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**Report of the Ad Hoc Experts Group Meeting on Developing  
supplementary targets and indicators to strengthen social  
inclusion, gender equality and health promotion in the  
Millennium Development Goals in Africa**

7-9 May 2008

Addis Ababa, Ethiopia

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## ACRONYMS AND ABBREVIATIONS

ACGS	African Centre for Gender and Social Development
ACS	African Centre for Statistics
AEGM	Ad Hoc Expert Group Meeting
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral treatment
AU	African Union
CSOs	Civil Society Organisations
CBOs	Community Based Organisations
ECA	Economic Commission for Africa
ECE	Economic Commission for Europe
ECLAC	Economic Commission for Latin America and the Caribbean
ESCAP	Economic and Social Commission for Asia and Pacific
ESCWA	Economic and Social Commission for Western Asia
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IAEG	Inter-Agency and Expert group Meeting
ICPD	International Conference on population and Development
ICT	Information, communication and technology
IDPs	Internally displaced people
MDGS	Millennium Development Goals
MOH	Ministry of Health
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organisations
NSOs	National Statistical Offices
OVCs	Orphans and vulnerable children
PLWHA	People living with HIV/AIDS
PRSP	Poverty reduction strategy papers
PRSP-LG	African Learning Group on Poverty Reduction Strategy Papers
PWD	Persons with disabilities
RECs	Regional Economic Communities
SRH	Sexual and reproductive health
SRO-CA	Sub regional office for Central Africa
SRO-EA	Sub regional office for East Africa
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNSD	United Nations Statistics Division
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

# EXECUTIVE SUMMARY

This is a report of a meeting of experts from the fields of social protection, population, gender, health, ageing, disability, MDGs, statistics and poverty alleviation which took place in Addis Ababa, Ethiopia from 7 to 9 May 2008. The aim of the meeting was to critically review the draft report on *Strengthening social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa* and make suggestions to improve the draft document. ECA commissioned this study in the background of recent reviews that indicate that existing MDG targets and indicators may not adequately capture the progress that countries are making towards improving equity in health; gender equality and addressing the disparities among social groups and sub-national regions in reaping the benefits of actions taken by national governments towards achieving the MDGs.

In reviewing the study, the experts recommended that the definition of social exclusion in the African context and a discussion of the causes of social exclusion and the legal and institutional issues behind social exclusion and how much effort the countries have made to address it including the major challenges. Further, the report needed to include other socially excluded groups such as ethnic groups e.g. nomads, pygmies, and orphans and vulnerable children. The experts emphasized that all the indicators need to be disaggregated using a life-cycle approach to capture the transitions from one stage to another. The meeting recommended that the report needed to include a discussion of mainstreaming social inclusion in the national development plans and PRSPs and make reference to the social protection frameworks that are being developed in many African countries. Participants also recommended that the report makes reference to the regional and international policy frameworks that address social exclusion. The meeting recommended creation of two additional goals in the MDG framework focusing on persons with disabilities and minority groups.

With regard to the thematic areas of the meeting, participants suggested key issues and supplementary targets and indicators. On gender equality, the key issues were identified to include the negative traditions and culture; patriarchy; limited political participation of women; limited access by women to basic social services such as education, health, sexual and reproductive health; gender-based violence; and limited economic participation of women.

The suggested supplementary indicators to promote gender equality in the MDGs include:

***Goal 1: Eradicate extreme poverty and hunger***

- % population in informal and formal sector by sex and occupation
- Ownership of agricultural land by sex
- Share of unpaid work between women and men
- Access to extension services by sex
- Access to agricultural credit by sex
- % increase in local food production

***Goal 2: Achieve universal primary education***

- % of children registered at birth by sex and locality

***Goal 3: Promote gender equality and empower women***

- % of women at all levels of decision making

- % of women in parliament and local governance.
- % of women in decision making in private and public organizations
- Share of men and women's labour in unpaid work
- Incidence of gender based violence per 100,000 women/year
- % of GBV perpetrators convicted
- Reduced incidence of FGM and early marriages

**Goal 5: Improve maternal health**

- Percentage of female population within 2 hours travel distance of basic emergency obstetric care
- Proportion of 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
- Child bearing among girls aged 15-19 years
- Proportion of pregnant women who are anemic

**Goal 6: Combat HIV/AIDS, Malaria and other Diseases**

- Proportion of population with access to preventive and treatment medication by sex.

With regard to youth, the key issues were identified to include exclusion from the labour market; exclusion from decision-making; and exclusion from social participation. The meeting suggested the following supplementary indicators to promote the social inclusion of youth in development.

**Goal 1: Eradicate extreme poverty and hunger**

- Ratio of youth unemployment as a ratio of adult unemployment rate
- % of young people without contracts in the labour market
- Proportion of youth enrolled vocational and training institutions
- Proportion of the youth population who have been able to set up their own businesses

**Goal 2: Achieve universal primary education**

- Proportion of youth enrolled vocational and training institutions
- % of children registered at birth

**Goal 5: Improve maternal health**

- Percentage of adolescent pregnancies (young women aged 15-19)
- Percentage of young women with access to prenatal and reproductive health services
- Proportion of young females undergoing FGM

**Goal 6: Combat HIV/AIDS, Malaria and other Diseases**

- Proportion of children and youth with HIV/AIDS with access to ART

**MDG 8: Develop a global partnership for development**

- Proportion of young people with access to telephone, cellular and Internet services
- Proportion of HIPC relief going to youth

Participants also recommended an additional indicator: proportion of youth representation in parliament and local councils.

With regard to the promotion of health equity, sexual and reproductive health in the MDGs, the meeting identified the key issues to include high inequities in access to health services between rural and urban areas are evident in many countries; high prevalence of malaria; poor access to health services by the poor; and poor access to sexual and reproductive health. The meeting suggested the following supplementary indicators.

***Goal 4: Reduce child mortality***

- Mortality rate of new-borns
- Proportion of children under the age of 1 completely vaccinated
- Proportion of children with diarrhoea and ARI who receive treatment in a health facility
- Proportion of children with diarrhoea and ARI who are treated with oral rehydration salts at home

***Goal 5: Improve maternal health***

- Proportion of adolescents who have access to sexual and reproductive health services
- Proportion of pregnant teenage adolescents
- Proportion of pregnant women who sleep under bed nets
- Proportion of reproductive age women with access to pre-natal and natal services

ADDITIONAL TARGET – Increased resource allocation to the health sector

- Government health expenditures as percent of total government expenditures
- Percentage of funding reaching sub-national levels

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

- Proportion of people affected by HIV/AIDS who are working
- Access to ART disaggregated by sex
- Mortality rate due to malaria, by age and gender
- Mortality rate due to TB, by age and gender
- Percentage of pregnant women sleeping under treated mosquito nets
- Percentage of children sleeping under treated mosquito nets

With regard to the promotion of social inclusion of older people, persons with disability and PLWHA in the MDGs, participants identified the key issues to include: lack of full participation in economic life due to labour constraints; lack of social protection; discrimination and stigma; and high poverty; exclusion from social participation such as limited access to social services, and lack of social networks; and exclusion from political and community participation. The suggested supplementary indicators to promote the social inclusion of persons with disabilities, older persons, PLWHA, OVCs include the following.

***Goal 1: Eradicate extreme poverty and hunger***

- Percentage of older people/PWD-headed households living in extreme poverty
- Percentage of older persons/PWD/PLWHA/OVCs suffering from hunger
- Proportion of older persons/PWD/PLWHA/OVCs who have access to social protection
- Proportion of older persons/PWD/PLWHA/OVCs who have access to poverty reduction programmes
- Proportion of PWD in formal sector employment
- Share of older women/women with disabilities in wage employment in the non-agricultural sector

***Goal 2: Achieve universal primary education***

- Net enrolment ratio in primary and secondary education of children with disabilities and OVCs.
- Ratio of school attendance of orphans to school attendance of non-orphans disaggregated by sex
- Proportion of pupils with disabilities and OVCs starting grade 1 who complete primary and secondary education

ADDITIONAL TARGET – Double adult literacy rate by 2015

- Percentage of older persons who access adult literacy services/programmes

***Goal 5: Improve maternal health***

- Percentage of women with disabilities with access to prenatal and reproductive health services

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

- HIV prevalence amongst older persons/PWD and different age groups
- Percentage of older carers of OVCs and PLHA receiving support in their role
- Proportion of OVCs who receive free support
- Percentage of older persons/PWD with access VCT services
- Percentage of PLWHA with access to antiretroviral drugs by age and sex

***Goal 7: Ensure environmental sustainability***

- Proportion of the population with disabilities/older population with sustainable access to improved water source, urban and rural
- Proportion of the population with disabilities/older population with access to improved sanitation, urban and rural

ADDITIONAL TARGET – Increase accessibility to public infrastructure for people with disabilities

- Proportion of public services with adequate access for people with disabilities

***MDG 8: Develop a global partnership for development***

- Proportion of donor funds allocated to disability, older persons and OVCs.

Participants identified the challenges and opportunities and recommendations in implementing the suggested supplementary indicators. The identified challenges include: lack of disaggregated data – by sex, by social group and by age; unavailability of data for measuring the new indicators; cost and capacity constraints to collection of new data; and lack of baseline data for some thematic groups such as disability. The identified opportunities include: potential use of the existing data mainly from primary sources; the upcoming 2010 and 2011 round of population censuses; and adding specific questions to DHS, national household surveys. In conclusion participants made recommendations that can help facilitate the adoption of the additional indicators by countries to include: make use of existing sources of data as much as possible; undertake capacity building and development of training personnel in national statistical systems so that they are able to fully analyse and utilize existing primary data and collect new data; government commitment on resource allocation for statistics needs to be strengthened; coordination between NSOs and line ministries need strengthening; promote wide dissemination of statistics to all users including through networks; and taking advantage of the upcoming census to collect data that can be used for monitoring social inclusion, gender equality and health equity.

## **1. 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 have indicated that MDGs targets and indicators, as they exist, may not meaningfully measure the progress that countries have made towards the empowerment of women and the inclusion of socially vulnerable groups such as the elderly and the disabled. The reviews also indicate that existing MDG targets and indicators may not adequately capture the progress of countries towards improving equity in health; gender equality and addressing the disparities among social groups and sub-national regions in reaping the benefits of actions taken by national governments towards achieving the MDGs. Yet it is crucial that the progress made on social inclusion of vulnerable groups, gender equality and health equity is measured and closely monitored to provide information essential for effective policy development.

It is in this context that ECA commissioned a study to develop supplementary targets and indicators relevant to Africa, that would improve the capacity of countries to measure progress towards inclusion of vulnerable groups, promote gender equality and address health inequities, thereby improving the effectiveness with which MDGs are monitored and convened an Ad Hoc Expert Group Meeting to review the outcome of the study.

## **2. ATTENDANCE AND AGENDA OF THE MEETING**

The Ad Hoc Expert Group Meeting (AEGM) on Developing supplementary targets and indicators to strengthen social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa was held at the United Nations Conference Centre in Addis Ababa, Ethiopia, from 7-9 May 2008.

A selected group of experts from the fields of social protection, population, gender, health, ageing, disability, MDGs, statistics and poverty alleviation representing governments, academia, research institutions, civil society and other UN agencies attended the meeting. Staff from ECA Sub Regional Office for East Africa (SRO-EA), Sub Regional Office for Central Africa (SRO-CA), African Centre for Statistics (ACS) and African Centre for Gender and Social Development (ACGS) participated in the ad hoc expert group meeting. Names of participants and their affiliation appear as Annex 1.

The meeting adopted the agenda that is presented in annex 2.

### **3. OPENING SESSION**

#### **3.1 Opening Statement**

A representative of the ECA's ACGS welcomed the experts to the AEGM and introduced the Officer in Charge of ACGS, Ms. Thokozile Ruzvidzo to the meeting and invited her to deliver the opening statement.

In her opening remarks, the Officer in Charge thanked the experts for accepting the invitation to the meeting. She indicated that the AEGM was being held as part of an interregional Development Account project entitled "Interregional cooperation to strengthen social inclusion, gender equality and health promotion in the MDG process" in collaboration with the other regional commissions in Asia, South America and Europe. She indicated that the objective of the project is to enhance the capacity of member States in these regions to design and implement development policies and programmes in a manner that substantially contributes to social inclusion and achievement of gender equality and health promotion through development of contextualized targets and indicators in the MDGs. The Officer In Charge informed the meeting that in ACGS, the project was being led by a task team composed of all the three sections of the division that include the MDGs, Poverty Analysis and Monitoring section, Human and Social Development, and the Gender and Women in Development Section.

She noted that recent reviews of the progress made towards achieving the MDGs have highlighted that the existing MDG targets and indicators may not fully reflect the progress being made towards the inclusion of the socially excluded and marginalized groups in mainstream development. She emphasised that meeting the MDGs requires addressing social exclusion through deliberate policies and interventions that address social exclusion and attempt to construct more socially cohesive societies. She added that it also requires close monitoring of indicators that can track the progress made on social inclusion, gender equality and health equity for effective policy development.

Turning to the focus of the AEGM, the Officer in Charge challenged the experts to find answers on how the MDG targets and indicators can be strengthened so as to improve the capacity of African countries to measure progress towards inclusion of vulnerable groups, promote gender equality and address health inequities. She urged the experts to critically review the draft report on *Strengthening social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa* and make suggestions to improve the draft document. In conclusion, she appealed to the participants to openly discuss the issues and share information so that the meeting can come up with the best possible indicators and guidance for our governments to promote the social inclusion of vulnerable groups, address gender equality concerns and promote health equity in their national development agenda.

#### **3.1 Introduction to the project and EGM objectives**

Mr Kasirim Nwuke, the Chief of the MDGs, Poverty Analysis and Monitoring section of ACGS made a presentation on the background of the project and objective. He indicated that as highlighted by the Officer in Charge, the project was part of an interregional Development Account project entitled "Interregional cooperation to strengthen social inclusion, gender equality and health promotion in the MDGs". The project is being implemented in collaboration

with Economic and Social Commission for Asia and Pacific (ESCAP) (which is the lead agency), Economic and Social Commission for Western Asia (ESCWA), Economic Commission for Europe (ECE), and Economic Commission for Latin America and the Caribbean (ECLAC). The aim of the project was to increase the capacity of the Governments in the 5 regions to promote the social inclusion of vulnerable groups, gender equality and health equity in mainstream development through the development of contextualized targets and indicators for the MDGs. In Africa the project aimed at developing additional Africa-specific targets and indicators on inclusion of the socially excluded groups, gender equality and health equity and sexual and reproductive health; and developing knowledge networks to discuss and disseminate relevant information on social exclusion and the MDGs.

The meeting was informed that the main activities of the project in Africa included: a desk review of existing information to identify targets/indicators; consultations with key informant to solicit additional information on social inclusion issues and supplementary targets and indicators in selected member countries; an AEGM; knowledge and experience sharing on the sub-themes through electronic discussion; and an inter-regional meeting. He informed the meeting that the sub-themes of the project included gender equality; youth; other socially excluded groups that include older persons, persons with disability, and people living with HIV/AIDS; and health equity and sexual and reproductive health. He highlighted the objectives of the meeting to include the following:

- a. Critically review the draft report and make suggestions to improve the draft document;
- b. Identify key issues, in the selected thematic areas of social exclusion
- c. Suggest, prioritise and recommend supplementary MDG targets and indicators that can help foster the monitoring of the inclusion of the marginalized groups, gender equality and health equity into mainstream development; and
- d. Identify constraints and opportunities faced by countries in adopting these suggested additional indicators.

#### **4. PRESENTATION OF THE DRAFT REPORT ON STRENGTHENING SOCIAL INCLUSION, GENDER EQUALITY AND HEALTH PROMOTION IN THE MILLENNIUM DEVELOPMENT GOALS IN AFRICA**

Ms Gladys Mutangadura of ECA presented the background document for this meeting, the report on “*Strengthening social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa*”. In her presentation, she informed the meeting of the objectives of the report, the methods used in preparing the document, the definition of social exclusion used in the project, the major causes of social exclusion in Africa, the type of inclusive policies implemented by African governments, issues and gaps in the current MDG framework, the country case studies prepared by ECA, and some possible supplementary indicators.

Ms Mutangadura defined social exclusion to be the process through which individuals or groups are wholly or partially excluded from the society in which they live. The three principal dimensions were indicated to include economic, social, and political. The main groups that maybe socially excluded in Africa were identified to include women; older persons; persons with disabilities; the youth; PLWHA; the poor; street children; refugees and internally displaced people; and some ethnic groups. She indicated that the root causes of social exclusion can be

broadly grouped to be resulting from (i) poverty related factors and (ii) due to identity, stigmatisation and discrimination.

She indicated that the aim of the report was to identify supplementary MDG targets and indicators that can help ensure inclusion of socially excluded groups, promote gender equality, health equity and sexual and reproductive health in mainstream development. The presenter indicated that the study was based on a desk review of existing information and interviews with key informants who were experts from government and non government institutions in selected countries that included Sudan, Congo, Ethiopia, Ghana and Mali. The presenter noted that the desk review and case studies confirmed existence of socially excluded groups including: PLWHA; women; youth; persons with disability; older persons; refugees and internally displaced people; pygmies; prostitutes and street children (problem of unregistered children).

Ms. Mutangadura noted that in order to reinforce the existing MDG framework, where applicable, both old and new indicators must be measured using data disaggregated by sex, age and by social group. She then presented the suggested indicators for each of the MDGs as outlined in the draft report on *“Strengthening social inclusion, gender equality and health promotion in the Millennium Development Goals in Africa”*.

In conclusion, the presenter noted that better indicators are required to monitor the progress made on social inclusion, gender equality and health equity for effective policy development; and called on the meeting to critically review the supplementary indicators proposed by the report, prioritize and provide recommendations.

## **Discussion**

In the discussion, the experts commended ECA for the excellent report and stimulating presentation. The meeting debated on the need to work within the current MDGs or consider proposing additional goals that capture social exclusion. The participants agreed that they would focus the deliberations on developing supplementary targets and indicators that fall within the currently existing goals and make suggestions on additional goals that would be included as recommendations of the meeting. The meeting suggested that the report should accurately reflect on: 1) The definition of social exclusion; 2) The types of groups excluded; and 3) The causes of social exclusion.

When reflecting on the issues of age, gender and other dimensions of exclusion, a number of participants proposed that a life-cycle approach be used to capture the transitions from one stage to another. The meeting noted that exclusion can be intergenerational such as in the case of PLWHA and their orphaned children. Overall, with respect to disaggregation, experts were emphatic that all existing MDG indicators be disaggregated based on gender, age and social groups.

The experts requested that the group consisting of the older persons, persons with disabilities and people living with HIV/AIDS be split up to ensure that the issues peculiar to these groups are not excluded by aggregating the issues of the three groups. In this respect, it was proposed that persons with disabilities need their own goal in the MDG framework.

Participants suggested that the report should include other socially excluded groups such as ethnic groups like the tribes living along rivers in Cameroon and the nomads. In this context, it was proposed that minority groups also need their own goal. The meeting suggested that the report should incorporate the legal and institutional issues behind social exclusion including weak capacity and the lack of resources for ministries, and how social exclusion is considered in the planning and budgetary processes. Other issues recommended for inclusion in ECA's report include access to information, access to services, and reference to social protection strategies, which are being implemented in over 20 African countries.

The meeting suggested that monitoring of the indicator access to anti-retroviral treatment (ART) should be taken into account in connection with issues of nutrition, adherence to medication and distance travelled to get ART. The meeting recommended that the report should include discussion of MDG 8.

With regards to specific recommendations, the participants proposed some of the following supplementary indicators:

- Proportion of seats in local councils held by women
- Proportion of women who own land
- Percentage of women heading political parties, companies and holding decision-making positions
- Length of time on ART

The experts also underscored that there are many obstacles to the collection of data and monitoring of existing MDG indicators that need to be highlighted in the report. These capacity constraints would make it difficult to track supplementary indicators in terms of both disaggregation of existing data and the collection of new indicators.

## **5. PANEL DISCUSSION ON PROMOTION OF SOCIAL INCLUSION OF WOMEN AND GENDER EQUALITY IN THE MDGS**

In this session, three discussants made presentations on their responses to the issues raised in the draft report on promotion of the social inclusion of women and gender equality in the MDGs; Ms. Beatrice Duncan; Dr. Akinyi Nzioki, and Ms. Aminata Diouf Ndiaye.

Ms. Beatrice Duncan of the University of Birmingham indicated that her general observations of the report included: (a) limited reference to the on going social protection policies, programmes and interventions in Africa, for example, in Ghana, Nigeria, Malawi, Tanzania, Chad, Tunisia; (b) duplication of some indicators; and (c) the need to improve visibility of the social inclusion of persons with disabilities. She highlighted that socially inclusive methods should be used to measure all indicators: by sex, household, age (life cycle approach), locality, and occupational grouping. With regard to the household, she indicated that the different types of heads of households should be included in the indicators which are households headed by adult males; by adult females; by child females; by child males; by elderly females; and by elderly males. She also made the suggestion that the indicators need to be disaggregated by (a) rural and urban area

of residency and (b) by specific age group; (0-6, 7-14, 14-24, 25-40, 40-60, 60+) in order to identify and monitor social exclusion.

Ms Duncan suggested that for MDG 1 the following additional indicators need to be included: percentage increase in local food production; % population in informal sector by sex and occupation; ownership of agricultural land by sex; access to extension services by sex; and access to agricultural credit by sex. She recommended that the indicator on the proportion of pregnant women with anaemia be moved to Goal 5. For MDG 2 she proposed that an additional indicator for consideration could be % of children registered at birth by sex and locality.

Ms Duncan also made a proposal that all education issues need to be removed from Goal 3 to Goal 2 for consistency and suggested that MDG 3 should deal with human rights and political participation only. She suggested that the indicator on child bearing be moved to Goal 5. She suggested that the title for MDG 3 should be all encompassing ie: *Eliminate violence against women and girls and promote equal participation of women in decision-making*. With respect to MDG 5 she suggested the following additional indicators: percentage of the population practicing female genital mutilation (FGM) and % of maternal mortality deaths caused by FGM.

Dr Akinyi Nzioki of the Centre for Land, Economy and Rights of Women highlighted that women's rights advocates in the past have argued that MDGs do not represent the full vision of gender equity, equality and women's empowerment as reflected in the 1995 Beijing Platform for Action. She indicated that gender equality and women's empowerment are essential cross-cutting components for achieving all the goals including health promotion. Dr Nzioki indicated that some of the gaps in the MDGs with respect to gender equality include the failure to include issues of reproductive rights and women's human rights.

She suggested that supplementary indicators to promote gender equality in Africa should incorporate indicators disaggregated by sex, age and socio-economic background. She emphasized that such disaggregation would ensure that gender disparities and other socially excluded groups are adequately measured and that the country frameworks and policies are developed to meet the 2015 targets.

Dr Nzioki suggested the following supplementary indicators:

***Goal 1: Eradicate Extreme Poverty and Hunger***

- Proportion of women with access to social housing and services.
- Share of unpaid work between women and men
- Proportion of women in economic decision-making at all levels

***Goal 2: Achieve universal primary education***

- Overall literacy rate by sex

***Goal 4: Reduce Child Mortality***

- Women's access to reproductive health services and health education.

### ***Goal 6: Combat HIV/AIDS, Malaria and other Diseases***

- Proportion of population with access to preventive and treatment medication by sex.

### ***Goal 7: Ensure Environmental Sustainability***

- Percentage of female population with access to drinking water
- Number of irrigation and water projects addressing differential needs, constraints and opportunities of women.

The third discussant, Ms. Aminata Diouf Ndiaye of the Ministry of Women Affairs, Family Affairs and Social Development, Senegal made a presentation on gender equality and social inclusion, drawing from the situation in Senegal. After providing an overview of the socio-economic context in Senegal, Ms. Ndiaye stressed the need to look at the definition of both social inclusion and gender. She also informed the meeting that Senegal is committed to gender equality as reflected in their efforts to tackle such issues as sexual harassment and FGM. Senegal has also ratified CEDAW. Ms. Ndiaye also reported on women's participation in political processes in Senegal. In this respect, she informed the meeting that 33 per cent of members of the national assembly are women, 40 per cent of senators are women, while four ministers out of a total of 28 are women.

In addition, women are very active in the economy, particularly in the agricultural sector. They are also involved in animal husbandry and fisheries. Women in Senegal are also highly represented in the health and other sectors.

Ms. Ndiaye ended her presentation by proposing a number of supplementary indicators:

#### **MDG 1:**

- Percentage of women living in extreme poverty
- Percentage of men and women living under the poverty line
- Number of men and women who own land
- Percentage of unemployed (men, women, age, duration)
- Rate of employment per category of targeted groups (men, women, age group)
- Percentage of poor men and women by geographic location, age

#### **MDG 2:**

- Percentage of boys and girls by level of education
- Drop out rate of girls and boys at all levels of education
- Percentage of women and men in adult education programs

#### **MDG 3:**

- Proportion of women over men who have access to and control land
- Percentage of men and women in decision-making positions and accessing health services, the justice system, and leisure activities
- Sex disaggregated household income
- Rate of improvement in standard of life following every social programme, disaggregated by sex and age

- Percentage of men and of women who benefit from every development project
- Women's portion of the gross national revenue
- Number of men and women parliamentarians
- Proportion of elected women at all levels
- Proportion of women leading political parties, trade unions, NGOs

#### **MDG 7:**

- Number of men and women who occupy decision making positions in the environmental management sector
- Number of environment-based projects that take into account the different needs of men and women

#### **Discussion**

During the ensuing discussion the meeting highlighted a number of issues and potential supplementary indicators that should be considered under the theme of social inclusion of women and gender equality. In terms of the presentation, the experts queried the proposal to move all education indicators to MDG 2 and leave MDG 3 to focus on violence against women and women's political participation. It was agreed that although the title of MDG 3 should be more encompassing than the existing title that only focuses on education, the proposal suggested in the panel presentations was not adequate.

The proposals to use the life cycle approach and to disaggregate by sex, age and social group were supported. The meeting suggested that the proposed indicators for access to extension and credit need to be disaggregated by age. Other issues raised in the discussion include the payment of maintenance to young mothers, skills development, and that gender is not just about women but also men.

Participants further noted that the limited availability of sex and gender disaggregated data was a major constraint to policy-making. They suggested that Member States should try to fully utilize the existing sex and gender disaggregated data collected for Poverty reduction strategy papers (PRSPs).

#### **6. PANEL DISCUSSION ON PROMOTION OF SOCIAL INCLUSION OF YOUTH IN THE MDGS**

In this session, two presentations were made by: Mr. Kirui of the Ministry of Youth and Sports, Kenya and Ms. Mary Mpereh from the National Development Planning Commission, Ghana.

Mr Kirui's presentation was entitled the status of youth in Kenya. He defined the youth to be 15-30 years old and indicated that they account for 32% of the country's population i.e 9.1 million with about half being female. Even though the youth form about 60% of the labour force the majority are unemployed.

He then highlighted the main challenges facing youth in Kenya to include:

- **Unemployment:** The labour force increases by 500,000 annually but only 25% are absorbed leaving the rest unemployed.

- **Health related problems:** HIV/AIDS affects 33% of the youth; the young orphans are head of households; FGM 38% of all Kenyan women (1998) and 32% in 2003.
- **Crime and drugs:** over 50% of convicted criminals are youth and there is a growth of criminal gang networks.
- **Limited participation and lack of opportunities:** There is little or no representation of young people in socio-economic and political processes;
- **ICT:** Access to ICT by the rural youth is minimal.
- **Environmental problems:** The majority of slum dwellers are young people. Youth involvement in sustainable development is low.
- **Education and training:** The current training institutions have not effectively equipped the youth with the necessary skills that are respondent to the dynamics of the labour market.

Mr. Kirui proposed the following supplementary targets and indicators:

**MDG 1:**

- Proportion of young people enrolled in vocational, technical training institutions

**MDG 5:**

- Target: By 2015, reduce the occurrence of FGM by 50%
- Indicator: Proportion of young females undergoing FGM

**MDG 6:**

- Target: By 2015, halve the number of young HIV and AIDS orphans taking care of their siblings
- Indicator: Proportion of young HIV and AIDs Orphans taking care of their siblings

**MDG 7:**

- Proportion of self-dependent youth living in urban slums
- Proportion of young people migrating from rural to urban areas

**MDG 8:**

- Proportion of young people with access to telephone, cellular and internet services

Ms. Mpereh presented her comments on youth and the MDGs with specific reference to Ghana. She indicated her support on the proposal of using a life-cycle approach in the context of MDG 1. She suggested a supplementary indicator to monitor youth unemployment since youth are more likely to face income poverty more than prime-aged adults, based on evidence from Ghana where youth unemployment is highest in the 15 to 24 age group. She indicated that tracking the incidence of poor youth headed households would also shed light on likelihood of intergenerational transfer of poverty to children. The presenter suggested that the extent of casualisation of labour or precarious employment among the youth need to be monitored. She emphasized the need to support youth entrepreneurship training and start-ups for youths who have opted for self-employment, especially young women

In terms of MDG 2, Ms. Mpereh stressed that tracking gross secondary and tertiary enrolment ratios is important, but may not necessarily be a measure of “employability” especially in the case of wage employment. She indicated that skills deficits may deny some unemployed youths from taking advantage of emerging opportunities such as employment in garments and textiles sector and recommended promotion of skills training programmes for youth. She suggested the integration of children in difficult circumstances such as OVCs, trafficked children, children in conflict with the law, child labor and streetism, child abuse, child prostitution, children in armed conflicts etc. into the formal educational system. Ms. Mpereh recommended the development of social protection programmes for children in difficult circumstances in order to break the intergenerational transfer of poverty. In addition, she suggested that indicators should be proposed also for children with disabilities covering all levels of schooling.

She proposed the following specific indicators:

- % share of budgets for social protection for children
- Access of school drop-outs to alternative and flexible formal streams of education
- Number of out of school children who have been enrolled in alternative forms of formal education
- % decrease in incidence of child labour and streetism
- % share of budget allocated to social safety nets for poor out of school youth

With respect to MDG 5, the presenter highlighted the need to track both ante and postnatal care. With regard to MDG 6, Ms. Mpereh proposed that an indicator for ART coverage for youth. On MDG 7, she underscored that resource degradation is a major cause of rural urban migration amongst youth. She highlighted that additional indicators can include: Proportion of youth with correct knowledge about environmental regulations; and participation of youth in environmental impact assessments and negotiation of contracts with investors

On MDG 8, the presentation proposed that supplementary indicators also focus on the proportion of Heavily Indebted Poor Countries (HIPC) debt relief going to youth, while others reflect on the lack of access to credit and inputs and the ICT skill deficit.

Ms. Mpereh also requested that the definition of social exclusion be broadened as done by the Ghana Human Development Report on social exclusion. She also pointed out that the danger to mainstreaming social exclusion is ending up “outstreaming” the issues. Furthermore, she underscored that the current MDG framework is too restrictive to consider the issues of social exclusion, since what was required is to take a more holistic view.

## **Discussion**

During the discussion following these two interventions, the experts raised a number of issues. It was highlighted that children also face issues of social exclusion, orphans (particularly HIV/AIDS orphans). In this respect, the participants proposed that additional indicators be included such as the rate of children on ART and the proportion of children living with HIV/AIDS. The definition of youth was also raised as an issue since it varies across the continent.

Participants stressed the importance of monitoring the share of debt relief and public expenditure that goes to socially excluded groups and suggested that indicators in line with this be included under MDG 8.

## **7. PANEL DISCUSSION ON HEALTH EQUITY, SEXUAL AND REPRODUCTIVE HEALTH IN THE MDGS**

Under this item, three presentations were made by Dr Michele Odile Randriamananjara of AED/Hygiene Improvement Project, Madagascar, Dr. Sandhya Joshi of the Addis Ababa University, and Dr. Cornelia Atsyor of the WHO Country Office in Addis Ababa.

Dr. Randriamananjara made a presentation on “Health Equity and the Promotion of Sexual and Reproductive Health”. The presenter noted that while progress has been made towards achieving the targets of the MDGs this has been very slow-paced. The problems of health inequity are self-evident; the question should be “how to better to monitor the situation of inequity”. Health equity involves: equal access to available services for equivalent needs; equality in use of services; and quality in the services provided.

Dr. Randriamananjara informed the meeting that there are inequalities in access, use and quality for example at the socio-economic level, in the use of contraceptives and rate of assisted births; in access to vaccines and prenatal healthcare; and at the urban/rural level in terms of the rate of assisted births and care for children affected by diarrhoea.

Referring to the specific case of Madagascar, Dr. Randriamananjara noted that inequities exist between urban and rural populations: with a 50 per cent public health services usage rate and with 65 per cent of the population living within a 5km radius from a health centre and 30 percent of the population living outside a 10km radius from a health centre. Further inequalities exist between the urban and rural populations in the quality of essential health services they receive. Only 59 per cent of health centres have access to clean water, thus leading to sanitation related illnesses (malaria, diarrhoea, etc). Uneven distribution of health professionals: 72% of doctors are in urban areas, and 50% of medical care givers are in Antananarivo; 41% of health care givers treat only 21% of the population. The presenter also stressed that inequities exist because of limited investment to health resulting in inequitable distribution of the available resources. Health insurance is available for only 5-10% of the total population. The state funds 32% of the health system, while donors fund 36% and the private sector funds 32%. The state budget for health is 8.7% of its total budget, translating to US\$ 5 per capita. Only 1% of the population benefits from health coverage packages with only 30% of facilities offering such services.

In terms of sexual and reproductive health, Dr. Randriamananjara informed the meeting that as many as 70 per cent of girls of 16 years in some regions of Madagascar have had children, it is important to monitor the health status of these young mothers. Also, 24% of girls said they would use contraceptives, if these were made available to them, so it would be important to measure the percentage of youth who have access to contraceptives. It should be noted that access to health services focused on reproduction, family planning for teenagers and youth groups is very limited. As less than 40% of pregnant women receive prenatal care, it is important

to follow up on the proportion of births attended by a health care professional and the proportion of pregnant women sleeping under a treated mosquito net.

Dr. Randriamananjara proposed that additional indicators that could be used to track the health inequities include the following:

- Proportion of households within a 5km radius from the nearest health centre
- Availability of health caregivers and their distribution levels between urban and rural areas
- Proportion (rate) of availability of clean water and latrines in health centres
- Percentage of government health expenditure/total government expenditure
- Proportion of government health expenditure/total health expenditure
- Proportion of private health expenditure/total health expenditure
- Proportion of children under the age of 5 sleeping under treated mosquito nets
- Proportion of children completely vaccinated

Dr. Joshi made a presentation on the general issues of health equity and sexual and reproductive health (SRH) and then made specific reference to the Ethiopian context. She started out by defining health equity/inequity and looking at the consequences and sources of this situation. Dr. Joshi informed the meeting that the major sources of inequities in health include income, gender, residence location, race and ethnicity.

Turning to the situation in Ethiopia, Dr. Joshi pointed out that both health inequity and SRH are of major concern in the country. Ethiopia battles with high maternal mortality, unsafe abortions, low uptake of ante-natal, natal and post-natal services, low contraception use, high incidence of fistula, to name a few areas of concern. However, noteworthy progress has been made in reaching child immunization coverage. Looking at the socially excluded groups in Ethiopia, Dr. Joshi proposed that other groups should be added including specific ethnic groups, which suffer all forms of exclusion.

Dr. Joshi highlighted the need to include demand-side factors in monitoring progress towards addressing health inequities. Demand side factors include reasons why women do not seek obstetric emergency care or maternal health services such as lack knowledge of when to seek treatment; poor information on services; lack of ability to understand health messages; lack of 'permission' from the family; and more faith in traditional healers or other beliefs. She agreed with the new target to monitor resource allocation to health but stressed that four new indicators are required.

Dr. Joshi proposed the following supplementary indicators:

- Utilization of pre-natal and natal services;
- Access to ART disaggregated by gender;
- Indicators reflecting the exclusion of PLWHAs from employment, housing, social interaction, and access to social services such as health and education; and
- Indicators to monitor utilization of male and female SRH services.

The third discussant, Dr. Cornelia Atsyor reflected on health equity and sexual and reproductive health. She informed the meeting that ECA's report is very relevant and aligned to the goals of

reducing health inequities and contributing to promoting health as a major human rights issue. She suggested that the report should include discussion of MDG 7 target 10 and 11 and MDG 8 under the health equity section.

In terms of MDG 4, Dr. Atsyor agreed with the proposal to disaggregate by social groups as well as demographic indicators. On MDG 7, she stressed the importance of looking at the relationship between health and the environment. For example, 24 per cent of global disease is caused by environmental exposure, which is responsible for 33 per cent of disease in children under five years. Preventing environment risk can, therefore, save lives. In this respect, over 40 per cent of deaths from malaria and 94 per cent of diarrhoeal diseases could be prevented through better environmental management. On MDG 8, Dr. Atsyor stressed the importance of looking at an indicator on access to affordable essential drugs. She also emphasised the need to include an indicator on the percentage of budget allocation to health that actually reaches the sub-national level.

### **Discussion**

In the discussion following the presentations participants stressed the importance of addressing maternal mortality and requested more information on how Madagascar dealt with the high maternal mortality and other health challenges so that other countries can learn from their experience. The meeting highlighted that in addition to increasing the physical availability of health facilities, there is need for outreach programs that can bring health services into communities. The meeting emphasised that HIV/AIDS prevention is a major gap that is crucial in addressing health inequities. It was also stressed that access to ARTs is the right of all age groups, including the elderly.

## **8. PANEL DISCUSSION ON PROMOTING SOCIAL INCLUSION OF OLDER PEOPLE, PERSONS WITH DISABILITY AND PLWHA IN THE MDGS**

In this session, two discussants made presentations on their responses to the issues raised in the draft report on promotion of the social inclusion of older people, persons with disability and PLWHA in the MDGs; Dr Douglas Lackey, of Helpage International and Dr. Alessandro Conticini, of UNICEF Addis Ababa.

Dr Douglas Lackey highlighted that older people fall victim to all the 3 dimensions of social exclusion: (i) Lack of full participation in economic life: restricted access to earn income, livelihood opportunities; (ii) Exclusion from social participation: restricted access to social services, social security, community and family support; (iii) Exclusion from political and community participation: restricted access to consultation, decision-making, community organisations. He indicated that poverty was a major contributing factor to all the dimensions of social exclusion of older persons.

The meeting was informed that there were national, regional and international policy frameworks that included: National Plans of Action on Ageing for example in Tanzania, Mozambique, Ethiopia, South Africa, Mali; African Union Policy Framework and Plan of Action on Ageing 2002; UN Madrid International Plan of Action on Ageing 2002; and Livingstone Call for Action:

Social Protection 2006. All these frameworks include policy recommendations in key issue and thematic areas such as Rights, Poverty, Health, Social Welfare, Gender, and HIV/AIDS.

Dr Lackey highlighted that major gaps in national, regional and international policies regarding older people include minimal reference to the impact of HIV/AIDS on older people in national HIV/AIDS policies and strategic plans and regional policies such as the Abuja Declaration on HIV/AIDS; lack of prioritised support to alleviate poverty of older people in poverty reduction strategies; and the United Nations General Assembly Special Session (UNGASS) indicators for the implementation of the declaration of commitment on HIV/AIDS do not assess the impact on older people and persons with disability. He indicated that demographic trends show that 10% of the population by 2050 will be elderly. The scale of poverty among older persons was high; (100 million older people living on less than \$1 a day, 80% no income), leading to food insecurity particularly for OVC and older carers, limited access to health services, risk of disability. Most of the older persons lack access to poverty alleviation and OVC programmes.

He summarized some of the key issues that need to be taken into account with regard to older persons to include: the impact of HIV/AIDS, particularly on older carers of OVC; the HIV prevalence rates of older people and access to VCT and ART; linking disability as an issue of ageing; inclusion of older people in key policy issues at national and regional levels; and poverty reduction strategic plans.

Dr Lackey suggested the following supplementary indicators:

***MDG 1: Eradicate Extreme Poverty and Hunger***

- Percentage of older people accessing poverty alleviation programmes

***MDG 6: Combat HIV/AIDS, Malaria and other Diseases***

- Percentage of older people who are accessing VCT services and know their HIV status
- Percentage of older carers of OVC and PLWHA who are receiving support

In concluding his presentation, Dr Lackey highlighted that one of the challenges of implementing the suggested indicators is lack of disaggregated data by age for HIV/AIDS-related health facilities – VCT, ART; access to health services; access to poverty reduction programmes; and profile of caregivers of OVC/PLWHA. He indicated that the opportunities include analysing the existing data being collected by sex and age for VCT and ART; including key questions on the impact of HIV/AIDS on older people in HIV/AIDS prevalence surveys, demographic and health studies; and prioritising support to older carers in annual HIV/AIDS and poverty reduction strategic plans.

Dr. Alessandro Conticini's presentation was on the promotion of the social inclusion of persons with disabilities in the MDGs. He stressed that disability is a social construct and that the sector overall is poorly funded. Societies create disability from their perceptions of impairment, which create incapacity to fully participate in society (school, work, social activities, etc.).

Dr. Conticini underscored that so far, disability has been approached as a medical problem, which needs a medical solution. Rather, he stressed that the focus should be geared towards

making the society more agreeable to the situations of the impaired. For example, instead of segregating special needs children, the capacity of the classroom and the teacher should be built in a manner that will enable them to take care of 'disabled' children. Thus, intervention should not be on the 'disabled' person but on the society as a whole.

The presenter informed the meeting that it is important to have an appropriate baseline set up in order to track changes. According to the WHO, 10 per cent of people live with a disability worldwide. In Ethiopia, it is estimated that 17-18 per cent of the population lives with a disability. There is a large gap between the WHO's global estimates and the Ethiopian estimate, thus the importance of a proper baseline to track indicators.

Dr. Conticini underscored that programmes that deal with disability are not well funded (as compared to programmes that tackle HIV/AIDS), and subsequently, it is important to ask: how fair is it to monitor a developing country by its programmes for ageing or disabled people, when these two sectors are constantly under-funded? While developing countries need to develop policies on these issues and include them in their PRSs, donors need some form of accountability, in terms of the percentage of aid that is allocated to disability or to the elderly. In the same way gender has been mainstreamed, each single donor agency needs to have a policy on disability. In this respect, the presenter stressed that proper mechanisms need to be set up to successfully mainstream HIV/AIDS within the disabled and elderly populations. People living with disabilities do not need special human rights, what they need is a guarantee to the same human rights as everyone else.

As indicated by Dr. Conticini, disability is normally classified either as physical or intellectual. While physical disability is easier to translate into data, assessing and quantifying, intellectual disability is very controversial as much disagreements exists within academia. For example, it would be very difficult to have such an assessment done for Ethiopia with measures used elsewhere as they may not be applicable. Social protection systems are a key issue that can include age, gender, and other vulnerabilities for identifying beneficiaries. In this respect, Dr. Conticini suggested that the report should include a discussion of social protection systems.

Dr. Conticini recommended the following indicators:

#### **MDG 2**

- The proportion of children with disability in primary or secondary education should be expressed as  $\frac{\text{Children with disability going to school}}{\text{Children with disabilities NOT going to school}}$

#### **MDG 5**

- Proportion of mothers with disability with access to specialized services. Services need to be designed to meet the needs of those faced with disability.

#### **Discussion**

In the ensuing discussion the meeting stressed that it is important to look at the social protection strategies existing in Africa. Social security for older people is crucial for their survival and needs to be addressed under Goal 1 (fighting against poverty). The meeting stressed that the attitudes of many who consider older persons as social burden with little contribution to society

needs to be changed through awareness campaigns. Older persons have once again become parents as they are now taking care of their grandchildren, which is a major contribution.

Again, it was suggested that the cluster covering the older persons, persons with disabilities and PLWHA be “de-clustered” to give visibility to each group and their specific needs. The meeting also observed that it is up to African states to tell donors that the older persons, the disabled and other vulnerable groups are a part of our societies and they need a significant share of money. These groups should be included in the PRSPs, as governments need to do their homework and then demand funding. The meeting indicated that countries need to develop policies on older persons, persons with disabilities and PLWHA that should be provided with adequate resources for successful implementation. It was also pointed out that it is difficult to understand the issues facing persons with disabilities since all the participants in the meeting are persons without any disability hence the need for increasing the participation of these excluded groups in policy development and implementation at national and regional levels.

With respect to supplementary indicators, the experts suggested that indicators are needed to look at caregivers and the level of social protection. In terms of the latter, it was noted that in Senegal, older people receive free health care, which allows the collection of data, which in turns allows the government to set up indicators. Participants also noted the importance of gathering statistical data that can help monitor the inclusion of older persons, persons with disabilities and PLWHA into mainstream development.

In relation to HIV/AIDS, the meeting stressed that there is a need for a paradigm shift in attitudes. We need to compensate caregivers who are responsible for raising our future children. The older persons have lost their children, thus losing their social security, but in addition, they have the burden of raising their grand children. In addition, the meeting observed that it is important to set up mechanisms that support able bodied older persons to support non-able bodied older persons at the community level.

## **9. PRESENTATIONS OF COUNTRY EXPERIENCES**

The presentation made during this session include: South Africa, by Ms. Raphaahle Ramokgop; Zimbabwe, by Mr Sidney G. Mhishi; Malawi by Mrs. Victoria Geresomo, Zambia, by Mr Gregory Mwanza and Ms. Christine Kalamwina; Cameroon, by Ms Gladys Ngwafor; Uganda, by Mr Stephen Kasaija; Tanzania, by Mr. Lelansi Mwakibibi; Sierra Leone, by Mr. Mani Koroma, and Mali, by Mr. Alassane Ba.

In general the presentations focused on five main points, namely: brief overview of the socio-economic context; majors groups that faced social exclusion; major forms of social exclusion; government’s initiatives to promote social inclusion and suggestions on supplementary targets and indicators.

### **Overview of socio- economic context**

High levels of poverty and social exclusion emerged as the main feature of socio-economic contexts as presented by delegates. One peculiarity appears with the case of Sierra Leone because it is a post-conflict country a lot of social exclusion in the country is accounted for by the decade long war. In some countries notably South Africa, the history of discrimination under

apartheid characterises the pattern of social exclusion. In Zimbabwe, international political isolation and economic sanctions as retaliation to its land reform program has severely crippled the country's productive base that has resulted in increased poverty, which in turn increased social, and economic marginalisation of already disadvantaged groups.

The different countries have their PRSP or national development plan which provides general guidelines to poverty reduction policies that provide to some extent social protection nets. Presenters suggested the need to link social inclusive MDGs needs assessment as a framework to developing the second generation PRSPs and the Medium Term Expenditure Framework.

Presenters also noted that although social exclusion within countries is the result of the way in which economic, social and political institutions are changing and the nature of domestic policies, social exclusion cannot simply be attributed to "internal factors". Presenters indicated that international relationships are increasingly and ever more deeply implicated in what is happening in some of the African countries. They pointed out that reform programmes that encourage economic restructuring and redefining the role of the state in social provision and economic activity are actually increasing the incidence of social exclusion. Reforms which seek to open up economies to competition from the rest of the world have been associated with the erosion (or complete breakdown) of old social contracts which were a central means of social integration. In this process, citizenship rights have shrunk.

### **Major groups that faced social exclusion**

In general, the groups that face social exclusion identified by the presenters include orphans and vulnerable children, young people, women, persons with disability, older persons, people living with HIV/AIDS, very poor people and informal sector workers. A number of peculiarities appear in some countries where ethnic minority groups (Bororos, montagnards and pygmies for Cameroon), prisoners, prostitutes, victims of catastrophes, internally displaced persons and street children appear as being marginalized.

### **Major forms of social exclusion**

In general, the presenters highlighted that the main forms of exclusion include exclusion from participating economically, politically and socially due to discrimination based on gender, HIV status, disability and age; and poverty, unemployment and job precariousness. Some presenters (Tanzania, Zimbabwe) noted that women under customary law have inferior land rights and their access to land is indirect and insecure. Social exclusion facing the older persons include loneliness, low income, dwindling respect and lack of access to health services; and, in some areas, they are molested on account of belief in witchcraft. Presenters noted that one reason for the social exclusion of children and youth is the lack of access of proper identification (or registration) which restricts their ability to access education and other social services.

### **Government's initiatives to promote social inclusion:**

Generally, governments have created policy, legal and institutional frameworks that promote social inclusion. Many countries have adopted specific policies that address the social exclusion issues of some groups eg. Women development policy, National Youth Development policy, Policy on Development of People with Disabilities, National Ageing policy, Affirmative action policy for tertiary education etc. The presenter from Tanzania indicated that recently, the

government had developed a social protection framework that ensures that the needs and rights of the poor are adequately protected and addressed including preventing the population from falling into poverty and vulnerability to enable them gainfully engage in productive activities.

Many countries have put in place several institutions especially in charge of social inclusion. For instance, many countries have created ministries specially charged to handle women, youth affairs and disability. The activities conducted by these various institutions of social inclusion include: cash transfers; free provision of basic services (education, health care, housing, potable water, etc.); special assistance to target groups (micro-credit and entrepreneurship programs, social insurance scheme); special funds such as the Disabled persons fund (in Zimbabwe), Umsombovu Youth Fund (in South Africa) created specifically to meet the needs of the vulnerable groups; expanded program against HIV/AIDS, epidemic and other disasters; capacity building (training in information, communication and technology (ICT), vocational training to unskilled unemployed); employment creation programmes such as public works programmes; improved pension schemes .

The Governments have also adopted various laws and regulation to promote social inclusion such as the ratification of certain conventions (The Convention on the Right of the Child, the African Charter on the Right and the Welfare of the Child, etc.); Children’s Act; Social Welfare Assistance Act; The disabled Persons Act; Domestic violence Act.

All these public initiatives are often supplemented by similar initiatives from NGO, churches, international organization and private sector.

Presenters noted the increase, though slight, of the participation of women at high level of decision-making. For the first time, several women have been appointed at high level of executive (Vice-President in Zimbabwe, Prime Minister in Senegal, Divisional Officer in Cameroon, etc.).

### **Proposals on additional targets and indicators**

Presenters suggested the following additional targets and indicators:

#### **(i) Zimbabwe**

##### ***Orphan and vulnerable children:***

##### **Targets**

- Zero % orphans and vulnerable children dropouts in primary and secondary schools by 2015;
- Eliminate “streetism” by children of school-going age by 2015;
- Improve nutritional status of at least 2/3 of all orphans and vulnerable children by 2015.

##### **Indicators**

- Orphans and vulnerable children primary and secondary school completion rates;
- Orphans and vulnerable children net enrolment ratios (primary and secondary);
- Percentage of orphans and vulnerable children who are undernourished.

***Older persons:***

**Target**

- Reduce by 2/3 the percentage of elderly destitution by 2015.

**Indicators**

- Percentage of elderly living below the food poverty line;
- Proportion of elderly with access to social security;
- Proportion of elderly in institutional homes.

**People living with disabilities:**

**Targets**

- Universal access to basic education for all disabled children by 2015;
- 100% full or proxy employment for people with disabilities by 2010.

**Indicators**

- Net enrolment ratios in primary and secondary schools for disabled children;
- Proportion employed of disabled persons as a percentage of labour force for Government and private Sector.

***Gender:***

**Targets**

- Eliminate gender based violence by 2015;
- Increase the participation of women by 60% in all decision making processes by 2015;
- Promote gender equality in labour force participation by 2015.

**Indicators**

- Incidence of gender-based violence per 100 000 women per year;
- Proportion of female employees to total labour force;
- Percentage of women in decision-making positions by categories.

**(ii) Malawi**

***MDG 1***

- Proportion of elderly persons below the minimum level of the recommended dietary energy consumption.

***MDG 2***

- Net enrolment ratio in primary education of children with disabilities;
- Percentage of disabled children completing primary school each year;
- Percentage of disabled children who complete secondary school each year.

***MDG 3***

- Percentage of persons with disabilities employed;
- Proportion of women in decision-making positions in private and public sectors.

***MDG 6***

- Proportion of the elderly persons who are the main providers of care and support to those living with HIV and AIDS.

### **(iii) Zambia**

The delegate stressed the need to know the number of disabled people accessing services in various sector and the real income of the poorest 30 of the population.

He argued that the later indicator would allow tracking the performance of most of the socially excluded groups.

### **(iv) Uganda**

#### ***MDG 1:***

- Proportion of disabled, youth, elderly and women in paid formal employment.

#### ***MDG 2:***

Adjustment of Goal 2 to incorporate secondary and tertiary education and disaggregate the new indicators by sex, age and disability.

#### ***MDG 5:***

- Percentages of female population within 10Km travel distance to the nearest emergency obstetric care.

### **(v) Sierra Leone**

- % of population below minimum level of dietary energy consumption.
- % of women in governance at all levels of decision making (Ministers, Deputy Ministers, Parliamentarians, Heads of parastatals/departments/commissions/local councils).

### **Discussion**

In the ensuing discussion, the meeting commended the creation of a network for older persons in South Africa, the affirmative action for girls' education in Mali and Zimbabwe and Zambia's children streetism eradication. The policy of providing institutional care as the last resort for orphans in Zimbabwe, was highly commended as a policy that promotes social integration of orphans.

Participants stressed the major role that HIV/AIDS plays as a major cause of exclusion in many countries, especially with regard to the feminization of the epidemic. In this context, the meeting suggested the need to focus more on prevention activities. The meeting recognised the fact that good policies or laws may be in place but lack of implementation and enforcement greatly affects achievement of intended impact on the ground. The meeting agreed that adequate resource allocation and capacity building were necessary for implementation of the supportive policies and laws to succeed.

Concerns were raised on the financing of the various programmes and their sustainability. Apart from South Africa, where donor's interventions are confined to capacity development issues, in all other countries, development partners are supporting financially the social programmes.

Participants also noted that coordination among the various stakeholders is of paramount importance and an integrated approach could help to streamline all interventions.

## **10. REPORTS OF BREAK-OUT SESSIONS**

The discussions in break-out sessions focused in more detail on the four main themes of the meeting: 1) Gender equality; 2) Older persons, persons with disabilities, PLWHA and other groups; 3) Sexual and reproductive health and health equity; and 4) Youth. These break-out sessions were tasked with the following: (i) Identify the key social exclusion issues that need to be monitored in the MDGs that pertain to the thematic area, including the forms and causes of social exclusion; (ii) Based on 1, identify supplementary MDG targets and indicators that can help monitor the progress in promoting social inclusion for the thematic area (not goals at this stage); (iii) Prioritise the suggested indicators – the top 10 indicating the reasons: and (iv) Identify the challenges and opportunities faced by countries in adopting the suggested indicators.

### **10.1 Gender equality**

#### **Forms and causes of social exclusion**

The group identified the major forms of social exclusion of women to include political, economic (from employment opportunities, owning land and property, accessing credit and other production resources) and social (exclusion from accessing health, education and other social services).

The major causes of the social exclusion were identified to include the negative traditions and culture that affects women's human rights; patriarchy; political and social structures that are not favorable for effective female participation; lack of education and skills; and gender-based violence.

#### **Suggested indicators**

- % population in informal sector by sex and occupation
- Ownership of agricultural land by sex
- Access to extension services by sex
- Access to agricultural credit by sex
- % increase in local food production
- % of women at all levels of decision making
- % of women in parliament and local governance.
- % of women in decision making in private and public organizations
- Share of men and women's labour in unpaid work
- Incidence of gender based violence per 100,000 women/year
- Prevalence of contraceptive use by sex.
- Age at marriage by sex
- Child bearing among girls aged 15-19 years

## 10.2 Youth

### Forms and causes of social exclusion

The group identified that the major forms of exclusion experienced by youth include exclusion from the labour market, exclusion from decision-making, and exclusion of vulnerable children.

The major causes of social exclusion were identified to include: lack of employable skills – mismatch between training received and labour demand; racial discrimination in access to marketable skills; slow economic growth with limited absorption of the youth; lack of work experience; national definition of youth as prescribed by legislation – statutory age for employment (18, 16 in others); casualisation/ precarious employment; illiteracy; lack of information on decision-making spaces; lack of registration of children; streetism; child trafficking; child labour; child prostitution; child poverty; children in conflict with the law and orphanhood.

### Suggested supplementary target

- To achieve full and productive employment for all, including young people

### Suggested supplementary indicators

- Ratio of youth unemployment as a ratio of adult unemployment rate
- % of young people without contracts in the labour market
- Proportion of youth enrolled in vocational and training institutions
- Proportion of the youth population who have been able to set up their own businesses
- Proportion of youth representation in parliament and local councils
- % of children registered at birth

The group indicated that the major challenges faced by countries in adopting the new indicators included availability of data for measuring the new indicators and cost and capacity issues with regard to the collection of the new data. The group highlighted that the major opportunity for countries to adopt the indicators is the 2010 and 2011 round of population censuses.

## 10.3 Sexual and reproductive health and health equity

### Forms and causes of social exclusion

The group identified the major forms of exclusion to be unavailability of health services within reasonable distance; lack of access to health services because of lack of financial resources; and cultural and traditional issues that constrain the demand side of health.

The main causes of inequities in accessing health services were indicated to include income, gender, residence location, race and ethnicity.

### Suggested supplementary indicators

- Mortality rate of new-borns
- Proportion of children completely vaccinated against measles
- Proportion of children who sleep under mosquito nets
- Proportion of adolescents who have access to sexual and reproductive health services

- Proportion of pregnant teenage adolescents
- Proportion of pregnant women who sleep under bed nets
- Proportion of reproductive age women with access to pre-natal and natal services
- Proportion of people affected by HIV/AIDS who are working
- Access to ART disaggregated by sex

#### **10.4 Older persons, persons with disabilities, PLWHA and other groups**

##### **Forms and causes of social exclusion**

The group identified the other groups to include OVCs, ethnic minorities, commercial sex workers, street beggars and internally displaced people. The main forms of exclusion were identified to include socially from social services (health, education, specialised services for the older persons), economic (from employment and livelihood opportunities and resources), heavy caring burden for the older persons and lack of consultation in decision making.

The causes of social exclusion were identified to include stigma; discrimination based on ethnicity; lack of accessible services for persons with disability; lack of social security and social protection systems; HIV/AIDS and poverty.

##### **Suggested supplementary indicators**

- Percentage of older people/PWD-headed households living in extreme poverty
- Percentage of older persons/PWD/PLWHA/OVCs suffering from hunger
- Proportion of older persons/PWD/PLWHA/OVCs who have access to social protection
- Proportion of older persons/PWD/PLWHA/OVCs who have access to poverty reduction programmes
- Proportion of PWD in formal sector employment
- Net enrolment ratio in primary and secondary education of children with disabilities and OVCs.
- Proportion of pupils with disabilities and OVCs starting grade 1 who complete primary and secondary education
- Percentage of older persons who access adult literacy services/programmes
- Percentage of women with disabilities with access to prenatal and reproductive health services
- HIV prevalence amongst older persons/PWD by the different age groups
- Percentage of older carers of OVCs and PLWHA receiving support in their role
- Proportion of OVCs who receive free support
- Percentage of older persons/PWD with access VCT services
- Percentage of PLWHA with access to antiretroviral drugs by age and sex
- Proportion of the population with disabilities/older population with sustainable access to improved water source, urban and rural
- Proportion of the population with disabilities/older population with access to improved sanitation, urban and rural
- Proportion of public services with adequate access for people with disabilities

The group identified the major challenge in adopting the new indicators to be obtaining the statistical data required for calculating the indicators and the major opportunity to be the political commitment of the government.

## **11. STATISTICAL FEASIBILITY OF PROPOSED ADDITIONAL INDICATORS**

The session on statistical feasibility had two presentations by Mr. Oumar Sarr of ECA's African Statistical Centre, and Mr Zenaslase Siyum from the Central Statistical Agency of Ethiopia.

Mr Sarr's presentation outlined the African social, economic and political context in which monitoring data on internationally agreed goals should be placed. He indicated that the current priority activities of the national statistical offices (NSOs) include economic statistics; some social indicators; and poverty and living conditions indicators to support development of PRSPs disaggregated by sex and gender. He suggested that new areas that need statistics include gender; environment; and good governance. Mr Sarr highlighted that the major challenges facing NSOs include human and financial capacity constraints and cultural barriers.

The presenter indicated that there were a number of sources of data production and collection, namely the Household Surveys, Employment and Agricultural Surveys and demographic and Health Surveys, and Multiple Indicator Cluster Surveys (MICS). He emphasised that the respective costs and periodicity of these data sources have to be taken into account. Mr Sarr highlighted that there are particular problems in capturing the new indicators suggested in the draft report, particularly indicators on gender and gender-based violence. He pointed out that one of the reasons is because data collection from line ministries to the NSOs is not well coordinated. The presenter concluded that in order to strengthen statistical capacity for estimating the indicators it is important to promote advocacy for better statistics; promote wide dissemination of available statistics; and improve coordination between NSOs and line ministries.

Mr. Siyum gave a presentation that focussed on the statistical feasibility of the proposed additional indicators in the case of Ethiopia. The presenter indicated that the production of statistical data was ongoing in Ethiopia and argued that most of the suggested additional indicators can be generated from the currently available primary and secondary data from surveys and census. He further highlighted that data from the social sector particularly education and health is updated on an annual basis. The presenter noted that some of the indicators that might not be currently available from primary sources include: incidence of gender based violence per 100,000 women/year; proportion of women and girls who are victims of sexual and other forms of violence who have access to medical, psychological and legal services; proportion of women within 2 hours travel distance of basic emergency obstetric care; proportion of women with disabilities with access to prenatal and reproductive health services and proportion of pregnant women living with HIV/AIDs who receive ART to reduce the risk of mother to child transmission of HIV/AIDS. He added that these proposed additional indicators could be collected through the inclusion of new variables in appropriately designed household surveys.

Mr. Siyum pointed out that geographical coverage of household surveys is a serious constraint in Ethiopia, as they cover only sedentary areas missing out a relatively large nomadic population, which is estimated to be 4 million and accounts for 5 per cent of the population. He indicated

that nomadic populations are only covered during a census. Mr. Siyum concluded by giving a three-year schedule of surveys and their expected products highlighting that these activities provide an opportunity to generate statistical data for new indicators.

### **Discussion**

The participants appreciated both presentations and recommended the need for standardizing data collection methods and definitions to allow for comparability across countries. The participants also reiterated the need to improve coordination between line ministries and statistical services in the identification of excluded groups and to bring the perspective of these groups in designing questionnaires. Participants noted further that there generally there is some usable primary data that is available, the greatest challenge facing countries is the capacity to analyse this existing data. In this regard the meeting emphasised the need to improve the technical capacity of the NSOs.

## **12. IMPORTANCE OF KNOWLEDGE SHARING TO SUPPORT THE MDGS.**

Two presentations were made in this session by Mr. Adrian Gauci, and Ms. Gladys Mutangadura both representing the African Center for Gender and Social Development, ECA.

Mr. Gauci made a presentation entitled “Knowledge and experience on PRS/ MDGs Project”, which was structured around four main points: background, project objectives, project outputs and way forward. The presenter informed the meeting that the African Learning Group on Poverty Reduction Strategy Papers (PRSP-LG) was introduced in 2001 to serve as a platform for the articulation of an African view on the PRSPs and to facilitate systematic knowledge sharing on poverty reduction strategies among African countries. ECA in collaboration with the African Union and the UNDP jointly convened a plenary session for African states on PRS and MDGs in Cairo in 2006. The thrust of that Plenary was to undertake a post mortem of the PRSPs that were prepared between 2000 and 2005, to explore how best to make the PRS MDGs-consistent and to further encourage knowledge sharing through electronic platform. Following this Plenary, the mandate of the Learning Group was broadened so as to embrace the MDGs.

The objectives of knowledge sharing on PRS and MDGs under the newly reformed platform are multi-fold. The first objective is to build upon findings and the lessons learnt under the PRSP-LG. The second is to share experiences in designing, planning, implementing and monitoring MDG-based PRSs, thus building capacities across the continent. The third is to further encourage exchanges on MGD-related issues among PRS-MDG practitioners, think tanks and the diaspora.

The project has three major components. The first consists in building country team knowledge network and identifying focal points within specific PRS country units. The second involves conducting electronic roundtables on key issues and themes. Finally, the third is to provide research and training support to the PRS.

The products of the project include a knowledge audit, electronic discussions on different thematic areas and training of PRS and MDG experts from different African countries. Although having produced some positive outcomes, the presenter noted that the knowledge-sharing project

faces a number of challenges some of which include dwindling participation due to participation fatigue and inadequate electronic infrastructure in the countries.

Ms Mutangadura presented experiences on knowledge sharing on the project on strengthening social inclusion, gender equality and health promotion. She informed the meeting that the project was conducting a series of electronic discussions. The series began with a four-week-long moderated e-discussion entitled '*Promotion of Social Inclusion of Women and Gender Equality in the MDGs in Africa*' that was initiated on 21 April and was to continue to 20 May 2008. The objectives of this e-discussions included: i) the identification of multiple manifestations of gender inequality and social exclusion of women, ii) the exchange of national experiences with respect to the engendering of the MDGs, iii) the identification of additional targets and indicators that can used to monitor gender inequalities.

The e-discussion had 29 people participating and had received contributions from Burundi, Cameroon, Chad, Comoros, Madagascar, Mauritania and Senegal. Preliminary discussion of the e-discussion indicates that factors behind persistence inequalities and social exclusion of women are broad. They include the lack of education and skills, the prevalence of patriarchal systems, financial dependency, the persistence of traditional practices that are harmful to girls and women and early marriages of girls. As a way forward, the presenter invited participants to join the discussions, which would wrap up on 20 May.

### **Discussion**

In the ensuing discussion participants acclaimed the importance of knowledge and experience sharing to support the MDGs. The meeting suggested that the membership should be widened to reflect the broad spectrum of actors involved in social policy design and implementation. Participants also noted that sharing of information is important within countries, between countries and internationally and is essential to the successful development and implementation of inclusive policies. There is need to promote information sharing on experiences with successful and unsuccessful practices.

## **13. SYNTHESIS OF THE EXPERTS GROUP MEETING**

Ms. Gladys Mutangadura presented a synthesis of the main issues emerging from discussions held in the meeting. This synthesis also forms the main recommendations of the meeting. This section already incorporates the comments that were suggested by participants in the discussion following the presentation of the synthesis.

### **13.1 General substantive recommendations on promotion of the inclusion of vulnerable groups, gender equality and health equity in mainstream development**

The AEGM adopted the following recommendations directed to member States and all stakeholders aimed at promoting the inclusion of vulnerable groups, gender equality and health equity in mainstream development.

- For countries that have not yet done so develop comprehensive social protection policies that that can promote inclusive development;

- Mainstream social inclusion into the national development strategies and poverty reduction strategies;
- Increase resources allocated towards promotion of social inclusion, gender equality and health equity;
- Monitor the share of debt relief, development aid and public expenditure that goes to socially excluded groups;
- Improve collaboration mechanisms between government departments and other key stakeholders in undertaking social protection strategies;
- Promote capacity building to support implementation of social protections strategies;
- Undertake policies that encourage the registration of children;
- Promote sharing of experiences on promotion of social inclusion, gender equality and health equity within the countries, region and internationally;
- Promote HIV/AIDS prevention as it is a major cause of social exclusion;
- Promote outreach of health services into communities.

### **13.2. Recommendations to improve the draft report**

To enhance the report the meeting suggested the following recommendations:

1. The definition of social exclusion in the African context and a discussion of the causes of social exclusion.
2. The group consisting of the elderly, persons with disabilities and people living with HIV/AIDS be split up to ensure that issues pertaining to these groups are not lost through aggregation;
3. Additional socially excluded groups should also be considered such as ethnic groups e.g. nomads, pygmies, and OVCs.
4. A box on the definition of disability can be included.
5. A life-cycle approach can be used to capture the transitions from one stage to another.
6. A discussion on the legal and institutional issues behind social exclusion and how much effort has been made to address it should be added to the report. A discussion is also needed on the weak capacity and the lack of resources for ministries, and overall, how social exclusion is considered in the planning and budgetary processes.
7. A discussion on vulnerability to poverty, and reference to the social protection frameworks being developed in many African countries; for example, in Ghana, Nigeria, Malawi, Tanzania, Chad, Mozambique, South Africa, Mali, Tunisia and others.
8. Discussion of mainstreaming social inclusion in the national development plans and PRSPs and highlighting the major challenges facing the implementation of the well developed social protection plans and strategies.
9. Reference to the regional and international policy frameworks that address social exclusion such as: AU Policy Framework and Plan of Action on Ageing 2002; UN Madrid International Plan of Action on Ageing 2002; and Livingstone Call for Action: Social Protection 2006.
10. Discussion of the major challenges that countries currently face in monitoring social inclusion in the current MDG indicators.
11. Reference to country case studies to strengthen the report in terms of the forms of social exclusion experienced, and the rich initiatives being undertaken (ranging from Specialised funding, universal education, skills training, social transfer programmes etc.)

### **13.3 Recommendations on new goals**

- Persons with disabilities need visibility and it is important that there is a goal on persons with disability in the MDG framework.
- Minority groups also need their own goal.

### **13.4 Key issues and recommendations on the promotion of gender equality in the MDGs**

#### **Key issues**

##### **Negative traditions and culture**

- Affects reproductive rights and women's human rights, e.g. harmful traditional practices (FGM, widow inheritance, widowhood rites, early marriages)
- Taboos on food

##### **Patriarchy**

- Unequal power relations between men and women affect inheritance patterns. Men are given preference over immovable property and land. Patriarchy leads to discriminatory attitudes towards females throughout their life cycle including son preference.

##### **Political**

- Political and social structures are not favorable for effective female participation resulting in limited participation of women to elective and non-elective posts.

##### **Social**

- Limited access to basic services (education, health, sexual and reproductive health).
- Gender-based violence and inadequate/discriminatory/un-enforced laws and lack of knowledge of laws

##### **Economic**

- Income inequalities at all levels
- Unpaid work of women (domestic, reproductive, care and support)
- Limited access to the means of production (credit, land, technologies, extension messages)
- Unemployment and limited access to higher paying jobs

##### **Suggested indicators**

Existing indicators should be disaggregated by sex, age and socio-economic background. Suggested additional indicators are presented in table 13.1.

**Table 3.1 Supplementary indicators to promote of gender equality in the MDGs**

Goal	Additional Indicator
<b>Goal 1: Eradicate extreme poverty and hunger</b>	
	<ul style="list-style-type: none"> <li>• % population in informal and formal sector by sex and occupation</li> <li>• Ownership of agricultural land by sex</li> <li>• Share of unpaid work between women and men</li> <li>• Access to extension services by sex</li> <li>• Access to agricultural credit by sex</li> <li>• % increase in local food production</li> </ul>
<b>Goal 2: Achieve universal primary education</b>	
	<ul style="list-style-type: none"> <li>• % of children registered at birth by sex and locality</li> </ul>
<b>Goal 3: Promote gender equality and empower women</b>	
	<ul style="list-style-type: none"> <li>• % of women at all levels of decision making</li> <li>• % of women in parliament and local governance.</li> <li>• % of women in decision making in private and public organizations</li> <li>• Share of men and women's labour in unpaid work</li> <li>• Incidence of gender based violence per 100,000 women/year</li> <li>• % of GBV perpetrators convicted</li> <li>• Reduced incidence of FGM and early marriages</li> </ul>
<b>Goal 5: Improve maternal health</b>	
	<ul style="list-style-type: none"> <li>• Percentage of female population within 2 hours travel distance of basic emergency obstetric care</li> <li>• Proportion of women in the reproductive age (15-45) who have access to prenatal care at the primary health care level</li> <li>• 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</li> <li>• Prevalence of contraceptive use by sex.</li> <li>• Age at marriage by sex</li> <li>• Child bearing among girls aged 15-19 years</li> <li>• Proportion of pregnant women who are anemic</li> </ul>
<b>Goal 6: Combat HIV/AIDS, Malaria and other Diseases</b>	
	<ul style="list-style-type: none"> <li>• Proportion of population with access to preventive and treatment medication by sex.</li> </ul>

### 13.5 Key issues and recommendations on the promotion of social inclusion of youth in the MDGs

#### Key issues

##### Exclusion from the labour market

- Lack of employable skills – mismatch between training received and labour demand; racial discrimination in access to marketable skills
- Slow economic growth with limited absorption of the youth
- Mistrust of the youth e.g. lack of work experience

##### Exclusion from decision-making

- Lack of information on decision-making spaces
- Illiteracy
- Limited representation of young people in socio-economic and political processes

### Exclusion from social participation

- Physical and intellectual disabilities, depression, suicidal tendencies, hopelessness
- Increased school drop out, poverty level, child abuse, abortion, teenage mothers,
- Crime and drugs: youth involved in substance abuse; young offenders; young victims and survivors of violence and crime; young people involved in gangs; young people from dysfunctional families;
- Homeless young adults surviving on the streets;
- Young people living with HIV and AIDS;
- Youth headed households;
- FGM
- Limited access to sexual and reproductive health
- Limited access to ICT by the rural youth

Table 13.2 shows the suggested supplementary indicators.

**Table 13.2 Suggested supplementary indicators to promote the social inclusion of youth**

<b>Goal 1: Eradicate extreme poverty and hunger</b>	
	<ul style="list-style-type: none"> <li>▪ Ratio of youth unemployment as a ratio of adult unemployment rate</li> <li>▪ % of young people without contracts in the labour market</li> <li>▪ Proportion of youth enrolled vocational and training institutions</li> <li>▪ Proportion of the youth population who have been able to set up their own businesses</li> </ul>
<b>Goal 2: Achieve universal primary education</b>	
	<ul style="list-style-type: none"> <li>▪ Proportion of youth enrolled vocational and training institutions</li> <li>▪ % of children registered at birth</li> </ul>
<b>Goal 5: Improve maternal health</b>	
	<ul style="list-style-type: none"> <li>▪ Percentage of adolescent pregnancies (young women aged 15-19)</li> <li>▪ Percentage of young women with access to prenatal and reproductive health services</li> <li>▪ Proportion of young females undergoing FGM</li> </ul>
<b>Goal 6: Combat HIV/AIDS, Malaria and other Diseases</b>	
	<ul style="list-style-type: none"> <li>▪ Proportion of children and youth with HIV/AIDS with access to ART</li> </ul>
<b>MDG 8: Develop a global partnership for development</b>	
	<ul style="list-style-type: none"> <li>▪ Proportion of young people with access to telephone, cellular and Internet services</li> <li>▪ Proportion of HIPC relief going to youth</li> </ul>
	<ul style="list-style-type: none"> <li>▪ Proportion of youth representation in parliament; local councils</li> </ul>

### 13.6 Key issues and recommendations on the promotion of health equity, sexual and reproductive health in the MDGs

#### Key issues

- High inequities in access to health services between rural and urban areas are evident in many countries
- Poor access to health services by the poor.
- Poor access to sexual and reproductive health.
- Low contraception use, unsafe abortions, low uptake of ante-natal, natal and post-natal services, high incidence of fistula in some countries, early marriages, unattended obstetric emergencies all lead to high maternal mortality.

- High prevalence of malaria.

### Suggested indicators

Sex disaggregated data is required for monitoring progress, though other demand-side factors should also be considered. The suggested supplementary indicators are shown in table 13.4.

**Table 13.4 Supplementary indicators to promote the social inclusion of youth in Africa**

<i>Goal 4: Reduce child mortality</i>	
	<ul style="list-style-type: none"> <li>• Mortality rate of new-borns</li> <li>• Proportion of children under the age of 1 completely vaccinated</li> <li>• Proportion of children with diarrhoea and ARI who receive treatment in a health facility</li> <li>• Proportion of children with diarrhoea and ARI who are treated with oral rehydration salts (ORS) at home</li> </ul>
<i>Goal 5: Improve maternal health</i>	
	<ul style="list-style-type: none"> <li>• Proportion of adolescents who have access to sexual and reproductive health services</li> <li>• Proportion of pregnant teenage adolescents</li> <li>• Proportion of pregnant women who sleep under bed nets</li> <li>• Proportion of reproductive age women with access to pre-natal and natal services</li> </ul>
ADDITIONAL TARGET – Increased resource allocation to the health sector	
	<ul style="list-style-type: none"> <li>• Government health expenditures as percent of total government expenditures</li> <li>• Percentage of funding reaching sub-national levels</li> </ul>
<i>Goal 6: Combat HIV/AIDS, malaria and other diseases</i>	
	<ul style="list-style-type: none"> <li>• Proportion of people affected by HIV/AIDS who are working</li> <li>• Access to ART disaggregated by sex</li> <li>• Mortality rate due to malaria, by age and gender</li> <li>• Mortality rate due to TB, by age and gender</li> <li>• Percentage of pregnant women sleeping under treated mosquito nets</li> <li>• Percentage of children sleeping under treated mosquito nets</li> </ul>

### 13.7 Key issues and recommendations on the promotion of social inclusion of older people, persons with disability and PLWHA in the MDGs

Additional socially excluded groups include orphans and vulnerable children; ethnic minorities; commercial sex workers; street beggars; nomads; and internally displaced people.

#### Key social exclusion issues

- Lack of full participation in economic life: restricted access to earn income and livelihood opportunities; labour constraints; lack of social protection; discrimination and stigma; high poverty.
- Exclusion from social participation: restricted access to social services, social security, community and family support; discrimination and stigma; impact of HIV/AIDS the resulting care giver role especially for older women; limited access to specialised services; lack of social networks; limited access to education; lack of prioritised support to alleviate poverty of these excluded groups in poverty reduction strategies.
- Exclusion from political and community participation: restricted access to consultation, decision-making, community organisations. He indicated that poverty was a major contributing factor to all the dimensions of social exclusion of older persons.

## Exclusion of orphans and vulnerable children

- Lack of registration of children
- Breakdown of family and other social support structures
- Streetism, child trafficking, child labour
- Child prostitution, child poverty, children in conflict with the law
- Orphans and child headed households

**Table 13.4 Suggested supplementary indicators to promote the social inclusion of persons with disabilities, older persons, PLWHA, OVCs**

	Additional Indicator
<b><i>Goal 1: Eradicate extreme poverty and hunger</i></b>	
	<ul style="list-style-type: none"> <li>▪ Percentage of older people/PWD-headed households living in extreme poverty</li> <li>▪ Percentage of older persons/PWD/PLWHA/OVCs suffering from hunger</li> <li>▪ Proportion of older persons/PWD/PLWHA/OVCs who have access to social protection</li> <li>▪ Proportion of older persons/PWD/PLWHA/OVCs who have access to poverty reduction programmes</li> <li>▪ Proportion of PWD in formal sector employment</li> <li>▪ Share of older women/women with disabilities in wage employment in the non-agricultural sector</li> </ul>
<b><i>Goal 2: Achieve universal primary education</i></b>	
	<ul style="list-style-type: none"> <li>▪ Net enrolment ratio in primary and secondary education of children with disabilities and OVCs.</li> <li>▪ Ratio of school attendance of orphans to school attendance of non-orphans disaggregated by sex</li> <li>▪ Proportion of pupils with disabilities and OVCs starting grade 1 who complete primary and secondary education</li> </ul>
ADDITIONAL TARGET – Double adult literacy rate by 2015	
	<ul style="list-style-type: none"> <li>▪ Percentage of older persons who access adult literacy services/programmes</li> </ul>
<b><i>Goal 5: Improve maternal health</i></b>	
	<ul style="list-style-type: none"> <li>▪ Percentage of women with disabilities with access to prenatal and reproductive health services</li> </ul>
<b><i>Goal 6: Combat HIV/AIDS, malaria and other diseases</i></b>	
	<ul style="list-style-type: none"> <li>▪ HIV prevalence amongst older persons/PWD and different age groups</li> <li>▪ Percentage of older carers of OVCs and PLHA receiving support in their role</li> <li>▪ Proportion of OVCs who receive free support</li> <li>▪ Percentage of older persons/PWD with access VCT services</li> <li>▪ Percentage of PLWHA with access to antiretroviral drugs by age and sex</li> </ul>
<b><i>Goal 7: Ensure environmental sustainability</i></b>	
	<ul style="list-style-type: none"> <li>▪ Proportion of the population with disabilities/older population with sustainable access to improved water source, urban and rural</li> <li>▪ Proportion of the population with disabilities/older population with access to improved sanitation, urban and rural</li> </ul>
ADDITIONAL TARGET – Increase accessibility to public infrastructure for people with disabilities	
	<ul style="list-style-type: none"> <li>▪ Proportion of public services with adequate access for people with disabilities</li> </ul>
<b><i>MDG 8: Develop a global partnership for development</i></b>	
	<ul style="list-style-type: none"> <li>▪ Proportion of donor funds allocated to disability, older persons and OVCs.</li> </ul>

Note: PWD = persons with disabilities.

### **13.8 Challenges and opportunities and recommendations in implementing the suggested supplementary indicators**

#### **Challenges**

- Lack of disaggregated data – by sex, by social group and by age
- Unavailability of data for measuring the new indicators
- Cost and capacity constraints to collection of new data
- For some thematic groups there is no data that is systematically collected to form the baseline eg. Disability.

#### **Opportunities**

- The existing data can be used; for example data being collected by sex and age for VCT and ART can be used.
- 2010 and 2011 round of population censuses
- Adding specific questions to DHS, national household surveys

#### **Recommendations**

- Make use of existing sources of data as much as possible.
- Undertake capacity building and development of training personnel in national statistical systems so that they are able to fully analyse and utilize existing primary data and collect new data.
- Government commitment on resource allocation for statistics needs to be strengthened.
- Coordination between NSOs and line ministries need strengthening.
- Promote wide dissemination of statistics to all users including through networks.
- Take advantage of the upcoming census to collect data that can be used for monitoring social inclusion, gender equality and health equity.

### **14. CLOSING OF THE EXPERT GROUP MEETING**

To close the meeting, Ms. Thokozile Ruzvidzo, Officer-in-Charge of the African Centre for Gender and Social Development, made some remarks thanking participants for providing important suggestions that will help in improving the draft report. She indicated that the revised report will be widely disseminated to all partners who might find this information important to their work. She indicated that the suggestions on the supplementary MDG targets and indicators will be used to inform global processes on the MDGs. She called on participants to participate in the knowledge sharing initiatives being undertaken as part of this project. She informed the participants that all the documents for the meeting will be posted on the website of the Division.

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## **ANNEX 2. AGENDA OF THE AD HOC EXPERT GROUP MEETING**

Agenda item 1: Opening of the Expert Group Meeting

Agenda Item 2: An overview of social exclusion in Africa and suggested targets and indicators to promote social inclusion of vulnerable groups, gender equality and health promotion in the MDGs

Agenda Item 2.1: Panel of discussants on promotion of social inclusion of women and gender equality in the MDGs

Agenda Item 2.2: Panel of discussants on promotion of social inclusion of the youths in the MDGs

Agenda Item 2.3: Panel of discussants on promotion of health equity, sexual and reproductive health in the MDGs

Agenda Item 2.4: Panel of discussants on promotion of social inclusion of the other excluded groups in the MDGs: older persons, persons with disabilities and People living with HIV/AIDS and others

Agenda Item 3: Presentation on country experiences

Agenda Item 4: Break-out sessions

Agenda Item 5: Plenary session report back

Agenda Item 6: Presentations on statistical feasibility of proposed additional indicators

Agenda item 7: Presentation on importance of knowledge sharing to support MDGs

Agenda Item 8: Synthesis of EGM.

Agenda item 9: Closing