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Report on progress in achieving the Millennium Development Goals in Africa, 2013

Introduction

1. This report is the latest update by the United Nations Economic Commission for Africa (ECA) on the progress that Africa is making towards the Millennium Development Goals (MDGs). It builds on the reports of previous years in taking stock of progress made by African countries in the implementation of the MDG commitments in 2012, including the support provided by the ECA secretariat.

2. The central message of this year's report is that Africa has made significant progress towards the MDGs, but that it is uneven and too slow. There are also wide variations in performance across regions and countries, as well as across targets and indicators within the goals. The report concludes that with the agreed deadline of 2015 approaching fast, there is still much to be done to increase the pace and improve the quality of performance on various goals and indicators. With two years remaining until 2015, this assessment is of the utmost importance as it will help countries identify the targets that require concerted efforts for achievement of the MDGs.

Goal 1: Eradicate extreme poverty and hunger

3. Africa is off-track in seeking to halve poverty by 2015, even though recent figures point to substantial progress in this area. The share of the population that is employed is rising, and under-nourishment is on the decline, as is the proportion of employed people living on less than the poverty benchmark value of $1.25 per day. Similarly, the share of self-employed persons in total employment is declining, perhaps signalling a decline in subsistence employment, and reflecting an increase in commercial farming and rapid rural urban migration. However, the employment figures mask the vulnerable nature of such jobs. Much more progress can be achieved if concerted efforts are made to add value to raw materials through an aggressive industrialization drive that generates decent employment opportunities for the workforce.

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

Indicator 1.1: Proportion of people living on USD$1.25 a day

4. Poverty rates in Africa dipped below 50 per cent in 2008 (to 47.5 per cent) for the first time, and the absolute number of people living in poverty also fell. However, Africa, (excluding North Africa) is off track on this target. The decline in poverty masks significant gender and rural-urban disparities which call for targeted policy responses to address inequality. Sustaining progress in poverty reduction will require increasing the pace and inclusiveness of the growth process as well as investment in social services and infrastructure to enhance the health, incomes and productivity of the active labour force as well as supporting the vulnerable segments of society, particularly the aged, the disabled and children.

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

Indicator 1.5: Employment to population ratio

Africa's employed workforce is on the rise

5. Employment is a pathway to exiting poverty. Since 1991 Africa's average employment to population ratio has ranged between 50 and 60 per cent. Since 2008, it has been on the rise, after peaking in 2006. These figures, however, do not take into account the quality of jobs available to the labour force. In the absence of functional social protection systems in most African countries, most workers have no choice but to work in the informal sector, and in conditions where minimum occupational safety and health standards are often not met. In effect, the employment-to-population ratio overstates the level of well-being experienced by Africa's labour force.

Indicator 1.6: Proportion of employed people living on less than $1.25 a day

Decline in poverty rates among the employed

6. On average, the proportion of employed persons living on less than $1.25 per day declined between 2008 and 2010 to below the 1991 level (United Nations 2012). However, most of the jobs are vulnerable, and the rising cost of living and recent spikes in food prices suggest the need for caution in interpreting this trend. The World Bank reported sharp increases in food prices in Africa during the third quarter of 2012.

Indicator 1.7: Proportion of own account and contributing family workers in total employment

The proportion of own-account workers is declining

7. The average share of own-account workers[1] in total employment provides an indication of livelihoods and self-employment opportunities for workers. The evidence suggests wide variations in country performance on this indicator, ranging from a high of about 60 per cent in Burkina Faso and Ethiopia to negligible amounts in South Africa and Swaziland. The figures could, however, reflect a high prevalence of subsistence farming and informal sector employment in several African countries, in contrast to the more structured and formalized economies of southern Africa in general.

Indicator 1.9: Proportion of population below minimum level of dietary consumption

Undernourishment is declining, but slowly

8. For African countries as a whole, the prevalence of undernourishment fell from 27.3 to 22.9 per cent over the period 1990-2010. However, the rate of improvement was very slow (16.1 per cent) as compared to other regions of the world except Oceania (11 per cent). Ghana (87.6 per cent), Djibouti (70.9 per cent), Mali (68.8 per cent), the Niger and Sao Tome and Principe (65.9 per cent)

[1] Own-account workers are those workers who, working on their own account or with one or more partners, hold the type of job defined as a self- employed job, and have not engaged on a continuous basis any employees to work for them during the reference period.

were the best-performing countries during the period 1991-2011. However, the prevalence of undernourishment worsened in 10[2] African countries during the same period (FAO 2012).

Goal 2: Achieve universal primary education

9. Education plays a crucial role in economic development, and progress towards this goal has positive spillover effects on other MDGs. The rise in primary enrolment is significant globally, but even more pronounced in Africa (excluding North Africa), where enrolment rates rose by more than two thirds, with 43 million more children enrolled in primary school in 2010 than in 1999 (United Nations 2012). However, the significant strides in enrolment rates have not been matched by commensurate improvements in completion rates. While the global completion rate stands at 90 per cent, the figure for Africa (excluding North Africa) is a mere 70 per cent. Low completion rates reduce the number of qualified students who successfully transit from primary to secondary education and raise questions about the quality of primary education in Africa.

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

Indicator 2.1: Net enrolment in primary education

10. Aggregate net primary school enrolment rose from 64 per cent in 2000 to 87 per cent in 2010 in 29 African countries (latest from United Nations Statistics Division figures). Excluding North Africa, enrolment increased markedly from 58 to 76 per cent between 1999 and 2010. This annual rate of increase of 1.5 percentage points over the 12 year period is significant given the high population growth in the continent (United Nations 2012). Although progress has been positive across the continent, the pace of progress varied widely across countries. Worthy of note is that the Niger increased its enrolment from 53 to 62 per cent between 2009 and 2011, while Ghana and Mali increased their enrolment rates from 77 to 84 per cent and 64 to 67 per cent respectively during the same period (United Nations 2012).

Indicator 2.2: Primary completion rates

11. Progress with completion rates in Africa has not kept pace with the significant strides made in enrolment. As reported in the 2012 MDG report, approximately 70 per cent of children complete the primary school cycle. However, there have been some notable achievers. For example, Ghana raised its completion rate from 86 to 94 per cent between 2009 and 2011, and Ethiopia raised its rate from 55 to 72 per cent between 2009 and 2010 (United Nations 2012).

Low completion rates are a nagging problem

12. Low completion rates are partly attributable to poor educational quality. However, late entry into school and poverty also play a role. As much as 41 per cent of children starting primary school in Africa are two or more years older than the official school entry age. By grade 3, children who have entered late can be four times as likely to drop out as children who started school at the appropriate age. Children from poor households are more likely to start late, for reasons ranging from long home-to-school distances to poor health and nutritional status or lack of parental awareness of the importance of sending children to school on schedule. Poverty also has a negative

[2] Botswana, Burkina Faso, Burundi, Comoros, Côte d'Ivoire, Madagascar, Swaziland, Uganda, United Republic of Tanzania and Zambia.

effect on completion rates. In 2006, 97 out of every 100 children from the richest quintile in Uganda entered primary school, and 80 of the 97 reached the last grade. In the case of children from the bottom quintile, 90 out of 100 entered school but only 49 of the 90 reached the last grade (UNESCO 2012).

13. Efforts have been made to improve completion rates in some African countries. Social protection schemes, particularly featuring cash transfers and school feeding programmes, have helped to raise enrolment and completion rates. The introduction of pre-schooling, for example in Nigeria and the United Republic of Tanzania, has fostered a smooth transition to the primary level, but more importantly the completion of the full primary cycle (UNESCO 2012).

Indicator 2.3: Literacy rates of 15-24 year old men and women

14. Literacy rates in Africa (excluding North Africa) remain low at 72 per cent for both sexes, but female literacy rates are higher than men's. Inadequate numeracy and literacy skills among primary school leavers reflect the low quality of education. It is generally acknowledged that it takes four or five years of good-quality primary schooling to provide children with functional literacy and numeracy skills. Recent analysis of household surveys shows, however, that far more children than expected in low-income and lower middle-income countries are completing primary school without becoming literate. In Ghana, for example, over half of women and over a third of men aged 15 to 29 who had completed six years of school could not read a sentence at all in 2008. A further 28 per cent of the young women and 33 per cent of the young men could read only part of a sentence (UNESCO 2012).

Goal 3: Promote gender equality and empower women

15. Africa is progressing well towards achieving MDG 3, especially in terms of the gender parity index (GPI) in primary enrolment. A number of reforms such as the introduction of free primary education have contributed to this progress. However, the GPI remains low at the secondary and tertiary levels. Challenges like poverty, early marriage and child labour have contributed to this state of affairs. However, some countries display an increasing imbalance against boys, especially at primary level, which needs to be addressed as well. Further reforms and campaigns for the empowerment of women have contributed to increasing the percentage of seats held by women in parliament.

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

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

Gender parity indices at primary level are encouraging

16. The GPI for primary enrolment in Africa is on track. Out of 37 African countries with data, 27 had a GPI of 0.9 or higher in 2010. Of these 27, data from 9 countries indicates an imbalance against boys, i.e. a GPI higher than 1.0. Between 1991 and 2010, 24 countries recorded an increase in their GPI for primary enrolment. Benin recorded the highest increase, of 78 per cent while in Chad and Guinea the increases were over 50 per cent. For many of these countries, the increases are a result of education reforms such as the introduction of free primary education and efforts to promote the girl child. However, as more countries move towards achieving gender parity at primary level, there may be concern that in the future in more countries there may be an imbalance

against boys. Angola, Eritrea, Lesotho and Swaziland recorded a slight fall in their primary GPI. In Lesotho's case, the fall is explained by continued efforts to correct the imbalance against boys.

Scattered progress towards gender parity in secondary education

17. The GPI in secondary level enrolment is lower than that for primary enrolment. But over the years, the former has been improving, albeit slowly. Because many reforms do not extend to or are difficult to finance at the secondary level, the rate of enrolment for girls is lower. Poverty and gender bias also affect girls' enrolment. When faced with an income constraint, families tend to favour boys over girls in decisions regarding secondary education. Girls are therefore forced to seek alternatives like employment or marriage.

18. Out of 26 countries with available data for 2010, 7[3] had achieved gender parity at secondary level. Of these, 5 showed an imbalance against boys, with Lesotho having the highest GPI at 1.38. Chad recorded the lowest GPI of 0.42 in 2010. Between 1991 and 2010, 14 countries[4] raised their secondary GPI. Lesotho registered a slight decline. The Gambia, the Niger and Mauritania recorded the highest increases, of 94, 78 and 77 per cent respectively.

Gender parity in tertiary education remains low

19. The GPI in tertiary enrolment is the slowest-progressing of the three. Some African countries are recorded as having tertiary GPIs lower than 0.5. These include Burkina Faso, the Central Africa, Chad, Eritrea, Ethiopia, Mali, Mauritania and the Niger, with Chad having the lowest GPI, at 0.17. Algeria had the highest, at 1.46, followed by Cape Verde (1.29) in 2010. Egypt, Madagascar and Sao Tome and Principe are close to achieving gender parity at tertiary level, with indices all above 0.9. On the basis of data for 2010, and a comparison of progress made since 1991, it is unlikely that many African countries will achieve gender parity in enrolment at the tertiary level.

Target 3.3: Proportion of seats held by women in national parliament

20. African countries are slowly progressing towards the achieving the target of 30 per cent representation of women in parliament. However, data for 2012 show that more than half the countries still stand below 20 per cent, with the majority ranking between 10 per cent and 20 per cent. Only eight countries[5] have met or surpassed the 30 per cent target. Cape Verde, Eritrea, Ethiopia, Lesotho, Malawi, Mauritania, Namibia, Senegal, the Sudan and Tunisia all have more than 20 per cent female representation in their national parliaments.

Goal 4: Reduce child mortality

21. Africa is making insufficient progress to achieve MDG 4, and remains the region with the highest global burden of under-five deaths. Reduction in neonatal and infant mortality has been especially slow, illustrating the importance of improving prenatal and maternal health care in the region. Lack of access to basic health services to prevent and treat infectious diseases such as pneumonia, malaria and diarrhoea has also hindered progress in most countries. Nonetheless, Liberia, Malawi, Rwanda and others are on track to reduce child mortality by two thirds by 2015. North Africa as a whole is also on track with respect to MDG 4.

[3] Cape Verde, Lesotho, Mauritius, Rwanda, Sao Tome and Principe, Seychelles and Swaziland.
[4] Countries with available data for both 1991 and 2010.
[5] Angola, Burundi, Mozambique, Rwanda, Seychelles, South Africa, Uganda and the United Republic of Tanzania.

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

Indicator 4.1: Under-five mortality rate

22. Africa continues to make steady yet slow progress in reducing the under-five mortality rate. Since 1990, Africa has reduced the rate from 174 deaths per 1,000 live births to 121 in 2010, with an annual reduction rate of 2.3 per cent between 1990 and 2010. Eleven countries in Africa[6] successfully reduced child mortality by at least 60 per cent between 1990 and 2010, and are thus on track to achieve MDG 4. This progress has been the product of multiple factors, such as gains in medical technology, development programming, health service delivery and improvements in education, child protection and economic growth (UNICEF 2012).

23. However, with an annual rate of reduction of just 2.3 per cent, Africa as a whole will not achieve a two-thirds reduction in under-five mortality by 2015. Furthermore, as global rates of under-five mortality fall, child deaths, where, alarmingly, one in nine children dies before age five, are becoming more and more concentrated in Africa. Africa, excluding North Africa, accounted for almost half of the global total of under-five deaths in 2011. While all African countries but one – Swaziland[7] – have reduced the under-five mortality rate since 1990, many are seeing increases in the absolute number of under-five deaths. These countries[8] have experienced increases in their national burden of under-five deaths since 1990 owing to a combination of high population growth and nearly static resource allocation.

North Africa is on track, while malaria is slowing progress in Central Africa

24. Subregionally, North African countries have made the most progress in reducing under-five mortality, from an average of 89 deaths per 1,000 live births in 1990 to 41 in 2011, a 54 per cent decrease, followed by Southern Africa (46 per cent) and Eastern and West Africa, each registering a 42 per cent decline. Central Africa is making the slowest progress and remains the subregion with the highest rate, at 139 deaths per 1,000 live births in 2011. It is also the only subregion recording more under-five deaths now than in 1990. This may be due largely in part to high mortality rates from malaria, which account for over 18 per cent of under-five deaths in Central Africa versus an average of just 7.5 per cent in all the other subregions combined (UNICEF 2012). It is clear that expanded malaria prevention and treatment efforts could dramatically reduce child mortality in Central Africa.

Fighting infectious diseases is critical to success

25. Infectious diseases such as pneumonia, diarrhoea, malaria, meningitis, tetanus, AIDS and measles account for approximately 41 per cent of under-five deaths in Africa. When compared with countries with very low child mortality (an under-five mortality rate below 10 per 1,000 live births) which have virtually no under-five deaths from infectious diseases, one can see how infectious diseases are a marker of equity and access to basic prevention and treatment interventions (UNICEF 2012).

[6] Cape Verde, Egypt, Ethiopia, Liberia, Libya, Madagascar, Malawi, Morocco, Níger, Rwanda and Tunisia.
[7] The rate in Swaziland's increased from 83 deaths per 1,000 live births in 1990 to 104 in 2011. 23 per cent of Swaziland's under-five deaths are due to AIDS.
[8] Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Kenya, Mali, Mauritania, Somalia and Swaziland.

26. Under-five deaths from infectious diseases are largely preventable, and evidence suggests that many of the major declines in under-five deaths globally were related to expanded efforts against infectious diseases. For example, expanded coverage of insecticide-treated bednets in the Niger has led to a considerable decline in under-five deaths. In 2000, just one per cent of children under five were sleeping under such a bednet, and there were 216 deaths of children under five per 1,000 live births. Today, 64 per cent of children under five sleep under such bednets, and the Niger's under-five mortality rate has fallen to 125 deaths per 1,000 live births – a decline of nearly 50 per cent since 2000 (UNICEF 2012).

Indicator 4.2: Infant mortality rate

Most child related-deaths occur within the first year of life

27. Under-five deaths in Africa usually occur in the first 28 days of life, with an average of 33.6 per cent of under-five deaths on the continent occurring in this neonatal period. Approximately 65 per cent of under-five deaths in Africa occur within the first year of life. Unfortunately, infant mortality rates in Africa have been slower to decline than under-five mortality rates.

Birth-related complications account for a significant share of deaths

28. The majority of neonatal deaths result from complications related to preterm birth or complications during birth. Delivering at home without a skilled health-care provider leaves women and babies at greater risk of such complications, and thus accessing health care during pregnancy and delivery is essential for improving both maternal and child health. Simple interventions such as folic acid supplementation, pre-eclampsia and eclampsia prevention, malaria treatment, clean delivery practices and breastfeeding can drastically reduce neonatal morbidity and mortality.

Goal 5: Improve maternal health

29. Africa is making promising progress in its efforts to improve maternal health. The most recent report by WHO (WHO and others, 2012c) , notes substantial gains. However, Africa still has the highest maternal mortality rate in the world, and has a long way to go before achieving MDG 5. Measures that expand family planning coverage, tackle HIV/AIDS, improve civil registration systems and boost female education can help accelerate progress toward improving maternal health by 2015.

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

Indicator 5.1: Maternal mortality ratio (MMR)

Some progress in maternal health has been achieved

30. On average, African countries have reduced their MMR from an average of 745 deaths per 100,000 live births in 1990 to 429 in 2010, a 42 per cent reduction (United Nations 2012). Equatorial Guinea is the only country in Africa which has reduced its MMR rate enough to achieve MDG 5, with an 81 per cent reduction since 1990[9]. Other countries making good progress are Egypt and Eritrea, which are "on track", and Botswana, Cape Verde and Rwanda, which have been averaging a reduction of 5.5 per cent or more since 2000 (WHO 2012).

[9] Cape Verde, Sao Tome and Principe and Mauritius have low MMRs (defined as 20-90 maternal deaths per 100,000 live births) and are making significant progress towards this goal.

Africa's maternal death burden is the highest globally

31. Despite such progress, Africa still bears the largest burden of maternal deaths in the world, with over 50 per cent of the global maternal deaths occurring on the continent. At 429 deaths per 100,000 live births, Africa lags behind developing regions as a whole (240), Southern Asia (220) and the Caribbean (190). In fact, the 10 highest MMR countries[10] are in Africa, and an estimated 14 per cent of maternal deaths globally occur in Nigeria. It is important to note that four countries (Central African Republic, Gabon, Kenya and Zambia) have made no progress, while nine (Botswana, Cameroon, Chad, Congo, Lesotho, Somalia, South Africa, Swaziland and Zimbabwe) registered an increase in MMR during the period 1990-2010 (WHO 2012c).

HIV/AIDS is a major contributing factor

32. Why do African countries continue to make insufficient progress toward achieving MDG 5? A prominent reason is the high prevalence of HIV/AIDS in the region. Of the estimated 19,000 maternal deaths attributed to HIV worldwide, 17,000, or 89 per cent, are in Africa, excluding North Africa. Without HIV, it is estimated that the MMR for Africa, excluding North Africa, would be 450 maternal deaths per 100,000 live births, instead of 500. Thus, improving access to prevention measures, testing and treatment would assist the continent to decrease its number of maternal deaths.

Access to good-quality health services is vital

33. In addition to HIV, many maternal deaths result from lack of access to reproductive health services. Progress towards the second target of MDG 5, achieving universal access to reproductive health by 2015, is therefore also imperative. With improved access to contraceptives and antenatal care coverage, and a reduction in adolescent birth rates, women are more likely to have well-planned and safe pregnancies. There is a large disparity in the receipt of good-quality health care in African subregions (see figure1). Antenatal care visits are almost universal in Southern Africa, whereas in West Africa about a third of pregnant women received no antenatal care visit in 2010.

Civil registration systems facilitate tracking of causes of death

34. Lastly, the lack of complete civil registration systems with good attribution of cause of death is a challenge in many African countries in monitoring health-related MDGs. Only Mauritius's country estimates for maternal mortality are based on good civil registration data. Nearly 80 per cent of African countries are classified as "lacking good complete registration data, but other types of data are available", meaning that periodic population-based surveys (such as demographic and health surveys and multiple-indicator cluster surveys) are used for maternal death estimates. Furthermore, 10 countries[11] have no good-quality national data on maternal mortality, and thus it is challenging to accurately assess progress made toward MDG 5 (WHO 2012). In order to better track progress and therefore plan targeted interventions, African countries must adhere to the recommendation of the high-level Commission on Information and Accountability for Women's and Children's Health that "by 2015, all countries should have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys" (WHO 2012c). African countries are working towards the improvement of their civil registration and vital

[10] Burundi, Cameroon, Central African Republic, Chad, Guinea-Bissau, Liberia, Nigeria, Sierra Leone, Somalia and Sudan.
[11] Angola, Burundi, Cape Verde, Comoros, Djibouti, Equatorial Guinea, Gambia, Guinea-Bissau, Libya and Somalia.

statistics systems by supporting and implementing the Africa Programme on Accelerated Improvement of Civil Registration and Vital Statistics.

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

35. Progress in curtailing HIV/AIDS, tuberculosis and malaria continues to gain momentum in Africa, where unprecedented gains have been achieved in reducing the number of both adults and children newly infected with HIV and in lowering the numbers of people dying from AIDS-related causes. While malaria incidence and deaths continue to decline, the reductions were not sufficient to meet the target of a 50 per cent reduction by 2010. There were an estimated 216 million episodes of malaria in 2010, of which approximately 81 per cent, or 174 million cases, were in Africa. An estimated 655,000 malaria deaths occurred in 2010, of which 91 per cent were in Africa and 86 per cent involved children under five years of age.

36. At the global level, new cases and numbers of deaths from tuberculosis have been falling for several years. Incidence fell at a rate of 2.2 per cent between 2010 and 2011, and the tuberculosis mortality rate has decreased by 41 per cent since 1990. The world is on track to achieve the global target of reducing tuberculosis mortality by 50 per cent by 2015, yet in Africa this will most likely not be achieved.

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

37. Africa, excluding North Africa, remains the most severely HIV-affected region globally, with nearly 1 in every 20 adults (4.9 per cent) living with HIV, accounting for 69 per cent of the people living with HIV worldwide. Twenty-three of the countries which have achieved steep declines in HIV incidence are in Africa excluding North Africa, where the number of people infected by HIV in 2011 was 25 per cent lower than in 2001 (UNAIDS 2012).

38. The number of people dying from AIDS-related causes began to decline in the mid-2000s thanks to scaled-up antiretroviral therapy and the steady decline in HIV incidence since its peak in 1997. In 2011, this decline, continued. The number of people dying from AIDS-related causes in Africa excluding North Africa showed a further decline, dropping by 32 per cent between 2005 and 2011, although the region still accounted for 70 per cent of all the people dying from AIDS in 2011.

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

39. The HIV status of young people has also changed positively in Africa excluding North Africa. Young females in Africa, excluding North Africa, remain more susceptible to HIV infection than males, but females experienced a sharper decline in prevalence rates than men (5.1 to 3.1 per cent compared with 2.0 to 1.3 per cent) over the period 2005 to 2011.

Indicator 6.2 Condom use at high-risk sex

40. Favourable changes in risky sexual behaviour are evident in many countries, including Kenya, Malawi, Mozambique, Namibia, Nigeria and Zambia. However some countries – such as Côte d'Ivoire and Rwanda – exhibit increases in risky behaviour, highlighting the need to intensify efforts to change behaviour and create awareness about HIV and its transmission. In 26 of 31 countries with a generalized epidemic, recent surveys find that less than 50 per cent of young women have comprehensive and correct knowledge about HIV (UNAIDS 2012). With few exceptions (i.e., Benin, Burkina Faso, Côte d'Ivoire and Uganda), reported condom use is generally

on the rise in Africa. However, awareness remains low in several of the high-prevalence countries, especially among young women. Besides, condom supply remains inadequate.

Target 6.B: Achieve, by 2015, universal access to treatment for HIV/AIDS for all those who need it

Indicator 6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

41. Since 1995, antiretroviral therapy has added 14 million life-years in low-income and middle-income countries, including 9 million in Africa excluding North Africa. Coverage in Africa excluding North Africa is modestly higher than the global average, with 56 per cent of eligible individuals receiving therapy. Worthy of note is that Botswana, Namibia and Rwanda have achieved universal coverage, estimated at least 80 per cent treatment coverage, and the number of countries with coverage below 20 per cent fell from 28 in 2009 to 10 in 2011 (UNAIDS 2012).

42. Antiretroviral therapy coverage remains higher for women (68 per cent) than for men (47 per cent) in low-income and middle-income countries, possibly contributing to lower prevalence rates. However, the provision of antiretroviral treatment to children is low, at approximately 20 per cent. Increased access to such therapies, particularly for children, is critical to achieving the goal of zero new infections (UNAIDS 2012).

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

Indicator 6.6: Incidence and death rates associated with malaria

43. In the African region, of 43 countries with ongoing malaria transmission, 8 (Algeria, Botswana, Cape Verde, Namibia, Rwanda, Sao Tome and Principe, South Africa and Swaziland) have achieved reductions in malaria case incidence or malaria admission rates of 75 per cent or more. Eritrea is on track to achieve reductions in malaria admission rates of 75 per cent or more by 2015, while Madagascar and Zambia are projected to achieve reductions in malaria admission rates of 50 – 75 per cent by 2015 (WHO 2012a).

Indicators 6.7 and 6.8: Proportion of children under five sleeping under insecticide-treated bednets, and proportion of children under five with fever who are treated with appropriate antimalarial drugs

44. The percentage of children sleeping under insecticide-treated bednets in Africa excluding North Africa is estimated to have grown from 2 per cent in 2000 to 39 per cent in 2010. In addition, the reported percentage of the population at risk who were protected by indoor residual spraying rose from less than 5 per cent in 2005 to 11 per cent in 2010.

45. Although the proportion of suspected cases receiving a parasitological test has increased in Africa, according to the latest survey (2010-2011) in 12 African countries, than 40 per cent of children under 5 received adequate treatment. In addition, the fact that 30 per cent of anti malarial drugs are privately supplied and 10 per cent directly obtained from pharmacies exacerbates the inequities of access for low income groups.

Indicator 6.9: Incidence, prevalence and death rate associated with tuberculosis

46. Increasing numbers of tuberculosis patients have access to high-quality treatment, but more than a third of new cases still go unreported and do receive DOTS not treatment (Directly Observed Treatment – Short Course). Worryingly, over 84 per cent of the estimated 290,000 cases of multi-drug resistant tuberculosis present in Africa in 2010 were not diagnosed and treated in accordance with international guidelines. Moreover, many HIV-positive tuberculosis patients do not know their HIV status, and most of them are not yet accessing antiretroviral therapy (WHO 2012b).

Goal 7: Ensure environmental sustainability

47. Africa is making some progress on MDG 7. Although CO_2 emissions increased in a number of countries, most of the increases were less than per cent, and Africa in general continues to produce low emissions. In addition, most countries are on track to meeting this target. The target for safe drinking water has been met worldwide, but although Africa too has made progress, the continent still remains far behind the rest of the world.

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

Indicator 7.1: Proportion of land area covered by forest

48. There are no data available for this indicator for 2011, but there is evidence from several African countries that the proportion of land area covered by forests is declining and that the rate of deforestation is alarming. Reasons for this trend include illegal logging and the use of forest land for investment purposes. In Liberia, for example, more than half the forests have been given to logging companies for investment (Tamasin Ford 2012). In the Democratic Republic of Congo, forests are cleared for mining activities.

Indicator 7.2: CO_2 emissions, total, per capita and per $1 GDP (PPP)

49. Historically, CO_2 emissions in Africa have been low, with the continent contributing less than 4 per cent to total world emissions. Libya, South Africa, Seychelles, Equatorial Guinea and Algeria contributed most to emissions in Africa. Nonetheless, Africa remains at high risk of suffering the effects of climate change, which has been evidenced in the past few years by severe droughts and floods.

Indicator 7.3: Consumption of ozone-depleting substances

50. This indicator tracks countries' progress in reducing and ultimately phasing out the consumption of ozone depleting substances in accordance with their commitments and schedules in the 1987 Montreal Protocol on Substances that Deplete the Ozone Layer. This Protocol is the most widely ratified and one of the most successful treaties in the history of the United Nations, with 197 ratifications. It has led to reductions of more than 97 per cent in ozone-depleting substances worldwide.

51. Many African countries are steadily reducing their consumption of these substances and are on track to meet the target. More than half the countries that reduced their consumption did so by more than 50 per cent. Conversely, countries that recorded increases also did so by more than 50

per cent, with Egypt recording the highest increase. This increase is largely attributed to massive increases in consumption of hydro chlorofluorocarbons.

52. Drawing from Zimbabwe's experience, African countries have accelerated their efforts towards reducing the consumption of ozone-depleting substances by seeking alternatives to methyl bromide for agricultural fumigation (UNEP 2012). There is, however, still a need to organize more training on these alternatives, create public awareness and involve the public in the phase out of methyl bromide, infrastructure upgrades and regulatory reform.

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

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

53. Globally, the target on sustainable access to water (88 per cent) has been surpassed by one percentage points (WHO/UNICEF 2012). However, Africa is off-track on this indicator. More than 40 per cent of the world's population without access to drinking water is in Africa. Moreover, there are significant rural urban disparities in access to improved water sources. In many cases, limited access to water has also slowed progress on sanitation and contributed to outbreaks of diseases such as cholera and diarrhoea.

54. The challenges that are hindering progress include political instability, the refugee problem and growing populations that are putting pressure on available resources. Additionally, African countries generally lack the technologies needed to improve water and sanitation. Where they exist, they do not trickle down to many rural areas that would benefit from them.

Goal 8: Develop a global partnership for development

55. As Europe continues to struggle with the sovereign debt crisis and inflation rates increase, the impact has translated into falling official development assistance (ODA) to developing countries. However, ODA to Africa increased slightly. Developed country imports from developing countries remained largely unchanged in 2010. In terms of information and communications technologies, Africa's progress is encouraging. The growing importance of the Internet, the expanding use of mobile phones and increased investment in telecommunications in Africa have improved the landscape in this respect.

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

Indicator 8.1: Net ODA, total and to the least Developed Countries, as percentage of OECD/DAC donors' gross national income

56. Global ODA from donor countries which are members of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) dropped for the first time in 15 years (OECD 2012). In 2011, many OECD/DAC countries reduced their net ODA, and most are still not close to meeting the target of 0.7 per cent of donor countries' gross national invome. Only 5 of the 23 OECD/DAC member States met the target (i.e. Denmark, Luxembourg, Netherlands, Norway and Sweden), and only 7 increased their net ODA. On average, net ODA to Least Developed Countries (LDCs) as a proportion of gross national income rose steadily from 0.06 per cent in 2006 to 0.11 per cent in 2010, falling 0.04 per cent age points below the minimum threshold of 0.15 per cent. Only 10 out of 23 DAC countries met the 0.15 – 0.20 per

cent target for ODA to LDCs in 2010; Luxembourg ranked the highest with 0.4 per cent, while Belgium, Denmark, Finland, Ireland, the Netherlands, Norway, Sweden and the United Kingdom recorded 0.2 per cent or above. Canada met the lower bound target of 0.15. Against a background of uncertainty about the sovereign debt crisis which contributed to the fall in net ODA to developing countries, it remains to be seen whether this target will be met over the medium term.

Target 8.C: Address the special needs of landlocked developing countries and small island developing States

Indicator 8.4: ODA received in landlocked developing countries as a proportion of their gross national incomes

57. Total ODA to all landlocked developing countries (LLDCs) increased by only 2 per cent between 2009 and 2010. Lesotho, Malawi and the Niger experienced the highest increases, while Botswana, Chad, Ethiopia, Uganda, Zambia and Zimbabwe suffered declines. LLDCs face unique challenges that constrain their economic growth and development. Rising world crude oil prices and reliance on ports of entry in other countries highlight the importance of effective intergovernmental coordination for LLDCs. Regional integration and trade facilitation are also increasingly becoming important in this context.

58. In 2012, the United Nations General Assembly decided to hold a conference in 2014 to conduct a comprehensive ten-year review of the Almaty Programme of Action to address the special needs of LLDCs. The eleventh annual meeting of foreign ministers of LLDCs called for the accelerated implementation of the Almaty Programme of Action, for example by ensuring that Aid for Trade (which is part of ODA) takes into account the special needs and requirements of such countries.

Indicator 8.6: Proportion of total developed country imports (by value and excluding arms) from developing countries and admitted least developed countries, free of duty

59. Imports to developed countries from Africa admitted free of duty have increased for only a few countries since 1996. The failure to finalize the Doha Round, coupled with the global economic crisis which began in 2008, contributed to this trend.

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

Indicator 8.14: Fixed telephone lines per 100 inhabitants

60. There has been limited growth in the number of fixed telephone lines in Africa. Between 1990 and 2011, only nine countries[12] registered significant increases in the number of fixed telephone lines. No African country has more than 50 fixed telephone lines per 100 inhabitants, and only Mauritius and Seychelles have more than 20 lines for every 100 inhabitants. The stagnation in the growth of fixed-line telephony is linked to the rapid adoption of mobile telephony by the population.

[12] Algeria, Botswana, Cape Verde, Egypt, Libya, Mauritius, Morocco, Seychelles and Tunisia.

Indicator 8.15: Mobile cellular subscriptions per 100 inhabitants

61. The number of mobile cellular subscriptions in African countries continues to grow steadily, increasing on average by 8 per 100 inhabitants between 2010 and 2011. Africa is the fastest growing mobile market in the world (Natasha Lomas 2012). Technological innovation in the use of cellular phones is on the rise in Africa, as evidenced by the use of such devices for financial transactions such as money transfers, mobile banking and bill payments. Between 2010 and 2011, Namibia registered the highest growth in subscriptions, followed by South Africa, Botswana and Zambia.

Indicator 8.16: Internet users per 100 inhabitants

62. The number of Internet users in Africa increased by an average of two users for every 100 inhabitants in 2011, in part owning to the increasing use of smart phones for Internet services. A recent survey revealed that more Kenyans use mobile phones for Internet access than for phone calls. Kenya is targeting 100 per cent Internet access penetration by 2017 through improvements in information and communications infrastructure. Rwanda, which has the fastest Internet speed in Africa, is working to make broadband more affordable to users (AllAfrica 2012).

63. The Sudan recorded a more than 100 per cent increase in Internet users between 2010 and 2011, and Kenya more than 99 per cent. In the Democratic Republic of Congo, the Niger and Swaziland, the number of Internet users rose by more than 50 per cent.

Conclusions and policy recommendations

64. Progress towards the MDGs is mixed across regions, countries, goals, indicators and targets. While Africa as a whole is making considerable progress towards many of the MDGs, many countries are still far from achieving most of the goals. Issues of quality of service delivery, particularly in the education and health sectors, inequality in access to services, lack of decent jobs, and unemployment, particularly among young people, remain high on the agenda.

65. Job creation will require that countries embark on commodity-based industrialization that diversifies their economies and creates employment opportunities through value addition and integration in global value chains. Complementary investment in education and health systems will improve the quality of social services, strengthen productive capacities and enhance market competitiveness. Such measures will not only reduce poverty on the continent, but also assist in narrowing gaps in access to education, health services, clean water and sanitation.

66. Health interventions must prioritize primary health care and rural and vulnerable segments of the population. Policymakers must lobby development partners to allocate an increasing proportion of vertical funding to strengthening health systems. A robust health system with qualified health workers and adequate medical equipment is necessary to sustain and reinforce the targeted interventions of vertical funds. African countries must also improve civil registration systems to effectively monitor health trends, particularly in maternal and child health.

67. Investment in education should focus on enhancing access, quality and the relevance of the educational curricula to the labour force. This will require ensuring appropriate teacher-to-pupil ratios, upgrading the skills of teachers and encouraging timely entry into school. In addition, providing transport to children in remote areas, and introducing legislation on early marriages, will

improve educational access, reduce dropout rates and enhance the overall quality of education in Africa.

68. Through its capacity building initiatives ECA will continue to support member States in accelerating progress towards the MDGs. In this context, ECA, in collaboration with the African Union Commission and the African Development Bank, is assisting African countries to implement a Reference Regional Strategic Framework for Statistical Capacity-Building in Africa aimed at strengthening capacities to collect, compile and disseminate data. It will also facilitate more reliable intercountry comparisons on development indicators, including the MDGs. In addition, ECA assists countries in the design, implementation and monitoring of MDG-based development plans through training, knowledge- sharing and peer learning initiatives. Examples include the newly developed network of development planners, as well as the LDC Monitor, which assists African LDCs to track progress towards the MDGs and the objectives of the Istanbul Programme of Action for the LDCs. ECA also contributes to the MDG policy discourse through research and country studies. The Commission's eight-country study on social protection provided policymakers with lessons learnt on how to empower vulnerable groups and minimize inequalities through the use of this instrument.

69. To ensure that the post 2015 development agenda takes into account the priorities of the continent, ECA, in collaboration with AUC and other partners, has helped to organize a series of regional and subregional consultations aimed at articulating an African common position on the post 2015 agenda, which will be presented to the African Union Heads of State for adoption in May 2013.

70. The post 2015 development agenda must not, however, distract Africa from its immediate task of eradicating poverty, providing quality education for all, empowering women, improving child and maternal health, fighting HIV/AIDS, malaria and tuberculosis and ensuring environmental sustainability. Even as the world looks beyond 2015 towards a new development agenda, countries must stay on track to make as much progress as possible by the target date. The continent has made considerable progress toward the MDGs since 2000, and has learned a great deal over the past 12 years. By implementing lessons learned, African countries should be able to overcome challenges and fast-track progress over the next three years.

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