



UNITED NATIONS  
ECONOMIC AND SOCIAL COUNCIL  
ECONOMIC COMMISSION FOR AFRICA

*Twenty-ninth meeting of the Committee of Experts*



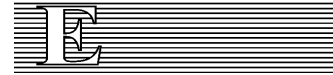
AFRICAN UNION  
COMMISSION

*Fifth meeting of the Committee of Experts*

---

**Meeting of the Committee of Experts of the 3<sup>rd</sup> Joint  
Annual Meetings of the AU Conference of Ministers  
of Economy and Finance and the ECA Conference  
of African Ministers of Finance, Planning and  
Economic Development**

*Lilongwe, Malawi  
25–28 March 2010*



Distr.: GENERAL  
E/ECA/COE/29/15  
AU/CAMEF/EXP/15(V)  
Date: 5 March 2010

Original: **ENGLISH**

---

## **Assessing Progress in Africa towards the Millennium Development Goals, 2010**



## Contents

Acronyms .....	ii
Section 1: Introduction.....	1
Section 2: Tracking progress on the targets of the MDGs .....	2
2.1 Progress on poverty and hunger goals .....	2
2.2 Progress towards the education MDGs .....	6
2.3 Progress towards the gender goal.....	8
2.4 Progress towards the health MDGs.....	10
2.5 Progress towards the environment MDG.....	19
2.6 Progress towards international cooperation and global partnership .....	21
Section 3: Conclusion and Way Forward.....	23
Reference.....	25

## Acronyms

ACT	Artemisin-based Combination Therapy
AfDB	African Development Bank
AUC	African Union Commission
DFID	Department for International Development
DOTS	Directly Observed Short Treatment
DRC	Democratic Republic of the Congo
GDP	Gross Domestic Product
GNI	Gross National Income
HIPCs	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IMR	Infant Mortality Rate
ITNs	Insecticide Treated Nets
LDCs	Least Developed Countries
LLDCs	Landlocked Developing Countries
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MDR-TB	Multi-Drug-Resistant TB
MMR	Maternal Mortality Ratio
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PPP	purchasing power parity
SIDS	Small Island Developing States
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNSD	United Nations Statistics Division
WHA	World Health Alliance
WHO	World Health Organization
WHS	World Health Statistics

## Section 1: Introduction

1. In September 2010, world leaders will once again gather at the United Nations (UN) Headquarters in New York to evaluate progress made by countries towards the targets of the UN Millennium Development Goals (MDGs) agreed to at the UN Millennium Summit in 2000. The leaders will examine strategies that have worked and those that have failed, as well as reaffirm their commitment to the goals. While many world leaders will report commendable progress towards several of the goals, the story from the African leaders will not be as hopeful.

2. As a region, Africa is often portrayed as lagging on the MDGs relative to other regions. The data used in this analysis, albeit current up to 2007, confirm this verdict. However, this broad brush ignores the significant achievements individual countries are making on the goals and the scale-up opportunities that this provides. Overall, this report shows that African countries have maintained their steady progress toward the targets of the MDGs. The continent is on track, as reported in past reports, to meet the primary education and gender goals. There is commendable progress on reducing tuberculosis and the proportion of children sleeping under insecticide treated bednets is increasing.

3. Equally commendable is the fact that high-level political commitment to the MDGs has not been eroded by the crises—fuel, food price, financial and economic—that plagued the continent in the recent past. Many countries have introduced significant institutional innovations—decentralization to improve social services delivery, improved policy coordination and coherence, MDGs-based planning—to give greater impetus to efforts to reach the MDGs. International support for the MDGs in Africa remains high. These provide a platform for accelerating the rate of progress in the final quinquennium of the MDGs agenda.

4. However, the challenges ahead are difficult. Economic conditions were difficult in 2009. The eddies of the global financial and economic crisis are only beginning to settle but the impact of the crises on African economies and on their ability to attain the MDGs will be long felt. The crisis has had a major impact on the fiscal health of many African economies weakening the rate of progress towards the targets of the MDGs and stalling or reversing progress already made.

5. This report is the abridged version of a more comprehensive report “*Assessing Progress in Africa toward the Millennium Development Goals, 2010*”, an annual report produced by United Nations Economic Commission for Africa (ECA), the African Union Commission (AUC) and the African Development Bank (AfDB) and, this year, in collaboration with the United Nations Development Programme (UNDP). The report is based on data from the United Nations Statistics Division (UNSD), the agreed repository of data for assessing progress towards the targets of the MDGs.

6. The report is organized as follows: Section 2 provides an assessment of progress on each of the eight goals. The discussion is organized in six thematic clusters: (a) Goal 1 is covered by the hunger and poverty section; (b) Goal 2 is discussed in the education cluster; (c) Goal 3 is covered by the gender cluster, (d) Goals 4, 5 and 6 are discussed in the health cluster, (e) Goal 7 is covered in the environment cluster, and (f) Goal 8 is discussed in the global partnership cluster. Section 3 provides overall conclusions and proposes a way forward.

## **Section 2: Tracking progress on the targets of the MDGs**

### **2.1 Progress on poverty and hunger goals**

#### **7. Goal 1: Eradicate Extreme poverty and hunger:**

- Target 1.A - Halve between 1990 and 2015, the proportion of people whose income is less than USD 1 a day;
- Target 1.B - Achieve full and productive employment and decent work for all, including women and young people; and
- Target 1.C - Halve between 1990 and 2015, the proportion of people who suffer from hunger.

8. Africa as a region has not shared in the global success in reducing poverty even though average incomes in the region have risen. Some countries such as Ghana, are making progress on poverty reduction (Ghana has already met the target) but the region as a whole will not meet the target of poverty reduction by the target date. According to World Bank estimates the number of Africans living below the poverty line is likely to increase by the target date. A significant proportion of the poor in Africa are chronically poor, meaning that it will require much more effort to lift them out of poverty.

9. In 2005, rich countries made far-reaching commitments to the fight against global poverty. At the Gleneagles Summit, G-8 countries<sup>1</sup> agreed to scale up aid to Africa and improve aid effectiveness. African leaders, on their part, committed to lead their own development by improving governance, upholding the rule of law, and using their resources to fight poverty.

#### ***Indicator 1.1: Proportion of population below USD 1 (PPP) per day***

10. According to World Bank estimates in Africa excluding North Africa, the \$1.25 a day rate was 50 per cent in 2005—the same as it was in 1981, after rising, then falling during the period. The number of poor has almost doubled, from 200 million in 1981 to about 380 million in 2005. If the trend persists, a third of the world's poor will live in Africa by 2015. Average consumption among poor people in sub-Saharan Africa stood at a meager 70 cents a day in 2005. Given that, poverty is so deep in Africa, even higher growth will be needed than for other regions to have the same impact on poverty (World Bank, 2009).

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

11. Sustained labour productivity growth is critical for improving the potential of African economies to reduce poverty. The evidence from Africa on growth rate of Gross Domestic Product

---

<sup>1</sup> Canada, France, Germany, Italy, Japan, Russia, United Kingdom and United States of America.

(GDP) per person employed, as an indicator first introduced in 2007, is mixed. Over 84 per cent of the 48 countries for which data are available report positive trends in labour productivity growth between 1992 and 2007. Leading the pack are, (albeit beginning from negative growth rates) Angola, Democratic Republic of Congo, Ethiopia, Malawi, Mozambique and Sierra Leone. Ten countries<sup>2</sup> reported a decline in labour productivity growth rate during the period under review.

12. Further analysis of the data by subregion shows that all subregions, except North Africa, had negative labour productivity growth rate in 1992, the base year. Yet, all subregions saw improvements during the 16-year period. Between 1992 and 2008, East Africa and Southern Africa were the best performers, improving their labour productivity growth rate by about 11.5 percentage points, followed by North Africa and Central Africa. Labour productivity gain was least in West Africa perhaps due to the region's many conflicts.

***Indicator 1.5: Employment-to-population ratio***

13. Employment-to-population ratio, a measure of dependency, stagnated between 1991 and 2007 in all subregions of the continent. The ratio declined in 28 out of the 50 countries with data, most notably in Mauritania, Rwanda and the United Republic of Tanzania where employment-to-population ratio declined by 9.3, 7.5 and 7.0 percentage points, respectively. Remarkable exceptions with positive change are Lesotho, Ethiopia and Algeria where employment-to-population ratio rose by 5.5, 8.8 and 11.1 percentage points, respectively.

14. At the subregional level, employment-to-population ratio in 2007 was about the same as in 1991 in all subregions except West Africa which registered a decline. A number of factors may be driving the decline in West Africa, including population growth, as well as the adverse employment effects of the region's many conflicts. East Africa had the highest percentage of employment to population ratio.

15. Target 1.C of this goal is a measure of food deprivation. Progress on this target was threatened by the combined effect of the food crisis of 2008, the fuel crisis, and the global economic and financial crisis. In 2010, hunger continues to persist in many African countries. The recent global food crisis and economic crisis have contributed to render the achievement of this target unrealizable for many African countries (UN MDG Report 2009).

16. Overall review of progress in reducing hunger shows that in 2007, the continent had maintained progress towards this target in terms of proportion, even though the actual number of people suffering from hunger had increased. Ghana had already met the target due in large measure to its stable good governance, sound macroeconomic policies, and increased agricultural investments. North African countries have also met the target. Nonetheless, efforts need to be scaled up to meet this target because of its interaction with the other MDGs, especially the health-related MDGs, and international cooperation remains essential in this regard.

---

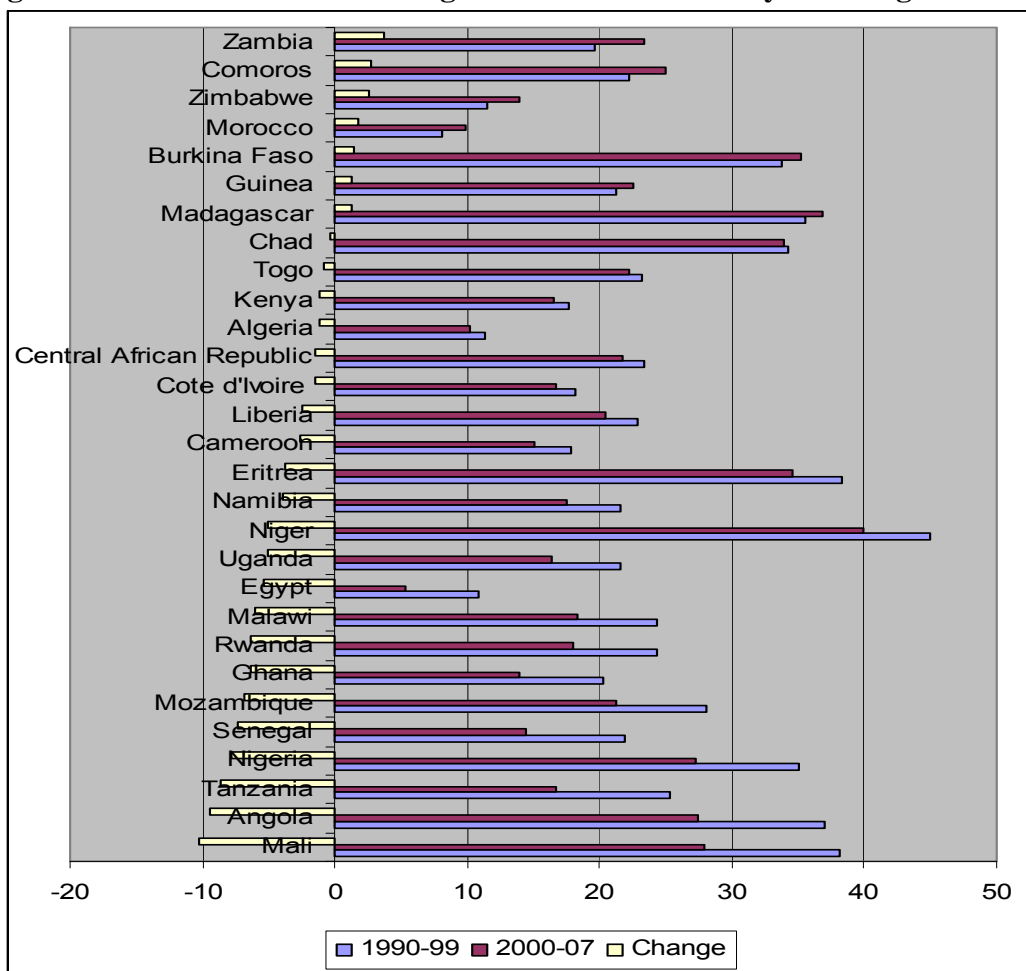
<sup>2</sup> Comoros, Rwanda, Equatorial Guinea, Chad, Mali, Namibia, Tunisia, Eritrea, Botswana and Lesotho

17. Overall, efforts to boost agricultural production are beginning to yield fruits. Malawi, for example, has succeeded in boosting agricultural productivity. However, there is no consensus on the cost of hunger in Africa. The 2009 World Food Summit on Food Security estimated that \$44 billion would be required each year to end hunger and achieve food security while the World Bank has estimated that intervention in high burden countries will cost \$11.8 billion per year.

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

18. Another measure of food deprivation is the prevalence of underweight children under-five years of age falling below minus two (-2) standard deviations (moderate and severe) and minus three (-3) standard deviations (severe) from the median weight-for-age of the reference population. This indicator has the potential to capture the combined effects of acute and chronic under-nutrition. The overall progress towards reducing the prevalence of underweight children under-five years of age in Africa has been slow but positive for the majority of countries. As figure 1 shows, 22 out of 29 countries for which data are available made progress in reducing the prevalence of underweight children over the period 1990-1999 to 2000-2007 with the rate of progress varying by country. Twelve countries reduced prevalence of underweight children by over 5 percentage points while the remaining ten countries reduced it by less than 5 percentage points. In seven countries the prevalence of underweight children increased over the same period.

**Figure 1: Prevalence of underweight children under-five years of age**



Source: ECA computations based on WHS 2009. No data for 24 countries<sup>3</sup> for the period specified.

**Indicator 1.9: Proportion of population below the minimum level of dietary energy consumption**

19. On this indicator, Africa is performing poorly. Although the absolute number of undernourished people in the region has increased on average from 172.8 million in 1990-1992 to 217.2 million in 2004-2006, the proportion of population below the minimum level of dietary energy consumption came down marginally from 34 to 30 per cent in Africa excluding North Africa where less than 5 per cent of the population is undernourished. Moreover, West Africa reported a decrease in the absolute number of undernourished people during the period.

<sup>3</sup> These countries include Benin, Botswana, Burundi, Cameroon, the Congo, DRC, Equatorial Guinea, Ethiopia, Gabon, the Gambia, Guinea-Bissau, Lesotho, Libyan Arab Jamahiriya, Mauritania, Mauritius, Sierra Leone, Somalia, South Africa, the Sudan, Swaziland, Tunisia, Djibouti, Sao Tome and Principe and Cape Verde.

## 2.2 Progress towards the education MDGs

### 20. *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.

#### *Indicator 2.1: Net enrollment ratio in primary education*

21. African countries continue to do well on most of the education goals. Net primary education enrollment has gone up in all countries and the region as a whole will attain this indicator. Countries reporting remarkable improvements include Morocco, Mali, Madagascar, Malawi, Mauritania, Guinea and Ethiopia. As of 2007, Mauritius, Zambia, Algeria, Tunisia, Egypt, Madagascar, Sao Tome and Principe have achieved the target or were only less than 5 percentage points away from achieving the target, while Morocco, South Africa, Rwanda and Uganda were within the range of 5-10 percentage points from the target. Thirteen other countries are also likely to achieve this target. In seven other countries, net primary enrollments were very low and behind the target by about 37 to 58 percentage points. But all is not rosy as this success is under threat. Between 2005 and 2007, Tunisia, Algeria, Cape Verde, South Africa, Togo, Eritrea and Malawi had net primary enrollment rates that actually regressed.

#### *Indicator 2.2: Proportion of pupils starting grade 1 who reach last grade of primary school*

22. While the news on enrolment is heartening, progress on completion rate remains very slow. Although completion rate is not an official MDG indicator, it has nonetheless been used as a proxy for this indicator due to lack of data, to measure the quality of the education system. It helps measure the success of an education system in curbing dropouts and thereby improving retention or keeping children in school to complete their primary education.

23. Of 24 countries<sup>4</sup> with available data for the years 1991 and 2007, 92 per cent have shown a significant improvement on primary completion rates. From this group of countries, 31 per cent had an improvement with the range of 25 and 47 percentage points while another 30 per cent of countries registered improvements of about ten to 25 percentage points. The remainder showed improvement of less than 10 percentage points.

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

24. Progress in youth literacy across the continent (*see figure 2*) continues to be commendable and closely tracks countries with higher primary completion rates. In 2007, eight countries<sup>5</sup> were less than 5 percentage points from achieving the target while another four countries were less than

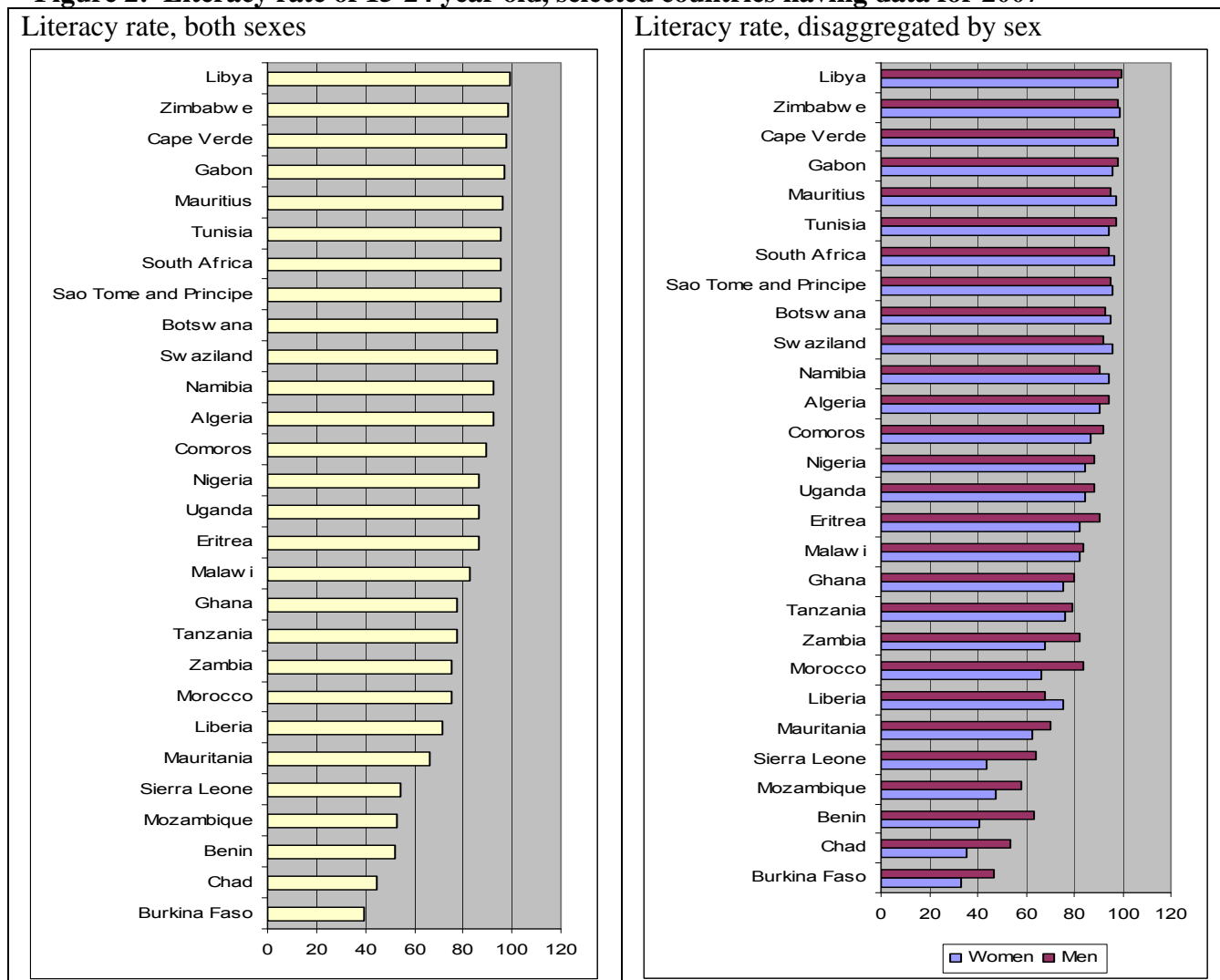
---

<sup>4</sup> Algeria, Burkina-Faso, Burundi, Cameroon, Central African Republic, Chad, the Congo, Cote d'Ivoire, DRC, Guinea, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Morocco, the Niger, South Africa, the Sudan, Swaziland, United Republic of Tanzania, Togo and Tunisia.

<sup>5</sup> Sao Tome and Principe, South Africa, Tunisia, Mauritius, Gabon, Cape Verde, Zimbabwe and Libyan Arab Jamahiriya.

10 percentage points far from the target. In contrast, seven out of the 28 countries, for which data are available, were very far from the target by 28 to 60 percentage points. Literacy rate by gender is mixed. Although young men are on average more likely to be literate in a number of countries<sup>6</sup>, more women are literate than men.

**Figure 2: Literacy rate of 15-24 year old, selected countries having data for 2007**



*Source: ECA computations based on UNSD data, updated July 2009. No data for 25 countries in 2007 (These countries include Angola, Burundi, Cameroon, Central African Republic, the Congo, Cote d'Ivoire, Djibouti, DRC, Egypt, Equatorial Guinea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Mali, the Niger, Rwanda, Senegal, Seychelles, Somalia, the Sudan and Togo)*

<sup>6</sup> Zimbabwe, Cape Verde, Mauritius, Botswana, South Africa, Namibia and Liberia.

## 2.3 Progress towards the gender goal

### 25. *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.

26. African countries continue to show overall progress in gender equality and empowerment of women. Gender parity in primary education is likely to be achieved by most countries. Unfortunately, parity decreases in secondary education, and is widest by tertiary education. Assessment of the share of women in wage employment in the non-agricultural sector remains difficult because of inadequate data. In 2009, the overall trend of an upward increase of the proportion of women in African national parliaments remains strong. Countries like Angola, Mozambique and Rwanda lead the continent on this indicator.

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

27. Gender parity in primary education continues to improve. Data to assess progress on this indicator is available for 38 countries. Between 1991 and 2007, the gender parity index in primary education fell slightly in Eritrea, Swaziland, South Africa, Namibia, Madagascar and Equatorial Guinea. Mauritius is the only country that managed to maintain gender parity throughout 1991 to 2007. Cameroon, Cape Verde and the United Republic of Tanzania did not show any changes in their gender parity levels. The remaining 28 countries have increased gender parity from 0.02 to 0.37 percentage points. Overall, if the current trend continues, most African countries will achieve gender parity in primary education by the target date.

28. Regional comparison shows that Southern African countries, though closest to achieving parity, have shown the least progress, with Madagascar, Namibia, South Africa and Swaziland actually experiencing regression in gender parity. West African countries show the most progress achieved, with the Gambia, Guinea, Mauritania and Senegal leading the pack. North Africa, East Africa and Central Africa show overall progress in achieving gender parity.

29. The gender parity index at secondary education level between 1991 and 2007 has improved in the 26 countries with available data. The rate of progress was negative in Ethiopia, Madagascar, Namibia, South Africa and Swaziland. The rate of progress deteriorated the most in South Africa. The remaining nineteen countries reduced gender disparity by 0.03 to 0.4 percentage points, with the Gambia and Mauritania reducing gender disparity the most by 0.4 and, closely followed by Malawi (0.37). Sao Tome and Principe, Cape Verde, South Africa and Namibia with a gender parity index in secondary education above one, have more girls enrolled in secondary schools than boys. With most countries not having yet achieved a gender parity index of 0.90 in 2007, if the current trends continue, it is highly unlikely that the region as a whole will reach this target by 2015.

30. Regional comparison shows that Southern African countries, though closest to achieving parity, have shown the least progress. North Africa has shown considerable progress in achieving

parity and in 2007 was at par with Southern Africa. Though West Africa has shown the most progress in achieving gender parity, it still lags behind East Africa. Central African countries show a higher progress rate than their counterparts in East and Southern Africa, yet the region continues to lag behind the rest of Africa in achieving gender parity at the secondary level.

31. Many African countries continue to fail to report on gender parity at the tertiary level, with only eight countries providing data for 1991 and 2007 (Burkina Faso, Burundi, Ethiopia, Ghana, Madagascar, Malawi, Morocco, the United Republic of Tanzania and Tunisia). Analysis of the data available for these eight countries show that all of them have reduced gender disparity, with Tunisia (0.85) having reduced disparity the most, followed by Morocco (0.31) and the United Republic of Tanzania (0.29). Data for 2007 show, that Cape Verde, Algeria and Tunisia have actually surpassed parity and recorded indexes of 1.21, 1.4 and 1.51 respectively, indicating that in these countries, women are much more likely than men to access tertiary level education. With the majority of African countries not having yet achieved a gender parity index of 0.90 in 2007, and many still struggling to reach a gender parity index of 0.50, it is highly unlikely that African countries will reach this target by 2015 if the current trends continue.

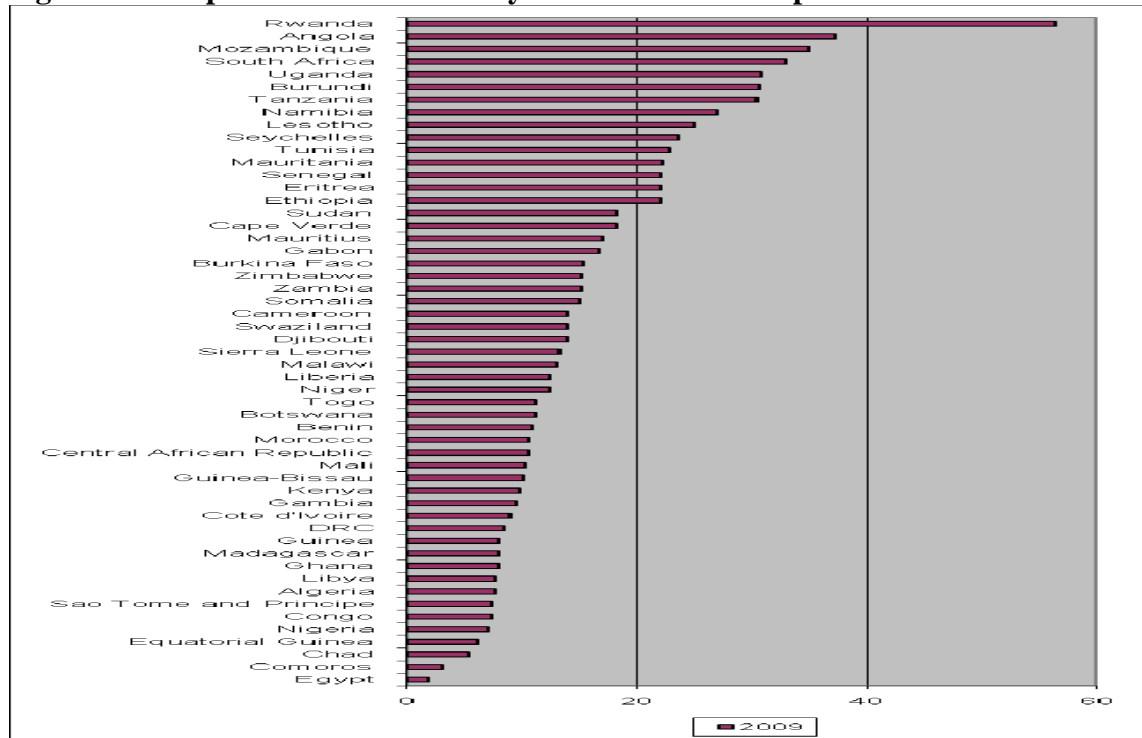
***Indicator 3.2: Share of women in wage employment in the non-agricultural sector***

32. This indicator is one area that measures gender equality, but it is difficult to report on due to lack of data. From the available information Ethiopia (47 per cent), Central African Republic (47 per cent), South Africa (44 per cent) and Botswana (44 per cent) seem to be in the right track in achieving gender parity. While countries like Senegal (11 per cent), Liberia (11 per cent), Algeria (15 per cent), Libyan Arab Jamahiriya (16 per cent) and Egypt (18 per cent) need to exert more effort in achieving gender parity in wage employment.

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

33. Changes in women's representation in national parliaments from the baseline year of 1990 and to 2009 have been impressive. Of thirty-seven African countries with available data for 1990 and 2009, thirty-one countries have increased the proportion of seats held by women, while Cameroon, the Congo, Egypt, Equatorial Guinea, Guinea-Bissau and Sao Tome and Principe, show a reduction in the percentage of parliamentary seats held by women. Rwanda takes the lead by far with 56.3 per cent of parliamentary seats held by women, followed by Angola (37.3 per cent), Mozambique (34.8 per cent), South Africa (33 per cent) and Uganda (30.7 per cent). The remaining twenty-six countries that show improvements in this time period have a proportion of seats held by women in national parliaments of less than 30 per cent. While overall trends for Africa for this indicator are positive, minimum quota of women holding parliamentary seats needs to be institutionalized in order not to lose gains made from one election to another.

**Figure 3: Proportion of seats held by women in national parliament 2009**



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

34. Of the fifty-three African countries (*see figure 3*), seven countries report a proportion of seats held by women in parliament that is above 30 per cent, another 17 report a proportion of seats held by women in parliament that is below 10 per cent. The remaining 29 countries have a proportion of women holding parliamentary seats that ranges from 10 to 30 per cent.

35. A review of subregional trends shows that all subregions, save for Central Africa, saw overall improvements in the proportion of parliamentary seats held by women from 1990 to 2009, with Southern Africa and East Africa showing the most significant improvements. However a closer look at subregional trends shows that improvements were most significant in North, West, East and Southern Africa, between 1990 and 2005, while Central Africa saw a sharp decline in the proportion of women holding parliamentary seats.

## 2.4 Progress towards the health MDGs

36. **Goal 4: Reduce child mortality:**

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

37. **Goal 5: Improve maternal health:**

- Target 5.A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; and
- Target 5.B: Achieve, by 2015, universal access to reproductive health.

38. **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;
- Target 6.B: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it; and
- Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

## **Child Health**

39. Child mortality measured using *under-five mortality rate* (the probability - expressed as a rate per 1,000 live births - of a new born in a specified year dying before reaching the age of five) is commonly used, if subject to current age-specific mortality rates. There continues to be progress, albeit slow, in Africa in reducing under-five mortality. The under-five mortality rate has declined by 21 per cent from 168 deaths per 1000 live births in 1990 to 132 deaths per 1000 live births in 2008 (Danzhen et al., 2009).

### **Indicator 4.1: Under-five mortality rate**

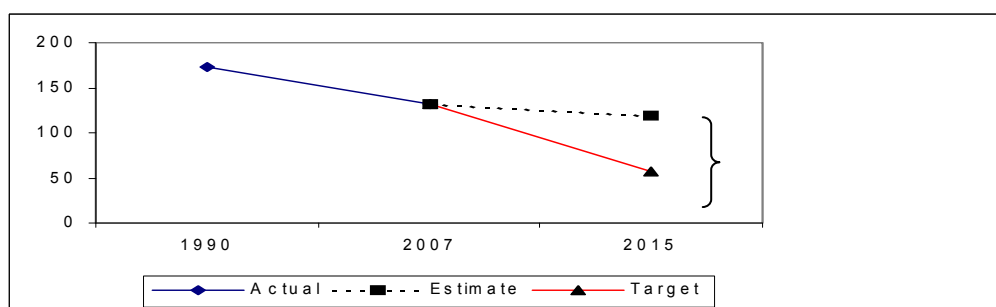
40. Progress in reducing under-five mortality varies enormously by country. Africa's middle income countries of Algeria, Cape Verde, Egypt, Libyan Arab Jamhiriya, Mauritius, Morocco, Seychelles and Tunisia are on track to achieve the target of reducing under-five mortality by two-thirds. Countries such as Angola, Benin, the Comoros, Ethiopia, Eritrea, Guinea, Liberia, Madagascar, Malawi, Mali, the Niger, Rwanda, Somalia and Togo report rapid improvements under-five mortality rates (a decrease of about 50 percentage points or more) from very high initial values, but the rate of progress is insufficient to reach the target. Progress remains very slow (less than ten per cent) in ten countries<sup>7</sup>. In six countries, namely Cameroon (6.5 per cent), Central African Republic (0.6 per cent), Chad (4 per cent), the Congo (20.2 per cent), Kenya (24.7 per cent) and Zambia (4.3 per cent), under-five mortality rate has increased between 1990 and 2008.

---

<sup>7</sup> Sierra Leone (9.7 per cent), Mauritania (8.5 per cent), South Africa (7.8 per cent), Burkina Faso (7.3 per cent), Zimbabwe (5.3 per cent), Swaziland (5.2 per cent), Burundi (4.8 per cent), Ghana (4.2 per cent), Sao Tome and Principe (2 per cent) and Gabon (1.1 per cent).

41. Over-all if the current trend continues, the continent as a whole is unlikely to meet the target of reducing under-five mortality by the target date as shown in figure 4. Lack of access to quality health care, clean water and sanitation, under-nutrition, HIV/AIDS, high neo-natal death, malaria, diarrhoea and measles are the major causes of under-five mortality. Expanding low-cost prevention and treatment measures could save most of these child deaths from these causes. Vital registration systems –record of births and deaths– are the best sources of data on infant and under-five mortality rates. As these are practically non-existent in many African countries, household surveys of child histories are used instead.

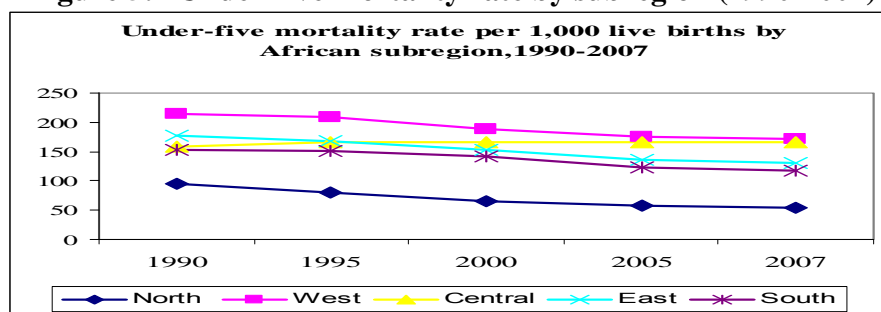
**Figure 4: Under-five mortality rates 1990, 2007, 2015 estimate and 2015 target**



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

42. Figure 4 summarizes the evidence by subregion. All subregions except Central Africa have made progress in reducing under-five mortality. North Africa has made the most progress by reducing under-five mortality rate by 42 per cent between 1990 and 2007 followed by East Africa (26 per cent), Southern Africa (24 per cent) and West Africa (20 per cent). The period from 1995 to 2007 indicates that improvements in under-five mortality have stagnated in Central Africa and under-five mortality rate has increased by five per cent between 1990 and 2007. Data for 2007 indicates that West Africa and Central Africa have registered the highest under-five mortality rates.

**Figure 5: Under-five mortality rate by subregion (1990-2007)**



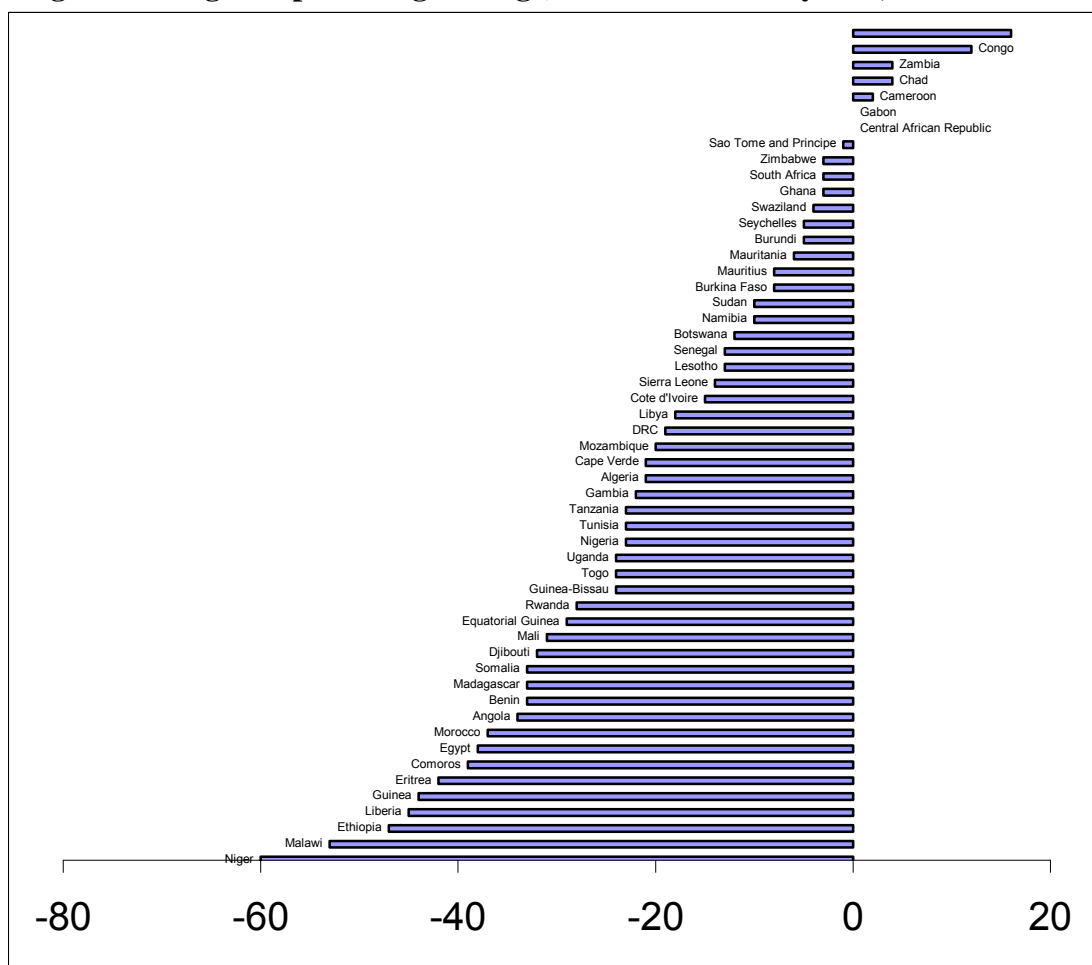
*Source: ECA computations based on UNSD data as updated in July 2009.*

43. At the subregional level, progress on this indicator depends critically on progress in Africa’s most populous countries within each subregion. Hence, subregional progress rates are highly determined by progress achieved in Cameroon, Democratic Republic of the Congo, Ethiopia, Egypt, Nigeria and South Africa.

**Indicator 4.2: Infant mortality rate**

44. A critical challenge for Africa is reducing the number of children who die before their first birthday. The Infant Mortality Rate (IMR) - number of deaths of infants under one-year of age in the indicated year per 1000 live births in the same year—is the most widely used measure of child survival. IMR shows a declining trend in most African countries between 1990 and 2007. Figure 5 reveals significant differences in the rate of progress among countries. The best performing countries are countries on the left-hand side of the figure and the least performing countries are countries on the right-hand side. Niger performed the best in reducing IMR, while Kenya is the least performing country followed by Cameroon, Chad, Congo and Zambia. Of note is the fact that of the five least performing countries three are in Central Africa and two of the countries, which showed no change in infant mortality, are also in Central Africa. In summary, the rate of progress in the region in reducing under-five mortality rate continues to be insufficient.

**Figure 6: Progress (percentage change) in infant mortality rate, 1990 and 2007**



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

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

45. The proportion of one-year-olds immunized against measles provides a measure of the coverage and quality of the child health care system in the country. Measles is vaccine preventable. Of the 53 African countries, 15 reported 90 per cent and above coverage rate and three countries reported coverage rate below 50 per cent. While overall rate of progress on this indicator is good, it is important to flag the point that measles immunization coverage declined in 13 countries underscoring the need for countries to be very vigilant in securing successes already achieved.

**Maternal Health**

46. Africa continues to have the World's highest maternal mortality rates, with an estimated 48 per cent of recorded maternal deaths<sup>8</sup>. Improving maternal health is not only important in its own right but it is essential to improving the health of children, families and communities. The repercussion of maternal mortality is felt far beyond the death of one person. It can mean a shortened life for the newborn, as well as a decline in living standard for the existing children as well as other dependents of the deceased woman.

***Indicator 5.1: Maternal mortality ratio***

47. Maternal Mortality Ratio (MMR) data remains inadequate to assess progress on this target in Africa. Nonetheless, what data there are suggest that maternal mortality has declined significantly in other regions of the world except Africa. According to a 2004 study by the United Kingdom's Department for International Development (DFID), a woman in Africa excluding North Africa has a risk of 1 in 22 of dying due to obstetric conditions compared with 1 in 8000 in the industrialized world. Based on trends observed from 1990 to 2005 and unless significant interventions are implemented, the majority of African countries will not meet this target by 2015.

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

48. A key intervention for reducing maternal death is the number of skilled health personnel who attend to births. Thus increasing the *proportion of births attended by skilled health personnel* is a proxy for measuring improvement in maternal mortality since most maternal deaths are caused by hemorrhaging which can be prevented if birth is attended by a skilled health personnel. Data from the World Health Statistics (WHS) show significant improvements in many African countries. Of the 53 African countries, seven countries report a proportion of birth attended by a skilled health professional of 90 per cent and above. With only six per cent of all births attended by a skilled professional, Ethiopia has the lowest proportion. An outstanding 19 countries have a birth attended by a health personnel rate below 50 per cent, of which 12 countries fall behind the World Health Organization (WHO) regional average rate of 46 per cent. Forty countries rank above this average.

---

<sup>8</sup> UNFPA, UNICEF and WHO 2003.

***Indicator 5.3: Contraceptive prevalence rate for married people***

49. The WHO regional average rate for contraceptive prevalence rate is 24.4 per cent. Of the 53 African countries for which data are available, 25 countries are above this average while 21 countries fall below it with six countries not reporting any data. At this rate, most African countries, except North African countries, will fail to achieve this target by the target date. While North Africa leads, West Africa brings up the rear in contraceptive prevalence. While increasing contraceptive prevalence rates seems an easy-to-reach target through reproductive health education and increased access to contraceptives, cost, and socio-cultural norms (preference for large families in rural areas) continue to hamper efforts to expand the use of contraceptives.

***Indicator 5.4: Adolescent birth rate***

50. Another measure for maternal health is the adolescent birth rates – the fertility rate per 1000 of girls aged fifteen to nineteen. Of the 53 countries for which data are available, adolescent birth rate is lowest in northern African countries (Algeria - 4/1000; Libyan Arab Jamahiria - 4/1000; and Tunisia - 6/1000), followed by Morocco, Djibouti and Egypt.

***Indicator 5.5: Antenatal care coverage***

51. Progress in antenatal care coverage has remained unchanged in the region. In 2009, according to WHO data of the 53 African countries, seventeen countries report a rate above 90 per cent for at least one antenatal visit. Only four countries (Chad, Ethiopia, the Niger and Somalia) report a rate below 50 per cent.

***Indicator 5.6: Unmet need for family planning***

52. Family planning is an essential element of policies and interventions to improve maternal health. In Africa, bridging unmet need for planning has been a challenge and assessment of progress on unmet need for family planning is constrained by inadequate data. Power asymmetry in gender relations is also a factor as well as restrictive cultural and social norms that limit revelation of need. Nonetheless, of the 53 countries, 19 report a rate above the WHO regional average of 24.4 per cent, while 14 fall below this average. Twenty countries have failed to report data on this indicator.

**HIV/AIDS, Malaria and Other Major Diseases**

***Indicator 6.1: HIV prevalence among population aged 15-24 years***

53. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), Africa has maintained the progress made in tackling HIV/AIDS. HIV/AIDS-related mortality rate did not increase since the 2009 Report. Access to Antiretroviral Therapy (ART) for HIV patients has expanded in most countries, especially in countries at the epicenter of the epidemic. Cumulatively, the number of adults and children newly infected with HIV has dropped by 17.4 per cent between 2001 and 2008. Nonetheless, the number of people living with HIV remains high in part due to the

paradox of success: increased access to treatment is reducing HIV/AIDS mortality and increasing the number of people living with AIDS. This is a strain on health systems.

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

54. Despite the high HIV/AIDS prevalence rate, condom use at high-risk sex remains low. In 2006, only 15 African countries reported data on this indicator. And according to that data 42 per cent of women and 52 per cent of men used a condom during high-risk sexual encounters. Gender inequities continue to affect women's decision-making and risk-taking behaviour.

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

55. Comprehensive knowledge of HIV/AIDS and HIV-prevention is improving among young people aged 15-24 years. The UN General Assembly Special Session on HIV/AIDS set the target of comprehensive HIV knowledge at 95 per cent by 2010. Most countries will not meet this target. The drop in infection rate among young people suggests that comprehensive knowledge is increasing and having a positive impact on behaviour. Sex education in schools is a critical intervention in this regard.

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

56. Progress in achieving the goal of reversing HIV/AIDS is critically dependent on the proportion of orphans aged 10-14 years who attend school. Unfortunately, most African countries, do not collect and report data on this indicator. The effect of education on providing life opportunities and decreasing the possible transmission of the disease remains a key element in the integration of HIV orphans in African societies.

***Indicator 6.5: Proportion of people with advanced HIV infection with access to Antiretroviral drugs***

57. There is no further update from 2007. The latest figures of patients receiving ART at 31 per cent in Africa, rather low related to the demand, however this has had an estimated gain of 2 million years of life from ART coverage just in sub-Saharan Africa (UN 2008). The momentum achieved up to 2007 needs to be sustained and accelerated through increased interventions and better data acquisitions.

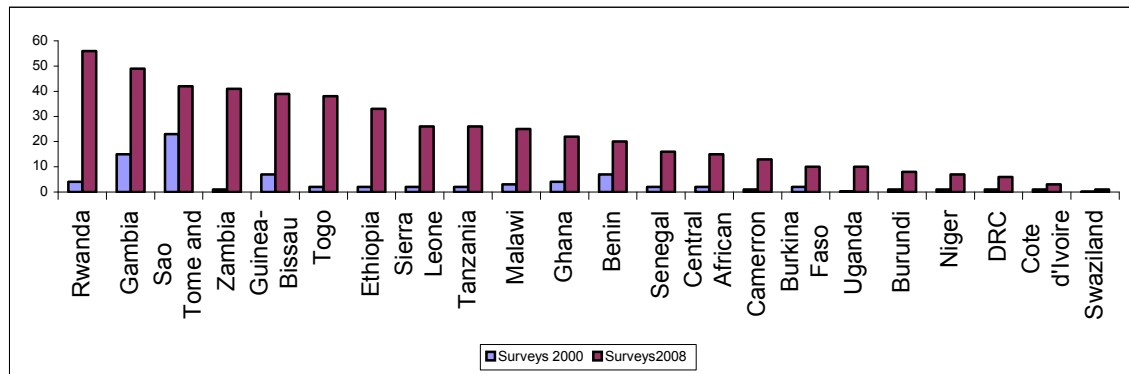
***Indicator 6.6: Incidence and death rates associated with malaria***

58. Malaria continues to be the biggest cause of morbidity and mortality in Africa. However, data on malaria incidence and mortality are not consistently reported. In 2006, there were an estimated 247 million episodes of malaria worldwide resulting in 881 000 deaths, of which 91 per cent were in Africa. Of this, 85 per cent were of children under-five-years of age. Pregnant women are also particularly vulnerable, being three times more likely to develop serious malaria than other adults during a malaria epidemic (GAVI fact sheet 2009).

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

59. The number of African households with at least one Insecticide Treated Net (ITNs) increased from 17 per cent in 2007 to 31 per cent in 2008. In 2008, the proportion of children under-five that used an ITNs was 24 per cent. These figures, although improving, are still far from the World Health Alliance (WHA) target of 80 per cent coverage. Countries for which data are available showed increases in ITNs use among children under-five. Sixteen of the 20 countries have at least tripled their coverage since 2000. Household ownership of ITNs surpassed 60 per cent in Equatorial Guinea, the lowlands of Ethiopia, Gabon, Mali, Sao Tome and Principe, Senegal and the Zanzibar region of Tanzania. However, widespread diffusion of ITNs remains poor due to supply constraints. Figure 2.4.5 summarizes the evidence for selected African countries between 2000 and 2008 on the proportion of children under-five sleeping under ITNs.

**Figure 7: Proportion of children under five sleeping under insecticide-treated bednets, selected African countries around 2000 and around 2008 (per centage)**



Source: UN 2009.

60. There has been less progress in treating malaria than in preventing it, and a vaccine for malaria still does not exist. Although treatment among febrile children is moderately high across malaria endemic regions of Africa, few countries have expanded treatment coverage since 2000. Of greater concern, most patients often receive less effective medicines. The number of Artemisinin based Combination Therapy (ACT) distributed at country level slowed in 2006-2008 relative to 2004-2006 in due to the low approval of funds for malaria activities in Rounds Five and Six of the Global Fund.

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

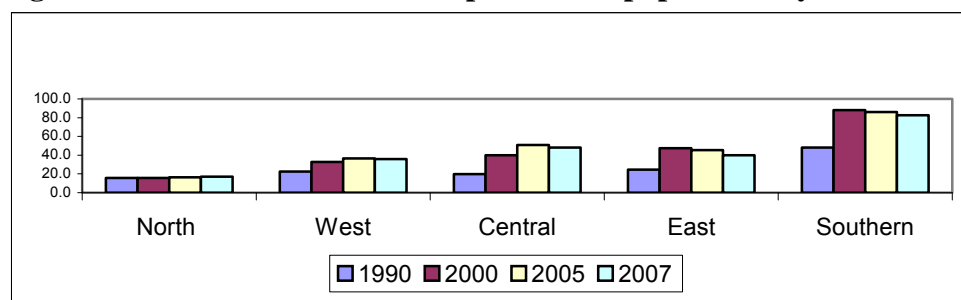
61. Preliminary reviews undertaken in ten African countries in 2008 provide some evidence on the two treatment indicators for malaria, namely the proportion of children treated with anti-malarial drugs, and treated with ACT. The weighted average of the surveyed countries of children treated with anti-malarial was 32 per cent and 16 per cent for ACT although the latter was reported only in seven out of ten survey countries. Treatment of children with anti-malarials and ACT remains low. As these interventions are known to work, it is important for success that countries

scale up the treatment of children under-five with fever who are treated with appropriate anti-malarial drugs.

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

62. Tuberculosis (TB) remains a significant health risk and major contributor to Africa’s burden of disease. Southern Africa continues to report the highest tuberculosis incidence rate and North Africa the lowest. Except for North Africa where the incidence rate remained unchanged, all subregions of the continent show a decline, although in varying degrees, of TB prevalence rate between 2005 and 2007 (see figure 7). The decline is most pronounced in Central, Eastern and Southern Africa. The picture slightly varies if large populous countries are excluded from the analysis.

**Figure 8: Tuberculosis death rate per 100000 population by African subregion**



*Source: ECA computations based on UNSD data, updated July 2009 excluding the most populous countries per subregion (Nigeria, Ethiopia, Cameroon, DRC and South Africa).*

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

63. The Directly Observed Short Treatment (DOTS) target set is 85 per cent, though success in this regard will be a 100 per cent level of achievement. DOTS is based on the three “Is” (Intensified case-finding, Isoniazid prevention therapy and Infection control), which involves the appropriate diagnosis and registration of each tuberculosis patient followed by standardized multi-drug treatment. This treatment regime has a demonstrable impact on TB prevalence rate and TB-related deaths. Efforts to control TB have been made more difficult by the emergence of Multi-Drug-Resistant TB (MDR-TB) that is difficult and expensive to treat and fails to respond to first-line drugs. South Africa is among the top five countries with the largest number of cases of MDR-TB (Stop TB partnership 2010).

64. In summary, on the health-related MDGs, this report comes to the same sober conclusion as it did in 2009: If current trends persist, Africa as a region is unlikely to achieve any of the health MDGs.

## 2.5 Progress towards the environment MDG

### 65. *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;
- Target 7.B: Reduce biodiversity loss, achieving by 2010, a significant reduction in the rate of loss;
- Target 7.C: Halve by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation; and
- Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers.

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

66. Protected areas are the cornerstone of efforts to conserve the world's species and ecosystems as well as a key component in climate change mitigation. The Democratic Republic of the Congo in 2007 had managed to establish the largest rainforest in the world covering a total of 9,000 square kilometres (UN 2009). Deforestation on the other hand continues unabated. In Africa excluding northern Africa the forest loss in 2000-2005 was 4.1 per cent, although this was an improvement on 1990-2000 at 4.4 per cent of loss in forest area. It is important to note that forestry accounted for 17.4 per cent of anthropogenic greenhouse emissions in 2004 and the reduction in forestry could play a key role in mitigating climate change effects.

### *Indicator 7.2: CO<sub>2</sub> emissions, total, per capita, and per USD1 GDP (PPP)*

67. The threat that the adverse effects of climate change could present to Africa is giving impetus to greater focus in Africa on the environment MDGs. An important measure for assessing progress on climate change is carbon dioxide emissions per capita measured in metric tonnes. Africa, the evidence shows, is the lowest emitter of carbon dioxide. The cost of dealing with the adverse consequences of climate change is likely to hamper progress on the MDGs in Africa. For example, the World Bank estimates that adaptation measures would cost about \$18.1 billion per year for sub-Saharan Africa (World Bank 2009). The adaptation cost for the health sector is calculated at \$4 to \$12 billion and represents possible setbacks in malnutrition and increases in vector borne diseases from 2010 to 2030.

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

68. The majority of African countries currently party to the Montreal Protocol have achieved a 97 per cent reduction in the consumption of substances that deplete the Earth's ozone layer. This extraordinary accomplishment is a prime example of both the integration of sustainable

development principles into national policy frameworks (MDG 7) and global partnership for development (MDG 8).

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

69. National Action is being taken to limit the impact of fishing and other human activities on exploited fish populations. Nevertheless, the percentage of depleted, fully exploited or overexploited and recovering fish species has increased from 70 per cent in 1995 to 80 per cent in 2006. The effect of climate change on all targets and indicators of the MDGs, particularly on Goal 7 is exacerbating the vulnerability of environmental resources in Africa. For example, climate change could alter marine and fresh water ecosystems, affecting the seasonality of certain biological processes, thus disrupting marine and freshwater food webs. This, in turn, has unpredictable consequences for fish stocks. Given the uncertainty of the impact of climate change on resources and ecosystems, a higher level of precaution is required in managing fishery resources.

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

70. About 70 per cent of water withdrawn in Africa is for agriculture. When more than 75 per cent of river flows are diverted for agricultural, industrial and municipal purposes, there is simply not enough water to meet both human demands and environmental flow needs. Physical water scarcity — characterized by severe environmental degradation, declining groundwater, and water allocations is increasing. Water withdrawals are highest in arid and semi-arid lands, where they are needed mostly for irrigation, and lowest in tropical countries.

***Indicator 7.6: Proportion of terrestrial and marine areas protected***

71. Protected areas, the cornerstone of efforts to conserve the world's species and ecosystems and a key element in climate change mitigation, have been expanding in Africa. This is an indicator in which the continent continues to make notable progress. DRC established in 2007 the largest rainforest in the world covering a total of 9,000 square kilometres (UN 2009). Deforestation on the other hand continues to present a problem. In 2000-2005, Africa lost its forests at a rate of 4.1 per cent although this was an improvement on the 4.4 per cent of loss in forest area reported for 1990-2000. It is important to note that forestry accounted for 17.4 per cent of anthropogenic greenhouse emissions in 2004 and the reduction in forest loss could play a key role in mitigating climate change effects. The improvement in protected areas augurs well for the reduction in biodiversity loss, although environmental degradation and rapid urbanization remain serious problems.

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

72. 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. The urban-rural divide in access to improved water source continues to be a policy challenge. Nonetheless, the proportion of rural households with improved access to drinking water sources increased from 54 to 65 per cent during the period 1990 and 2006.

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

73. This indicator aims to provide improved sanitation to 63 per cent of the region's population. This requires an improvement for approximately 370 million more people than the estimated 242 million people using such facilities in 2006. Improvements in sanitation largely remain an urban phenomenon. Open defecation remains very common in rural areas and has not been extinguished in many urban areas of the continent. Simple policy interventions such as public and community toilets and water sources can go a long way in accelerating regional efforts in providing improved sanitation.

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

74. In Africa excluding North Africa, the proportion of the population living with shelter deprivation decreased from 71 to 62 per cent between 1990 and 2005, while in North Africa, the proportion decreased from 36 to 15 per cent (UN 2009). Despite some advances, Africa, excluding North Africa, remains the region with the highest prevalence of slums. Both slums and urban areas in the region appear to be growing at an equally rapid pace, and the living conditions among impoverished populations are severe, often involving multiple deprivations.

## **2.6 Progress towards international cooperation and global partnership**

75. ***Goal 8: Develop a global partnership for development:***

- Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system;
- Target 8.B: Address the special needs of the least developed countries;
- Target 8.C: Address the special needs of landlocked developing countries and small island developing states;
- 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;
- Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries; and
- Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

***ODA, Market Access and Debt Sustainability (Indicators 8.1 to 8.12)***

76. International cooperation and global partnership is critical for achieving the MDGs. Development assistance to Africa rose in 2008 in spite of the global financial and economic crisis

although still far below of the 0.7 per cent commitment by Organization for Economic Cooperation and Development (OECD) countries.

77. Among African countries, landlocked countries present a special challenge. The MDGs envisage an increase in Official Development Assistance (ODA) as a proportion of the gross national income of these countries. ODA received by African Landlocked Developing Countries (LLDCs) as a percentage of their Gross National Income (GNI) increased from 2006 to 2007 in half of the countries for which data are available. For most of the Heavily Indebted Poor Countries (HIPC), ODA received as a percentage of their GNI increased from 2005 after the introduction of the Multilateral Debt Relief Initiative (MDRI), suggesting the effectiveness of debt relief for attracting foreign aid.

78. Africa is also home to Small Island Developing States (SIDS). The MDGs envisage an increase in ODA—measured as a proportion to their gross national income—to this group of countries. ODA received by African SIDS as a proportion of their GNI has declined since 2000, although it remains high in Guinea-Bissau and Sao Tome and Principe. The two non-Least Developed Countries (LDC) SIDS, Mauritius and Seychelles, have consistently performed better than the rest in terms of economic growth and human development. They have also received lower ODA compared to the other states, implying that they have not had to rely on donor assistance.

79. Debt service as a percentage of exports of goods and services fell from seven per cent in 2007 to 4.7 per cent in 2008. There has been a significant reduction of debt service as a proportion of exports in Africa from 2000 to date. This could be attributed to the various debt relief initiatives that have been directed towards the continent. However, the debt service as a proportion of exports varies from country to country with the proportion having increased from 2000 in countries like the Comoros, Eritrea, Guinea, and Sao Tome and Principe. Three of these countries, with the exception of Sao Tome and Principe, are either interim or pre-decision point countries, which would explain the high amount of debt repayment.

80. The HIPC initiative continues to make an impact on reduction of the debt burden on countries that qualify for debt relief. Central African Republic has now reached post completion point and, therefore, qualifies for irrevocable debt relief. Africa's creditors continue to provide debt relief under the HIPC initiative and the MDRI. In 2009, 21 African countries reached the HIPC post-completion stage; another eight are between decision and completion points, while only four are in the pre-decision point stage. Under the MDRI, assistance had been delivered to all post-completion countries by March 2009. The total amount of debt relief delivered was \$18,291 million. The HIPC initiative delivered \$45,524 million during the same period. Nonetheless, debt continues to be a constraint on the efforts of African countries to achieve the MDGs because the insufficiency of the debt relief granted. This has limited fiscal policy space and thus, the ability of countries to scale up MDGs-critical interventions.

***Indicator 8.13: Proportion of population with access to affordable essential drugs on a sustainable basis***

81. Country reports suggest huge gaps in the availability of medicines in both the public and private sectors, as well as a wide variation in prices, rendering essential medicines unaffordable to

poor people (UN MDG Gap Task Force report 2009). Generic medicines are also not readily available and where available cost significantly higher than the international reference price. High prices render medicines unaffordable. The cost of treatment for chronic diseases is particularly unaffordable because of the need for lifelong treatment, which is less amenable to short-term financial coping strategies. This low nominally and effective access to medicines has created a thriving market for fake and expired medicines in Africa. At the continental level, efforts needed to be made to complete on time the long-planned regional drug production centres. Similarly, countries could make arrangements for bulk purchase of drugs to reduce cost. Finally, incentives such as tax holidays and other subsidies could be given to pharmaceutical companies to encourage production in African countries.

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

82. Communication is essential for creating an integrated economic and social space, for building and harnessing social capital, for accessing knowledge, and for economic growth. The number of fixed telephone lines per 100 population in Africa, stagnated between 2006 and 2007. Half of the countries with available data registered only marginal growth, while the other 50 per cent registered either no growth or a decline for this indicator. This is largely due to high fixed cost of fixed line telephony and the relative attractiveness of mobile telephony, which continues to grow at a very high rate on the continent.

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

83. The rate of cellular subscription increased between 2006 and 2007 in all African countries (except in Djibouti where data were not available and Guinea and Sierra Leone, where there were no data for 2006). Progress is mixed within and across regions, with North Africa registering the most progress and East Africa the least. Within the North Africa region, Algeria had 81 cellular subscribers per 100 population, while Egypt had 40 cellular subscribers per 100 population in 2007, showing disparities within regions. Mobile phones are clearly more accessible than fixed-line telephones across the continent.

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

84. Use of internet in Africa is increasing since 2000. Seychelles was the country with the highest number of internet users followed by Mauritius, Morocco, Tunisia, Sao Tome and Principe and Egypt in 2007. Internet penetration is lower (less than one per 100 population) in DRC, Ethiopia, Liberia and Sierra Leone.

### **Section 3: Conclusion and Way Forward**

85. As we come to the end of the first decade of the MDGs and with five years remaining to the MDGs end date, the evidence shows that Africa has made some progress in meeting the targets of the MDGs. Notable advances have been made in social indicators such as net primary enrolment, childhood immunization, stemming the spread of HIV/AIDS and TB, and gender parity including the representation of women in decision making. Progress in the key areas of poverty reduction, employment and most health-related goals remain disappointing.

86. But challenges remain. Critical among these is the challenge of reducing inequity in access to social services and thus in outcomes. High degree of inequity characterizes access to many social services in Africa including health and education. These inequities explain in large measure the region's slow progress in attaining the health MDGs. Furthermore, with just five years left to the MDGs end date and with the slow rate of progress on most of the goals, African governments may have to make a difficult choice. In the context of limited financial, human resource and time constraints, they must choose between aiming to achieve all the goals by the target date or to achieve a few that they consider most critical for their long term development. The choice is for each country to make. Governments may need to re-calibrate and identify which MDGs are within reach and focus on those.

87. On the positive side, the MDGs have helped catalyse a consensus on the imperative of development. The goals have facilitated benchmarking and encouraged cross-country comparisons. Democratic governance, rule of law, accountability and transparency, key ingredients for development, widely taken for granted in most parts of the world, are only just beginning to take root in Africa. In addition, over the past couple of years, African economies, have been growing, making it possible for countries to expand fiscal space.

88. Furthermore, institutions to accelerate progress towards the MDGs have been or are being created in many countries. Indeed many African countries, have or are addressing the institutional challenges in three key areas i.e MDG-based planning; decentralization and policy coordination. Progress in these areas are evident in some countries such as Ethiopia, Nigeria and Tanzania. However, increased focus by all African governments is needed to scale up progress within the next crucial 5 years.

## Reference

Danzhen You, Tessa Wardlaw, Peter Salama, Gareth Jones (2009) United Nations Children's Fund, New York, Available online at: [WWW.TheLancet.com](http://WWW.TheLancet.com) published online September 10,2009.

GAVI Fact Sheet (2009). Available online at: [www.gavialliance.org](http://www.gavialliance.org)

Stop TB partnership. Available online at: [www.stoptb.org](http://www.stoptb.org)

UN (2009). The Millennium Development Goals Report, New York.

UN (2009a). MDG Gap task Force Report 2009: Strengthening the Global partnership for Development in a time of Crisis. Available online at:

[http://www.un.org/millenniumgoals/pdf/MDG\\_Gap\\_%20Task\\_Force\\_%20Report\\_2009.pdf](http://www.un.org/millenniumgoals/pdf/MDG_Gap_%20Task_Force_%20Report_2009.pdf)

UNSD database; see <http://unstats.un.org/unsd/default.html>

World Bank (2009), The Cost to Developing Countries of Adapting to Climate Change- New Methods of Estimates. The Global Report of the Economics of Adaptation to Climate Change Study.