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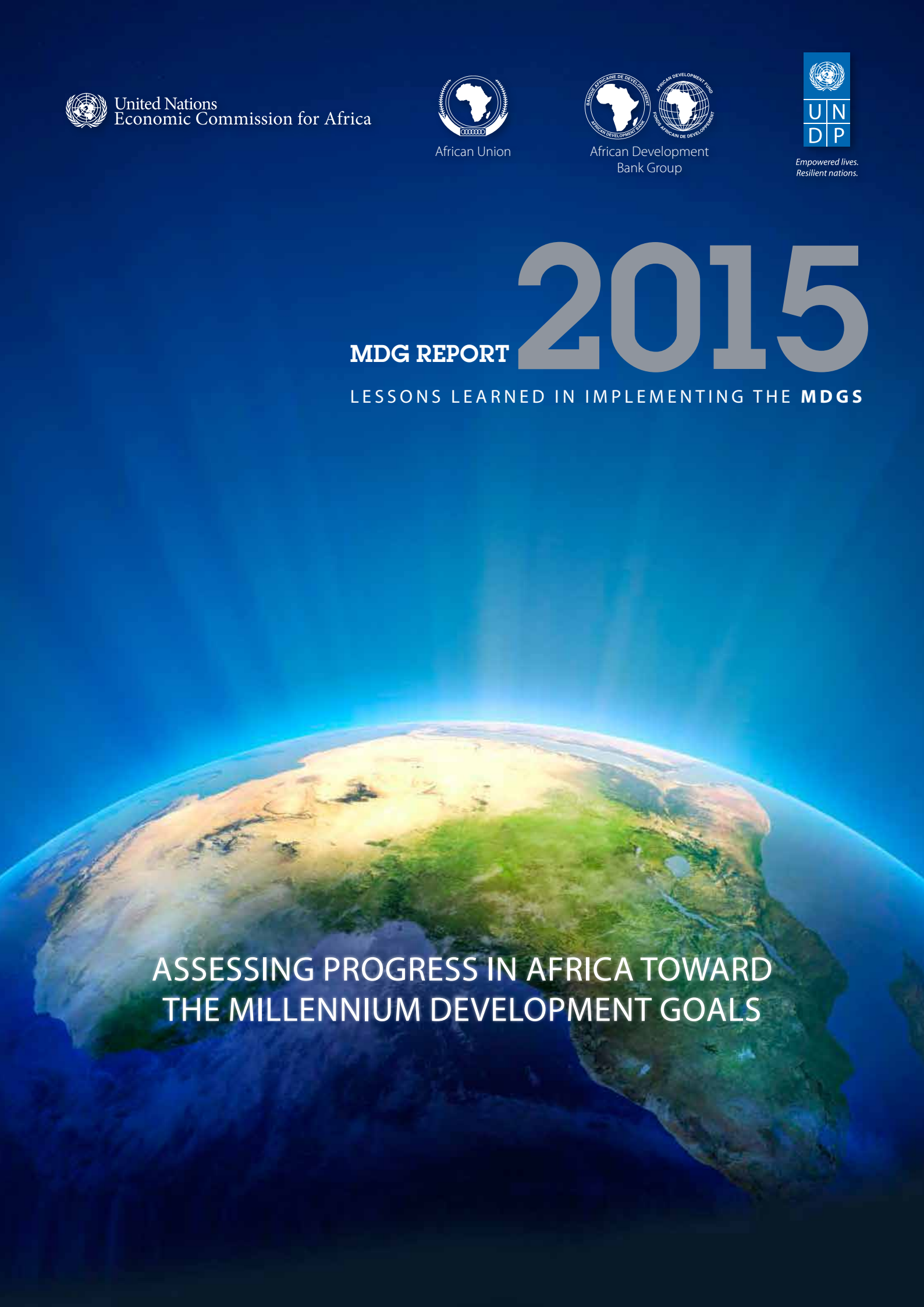
LESSONS LEARNED IN IMPLEMENTING THE **MDGS**



ASSESSING PROGRESS IN AFRICA TOWARD THE MILLENNIUM DEVELOPMENT GOALS

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Foreword

2015 is a watershed year for global development discourse. It marks the winding down of the MDGs, and also the confluence of events which will shape the global development agenda for years to come: the recently concluded Sendai Third UN World Conference on Disaster Risk Reduction; the Third International Conference on Financing for Development; the upcoming United Nations summit for the adoption of the post 2015 development agenda in September; and the United Nations Climate Change Conference (COP 21) in December.

These landmark events are ushering in new global agendas and defining their means of implementation.

The MDGs have helped focus the efforts of governments and development partners on pressing issues in human development. The Goals have underscored the power of communication in galvanizing global action and resources around a core set of development objectives, and establishing the role which global partnerships can play. Indeed, global initiatives such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the Global Vaccination Alliance (GAVI); and Education for All (EFA) have had a measurable impact on combating diseases specified in MDG 6, and facilitating immunisation and primary school enrolment respectively.

As the MDG era comes to an end and the new development agenda is launched, it is timely to reflect on the lessons learned from the MDG experience to inform our next steps. It is in this context that this year's Africa MDG progress report is written.

An important lesson from the MDG experience is that initial conditions influence the pace of progress a country can make on global development agendas. Thus it is not surprising that Africa as a whole will not achieve all the MDGs by 2015. Nevertheless, substantial progress has been achieved on a number of goals and targets. Significant achievements in increasing women's representation in national parliaments, reducing infant and HIV-related deaths, and enrolling more children in primary schools owe a lot to the effort and commitment of African people and their governments to meet the Goals. The often uncelebrated achievements of countries which have made significant progress without meeting MDG targets also deserve special recognition.

This year's report highlights innovative policies and progammes which countries have adopted to accelerate progress on the MDGs, such as the deployment of community members as health workers, Niger's Ecole des Maris (School for Husbands) initiative, and the establishment of community-run and -funded schools. It is our hope that publicizing such success stories will not only help document policy innovations for SDG implementation, but also keep the focus on the unfinished business of the MDGs as countries and the global community make the transition to implementation of the post-2015 Development Agenda.

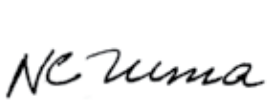
The report demonstrates that sustaining and advancing beyond the gains made under the MDGs require new approaches which embrace all three dimensions of sustainability – the environmental, economic and social. Progress under the SDGs will be assessed not only by the results achieved, but also by considering how they were achieved. Method will assume greater relevance in the post-2015 development paradigm.

The Ebola crisis has reminded us how quickly progress can unravel when health systems are not resilient to shocks. It has underlined the importance of complementing targeted health interventions with integrated approaches which strengthen healthcare systems overall. Tackling all three dimensions of sustainability will require rigorous development planning approaches underpinned by strengthened capacities, integrated

approaches to the continent's development challenges, and access to reliable and quality data.

The MDG experience exposed the data challenges facing national statistical systems and underscored the importance of strengthening statistical and analytical capacities. The data requirements for tracking SDG progress will be greater than those for the MDGs, reflecting the SDGs' broader scope and the emphasis on disaggregation of data. Confronting this challenge will require strengthened human and financial capacities, together with new approaches and methodologies for harnessing the wealth of information which can be obtained from 'big data'.

The accumulated knowledge and experience gained under the MDGs positioned the international community well for crafting an ambitious, yet achievable, successor agenda. The level of ambition reflected in the new agenda must now be matched by its means of implementation. We trust that the findings of this report will add to the body of knowledge on the MDGs from the African regional perspective, and inform the approaches which Member States adopt in their transition from the MDGs to the SDGs.



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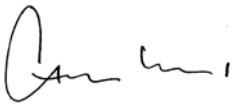

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It was prepared by a core team which was led by Bartholomew Armah, Chief, Renewal of Planning Section, Macroeconomic Policy Division, ECA; Dossina Yeo, Acting Head, Statistics Division, Economic Affairs Department, AUC; Bilal Kedir Nejmudin, Principal Health Economist, Health Division, Human Development Department, AfDB; Mohamed Gueye, Principal Education Analyst, Education Division, Human Development Department, AfDB; and Eunice Kamwendo, Strategic Advisor, Strategy and Analysis team, UNDP-RBA. The team also included Selamawit Mussie (AUC), Habaasa Gilbert (ECA/AUC), Janet Byaruhanga (AUC), Nougbodohoue Samson Bel-Aube (AUC), Mama Keita (ECA), Aissatou Gueye (ECA), Deniz Kellecioglu (ECA), Seung Jin Baek (ECA), Judith Ameso (ECA), Maimouna Hama Natama (ECA), Stanley Kamara (UNDP), El Hadji Fall (UNDP), Sallem Berhane (UNDP) and James Neuhaus (UNDP), with technical inputs from Yemesrach Workie (UNDP), Glenda Gallardo Zelaya (UNDP), Fatou Leigh (UNDP), Frederick Mugisha (UNDP), Wilmot Reeves (UNDP), Fitsum G. Abraha (UNDP), James Wakiaga (UNDP), Rogers Dhliwayo (UNDP), Amarakoon Bandara (UNDP), Becaye Diarra (UNDP), Celestin Tsassa (UNDP), Ginette Mondongou Camara (UNDP), Ahmadou MBoup (UNDP) and Khady Ba Faye (UNDP).

The work was carried out under the supervision of Dr. René N'Guettia Kouassi, Director, Economic Affairs Department, AUC; Dr. Adam B. Elhiraika, Director, Macroeconomic Policy Division, ECA; Dr. Agnes Soucat, Director, Human Development Department, AfDB; and Dr. Ayodele Odusola, Chief Economist and Head of Strategy and Analysis Team, UNDP-RBA.

Guidance to the team was provided by Dr. Anthony Mothae Maruping, Commissioner for Economic Affairs, AUC; Abdalla Hamdok, Deputy Executive Secretary, ECA; Steve Kayizzi-Mugerwa, Acting Chief Economist and Vice President, AfDB; and Abdoulaye Mar Dieye Assistant Administrator and Director, UNDP-RBA. The report was prepared under the general direction of AUC Chairperson Dr. Nkosazana Dlamini Zuma, the United Nations Under-Secretary-General and ECA Executive Secretary Dr. Carlos Lopes, AfDB President Dr. Donald Kaberuka and United Nations Development Programme (UNDP) Administrator Helen Clark.

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A note on methodology

This year's report, entitled "Assessing Progress in Africa towards the Millennium Development Goals", uses the latest updated and harmonized data from the United Nations Statistics Division (UNSD), the official data repository for assessing progress towards the Millennium Development Goals (MDGs). It also uses complementary data from United Nations agencies, including the World Bank, and from statistical databases of the Organisation for Economic Co-operation and Development (OECD). The main reason for using international sources is that they collect and provide accurate and comparable data on MDG indicators across Africa. The irregularity of surveys and censuses, ages, definitions and methozone-depleting substances for producing the indicators might explain the lag between the reporting year and the data years. Another irregularity is the paucity of data, especially for recent years and from some countries that persistently fail to produce and submit data sets.

In order to mitigate such shortcomings, United Nations agencies regularly compile data from countries using standardized questionnaires or through other agreed on mechanisms. Submitted questionnaires are then validated through a peer review process based on the data collection and processing methozone-depleting substances. The agencies provide estimates, update data, fill in data gaps by estimating missing values, and make adjustments if needed to ensure cross-country comparability. OECD is the premier source for recent aid flows, which are based on a standard methodology and agreed on definitions to ensure comparability of data among donors and recipients. These United Nations agencies and OECD provide harmonized and comparable sources of data for producing MDG reports at the continent level. However, this report uses some country-level national data and information on some MDGs to enrich its analysis. Such data are generally utilized inside specific boxes in the report.

Over the last few years, African countries have taken commendable steps, with the support of internationals organizations, to obtain data for tracking MDG progress. The African Union Commission (AUC), the United Nations Economic Commission for Africa (ECA) and the African Development Bank (AfDB) have developed programmes that respond to data challenges and that improve African countries' statistical capacity, such as: the Africa Symposium for Statistics Development, an advocacy framework for censuses; the African Charter on Statistics, a framework for coordinating statistics activities in the continent; the Strategy for the Harmonization of Statistics in Africa, which provides guidance on harmonizing statistics; and a new initiative on civil registration and vital statistics. Since 2009, the three institutions have set up a joint mechanism for continental data collection and validation in order to produce an Africa statistical yearbook. These initiatives will scale up the availability of data for tracking future development progress. In fact, the four pan-African institutions behind this report have launched the concept of data revolution in Africa. A large number of Member States have also recognized the utmost importance of data because they inform development outcomes, which are in turn associated with implemented policies and changed circumstances. Data also serve as a foundation for accountability, investment decisions, research, and many other fields.

Acronyms and abbreviations

AfDB	African Development Bank
AUC	African Union Commission
DAC	Development Assistance Committee
DOTS	Directly observed treatment, short-course
ECA	Economic Commission for Africa
EFA	Education for All
FAO	Food and Agricultural Organization of the United Nations
GNI	Gross national income
GPI	Gender Parity Index
HIPC	Heavily indebted poor countries
ILO	International Labour Organization
IMF	International Monetary Fund
LDC	Least developed country
LLDC	Landlocked developing country
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
NGO	Non-governmental organization
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
SIDS	Small Island and Developing States
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDP–RBA	United Nations Development Programme–Regional Bureau for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UN-OHRLLS	United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
UNSD	United Nations Statistics Division
WHO	World Health Organization
WTO	World Trade Organization

Executive Summary

Africa has made considerable progress towards achieving the Millennium Development Goals despite challenging initial conditions. The baseline figures for Africa on most Millennium Development Goal indicators were relatively low compared to other regions. Nevertheless the continent has achieved impressive gains, including in placing more children in primary school, bridging the gender gap in primary enrolment, increasing the representation of women in national parliaments, reducing child and maternal deaths and reducing the prevalence of HIV/AIDS. These achievements underscore the important role that national commitment, supported by global partnership, can play in realizing development objectives. The highlights of Africa's performance on the MDGs are discussed below.

Poverty is falling, albeit slow, with a real risk of reversals from shocks

Africa excluding North Africa reduced poverty levels from 56.5 per cent in 1990 to 48.4 per cent in 2010, a 14 per cent reduction, well below the MDG target of 28.25 per cent. Efforts at the country level vary, however, with some countries reducing poverty rates much faster than others. The greatest reduction was in the Gambia with a 32 per cent reduction, followed by Burkina Faso, Niger, Swaziland, Ethiopia, Uganda and Malawi. Poverty declined in 24 out of 30 African countries with available data, and increased in the remaining 6 countries. Additionally, growth has neither been robust nor sufficient enough to sustain poverty reduction efforts. Many countries, particularly in Africa excluding North Africa are dependent on primary commodities and susceptible to shocks that tend to disrupt development gains. Early estimates on the socioeconomic impact of the outuberculosisreak of Ebola virus disease alone indicate extensive losses in livelihoozone-depleting substances, which have already pushed many households back into poverty and destitution in the most affected countries.

Africa's productivity, as measured by output per person employed, is on the rise

Globally, almost all regions doubled their annual growth rate of gross domestic product (GDP) per person employed since 2001. Developing regions as a group more than doubled their GDP growth rate per person employed from 1.4 per cent in 2001 to 3.2 per cent in 2013, with strong growth rates registered in Asia (2.6 per cent in 2013), followed by Africa excluding North Africa (1.4 per cent in 2013). On balance, Africa excluding North Africa has made the most effort in increasing its GDP growth rate per person, an increase of 0.6 basis points, compared with Asia's 0.4 basis points. By contrast, North Africa experienced negative growth from its strong growth of 2 per cent in 2001 to 0.5 by 2013, due largely to the lingering effects of the mass revolutions and unrest that have swept through the subregion and the Middle East since 2010.

Africa's growth has been relatively strong but not rapid or inclusive enough to create adequate decent employment opportunities

Africa's GDP growth has remained positive since 2001, averaging at least 5 per cent above the global average of 3 per cent. Extractive industries, particularly minerals, oil and gas have accounted for the largest share of Africa's growth. This has led to improvements in some areas, but these have not been sufficient or inclusive enough to provide decent job opportunities for the majority of the labour force. Indeed, the employment to population ratio has declined on average from 57.7 per cent in 2005 to 44.4 per cent in 2012. Unemployment rates are in the double digits in some subregions, but these are masked, in some cases, by high levels of informality. Southern Africa had the highest unemployment rates in 2013 (21.6 per cent), followed by North Africa (13.2 per cent), Central Africa (8.5 per cent), and East Africa (7.9 per cent), whereas West Africa had

the lowest unemployment rates (6.9 per cent). Youth and female unemployment are persistently higher than male unemployment rates in all regions. Responding to the youth unemployment challenge is vital if Africa is to derive a dividend from the youth bulge. Owing to a lack of decent jobs, most of the population in Africa is engaged in vulnerable employment, which is largely concentrated in the informal sector.

Disasters and persistent conflict are obstructing the path to food security

The overall net change in the proportion of persons whose food intake falls below the minimum level of dietary requirements in Africa between 2012 and 2013 is zero. Africa excluding North Africa remains the most food-deficient of all regions of the world, with 25 per cent of its population having faced hunger and malnutrition during the 2011-2013 period, a modest 8 per cent improvement from the level experienced during the 1990-1992 period. Persistent conflicts in Central Africa and unfavourable weather conditions such as droughts and flooding in the Sahel, the Horn of Africa and Southern Africa continue to exert pressure on food security and nutrition. In addition, the Ebola outuberculosisreak in Guinea, Liberia and Sierra Leone has increased food inflation in the three countries and the subregion, threatening to push many people below the minimum level of dietary energy consumption.

Africa is close to the universal primary education enrolment target

Since 2000, most African countries have shown accelerated progress in expanding access to basic education. In 2012, Algeria, Benin, Cabo Verde, Cameroon, Congo, Mauritius, Rwanda, South Africa, Tunisia and Zambia recorded a net enrolment rate of over 90 per cent. Overall, most African countries have made significant progress as a result of policy reforms using participatory approaches, improved service delivery and governance. Progress has been slower in meeting the needs of the hardest-to-reach categories such as out-of-school youth, children with disabilities, children living in conflict-affected States, nomadic people and some ethnic minorities.

Improving primary education completion rates remains a challenge

There is steady progress in achieving primary completion for all, but one third of pupils who start grade 1 will likely not reach the last grade of primary education. With a 67 per cent primary completion rate, Africa is still far from the achieving primary completion rates for all by 2015. Barely 20 per cent of African countries reached the target in 2012. Between 2000 and 2012, some countries, for example, Ghana, Morocco, Rwanda and the United Republic of Tanzania, registered fast progress, while others stagnated or experienced severe declines. Regression is largely attributed to conflict, political unrest, or poor educational quality and limited capacity of schools to absorb all pupils.

High primary enrolment rates are boosting youth literacy

The youth literacy rate for the population aged 15-24 years has improved in Africa as a result of the increased access to universal primary education observed since 2000. In 2012, only Niger, Chad and Côte d'Ivoire recorded youth literacy rates below 50 per cent. Over 58.8 per cent of African countries have achieved at least a 75 per cent youth literacy rate. The performance of Algeria, Botswana, Equatorial Guinea, Libya, South Africa, Swaziland and Tunisia has been exemplary with youth literacy rates above 95 per cent.

Improvements in girls' enrolment and achieving gender parity

Gender parity in primary education has increased in most regions of the world, with several countries adopting universal primary education policies and implementing gender-responsive interventions that have helped increase girls' enrolment substantially over the years. Within Africa, West Africa is the most improved subregion, followed by North Africa. In terms of reaching parity at all levels of education, Southern Africa has continued to register a strong performance, followed by North Africa, which has reached parity in all levels except

for primary education and has made exceptional progress in tertiary education. East Africa is making steady progress from its relatively poor initial conditions, and although it is yet to reach the target at all levels, it has made significant progress in closing the gender gap in tertiary education. Central Africa, however, trails all regions in making progress towards this target.

Uneven gains in the share of women in wage employment in the non-agricultural sector

Historically, in the agricultural sector in Africa, labour participation is generally high and almost the same for men and women. However, in the services sector, the participation of women is higher than that of men. For example, over the 2004-2007 period in Southern Africa, female and male labour force participation was 70 and 49 per cent, respectively. In the industrial sector, during the same period, however, female labour force participation was lower than that of men, at 11 per cent against 20 per cent. Furthermore, Africa's growth has had a limited impact on the welfare of women and youth, and several constraints perpetuate significant gender gaps in women's participation in gainful employment in the formal sector. In order to enhance the productive capacities and economic empowerment of women together with skills development geared towards the formal sectors, it is imperative to remove barriers such as access to inputs, land, credit, capital and technology.

Africa is leading the way in women's representation in national parliaments

The global average for women's representation in national parliaments has risen steadily, from 14 per cent in 2000 to 22 per cent in 2014. Africa has made the most progress on this target, with an increase of the share of women in national parliaments by at least 15 per cent over the same period, followed by Latin America and the Caribbean (11 per cent increase), Asia (9.8 per cent increase) and developed regions (9 per cent increase). There are significant differences, however, within the African regions and across countries. East Africa continues to lead the way, with Rwanda registering the highest percentage of women in its national parliament, followed by Southern, Central, West, and finally, North Africa. Legislated or voluntary quotas have had a positive impact on the share of women in national parliaments, as observed in most countries that were the first to adopt such policies in Southern and East Africa in the early 1990s.

Impressive progress in reducing child mortality

Overall, African countries have made substantial progress towards achieving MDG 4 (Reduce child mortality). Indeed, 99 of 188 countries, including 43 in Africa, excluding North Africa, observed more significant decreases in child mortality during the 2000-2013 period than during the 1990-2000 period. Continent-wide, the U5MR reduced from 146 deaths per 1,000 live births in 1990 to 65 deaths in 2012, i.e. a 55.5 per cent reduction against the target of a two-thirds reduction. In addition, the infant mortality rate fell from 90 deaths per 1,000 live births in 1990 to 54 deaths per 1,000 live births in 2014, an average decline of 40 per cent. Nevertheless, many African countries have demonstrated either slow progress or stagnating neonatal mortality rates. The situation is worse for the large rural populations of Africa that have poor access to and utilization of maternal and newborn health services. For these populations, social protection mechanisms are needed to improve access to high-impact interventions.

Challenges abound in maternal health despite tremendous progress

Africa has made progress in improving maternal health, although only Cabo Verde, Equatorial Guinea, Eritrea and Rwanda have reduced their maternal mortality ratio by more than 75 per cent between 1990 and 2013, hence meeting MDG 5 (Improve maternal health). Africa still remains the region with the highest maternal mortality ratio compared to the rest of the world, registering 289 maternal deaths per 100,000 live births compared to the global average of 210 maternal deaths per 100,000 live births in 2013. Africa is also grappling with low proportions of births attended by skilled health personnel, low contraceptive prevalence

rates, high adolescent birth rates, limited antenatal care coverage, and high unmet need for family planning, all of which are contributing to a high maternal mortality ratio in the continent. Other challenges include difficulty in measuring maternal deaths according to the recommended World Health Organization (WHO) definition, and poor auditing and registration of the causes and number of maternal deaths, which affect accurate reporting and monitoring of progress on MDG 5.

Downward trend in HIV/AIDS, malaria and tuberculosis

Efforts to combat HIV/AIDS, malaria and tuberculosis in Africa have yielded impressive results since 1990 and are placing the continent on a solid path to reversing the spread of these diseases. Indeed, a downward trend is observed in the incidence, prevalence and death rates associated with HIV/AIDS, malaria and tuberculosis, especially since 2000. The efforts to combat these diseases have been largely through: the adoption of WHO recommended programmes and interventions, such as Directly Observed Treatment Shortcourse (DOTS) for tuberculosis; the use of insecticide treated nets and artemisinin-based combination therapies for malaria; and the use of condoms and antiretroviral therapy for HIV/AIDS. These initiatives demonstrate the high level of political commitment to combating these diseases. Notwithstanding the progress being made, Africa accounts for more than half of all cases and death rates of HIV/AIDS, malaria and tuberculosis.

Africa's progress on environmental targets exceeds global performance

Carbon dioxide emissions per capita were highest in developed regions and lowest in Africa excluding North Africa in 2010. However, rising carbon dioxide emissions in a few African countries and slower progress in other regions of the world raise concern about future trends. Over the 1990-2010 period, only 16 African countries reduced their carbon dioxide emissions, while 38 increased them.

Consumption of ozone-depleting substances declined by 94 per cent in Africa, 86 per cent in developing regions, and 100 per cent in developed regions between 1986 and 2012. In effect, most African countries are on the right track in terms of reducing the consumption of these substances. Nonetheless, six countries experienced an increase in their consumption between 2000 and 2012. The proportion of protected terrestrial and marine areas increased in all regions of the world; in 2012, globally, 14 per cent of terrestrial and marine areas were protected. In Africa excluding North Africa, protected area coverage increased from 10.7 to 15.2 per cent between 1990 and 2012. More African countries are registering improvements in the proportion of protected terrestrial and marine areas; by 2012, a total of 32 African countries had reached the target of protecting at least 10 per cent of their territorial and marine areas compared to 19 countries in 1990.

Access to safe drinking water and sanitation is improving slowly, but progress remains skewed towards urban areas

Almost a quarter of the current African population (24 per cent) have gained access to an improved drinking water source since 2000, which is the lowest globally. Furthermore, only 16 per cent of the population has access to piped drinking water, which is also the lowest in the world. There are wide rural-urban disparities in access to safe drinking water that tend to pull down national aggregate figures in some countries. The weak initial conditions (low 1990 baseline), combined with high population growth relative to the rest of the world exacerbate the challenge of meeting the target in Africa. Similarly, the proportion of people with access to improved sanitation has increased only moderately in Africa excluding North Africa, from 24 per cent in 1990 to 30 per cent in 2012. This is in stark contrast to North Africa, where it increased from 72 to 91 per cent, and developing regions, from 36 to 57 per cent during the same period. The rural-urban divide and the poor situation of slum dwellers further compound this slow progress.

North Africa maintains the lowest slum prevalence among developing regions

The proportion of people living in slum conditions in urban areas was highest in Africa excluding North Africa (62 per cent). The lowest slum prevalence is observed in North Africa, with a level of 13 per cent. From 2000 to 2012, the share of urban residents in the developing world living in slums declined from 39 to 33 per cent. Globally, the MDG target of significantly improving the lives of at least 100 million slum dwellers by 2020 has been attained, 10 years in advance.

Wide gap between trade and ODA commitments and delivery

The Ninth Ministerial Conference of the World Trade Organization, held in Bali, Indonesia, in December 2013, revitalized the Doha Development Agenda with the Bali Package, which covered trade facilitation and agriculture, and developed and least developed countries. However, new forms of protectionism through a proliferation of non-tariff barriers are prejudicial to Africa's trade. This is reflected in the share of Africa's exports in global merchandise exports, which declined from 3.5 per cent in 2012 to 3.3 per cent in 2013, compared with 4.9 per cent in the 1970s. Meanwhile, official development assistance (ODA) from the States members of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) declined 0.5 per cent in real terms between 2013 and 2014. In nominal terms it was virtually unchanged – $135.2 billion in 2013 as against $135.1 billion in 2014. Of particular concern is the fact that ODA to least developed countries, landlocked developing countries, and small island developing States declined 16 per cent in real terms compared to 2013, pushing donors further from the targets. On average, DAC countries delivered 0.29 per cent of the group's gross national income (GNI) as ODA, which is unchanged relative to 2013 and below the United Nations target of 0.7 per cent. On a positive note, 5 of the 28 DAC countries (i.e. Denmark, Luxembourg, Norway, Sweden and United Kingdom) continue to exceed the 0.7 per cent target. The United Arab Emirates, a country that is not a member of DAC, posted the highest ODA/GNI ratio of 1.17 per cent in 2014. Beyond shortfalls in commitments, there are also concerns about the quality of ODA since substantial amounts stay in donor countries, while some ODA reaching recipient countries is associated with little or even negative development impact.

Debt sustainability is a growing concern

Total foreign debt has been higher than 30 per cent of GDP in Africa since 2010 and is expected to rise to 37.1 per cent of GDP in 2015. Net foreign debt as a share of GDP is projected to be only 1 per cent of GDP in 2015; it has been negative since 2006 owing to high international reserves in oil-exporting economies. Mineral-rich and oil importing countries have positive net foreign debt, and some extreme cases have very high ratios, raising issues of debt sustainability. Moreover, Africa's long-term debt sustainability remains a challenge for the post-completion point of heavily indebted poor countries, due mainly to the structural problems of these countries and inadequate debt management capacity. With completion of the Heavily Indebted Poor Countries Initiative, the rising concern about debt sustainability raises the more basic issue of how to ensure a fair debt workout mechanism to address future sovereign debt crises.

Notable progress in technology indicators

Notable progress can be observed in Africa in the technology indicators, to different degrees. Fixed telephone subscriptions per 100 inhabitants peaked in 2009, averaging 4.17 from 1.44 in 1990. Thereafter, it has steadily declined to 3.60 in 2013. This is closely related to fast growth of populations and mobile telephone subscriptions. Mobile telephone subscriptions have indeed grown massively in Africa from only four African countries registering mobile-cellular subscriptions in 1990, to all African countries having mobile subscriptions in 2013. Subscriptions averaged 80.20 per 100 inhabitants, with 15 African countries registering over 100 subscriptions per 100 inhabitants. In 2013, at 11.1 per cent, mobile subscriptions in Africa continue to grow and surpass the global average of 6.3. Africans have been able to utilize

mobile phone technology in a number of innovative ways that have changed their lives in banking, activism, education, entertainment, disaster management, agriculture and health. In Africa, 14.7 out of 100 inhabitants use Internet, which is much lower than the world average of 43.7. However, during the 2004-2013 period, the average annual growth of Internet users per 100 inhabitants was much faster in Africa (21.7 per cent) than the global average (10.2 per cent). If the current growth rates are maintained over the coming years, Africa as a whole may reach the global rates.

Lessons learned from MDG implementation

The MDGs implementation process has generated invaluable lessons that can inform policymaking going forward. This is particularly important in the context of the new development agenda that will build on several elements of the MDGs. While sector-specific lessons can be drawn from each goal, there are some overarching lessons that cut across various sectors and even into the new areas that will be covered by the post-2015 development agenda.

- Initial conditions are important in achieving and accelerating progress on the MDGs. Differentiated approaches to supporting and evaluating progress are therefore imperative. For countries close to achieving specific targets, incremental progress may not be as relevant as the quality of such progress. Alternatively, for those countries and regions that are furthest from the target, the pace of progress relative to their baselines is a more appropriate measure of performance.

- Effective communication and follow-up are critical for the success of global agendas. Even though the commitments made by its signatories were not binding, the MDGs generated some success. This positive outcome was partly due to the effective communication and continual follow-up processes undertaken at the national, regional and global levels, which helped to sustain pressure on governments to fulfil their social compacts.

- Policymakers must be mindful of the utility and sustainability of their investments. Investments in brick and mortar such as schools and hospitals can be sustainable and useful only if they are matched by complementary investments in recurrent expenditure on teaching materials, equipment and skilled health professionals.

- Sustainability requires addressing the root causes, not the symptoms of underdevelopment. Donor support is more likely to result in sustainable development if it focuses on giving Africa a "helping hand" rather than a "handout". The MDG focus on outcomes such as poverty reduction without particular attention to the pathway or enablers required to achieve them is ultimately unsustainable. Critical areas of priority should include: supporting Africa's agenda for structural transformation; strengthening capacities in development planning, domestic resource mobilization and public expenditure management; strengthening cooperation in stemming illicit outflows; returning stolen assets; supporting technology, innovation and science; promoting fair trade; strengthening trade facilitation; and facilitating good governance.

- Global development agendas are likely to succeed if they are underpinned by a credible and committed means of implementation that takes into account both financial and non-financial resources. The lack of these means rendered the implementation of the MDGs vulnerable to resource shortfalls.

- Given the interrelatedness of the goals, focusing on development interventions that have the greatest knock-on effects heightens impact.

- There are effective and often low-cost impact interventions that can drive progress on the MDGs. More importantly, these interventions must be focused on populations that are vulnerable or most at risk, which include women and girls, the extremely poor and rural dwellers, among others.

Section I: Tracking progress

MDG 1: Eradicate extreme hunger and poverty

Significant progress has been made globally towards reducing poverty by half from the 1990 levels, attributable in part to notable advancements in economic growth and development globally, particularly in China. Strong growth, decent jobs, increased productive capacities and the provision of social protection for the most vulnerable groups have accounted for most of the reduction in poverty rates across the world. There are regional variations, however, revealing significant caveats to growth, reinforcing the inclusive growth notion and necessary conditions for poverty reduction. In Africa, it still remains a serious challenge to reduce the region's poverty rates by half despite a positive GDP growth since 2001, an average of at least 5 per cent above the global average of 3 per cent (AfDB, 2014).

Extractive industries in minerals, oil and gas have accounted for the largest share of Africa's growth, which has led to improvements in some areas. However, this has not been sufficient or transformational enough to effectively respond to challenges posed by shocks (commodity prices, climate change, Ebola etc.), widespread poverty, rising inequalities, unemployment, the youth bulge, unplanned urbanization and many others. Economies in Africa, in particular those in the Southern, East, West and Central subregions, remain undiversified, in enclave sectors and heavily dependent on a few commodities. As a result, poverty has remained widespread despite: (i) a decline from 56.5 per cent in 1990 to 48.4 per cent in 20101 for Africa excluding North Africa; (ii) relatively high levels of unemployment, particularly for youth and women, with a large share of the population engaged in vulnerable employment with low productivity; (iii) the largest proportion of its population living below the minimum level of dietary energy consumption out of all regions; and (iv) the relatively strong growth in West Africa of around 6.7 per cent, followed by East Africa (6.2 per cent), Central Africa (3.7 per cent) and a significant contraction in Southern Africa (3 per cent) in 2014 alone (Ibid).

The focus on growth as a necessary condition for poverty reduction provides important lessons as the world transitions from the implementation of the MDGs to that of Sustainable Development Goals . The type and sources of growth are important in order for development to be sustained over the long term. The lack of structural transformation and economic diversification has limited poverty reduction efforts in Africa, which remains increasingly vulnerable to shocks. In West Africa, the Ebola outbreak is estimated to have significantly reduced growth prospects in the three affected countries (Guinea, Liberia and Sierra Leone) by at least 2 to 3 per cent in the short to medium term (UNDP, 2015b). At the same time, short-run shocks such as the commodity price decline that is affecting commodity-dependent economies in Africa, threaten to have precarious medium-run balance of payments effects. Recurrent shocks, such as flooding in southern Africa, severe droughts in the Sahel and the Horn of Africa, instability in the Great Lakes region, and sluggish growth in South Africa owing to persistent industrial action continue to cloud the regional outlook and highlights Africa's vulnerabilities to shocks. Strengthening Africa's resilience to shocks will first require: a strengthening domestic and regional policies to respond and promote structural transformation and inclusive and job-rich growth; improvements in political and economic governance; enhancement

1 Latest available data, estimates by the World Bank, April 2013.

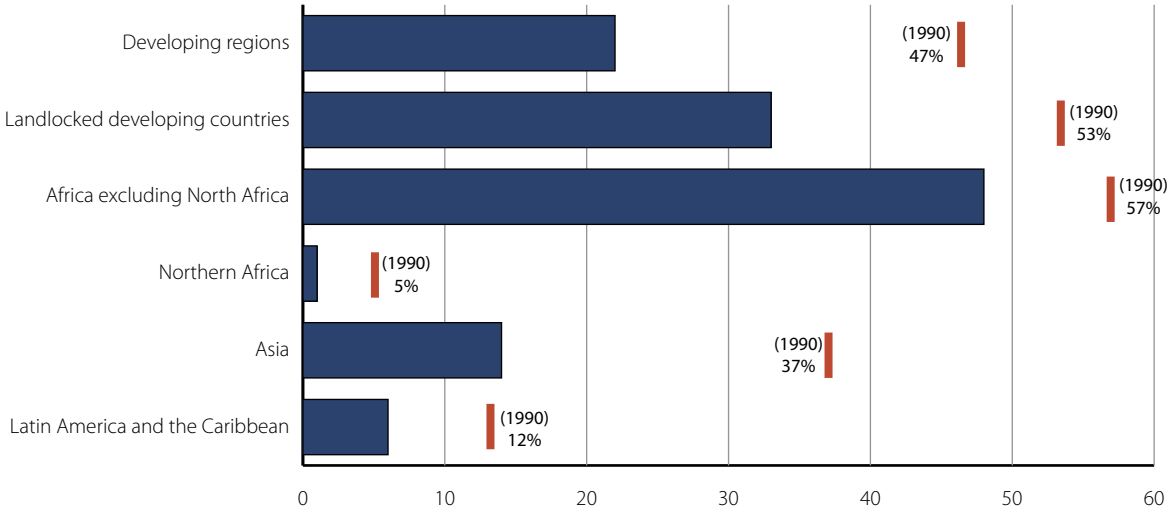
of domestic/regional institutions and infrastructure; the empowerment of women and youth; scaled-up action on climate change adaptation; effective health systems; resilience building and recovery; and finishing the unfinished business of the MDGs and the effective implementation of the post-2015 Development Agenda.

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

Significant global progress has been made in reducing poverty by half since 1990; however, the progress is uneven across regions and countries (see figure1.1). While globally the target has been met for developing regions, challenges remain at subregional levels – with Africa excluding North Africa and the Oceania regions lagging behind the rest of the world in responding to the poverty challenge; between 1990 and 2010, poverty rates declined by only 8.1 per cent and 7 per cent, respectively. Over the same period, Asia as a whole has made the greatest improvements in poverty reduction attributable in part to strong growth in China and India: East Asia, from 60.2 per cent to 48.6 per cent, Southeast Asia, 45.4 to 31 per cent, and Southern Asia, 51.5 to 21.8 per cent. By contrast, the Caribbean subregion excluding Latin America experienced a 4 per cent increase from its 1990 poverty levels. It should be pointed out the regions that have experienced rapid and robust growth per person employed are those that have made significant dents on poverty, thus reinforcing the relationship between increased productivity, jobs and poverty reduction.

Africa also lagged behind other regions in its attempt to reduce the intensity of poverty; 2 between 1990 and 2010, it has only reduced it by 2 basis points between (from 13 per cent to 11 per cent), while developing regions as a whole reduced the intensity of poverty by at least 9 basis points. Asia accounts for most of this reduction, having reduced its poverty gap ratio from 11 per cent in 1990 to 3 per cent in 2010. Hunger also remains a challenge on the continent, especially for Africa excluding North Africa, which has the highest proportion of its population living below the minimum level of dietary energy consumption in the world, exceeding the developing regions' average. Progress has been made on this target, albeit slow (from 33 per cent in 1990 to 25 per

Figure 1.1 Proportion of the population living below $1.25 purchasing power parity per day



Source: *UNSD data, 2014.*

2 The intensity of poverty, measured by the Poverty Gap Index, estimates the average poverty gap in the population as a proportion of the poverty line; it estimates the depth of poverty by considering how far on average, the poor are from the poverty line.

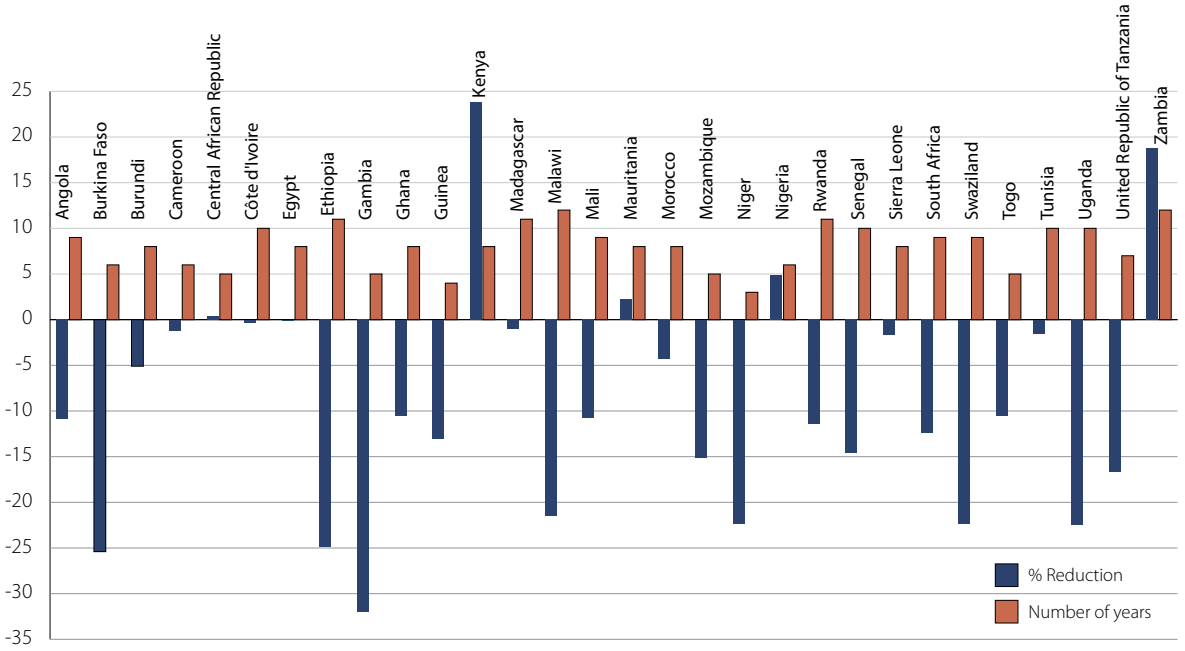
cent in 2013). Asia and Latin America and the Caribbean have made the most progress in reducing hunger, with close to a 45 per cent reduction in incidence of hunger in both regions.

Poverty is falling, albeit slow, with a real risk of reversals from shocks

Africa's progress in reducing poverty has been slow compared to that of developing regions as a whole. Africa excluding North Africa only reduced poverty levels from 56.5 per cent in 1990 to 48.4 per cent in 2010 (a 8 per cent reduction), which is well below the MDG target of 28.25 per cent by 2015. Efforts at the country level vary, however, with some countries reducing poverty rates much faster than others (see figure 1.2). Based on 30 African countries for which at least two data points are available, the collective poverty reduction efforts resulted in an 8.7 per cent drop in poverty over a period of eight years. The greatest reduction was in The Gambia, with a 32 per cent reduction, followed by Burkina Faso, Niger, Swaziland, Ethiopia, Uganda and Malawi. Poverty declined in varying degrees in 24 out of the 30 countries, ranging from a 0.1 per cent in Egypt to 32 per cent in The Gambia. However, poverty rates also increased in six out of the 30 countries, from an average of 0.4 per cent in Central African Republic and 28.4 per cent in Kenya, representing the lowest and highest increases over the same period. Increases in poverty have also been notable in Mauritania, Nigeria and Zambia, while Madagascar, Sierra Leone and Tunisia registered significant poverty reduction over eight years.

While many countries have shown progress towards poverty reduction over the years, in part owing to the positive growth rates of recent times, the growth has neither been robust nor sufficient enough to sustain such efforts. Many countries, particularly in Africa excluding North Africa, are susceptible to shocks that almost always reverse development gains. Early estimates on the socio-economic impact of the Ebola outuberculosisreak alone indicate massive losses in livelihoozone-depleting substances, which has already pushed many households back into poverty and destitution. Liberia, Sierra Leone and Guinea will certainly experience reversals in their efforts to reduce poverty and generate decent jobs and food security for at least the next five years (UNDP RBA, 2015). The knock-on effects for the subregion as a whole are estimated to be large, with negative impacts

Figure 1.2 Poverty reduction in 30 African countries



Source: *Authors' calculations based on 2014 UNSD data, which covers different periozone-depleting substances depending on data availability.*

on growth, food security and poverty in the short to medium term.

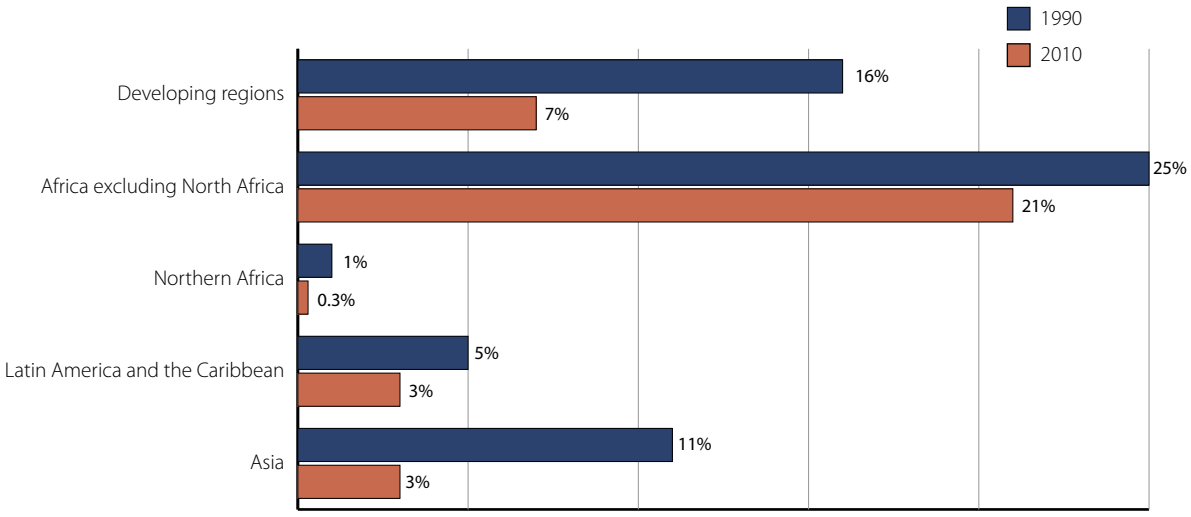
Other endogenous shocks such as the commodity price decline will also have huge spillover effects in many countries in Africa, since most countries do not have the fiscal space to respond to such shocks. Out of the ten fastest growing economies in Africa, eight are commodity-dependent (Nigeria, Democratic Republic of the Congo, Liberia, Sierra Leone, South Africa, Côte d'Ivoire, Chad and Angola). Dependence on natural resources is a driver of inequality since it tends to have deleterious impacts on building inclusive and accountable institutions, economic diversification and structural transformation (UNDP, 2015a).Yet, on a positive note, Ethiopia and Rwanda have largely been driven by the expansion of infrastructure development and services, reflecting a gradual shift to other sectors overtime. Although growth in GDP has contributed to poverty reduction efforts in general, the intensity of poverty remains severe for the rest of Africa excluding North Africa, which is compounded by growing income inequalities on the continent and the interaction between growth, poverty and inequality. These issues require urgent attention in order to resolve social unrest and uprisings, growing radicalization, and the lack of social cohesion within countries and communities that Africa has witnessed in recent times.

The intensity of poverty in Africa excluding North Africa alone surpasses that of all developing regions, with a minimal reduction from 25 per cent in 1990 to 21 per cent in 2010 (see figure 1.3). Asia, Latin America and the Caribbean, and North Africa reduced the intensity of poverty considerably over the same period. Non-inclusive growth due to structural constraints, underdevelopment and poor infrastructure, the lack of decent jobs and food insecurity have all contributed to the intensity of poverty in Africa.

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

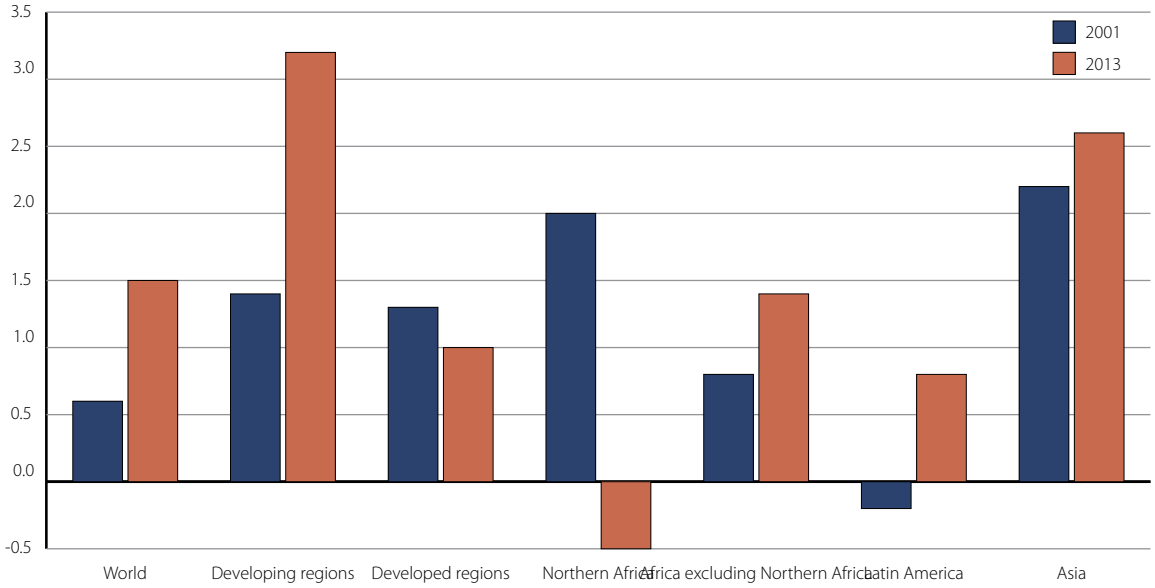
The achievement of full and productive employment for all remains elusive, particularly for women and youth. The world and almost all regions doubled the annual growth rate of GDP per person employed from 2001. Developing regions together more than doubled their GDP growth rate per person employed from 1.4 per

Figure 1.3 Poverty gap ratio (per cent)



Source: *UNSD, 2015.*

Figure 1.4 Growth rate of GDP per person employed (per cent)



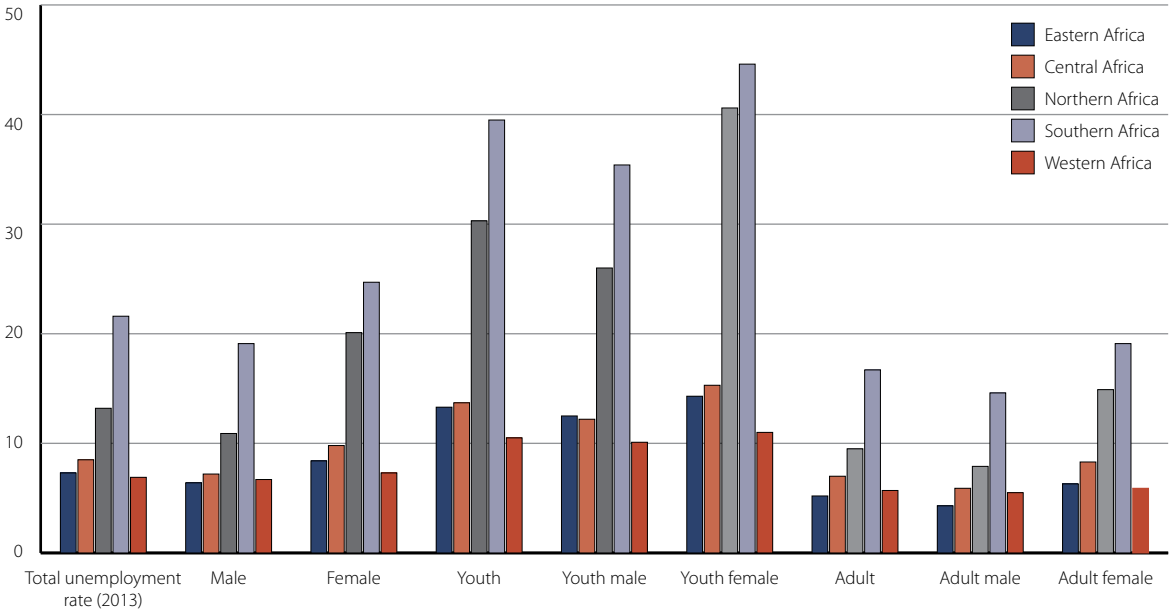
Source: *UNSD data, 2015*

cent in 2001 to 3.2 per cent in 2013, with high strong growth rates registered in Asia (2.6 per cent in 2013), followed by Africa excluding North Africa (1.4 per cent in 2013) (see figure 1.4). On balance, Africa excluding North Africa made the greatest effort in increasing its GDP growth rate per person by 0.6 basis points, compared to Asia's 0.4 basis points. However, North Africa experienced negative growth from its strong growth of 2 per cent in 2001 to 0.5 by 2013, due largely to the lingering effects of the mass revolutions and unrest that swept through North Africa and the Middle East since 2010.

Although Africa's growth has been relatively strong, it has not been sufficient to create adequate decent employment relative to population and size. In 2013, Southern Africa had the highest unemployment rates (21.6 per cent), followed by North Africa (13.2 per cent), Central Africa (8.5 per cent), East Africa (7.9 per cent), whereas West Africa has the lowest unemployment rates (6 per cent).

In all regions, youth and female unemployment are persistently higher than the male unemployment rates across all regions (see figure 1.5), a

Figure 1.5 Regional breakdown of unemployment, 2013



Source: *ILO – Trends Econometric Models, October 2014.*

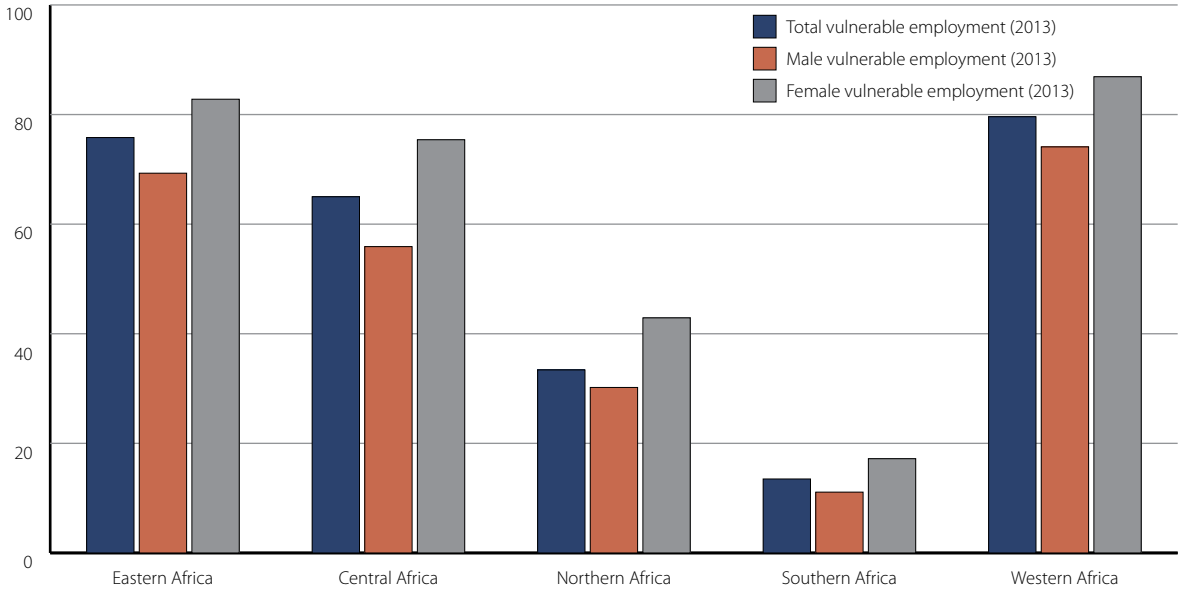
situation that needs urgent attention in order to address the persistent gender imbalances and benefit from the demographic dividend and the youth bulge.

While the above rates give a sense of unemployment trends in Africa, they do not fully explain labour force participation in both formal and informal sectors, including the underemployed, vulnerable and discouraged workers. Owing to the lack of decent jobs, most of the population in Africa are engaged in vulnerable employment and largely in the informal sector. Using 2013 figures (figure 1.6), most of Africa's population is engaged in the informal sector. The figures are relatively high in West Africa, with a total of 79.6 per cent for both female and male population groups. The ratio of women engaged in vulnerable employment is much higher, at 86.9 per cent compared to 74.1 per cent for men. East Africa follows, with 75.8 per cent of its labour force engaged in vulnerable employment (69.3 per cent, males and 82.8 per cent, females). Similar situations are mirrored in the rest of the regions, with Central Africa a close third, with at least more than 50 per cent of its labour force in vulnerable unemployment and North Africa, just above 30 per cent. Southern Africa's labour force has the lowest percentage of vulnerable employment, with combined rates for men and women below 20 per cent. This is partly due to the relatively highly formalized economic structures of the subregion. The rates are disproportionally larger for women than men in all regions, and are definitely much higher for young people.

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

The proportion of the population facing hunger is falling slowly; however, disasters and persistent conflict are an impediment to food security. Although there has been some progress since 1990 in reducing global hunger, at least 805 million people were still chronically undernourished by the end of 2014. The Food and Agricultural Organization of the United Nations (FAO) notes that only 63 countries are reaching the MDG 1 hunger target, and that while the hunger target is globally within reach, Africa and Eastern Asia, plagued by disaster and conflict, have made modest progress (FAO, 2014). Based on the analysis of the changes in the proportion of persons falling under the dietary requirements in Africa, the overall net change in this target between 2012 and 2013 is zero. This implies that, although reduc-

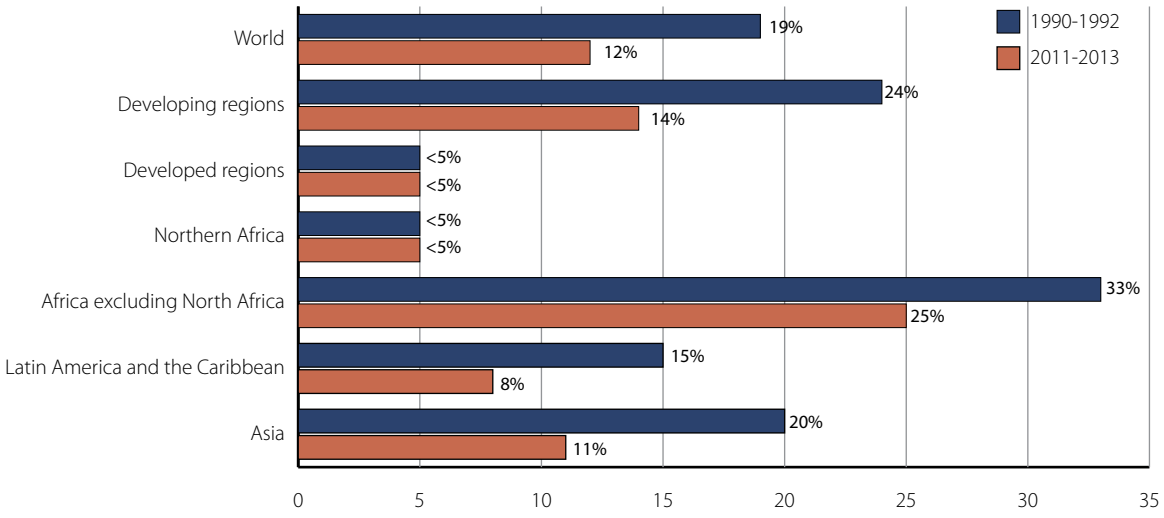
Figure 1.6 Regional breakdown of vulnerable employment



Source: *ILO – Trends Econometric Models, October 2014.*

tions in dietary deficiency have been observed in around 20 countries, others, in dietary deficiencies had also increased, leading to modest or no overall net progress for the Africa region as whole.3 Africa excluding North Africa remains the most food-deficient of all regions of the world, with 25 per cent of its population facing hunger and malnutrition in 2011-2013, an 8 per cent improvement from its 1990-1992 figures (see figure 1.7). Persistent conflicts in Central Africa and unfavourable weather conditions such as droughts and flooding in the Sahel, the Horn of Africa and Southern Africa continue to put pressure on food security and nutrition in the region. In addition, the Ebola outuberculosisreak in Guinea, Liberia and Sierra Leone has already increased food inflation in the

Figure 1.7 Proportion of the population below minimum level of dietary energy consumption



Source: *UNSD data, 2015.*

3 The analysis is based on UNSD data, 2014.

three countries and the subregion, threatening to push many people below the minimum level of dietary energy consumption.

Dietary deficiencies continue to be more severe in rural than urban areas in all regions of the world. In Southern Asia there are more underweight children in rural areas (around 45 per cent) than in urban areas (33 per cent), whereas in Africa excluding North Africa, around 22 per cent of children living in rural areas are underweight compared to 15 per cent in urban areas.

MDG 2: Achieve universal primary education

Africa's future transformation depends to a large extent on its capacity to provide compulsory and inclusive quality basic education that will further lead to a productive workforce, economic prosperity and social stability. In placing education at the heart of their national development policies for the past 15 years, African countries have demonstrated their conviction about the potential contribution of education to building an equitable, competitive and cohesive society. That potential is particularly critical in fragile States. For that reason, African countries have consistently allocated substantial resources to education. Between 2000 and 2012, the average amount of resources allocated to education increased from 4.2 per cent to 4.9 per cent of GDP, compared to a decrease from 4.7per cent to 4.6 per cent in all other developing countries. This unprecedented commitment by African governments has been complemented by consistent development assistance towards education, including debt savings that contributed to the enrolment of over 54 million children in schools in the subregions of Southern, East, Central and West Africa between 2000 and 2012. For example, to meet its international commitment, Senegal allocated up to 5 per cent of its GDP to education between 2000 and 2011. The public financial allocation to the sector registered a significant increase (on average the annual rate of increase stood at 12.5 per cent over the 2000-2011 period). This enabled the country to boost the net enrolment rate from 44.7 per cent in 1990 to 79.4 per cent in 2012. Burkina Faso also achieved outstanding progress in increasing its net enrolment rate from 36.7 per cent in 2000 to 66.8 per cent in 2012.

While the overwhelming majority of countries have addressed the issue of enrolment and gender imbalances in primary education, almost one third remain far from meeting the MDG targets. Despite the continuous rise in the net enrolment rate in primary education, only 67 per cent of children starting grade 1 are likely to reach the last grade of primary education, particularly in Africa excluding North Africa. This poor performance in primary completion is due to a number of factors including insufficient education infrastructure, limited choice for girls and other vulnerable social groups, inadequate consideration of the reality of traditionally hard-to-reach groups such as nomadic people, persons with disabilities, and children from disadvantaged economic and ethnic groups. The insufficient number of qualified teachers and the lack of relevant curricula to meet the needs of these groups are also root causes of the poor quality of education. As a result, African countries still perform poorly on international assessments of student learning achievements. In 2011, the two countries (Tunisia and Morocco) which participated in the Trends in International Mathematics and Science Study (TMISS) at grade four, ranked 49th and 51th out of 52 participant countries, respectively with scores of 359 and 335 points in mathematics, well below the TIMSS scale centre point (500). Botswana scored 396 points in the sixth grade mathematics test.. The majority of students tested did not demonstrate a good knowledge or understanding of basic mathematical concepts. The results of the 2011 international assessment of reading comprehension (PIRLS 2011) are quite similar. All these impediments drastically limit the opportunities of children to progress to upper grades and to move onto secondary education.

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

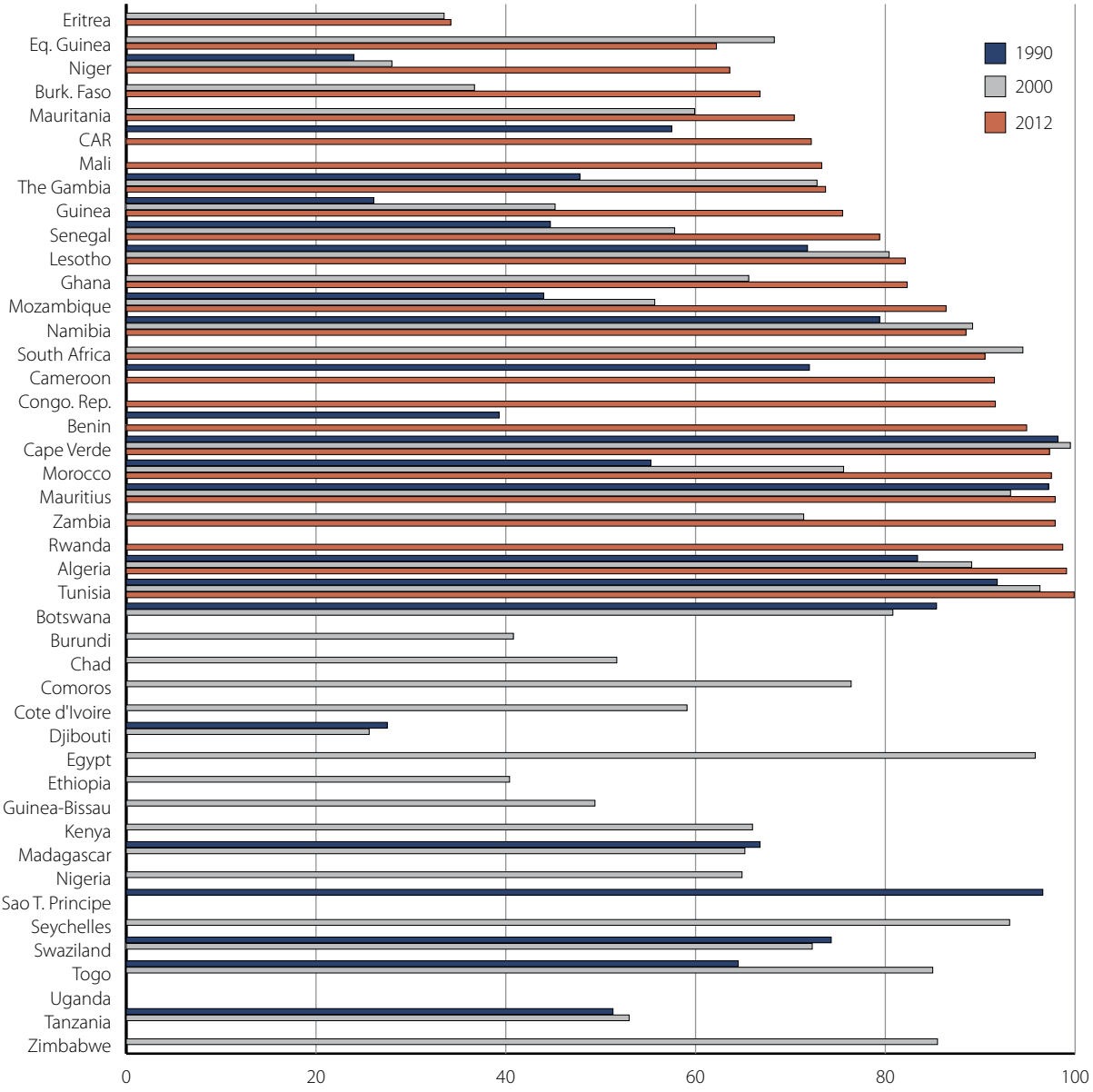
Africa is surely moving towards universal primary education. Since 2000, the majority of African countries have been showing accelerated progress in expanding access to basic education, thus steadily narrowing the gaps in universal primary education. In 2012, over 68 per cent of

the 25 countries for which data were available achieved a net enrolment rate of at least 75 per cent in primary education. Eleven these countries (44 per cent) (Tunisia, Algeria, Rwanda, Zambia, Mauritius, Cabo Verde, Benin, Republic of the Congo, Cameroon, Morocco and South Africa) recorded a net enrolment rate over 90 per cent. Between 2000 and 2012, four of the 25 African countries for which data are available (Niger, Burkina Faso, Guinea and Mozambique) experienced an impressive increase in net enrolment of over 30 per cent (see figure 2.1). These good examples must be capitalized on and disseminated. As highlighted by Easterly (2007):

> *Yet, Burkina Faso has expended elementary education at more than twice the rate of Western historical experience, and is even far above the faster education expansions of all other developing countries in recent decades.*

Overall, most of the countries have made significant progress as the result of improved education policy formulation using participatory approaches, service delivery and governance. Indeed, the combined effects of the Education for All and the MDGs have led countries to develop and adopt holistic policies and legal frameworks

Figure 2.1 Trends in primary school enrolment, 1990, 2000 and 2012



Source: *UNSD data, 2015.*

conducive to democratically meeting their citizens' economic and social education needs, and capitalizing on the demographic dividend.

Although international aid flows from the traditional education donors have slowed down over the past five years, especially in 2011 when a 7 per cent decrease was registered, domestic financing tends to be maintained at a significant level in a context where new needs have been emerging. In assessing the effectiveness of sector-specific aid in achieving MDG2 in the 35 countries in Africa excluding North Africa over the period 2000-2010, Yogo and Mallaye (CERDI, 2015) concluded:

> *[H]igher aid to education significantly increases primary completion rate. This result is robust to the use of various methozone-depleting substances of estimation, the inclusion of instrument to account for the indignity of aid and the set of control variables included in regressions.*

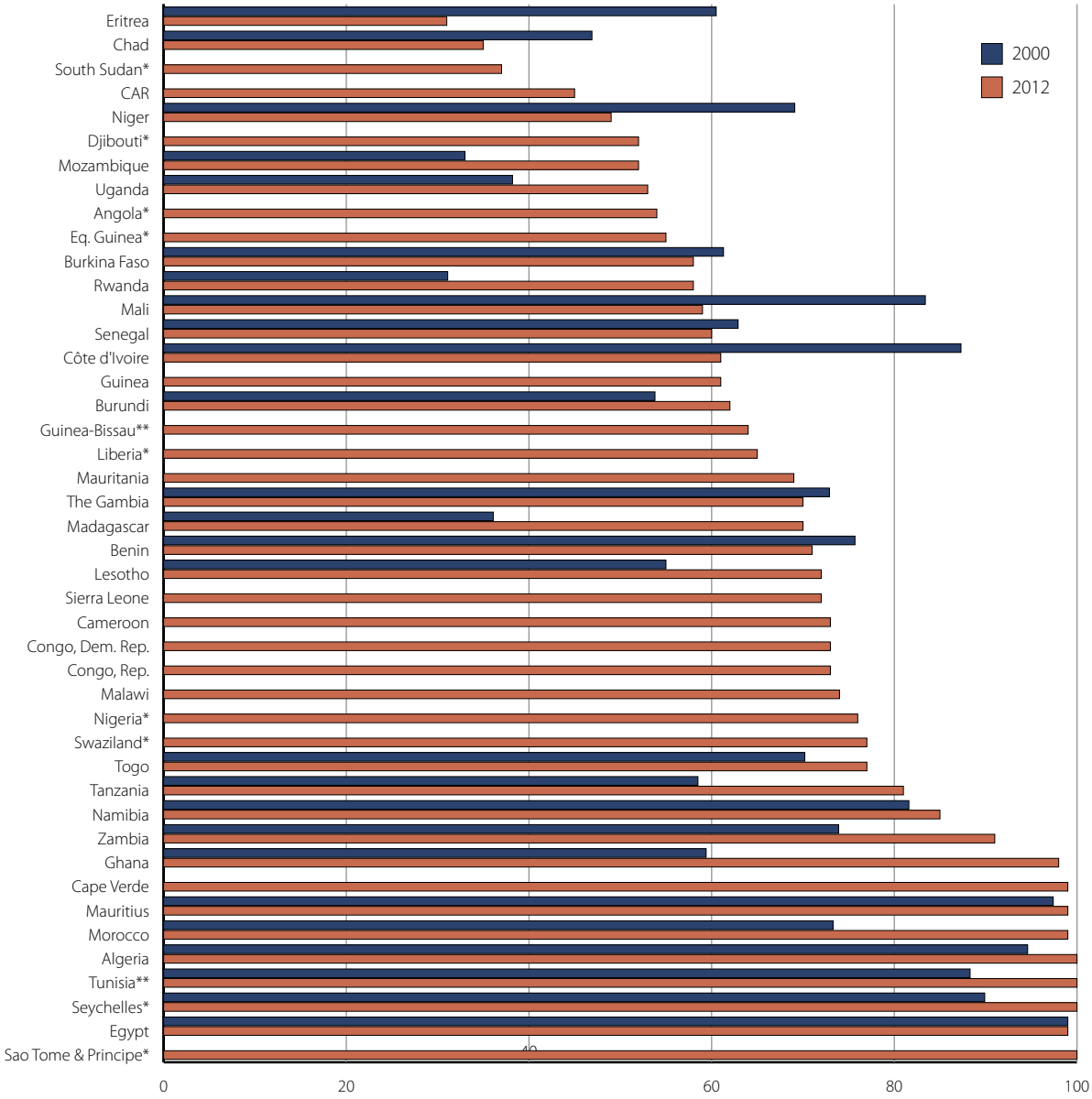
The authors also demonstrate that there is a strong heterogeneity in the efficient use of aid. For instance, countries such as Botswana, Togo and Kenya show high efficiency gains, whereas Burkina Faso, Niger and Rwanda are unlikely to make efficient use of aid to education. Such findings urge international donors to meet their commitment in a timely manner and encourage countries in Africa excluding North Africa to improve sector governance, financing and partnership to sustain their achievements.

One country, Eritrea recorded a net enrolment far below 50 per cent, and Equatorial Guinea, Namibia and Cabo Verde experienced a slight regression. Progress has also been slower in meeting the needs of the hardest-to-reach categories such as out-of-school youth, children with disabilities, children living in fragile States, nomadic people and some ethnic minorities. There is a need to pay particular attention to these gaps and carry out deeper analysis to better identify the bottlenecks and identify the appropriate ways to address them in the post-2015 development agenda/Sustainable Development Goals.

Steady progress in achieving primary completion for all, but one third of pupils who start grade 1 will likely not reach the last grade of primary education

With a 67 per cent primary completion rate, Africa is still far from the achieving primary completion rates for all by 2015. Barely 20 per cent of African countries (i.e. Algeria, Cabo Verde, Egypt, Ghana, Morocco, Sao Tome and Principe, Seychelles and Tunisia) reached the target in 2012. In 24 out of the 44 countries (around 53 per cent) for which 2012 data are available (see figure 2.2), the primary education completion rate was at least 70 per cent, and only five countries (Central African Republic, Chad, Eritrea, Niger and South Sudan) deviated widely from the average value with a completion rate not exceeding 50 per cent. Within the region, the general trend is highly diverse, with fast progress between 2000 and 2012 recorded in Ghana (net increase of 38.6 per cent), Rwanda (26.9 per cent), Morocco (25.7 per cent) and the United Republic of Tanzania (22.5); slight stagnation in others; and severe declines in Benin, Burkina Faso, Chad, Côte d'Ivoire, Eritrea, Mali and the Niger. The main causes for this regression may be due to conflict, political unrest, or the impact of the higher enrolment on education quality in the short term as some governments have not been able to sustain quality in a context where the operational needs for qualified teachers, classrooms and learning materials have been dramatically increasing. The disturbing pattern of stagnation observed in many countries over the 2000-2012 period is partly explained by the lack of rigorous data available because of poor education management information systems, but also by the lack of sustained and deep reforms focused on quality improvement. Yet, the UNESCO Education for All Global Monitoring Report states: "One third of young people in sub-Saharan Africa fail to complete primary school and lack skills for work" (UNESCO, 2010). The overall status has not changed since then, and the subregion still has the greatest need for teachers to meet the goal of universal primary education completion, estimated at 1.6 million.

Figure 2.2 Trends in primary education completion rate, 2000 and 2012



Source: *UNSD data, 2015.*

High primary enrolments are bolstering youth literacy

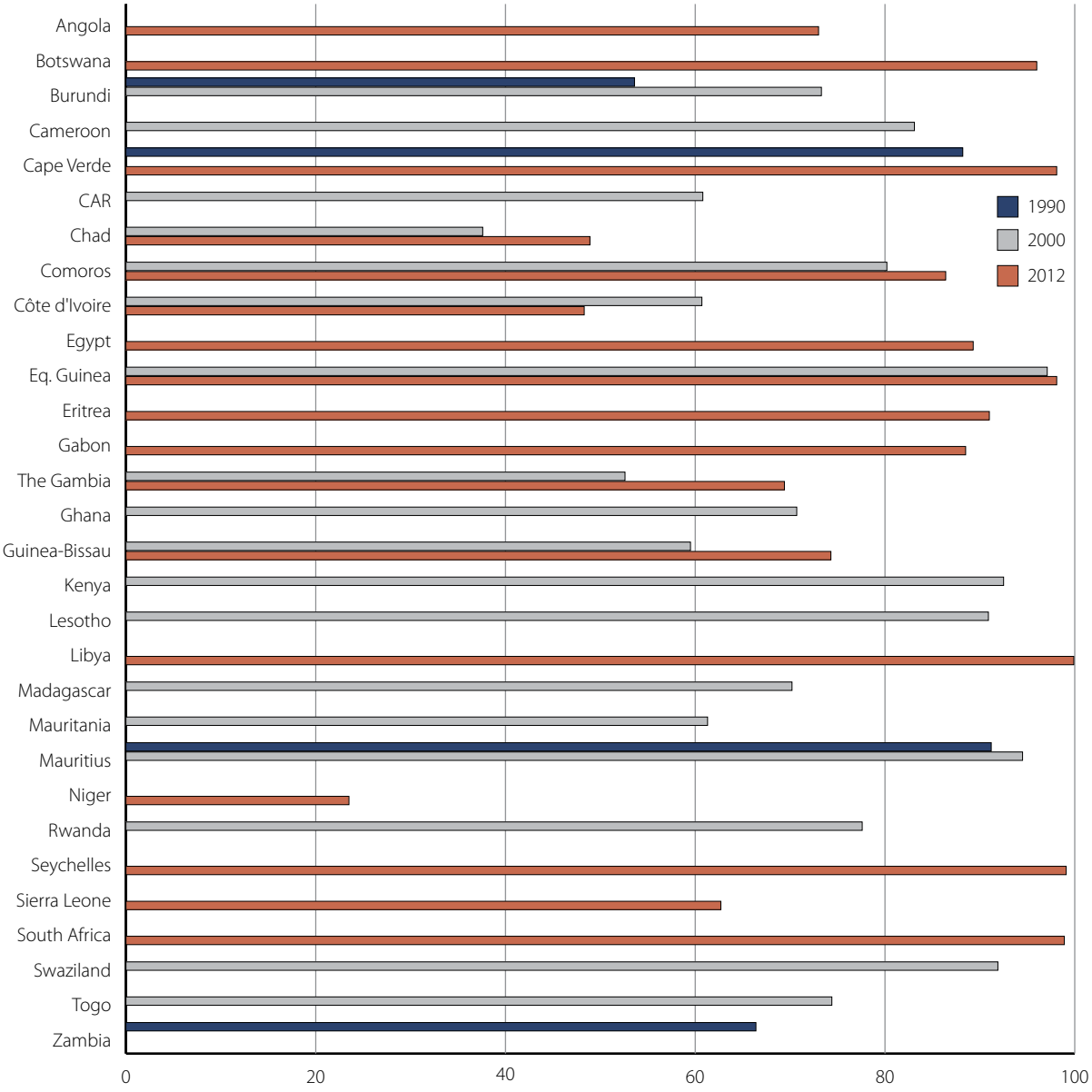
The development of literacy skills is a critical condition to achieving sustainable development and inclusive growth. "It is generally recognized that a literacy rate of 70 per cent is essential for a developing country to make a sustainable economic take-off" (UNESCO EFA-GMR, 2006). The youth literacy rate for the population aged 15-24 years has overall improved in Africa, reaching 69.61 per cent in 2012. This progress is partly due to the result of the increased access to universal primary education observed since 2000. Based on the sample of countries for which data were available in 2012, only Niger, Chad and Côte d'Ivoire recorded youth literacy rates below 50 per cent. The sample shows great variance in literacy rates, from 27 per cent in Niger to 99.1 per cent in Seychelles. Over 66.7 per cent of the 50 African countries for which data are available have achieved at least a 75 per cent youth literacy rate. Globally, 27.8 per cent of the countries are on good track to achieve universal youth literacy. In around 33 per cent of countries for which data are available, the youth literacy rate reached at least 90 per cent in 2012.A stellar performance is recorded in Libya, Cabo Verde, South Africa, Equatorial Guinea, Botswana, Seychelles and Swaziland, where the youth liter-

acy rate is above 95 per cent (see figure 2.3). Three countries have made outstanding progress in increasing their youth literacy rate over the 2000-2012 period: the Gambia (increase of 16.8 per cent), Guinea-Bissau (increase of 14.8 per cent) and Chad (increase of 11.3 per cent).

Some countries experienced a drop in literacy rates, such as Côte d'Ivoire, from 60.7 to 48.3 per cent between 2000 and 2012. In general, these countries have undergone either political or a social unrest during the past decades, which resulted in a limited investment on literacy.

Africa excluding North Africa continues to record the lowest youth literacy rates, and boys are more likely to be able to read and write than girls. In spite of the progress achieved since 2000, Africa excluding North Africa is lagging behind, with a youth literacy rate of 69.6 per cent in 2015 compared to 89.2 per cent in North Africa, 87.8 per cent in other developing countries and 99.6 per cent in the developed world. The performance of the region reflects serious disparities in access to quality basic education and to literacy opportunities within the countries. Although all governments recognize the economic, social and human benefits associated with literacy, the impact of sector

Figure 2.3 Youth literacy trend, 2000 and 2012



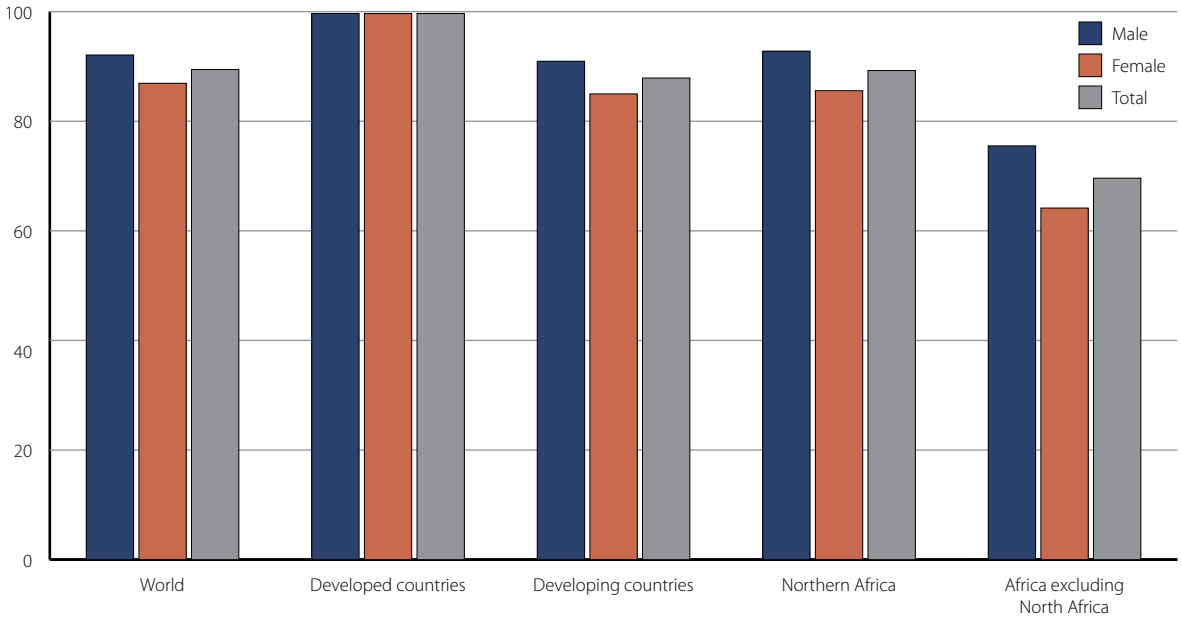
Source: *UNSD data, 2015.*

policies are limited both by inconsistent investment in literacy and the lack of rigorous learning assessments for non-formal education systems. In addition, an important number of civil society organizations (CSOs) are investing in literacy and showcase good examples of best practices that are insufficiently capitalized on at national level and disseminated on large scale. In regard to the low completion rates at the primary education level and limited opportunities for non-formal education, African countries have no choice but to develop continuous and flexible lifelong learning and functional literacy programmes in order to equip youth with the critical basic skills they need to further enter and successfully compete in the labour market. An important reform that has been used by many African countries since 2000 is the transitional use of mother tongue for instruction in early grades of primary education as well as in adult literacy. It is urgent to capitalize on the best innovative practices in this field, particularly in West Africa, and disseminate the findings to the whole region.

In 2012, the gap in youth literacy rates between girls (64.2 per cent) and boys (75.5 per cent) was the widest in Africa excluding North Africa, i.e. 11.35 per cent in favour of boys. The other regions had a lower gap between youth literacy rates for girls and boys: 7.2 percentage in North Africa, 5.9 percentage in the developing world and 5.2 percentage worldwide (see figure 2.4). The level of literacy in the countries in the Southern, East, Central and West African subregions was very far from the absolute goal target when they began. Therefore, the countries that achieved remarkable results established a set of indicative benchmarks that could be used to guide future literacy policy and programme delivery.

The challenges in achieving youth literacy include: limited national and regional literacy policy frameworks; the lack of quality assurance mechanisms; and financing gaps that should be bridged to enable Africa to realize its demographic dividend.

Figure 2.4 Youth literacy by region and gender, 2012



Source: *UNSD data, 2015.*

MDG 3: Promote Gender Equality and Empower Women

Since 1990, Africa has made considerable progress in the achievement of gender equality and women's empowerment, but challenges remain. Structural and cultural impediments continue to limit progress and expose significant gender and socioeconomic inequalities, which will require focused attention if Africa is to achieve its long-term vision of prosperity, structural transformation, human development and enhanced productive capacities. Achieving gender equality and women's empowerment is central to the achievement of many other goals, including reducing poverty and mitigating hunger, improving health and educational outcomes in families and communities, as well as ensuring environmental sustainability. Gender inequality therefore represents the archetypal inequality trap that reproduces further inequalities, with negative developmental consequences that continue to be experienced in the world to date. The initial conditions for gender equality and empowerment of women in Africa were relatively poorer than the rest of the world and only slightly comparable to the Western Asian region in 1990 (UNSD, 2014). In 1990, the Gender Parity Index (GPI) for gross enrolment ratios in all levels of education was 0.82 in North Africa and 0.83 in Africa excluding North Africa. South Asia's initial conditions were the poorest, with a combined GPI of 0.74 over the same time period. Africa has therefore made progress towards closing the gender gap in primary education and increasing literacy levels for women and girls. This is due to Africa's drive to achieve universal primary education and other gender-informed policies that have accounted for the impressive results observed in gender parity in many countries. Similar success stories abound in increasing women's participation in political spaces and society, as evidenced by a higher share of women in national parliaments in Africa, with significant subregional and country variations. Although there have been more modest advances in the share of women in wage employment in the non-agricultural sector since 1990, the structural rigidities of most countries in the region have made it difficult to close the gender gap in this target. There is a similar narrative for other countries where gender gaps have narrowed considerably, especially in Europe, Central Asia, Latin America and the Caribbean, East Asia and the Pacific, the Middle East and North Africa, and South Asia, in that order, with variations across countries and subregions.

In spite of these efforts, however, Africa as a region continues to lag behind in most areas measured by MDG 3 (Promote gender equality and empower women). Important lessons and considerations can be drawn from the failure to meet this goal. Gender-informed policy interventions such as stipends, conditional cash transfers and vouchers have had significant pay-offs in increasing the parity ratios in education, while candidate quotas and reserved seats that were adopted by a large number of countries in the 1990s have accounted for notable increases in women's participation in national parliaments. Because of legislated quotas and voluntary party quotas, there have been substantial increases in the proportion of seats held by African women in national parliaments. Impressive progress has been recorded by most of the countries in East and Southern Africa, and more recently, by a few West African countries such as Burkina Faso, Cabo Verde, Senegal and Togo. However, progress in the non-agricultural wage employment sector has remained limited, showing modest increases in some countries but a lack of progress in most. Trends and patterns are difficult to monitor for this indicator owing to lack of data and limited reporting on this target.

Important lessons can be drawn from 15 years of experience implementing the MDGs, which will inform the implementation of the post-2015 development agenda and the Sustainable Development Goals. For MDG 3, the positive experiences reflect the good practices that accelerate

progress, while the challenges reveal areas where further efforts need to be made. Over time, there have been increases in enrolment in primary education and completion rates, girls' school retention, and in maintaining the transition between levels of education, which are imperative for long-term objectives.

Although vital for addressing multiple deprivations, improving the share of women in non-agricultural wage employment is currently beyond the scope of many low-income countries, where formal employment is not a main source of income or jobs. Barriers to women's participation in the non-agricultural sector include, but are not limited to, low educational attainment; time burden of domestic tasks; limited availability of child care; and the impact of laws and customs on women's ability to work outside the home. In addition, women's political participation is only captured at the national level, whereas participation in democratic spaces should also include the provincial and local levels where access to women's decision making is also important (ECA et.al, 2012). All of these are important lessons that should provide information on gender equality and the empowerment of women beyond 2015, which has yet to be accomplished. The MDGs have certainly laid important foundations that Africa should build on for the future.

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

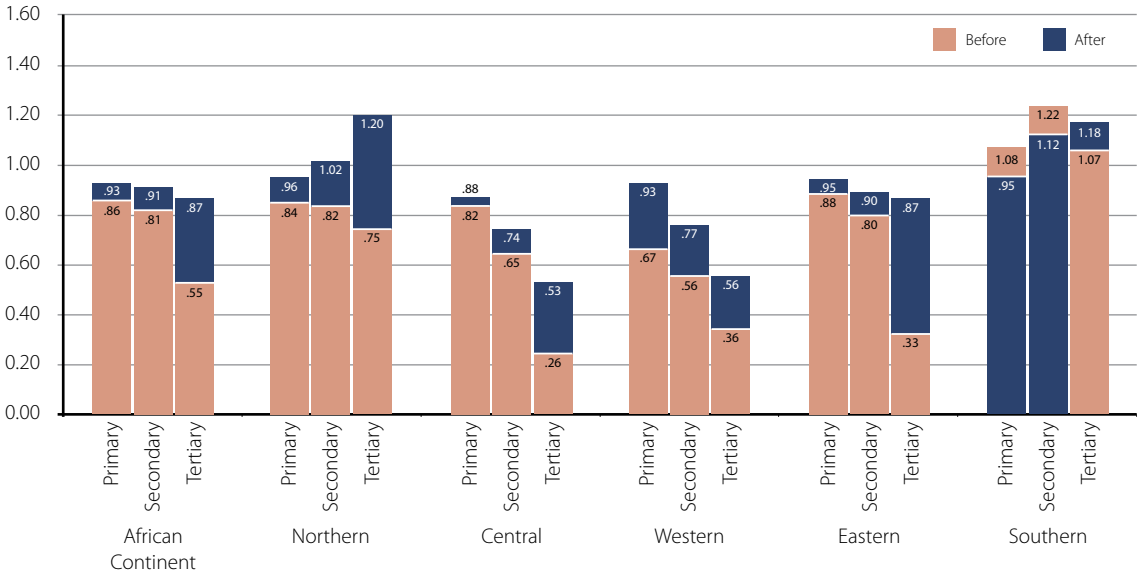
Education is one sure source for imparting skills and competencies that are central to human development and an enhanced quality of life, bringing multiple benefits to individuals and societies. It is a basic human right that should be made available to all. Investing in education for all has long been recognized as a fundamental right with far-reaching consequences for human development and societal progress. Investing in girl's and women's education in particular, produces exceptionally high social and economic returns (World Bank, 2014a). There are many benefits to having an educated population in general; for women and girls, the benefits are large since educated women tend to invest more in the welfare of their children and households, therefore contributing directly to a well-educated and healthier population. By breaking of the cycle intergenerational 'scourges' of illiteracy and poverty, education facilitates the participation of individuals in the labour market, which allows them to earn decent and reliable incomes, know and claim their rights, and contribute positively to their households and societies. At a time that the world is contending with inequalities of different kinds, educating and empowering women and girls remains a critical avenue for reducing inequalities.

Africa is close to achieving the universal primary education target

Gender parity in primary education has increased in most regions of the world, with several countries adapting universal primary education and implementing gender-responsive interventions that have helped increase enrolments substantially over the years. The rate of gross enrolment for school-aged girls have increased significantly in most regions, yet Africa excluding North Africa, Oceania, Western Asia and North Africa still face continued disparities for girls. The global average assessment, however, does not reveal regional and country variations including degrees of effort. Developing regions which had relatively low initial conditions in 1990 made notable strides towards improving parity levels with an increase of at least 10 per cent from 0.84 in 1990. From 1990 to 2012, Southeast Asia made the greatest effort in achieving gender parity, having increased its primary school enrolment ratios from 0.74 to 1.00. Other most improved regions include North Africa (0.82 to 0.96), Western Asia (0.85 to 0.93) and Africa excluding North Africa (0.83 to 0.92) (UN Statistics, 2013).

Within Africa, West Africa is the most improved subregion within the continent, followed by North Africa. In terms of reaching parity at all levels of education, Southern Africa has continued to register strong performances over the years, followed by North Africa, which has reached parity in all levels except for primary education and has made exceptional progress in tertiary education. East Africa is making steady and significant

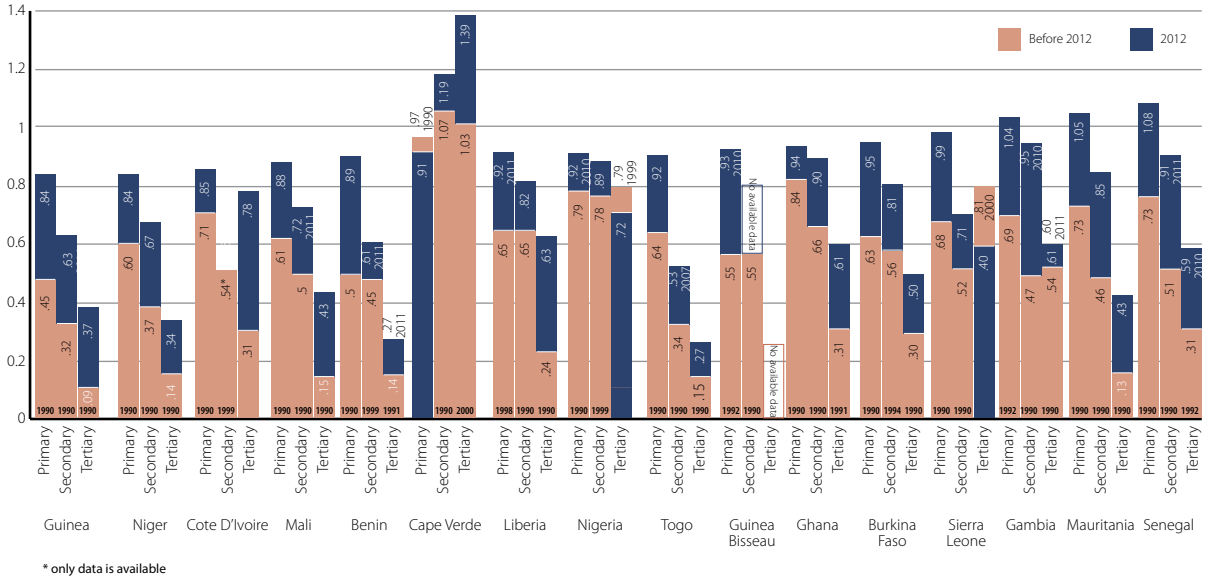
Figure 3.1 Ratio of girls to boys in primary, secondary and tertiary education in Africa, before and after 2012



Source: *Authors' calculations based on UNSD, 2015.*

Note: *The closest data points to 1990 and 2012 are used.*

Figure 3.2 Ratio of girls to boys in primary, secondary and tertiary education, West Africa

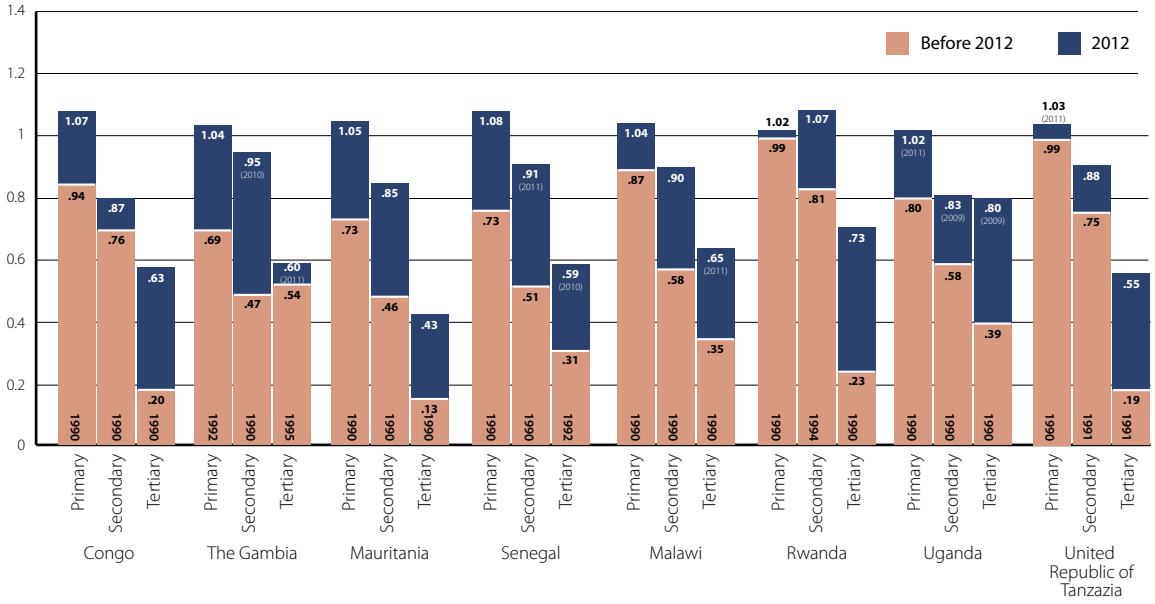


* only data is available

Source: *UNSD, 2015.*

progress from its initial conditions in closing the gender gap in tertiary education, although it is yet to reach target 3.A. Central Africa, on the other hand, trails behind all regions in making progress towards this target (see figure 3.1). A number of countries have contributed to the increase in the West African average, such as Cabo Verde, Senegal, Mauritania, the Gambia, Sierra Leone, Burkina Faso, Ghana, Nigeria and Liberia, among many others (see figure 3.2). These countries have almost reached (see figure 3.3) or exceeded parity (in primary education); similar progress is also observed in almost all North African countries.

Figure 3.3 African countries reaching parity in primary enrolment



Source: *UNSD, 2015.*

Countries that have exceeded parity in primary school enrolment include Algeria, Tunisia and Libya in North Africa (GPI scores of around 1.10); Sao Tome and Principe (1.14) and Equatorial Guinea (1.07) in Central Africa; Cabo Verde, Sierra Leone, the Gambia, Mauritania and Senegal (an average GPI of 1.09) in West Africa, and 14 other countries in Eastern and Southern Africa that have an average combined index of 1.06 with high GPI scores observed in Lesotho (1.25), Namibia (1.09), Botswana (1.07) and Seychelles (1.05). While this is remarkable progress, increasing disparities against boys at any level of education is an element that needs to be followed closely to avert negative developmental effects in the long term. However, a number of countries continue to face challenges in closing gender gaps in education such as Niger, Chad, Central African Republic and Angola with indices below the 1990 levels.

Gender barriers still exist at different levels of education

While there has been substantial progress in closing gender gaps in education, gender barriers remain and are more pronounced at different levels of education. These disparities manifest themselves in low completion rates for girls at the primary level and low transition rates between levels – primary to secondary, tertiary and into wage employment, with the exception of the Southern and North Africa subregions. Consequently, while parity may have been achieved at primary school enrolment, the gap widens and enrolment is much lower for girls at secondary and tertiary levels. Furthermore, the transition to paid employment in Africa excluding North Africa and other developing regions is much more difficult for girls than boys. The unfinished agenda in gender equality in education requires resolving some key challenges in the quality of education in most countries, but also particularly in fragile states and countries in recovery, such as those in Central Africa that face persistent developmental challenges (World Bank, 2007). These challenges include: reaching out to disadvantaged and socially excluded groups, which in most cases are in rural areas; increasing enrolments rates at secondary and tertiary levels with incentives and relevant policy interventions informed by gender equality concerns; and promoting transitioning from one level to the next in the education levels through to the labour market.

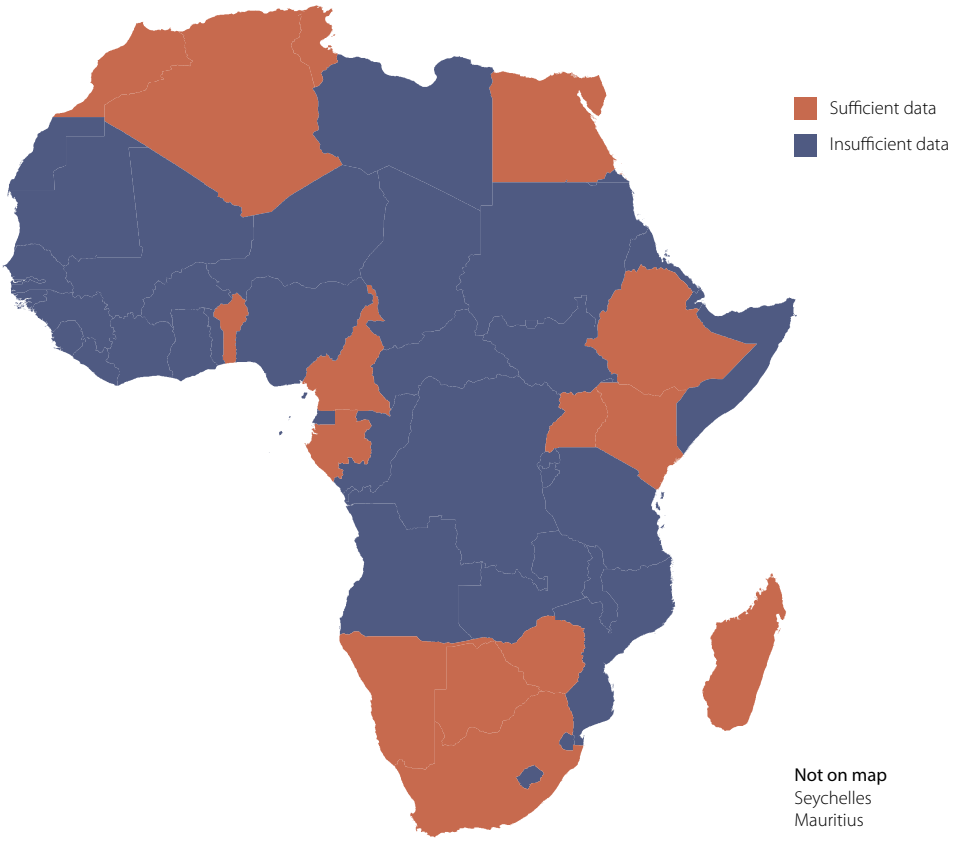
Uneven gains in the share of women in wage employment in the non-agricultural sector

Income inequalities may be the most pronounced form of inequalities that have been rising over time globally. Africa is no exception, with a number of countries showing sharper increases in income inequalities than others. For a continent that is growing rapidly, this trend reveals the non-inclusiveness of Africa's growth and the limited impact on the welfare of women and youth. Women constitute nearly half of the population of the world and should make up close to half of the world's labour force. Yet, owing to several constraints, such as low educational qualifications and skills, large wage differentials, conditions of work, family responsibilities and cultural barriers, significant gender gaps persist in their participation in gainful employment in the formal sector. The removal of barriers they face to gainful employment is a huge step towards reducing inequalities and unlocking the potential for their meaningful contribution to socioeconomic development. Therefore, the call for economic structural transformation contained in the African Union's Agenda 2063 and the African Common African Position on the post-2015 Development Agenda is a justifiable development objective for the economic and social inclusion of Africans including women.

Progress towards this end has been made with uneven gains across countries and subregions. The analysis of this target, however, is constrained by data limitations, especially in Africa where less than 25 per cent of the countries have reported on it (see figure 3.4). Different datasets have therefore been used as proxies for women's participation in the labour market, including in the formal and informal sectors.

For the purposes of this report, women's labour force participation has been limited to three main sectors in most economies – agriculture, industry and services. Globally, there is a general decline of labour force participation for both women and

Figure 3.4 Countries with sufficient and insufficient data of women in wage employment in the non-agricultural sector in Africa



Source: *Authors 'computations based on UNSD data, 2015.*

men in the agricultural sector, with gradual shifts to services and industry, which has absorbed labour force mainly from agriculture. The reductions have been much faster in some regions depending on the pace of economic transformation and diversification. Developed regions and Latin America and the Caribbean have significantly lower levels of female than male labour force participation in all sectors, whereas Asia and Africa had higher shares of women than men in the agricultural sector between 2004 and 2007 (see table 3.1) (ILO, 2014).

The more advanced economies are, the lower the labour force participation in the agricultural sector, which shifts to other sectors. This shift can be observed to a great extent in the services sector and industry. In the African region, participation in the agricultural sector is highest in East, Central and West Africa for both women and men, followed by North Africa (42 per cent of women and 28 per cent of men), while Southern Africa has much lower participation of women (16 per cent) than men (26 per cent). However, female labour participation in the services sector (26 per cent) is higher than that of men in Southern Africa and East, Central and West Africa, with the exception of North Africa where male participation (49 per cent) is higher than female participation.

There are large gender gaps in the labour force participation in the industrial sector. In all regions, there are more males than females in the industrial sector (i.e. at least 20 per cent males against 11 per cent females).

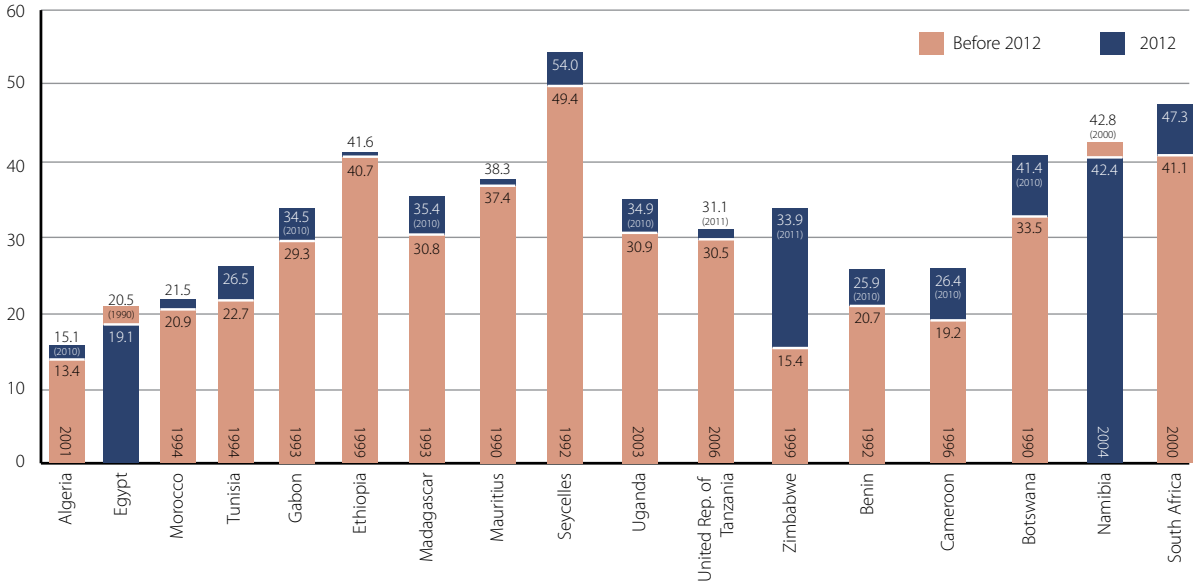
For countries with recent data (see figure 3.5), there is steady but slow progress towards meeting this target. Botswana, Ethiopia, Mauritius, Namibia, Seychelles and South Africa, have raised the share of women in the non-agricultural sector to at least above 40 per cent, while a few other

Table 3.1 Sectoral distribution of employed persons, by region and gender, 2004-2007 (per cent)

	Women			Men		
Region/country	Agriculture	Industry	Services	Agriculture	Industry	Services
North Africa	42	16	41	28	25	47
Southern Africa	19	11	70	26	25	49
East, Central and West Africa	68	6	26	9	9	20
Asia	**31.8**	**12.4**	**56**	**25.6**	**25.4**	**48.6**
Eastern Asia	11	13	76	13	25	62
Southeast Asia	30	17	54	34	23	43
South Asia	55	17	28	32	24	43
West Asia	15	8	77	8	32	59
Common Wealth of Independent States and Asia	48	7	45	41	23	36
Latin America and the Caribbean	**3**	**12.67**	**80**	**22**	**27**	**51**
Caribbean	4	10	85	15	29	56
Central America	6	16	78	30	24	46
South America	10	12	78	21	27	51
More Developed Regions	**6.2**	**15**	**78.8**	**8.2**	**36.4**	**55.4**

Source: *Computed using ILO Key Indicators of the Labour Market data – 6th ed., 2010 and UNMDG Report, 2014.*

Figure 3.5 Share of women in wage employment in the non-agricultural sector



Source: *UNSD data, 2015.*

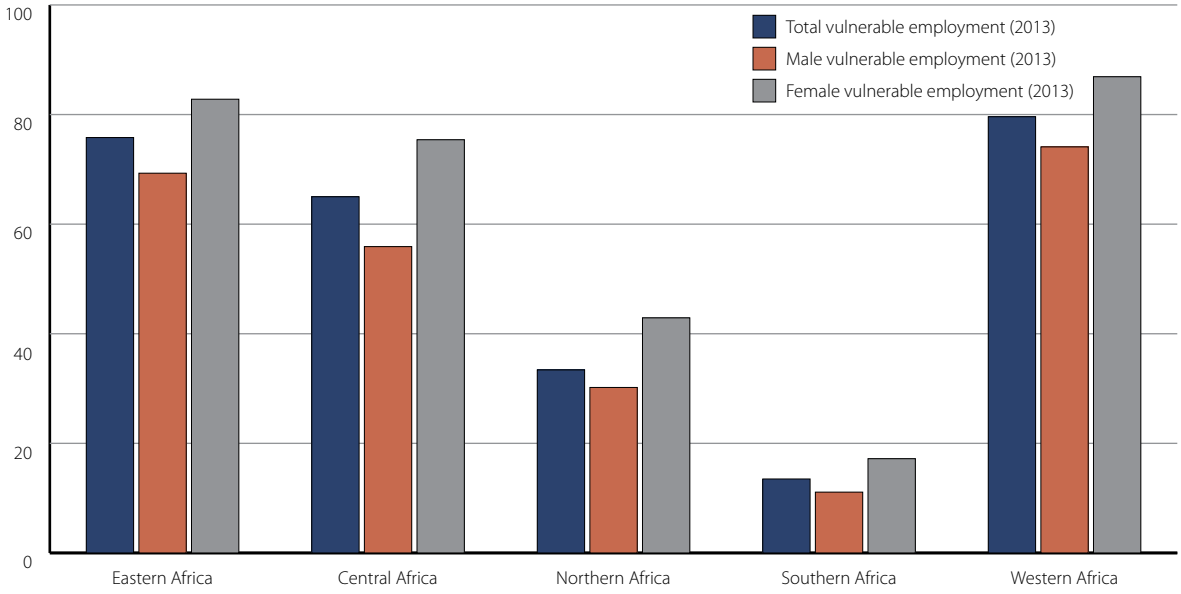
countries, – Benin, Burkina Faso, Burundi, Gabon, Madagascar, Tunisia and Zimbabwe – have made the greatest improvements (by at least 5 per cent) from their initial conditions.

Enhancing women's productive capacities is critical in women's empowerment

Enhancing women's productive capacities is critical, whether women are engaged in self- or wage employment; working women are more likely to invest their earnings in building human capital in their homes and communities. Such microeconomic contributions can be crucial in keeping households out of poverty, increasing educational attainment and contributing to health outcomes in order to meet larger macroeconomic objectives. It is important, therefore, to ensure that women's productive capacities are enhanced by removing the barriers to entry in both the formal and informal sectors. The upward trend in the share of women in the non-agricultural and formal sectors is a strong indication of the gradual shift towards decent jobs for the majority of population groups including women. More women, however, are likely to be unemployed than men, and likely to be engaged in the informal sector (including the services sector) and vulnerable employment than their male counterparts in all regions (see figure 3.6). The ratio of women in vulnerable employment is persistently higher than that of men, especially in West, East and Central Africa. A similar trend is also observed in the unemployment ratios, which are typically much higher for women (adult and youth) than for their male counterparts.

Self and vulnerable employment provides opportunities for most women and men where there are barriers to entry into the formal sector. The share of women in vulnerable employment is persistently higher than that of men in all regions; West Africa has the largest share, followed by East and Central Africa, whereas Southern and Northern Africa have the lowest shares. It should be highlighted that the economies in Southern and Northern Africa are relatively well transformed and diversified enough to offer more formal and reliable employment opportunities than the rest of the continent. The reality for most of Africa, however, is the lack of decent jobs in the formal sector, which has left many people unemployed or in vulnerable employment. Women and the youth make up the majority of the population that is either unemployed or in vulnerable employment, and unemployment is persistently higher for adult women and female youth in all regions than for their male counterparts. The subregions with the least shares of vulnerable employment (i.e. Southern and Northern Africa) have relatively

Figure 3.6 Regional breakdown of vulnerable employment



Source: *ILO, Trends Econometric Models, October 2014.*

the highest rates of unemployment and inequalities in Africa compared to the other subregions where vulnerable employment is most prevalent in all age groups, and particularly for female youth and women. This is due to the lack of informal employment options available to them and the availability of social protection programmes that cushion the unemployed. In countries with weak social protection systems, unemployment is not an option and therefore precarious jobs provide the much needed cushion and the means for survival for a large share of the working poor.

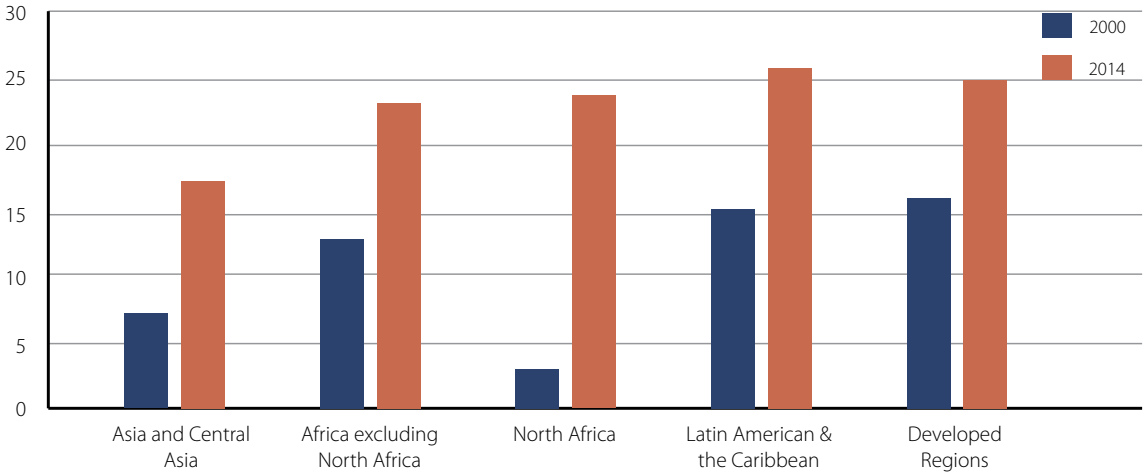
By 2013, Southern Africa had an adult male unemployment rates of 14.6 per cent compared to an adult female unemployment rate of 19.1 per cent, and a male youth unemployment rate of 35.4 per cent compared to a female youth unemployment rate of 44.6 per cent. In North Africa, in the same year, adult male unemployment was 7.9 per cent compared to 14.9 per cent for the adult female population; youth unemployment rates were 26 per cent for males and 46.6 per cent for females (ILO, 2014). These trends account for a significant portion of the rising inequality patterns observed in Africa in recent times, which is disproportionately affecting large segments of the population within countries and regions. This needs urgent attention.

Africa is leading in women's representation in national parliaments

Ensuring that women are well represented in positions of power and decision making can remove some of the barriers they face in access to education, health and employment, thereby substantially reducing inequalities. Although the full impact of women's representation is yet to be realized, their slow but increasing representation in national parliaments has empowered women globally. This has been achieved by promoting women's issues and concerns through the legislature in order to reduce inequalities between genders. From 2000 to 2014, the global average for women's representation in national parliaments rose steadily from 14 to 22 per cent (UNSD, 2014). Over the same period, Africa has made the most progress on this target, with an increase of the share of women in national parliaments by at least 15 per cent, followed by Latin America and the Caribbean (11 per cent increase), Asia (9.8 per cent) and developed regions (9 per cent) (see figure 3.7).

There are significant differences, however, within regions and across countries, with results showing a direct correlation between policy measures put in place and the increase in numbers and levels of representation of women in national

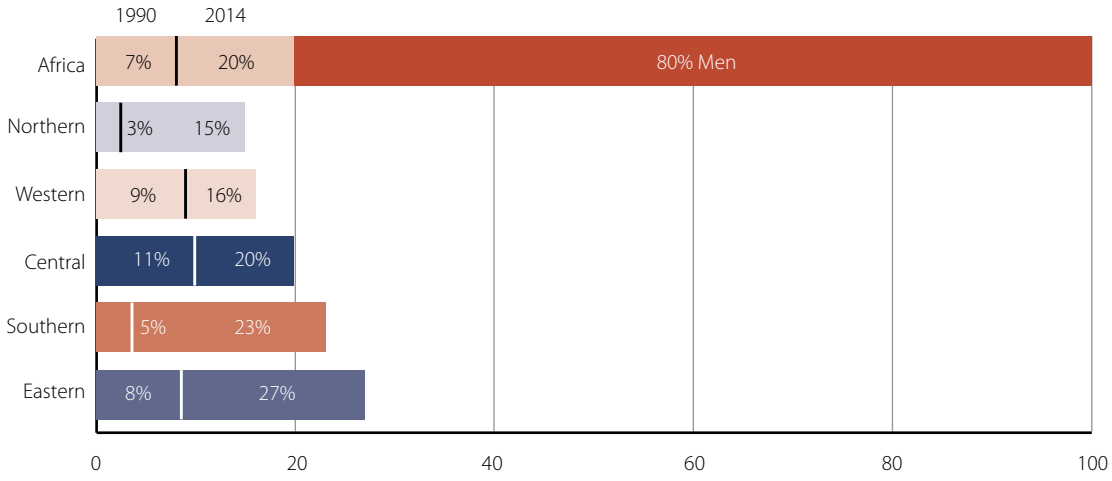
Figure 3.7 Proportion of Seats held by Women in national parliaments, 2000 and 2014 (per cent), per region



Source: *Authors' computations based on UNSD data, 2015.*

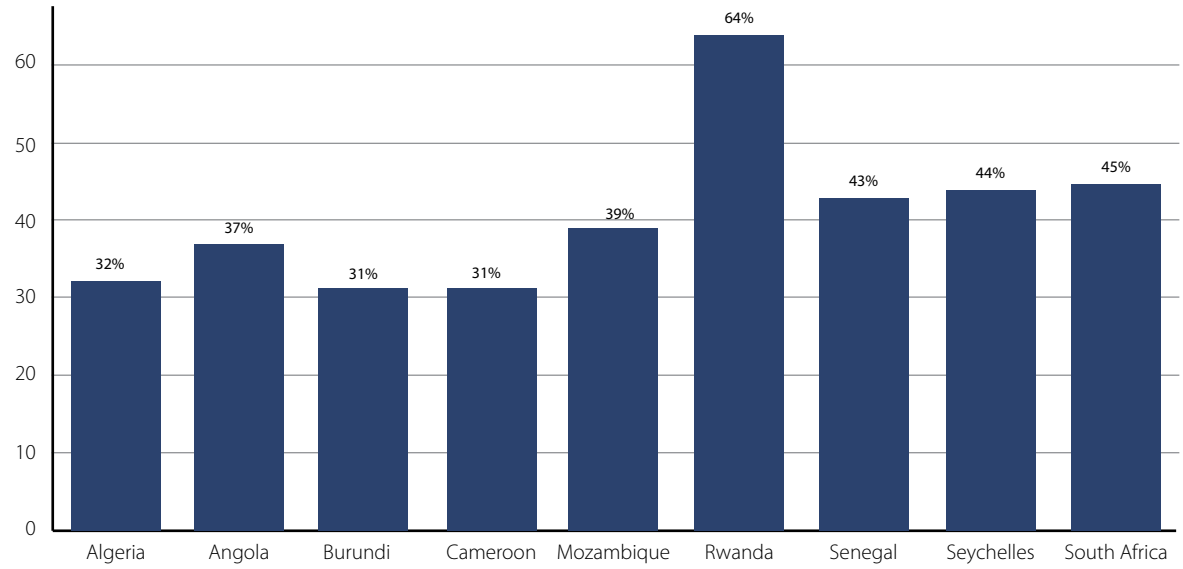
parliaments (see figure 3.8). Female members of parliament remained unchanged in 2014 from 2012 and accounted for 20 per cent of all parliamentary seats in Africa with significant variations across subregions and countries. East Africa continues to lead (see figure 3.8), with Rwanda registering 63.8 per cent of women in its national parliament followed by Ethiopia (41.6 per cent), United Republic of Tanzania (36 per cent), Uganda (35 per cent) and Burundi (31.1 per cent). Several countries in Southern Africa maintained a steady growth in the share of women in national parliaments: South Africa has maintained its leadership in the subregion, with a share of 44.8 per cent of women in its national parliament, followed by Seychelles (43.8 per cent), Namibia (42.4 per cent), Botswana (41.4 per cent), Mozambique (39.2 per cent), Mauritius (38.3 per cent), Madagascar (35.4 per cent) and Zimbabwe (31.5 per cent), all of which have met the 30 per cent target and are aiming at a 50 per cent share of representation. In Central Africa, three countries have reached

Figure 3.8 Seats held by women in national parliaments (per cent)



Source: *UNSD data, 2015*

Figure 3.9 African countries with more than 30 per cent of seats held by women in national parliaments



Source: *Authors' calculations based on UNSD data, 2015.*

the 30 per cent target: Angola (36.8 per cent), Gabon (34.5 per cent) and Sao Tome and Principe (32.1 per cent). Recently, Senegal has shown a very strong performance in its representation levels in the national parliament. In 2014, Senegal registered a share of 43.3 per cent of women in its national parliament, up from 22.7 per cent in 2010. Although only one country (Algeria) has reached the target in North Africa, the subregion is the most improved of all regions. From 2010 to 2014, Algeria more than tripled its share of women in its national parliament from 7.7 per cent to 31.6 per cent; Morocco, from 10.5 per cent to 17 per cent; and Libya, from 7.7 per cent to 16.5 per cent.

Legislated or voluntary quotas have had a positive impact on the share of women in national parliaments as seen in most countries that were early adopters of such policies in Southern and East Africa in the early 1990s. However, there is a push for more gender reforms within political parties to field and support more women candidates. In addition to the quotas at the national level, however, it is important to increase women's participation at local levels in order to have a pool of candidates that can participate and increase the number of women at the national level as well as to address political violence against women, which has acted as a deterrent for women's political participation.

MDG 4: Reduce child mortality

This section provides the progress made in reducing child mortality and achieving MDG 4 both globally and in Africa. It also looks into the variations in progress made to date.

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

Impressive progress in reducing child mortality

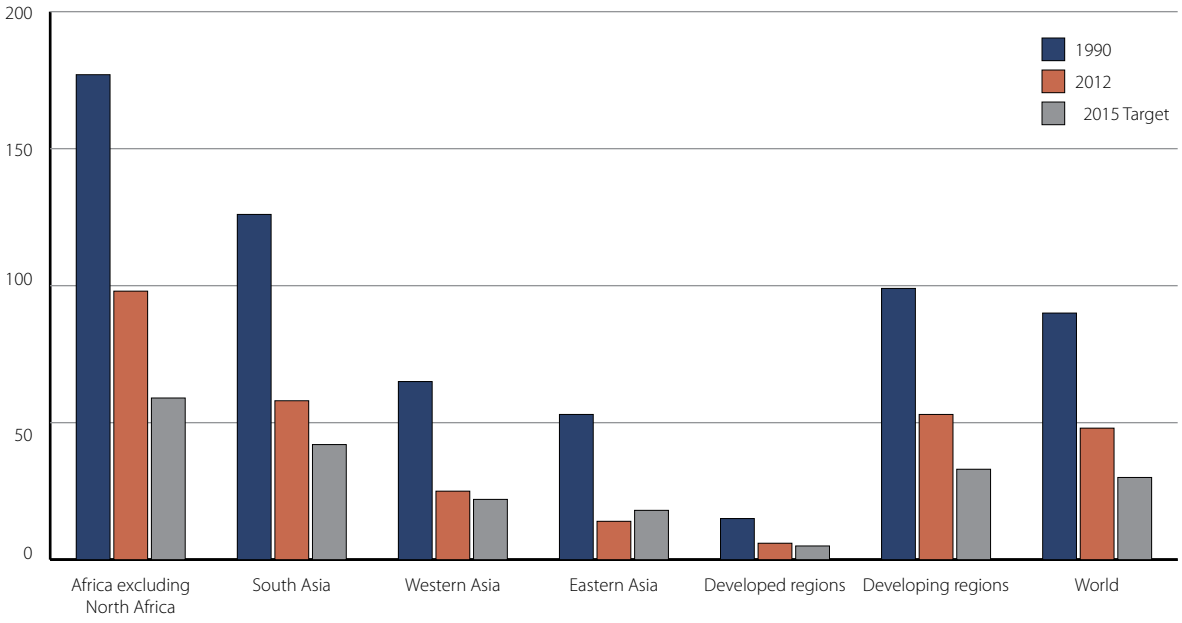
Continent-wide, U5MR was reduced by 55.5 percent, from 146 deaths per 1,000 live births in 1990 to 65 deaths in 2012, against the target of the two-thirds reduction. Yet, the continent is still the region with the highest proportion of U5MR globally, accounting for 1 in 9 child deaths before the age of five as indicated in figure 4.1.

Globally, an estimated 6.6 million children under-five died in 2012, a remarkable decline from the 12.6 million deaths in 1990 (UNICEF, 2013b). Yet, there are variations in the rate of reduction of child mortality across the various regions (see figure 4.1). Although Africa has shown encouraging progress in reducing child mortality, 3.2 million of the continent's children did not reach their fifth birthday in 2012. Consequently, Africa accounts for almost half of all child deaths globally, an increase from 29 per cent two decades ago (Ibid.); most died as a result of easily preventable infectious diseases.

Twenty-seven developing countries are expected to achieve MDG 4 by 2015 (McKinnon, et al., 2014; The Lancet, 2014). In addition, the annualized rates of change from 1990 to 2013 ranged from –6.8 per cent to 0.1 per cent. Ninety-nine out of 188 countries, including 43 of 48 countries in Africa excluding North Africa, had faster decreases in child mortality during 2000–2013 than during 1990–2000. The average annual rate of decline in child deaths reached 4.1 per cent in 2005–2012, against 0.8 per cent in 1990–1995 (UNICEF, 2013b).

In Africa excluding North Africa, under-five mortality rate was reduced by 44.6 per cent, from 177 deaths per 1,000 live births in 1990 to 98 deaths in 2012, against the target of the two-thirds reduction.

Figure 4.1 Under-five mortality rates by region, 1990, 2012 and 2015 target



Source: *UNSD, 2013.*

Egypt, Ethiopia, Liberia, Malawi, Tunisia and the United Republic of Tanzania met the under-five mortality rate target in 2012; Algeria, Cabo Verde, Eritrea, Libya, Madagascar, Morocco, Mozambique, Niger, Rwanda, South Sudan and Uganda reduced their rate by 60 per cent or more, or have come very close to the target of reducing it by two thirds. Increases were recorded in the under-five mortality rate during this period in Botswana, Lesotho, Swaziland and Zimbabwe is largely attributed to HIV/AIDS-related deaths.

There is also wide variation in the level of achievement among countries on the infant mortality rate target. The continent-wide infant mortality rate fell from 90 deaths per 1,000 live births in 1990 to 54 deaths per 1,000 live births in 2014, a decline of 40 per cent. In addition, from 1990 to 2012, 18 countries reduced their infant mortality rates by more than one half, including Egypt, Liberia, Malawi and Tunisia (by over 65 per cent); and 26 countries registered reductions of between 20 and 49.9 per cent. Over the same period, Lesotho, Swaziland and Zimbabwe also registered increases in their infant mortality rates and in their under-five mortality rate. In 2012, the Democratic Republic of the Congo, Sierra Leone, Somalia and the Central African Republic remained the countries with the highest infant mortality rates, all registering rates above 100 deaths per 1,000 live births. Botswana's under-five mortality rate increased from 57 in 1990 to 76.0 in 2007, and then declined to 28 in 2011, while its infant mortality rate increased from 48 in 1990 to 57.0 in 2007, and declined to 17 in 2011.

Many of the African countries have demonstrated either slow progress or stagnating neonatal mortality rates. The situation is worse for the large rural populations of Africa that have poor access to and utilization of maternal and newborn health services. Globally, some countries have made substantial progress in reducing neonatal mortality rates, most notably China and Egypt (both with a 60 per cent per cent reduction in newborn deaths) and Cambodia (51 per cent). In contrast, Africa excluding North Africa, where about a third of under-five deaths occurred during the neonatal period, has the highest neonatal mortality rate (32 deaths per 1,000 live births in 2012) and accounts for 38 per cent of global neonatal deaths (UNICEF, 2013b).

Overall, African countries have made substantial progress towards achieving MDG 4 (Reduce child mortality). In particular, Africa excluding North Africa has seen a faster decline in its under-five mortality rate, with the annual reduction rate doubling between 1990–2000 and 2000–2011. Accelerated efforts in reducing the under-five mortality rate in Africa has enabled the continent achieve good progress at reaching this target.

Curbing neonatal mortality is critical for improving child survival. Among the proven, cost-effective and high-impact interventions are: skilled care at birth and emergency obstetric care; management of pre-term births, including antenatal corticosteroids for lung maturation; basic neonatal care; neonatal resuscitation; early identification and antibiotic treatment of serious infections; inpatient care for small and sick newborns; and prevention of mother-to-child transmission) of HIV. Prioritization and integration of these interventions into the service delivery modalities is crucial. Combining quality health services at the health facility, supported by strong outreach, follow-up and referral services, promoting healthy behaviours at home and making early decisions to seek care will have the greatest impact. Concerted effort should be focused on social determinants of health (education, income, gender orientation, household food security, water and sanitation etc.) and an education campaign is crucial. For children living in the poorest households, social protection mechanisms including health insurance are needed to improve access to high-impact interventions.

MDG 5: Improve maternal health

Ensuring that African countries meet MDG 5 (Reducing the maternal mortality ratio by three quarters between 1990 and 2015) remains a challenge. Less than two fifths of countries have a complete civil registration system with good attribution of cause of death, which is necessary for the accurate measurement of maternal mortality. Owing to the existence of only scant data on MDGs, particularly on maternal health, most countries and development partners are relying on estimates to have an idea of the maternal health situation in Africa.

Globally, WHO reported 800 maternal deaths per 100,000 live births daily in 2013 alone, as a result of complications of pregnancy and childbirth. It is indicated that the risk of a woman in a developing country especially in Africa dying from a maternal cause is around 23 times higher than for a woman living in a developed country (WHO, 2014a). Maternal mortality in Africa has been largely associated with three kinds of delays in the childbearing process – delays in seeking health care, delays in reaching caregivers, and delays in receiving care (ECA et al., 2011).

The Yamoussoukro Declaration gave a boost to the measurement of maternal mortality. The Declaration arose out of the third Conference of African Ministers Responsible for Civil Registration, held in Côte d'Ivoire on -13 February 2015. Among other resolutions adopted at the Conference, the Declaration focused on the strengthening of statistics on death and causes of death. Implementation of the resolutions will be a great opportunity for the continent to accurately measure maternal deaths and consequently contribute to strengthening policies to improve maternal health. Furthermore, the United Nations Secretary-General's Global Strategy for Women's and Children's Health, launched in September 2010, has been instrumental in the mobilization of commitments among African governments, civil society organizations and development partners to accelerate progress in meeting MDG 5 (UNSD, 2010).

Africa has made tremendous progress in improving maternal health, but only a few countries (Cabo Verde, Equatorial Guinea and Rwanda) have met the target of reducing the maternal mortality ratio by two thirds by 2015.

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

Africa has the highest maternal mortality ratio globally

Africa is the region with the highest maternal mortality ratio (MMR) in the world. According to United Nations Statistics Division (UNSD) data, by 2013, Africa had 289 maternal deaths per 100,000 live births, compared to the world average of210 maternal deaths per 100,000 live births. In 2013, the developed regions of the world reported the lowest MMR (16 deaths per 100,000 live births), followed by Eastern Asia (33 deaths per 100,000 live births), and Caucasus and Central Asia (39 deaths per 100,000 (table 5.1).

Between 1990 and 2013, only four African countries reduced their MMR by over 75 per cent, thereby meeting MDG 5: Cabo Verde, 77 per cent; Equatorial Guinea, 81.9 per cent; Eritrea, 77.6 per cent; and Rwanda, 77.1 per cent. Some countries reduced their MMR by over 60 per cent and are thereby on track to meeting MDG 5: Ethiopia, 70 per cent; Angola, 67 per cent; Mozambique, 63 per cent; Egypt, 62.5 per cent; and Morocco, 61.3 per cent. Some African countries only slightly reduced their MMR, by less than 10 per cent: Zimbabwe, 9.6 per cent; South Africa, 6.7 per cent; and Côte d'Ivoire, 2.7 per cent. Only Mauritius increased its MMR, by 4.3 per cent (70 per cent in 1990 to 73 per cent in 2013). However, countries that already had a low MMR in 1990 found it difficult to further reduce it by 2013. Countries that have emerged from, or are in conflict, such as Burundi, Chad, the Democratic Republic of the Congo, Sierra Leone and Somalia reported exceedingly high MMRs (see figure 5.1).

Table 5.1 Global comparisons on maternal mortality ratio (maternal deaths per 100,000 live births, women aged 15-49)

Maternal mortality ratio	1990	2000	2013
World	380	330	210
Developing regions	430	370	230
Africa	575	470	289
Latin America and the Caribbean	140	110	85
Eastern Asia	95	63	33
Southern Asia	530	360	190
South-East Asia	320	220	140
Western Asia	130	97	74
Oceania	390	290	190
Caucasus and Central Asia	70	65	39
Developed regions	26	17	16

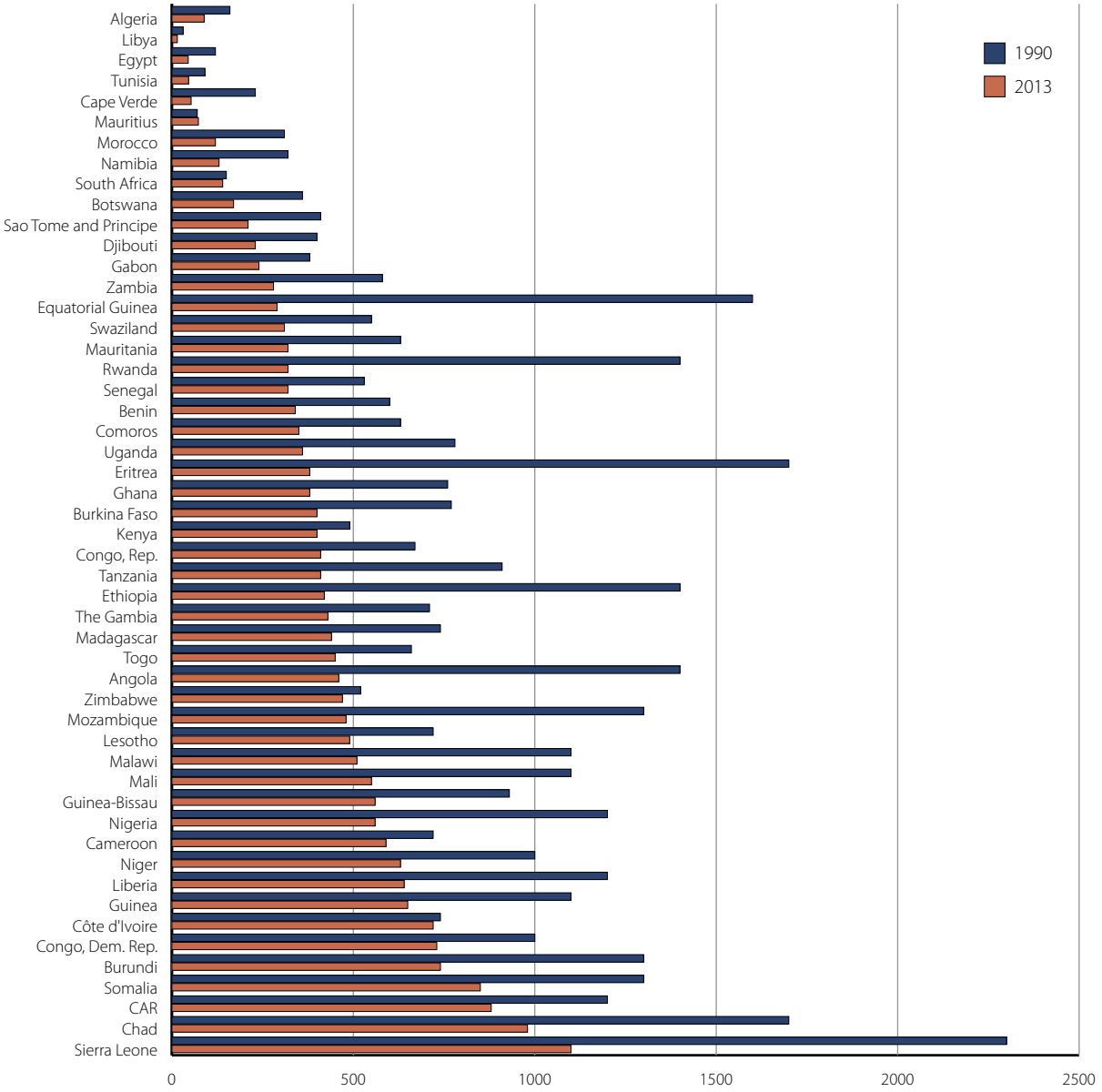
Source: *UNSD data, updated on 7 July 2014.*

Limited access to skilled health personnel constrains the fight against child and maternal deaths

Global data on the proportion of births attended by a skilled health personnel indicate that Africa is still one of the regions with the lowest proportion of births attended by a skilled health personnel (68 per cent), although it performed better than Southern Asia, which reported 51 per cent in 2012 (table 5.2).

Four African countries registered an impressive performance, with over 95 per cent of the births being attended by skilled health personnel (Libya, 99.8 per cent; Tunisia, 98.6 per cent; Mauritius, 98.4 per cent; and Algeria, 95.2 per cent). Results also indicate that Chad, Eritrea, Ethiopia, Niger and Sudan were the weakest performers in Africa (see figure 5.2).

Figure 5.1 Progress in reducing the maternal mortality ratio, 1990-2013



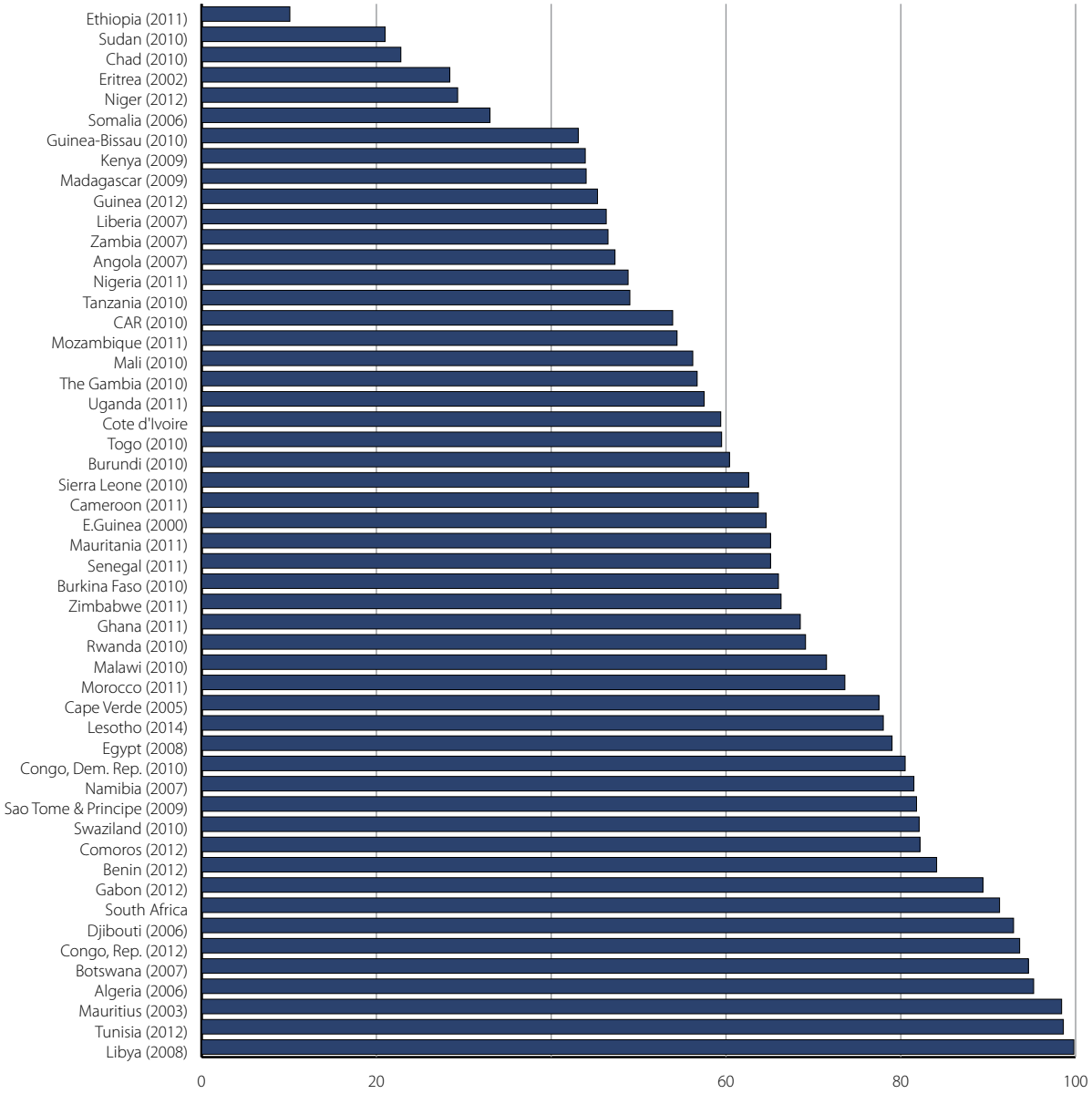
Source: *UNSD data, updated on 7 July 2014.*

Table 5.2 Global proportion of births attended by skilled health personnel (per cent)

Births attended by skilled health personnel (per cent)	1990	2000	2012
World	57	58	69
Developing regions	56	57	68
Africa	47	56	68
Caribbean	70	71	74
Eastern Asia	94	97	100
South Asia	33	38	51
South-East Asia	49	66	79
Western Asia	60	70	80
Caucasus and Central Asia	97	92	98

Source: *UNSD, 2015.*

Figure 5.2 Proportion of births attended by skilled health personnel (per cent)



Source: *UNSD data, updated on 7 July 2014.*

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

Increasing contraceptive prevalence rates can lower maternal deaths

The contraceptive prevalence rate for married women indicates the ability of a woman's choice to determine the number of children she will bear and the timing of child birth (UNFPA, 2012). UNSD data on the 2012 contraceptive prevalence rate indicates that Africa (44.3 per cent) registered the highest improvement during the MDG era and moved ahead of Oceania (37.3 per cent) (Table 5.3).

More than 70 per cent of African countries have a contraceptive prevalence rate of less than 50 per cent, which may explain the high maternal deaths that have persisted in Africa. Five countries, namely Chad, Eritrea, the Gambia, Guinea and Mauritania,

Table 5.3 Global contraceptive prevalence rates among women aged 15 - 49 years, married or in union, using any method of contraception (per cent)

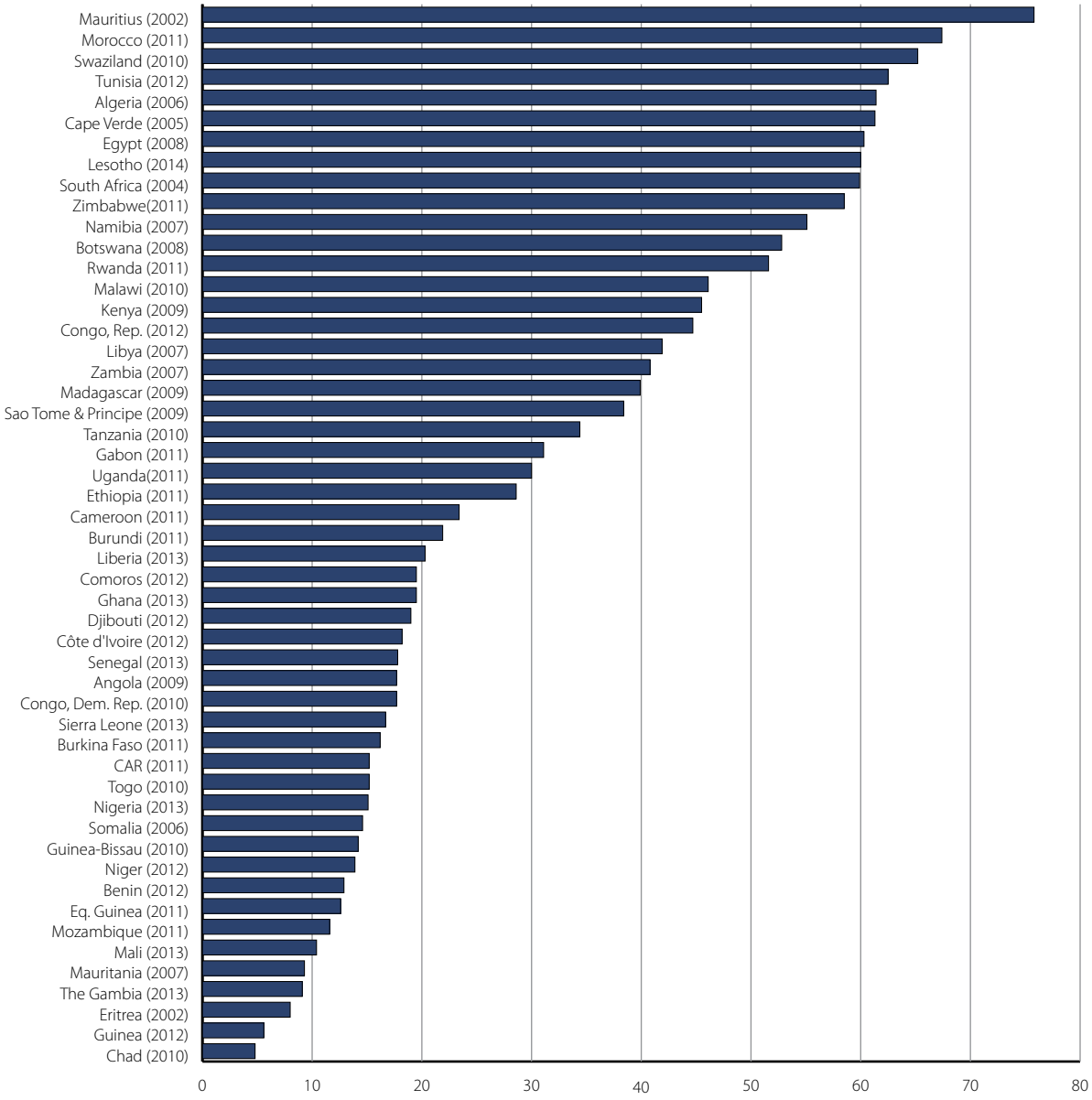
Contraceptive prevalence rate	1990	2000	2012
World	55.2	61.5	63.5
Developing regions	51.8	59.8	62.5
Africa	28.0	38.2	44.3
Latin America and the Caribbean	61.1	69.9	73.2
Eastern Asia	78.1	85.7	83.5
Southern Asia	39.2	48.3	57.0
South-East Asia	48.1	57.1	63.1
Western Asia	44.0	51.0	57.6
Oceania	28.4	31.6	37.3
Caucasus and Central Asia	49.3	57.9	56.4
Developed regions	68.4	70.1	69.8
Small Island Developing States	49.6	53.1	55.7

Source: *UNSD, 2014.*

reported a rate of less than 10 per cent, in contrast to Mauritius, which has the highest contraceptive prevalence rate in Africa (see figure 5.3).

Condom use is one of the most important modes of contraception, especially in the spacing of pregnancies. Despite the popularity of condom use in Africa, only a small proportion of married women use it as a method of contraception. Figure 5.4 indicates that Botswana, the Congo, Lesotho, Namibia and Swaziland are the highest users of condoms among married women aged 15-49 years, although all African countries have condom prevalence rates of less than 50 per cent. Other African countries reported less than a 10 per cent prevalence rate for condom use among women in 2013 (UNSD, 2015).

Figure 5.3 Contraceptive prevalence rate, any method (per cent)



Source: *UNSD data, updated on 7 July 2014.*

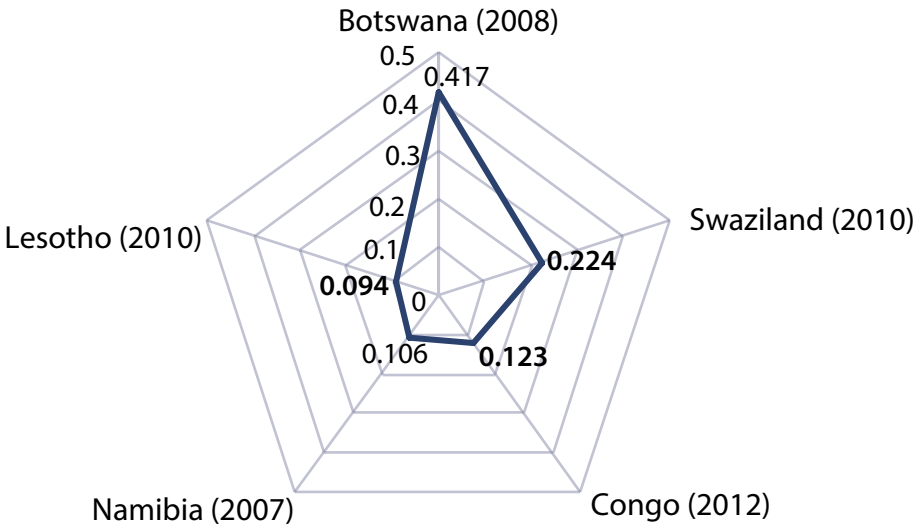
Early childbearing is a maternal health risk

Early childbearing is associated not only with health risks to both the young mother and her child, but also with missed opportunities at school and work, and the consequent intergenerational transmission of poverty. Therefore, reducing early childbearing can impact the achievement of other MDGs on poverty, education, gender equality and child mortality (UNSD, 2014).

Globally, almost all the regions are witnessing a decline in adolescent birth rates among girls aged 15-19 years. Africa has also seen substantially higher decline in adolescent births rates than Latin America and the Caribbean by 2011 see table 5.4).

Nevertheless, Africa still has a major challenge in addressing adolescent birth rates; half of African

Figure 5.4 Current condom use among married girls and women 15-49 years (five highest African countries) (per cent)



Source: *UNSD data, updated on 7 July 2014.*

Table 5.4 Live births per 1,000 adolescent girls aged 15 - 19

Live births per 1,000	1990	2000	2011
World	58.8	51.6	50.1
Developing regions	63.7	56.1	54.3
Africa	82.8	76.5	74.6
Latin America and the Caribbean	85.8	86.2	75.9
Eastern Asia	15.3	5.8	6.0
Southern Asia	87.6	60.8	49.5
South-East Asia	54.2	43.4	43.2
Western Asia	62.9	50.5	47.0
Oceania	84.1	64.5	58.5
Caucasus and Central Asia	44.6	28.5	31.8
Developed regions	33.7	25.5	20.6
Small Island Developing States	77.2	72.7	62.7

Source: *UNSD data, updated on 7 July 2014.*

countries have adolescent birth rates of more than 100 births per 1,000 women. Since, according to WHO, rates above 100 are considered very high, concerted efforts are required to minimize these pregnancies if Africa is to witness a high reduction in maternal deaths (WHO, 2013). Only seven African countries reported adolescent birth rates of less than 50 births per 1,000 women –Libya, Algeria, Tunisia, Djibouti, Mauritius, Morocco and Rwanda (see table 5.5).

Table 5.5 Country performance on adolescent births per 1,000 women

Over 150 births		100-150 births		50-99 births		10-49 births		Below 10 births	
Central African Republic (2009)	229.0	Liberia (2011)	149.0	Benin (2009)	98.1	Rwanda (2008)	41.0	Tunisia (2011)	6.9
Niger (2010)	206.0	Congo (2009)	147.0	Lesotho (2007)	92.0	Morocco (2008)	32.0	Algeria (2006)	4.4
Chad (2009)	203.4	Madagascar (2006)	147.0	Cabo Verde (2003)	92.0	Mauritius	31.0	Libya (2002)	4.1
Angola (2008)	188.0	Uganda (2009)	146.0	Swaziland (2009)	89.0	Djibouti (2010)	20.6		
Mali (2011)	172.0	Guinea-Bissau (2009)	136.7	Mauritania (2001)	88.1				
Mozambique (2009)	166.0	Burkina Faso (2008)	136.0	Togo (2009)	88.0				
Malawi (2008)	157.0	Democratic Republic of the Congo (2009)	135.0	Gambia (2011)	88.0				
Guinea (2009)	154.0	Equatorial Guinea (2001)	128.1	Ethiopia (2008)	87.0				
Zambia (2005)	151.0	Cameroon (2008)	128.0	Eritrea (1999)	85.0				
		Tanzania (2007)	128.0	Senegal (2011)	80.0				
		Côte d'Ivoire (2009)	125.0	Namibia (2004)	74.0				
		Sierra Leone (2012)	125.0	Seychelles (2011)	70.3				
		Somalia (2005)	123.0	Ghana (2006)	70.0				
		Nigeria (2011)	122.0	Comoros (2011)	70.0				
		Gabon (2009)	115.0	Burundi (2008)	65.0				
		Zimbabwe (2008)	112.0	South Africa (2007)	54.0				
		Sao Tome and Principe (2006)	110.0	Botswana (2006)	51.0				
		Kenya (2006)	106.0	Egypt (2005)	50.0				

Source: *UNSD data, updated on 7 July 2014.*

Increasing antenatal care coverage is a life-saver for mothers and newborns

The WHO has recommended a minimum of four antenatal care visits to ensure the well-being of mothers and newborns (WHO, 2014a). According to the global MDG Report 2014, only 52 per cent of pregnant women had four or more antenatal care visits during pregnancy in 2012, an increase from 37 per cent in 1990. The findings indicate that Africa continues to show a poor performance on this indicator with less than 50 per cent attendance of the recommended four antenatal care visits. However, it should be noted that 80 per cent of the women in Africa attended antenatal care in a health facility at least once.

Among African countries, Ghana, South Africa and Tunisia have the highest antenatal care coverage, i.e. above 80 per cent of the pregnant women, whereas Djibouti and Somalia have the lowest (see figure 5.5).

Regular contact with health professionals among pregnant women is essential and presents a number of benefits including prevention of mother-to-child transmission of HIV/AIDS micronutrient supplementation, birth preparedness information, as well as treatment of any imminent diseases. Early detection of problems in pregnancy will be facilitated by antenatal care, and timely referrals will also be facilitated in case of pregnant women with complications (UNICEF, 2013a).

The unmet need for family planning remains a challenge

According to a 2012 report by United Nations Population Fund (UNFPA), women who wish to delay pregnancy for two or more years, or avoid pregnancy, but are not using a contraceptive method have an unmet need for family planning (UNFPA, 2012). According to data from UNSD, Africa had the highest unmet need for family planning in 2012, a figure slightly higher than that of the small island developing States.

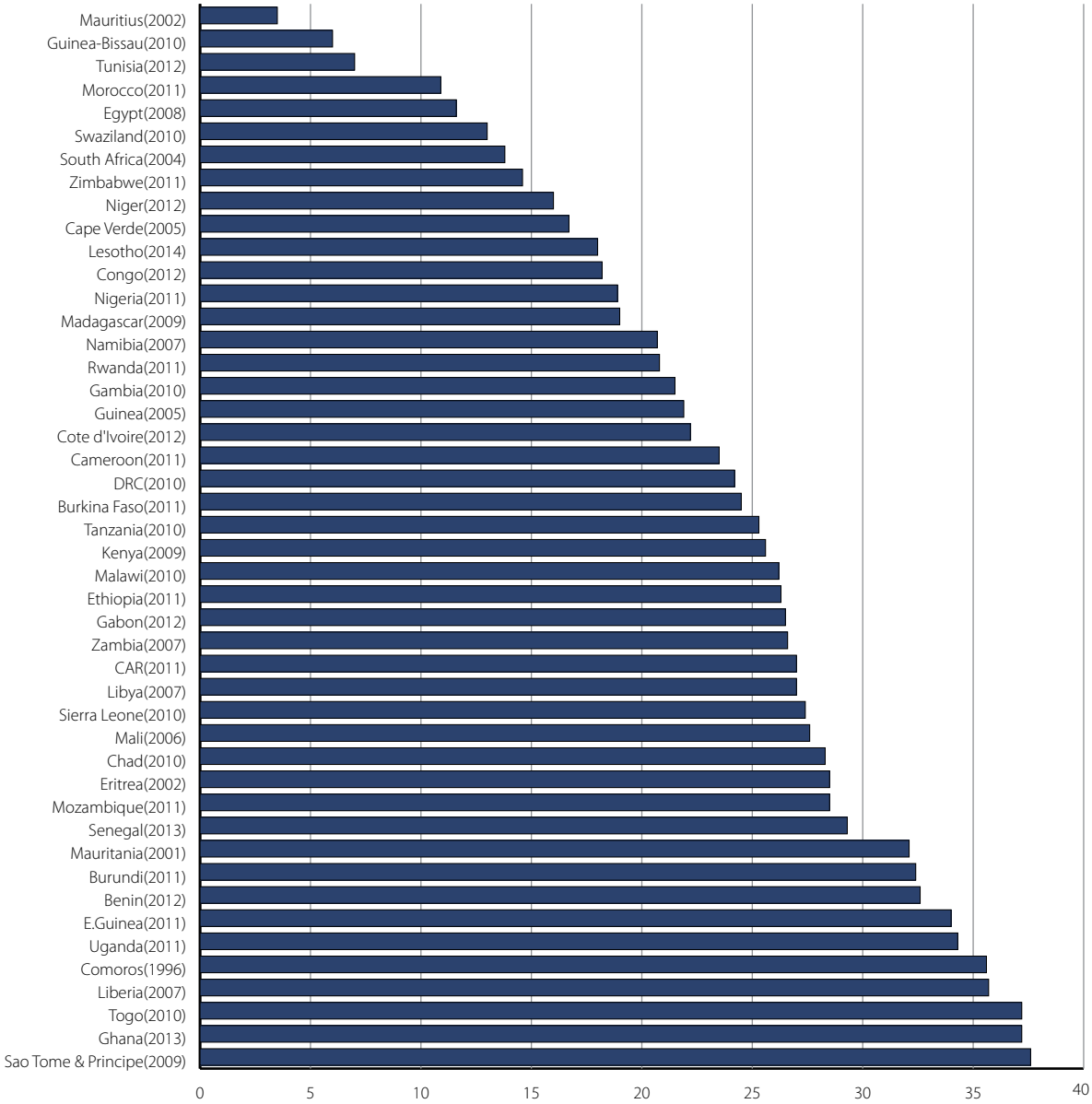
Sao Tome and Principe reported the highest unmet need for family planning, whereas Mauritius has the lowest unmet need for family planning in Africa. Although all the rates for the unmet need for family planning are lower than 50 per cent, the target should be to achieve a rate of zero (see figure 5.6). The proactive role of the Government of the Niger in reducing the unmet need for family planning through the involvement of husbands has been commendable and has resulted in a reduction of 16 per cent in 2012 (UNSD, 2014).

Table 5.6 Global unmet need for family planning among married or women in union aged 15-49 (%)

Unmet need for family planning (per cent)	1990	2000	2012
World	15.2	12.8	12.0
Developing regions	16.5	13.5	12.4
Africa	24.9	20.3	18.5
Latin America and the Caribbean	17.3	12.8	10.6
Eastern Asia	5.7	3.2	3.9
Southern Asia	21.3	17.6	14.4
South-Eastern Asia	18.8	15.5	12.5
Western Asia	21.6	19.3	15.9
Oceania	27.4	26.7	24.6
Caucasus and Central Asia	18.0	14.0	14.1
Developed regions	10.4	9.7	9.8
Small Island Developing States	20.2	19.5	18.4

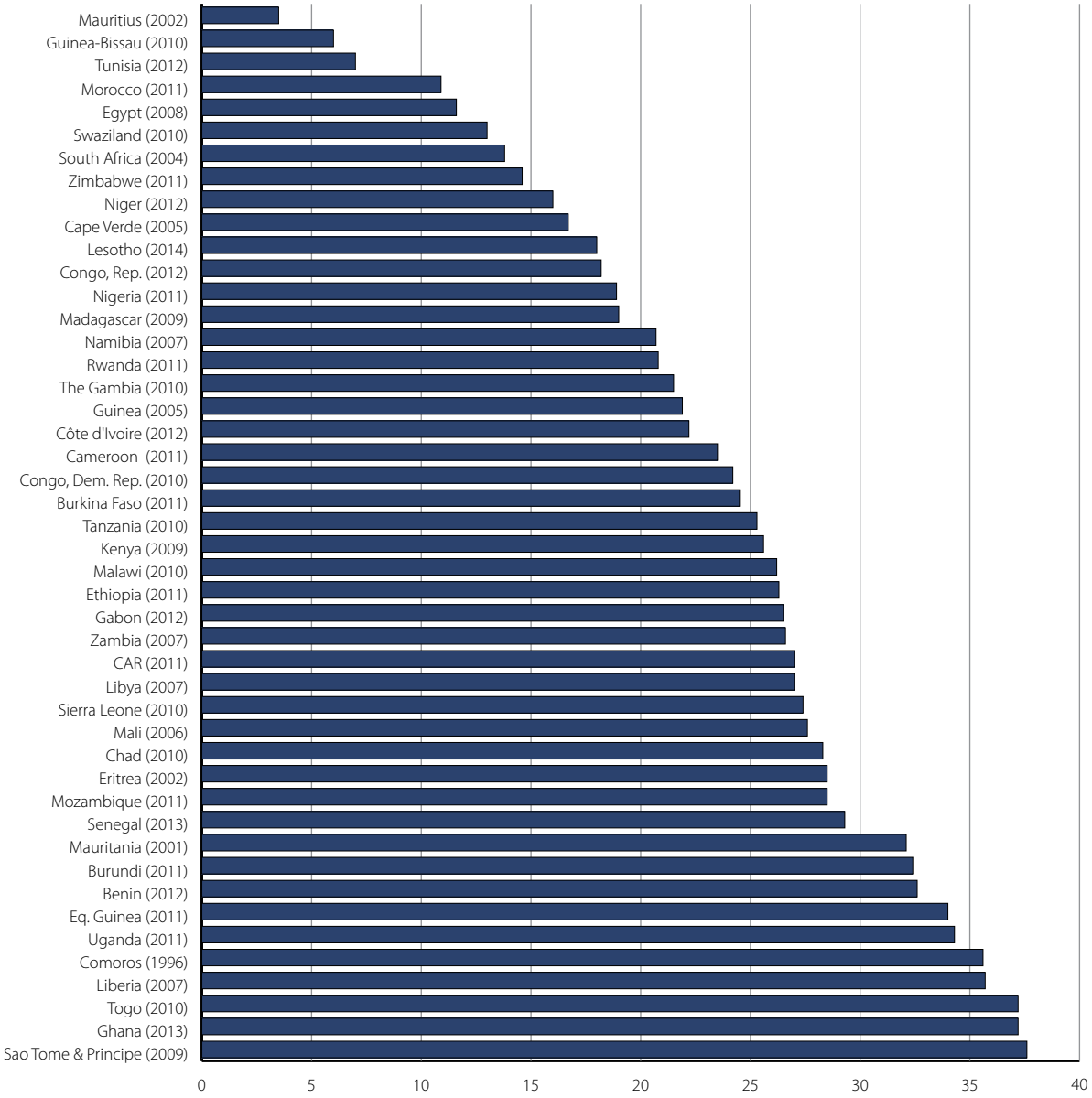
Source: *UNSD data, updated on 7 July 2014.*

Figure 5.5 Antenatal care coverage, at least four visits (per cent)



Source: *UNSD data, updated on 7July 2014.*

Figure 5.6 Unmet need for family planning, total (%)



Source: *UNSD updated on 7 July 2014.*

Challenges in measuring maternal health

Lack of data is one of the major hurdles in tackling the implementation of the MDGs, particularly MDG 5. The latest available data from the United Nations Statistics Division, which is the major repository of MDG data, is 2013. Without updated data, countries cannot adequately determine whether certain interventions are working, including how to distribute the meagre resources on improving maternal health (ECA et al., 2012).

African countries have faced challenges in measuring maternal deaths according to the recommended WHO definition. This definition allows the identification of maternal deaths based on their causes as either indirect or direct. Direct maternal deaths are those resulting from obstetric complications of the pregnant state including pregnancy, delivery and postpartum. Other direct causes of maternal deaths are associated with interventions, omissions, incorrect treatment or a chain of events resulting from any of the above. This implies that deaths due to obstetric hemorrhage, complications of anesthesia or caesarean section are part of the direct causes of maternal deaths. Indirect maternal deaths result from diseases developed during pregnancy and are aggra-

vated by the physiological effects of pregnancy such as cardiac or renal diseases (WHO, 2012).

In African countries where most deliveries and deaths occur outside the health facilities, identification of causes of maternal death becomes highly challenging, including obtaining the accurate figures of MMR. In settings where there is a lack of medical certification of causes of death, it is difficult to accurately attribute female deaths to maternal deaths. According to a joint report by WHO, UNICEF and UNFPA, maternal deaths in developed countries may also be underreported owing to miscalculations of the International Statistical Classification of Diseases and related health problems, despite routine death registration that has been taking place for over a decade (WHO, UNICEF and UNFPA, 2014a).

In addition, with weak civil registration systems in Africa, it is challenging to identify maternal deaths since the deaths of women within the reproductive age group of 15 to 49 years might not have been recorded. According to the United Nations principles and recommendations of Civil Registration and Vital Statistics revision 3, civil registration remains the most ideal and accurate system to provide maternal deaths statistics and causes of these deaths. Accordingly, the African Programme on Accelerated Improvement of Civil Registration and Vital Statistics was established to remove barriers to death and causes of death registration ought to be supported (UNSD, 2014).

Conclusion

Given the enormous efforts by the African countries in improving maternal health, the current momentum is likely to lead to a significant reduction in maternal deaths even after the set deadline of 2015 in meeting the MDGs. A number of innovative approaches have been implemented in several African countries to reduce maternal mortality that should be adopted and replicated in the other African countries.

Routine civil registration systems including registration of births, death and causes of deaths should be strengthened. For deaths outside health facilities, WHO recommends that the verbal autopsy approach should be applied. Verbal autopsy is essential in obtaining information on the probable cause of death, which is performed through interviews with family members or community members. In 2012, WHO published a revised shortened verbal autopsy questionnaire called Release Candidate 1 (WHO, 2012b). This approach is often used where medical certification of cause of death is not available.

The contraceptive prevalence rates as well as the unmet need for family planning indicators in Africa show that, inasmuch as contraceptives should be made available and affordable, concerted efforts should focus on raising awareness on the different contraceptive products and how they can address the needs of women.

With the upcoming post-2015 development agenda, the steady progress witnessed to date, especially in Africa, indicates that maternal health will be improved in the long term provided that the current and additional interventions are maintained.

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

Efforts to combat HIV/AIDS, malaria and tuberculosis in Africa have yielded impressive results since 1990 and are placing the continent on a solid path to reversing the spread of all the above diseases. Indeed, a downward trend is observed in the incidence, prevalence and death rates associated with HIV/AIDS, malaria and tuberculosis, especially since 2000. The efforts to combat these diseases have been mostly made by: adopting WHO recommended programmes and interventions such as DOTS for tuberculosis; using insecticide-treated nets and artemisinin-based combination therapy for malaria; and using condoms and antiretroviral medicines for HIV/AIDS. These efforts demonstrate the high level of political commitment to combating each of the diseases, one of the highest for any of the MDGs. Notwithstanding the progress being made, Africa carries the highest burden of HIV/AIDS, malaria and tuberculosis, accounting for more than half of all cases and deaths worldwide.

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

Significant strides in the battle against HIV/AIDS

In the last 15 years, Africa has made significant strides in combating HIV/AIDS and is succeeding in reversing the evolution of the pandemic and reducing its death toll. The progress has encompassed all five of Africa's geographical subregions. Between 2001 and 2013, the incidence of the disease among adults, i.e. the number of new HIV infections per year per 100 people aged 15-49 years, was more than halved in Southern, West and Central Africa, reduced by 46 per cent in East Africa, and remained constant at the low level of 0.01 per cent in North Africa (see table 6.1). In fact, all countries but Angola and Uganda are registering downward trends in the occurrence of new infections. The two countries are actually faced with a worsening situation.

As a result of the decline in new infections, from 2005 to 2013, the HIV prevalence[4] among adults in Africa excluding North Africa decreased from 5.6 to 4.7 per cent (see figure 6.1) and AIDS-related deaths in the population (all ages) recorded a 40 per cent drop, from 1.8 million people to 1.1 million people (figure 6.2).In North Africa, the prevalence of HIV among adults was 0.1 per cent over the same period; however, the AIDS-related deaths in the population (all ages) increased slightly, from 6,700 to 10,100 people (UNSD, 2015, Statistical Annex).

Countries that recorded major declines in AIDS-related deaths in the continent include Rwanda (76 per cent), Eritrea (67 per cent), Botswana (58 per cent), Burkina Faso (58 per cent), Ethiopia (63 per cent), Kenya (60 per cent), Zimbabwe (57 per cent), Malawi (51 per cent), South Africa (48 per cent) and the United Republic of Tanzania (44 per cent) (UNAIDS, 2014).

Progress rests on a number of factors including: improvement in testing, counselling and access to antiretroviral therapy; the reduction in mother-to-child transmission; the increase in prevention through the use of condoms and treatment as prevention; and the improvement in the general awareness and knowledge of the disease, including a better understanding of the link between HIV and tuberculosis.

Having accurate and comprehensive knowledge is captured here through: (i) the ability to identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner); and (ii) the ability to reject common misconceptions, such as that a healthy-looking person cannot

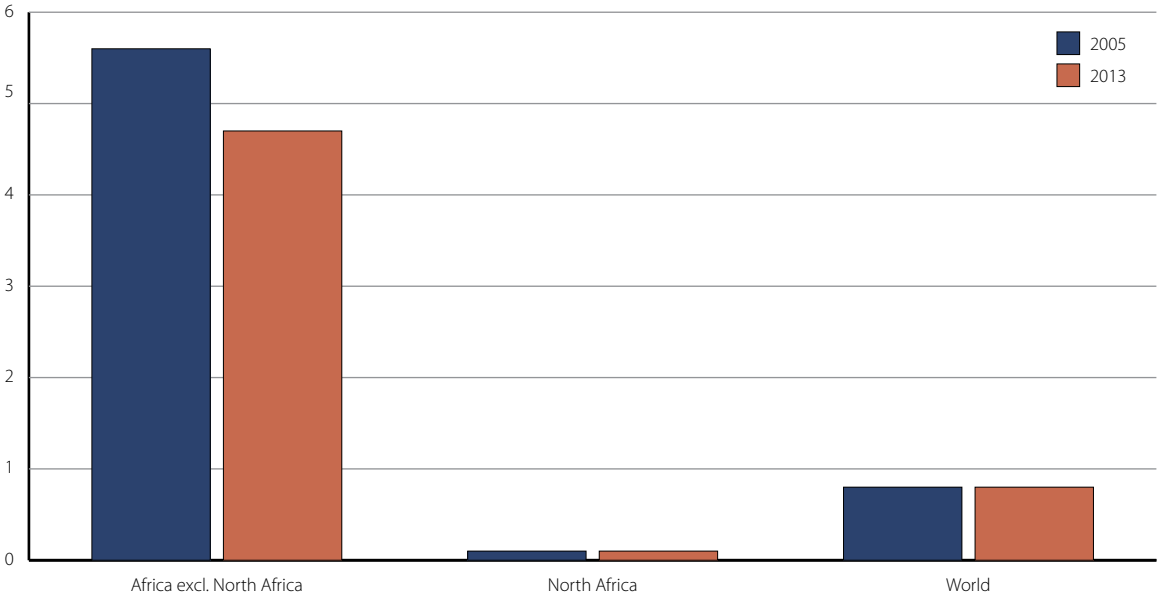
4 Prevalence is now a complex measure that may actually increase as people living with HIV survive due to treatment. Thus, a better measure is incidence, as presented on table 6.1. Incidence among adults refers to the number of new HIV infections per year per 100 people aged 15 - 49 years.

Table 6.1 HIV incidence rates in subregions of Africa

(No. of new HIV infections per year per 100 people aged 15 to 49 years)	2001	2013	Change (per cent)
Central Africa	0.67	0.25	62
East Africa	0.38	0.20	46
North Africa	0.01	0.01	No change
Southern Africa	2.15	0.95	56
West Africa	0.38	0.14	63

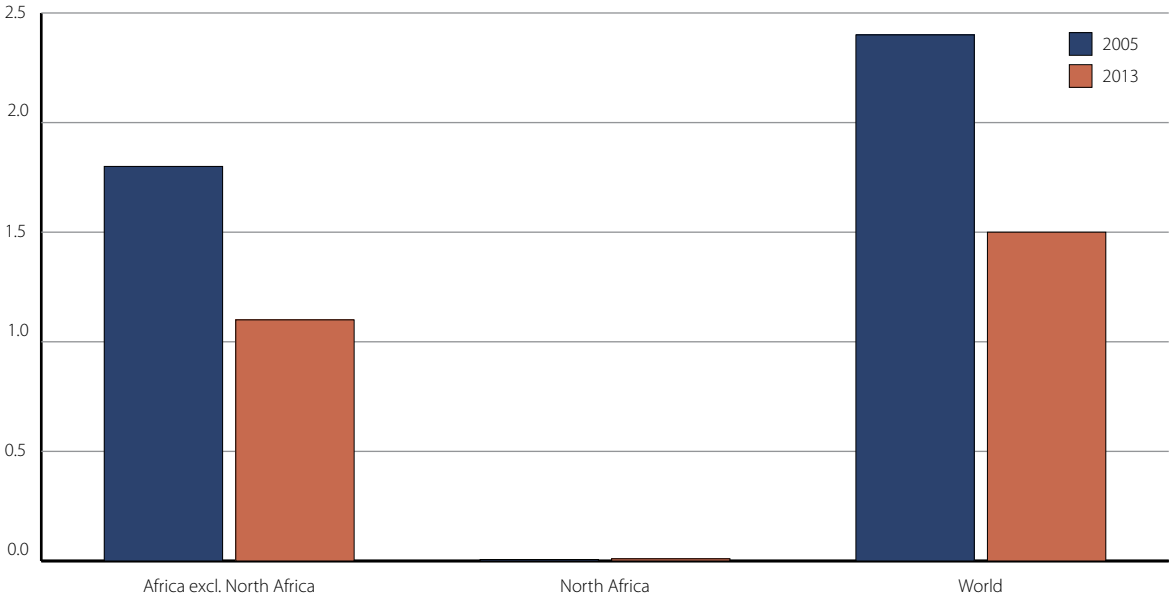
Source: *UNAIDS HIV Estimates, 2013.*

Figure 6.1 Estimated HIV prevalence among individuals 15-49 years of age (%)



Source: *UNSD, 2014.*

Figure 6.2 Number of AIDS-related deaths, all ages (million)



Source: *UNSD, 2014.*

transmit HIV. Figures from 2013 indicate that such HIV/AIDS awareness is estimated at 26.7 per cent among young women and 35.7 per cent among young men aged 15-24 (UNSD 2014 Statistical Annex). This level is still low but encouraging when compared to the situation in Southern Asia, for instance, where the proportions are 17.1 per cent for young women and 30.2 per cent for young men. Increasing awareness about HIV can contribute to curbing the pandemic by limiting risky behaviours, which are still high, especially among young people. This is illustrated by the relatively low percentage of people aged 15-24 years reporting the use of a condom during sexual intercourse with a non-regular sexual partner in the past 12 months: the indicator was of 37 per cent for women and 57.4 per cent for men in 2013. Stigma continues to be a challenge to the national response in the effort to eliminate HIV. There is the need to educate people to avoid discrimination against people living with HIV.

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

Currently, the proportion of people living with HIV that have access to treatment is estimated at 37 per cent in Africa excluding North Africa; however, there are large disparities among countries. Nigeria and South Africa, for instance, are the two countries with the largest number of people living with HIV in the region, i.e. 3.2 and 6.3 million, respectively, but access to treatment covers 20 per cent of the infected people in Nigeria and 42 per cent in South Africa (UNAIDS, 2014). There are also treatment differentials within countries; children and men less likely than adults and women to undergo treatment (Ibid).

Access to HIV counselling, testing and therapy has improved among people who have tuberculosis. In 2012, 74 per cent of all notified tuberculosis cases were tested for HIV. It is established that HIV treatment lowers the risk of death among people who have both HIV and tuberculosis by 50 per cent. Similarly, among tuberculosis-free HIV patients, antiretroviral treatment reduces the risk of contracting the tuberculosis by 66 per cent (UNAIDS, 2014).

According to UNAIDS Gap Report 2014 (UNAIDS, 2014), there are around 24.9 million people living with HIV in Africa, of whom only 154,000 in North Africa. The rest are distributed across the four other geographical subregions, with Nigeria and South Africa alone accounting for up to 38.4 per cent of people living with HIV. More specifically, the bulk of people living with HIV in Africa excluding North Africa are concentrated in ten countries, namely Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. Taken together, these countries account for 81 per cent of all people living with HIV in the region. The situation is skewed towards women,58 per cent of the people living with HIV are female. It is of serious concern that 2.9 million children are infected, in addition to other vulnerable groups such as young people and the people affected by conflicts, disaster or displacement. Young women and adolescent girls face specific inequities that render them more vulnerable to the pandemic, which calls for specific attention in order to protect them, including from gender-based violence and sexual abuse. They also lack of access to education, health services and social protection. These circumstances are likely to undermine their ability to protect themselves against HIV and to access antiretroviral therapy when they become adults.

Engaging men in the fight against HIV has also proven a winning strategy. Voluntary medical male circumcision has the potential of reducing the risk of acquiring HIV among men by 66 per cent (UNAIDS, 2014). In addition, when men know their HIV status, they are more likely to appropriately resort to prevention and seek treatment. Sex workers, men who have sex with men, and people who inject drugs are also part of the group that needs to be followed closely owing to the particularly high level of infection among them.

Notwithstanding the appreciable progress, HIV is still a real challenge in Africa, and efforts must continue until the zero-case situation is reached. To date, Africa excluding North Africa accounts for around 71 per cent of the total people living with the HIV in the world; therefore, even though the support of the international community will be a

determining factor to win the battle, the region and more specifically, the most affected countries will have to lead. UNAIDS estimates for 2012 indicate that around $6.6 billion was invested in the AIDS response in Africa excluding North Africa, 47 per cent of which came from domestic sources and the rest from international sources. This situation is commendable but needs to be strengthened with much more domestic funding. HIV/AIDS can undermine human capital and productivity, and hence become an obstacle to structural transformation that countries must address by all possible means.

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

Downward trend in malaria cases and deaths

Africa continues to make good gains in combating malaria and is progressing towards halting its spread in the continent. Impressively, the percentage reduction in malaria cases and deaths in Africa is slightly higher than the world average see table 6.2). Since 2000, in Africa excluding North Africa, malaria cases have dropped by 34 per cent and the death rate by 54 per cent compared to 30 per cent and 47 per cent at the global level, respectively (WHO, 2014b). According to WHO projections, if the current rate of reduction continues, globally malaria deaths will be reduced by 55 per cent, and in Africa excluding North Africa, by 62 per cent (total for both adults and children) and 67 per cent (children under five).

The global burden of malaria mortality and morbidity is highest in Africa excluding North Africa. In 2013, 90 per cent of all malaria deaths occurred in Africa excluding North Africa. The Democratic Republic of the Congo and Nigeria alone accounted for 34 per cent of all malaria cases and 39 per cent of all malaria deaths in 2013 (WHO, 2014b). International targets for reducing cases and deaths will not be attained unless considerable progress is made in these two countries.

Northern African countries with ongoing malaria transmission are in particular progressing very well in malaria elimination efforts. In 2013, Egypt and Morocco were among a group of 11 countries that succeeded in stabilizing the number of cases of malaria. In fact, Morocco was declared malaria-free in 2010, while Egypt has eliminated malaria and is at the stage of preventing its reintroduction. Cabo Verde and Algeria are in the pre-elimination and elimination stages of malaria respectively, each having recorded less than 10 malaria cases in 2013 (WHO, 2014b). In addition to the above countries, Botswana, Eritrea, Namibia, Rwanda, Sao Tome and Principe, South Africa and Swaziland have reduced their malaria incidence by no less than 75 per cent between 2000 and 2013.

The use of effective interventions remains at the heart of Africa's success in combating malaria. Vector control interventions, use of insecticide-treated bednets, quality-assured artemisinin-based combination therapy and rapid diag-

Table 6.2 Malaria cases and death rates, 2000 and 2013

	Number of cases, 2000	Number of cases, 2013	Number of cases, % change	Deaths, 2000	Deaths, 2013	Deaths % change
Total malaria figures						
World	227,000,000	198,000,000	-30	882,000	584,000	47 per cent
Africa	174,000,000	163,000,000	-34	801,000	524,000	54 per cent

Source: *WHO, 2014b.*

Notes: *Here, Africa refers to Africa excluding North Africa.*

nostic tests have expanded in Africa over the past 10 years. In 2013, 49 per cent of the at-risk population in Africa excluding North Africa had access to an insecticide-treated bednet, compared to 3 per cent in 2004. At least 55 million people at-risk of malaria lived in homes that were regularly sprayed (WHO, 2014b). However, specific efforts to protect pregnant women and children against malaria are progressing rather slowly. The World Malaria Report 2014 (WHO, 2014b) indicates that approximately 15 million of the 35 million pregnant women in Africa excluding North Africa in 2013 did not receive any dose of the preventive malaria treatment in pregnancy. Similarly, only 6 out of the 16 countries for which WHO recommended the adoption and rolling out of preventive therapies for children under five have adopted the treatment as national policy, while only one country (Burkina Faso) has adopted the recommended preventive therapy for infants.

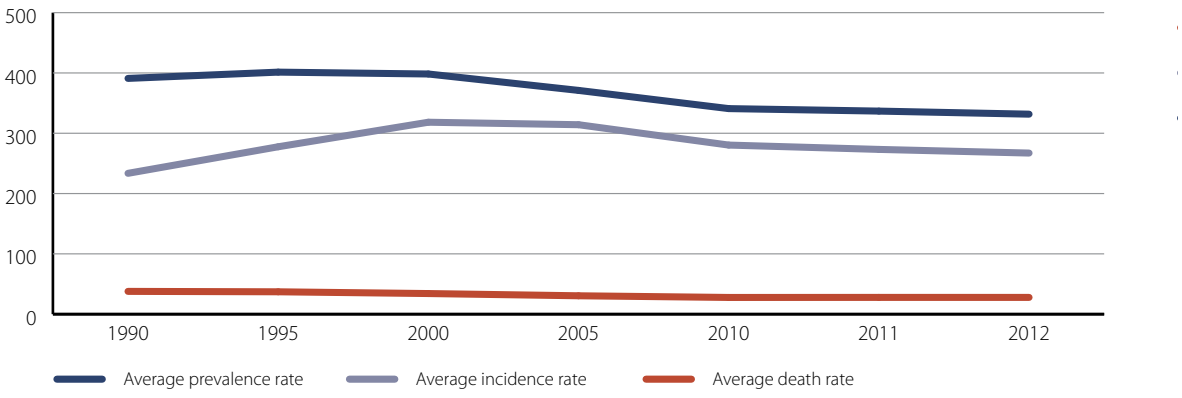
Slow progress in tuberculosis control

Since 2000, Africa has experienced a downward trend in tuberculosis prevalence, incidence and death rates (see figure 6.3). The incidence rate declined together with the prevalence rate after peaking in 2000. However, the average percentage reductions between 1990 and 2012 are low. Indeed, while tuberculosis prevalence and death rates decreased by an average of 15 per cent and 26 per cent, respectively, the incidence rate increased by an average of 14 per cent. Central African Republic, Egypt, Eritrea, Ghana, Malawi, Niger, Rwanda and Uganda are some of the best performing countries, recording reductions of more than 50 per cent in all three indicators. By contrast, Cameroon, Equatorial Guinea, Lesotho, Liberia, Mauritania, Sierra Leone, South Africa and Swaziland all more than doubled their 1990 rates for at least two of the above tuberculosis indicators.

The changes in tuberculosis prevalence and death rates mirror the rate of detection and treatment success under DOTS. Average tuberculosis detection rate under DOTS improved from 47.77 per cent in 1995 to 60.47 per cent in 2012, while the treatment success rate improved from 64.05 per cent to 78.98 per cent in 2011 (figure 6.4)

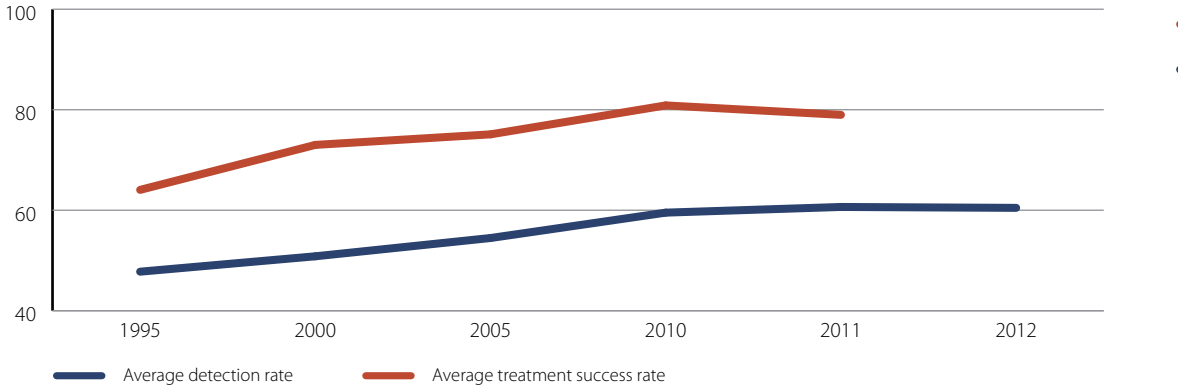
The challenges in tuberculosis control are rife, however, and require much greater effort to overcome, such as tuberculosis and HIV co-infection, and the occurrence of multi-drug resistant and now extensively resistant tuberculosis strains. Therefore, making quality care accessible to all people regardless of the type of disease (tuberculosis), gender, age and social status must be the

Figure 6.3 Tuberculosis prevalence, incidence and death rate, 1990-2012



Source: *Based on UNSD, 2015.*

Figure 6.4 Tuberculosis detection rate and treatment success under Directly Observed Treatment Shortcourse (DOTS), 1995-2012



Source: *Based on UNSD 2015.*

foundation of tuberculosis control. The challenges must be addressed by focusing on 'at risk' groups including women, children, refugees and prisoners, and by tailoring tuberculosis response to each of the identified groups.

MDG 7: Ensure environmental sustainability

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

Africa's progress on environmental targets exceed global performance

Land area covered by forests

Forests serve multiple environmental, socio-economic and cultural roles in many countries. They are among the most diverse and widespread ecosystems of the world. Forests provide many significant resources and functions including wood products and non-wood products, recreational opportunities, wildlife habitats, conservation of biological diversity, water and soil. They also play a crucial role in the global carbon cycle. There is general concern over the impact of human activity on forest health and on the natural processes of forest growth and regeneration.

A continuing and fast-decreasing forest area in a country might be a signal of unsustainable practices in the forestry and agricultural sector. The availability of accurate data on a country's forest area, a basic characteristic of its forest resources, is an essential requirement for forest policy and planning within the context of sustainable development.

The global rate of deforestation has slowed in the last decade, but is still alarmingly high in many parts of the world, and the MDG indicator on forests has not been achieved. In most regions of the world, the proportion of land area covered by forest shrank between 1990 and 2010 (table 7.1).

Without convincing evidence of the many contributions of forests to sustainable development, policymakers are unlikely to take decisive action to discontinue land-use policies that favour the conversion of forests to agriculture and other land uses. There is a need to develop and implement

Table 7.1 Proportion of land area covered by forest (%)

	1990	2000	2010
World	32.0	31.4	31.0
Developing regions	29.4	28.2	27.6
North Africa	1.4	1.4	1.4
Africa excluding North Africa	31.2	29.5	28.1
Latin America and the Caribbean	52.0	49.6	47.4
Eastern Asia	16.4	18.0	20.5
Eastern Asia excluding China	15.2	14.0	12.8
Southern Asia	14.1	14.1	14.5
Southern Asia excluding India	7.8	7.3	7.1
South-East Asia	56.9	51.3	49.3
Western Asia	2.8	2.9	3.3
Oceania	67.5	65.1	62.5
Caucasus and Central Asia	3.9	3.9	3.9
Developed regions	36.3	36.6	36.7
Landlocked developing countries	19.3	18.2	17.1
Small Island Developing States	64.6	63.7	62.7

Source: *UNSD, 2014.*

policies that encourage the sustainable management of forests in order to provide a wide range of goozone-depleting substances and services and that also contribute to poverty reduction and the development of rural communities.

Carbon dioxide emissions

Rising carbon dioxide (CO_2) emissions in few countries raise concern about future trends. Over the period 1990–2010, only 16 African countries[5]reduced their carbon dioxide emissions, while 38 increased them. Gabon recorded the largest reduction (3.5 metric tonnes per capita), whereas Equatorial Guinea (6.4 metric tonnes) and Seychelles (6.5 metric tonnes) recorded the greatest increases (UNSD, 2013). Carbon dioxide emissions per capita were highest in developed regions and lowest in Africa. Most regions of the world recorded an increase in carbon dioxide emissions between 1990 and 2010 except Africa excluding North Africa and Oceania. Developed regions also experienced a decline (see table 7.2).

Consumption of ozone-depleting substances

This indicator measures the progress made towards meeting the commitments to phase out the use of Ozone-depleting substances in the countries that have ratified the 1987 Montreal Protocol on Substances that Deplete the Ozone Layer and its Amendments of London (1990), Copenhagen (1992), Montreal (1997) and Beijing (1999). Ozone-depleting substances is any substance containing chlorine or bromine, which destroys the stratospheric ozone layer that absorbs most of the biologically damaging ultraviolet radiation. The phasing out of Ozone-depleting substances, and their substitution by less harmful substances or new processes are aimed at the recovery of the ozone layer.

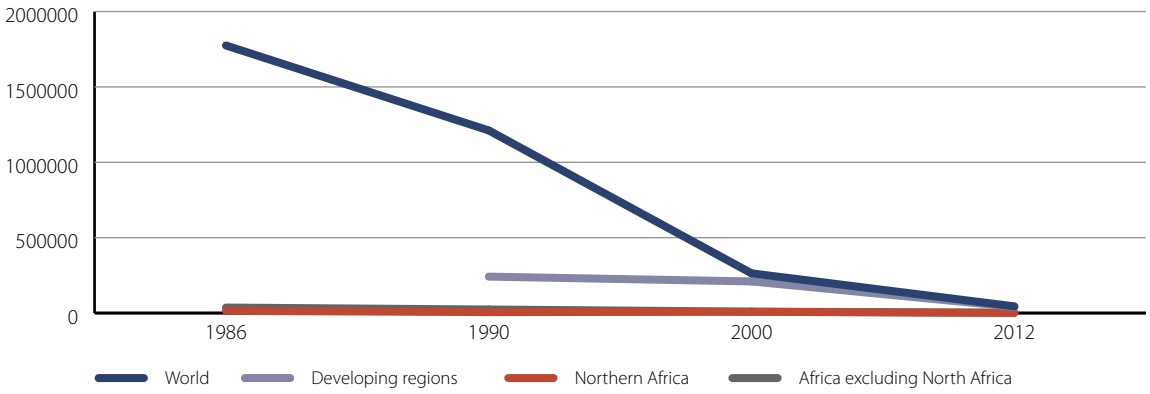
Table 7.2 Carbon dioxide (CO_2) emissions (metric tonnes of CO2 per capita)

	1990	2000	2005	2010
World	4.08	3.91	4.30	4.57
Developing regions	1.66	2.03	2.57	3.16
North Africa	1.91	2.33	2.57	2.80
Africa excluding North Africa	0.91	0.83	0.84	0.83
Latin America and the Caribbean	2.29	2.57	2.70	2.90
Caribbean	2.76	2.87	2.88	3.63
Latin America	2.26	2.55	2.68	2.85
Eastern Asia	2.46	2.95	4.60	6.30
Eastern Asia excluding China	7.42	7.31	7.40	8.30
Southern Asia	0.83	1.17	1.31	1.66
Southern Asia excluding India	0.94	1.28	1.49	1.70
South-East Asia	0.95	1.48	1.79	2.05
Western Asia	4.85	5.73	6.32	6.85
Oceania	1.00	0.96	1.25	1.09
Caucasus and Central Asia	7.33	4.59	5.25	6.10
Developed regions	12.37	11.67	11.79	10.90
Landlocked developing countries	0.26	1.21	1.25	1.37
Small island developing States	3.20	3.15	2.74	2.85

Source: *UNSD, 2015.*

5 These countries are Burundi, the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Gabon, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, the Niger, Rwanda, Western Sahara, Zambia and Zimbabwe.

Figure 7.1 Consumption of ozone-depleting substances (1,000 metric tonnes)



Source: *UNSD, 2014*

Global consumption of Ozone-depleting substances decreased by over 98 per cent between 1986 and 2013 (UNSD, 2014). Consumption of such substances declined by 94 per cent in Africa, by 86 per cent in developing regions, and by 100 per cent in developed regions between 1986 and 2012 (see figure 7.1).

Most African countries are on the right track in terms of reducing their consumption of Ozone-depleting substances. Furthermore, most African countries that are currently party to the Montreal Protocol have made remarkable progress with respect to reducing their consumption of substances that deplete the Earth's ozone layer. The best performers are Algeria, the Comoros, Djibouti, Sao Tome and Principe, Sierra Leone, Uganda, United Republic of Tanzania, and Zimbabwe, which achieved a reduction of over 95 per cent between 2000 and 2012; four other countries namely Angola, Libya, Morocco and Tunisia achieved a reduction of between 90 and 95 per cent, and 15[6] achieved between 80 and 90 per cent reductions. Botswana, Egypt, Libya, Nigeria, South Africa, Swaziland, Togo and Sierra Leone have seen reversals in progress between 2011 and 2012. Despite the achievements made by most African countries in this indicator, six countries experienced an increase in Ozone-depleting substances consumption between 2000 and 2012; Swaziland and the Central African Republic, for instance, recorded an increase of over 100 per cent. This might be due to imports of hydrochlorofluorocarbon (HCFC)-based equipment (ECA et al., 2013).

6 Burundi, Cabo Verde, Cameroon, Democratic Republic of the Congo, Equatorial Ethiopia, Guinea, Guinea Bissau, Kenya, Liberia, Malawi, Namibia, Nigeria, Rwanda, Somalia and Zambia.

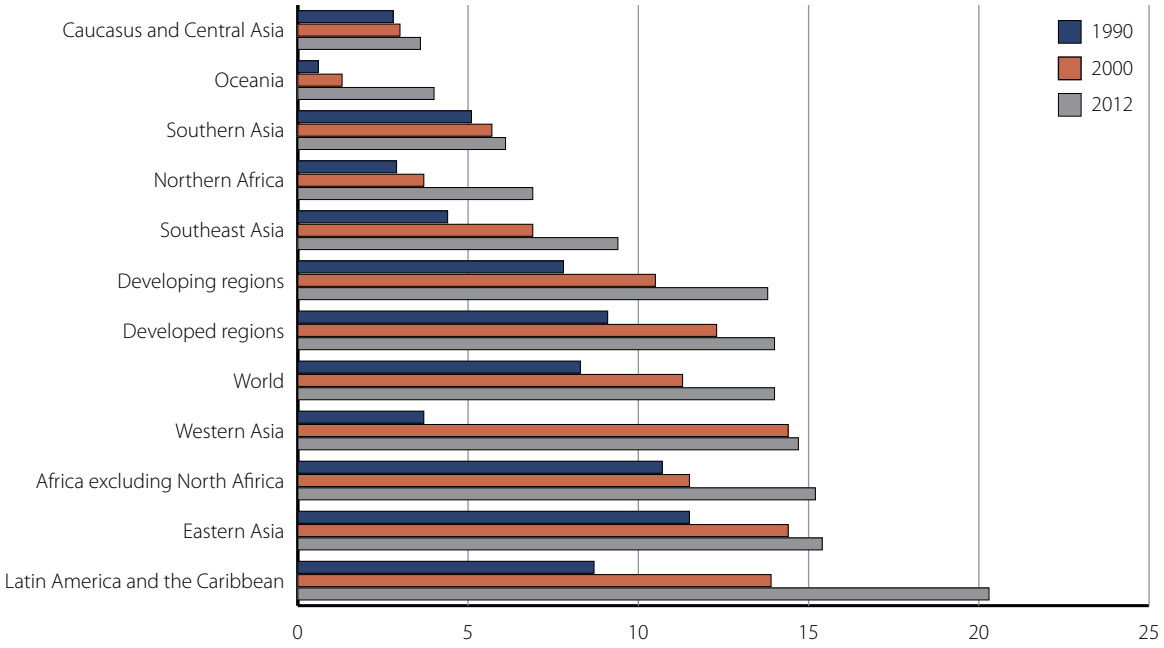
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss

Increasing proportion of terrestrial and marine areas protected

Protected areas are essential to the conservation of species, ecosystems and the livelihoozone-depleting substances they support. They also play a key role in adaptation and mitigation of the impacts of climate change. The proportion of protected terrestrial and marine areas has increased in all regions of the world. Globally, 14 per cent of terrestrial and marine areas were protected in 2012.In Africa excluding North Africa, protected area coverage increased from 10.7 in 1990 to 15.2 in 2012 (see figure 7.2).

Protected areas, which have been the focus of efforts in order to conserve the world's species and ecosystems, and a key element in climate change mitigation, have been expanding in Africa. By 2014, a total of 32 African countries had reached the target of protecting at least 10 per cent of their territorial and marine areas compared to 19 countries in 1990. The Congo, Gabon, Guinea, Guinea-Bissau, Morocco, Namibia, Togo and the Niger also made large strides in extend-

Figure 7.2 Protected terrestrial and marine areas, 1990, 2000 and 2012



Source: *UNSD, 2015.*

ing protection. The poorest performers are Cabo Verde, Djibouti, Eritrea, Lesotho, Liberia, Libya, Mauritania, Mauritius, Seychelles and Somalia

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

Access to safe drinking water is improving, but progress remains skewed towards urban areas

Since 2000, almost one quarter of the current African population (24 per cent) – the lowest globally – has gained access to an improved drinking water source. Furthermore, only 16 per cent of the population has access to piped drinking water; this is also the lowest figure in the world (ECA et al., 2014). There are also wide rural urban disparities in access to safe drinking water that tend to bring down national aggregate figures in some countries. The weak initial conditions (low 1990 baseline) combined with high population growth relative to the rest of the world exacerbate the challenge of meeting the target in Africa. In 2012, in Africa excluding North Africa, the use of improved drinking water sources (64 per cent of the population) is the second lowest in the world, following Oceania (56 per cent of the population) (see table 7.3).

Access to an improved sanitation facility is still a daunting challenge

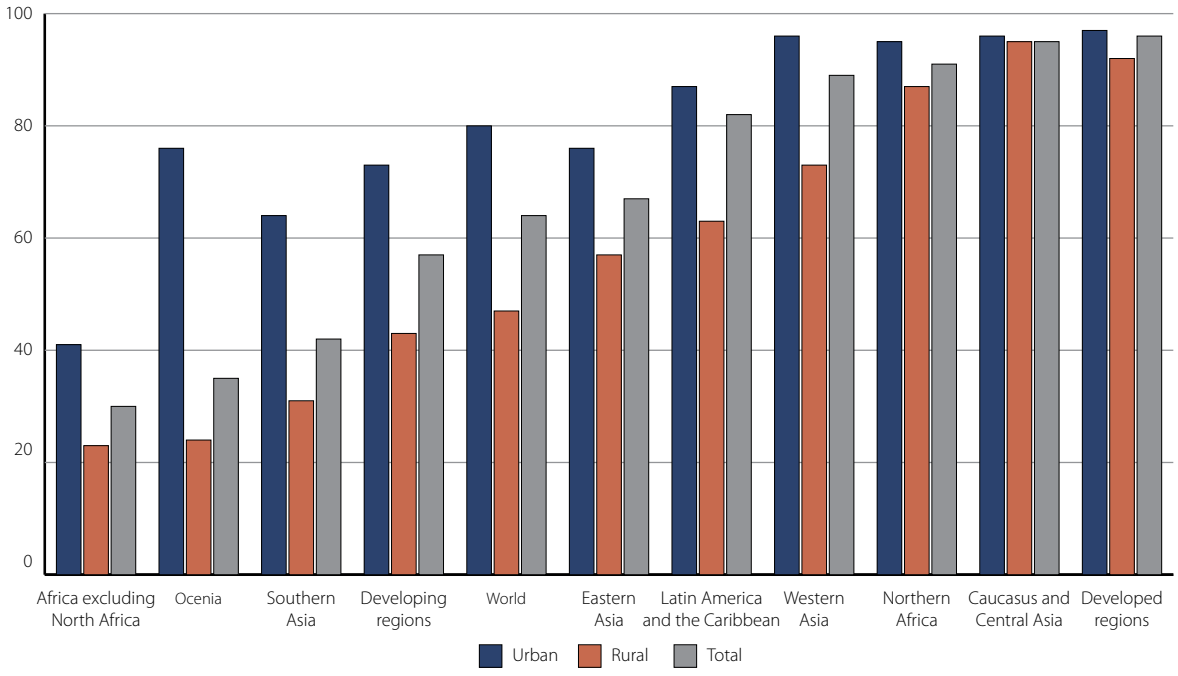
The proportion of people with access to improved sanitation is low for all developing regions. From 1990 to 2012, access to improved sanitation facility this indicator has increased moderately in Africa excluding North Africa (from 24 per cent to 30 per cent), compared to North Africa (from 72 per cent to 91 per cent) and developing regions (from 36 to 57 per cent) during the same period. Africa also remains far from the target of 66 per cent coverage to be met by 2015. There are disparities across countries. Only 4 out of the 77 countries that met this target in 2012 were from Africa (Algeria, Cabo Verde, Egypt and Tunisia) and six countries (Angola, Botswana, Libya, Morocco, Rwanda and South Africa) are on track. Nevertheless, eight countries doubled their 1990 level in 2012 (Angola, Benin, Burkina Faso, Ethiopia, Ghana, Guinea, Mozambique and Rwanda), albeit from a very low base (below 30 per cent). Libya and Seychelles stagnated over the period and six countries experienced setbacks (Djibouti, Gambia, Nigeria, Sudan, Togo and Zimbabwe). The rural-urban divide, lack of adequate infrastructure and the poor situation of slum dwellers further compound this slow progress (see figure 7.3).

Table 7.3 Use of improved drinking water sources, 2012

	Urban	Rural	Total
Oceania	94	45	56
Africa excluding North Africa	85	53	64
Caucus and Central Asia	96	78	86
Developing regions	95	80	87
World	96	82	89
Western Asia	96	79	91
Southern Asia	96	89	91
North Africa	95	89	92
Eastern Asia	98	85	92
Latin America and Caribbean	97	82	94
Developed regions	100	98	99

Source: *UNICEF and WHO, 2012.*

Figure 7.3 Access to improved sanitation by region (per centof the population), 2012



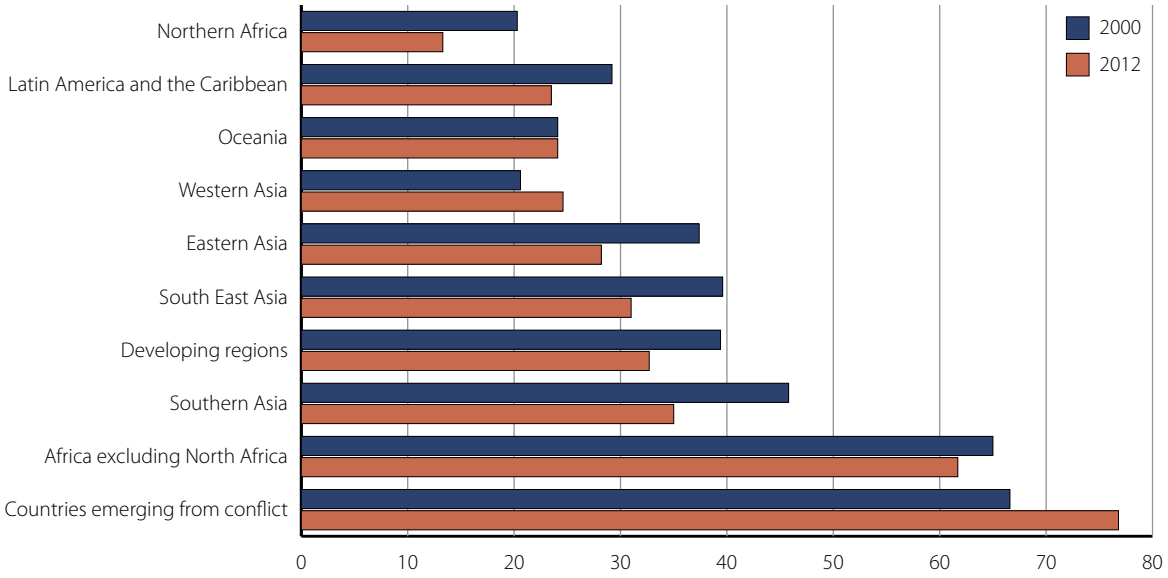
Source: *WHO and UNICEF,2014.*

Target 7.D: Achieve, by 2020, a significant improvement in the lives of at least 100 million slum dwellers

Target on slum dwellers achieved globally

Slums are characterized by the lack of basic services such as improved drinking water and adequate sanitation, and poor energy supply, together with insecure tenure, non-durable housing and over-crowding. One out of every three people living in cities of the developing world lives in a slum. United Nations Human Settlements Programme (UN-Habitat) estimates indicate that in 2012, slum prevalence – i.e. the proportion of people living in slum conditions in urban areas – was highest in Africa excluding North Africa (62 per cent); the lowest prevalence was observed in North Africa, at 13 per cent. From 2000 to 2012, the share of urban residents in the developing world living in slums decreased from 39 to 33 per cent. More

Figure 7.4 Proportion of urban population living in slum areas, 2000 and 2012 (%)



Source: *UN Habitat, 2013.*

than 200 million of these people gained access to either improved water, sanitation or durable and less crowded housing (see figure 7.4). This MDG target has thus been attained, 10 years in advance. However, in absolute terms, the number of slum dwellers continues to grow, owing in part to the fast pace of urbanization. The number of urban residents living in slum conditions is now estimated at approximately 863 million, compared to 650 million in 1990 and 760 million in 2000 (UN Habitat 2013).

In slum areas, where there are few or no streets, provision of basic services is hampered since there is no network in place that allows for the provision of water, sanitation and electricity, among other services. One main physical characteristic of slum areas or informal settlements in cities of the developing world is the lack of streets, which makes it difficult to provide urban basic services to slum areas. Therefore, street networks are a precondition for slum upgrading.

MDG 8: Develop a global partnership for development

The Ninth Ministerial Conference of the World Trade Organization (WTO), held in Bali, Indonesia, in December 2013, revitalized the Doha Development Agenda with an agreement known as the 'Bali Package'. The Agenda's three components consist of trade facilitation, agricultural issues, especially those concerning cotton production, and issues affecting developed and least-developed countries (WTO, 2013). However, in Africa, the gap between MDG 8 targets and delivery remains very wide. New forms of protectionism through a proliferation of non-tariff barriers, including subsidies, are prejudicial to Africa's trade. This is already reflected in the share of Africa's exports in global merchandise exports, declining marginally from 3.5 per cent in 2012 to 3.3 per cent in 2013, compared to 4.9 per cent in the 1970s (ECA, 2015).

Concurrently, official development assistance (ODA) from the States members of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) in 2014 is projected to be 0.5 per cent lower in real terms than the previous year. In nominal terms total ODA from DAC countries are estimated to be $135.2 billion in 2014, compared to $135.1 billion in 2013. Provisional data also suggest that bilateral aid to least developed countries in 2014 was 16 per cent lower, in real terms, than the year before. On average DAC countries deliver only 0.29 per cent of the group's GNI as ODA, which is substantially lower than the United Nations target of 0.7 per cent. Nevertheless, Denmark, Luxembourg, Norway, Sweden and the United Kingdom continue to exceed the 0.7 per cent target. The United Arab Emirates, a country that is not a member of DAC, topped the list of ODA to GNI providers with a share of 1.17 per cent in 2014 (OECD, 2015a).

Beyond the limited progress in meeting their commitments, there are also concerns about the quality of ODA, since substantial amounts stay in donor countries, while some ODA reaching recipient countries is associated with little or even negative development impact.

In terms of the technology aspects of MDG 8, Africa continues to progress well. However, on a country-by-country case, there seem to be challenges in matching the growth of subscribers to communications technology to improvements in quality of service and affordability.

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

During the Ninth Ministerial Conference, WTO members reached a trade facilitation agreement aiming to cut trade transaction costs and increase trade competitiveness in developing countries. In the area of agriculture, decisions were made responding to demands by the developing countries on issues of food security, tariff rate quota administration and export competition. On development issues, Members agreed to put in place a monitoring mechanism for special and differential treatment provisions, and took decisions specific to least developed countries on duty-free, quota-free market access, preferential rules of origin, operationalization of the services waiver and cotton trade reform.

The most important component for Africa is trade facilitation because it can help countries to reduce trade costs and increase competitiveness of the private sector. However, that raises some concerns. Indeed, Africa has little export capacity reflected in its declining share in global merchandise from 3.5 per cent in 2012 to 3.3 per cent in 2013 see table 8.1), compared with 4.9 per cent in the 1970s. Thus, in the short term, it is expected that Africa's imports will increase more than its exports, deteriorating national trade balances. In the meantime, intra-African trade, at 16.3 per cent

Table 8.1 Growth in merchandise trade by region, 2012-2013

	Exports		Imports	
	2012	2013	2012	2013
Africa	6.5	-2.4	12.9	4.1
Asia	2.8	4.7	3.7	4.5
Commonwealth of Independent States	0.9	0.8	6.8	-1.3
Europe	0.8	1.5	-1.8	-0.5
Middle East	5.2	1.9	10.5	6.2
North America	4.4	2.8	3.1	1.2
South and Central America	0.7	1.4	2.3	3.1
World	2.4	2.5	2.1	1.9

Source: WTO 2014, International Trade Statistics on http: //www.wto.org.

of total trade in 2013, is still low compared with other regions (ECA and AUC, 2015).

Greater efforts are required to address supply-side constraints and ensure that multilateral trade agreements deliver for Africa. This not only highlights the critical need for Africa to diversify its economy, but also to meet international norms and standards and rules of origin. Failing to do so could undermine gains from trade facilitation reforms. Further discussions on these reforms should emphasize the reduction or removal of agricultural subsidies in major developed countries and on non-agricultural market access (NAMA) negotiations. On 27 November 2014, the then-160 WTO members reached an agreement that will formally incorporate the Bali Package into the legal framework of WTO and will enter into force when at least two thirds of members have completed their national ratification process, which is a promising development.

Negotiations on economic partnership agreements between African countries and the European Union are continuing, but little progress has been made. Such agreements have not had the desired impact on Africa's economies. Renegotiated economic partnership agreements, which technically came into effect on 1 October 2014, were aimed at changing this. The United States African Growth and Opportunity Act entered its final year on 1 October 2014 and has been renewed until 20 September 2025. Nevertheless, in both cases, there is no evidence that the stated goals of trade development and sustainable growth have been achieved in African countries. Despite efforts, many countries have found it difficult to expand trade and take advantage of the preferential market access programmes (World Bank, 2012). Indeed, trade preferences spur growth assuming that required skills and infrastructures that meet global standards are available. For many African countries, logistical bottlenecks at ports and foreign exchange policy constraints constitute major hindrances. There is also a shortage of skilled workforce in many countries. The continent continues to run a very large infrastructure deficit and there are other supply-side constraints as well, including relatively lower labour productivity, little or no scale economies, and shallow capital markets. The expected relocation of the more value-adding, employment-generating and growth-driving labour-intensive manufacturing from Asia to Africa has not been forthcoming owing in part to these constraints.

Most DAC countries continue to ignore their long-standing United Nations commitment to disburse 0.7 per cent of their GNI in ODA (see figure 8.1). However, the United Kingdom increased its ODA by 29 per cent between 2012 and 2013, which translates into a disbursement of 0.72 per cent of GNI. This was the first time that the United Kingdom surpassed the important target of 0.7 per cent of GNI (UNSD, 2015).[7] The United Kingdom also surpassed the 0.7 level in 2014, disbursing

7 Note that nearly all of the additional British aid in 2013 was provided through the Department of Energy and Climate Change of the United Kingdom (Government of the United Kingdom 2015. Excel tables: Statistics on International Development 2014, www.gov.uk/government/statistics/statistics-on-international-development-2014,

current US$17.9 billion, or 0.71 per cent of the country's GNI in ODA (OECD, 2015a).

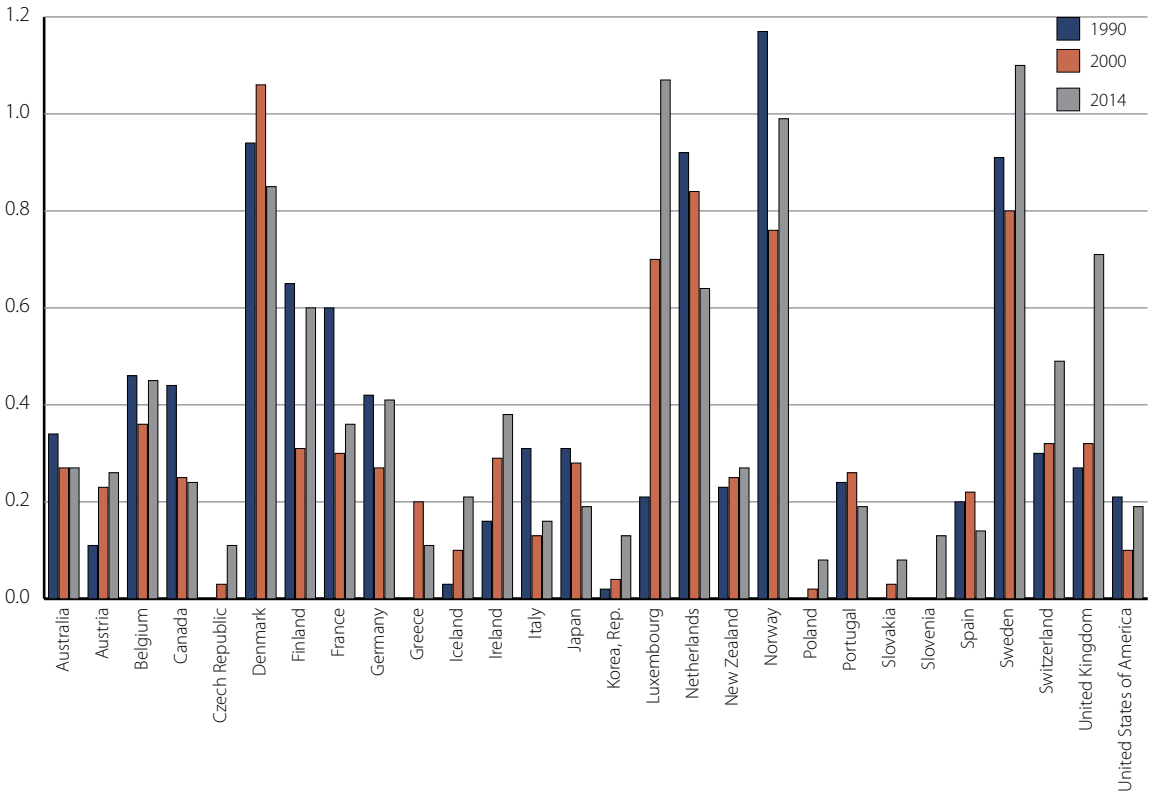
Five countries surpassed the 0.7 target in 2013 and 2014 compared to four in 2012: Denmark, 0.85; Luxembourg, 1.07; Norway, 0.99; Sweden, 1.10; and United Kingdom, 0.71. ODA disbursements among the 28 DAC countries vary between 0.11 (Czech Republic and Greece) to 1.10 (Sweden) in 2014 (OECD, 2015a). The total amount of ODA is estimated at current US$ 135.2 billion in 2014, up from current US$ 135.1 billion in 2013. However, the 2014 amount represents a downturn of 0.5 per cent in real 2013 prices. The 2014 current US dollar disbursements ranged from only 35 million (Iceland) to 31.5 billion (United States). As a group, total ODA reached only 0.29 per cent of the combined GNI of DAC countries in 2014, which implies a delivery gap of 0.41 per cent when compared with the United Nations target. This delivery gap was lower the year before, at 0.40 (OECD, 2015a). The delivery gap in absolute dollars was $169.6 billion in 2013, on top of similar delivery gaps over previous years. This is equivalent to half of the total GDP of South Africa, or to the combined GDP of the 28 smallest African countries. Thus, the annual delivery gaps are huge and could have contributed significantly to speeding up Africa's development.

It is estimated that ODA from DAC countries to Africa will be substantially lower in 2014 ($46 billion) compared to 2013 ($50 billion), both amounts in 2013 US dollars. Moreover, a 2014 survey conducted by OECD shows that ODA to Africa is projected to remain low over the period 2015-2018 at an average of around constant 2013 US$ 47 billion annually (OECD, 2015a). This does not seem promising ahead of the post-2015 development agenda.

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

In addressing the special needs of the least developed countries (LDCs), the ninth WTO Bali Ministerial Conference called for: full implementation of duty-free and quota-free market access

Figure 8.1 DAC ODA as a percentage of GNI, by country, in 1990, 2000 and 2014



Source: *UNSD, 2015 and OECD, 2015 for 2014 estimates data.*

for LDCs; the simplification of preferential rules of origin benefitting LDCs; the operationalization of the services waiver for LDCs; and a reaffirmation of the Doha mandate on cotton with respect to both its trade and development components (WTO, 2013). These decisions, which are of particular importance to African LDCs, need to be translated into their broader economic and social development objectives. Greater efforts will be required to help these countries increase their capacities to enhance their global competitiveness and exploit the opportunities provided by the increased market access. It will also be important to ensure that African LDCs have the appropriate skills and capabilities to comply with product standards in major markets.

ODA to LDCs deteriorated between 2011 and 2012, then resurged in 2013, but is estimated to have deteriorated further in 2014 to $37.8 billion, representing 28 per cent of all ODA from DAC countries. Indeed, ODA from those countries to LDCs amounts to only about one third of total ODA disbursed since 1990 (UNSD, 2015). In fact, according to the most recent metadata available, only eight DAC countries met the 0.15 per cent United Nations target of net ODA to LDCs in 2012. ODA from DAC countries to African LDCs has not changed much in recent years. Between 2004 and 2013, the share of ODA flows averaged 20 per cent to LDCs and only 13 per cent to African LDCs (see figure 8.2).

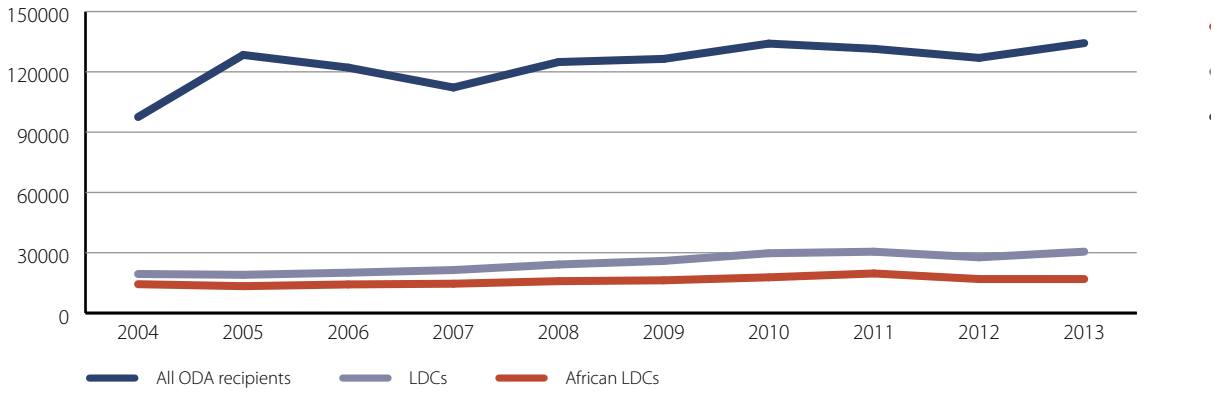
The Istanbul Declaration and Programme of Action on the Least Developed Countries (2011) primarily emphasizes shared responsibility and strengthened joint efforts as the key to the successful achievement of the overriding objective of reactivating and accelerating growth and sustained development in LDCs. The midpoint review of the implementation of the Istanbul Programme of Action will take place in Turkey, in 2016. The latest assessment of progress in the priority areas of the Programme of Action indicates that the GDP growth rates of African LDCs declined from 5.6 per cent in 2010 to 3.37 per cent in 2012 and then rose to 3.53 per cent in 2013 (ECA and African Union, 2015).

Measured by GDP output per person employed, productive capacities have been rising since 2005, despite a dip in 2011. Notwithstanding a series of ongoing regional infrastructure projects initiated in Africa, recent data suggests that, after expanded considerably in 2007, road infrastructure has deteriorated ever since, while rail infrastructure has remained stagnant. African LDCs account for less than 1 per cent of global trade and their economies are dependent on a few primary commodities, which makes them vulnerable to shocks and highly dependent on ODA.

There have been some improvements in the health sector, particularly with respect to child and maternal mortality and malnourishment. However, the Ebola pandemic in Sierra Leone, Liberia and Guinea has exposed the vulnerability of the health systems of African LDCs to shocks.

The Paris Declaration on Aid Effectiveness (2005) has not worked, since it involved a commitment to provide more aid to LDCs (High Level Forum 2005). The stated objective of ODA is to improve the livelihoods substances of the most vulnerable of the world. This would be particularly important from an African perspective since 34 of the 54 countries in the continent are classified as LDCs.

Figure 8.2 ODA from DAC countries in constant 2012 US$ million, 2004-2013



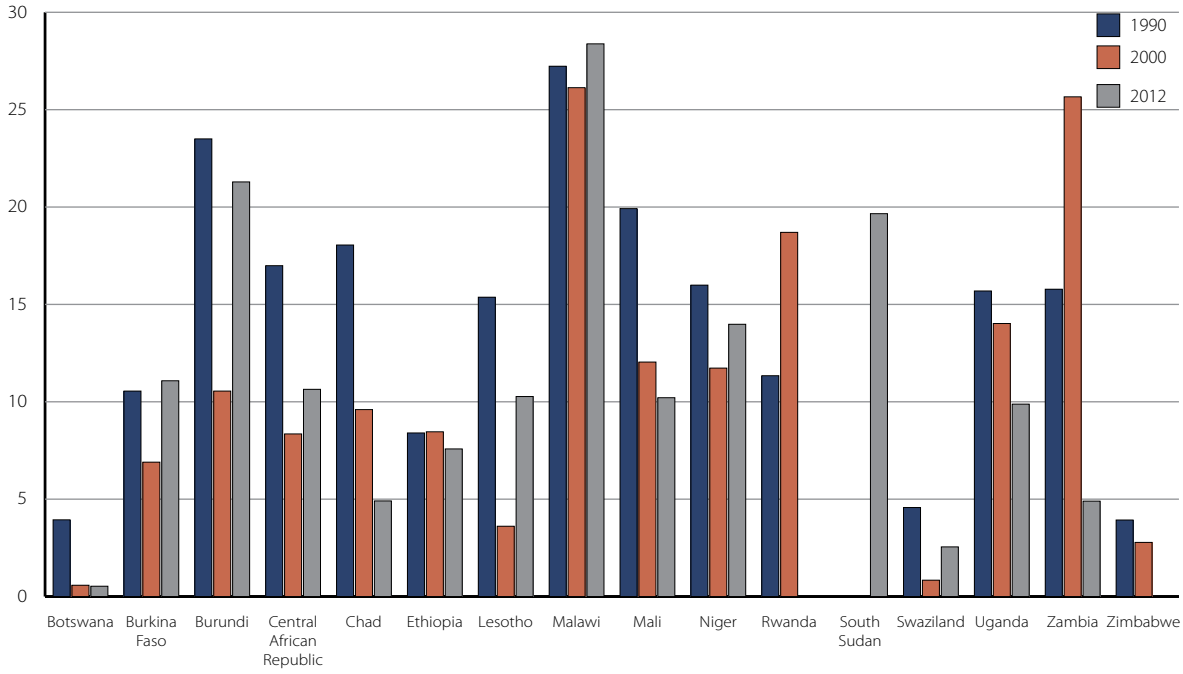
Source: *OECD, 2014.*

Target 8.C: Address the special needs of landlocked developing countries and Small Island Developing States

Lack of access to the sea, remoteness and isolation from world markets, as well high transit costs impose real burdens on socioeconomic progress in landlocked developing countries (LLDCs) (ECA et al., 2012). The Almaty Declaration and the Almaty Programme of Action, adopted in 2003, marked an effort to address these problems. Implementation of the latter was to be supported by donors through funding and technical assistance. However, donors did not fulfil their commitments as evidenced by lower ODA flows to these countries. In general, African LLDCs as a group experienced ODA reductions (see figure 8.3), so that the average ODA as a percentage of their GNIs dropped steadily from 14.1 in 2004 to 11.1 in 2012 (UNSD, 2015). Over the longer time horizon, 1990-2012, the average ODA to African LLDCs amounted to 13.6 per cent of the recipient group's GNI, while being 14.4 during the 1990-2003 period, compared with 12.3 over the 2004-2012 period.

Recognizing the trend, in 2012, the United Nations General Assembly decided to hold a comprehensive 10-year review conference of the Almaty Programme of Action. The eleventh Annual Ministerial Meeting of Landlocked Developing Countries called for accelerated implementation of the Almaty Programme of Action by ensuring that Aid for Trade to LLDCs takes into account their special needs and requirements (UN-OHRLLS, 2012).

Figure 8.3 ODA to African LLDCs, as a percentage of their GNI, in 1990, 2000 and 2012



Source: *UNSD, 2015.*

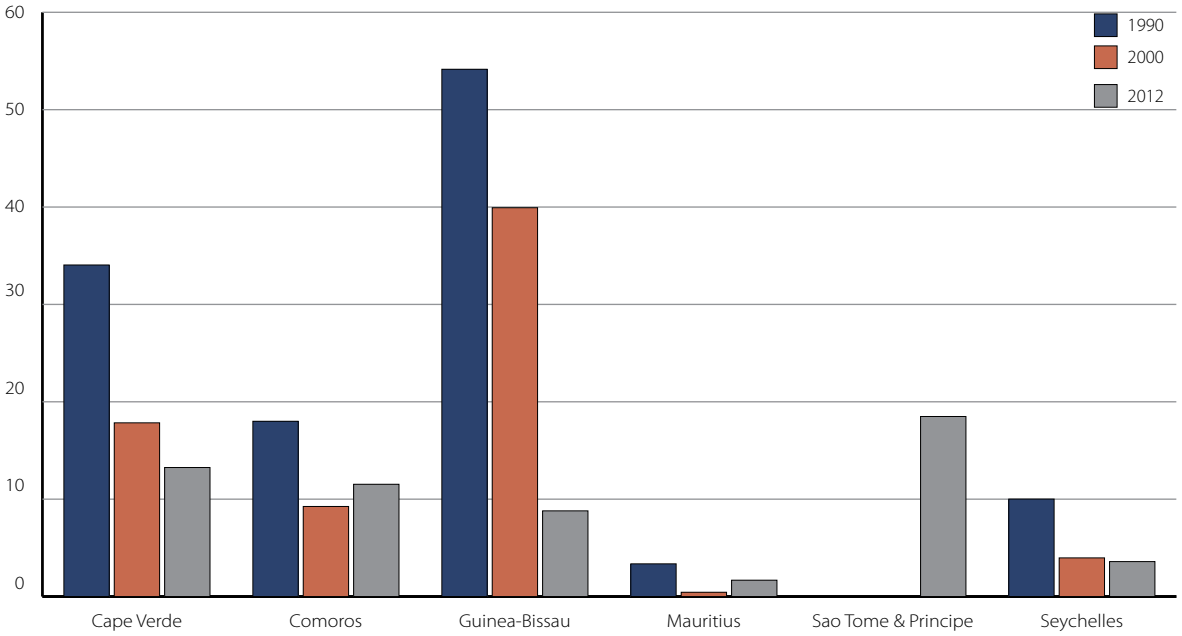
Note: *Data is missing for Rwanda and Zimbabwe for 2012.*

Similarly, SIDS have not been spared from cuts in ODA (see figure 8.4). In 2012, the average ODA as a percentage of SIDS's GNI was only 9.6, compared to the1990-2003 average of 18.3, and the 2004-2012 average of 10.7. Four of the six African SIDS experienced reductions of ODA as a percentage of their GNI of over 25 per cent, namely, Cabo Verde, the Comoros, Guinea-Bissau and Seychelles.

Clearly, the ODA reductions as stated in relative terms are highly related to economic growth in some of the LLDCs and particularly SIDS. The donor community, however, should not lose focus on the special needs of these countries while utilizing the momentum of economic growth to further boost development and poverty reduction. This is particularly important given the complex relationship between economic growth and poverty reduction (ECA et al., 2014).

In the area of trade, LLDCs depend on their neighbours for efficient procedures for clearing transit goods. The trade facilitation agreement of the Ninth WTO Ministerial Conference will create a common platform that WTO members are expected to implement in order to respect the principles of transparency, consistency and predictability, which will help traders in LLDCs. One of the decisions in Bali also reaffirmed the importance of the WTO Work Programme on Small Economies, which covers all of the countries that are included in the SIDS category. This Work Programme calls for framing responses to the trade-related issues identified in improving the participation of LLDCs and SIDS in the multilateral trading system.

Figure 8.4 ODA to African SIDSs, as a percentage of their GNI, in 1990, 2000 and 2012



Source: UNSD, 2015.

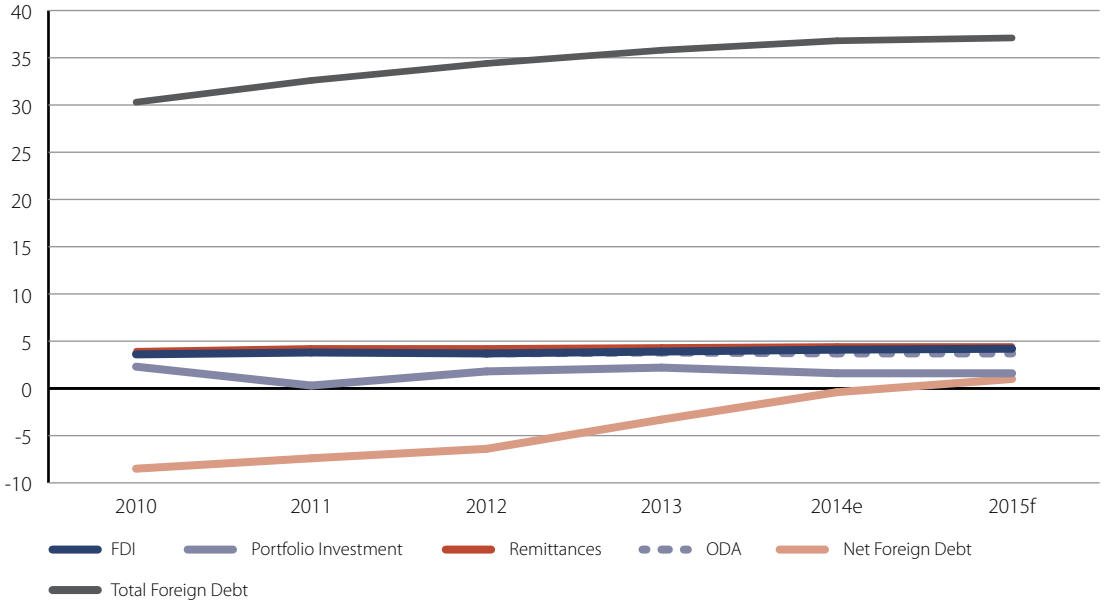
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Since 2010, total foreign debt has been higher than 30 per cent of GDP in Africa and is expected to rise to 37.1 per cent of GDP in 2015. In 2015, net foreign debt (total debt minus reserves) as a share of GDP is projected to be only 1 per cent of GDP, following a negative trend since 2006 due to high international reserves in oil-exporting economies (ECA, 2015b). Mineral-rich and oil importing African countries have positive net foreign debt, and some extreme cases[8] have very high ratios, raising issues of debt sustainability (ECA, 2015).

The Heavily Indebted Poor Countries (HIPC) Initiative continues to make an impact on reducing the debt burden of countries that qualify for debt relief. As of September 2014, 29 African countries were eligible under HIPC, reached the completion point and received irrevocable debt relief (IMF, 2015a).The total debt relief effort for all eligible African HIPC amounted to $105 billion in nominal terms by the end of 2012 (ECA and OECD, 2014). Over $5.5 billion of external commercial debt has been written-off in 15 African HPIC supported by the World Bank's Debt Reduction facility (Ibid).In addition, after the recommendation of the Group of Eight (G8)in the 2005 G8 Summit, the International Monetary Fund (IMF) provided a 100 per cent debt cancellation under the Multilateral Debt Relief Initiative (MDRI) to low-income African countries, amounting to $3.4 billion in nominal terms (IMF, 2015b).

8 These include Cabo Verde (59 per cent of GDP), Ghana (28 per cent of GDP); Sudan (55 per cent of GDP); Mauritania (52 per cent of GDP); Mozambique (28 per cent of GDP); Sao Tome and Principe (117 per cent of GDP); Senegal (25 per cent of GDP); Seychelles (90 per cent of GDP); Tunisia (50 per cent of GDP) and Zimbabwe (338 per cent of GDP).

Figure 8.5 Inflows of external finance, 2010–2015 ($ billion)



Source: *ECA and AUC, 2015.*

The HIPC Initiative is almost completed, as 35 out of 39 HIPC eligible countries have now reached the completion point. However, three African countries are currently eligible for the HIPC initiative, but have yet to start the process: Eritrea, Somalia and Sudan. Still, Africa's long-term debt sustainability remains a challenge for post-completion point countries owing mainly to structural problems and inadequate debt management capacity. With completion of the HIPC Initiative, the growing concern about debt sustainability raises the more basic issue of how to ensure a fair debt workout mechanism to address future sovereign debt crises.

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

Notable progress on technology indicators

Fixed telephone subscriptions

The number of fixed telephone subscriptions per 100 inhabitants seem to have reached its tipping point in 2009 for the African continent as a whole. This figure grew steadily from 1.44 in 1990 to 4.17 in 2009; thereafter, it steadily dropped to 3.60 in 2013. The range between the countries is very large, however. Twenty-five African countries recorded one or less subscriptions per 100 inhabitants whereas Mauritius and Seychelles recorded the highest numbers in 2013, with 29.17 and 23.43, respectively. Out of the 53 African countries with available 2013 data for 2013, 25 recorded less than 10 fixed telephone subscriptions per 100 inhabitants (UNSD, 2015). Clearly, the stagnation is closely related to existing or slow growth of telephone lines with respect to population growth and mobile telephone subscription growth, which is the next indicator on this target.

Mobile-cellular subscriptions

In 1990, only four African countries recorded mobile-cellular subscriptions: Egypt, Mauritius, South Africa and Tunisia, but with an average of only 0.005 per 100 inhabitants. Ten years later, 48 out of the 53 countries with available data had mobile subscriptions, with an average of 2.57, ranging between 32.54 (Seychelles) to 0.1 (Mali). Regional changes for mobile-cellular subscriptions can be seen in table 8.2. In 2013, all 53 countries with available data had mobile subscriptions, averaging 80.20 per 100 inhabitants, ranging between 214.75 (Gabon) and 5.6 (Eritrea); 15 countries recorded over 100 subscriptions per 100 inhabitants. This is due to the common practice of multiple subscriptions for each mobile-cel-

Table 8.2 Mobile-cellular subscriptions per 100 inhabitants, by regions

	1995	2000	2012
World	1.6	12.1	89.3
Developing regions	0.4	5.4	82.6
North Africa	<0.1	2.8	116.1
Africa excluding North Africa	0.1	1.7	59.3
Latin America and the Caribbean	0.8	12.1	109.1
Caribbean	1.2	7.5	63.6
Latin America	0.8	12.5	112.4
Eastern Asia	0.5	9.8	82.1
Eastern Asia excluding China	3.4	50.2	98.7
Southern Asia	<0.1	0.4	69.2
Southern Asia excluding India	<0.1	0.5	67.5
South-East Asia	0.7	4.2	111.8
Western Asia	0.6	13.1	101.5
Oceania	0.2	2.4	47.4
Caucasus and Central Asia	<0.1	1.3	107.3
Developed regions	6.4	39.8	120.3
Least developed countries	<0.1a	0.3	48.6
Landlocked developing countries	<0.1	1.1	59.4
Small island developing States	1.5	11	70.3

Source: *UNSD, 2015.*

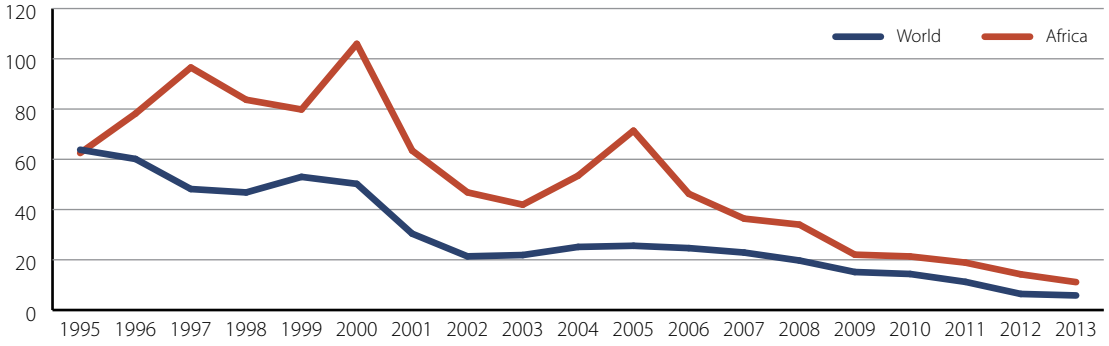
lular phone user in Africa. It is difficult, therefore, to trace the accurate number of individuals who own a mobile-cellular phone, and who are also able to use it. For instance, Africa Renewal (2013) reports that phone users are buying several SIM cards in order to switch between operators and save interconnection fees.

What is clear, however, is that mobile-cellular subscriptions continue to grow. In 2013, there were 823.7 million mobile-cellular subscriptions in Africa. Its growth has recently stagnated, but continues to surpass the global average, with 11.1 per cent against 6.3 in 2013. Over a longer horizon, between 2004 and 2013, the average annual growth of mobile-cellular subscriptions was 33 per cent in Africa compared to 17 per cent globally (UNSD, 2015); i.e. Africa has recently made significant progressing in the use of this technology (see figure 8.6 and 8.7). Moreover, Africans have been able to utilize the mobile phone technology in a number of innovative ways. CNN (2012) lists seven ways in which mobile phones have changed lives in Africa: in banking, activism, education, entertainment, disaster management, agriculture and health.

Internet users

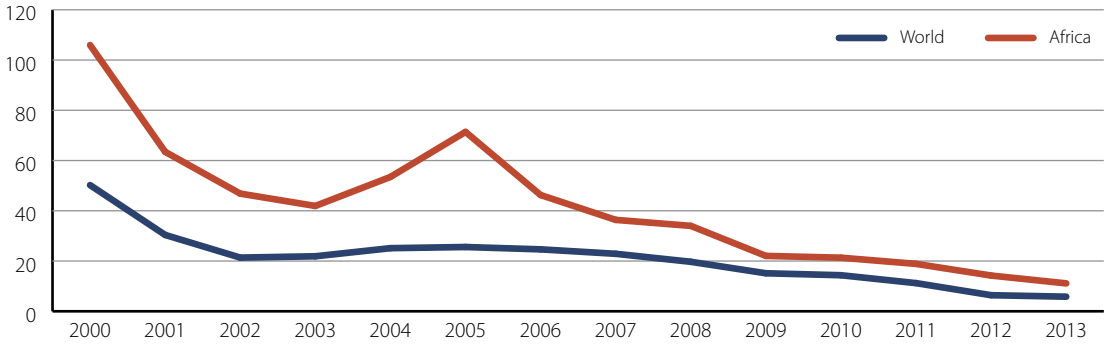
Similarly, over 2004-2013, the number of Internet users per 100 inhabitants has grown much faster in Africa than in the world, an average annual growth of 21.7 per cent versus 10.2 per cent (see figure 8.6 and 8.7). Currently, this indicator is 14.7 per cent for the African continent, against 43.7 per cent for the world. However, if the current growth rates are maintained over the coming decades, Africa as a whole may reach the global levels. Yet, Internet access will not be consistently available throughout and within the African countries. Once again, there are great variances between the countries. The top performers in 2013 were Egypt (49.6), Morocco (56.0), Seychelles (50.4), South Africa (48.9) and Tunisia (43.8). At the same time, 14 countries had less than five Internet users per 100 inhabitants.

Figure 8.6 Growth of number of mobile-subscriptions, 1995-2013



Source: *UNSD, 2015.*

Figure 8.7 Growth of mobile-cellular subscriptions per 100 inhabitants, 2000-2013



Source: *UNSD, 2015.*

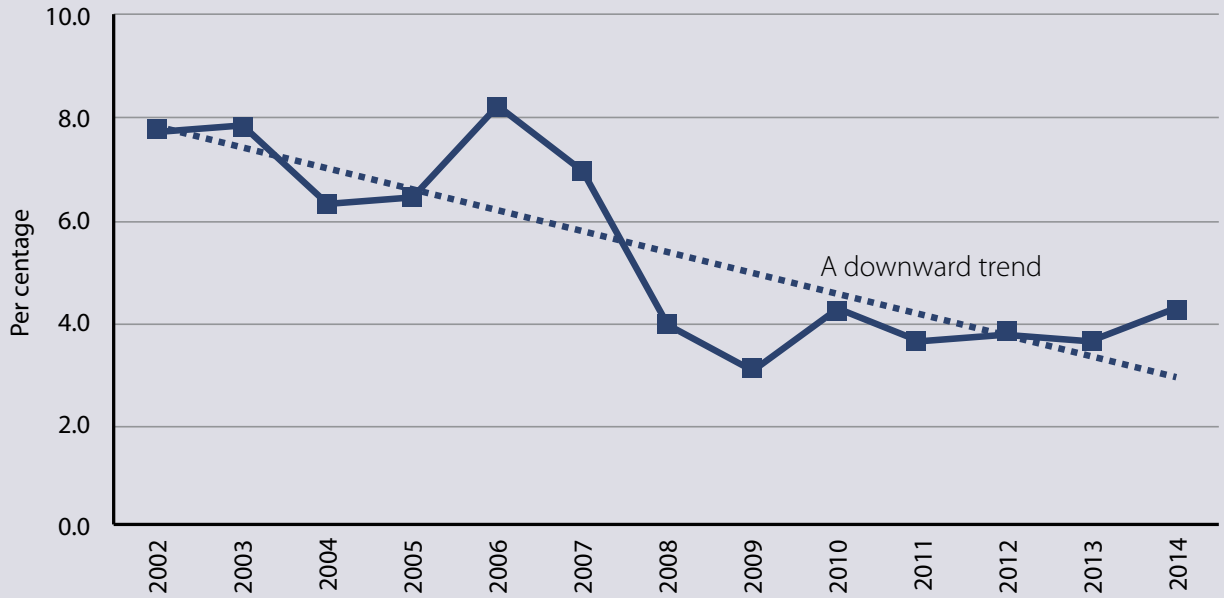
In general, Africa has shown notable progress on these technology indicators. However, the quality aspects of the technology usage are still very limited, owing to costs, disturbances in service and energy supply, as well as close monitoring of information flows by the authorities to obstruct political activism (Donovan and Martin, 2014).

Box 8.1. Mauritius and MDG 8

Mauritius, a small island developing State, continued to benefit from ODA, but the amount granted was consistently less than 1 per cent of GNI in 2014. Mauritius received 406 million Mauritian rupees in ODA, representing only around 0.1 per cent of its GNI.

The debt burden measured as a proportion of external debt service to export revenue declined from 8 to 4 per cent over the 2002-2014 period. The improvement in the debt burden reflects an improvement in the country's vulnerability to economic shocks. From 2002 to 2007, the proportion was around 6 to8 per cent; it then dropped significantly to about 4 per cent until 2014.

Share (%) of debt service on total exports of goods and services in Mauritius, 2002-2014



In addition, 100 per cent of the population have access to essential drugs, since the Government provides free health care and services with essential drugs in all public health centres located in various parts of the country.

Mauritius has attained substantial progress in information and communications technology. The usage of cellular phones and Internet has increased substantially. The number of fixed line telephone subscribers per 100 inhabitants increased from 7 per cent in 1990 to 31 per cent in 2010. It then decreased to 29 per cent in 2013 owing to the emergence and rapid expansion of cellular phones, which are more accessible and also provide a large variety of services such as Internet access. The number of mobile-cellular subscriptions per 100inhabitants, which was 0.2 per cent in 1990, has been over 100 per cent since 2011.

Internet penetration is also increasing rapidly: in 2006, Internet users made up 19 per cent of the population aged 12 years and over; in 2012, the proportion doubled to 38 per cent.

SECTION II:

Lessons learned from the implementation of the Millennium Development Goals

Over a decade's worth of experience with the Millennium Development Goals (MDGs) has generated invaluable lessons that can guide policymakers in implementing the post-2015 development agenda. The lessons are categorized along the following themes: overarching lessons; lessons in poverty reduction and inclusive growth; lessons in social development; and lessons in environmental sustainability.

Overarching lessons

The MDGs will not be achieved by all countries or all regions; however all countries have made progress on at least one target of the MDGs. This is true both globally and for Africa. The experiences of countries on the MDGs reveal some overarching lessons that should inform the successor development framework.

Initial conditions matter

An often overlooked issue in the assessment of MDG achievements is the role of initial conditions. Initial conditions influence the character and pace of a country's progress towards the MDGs. As a result, differentiated approaches to supporting and evaluating progress are imperative. For countries and regions that are furthest from the target, the pace of progress relative to their baselines is just as important as proximity to the target.

Effective communication and follow-up are critical for the success of global agendas

An important lesson to be drawn from implementing the MDGs is that, although the commitments made by its signatories were not binding, some success was generated. This positive outcome was partly due to the effective communication and continual follow-up processes undertaken at the national, regional and global levels. Effective communication of performance, including through national country reporting, mobilized civil society and helped to sustain pressure on governments to fulfil their social compacts. Regional MDG reporting provided a mechanism for cross-country comparisons and peer learning. Good performing countries unwittingly encouraged weaker performers to improve their performance by generating a spirit of positive competition.

MDGs induced demand for more comprehensive and timely data

The MDGs underlined the importance of timely access to disaggregated data as an important ingredient for monitoring results and holding relevant stakeholders accountable for their actions and or inactions. The desire of governments to demonstrate results and of stakeholders to track performance invariably generated demand for data and contributed to improvements in data availability (WHO, 2014a). Notwithstanding progress in data access, data deficits persist and can be improved, including through investments in civil registration and vital statistics as well as innovative methods to optimize the use of "big data".

Strengthening both access and quality of service delivery

The MDGs have also revealed that improvements in access to basic services have often not been associated with improvements in the quality of service delivery. Given the substantial resources required to leverage change and the urgency to improve access, the quality of service delivery has not received the desired attention; more

efforts must be made in this area. Poor quality can also be linked to failure by policymakers to fully account for the recurrent cost implications of capital expenditure. More attention has been paid to capital investments, such as building schools and clinics, than in investing in the recurrent costs that assure the smooth functioning of such projects. The recurrent costs of running schools and medical facilities including human resources, for instance, are often not appropriately factored into the capital costs of constructing such facilities, especially when such investments take place outside the budget. Where such capital costs are funded by donors, there is the need to situate such initiatives in a broader conversation about sustainability and quality of service delivery over the long term. In this context, donors must not only be more flexible about the parameters of their aid, but align aid with national strategic frameworks and priorities.

Sustainability requires adopting an integrated approach to development

The MDG focus on outcomes such as poverty reduction without particular attention to the underlying causes has led in some cases to undesirable, unintended and often unsustainable consequences. For instance, Africa has made substantial progress in reducing HIV, malaria and tuberculosis as a result of access to vertical funds. However, these funds narrowly target specific diseases, paying less attention to the health systems of the countries. Cumulatively, signed funding expenditures by the Global Fund on strengthening health systems accounted for 2.5 per cent of the total for the 2002-2013 period (The Global Fund, 2015). These developments raise two important issues: the sustainability of health-care programmes dependent on vertical funding and the sustainability of the vertical funding approach in general in a context of weak health systems. In effect, while vertical interventions have undoubtedly been beneficial, the Ebola experience clearly demonstrates that to be sustainable, they must be complemented by horizontal or integrated interventions to strengthen the health-care system in general.

Exploiting inter-sectoral synergies heightens impact

The MDGs have highlighted the benefits and efficiency gains that can be achieved by leveraging inter-sectoral synergies as well as the important role of development planning in making this happen. African countries have been more successful in integrating the MDGs in their development planning frameworks than in exploiting synergies among the goals and targets. This is perhaps due to the lack of technical capacities required to objectively assess and estimate the interrelationships among the different goals and identify the entry points that generate the greatest impact.

Country experiences in child and maternal deaths illustrate that an integrated approach to addressing health needs is critical to success. In effect, improving child and maternal health is not merely a health issue, but requires related non-health interventions such as changing nutritional or infant-care behaviours, and improving access to sanitation and improved water sources. Further, it is necessary to address cultural practices that promote early marriages and discourage the education of the girl-child. Gender parity in education and women's empowerment has a positive effect on fertility and access to health information. Similarly, poorer women are disproportionately affected by higher mortality rates owing to lower access and use of health services. Malaria, HIV/AIDS, tuberculosis and other health threats to pregnant women significantly impacts on maternal mortality ratios. On the other hand, reducing early childbearing can impact the achievement of other MDGs on poverty, education, gender equality and child mortality (UNSD, 2014).

Notwithstanding the significant payoffs from tackling teenage pregnancy, investing in better sanitation, and expanding access to improved drinking water, progress in these areas has been limited. Only seven African countries reported adolescent birth rates of less than 50 births per 1,000 women (UNSD, 2015); since 2000, only one in four Africans (24 per cent) has had access to an improved drinking water source, and only one in three Africans has access to improved sanitation.

Progress is tied to a robust means of implementation

The MDGs lacked a robust mechanism for their implementation. While the Monterrey Consensus provided a framework for funding the MDGs, the follow-up mechanism was ineffective; the Consensus focused exclusively on financial resource mobilization with little attention to complementary factors such as technology, institutions and capacity-building. Furthermore, excessive reliance on ODA undermined the economic sustainability of several MDG interventions, rendering them susceptible to the economic fortunes of donor countries. Strengthening the means of implementation of global agendas is therefore key to success. While such efforts must emphasize all sources of development financing, it must also include non-financial enablers of development such as technology and capacity-building efforts. In this context, critical areas of priority should include: supporting Africa's agenda for structural transformation, including value addition (e.g. in banking and microfinance development) and quality of public spending and planning; strengthening domestic capacities for resource mobilization; strengthening cooperation in stemming illicit outflows (e.g. tax evasion, abusive trade mispricing), including by limiting the use of secrecy jurisdictions by development finance institutions); returning stolen assets; supporting technology, innovation and science; promoting fair trade; strengthening trade facilitation; and facilitating good governance.

Lessons in poverty reduction and inclusive growth

Inclusive and sustained growth promotes poverty reduction. Africa is unlikely to achieve the MDG target of halving extreme poverty; however, important lessons can be drawn from the efforts made in addressing the poverty and hunger challenge over the past 15 years. The continent has made remarkable progress since 1990: Egypt, Cameroon, the Gambia, Guinea, Senegal and Tunisia have already achieved the target on extreme poverty reduction.

Poverty reduction is underpinned by rapid, sustained and inclusive growth

For example, critical to Tunisia's success in reducing extreme poverty by 76.3 per cent over the1990-2005 period was rapid and sustained real GDP growth of around 5 per cent over the past two decades combined with a long-standing commitment to social and physical development. Investments in infrastructure across rural and urban areas facilitated a more equitable spatial distribution of the benefits of growth. Agricultural development, especially in rural areas, promoted self-sufficiency, generated employment and improved living conditions. The events of the Arab Spring, however, suggest that reducing extreme poverty is not a sufficient condition for satisfying the basic needs of all countries or societies. A differentiated approach to establishing poverty benchmarks is necessary to reflect the realities of countries at different levels of development (ECA et al., 2013).

Ethiopia has also made remarkable progress on the MDGs through investments in rural development and in agricultural productivity, and social protection despite limited natural resource endowments. The proportion of Ethiopians living below the poverty line fell from 45.5 per cent during the period 1995-1996, to 29.6 per cent during the period 2010-2011, a decline of around one third. This represents an annual average decline of 2.32 per cent against 0.5 per cent for Africa excluding North Africa over the same period. As a result, the country is just around 7 percentage points short of achieving MDG 1. Both rural and urban communities have benefited from the declines in poverty, which fell by 36.0 and 22.8 per cent, respectively, between 1995 and 2011 (Federal Republic of Ethiopia, 2012).

Rural poverty declined as a result of a wide range of pro-poor programmes in rural areas, including improved agricultural technologies; expansion of agricultural extension services; commercialization of smallholder farming; rural infrastructural development; access to social protection programmes, especially those relating to productive safety net programmes; and provision of credit. Progress on urban poverty reduction, especially during the

2006-2011 period, was linked to improvements in the investment climate, the provision of food subsidies to the urban poor during periods of rising food prices, and job creation efforts (ECA et al., 2012).

Although the poverty headcount ratio and poverty gaps are declining, there are still issues for urgent policy consideration, such as a widening poverty gap between rural and urban areas since 2006 and a rising poverty severity index. Widening inequality in rural areas is also a concern: the Gini coefficient in rural areas increased from 0.26 to 0.27 but fell in urban areas from 0.44 to 0.37 between 2006 and 2011. The poverty disparity among regions also requires policy and programme attention (Federal Republic of Ethiopia, 2012).

Burkina Faso cut poverty by 37.3 per cent from 1994 to 2009, aided by livestock farming. This initiative is also contributing to food security and human development in rural areas. During the period 2007-2008, income from livestock covered 56 per cent of households' food needs, 42 per cent of their health expenses and 16 per cent of children's educational costs (ECA et al., 2012).

Growth need not compromise on equality

Rwanda's experience illustrates how growth can occur hand-in-hand with improvements in income distribution. The country's growth has been associated with falling inequality since 2007. This is in contrast to the figures registered between the 2000-2001 and 2005-2006 periods, when inequality, as measured by the Gini coefficient, rose from 0.51 to 0.52. Thereafter, the Gini coefficient declined from 0.52 to 0.49 during the 2006-2011 period. All provinces (except for the Northern Province) benefitted from the growth process. Specific policy measures contributing to this trend included: investments in access to energy; improved agricultural productivity and market access; increased access to credit by small- and medium-sized enterprises; and investments in social protection. During the 2006-2011 period, household access to electricity for lighting increased by 6.5 per cent while the share of marketed agricultural output increased from 22 to 27 per cent. Furthermore, participation in social protection programmes, such as the Ubudehe credit scheme, the Rural Sector Support Project and direct support from the Vision 2020 Umurenge Programme, increased substantially (NISR, 2011; NISR and UNDP, 2007).

Strengthening capacities through social protection reduces poverty and inequalities

Social protection programmes have played an effective complementary role in reducing poverty and enhancing the skills and capacities of vulnerable groups. Such programmes have been effective in countries that view it not as a "handout", but rather as a long-term investment in people, reinforced by regular budgetary allocations. For example, in Algeria, it accounts for approximately 11 per cent of the State budget.

Rwanda's system of multiple social mechanisms,, including universal health insurance (which covers 91 per cent of the population), free education and social transfers such as a pension scheme – have been linked to the overall decrease in extreme income poverty from 39 per cent in 2006 to 34.5 per cent in 2009 (ECA et al., 2011).

Mauritius's universal social pension has been instrumental in lowering the poverty rate. Likewise, South Africa's old age pension plan has reduced the country's poverty gap by 2.5 per cent, while its disability grants have reduced the total rand poverty gap by 5.1 per cent, and the child support grant that extends to 18 years, has contributed to a 21.4 per cent reduction in the poverty gap (ECA et al., 2014).

The Namibian multidimensional social protection programme has had a significant impact on poverty reduction of vulnerable groups. Malawi's social protection programme has also significantly reduced hunger. Ethiopia's Productive Safety Net Programme has reached 8 million beneficiaries in around 1.5 million households, by providing cash and food support through public works in areas affected by drought.

Ghana, Kenya, Mozambique, Nigeria, Senegal and the United Republic of Tanzania have set up

a variety of safety nets such as emergency food distribution to support vulnerable groups (e.g. orphans, widows and the elderly). Benin, Burkina Faso, Mali and the Niger have provided emergency food distribution through cereal banks that sell food staples at subsidized prices, while Kenya has developed an extensive set of hunger safety net programmes targeting arid and semi-arid areas (APP, 2014).

Notwithstanding the successes, more efforts need to be made to improve access to funding, ensure fiscal sustainability, expand coverage, reduce fragmentation and improve targeting of social protection programmes in Africa. Kenya and United Republic of Tanzania still spend less than 0.3 per cent of GDP on social protection programmes. Although 75 per cent of Madagascar's population are classified as poor, its social protection programme only covers 1 per cent of the population. In Burundi, 67 per cent are below the national poverty line, but only 5 per cent are reached by social safety nets. Social protection programmes also tend to be fragmented, comprising small, donor-funded pilots or projects that operate in isolation from other similar projects. Most of these interventions are at the pilot stage and a very limited number are scaled up. Other challenges include targeting the suitable beneficiaries and improving programme coordination (APP, 2014; ECA et al., 2011; World Bank, 2012).

Public works programmes are a form of social protection that has played an important role in providing livelihoods for vulnerable groups. A review by the Overseas Development Institute of nearly 170 public works programmes found that earnings from public works programmes contribute significantly to household incomes. However, while such programmes reduce the depth of poverty, their impact on the poverty headcount tends to be negligible. Furthermore, the effectiveness of such programmes depends on their ability to target vulnerable groups. Well-targeted programmes have a greater impact on poverty reduction. Targeting is, however, a data-intensive process requiring timely access to information on potential beneficiaries. In most African countries, however, access to data is limited.

Public works programmes also tend to rely heavily on donor funding, rendering them susceptible to volatilities in the flow of such resources. Approximately 83 per cent of the public works programmes reviewed by Overseas Development Institute were donor-funded (McCord and Slater, 2009).

Employment subsidies can create jobs

Access to decent jobs is a sustainable exit strategy from poverty. The experience of Algeria provides some insights into how job creation can be addressed through employment subsidies. Like several African countries, Algeria experienced a formidable unemployment challenge. Unemployment rates were as high as 30 per cent in 2000 and 48 per cent in 2001. To tackle the problem, the Government implemented a rigorous employment policy that focused on granting subsidies to firms as incentives to hire the unemployed and establishing a public works programme for the unskilled. Firms were given the opportunity to hire the unemployed at no cost for one year, while the Government paid 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 labour supply (job seekers) with labour demand (vacancies). As a result, the annual number of job seekers matched through the National Employment Agency (ANEM) over the period 2005-2009 increased by 167 per cent. Moreover, during this period, female employment rose from 1.2 million to almost 1.5 million, an increase of around 20 per cent. Between 2004 and 2009, the Algerian Government was able to create 1.3 million new jobs. This development led to a reduction in the total unemployment rate from 30 per cent in 2000 to 15.3 per cent in 2005, falling further to 10.2 per cent in 2009. In particular, youth unemployment dropped from 48 per cent in 2001 to 31 per cent 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 per cent in

1995 to 5 per cent in 2008, as measured by the national poverty line (Kpodar, 2007 and Government of Algeria, 2010).

Nigeria's Youth Empowerment Scheme administered by Oyo State has also been effective in generating jobs for youth. Established in July 2011, the project aims to: generate 20,000 jobs annually in agriculture, public works, health and education, and environmental services; and build capacity in life skills, including cognitive and entrepreneurial skills. It is supported by seed money to build a critical mass of small entrepreneurs for the state. In less than a year, the project had created 20,000 jobs in different sectors, including 5,000 in agriculture and related activities, 3,000 as traffic control officers and 2,500 as environmental officers. The outcomes were achieved by re-activating eight abandoned farm settlements for agricultural production and processing by youth. The main challenge is sustaining the project, scaling it up and replicating it in other states of the country.

In conclusion, countries have largely focused on rural and infrastructure development complemented by social protection programmes to promote inclusiveness and reduce poverty. However, in many countries, the pace of reduction in the poverty levels could have been further accelerated by improving targeting of the poor and improving labour productivity. To promote inclusive growth and have a further multiplier effect on poverty, attention needs to be given to improving labour productivity as key driver of economic growth and change in living standards. Labour productivity growth implies a higher level of output for every hour worked. This can be achieved if more capital is used in production or through improved overall efficiency with which labour and capital are used together, i.e. higher multifactor productivity growth. Labour productivity is also a key driver of international competitiveness, as measured by, for example, unit labour cost. Paying greater attention to vulnerable employment with a focus on youth is imperative to the poverty reduction.

Improving targeting will require a greater emphasis on producing disaggregated data to capture the gender, spatial and age dimension of poverty. Targeted interventions to address child and youth poverty are vital for realizing Africa's demographic dividend.

Lessons in social development

Most African countries are on track to achieve the goal of universal primary enrolment by 2015. Although improving the quality of education and reducing dropout rates still remain a challenge, some African countries have demonstrated success through innovative policies.

Education

Investments in rural education infrastructure

Investments in rural education infrastructure have proven effective in expanding access to primary schools. Ethiopia increased its net primary enrolment rate from 50 per cent in 1990 to 86.5 per cent during the period 2009-2010, owing in part to the construction of classrooms, particularly in rural areas where access poses an acute challenge. Sixteen thousand classrooms were constructed in 2004 and 25,000 during the period 2008-2009; 80 per cent of these are in rural areas. In addition, education is emphasized in public policies and prioritized in public spending

Community empowerment

Empowering local communities to run their own schools has boosted primary enrolment, particularly in poor communities. Prompted by fiscal constraints, Burundi and Togo adopted an innovative approach of direct community involvement in the running of schools. In the poorest region of Togo, Savanes, most of the schools are entirely funded by rural households, which include building classrooms and paying teachers' wages. As a consequence, the net enrolment rate increased from 67 per cent in 1990 to 87 per cent in 2008. At the same time, the country was able to score 0.95 in the Gender Parity Index for primary education (National MDG Progress Reports 2010 – Ethiopia, Egypt and Togo).

Policy reforms

Education policy reforms that reduce financial and cultural barriers to education, enforce com-

pulsory primary education and prioritize early childhood development have yielded success in spurring enrolment. These inclusive policies were also adopted in other subsectors such as secondary education and non-formal education where access has also been expanded. From 1995 to 2008, Egypt increased net primary enrolment rates from 83 to 90 per cent, through investments in early childhood development projects, cash transfers to poor families and the launch of girl-friendly schools.

Uganda doubled its gross primary enrolment over a three-year period, from 1996 to 1999, by abolishing school fees for up to four children per family. This policy not only improved access, but also signalled to households the economic benefit of lower fertility rates. To sustain such subsidies, the Government prioritized economic growth, macroeconomic stability and social spending (ECA, 2005).

Other countries such as Namibia have enshrined compulsory education in their constitution and have established educational policies and programmes to enforce compulsory primary education. Mauritius imposes penalties on parents who do not send their children to primary school. Seychelles has eliminated all forms of educational discrimination, including against disabled people. By contrast, increased budgetary allocations, a primary education development plan and capitation grants are driving progress in the United Republic of Tanzania (UNDP–RBA 2010; ECA et al., 2012).

Reducing dropout rates

Increasing access to primary schools must be complemented by improved completion rates if education is to have its intended effects. Low completion rates in primary school have been attributed to: poor health or malnutrition status of pupils; household situation (including child labour and poverty); and school factors such as teacher absenteeism, school location and poor educational provision (Sabates et al., 2010). Other factors include late entry of pupils into the school system, which increases the pressure to join the labour market, or for girls, start a family, prior to completing the cycle. This reduces the incentive to advance to secondary and higher levels of education (UN, 2007). Countries have adopted wide-ranging responses to the dropout challenge.

Tracking attendance and enhancing the learning experience

The United Republic of Tanzania is addressing this challenge by mapping, as much as possible, all primary education facilities and identifying all school-aged children, including tracking down out-of-school children. This information is useful in gauging the scope of the nation's educational resource needs. The Government then instituted a policy of compulsory enrolment of all children of seven years and over, including over-aged children who were out of school. Furthermore, education was devolved to the regions, with a community approach to education. To tackle inefficiencies in the system, children were enrolled at the official age of entry in primary school. At the same time, the Government introduced quality-improvement measures, such as child-friendly teaching and learning skills for teachers; flexible learning hours; the abolition of corporal punishment and compulsory school uniforms; wider availability of textuberculosisooks; school health measures, such as improved access to water and sanitation facilities in school; and school meals in drought-prone areas. Over-aged and out-of-school children were accommodated through a condensed curriculum of three years equivalent, rather than the traditional seven years (Sabates et al., 2010; ECA et al., 2012).

Gender and women's empowerment

There has been considerable progress in increasing the share of women in national parliament but less progress in increasing the share of women in paid non-agricultural employment. The economic and political empowerment of women cannot however be decoupled from inequities in access to primary education.

The importance of removing barriers to female education

The removal of economic and social cultural barriers to education is an imperative for progress in gender equality and the empowerment of

women. This is also true for the labour market and women's participation in the social and political spheres.

Increased gender mainstreaming in education has enabled countries to achieve gender parity in enrolment in primary education. The various campaigns conducted at different stages throughout the continent have helped to steadily address the differential educational needs of girls and boys in primary education. With the technical and financial support of relevant United Nations agencies and multilateral and bilateral donors, many African countries have developed a follow-up framework including gender-disaggregated education indicators. Morocco and Senegal, for example, have gone further by adopting gender-budgeting mechanisms. The focus on girl's education has also been strengthened by the non-State organizations that have contributed to developing and disseminating best practices in removing the traditional and social barriers to girls' education and institutionalizing gender-equitable practices and policies both at the national and regional levels.

From 1990 to 2008, in Zambia, the ratio of girls to boys in primary school enrolment increased from 0.90 to 0.97 due in part to the Government's Programme for Advancement of Girls' Education, introduced in 1994.The programme has focused on policy development, capacity-building, gender sensitization, material development and research. In addition, it has introduced single-sex classes, strengthened parent-teacher associations, increased the number of women in educational management, introduced girl-friendly curricula, provided education grants for vulnerable children, and launched advocacy programmes at the community level for girls' education. Despite these efforts, boys are more likely than girls to remain enrolled in school (Mumba, 2002; Ministry of Finance and National Planning and UNDP, 2011).

Improving household incomes contributes to gender parity in education

Studies have shown that household income and wealth are important in explaining gender parity in primary education. The Gender Parity Index is higher among high-income groups, and lower among children from low-income groups. Thus, females from higher income households are more likely to attend school than those from lower income households. Commitment to education such as the proportion of the national budget devoted to education at all levels and the number of years of compulsory education are also important drivers (ECA et al., 2012; UNSD, 2010).

Empowering women economically

Kenya's innovative approach to women's empowerment through the Table banking initiative has generated notable success. Launched by the non-governmental organization (NGO) Joyful Women in 2009, the initiative is a revolving fund for women's groups. Minimum savings deposits of $2 provide a revolving fund of short- and long-term loans for business ventures. From an initial number of 17 women's groups with a $750 fund, the group has grown to over 12,000 groups with a revolving fund of $17.5 million. The group has raised $1.2 million for on-lending and paid out $1million in bonuses and dividends. As a result of its activities, the average incomes of participating women increased from $20 to $2,000 per month.

Joyful Women is also training women to take advantage of the Kenya's affirmative action legislation, which sets aside 30 per cent of all government procurement projects for women and people with disabilities. In total, this amounts to approximately $2.4 billion in potential resources for women entrepreneurs. To date, the group has trained 2,000 women in public procurement. As a result, more than 500 women businesses have been recorded, and over 50 of the registered businesses have won procurement tenders.[9]

Policy reforms and affirmative action promote political empowerment

The introduction of legislated quotas and voluntary quota systems has been instrumental in boosting the representation of women in national parliaments and political parties. Mauritania, for example, mandated a minimum quota of 20 per cent women's representation in municipal and

9 See www.joywo.org

legislative bodies in an Act promulgated in July 2006. Subsequently, the proportion of seats held by women in the national parliament reached 18 per cent in 2007, from no seats in 1992 and 4 per cent in 2003. The most significant progress was at the local level. In the 2007 municipal council elections, 1,120 out of 3,688 seats were held by women (around 30 per cent, against 18 per cent of national parliamentary seats).

Uganda has made a legal provision for 69 women representatives in the national parliament – around 22 per cent of the total (Electoral Commission, 2006). Recent gains in Egypt and Mauritania can also be attributed to legal provisions. Similarly, affirmative actions and explicit constitutional provisions for dealing with gender-based discrimination have advanced women's positions in Ethiopia, Mozambique, Rwanda, South Africa and the United Republic of Tanzania.

Notwithstanding the progress in representation, much remains to be done to ensure that women leverage their representation to advocate for issues that advance gender equality and women's empowerment. Affirmative action should be viewed as a means to achieve gender equality and women's empowerment, not an end. To link gender equality to sustained development, Africa should go beyond participation to capacity-building. The latter can be achieved through training and advocacy on how women can enhance their leadership role and contribute fully to public debate and policy decisions.

Health

The main adversaries of child survival are preventable and treatable. Most child deaths in low-income countries are primarily the result of diarrhoea, pneumonia, measles, malaria, HIV/AIDS, undernutrition, asphyxia, preterm delivery, sepsis, and tetanus for deaths among neonates (WHO, 2014a). Globally, in 2013, approximately 45 per cent of deaths of children under five occurred during the first month of life. Risk factors of neonatal mortality include unsafe and unhygienic delivery environments, delays in seeking skilled medical care, home deliveries, poor antenatal surveillance and poor postnatal care, and complex ancestral traditions. Improving quality and access to primary health care throughout pregnancy, birth, and neonatal periods greatly enhances neonatal survival; women's education and other educational campaigns are also important as is health insurance.

Scaling up high-impact interventions

Scaling up of cost-effective, high impact interventions and best practices in service delivery mechanisms is crucial to reduce preventable child deaths. High-impact interventions that can significantly reduce preventable maternal, neonatal and child deaths have already been identified. These interventions increase maternal, newborn and child survival by addressing the main causes of maternal, newborn and child mortality, are suitable for implementation in low- and middle-income countries, and can be delivered from the community up to the first referral level of health service delivery systems. However, the level of coverage and quality of these interventions in many African countries leaves much to be desired. Inadequate financing, weak health systems and inadequate mobilization of communities are among the key factors contributing to low coverage. Countries that have reduced their under-five mortality rate have prioritized these interventions and adopted health systems strategies that enhance the coverage and quality of these services.

Investing in health-care workers

Improving the skills of health workers in delivering high-impact interventions is fundamental to improving child survival. Ethiopia's Health Extension Programme and integrated Community Case Management programme, and the Health Development Army have been critical for successful community-based newborn care (Pearson et al., 2014). The impact of such initiatives is further strengthened through investments in training. A report from Ethiopia indicated that health extension workers that have been provided with adequate training have performed better on provision of integrated community case management of childhood illnesses (Pearson et al., 2014).

Socioeconomic status influences health outcomes

Levels of education and income are important determinants of health. Studies show that child mortality trends have been worse for children born to women who do not have basic education and are in the low socioeconomic class. Some studies have shown that in Africa excluding North Africa, higher per capita incomes and improved maternal education have been associated 0.9 million and 2.2 million fewer child deaths, respectively. Hence, promoting and securing women's economic empowerment and maternal well-being are a critical and integrated component of addressing child survival.

Improving maternal health

Although the decline in the maternal mortality ratio between 1990 and 2015 has been relatively slow, several African countries have made significant progress in reducing maternal deaths. Almost all African countries have experienced some reduction in maternal deaths.

Key to the progress achieved are interventions that target the main causes of death and the most vulnerable newborn babies and children. Some of the primary causes of maternal deaths are haemorrhage, sepsis, hypertensive disorders, unsafe abortion and prolonged or obstructed labour. These complications can often be avoided with a health system that provides skilled personnel and facilities to handle emergencies and post-partum care. Thus, access to and use of health services focused on childbearing is vital (UNSD, 2010; ECA et al., 2012). Progress has also been associated with leadership, partnerships, evidence-based data, innovations, development of dual short- and long-term strategies, as well as the adaptation to change for sustained progress (WHO, 2013).

Enhancing access to skilled health-care workers, particularly for rural dwellers

North Africa has made significant progress in reducing the maternal mortality ratio by strengthening access to professional health workers. Most births in this subregion are attended by professional health workers. In Egypt, in 2002, skilled personnel attended 61 per cent of all births, leading to a 50 per cent decline in all maternal deaths in only eight years. In stark contrast, in Africa excluding North Africa, only about 50 per cent of all births are attended by health workers, although exceptions are found in Botswana, Cabo Verde, and Mauritius. From 1990 to2013, Ethiopia reduced its maternal mortality ratio from 1,400 to 420 deaths per 100,000 live births, by using low-cost impact interventions through the deployment of the Health Extension Programme, especially in rural areas (ECA et al., 2014). The programme has succeeded in bringing services closer to the people, particularly rural dwellers who historically have had challenges in accessing health services and who live in areas where the maternal mortality ratio is highest.

Rwanda significantly reduced maternal deaths by increasing access to the services of professional health workers. In 1995, following the 1994 genocide and years of conflict, Rwanda had an extremely high maternal mortality ratio of 1,400 deaths per 100,000 live births, then the highest in Africa. Less than one third of births were attended by a skilled health worker, only 13.7 per cent of women used contraceptives; and just 10 per cent of women had the recommended four antenatal visits. The Government deployed community health workers and volunteers to address immediate and urgent health needs of women. Furthermore, there was huge investment in the continuous development and training of a professional health workforce within and outside the country. The Ministry of Health in Rwanda institutionalized maternal audits to identify better when, where and how maternal deaths occurred throughout the country. To further address maternal health challenges, the Government launched the Rapid Short Message Services initiative in 2010. The service trains health providers to track expectant mothers and to provide antenatal care and delivery advice via short message service. Between March and May 2010, 432 community health workers were trained in using the service, and 14,000 pregnancies were tracked. During the period, they reported 583 births, 115 pregnancy-related risks, and no maternal or child deaths. This service also increased the share of women receiving antenatal visits: since the launch of the programme, nearly 100 per cent of Rwandan

women have attended at least one antenatal care visit, and the proportion who have attended at least four visits has more than doubled since 1995.

Reducing financial barriers to health services

A number of countries including Burundi, Ghana and Sierra Leone have abolished user fees in the provision of maternal health-care services while many others are providing subsidies and protection schemes in a bid to improve maternal health. (ECA et al., 2011).

Nigeria's Conditional Grant Scheme is considered a success story in the fight against maternal deaths. The Government of Nigeria introduced the Conditional Grant Scheme in 2007 to help scale up progress on the MDGs by supporting over 100,000 pro-poor high impact projects in states and local governments. This involved the construction of 6,005 health facilities; the provision of 152,164 pieces of health equipment; rehabilitation of 89 health institutions; and recruitment of 75,103 health workers. The result was a dramatic decline, from 1990 to 2013, in the maternal mortality ratio from 1,200 to 560 deaths per 100,000 live births (ECA et al., 2014).

The rapid-roll-out of anti-retroviral therapy in the past few years has brought about a significant reduction in mortality, particularly maternal deaths, owing to their links with HIV/AIDS. A 2013 UNAIDS report indicated that in at least 10 countries, 80 per cent or more of adults including pregnant women are eligible for anti-retroviral therapy: Botswana, Cabo Verde, Eritrea, Kenya, Namibia, Rwanda, South Africa, Swaziland, Zambia and Zimbabwe (UNAIDS, 2013a).

Breaking down cultural barriers

Even when health-care services are available, access is often constrained by patriarchal cultural practices. However, some countries have been able to overcome such barriers through innovative approaches. The Niger's Ecole des Maris (School for Husbands) initiative has been successful in transforming men into allies in promoting women's reproductive health, family planning and behavioural change towards gender equality. The project is anchored by a spirit of volunteerism and community participation involving health authorities, health agents, national NGOs and married men from local communities (25 years or older). These schools meet twice a month to discuss and analyse specific challenges related to reproductive health in the community, propose solutions and raise awareness on the issues. In 2011, a total of 131 schools were operational in Zinder and 46 schools were operational in Maradi region. The initiative has engendered political and financial commitment as well as country ownership resulting in fiscal allocations for the procurement of reproductive health commodities. Husbands have obtained a better understanding of women's reproductive health, which has consequently contributed to putting an end to certain cultural taboos and misconceptions about reproductive health. Furthermore, the Governments of Burkina Faso and Guinea have expressed interest in replicating the programme to encourage demand for family planning services (UNFPA, 2012).

Regional initiatives

Although, it is difficult to measure the impact of global and African initiatives on improving maternal health, clearly, the reduction in maternal deaths in Africa is attributable in part to programmes including the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CAARMA), launched by the African Union and partners in 2009. By 2011, 26 African countries implemented the programme at the national level and instituted follow-up mechanisms to minimize maternal deaths. In line with the CAARMA initiative, six African countries allocated a minimum of 15 per cent of their budget to fast-track health-related MDGs by the end of 2010 in accordance with the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

HIV/AIDS

There are approximately 24.9 million people living with HIV in Africa, of whom only 125,000 are located in North Africa. The others are distributed across the four other geographical subregions, with Nigeria and South Africa alone accounting for up to 38.4 per cent. The bulk of people living with HIV in Africa excluding North Africa are concentrated in 10 countries, namely Ethiopia, Kenya,

Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. These countries together account for 81 per cent of all people living with HIV in the region.

Botswana, a country with a historically high HIV prevalence rate, has had a successful programme for the prevention of mother-to-child transmission of HIV. By September 2009, over 90 per cent of HIV-infected pregnant women had benefitted from services under the programme. Mother-to-child transmission of HIV had been reduced from 20 to 40 per cent in 2001 to around 4 per cent during the period 2008-2009. The Government plans to ensure access to highly active antiretroviral therapy for all pregnant women infected with HIV, which should reduce mother-to-child transmission further, to under 1 per cent (UNSD, 2010).

Recent innovations in HIV/AIDS testing adopted by African countries are contributing to more effective treatment regimes. CD4 cells are a type of white blood cell that identifies and destroys harmful bacteria and viruses. Together with other tests, a CD4 count helps to indicate the strength of our immune system and to identify and treat HIV patients. According to new WHO guidelines, a person with HIV becomes eligible to begin life-saving highly active antiretroviral therapy when his/her CD4 count falls below 500. Several countries in Africa are already rolling out these guidelines. Malawi has made the most advances of any country by enhancing access to CD4 testing through investments in the relevant testing equipment. The country is currently using a CD4 threshold of 350 for diagnosis. The lower range of CD4 cell counts reflects the fact that HIV-negative populations in Malawi have CD4 counts considerably lower than their European reference range (Crampin et al, 2011).

In general, engaging men in the fight against HIV has proven a winning strategy. Voluntary medical male circumcision has the potential of reducing the risk of acquiring HIV among men by 66 per cent (UNAIDS, 2014). In addition, when men know their HIV status, they are more likely to appropriately resort to prevention and seek treatment. Sex workers, homosexuals and people who inject drugs also need to be followed closely as the level of infection is particularly high among them.

In general, relentless advocacy and partnerships have placed HIV/AIDS high on the development agenda and helped to address stigma and mobilize substantial resources to address the scourge of the disease.

Malaria

The WHO made recommendations of pertinent interventions that have proven effective in controlling, and some cases, eliminating malaria in countries across the world. They include: vector control, which reduces malaria transmission from humans to mosquitoes and back to humans; use of insecticide-treated nets; indoor residual spraying; chemoprevention; and case management, which includes diagnosis and treatment of infections. Indeed, all countries that were successful in controlling malaria have done so by employing one of the above interventions, but in most cases, a combination of them.

Rwanda's entire population was once at risk of malaria, but is now one of Africa's success stories in combating malaria. The country initially adopted two major strategies –a preventive one (promoting the use of insecticide-treated nets) and a curative one (providing early diagnosis and timely treatment with a combination of amodiaquine and sulfadoxine/pyrimethamine). The preventive strategy focused on vulnerable groups such as pregnant women and children under five, and yielded faster results compared to the curative strategy, in part because of widespread resistance to the drugs that were older first-line antimalarials. Rwanda then changed the drugs used in treatment of malaria, and in 2005, artemisinin-based combination therapy was made the country's official first-line antimalarial drug.

Strengthening health systems

Furthermore, the Rwandan Government, with the support of multiple donors, went beyond these two strategies and engaged in strengthening the health system as a way to ensure success of these interventions. The Global Fund, for exam-

ple, approved a grant of $33.9 million to finance the strengthening of the country's health system in 2005. As a result, more than 100 health-care administrators were trained in health financing and management for health information systems, the quality of health care provided in health centres improved, and the cost of health services declined (World Bank, 2010). Within four years, more people were seeking treatment in health facilities, as evidenced by a 10 per cent increase in the use of health centres and a 16.8 per cent increase in use of district hospitals (Malaria Free Future, 2008). Additionally, from 2006 to 2008, the number of people infected by malaria fell from 1.5 million people to 800,000, and the malaria mortality rate decreased from 41 to 16 per cent. Rwanda has reduced malaria incidence by more than 75 per cent (WHO, 2014b).

In Zambia, the Ministry of Health identified malaria control as one of its main public health priorities and included it in both the National Development Plan (2006-2010) and the National Health Strategic Plan (2006-2010). It developed a detailed National Malaria Strategic Plan, whose objective was to reduce the malaria burden significantly and achieve a malaria-free Zambia. The focus was on scaling up malaria control interventions and supporting broader improvements in health systems, such as decentralizing budgeting and planning, capacity-building throughout the supply chain for procurement, and forecasting of commodities, among others. By 2008, malaria deaths had fallen by more than 40 per cent, prevalence by more than 50 per cent, and prevalence in children under five from 22 per cent to 10.2 per cent (Government of Zambia, 2008). However, a delay in external financing between June 2009 and December 2010 slowed down the implementation of malaria control interventions, which led to a loss in the gains that had already been made in parts of the country. Between 2008 and 2010, malaria resurged, especially in rural areas and among the poorest populations who could not afford mosquito nets (Government of Zambia, 2010). Zambia was able to regain success by improving access to artemisinin-based combination therapy, one of the most effective interventions for malaria treatment. It also provided life-saving malaria medicines to health centres in selected districts. Nevertheless, the volatility in aid reinforces the call for more sustainable financing mechanisms to fund development programmes.

Involving local communities

In northern Ethiopia, the pioneer community health programme in the Tigray region started in 1992 and over a period of eight years, contributed to a 40 per cent reduction in death rates among children under five, most of whom would have died from malaria (WHO et al., 2000). The scheme used village networks of community health volunteers including traditional birth attendants and mothers to provide health and malaria education. This contributed to: improving the identification and home treatment of malaria; supervising and ensuring regular supply of preventive malaria drugs for pregnant women; and organizing vector control activities such as insecticide spraying and environmental management to destroy and prevent the increase of mosquito breeding sites. The scheme focused on women and children who were most at risk of malaria infections and deaths. Mothers were recruited to teach other mothers how to treat malaria at home, ensuring availability of malaria drugs before the disease became severe, particularly in children under five. In Western Tigray, a community financing scheme was established to supply insecticide-treated nets for use by returnees and demobilized soldiers in resettlement areas with high rates of malaria. The communities involved agreed on financing and management responsibilities for the sale of imported bednets and insecticide for re-treatment.

Integrated approaches

Mauritius, a country with relatively high transmission potential, has nevertheless been successful in eliminating malaria and preventing its reintroduction. Financed almost entirely from domestic resources, the programme requires residents to participate in environmental management and vector control, resulting in high coverage of populations at risk with effective interventions. Entomological surveillance and geographical reconnaissance with detailed hand-drawn maps were used extensively to identify transmission foci and

provide information for interventions. Mauritius's unique passenger screening programme closely tracks people arriving from malaria-endemic countries to reduce the risk of cross-border transmission of the disease (Government of Mauritius and WHO, 2012).

Swaziland has also made remarkable progress in reducing malaria incidence by over 75 per cent between 2000 and 2012, and also by significantly reducing malaria-related death rates. Malaria control and prevention efforts were intensified in Swaziland in 2000 in a bid to achieve the Abuja target of halving malaria mortality and morbidity by 2010; the 2003-2007 Strategic Plan to reduce malaria morbidity and mortality was developed for this purpose. The interventions included: high coverage of indoor residual spraying in most at-risk areas; use of insecticide-treated nets, especially among vulnerable groups; improving health facility surveillance; and information sharing and awareness-raising activities.

Swaziland developed the Malaria Elimination Strategic Plan (2008-2015) with the aim of reducing local malaria cases to 0 per 1,000 of the population by 2015. Previously used interventions were scaled up and four key areas of intervention were identified for the elimination strategy: integrated vector management; surveillance; case management; and information, education and communication on malaria-related issues. As a result of these efforts, at least 53 per cent of the at-risk population has been protected through spraying and use of treated nets; all malaria cases are now treated with artemisinin-based combination therapy; in one year alone (2011 to 2012), confirmed cases decreased by 42 per cent; and between 2000 and 2012, approximately 33,000 cases were averted.

The above experiences show that there are indeed effective interventions for malaria prevention and treatment, and even more importantly, that these interventions are cost-effective and affordable. However, political commitment is imperative for initiating and implementing the intervention. A key lesson is that an integrated approach encompassing the strengthening of the health system and improvements in socioeconomic development is required to address the malaria challenge. Poverty, low levels of education and rural dwelling are major impediments to intervention coverage since they undermine access to insecticide-treated nets, diagnostic testing and artemisinin-based combination therapy.

Ethiopia's experience highlights the importance of community involvement and commitment for the success of malaria-related interventions. It also showcases the importance of targeting the most at risk populations for good results. There is also a need for sufficient and timely funding to sustain and protect the gains made in malaria control. In this context, Zambia's experience shows how easily funding gaps and delays, however short, can derail malaria control efforts.

Tuberculosis

Over the years, numerous initiatives have been developed to address tuberculosis. The Directly Observed Treatment Shortcourse (DOTS) is one of the most widely advocated and used strategies that was developed and proved to be a low-cost effective strategy for the detection and treatment of tuberculosis through which millions of tuberculosis deaths could be prevented. It is a five-pronged strategy for tuberculosis control that involves: government commitment to sustained tuberculosis control; detection of tuberculosis cases through sputum smear microscopy among symptomatic people; regular and uninterrupted supply of high-quality tuberculosis drugs; six to eight months of regularly supervised treatment; and reporting systems to monitor treatment progress and programme performance. DOTS achieved great success initially; the average global treatment success rate under DOTS was almost 80 per cent in 1997.

China had the world's largest DOTS programme in the 1990s and achieved massive success, serving more than 700 million people and preventing approximately 50 per cent of all tuberculosis deaths in areas covered by the programme. In the first seven years of operation, about 30,000 lives were saved annually and more than 90 per cent of patients were cured under the DOTS pro-

gramme (WHO et al., 2000). Pilot projects were launched in 1991, in which expensive and usually ineffective hospital-based treatment was abandoned and replaced by the DOTS programme, which provided tuberculosis care and treatment at the village level through the supervised use of a combination of four inexpensive drugs. Drugs were obtained on the international market at competitive prices of about $20 for a six-month course of drugs, supplies were centralized, and diagnosis and treatment were free for patients. Village health workers gave a bonus for every tuberculosis case identified and every patient who was cured. This served as an incentive for people to seek treatment. The health workers were responsible for: storing the drug; monitoring every patient to ensure they took the correct dose of drugs at the right time; and organizing periodic sputum checks in a laboratory to monitor progress and validate eventual cure. As a result, DOTS had a 94 per cent cure rate in the pilot provinces and was consequently expanded to cover 13 of China's 31 provinces in 1992 (WHO et al., 2000).

Cambodia also achieved success in halving the incidence of tuberculosis and meeting global targets for tuberculosis detection and treatment by providing universal access to tuberculosis care through primary health centres. Following years of conflict and economic hardship, Cambodia's health system was destroyed, and it had one of the highest tuberculosis infection rates in the world. In 1993, Cambodia re-launched its national tuberculosis programme, adopting the DOTS strategy, and by the late 1990s, had decentralized health services for the communities. This changed the way tuberculosis services were delivered. Cambodia has transformed its tuberculosis programme from a hospital-based system to one with free, universal access to tuberculosis care at the grassroots level. In tandem, health system reforms helped to expand access to primary health care. Community-based health centres providing free, DOTS-based tuberculosis services surged from 60 in 2000 to more than 1,000 in 2005, and the number of health workers trained in tuberculosis care and control increased from 800 to 2,500 (WHO, 2012a).

Evidence-based tuberculosis policy and planning were helpful in Cambodia's policy formulation and planning. A 2002 survey showed that Cambodia had one of the highest tuberculosis prevalence rates (more than 1,500 cases per 100,000 people) in the world. The results of this survey helped to define the tuberculosis problem, map out local conditions, guide resource allocation and attract international attention. Such surveys further facilitated knowledge generation and training of so-called "DOTS watchers" at the village level, who helped in early detection of tuberculosis to enable effective treatment at home, with local support and reduced spread of infection. By 2005, Cambodia had achieved the global tuberculosis targets of a 70 per cent case detection rate and an 85 per cent treatment success under DOTS; between 2002 and 2011, tuberculosis prevalence had fallen from more than 1,500 cases to 820 cases per 100,000 people, a reduction of 45 per cent (WHO, 2012a).

These experiences underscore the importance of evidence-based policies and planning, government leadership and strong technical expertise for successful implementation and results. They also highlight the important role of DOTS in promoting effective interventions for tuberculosis control

Lessons in environmental sustainability

Africa is making good progress in limiting carbon dioxide emissions and ozone-depleting substances; by 2012 at least 32 countries had protected 10 per cent or more of their terrestrial and marine areas. However, as more African countries industrialize, carbon dioxide emissions will likely increase. One challenge to Africa's industrialization efforts is that under the United Nations Framework Convention on Climate Change, current and future international obligations on climate change mitigation and adaptation could impose constraints on how Africa can industrialize. As the international community accelerates plans for cutting greenhouse gas emissions, African industries might need to comply with environmental standards and laws at national and international levels.

Investing in renewable energy

African governments should invest heavily in promoting the efficient production and use of energy sources over which they have a comparative advantage. The Government of Seychelles has recently geared up its efforts to promote renewable energy through investments in wind turbines and solar water heaters. These activities have been supported and encouraged by the National Energy Act (ECA et al., 2013). Cabo Verde, the Gambia, Rwanda and Tunisia have launched reforestation programmes.

Intensifying reforestation efforts

In Cabo Verde, the proportion of forested area climbed by 6.7 percentage points to 21.1 during the 1990-2010 period. The Great Green Wall of the Sahara and Sahel is another initiative conceived as a set of cross-sectoral actions and interventions aimed at conserving the natural resources, securing economic development and, particularly, reducing poverty. The declining trend cannot be significantly reversed, however, unless these actions are supported by strong forestry institutions, policies and regulatory frameworks combined with adequate human resources and accompanying effective monitoring systems.

Malawi has had some success in addressing deforestation. A project run by RIPPLE Africa in Malawi provides a sustainable source of timber by planting fast-growing, exotic trees, conserving indigenous trees by decreasing the demand for wood from Malawi's natural forests, and restoring degraded land by planting indigenous trees where appropriate. Since its launch in 2006, the project has helped over 175 community groups to plant more than 3 million trees in the Nkhata Bay District. The programme provides a long-term solution to deforestation by planting thousands of quick growing exotic trees in community woodlots that provide a sustainable source of timber for local people. These trees provide an immediate benefit to the community who use them like a crop; coppicing the trees (i.e. cutting off the branches for firewood without felling the whole tree), which then grow back quickly to provide more wood. This eases the heavy pressure on the indigenous forests and helps change the way people in Malawi think about their natural resources[10] (RIPPLE Africa).

Water and sanitation

Progress on access to safe drinking water in the continent has been steady; however, many countries are experiencing water stress, which is likely to be exacerbated by climate change. As water use for irrigation and other agricultural purposes continues to increase, countries will need to introduce more efficient water management systems. Some countries have achieved interesting results in this area (ECA et al., 2013). For example, Ghana has rehabilitated its infrastructure, expanding and building new elements to meet current and growing demand with funding from government and development partners. These investments are enhancing access to urban, rural and small town water supplies and improving irrigation facilities for more than 2,400 peasant farmers.

Mozambique has also given high priority to water-related infrastructure development by financing large schemes for rainwater harvesting in order to minimize the severity of droughts. In Benin, many boreholes, hand-dug wells and piped systems were built for rural and small towns' water supply, and as a result, the average coverage of drinking water in rural areas increased from 39 per cent in 2004 to 57 per cent in 2010.

With respect to sanitation, Ethiopia's efforts have led to a decrease in the practice of open defecation from 82 per cent in 1990 to 34 per cent in 2012. The key to success was advocacy aimed at encouraging communities to stop open defecation and investments in the construction of sanitation facilities. The result was a remarkably steep decline in open defecation and steady progress in sanitation coverage across all 11 states of Ethiopia, despite wide variations in wealth, ethnicity and other socio-economic characteristics (WHO and UNICEF, 2014).Benin was also able to reduce open defecation from 80 per cent to 54 per cent during the same period.

10 www.rippleafrica.org/environment-projects-in-malawi-africa/tree-planting-africa

Advocacy targeted at local communities

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Conclusions

The MDGs have helped African countries to made tremendous efforts towards poverty and social sectors. Even if African countries will not meet all the MDGs because of challenging initial conditions, this should not overshadow the progress made in devising innovative solutions to some of their pressing development challenges. In poverty and social development, progress has been underpinned by rapid growth and investments in social and economic infrastructure, greater involvement of local communities in service delivery, and policy reforms aimed at reducing financial and cultural barriers to access to social services. Girls and women have been empowered through affirmative action programmes, and by addressing cultural biases and investing in gender-appropriate infrastructure.

Country experiences suggest that, while vertical interventions have contributed to the advancement of health goals, more integrated approaches that strengthen health systems and improve the socioeconomic contexts of households yield more enduring health outcomes; taking into account cultural rigidities is also important.

Strengthening governance systems through rigorous monitoring mechanisms for results and budget tracking are critical. The availability of data on pupils' enrolment, completion, learning achievement and other budget- and results related-information is also critical. The experiences underline the importance of addressing data gaps at the national and regional levels to ensure effective follow-up.

Reforestation and rain harvesting interventions have helped to reduce the rate of deforestation and improve access to improved water sources. Despite limited progress on sanitation, advocacy and awareness raising have generated progress in this area.

Moving forward, countries will benefit from continued support to develop home-grown solutions to development challenges.

Section III:

Conclusions and policy perspectives

The MDG report 2015 marks the 10th edition of the series that began in 2005, when the African Union Assembly of Heads of State mandated the AUC, ECA and AfDB to monitor the progress in Africa towards the MDGs. UNDP-RBA joined these organizations later on. This year's report also represents the final year of implementation of the MDGs.

Overall progress on the MDGs

At this turning point, the MDG report 2015 can be seen as a broad baseline informing on where the continent stands on the eve of the new development agenda. Although more efforts need to be made, the detailed review of the eight goals has highlighted that Africa has achieved great progress across the board. Thus, Africa is on track in attaining almost three out of the eight MDGs – MDG 2 (Achieve universal primary education), MDG 3 (Promote gender equality and empower women) and the targets related to MDG 6 (Combat HIV/AIDS, malaria and other diseases).

Recommendations based on some overarching and thematic lessons learned from the MDGs process

Producing MDG reports for 10 years now has generated a wealth of knowledge that needs to be tapped into in order to be well prepared for the process of inclusive structural transformation and prosperity for all in Africa. For this reason, the thematic focus of this year's MDG report is on the lessons learned after over a decade of experiences in pursuing the MDGs in Africa. The overall rela-

AFRICA'S MDG PERFORMANCE AT A GLANCE

Goals	Status	Remarks
Goal 1: Eradicate extreme poverty and hunger	Off track	• Poverty in Africa excluding North Africa declined from 56.5% in 1990 to 48.4% in 2010, and in North Africa from 5% to1%. • Poverty is perpetuated by rising inequalities, unemployment, the youth bulge, unplanned urbanization, lack of diversification, etc. • Hunger declined by 8% in Africa excluding North Africa between 1990 and 2013. • Africa excluding North Africa is the most food-deficient of all regions of the world, with 25% of its population facing hunger and malnutrition in 2011-2013.
Goal 2: Achieve universal primary education	On track	• In 2012, over 68% of African countries had a net enrolment rate of at least 75% in primary education. • Average primary completion rate stands at 67%. • The youth literacy rate reached 69.61% in 2012, in part owing to increased access to universal primary education.

Goals	Status	Remarks
Goal 3: Promote gender equality and empower women	On track (GPI in primary education and seats held by women in national parliaments)	• GPI in primary education increased from 0.82 to 0.96 in North Africa and from 0.83 to 0.92 in Africa excluding North Africa between 1990 and 2012. • Gender barriers manifest themselves in low transition rates between education levels and into employment and at higher educational levels owing to pregnancy and other barriers. • Africa has made the most progress in increasing the number of seats held by women in national parliaments, with an average increase of 15% between 2000 and 2014.
Goal 4: Reduce child mortality	Off track	• Under-five mortality rate fell by 55% between 1990 and 2012, while the infant mortality rate fell by 40%. • Only Egypt, Liberia, Malawi and Tunisia have achieved both targets on reducing child mortality.
Goal 5: Improve maternal health	Off track	• By 2013, Africa had 289 maternal deaths per 100,000 live births, compared to the world average of 210 maternal deaths per 100,000 live births.
Goal 6: Combat HIV/AIDS, malaria and other diseases	On track	• A downward trend is observed in the incidence, prevalence and death rates associated with HIV/AIDS, malaria and tuberculosis, especially since 2000.
Goal 7: Ensure environmental sustainability	Off track	• Declining forest cover in Africa. • Consumption of ozone-depleting substances declined by 94% between 1986 and 2012. • Increasing proportion of terrestrial and marine areas protected. • In 2012, only 64% of the population in Africa excluding North Africa used an improved drinking water source. • The proportion of people with access to improved sanitation between 1990 and 2012 increased only moderately in Africa excluding North Africa (from 24% to 30%), compared to North Africa (from 72% to 91%).

tively low progress made on the MDGs, together with the overarching and theme specific lessons learned throughout their implementation process suggest a number of recommendations:

Effective communication and follow-up is critical for the success of global agendas

Countries and pan-African organizations need to continue efforts and commitment towards effective communication on progress registered in achieving internationally agreed goals. In particular, they need to pursue the production of national and regional progress reports for the successor to the MDGs. Indeed, experience shows that national MDG reports helped mobilize civil society organizations and other stakeholders to put pressure on governments to intensify efforts and devote resources towards achieving agreed goals, while regional reports such as the MDG report for Africa permitted cross-country comparison, peer-learning and emulation.

Address the root causes rather than the symptoms of underdevelopment.

Countries and their development partners including donors need to adopt an integrated approach to development and put emphasis on the root causes rather than the symptoms of underdevelopment. The recent Ebola outbreak in West Africa provides a good illustration. The crisis shed light

on the fragility of health systems demonstrating that all the efforts in the fight against HIV, malaria and tuberculosis through MDG 6 did not contribute enough to the establishment of strong health systems. With the Ebola outbreak, the health systems of the three most affected countries almost collapsed, to the extent of jeopardizing progress made in several areas, including the diseases concerned by MDG 6.

Exploiting inter-sectoral synergies to maximize impact

For benefits and efficiency, countries should strive and leverage inter-sectoral synergies in the implementation of development objectives. This will be even more necessary in the post-MDG era with the three dimensions of sustainable development, namely economic, social and environmental. This will be achieved through improved technical capacities in development planning and result based management, which will require appropriate studies and analyses identifying interrelations among the different objectives together with the interventions and measures that are likely to maximize positive impacts.

Invest in data collection and analysis

Monitoring and evaluation has proven key to advance development agendas by detecting problems in the implementation process and proposing adequate corrective actions. To take full advantage of the monitoring and evaluation (M&E) function, countries and donors need to invest in data collection and analysis, with particular emphasis on generating disaggregated data for key social groups.

Reduce poverty, inequality and unemployment through inclusive and sustained growth

To achieve inclusive and sustained growth African countries need to structurally transform their economies including through value addition and commodity-based industrialization where feasible. This will require investing in people, promoting rural development, enhancing agricultural productivity, prioritizing social protection, improving access to energy, markets and credit banking, and supporting small- and medium-sized enterprises.

Countries need to explore job creation opportunities by, inter alia, increasing labour productivity; providing employment subsidies to firms willing to hire the unemployed and young people with relevant qualifications; and providing tax incentives to employers able to create and safeguard jobs. A focus on agriculture could also be a winning strategy, as re-activating or upgrading farm settlements for agricultural production and processing has created jobs for thousands of young people, for instance, in Nigeria.

Inclusiveness, economic growth and structural transformation are mutually reinforcing. Countries need to define transformative agendas that promote all these objectives in a well-articulated manner.

There is also a need to strengthen resilience to external and internal shocks such as those associated with international prices and the recent Ebola outbreak in West Africa because these shocks almost always reverse development gains. In this regard it is recommended that countries, particularly those that are natural resources-rich, develop fiscal buffers to respond to shocks.

Enhance social development

There is a need to redouble efforts in social development in African order to increase its productive capacity and generate the quantity of wealth required to bring about prosperity for all. In the area of education, countries need to focus on quality together with improving access. They also need to promote higher levels of education while sustaining the achievements in primary education and implementing preschool programmes that develop innovative behaviours. Vocational training must be promoted to ensure a good matching of skills with the labour requirements of Africa's structural transformation and industrialization agenda. In this respect, investments in education infrastructure, curricula and qualified teachers will be vital.

Empowering local communities to run their own schools may boost enrolment, particularly in poor communities; countries should foster it. Education policy reforms that reduce financial and cultural

barriers to education, enforce compulsory primary education, and prioritize early childhood development are recommended to spur enrolment. Examples of such reforms include cash transfers to poor families and the launch of girl-friendly schools; abolishing school fees; enshrining compulsory education in the constitution and establishing educational policies and programmes to enforce compulsory primary education.

In the area of health, scaling up of cost-effective, high-impact interventions and best practices in service delivery mechanisms is crucial to reduce child and maternal mortality and sustain progress in HIV, malaria and tuberculosis, and all other diseases.

Non-communicable diseases are becoming a growing concern in the continent; this situation calls for a special attention. Countries should make greater efforts in financing health systems adequately, and mobilizing communities better in view of enhancing the coverage of health services. It is also paramount to invest in skilled health-care workers and in removing the barriers to health-care services, including financial and physical ones. Specific measures in connection to this include the abolishment of user fees in the provision of some health-care services, notably those targeting maternal and child health. The provision of subsidies and protection schemes in a bid to improve health for such targets is also advisable. As regards HIV, malaria and tuberculosis, countries are encouraged to pursue the adoption of WHO recommended programmes, which have proven highly effective in curbing this disease. More specifically the use of condoms and antiretroviral therapy are advised for HIV, insecticide-treated nets and artemisinin-based combination therapy for malaria, and DOTs for tuberculosis.

The Ebola crisis has underscored the fragility of health systems and the harsh consequences that such a situation may have on income, jobs and livelihoods of households and on the fiscal position of a country as a whole. This experience calls for major efforts from countries and their development partners to establish solid health systems along with adequate infrastructures to improve access to health-care facilities. These medium-term development objectives should be clearly integrated into national development planning frameworks for them to be given adequate priority.

Women's empowerment is central to the achievement of many other social development goals, notably in the areas of poverty, inequality, hunger, employment, education, and health. Hence countries should promote gender informed policy interventions such as stipends, conditional cash transfer to enhance parity in education together with quotas and reserved seats measures to increase representation in the political sphere. Countries should also take bold steps to remove structural and cultural impediments hindering women's economic and social opportunities through limited access to and control over productive resources.

Access to energy, safe drinking water and sanitation, and improved dwellings and settlements are also crucial elements that countries need to pay greater attention to for an enhanced social development and an optimal contribution of human resources to production and consumption. Measures recommended in these areas include rehabilitating, expanding and building water, sanitation and housing infrastructures to meet current and growing demand with funding from government, development partners and the private sector.

In order to enhance socioeconomic development prospects, African countries should devote all efforts to the preservation of their natural asset such as forests, oceans and marine resources, and promote environmental-friendly development strategies.

Promote diversification as a major strategy to improve productive capacities and improve global partnership prospects

African countries must be proactive in responding to development challenges that prevent them from fully taking advantage of global partnership opportunities. In this respect diversification of their economies is identified as a priority in view of removing the supply-side constraints and

improving their production capacities. Effective diversification requires the prudent economic management of natural resources. Well-defined economic reform programmes targeting macroeconomic stability and long-term growth through export-led industrialization may help promote export diversification. Diversification may also be envisaged as part of a private sector development strategy. This entails outlining diversification among the specific policies and strategies that need to be pursued in order to enhance private sector growth and competitiveness in the country.

Countries and the international community to commit to effective means of implementation

Finally, it is imperative to mobilize adequate means of implementation if countries are to achieve their priority development goals and objectives. There is a need, therefore, for African countries to negotiate a more catalytic role for ODA that leverages domestic resources and productive capacities. Strengthening tax administration and improving capacities to stem the tide of illicit financial outflows are critical for increasing domestic resources. ODA can play an important role in financing investments in both areas. In this respect, donors should fulfil their existing ODA commitments and allocate a greater share of such resources to the strengthening of fiscal capacities. African countries should strengthen cooperation with their external partners in curbing illicit outflows, returning stolen assets, and diversifying the destination and sectoral composition of foreign direct investment flows to Africa. Notwithstanding some improvements, foreign direct investment is concentrated in a few countries and in the extractive sectors. The international community should support African countries in promoting technology, innovation and science, fair trade, strengthening trade facilitation and facilitating good governance. Governments should also reinforce and improve their cooperation with their domestic private sector and involve them more in the implementation of national development strategies. All internal and external efforts should be directed towards critical priority areas starting with Africa's agenda for structural transformation through value addition and industrialization.

The MDGs remain an unfinished business in Africa, but the numerous lessons generated throughout their implementation can expedite progress towards achievement of the goals provided that adequate measures are adopted to take advantage of the new knowledge.

Recommendations on the successor to the MDG report

The end of the MDGs era provides the opportunity to think about how to improve the process of tracking and assessing progress towards achieving the internationally agreed development goals. In the past ten years, the MDG reports have served greatly to provide a rigorous assessment of Africa's progress in achieving the MDGs, they have served as a basis for policy discussion, peer learning and advocacy. They have also provided the impetus for strong and coordinated action by Africa's top decision makers towards accelerating progress in the MDGs. Against this background, underscoring the importance of the MDG report, the expert group meeting organized for the validation of the 2015 edition expressed support for a successor report that would go further than the mere monitoring of progress. The meeting recommended that the new report should contribute more to the debate on policies and reforms underlining progress towards achieving the Sustainable Development Goals (including promotion of national debates around the report). By way of innovation, it was suggested to the four partners currently producing the MDG report to undertake original country case studies jointly with experts from the selected countries. Such studies aim to be a flagship section of the next report.

Annex 1: Official list of MDG indicators

Millennium Development Goals (MDGs) Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1.25 a day	1.1 Proportion of population below $1 purchasing power parity per day* 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 purchasing power parity per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1-year-old children immunized against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Millennium Development Goals (MDGs) Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under DOTS
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 Carbon dioxide emissions, total, per capita and per $1 GDP purchasing power parity 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: Achieve, 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**

Millennium Development Goals (MDGs) Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 8.C: Address the special needs of landlocked developing countries and Small Island Developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	Some of the indicators listed below are monitored separately for the least developed countries, Africa, landlocked developing countries and small island developing States. Official development assistance (ODA) 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes Market access 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity Debt sustainability 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under the HIPC and Multilateral Debt Relief Initiatives 8.12 Debt service as a percentage of exports of goozone-depleting substances and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Fixed-telephone subscriptions per 100 inhabitants 8.15 Mobile-cellular subscriptions per 100 inhabitants 8.16 Internet users per 100 inhabitants

References

ActionAid. 2005. Real aid: *An agenda for making aid work*. ActionAid.org.

––––. 2014. *Aid to, with and through the private sector: emerging trends and ways forward*. ActionAid.org.

AfDB (African Development Bank) 2014. *African Economic Outlook, 2014*. Abidjan, Côte d'Ivoire.

Africa Progress Panel (APP). 2014. Grain Fish Money: Financing Africa's Green and Blue Revolutions, Africa Progress Panel Report 2014.

Africa Renewal. 2013. *Africa's mobile youth drive change*. New York, United Nations. Retrieved from http://www.un.org/africarenewal/magazine/may-2013/africa%E2%80%99s-mobile-youth-drive-change.

Bountagkidis, G.K., Fragkos, K.C., and Fragkos, C.C. 2015. *EU development aid towards sub-Saharan Africa: exploring the normative principle*. Social Sciences Vol. 4, 85-116.

Crampin, A.C., Mwaungulu, F.D., Ambrose, L.R., Longwe, H., and French, N. 2011. Normal Range of CD4 Cell Counts and Temporal Changes in Two HIV-Negative Malawian Populations. *Open AIDS J.* Vol. 5, 74-79.

CNN. 2012. *Seven ways mobile phones have changed lives in Africa*. CNN.com.

Donovan, K. and Martin, A. 2014. *The rise of African SIM registration: the emerging dynamics of regulatory change*. First Monday – Peer-reviewed journal on the Internet Vol. 19, No. 2, 3 February 2014.

Easterly, W. 2006, *The white man's burden: Why the West's efforts to aid the rest have done so much ill and so little good*. Penguin Press.

––––. 2007. 'How the MDGs are unfair to Africa', Brookings Global Economy and Development, Working Paper 14. November. Washington, DC.

ECA (Economic Commission for Africa). 2005. The Millennium Development Goals in Africa: Progress and Challenge. Addis Ababa, Ethiopia.

––––. 2015. Economic Report on Africa. Industrialization through trade. Addis Ababa, Ethiopia.

ECA (Economic Commission for Africa) and OECD (Organisation for Economic Co-operation and Development). 2014. THE MUTUAL REVIEW of Development Effectiveness in Africa: Promise & Performance. 2014. Addis Ababa, Ethiopia.

ECA (Economic Commission for Africa), AUC (African Union Commission), AfDB (African Development Bank) and UNDP (United Nations Development Programme). 2011. Assessing Progress in Africa toward the Millennium Development Goals. 2011. Addis Ababa, Ethiopia.

––––. 2012. Assessing Progress in Africa toward the Millennium Development Goals, 2012. Emerging Perspectives from Africa on the post-2015 Development Agenda. Addis Ababa, Ethiopia.

––––. 2013. Assessing Progress in Africa toward the Millennium Development Goals, 2013. Food Security in Africa: Issues, Challenges and Lessons. Addis Ababa, Ethiopia.

––––. 2014, Assessing Progress in Africa toward the Millennium Development Goals, 2014. Analysis of the Common African Position on the post-2015 Development Agenda. Addis Ababa, Ethiopia.

FAO (Food and Agriculture Organization of the United Nations). 2014. *Food Security World Report, 2014*. Rome, Italy.

Federal Republic of Ethiopia. 2012. Ethiopia's Progress towards Eradicating Poverty: An Interim

Report on Poverty Analysis Study (2010/11). Ministry of Finance and Economic Development, Addis Ababa, Ethiopia.

Government of Algeria. 2010. Algérie 2ème Rapport National sur les Objectifs du Millénaire pour le Développement

Government of Egypt. 2010. The National MDG Report, Cairo, Egypt.

Government of Ethiopia. 2010. The National MDG Report, Addis Ababa, Ethiopia.

Government of Mauritius and WHO (World Health Organization). 2012. *Eliminating Malaria, Case Study 4: Preventing Reintroduction in Mauritius*. Geneva, Switzerland.

Government of Togo. 2010. The National MDG Report, Lomé, Togo.

ILO (International Labour Organization). 2010. Key Indicators of the Labour Market – Sixth Edition, 2010.

––––. 2014 Trends Econometric Models, October 2014.

IMF (International Monetary Fund). 2015a. HIPC Factsheet: Debt Relief under the Heavily Indebted Poor Countries (HIPC) Initiative. Retrieved from http://www.imf.org/external/np/exr/facts/hipc.htm.

––––. 2015b. MDRI Factsheet: The Multilateral Debt Relief Initiative. Retrieved from http://www.imf.org/external/np/exr/facts/mdri.htm Accessed 10 March 2015.

Kpodar, K. 2007. Why Has Unemployment in Algeria Been Higher than in MENA and Transition Countries? Washington, DC: IMF.

Kuziemko, I. and Werker, E. 2006. How much is a seat on the Security Council worth? Foreign aid and bribery at the United Nations *Journal of Political Economy*. The University of Chicago University Press.

Malaria Free Future. 2008. Rwanda: Winning the Fight against Malaria. Baltimore, United States of America.

McCord, A. and Slater, R. 2009. Overview of Public Works Programmes in Sub-Saharan Africa. Overseas Development Institute, London, United Kingdom.

McKinnon, B., Kaufman, J.S. and Bergevin, Y. 2014. Socioeconomic inequality in neonatal mortality in countries of low and middle income: A multicountry analysis. *The Lancet Global Health*, Vol. 2, Issue 3, e165 - e173, March 2014.

Ministry of Finance and National Planning of Zambia and UNDP. 2011. Millennium Development Goals Progress Report 2011. Ministry of Finance and National Planning, Lusaka, Zambia.

Mumba, E.C. 2002. Education for All: Increasing Access to Education for Girls in Zambia. Paper presented at the 2nd Pan-Commonwealth Forum on Open Learning, Durban, South Africa. 29 July – 2 August 2002.

NISR (National Institute of Statistics of Rwanda). 2011. The Third Integrated Household Living Conditions Survey (EICV3): Main Indicators Report. Kigali: NISR.

NISR (National Institute of Statistics of Rwanda) and UNDP (United Nations Development Programme). 2007. Millennium Development Goals – Towards Sustainable Social and Economic Growth: Country Report 2007. Kigali: NISR.

OECD (Organisation for Economic Co-operation and Development). 2005a. High Level Forum 2005 Paris Declaration on Aid Effectiveness. Paris, France.

––––. 2014. "Aid to developing countries rebounds in 2013 to reach an all-time high" (Press release, Paris, 8 April 2014).

––––. 2015a. States of Fragility 2015: Meeting Post-2015 Ambitions, OECD Publishing, Paris, France.

––––. 2015b. 2015 Dataset: Aid (ODA). Paris, France.

Olukoshi, A.O. 2006. *The quest for a new paradigm for Swedish development co-operation in Africa – issues, problems, and prospect*. In Swedish and EU Africa Policy (ed. L. Wohlgemuth). Center for African Studies, Gothenburg University, Sweden.

Pearson, L., Degefie, T., Hiluf, M., Betamariam, W., Wall, S., Taylor, M., Admasu, K. 2014. From integrated community case management to community-based newborn care. Ethiop Med J, 2014, Vol. 52, Sup. 3.

Riddel, R.C. 2007. *The political and commercial dimensions of aid*. In Does foreign aid really work? Oxford University Press, Oxford, United Kingdom.

RIPPLE Africa. Retrieved from http://www.ripplea-frica.org/environment-projects-in-malawi-africa/tree-planting-africa).

Sabates, R., Akyeampong, K., Westbrook, K. and Hunt, F. 2010. *School Dropout: Patterns, Causes, Changes and Policies*. Paper commissioned for the EFA Global Monitoring Report 2011, The Hidden Crisis: Armed Conflict and Education. UNESCO.

The Global Fund. 2015. Maximizing the Impact of Global Fund Investments by Improving the Health of Women and Children: Second report to the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. June 2015.

The Lancet. 2003. Child survival II. How many child deaths can we prevent this year? By Gareth Jones. 2014. Every newborn, every mother, every adolescent girl, Vol. 383, Issue 9919, p. 755, 1 March 2014.

The Reality of Aid International Coordinating Committee, 2011. Achieving progress for development effectiveness in Busan: an overview of CSO evidence IBON books. Quezon City, Philippines.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2013a. Access to Antiretroviral Therapy in Africa: Status Report on Progress towards the 2015 Targets. Geneva, Switzerland.

––––. 2014. The Gap report. UNAIDS. Geneva, Switzerland.

UNDP (United Nations Development Programme). 2015a. Drivers of Inequalities in sub-Saharan Africa (in press). New York, United States of America.

UNDP. 2015b. *RBA Policy Notes*. New York, United States of America.

UNESCO (United Nations Educational, Scientific and Cultural Organization). 2006. EFA Global Monitoring Report 2006: Literacy for Life. Paris, France.

––––. 2010. EFA Global Monitoring Report 2010: Reaching the Marginalized. Paris, France.

UNFPA (United Nations Population Fund). 2012. Ten Good Practices in Essential Supplies for Family Planning and Maternal Health. UNFPA Niger: Niamey, Niger.

UN-Habitat (United Nations Human Settlements Programme). 2013. State of the world's cities 2012/2013, Nairobi, Kenya.

UNICEF (United Nations Children's Fund). 2013a. Immunization facts and figures. www.unicef.org/immunization/files/UNICEF_Key_facts_and_figures_on_Immunization_April_2013(1).pdf.

–––– .2013b. Levels and Trends in Child Mortality; New York, United States of America.

UNICEF and WHO (World Health Organization). 2012. Progress on Drinking Water and Sanitation: 2012 Update, New York, United States of America.

United Nations. 2010. Ban Ki-Moon: The Global Strategy for Women's and Children's Health. New York, United States of America.

––––. 2014. The Millennium Development Goal report 2014. New York, USA. www.un.org/en/development/desa/publications/mdg-report-2014.

––––. 2015. Millennium Development Goals Indicators database. New York, USA. http://mdgs.un.org/unsd/mdg/Data.aspx.

UN-OHRLLS (United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States). 2012. Report of the 11th Annual Ministerial Meeting of Landlocked Developing Countries, New York, United States of America.

UNSD (United Nations Statistics Division). 2014. Principles and Recommendations for a Vital Statistics System. Revision 3. Department of Economic and Social Affairs. Statistics Division Statistical Papers, Series M, No. 19/Rev.3. New York, United States of America.

WHO (World Health Organization). 2012a. Application of ICD-10 to deaths during pregnancy, childbirth and the puerperium: ICD maternal mortality (ICD-MM). Geneva, Switzerland.

––––. 2012b. Verbal autopsy standards: The 2012 WHO verbal autopsy instrument. Release Candidate 1.WHO, HMN and INDEPTH Network. Geneva, Switzerland.

––––. 2013. Women's and children's health: evidence of impact of human rights. Geneva, Switzerland.

––––. 2014a. Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, World Bank and United Nations Population Division. WHO Press, World Health Organization, Geneva, Switzerland.

––––. 2014b. World Malaria Report 2014. Geneva, Switzerland.

WHO, UNICEF, UNAIDS, World Bank, UNESCO and UNFPA. 2000. Health a key to prosperity: success stories from developing countries. Retrieved from http://documents.worldbank.org/curated/en/2013/01/17985497/health-key-prosperity-success-stories-developing-countries.

World Bank. 2007, Confronting the Challenges of Gender Equality in Fragile States – Global Monitoring Report, 2007. Washington, D.C., United States of America.

––––. 2010. World Bank Policy Note: Enhancing Supply Chain Management in Zambia. Africa Health Unit. Washington, D.C., United States of America.

––––. 2012. De-Fragmenting Africa. Deepening Regional Trade Integration in Goods and Services. Washington, D.C., United States of America.

––––. 2013. World Bank Statistics, April 2013.Washington, D.C., United States of America.

WTO (World Trade Organization). 2013. Ninth WTO Ministerial Conference. Geneva, Switzerland. http://mc9.wto.org/.

Yogo U.T. and Mallaye D. 2015. *How Aid Helps Achieving MDGs in Africa*: the Case of Primary Education, Centre d'études et de recherches en développement international (CERDI), Clermont Ferrand, France.

Zambia NMCC (National Malaria Control Center). 2008. Zambia Malaria Indicator Survey 2008. Ministry of Health, Lusaka, Zambia.

––––. 2010. Zambia Malaria Indicator Survey 2010. Ministry of Health, Lusaka, Zambia.

One important lesson from the MDG experience is that initial conditions invariably influence the pace of progress on global development agendas. Given their relatively low scores on most MDG indicators in 1990, it is not surprising that Africa will not achieve all the MDGs by 2015. Nevertheless, several countries introduced successful institutional and policy reforms to improve governance, promote economic growth and enhance access to social services. As a result, the pace of progress on all indicators has accelerated since 2005.

In particular, African countries have made significant strides in enhancing women's representation in national parliaments, reducing maternal, infant, and HIV-related deaths, and placing more children in primary schools. These achievements are a testament to the effort and commitment of the African people and their governments to meet the Goals.

However, several challenges remain: a high degree of inequity still characterizes access to social services including health and education; much remains to be done to achieve full and productive employment for all, particularly for women and youth; the threat of conflict and climate change looms large and could derail the progress made so far; and shocks such as the Ebola crisis have exposed the weakness of the health systems in some countries.

Sustaining the momentum and advancing the gains made under the MDGs will therefore require new approaches which embrace all three dimensions of sustainability – environmental, economic and social. In this context, African countries will need to adopt more inclusive growth strategies that create decent jobs for broad sections of society, promote equity and meet the development needs of present generations without compromising the ability of future generations to meet their own needs.

Africa's regional strategy for sustained and inclusive development complemented by the global post 2015 development agenda provide an appropriate framework for sustainable development. Nevertheless, an important lesson of the MDGs is that success will hinge on a credible means of implementation. This report highlights successful policy interventions in Africa that should guide the implementation of the post 2015 development agenda going forward.

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