Economic
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African Union

Assessing Progress in Africa towards **the Millennium Development Goals**

2008

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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 Assistance
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/AIDS
UNECA	United Nations Economic Commission for Africa
UN-DESA	United Nations Depart 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

Section I: Introduction

Recent evidence suggests that progress in Africa in meeting the Millennium Development Goals (MDGs) by the target date is picking up although a lot remains to be done. 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. And there has been significant reduction in the prevalence of HIV.

This report, the third in the series, presents progress made since the last report, discusses how far the continent still needs to travel, at what speed, and what needs to be done further. It is an abridged version of a much more comprehensive joint Economic Commission for Africa (ECA), African Union Commission (AUC), and African Development Bank (AfDB) report to the July 2008 African Union Summit.

The conditions for accelerating growth and development to meet the targets of the MDGs are largely in place. Since the last report, the number of African countries with MDGs-consistent poverty reduction strategies or national development plans has risen to about 41. Growth, fueled in large measure by appropriate policy reforms, favourable primary product prices and a marked improvement in peace and security, notably in the west and south central regions remains strong. In 2007, for example, more than 25 African countries achieved a real GDP growth rate of 5 per cent or above while another 14 grew at between 3 and 5 per cent1.

However, the continent's average annual growth rate of approximately 5.8 per cent still remains significantly lower than the 7 per cent annual growth rate required to reduce poverty by half by 2015. This growth is increasingly coming under threat from new developments. A new threat is the escalating price of staples. In a number of countries (Cameroon, Burkina Faso, Senegal, and Mauritania), violent protests have broken out against rising food prices. Africa's net food importers will be seriously affected by the escalating price of food. This could pose serious risks to governance, peace and security. Similarly, rising oil prices and climate change pose significant risks to the preservation and acceleration of growth and to progress towards the targets of the MDGs in the region.

There has also been a reinforcement of state capacity to deliver growth in many countries. Indeed, the MDGs underscore the critical importance of a capable state for progress. During the period under review, many countries took actions

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to institutionalize good governance. Three new countries have acceded to the African Peer Review Mechanism (APRM). Elections were held in countries such as Nigeria and the Democratic Republic of Congo. Peace is gradually returning to countries such as Somalia and DRC while countries such as Uganda and Cote D'Ivoire are moving towards generalized peace (i.e. peace that cuts across the swathe of the whole country). Nonetheless, the spreading of the conflict in the Darfur region of the Sudan, the conflict in Chad and the Comoros Islands continue to be a drag on growth and progress towards the targets of the MDGs.

Broad regional and subregional support for the MDGs remains very strong. African Union continues to see the MDGs as a core element of its New Partnership for Africa's Development (NEPAD) programme. AU, at its July 2007 Accra Summit and at its January 2008 Addis Ababa Summit adopted resolutions reiterating the importance of achieving the MDGs. Both Summits resolved that the Assembly of Heads of State must be briefed on a regular basis on the continents progress towards the MDGs.

There is also deepening recognition at the subregional level of the imperative of achieving the MDGs. To advance the MDG agenda, a number of African Regional Economic Communities (RECs) are developing (or have developed) regional poverty reduction strategies consistent with the MDGs. The Economic Community of West African States (ECOWAS) recently adopted a regional poverty reduction strategy with the MDGs at its core and the Southern African Development Community (SADC) is in the process of developing one. At the 40th session of the United Nations Economic Commission for Africa and 2007 Conference of Ministers of Finance, Planning and Economic Development, African Finance Ministers reiterated their commitment to achieving the MDGs and adopted an action agenda.

Developments in the international community were generally conducive. Official development assistance, although still falling far short of commitments, grew at a respectable pace thus increasing from an average of $US16 billion during the 1998-2001 period to $US28 billion during the 2002-20052 period. Efforts to align ODA with national priorities in a manner consistent with the Paris Declaration continued. Trade with ODA from emerging south-south donors like China and India brought in additional resources for scaling-up especially in the area of infrastructure. Non-governmental actors, such as the Bill and Melinda Gates Foundation continue to play an active role in supporting the continent's efforts to meet the MDGs.

United Nations intensified its lead advocacy role for the achievement of the MDGs in Africa. The Secretary-General established the MDG Africa Steering Group, supported by the MDG Africa Working Group to mobilize resources and sustain

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international support for achieving MDGs in Africa. The scope for peer learning, experience sharing, and resource mobilization was broadened through ongoing reforms of the United Nations Economic and Social Council (ECOSOC) with the establishment of an Annual Ministerial Review (AMR) and the Development Cooperation Forum (DCF). The AMR presents an opportunity for both developing and developed countries, to make voluntary presentations and exchange lessons on their efforts to meet the internationally agreed development goals (IADG), including MDGs while the DCF provides a platform for exploring how best to scale-up development cooperation in order to meet the commitments.

This Report presents a picture that is slightly at variance with many other reports on Africa's progress towards the targets of the MDGs. It shows 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. If this rate of progress continues, the continent will be on course to meet a significant number of the MDGs by the target date. This will still be disappointing since the objective is to reach all the targets by 2015. Furthermore, the report shows that a critical area for progress is the health-related MDGs where progress is slowest. Interventions to accelerate progress on the health MDGs will yield significant dividend. In sum, the preconditions for accelerating progress to meet the targets of the MDGs are now largely in place, albeit constrained by inadequate resource flows and capacity in some critical areas like health capacity.

Section II: Tracking Progress

This section presents the goal-by-goal progress report on the continent's efforts to reach the targets of the MDGs. It differs slightly from the 2007 report because it includes a new set of indicators recommended for inclusion by the 62nd Session of the United Nations General Assembly which reviewed the status of progress on a few issues, including those related to employment, reproductive health, bio-diversity and access to treatment for HIV/AIDS and determined that they have been largely neglected. The additional new indicators and targets were operationalized in 2007 by the Inter-Agency and Expert Group on MDG indicators.

Consistent with the practice established in the 2007 report, there is no reporting on income poverty due to lack of reliable and consistent data on 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. All data used in this report are from the United

Nations Statistics Division (UNSD) at the United Nations Department for Economic and Social Analysis (UN- DESA).

Goal 1: Eradicate extreme poverty and hunger

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

There is no recent update of the data on this target in the UNSD dataset to enable an update on progress towards halving hunger by 2015. The evidence presented in the 2007 report showed significant variation across regions of the continent on this score: North Africa has met the goals while many countries along the west coast of the continent, except for countries in or just emerging from conflict, on track to meet it. There is no reason to expect this to change adversely in the year that has elapsed. However, there are new threats to food security that need to be flagged. The first is increased weather variability and the threat of climate change in view of the heavy dependence of Africa on rain-fed agriculture. Second, is the threat of rising food prices driven by rising incomes in China, India and other parts of the world, and increasing use devotion of large acres of land for biofuels3. These developments will likely have an adverse impact on the achievement (or security of the success already achieved) of this goal in many countries. Africa's net food importers are likely to be seriously hurt.

Goal 2: Achieve universal primary education

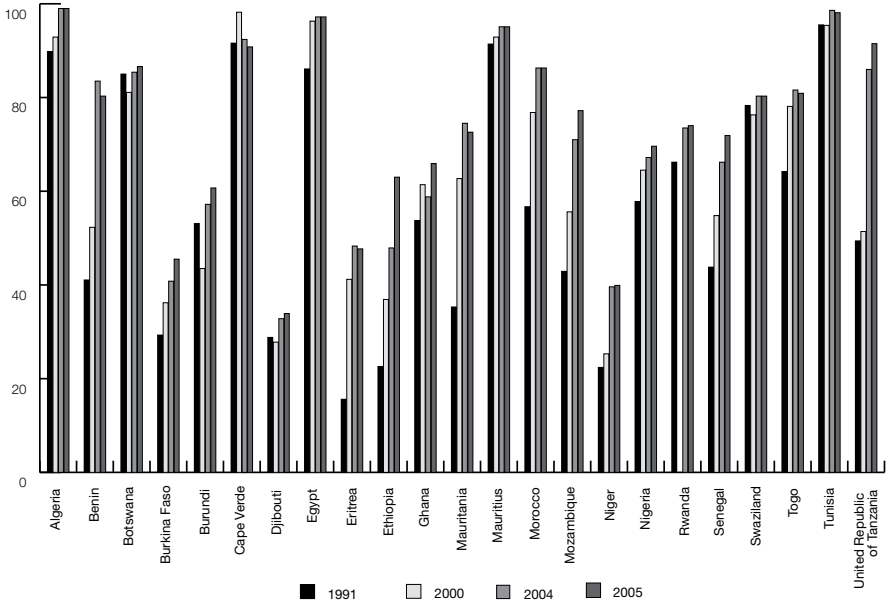
Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Indicator 2.1: Net enrolment in primary education

New data reported to UNSD show a marked improvement in 2005 over 2004 in net primary enrolment in a number of African countries. If this trend continues, many countries in the region will meet the target of achieving universal primary enrolment (figure 1). Progress is broad, occurring both in countries with very high initial net primary enrolment rates relative to 1990, and in those that had very low initial net primary enrolment rate when the MDGs were adopted.

3 Complicating the picture is the diversion of significant amounts of staples such as maize for ethanol production.

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



Source: *UNSD data.*

For countries for which we have data, between 2004 and 2005, six countries have increased enrolment by more than 4 per cent while in five countries enrolment rates have expanded between 2 and 4 per cent. The remaining countries recorded increases that are between 0 and 2 per cent. 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 Tanzania4 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 from 2005 to 2006, respectively. 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 20045 and 2005. This rate of progress, if sustained, will place more African countries on track to achieve universal primary enrolment.

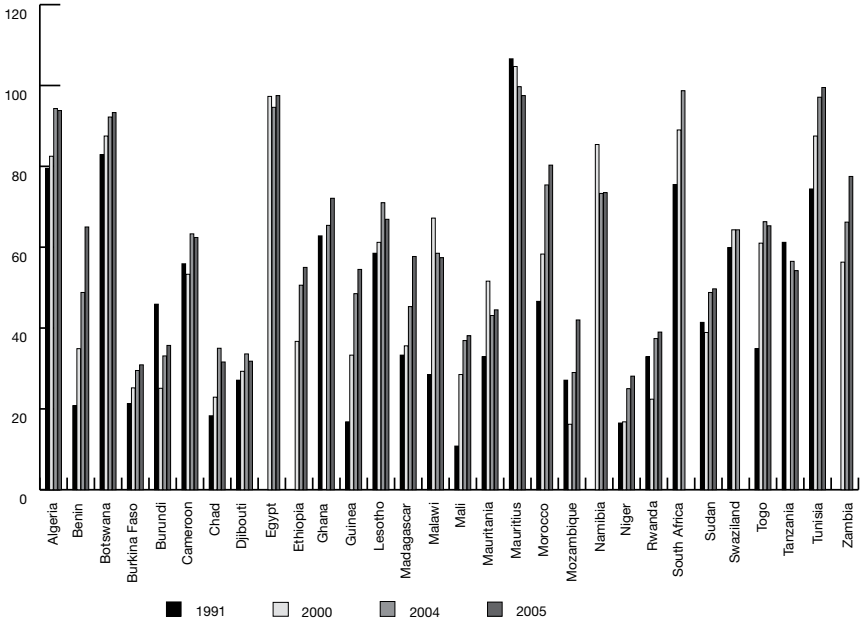
4 Only these three countries have 2006 data on UNSD database.

5 *Assessing progress towards the Millennium Development Goals*, Addis Ababa 2007.

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

Continued improvement in primary enrolment rates has not been matched by a commensurate increase in primary school completion6 rate. Relative to 1991, there has been a significant improvement. However, there has been a slowdown in the recent past as can be seen in Figure 2 below. Benin, Ethiopia, Ghana, Guinea and Madagascar 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, Cape Verde, Mauritius, and Tanzania recorded reversals.

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

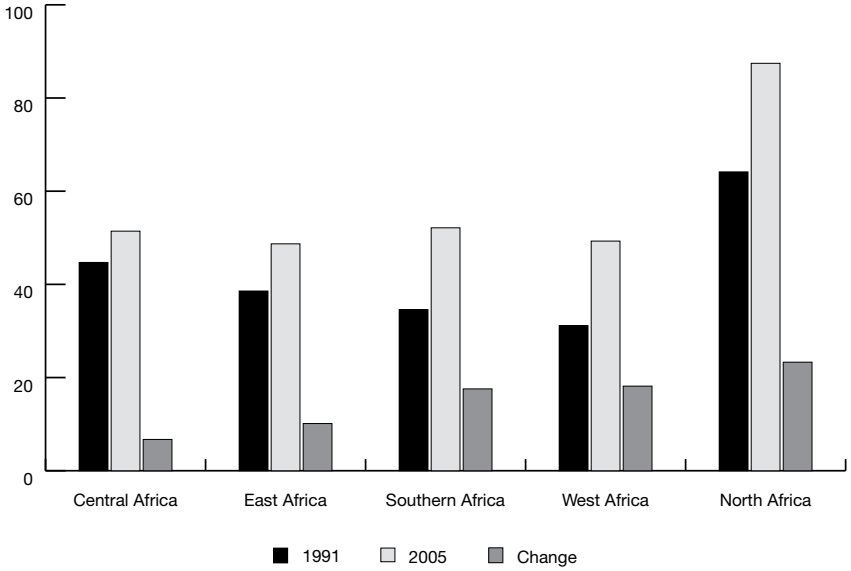


Source: *UNSD database.*

Variation in performance is also evident when the subregions 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 remains on average at 60 per cent over the period under consideration. However, completion rate improved in West Africa in 2005 over 2004.

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).

Figure 3: Changes in primary completion rates across subregions



Source: ECA calculations from UNSD database.

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 (or for girls start a family) prior to completing the cycle. This reduces the incentive to advance to secondary and higher levels of education (UN 2007).

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

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 foreign7 (English or French) language. This is in part, a consequence of improved enrolment in primary education. This trend is observed both in countries with low initial youth literacy rates as well as in countries with high initial youth literacy rate and portend good news for meeting this target.

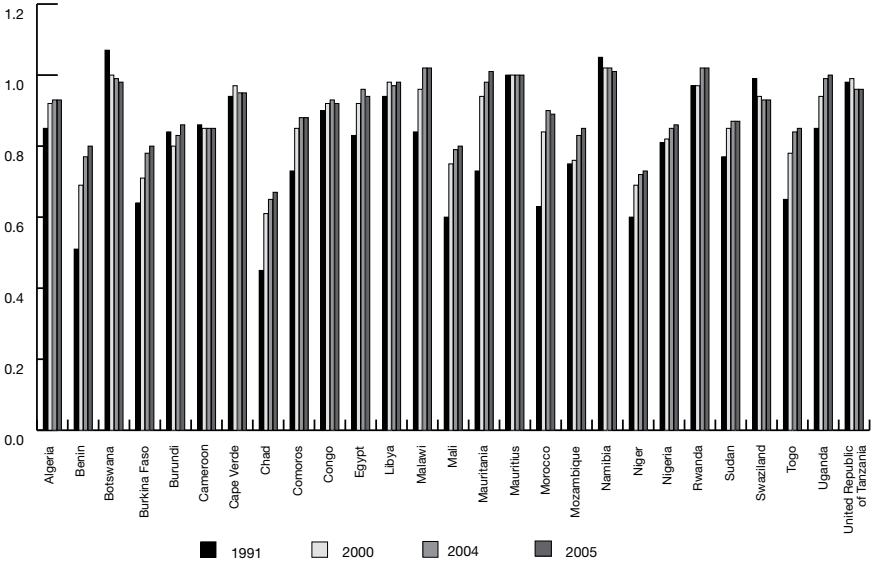
7 "Foreign" meant the language of a former colonial power.

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

Primary education: Most African countries are likely to reach gender parity by 2015[8] (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.

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



Source: UNSD database.

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

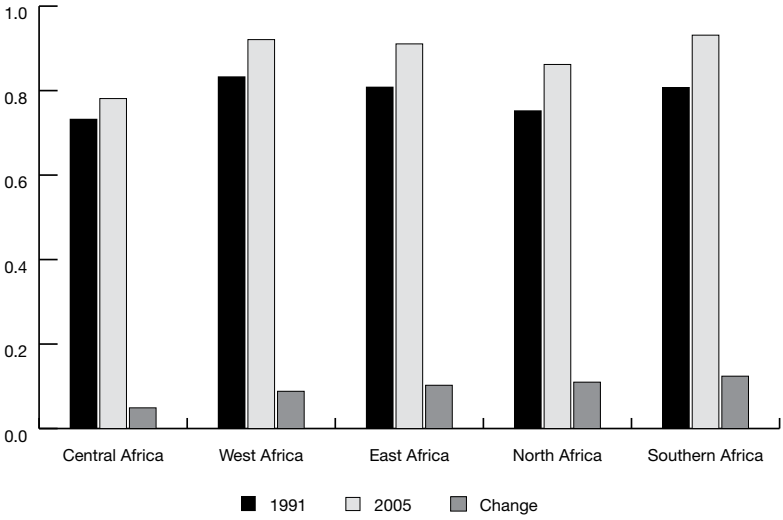
9 Countries that have reached gender parity: the Gambia, Gabon, Lesotho, Libya, Malawi, Mauritius, Mauritania, Namibia, Rwanda, Seychelles and Uganda.

10 Countries with 0.9 achievement of gender parity in primary education in 2005: 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.

The latest available data show that 13 African countries have scaled-up their already significant rate of progress towards gender parity in primary education. The significant progress reported in 2007 and the latest updates confirm that most of the African countries are on track to achieve gender parity in primary education.

However, there are significant variations in the rate of progress at the subregional level. As Figure 5 below shows, parity is highest in southern and West Africa and lowest in North and Central Africa. However, between 1991 and 2005, the latest year for which data are available, southern Africa, North Africa and East Africa made the most progress while West and Central Africa bring up the rear.

Figure 5: Level and changes in girls to boys ratio in primary enrolment across subregions



Source: ECA calculations from UNSD database.

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. The picture of progress is mixed. Consistent with what was reported in the 2007 report, eight11 countries have achieved gender parity in secondary education, while six12 others have achieved a gender parity index of over 0.90. By contrast, 14

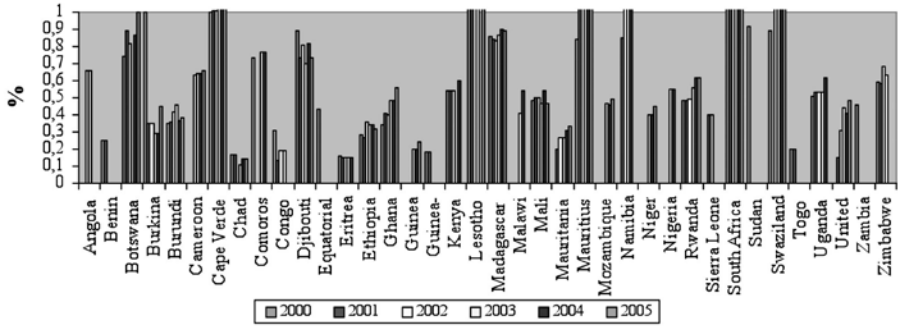
11 Gender parity in secondary education in 2005: Algeria, Botswana, Cape Verde, Lesotho, Namibia, Sao Tome and Principe, Seychelles (2004), South Africa (2004).

12 Over 0.90 in gender parity in Secondary education: Egypt, Kenya. Mauritius, Sudan and Swaziland

countries regressed over the same period.The rate of progress is thus too slow and fragile for this target to be achieved by 2015.

The status of women in universities and tertiary institutions remained unchanged relative to what it was in the 2007 report (figure 6). Nine 13 countries had achieved gender parity. Madagascar and the Sudan are likely to achieve gender parity in tertiary education by 2015.

Figure 6: Gender parity in tertiary education for a selected number of African countries (2000 – 2005)

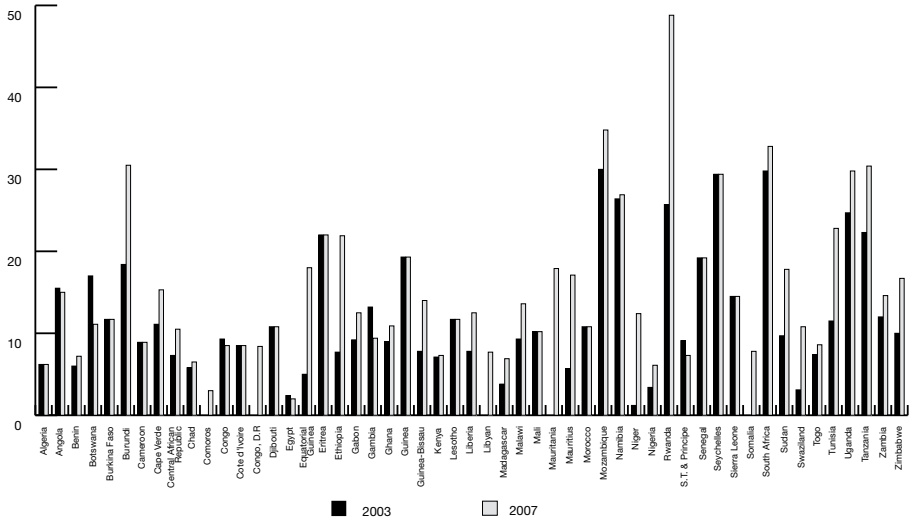


Source: UNSD database.

Women's representation in national parliament has improved in a majority of African countries (figure 7). Africa has the highest reported rate of progress, 10 per cent, on this target in the world over the period 1990 to 2007. But the story is not all together cheerful as 17 countries have shown only a slight improvement over the period 2003-2007.

13 Gender parity in Tertiary education in 2005: Algeria, Botswana, Cape Verde, Mauritius, Libya, Namibia(2004) South Africa. Swaziland and Tunisia

Figure 7: Percentage of women in National Parliament



Source: UNSD database.

Gender parity in decision-making has advanced the 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. Dated (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.

Box 1: Measuring gender parity-AGDI a contribution Source ECA (2006) African

The cross-cutting nature of gender in most of the MDGs poses a problem for identifying comprehensive indicators that capture progress on gender issues adequately. To address the inadequacy of monitoring mechanisms and assist African Governments to track progress towards gender equality and women's advancement, the United Nations Economic Commission for Africa (UNECA) through its African Centre for Gender and Social Development has developed the African Gender and Development Index (AGDI). The AGDI is a tool that maps the extent of gender inequality in Africa and assesses government performance in addressing that issue. The assessment of the AGDI on 12 African countries indicates that African women's income is slightly more than half of that of men in most of those countries. When used to assess the performance of African countries in implementing international and regionally agreed commitments, the AGDI shows that governments score high both in terms of ratifying and developing policies for gender equality. However, their performance is rather poor when it comes to implementing the process.

Source: ECA African Gender Development Index (AGDI).

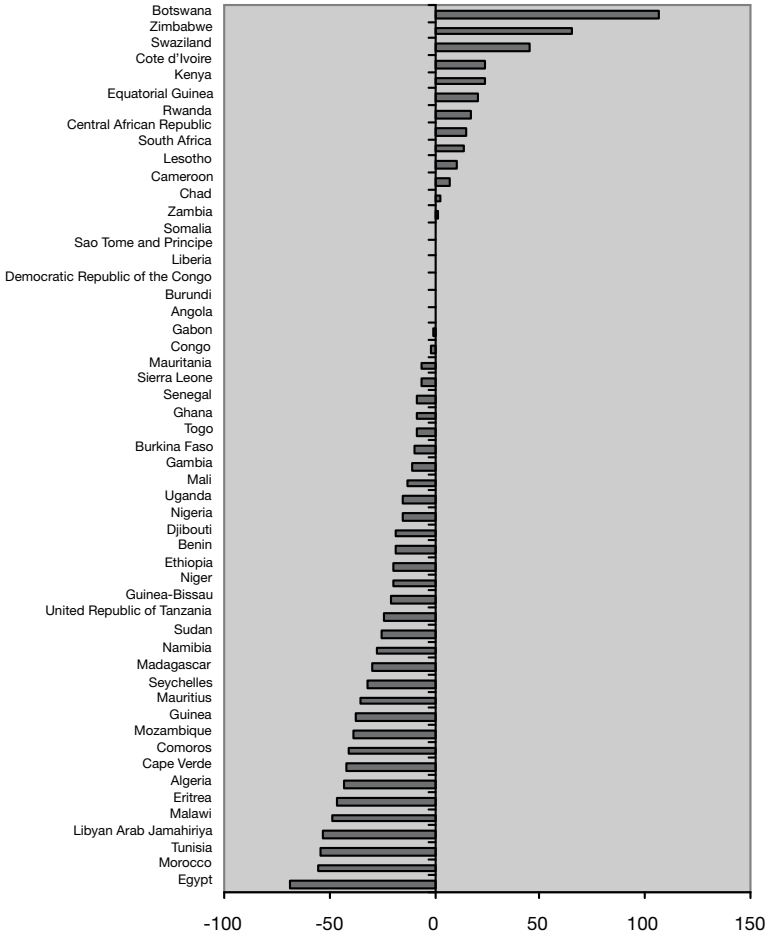
Goal 4: Reduce child mortality

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

Under-five mortality rate

Africa as a region, made very little progress towards reducing under-five mortality rates over the period 1990-2005 (figure 8). The vast majority of African countries experienced negligible improvements in under-five mortality of 1.8 per cent between 1990 and 2005, which translated into an annual improvement of 0.1 per cent. This places most African countries significantly off track to achieving this goal. 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. In some countries, high child mortality is attributable to particular health situations. For example, HIV/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. Conflict is also an important contributor to the high rate of under-five mortality.

Figure 8: Progress14 in under-five child mortality rates between 1990 and 2005



Source: UNSD data.

Several countries such as Eritrea, Ethiopia, Madagascar, Malawi, Niger and Tanzania have made significant progress in reducing under-five mortality in recent years. This progress is lent credence by recent data from UNICEF (2008) which show that under-five mortality in Africa dropped from 166 per 1000 live births in 2005 to 160 per 1000 live births in 2006 (UNICEF 2008). Nonetheless, this rate of progress is below the rate required to meet the MDG 4 by 2015.

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

Infant mortality rate

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

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

The proportion of one year old immunized against measles in Central, East, South and West Africa, as a whole, increased from 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 posted 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 2: 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

Data on maternal mortality ratio is not readily available and updated for all countries. The latest data on maternal mortality ratio from UNSD is up to 2000. Estimated data for 2005 from WHO, UNICEF, UNFPA and the World Bank indicate that the vast majority of African countries experienced a very negligible improvement in maternal mortality rate (MMR) of 1.8 per cent between 1990 and 2005, which amounts for an annual average improvement of 0.1 per cent, off-track to meet the goal. Twelve countries have an 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.

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 2004and declined marginally to 45 per cent in 2005 according to recent UNSD data.

Target 5.B: Achieve, by 2015, universal access to reproductive health

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).

Contraceptive prevalence rate increased from 12.3 per cent in 1990 to 21.3 per cent in married women or women in a stable union during the period 1990 to 2005. 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.

There is a global decrease in fertility rates, and Africa is no an 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.

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.

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 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/AIDS, malaria and other diseases

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

Africa continues to be the region most affected by HIV/AIDS in the world, with almost 68 per cent of the 33.2 million people living with HIV/AIDS globally are 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/AIDS remains a leading cause of adult morbidity and mortality in all of the subregions, 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.

The proportion of women infected by HIV is high and increasing. As of December 2007, women constitute 61 per cent of infected people in the four subregions. 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/AIDS

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

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). Although a number of countries have widened insecticide-treated nets (ITNs) coverage, equitable coverage is just as important. 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 ITN 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

While being on the decline in Northern Africa, the trends in TB incidence, prevalence and morbidity have been on the rise in all other subregions across the continent (table 1). The incidence of tuberculosis in Africa has increased in tandem with the HIV/AIDS epidemic, as people with HIV easily contract tuberculosis infections. The tuberculosis burden is felt most in Southern Africa followed by Eastern and Western Africa. Thirteen of the fifteen countries that have the highest incidence rate of TB per capita in 2005 are 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 Western Africa. In sum, the number of deaths due to TB increased marginally.

Table 1: 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.

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

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 jumped 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 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. 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, as a whole, from 2006 to 2015 is estimated at $ US US519 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.

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).

Box 3: Inequities in access to health care – a constraint to achieving the health MDGs in Africa

Health inequities are avoidable inequalities that are unfair and unjust in access of health services, between regions and population subgroups within a country and have severe implications for human development and achieving the MDGs.

The extremely slow progress towards achieving the maternal and child mortality MDGs in Africa is partly caused by inequities in accessing health services due to social-economic factors such as income, gender, race, rural/urban residency and ethnic background. For example, in a survey of 30 African countries, children under-five living in urban areas were nearly 2.5 times as likely to be sleeping under an insecticide treated net as their rural counterparts and women living in the top income quintile are six times more likely to deliver with skilled personnel at hand (UN, 2007).

ECA recently undertook a study to identify the main sources of inequities in access to and utilization of health care in selected ten study countries that include Ethiopia, Kenya, Ghana, Senegal, Zambia, Malawi, Egypt, Morocco, Chad and Cameroon, based on the analysis of Demographic and Health Surveys (DHS) data. Findings of the study reveal striking evidence of inequities in access to and utilization of health care resulting from income differences and rural urban location. In all the study countries women from the poorest quintiles are less likely than those in better off quintiles to use basic health services such as prenatal care, modern contraceptives, delivery assistance by a health professional, and immunization. Similarly the rural population group is disadvantaged in accessing health care services than the urban population. Inequities are most extreme for delivery assistance, while immunization is the most equitable service across income groups and rural-urban location. Over two DHS time periods, the results reveal that Morocco and Egypt have made some progress in closing the inequity gap, while Ghana, Malawi, Senegal and Cameroon made some marginal progress.

A review of the national health plans of the studied countries indicates that they all made a reference to equity to a varying degree. Some plans have a clear articulation of the health equity objectives and the strategies to be adopted to achieve the equity objectives. However there is generally a need to improve on the targets of the health goals so that they reflect both geographical and financial access. It is also important that the equity objectives are indeed translated into implementation programs that do take place on the ground. Scale-up of resources allocated to health to achieve the minimum commitment of 15 per cent endorsed by African leaders in Abuja is essential to improve implementation. Overall, given the multi-sectoral nature of health, it is important that relevant sectors such as water and sanitation; education, agriculture; transport; social welfare securely mainstream health equity into their sectoral policies to assist in improving geographical and financial access to health care. This can be successfully achieved through integration of health equity in the overarching framework for national development.

Source: ECA forthcoming from computations on DHS data.

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

From 1990 to 2005, land covered by forest decreased in sub-Saharan 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).

On a positive note, the fight against desertification in the Sahel, a critical factor contributing to poverty shows promising results, especially on reversing earlier forest losses (UN, 2007). Furthermore, four African countries increased forest areas by more than 25 per cent, and two African countries have kept the percentage of total area covered by forest at a high 85 per cent (ECA, 2007).

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

In comparison with other parts of the world, Africa's biodiversity is still in a good state relatively. 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).

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

There has been some improvement in 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.

Yet, 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 drinking water by 2015.

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

The proportion of people with improved sanitation in sub-Saharan 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

One of the aims of the World Trade Organization (WTO) Doha Round of Multilateral 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

As of February 2008, 26 African countries have reached the decision point under the Enhanced Highly Indebted Poor Countries (HIPCs) initiative - a voluntary effort started in 1996 and enhanced in 1999 by all creditors to provide debt relief which aims to provide a fresh start to countries struggling to cope with

foreign debt that places too great a burden on export earnings or fiscal revenues. Of these countries 19 have made it to the completion point, the point at which lenders provide the full debt relief committed at the decision point. It is worth noting that the delay HIPCs encounter between decision and completion points has expanded since 2000, and there are still several countries that have not reached the decision point, although eligible to the HIPC initiative.

G-8 countries at their 2005 Summit in Gleneagles, Scotland, in addition to committing to scale-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 will 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.

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 sub-Saharan Africa in the recent past has been due to debt relief and humanitarian assistance[16].

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 ($US1.47 billion) of African debt and committed to double ODA to Africa. Also, India cancelled debts owed by many African countries, within the context of the HIPC initiative.

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.

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

16 The Secretary-General's new initiative, MDG Africa Steering Group, which brings together all the major multilateral financial institutions and the UN aims to correct this. The UN MDG Gap Task Force also aims to address the MDG financing gap.

Section III: Constraints to accelerating progress

In this section, we discuss a few constraints to progress. 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 Report17.

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 Goal 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.

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.

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

17 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".

quality of aid delivery is equally important. 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.

Section IV: Conclusion

This Report has, like its predecessors, 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 it is not all gloomy; that progress is being made, and that the region is on course to reach some targets by the target year.

Much 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. Above all, new mechanisms must be devised to empower Africa to achieve the MDGs.

The Economic Commission for Africa has been scaling-up its support to member States to achieve these goals. Along with the African Union Commission (AUC) and the African Development Bank (AfDB), it prepares an annual report on the continent's progress towards the targets of the MDGs to the African Union Summit. At its January 2008 Summit, the African Union passed a resolution applauding United Nations Secretary-General Ban ki Moon for setting up an Africa MDG Steering Group and mandated the AUC and ECA to report to it on an annual basis, progress made on this initiative.

ECA is scaling-up its diagnostic and analytical tools to scale-up support. It has developed an MDG Mapper to enable a visual representation of comparative

progress across the continent and to enable countries better target interventions at the subregional level. Jointly with the UNDP, ECA is contributing to the development of MDGs-consistent national development strategies as resolved by the 2005 United Nations World Summit.

The critical issue of data is also being addressed by ECA through the African Centre for Statistics (ACS). It is supporting several African countries to conduct national population censuses during the 2010 Round of Population and Housing Censuses (PHC). Progress on this front is very impressive. Twelve countries (Burkina Faso, Cameroon, Congo, Djibouti, Egypt, Ethiopia, Guinea, Lesotho, Mozambique, Nigeria, Saint Helena and Swaziland) have already carried out their censuses between 2005 and 2007. Another 21 countries, namely Algeria, Burundi, Cape Verde, Chad, Cote d'Ivoire, Democratic Republic of the Congo, Eritrea, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, the Niger, Seychelles, the Sudan, Togo and Zambia, plan to conduct censuses during the period 2008-2010. ECA will assist the countries to analyse data collected from these censuses and it is expected that these data will significantly improve tracking and monitoring of progress towards MDGs as well as improve decision-making for accelerating progress.

Appendix I:

Revised MDG monitoring framework including new targets and indicators, as presented to the 62nd General Assembly, and new numbering, as recommended by the Inter-agency and Expert Group on MDG Indicators at its 12th meeting, 14 November 2007

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[1] 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 2.2. 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 Infant mortality rate 4.2. Proportion of 1 year-old children immunized against measles

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/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/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/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/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[2]

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 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	*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 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

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(Footnotes)

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

2 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.