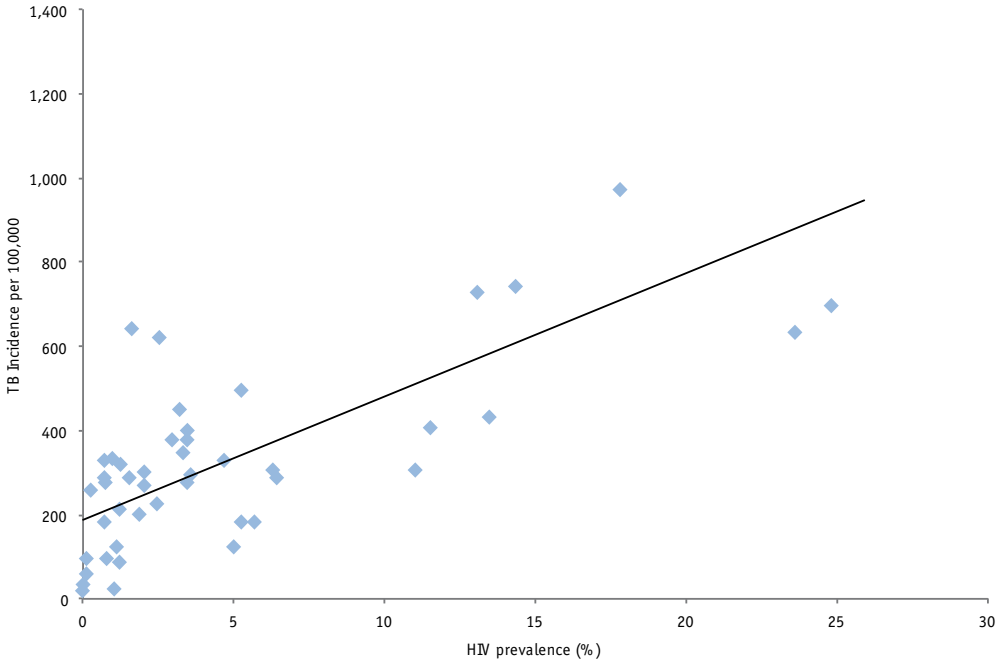
34 Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Niger, Nigeria, São Tomé and Príncipe, South Africa, Swaziland, Tanzania and Zambia.

35 Algeria, Angola, Botswana, Burundi, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Ghana, Kenya, Lesotho, Namibia, São Tomé and Príncipe, South Africa, Tanzania and Zambia.

36 Algeria, Benin, Burundi, DRC, Eritrea, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Tanzania and Zambia.

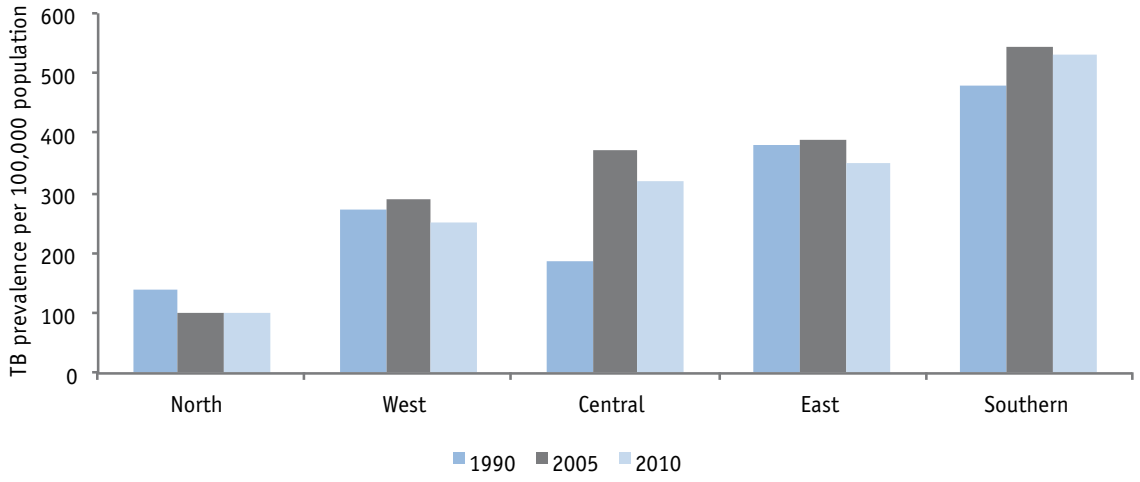
37 Algeria, Burundi, Ghana, Namibia, Kenya, São Tomé and Príncipe, Tanzania and Zambia.

Figure 6.3 TB incidence is closely related to HIV prevalence, selected African countries, 2009



Source: Computations from UNSD, accessed December 2011.

Figure 6.4 TB prevalence rate per 100,000 population by African sub-region, 1990, 2005 and 2010



Source: Compiled from WHO (2011c).

Note: The data are weighted by the population in each country.

HIV is not the only driver of TB infections

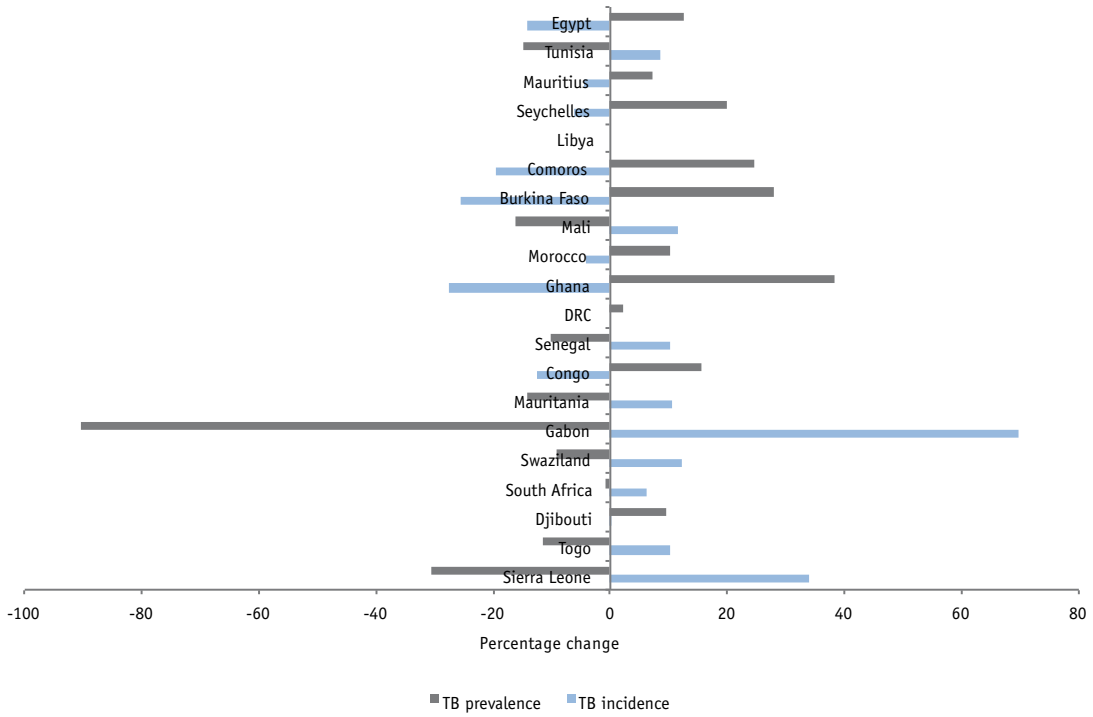
In Africa, new TB infections (incidence) are generally decreasing at a slower pace than prevalence rates, unlike HIV and malaria where incidence and prevalence are declining at similar rates. Incidence has, though, increased and prevalence fallen in, for example, Sierra Leone, South Africa, Tunisia and Swaziland (figure 6.5).

TB infection rates depend not only on HIV status and behavioural adaptation, such as condom use or sleeping under ITNs, but also on institutional and socio-economic factors, such as crowded living and working conditions and poor sanitation. They are also driven by inadequate health care access, as well as by, for example, malnutrition, diabetes mellitus, smoking, and alcohol and drug abuse (WHO, 2011c).

Tackling such factors must run alongside reducing HIV prevalence to manage TB incidence, including the socio-economic conditions that give rise to new infections.

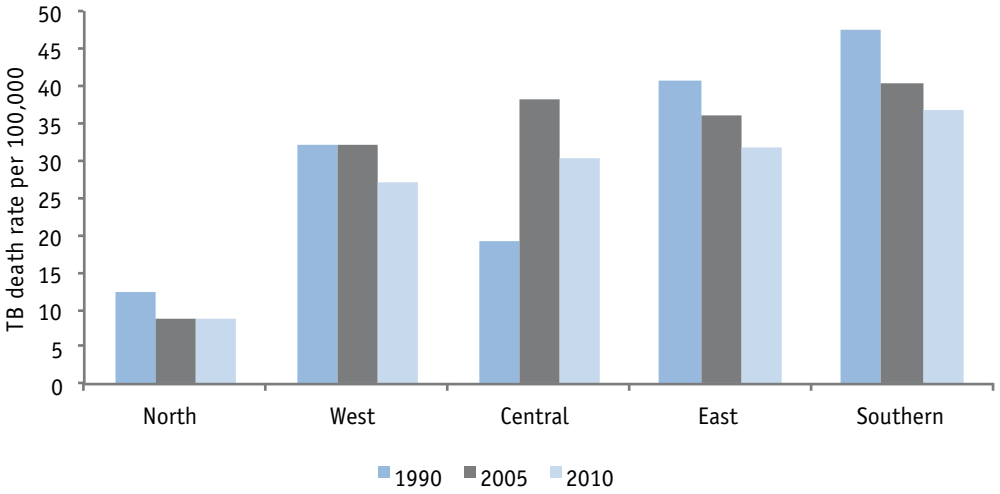
The TB death rate in 2010 was lower than in 1990 in all sub-regions except one (figure 6.6). North Africa has the fewest deaths. The biggest drop came from Southern Africa.

Figure 6.5 Change in prevalence and incidence of TB, 2005–2010, selected African countries



Source: Computations from UNSD, accessed December 2011.

Figure 6.6 TB death rate per 100,000 population by African sub-region, 1990, 2005 and 2010



Source: Compiled from WHO (2011c).

Note: The data are weighted by the population in each country.

Conclusions

Africa's progress towards this goal is encouraging, although the burden of HIV/AIDS, malaria and TB on health systems and populations' health status is still heavy. Vertical funding has contributed greatly to this progress and to minimizing the impact of related interventions on the health budgets of several African countries, but this very success has had a toll on health resources required to sustain the advances.

And so more has to be done in addressing the capacity and resource gaps of national health systems as well as tackling inequities in access and use, particularly among low-income groups, rural populations and women. The quantity and quality of domestic resources for these three diseases need to be boosted to consolidate and build on the gains, and to provide alternatives to the unpredictability of future vertical funding. An integrated approach to HIV/AIDS, malaria and TB will have positive spillover effects on maternal and child mortality, educational performance and the overall socio-economic development of the continent.

Goal 7: Ensure environmental sustainability

Ensuring environmental sustainability has a great impact on reaching most of the other goals. Preserving and properly managing the environment is an essential foundation for sustainable development and poverty reduction. Most African countries are demonstrating commitment to MDG 7, but in many of them difficulties are hampering steady progress. These include lack of political will, pressure on environmental resources to support economic growth, weak governance and planning frameworks, and a lack of financial resources.

Some of these challenges will be issues for discussions and reflections at the 20th anniversary of the 1992 UN Conference on Environment and Development, in Rio de Janeiro in June 2012 (Rio+20). The conference's objective will be to secure renewed political commitment for sustainable development, assess progress so far as well as the remaining gaps in achieving the outcomes of major summits on sustainable development and address new and emerging challenges. The meeting will provide an opportunity to discuss the green economy in sustainable development and poverty eradication, as well as an institutional framework for sustainable development. Some of the outcomes of the meeting will feed into the post-2015 development agenda.

The UN Climate Convention of the 17th Conference of the Partiesin Durban, South Africa, in December 2011 took several important steps on gas emissions, including an agreement to negotiate a more inclusive treaty on global emissions and to establish a Green Climate Fund. The outcomes of the convention provide a welcome boost for global climate action and reflect the growing – and in some quarters unexpected – resolution of countries to act collectively. This provides a measure of predictability to economic planners, businesses and investors about the future of low-carbon economies. Specific commitments agreed to at the convention also indicate that some previous decisions on financing, technology and reduced emissions from deforestation and forest degradation are moving towards implementation.

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

Indicator 7.1: Proportion of land area covered by forest

Declining forest cover threatens rural livelihoods

In 1990, Africa (excluding North Africa) had 31.2 per cent of land area covered by forest; by 2010, this had shrunk to 28.1 per cent. This decline stems from over-exploitation and conversion of forests to other uses, driven by population growth, economic development and the need for people to meet their basic needs.

This rapid, continuing loss of forests and forest degradation in many developing countries, especially in tropical regions, is a crucial global challenge. Rural livelihoods often depend on productive forests that support employment and income, reducing poverty. The cause of much deforestation is that most African countries rely on biomass (90 per cent of total energy consumption) to meet their primary energy needs. Chronic energy poverty and lack of access to modern forms of energy put forests under stress for firewood and charcoal production.

During 1990–2010, 38 African countries recorded a loss in forest area at varying rates (figure 7.1). Zimbabwe, Benin, Nigeria, Uganda, Ghana, Comoros and Tanzania were among the worst hit. Comoros, for instance, had 6.5 per cent of land area covered by forest in 1990 but only 1.6 per cent in 2010. Only nine countries saw their forest cover improve.[38]

Some countries, including Cape Verde, Gambia, Rwanda and Tunisia, have launched reforestation programmes. In Cape Verde, for example, the proportion of forested area has climbed by 6.7 percentage points to 21.1 per cent over the period. The Congo has also embarked on a vast tree-planting programme to guard against deforestation and soil degradation (box 7.1).

In Malawi, one of the major causes of the destruction of indigenous forests is the high demand for wood. Some Malawian communities are therefore working with RIPPLE Africa, a United Kingdom charity engaged in activities to improve the environment, healthcare and local education (box 7.2).

38 Cape Verde, Côte d'Ivoire, Egypt, Gambia, Lesotho, Morocco, Rwanda, Swaziland and Tunisia.

The Great Green Wall of the Sahara and Sahel is another initiative conceived as a set of cross-sectoral actions and interventions aimed at conserving natural resources, securing economic development and, particularly, reducing poverty.[39] The initiative has grand ambitions, including holding off desertification and protecting local water resources like Lake Chad from drying out, and enabling biodiversity to flourish. Not only does it aim to combat climate change, but also help communities to adapt to it. The Green Wall Project in Senegal has managed to plant nearly 8 million seedlings since 2008.[40]

The declining trends in forest cover require African countries to prioritize sustainable forest management programmes. But weak forestry institutions, policies and regulatory frameworks, coupled with inadequate human resources, are making it hard to carry out such programmes – matters that countries are urged to address.

Indicator 7.2: CO_2 emissions, total, per capita and per $1 GDP (PPP)

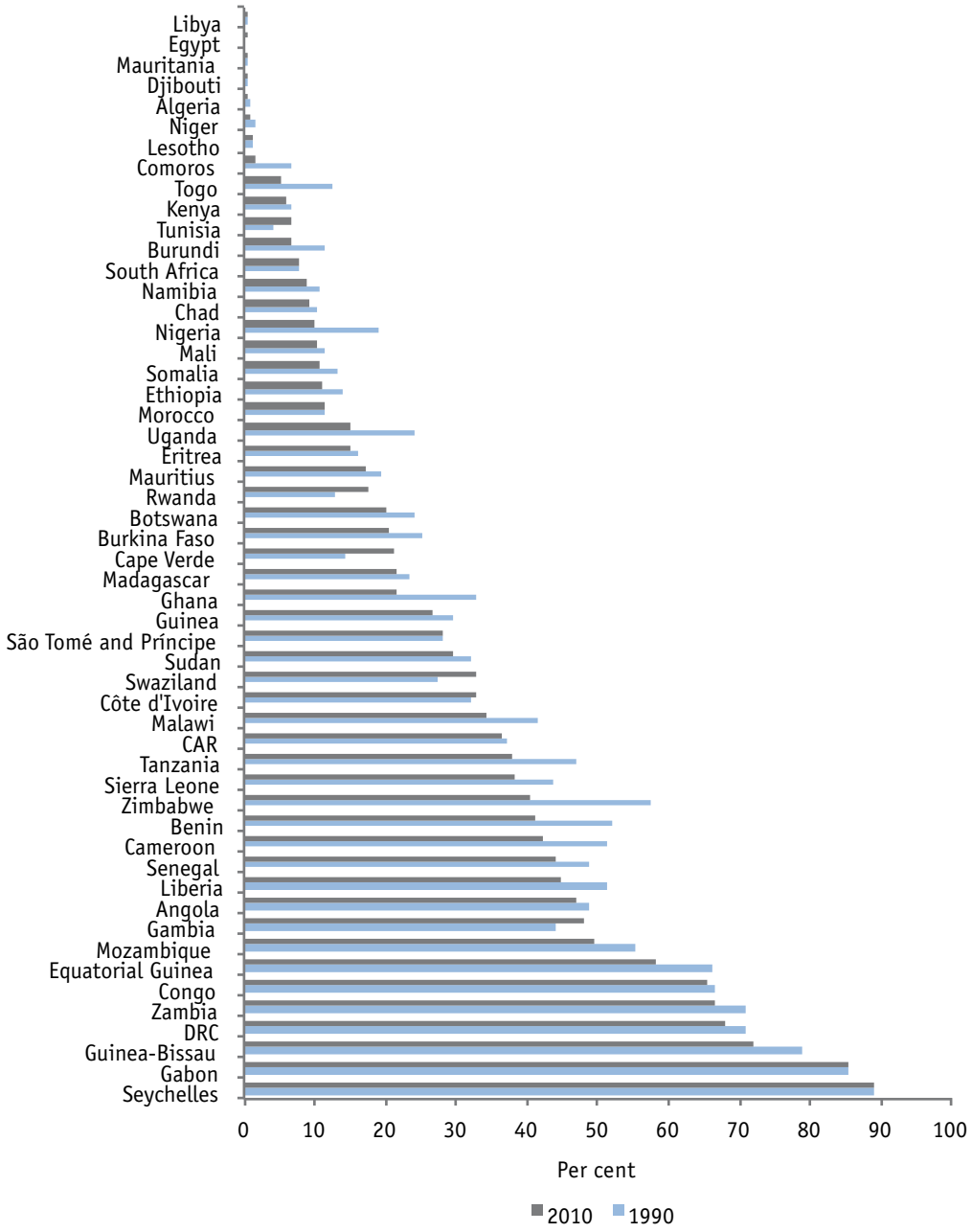
CO2 emissions are low and largely unchanged

Emissions of CO_2 per capita are an important indicator in assessing progress towards environmental sustainability and climate change. Africa is very vulnerable to climate change given its low capacity to respond and adapt, but the continent emits quite little greenhouse gas relative both to its population and to other regions.

39 UNEP-WCMC, http://www.unep-wcmc.org/unep-support-to-the-great-green-wall-for-the-sahara-and-the-sahel-initiative_862.html.

40 OneWorld UK, http://uk.oneworld.net/guides/senegal/climate-change.

Figure 7.1 Proportion of land area covered by forest, 1990 and 2010



Source: Computations from UNSD, accessed December 2011.

Box 7.1 After years of degradation, some help for the Congo Basin's forests

The Congo is one of 10 central African nations in the Congo Basin, which, after the Amazon Basin, has the world's largest tropical rainforest.

The African Development Bank hosts the Congo Basin Forestry Fund, which was set up to mobilize resources for activities and projects to promote equitable and sustainable use, conservation and management of the Congo Basin's forests and ecosystems. The ultimate aims are to reduce poverty, sustain socio-economic development, tighten regional cooperation and strengthen environmental conservation.

Climate change is already eroding decades of hard-won development achievements in Africa. Countries most affected – by floods, loss of biodiversity, desertification, erratic rainfall, higher temperatures and water scarcity – include Botswana, Malawi, Mozambique, Zambia and Zimbabwe. Agriculture's expansion into marginal lands has deforested large tracts of land, affecting water tables. Addressing climate change and ensuring climate-resilient development through adaptation and mitigation have become priorities for governments and development agencies.

During 1990–2008, 16 countries recorded declines in CO_2 emissions at varying rates, with Gabon recording a steep reduction, probably on account of its high proportion of land area covered by forest. Equatorial Guinea and Seychelles recorded the highest increase in CO_2 emissions. In the rest of the Africa, CO_2 emissions have registered little change (figure 7.2).

Box 7.2 Communities benefit from trees, Malawi

RIPPLE Africa runs a tree planting project in Malawi. The project aims to:

- provide a sustainable source of timber by planting fast-growing, exotic trees;
- conserve existing indigenous trees by decreasing the demand for wood from Malawi's natural forests; and
- restore degraded land by planting indigenous trees where appropriate.

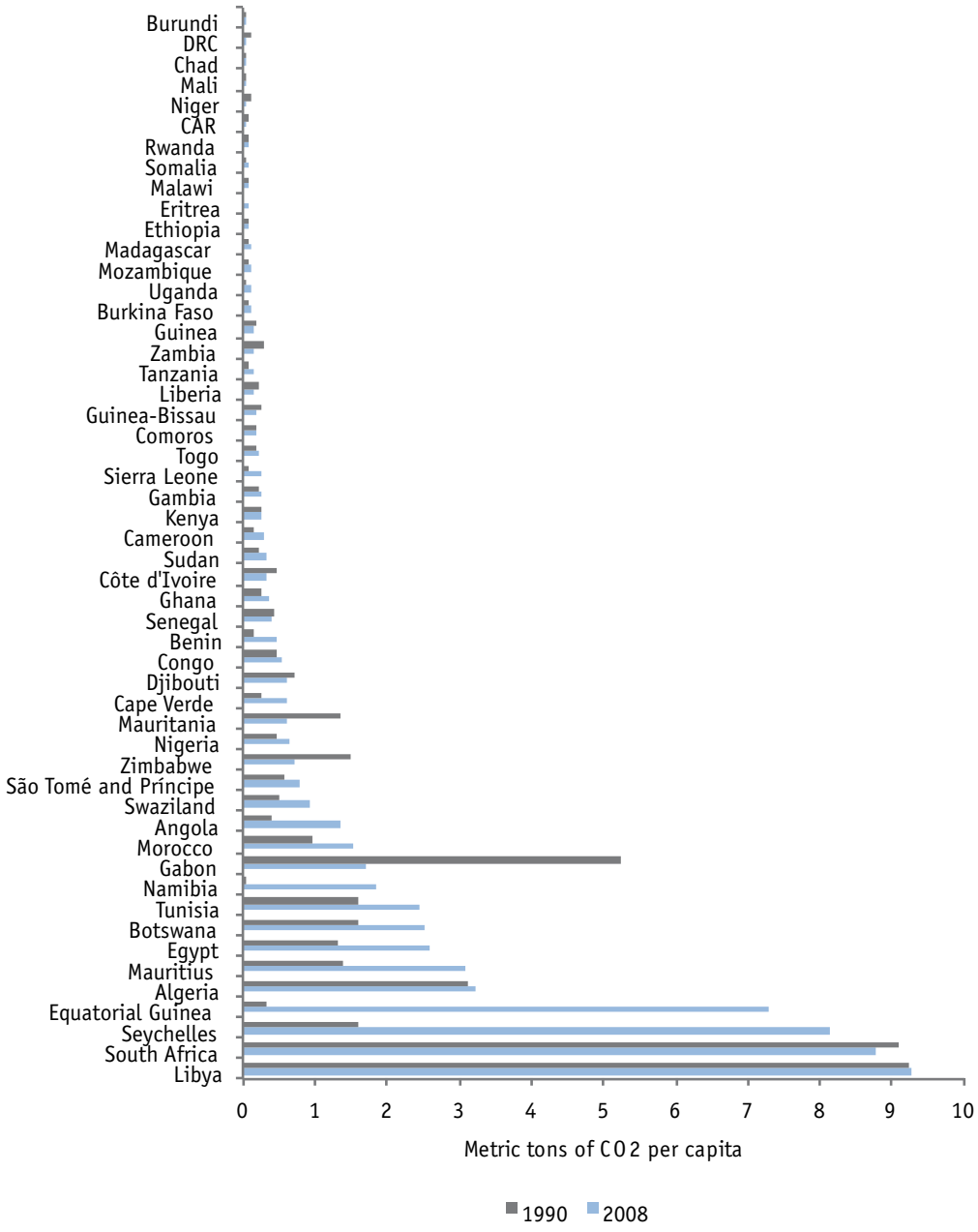
Since its launch in 2006,the project has helped over 175 community groups to plant more than 3 million trees in the Nkhata Bay District.

The project is one of the most important environment-focused initiatives in the country, and provides a long-term solution to deforestation. It directly fights deforestation by planting thousands of quick-growing exotic trees in community woodlots that provide a sustainable source of timber for local people.

These trees provide an immediate benefit to the community who use them like a crop – coppicing the trees (cutting off the branches for firewood without felling the whole tree), which then grow back quickly to provide more wood. This eases the heavy pressure on the indigenous forests, and helps to change the way people in Malawi think about their natural resources.

Source: RIPPLE Africa, www.rippleafrica.org/environment-projects-in-malawi-africa/tree-planting-africa.

Figure 7.2 CO_2 emissions, 1990 and 2008



Source: Computations from UNSD, accessed December 2011.

Indicator 7.3: Consumption of ozone-depleting substances

The majority of African countries are on the right track

This indicator marks the commitment to reducing carbon dioxide emissions and progress in phasing out the consumption of ozone-depleting substances, such as chlorofluorocarbons, by countries that have ratified the Montreal Protocol of 1987. The protocol requires countries in particular to freeze consumption of hydro-chlorofluorocarbons (HCFCs) by 1 January 2013 and to reduce it by 10 per cent by 1 January 2015.

The majority of African countries have committed to full compliance with the protocol and have reduced consumption of ozone-depleting substances (ODS) (table 7.1). In Zimbabwe, one of the contributing factors to the reduction in ODS was a total phase-out of methyl bromide in the tobacco, grain fumigation and horticulture industries. Some countries, however, have increased their consumption of ODS, owing to weak regulatory measures, and need to take steps to reverse this trend.

The steep rise in HCFC consumption in many countries is a concern, especially given the approaching compliance targets. A rapid increase in imports of HCFC-based equipment and growing HCFC consumption in services have been reported (UNEP, 2011). For this reason, a call-up to all countries has been made to review their ODS policies to ensure that they are comprehensive, updated and have the objective of reducing the growth in HCFC consumption.[41] African countries have developed a new policy tool – the informal Prior Informed Consent mechanism –that will help strengthen the enforcement of countries' systems for licensing imports of ODS.

To mitigate the effects of climate change, countries need to promote clean and renewable energy generation, as well as forestation. For instance, in view of South Africa's energy-intensive industries and the predominance of coal as a cheap source of energy, the country is one of the five highest greenhouse gas–emitting emerging markets, accounting for 65 per cent of Africa's emissions. South Africa – as well as other African countries – has already started promoting clean energy resources, in particular through AfDB's assistance with the Clean Technology Fund.

Target 7B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss

Indicator 7.6: Proportion of terrestrial and marine areas protected

More countries are making progress

This indicator represents the degree to which components of biodiversity are formally protected. It illustrates the changes in extent of protected areas relative to geographical and political units and to different measures of distribution of the components of biodiversity, such as priority areas, ecosystem or habitat maps and species distributions (Bubb, Fish and Kapos, 2009).

Twenty-seven countries saw improvements during 1990–2010 (table 7.2). Twenty-five countries in 2010 had achieved the target of having at least 10 per cent of their territorial and marine areas

41 The call-up was made by UNEP OzonAction Branch during a meeting of the Ozone Depleting Substances Officers Network in Africa in October 2011 in Harare.

Table 7.1 Change in consumption of ODS, 2000–2009 (%)

An increase		A reduction of more than 50%		A reduction of less than 50%	
Swaziland	475.0	Benin	-50.9	Cape Verde	-5.26
Lesotho	329.2	Mali	-52.3	Niger	-7.09
CAR	164.4	South Africa	-57.1	Burkina Faso	-23.5
Madagascar	132.4	Mauritius	-61.2	Chad	-26.5
Gabon	83.3	Angola	-67.0	Guinea	-42.0
Botswana	66.7	Côte d'Ivoire	-67.3	Somalia	-42.4
Seychelles	55.6	Senegal	-69.0	Togo	-47.6
Ghana	42.3	Mozambique	-70.7		
Mauritania	30.8	Egypt	-71.3		
São Tomé and Príncipe	2.5	Equatorial Guinea	-71.9		
		Gambia	-74.2		
		Cameroon	-74.9		
		Namibia	-74.9		
		Congo	-74.9		
		Sudan	-75.3		
		DRC	-80.3		
		Kenya	-84.7		
		Guinea-Bissau	-85.0		
		Burundi	-86.5		
		Rwanda	-87.5		
		Morocco	-87.9		
		Liberia	-88.3		
		Tunisia	-89.2		
		Sierra Leone	-91.5		
		Algeria	-91.5		
		Malawi	-91.5		
		Libya	-91.9		
		Nigeria	-92.0		
		Zambia	-92.7		
		Zimbabwe	-93.1		
		Djibouti	-94.2		
		Tanzania	-94.6		
		Eritrea	-95.7		
		Ethiopia	-96.4		
		Uganda	-100.0		

Source: Computations from UNSD, accessed December 2011.

Table 7.2 Terrestrial and marine areas protected as a share of total territory

	Some progress since 1990 (% protected)			No progress since 1990
Country	1990	2000	2010	
Algeria	6.2	6.2	6.2	Angola
Botswana	30.3	30.9	30.9	Benin
Burkina Faso	13.7	13.9	14.2	Cape Verde
Burundi	3.8	4.9	4.9	CAR
Cameroon	6.9	8.5	9.0	Chad
Congo	5.4	8.1	9.7	Côte d'Ivoire
Egypt	2.1	4.4	6.1	DRC
Equatorial Guinea	5.0	14.0	14.0	Djibouti
Eritrea	3.7	3.7	3.8	Ghana
Ethiopia	17.7	17.7	18.4	Guinea
Gabon	4.3	5.3	14.6	Lesotho
Gambia	1.2	1.3	1.3	Libya
Guinea-Bissau	5.8	26.9	26.9	Malawi
Kenya	11.5	11.7	11.7	Mali
Liberia	1.4	1.4	1.6	Mauritania
Madagascar	1.9	2.5	2.5	Niger
Mauritius	0.4	0.7	0.7	Seychelles
Morocco	1.1	1.5	1.5	Sierra Leone
Mozambique	13.8	13.8	14.8	Somalia
Namibia	13.9	13.9	14.7	Sudan
Nigeria	11.3	12.6	12.6	Swaziland
Rwanda	9.9	9.9	10.0	Togo
Senegal	23.1	23.1	23.5	Tunisia
South Africa	6.2	6.7	6.9	Zambia
Uganda	7.9	8.5	10.3	
Tanzania	25.7	26.4	26.9	
Zimbabwe	18.0	18.1	28.0	

Source: Computations from UNSD, accessed December 2011.

protected, up from 20 in 1990 (figure 7.4). Equatorial Guinea, Gabon, Guinea-Bissau and Zimbabwe made large strides in extending protection.

Countries can adopt various strategies to move towards this target. Some countries have, for example, expanded their national parks. Developing a framework for managing the environment better, through legislation, is another option. South Africa, for example, has developed a national framework for an integrated approach among all stakeholders to managing biodiversity. The framework identifies priority actions for conserving biodiversity and sets out the implications of these priority actions for agencies that lead implementation.

Countries are therefore advised to adopt and implement policies and programmes that prevent pollution and ecological degradation, that promote conservation and that secure the ecologically sustainable use and development of natural resources.

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

Rural–urban disparities are glaring

This MDG target has globally been met well in advance of the MDG 2015 deadline. Over 2 billion people (89 per cent versus the 88 per cent target) gained access to an improved drinking water source during 1990–2010, such as piped supplies and protected wells (WHO/UNICEF, 2012).

But not Africa. The relevant proportion has indeed increased over the period, from 56 per cent to 66 per cent, but the rate of progress is still too slow to hit the continent-wide 78 per cent target by 2015. There are even worrying signs of reversals: although Africa's overall access to an improved water source in rural areas increased from 42 per cent to 53 per cent during 1990–2010, access in urban areas fell from 86 per cent to 85 per cent. This decline may partly be attributed to rapid urbanization and growth of slums.

Of 42 countries with data, 35 reported gains in the proportion with access to an improved drinking water source. Five countries (Algeria, Lesotho, Rwanda, Sudan and Tanzania) registered declines, and two countries (DRC and Mauritius) remained stagnant (figure 7.5).

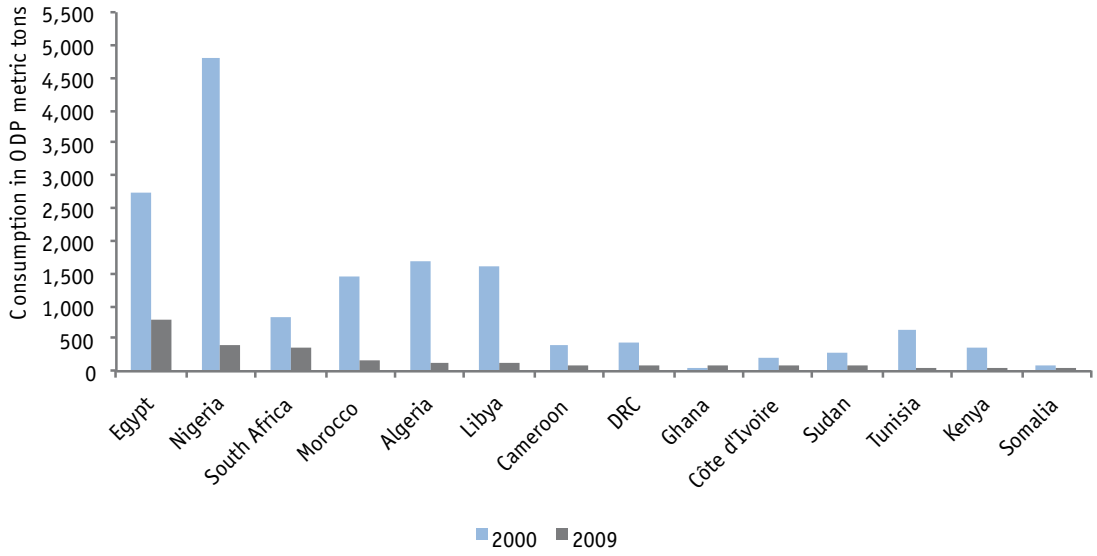
Urban and rural access show a stark disparity in access of over 30 percentage points. The aggregate progress has largely been driven by the urban sector, reflecting countries' water reforms.

Improvements in urban and rural water supply coverage

In 2010, the share of the urban population with access to an improved water source ranged from 52 per cent (Mauritania) to 100 per cent (Egypt, Mauritius, Niger and Seychelles). The number of countries with at least 80 per cent access to an improved water source in urban areas climbed from 26 in 1990 to 38 in 2010. In 2010, no country had a coverage rate of less than 50 per cent, an improvement from four countries with less than 50 per cent coverage in 1990 (figure 7.6).

Coverage varied widely in 2010, from 7 per cent in Somalia to 99 per cent in Mauritius. The number of countries for which rural access was 80 per cent or more rose from 5 in 1990 to 10 in 2010. Other

Figure 7.3 Countries with consumption of ODS above 500 ODP metric tons, 2000 and 2009



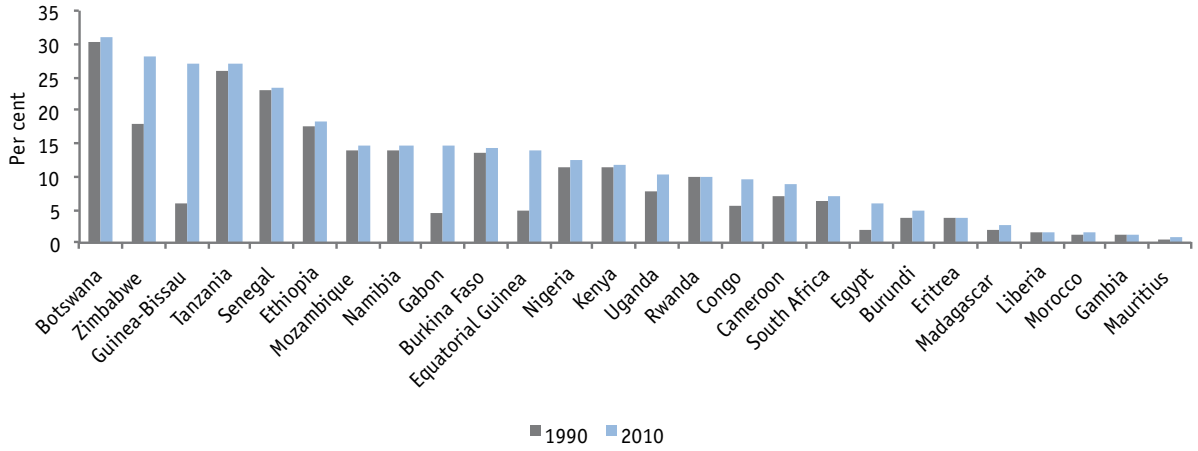
Source: Computations from UNSD, accessed December 2011.

good news was that the number of countries with less than 50 per cent coverage fell from 27 to 16 (figure 7.7).

Indicator 7.9: Proportion of population using an improved sanitation facility

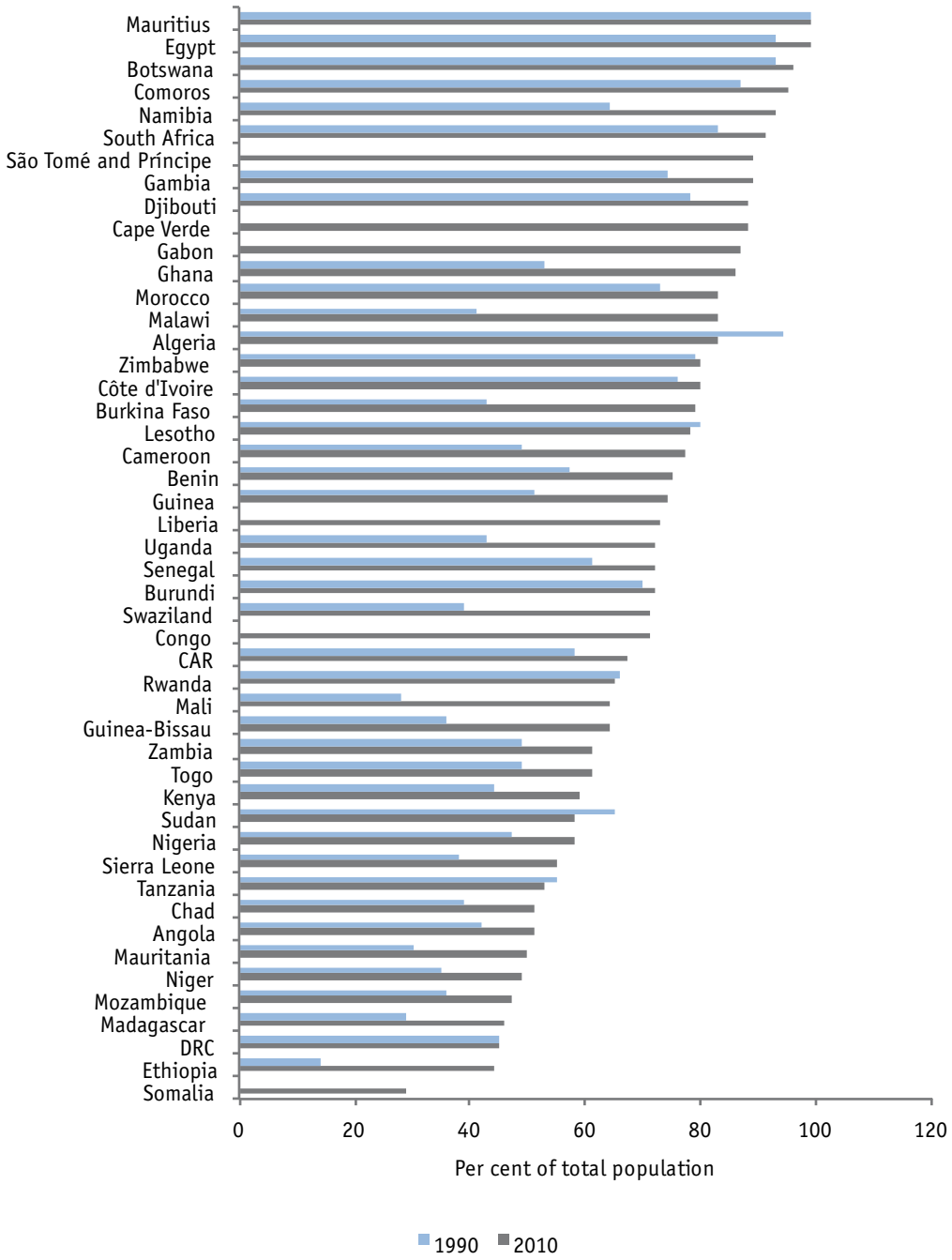
This proportion is generally low – just 40 per cent in 2010 and an increase of only 5 percentage points

Figure 7.4 Terrestrial and marine areas protected as a share of total territorial area, 2010



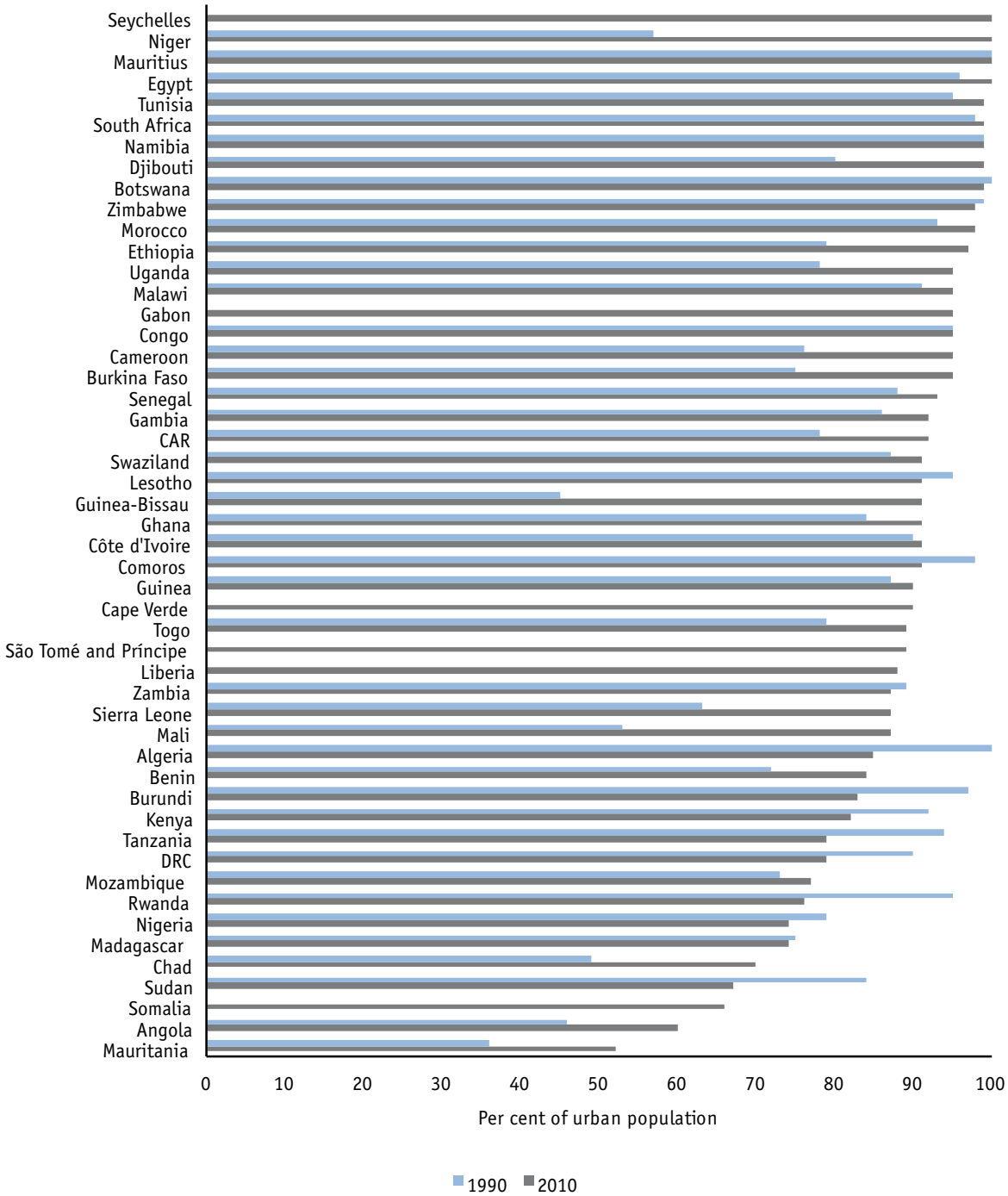
Source: Computations from UNSD, accessed December 2011.

Figure 7.5 Change in access to an improved water source, urban and rural, 1990–2010



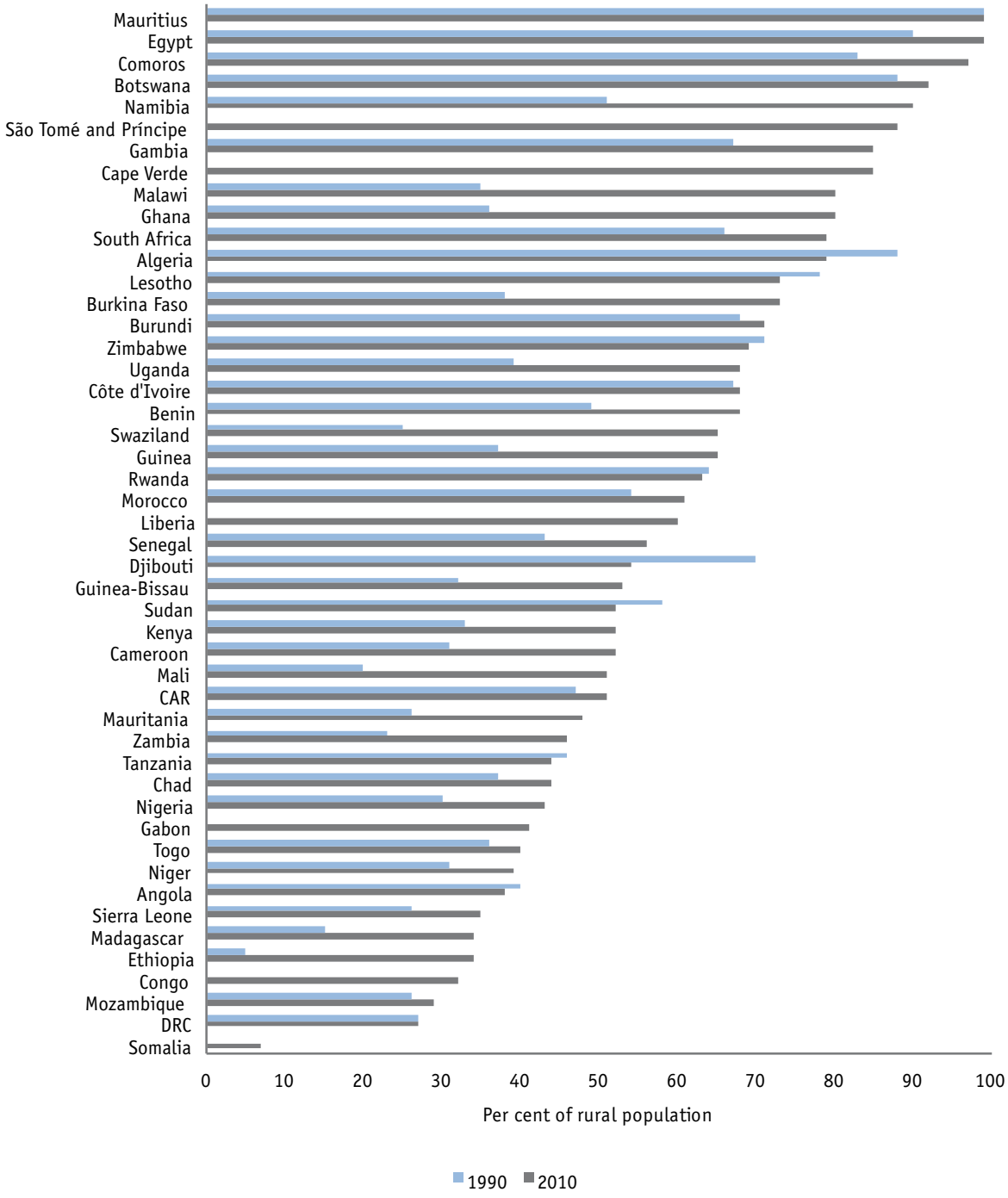
Source: WHO/UNICEF (2012).

Figure 7.6 Change in urban access to an improved water source, 1990–2010



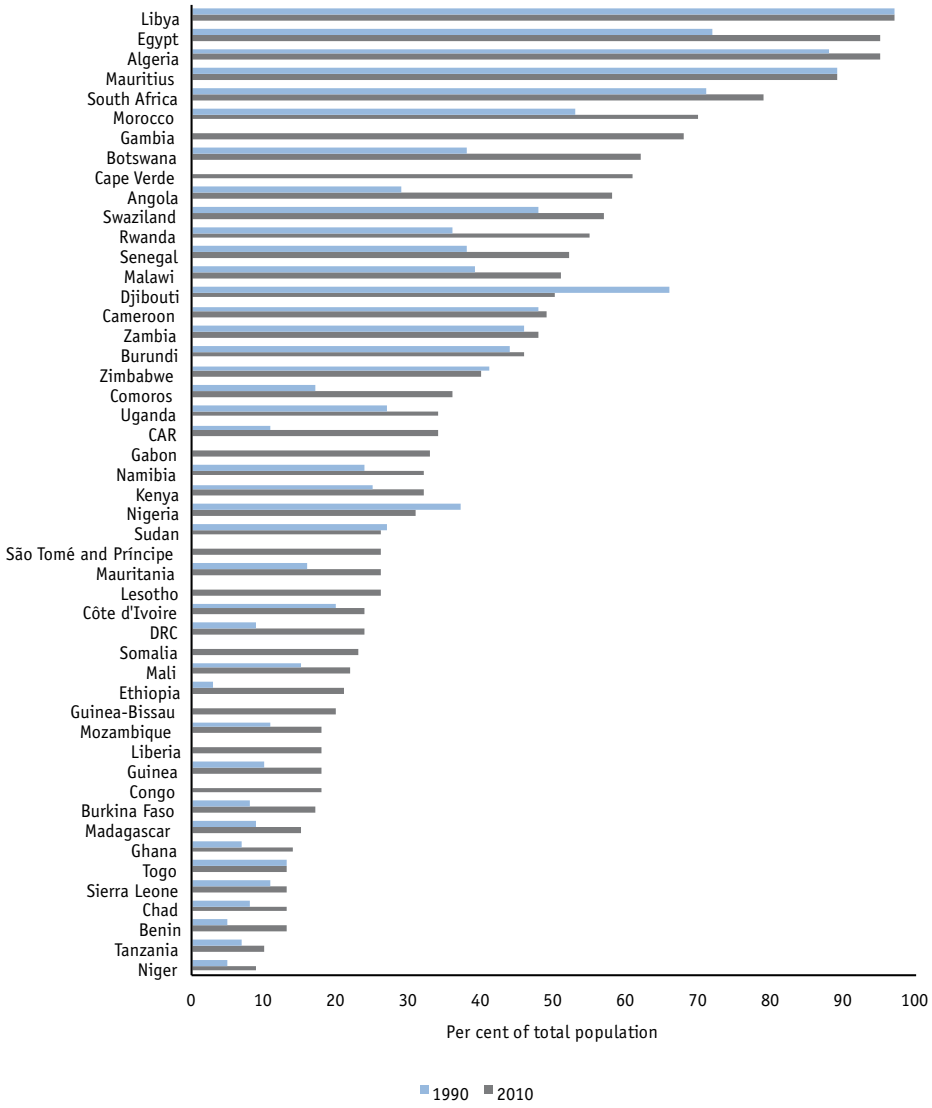
Source: WHO/UNICEF (2012).

Figure 7.7 Change in rural access to an improved water source, 1990–2010



Source: WHO/UNICEF (2012).

Figure 7.8 Change in access to improved sanitation facilities, urban and rural, 1990–2010

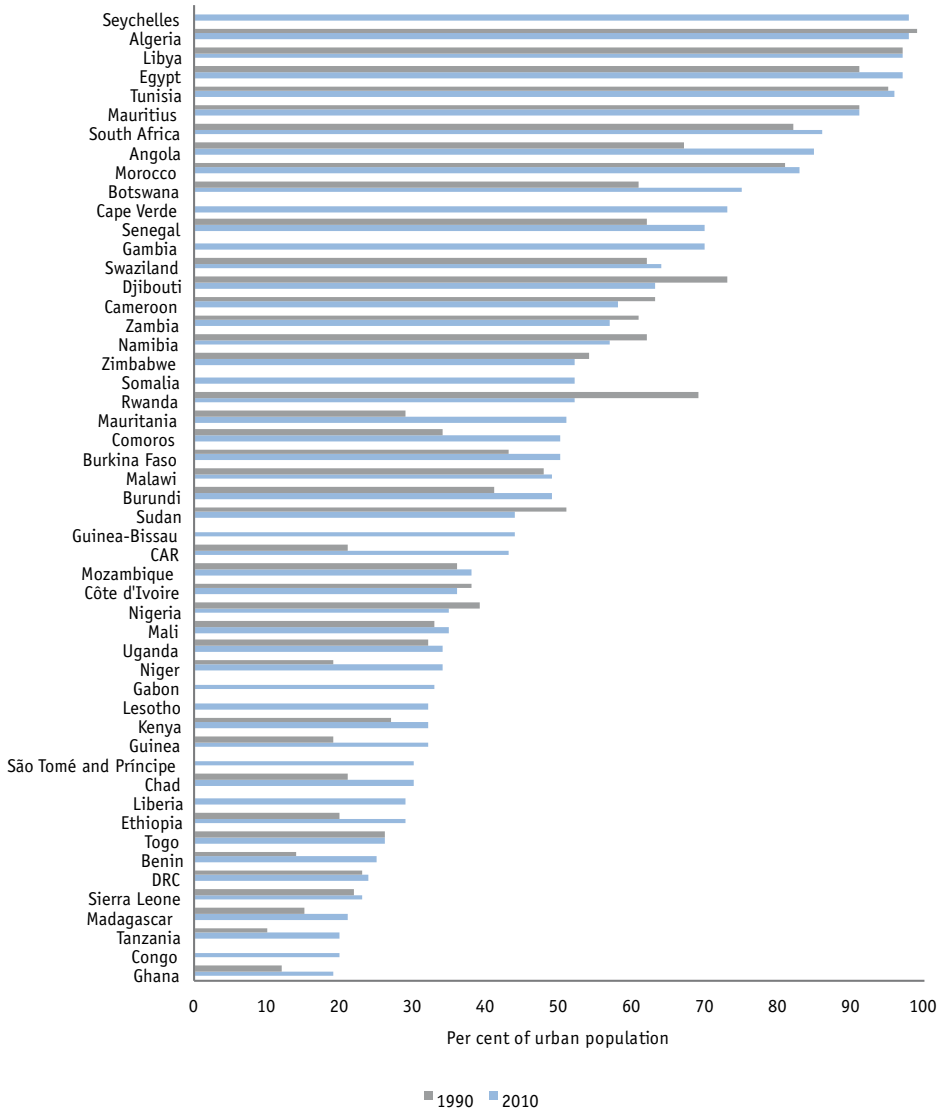


Source: WHO/UNICEF (2012).

from 1990 (WHO/UNICEF, 2012). At this rate, the target is unlikely to be reached. Two of the key constraints are the high cost of infrastructure and the low returns to investment for the private sector, especially in rural areas. The latter helps to explain why public–private partnerships are rare in sanitation.

Of the 40 countries with data, 33 reported gains. Only four (Djibouti, Nigeria, Sudan and Zimbabwe) recorded declines, while three (Libya, Mauritius and Togo) showed no improvement from 1990 (figure 7.8).

Figure 7.9 Change in urban access to improved sanitation facilities, 1990–2010

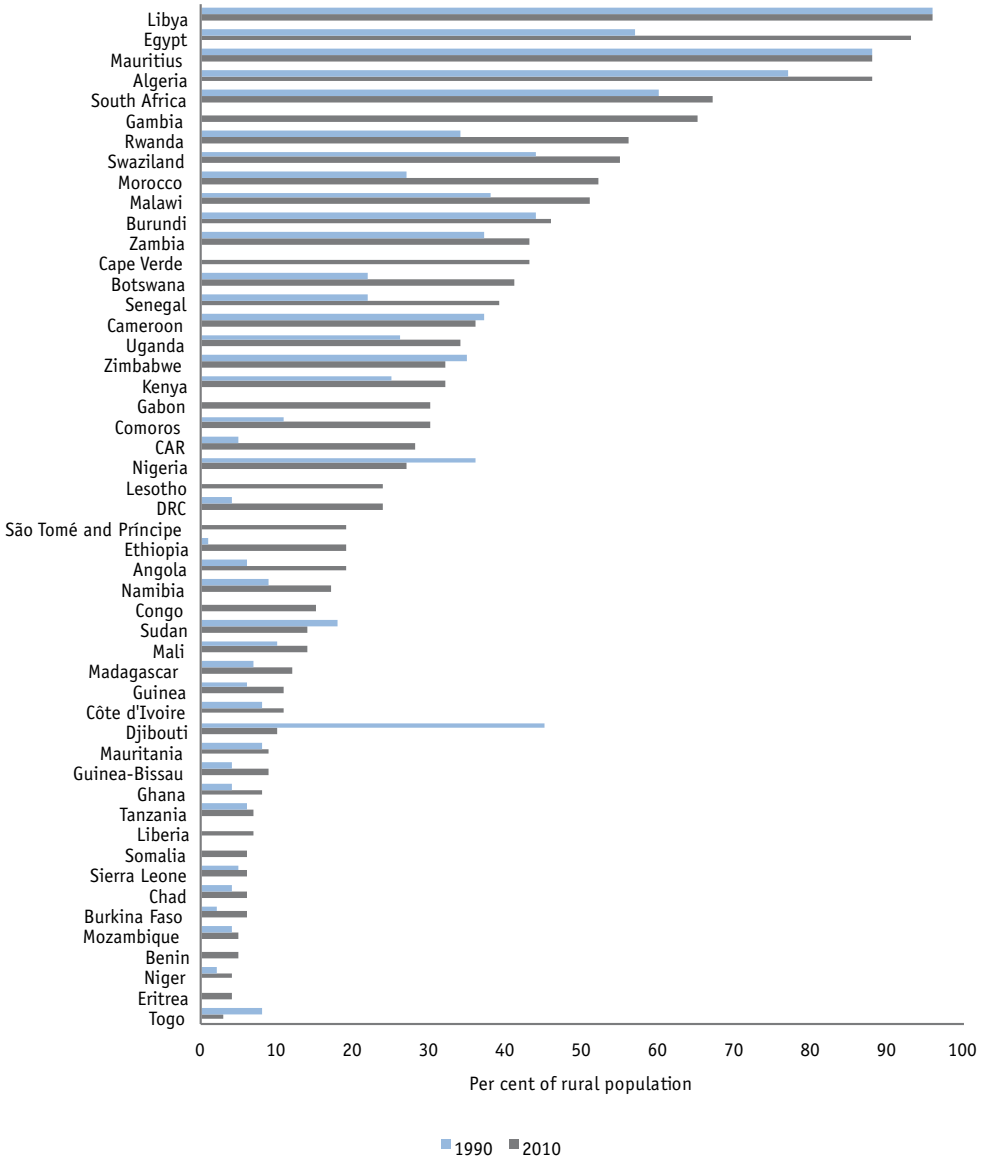


Source: WHO/UNICEF (2012).

As with improved drinking water supply, access to sanitation facilities shows a sharp contrast in urban and rural areas – in 2010, 54 per cent and only 31 per cent, respectively. However – again as with improved drinking water supply – urban areas actually recorded a decline in coverage from 1990's 57 per cent, and again this can be attributed to the high proportion of slum dwellers in a fast-expanding urban population. Rural areas saw slight progress, up from 25 per cent in 1990.

The range for the share of the population with access to improved sanitation facilities in urban areas in 2010 goes from 19 per cent (Ghana) to 98 per

Figure 7.10 Change in rural access to improved sanitation facilities, 1990–2010



Source: WHO/UNICEF (2012).

cent (Seychelles) (figure 7.9); in rural areas, from 3 per cent (Togo) to 96 per cent (Libya) (figure 7.10).

Underneath these data, however, social equity should be considered. For example, it is highly likely that wealthier populations have far greater access than the poor to improved water and sanitation. Countries therefore need to develop policies for integrated water and sanitation, in order to make progress towards equitable coverage.

Conclusions

Countries are demonstrating commitment to meeting MDG 7 but several challenges are retarding progress. One is the lack of coordination among authorities, stemming from an unclear definition of roles and responsibilities, coupled with lack of harmonization of laws and policies related to environmental management. Inadequate staffing in government departments that deal with environmental issues is another factor in the downward trend in environmental sustainability in some countries. Community-based natural resource management can improve environmental sustainability, but they require supporting laws and technical capacity. Devising and pushing through with appropriate climate change adaptation measures is another aspect that will underpin progress towards this MDG.

Still, opportunities can be exploited. These include new global resources that can be tapped to strengthen countries' sustainable development. Natural resource management strategies, including reforestation that have until now often been ignored, should be given priority. Innovative private instruments, too, should be promoted, particularly those for risk pooling and risk transfer. Similarly, well-thought-out public–private partnerships for addressing climate change should be brought into play.

African countries, supported by development partners, have already undertaken several adaptation and mitigation measures – nationally, sub-regionally and regionally – to address climate change impacts, directly or indirectly. These measures could usefully be grouped under those that are mandated or encouraged by multilateral environmental agreements, natural resources management, early-warning climate systems and research such as that conducted by the Consultative Group on International Agricultural Research.

Adaptation measures are an extension of good development practice that will contribute to sustainable development. There is, therefore, a case for national policies (especially fiscal policies) to assist in shifting investments and financial flows made by private and public investors into more climate-friendly alternatives, and thus optimize the use of funds by spreading the risk across private and public investors. More specifically, national policies need to provide incentives for private investors to adapt new physical assets to the potential impacts of climate change. They should also integrate climate change with development strategies and with local government adaptation policies in key sectors.

Goal 8: Develop a global partnership for development

Developing a global partnership for development remains key for African countries to individually and collectively attain the MDGs. Progress, though, towards some of the targets has been rather slow. Access to affordable essential drugs still remains a challenge on the continent and partnerships with pharmaceutical companies need to be strengthened to achieve this target. Access to information and communications technology (ICT) is increasing slowly and at this rate the target may not be reached. Commitments that were made by donor nations at various international forums to increase development financing towards the continent have largely been unmet.

Still, the international community has re-committed to meeting its pledges to accelerate progress towards the MDGs and to meet other internationally agreed development goals. For example, at the September 2010 UN Summit on Accelerating Progress towards the MDGs, donor nations reaffirmed their commitments to increase official development assistance (ODA). Many committed to the target of 0.7 per cent of gross national income (GNI)[42] or 0.15–0.20 per cent of GNI[43] as ODA to the least developed countries. The European Union (EU) pledged to reach the 0.7 per cent target by 2015. Countries that had set interim ODA volume goals for 2010 also pledged to try to meet them by year's end.

The Fourth High-Level Forum on Aid Effectiveness, in Busan, Republic of Korea, from 29 November to 1 December 2011, also brought a number of aid recipients together with the donor community to take stock of recent efforts to improve the impact of aid. It recognized that development cooperation has a crucial catalytic role in poverty eradication, social protection, economic growth and sustainable development. Nevertheless, recipients resolved to reduce dependence on aid over time through reaffirming national policies that take advantage of opportunities presented by international investment and trade, as well as through expanding domestic capital markets. The forum saw a shift from aid effectiveness to development effectiveness and committed to establish a new Global Partnership for Effective Development Cooperation with light working arrangements in place by June 2012 to ensure accountability for implementation of commitments.

The international environment, since the 2008–2009 global economic and financial crisis, has become less favourable for low-income countries, especially in Africa. Donors face sharp increases in budget challenges of their own, making their aid commitments more challenging, though no less important. Attention has thus turned to

42 Belgium, Finland, Germany, Liechtenstein, Monaco and the United Kingdom. The Republic of Korea and Romania also pledged to increase their ODA as a share of GNI to 0.25 per cent and 0.17 per cent by 2015, respectively. Denmark, Luxembourg, Norway and Sweden pledged to maintain their levels of over 0.7 per cent.

43 Australia.

non-concessional finance for public investment in low-income countries. But as shown by Berg et al. (2012), higher non-concessional lending is at best a very risky and imperfect substitute for more aid for Africa. The continent must avoid running into unsustainable debt that could trigger future macroeconomic instability.

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

Domestic resource mobilization and regional integration contribute to development finance

Ten years after the International Conference on Financing for Development held in Monterrey, Mexico, finance for development remains a major item on the international agenda.

As the impact of the global economic crisis weighs on aid budgets in OECD donor countries, the challenge of meeting the MDGs globally is becoming unaffordable on ODA alone. Additionally, the full impact of the eurozone sovereign debt crisis is yet to be felt in Africa, although it is clear that it will dampen the global recovery and ultimately have measurable effects on European demand for Africa's exports, foreign direct investment and the volume of ODA to Africa, as well as debt relief to low-income countries in Africa. The impact of these two crises is affecting the degree to which global trade will benefit low-income countries.

The combined effects of these developments will likely slow Africa's progress towards the MDGs. Africa needs to avoid a situation where the fiscal burden in OECD countries will hinder its development agenda, and therefore needs to diversify its development financing sources from its overdependence on ODA.

As suggested by the MDG Africa Steering Group and supported by African leaders, improved domestic tax collection and management will play an important role in financing African development. Tax revenues have been rising across the developing world, particularly Africa, over the last decade. The average tax ratio – all collected taxes as a share of GDP – has been increasing in Africa over the last two decades, implying improving tax collection.

Needless to say, country disparities are marked: in 2009, Burundi, DRC, Ethiopia and Guinea-Bissau collected taxes amounting to only $35 per inhabitant. Equatorial Guinea, Libya and the Seychelles, in contrast, collected per capita taxes of over $3,000.

Initiatives aimed at increasing domestic resource mobilization need to be scaled up across the continent to provide an alternative source for development finance. They could include "banking the unbanked" through financial reforms to increase domestic savings rates, improving tax collection through reforming the public financial management system, and developing capital markets.

Alongside these measures, African countries must continue attracting foreign direct investment. The EU and the US remain the biggest sources of such investment in Africa, although the share of emerging partners is growing fast. These partners provide Africa with a range of alternative finance modalities that tend to adopt a more holistic approach to promoting their exports, supporting direct investment, and offering development assistance.

The cooperation activities of emerging partners are also typically complementary to those of traditional partners. Traditional partners have focused their assistance, mostly through ODA, on poverty reduction, health, education and governance. Emerging partners are more focused on removing infrastructural bottlenecks, which is critical to rejuvenate economic transformation, as indicated by the growing allocation of resources to infrastructure development. For example, China's infrastructure finance commitment in Africa (excluding North Africa) increased from $470 million to $4.5 billion during 2001–2007 (UNCTAD, 2010).

Still, most African countries need to enhance their bargaining power with all development partners to ensure that these partnerships are mutually beneficial, preferably with developing countries' needs as the primary objective. African regional integration, too, is important to better coordinate individual African countries' efforts and to increase their bargaining power.

Although the past decade has seen a steady lowering of trade barriers, intra-African trade – around 12 per cent of the continent's total trade – is still too low to spur the continent's economic development and transformation. Partly for this reason, boosting intra-African trade was the theme of the January 2012 African Union Summit. One of the key decisions of that summit was on a comprehensive action plan for boosting intra-African trade in the short, medium and long term, and, of greater importance, on setting up a continental free trade area by 2017.

Target 8B: Address the special needs of the least developed countries

Target 8.1: Net ODA, total, and to the least developed countries, as a percentage of OECD/DAC donors' gross national income

ODA is at historic highs but still well short of commitments

ODA from OECD Development Assistance Committee (DAC) donors reached a record high of almost $129 billion in 2010, according to preliminary data from the OECD. ODA was 0.32 per cent of DAC member countries' GNI in 2010, up from 0.31 per cent in 2009. Yet ODA continues to fall well short of the UN target of 0.7 per cent of donor countries' GNI. Only five countries – Denmark, Luxembourg, the Netherlands, Norway and Sweden – met the UN target in 2010. Two of the largest donors in absolute terms, the US and Japan, increased aid in 2010, but remain among the smallest donors when their aid is measured as a share of GNI (table 8.1).

At the Gleneagles conference held in Scotland in July 2005, G8 donors envisaged an increase in total ODA to Africa of $25 billion by 2010. However, preliminary estimates show that Africa only received an additional $11 billion. This shortfall is larger in percentage terms than the shortfall in total ODA, principally because of the constrained performance of several of the donors that provide large shares of their aid to Africa.

Bilateral ODA from OECD/DAC to Africa reached $29.3 billion in 2010, an increase in real terms of 3.6 per cent from 2009. ODA to Africa has been on an increasing trend since 2004. Net ODA from all donors to Africa reached $47.9 billion in 2010. However, as development partners have

Table 8.1 DAC members' net ODA, 2010

	2010		2009		% change
	ODA	ODA/GNI	ODA	ODA/GNI	2009 to 2010
Country	$ million	%	$ million	%	in real terms[a]
Australia	3,826	0.32	2,762	0.29	11.4
Austria	1,208	0.32	1,142	0.30	9.6
Belgium	3,004	0.64	2,610	0.55	19.3
Canada	5,202	0.34	4,000	0.30	14.3
Denmark	2,871	0.91	2,810	0.88	4.5
Finland	1,333	0.55	1,290	0.54	6.7
France	12,915	0.50	12,602	0.47	7.3
Germany	12,985	0.39	12,079	0.35	12.1
Greece	508	0.17	607	0.19	-14.9
Ireland	895	0.52	1,006	0.54	-4.9
Italy	2,996	0.15	3,297	0.16	-5.1
Japan	11,054	0.20	9,457	0.18	11.9
Korea, Rep.	1,174	0.12	816	0.10	26.4
Luxembourg	403	1.05	415	1.04	0.5
Netherlands	6,357	0.81	6,426	0.82	2.4
New Zealand	342	0.26	309	0.28	-6.8
Norway	4,580	1.10	4,081	1.06	3.7
Portugal	649	0.29	513	0.23	31.6
Spain	5,949	0.43	6,584	0.46	-5.3
Sweden	4,533	0.97	4,548	1.12	-7.0
Switzerland	2,300	0.40	2,310	0.45	-4.3
United Kingdom	13,053	0.57	11,283	0.51	13.3
United States	30,353	0.21	28,831	0.21	4.2
Total DAC	128,492	0.32	119,778	0.31	6.3

Source: OECD, updated December 2011.

a. Accounting for inflation and exchange rate movements.

not met their commitments in full, they should consider intensifying their efforts to meet their aid commitments, at the same time as African countries strengthen their efforts to boost domestic resources.

A recent study on scaling up development assistance in 10 African countries concluded that a further increase in aid is still necessary to meet the Gleneagles commitments (Berg et al., 2012),[44] as, despite rises in recent years, aid to Africa is well below the goals set in 2005 at Gleneagles. In addition, because existing development plans are underfunded in many countries, fulfilling the 2005 Gleneagles commitment – in tandem with improved national development results – would go a long way towards closing the gap.

Target 8.2: Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors in basic social services (basic education, primary health care, nutrition, safe water and sanitation)

Declining share of ODA to social services

It is important to analyse the proportion of ODA allocated to basic social services for assessing the inclusiveness of ODA for all population segments. As in prior years, in 2010 the social sector absorbed the largest share in ODA to Africa from OECD/DAC countries, though slightly down in 2010 (table 8.2). Within that sector, ODA commitments from OECD/DAC countries to water and health fell from 2009 to 2010. Several donors reduced their commitments to the social sector, notably Denmark, Germany, Netherlands, Spain and the United Kingdom.

Target 8C: Address the special needs of landlocked developing countries and small island developing states

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

Nothing to shout about

Lack of access to the sea, remoteness and isolation from world markets, and high transit costs impose real burdens on socio-economic progress in landlocked developing countries (UN, 2012). The Almaty Declaration and the Almaty Programme of Action, adopted in 2003, marked an effort to deal with these problems. Implementation of the latter was to be supported by donors through funding and technical assistance.

During 1990–2009, ODA as a share of their GNI increased in only four of the 15 African landlocked developing countries – Burkina Faso, Burundi, Ethiopia and Rwanda (figure 8.1) – all of which are least developed countries.

Indicator 8.5: ODA received in small island developing states as a proportion of their GNI

A declining proportion

ODA received by Africa's six small island developing states as a share of their GNI generally declined during 1990–2009, although it remains quite high in Guinea-Bissau and São Tomé and Príncipe. After 2005, the proportion of ODA rose a little in four of them (figure 8.2).

44 The 10 are Benin, CAR, Ghana, Liberia, Niger, Rwanda, Sierra Leone, Tanzania, Togo and Zambia.

Table 8.2 ODA to Africa by sector, 2005–2010 (as % of total bilateral commitments from OECD/DAC donors)

Sector	2005	2006	2007	2008	2009	2010
Social	27.4	28.7	43.7	42.6	44.8	41.4
Economic	7.7	4.4	10.0	16.1	11.6	15.3
Production	3.9	5.1	6.4	6.5	7.8	9.8
Multi-sector	5.3	3.2	5.1	5.1	4.8	6.2
General Programme Aid	5.2	8.0	9.2	8.4	10.2	5.4
Debt	36.5	40.8	12.7	7.5	7.4	10.3
Humanitarian	11.7	8.7	11.2	12.0	11.9	9.2
Other	2.2	1.2	1.7	1.9	1.6	2.4

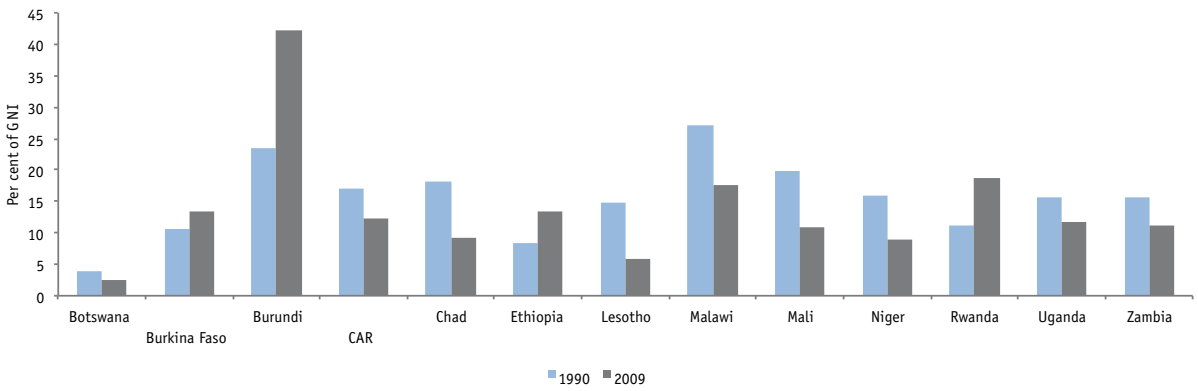
Source: OECD (2012).

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

Average tariffs on the decline, particularly for agricultural products

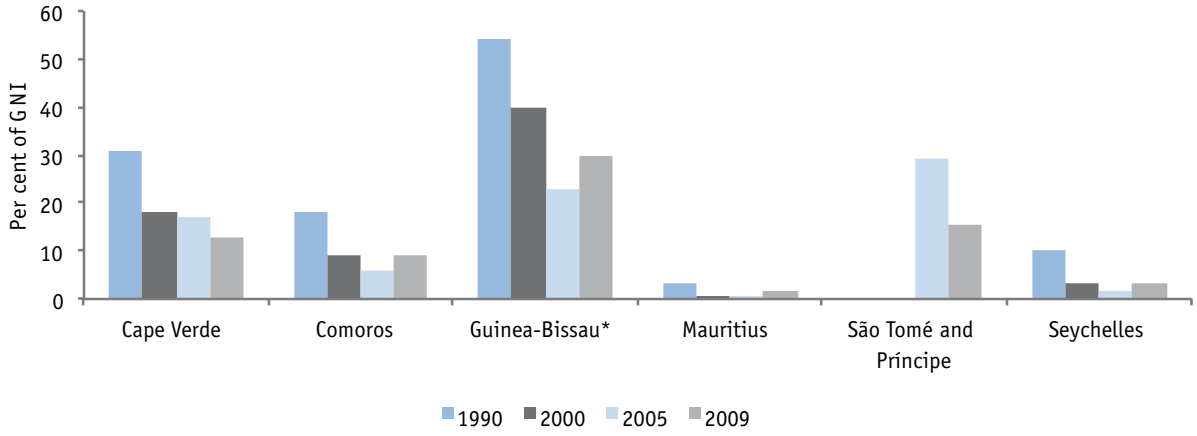
Average tariffs imposed by developed countries on agricultural, textile and clothing imports from all developing countries have been falling since 1996. A sharp decline was seen in tariffs on clothing exports from Africa (excluding North Africa) after 2000, and a milder one for agricultural goods after 2005 (table 8.3).

Figure 8.1 ODA received by landlocked developing countries, share of GNI, 1990 and 2009



Source: Computations from UNSD, accessed December 2011.

Figure 8.2 Small island developing states' ODA as share of GNI, 1990–2009



Source: Computations from UNSD, accessed December 2011.

*2008 data.

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

AfT commitments exceed ODA commitments

Trade and trade policy have become fundamental to attaining national development objectives and are crucial to achieving the MDGs. AfT provides financial and technical assistance to developing countries to help them build their supply-side capacity and strengthen their trade-related infrastructure. AfT has highlighted trade as central to development and is being integrated in broader development strategies, with objectives focusing on competitiveness, economic growth and poverty reduction. Donors are harmonizing their procedures and aligning their support around

Table 8.3 Average tariffs imposed by developed countries on exports of agricultural goods, textiles and clothing, various years (%)

Area/region	Category	1996	2000	2005	2009
Developing countries	Agricultural goods	10.5	9.2	8.8	7.8
	Textiles	7.3	6.5	5.2	5.1
	Clothing	11.4	10.8	8.3	8.1
North Africa	Agricultural goods	6.7	7.4	7.2	6.4
	Textiles	8.0	7.2	4.4	3.9
	Clothing	11.9	11.1	8.0	5.9
Africa (excluding North Africa)	Agricultural goods	7.4	6.2	6.2	4.5
	Textiles	3.9	3.4	2.9	2.9
	Clothing	8.5	7.9	1.6	1.6

Source: UN (2011).

Table 8.4 Recipients of AfT commitments in 2009 ($ million)

Country	Amount received
Nigeria	1,300
Uganda	1,000
Kenya	962
Ethiopia	884
Tanzania	881
Algeria	13
Libya	8.2
Botswana	4.7
Seychelles	2.3
Equatorial Guinea	1.1

Source: UN (2011)

these strategies. AfT flows reached $40 billion in 2009 – an increase of 60 per cent in four years (WTO, 2011).

AfT to Africa showed continued growth until 2009 despite the global economic crisis. The increase in AfT commitments was nearly twice that from ODA during 2006–2009, with average annual growth of 21.4 per cent versus 11.1 per cent in real terms.

In that period, the top 10 recipients had 56 per cent of Africa's AfT, the bottom 10 just over 1 per cent collectively (UNECA, 2011), reflecting the huge variation in commitments (table 8.4).

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

Indicator 8.10: Total number of countries that have reached their Heavily Indebted Poor Country (HIPC) decision points and number that have reached their HIPC completion points

The majority of HIPC-eligible countries have reached their completion point

The HIPC initiative continued to reduce the debt burden of countries qualifying for debt relief in 2011. Of the 33 African countries that are potentially eligible for the HIPC/Multilateral Debt Relief Initiative (MDRI) assistance, 26 have reached the completion point, qualifying for irrevocable HIPC debt relief and MDRI debt cancellation. Under the HIPC initiative, the World Bank Group provided $2.9 billion (51.3 per cent of the total $5.7 billion committed) on nominal terms to Africa. Four African countries are between decision and completion points, and three are at the pre-decision point (table 8.5).

Table 8.5 HIPC status of African countries, 2011

Post-completion point (26)		
Benin	Ghana	Rwanda
Burkina Faso	Guinea-Bissau	São Tomé and Príncipe
Burundi	Liberia	Senegal
Cameroon	Madagascar	Sierra Leone
CAR	Malawi	Tanzania
Congo	Mali	Togo
DRC	Mauritania	Uganda
Ethiopia	Mozambique	Zambia
Gambia	Niger	
Between decision and completion points (4)		
Chad	Côte d'Ivoire	
Comoros	Guinea	
Pre-decision point (3)		
Eritrea	Somalia	Sudan

Source: IMF (2011)

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 on a sustainable basis

Access to affordable, essential drugs is problematic

Essential medicines were on average available in only 42 per cent of public, and 58 per cent of private, facilities during 2001–2009 (table 8.6). In the 17 African countries with data, median prices were 2.7 times as high as international reference prices in the public sector and 6.4 times as high in the private sector. Several regional and sub-regional plans are focusing on expanding local production capacity, including the African Union's Pharmaceutical Manufacturing Plan for Africa, the Pharmaceutical Business Plan of the Southern African Development Community and the draft regional pharmaceutical manufacturing plan of action of the East African Community.

Table 8.6 Availability and consumer price ratio of essential medicines, 2000s

Country	Period	Median availability in facilities of selected generic medicines (%)		Median consumer price ratio in facilities of selected generic medicines[a]	
		Public	Private	Public	Private
Burkina Faso	2009	87.1	72.1	2.2	2.9
Cameroon	2005	58.3	52.5	2.2	13.6
Chad	2004	31.3	13.6	3.9	15.1
Congo	2007	21.2	31.3	6.5	11.5
DRC	2007	55.6	65.4	2.0	2.3
Ethiopia	2004	52.9	88.0	1.3	2.2
Ghana	2004	17.9	44.6	2.4	3.8
Kenya	2004	37.7	72.4	2.0	3.3
Mali	2004	81.0	70.0	1.8	5.4
Morocco	2004	0.0	52.5		11.1
Nigeria	2004	26.2	36.4	3.5	4.3
São Tomé and Príncipe	2008	56.3	22.2	2.4	13.8
South Africa	2004		71.7		6.5
Sudan	2006	51.7	77.1	4.4	4.7
Tunisia	2004	64.3	95.1		6.8
Uganda	2004	20.0	80.0		2.6
Tanzania	2004	23.4	47.9	1.3	2.7

Source: WHO (2011).

a. Relative to international reference prices.

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

Indicator 8.14: Telephone lines per 100 population

No growth in number of fixed telephone lines

The number of fixed telephone lines per 100 population in Africa changed little during 2000–2010, largely explained by the rapid expansion and attractiveness of mobile telephony. Seven countries had more than 10 fixed lines per 100 population in 2010,[45] but 20 countries had less than one.[46] Nine countries saw the number decline during 2000–2010.[47]

45 Mauritius, Seychelles, Libya, Cape Verde, Tunisia, Egypt and Morocco.

46 Liberia, Congo, Guinea, CAR, Guinea Bissau, Rwanda, Mozambique, Burundi, Tanzania, Niger, Chad, Sierra Leone, Mali, DRC, Zambia, Uganda, Sudan, Madagascar, Nigeria and Burkina Faso.

47 Liberia, Guinea, Guinea Bissau, Congo, Zambia, Gabon, Sierra Leone, DRC and South Africa.

Table 8.7 Access to ICT by region, 1990, 2000 and 2010

Region	Fixed telephone lines per 100 population			Cellular subscribers per 100 population			Internet users per 100 population		
	1990	2000	2010	1990	2000	2010	1990	2000	2010
North Africa	2.8	7.2	11.4	0.0	2.8	95.2	0.0	0.7	28.1
Africa (excluding North Africa)	1.0	1.4	1.4	0.0	1.7	44.7	0.0	0.5	10.6
Developing regions	2.3	7.9	11.9	0.0	5.4	70.0	0.0	2.1	21.1
Developed regions	37	49.4	41.6	0.9	40.0	114.3	0.2	24.9	68.8
World	9.8	16	17.3	0.2	12.1	78.0	0.1	6.5	29.7

Source: ITU (2011).

Indicator 8.15: Cellular subscribers per 100 population

Huge growth in cellular subscribers

Global mobile cellular penetration reached 75 per cent in 2010, with strong growth in the developing world (table 8.7).

The spread of mobile cellular service remains fast in Africa, where fixed-line services are undersupplied. In Libya, Seychelles, Botswana, Gabon, Tunisia, South Africa and Morocco, each inhabitant had more than one mobile line in 2010 (figure 8.3). The Congo, Algeria and Mauritius each had more than 90 mobile subscriptions per 100 inhabitants, although Eritrea, Ethiopia and Somalia had less than 10. Sub-regionally, North Africa had the highest proportion, at 95.

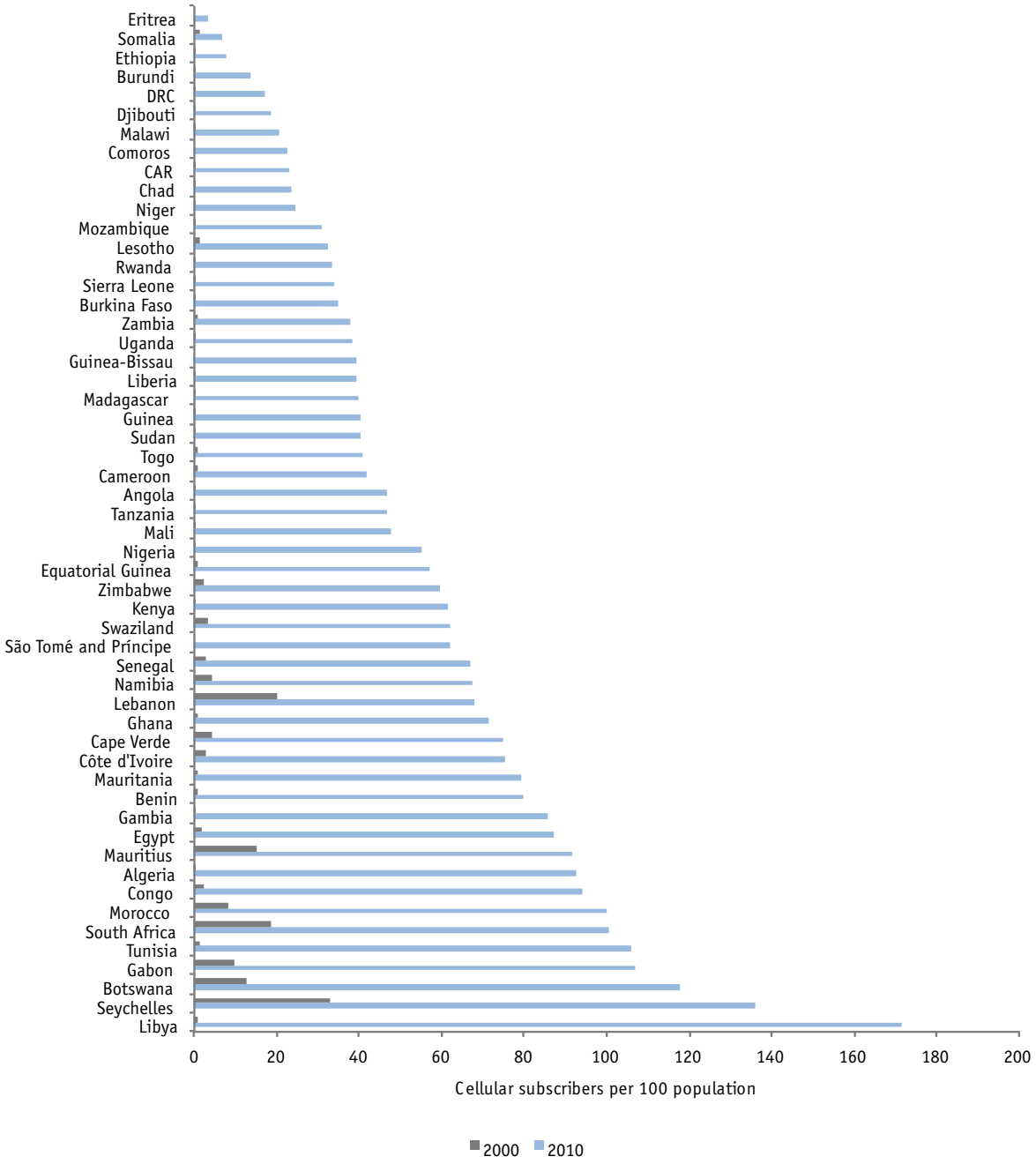
Indicator 8.16: Internet users per 100 population

Internet penetration is still too low in Africa

Worldwide Internet penetration rates increased by around 14 per cent a year during 2005–2010, and faster in developing than developed countries (22 per cent versus 7 per cent). Internet penetration in the continent remains low relative to developed regions (see table 8.7), which is entirely consistent with the undersupply of fixed-line networks. Still, African rates continue to improve, and are set to grow further as mobile broadband becomes more widely available to cellular phone subscribers.

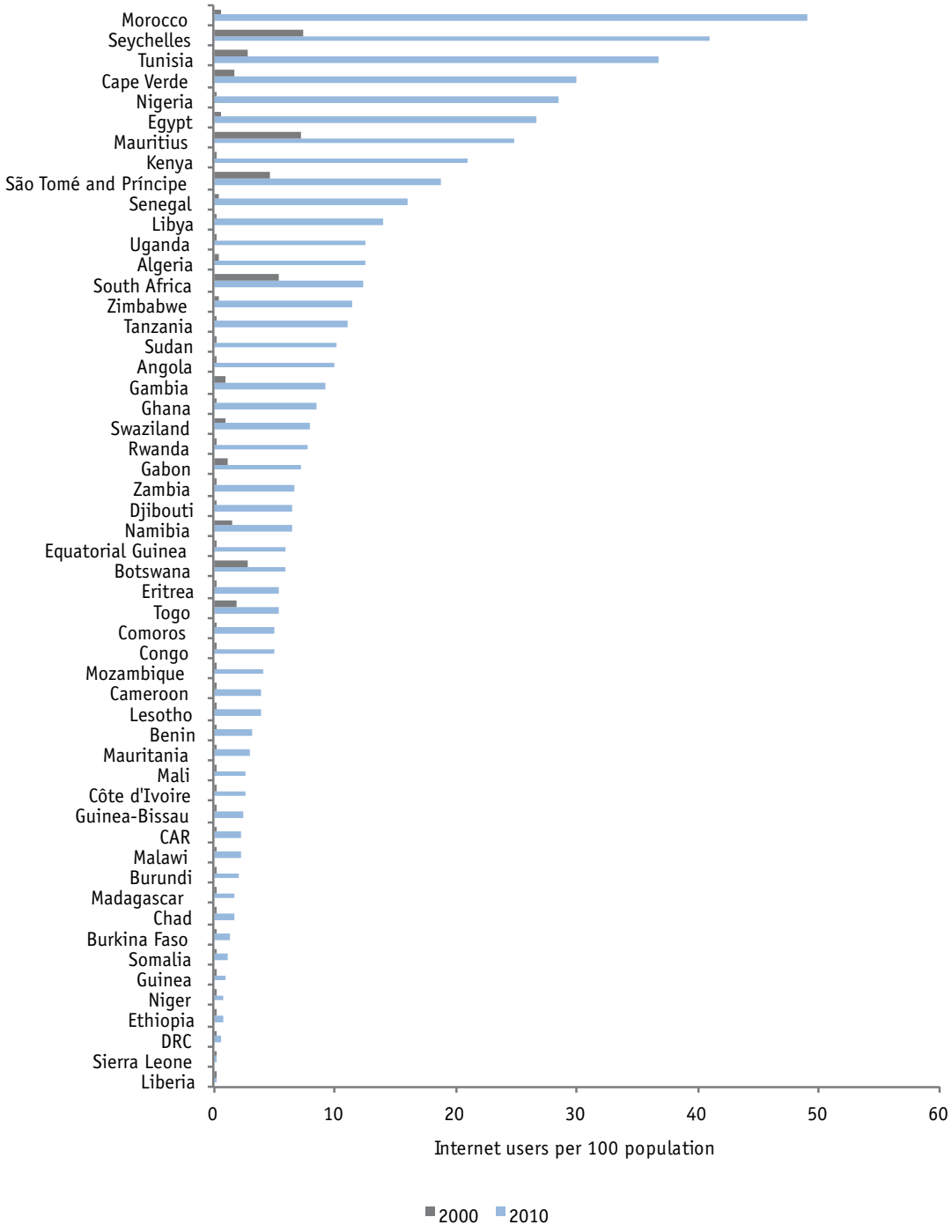
Morocco had the highest number of Internet users in 2010, followed by Seychelles, Tunisia, Cape Verde, Nigeria and Egypt (figure 8.4). Ethiopia, Liberia, Niger and Guinea had the least number of Internet users, with less than one per 100 inhabitants.

Figure 8.3 Cellular subscribers per 100 population, 2000 and 2010



Source: Computations from UNSD, accessed December 2011.

Figure 8.4 Internet users per 100 population, 2000 and 2010



Source: Computations from UNSD, accessed December 2011.

Conclusions

International cooperation and global partnership are critical for achieving the MDGs. To this end, the international community has re-committed to meeting its pledges to accelerate progress towards the MDGs at different forums. ODA reached 0.32 per cent of DAC member countries' GNI in 2010, up from 0.31 per cent in 2009. However, the volume of ODA continues to fall short of the UN target of 0.7 per cent of donor country GNI. Further, despite better access to ICT, the rate of progress is not enough to reach the target. Access to affordable essential drugs also remains a challenge on the continent, and strengthening partnerships with pharmaceutical companies is vital to achieving this target.

African countries have to identify alternative sources of financing, strengthen efforts to mobilize domestic resources and foster intra-Africa trade to mitigate the adverse domestic effects of eurozone debt crisis. In addition, African countries also need to enhance their bargaining power with all development partners to ensure that these partnerships are mutually beneficial.

Section III:
Emerging perspectives from Africa on the post-2015 development agenda

In September 2000, the UN Millennium Summit endorsed the MDGs in the Millennium Declaration, and more than 180 countries signed it. The main objective of the summit was to set quantifiable and time-bound global development goals to end human suffering from hunger, destitution and disease, mainly in developing countries. Since inception, the MDGs have been embedded in several international and regional initiatives and have had a huge influence on policy discourse throughout the developing world. The MDGs – comprising eight goals, 21 targets and 60 indicators – were the culmination of international efforts to mobilize resources for development (box 9.1).[48]

With under three years to the 2015 deadline, it is imperative that development partners and policymakers accelerate progress on the MDGs and assess the successes and failures of the current goals, in an attempt to shape and develop an inclusive and sustainable post-2015 development agenda. The question is not about having a set of international development goals after 2015, but rather, what the proposed framework will consist of. Indeed, should the MDGs be retained in their current configuration with an extended deadline? Reformulated? Or replaced by an alternative framework? Underlying all these is the question of which option is likely to have the greatest impact on poverty eradication in Africa.

To articulate Africa's position on the post-2015 agenda, UNECA commissioned papers (Gohou 2011;Ohiorhenuan, 2011;Ewang, 2011;Nyarko, 2011)on these three options. Given the centrality of the New Partnership for Africa's Development (NEPAD) to the continent, UNECA also commissioned a paper on the likely implications of the post-2015 agenda for NEPAD. UNECA also initiated consultations to capture member States' perspectives on the issue. Working with the AUC and UNDP–RBA, UNECA convened a regional workshop on 15–16 November 2011 in Accra, Ghana, attended by 47 representatives from 18 African countries[49]of government, civil society and academia. In tandem, UNECA and AUC administered an electronic survey on the post-2015 agenda, completed by 112 representatives (in 32

48 The most notable were the UN Development Decade, UN 1961; 25th Session of the General Assembly, 1970; UN Conference on Environment and Development, Rio de Janeiro, 1992; UN International Conference on Population and Development, Cairo, 1994; Copenhagen UN World Summit for Social Development, 1995; and Fourth UN Conference on Women, Beijing, 1995.

49 Benin, Botswana, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Kenya, Mali, Morocco, Nigeria, Sierra Leone, South Africa, Togo, Uganda and Zimbabwe.

Box 9.1 Development goals – A brief time line

The MDGs date back to 1961 when the UN Development Decade was launched. With no international development strategy at the time, the UN General Assembly called on economically advanced economies to give 1 per cent of their combined national incomes as ODA to developing nations.

After the 25th session of the General Assembly in 1970, economically advanced countries committed to increasing ODA to a net amount of 0.7 per cent of gross national product. In the 1980s, structural adjustment programmes began to dominate development thinking and policymaking. Once these approaches came under scrutiny, the development community sought alternatives.

The next couple of decades saw the emergence of the African Alternative Framework to Structural Adjustment Programmes for Socio-economic Recovery and Transformation, and later, the International Development Goals, the immediate precursors to the MDGs, created in 1996.

African countries across the five sub-regions) of civil society and non-governmental organizations, research institutions and ministries of planning, finance and economic development.

Drawing on the commissioned papers, the outcome document of the workshop and the findings of the electronic survey, this chapter assesses the MDGs to date by reviewing their positive contributions and challenges, the three options proposals for improvement and suggestions for the post-2015 agenda, and ends by articulating the emerging common African position.

The MDGs assessed

Positive contributions

The MDGs have focused attention on the poor

Without doubt, the MDGs have made significant contributions to the social and economic development of countries across the globe. Indeed, the goals have had unprecedented success in galvanizing international support, not only from governments and inter-governmental bodies, but also from civil society, the private sector, charities, foundations, the media and academia about focusing on a common set of goals that seek to enhance human capabilities (Vandemoortele, 2009; Moss, 2010; UN, 2011).

Further, the MDG framework has helped to raise global consciousness about the multiple dimensions of poverty and has made the complexity of the development process more easily comprehended by policymakers and the public (UN, 2011).[50] Since adopting the MDGs, developing countries have given poverty reduction greater priority, embedded the MDGs in their national poverty reduction strategies and development plans, and run MDG-focused policies (Polard et al., 2010).

The MDGs have been associated with increased funding

Although a causal relationship has not been established, there is a growing consensus among development practitioners that the MDGs have improved and increased the targeting and flow of aid and other investments in development (Waage et al., 2010; Moss, 2010; Bourguignon et al., 2008).

50 Global campaigns such as Make Poverty History, and End Poverty 2015also contributed to enhancing MDG exposure globally (Melamed and Scott, 2011).

From 1992 to 1997, total aid plummeted by more than 20 per cent. Around the September 2000 summit when the MDGs were adopted, total aid was about $60 billion a year, but by 2005 it had doubled to roughly $120 billion, and remained around this level for several years (Moss, 2010). Before the Millennium Declaration, ODA amounted to 0.22 per cent of DAC countries' GNI, but by 2006 had climbed to $104.4 billion, or 0.31 per cent of their GNI (Bourguignon et al., 2008). While this ODA increase cannot perhaps be fully attributed to the MDGs, there is still no doubt that they played an instrumental role in targeting the flow of aid.

OECD figures for 2000–2006 show that total development assistance for health more than doubled from $6.8 billion to $16.7 billion. Indeed, the World Bank's 2010 *Global Monitoring Report* indicates a steep rise in development financing over the last decade, particularly in response to health-related issues (World Bank, 2010b). For example, from 2001 to 2005, aid commitments to HIV/AIDS programmes rose by nearly 30 per cent ($4.75 billion), fuelled by the establishment of the Global Fund and philanthropic efforts of the Clinton Foundation and of the Bill & Melinda Gates Foundation (World Bank, 2010b).

The United States President's Emergency Plan for AIDS relief (PEPFAR) and UNITAID are examples of other financial mechanisms inspired by the MDGs. In 2008, public and private entities allocated $15.8 billion for global HIV/AIDS programmes. Pledges to the Global Fund rose from $2.5 billion in 2007 to $3.0 billion in 2008, before declining to $2.6 billion in 2009 as a result of the global economic downturn. The United States PEPFAR programme increased its contributions from $4.5 billion in 2007 to $6.2 billion in 2008 and then increased its annual budget. The 2010 fiscal year allocation is just shy of $7 billion, suggesting that US support was continuing (World Bank, 2010b).

The MDGs have ensured greater focus on results

As a third contribution, the MDGs focused the international community on measurable outcomes, creating a shift in practice to tracking progress on intended targets rather than merely calculating inputs (Moss, 2010). In other words, with specified targets, the MDGs allow countries to track and report on specific indicators, emphasizing the importance of data collection and analysis: "the MDGs have stimulated an improvement in monitoring development programmes through data collection and analysis: Once the MDGs gained currency, a cascade of statistical and analytical work got underway" (Waage et al., 2010: 6).

This not only influences countries to adopt better data monitoring, evaluation and reporting systems, but also allows governments to create social and economic development policies that better reflect the reality of their countries.

MDG challenges

The MDGs have been misinterpreted

A first criticism of the MDGs is that "while they were initially intended as global aspirations, they quickly became actual targets for countries" (Moss, 2010: 218). Consequently, they are wrongly expected to be achieved individually (by countries), as opposed to globally. The MDGs have been "over-abstracted", "over-generalized", "over-simplified" and altogether misinterpreted as global one-size-fits-all targets, and perceived as yardsticks against

which countries' performance is to be measured and judged.

In fact, "the MDG agenda has overlooked differences in initial conditions and capacities of countries and as such, by using a uniform set of targets, could unfairly judge efforts made by countries that started in more disadvantaged positions" (UN, 2011: 19). It is for this reason that some analysts (Vandemoortele, 2009; Hailu and Tsukada, 2011;Bourguignon et al., 2008; Moss, 2010) maintain that countries in South Asia and Africa (excluding North Africa) in particular, were not only initially set up to fail but "still lag behind" in achieving the MDGs, further reinforcing the perception of Afro-pessimism among critics.

Trenchantly: "Given the vast disparity of starting points, and the diversity of country capabilities, using a universal measuring stick seems not just simplistic, but absurd" (Moss, 2010: 219). Poorer countries that started from a higher poverty rate and a wider poverty gap are likely to take longer and/or require more effort to cross the poverty line (World Bank, 2010b). Especially because "high initial poverty incidence slows progress against poverty at any given growth rate" (World Bank, 2010b: 22) some commentators (Hailu and Tsukada, 2011) advocate a more comprehensive method of assessing country performance. Rather than monitoring levels of indicators and how on or off track the MDG countries are, they propose a new rate of progress methodology which evaluates the commitment of countries, as measured by their effort to accelerate MDG progress.

The MDGs often lack ownership and leadership

The MDGs are often criticized for lacking clear ownership and leadership at national and international levels, and for not assigning accountability to any one institution, party or country. The MDGs were conceived as a top-down approach and so developing countries' involvement in the initial framework was minimal, leading to weak national ownership. In addition, they were not aligned with continental programmes in Africa, leaving a discontinuum between the two sets. Although many low-income countries have linked their national strategies and poverty reduction strategy plans to the MDGs, their focus has often been selective at best, suggesting that this compliance could be for mere "political correctness".

It was perhaps for this reason that the 2005 Global Mid-Term Review of the MDGs urged low-income countries to develop MDG-consistent poverty reduction strategies and national development plans that more closely aligned national priorities with international goals. Although efforts to promote MDGs-consistent development strategies did not fully rectify ownership and accountability concerns, it did help to accelerate progress towards the MDGs after 2005.

Internationally, the fragmented and contested nature of institutional ownership of health-related MDGs, for example, has complicated overall coordination and leadership. "Within United Nations agencies, ownership of maternal health is split, causing ambiguity in leadership for MDG 5. Within WHO, maternal health is split between *Making Pregnancy Safer*, the *Human Reproduction Programme*, and the Department for Child and Adolescent Health. Among agencies with funds for implementation, both UNICEF and the United Nations Population Fund (UNFPA) have a role" (Waage et al., 2010: 12–13).

The MDGs are limited in scope

Critics of the MDGs caution that the goals either limit the scope of, or altogether omit, several important issues that they regard as indispensable for enhancing human development (German Watch, 2010). These include the protection of human rights, gender equality, peace, security, and disarmament, environmental sustainability and climate change, (Vandemoortele, 2009; UN, 2011).

The MDGs do not take inter-sectoral synergies into account

Another criticism is that the MDGs are sector specific and thus too narrow to realize synergies among sectors. "The MDGs were not a plan derived bottom-up from a broad, inter-sectoral conceptualization of development and prioritization of development needs, although superficially, they might seem to have been" (Waage et al., 2010: 5).

The MDGs have a disproportionate focus on the social sector

Critics allege that the MDGs have a disproportionate focus on social indicators and de-emphasize the productive sectors. This has created a disconnect between achievement of outcomes and the sustainability of such achievement. Without growth and strengthened productive capacities, the observed positive social outcomes are unlikely to be fiscally sustainable. For instance, the positive performance on HIV/AIDS indicators has been successful largely because of inflows from global funds. These gains are likely to be reversed if such resources cease.

The MDGs are weak on issues of quality

The MDGs are criticized for being too focused on quantity rather than quality. For African education, for example, emphasis is often placed on increasing primary enrolment ratios, while the overall quality of education remains challenging (UNECA et al., 2011).

The MDGs have promoted dependency

It is also said that the MDGs promote a "money-metric" and "donor-centric" view of development (Vandemoortele, 2009) because until recently, the development discourse overemphasized donor funding, thus creating foreign aid–dependent countries and reinforcing an imbalanced partnership between recipients and donors.

The MDGs lack data for consistent monitoring

An obstacle to monitoring MDG performance in Africa is the lack of timely and reliable high-quality data, as well as efficient monitoring and evaluation systems. Both shortfalls have limited countries' ability to assess the impact of interventions and thus inform their future policies (UNECA et al., 2011).

The MDGs neglect issues of inequality

The MDGs are silent on issues of equity in access to social services. The emphasis on national aggregates in performance has shifted attention from critical issues such as spatial (mainly rural–urban), vertical (high-versus low-income) and horizontal (cultural and ethnic group) inequality, manifested in part by disparities in access to social services. Undoubtedly, this shift can be partly attributed to data constraints that make it hard to track inequality. Still, one can argue that the absence of targets to capture the MDGs'distributional dimensions has absolved statistical institutions from strengthening data on inequality indicators.

Options for improvement

A review of available literature suggests three main options for the post-2015 agenda: retain the MDGs in their current configuration; reformulate them to take account of some of the criticisms; or develop an alternative framework altogether.

Retaining the MDGs in their current configuration

This case hinges on the argument that the timeframe for implementation was too short. Although the MDGs were introduced in 2000, it took eight years to design and fine-tune the current "final" set-up of goals, when the MDGs were improved and tested. Today, they are known globally, and many, if not all, countries are striving to mainstream the goals in their national development strategies.

Over the last decade, the MDGs have been the subject of 10 world summits and numerous international discussions and meetings. Indeed, there is significant political momentum around the MDGs that unifies global efforts to eradicate poverty and achieve the human development goals. In light of the time it has taken to finalize the current framework and the solid political momentum the MDGs have garnered, advocates for retention maintain that the 2015 MDG deadline should be extended to give developing countries more time (Gohou, 2012). According to this view, developing countries have not been given enough time or resources, and so reformulating the MDGs or developing an alternative agenda would be premature and ill-advised.

Moreover, given that the very existence and livelihoods of the world's poorest and most vulnerable are at stake, retentionists argue that the international community cannot afford to invest more time and resources in reformulating the MDGs – nor can it afford to experiment with developing an alternative framework. Economic development requires effective and sustained policies as well as adequate time. Despite wide variation in performance among MDGs and countries – the argument runs – African countries have made good progress, and although the overall advance is too slow for the continent to achieve all the MDGs, its countries will fare better with additional time and resources.

Reformulating the MDGs – "MDG-plus"

This case is based on the premise that, although the MDGs have weaknesses, they also have enough successes to warrant continuation. Nevertheless, given that the current global context for development differs markedly from the 1990s when the MDGs were negotiated, any post-2015 agenda should reformulate or customize them to robustly address the new, complicated challenges that have come to the fore (Ohiorhenuan, 2011).

Proponents for reformulating the MDGs argue that it would be most beneficial, post-2015, to adopt an "MDG-plus" approach that restructures the MDGs, eliminating overlaps and thus creating space for salient issues that were omitted in the original set (Vandemoortele, 2009). Simply extending the 2015 deadline would, they argue, be an implicit acceptance of failure. On the other hand, abandoning the MDGs would hinder progress and prevent the development community from building on achievements made so far.

The global development context in Africa has undeniably evolved in recent years. Africans continue to suffer from the impacts of crises. The continent is also increasingly vulnerable to the impacts of climate change and variability – and greater population stresses. By 2020, its population will likely exceed 1 billion, perhaps even hitting 1.4 billion by 2035, with roughly half the population under the age of 24 (UN-DESA, 2007), accentuating the scale of the young population joining the labour force. High economic growth rates registered in many African countries have not had a commensurate effect on employment creation.

The post-2015 agenda must therefore be revised to focus on creating institutional mechanisms that will foster inclusive and equitable growth and improve the living conditions of the majority of the population, including creation of decent jobs.

Developing an alternative framework

Proponents of an alternative framework argue that the focus on development outcomes is misplaced, particularly for developing countries. They propose a framework that is largely process oriented and driven by a transformative agenda (Nyarko, 2011). They maintain that economic development requires new ideas and new enterprises, facilitated by a developmental state and anchored by economic revolutions that generate economic transformation. Environments conducive to concretizing viable ideas need to be created. Education and markets are a key part of the idea formation and implementation processes.

Although the MDGs aim to reduce global poverty, their focus is, proponents argue, primarily on outcomes (human development indicators such as education and health) and not on processes (increasing the sophistication and complexity of developing countries' economies, including economic transformation). The current global framework has failed to create the required economic revolutions, which are generated by new ideas and experiments in key sectors and which are necessary to enable Africa to maximize its full potential. For this reason, they claim, a new set of development goals that specifically target structural transformation of developing economies should be initiated after 2015.

Proponents of this option argue that an alternative framework should thus focus on transforming the structure of the economies of developing countries; developing internal economic institutions to facilitate and sustain structural transformation; strengthening the capacities of developing countries for greater reliance on domestic resources and revenue; and spawning formal and entrepreneurial skills.

The key elements are:

- Supporting human capital development, especially in higher education and skills.
- Encouraging sophisticated agricultural markets.
- Supporting financial markets to help with screening new ideas and mitigating risks.
- Pursuing deep and sophisticated energy markets.
- Enhancing cross-border trade and regional markets in Africa through appropriate infrastructure development.
- Encouraging development partners to focus on investments in Africa (excluding North Africa), particularly in infrastructure.

What distinguishes the proposed alternative framework from the existing MDGs is the relative emphasis on intermediate rather than final outcomes and a focus on "enablers" (as listed in the next section) of development as opposed to development objectives in themselves. The alternative framework is thus more prescriptive than the MDGs, which highlight selected targets but leave the mechanisms and strategies for their achievement to policymakers.

Moving towards a common African position

Which of the three options should shape Africa's position on the post-2015 agenda? Which is likely to yield maximum poverty reduction, and improve the livelihoods of Africa's poor?

The outcomes of the electronic survey, as well as the consensus statement from the regional workshop in Accra, strongly point to the adoption of an "MDG-plus" agenda for Africa, post 2015.

Findings from the electronic survey

The UNECA/AUC-administered electronic survey yielded the following perspectives on the post-2015 development agenda.

The MDGs remain relevant to Africa

The overwhelming majority of survey respondents agreed that the MDG areas are important development priorities for their countries, reflect "most/all" or "some" of the development priorities of their countries, and should feature in the post-2015 agenda.

The MDGs reflect only a subset of development priorities

A fair share of survey respondents identified other broad development areas that the current MDGs neglect. MDG 3 and 7, for example, do not adequately capture the development priorities and concerns of member States (figure 9.1). They made suggestions for improvements.

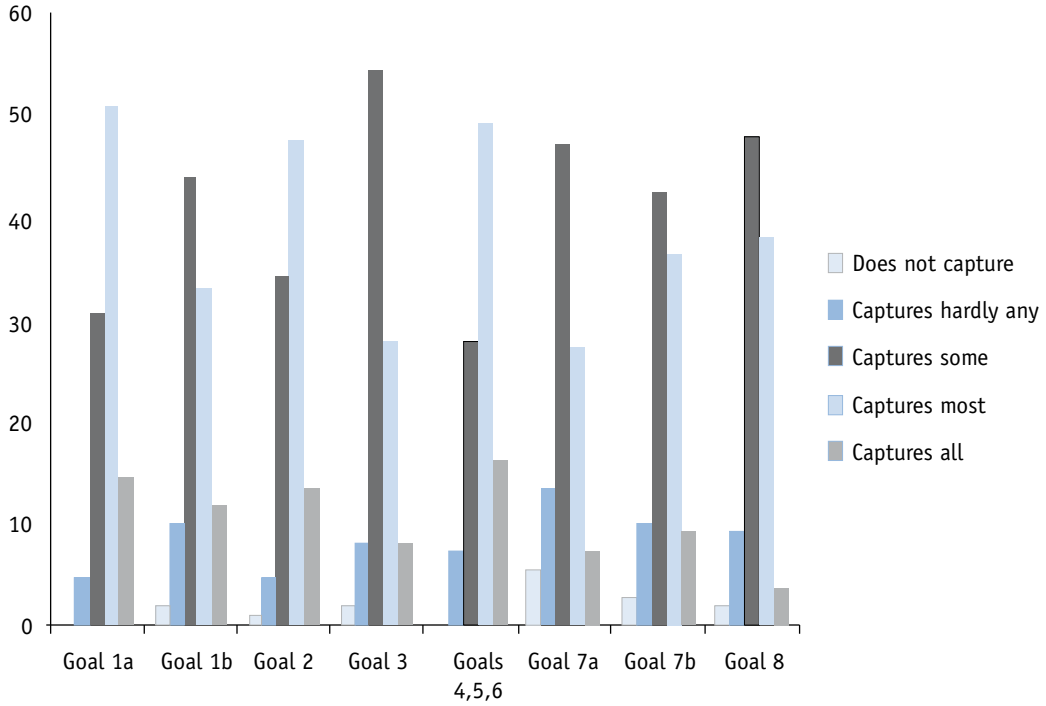
Suggestions for reformulating the MDGs

On Goal 1, respondents reported that there was insufficient focus on inclusive growth and job creation. With education (Goal 2) they decried the exclusive focus on primary education and called for greater emphasis on post-primary education. They also argued for greater focus on education outcomes and not only on enrolments.

For gender (Goal 3), they urged that indicators of women's empowerment must extend beyond women's representation in parliament to include representation in local government, as well as issues of sexual and gender-based violence, sexual division of labour, access to finance and early marriage. Respondents also noted that the goal did not take full account of early pregnancy and its implications for population growth and high dependency rates.

On the health goals (4–6), a key criticism was the neglect of the health status of the aged, non-communicable diseases and mental health issues. On the environment (Goal 7), respondents observed that, despite the importance of rural–urban migration, internal displacement and climate change, these issues were not captured in the MDGs. For instance, there are no specific indicators and targets for climate change adaptation or

Figure 9.1 To what extent do the MDGs capture countries' priorities and concerns?



Source: Compiled from the UNECA/AUC electronic survey.

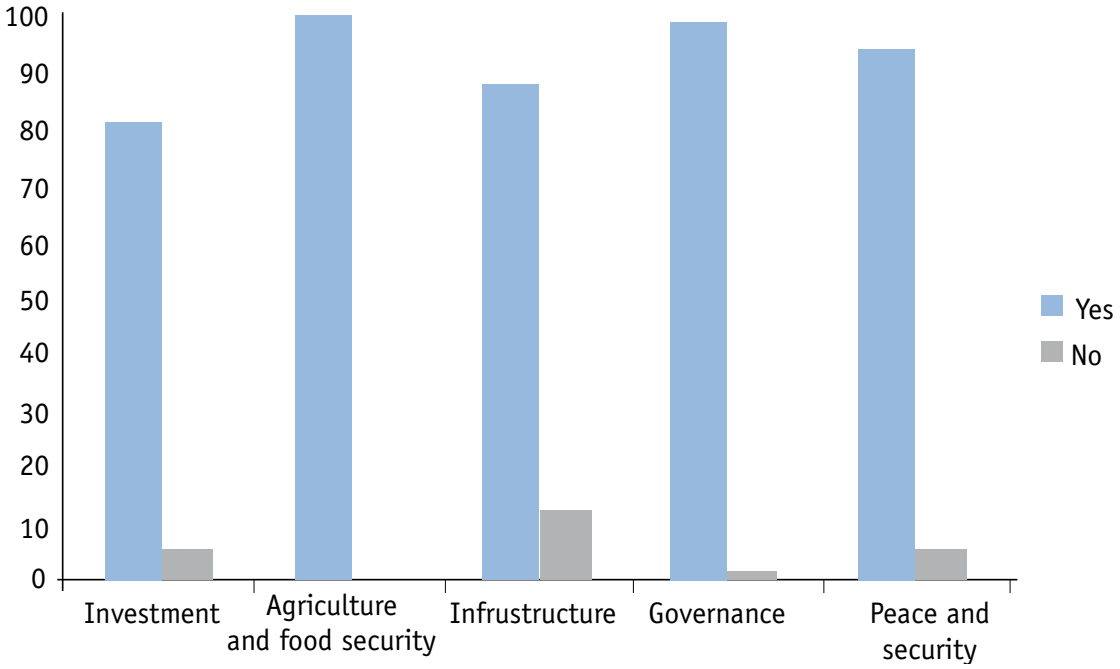
for financing adaptation programmes. Moreover, there are no indicators to measure the gender, health and poverty dimensions of climate change.

Related to international partnerships (Goal 8), respondents argued that the period after 2015 should focus on trade – global and intra-African – rather than aid.

Suggested priorities for the post-2015 development agenda

Respondents were asked their opinions on whether investment, agriculture and food security, infrastructure, peace and security, and governance should feature as priorities for the post-2015 development agenda. The responses provided below suggest that most respondents perceive the areas identified above as priorities for the post-2015 agenda. However, in addition to the options provided in the questionnaire, respondents identified other priority areas, particularly lowering of intra-continental trade barriers, confronting the challenges of climate change and promoting economic growth and employment creation. Furthermore, respondents called for the agenda to be more participatory in design to provide guidelines for funding mechanisms and measure results in quantity and quality of service delivery (figure 9.2).

Figure 9.2 Suggested new areas for the post-2015 agenda



Source: Compiled from the UNECA/AUC electronic survey.

Findings from the regional workshop on the post-2015 development agenda

The consensus from the regional workshop was similar to that among the electronic survey respondents, namely that the MDGs should be amended post-2015, because as now constituted they have limited focus on economic growth and transformation; do not sufficiently emphasize domestic resource mobilization in Africa's development agenda; tend to neglect issues relating to the quality of service delivery; are silent on inequality, including spatial and horizontal inequality; and disproportionately focus on outcomes, with limited consideration of the enablers of development, thereby excluding the role of factors such as infrastructure and peace and security.

Workshop participants stressed the need for the post-2015 development agenda to reflect an appropriate balance of development outcomes and enablers (see table 9.1 below). Participants also urged that the post-2015 agenda should focus on economic transformation, human development and education and technology (see table 9.2 below).

Suggestions for a post-2015 development agenda

Consultations with African member States so far suggest that reformulating the MDGs – "MDG-plus" – is the preferred option. Drawing on the findings of the commissioned papers and outcomes of multi-stakeholder consultations – that is, the regional workshop and the electronic surveys – in

Table 9.1 Enabling the post-2015 development agenda: perspectives from Africa

Goal	Enablers
To create an enabling environment for the realization of the post-2015 development agenda	• Enhanced peace and security • Good governance • Human rights for all • Strengthened access to justice and equality • A credible participatory process • Enhanced capacity to measure progress and ensure accountability

Source: Based on UNECA/AUC/UNDP consultations (regional workshop and electronic survey) on the post-2015 development agenda.

Africa, this section makes specific proposals for the post-2015 agenda.

Policymakers face many suggestions for the post-2015 agenda, and there are concerns that the agenda could get overloaded. It is important to remember that the simplifying and concise nature of the MDGs helped to "brand" them and their subsequent implementation efforts. Given that no development framework can be conceived as a comprehensive expression of the complexity of human development, goals and targets should be kept to a minimum, post-2015 (Vandemoortele, 2009). It will therefore be necessary to minimize overlaps among goals and to select MDG areas that are likely to have the greatest multiplier effects in socio-economically advancing developing countries. In addition, it is important to maintain a balance between development outcomes and enablers, and to highlight common, binding constraints to achieving the MDGs and thereby create a global platform for advocacy and support for addressing such constraints.

An analysis of the above consultations highlights key enablers of development, which should serve as the basic preconditions for success in carrying out the post-2015 agenda (table 9.1). It is however, debatable whether specific targets should be established for all the enablers. Monitoring should though be encouraged for indicators such as infrastructure and domestic resource mobilization, for which data are at hand.

As well as tracking enablers, reformulating the MDG outcomes is required to take into account emerging issues, priorities and aspirations (table 9.2), based on the African consultations so far.

An important obstacle to monitoring MDG performance in Africa is the lack of timely and reliable high-quality data, as well as efficient monitoring and evaluation systems. This has limited countries' ability to assess the impact of interventions. After 2015, investments in data collection, analysis and dissemination will need to be scaled up.

Moving forward

As the international development community evaluates the contributions of the MDGs and begins the process of defining a post-2015 global

Table 9.2 Priorities for the post-2015 development agenda: perspectives from Africa

Goal	Priority areas
Promote transformation and sustainable growth	• Prioritize employment creation • Promote rural development • Promote agriculture, value addition of primary commodities and resources • Ensure food security • Promote and expand trade, markets and regional integration and investment • Prioritize sustainability and support green economy initiatives • Increase commitments to multilateral environmental agreements
Promote education and technological innovation	• Strengthen quality and access to basic and tertiary education • Invest in secondary, tertiary and vocational education • Promote technology transfer • Invest in research and development
Promote human development	• Promote gender parity/empowerment of women in all spheres of endeavour • Protect human rights and ensure justice and equality • Promote access to social protection • Promote maternal and child health • Support and empower the elderly and disabled • Prioritize disaster risk reduction and climate change adaptation initiatives • Promote access to ecosystem services and biodiversity benefit sharing

Source: Based on UNECA/AUC/UNDP consultations (regional workshop and electronic survey) on the post-2015 development agenda.

framework, Africa too must articulate its common position. Although the MDGs have led to socio-economic gains in the continent, poverty remains rampant and much more needs to be done.

Discussions on a post-2015 agenda currently revolve around three options –retaining the MDGs in their current configuration, reformulating them and developing an alternative framework. Feedback from African member States through the regional workshop in Accra and the electronic survey suggests that it is in Africa's interest to reformulate the MDGs – the "MDG-plus" option – post-2015, to reflect current and emerging challenges. This approach must comprise a judicious mix of development enablers and outcomes.

The post-2015 development agenda should include all policy areas currently addressed by the MDGs. It should, however, be amended to take into account elements of emerging challenges. In addition, two new policy areas should drive the post-2015 agenda: agriculture, food security and rural development; and economic transformation of developing countries.

Section IV: Conclusions and policy perspectives

As highlighted in previous reports *Assessing Progress in Africa towards the Millennium Development Goals*, Africa continues to make progress towards attaining the MDGs. Performance among countries and by target is mixed, however, and the overall pace of progress falls short of what is required to achieve the majority of goals by 2015. With under three years to the deadline, African countries must first ensure that policies sustain and fast-track gains made so far, particularly for lagging MDGs, then begin to articulate a common position on the post-2015 agenda, while ensuring that lessons learnt from the MDG experience inform international discussions on that agenda.

Progress

Given African countries' comparatively unfavourable initial conditions in 2000, their performance over the last 12 years is commendable. In particular, Africa's overall performance on net enrolment and gender parity in primary education, women's representation in parliament, literacy rates of 15–24-year-olds, and combating HIV/AIDS and malaria (mainly prevalence rates among the population aged 15–24) has been especially strong.

Most African countries are advancing well towards MDG 2. Primary school enrolment in Africa increased from 64 per cent in 2000 to 84 per cent in 2009. Seventeen countries have achieved the 90 per cent enrolment target. Furthermore, more countries are recording substantial improvements in their youth literacy rates, although these are still biased towards males. Government focus on policy reviews for paying school fees, efforts to institute reforms to address institutional constraints to delivering high-quality education services in rural and urban areas as well as efforts to scale up non-formal education have been the main drivers of success.

Owing to targeted budgetary allocations, a special focus on girls' schooling, free education and school feeding programmes, and the promotion of parity among regions and among towns, Africa is making good progress on attaining gender parity in primary schools. Similarly, notable political will and the explicit adoption of legal frameworks and quotas have contributed to promoting gender equality and empowering women. On the proportion of seats held by women in national parliaments, seven African countries have already reached the 30 per cent target, while most others are making progress. The share of women working in the informal non-agricultural sector is increasing, however; women are still disproportionately in vulnerable employment.

Yet there can be no room for complacency. To sustain and then increase performance on this goal, targeted policies should be introduced to

address cultural practices and discrimination against girls and women in school and at work, promote women's political empowerment and participation in productive economic activities, and address male–female wage disparities.

Encouraging – albeit slow – progress has also been made against HIV/AIDS and malaria. Africa (excluding North Africa) has recorded a drop in HIV infections and, notably, in young women's prevalence rates. As a result of enhanced universal access to ART for HIV/AIDS, more Africans are living longer with the disease.

Africa (excluding North Africa) contributed significantly to global reductions in malaria deaths between 2000 and 2009. Here, attention to malaria control, coupled with the use of ITNs and artemisinin-based combination therapies, as well as increased vertical funding, have been key.

This illustrates what can be achieved with political will at the highest levels coupled with adequate funding. But with 84 per cent of spending from vertical and trust funds, sustainability could become a problem for the continent, especially in light of recent crises, setting Africa back.

Challenges

The slow progress in key areas of poverty reduction, employment and some health-related goals remains a key concern. Rural poverty is pervasive, and poverty is increasingly feminized. Although poverty in Africa (excluding North Africa) fell between 2005 and 2008, the declining trend lags behind that in many other regions of the developing world. This is mainly because of high rates of population growth, low growth elasticity of poverty and high levels of inequality. Lack of productive employment and few decent jobs (particularly for youths) are serious issues, with too many people in informal and vulnerable employment. If Africa is to accelerate progress on poverty reduction and employment, governments will need to make fundamental policy and institutional innovations.

Rising primary school enrolment ratios have not been matched by a proportionate increase in completion rates, undermining the literacy rate. Despite progress in gender equality and women's empowerment, Africa is off track to achieve gender parity at secondary and tertiary levels. Efforts to restore parity in countries where trends are now biased against boys must also be scaled up.

Africa still faces formidable problems in reducing under-five, infant and maternal mortality. Although all African countries except Somalia reduced infant mortality between 1990 and 2010, the rate of progress was slow. Equally, efforts to reduce neonatal mortality and to develop well-functioning health management information systems must be expanded. And despite numerous international, continental and national initiatives to improve maternal health in Africa, maternal mortality remains disproportionately high and has only decreased by an average of 1.6 per cent a year across the continent. To accelerate progress on lagging health MDGs, development interventions need to maximize links among the MDGS, rather than tackling each goal in isolation.

Africa's performance on environmental indicators is also mixed. The challenge in achieving MDG 7 – and indeed other MDGs – is exacerbated by the threat of climate change and its impacts on ecosystems, water supply and biodiversity. Owing

to weak forestry institutions, policies and regulatory frameworks, as well as inadequate human resources, forest cover is declining in Africa. Carbon tax policies that aim to reduce the carbon footprint in various countries have helped to stabilize carbon dioxide emissions, however. Yet although many African countries have reduced their consumption of ODS, several recorded pick-ups during 2000–2009 (as well as increases in HCFC consumption), suggesting that countries need to review their ODS policies.

Although ODA to Africa has risen in recent years, it still remains below earlier targets and commitments. In order to reduce dependency on international donors and to ensure availability of development funding, African countries must prioritize and mobilize domestic resources robustly, especially given the global crisis and its impact on OECD donor countries.

In conclusion, Africa has undeniably made significant strides over the last 12 years. Despite exposure to shocks and reversals from external and internal factors, countries must now concentrate on sustaining areas of progress. For lagging MDGs where performance is still modest, efforts to fast-track progress must be intensified.

More fundamentally, as 2015 draws near, the international community will need to decide on whether the MDGs should be retained in their current configuration, reformulated to take account of some of the criticism or replaced by an alternative framework. Consultations with African member states suggest that reformulating the MDGs to take into account emerging issues and to reflect a judicious mix of development enablers and outcomes is the preferred option. Enablers, such as peace and security as well as individual and institutional capacity building, are vital preconditions for the changes needed to achieve progress on international agreed goals. The post-2015 development agenda must be framed by an enabling environment that is grounded in a transformative agenda of nurturing vibrant, diversified and resilient economies.

Appendix 1 Summary of Africa's performance on the MDGs, 2012

Goals and Targets (from the Millennium Declaration)	Indicator	Status of Africa Region	Remarks
Goal 1: Eradicate extreme poverty and hunger		Off Track	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1.25 (PPP) per day[1]	1.1 Moderate progress	Poverty declined from 52.3%–47.5% between 2005 and 2008.
	1.2 Poverty gap ratio	1.2 No updated data	
	1.3 Share of poorest quintile in national consumption	1.3 No updated data	
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed	1.4 Good progress	Rising except N. Africa
	1.5 Employment-to-population ratio	1.5 Moderate progress	
	1.6 Proportion of employed people living below $1.25 (PPP) per day	1.6 Good progress	Rise in vulnerable employment
	1.7 Proportion of own-account and contributing family workers in total employment	1.7 Little progress	
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age	1.8 Moderate progress	North Africa on track
	1.9 Proportion of population below minimum level of dietary energy consumption	1.9 No updated data	
Goal 2: Achieve universal primary education		On Track	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education	2.1 Rapid progress	Does not translate to quality
	2.2 Proportion of pupils starting grade 1 who reach last grade of primary	2.2 Moderate progress	Most countries not expected to meet completion target
	2.3 Literacy rate of 15–24 year-olds, women and men	2.3 Good progress	Literacy exceeds 50% in most countries

Goals and Targets (from the Millennium Declaration)	Indicator	Status of Africa Region	Remarks
Goal 3: Promote gender equality and empower women		On Track	
Target 3.A: 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	3.1 Rapid progress 3.2 Rapid progress 3.3 Rapid progress	Low parity at tertiary level Comparable to global average 7 countries have met target
Goal 4: Reduce child mortality		Off Track	
Target 4.A: Reduce by twothirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1-year-old children immunized against measles	4.1 Moderate progress 4.2 Moderate progress 4.3 Rapid progress	Egypt and Tunisia have met target Declining in all African countries
Goal 5: Improve maternal health		Off Track	
Target 5.A: 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	5.1 Good progress 5.2 Slow progress	Inadequate skilled birth attendants
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning	5.3 Moderate progress 5.4 Slow progress 5.5 Slow progress 5.6 No progress	Progress improves with 4 antenatal visits High unmet need
Goal 6: Combat HIV/AIDS, malaria and other diseases		Off Track	
Target 6.A: 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 at last 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	6.1 Rapid progress 6.2 Moderate progress 6.3 No updated data 6.4 No updated data	Southern Africa has made significant gains due to behavioural change and access to ARTs.
Target 6.B: 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	6.5 Rapid progress	ARTs have reduced new infections

Goals and Targets (from the Millennium Declaration)	Indicator	Status of Africa Region	Remarks
Target 6.C: 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	6.6 Rapid progress	
	6.7 Proportion of children under 5 sleeping under insecticide-treated bednets	6.7 Rapid progress	
	6.8 Proportion of children under 5 with fever who are treated with appropriate antimalarial drugs	6.8 Rapid progress	
	6.9 Incidence, prevalence and death rates associated with tuberculosis	6.9 Moderate progress	
	6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course	6.10 No updated data	
Goal 7: Ensure environmental sustainability		Off Track	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest	7.1 Little progress	Few countries have reforestation plans
	7.2 CO2 emissions, total, per capita and per $1 GDP (PPP)	7.2 Little progress	Emissions minimal for most countries with little increase
	7.3 Consumption of ozone-depleting substances	7.3 Good progress	Most countries reduced consumption of ODS by more than 50%
	7.4 Proportion of fish stocks within safe biological limits	7.5 No updated data	
	7.5 Proportion of total water resources used		
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected	7.6 Moderate progress	Just over 50% of countries showed progress
	7.7 Proportion of species threatened with extinction	7.7 No updated data	

Goals and Targets (from the Millennium Declaration)	Indicator	Status of Africa Region	Remarks
Target 7.C: 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	7.8 Slow progress 7.9 Little progress	Urban rural disparities in access to water and sanitation persist
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers[2]	7.10 Proportion of urban population living in slums[1]	7.10 No updated data	

[1] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[2] 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: lack of access to improved water supply; lack of access to improved sanitation; overcrowding (three or more persons per room); and dwellings made of non-durable material.

Appendix 2 Technical notes

MDG 1: Growth required for poverty reduction, 2010–2025

It can easily be shown, assuming constant inequality and growth elasticity of poverty, that the growth required to halve poverty in Africa in the 15 years from 2010 to 2025 can be expressed as:

$$0.5 = \left[1 + \varepsilon * \frac{g}{100}\right]^{15}$$

where ε is the growth elasticity of poverty and *g* is the per capita real GDP growth rate.

This can be rearranged to be:

$$g = \frac{0.5^{\frac{1}{15}} - 1}{\varepsilon} * 100$$

In order to calculate the required GDP growth rate, the per capita GDP growth rate (*g*), is added to the projected population growth rate, which is calculated as the weighted average of the population growth for each country over the past seven years. The sub-regional and regional aggregates reported in tables 1.2 and 1.3 are population weighted.

MDG 5: Computation of correlations

The correlations for MDG 5 come from the latest available UNSD data on the relevant indicators. In calculating the change in the MMR, the log change between 1995 and 2008 was calculated for 50 countries that had data for these two years. MMR statistics are calculated based on household surveys that use the "sisterhood" method. This method asks respondents about the survivorship of their sisters who gave birth, and, while they are asked to report the date of death, it still has a reference period of 0–6 years before the survey. Thus MMR estimates may capture deaths occurring six years before the survey.

For the correlation with percentage of births attended by skilled health personnel (figure 5.3), the log change in MMR was correlated against the log change in percentage of births attended by a skilled health worker or countries that had a first data point between 1990 and 1995 and a last data point between 2005 and 2008. Thirty-three countries were included in this regression.

For antenatal care coverage (figures 5.8 and 5.9), the same method was used. The first figure represents a calculation of correlating the log change in MMR against the log change in percentage of women attending at least one antenatal care clinic for countries that had a first data point between 1990 and 1995 and last data point between 2005 and 2008. Twenty-five countries were included in this regression. The second figure represents the correlation of the log change in MMR against the log change in percentage of women attending at least four antenatal care clinic visits. Fewer countries had overlapping data points for this indicator, thus only 17 countries were included in the regression.

Finally, for adolescent birth rates (figure 5.7), data were insufficient to compare percentage changes, thus a correlation was calculated for countries that

had data points available for either 2005–2006 or 2007–2008. Thirty-one countries had available data points, and these figures were correlated against the MMR for either 2005 or 2008.

MDG 6: Computation of correlations

The correlation in MDG 6 is drawn from UNSD data for a selected number of African countries. It correlates the relationship between Tuberculosis incidence against HIV prevalence in 2009. The strong correlation in Figure 6.3 (0.6) gauges the link between the two diseases but is not a measure of or indicates causation.

Appendix 3 Proportion of children aged 0–59 months with fever receiving antimalarial drugs in selected African countries

			Sex		Residence		Wealth index quintiles	
Country	Year	Total	Male	Female	Urban	Rural	Poorest	Richest
Angola	2006–2007	29.3	..	..	38	22.5	16.9	46.4
Benin	2006	54	..	..	56.7	52.8	44.3	60.6
Burkina Faso	2006	48	48.9	47	70.4	42.1	35.5	69.5
Burundi	2010	17.2	..	..	12.2	17.6	..	..
Cameroon	2006	57.8	57.4	58.2	69.1	50.4	33.2	75
CAR	2006	57	59.3	54.3	67.6	46.6	38.3	73.3
Chad	2010	35.7	36.5	35	44.5	33.2	30.2	47.3
Comoros	2000	62.7	62.2	63.1	65.2	62.1	51.2	66.3
Congo, Rep.	2005	48	..	..	42	52.4	51.7	42.3
DRC	2010	39.1	38.7	39.6	49.4	36.1	33.7	57
Côte d'Ivoire	2006	36	35.9	36	45.2	31.8	27.8	56.9
Equatorial Guinea	2000	48.6	47.2	50.2	55	42.9	44.2	53.2
Eritrea	2008	13.1	14.4	11.3	1.9	15	12.7	..
Ethiopia	2007	9.5	7.8	11.3	12.6	9.2	13.9	9.6
Gambia	2005–2006	62.6	61.4	64	59.3	64.8	61.1	61.2
Ghana	2008	43	43.7	42.1	52.6	37.5	27.9	42.4
Guinea	2007	73.9	74.1	73.6	84.1	70.5	67.2	74.9
Guinea-Bissau	2010	51.2	51	51.5	54.7	48.7	46.1	54.3
Malawi	2010	30.9	31.2	30.6	29.6	46	27.9	41.1
Mali	2006	31.7	..	..	35.2	30.5	30.5	41.7
Mauritania	2007	20.7	20.2	21.2	23	19.1	16.8	24.2
Mozambique	2008	36.7	37.6	35.8	38.4	36.1	32	31.8
Namibia	2009	20.3	21.8	18.9	23.6	19.5	15.3	17.9
Somalia	2006	7.9	9.7	6	14.3	5.7	3.8	11.6
Sudan	2000	50.2	51.7	48.5	60.6	42.1	32.1	75.3
South Sudan	2009	35.8	..	..	49.7	32.9	27.1	51
Swaziland	2006–2007	0.6	0.6	0.6	1.7	0.5	0	0.9
Tanzania	2010	59.1	..	..	66.6	56.5	57.1	67.9
Togo	2006	47.7	46.7	48.8	57.3	43.1	36.2	67.4
Uganda	2009	59.6	..	..	52.7	60.7	63	62.1
Zambia	2010	34	34	34.1	35.4	35.6	33.3	39.7
Zimbabwe	2009	23.6	24.4	22.8	8.4	29	38.6	7.2

Appendix 4 Official list of MDG indicators

All indicators should be disaggregated by sex and urban/rural as far as possible.

Effective 15 January 2008

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day1 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: 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 $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: 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
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 3: Promote gender equality and empower women	
Target 3.A: 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
Goal 4: Reduce child mortality	
Target 4.A: 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 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: 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 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: 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 at last 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 6.B: 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 6.C: 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
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 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 7.B: 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 7.C: 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 7.D: 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 slums2

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries 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 Target 8.C: 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)	Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States. **Official development assistance (ODA)** 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 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) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes **Market access** 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
	Debt sustainability
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: 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 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Fixed telephone lines per 100 inhabitants 8.15 Mobile cellular subscriptions per 100 inhabitants 8.16 Internet users per 100 inhabitants

The Millennium Development Goals and targets come 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".

[a] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[b] 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.

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