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Uganda's Poverty Eradication Agenda: Measuring up to the Millennium Development Goals (MDGs)[1]

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Acronyms

ACP	AIDS Control Program
AIDS	Acquired Immuno Deficiency Syndrome
EPRC	Economic Policy Research Center
ESIP	Education Sector Investment Plan
GDP	Gross Domestic Product
HIPC	Heavily Indebted Poor Countries
HIV	Human Immuno Virus
HSSP	Health Sector Strategic Plan
IMR	Infant Mortality Rate
MDG	Millennium Development Goal
MFPED	Ministry of Finance, Planning and Economic Development
MHCP	Minimum Health Care Package
MMR	Maternal Mortality Ratio
MOES	Ministry of Education and Sports
MOH	Ministry of Health
NEPAD	New Partnership for Africa's Development
NSCG	Non –Sectoral Conditional Grant (PMA Grant)
NSF	National Strategic Framework (for AIDS)
ODA	Overseas Development Assistance
PEAP	Poverty Eradication Action Plan
PMA	Plan for Modernization of Agriculture
SFG	School Facilities Grant
STI	Sexually Transmitted Infection
UBOS	Uganda Bureau of Statistics
UNAIDS	United Nations AIDS Program
UNDP	United Nations Development Programme
UNICEF	United Nations Children Education Fund
UPE	Universal Primary Education
UPPAP	Uganda Participatory Poverty Assessment Project

Introduction

The United Nations, at the Millennium Summit in September 2000 made a commitment to working toward a world in which sustaining development and eliminating poverty would have the highest priority. At the Summit, a declaration known as the Millennium Declaration, was made in which the world leaders agreed to set time-bound and measurable goals and targets for combating the ills of underdevelopment. The Millennium Development Goals (MDGs) grew out of the agreements and resolutions of world conferences organized by the United Nations in the past decade. The goals have been commonly accepted as a framework for measuring development progress. The goals focus the efforts of the world community on achieving significant, measurable improvements in people's lives. There are eight MDGs namely to: (i) eradicate extreme poverty and hunger; (ii) achieve universal primary education; (iii) promote gender equality and empower women; (iv) reduce child mortality; (v) improve maternal health; (vi) combat HIV/AIDS, malaria and other diseases; (vii) ensure environmental sustainability; and (viii) develop a global partnership for development.

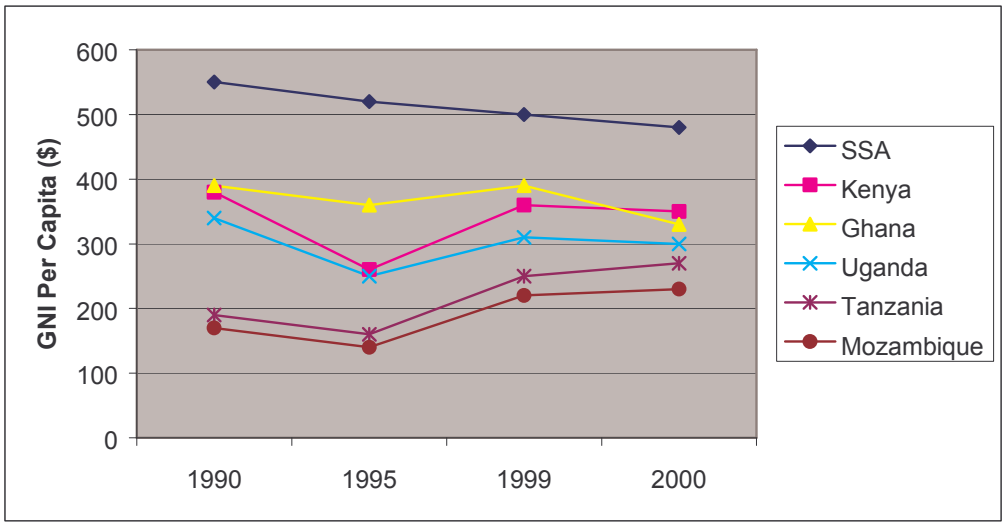
At the global level, for each MDG, targets and indicators have been developed by several international organisations. A summary of the goals, indicators and targets for global monitoring is provided in appendix 1. The purpose of this paper is to review Uganda's poverty reduction agenda contained in its Poverty Eradication Action Plan (PEAP), other sectoral plans (e.g. agriculture, education, health, water and sanitation) and the targets set therein and compare the progress made against the MDG targets. Besides progress made, the paper discusses some of the constraints to achieving the targets and the policy, capacity and resources needed to realise the PEAP/MDG targets. In addition, the paper provides comparative statistics for other African countries, details of which are provided in appendix 2. Four countries were selected for comparison. Ghana and Kenya has slightly higher gross national income (GNI) per capita, and Mozambique and Tanzania had lower GNI per capita in 2000. For regional comparison, data for similar indicators are presented for Sub-Saharan Africa Figure 1 shows the GNI per capita (US$) for the five countries and for SSA.

Uganda's Poverty Reduction Agenda and the MDGs

Since the early 1990s, Uganda's development agenda has been driven by the need to eradicate mass poverty. The efforts started in 1992 with the Integrated Household Survey (IHS) data which revealed that 56 percent of the population at that time was living below the national consumption-based poverty line. Since then commendable progress has been made and the 1999/2000 National Household Survey revealed that 35 percent of the population was living in poverty (Appleton, 2001). This translates into 37.5 percent reduction in poverty in only eight years, an average of 4.7 percent per year. In order to address poverty, the government of Uganda formulated a strategy in 1997 that is popularly known as the Poverty Eradication Action Plan (PEAP). The PEAP emerged out of consultations among government, civil society, academicians, researchers and development partners. However, with increasing desire to involve the poor and have their voices heard and their concerns addressed both at policy and budget level, the government launched the Uganda Participatory Poverty Assessment Project (UPPAP) in 1998. This brought the voices of the poor at the forefront of policy debate and formulation. As a result of this the PEAP was revised in 2000 in

order to include the lessons learned from UPPAP, the first Poverty Status Report (1999), and other work by researchers, NGOs and civil society.

Figure 1: Per Capita GNI for Selected African Countries



The PEAP (2000) has four specific goals, under which sectoral plans and programs for poverty eradication have been developed. The four goals are: (i) creating an enabling environment for rapid and sustainable economic growth and structural transformation. The main objectives of this goal are to maintain macroeconomic stability and provision of macroeconomic incentives for private sector development; and equitable and efficient use of public resources; (ii) ensuring good governance and security -this covers decentralisation, law and order, increased transparency, accountability for public expenditure, and public information; (iii) increasing the ability of the poor to raise their incomes. Under this pillar, the main areas of focus are feeder roads, agriculture- particularly extension services, small-scale enterprises, vocational education and energy for the poor. (iv) improving the quality of life of the poor. This is aimed at improved provision of basic social services such as primary health care, water and sanitation, primary education and adult literacy. It is from these four pillars that the line ministries derive their mandate to develop comprehensive development programs that are supposed to meet the overall national development objectives. A unique aspect of Uganda's approach to poverty reduction is the close working partnership among the key stakeholders: government, private sector, civil society, NGOs, researchers, academicians and development partners. This has brought about increased ownership of the programs designed to implement the PEAP.

Implementation of the PEAP and other sectoral plans at the grassroots level is through the decentralised system of government. Local governments (districts and sub-counties) are required to have development plans which are the basis for central level planning, but also for release of funds from the centre to local governments to implement the PEAP priorities and other sectoral interventions. Decentralisation offer an opportunity to accelerate rural development as it brings services closer to the people, but also presents challenges because not all districts have the capacity to cope with the ever increasing challenges of development. Attainment of MDGs ultimately depends on what happens beyond the centre and therefore issues regarding local governments' capacity have to be addressed.

Several sectoral plans have been developed including the Plan for Modernization of Agriculture (PMA, 2002) for rural development the Health Sector Strategic Plan (HSSP) (2001) for health, the Education Sector Investment Plan (ESIP), the Road Sector Development Plan (RSDP). Sectoral plans and strategies are supposed to operationalise the PEAP. Many of the sectoral plans have targets that are used to compare against the MDG targets. Following is a comparison of the MDG targets and PEAP/Sectoral targets and a review of Uganda's progress to realising the targets.

Achieving the PEAP/MDG Targets: Status, Progress and Challenges

Goal 1:Eradicate Extreme Poverty and Hunger

The PEAP target is to reduce mass poverty to 10 percent of the population by 2017 (MFPED, 2001 (a); MFPED, 2002) When the PEAP was designed in 1997, its target was based on a 20-year time horizon (1997-2017). In 1997, the poverty head-count was 44 percent, implying that to achieve the target, poverty would have to fall by an average of 1.7 percent per year. The MDG targets, on the other hand are based on a 25-year time horizon (1990-2015)[2]. The MDG poverty target is to halve poverty by 2015. By comparison, the PEAP target is more ambitious than the MDG target and given the current trend, Uganda will surpass the MDG target. Figure 2 shows Uganda's progress towards achieving the PEAP and MDG targets.

Uganda has made tremendous progress in the fight against poverty. According to the income poverty lines developed from the national household survey data, poverty declined from a national average of 56% of Ugandans being unable to meet their basic requirements in 1992 to a corresponding figure of 35% in 2000 (Appleton, 2001). Although at a much lower rate, the rural areas also registered a decline in the percentage of poor people, from 60% in 1992 to 39% in 2000. In urban areas, poverty declined by about the same percentage points as was the case at the national level – from 28 to 10 percent between 1992 and 2000. On the whole, poverty in Uganda is largely a rural phenomenon, with 96% of the poor found in the rural areas in 2000 – up from 93% in 1992 (EPRC, 2002). The decline in poverty is also reflected by the Human Development Index (HDI) for Uganda which increased from 0.272 in 1995 to 0.444 in 2000 (UNDP, 2000; HDR 2002).

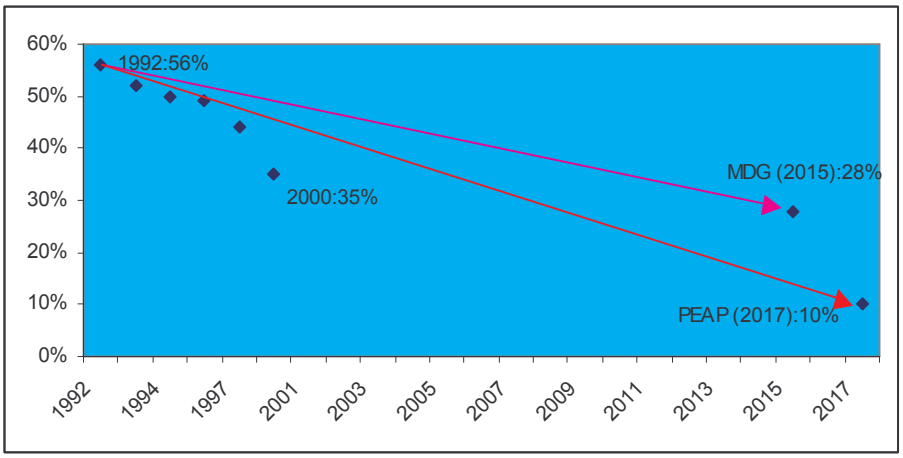
A regional analysis of the survey data shows that poverty is highly concentrated in the Northern region, where poverty headcount initially declined from 72% in 1992 to 59% in 1997 after which it rose to 66% in 2000. Although the northern region is home to only 21% of Uganda's population, its share of the country's poor is 35% (EPRC, 2002). Further evidence of the poverty situation in the north is provided by the Uganda Human Development Report 2000 (UNDP, 2000), which shows that among the ten districts in Uganda with the lowest human development index (HDI), seven were from the northern region. These districts are invariably associated with the civil war (mainly by the Lords Resistance Army (LRA)) that has been in the north for over

[2] The MDG target of achieving as significant improvement in the lives of slum dwellers has a longer time horizon, up to 2020.

15 years. Bundibugyo is another districts among the bottom ten districts, and it too was affected by the Allied Defence Forces (ADF) rebel activities.

The second Uganda Participatory Poverty Assessment Process (PPA 2) (MFPED, 2002) also indicated that in northern districts (Moroto, Arua and Kitgum) and in Bundibugyo, insecurity was ranked as the number one cause of poverty. Insecurity resulted in loss of access to farming land, inadequate access to and low quality health care and education, and low prices for agricultural produce. Ending insecurity in affected areas, especially in the north and Bundibugyo is critical so that agricultural and other private investment can flourish and household incomes rise.

Figure 2: Uganda's Progress in Poverty Reduction



In response to the rural poverty concerns and also to operationalise the PEAP objective of increasing the ability of the poor to raise their incomes, the government designed the Plan for Modernization of Agriculture (PMA). The PMA is a poverty-focused rural development framework focussing on agriculture, the main activity of the poor. The main objectives of the PMA are to (i) increase incomes and improve the quality of life of poor subsistence farmers through increased agricultural productivity and increased share of marketed production, (ii) improve household food security through the market rather than emphasising self-sufficiency, (iii) provide gainful employment through the secondary benefits of PMA implementation such as agro-processing factories and services, and (iv) promote sustainable use and management of natural resources by developing a land use and management policy and promotion of environmentally friendly technologies (MAAIF and MFPED, 2000). In order to achieve these objectives, seven intervention areas were identified and they include: research and technology development, agricultural advisory services, rural finance, agro-processing and marketing, agricultural education, supportive infrastructure, and sustainable natural resource use and management. An additional intervention is a non-sectoral conditional grant (NSCG) to local governments to implement poverty reduction programmes.

Implementation of the PMA is already underway. The National Agricultural Advisory Services (NAADS) is operational in sixteen districts. The program is designed to be demand driven to provide farmers with access to the expertise of agricultural professionals to help them with the decisions they face in their farming enterprises. Under NAADS, public funds are channelled to farmer fora at the sub-county level for

them to contract the services of farm advisors. Additional funds will be available at the district level to train farmers and extension workers, and give them access to the services of agricultural advisors and researchers. The Non-Sectoral Conditional Grant (NSCG), sometimes called the PMA grant, is aimed at empowering local communities in planning and decision-making. The grant provides funds to local governments for investment in areas that are poverty-reducing, identified by the community, and benefit the community as a whole, rather than individuals. Implementation of the NSCG started in June 2001 in 24 districts that met the minimum access criteria.

Addressing the inequalities in access to and ownership of productive resources is imperative to achieving this goal. In Uganda's Participatory Poverty Assessment Process 2 (2002) (PPA 2) women and men perceived that the gendered division of ownership and control as a cause of poverty amongst women. PPA 2 stresses the need to recognise the difference in control over resources in all developmental initiatives, e.g. PMA, otherwise these activities may lead to investing in activities that favour only men in communities thereby poverty eradication would not be achieved for all community members.

Land is a vital productive resource. Gender inequalities in access to and ownership of land were identified as a cause of poverty in PPA. Government needs to address the issue of co-ownership of land. Equal access to and control of land will contribute to addressing hunger at household level, since both men and women would be involved in decision making to favour both cash crop and food crop growing and optimum usage of incomes that accrue from agriculture at household level.

Even though the PMA interventions are geared towards the agricultural based livehoods there is evidence to show that non-farm income is also very important. Balihuta and Sen (2001), using household survey data found that between 1992 and 2000, non-farm income had grown while the share of agricultural income had declined, even though it was still large. Ellis and Bahiigwa (2001) carried out household surveys in three districts (Male, Kamuli and Mubende) and found better off households had as much as 40 percent of their income from non-farm activities. These results point to the need for policy to focus on non-farm activities in order to diversify income sources in rural areas.

The World Development Report 2000/2001 (World Bank, 2001) broadened the definition of poverty to encompass other dimensions such as lack of empowerment, opportunity, capacity and security, meeting the poverty goal requires a multi-dimensional approach as is reflected in the PEAP. Because many aspects of gender inequality influence the different dimensions of poverty, interventions that promote gender equality are critical in the design of strategies and actions to meet the poverty goal.

Goal 2: Achieve Universal Primary Education

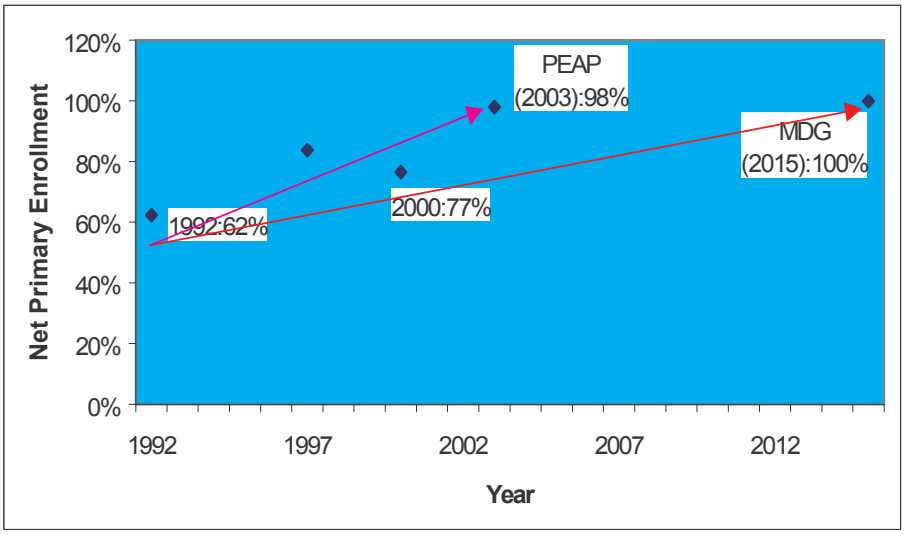
Uganda's target is to achieve 98% enrolment of 6-12 year old children into primary schools and 100 percent beyond 2003. This is consistent with the MDG target of 100 percent by 2015. Figure 3 shows Uganda's progress towards achieving universal

primary education. The figures are net enrolment rates (the proportion of 6-12 year olds children who are in primary schools to those who are eligible in that age group).

In 1997, the government of Uganda introduced the policy of Universal Primary Education (UPE), in line with the recommendations made in the 1992 White Paper on education. The minimum necessary facilities and resources required to achieve this goal were to be provided by the government. The introduction of UPE saw enrolment more than double, from 3.4 million in 1996 to 6.9 million in 2001 (MOES, 2002; World Bank, 2002a). Provisional estimates by the Ministry of Education and Sports (MOES) indicate UPE enrolment of 7.2 million for 2002 (MOES, 2002).

The challenge facing the education sector is ensuring the sustainability of the UPE programme, as well as embarking on the expansion of secondary school facilities early enough to meet future enrolment demands. Within the UPE programme, the recruitment of more teachers to meet the increased demand for education, classroom construction and the maintenance of academic standards are the key issues demanding constant attention. Certainly the UPE programme has increased access although there are concerns that the quality of education has gone down due to inadequate classrooms, lack of instructional materials and lack of trained teachers. While enrolment figures are very impressive, it would be helpful to examine attendance of pupils throughout the year. Attendance may be a much more robust indicator of access to primary education than enrolment because not every pupil that enrols attends classes. Another concern with regard to the UPE programme is the rate of increase in population, which threatens to stretch resources available for and gains from UPE.

Figure 3: Uganda's Progress Towards Universal Primary Education



The high enrolment rates resulting from UPE has necessitated construction of more classrooms, training and recruiting of more teachers and the provision of more instructional materials. However, the available resources can only allow 24,657 classrooms to be built by 2002/3. This leaves a deficit of 68,999 classrooms. With effect from 2001/02, local governments are also required to use 15% of their School Facilities Grant (SFG) to build teachers' houses in schools.

In December 2000, a massive teacher recruitment exercise was launched, aimed at increasing the number of teachers in order to fill existing vacancies. By end of 2001, there were 114,835 primary teachers on the government payroll, up from 88,033 during FY 1999/2000 (MOES, 2002).

Table 1 shows primary enrolment rates by gender for 2001. There are more males enrolled than females, and the difference in each class gets more pronounced the higher the class level. The ratio of females to males was 99 percent in P1, but was 79 percent for pupils in P7[3]. This probably means that girls are more likely to drop out of school than boys, a reflection of the various social and cultural disadvantages that girls face. If this is true, then government has to identify and deal with the factors that force girls to drop out of school, otherwise the benefits of the policy of equal access will not be fully realised. However, it is fair to note that in the formulation of the UPE policy, a specific provision was made to address the issue of gender imbalance. Where there were both boys and girls in a family, at least two of the four eligible children were required to be girls. This stipulation went a long way in addressing the gender inequality that existed in primary education. Indeed in 2001, there were 3,528,035 males and 3,372,881 females enrolled in primary schools, reflecting a female to male ratio of 96 percent (MOES, 2002). This shows that the gender disparity in access to early primary education has been greatly reduced due to the UPE program.

The first cohort of UPE will complete primary 7 in 2003 and they will need to go to secondary education. The government is yet to commit to providing universal primary education. Secondary school enrolment is about 10% of the eligible number and this is before the UPE graduates who will add pressure on the need for secondary education. Without the UPE graduates continuing to secondary schools and vocational institutions that impart practical skills, the UPE gains will be lost. As pointed out later in goal 3, there hardly any difference in the social indicators for mothers with primary education and those with no education at all, where indicators for mothers with secondary education are significantly better than for the former group.

Table 1: Primary School Enrolment for 2001 (UPE)

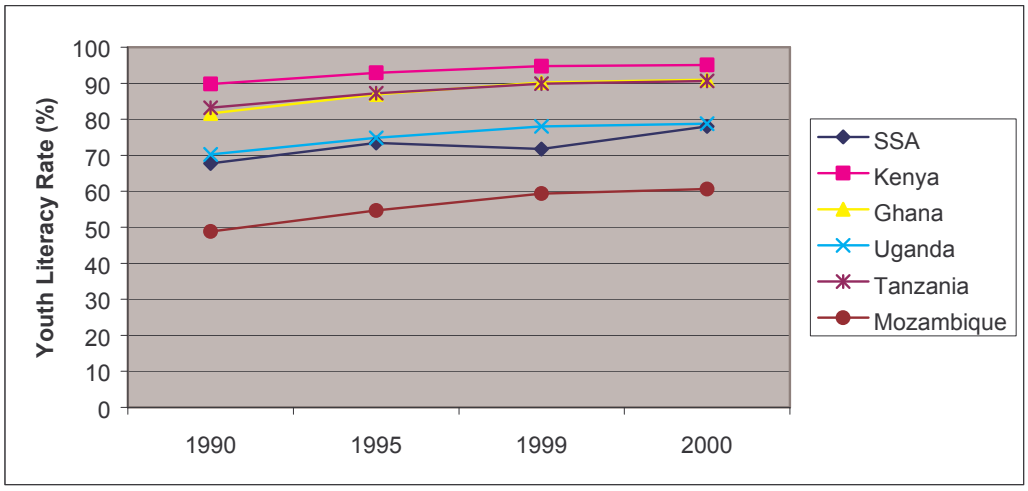
Class	Male	Female	Female/Male Ratio
P1	803,803	797,005	99
P2	551,453	537,072	97
P3	537,622	526,931	98
P4	488,468	478,142	98
P5	408,509	384,272	94
P6	316,162	282,382	89
P7	228,385	179,337	79
Total	**3,334,402**	**3,185,141**	96

Source: Ministry of Education and Sports (2002)

[3] Ideally, in order to appreciate the dropout rates, one should have the data for the same cohort over a 7-year period. Otherwise data from a single year could be misleading.

Another indicator under this goal is the youth literate rate (% ages 15-25). Uganda has made progress in this, with the proportion rising from 67.7 percent in 1990 to 78 percent in 2000 (World Bank, 2002b). Figure 4 shows the youth literacy rate for selected African countries. Even though Tanzania has consistently had a lower per capita income than Uganda since 1990, its youth literacy rates have been higher, perhaps pointing to the fact that successful economic growth is not enough to ensure success in education. Tanzania deliberately invested in education. Uganda's successful implementation of UPE should go a long way in raising the youth literacy rates. Interestingly, Kenya has the highest levels of youth literacy among the five countries, much above the SSA average, even though SSA per capita income is higher.

Figure 4: Youth Literacy Rates in Selected African Countries



Goal 3: Promote Gender Equality and Empower Women

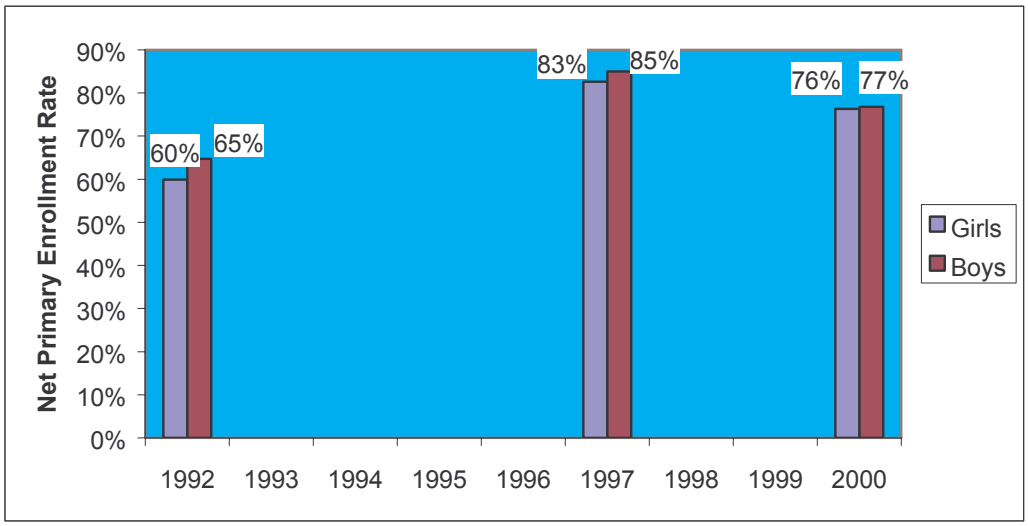
The MDG target is to eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels by 2015. Uganda does not have specific targets for this. As mentioned in the MDG on universal primary education, Uganda designed in the UPE program with equity in mind. UPE allowed for four kids per family, two of whom had to be girls. As a result, the enrolment of girls in primary education has grown tremendously. Analysis of the household survey data for 1992 and 2000 revealed that net primary enrolment for girls increased from 59.9 percent in 1992 to 76.3 percent in 2000. For boys, over the same period, the net enrolment increased from 64.7 percent to 76.8 percent (MFPED, 2001b). Figure 5 shows the trend in net primary enrolment for boys and girls. While there was a gap of about 5 percentage points between the girls' and boys' enrolment rates in 1992, that gap was narrowed to half a percent by 2000. This is a reflection of the success in reducing gender disparity in access to primary education.

Secondary enrolment rates are much lower. In 1992, the net enrolment rate was 10 percent (9% girls and 10% boys) and only increased to 12.4 percent in 2000 (12.9% girls and 12% boys) (MFPED, 2001b). However, it is worth noting that the enrolment rate for girls has surpassed that for boys. More effort is needed on the part of government to extend the success of UPE to secondary education. Without secondary

education, the long-term benefits of UPE will be lost. The Uganda Demographic and Health Survey (UDHS) 2000-2001 (UBOS and ORC Macro, 2001) demonstrates that mothers with secondary education or higher had much lower infant mortality and under-five mortality rates that those with primary education. The UDHS also revealed that there was no difference in the number of children born to a girl without education and one who had completed primary education. It also revealed that with a higher education level the number of children a woman had were fewer.

Another indicator under this goal is the ratio of young literate female to males (% ages 15-24). Again, Uganda has made progress in this, with the ratio rising from 79.8 percent in 1990 to 88.7 percent in 2000 (World Bank, 2002b).

Figure 5: Uganda's Progress Towards Gender Equality in Access to Primary Education



In order to empower women further, Uganda has since the early 1990 had an affirmative policy towards women admitted to Makerere University. To increase admission of women to university, 1.5 points are added to the performance of girls at HSC at the time of admission. However, while this is good it is important to understand the beneficiaries of this affirmative action. There is a wide disparity in academic standards and performance in school, especially between urban and rural areas. Urban areas perform better and are more expensive and can only be afforded by better off households. Therefore, the affirmative action effectively benefits those girls in urban schools from better-off households. Girls from rural schools and poor families may not benefit from this affirmative action. A difference approach would have to be used. The recent decision to introduce district-based quotas may to some extent help address this imbalance.

The affirmative action was also extended to politics. Since 1986 when the Movement Government took power, one third of the Local Government Council (LC1 to LC5) representatives had to be women, including a secretary for women. In parliament, there is a woman member of parliament for each of the 56 districts; in addition to women who compete for and get elected as representatives of constituencies. However, there are still some areas where women are still disadvantaged. One such area is land ownership that was not adequately addressed in the Land Act 1998.

Women are seeking legal co-ownership of family land through either the Domestic Relations Bill or an amendment of the Land Act. Other issues of concern include rampant defilement of young girls and other aspects of sexual harassment of women. More needs to be done to advance the causes for women.

The 1995 Constitution provides for equality between sexes and contains a number of provisions for the protection and promotion of the rights, interest and welfare of women, and the family. However, Government has yet to enact laws to correspond with the provisions in the Constitution of Uganda that provide for gender equality and thereby empower women. The Domestic Relations Bill (DRB) is one such law, which has been written for the last 38 years and has never been gazetted. Issues of gender equity and equality start and are embedded at household level and in household relations. It is therefore imperative the Government finalise the DRB and tables it to parliament so that it is enacted in law. The co-ownership of land clause is still an unresolved issue. The Constitution provides for the establishment of an Equal Opportunities Commission, which has yet to be established.

The Decentralisation programme provides an excellent opportunity to empower women. It is therefore imperative that the Local Government Development Programme that is being developed includes strategies to ensure the meaningful participation of women. The National Gender Policy is being revised. An assessment of the extent to which the policy has promoted gender empowerment could inform the revision process. Gender sensitive employment laws will promote gender equality and empowerment of women. There is a need to revise these laws to make them more gender sensitive.

Gender inequalities bar women from enjoying their human rights, therefore, reducing gender inequalities is important not only because it can lead to development, but also importantly by addressing these inequalities women are enabled to enjoy their human rights.

Goal 4: Reduce Child Mortality

Uganda has two targets under this MDG. The first is to reduce infant mortality rate (IMR) from 97 to 68 per 1000 live births (30% reduction) by 2005. The second is to reduce under-five child mortality from 147 to 103 per 1000 live births (30% reduction) by 2005 (MOH, 2000). Both targets are based on a five year time horizon (2001-2005), implying that an average of 6 percent decline per year. The MDG target is to reduce, by two third, the under-five mortality rate (U5MR) by 2015. This would mean for Uganda to reduce the U5MR from 147 to 49 per 100 live births and reduce IMR from 97 to 32 per 100 live births.

Uganda had made positive progress between 1989 and 1995. The IMR declined from 92 to 81 deaths per 1000 live births. However, the situation deteriorated between 1995 and 2000 with IMR rising from 81 to 88 deaths per 1000 live births. This trend is disturbing, especially when expenditure in health has risen, and especially when there has been a notable decline in poverty over the same period, from 49% in 1995 to 35% in 2000 (Appleton, 2001). A rigorous analysis of the causes of this is beyond the objective of this paper, but suffice to note that three key direct causes of infant

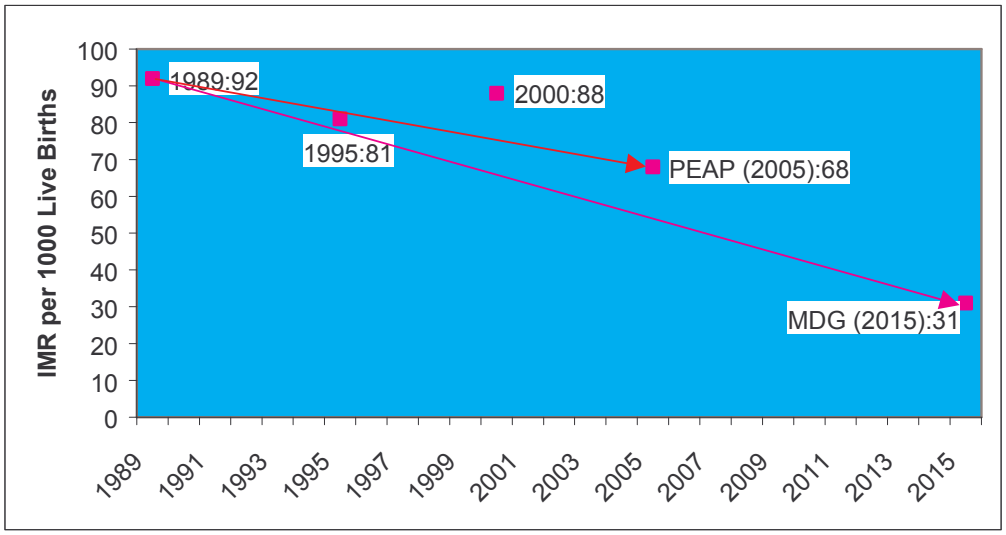
mortality (malaria, diarrhoeal prevalence (<6 months), diarrhoeal prevalence (6-11 months)) deteriorated over the same period. A study by MFPED (2002b) identified high fertility (6.9 children per woman) and a very short median birth interval (29 months) as key determinants of infant mortality and adds that these two are high risk factors for infant mortality in Uganda. It would seem that educating the population about the benefits of longer child spacing would reduce infant mortality.

This study also revealed that infant mortality was 50% higher for "disempowered" women vis á vis women who enjoyed some influence in making household decisions. Women who did not accept wife beating (another measure of female empowerment) had a 28% lower risk of experiencing infant mortality than women who did accept wife beating. The study concludes that the two different measures of empowerment (decision making and justification for wife beating) clearly demonstrated that gender imbalances were statistically associated with infant mortality. It is therefore crucial that government puts in place policies and enacts laws that will reduce gender imbalances and promote empowerment of women.

Figure 6 shows Uganda's progress toward reducing IMR. Originally Uganda has IMR of 78 per 1000 live births by 2002, but that will be missed. The next target as pointed our above is 68 by 2005. Achieving this goal will require direct efforts at reversing the trend of the main causes and determinants of infant mortality. If this does not happen, certainly the MDG target of IMR of 31 per 1000 live births, which is more ambitious than the Ugandan target, will most likely not be achieved.

Figure7 provides a comparison of IMR among selected African countries. By and large it is the opposite of the per capita GNI graph (except for the SSA average). The countries with the lowest GNI per capita have the highest IMR.

Figure 6: Uganda's Progress in Reducing Infant Mortality

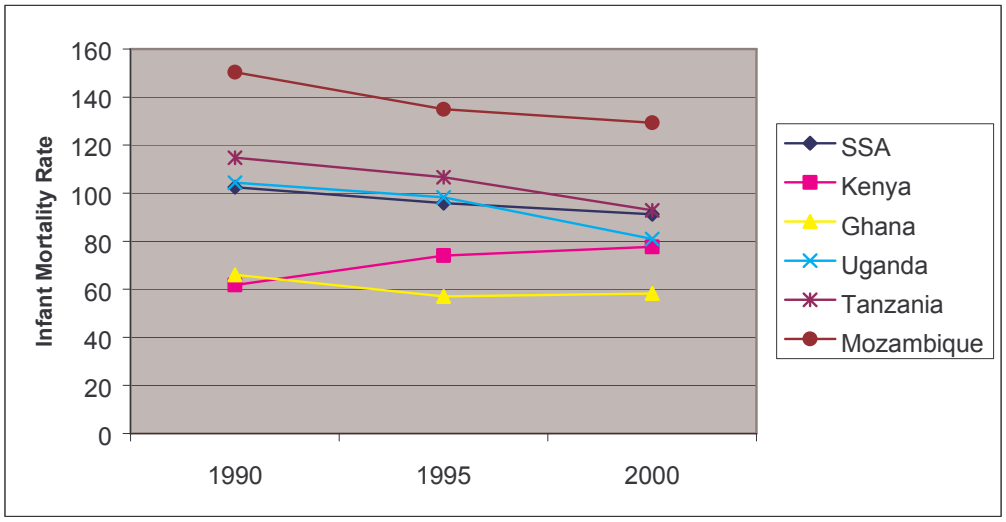


Goal 5: Improve Maternal Health

The MDG target is to reduce, by three quarters, the maternal mortality ratio (MMR) by 2015. Uganda's target is to reduce the MMR from 506 to 354 per 100,000 live

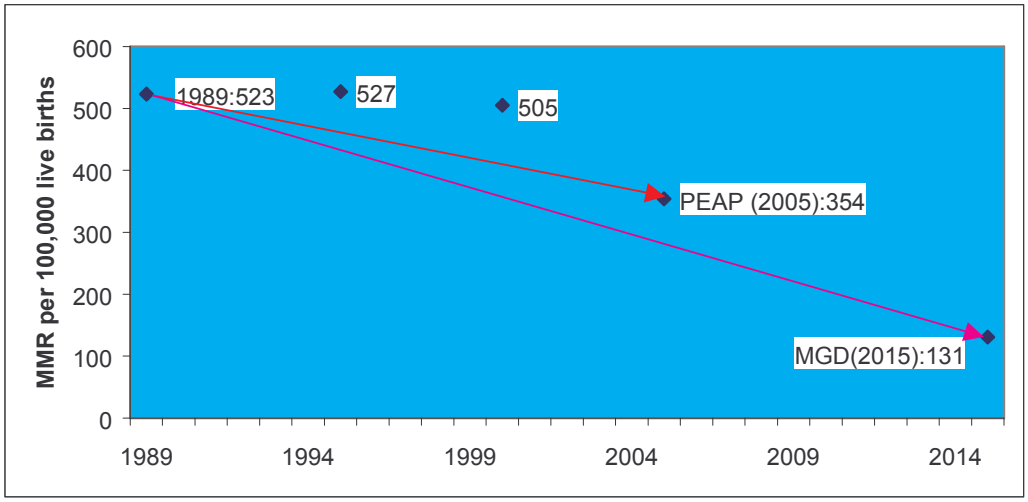
births (30% reduction) by 2005 (MOH, 2002). To meet the MDG target, Uganda would have to reduce the MMR from the 506 to 127 per 100,000 live births by 2015. Maternal mortality, unlike infant mortality showed improvement between 1995 and 2000, from 527 to 506 deaths per 100,000 live births, respectively (UBOS and ORC Macro, 2001). Uganda's progress in shown in Figure 8. The MDG target is more ambitious than Uganda's target and it might prove difficult to achieve unless there are improvements in the delivery of primary health care. Below is general discussion of efforts by the Ministry of Health to improve health service delivery, through its strategic five-year plan that has specific targets.

Figure 7: Infant Mortality Rates for Selected African Countries



The targets set out in the Health Sector Strategic Plan (HSSP) 2001/01-2004/05 (MOH, 2000) indicate that realisation of the MDGs would be well within reach if they are achieved over the stipulated five-year period, and the trends maintained thereafter. Realization of these targets is planned through the delivery of the minimum health care package (MHCP) to the population. The MHCP is a collection of cost effective technical health care programmes that are thought to be the most effective way of reducing vulnerability to the major causes of death and disease in Uganda. The programs in the package include: Control of communicable diseases (CCD): Malaria; STD/HIV/AIDS, Tuberculosis; Integrated Management of Childhood illness; Sexual and Reproductive Health and Rights; Immunisation; Environmental Health; Health Education and Promotion; School Health; Epidemic and Disaster Prevention, Preparedness and Response; Improving Nutrition; Interventions against diseases targeted for elimination or eradication; Strengthening mental health services; and, Essential Clinical Care.

Figure 8: Uganda's Progress in Reducing Maternal Mortality



Each of these health care programmes affects the realisation of the MDGs. However, STD/HIV/AIDS, childhood illness management, sexual and reproductive health, and immunization are specified in the MDGs. The Integrated Management of Childhood diseases addresses the problem of infant and under five mortality. Its components include the control of diarrhoeal diseases, immunisation and case management of malaria and child nutrition. These elements are responsible for 70% of childhood illnesses in Uganda. Specific targets for each element have been set over the five-year period, for example, the Ministry aims at halving diarrhoeal disease incidence from 30 to 15 per 1,000, and reducing the case fatality rate from diarrhoeal diseases of epidemic potential from 6% to 1% by 2005.

Various attempts at explaining these negative trends have been made[4]. It is thought that the poor performance of the sector is due to the delayed review of the poor reform policies that governed the health sector in the 1980s, as well as the circumstances and fragmented nature of the sector during this period. Although government has made social service delivery one of its key priorities, the policy change is quite recent, and therefore may not enable revamping the structure of this sector in the short-run.

The stagnation in the number of deliveries supervised by trained medical staff is thought to be a major cause of increased child and infant mortality, and little changing maternal mortality. Participatory research has attributed these trends to the attitudes of health workers, who allegedly discriminate against women because they do not have money to pay for services compared to men, in addition to embarrassment by the health workers. Health workers have also been known to solicit bribes for attending to patients. Gender inequality in the control of household's economic resources, and in the right to make decisions also contribute to poor maternal health. Cultural aspects have contributed to low levels of utilisation of institutional deliveries. All these factors discourage women from seeking professional help during times of delivery.

[4] See Uganda Health Bulletin, Vol.7, No.4, Oct – Dec 2001.'The paradox of Uganda's poor and worsening health indicators in the era of economic growth, poverty reduction and health sector reforms.'

Poor health indicators have also been attributed to the significant decline in immunisation coverage. Between 1994/95 and 1998/99 immunisation coverage rates for all the major diseases affecting infants dropped significantly. Measles fell from 82 to 49%, DPT from 74 to 46%, BCG from 96 to 69%, and tetanus for pregnant women from 74 to 38%[5]. The fall in immunisation rates has been blamed partly on the changing structure of the service delivery mechanism through the ongoing implementation of decentralisation policy. Shifts in donor priorities have also contributed to this negative trend. In 1997, UNICEF stopped paying for vaccinations. While resources could easily have been shifted from the Centre by government, it was more difficult for all the districts to individually shift resources. Indeed, many districts failed to do so. Thirdly, there has been a reduction in national support for the immunisation program, as a result of public misconceptions and ignorance about the merits of immunisation. Other contributing factors include limited community involvement and inadequate publicity.

However, the Ministry of Health is optimistic that the next round of statistics will present a more optimistic picture. According to its Health Policy Statement for 2001/02, the Expanded Programme on Immunisation is gaining momentum. Mass measles and Vitamin A supplementation campaigns were implemented in 18 districts, with an average coverage rate of 80%. In addition, the two rounds of polio immunisation carried out in August and September 2001 both achieved national coverage rates of over 100%. More efforts need to be expended in training health workers in attitudinal and behavioral change, and in implementing pay reform recommendations. A provision for health workers' lunch allowances has been included in the health sector budget as an incentive for improving the quality of service. If these measures are implemented on a sustained basis, the next demographic and health survey should reveal improvement in health indicators.

Meeting health goals requires an awareness of not only the biological aspects of disease transmission and treatment, but also of the social and cultural factors that promote or reduce good health. Issues such as the different health risks faced by men and women; the implications of these differences for health service delivery; the effect of differences in the availability of and access to health services; and the ability of women to independently decide on the use of health services are important when designing strategies aimed at meeting the health goals.

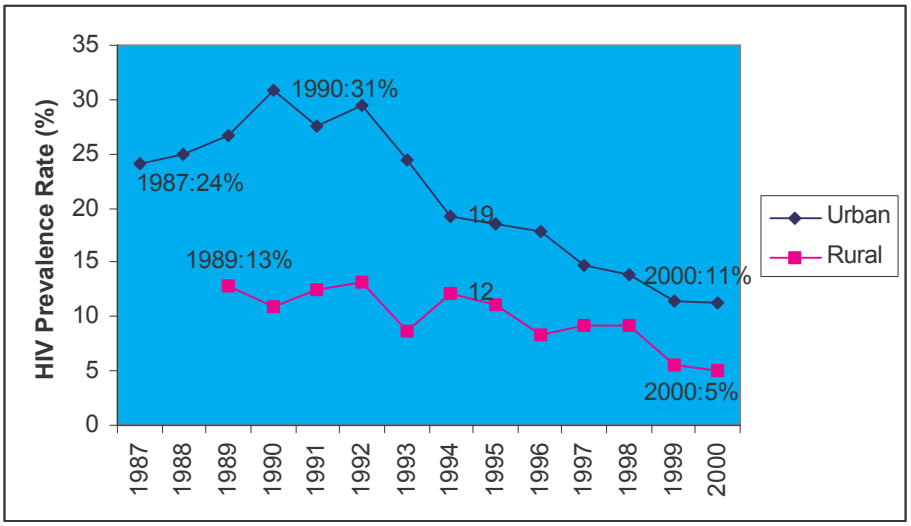
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Uganda's target is to reduce the 2000 HIV prevalence rate (about 6.1 percent among adults) by 25 percent by 2005 (MOH, 2000). The MDG target is not specific but rather to halt by 2015 and begin to reverse the spread of HIV/AIDS. Uganda is over the peak and has seen the prevalence rates fall from about 30 percent in 1990 to 11.25[6] percent in 2000 among pregnant women in urban areas (UNAIDS, 2002). The pregnant women reported here are those who attended antenatal care and were tested for HIV. Figure 9 shows the HIV prevalence rates among pregnant women for major urban areas (urban) and outside major urban areas (rural). For major urban areas, the peak was 1990 at 31 percent while for rural areas the peak was in 1993 at 13 percent.

[5] UNEPI 1999, 'Immunisation Coverage for children aged 12 – 24 months, 1994 – 1997', Entebbe.
[6] These rates are based on HIV sentinel surveillance at various site in Uganda, both in major urban areas and outside major urban areas.

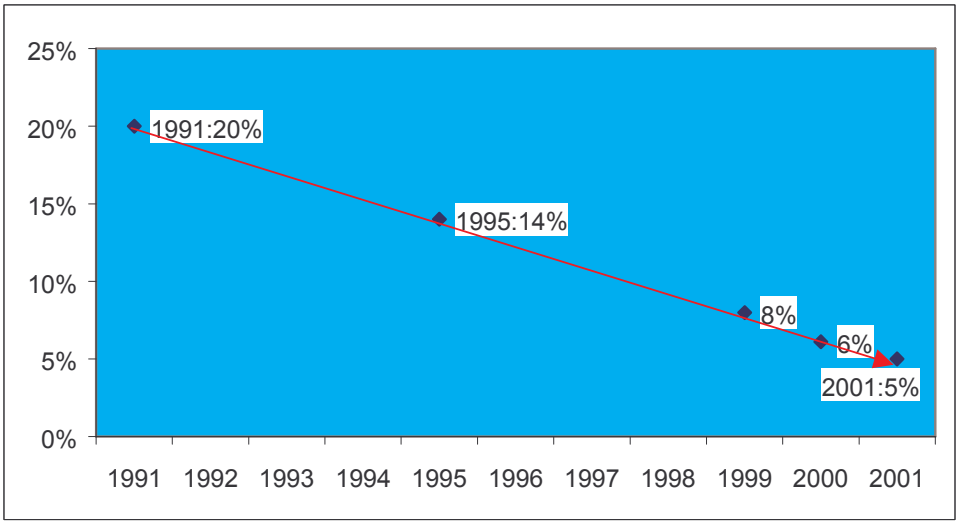
Overall, HIV infection rates in 2000 were twice as high among urban than rural pregnant women. This could be a reflection of either lower infection rates in rural areas, or that there are fewer women attending antenatal care in rural areas. However, the rural median values are based on more than 10 surveillance sites compared to two for major urban sites (Rubaga and Nsambya hospitals). With this trend of events, the MDG target is irrelevant for Uganda since the country started reversing the trend in the early 1990s.

Figure 9: HIV Prevalence Among Pregnant Women in Uganda.



For the entire population, UNAIDS estimates an HIV prevalence rate of 5% among adult (women and men aged 15to 49) at the end of 2001 (UNAIDS, 2002). Figure 10 shows the trend of HIV prevalence among adults in Uganda.

Figure 10: HIV Prevalence Rates Among Adults in Uganda



The first HIV/AIDS was first identified in Uganda in 1982. UNAIDS estimates that at the end of 2001, 510,000 Ugandans were infected with HIV whether or not they have

developed symptoms of AIDS. HIV/AIDS is responsible for up to 12% of deaths annually. It is the leading cause of death among individuals aged 15 to 49.

Effects of AIDS and Government Response

In 1986 the government created an AIDS Control Program (ACP) in the Ministry of Health as the first major step in mainstreaming HIV/AIDS policy making. In 1992, the Uganda Aids Commission was formed under the Office of the President, and charged with co-ordinating multi-sectoral efforts against the epidemic. The government has been open and committed to combating the spread of HIV/AIDS both internally and internationally. In addition, a number of NGOs have also played a key role in providing logistical support and counselling services to infected people and their families. These concerted efforts led to an enhanced level of awareness about the dangers and methods of prevention of the disease. As a result, national AIDS prevalence rates declined from as high as 20% in the general population to 6.1 percent in 2000.

An immediate social impact of the HIV/AIDS pandemic has been the large and increasing number of AIDS orphans. UNAIDS estimates that at the end of 2001, there were 880,000 orphans (under age 15) in Uganda who had lost either their mother, father or both parents to the disease (UNAIDS, 2002). The traditional African extended family social network has been severely over-stretched by AIDS-related burden. Recent data from the UDHS (2000-2001) reveal that one in every four families rears an orphan. Orphaned children usually bear the brunt of domestic work, and girls are especially vulnerable to HIV infection through early marriages, defilement and sexual abuse.

AIDS has also had an adverse effect on the economy, through its decimation of the labour force, which has affected production. The young and working adult population (15-49 years) has been most affected by the disease. Investment in human capital has been severely undermined by the loss of well-trained, highly skilled professionals. Also, the time and money that has gone into treating and caring for AIDS sufferers has had a negative impact on productivity, investment and saving.

HIV/AIDS is therefore considered to be a crosscutting aspect affecting development. Consequently, the government has developed the National Strategic Framework (NSF) for HIV/AIDS activities in Uganda. It runs from 2000/1 to 2005/6, and is a partnership involving the government, the Uganda AIDS Commission, the Joint United Nations Programme on AIDS (UNAIDS), and other stakeholders in HIV/AIDS, including non-governmental and community-based organizations. Among other objectives, the National Strategic Framework aims at providing overall guidance for activities geared towards preventing the spread of HIV/AIDS and mitigating its effects within the framework of the PEAP. It also aims at establishing indicators for measuring the progress and impact of anti HIV/AIDS interventions, as well as serving as the basis for the costing and mobilisation of resources to implement the national AIDS programme.

The first goal of the NSF corresponds to the MDG for HIV/AIDS. However, it is more specific, in that it aims at 25% reduction in the prevalence rate by 2006. The NSF has six main objectives: to promote behavioural change (abstinence, faithfulness

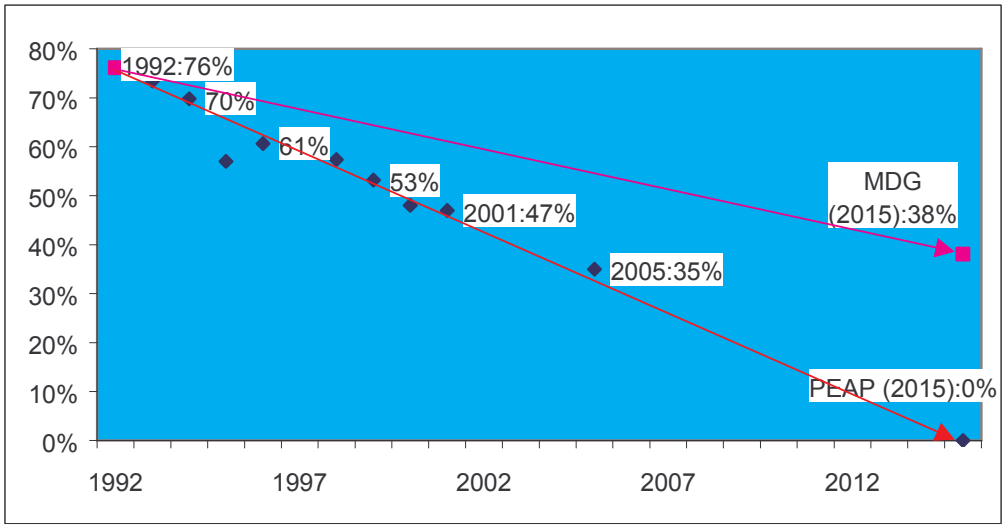
and safer sex) among the sexually active population, particularly young people aged 15 – 24; to reduce the current risk of blood borne HIV transmission by at least 50%; to reduce sexually transmitted infections by 25%; To reduce the vulnerability of individuals and communities to HIV/AIDS with a focus on children, women and youth by intensifying awareness; to reduce the current risk of mother to child HIV transmission by a third; and, to promote therapeutic and preventive HIV vaccine development and trials in different categories of the population. In 2000, the government identified the control of HIV/ AIDS as a priority area eligible for funding under PAF. It has also been proposed, and it is being debated, that each sector earmarks a certain amount of funds for AIDS activities.

Goal 7: Ensure Environmental Sustainability

There are three MDG targets: (i) integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources; (ii) halve, by 2015, the proportion of people without sustainable access to safe drinking water; and (iii) have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers. The third target includes improvement in sanitation. Uganda has a target for provision of safe drinking water to 100 percent of the urban population by 2010 and 100 percent of the rural population by 2015 (PEAP, 2000).

In 1992 76 percent of Uganda's population did not have access to safe water (24 had access). To meet the MDG target would mean reducing the proportion without access from 76 to 38 percent by 2015. The PEAP target is to reach have no person without access to safe water (100% access) by 2015. Figure 11 shows the declining trend of people without access to safe water.

Figure 11: Uganda's Progress to Reducing the Proportion of the Population Without Access to Safe Water



In the medium term Uganda's target is to reach 65 % of the urban population and 80% of the urban population by 2005 (MFPED, 2001). Other objectives included building the community's capacity to operate and maintain water facilities, and increasing community ownership through their participation and financial contribution towards

the construction of these facilities. According to the PEAP (2000), by 1999, an estimated 47% of the rural population had access to safe water. However, coverage varied across districts, with 10 districts having coverage of 30% or less. In 2000 and 2001, 52 % and 53% of the rural population had access to safe water, respectively. The corresponding figures were 60% and 62% for the urban population (MFPED, 2002 c).

Although one of the key sector goals had been to ensure that water was within easy reach of 75% of the rural population by the year 2000, this target has not been met. Officials in the water sector blame the slow progress on decentralisation. According to them, between 1991 and 1995, they doubled coverage from 18% to 36%. Between 1995 and 2000 an additional 14% coverage had been achieved. The slackness is attributed to lack of implementation capacity at the district level, and the receding water table, which has increased the cost of drilling.

Goal 8: Develop a Global Partnership for Development

The MDG targets under this goal are seven: (i) develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development, and poverty reduction - both nationally and internationally; (ii) address the special needs of the least developed countries. Includes: tariff and quota-free access for least-developed countries' exports; enhanced programme of debt relief for HIPCs and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction; (iii) address the special needs of landlocked countries; (iv) deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term; (v) in cooperation with developing countries, develop and implement strategies for decent and productive work for the youth (vi) in cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries; (vii) in cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

Uganda has no specific targets for this goal. However it is at the core of development. The first seven goals are about monitoring the improvements in the quality of lives of the people. This last MDG is very critical if the first seven are to be achieved. It covers aspects regarding sources of financing development in Uganda, namely: the need to have fair and transparent trading systems that will help Uganda access markets of developed countries; debt relief to allow more resources to remain in the country to fund development activities; increased overseas development assistance by the developed countries. It emphasises the need for good governance and transparency that are critical for development. In addition, it covers employment for the youth, access to essential drugs necessary for a healthy and productive population, and information and communication technology that are essential to build a competitive economy.

Conclusion and Way Forward

Uganda has a clearly defined poverty agenda in its Poverty Eradication Action Plan (PEAP). Some of the development targets are in the PEAP, others are in sectoral development plans and strategies. However, the sectoral programs are designed based on the PEAP principles, and when the PEAP is revised in 2003, it should reflect all the development targets set for all the sectors. Even though the PEAP was designed before the Millennium Development Goal (MDGs) were popularised after the UN Millennium Summit in September 2000, there are close similarities between Uganda's PEAP targets and the MDG targets.

Uganda has made tremendous progress in fighting poverty. Income poverty declined from 56% in 1992 to 35% in 2000. Uganda's target of reducing mass poverty to 10% by 2017 is more ambitious than the MDG target of halving poverty by 2015. However, while progress has been made, not all part of the country had benefited from the economic growth of the 1990s that averaged 6.5% per annum. Between 1997 and 2000, poverty in rural northern Uganda increased from 61% to 66%. In addition, income inequality increased. This calls for more efforts in increasing the incomes of the poor, especially in rural areas. The implementation of the PMA should go a long way in increasing the productivity of the poor subsistence farmers. The NAADS programs should be quickly extended to all districts and also the NSCG should be extended to all 56 districts. Non-farm income sources are important for diversification and therefore, policies that encourage these activities in rural areas should be pursued.

The UPE program that started in1997 has been very successful in increasing gross enrolment into primary schools, reaching 96% in 2001. The government's medium term target is to reach 98% in 2003. This is well within reach if the current trend continues. The long-term target is to attain 100 percent enrolment by 2015, just like the MDGs. Success in UPE has been attributed to the strong political commitment by the government; the buy-in by key ministries such as Education, Finance, Local Government and Public Service; strong partnership with and support from the international community; increased transparency and accountability; and the participation of the private sector and non-governmental organisations. While access has improved, there are concerns about the quality of education. There are insufficient instruction materials, especially books, insufficient classrooms, and the pupil/teacher ratio of 58:1 is still high, but improving.

Uganda has taken deliberate action to reduce the gender disparity in access to education. As a result, there is hardly any difference between the enrolment rates for boys and girls. In 2000, the net enrolment for girls in primary schools was 76% while for boys it was 77%. In secondary schools, enrolment rates for both boys and girls are low. However, in 2000, the enrolment rate for girls was higher than that for boys. The first cohort of UPE will complete primary in 2003. There is need for government to increase its investment in secondary education, otherwise the benefits of UPE will not be fully realised. Evidence shows that mothers with secondary education or higher have much healthier children as reflected by the significantly lower infant mortality and under-five mortality rates than those of mothers with primary education.

Between 1995 and 2000, many key health indicators deteriorated. Both infant mortality and under-five mortality rates increased. Maternal mortality improved only slightly. This negative trend is attributed to several factor such is increase in morbidity due to malarial, diarrhoeal diseases among children, falling rates in immunisations. The main problem of the health sector is under-funding. Per capita expenditure is about US $8 (both government and donor support), yet in order to implement the MHCP in the Ministry of Health's HSSP, US $28 per capita is needed. Therefore, unless funding of the health sector in increased, improving the health indicators and reaching the MDG targets might be difficult.

In the health sector, the most notable success has been in HIV/AIDS. The prevalence of HIV in the population fell from about 20% in 1991 to about 5% in 2001. The MDG target for HIV/AIDS is irrelevant for Uganda because the peak was reached in the early 1990s. However, this does not call for complacence as the rate of 5% is still very high. Efforts to fight the disease must be increased and sustained. The strong partnership among government, donors and NGOs must be maintained. The strong political commitment, openness about the disease, public awareness campaigns and promotion of safe sex education have been key in reducing HIV prevalence in the population and need more support.

Access to safe water for the entire population by 2015 is one of the targets in the PEAP. In 2001, 53% of the population had access to safe water, having increased from 24% in 1992. In more investment is made in the water sector, the MDG target of 100% by 2015 is within reach.

Gender equality is not only a goal in its own right, but an essential ingredient for achieving all the other MDGs. Efforts to meet the MDGs without addressing the gender issues pertaining to these goals will increase the costs and minimise the likelihood of attaining the goals. Working for gender equality and women's empowerment will be crucial if the difficult challenge of attaining the MDGs is to be overcome.

As a way forward, in order to achieve the MDG goals, especially in areas that show poor indicators (e.g. child mortality and maternal mortality) the implementation of the PEAP and the sectoral strategies and plans need to be strengthened. The MDGs need to be mainstreamed in the PEAP during its revision in 2003 and all sectoral plans, as well as district and sub-county development plans. The government should develop targets and include them in the PEAP and sectoral plans so that monitoring is much easier and comparison with MDG targets possible. In addition, the current monitoring system development outcomes is fragmented in different government institutions, yet there should be a central place that brings together data for monitoring and evaluation of progress made. One possibility is to expand the poverty monitoring strategy in the Ministry of Finance, Planning and Economic Development, and ensure that it has indicators that will enable monitoring Uganda's progress towards achieving its PEAP and MDG targets.

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Appendix 1: Millennium Development Goals, Targets and Indicators[7]

Goals and targets		Indicators
Goal 1	**Eradicate extreme poverty and hunger**	
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	• Proportion of population below $1 a day • Poverty gap ratio (incidence x depth of poverty) • Share of poorest quintile in national consumption
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	• Prevalence of underweight in children (under five years of age) • Proportion of population below minimum level of dietary energy consumption
Goal 2	**Achieve universal primary education**	
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Net enrolment ratio in primary education • Proportion of pupils starting grade 1 who reach grade 5 • Literacy rate of 15 to 24-year-olds
Goal 3	**Promote gender equality and empower women**	
Target 4	Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015	• Ratio of girls to boys in primary, secondary, and tertiary education • Ratio of literate females to males among 15- to 24-year-olds • Share of women in wage employment in the non-agricultural sector • Proportion of seats held by women in national parliament
Goal 4	**Reduce child mortality**	
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of one-year-old children immunized against measles
Goal 5	**Improve maternal health**	
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6	**Combat HIV/AIDS, malaria, and other diseases**	
Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	• HIV prevalence among 15- to 24-year-old pregnant women • Contraceptive prevalence rate • Number of children orphaned by HIV/AIDS

[7] The indicators are generic. Some apply to Uganda's situation and others do not.

Target 8	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• Prevalence and death rates associated with malaria • Proportion of population in malaria-risk areas using effective malaria • Prevention and treatment measures • Prevalence and death rates associated with tuberculosis • Proportion of TB cases detected and cured under DOTS
Goal 7	**Ensure environmental sustainability**	
Target 9	Integrate the principles of sustainable development into country policies and program and reverse the loss of environmental resources	• Change in land area covered by forest • Land area protected to maintain biological diversity • GDP per unit of energy use • Carbon dioxide emissions (per capita)
Target 10	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	• Proportion of population with sustainable access to an improved water source
Target 11	Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	• Proportion of population with access to improved sanitation • Proportion of population with access to secure tenure [Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]
Goal 8	**Develop a global partnership for development**	
Target 12	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)	
	Official development assistance	
Target 13	Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)	• Net ODA as a percentage of DAC donors' gross national income • Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water, and sanitation) • Proportion of ODA that is untied • Proportion of ODA for environment in small island developing states • Proportion of ODA for the transport sector in landlocked countries

	Market access	
Target 14	Address the special needs of landlocked countries and small island developing states (through the Barbados Programme and 22nd General Assembly provisions)	• Proportion of exports (by value, excluding arms) admitted free of duties and quotas • Average tariffs and quotas on agricultural products and textiles and clothing • Domestic and export agricultural subsidies in OECD countries • Proportion of ODA provided to help build trade capacity
	Debt sustainability	
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	• Proportion of official bilateral HIPC debt cancelled • Debt service as a percentage of exports of goods and services • Proportion of ODA provided as debt relief • Number of countries reaching HIPC decision and completion points
	Other	
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	• Unemployment rate of 15- to 24-year-olds
Target 17	In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	• Proportion of population with access to affordable, essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	• • Telephone lines per 1,000 people • Personal computers per 1,000 people

Source: MDG Website (http://www.millenniumgoals.org/), October 2002.

Appendix 2: Regional and Country Data Tables

Sub-Saharan Africa Regional Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)	47.7		48.1	
Poverty gap at $ 1 a day (%)				
Percentage share of income or consumption held by poorest 20%				
Prevalence of child malnutrition % of children under 5				
Population below minimum level of dietary energy consumption (%)	32.0		33.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)			54.4	
Percentage of cohort reaching grade 5 (%)				
Youth literacy rate (% ages 15-24)	67.7	73.4	77.1	78.0
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)	78.6	78.2	79.9	
Ration of young literate females to males (%) ages 15-24)	79.8	84.8	87.9	88.7
Share of women employed in the non-agricultural sector (%)				
Proportion of seats held by women in national parliament (%)				
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	185.5	159.2		161.6
Infant mortality rate (per 1,000 live births)	102.5	95.8		91.2
Immunization, measles (% of children under 12 months)	64.2	55.1	52.9	
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)				
Births attended by skilled health staff (% of total)				
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			9.2	
Contraceptive prevalence rate (% of women ages 15-49)				
Number of children orphaned by HIV/AIDS				
Incidence of tuberculosis (per 100,000 people)			339.3	
Tuberculosis cases detected under DOTS (%)				
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	29.5			27.3
Nationally protected areas (% of total land area)		6.2	6.2	
GDP per unit of energy use (PPP $ per kg oil equivalent)	2.2 million	2.4 million	2.6 million	
CO2 emissions (metric tons per capita)	0.9	0.9	0.8	
Access to improved water source (% of population)	48.7			55.4
Access to improved sanitation (% of population)	55.2			54.8
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	9.9	12.1	24.3	31.6
Personal computers (per 1,000 people)		7.5	8.2	9.2
General indicator				
Population	508.6 million	579.2 million	643.3 million	658.9 million
Gross national income ($)	280.3 billion	303.4 billion	319.7 billion	318.6 billion
GNI per capita ($)	550.0	520.0	500.0	480.0
Adult literacy rate (%of people ages 15 and over	49.8	55.7	60.3	61.5
Total fertility rate (births per woman)	6.1	5.6		5.2
Life expectancy at birth (years)	50.0	49.2		46.5
Aid (% of GNI)	6.4	6.2	4.3	4.3
External debt (% of GNI)				
Investment (% of DGP)	14.7	18.2	17.2	16.6
Trade (% of GDP)	52.7	58.7	58.9	59.8

Source: World Development Indicators Database, April 2002.

Ghana Country Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)			44.8	
Poverty gap at $ 1 a day (%)			17.3	
Percentage share of income or consumption held by poorest 20%			5.6	
Prevalence of child malnutrition % of children under 5	30.3	27.3	24.9	
Population below minimum level of dietary energy consumption (%)	32.0		15.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)			50.5	
Percentage of cohort reaching grade 5 (%)	85.0			
Youth literacy rate (% ages 15-24)	81.6	86.9	90.2	91.0
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)				
Ration of young literate females to males (%) ages 15-24)	85.0	90.4	93.6	94.3
Share of women employed in the non-agricultural sector (%)	59.4			
Proportion of seats held by women in national parliament (%)				18.0
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	119.0	108.0		112.1
Infant mortality rate (per 1,000 live births)	66.0	57.0		58.2
Immunization, measles (% of children under 12 months)	61.0	70.0	73.0	
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)		590.0		
Births attended by skilled health staff (% of total)	55.0	44.0	44.0	
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			3.4	
Contraceptive prevalence rate (% of women ages 15-49)	12.9	20.3	22.0	
Number of children orphaned by HIV/AIDS			170.0 thousand	
Incidence of tuberculosis (per 100,000 people)			281.0	
Tuberculosis cases detected under DOTS (%)			23.0	
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	33.1			27.8
Nationally protected areas (% of total land area)		4.8	4.9	
GDP per unit of energy use (PPP $ per kg oil equivalent)	3.9	4.4	5.0	
CO2 emissions (metric tons per capita)	0.2	0.2	0.2	
Access to improved water source (% of population)	56.0			64.0
Access to improved sanitation (% of population)	60.0			63.0
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	2.9	4.0	11.6	18.1
Personal computers (per 1,000 people)	0.0	1.2	2.5	3.0
General indicator				
Population	15.5 million	17.3 million	18.9 million	19.3 million
Gross national income ($)	5.8 billion	6.3 billion	7.4 billion	6.5 billion
GNI per capita ($)	390.0	360.0	390.0	330.0
Adult literacy rate (%of people ages 15 and over	58.4	65.1	70.2	71.5
Total fertility rate (births per woman)	5.5	4.6		4.2
Life expectancy at birth (years)	57.2	59.2		56.2
Aid (% of GNI)	9.7	10.3	8.1	12.6
External debt (% of GNI)	67.2	93.9	92.9	137.8
Investment (% of DGP)	14.4	20.0	21.0	23.7
Trade (% of GDP)	42.7	57.4	81.1	118.8

Source: World Development Indicators Database, April 2002.

Kenya Country Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)		26.5		
Poverty gap at $ 1 a day (%)		9.0		
Percentage share of income or consumption held by poorest 20%		5.6		
Prevalence of child malnutrition % of children under 5		22.5	22.1	
Population below minimum level of dietary energy consumption (%)	47.0		46.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)				
Percentage of cohort reaching grade 5 (%)				
Youth literacy rate (% ages 15-24)	89.8	92.9	94.7	95.1
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)			96.3	
Ration of young literate females to males (%) ages 15-24)	93.4	96.3	97.8	98.1
Share of women employed in the non-agricultural sector (%)	21.6		30.4	
Proportion of seats held by women in national parliament (%)	1.1	8.0		
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	97.0	112.0		119.8
Infant mortality rate (per 1,000 live births)	61.8	74.0		77.7
Immunization, measles (% of children under 12 months)	78.0	83.0	79.0	
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)		1,300.0		
Births attended by skilled health staff (% of total)	50.0	45.0	79.0	
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			13.0	
Contraceptive prevalence rate (% of women ages 15-49)	26.9	33.0	39.0	
Number of children orphaned by HIV/AIDS			730.0 thousand	
Incidence of tuberculosis (per 100,000 people)			417.0	
Tuberculosis cases detected under DOTS (%)			53.0	
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	31.7			30.0
Nationally protected areas (% of total land area)			6.2	
GDP per unit of energy use (PPP $ per kg oil equivalent)	1.8		2.1	
CO2 emissions (metric tons per capita)	0.2		0.3	
Access to improved water source (% of population)	40.0			49.0
Access to improved sanitation (% of population)	84.0			86.0
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	7.6	8.5	11.1	14.6
Personal computers (per 1,000 people)	0.3	0.6	4.2	4.9
General indicator				
Population	23.4 million	26.7 million	29.4 million	30.1 million
Gross national income ($)	8.8 billion	7.0 billion	10.6 billion	10.6 billion
GNI per capita ($)	380.0	260.0	360.0	350.0
Adult literacy rate (%of people ages 15 and over	70.8	77.0	81.4	82.4
Total fertility rate (births per woman)	5.6	4.9		4.4
Life expectancy at birth (years)	57.1	52.6	47.7	47.0
Aid (% of GNI)	14.7	8.4	3.0	5.0
External debt (% of GNI)	87.3	85.3	62.6	61.6
Investment (% of DGP)	19.7	17.5	14.0	12.7
Trade (% of GDP)	57.0	71.4	56.8	62.1

Source: World Development Indicators Database, April 2002.

Mozambique Country Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)		37.9		
Poverty gap at $ 1 a day (%)		12.0		
Percentage share of income or consumption held by poorest 20%		6.5		
Prevalence of child malnutrition % of children under 5		27.0		
Population below minimum level of dietary energy consumption (%)	69.0		54.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)	46.8	39.8	50.1	
Percentage of cohort reaching grade 5 (%)	32.9	46.3	46.2	
Youth literacy rate (% ages 15-24)	48.8	54.7	59.4	60.6
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)	73.4	71.0	72.0	
Ration of young literate females to males (%) ages 15-24)	47.8	54.6	60.2	61.5
Share of women employed in the non-agricultural sector (%)	11.3			
Proportion of seats held by women in national parliament (%)			75.0	
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	238.0	201.0		199.7
Infant mortality rate (per 1,000 live births)	150.4	135.0		129.3
Immunization, measles (% of children under 12 months)	59.0	61.0	57.0	
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)		980		
Births attended by skilled health staff (% of total)		44.0		
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			14.7	
Contraceptive prevalence rate (% of women ages 15-49)		5.6		
Number of children orphaned by HIV/AIDS			310.0 thousand	
Incidence of tuberculosis (per 100,000 people)			407.0	
Tuberculosis cases detected under DOTS (%)				
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	39.8			
Nationally protected areas (% of total land area)		6.1	6.1	39.0
GDP per unit of energy use (PPP $ per kg oil equivalent)	1.0	1.5	2.1	
CO2 emissions (metric tons per capita)	0.1	0.1	0.1	
Access to improved water source (% of population)				60.0
Access to improved sanitation (% of population)				43.0
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	3.3	3.4	4.6	6.9
Personal computers (per 1,000 people)		0.8	2.6	3.0
General indicator				
Population	142.2million	15.8 million	17.3 million	17.7 million
Gross national income ($)	2.3 billion	2.2 billion	3.8 billion	4.1 billion
GNI per capita ($)	170.0	140.0	220.0	230.0
Adult literacy rate (%of people ages 15 and over	33.5	38.5	42.9	44.0
Total fertility rate (births per woman)	6.3	5.6		5.1
Life expectancy at birth (years)	43.4	44.6	43.1	42.4
Aid (% of GNI)	43.2	49.9	21.3	24.5
External debt (% of GNI)	200.4	349.7	184.9	199.2
Investment (% of DGP)	15.6	22.8	31.9	33.7
Trade (% of GDP)	44.2	55.1	48.2	54.5

Source: World Development Indicators Database, April 2002.

Tanzania Country Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)		19.9		
Poverty gap at $ 1 a day (%)		4.8		
Percentage share of income or consumption held by poorest 20%		6.8		
Prevalence of child malnutrition % of children under 5	28.9	30.6	29.4	
Population below minimum level of dietary energy consumption (%)	34.0		46.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)	51.4	47.7	46.7	
Percentage of cohort reaching grade 5 (%)	78.9	81.3	80.9	
Youth literacy rate (% ages 15-24)	83.2	87.2	89.9	90.6
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)	96.8	96.8		
Ration of young literate females to males (%) ages 15-24)	86.5	90.7	93.6	94.3
Share of women employed in the non-agricultural sector (%)	30.3			
Proportion of seats held by women in national parliament (%)	11.0			61.0
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	178.0	147.0		148.6
Infant mortality rate (per 1,000 live births)	114.8	106.6		92.8
Immunization, measles (% of children under 12 months)				
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)		1,100.0		
Births attended by skilled health staff (% of total)	44.0	38.0	35.0	
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			8.1	
Contraceptive prevalence rate (% of women ages 15-49)	9.5	18.0	25.4	
Number of children orphaned by HIV/AIDS			1.1 million	
Incidence of tuberculosis (per 100,000 people)			340.0	
Tuberculosis cases detected under DOTS (%)			51.0	
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	45.0			43.9
Nationally protected areas (% of total land area)		15.6	15.6	
GDP per unit of energy use (PPP $ per kg oil equivalent)	0.9	1.0	1.1	
CO2 emissions (metric tons per capita)	0.1	0.1	0.1	
Access to improved water source (% of population)	50.0			54.0
Access to improved sanitation (% of population)	88.0			90.0
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	2.8	3.1	6.1	10.0
Personal computers (per 1,000 people)		1.6	2.4	2.8
General indicator				
Population	25.5 million	29.6 million	32.9 million	33.7 million
Gross national income ($)	4.8 billion	4.9 billion	8.3 billion	9.0 billion
GNI per capita ($)	190.0	160.0	250.0	270.0
Adult literacy rate (%of people ages 15 and over	63.0	69.2	73.9	75.1
Total fertility rate (births per woman)	6.3	5.7	5.6	5.3
Life expectancy at birth (years)	50.1	48.5	45.0	44.4
Aid (% of GNI)	28.8	17.1	11.8	11.6
External debt (% of GNI)	158.5	144.5	95.9	82.9
Investment (% of DGP)	26.1	19.8	15.9	17.7
Trade (% of GDP)	50.1	59.3	40.6	37.9

Source: World Development Indicators Database, April 2002.

Uganda Country Profile

	1990	1995	1999	2000
1. Eradicate extreme poverty and hunger	**2015 target = Halve 1990 $ 1 A day poverty And malnutrition rates**			
Population below $ 1 a day (%)				
Poverty gap at $ 1 a day (%)				
Percentage share of income or consumption held by poorest 20%		7.1		
Prevalence of child malnutrition % of children under 5	23.0	25.5		
Population below minimum level of dietary energy consumption (%)	24.0		28.0	
2. Achieve universal primary education	**2015 target = Net enrolment to 100**			
Net primary enrolment ration (% of relevant age group)		87.3	108.9	
Percentage of cohort reaching grade 5 (%)			44.7	
Youth literacy rate (% ages 15-24)	70.2	74.8	78.0	78.8
3. Promotion gender equality	**2005 target =Education Ratio to100**			
Ratio of girls to boys in primary and secondary education (%)			88.2	
Ration of young literate females to males (%) ages 15-24)	75.7	80.3	88.3	84.3
Share of women employed in the non-agricultural sector (%)	29.0			
Proportion of seats held by women in national parliament (%)	12.2			
4. Reduce child mortality	**2015 target =Reduce 1990Under 5 mortality By two-thirds**			
Under 5 mortality rates (per 1,000)	165.0	162.1		161.0
Infant mortality rate (per 1,000 live births)	104.4	98.2		83.0
Immunization, measles (% of children under 12 months)	52.0	57.0	53.1	
5. Improve maternal health	**2015 target = reduce 1990 maternal mortality by three-fourths**			
Maternal mortality ratio (modelled estimate, per 100,000 live births)		1,100.0		
Births attended by skilled health staff (% of total)	38.0	38.0		
6. Combat HIV/AIDS, malaria and other diseases	**2015 target = halt, and begin to reverse, AIDS, etc.**			
Prevalence of HIV, female (%) ages 15-24)			7.8	
Contraceptive prevalence rate (% of women ages 15-49)	5.0	14.8		
Number of children orphaned by HIV/AIDS			1.7 million	
Incidence of tuberculosis (per 100,000 people)			343.0	
Tuberculosis cases detected under DOTS (%)			59.0	
7. Ensure environmental sustainability	**2015 target = various (see notes)**			
Forest area (% of total land area)	25.9			21.3
Nationally protected areas (% of total land area)		9.6	9.6	
GDP per unit of energy use (PPP $ per kg oil equivalent)				
CO2 emissions (metric tons per capita)	0.0	0.0	0.1	
Access to improved water source (% of population)	44.0			50.0
Access to improved sanitation (% of population)	84.0			75.0
Access to secure tenure (% of population)				
8. Develop a Global Partnership for Development	**2015 target = various (see notes)**			
Youth unemployment rate (% of total labor force ages 15-24)				
Fixed line and mobile telephones (per 1,000 people)	1.6	2.1	5.2	11.2
Personal computers (per 1,000 people)		0.5	2.5	2.7
General indicator				
Population				
Gross national income ($)	5.6 billion	4.7 billion	6.8 billion	6.7 billion
GNI per capita ($)	340.0	250.0	310.0	300.0
Adult literacy rate (%of people ages 15 and over	56.1	61.8	66.0	67.1
Total fertility rate (births per woman)	7.0	6.7		6.2
Life expectancy at birth (years)	46.8	43.8	42.1	42.1
Aid (% of GNI)	15.8	14.7	9.2	13.3
External debt (% of GNI)	61.1	62.7	54.0	55.4
Investment (% of DGP)	12.7	16.4	14.4	18.2
Trade (% of GDP)	26.6	32.6	34.4	35.9

Source: World Development Indicators Database, April 2002.

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