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Report on the Progress and Prospects for the Attainment of Millennium Development Goals (MDGs) in Southern Africa

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	anti-retroviral drugs
AU	African Union
BOP	balance of payments
COMESA	Common Market of Eastern and Southern Africa
DAC	Development Assistance Committee/OECD
DHS	Demographic and Health Survey
DOTS	direct observation treatment
ECA-SA	Southern Africa Office of the Economic Commission for Africa
GNI	gross national income
HBC	home-based care
HDI	Human Development Index
HIPC	Highly-Indebted Poor Country
HIV	Human Immuno-Deficiency Virus
ICE	Intergovernmental Committee of Experts
ITNs	insecticide-treated nets
MDGs	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
NACs	National AIDS Councils
NDPs	National Development Plan
NEPAD	New Partnership for Africa's Development
ODA	official development assistance

OECD	Organization for Economic Co-operation and Development
OVC	orphans and vulnerable children
PLWHA	people living with HIV and AIDS
PMTCT	prevention of mother-to-child transmission
PPP's	Public-Private Partnerships
PRSPs	Poverty Reduction Strategy Papers
RBM	roll back malaria
SADC	Southern African Development Community
TB	tuberculosis
TOT	terms of trade
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCTs	voluntary counselling and testing centres
WTO	World Trade Organization

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EXECUTIVE SUMMARY

This report assesses the progress and prospects for the attainment of Millennium Development Goals (MDGs) in Southern Africa covering the eleven countries served by the Economic Commission for Africa, Southern Africa Office ECA-SA. More specifically, the report tracks progress since around 2002, provides an overview of the progress made from the 1990 MDG base period, highlights the supportive environments and the challenges faced and proposes strategies towards the attainment of MDGs in the region.

The Southern African region is likely to achieve the universal primary education goal. However, poverty, food insecurity, child malnutrition, gender inequality in secondary and tertiary levels of education, in the economy and political sphere, high child and maternal mortality, deforestation, rural water and sanitation remain major challenges. The falling trend in the otherwise generally high coverage of child immunization is a cause for concern. The subregion remains the epicentre of HIV and AIDS with double-digit prevalence levels, on the increase in most countries. This underlies the high morbidity, mortality and orphan burden. This is against declining official development assistance (ODA) to land-locked Southern African countries, and a high debt burden.

In order to accelerate progress towards the attainment of the MDGs, interventions should transcend the symptomatic treatment of poverty and food insecurity and begin to address the structural causes of these problems. Pursuing broad-based comprehensive development strategies in the subregion is thus critical. Southern Africa should implement comprehensive agrarian reform programmes that include land re-distribution, support to improved agricultural productivity, environmental conservation and the creation of decent employment opportunities. Social sectors should continue to be supported adequately in national budgets with particular attention being paid to the quality of education and health services. There is need for increased investment in and maintenance of improved water sources and sanitation in order to accelerate progress towards their attainment. Further, the provision of alternative sources of energy particularly in rural areas has to be prioritized. The gender equality and women's empowerment agenda should remain a priority in Southern Africa with all policies and programmes being gender-sensitive in both design and implementation.

Given the high child and maternal mortality, largely as a result of the HIV and AIDS pandemic, combating and reversing the pandemic remains critical. Global and local partnerships with all stakeholders such as the private sector, non-governmental organizations (NGOs), civil society and communities are key to combating the pandemic. In this regard, local and global resources should be well coordinated to ensure optimal use. Behaviour change strategies targeting all levels of society remain the cornerstone of fighting the pandemic.

Given that MDGs are a global compact, developed countries should honour commitments made at different international fora to increase the quantity and quality of ODA to least developed countries and to harmonize their policies to align aid with the 'needs' of recipient countries. In the meantime, the region should promote value addition in order to increase export earnings to ensure both improved local investment and less painful debt servicing. Further, there is need to speed up the process of regional integration particularly in the areas of trade and investment.

1. INTRODUCTION

1. This report assesses the progress and prospects for the attainment of Millennium Development Goals (MDGs) in Southern Africa covering the following eleven countries: Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Swaziland, South Africa, Zambia and Zimbabwe. More specifically, the report:

- Tracks progress in the attainment of MDGs in the subregion in the recent past since around 2002 to date i.e. since the last report of 2005;
- Provides member States with an overview of the progress made to date on the MDGs in the sub-region since the 1990 MDG base period;
- Highlights the supportive environments in the subregion;
- Highlights the challenges faced by member States; and
- Proposes strategies towards the attainment of MDGs in the sub-region.

2. The Millennium Development Goals (MDGs) agreed upon by world leaders in 2000 consist of eight (8) goals, 15 targets and 44 indicators set, for 2015, using 1990 as a benchmark. Indicators help to track progress against each target and a goal can have one target or more (see Appendix III). It is important to note that MDG targets are not meant to be a disempowering tool for classifying countries and subregions as 'poor performers' but they are meant to encourage countries and subregions to strive for accelerated progress in pursuit of the noble goal of sustainable development.

3. Whilst it is desirable to use local data and indicators for monitoring progress towards the attainment of MDGs, their comparability across nations remains a major challenge. This is because for some key indicators such as poverty, member States use different methodologies and hence comparison across nations becomes impossible. Further, since there is no subregional database on MDG indicators, this report relied wholly on harmonized international data sets such as the United Nations Statistics Division MDG and the United Nations Development Programme (UNDP) Human Development Databases.

4. The international sets, though allowing us to make comparisons across countries, are not without their own shortcomings. For example, there are a lot of data gaps in both the UN MDG and UNDP databases' series. Most of the series are not up to date as they mostly go up to 2004, whilst some still refer to data for 2000 and for some there are huge data gaps. For instance, data for about 11 MDG indicators are not available. Gaps in such critical indicators on poverty and most Goal 8 indicators create problems in attempts to bring out the complete subregional picture regarding progress towards the attainment of MDGs. There is, thus, an urgent need to compile a harmonized subregional database for use in tracking both progress towards the attainment of MDGs and general development programming at the subregional level. It is also imperative for national statistical offices in the subregion to be proactive in submitting recent statistics to the international databases.

5. The rest of the report is structured as follows. First, the development context of Southern Africa is presented, highlighting the key challenges and supportive environments in relation to the attainment of MDGs in the subregion. Second, a report on each of the eight goals providing a

summary on progress and prospects and tracking progress under each target using key indicators, for the overall MDG period to date 1990-2004 as well as highlighting progress in the more recent past 2002-2004 is presented. Strategies for consolidating progress towards attainment in the subregion conclude each goal discussion. Detailed graphical and data presentations referred to in the report are provided in the Appendices.

2. SOUTHERN AFRICA'S DEVELOPMENT CONTEXT

6. The Southern African crises of high levels of poverty and the HIV and AIDS pandemic pose great challenges towards the attainment of MDGs in the subregion. For example, in six countries in the subregion – Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe – there have been serious food shortages since 2000 and, related to this, the HIV and AIDS pandemic which continues to endanger the lives and livelihoods of millions of people. The combination of HIV and AIDS with chronic poverty, erratic rainfall, natural resource degradation and also the inextricable link between gender and poverty all culminate in an acute humanitarian crisis that demands immediate action. Just like in many countries around the world, governance and institutional challenges overarch the development context in Southern Africa. All these issues have resulted in the reversal of progress already made towards the attainment of the MDGs in many countries in the subregion.

2.1 Poverty, economic and inequality challenges

7. Southern Africa is experiencing a complex interplay of structural chronic poverty combined with transient poverty [1]. Poverty in Southern Africa is a multifaceted social phenomenon that includes lack of access to productive assets and to adequate food, health, education and other basic social amenities including clean water and affordable energy. Poverty also includes the condition of gender inequality, lack of environmental management and powerlessness to widen the choices necessary for improved human well-being. These factors combine into a self-reinforcing process that deprives the poor of capabilities to improve their livelihoods. High poverty levels inhibit prospects for achieving the MDGs in Southern African countries.

8. According to UNDP (2006), Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe have all experienced reversals in human development as measured by the Human Development Index (HDI)[2] since 1990 and six of the eleven Southern African countries under consideration are in the low human development category (see Table 1 in Appendix II). In the immediate past, Malawi and Mozambique have consistently remained in the low human-development category with slight improvements between 2000 and 2004 while Lesotho and Zimbabwe have fallen from the medium human-development category to the low one during the same period. With the exception of Mauritius which moved from the medium to high human-development category, the rest of the subregion experienced declining human development (see Table 1 in Appendix II). Over one third of the population in Southern Africa are living on less than US $1 a day. High levels of poverty co-exist with equally high levels of within-country income inequalities. Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe make six of the thirteen most unequal societies in the world as reflected in the Gini coefficient [3] in Table 1 in Annex II.

9. The attainment of the MDGs in Southern Africa will be a costly exercise requiring enormous financial resources for the massive public investments needed. Given that Southern Africa is home to some of the world's poorest countries, the scale of the funding requirements necessary to achieve the MDGs is beyond the means of countries in the subregion. Domestic economic growth will be critical in expanding the 'resource envelope' necessary to finance the MDGs. However, recent experience of economic growth in the agriculturally dependent subregion is sobering (see Table 2 in Appendix II). Southern Africa has experienced stagnant and/or declining export earnings, export concentration in primary commodities has increased and terms of trade (TOT) have declined, all culminating in severe balance-of-payments (BOP) problems and sluggish and/or declining growth. It has been estimated that US$ 17.6 billion in external financing is required to halve the proportion of people living in extreme poverty and hunger in Southern Africa by 2015. The costs of funding the remaining MDGs have been calculated at US$ 10.5 billion.

10. The high external debt is a serious resource constraint to achieving the MDGs in the subregion. Southern African countries have a total debt stock of US$ 78.1 billion with total annual debt service amounting to US$6.8 billion. Excluding South Africa, debt as a percentage of GDP in the subregion is 100 per cent. According to UNDP (2002), some countries in the subregion spend more on their debt-servicing obligations than on the social sectors necessary to achieve the MDGs. Past debt relief strategies, including the contemporary HIPC initiative, have not as yet resulted in debt sustainability in Southern Africa and debt-service obligations are severely constraining the public expenditures that are necessary to accelerate progress towards achieving the MDGs in the subregion.

2.2 Food insecurity and environmental degradation challenges

11. Food insecurity is one of the major challenges to achieving the MDGs in Southern Africa. According to the United Nations, between September 2002 and March 2003, more than 14 million people in Southern Africa needed food aid amounting to 1,051,000 metric tonnes in order to avoid starvation. In 2002/3 about 25 percent of the population in Southern Africa faced severe food shortages (see Table 3 in Appendix II). Malawi, Zambia and Zimbabwe are the countries most affected by food shortages in the subregion due mainly to erratic rainfall. Although some countries harvested enough food after the drought of 2002, household food security remains endemic in the subregion. Periodic floods and droughts, inappropriate agricultural practices and non-supportive government policies are some of the causes of food insecurity in the subregion. However, poverty is now recognized as the main obstacle to achieving food security in Southern Africa. In Malawi, Lesotho, Swaziland, Zimbabwe and Zambia, HIV and AIDS has also been identified as severely undermining food security especially in rural communities. This is further compounded by gender inequalities, and especially women's limited access to and control of land despite them being the majority of smallholder farmers in the subregion.

12. The Southern African subregion also faces severe environmental challenges that threaten the livelihoods of millions of people. Natural climatic phenomena such as floods and droughts as well as human induced deforestation have exacerbated food insecurity and hunger.

2.3 HIV and AIDS challenge

13. The HIV and AIDS pandemic poses the most severe development challenge in Southern Africa, and recent research has shown that the pandemic has started to reverse progress made towards achieving human development in the subregion. Southern Africa has the highest HIV prevalence rates in the world, fuelled by high levels of poverty, gender inequality and weak health-care delivery systems. Out of the 28,500,000 people living with HIV and AIDS in subSaharan Africa, 42 percent are in Southern Africa. The subregion accounts for a third of all AIDS deaths globally. HIV and AIDS and poverty have disproportionately affected women, while children have also not been spared by both the disease and orphanhood.

14. According to the World Health Organization (WHO), HIV and AIDS has reduced life expectancy by an average of fifteen years in the subregion, and the average life expectancy in subSaharan Africa is 47 years when it would have been 62 years without HIV and AIDS. The United Nations Joint Programme on HIV/AIDS the United Nations Joint Programme on HIV and AIDS (UNAIDS) estimates for Botswana, Lesotho, Swaziland and Zimbabwe indicate that, HIV/AIDS has reduced life expectancy for men and women by up to 20 years. It is also straining the capacities of health-care delivery systems in the sub region.

15. Despite the progress made to date on governance in the subregion, there are various areas of political, economic and corporate and institutional governance which still need improvement. For example, consolidation of democratic political governance, adoption of sound broad-based, pro-poor economic policies, and implementing institutional checks and balances remain major challenges in the subregion and these need to be addressed.

2.4 Supportive environments

16. Despite all these development challenges the subregion is facing, a lot of effort is ongoing in the subregion in support of the attainment of MDGs and sustainable development in general. Some of this supportive environment is highlighted below.

17. The achievement of the MDGs is hard to envision without the necessary governance institutions and practices necessary to create the conditions for translating development policies into reality, and to motivate people into building sustainable livelihoods for themselves. The political and economic landscape in Southern Africa has changed dramatically over the last two decades. The one-party state systems have largely been discarded, and the urge for state ownership and control of national economies has ebbed. Governments have elevated the private sector to special prominence, conferring upon it the tasks of growing the economies and creating jobs. The civil society has adopted an active posture, raising their influence on national policies, and steadily inducing political and economic inclusiveness. Donors are overhauling their assistance approaches, stressing partnership for, and countries' ownership of their own development process.

18. Political commitment to address high poverty levels through various initiatives such as Poverty Reduction Strategy Papers (PRSPs), National Development Plans (NDPs), Medium-Term Expenditure Frameworks (MTEFs), Sectoral Development Plans among many other strategies developed, are being implemented in all countries in the subregion. Land re-distribution and general wealth re-distribution programmes to address structural poverty and

chronic food insecurity are ongoing in the subregion. Some of the countries in the subregion have adopted affirmative action strategies to address the plight of the previously disadvantaged. National budgets continue to prioritize social sectors in most countries in the subregion.

19. In the area of HIV and AIDS, National AIDS Councils (NACs) and HIV and AIDS Policies and Strategic Frameworks are being implemented. These include mechanisms for multi-sectoral responses on prevention, treatment and care. The pandemic has been mainstreamed by all sectors be they public, private, non-governmental, religious, traditional and civil society groups. Many sector-specific policies on HIV and AIDS have been developed in the subregion including the establishment of voluntary counselling and testing centres (VCTs), prevention of mother-to-child transmission (PMTCT) programmes, support to home-based care (HBC) programmes, special nutrition programmes for people living with HIV and AIDS (PLWHA), support to orphans and vulnerable children (OVC) and youth programmes on HIV and AIDS. The initiatives face many challenges mainly related to sustainable funding. Partnership with the Global Fund to Fight against HIV and AIDS, malaria and other diseases is key particularly in the provision of anti-retroviral drugs (ARVs), Zimbabwe's National AIDS Trust Fund or 'AIDS Levy' established from a contribution from all formally-employed Zimbabweans, is an example of a domestic programme to support the fight against the pandemic.

20. Many countries in the subregion are involved in the global social movement to roll back malaria (RBM), involving the provision of insecticide treated nets (ITNs), malaria prevention treatment and other initiatives. The WHO international standard for the treatment of tuberculosis (TB) using the direct observation treatment (DOTS), has been domesticated in the subregion.

21. The New Partnership for Africa's Development (NEPAD) is an important framework in the development process in the subregion. Several international donor agencies remain active in the subregion's development. National environment policies and many community-based and institution-based environmental conservation programmes are ongoing across the subregion. Gender policies, gender machineries and affirmative action programmes are in place in all countries.

22. It is within this context of challenges and supportive environments that progress and prospects for the attainment of MDGs in Southern Africa is discussed in this report. The report tracks progress and prospects in each country, for each goal, inferring a possible subregional outcome by 2015, and provides recommendations on accelerating progress towards attainment of MDGs.

3. ASSESSMENT OF PROGRESS AND PROSPECTS

3.1 MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Box 1: Poverty and Hunger

Poverty

For most Southern African countries, the target of halving the proportion of the population below the US$1PPP per day seems unachievable.

Hunger

Hunger, food insecurity and child malnutrition remain a problem in the subregion, and most of the Southern African countries may be unable to achieve the hunger reduction targets.

Progress Towards 2015 MDG Targets

TARGET 1: Halve between 1990 and 2015 the proportion of people whose income is less than US$1 PPP a day.

23. Harmonized data on poverty levels remains scanty, as shown in Indicator 1 Table in Appendix II. The Southern African crisis, characterized by high levels of poverty, food insecurity and the HIV and AIDS pandemic, poses challenges towards the attainment of MDGs. For most of these countries, the target of halving the proportion of the population below the US$1PPP per day seems unachievable except for Mauritius which has no poverty problem. The poverty situations in Zambia and Zimbabwe are worsening, while poverty levels in Malawi, Mozambique and Namibia are relatively high as shown in Indicator 1 graph in Appendix I.

TARGET 2: Halve between 1990 and 2015 the proportion of people who suffer from hunger.

24. The situation as regards malnutrition is not improving at the expected rate so as to reduce by two-thirds the 1990 level. Angola had the highest malnutrition prevalence of 31 per cent in 2001. While malnutrition has fallen in Malawi, Mozambique, Namibia and Zambia, it has increased in Lesotho, and Zimbabwe (see Indicator 4 graph in Appendix I). There are many gaps in malnutrition data in the subregion (see Indicator 4 Table in Appendix II).

25. The proportion of the population below minimum level of dietary energy consumption and decreased significantly between 1991 and 2002 in Angola, Lesotho, Malawi, Mozambique Namibia and these countries are likely to meet their 2015 MDG targets(see Indicator 5 graph in Appendix I). However, the proportion increased in Botswana and Swaziland and remained relatively high and constant in Mauritius, Zambia and Zimbabwe. There is no recent data beyond 2002 on this indicator.

Proposed strategies

26. It is important that interventions transcend the symptomatic treatment of poverty and food insecurity and begin to address the structural causes of these problems. Too often, hunger interventions in the subregion have an 'emergency- relief' bias rather than a comprehensive development strategy bias which is more desirable.

27. There is urgent need to realign and reorient domestic policies and institutions including the Poverty Reduction Strategy Papers (PRSPs) and Medium-Term Expenditure Frameworks (MTEFs), and other Macroeconomic Frameworks towards meeting specific MDGs. Domestic policies must trigger sustained broad-based economic growth in order to ensure long-term poverty reduction and food security at the household levels and nationally.

28. Southern Africa should pursue comprehensive agrarian reform programmes that include land re-distribution, support to improved agricultural productivity, environmental conservation and creation of decent employment opportunities. Improved agricultural productivity requires timely availability of agricultural inputs such as seed and fertilizer, improved agricultural technology, effective agricultural extension, marketing and distribution services, and effective price incentives among other factors. Such programmes need support at both the subregional and national levels.

29. It is imperative that the private sector should form an alliance with government in exploiting every opportunity to enhance wealth and job creation. The private sector plays an important role in the quest to eradicate poverty and hunger through enabling the informal trading sector to supply affordable quality and quantities of goods into the consumer markets. The private sector can address the commercial use of affordable and indigenous base foods such as cassava, millet and sorghum to influence acceptability and sustainability.

3.2 MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Box 2: Primary School Education

The number of children attending primary school in Southern Africa is high with most countries likely to achieve the universal primary education goal and targets. Internal efficiency has been maintained in the primary education system as Grade 5 completion rates have generally increased in all countries between 1991 and 2004. Literacy rates for the 15-24 year olds are very high in the subregion.

Progress towards 2015 MDG targets

TARGET 3: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

30. The subregion is making great strides in primary education and the 2015 MDG target is likely to be achieved in most countries. Zimbabwe, Malawi and Mauritius have made the most progress and have almost achieved universal primary education with net enrolment ratios (NERs)

of 97, 95 and 95 percent respectively. Botswana, Lesotho and South Africa, have very high primary school enrolment ratios of above 80 per cent. Namibia at 74 percent and Swaziland at 77 percent have remained stable between 1991 and 2004, (see Indicator 6 graph in Appendix I). Between 2002 and 2004 primary school NERs have remained high with Lesotho, Mauritius, Mozambique and Zambia making progress as shown in Indicator 6 Table in Appendix II.

31. Internal efficiency has been maintained in the primary education system as Grade 5 completion rates generally increased in all countries between 1991 and 2002 except in Lesotho, Malawi and Zimbabwe with Angola and Swaziland remaining stable as shown in Indicator 7 graph in Appendix I. The Grade 5 completion rate for Angola remained constant and very low at 5 per cent between 1991 and 2002. While Malawi and Zimbabwe have almost achieved universal primary education, a situation of decreasing completion rates indicates problems that are creeping in as fewer children are managing to complete Grade 5. This has mainly to do with economic hardships which translate into children dropping out of school. There is no recent data to 2004 on Indicator 7, (see Indicator 7 Table in Appendix II).

32. Literacy rates for the 15-24 year olds are very high in the subregion, with Zimbabwe topping the list at 99 per cent in 2004 as shown in Indicator 8 graph in Appendix I. The progress so far in all countries except Zambia, which is declining, shows that the 2015 MDG target is achievable.

Proposed strategies

33. Social sectors should continue to be protected in national budgets to ensure protection and enhancement of attainments to date, and particularly in primary education. Particular attention is still required in ensuring high quality primary education. Pupil and teacher ratios, and pupil/book ratios, are generally high in the subregion and school infrastructure particularly in rural areas is run down. Education budgets and partner resources should now be directed towards addressing the question of quality of primary education in Southern Africa to ensure that the quantum attainments are consolidated by quality attainments.

34. The private sector has already identified education as a profitable investment sector. In many countries both on the continent and abroad where government has not invested adequately in primary education, the private sector has already made progress in trying to fill the gap. The private sector has to be motivated to invest in new schools and possibly to devise a financing system for education whereby education loans are provided and can be repaid when students graduate and are gainfully and productively employed. This mechanism could free resources in government to be targeted on the provision of primary education for the less privileged and vulnerable living in urban slums and rural areas.

35. Increasing economic and HIV/AIDS-related hardships in the subregion are beginning to reflect in increasing child dropouts from primary school. There is a need to design and implement innovative education programmes to ensure that children remain in school and complete a full course of primary education. Programmes targeting the education and general social protection of orphans and vulnerable children should be designed and implemented in the subregion. Countries such as Lesotho, Malawi, Mozambique and Zimbabwe, with declining or low primary school completion rates, should pay special attention these strategies.

3.3 MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Box 3: Gender Parity in Education, Economic and Political Empowerment

Primary, Secondary and Tertiary Education

Gender parity in primary and secondary education has been reached or is likely to be achieved in most Southern African countries. Consequently, gender parity in the number of girls and boys aged 15 -24 years who are literate is achieved or likely to be achieved in most countries.

However, there is a lot of gender imbalance in tertiary education in the subregion with five countries having a bias against girls, three countries a bias against boys and one country having achieved the target. Thus, overall gender parity in tertiary education may not be achievable in Southern Africa by 2015**.** It should be noted that at secondary school level, the NERs are generally low such that the issue of concern should not only be to achieve parity but to increase enrolment of both boys and girls.

Economic and Political Empowerment

The share of women in wage employment in the non-agricultural sector remains very low in the subregion; as such the overall target of 50 percent by 2015 is not achievable for most countries.

More women are in parliaments in all Southern African countries today than ever before. However, in most countries women remain vastly under-represented in politics.

Progress towards 2015 MDG targets

TARGET 4: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015.

36. There is near gender parity in primary education in all countries in the subregion except for Angola and Mozambique which still have girls-to-boys ratios of 0.86 and 0.83 respectively, indicating fewer girls enrolled in primary school than boys, (see Indicator 9a graph in Appendix I). The early 1990 situation in Lesotho where there were fewer boys enrolled in primary school than girls, is slowly changing. The falling ratio in Angola which reflects a bias against girls is a cause for concern. Between 2002 and 2004 the ratio of girls to boys in primary school have moved towards parity in most countries as shown in Indicator 9a Table in Appendix II.

37. Gender parity in secondary education has been reached or is likely to be achieved in most Southern African countries except Angola and Zambia which have shown some decline, as shown in Indicator 9b graph in Appendix I. In fact, Lesotho and Namibia now have more boys than girls in secondary school but this is being adjusted. The situation in Malawi and Mozambique in the early 90s reflected a bias against girls but significant progress has been registered. Malawi, Mozambique and Zimbabwe improved between 2002 to 2004, Zambia has registered a decline, whilst Lesotho and Namibia continued to have a bias for girls in secondary school enrolment. The other countries remained constant at near gender parity during the same period, see Indicator 9b Table in Appendix II.

38. However, it should be noted that at secondary school level, the NERs are generally low such that the issue of concern should not only be to achieve parity but to increase enrolment of both boys and girls. Five out of the nine countries under consideration have secondary NERs of less than 30 per cent, with South Africa being the highest at 62 per cent and Mozambique the lowest at 4 percent (see Table 4 in Appendix II).

39. Gender inequality in enrolment at tertiary school level remains a major challenge. In 2004 Lesotho, Namibia, and South Africa had more women in tertiary institutions than males. This is largely attributable to males migrating early in search of jobs in the South African mines and losing the opportunities to continue with education. For the rest of the subregion there are more males in tertiary institutions than females. Mozambique and Zambia with very low ratios (about 0.46 each) of women to men enrolled in tertiary institutions remained on a par between 1991 and 2004, (see Indicator 9c graph in Appendix I). Overall, there is an improvement in gender parity in tertiary education in the subregion between 2002 and 2004, see Indicator 9c Table in Appendix II.

40. Gender parity in the literacy of girls and boys aged 15 -24 years is achieved or likely to be achieved in most countries except in Angola and Lesotho with a girls to boys ratio of 0.75 and 1.26 respectively in 2004, as shown in Indicator 10 graph in Appendix I. Mozambique with 0.48 in 1990 is a cause for concern.

41. The share of women in wage employment in the non-agricultural sector remains very low across the subregion, ranging from a minimum of 13 per cent in the case of Malawi to a maximum of 46 per cent in South Africa in 2004, (see Indicator 11 in Appendix I). In 2002 - 2004, the proportions of women in the non-agricultural sector have remained relatively stable, ranging between 12 per cent in Malawi and 45 per cent in South Africa in 2002, see Indicator 11 Table Graph in Appendix II.

42. The overall target of 50 per cent by 2015 is not achievable for most countries except Botswana and South Africa. The participation of women in the non-agricultural labour market increases their opportunities for higher income generation. However, most women have remained in the agricultural, household informal sector/household business and in unpaid household work, and this has exacerbated their poverty situation. In Botswana, Malawi, South Africa, and Zimbabwe the share of women in wage employment in the non -agricultural sector increased over the period 1990 - 2004 and this is positive for the welfare of women.

43. More women are in parliaments in all Southern African countries today than ever before. However, in most countries women remain vastly under-represented in politics. All countries in the subregion have seen an improvement in the proportion of women who are members of parliament ranging from an increase of 3 per cent in Angola to 1 072 percent in South Africa between 1990 and 2006, as shown in Indicator 12 graph in Appendix I. Mozambique has 35 per cent of its national parliament seats held by women, followed by South Africa with 33 per cent and these have already achieved the previous Southern African Development Corporation (SADC) target of 30 per cent share of women parliamentarians by 2005. Namibia has achieved a high ratio of women parliamentarians of 27 per cent. Botswana, Lesotho and Swaziland with 11 per cent each have the lowest proportion of women in parliament. Angola, Malawi, Mauritius,

Zambia, and Zimbabwe have relatively low proportions of women parliamentarians. For the period 2002 to 2006 most countries in the subregion registered progress in the participation of women. However Angola and Botswana experienced declines during the same period, see Indicator 12 Table in Appendix II.

Proposed strategies

44. The gender equality and women's empowerment agenda should remain a priority in Southern Africa with all policies and programmes being gender-sensitive in both design and implementation. Progress in this area, though slow and painful, is beginning to be noticeable. There is near gender parity in primary and secondary education and notable strides have been made in the area of women's representation in parliament.

45. Women have been recognized as valuable labour in the private sector due to their approach towards employment. To this end, the private sector is challenged to advocate for better laws that protect women's rights, and to invest in programmes that provide victim support strategies and child abuse interventions for women and the girl child in particular. The small and medium enterprise (SME) sector, which is dominated by women, requires targeted support from governments as well as strong forward and backward linkages with the larger companies.

46. Aggressive advocacy campaigns for the participation of women in politics particularly in parliament should be intensified and sustained if the 2015 MDG target of 50:50 shares of women and men in parliament is to be achieved. Implementing quota systems institutionalized at both subregional and national levels may also speed up attainments in this area.

47. The bw secondary school net enrolment ratios remain a cause for concern in Southern Africa. The first four years of secondary education should be made compulsory in the subregion and such education should be heavily supported by both national resources and partners. Affirmative action and targeted girl child empowerment programmes should be effectively used to reduce the gender imbalance in tertiary education. Tertiary education determines to a large extent the gender outcome in the labour market as illustrated in women's low share in wage employment in the subregion's non-agricultural sector.

3.4 MDG 4. REDUCE CHILD MORTALITY

Box 4: Under-Five and Infant Mortality, and Immunization against Measles

Under-five and infant mortality

Under-five and infant mortality rates remain high in Southern Africa with most countries experiencing increases, thus, most countries in the subregion will not be able to achieve the 2015 targets.

Immunization against measles

While high immunization levels of one-year-olds against measles had been achieved in most Southern African countries by 1990, and current immunization levels remain generally high, the declining coverage in a number of countries by 2004 is a cause for concern.

Progress towards 2015 MDG targets

TARGET 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

48. Under-five and infant mortality rates remain high in Southern Africa with Botswana, South Africa, Swaziland, Zambia and Zimbabwe most countries all experiencing increases between 1990 and 2004, as shown in the Indicators 13 and 14 graphs in Appendix I. Under-five mortality was above 110 per 1 000 live births in 7 out of the 11 countries under consideration in 2004. Between 2000 and 2004, under-five and infant mortality rates worsened in Botswana, South Africa, Swaziland and Zimbabwe, remained high and constant in Angola and Zambia and improved in the rest of the countries as shown in Indicators 13 and 14 Tables in Appendix II.

49. The trend in the infant mortality rate is similar to that of the under-five mortality rate but with lower levels for most of the countries -- assuming the same rates of decline continue -- in the subregion, as shown in the Indicator 14 in Appendix I. The infant mortality rate ranged from 47 per 1 000 live births in Namibia to 154 in Angola in 2004. Even though Malawi and Namibia have experienced significant declines in both under-five and infant mortality in the past decade, the two countries are likely to still miss 2015 targets though with commendable progress made. Mauritius has very low levels of under-five and infant mortality rates.

50. Ideally all children should be immunized against measles. High levels of immunization of at least 79 per cent had been achieved in most countries in 1990 except for Angola (38 per cent) Namibia (57 per cent) and Mozambique (59 per cent), as shown in Indicator 15 graph in Appendix I. However, the situation in Angola, Mozambique and Namibia as regards immunization, improved between 1990 and 2004. The declining trends in proportions of one-year-olds vaccinated between 1990 and 2004 in Lesotho, Swaziland, Zambia and Zimbabwe and the stagnation in Malawi is a cause for concern at the level of the subregion. Over the period 2002 to 2004, the proportion of children immunized against measles improved in Malawi, Mauritius, Namibia, South Africa and Zimbabwe while it remained constant but high in Botswana, Lesotho, Mozambique and Zambia and declined in Angola (see Indicator 15 Table in Appendix II).

Proposed strategies

51. Given that the high infant and under-five mortality rates are largely as a result attributable to HIV and AIDS, combating and reversing the pandemic remains critical for reducing the child mortality rates. The discussion under MDG 6 explores this strategy further.

52. However, intensifying some interventions targeted at children will be of great benefit in this area. For example scaling up of the prevention of mother to child transmission (PMTCT) programmes in the subregion will go a long way in saving the lives of infants. In addition, expansion of focused strategies for combating preventable diseases such as polio, smallpox, measles, etc and breastfeeding, supplementary feeding/nutrition and micronutrients programmes will no doubt yield positive results for children. Primary health care should be available as a comprehensive package, for free, to children.

53. The private sector has substantially invested in reducing child mortality with financing from both public health delivery programmes and the donor community health intervention programmes. Investment in locally assembled maternity delivery kits, vitamin supplements, fortified foods, oral re-hydration salts, insecticide-treated nets, and malaria treatment kits, are widespread and should be sustained. Tax breaks and other incentives could be used to entice the private sector to actively participate in the manufacture and supply, of drugs at reasonable cost to the users. As part of its corporate social responsibility, the private sector can take the lead in re-introducing the use of DDT for malaria eradication as supported by WHO.

54. There is a need to intensify resource mobilization efforts for complete child vaccination and comprehensive targeted support for orphans and vulnerable children across the subregion. This will ensure that gains made in the past will not be eroded. Support is needed for the scaling up of treatment for HIV positive children including infants. The provision of ARV pediatric formulas in large enough quantities remains a challenge. It is also important to develop 'child friendly' services, as well as educational materials targeted for and at children infected or affected by HIV and AIDS.

55. Protecting the health budgets, removing fees for primary health care, training and retention schemes for skilled health workers, many of whom leave Africa for better pay and working conditions on other continents, will go a long way in reducing the quantum and momentum of child mortality in Southern Africa.

3.5 MDG 5: IMPROVE MATERNAL HEALTH

Box 5: Maternal Mortality

Maternal mortality remains high and is falling at a painfully slow rate in most Southern African countries and this is combined with alarming increases in two of the countries under consideration. The target of reducing by three quarters the maternal mortality ratio will not be met by most countries in the sub-region. The most recent increasing trend is due to the impact of the HIV/AIDS pandemic.

Progress towards 2015 MDG targets

TARGET 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality rate.

56. Maternal mortality remains high and is falling at a painfully slow rate in most Southern African countries and this is combined with alarming increases in two of the countries (see Indicator 16 graph in Appendix I). Major causes of childbirth-related death are to do with bleeding after childbirth, malaria, puerperal sepsis, HIV and AIDS, anemia and ruptured uterus. With an efficient health delivery system most of these are preventable. The review shows that the target of reducing by 75 per cent the maternal mortality ratio will not be met by most countries in the subregion.

57. Maternal mortality has been falling in all countries of the subregion between 1990 and 2000 except for Malawi and Zimbabwe where alarming increases have been recorded. It has also been on the increase in Angola. However, the trend between 1995 and 2000 shows that maternal

mortality fell in Botswana, Mauritius, Namibia, South Africa and Zambia whilst it increased in Angola, Lesotho, Malawi, Mozambique and Zimbabwe, as shown in Indicator 16 Table in Appendix II. Swaziland's maternal mortality remained constant between 1995 and 2000. In 2004, Malawi had the highest maternal mortality rate (MMR) of 1800 maternal deaths per 100 000 births, followed by Zimbabwe with 1 100 and Mozambique with 1 000 whilst Mauritius had the lowest at 24. Mauritius has achieved its 2015 MDG target of 30. There is no recent data on maternal mortality for the subregion. The general fall between 1990 and 2000 is reflective of the improvement in health systems during the early 1990s and the increase from 1995 onwards into the recent alarming maternal mortality rates is reflective of the HIV/AIDS impact.

58. Data on the proportion of births attended by skilled personnel is scanty (see Indicator 17 Table in Appendix II). Up to 2003, the proportion of births attended by skilled personnel remained very low in the subregion. Botswana and Mauritius had a very high proportion of births attended by skilled personnel (98 per cent and 94 per cent respectively). The proportions in Zambia (43 per cent in 2002), Angola (45 per cent in 2001) and Mozambique (48 per cent in 2003) are also low.

Proposed strategies

59. The lifeline of Southern Africa is dwindling as mothers continue to die at an alarming rate from the feminized HIV/AIDS pandemic. As with the child mortality goal, combating and reversing the pandemic remains critical for reducing the high maternal mortality rates in the subregion. More on this strategy will be discussed under MDG 6.

60. Targeted interventions, including scaling up of comprehensive PMTCT in which the mother is also put on anti-retroviral therapy (ART), will go a long way in saving the lives of mothers. Significant benefits can also come from scaling up programmes such as malaria control, contraception, fertility, micronutrients programmes, nutrition for pregnant women, and access to basic antenatal care in health institutions.

61. It is critical to address gender inequality as it is one of the root causes of women's vulnerability to both poverty and HIV/AIDS. Programmes that empower women to take charge of their reproductive rights are important because educated and working women are more likely to marry at an older age and to seek neonatal and postnatal care, all of which are crucial in reducing child and maternal mortality.

62. In addition to safeguarding health care budgets, governments should treat maternity care as basic health care and remove maternity fees or make them nominal so that no woman dies from failure to afford hospital fees, a feature which is growing with increasing economic hardships in the subregion.

63. To further complement professional health staff, whose working conditions and remuneration should be kept attractive -- and more so in the "burnout" associated with the demands of the HIV/AIDS on the health sector -- traditional birth attendants must have their skills upgraded so that they become an effective back-up in the communities. It is imperative that health institutions be well equipped with obstetric care equipment.

64. There is a need to sustain the current aggressive engagement by the private sector in the manufacture and assembly of vitamins, supplements, cereals and boosters for expectant mothers. The production of new products such as prophylactics against malaria for pregnant women and HIV mitigation and PMTCT kits should be expanded. The private sector should also continue to invest in clinics, maternity hospitals, testing laboratories and a broad range of drugs. It should also seek new ways of financing maternal health through the introduction of health insurance schemes. This will remove the pressure for governments to finance all health services and make funding available for maternal health services across the subregion.

3.6 MDG 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES

Box 6: Combat HIV/AIDS and Tuberculosis, and the Plight of Orphans

Combat HIV and AIDS

The subregion remains the epicentre of HIV and AIDS with HIV prevalence still in the double digit and on the increase in most countries in the subregion. The target of halting and reversing the spread of HIV and AIDS by 2015 is not likely to be met by most countries in the subregion.

Combat tuberculosis

Deaths associated with tuberculosis have drastically increased in most countries in the subregion in the past decade since 1990 and the trend continued in the recent past since 2002. Given the current context of high HIV prevalence, the 2015 target of halting and reversing the incidence of tuberculosis will not be met.

Orphans

Although school attendance by orphans is generally very high, a notable proportion of orphans continue to be disadvantaged in terms of school attendance in most Southern African countries. The 2015 MDG target of universal school attendance by orphans is achievable.

Progress towards 2015 MDG targets

TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV and AIDS

65. Data on HIV prevalence in the subregion are scanty and statistics are available from 2000/2001 (see Indicator 18 Table in Appendix II). The subregion remains the epicentre of HIV and AIDS with HIV prevalence still at double digit and on the increase in most countries. Swaziland had the highest HIV prevalence among pregnant women aged 15-24 years of 37 per cent in 2005 whilst Angola had the lowest prevalence of 3 per cent. Botswana's situation has remained stable but at a very high prevalence of 34 per cent in 2004. Zimbabwe registered a significant decline in HIV prevalence between 2000 and 2005; yet it had had an HIV adult prevalence rate of 24.6 per cent in 2003 which had declined to 20.1 per cent by 2005. However, the recent DHS results gave an adult HIV prevalence rate of 18.1 per cent in 2005/6 [4]. These results show a decline in HIV prevalence, the first such decline for Southern Africa. The results are indicative of change in sexual behaviour. The many interventions by both government and the international community and local players have yielded positive results. Zimbabwe's HIV prevalence among 15-to- 24-year-old women in 2005/6 was at 11 percent.

66. Data on school attendance by orphans are also scanty, (Indicator 20 Table in Appendix II). Given the high HIV prevalence in the subregion and limited access to anti-retroviral drugs, the orphan burden is noticeably on the increase in most countries. Although school attendance by orphans is generally very high, a notable proportion of orphans continue to be disadvantaged in terms of school attendance in most Southern African countries. The situation worsened between 1992 and 2003 in countries such as Namibia and Zimbabwe (see Indicator 20 graph in Appendix I). Malawi and Mozambique registered great improvements in the attendance of school by orphans. Orphans in Mozambique are the most disadvantaged in the subregion, whilst in Botswana there is not much difference between orphans and non orphans. The 2015 MDG target of universal school attendance by orphans is achievable.

TARGET 8: Have halted by 2015 and begun to reverse the incidence of malaria, TB and other diseases

67. With HIV and AIDS the incidence of death rates associated with tuberculosis have been increasing in all countries in the subregion since 1990. For the period 2002 to 2004, the prevalence of death rates associated with tuberculosis has increased in 9 out of the 11 countries in the subregion, as shown in Indicator 23 Table in Appendix II. In 2004, Swaziland had the highest prevalence of 269 per 100 000 population and Angola the lowest of 32 per 100 000. The 2015 MDG target of halting and reversing the trend may not be achievable.

Proposed Strategies

68. Global and local partnerships with all stakeholders such as the private sector, NGOs, civil society and communities, are essential to combating HIV and AIDS. Communities, households and individuals need to be empowered to play a critical role in combating HIV and AIDS. The private sector should be supported to scale up their role in combating HIV and AIDS through the local manufacture of ARVs. This will help scale up ART coverage and provide comprehensive PMTCT. Local and global resources should be well coordinated to ensure optimal use. Zimbabwe's 'AIDS Levy' is a best practice on local resource mobilization to combat the pandemic even in the midst of economic hardships.

69. The implementation of prevention strategies, targeting all levels of society and all age groups, remain the cornerstone of fighting the HIV/AIDS pandemic. Innovative programmes that specifically target adolescents, orphan and vulnerable children, and prevention of HIV transmission in newborns should remain high on the subregional and national agendas. Sharing experiences and best practices within the subregion will help in the building of a coordinated subregional response. Addressing cultural gender biases and the development and attainment of strategies that address gender equity and women's empowerment will go a long way in defusing the pandemic. Behaviour change strategies to encourage greater male participation in all family-oriented HIV services should be promoted and implemented.

70. The subregion should support the scaling-up of treatment for not only HIV-positive children (including infants) but also strengthen the links to adult ART and HIV services. Such integration of services also goes beyond treatment to the strengthening of psychosocial support services provided to PLWHA. Resources should be mobilized towards the social support of

orphans and vulnerable children to ensure that they remain in school, lead a decent life and thus grow up into responsible adults in society.

71. There is a need to intensify the current efforts in which the private sector with government support has made it possible for anti -retroviral drugs (ARVs) to be available on the local market either, free of charge, or at a minimal cost to the patient. Governments and donors have contracted the private sector to manufacture insect-treated nets (ITNs) to combat malaria, as well as insecticides, chlorine kits, and vaccination kits. Governments, in partnership with the private sector, should continue public programmes to educate the citizenry on good hygiene, anti-malaria campaigns, HIV and AIDS awareness, and voluntary counseling and testing (VCT).

3.7 MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Box 7: Deforestation, Access to Improved Water Sources and Improved Sanitation

Deforestation

Deforestation is on the increase in the Southern African subregion, with most countries experiencing a diminution in land area covered by forest. The proportion of land area maintained to protect biological diversity is slightly on the increase in the subregion, with most countries maintaining stable proportions and the rest slightly increasing. However, given the high rate of deforestation, the 2015 targets of reversing the loss of environmental resources are unlikely to be achieved.

Access to Improved Water Source

Most Southern African countries have achieved or are likely to achieve the 2015 targets of sustainable access to safe drinking water in urban areas. Even though most of these countries have seen an improvement in the sustainable access to an improved water source in rural areas, meeting the 2015 targets remains a challenge for the subregion.

Access to Improved Sanitation

Most Southern African countries are experiencing a decline in access to improved sanitation in urban areas and a rise in such access in rural areas. However, overall, the 2015 MDG targets on improved sanitation will not be achieved in the subregion.

Progress towards 2015 MDG targets

TARGET 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

72. The proportion of total land area covered by forest has been falling in all countries in the subregion between 1990 and 2005, signifying deforestation – with the exception of South Africa and Swaziland as shown in the Indicator 25 graph in Appendix I Zimbabwe registered the sharpest decrease in the proportion of total land area covered by forest between 1990 and 2005 of 21 percent whilst in South Africa the proportion is constant. For the period 2000 to 2005, deforestation continued in 8 out of the 11 countries in the subregion, as shown in Indicator 25

Table in Appendix II. At this rate, the MDG target of reversing the loss of environmental resources by 2015 may not be achieved in the subregion.

73. Biodiversity data appear to consist of estimates and projections rather than annual. The proportion of land area maintained to protect biological diversity is slightly on the increase in the subregion with most countries maintaining stable proportions and the rest slightly increasing. Zambia has the highest ratio of land area maintained to protect biological diversity to surface area in the subregion (42 percent) followed by Botswana with 30 percent whilst Swaziland (3.46 percent) and Lesotho (0.22 per cent) have the lowest. Botswana, Mozambique, South Africa and Zambia have slightly increased their ratio of land area maintained to protect biological diversity to surface area between 1990 and 2005 while Angola, Lesotho, Malawi, Namibia, Swaziland and Zimbabwe have maintained stable ratio,s as shown in Indicator 26 graph in Appendix I. Between 2002 to 2005, biodiversity has remained constant in all countries, as shown in Indicator 26 Table in Appendix II.

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

74. Urban and rural indicators on the proportion of people without sustainable access to safe drinking water and sanitation are only available for 1990 and 2004. In 7 out of the 11 countries, namely, Angola, Botswana, Malawi, Mauritius, Namibia, South Africa, and Zimbabwe, sustainable access to an improved water source in urban has been achieved (see Indicator 30a graph in Appendix I). However, Mozambique (72 per cent) and Swaziland (87 per cent still have to improve their situations if the 2015 MDG targets are to be met. While Zambia improved between 1990 and 2004, the worsening situation in Mozambique is a cause for concern. Zimbabwe has also experienced a slight reversal during the reporting period, challenging its ability to maintain its high level of access to a sustainable water source.

75. Sustainable access to an improved water source in the rural areas remains a challenge in the subregion. This reflects mainly inadequate investment and poor maintenance. However, all countries have seen an improvement in the sustainable access to an improved water source in rural areas, (see Indicator 30b graph in Appendix I). Malawi and Namibia had, by 2004, managed to halve their 1990 proportions of persons without access to an improved water source. Botswana and Mauritius are on course while Mozambique, South Africa, Zambia, and Zimbabwe, are improving but not enough to meet the 2015 MDG targets. These proportions are low in the case of Angola and Zambia, at 40 per cent each, given the target of 70 and 64 percent respectively. Mozambique with only 26 per cent of its rural population having sustainable access to an improved water source in 2004 is very far from its 2015 MDG target of 62 percent.

76. Most countries in the sub region have experienced a decline in access to improved sanitation in urban areas with the exception of Mozambique where there was a slight increase and Lesotho which remained unchanged as shown in Indicator 31a graph in Appendix I. None of the countries will meet their 2015 MDG of improved sanitation targets in urban areas. In 2004 South Africa had the highest proportion of the population with access to improved sanitation (79 per cent) and Namibia the lowest (50 per cent).

77. The analysis shows that most Southern African countries are experiencing an upward trend in terms of access to improved sanitation in rural areas. However, the 2015 MDG targets for this benchmark not be achieved in the subregion. In terms of access to improved sanitation in the rural areas, the levels remain very low, as shown in Indicator 31b graph in Appendix I. Mauritius had the highest proportion (94 per cent) of the population with access to improved sanitation and Angola (16 per cent) the lowest in 2004. However, the situation has improved in all countries except for Lesotho and South Africa. In the case of Lesotho, the situation had not changed whilst in South Africa there was a 7 per cent decline in the proportion of the population with access to improved sanitation between 1990 and 2004.

Proposed Strategies

78. Considering that deforestation combined with poor land use and management are among some of the factors that have had a devastating climatic effect on the continent, increasing the subregion's historic vulnerability to both extremes of droughts and floods, leading to lower agricultural productivity, hunger and loss of biodiversity among other problems, it is worthwhile to keep as a high priority the sustainable environmental management agenda in the subregion.

79. There is a need to find innovative ways to mobilize and channel resources towards afforestation and forest management programmes, management of water catchment areas, reduction of overpopulation in fragile areas, sustainable agricultural systems, and so on. Intensive awareness campaigns with appropriate investment measures to effect results should be carried out on regulations governing the sustainable utilization, land management programmes, and conservation of natural resources and the environment, especially in the areas of small-scale mineral extraction, waste management, forestry, control of veld fires, sustainable wetlands and wildlife utilization to safeguard livelihoods and environmental sustainability of the production systems based on ecosystems and land.

80. There is a need to increase investment in and maintenance of improved water sources and sanitation in rural areas. This will go a long way in improving the basic health situation in Southern Africa. The worsening of urban sanitation in most countries in the subregion and that of the urban water situation in some countries calls for urgent attention to the basic health situation in urban areas. In this respect, increased investment is also needed for urban water and sanitation systems.

81. It is imperative to intensify research on development of affordable and accessible alternative sources of energy in all sectors for all categories particularly in the rural areas, in order to reduce the accelerated increase in the use of woodfuel for cooking. There is also a need to intensify private-sector sustainable-environment initiatives such as reafforestation, alternative energy sources like solar technologies and easily accessible paraffin/kerosene fuel for both rural and non-electrified urban dwellers and game farms for the conservation of flora and fauna. There should be a focus on protecting rivers and lakes from pollution and siltation.

3.8 MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Box 8: Official Development Assistance and Debt Burden

Official Development Assistance
Official development assistance (ODA) to the Southern Africa subregion is declining with most countries experiencing this decline between 1990 and 2004.

Debt Burden
Debt burden is still high in the Southern African subregion with about half of the countries experiencing high, double-digit, debt service ratios.

Progress towards 2015 MDG targets

TARGET 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes commitment to good governance, development and poverty reduction.

82. Official development assistance (ODA) to landlocked countries in Southern Africa is declining with most countries experiencing this decline between 1990 and 2004. Malawi and Zambia remain favourite destinations for ODA while Botswana and Zimbabwe are the least favoured destinations for very different reasons, though, as shown in Indicator 36 graph in Appendix I. However, between 2002 to 2004, ODA to Botswana and Lesotho, declined increased in the case of Malawi, Swaziland and Zambia, and there is no data on Zimbabwe (see Indicator 36 Table in Appendix II.

TARGET 15: Deal comprehensibly with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

83. There is still a high debt burden in the Southern African subregion with about half of the countries experiencing high double-digit debt service ratios and these include Angola, Botswana, Malawi, Zambia and Zimbabwe, as shown in Indicator 44 graph in Appendix I. Malawi, with a huge decline, is likely to meet its target of below 5 per cent. Zimbabwe is declining but is unlikely to meet its target, while Botswana and Zambia incurred significant increases. Lesotho and South Africa are already in the achieved range of below 5 per cent while for Mozambique, with a huge decline from 28 per cent in 1990 to 14 per cent in 2004, is also likely to achieve the target. In the recent past, -- and more specifically 2002 to 2004 -- the debt service ratio increased for Botswana, Malawi and Zambia, dropped in regard to Angola, Lesotho, Mauritius, Mozambique and South Africa, but remained constant for Zambia.

Proposed strategies

84. Given that MDGs are a global compact, developed countries should honour the commitments they have made at different international fora to increase the quantity and quality of ODA to least developed countries and to harmonize their policies so as to align aid with the 'needs' of recipient countries. In this regard, support for HIV/AIDS programmes, and particularly the provision of ARVs, should be given priority in Southern Africa. Donor policy reforms should be in the direction of making ODA long-term and predictable, and thus amenable to planning by recipient countries. Aid should be oriented to support the MDG based poverty reduction strategy rather than to support donor-driven projects. There is a need to deepen and broaden debt relief, including cancelling the external debt of the poorest Southern African countries and finance new commitments through grants not new loans.

85. In the meantime, the subregion should promote value addition in order to increase export earnings to ensure both improved local investments and less painful debt servicing. There is a need to promote economic integration at the subregional level and particularly in the area of trade and investment in the context of the AU, SADC, NEPAD and the Common Market for Eastern and Southern Africa (COMESA).

4. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

86. Countries in the subregion have implemented varying national strategies aligned to the achievement of the social dimensions of the MDGs. During the period 2000 to 2005, many of these strategies have been in the form of World Bank/IMF initiated Poverty Reduction Strategy Papers (PRSPs), and more recently, country driven National Development Plans (NDPs). Mostly the PRSPs reflected many of the MDGs and reviews reveal that all PRSPs covered poverty headcounts, education enrolment/attendance, and maternal health while about 90 per cent covered child mortality and water. In this regard, Southern Africa is responding to the social dimensions of the MDGs through both subregional commitments and in-country strategies.

87. However, many challenges inhibit the complete realization of the MDG commitments in the subregion. Southern Africa is experiencing a complex interplay of chronic structural poverty combined with transient poverty. Poverty in Southern Africa is a multifaceted social phenomenon that includes lack of access to productive assets, coupled with lack of adequate food, health, education and other basic social amenities. To this must be added the condition of gender inequality, lack of environmental management and powerlessness to widen the choices necessary for improved human-well-being. These factors combine into a self-reinforcing process that deprives the poor of capabilities to improve their livelihoods. These high poverty levels inhibit prospects for achieving the MDGs in the subregion.

88. According to UNDP (2006), Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe have all experienced reversals in human development as measured by the Human Development Index (HDI) since 1990 and six of the 11 Southern African countries under consideration are in the low human development category .With the exception of

Mauritius which moved from medium to high in terms of the human-development category, the rest of the countries in the subregion experienced declining human development. High levels of poverty co-exist with equally high levels of within-country income inequality, exhibiting with six of the thirteen most unequal societies in the world.

89. Food insecurity is one of the major challenges to achieving the MDGs in Southern Africa. Food insecurity is caused by many factors including periodic floods and droughts, inappropriate agricultural practices and non-supportive government policies. However, poverty is now recognized as the main obstacle to achieving food security in Southern Africa. HIV/AIDS severely undermines food security, especially in rural communities. This, in turn, is compounded by gender inequalities such as women's limited access to and control of land, despite women being the majority of farmers. The Southern African subregion also faces severe environmental challenges that threaten the livelihoods of millions of people. Natural climatic phenomena such as floods and droughts as well as human-induced deforestation, have exacerbated food insecurity and hunger.

90. The HIV/AIDS pandemic poses the most severe development challenge in Southern Africa and has started to reverse the progress made towards achieving human development. The combination of high HIV prevalence rates, poverty, gender inequality and weak health-care delivery systems complicate the fight against the pandemic. Further, HIV/AIDS, and poverty, have disproportionately affected women while children have not been spared either by both the disease and orphanhood.

91. The attainment of the MDGs in Southern Africa will be a costly exercise requiring enormous financial resources for the massive public investments needed. Given that Southern Africa is home to some of the world's poorest countries, the scale of the funding requirements necessary to achieve the MDGs is beyond the means of many Southern African countries. Domestic economic growth will be critical in expanding the 'resource envelope' necessary to finance the MDGs. However, recent experience of economic growth in the agriculturally dependent SubSaharan Africa is sobering as the growth has not translated into reductions in poverty. External debt remains a serious resource constraint to achieving the MDGs.

92. The kind of macroeconomic policies a country pursues determine the progress towards the attainment of MDGs and the rate of wealth accumulation. Economic growth and the distribution of its gains for poverty reduction is highly critical to the attainment of the MDGs. In this regard, supportive macroeconomic policies and more direct interventions to support 'growth with livelihoods and equity' require a focus on a new framework for the role of development partners.

93. Even though many countries in the subregion are unlikely, under current conditions, to meet the MDGs, the outlook is not completely bleak.

94. The achievement of the MDGs is hard to envision without the necessary governance institutions and practices, to create the conditions for translating development policies into reality, and to stir people into building sustainable livelihoods for themselves. The political and economic landscape in Southern Africa has changed dramatically over the last two decades. The one-party state systems have largely been discarded, and the urge for state ownership and control

of national economies has ebbed. Governments have elevated the private sector to special prominence, conferring upon it the tasks of growing the economies and creating jobs. The civil society has adopted an active posture, raising their influence on national policies, and steadily inducing political and economic inclusiveness. Donors are overhauling their assistance approaches, stressing partnership for, and countries' ownership of, their own development. Despite the progress made to date, there are various areas of political, economic and corporate and institutional governance which still need improvement. For example, consolidation of democratic political governance, adoption of sound broad-based pro-poor economic policies as well as implementing institutional checks and balances remain major challenges in the subregion.

95. The AU and SADC have evolved various treaties and protocols to urge member States to commit themselves to sustainable development agenda in areas such as health, education, water and sanitation. The subregional protocols and declarations reflect subregional commitments and pledges to the various social dimensions of the MDGs. The realization of these dimensions depends on factors such as in-country strategies, finances, and political will and commitment.

4.2 Recommendations

96. Given that there is no harmonized regional or subregional database for the monitoring of MDGs and development in general, there is an urgent need to compile such a database. It is also imperative for national statistical offices in the subregion to be proactive in submitting up-to-date statistics to the international databases.

97. There is a need to adopt sound broad based, pro-growth, pro-poor economic policies in the sub-region. The issue of growth and development for the attainment of MDGs goes beyond the requirement for macroeconomic stability; it includes policy imperatives such as debt sustainability, cautious trade liberalization and promotion of fair trade, job creation, promotion of sustainable livelihoods, poverty reduction and good governance. These actions need to be reinforced through stronger international action and partnerships, including reforming trade, delivery of more effective aid and stronger private flows in order to make progress on MDGs.

98. Southern Africa should pursue comprehensive agrarian reform programmes that include land re-distribution, support to improved agricultural productivity, environmental conservation and creation of decent employment opportunities. Improved agricultural productivity requires timely availability of agricultural inputs such as seed and fertilizer, improved agricultural technology, effective agricultural extension services, marketing and distribution, effective price incentives among other factors. Such programmes need support at both the subregional and national levels.

99. Given that the economy of the subregion is strong in agriculture and mining, there is a need to actively promote value addition in support of the growth of a strong manufacturing sector. Value added exportables generate higher foreign exchange earnings to sustain growth and development in the subregion.

100. Decent employment creation remains the key link between economic growth, creation of livelihoods and poverty reduction, and these elements have to feature prominently in the design

of poverty reduction strategies and interventions for attaining the MDGs. The private sector is a key player in wealth creation and in the decent work agenda, and an enabling environment should be created to allow the sector to flourish.

101. For aid to generally be effective in the subregion, there is a need for home-grown institutional competence and transparent budgetary processes to be able to manage the resource flows effectively and avoid the currency overvaluation problem. Aid should now be tailored to long-term poverty needs and the attainment of MDGs rather than short-term agendas of the donor countries.

102. While debt cancellation has provided financial relief to allow some governments in the subregion to redirect critical resources from debt repayment to the provision of critical social services, a report by the Commission for Africa reveals that debt cancellation is inadequate and more resources are required for poor countries to attain the MDGs. It is desirable for developed countries to offer developing countries grants rather than loans for social services provision, with minimal conditionalities to avoid undermining local accountability.

103. The subregion needs to emphasize infrastructure development as the basis for sustainable growth and development towards the attainment of MDGs.

104. Given that many countries in Southern Africa are poor and facing severe HIV and AIDS crises, there is a need for more aid and increased public spending to tackle the pandemic. This may require expansionary rather than contractionary fiscal and monetary policies, depending on the circumstances in a particular country. Increased public spending, although it may pose challenges for macroeconomic management, is unavoidable under such circumstances. Inflation management should not mean curtailing essential expenditures needed for attainment of the MDGs.

105. Furthermore, there is a need for more expansionary public-investment-led economic policies with a view to promoting more broad-based, pro-growth and pro-poor economic strategies. Fiscal policies should be focused on substantially scaling up public investment, towards channeling considerably more lending to productive private investment combined with monetary policies reshaped to target, not just inflation, but also real economic variables, such as increases in incomes and jobs as well as reduction in poverty.

106. Key areas of focus on political governance in the subregion include promoting popular participation in policymaking, reviewing mechanisms for political party funding, strengthening election systems and enforcing and monitoring gender-related protocols, conventions and agreements. The separation of powers between the executive, legislature and judiciary should be clear and strengthened through adequate funding, and by ensuring that the operational autonomy of the legislature and judiciary is well established. The separation of powers in governance, coupled with national constitutions that guarantee and protect the rights of all citizens, presents an environment that will promote positive participation of the private sector and civil society in national development. Parliamentarians have a key role in ensuring that governments deliver their responsibilities to citizens. In this regard, the skills of parliamentarians need to be enhanced. Accountability is pivotal to good governance.

107. Institutionalizing the culture of political pluralism by, say, welcoming other political parties' input in the management of national affairs, is still receiving a tepid support from ruling parties. Countries in the subregion still need to ensure that the legislatures and watchdog bodies are legally and institutionally empowered to perform their oversight functions effectively. Moreover, more civil society activism must be encouraged. It is this inclusiveness that will ensure a prudent use of national resources for the eradication of extreme poverty and hunger.

108. The SADC/AU target of 50 per cent for women's presence in parliaments and other State organs must be taken to heart by all member States. While good progress has been made, women's participation in national economic and political affairs in the subregion remains low. Given that poverty affects women more than men, gender equality and women empowerment both in public and private sectors will lead to policies that are attuned much more effectively to addressing health issues such as maternal health, child mortality and poverty in general.

109. Key areas of focus in economic management and corporate governance in the subregion include the adoption of sound economic policies, creating effective public sector management, having strong political leadership to mitigate the impact of HIV/AIDS and ensuring public participation in economic policymaking. The momentum on the implementation of economic and corporate governance reforms since the 1990s, which stabilized macroeconomic indicators, raised spending on social sectors and tackled economic crimes, must be sustained. This progressive shift in public spending should bolster the fight against HIV/AIDS, malaria and other diseases, while improving the quantity and quality of education, especially for girls.

110. To boost private-sector growth, authorities must exert their energies on implementing and enforcing the existing large number of provisions on corporate governance for the creation of an attractive business environment. Companies need to intensify their work on corporate social responsibility, especially in the areas of environmental protection and the provision of social services such as health, water and sanitation and education.

111. The MDGs are a tall order for any LDC to deliver. Governments on their own cannot manage to address the demands of attaining the MDGs. There is a need for government, the private sector and civil society to enter into a sincere partnership to ensure that the MDGs are met. Public private partnerships (PPP's) can help tackle the issues of HIV/AIDS, waste management, water delivery, and sanitation services amongst many other domestic goals. At an international level PPP's can ensure that World Trade Organization (WTO) negotiations are equitably handled for the benefit of the continent. United Nations resolutions can be thoroughly discussed and domesticated with a sense of commitment. Subregional integration programmes can be clearly assessed and analysed before being adapted. Bilateral and multilateral agreements can be studied and internalized such that as much benefit as possible can be derived from their implementation.

112. There is a need to promote subregional economic integration, particularly in the area of trade and investment, in the context of the AU, SADC, NEPAD and COMESA. SADC as a body should continue to develop protocols around the core social dimensions of the MDGs and immediately address the protocol gap in the area of water, as recommended by the Sirte Protocol of AU. To strengthen delivery, SADC should devise systems of closely monitoring these pledges. There should be a commitment to localizing core human development protocols, by, for

instance, enshrining social rights including especially those related to the MDGs, in the country-level constitutional bill of rights, so that citizens can take governments to court for failure to deliver.

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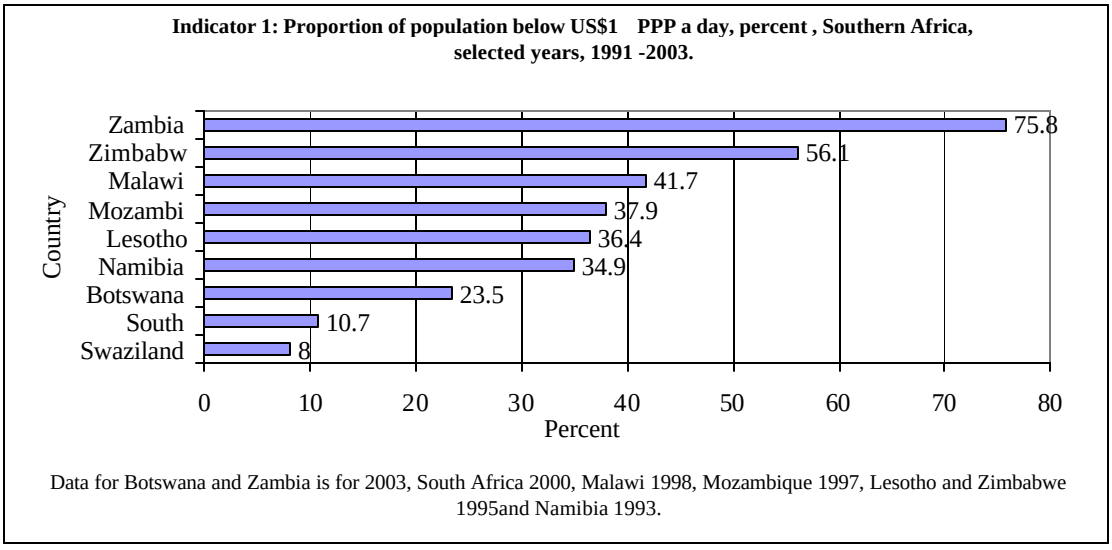
6. APPENDICES

APPENDIX I

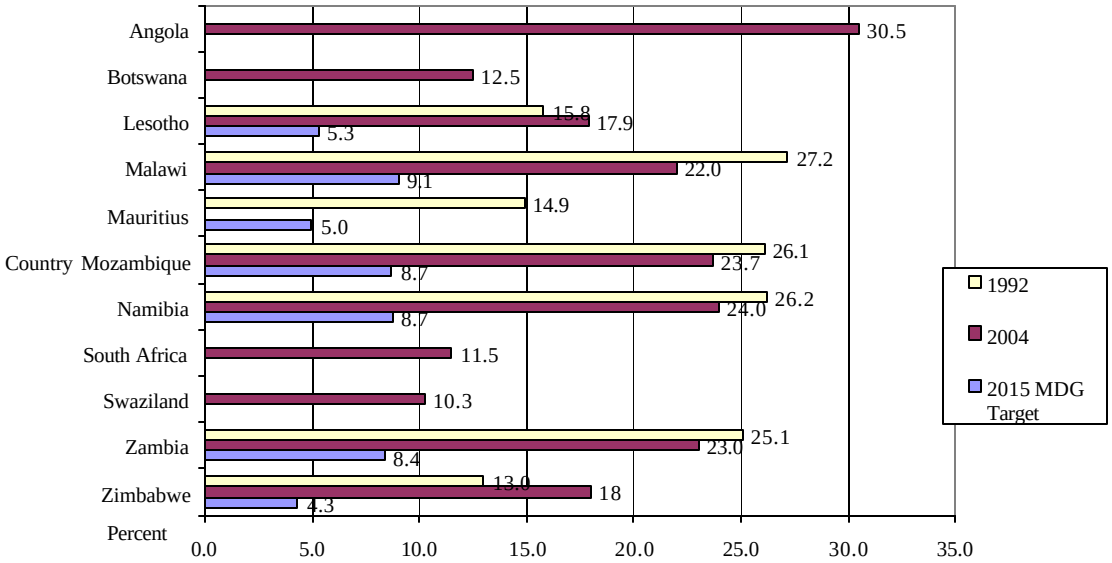
Source: All MDG indicators were compiled from an international MDG UN data base on the following website: www.devinfo/mdginfo2006/

For most Southern African countries, the target of halving the proportion of the population below the US$1PPP per day seems unachievable.



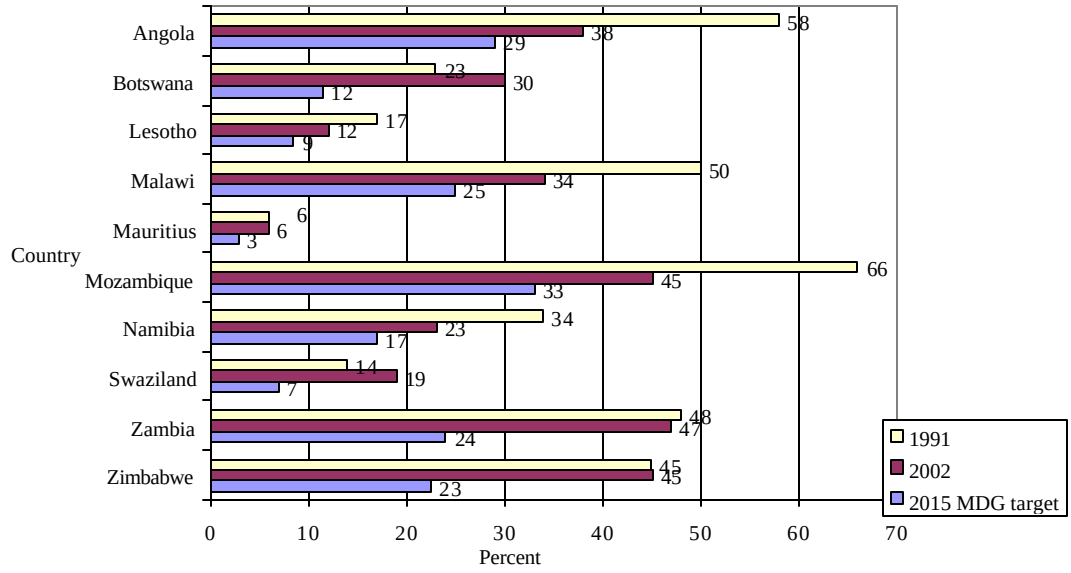
Hunger, food insecurity and child malnutrition remain a problem in the sub-region, with most countries unlikely to meet their malnutrition and minimum dietary energy consumption requirement targets.

Indicator 4: Prevalence of underweight children under five years of age, percent, Southern Africa, selected years 1992- 2004



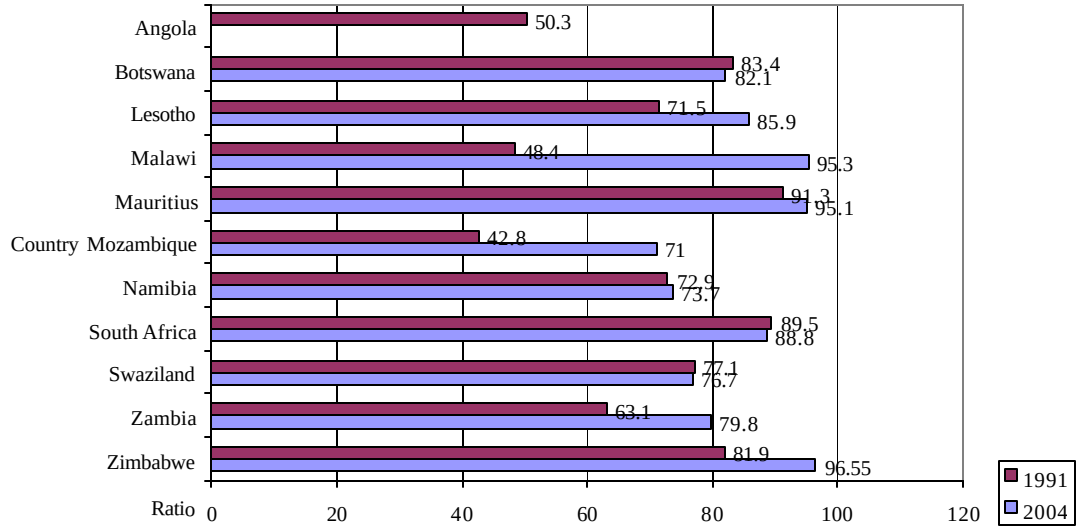
Under 1992, the indicator for Mauritius is for 1995 and that of Zimbabwe is for 1999. Under 2004, the indicator for South Africa is for 1999, Angola for 2001, Botswana, Lesotho, Namibia, Swaziland for 2000, and Mozambique, Zambia and Zimbabwe for 2003.

Indicator 5: Proportion of population below minimum level of dietary energy consumption , percent, Southern Africa, 1991 and 2002



The number of children attending primary school in Southern Africa is high with most countries likely to achieve the universal primary education goal and targets.

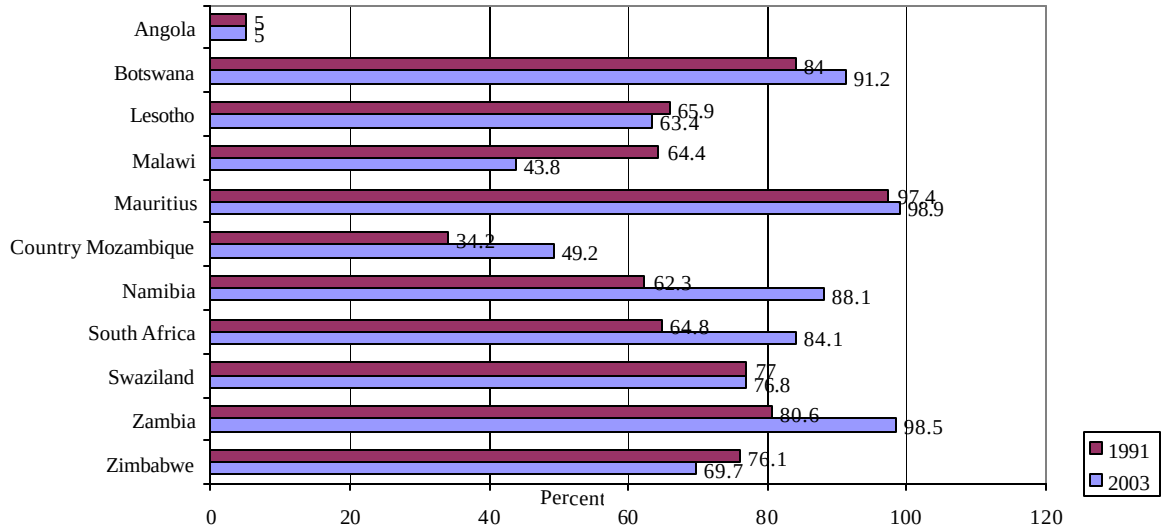
Indicator 6. Net enrolment ratio in primary education, percent , Southern Africa, selected years, 1991 - 2004



Under 1991, the indicator Zimbabwe is for 1994 and for Namibia and Zambia its for 1999. Under 2004 the indicators for Namibia, Swaziland and South Africa are for 2003.

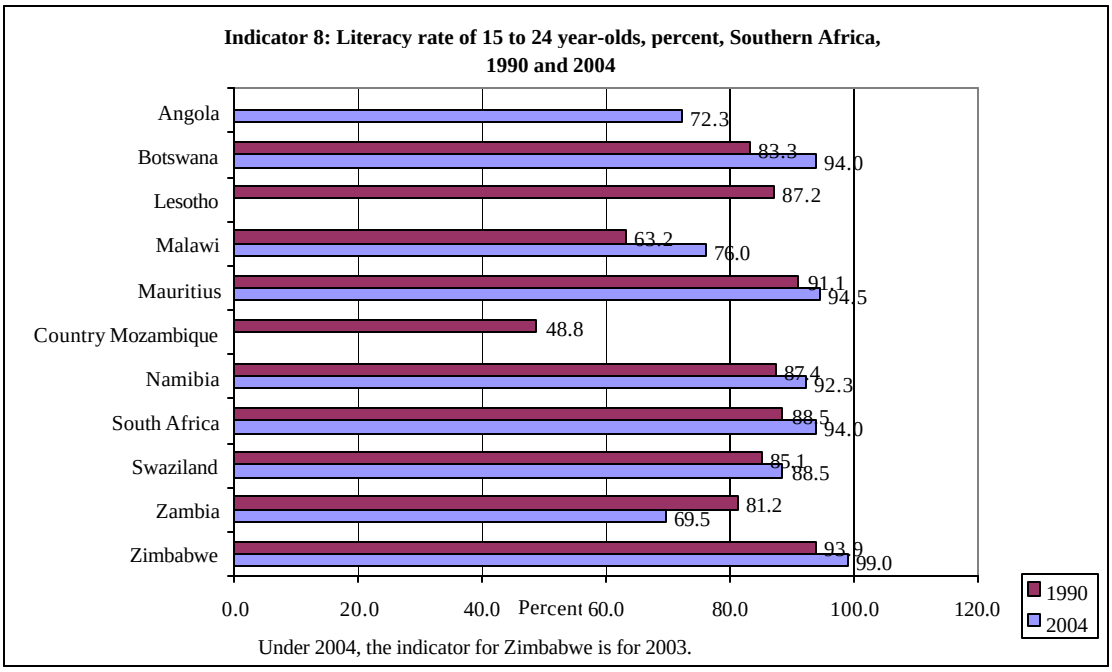
Internal efficiency has been maintained in the primary education system as Grade 5 completion rates have generally increased in all countries between 1991 and 2004.

Indicator 7 : Proportion of pupils starting grade 1 who reach grade 5, percent, Southern Africa , selected years, 1991-2003

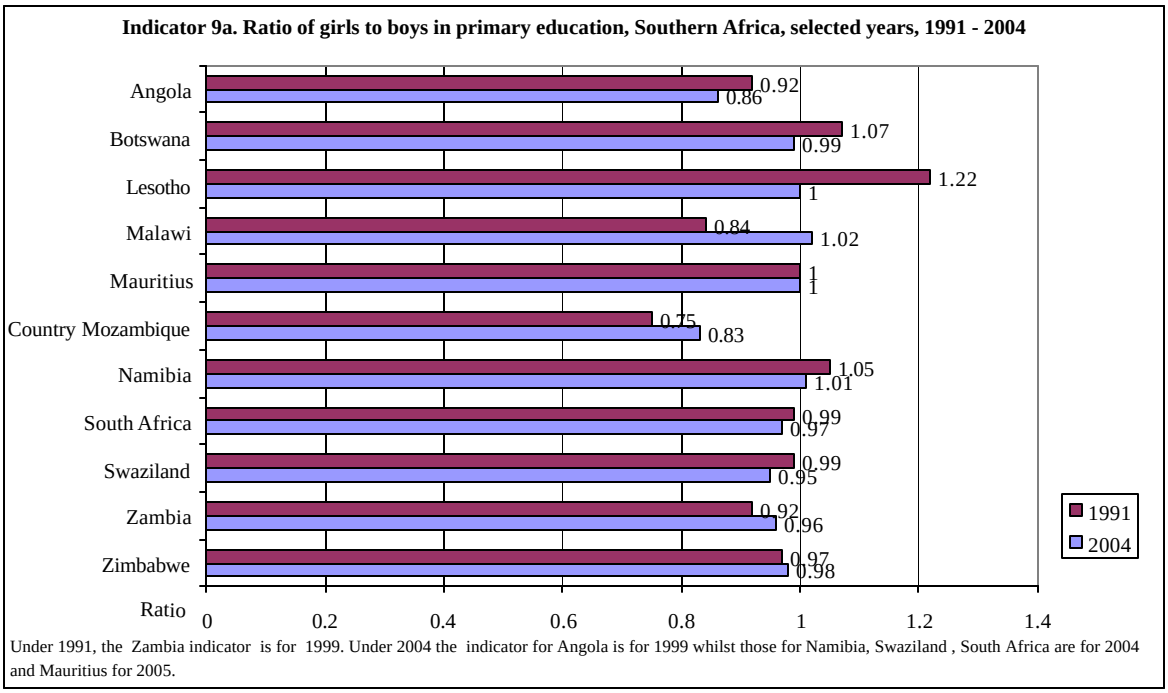


Under 1991, indicators for South Africa and Zambia are for 1999. Under 2004 indicators for Mauritius, Malawi, Mozambique and Zambia are for 2001, indicators for Namibia, Swaziland, South Africa and Zimbabwe are for 2002 and indicators for Angola, Botswana and Lesotho are for 2003.

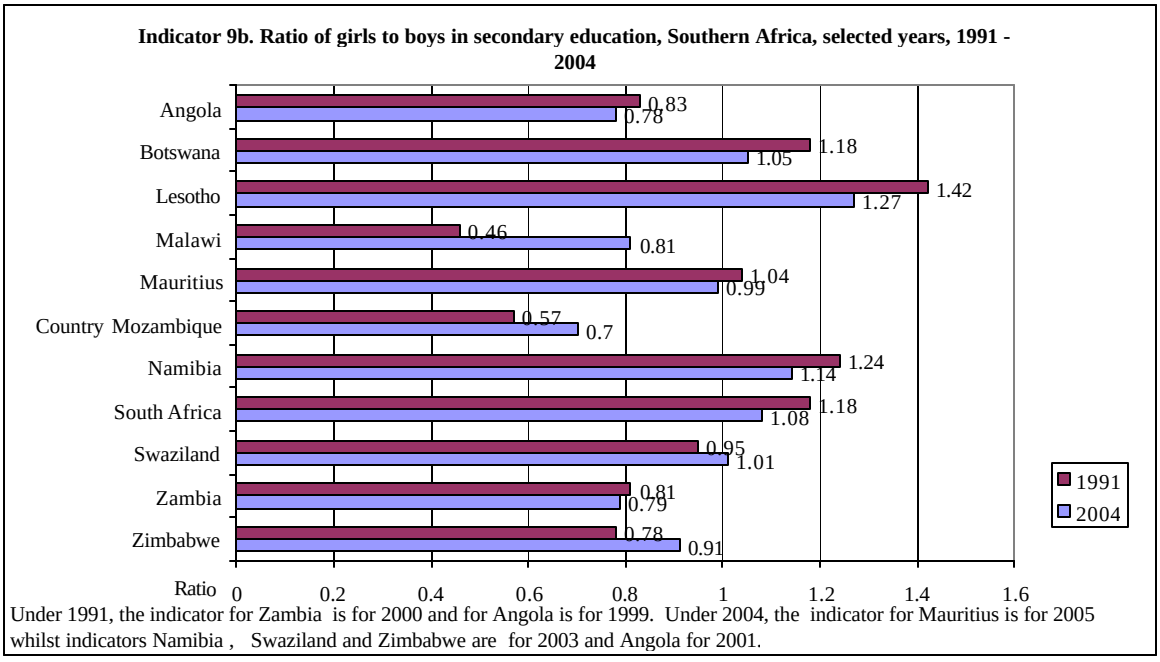
Literacy rates for the 15-24 year olds are very high in the sub-region.



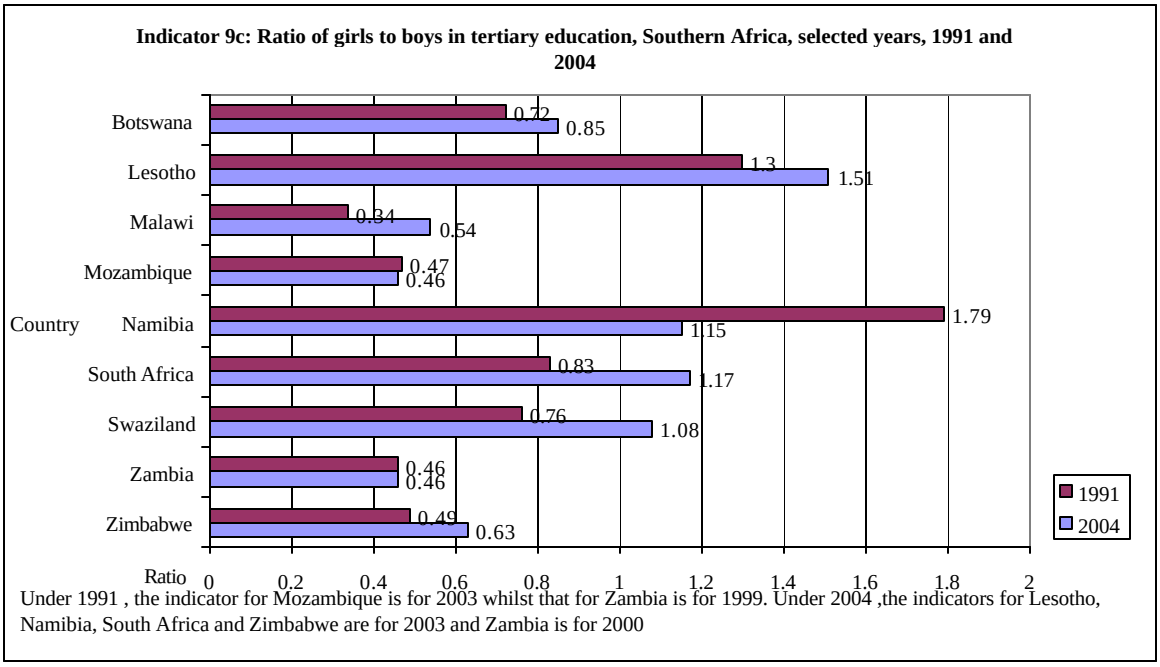
Gender parity in primary education has been reached or is likely to be achieved in most Southern African countries.



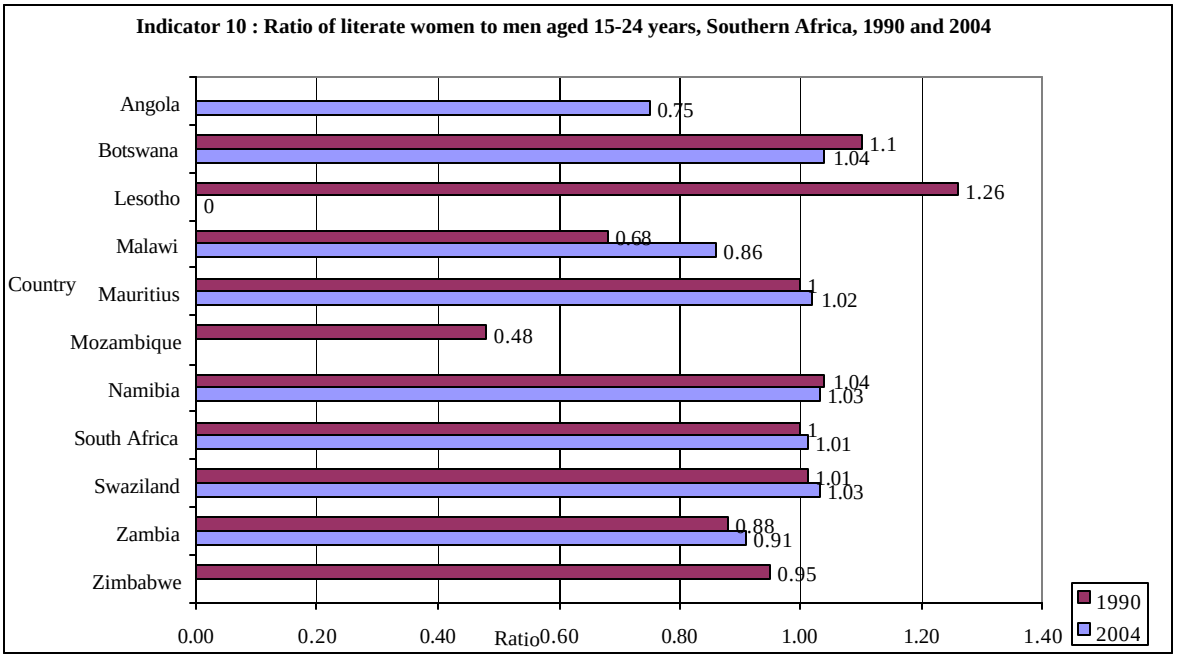
Gender parity in secondary education has been reached or is likely to be achieved in most Southern African countries. However, it should be noted that at secondary school level, the NERs are generally low such that the issue of concern should not only be to achieve parity but to increase enrolment of both boys and girls.



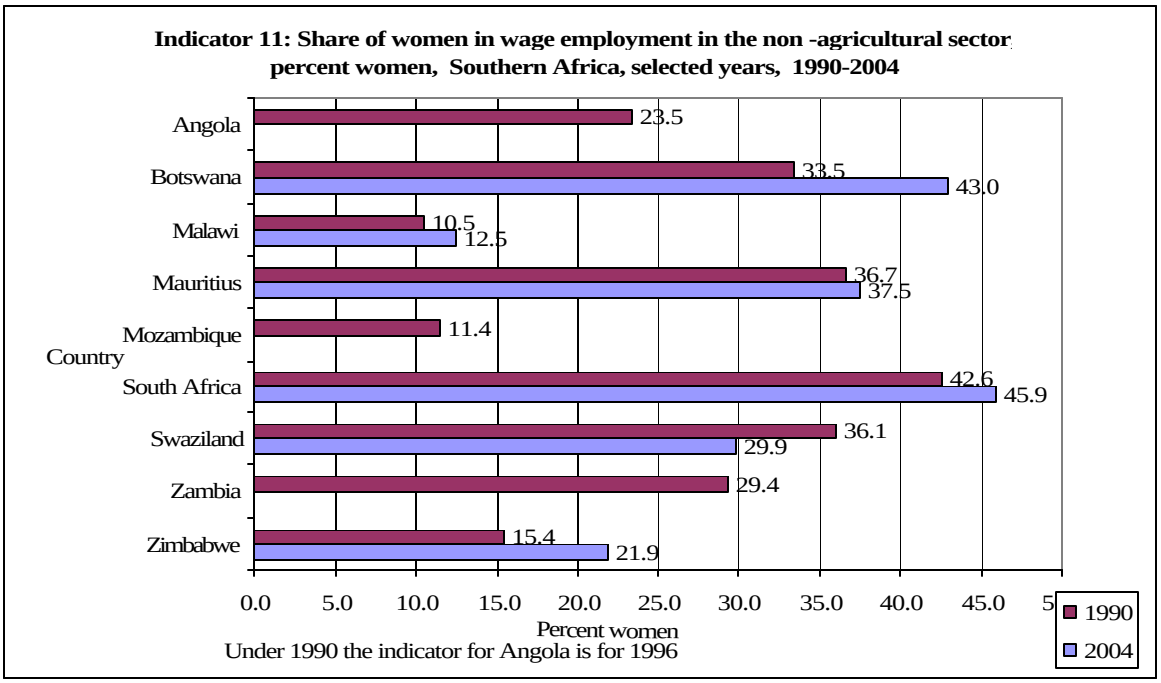
There is a lot of gender imbalance in tertiary education in the sub-region with five countries having a bias against girls, three countries a bias against boys and one country having achieved the target. Overall gender parity in tertiary education may not be achievable in Southern Africa by 2015.



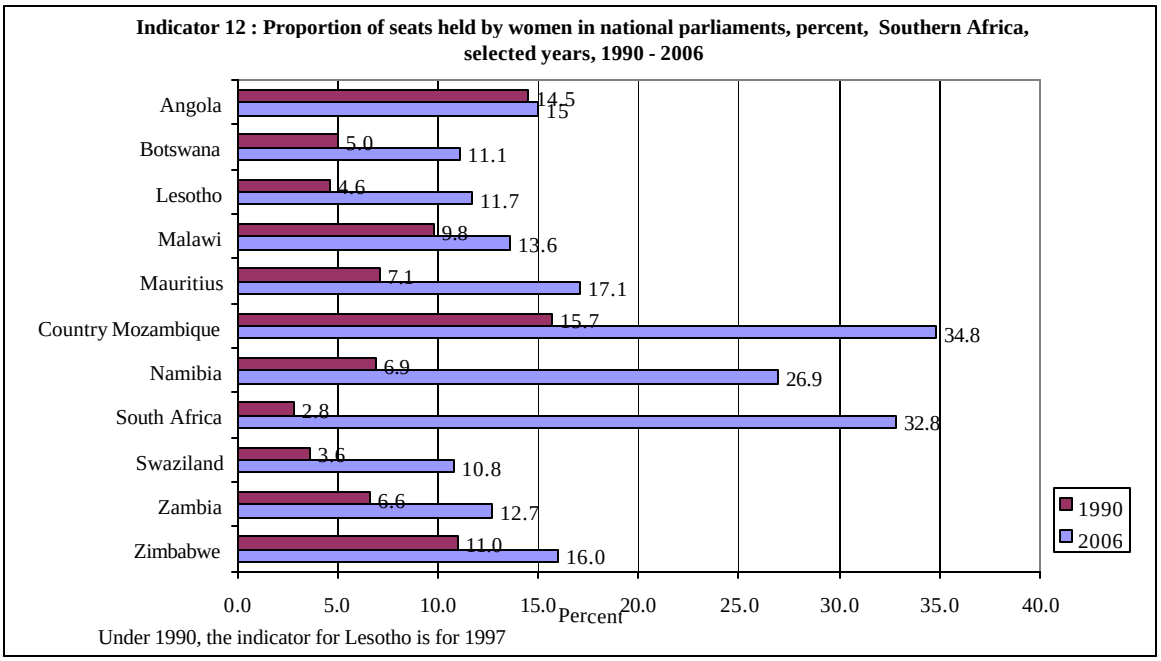
Gender parity in the number of women and men aged 15 -24 years who are literate is achieved or likely to be achieved in most countries.



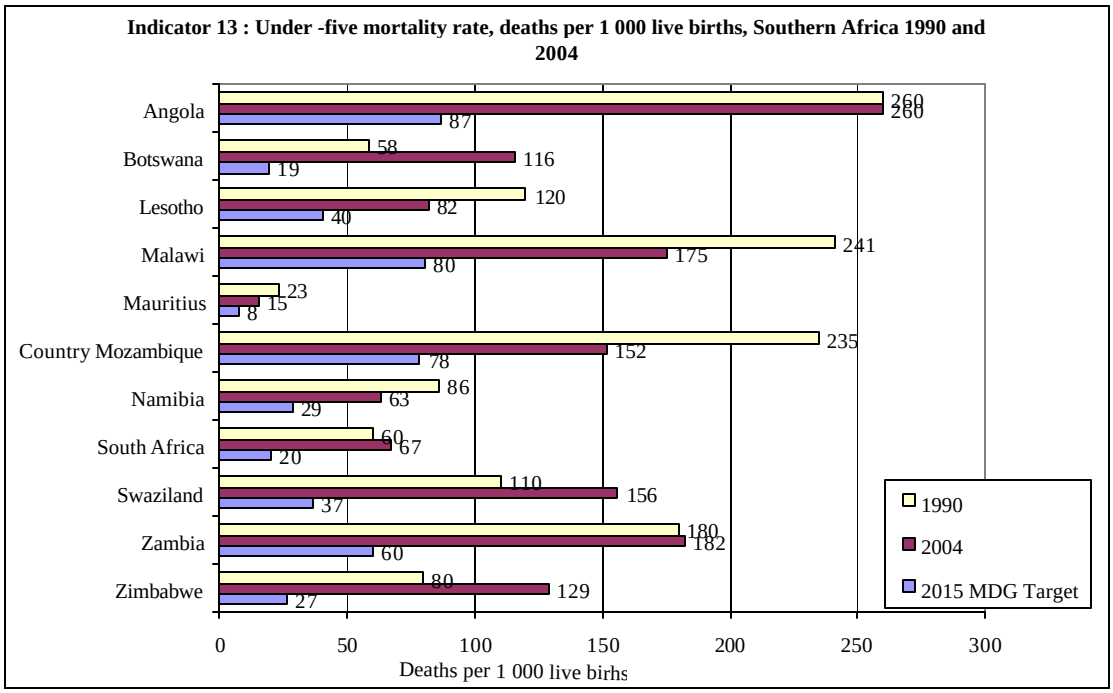
The share of women in wage employment in the non-agricultural sector remains very low in the sub-region, as such the overall target of 50 percent by 2015 is not achievable for most countries.

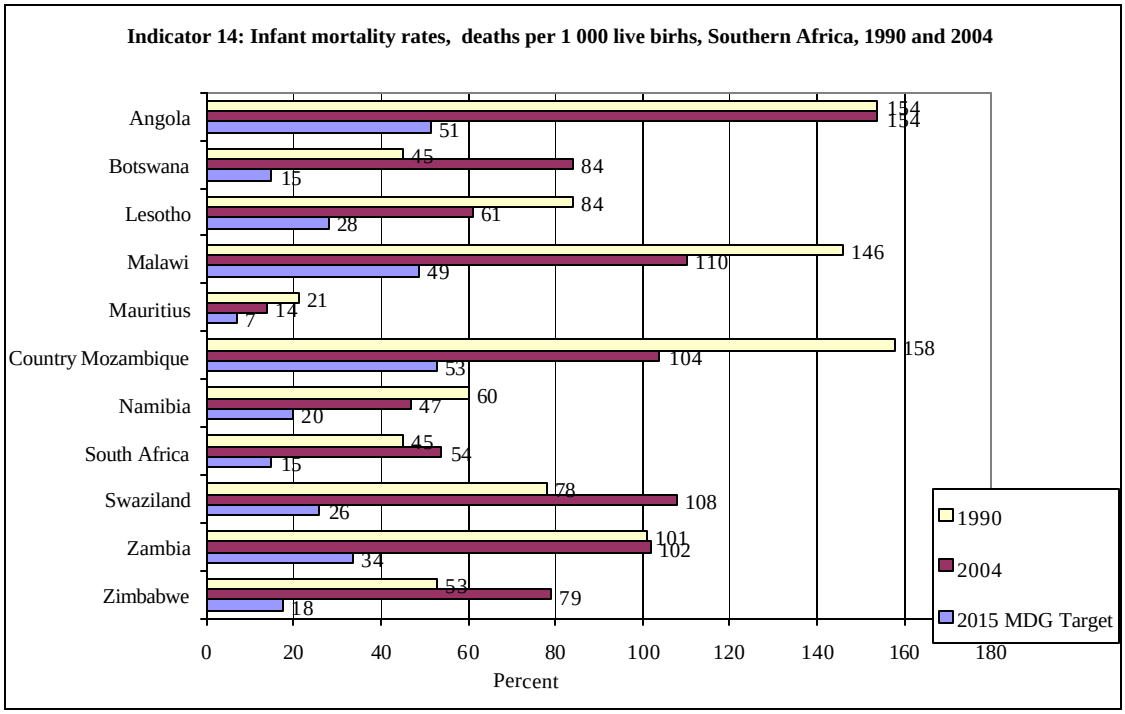


More women are in parliaments in all Southern African countries today than ever before. However, in most countries women remain vastly under-represented in politics.

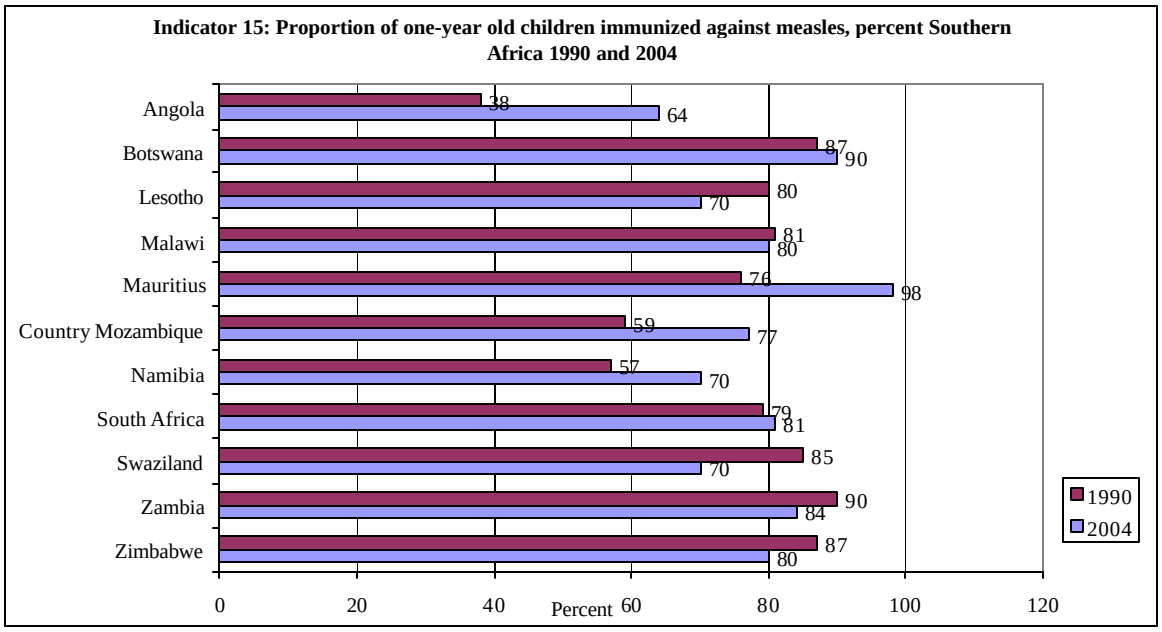


Under-five and infant mortality rates remain high in Southern Africa with most countries experiencing increases.

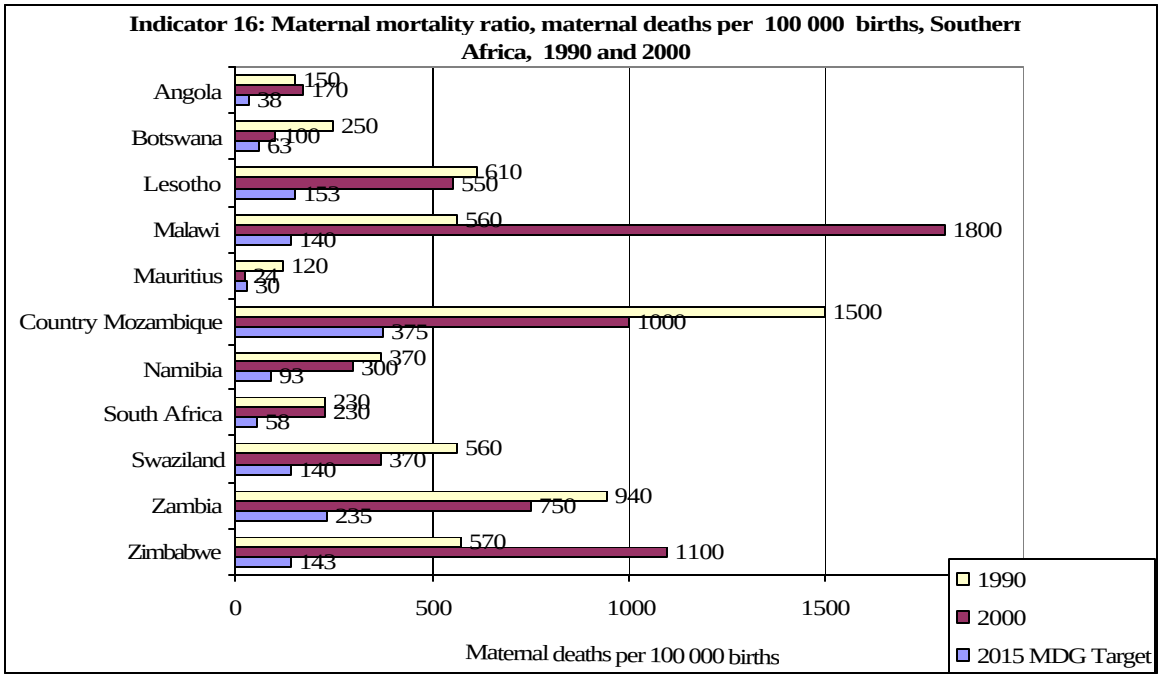




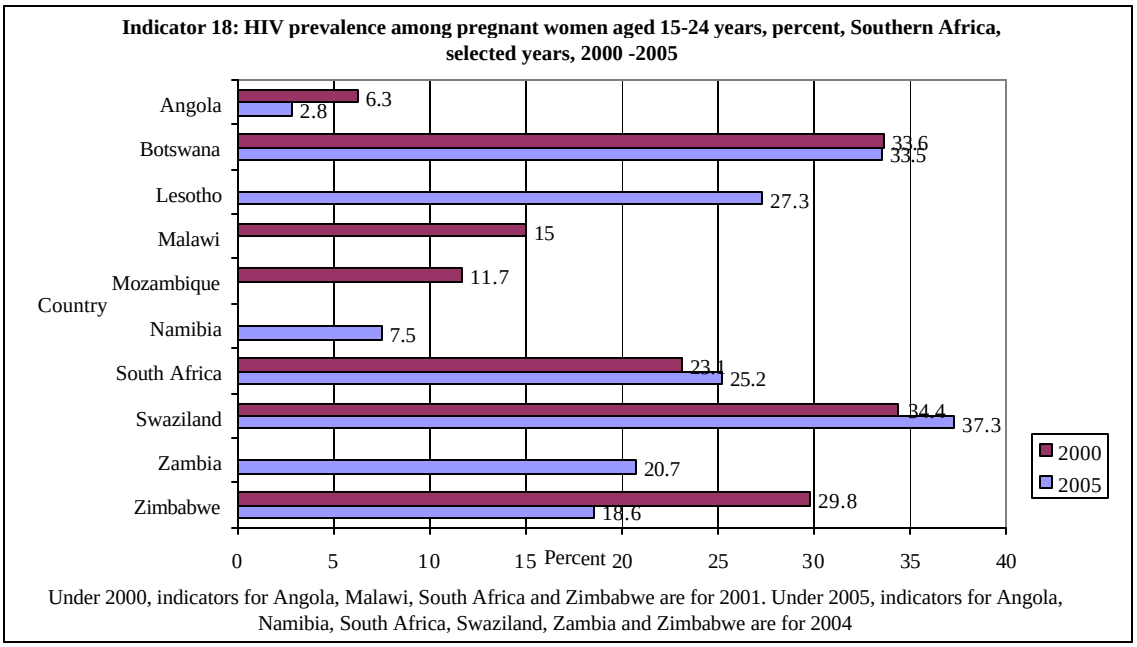
While high immunization levels of one year olds against measles had been achieved in most Southern African countries by 1990, and current immunization levels remain generally high, the declining coverage in a number countries by 2004 is a cause for concern.



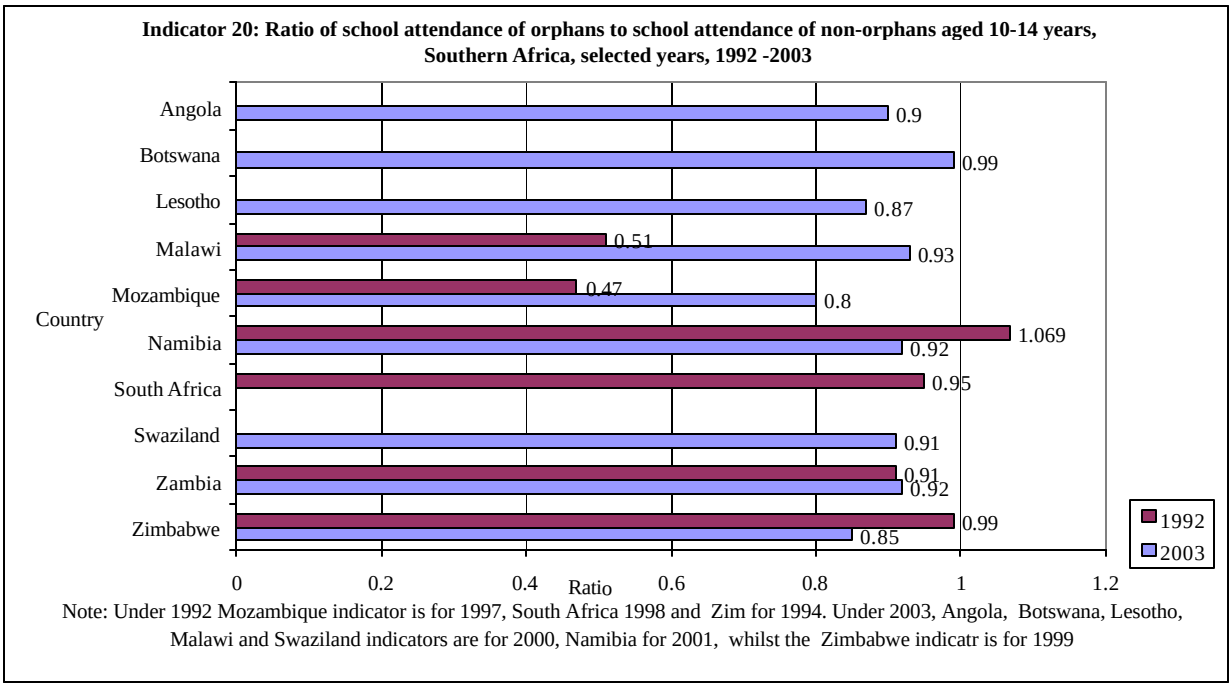
Maternal mortality remains high and is falling at a painfully slow rate in most Southern African countries and this is combined with alarming increases in two of the countries. The target of reducing by three quarters the maternal mortality ratio will not be met by most countries in the sub-region.



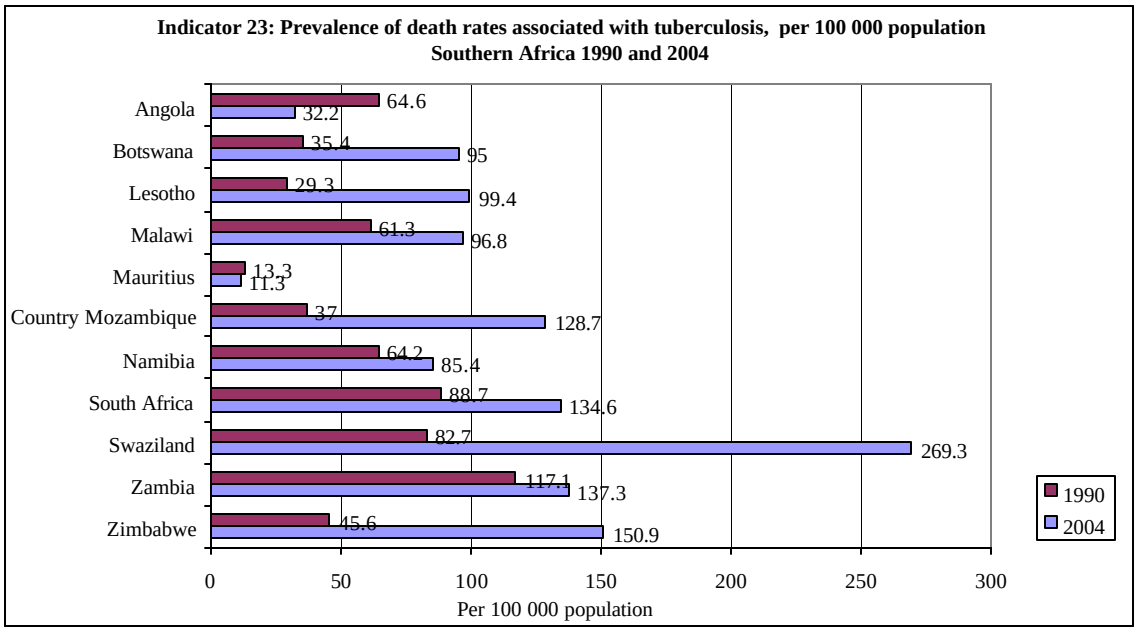
The subregion remains the epicenter of HIV and AIDS with HIV prevalence still recording double digit and on the increase in most countries in the sub-region.



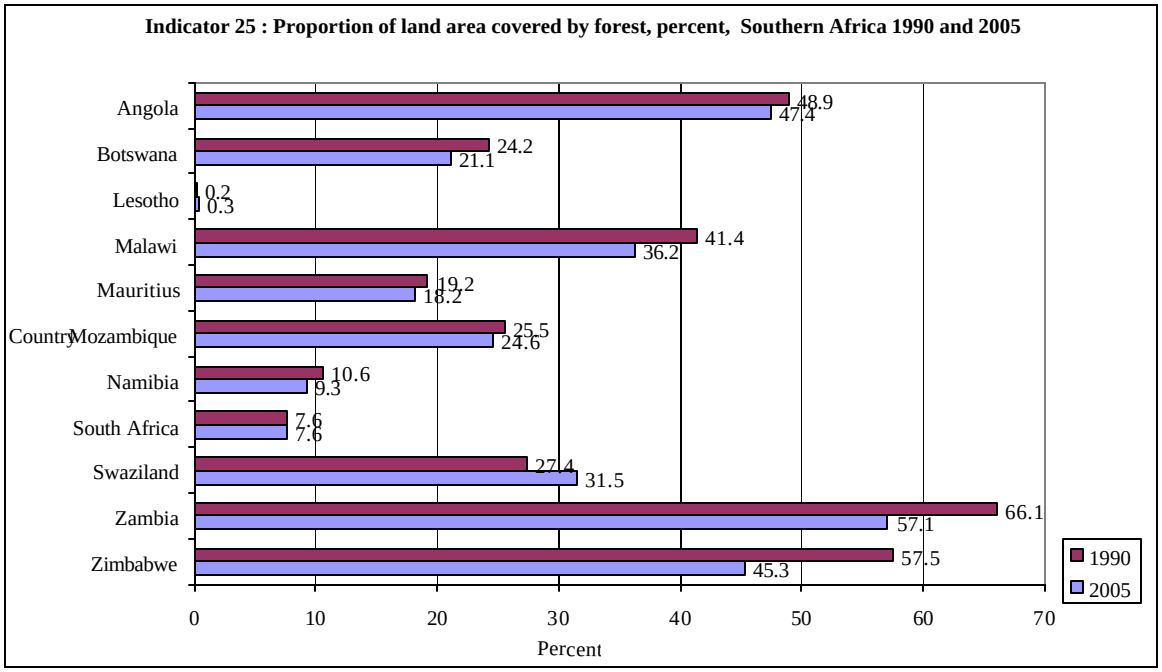
Although school attendance by orphans is generally very high, a relatively significant proportion of orphans continue to be disadvantaged in terms of school attendance in most Southern African countries.



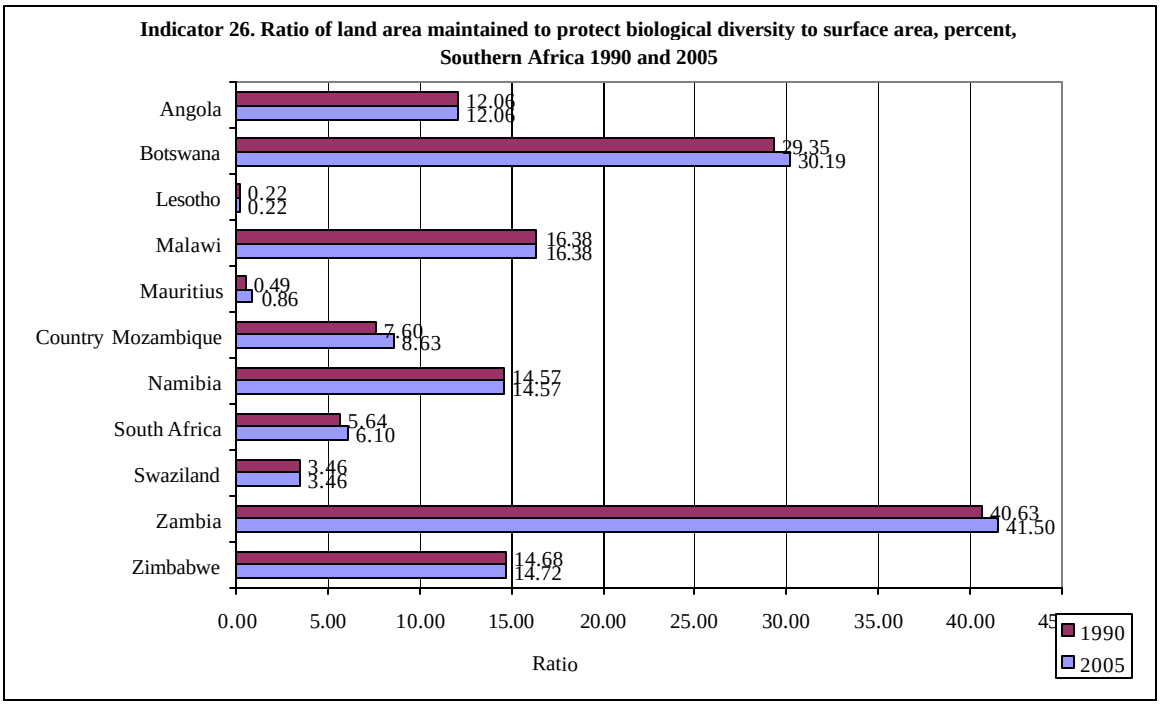
Deaths associated with tuberculosis have drastically increased in most countries in the sub-region in the past decade since 1990. Given the current context of high HIV prevalence, the 2015 target of halting and reversing the incidence of tuberculosis will not be met.



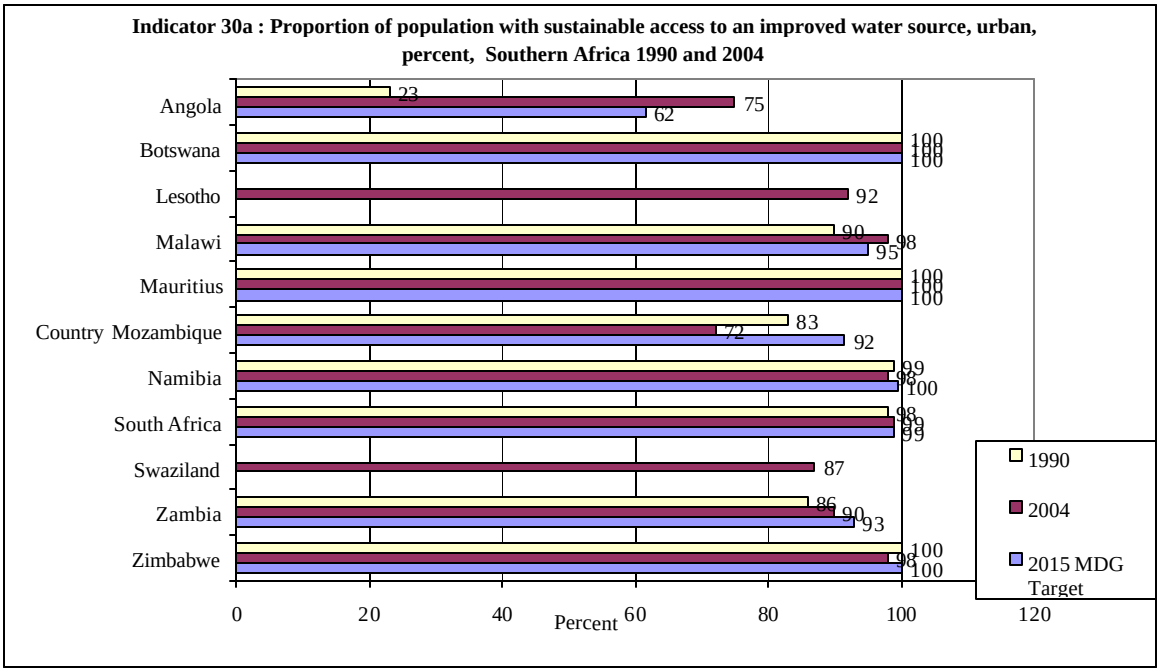
Deforestation is on the increase in the Southern African sub-region with most countries experiencing a fall in land area covered by forest.



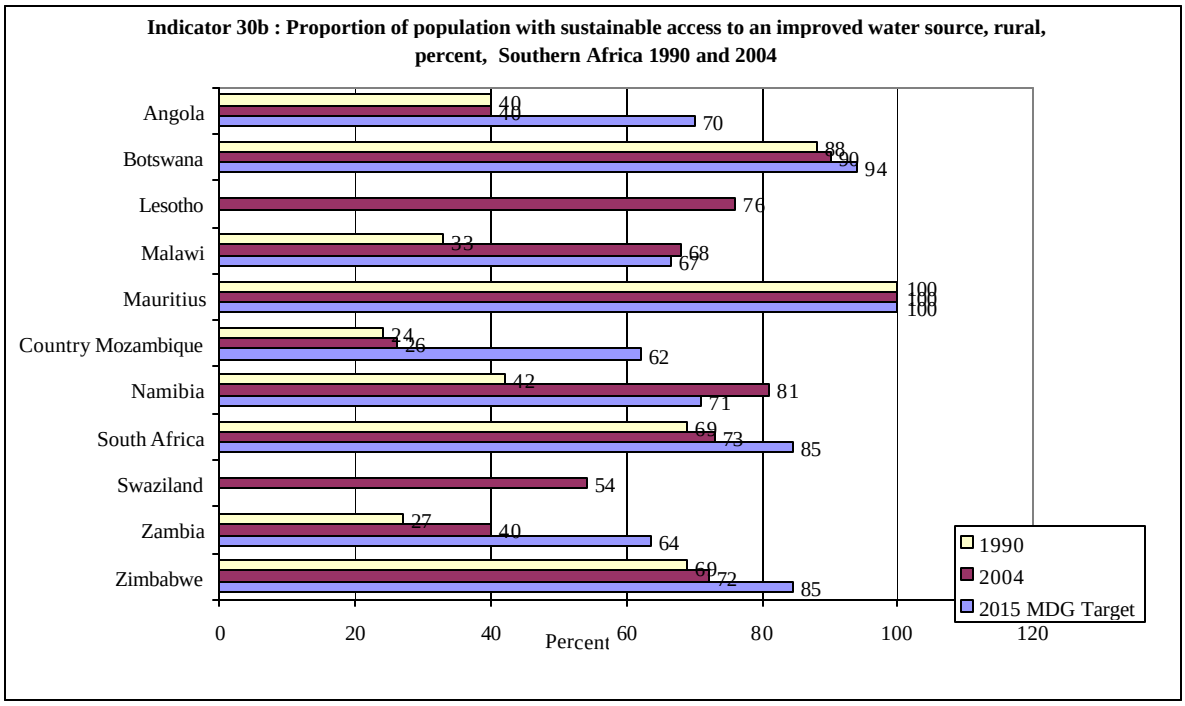
The proportion of land area maintained to protect biological diversity is slightly on the increase in the subregion with most countries maintaining stable proportions and the rest slightly increasing.



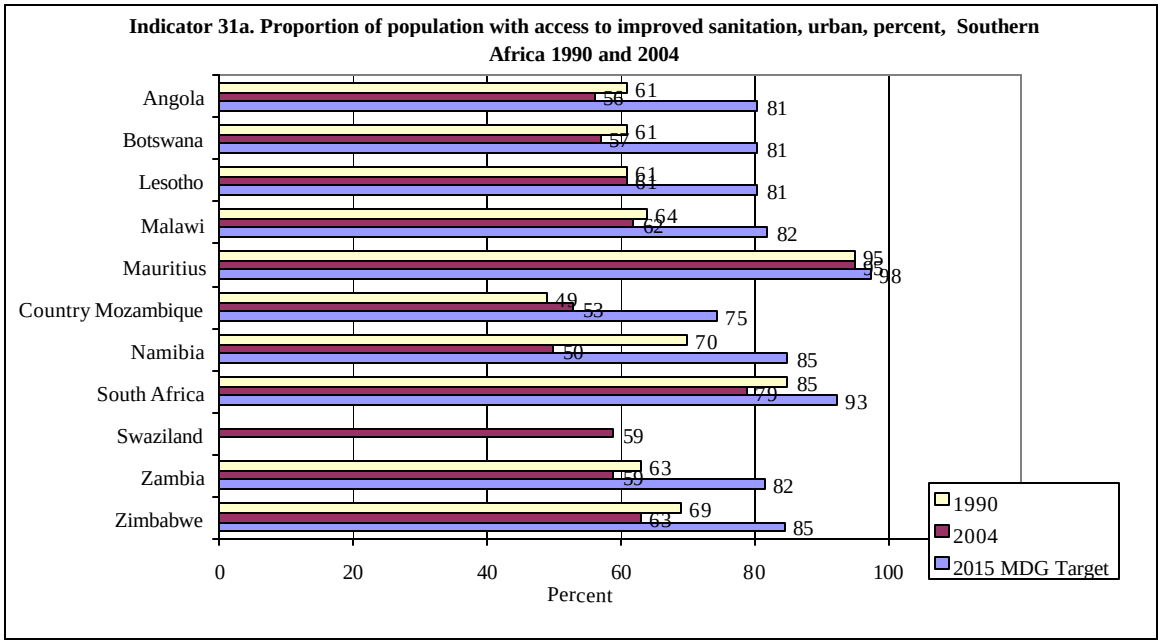
Most Southern African countries have achieved or are likely to achieve the 2015 targets of sustainable access to safe drinking water in urban areas.



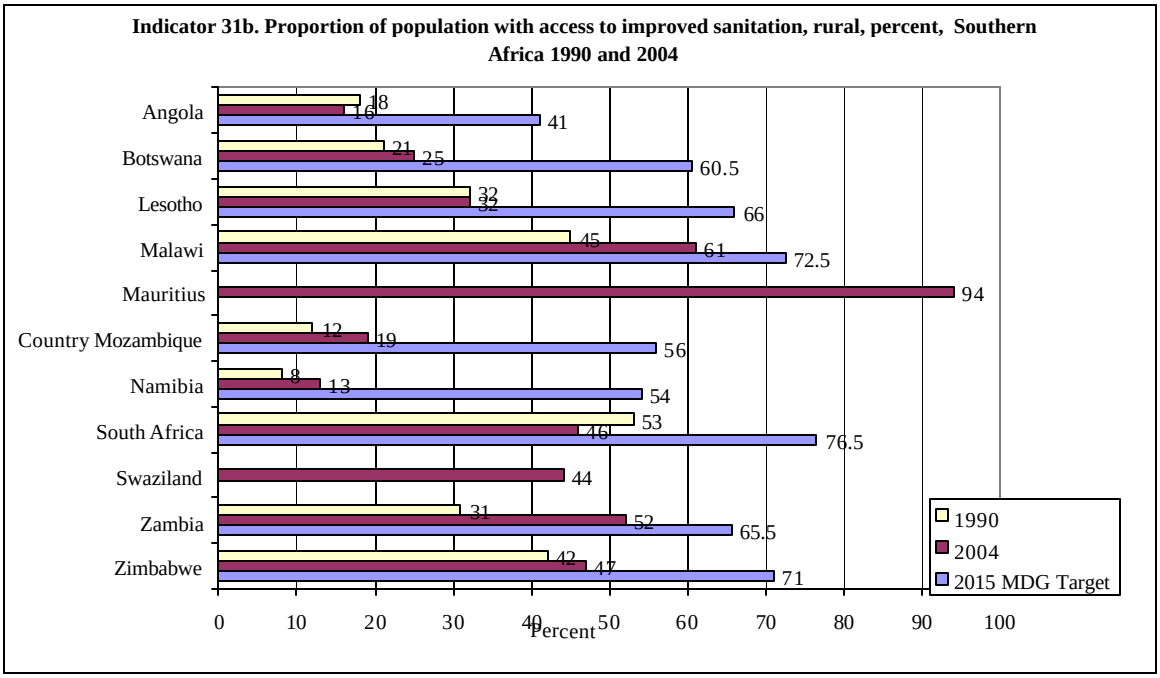
Even though most countries in Southern Africa have seen an improvement in the sustainable access to an improved water source in rural areas, meeting the 2015 targets remains a challenge in the sub-region.



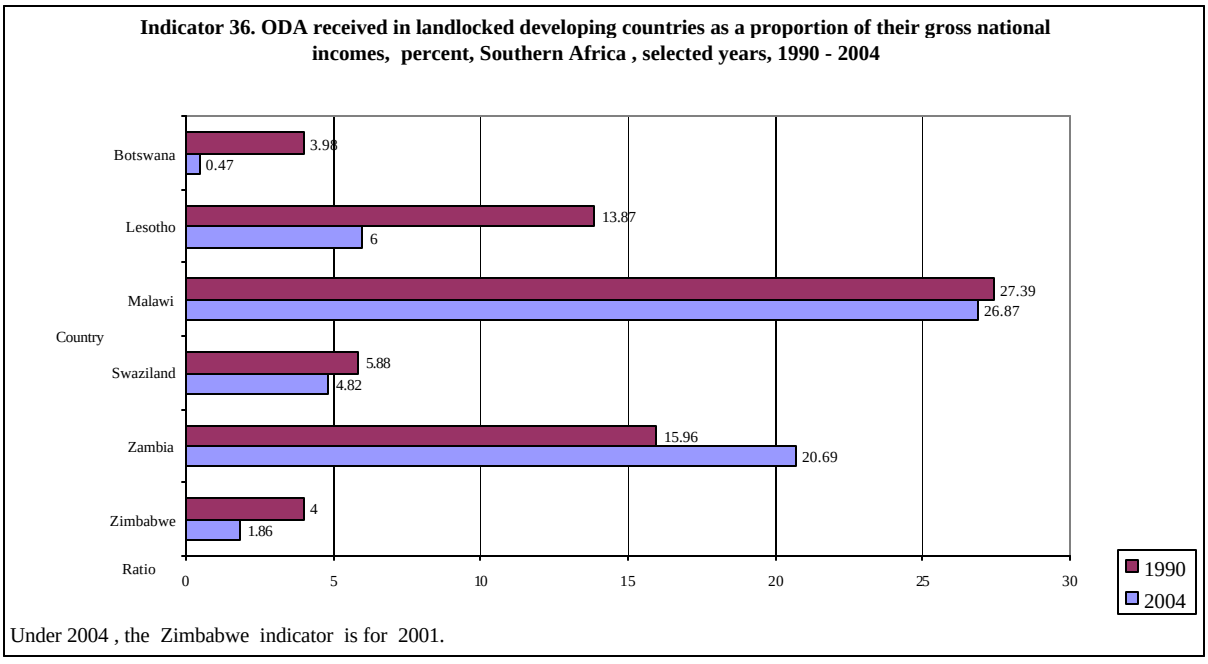
Most Southern African countries are experiencing a decline in access to improved sanitation in urban areas and a rise in such access in rural areas. However, overall, the 2015 MDG improved sanitation targets will not be achieved in the sub-region.



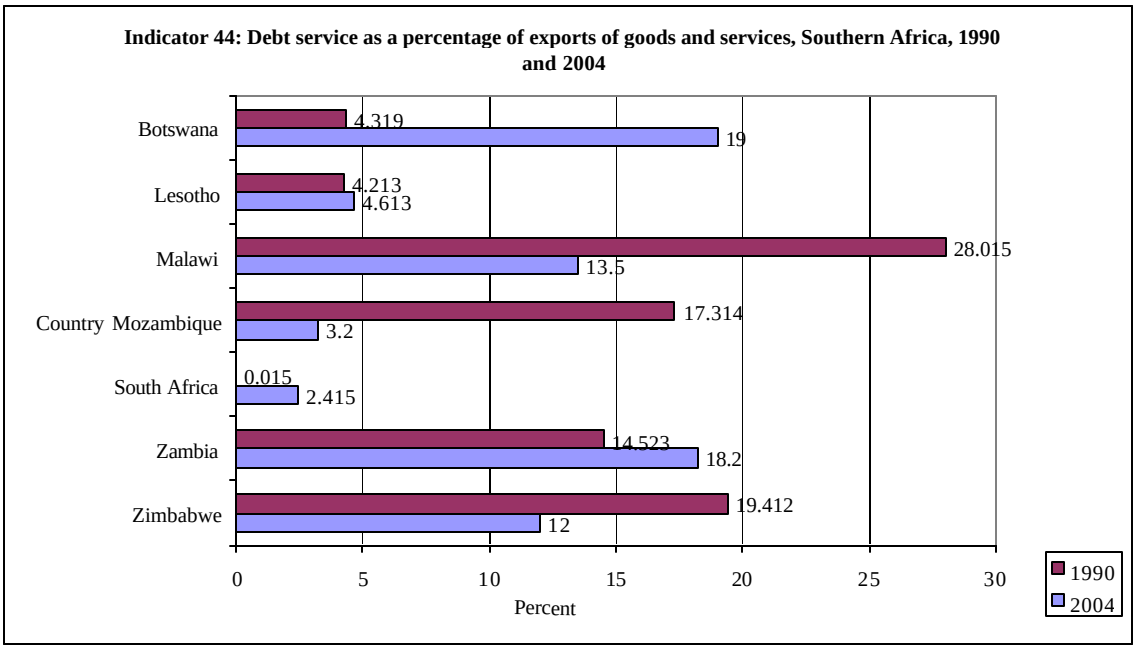
Most Southern African countries are experiencing a rise in access to improved sanitation in rural areas. However, the 2015 MDG targets for improved sanitation in rural areas will not be achieved in the sub-region.



Official development assistance (ODA) to the Southern Africa sub-region is declining with most countries experiencing this decline between 1990 and 2004.



Debt burden is still high in the Southern African sub-region with about half of the countries experiencing high double digit debt service ratios.



APPENDIX II

Table 1: Human Development and Inequality in Southern Africa, Human Development Index and Gini coefficient, Southern Africa, selected years, 1990 -2004.

Country	Human Development Index (HDI) Trend				Gini Coefficient	
	1990	1995	2000	2004	Year	
Angola	..	..	..	0.439	--	--
Botswana	0.680	0.660	0.598	0.570	1993	0.63
Lesotho	0.572	0.573	0.524	0.494	1995	0.63
Malawi	0.372	0.414	0.398	0.400	1997	0.50
Mauritius	0.726	0.749	0.779	0.800	--	--
Mozambique	0.316	0.330	0.364	0.390	1997	0.40
Namibia	..	0.694	0.647	0.626	1993	0.74
Swaziland	0.622	0.604	0.536	0.500	1994	0.61
South Africa	0.735	0.741	0.691	0.653	2000	0.58
Zambia	0.464	0.425	0.409	0.407	2003	0.42
Zimbabwe	0.639	0.591	0.525	0.491	2003	0.61

HDI 0.8-1 is high, 0.5 - <0.8 is medium and 0 - <0.5 is low human development
Source: Human Development Report, 2006.

Table 2: Real GDP Growth Rates , percent per annum, by Country, Southern Africa 2000 - 2004

Country	2000	2001	2002	2003E	2004F
Angola	2.4	3.5	11.7	10.5	8.5
Botswana	4.7	4.8	4.1	5.4	7.4
Lesotho	4.0	2.8	4.0	4.0	4.0
Malawi	2.3	-1.5	-2.0	1.8	2.6
Mauritius	4.0	5.4	5.2	4.8	5.1
Mozambique	1.6	13.9	12.0	10.2	8.0
Namibia	3.9	3.0	2.3	4.0	4.5
South Africa	3.1	2.5	3.0	2.7	3.5
Swaziland	2.5	2.6	1.6	2.4	3.0
Zambia	3.0	5.2	3.7	3.2	3.1
Zimbabwe	-4.1	-7.3	-8.5	-8.8	-4.7

Source: ECA-SA Economic and Social Conditions in Southern Africa 2003.

Table 3 : Populations in Need of Emergency Food Aid and Cereal Requirements (MT) September 1, 2002 through March 31, 2003

Country	Max Number of People in Need	Max Percent of Total Population	Cumulative Requirements (MT)
Zimbabwe	6,700,000	49	486,000
Malawi	3,300,000	29	237,000
Zambia	2,900,000	26	224,000
Lesotho	650,000	30	36,000
Swaziland	270,000	24	20,000
Mozambique	590,000	3	48,000
Southern Africa	**14,410,000**	**25**	**1,051,000**

Source: United Nations, Update Sub-regional Strategy, Crisis in Southern Africa, Nov 2002.

Table 4: Net Secondary Enrolment Ratio (NER), percent, Southern Africa, 2004	
Country	**Net Secondary Enrolment Ratio , 2004**
Angola	..
Botswana	61
Lesotho	23
Malawi	25
Mauritius	80
Mozambique	4
Namibia	37
Swaziland	29
South Africa	62
Zambia	24
Zimbabwe	50
Source: Human Development Report, 2006	

Source: All MDG indicators were compiled from an international MDG UN data base on the following website: www.devinfo/mdginfo2006/

Indicator 1: Proportion of population below (US$1 PPP) a day, percent, Southern Africa, selected years, 1991-2003.

Country	1991	1993	1995	1996	1997	1998	2000	2003
Lesotho	..	43.1	36.4	..	..	..	..	..
Malawi	..	..	..	..		41.7	..	..
Mauritius	..	..	..	..		..	..	..
Mozambique	..	..	..	..	37.9	..	..	..
Namibia	..	34.9		..	..	..	..	..
Swaziland	..		8	..	..	..	..	..
South Africa	..	10	6.3	..	..	..	10.7	..
Zambia	64.6	73.6		72.6		64.8	..	75.8
Zimbabwe	33.3	..	56.1	..	..	..	..	..

* There was no data for missing years for all countries and there was no poverty data for Angola and Mauritius for any year.

Indicator 4: Prevalence of underweight children under five years of age, percent, Southern Africa, selected years, 1992-2004.

Country	1992	1995	1999	2000	2001	2002	2003	2004
Angola	..	..	..	..	30.5	..	..	..
Botswana	..	..	..	12.5		..	..	..
Lesotho	15.8	..	..	17.9		..	..	..
Malawi	27.2		..	25.4		21.9	..	22
Mauritius		14.9	..		..	..	..	
Mozambique		..	..	26.11	..	..	23.7	
Namibia	26.2	..	..	24	..	..	..	..
Swaziland		..	..	10.3	..	..	..	..
South Africa		..	11.51	..	..	..	..	..
Zambia	25.1	..	..	..	..	28.1	23.02	..
Zimbabwe	..	..	13	..	..	..	..	..

Indicator 5: Proportion of population below minimum level of dietary energy consumption , percent, Southern Africa, 1991, 1996 and 2002

Country	1991	1996	2002
Angola	58.02	49.03	38.04
Botswana	23.01	27.02	30.03
Lesotho	17.02	14.03	12.04
Malawi	50.01	40.02	34.03
Mauritius	6.01	6.02	6.03
Mozambique	66.01	58.02	45.03
Namibia	34.01	35.02	23.03
Swaziland	14.01	23.02	19.03
Zambia	48.02	48.03	47.04
Zimbabwe	45.01	47.02	45.03

Indicator 6: Net enrolment ratio in primary education, percent, Southern Africa, selected years, 1991-2005.

Country	1991	1999	2000	2001	2002	2003	2004	2005
Angola	50.3	..	..	..	..	..	..	..
Botswana	83.4	78.4	79.6	81.4	81.9	82.2	82.1	..
Lesotho	71.5	59.5	81.6	82.9	84.7	86.7	85.9	..
Malawi	48.4	98.3	..	..	..	..	95.3	..
Mauritius	91.3	96.9	92.9	92.4	93.9	95.9	95.1	94.5
Mozambique	42.8	52	55.5	60.2	56.3	..	71	..
Namibia	..	72.9	74.1	74.8	75.4	73.7	..	..
Swaziland	77.1	74.6	76.1	76.3	76.2	76.7	..	..
South Africa	89.5	92.9	90.4	90	89	88.8	..	..
Zambia	..	63.1	62.6	62.7	65.2	..	79.8	..
Zimbabwe	..	81.5	82.2	84.7	82.2	81.9	..	..

Indicator 7: Proportion of pupils starting grade 1 who reach grade 5, percent, Southern Africa, selected years, 1991-2003.

Country	1991	1999	2000	2001	2002	2003
Angola	5	5	5	5	5	5
Botswana	84	86.6	89.5	88.3	89.3	91.2
Lesotho	65.9	74	66.7	73	78.1	63.4
Malawi	64.4	49	51.9	43.8	..	..
Mauritius	97.4	99.5	99.3	98.9	..	..
Mozambique	34.2	42.7	51.9	49.2	..	..
Namibia	62.3	92.2	94.2	94.7	88.1	..
Swaziland	77	79.9	73.9	73.2	76.8	..
South Africa	..	64.8	..	86	84.1	..
Zambia	..	80.6	..	98.5		..
Zimbabwe	76.1	..	..	59.8	69.7	..

Indicator 8-Data is only available for 1990 and 2004 as graphed.

Indicator 9a: Ratio of girls to boys in primary education, Southern Africa, selected years, 1991-2005.

Country	1991	1999	2000	2001	2002	2003	2004	2005
Angola	0.92	0.86	..	..	..	..	..	..
Botswana	1.07	1.00	1.00	1.00	0.99	0.99	0.99	
Lesotho	1.22	1.08	1.04	1.02	1.02	1.01	1.00	..
Malawi	0.84	0.95	0.96	0.96	0.97		1.02	..
Mauritius	1.00	1.00	1.00	1.00	1.01	1.01	1.00	1.00
Mozambique	0.75	0.74	0.76	0.77	0.79	..	0.83	..
Namibia	1.05	1.02	1.02	1.02	1.02	1.01	..	..
Swaziland	0.99	0.95	0.94	0.95	0.93	0.95	..	..
South Africa	0.99	0.98	0.96	0.97	0.97	0.97	..	..
Zambia	..	0.92	0.93	0.94	0.93	..	0.96	..
Zimbabwe	0.97	0.97	0.97	0.97	0.98	0.98	..	..

Indicator 9b: Ratio of girls to boys in secondary education, Southern Africa, selected years, 1991-2005.

Country	1991	1999	2000	2001	2002	2003	2004	2005
Angola	..	0.83	0.82	0.78	..	..	..	..
Botswana	1.18	1.07	1.06	1.05	1.06	1.07	1.05	..
Lesotho	1.42	1.35	1.31	1.27	1.28	1.27	1.27	..
Malawi	0.46	0.70	0.74	0.77	0.77	..	0.81	..
Mauritius	1.04	0.98	0.96	0.97	1.00	0.99	0.99	0.99
Mozambique	0.57	0.69	0.63	0.64	0.66	..	0.70	..
Namibia	1.24	1.13	1.14	1.15	1.13	1.14	..	..
Swaziland	0.95	1.00	1.00	1.03	1.02	1.01	..	..
South Africa	1.18	1.13	1.11	1.10	1.08	1.07	1.08	..
Zambia		0.77	0.81	0.77	0.83	..	0.79	..
Zimbabwe	0.78	0.88	0.88	0.89	0.88	0.91	..	..

Indicator 9c: Ratio of girls to boys in tertiary education, Southern Africa, selected years, 1991-2004.

Country	1991	1999	2000	2001	2002	2003	2004
Botswana	0.72	0.79	0.74	0.89	0.82	0.75	0.85
Lesotho	1.3	1.64	1.52	1.64	1.31	1.51	..
Malawi	0.34	0.38	..	..	..	0.41	0.54
Mozambique	..	..	..	..	..	0.47	0.46
Namibia	1.79	..	..	0.85	1.39	1.15	..
Swaziland	0.76	0.86	0.89		1.15	1.16	1.08
South Africa	0.83	1.17	1.24	1.15	1.17	1.17	..
Zambia	..	0.46	0.46	..	..	..	..
Zimbabwe	0.49	..	0.59	0.58	0.68	0.63	..

Indicator 10- Data is only available for 1990 and 2004 as graphed.

Indicator 11: Share of women in wage employment in the non-agricultural sector, percent women, Southern Africa, selected years, 1990-2004.

Country	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Angola	..	..	23.5	..	..	..	..	..	..	..	..
Botswana	33.5	38.4	37.4	39.1	38.8	40.5	40.2	41.1	42.4	42.3	43
Lesotho	..	..	..	44.2	..	..	..	..	..	..	..
Malawi	10.5	11.3	11.2	11.4	11.5	11.7	11.9	12	12.2	12.4	12.5
Mauritius	36.7	36.4	36.4	36.7	37.5	38.4	38.6	39	38.1	38.4	37.5
Mozambique	11.4	..	..	..	..	..	..	..	..	..	..
Namibia	..	..	..	..	..	..	48.8	..	..	..	..
Swaziland	36.1	33.2	33	33.2	32.7	32.3	31.8	31.3	30.8	30.4	29.9
South Africa	42.6	43.6	43.9	44.1	44.4	44.6	45.4	45.6	45	46.1	45.9
Zambia	29.4	..	..	..	..	..	..	..	..	..	..
Zimbabwe	15.4	17.2	17.7	18	18.6	18.9	20.4	21.5	21.9	21.4	21.9

Indicator 12: Proportion of seats held by women in national parliaments, percent, Southern Africa, selected years, 1990-2006.

Country	1990	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Angola	14.5	9.5	9.5	15.5	15.5	15.5	15.5	15.5	15.5	15.0	15.0
Botswana	5.0	8.5	8.5	8.5		17.0	17.0	17.0	17.0	11.1	11.1
Lesotho		4.6	4.6	3.8	3.8	3.8	3.8	11.7	11.7	11.7	11.7
Malawi	9.8	5.6	5.6	5.6	8.3	9.3	9.3	9.3	9.3	14.0	13.6
Mauritius	7.1	7.6	7.6	7.6	7.6	5.7	5.7	5.7	5.7	5.7	17.1
Mozambique	15.7	25.2	25.2	25.2		30.0	30.0	30.0	30.0	34.8	34.8
Namibia	6.9	18.1	22.2	22.2	22.2	25.0	25.0	26.4	26.4	25.0	26.9
Swaziland	3.6	3.1	3.1		3.1	3.1	3.1	3.1	10.8	10.8	10.8
South Africa	2.8	25.0	25.0	29.5	30.0	29.8	29.8	29.8	29.8	32.8	32.8
Zambia	6.6	9.7	9.7	10.3	10.1	10.1	12.0	12.0	12.0	12.0	12.7
Zimbabwe	11.0	14.7	14.7	14.7	14.0	9.3	10.0	10.0	10.0	10.0	16.0

Indicator 13. Under-five mortality rate, deaths per 1 000 live births, Southern Africa, selected years, 1990-2004.

Country	1990	1995	2000	2004
Angola	260	260	260	260
Botswana	58	66	101	116
Lesotho	120	103	91	82
Malawi	241	216	188	175
Mauritius	23	21	18	15
Mozambique	235	212	178	152
Namibia	86	77	69	63
Swaziland	110	110	142	156
South Africa	60	59	63	67
Zambia	180	182	182	182
Zimbabwe	80	90	117	129

Indicator 14: Infant mortality rate, deaths per 1 000 live births, Southern Africa, selected years, 1990-2004.

Country	1990	1995	2000	2004
Angola	154	154	154	154
Botswana	45	50	74	84
Lesotho	84	75	67	61
Malawi	146	133	117	110
Mauritius	21	19	18	14
Mozambique	158	145	122	104
Namibia	60	55	50	47
Swaziland	78	78	98	108
South Africa	45	45	50	54
Zambia	101	102	102	102
Zimbabwe	53	60	73	79

Indicator 15: Proportion of one-year old children immunized against measles, percent, Southern Africa, selected years, 1990-2004.

Country	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Angola	38	46	62	78	65	46	41	72	74	62	64
Botswana	87	89	89	89	90	90	90	90	90	90	90
Lesotho	80	83	82	80	78	77	74	70	70	70	70
Malawi	81	90	90	87	90	83	73	82	69	77	80
Mauritius	76	89	61	87	85	80	84	90	84	94	98
Mozambique	59	71	58	61	64	66	71	74	77	77	77
Namibia	57	68	61	59	64	65	69	58	68	70	70
Swaziland	85	94	82	92	82	72	72	72	94	94	70
South Africa	79	76	76	82	82	82	77	72	78	83	81
Zambia	90	86	86	86	85	85	85	84	84	84	84
Zimbabwe	87	87	88	84	79	79	70	68	60	80	80

Indicator 16. Maternal mortality ratio, maternal deaths per 100 000 births, Southern Africa, selected years, 1990-2000.

Country	1990	1995	2000
Angola	150	130	170
Botswana	250	480	100
Lesotho	610	530	550
Malawi	560	580	1 800
Mauritius	120	45	24
Mozambique	1 500	980	1 000
Namibia	370	370	300
Swaziland	560	370	370
South Africa	230	340	230
Zambia	940	870	750
Zimbabwe	570	610	1 100

Indicator 17: Proportion of births attended by skilled personnel, percent, Southern Africa, selected years, 1998-2003.

Country	1998	1999	2000	2001	2002	2003
Angola	..	..	..	44.7	..	..
Botswana	..	..	94.2	..	..	..
Lesotho	..	..	59.8	..	..	..
Malawi	..	..	..	..	60.5	..
Mauritius	..	..	..	..	..	98.4
Mozambique	..	..	..	..	..	47.7
Namibia	..	..	75.5		..	..
Swaziland	..	..	..	..	74	..
South Africa	84.4	..	..	..	..	..
Zambia	..	..	..	..	43.4	..
Zimbabwe	..	72.5	..	..	..	..

Indicator 18: HIV prevalence among pregnant women aged 15-24 years, percent, Southern Africa, selected years, 2000-2005.

Country	2000	2001	2002	2003	2004	2005
Angola	..	6.3	..	..	2.8	..
Botswana	33.6	..	..	..	..	33.5
Lesotho	..	..	..	..	..	27.3
Malawi	..	15	..	..	..	..
Mauritius	..	..	..	..	..	..
Mozambique	11.7	..	..	..	..	..
Namibia		..	..	..	7.5	..
Swaziland	34.4	..	..	..	37.3	..
South Africa	..	23.1	..	..	25.2	..
Zambia	..	..	..	..	20.7	..
Zimbabwe	..	29.8	..	..	18.6	..

Indicator 20: Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years, Southern Africa, selected years, 1990-2003.

Country	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Angola	..	..	..	..	..	..	..	..	0.9	..	..	..
Botswana	..	..	..	..	..	..	..	..	0.99	..	..	..
DRC	..	..	..	..	..	..	..	..	0.72	..	..	..
Lesotho	..	..	..	..	..	..	..	..	0.87	..	..	..
Madagascar	0.73	..	..	..	..	0.56	..	..	0.66	..	..	0.76
Malawi	0.51	..	..	..	..	..	..	..	0.93	..	..	..
Mauritius	..	..	..	..	..	..	..	..	..	..	..	..
Mozambique	..	..	..	..	..	0.47	..	..	..	..	..	0.8
Namibia	1.07	..	..	..	..	..	..	..	..	0.92	..	..
Swaziland	..	..	..	..	..	..	..	..	0.91	..	..	..
South Africa	..	..	..	..	..	..	0.95		..	..	..	..
Tanzania	0.6	..	..	..	0.87	..	..	0.75	..			0.82
Zambia	0.91	..	..	..	0.88	..	..		0.98	0.91		0.92
Zimbabwe	..	..	0.99	..	..	..	..	0.85		..	..	..

Indicator 23: Prevalence of death rates associated with tuberculosis, per 100 000 population, Southern Africa, selected years, 1990-2004.

Country	1990	2000	2001	2002	2003	2004
Angola	64.6	71.1	45.5	31	26.6	32.2
Botswana	35.4	85	91.7	85.8	96.1	95
Lesotho	29.3	81.3	85.4	95.5	95.3	99.4
Malawi	61.3	103.7	97.1	102.1	99.4	96.8
Mauritius	13.3	11.4	11.6	11.5	11.4	11.3
Mozambique	37	116.1	122.4	125.4	126.7	128.7
Namibia	64.2	81.9	74.4	81.4	63.8	85.4
Swaziland	82.7	332.2	382.3	240.3	248	269.3
South Africa	88.7	141.8	143.3	111.3	119.9	134.6
Zambia	117.1	210	226	138.7	128.2	137.3
Zimbabwe	45.6	150.7	150.4	145.2	161.2	150.9

Indicator 25: Proportion of land area covered by forest, percent, Southern Africa, selected years, 1990-2005.

Country	1990	2000	2005
Angola	48.9	47.9	47.4
Botswana	24.2	22.1	21.1
Lesotho	0.2	0.2	0.3
Malawi	41.4	37.9	36.2
Mauritius	19.2	18.7	18.2
Mozambique	25.5	24.9	24.6
Namibia	10.6	9.8	9.3
Swaziland	27.4	30.1	31.5
South Africa	7.6	7.6	7.6
Zambia	66.1	60.1	57.1
Zimbabwe	57.5	49.4	45.3

Indicator 26: Ratio of land area maintained to protect biological diversity to surface area, percent, Southern Africa, selected years, 1990-2005.

Country	1990	1995	2000	2001	2002	2003	2004	2005
Angola	12.06	12.06	12.06	12.06	12.06	12.06	12.06	12.06
Botswana	29.35	30.19	30.19	30.19	30.19	30.19	30.19	30.19
Lesotho	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22
Malawi	16.38	16.38	16.38	16.38	16.38	16.38	16.38	16.38
Mauritius	0.49	0.84	0.86	0.86	0.86	0.86	0.86	0.86
Mozambique	7.60	7.60	7.60	7.77	8.63	8.63	8.63	8.63
Namibia	14.57	14.57	14.57	14.57	14.57	14.57	14.57	14.57
Swaziland	3.46	3.46	3.46	3.46	3.46	3.46	3.46	3.46
South Africa	5.64	5.98	6.00	6.00	6.00	6.10	6.10	6.10
Zambia	40.63	40.64	41.50	41.50	41.50	41.50	41.50	41.50
Zimbabwe	14.68	14.68	14.68	14.68	14.72	14.72	14.72	14.72

Indicators 30 and 31 –Data is only available for 1990 and 2004

Indicator 36: ODA received in landlocked developing countries as a proportion of their gross national incomes, percent, Southern Africa, selected years, 1990-2004.

Country	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Botswana	3.98	1.9	1.64	2.41	2.11	1.28	0.63	0.58	0.8	0.39	0.47
Lesotho	13.87	8.6	8.17	6.75	5.38	2.69	3.4	6	8.88	5.89	6
Malawi	27.39	32.22	21.93	13.11	25.43	25.76	26.14	24.17	20.73	31.2	26.87
Swaziland	5.88	4.02	2.31	1.8	2.6	2.05	0.93	2.13	1.88	1.5	4.82
Zambia	15.96	62.87	19.9	16.46	11.54	20.96	25.82	10.06	18.09	13.88	20.69
Zimbabwe	4	7.24	4.5	4.18	4.89	4.75	2.56	1.86	..	..	..

Indicator 44: Debt service as a percentage of exports of goods and services, Southern Africa, selected years, 1990-2004.

Country	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Angola	7.11	10.71	17.51	18.31	40.21	25.91	20.41	22.31	16.71	13.91	14.81
Botswana	4.32	3.12	5.22	2.82	2.62	2.12	2.02	1.72	1.92	1.22	19.00
Lesotho	4.21	6.11	5.61	6.51	8.51	10.11	11.31	12.41	11.31	8.11	4.61
Malawi	28.02	24.42	15.22	13.92	15.60	13.00	22.80	15.10	11.80	22.40	13.50
Mauritius	7.39	6.09	5.09	6.89	6.89	5.69	16.49	4.79	6.39	4.89	5.49
Mozambique	17.31	33.21	24.81	17.81	41.00	9.40	2.50	2.70	5.20	5.30	3.20
South Africa	0.02	5.12	6.22	6.92	8.62	2.92	5.52	6.72	4.12	4.22	2.42
Zambia	14.52	23.00	23.00	18.32	16.00	14.90	15.90	13.50	11.40	15.20	18.20
Zimbabwe	19.41	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00

APPENDIX III

Box 9: MDGs Targets and Indicators

MDGs Targets and Indicators

Goals and Targets	Indicators for monitoring progress
Goal 1. Eradicate Extreme Poverty and Hunger **Target 1**. Halve between 1990 and 2015 the proportion of people whose income is less than $1 a day	1. Proportion of population below $1 PPP) a day 2. Poverty gap ratio 3. Share of poorest quintile in national consumption
Target 2. Halve between 1990 and 2015 the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of a of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2. Achieve Universal Primary Education **Target 3.** Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6.Net enrolment ratio in primary education 7. Proportion of pupils staring grade 1 who reach grade 5 8. Literacy rate of 15 to 24 year-olds
Goal 3. Promote Gender Equality and Empower Women **Target 4.** Eliminate gender disparity in primary and secondary education, preferably by 2005, to all levels by of education no later than 2015	9. Ratio of girls to boys in primary, secondary and tertiary education 10.Ratio of literate women to men ages 15-24 11.Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliaments
Goal 4. Reduce child mortality **Target 5:** Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rates 14. Infant mortality rates 15. Proportion of one-year old children immunized against measles
Goal 5. Improve maternal health **Target 6.** Reduce by three quarters, between 1990 and 2015, the maternal mortality rate	16. Maternal mortality ratio 17. Proportion of births attended by skilled personnel
Goal 6. Combat HIV and AIDS, malaria and other diseases **Target 7**.Have halted by 2015 and begun to reverse	18. HIV prevalence among 15-24 year old pregnant women 19. Condom use rate of the contraceptive

the spread of HIV/AIDS	prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans ages 10-14
Target 8. Have halted by 2015 and begun to reverse The incidence of malaria and other major diseases	21.Prevalence of death rates associated with malaria 22. Proportion of people in malaria risk areas using effective malaria prevention and treatment measures 23.Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7. Ensure environmental sustainability **Target 9.** Integrate the principles of sustainable development into country policies and programmes and reverse the loss environmental resources	25. Proportion of land area covered by forest 26. Ratio of land area maintained to protect biological diversity to surface area 27. Energy use (kilograms of oil equivalent) per $1 GDP(PPP) 28. Carbon dioxide emissions per capita and consumption of zone-depleting chlorofluorocarbons (ODP tons) 29. Proportion of population using solid fuels
Target 10. Halve by 2015 the proportion of people without sustainable access to safe drinking water and sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural 31. Proportion of population with access to improved sanitation, urban and rural 32. Proportion of population with access to secure tenure, urban and rural
Goal 8. Develop a global partnership for Development **Target 12.** Develop further an open, rule-based, predictable, non-discriminatory trading and Financial system. Includes commitment to Good governance, development and poverty reduction	33. Net ODA, total to least developed countries, as percentage of OECD/DAC donors' Gross National Income (GNI) 34. 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 35. Proportion of bilateral ODA of OECD/DAC donors that is untied 36. ODA received in landlocked developing countries as a proportion of their gross national incomes 37. ODA received in small Island developing States as a proportion of their gross national incomes
Target 13. Address the special needs of the least least developed countries, includes tariff and quota-free access for least developed	38. Proportion of total developed country imports from developing countries and from the least developed countries admitted

	countries' exports, enhanced programme of debt relief for HIPCs and cancellation of official bilateral debt and more genera us ODA for countries committed to poverty reduction	free of duties 39. Average tariffs impose developed countries on agricultural products and textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as a percentage of their gross domestic product 41. Proportion of ODA provided to help build trade capacity
Target 15.	Deal comprehensibly with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	42. Total number of countries that have reached their HIPC completion points 43. Debt relief committed under HIPIC initiative 44. Debt service as a percentage of exports of goods and services

ENDNOTES

1. **Structural chronic poverty** is rooted in socio-economic, political and cultural dynamics and institutions, is experienced over the long term and is often transferred inter-generationally. **Transient poverty** is due to cyclical or temporary factors and is experienced over shorter periods of time. Typical examples of transient poverty include poverty induced by macro-economic policy shifts such as under economic refo rm programmes, natural disasters, cyclical unemployment, inflation, technological changes, and so on. It is important to note that structural chronic and transient poverty often co-exist and are not mutually exclusive.
2. **The Human Development Index (HDI)** measures the average attainments in a country in three basic dimensions of human development: a long and healthy life as measured by life expectancy at birth; knowledge as measured by adult literacy and average years of schooling; and decent standard of living as measured by mean income per capita.
3. **The Gini Coefficient** measures income inequality by determining the extent to which the distribution of income (or consumption) among individuals or households within a country deviates from a perfectly equal distrib ution. The Gini coefficient measures the area between the Lorenz curve and a hypothetical line of absolute equality, expressed as a percentage of the maximum area under the line. A value of zero represents perfect equality while a value of 1 represents perfect inequality.
4. **The Zimbabwe Demographic and Health Survey (DHS) 2005/6** conducted actual HIV testing on the survey population.