

March 2002

Summary Report

Financing the Development Goals

An analysis of Tanzania, Cameroon,
Malawi, Uganda and Philippines



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INTRODUCTION

This report tries to advance one of the most important tasks before the International Conference on Financing for Development (FfD) in March 2002 by attempting to answer a single critical question: *What will it take, in resource terms, to meet the universal human development goals of the Millennium Declaration – the Millennium Development Goals?* Prepared specially for the Conference, the report takes one step further the work that UNDP — as chief “scorekeeper” for the goals — has undertaken in conjunction with other agencies of the UN system to prepare progress reports on the MDGs in every country.

Some costing and financing answers are provided here for five countries that have participated in the research: Tanzania, Cameroon, Malawi, Uganda and Philippines. The findings are based on the analysis of researchers in those countries, working in conjunction with policy-makers in government, using a basic methodology agreed in advance, but adapted to local realities. As the Note on that methodology states, no study attempted to capture the full range of factors that determine a given outcome, important as this is. Instead, the national teams concentrated on identifying and costing those policy actions that are known to have the most direct bearings on the outcome within the particular national context.

Even so, there are no simple answers. No single price-tag can be attached to meeting each goal in each country, in part because the goals themselves are mutually reinforcing — often in unanticipated ways — in patterns that differ not only from one country to another, but among geographic regions within national frontiers and, within these, across rural/urban divides. Nonetheless, the findings of this composite study give some indication of the enormity of the tasks these five countries face in mobilising the substantial resources required. Each of the national studies, which form the basis of this report, also identifies the significant policy, institutional and capacity development needs that will have to be met.

The eight MDGs and their targets, all but two with the date of 2015, are the following:

- 1. Eradicate Extreme Poverty and Hunger:** halve the proportion of people living on less than \$1 a day and halve the proportion of people who suffer from hunger.
- 2. Achieve Universal Primary Education:** ensure that children everywhere, girls and boys alike, will be able to complete a full course of primary education.
- 3. Promote Gender Equality and Empower Women:** eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.
- 4. Reduce Child Mortality:** reduce the under-five mortality rate by two thirds.
- 5. Improve Maternal Health:** reduce the maternal mortality rate by three quarters.
- 6. Combat HIV/AIDS, Malaria and Other Diseases:** halt the spread of the HIV/AIDS, along with the incidence of malaria and other major diseases, and begin to reverse them.
- 7. Ensure Environmental Sustainability:** integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources; halve the proportion of people without sustainable access to safe drinking water; achieve by 2020 a significant improvement in the lives of at least 100 million slum dwellers.
- 8. Develop a Global Partnership for Development:** with seven targets related, respectively, to Official Development Assistance (ODA), market access, and debt sustainability.

Out these eight, this report examines the progress the five countries have made towards specific targets

set for six of the MDGs, combining Maternal Health and Child Mortality under a single goal entitled “Health” and measuring progress towards one target of Environmental Sustainability, halving the proportion of people without access to safe drinking water. Promoting Gender Equality and Empowering Women is glimpsed in part under “Health” and “HIV/AIDS” and education. Finally, developing a Global Partnership for Development is approached under a number of headings throughout the report, particularly in the section entitled “Financing the Goals”.

Each country study was written by a team of local researchers in collaboration with national policy makers. The basic methodology used for estimating costs and the inevitably tentative estimates of financing sources mean that the costing numbers in this summary report and in the 5 country studies must remain somewhat conjectural at this stage and subject to continuing refinement. With this summary report, they should be seen as work in progress, which UNDP and its UN partners wish to continue supporting as part of the ongoing global MDG Campaign.

THE FIVE COUNTRIES

TANZANIA

Tanzania, one of the world's poorest countries, has an annual per capita income of approximately \$280 and low human development indices. Its population of 33 million is growing at about 2.8% per year and more than half its people live below the national poverty line. The economy and most of the population depend heavily on agriculture, which accounts for some 45% of GDP and provides 85% of export earnings (of which coffee and cotton are the most important). Industry accounts for some 15% of GDP, while the tourism sector has recorded significant growth in recent years. The mining sector has good, but as yet under-exploited, potential. Both the service sector and the informal sector are increasingly important sources of employment. Recent economic performance has been robust; real GDP growth has averaged 4% during the last four years. In the absence of external shocks caused by adverse climatic conditions, performance is expected to remain strong across the board.

CAMEROON

Cameroon is a middle human development country with an HDI above the average for both least developed and Sub-Saharan countries. This West African country has a population of 15 million, half of whom live below the national poverty line, with

an annual per capita income of \$570. The economy depends largely on agriculture, which accounted for some 44% of GDP in 1999 and provides for the livelihoods of 49% of the population. Industry and services account, respectively, for 19% and 38% of GDP. Oil provides 46% of the country's exports earnings, followed by coffee and cocoa. Given its reliance on three export products and an export to GDP ratio of 31%, the country's economy is particularly exposed to volatility in international commodity markets. Real GDP growth rates over the last four years have risen to the 4% – 5% range with continued prospects for accelerated growth in the future.

MALAWI

This small southern African country on the shores of Lake Malawi remains one of the world's poorest, despite its having some of the most fertile land in the region. Per capita income is among the lowest in the world at \$170 and some two thirds of its population lives below the national poverty line. Other development indicators also depict a country faced with daunting development challenges. Malawi was ranked eighth from the bottom on the basis of its Human Development Index. Its economy is based largely on agriculture, which accounts for more than 90% of its export earnings, 40% of GDP, and supports 90% of its 11 million people. Industry accounts for 19% of GDP

	TANZANIA		CAMEROON		MALAWI		UGANDA		PHILIPPINES	
		<i>year</i>		<i>year</i>		<i>year</i>		<i>year</i>		<i>year</i>
Population (in millions) ^c	33	2000	15	2000	11	2000	22	2000	76	2000
Growth (%) ^c	2.8	2000	3.0	2000	2.0	2000	3.0	2000	2.4	2000
% urban ^c	34	2000	49	1999	25	1999	14	2000	59	2000
% below poverty line ^a	52.8	2000	50.0	1999	65.3	2000	35.0	2000	31.8	1997
HIV/AIDS prevalence in adult pop. (%) ^a	9.4	2000	11	2000	16	2000	8	2000	0.07	1999
GDP growth (%) ^c	5	2000	4	2000	2	2000	5	2000	4	2000
Income per capita (current US\$) ^c	280	2000	570	2000	170	2000	310	2000	1040	2000
GNP per capita (PPP US\$) ^b	501	1999	1573	1999	586	1999	1167	1999	3805	1999
Agriculture as % of GDP ^c	45	1999	44	1999	40	2000	44	1999	17	2000
Industry as % of GDP ^c	15	1999	19	1999	19	2000	18	1999	30	2000
Services as % of GDP ^c	40	1999	38	1999	41	2000	38	1999	53	2000
Life expectancy at birth ^b	51.1	1999	50.0	1999	40.3	1999	43.2	1999	69.0	1999
Adult literacy rate (%) ^b	74.7	1999	74.8	1999	59.2	1999	66.1	1999	95.1	1999
Human Development Index and rank out of 162 countries in 2000 ^b	0.436 (140)		0.506 (125)		0.397 (151)		0.435 (141)		0.749 (70)	

Sources: ^anational studies, ^bUNDP, ^cWDI

and is mainly limited to the processing of agricultural products such as tobacco, tea, cotton, coffee and sugar. Some two-thirds of agricultural production comes from the smallholder sector. Recent economic growth, 2% in 2000, has been modest.

UGANDA

This landlocked East African country on the shore of Lake Victoria has a population of 22 million, 35% of whom live below the national poverty line. Per capita income is \$310 and overall human development indicators are low. Uganda has substantial natural resources, including fertile soils, regular rainfall, and sizable mineral deposits of copper and cobalt. Agriculture is the most important sector of the economy, accounting for 44% of GDP and employing over 80% of the work force. Coffee is the major export crop, accounting for over half of export earnings. Industry and services make up 18% and 38% of GDP respectively. Real GDP growth averaged over 7% annual during the past decade, and underlying inflation has averaged some 6%. High rates of growth in a non-inflationary environment are expected to continue. Uganda was the first country to benefit from the HIPC initiative.

PHILIPPINES

The Philippines is a medium human development country with a population of 75.6 million and a per capita income of \$1040; approximately one-third of its population lives below the national poverty line. Services make up 53% of its GDP, followed by industry and agriculture with 30% and 17% respectively. Export growth has been strong, particularly in electronics. The ratio of exports to GDP has more than doubled between 1990 and 2000. However, the country's economy has followed a boom-bust cycle with periods of economic growth followed by financial or balance of payments crisis. The last of these, the 1997 East Asian financial crisis, brought GDP growth rates down to 0.6%. Nonetheless, the economy of the Philippines has recovered; GDP growth in 2000 was 4% and is expected to remain in that range.

KEY FINDINGS: What will it take to meet the goals?

HOW ARE THE COUNTRIES FARING?

INCOME POVERTY: Progress in reducing income poverty has been very uneven. In the 1990s:

Tanzania:	poverty rose from 49% to 53%
Cameroon:	poverty at 50% did not fall
Malawi:	poverty at 65% did not fall
Uganda:	poverty fell from 56% to 35%
Philippines:	poverty fell from 45% to 39%

HIV/AIDS: In the four African countries, where adult infection rates vary from 8% to 16%, progress in halting the epidemic will determine advances towards all the other goals. In many African countries, AIDS is raising under-5 mortality rates and reducing life expectancy to 1950s levels. In Africa as a whole, where 55% of those infected are women and girls, 35 million more people will die of AIDS before 2010, if trends continue. The epidemic will undermine and reverse progress and take away the human resources — civil servants, doctors, teachers, and other front-line actors — who provide the foundations for the development effort. In addition, women are adversely affected not only because of their biological vulnerabilities to HIV/AIDS, but because of their status relative to men, which often diminishes their ability to adhere to safe sexual practices or access contraceptives. Moreover, particularly in Sub-Saharan Africa, where women grow much of the food supply and often care for communities as well as families, their illness or death undermines food security and weakens the informal support systems on which poor communities depend, thereby exacerbating other poverty indicators. The costs of containing the pandemic are daunting. If life-prolonging anti-retroviral drugs could be made available to just one-third of those living with AIDS at the lowest available commercial price the annual costs would be \$10 billion.

EDUCATION: Despite marked progress towards universal primary enrolment, a huge effort will be needed to combat truancy, which has basic economic as well as cultural causes. Girls still fall significantly behind boys, especially in the most impoverished areas.

HEALTH: In three of the five countries, there have been no significant improvements in health status since 1990.

WATER SUPPLY: In two countries, only one in two households has access to safe water. There is slow improvement, but more rural populations are much worse served than urban.

WHAT IS NEEDED?

GROWTH: There will be no substitute for sustained economic growth in order to halve income poverty. Given current income distributions, a significant acceleration will be required in almost all cases:

Tanzania:	will need to achieve a minimum of 5% compared with 3.1% during the 1990s
Cameroon:	7% compared with 1.7%
Malawi:	6% compared with 4.2%
Uganda:	on track (present rate above 5% requirement)
Philippines:	5-6% compared with 3.2%

PRO-POOR POLICIES: Such policies, necessary in all five countries, will invariably have to favour rural-based households, especially those headed by women. National strategies will also have to emphasize rural infrastructure, farming terms of trade (i.e. prices received against prices paid), and small, labour-intensive enterprises.

DOMESTIC RESOURCES: All five countries will need to pursue policies to increase domestic savings and tax revenues; in the long run, robust domestic resources will be the basis for sustainable progress in meeting the MDGs. Experience indicates that more efficient management and use of existing resources could have significant benefits.

EXOGENOUS SHOCKS: All five countries have suffered economic disadvantages as a result of external economic factors that they cannot control. The four African economies have experienced large price falls in key export commodities, along with continuing barriers to trade expansion and diversification, while the Philippines was a victim of the Asian financial crisis after 1997. Trade liberalisation and lower import tariffs in the poorer countries detract from their capacity to raise fiscal revenues. Policy consistency by donors implies opening their markets more widely to poorer countries, if aid is not merely to become partial compensation for disadvantageous external conditions.

FDI: All five countries are committed to trying to attract more foreign direct investment, for which a record of sound and consistent economic governance will be essential.

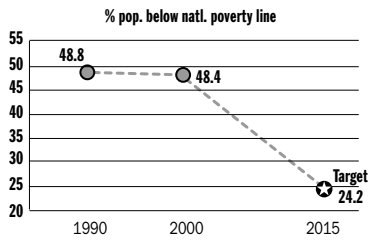
DEBT: For the four African countries, HIPC relief has provided anti-poverty dividends of varying significance. The longer-term sustainability of the remaining debt will be a preoccupation, particularly with new borrowing and in the face of flaccid export performance.

ODA: If the MDGs are to be met, there will be no alternative to increasing aid — matched by sound economic governance and by concerted efforts by the governments of recipient countries to continue to raise levels of domestic financing.

EXTREME POVERTY: HALVE THE PROPORTION OF PEOPLE LIVING IN EXTREME POVERTY BY 2015.

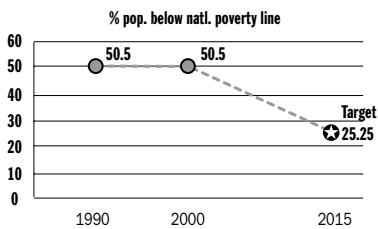
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TANZANIA



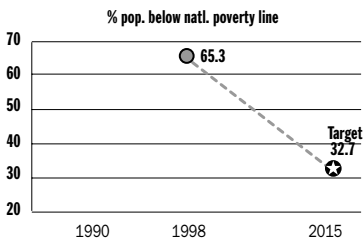
Between 1991 and 2000, the percentage of Tanzania's population living below the Basic Needs Poverty Line rose from 48.8% to 52.8%. Given past medium-term trends in economic growth, it seems unlikely that the 24.2% target will be met in 2015. Despite recent robust economic performance, the country's economy remains vulnerable to exogenous shocks, especially from climatic factors and changes in world markets. Agriculture plays the predominant economic role. It constitutes over 45% of GDP, is the source of livelihood and employment for 90% and 81% of the population respectively and accounts for 85% of exports. Though generalized, poverty in Tanzania is predominantly rural. Nonetheless, the government has set out to halve poverty by 2010, five years earlier than the MDG date.

CAMEROON



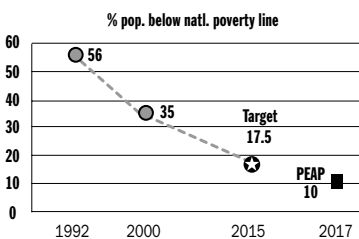
The 1996 national household survey indicated that about 50.5% of the population lacked a minimum consumption basket (poverty line), while 23% were short of even the food component of this basket (extreme poverty line). Some 86% of the country's poor live in its rural areas, where poverty is particularly widespread among export crop farmers. Overall, similar levels of poverty incidence prevailed at the beginning of the 1990s. Cameroon's poverty reduction target for 2015 stipulates reducing the poverty rate to 25%.

MALAWI



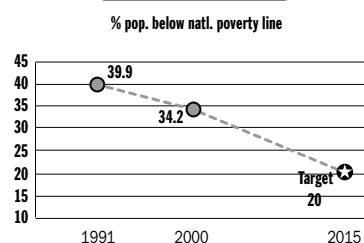
Malawi's 1997/98 Integrated Household Survey (IHS) resulted in a poverty estimate of 65.3% of the country's population. The survey also revealed that about 28.7% of the population lived in extreme poverty (89.8% of this number in the rural areas and 10.2% in the urban). Although comparable data for earlier years are lacking, poverty probably has not declined over past decade, despite positive economic growth rates in all but one year. Given these factors, Malawi has set its 2015 poverty target at 32%, which will require an ambitious 2% annual decrease in poverty.

UGANDA



Although Uganda's economy more than doubled during the 1990s, national household survey data reveal inequality along urban/ rural lines. Between 1997 and 2000, real consumption levels for the richest 10% of the population grew by 20%, compared to 8% for the poorest 10%. The country's economy depends largely on agriculture, which accounts for 43% of its GDP, 90% of its total export earnings, and provides livelihoods for 80% of its population. The government's goal of reducing absolute poverty to less than 10% by 2017, articulated in its Poverty Eradication Action Plan (PEAP), is more ambitious than the implicit MDG target and may well be met, provided that economic performance remains robust and that distributional aspects are addressed.

PHILIPPINES



Between 1991 and 2000, the percentage of the Filipino population living below the poverty line declined from 45.3% to 39.7%. Until 1997, there was a period of marked macroeconomic stability, economic re-structuring and liberalization. GDP growth was robust with concomitant spillover benefits for the country's poor. However, with the onset of the East Asian crisis in 1997, poverty incidence crept up again, particularly in the rural areas. In addition to highlighting the vulnerability of the national economy to external shocks, the East Asian crisis illustrates the effects of financial crises on the incidence of poverty. Notwithstanding the progress made over the decade as a whole, the rate of poverty incidence in the Philippines remains the highest among the ASEAN nations.

PROSPECTS

To meet this goal, Tanzania's economy will have to sustain annual growth rates of 5-6% in the future. Given its vulnerability, higher growth rates will need to compensate for the setbacks in bad years. While Tanzania has some potential for improving economic growth, enhancing GDP requires ensuring a pro-poor pattern. The country's demographic and economic structure call for accelerating growth and productivity in the agricultural/rural sector in a non-inflationary environment. Specific challenges are: (i) expanding access to key resources and services (credits and inputs, adequate information

and distribution channels, and rural extensions services); (ii) adopting a pro-poor-farmer fiscal framework; (iii) broadening of the export base and expanding capacity to process primary products; (iv) reducing dependence on rain-fed agriculture and (v) developing a long-term strategy for sustainable livelihoods in drought-prone areas.

The success of Cameroon's poverty reduction strategy hinges upon high rates of pro-poor economic growth that require a buoyant economic climate, increased employment and expanded income-generating opportunities. Given the nature of poverty in the country, effective management of both endogenous and exogenous economic shocks must protect the rural poor. The government also emphasizes addressing long-term population growth (currently 2.8%) by reducing the total fertility rate through enhanced education, child survival, and reproductive health services; improving the productivity of

labour in rural areas; taking urgent measures to meet the growing risks implied by the spread of HIV/AIDS; reducing disparities in the availability of public services; improving the security of persons and goods; building capacity of the public administrations at all levels; and developing partnerships with private sector and civil society actors.

Malawi's ability to reduce poverty incidence to 32% by 2015 will require economic growth rates ranging up to 6%, depending on the evolution of income distribution. Although it is estimated that the composition of GDP will not undergo any substantial structural transformation, the government proposes to allocate greater resources to rural areas, infrastructure and support for small and micro-enterprise, thereby fostering more sustainable growth through improving the productivity of labour-intensive sectors and narrowing the gap between modern and neglected sectors in agriculture, manufacturing, and services. Given the extreme

vulnerability of Malawi's economy to endogenous and exogenous shocks, greater incentives to broaden income and employment opportunities for the poor will be required. The need for higher and sustained growth necessitates an enabling environment, particularly in sectors involving traditional agriculture and small production units. In these sectors, the levels of productivity and competitiveness will increase through concrete actions in the areas of rural development, road infrastructure, technical assistance and technology, development of micro- and small enterprise, development of micro-finance, and land access and tenure.

Meeting the millennium poverty goal, as well as Uganda's own 2017 poverty reduction target, will require economic growth rates ranging between 5% and 8%. Based on the country's growth path since the early 1990s and its more recent emphasis on pro-poor growth and increasing private sector development, Uganda may well meet the established targets before the set dates. Sustained long-term growth, however, will entail substantial productivity gains across all sectors, particularly agriculture, along with building on the benefits derived from promoting private sector activity, investment in infrastructure and the restoration of investor

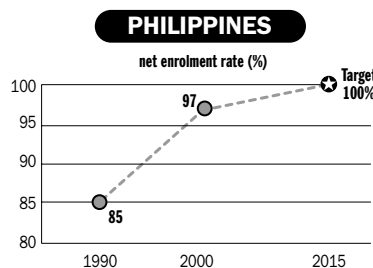
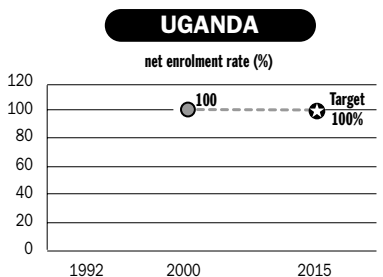
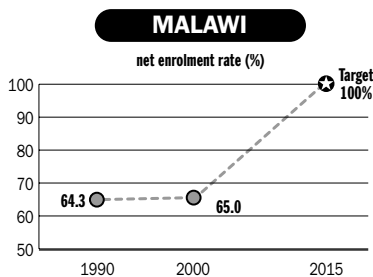
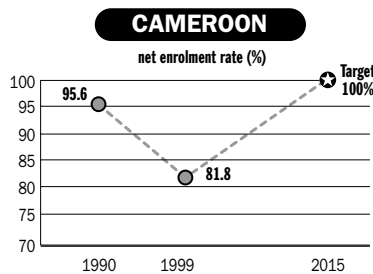
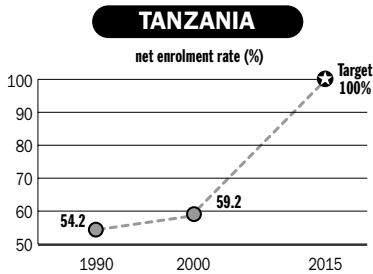
confidence. In this regard, Uganda has developed a comprehensive plan to transform subsistence agriculture into viable commercial activity through providing research and extension services. In addition, the government is committed to developing its social, transportation and communication infrastructures. An enabling environment for rapid and sustained growth will also depend upon macroeconomic stability and the provision of incentives for private sector development, as well as good governance, particularly in the management, allocations and use of public resources.

The emphases of the Medium-Term Development Plan for 2000 – 2004 reflect the government's commitment to protecting society's core priorities even as fiscal discipline is restored. Its prime strategies for fighting poverty concentrate on (i) asset reform, particularly redistribution of land and credit; (ii) providing human development services, notably basic education, health, shelter, water and electricity; (iii) social protection of the poorest and most vulnerable sectors and communities through social welfare and assistance and social security and insurance; (iv) participation of the poor in governance and (v) security

and protection against violence. Under the Plan, economic growth is expected to accelerate from 3.3% in 2001 to 6.3% in 2006. and may diminish the current income poverty rate to as little as 22% — at least to 29% — by 2015. However, even the asset reforms, rural infrastructure development and agricultural modernization programmes currently under way will not suffice to meet the initial hope of reducing poverty to 20% by the Millennium target date.

EDUCATION: ACHIEVE UNIVERSAL PRIMARY EDUCATION BY 2015

STATUS



Although enrolment reached 69.7% in 1981, it fell to 54.2% in 1990 and, by 2000, it had recovered to only 59.5%. Moreover, general educational attainment is compromised by high repetition/low retention rates caused by truancy; the overall cost of schooling, including the opportunity cost to poor households for maintaining children in school; and the perceived disconnect between formal education and actual possibilities for earning a living. The pass rate for the primary learning exam stands at 20% and transition to secondary education is very low. Among girls, early pregnancies contribute to higher dropout rates. In addition, performance indicators for girls are worse than for boys at primary level even though the gender target (parity in enrolment rates for boys and girls) appears to have been attained. Geographic disparities in enrolment rates are also significant.

During the last decade, the deterioration of educational quality and enrolment rates parallels that of countries that have undergone armed conflict and intense civil strife. After coming close to universal primary education (UPE) in the late 1980s (95.6% in 1989/1990), gross enrolment rates fell to 81.8% in 1998/1999 (net enrolment to 61.7%) in primary education and to less than 50% in secondary education — with wide geographic and gender disparities. Concomitantly, record repetition rates, estimated at 28% each year, as well as substandard achievement scores, point to marked qualitative downturns. These negative trends appear to stem from the fiscal constraints of the early 1990s, which lowered teacher salaries, reduced allocations for materials, and led to the neglect of infrastructures.

Net enrolment rates registered only marginal progress between 1990 and 2000. However, 78% had been achieved by 1999, following the introduction of free primary education in 1995, together with the use of local languages, the suspension of the school uniform requirement, and the establishment of community schools to reduce walking distances for small children. However, as the number of teachers has remained stable, pupil/teacher ratios have deteriorated, and completion and transition rates have remained low. The prevailing gender discrepancies in enrolment ratios tend to become more accentuated at higher levels of education.

The government introduced its policy on UPE in 1997 with the overall goal of enrolling all children from 6 – 12 with a retention rate of 100%. The policy's implementation tripled enrolment, although gender disparities persist and tend to be more pronounced at higher educational levels (even though the retention rates of girls surpass those of boys in the primary cycle). Despite impressive enrolment figures and continuing trends, completion rates remain low and the ratio of pupils to teachers, facilities, textbooks and other learning aids are still problematic, raising questions about the effectiveness of several aspects of the UPE programme.

Net enrolment rates in primary education increased from 85% to 97% between 1990 and 2000, thereby suggesting that the Philippines is very close to reaching UPE well before 2015. At the secondary level, enrolment rose from 55% to 72% during the same period. However, completion rates at the elementary level have not increased significantly beyond the 1990 figure of 68%, largely because of the poor quality of basic education in the country and its high out-of-pocket costs (textbooks, school supplies, transportation), chronic shortages of key inputs and general welfare factors, including ill health and livelihood requirements that point to a need for a special subsidy to poor families. In addition, government recurrent expenditure in basic education (used to fund teacher training, learning/instructional materials and other operational needs of schools) declined by more than half per pupil between 1990/91 and 2001/02. By the latter date, the public school system lacked 38,050 teachers and 8442 classrooms.

PROSPECTS

To achieve UPE by 2015, Tanzania's net enrolment rate will have to increase by an average annual rate of 3%, following a 6% advance in 2002. Overall performance in the sector is currently hampered by public expenditure constraints; slow implementation of the educational reform now under way; limited capacity for effective management and planning; inadequate school infrastructures and equipment in increasing disrepair; and lack of community and parental involvement in both the education and decision-making processes. Despite an encouraging acceleration of the current reform process, it must overcome serious capacity constraints at the

Five key factors militate against educational improvement in Cameroon: (i) inadequate allocations for materials; (ii) poor instruction and curricula insufficiently related to basic needs and current livelihood opportunities; (iii) income poverty; (iv) cultural factors, mainly in the northern provinces; (v) low teacher salaries. To foster educational co-management at the local level, the government has re-instituted school "advisory" committees comprising the parents of primary-level students, the school administration, teachers and their unions, and representatives of the local administration and civil society groups. A similar mechanism exists at the secondary level.

Achieving 95% NER by 2015 will require considerable quantitative and qualitative improvements beyond the sector as well as within it. Malawi's 1995-2005 Education Development Plan and its 2000-2015 Policy and Investment Framework emphasize free and compulsory primary education for all children from 6-13 (including those with learning disabilities). The strategies encompass increasing the number of schools, permanent classrooms, sanitation facilities, teachers, teacher housing, desks and teaching and learning materials, as well as measures to reduce the direct and indirect costs

UPE has necessitated the construction of more classrooms, the provision of more instructional materials and the recruitment and training of more teachers. A massive recruitment campaign in 2000 brought 10,515 new teachers into the system, along with 3000 trainees for a 3-year certification course. However, sustaining the UPE programme will require another 180,000-200,000 teachers by 2015 and building approximately 70,000 classrooms, as well as embarking on the expansion of secondary school facilities early enough to meet future enrolment demand. To

Given demographic projections and anticipated increases in enrolment and completion rates, as well as the desired qualitative improvements, the public school teaching force will have to grow by 70% between 2001 and 2015 and inefficiencies in teacher deployment must be reduced. During the same period, the number of classrooms will have to expand by 60% and the stock of textbooks by 130%. Current trends indicate that the elementary school completion rate is expected to rise by 1% annually to 71% in 2004/5 and thereafter by an average of 2.6% per year to 100% in 20015/16. Moreover, savings resulting from such items as the

central, regional and local levels. This calls for capacity-building at the lower levels of government in financial management and the adoption of strict monitoring mechanisms. Given the many reciprocal linkages between household poverty and low educational attainment, progress towards the country's educational targets is inseparable from concomitant advances in reducing the overall incidence of income poverty. Gains on those twin fronts will encourage families to release their 7-13 year-olds from subsistence activities and prepare them for bettering household living standards as well as their own future prospects.

In addition to building education capacities by constructing, equipping and maintaining schools, in fiscal 200/2001, the government undertook specific activities directed at: finalising the new 10-year national education plan; enforcing the decision granting free access to education at government primary schools; consolidating partnerships in the education sector; opening teacher training colleges; opening government secondary schools and parallel establishments; accelerating the current absorption of 1,700 part-time primary school teachers; and implementing the national policy on school text books and teaching aids.

of schooling and other actions to foster attendance. These include providing basic learning materials, fee-waivers for girls in secondary school to encourage them to complete primary education and the introduction of attendance-related school feeding programmes during periods of drought, as well as the adjustment of the school calendar to seasonal agricultural needs. All these reforms can help alter parents' attitudes towards schooling. Another tool is the promotion of parental involvement in school committees, along with high-level community authorities and other local citizens.

maintain quality of service, the government has committed to increasing the non-salary component of recurrent costs in the sector and improving the targeting and effectiveness of the primary cycle. It has also undertaken to guide communities in streamlining their own contributions to primary education. As of 2001/2002, for example, local governments have been required to use 15% of their School Facilities Grant from the Ministry of Education to build teacher housing in schools.

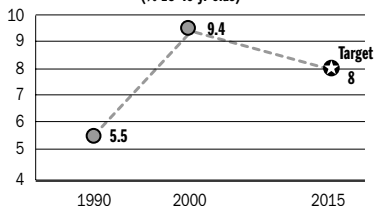
unit costs of textbooks and school buildings, as well as better deployment of teachers (transfers across geographic borders, removal of their administrative/clerical functions, etc.), can reduce the present resource gap projections considerably.

HIV/AIDS: HALT AND REVERSE THE SPREAD OF HIV/AIDS AND OTHER INFECTIOUS DISEASES BY 2015

STATUS

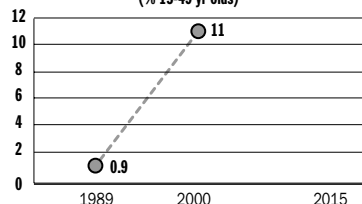
TANZANIA

HIV Adult Prevalence
(% 15-49 yr olds)



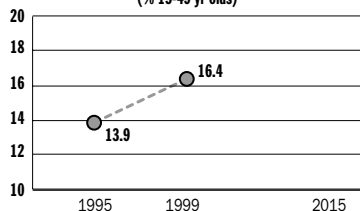
CAMEROON

HIV Adult Prevalence
(% 15-49 yr olds)



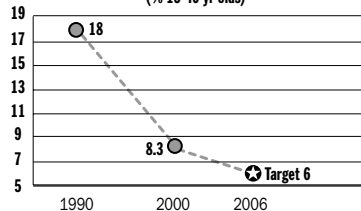
MALAWI

HIV Adult Prevalence
(% 15-49 yr olds)



UGANDA

HIV adult prevalence
(% 15-49 yr olds)



Most indicators suggest that the prevalence rate of HIV rose steadily throughout the 1990s, from an average of 5.5% in 1992 to 9.4% in 1999. The gender gap of the infection also widened: in 1992, little difference existed between male (5.3%) and female (5.9%) rates, whereas by 1999, prevalence among women stood at 12.6% in comparison to 8.7% among men. Tanzania considers HIV/AIDS the single greatest threat to national security and socio-economic development, as well as to the survival and well-being of its citizens as individuals. The government has set a national target in line with that of the International Conference on Population and Development (ICPD+5): 25% reduction in infection rates among 15-24 year olds by 2015. Applied to the population as a whole, this ambitious target translates into cutting HIV prevalence to below 8% by 2015. Nonetheless, given significant declines in new infections among young pregnant mothers (15-24 year-olds) in two regions of Tanzania, there is good reason to hope for comparable progress elsewhere.

HIV/AIDS in Cameroon appears to have increased alarmingly in recent years, rising from a rate of 0.9% in 1989 to 11% in 2000. In addition, the 1998 Joint UN Programme on HIV/AIDS (UNAIDS) estimates for the country reveal that by the mid-1990s, more than 15% of the army and of truck-drivers were HIV-positive, and that rates among commercial sex workers in Yaoundé and Douala exceeded 20%. Recent statistics of the Minister of Public Health confirmed about 937,000 cases, while the 2000 edition of UNICEF's Progress of Nations indicates that 7.8% of Cameroon's young girls and 3.8% of young boys below 24 are infected. Geographic prevalence varies widely, ranging from 6% in the Western Province to 17% in Adamoua. As women are particularly vulnerable, mother-to-child infection adds to the national threat.

In 1995, when the first statistics on HIV/AIDS were collected, experts estimated that 13.8% of the population between 14 and 49 years of age were living with HIV. Four years later that figure had risen to 16.4%, with a 24% rate of seroprevalence among women (26% urban, 27% peri-urban and 12% rural). However, statistics mask the true magnitude of the pandemic because of under-reporting and misdiagnosis. What is clear from even the available figures is that the HIV incidence is generally increasing because knowledge and awareness of the disease has translated only very slowly into behavioural change. Moreover, condom use remains very low, in part because the subordinate status of women limits their ability to demand safe, responsible sexual practices.

HIV/AIDS was first identified as early as 1982, with an estimated 1.9 million infected Ugandans. In 1986 the government launched an AIDS Control Programme as the first major step towards mainstreaming the issue in policy circles and, by 1992, had created the Uganda AIDS Commission to coordinate a multi-sectoral response to the pandemic. By 2000, national AIDS prevalence rates dropped from 18% in the early 1990s to 8.3%. A number of NGOs have been instrumental in providing logistical support and counselling. Nonetheless, AIDS remains the cause of 12% of Uganda's annual deaths, is the single largest killer among 15-49 year-olds and has orphaned more than 1.1 million children. The country's National Strategic Framework calls for a further reduction of 25% in incidence by 2006.

The crippling costs of HIV/AIDS in Sub-Saharan Africa

As 2001 closed, approximately 28 million Africans were living with HIV and AIDS and nearly 18 million had died. At current rates — almost 40 per cent among adults — more than 40 million will contract the virus by 2010 and over 35 million will die. However, if effective national

responses are put in place and resources commensurate with the challenge are made available, the pandemic can be reversed. Region-wide, this will require US\$ 4.6 billion a year (from all sources combined) for prevention, social mobilisation and treatment for those living

with HIV/AIDS, including limited delivery of antiretrovirals. Bringing these medicines to most of those who need them (approximately one third of people now infected) calls for more than US\$10 billion per year — assuming drastic price cuts of patented drugs or access to generics.

PROSPECTS

Halting and reversing the spread of HIV/AIDS in Tanzania requires overcoming persistent gender inequalities and inequities that lead to a higher prevalence among women and, subsequently, high infection rates among newborn children. The stigmatization of AIDS victims at all social levels leads to widespread denial that, in turn, fuels ignorance and prevents the changes necessary in sexual behaviour to stem the pandemic. Many of those who are infected do not know that they are HIV- positive or that continuing certain sexual life-styles puts others at risk. Widespread and accurate testing must be

promoted, access to protection must increase and all people must be empowered to adequately protect themselves, particularly those most at risk. Recognizing AIDS as a cross-sectoral challenge, the government has launched a multi-dimensional response whose management will require considerable resources and other support of all kinds.

The government recognizes that its HIV/AIDS problem has grown well beyond the realm of public health issues and that, if not contained, the pandemic will become the single greatest danger to national development. Three major challenges in halting and reversing its spread are: - (i) Raising awareness and improving information; (ii) Aggressively promoting behaviour change; (iii) Increasing condom use in identified risk groups (sex workers, truck-drivers, etc.) and among the population at large. The govern-

ment has established a network of decentralized public/private partnerships charged with making a multi-sectoral campaign against HIV/AIDS operational.

Given prevailing sexual attitudes, containing the pandemic calls for going well beyond casual civic education, voluntary counseling and testing and advertisements of condoms. Malawi is paying special attention to young boys and girls through proper and continuous sex education by parents as well as teachers. Controversial proposals — such as mandatory testing for those seeking government scholarships to universities, training institutions and secondary school and preparing to marry — have been advanced. The current HIV/AIDS Strategic Plan concentrates on (i) preventing infection among youth by incorporating HIV/AIDS in school curricula at all levels, increasing adolescent reproductive health services and downplaying initiation rites; (ii) abstinence and increased use of condoms, including

those for females, distribution and education; (iii) control of mother-to-child transmission; (iv) promotion of Voluntary Counselling and Testing underlined by the introduction of the service at health centres and district and referral hospitals. These strategies should be complemented by apparently radical steps for protecting young people and the HIV-free adults, even at the cost of infringing some rights. The HIV/AIDS prevention campaign is under-resourced, carried out largely by NGOs. The introduction of HIV/AIDS counselling and testing units at district hospitals and health centres will require staff recruitment and/or redeployment and training and/or re-training current personnel in the requisite skills.

Although the Ugandan government adopted timely and decisive measures to address the HIV/AIDS pandemic, with highly visible results in less than a decade, continued efforts to prevent the disease and mitigate its effects are a central element of the National Poverty Eradication Plan. The National Strategic Framework on HIV/AIDS seeks to foster behavioural change, reduce infection rates among vulnerable groups and promote therapeutic/preventive activities. In this domain, the health sector

is expected to continue playing a leading role through expanding capacity to monitor and administer anti-retro-viral drugs. The cost of such treatment, currently estimated to range from US\$214 – US\$740 per month constitutes an insurmountable financial hurdle. Awareness campaigns have intensified, home-based care is being strengthened, and a new strategy for HIV surveillance has been launched to track infection rates among lower age groups. Vaccine trials, pioneered in 1999, will continue.

Coping with the socio-economic consequences of the pandemic requires even greater resources. Because HIV/AIDS is decimating Africa's most productive age group, it threatens decades of development achievements. Its effects may well increase the proportion of people living in ab-

solute poverty by 10-20% by 2015. Life expectancy will fall to 1950s levels, infant mortality will rise, and educational gains will shrink because of high teacher mortality and mounting drop-outs among orphans. The impact on households and communities, already incalculable,

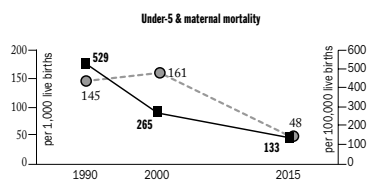
will require a radical upscaling of national poverty reduction strategies. In addition, resources will have to redress repercussions in the public sector. Essential services, still inadequate, have been further weakened by dying staff and drastically reduced public revenues.

Without an effective and comprehensive response to all these elements, most of Sub-Saharan Africa cannot hope to reach the Millennium Development Goals.

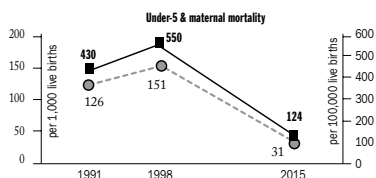
HEALTH: 2/3 REDUCTION IN UNDER-FIVE MORTALITY RATE 3/4 REDUCTION IN MATERNAL MORTALITY BY 2015

STATUS

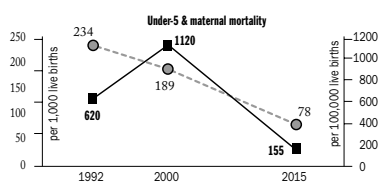
TANZANIA



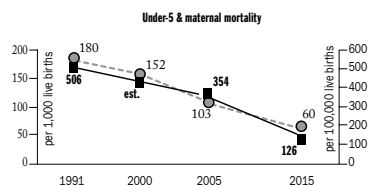
CAMEROON



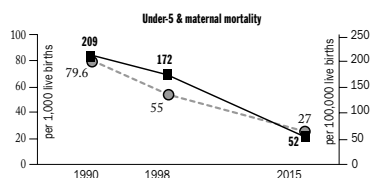
MALAWI



UGANDA



PHILIPPINES



One symptom of Tanzania's health problems is the fact that the sole nationally representative figure for maternal mortality — 529 deaths per 100,000 — dates from 1996. Other evidence suggests that this indicator, along with the under-five mortality rate, has either remained constant or deteriorated since 1990. Tanzania therefore seems unlikely to reduce under-five mortality from 145 to 48 deaths per 1000 live births by 2015. Moreover, the percentage of births attended by trained health practitioners (an acceptable proxy) has declined from 44% in 1991/92 to 36% in 1999, suggesting that the target of 133 maternal deaths per 100,000 live births by 2015 may be difficult to reach. Despite rising access to reproductive health services and increases in contraceptive prevalence, a core package of reproductive health services is available in only 16% of health facilities. The overall deterioration of several health indicators throughout the 1990s stems at least in part from the impact of the HIV/AIDS pandemic.

Between 1991 and 1998, under-five mortality rates increased from 126.3 to 150.7 per 1,000 live births, a trend difficult to reverse in the next few years because of the HIV/AIDS pandemic. Similarly, the health status of women deteriorated during this period, the maternal mortality rate standing at 550 per 100,000 live births in 1998/99, while the number of births not attended by trained personnel, increased from 36.2% to 41.8%. These trends distance Cameroon from the global target for 2015. Moreover, despite increasing knowledge of modern contraception (80% in 1998 against 66% in 1991), few women translated this into practice (7% in 1998 against 4% in 1991).

Health surveys carried out in 1992 and 2000 reveal little progress, in large measure because of a high incidence of malaria among children and pregnant mothers, along with other water- and food-borne diseases as well as HIV/AIDS. Indeed, maternal mortality rates almost doubled between 1992 and 2000, rising from 620 deaths per 100,000 live births to 1120. Reaching the target of 155 by 2015 will therefore require a complete reversal of this trend and an annual reduction of 67 fewer deaths per year. Fortunately, despite anemia and low birth weights attributable to malaria, under-five mortality declined from 234 to 189 deaths per 1000 live births. However, this rate, too, is insufficient to meeting the 2015 target of 78 deaths per 1000 live births.

Uganda's policy framework has integrated health sector millennium goals into its Health Sector Strategic Plan (HSSP), which has begun delivery of a minimum health care package at the district level. Although the early 1990s had witnessed modest improvements in selected health indicators, most of these had deteriorated, in large measure because of a decline in immunization rates and in the number of assisted deliveries. Specifically, under-five mortality decreased from 180 deaths per 1000 live births in 1991 to 147 in 1995, but climbed to 152 by 2000. HSSP has set targets for five-year periods on the assumption that if these can be achieved and the trend maintained, the MDGs will be well within reach. Thus, HSSP stipulates a 30% under-five mortality reduction to 103 by 2005, in line with the MDG target of 60 by 2015. In terms of maternal mortality, HSSP calls for a reduction from 506 deaths per 100,000 live births in 1990 to 354 in 2005; the 2015 target is 126 deaths per 100,000 live births.

During the 1990s, under-five mortality rates declined steadily from 79.6 deaths per 1000 live births in 1990 to 66.8 in 1995 and 55.0 in 1998. Meeting the 2015 target of 26.5 deaths per 1000 live births will require accelerating the current trend. Similarly, maternal mortality decreased from 209 deaths per 100,000 live births in 1990, to 180 and 172 in 1995 and 1998 respectively — a rate of progress also insufficient if the MDG of 25.5 deaths per 100,000 live births is to be met by 2015. However, Philippine figures are already relatively low by international standards.

PROSPECTS

Tanzania's ability to meet the health-related MDGs depends on removing specific constraints both within the sector and outside it, notably the following: (i) public expenditure shortcomings, particularly allocations for primary health and reproductive care; (ii) the deterioration and understaffing of existing health and reproductive health facilities, including limited capacity for management and planning; (iii) inadequate involvement of non-state actors in service delivery; and (iv) insufficient knowledge of health issues. Limited community involvement, harmful traditional practices and barriers to reproductive health services for adolescents compound these

Cameroon confronts five major challenges in reducing its under-five mortality rate significantly: (i) poverty; (ii) deteriorating access to quality health and reproductive care services; (iii) insufficient community involvement; (iv) poor maternal health and (v) insufficient knowledge and awareness of health issues. These factors also obstruct progress towards reducing the maternal mortality rate, along with continuing adherence to harmful traditional practices and inadequate involvement of both non-governmental actors and the private sector in health service delivery. Despite a new 10-year health plan, public spending

A National Malaria Policy to deal specifically with this number one killer, along with other efforts to reduce child and maternal mortality, will be linked to HIV/AIDS prevention strategies, among these voluntary counselling and testing for the disease and preventing its transmission from mother to child. The government has also introduced a package of essential health services that target the major conditions (including respiratory infections and acute diarrhoeal diseases). The rise in maternal mortality has prompted the intensive recruitment and training of traditional birth attendants and midwives at health centres, as well as measures

The success of Uganda's health care system stems from its policy of decentralizing services and will require considerable capacity development at the district level, the more so since the minimum health care package ranges from environmental and nutrition programmes through the integrated management of childhood illness and sexual and reproductive health and rights. Increases in budgetary allocations have gone hand in hand with greater attention to internal efficiency through the use of NGOs as service providers, among other innovations. Nonetheless, the changing

The government's Health Sector Reform Agenda posits undertaking the following: (i) secure funding for priority health programmes; (ii) promote the development of local health systems; (iii) strengthen the capacities of health regulatory agencies; (iv) provide fiscal autonomy to government hospitals; and (v) expand the coverage of the National Health Insurance Programme. Within this framework, attention is being devoted to persistent infectious diseases and chronic and degenerative diseases that have recently become prevalent, large variations in the health status of

problems. Empowering women to make reproductive health choices requires special efforts, among these, enhancing educational opportunities for young women. Cutting both maternal and under-five mortality rates calls for reducing malaria, viral hepatitis, pulmonary tuberculosis, and tetanus and, above all, containing and curbing the spread of HIV/AIDS. Last but hardly least, raising health indicators depends on alleviating the widespread income poverty that narrows access to nutritious food and basic amenities.

restrictions constitute an additional barrier to increasing budgetary allocations to basic health services. Finally, the country needs further assistance in reorganising its health sector, including the decentralisation of health care delivery systems, together with the strengthening of all stakeholders in these systems.

to facilitate access to such services. The training of health workers at the district and community level will also be required. In addition, the National Safe Motherhood Policy Framework, which pays special attention to young mothers, will redress the current low uptake of family planning services. The country's Poverty Alleviation Programme calls for the decentralization of health service delivery and the involvement of the private sector and NGOs in providing PHC services.

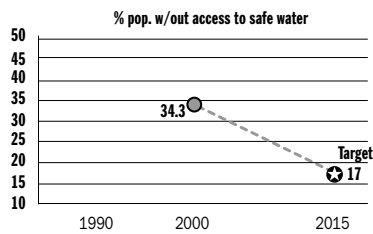
structure of health delivery has led to some disruption of the system. National support for immunization programmes must regain the momentum lost in the late 1990s. Greater efforts are also required to implement pay reform for health workers and to train them in fostering attitudinal and behavioural change among those they serve.

population groups and strengthening management systems. The government has also identified a series of time-bound targets for 13 objectives, ranging from expanding full infant immunization to 98% by 2015, achieving 100% health coverage of the indigent by that date, and reducing Vitamin A, iron and iodine deficiencies among pregnant and lactating women. Nonetheless, even within the most optimistic scenario, the resource needs of the basic health sector are not likely to be met

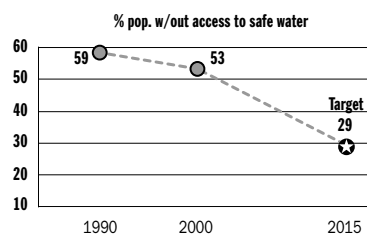
WATER: HALVE THE PROPORTION OF PEOPLE WITHOUT ACCESS TO SAFE DRINKING WATER BY 2015

STATUS

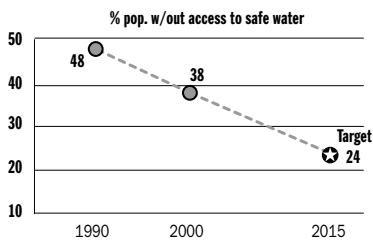
TANZANIA



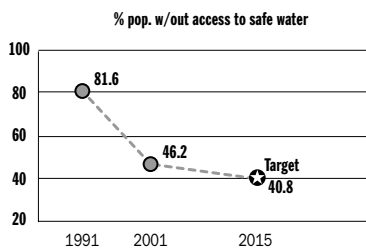
CAMEROON



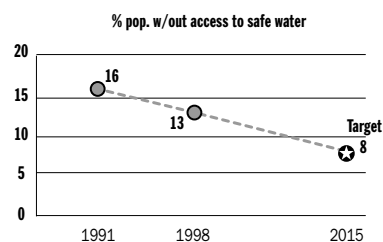
MALAWI



UGANDA



PHILIPPINES



According to a 1999 national survey, only 65.7% of Tanzanian households were using safe water supplies. This national figure conceals urban-rural disparities: 92.1% of urban households had access to safe water, compared with 56.3% of those in the countryside. This survey was the first to use a standardized definition — water from a pipe, public tap, borehole/pump, protected well or protected spring — which will assist analysts in projecting future trends and needs. The indicative national target of 82.1% for 2015 will require the substantial increase of access to safe water in rural areas. In addition to the general poverty that limits the viability of cost-sharing programmes, other constraints include low capacity at the community/local level to plan, manage and maintain village water infrastructure, as well as the destruction of catchment areas and other water sources.

Access to safe drinking water (tap or quality-controlled) remained virtually unchanged throughout the 1990s, having increased only from 41% to 47% between 1990 and 2000. However, the number of people without safe water grew by approximately two million over this decade. Wide disparities persist between urban and rural areas. In the main towns, seven households in ten had access to safe supplies, compared with only two in the countryside. The 2015 target of a 29% increase will require a rapid acceleration of past trends.

Between 1990 and 2000, the percentage of Malawi's population with access to potable water increased from 52% to 62%. In urban areas, coverage expanded from 85% to 92% between 1990 and 1995, but declined to 1990 levels by the end of the decade. By contrast, rural rates deteriorated during the early 1990s, but after 1995, increased from 44% to 58%. Reaching the 2015 target of 78% will require an annual increase of 1.1%, with emphasis on rural water supply. Despite the development of many new water supply networks, a great number with community involvement, some 40% of these do not function.

Over the last decade, Uganda's water sector has expanded considerably. Coverage rates rose 18.4% in 1991 to 53.8% in 2001 — with, however, significant variations across districts and between rural and urban areas. Overall rural coverage is estimated at 47% and that of ten districts remains below 30%. By contrast, urban coverage is close to 60%. Uganda's targeting strategy appears to have put the country well within reach of the MDG target of ensuring that no more than 40% of its population lacks access to safe drinking water. However, the national target of 100% coverage will require considerable acceleration of the current rate of expansion.

The proportion of households with access to safe drinking water increased from 72% in 1991 to 87% in 1999, thereby suggesting that the country has already met the Millennium Target of halving the proportion of those without access. With further improvements envisaged, the country could achieve universal access before 2015.

PROSPECTS

Reaching a target of 82.1% for 2015 will demand increasing coverage by close to 1.5% each year. The Ministry of Water, currently undergoing reform, will need to shift its role from provider to coordinator and facilitator. At the same time, local government must develop its capacity to coordinate access to safe water and that of local communities to plan and manage village water infrastructure. Partnerships with other stakeholders, such as NGOs and the private sector, need strengthening, particularly in the countryside. Increased cost recovery will depend largely on

the evolution of household incomes. In urban areas, the government's strategy focuses on private sector participation. Delegating responsibilities from the state to private agents will require the development of an adequate and enforceable regulatory framework.

Expanding Cameroon's safe water supply network confronts three key challenges: (i) Sector reform: the government has concentrated on privatizing the main supplier of water and privatization is expected to play an increasingly important role in the provision, rehabilitation, and maintenance of infrastructure; (ii) Low incomes: adherence to a philosophy of cost recovery will require the economic empowerment of users; (iii) Community capacity: training and support will be needed to ensure that communities are able to plan, manage and maintain village water infrastructures.

Malawi's Poverty Alleviation Programme now emphasizes continuous training of water point committees, repair teams and providing adequate stocks of spare parts. In addition, the 1999 revision of the national water policy stresses river basin development and protection, catchment conservation and NGO and private participation, as well as increasing the efficiency of regional water boards. Under these twin initiatives, each of the country's 27 districts must have technical staff assigned full-time to training, as well as a water supply monitoring and evaluation system. Further, each traditional Authority will have a water

support group. Nation-wide, coverage of some 7000 rural communities is envisaged, along with the recruitment of technical staff in each district and their training as trainers at the community level.

Despite impressive gains in extending coverage, Uganda must increase attention to protecting its water sources, notably in view of its receding water table — a key consideration in ensuring the long-term sustainability of present expansion. This calls for fostering community participation and ownership to enhance a sense of collective responsibility, as well as for building implementation capacity at the district level, especially in view of rising drilling costs. A Department of Water Resource Management has been created in the Ministry of Water, Lands and the Environment with responsibility for sustainable water use, a

water permit system has been introduced for regulating use, and water resource assessments have been undertaken in a number of areas. Furthermore, regional collaboration under the Nile Basin Initiative and Lake Victoria Environment Management Programme provides opportunities for harnessing the benefits of shared water resources.

Despite considerable progress, cumulative resource gaps imply that the MDG goals for sanitation will not be met as early.

TANZANIA

INCOME POVERTY

Given current income distribution patterns (Gini coefficient estimated at 0.40), Tanzania will need to sustain overall real growth-rates of 5% or more in order to achieve a halving of income poverty incidence. GDP growth of 5% will bring per capita income up to \$422 by 2015. Growth at this level will require that the economy can sustain gross investment rates of up to 20%, which have been shown to be feasible in recent years, with foreign investment accounting for about one-third. Tanzania will need to continue to attract foreign investment, boost its modest tax take (11% of GDP in 2000) and increase domestic household savings levels, which are currently very low. To make growth pro-poor, investment will need to favour the rural sector and other labour-intensive activities and will require considerable investment in rural infrastructure and extension services.

BASIC SOCIAL SERVICES

The Tanzania country study has estimated the additional annualised expenditures to meet the key MDGs as follows:

Primary education	\$70 million in 2002, falling to zero in 2015
Health	\$101 million in 2002, rising to \$134 million in 2015
Water	\$55 million in 2002, rising to \$98 million in 2015
TOTAL	\$226 million in 2002, rising to \$232 million in 2015
As % of GNP	2.8% in 2002

The education costs include both capital and current expenditures. Given a fall in enrolment rates during the last decade, a huge effort is implied by these figures, particularly because they do not take into account necessary improvements in quality (including smaller classes, more textbooks, and drop-outs because of pregnancies, as well performance indicators for girls). Although the annual costs fall steadily to 2015, the additional expenditures in the early years represent a substantial increase in education spending.

The additional health costs assume that a package of health services will be required to meet the goals of reducing maternal mortality, under-5 mortality and bringing the HIV/AIDS epidemic under control. In this connection, the gender gap in seroprevalence rates has also widened and is aggravated by persistent gender inequalities. The annual cost of the anti-AIDS programme is almost \$20 million. These expenditures would mean an increase of about 50% in health costs.

Given the low current levels of access of the population to water and sanitation, a major effort will also be required in this sector. Coverage will need to increase at a rate of 1.5% per year.

RESOURCES

The government is looking to increased access to markets of rich countries, to new concessional borrowing, debt relief, grant aid and the private sector to meet most of the additional resources it will need to meet these basic social service needs. A huge additional effort will also be needed to raise tax revenues, which have slipped sharply as a proportion of national income.

In 2002, Tanzania's debt servicing was \$144 million after the country began to benefit from debt relief through the HIPC. This amount is almost two-thirds of the additional spending required to meet the basic social service goals in 2002. Unfortunately, servicing is expected to rise steadily to \$175 million by 2006, with the largest increases going to IMF. Of this total, continuing Paris Club bilateral debts continue to absorb \$50 million each year. Debt relief therefore continues to be a high priority for Tanzania's resource needs, particularly because a sustainable debt service to exports ratio (i.e. below 10%) can only be maintained in the unlikely scenario of sustained export growth of 10%-15% per annum.

Tanzania has been a large recipient of ODA, and remains heavily dependent on aid, although the amounts have fallen off sharply in recent years.

The private sector will have a role to play, particularly in the water sector. The government anticipates that beneficiaries will meet a part of the additional costs of water access either directly, through payments for consumption, or through community management schemes. Partial or full cost recovery will become more viable as general income levels increase.

Resources as % of GDP	1990	1999
Government spending:		
education	2.8	2.7
health	1.6	1.3
Tax revenue	18.8	11.3
Grant aid	27.5	4.5
Foreign direct investment (net)	0.0	2.1
Exports	13.0	13.0
Debts service	4.2	2.2

CAMEROON

INCOME POVERTY

To reach the Millennium Development Goal of halving poverty by the year 2015, Cameroon will need to sustain an average annual GDP growth of the order of 6 to 7%. This is based on prevailing income distribution patterns (an estimated Gini coefficient of around 0.5 to 0.6), and a poverty/income elasticity around unity. In view of recent trends in the Cameroonian economy (almost no gain in per-capita income in the early 1990s, and only 2 points gain during the 1997/2001 period), a sustained growth of 6-7% constitutes a significant challenge to the country as a whole. But recent trends indicate marked improvement, especially in macroeconomic performances, and a renewed commitment from the government, which may allow the country to attain the goal.

The accelerated growth performance will require higher volume, as well as improved efficiency of investment. Cameroon's macro-econometric model indicates that, given the prevailing efficiency of capital, a 25% investment rate would be required to support the target growth rate. This, in turn, will require a significant effort to raise the domestic savings rate and attract foreign investment. To this end, the government will need to rekindle effort to create a favourable investment climate and, more generally, an enabling environment for export and growth led by the private sector. Meanwhile, as the oil sector is fading as an engine of growth, Cameroon faces the challenge of identifying alternative sources of growth that would be more sustainable, distribute income more equitably and thus impact more significantly on poverty reduction.

BASIC SOCIAL SERVICES

The country faces a major challenge in meeting the MDGs in education, health and water, as indicated in the MDG annual progress report. Additional costs are envisaged as follows:

Primary education: \$550 million

Health: \$607 million

HIV/AIDS: \$77 million (2002-2007)

In the case of education, more than 30,000 new teachers will need to be trained by 2015, an increase of over 70%, and the number of classrooms will need to more than double. A satisfactory strategy on education has been prepared, but implementation has yet to begin. Meanwhile, school tuition for primary schools have been abolished. This will certainly contribute to meet the MDG related to the primary enrolment rate.

In the struggle against HIV/AIDS, the total cost of the national programme is estimated at \$77 million over the next five years. The most recent supervi-sion report indicates little forward movement in combating AIDS, notwithstanding some positive developments over the last few months.

In the case of health care in general, a massive effort will be needed to increase substantially the number of doctors — currently only 750 — nurses and other medical personnel. An increase of 60% is envisaged in the number of health centres.

RESOURCES

A considerable fiscal effort will be required to diversify, steering the economy away from dependence on oil revenues while expanding the overall revenue base. By 2003, the government intends to raise the revenue (tax and non-tax) ratio from 16% to 20% of GNP; this should rise to around 20% over the period up to 2015. Within the overall budget, the total resources of the three corresponding Ministries (Health, Education, Water) will need to increase their respective shares. Taken as a whole, these fell as a proportion of the total budget from 17.7% in 1991/92 to 9.6% in 1997/98, recovering to 13.5% in 2001/02.

The government is also seeking to improve the efficiency of public resource utilisation and to increase its delivery of aid projects. In this regard, measures have been taken to improve expenditure management and increase its efficiency and transparency. An anti-corruption "observatory" has recently been set up under the National Governance Programme. However, there are serious implementation delays.

Cameroon has been a beneficiary of the expanded HIPC process, annual debt service costs falling from \$470 million in 1999 to \$177 million in 2001. A Consultative Committee to oversee the use of these funds includes donors and civil society representatives. Disbursements, however, have been slow, reflecting low absorptive capacity.

Debt relief will be the single most important potential source of new funding for meeting the MDGs at least in the immediate future. These debt relief funds are expected to increase steadily in coming years, reaching almost \$350 million in 2009, mainly as a result of relief on debt owed to bilateral creditors and to the World Bank. Debt sustainability, measured by the ratio of debt servicing to exports of less than 10% will depend on projected real export growth of 6-8% per year.

In recent years, Cameroon has been the recipient of important ODA flows, which account for between 4% and 5% of GDP. Foreign direct investment has been at very modest levels despite the country's rich resources. However, the trend of the ratio FDI/GDP (%) shows a positive evolution from 1995 to 1998.

Resources as % of GDP	1990	1999
Government spending:		
education	2.8	1.82
health	0.9	1.0
Tax revenue	10.8	12.8
Grant aid	4.0	4.7
Foreign direct investment (net)	-0.4	.4
Exports	20.0	24.0
Debts service	4.7	6.0

MALAWI

INCOME POVERTY

There were marked fluctuations in growth-rates during the 1990s, reflecting Malawi's high exposure to external economic shocks and its susceptibility to climatic conditions. But a respectable average of 4.2% was achieved for the decade as a whole. Income inequality appears to have declined during the last decade (from a high Gini coefficient of 0.62 in 1992 to a more moderate 0.40 in 1998), but higher growth — estimated by the country study at 6.0% — will have to be achieved up to 2015 if there is to be a significant reduction in income poverty.

To render growth pro-poor, more resources will need to be allocated to rural areas, and particularly to smallholder agriculture and rural infrastructure. The development of small and medium labour-intensive enterprises will also be a priority. The government has determined that sectoral support programmes — including for agriculture, rural infrastructure, small and medium enterprises, and trade — will cost approximately \$1.6 billion over the period.

BASIC SOCIAL SERVICES

As a proportion of the total budget, public expenditure on basic social services increased markedly after 1996/97 to reach around 40%. Notwithstanding this redistribution, the total additional costs of meeting the goals over the whole period 2002-2015 will be as follows:

Primary education	\$1,030 million
Health	\$1,210 million
HIV/AIDS	\$2,500 million
Water	\$80 million
TOTAL	\$4,820 million

The costs of the primary education programme result from the continuing commitment to free access, established after 1995, following which, enrolment levels increased immensely — though gender discrepancies persist and tend to become more accentuated at higher levels of education. Substantial costs will be involved, therefore, in improving the quality of education with more teachers, classrooms and textbooks. Another challenge is the very high drop-out rate, particularly among girls; only 20% of all children actually completing primary education. Truancy, however, will be best countered through a general increase in economic opportunities and income levels.

The costs of meeting the health goals include the financing of an essential health package and nutrition programmes. The costs of the anti-AIDS programme are also substantial, but these include the cost of anti-retroviral drugs. The costs are expected to be met by the public budget (24%), debt relief (23%), external donors (18%), household user fees (22%) and employer-paid medical insurance (13%).

To meet the water needs, some 30 water schemes would need to be constructed or rehabilitated. In addition to infrastructure, there will

be capacity building needs to maintain water supplies and protect the environment. For urban areas, Government will work with urban and peri-urban water supply parastatals, either by guaranteeing their loans or sourcing loans on their behalf.

RESOURCES

Reaching higher growth levels and meeting the needs for basic social services will require a major fiscal effort. Domestic savings rates are currently very low (3% of GDP in 2000). Fiscal revenues are around 17%, but have declined slightly over the past decade. The most optimistic scenario sees this percentage rising to 25% by 2015. Foreign direct investment amounts to about 7% of GDP. To maintain adequate investment rates, Malawi will need to attract more overseas investors through improving the economic climate and upgrading infrastructure.

Debt relief has resulted in a sustained fall in service payments, although the country will continue to have significant obligations. Annual payments fell from \$110 million in 2000 to \$64 million in 2002. In coming years, payments are expected to remain at or below this level until at least 2010. Relatively modest export growth of 5% will be needed to keep the debt-servicing ratio to exports at or below 10% until 2010.

Malawi continues to benefit from generous levels of grant aid. But, as the country study confirms, without continuing donor commitment towards the MDGs there is very little the government can do to reach the goals. Currently, donor commitment depends on many factors, some of which are independent of the high priorities attached to the MDGs.

Resources as % of GDP	1990	1999
Government spending:		
education	2.8	Na
health	1.5	2.8
Tax revenue	18.0	17.5
Grant aid	27.9	24.6
Foreign direct investment (net)	0.0	3.3
Exports	25.0	27.0
Debts service	7.4	3.8

UGANDA

INCOME POVERTY

The country study assumes growth/poverty elasticities in the range -1.39 and -1.67 (1% increase in average income levels results in a more than commensurate decline in income poverty). These will ensure that Uganda stays on target to reduce income poverty significantly if it can maintain the 5-8% average annual growth-rates achieved since 1995, and prevent a further aggravation of the inequalities noted above (current Gini coefficient is 0.38). A high growth scenario of 7% and high constant elasticity of -1.67 would bring income poverty rates down to just over 5%, while lower growth (4.5%) and lower elasticity (-1.39) would reduce the rate to 13%.

Two fundamental weaknesses that detract from an otherwise optimistic outlook are the high dependence on commodity exports, and in particular coffee — the price of which has fallen precipitously in recent years — and the relatively low levels of revenue generation: 11-12% of GDP in recent years, which obliges the country to remain dependent on substantial external aid. A further destabilising factor is the simmering conflict in the northern part of the country.

BASIC SOCIAL SERVICES

The country study examined the costings of the MDGs using a range of different scenarios. The additional resources required for individual years, shown below, assume a constant population increase (2.9% per year). They are calculated as the difference between the maintenance of current spending levels and the “optimal” spending needed to achieve the goals:

Primary education \$161 million in 2002, rising to \$233 in 2015

Health \$117 million in 2002, rising to \$170 million in 2015

HIV/AIDS \$127 million in 2002, rising to \$184 million in 2015

Water \$80 million

TOTAL \$405 million in 2002, rising to \$588 million in 2015

As % of GNP 6.6% in 2002, falling to 4.8% in 2015

Primary education is a very high priority in Uganda and has benefited from substantial increases in funding, despite continued gender imbalance in favour of boys. Spending has increased three-fold over the past three years and now accounts for 70% of the education budget, which is in turn 30% of total government spending. The government's own resources — which have been put to more effective use through closer parent-teacher surveillance — have been generously supplemented by budget support from donors and by the Poverty Action Fund, which is supported by the proceeds of HIPC debt relief. Maintaining current spending levels, however, will still mean a

pupil:teacher ratio of 55 and a sharing of textbooks among 6 pupils. Substantial new spending will be required if reasonable quality education is to be universally available and gender gaps addressed.

There has also been an increase in health spending, which now accounts for about 9% of government spending. The additional resource requirements are intended to bring spending per person up to \$11. The additional resources for combating HIV/AIDS are derived from the country's National Strategic Framework.

RESOURCES

Uganda has made progress in recent years in marshalling the resources needed to meet the goals. As already noted, a considerable effort is still required to raise levels of tax revenues, and increase the effectiveness of government spending. But a significant resource windfall resulted from debt relief under the HIPC and the cancellation of bilateral official debts. These resources are funding the Poverty Action Fund, which supports a major part of the needs of basic social services.

Uganda has also benefited from substantial inflows of ODA, which in recent years has topped \$600 million, although the amounts have fallen as a proportion of national income. A growing proportion of this aid is channelled into budgetary support. Foreign direct investment has also grown, but remains at quite modest levels. The Uganda Investment Authority is helping to promote the country as an investment destination, but prospects are linked to trade and increased export competitiveness. Uganda would gain from expanded trade opportunities through more access to the richer markets and closer regional integration.

Resources as % of GDP	1990	1999
Government spending:		
education	3.5	2.6
health	Na	1.9
Tax revenue	—	—
Grant aid	15.5	9.2
Foreign direct investment (net)	0.0	3.5
Exports	7.0	11.0
Debts service	3.4	2.9

PHILIPPINES

INCOME POVERTY

The Philippine economy was buffeted by the Asian financial crisis after 1997, which reversed the declining incidence of income poverty. In recent years, the economy has enjoyed real annual growth of 3-4%, which will not be sufficient to achieve the MDG. If stability can be maintained, however, and confidence in the economy returns, the prospects are good for an acceleration in growth — buoyed by rapid expansion in investment and exports — leading to faster reductions in income poverty.

The country study has determined that if historical average growth rates of the economy and of population are maintained, the poverty incidence will be reduced by a further 10 percentage points. Growth in the range 4.0 - 6.5%, and a decline in the rate of population increase, would ensure that the poverty rate was halved by 2015.

BASIC SOCIAL SERVICES

The country study has made detailed projections of the annual additional costs of meeting the goals, which are summarised below. Compared with the other countries considered in this report, basic social services have benefited from considerable past investments and the additional resource efforts will mainly be confined to the next few years.

Primary education \$464 million in 2002, falling to zero in 2007

Health \$131 million in 2002, falling to zero in 2008

Water \$22 million in 2002, falling to zero in 2014

TOTAL \$617 million in 2002

As % of GNP 0.75 % in 2002

High enrolment rates have already been achieved, and the main policy emphasis will be on raising completion rates above 70% and improving quality. Completion rates will improve as a matter of course as incomes grow, but to enhance educational quality, the number of additional teachers will have to grow by 70% between now and 2015, the number of classrooms by 60% and the stock of textbooks by 130%. The major part of the resources could be found domestically, in part through a reordering of education spending to favour the primary level.

Additional cost estimates for meeting the health goals encompass improvements in health facilities, especially at the district level and in rural areas; increased immunisation coverage; control of malaria, tuberculosis and schistosomiasis; and micronutrient supplementation. The needs could be met through the public finances, but there is also scope for a better use of resources, including through more health promotion measures — as opposed to mainly treatment of sickness — and private sector provision.

The resource needs to meet the water goal are relatively modest, but success will depend in part on the necessary priority being given to this sector in the public budget.

RESOURCES

A high priority in meeting the goals in education, health and water supply will be an improvement of the domestic tax effort. Experience in recent years indicates that an improvement is feasible and the priority will be on raising the tax ratio to GNP from 14% currently to over 16% in the next five years.

There is also scope for a reallocation of resources, within the budget, in favour of basic social services (e.g. from tertiary to primary education). Cost savings could also be realised through a more efficient use of resources, including raising the efficiency of service delivery and procurement service reforms.

Also envisaged is the increased involvement of the private sector in providing basic social services. For infrastructure needs, the government can have recourse to borrowing. Grant aid still runs at over \$500 million per year, but has diminished as a proportion of national income.

Overall, the development goals appear achievable by 2015. If the economy can regain its former dynamism, there will be cumulatively favourable consequences, as more people will be able to supplement access to basic services from their own incomes.

Resources as % of GDP	1990	1999
Government spending:		
education	2.1	3.4
health	1.5	1.7
Tax revenue	14.1	14.4
Grant aid	2.9	0.9
Foreign direct investment (net)	1.2	0.7
Exports	28.0	51.0
Debts service	8.1	8.8

Costing the MDGs

A note on methodology

Various global estimates have been made of the costs of meeting the Millennium Development Goals (MDGs). For the most part, they have relied on standard costings (e.g. minimum expenditures per head) applicable to all countries to arrive at the totals. This report tackles the question at the level of individual countries, where costs can vary enormously, for a variety of reasons, among them different salary levels and availability of materials. In addition, the country studies have tried to take into account some critical quality dimensions that the MDG indices do not themselves reflect, such as the size of school classes and numbers of water pumps per household.

Another vital dimension of costing and financing concerns the “efficiency” of spending — the extent to which appropriated funds are used as intended and reach the stipulated beneficiaries. These issues of financial management encompass governance questions that are both administrative (e.g. the degree of decentralisation) and “moral” (corruption).

Among the different goals, the methodologies of costing vary. Whereas a coverage target such as that selected for education may be costed in a relatively straightforward manner, “outcome” targets require more complex approaches. The causal relationships between certain policy actions and the particular development indicator need to be ascertained. This does not mean capturing and studying the full range of factors that determine a given outcome — important as that is — but, rather, identifying and costing those policy actions that are known to have the most direct bearings on the outcome within the particular country context. Similarly, the MDGs are mutually reinforcing; progress on one front has positive spill-over effects on other variables. Thus, lower income poverty and increased household income levels facilitate higher school enrolment levels. Better access to clean water reduces the toll of disease, including school drop-out rates.

For the five country studies, some basic methodological approaches were proposed, but the country teams determined their own variants. Perhaps the most important aspect of this exercise was the fact that the researchers, working in conjunction with policy-makers in government, were challenged to make a comprehensive determination — perhaps for the first time — of the resources, policies and capacities required to meet the goals, taking local realities fully into account.

For the purpose of this study, six MDG targets were selected — on income poverty, primary education, health (encompassing both under-5 mortality and maternal mortality), HIV/AIDS and water. In addition, wherever information was available, the studies attempted to mainstream the crosscutting dimension of gender across the five areas.

INCOME POVERTY

The percentage of the population living below the national poverty line is a function of two key elements: the size of the economy and the distribution of the resources within it. Country teams attempted to estimate the level of growth under different distributional scenarios that would be required to shift the necessary percentage of the population across the national poverty line. Determining the growth-rates required to realise the income poverty goal relied in most cases

on observed “elasticities”, which predict the degree to which income poverty falls for every increment of average income levels.

EDUCATION

The selected indicator, net primary enrolment rate (the number of primary school age children enrolled in primary school divided by the population of primary school age children) is held as the best estimator of sector performance towards UPE. By contrast, gross enrolment rate (the number of students enrolled in primary school divided by the population of primary school age children) tends to misrepresent reality — high repetition/retention rates and adult education programmes can yield gross enrolment rates in excess of 100% (as in Uganda). Based on population cohort projections and estimated unit costs, progress towards 100% net enrolment was costed assuming a linear progression. These estimates were augmented by the costs of quality improvements in education, including falls in teacher pupil ratios, class sizes and increasing density of textbooks.

HIV/AIDS

The containment and reversal of the spread of HIV/AIDS is probably the most complex MDG to cost. Despite some success stories, there are still limits to our understanding of what works and what doesn't in the fight against this pandemic. Moreover, HIV/AIDS has long since ceased to be seen as a health problem, but rather as social problem with broad economic ramifications requiring a multi-sectoral response. Consequently, the country studies attempted to reflect the cost of the national plans, usually including the costs of anti-retroviral drug treatments. No attempt was made to quantify the cost of non-intervention that, in the case of some of the countries analysed, would most certainly dwarf the global cost of the full range of MDGs and would compromise and even reverse the performance of all other indicators.

HEALTH

Under-five mortality (number of deaths per 1,000 live births) and maternal mortality (number of deaths per 100,000 live births) are outcome indicators that depend on health sector interventions and other measures that contribute to general health. Estimates were based on the projected costs of such health sector interventions as immunization, family planning, control of infectious diseases, and the required numbers of health facilities and trained personnel.

ACCESS TO SAFE DRINKING WATER

By deriving per capita expenditure requirements, estimates were made on the basis of the projected population and effort required to expand access to the target levels.

