

**THE
MILLENIUM DEVELOPMENT GOALS IN AFRICA:
Progress & challenges**

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STATUS OF THE MILLENNIUM DEVELOPMENT GOALS IN AFRICA: Progress and challenges.

*“We will assist Africans in their **Struggle** for lasting **peace, poverty eradication and sustainable development**”*
United Nations Millennium Declaration, 2000

*“We will spare no effort to free our fellow **men, women, and children** from the abject and **dehumanizing** condition of **extreme poverty**, to which more than a billion of them are currently subjected”*
United Nations Millennium Declaration, 2000

But repeatedly asked?

“Will the legacy of our generation be more than a series of broken promises?”
Nelson Mandela 2001

1: INTRODUCTION

During the United Nations Millennium Summit held in September 2000, world leaders placed development at the heart of the global agenda by adopting the Millennium Declaration and a set of accompanying Millennium Development Goals (“MDGs” or “Goals”), which set clear targets for reducing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015.

The millennium development goals MDG originated from a series of UN resolutions and agreements made at the world conference held over the past decade, the goals were put forward with recognition that, while substantial improvements in living conditions have occurred in many countries, performances have been uneven and painfully slow in much of the developing world. The problem of faltering social progress is especially acute in Africa, contrast to other regions that have witnessed more sustained improvements in living standards. Further more, in the light of the weak and often unstable macro economic performances in much of the sub-Saharan Africa coupled with the prospects of continued civil conflicts and vulnerability to negative shocks due to weather and related

natural events, and the fact that fertility rates and population growth out pace other regions, realizing the MDGs in the years ahead will be a difficult and challenging task for Africa and especially Sub-Saharan Africa.

The MDGs embody the aspiration for human development expressed in limited set of numerical and time –bond targets which are to be achieved by the year 2015 from their level in 1990. Poverty is a term that is commonly used in development circles and debate. Africa has within development discourse almost become synonymous with poverty due to among others the media coverage of the many incidences of fleeing refugees, internally displaced people, disease, hunger, civil wars, corruption, poor governance etc. It is important to note that poverty is multidimensional which includes material deprivation in so far as income and consumption is concerned and social marginalization. Social poverty in this case results mainly from low achievements in health and education which in turn render the poor vulnerable, voiceless and powerless in society.

Although global wealth, technological capabilities, and linkages have improved greatly during the last fifty years, the wealth is however, unequally distributed thus creating major gaps regionally and nationally. For instance, the gap between the 20 richest and 20 poorest nations has doubled in the last forty years (World Bank 2001). Out of the 6 billion people in the world, 2.8 billion live on less than 2 \$ and 1.2 billion live on less than 1 \$ per day. As far as regional manifestation of poverty is concerned 43.5% of the poor live in South East Asia; 24.3% in Sub Saharan Africa; 23.2% in East Asia and Pacific; 6.5% in Latin America and the Caribbean; 2.0% in Europe and Central Asia and 0.5 % in Middle East and North Africa (World Bank 2001).

The presentation on poverty eradication in Africa will focus on the United Nations Declaration on Millennium Development Goals (MDGs) as a departure point. For the last forty years, the UN continuously declared development decades with a view to combating poverty which were also implemented. During the 1990s however, most UN conferences and declarations on global poverty eradication indicated failure to attain the objectives set. In fact it was observed at the UN Social Summit held in Copenhagen, Denmark in 1995, that poverty had become a global phenomenon and not merely a developing countries feature.

Given the global nature of poverty and threat to human security the UN was prompted to initiate another approach to poverty eradication that aims at engaging all key players in development including lessons learnt from past experiences/interventions. Hence the UN declaration on MDGs that set several goals for the 21st century. The declaration of the MDGs was in September, 2000 in New York by the entire global community.

2: WHAT ARE AND WHY THE MILLENNIUM DEVELOPMENT GOALS?

By the year 2015 all the 191 United Nations members states have pledged to meet the eight MDGs as stated below:

- **Eradicate extreme poverty and hunger:** to reduce by half the proportion of people living on less than a dollar a day and to reduce by half people who suffer from hunger.
- **Achieve universal primary education:** ensure that all boys and girls complete a full course of primary schooling.
- **Promote gender equality and empower women:** eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.
- **Reduce child mortality:** reduce by two thirds the mortality rate among children under five.
- **Improve maternal health:** reduce by three quarters the maternal mortality ratio.
- **Combat HIV/AIDS, malaria and other diseases:** halt and begin to reverse the spread of HIV/AIDS. Halt and begin to reverse the incidence of malaria and other major diseases.
- **Ensure environmental sustainability:** integrate the principles of sustainable development into country policies, strategies and programmes by all countries by 2005; reverse loss of environmental resources by 2015. Reduce by half the proportion of people without sustainable access to safe drinking water. Achieve significant improvement in lives of at least 100 million slum dwellers by 2020.
- **Develop a global partnership for development:**
 - 1). Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. This includes a commitment to good governance, development and poverty reduction-nationally and internationally.
 - 2). Address the least developed countries' special needs. Which includes tariff-and quota-free access for their exports; enhanced debt relief for heavily indebted countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction.
 - 3). Address the special needs of landlocked and small island developing states.

- 4). Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term.
- 5). In cooperation with developing countries, develop descent and productive work for youth.
- 6). In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
- 7). In cooperation with the private sector, make available the benefits of new technologies – especially information and communications technologies.

Note: The bench marks for the attainment of MDGs are based on the figures of 1990.

Both goals one and eight are important because other goals address an aspect of poverty and are mutually reinforcing while partnership is equally crucial in harnessing resources and technologies as well as ensuring collaborative endeavours.

2.1: THE ROLE OF DEVELOPMENT ACTORS

In order to achieve the above goals, roles and responsibilities are assigned to various development actors which in summary are the following:

1: Developed Countries

- Ensure that their macroeconomic policies contribute to stability and growth in the world economy through for example, curbing inflation, physical policies/taxation, monetary etc.
- Increased support in the area of trade policy and development by opening up market, removal of subsidies, increasing levels bilateral aid – financial support to developing countries.

2: Developing Countries

That the developing countries;

- Fully understand a development agenda, lead and own it -- Thus the developing countries must own and be the driving force for MDGs to succeed.
- Put in place the *enabling environment for achieving the MDGs* through adoption and implementation of appropriate policies that lead to achievement of pro-poor economic growth, private sector investment, and empowerment of the poor.
- Develop and implement policies for enabling economic climate e.g sound macroeconomic policies; policies to enhance investors' confidence; appropriate

trade policies; good governance and appropriate financial and physical infrastructure.

- Investing in the Poor by giving access to key public services, ensuring social inclusion

- 1). Improved quality of services
- 2). Improved public sector governance
- 3). Provision of we targeted safety nets – participation in decision making

- Environmental Sustainability

3): Multilateral Institutions

- Monitoring the progress made by states towards the achievement of MDGs led by UN which is supported by a research and advocacy.
- UN Team led by UNDP supports respective countries with monitoring progress.
- MDG Reports are produced to create awareness, promote study and debate around the great development challenges.
- MDG Reports also meant to help focus the national debate on key development priorities.
- MDG Reports build on Common Country Assessments, Poverty Reduction strategy Papers/ National Human Development Reports.

Note: It is expected that each country will by the end of 2004 have produced at least one timely report to the Secretary General UN. So far many have not submitted.

4: The World Bank, IMF and Regional Development Banks

The multilateral financial institutions including regional banks are mandated to engage in policy dialogue with respective countries and report to their Boards progress.

5: The International Donor Community

- Provide the financing needed to achieve MDGs about \$40 to \$60 billion is required in order to realize MDG goals.

6: The Poor

To assume centre stage in the design and implementation and monitoring of poverty reduction strategies.

7: Civil Society and Faith Based Organizations

There is very little mention of the role of these critical actors in MDGs except general recognition.

3: MDGs COMPLIANCE BY MEMBER STATES AND OTHER DEVELOPMENT ACTORS

An effort is hereby made to determine how far the various actors have come in terms of performance and commitments since four years ago. In a summary form the following are observed:

- North Africa has performed very well. All of the member states are on track. This should not be a surprise given the level of their per capita income, government political commitment and their geographical proximity to the developed world.
- In Sub Saharan Africa a few countries are more or less on track. For example, Uganda, Mauritius, Botswana, South Africa, Senegal but most others are lagging behind.
- The multilateral institutions and other development partners are not fully on course in terms of their financial commitments. As the time factors, quantity and quality are not met hence MDG number eight remains a big challenge.
- It seems that the role of civil society remains undefined and many within the sector itself although making a substantive contribution to poverty alleviation is not fully conversant with the MDGs.

These targets are often said to be easily set but seldom met ,but in fact the 1990s saw many success stories in Africa where a number of countries; Cape Verde, Mauritius, Mozambique, and Uganda have had sustained growth rates close to 7 or 8 % per year. The peaceful transition from apartheid to democracy in South Africa ,as well as the lengthening list of countries where democratic elections took place during the 1990s to 20s including but not limited to - Benin, Cape Verde, Ghana, Malawi, Senegal, Tanzania, Uganda, Nigeria and Kenya underscores the aspiration for democratic governance and the protection of human rights .

In addition to the improvements of education in Guinea, Malawi and Kenya, reduction in child mortality rate in most of the countries with exception of Kenya, Cameroon and

Zambia, as well as the commitment to reduction of HIV/AIDS in Senegal and Uganda deserve to be highlighted as concrete achievements.

Turning to the other side of the coin, certain set backs have been experienced over the past decade, the primary school enrolment dropped in Cameroon, Lesotho, Mozambique and Tanzania among many other countries. The gender gap in primary education did widen in Eritrea, Ethiopia and Namibia and as if expected most countries saw their HIV prevalence rate increase several times during the 1990s, severely undermining the feasibility of most MDGs, in health and beyond while there was slow progress on child mortality, basic education and malnutrition, improved water supply , maternal mortality and gender discrimination in primary enrolments.

Given the available generalized evidence on the performance of regions towards realizing these goals, the empirical evidence on how well particular countries are performing relative to these goals remains sparse. Where information exists, it is often not based on the type of detailed empirical analysis of data needed to get accurate progress report and thus general averages apply.

While averages give a good sense of overall progress/growth they can be misleading since different groups in the society usually have very different levels of social and economic well being based on a wide range of characteristics such as gender, age, location (urban/rural) ethnicity, religion, or wealth and failure to disaggregate these would tend to hide away the real realities that shed light on the most disadvantaged groups in a society.

The first seven goals as discussed below are mutually reinforcing and are directed at reducing poverty at all level while the last goal -global partnership for development - is about the means to achieve the first six goals.

3.1: PERFORMANCE PER GOAL

GOAL ONE: ERADICATE EXTREME POVERTY AND HUNGER.

“**Target 1:** Half, between 1990 and 2015 the proportion of people whose income is less than 1 dollar a day”.

“**Target 2:** Half, between 1990 and 2015, the proportion of people who suffered from hunger”.

The MDGs call for the reduction of the proportion of people living on less than a dollar a day to half the 1990 level of 27.9 % by 2015. Sub-Saharan Africa has the highest proportion of people living in poverty, with nearly half of its population below the international poverty line which means that some 300 million people face the daily struggle of surviving on less than one dollar. Between 1990 and 1999, the number of poor people in the region increased by one – quarter, or over 6 million yearly and if the current trend is maintained then Africa will be the only region where the number of poor people in 2015 will be higher than in 1990.

Though several intervention measures in form of government policies have been advanced to reverse the rising rates of poverty, these have met stiff pressure from certain factors resulting to weak economic performance especially during the 1990s.

- Population growth rates have been on the rise over the decade as compared to the general economic growth resulting in to the decline in the per capita income in these countries.
- Economic performance was also highly uneven across countries: twenty countries with more than half the regions population are actually poorer now than in 1990, while per capita grew by less than 1% in a further six countries. In only five countries was growth greater than 3 per cent during the decade.
- Political turmoil and civil unrests in a significant number of countries were a major factor in the regions weak growth factors as a group. The worst affected countries included Angola, Burundi, DRC Congo, Rwanda, and Sierra Leone – which saw their GDP decline.

- The vagaries of weather has been another important contributor to poor performance of many countries predominantly commodity exporters. Protracted drought in Eastern, Southern Africa and Horn of Africa, as well as typhoons and floods in Southern Africa, resulted in a major disruption of agricultural production, which constitutes the main source of livelihood for the bulk of Africa's population.
- Poverty reduction measures were further complicated by the highly skewed income distribution-Equatorial Guinea, Gabon, Guinea , Kenya ,Lesotho, Senegal, South Africa, and Zambia are among the countries with unequal income distribution. These inequalities not only inhibit growth but they also cancel out the positive impacts growth has on poverty reduction.

As a result of this income poverty the proportion of the population below the minimum level of dietary energy consumption in Africa which stood at 29 per cent in 1990, declined by 1 percent to 28 per cent way above the expected 14 per cent by 2015 representing the little progress made in tackling food insecurity and malnutrition in these countries. In 18 out of the 40 Sub-Saharan countries, the proportion of the under nourished was very high, affecting one third or more of the population while in 6 of these, the proportion of under-nourished people is actually increasing.

The problem is especially severe in Central, East and Southern Africa, where almost half of their combined population of 360 million is undernourished. Children and women are particularly the vulnerable groups, to food insecurity. The situation is further aggravated by;

- The ever increasing population, result to increase of under weight children under 5 years of age through out the region estimated to be 8 million children in the sub Saharan Africa alone.
- Desertification which affects the agro-pastoral activities also does aggravates the situation given that almost one third of the land area is already affected.

- Problems of escalating soil erosion, rapid population growth, inequitable persistent drought, land distribution and poor farming methods often exacerbate the declining fertility.
- The spread of HIV/AIDS which does also have devastating effects on families and communities as it affects their productivities and the nutritional demands.
- Women status in the society, and particularly the level of women's education, has an important bearing on the household well-being.

Note: The approach of PRSPs has not yielded the desired fruits as will be further explained. Moreover, lack of food policies by many a government undermines the goal especially when arable land is used to produce export goods such as flowers and not food. Therefore poverty eradication remains elusive due to a combination of factors including international and national structural issues and policies.

GOAL TWO: ACHIEVE UNIVERSAL PRIMARY EDUCATION.

“Target: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education”

The conference on education for all, held in Jomtien, Thailand, in 1990, pledged to achieve universal primary education by 2000. But as history has it in 1999 there were still 120 million primary school – age children not in school, three-quarters of them were in south Asia and Sub – Saharan Africa .

The adoption of MDG did set a more realistic but still difficult deadline of 2015 for all children to complete full course of primary schooling. In many of the affected countries, schools registered a rise in enrolment of children but reported large gaps between reported enrolment, attendance and completion rates over the past decade.

In Sub-Saharan Africa the net primary school enrolment ratio grew by 6 % points over the decade, from 60% in 1990 to 63% in 2000. The increase was faster for girls (63% to 65%) than for boys (63% to 65%) there by closing the gender gap. **But despite this only seven countries are on track to make primary education universal by 2015.**

The main challenge hindering the attainment of this goal by most countries in Saharan Africa is the operational costs of running free primary education by the already overstretched governments, in addition to the divergent social, political, economic, and cultural factors surrounding the different communities and countries.

Urban-rural disparities in net primary school enrolment are also all too common. In some countries, the ratio in urban areas is two or three times as high in the rural areas while in countries like Burkina Faso, Mali, or Senegal, there are three urban children going to school for every child of primary school age attending a rural school, while in others e.g. Kenya the gap declined almost entirely during the decade as the government declared free education for all school going aged children. A lot of emphasis should therefore be placed on the achievement of this paramount since within it lies the chances of reaching other MDGs goals as it unlocks positive externalities and synergies.

GOAL THREE: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

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

In most low – income countries girls are less likely to attend school than boys, and even where girls start school at the same time as the boys, they are more likely to drop out-often because of the parents' traditional and cultural thinking that boy's schooling is more important or that girl's work at home seems more valuable than schooling. This gives the reason as to why more young girls are illiterate than boys. In an effort to address this, the MDGs call for the elimination of gender disparities in primary and secondary by 2005 and at all levels by 2015.

In Sub Saharan Africa the gap between the girl and boy net primary enrolment ratios has declined over the past decade. In more than half of the countries in Africa girls enrolment represents over 90% that of boys, and in Botswana, Malawi, Namibia, Tanzania, Zambia and Equatorial Guinea, the net enrolment of girls is equal or even larger than boys.

In other countries the gap is still evident with up to one third or more below that of boys especially in countries where the overall net enrolment is low, while some countries even experienced worsened gender ratios- Eritrea and Ethiopia did register marginal increase of both male and female enrolments ,but most of the gains accrued to boys.

On average female literacy rose as a proportion of male literacy throughout the 1990s. For every ten literate men in 1990, less than seven women could read and write. Currently, for every ten literate men, almost eight women are literate. The smallest reductions in female/male disparity occurred in countries where female to male literacy ratios already were over 90 per cent, that is in -Botswana, Lesotho, Mauritius, Namibia, South Africa, Swazi-land, and Zimbabwe. In Botswana and Lesotho, female literacy is actually higher than that for males, while by contrast, countries with the largest increases in the proportion of literate women to literate men are those with the lowest overall literacy rates and where primary schooling has expanded, even if slowly- Ethiopia, Mali and Nigeria. *Despite steady improvements in closing the gender gap in literacy, the pace will need to accelerate if the goal of gender equality is to be achieved by 2015.*

Evidence shows that babies born to mothers without formal education are at least twice as likely to suffer from malnutrition or die before age 5 than are baby boom to mothers who completed primary school. An educated girl is also the best guarantor that her children will attend school thereby ending the inter-generational transmission of poverty. Girls' education, therefore, is key to achieving the MDGs.

GOAL FOUR: REDUCE CHILD MORTALITY

Target: Reduce by two thirds, between 1990 and 2015, the under- five mortality rate (U5MR).

Almost one of six children in the sub Saharan Africa will not live to see their fifth birthday .Though the U5MR declined over the years, the progress has been too slow to achieve the universal goal. Nevertheless some African countries seem to be on track for meeting the target–Equatorial Guinea, Eritrea and Guinea achieved over 20 % reduction in U5MR over the past decade. Cape Verde and Comoros reduced U5MR by one third while even larger reduction were registered in Egypt , Gambia, Morocco, and Tunisia, but in contrast, in many countries where the spread of HIV/AIDS is high there was increased levels of U5MR.

The diversity observed across countries is also reflected in the presence of vast socio-economic disparities within countries. When households are ranked from the poorest to the wealthiest, a distinct pattern emerges: a child from a rich family invariably faces a much lower risk of premature death than a child from a poor family. On average, the latter is twice as likely to die than the former before age 5. The gap in terms of mortality between the bottom 20 per cent of a country's population and the top 20 per cent increased in most countries, including in Ghana, Kenya, Tanzania and Zimbabwe, while only Togo reported a significant improvement over time in child mortality for the poorest quartile vis-à-vis the richest quartile.

Gender disparities are usually not significant in child mortality. But differences between urban and rural families normally are. In some countries - Kenya, and Tanzania, the rural U5MR is only 20 per cent higher than in urban areas, but they are almost double the urban rates in Burkina Faso or Senegal.

Measles is among the leading causes of child mortality that can be easily prevented through immunization. Because of its contagious nature and the fact that a small number of those vaccinated do not develop immunity, immunization coverage must be at least 90 per cent to prevent deaths from measles. Yet the proportion of children immunized

against measles was much lower in Africa, representing an 11% drop from the 66 % level in 1990 to about 55 per cent in 2000. Only Egypt, Eritrea, Gambia, Libya, Morocco, Seychelles, and Zambia surpass the 85 per cent coverage. The level of immunization against other child-hood diseases is not very different.

Therefore despite the wide spread availability of safe and effective vaccines. Measles continues to be a major killer of children in sub Saharan Africa. In countries like Burkina Faso, Central African Republic, Congo, the Democratic Republic of Congo, Djibouti, Equatorial Guinea, Ethiopia, Gabon, Nigeria and Togo for example, saw a dramatic drop in immunization against measles by at least 20 percentage points of the population.

Amidst all this, still a few countries -Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Namibia and Niger succeeded in achieving more than 20 per cent growth in the coverage of measles vaccine between 1990 and 1999 though none had surpassed 75 per cent coverage by the end of the decade.

The greatest challenge facing the governments and the international communities remains the need to educate and sensitize the communities and especially the rural communities on the importance of immunization and post natal care besides availing the same services to them.

GOAL FIVE: IMPROVEMENT OF MATERNAL HEALTH

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

The WHO and UNICEF estimates that more than half million women in developing countries die from complications of pregnancy and child birth, the leading causes of death and disability among women of reproductive age.

In Sub-Sahara Africa alone complications during pregnancy and childbirth causes the death of approximately 250,000 women each year i.e. about one in every two minutes. The countries with the highest maternal mortality ratio include; Rwanda, Sierra Leone, Burundi, Ethiopia, Somalia and Chad. The continent is also home to seven of the twelve countries with the highest number of maternal deaths in the world i.e. Ethiopia (46,000 per year), Nigeria (45,000) Democratic Republic of Congo (20,000), Kenya (13,000) and Sudan (13,000), Tanzania (13,000) and Uganda (10,000) The above mentioned seven countries account for one- third of all maternal deaths in the world.

Accessibility to maternal health care and to health facilities in general still poses a big challenge to many governments in Africa especially within the rural populations which accounts to majority of the people. This problem is further compounded by the high poverty and illiteracy level characterized in these areas.

There is consensus that the proportion of births attended by skilled health personnel; doctor, nurse or midwife is very closely correlated with maternal mortality and therefore access to the care by a skilled health provider at childbirth when obstetric complications are more likely to occur greatly reduces maternal Mortality.

There is also need to educate the communities on the importance of wider spacing of pregnancies, proper nutrition, and prenatal care.

GOAL SIX: COMPACT HIV/AIDS

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

With an estimate of over 40 million people living with HIV/AIDS and 20 million deaths since the disease was identified, AIDS poses an unprecedented public health, economic and social challenges, these broader and deeper development implications of the pandemic are nowhere more vividly underscored than in Africa where half of all new HIV infections are among the adolescents 15-24 year olds while many adults die at their prime age. WHO estimates that there were 2.3 million AIDS related deaths in Sub Saharan Africa, with the adult prevalent rates estimated to be over 8.4%.vis -a- vis the global HIV/AIDS prevalent rate is which stood at 1 %.

In Southern Africa, there are seven countries with prevalence rates above 25 per cent, with the highest in Botswana at about 35 per cent. Even countries with a relatively low national HIV prevalence have pockets of cases that are concealed by national statistics for there are clusters of people or specific locations where the prevalence rate is as high as 20 percent or more.

However, about one-third of those currently living with HIV/AIDS are young women with little or no education and those without much empowerment from society. In many parts of Africa, teenage girls are five to six times more likely to be infected by the HIV virus than boys their age. Further, due to myths girls and women are raped thereby increasing the risk of infection for women.

The war against the spread of HIV/AIDS faces several challenges across the nations;

- In many countries, open and frank discussions about HIV transmission face a wall of silence. Four allies make the virus so prevalent in many societies; silence, shame, stigma and superstition. These four S's thrive in a climate of ignorance and illiteracy, making education a key to defeating this deadly alliance by dispelling stigma, discrimination and denial.
- Absenteeism and deaths among teachers as a result of either being infected or affected also does aggravate the situation. In Zambia alone, 1,300 teachers died in the first ten months of 1998 twice the number of deaths reported in the previous

year, and in the Central African Republic, 300 teachers died in 2000, 85 per cent of them because of AIDS as several African countries are reportedly losing more teachers than the number of new recruits thus negating the very efforts of promoting education which is closely linked to the spread of HIV/AIDS.

- HIV/AIDS also reduces the demand for basic education, due to family's inability to pay for schooling, as the available resources are diverted towards meeting the medical demands of the infected.

HIV/AIDS has, therefore, become the leading cause of death in the African continent- It not only constitutes a serious constraint to growth and stability of most African economies and societies, but it has actually begun to destroy the hard-won development gains even of countries like Botswana, South Africa and Zimbabwe. As former President Nelson Mandela put it very vividly, "AIDS to day in Africa is claiming more lives than the sum total of all wars, famines, and floods, and the ravages of such deadly diseases as malaria."

How can development partners assist improve the health systems that are so crucial to treatment which many currently are unable to access to lack of functioning health service delivery system? How can the drugs be made available when pharmaceutical companies want to trade in patents at the expense of life by making generics difficult to market? What are the politics of HIV/AIDS that development actors are not discussing? Is it moral to deny people medication because of government politics? In spite of available resources, they are not reaching the poor and sick at community levels why?

GOAL SEVEN: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target: Half, by 2015, the proportion of people without sustainable access to safe drinking water.

Africa is richly endowed with natural resources but it has yet to put in place an effective and efficient system to enable it to fully exploit their development potential. And how can it do so when wars and conflicts including over the same resources continue unabated? Since environment is the main source of goods and services that sustain human development there is need to ensure that development interventions are concerned about a sustainable environment. This is particularly true for poor people whose livelihoods rely heavily on environmental services. In addition, they are disproportionately affected by the impacts of degradation. The sustainable use of natural re-sources can improve the lives of the poor in many ways, including reducing vulnerability, increasing income, and improving health. Progress has been made in many areas, but challenges persist and new ones are emerging. Due to the degradation of environment, a number of communities are changing their healthy diets to poor ones and thereby increasing the rate of health infections and disease.

Access to a safe and reliable water supply's a key determinant of health. Over the last decade nearly one billion people gained access to an improved water source, though 1.1 billion people still lack access. Of these people, more than 40 percent live in East Asia and the Pacific, 25 per-cent in Sub-Saharan Africa, and 19 percent in South Asia. Despite the achievements of the last decade, 1.5 billion more people must gain access to safe drinking water to reach a global coverage rate of 90 percent by 2015, and the quantity of water must be improved for many more.

Access to improved water in urban areas has slightly declined during the 1990s, as the urban population increased faster than the expansion of safe water supply systems, especially in marginal and peri-urban areas. Although the trend has been more positive in rural areas, the pace of progress has been quite slow.

Improvements in safe water supply, and in particular in hygiene and sanitation, can reduce the incidence of diarrhea, as well as the number of under-5 deaths. Yet the proportion of African people enjoying access to adequate sanitation (both in urban and rural areas) has stayed essentially the same during the last ten years.

Lack of sanitation is a major public health problem throughout the region. Poor sanitation in school buildings makes them unsafe places where diseases are easily transmitted. It impairs children's health, limits school attendance, and negatively affects students' ability to concentrate and learn. Indeed, about one in ten school-age African girls drop out at puberty because of lack of clean and private sanitation facilities in schools.

Access to improved sanitation facilities has increased, but 2.4 billion people still lack sanitary means of disposing of human wastes, including more than half of all those living in Asia. About 80 percent of those lacking adequate sanitation live in rural areas.

A few countries did manage to register some progress through the 1990s. An additional 12 per cent of the population gained access to improved water in Cote d'Ivoire, followed by Mali (10 per cent), Central African Republic (9 per cent) and Kenya (9 per cent). In turn, Senegal (13 per cent) and Chad (11 per cent) registered the fastest progress in sanitation.

But still, an additional 400 million persons will need to be provided with safe water supplies to reach the target by 2015. This implies roughly a tripling of the pace observed during the 1990s and roughly a similar numbers of additional people, both in urban and rural areas, will need to gain access to sanitation to meet the 2015 goals. This represents a rate of progress about four times higher than in the preceding decade.

A major concern is the privatization of water in urban areas in the effort to ensure efficiency and effectiveness. Unfortunately such undertakings show that the poor are further marginalized as they are unable to access the water which is a major contradiction of the MDG.

GOAL EIGHT: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target 1: Develop further an open, rule based, predictable, non-discriminatory trading and financial systems.

Target 2: Address the special needs of the least developed countries.

Target 3: Deal comprehensively with the debt problems of the developing countries

Achieving the MDGs will require greater international cooperation and assistance by the industrialized countries. While much will depend on the actions of developing countries and on the policy frameworks they have in place, the support of the international community is very critical.

Despite the commitment of the international community to the international development goals that preceded the MDGs, the real value of aid to developing countries is down about 8 percent in the past decade. Combined with the weak trade performance and the continent's inability to attract foreign direct investment in significant quantities, the reduced flow in ODA further constrains Africa's growth and poverty reduction efforts.

Africa's continuing heavy debt burden is another important constraint. As at the end of 2000, the continent's total debt stock was estimated at \$206 billion, up from \$177 billion in 1990. Close to 60 per cent of it is owed to bilateral creditors, much of it in non concessional form, and another 25 per cent of multilateral institutions. On average, therefore the ratio of the region's total external debt to its exports of goods and services stood at 180 per cent in 2000, while the ratio to GNP was 66 per cent.

As a result of this, many countries spend more on debt servicing, sometimes three to five times more than on basic social services. On average, Sub-Saharan countries spent about twice as much to comply with their financial commitments vis-a-vis external creditors than to comply with their social obligation vis-a-vis their population. To spend more on external debt than on basic social services when tens of millions of people lack access to basic education, primary health, adequate food and safe drinking water makes little economic and moral sense.

The HIPC Initiative under the debt relief framework would therefore need to be enlarged and sustained .The industrialized countries would also need to reduce the agricultural subsidies and remove the remaining protectionist trade barriers that still discourage

exports, particularly from the less developed countries with a greater bias on the manufactured good vis avis the primary commodities as a means of encouraging export diversification.

The average growth rate of Africa's exports of manufactured goods was over 30% per year in the 1980s but slowed down to less than 3 per cent in 1990s. The extent of export diversification actually declined during the 1990s, with exports largely concentrated on primary commodities. In addition, the regions share of the worlds export market for primary commodities witnessed a declined from about 5 per cent in the 1980s to less than 3 per cent in the1990s. Coupled with deteriorating terms of trade, the weak export performance inhibited renewed economic growth in the 1990s.

Thus a lot still needs to be done by both the African countries and the international community to ensure that there is continuous economic growth and development ensuring that the millennium goals are not just broken promises but a reality. More critical to note is that economic growth without equitable distribution will not bring about sustainable development and poverty reduction. This is why even where countries experience economic growth and policies are anti-equitable distribution and also not pro-poor, poverty continues to be rampant.

Just as Koffi Annan, the UN Secretary General said in the opening of the Children's Summit in may 2002 "We the grown ups must reverse the list of failures," the MDGs remain unfulfilled, but they also remain feasible and affordable.

If the legacy of our generation is to be more than a series of broken promises, then committed leadership, strong partnership, and deeper participation by the poor are needed to bring the region back on track towards the MDGs.

4: CHALLENGES

- Despite the UN Millennium Declaration on MDGs poverty is still rampant among various countries especially those experiencing war like the Great Lakes region,

Horn of Africa and where economic mismanagement still persists due to corruption for instance Kenya.

- Lack of political will and commitment as well bad governance.
- Unsound/prohibitive macroeconomic policies especially trade policies.
===== debt burden,
===== trade barriers in developed countries,
- Lack of effective participation by civil society
- High population growth in some countries.
- The prevalence of HIV/AIDS and other diseases e.g malaria, TB etc

5: The Way Forward to Poverty Eradication

- The need for consistent and systematic monitoring and evaluation of the MDGs achievements. Herein lies a critical role of FBOs and CSOs.
- Stronger coordination among the key players in the implementation of the MDGs.
- Pledges by the member states, multilateral institutions and donor community must be honored.
- The poor who are vulnerable, voiceless and powerless must be included in the decision making.
- Patterns of consumption and resource utilization must be addressed with a view to ensuring sustainable development and integrity of creation in particular the industrialized countries and the elite in the south.
- Women's potential needs to be harnessed and used appropriately for the common good.
- There is need for a visionary, committed and focused leadership.
- Evolution of a new value ethical system that affirms human dignity and sharing of resources as opposed to resource generation for profit purposes.

- Embrace African initiatives such as NEPAD and creative and innovative national plans that are pro-people.

Critique the PRSP Methodology in order to ensure

See the attached paper that assesses the current dilemmas and challenges of PRSP.

To conclude, the efforts of the poor and FBOs who have worked on poverty for a very long time must be included in the MDG agenda for it to be successful. Issues of Faith and Culture are not adequately addressed and yet they are at the heart of behavioural change. And it is evident that the rich and the poor must change if we have to co-exist peacefully and if at all mother earth is to continue to remain a hospitable dwelling place. Sustainable environment is not simply for purposes of exploitation but for living in harmony. The poor continue to cry to their God to hear and see their suffering and pain. Are the international institutions really concerned about them or shall they continue to ride on their poverty?

ANEX 11

Adult prevalence of HIV/AIDS under 15 who have lost one or both parents since the beginning of the epidemic

	Adult prevalence(%)	Orphaned child-en (total)
Angola	2.8	98,000
Benin	2,5	22,000
Botswana	35.8	66,000
Burkina Faso	6.4	320,000
Burundi	1 1.3	230,000
Cameroon	7,7	270,000
Central African Republic	13,8	99,000
Chad	2.7	68,000
Comoros	0.1*	
Congo	6.4	53,000
Cote d'voire	10.8	420,000
Dem. Republic of Congo	5.1	680,000

Djibouti	1 1.7	7,200
Equatorial Guinea	0.5	860
Eritrea	2.9*	
Ethiopia	10.6	1,200,000
Gabon	4.2	8,600
Gambia	1.9	9,600
Ghana	3.6	17,000
Guinea	1.5	30,000
Guinea-Bissau	2.5	6,100
Kenya	13.9	730,000
Lesotho	23.6	35,000
Liberia	2.8	31,000
Madagascar	0.1	2,600
Malawi	15.9	390,000
Mali	2.0	45,000
Mauritania	0.5	
Mauritius	0.1*	
Mozambique	13.2	310,000
Namibia	19.5	67,000
Niger	1.3	31,000
Nigeria	5.1	1,400,000
Rwanda	11.2	270,000
Senegal	1.8	42,000
Sierra Leone	2.9	56,000
Somalia		
South Africa	19.9	420,000
Swaziland	25.2	12,000
Togo	5.9	95,000
Uganda	8.3	1,700,000
United Rep. of Tanzania	8.1	1,100,000
Zambia	19.9	650,000
Zimbabwe	25.1	900,000

Source: Africa Recovery, October 2001 and UNAIDS.

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