DRAFT

Strengthening social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa

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SECTION 1
Introduction

1.0 Background

Mid-term reviews of the progress made towards achieving the Millennium Development Goals (MDGs) have highlighted the need to measure the progress made towards reaching them in a way that truly represents the empowerment of women and the inclusion of vulnerable groups in society. Certain social groups are wholly or partially excluded from the society in which they live from participating in the economic, social and political life of the community, resulting not only in diminished material and non-material quality of life, but also in tempered life chances, choices and reduced citizenship. Countries have been adopting policies to improve social inclusion and gender equality. However recent reviews[1] indicate that the current MDG framework may not explicitly incorporate issues of social integration whose inclusion into broader development agendas is critical for sustained social development and poverty reduction. The reviews also indicate that existing MDG targets and indicators may not capture progress with regard to inclusion of socially vulnerable groups.

Africa is experiencing the greatest challenges in attaining the MDGs. Whilst many African countries have made progress towards achieving the target of MDG 2 on education, the progress on the other goals has been slow. However the existing MDG targets and indicators may not fully reflect the progress being made towards inclusion of the socially excluded and marginalized groups in mainstream development and in addressing inequities in health. Yet it is crucial that the progress made on social inclusion, gender equality and health equity is measured and closely monitored to provide information essential for effective policy development. Social inclusion is a key element of a strategy to minimize social conflict and tap into the productive potential of minority groups that may otherwise feel alienated. It is in this context that a need to develop supplementary targets and indicators relevant to Africa arose, that would improve the capacity of countries to measure progress towards inclusion of vulnerable groups, promote gender equity and address health inequities, thereby improving the effectiveness with which MDGs are monitored. This project is being undertaken jointly with the other regional Commissions (Economic and Social Commission for Asia and Pacific (ESCAP), Economic and Social Commission for Western Asia (ESCWA), Economic Commission for Europe (ECE), and

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[1] UNECA, 2007a, The Millennium Development Goals in Africa: Progress and Challenges.
UNECA, 2007b, Accelerating Africa's Growth and Development to meet the MDGs: Emerging Challenges and the way forward: An Issues Paper for the Conference of African Ministers of Finance, Planning and Economic Development/Fortieth session of the Commission Twenty-sixth Meeting of the Committee of Experts held in Addis Ababa, Ethiopia, 29 March – 1 April 2007.
UNESCAP (2005) A Future within Reach- Reshaping institutions in a region of disparities to meet the Millennium Development Goals in Asia and the Pacific.
WHO, (2003) En-gendering the Millennium Development Goals on Health.
UNDP (2005) En route to equality: a gender review of national MDG reports 2005.

Economic Commission for Latin America and the Caribbean (ECLAC)), as part of an interregional Development Account project entitled “Interregional cooperation to strengthen social inclusion, gender equality and health promotion in the MDGs.”

1.2 Objective of the project in the African region

The objective of the report is to identify supplementary targets that can help ensure inclusion of socially excluded groups that include women, youths, the elderly, the disabled and people living with HIV/AIDS; and promote health equity and sexual and reproductive health in the MDG framework. This information will help increase the capacity of African Governments to promote the social inclusion of vulnerable groups, address gender equality concerns and promote health equity in national development plans through the development of contextualized targets and indicators for the MDGs.

1.3 Methodology

The research methodology used to inform this report involved a combination of secondary and primary research and electronic consultations to identify the additional targets and indicators. Secondary research included a desk review of existing information to identify targets/indicators that are needed in the identified issue areas. A questionnaire was developed to solicit additional information from government and specific interest groups (organisations working on women’s, youth, the elderly, disability and people living with HIV/AIDS) in selected member countries that included Sudan, Congo, Mali, Ethiopia, and Ghana. The questionnaire was also administered with the assistance of the ECA sub regional offices using a national consultant in Zambia and Cameroon.

SECTION 1I

An overview of social exclusion in Africa: A survey of existing literature

2.0 Introduction

This section analyses the incidence of social exclusion in Africa highlighting the major causes and the nature of its extent in African countries based on secondary research and findings from the survey conducted in selected countries. It suggests policy options that can be used to address the problems of social exclusion in a feasible and sustainable manner. The outline of the section is as follows: first a presentation of the definition of social exclusion is made; followed by the empirical evidence on social exclusion in Africa highlighting the major causes; thirdly a presentation of policies that can be used to address social exclusion followed by some conclusions.

2.1 Defining social exclusion

Social exclusion is the process through which individuals or groups are wholly or partially excluded from the society in which they live. Social exclusion is not synonymous with poverty and inequality (e.g. it is possible to be excluded without being poor), but seeks to provide a broader view of deprivation and disadvantage than poverty (UNICEF, 2006). Literature[2] indicates that social exclusion has three principal dimensions that include economic, social, and political. The economic dimension of social exclusion is a direct product of poverty: the excluded are, the unemployed who find themselves entirely eliminated from the labour market and thus deprived of a regular income and those persons or groups who are deprived of access to assets such as land or credit. The social dimension of exclusion involves the loss of an individual's links to mainstream society including restricted access to infrastructure, services, and amenities, social services (education and health), social security and protection, community and family support. Political exclusion is when certain categories of the population - such as women, ethnic and religious minorities, or migrants - are deprived of part or all of their political and human rights.

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[2] Bhalla and Lapeyre (1997), Beall and Piron, 2005

Table 1. Overview of the different dimensions of social exclusion

Exclusion from full participation in economi life	Restricted access from the opportunities to earn income, the labour markets, and from factors of production such as land and a wide range of livelihood opportunities.	• Exclusion from land and other natural resources (because of scarcity, landlessness and lack of legal entitlement) • Exclusion from agricultural livelihood (due to lack of access to inputs or labour availability) • Exclusion from formal and informal employment (due to lack of education, gender, race and ethnic background, disability, age)
Exclusion from social participation	Restricted access to infrastructure, services, and amenities, social services (education and health), social security and protection, community and family support.	• social services health, education, housing, water, sanitation (due to distance, usage costs) • physical infrastructure (distance, usage costs)
Exclusion from political and community participation	Restricted access to organization, consultation, decision-making and the rights and responsibilities of citizenship.	• organisation and representation (due to patterns of political inclusion)

Source: Adapted from Beall and Piron, 2005, Adato et al, 2005.

Some of the groups that are at risk from exclusion along some or all of these dimensions in Africa include: women, the elderly, the disabled, the youth, People Living with HIV/AIDS (PLWHA), the poor, refugees and internally displaced people, and some ethnic groups.

2.2 Causes of social exclusion and evidence in Africa

The major causes of social exclusion in Africa, have been identified in different literature to include; generalized poverty, income inequalities; unequal rural urban development; unequal distribution of assets (land); discrimination based on gender, race, disability and ethnicity; HIV/AIDS; unequal access to social services; lack of social protection strategies; internal and persistent conflict; market failures; unenforced rights and (UNICEF, 2006, Adato et. al., 2005,).

Poverty

Poverty is one of the factors contributing to exclusion but does not necessarily bring it about. The poor are the most vulnerable to exclusion from accessing economic activities and social services. Poorer households suffer from different levels of deprivation in education, food security, safe drinking water, decent sanitation facilities, health care,

adequate shelter and information. Poverty is also a consequence of a series of political and social exclusions from employment and economic assets such as land. Although data on poverty in Africa is not complete, available data for selected African countries from the Human Development Report 2006, indicates poverty levels to be high in Africa. Furthermore, in most of the countries, the incidence of poverty is higher in rural areas than in urban areas not only because the majority of people live in rural areas and due to the distribution of economic activity between rural and urban areas (UNECA, 2005).

In addition, the prevalence of poverty in Africa is not gender neutral. National level data show that poverty is more extreme among female-headed households than male-headed households. This is because women are more vulnerable to poverty because of inequalities in access to productive resources such as land, credit and education; lack of control over their own labour and earned income; gender- biases in labour markets; and the exclusion of women in a variety of economic, social and political institutions. Women also experience poverty as a direct result of the differences between the roles of men and women ascribed to them by existing norms, practices and institutions. These inequalities result in a higher incidence of poverty among women – often accompanied by rising poverty among children and invariably lower health and educational outcomes (UNECA, 2005).

Income inequality

High levels of poverty co-exist with equally high levels of within-country income inequality. Despite Africa's tangible achievements on the economic growth front for the past 5 to 6 years, there is consensus that this positive economic performance has not yet had a demonstrably meaningful impact on poverty eradication (UNECA, 2007b). Inequality is most severe in Swaziland, Botswana, Namibia, Central African Republic and South Africa where the richest 10 percent consume well over 50 percent of national income. Racially imbedded inequality makes it extremely difficult for people to escape poverty in South Africa (Adato, 2005).

Unequal rural urban development

Sub-Saharan Africa is the fastest urbanizing region in the world, with the annual urban growth rate estimated at 4.58% (UN Habitat, 2006). The high urbanization rates in Africa are due to rural-urban migration and high population growth rates. The proportion of those socially excluded and poor has risen in the large cities. Many poor people live in the shantytowns or slums devoid of infrastructure, lacking access to secure tenure and basic social services.

Unemployment

Unemployment remains high – the (official) rate of unemployment persisted at around 10 per cent (ILO 2006). However when comparisons are made on a sub-regional basis, Southern Africa had the highest unemployment rate of 31.6% whilst Eastern Africa had 11%, Central Africa had 9.4%, Northern Africa had 10.4% and West Africa had the lowest rate of 6.7 % (ECA 2005). National unemployment rates surpass 20% in most of the countries for example in some countries (ie. Botswana, Lesotho, South Africa, Swaziland,

Mozambique (estimated to be 21% in 2000), and Angola (estimated to be 45% in 2002). Unemployment has been found to be high among some disadvantaged groups that include women, youths, people with disabilities; people living with HIV/AIDS; cross border migrants; and the elderly (UNECA, 2006).

The share of youth unemployment rate is very high. The youth aged 15-24 years form 20% of Africa's total population. However today these youths form a major group of those that are excluded because 41% of all unemployed in Africa belong to this 15-24 years age group (ILO, 2006). For example South Africa's September 2005 labour force survey revealed that the unemployment rate for persons aged 15-24 and 25-34 years was 51% and 32% respectively compared to unemployment rates of 11% and 8% in the 45-54 years and 55-65 years categories respectively (Government of South Africa, 2006).

Exclusion to employment due to racial discrimination still persists in some countries. For example while the national unemployment rate for South Africa was 26.7 in 2005, the unemployment rate among black Africans was the highest at 31.5% compared to 22.4% among coloured people, 15.8% among Indians/Asians and 5.1% among white people (Government of South Africa, 2006).

The exclusion of women from high paying job opportunities persists, with significant costs to overall socio-economic development. In 2004, the female labour force participation rate (for ages 15+) was 62.7 per cent, compared to the male labour force participation rate of 85.9 per cent in Sub-Saharan Africa (ILO 2005). Less than 10 per cent of women are in formal employment compared with more than 20 per cent for men, leading a larger majority of women to take up work in unpaid rural or low-paying urban informal jobs.

Exclusion from agricultural land

More than 60% of Africa's population is characterized as rural and dependent on agriculture and use of natural resources. However the pattern of access and control of land in Africa has resulted in some groups being excluded or marginalized from owning or accessing agricultural land. Access to land in most of rural Africa continues to be determined by indigenous/communal systems of land tenure. Formal land tenure and management systems introduced in the colonial period and in post-independence land reforms have generally very limited coverage and the land rights claimed and allocated by the modern state often conflict with the communal land tenure practices. As a result land tenure is insecure for many in rural areas, in particular women, the rural poor, pastoralists, hunter-gatherers and others. In addition, land remains extremely inequitably distributed in the former white settler economies of southern Africa, with the majority of rural people excluded from access to the most productive and valuable land. Since most rural populations will continue to rely on land as a principal source of livelihoods in the foreseeable future, it is important that land policy secures the rights of all land users ensuring that exclusion is addressed. In addition, where land has been inequitably distributed since colonial times, more equitable patterns of land ownership can help improve the inclusion of some groups in securing a form of livelihood.

Internal and persistent conflict
Conflicts and instability are a major source of social exclusion especially for those who are displaced as a result. Conflicts have resulted in increased number of internally displaced people and refugees in Africa (see annex 2). The numbers are extremely high for Sudan and the Democratic Republic of Congo (DRC). Internally displaced people and refugees experience many forms of social exclusion in particular women and children. Children in conflict situations may be deprived of education, healthcare and protection, and are vulnerable to being exposed to abuse, violence and exploitation (UNICEF, 2006). Destruction of the physical infrastructure including roads, health, and education facilities; increased personal insecurity; and reduced personnel and supplies for social services, exacerbates the risk of social exclusion for displaced people and refugees.

HIV/AIDS
Sub-Saharan Africa continues to have the highest HIV/AIDS adult prevalence rate globally of 6.1%. The latest UNAIDS update on HIV/AIDS prevalence show HIV rates that surpass 15% in eight countries in the region. About 24.5million adults and children are living with HIV in sub Saharan Africa as at the end of 2005. HIV/AIDS forms a major source of social and economic exclusion through stigma, and its devastating economic impacts. Women remain at a higher risk of contracting HIV. The percent of adults living with HIV who are women increased from 54% in 1990 to 59% in 2006 (UNAIDS, 2006).

Orphans and vulnerable children (OVC) constitute one of the most vulnerable groups to social exclusion in Africa today. OVCs are largely a result of the AIDS pandemic, as well as displacement caused by civil conflict, wars, drought and floods. The total number of orphans due to AIDS reported in Africa at the end of 2005 was about 12 million, representing a very large proportion of the 0-17 year old group (UNAIDS, 2006). One of the main consequences of orphaning is limited access to education. Traditionally in Africa the extended family and the community at large were responsible for assisting orphans socially, economically, psychologically, and emotionally. However these extended families are now under stress due to mounting need as a result of high mortality among the adults of reproductive age, and deepening poverty, and are thus failing to secure education for all orphans in need (Tibaijuka and Kaijage, 1994, UNICEF, 2006). By not getting an education today, these orphans risk exclusion in the future. Without a decent education they will not be able to secure gainful employment or ability to obtain a source of livelihood in the future.

Discrimination based on gender, race, disability and ethnicity
Gender inequality resulting in some women becoming socially excluded is still a major challenge facing African countries. Women still experience unequal access to political, social and economic resources due to society's gendered values, structures and processes. Besides discrimination by gender, the socially excluded also suffer from discrimination by race, disability and ethnicity. Strategies should aim to promote equal opportunities for women and men and for all groups particularly in accessing: productive resources such as assets such as land, capital, and technology; basic infrastructure (water, energy, roads);

agriculture and rural development services; basic health services; as well as to employment opportunities and decision-making processes.

Unequal access to social services due to income differences

2.3 Policies to address social exclusion

The evidence of social exclusion in Africa is alarming as noted in the foregoing passage. It is imperative that countries adopt policies that address social exclusion and attempt to construct more socially cohesive societies. This section highlights some of the suggested policies. The policies suggested include both mitigating approaches that address the symptoms of social exclusion and transformative approaches that address the causes.

Improving access to economic opportunities

Given that exclusion from the formal labour market is one of the principle causes of poverty and marginalization, it is essential to address unemployment with an active job creation policies and interventions directly aimed at ensuring that the disadvantaged are included. Governments must strengthen laws that eliminate discrimination by gender, disability, ethnic origin, HIV status, race, religion or other discriminatory criteria. In order to promote greater equality in access to work and in working conditions, it will be necessary, wherever possible, to contemplate affirmative action measures or positive discrimination. It is also important to enhance education, managerial and entrepreneurial skills training to enable the unemployed especially youth and women to take advantage of the opportunities offered by self-employment. Such capacity building efforts should be complemented by policies that improve access to productive resources such as land, and water, availability of easily accessible sources of credit, new technologies and markets.

Addressing income inequalities and redistributing assets

Given that the unequal distribution of wealth and of factors of production are among the principle causes of exclusion, it is important to adopt policies that address inequalities and can improve distribution of assets. Evidence does show that reduction in inequality in access and ownership of land improves equity, productivity, and efficiency. It is important that land reform policies are targeted at improving equitable access and ownership of land so as to improve the source of livelihood for those excluded. It is also important to have access to credit as an important part of a policy of redistributing assets.

Investment in human capital of the poor and the excluded

Improved social spending (quantity, quality and equitable distributed) on basic services that include health, education, clean water supply, sanitation and other services is required if development is to become inclusive. Education is considered to be the primary mechanism to reduce future inequalities and overcome intergenerational poverty and social exclusion. Access to quality education and effective learning promotes opportunities to achieve a better living standard, greater labor and income generation options, and greater access to well being and participation in the public sphere.

Literature indicates that there is need to combine universal approaches with targeted programmes in order to ensure that the excluded are reached by the social services (Kabeer, 2006, Weeks, 2007). There are pros and cons for focusing only on one of the strategies. Universal coverage aim to provide access for all; however they might not be able to reach all the socially excluded groups. Targeting approaches are essential to ensure that inclusion is achieved. Literature suggests group or regional targeting to be more effective than targeting by income (Weeks, 2007). Governments need to combine different methods of targeting the excluded to include: direct transfers such as school feeding programmes; satellite and mobile services to reach groups that are in remote areas; increased community participation in the delivery of social services (eg. community health extension worker programme in Ethiopia); packaging services together to improve access for example packaging child immunization programmes with nutrition and anti-malaria campaigns.

Infrastructure

The physical isolation of marginalized groups makes the provision of infrastructure a priority if they are to benefit from basic social services and to be integrated in the market economy. Infrastructure investments into schools and basic health facilities, roads and pathways, clean water supply, sanitation, electricity are a prerequisite for the socially excluded to access social services and improved livelihoods.

Mainstreaming social protection into national development plans

As the traditional safety nets become overloaded by the HIV/AIDS epidemic and other income shocks, vulnerable groups should be guaranteed social protection. Social protection that includes a range of public actions (eg. protective ones such as safety nets like targeted assistance for OVCs to access schooling through bursaries, supplementary feeding programmes, preventive ones like pensions, and insurances and promotive ones like micro-credit) carried out by the state are required to guarantee relief from destitution for vulnerable populations. Social protection is an investment in the people that yields positive benefits to society in terms of making development be more inclusive. Examples from some countries indicate that social protection is feasible and affordable. These include: Lesotho where a universal old age pension scheme is being implemented since January 2005, South Africa where 94% of older people receive a social pension and child support grant; Mozambique where a small cash transfer scheme to the poorest citizens in urban areas is operational; the presentations highlighted. Social transfer programs need to be well-targeted to the socially excluded which include vulnerable children, older persons and people with disabilities and poor households.

Social inclusive budgets

National budgets need to be more socially inclusive. They should have specific impact on the socially excluded and should be able to target effectively the needs of the socially excluded. Resources that reach the socially excluded groups such as the very poor, the

disabled, street children, poor women, the aged etc,; need to be made visible in the budgets.

Strengthening and creating a legal framework for the promotion of social integration
Both statutory and customary laws as well as administrative practices with regards to the rights of those who are excluded need to be reviewed and strengthened. Legislation that discourages all forms of discrimination (by gender, race, disability, ethnic origin, HIV status etc) need to be introduced or strengthened. For example legislation on the rights of physically disabled people in industrialized countries has transformed their access to many public buildings and resulted in a more inclusive approach by schools (UNICEF, 2006). Countries need to domesticate international conventions (eg. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child, the Dakar Platform for Action; the Beijing Platform for Action and the African Charter on Human and Peoples' Rights etc). Legislation has to be reinforced through rigorous enforcement, monitoring and active campaigning on behalf of those who are excluded.

Sensitization and education campaigns to change discrimination
Establishing new laws alone is not enough; existing public perceptions on marginalized groups and the gendered social relations and cultural norms in society may quickly shape these laws. There is need for measures to counter preexisting social forces through education campaigns and training of the public on non discriminatory practices and the need to recognize the civil and political rights of excluded groups. The media can play a powerful role in changing public perceptions to break down some of the barriers that separate socially excluded groups from the rest of society.

Capacity building to empower the socially excluded
The socially excluded groups face restricted access to organization, consultation, decision-making and the rights and responsibilities of citizenship. Removing the obstacles to their participation and building their capacity to participate is essential to further their rights. This may involve awareness campaigns that target the socially excluded about their rights, entitlements and essential information that can improve their participation in the economic, social and political spheres. This is an area where the civil society can complement the national efforts.

The 'voice' of the socially excluded need to become integral to social policy design by ensuring their full participation. This is because if users co-design social services, the related interventions are far more likely to truly meet their needs and expectations.

Affirmative action in the form of numerical quotas and reservations are required for political representation, but also in access to higher education and key resources such as land.

Improved governance, peace and stability essential

Countries need to take good governance seriously ensuring the respect for human rights and the rule of law, strengthening democratization and promoting transparency and capability in public administration. Efforts to end conflicts are necessary to accelerate progress towards addressing social exclusion and in achieving inclusive development across Africa.

2.4 Conclusions

The aim of this paper was to define social exclusion and identify the evidence on social exclusion in Africa highlighting the major causes and suggest policy options that can be used to address the problems of social exclusion. The discussions showed that women, the youths, ethnic minorities, the disabled, people living with HIV/AIDS suffer a situation of relatively greater exclusion, vulnerability, poverty and/or social exclusion in Africa. It is clear that social policies (health, education, sanitation, etc) need to be underpinned by special efforts or special interventions which enable and empower the socially excluded to claim their rights. Societies plagued by social exclusion need forms of deliberate social inclusion to move towards universal delivery of services and entitlements.

Annex 1. Internally displaced people and refugees in selected African countries

Country	Internally displaced people (thousands) 2005	Refugees by country of origin (thousands) 2005
Sudan	5,355	693
Uganda	1,740	38
Zimbabwe	570	11
Kenya	382	5
Eritrea	64	144
Cote d'Ivoire	800	18
DRC	1,664	431
Burundi	117	439
Angola	82	216

Source: UNDP, 2006

SECTION 3

Promotion of social inclusion of women and gender equality in the MDGs

3.0 Introduction

International commitments to gender equality, equity and women's empowerment have been made reaffirmed in several United Nations Conferences and forums including the Beijing Conference on women held in 1995, which agreed on a Platform for actions focused on twelve critical areas. The 'Outcome and Way Forward document' that emanated from Beijing Plus Ten review process in 2004 at the regional level indicated that although some progress in addressing gender equality concerns in Africa had been made in some areas such as increased representation in parliaments, gender parity in primary education, and development of national plans that included gender concerns; these normative gains have not yet significantly impacted the lives of women, especially those living in rural areas, due to implementation gaps. Gender inequalities still prevail in access to social capabilities, economic opportunities and political power and the safeguard of women's human rights is not always guaranteed (ECA, 2004). The persistence of gender inequality in all sectors compounds the achievement of the MDG in Africa. Achieving the MDG targets requires addressing the strong interaction between factors such as women's education and their lower status, and child and maternal mortality and morbidity, HIV/AIDS prevalence, nutritional status, poverty, population growth, and economic productivity. Failure to address such interaction impedes the relevance, efficiency, effectiveness and sustainability of efforts to achieve the MDGs. Although gender is only articulated in MDG 3, the centrality of gender equality to the achievement of all MDGs is widely recognized (ECA 2007, ESCAP, 2006). Since gender is a crosscutting issue, gender equality is important not only as a goal in itself but also as a path to achieving the other goals.

This section reviews the gaps in the existing MDGs with respect to gender equality and proposes supplementary targets and indicators that would enable more effective measurement of social inclusion of women and gender equality in Africa. In so doing it draws on several regional and international developmental agendas including the Beijing Platform for Action, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), International Conference on Population and Development (ICPD) and Programme of Action and the Protocol to the African Charter on Human and People's Rights on Women's Rights Protocol adopted in 2003.

3.1 The existing gaps

In Africa, most factors perpetuating poverty and hindering economic development are rooted in gender inequality and women's lower status. There is growing recognition that the majority of the poor in Africa are women because of unequal access to social capabilities, economic opportunities and political power and voice, all of which violate the principles of gender equality and women's empowerment set out in CEDAW, the BPFA and other instruments. Existing literature indicates that it is important to achieve gender

equality in four broad inter-related areas: economic, social, political participation and women's human rights (ECA, 2004, ECA forthcoming, Longwe, 2000). These four areas also closely reflect the major areas where women are socially excluded. The currently existing indicators on gender equality and women's empowerment included in MDG 3 are gender parity in education (primary, secondary and tertiary levels), and literacy for the age group 15-24, women's representation in national parliaments and wage employment in the non-agricultural sector. Although these three indicators address equality in access to core economic opportunities, social capabilities, and political power and voice, due to their limited number, they can not capture and reflect faithfully all the scope of gender inequality in all aspects of social, economic and political life. Therefore, they present some gaps that are highlighted and discussed in this section.

3.1.1 Economic participation

The existing MDG framework captures well under MDG 3 gender differentials in the non-agricultural sector through the indicator *Share of women in wage employment in the non-agricultural sector*. However important gaps in tracking gender equality are evident in the following areas: poverty; gender dimension of unemployment; women's ownership of land; access to credit; and women's participation in the informal sector (where most women are economically engaged). Although poverty in Africa is known to be high among women, the current MDG reporting framework does not adequately reflect the issue. Evidence from research indicate that some households headed by women face higher levels of poverty due to constraints faced by women in accessing productive resources and joining the labour market. It is important to engender the monitoring of poverty by providing sex-disaggregated data on poverty (WEDO, 2004, ECA, forthcoming).

Irrespective of population group, unemployment and underemployment rates among women in Africa are substantially higher compared to men (ECA, 2005). Indicators that track the gender dimensions of unemployment and underemployment are important in monitoring the inclusion of women into both the formal and informal labour market. While there has been an increase in female presence in the formal sector, the informal sector remains dominated by women due to historically high levels of female illiteracy and gender segregated roles in the economy. Most women in Africa are therefore dependent on fields such as small scale trading, agriculture production and food processing as major sources of income to meet livelihood needs. Even within this gender-segregated mould, women's capacities are not being fully exploited due to their denial or limited access to the tools of production. Within the African context, secure access and control over land, access to credit and technical capacity are important with respect to the areas where women are economically dominant. Indicators reflecting women's ownership of land and access to credit are important in ensuring that the MDGs monitoring reflect improvements in gender equality.

3.1.2 Social participation

The improved access of women and girls to social services such as education, health, water, sanitation and energy sources are key determinants of their ability to be able to engage in productive opportunities and to secure their overall well being. The BPFA and the ICPD frameworks, the African Charter on the Rights of the Child, the 2001 Abuja Declaration on HIV/AIDS and the Protocol on the rights of women in Africa, highlight the importance of women's access to social services. However while some of the MDG indicators capture the gender dimensions of participation in primary, secondary and tertiary education, and literacy for the age group 15-24, there remains gaps outstanding in other important aspects of social capabilities. Additional areas that need to be addressed include sexual and reproductive health, women's nutritional status, access to antenatal health services and emergency treatment for maternal health, and access to antiretroviral treatment (ART).

The reasons are founded on the fact that Africa has the highest maternal mortality rate in the world (WHO, UNICEF, UNFPA and the World Bank, 2007). Most deaths are due to poverty, HIV/AIDs, shortage of qualified health personnel, adequate health facilities, access to health facilities, illiteracy and lack of knowledge on the importance of pre-natal care. It is important to include in the MDG framework indicators that will monitor improvements in the provision of sexual and reproductive health, antenatal care services, and women's access to emergency health services.

In Africa, women remain at a higher risk of contracting HIV. The percentage of adults living with HIV who are women increased from 54% in 1990 to 59% in 2006 (UNSD, 2007). HIV prevalence among the 15 to 24 year old age group is up to six times higher for women than for men in most countries (ECA, et al, 2004). Women are more vulnerable to HIV infection because of their low nutritional status, limited education and employment opportunities and low status. Once infected women are more likely to avoid or postpone seeking care due to constraints based on gender, among which include, stigmatization, domestic and reproductive responsibilities and the costs of travel and treatment. It is important that gender inequalities that make women be more vulnerable to HIV/AIDs are addressed and sexual and reproductive rights are enforced. In this regard it is essential to have indicators that can monitor improvements in Voluntary Counseling and Testing (VCT) services and access to Anti Retroviral Treatment (ART).

3.1.3 Political participation

The third issue relates to the participation of women in decision-making at all levels from household, to community and national. This has been noted to influence the extent to which gender equality concerns and women's specific issues are mainstreamed in the national development agenda, including poverty reduction strategies and resource allocation mechanisms (ECA, 2004a). Therefore, assessing women's power to influence policymaking, legislation enactment, institutional setting, planning, and resource allocation is key for monitoring all the MDGs. Women's equal participation in the decision-making process has been identified in both the BPFA and CEDAW as crucial to the achievement of gender equality and sustainable poverty eradication.

The current MDG 3 captures decision-making through the proportion of seats held by women in national parliament. However, this indicator alone might not capture adequately the status of women's participation in decision-making. Although African countries have made some progress in women representation in parliament and ministries, it is important to note that this higher representation of women has not yet systematically led to adequate budgets, institutional frameworks and policies for implementing gender programmes for gender equality (ECA, 2007). A few countries have created parliamentary portfolio committees on gender, which function as accountability mechanisms. During the 2004 Beijing Plus Ten review process of the Africa region, it was found that less than 15% of the participating countries had parliamentary committees for enforcing accountability on gender mainstreaming and implementing gender policies, including those related to gender equality in decision-making (ECA, 2004b).
There is a clear need for the design of supplementary indicators that would embrace a more pluralistic view of decision-making levels including representation in local councils, and in higher public and private sector positions. This step has become all the more important with the rapid spread of political and economic decentralization across many African countries.

3.1.4 Women's human rights

According to ECA's AGDI, and follow up process for CEDAW, and the Protocol on the rights of women in Africa, recognition of women's human rights are important for the achievement of gender equality. Some African countries are still beset by widespread practices, which are inimical to the advancement of women, of which violence against women and girls constitute the most pervasive. As a form of violence harmful traditional and cultural practices negatively affect the fundamental rights of women and girls, such as their rights to life, education, health and bodily integrity. Examples include FGM, early/enforced marriages, child betrothal and polygamy (ECA, forthcoming). Thus, Additional indicators are required for monitoring progress being made in the elimination of these practices.

3.2 Suggested targets and indicators to monitor inclusion of women and gender equality

The proposed supplementary indicators to strengthen and ensure the social inclusion of women as both beneficiaries and effective participants in development shall mainly relate to the gaps identified in the preceding section in connection with improving the economic, social and political power of women and girls in addition to providing a basis for monitoring their human rights in line with laid down international treaties. A general recommendation being made for all indicators is that where applicable, both old and new indicators must be measured using data disaggregated by sex. This is important because firstly, it provides an indication of the gender gaps and secondly, it will measure the incidence of exclusion of younger women, who are more vulnerable compared to older

women and men as a whole. This section presents the suggested additional indicators for each MDG.

MDG 1 Eradicate extreme poverty and hunger
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

The suggested additional indicators reflect the gaps discussed in 3.1.1 that relate to the gender dimensions of poverty, unemployment and under employment. Issues of women's access to land and credit and participation in the informal market are addressed in table 3.1 below.

Table 3.1 Current and suggested indicators for MDG 1 target 1.

Indicator 1. Proportion of population below $1 (PPP) per day by sex
Indicator 2. Poverty gap ratio by sex
Indicator 3. Share of poorest quintile in national consumption
Suggested additional indicators
Percentage of households headed by females below poverty line
Number of unemployed by sex
Women's participation in the informal sector; (Percentage of female workers in informal secto)
Ownership of land by sex;
Access to credit by sex;
Share of women among the poorest quintile in national consumption
Proportion of women and men working in non agricultural sector

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

The additional indicator for target 2 relates to tracking the level of nutrition of women which is important for maternal health as shown in table 3.2.

Table 3.2 Current and suggested indicators for MDG 1 target 2.

Indicator 4: Prevalence of underweight children under-five years of age by sex
Indicator 5: Proportion of population below minimum level of dietary energy consumption by sex
Suggested additional indicators
Proportion of pregnant women who are anemic

MDG 2: Achieve universal primary education
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Table 3.3 Current indicators for MDG 2 target 3.

Indicator 6: Net enrolment ratio in primary education by sex

Indicator 7: Proportion of pupils starting grade 1 who reach grade 5 by sex
Indicator 8: Literacy rate of 15-24 year-olds by sex

The current MDG indicators monitors the gender gaps in primary school enrolment, as well as drop out or primary school completion rate. All the indicators need to be disaggregated by sex to reflect the gender differences.

MDG 3: Promote gender equality and empower women
Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. (need a more encompassing title for this target as this target only focuses on education).

Additional indicators under this MDG relate to women's representation at lower levels of governance such as local councils; violence against women; existence of institutional mechanisms on gender equality such as a parliamentary committee on gender equality and gender sensitive budgets as shown in table 3.4.

Table 3.4 Current and suggested indicators for MDG 3 target 4.

Indicator 9: Ratios of girls to boys in primary, secondary and tertiary education
Indicator 11: Ratio of literate women to men, 15-24 years old
Indicator 12: Share of women in wage employment in the non-agricultural sector
Indicator 13: Proportion of seats held by women in national parliament
Suggested additional indicators
Proportion of seats held by women in local councils
Incidence of gender based violence per 100,000 women/year
Legislation against gender-based violence
Proportion of woman and girl victims of sexual and other forms of violence who have access to medical, psychological and legal services
Existence of a parliamentary committee on gender equality
Gender sensitive budgets
Child bearing among girls aged 15-19 years

MDG4: Reduce child mortality
No additional indicators are suggested under MDG4. (Have current indicators disaggregated by sex)

MDG5: Improve maternal health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

The low social status of women which leads to their lack of access to decision making, employment, finance and education also limits their access to health care and limited reproductive health rights when it is needed. Suggested additional indicators on maternal mortality include improved access to reproductive health, access to prenatal and

emergency obstetric care, prevalence of contraceptive use and age at marriage as shown in table 3.5.

Table 3.5 Current and suggested indicators for MDG 5 target 6.

Indicator 16. Maternal mortality ratio. Maternal deaths per 100,000 live births
Indicator 17: Proportion of births attended by skilled health personnel Percentage of deliveries
Suggested additional indicators
Percentage of female population within 2 hours travel distance of basic emergency obstetric care
Proportion women in the reproductive age (15-45) who have access to prenatal care at the primary health care level
Proportion of population in the reproductive age (15-45) who have full access to reproductive health services at the primary health care level by sex
Prevalence of contraceptive use by sex.
Age at marriage by sex
Age at first birth

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

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Suggested additional indicators include improved access by women to ART and VCT as shown in table 3.6.

Table 3.6 Current and suggested indicators for MDG 6 target 7.

Indicator 18: HIV/AIDS prevalence Estimated adult (15 - 49) HIV prevalence (%) by sex
Indicator 19: Condom use at last high risk sex by sex
Indicator 20: Ratio of school attendance of orphans to school attendance of non-orphans
Suggested additional indicators
Proportion of HIV infected population with access to ART by sex

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

No additional indicators are suggested under this target.

SECTION 4

Promotion of social inclusion of the youths in the MDGs

1. Introduction

African youth, like their counterparts in other regions, experience considerable social exclusion due to barriers they experience in accessing education and health services, finding decent jobs, participating in political and decision-making processes, and ultimately, getting out of poverty.

Fortunately, this predicament has been increasingly recognized by governments and international partners, who now acknowledge that African youth represent not only a major development challenge, but that they are also a major force for positive change on the continent. Tackling youth development issues is key to accelerating overall economic and social development as envisaged by the Millennium Development Goals (MDGs), besides improving the specific situation of young people in Africa.

In recent decades a number of global and regional initiatives have been adopted by governments to help push the youth development agenda forward. The World Programme of Action for Youth to the Year 2000 and Beyond adopted in 1995 provided a policy framework for governments to promote youth development and the role of youth as agents of change. At the African level, the adoption of the African Youth Charter by the African Union Heads of State Summit in 2006 represented a milestone event for the continent.

Despite this recognition, progress in overcoming the main developmental challenges facing Africa's youth continues to be inadequate. To accelerate progress, governments and partners need to be able to monitor and evaluate targeted interventions. However, this in turn requires the development of statistics that go beyond the current MDG indicators.

As noted in the report of the United Nations Secretary-General on *Goals and Targets for Monitoring the Progress of Youth in the Global Economy*: "The existence of concrete benchmarks in the form of specific goals and time-bound targets may facilitate shaping and clarifying the youth development agenda at both the national and international levels, and provide better opportunities to assess national progress." (UN 2007: 2). At the sixtieth session, United Nations General Assembly adopted a resolution (60/2) requesting the United Nations Secretariat in collaboration with United Nations programmes and agencies to establish a set of youth development indicators.[3]

To address this concern, this section investigates firstly how the Millennium Development Goals relate to youth before looking specifically the gaps in the MDGs in terms of social

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[3] See the United Nations Programme on Youth for details of responding to Resolution 60/2 (www.un.org/youth).

exclusion of this vulnerable group. Based on the analysis in these sections, both disaggregated and new indicators are proposed to help governments monitor progress in promoting the social inclusion of youth in Africa.

2. The Millennium Development Goals and Youth

Since their adoption at the Millennium Summit in 2000, the Millennium Development Goals (MDGs) have helped galvanize governments, the United Nations System, donors and civil society around a comprehensive economic and social development framework. The eight goals cover various dimensions including poverty, access to education, and health. By design, the MDGs do not, however, directly address all of the specific concerns of vulnerable groups such as youth.

Before turning to the gaps in the MDGs, it is important to acknowledge where the goals do directly or indirectly refer to young people. As presented in Table 1, only Target 16 of Goal 8 (develop a global partnership for development) directly relates to youth in terms of developing and implementing strategies for decent and productive work for youth. This target is measured using the unemployment rate of young people aged 15-24, also disaggregated by gender.

In addition, goals 2-6 refer to youth indirectly.[4] Goal 2 (achieving universal primary education) indirectly relates to youth because young people are those that benefit from increased access to primary school when they are children (youth also are enrolled in primary education). A similar argument can be made for Goal 3 in terms of reducing gender disparities in primary and secondary education. With respect to Goal 4 (reducing child mortality), youth are implicated because adolescent pregnancies increase the risk of child mortality. Likewise, Goal 5 refers to maternal mortality, which is higher for adolescents. Finally, the goal of combating HIV/AIDS, malaria and other diseases (Goal 6) is pertinent to the situation of youth, especially in Africa. In the case of HIV/AIDS, young people, particularly young females, are more susceptible to acquiring the HIV/AIDS due to their vulnerability and poverty.

Though Goal 1, eradicating extreme poverty and hunger, does not directly or indirectly refer to youth, achieving this objective would require progress in terms of the situation of young people. This is especially relevant in Africa where young people make a significant proportion of the population (youth aged 15-24 represent around 20 per cent) and are also more likely to suffer from income poverty than prime-aged adults (United Nations 2005). This point highlights the need to have data disaggregated by age to understand the underlying trends with regards to such goals, and to identify where progress is being made and the effectiveness of interventions.

[4] See Ad-Hoc Working Group for Youth and the MDGs (2005) for a further discussion.

Goal 7, ensuring environmental sustainability, also does not specifically relate to young people. Nonetheless, achieving sustainable development will require the involvement of young people, as recognized at the World Summit on Sustainable Development in 2002.

Table 1: How the Millennium Development Goals Reflect the Situation of Youth

	Refers to youth	
Goal	**Directly**	**Indirectly**
Goal 1: Eradicate extreme poverty and hunger		
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	No	No
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	No	No
Goal 2: Achieve universal primary education		
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	No	Yes
Goal 3: Promote gender equality and empower women		
Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	No	Yes
Goal 4: Reduce child mortality		
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	No	Yes
Goal 5: Improve maternal health		
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	No	Yes
Goal 6: Combat HIV/AIDS, malaria and other diseases		
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	No	Yes
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	No	No
Goal 7: Ensure environmental sustainability		
Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	No	No
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	No	No
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	No	No
Goal 8: Develop a global partnership for development		
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Target 13: Address the special needs of the least developed countries Target 14: 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)	No	No

Target 15: 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 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	Yes	-
Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	No	No
Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	No	No

In spite of this youth coverage within the MDGs, the goals fail to address a number of barriers to the social inclusion of this vulnerable group, especially as it relates to the African context. In the next sections, the nature of social exclusion for youth in Africa and the subsequent gaps in the MDGs are identified.

3. Social Exclusion of Youth in Africa

While the Millennium Development Goals focus largely on basic needs such as food, education, health, and sanitation, the concept of social exclusion is centred on a broader notion of participation in terms of economic, social and political areas. Thus, the conceptualisation of social exclusion is similar to Amartya Sen's ideas on multidimensional poverty and disadvantage, which revolve around the belief that, in order to function effectively in the modern world, people require a fairly wide range of capabilities, and not just an adequate money income (Sen 1999). According to Sen, the socially excluded are denied access to resources and opportunities, restricting the potential for these individuals to acquire the necessary capabilities.

Using this conceptualisation, understanding the exclusion of youth in Africa requires analysing their situation in economic, social and political dimensions.

Key dimensions of economic participation of youth

In terms of economic participation of youth, the main issues are access to education and the labour market.

Firstly, for African youth to actively participate in all spheres of life, they need to gain an education that provides them with the skills to compete in an increasingly competitive globalized world. MDG 3 focuses on access to primary education as measured by the net primary enrolment ratio, proportion of pupils starting grade 1 who reach grade 5, and the literacy rate of youth aged 15-24.

While primary education is the starting point for developing a basic level of human capital, it does not alone provide youth with the skills to compete in the African or global labour market. In order to be competitive and have a chance of finding a decent job, African youth need in fact to acquire knowledge and skills through higher levels of education and training. Therefore, dimensions missing from the MDGs include access to secondary and tertiary education in addition to training and vocational education.

Secondly, as evident across the continent, most African youth face bleak prospects in terms of finding a job. Most end up in the informal sector or unemployed if they have some means of support. Though this issue is recognized by the MDGs, there are some aspects not captured by the target (Target 16 as discussed above). For example, the challenge here is not just about finding a job but finding one that pays a wage to lift young people and their families out of poverty. The situation where an individual is working but nonetheless falls below the poverty line is known as working poverty. Working poverty is a common feature of the labour market in Africa because most jobs are located in the informal economy.

Another dimension of the labour market that is important to consider is the inactivity rate, which is defined as the proportion of the working-age population (in this case aged 15-24) who are not in the labour force. Youth can remain outside the labour market for a variety of reasons such as education, childbearing and childcare, illness/disability, or because they are discouraged from participating at all (see ILO (2006) for more details). Consequently, some components such as education can be considered voluntary, while others are more involuntary (illness/disability), and hence, it is important to consider these various factors when analysing this indicator of inactivity.

In addition to the education and the labour market, other important dimensions of economic participation of youth include access to credit, land and other assets.

Key dimensions of social participation of youth

The participation of African youth in social areas is reflected by their ability to access health services, support from families and communities and participate in social networks and organizational memberships. Education can also be considered here, though it has been addressed above under economic participation.

In the area of health, illnesses, mental health problems and disabilities can exclude youth from fully participating in society. Young people can also experience considerable burdens as a result of caring for other family members, a situation that has arisen as a result of HIV/AIDS.

In addition to these health dimensions, social participation can be viewed in terms of the lack of access to social networks and organizational memberships. Poor health and education will reinforce exclusion from such social structures.

Key dimensions of political participation of youth

Alongside economic and social participation, the ability to contribute to political and decision-making processes at all levels is a crucial component of the development process.

Until recently, policymakers, however, rarely included youth in the decision-making process or even consulted with them on their concerns. Cultural attitudes have been a major stumbling block to establishing inter-generational dialogues, not just in Africa but also globally. Traditionally, wisdom was seen as an increasing function of age, and subsequently, adult leaders and policymakers took it upon themselves to make decisions on behalf of youth. However, without real participation, youth policies and programmes, especially relating to MDGs, will be ineffective.

The MDG indicators only address political participation in terms of women as reflected by MDG 3 (see Indicator 12).

4. The Gaps in the MDG Framework

Based on the discussion in sections 2 and 3, a number of gaps in the MDG framework can be identified with respect to youth and social exclusion. Additional indicators are proposed to assist African governments and development partners to better track progress in improving the social inclusion of youth on the continent. These supplementary indicators are either disaggregated statistics covered by the existing MDG framework or new proposals for indicators.[5]

Table 2: Supplementary indicators to promote the social inclusion of youth in Africa

Goal	Disaggregated Indicator	Additional Indicator
Goal 1: Eradicate extreme poverty and hunger		
	Percentage of youth-headed households living in extreme poverty	
	Percentage of young women and men suffering from hunger	
Goal 2: Achieve universal primary education		
		Gross secondary enrolment ratio
		Gross tertiary enrolment ratio
Goal 5: Improve maternal health		
		Percentage of adolescent pregnancies

[5] For a further discussion on a proposal for youth-related goals and targets, see United Nations (2007).

		(young women aged 15-19)
		Percentage of young women with access to prenatal and reproductive health services
Goal 8: Develop a global partnership for development		
		Percentage of youth who working poor
		Percentage of youth without employment or enrolled in education (inactive)

As listed in Table 2, two disaggregated indicators are proposed in relation to MDG 1, eradicating extreme poverty and hunger. The first indicator is important to monitor whether there is any progress in improving the situation of youth-led households, which are more vulnerable to poverty that those led by prime-age adult.

Under MDG 2, two additional indicators are proposed in terms of enrolment ratios for secondary and tertiary education. As argued above, young people need more than a primary education in order to escape social exclusion. For this reason, it is important that governments monitor progress in increasing enrolments at higher levels of education.

With respect to MDG 5, two indicators are suggested here: the percentage of adolescent pregnancies and the percentage of young women with access to prenatal and reproductive health services. Young African women are more vulnerable to suffering complications during birth and governments need to monitor progress in reducing this risk.

Finally, to supplement the indicators used for Target 16, additional indicators relating to the situation of youth in the labour market are proposed, namely the rate of working poverty and inactivity. As argued above, youth in most African countries face the challenge of finding a decent job that will lift them and their families out of poverty. Furthermore, in some countries, young Africans are discouraged altogether from participating in the labour market. These two dimensions are not captured by the unemployment rate.

SECTION 6

Promotion of health equity in the MDGs

1.0 Introduction

Inequities in access to health care are increasingly being seen as a major impediment to the achievement of the MDGs in Africa. All African countries are signatory to the World Health Organization (WHO) Alma-Ata Declaration of 1978 wherein they committed themselves to achieve health-for-all by the year 2000. Towards the end of the twentieth century, it was recognized that achieving health-for-all was still a major challenge so renewed global commitments were made in the "World Health Declaration" of the World Health Assembly in 1998 wherein member States affirmed the need to give effect to the "Health-for-All policy for the twenty first century" through the implementation of relevant regional and national policies aimed at reducing social and economic inequities in improving the health of the whole population. At the regional level, African Governments have repeatedly highlighted the importance of bridging health inequities by improving access to health for all.

Inequities in access to health care matter because they have severe implications for human development. First they violate the basic precepts of social justice for everyone to have equal opportunity to be healthy. The Universal Declaration of Human rights recognizes access to health as a human right and emphasizes the importance of governments and development actors to guarantee access to basic health for all. Health inequities are thus a major form of social exclusion. Secondly; health inequities have a negative impact on the progress towards achieving the targets of the MDGs – the health MDGs cannot be fully achieved if large segments of the population do not have access to health. Third; inequities in accessing health care are also bad for growth, poverty reduction and overall development that is inclusive. Extreme inequities in health can result in intergenerational deprivation of access to health that can be linked to limited access to other livelihood assets such as education resulting in limited opportunities to break out of poverty.

Overall, despite the commitments, many African governments are grappling with the challenge of how to devise health policies and health care systems that can ensure equity of access to adequate health care and how they can measure and monitor their progress towards improved inclusion of vulnerable groups in access to health care and health outcomes. Empirical evidence shows glaring intra-country differences in access and utilization of health care and health status based on income, gender, urban-rural populations and between dominant and marginalized ethnic groups. Even in countries that improved resources to health and strengthened their health systems and had achieved some progress on health outcomes; this progress has not been "inclusive" enough. Besides economic inequalities, social and geographic factors such as gender, race, rural/urban residency and ethnic background also contribute for the large differences in health status and the exclusion of some groups to health services (Carr, 2004).

The objective of this section is to review the progress made on health MDGs in Africa highlighting the major challenges; review the evidence and causes of health inequities in selected African countries; identify the strategies that countries are adopting to address health inequities; suggesting policy options that can be used to address health inequities in a feasible and sustainable manner; and suggest areas for supplementary targets or indicators in the MDGs that can be used to improve the capacity of countries to monitor inclusion in the health.

The section is divided into six sections. Section 6.1 presents a review of the progress made in achieving the health MDGs in Africa and the major challenges. Section 6.2 presents the evidence on health inequities in the selected African countries. Section 6.3 presents areas where the current MDGs are not fully addressing equity and suggested areas for supplementary targets or indicators in the MDGs.

6.1 Progress made in achieving the health MDGs in Africa and the major challenges

The MDGs related to health include 3 specific goals (Goals 4, 5 and 6) and Target 2 of MDG1 and target 10 of MDG7. Overall, progress in achieving the health MDGs has been slow. As shown in table 1, the data suggest very little improvements by Sub Saharan Africa on the MDGs on child mortality, maternal mortality, HIV/AIDS, malaria and other diseases, whereas North Africa has made better progress. Sub-Saharan Africa still has the highest HIV/AIDS prevalence rates that is disproportionately affecting women; it still has the highest TB incidence in the world; and the highest maternal and child mortality ratios.

However the aggregated regional level data shown in table 1 does not reveal the wide disparities across the countries. Some countries have performed better than the others in making progress towards the attainment of the health MDGs. For example Botswana, Mauritius, Gambia, Cape Verde and Northern African countries have made progress towards reducing maternal mortality since 1990 and are likely to achieve the goal, whilst other countries have been slow (UNECA, 2007). The same can be said for the other MDGs, a few countries have made more progress than others.

Table 1: Progress on the Health MDGs and targets

MDG, Target and Indicator	**Developing Regions**		**Northern Africa**		**Sub-Saharan Africa**	
	1990	**2005**	**1990**	**2005**	**1990**	**2005**
MDG4: Reduce child mortality **Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate**						
Indicator 13: Under-five mortality rate Deaths per 1000 live births	106	88	88	35	185	166
Indicator 14: Infant mortality rate Deaths per 1000 live births	72	57	66	30	110	99
Indicator 15: Proportion of 1 year-old children immunized against measles Percentage of children 12-13 - months who received at least one dose of measles vaccine	71	75	85	95	57	64

MDG5: Improve maternal health **Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio**						
Indicator 16. Maternal mortality ratio. Maternal deaths per 100,000 live births[2]	n.a	450	n.a	130	n.a	920
Indicator 17: Proportion of births attended by skilled health personnel Percentage of deliveries	43	57	40	75	42	45
MDG 6: Combat HIV/AIDs, malaria and other diseases **Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS**						
Indicator 18: HIV/AIDS prevalence Estimated adult (15 - 49) HIV prevalence (%)[3]	0.3	1.1	<0.1	0.1	2.0	5.7
Indicator 19: Percent of adults living with HIV who are women (%)[3]	n.a	n.a	<20	23	54	59
MDG 6: Target 8 **Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**						
Indicator 23: Prevalence and death rates associated with tuberculosis (a) Incidence Number of cases per 100,000 population (excluding HIV infected)	148	149	54	44	148	281
(b) Prevalence Number of cases per 100,000 population (excluding HIV infected)	367	255	59	44	331	490
(c) Deaths Number of deaths per 100,000 population (excluding HIV infected)	34	31	5	4	7	55
Indicator 24: Proportion of tuberculosis cases detected and cured under directly observed treatment strategy (DOTS) (a) New cases detected under DOTS: DOTS smear-positive case detection rate (%)[4]	29	61	84	92	36	49
(b) Patients successfully treated under DOTS Treatment success (%)[4]	82	84	88	84	72	74

[1] Data is for the years 1990 and 2003, [2]Data is for year 2000; [3]Data is for the years 1990 and 2006; [4]Data is for the years 2000 and 2004
Source: UN, 2007.

Some of the major reasons for the poor progress on the health MDGs identified from different literature include: the challenge of the HIV/AIDS pandemic; policy challenges such as lack of robust sectoral strategies, plans and budgets and weak linkages between the health sector and the countries' development strategy institutional challenges such as shortage of skilled staff; inadequate funding; and lack of a multi-sectoral approach to achieving health outcomes. Inequities in accessing and utilizing health care are now increasingly being seen as a challenge to achieving the health MDGs. This study focused on 10 African countries to identify evidence on health inequities The selected countries include Ethiopia, Kenya, Ghana, Senegal, Zambia, Malawi, Egypt, Morocco, Chad and Cameroon.

6.2 Evidence on health inequities in the selected African countries

Using data from Demographic and Health Surveys (DHS) simple stratification (bivariate analysis) for health access and utilization indicators between groups were performed. In

addition to the bivariate analysis of the data, concentration indices[6] were also calculated to identify income-related sources of health inequity. The DHS variables used in this study were based on the utilization of maternal and child health services for the following: modern contraceptive methods; prenatal care services; women receiving delivery assistance from skilled health worker; immunization coverage rates; children with acute respiratory infection taken to a health facility; children with diarrhea that were taken to a health facility; and a proxy for access to a health facility. This study stratified these health utilization variables by socio-economic status and rural/urban location. The study used the DHS constructed wealth quintiles that are based on a household wealth index calculated using a factor analysis procedure[7]. In addition, to add to the dynamic nature of the study two DHS data points were used to identify the trend in inequity for all the study countries. The detailed results of the study are presented in separate document "Mainstreaming health equity in the development agenda", this section just highlights evidence on health inequities that were revealed in the study.

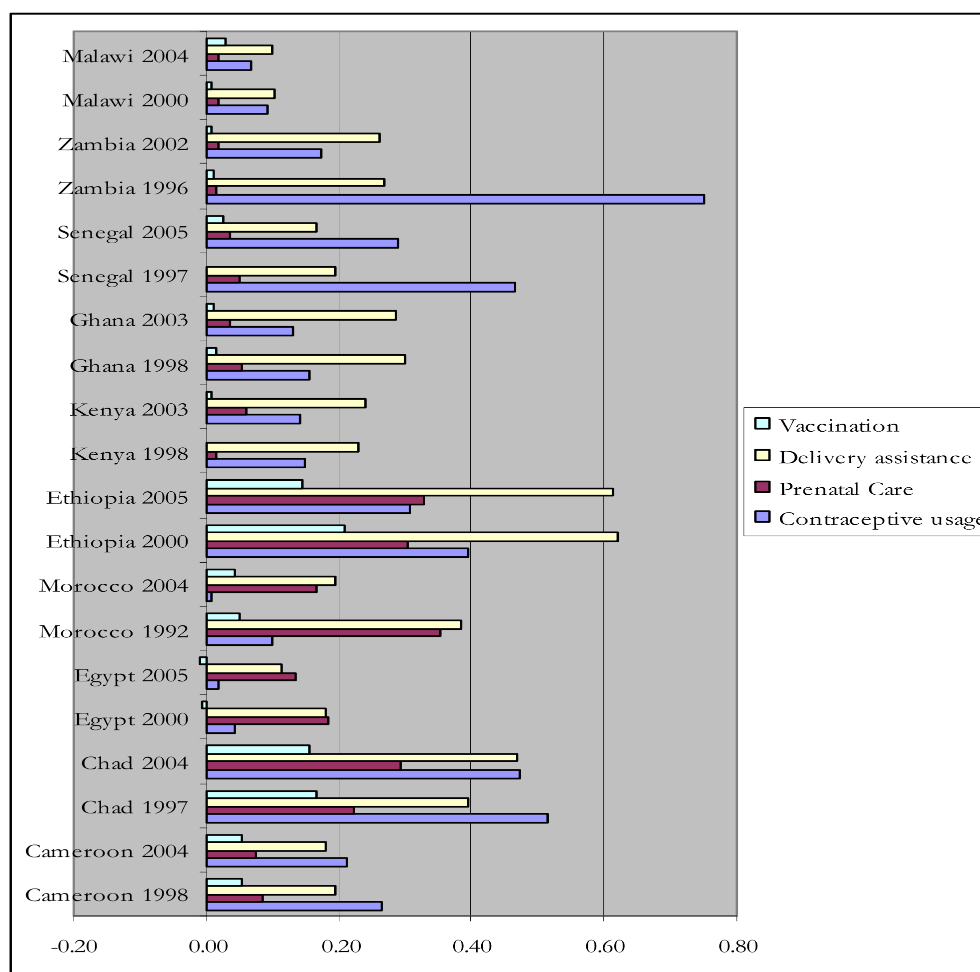
6.2.1 Evidence of health inequities for all health indicators by wealth

Income differentials in access to health are observed in different magnitude across all countries and across all health variables analysed. Figure 1 shows the concentration indices for all health indicators across all the countries (annex 1 also shows concentration curves for all the indicators for the latest year). Comparison across access to health indicators reveals that the indicator with the greatest inequity due to wealth differences is contraceptive usage followed by delivery assistance in all countries. An equitable distribution for these indicators is a concentration index of 0.0. Although access to immunization and prenatal care services appear closer to equity (closer to 0.0) in Zambia, Malawi, Ghana, Senegal and Kenya, huge disparities are evident in Ethiopia and Chad (see figure 1 and annex 1).

Figure 1. Concentration indices for selected access to health variables

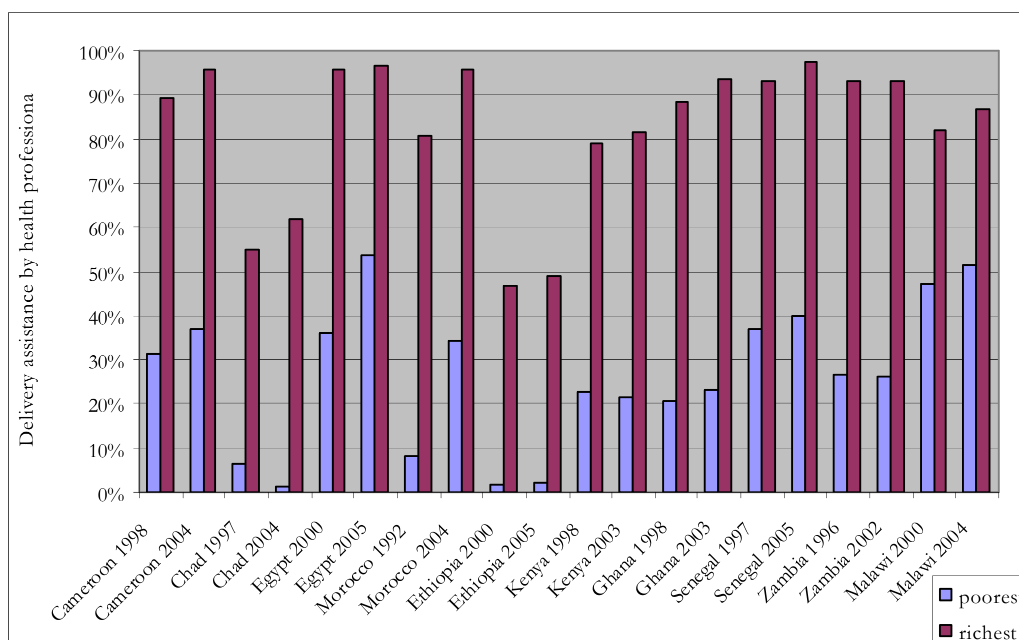
[6] The concentration index is analogous to the gini coefficient for income distribution. The range of values of a concentration index range from -1.0, which would occur if access to health for an indicator for example immunization covers all in the poorest population, to +1.0, which would occur if access to health for an indicator covers all in the wealthiest quintile. Where there is no income-related inequality, the concentration index is zero.

[7] See Rutsein and Johnson, 2004 for details.



Overall, presence of inequities due to wealth differences implies the need for policies that can address the rich poor source of inequities particularly for delivery assistance and contraceptive use. In all study countries women from the poorest quintiles are less likely than those in better off quintiles to use basic health services such as prenatal care, modern contraceptives, delivery assistance by a health professional, and immunization. The health indicator with the greatest inequity due to economic reasons is delivery assistance by health professional. Stratification of the delivery assistance indicator by wealth reveals striking evidence on inequities. Women in the richest wealth quintile have greater access to delivery assistance by a health professional when compared to the poorer groups in all the study countries (see figure 2 and annex 1). Ethiopia and Chad that have the lowest figures overall of women receiving delivery assistance from a health professional, also show wide disparities between the richest and the poorest – less than 3% of the poorest wealth quintile are able to access delivery assistance from a health professional compared to almost 50% and 60% of those from the richest group in Ethiopia and Chad respectively.

Figure 2. Women with access to delivery assistance by richest and poorest wealth quintiles



Source: ECA calculations using DHS data

6.2.2 Evidence of health inequities for all health indicators by rural - urban location

Although income differentials are important prerequisites to access and utilization of health services, location is even more inequitable. The urban-rural divide cuts across all health variables with the rural population severely under-serviced (see annex 3 for summary table). Rural-urban inequities are most extreme for delivery assistance, and children with ARI and diarrhea taken to a health facility.

6.3 Suggested areas for supplementary targets or indicators in the MDGs

Three MDG goals 4, 5 and 6 specifically focus on health. The gaps and supplementary indicators were identified by applying the framework on equity to health developed by the International Society for Equity in Health. The three equity goals applied include equity in access and utilization of health care; equity in resource allocation; and equity in health status/outcome. The health MDGs are expressed as national averages and do not reflect what happens to poorer groups; rural/urban geographical location and differences by gender. To reflect equity data for existing indicators there is need for disaggregation depending on the perculiarities and priorities of the country. This section analyses the issues pertaining to each goal.

6.3.1 MDG4: Reduce child mortality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicator 13: Under-five mortality rate Deaths per 1000 live births
Indicator 14: Infant mortality rate Deaths per 1000 live births
Indicator 15: Proportion of 1 year-old children immunized against measles Percentage of children 12-13 - months who received at least one dose of measles vaccine

To reflect equity, there is need to disaggregate these indicators to show progress among the excluded communities for example by socio-economic groupings. Two of the three indicators reflect equity in terms of outcome while indicator 15 reflects access or utilization. It is important to have additional indicators that reflect access or health utilization to capture improvements in equity. These are:

- Distance to the nearest health facility (% within 5km) and
- Children with diarrhea / ARI who were taken to a health facility.

Summary of suggested indicators for MDG4: Target 5 include:

Indicator	Note
Indicator 13: Under-five mortality rate Deaths per 1000 live births	All indicators to be calculated for national average and Disaggregated by socially excluded groups in the country eg. the different socio economic groupings.
Indicator 14: Infant mortality rate Deaths per 1000 live births	
Indicator 15: Proportion of 1 year-old children immunized against measles Percentage of children 12-13 - months who received at least one dose of measles vaccine	
Suggested supplementary indictor: Distance to the nearest health facility (% within 5km)	
Suggested supplementary indictor: Children with diarrhea / ARI who were taken to a health facility	

6.3.2 MDG5: Improve maternal health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicator
Indicator 16. Maternal mortality ratio. Maternal deaths per 100,000 live births
Indicator 17: Proportion of births attended by skilled health personnel Percentage of deliveries

Indicator 16 is an outcome indicator, indicator 17 is an access/utilization indicator. The two indicators do not adequately reflect how the maternal health of women from the socially excluded groups can be monitored. It is therefore important to express the proportion of births attended by skilled health personnel in terms of the socially excluded groups. In addition, there is need to come up with additional indicators that can more appropriately capture access or utilization in order to fully reflect equity. These indicators can include the following:

- Contraceptive prevalence rate[8]
- Utilization of prenatal care services
- Percentage of population within 1 hour travel distance of basic emergency obstetric care
- Proportion of women of reproductive health/pregnant women who are anemic

Summary of suggested indicators for MDG5: Target 6 include:

Indicator	
Indicator 16. Maternal mortality ratio. Maternal deaths per 100,000	

[8] Already captured in the revised MDG monitoring framework

live births	
Indicator 17: Proportion of births attended by skilled health personnel Percentage of deliveries	These indicators need to be calculated for national average and Disaggregated by socially excluded groups in the country eg. the different socio economic groupings so as to more appropriate reflect equity and inclusion in monitoring.
Suggested supplementary indictor: Contraceptive prevalence rate	
Suggested supplementary indictor: Utilization of prenatal care services	
Suggested supplementary indictor: Percentage of population within 1 hour travel distance of basic emergency obstetric care	
Suggested supplementary indictor: Proportion of women of reproductive health/pregnant women who are anemic	

6.3.3 MDG 6: Combat HIV/AIDs, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicator 18: HIV/AIDS prevalence Estimated adult (15 - 49) HIV prevalence (%)
Indicator 19: Condom use at last high risk sex
Indicator 20: Ratio of school attendance of orphans to school attendance of non-orphans

The indicators expressed in national averages do not capture progress in addressing equity issues among all the groups. It is important that all the indicators are disaggregated to reflect the socially excluded groups. Possible additional indicator that can also help reflect equity is the following:

- Proportion with access to antiretroviral drugs

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Indicator 23: Prevalence and death rates associated with tuberculosis (a) Incidence Number of cases per 100,000 population (excluding HIV infected)
(b) Prevalence Number of cases per 100,000 population (excluding HIV infected)
(c) Deaths Number of deaths per 100,000 population (excluding HIV infected)
Indicator 24: Proportion of tuberculosis cases detected and cured under directly observed treatment strategy (DOTS) (a) New cases detected under DOTS: DOTS smear-positive case detection rate (%)
(b) Patients successfully treated under DOTS Treatment success (%)

All the indicators for target 8 need to be calculated for the different socio-economic groups in order to reflect equity.

Summary of suggested indicators for MDG6 include:

Indicator 18: HIV/AIDS prevalence Estimated adult (15 - 49) HIV prevalence (%)	All the indicators to be calculated for national average and should be
Indicator 19: Condom use rate of the contraceptive prevalence rate	
Indicator 20: Ratio of school attendance of orphans to school attendance of non-orphans	
Suggested supplementary indictor: Proportion with access to antiretroviral drugs	

Indicator 23: Prevalence and death rates associated with tuberculosis (a) Incidence Number of cases per 100,000 population (excluding HIV infected)	disaggregated by socially excluded groups in the country eg. the different socio economic groupings
(b) Prevalence Number of cases per 100,000 population (excluding HIV infected)	
(c) Deaths Number of deaths per 100,000 population (excluding HIV infected)	
Indicator 24: Proportion of tuberculosis cases detected and cured under directly observed treatment strategy (DOTS) (a) New cases detected under DOTS: DOTS smear-positive case detection rate	
(b) Patients successfully treated under DOTS Treatment success (%)	

6.3.4 Proposals on Equity in resource allocation

In the current MDGs there are no indicators to measure the capacity of health systems to deliver good quality health services in an equitable manner and also to measure financing of health services. In order to fill in this gap, the following

- Government health expenditures as percent of total government expenditures
- Government health expenditure as a proportion of total health expenditure
- Out of pocket expenditures as a proportion of the total health expenditures
- Availability of health personnel especially rural/ urban distribution.

SECTION 7

Promotion of sexual and reproductive health in the MDGs

Sexual and reproductive health (SRH) was given an international consensual definition in 1994 at the International Conference on population and Development (ICPD). This is based on the promotion of healthy, voluntary and safe sexual and reproductive choices for individuals and couples that are fundamental to human well-being. SRH does not only involve reproductive health services or facilities but emphasizes the need for a life-cycle approach to health (Bernstein 2006). The ICPD adopted the goal of ensuring universal access to reproductive health by 2015as part of its framework for a broad set of development objectives.

The lack of access to SRH is a serious public health issue, particularly for developing countries. For example due to the HIV/AIDS pandemic in Africa, the reproductive health burden constitutes one third of Africa's total disease burden (Bernstein 2006). In addition, the maternal mortality rate for SSA at 920 per 100,000 births in 2000 is extremely high. In 1990 the figure was practically the same at approximately 920 per 100,000 births. The latest figure of this rate has been a serious problem of national data compilation, lack of referral cases to health clinics, and national health sample surveys (UNFPA 2005, UNICEF 2006). One of the input indicators for assessing progress towards maternal mortality figures is health personnel at birth delivery, and this indicator stood at 42% in 1990 and this increased to 46% in 2004 (ECA 2007). It is extremely important to note that in 33 countries with data, urban women are three times more likely to deliver with health personnel and women living in the top income quintile are six times more likely to deliver with skilled personnel at hand (UN 2007).

Family planning and contraceptive use are particularly lacking in Africa. Although there have been some dramatic increases in contraceptive use, unmet needs remain very high. There is also a tendency within African countries that contraceptive use shows that women's access to modern contraceptives improves with increasing level of wealth, thereby confirming some clear correlation between health and poverty. Similarly prenatal care follows the same pattern. This variation is also confirmed when comparing the spatial distribution (urban/rural) of health services (ECA 2007a).

The importance of SRH in the attainment of international development goals is vital, and its translation to actionable time bound objectives is vital. The lack of a clear reflection of SRH within acknowledged development objectives, the Millennium Development Goals being aurguably the most important, is of importance. The reasons for this are varied and require some attention.

Matters related to sex and reproductive health are sensitive issues and embedded in varied cultural and traditional norms and institutions. This could have the effect of different

understandings and therefore different public service provisions of SRH. Thus, different political groups within the same country could establish distinct priorities. For example, family planning provision could have a meaning in the urban more sophisticated setting, whilst in rural areas it could be associated with a “disease-oriented” approach.

A disease-oriented approach to health concerns in Africa can have detrimental effects on prevention. Unwanted pregnancies, spacing children etc are not diseases as such but are clear public health concerns that extend to familial health and empowerment issues. In fact, SRH is particularly complex because of its links to larger and wider issues-gender equality and social norms.

Sexual and reproductive health and the MDGs.

The link between SRH and wider societal issues renders the SRH itself to be vital for the economic and social development in Africa. Apart from being important in and of itself, it is clear that reproductive health and rights are instrumental for achieving the MDGs (Sachs 2005).

High fertility, high infant mortality, and the HIV/Aids pandemic has exacerbated poverty levels on the continent and plays a significant negative role in eradicating extreme poverty and hunger (Goal 1). There is no doubt that health affects productivity and therefore food production and economic growth and the deepening of human capital investment would require a healthier society to improve economic growth and reduce extreme poverty. SRH programmes assists through supplementary feeding to pregnant women, control of anemia and therefore birth size and cognitive development of children in creating a “level-playing field” of households to participate actively in economic activity and reduce poverty (World Bank 2006).

SRH also contributes to achieving to achieving universal primary education. The proportion of children out of school are negatively skewed towards girls, 57% of age cohort of primary school children out of school are girls (UN 2007). There is also evidence that the gender gap in education is dependent on parental preference for sending boys to school. However, even as States increasingly subsidize primary education, educational attainment has been found to be linked to family size (Bertrand 2006). In addition, late enrolment renders primary school students in post-puberty age group, increasing pregnancy risk and exacerbating girls dropping out of school or not being sent due to the perceived risk.

The link between SRH and gender equality is aurguably the most apparent connection (Goal 3). The empowerment of women measured in the current MDGs through gender parity in all levels of schooling, women’s participation in non-agricultural labour market and the percentage of women in national parliaments (UN 2000). Similar to the above, the implementation of SRH creates an equal opportunity that allows the effective measurement of gender equality and the empowerment of women. An important aspect is this regard is

gender-based violence that includes sexual coercion and female-genital cutting (FGM). The balance of power between genders is not only a micro, household aspect but has ramifications at the macro level. In fact, addressing gender equality and its positive effect on economic growth has been demonstrated (ESCAP 2007).

Estimates have shown that 10.1 million children die before their fifth birthday, mostly from preventable diseases. In Africa, the situation has improved with the international Measles Initiative where due to a combined effort by donors and African national governments in 47 priority countries measles deaths decreased by 75% between 2000 and 2005 (UN 2007). However, the vulnerability of 1-year olds remains serious indeed. It is in this context that birth spacing is an important life saving mechanism. Children spaced three to four years are more likely to survive. In less developed countries, including the African continent, if no births occur within 36 months of a preceding birth the infant mortality rate would drop by 24% and under five mortality by 35% (Bertrand 2006).

Each year half a million women die of preventable complications of pregnancy and childbirth. Among married women of childbearing age, demand for birth spacing represented 33-75% of demand for family planning services. Antenatal visits and proportion of health deliveries attended by health attendants remains low in Africa. The need to support through SRH is crucial if maternal mortality (Goal 5) is to drop to more reasonable levels.

Addressing HIV/Aids, malaria and other diseases (Goal 6) is linked to the provision of SRH. The correct and consistent use of condoms in the accepted Abstinence Be Faithful and Condom Use (ABC) strategy proposed is still facing a wide gap in condom availability. In addition, the power dynamics within households create exposure to the vulnerability of women to sexual risky behaviour. SRH services that actively target men as well as women are important aspects to undermine HIV transmission. It is also important in the treatment of pregnant women with malaria- the adverse health outcomes for the unborn child are crucial in under five mortality rates and cognitive development if left untreated. SRH as an integrated package including antenatal care are vital in this aspect.

The link between population growth and environmental degradation is complex. Ensuring environmental sustainability (Goal 7) does require an integrated approach to the population dynamics that adversely impact biological fragile lands. Providing drinking water and sanitation to all in Africa underpins the acceleration to better health conditions, given the water borne vectors constituting a large part of the disease burden. The unmet needs of family planning particularly in the rural poor areas exacerbate the stress on resources and services provided.

Institutional response

The fact that SRH is not reflected in the current MDGs has been recognized and acknowledged. In "Investing in Development: A practical plan to reach the MDGs" claims that the neglect of sexual and reproductive health can have devastating effects on the well being of populations. It goes on to say that differences in reproductive health-between the rich and the poor, both within and between countries- are larger than in other areas of health care (UN 2005).

The integrated approach to reproductive health is critical to well functioning health systems and improving the linkages between the services provided. For example, maternal and child health services can provide can provide complimentary services in family planning, reproductive health and service interventions.

In fact, the UN Millennium Project has identified key interventions that can accelerate progress towards the MDGs. The said Un Millennium Project identified results that can be produced within a relatively short-time frame. The Reproductive Health Quick Impact Initiative has two major components:

- Improving access to reproductive health information and services
- Close the funding gap for commodities, supplies and logistics

The acknowledgment of the importance of SRH to accelerate towards the MDGs was also reflected in processes proposed across al, MDGs. There was a call to integrate SRH analyses and investments into national poverty reduction strategies. In addition, systematically collecting data and meeting the special needs of special populations emerged from the World Summit Outcome Document 2005.

The momentum catalyzed by the World Summit Outcome document based on effective coordination, community participation and adequate resources was carried forward to the operative level on proposing new indicators.

The Inter-Agency and Expert group Meeting (IAEG) on the Millennium development Indicators met in November 2007 and among the objectives of the meeting was to propose new products. Whilst keeping in mind, the national capacity concerns of the present list of MDG indicators in terms of adequate, rigorous and updated data and the monitoring of these new indicators, the IAEG proposed the following:

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

Under the Goal of maternal health a new goal was proposed with four indicators. Certain problems do arise of measurement (a key aspect of the MDGs) of the indicators. For example how does one measure *unmet needs for family planning*?

The institutional response to SRH and its conversion into a new goal and new indicators should be lauded and verified by African countries (represented by 7 countries at the IAEG).

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Annex 1. Concentration curve across health indicators for selected countries

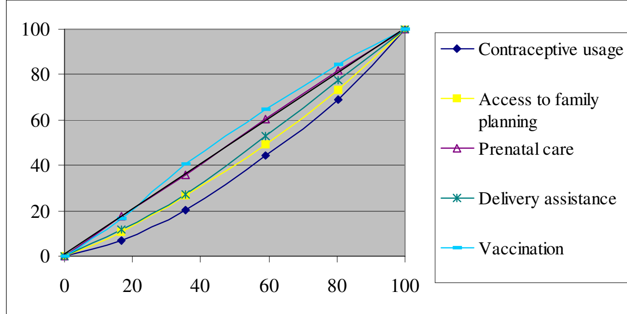

Fig 1. Cameroon: concentration curves across indicators, DHS 2004

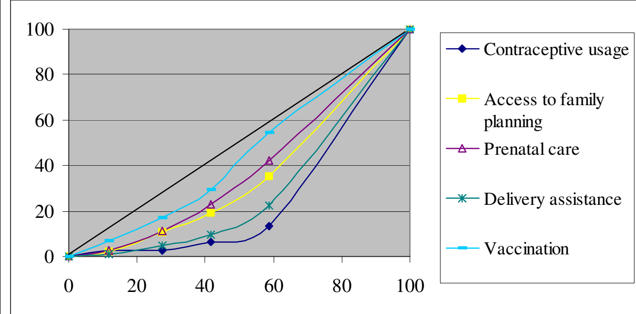

Fig 2. Chad: concentration curves across indicators, DHS 2004

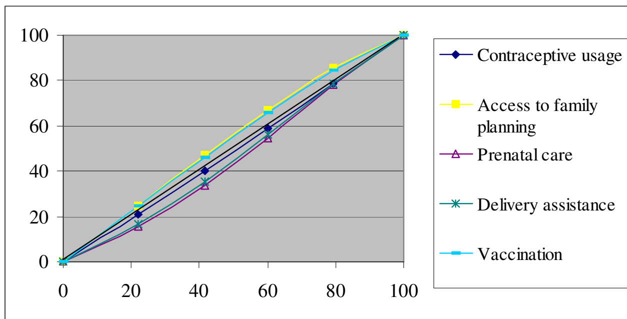

Fig 3. Egypt: concentration curves across indicators, DHS 2005

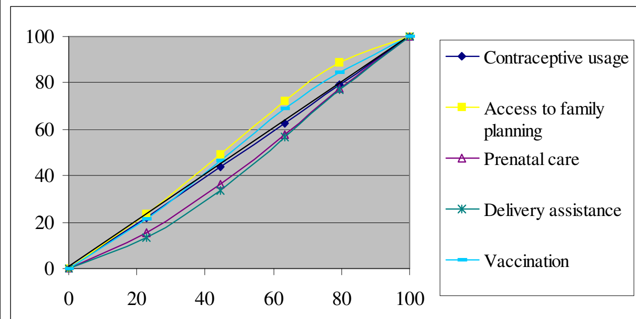

Fig 4. Morocco: concentration curves across indicators, DHS 2003/04

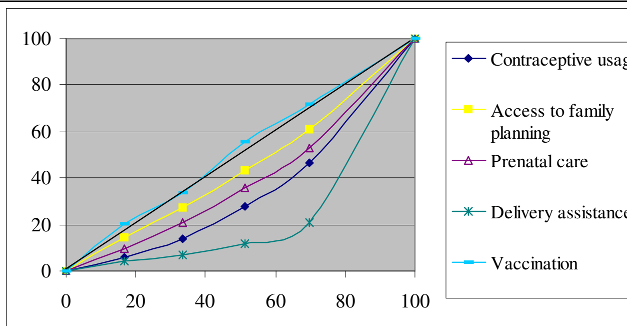

Fig 5. Ethiopia: concentration curves across indicators, DHS 2005

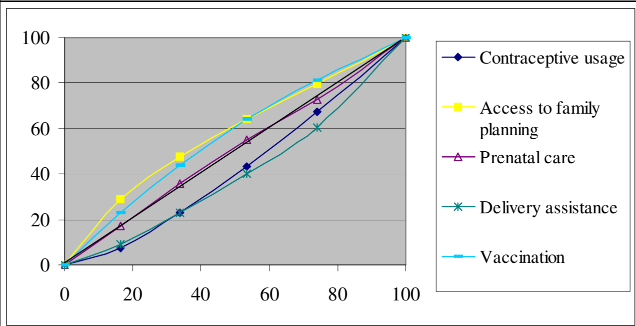

Fig 6. Kenya: concentration curves across indicators, DHS 2003

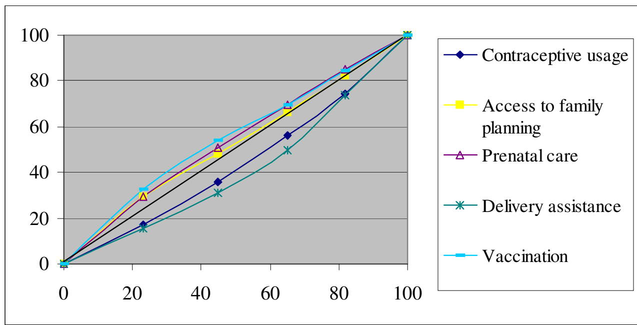

Fig 7. Ghana: concentration curves across indicators, DHS 2003

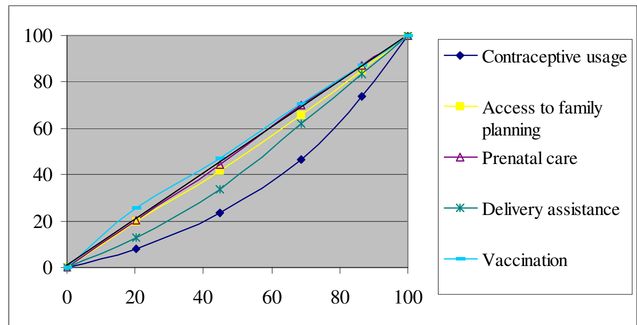

Fig 8. Senegal: concentration curves across indicators, DHS 2005

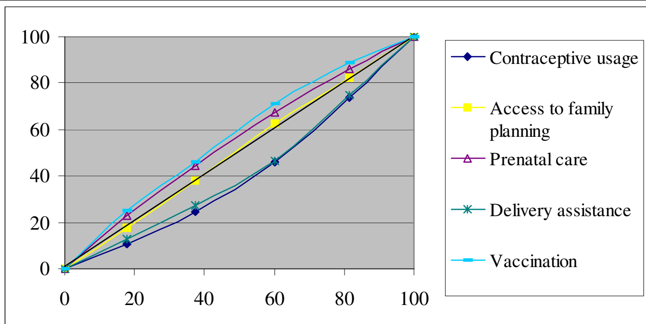

Fig 9. Zambia: concentration curves across indicators, DHS 2001/02

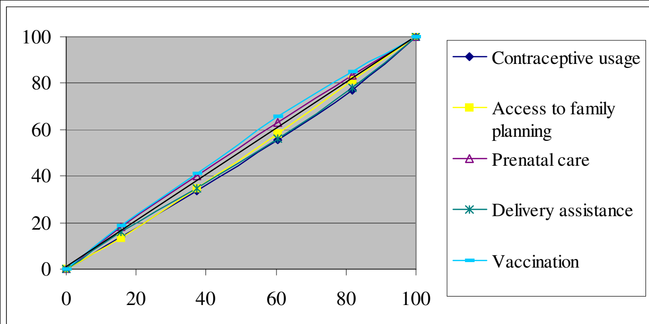

Fig 10. Malawi: concentration curves across indicators, DHS 2004

Annex 2. Stratification of health variables by wealth quintiles (%)

	Indicator	DHS Year	poorest	poorer	middle	richer	richest	Low-High Diff.*	Conc. Index Value	C.I. Std Error
Central Africa Sub-Region	**Cameroon**									
	Women's access to modern contraceptives	1998	13.7	16.5	27.9	48.3	59.8	46.1	0.266	0.022
		2004	20.6	35.2	49.8	57.0	77.7	57.1	0.211	0.013
	Women's access to family planning services	1998	11.1	14.1	22.5	24.7	29.7	18.6	0.178	0.018
		2004	8.7	13.9	17.6	20.5	24.4	15.7	0.180	0.014
	Prenatal care services	1998	61.4	70.7	86.4	94.2	94.8	33.4	0.086	0.006
		2004	67.9	77.7	89.2	95.8	97.5	29.6	0.073	0.003
	Delivery assistance by health professional	1998	31.4	43.0	67.6	86.0	89.4	58	0.194	0.01
		2004	36.7	53.5	75.5	90.2	95.8	59.1	0.180	0.005
	Immunization coverage	1998	51.2	51.1	51.4	57.4	66.4	15.2	0.054	0.019
		2004	47.3	65.9	53.6	64.3	70.9	23.6	0.053	0.017
	Chad									
	Women's access to modern contraceptives	1996/97	1.1	.0	2.7	2.8	14.2	13.1	0.515	0.046
		2004	2.3	.0	3.0	4.0	21.7	19.4	0.473	0.038
	Women's access to family planning services	1996/97	3.8	5.4	6.0	11.2	22.0	18.2	0.340	0.019
		2004	1.0	5.4	6.1	8.8	16.8	15.8	0.354	0.002
	Prenatal care services	1996/97	21.7	33.2	32.7	49.1	75.2	53.5	0.224	0.008
		2004	7.9	27.1	41.6	53.7	76.7	68.8	0.294	0.009
	Delivery assistance by health professional	1996/97	6.6	9.9	11.6	23.9	54.9	48.3	0.395	0.01
		2004	1.5	7.3	10.3	21.0	61.7	60.2	0.468	0.011
	Immunization coverage	1996/97	21.0	18.6	25.2	38.6	41.4	20.4	0.168	0.024
		2004	11.7	21.0	26.5	39.3	34.1	22.4	0.156	0.027
North Africa Sub-Region	**Egypt**									
	Women's access to modern contraceptives	2000	73.5	84.1	88.1	92.7	93.1	19.6	0.042	0.002
		2005	86.0	90.0	91.7	94.7	94.5	8.5	0.020	0.002
	Women's access to family planning services	2000	12.5	14.3	14.6	11.9	7.2	-5.3	-0.10	0.012
		2005	21.3	20.7	19.2	17.2	13.0	-8.3	-0.09	0.009
	Prenatal care services	2000	33.0	43.4	55.1	70.0	86.2	53.2	0.183	0.005
		2005	47.6	61.8	74.6	86.9	93.6	46	0.133	0.004
	Delivery assistance by health professional	2000	35.9	50.9	67.4	81.4	95.6	59.7	0.179	0.005
		2005	53.7	69.5	81.6	90.0	96.7	43	0.113	0.003
	Immunization coverage	2000	71.1	76.0	78.3	77.7	65.5	-5.6	-0.01	0.008
		2005	77.4	76.1	76.9	73.2	73.4	-4	-0.01	0.006
	Morocco									
	Women's access to modern contraceptives	1992	47.8	68.2	78.1	82.1	86.8	39	0.101	0.007
		2003/04	92.6	94.0	95.3	95.9	95.8	3.2	0.007	0.002
	Women's access to family planning services	1992	-	-	-	-	-	-	-	-
		2003/04	12.9	14.5	14.6	12.4	7.6	-5.3	-0.073	0.015
	Prenatal care services	1992	10.7	20.4	36.4	58.8	77.5	66.8	0.352	0.011
		2003/04	39.7	56.8	70.5	85.7	93.4	53.7	0.167	0.006
	Delivery assistance by health professional	1992	8.2	18.6	35.0	61.9	80.7	72.5	0.386	0.011
		2003/04	34.2	55.3	73.7	87.4	95.8	61.6	0.194	0.006
	Immunization coverage	1992	54.1	66.1	69.7	76.3	66.4	12.3	0.051	0.013
		2003/04	70.4	74.2	84.9	84.8	84.0	13.6	0.041	0.009
East Africa Sub-	**Ethiopia**									
	Women's access to modern contraceptives	2000	9.1	11.0	11.7	20.5	59.6	50.5	0.395	0.014
		2005	11.3	16.5	26.1	33.6	59.9	48.6	0.306	0.012
	Women's access to family planning services	2000	10.4	10.1	9.3	14.9	24.9	14.5	0.209	0.014
		2005	8.4	10.3	13.5	15.7	20.7	12.3	0.188	0.015
	Prenatal care services	2000	15.5	17.4	22.3	28.8	66.8	51.3	0.305	0.009
		2005	12.3	20.1	26.6	33.1	67.1	54.8	0.328	0.009
	Delivery assistance by health professional	2000	1.6	1.9	3.4	5.0	46.9	45.3	0.622	0.011
		2005	2.3	2.1	3.6	7.7	48.8	46.5	0.612	0.012
	Immunization coverage	2000	20.6	19.6	21.2	31.4	51.3	30.7	0.210	0.02
		2005	23.6	24.8	40.0	34.3	47.6	24	0.146	0.027

Indicator	DHS Year	poorest	poorer	middle	richer	richest	Low-High Diff.*	Conc. Index Value	C.I. Std Error
Kenya									
Women's access to modern contraceptives	1998	33.3	48.2	55.5	65.1	76.4	43.1	0.150	0.01
	2003	30.9	57.6	68.9	77.2	82.6	51.7	0.141	0.009
Women's access to family planning services	1998	19.2	20.1	20.3	22.7	28.8	9.6	0.077	0.015
	2003	7.2	5.5	4.9	4.4	3.8	-3.4	-0.132	0.035
Prenatal care services	1998	90.1	92.3	93.7	96.2	95.9	5.8	0.014	0.003
	2003	67.2	85.7	91.0	92.1	94.0	26.8	0.059	0.004
Delivery assistance by health professional	1998	22.8	34.9	42.1	57.1	79.0	56.2	0.230	0.011
	2003	21.4	39.0	47.2	62.0	81.6	60.2	0.240	0.008
Immunization coverage	1998	52.6	56.3	65.1	59.9	46.2	-6.4	-0.001	0.015
	2003	53.1	63.9	62.7	65.7	53.4	0.3	0.008	0.015
West Africa Sub-region									
Ghana									
Women's access to modern contraceptives	1998	26.4	35.3	39.0	49.3	57.4	31	0.156	0.019
	2003	35.1	41.8	48.1	52.5	69.3	34.2	0.129	0.016
Women's access to family planning services	1998	-	-	-	-	-	-	-	
	2003	32.2	30.0	32.3	30.9	31.8	-0.4	-0.002	0.014
Prenatal care services	1998	76.2	85.8	93.5	96.1	98.1	21.9	0.055	0.005
	2003	83.2	90.9	94.2	95.9	98.9	15.7	0.035	0.003
Delivery assistance by health professional	1998	20.4	28.9	52.8	68.2	88.5	68.1	0.299	0.012
	2003	23.1	36.2	49.9	77.6	93.6	70.5	0.284	0.01
Immunization coverage	1998	73.5	75.2	83.9	75.2	78.8	5.3	0.015	0.012
	2003	78.9	80.9	84.1	82.6	83.5	24	0.013	0.01
Senegal									
Women's access to modern contraceptives	1997	3.2	6.8	12.8	31.5	51.5	48.3	0.467	0.022
	2005	13.4	21.7	33.5	52.9	64.9	51.5	0.288	0.016
Women's access to family planning services	1997	-	-	-	-	-		-	-
	2005	13.8	13.4	14.8	17.2	17.6	3.8	0.054	0.013
Prenatal care services	1997	77.3	80.4	90.5	96.5	97.6	20.3	0.052	0.003
	2005	83.5	90.2	95.9	98.9	99.6	16.1	0.035	0.002
Delivery assistance by health professional	1997	36.7	42.9	64.5	82.9	93.0	56.3	0.195	0.007
	2005	39.8	59.5	80.2	94.9	97.3	57.5	0.168	0.004
Immunization coverage	1997	-	-	-	-	-		-	-
	2005	71.3	65.7	76.1	76.8	77.9	6.6	0.024	0.013
Southern Africa Sub-region									
Zambia									
Women's access to modern contraceptives	1996	19.2	31.5	32.6	53.1	73.5	54.3	0.750	0.017
	2001/02	36.7	41.7	56.5	77.2	85.2	48.5	0.173	0.011
Women's access to family planning services	1996	68.4	69.1	69.2	69.1	79.2	10.8	0.020	0.005
	2001/02	23.4	26.9	29.7	31.1	34.4	11	0.070	0.013
Prenatal care services	1996	93.2	96.4	96.3	99.4	99.7	6.5	0.014	0.002
	2001/02	89.0	91.1	92.8	95.6	99.0	10	0.019	0.002
Delivery assistance by health professional	1996	26.5	31.6	45.3	75.6	93.0	66.5	0.268	0.008
	2001/02	26.2	30.5	41.1	73.4	93.1	66.9	0.263	0.008
Immunization coverage	1996	79.5	83.1	81.4	82.7	84.6	5.1	0.010	0.007
	2001/02	79.5	78.1	82.6	81.2	80.8	1.3	0.007	0.008
Malawi									
Women's access to modern contraceptives	2000	36.8	46.0	45.4	49.1	63.0	26.2	0.093	0.01
	2004	50.2	53.4	55.3	59.1	73.1	22.9	0.066	0.008
Women's access to family planning services	2000	41.2	44.9	46.8	48.1	49.6	8.4	0.034	0.006
	2004	37.8	41.6	43.3	44.8	46.2	8.4	0.033	0.007
Prenatal care services	2000	87.9	90.0	93.6	92.7	96.3	8.4	0.017	0.002
	2004	88.9	89.9	90.5	94.7	97.2	8.3	0.017	0.002
Delivery assistance by health professional	2000	47.1	55.6	63.5	64.1	82.0	34.9	0.102	0.005
	2004	51.7	53.3	56.8	68.6	86.5	34.8	0.099	0.005
Immunization coverage	2000	79.3	80.9	82.9	86.8	79.7	0.4	0.007	0.006
	2004	69.8	70.8	81.5	77.1	79.6	9.8	0.028	0.007

*** Absolute difference between the richest and poorest quintiles**

Source: ECA calculations using DHS data

Annex 3. Health variables stratified by place of residence (percent)

Country	DHS Year	Women's access to modern contraceptive methods			Prenatal care services			Delivery assistance by health professional			Immunization coverage		
		Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Cameroon	1998	53	24	38	93	75	82	87	50	65	60	53	56
	2004	60	40	49	95	78	85	89	54	69	65	55	59
Chad	1996/97	12	1	6	72	31	47	53	9	26	42	24	31
	2004	20	1	10	74	28	49	57	7	29	35	23	28
Egypt	2000	91	83	87	73	47	58	85	54	67	71	76	74
	2005	94	89	91	85	62	71	90	68	77	74	77	76
Morocco	1992	86	62	73	64	22	38	69	19	38	73	62	65
	2003/04	96	93	95	85	48	65	87	46	65	85	73	79
Ethiopia	2000	66	15	28	74	23	32	57	4	13	58	24	30
	2005	67	24	34	75	24	32	62	5	14	55	30	33
Kenya	1998	70	52	55	97	93	93	72	40	44	43	59	56
	2003	78	62	66	92	83	86	75	42	51	52	61	59
Ghana	1998	52	36	41	95	85	87	79	34	44	78	76	77
	2003	61	42	48	98	88	91	83	34	49	85	80	81
Senegal	1997	43	8	19	97	83	87	91	47	59	-	-	-
	2005	53	22	34	98	90	93	92	59	70	75	72	73
Zambia	1996	60	29	42	99	95	97	82	34	50	82	82	82
	2001/02	79	50	60	98	91	93	82	35	48	83	80	80
Malawi	2000	61	46	49	98	91	92	85	58	63	79	83	82
	2004	67	57	58	97	91	92	87	59	62	73	76	76

Source: ECA calculations using DHS data