Report Card
The Millennium Development Goals, 2013

4 out of 21 targets are already met.

Countries on track to meet MDG 4: 2015
17

Countries projected to meet MDG 4: 2015–2020
20

Progress on MDG 4

MDG 3
Promote gender equality and empower women

72 out of 144 countries have met MDG 3

Global Progress on MDGs

72 out of 144 countries have met MDG 3
Goals and Targets from the Millennium Declaration

1. Eradicate extreme poverty and hunger
   - **TARGET 1.A** Halve, between 1990 and 2015, the proportion of people whose income is less than $1.25 a day
   - **TARGET 1.B** Achieve full and productive employment and decent work for all, including women and young people
   - **TARGET 1.C** Halve, between 1990 and 2015, the proportion of people who suffer from hunger

2. Achieve universal primary education
   - **TARGET 2.A** Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

3. Promote gender equality and empower women
   - **TARGET 3.A** Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015

4. Reduce child mortality
   - **TARGET 4.A** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
TARGET 8.A Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (including a commitment to good governance, development, and poverty reduction, nationally and internationally)

TARGET 8.B Address the special needs of the least-developed countries (including tariff- and quota-free access for exports of the least-developed countries; enhanced debt relief for heavily indebted poor countries and cancellation of official bilateral debt; and more generous official development assistance for countries committed to reducing poverty)

TARGET 8.C Address the special needs of landlocked countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the 22nd special session of the General Assembly)

TARGET 8.D Deal comprehensively with the debt problems of developing countries through national and international measures to make debt sustainable in the long term

TARGET 8.E In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries

TARGET 8.F In cooperation with the private sector, make available the benefits of new technologies, especially information and communications


Note: The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of state and government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm) and from further agreement by members states at the 2005 World Summit (Resolution adopted by the General Assembly—A/RES/60/1). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries “to create an environment—at the national and global levels alike—which is conducive to development and the elimination of poverty.”
Only two years away from the 2015 target set for reaching the Millennium Development Goals (MDGs), progress is diverse across goals and regions. Global estimates indicate that targets such as reduction of extreme poverty (MDG 1.a), gender equality in primary education (MDG 3.a), access to safe drinking water (MDG 7.c), and improved lives for at least 100 million slum dwellers (MDG 7.d) have been reached. The proportion of people whose income is less than $1.25 a day fell from 43.1 percent in 1990 to below 20.6 percent in 2010, leaving 1.2 billion people in extreme poverty. Gender equality in primary school enrollments was also achieved in 2010. Similarly, the goal of halving the proportion of people without sustainable access to safe drinking water has already been reached.

At the same time, progress on the remaining MDGs has been lagging, especially for education- and health-related MDGs. Global targets for infant, under-five, and maternal mortality (MDGs 4.a and 5.a), and to a lesser extent, access to basic sanitation (MDG 7.c) are significantly behind, and progress needs to be greatly accelerated if all of the goals are to be achieved by 2015. The goal for primary school completion should have been within sight by 2011, but only half the progress needed has been made.

Regionally, progress toward the MDGs is more diverse, although most regions will likely miss health-related targets. In East Asia and the Pacific, the targets on extreme poverty, gender parity, and access to water and sanitation have been reached. The region is still lagging on the under-five, infant, and maternal mortality goals.

In Europe and Central Asia, the goals on poverty and water are likely to be met. This region has managed to achieve only 63 percent of the progress needed to meet the primary completion rate goal, 84 percent of the child mortality target, and 72 percent of the maternal mortality goal. The region is farthest behind on meeting the target for access to basic sanitation.

Latin America and the Caribbean have already reached the targets on extreme poverty,
FIGURE 2  Starting position for each MDG by region, 1990

Source: WDI and GMR.
Note: Weighted by population. PPP = purchasing power parity.

FIGURE 3  Global progress toward the MDGs achieved, by region

Source: WDI and GMR.
Note: The corresponding target for 2010, 80 percent, and for 2011, 84 percent. Any value above those corresponding targets indicates that the region seems on track to meeting the MDG using a simple linear approximation. A value larger than 100 percent means that more progress has been made than is necessary at the year reported. A zero value indicates deterioration. PPP = purchasing power parity.
primary completion, and access to safe water. The region stagnated on the gender equality target but is very close to reaching it. Although the region has achieved more than 80 percent of the progress needed to reduce under-five mortality by two-thirds, progress on maternal mortality has been significantly slower than elsewhere, with the region moving only 57 percent of the distance needed to meet the goal.

The Middle East and North Africa region has also reached the targets on poverty and access to improved sanitation facilities. The region is making progress toward achieving universal primary education, gender equality, and child mortality. However more effort is needed to ensure access to safe drinking water.

South Asia has reached the target on access to safe water and has already achieved nearly 85 percent of the goal to close the gender disparity gap in primary and secondary education. The region has also made progress on primary completion and child mortality rates. Progress on poverty reduction and access to basic sanitation has been slower, however. Faster progress is required to reduce child and maternal mortality and improve access to sanitation facilities if the region is to reach these goals by 2015.

Sub-Saharan Africa is lagging behind other regions and on most MDGs. However, this region had the furthest to go from the start. Currently, Sub-Saharan Africa has achieved more than 40 percent of the progress required to reach, by 2015, the targets for gender parity, child mortality, maternal mortality, and access to safe water.

Most countries need to pay particular attention to the health-related MDGs if they are to reach these goals by 2015.

**FIGURE 4**  Number of countries making progress toward the various MDGs

<table>
<thead>
<tr>
<th>MDG 1.a Extreme poverty (% of population below $1.25 a day, 2005 PPP)</th>
<th>MDG 1.c Prevalence of undernourishment (% of population)</th>
<th>MDG 2.a Primary completion rate (% of relevant age group)</th>
<th>MDG 3.a Ratio of girls to boys in primary and secondary education (%)</th>
<th>MDG 4.a Infant mortality rate (per 1,000 live births)</th>
<th>MDG 4.a Under-5 mortality rate (per 1,000 live births)</th>
<th>MDG 5.a Maternal mortality ratio (modeled estimate, per 100,000 live births)</th>
<th>MDG 7.c Access to safe drinking water (% of population with access)</th>
<th>MDG 7.c Access to basic sanitation (% of population with access)</th>
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<td>Seriously off target</td>
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Source: WDI and GMR team estimates.

**Note:** Progress is based on extrapolation of latest five-year annual growth rates for each country, except for MDG 5, which uses the last seven years. “Sufficient progress” indicates that an extrapolation of the last observed data point with the growth rate over the last observable five-year period shows that the MDG can be attained. “Insufficient progress” is defined as being able to meet the MDG between 2016 and 2020. “Moderately off target” indicates that the MDG can be met between 2020 and 2030. “Seriously off target” indicates that the MDG will not even be met by 2030. “Insufficient data” points to the fact that not enough data points are available to estimate progress or that the MDG’s starting value is missing (except for MDG 2 and MDG 3). PPP = purchasing power parity.

* In the poverty target, 11 out of the 66 countries that have met the target have less than 2% of people living below $1.25 a day.
Eradicate extreme poverty and hunger

The proportion of people living on less than $1.25 a day fell from 43.1 percent in 1990 to 20.6 percent in 2010, leaving 1.2 billion people in extreme poverty. Although the food, fuel, and financial crises over the past five years have worsened the plight of vulnerable populations and slowed poverty reduction in some countries, global poverty rates have continued to fall. Between 2005 and 2008, both the poverty rate and the number of people living in extreme poverty fell in all six developing-country regions, the first time that all regions had posted declines in poverty. Preliminary estimates for 2010 show that the extreme poverty rate fell further, reaching the global target of halving world poverty five years early, as close to 90 million more people were lifted out of extreme poverty.

Further progress is not only possible but likely before the MDGs’ 2015 target date. Current economic forecasts suggest that gross domestic product (GDP) in developing economies will maintain a growth rate of 5.5–6.0 percent over the next three years. Economic growth will be fastest in East Asia and South Asia, regions that are home to more than half of the world’s poorest people. Growth will be slower in Sub-Saharan Africa, the poorest region in the world, but faster than in preceding years, quickening the pace of poverty reduction. According to these forecasts, the proportion of people living in extreme poverty will fall from 20.6 percent in 2010 to 15.5 percent by 2015, leaving slightly more than 1 billion people in extreme poverty. Of these, 42 percent will live in South Asia and 42 percent in Sub-Saharan Africa.

The pace of poverty reduction depends not just on the growth of GDP but also on its distribution. A common assumption is that growth is “distribution neutral”; that is, growth in average income results in similar changes in the incomes of everyone, rich or poor. Although that has been the general experience over the past 20 years, there are notable variations: income distribution has improved in some countries, such as Brazil, while worsening in others, such as China. To accelerate progress toward the elimination of extreme poverty, development strategies should attempt to increase not only the mean rate of growth but also the share of income going to the poorest segment of the population. Sub-Saharan Africa, where average incomes are low and the average incomes of those below the poverty line are even lower, will face great difficulties in bringing its poorest people to an adequate standard of living.
The distribution of the poor is notable in the differences between poverty rates in rural and urban areas. As global poverty declined, so did the differential between urban and rural poverty. East Asia and the Pacific narrowed the gap by almost half by 2008. In other regions, such as Sub-Saharan Africa, Latin America and the Caribbean, and South Asia, there was less progress in closing this gap.

Hunger and malnutrition are measured by two different MDG indicators. Undernourishment reflects a shortage of food energy to sustain normal daily activities and is affected both by changes in the average amount of food available and by its distribution. Undernourishment declined steadily in most regions from 1991 to 2005, but further improvements have stalled since, leaving 13 percent of the world’s population, almost 900 million people, without adequate daily food intake.

Malnutrition, measured in children by comparing their weight with other children of similar age, reflects a shortfall in food energy, poor feeding practices by mothers, and a lack of essential nutrients in their diets. Malnutrition in children often begins at birth, when poorly nourished mothers give birth to underweight babies. Malnourished children develop more slowly, enter school later, and perform less well. Based on available data, malnutrition rates in developing countries have dropped substantially, from 28 percent of children under age five in 1990 to 17 percent in 2011. Every developing region except Sub-Saharan Africa is on track to cut child malnutrition rates in half by 2015. However, data collection on malnutrition using surveys that directly measure children’s weight and height is costly, and many countries lack sufficient information to calculate time trends.
Figure 1c  Average daily income of the poor by region, 2008

Figure 1d  Malnutrition prevalence (weight for age) by region, 1990–2011

Source: World Bank, Povcalnet.

The commitment to provide primary education to every child is the oldest of the MDGs, having been set in 1990 at the first Education for All conference, in Jomtien, Thailand. Achieving this goal has often seemed tantalizingly near, but it has been reached only in Latin America and the Caribbean, although Europe and Central Asia is close. (This goal had been reached at the outset by East Asia and the Pacific; then there was some backtracking, but the region is now close to reaching the goal again.) Progress among the poorest countries, slow in the 1990s, has accelerated since 2000, particularly in South Asia and Sub-Saharan Africa, but full enrollment remains elusive. Many children start school but drop out before completing the primary stage, discouraged by cost, distance, physical danger, and failure to progress. Even as countries approach the MDG target, the education demands of modern economies are expanding. In the 21st century, more than ever before, primary education is a critical stepping stone in building the human skills necessary for continued growth and prosperity.

In most developing regions, school enrollment rates picked up after the MDGs were promulgated in 2000, when the completion rate was 80 percent. By 2009, that rate had climbed to nearly 90 percent but has stalled since. Completion rates in the Middle East and North Africa have stayed at 90 percent since 2008. Sub-Saharan Africa and South Asia, which started out farthest behind, have made substantial progress in absolute terms: South Asia has reached 88 percent but progress has been slow, while Sub-Saharan Africa lags far behind, at 70 percent. Even if schools in these regions were to begin now to enroll every eligible child in the first grade, those children would not be able to achieve a full course of primary education by 2015. But they would at least be on their way.

Many children enroll in primary school but attend intermittently or drop out entirely. This is particularly true for girls. Almost all school systems with low enrollment rates show underenrollment of girls in primary school. In rural areas, the work of children of both sexes may be needed during planting and harvest. Other obstacles, including school fees, lack of suitable facilities, and absence of teachers, discourage parents from sending their children to school. The problem is worst in South Asia and Sub-Saharan Africa, where more than 48 million children of primary school age are not in school.

Urban and rural primary completion rates are very similar in many countries around the world. The quality of primary education, however, differs more substantially, as

![Figure 2a](image1.png)

**FIGURE 2a** Progress toward achieving complete primary education by region

![Figure 2b](image2.png)

**FIGURE 2b** More girls than boys remain out of school by region, 2010
evidenced by the notable differences in the percentage of pupils reaching competency levels in reading in urban versus rural areas.

In Ghana, for example, enrollment in basic education nearly doubled by 2011, to 7 million pupils, and government expenditures on basic education more than tripled in real terms. More children are accessing basic education, graduating from junior high school, and enrolling in senior high school than at any time in Ghana’s history.

Despite these achievements in access to basic education, inequity remains a persistent feature of Ghana’s education service delivery and its most critical challenge. The primary net enrollment ratio has remained close to 80 percent over the past five years, meaning that nearly 1 million primary school-age children are not in school. These students are disproportionately from poor households and rural or marginalized areas or language groups (including the three northern regions) or are living in foster situations. Instead of compensating for deprivation, public expenditures appear to exacerbate the inequality by allocating fewer resources per child to the regions with the majority of deprived districts. Such a system perpetuates poverty and inequality.

This picture of inequity is mirrored in data on Ghanaian children’s primary learning outcomes, primary completion rates, and access to senior high school. Notably, although the Ministry of Education has introduced several equity-improving initiatives, challenges with program design, targeting, and implementation have not been overcome, and the initiatives disproportionately benefit individuals from wealthier populations. Hence, Ghana’s scores in the Trends in International Mathematics and Science Study (TIMSS) 2003 were lower than any other African country evaluated, including Botswana, the Arab Republic of Egypt, Morocco, South Africa, and Tunisia. Ghana’s scores on the TIMSS 2007 were better but still among the lowest among African countries whose students took the tests.

**FIGURE 2c** Urban and rural primary completion rates are not very different worldwide

**FIGURE 2d** Reading competency levels (4-8) in urban and rural areas, 2007
Women make important contributions to economic and social development. Expanding opportunities for them in the public and private sectors is a core development strategy. Education is the starting point. By enrolling and staying in school, girls gain the skills they need to enter the labor market, care for families, and make decisions for themselves. Achieving gender equity in education is an important demonstration that young women are full, contributing members of society.

Girls have made substantial gains in primary and secondary school enrollment. In 1990, the primary school enrollment rate of girls in developing countries was only 86 percent that of boys. By 2011, the average was 97 percent. Similar improvements have been made in secondary schooling, where girls’ enrollments have risen from 78 percent to 96 percent of that of boys. Progress has been greatest in richer countries. In countries classified by the World Bank as upper-middle-income, girls’ enrollments in primary and secondary schools now exceed those of boys. But averages can obscure large differences between countries: overenrollment of girls in one country does not counterbalance underenrollment in another. At the end of the 2011 school year, 31 upper-middle-income countries and 23 lower-middle-income countries had reached or exceeded equal enrollment of girls in primary and secondary education, but only 9 low-income countries had done so. Two regions lag behind: South Asia and Sub-Saharan Africa. The differences are also notable for urban-rural areas. For several African countries, the gap between male and female enrollment remains large, especially for secondary enrollment. Only a few countries in Sub-Saharan Africa have higher enrollment rates for girls (Niger, Rwanda, and Senegal in urban areas). However, most of the countries included in figure 3b show that boys have higher enrollment rates compared with girls.

More women are participating in public life at the highest levels. The proportion of parliamentary seats held by women continues to increase. The Latin America and Caribbean region, where women now hold 23 percent of all parliamentary seats, remains in the lead. The most impressive gains have been made in South Asia, where the number of seats held by women more than tripled between 1999 and 2010. In Nepal, women held one-third of parliamentary seats in 2011. In Sub-Saharan Africa, Rwanda leads the way: since 2008, 56 percent of its parliamentary seats have been held by women. The Middle East and North Africa lag far behind.

Full economic empowerment of women remains a distant goal. While many women work long hours and make important contributions to their families’ welfare, they often work in the informal sector, typically as unpaid family workers. Women’s share in paid employment in the nonagricultural sector has risen marginally but remains less than 20 percent in South Asia and in the Middle East and North Africa. The largest proportion of working women is found in Europe and Central Asia, where in recent years, 47–48 percent of nonagricultural wage employees were women.

### FIGURE 3a Gender parity in primary, secondary, and tertiary education by region, 2011

- **East Asia & Pacific**
- **Europe & Central Asia**
- **Latin America & the Caribbean**
- **Middle East & North Africa**
- **South Asia**
- **Sub-Saharan Africa**

Source: UNESCO Institute of Statistics and World Development Indicators database.

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1. The ratio between the enrollment rate of girls and boys (gender parity ratio) increased from 91 in 1999 to 97 in 2010 for the developing regions as a whole—falling within the plus-or-minus 3-point margin of 100 percent that is the accepted measure for parity.
Figure 3b: Gap in male-female enrollment ratios

Source: World Development Indicators database.
In most countries around the world, most children’s deaths occur in the first year. In developing countries, the under-five mortality rate fell from 87 per 1,000 live births in 1990 to 51 in 2011. This progress is not sufficient to meet the health-related MDG target of a two-thirds reduction by 2015. Only 25 countries have achieved this target, and only an additional 26 have made enough progress to be able to meet the target by 2015.

For the infant mortality rate, the numbers are worse: only 5 countries met the target of reducing the infant mortality rate by two-thirds between 1990 and 2015, and only 13 countries are making enough progress to reach it by 2015. More than 120 countries still have not made sufficient progress to meet the goal on time. Overall, the MDG health indicators have seen the least progress of all the MDGs.

As a country urbanizes, children in urban areas tend to have access to better health services and thus lower rates of child mortality than children in rural areas. In addition, as countries become more urbanized, the proportion of children in rural areas declines, further narrowing the difference between the mortality rates of rural and urban children. Notably, the highest rates of child mortality are in Sub-Saharan Africa, whose countries are the least urbanized.

The disparities between urban and rural infant mortality rates display a similar pattern. Higher infant mortality rates in rural areas are in part attributable to the disadvantages faced by rural households, such as lack of access to a safe source of drinking water and electricity. As discussed in chapter 2 of the *Global Monitoring Report (GMR)*, governments need to provide basic services in rural areas as well as in urban ones to correct such deficiencies, to the extent possible.

**FIGURE 4a** Urban versus rural child mortality gap

Source: Demographic and Health Surveys (DHS).
FIGURE 4b Urban versus rural infant mortality gap

Source: Demographic and Health Surveys (DHS).
MDG 5 centers on improving maternal health, with a target of reducing the maternal mortality ratio by three-quarters between 1990 and 2015. With only two years remaining before the target date, progress on maternal health is still lagging. Despite some notable exceptions such as Sri Lanka and Malaysia, the level of maternal mortality remains high in much of the developing world. Although on the aggregate the rate of progress has doubled across the globe from 2005 to 2010, it is unlikely that this MDG will be achieved by 2015.

South Asia is the only region on track to reach the target for reducing maternal mortality, assuming the region continues at the same rate of progress made from 2005 to 2010. The Middle East and North Africa might also be able to reach the MDG target if it doubles the effort it made from 2005 to 2010. The starting point in the level of maternal mortality obviously affects progress made in achieving the target but is not the only factor. Europe and Central Asia started with 70 maternal deaths per 100,000 live births in 1990, while Sub-Saharan Africa started with 850. However, if Sub-Saharan Africa doubles the progress made during 2005 to 2010, it will be able to reach its goal by 2016—just a year past the target, while Europe and Central Asia would need to more than double its effort to meet the goal in 2015.

The starting point for the maternal mortality ratio in middle-income countries in 1990 was nearly half that of low-income countries (370 deaths per 100,000 live births compared to 810). However, neither group of countries is close to achieving the goal on time. Although they will miss the 2015 target date, middle-income countries could reach the maternal mortality goal by 2016 if they doubled their effort. The low-income group will need even longer.

Despite this bad news, there are some bright spots. Fragile states as a group started with a similar number of maternal deaths to Sub-Saharan Africa (780 deaths per 100,000 live births in 1990), but several of them have managed, or are on track, to achieve this particular MDG. Nepal reduced its maternal mortality rate from 770 deaths per 100,000 live births in 1990 to 170 in 2010, earning it the MDG Millennium Award in 2010. Nepal has also made extraordinary progress in reducing its proportion of poor people in recent years. Other fragile states such as Afghanistan, Angola, Eritrea, Timor-Leste, and the Republic of Yemen are still on track to meet the MDG, some with acceleration, and others following their current growth trend.

The issue of teenage pregnancy still requires significant attention, especially in rural areas, where the rate of teen pregnancy is higher than in urban areas.
**FIGURE 5a** Expected year when maternal mortality goal will be met, by region

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a. Developing countries only.

**FIGURE 5b** Expected year when maternal mortality goal will be met, by income level and by fragile and small states

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<td></td>
<td></td>
</tr>
</tbody>
</table>


**FIGURE 5c** The percentage of teenagers who had children or are currently pregnant is higher in rural areas than in urban ones

Source: Demographic and Health Surveys (DHS).
Combat HIV/AIDS, malaria, and other diseases

Epidemic diseases exact a huge toll in human suffering and lost opportunities for development. Poverty, armed conflict, and natural disasters contribute to the spread of disease and are made worse by it. In Africa, the spread of HIV/AIDS has reversed decades of improvement in life expectancy and left millions of children orphaned. It is draining the supply of teachers and eroding the quality of education. Malaria takes a large toll on young children and weakens adults at great cost to their productivity. Tuberculosis caused the deaths of some 1 million people in 2011, most of them aged 15–45, and sickened millions more. Tuberculosis is one of the principal causes of adult death from a single infectious agent in developing countries.

Some 34 million people were living with HIV/AIDS in 2011, and 2.5 million people acquired the disease during the year. Sub-Saharan Africa remains the center of the epidemic, but the proportion of adults living with AIDS has begun to fall as the survival rate of those with access to antiretroviral drugs has increased. By the end of 2010, 6.5 million people worldwide were receiving antiretroviral drugs. That represented the largest one-year increase in coverage but fell far short of the target of universal access. In Africa, 58 percent of adults with HIV/AIDS are women; among youth aged 15–24, the prevalence rate among women is more than twice that of men. The second highest prevalence rate is in Latin America and the Caribbean, where 0.5 percent of adults are infected.

The prevalence of HIV infection in urban and rural areas varies significantly from country to country. For most Sub-Saharan Africa countries, the rates of HIV infection are higher in urban areas than in rural ones. Because evidence from health surveys confirms that a prominent decline in prevalence is associated with higher education, increased condom use, and a reduced number of sexual partners, most of the effort to prevent HIV/AIDS should continue to be concentrated in urban areas.

In 2011, 8.7 million people were newly diagnosed with tuberculosis, but its incidence, prevalence, and death rates are all falling. The global incidence rate
**FIGURE 6a** Population infected with HIV, ages 14-49

![Graph showing population infected with HIV, ages 14-49](image)

**Source:** UNAIDS and World Development Indicators database.

**FIGURE 6b** Tuberculosis-infected population in low- and middle-income countries

![Graph showing tuberculosis-infected population](image)

**Source:** UNICEF and World Development Indicators database.

**FIGURE 6c** Millions of people still afflicted with HIV/AIDS

- **India** (2006)
- **Burkina Faso** (2010)
- **Cambodia** (2005)
- **Ethiopia** (2011)
- **Senegal** (2005)
- **Vietnam** (2005)
- **Senegal** (2010)
- **Ethiopia** (2005)
- **Dominican Republic** (2007)
- **Burundi** (2010)
- **Niger** (2006)
- **Rwanda** (2005)
- **Congo, Dem. Rep.** (2007)
- **Liberia** (2007)
- **Sierra Leone** (2008)
- **Burkina Faso** (2003)
- **Haiti** (2006)
- **Rwanda** (2010)
- **Dominican Republic** (2002)
- **Ghana** (2003)
- **Mali** (2006)
- **Côte d’Ivoire** (2005)
- **Guinea** (2005)
- **Mali** (2003)
- **São Tomé & Príncipe** (2008)
- **Congo, Rep.** (2009)
- **Cameroon** (2011)
- **Tanzania** (2007)
- **Tanzania** (2003)
- **Uganda** (2004)
- **Cameroon** (2004)
- **Malawi** (2010)
- **Kenya** (2008)
- **Kenya** (2013)
- **Zambia** (2007)
- **Zimbabwe** (2010)
- **Zambia** (2002)
- **Mozambique** (2009)
- **Zimbabwe** (2005)
- **Lesotho** (2009)
- **Lesotho** (2004)
- **Swaziland** (2006)

**Source:** Demographic and Health Surveys (DHS).

**FIGURE 6d** Urban versus rural children under age 5 who sleep under insecticide-treated bed nets

![Graph showing urban versus rural children under age 5](image)

**Source:** Demographic and Health Surveys (DHS).
peaked in 2002; the prevalence rate—the proportion of people living with the disease—began to fall in 1997. If these trends are sustained, the world could achieve the target of halting and reversing the spread of tuberculosis by 2015. People living with HIV/AIDS, which reduces resistance to tuberculosis, are particularly vulnerable, as are refugees, displaced persons, and prisoners living in close quarters and unsanitary conditions. Well-managed medical intervention using appropriate drug therapy is the key to stopping the spread of tuberculosis.

There are 300 million–500 million cases of malaria each year, leading to more than 1 million deaths. Encouraging progress against the disease is being made. In 2011, Armenia was added to the list of countries certified free of the disease. Malaria, a disease of poverty, occurs in all regions, but Sub-Saharan Africa, where the most lethal form of the malaria parasite is most abundant, is the epicenter. Prevention and control measures, such as the use of insecticide-treated mosquito bed nets, have proven effective and their use is spreading. In Sub-Saharan Africa, the use of treated nets is estimated to have grown from 2 percent in 2000 to 39 percent in 2010. Better testing and the use of combination therapies with artemisinin-based drugs are improving the treatment of at-risk populations. But malaria is a difficult disease to control. Emerging resistance to artemisinins and to the pyrethroid insecticides used to treat mosquito nets has been detected.

The differences in the rate of use of treated mosquito nets between rural and urban areas are minor. The cost of distributing nets is lower in urban areas thanks to agglomeration effects, likely contributing to the typically higher usage there.
Ensure environmental sustainability

As part of the MDGs, most countries have agreed on the principles of sustainable development, and there is international consensus to protect the environment. To this end, MDG 7 includes a target of halving the proportion of the population without access to improved sanitation and water sources by 2015. For many people in developing countries, however, access to safe water and sanitation remains a problem.

Fifty-six countries have still not made enough progress to reach the target of improved water sources on time; moreover, 20 countries do not have enough data to measure their progress on this target. Sub-Saharan Africa is lagging the most, although it has improved access to clean water in rural areas from 35 percent in 1990 to 49 percent in 2010; access in urban areas has not changed and remains at 83 percent. East Asia and Pacific made impressive improvements in rural areas, from a starting position of only 58 percent in 1990 to 84 percent in 2010; in urban areas access was nearing 100 percent. In general, the other regions have already managed to reach access rates of more than 80 percent in urban and rural areas.

Poor sanitation causes millions of people worldwide to contract illnesses. Around 1.7 million people die each year because of unsafe water and sanitation, and 90 percent of those are children under age five. Almost all sanitation-related deaths occur in the rural areas of developing countries, where sanitation problems are more severe (and access to adequate health care is less available). Some regions have made more progress than others, but even though most regions have improved access to sanitation by more than 20 percentage points, differences between urban and rural areas are considerable.

South Asia and Sub-Saharan Africa are the only regions where progress has not been significant, with an increase in access of only 17 percentage points in South Asia and 4 percentage points in Sub-Saharan Africa from 1990 to 2010. These regions also had the worst starting positions.

The increase in access to improved sanitation has not been impressive in urban areas either. The biggest advance came in the East Asia and Pacific region, where access increased about 22 percent during 1990–2010.

Although the gap between urban and rural access to sanitation is still wide, it has decreased in all regions. Between 1990 and 2010, for example, the gap narrowed from 42 percent to 25 percent in Latin America and the Caribbean, and from 44 percent to 31 percent in South Asia. Most striking, in Europe and Central Asia, the gap narrowed from 20 percent in 1990 to 7 percent in 2010, suggesting that even though progress is slow, it does reach underserved rural populations.

**FIGURE 7a** Access to water by region, 1990 and 2010

- **Source:** World Development Indicators database, 2013.
FIGURE 7b  Access to sanitation by region, 1990 and 2010


FIGURE 7c  Urban-rural gap in access to sanitation by region

Develop a global partnership for development

The use of information and communication technology (ICT) for economic development is part of the MDG 8 indicator, which focuses on the deepening of a global partnership for development. A specific description of this specific target was chosen and indicators identified. Target 8.F states that, in cooperation with the private sector, the benefits of new technologies, especially those related to information and communications, will be made available. The indicators measuring this progress are the number of fixed telephone lines, cellular subscribers, and Internet users.

These indicators show that mobile phone subscriptions have risen impressively across the world, while the growth in the number of fixed telephone lines has stagnated. Remarkable increases have also taken place in Internet usage, although here progress is more diverse, with stronger growth in high-income countries than in low- and middle-income countries. Even though access challenges remain, particularly in low-income countries, the spectacular rise in mobile phone penetration has led to the emergence of a variety of innovations that allow citizens, governments, and international organizations to be more engaged and better informed, and that enable aid providers to identify and communicate more directly with beneficiaries.

**FIGURE 8a Use of information and communication technology by region and income group**

Improving the measurement of development goals

The Millennium Development Goals (MDGs) provide a yardstick against which to measure development outcomes. They have also stimulated demand for better statistics and new programs to increase the capacity of developing countries to produce and use statistics. The United Nations and its specialized agencies, including the World Bank and the International Monetary Fund, and the Organisation for Economic Co-operation and Development responded to these demands by creating new partnerships and mobilizing additional resources to provide support for statistics in developing countries. The result has been a marked improvement in the quality and availability of statistics on core development outcomes: poverty and income distribution, school enrollments, mortality and morbidity rates, and environmental conditions.

The MDGs posed three challenges: the selection of appropriate targets and indicators with which to monitor them; the construction of an international database to use for global monitoring; and the need for significant improvements in the quality, frequency, and availability of the relevant statistics, especially at the national level. The selection of goals and targets was determined by the Millennium Declaration adopted unanimously by the member states of the United Nations. Building the database and strengthening the statistic systems of developing countries has required the efforts of many partners over many years. When countries produce statistics to monitor their own development programs, differences in definition and methodology often limit comparability across countries. Whether monitored at the national, regional, or global level, international monitoring of the MDGs requires indicators that are comparable across countries and over time.

To produce harmonized statistics suitable for international comparisons, agencies often revise national data or recompile data using different reference periods or standards, such as the “dollar a day” poverty indicator. They may also impute values for missing data or use statistical models to combine multiple estimates. Interagency efforts such as these have been very important for filling the gaps in child and maternal mortality series. However, they inevitably result in data series that differ from nationally reported data and international assessments of country progress that differ from those produced by the countries.

When the MDGs were adopted, few developing countries had the capacity or resources to produce statistics of the requisite quality or frequency. Many countries had not conducted a recent census or a household survey capable of producing information on income, consumption, or health status. Values for many indicators disseminated by international agencies were based on unverified reports from national authorities. Statistical activities sponsored by bilateral donors and multilateral agencies often focused narrowly on securing data of interest to them but doing little to increase the capacity of the national statistical system to serve the needs of local decision makers or citizens.

The early efforts to monitor the MDGs revealed large gaps in both the international database and in many national databases. In 2003–04, the Partnership in Statistics for Development in the 21st Century (PARIS21) conducted six case studies of developing-country statistical systems. The studies found that the countries generally had very limited capacity to manage their own statistical programs.

Although the developing world has made some headway in improving its data collection and reporting, the systems are characterized by underfunding, reliance on donor support, particularly for household surveys, and very weak administrative data systems. The basic demographic information needed to underpin key indicators is out of date in some countries, and funding for major activities, such as population censuses, is particularly difficult to secure. Overall, there continues to be a shortfall in funding for core statistical systems required to provide information both for economic management and for monitoring the MDGs.

The proportion of countries with two or more data points (the bare minimum needed for assessing trends)
for selected MDG indicators in 2005 and 2013 is shown in
Table 1. For some indicators, the improvement has been
much more dramatic. But for other less prominent indica-
tors, progress has been slower.

Despite the progress made in the past decade,
national systems face immense difficulties on many fronts
including funding, sectoral shortcomings, and poor data
access, and the development of skills needed to use statis-
tics effectively in planning and management. In 2011, the
High Level Forum on Aid Effectiveness meeting in Busan,
Republic of Korea, endorsed a new action plan for statis-
tics. Several statistical domains have been identified as
priorities for international action because of large deficits
in data quality and availability. The high-priority domains
include agricultural statistics, poverty statistics and house-
hold surveys, gender statistics, labor force statistics, envi-
ronmental accounting and the system of national
accounts, and vital registration systems. The Busan Action
Plan for Statistics provides an agreed framework for
addressing capacity limitations in developing countries
and work is already under way in some domains.

Resources are limited, however, and even with greater
resources, capacity building is a slow, deliberate process.
The MDGs have contributed to the development of a sta-
tistical infrastructure that is increasingly capable of pro-
ducing reliable statistics on a variety of topics.

**TABLE 1  Proportion of countries with two or more observations**

<table>
<thead>
<tr>
<th>Selected MDG indicators with two or more observations in period show</th>
<th>2005 database</th>
<th>2013 database</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDG 1.a Extreme poverty (% of population below $1.25 a day, 2005 PPP)</td>
<td>63</td>
<td>—</td>
</tr>
<tr>
<td>MDG 1.c Malnutrition prevalence, weight for age (% of children under age 5)</td>
<td>77</td>
<td>—</td>
</tr>
<tr>
<td>MDG 2.a Primary completion rate (% of relevant age group)</td>
<td>111</td>
<td>83</td>
</tr>
<tr>
<td>MDG 3.a Ratio of girls to boys in primary and secondary education (%)</td>
<td>105</td>
<td>62</td>
</tr>
<tr>
<td>MDG 4.a Infant mortality rate (per 1,000 live births)</td>
<td>135</td>
<td>2</td>
</tr>
<tr>
<td>MDG 4.b Under-5 mortality rate (per 1,000)</td>
<td>135</td>
<td>1</td>
</tr>
<tr>
<td>MDG 5.b Births attended by skilled health staff (% of total)</td>
<td>86</td>
<td>1</td>
</tr>
<tr>
<td>MDG 6.c Immunization, measles (% of children, ages 12–23 months)</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td>MDG 7.c Improved sanitation facilities (% of population with access)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>MDG 7.c Improved water source (% of population with access)</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: World Development Indicators.
Note: — = not available; PPP = purchasing power parity.