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REPORT ON THE MILLENNIUM DEVELOPMENT GOALS AND THE STATUS OF IMPLEMENTATION OF THE MDGs AFRICA STEERING AND WORKING GROUP RECOMMENDATIONS

Table of Contents

List of Tables

List of Figures

List of Boxes

LIST OF ACRONYMS

ABC	Abstinence Be Faithful and Condom Use
ACT	Artemisin-based Combination Therapy
AfDB	African Development Bank
AGDI	African Gender and Development Index
AMR	Annual Ministerial Review
APRM	African Peer Review Mechanism
AUC	African Union Commission
DAC	Development Assistance Committee
DCF	Development Cooperation Forum
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Strategy
DRC	Democratic Republic of Congo
ECA	Economic Commission for Africa
ECOWAS	Economic Community of West African States
ECOSOC	United Nations Economic and Social Council
ERA	Economic Report on Africa
GDP	Gross Domestic Product
HIPCs	Highly Indebted Poor Countries
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
IDA	International Development Agency
IADG	Internationally Agreed Development Goals
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
ITNs	Insecticide-Treated Nets
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MMR	Maternal Mortality Rates
NAMA	Non-Agricultural Market Access
NEPAD	New Partnership for Africa’s Development

ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PRSPs	Poverty Reduction Strategy Papers
RECs	Regional Economic Communities
RMB	Renminbi (Chinese currency)
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV AND AIDS
UNECA	United Nations Economic Commission for Africa
UN-DESA	United Nations Department for Economic and Social Analysis
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSD	United Nations Statistics Division
WHO	World Health Organization
WTO	World Trade Organization

EXECUTIVE SUMMARY

This report is a response to the Heads of State and Government Decisions, during various AU Summit, requesting the African Union Commission in collaboration with the Economic Commission for Africa (ECA) to prepare status reports and related statistics on the progress in Africa towards the attainment of the Millennium Development Goals. It reviews progress made by African countries towards the attainment of Millennium Development Goals (MDGs) and proposes recommendations on how to accelerate the attainment of the MDGs. In addition, it presents the findings and recommendations of the MDG Africa Steering Group set up by the UN Secretary-General in 2007. It then calls on African Union Member States and partners to support the implementation of the recommendations in order for Africa to attain the MDGs by the target date of the 2015.

Status of MDGs in Africa

According to available data, Africa is making some progress in meeting the Millennium Development Goals (MDGs) by the target date. However, more work needs to be done in order to accelerate progress. Since the last report in 2007, a number of African countries which have incorporated MDGs in their poverty reduction strategies or national development plans has risen to about 41. Statistics indicate that progress is being made in a number of areas such as primary enrolment, gender parity in primary education, malaria deaths, and representation of women in parliaments. It is envisaged that if this rate of progress continues, the continent will be on course to meet a significant number of the MDGs by the target date.

Under goal 1, the report indicates that over 62 per cent of African countries recorded an improvement in hunger conditions between 1991 and 2002. However, this significant improvement has been challenged by the recent threats to food security, such as climate change and rising food and oil prices, in view of the fact that many African countries are heavily dependent on rain-fed agriculture.

Goal 2 calls for attainment of universal enrolment in primary education by 2015. The report reveals that a number of African countries are on track to achieve all the indicators under this goal. Of more importance is the net primary enrolment where many counties have registered a significant improvement. For instance, between 2004 and 2005, 9 countries registered net enrolment in primary education of above 80 per cent. Overall, aggregate enrolment rate for African countries has increased by 6 per cent between 2004 and 2005. Regarding the completion rate, the report indicates variations among African regions. North Africa has the highest primary school completion rate, followed by Southern Africa while West Africa has the lowest. In general, completion rates remained on average at 60 per cent over the period under consideration.

Regarding goal 3, which aims at promoting gender equality and empowering women, the report indicates that a number of African countries are likely to reach gender parity by 2015, mainly in primary education. According to the statistics available, eleven countries had already achieved gender parity in primary education in 2005, and 17 countries had

over 0.90 parity rate in the same year. However, the Central African Republic and Chad have recorded limited progress on gender parity in primary education. In addition, 13 African countries have scaled-up their rate of progress towards gender parity in primary education. However, the report also indicates that impressive improvement in gender parity in primary education is not the same in secondary education where there is still significant under-representation of girls.

The report also outlines the status of representation of women in national parliament. According to figures, Africa has the highest reported rate of progress compared to the 10 per cent achieved world-wide over the period 1990 to 2007. Between 2003 and 2007, gender parity in decision-making advanced most in Rwanda (48.8 per cent), Mozambique (34.8 per cent), South Africa (32.8 per cent), Tanzania (30.4 per cent), Burundi (30.5 per cent), Uganda (29.8 per cent), Seychelles (29.4 per cent), Namibia (26.9 per cent), Tunisia (22.8 per cent), Eritrea (22 per cent) and Ethiopia (21.9 per cent).

Goal 4 calls for a reduction by two-thirds, between 1990 and 2015, of the under-five mortality rate. Overall, few Africa countries seem to be on track, particularly in treatment of diseases which are more likely to cause death for children under 5 years of age, including measles. Figures given by UNICEF (2008) indicate that under-five mortality rate in Africa dropped from 185 per 1,000 live births in 1990 to 165 per 1,000 live births in 2005. Despite this progress, African countries still remain below the required objective of a two-thirds reduction by 2015 in order to attain the MDGs. Africa as a region, made very little progress towards reducing under-five mortality rates over the period 1990-2005. The vast majority of African countries experienced a slight improvement in under-five mortality of 1.8 per cent between 1990 and 2005.

The report indicates that high child mortality rates in some countries are attributable to particular health situations. This was evident in Botswana, Lesotho, South Africa, Swaziland, and Zimbabwe where HIV and AIDS explains in large measure the high level of under-five mortality while malaria explains the high rates in West African countries. On the other hand, the infant mortality rate for the period 1990-2005 indicates that Central, East, South and West Africa, made only marginal improvement from 110 to 99 deaths per 1,000 births over the period. However, countries such as Malawi, Djibouti, Mauritius, Morocco and Tunisia recorded improvements of more than 5 per cent.

Goal 5 is on maternal mortality health. The report reveals that data on maternal mortality ratios are not readily available in a number of countries and that the latest data available were up the year 2000. However, estimated data for 2005 from WHO, UNICEF, UNFPA and the World Bank indicate that the vast majority of African countries experienced a slight improvement in maternal mortality rate (MMR) of 1.8 per cent between 1990 and 2005. Twelve countries had a MMR of more than 1000, and these include Angola, Burundi, Chad, Democratic Republic of the Congo, Guinea-Bissau, Liberia, Malawi, Nigeria, the Niger, Rwanda, Sierra Leone, and Somalia.

Regarding goal 6, Combat HIV and AIDS, malaria and other diseases, Africa continues to be the region most affected by HIV and AIDS in the world, with almost 68 per cent of the 33.2 million people living with HIV and AIDS. The adult HIV prevalence rate varies from

well below 1 per cent in all Northern African countries to above 15 per cent in many of the countries in Southern Africa (UNAIDS, 2007). In most countries, HIV prevalence rate has either stabilized or is showing signs of decline (UNAIDS, 2007). Cote d'Ivoire, Togo, Zimbabwe and Kenya have experienced decreases in their national prevalence rates.

In general, women are heavily infected by HIV and the number is still increasing. As of December 2007, women constituted 61 per cent of infected people in the four sub-regions. The number of people who received antiretroviral treatment in Central, East, South and West Africa, increased from 100, 000 in 2003 to 1.3 million in 2006 (WHO, UNAIDS and UNICEF, 2007). Despite these alarming figures, Malaria remains the leading cause of child mortality and anaemia in pregnant women in Africa. According to statistics, Malaria accounts for a high percentage of child mortality and endemic in 46 countries. The use of insecticide treated bed nets by children under-five has improved in malaria risk areas in Central, East, South and West Africa, from 2.1 to 5 per cent between 2001 and 2005.

The report indicates that the trends in TB incidence, prevalence and morbidity have been on the rise in all sub-regions across the continent, except in North Africa. The tuberculosis burden is felt most in Southern Africa followed by East and West Africa. Thirteen of the fifteen countries that had the highest incidence rate of TB in 2005 were in Africa, and they included Botswana, Cote d'Ivoire, Djibouti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Sierra Leone, South Africa, Swaziland, Zambia and Zimbabwe. The death burden from the disease follows a similar pattern, with Southern Africa bearing the heaviest burden, followed by East and West Africa. In 2005, the rate of TB deaths excluding HIV in North Africa was 3 in 100,000 while in other regions was about 55 in 100,000. The TB prevalence rates on the other hand, had a different picture. Despite these low rates in TB deaths, the TB prevalence rates seem to be on the higher side for the other regions except North Africa. For example in 2005, the rate of TB prevalence excluding HIV and AIDS in North Africa was only 44 in 100,000 while in other regions was about 490 in 100,000.

Regarding goal 7 on ensuring environmental sustainability, the report indicates that between 1990 to 2005, land covered by forest decreased in Africa, except North Africa by 3 per cent. Generally, deforestation continues to contribute to the increase in agricultural land but had two negative effects. First, increased agricultural productivity on reclaimed forests turns to be short-lived as the land is quickly depleted from the nutrients that boost production in the first place. In addition, there is a loss of biodiversity which is responsible for 18 to 25 per cent of green house emissions, a key factor in climate change (UN, 2007).

There has been some improvement in provision of safe drinking water from 1990 to 2004. Fifteen African countries have increased access to clean water in rural areas by 25 per cent. However, the rural-urban gap in access to safe drinking water is still wide and that tends to pull down national aggregate figures in some countries. Although there has been some progress, the changes are still too low to reach the target of halving the people without safe drinking water by 2015.

Further, the proportion of people with improved sanitation in Africa, except North Africa, increased moderately, from 32 per cent in 1990 to 37 per cent in 2004, far from the target of 66 per cent coverage to be met by 2015. The rural-urban divide and the poor situation of slum dwellers further compound this slow progress. Urban migration and rapid population growth has contributed to poor housing, inadequate sanitation and insufficient safe water.

As for goal 8, Develop a global partnership for development, 26 African countries had reached the decision point under the Enhanced Highly Indebted Poor Countries (HIPCs) initiative as of February 2008. Of these countries, 19 made it to the completion point. The report also outlines some of the commitments made at the Gleneagles G8 and UN Millennium +5 summits in 2005, donors to increase to Africa. The pledges made at these summits, combined with other commitments, implied lifting aid from US $ 80 billion in 2004 to US $ 130 billion in 2010. Progress in fulfilling the Gleneagles commitments has been slow. Net Official Development Assistance (ODA) (according to OECD/DAC) declined between 2006 and 2007.

Donors have also programmed an additional aid around US $ 11 billion so far into their planned annual spending by 2010, on top of the extra USD 5 billion for country programmes that they delivered in 2005. This shows that efforts to increase aid are being factored into some donors' forward plans, but it still leaves about US $ 34 billion in 2004 dollars – about US $ 38 billion in 2007 dollars – to be programmed into donor budgets if the commitments made in 2005 to substantially increase aid by 2010 are to be fully met (OECD). One of the major developments of recent years is the growing importance of non-DAC donors. China and India have been providing significant development assistance to Africa. China wrote-off RMB 10.9 billion (US $1.47 billion) of debt to Africa and committed to double ODA to Africa.

Constraints to accelerating progress

Among others, the report identifies unavailability of data as one of key constraints affecting the reporting on progress of MDGs as well as in decision-making. To this effect, a number of indicators were not reported on due to unavailability of data, particularly relating to Target 1 of Goal 1.

Another constraint is lack of adequate resources, both from international partners and African countries (domestic resources). The Monterrey Consensus of 2002 emphasized the important role of ODA as a complement to other sources of financing in poor countries. Since the Consensus was adopted, several promises have been made to the region both on scaling-up aid quantity and on improving aid effectiveness. The outcomes of the 2005 G-8 Gleneagles Summit and the Paris Declaration, both re-affirmed the commitments made in the Monterrey Consensus and contain some of the most recent pledges made by development partners on aid quantity and quality.

According to the available data, the total share of ODA to Africa has increased from 32 per cent to 40 per cent, this still falls short of the commitments made. The increase from 0.25 to 0.27 of GNI from donor countries (0.7 per cent of the commitment) is still too low.

Besides, ODA flows have been largely channelled to a restricted number of African countries.

The MDGs Africa Initiative

The initiative, launched by the UN Secretary-General in 2007, underscores the primary responsibility of African governments in meeting the goals and the need for international organizations to support country-led strategies. The main objective is to address shortcomings in the approach adopted by international partners in supporting African countries towards the attainment of the MDGs. In implementing the above objective, the MDG Africa Steering Group, a high–level group set up by the UN Secretary–General under the initiative, has identified the following thematic areas of focus, which are key in the attainment of the MDGs: Agriculture, Food Security and Nutrition; Education; Health; Infrastructure and Trade Facilitation; National Statistical Systems; Aid Effectiveness and Aid Predictability; and Translating the MDGs into integrated programmes on the ground. In addition, it has made a number of key recommendations under each one of the thematic areas, which if implemented will assist African countries attain the MDGs by the target date.

Summary and Conclusions

The report shows that some progress is being made, and that the region is on course to reach some targets by 2015. Under financing, the report observes that private financing of investment and MDGs could be explored, particularly as official development assistance or aid excluding debt relief and humanitarian aid has declined in recent years. The report recommends financing options include domestic resources mobilization, resources from emerging partners such as China and India, and public-private partnerships. Since the financing requirements for realizing the MDGs are substantial, the private sector is increasingly called upon to fill investment gaps.

In addition to the scaling-up of resources, African countries should intensify the implementation of their MDG-consistent national development strategies and poverty reduction strategies. Finally, the African Union Member States and international partners are called upon to support the implementation of the recommendations made by the MDG Africa Steering Group.

Section I: Introduction

1. This report is a response to the Sirte Decision of July 2005 Assembly/AU/Dec 78 (v) requesting the African Union Commission, in collaboration with the Economic Commission for Africa (ECA), the African Development Bank (AfDB), and the Regional Economic Communities (RECs) to monitor the implementation of the Millennium Development Goals (MDGs) and continue with the pertinent reflections in order to report to the Assembly. Equally, it is a response to the Addis Ababa January 2008 Decision Assembly/AU/Dec. 180 (X) requesting the African Union Commission in collaboration with ECA to prepare status reports and related statistics on the progress in Africa towards the attainment of the Millennium Development Goals.

2. The report has been prepared jointly by the African Union Commission (AUC), and the Economic Commission for Africa (ECA). It reviews progress made to date, since the second report, by African countries towards the attainment of Millennium Development Goals (MDGs). It also provides solutions and recommendations on how to accelerate the attainment of the MDGs. Further, the report outlines progress on the on-going work of the MDG Africa Initiative[1].

3. According to the report, Africa's progress in meeting the Millennium Development Goals (MDGs) by the target date is advancing. However, more work needs to be done in order to accelerate progress. Since the last report in 2007, the number of African countries which have incorporated MDGs in their poverty reduction strategies or national development plans has risen to about 41. Significant progress has been reported for indicators such as universal primary education and gender equality. Ghana, for example, is reported to be on track to meet the target of halving poverty by 2015. Further, Ghana has made tremendous progress in reducing the prevalence of HIV.

4. Growth, fueled in large part by appropriate policy reforms, favourable primary product prices and a marked improvement in peace and security on the continent remains strong. In 2007, for example, GDP growth rate stood at 5.8 per cent with more than 25 African countries achieving a real GDP growth rate of 5 per cent or above while another 14 grew at between 3 and 5 per cent. In 2008, this real GDP growth rate for the continent is projected at 6.2 per cent. However, the continent's average annual growth rate of approximately 5.8 per cent is still below the 7 per cent annual growth rate required to reduce poverty by half by 2015. In addition, this growth is increasingly coming under threat from new developments such as the escalating prices of food and oil as well as climate change.

5. There have been initiatives in response to the above challenges by African leaders and partners at national, regional and continental levels. These include: (i) integrating the MDGs into national poverty reduction strategies and national development plans; (ii) the African Common Position on the MDGs by the African Union Commission; (iii) the decision by the AU Assembly of Heads of States and Government, held in Khartoum, The Sudan, requesting the African Union Commission in collaboration with the AfDB, to carry out the study on the

[1] The MDG initiative was launched by the United Nation (UN) Secretary General in 2007 to mobilize the full resources of the UN system and its partners in support of the Millennium Development Goals (MDGs) in Africa.

establishment of an African oil fund; (iv) the on going work by the African Union Commission aimed at providing solutions to the current food crisis; and (v) the launch of the UN MDG Africa initiative by the UN Secretary-General to mobilize resources and sustain international support for achieving MDGs in Africa.

6. Development partners have been supportive in providing financial assistance aimed at accelerating work towards attainment of the MDGs. Achievement has been seen in Official Development Assistance (ODA) flows, which grew from an average of US $16 billion between 1998-2001 to US $28 billion between 2002-2005[2]. The decision to cancel debt owed by Highly Indebted Poor Countries (HIPC) has also played a significant role in promoting growth. Countries whose debt has been cancelled have managed to shift resources meant for debt repayment to growth sectors. In addition, efforts have been made to align ODA with national priorities and programmes in a manner consistent with the Paris Declaration. Further, emerging economies such as China and India have provided additional resources to Member States which have gone a long way in accelerating the attainment of the MDGs. There have also been initiatives by non-governmental actors, such as the Bill and Melinda Gates Foundation to support the continent's efforts to meet the MDGs.

7. This report indicates that progress towards the attainment of the MDGs has been made in a number of areas such as primary enrolment, gender parity in primary education, reduction in malaria deaths, and empowerment of women, among others. If this rate of progress continues, the continent will be on course to meet a significant number of the MDGs by the target date of 2015. The report also shows that many African countries have not made significant progress in health-related MDGs. Further, the report outlines the MDGs Africa Initiative and calls upon African countries and partners to support the implementation of its recommendations.

Section II: Tracking Progress

8. This section presents the goal-by-goal progress report on the continent's efforts to reach the targets of the MDGs. It also includes a new set of indicators related to employment, reproductive health, bio-diversity and access to treatment for HIV AND AIDS and indicates that they have been largely neglected. The report does not cover issues on income poverty due to lack of reliable and consistent data for most African countries. This is because many African countries do not have recent household surveys on which an assessment of progress towards the poverty targets can be reliably based. Given the continent's high population growth rate, it is conceivable that progress in reducing poverty has been slow.

Goal 1: Eradicate extreme poverty and hunger

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

9. There are no recent data on this target in the UNSD database to update the progress towards halving hunger by 2015. According to the 2007 MDG report prepared jointly by the AUC and ECA, 62 per cent of the African countries for which data were available, recorded an improvement in hunger conditions between 1991 and 2002. However, there are new threats to food security in view of the fact that

[2] Joint AUC/ECA Economic Report for Africa 2008.

many African countries are heavily dependent on rain-fed agriculture. These include: climate change and rising food and oil prices. These developments will likely have an adverse impact on the progress already achieved by many countries.

Indicator 1D: Prevalence of underweight children under five years of age

10. According to the report of African Ministers of Health of 2008, the overall regional average of proportion of underweight children in Africa, excluding North Africa, was 28 per cent. Countries in West and Central Africa such as Democratic Republic of Congo, Congo, Ghana, Guinea, Mali, Nigeria, Senegal and Togo have an average annual rate of reduction (AARR) of 1.6 but this is not sufficient to reach the MDG target. Other countries have not shown much improvements since the 1990's and these include: Burkina Faso, Cameroon, the Central African Republic, Djibouti, Niger, Sierra Leone, Somalia, and Sudan.

Goal 2: Achieve universal primary education

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

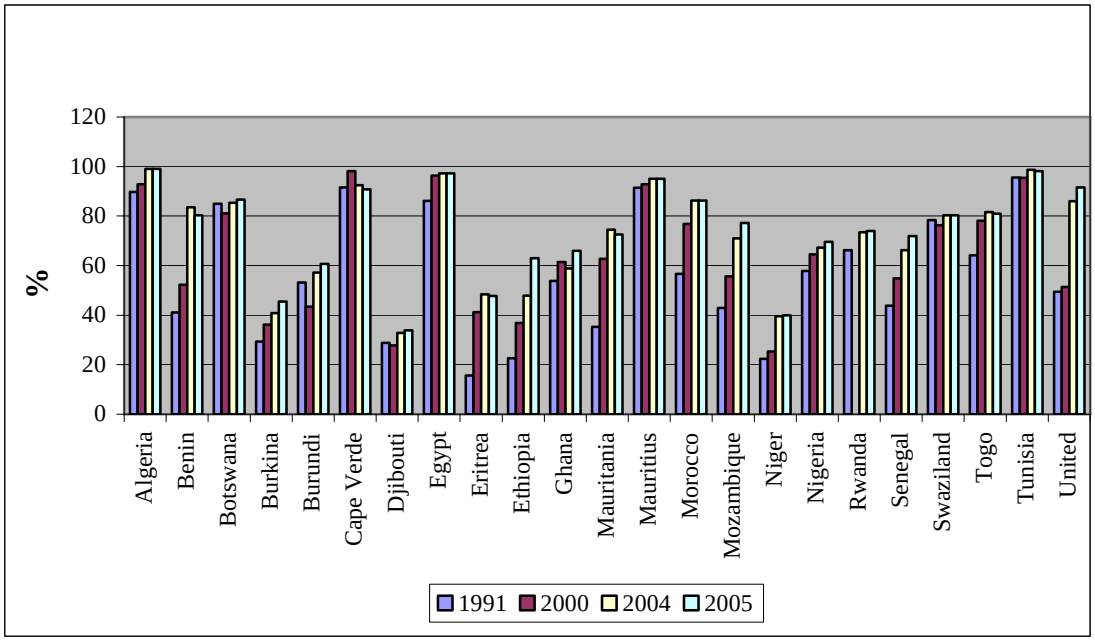
11. Goal 2 calls for attainment of universal enrolment in primary education by 2015. Most African countries are on track to achieve all the indicators under this goal[3]. It is important that more efforts should be geared towards achieving universal primary education in view of the fact that this goal is fundamental to the achievement of the other MDGs.

Indicator 2.1: Net enrolment in primary education

12. Net primary enrolment between 2004 and 2005 showed that a number of African countries registered a significant improvement as shown in Figure 1 below which shows net enrolment for some selected African countries in 1991, 2000, 2004, and 2005. If this trend continues, many countries in the region will meet the target of achieving universal primary enrolment by 2015.

[3] According to the 2007 AUC and ECA MDG report

Figure 1: Net enrolment of primary education in selected African countries



Source: *UNSD*

13. From Figure 1 above, between 2004 and 2005, 9 countries registered net enrolment in primary education above 80 per cent. During the same period, four countries, namely Burkina Faso, Djibouti, Eritrea and Niger had net enrolment of below 50 per cent. For countries where data were available, between 2004 and 2005, six countries increased enrolment by more than 4 per cent while in five countries enrolment rates expanded by between 2 and 4 per cent. The remaining countries recorded increases that were between 0 and 2 per cent.

14. Progress on this indicator is driven by large enrolments in countries such as Ethiopia, Mozambique, Mauritius, Kenya, and Zambia. High achievers such as Ethiopia, Ghana and Tanzania[4] have maintained the momentum of the previous years, posting growth rates in enrolment of 6.5 per cent, 4.2 per cent and 17.3 per cent, respectively, from 2005 to 2006. Progress was at risk of reversal in Cape Verde, Eritrea and Mauritania and modest in Mauritius and Sao Tome and Principe. Overall, aggregate enrolment rate increased by 6 per cent between 2004[5] and 2005. This rate of progress, if sustained, will place more African countries on track to achieve universal primary enrolment.

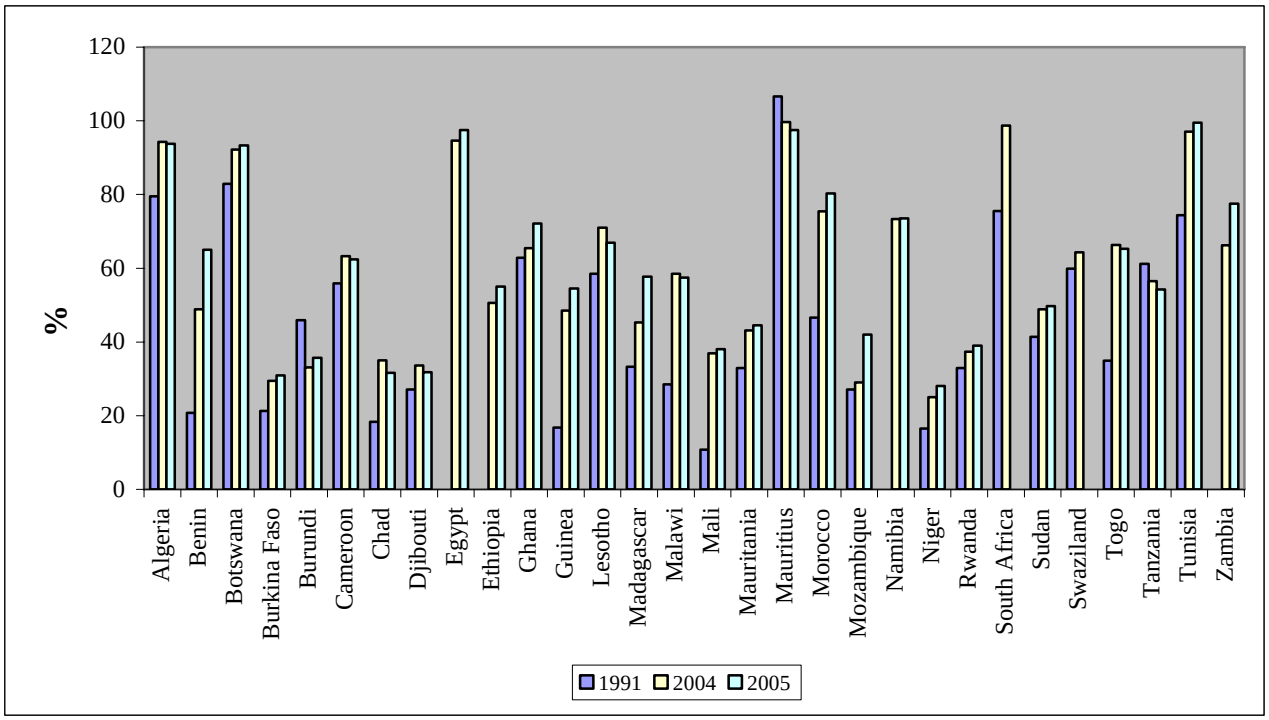
Indicator 2.2: Proportion of pupils starting grade 1 and reaching last grade of primary school

15. According to the available data, continued improvement in primary enrolment rates has not been matched by a commensurate increase in primary school completion rate[6]. In addition, there has been a slowdown in completion rates in the recent years as can be seen in Figure 2 below which indicates primary school

[4] Only these three countries have 2006 data on UNSD database.
[5] AUC, ECA-*Assessing progress towards the Millennium Development Goals*, Addis Ababa 2007.
[6] *Primary completion rate* is the ratio of the total number of students successfully completing (or graduating from) the last year of primary school in a given year to the total number of children of official graduation age in the population (UNSD).

completion rates for selected African countries in 1991, 2004 and 2005. However, Benin, Ethiopia, Ghana, Guinea and Madagascar had completion rates increased by 16.2 per cent, 4.4 per cent, 6.7 per cent, 6.1 per cent and 12.4 per cent, respectively in 2005 over 2004 but countries such as Cameroon, Mauritius, and Tanzania recorded reversals.

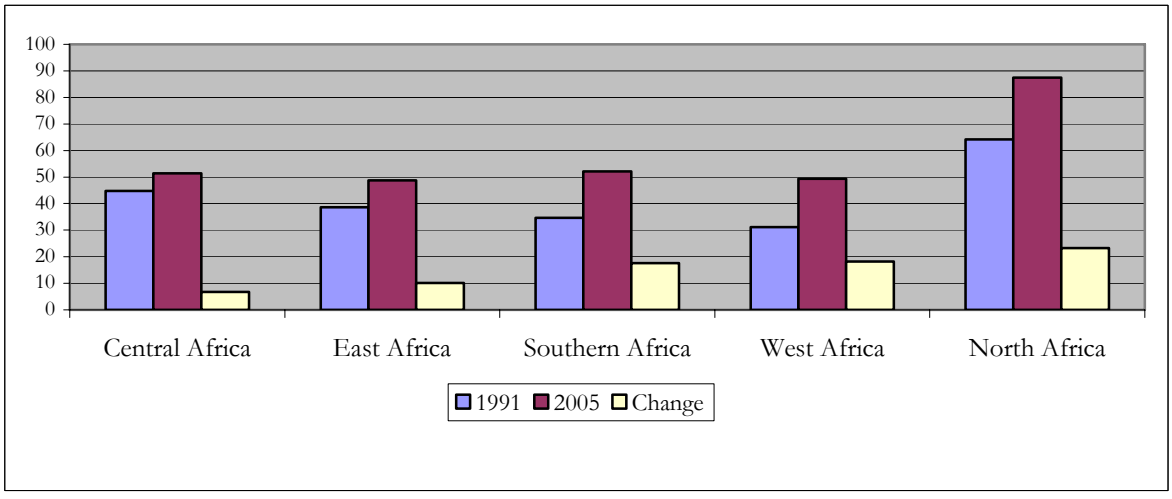
Figure 2: Completion rates for selected African countries (1991 – 2005)



Source: *UNSD*

16. Variation in performance is also evident where the sub-regions are used as the basis of analysis. North Africa has the highest primary school completion rate, followed by Southern Africa while West Africa has the lowest (Figure 3). Completion rates remain on average at 60 per cent over the period under consideration. However, completion rate improved in West Africa in 2005 over 2004.

Figure 3: Changes in primary completion rates across sub-regions



Source: AUC/ECA calculations from UNSD

17. A major factor affecting primary school completion rate in many countries is the generally late entry of pupils into the school system. More children of secondary school age are attending primary school, especially in countries where there has been a considerable expansion in outreach programmes and enrolment. Late entry increases the pressure to join the labour market prior to completing the cycle. This reduces the incentive to advance to secondary and higher levels of education.

Indicator 2.3: Literacy rates (15-24 year old), women and men

18. There have been no new updates to the data reported in the 2007 MDG report, except for Burkina Faso and Niger where youth literacy rate improved by 2 per cent and 36.5 per cent in 2005 respectively. Nonetheless, an unsung change going on in Africa is the rising rate of basic literacy among Africa's youth, not just in the national language, but also in at least one foreign[7] (English or French) language. This is in part, a consequence of improved enrolment in primary education. This trend is also observed both in countries with low initial youth literacy rates and high initial youth literacy rate and indicate progress in meeting this target.

Goal 3: Promote gender equality and empower women

Target 4: Eliminate gender disparity in primary and secondary education by 2005, and in all levels of education by 2015

19. The main objective of goal 3 is to promote gender equality and empower women. According to available statistics, most African countries are likely to reach gender parity by 2015[8] in primary education (see Figure 4). Eleven countries[9] had already achieved gender parity in primary education in 2005, and 17 countries[10] had over 0.90 parity rate in the same year. However, the Central African Republic and Chad have recorded limited progress on gender parity in primary education.

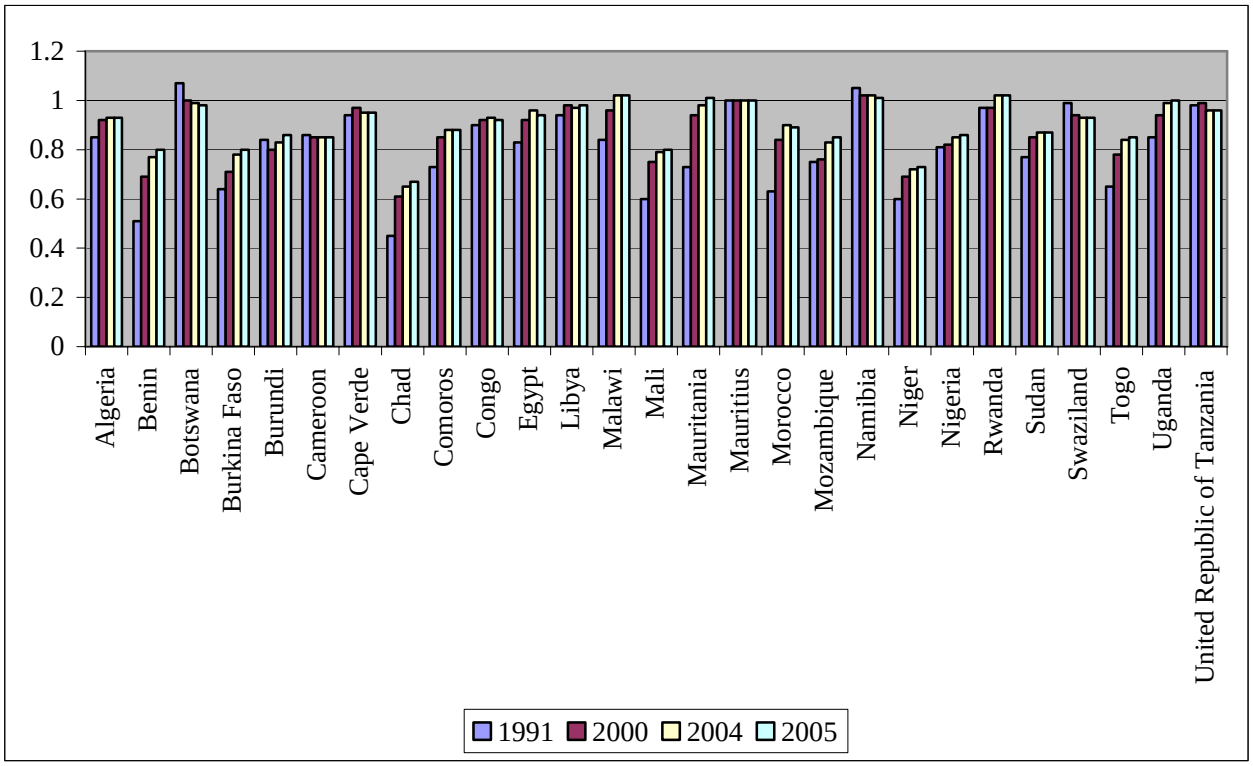
[7] "Foreign" meant the language of a former colonial power.

[8] See Millennium Development Goals Report, Report to the Conference of Ministers of African Ministers responsible for Finance, Planning, and Economic Development, April 2007.

[9] The Gambia, Gabon, Lesotho, Libya, Malawi, Mauritius, Mauritania, Namibia, Rwanda, Seychelles and Uganda.

[10] Algeria, Botswana, Cape Verde, Congo, Egypt, Equatorial Guinea, Ghana, Kenya, Madagascar, Sao Tome and Principe, Senegal, South Africa, Swaziland, Tunisia, United Republic of Tanzania, Zambia and Zimbabwe.

Figure 4: Gender parity in primary education in selected African countries (1991-2005)



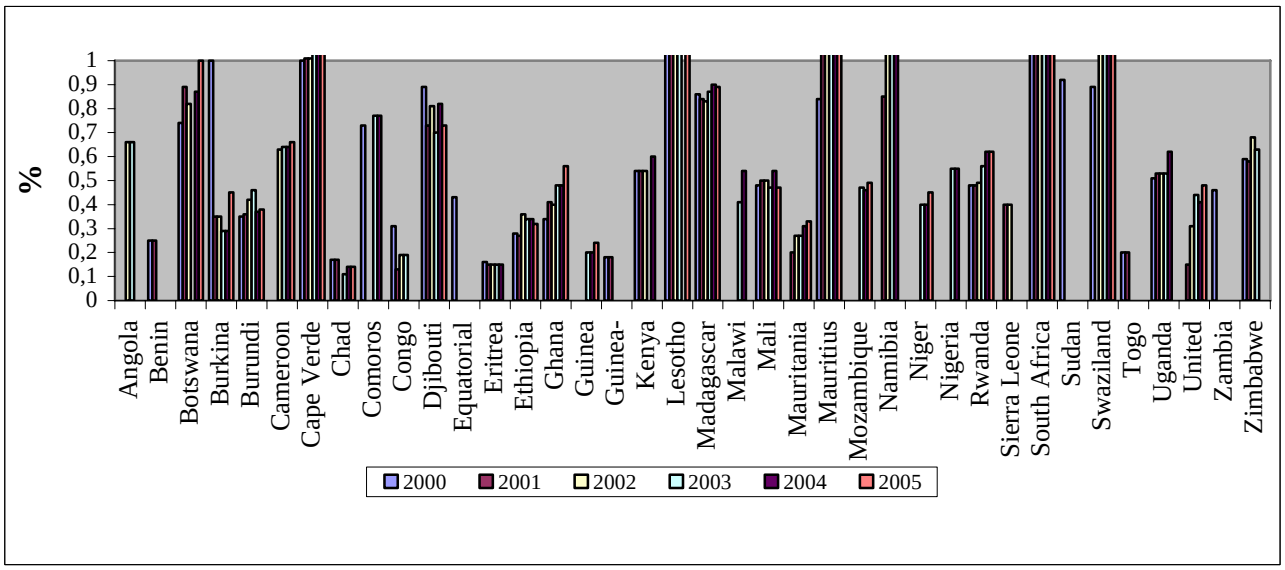
Source: UNSD

20. The latest available data show that 13 African countries have scaled-up their rate of progress towards gender parity in primary education. The significant progress reported in 2007 confirms that most of the African countries are on track to achieve gender parity in primary education. However, the impressive improvement in gender parity in primary education is not mirrored in secondary education where there is still significant under-representation of girls. Consistent with what was reported in the 2007 report, eight[11] countries have achieved gender parity in secondary education, while six[12] others have achieved a gender parity index of over 0.90. By contrast, 14 countries regressed over the same period. The rate of progress is thus too slow and fragile for this target to be achieved by 2015.

21. The ratio of women to men in universities and tertiary institutions remained unchanged relative to what it was in the 2007 report (Figure 5). Nine 13 countries had achieved gender parity. However, Madagascar and the Sudan are likely to achieve gender parity in tertiary education by 2015.

[11] Gender parity in secondary education in 2005: Algeria, Botswana, Cape Verde, Lesotho, Namibia, Sao Tome and Principe, Seychelles (2004), South Africa (2004).
[12] Over 0.90 in gender parity in Secondary education: Egypt, Kenya. Mauritius, Sudan and Swaziland
[13] Gender parity in Tertiary education in 2005: Algeria, Botswana, Cape Verde, Mauritius, Libya, Namibia(2004)South Africa. Swaziland and Tunisia

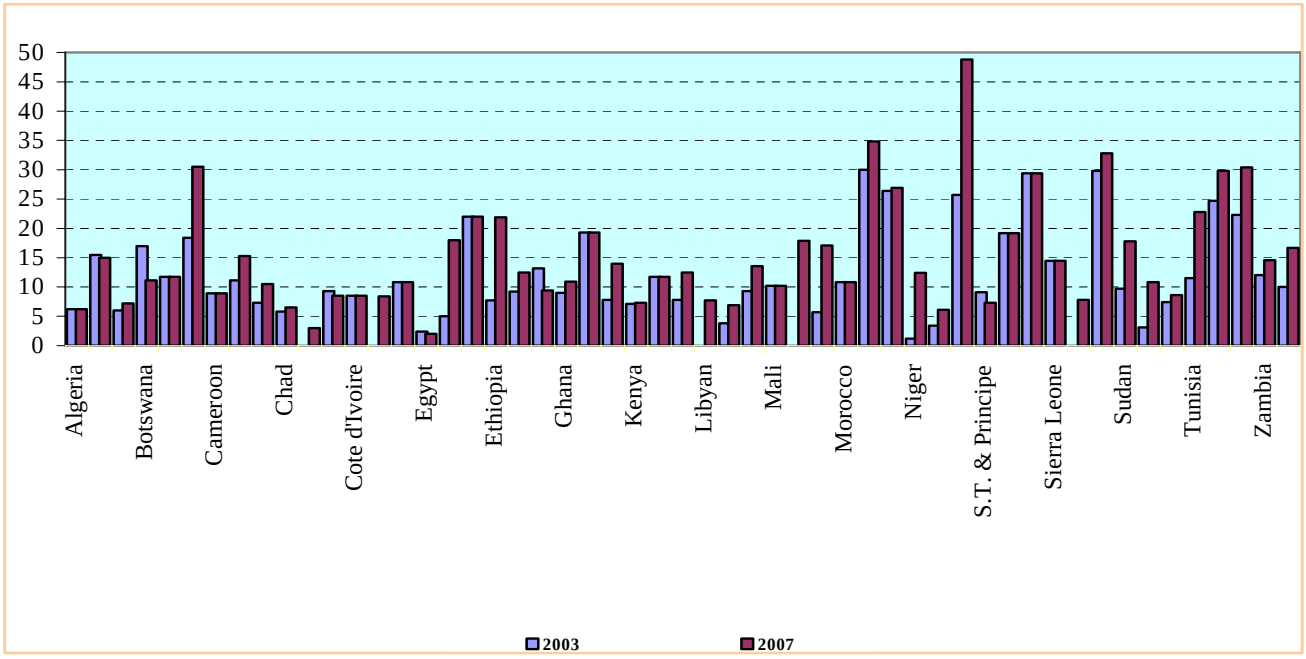
Figure 5: Gender parity in tertiary education for a selected number of African countries (2000 – 2005)



Source: UNSD

22. Women's representation in national parliament has improved in a number of African countries (Figure 6). Africa has the highest reported rate of progress compared to the 10 per cent achieved world-wide over the period 1990 to 2007. Despite this development, 17 African countries still remain below average between 2003-2007.

Figure 6: Percentage of women in National Parliament



Source: UNSD

23. Between 2003 and 2007, gender parity in decision-making has advanced most in Rwanda (48.8 per cent), Mozambique (34.8 per cent), South Africa (32.8 per cent), Tanzania (30.4 per cent), Burundi (30.5 per cent), Uganda (29.8 per cent),

Seychelles (29.4 per cent), Namibia (26.9 per cent), Tunisia (22.8 per cent), Eritrea (22 per cent) and Ethiopia (21.9 per cent). Data are inadequate to report on progress on the proportion of women in wage employment in the non-agricultural sector. Historical data indicate that no country has reached gender parity. Mali reported that women represented 49.7 per cent of the non-agricultural wage earners in 2004, and that ratio stood at 42 per cent in South Africa in 2005.

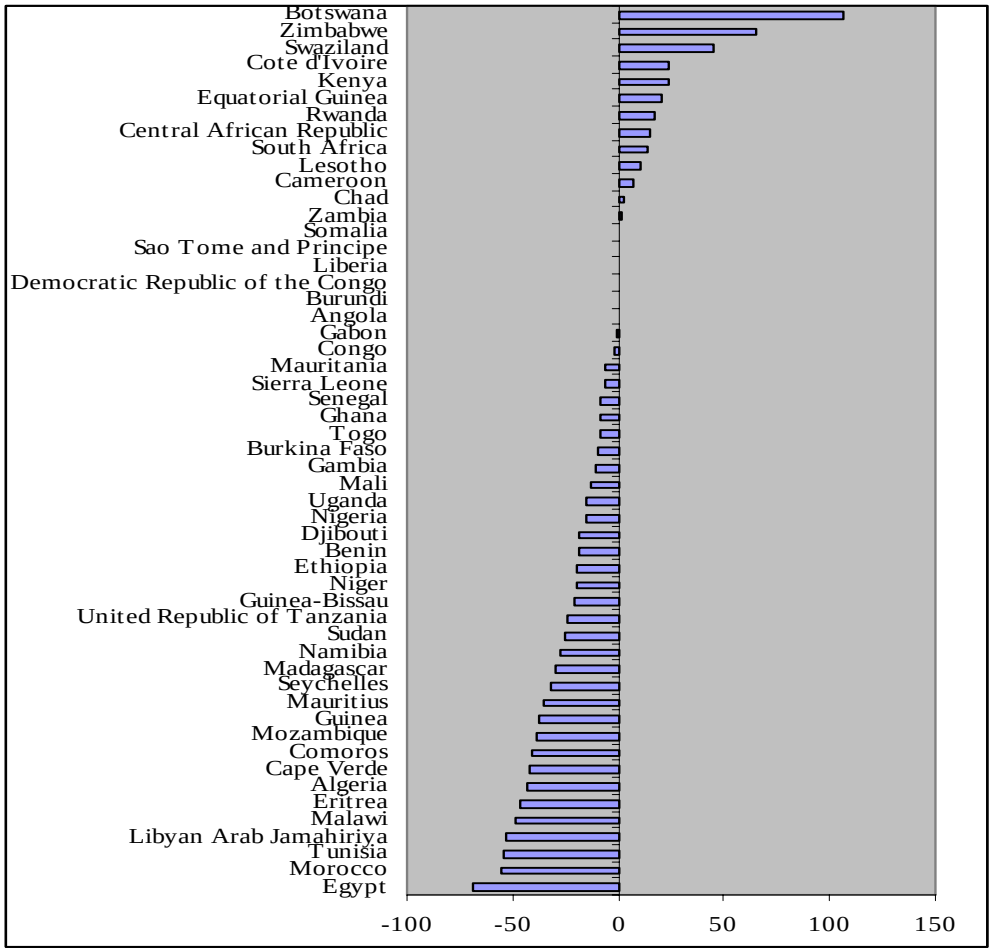
Goal 4: Reduce child mortality

24. Millennium Development Goal 4 calls for a reduction by two-thirds, between 1990 and 2015, of the under-five mortality rate. Progress seems to be on track in many African countries, particularly in treatment of diseases which are more likely to cause death for children under 5 years of age, including measles.

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

25. Under-five mortality rate: Under-five mortality rates in Africa dropped from 185 per 1,000 live births in 1990 to 166 per 1,000 live births in 2005. Further, UNICEF (2008) reported that under-five mortality in Africa dropped from 166 per 1000 live births in 2005 to 160 live births in 2006. However, this progress is far from the required objective of a two-thirds reduction by 2015 in order to attain the MDGs. Africa as a region, made very little progress towards reducing under-five mortality rates over the period 1990-2005 (Figure 7).

Figure 7: Progress[14] in under-five child mortality rates between 1990 and 2005



Source: UNSD

26. The vast majority of African countries experienced a slight improvement in under-five mortality of 1.8 per cent between 1990 and 2005. There was no change in under-five mortality in 19 countries, while in 10 countries, namely: Botswana, Chad, Côte d'Ivoire, the Comoros, Djibouti, the Gambia, Lesotho, South Africa, Swaziland and Zimbabwe, under-five mortality increased (Table 1). This places most African countries significantly off track to achieving this goal. Africa accounts for 44 percent of the world's under-five mortality and each year over 4.6 million children under the age of 5 years die. Most of these deaths are due to common, preventable and treatable conditions such as: Neonatal causes (26 per cent), Respiratory infections (21 per cent), Malaria (17 per cent), Diarrhea diseases (17 per cent), HIV AND AIDS (7 per cent), and others (4 per cent). Under-five mortality is also caused by malnutrition which accounts for nearly 50 per cent of deaths.

14 Change in percentage points of under-five child mortality rates – the negative Figure indicates progress.

Table 1: Progress in under-five mortality rates

Target achieved or trend towards achievement	Progress but insufficient trend to reach the target	No progress or decline	Data incomplete or not available
Algeria Cape Verde Eritrea Mauritius Seychelles	Benin , Côte d'Ivoire Gambia , Ghana Guinea, Guinea Bissau Mauritania, Niger Senegal, Togo Comoros, Ethiopia Lesotho, Madagascar Malawi, Mozambique Namibia, Nigeria Tanzania, Uganda Zimbabwe	Burkina Faso, Liberia Mali, Sierra Leone Angola, Burundi Cameroon Central African Republic Chad, Congo, DRC Equatorial Guinea Kenya, Gabon, Rwanda Sao Tome & Principe Botswana, South Africa Swaziland, Zambia	

Source: World Health Statistics, 2007

27. In some countries, high child mortality is attributable to particular health situations. For example, HIV AND AIDS explains in large measure the high level under-five mortality in Botswana, Lesotho South Africa, Swaziland, and Zimbabwe while malaria explains the high rates in West Africa. Conflicts also contribute to the high rate of under-five mortality.

28. **Infant mortality rate**: The infant mortality rate for the period 1990-2005 indicates that Central, East, South and West Africa, as a whole have made only marginal improvement from 110 to 99 deaths per 1,000 births over the period. However, countries such as Malawi, Djibouti, Mauritius, Morocco and Tunisia recorded improvements of more than 5 per cent.

29. Updated data from UNICEF indicate that Central, East, South and West Africa, as a whole, have seen additional marginal progress in reducing infant mortality rates, which stood at 95 per 1000 live births in 2006. This drop, although more pronounced from 2005 to 2006, is still insufficient to achieve the target of the MDG 4 by 2015.

Proportion of one year old immunized against measles

30. The proportion of one year old immunized against measles in Central, East, South and West Africa, as a whole, increased to 64 per cent in 2005, from the 56 per cent recorded in 1990 and slightly `down from the 65 per cent achieved in 2004. The rates of immunization against measles vary across countries. Botswana, Egypt, Liberia, Libya, Mauritius, Seychelles, Tanzania and Tunisia registered coverage rates greater than 90 per cent, while Chad, Central African Republic, Nigeria and Somalia have coverage rates less than 40 per cent. Twenty three countries improved the

proportion of children immunized against measles, while 18 countries had no change. The countries that made substantial progress, with increases exceeding 5 per cent in improving the proportion of children that are immunized against measles include Burkina Faso, Cameroon, the Comoros, Democratic Republic of the Congo, Djibouti, Ethiopia, Guinea, Liberia, Mali, the Niger, Rwanda, Senegal, and Zimbabwe. In particular, Liberia experienced a large increase in the proportion of children immunized against measles. Some countries experienced a 10 per cent decrease or more in their immunization coverage, and these include Angola, Congo, Somalia and Swaziland.

Box 1: Quick wins: coordinated action to achieve fast results

Progress in achieving the health-related MDGs has been limited by inadequate human and financial resources and inefficiencies in the delivery of international support. Fragmentation and poor coordination of the international response is a key culprit. The success in the reduction of measles deaths between 2000 and 2007 shows what can be achieved through improved coordination.

Globally, deaths from measles fell by over 60 per cent between 2000 and 2005. The most significant progress was achieved in Africa, where measles deaths dropped by nearly 75 per cent- from an estimated 506,000 to 126,000 through strengthening immunization campaigns. This success was largely due to coordinated action between the International Measles Initiative and 47 priority countries, which has gathered speed since 2000. The implementation of this initiative has had a significant effect on mortality and morbidity rates of children under five and amply demonstrates what can be achieved through coordinated action.

Source: UN 2007.

Goal 5: Improve maternal health

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

31. Data on maternal mortality ratio are not readily available and updated for all countries. The latest data on maternal mortality ratio from UNSD are up to the year 2000. Estimated data for 2005 from WHO, UNICEF, UNFPA and the World Bank indicate that the vast majority of African countries experienced a slight improvement in maternal mortality rate (MMR) of 1.8 per cent between 1990 and 2005. Twelve countries have a MMR of more than 1000, and these include Angola, Burundi, Chad, Democratic Republic of the Congo, Guinea-Bissau, Liberia, Malawi, Nigeria, the Niger, Rwanda, Sierra Leone, and Somalia.

32. The latest available data on delivery assistance by a skilled health worker show that no progress has occurred in Central, East, South and West Africa, as a whole. In 1990, the proportion of births with health personnel in attendance in these four sub-regions stood at 42 per cent, and this increased to 46 per cent in 2004 and declined marginally to 45 per cent in 2005, according to recent UNSD data.

Target 6 B: Achieve, by 2015, universal access to reproductive health

33. Sexual and reproductive health (SRH) was given an international consensual definition in 1994 at the International Conference on Population and Development (ICPD). The available data do not allow monitoring of progress, but provide a glimpse of the magnitude of what has been achieved. The close link between SRH and wider societal issues makes SRH vital to economic and social development in Africa. Apart from being important, it is clear that reproductive health and rights are instrumental for achieving the MDGs (Sachs, 2005).

34. Contraceptive prevalence rate increased from 12.3 per cent in 1990 to 21.3 per cent in 2005 in married women. The correct and consistent use of condoms as recommended in the Abstinence Be Faithful and Condom Use (ABC) strategy creates a wide gap in condom availability. In addition, the power dynamics within households increases the vulnerability of women to sexual risky behaviour.

35. There is a global decrease in fertility rates, and Africa is no exception, although the high adolescent birth rates prevailing in 1990 have not declined. This also contributes to a higher probability of birth health-related problems and increases in maternal mortality.

36. Antenatal care is a core component of maternal health services. Since 1990, more than two-thirds of women receive at least one antenatal care during pregnancy, albeit the medical recommendation is at least 4 visits. For example, 87 per cent of Kenyan women visited an antenatal clinic at least once, but this number dropped to 51 per cent for the recommended 4 times.

37. Each year half a million women die of preventable complications of pregnancy and childbirth. Among married women of childbearing age, demand for birth spacing represented 33-75 per cent of the demand for family planning services, an important life saving mechanism. Children spaced three to four years are more likely to survive. In less developed countries, including those in Africa, if no births occur within 36 months of a preceding birth, the infant mortality rate would drop by 24 per cent and under-five mortality by 35 per cent (Bertrand and Anhang, 2006). In addition, the need for family planning services is strong and highly inequitable. The large inequities between the rich and the poor in these countries may reflect the disparities in accessing family planning services as well as differences in the demand for contraceptives.

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

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

38. Africa continues to be the region most affected by HIV and AIDS in the world, with almost 68 per cent of the 33.2 million people living with HIV and AIDS globally in Central, East, South and West Africa (UNAIDS, 2007). The adult HIV prevalence rate varies from well below 1 per cent in all Northern African countries to above 15 per cent in many of the countries, in Southern Africa (UNAIDS, 2007). In most countries HIV prevalence rate has either stabilized or is showing signs of decline (UNAIDS, 2007). Cote d'Ivoire, Togo, Zimbabwe and Kenya have experienced decreases in

their national prevalence rates. Yet HIV and AIDS remains a leading cause of adult morbidity and mortality in all of the sub-regions, except in North Africa. In 2007, 76 per cent of the global total of 2.1 million adult and child deaths due to AIDS occurred in Central, East, South and West Africa.

39. The proportion of women infected by HIV is high and increasing. As of December 2007, women constituted 61 per cent of infected people in the four sub-regions. In almost every country in the region, prevalence rates are higher among women than men. The vulnerability of African women and girls to HIV infection is integrally linked to underlying gender inequalities, societal norms and discrimination.

Target 6.B: Achieve, by 2010, universal access to treatment for HIV and AIDS

40. The indicator for this new target is the proportion of population with advanced HIV infection with access to antiretroviral drugs. The number of people who received antiretroviral treatment in Central, East, South and West Africa, increased from 100, 000 in 2003 to 1.3 million in 2006 (WHO, UNAIDS and UNICEF, 2007). The corresponding coverage of people who received treatment improved from 2 per cent in 2003 to 28 per cent in 2006. Although widening, coverage rate is still very low, especially when the supply is set against the demand of those in need.

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

41. Malaria is the leading cause of child mortality and anaemia in pregnant women in Africa. Data on malaria incidence and death rates are not comprehensive and do not show trends. However, scarcely available data indicate that the disease accounts for a high percentage of child mortality and endemic in 46 countries. Although the use of insecticide treated bed nets by children under-five is reported to have improved in malaria risk areas in Central, East, South and West Africa, from 2.1 to 5 per cent between 2001 and 2005, the scale of the need is still large (WHO, 2006b). A survey conducted in 30 African countries between 2000 and 2006 indicates that under-five children living in urban areas, where malaria is less endemic, are 2.5 times more likely to sleep under an insecticide-treated nets (ITNs) than those who live in rural areas (UN, 2007). Furthermore, the substitution of chloroquine-resistant malaria treatment with artemisin-based combination therapy (ACT) is confronted with problems related to procurement and supply-chain processes in a number of African countries.

Tuberculosis incidence, prevalence and death rates associated with tuberculosis

42. The trends in TB incidence, prevalence and morbidity have been on the rise in all other sub-regions across the continent, except in North Africa (see Table 1). The incidence of tuberculosis in Africa has increased in tandem with the HIV and AIDS epidemic, as people with HIV easily contract tuberculosis infections. The tuberculosis burden is felt most in Southern Africa followed by East and West Africa. Thirteen of the fifteen countries that have the highest incidence rate of TB in 2005 were in Africa, and they include Botswana, Cote d'Ivoire, Djibouti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Sierra Leone, South Africa, Swaziland, Zambia and

Zimbabwe. The death burden from the disease follows a similar pattern, with Southern Africa bearing the heaviest burden followed by East and West Africa.

Table 2: Trends in TB incidence, prevalence and deaths in Africa

	Northern Africa			**Central, East, South and West Africa**		
	1990	2000	2005	1990	2000	2005
TB Incidence- Number of new cases per 100,000 population (excluding HIV-infected)	54	50	44	148	253	281
TB Prevalence- Number of existing cases per 100,000 population (excluding HIV-infected)	59	53	44	331	482	490
TB Deaths - Number of deaths per 100,000 population (excluding HIV-infected)	5	4	3	37	54	55

Source: UNSD data 2008.

43. From Table 2 above, the number of TB deaths excluding HIV infection in Africa varies from region to region. For example in 2005, the rate of TB deaths excluding HIV in North Africa was 3 in 100,000 while in other regions was about 55 in 100,000. The TB prevalence rates, on the other hand, had a different picture. Despite these low rates in TB deaths, the TB prevalence rates seem to be on the higher side for the other regions except North Africa. For example, in 2005, the rate of TB prevalence excluding HIV in North Africa was only 44 in 100,000 while in other regions was about 490 in 100,000.

44. From Table 3 below, few countries mainly in Southern Africa have started observing a decline in HIV prevalence trends among pregnant women aged between 15-24. However, not many countries are collecting and reporting age specific HIV prevalence especially among Ante Natal Care (ANC) attendees aged 15-24 years, whose HIV prevalence acts as indicator of the rate at which new infectious are occurring.

Table 3: HIV prevalence among pregnant women aged 15-24 years

Target achieved or trend towards achievement	Progress but insufficient trend to reach the target	No progress or decline	Data incomplete or not available
Botswana Burundi Ethiopia Lesotho Malawi Namibia Rwanda Zimbabwe	Chad Eritrea	Benin Ghana Swaziland Senegal South Africa Zambia	Algeria, Angola Burkina Faso, Cameroon Cape Verde Central African Republic Congo, Cote d'Ivoire DRC, Equatorial Guinea Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mauritius, Mozambique, Niger, Nigeria, Sao Tome & Principe, Seychelles Sierra Leone, Togo Uganda, Tanzania

Source: WHO TB Global Report 2008

45. Results from ANC HIV surveillance indicate substantial variations in HIV prevalence among young ANC attendees aged 15-24 years between sub regions, countries and within countries. In 2005-2006, median HIV prevalence among young ANC attendees aged 15-24 years ranged from less than 1 per cent to 25.8 per cent. Countries in Southern Africa have the highest HIV prevalence among ANC attendees aged 15 –24 years exceeding 15 per cent.

Proportion of tuberculosis cases detected and cured under directly observed treatment short course

46. The Directly Observed Treatment Strategy (DOTS), which turns to be the effective approach to combating TB, has been successfully implemented in many African countries. The share of cases detected and cured under the DOTS increased from 36 per cent in 1990 to 47 per cent in 2004 and 49 per cent in 2005, while the proportion of successfully treated patients increased slightly from 72 per cent in 2000 to 74 per cent in 2004. The rising incidence and prevalence of TB highlights the need for continued strengthening of responses towards addressing the TB epidemic.

47. A recent study by the World Bank on *The Economic Benefit of Global Investments in Tuberculosis Control* indicates that the economic cost of TB-related deaths (including HIV co-infection) in Central, East, South and West Africa from 2006 to 2015 is estimated at US $519 billion when there is no effective TB treatment. If an effective treatment to TB patients is put in place, these countries would experience economic benefits that exceed the costs related to the disease by about nine times. The positive externalities arising from TB control constitute a strong case for governments and donors to sharply reduce TB prevalence and deaths. Yet the rate of progress at which countries are addressing the TB burden is not enough to reach the MDG target.

48. WHO launched the Global Stop TB Strategy in 2006 that builds on the successes of DOTS while addressing its shortcomings. The Stop TB strategy aims at dramatically reducing the global burden of tuberculosis by 2015 by ensuring all TB patients, including those co-infected with HIV and those with drug-resistant TB, benefit from universal access to high-quality diagnosis and patient-centered treatment. The strategy promotes scaling-up of DOTS through increased and sustained financing, improved case detection, standardized treatment with supervision and patient support, effective drug supply and management system, improved monitoring and evaluation system, and impact measurement, prevention and control of multidrug-resistant TB, strengthening of the health system and empowerment of people with TB and communities (WHO, 2007b).

49. Generally, Africa is unlikely to achieve the 2015 MDG targets for Tuberculosis control. However, 5 countries have already achieved the target and 7 countries are likely to meet the target. Based on WHO TB Global Report 2008, 10 countries have met the World Health Assembly target of 70% case-detection rate and 8 countries have achieved the treatment-success rate of 85% with only 2 countries meeting both targets.

Goal 7: Ensure environmental sustainability

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

50. From 1990 to 2005, land covered by forest decreased in Africa, except North Africa by 3 per cent. Generally, deforestation continues to contribute to the increase in agricultural land but has two negative effects. First, increased agricultural productivity on reclaimed forests turns to be short-lived as the land is quickly depleted from the nutrients that boost production in the first place. In addition, there is a loss of biodiversity which is responsible for 18 to 25 per cent of green house emissions, a key factor in climate change (UN, 2007).

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

51. In comparison with other parts of the world, Africa's biodiversity is relatively in a good state. However, there are a number of eco-regions that have gone through radical transformation and approximately 50 per cent of Africa's terrestrial eco-regions have lost 50 per cent of their area to cultivation, degradation or urbanization (UNEP, 2006).

52. Africa has over 2 million square km of protected areas, which are largely savannah habitats. Of the one hundred and nineteen eco-regions, eighty nine have less than 10 per cent of total area protected. The coastal area on the continent is faced with conflicting priorities: oil and mineral extraction, costal development, fishing communities that are confronted with the lack of capacity in ensuring biodiversity and fishing stocks for sustained development (UNEP, 2006).

Target 10: Halve by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

53. There has been some improvement in provision of safe drinking water from 1990 to 2004 according to the latest Figures. Fifteen African countries have increased access to clean water in rural areas by 25 per cent. However, the rural-urban gap in access to safe drinking water is still wide and that tends to pull down national aggregate Figures in some countries. Although there has been some progress, the changes are still too low to reach the target of halving the people without safe drinking water by 2015.

Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

54. The proportion of people with improved sanitation in Africa, except North Africa has increased moderately, from 32 per cent in 1990 to 37 per cent in 2004, far from the target of 66 per cent coverage to be met by 2015. The rural-urban divide and the poor situation of slum dwellers further compound this slow progress. Urban migration and rapid population growth has contributed to poor housing, inadequate sanitation and insufficient safe water.

Goal 8: Develop a global partnership for development

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

55. One of the aims of the World Trade Organization (WTO) Doha Round was to take on board development concerns in the design of the multilateral trading system and address inequities in the existing system, especially those that were significantly disadvantageous to developing countries. Despite such good intentions, little progress has been made in the negotiations. There has not been any major agreement on the reduction or the removal of agricultural subsidies in major developed countries, and no major breakthrough on non-agricultural market access (NAMA) negotiations. Recent efforts such as the Aid for Trade Initiative, intended to serve as a tool to build capacities in trading and marketing to boost trade-related infrastructure in developing countries, particularly in Africa, are yet to begin to bear fruits.

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

56. As of February 2008, 26 African countries had reached the decision point under the Enhanced Highly Indebted Poor Countries (HIPCs) initiative. Of these countries, 19 have made it to the completion point. It is worth noting that the delay encountered by HIPCs between decision and completion points has expanded since 2000, and there are still several countries that have not reached the decision point.

57. G-8 countries at their 2005 Summit in Gleneagles, Scotland, in addition to committing to scaling-up aid to Africa, also initiated the Multilateral Debt Relief Initiative (MDRI) under which 100 per cent of the eligible outstanding debt owed to

multilateral institutions by all HIPC countries reaching the completion point of the HIPC Initiative would be forgiven. The MDRI effectively aims to double the volume of debt relief already expected from the enhanced HIPC Initiative and "provides HIPCs that have reached the completion point irrevocable, up-front cancellation of debt owed to IDA, the African Development Fund, IMF, and IADB. Debt cancellation under MDRI will be in addition to debt relief already committed under the HIPC Initiative"[15]. Progress on MDRI remains at best tepid.

58. At the Gleneagles G8 and UN Millennium +5 summits in 2005, donors also committed to increase their aid. The pledges made at these summits, combined with other commitments, implied lifting aid from US $ 80 billion in 2004 to US $ 130 billion in 2010. Progress in fulfilling the Gleneagles commitments has also been slow. Net Official Development Assistance (ODA) (according to OECD/DAC) declined in 2006-2007. Most of the growth in net ODA to Africa in the recent past has been due to debt relief and humanitarian assistance. Overall, most donors are not on track to meet their stated commitments to scale up aid and they will need to make unprecedented increases to meet their 2010 targets.

59. Donors have programmed an additional aid of around US $11 billion so far into their planned annual spending by 2010, on top of the extra US $5 billion for country programmes that they delivered in 2005. This shows that efforts to increase aid are being factored into some donors' forward plans, but it still leaves about US $ 34 billion in 2004 dollars – about US $ 38 billion in 2007 dollars – to be programmed into donor budgets if the commitments made in 2005 to substantially increase aid by 2010 are to be fully met (OECD).

60. One of the major developments of recent years is the growing importance of non-DAC donors. China and India have been providing significant development assistance to Africa. China wrote-off RMB 10.9 billion (US $1.47 billion) of debt to Africa and committed to double ODA to Africa. Also, India cancelled debts owed by many African countries, within the context of the HIPC initiative.

61. Despite the progress made in reducing Africa's debt burden, the debt sustainability goal has not been achieved in several African countries. In addition, recent litigations initiated by some commercial creditors against some African countries, namely, Congo, Cameroon and Uganda, pose a serious challenges for both the implementation of the HIPC Initiative and its credibility.

Target 8.H: In Cooperation with Pharmaceutical Companies, Provide Access to Affordable Essential Drugs in Developing Countries

62. Essential medicines save lives and improve health when they are available, affordable, of good quality and properly used. Increasing the availability and affordability of medicines are major challenges for many countries in Africa. An increasing number of countries have been implementing national medicine policies including traditional medicine, with the overall aim of improving access to quality medicines at affordable prices and ensuring their rational use.

[15] See http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20040942~

63. In addition, the African Union Commission has developed a Pharmaceutical Manufacturing Plan for Africa, aimed at strengthening health systems and development and increasing local production and access to affordable generic medicines in Africa. The Plan was adopted by AU Ministers of Health in April 2007.

64. Furthermore, OAU Decision (July 2001) on the Decade of Traditional Medicine and later the development of the plan of action of the decade was intended to provide a general framework to guide Member States in formulating their National Strategies. Many African countries are conducting traditional medicines research and development for producing evidence on safety, efficacy and quality for local production in order to contribute to improving access to essential medicines. Despite these efforts, access to medicines remains limited in the region.

Section III: Constraints to accelerating progress

65. As noted earlier in this report, conditions to accelerate progress are ripe. African countries have put in place the necessary institutional and policy reforms. Commitment to MDGs on the continent remains broad and deep. The success demonstrated by many countries across a range of indicators shows that MDGs can be met by the target date. But progress depends critically on overcoming a number of key constraints, many of which were discussed in the 2007 Report[16].

66. Among the key constraints is the availability of data to report on progress and decision-making. As shown in this report, a number of indicators were not reported on due to unavailability of data. This is especially critical in respect of Target 1 of Goal 1 because of the lack of regular household surveys in African countries. Education and gender data are available, although with little up-to-date information. This has allowed a deeper analysis on rates of progress towards Goals 2 and 3. By contrast, health data exhibit deep lacunae for an appropriate monitoring of progress towards health objectives. Data availability, constant and systematic updates are critical for policy and decision-making, proper allocation and targeting of resources and consequentially MDG based national plans implementation.

67. Success and progress in international financial and technical cooperation will have some influence on the speed of the region's progress towards the targets of the MDGs. The Monterrey Consensus of 2002 emphasized the important role of ODA as a complement to other sources of financing in poor countries. It also stressed that substantial increases in ODA to developing countries, especially in Africa, will be needed if these countries are to achieve the internationally agreed development goals, including the MDGs. Since the Consensus was adopted, several promises have been made to the region both on scaling-up aid quantity and on improving aid effectiveness. The outcomes of the 2005 G-8 Gleneagles Summit and the Paris Declaration, both re-affirmed the commitments made in the Monterrey Consensus and contain some of the most recent pledges made by development partners on aid quantity and quality.

[16] See also, the Issues Paper for the 2007 ECA Conference of Ministers of Finance, Planning and Economic Development "Accelerating Africa's Growth and Development to meet the MDGs: Emerging Challenges and Way Forward".

68. Although the total share of ODA to Africa has increased from 32 per cent to 40 per cent, this still falls short of the commitments made. The increase from 0.25 to 0.27 of GNI from donor countries (0.7 per cent of the commitment) is still too low. ODA flows have been largely channelled to a restricted number of African countries. Not only does the volume of assistance matter, but the quality of aid delivery is equally important.

69. A key concern for African countries is that most of the recent increases in aid are due to debt relief and humanitarian assistance and so do not reflect additional resources available to finance development programmes. When these two components of aid are removed, it becomes clear that there have not been any significant changes in real aid flows to the region since 2004 (ERA, 2008). Aligning aid priorities to those defined in countries' Poverty Reduction Strategy Papers (PRSPs) or MDG-based national development strategies as well as harmonizing aid practices are critical in ensuring the effectiveness of donor assistance. Equally important, many African countries could reap sustained gains from trade only if issues of short-term loss of fiscal revenues and existing supply and export constraints are properly addressed.

70. One of the specific challenges remain the absence of clearly defined and agreed upon indicators commensurate with health related MDGs to adequately measure and monitor progress on proportion of populations' access to affordable essential medicines

71. The achievement of the MDGs also calls for and requires comprehensive and focused partnerships for going to scale on essential health interventions and at the same time achieving sustainable development. Different international and regional Partnerships /Initiatives have been launched to support countries towards the achievement of the health MDGs. While they provide opportunities for more financial resources, the challenge is to ensure that they are long term, and to harmonize and align them with country priorities and ensure that the resources are effectively utilized.

Section IV: The MDG Africa Initiative

72. The initiative, launched by the UN Secretary General in 2007, underscores the primary responsibility of African governments in meeting the Goals and the need for international organizations to support country-led strategies. The main objective is to address shortcomings in the approach adopted by international partners in supporting African countries towards the attainment of the MDGs. Following the launch of the initiative, the UN Secretary General set-up the MDG Africa Steering Group and its supporting MDG Africa Working Group[17].

[17] The MDG Africa Steering Group is chaired by the UN Secretary General and includes the President of the African Development Bank, the Chairperson of the African Union Commission, the President of the European Commission, the Managing Director of the International Monetary Fund, the President of the Islamic Development Bank, the Chair of the United Nations Development Group, and President of the World Bank. The MDG African Working Group is chaired by the UN Deputy Secretary General and its membership includes the Commissioner for Economic Affairs of the AU, the UN-Under-Secretary General and the Executive Secretary of the ECA, and the Chief Economist of the AfDB.

73. The MDG Africa Steering Group agrees on core deliverables, provides strategic guidance and coordination across member organizations, and engages in high-level advocacy and outreach to governments to ensure the implementation of its recommendations. Following its establishment, it has identified the following thematic areas of focus, which are key in the attainment of the MDGs:

i. Agriculture, Food Security and Nutrition;
ii. Education;
iii. Health;
iv. Infrastructure and Trade Facilitation;
v. National Statistical Systems;
vi. Aid Effectiveness and Aid Predictability; and
vii. Translating the MDGs into integrated programmes on the ground.

74. Agriculture has been perceived as key to eradicating extreme poverty and hunger (meeting MDG 1), and accelerating growth in Africa. Of particular importance is the need to focus on smallholder farmers, who are predominantly women and are the hardest-hit by poverty. In this respect, the Steering Group has emphasised the need to avail basic agricultural inputs. On universal primary education, the Steering Group has observed that many African countries are likely to achieve the target by 2015. Overall approximately US $8.3 billion is required annually to ensure achievement of the education MDGs and Education For All Fast Track Initiative (EFA-FTI) goals in Africa by 2015. This figure excludes school feeding programmes. It also does not cover expenditure for technical and vocational education as well as tertiary education, which are critical for increasing economic growth and will require additional financing. However, the Steering Group has recognised the fact that the education sector is under funded.

75. The general observation of the Steering Group is that the continent is off track to meeting the Health MDGs despite the efforts being made globally to finance the health sector in Africa. Taking into account synergies across the health goals, it is estimated that external financing for the above identified needs may need to reach some US$25-30 billion per year by 2010. Most of this financing should be provided with enough flexibility to cover the funding gaps in national plans, including those plans developed under the International Health Partnership (IHP) framework.

76. Lack of predictability of aid continues to affect African governments to effectively plan and programme public investments and current expenditure. The Steering Group has recognised the importance of accurate aid disbursement schedules for effective implementation of projects, particularly infrastructure projects, which are key for Africa's economic growth, trade development and poverty reduction. The availability of statistics is important for monitoring progress towards the attainment of MDGs and the Steering Group has noted that some African countries do not have adequate statistics due mainly to weak statistical capacity with national governments.

77. In view of the foregoing, the Steering Group has identified mechanisms for supporting African governments in achieving the MDGs, including multilateral

financing mechanisms, policy support and coordination of donor support. Under each thematic group, it has made some key recommendations, which are attached as Annex II.

Section V: Summary and Conclusions

79. This Report has presented a picture of the continent's progress towards meeting the targets of the MDGs. It has noted the improved political and economic environments in Africa and persistent commitment at the highest levels of decision-making to MDGs in Africa. The report shows that some progress is being made, and that the region is on course to reach some targets by 2015.

80. Regarding financing, the report has observed that private financing of investment and MDGs could be explored as a general way to ensure availability of basic services, particularly since the official development assistance or aid excluding debt relief and humanitarian aid has declined in recent years. Financing options should also include domestic resources mobilization as well the nurturing of partnerships with the emerging partners such as China and India. It should also be noted that foreign direct investment (FDI) has significant impact on the attainment of MDGs and a conducive investment climate must be created in Africa in order to attract FDI. This will assist to avoid having a significant proportion of FDI being concentrated in just a few countries. In addition, it could be useful for African countries to fulfill their own commitments to increase budget allocation to MDG-sensitive sectors.

81. Ideally, the public and private sectors complement each other, with the government providing an appropriate enabling environment for private initiatives to develop. Public-private partnerships are, therefore, an important way to increase financial, human, and social capital in Africa. Partnerships can include publicly provided training for small- and medium-scale enterprises, partnerships in education, agricultural research, health, energy, the provision of information and communication technologies, and the expansion of infrastructure including roads.

82. As the financing requirements for realizing the MDGs are substantial, the private sector is increasingly called upon to fill investment gaps. Its complementary and supporting role in the provision of basic services in water, land, health, and other infrastructure development that is lacking in most developing countries cannot be ignored. It will take a particular kind of private sector involvement to generate the necessary economic transformations. Private entrepreneurs are now increasingly held to environmental, social, and corporate governance principles that stress sustainable business practices and adherence to labor standards.

83. More remains to be done, and critical among these is the scaling-up of resources to accelerate the rate of progress. Countries have to intensify the implementation of their MDG-consistent national development strategies and poverty reduction strategies. In the same vein, intensified efforts have to be made to snuff out the new flickers of conflict that could undermine the fragile progress in some of the conflict countries and to address the potential challenges of climate change, rising food and energy prices. Above all, new mechanisms must be devised to empower Africa to achieve the MDGs.

84. Finally, Member States and international partners are called upon to support the implementation of the recommendations made by the MDGs Africa Steering Group, as contained in Annex II. Implementation of these recommendations and those made in this section will go a long way in propelling Africa towards the attainment of the MDGs by the target date of 2015.

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REVISED MDG MONITORING FRAMEWORK

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1. Proportion of population below $US1 (PPP) per day[18] 1.2. Poverty gap ratio 1.3. Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4. Growth rate of GDP per person employed 1.5. Employment-to-population ratio 1.6. Proportion of employed people living below $US1 (PPP) per day 1.7. Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8. Prevalence of underweight children under-five years of age 1.9. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1. Net enrolment ratio in primary education 2.2. Proportion of pupils starting grade 1 who reach last grade of primary 2.3. Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1. Ratios of girls to boys in primary, secondary and tertiary education 3.2. Share of women in wage employment in the non-agricultural sector 3.3. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1. Under-five mortality rate 4.2. Infant mortality rate 4.3. Proportion of 1 year-old children immunized against measles

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

Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1. Maternal mortality ratio 5.2. Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3. Contraceptive prevalence rate 5.4. Adolescent birth rate 5.5. Antenatal care coverage (at least one visit and at least four visits) 5.6. Unmet need for family planning
Goal 6: Combat HIV AND AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV AND AIDS	6.1. HIV prevalence among population aged 15-24 years 6.2. Condom use at last high-risk sex 6.3. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV AND AIDS 6.4. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV AND AIDS for all those who need it	6.5. Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6. Incidence and death rates associated with malaria 6.7. Proportion of children under 5 sleeping under insecticide-treated bed nets and Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.8. Incidence, prevalence and death rates associated with tuberculosis 6.9. Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1. Proportion of land area covered by forest 7.2. CO2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances 7.3. Proportion of fish stocks within safe biological limits 7.4. Proportion of total water resources used

Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.5. Proportion of terrestrial and marine areas protected 7.6. Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.7. Proportion of population using an improved drinking water source 7.8. Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.9. Proportion of urban population living in slums[19]
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction Target 8.C: Address the special needs of landlocked	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.* <u>Official Development Assistance (ODA)</u> 8.1. Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3. Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4. ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5. ODA received in small island developing States as a proportion of their gross national incomes <u>Market access</u> 8.6. Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty

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

special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.7. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8. Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9. Proportion of ODA provided to help build trade capacity <u>Debt sustainability</u> 8.10. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11. Debt relief committed under HIPC and MDRI Initiatives 8.12. Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14. Telephone lines per 100 population 8.15. Cellular subscribers per 100 population 8.16. Internet users per 100 population

RECOMMENDATIONS FROM THE MDGS AFRICA GROUP

a) Agriculture, Food Security and Nutrition

i. To meet short-term emergency needs resulting from the global rise in food prices, the international community needs to mobilise an estimated US $755. The MDG Africa Steering Group urges governments to seize the opportunity presented by high agricultural commodity prices to reduce trade distorting subsidies as well as barriers to trade in agricultural products;

ii. Governments and the international community should lend their full support to implementing the Comprehensive Africa Agriculture Development Programme (CAADP), which provides the framework for supporting the design and implementation of national agriculture and food security strategies;

iii. African Governments, with support from development partners and in collaboration with the private sector, should launch an African Green Revolution within the framework of CAADP. Key interventions include providing access to improved seeds, fertilizers and agricultural as well as financial extension services; strengthening land and water management; improving rural infrastructure; strengthening farmers' associations; and increasing access to markets in close collaboration with the private sector. These interventions need to be supported by reforms of agricultural policies and institutions as well as local purchases of food assistance;

iv. Working with African Governments, the international community needs to increase external financing for African agriculture from the current US$1-2 billion per year to roughly US$8 billion by 2010. All available bilateral and multilateral financing channels need to be mobilized for this urgent and unprecedented effort in strict adherence to the principles of the Paris Declaration on Aid Effectiveness The MDG Africa Steering Group will elaborate a detailed set of proposals for how such financing can be mobilized;

v. Interested African Governments should be supported in rolling out school feeding programmes -using 1ocally produced food -that cover all children in primary school. Likewise, comprehensive national-scale nutrition programmes are required to tackle micronutrient deficiencies (i.e., Iodine, Vitamin A, Zinc, Iron, etc.) with a particular focus on children aged 0-2. Providing take-home food rations will increase incentives for girls to attend schools. These programmes can be implemented with support from the United Nations Children's Fund (UNICEF) and the World Food Programme (WFP) and will require an estimated US$4 billion per year in external financing. Over time their financing has to be assured through a rising share of domestic resources;

vi. Investments in agricultural research need to be significantly scaled up to support research into high-yielding crop and livestock varieties as well as sustain able agricultural practices that are also resistant to drought and the anticipated effects of climate change. Incremental investments need to adhere to the CAADP, in particular its Framework for African Agricultural Productivity

(FAAP), and support African research through the Forum for Agricultural Research in Africa (FARA), sub-regional organizations, and centres belonging to the Consultative Group on International Agricultural Research (CGIAR);

b) Education

i. The international community should fulfill its commitments towards education using the full range of bilateral and multilateral instruments, including a fully funded EFA-FTI Catalytic Fund. In particular, development partners need to:

- Urgently meet the current shortfall in the FTI for primary education funding to low-income countries with endorsed sector plans requiring at least US$1 billion;

- Increase resources through FTI and other bilateral/multilateral channels to support countries whose plans will be endorsed in the foreseeable future; and

- Ensure that education in countries experiencing fragility and in countries with low-level donor involvement is adequately supported.

ii. As part of the endorsement process, FTI partners should systematically review countries' sector plans for consistency with projected resource requirements for achieving the MDG and EFA goals by 2015. Where feasible, FTI partners should support each country to revise and better align its education plans with the 2015 goals. Critically, partners need to adopt a longer-term approach to look beyond the results that can be achieved over a four-or five-year planning cycle.

iii. All development partners should systematically meet recipient governments' requests for long-term education sector support to ensure country ownership, predictable financing, a sound division of labour among donors, and full alignment with country systems over multiple years.

iv. African leaders should give high priority to setting up strong national statistical systems for tracking progress toward the education goals. In support of their Goals in Africa efforts, the international community should invest in strengthening the EFA High Level Group and its supporting EFA Working Group as a platform for:

- Countries to share best practices and learn from each other to design and implement holistic education sector plans for achieving the MDGs and EFA goals, and
- Monitoring progress globally through the annual Global Monitoring Report (GMR).

c) Health

i. All development partners, including non-DAC donors, philanthropic donors and others, should systematically meet recipient governments' requests for sector wide approaches and long-term health compacts, as supported by the IHP, to map out financing needs, ensure multiyear predictable financing for health systems, a sound division of labour among donors, and full alignment of donor support with country systems;

ii. The Steering group requested the international community to support African Governments to expand:

- Primary healthcare systems to provide basic and vital health services identified above;
- Emergency obstetric care to reach all women by 2015; and
- Scaling up of community and mid-level health workers, while addressing the need for more highly trained and specialized staff.

iii. Funding for health systems can be channeled through the health systems windows of the Global Fund and GAVI or other multilateral and bilateral channels.

iv. International support for comprehensive family planning should be expanded through the United Nations Population Fund (UNFPA), other reference institutions and bilateral channels.

v. Continue the expansion of prevention, control, and treatment programmes for HIV AND AIDS, malaria, and TB and other priority diseases including endemic Neglected Tropical Diseases (NTDs) through the Global Fund and other mechanisms.

d) Infrastructure and Trade Facilitation

i. Launch a "New Deal" for the energy sector to plan and build transformational generation and transmission facilities across Africa, and improve the performance of power utilities. In particular, they requested the flow of ODA for energy needs to increase to US $11.5 billion per year;

ii. The international community should assist in financing regional infrastructure (e.g., road corridors, power pools, multipurpose water infrastructure, information and communications technology), as outlined in the African Union NEPAD Infrastructure Short-Term Action Plan and other regional plans. This will require a one-off US $l0 billion investment for power and transport networks, respectively, and an estimated US$2 billion to complete regional broadband communications networks;

iii. The international community needs to support Mrican countries in implementing national strategies to achieve the water supply and sanitation targets. This will require an estimated US $5.8 billion per year in external financing. Additionally, the sum US $0.8 billion will be required each year to invest in irrigation infrastructure;

iv. ODA for infrastructure in Africa, including for water and sanitation facilities, needs to be at least doubled by 2010 and delivered through the infrastructure facilities set up by G8 bilateral development agencies, the African Development Bank, European Commission, Islamic Development Bank and World Bank;

v. Fully operationalization of the Enhanced Integrated Framework and Aid for Trade mechanisms in order to support country's efforts to develop their trade capacity and performance;

vi. Multilateral and bilateral donors should increase the use of public-private partnerships (PPPs) to leverage public financing and strengthen collaboration with non-DAC donors and other partners through project co-financing and other new hybrid financing instruments; and

vii. The Infrastructure Consortium for Africa (lCA) should be strengthened to support the monitoring of infrastructure results, particularly in the transport and power sectors, where progress is necessary to achieve MDG 1 on poverty and MDG 7 on environmental sustainability.

e) National Statistical Systems

i. Governments, with support from development partners, should finance and implement bankable National Strategies for the Development of Statistics (NSDS) to strengthen data systems and develop statistical capacity across Africa. To this effect, the following estimates were given:

- n particular, support is required for the 2010 census round, the creation of national systems for civil registration and vital statistics, and the infrastructure to conduct enhanced and comparable socio-economic surveys across Africa;

- Approximately US$250 million10 will be required annually in external financing to support needed investments and associated operating expenditure.

f) Aid Effectiveness and Aid Predictability

i. Each country that provides development assistance should reconfirm its intention to fully implement the Paris Declaration on Aid Effectiveness as

well as its 2005 commitment to increase ODA, in line with the Monterrey Consensus commitment to make concrete efforts towards the target of ODA equal to 0.7 per cent of GNI;

ii. Each bilateral donor should provide country-by-country schedules on how it will scale up its aid to Africa to meet existing commitments, including the Gleneagles and other commitments for 2010 that equate to an extra US $25 billion to total US $54 billion or US $90 per capita at 2004 prices and exchange rates;

iii. The African Development Bank, African Union, IMF, UN System, and the World Bank should assist African Governments in maintaining strong domestic policy frameworks as well as designing policies and programmes for the effective use of projected aid increases while maintaining macroeconomic growth and stability;

iv. Governments and development partners should formalize compacts that outline each others' roles and responsibilities to ensure that financing commitments are met and aligned with national systems, untie aid, and design and implement any conditionality in a way that promotes predictability.

9) Translating the MDGs into integrated programmes on the ground

i. The African Development Bank, African Union, IMF, UN System and be World Bank should assist African Governments that request support in the preparation of “Gleneagles/MDG scenarios”. The scenarios will show how the international commitments, which tries equate to an increase of development assistance to Africa to an average of US $105 per capita (US $90 per capita in 2004 US $ terms) by 2010, can be operationalised through the implementation of policies and programmes a the country and community level to achieve tangible results.

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African Union

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