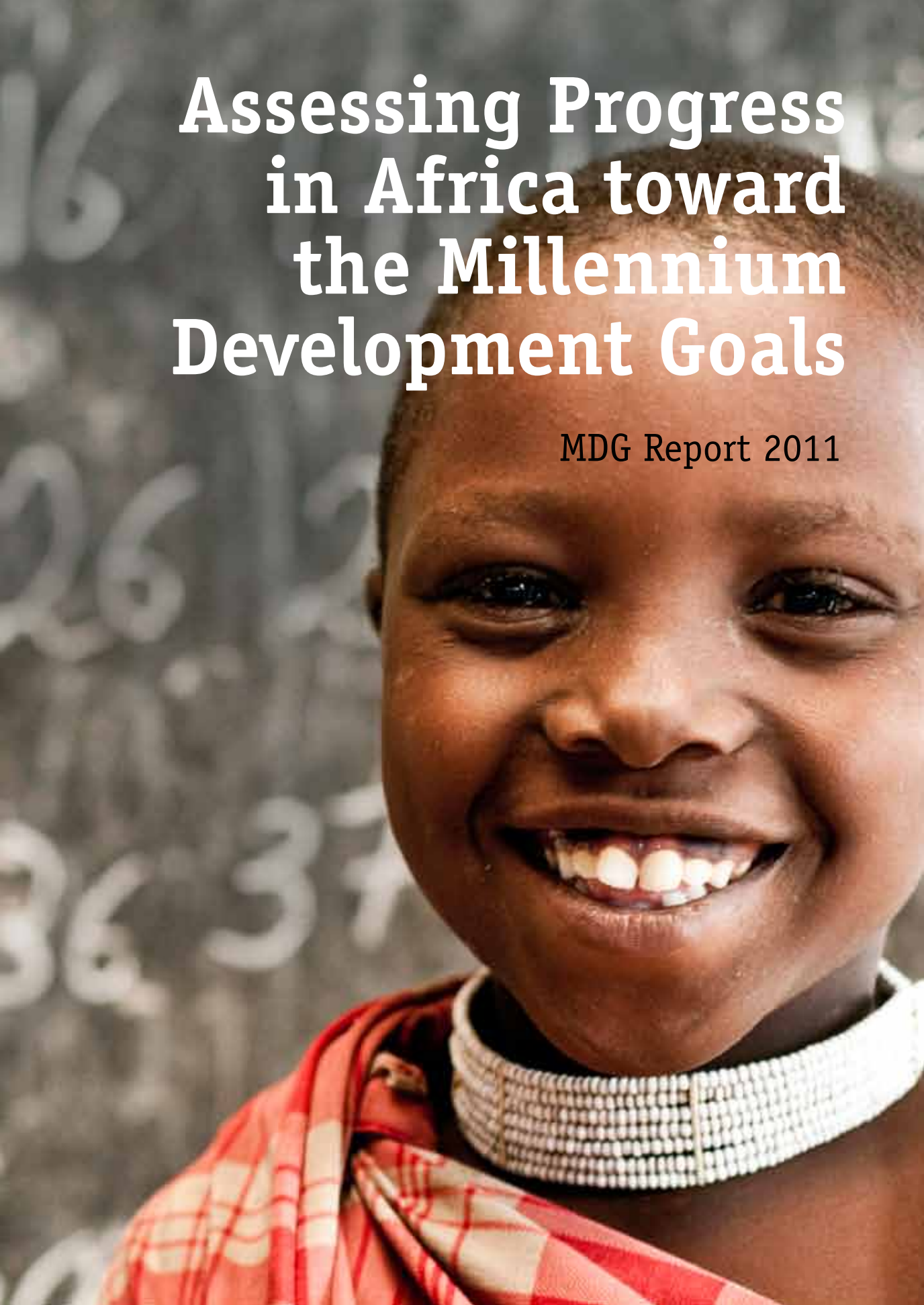


Assessing Progress in Africa toward the Millennium Development Goals

MDG Report 2011



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Foreword

This report continues the tradition of excellent collaboration among the Pan African institutions – the African Union Commission (AUC), the United Nations Economic Commission for Africa (ECA), the African Development Bank (AfDB), and the United Nations Development Programme (UNDP). It provides the latest update on Africa's progress towards the Millennium Development Goals (MDGs), following the landmark September 2010 High Level Panel event. This event noted that the global achievement of the MDGs by 2015 is still possible through strengthened international partnership, closer collaboration between national authorities and development partners, and committed political will at the national level.

The report notes that progress toward the MDGs is continuing, but that the food, fuel, and financial crises over the past few years, coupled with the instability in North Africa in 2011, may impact on the pace of advancement. This calls for efforts to be redoubled to preserve gains and ensure success.

In particular, declines in labor productivity, increasing youth unemployment, and rising numbers of working poor are worrisome trends for the continent. Indeed, the recent political developments in North Africa and the Middle East are a wake-up call both for Africa and other global regions on the need for a more inclusive and equitable approach to growth.

The rising numbers of the working poor should also remind us that the essence of job creation is to provide a decent living wage and not simply a

wage. Furthermore, the disproportionate representation of women among the ranks of the working poor calls for more concerted efforts to address the gender imbalance in the workforce, focusing not only on the share of female employees but on their distribution across the broad spectrum of occupational and skills categories.

The report underscores that the MDGs are closely interlinked, hence the need for an integrated approach to accelerate their achievement. To this end, it is imperative that policymakers prioritize those interventions that will have the greatest leverage or cascading effects on a wider range of indicators. For instance, we know that gender empowerment, education, poverty, and health are inextricably linked. We must therefore exploit these and other relationships to sharpen the strategic focus of our interventions.

Monitoring is central to assessing performance on the MDGs. Effective monitoring requires more substantial investments in data collection, analysis, and dissemination than is currently the case in Africa. Improved data coverage and quality, particularly at subnational levels, are critical for unmasking intra-country variations on MDGs performance and in identifying pockets of vulnerability as a basis for targeted interventions. Indeed, this report continues to observe considerable variations in MDGs performance between subregions, within subregions, and within individual countries.

Despite the slow progress recorded on several indicators in Africa, there are a number of documented best practices and lessons that can be harnessed in order to accelerate progress. It is encouraging to note that these success stories can be found even in countries recovering from conflicts, such

as Liberia and Sierra Leone. These countries have made remarkable progress in infant mortality (Liberia) and maternal health (Sierra Leone). Their performance demonstrates that with the right level of political will and appropriate external support, the MDGs can be achieved even under very difficult conditions.

In this report we underscore the potential for social protection programs in accelerating progress toward the MDGs. Consequently, we urge policymakers to recalibrate their social protection programs, so that they are perceived not as handouts but rather as measures to strengthen productive assets. These perspectives are pertinent and timely in light of the impact of the food, fuel, and financial crises on the lives of many. It is clear that the role of the state in designing and implementing innovative and fiscally sustainable social protection programs is more vital now than ever before.

Domestic resources must be complemented by scaled-up development assistance if African countries are to attain the MDGs. In this regard, we call for increased development assistance for the achievement of the MDGs in Africa and note with concern that several Official Development Assistance (ODA) commitments to Africa, including those made in Monterrey in 2002, Gleneagles in 2005, and L'Aquila in 2009, have yet to be fulfilled. A more worrisome prospect is that they are even

less likely to be met in the current environment of fiscal consolidation in response to the global economic crisis. However, it is encouraging to note that developing countries are benefiting from new donors that are non-DAC members and from private sector donations from advanced economies. Nonetheless, aid to African countries is expected to rise by only 1 percent per year between 2011 and 2013, in real terms. Beyond advocacy for more ODA, stepped-up efforts are therefore required on a number of fronts, namely to seek out alternative sources of financing; to be more judicious in the use of existing resources; and to develop credible and robust systems of domestic resource mobilization.

Undoubtedly, aid effectiveness requires close alignment of donor assistance with national priorities, including the MDGs. To this end, implementation of the Paris Declaration and Accra Agenda for Action is key to ensuring a sharper focus by donors on the objectives of recipient countries toward poverty reduction and development.

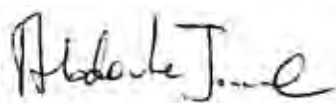
We wish to thank all those who have contributed to the preparation of this report. We commend and encourage the report's commitment to take into account the views and experiences of leaders, policymakers, and development practitioners who are actively promoting the achievement of the MDGs in Africa and especially in meeting the agreed targets.



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List of Abbreviations

ACT	Artemisinin-based Combination Therapy	DOTS	Directly Observed Short-Course Treatment
AfDB	African Development Bank	DRC	Democratic Republic of Congo
AIDS	Acquired Immunodeficiency Syndrome	EAC	East African Community
ALSF	African Legal Support Facility	ECA	Economic Commission for Africa
ANEM	Algeria National Employment Agency	ECOWAS	Economic Community of West African States
ART	Antiretroviral Therapy	EDND	Economic Development and NEPAD Division
AUC	African Union Commission	ERD	European Report on Development
CAADP	Comprehensive African Agriculture Development Program	EPA	Economic Partnership Agreement
CAR	Central African Republic	EPRI	Economic Policy Research Institute (South Africa)
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa	ESA	Eastern and Southern Africa
CBD	Convention on Biological Diversity	EU	European Union
CBHI	Community Based Health Insurance	FAO	Food and Agriculture Organization
CDIAC	Carbon Dioxide Information Analysis Center	FHCI	Free Health Care Initiative (Sierra Leone)
CFCs	Chlorofluorocarbons	FISP	Farm Input Subsidy Program
CIS	Commonwealth of Independent States	FSP	Food Security Program
COPE	Care of the People (Nigeria)	GAFSP	Global Agricultural and Food Security Program
CPR	Contraceptive Prevalence Rate	GDP	Gross Domestic Product
CSG	Child Support Grant	GHI	Global Hunger Index
DAC	Development Assistance Committee	GNI	Gross National Income
DI	Disability Insurance	GPI	Gender Parity Index
DFID	Department for International Development (UK)	HAART	Highly Active Anti-Retroviral Treatment
DHS	Demographic and Health Survey	HDI	Human Development Index
		HIPCs	Heavily Indebted Poor Countries
		HIV	Human Immunodeficiency Virus
		ICT	Information Communications Technology

IFAD	International Fund for Agricultural Development	PPP	Purchasing Power Parity
IFPRI	International Food Policy Research Institute	PSNP	Productive Safety Net Program (Ethiopia)
IGAD	Inter-Governmental Authority on Development	RSA	Republic of South Africa
IGME	Inter-agency Group for Child Mortality Estimation	SADC	Southern African Development Community
ILO	International Labor Organization	SI	Social Insurance
IMF	International Monetary Fund	SOAP	State Old Age Pension
IMR	Infant Mortality Rate	SPF	Social Protection Floor
ITNs	Insecticide Treated Nets	TB	Tuberculosis
ITU	International Telecommunication Union	U5MR	Under-Five Mortality Rate
IUCN	International Union for Conservation of Nature	UEMOA	Union économique et monétaire ouest-africaine
IUDs	Intrauterine devices	UN	United Nations
LDCs	Least Developed Countries	UNAIDS	Joint United Nations Program on HIV/AIDS
LEAP	Livelihood Empowerment Against Poverty program (Ghana)	UNDP	United Nations Development Programme
LIFDC	Low-Income Food-Deficit Country	UNDP-RBA	United Nations Development Programme – Regional Bureau for Africa
MAF	MDG Acceleration Framework	UNESCO	United Nations Educational, Scientific and Cultural Organization
MDGs	Millennium Development Goals	UNFPA	United Nations Population Fund
MMR	Maternal Mortality Ratio	UNICEF	United Nations Children’s Fund
MPS	Making Pregnancy Safe Initiative	UNSD	United Nations Statistics Division
NEPAD	New Partnership for Africa’s Development	US\$	American Dollars
ODA	Official Development Assistance	WFP	World Food Program
ODI	Overseas Development Institute (UK)	WHO	World Health Organization
ODP	Ozone Depletion Potential	WTO	World Trade Organization
ODS	Ozone Depleting Substances		
OECD	Organization for Economic Cooperation and Development		
OVC	Orphans and Vulnerable Children		
PEPFAR	President’s Emergency Plan For AIDS Relief (U.S.)		
PMTCT	Prevention of Mother to Child Transmission		

SECTION I:

Introduction

In September 2010, at the UN Millennium Development Goals High-Level Summit in New York, the international community reaffirmed its commitment to the MDGs,¹ acknowledged the progress made so far, and noted that the global achievement of the MDGs by 2015 is still possible through strengthened international partnerships, closer collaboration between national authorities and development partners, and clear-sighted political will at the national level.

This annual report is based, as in previous editions, on the database compiled by the United Nations Statistical Division (UNSD).² This is the official data repository for assessing progress toward the MDGs. The UNSD harmonizes data using the same definitions and standards across national datasets, allowing for comparability across countries. An obvious drawback of this process is that it considerably lengthens the time lag between national data availability and international updates. For example, the most recent data used in this report are from the year 2009. As in previous reports, specialized UN agencies such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the International Fund for Agricultural Development (IFAD) have served as important data sources for the report.

In addition, this report utilizes 10 African national MDG³ reports and supplements the analysis based on UNSD data and other credible international sources and observations, which document MDG-relevant policy initiatives and lessons learned.

The overall assessment of Africa's progress toward the MDGs reveals that, while progress has generally been positive, performance has been mixed across indicators and countries, and based on current trends, the overall pace of progress is insufficient to achieve the MDGs by the target date of 2015.

Indeed, the recent progress toward achievement of the MDGs occurred against the backdrop of global food, fuel, and financial crises. Depending on national capacities to design and implement effective counter-cyclical measures, the crises invariably had adverse effects on a wide range of MDG indicators. Despite positive albeit modest indications of global recovery, the crises are far from over and have lagged negative effects on MDG indicators. Furthermore, the recovery in the developed world remains fragile with many European economies, most recently in Greece, experiencing fiscal consolidation. Such setbacks will invariably dampen Africa's growth prospects by constraining access to ODA. Food hikes have to some extent continued since 2008, with price levels above pre-crisis figures to the detriment of

1 A listing of the official MDGs, their targets, and indicators is presented in Annex 1 of this report.

2 All UNSD data used in this report are available at <http://mdgs.un.org/unsd/mdg/Default.aspx>.

3 Algeria, Egypt, Ethiopia, Lesotho, Mozambique, Nigeria, Sierra Leone, South Africa, Togo, and Uganda.

lower-income groups who have become more vulnerable in the face of rapidly declining real incomes. Climate change poses yet another formidable challenge to Africa's agricultural production, food security and livelihoods, as demonstrated by the recent floods in Southern and West Africa, and the drought in Eastern Africa.

Africa will need more predictable and timely resources to respond to the emerging development challenges. However, the prospects for increased official development assistance (ODA) are not very encouraging, especially when one takes into account the growing fiscal imbalances in developed countries. Indeed, development partners' ODA commitments still fall far short of the 0.7 percent of GDP target, and there is little indication that the situation will change significantly over the short to medium term.

Notwithstanding the crises, African countries have in recent years generally been on a steady path toward achievement of universal primary education and the empowerment of women. This has been especially evident in the ratio of girls to boys in primary education. Significant progress has also been made in the fight against HIV and AIDS, using methods such as awareness campaigns focusing on behavioral change and the promotion and use of antiretroviral therapy (ART), which have curbed the numbers of new infections and AIDS-related deaths. However, several targets related to HIV and AIDS have still not been met, while some countries have witnessed a retrogression. Progress on health indicators has generally been weak. While a few countries have made commendable advances, overall the continent lags behind other global regions in terms of maternal and child health. Similarly, efforts to eradicate malaria and

tuberculosis have been met with limited success, partly due to weak primary healthcare infrastructure, inadequate levels of medical personnel, and a lack of access to affordable drugs.

Aggregate trends in Africa's progress toward the MDGs mask high levels of spatial and group disparities in performance. In particular, progress on all indicators is skewed in favor of higher-income groups and urban populations. The inequities in access to public services (such as education, health, water and sanitation) result in the further marginalization of excluded groups. This state of affairs was acknowledged in the 2010 High Level Meeting on the Millennium Development Goals' (MDGs) Outcome Document, which proposed tackling inequalities as an important way to scale-up progress for all segments of the population. The document proposes specific interventions, such as social protection programs to create a level playing field for all, to ensure the availability, continuity, and access to public services, and to accelerate progress toward the MDGs.

Recognizing the importance of addressing vulnerability and inequality, Section III of this report adopts a thematic focus on social protection programs in Africa. Social protection programs in a selected number of African countries are analyzed in terms of their effectiveness and overall contribution toward the MDGs. This provides further lessons and opportunities for peer learning and knowledge sharing on such programs, as they relate to the MDGs.

Productive employment remains a key to exit poverty and address inequality. Creating economic growth is a crucial way to increase employment opportunities in Africa and boost incomes. The

employment-to-population figures remain somewhat static on the continent. Besides enlarging the vulnerable informal sector, unemployment can lead to political instability, as witnessed in the recent events in Tunisia and Egypt. African countries need to translate relatively strong economic growth into meaningful employment creation to reduce absolute poverty and create social inclusiveness. Unlocking entrepreneurship across regions and sectors and instituting well-designed and supportive policies and actions is the roadmap to strong, shared, and sustainable growth. Africa can achieve such growth through structural transformation guided by a developmental state, underpinned by a vibrant private sector, productive entrepreneurship, and a diversified economy. Industrial policy can play an important role in nurturing the entrepreneurial spirit and removing obstacles to growth in high-potential sectors and industries, thereby generating employment across the continent. Success in this area depends on a number of structural factors, including addressing the infrastructure gap (e.g., improving access to a reliable electricity supply, reliable road networks and ICT connectivity, and better access to water and sanitation). It is also contingent on promoting a strong linkage between the agriculture and industrial sectors.

The evidence gathered in this report suggests that scaling-up efforts to accelerate progress toward achieving the MDGs on the continent is indeed possible. A crucial factor is that the much-needed political will to support the MDGs did not wane during or after the financial crisis – African countries and development partners remain fully committed to the Goals. However, one point of concern is the extent to which governments can maintain fiscal stability as they implement stimulus-related packages to cushion households from the impact of the crises. Of equal concern is the implication of the crises for concessional resource flows and global trade. In particular, fiscal consolidation in developed countries will likely have adverse consequences for both commodity exports and aid flows to developing countries.

This report is organized as follows. After this first introductory section, Section II assesses progress on each of the eight Goals. Section III takes as its thematic focus social protection programs as they relate to the MDGs in a selected number of African countries. Section IV concludes with recommendations on the way forward.

SECTION II:

Tracking 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 US\$ 1.25⁴ a day

In recent years, extreme poverty has been falling rapidly, even in low-income countries, despite their growing populations. Across developing countries globally, the proportion of people living on less than US\$ 1.25 a day fell from 42 percent of the population in 1990 to 25 percent in 2005. This is attributable to the rapid economic growth in most developing countries and the significant progress in poverty reduction on the part of highly populated countries such as China, India, and Indonesia. If this trend continues, developing countries are likely to reach the target of 21 percent of the population living on less than US\$ 1.25 a day by 2015.

Over the past decade, Africa has contributed significantly to global economic growth, however, economic performance has not translated into a significant reduction in poverty among its populations. In particular, the proportion of Africans (excluding those in North Africa) living on less than US\$ 1.25 a day marginally decreased from 58 percent in 1990 to 51 percent in 2005.⁵ However,

this falls far short of the target of 29 percent by 2015 (*Figure 1*). Furthermore, due to the cumulative impacts of the food, fuel, and financial crises between 2006 and 2008, there has been a reversal in the hard-won gains made in the past decade toward reducing absolute poverty⁶. Notwithstanding this setback, from 1998 to 2008, some African countries such as Cameroon, Ethiopia, The Gambia, Ghana, Senegal, and Morocco did manage to buck the trend and make strides in poverty alleviation⁷ (*Figure 2*).

An important challenge to monitoring progress on poverty reduction in Africa is the lack of data originating from comprehensive, quality surveys

financial crisis. For instance, Pinkovskiy and Sala-i-Martin (2010) argued that poverty is reducing faster than expected through the distributive impact of rapid economic growth in the region, which could fast-track the achievement of the target before 2015. However, Chen and Ravallion (2008) concluded that Africa's poverty is not declining fast enough to offset the region's high population growth rate. Wodon (2007), while appreciating the role of economic growth in poverty reduction, noted that changes in inequality are limiting the gains from growth for the poor in several African countries. The World Bank and IMF (2010) also explained that the initial conditions in Africa made it difficult for growth to lead to a rapid reduction in poverty; that the pace of progress is inversely related to initial conditions.

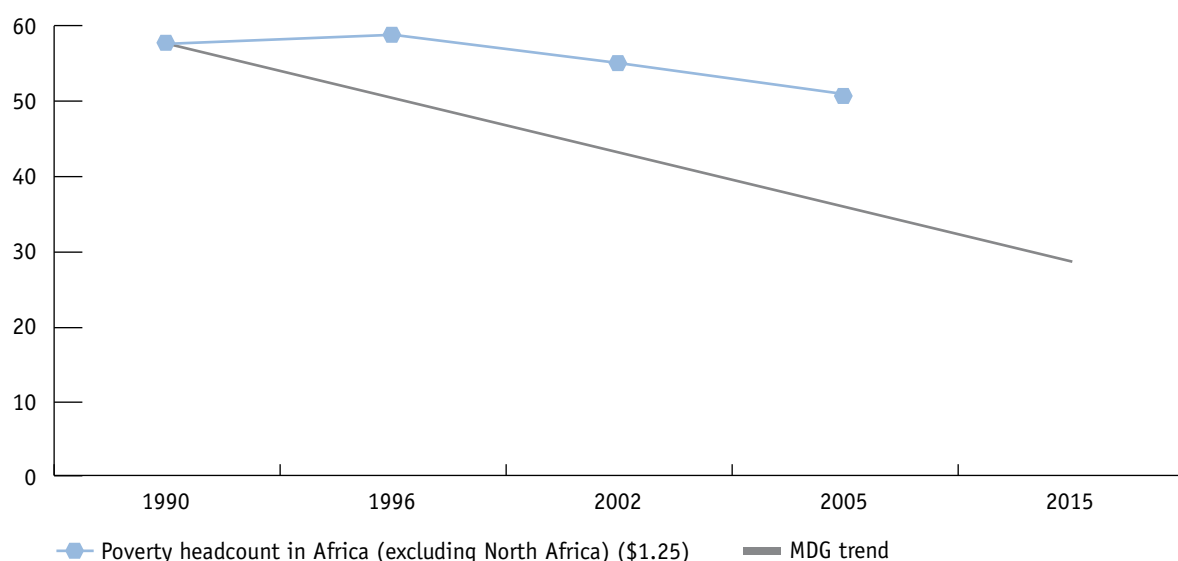
6 The projection from IFAD (2010) puts the proportion of the population living below the poverty line in Africa (excluding North Africa) at 52.5 percent in 2008.

7 Many countries' reports also indicated they have made appreciable progress on poverty reduction (in contrast with international statistics). For instance, official statistics from Algeria reported a substantial fall in poverty from 14.1 percent in 1995 to 5 percent in 2008.

4 The poverty rate is the proportion of the population living on less than US\$ 1.25 a day, measured at 2005 international prices, adjusted for purchasing power parity (PPP).

5 It is important to acknowledge the controversy surrounding the extent of poverty reduction in Africa prior to the global

Figure 1: The declining poverty trend in Africa (excluding North Africa) compared to trended target for 2015 (%)



Source: Compiled from <http://iresearch.worldbank.org/PovcalNet/povDuplic.html>.

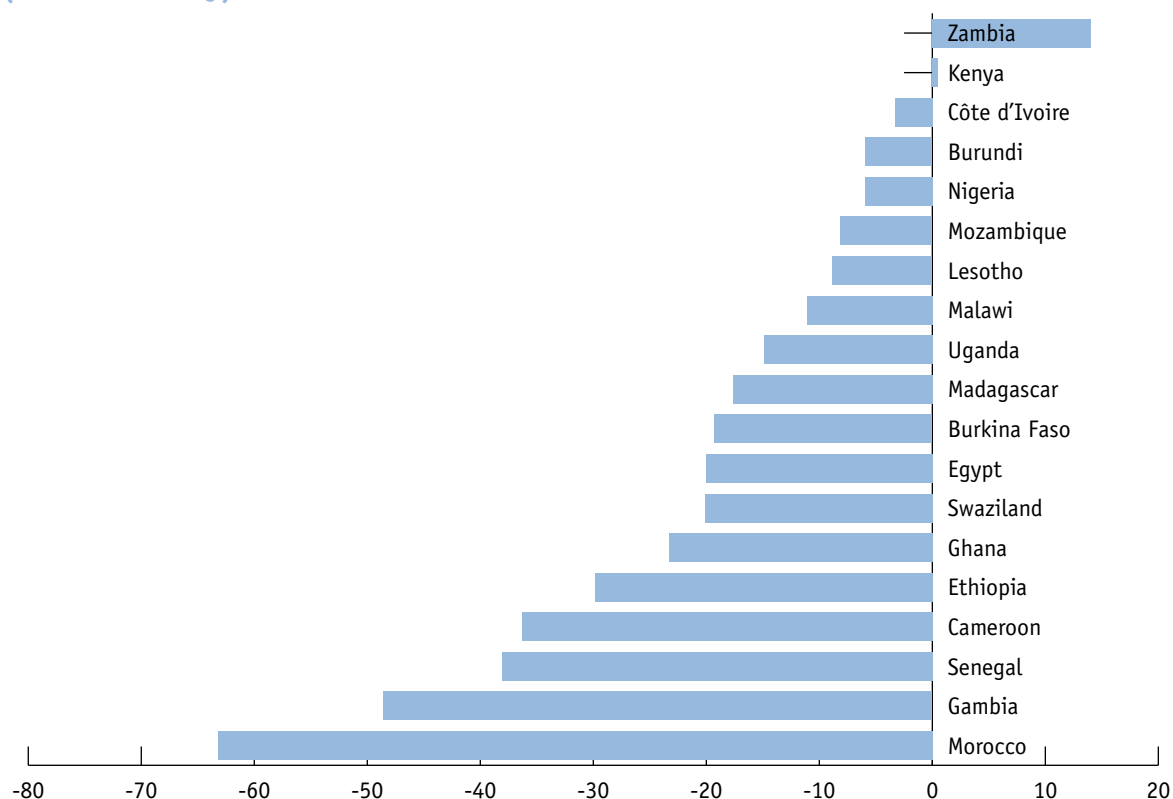
carried out at regular intervals. Even where good-quality surveys are available, delays in reporting the results continue to hamper the monitoring of poverty in the continent. Gaps are particularly acute in Africa (excluding North Africa), where close to half the countries lack sufficient data to make comparisons over time. To ensure evidence-based decision-making on the continent, governments, the private sector, and development partners should pay greater attention to the conduct of household surveys through better resource allocation and capacity development. The need to bridge the discrepancies between national and international statistics should also be given serious consideration.

Poverty gap remains high in Africa

The poverty gap measures the shortfall in the incomes of people living below the poverty line.

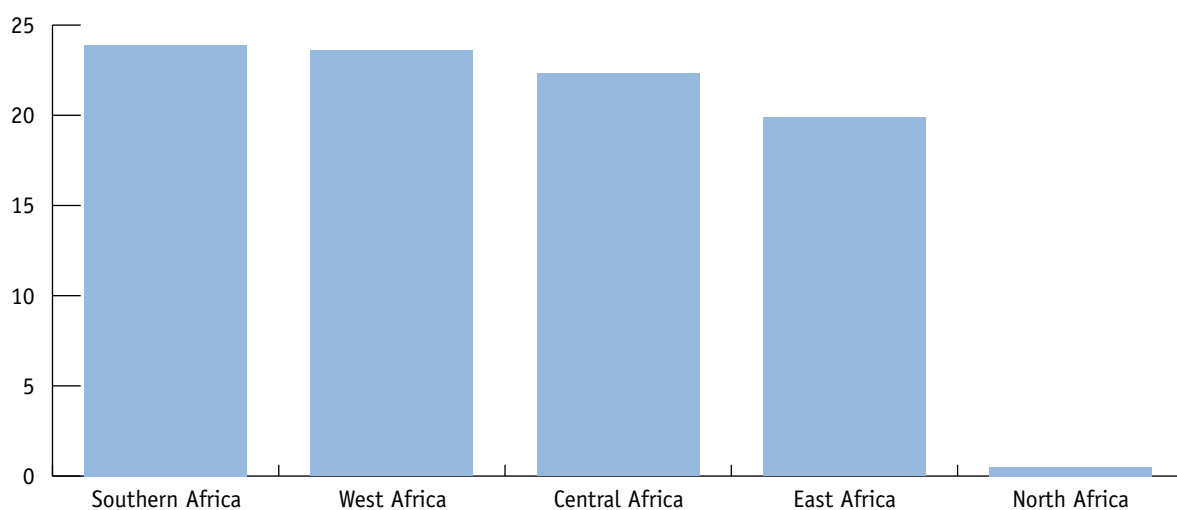
While the international poverty line of US\$ 1.25 a day is set at a level typical of very poor countries, many people subsist on even less than that amount. Economic growth and improvements in the distribution of income or consumption can reduce the depth of poverty. In North Africa, the poverty gap ratio remained static at 1 percent between 1990 and 2005, whilst in the rest of Africa the ratio posted an improvement from 26 to 21 percent during the same period. The subregional variations in the poverty gap are high (*Figure 3*). These data indicate the percentage of people living far below the threshold of US\$ 1.25 a day, and hence the magnitude of vulnerable groups that require policy interventions. Efforts to spur growth and productivity in sectors where the poor are most active (e.g. agriculture and informal businesses) will help to improve this ratio.

Figure 2: Percentage change in population living below the poverty threshold (US\$ 1.25 a day) between 1998 and 2008



Source: Compiled from IFAD (2010, pp. 245–252).

Figure 3: Poverty gap ratio by African subregion, 2008 (%)



Source: Compiled from IFAD (2010).

Proportion of the “working poor” remains a challenge

The “working poor” are defined as those who are employed but live in households where individual members subsist on less than US\$ 1.25 a day. Most of these workers lack the social protection and safety-nets that guard against times of low economic demand. Often they are unable to generate sufficient savings to offset hard times. Since vulnerable employment tends to be characterized by low-productivity work, and the global financial crisis has decreased labor productivity,⁸ working poverty is likely to have increased over recent years and this trend is projected to continue (UN, 2010). Data show that the proportion of the African working population (excluding those in North Africa) earning less than US\$ 1.25 a day in 1998 was 67 percent, which improved to 58 percent in 2008, but this is projected to slip back to 64 percent in 2009. This stands in contrast to far more substantial improvement in most other global regions over the same timeframe (e.g., from about 67 percent to 11 percent in East Asia and from about 22 percent to 14 percent in North Africa) (ILO, 2010b).

The rural–urban divide in poverty incidence persists

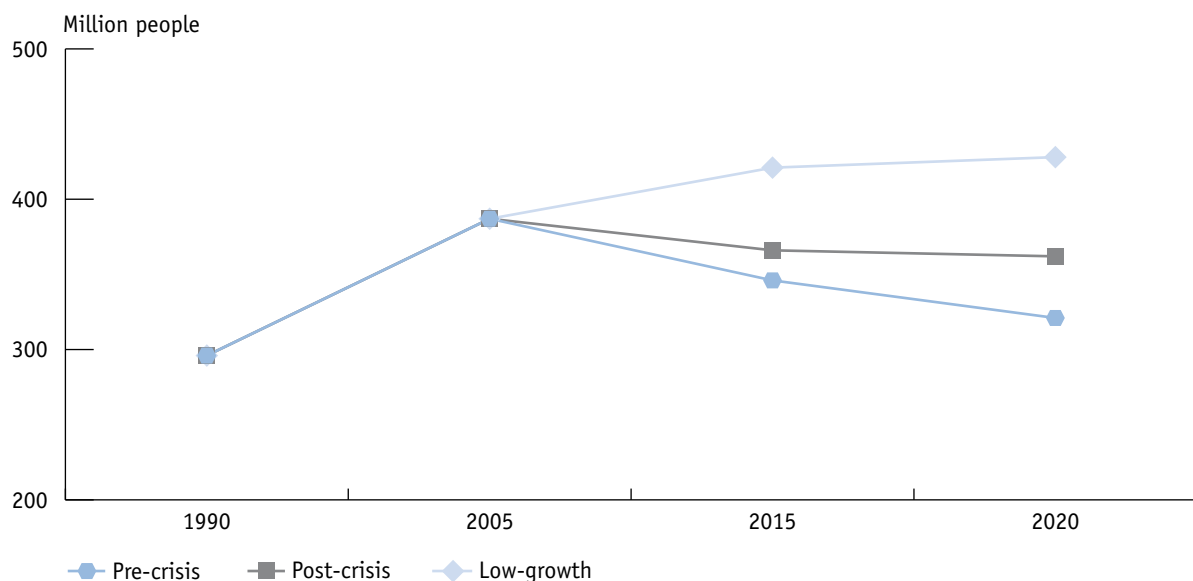
Evidence from the *Rural Poverty Report 2011* (IFAD, 2010) shows that rural poverty is still very high in Africa (excluding North Africa). While it

marginally declined from 64.9 percent in 1998 to 61.6 percent in 2008, this is almost double the average of 34.2 percent for all developing countries (IFAD, 2010). Although Africa (excluding North Africa) reduced rural poverty by 5.1 percent between 1998 and 2008, developing countries in other global regions fared much better. Latin America and the Caribbean decreased their levels of rural poverty by 68.8 percent, South East Asia by 51.4 percent, and the Middle East and North Africa by 45.5 percent.

These regions were able to deal with the root causes of rural poverty such as lack of assets, limited economic opportunities (including weak access to markets and poor harvests), and poor education, as well as disadvantages rooted in social and political inequalities. Rural development, green growth, and good health systems in other developing regions contributed to rapid exits out of rural poverty. Addressing this issue in Africa is central to reducing spatial inequality. It will require governments to facilitate individual and collective access to physical assets such as land, houses, credit and occupational inputs, while at the same time strengthening the rural population’s capabilities (e.g., through better education, access to information, and greater participation in dialogue and decision-making). This should be complemented by the creation of local economic opportunities (especially non-farm); increasing rural people’s capacity to better manage the risks they face; and investments in rural infrastructure such as energy, water and sanitation, and transportation. It also calls for better governance at both national and local levels.

⁸ Labor productivity declined in almost all the regions of the world during the recent financial crisis. The exceptions were in East Asia, South Asia, and North Africa, which weathered the crisis rather well in comparison with other regions. Labor productivity was particularly hard-hit in Latin America and the Caribbean, Central and South-Eastern Europe (non-EU) and the CIS region, the Middle East, and Africa (excluding North Africa) where it went into negative territory between 2007 and 2009 (ILO, 2011).

Figure 4: Projected impact of the economic crisis on poverty reduction in Africa (excluding North Africa), 2005–2020



Source: Compiled from World Bank and IMF (2010).

The global financial crisis and its impact on poverty reduction

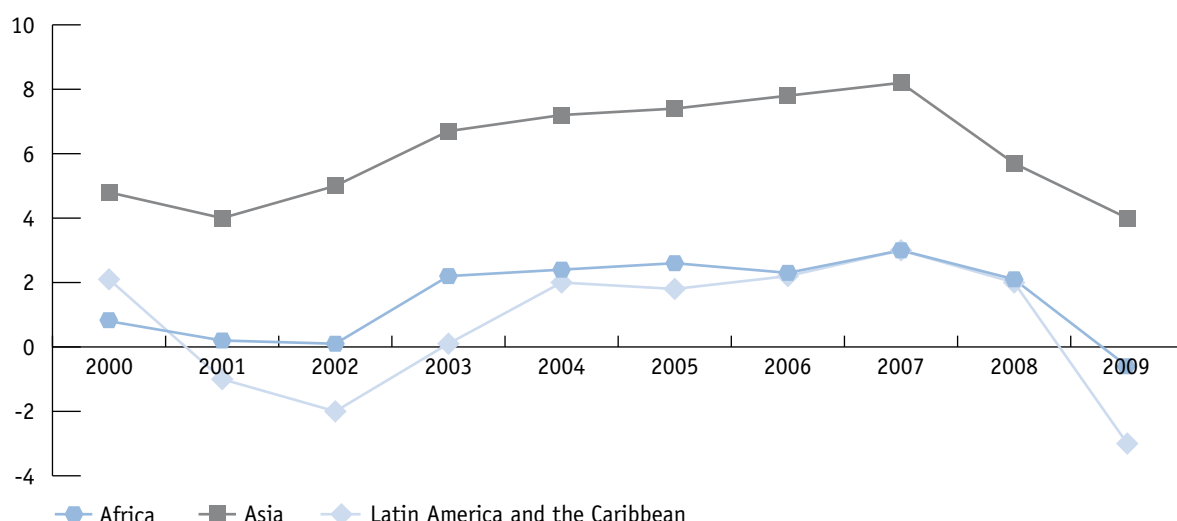
In spite of the promising economic growth projection for the continent, the aftermath of the global financial crisis is likely to have a significant impact on progress toward MDG 1, both up to 2015 and beyond. Although much of the rest of the world is largely on track to meet the target of halving its income poverty rate, this presents a major challenge for Africa (excluding North Africa). Before the crisis, the region was projected to reach a poverty rate of 35.9 percent by 2015, but this has now been revised to 38 percent. The implication is that an additional 20 million people will be left in poverty by 2015. However, if the low-growth scenario comes to

pass,⁹ this number would more than double to 55 million over the same period¹⁰ (Figure 4). Indeed, revised estimates from the World Bank suggest that the crisis left an additional 50 million people in extreme poverty in 2009 and a further 14 million in 2010. Those hardest hit were principally living in Africa (excluding North Africa) and in Eastern and South-Eastern Asia.

⁹ The low-growth scenario assumes little or no growth for about five years, when it begins to slowly recover (World Bank and IMF, 2010).

¹⁰ Ibid.

Figure 5: Growth of labor productivity in Africa and other developing regions, 2000–2009



Source: Compiled from ILO (2010c).

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

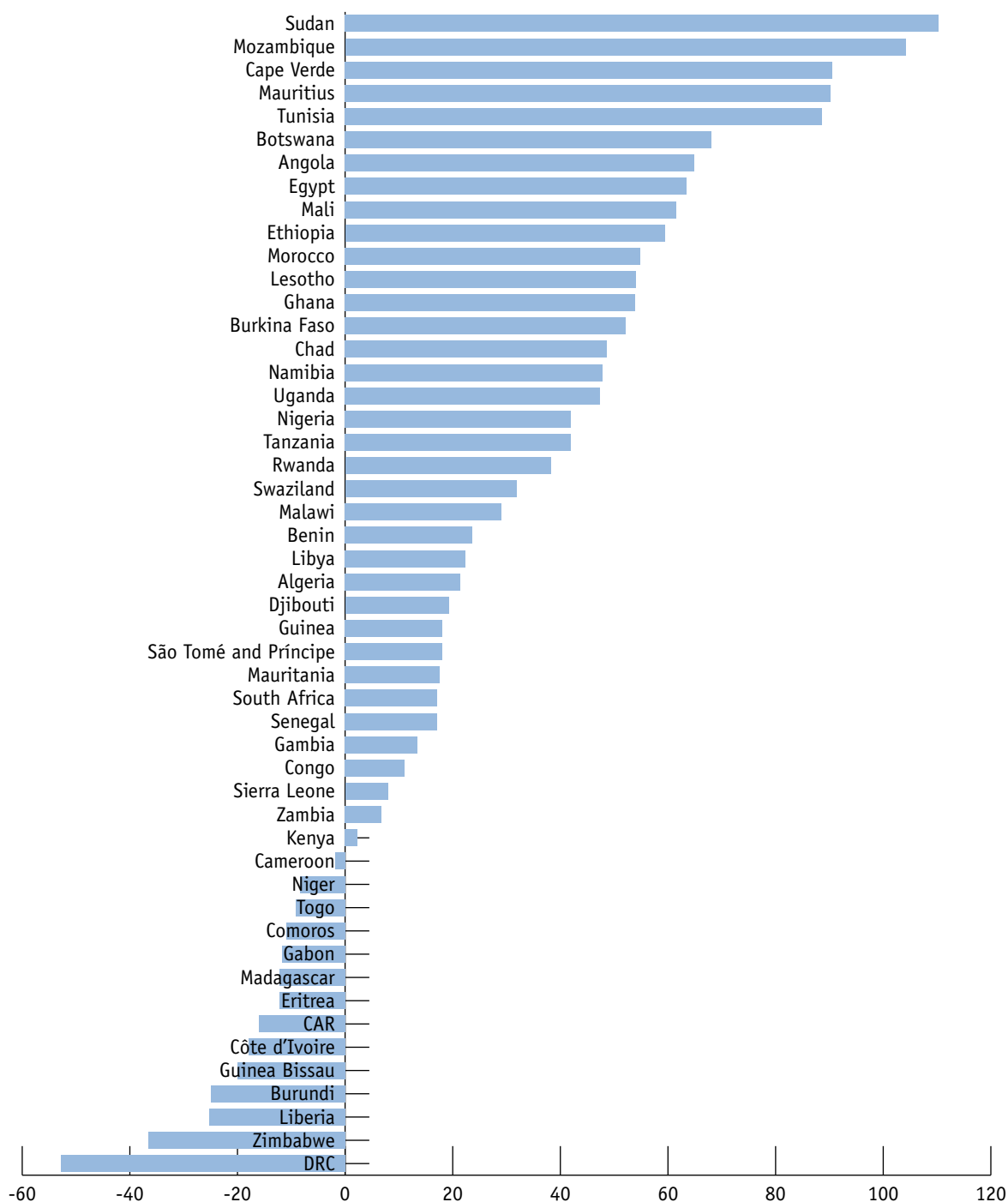
Indicator 1.4: Growth rate of GDP per person employed

An important indicator for measuring changes in the quality of employment is labor productivity.¹¹ Growth in labor productivity is essential for improving living standards and sustaining poverty reduction. Like many other developing regions, output per worker in Africa, which has been rising since 2002, witnessed a substantial decline in 2009 due to the global economic crisis (Figure 5). While the growth of labor productivity remained positive in North Africa, it was curtailed – dropping from 2.9 percent in 2007 to 1.6 percent in 2009. There was a much sharper

decline in other subregions of Africa, from 3.5 percent to -1.2 percent during the same period. The slowdown in the rate of capital accumulation and weak growth in total factor productivity¹² could have accounted for the sharp fall in labor productivity. Generally, output per worker is very low in Africa (excluding North Africa), relative to other global regions. For instance, in 2009 it was estimated to be US\$ 5,141 for Africa (excluding North Africa), compared to US\$ 16,236 (North Africa), US\$ 12,383 (East Asia), US\$ 22,352 (Latin America and the Caribbean), and US\$ 70,946 (developed economies and European Union) (ILO, 2011).

¹¹ Labor productivity is defined as output per unit of labor.

¹² Productivity gains come from a more efficient use of capital and labor, as well as from technological progress.

Figure 6: Percentage change in GDP per capita, 1990–2009

Source: Compiled from <http://hdrstats.undp.org/fr/indicateurs/62006.html>

Note: There were no data for Seychelles and Somalia, while Equatorial Guinea data were excluded because of its impact on the graph. Data from Eritrea and Libya started from 2000, while São Tomé and Príncipe data started from 2005.

Subregional averages mask wide variations across African countries on productivity, as measured by GDP per capita. For countries where comparable data are available between 1990 and 2009, the average GDP growth per capita was 55.8 percent in Africa. Thirty-seven countries recorded positive growth while it was negative in 14 countries during the same ten-year period. Two oil-producing countries (Equatorial Guinea and The Sudan) were the highest-performing countries, followed by Mozambique, Cape Verde, Mauritius, and Tunisia.

The use of revenues from offshore oil extraction for the transformation of infrastructure in Equatorial Guinea accounts for the massive rise in productivity in that country, while the efficient use of capital, labor, and technological advances explains better performance in other countries. The least-performing countries in terms of GDP growth per capita over 1990–2009 were DRC, Zimbabwe, Liberia, Burundi, and Côte d'Ivoire (*Figure 6*). Most countries lagging behind on productivity are postconflict countries. Conflicts often lead to the total destruction of infrastructure, which undermines the efficient use of factors of production (including labor and capital). Resources that could be used for capital accumulation are instead devoted to humanitarian support and social cohesion efforts. The resurgence of conflicts in some countries and the spread of political instability in North Africa could further affect overall productivity on the continent.

Indicator 1.5: Employment-to-population ratio

Employment generation

The employment-to-population ratio,¹³ which provides a snapshot of the quantity of employment

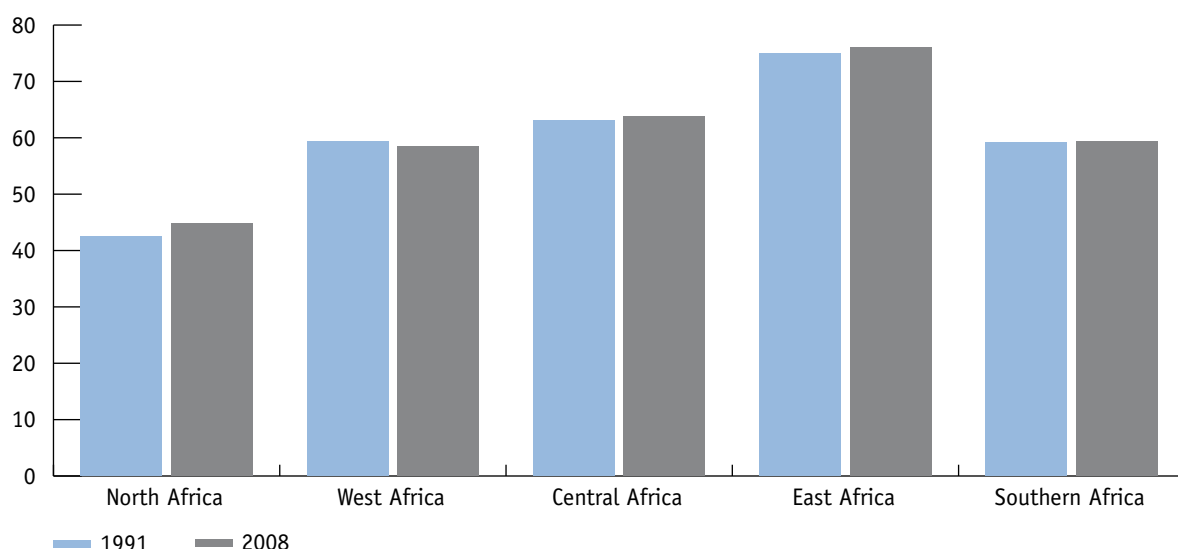
being generated in an economy, grew by about 0.5 percent between 1991 and 2008 for the continent as a whole. During this period, North Africa recorded the largest improvement, while West Africa regressed slightly. Relative to all the subregions, East Africa has the highest ratio of population in employment, while North Africa has the lowest (*Figure 7*). This could be attributed to the low participation of women and youth in the workforce in North Africa and to a high unemployment rate there.¹⁴ This potent mix of destabilizing factors was no doubt a contributory factor behind the social and political instability recently witnessed in the subregion.

Turning to West Africa, the large share of capital-intensive extractive industries in national output and the prevalence of conflicts in many member countries have contributed to the decline in the employment-to-population ratio in the subregion. By contrast, East Africa's relative social stability and appreciable economic diversification played a positive part in its sustained good performance.

Unemployment rates are generally higher in North Africa than in the other subregions, although it achieved a higher rate of progress over the time span 1991–2008. In North Africa, unemployment declined from about 14 percent in 2000 to 9.5 percent in 2008 before rising marginally to 9.8 percent in 2009, due to the global economic crisis. The decline was subdued in the rest of the continent, falling from about 9.0 percent in 1990 to 8.0 percent in 2007, before rising by just 0.2 percent in 2009 (ILO, 2011).

13 Employment-to-population ratio is defined as the proportion of a country's working-age population, aged 15 years and older, who are in employment.

14 See ILO (2010a) for more on the employment situation in North Africa.

Figure 7: Employment-to-population ratio by African subregion, 1991 and 2008 (%)

Source: Compiled from UNSD data (updated in June 2010).

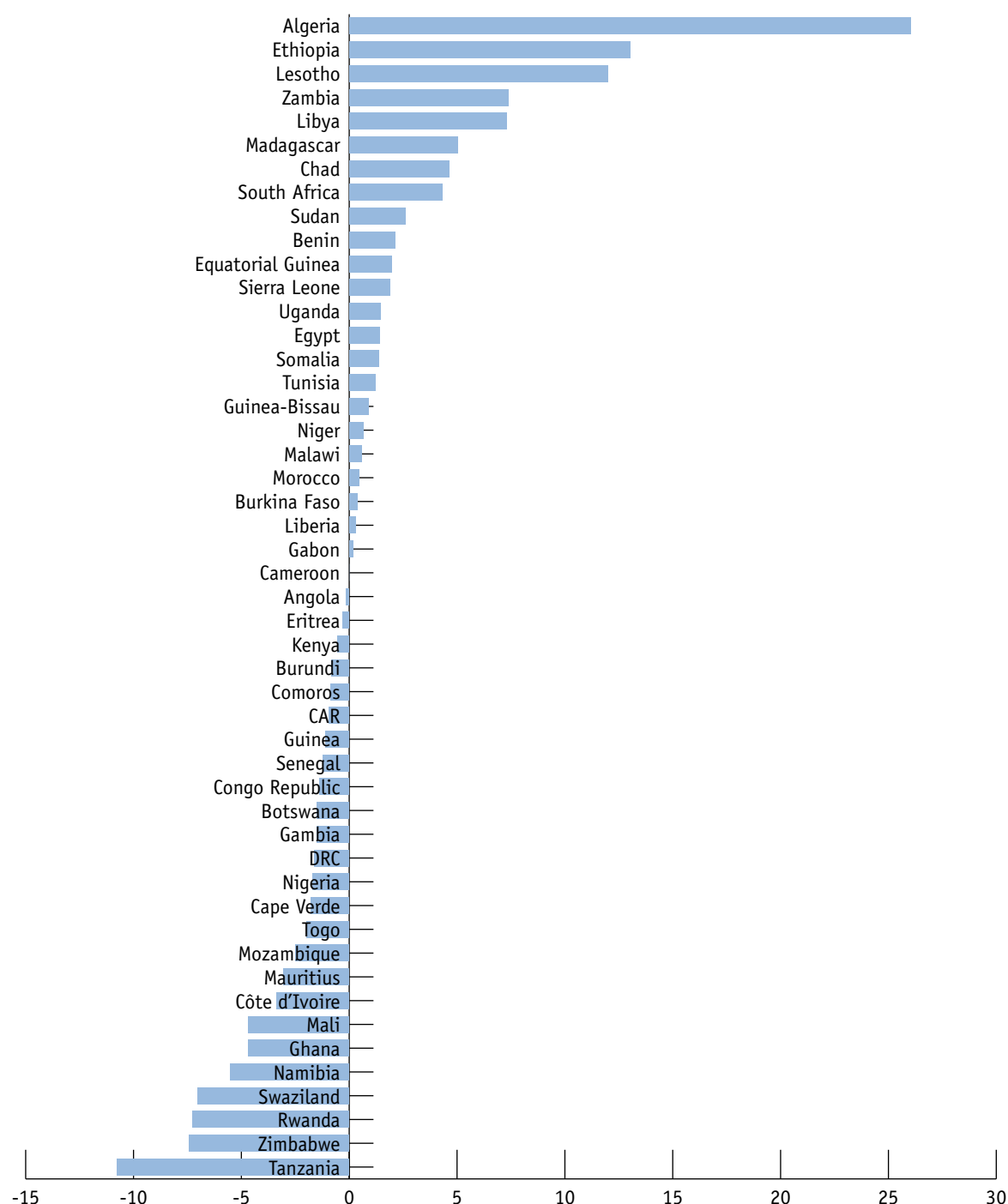
Note: No data for Djibouti, Mauritania, São Tomé and Príncipe, and Seychelles.

Employment-to-population ratios at the country level exhibit substantial variations. Of the 49 countries for which comparable data are available, 25 countries made progress, with Algeria, Ethiopia, Lesotho, and Zambia recording more than a 5 percent improvement. Only Cameroon was stagnant during the period, while 23 countries regressed. Namibia, Rwanda, Swaziland, Tanzania, and Zimbabwe registered a decline of more than 5 percent between 1991 and 2008 (*Figure 8*). To remedy the situation, efforts should be made to diversify the economy away from traditional commodities into the service sector. Countries must also build the capacity to absorb both skilled and unskilled labor and to better align educational curricula to labor market realities in order to enhance the employment opportunities of young graduates.

Tackling youth employment

Young people are the foundation for building solid economies and vibrant societies for today and tomorrow; however, young people have often been excluded from social and productive activities. For instance, employment among youths (15–25 years old) globally is on the decline and the fall was steeper during the economic crisis and its aftermath, between 2007 and 2009. Youth unemployment rose from 11.9 percent in 2007 to 13.0 percent in 2009 and was estimated at 13.1 percent in 2010 (ILO, 2010a). Youth unemployment is a major issue in Africa, as it has the largest share of youths to total population worldwide, in addition to a very high poverty incidence and low economic diversification.

Figure 8: Percentage change in employment-to-population ratio for selected African countries, 1991–2008



Source: Compiled from UNSD data (updated in June 2010).

Box 1: Employment policy in Algeria

Unemployment has been a serious long-term development challenge in Algeria. Indeed, total and youth unemployment rates were as high as 30 percent in 2000 and 48 percent in 2001 respectively. To reduce unemployment and tackle poverty in the country, the government decided to implement a rigorous employment policy. Subsidies were granted to firms as incentives to hire the unemployed, and a public works program was established for unskilled people. Firms were given the opportunity to hire the unemployed at no cost for one year, with the government paying the salaries for skilled youth. Subsidies and financing were provided to micro enterprise projects to take on skilled youth with relevant qualifications. Tax incentive measures were also provided to employers who were able to create and safeguard jobs.

These efforts improved performance in terms of matching labor supply (job seekers) with labor demand (vacancies). As a result, the annual number of job matching through the National Employment Agency (ANEM) over the period 2005–2009 increased by 167 percent. Moreover, female employment during this period rose from 1.2 million to almost 1.5 million; an increase of about 20 percent. Altogether, between 2004 and 2009, Algeria's government was able to create 1.3 million new jobs. This development led to a reduction in the total unemployment rate from 30 percent in 2000 to 15.3 percent in 2005, falling further to 10.2 percent in 2009. In particular, youth unemployment fell from 48 percent in 2001 to 31 percent in 2005.

The government's employment policy has surely contributed to the significant reduction of the poverty rate in the country, which decreased from 14.1 percent in 1995 to 5 percent in 2008, as measured by the national poverty line.

Sources: Kpodar (2007) and *Algeria MDG Report* (2010).

Youth unemployment in Africa has become a development concern in recent times and is more precarious in North Africa.¹⁵ More than 20 percent of the youth labor force in North Africa in 2008 was unable to find jobs. Indeed, only 40.7 percent of male youths and 15.9 percent of female youths in North Africa were in employment in 2008. This explains why youth unemployment worsened by 3.2 percentage points between 1998 and 2008 in North Africa, compared to 1.7 percentage points for the rest of the continent (ILO, 2010a). The difference in the rate could reflect the lack of social protection, which forces the youths into low-productivity employment, especially in the

informal sector.¹⁶ These developments are seen to have contributed to the increasing wave of protests in North Africa and the Middle East in recent times.

Investing in the youth is an important strategy to transform the demographic challenge into economic opportunities, social inclusion, and poverty reduction. The need for countries to develop a national action plan for youth employment is more relevant than ever. This action plan should examine

16 Although the informal sector in Africa provides a good opportunity to absorb the unemployed youths, yet substantial challenges still inhibit access to this sector. These include lack of resources to enter the upper-tier informal sector; barriers in terms of acquiring technical or entrepreneurial skills, non-conducive operating environments, such as a lack of infrastructure (e.g., electricity); and wage rigidity in the informal wage employment (Chaudhuri and Mukhopadhyay, 2010).

15 Youth unemployment has become a recurring issue in North Africa and the Middle East, which have the worst rates of youth unemployment in the world (ILO, 2010c).

and address the key barriers to youth employment at local and national levels and be ready to scale up interventions that are proving to be innovative in the promotion of youth participation and private sector involvement. Some of the issues requiring urgent attention in many African countries include addressing technical and nontechnical (numeracy and literacy) skill mismatches, tackling slow growth job barriers, dealing with discrimination in the labor market, and improving access to start-up capital, among others.

Indicator 1.6: Proportion of employed people living on less than US\$ 1.25 (PPP) per day

This is an indicator for measuring extreme poverty among the working population. Globally, the number of working poor (living on less than US\$ 1.25 a day) declined from 875.1 million in 1999

to 631.9 million in 2009. In contrast to the global trend, this indicator rose in Africa from 158 million to 185 million during the same period (*Table 1*). The rigidity of nominal wages accompanied by a rising cost of living relative to many other regions of the world contributed to this trend.

Although the number of the working poor in Africa is on the increase, the ratio of the working poor to the total workforce has been on a declining trend. A marginal reversal was however recorded in 2009 due to the global economic crisis, which led to the loss of many formal jobs and an expansion of vulnerable employment. Relative to the global average of 20.7 percent in 2009, the share of the working poor in Africa (excluding North Africa) was 58.9 percent. A similar trend was observed for the poverty threshold of US\$ 2.0 per day (*Table 1*).

Table 1: Indicators of the working poor in Africa, 1999–2009

	North Africa		Africa, excluding North Africa	
Year	Working poor (million)	% of total employment	Working poor (million)	% of total employment
Working people living on less than US\$ 1.25 per day				
1999	10.5	21.4	147.5	66.9
2003	11.1	20.2	156.2	63.0
2008	10.5	16.2	170.2	58.5
2009	10.7	16.1	174.6	58.5
Working people living on less than US\$ 2.0 per day				
1999	20.7	42.2	189.6	86.1
2003	21.5	39.1	209.3	84.4
2008	20.6	31.7	236.7	81.4
2009	20.7	31.2	243.2	81.5

Source: Compiled from ILO (2011)

Reducing the proportion of the working poor in Africa will require a comprehensive strategy to confront the casualization of labor, by promoting wage indexation and encouraging the integration of the informal sector into the mainstream economy across African countries.

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

Limited progress has been achieved in reducing the proportion of vulnerable employment¹⁷ in Africa. Globally, the number of vulnerable workers rose from 1.38 billion in 1999 to 1.53 billion in 2009 –an increase of about 11.0 percent, as opposed to around 30 percent in Africa. The preponderance of the informal sector in Africa (excluding North Africa) accounts for this regional trend.

Although the actual number of such workers is on the increase, the ratio of vulnerable employment to total employment in Africa is on the decline. Between 1998 and 2008 it fell from 43.7 percent to 40.2 percent in North Africa, and from 80.5 percent to 75.3 percent in the other subregions. The trend was however reversed in 2009 (*Table 2*) due to the global financial crisis. In hard times, people use the informal sector as a coping strategy in response to formal sector job displacements. The number of people engaged in vulnerable employment rose by 7.4 million

in 2009, compared to 8.5 million in South Asia (ILO, 2011). Vulnerable employment in Africa (excluding North Africa) in 2009 peaked at 75.8 percent of the labor force, which is considerably higher than the global average of 50.1 percent in the same year.

Precarious jobs are common where the informal economy is prevalent. Targeted measures should be taken by governments to enhance the productivity and conditions of the service sector. Such measures could include improving access to product markets (e.g. promoting subcontracting between formal and informal operators), encouraging venture capital, and improving the regulatory framework.¹⁸

Another characteristic of vulnerable employment in Africa is the emerging trend of feminization. About six out of ten female workers in North Africa is engaged in vulnerable employment, but this ratio rises to eight out of ten female workers in the rest of Africa. The gender gap between the vulnerable employment of women compared to men in 2009 amounted to 21.8 and 14.5 percentage points for North Africa and the rest of Africa respectively (*Table 2*). It is clear that more efforts are required to tackle discrimination against women in formal employment, both in the private and public sectors.

¹⁷ “Vulnerable employment” is the sum of own-account workers and unpaid family workers. It provides an insight into the widespread use of informal work arrangements, where workers lack adequate social protection and social dialogue mechanisms. Such arrangements are often associated with low pay and difficult working conditions (ILO, 2011). Work vulnerability is an important indicator for measuring the overall employment quality.

¹⁸ See Obadan et al. (1999) for detailed strategies to address the challenges of precarious employment and informal sector.

Table 2: Share of vulnerable employment to total employment in Africa, 1998–2009

	North Africa			Africa, excluding North Africa		
	Total	Male	Female	Total	Male	Female
1998	43.7	40.1	55.4	80.5	75.5	87.3
1999	42.1	38.1	52.9	79.9	74.5	87.1
2000	42.4	38.2	56.0	79.5	74.0	86.9
2005	42.6	37.0	59.7	77.1	70.1	86.2
2006	41.1	35.4	58.3	76.6	69.6	85.6
2007	41.2	35.1	69.3	76.0	69.2	84.9
2008	40.2	34.1	58.2	75.3	68.5	84.0
2009	40.4	34.9	56.7	75.8	69.5	84.0

Source: Compiled from ILO (2011).

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

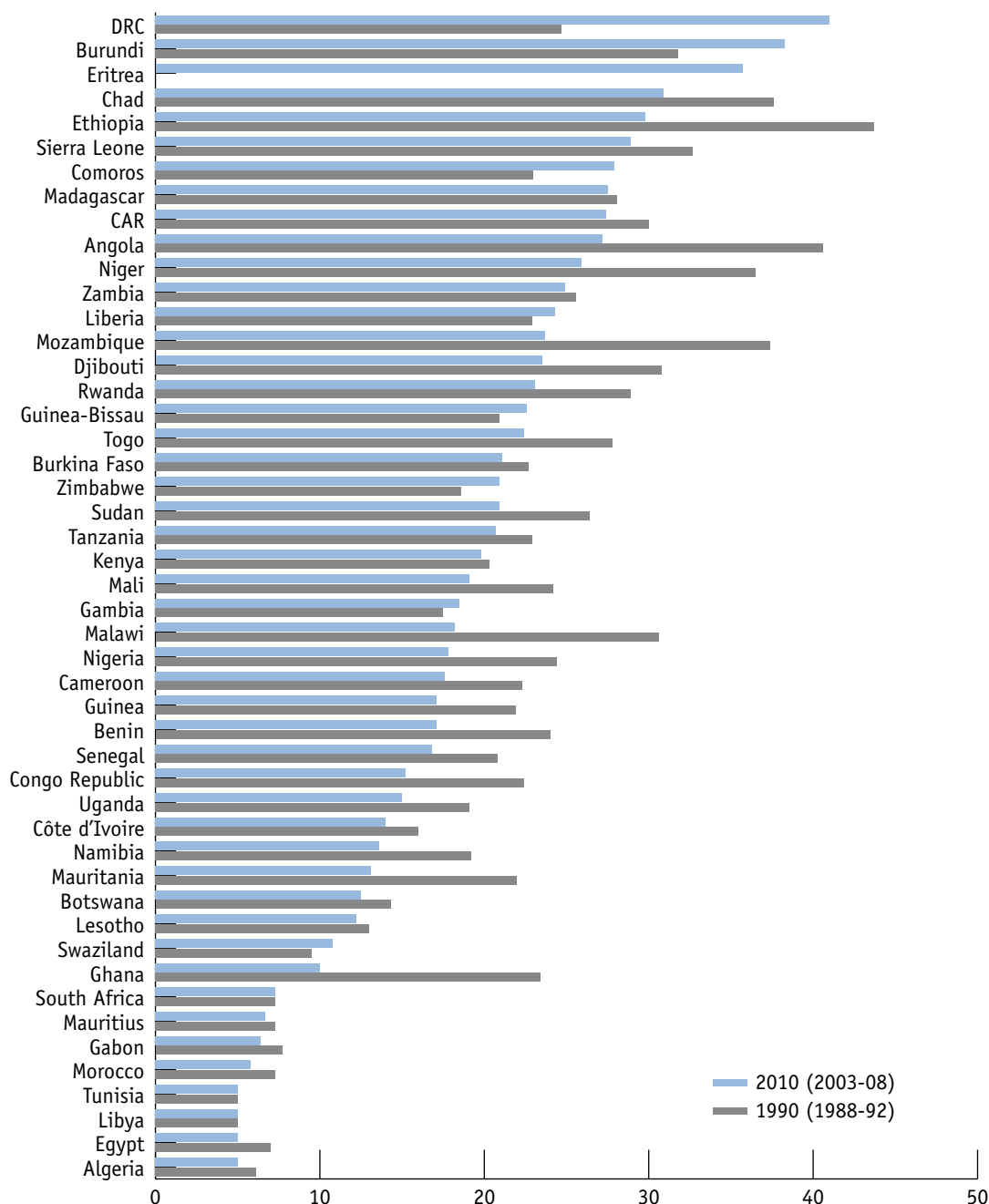
Progress on this indicator in Africa has been quite sluggish since the 1990s. The proportion of people in Africa (excluding North Africa) suffering from hunger declined slightly from 25.3 percent in the Global Hunger Index (GHI) of 1990 to 21.7 percent in 2010. This falls far short of the progress achieved in Southeast Asia (25 percent) and in the Middle East and North Africa (33 percent) over the same timeframe.¹⁹ One major factor was the price of staple foods, which remained high in 2009, after the food crisis of 2008.

The trend of rising global food prices has had a major impact on Africa. Evidence from FAO's 2010

October Food Price Index shows that food prices in Africa rose by 34 points, 16 points below the peak June 2008 level (FAO, 2010). This makes the food security situation in low-income food-deficit countries (LIFDCs) in Africa more vulnerable. The recent high price of bread in countries like Kenya, Zimbabwe, and Mozambique also gives cause for concern. Although maize prices are stable in Burkina Faso, Ethiopia, Kenya, Mali, Niger, and Tanzania due to good harvests, they are rising in Somalia due to drought and in Uganda, owing to high import demand.

Coupled with the rising food prices, the incomes of poor households fell due to high unemployment following the economic downturn. All these factors contributed to a considerable reduction in the effective purchasing power of poor consumers, who spend a substantial share of their income on basic foodstuffs.

¹⁹ See IFPRI (2010), *Global Hunger Index (GHI)*. The GHI is a multidimensional statistical tool used to measure progress and failures in the global fight against hunger. It combines three equally weighted indicators: 1) the proportion of the undernourished as a percentage of the population; 2) the prevalence of underweight children under the age of five; and 3) the mortality rate of children under the age of five.

Figure 9: Hunger index for Africa, 1990 and 2010

Note: Data not available for São Tomé and Príncipe, Seychelles, Somalia, and Namibia.

Source: Compiled from IFPRI (2010).

Although the continent is too far off-track to achieve the hunger reduction target, there are wide variations in the performance of various countries. Some have made giant strides (*Figure 9*); Ghana and Tunisia are the only countries to have already achieved this target. Ghana, for instance, was able to reduce hunger by 57 percent between 1990 and 2008 owing to favorable rainfall patterns, stable good governance, sound macroeconomic policies, and substantial investments in agriculture. Both Malawi and Mauritania reduced hunger by about 40 percent during the same period. In North Africa, Morocco had a Global Hunger Index score of 5.8 in 2010, while others (Tunisia, Libya, Egypt, and Algeria) scored less than 5. The alarming level of hunger in other countries results from many factors, including armed conflict (e.g. DRC and Burundi), natural disasters (e.g. Chad, Eritrea, Ethiopia, and Kenya), weak governance, weak social protection systems (e.g. The Gambia) and the breakdown of local institutions (e.g. Zimbabwe).

Improving the quantity and quality of domestic investment in agriculture and agricultural productivity is central to addressing the challenge of hunger and food security in Africa, yet the sector has not been receiving the attention it deserves over the past two decades. The proportion of total ODA allocated to agriculture has been falling since the late 1980s – it declined from about 15 percent in 1990 to about 5 percent in 2008.²⁰ Between 2005 and 2008, for instance, the share of ODA allocated to agriculture in countries facing food crises was disproportionately low. It was less than 2 percent in Chad, Congo Republic, DRC, Liberia,

Somalia, and The Sudan; and between 2 and 5 percent in Angola, Burundi, CAR, Eritrea, Guinea, Sierra Leone, Uganda, and Zimbabwe. This falls short of the average of about 6 percent for all Least Developed Countries (LDCs). On the other hand, countries like Côte d'Ivoire, Ethiopia, and Kenya received between 5 and 8 percent during the period (FAO and WFP, 2010).

Another factor compounding the problem is the mismatch between humanitarian support and aid to agriculture being delivered to Africa. A large proportion of funding for food security is still delivered through food aid, in both emergency and non-emergency situations. In 2008, for instance, the G-8 provided US\$ 3.0 billion in food aid, far above the US\$ 1.8 billion provided for agriculture.²¹ The situation in countries with protracted crises is more serious still. Between 2000 and 2008, more than 60 percent of total ODA was spent on humanitarian support in Somalia and The Sudan and more than 20 percent in Angola, Burundi, Chad, Congo, DRC, Eritrea, Ethiopia, and Zimbabwe (FAO and WFP, 2010, p.13).

20 See ONE (2010, p.125).

21 Ibid., p. 126.

Although international assistance to Africa for meeting the hunger target has been positive in recent times,²² the region still needs substantial technical and financial support to ensure food security. Food aid is necessary to meet urgent food and nutritional needs (especially in prolonged crisis countries), but it should not be provided at the expense of long-term agricultural investment that will enable communities to become self-sufficient and food secure. Food aid is a short-term solution and will not assist countries to achieve Target 1.C in the long run. This issue is best addressed through targeted national programs aimed at providing basic nutrition to pregnant women from poor households and school meals tied to local productive capacity (e.g. using locally produced food).²³

Based on the need to promote long-term agricultural investment in the region, the African

22 For instance, the G-8 communiqués from 2005 to 2007 recognized the importance of supporting increased agricultural productivity in Africa. Between 2008 and 2009 there was a collective commitment to reverse the declining trend of ODA to agriculture. While the 2008 Hokkaido Toyako Summit committed US\$ 10.0 billion to address the global food crisis and support the agricultural sector, the 2009 L'Aquila Summit committed to provide US\$ 20.0 billion over three years (since revised to US\$ 22.0 billion) through the Aquila Food Security Initiative. This initiative committed to support countries' vetted agricultural plans through predictable, long-term and well-coordinated funding as well as country-led processes, including the Comprehensive African Agriculture Development Program (CAADP). The Global Agricultural and Food Security Program (GAFSP), a multilateral food security trust fund managed by the World Bank, was established during the 2009 Pittsburgh G-20 meeting to complement the Aquila initiative (see UNDP, 2011).

23 The Home-Grown School Feeding Program, funded by the World Food Program and DFID-UK to the tune of US\$ 25 million, is such a scheme. It comes under Pillar 3 of CAADP and is designed to link school feeding to agricultural development through the purchase and use of locally and domestically produced food.

Union is spearheading the Comprehensive Africa Agriculture Development Program (CAADP). This program pays special attention to enhanced fertilizer coverage, the use of improved seedlings, and expanded irrigation programs to substantially reduce malnutrition in Africa. Furthermore, the joint program on regional value chains for agricultural products will contribute to food security and improvements in malnutrition (ECA, 2007). These initiatives must be supported and expanded by African governments and development partners in order to achieve rapid agricultural productivity in Africa.

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

Progress on reducing the proportion of children under five who are underweight has also been sluggish and it is unlikely that this target will be met by 2015. Of the 36 countries for which complete data were available, 28 countries had reduced the prevalence of underweight children, albeit at a slow rate, whilst eight countries showed a regression. Only Algeria had reached the target as of 2009, while countries like Djibouti, Morocco, and Zimbabwe are now worse off than they were in 1990 (*Table 3*). Zimbabwe, which was once regarded as the breadbasket of Africa, has been particularly hard-hit on this indicator, owing to the economic collapse the country is grappling with.

Table 3: Prevalence of underweight children under five years old for selected African countries (1990–1999 and 2000–2009) (%)

Ten best-performing countries		Ten worst-performing countries	
Countries	% Change in underweight children	Countries	% Change in underweight children
Algeria	-67.26	Nigeria	-2.20
Egypt	-37.04	Guinea	-1.89
Malawi	-36.48	Chad	-1.17
Senegal	-33.79	Madagascar	3.66
The Gambia	-31.90	Burkina Faso	10.98
Ghana	-29.56	Comoros	12.11
Botswana	-29.14	Lesotho	18.57
Mali	-26.96	Zimbabwe	21.74
Rwanda	-25.93	Morocco	22.22
Angola	-25.68	Djibouti	85.00

Source: Compiled from WHO (2010b).

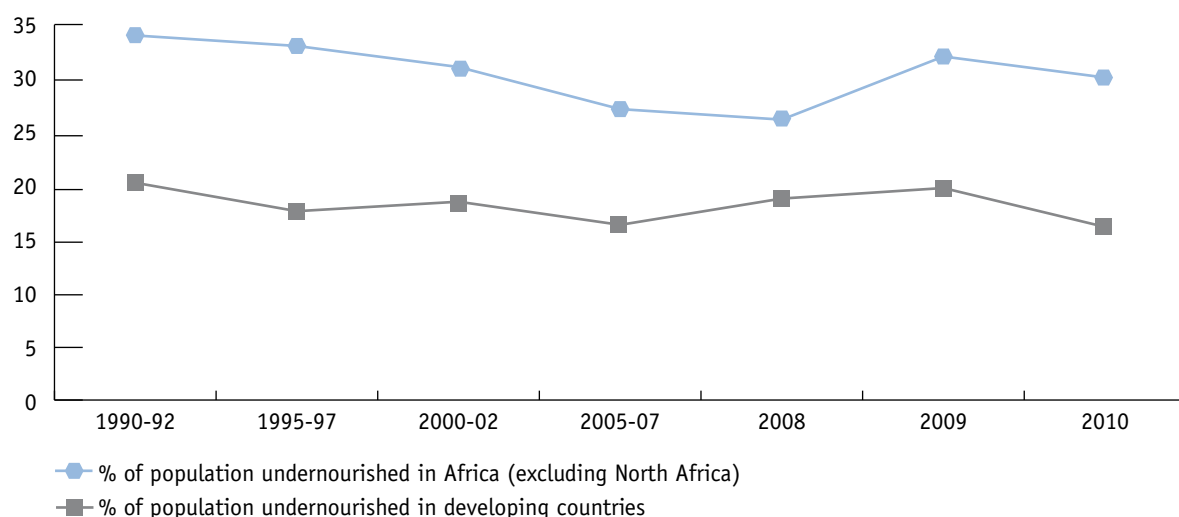
Child malnutrition tends to perpetuate a cycle of regression in other MDGs, especially Goals 4 and 5. For instance, child malnutrition contributes to more than one-third of the disease burden of under-fives, while during pregnancy it results in more than 20 percent of maternal mortalities.²⁴ Evidence from the 2010 GHI reveals that when poorly nourished girls grow up, they tend to give birth to underweight babies. Indeed, this is one of the causes for slow progress in the reduction of child mortality.

A comprehensive approach is needed to address early childhood malnutrition. Such interventions should focus on improved maternal nutrition

during pregnancy, promotion of lactation and exclusive breast-feeding, as well as the provision of essential micronutrients and comprehensive immunization packages targeted at infants aged 0–24 months. Governments and other stakeholders should also proactively address the fundamental causes of malnutrition, including food insecurity, inequitable access to basic health services, unhygienic feeding practices, and inadequate nutrition and education programs. To make good progress, what is needed is a comprehensive development program where food security, nutrition, and equitable access to basic health services are fully integrated.

²⁴ See Go et al. (2010).

Figure 10: Proportion of undernourished population in Africa (excluding North Africa) compared to other developing countries, 1990–2010



Source: Compiled from FAO and WFP (2010).

Note: Figures for 2009 and 2010 are projections from FAO Statistics 2010.

Indicator 1.9: The proportion of population below the minimum level of dietary energy consumption

The continuous reduction in the number of undernourished people that had been achieved in Africa since 1990 was reversed by the increase in food prices during 2006–2008. As a result, in 2009 Africa (excluding North Africa) found itself reverting to its pre-2002 level for this indicator.²⁵ The impacts of the food, fuel and financial crises on the continent seemed more pronounced than on other developing regions. After 1990, the gap between the proportion of malnourished people in Africa (excluding North Africa), and in other developing countries narrowed, but since 2008 it has

widened (Figure 10). Based on FAO's projection for 2010, Africa (excluding North Africa) accounted for 25.8 percent of the total number of undernourished people in the developing world after Asia and the Pacific, which accounted for 62.5 percent.²⁶

Until the impact of the 2006–2008 food crisis became manifest, the number of malnourished people had been declining in all subregions of the continent except Central Africa, where the reduction was only witnessed from 2000–2002. Of the countries where data are available, 31 made progress, 11 regressed, while one (Guinea-Bissau) stalled in its progress between 1990 and 2007. As indicated in Table 4, by 2007 Ghana, Congo, Nigeria, Mali, and Djibouti had achieved the target while countries such as Niger, Mauritania, The Sudan, and Namibia, among others, had moved closer to the target. In the DRC

²⁵ Although the proportion of malnourished people consistently declined between 1990 and 2008, the actual number of people of malnourished people rose from about 175 million in 1990 to about 250 million in 2009. See FAO and WFP (2010, p. 11).

²⁶ See FAO and WFP (2010).

however, due to the protracted conflict, economic collapse, a massive displacement of people, and a chronic state of food insecurity, the proportion of malnourished people rose from 26 percent in 1990 to 69 percent in 2007. Other countries with worsening trends on this indicator include Swaziland, Burundi, The Gambia, and Botswana.

The slow progress being made toward halving poverty levels, creating meaningful employment, and decreasing malnutrition contributes to the sluggish performance recorded for the other goals. A dual-track approach of addressing food insecurity in both the short and long term is vital. Supporting extremely poor consumers through social protection interventions combined with efforts to boost

agricultural production (especially for smallholder farmers) and managing food markets will lead to a more inclusive economic growth path (Ortiz et al., 2011). Such an approach should be underpinned by a participating, educated, and healthy workforce.

Strong economic performance correlates with good nutrition. For this reason, efforts to improve pro-poor economic growth need to be strengthened, with a particular focus on agricultural performance and gender equity. Implementation of the CAADP – with special attention on enhanced fertilizer coverage, use of improved seedlings, and expanded irrigation program – can help to substantially reduce malnutrition and promote food security in Africa.

Table 4: Eleven leading and lagging African countries for reducing malnutrition, 1990–2007

Leading countries		Lagging countries	
Countries	% level of improvement	Countries	% level of retrogression
Ghana	-81.5	DRC	165.4
Congo	-64.3	Swaziland	50.0
Nigeria	-62.5	Burundi	40.9
Mali	-55.6	The Gambia	35.7
Djibouti	-53.3	Botswana	31.6
Niger	-46.0	Zambia	22.9
The Sudan	-43.6	Tanzania	21.4
Mauritania	-41.7	Comoros	21.1
Namibia	-40.6	Madagascar	19.1
Ethiopia	-40.6	Uganda	10.5
Benin	-40.0	Liberia	10.0

Source: Compiled from UNSD data (updated in June 2010).

Note: Incomplete data for eight countries: Algeria, Egypt, Gabon, Libya, Morocco, São Tomé and Príncipe, South Africa, and Tunisia.

Social protection and poverty reduction

Despite the positive economic growth path projected for Africa, the possibility of further global shocks coupled with persistent risks for households make proactive social policies – especially heavy investment in social protection – of critical importance. Successful social protection strategies abound in Africa, such as the old age pension in South Africa and Lesotho, a national health insurance scheme in Ghana, a home-grown school feeding program in Kenya, a productive safety-net program in Ethiopia, and a public works and unconditional cash transfer scheme in Rwanda.

Social protection should not be seen as a “hand-out,” but rather as a long-term investment, with regular budgetary allocations. Indeed, it accounts for about 11 percent of the state budget in Algeria. Those mechanisms that suffer from fewer disincentive effects tend to have a significant impact on poverty reduction and human development. A comprehensive approach based on a combination of one or more of the following elements has proven to be successful in many countries: productivity-based, labor-based, trade-based, and transfer-based interventions. South–South cooperation can also play an important role through experience sharing, transferability of lessons, and relevant technical assistance in promoting human development-oriented social protection policies and programs.

Social protection engenders social cohesion and empowers women, especially when it is targeted at female children and at enhancing the household levels of consumption. Income transfer enhances women’s participation in decision-making at home, allowing the benefits to be channeled to sending children to school and accessing medical

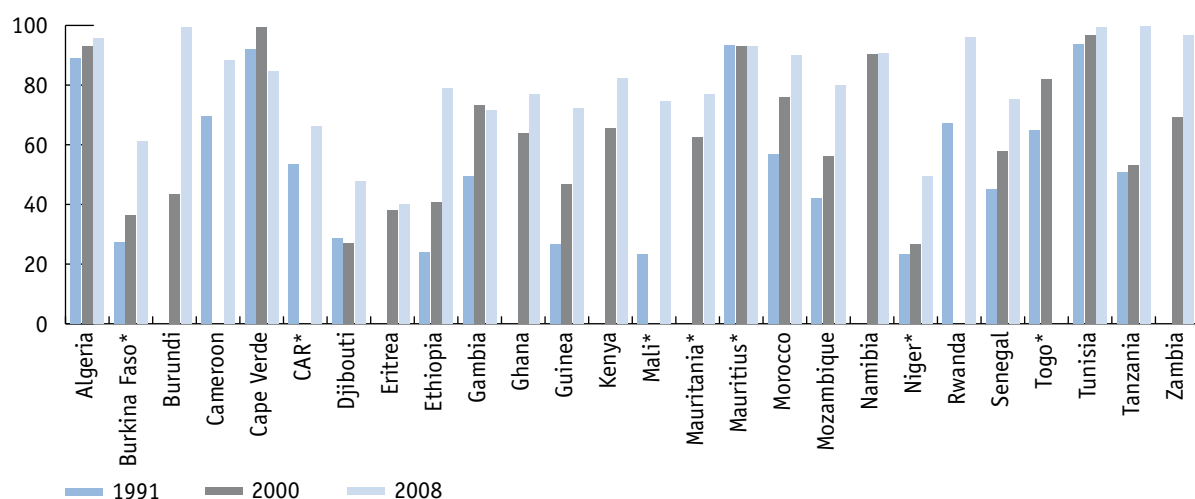
services. In this way, gender-sensitive interventions produce positive multiplier effects, especially for girls’ education, child and maternal health, and the economic empowerment of women. Specific interventions for child nutrition and youth employment also have positive effects on the other MDGs.

Strong political will, institutional and administrative capacity, financial sustainability, and affordability are critical to the success of social protection schemes in Africa. (See also Section III of this report, which focuses on social protection and its role in accelerating progress toward the MDGs in Africa.)

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Enrollment in primary education has continued to rise, reaching 89 percent in the developing world. However, the pace of progress is insufficient to ensure that, by 2015, all girls and boys in developing countries will complete a full course of primary schooling. Nonetheless, Africa has made tremendous strides toward achieving universal primary education, increasing its net enrollment rate from 65 percent in 1999 to 83 percent in 2008. Indeed, this is the MDG where African countries have made the most progress (*Figure 11*). While a majority of African countries are set to achieve universal primary enrollment by the target date, far fewer countries are expected to meet the goals for primary completion rates and young adult literacy rates. Education beyond primary school is though also critical to ensure sustained progress toward other goals such as full employment, poverty reduction, and health-related MDGs.

Figure 11: Progress in net enrollment in primary education for selected African countries, 1991 and 2008/2009 (%)



Source: Compiled from UNSD data (updated in August 2010).

Key: * 2009 data.

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

Indicator 2.1: Net enrollment in primary education

Most African countries have registered a significant improvement in net enrollment in primary education. Of the 36 African countries with data for 2008/2009, a total of 16²⁷ have achieved net enrollment ratios of over 90 percent. Algeria, Burundi, Egypt, Madagascar, Rwanda, São Tomé and Príncipe, Tanzania, Tunisia, Uganda, and Zambia have already reached or even surpassed the minimum target, which is to achieve 95 percent net enrollment rate by 2015. Benin, Malawi, Mauritius, Morocco, Namibia, South

Africa, and Togo, recorded a 5 to 10 percent achievement gap for this target (*Figure 12*). The other countries are also moving on a positive track to achieve this target but further actions are needed to speed up the process. Ten countries (Burkina Faso, Ethiopia, Guinea, Mali, Morocco, Mozambique, Niger, Rwanda, Senegal, and Tanzania) improved their net enrollment rates by more than 25 percentage points between 1991 and 2008 (*Figure 11*). The improvement in enrollment rates was driven by specific public interventions underpinned by resolute political will to achieve universal primary education. School feeding, increased budgetary allocations to education, and cash transfers to poor households were among the factors that contributed to this positive trend (see *Box 2*).

While the majority of African countries are on track to achieve this MDG, some countries still lag far

27 Algeria, Benin, Burundi, Egypt, Madagascar, Malawi, Mauritius, Namibia, Rwanda, São Tomé and Príncipe, South Africa, Togo, Tunisia, Uganda, Tanzania, and Zambia.

Box 2: Success in primary education enrollment

The political focus of primary education and its related implementation have placed Africa on track to achieve full enrollment by 2015. A significant number of African countries have excelled in this regard through committed policy interventions and adequate resource allocations.

Ethiopia had a low initial net enrollment rate (50 percent in 1990), but this now stands at 86.5 percent (2009/2010). This robust progress is based on, among other measures, the construction of classrooms: 16,000 in 2004 and 25,000 in 2008/09, of which 80 percent are in rural areas. In addition, education is emphasized in public policies and prioritized in public spending.

Egypt attained even higher net enrollment rates in primary education, from 83 percent in 1995 to 90 percent in 2008, underpinned by early childhood development projects, cash transfers to poor families to encourage children's retention in schools, and the launch of girl-friendly schools.

Another interesting case is **Togo**. In response to a lack of public funds, families and communities became directly involved in the running of schools. In the poorest region (Savanes), most of the schools are entirely funded by rural households, which includes building classrooms and paying teachers' wages. As a consequence, the net enrollment rate increased from 67 percent in 1990 to 87 percent in 2008. At the same time, the country was able to achieve a gender index of 0.95 in primary education.

Sources: Ethiopia, Egypt and Togo *National MDG Progress Reports 2010*.

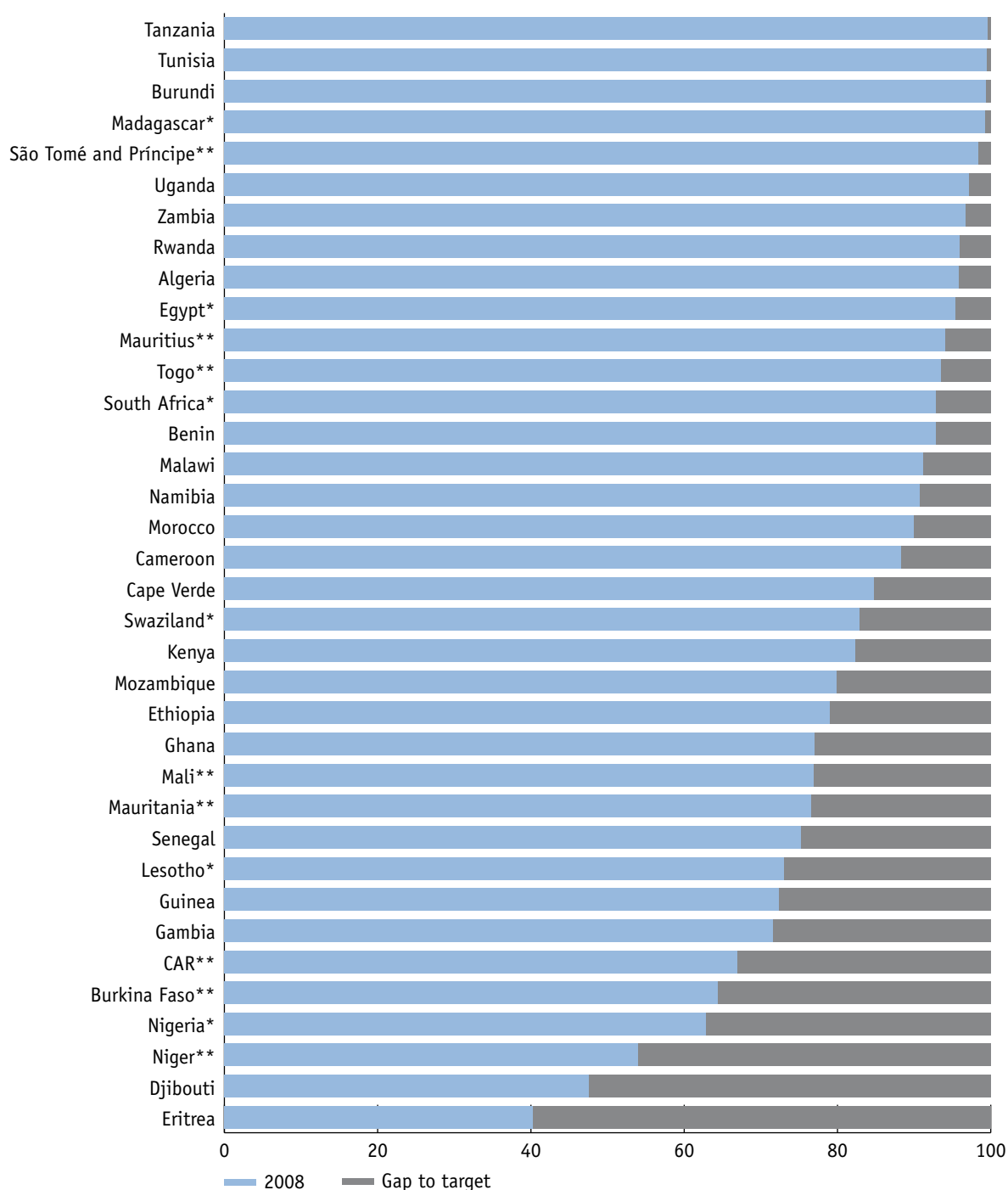
behind in the enrollment targets, and have made little progress over several years. This is the case, for example, in the Central African Republic, where the net enrollment ratio remains at 66.9 percent, compared to 53.4 percent in 1991. Djibouti and Eritrea also lag behind on this indicator, registering below 50 percent net enrollment ratios.

However, a number of countries with initially very low net enrollment ratios have made remarkable progress, even though they are unlikely to achieve universal primary education by the target date of 2015. In Burkina Faso, for example, the net enrollment ratio soared from 27.3 percent in 1991 to 64.4 percent in 2008. Likewise, Ethiopia's rate increased from 24 percent in 1991 to 86.5 percent in 2009 (see *Box 2*). The Gambia, Guinea, Kenya, Mali, Mozambique, and Niger, while all still below 90 percent enrollment ratio, have witnessed improvements of over 20 percentage

points, and in some cases up to 50 percentage points, since 1991.

The progress of most countries, whether they have achieved over 90 percent enrollment or are still struggling around 75 percent, indicates the necessity of a continued focus on primary school education. It remains to be seen what the effects of improved primary school enrollment will be; in fact, 2015 may be too soon to observe the outcomes. In order for countries to advance the progress they have made in education, there must be adequate planning to improve the quality of primary school education and to scale up enrollment rates beyond primary school. As more African countries raise their primary school enrollment rate, resources have to keep pace to ensure improved primary completion rates and adult literacy rates.

Figure 12: Gap to net enrollment target in primary education for selected African countries, 2008



Key: *2007 data. **2209 data.

Source: Compiled from UNSD report (updated in August 2010).

In terms of budgetary allocations to the education subsector, only a few African countries provide free primary education and free ancillary items such as uniforms, books, etc. The need for households to fund schooling accentuates inequities in access to primary education. Indeed, in 27 African countries there are no legal guarantees of free schooling (UNESCO, 2009) and no clear link between educational expenditure and primary enrollment. The monetary funding allocated is not the only criteria, as is evident from Botswana and Mauritius (*Figure 13*). It is the quantum of resource allocation together with spending efficiency that results in higher enrollment in primary education.

Indicator 2.2: Primary completion rate

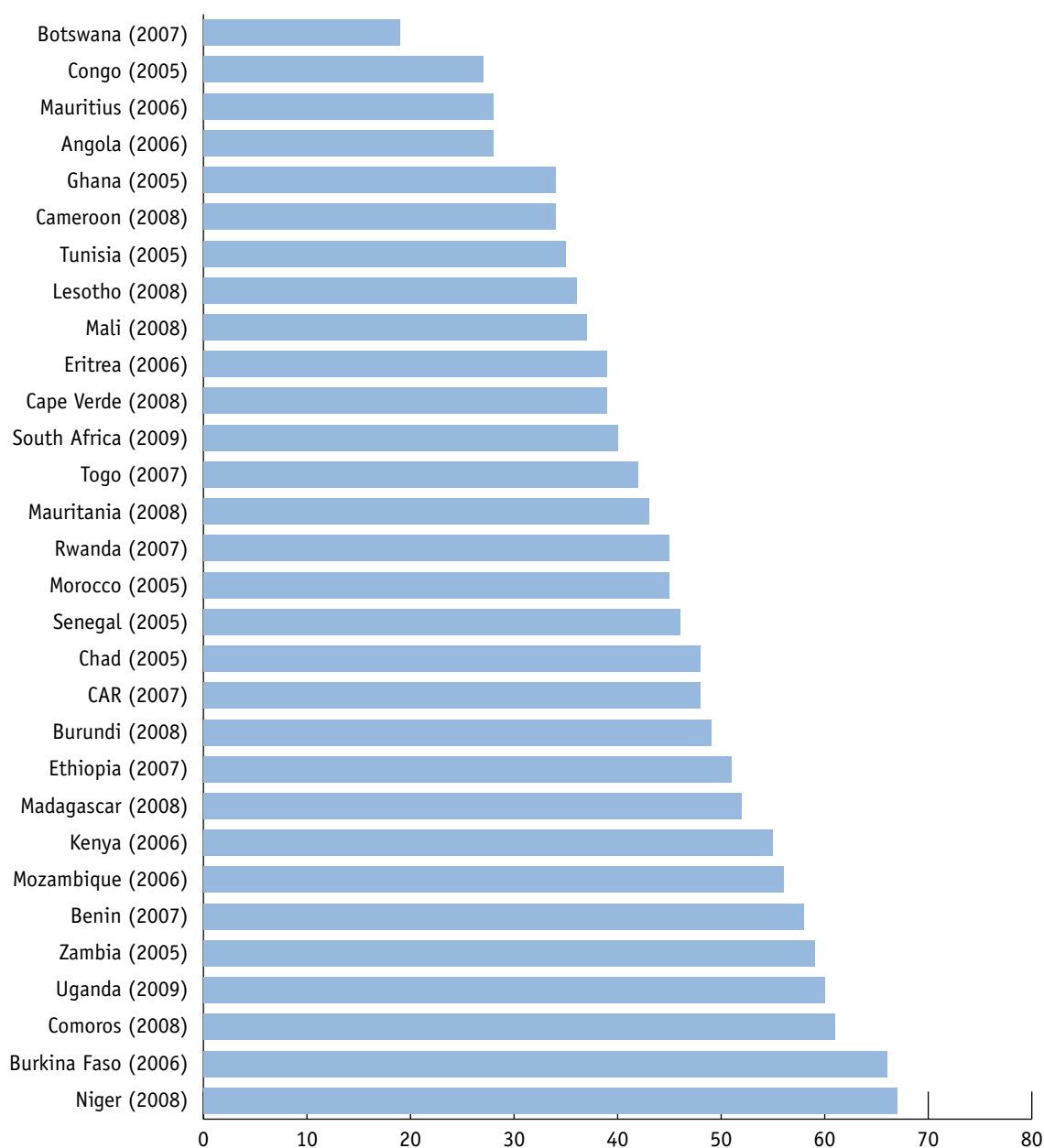
Despite good performance by the majority of African countries toward universal primary school enrollment, this progress has yet to translate into commensurate primary completion rates. *Figure 14* summarizes evidence on net enrollment and completion rates for selected African countries, with 2008 data for both indicators. Few countries have improved their rates since 2007, and some countries such as Chad, Congo, Eritrea, Namibia, and Tunisia have evidenced some decline in their primary completion rate since 2007. Furthermore, the trends toward primary completion are, for the most part, worse than last year. The slow and in some cases regressive trend is driven by a number of factors. First, in many African countries, the primary school entry age is higher than the formal age required. This increases peer pressure on older students to enter the labor market prior to completing the primary school cycle (ECA, 2005). Second, a major setback in Africa is the unequal access to education services, which affects low-income households, weakens retention and learning outcomes, undermines

the quality of education, and increases grade repetition.²⁸ In North Africa, the percentage of children out of school improved from 3 percent in 1999 to 2 percent in 2008. However, in the rest of Africa the percentage of children out of school grew marginally from 43 percent in 1999 to 46 percent in 2008. This means that there were 31 million children who were school-aged but not enrolled in school²⁹ in Africa (excluding North Africa).

On the other hand, a number of countries have made excellent progress toward higher primary completion rates. Benin increased its completion rate from 22.1 percent in 1991 to 65.1 percent in 2008. Cameroon evidenced a remarkable 17 percentage point increase from a 55.5 percent completion rate in 2007 to 72.7 percent in 2008. Comoros, Mozambique, Rwanda, and The Sudan have also shown strong improvements of over 10 percentage points for this indicator over the past several years. Relative to 1991, Algeria, Benin, Guinea, Madagascar, Mali, Mauritania, Morocco, and Mozambique have also made significant progress. However, seven countries (Burkina Faso, Burundi, CAR, Côte d'Ivoire, Djibouti, Eritrea, and Niger) recorded a completion rate of below 50 percent in 2008 (*Figure 15*).

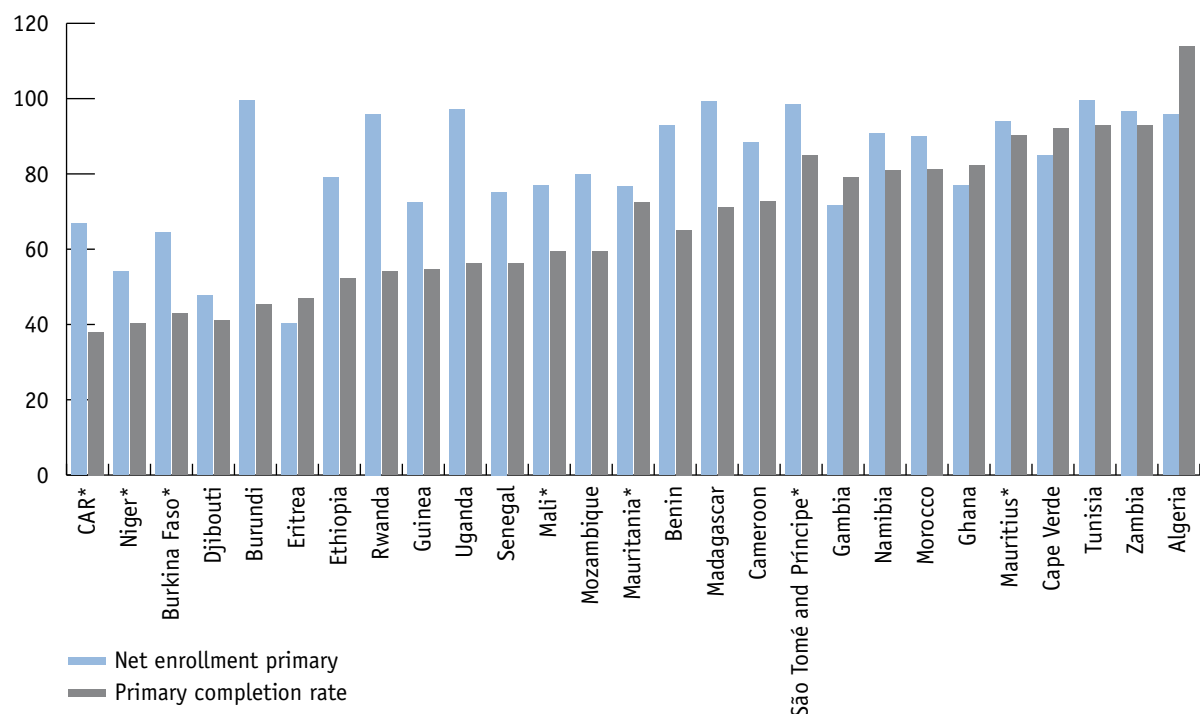
²⁸ UNICEF and UNESCO (2011).

²⁹ UN (2010).

Figure 13: Primary education expenditure as % of total educational expenditure

Source: Compiled from UNESCO (2010).

Figure 14: Primary education enrollment and completion rates for selected African countries, 2008



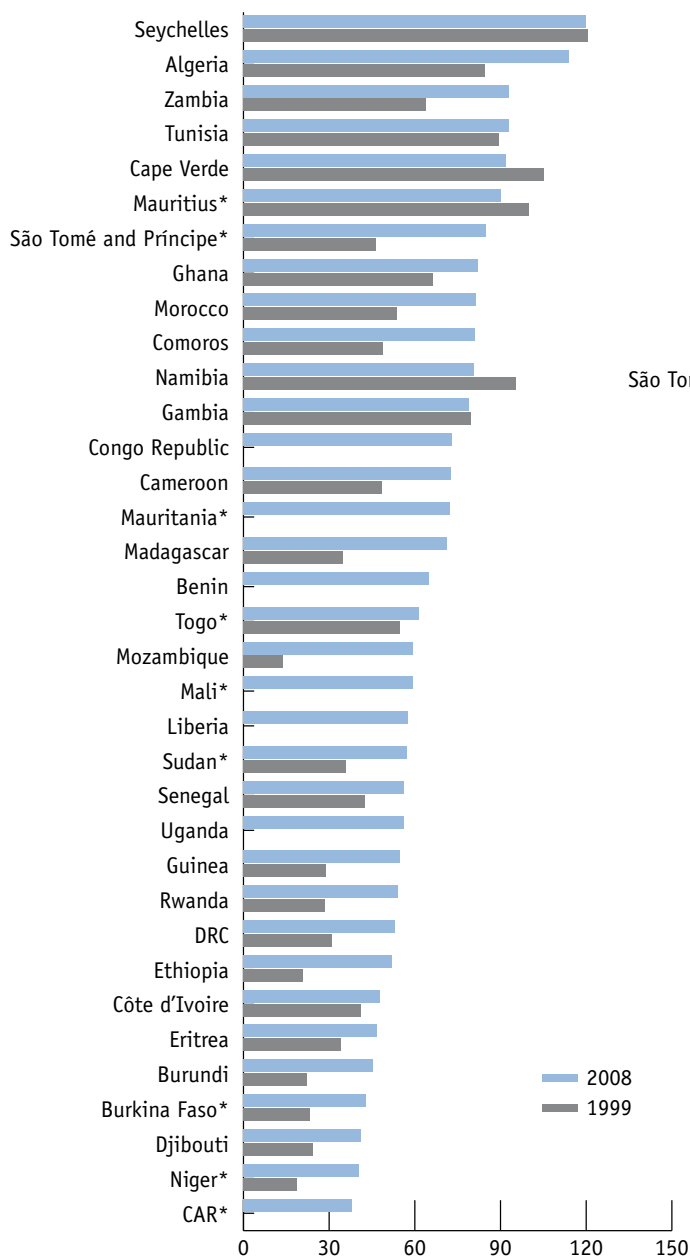
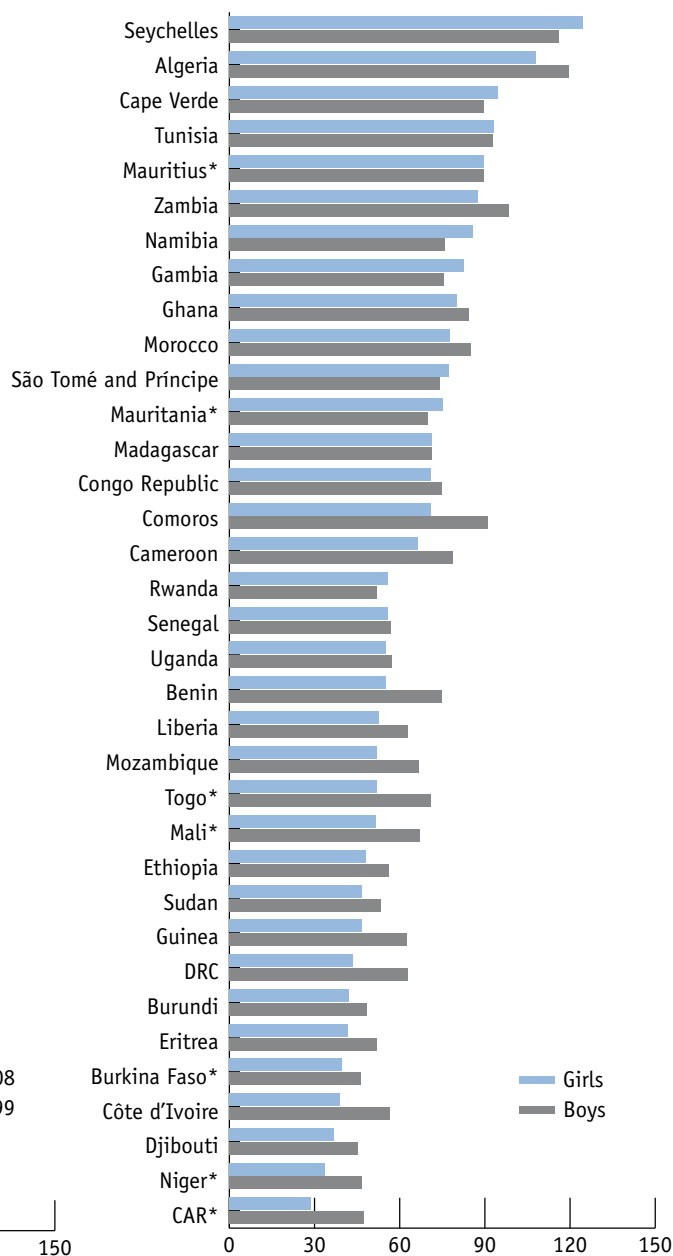
Source: Compiled from UNSD data (updated in August 2010).

Key: *data for 2009.

Analysis of data disaggregated by sex shows that in 14 countries,³⁰ the completion rates of boys surpassed that of girls by more than 10 percentage points in 2008. On the other hand, in others (i.e., Cape Verde, The Gambia, Mauritania, Mauritius, Namibia, Rwanda, São Tomé and Príncipe, Seychelles, and Tunisia), the girls' completion rate was slightly higher than that of boys during the same period. Similar to enrollment trends, completion rates are skewed towards higher-income households, urban populations, and boys rather

than girls. In fact, girls in the poorest 20 percent of households are three times more likely to be out of school than girls in the highest-income group (UN, 2010). Moreover, household data from 42 countries show that rural children are twice as likely to be out of school as children living in urban areas (UN, 2010). In addition, the quality of education proxied by teacher–pupil ratios at 1:45 has remained extremely low on the continent and the supply of qualified teachers – estimated at a gap of over 3 million – is clearly insufficient to meet demand.

30 Algeria, Benin, Cameroon, CAR, Comoros, Côte d'Ivoire, DRC, Eritrea, Liberia, Mali, Mozambique, Niger, and Zambia.

Figure 15: Primary completion rate for selected African countries (%)**15a: Both sexes, 1999 and 2008****15b: Disaggregated by sex, 2008**

Source: Compiled from UNSD data (updated in August 2010).

Key: *2009 data; **1991 data

Indicator 2.3: Literacy rate of 15- to 25-year-olds

The goal of increasing adult literacy by 50 percent is unlikely to be achieved by 2015. Literacy rates show a similar trend to primary completion rates. As expected, countries that have high primary completion rates also have better literacy rates for young adults. In addition, a gender imbalance persists in many African countries (*Figure 16*). Most countries have more or less stagnant literacy rates, with only three countries (Côte d'Ivoire, Guinea, and Mozambique) showing any improvement over the past several years. Whereas many countries record literacy rates above 75 percent, only 15 countries have reached 90 percent, and most of these had reached that high level by 1991.

Countries with literacy rates below 75 percent have made little progress in recent years. Sierra Leone's literacy rate is currently just 55.7 percent, compared to 47.9 percent in 2004. Chad has the lowest literacy rate at 45.4 percent, which is a small improvement from 37.6 percent in 2000. Ethiopia has remained at 49.9 percent literacy since 2004. Whereas these same countries have shown improvements in net enrollment ratios, the lack of progress toward literacy demonstrates the often poor quality of primary school education. With few exceptions, such as Lesotho and Liberia, literacy rates generally tend to be biased in favor of men.³¹

Despite the efforts of governments and partners, there are still 153 million illiterate adults in Africa today. This represents 20 percent of the 759 million people globally who are illiterate. Moreover, of the

illiterate adults in Africa, two-thirds are women. Some African governments, through the Literacy Initiative for Empowerment, have taken positive steps to address the problem, which has yet to command the attention it deserves.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

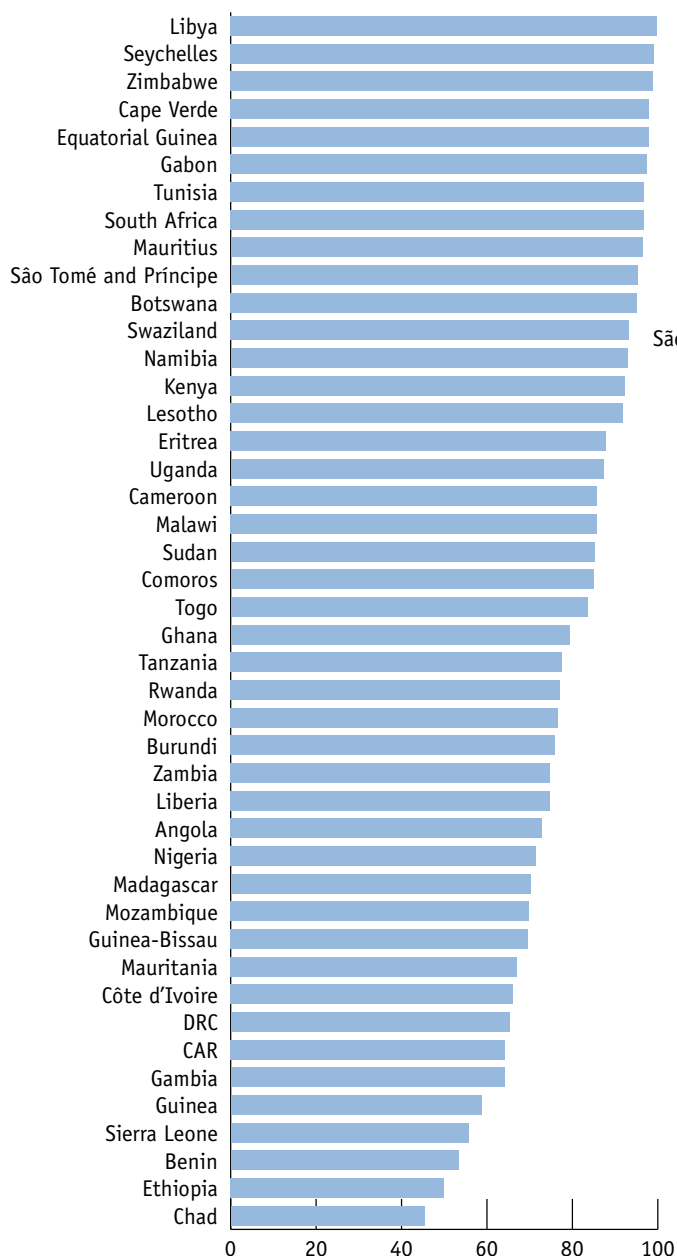
African countries have shown good overall progress in gender equality and the empowerment of women in recent years. The ratio of girls to boys in primary education is approaching parity in almost every country, and the proportion of women in African national parliaments continued its upward trend in 2010. However, additional commitments are needed to maintain and fast-track progress, as few countries have achieved gender parity in secondary or tertiary education, and the majority of countries still have a small minority of women in national parliaments.

Furthermore, promoting gender equality and empowering women must be integrated in other MDGs, such as reducing poverty, improving child and maternal health, and combating major diseases, which all require a special focus on women.

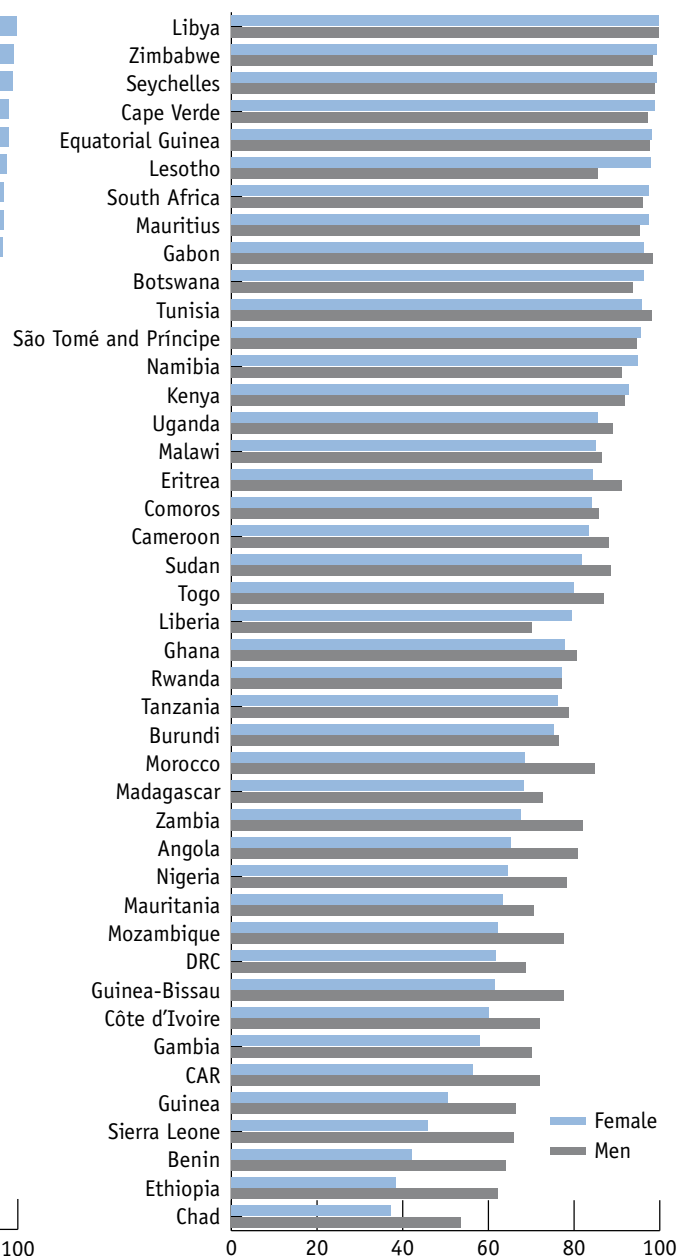
In order to fast-track progress related to gender, there need to be laws and policies in place that make long-term commitments to empower females of all ages, irrespective of their occupational status. Such policies will help to ensure that gender equality remains a top priority post-2015. Since gender issues affect all segments of the society, involving males in programs, clubs, social networks, and organizational activities that target females is also recommended.

31 Botswana, Cape Verde, Equatorial Guinea, Kenya, Lesotho, Liberia, Mauritius, Namibia, São Tomé and Príncipe, Seychelles, South Africa, Swaziland, and Zimbabwe.

Figure 16:
(a) Literacy rate both sexes, 2008 (%)

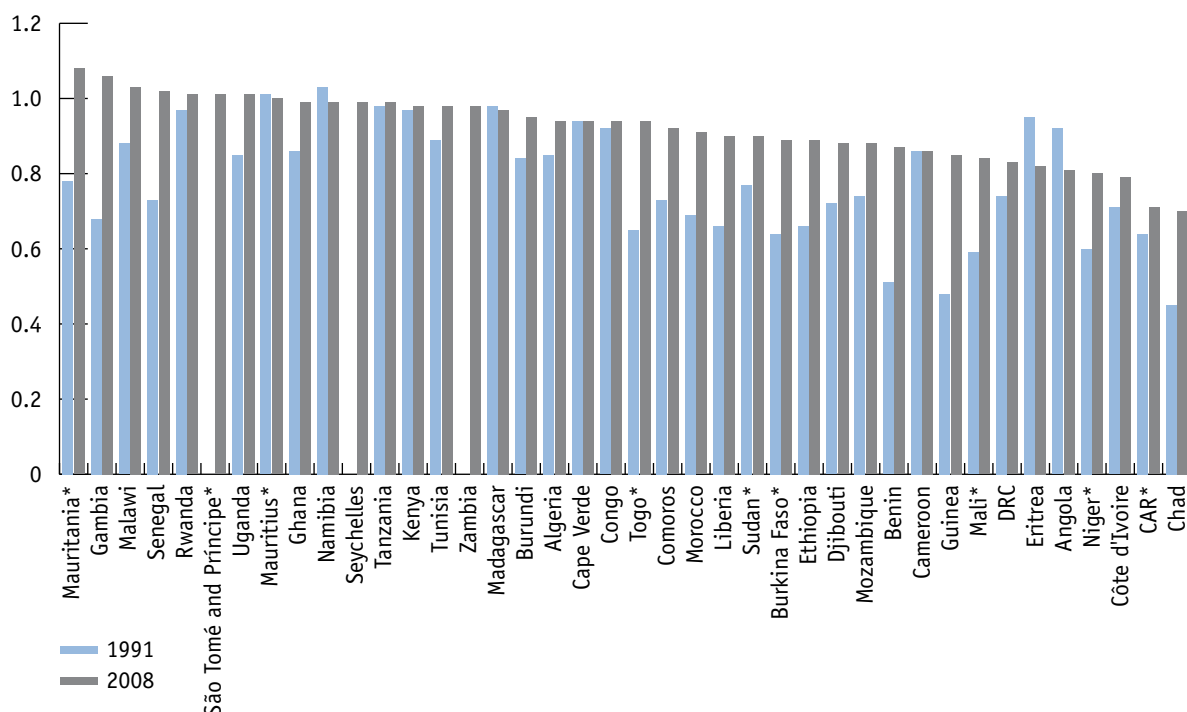


(b) Literacy rate disaggregated by sex, 2008 (%)



Source: Compiled from UNSD data (updated in June 2010).

Figure 17: Gender Parity Index in primary level enrollment in selected African countries, 1991 and 2008



Source: Compiled from UNSD data (updated in July 2010).

Key: * data for 2009.

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

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

Primary education

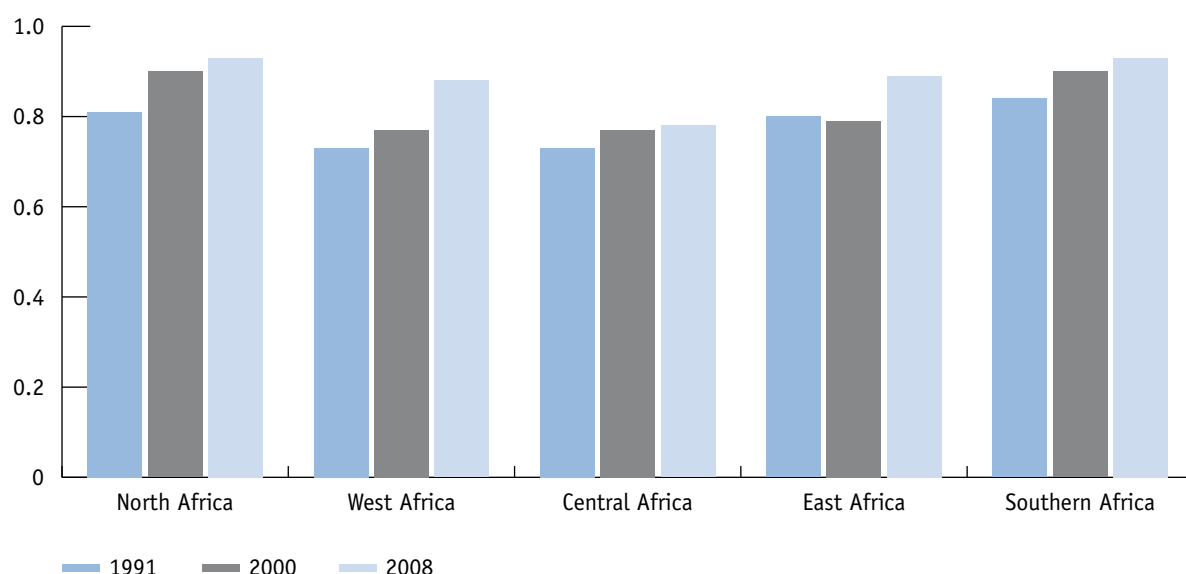
Although recent initiatives have promoted girls' enrollment, especially at the primary school level, the data show that by 2008, parity between boys and girls had not yet been achieved in Africa (excluding North Africa). Overall, there were 91 girls enrolled in primary school for every 100 boys, and

only 84 girls enrolled in junior secondary school for every 100 boys. Despite scaled-up policies and funding for girls' education, major challenges remain, such as gendered poverty and traditional and cultural practices that tend to favor boys.³²

In Africa, school fees represent a major constraint to girls' enrollment in schools. In countries where state education is free, the number of girls in schools tends to be higher.³³ Where boys may already be favored to go to school, school fees pose an additional constraint to girls' access to education.

³² UNICEF and UNESCO (2011).

³³ UN (2010).

Figure 18: Gender Parity Index in primary education by African subregion, 1991–2008

Source: Compiled from UNSD data (updated in July 2010).

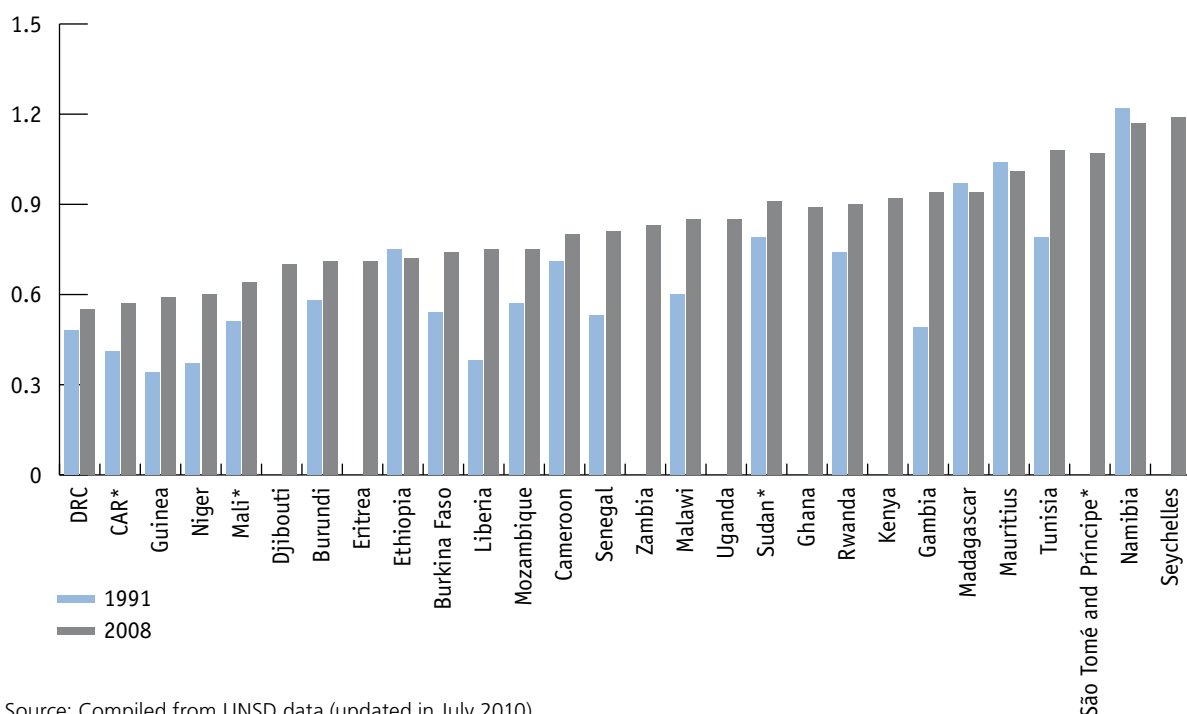
Of the 37 countries with available data, analysis of the Gender Parity Index (GPI) at primary education level between 1991 and 2008 shows that most African countries will achieve gender parity at the primary education level by 2015. Seventeen countries³⁴ are approaching parity with a score of 90 and above in the year 2008 (*Figure 17*). In fact, Malawi, Mauritania, São Tomé and Príncipe, Rwanda, Senegal, Togo, and Uganda scored a GPI of slightly more than 1.0, indicating a higher enrollment of girls than boys in primary school in these countries. Thus the emerging policy challenge in such countries is to increase boys' enrollment in primary education to ensure true gender equality. Benin, The Gambia, and Guinea reduced gender disparity in primary education the most between

1991–2008, by more than 0.35 points. At the other end of the spectrum, the gender gap in primary school increased in Angola and Eritrea over the same timeframe. No changes were recorded for Cameroon and Cape Verde between 1991 and 2009 for this indicator. But overall, given current trends, achieving gender parity in primary education is still possible for most African countries by 2015.

Figure 18 summarizes the performance of Africa's subregions toward gender parity in primary level enrollment. Overall, the African subregions have been showing positive growth in GPI in primary education. West Africa registered the most progress, followed by North Africa and East Africa during the period 1991–2008. However, progress was slower in Central and Southern Africa.

34 Algeria, Burundi, Cape Verde, Comoros, Congo Republic, Ghana, Kenya, Liberia, Madagascar, Morocco, Namibia, Seychelles, The Sudan, Tanzania, Togo, Tunisia, and Zambia.

Figure 19: Gender Parity Index in secondary level enrollment for selected African countries, 1991 and 2008



Source: Compiled from UNSD data (updated in July 2010).

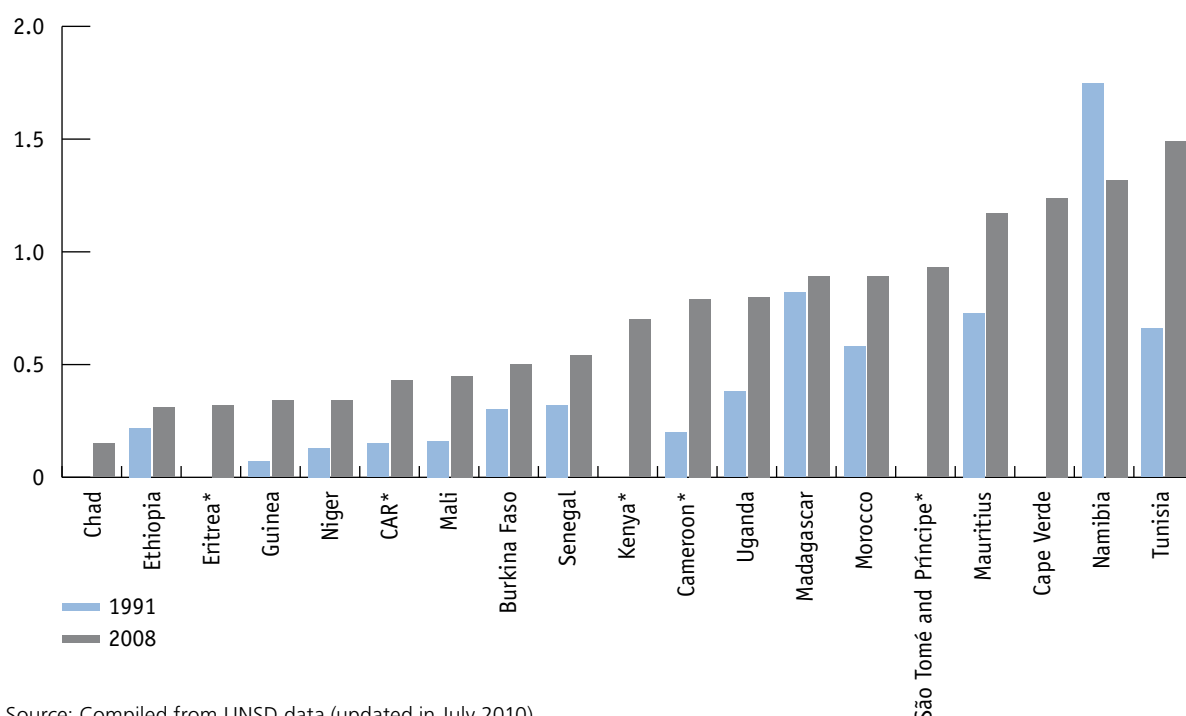
Key: * data for 2009.

Secondary education

The impressive improvement in gender parity in primary education enrollment is not reflected at the secondary level, where a significant gap still exists. Of the 29 African countries with available data, Mauritius, Namibia, São Tomé and Príncipe, Seychelles, and Tunisia slightly surpassed gender parity in the period 1991–2008/09 (*Figure 19*), registering a GPI above 1.0, which means they have a greater ratio of girls than boys enrolled at secondary level. Countries such as The Gambia, Guinea, Liberia, Malawi, Niger, Senegal, and Tunisia significantly reduced the gender gap in secondary enrollment by between 25 and 45 percentage points

from 1991–2008. However, Ethiopia, Madagascar, Mauritius, and Namibia recorded a slightly higher gender gap in secondary education in 2008 compared to 1991. Overall, it is unlikely that African countries will reach the target of gender parity in secondary education by 2015, if current trends continue.

Figure 20: Gender Parity Index in tertiary education for selected African countries, 1991 and 2008



Source: Compiled from UNSD data (updated in July 2010).

Key: * 2009 data.

Box 3: Goal 3 – Achieving gender equality in South Africa

Gender equality is a constitutional imperative in South Africa. The government has therefore introduced a range of policies, laws, programs and mechanisms that specifically address the needs of women and girls.

In terms of Indicator 3.1, the ratio of girls to boys in primary, secondary, and tertiary education is 0.96, 1.05, and 1.26 respectively (2009 data). In other words, there are more girls than boys in secondary and tertiary education. In terms of Indicator 3.2 (share of women in wage employment in the non/agricultural sector) the figure was 45 percent in 2009, a marginal increase from 43 percent in 1996. Progress is much clearer regarding Indicator 3.3 (proportion of seats held by women in the national parliament), which stood at 44 percent female participation in 2009 compared to 25 percent in 1994. Altogether, South Africa has performed so well that the country has reached most of the MDG gender-related targets. Of course, there is still room for improvement, especially in the area of violence against women. Nevertheless one can conclude that South Africa remains committed to tackling gender inequality.

Source: *South Africa National MDG Report, 2010*.

Tertiary education

Progress towards gender parity in tertiary education is also slow. Of the 19 countries for which data are available for 2008/2009, Cape Verde (1.24), Mauritius (1.17), Namibia (1.32), and Tunisia (1.49) surpassed gender parity, having more girls than boys enrolled in tertiary education. The present challenge for these countries is to increase the ratio of boys' enrollment, so as to achieve true gender parity in tertiary education. As with primary school enrollment, which has shown similar trends, it is necessary for governments to be aware of this emerging issue and where necessary to implement corrective policy actions.

Of the 14 countries for which data were available for both 1991 and 2008, Cameroon, Mauritius, Tunisia, and Uganda recorded noticeable progress in reducing gender disparity in tertiary education (*Figure 20*). Eight³⁵ countries registered a GPI of less than 0.50 in tertiary education in 2008. With the majority of African countries failing to reach a GPI of 0.90 in 2008, and many still struggling to reach a level of 0.50, it is highly unlikely that African countries will attain this target by 2015 if current trends continue.

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

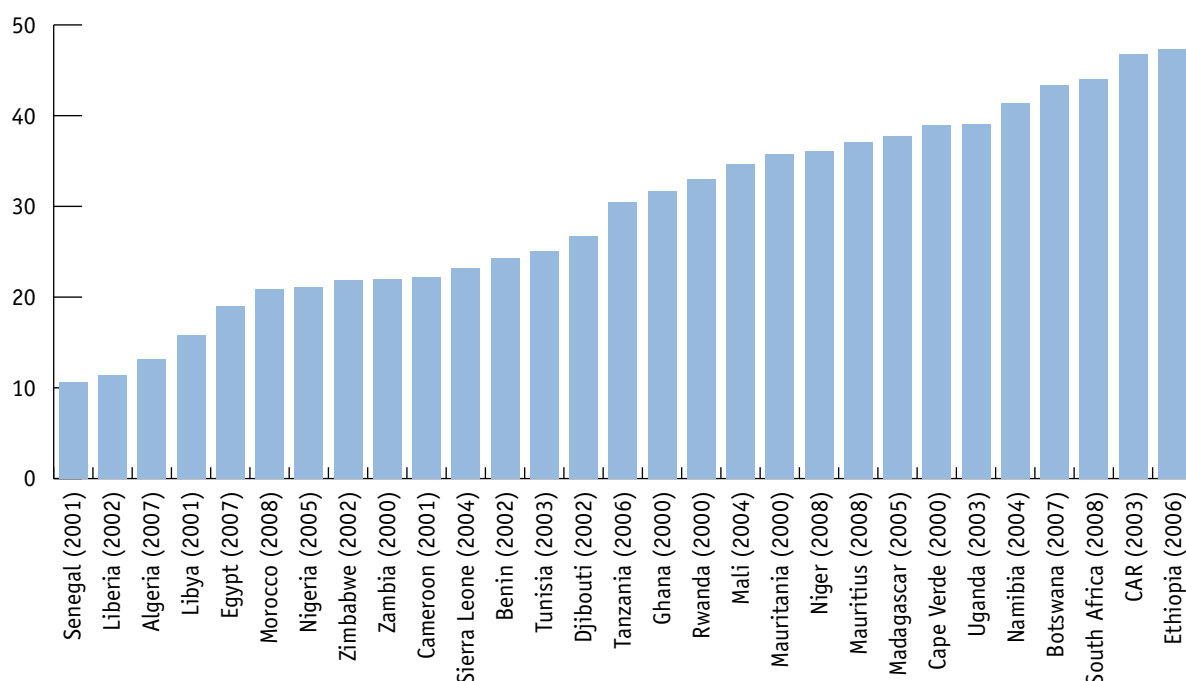
Tracking progress for this indicator is problematic due to a lack of data. Consequently, the analysis has been based on the most recent data available for each country (*Figure 21*). Surveys that measure the share of women in wage employment in the non-agricultural sector are rarely

conducted. In fact, most countries only have data on this indicator for a single year, which makes it impossible to track an individual country's progress. Furthermore, since countries' most recent data cover different years (ranging from 2000 to 2008), there is a lack of comparability which makes it impossible to monitor different countries' progress.

Nevertheless, it can be said that Africa's overall performance on this indicator has been disappointing. For the continent as a whole, less than 50 percent of wage employment in the non-agricultural sector is undertaken by women. Ethiopia reported the highest share (47.3 percent) in 2006 and is thus considered to be the best performer for this indicator. This might be due to the Ethiopian government's special focus on small and medium-size enterprises (SMEs) as an effective means of creating job opportunities for women.

It is likely that the financial crisis of 2007/08 also contributed to a surge in informal employment, as a result of job losses in the formal sector. In some developing countries, over 80 percent of workers have informal jobs – as owners of informal-sector businesses or as contributing family workers or employees. Such jobs are highly vulnerable, lacking written contracts or social security benefits (this applies also to subcontracted workers operating from home and domestic services workers). In most African countries, women are over-represented in informal employment. (See also Section III of this report on social protection as a means to address the vulnerability of informal employment.)

35 Burkina Faso, CAR, Chad, Eritrea, Ethiopia, Guinea, Mali, and Niger.

Figure 21: Share of women in wage employment in the non-agricultural sector

Source: Compiled from UNSD data (updated in June 2010).

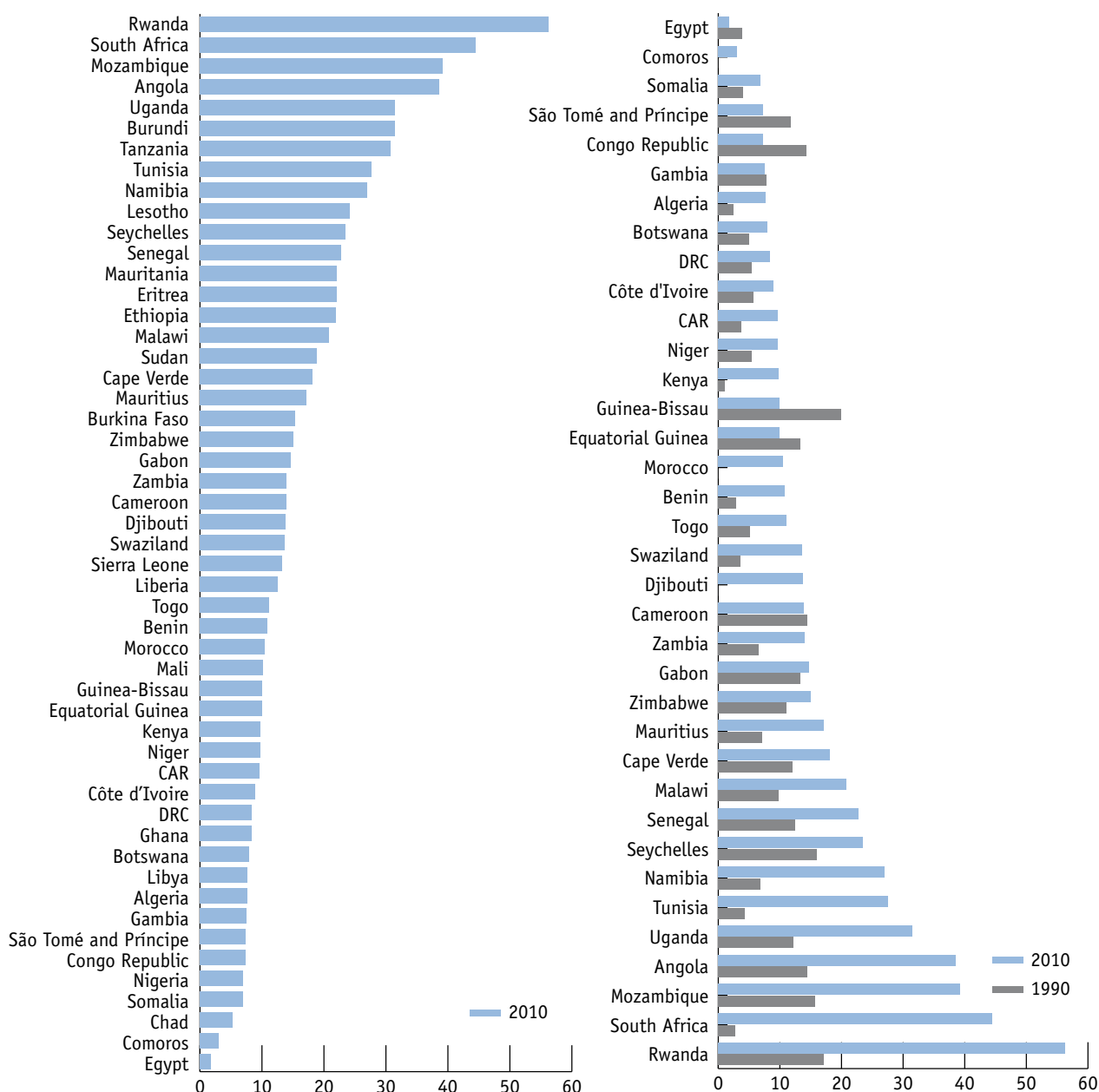
Indicator 3.3: Proportion of seats held by women in national parliaments

It is encouraging that data on the proportion of seats held by women in national parliaments were available for all 53 African countries in 2010. Women's representation in national parliaments has improved in a number of African countries. The best performers in 2010 were: Rwanda (56 percent), South Africa (45 percent), Mozambique (39 percent), Angola (39 percent), Uganda (31.5 percent), Burundi (31.4 percent), and Tanzania (30.7 percent). Of the 36 African countries with data for the base year of 1990 and for 2010, over 80 percent (29 countries) increased the proportion of national parliamentary seats represented by women over this time span (*Figure 22*). The greatest progress between 1990 and 2010 was recorded

by Angola, Mozambique, Namibia, Rwanda, South Africa, and Tunisia. In South Africa's elections of 2009, women took 44 percent of seats in the lower-house, placing the country third in terms of global ranking for this indicator, after Rwanda and Sweden (UN, 2010). Women's progress in national governments is clearly shown in their attainment of the following high positions in recent years: President of the National Assembly in both South Africa and Lesotho; President of the Senate in Swaziland and Zimbabwe; Speaker of the National House of Assembly in Nigeria; and President in Liberia.³⁶

36 www.escueladefeminismo.org/IMG/pdf/models.pdf

Figure 22: Percentage of seats held by women in national parliaments, 1990 and 2010



Source: Compiled from UNSD data (updated in June 2010).

However, seven countries (Cameroon, Congo Republic, Egypt, Equatorial Guinea, The Gambia, Guinea-Bissau, and São Tomé and Príncipe) recorded a decline in the number of women in parliament between 1990 and 2010. Furthermore, in 2010 there were 17 countries³⁷ with less than 10 percent of women's representation, with Egypt and Comoros as the worst performers (1.8 and 3.0 percent representation respectively). Women's participation in the executive, judicial, traditional, and other public spheres is low across the majority of the countries, with only 29 percent of women holding positions as senior officials or senior managers.³⁸ Overall though, Africa's progress toward achieving gender parity in the national parliaments is very encouraging. In order to ensure continued gains in this and other public spheres, governments should institutionalize a minimum quota of women parliamentarians, while also addressing challenges such as cultural norms and traditional institutions. This will ensure that governments continue to strive for gender parity in public life beyond 2015.

GOAL 4: REDUCE CHILD MORTALITY

According to the World Health Organization (WHO), almost 90 percent of all child deaths are attributable to just six conditions: neonatal causes, pneumonia, diarrhea, malaria, measles, and HIV/AIDS. Progress to reach MDG 4 (reducing under-five mortality by two-thirds from 1990 to 2015), will require universal coverage with the following key effective and affordable interventions: care for newborns and their mothers; infant and young child feeding programs; vaccines; prevention and case management of diarrhea, pneumonia and sepsis; malaria control; and prevention and care of HIV and AIDS. It is believed

37 Algeria, Botswana, CAR, Chad, Comoros, Congo Republic, Côte d'Ivoire, DRC, Egypt, The Gambia, Ghana, Kenya, Libya, Niger, Nigeria, São Tomé and Príncipe, and Somalia.

38 UN (2010).

that these interventions could reduce the number of child deaths by more than half, particularly in countries where child mortality is high.³⁹

Generating accurate estimates of under-five mortality poses a considerable challenge because of the limited availability of high-quality data for many developing countries. New estimates at the global level, by the United Nations Inter-agency Group for Child Mortality Estimation (IGME), show that of the 31 countries recording an under-five mortality rate (U5MR) of at least 100 deaths per 1,000 live births in 2009, 30 were in Africa. The global U5MR has declined by almost one-third over 20 years, from 89 deaths per 1,000 live births in 1990 to 60 deaths per 1,000 live births in 2009. However, progress in some regions – notably Africa (excluding North Africa), Southern Asia, and Oceania – is insufficient to meet the Goal (IGME, 2010).

Overall there has been some progress in the three indicators tracking the achievements of countries towards MDG 4. Despite these achievements, and due to the fact that most child deaths are preventable or treatable, African countries should revitalize comprehensive and integrated efforts against the main diseases that cause child mortality within the framework of strengthening health systems and ensuring a quality continuum of care.

Target 4.A: – Reduce by two-thirds between 1990 and 2015, the mortality rate among children under five years old

Indicator 4.1 – Under-five mortality rate (U5MR)

Africa recorded a decline in U5MR from 165 deaths per 1,000 live births in 1990 to 118 deaths per

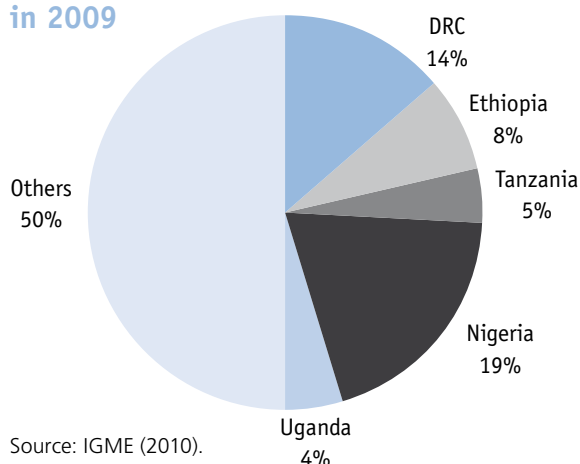
39 UN (2010).

1,000 live births in 2009 – a 28 percent reduction over a period of 20 years. This reduction translates into an annual average reduction of 1.8 percent, which is considered to be insufficient to enable the continent as a whole to reach the target (IGME, 2010). In terms of the number of infant deaths, there has been a slight decline of 4 percent from 4.2 million in 1990 to 4.1 million in 2009.

DRC, Ethiopia, Tanzania, Nigeria, and Uganda accounted for about 50 percent (2.0 million) of the deaths in 2009 (*Figure 23*). Nigeria has identified some factors contributing to the elevated U5MR, including a decline in resource allocation and inequality in access to healthcare facilities. In the case of Tanzania, constraints include inadequate financial and human resources in the health sector and the lack of a management information system for monitoring and evaluation (M&E) purposes. Certain countries, such as Sierra Leone, have initiated various public interventions to improve child and maternal health (see *Box 4* under MDG 5). Nevertheless, the U5MR continues to be high in the majority of countries, with 30⁴⁰ out of 53 countries registering rates of more than 100 deaths per 1,000 live births in 2009 (*Figure 24*). The slow progress toward a reduction in child mortality is exacerbated by the high levels of population growth.

40 Angola, Benin, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d'Ivoire, DRC, Equatorial Guinea, Ethiopia, The Gambia, Guinea, Guinea-Bissau, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Somalia, The Sudan, Tanzania, Uganda, and Zambia.

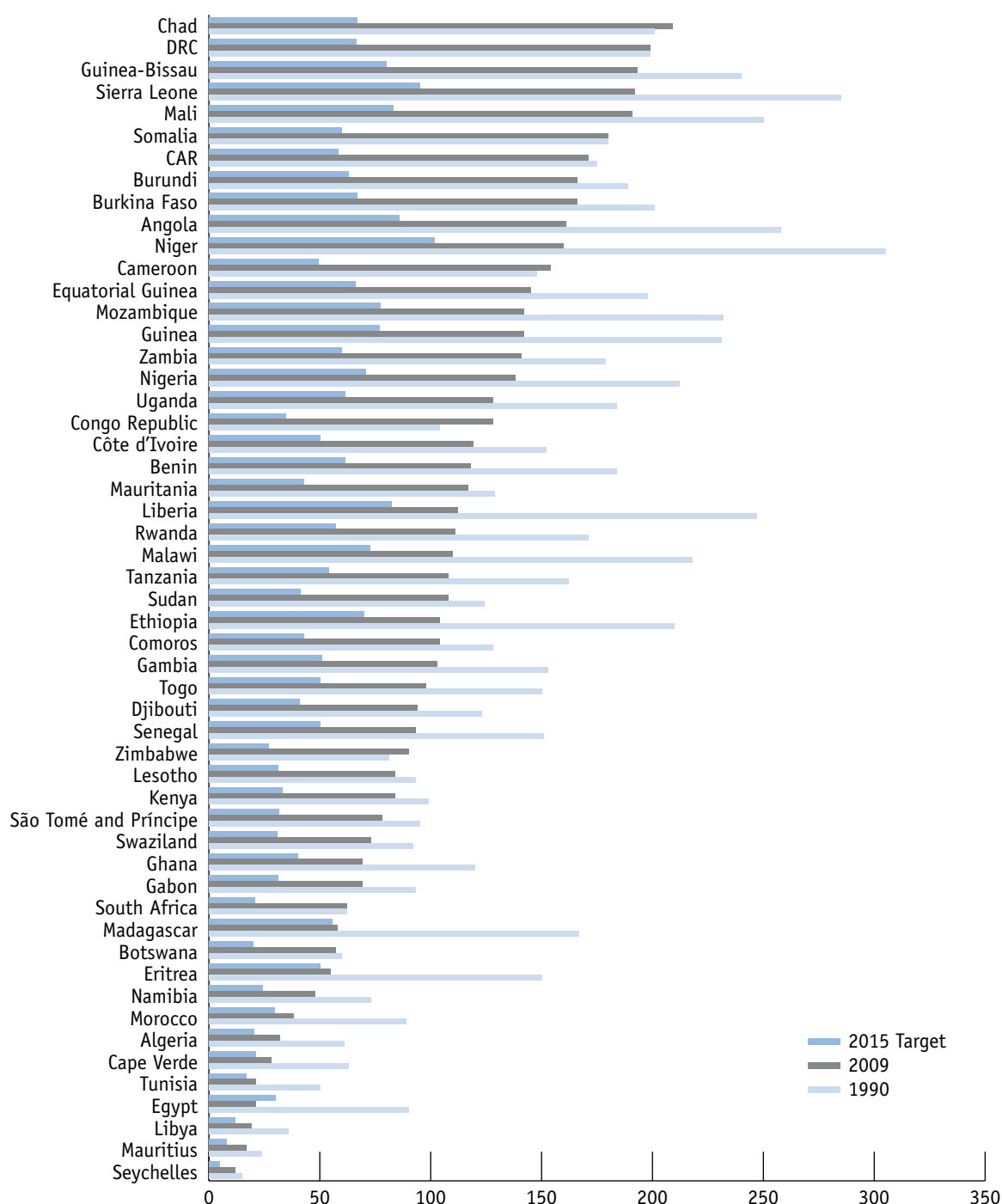
Figure 23: Countries with the highest prevalence of under-five deaths in Africa in 2009



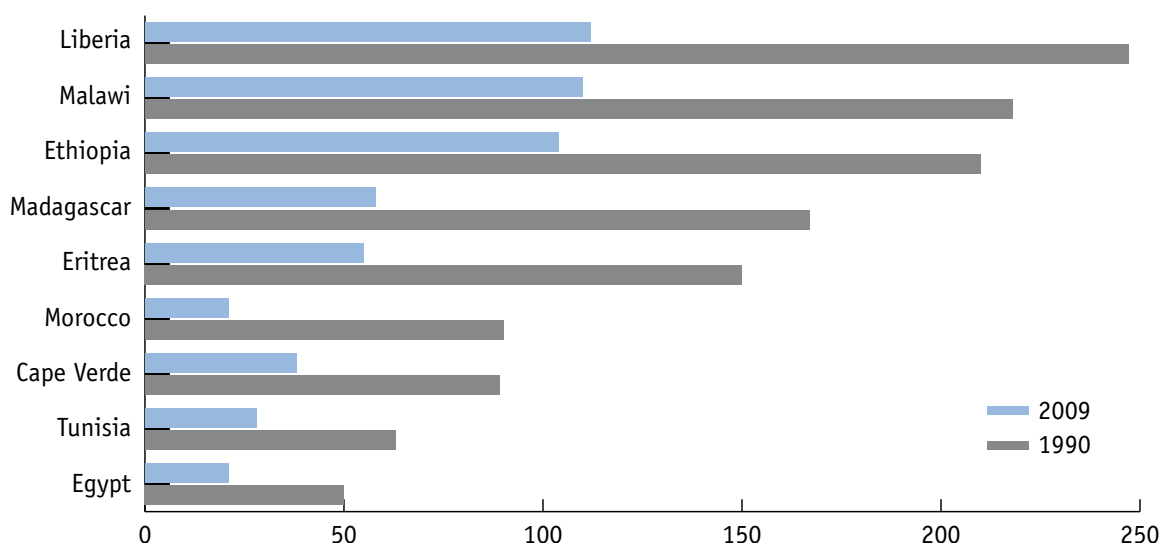
Source: IGME (2010).

As with the other MDGs, the regional average for this indicator conceals disparate rates of progress among individual countries. Based on the pace of progress achieved from 1990 to 2009, six countries (Algeria, Cape Verde, Eritrea, Libya, Morocco, and Tunisia) are definitely on course to achieve the target, having reduced their under-five mortality rates by more than 45 percent. This has been largely attributable to improvements in the mothers' level of education; the strengthening of health systems through policies that provide a balance between curative and preventative interventions; increased access to health facilities; and the implementation of robust monitoring and evaluation (M&E) systems. Furthermore, among the countries that have managed to reduce U5MR by at least 33 percent, five countries (Ghana, Madagascar, Namibia, Senegal, and Togo) are classified as being on track to achieve the target of MDG 4. However, the majority of countries have failed to make sufficient headway in reducing U5MR. Chad and DRC have displayed tendencies of either stalling or regressing in their U5MR since 1990, mainly due to insufficient funding, low-skilled professionals in their health sectors, and the failure of government policies to effectively address the situation.

Figure 24: Progress toward reducing the U5MR rate, 1990, 2009, and 2015 (target)



Source: Compiled from IGME (2010).

Figure 25: The nine best U5MR-performing countries, 1990 and 2009

Source: Compiled from IGME (2010).

It is noteworthy that Ethiopia features in the best-performing countries' list, with a 50 percent reduction between 1990 and 2009 (*Figure 25*). This achievement should be viewed in the context of the very high population levels in Ethiopia and Nigeria. For both these countries, a very high initial U5MR has created a greater challenge for the achievement of a two-thirds reduction.

Figure 25 reveals that nine countries have made the most progress by reducing their U5MR by 50 percent or more from 1990 to 2009. Egypt has already met the target and other countries are likely to do so by 2015 if the current trend is maintained. The number of countries with an U5MR below 100 deaths per 1,000 live births

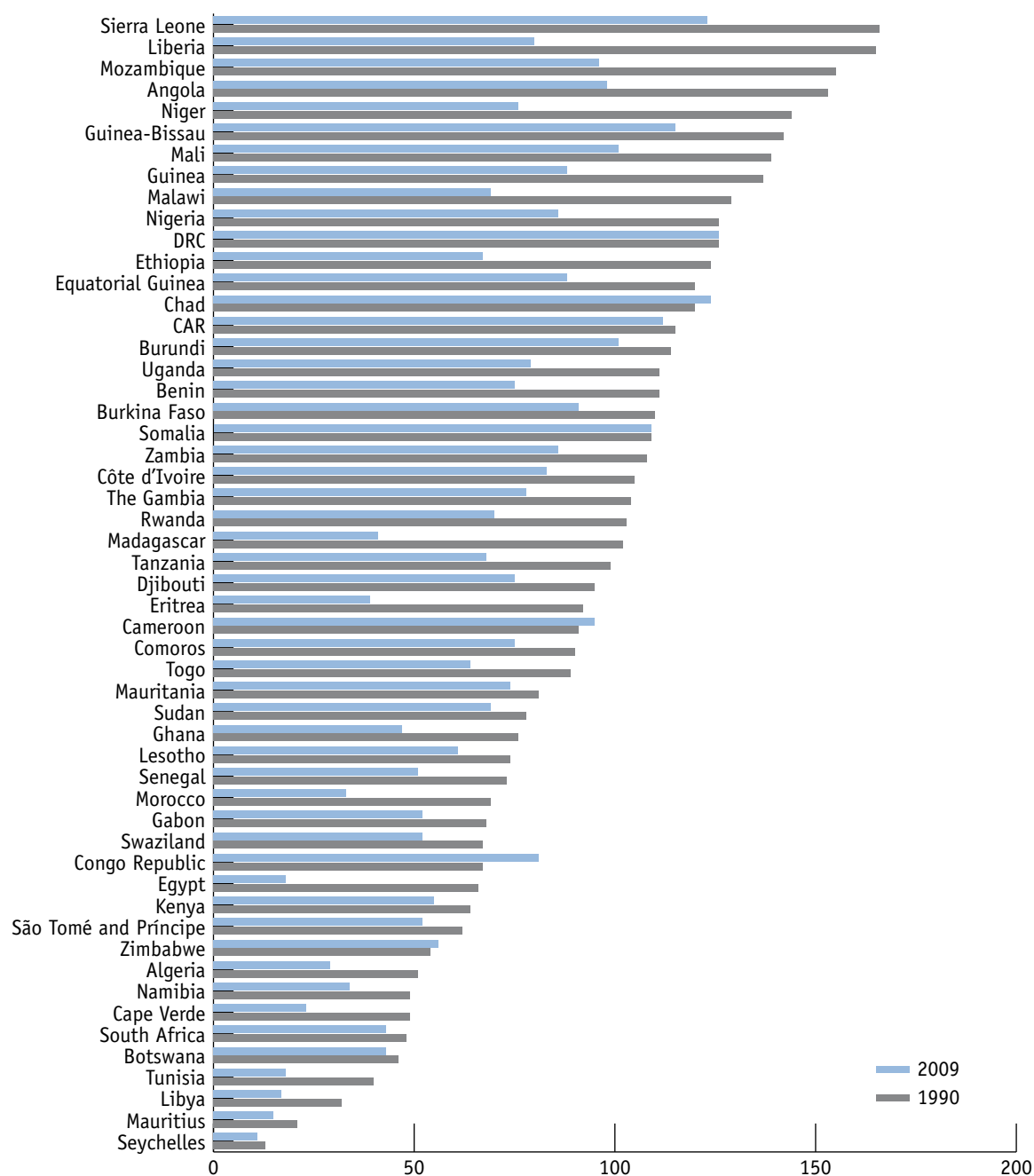
increased from 17 countries⁴¹ in 1990 to 23 countries⁴² in 2009.

The policy interventions that resulted in a high reduction in the U5MR are country-specific but certain commonalities exist. The political will to reduce child mortality is crucial to success, and this is the bedrock for prioritized budget allocations and for more focused interventions. For example, Ethiopia has expanded the supply of health workers in rural areas to provide information and advocacy on nutritional and vaccination information, and general child medical advice to mothers. Malawi has implemented an integrated management of

41 Algeria, Botswana, Cape Verde, Egypt, Gabon, Kenya, Lesotho, Libya, Mauritius, Morocco, Namibia, São Tomé & Príncipe, Seychelles, South Africa, Swaziland, Tunisia, and Zimbabwe.

42 The 23 countries included the 17 countries above plus Djibouti, Eritrea, Ghana, Madagascar, Senegal, and Togo.

Figure 26: Progress in reducing the Infant Mortality Ratio (per 1,000 live births), 1990 and 2009



Source: Compiled from IGME (2010).

its childhood illness program, which focuses on leveraging synergies across different state and non-state implementing agencies, to increase coordination and effectiveness (WHO, 2009).

What is particularly commendable is that among these top-performing countries, we find the post-conflict states of Liberia and Eritrea, which managed to reduce their U5MR by 55 percent and 63 percent, respectively. In the case of Liberia, key ingredients in its robust performance include: leadership commitment, strong partnerships, and enhanced service delivery, as well as secondary factors such as infrastructure development, improvements to formal education, increased domestic food production, and successful development of the private sector. Indeed, the private sector can play a key role by providing better wages, thereby increasing the amount households have to spend on health services. The reported reductions in the child mortality ratio for Eritrea are attributed to increased use of targeted health interventions, such as immunizations, (including measles vaccinations), the use of insecticide-treated bed-nets to prevent malaria, and Vitamin A and food supplements.

Accelerating progress on this indicator will require targeted interventions to address its root causes. Four diseases – pneumonia, diarrhea, malaria, and AIDS – accounted for 43 percent of all deaths in children under five worldwide in 2008. Most of these lives could have been saved through low-cost preventive and curative measures, including antibiotics for acute respiratory infections, oral rehydration for diarrhea, immunization, the use of insecticide-treated mosquito nets and appropriate drugs for malaria. There is an urgent need to refocus attention on pneumonia and diarrhea, which are two of the three leading killers of children.

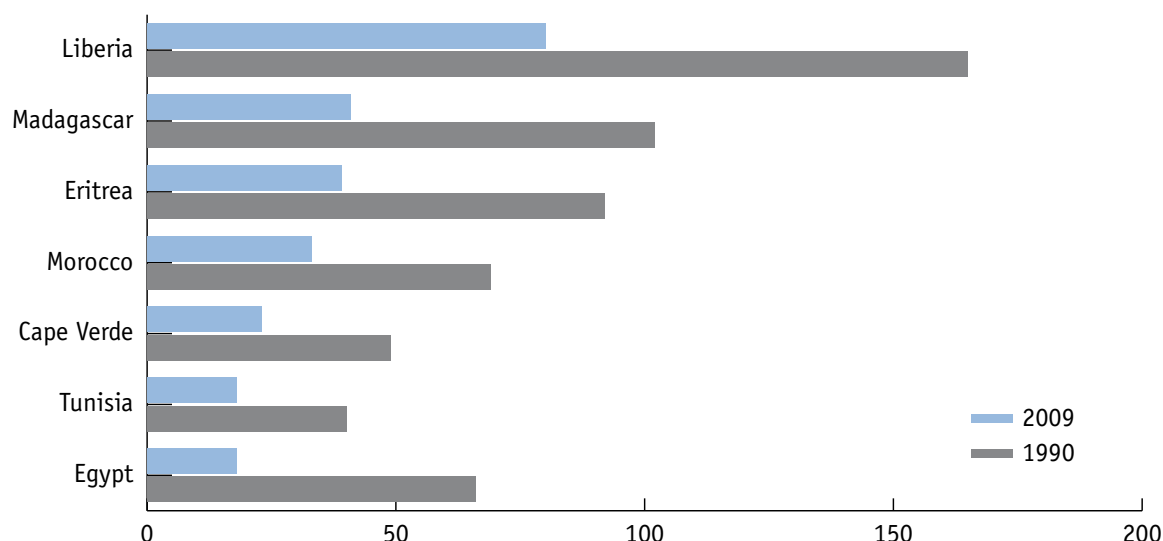
The use of new tools, such as vaccines against pneumococcal pneumonia and rotaviral diarrhea, could add momentum to the fight against these common yet deadly diseases. Combined with a renewed focus on adequate nutrition, such tools provide an entry point for the revitalization of comprehensive programming.

Indicator 4.2 – Infant Mortality Rate (IMR)

The Infant Mortality Rate (IMR) – deaths of infants under one-year-old per 1,000 live births in the same year – also registered a downward trend in Africa, from 102 deaths per 1,000 live births in 1990 to 75 deaths per 1,000 live births in 2009. This represents a decrease of 26 percent over a period of 20 years. In terms of the actual number of infant deaths, there was a marginal 2 percent reduction from 2.64 million in 1990 to 2.59 million in 2009 for the continent as a whole. The total number of infant deaths in Africa, excluding North Africa, amounted to 2.5 million. This represents a staggering 97 percent of infant deaths that occurred in 2009 on the continent as a whole.

The continental aggregate figure for IMR exhibits wide variations among countries. The majority of African countries have registered positive, albeit slow, progress for this indicator. A total of 47 countries registered reductions in IMR between 1990 and 2009 that ranged from 3 to 73 percent (*Figure 26*).

Figure 27 shows the seven best-performing countries in reducing IMR by at least 50 percent between 1990 and 2009. Three of these seven top performers are in North Africa (Egypt, Morocco, and Tunisia); two in West Africa (Cape Verde and Liberia), while East Africa is represented by

Figure 27: The seven best IMR-performing countries, 1990 and 2009

Source: Compiled from IGME (2010).

Madagascar and Eritrea. It should be noted that Liberia and Eritrea, which are both included in this list, are postconflict countries. This demonstrates not only that conflict is a cause of high child and infant mortality, but that political will and pertinent policy interventions can translate into significant positive change.

The Central Africa and Southern Africa subregions are not represented in this list. Furthermore, of the three countries (Cameroon, Chad, and Zimbabwe) where IMR has increased, two are in Central Africa (Figure 28). This may be an indication of the high prevalence rates of diseases such as malaria that are major causes of infant deaths in the subregion, combined with weak capacity to respond to the threats.

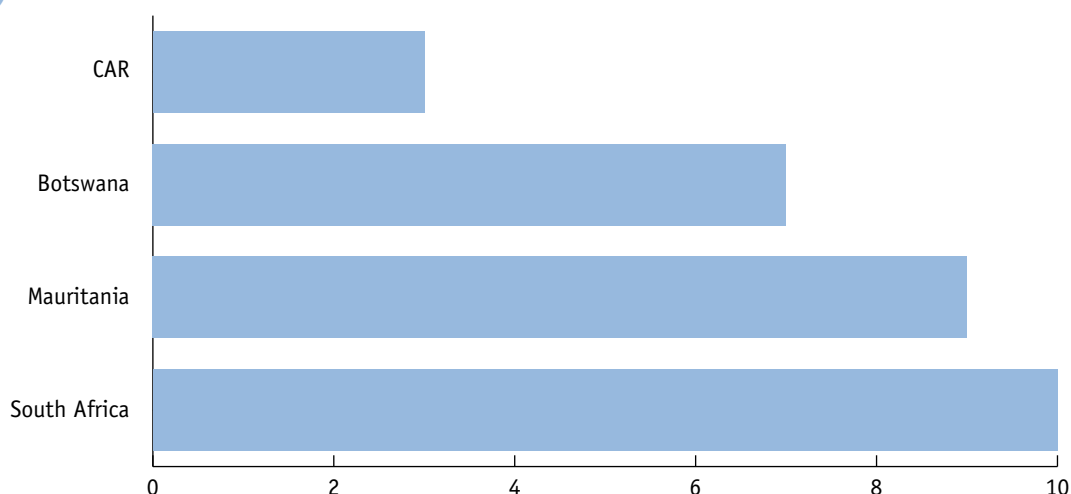
Overall, tackling infant and under-five mortality will require integrated maternal and child care

systems, improved infant nutrition, and a scaling-up of immunization coverage.

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

In view of the potential of the measles vaccination to reduce child mortality, routine measles vaccination coverage has been selected as an indicator of progress toward achieving MDG 4. In addition, measles vaccination coverage is often used as a proxy for a country's level of access to child health services. Measles is the leading cause of death in children in Africa ahead of AIDS, tuberculosis, and malaria (WHO, 2009).

Figure 28: Four worst IMR-performing countries, 1990–2009 (reductions of 10% or less)



Source: Compiled from IGME (2010).

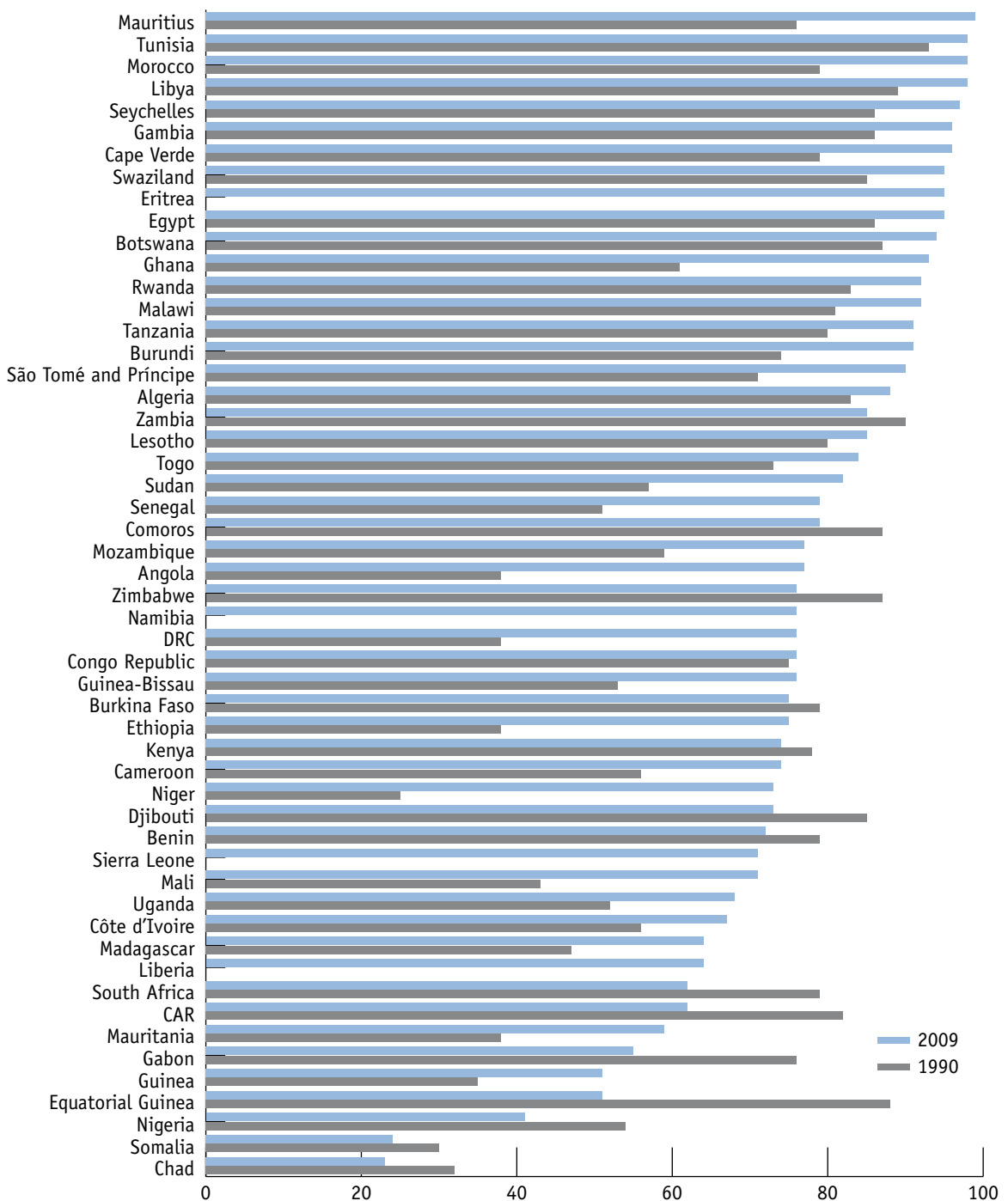
While vaccination coverage against measles registered an improvement in Africa from 54 percent in 1990 to 84 percent in 2009, this is not considered adequate to effectively ensure the survival of children. The rates of immunization against measles across the continent vary from one country to the next and a number of countries have made great efforts to increase coverage. For example, 17 countries⁴³ reported a 90 percent and above coverage rate, with only three countries (Nigeria, Somalia, and Chad) below 50 percent immunization coverage in 2009. There was, however, a reversal in immunization coverage rates for some countries between 1990 and 2009 (*Figure 29*).⁴⁴ The decrease

in coverage rates in some of these countries has been variously attributed to conflicts, traditional practices, and inadequate access to healthcare.

A single-dose vaccine strategy is insufficient to prevent measles outbreaks. In countries with weak health systems, the second dose is offered during campaigns to ensure high coverage. Between 2000 and 2008, the combination of improved routine immunization coverage and the provision of a second-dose opportunity led to a substantial reduction in measles mortality. Projections show that without supplementary immunization activities in these countries, mortality will quickly rebound, resulting in approximately 1.7 million measles-related deaths between 2010 and 2013. However, with sufficient funding, political commitment, and high-quality implementation of the second-dose measles strategy in priority countries, it should be possible to maintain the exceptional gains made so far.

43 A coverage of 90 percent or over was attained by Botswana, Burundi, Cape Verde, Egypt, Eritrea, The Gambia, Ghana, Libya, Malawi, Mauritius, Morocco, Rwanda, São Tomé & Príncipe, Seychelles, Swaziland, Tanzania, and Tunisia.

44 Reversals were recorded over the 1990–2009 period for Benin, Burkina Faso, CAR, Comoros, Djibouti, Equatorial Guinea, Gabon, Kenya, South Africa, and Zambia.

Figure 29: Progress on measles vaccination in African countries, 1990–2009 (%)

Source: WHO (2010).

Overall, there has been some progress in the three indicators tracking the achievements of countries toward MDG 4. Despite these achievements, and due to the fact that 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, diarrhea, malaria, and AIDS. This should be done within the framework of strengthening health systems and ensuring a continuum of care.

GOAL 5: IMPROVE MATERNAL HEALTH

At the September 2010 High Level Meeting on the MDGs, world leaders expressed grave concern over the slow progress in improving maternal and reproductive health and reducing maternal mortality. Nonetheless, they commended regional efforts made to address the challenge.

A notable initiative is the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which was successfully launched by the African Union in partnership with the UNFPA and other UN agencies in May 2009 and began to be implemented at the national level in 26 countries⁴⁵ over the period 2010/11 under the slogan *"Africa Cares: No Woman Should Die While Giving Life."* All these countries have instituted follow-up maternal, newborn and child health interventions to reduce morbidity and mortality.

45 Benin, Botswana, Cameroon, CAR, Chad, Congo Republic, Eritrea, Ethiopia, The Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia, and Zimbabwe. Eight of these countries launched the campaign in 2009, namely Chad, Ghana, Malawi, Mozambique, Namibia, Nigeria, Rwanda, and Swaziland.

African leaders have also committed to enhancing budgetary allocations to the health sector. Several countries have dedicated themselves to the implementation of the 2001 Abuja Declaration, whereby African Heads of State and Government agreed to allocate a minimum of 15 percent of their budget to the health sector in an effort to fast-track progress on health-related MDGs. By the end of 2010, six countries (Botswana, Burkina Faso, Liberia, Madagascar, Rwanda, and Tanzania) had fulfilled their commitments while many others remain on track.⁴⁶ In this regard, certain countries (notably Burundi, Ghana, and Sierra Leone) have made significant commitments to abolish user fees in the provision of maternal healthcare services, and many other countries provide subsidies or protection schemes. These initiatives echo the sentiments of the Fifteenth AU Summit held in Kampala, Uganda, which reaffirmed the need for increased budgetary allocations to maternal and child health services. Several countries in Africa, including Ghana and Uganda, have adopted MDGs Acceleration Frameworks (MAFs) that identify bottlenecks to implementation for specific prioritized interventions (see *Box 4*).

Although the lack of data on maternal health continues to be a major challenge to tracking progress, the available information suggests that while some progress has been made, it is not sufficient to achieve this Goal by the target date.

46 As of year-end 2009, government expenditure on health as a percentage of total government expenditure for Botswana, Burkina Faso, Liberia, Madagascar, Rwanda, and Tanzania was 16.7, 16.3, 17.2, 15.1, 16.8, and 18.1 percent respectively. In four more countries (Chad, Djibouti, Namibia, and São Tomé & Príncipe), this percentage has increased steadily and is expected to reach the 15 percent target. In 2009, these countries respectively spent 13.8, 13.9, 14.5 and 13.2 percent of their budget on the health sector (WHO, 2010b).

Box 4: The MDG 5 Acceleration Framework (MAF) in Uganda and the Free Health Care Initiative (FHCI) in Sierra Leone

While the majority of African countries are failing to make sufficient advancements toward improving their Maternal Mortality Ratios, some countries are implementing innovative initiatives to accelerate progress toward MDG 5.

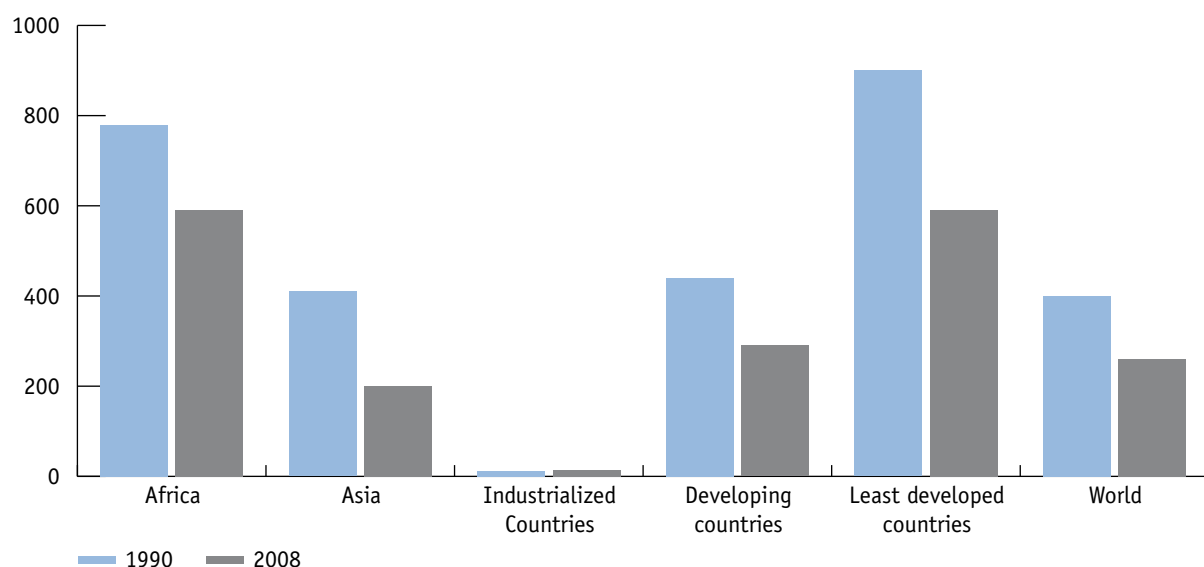
Uganda: In Uganda, the acceleration efforts will help operationalize the Maternal Health Roadmap, which was originally conceived in 2007. The MDGs Acceleration Framework (MAF) strikes a balance between activities that will yield immediate benefits, and those with longer-term benefits which will serve to sustain improvements in maternal health. For example, in order to address the issue of inadequate numbers of healthcare staff, a recruitment efficiency drive is being implemented in the District Service Commissions. The MAF also explores how to improve service delivery by shifting certain responsibilities from doctors to nurses or assistants. Both these actions are expected to yield results in the short-run. At the same time, for the longer-term, a strategy is being proposed to boost science education for girls in order to grow a pool of skilled midwives.

At the local level, the Soroti District in Eastern Uganda, 200 miles from Kampala, has implemented a WHO Making Pregnancy Safe (MPS) Initiative, which provides many lessons for the MDG 5 Acceleration Framework. The District is working to decrease maternal mortality through a multisector approach in order to remove all the bottlenecks in the system, not only health-related ones. In looking at the three delays of childbearing (delay in seeking care, delay in reaching care, and delay in receiving care), there are many non-health factors that contribute to safe childbirth. In this sense, efforts have been made in Soroti on a number of different fronts: (i) to educate women and health providers about the danger signs to look out for in labor; (ii) to improve roads in order to facilitate access to health units for pregnant women; and (iii) to provide standby ambulances for the transport of women in labor. According to WHO statistics, the Soroti district reduced maternal deaths through these actions by 75 percent – from 750 per 100,000 live births in 2000 to 190 deaths in 2006. Similarly, 43 percent of women living in Soroti now give birth with help from a trained health worker, as opposed to 26 percent before the MPS project started.

Sierra Leone: As of April 2010, Sierra Leone had introduced the Free Health Care Initiative (FHCI) for all pregnant women, lactating mothers and children under five years old. This aimed to provide a package of services, free of charge, at the point of service delivery. The government hopes to sustain the FHCI through the signing of a National Health Compact, which ensures that all existing and future investments in healthcare will be based on one validated national Health Strategy. This will safeguard partners' commitments; improve the harmonization of aid; improve coordination between governments, national stakeholders, and development partners; strengthen transparency and mutual accountability of all development partners; and reduce the complexity and transaction costs of health services delivery. In doing so, Sierra Leone is committed to driving down its MMR, which declined from 1,800 deaths per 100,000 live births in 2000 to 857 deaths per 100,000 live births in 2008.

Sources: *Uganda National MDG Report, 2010; Sierra Leone National MDG Report, 2010.*

Figure 30: Maternal Mortality Ratio for selected global regions (per 100,000 live births), 1990 and 2008



Sources: Compiled from WHO, UNICEF, UNFPA, and World Bank (2010).

Target 5.A: Reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Indicator 5.1: Maternal Mortality Ratio (MMR)

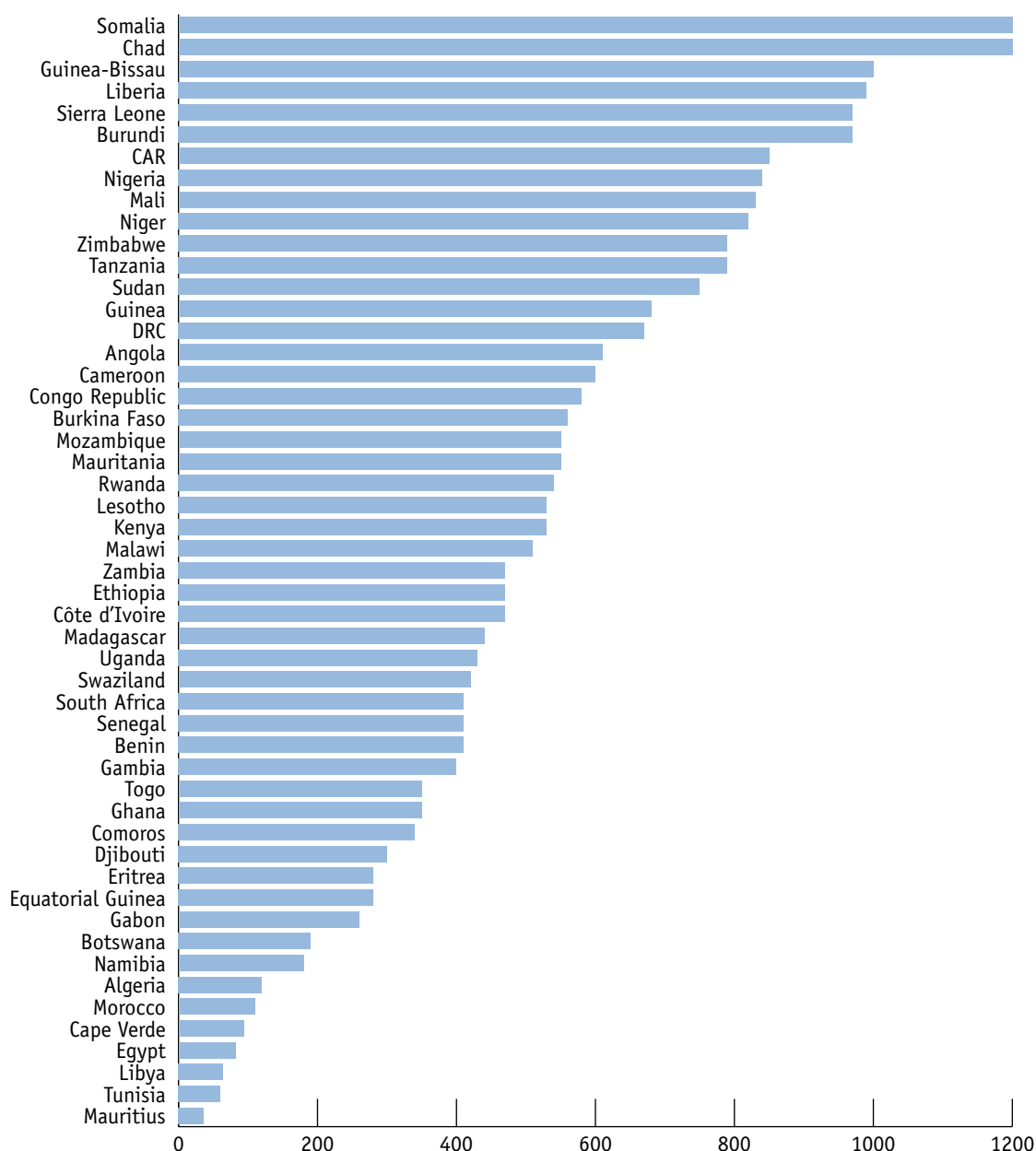
The Maternal Mortality Ratio (MMR), the most common measure of maternal health, continues to be a major challenge in Africa, particularly when compared to performance in the rest of the world. Although there was significant progress in all developing regions over the past two decades (*Figure 30*), the average annual percentage decline in the global MMR was 2.3 percent between 1990 and 2008, short of the 5.5 percent rate required to achieve the MDG target. However, when we look at the figure for Africa (excluding North Africa), the MMR declined at an average annual rate of just 1.7 percent there – worse than any other global region. However, North Africa performed much better than

the other subregions, recording between 1990 and 2008 a 59 percent decline in the MMR, compared to an average of only 26 percent in the rest of Africa.⁴⁷

In 2008 three African countries (Chad, Guinea-Bissau, and Somalia), all of which have either emerged from or are in conflict, registered an exceedingly high MMR above 1,000 per 100,000 live births. In terms of the best performers for this indicator, five countries (Cape Verde, Egypt, Libya, Mauritius, and Tunisia) recorded an MMR of less than 100 per 100,000 live births for the same year. Of the remaining countries, 21 registered an MMR of between 100 and 500 per 100,000 live births, while 22 recorded a ratio of between 500 and 1,000 per 100,000 live births (*Figure 31*).

⁴⁷ See WHO, UNICEF, UNFPA, and the World Bank (2010).

Figure 31: Maternal Mortality Ratio for selected African countries (per 100,000 live births), 2008⁴⁸



Sources: Compiled from WHO/UNICEF/UNFPA/ World Bank (2010).

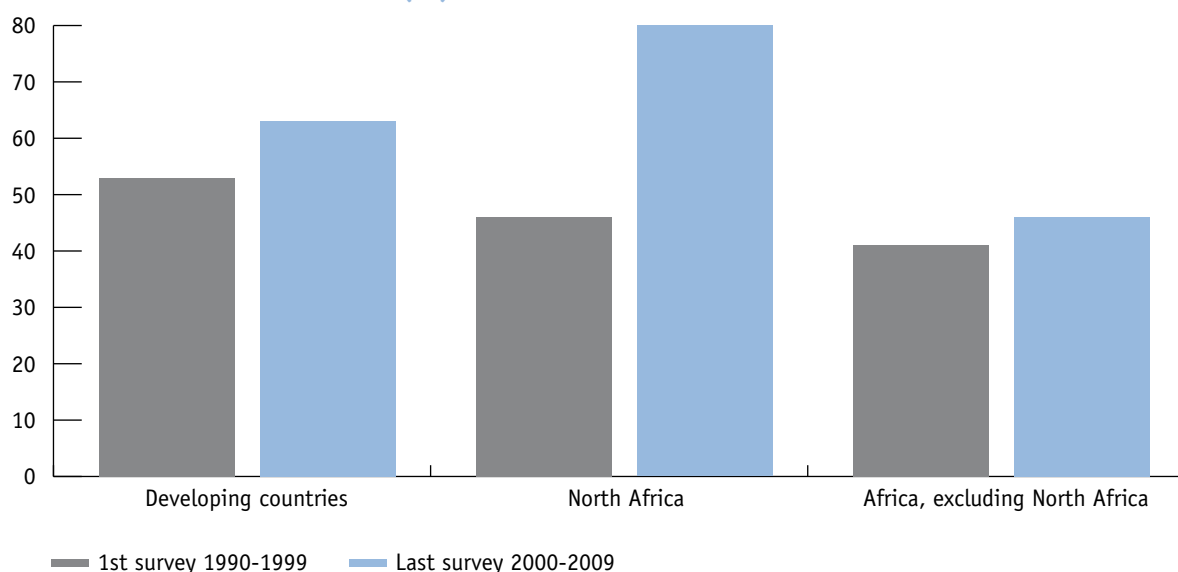
48 National estimates for maternal mortality may differ from UNSD estimates. This is because the Inter-Agency Group (composed of WHO, UNICEF, UNFPA, and World Bank) adjusts these national estimates to account for flaws in some national reporting systems. For example, the national estimate for Algeria in 2008 was 81.4 per 100,000 births. After adjustment, the Inter-Agency Group estimated this to be 120.

Indicator 5.2: Proportion of births attended by skilled healthcare attendant

Assistance during childbirth influences the birth outcome and health of both mother and infant during and after delivery. The skills and performance of the birth healthcare attendant determine whether or not he or she can manage complications and observe hygienic practices. The quality of the birth attendant services also influences a mother's initial decision to seek the care of a skilled healthcare worker. As shown in Figure 30, giving birth is particularly risky in Africa (excluding North Africa), where more than 50 percent of pregnant women deliver without skilled care. During the period 1990–2009, progress was very advanced in North Africa (Figure 32) but slow in the rest of the continent. The proportion of births attended by skilled health personnel is currently lower in Africa (excluding North Africa) than in all other developing regions worldwide.

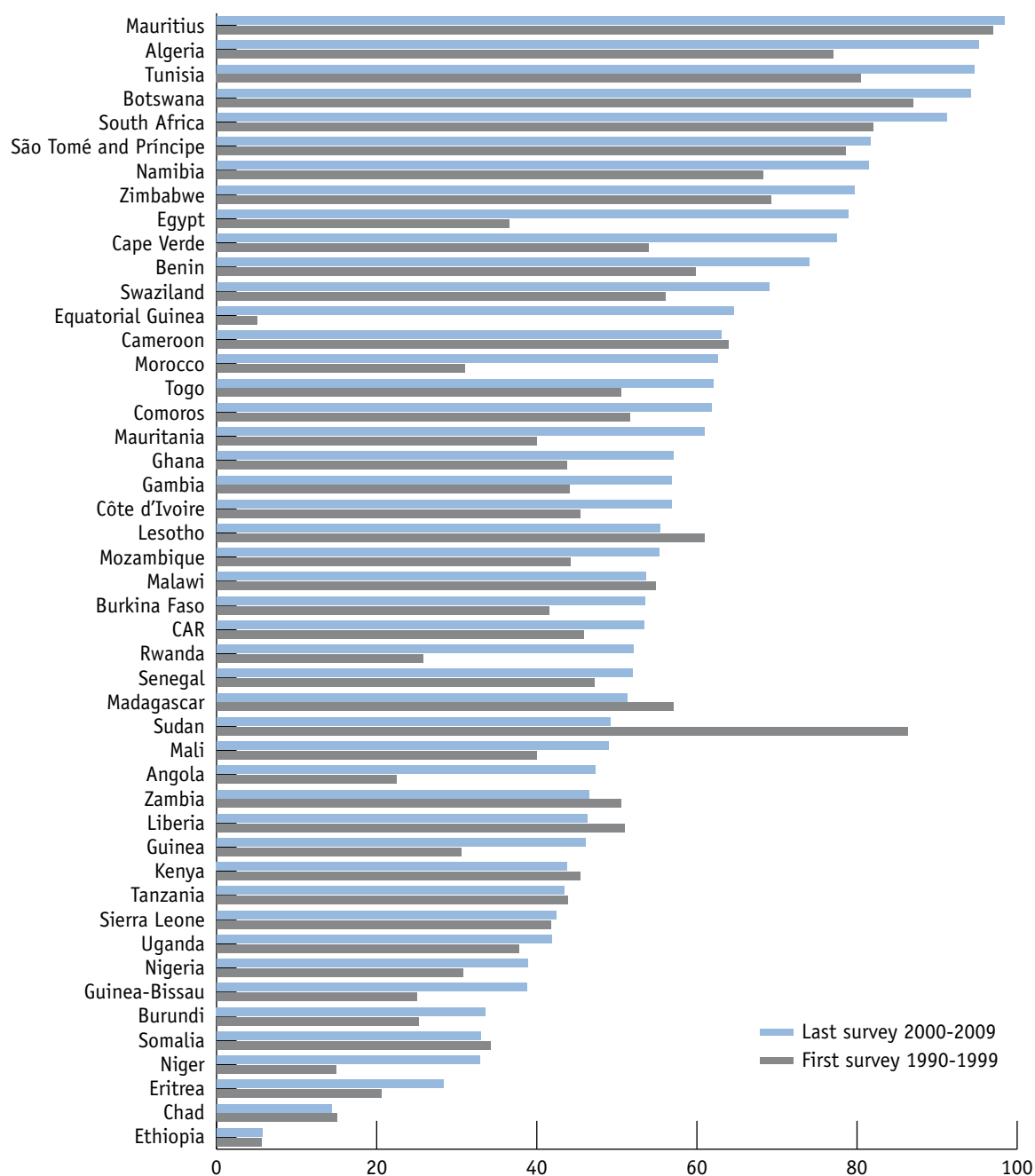
Addressing maternal health is a complex issue, as challenges lie on both the supply and demand sides of healthcare. Maternal mortality can be largely attributed to three delays in the childbearing process: delay in the decision to seek care; delay in reaching care; and delay in receiving care. The first delay – seeking care – occurs on the demand (mother's) side, while the other two delays are more supply-related. Distance to health facilities is an indicator of supply but it also affects demand for maternal care, as long distances to a health center may deter a pregnant woman from seeking care. On the supply side, the availability, quality, and cost of services clearly impact maternal mortality outcomes. On the demand side, the cost of services, the quality (both actual and perceived) of care, trust in health staff, and cultural barriers deter many women from seeking care, even when health services are available.

Figure 32: Proportion of births attended by skilled healthcare personnel by region, 1990–1999 and 2000–2009 (%)



Source: Compiled from UNSD data (updated in August 2010).

Figure 33: Proportion of births attended by skilled healthcare personnel for selected African countries, 1990–1999 and 2000–2009 (%)



Source: Compiled from UNSD data (updated in August 2010).

While most strategies to address maternal mortality focus on supplying more equipment and making services more affordable for expectant mothers, an effective strategy would be to attract more demand for such services, especially by training traditional birth attendants in rural settings in the practices of modern medicines, thereby building on the trust that already exists among them and local women.

Furthermore, there are major differences in performance for this indicator among the African countries. In the six worst-performing countries (Burundi, Chad, Eritrea, Ethiopia, Niger, and Somalia), only one-third of women delivered with a skilled healthcare worker present. Other countries (e.g. Kenya, Lesotho, Liberia, Madagascar, Somalia, and Zambia) recorded no progress on this indicator or even a regression. The Sudan saw a drastic drop from 86.3 percent in the period 1990–1999 to 49.2 percent in the period 2000–2009, which is most likely due to the ongoing conflicts in the country. The top-performing countries in the 2000–2009 survey (with 75 percent or higher of women who received skilled assistance during delivery) were (in order of achievement): Mauritius, Algeria, Tunisia, Botswana, South Africa, São Tomé and Príncipe, Namibia, Zimbabwe, Egypt, and Cape Verde (*Figure 33*). Of these top performers, only São Tomé and Príncipe is a Least Developed Country (LDC).

Target 5B: Achieve universal access to reproductive health by 2015⁴⁹

Tracking and reporting on contraceptive prevalence rates, adolescent pregnancy rates, antenatal

care coverage, and unmet need for family planning is difficult in Africa. Indeed, contraceptive prevalence rates are usually recorded only for married women and do not cover all modern contraceptive methods. Moreover, a significant proportion of adolescent pregnancies are not declared, while delivery outside of health facilities is at least as common in adolescent as in adult women. Notwithstanding last year's *MDGs Progress Report for Africa 2010*, for which recent data were available, overall time-series information on these indicators remains scant and an overview of progress achieved since 1990 is not feasible. The data presented below are the same data as presented in the 2010 Report, however different aspects of progress are assessed.

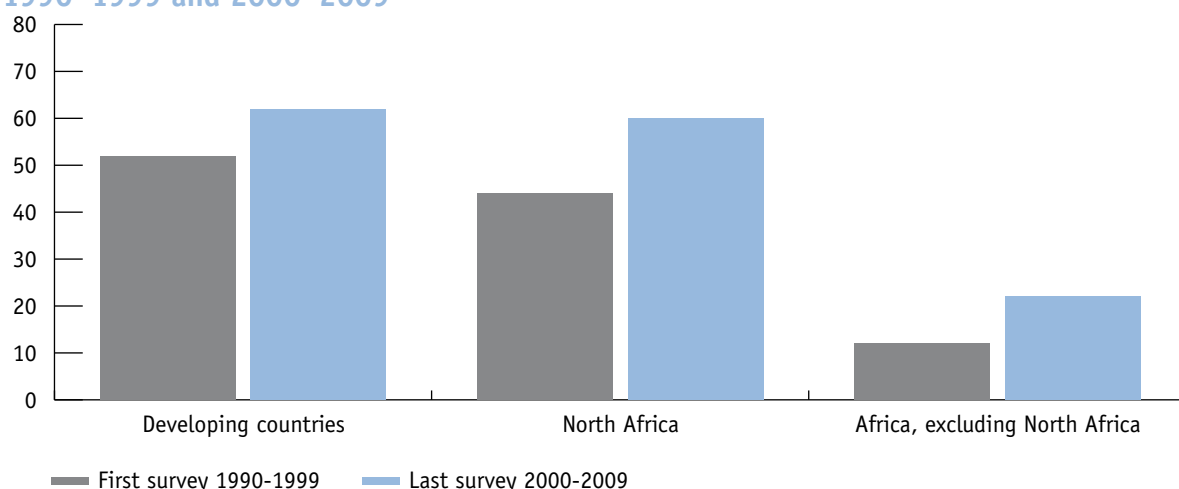
Indicator 5.3: Contraceptive prevalence rates for married people

The Contraceptive Prevalence Rate (CPR), which gives the percentage of married women aged 15–49 using any method of family planning, is relatively high in North Africa (60 percent) compared to the rest of Africa (22 percent) (*Figure 34*). CPR illustrates the ability of women to plan when to have children and how many children to have. During the latest survey period 1990–2009, the use of contraceptives increased among women in almost every country in Africa. The highest prevalence rates (more than 30 percent) were recorded for 12 countries: Algeria, Botswana, Egypt, Kenya, Malawi, Mauritius, Morocco, Namibia, South Africa, Swaziland, Tunisia, and Zimbabwe (*Figure 35*). Condom use is still relatively low, with the highest rate recorded in Botswana (15.5 percent). As highlighted under *Indicator 5.6: Unmet need*

49 This target was adopted at the 2005 UN World Summit and Midterm Review of progress toward the MDGs. It came

into effect in 2007, after it was operationalized by the Inter-agency Expert Group on MDGs Indicators.

Figure 34: Percentage of married women aged 15–49 using any contraceptive method, 1990–1999 and 2000–2009



Source: Compiled from UNSD data (updated in August 2010).

for family planning, it is critical to look at both the demand and supply side of contraceptive use. Whether a woman wishes to space her pregnancies or stop childbearing altogether has an impact on the type of contraceptive that she will choose. In order to increase use, it is important not only to make contraceptives more readily available and more affordable (supply side), but also to raise social awareness about the different types of contraceptives and how they address the different needs of women (influencing the demand side).

Indicator 5.4: Adolescent birth rate

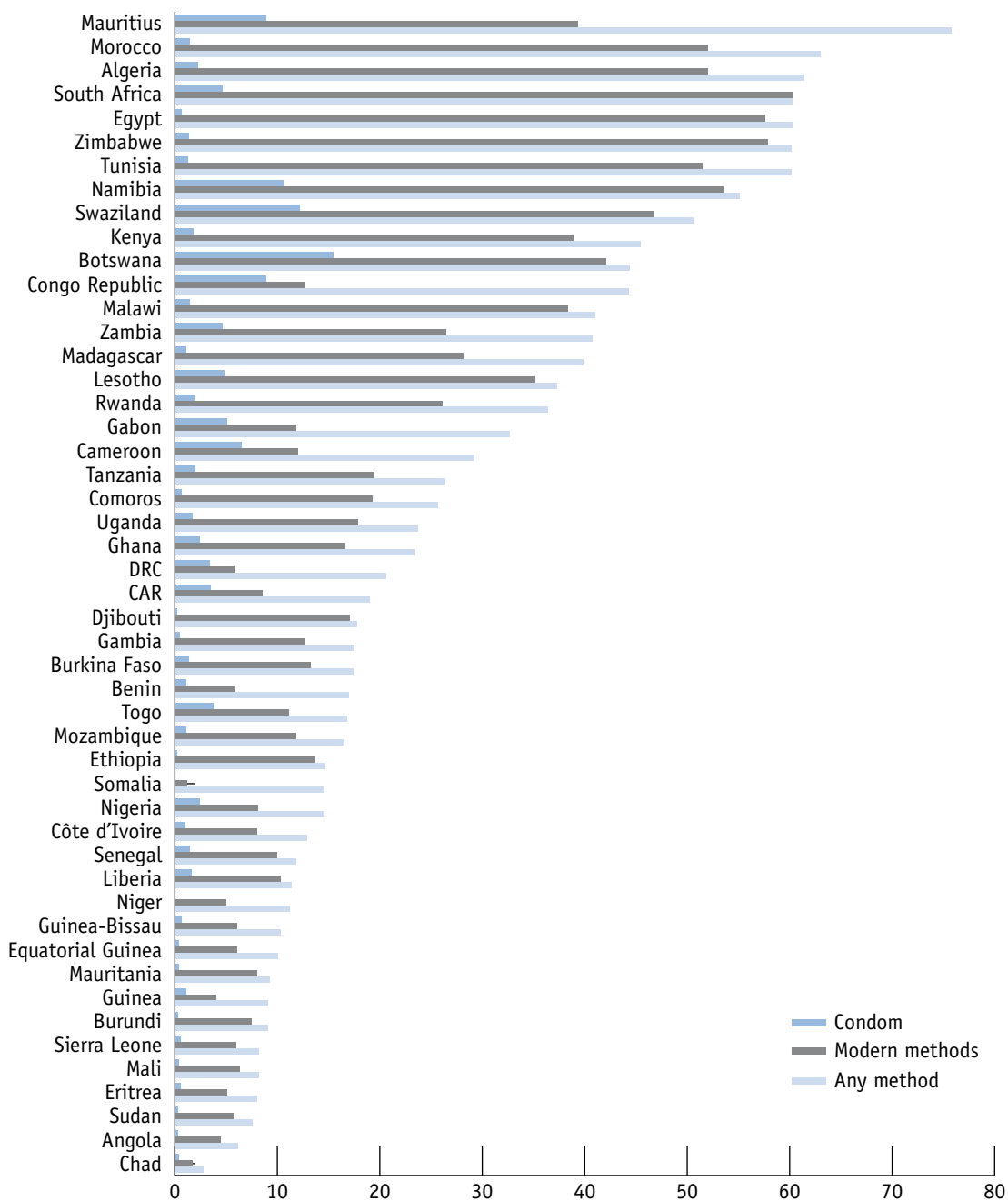
Globally, the highest birth rate among adolescents (defined as the number of births per 1,000 women aged 15–19) is observed in Africa (excluding North Africa), and there was little progress during the period 1990–2009 (Figure 36). In fact, there was no significant decrease in the adolescent birth rate from the period 1990–1999 (124 per 1,000) to 2000–2009 (121 per 1,000). The highest rates

(more than 150 per 1,000) are found in ten African countries: Angola, Chad, Guinea, Liberia, Malawi, Mali, Mozambique, Niger, Uganda, and Zambia. Adolescent birth rates of this magnitude are a contributing factor to high maternal mortality rates.

Indicator 5.5: Antenatal care coverage

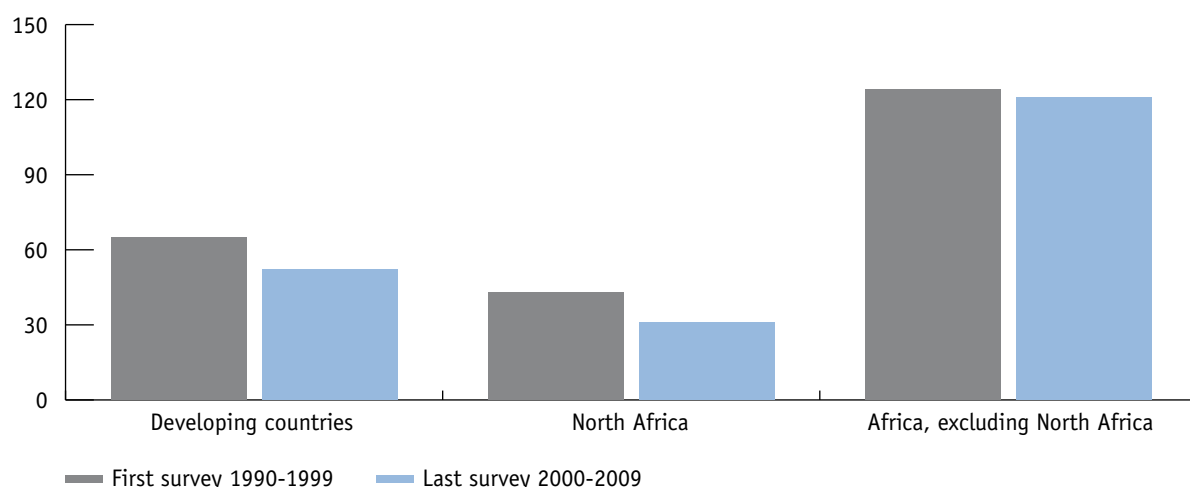
Antenatal care is more effective in preventing adverse outcomes when it is sought early on in the pregnancy and is continued through to delivery. Early detection of problems in pregnancy leads to more timely referrals in the case of women in high-risk categories or with complications. Early antenatal care also increases the chances that a woman will give birth with a skilled healthcare attendant present, which further improves outcomes. This is particularly true in Africa, where a large proportion of the population live in rural areas and where physical and cultural barriers continue to pose a challenge to healthcare delivery.

Figure 35: Different types of contraceptive use among married women aged 15–49 years, 2000–2009



Source: Compiled from UNSD data (updated in August 2010).

Figure 36: Number of births per 1,000 adolescent women aged 15–19 in 1990–1999 and 2000–2009



Source: Compiled from UNSD data (updated in August 2010).

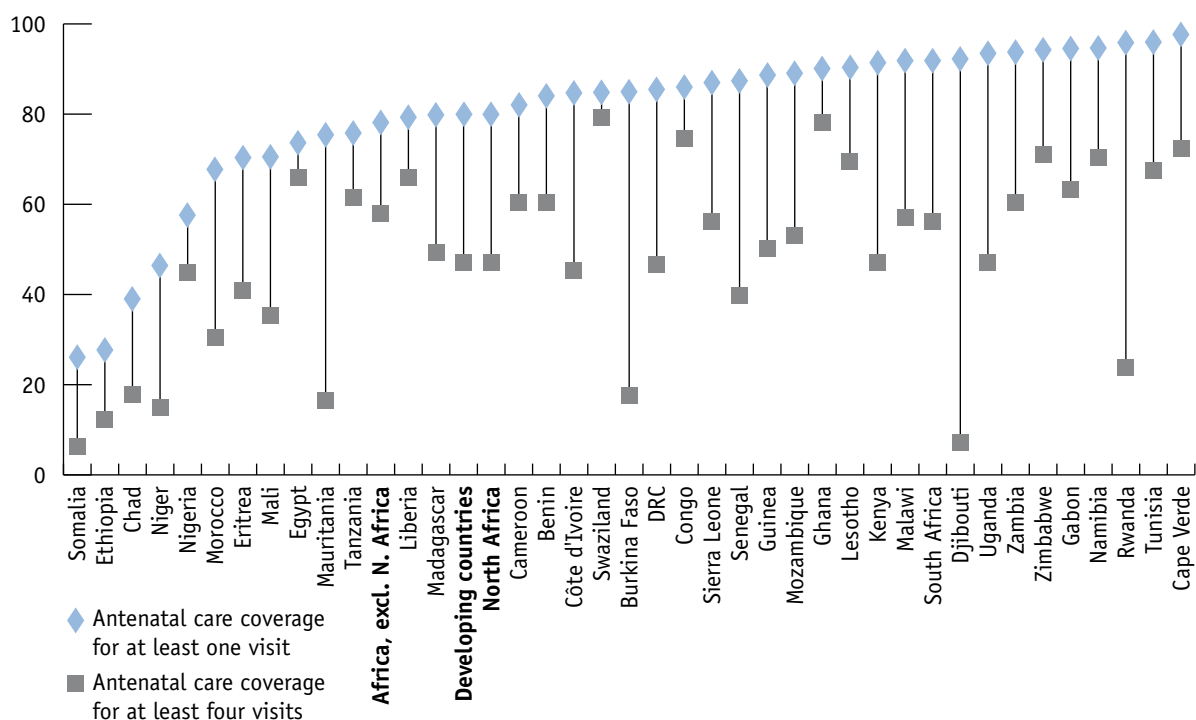
Remarkable gains in antenatal care have been recorded across the continent. The proportion of women who saw a skilled health worker at least once during pregnancy increased by 25 percent in North Africa and by 69.6 percent in the rest of Africa over the period 2000–2009. Under normal circumstances, the WHO recommends that a woman without complications should have at least four antenatal care visits, the first of which should take place during the first trimester. However, as illustrated in *Figure 37* below, only 15 countries (Benin, Cameroon, Cape Verde, Congo Republic, Egypt, Gabon, Ghana, Lesotho, Liberia, Namibia, Swaziland, Tanzania, Tunisia, Zambia, and Zimbabwe) out of a total of 38 for which data are available, recorded more than 60 percent of pregnant women who received the recommended four visits between 2000 and 2009.

Indicator 5.6: Unmet need for family planning

The proportion of women who would like to stop childbearing altogether or who wish to space their

next birth is a crude measure of the extent of family planning requirements. It should be noted that not all of these women are exposed to the risk of pregnancy and some of them may already be using contraception. Women who wish to delay giving birth for two or more years or who want to avoid pregnancy altogether but are not using a contraceptive method are said to have an “unmet need for family planning.” Pregnant women are considered to have an unmet need for spacing or limiting their children if their pregnancy was mistimed or unwanted. Similarly, women who are not menstruating and therefore not able to get pregnant are categorized as having an unmet need if their last birth was mistimed or unwanted. Women who are currently using family planning are said to have a met need for family planning. The total demand for family planning services comprises those who fall in both the met and the unmet need categories.

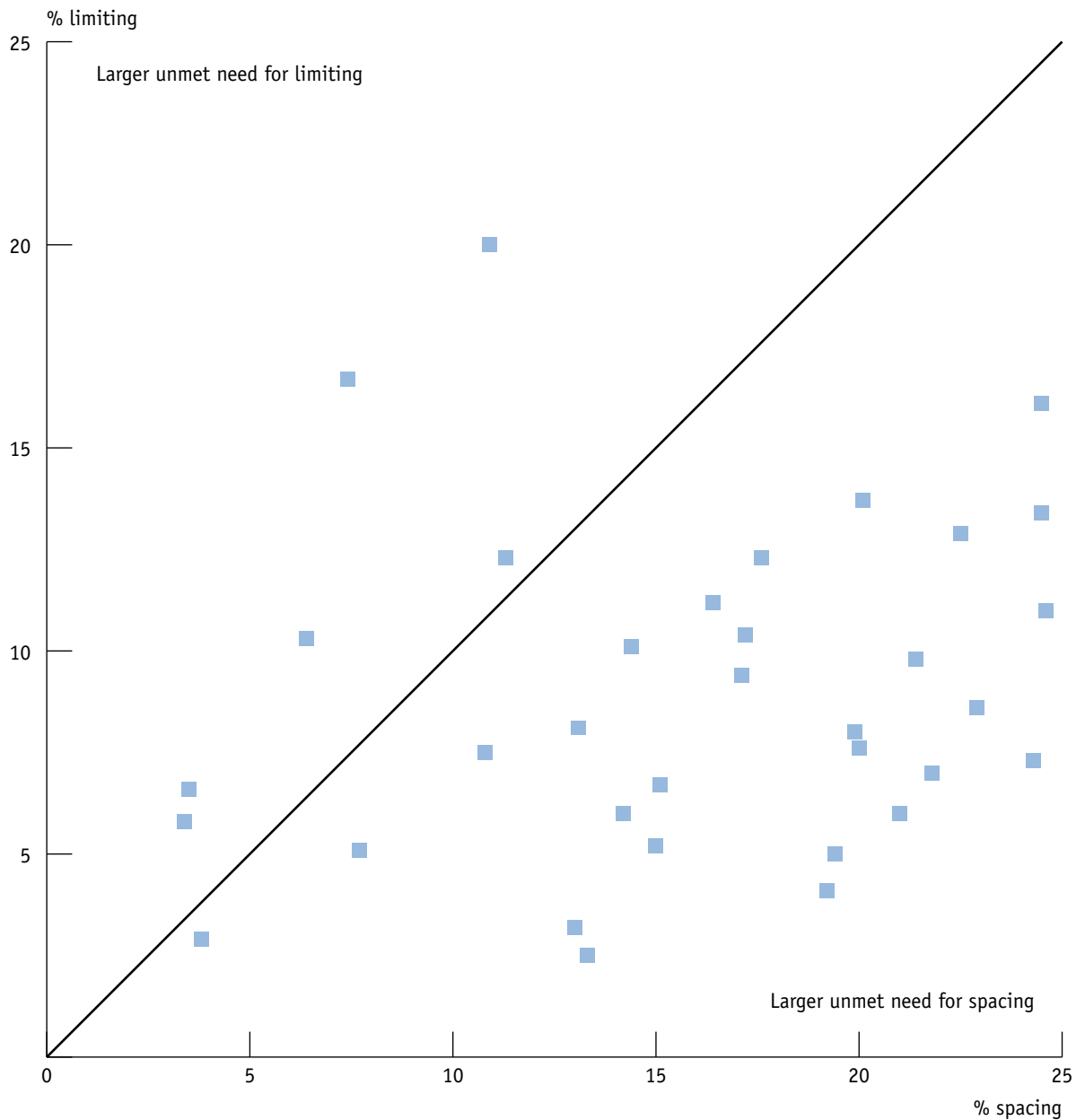
Figure 37: Number of antenatal care visits by trained healthcare practitioner in 38 African country surveys, 2000–2009 (% of pregnant women)



Source: Compiled from UNSD data (updated in August 2010).

All African countries have an unmet need for family planning. *Figure 38* categorizes African countries in two groups: the first group represents two countries with a large unmet need for limiting childbearing (Lesotho and Swaziland), where more than 15 percent of women want to stop childbearing altogether. The second group counts 18 countries with a greater unmet need for spacing (more than 15 percent), namely Benin, Burkina Faso, Chad, Côte d'Ivoire, DRC, Eritrea, Ethiopia, Gabon, Ghana, Liberia, Malawi, Mali, Mauritania, Rwanda, Senegal, Sierra Leone, Uganda, and Zambia. The graph shows that, while countries have an overall larger need for birth spacing, the majority of countries have at least 5 percent of women who

do not wish to have any more children. Furthermore, the discrepancy between countries having an unmet need for limiting versus an unmet need for spacing has critical policy implications. Countries that have a greater need for limiting childbearing should focus on long-acting and permanent methods of family planning such as Intra-Uterine Devices (IUDs) and female sterilization. Those that have a greater unmet need for spacing should focus on short-term contraception methods, such as the pill and condoms. Assessing the percentage of women with each type of unmet need focuses attention on the demand-side of health services; this is crucial if countries want to effectively plan their health interventions.

Figure 38: Unmet need for family planning in 34 African country surveys, 2000–2009

Source: Compiled from UNSD data (updated in August 2010).

Table 5: HIV/AIDS statistics for Africa (excluding North Africa), 2001 and 2009

Year	People living with HIV (million)	People newly infected with HIV (million)	Children living with HIV (million)	AIDS-related deaths (million)
2009	22.5	1.8	2.3	1.3
2001	20.3	2.2	1.8	1.4

Source: UNAIDS (2010).

GOAL 6: COMBAT HIV/AIDS, MALARIA, AND OTHER MAJOR DISEASES

Efforts to combat HIV and AIDS, tuberculosis, and malaria under MDG 6 have led to significant advances in preventing and treating these diseases. Goal 6 currently exhibits better progress than in previous years due in part to better performance of global funds, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, this progress needs to be sustained for Targets 6.A and 6.B, and accelerated for Target 6.C in order to meet Goal 6.

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

According to the *Report on the Global AIDS Epidemic 2010* (UNAIDS, 2010), HIV and AIDS are now more under control in Africa than ever before. Advances in stemming the HIV and AIDS pandemic have been significant in the majority of African countries, both in terms of preventing new infections and in making Anti-Retroviral Treatment (ART) more readily available to infected people.

UNAIDS estimated the HIV and AIDS prevalence rate in Africa (excluding North Africa), to have decreased to 5.0 percent in 2009, compared with 5.9 percent

in 2001.⁵⁰ However, this does not translate into a decrease in the actual number of people living with HIV and AIDS, due to population growth. Indeed, 22.5 million people were living with HIV and AIDS at the end of 2009, compared with 20.3 million at the end of 2001 (*Table 5*). Although the annual number of new HIV infections (incidence⁵¹) has been steadily declining since the late 1990s, this decrease is offset by the reduction in AIDS-related deaths (1.3 million in 2009 compared to 1.4 million in 2001) due to the significant scaling-up of ART over the past few years. This encouraging drop in AIDS-related deaths means that more people are surviving longer, i.e. they are classified as living with HIV.

Despite the overall positive trend toward Target 6.A, progress is mixed among countries and some of them have recorded setbacks, both in terms of prevention and treatment (*Box 5*). It is also a matter of grave concern that the number of children living with HIV is rising (500,000 more between 2001 and 2009), as this phenomenon does not

50 It is important to note that UNAIDS data aggregate North Africa with Arab countries; hence, it is not possible to provide separate figures for North Africa.

51 Incidence represents the number of new infections while prevalence represents the total number of infections. Incidence is a better indicator of the evolution of the epidemic, as it accounts only for new infections, while prevalence also accounts for deaths related to the infection.

Box 5: Setbacks in the fight against HIV and AIDS: the case studies of Mozambique and Uganda

Despite the continent's overall steady progress in the fight against the HIV and AIDS epidemic, some countries are recording setbacks, not only in prevention but also in treatment.

In **Mozambique**, the prevalence rate among adults (15-49 years) has increased significantly, from 8.6 percent in 1997 to 11.5 percent in 2009. Moreover, women are much more susceptible to infection than men. The prevalence rate for women is 18.4 percent compared to 12.8 percent for men. Indeed, women bear most of the AIDS burden across Africa – an average of three women are HIV-infected for every two men in the region. This is due to women's role in society as well as their biological vulnerability to HIV infection. Similar skewed infection rates are evident between the urban (15.9 percent) and rural (9.2 percent) areas. In addition, there is a clear-cut correlation between higher prevalence and location near the border of South Africa (RSA). The prevalence varies from 3.7 percent in Niassa (the province furthest from RSA) to 25.1 percent in Gaza (the nearest province to RSA). This effect is strongly related to people from these nearby provinces working in the mines of RSA. Another noteworthy statistic is that prevalence is higher in the wealthier quintiles. What is most worrisome is that despite the limited success in reducing HIV prevalence rates, performance targets remain unambitious. For instance, the target of reaching infected children with ARTs has been set at only 12.3 percent for the year 2014, compared to 9.9 percent in 2010.

Uganda illustrates another example of a setback in the fight against HIV and AIDS. While in the past the country was cited as a success story in halting the spread of HIV, the situation today is deteriorating. Indeed, Uganda made commendable progress during the 1990s to reduce the spread of HIV and AIDS. For example, the proportion of pregnant women attending antenatal clinics who were identified as HIV-positive fell from a high of 18 percent in 1992 to around 6 percent in 2000. This success was due to a variety of measures that enabled changes in sexual behavior, as well as the provision of care and support services. However, recent data reveal significant challenges in sustaining past gains. It is estimated that more than 130,000 people were infected with HIV in 2010 alone. The total number of people living with HIV in 2010 was around 1.2 million, which is higher than at the peak of the epidemic in the 1990s. The recent expansion in the absolute number of new infections is related not only to high population growth, but most importantly to the worsening of many indicators of risky behavior (e.g., multiple partners and decreased condom use). The government of Uganda plans to reassess their national HIV and AIDS policy to refocus on preventing new infections rather than providing ART.

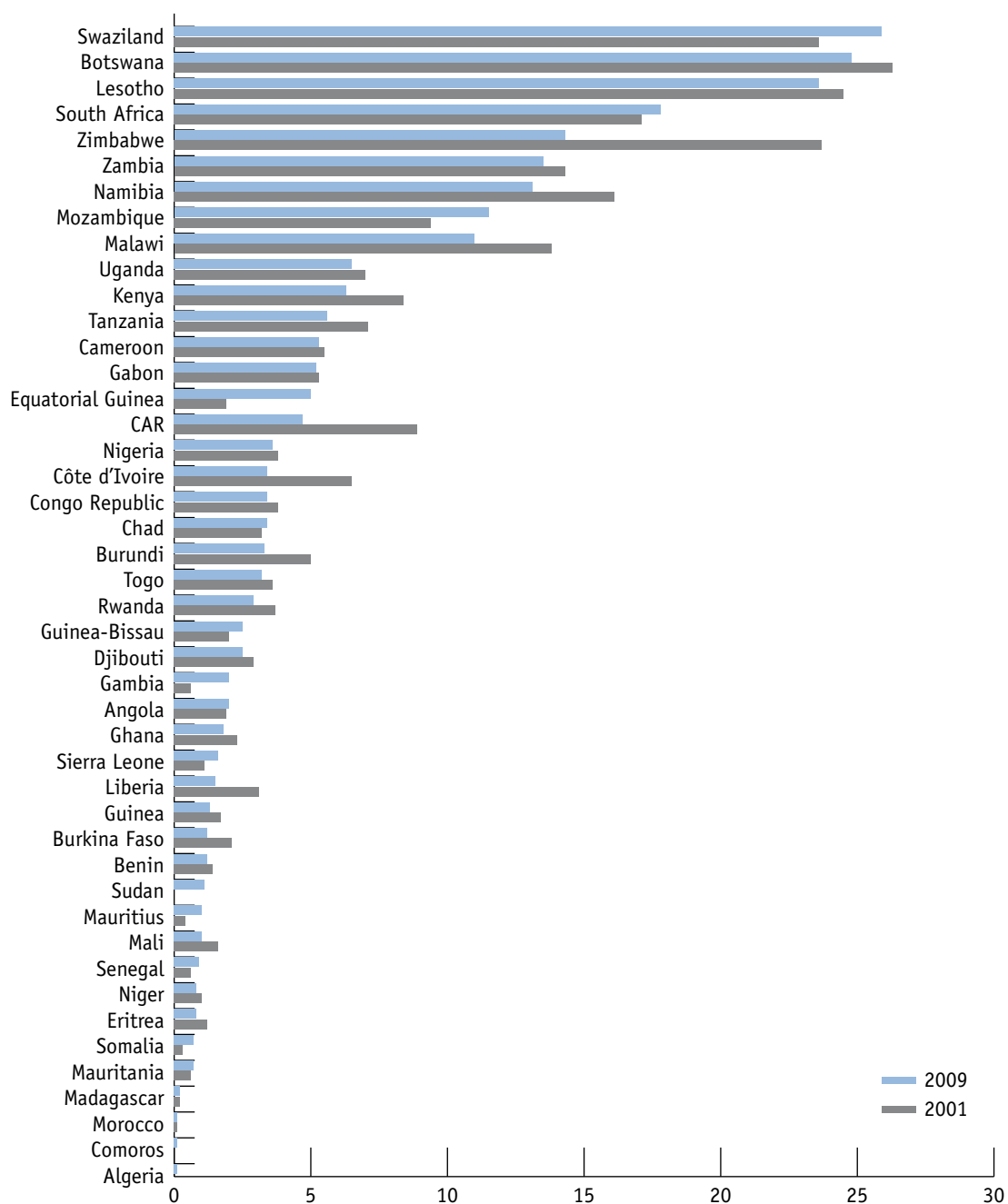
Sources: *Mozambique MDG Progress Report, 2010*; *Uganda MDG Progress Report, 2010*.

reflect the increased availability of ART for children (see Target 6.B below).

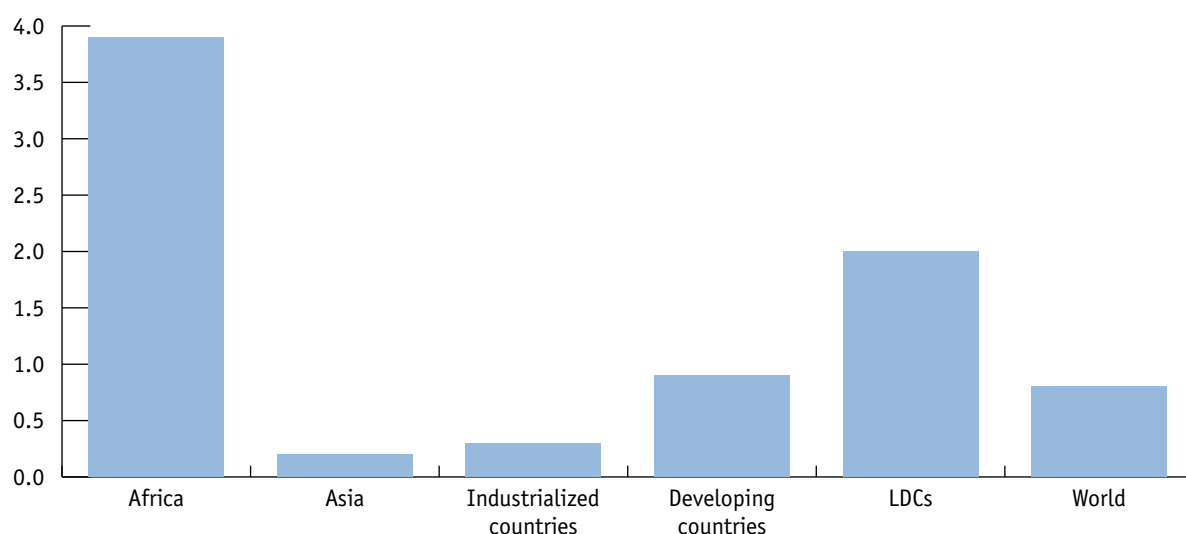
HIV incidence fell by 25 percent between 2001 and 2009 in 22 African countries (excluding North Africa), while expanding access to treatment has contributed to a 19 percent decline in deaths

among people living with HIV since 2001. However, adult HIV prevalence⁵² increased between 2001 and 2009 in Angola, Chad, Equatorial Guinea, The Gambia, Guinea-Bissau, Mauritius, Mozambique,

⁵² UNAIDS defines an adult as being 15 years of age or above.

Figure 39: Adult HIV prevalence in African countries, 2001 and 2009 (%)

Source: Compiled from UNAIDS (2010).

Figure 40: Adult HIV prevalence by global region, 2009 (%)

Source: Compiled from UNAIDS (2010).

Senegal, Sierra Leone, Somalia, South Africa, and Swaziland (*Figure 39*). Moreover, regardless of the significant improvements made, adult HIV prevalence is still high in Africa compared to other regions of the world, as shown in *Figure 40*.

The UNAIDS report provides evidence that the largest epidemics in the region in terms of the number of infected people (as opposed to the prevalence rate) – i.e. in Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe – have now stabilized or are showing signs of decline.

Indicator 6.1: HIV prevalence⁵³ among the population aged 15–24

Surveys undertaken by UNAIDS indicate that the incidence rate is lower among 18-year-olds. For

this age range, it declined sharply from 1.8 percent in 2005 to 0.8 percent in 2008 (UNAIDS, 2010). Recent analysis provides further evidence of decreasing incidence and safer sexual behavior among young people. Five countries – Botswana, South Africa, Tanzania, Zambia, and Zimbabwe – showed a significant decline in HIV prevalence among young women or men in national surveys. Improved behavior change (including increased condom use, delayed sexual debut, and reductions in multiple partnerships) helps to account for the encouraging declines in new HIV infections in African countries.

Indicator 6.2: Condom use for high-risk sex

There has been a marked improvement in sexual behavior in many African countries, especially among young people. For example, in Zambia where HIV incidence declined by more than 25 percent between 2001 and 2009, there was a

⁵³ As there are no new data on prevalence for this age group, we assess progress here using incidence rates.

sharp drop in the number of both young and older adults who had multiple partners. Another decline was in the proportion of men and women aged 15–24 years who reported having more than one partner over the previous 12 months and who did not use a condom at the last high-risk sexual encounter.

Trend data from Demographic and Health Surveys (DHS) show that condom use is increasing on the continent. Despite this positive trend, condom use for high-risk sex is still low in Africa due to a variety of factors, including cultural barriers and gender imbalances. In addition, the aggregate figure masks huge disparities between urban/rural areas and different age groups. A further complication is that condom use is very difficult to negotiate in the context of marriage/stable relationships,⁵⁴ yet high-risk sex may occur in these settings too, especially when one of the partners is not faithful.

In recent surveys undertaken at the country level, Botswana reported that at least 80 percent of men had used a condom at their last high-risk sexual encounter. At the other end of the spectrum, 14 African countries reported condom use rates of 20 percent or less for those with more than one partner in the past year, for both males and females. This low figure for condom use included high-prevalence countries like the DRC, Ethiopia, Malawi, Rwanda, Tanzania, and Uganda. This illustrates the need to extend and, more importantly to sustain positive, continent-wide behavior change.

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

Knowledge of HIV and AIDS and related issues among the youth is not increasing as expected. For instance, less than half of young people living in 15 of the 25 countries with the highest HIV prevalence⁵⁵ can correctly answer five basic questions about HIV and its transmission. Although young people aged 15–24 years old have shown gradually improving knowledge about HIV in these 15 countries, this still falls short of the global targets for comprehensive knowledge set in 2001. Urban/ rural disparities in access to technology, mass media, and to mobile telephony contribute to the limited progress of this indicator at all levels.

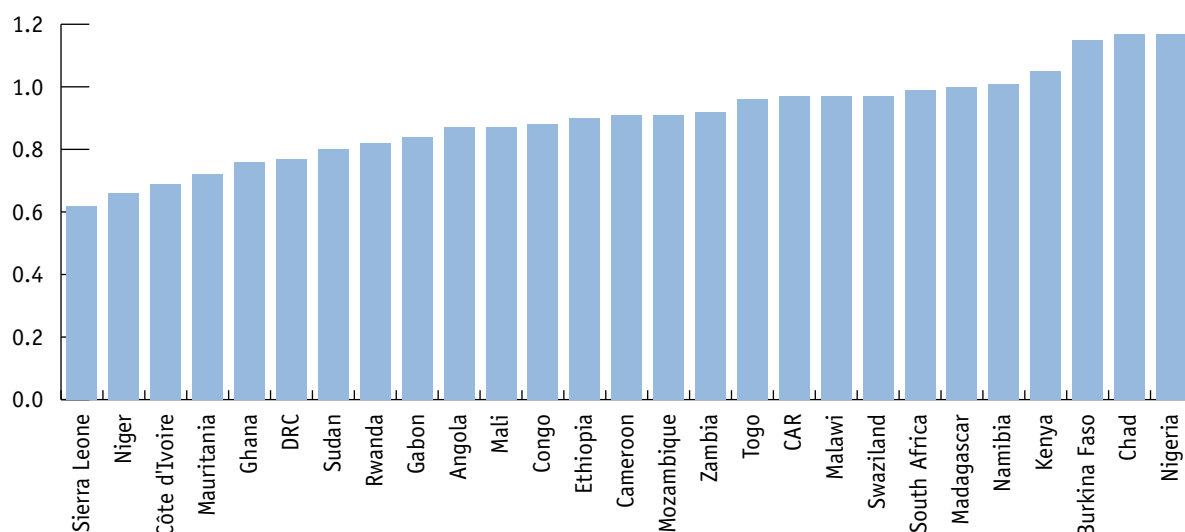
Indicator 6.4: Ratio of school attendance of orphans compared to school attendance of non-orphans (aged 10–14 years)

The ratio of school attendance of orphans to non-orphans aged 10–14 years is an indicator that varies widely among African countries. In 2008, the value of this indicator was above 0.6 for all countries with available data. Moreover, in Burkina Faso, Chad, Kenya, Namibia, and Nigeria, school attendance for orphans was higher than that of non-orphans, as illustrated in *Figure 41*. This indicator is strongly related to Goal 2; for this reason, policies and strategies aiming to achieve universal access to primary education should take this interdependence into account.

⁵⁴ See *Figure 35* (Goal 5) for contraceptive use among married women. Condom use rates are much lower than the figures indicated, which include *all* contraceptive methods.

⁵⁵ Botswana, Burundi, Cameroon, CAR, Chad, Congo, Côte d'Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Tanzania, Togo, and Zambia.

Figure 41: Ratio of school attendance of orphans to non-orphans aged 10–14 years in selected African countries, 2008



Source: Compiled from UNAIDS data (2010).

Target 6.B: 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 who have access to antiretroviral drugs

There were significant advances made in 2009 toward universal access to treatment, care and support services for those with advanced HIV infection in the continent. This was particularly encouraging, given the stagnation of global funding for HIV programs in low and middle-income countries. More people are now receiving antiretroviral therapy (ART) in Africa, as in all regions of the world, than at any previous time in the epidemic's history.

UNAIDS has estimated that nearly 37 percent of people eligible for treatment in Africa (excluding North

Africa) were able to access life-saving medicines in 2009. Three African countries – Botswana, Namibia, and Rwanda – achieved ART coverage of 80 percent or more (Box 6). However, seven high-prevalence countries (Cameroon, Côte d'Ivoire, Ghana, Mozambique, South Africa, Tanzania, and Zimbabwe) had ART coverage of less than 40 percent, and coverage for children was lower than that for adults.

The increased availability of ART, while commendable, exhibits potentially negative features of its own success. First, people with access to treatment live longer and so are more likely to transmit the virus. Second, the fiscal sustainability of ART in the future is not guaranteed due to three factors: (i) although the price of first-line treatment⁵⁶ has

⁵⁶ The first-line treatment recommended by WHO costs US\$ 139 or US\$ 158, according to the drugs used in the combination (source: WHO, 2011).

Box 6: Universal access to treatment and care is achievable: the case of Botswana

Botswana has experienced considerable success with its publicly funded ART program. In 2007, coverage of people living with HIV and AIDS and eligible for antiretroviral drugs (ARVs) ranged from 82 percent in the low-coverage areas to well over 90 percent in areas of high coverage. This is a significant improvement from only 7.3 percent in 2003 and 62.7 percent in 2005.

Botswana also has high ARV adherence rates, resulting in secondary resistance rates of less than 4 percent after eight years of ARV provision. Mortality and survival rates in Botswana rival those in developed countries, making Botswana the gold standard for ARV programming, particularly in Southern Africa, where prevalence rates are the highest in the world.

Botswana has also implemented a successful Prevention of Mother To Child Transmission (PMTCT) program. Coverage of this program rose from 34.3 percent in 2003 to 89 percent in 2007. Consequently, rates of transmission of HIV from mother to child dropped tenfold in six years, from more than 40 percent in 2001 to less than 4 percent in 2007. The government plans to ensure universal access to Highly Active Anti-Retroviral Therapy (HAART) for all pregnant women infected with HIV, with the aim of reducing the rate of incidence of children born with HIV to less than 1 percent.

Source: *Botswana National MDG Progress Report, 2010.*

sharply declined in Africa, it still represents a substantive proportion of health budgets; (ii) ART is mainly financed by donors (Global Fund, PEPFAR) in many countries, and (iii) a portion of patients need to shift to the more expensive⁵⁷ second-line treatment because they develop resistance to first-line treatment.⁵⁸

The benefits of ART are especially evident in Africa (excluding North Africa), where an estimated 320,000 (or 20 percent) fewer people died of AIDS-related causes in 2009 than in 2004, when ART began to be dramatically expanded. Evidence indicates that disease-specific donor funding,

through vertical funds, positively impacts rates of progress. Predictable and adequate funding to tackle HIV and AIDS focuses on the provision of free treatment, and has proven to be successful in the fight against the disease. Moreover, there has been a paradigmatic shift in funding, since treatment is no longer seen as separate to prevention in terms of budgetary allocation, it is now recognized that treatment enhances prevention.

⁵⁷ The second-line treatment recommended by WHO costs US\$ 908 or US\$ 1,025, according to the drug used in the combination (source: WHO 2011).

⁵⁸ Between 2007 and 2010, WHO conducted 15 surveys of HIV drug resistance in Burundi, India, Malawi, Mozambique, and Nigeria. These surveys concluded that 6 percent of patients developed resistance to one or more of the drugs of the first-line treatment after 12 months (source: WHO, 2011).

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

Malaria is still endemic in most African countries and represents a major cause of morbidity and mortality. Indeed, the high prevalence rates of malaria combined with weak capacity to respond to the threat is a principal cause of infant deaths. Overall, the picture is mixed regarding progress toward Target 6.C. Significant advancements have been recorded in a number of areas, such as a reduction in the tuberculosis (TB) death rate in Southern Africa and improved access to insecticide-treated bednets (ITNs) to prevent malaria. However, TB prevalence in West Africa is increasing and the continent overall is largely falling short of this target.

It is good news that international funding for malaria control has risen steeply during the past decade. Disbursements reached their highest ever levels in 2009 at US\$ 1.5 billion. However, new commitments for malaria control appear to have stagnated in 2010, at US\$ 1.8 billion. Unfortunately, the amounts committed to the fight against malaria, while substantial, still fall short of the resources required, which are estimated at more than US\$ 6 billion for the year 2010.

Indicator 6.6: Incidence and death rates associated with malaria

Data from the latest *World Malaria Report* (WHO, 2010a) indicate that, out of the 46 African countries with available data, only four (Cape Verde, Egypt, South Africa, and Swaziland) had less than 100 notified cases of malaria per 100,000 population. While there has been a reduction in malaria mortality in a number of countries in the region, including Ethiopia, Mozambique,

Rwanda, Tanzania, and Zambia, much more work remains to be done. The malaria death rate is still high in Africa (*Table 6*). Sixteen countries (Benin, Burkina Faso, Cameroon, Chad, Congo Republic, DRC, Equatorial Guinea, Guinea, Guinea-Bissau, Mali, Niger, Nigeria, Sierra Leone, The Sudan, Zambia, and Uganda) recorded more than 100 deaths per 100,000 population in 2008. On a more positive note, eight countries registered a rate of less than 10 deaths per 100,000 population, namely Botswana, Cape Verde, Djibouti, Egypt, Eritrea, São Tomé and Príncipe, South Africa, and Swaziland.

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

A scaling up of donor financing to combat malaria has significantly increased access to insecticide-treated bednets (ITNs) over the past three years. By the end of 2010, approximately 289 million ITNs had been delivered to Africa (excluding North Africa), which was sufficient to cover 76 percent of the 765 million persons at risk of catching the disease. However, more effort is required to ensure that ITNs reach all the households where they are needed and that they are used properly and consistently to ensure effectiveness, including significant reductions in the infant mortality rate.

Household surveys undertaken between 2007 and 2009 found that Equatorial Guinea, Ethiopia, Gabon, Mali, Rwanda, Senegal, São Tomé and Príncipe, Senegal, Sierra Leone, Togo, and Zambia had ITN household ownership rates of more than 50 percent. Moreover, the median percentage of children aged less than five years sleeping under an ITN in these countries was 45 percent. This percentage is still far below the World Health

Table 6: Malaria death rate per 100,000 population of all ages, 2008

Country	Deaths per 100,000 people	Country	Deaths per 100,000 people
Egypt	0	CAR	98
Cape Verde	1	Comoros	98
Djibouti	1	Cameroon	103
Eritrea	1	Sierra Leone	103
South Africa	1	Sudan	106
Swaziland	1	Zambia	107
Botswana	3	Benin	113
São Tomé & Príncipe	8	Congo Republic	120
Madagascar	17	Guinea	140
Namibia	19	Guinea-Bissau	142
Zimbabwe	33	Uganda	149
Rwanda	40	Equatorial Guinea	150
Ethiopia	44	Nigeria	151
Somalia	65	Niger	154
Burundi	73	DRC	156
Ghana	74	Burkina Faso	163
Malawi	75	Mali	176
Mauritania	80	Chad	181
Mozambique	80		
Kenya	81		
Gabon	83		
Senegal	83		
Tanzania	84		
Liberia	87		
Côte d'Ivoire	88		
Togo	88		
Angola	97		
Gambia	97		

Note: Data not available for Algeria, Lesotho, Libya, Mauritius, Morocco, Seychelles and Tunisia.

Source: WHO (2010a).

Assembly target of 80 percent, partly because of low access to ITNs in some of the largest African countries. Thus, more effort is needed to ensure that services reach households, especially the most vulnerable.

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

Information from manufacturers indicates that the number of Artemisinin-based Combination Therapy (ACT) courses provided to malaria patients has increased every year since 2005. By the end of 2009, 11 African countries were providing sufficient courses of ACTs to cover more than 100 percent of malaria cases seen in the public sector, while a further eight African countries delivered sufficient courses to treat 50–100 percent of cases. These figures represent a substantial increase since 2005, when only five countries were able to provide sufficient courses of ACT to cover more than 50 percent of patients treated in the public sector. However, information on access to treatment is generally incomplete, particularly for the significant proportion of patients treated in the private sector. Moreover, most of the countries that still allow the marketing of monotherapies (for which patients are prone to develop resistance) are located in Africa.

Indicator 6.9: Incidence, prevalence, and death rate associated with tuberculosis⁵⁹

The number of persons infected with TB continues to increase globally, while Africa experiences

incidence rates that are much higher than in other parts of the world (WHO, 2010b). The rate is particularly elevated in the Southern African subregion, where it is closely linked to high HIV and AIDS prevalence rates. Between 2005 and 2008, TB rates leveled off across all African subregions, except for East Africa, where it showed a slight decline (*Figure 42*).

Though TB poses a significant health risk to African populations, particularly in countries with high HIV and AIDS prevalence rates, a decline in TB prevalence rates in Central, East, Southern, and West Africa was recorded in 2004. More pronounced declines in prevalence rates were observed in Central and in East Africa, compared with other subregions (*Figure 43*).

Overall, it can be said that the death rate from TB is slowly decreasing across most of Africa. The exception is in West Africa, where it increased slightly from 2007 to 2008, making it the subregion with the highest rate of TB. The Southern African subregion has witnessed the best performance for this indicator, due to a sharp decline in South Africa's⁶⁰ TB death rate – from 220 deaths to 39 deaths per 100,000 over the 2006–2008 period (*Figure 44*).

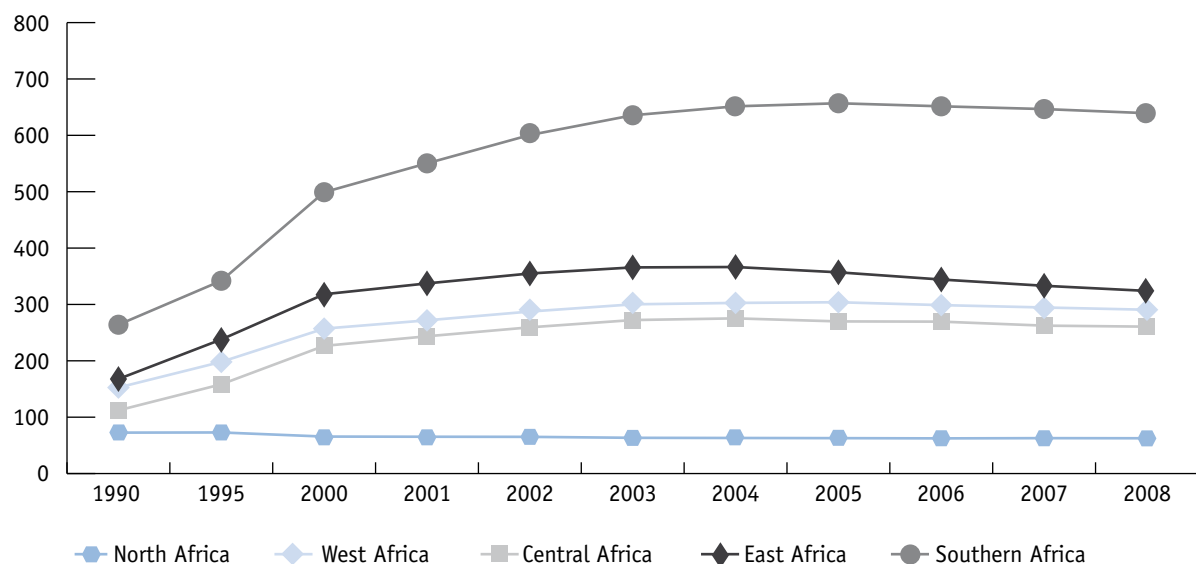
In order to fight malaria and TB effectively, and thus to accelerate progress toward Target 6.C, a number of issues across the whole health system have to be addressed. First, the funding, quality,⁶¹

⁵⁹ Incidence represents the number of new infections, while prevalence represents the total number of infections (old and new). Incidence is a better indicator of the evolution of the epidemic, as it accounts only for new infections, while prevalence also accounts for deaths related to the infection.

⁶⁰ Around 35 percent of the population of the Southern Africa subregion is made up of South African nationals.

⁶¹ WHO found that almost 30 percent of antimalarial medicines in six African countries were counterfeit and failed to meet international quality standards.

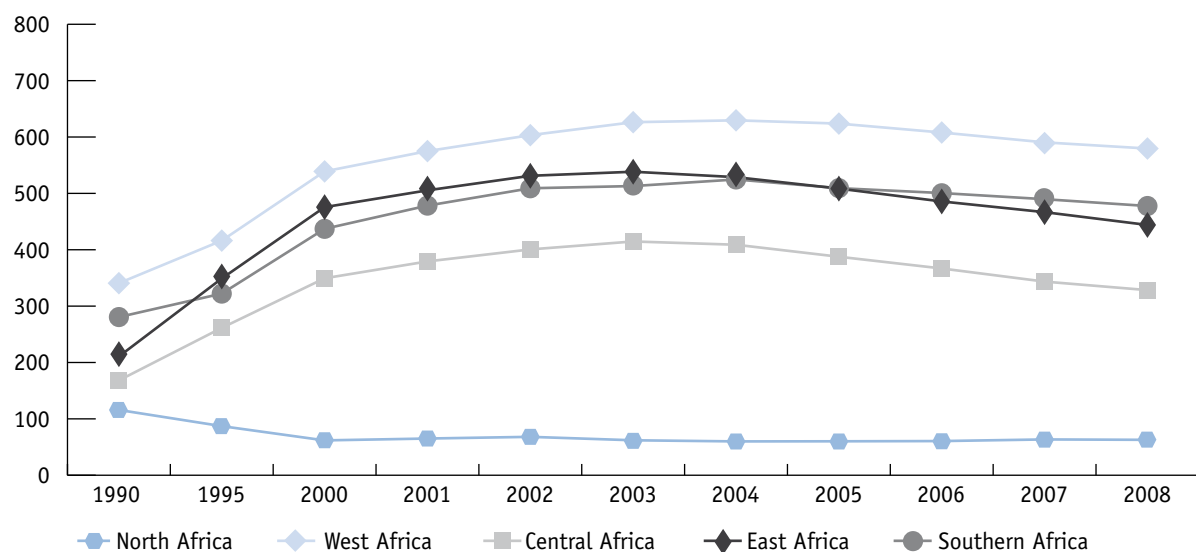
Figure 42: Tuberculosis incidence rate per 100,000 population by African subregion, 1990–2008



Source: Compiled from UNSD data (updated in June 2010).

Note: For the purposes of subregional analysis, the data are weighted by population size.

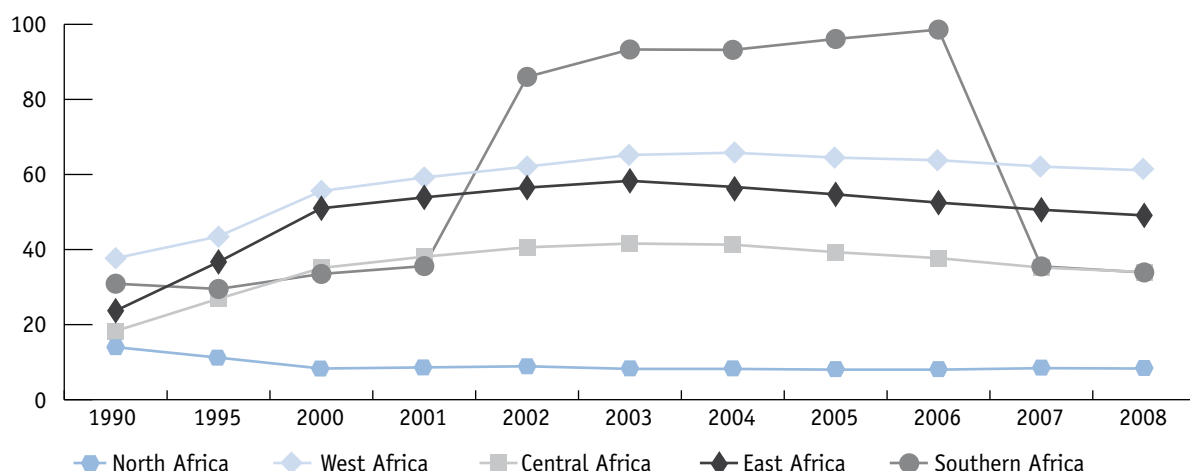
Figure 43: Tuberculosis prevalence rate per 100,000 population by African subregion, 1990–2008



Source: Compiled from UNSD data (updated in June 2010).

Note: For the purposes of subregional analysis, the data are weighted by population size.

Figure 44: Tuberculosis death rate per 100,000 population by African subregion, 1990–2008



Source: Compiled from UNSD data (updated in June 2010).

Note: For the purpose of subregional analysis, the data are weighted by population size.

and efficacy⁶² of medicines need to be better monitored. In particular, laboratory capability for malaria diagnosis, TB culture, and Directly Observed Short-Course Treatment (DOTs) is weak and needs to be strengthened.

Second, human resources in the sector are still insufficient to address the African health burden, in terms of numbers, skills, and remuneration. For example, WHO estimates that the minimum recommended health workforce density to achieve the health-related MDGs is 2.5 health workers per 1,000 population. However, for the Africa region, the average health workforce density is estimated at 0.8 workers per 1,000 population.

⁶² Resistance is a big challenge for TB treatment. There are several causes, including inadequate treatment regimes, inadequate dosage, poor quality drugs, over-the-counter medications, and poor adherence to treatment.

Finally, public health partnerships with the private sector need to be enhanced and better monitored. The situation is especially pressing because a significant part of the population seeks care from the private sector with over-the-counter medicines and monotherapies that can lead to resistance, yet regulatory mechanisms are not in place to address this problem. As a result, comprehensive monitoring of program performance remains a challenge.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Environmental preservation is an essential foundation for sustainable development and poverty alleviation. As such, failure to achieve biodiversity stability will undermine social and economic development efforts. Furthermore, forests play a critical role in sustaining the health of the environment by

mitigating climate change, conserving biological diversity, maintaining clean and reliable water resources, controlling erosion, protecting agricultural soils, providing low-cost and renewable energy, and enhancing the urban environment. It is a sad indictment of our global society that uncontrolled exploitation of natural resources such as forests, land, water, and fisheries – often by the powerful few – has caused alarming changes to our natural world in recent decades. This has proved especially harmful for the most vulnerable people in the world, who depend on natural resources for their livelihood (ECA, 2010b).

The overall situation for MDG 7 is that most countries seem committed, in principle, to achieving the goal of environmental sustainability, but progress is slow in meeting the targets. Greenhouse gas emissions are still rising and only a few countries have achieved substantial reductions. Difficulties are being experienced in meeting the biodiversity target, as only a small number of countries have made headway in protected area coverage.

Advances are being made in access to improved water sources, but access to improved sanitation is still a challenge in most countries, especially for the rural populations. The struggle to meet MDG 7, and indeed other MDGs in Africa, is exacerbated by the threat of climate change and its potential impacts on ecosystems, water supply, and the degradation of biodiversity.

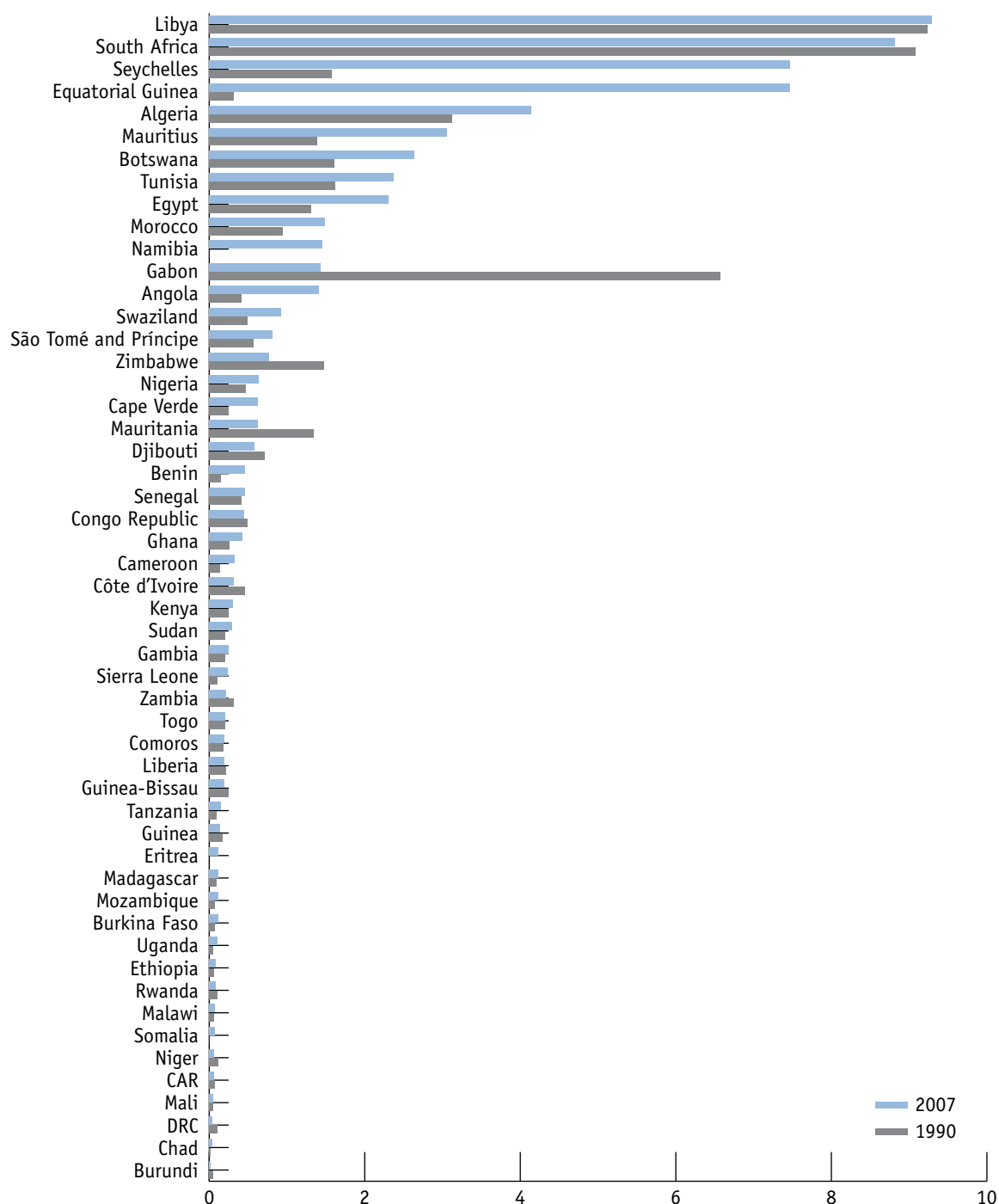
Most data for the four targets composing Goal 7 are either not available at the country level or have not been updated since the *2010 MDG Progress Report*. In this respect, the assessment of progress for this Goal will only cover indicators where data are available and have been updated.

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

Indicator 7.2: CO₂ emissions, total, per capita, and per US\$ 1 GDP (PPP)

Emissions from all fuel sources have increased on the African continent over time, with liquid and solid fuels each accounting for approximately 36 percent and gas fuels accounting for 16.3 percent of the region's total emissions (Boden et al., 2010). It should be noted, however, that Africa is a very small contributor to world CO₂ emissions (less than 4 percent). A few countries (Algeria, Egypt, Libya, Morocco, Nigeria, and South Africa) account for most of the emissions from fossil fuels. In 36 African countries, CO₂ emissions increased between 1990 and 2007 and among these, three countries – Equatorial Guinea (7.1 percent), Seychelles (5.9 percent), and Mauritius (1.7 percent) – recorded substantial increases. On the other hand, 16 countries registered reductions, with Gabon significantly reducing CO₂ emissions by 5.1 metric tons per capita between 1990 and 2007 (*Figure 45*).

Some African countries (e.g., South Africa and Zambia) have introduced carbon tax policies as a way of reducing their carbon footprint. The tax is levied on vehicles that cannot produce certified CO₂ vehicle emissions data, and is largely based on vehicle engine size. This demonstrates that regulatory interventions and environmental taxes can be introduced at the national level as a mechanism to shore up environmental sustainability.

Figure 45: Metric tons of CO₂ emissions per capita (CDIAC), 1990 and 2007

Source: Compiled from UNSD data (updated in June 2010).

The African Development Bank (AfDB) has introduced a Clean Energy Investment Framework ⁶³ aimed at increasing energy access on the African continent, while at the same time shifting the balance in favor of clean energy, low carbon development options. This takes account of the fact that the continent has vast renewable resources, including hydro-potential (estimated around 1,750 terawatt hour), geothermal (estimated at 9,000 megawatts), wind and solar power. Furthermore, renewable sources of energy are not only the best option to respond to the needs of Africa's large rural population, but also they can provide the necessary scale to avoid reliance on costly, small-scale, oil-based generation.

Indicator 7.3: Consumption of ozone-depleting substances (ODSs)

This indicator tracks progress toward phasing out ozone-depleting substances (ODSs), under the schedules defined by the 1987 Montreal Protocol on Substances that Deplete the Ozone Layer and its later Amendments. Globally, the Montreal Protocol has proved a great success, as evidenced by a 98 percent reduction in the consumption of ODSs between 1986 and 2008. ⁶⁴

In Africa the consumption of ODSs also declined markedly in a majority of countries between 1996

and 2008 (*Table 7*). The integration of sustainable development into national policy frameworks, as well as the strengthening of the global partnership for development, were factors contributing to this progress. Most African countries have managed to reduce the consumption of ODSs by cutting down on imports of ODS-associated substances. For example, South Africa has reduced its imports of halons and chlorofluorocarbons (CFCs) and has almost completely phased out the use of ODSs, for example in aerosol spray-can propellants.

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

Indicator 7.6: Proportion of terrestrial and marine areas protected

The International Union for the Conservation of Nature (IUCN) defines a protected area as "a clearly defined geographical space, recognized, dedicated and managed, through legal or other effective means, to achieve the long-term conservation of nature with associated ecosystem services and cultural values." Protected area coverage targets set by the Convention on Biological Diversity (CBD) for both terrestrial (10 percent by 2010) and marine (10 percent by 2012) environments provide a major incentive for countries to review and upgrade their protected area systems and track their progress.

⁶³ The AfDB's Clean Energy Investment Framework (CEIF) was approved by its Board in March 2008. It complements the Bank Group's Climate Risk Management and Adaptation Strategy (CRMA), which aims to reduce vulnerability within its regional member countries (RMCs) to climate variability and to promote climate resilience in Bank-financed development projects and programs. It also aims to build capacity and knowledge in its RMCs to address the challenges of climate change and to ensure sustainability through policy and regulatory reforms.

⁶⁴ UN (2010, p. 54).

Table 7: Consumption of ozone-depleting substances in Ozone Depletion Potential (ODP) metric tons, 1996 and 2008

Country	1996	2008	Country	1996	2008
Nigeria	5,111.1	312.7	Eritrea	43.2	3.1
Egypt	2,944.9	726.2	Mozambique	42.4	4.9
Algeria	2,654.5	236.9	Burkina Faso	41.8	27.2
Libya	1,498.7	111.6	Mauritius	37.7	6.9
Morocco	1,465.0	212.7	Chad	35.0	21.5
Tunisia	1,011.1	59.2	Namibia	33.9	5.8
DRC	960.4	16.6	Togo	33.7	9.4
Zimbabwe	901.3	37.3	Rwanda	30.4	2.9
South Africa	798.5	435.1	Guinea-Bissau	26.3	2.2
Sudan	436.4	91.9	Swaziland	23.8	3.3
Kenya	410.6	75.7	Madagascar	23.5	3.0
Côte d'Ivoire	394.5	24.1	Djibouti	21.5	1.5
Cameroon	333.5	36.1	Gambia	21.0	0.5
Senegal	298.4	19.5	Congo Republic	18.9	2.0
Tanzania	297.5	15.4	Niger	18.1	3.1
Somalia	259.4	28.3	Uganda	15.8	0.0
Malawi	181.3	6.7	Ghana	15.7	21.6
Angola	114.8	20.2	Gabon	13.5	5.2
Mali	111.6	5.1	Mauritania	7.8	6.5
Sierra Leone	111.5	5.8	Botswana	6.7	13.6
Liberia	89.0	3.4	Lesotho	6.6	11.6
Zambia	60.9	6.9	CAR	6.5	6.7
Equatorial Guinea	60.8	8.1	São Tomé and Príncipe	4.3	0.2
Benin	59.0	6.0	Seychelles	2.4	0.6
Burundi	58.8	1.0	Comoros	2.3	0.2
Guinea	52.4	2.7	Cape Verde	2.3	0.8
Ethiopia	47.7	4.3			

Source: UNSD data (updated in August 2010).

Table 8: Proportion of terrestrial and marine areas protected to total territorial area, 1990 and 2009 (%)

Country	1990	2009
Djibouti	0.1	0.1
Libya	0.1	0.1
Somalia	0.3	0.3
Lesotho	0.5	0.5
Mauritius	0.4	0.7
Seychelles	0.9	0.9
Mauritania	1.1	1.1
Tunisia	1.2	1.3
Gambia	1.2	1.3
Morocco	1.1	1.5
Madagascar	1.7	2.4
Mali	2.3	2.4
Cape Verde	2.5	2.5
Comoros	0.0	2.7
Swaziland	3.0	3.0
Sudan	4.7	4.8
Burundi	3.8	4.9
Eritrea	4.9	5.0
Sierra Leone	5.0	5.0
Liberia	5.1	5.1
Egypt	2.1	6.1
Algeria	6.2	6.3
Guinea	6.8	6.8
South Africa	6.2	6.8
Niger	6.8	6.8
Congo Republic	4.7	8.5
Cameroon	6.9	9.0

Country	1990	2009
Chad	9.4	9.4
Uganda	7.3	9.7
DRC	10.0	10.0
Rwanda	9.9	10.0
Togo	11.3	11.3
Kenya	11.4	11.6
Angola	12.1	12.1
Nigeria	11.3	12.6
Ghana	13.3	13.3
Burkina Faso	13.4	13.9
Namibia	13.9	13.9
Equatorial Guinea	5.0	14.0
Gabon	3.9	14.3
CAR	14.4	14.7
Mozambique	13.8	14.8
Malawi	15.0	15.0
Ethiopia	17.7	18.4
Côte d'Ivoire	21.8	21.8
Senegal	23.1	23.5
Benin	23.8	23.8
Guinea-Bissau	5.8	26.9
Tanzania	25.7	27.0
Zimbabwe	18.0	28.0
Botswana	30.3	30.9
Zambia	36.0	36.0

Source: UNSD data (updated June 2010).

In the period 1990–2009, 34 countries registered improvements in the proportion of terrestrial and marine areas protected. By 2009, a total of 23 countries had reached the target of having at least 10 percent of their territorial and marine areas protected, compared to 19 countries in 1990 (*Table 8*). Four countries that made noteworthy progress over the 1990–2009 period were Guinea-Bissau (from 5.8 percent to 26.9 percent protected areas), Equatorial Guinea (from 5.0 percent to 14.0 percent), Gabon (from 3.9 percent to 14.3 percent), and Zimbabwe (from 18.0 percent to 28 percent).

Target 7.C: 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

Although the population with access to safe drinking water increased from 56 percent in 1990 to 65 percent in 2008, the rate of progress is insufficient for the continent to reach the target by 2015 (*Table 9*). Access to an improved water source in rural areas increased from 40 percent in 1990 to 53 percent in 2008, while access in urban areas stagnated between 1990 and 2008 at 86 percent. The situation is exacerbated by rapid urbanization, linked to the growth of slums.

Table 9: Proportion of population using an improved drinking water source, 1990 and 2008 (%)

Population	1990	2008
Urban	86	86
Rural	40	53
Total	56	65

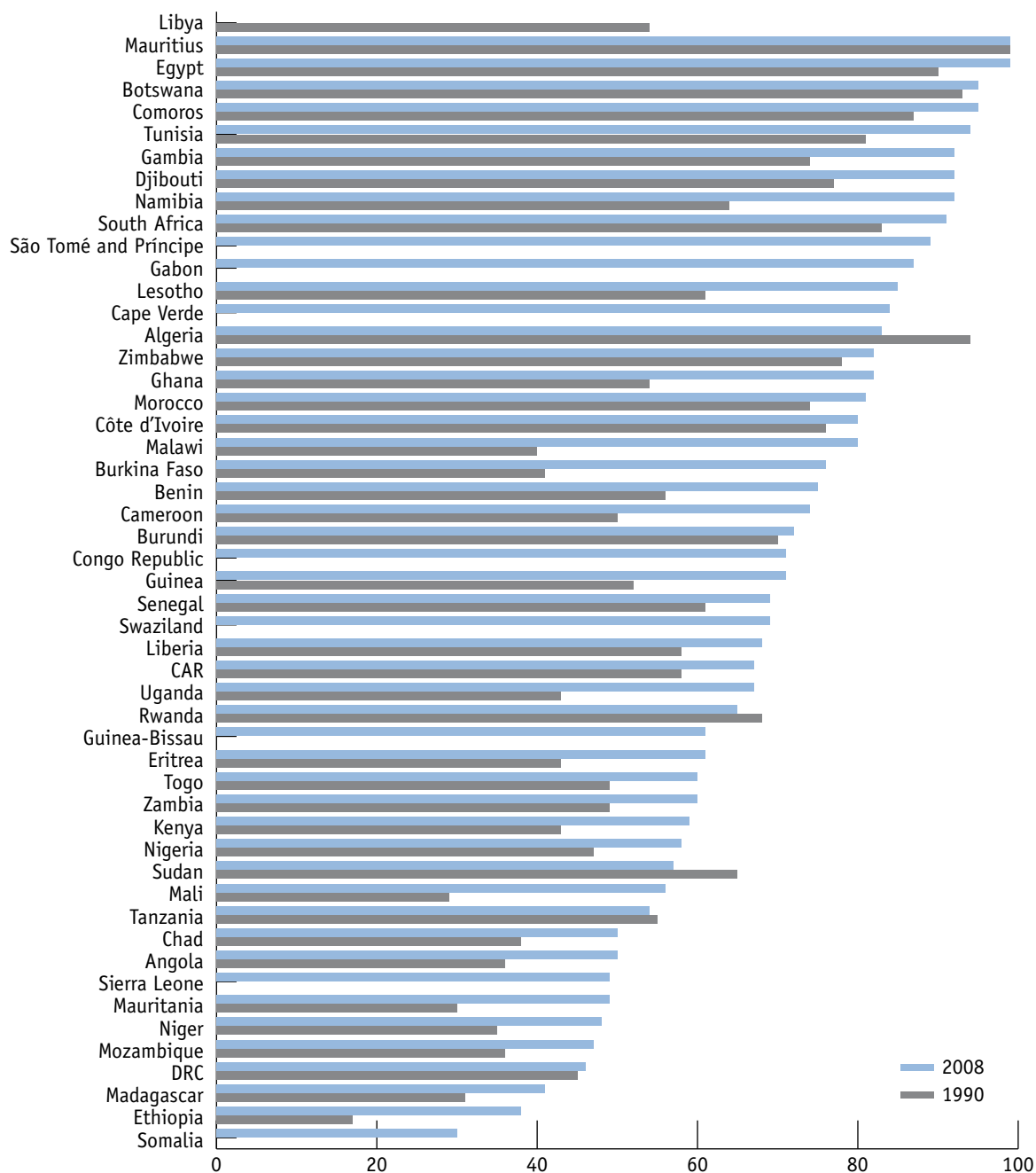
Source: UNSD (updated June 2010).

Between 1990 and 2008, a total of 37 of the 42 countries with data registered improvements of varying magnitudes in water coverage rates. However, four countries (Algeria, Rwanda, The Sudan, and Tanzania) registered declines, and in Mauritius the rate remained unchanged (*Figure 46*). Trends for this indicator reveal sharp urban-rural disparities in access, with rural dwellers having relatively less access to improved water facilities. Progress on this indicator has largely been driven by the urban sector. This can be attributed to water sector reforms which have been implemented in a number of countries. These reforms by and large have involved to some extent the private sector, but equity considerations in access to water supplies have not been adequately addressed (ECA, 2009a).

Urban coverage – improved water supply

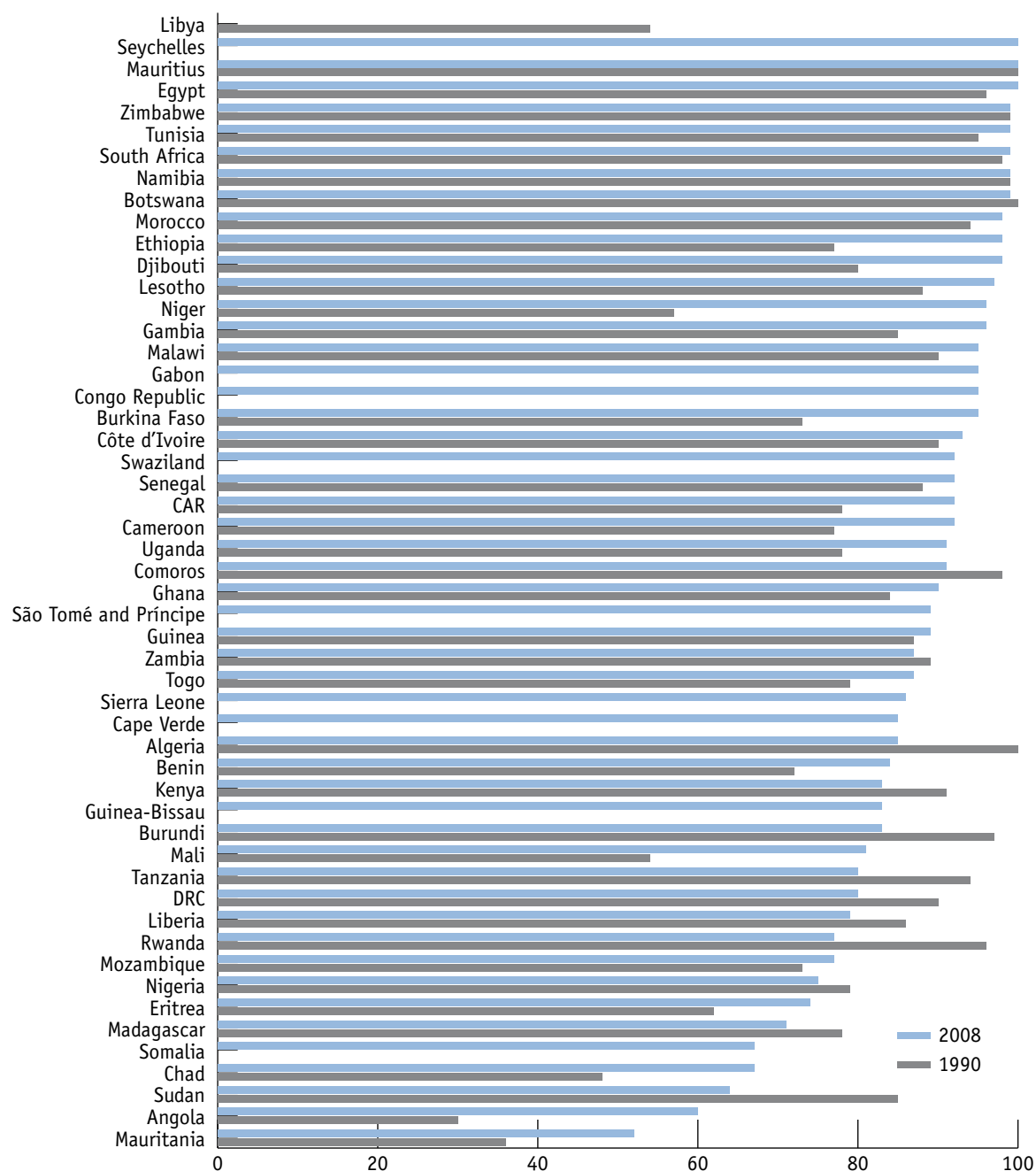
The percentage of the urban population with access to an improved water source ranged from 52 percent (Mauritania) to 100 percent (Egypt, Mauritius, and Seychelles) in 2008. In 1990, 26 countries had at least 80 percent coverage to an improved water supply in urban areas, compared to 40 countries in 2008. The worst-performers in 1990 were Angola, Chad, and Mauritania, which had urban coverage of less than 50 percent. However, by 2008 no country had a coverage rate of less than 50 percent in urban areas (*Figure 47*).

Figure 46: Progress on access to an improved water source – urban and rural (% of total population), 1990–2008



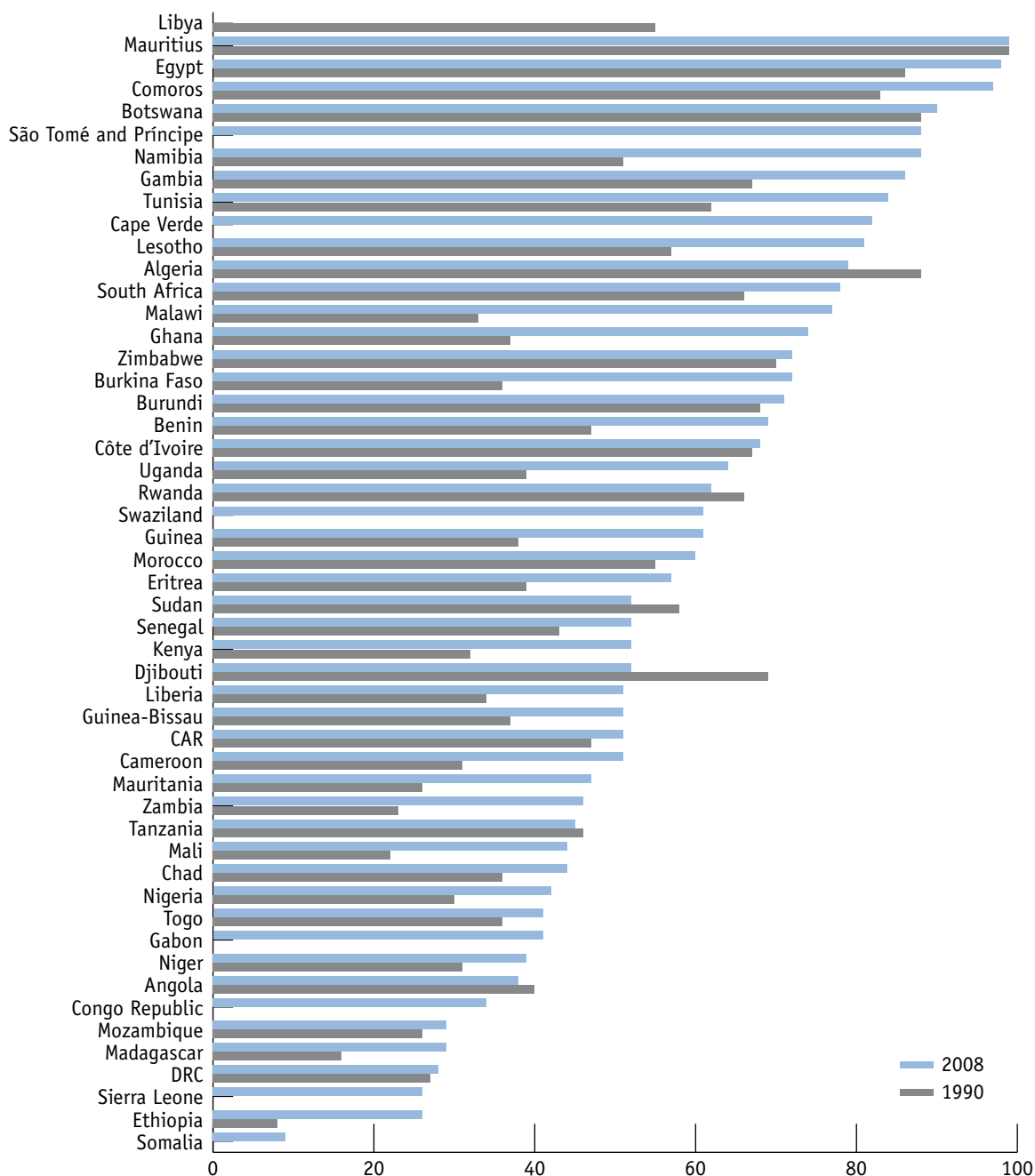
Source: Compiled from UNSD data (updated in June 2010).

Figure 47: Progress on urban access to an improved water source (% of urban population), 1990 and 2008



Source: Compiled from UNSD data (updated in June 2010).

Figure 48: Progress on rural access to an improved water source (% of rural population), 1990 and 2008



Source: Compiled from UNSD data (updated in June 2010).

Rural coverage – improved water supply

The number of countries with coverage rates to an improved water supply of 80 percent or more in rural areas increased from six countries (Algeria, Botswana, Comoros, Egypt, Equatorial Guinea, and Mauritius) in 1990 to 10 countries (Botswana, Cape Verde, Comoros, Egypt, The Gambia, Lesotho, Mauritius, Namibia, São Tomé and Príncipe and Tunisia) in 2008. The coverage rates of less than 50 percent in rural areas decreased from 26 countries in 1990 to 17 countries in 2008. There was a wide variation between countries for this indicator, from just 9 percent for Somalia to 99 percent for Mauritius (*Figure 48*).

Indicator 7.9: Proportion of population using an improved sanitation facility

The use of improved sanitation facilities is generally low in Africa, at just 41 percent in 2008. This means that it has increased by only 5 percentage points over a period of 20 years (from 36 percent in 1990). Two of the key constraints to improved sanitation are the high cost of infrastructural work and the low returns to investment for the private sector. The latter consideration helps to explain why public–private partnerships are rare in the sanitation sector. It is estimated that 242 million people were using improved sanitation facilities in 2006, so to increase this to 66 percent of the African population (to meet Target 7.C), African countries would need to extend such facilities to an additional 370 million people.

There are stark disparities between rural and urban areas in relation to this indicator. In urban areas, the proportion of population using an improved sanitation facility was 58 percent in 1990, which declined slightly to 56 percent in 2008. This may

be attributed to the high percentage of slum dwellers and a rapidly expanding urban population. Populations in rural areas continued to have lower access to improved sanitation than those in urban areas. However, the rate of progress in rural areas was greater – rising from 26 percent in 1990 to 32 percent in 2008 (*Table 10*). The percentage of the population using improved sanitation facilities in rural areas ranged from 3 percent (Togo) to 96 percent (Libya) in 2008 (*Figure 50*). In urban areas the range was from 15 percent (Madagascar) to 98 percent (Algeria) (*Figure 51*).

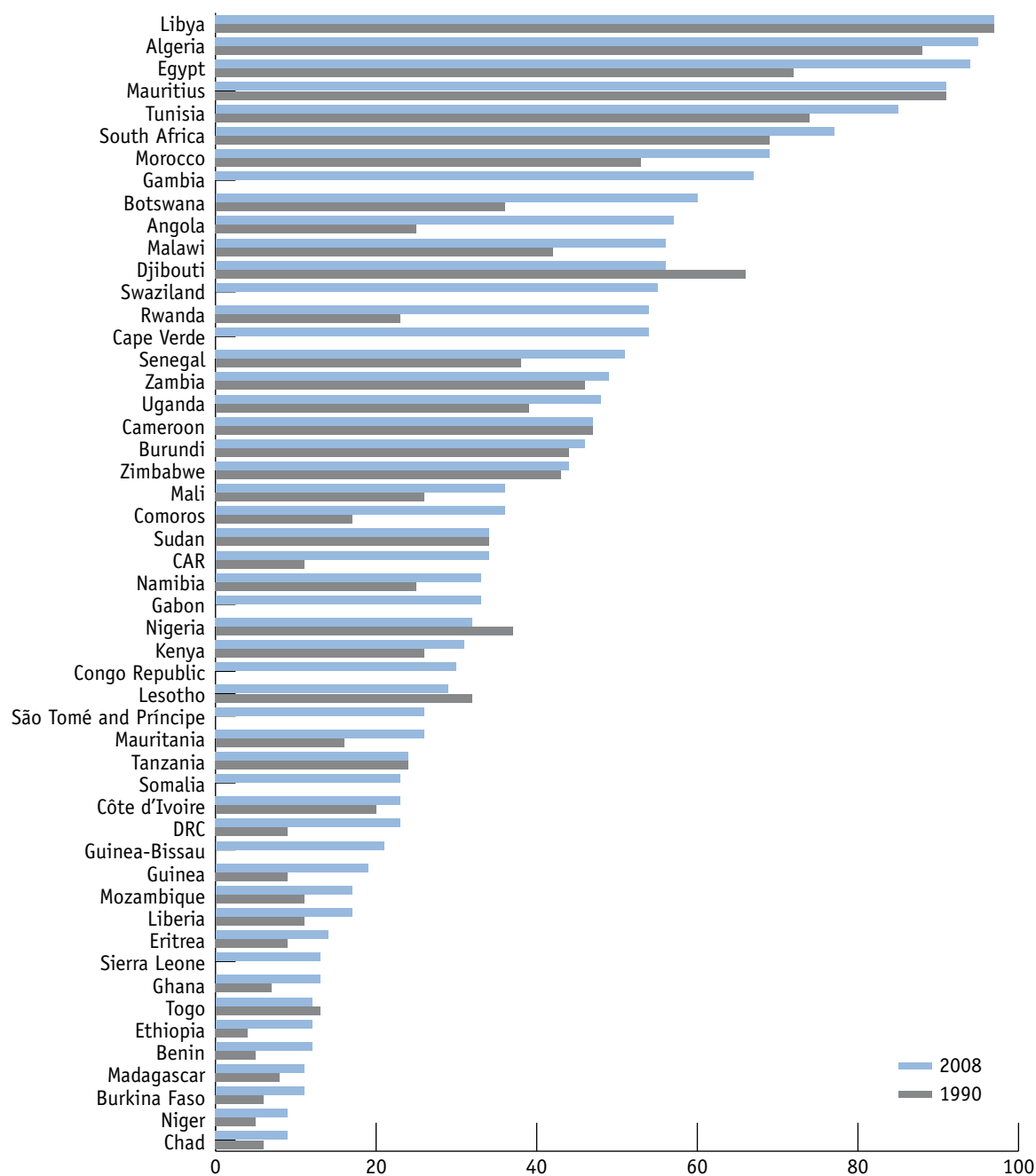
Overall, the majority of the countries (33 of 43 countries where data are available) registered improvements of varying magnitudes in the access to improved sanitation facilities. Only four countries (Djibouti, Lesotho, Nigeria, and Togo) registered regressions. Progress in five countries (Cameroon, Libya, Mauritius, The Sudan, and Tanzania) stalled, recording no improvements over the 1990 levels (*Figure 49*).

Table 10: Proportion of populations using an improved sanitation facility, 1990 and 2008 (%)

Population	1990	2008
Urban	58	56
Rural	26	32
Total	36	41

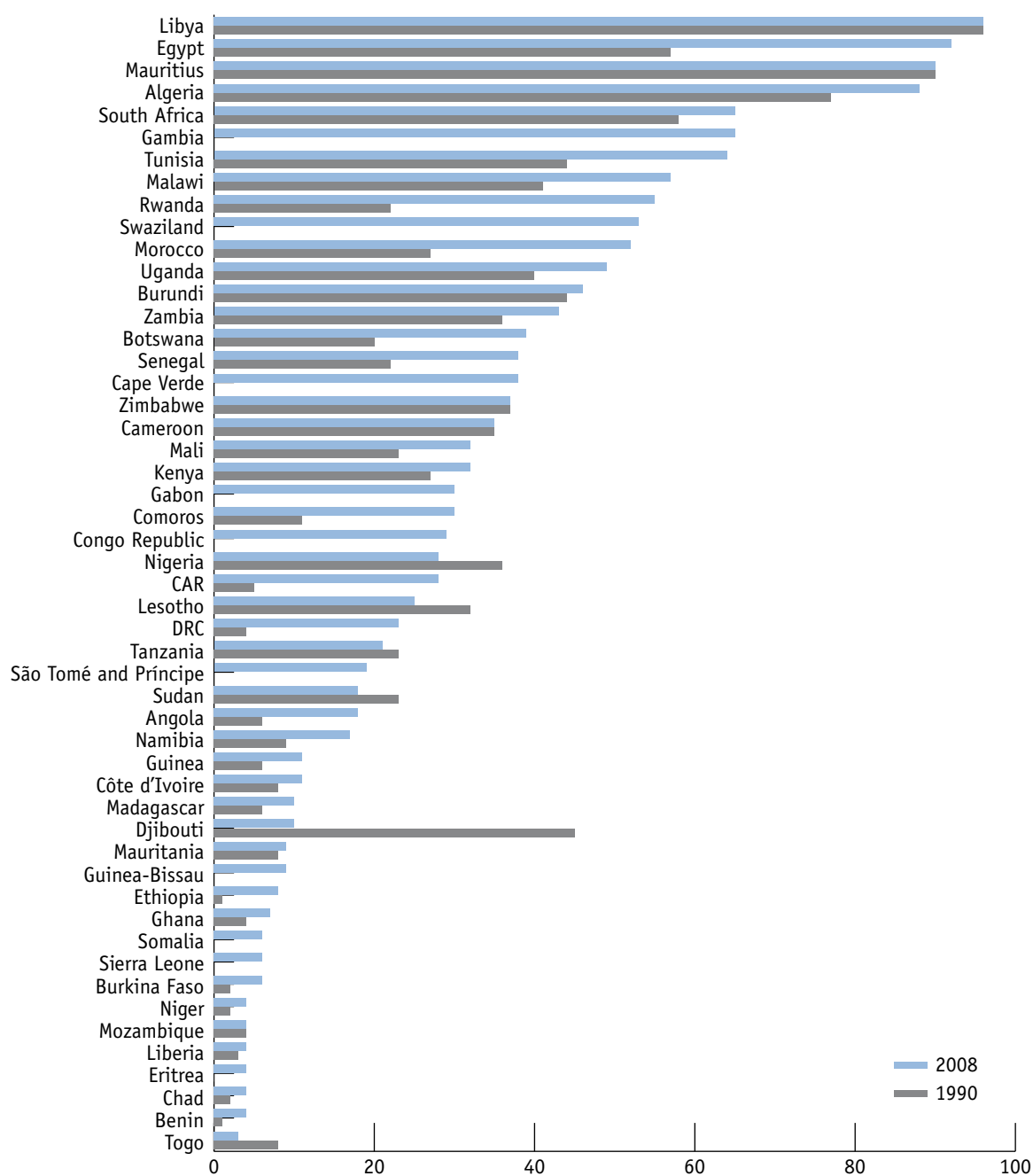
Source: OECD (2010).

Figure 49: Progress on access to improved sanitation facilities – urban and rural (% of total population), 1990 and 2008 (%)



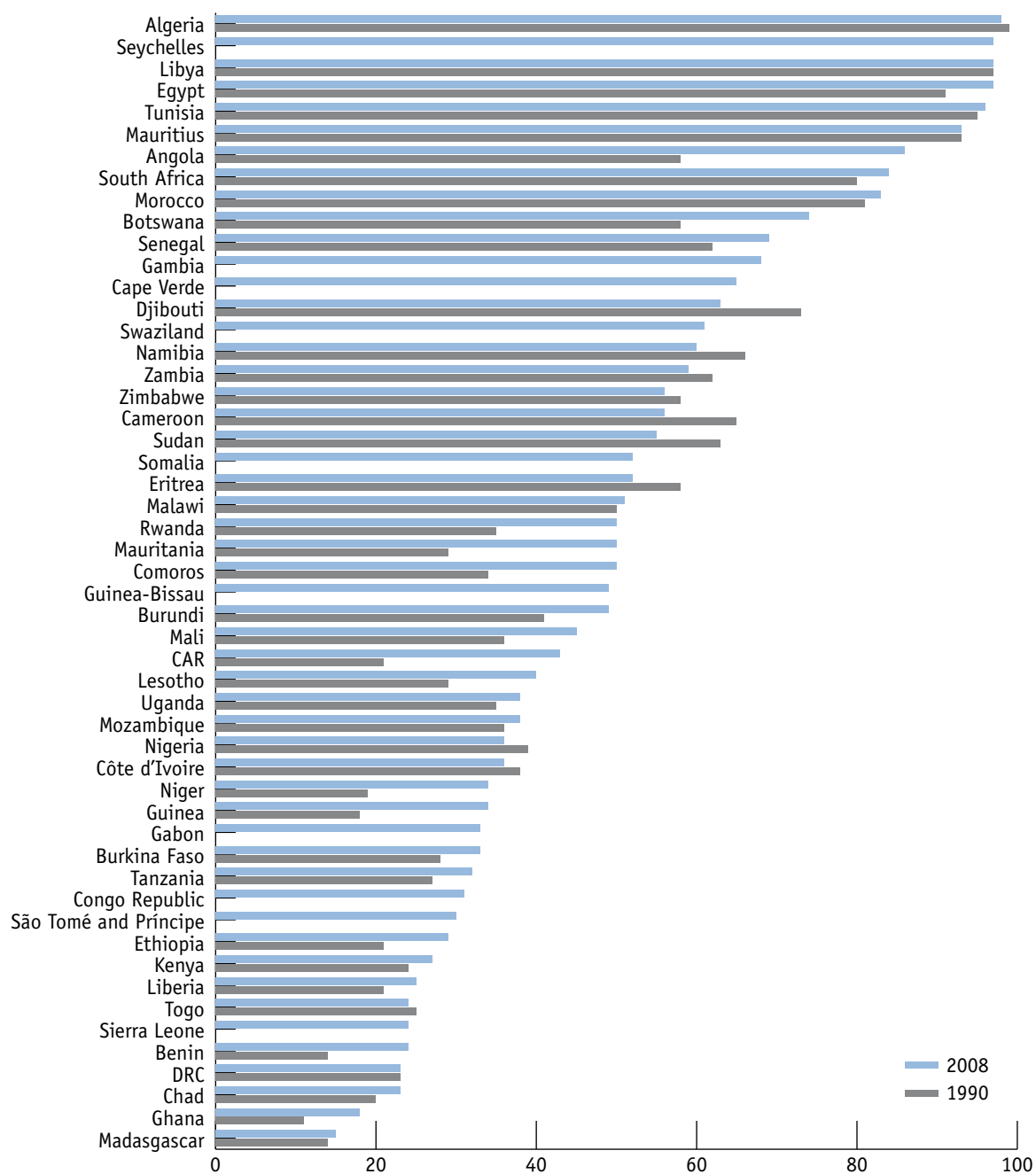
Source: Compiled from UNSD data (updated in June 2010).

Figure 50: Progress on rural access to improved sanitation facilities (% of rural population), 1990 and 2008

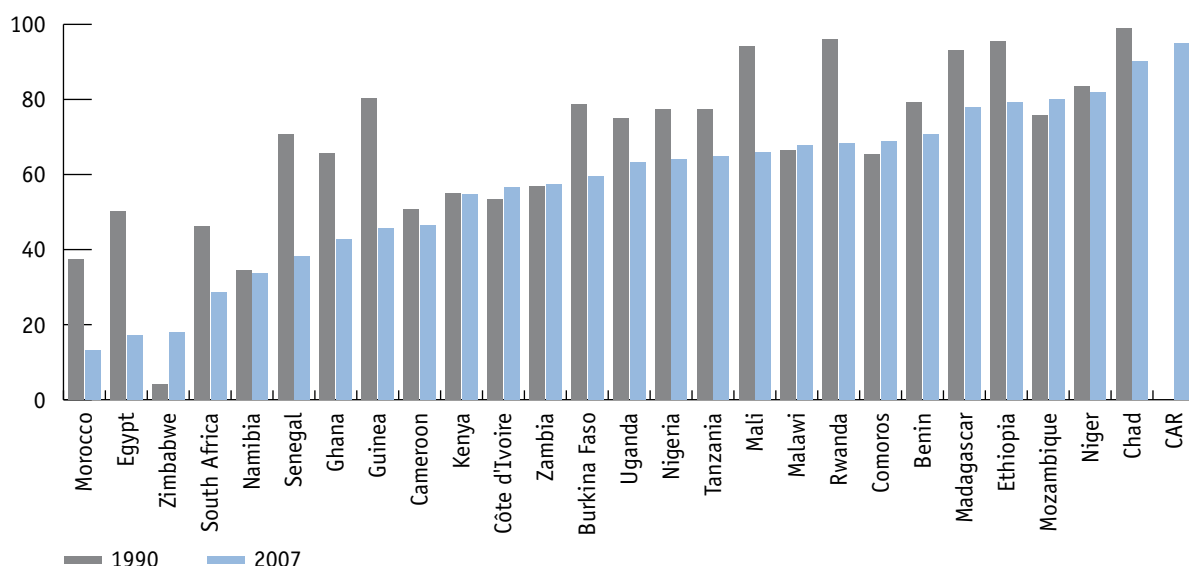


Source: Compiled from UNSD data (updated in June 2010).

Figure 51: Progress on urban access to improved sanitation facilities as (% of urban population), 1990 and 2008



Source: Compiled from UNSD data (updated in June 2010).

Figure 52: Slum population as % of urban population (selected countries), 1990 and 2007

Source: Compiled from UNSD data (updated in June 2010).

Social equity considerations have to be factored in when discussing the slow rate of progress toward improved sanitation access. According to an ECA study (ECA, 2009b) of 11 African Least Developed Countries (LDCs), countries such as Zambia, Niger, and Rwanda have witnessed a dramatic spread of unequal access. The study showed greater access to improved sanitation by wealthier populations, to the detriment of the poor. On a positive note, countries such as Uganda and Malawi, which have integrated a water and sanitation policy into their National Development Plans/Poverty Reduction Strategies, have made considerable progress toward more equitable water and sanitation coverage.

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

Indicator 7.10: Proportion of urban population living in slums

Africa has the largest slum population worldwide, with 211.3 million persons (or 75 percent of its urban population) living in slum areas. In North Africa, 13.3 percent of its population lives in slums, but in the rest of the continent the proportion is much higher, at 61.7 percent (UN-Habitat, 2010). In terms of progress, the lives of 24 million slum dwellers have improved during the last decade through improvements in housing conditions and better access to amenities such as water supply and sanitation (see earlier discussion on Indicators 7.8 and 7.9). However, there has been a reduction of only 5 percent in the number of slum residents in Africa (excluding North Africa).

North Africa, on the other hand, has made the greatest progress by improving the lives of 8.7 million, or 34.9 percent, slum dwellers (UN-Habitat, 2010).

At the country level, the trend shows that of the 27 African countries with available data for both 1990 and 2007, Egypt, Senegal, Guinea, Mali, and Rwanda made the most progress in reducing their urban slum populations by more than 25 percentage points during this time span. However, in CAR, Comoros, Côte d'Ivoire, Malawi, Mozambique, Zambia, and Zimbabwe the proportion of the urban population living in slums increased over the period 1990–2007. A number of countries (CAR, Chad, Ethiopia, Madagascar, Mozambique, and Niger) still exhibit high (over 75 percent) proportions of urban population living in slum areas, while countries such as Morocco and Egypt, which have made substantial progress on this indicator, now have less than 20 percent (*Figure 52*). This narrowing of the urban divide in Morocco and Egypt accounts for two-thirds of North Africa's progress.

Africa's high rate of urbanization is one of the most challenging aspects hampering improvement to the lives of slum dwellers. In this respect, African countries need to adopt a two-pronged approach: (i) to devise policies and strategies to transform slum areas and improve the lives of people living there and (ii) to take measures to prevent the formation of new informal settlements. In regard to the second approach, municipalities need to adopt long-term policies that address the root causes of slums, such as rural-to-urban migration. There is need for strong political will, increased financial resources, as well as strategic urban planning that integrates public–private partnerships, so that the needs of the poor will be met (UN-Habitat, 2010).

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT⁶⁵

International cooperation and global partnerships are critical for achieving the MDGs. Official Development Assistance (ODA) to Africa remains far below the 0.7 percent commitment made by development partners at the Gleneagles Group of Eight (G-8) Summit in 2005. Goal 8 is predicated on continuing close partnerships between development partners and developing countries. Notwithstanding, new South–South cooperation with emerging nations presents an opportunity for growth and development and should be harnessed for the achievement of MDGs in Africa.

The importance of Information and Communication Technology (ICT) for reaching the MDGs cannot be overemphasized. Africa lags behind all other regions in the use of ICT. The high cost associated with broadband connectivity in Africa has implications for the absorption of ICTs by African countries and this should be addressed in order to improve access. Overall, progress toward Goal 8 remains sluggish and more effort is needed to reap the full benefits of global partnerships.

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

Global recovery has been high on the agenda of various international forums since the onset of the 2007/08 global financial and economic crisis. These discussions continued through 2010 and were aimed at ensuring a sustainable recovery. Notable among these were the G-20 Summits,

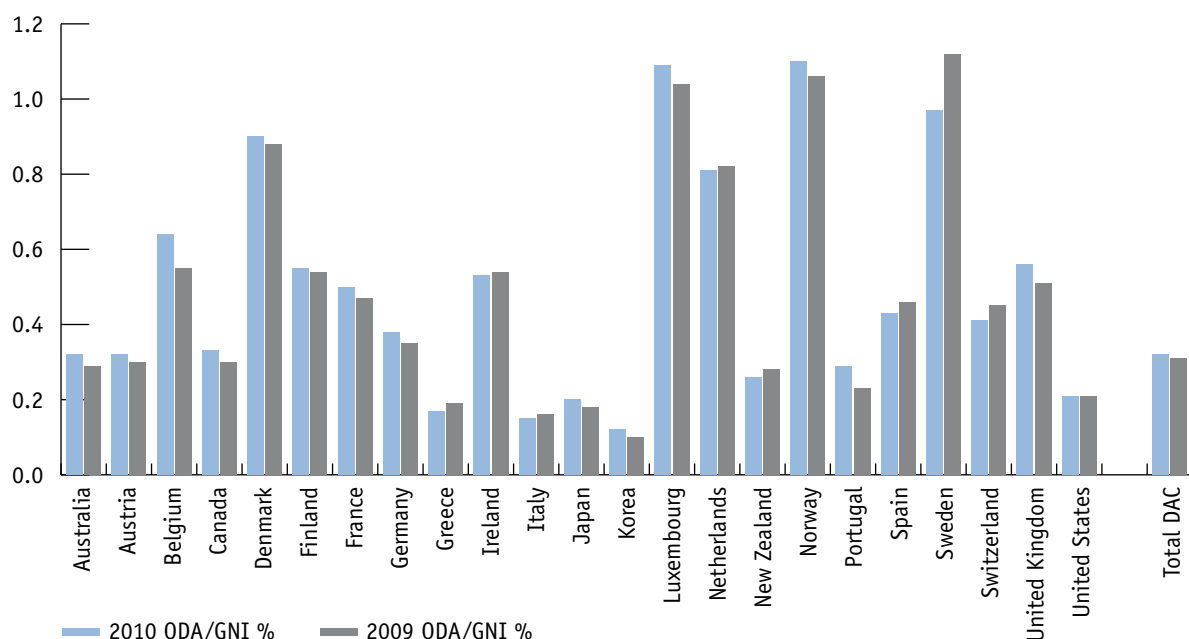
⁶⁵ Data for some of the indicators for Goal 8 have not been updated since the 2010 MDG Report and focus on this Goal will be on those indicators where data have been updated and are available for most countries.

including the November 2010 Summit, which resulted in the Seoul Action Plan. This strongly reaffirmed the need for robust, sustainable, and balanced growth, and the members reaffirmed their commitment to avoid trade protectionism. Nonetheless, there have been signs of growing protectionist pressures resulting from disorderly currency rate movements. This could have a negative impact on the global economy, which will further threaten Africa's economic growth. Furthermore, there was a focus on removing significant bottlenecks to attain sustainable and resilient growth. The *Global Monitoring Report* (World Bank and IMF, 2011) highlights some important measures to help integrate the poorest developing countries into the global trading system: (i) extending duty and quota-free access to the exports of these countries; (ii) providing financial and technical assistance to improve trade facilitation; and (iii) simplifying the rules of origin in preferential trade agreements.

With respect to the World Trade Organization (WTO) Doha Development Round, the G-20 envisioned 2011 as a window of opportunity. Negotiations toward a successful conclusion of the Round have intensified among members of the WTO across all areas. The potential outcome will depend largely on the conduct of these negotiations. If the enthusiasm so far observed in the engagement of the various stakeholders is anything to go by, the Doha Development Round should be brought to a positive, ambitious, comprehensive, and balanced conclusion as envisaged by the G-20 Leaders. There is a sense of wider and greater engagement and focus in the Negotiating Groups. However, lack of progress in key areas of the negotiations could pose a risk towards a successful closure to the talks.

The growth and consolidation of South–South linkages (particularly between Africa and its emerging partners China, India, and Brazil) over the past few years has important implications for Africa's development. South–South trade increased substantially from US\$ 0.5 trillion in 1990 to US\$ 2.9 trillion in 2008, representing 19 percent of global trade (OECD, 2010). African countries have failed, however, to take full advantage of this shift to improve their trade balance. An imbalance was reported in 2008, with Africa importing more from Asian countries than it exported to them. The continent needs to seize the potential for investment, trade, and technology transfers that South–South cooperation is offering. Efforts toward regional integration, aimed at reducing trade barriers and costs associated with border regulations, have to be intensified to ensure that Africa fully benefits from South–South trade. Moreover, as UNCTAD's *Economic Development Report 2010* emphasizes, Africa should manage its evolving relationships in a manner that supports and enhances technological progress, capital accumulation, and structural transformation in the region.

Negotiations on Economic Partnership Agreements (EPAs) between African countries and the European Union (EU) are continuing, but with little progress being made. In Central Africa, discussions center on issues of market access, rules of origin, and accompanying measures, among others. Only one country in Central Africa, namely Cameroon, decided to enter into a goods-only interim EPA with the EU in 2009. The East African Community (EAC) is the only region to have all its Member States sign up to the interim EPA. Negotiations are also continuing between the EU and the West African countries, Eastern and Southern Africa (ESA), and Southern African Development Community (SADC).

Figure 53: Net ODA as a percentage of GNI, 2009 and 2010

Source: OECD (2011).

Target 8B: Address the special needs of the least developed countries**Indicator 8.1: Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' gross national income**

Net OECD/DAC Official Development Assistance (ODA) to Africa rose to US\$ 29.3 billion in 2010 – an increase of 3.6 percent over the previous year and a record high since 1992. Even though the amount has increased, the proportion of net OECD/DAC ODA to OECD/DAC gross national income (GNI) remains stubbornly at the same level as in 2005, namely 0.32 percent.⁶⁶ Luxembourg and Norway continued to allocate more than 1

percent of their GNI to ODA in 2010 (1.09 percent and 1.10 percent respectively), which is a marginal increase over the previous year. Sweden, Denmark, and the Netherlands also continued to surpass the UN target of 0.7 percent of GNI.

If debt relief grants are excluded, bilateral ODA to Africa in 2010 fell by only -0.1 percent from 2009. On the other hand, total ODA from DAC rose from US\$ 119.7 billion in 2009 to US\$ 128.7 billion in 2010, with the United States continuing to allocate more ODA than any other DAC member.

⁶⁶ Based on OECD's preliminary data for 2010.

**Table 11: Total bilateral aid to all sectors from DAC countries, 2005–2010
(US\$ million)**

	2005	2006	2007	2008	2009	2010
<i>DAC Countries Total</i>	107,838	104,814	104,206	121,954	119,781	128,728
Australia	1,680	2,123	2,669	2,954	2,762	3,849
Austria	1,573	1,498	1,808	1,714	1,142	1,199
Belgium	1,963	1,977	1,951	2,386	2,610	3,000
Canada	3,756	3,683	4,080	4,795	4,000	5,132
Denmark	2,109	2,236	2,562	2,803	2,810	2,867
Finland	902	834	981	1,166	1,290	1,335
France	10,026	10,601	9,884	10,908	12,600	12,916
Germany	10,082	10,435	12,291	13,981	12,079	12,723
Greece	384	424	501	703	607	500
Ireland	719	1,022	1,192	1,328	1,006	895
Italy	5,091	3,641	3,971	4,861	3,297	3,111
Japan	13,126	11,136	7,697	9,601	9,457	11,045
Korea	752	455	696	802	816	1,168
Luxembourg	256	291	376	415	415	399
Netherlands	5,115	5,452	6,224	6,993	6,426	6,351
New Zealand	274	259	320	348	309	353
Norway	2,794	2,945	3,735	4,006	4,086	4,582
Portugal	377	396	471	620	513	648
Spain	3,018	3,814	5,140	6,867	6,584	5,917
Sweden	3,362	3,955	4,339	4,732	4,548	4,527
Switzerland	1,772	1,646	1,685	2,038	2,310	2,295
United Kingdom	10,772	12,459	9,849	11,500	11,283	13,763
United States	27,935	23,532	21,787	26,437	28,831	30,154

Source: OECD (2011).

Note: Preliminary data for 2010.

The overall DAC average ODA as a proportion of GNI was 0.32 percent in 2010, below the 2005 Gleneagles G-8 Summit forecast of 0.36 percent. However, the EU Member States that are also members of the DAC allocated 0.46 percent of their GNI to ODA in 2010, an improvement from 0.44 percent in 2009. The principal reasons for the rise in ODA in most EU countries in the DAC were increased bilateral grants and lending, and debt forgiveness. The United States surpassed its goal of doubling aid to Africa (excluding North Africa) between 2004 and 2010 before the target date.

Generally, the 2005 Gleneagles Summit commitments to Africa have not been met and this has been attributed to the poor economic performance of some of the donors. Aid to African countries is expected to rise by only 1 percent per year between 2011 and 2013, in real terms. It is, however, heartening to note that developing countries are also benefiting from new donors that are non-DAC

members, and from private sector donations from advanced economies.

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

The social sector's share of ODA to Africa from DAC countries as a percentage of total bilateral commitments grew marginally from 42.6 percent in 2008 to 44.8 percent in 2009. Of this allocation to the social sector, population and reproductive health received the largest share at 11.5 percent of total commitments. Greece and Ireland allocated more ODA to the social sector than to other sectors (70 percent and 61 percent, respectively), with a larger allocation to education by both countries.

Table 12: ODA to Africa by sector, 2005–2009 (as a % of total bilateral commitments)

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

Source: OECD (2011).

Most other sectors saw a fall in ODA allocated to them over the period 2008–2009, except for production (which increased from 6.5 percent to 7.8 percent) and general program aid (which increased from 8.4 percent to 10.2 percent) (*Table 12*). Within the production sector, agriculture, fishing and forestry received the largest share of total bilateral commitments. This may signal a shift in focus, both in Africa and the donor community, toward agriculture as an engine of growth and food security, especially in view of the recent global hikes in the price of food. However, as discussed in Goal 1, it is important for the donor community to address long-term agricultural development rather than focusing solely on short-term food assistance programs. Taking a longer perspective is the key to Africa's sustainable development and capacity to feed itself, thereby reducing hunger and poverty.

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 HIPC decision points and those that have reached their HIPC completion points (cumulative)

Since the publication of the 2010 report, four countries (DRC, Guinea-Bissau, Liberia, and Togo) have reached their HIPC completion points, making them eligible for final debt relief, if they wish to access it. In addition to these countries, Comoros reached the interim stage (between decision and completion point) and so became eligible for debt relief. As of mid-December 2010, 26 African countries were at post-HIPC completion point, four at an interim stage, between decision and completion point (Chad, Comoros, Côte d'Ivoire, and Guinea), while another three were at pre-decision point (Eritrea, Somalia, and The Sudan) (*Table 13*).

Box 7: Mozambique and debt sustainability

Every country in the world has debts, both domestic and foreign. However, it is vital to keep debt accumulation under control. In this respect, Least Developed Countries (LDCs) are particularly vulnerable in terms of foreign currency earnings, considering their non-diversified exports base. Mozambique has performed well in this regard.

Mozambique has utilized its reputation as a peaceful and politically stable country in order to benefit from significant debt relief from various multilateral and bilateral arrangements. In parallel, it has intensified its foreign currency earnings by significant growth in exports, from an average of 12.7 percent of GDP during the 1990s to 28.8 percent of GDP in the first decade of the current millennium. As a consequence, its performance for Indicator 8.12 (debt service as a percent of exports of goods and services) has fallen from around 20 percent (1997) to about 2.5 percent (2009). However, Mozambique needs to be aware of the sustained rises in total external debt stock, from US\$ 3.3 billion in 2007 to US\$ 3.9 billion in 2009, representing about 20 percent of GDP.

Source: *Mozambique MDGs Progress Report 2010*.

Table 13: Classification of African countries by HIPC status (as of December 17, 2010)

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

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

Significant progress has been recorded in dealing with the high debt burden of African countries through the HIPC Initiative, among others. However, care should be exercised because some post-completion point countries continue to shoulder high debt risks. The DRC, for instance, has a public guarantee on concessional borrowing for financing large-scale infrastructure projects.

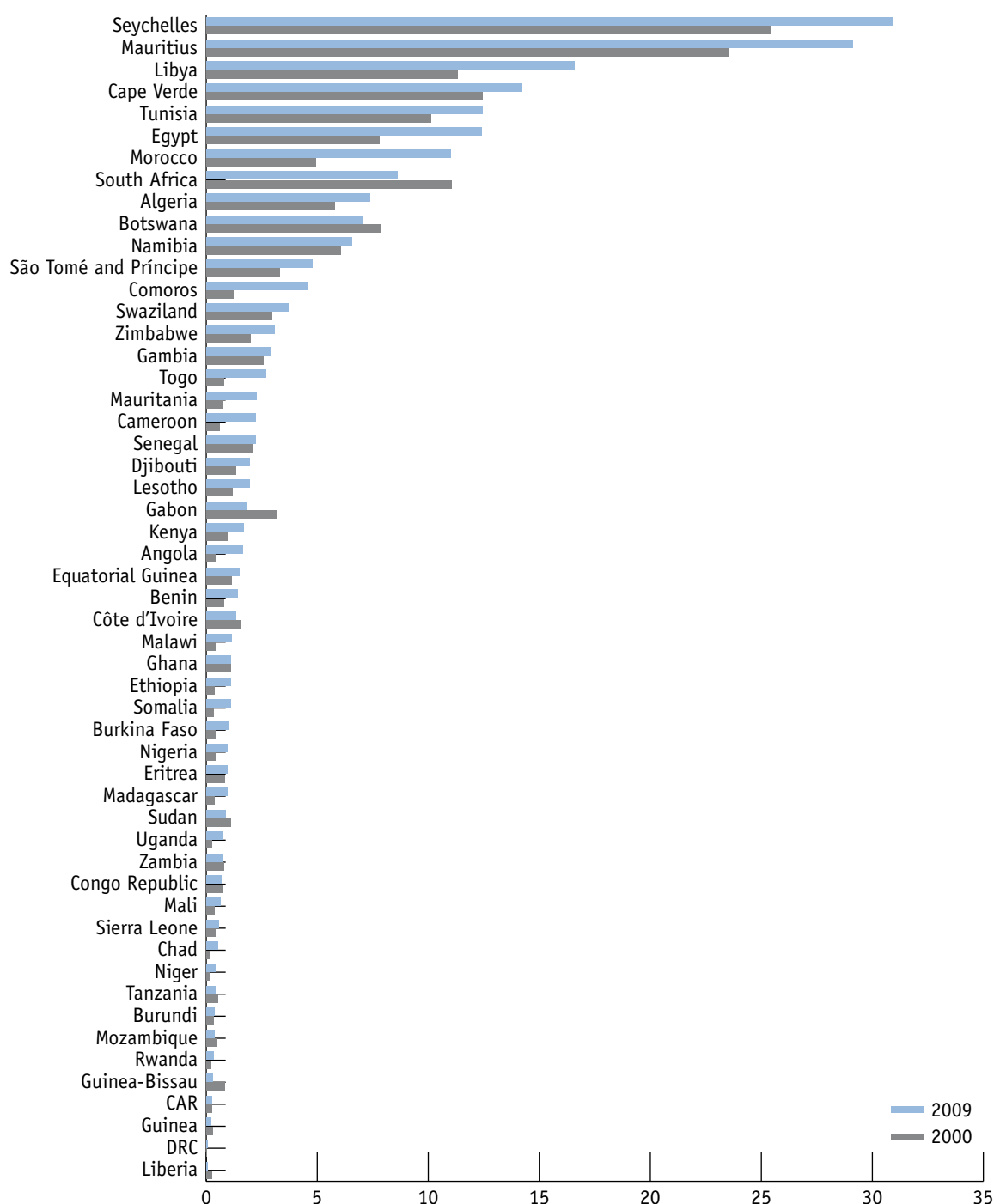
The 30 countries that have reached their decision or completion point have benefited from about US\$ 36 billion in net present value terms from creditors, as of October 2010. Evidence suggests that in post-decision point countries, poverty-reducing expenditure has increased since the inception of the HIPC Initiative. Nonetheless, debt continues to

be a constraint on the efforts of African countries to achieve the MDGs because of the insufficiency of the debt relief granted. This has limited fiscal policy space and the ability of countries to scale up MDG-critical interventions.

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

There was little change in the number of fixed telephone lines per 100 population in Africa between 2000 and 2009. There were an estimated

Figure 54: Telephone lines per 100 population, 2000 and 2009

Source: Compiled from ITU data (updated in 2010).

1.6 telephone lines per 100 inhabitants in 2010, compared to 1.5 in 2008 and 2009. Most countries for which data are available registered either a marginal increase or no increase. This slight change can also be observed over the longer trend, as there was only modest growth in fixed telephone lines between 1990 and 2009. This slow growth is largely due to high fixed costs of fixed line telephony and the relative attractiveness of mobile telephony, which continues to expand at a very high rate on the continent.

Morocco, Egypt, Tunisia, Cape Verde, Libya, Mauritius, and Seychelles were the best performers for this indicator, with more than 10 fixed telephone lines per 100 populations in 2009. Twenty-one African countries had less than one fixed telephone line per 100 population in 2009, while in 12 countries the number of fixed telephone lines declined between 2000 and 2009 (*Figure 54*).

Indicator 8.15: Cellular subscribers per 100 population

In Africa overall, the number of mobile cellular subscribers increased by a wide margin between 2000 and 2009. Mobile cellular penetration rates are expected to reach 41 percent by the end of 2010, compared to 32.1 percent in 2008 and 37.6 percent in 2009. Although this represents excellent progress, it still falls far below the global mobile penetration rate of 76 percent.

The continental average is, however, not representative of all countries. In Libya and Seychelles, most of the population had more than one mobile phone in 2009. Algeria, Botswana, Gabon, South Africa, and Tunisia recorded over 90 cellular subscribers per 100 population in 2009 (*Figure 55*). It is interesting to note that three of these

countries registered a decline in the number of fixed line telephones between 2000 and 2009, implying that the emergence of mobile telephony has been at the expense of fixed line telephony. On the other hand, Eritrea, Ethiopia, and Somalia had less than 10 mobile subscriptions per 100 inhabitants in 2009.

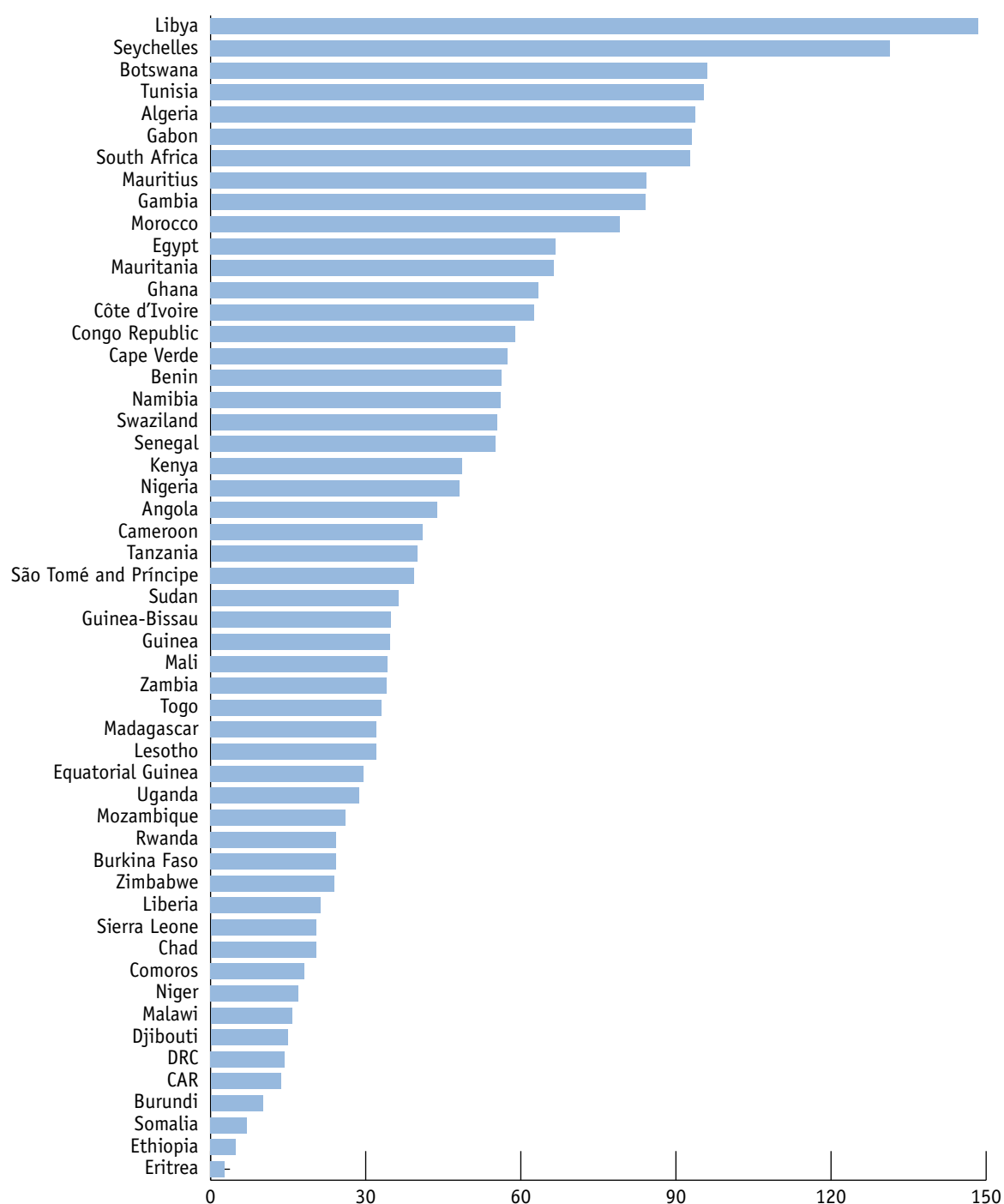
The use of cell phones has positive micro and macroeconomic effects on development. In developing countries, their use translates in reduced transaction costs, creating employment opportunities, and assisting in overall economic growth. This underscores the linkage between greater access to technology and acceleration toward better living standards (*Box 8*).

Indicator 8.16: Internet users per 100 population

In Africa the use of internet has been increasing slowly since 2000. Internet user penetration was expected to reach 9.6 percent by the end of 2010, up from 8.8 percent in 2009 and 5.9 percent in 2008. This though is well below the world average of 30 percent and the developing country average of 21 percent.

According to available data, in 2009 Morocco recorded the highest number of internet users, followed by Tunisia, Cape Verde, Nigeria, and Egypt. The African countries with the lowest internet penetration in 2009 were Sierra Leone, CAR, Liberia, Ethiopia, Niger, and Guinea (with less than one internet user per 100 inhabitants). There were no data for DRC, Eritrea, Seychelles, and The Sudan in 2009. Overall, however, between 2000 and 2009 the number of internet users improved in all of the countries with available data (*Table 14*).

Figure 55: Cellular subscribers per 100 population, 2009



Source: Compiled from ITU data (updated in 2010).

Africa has a fixed broadband penetration rate of less than 1 percent, which illustrates the challenges associated with access to high-speed, high-capacity internet. It is worth noting, however, that some countries in Africa have adopted a national broadband strategy, making broadband access a legal right for some. Mobile broadband subscriptions were estimated at 3.6 percent for Africa, compared to 5.4 percent for developing countries and 13.6 percent for the world. Clearly,

a lot more needs to be done to improve access to high-speed internet, including making it affordable.

Box 8: Socioeconomic gains through mobile telephony in Kenya and Tanzania

Kenya: Africa, with Kenya at the forefront, has the fastest growing cell phone market in the world. Over the past five years, the continent's cell phone take-up has increased at an annual rate of 65 percent – twice the global average. According to the government's 2005 Economic Survey, Kenya's small business sector, which employs the majority of workers, created approximately 437,900 new jobs last year. The boom of cell phones in Kenya has been credited for much of this growth. Indeed, it has been shown that adding an additional 10 cell phones per 100 people increases a developing country's GDP growth by an average 0.6 percent. A large part of this boost comes from the innovative use of mobile phone technology by local entrepreneurs.

Access to market information through cell phones also provides rural communities with invaluable information about centers of business. For example, many African fishermen check the local fish market prices on their phones to determine where to bring the day's catch. The Kenya Agricultural Commodity Exchange (KACE) now provides crop growers with up-to-date commodity information via text message (sms). This allows farmers to access daily fruit and vegetable prices from a dozen markets, and many have quadrupled their earnings because they have access to information about potential buyers and prices before making the often arduous journey into urban centers to sell their produce.

Tanzania: The community payphone, another innovation unique to the developing world, has helped bring cell phone usage to the poorest areas of Africa. These payphones are owned and operated by entrepreneurs who buy airtime from the network and subsequently sell it to local people who don't own phones themselves. A recent survey reported that 97 percent of Tanzanians now have access to a cell phone, thanks to the community payphone model, despite the lack of electrical infrastructure for much of the country. The payphones are easy to operate in isolated areas far from the nearest traditional telephone landline. They can be used even where there is no electricity, as they can be powered by either solar or car batteries. Africa's adaptation of cell phone technology shows the value of inexpensive, mobile communication for populations representative of the 1.4 billion cell phone users living in the developing world today.

Source: EPROM (2009).

Table 14: Internet users per 100 population, 2000 and 2009

Country	2000	2009	Country	2000	2009
Sierra Leone	0.12	0.26	Namibia	1.64	5.87
CAR	0.05	0.51	Botswana	2.90	6.15
Liberia	0.02	0.51	Zambia	0.19	6.31
Ethiopia	0.02	0.54	Congo Republic	0.03	6.66
Niger	0.04	0.76	Gabon	1.22	6.70
Guinea	0.10	0.94	Swaziland	0.93	7.60
Burkina Faso	0.08	1.13	The Gambia	0.92	7.63
Somalia	0.20	1.16	South Africa	5.35	8.82
Chad	0.04	1.50	Uganda	0.16	9.78
Tanzania	0.12	1.55	Kenya	0.32	10.04
Madagascar	0.20	1.63	Zimbabwe	0.40	11.36
Burundi	0.08	1.90	Algeria	0.49	13.47
Mali	0.14	1.92	Senegal	0.40	14.50
Equatorial Guinea	0.13	2.13	São Tomé & Príncipe	4.64	16.41
Benin	0.23	2.24	Mauritius	7.28	22.51
Mauritania	0.19	2.28	Egypt	0.64	24.26
Guinea-Bissau	0.23	2.30	Nigeria	0.06	28.43
Mozambique	0.11	2.68	Cape Verde	1.82	29.67
Djibouti	0.19	3.00	Tunisia	2.75	34.07
Angola	0.11	3.28	Morocco	0.69	41.30
Comoros	0.27	3.59			
Lesotho	0.21	3.72			
Cameroon	0.25	3.84			
Rwanda	0.06	4.50			
Côte d'Ivoire	0.23	4.59			
Malawi	0.13	4.69			
Togo	1.91	5.38			
Ghana	0.15	5.44			
Libya	0.19	5.51			

Source: Computations based on ITU data (updated in 2010).

SECTION III:

Social Protection as an Instrument to Accelerate Progress toward the MDGs in Africa

BACKGROUND

Definition of social protection

Social protection has been defined in various ways. For instance, the World Bank (2003a) defines it as a set of measures that support society's poorest and most vulnerable members and help individuals, households and communities to better manage risks. Such measures include labor market interventions (labor market regulations, programs, and wage-setting rules), social insurance programs (such as pensions, unemployment and family benefits, and sick pay), social assistance (transfers in cash or kind, subsidies, and workfare), and programs to assist people in need, especially vulnerable groups (disabled people, orphans, and vulnerable children, etc.).

The African Union (2008) defines social protection to encompass a range of public actions carried out by the state and others that address risk, vulnerability, discrimination, and chronic poverty. These include child support, old age pension, and disability allowance. Social protection is seen as a strategy to improve and sustain the social contract that binds citizens to governments and which is

founded on mutually agreed rights and obligations that advance common interests (ECA, 2009a).

The *2010 European Report on Development* provides a good framework for defining social protection as an investment in human development:

“a specific set of actions to address the vulnerability of people's life *through social insurance*, offering protection against risk and adversity throughout life; *through social assistance*, offering payments and in kind transfers to support and enable the poor; and *through inclusion efforts* that enhance the capability of the marginalized to access social insurance and assistance.”

(European Communities, 2010, p. 9).

The current conceptualization of social protection has seen a paradigm shift from public handouts to a provision of risk management instruments, and to informal and market-based arrangements. Such arrangements are geared to help individuals, households, and communities to better manage shocks in a way that promotes human development and reduces vulnerability.

This report sees social protection to be more than a safety-net that protects people from risks and shocks. It is about addressing the main causes of poverty by allowing the marginalized or vulnerable groups to benefit from and productively participate in the economic growth process. For social protection to impact directly on human development, it has to be protective and preventive, and to serve as an instrument of social justice. The need to use social protection mechanisms to fast-track the MDGs in Africa underscores the importance of integrating relevant strategies into countries' national development agendas and to complement them with concrete investment and implementation plans.

Momentum for social protection in Africa

The momentum for social protection, as an instrument of social transformation and development, has been growing. Developing countries' experiences with the recent economic crisis, structural adjustment programs, and globalization since the 1990s have brought to the fore the importance of integrating social protection schemes into social policies to promote human development. At the international level, there has been an increasing clamor for the use of social protection to promote the achievement of the MDGs and related development issues. An important milestone was the adoption in April 2009 of a Universal Social Protection Floor (SPF-I) as one of nine initiatives in response to the global economic crisis. Several international organizations subsequently endorsed the SPF-I, among them the G-20 Labor and Employment Ministers, the ILO's Global Jobs Pact, OECD-Povnet, the Forum of Ministers for Ministries responsible for Social Development, and the International Council on Social Welfare (ILO and WHO, 2009). The G-20's 2010 Seoul Development Consensus

and the September 2010 High Level Meeting on the MDGs also highlighted the importance of social protection in the African context.

As far back as 2003, the World Bank pointed out the important linkage between social protection and the MDGs by concluding that "without due consideration to risks in the development process and the provision of appropriate social risk management mechanisms, including social protection, the MDGs will not be achieved" (World Bank, 2003a). The evidence from many Latin American countries and Southeast Asian countries demonstrates the vital role that social protection can play in facilitating rapid poverty reduction and progress on the MDGs. This presents a compelling argument for adopting such measures in other regions, such as Africa.

At the continental level, political support for investment in social protection has been intensifying. In 2004, the Assembly of Heads of State and Government of the African Union adopted the Ouagadougou Declaration and Plan of Action, which aimed at empowering people, opening up employment opportunities, enhancing social protection, and security through decent work (Taylor, 2009). The March 2006 Livingstone (Zambia) Call for Action proclaimed social protection to be both an empowerment and rights agenda. In September of the same year, the Yaoundé Call for Action advocated comprehensive social protection, focusing on a universal pension especially for the older people (European Communities, 2010). The African Union's Social Policy Framework for Africa (AU, 2008) proposed a minimum package of essential social protection, targeting health-care, and benefits for children, informal workers, the unemployed, old people, and persons with

disabilities. The launch of the African Civil Society Platform for Social Protection added to the impetus growing for pan-African social protection. In 2010, the Khartoum Declaration on Social Policy Action towards Social Inclusion was launched, which sets out a comprehensive approach to social protection in Africa.

The momentum at the subregional level is even more intense in the Southern African Development Community (SADC). Its 2003 Charter of Fundamental Social Rights (Article 10) mandated Member States to ensure that workers be given adequate social protection. This was extended to social services and development social welfare in the 2007 SADC Code on Social Security. While the East African Community (EAC) is committed to improving social protection for persons with a disability, the Inter-Governmental Authority on Development (IGAD) emphasizes the link between social protection and food security. Harmonization of labor laws and child protection constitute the focal areas of the Economic Community of West Africa (ECOWAS), as the application and extension of social health protection are being promoted by the Union économique et monétaire ouest-africaine (UEMOA) (European Communities, 2010).

At the national level, there have been longstanding social protection interventions in some African countries, while other nations are relative newcomers to this agenda. In spite of the growing interest in this area, there is a general tendency to perceive social protection as a safety-net rather than as an investment in human capital and a major strategy for human development, notwithstanding the international and regional calls for a broader perspective.

At the level of the international donor community, there is a growing consensus among development partners that developing countries need to strengthen and formulate social protection policies and mechanisms to deal with increasing vulnerabilities and shocks (World Bank, 2003a; AU, 2008; ILO and WHO, 2009; European Communities, 2010; DFID, 2011). This reinforces the consensus that is unifying all the different national, regional, and international stakeholders on the criticality of social protection issues. This provides an excellent opportunity for Africa to take full advantage of the current support (both financial and technical) to review and institutionalize social protection mechanisms and enhance progress toward the MDGs.

WHY SOCIAL PROTECTION MATTERS IN ACCELERATING PROGRESS TOWARD THE MDGS IN AFRICA

Over the past decade, Africa has experienced rapid economic growth which began to generate social dividends; indeed, progress has been recorded across most of the MDGs. Improvements in governance, macroeconomic management, and more robust and transparent institutions made this possible. Yet, the continent is still prone to a myriad of potential and recurring shocks requiring ex-ante and ex-post social responses. Some of these include: macroeconomic vulnerability (including the impact of volatile food and fuel prices); perennial situations of fragility and civil conflicts; HIV/AIDS epidemic and other diseases such as TB and malaria; and increased vulnerability to climate change impacts and food insecurity. The erosion of the extended family system (due largely to modernization and migration), which was once the bedrock of the social security system in Africa, has also made people vulnerable. All this requires an institutionalized social protection mechanism to handle the fallout from these shocks.

What has become clear in recent years is that rapid economic growth – as witnessed in Africa over the past decade – has not translated into commensurate progress on poverty reduction and related MDGs. This tends to suggest that economic growth is a necessary but not a sufficient condition to achieve rapid progress on the MDGs. This calls for special, pro-poor interventions that directly address the needs of marginalized and vulnerable people in the short term, as well as protecting them from relapsing into poverty in the longer term, due to economy-wide, community-wide, or household-specific shocks. Such interventions must also ensure that the poor meaningfully participate in the growth process. This underpins the centrality of social protection in accelerating the realization of the MDGs.

Africa is a highly unequal continent, second only to Latin America. The continent is permeated with horizontal inequalities, characterized by the exclusion of certain groups from actively participating in the social, economic, and political processes in society. This inequality has rendered the economic growth impact on social outcomes rather meager. For instance, in 2010, when inequality was discounted from Africa's (excluding North Africa's), potential Human Development Index (HDI), it lost 32.8 percentage points, in contrast to 30.2 percent and 25.1 percent in South Asia and the Latin America and the Caribbean respectively. A similar trend was recorded in life expectancy, education and income indices (UNDP, 2010a). In addition, the drivers of economic growth rest primarily on fairly capital-intensive sectors, with few spillover effects on employment creation and the rest of the economy. The result has been rising income inequality. For instance, in Africa (where comparable data are available) 12 countries recorded a Gini

coefficient⁶⁷ of 0.50 and above between 2000 and 2010. Most of these countries are in the Southern Africa subregion and include Namibia (0.74), Comoros (0.64), Angola (0.59), South Africa (0.69), Lesotho (0.53), Liberia (0.53), and Botswana (0.51) (UNDP, 2010a).⁶⁸ Addressing inequality through social protection makes growth more inclusive; it builds a more cohesive society and promotes a harmonious citizen–state relationship. This lays the foundation for growth sustainability, reinforces social stability, and deepens political legitimacy.

The disparities in African societies though are not restricted to income but are reflected in the other MDGs as well. Wide variances exist among African countries in access to education and health services. In fact, the lack of social protection forces households to sell assets, reduce their food intake, and take children and wards out of school, thereby perpetuating a vicious cycle of poverty. The data reveal that out-of-school children largely comprise poor female household members, who live in the rural areas. Evidence shows that rural children are twice as likely to be out of school as urban children. In addition, girls in the poorest quintile are 3.5 times more likely to be out of school than girls in the richest quintile and four times more likely to be out of school than boys in the richest quintile. Unequal access to education based on income, gender, and location increases the vulnerabilities of the marginalized (UN, 2010).

67 Gini coefficient is an index of measuring inequality which ranges from 0 to 1. If its value is closer to 1, it shows the distribution of income is highly unequal; if it is closer to 0, it implies income distribution is almost equal.

68 Gini coefficient here may be different from national statistics due to the disparity between national and international statistics; this is an issue which the UN Statistical Commission is currently looking into.

Chronic hunger has irreversible developmental effects, such as stunting growth, creating ill health and low educational performance. Africa, excluding North Africa, registered the highest Hunger Index in 2010 (21.7 percent) after South Asia (22.9 percent). The need to staunch the irreversible developmental effects of malnourishment argues for protection of the most vulnerable in Africa. The case is clear: children from the poorest households are twice as likely to be underweight as those from richer households. Vulnerable employment, lacking the protection of more formal work arrangements, has increased in Africa since the global crisis and women are disproportionately represented in this sector. Similarly, for health-related MDGs (including access to improved water and sanitation), populations living in urban areas and belonging to higher-income groups have better outcomes (ECA, 2009a). The weak status of vulnerable groups has been exacerbated by the global financial, food and energy crises. Moreover, the crises have further marginalized these groups from access to broad-based policies that could alleviate their situation. Unless special interventions are designed for these groups, achieving rapid progress toward the MDGs will be difficult.

Social protection plays a central role in improving the quality of life of individuals and societies. It does this by developing and unleashing human potential, facilitating structural change, increasing stability, advancing social justice and cohesion, and promoting economic dynamism (Bonilla García and Gruat, 2003). The effective implementation of social protection can facilitate the link between economic growth and human development – an issue that has eluded many African countries over the past two decades.

Social protection can help to correct market failures which thus far have not been adequately addressed in Africa.⁶⁹ Countries where social protection has been effectively implemented (e.g., Brazil, Mexico, South Africa, and Ghana) have shown it to be an important instrument alleviating poverty and enhancing long-term growth. Social protection provides households with the safeguards that markets and informal networks are incapable of providing.

The foregoing factors make the implementation of social protection not only desirable, but also inevitable in Africa. Specifically, the intensity of poverty and inequality and the structural weaknesses in basic service delivery (especially in education and health) on the continent render the adoption of pro-poor interventions vital for advancing human development. However, the continuously diminishing fiscal space for governments, resulting partly from the effects of the global financial crisis, poses a serious challenge to the realization of the social protection agenda in some countries.

SOCIAL PROTECTION AS A STRATEGY FOR ACCELERATING PROGRESS: POTENTIALITIES, EXPERIENCES, AND LESSONS

Potential linkage between social protection and the MDGs

Social protection helps households to even out consumption, build human capital, accumulate productive assets, and participate in the labor market. It takes as its premise that risk,

⁶⁹ See Conning and Kevane (2001) on how social protection corrects for market failures and Subbarao (1998) for reciprocal-based sources of assistance from extended families and neighbors.

vulnerability, and deprivation are central to the poverty-generating process (whether transient or chronic poverty) and that addressing these issues will take people out of destitution. The World Bank (2003a) and Barrientos and Shepherd (2003) propose a conceptual framework that tackles the links between vulnerability, poverty, and social protection. They postulate that the impact of risk and vulnerability on welfare is determined by three factors: the risk of an adverse contingency, the realization of that risk, and the behavioral responses of households. People that are chronically poor always face higher risks and are less able to protect their welfare when adverse contingency strikes. Consequently, they are forced to adopt risk-minimizing strategies that can lead to a poverty trap, such as adopting safer but low-return production techniques, and reducing investment in physical and human capital, among others. Social protection is therefore targeted at reducing such risks and the behavioral responses that result from them.

There is a vicious cycle between poverty, low levels of health (including nutrition), and education capital for individuals and societies. This is borne out by the emerging evidence of a far higher incidence of education and health spending among the richest quintile of the population compared to the poorest quintile. For example, in Africa (excluding North Africa) the incidence of health spending of the poorest quintile is one-third that of the richest quintile (World Bank and IMF, 2011). Social protection that is targeted at managing health risks can boost access to healthcare and attend to illness in a timely and sustainable manner, thus helping to maintain the health capital. A similar pathway is applicable to education capital.

In Africa, risk and vulnerability can contribute directly and indirectly to poverty and low social outcomes. The direct route is through the degradation of productive assets, especially during periods of drought, conflicts, and natural disasters (e.g., cyclones and floods). The indirect route is through the risk-mitigation responses of poor households, which consist in reducing investments in physical assets (e.g. the selling of landed property); reducing investments in human capital (e.g., withdrawal of children from school, delaying healthcare or changing health-seeking behavior towards non-orthodox practices, and increased fertility with its repercussions on infant and maternal health); and in low productivity specialization (selection of crops, resorting to informal jobs).⁷⁰ Based on this realization, social protection has become an emerging unifying policy among development stakeholders on how to address chronic poverty and promote progress on the MDGs in Africa. *Table 15* presents a matrix of social protection interventions and their potential impacts on the attainment of the MDGs.

70 See Barrientos and Shepherd (2003) and World Bank (2003a) on how social protection contributes to poverty reduction.

Table 15: Potential contributions of various social protection interventions to the MDGs

Social Protection Intervention	MDG 1	MDG 2	MDG 3	MDGs 4-6	MDG 7
Pensions	Reduces poverty among the aged and disabled.			Increases access to health services for the aged.	Increases access to water and sanitation.
Unemployment benefits	Reduces transient poverty among the unemployed.		Provides temporal financial empowerment to women, enhancing their consumption and access to basic services.	Ensures health status and "employability."	Reduces poaching in game reserves and depletion of other natural resources. Increases access to water.
Fee waivers for health, education and related services	Allows families to access services without a drop in income.	Contributes to increased school enrollment.	As girls' education is sensitive to fees in some communities, a waiver contributes immensely to girls' enrollment.	Patronage of health facilities is sensitive to user charges, so a waiver improves access and general health status.	Increases access to water and sanitation.
Safety nets	Evens out/ raises incomes. Cash transfer to vulnerable children can reduce inter-generational poverty.	Support to physically challenged people and vulnerable children increases enrollment and school attendance. Benefits (cash / food) conditional upon school enrollment. Creates incentives for families to send children and wards (especially girls) to school.	Contributes to girls' enrollment. Special support to women increases their skills and productivity.	Increases health status of orphans and vulnerable children. Transfers to poor households enhance nutrition, resulting in gains in children's weight and height as well as nutritional and health status of women.	
School feeding program	Reduces child poverty, especially hunger.	Contributes to enrollment rate, attendance, and pupil performance.	Contributes to girls' enrollment and performance.	Reduces child morbidity.	

Social Protection Intervention	MDG 1	MDG 2	MDG 3	MDGs 4-6	MDG 7
Social funds, including waiving of user fees	<p>Empowers the extremely poor communities to build social infrastructure.</p> <p>Increases available household income for basic consumption.</p>	<p>Contributes to girls' attendance in schools through attention to appropriate sanitation, security, etc. in the construction of school buildings</p> <p>Construction and rehabilitation of school facilities boost enrollment, attendance and reduce class sizes.</p>	Increases girls' access to schools through the creation of girl-friendly environments (e.g. provision of girls' toilets and special support to female pupils).	<p>Construction and rehabilitation of health facilities through social funds increase access to primary health services.</p> <p>Social funds that focus on building awareness and advocacy on HIV and AIDS, basic hygiene enhance behavioral changes and health outcomes.</p> <p>Social funds targeted at infants and pregnant women contribute to improved child and maternal health through reduction in morbidity and mortality.</p>	Social funds targeted at tree planting, bio-diversity management, and erosion control promote environmental sustainability.
Self-help projects	Contribute to construction of feeder roads, bridges, and culverts which increases accessibility to markets and inputs.	<p>Construction and rehabilitation of schools increase enrollment, attendance and performance.</p> <p>Parent-Teacher Associations contribute to school management and quality of education.</p> <p>Construction of boreholes/wells increases attendance and learning for children who spend hours on water collection.</p>	<p>Creation of multi-functional platforms in remote communities increases women empowerment.</p> <p>Community support to out-of-school children enhances skills and employment status.</p> <p>Construction of boreholes/wells reduces the time women spend on water collection, which can then be diverted to more productive activities.</p>	<p>Construction and rehabilitation of clinics and maternity centers and drug revolving schemes⁷¹ increase access and make basic health services affordable.</p> <p>Construction of boreholes/wells reduces water-borne diseases and increases household hygiene.</p>	Community management of local forest reserves reduces deforestation and creates carbon sinks.

71 Drug-revolving schemes are designed to subsidize costly pharmaceuticals for those least able to afford them. After an initial investment of funds, drug supplies are replenished with monies collected from the sales of drugs.

Social Protection Intervention	MDG 1	MDG 2	MDG 3	MDGs 4-6	MDG 7
Labor market policies ⁷²	<p>Can create a more conducive environment for job creation, productivity and wage growth.</p> <p>Public employment programs provide temporary employment, especially in times of economic stress, thereby increasing the income of households in transient poverty.</p> <p>Support to informal workers in the form of skills and access to markets enhances their productivity.</p> <p>Workers' compensation policies and occupational safety policies protect the occupational health (and productivity) of workers and guard against work-related disability.</p>	<p>Addressing child labor can increase school enrollment and literacy rate.</p> <p>Wage increases can boost household spending on education and reduce child labor, thereby increasing primary school enrollment.</p>	<p>Encouraging women's labor force participation creates incentives for female education.</p> <p>Elimination of discrimination against women, physically challenged and ethnic minorities' participation in the labor market and public offices enhances empowerment and gender equality.</p> <p>Labor market policies that encourage women's participation in non-agricultural production can narrow the gap between men and women in recruitment and remuneration policies.</p>	<p>Gender-sensitive labor policies (maternity and paternity leave) promote child-care and give more attention to pre- and post-natal care.</p> <p>Maternity leave allows women to keep their jobs during pregnancy and child-caring stages.</p> <p>Provision of crèches in the workplace enhances exclusive breast feeding and childcare.</p>	<p>Income policy that favors forestry can lead to a better enforcement of environmental laws and regulations.</p>
Disability insurance (DI) and social insurance (SI)	<p>DI regularizes income for those temporarily or permanently unable to work.</p> <p>Sick leave safeguards a level of income during periods of illness and facilitates an ability to pay for treatment.</p>	<p>SI evens out household incomes (protecting them from shocks).</p> <p>SI increases school enrollment and reduces child labor.</p>	<p>Social insurance targeted at women reduces the impact of vulnerability and promotes gender equality.</p>	<p>Health insurance makes medical treatment more accessible.</p>	

Sources: World Bank (2003a); Ajakaiye and Odusola (2002); UNICEF and ODI (2009c); and DFID (2011).

72 Specifically, policies such as public works, child labor law, wage increases, policies supporting women's participation in the labor force, skills development program, etc.

COUNTRY STUDIES: THE IMPACT OF SOCIAL PROTECTION ON THE MDGS

This section reviews the impact of social protection on MDGs, using available quantitative (though limited) and qualitative evidence. Consistent with the matrix described above, the findings of the ECA 2010a case studies⁷³ demonstrate that most social protection instruments have had a positive impact on the MDGs. The vast majority of such interventions prioritize poverty reduction of a specific vulnerable group, such as the elderly or the food-insecure. The evidence suggests that social protection is having a greater impact on the reduction of poverty and hunger (MDG 1) than on most other Goals, as detailed below.

Poverty reduction

It is not always easy to establish empirical evidence on the effects of social protection in reducing poverty and enhancing progress toward the MDGs. This is because it is often conceptually and methodologically difficult to separate the impacts of social protection from those of other policies. The pathways through which social protection operates in the lives of poor families are so complex and so intertwined with other factors that few robust measurements of its impact exist. Estimations by the World Bank postulate that social protection interventions could reduce the total poverty headcount rate by 5 to 10 percentage points (World Bank, 2003a, p. 8). A simulation work by Dethier et al. (2010) for 18 Latin American countries shows that a universal minimum pension would substantially reduce poverty among the elderly, from between 25 to 50 percent. DFID's (2011) review further supports this argument: in Brazil, the

introduction of a cash transfer scheme accounted for a 28 percent fall in inequality (Gini Coefficient) between 1995 and 2004. Similarly, cash transfers reduced the poverty gap by 30 percent among beneficiaries of Progres-Opportunidades in Mexico within two years of its launch.

Social protection mechanisms in Africa have assumed various forms, including free provision of tax-funded national health services, voucher instruments; cash transfer schemes, and contribution-based systems such as social health insurance. Empirical studies on how social protection contributes to poverty reduction and other MDGs in Africa are slowly beginning to emerge. *Table 16* provides some good examples from a number of African countries.

The implementation of a universal social pension in **Mauritius** is contributing to the low poverty rate in the country. For instance, the poverty rate for older people living with more than one younger person was 30 percent lower than it would have been without the universal pension (Kaniki, 2007).

Evidence from **South Africa** (Samson et al., 2004) also shows that the social security system reduces poverty, deprivation, and destitution.⁷⁴ The South African social grant reduces the poverty headcount by 4.3 percent and the destitution gap by 45 percent. Specifically, the old age pension reduces the poverty gap by 2.5 percent, the disability grant reduces the total Rand poverty gap by 5.1 percent, while extending the child support grant to 18 years

73 The ECA commissioned case studies in nine African countries (Algeria, Ethiopia, Kenya, Mauritius, Malawi, Namibia, Nigeria, Tunisia, and South Africa).

74 Destitution is defined as the bottom 20 percent of the expenditure distribution – the lowest poverty line in the country, based on a poverty threshold of R 180 per person per month (DSD, 2004).

contributes to a 21.4 percent reduction in the poverty gap. Fiszbein and Schady (2009) also found that a child support grant reduced the poverty gap among recipients by 47 percent. Similarly, Samson (2007) shows that South Africa's social grants reduced the poverty gap by 48 percent and the destitution gap by 67 percent, while at the same time supporting human capital development and labor market participation. For instance, Samson found that workers in households receiving social grants have higher labor force participation rates and greater success rates in finding employment than those in households not receiving grants. The comprehensive system of social grants in South Africa has led to several positive outcomes: a reduction of three percentage points in the Gini Coefficient; a doubling of the poorest quintile's share of national incomes;⁷⁵ a reduction in poverty from 11.3 percent in 1994 to 5.0 percent in 2006 (Government of South Africa, 2010); and a diminution of hunger and malnutrition.

South Africa boasts the most extensive⁷⁶ social protection system in the continent, with a primary focus on the State Old Age Pension (SOAP), disability grant, child support grant, foster child grant, care dependency grant, war veteran's grant and the grant-in-aid. Most of these interventions have proved to be very successful. The social grants have a total coverage of about 14 million (representing about one-third of the total population). However, despite the high level of unemployment in the country (around 23 percent), the absence of unemployment benefits for youths shows that an important vulnerable group has been excluded.

Social grants as a share of GDP rose steadily from 1.5 per cent in 2001 to 3.4 per cent in 2007. Although this level is still sustainable given the wide coverage (over 14 million beneficiaries), efforts should be made to ensure that the program remains sustainable for the future. It is important to note that strong political will⁷⁷ has been a major factor driving the program's success in South Africa.

Namibia operates a multidimensional social protection program encompassing a social pension and disability grant, child welfare grant, school feeding program, war veteran subvention, ad-hoc relief program and resettlement program. Specifically, the appreciable coverage of the old age pension and cash transfer schemes in Namibia has had a high impact on poverty reduction of vulnerable groups, primary school enrollment, gender empowerment, and prevention of diseases. This is consistent with Levine et al. (2011), who conducted a multivariate analysis of the impact of cash transfers on household welfare in Namibia. Using the lower-bound poverty line (adult equivalent income), the report concluded that cash transfers reduced the poverty incidence by 4.3 percent, the poverty gap by 18.4 percent, and poverty severity⁷⁸ by 27.5 percent. The effects are substantially higher for adult equivalent

75 See DFID (2011) for more information on this.

76 This is in terms of scope (multiple instruments) and coverage and all unconditional.

77 Prior to President Thabo Mbeki's regime, poor delivery of social protection interventions was commonplace. His administration made social protection the cornerstone of his election campaign and mobilized the national action plan around it. Today, the delivery rate is adjudged to have reached 80 percent (Samson, 2007).

78 Poverty severity is special form of poverty gap which takes into account not only the distance separating the poor from the poverty line, but also the inequality among the poor. This measure captures households that are further away from the poverty line.

consumption expenditure. The multivariate results show that the old age pension and child maintenance grants have had a significant impact on poverty reduction at 95 percent confidence interval. For the old age pension, for instance, a 1 percent increase in pension reduces poverty by 0.2 percent. The authors conclude that poverty-reducing effects of the child grants are likely to increase further as access is being rapidly expanded. However, the impact in terms of reducing Namibia's high levels of socioeconomic inequality remains limited. (See *Table 16* for more information on Namibia.)

Namibia then offers lessons and experience for other countries to emulate (especially regarding the implementation of social pension and child support) and points to ways of ensuring financial sustainability. However, the implementation of social protection in the country is saddled with coordination challenges and an absence of mechanisms to assess the real impact of the various initiatives.

Social protection contributes to hunger reduction and food security in several African countries. In this regard, **Ethiopia's** Productive Safety Net Program (PSNP) stands out as an enviable success. The PSNP has three core components: labor-intensive public works (for the actively productive population), conditional transfers (for very poor people who cannot participate in other forms of productive work, e.g. pregnant women, nursing mothers, widows, and school children), and unconditional transfers (especially for people with no assets e.g. the destitute) (Desta, 2010). This innovative program still contends with a number of challenges, including a heavy dependence on external support, which could undermine

sustainability, and the absence of a well-developed strategic framework for social protection which translates into weak coordination. Nonetheless, between 2005 and 2008, the PSNP in Ethiopia led to the construction of many community assets: 2.1 million km of stone embankments to prevent soil erosion and improve water conservation; about 1 billion trees planted to restore degraded watersheds and improve soil and water conservation; 7,000 km of small-scale irrigation canals and 191,600 ponds constructed to provide water for agriculture. The program prevented vulnerable people from selling their assets as a result of external shocks, while 55 percent of the beneficiaries affirmed that PSNP had increased their household incomes. It improved food security for 7.8 million who had previously relied on emergency food relief (especially in communities facing chronic shortages).

Evidence from Devereux and Coll-Black (2007) revealed that 75 percent of the beneficiaries⁷⁹ of the PSNP program consumed more and better quality food, and 60 percent avoided selling off their productive assets to buy food during periods of shortage. This innovative program contributed to a reduction of around 41 percent in malnourishment between 1990 and 2007. As a result, the hunger index for Ethiopia fell from over 50 percent in 1990 to less than 30 percent in 2008. The cumulative effect of all these positive outcomes was a 30 percent reduction in the country's overall poverty level from 1998 to 2008.

79 See *Table 16* for the coverage of the program. Specifically, it operates in 300 rural communities with chronic food shortages and provides cash or food for work and unconditional transfer of food to people that were unable to participate in public works.

In the same light, **Malawi's** social protection program has significantly reduced hunger, resulting in a substantial increase in the number of food-secure households, from 67 percent in 2005 to 99 percent in 2009. Furthermore, per capita cereal consumption increased to 285 kg from 170 kg over the same period. The program also helped to stabilize food prices and increase the incomes of beneficiaries.

Rwanda provides a notable success story with a system of multiple social mechanisms, including universal health insurance (covering 91 percent of the population), free education, social transfers such as a pension scheme, the Vision 2020 Umurenge Program (VUP), support to survivors of the genocide, and the "one cow per family" program. For instance, the VUP has three components to redirect social protection programs to vulnerable populations: (i) *public works* using community assets to create off-farm employment infrastructure, like watershed management; (ii) the Ubudehe⁸⁰ *credit packages* to tackle extreme poverty and foster off-farm employment opportunities, and (iii) *direct support* to expand access to social services or provisions for landless households, as well as encouraging development of appropriate skills. The Rwandan government allocated about 4.7 percent of the budget to the social protection sector in 2009/2010, an amount expected to reach 4.9 percent in 2010/2011 and 5.1 percent in 2011/2012.

The VUP was launched as a pilot scheme in 2008 with the public works component, followed by the cash transfer in 2009 and the credit

scheme in February 2010. A rapid assessment of the implementation shows that about 55 percent of the beneficiaries saved part of their VUP benefits to buy foodstuffs and productive assets such as livestock and farm inputs.⁸¹ The public works and social grant programs (which constituted 50 percent of the national budget dedicated for social protection) have contributed to a reduction in extreme poverty from 40.6 percent to 9.0 percent among the beneficiaries (European Communities, 2010). The government has linked the success of the program to an overall decrease in extreme income poverty from 39 percent in 2006 to 34.5 percent in 2009. Important lessons from the implementation of this program are the alignment with national strategy, harmonization which provides a good framework for support (e.g. World Bank, EU, and DFID), and a decentralized approach using the Ubudehe mechanism.

Human capital development

There is evidence that social protection in several countries has contributed to human capital development in Africa, but the relationship is not straightforward. Emerging evidence suggests a minimum threshold support level needed for social protection to have a significant impact on the MDGs; moreover, it could lead to diminishing returns if not well managed.

Table 16 provides examples of countries that have used various forms of social protection instruments, including those geared to enhancing school attendance and enrollment. For instance,

81 Beneficiaries used the savings to acquire food commodities (53.3 percent) and to purchase productive assets such as livestock (24.5 percent), farm inputs (18.3 percent) and education (13.1 percent) (European Communities, 2010).

80 Ubudehe is a traditional practice with a culture of collective action to solve community problems.

in **Ethiopia**, the implementation of public works led to the construction of 4,494 school classrooms to improve education services in rural communities. In **Namibia**, both the cash transfers to Orphans and Vulnerable Children (OVC) and the old age pension increased enrollment. **Malawi** provides a good case for the impact of social protection on education. In addition to contributing to increased school enrollment particularly among dropouts (Baird et al., 2010), cash transfers also increased school enrollment by 5 percentage points among children aged 6–17 (Handa and Stewart, 2008).

The implementation of conditional cash transfers in Africa is not without its difficulties. **Nigeria's** conditional cash transfer targeted women whose children were of primary school age group (requiring a minimum of 80 percent attendance) and patronage of hospital facilities by household members (Aigbokhan, 2010). Yet, social protection in the country is still grappling with targeting, sustainability, monitoring and evaluation, and coordination challenges.

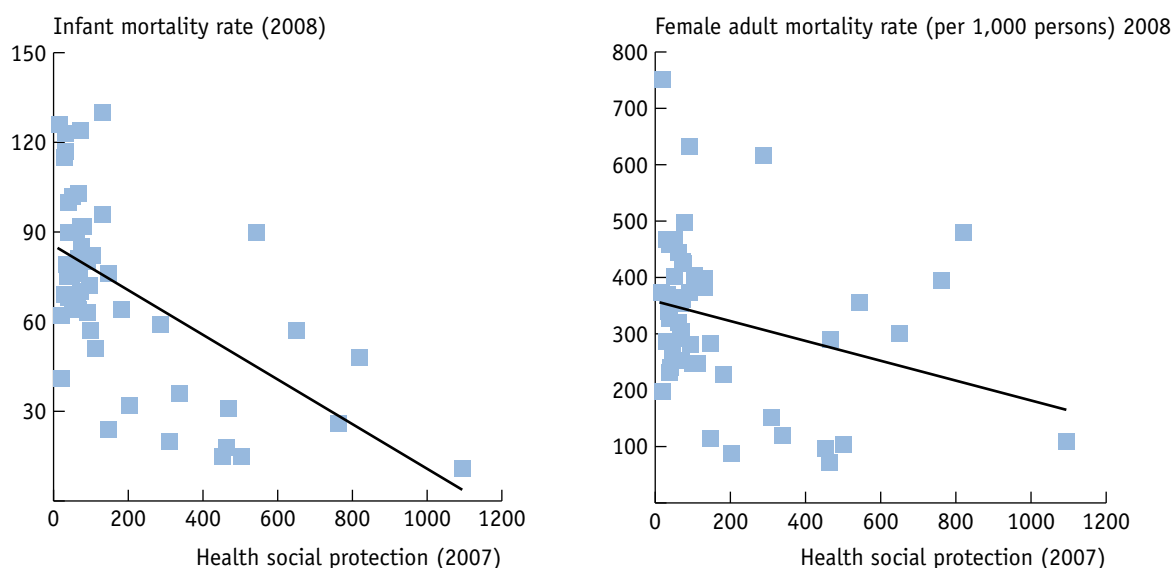
Malawi has also been implementing comprehensive social protection programs, including direct welfare instruments (conditional and unconditional cash transfers, school feeding programs, and food aid); productivity-enhancing programs (e.g., public works programs and fertilizer subsidies); and market intervention programs (control of the price of maize, minimum prices for agricultural produce, and maintenance of strategic food reserves). The impact of the agricultural input subsidies has been resounding and well acknowledged among policymakers and analysts. The program covered 1.7 million smallholder farmers in 2009, and contributed to about 26 percent

reduction in poverty over just four years (between 2005 and 2009). Several publications, including government reports, have linked this program to a 32 percent increase in the proportion of food-secure households during 2005–2009, and to a rapid reduction in under-five stunting and wasting among children. In spite of this achievement, the rising cost of operationalizing this program is threatening its sustainability. The cost of subsidy escalated from MK 5.1 billion (2.1 percent of GDP) in 2005/06 to MK 16.3 billion (3.4 percent of GDP) in 2007/08 and to MK 31.0 billion (5.5 percent of GDP) in 2008/09 (Chirwa, 2010).

An econometric analysis of the child support grant in **South Africa** also shows that children that benefited from the program in their first three years of life increased in height-for-age at age three. This is expected to translate into a 3.5 cm height gain as an adult (Aguero et al., 2007). However, the unconditional cash transfer in **Mozambique** did not show any appreciable impact on nutrition (Yablonski and O'Donnell, 2009). They point out that three major factors explaining the impact of cash transfer and children nutrition are: (i) the duration over which the transfer was received, (ii) the age of the recipient (the window period of 0–24 months of age produced the best result), and (iii) the size of the transfer (very low transfers generate limited impact).

UNICEF and ODI (2009c) reveal that countries with higher social health protection⁸² also have significantly better U5MRs, MMRs, and antenatal care indicators. Evidence from *Figures 56a* and

82 UNICEF and ODI (2009c) used per capita total health expenditure as a proxy for social health protection.

Figure 56a and 56b: Correlation between social protection and health outcomes, 2007

Source: Computations based on UNDP (2010a).

56b supports UNICEF's conclusions on the positive linkage between social protection and health outcomes. Countries that spend more on social protection tend to achieve better health outcomes (reduced infant and female adult mortality rates), especially those that directly support women.⁸³ As indicated by the elasticity of the slope of Figure 56b, a small increase in social protection spending on women substantially reduces female mortality in Africa. The fact that the relationship is U-shaped indicates some possibility of diminishing returns. The implementation of social protection does not automatically yield the desired results. Investment in social protection will support progress on the health MDGs, provided

such investments are efficiently and effectively managed. More efforts should therefore be focused on improving quality management of the social protection mechanisms.

⁸³ Analyses from DFID (2011) and European Communities (2010) suggest that there is limited evidence that conditional social protection yields a better result than the unconditional type.

Table 16: Cases of successful social protection interventions in Africa

Country	Program type and focus	Coverage	Impact
Namibia ⁸⁴	Nutritional support to Orphans & Vulnerable Children (OVC): in 2010; each OVC received N\$30 per month. Old age pension (OAP) (60 years and above) N\$500 per month	160,000 OVCs in rural areas. Beneficiaries of OAP and disability grants rose from 109,894 in 2003 to 130,455 in 2008, representing about 82% coverage of 60 years plus. ⁸⁵ As at 2009, it represented 4.05% of total expenditure and 1.36% of GDP.	Reduced infant mortality rate and increased primary school enrollment and completion rates. It also reduced child mortality. Cash transfer enhanced households' income, which substantially contributed to poverty reduction and gender empowerment while improving their health status (especially MDG 6) and school enrollment (Kaakunga, 2010). Cash transfers reduced poverty incidence by 4.3%, the poverty gap by 18.4% and poverty severity by 27.5 % (Levine et al., 2011).
Nigeria	Conditional cash transfer scheme, termed Care of the People (COPE), focusing primarily on female-headed households, physically challenged women, and women in special groups such as those living with HIV (all with children of basic education age); access conditional upon their investing in the human capital of their children.	Phase 1 of the scheme as at 2009 covered 8,850 households (44,250 individuals) with a threshold ranging from US\$ 100 per month for households with one child to US\$ 33.33 for households with more children.	The cash transfer increased the consumption level of women and hence reduced their poverty level. The scheme, which targets women, was found to have a positive impact on enrollment, school attendance, and use of hospital facilities.
Malawi	Zomba Conditional Cash Transfer Program	It targeted 1,230 school girls and 3,805 girl dropouts. It allocates from US\$ 1 to US\$ 5 per month to girls and from US\$ 4 to US\$ 10 per month to their guardians/parents.	Cash transfers increased school enrollment (particularly among dropouts) and the incidence of unsafe sexual activity was 38% lower among beneficiaries than in the control group (Baird et al., 2010). Cash transfers increased school enrollment by 5% among children aged 6–17 (Handa and Stewart, 2008). Between 2007 and 2008, illness was reduced by 23% among children participating in the Mchinji unconditional cash transfer program, as against 12.5 percent that did not participate in it (DFID, 2011).

84 Total social grants (old age pension and disability grant) as a percentage of government expenditure in Namibia increased from 3.1 percent in 2001/02 to about 6 percent in 2008/09. As a percentage of GDP, it rose from 1 percent to about 2 percent during the same period.

85 The level of coverage tends to vary from one report to another due to variation in population projection (see Levine et al., 2011).

Country	Program type and focus	Coverage	Impact
Malawi	Farm Input Subsidy Program (FISP): A beneficiary household is entitled to either a maize package of fertilizers and seeds or a tobacco package of fertilizers or a cotton package of chemicals and seeds.	Supporting small farm holders to access 2 bags of 50kg fertilizer per year. Approximately, 1.7 million small farm holders are benefiting from the project.	<p>Substantially increased the number of food-secure households from 67% in 2005 to 99% in 2009 and per capita cereal consumption from 170 kg to 285 kg. over the same period.</p> <p>FISP also helped to stabilize food prices and increase incomes of beneficiaries. Also, the proportion of stunting and wasting among under-five year old children fell from 6.4% and 6.8% respectively in 2005 to 4.9 percent and 5.8 percent in 2007.</p> <p>Overall, poverty fell from 52.4% in 2005 to 39.0% in 2009 (Chirwa, 2010).</p>
Ethiopia	Productive Safety Net Program (PSNP) ⁸⁶ was designed as a component of the overall government Food Security Program (FSP)	As at 2009, the program covered 7.56 million chronically food-insecure people in eight regions and 290 districts. This constituted about 10% of the total population. It provides predictable cash and/or food transfers for six months each year. Each household receives up to US\$ 137 in transfers per year, based on 2009 prices.	<p>Rapid expansion of community assets such as roads, dams, erosion control embankments, and schools to mention a few.</p> <p>About 55% of the beneficiaries confirmed that the program had enhanced their real income while about 50% declared that it prevented them from selling their assets during shocks, and more children now stay in schools.</p> <p>The program led to over 30% reduction in the poverty level between 1998 and 2008.</p> <p>It also improved food security by 11% and livestock holding by 7% (European Communities, 2010).</p> <p>PSNP provided food for 7.8 million people suffering from chronic food shortage and 15% of recipients spent unconditional cash transfer on education (DFID, 2011).</p>

86 The PSNP has three core components: labor-intensive public works (for actively productive population), conditional transfers (for very poor people who cannot participate in other form of productive work, e.g. pregnant women, nursing mothers, widows, school children), and unconditional transfers (especially for people with no assets, e.g. destitute).

Country	Program type and focus	Coverage	Impact
South Africa	Child Support Grant (CSG)	It covered poor children up to 18 years, which extended to 8,765,354 as at 2009. Each beneficiary was taking a monthly stipend of R250 (about US\$ 40.0). It represented 28.85% of total social grants in 2008. It presently covers 20% of total population and 70% of children.	Child support facilitated improved food baskets and nutritional status of the recipients and their households, thus reducing stunted growth which used to be a common phenomenon among the black population during apartheid (Delany et al., 2008). It increased height-for-age at three years with an expected increase of 3.4 cm in height at adulthood (Aguero et al., 2007). It has also contributed to better nutrition, primary school enrollment and completion rates, school attendance and functional literacy. Higher school attendance in householders receiving unconditional transfers was also noted in DFID (2011).
	State Old Age Pension (SOAP)	It covers South Africans of 60 years and above with a monthly stipend of R1080 (about US\$ 166.0). As at 2009, it covered 2.4 million beneficiaries, representing 5.3% of the total population and 80% of the elderly.	SOAP reduced the poverty headcount by 2.5% and the poverty gap by 5.1%. All the seven social instruments together ⁸⁷ reduced the poverty gap by 4.3% and the destitution gap by 45% (DSD, 2004 and 2006). Comprehensive system of social protection reduced inequality by three percentage points (Samson, 2007).
Rwanda	Vision 2020 Umurenge Program	It is a three-in-one program consisting in public works, cash transfers, and financial services (credit and savings) involving about 36,000 households. By January 2009 the transfer component had reached 6,800 households in 30 pilot districts.	In addition to enhancing the monitoring and evaluation system, it has contributed to a reduction in extreme poverty from 40.6% to 9.0% (European Communities, 2010).
Ghana	National Health Insurance Scheme	It covers 67% of the population (formal and informal sector employees).	It has reduced out-of-pocket expenditure for health by 50%. It has enhanced access to health services, thereby improving infant and maternal health.
	Livelihood Empowerment Against Poverty program (LEAP)	Monthly transfers from GHS 8 (US\$ 6.9) for one dependant up to a maximum of GHS 15 (US\$ 12.9) for four dependants. Targeting one-sixth of the extremely poor within five years, it provides cash transfers to households with orphaned and vulnerable children (OVC) and highly vulnerable elderly and disabled; reaching 26,200 households in May 2009.	This program contributed to Ghana's success in meeting the poverty target before 2015.

87 The system comprises seven different grants: the Old Age Pension (OAP), Child Support Grant (CSG), Disability Grant (DG), War Veterans' Pension, Foster Care Grant, Care Dependency Grant, and Grant in Aid.

Country	Program type and focus	Coverage	Impact
Algeria	Social Safety Net Program. This comprises The Flat Support Allowance (AFS) and Activities of General Interest (AIG).	<p>Algeria implements a multidimensional social protection system.</p> <p>The AFS is an aid to heads of families or people living alone without income, disabled or incapacitated, older than 60 years, and female heads of households with no income, regardless of age. Since February 2009, beneficiaries are paid 3000 dinars per month, plus an additional payment of 120 dinars per dependant up to a maximum of 3 people.</p> <p>Activities of General Interest (AIG): works of general interest relating to the maintenance and rehabilitation of the housing facilities in urban and rural development, educational activities, cultural, environmental health, and social, and preparation for self-employment.</p>	<p>Although the assessment of the impact of the program has not been carried out in the ECA case study, there is evidence that many people have benefited from the program. For instance, the number of beneficiaries of the AFS was about 622,000 in 2009. They include 288,000 disabled and 272,000 elderly. More than 300,000 dependants benefited from the addition of AFS. The activities of general interest have benefited more than 270,000 people (Boulahbel, 2010). The impact of social protection on reduction of unemployment was rated to be significant: unemployment reduced from 30% in 2000, to 15.3% and 10.2% in 2005 and 2009 respectively (Kpodar, 2007; Algeria 2010 MDG Report).</p>
Kenya	Home-grown school feeding program	Conditional transfers to schools for local purchase of food covering 500,000 pupils in 29 arid and semi-arid districts and two Nairobi slum areas.	The program boosted local food production, increased children's dietary intake, and children's learning capability and school attendance.
Lesotho	Old age pension	All registered citizens of 70 years and above. It is estimated to cost less than 2.0% of GDP.	<p>Increased household food and health security and participation of elderly in household and community activities (European Communities, 2010).</p> <p>50% of recipients have increased their spending on health since 2005 (Samson, 2007).</p> <p>48% of old age pensioners confirmed they never went hungry after the introduction of the grant compared to 19% before. Recipients also claimed they bought uniforms, books and materials for their grandchildren (DFID, 2011).</p>

Sources: Compilation based on the 2010 ECA case studies from 9 countries; Samson (2007); Holmes and Barrientos (2009); European Communities (2010); Baird et al. (2010); Boulahbel (2010), Chirwa (2010); Levine et al. (2011); and DFID (2011).

OPPORTUNITIES AND CHALLENGES

Lessons for policy consideration

The country studies cited above demonstrate a number of important aspects that should inform policy direction for African countries interested in introducing social protection interventions. Many African countries have shown that social protection is feasible if there is strong political will at the national level, linked to solid support from development partners. Nonetheless, there is a need for improvement in a number of areas.

Fiscal sustainability of social protection mechanisms: It is important to plan for the sustainability of social protection in Africa. Although the situation remains sustainable in several countries (e.g., South Africa and Namibia), this is not the case for many others, including Malawi, especially on the agricultural subsidy program. Planning for fiscal sustainability includes developing an efficient domestic resource mobilization strategy, the reallocation of budgets, and the judicious use of external support. Conditional and production-based social protection could also lead to financial sustainability. When specific social protection instruments (especially cash transfers) are implemented in isolation of complementary interventions that support livelihoods (such as skills acquisition), exiting from the poverty trap becomes difficult, which compromises sustainability.

Donor-driven social protection has severe resource limitations in terms of the predictability and sustainability of such programs. For this reason, social protection needs to be institutionalized to increase the likelihood of predictable and adequate budgetary allocations. A recent study by

the ILO (2008)⁸⁸ provides some guidelines for the implementation of basic social security schemes. A package of social protection that includes the following measures is considered to be potentially sustainable: targeted basic child healthcare support (15 percent of per capita GDP up to US\$ 0.50 a day in purchasing power parity – PPP); targeted income support to the poor and unemployed as well as pensions to the elderly and persons with disabilities (30 percent of per capita GDP up to US\$ 1.0 per day (PPP) paid to 1 percent of working-age population and all people of 65 years and above). However, the relatively low tax-GDP ratio (i.e., approximately 10–18 percent) in several African countries tends to suggest more robust domestic resource mobilization efforts are needed to ensure the long-term feasibility of such projects. In parallel, development assistance will be needed in the short term to supplement domestic resources.

Social protection strategies as a mutually reinforcing package: Social protection schemes should not be seen as individual instruments but rather as an integrated agenda. For instance, a “social security” agenda is concerned with delivering social assistance and basic services to vulnerable groups, while a “food security” agenda is concerned with ensuring sustainable livelihoods for the working poor: they are mutually reinforcing. In reality, protection is needed against both “life-cycle risks” (such as in early childhood and old age) and “livelihood risks” (such as unemployment or crop production shocks). When social protection

88 The study was conducted on 12 low-income countries (including Burkina Faso, Cameroon, Ethiopia, Guinea, Kenya, Senegal, and Tunisia) to determine the cost of a basic social security scheme consisting of universal primary health care, basic old age and disability pension, basic child benefits for the first two children, and provision of 100 day employment guarantee to the poorest decile of the working population.

mechanisms are managed holistically, they tend to generate maximum benefits toward attainment of the MDGs.

Coordination issues: Almost all the countries reviewed revealed an absence of effective coordination at both vertical and horizontal levels. This includes inter-governmental and inter-agency collaboration and coordination. Duplication of efforts across similar agencies of the same government or between tiers of governments adds to transaction costs, reduces effectiveness, and impairs results. There is a need for societal and political consensus to support the design, implementation, and evaluation of the program. The case studies have shown that while social protection in those countries has had a positive effect on the MDGs, the outcome has been largely accidental and not a conscious policy effort. In several countries, social protection interventions are generally individual interventions addressing a vulnerable group rather than an instrument for social development; they are therefore not explicitly linked to the MDGs. Forging closer links between such initiatives and MDG outcomes is vital to ensure coherence in national planning and budget execution and to promote coordination and synergies across line ministries. There is a need to acknowledge the transformational potential of social protection instruments and to link this to the overall MDG-based planning process.

Learning from other social protection mechanisms: South–South cooperation could play an important role in using social protection to accelerate the MDGs, although it must be remembered that country contexts may differ. Transferability of lessons will depend on the local context and ability to manage implementation challenges.

Monitoring and evaluation: Adequate monitoring and evaluation systems need to be developed in order to determine which interventions are successful, to assess impact, conduct cost/benefit analysis, and inform future interventions. For better policy impact, monitoring should be institutionalized and separated from implementation. Greater precision in targeting is necessary to ensure that only those who require social protection benefits receive them. This also helps to minimize the unintended exclusion of deserving beneficiaries.

Building and sustaining an implementation mechanism: A gradual process of implementation that allows for a feedback process is important for success. The social protection system should be tested through pilots and then scaled up, once the design features have been fully tested. Other integral parts of effective implementation strategies include the registration of potential beneficiaries, determining eligibility, and establishing payment mechanisms that are based on transparent and accountable processes. An important element of implementation is having the required human resources to manage the process. Effective implementation also calls for the development of national guidelines, focusing on how to coordinate interventions, efficiently target beneficiaries, ensure continuity, and limit wastage. It will also include the establishment and enforcement of a clear set of criteria to select beneficiaries.

Legitimization: To ensure the continuity of social protection schemes, social protection as a fundamental right of citizenship has to be legally enshrined. Legitimacy will also ensure the establishment of institutional frameworks, national guidelines, and budget provisions.

Strengthening capacity for social protection design and delivery: There needs to be in place adequate institutional and administrative capacity to design, implement, and broaden social protection programs. Governments need to invest in the capacity of those agencies responsible implementing social protection programs. This includes building human and institutional capacity, the provision of complementary services, and monitoring and evaluation. It also requires developing a robust evidence base and an accessible knowledge management system.

SECTION IV:

Conclusions and Perspectives on the Post-2015 MDG Agenda

The continent continues to make steady, albeit modest progress toward attainment of the MDGs, notwithstanding the adverse effects of the global financial, food and fuel crises. Africa's performance with respect to primary enrollment, gender equality in primary school enrollment, women's representation in decision-making, child immunization, and stemming the spread of HIV/AIDS and TB has been especially strong.

Countries recovering from conflict have also made tremendous progress in reducing the under-five mortality rate, despite their challenging economic and social conditions. These developments, particularly in postconflict and fragile states, suggest that with political will, adequate resources, and strengthened governance structures, the MDGs can be achieved even under very difficult circumstances.

However, emerging trends for a number of other indicators give cause for concern. The pace of progress in halving poverty rates, creating productive employment, and reducing hunger and malnutrition has been very slow. Favorable trends in poverty reduction were reversed by global shocks and the absolute number of the working poor is on the rise. Indeed, more than one out of every two workers is poor (i.e., earns less than US\$ 1.25 per day), and this figure is expected to rise. High youth unemployment, particularly among female

youth in North Africa, is another growing area of concern, given its potential for igniting conflict and social unrest.

Efforts to reduce the incidence of hunger have yielded positive results, but here too progress has been modest. The region merely succeeded in reducing hunger by an annual average of about 0.7 percent over the past two decades. Rising energy and food prices are likely to further undermine performance on this indicator, with adverse consequences for the prevalence of underweight and undernourished children. Indeed, Africa's progress in reducing the proportion of undernourished people was stalled by the increase in food prices during 2006–2008.

Rising primary enrollment rates have not been matched by a proportionate increase in primary school completion rates, which also impacts the literacy rate. And while there has been overall progress in gender equality and women's empowerment, the continent is off-track on achieving gender parity at the secondary and tertiary levels of education. In fact, in several countries, the trend is now biased against boys, which needs to be addressed to restore parity.

Progress on health indicators such as the under-five mortality, infant mortality, and immunization has been encouraging, although not at a sufficient

pace to achieve these targets by 2015. For example, the continent reduced under-five mortality by one-third over the period 1990–2009 but this performance is not sufficient to meet the Goal by 2015. Access to reproductive health in Africa is limited but improving steadily, although only one in five married women aged 15–49 uses any method of family planning. This trend may explain why the region has the highest birth rate among adolescents (defined as the number of births per 1,000 women aged 15–19). Africa, however, recorded remarkable gains in antenatal care, with a significant increase in the proportion of women attended by a skilled health worker at least once during pregnancy in North Africa – rising from 46 percent in 1990–1999 to 80 percent in 2000–2009.

Africa faces a formidable challenge in reducing the Maternal Mortality Ratio. While all regions made progress on this indicator, the rate remains exceedingly high and tops 1,000 deaths per 100,000 in several countries. Factors influencing high maternal death rates include delays in deciding to seek care, delays in reaching care, and delays in receiving care. Other contributing factors include the high level of adolescent births and high unmet family planning needs. In this context, the availability and take-up of skilled birth assistance are vital for reducing maternal deaths. Yet, access to such services is particularly limited in Africa (excluding North Africa), where more than half the pregnant women deliver without skilled assistance.

Efforts toward stemming the tide of HIV and AIDS appear to be yielding positive results. There has been significant progress both in preventing new infections and in making antiretroviral treatment available to infected people. The largest epidemics

in the region in terms of the number of newly infected people have stabilized or are showing signs of decline. There are, however, significant cross-country variations, with some countries recording setbacks, both in prevention and treatment. Furthermore, the absolute number of adults and children living with HIV and AIDS has increased. Improvements in sexual behavior among people in many African countries (i.e., an increase in condom use and a decline in the number of adults who have multiple partners) largely explain the decline in HIV and AIDS incidence and prevalence rates. Given the interdependence between HIV/AIDS and tuberculosis, improvements in HIV and AIDS prevalence rates have been associated with corresponding declines in TB prevalence rates, since 2004. Malaria mortality rates have also declined, supported by increased access to insecticide treated bednets and Artemisinin-based Combination Therapy (ACT). Strong political leadership underpinned by external financial support has been a major driver in the fight against malaria in the continent.

Africa's performance on environment indicators has been mixed. On the one hand, consumption of ozone-depleting substances (ODSs) has declined markedly and access to improved water sources has improved. On the other hand, although Africa's contribution to greenhouse gases is marginal, emissions are on the rise and most countries are off-track to meet the biodiversity target, due to limited progress in protected area coverage.

Notwithstanding substantial improvements in access to safe drinking water, the pace of progress is insufficient for the continent to reach the target by 2015. Relative to urban areas, progress has been rapid in rural areas. Access to safe water remained

virtually unchanged in urban settings over the same period. This is partly attributable to the growth in rural–urban migration and to poor living conditions in the informal settlements which have sprung up to accommodate the influx.

Sanitation is still a struggle in most countries, especially for the rural population; only one-third of this segment has access to improved sanitation. The number of slum dwellers in Africa has also declined but only marginally; approximately two out of every three urban dwellers live in slums.

The challenge for Africa in achieving MDG 7 – and indeed other MDGs – is exacerbated by the threat of climate change and its impacts on ecosystems, water supply, and the degradation of biodiversity in Africa. Rising temperatures and changing rainfall patterns in Africa may reduce agricultural output, exacerbating food insecurity and malnutrition. This is likely have a devastating impact on the food security situation of the most vulnerable households. Both short-term and long-term assistance will be needed to step up investments to African agriculture, including research, advisory services, and market-related infrastructure.

Official Development Assistance (ODA) to Africa has increased in recent years but still remains far below the commitments made by the development partners at the G-8 Gleneagles Summit in 2005 to double aid. Bilateral ODA to Africa increased modestly in 2010 as a result of increased bilateral grants and lending, and debt forgiveness. However, overall aid remains below the Monterrey targets and Gleneagles commitments. Nevertheless, debt forgiveness has helped to relieve the high debt burden of African countries, although some HIPC post-completion point countries remain at high risk

of debt relapse. Social services, particularly reproductive health, account for a substantial share of ODA, although the relative share of the productive sector (specifically agriculture, fishing and forestry) has been growing in recent years. This reflects a gradual shift in favor of a sectoral distribution of aid. It is also important to balance the flow of ODA going to food support with resource allocation to agricultural development, to sustain gains already made in lifting people out of poverty.

Overall, the pace of Africa's progress toward the MDGs has been slow and generally insufficient to meet the target date. Performance has also been mixed and characterized by substantial variations in access to basic social services across subregions and countries, as well as within countries. Intra-country variations in performance are typified by rural–urban splits and disparities across income groups. Where spatial differences in access to basic social services coincide with ethnic boundaries, horizontal inequalities (i.e., inequalities across different ethnic groups) are exacerbated. This could heighten tensions and become a source of social unrest.

THE WAY FORWARD: CONSIDERATIONS FOR ACCELERATING PROGRESS AND FOR THE POST-2015 MDG AGENDA

Accelerating progress toward 2015

As we approach 2015, we need to redouble our efforts to accelerate progress on the MDGs in a more systematic and pragmatic way. In this endeavor, we can learn from our past experiences, identify key bottlenecks militating against progress, and collectively find and prioritize solutions. National development strategies should prioritize action plans, and frame interventions that have

proven multiplier effects across all of the MDGs. In particular, the focus should be on expanding access to energy, investing in women and girls, and developing capacity for local and economic governance.

There are fruitful experiences and lessons to be drawn from many African countries that can support acceleration. However, most of the successful interventions are at the pilot stage and need to be scaled up for greater impact. Depending on the country context, such interventions should be identified for prioritization and funding at the national level. For instance, successes in the implementation of social protection can be strengthened, resourced, and accelerated. Existing social protection programs should be legitimized, their implementation mechanisms improved, coordination enhanced, and their sustainability planned for.

It is important to address the existing fragmentation of efforts and resources of government agencies, development partners, and other stakeholders on concrete and targeted measures. Interventions designed to address challenging MDGs should have multiplier effects for the other goals. Partnership and collaboration around the challenging MDGs need to be strengthened for better results.

The post-2015 MDG agenda

As the year 2015 draws inexorably closer, the question on the minds of most development practitioners is: What next? What should be the post-2015 development agenda? Should the current MDG agenda be replaced in its entirety, continue in a modified form, or simply be extended in its present configuration? These are difficult questions with no obvious answers. What is clear, however, is that the performances of different regions, countries, and

indeed subnational entities have varied markedly. Some have made very good progress while others have stalled or fallen behind. So for countries that have achieved the targets, such MDGs may no longer be relevant in their current form. What may be relevant for MDG achievers is an agenda that prioritizes the consolidation and sustainability of progress on the Goals.

For subregions in Africa with mixed progress on the MDGs, the priorities are twofold: achieving the unmet targets, while sustaining progress on those targets that have been achieved. For such subregions and countries, the post-MDG agenda should prioritize strengthening implementation modalities and forging partnerships to ensure that all the MDGs are indeed achieved. In parallel, to sustain progress on the achieved targets and prevent slippages, measures could include improving education quality, minimizing inequalities in access to social services, and strengthening capacities for disaster risk reduction.

So, as we approach the MDG target year, the post-2015 agenda needs to recognize that achieving the Goals is not a one-off event but a dynamic process, subject to shocks and reversals resulting from exogenous and endogenous factors. And while achieving the MDGs is a critical first step, consolidating and sustaining this hard-won progress may turn out to be an even more daunting challenge.

References and Web Resources

Aguero, J. M., M. R. Carter, and I. Woodland (2007). "The Impact of Unconditional Transfers on Nutrition: The South African Child Support Grant." UNDP International Poverty Centre Working Paper No. 39.

Aigbokhan, B. E. (2010). "Exploring the Scope of Social Protection as an Instrument for Achieving the MDGs in Nigeria." A Case Study commissioned by the ECA, September 2010.

Ajakaiye, D. O. and A. F. Odusola (2002). "Poverty in a Globalizing Nigerian Economy: The Role of Rural Institutions" in Mashiko Nissanke (ed.), *Globalization and Poverty: The Role of Rural Institutions*. Tokyo: Foundation for Advanced Studies on International Development (FASID).

AU (2008). "Social Policy Framework for Africa." First Session of African Union Ministers in Charge of Social Development, October 2008, Windhoek.

Baird, S., C. McIntosh, and B. Ozker (2010). "Cash or Condition? Evidence from a Cash Transfer Experiment?," World Bank Policy Research Working Paper No. 5259. Washington, DC: World Bank.

Baliamoune-Lutz, M. (2010). "Social Protection and Africa's Progress towards Achieving the MDGs." Available at: <<http://erd.eui.eu/media/2010/Baliamoune.pdf>>

Barrientos, A. and A. Shepherd (2003). "Chronic Poverty and Social Protection." Paper presented at the CPRC Conference on Chronic Poverty, University of Manchester, UK, April 2003.

Boden, T. A., G. Marland, and R. J. Andres (2010). *Global, Regional, and National Fossil-Fuel CO₂ Emissions*. Carbon Dioxide Information Analysis Center, Oak Ridge National Laboratory, U.S. Department of Energy, Oak Ridge, TN.

Bonilla García, A. and J. V. Gruat (2003). "Social Protection: A Life Cycle Continuum Investment for Social Justice, Poverty Reduction and Sustainable Development." Geneva: ILO.

Boulahbel, B. (2010). La portée des filets de sécurité sociale et des régimes de protection sociale pour faire avancer les progrès en vue de la réalisation des OMD en Afrique, ÉTUDE SUR L'ALGÉRIE. A Case Study Commissioned by ECA, November 2010.

Chaudhuri, S. and U. Mukhopadhyay (2010). *Revisiting the Informal Sector: A General Equilibrium Approach*. London/New York: Springer.

Chen, S. and M. Ravallion (2008). "The Developing World is Poorer than We Thought, but No Less Successful in the Fight against Poverty." World Bank Policy Research Working Paper No. 4703. Washington, DC: World Bank.

- Chirwa, E.W. (2010). "Exploring the Scope of Social Protection as an Instrument for Achieving the MDGs in Malawi". A Case Study commissioned by the ECA, October 2010.
- Clemens, M. (2004). "The Long Walk to School: International Education Goals in Historical Perspective," Working Papers No. 37. Washington, DC: Center for Global Development.
- Conning, J. and M. Kevane (2001). "Community Based Targeting Mechanisms for Social Safety Nets." Social Protection Discussion Paper Series, No. 0102. Washington, DC: World Bank.
- Conway, T., A. de Haan, and A. Norton (eds.) (2000). "Social Protection: New Directions of Donor Agencies." London: DFID.
- Delany, A., Z. Ismail, L. Graham, and Y. Ramkissoon (2008). "Review of the Child Support Grant: Uses, Implementation and Obstacles." Report commissioned for the Department of Social Development, South African Social Security Agency and the United Nations Children's Fund. Johannesburg: Community Agency for Social Enquiry.
- Desta, G. T. (2010). "Exploring the Scope of Social Protection as an Instrument for Achieving the MDGs in Ethiopia." A Case Study commissioned by the ECA, February 2010.
- Dethier, J.-J., P. Pestieau, and R. Ali (2010). "Universal Old Age Pensions: Impact on Poverty and Fiscal Cost in 18 Latin American Countries." Policy Research Working Paper, WPS 5292. Washington, DC: World Bank.
- Devereux, S. and S. Coll-Black (2007). "Review of Evidence and Evidence Gaps on the Effectiveness and Impacts of DFID-supported Pilot Social Transfer Schemes." Evaluation Working Paper (unpublished). London: DFID.
- DFID (2011). Cash Transfers Evidence Paper, April. Policy Division. London: Department for International Development.
- Dorward, A., E. Chirwa, and R. Slatter (2010). "Evaluation of the 2008/09 Agricultural Input Subsidy Programme, Malawi. Report on Programme Implementation." Paper prepared for the Malawi Government and DFID (Malawi).
- DSD (2004). *The Social and Economic Impact of South Africa's Social System*, Pretoria: Department of Social Development.
- DSD (2006). *The Incentive Structure of Social Assistance Grants in South Africa*. Pretoria: Department of Social Development.
- ECA (2005). "Meeting the Challenges of Unemployment and Poverty in Africa." *Economic Report on Africa 2005*. Addis Ababa: ECA.
- ECA (2007). "Accelerating Africa's Development through Diversification." *Economic Report on Africa 2007*. Addis Ababa: ECA.
- ECA (2009a). *The African Social Development Report 2009*. Addis Ababa: ECA.
- ECA (2009b). "Access to Social Services in African LDCs." Addis Ababa: ECA.

- ECA (2010a). "Promoting High level Sustainable Growth to Reduce Unemployment in Africa." *Economic Report on Africa 2010*. Addis Ababa: ECA.
- ECA (2010b). "Tracking Progress in the Implementation of Regional and International Agendas, Including NEPAD and Other Special Initiatives in the Sub-region: Ensuring environmental sustainability in West Africa." SRO-West Africa, ECA.
- ECA and AUC (2011). "Governing Development in Africa: The Role of the State in Structural Transformation." Issues Paper. Addis Ababa: ECA.
- ECA and OECD (2011). *The Mutual Review of Development Effectiveness in Africa: 2011 Interim Report*. Paris: OECD Publishing.
- EPROM (2009) "Why Africa?" Accessed July 3, 2011 at: <<http://media.mit.edu/ventures/EPROM/whyafrica.html>>
- European Communities (2010). *Social Protection for Inclusive Development: A New Perspective in EU Co-operation with Africa*, The 2010 European Report on Development. Robert Schuman Center for Advanced Studies. Florence: European University Institute.
- FAO (2010). *Food Prices in Africa: Quarterly Bulletin* – December 2010, Regional Price Update and Responses, No.7.
- FAO and WFP (2010). *The State of Food Insecurity in the World 2010: Addressing Food Insecurity in Protracted Crises*. Rome: FAO.
- Fiszbein, A. and N. Schady (2009). *Conditional Cash Transfers: Reducing Present and Future Poverty*. World Bank Policy Research Report. Available at: <<http://go.worldbank.org/UQEK2J5E0>>
- Go, D. S., R. Harmsen, and H. Timmer (2010). "Regaining momentum", *Finance and Development*, September 2010.
- Government of Algeria (2010). *The National MDG Report*, Algiers.
- Government of Egypt (2010). *The National MDG Report*, Cairo.
- Government of Ethiopia (2010). *The National MDG Report*, Addis Ababa.
- Government of Lesotho (2010). *The National MDG Report*, Maseru.
- Government of Mozambique (2010). *The National MDG Report*, Maputo.
- Government of Nigeria (2010). *The National MDG Report*, Abuja.
- Government of Sierra Leone (2010). *The National MDG Report*, Freetown.
- Government of South Africa (2010). *The National MDG Report*, Pretoria.
- Government of Togo (2010). *The National MDG Report*, Lomé.
- Government of Uganda (2010). *The National MDG Report. Special theme: Accelerating progress toward improving maternal health*. Kampala.
- Handa, S. and S. Stewart (2008). "The Orphan Targeting Dilemma in Eastern and Southern Africa," in: D. Halilu and F. V. Soares (eds.), *Cash Transfers, Lessons from Africa and Latin America*, Poverty in Focus No. 15, Brazil: International Poverty Centre.

- Holmes, R. and A. Barrientos (2009). "Child Poverty: a Role for Cash Transfers? West and Central Africa." UNICEF and ODI Briefing Paper Social Policy. UNICEF Regional Office, West Africa.
- IFAD (2010). *Rural Poverty Report 2011. New Realities, New Challenges: New Opportunities for Tomorrow's Generation*. Rome: IFAD.
- IFPRI (2010). *2010 Global Hunger Index*. Washington, DC: IFPRI.
- IGME (2010). *Levels & Trends in Child Mortality. Report 2010*. New York: UNICEF.
- ILO (2008). "Can Low-income Countries Afford Basic Social Security?" Social Security Policy Briefings, Paper No. 3. Geneva: ILO. Available online at: < www.ilo.org/public/english/protection/secsoc/downloads/policy/policy3e.pdf.>
- ILO (2009). *Global Employment Trend*. January 2009. Geneva: ILO.
- ILO (2010a). *Global Employment Trends for Youth: Special issue on the impact of the global economic crisis on youth*. August 2010. Geneva: ILO.
- ILO (2010b). *Compiling Country-level Working Poverty Indicators: Group Exercises*. Economic and Labour Market Analysis Department. Geneva: ILO.
- ILO (2010c). *Global Wage Report 2010/2011: Wage Policies in Times of Crisis*. Geneva: ILO.
- ILO (2011). *Global Employment Trends 2011: The Challenge of Jobs Recovery*. Geneva: ILO.
- ILO and WHO (2009). *The Social Protection Floor: A Joint Crisis Initiative of the UN in a Globalizing World*. Geneva: ILO/WHO.
- IMF (2010). *World Economic Outlook*. Washington, DC: IMF.
- Jones, N., W. Ahadzie, and D. Doh (2009). *Social Protection to Tackle Child Poverty in Ghana*. New York: UNICEF and ODI.
- Kaakunga, E. (2010). "Exploring the Scope of Social Protection as an Instrument for Achieving the MDGs in Namibia." Case Study commissioned by the ECA, February 2010.
- Kaniki, S. (2007). Mauritius Case Study. Unpublished report. Cape Town: Economic Policy Research Institute.
- Kpodar, K. (2007). "Why Has Unemployment in Algeria Been Higher than in MENA and Transition Countries?" Washington, DC: IMF.
- Levine, S., S. van der Berg, and D. Yu (2011). "The Impact of Cash Transfer on Household Welfare in Namibia," *Development South Africa*, Vol. 28, No.1, March.
- Miller, C. M., M. Tsoka, and K. Reichert (2010). "Targeting Cash to Malawi's Ultra-Poor: A Mixed Methods Evaluation," *Development Policy Review*, Vol. 28, No. 4, pp. 481–502.
- Obadan, M. I., A. F. Odusola, and W. O. Akerele (1999). "Strategies for Revitalizing the Nigerian Economy: The Role of the Informal Sector," in: *The Role of Human Capital Formation and the Public and Private Sectors in Revitalizing the Nigerian Economy*. Proceedings of the One-Day Seminars held in 1995 and 1996. Ibadan: Nigerian Economic Society.

- OECD (2010). *Perspectives on Global Development 2010: Shifting Wealth*. Paris: OECD.
- ONE (2010). *The DATA Report 2010: Monitoring the G8 Promise to Africa*. Washington, DC: ONE.
- Ortiz, I., J. Chai, and M. Cummins (2011). "Escalating Food Prices: The Threat to Poor Households and Policies to Safeguard a Recovery for All." UNICEF Social and Economic Policy Working Paper. New York: UNICEF.
- Pinkovskiy, M. and X. Sala-i-Martin (2010). "African Poverty is Falling ... Much Faster than You Think," NBER Working Paper No. 15775. Cambridge, MA: NBER.
- Samson, M. (2007). *Social and Economic Impact of Benefits of Children and Older People in Southern Africa*. Cape Town: EPRI Press.
- Samson, M. et al. (2004). "The Social and Economic Impact of South Africa's Social Security System." Economic Policy Research Institute (EPRI) Research Paper No. 37. Cape Town: EPRI Press.
- Samson, M., I. van Niekerk, and K. Mac Quene (2006). *Designing and Implementing Social Transfer Programmes*. Cape Town: EPRI Press.
- Subbarao, K. (1998). "Namibia's Social Safety Net: Issues and Options for Reforms." Mimeo, Poverty Reduction and Economic Management Network, World Bank Working Paper No. 1996. Washington, DC: World Bank.
- Taylor, V. (2009) "Social Protection in Africa: An Overview of the Challenges." Prepared for the African Union.
- UIS Fact Sheet, September 2010, No. 4.
- UN (2010). *The Millennium Development Goals Report*. New York: UN.
- UNAIDS (2010). *Report on the Global AIDS Epidemic 2010*. Geneva: UNAIDS.
- UNCTAD (2010). *Economic Development in Africa Report 2010. South-South Cooperation: Africa and the New Forms of Development Partnership*. Geneva: UNCTAD.
- UNDP (2010a): *Human Development Report 2010. The Real Wealth of Nations: Pathways to Human Development*. 20th Anniversary edition. New York: UNDP.
- UNDP (2010b): "The Role of Social Protection in Enhancing Food Security in Africa." Mimeo of the Regional Bureau for Africa. New York: UNDP.
- UNDP (2011). "Action Plan to Speed Up Progress on the MDGs (2011–2015)." Background Paper prepared for the MDG Africa Steering on Africa MDG Action Plan, Regional Bureau for Africa Mimeo. New York: UNDP.
- UNESCO (2009). *Overcoming Inequality: Governance Matters*. Education for All Global Monitoring Report. New York: UNESCO.
- UNESCO (2010). *Reaching the Marginalized*. Education for All Global Monitoring Report, New York: UNESCO.
- UNESCO (2011). *The Hidden Crisis: Armed Conflict and Education*. Education for All Global Monitoring Report. New York: UNESCO.

- UN-Habitat (2010). *State of the World's Cities 2010/2011: Bridging the Urban Divide*. Nairobi: UN-Habitat.
- UNICEF (2010). *Trailing Progress on Child and Maternal Nutrition: A Survival and Development Priority*. New York: UNICEF.
- UNICEF and ODI (2009a). *Promoting Synergies between Child Protection and Social Protection in West and Central Africa*. UNICEF Regional Office for West and Central Africa.
- UNICEF and ODI (2009b). *Social Protection to Tackle Child Poverty in Ghana*. UNICEF's Briefing Paper (Social Policy), February 2009.
- UNICEF and ODI (2009c). *Maternal and Child Health : The Social Protection Dividend*. Regional Thematic Report 4 Study for the West and Central Africa. February 2009.
- UNICEF and UNESCO (2011). "Imperative for Quality Education for All in Africa: Ensuring Equity and Enhancing Teaching Quality." Background paper prepared for the ECOSOC Annual Ministerial Review, held in Lomé, Togo, April 2011.
- WHO (2009). *World Health Statistics 2009*. Geneva: WHO.
- WHO (2010a). *World Malaria Report 2010*. Geneva: WHO.
- WHO (2010b). *World Health Statistics 2010*. Geneva: WHO.
- WHO (2011). "HIV Drug Resistant Factsheet." April 2011. Geneva: WHO.
- WHO/UNICEF/UNFPA and World Bank (2010). *Trends in Maternal Mortality: 1990 to 2008* Geneva: WHO.
- Wodon, Q. (2007). "Growth and Poverty Reduction in West Africa: A Brief Overview" in: Q. Wodon (ed.), *Growth and Poverty Reduction: Case Studies from West Africa*. Washington, DC: World Bank.
- World Bank (2003a). *Social Risk Management: The World Bank's Approach to Social Protection*. Washington, DC: World Bank.
- World Bank (2003b). *Kyrgyz Republic Poverty Assessment*. Chapter 8. Washington, DC: World Bank.
- World Bank (2010). *The World Bank's Reproductive Health Action Plan 2010-2015*, Washington, DC: World Bank.
- World Bank and IMF (2010). *Global Monitoring Report 2010: The MDGs after the Crisis —Overview*. Background report for the Development Committee Meeting, DC2010-0008, April 21, 2010. Washington, DC: World Bank/IMF.
- World Bank and IMF (2011). *Global Monitoring Report 2011. Improving the Odds of Achieving the MDGs (2011): Heterogeneity, Gaps and Challenges*. Washington, DC: World Bank/IMF.
- Yablonski, J. and M. O'Donnell (2009). *Lasting Benefits: The Role of Cash Transfers in Tracking Child Mortality*. London: Save the Children Fund.

Annex 1:

Official list of MDG indicators

Effective 15 January 2008

Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than USD 1 per day	1.1 Proportion of population below USD 1 (PPP) per day ⁸⁹ 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below USD 1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrollment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary school 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament

⁸⁹ For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Goal 4: Reduce child mortality	
Target 4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of one-year-old children immunized against measles
Goal 5: Improve maternal health	
Target 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rates for married people 5.4 Adolescent birth rate 5.5 Antenatal care coverage 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use for high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Goal 7: Ensure environmental sustainability	
Target 7A: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO ₂ emissions, total, per capita and per USD1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
Target 7B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums ⁹⁰
Goal 8: Develop a global partnership for development	
Target 8A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system <i>Includes a commitment to good governance, development and poverty reduction – both nationally and internationally</i> Target 8B: Address the special needs of the least developed countries	<i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i> 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 ODA of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their GNI

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

Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Goal 8: Develop a global partnership for development cont.	
<p><i>Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</i></p> <p>Target 8C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p>Target 8D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</p>	<p>8.5 ODA received in small island developing States as a proportion of their GNI</p> <p>Market access</p> <p>8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty</p> <p>8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries</p> <p>8.8 Agricultural support estimate for OECD countries as a percentage of their GDP</p> <p>8.9 Proportion of ODA provided to help build trade capacity</p> <p>Debt sustainability</p> <p>8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)</p> <p>8.11 Debt relief committed under HIPC and MDRI Initiatives</p> <p>8.12 Debt service as a percentage of exports of goods and services</p>
Target 8E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis

Millennium Development Goals (MDGs)

Goals and Targets (from The Millennium Declaration)	Indicators for Monitoring Progress
Target 8F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

The Millennium Development Goals and targets 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".



African Development Bank Group



Economic Commission
for Africa



African Union



United Nations
Development Programme