Are the MDGS Feasible?

Jan Vandemoortele[1]

Although the MDGs are ambitious, all targets will be met by some countries, including a few among the least developed. If these countries can achieve the goals, there is no reason why others cannot. However, "average" progress during the 1990s disguises the conditions of the poorest and most disadvantaged groups — and conceals the way social deprivation obstructs economic growth. Reaching the MDGs will require universal access to basic social services.

> *"As long as you travel to a goal, you can hold on to a dream."*
>
> *Anthony de Mello*

The Millennium Development Goals (MDGs) are a set of numerical and time-bound targets that express key elements of human development. They include halving income-poverty and hunger; achieving universal primary education and gender equality; reducing under-five mortality by two-thirds and maternal mortality by three-quarters; reversing the spread of HIV/AIDS; and halving the proportion of people without access to safe water. These targets are to be achieved by 2015, from their level in 1990 (United Nations, 2000).

It is often said that global targets are easily set but seldom met, which begs the question whether the MDGs are feasible. Progress in over 130 developing countries regarding the many dimensions of human development — such as education, health, nutrition and income — is difficult to summarise. The 1990s saw many success stories, including education in Guinea and Malawi; HIV/AIDS in Senegal, Thailand and Uganda; child mortality in Bangladesh and the Gambia; nutrition in Indonesia, Mexico and Tunisia; and income-poverty in China. Globally, the number of polio cases dropped from nearly 250,000 in 1990 to less than 3,000 in 2000, making its eradication by 2005 a realistic goal.

But for each success story there have been setbacks. The under-fives mortality rate increased in Cambodia, Kenya, Malawi and Zambia — an unprecedented trend after decades of steady decline. The primary school enrolment ratio dropped in Cameroon, Lesotho, Mozambique and Tanzania. The gender gap in primary education widened in Eritrea, Ethiopia and Namibia. Instead of decreasing, malnutrition increased in Burkina Faso and Yemen. Access to water became more difficult for millions of people; Bangladesh faced a major problem with arsenic water poisoning. In

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the 1990s, countless countries saw their HIV prevalence rate double, triple, quadruple, even increase ten-fold — severely undermining the feasibility of most MDG in health and beyond.

Monitoring can be done at different levels, from the global to the local. The level of assessment will influence the outcome regarding the feasibility of the MDGs. If MDGs appear feasible at the global level, it does not necessarily imply that they will be feasible in all nations or at all locations. Averages are commonly used at each level to measure MDG progress. While they give a good sense of overall progress, averages can be misleading. The failure to understand that the average is an abstraction from reality can lead to unwarranted conclusions that are based on deduction from abstractions, not on real observations.

A good assessment of progress towards the MDGs must, therefore, go beyond averages and aggregates. The failure to disaggregate for gender, for instance, easily leads to the fallacy of "misplaced concreteness" (Daly and Cobb, 1994). Average household income is very much an abstraction for women who have little or no control over how it is spent; it may exist in the mind of economists, but it does not necessarily correspond with the reality faced by millions of poor women.[2]

This article reviews global progress towards the MDGs during the 1990s. The picture that emerges shows a very uneven pattern across regions and countries and between different socioeconomic groups within the same country. Although the picture is mixed, the overall conclusion is that none of the agreed targets for the year 2000 was met at the global level. If the 1980s were the "lost decade for development", the 1990s should go down in history as the "decade of broken promises". If current trends prevail, only one MDG will be reached by 2015.

Is Progress on Target?

The review is based on the best data that are currently available. It focuses on indicators for which global information is reasonably reliable, comparable and up-to-date.[3] However, it must be kept in mind that global trends are estimates; they are never precise or actual values. Therefore, different sources often give different estimates, without necessarily being inconsistent. Indicators without trend data or with inconsistent data have been omitted. Hence, the review does not include all MDGs.

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[2] Cost recovery in a water project in western Kenya, for example, was low despite seemingly high average household income. The cause was traced to the fact that women were responsible for this expense but had little or no control over household income. Affordability studies often target the wrong group and frequently produce misleading policy advice.

[3] Based on the latest information from a variety of sources, mostly from within the United Nations system, and particularly UNICEF (2001).

Income Poverty

In developing countries, the average proportion of people living on less than $1 per day decreased from 32% in 1990 to 25% in 1999, according to the latest estimates (World Bank, 2002).[4] The simple extrapolation of this trend suggests that the world is on track to halving income-poverty by 2015. Unfortunately, the reality is more complicated and decidedly less satisfactory. Most of the global progress was due to a rapid decline in Asia, particularly in China. Progress in Latin America and the Caribbean, Sub-Saharan Africa, and the Middle East and North Africa, combined, was merely a tenth of what was required to meet the agreed target.

In addition, poverty estimates for China show large discrepancies, which seriously undermine the reliability of global poverty data. Diagram 1 shows a steep decline in China's income poverty between 1993-96, when the headcount index reportedly declined from 29% to 17%. This implies that the number of people in China struggling to survive on less than a $1 per day dropped by a staggering 125,000 people per day for three years running. This remarkable achievement came to a sudden — and mysterious — end in 1996. Actually, the number of poor people reportedly increased slightly between 1996 and 1999.

Diagram 1: Incidence of income-poverty in China *(percentage of the population below the poverty line)*
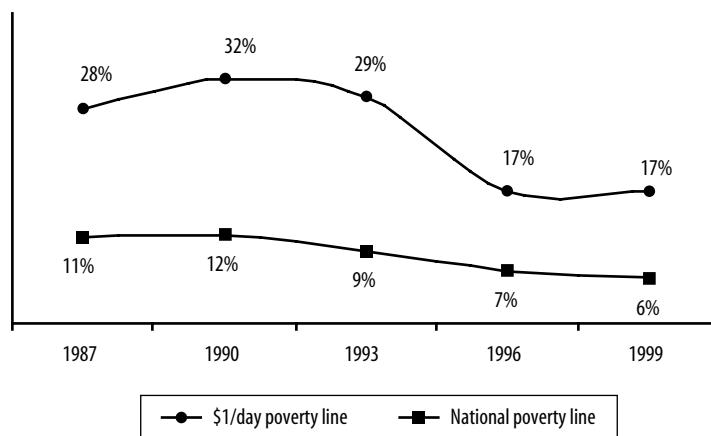
Source: Based on World Bank (2002) and data from the Ministry of Agriculture

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4   Global poverty estimates are often presented with a decimal point, which may give a false sense of sophistication and accuracy. Given their approximate nature, rounded figures are more appropriate.

National poverty estimates, on the other hand, show a less dramatic decline in China's poverty level. Poverty estimates reported by the Ministry of Agriculture show a decrease by less than 1 percentage point per year between 1993 and 1996 (Khan and Riskin, 2000), considerably less than the 4 percentage points suggested by the World Bank estimates.[5] Moreover, if demographic change has been a major force behind China's success in reducing income-poverty — as some analysts have documented (Gustafsson and Zhong, 2000) — then it would be unwise to assume that its rapid decline will continue till 2015.

In short, global poverty trends cannot be taken at face value. Given the inherent weaknesses associated with the fixed and static poverty line of $1 per day and given the inaccuracy of PPP conversion rates (purchasing power parity), global poverty estimates are not a reliable source of information. Global poverty data are not robust; therefore it cannot be argued that the world is on track to reaching the target for halving income-poverty by 2015. Dozens of countries experienced a decline in average living standards in the past decade. Moreover, the simple extrapolation of global poverty trends to 2015 is invalid because large countries — such as China and Indonesia — will gradually become less powerful in pulling global poverty down as they reach lower levels of poverty. Global poverty projections will only be meaningful if they are based on country-specific projections.

Education

In 1990, the goal was set to provide basic education to all children by the year 2000. The sad truth is that the 1990s saw only about a fifth of the global progress needed. For developing countries, the average net enrolment ratio for primary education increased from 78 in 1990 to 83 in 2000. Not surprisingly, the goalpost was moved to 2015; but this promise will not be kept either if progress does not accelerate two-fold between 2000 and 2015. At the current rate, the global education target will not be reached until the year 2030.

Diagram 2 shows that progress was significantly slower in the 1990s than in the preceding three decades, when the average enrolment ratio increased by approximately 10 percentage points per decade — compared with only 5 percentage points in the 1990s.[6] In 2000, an estimated 120 million school-age children

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[5]   The data of the Ministry of Agriculture relate to rural poverty, whereas World Bank data refer to total poverty. Since poverty in China is overwhelmingly rural, the discrepancy cannot be explained by the difference in geographical coverage. The national poverty line is lower than the international one based on $1 per day. Therefore, the national poverty estimate falls below the $1 poverty trend. It should be noted, however, that the difference between the two poverty trends was halved, narrowing from 20 percentage points in the early 1990s to about 10 percentage points in the late 1990s.

[6]   Another way of assessing progress is by measuring it against the remaining gap; but this interpretation of the data also shows that progress slowed down in the 1990s. It should be noted that global targets set for reducing U5MR and NER by 2015 are not out of line with historic trends.

were not enrolled — about the same as a decade earlier. They joined the ranks of the nearly 1 billion adults who cannot read or write — most of them women. Globally, the world is not on track to meeting the education target.

Failure to meet the education target will reduce the chances of reaching other MDGs because basic education is key to unlocking positive externalities and synergies. Basic education empowers a young woman and enhances her self-confidence; an educated mother is likely to marry later, space her pregnancies better, and seek medical care for her child and herself when needed. Evidence shows that babies born to mothers without formal education are at least twice as likely to suffer from malnutrition or die before age 5 than are babies born to mothers who completed primary school (Bicego and Ahmad, 1996). An educated girl is also the best guarantor that her children attend school — thereby ending the inter-generational transmission of poverty. Health investments are more efficient when the people are better educated, in large part due to the adoption of good hygienic behaviour. In short, girls' education is key to achieving the MDGs.

The good news is that the gender gap in primary enrolment narrowed in the 1990s. For developing countries, the number of girls per 100 boys enrolled in primary school increased from 83 in 1990 to 88 in 2000. However, this was insufficient to reach gender equality by 2005, as agreed in the MDGs. Progress would have to accelerate more than four-fold in the period 2000-05 if this target were to be achieved. Globally, the world is not on track to reaching gender equality in primary education by 2005.[7] At the current rate, the target will not be met until the year 2025. Gender discrimination in primary school enrolment remains a concern in several countries, particularly in Sub-Saharan Africa, South Asia and the Middle East and North Africa.

Diagram 2: Average net primary enrolment ratio *(NER)* and under-five mortality rate *(U5MR)* in developing countries
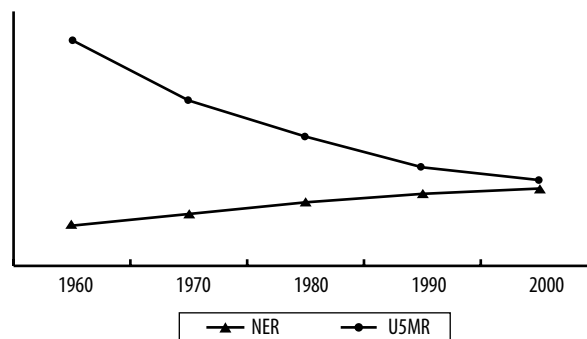
Source: Based on UNICEF (2001) and data from UNESCO

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[7] Faster progress was made toward gender equality in secondary and tertiary education, but it was not enough either to close the gender gap by the agreed date.

Child Mortality

In 2000, more than 10 million children under the age of five died, mostly due to preventable causes such as pneumonia, diarrhoea, measles malaria, HIV/AIDS and malnutrition. For developing countries, the average under-five mortality rate decreased from 103 to 91 deaths per 1,000 live births between 1990 and 2000. The rate of progress was less than half that achieved in the previous three decades, as shown in Diagram 2. For several countries, slow progress was due to the mother-to-child transmission of HIV, which is contributing to an unprecedented increase in infant and child mortality. In Zimbabwe, for example, some 70% of deaths among children under the age of five are due to AIDS.

There is no marked difference between girls and boys when it comes to the average under-five mortality rate, but Demographic and Health Surveys (DHS) show that in virtually all countries, baby-boys experience higher levels of infant mortality than baby-girls; mostly due to biological factors — sometimes 50% higher. After infancy, however, the gender gap in terms of mortality gradually reverses, switching from being pro-female in infancy to being pro-male in childhood (ages one-four). Such reversals are observed in Bangladesh, Bolivia, Brazil, Cameroon, Dominican Republic, Gabon, Guatemala, Haiti, India, Kenya, Kyrgyz republic, Nepal, Niger, Nigeria, Peru and Viet Nam.

In the absence of a biological explanation, environmental factors must be examined to understand the causes for this reversal. DHS surveys consistently show that baby-boys are more likely to be vaccinated and breastfed than baby-girls.[8] Both indicators suggest a greater commitment on the part of parents and service providers to the health and development of boys vis-à-vis girls.

If the global trend of the 1990s were to continue at the same rate until 2015, the reduction in the under-five mortality rate would be about one-quarter, far less than the agreed target of a two-thirds reduction. Meeting the global target will require that the rate of reduction increases more than five-fold between 2000 and 2015 — an extremely unlikely scenario. Almost half of the under-five deaths occur in sub-Saharan Africa, so that a sudden and dramatic improvement in child mortality in that region must come about if the global target is to be achieved. Globally, the world is not on track to reaching the target for child mortality.

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[8] Lower levels of vaccination among baby-girls explain, in part, their increased child mortality rate vis-à-vis boys. Countries where a significant shift occurs from a pro-female bias in infant mortality to a pro-male bias in child mortality are often those with the largest gender gap in terms of immunisation. Another factor that is likely to add to explaining the reversal in gender-specific mortality rates is nutrition. Food allocation within the family is frequently determined by gender, and disparities in feeding practices between girls and boys appear early in life. Data on breastfeeding reveals that in most countries, a baby-boy is more likely to be breastfed than a baby-girl.

Immunisation is essential to reducing child mortality. Measles is among the leading causes of child mortality that are vaccine-preventable, but immunisation coverage stagnated in the 1990s at about 70%. The coverage has to reach at least 90% to effectively reduce measles deaths. That level was reached only in Latin America and the Caribbean and in East Asia, whereas coverage actually decreased in Sub-Saharan Africa to about 50% in 2000, down from over 60% in 1990.

Child Malnutrition

Deaths among children under the age of five are often associated with malnutrition, mostly with moderate malnutrition; only one-quarter of the deaths result from severe malnutrition. The crisis is, therefore, largely invisible as the young victims seldom show outward signs of under-nourishment.

In 1990, the target was set to halve the proportion of children suffering from malnutrition by 2000. Data show that moderate and severe underweight declined from 32 % to 28%, respectively. Thus, only one-quarter of the promise was kept. As part of the MDGs, the goalpost was pushed to 2015; but the current rate of progress will have to increase three-fold if malnutrition in developing countries in 2015 is to be half the level that prevailed in 1990. Globally, the world is not on track to meeting the nutrition target.

The largest decline was observed in East Asia, especially in China; substantial improvements were made in Latin America and the Caribbean. Less progress was made in South Asia where underweight prevalence remains very high. Sub-Saharan Africa saw little or no change over the decade. Overall, the number of malnourished children in developing countries fell by approximately 25 million — or 15% — decreasing from 174 million to 150 million. However, their numbers increased in Sub-Saharan Africa and South Asia.

Data from over 100 countries do not suggest that girls are more likely to be malnourished than boys. Except for South Asia, most regions actually show a slightly higher rate of malnutrition for boys. However, gender gradually becomes a greater liability as girls grow older, and by the time they reach reproductive age, many suffer from anaemia. In almost all countries, rural children are more at risk of malnutrition than their urban counterparts. In some countries, the percentage of rural children who are underweight is more than 50% higher than that for urban children.

HIV/AIDS

Two decades after it was first reported, AIDS is the most serious threat to human development in a growing number of countries. It is the leading cause of death in Sub-Saharan Africa; worldwide, it is number four in the league of major killers. The pandemic — raging in Africa and spreading fast in other regions — is perhaps the greatest impediment to achieving the MDGs by 2015. Even countries with a relatively low national HIV prevalence rate can have clusters of people or specific locations where the prevalence rate is as high as 20% or more; but these pockets of crises are hidden in national statistics due to their relatively small population size.

About one third of those currently living with HIV/AIDS are aged between 15-24 years. Adolescent girls are at particularly high risk, due to a mix of biological and social factors. HIV/AIDS is a disease for which gender could not be more central; women represent a growing proportion of people living with HIV/AIDS. In countries with high HIV prevalence, young women with little or no education — i.e. those without much power in society — are at the greatest risk of infection (Vandemoortele and Delamonica, 2000). Studies in Africa show that teenage girls are five to six times more likely to be infected by the HIV virus than boys their age (UNAIDS, 2000). New HIV infections are disproportionately concentrated among poor and illiterate adolescent women.

After a strong public information campaign, Uganda saw the number of new cases of HIV/AIDS drop from 239,000 in 1987 to 57,000 in 1997. But even in this exceptional case, the impact on the poor — i.e. those with little or no education — was the least. The HIV infection rate among educated women dropped by almost half in the 1990s, whereas it did not show a significant decrease for women without formal schooling.

Millions of young people do not know how to protect themselves against HIV. In the late 1990s, surveys in Sub-Saharan African countries found that half the teenagers do not know that a healthy looking person can be HIV-positive. The proportion of young people who do not know that HIV/AIDS cannot be transmitted by mosquitoes is over 80% in Albania, Azerbaijan, Chad, Niger, Somalia, Tajikistan and Uzbekistan. Out of a sample of 23 countries, that proportion is less than half in only two: Cuba (35%) and Kenya (45%). In many countries, open and frank discussions about HIV transmission face a wall of silence. Four allies make the virus so prevalent in many societies: silence, shame, stigma and superstition. These four S's thrive in a climate of ignorance and illiteracy, making education a key to defeating this deadly alliance.

But several countries face a Catch-22: education is important to reverse the pandemic but HIV/AIDS undermines the education system. Absenteeism among teachers is high, due to AIDS-related illness and deaths, care for sick family members, atten-

dance at funerals, and increased moonlighting. In Zambia, for instance, 1,300 teachers died in the first 10 months of 1998 — twice the number of deaths reported in the previous year. In the Central African Republic, 300 teachers died in 2000, 85% due to AIDS. Several African countries are reportedly losing more teachers than the number of new recruits. HIV/AIDS also reduces the demand for basic education, due to the family's inability to pay for schooling, concerns about sexual activity at school as they are not always sanctuaries and safe heavens for children and the declining quality of education that make many children and parents lose interest in school. Globally, no progress has been made towards the target of reducing the HIV prevalence among young people.

Maternal Mortality

Complications during pregnancy and childbirth cause the death of approximately 500,000 women each year — about one every minute. But measuring maternal mortality is notoriously difficult due to under-reporting and incorrect diagnoses. Countries with a comprehensive vital registration system represent less than one-quarter of the world population.

Together with income-poverty, the maternal mortality ratio is among the most difficult indicators to monitor. But there is consensus that the proportion of births attended by skilled health personnel — doctor, nurse or midwife — is very closely correlated with maternal mortality. Access to care by a skilled health provider at childbirth — when obstetric complications are most likely to occur — greatly reduces maternal mortality.

In 1990, the target was set to reduce maternal mortality by half by the year 2000. In developing countries, the proportion of births attended by skilled health personnel increased from 42% to 53%, respectively. This was just over a third of the agreed target.[9] Not surprisingly, the goalpost was changed to reducing the maternal mortality ratio by three-quarters by 2015, which is slightly less ambitious. But the current rate of progress will have to increase more than three-fold if the target is to be met by 2015. Globally, the world is not on track to reaching the target for maternal mortality.

Progress differed across regions. Sub-Saharan Africa and the Middle East saw little or no change, whereas North Africa and East and South Asia observed considerable progress. Latin America and the Caribbean, with the highest percentage of births attended by skilled health workers, saw moderate progress. High fertility, combined with high maternal mortality risk, make a woman in Sub-Saharan Africa face a 1-in-13 chance of dying in childbirth over her lifetime, compared with 1-in-160 in Latin America and the Caribbean, and 1-in-280 in East Asia. In industrialised countries, the risk is 1-in-4100.

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[9] Assuming a proportionate change in the maternal mortality ratio and the percentage of births attended by skilled health personnel.

Safe Water

Safe sources of drinking water include piped water in the house, public standpipe, borehole, protected dug well, protected spring and rainwater collection. In developing countries, coverage of improved drinking water sources rose from 71% in 1990 to 78% in 2000 — leaving an estimated 1.1 billion people without access to safe water.

Progress fell far short of the goal set in 1990 to reach universal access to safe water by 2000. Not only was the goalpost moved to 2015, the new MDG target was lowered from universal coverage to halving the proportion of people without access to safe water. Thus, the new target is nearly five times less ambitious than the initial one. At the current rate of progress, the world is on track to reaching the new target for safe water by 2015.

The fastest progress was made in South Asia; little or no progress was made in the world's poorest nations — the Least Developed Countries. Rural areas lag far behind; the rural-urban gap in terms of access to safe water is greatest in Sub-Saharan Africa, where only 45% of the rural population have access — against 83% for their urban counterparts.

Do the Poor Benefit from "Average" Progress?

There are different ways for reaching a global or national target. At one extreme, it can be achieved by improving the situation of the already better-off segments of society — i.e. a top-down approach. At the other extreme, a target can be achieved by improving the situation of the worst-off population — i.e. a bottom-up approach. Many combinations are possible in between. The evidence suggests that most countries come closer to following the top-down rather than the bottom-up approach. Frequently, the poor are not fully taking part in national progress; evidence suggests that disadvantaged groups are often bypassed by "average" progress.

Different groups in society usually have very different levels of social and economic wellbeing — based on characteristics such as gender, age, rural/urban location, region, ethnicity, religion, wealth, and any combination thereof.[10] Disaggregated data confirm that social indicators vary enormously across groups within the same country. Thus, national indicators hide wide disparities.

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[10] Therefore, generalisations about the feminisation of poverty should be used with caution. Statements such as "70% of the poor are women" are not always backed by hard evidence. Aggregates and averages can be used — and abused — to back either side of an argument. The 1997 Human Development Report points out that not all evidence supports different poverty levels between male — and female-headed households (UNDP, 1997). A recent World Bank report on rural poverty in China states, "available evidence does not suggest that women are greatly over-represented among the poor"' (World Bank, 2001). Gender discrimination does not occur indiscriminately, but is often mediated through a multitude of factors. Gender, for instance, is more a liability to a poor girl than to her non-poor counterparts, to a girl from an ethnic minority than to one from the majority, to a rural girl than to an urban one.

Data from over 40 demographic and health surveys show that a child from a poor family is invariably more likely to die before age five than her counterpart from a rich family — on average, about twice as likely. Similarly, children from poor families are less likely to complete primary education than children from rich families. Data for 12 countries in Latin America show that over 90% of the children in the top income-decile complete primary education. The share falls to two-thirds for children in the middle-decile and drops below 40% for children in the bottom decile (IDB, 1998).

Given these significant differences in the absolute value of social indicators across groups, progress is likely to be very different for different groups. Indeed, an increase in a national indicator does not necessarily mean that all groups will see their situation improve at the same rate.

Demographic and Health Surveys for 1994 and 1997 in Bangladesh, for instance, show that improvements in access to basic education benefited foremost the children from better-off families, while children from poor families saw little or no improvement.[11] In Peru — where access to primary education worsened in the 1990s — only the poor bore the consequences; the non-poor were not affected. Data for over 40 countries indicate that poor children represent a growing proportion of the "education queue" as the national indicator for education improves, suggesting that the poor find themselves often at the end of the queue and do not always benefit from "average" progress.

There are 24 countries with at least two Demographic and Health Surveys between the late 1980s and the late 1990s, which makes it possible to track progress in child mortality across different groups in the same country. They show that disparities across wealth groups widened in the majority of them. The gap between the bottom and top quintiles increased most significantly in Brazil, Colombia, Dominican Republic, Ghana, Indonesia, Kazakhstan, the Philippines and Zimbabwe (diagram 3).[12]

In Indonesia, for instance, children in the bottom quintile witnessed a reduction in U5MR by one-fifth between 1987 and 1997; those in the top quintile saw a reduction by one-half. Thus, the ratio of U5MR for the bottom quintile over that of the top quintile rose from 2.3 to 3.8. The trend in Zimbabwe was even starker; a decline in average under-five mortality masked a rise in the number of deaths of children in the poorest fifth of the population. Between 1988 and 1999, the national under-five

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[11] DHS surveys do not collect income or consumption data, but the information on household assets such as a bicycle, radio, size of the dwelling, type of construction materials, and source of drinking water allows cross-tabulation social indicators by socio-economic groups, as has been done by Filmer and Pritchett (1999) and Gwatkin *et. al.* (1999).

[12] Only two countries — Guatemala and Togo — reported a significant improvement over time in child mortality for the poorest quintile vis-à-vis the richest quintile.

mortality rate decreased by a modest four percentage points, but that for the bottom quintile actually increased by some 20 percentage points. By 1999, children in the poorest quintile had a U5MR that was four times higher than that for their counterparts in the richest quintile. Thus, the average trend had little to do with the reality faced by poor Zimbabwean children during the 1990s. Indeed, averages can be deceiving.

On the income front, disparities are also on the rise. A growing body of data suggests that income disparities are widening, both between and within countries.[13] No matter how it is measured, it is increasingly difficult to dismiss the evidence that inequality is on the rise. Disparities are not only increasing between the rich and poor, but also among the poor. Nigeria, for instance, saw the poverty headcount index decline by nine percentage points between 1985 and 1992; but the incidence of extreme poverty increased by three percentage points (Demery and Squire, 1996). This led to the paradoxical situation in which the number of poor declined, yet the number of destitute people increased. A similar story emerges for rural Kenya and rural Tanzania.

In sum, averages do not tell the full story. Groups for which social progress has been fastest seldom represent the disadvantaged people. Some countries appears to be on track for reaching a particular target, based on "average" progress; yet the situation for disadvantaged groups is stagnant or deteriorating. As disparities are widening for

Diagram 3: Under-five mortality by wealth group in selected countries *(ratio of average U5MR for bottom/top quintile)*

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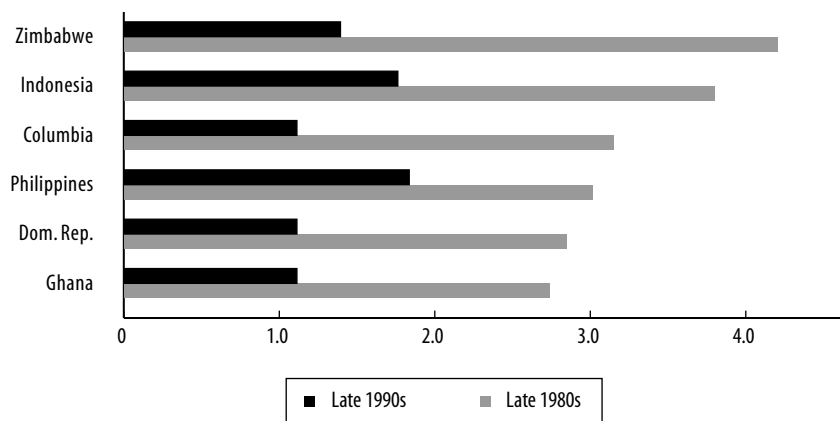
[13] See UNCTAD (1997); Galbraith *et. al.* (1998); UNDP (1999), Cornia (1999) and Milanovic (1999).

a range of indicators — such as income, mortality and education — the informational value of national averages is gradually decreasing, thereby augmenting their potential to induce misleading conclusions.[14]

Are the MDGS Affordable?

Why are the promises not being kept? Why are hundreds of millions of people struggling to overcome the daily grind of hunger, disease and ignorance when the global economy is experiencing unprecedented prosperity? Many reasons account for this apparent paradox, and they are often country-specific. However, two reasons stand out in virtually all countries: (i) under-investment in basic social services; and (ii) public action that frequently fails to take advantage of cross-sectoral synergies.[15]

Recognising the fact that global goals will require extra money as well as new approaches, the United Nations proposed the 20/20 Initiative (UNDP *et. al.*, 1998). It embodies the principle of shared responsibility for the MDGs by encouraging developing countries to allocate about 20% of their national budget to basic social services; and developed countries to devote about 20% of their development assistance to the same services. Experience shows that once access to an integrated package of basic social services of good quality becomes universal, social progress can be dramatic and economic growth can be sustainable and equitable.

But instead of a "20/20" deal, the reality comes closer to a "12/12" ratio (diagram 4) (UNICEF and UNDP, 1998). Governments in developing countries spend, on average, between 12-14% of the national budget on basic social services. Donor countries allocate, on average, about 10-12% of their aid budget on these services. Both shares have shown an upward trend in recent years, but they fall far short of the share of 20% that is accepted as a minimum — based on the experience of high-achieving countries such as Botswana, Costa Rica and the Republic of Korea.

Reaching the MDGs will require universal access to basic social services of good quality. The financial cost of reaching universal coverage is modest, whereas the benefits that beckon are enormous. Global public spending on basic social services falls short

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[14] An example of "'misplaced concreteness" is the well-publicised finding that income of the poor rises one-for-one with overall per capita income (Dollar and Kraay, 2001). Although the finding may be statistically correct, it is not necessarily true. When the same statistical analysis is applied to random values, the same results are obtained. The argument that a one-for-one relationship exists between the income of the poor and average per capita income is more the result of using aggregates and averages, rather than of actual behavioural relationships. It is striking how a simple analysis based on a set of aggregate averages can exert so much influence on so many people — policy-makers, researchers and journalists alike.

[15] Too often, health goals are pursued through health interventions alone; education goals are pursued through education programmes alone. Basic social services comprise an integrated package of basic education, primary health care, nutrition, reproductive health, water and sanitation.

by about $80 billion per year (at 1995 prices) of the level required to ensure univer-
sal coverage (UNDP *et. al.*, 1998).[16] The full implementation of the 20/20 initiative
would generate enough resources to close this financial gap. Although large in
absolute terms, $80 billion represents about one third of 1% of global annual
income. Indeed, achieving the MDGs is more about setting priorities than about
mobilising extra resources or making technological breakthroughs.[17]

Diagram 4: Under-investment in basic social services
(spending on basic social services as percentage of national budget and ODA)
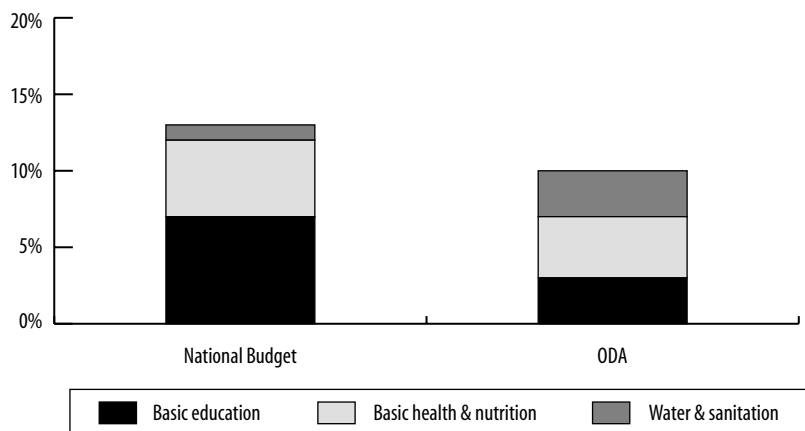

Source: Based on UNICEF and UNDP [1998]

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16 Estimating the cost for reaching the MDGs is a complex task, which is beset by serious methodological problems. Unit costs in absolute terms vary greatly from country to country because salaries dominate the cost structure, which relate to the level of economic development. In addition, expressing them in a common currency, such as the US dollar, introduces more inaccuracies. Unit costs vary much less when expressed in relative terms (as a percentage of per capita income). Using average regional unit costs unduly inflate the cost of reaching the target; relative country-by-country unit costs are preferable. However, average costs may lead to considerable under-estimation because reaching the last 10 or 20% of the population with basic social services is likely to be more costly (i.e. marginal costs will exceed average costs). On the other hand, efficiency gains can reduce overall costs, but improving quality may off-set these gains. HIV/AIDS has significant cost implications, but its quantification is virtually impossible given current knowledge and available data. Furthermore, calculating the costs of the each MDG separately will unduly inflate the total cost because synergies and complementarities will be missed. Last, but not least, dividing total cost between domestic sources and ODA flows is subject to judgment, and can always be challenged. Thus, costing the MDGs is not as straightforward as is seems at first glance. Approximating it by using the 20/20-rule is unlikely to be less "scientific" than other approaches.

17 Reaching the MDGs will not only require extra spending, but also better spending. Money alone will not solve the problem; human and institutional capacities need improvement too. However, the argument that existing resources must be used more efficiently first before investing extra money in basic social services misses the point that insufficiencies often create inefficiencies. For example, when teacher salaries absorb 98% of the budget for primary education but fail to provide a living wage, there is little scope for improving the quality of education. Indeed, inefficiencies and insufficiencies are not independent, but very much interdependent.

Although the MDGs appear affordable at the global level, many governments will be hard pressed to meet the financial requirements for achieving the targets by 2015. Sub-Saharan African and South Asian countries, in particular, will need to expand their budgetary outlays on basic social services at a rate that will be not be sustainable without additional assistance — in terms of aid, debt relief and trade. It would be unrealistic to expect that low-income countries can meet the MDGs without additional and concerted international support.

Official development assistance (ODA) and debt relief will be indispensable, especially for the least developed and low-income countries. A steady decline in ODA characterised the 1990s, when the relative aid effort fell by one third — dropping from 0.33% of the combined gross national income of developed countries in 1990 to 0.22% in 2000 (diagram 5) (OECD/DAC, 2001). It now stands at less than one-third of the agreed target of 0.7%. The total shortfall vis-à-vis that target amounts to about $125 billion per year. Aid efforts vary considerably among donor countries,[18] and none of the G-7 countries is a member of the "G-0.7" group, which comprises Denmark, the Netherlands, Norway and Sweden — and more recently, Luxembourg. An extra $50 billion per year in donor resources — as called for by the UK Chancellor of the Exchequer (Brown, 2001) — would go a long way towards reaching the MDGs at the global level.

Diagram 5: ODA in decline *(total ODA as percentage of combined gross national income of donor countries)*
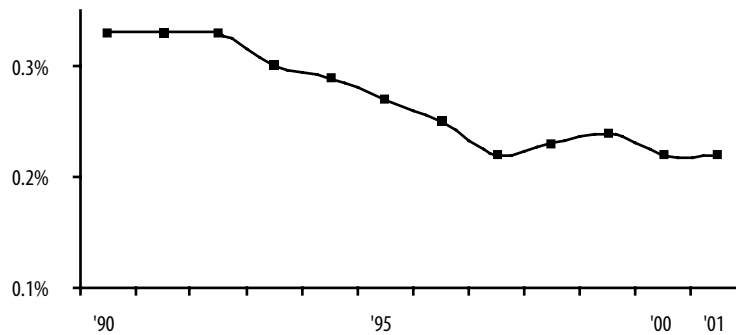
Source: Based on OECD/DAC (2001)

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[18] In 2000, they ranged from a high of 1.06% of gross national income for Denmark to a low of 0.10% for the United States. The aid effort of G-7 members is considerably lower than that of non-G7 countries. In 2000, the respective averages were 0.19 and 0.45% of their combined income.

A study of budgetary spending in 30 developing countries found that two thirds of them spend more on debt servicing than on basic social services (UNICEF and UNDP, 1998); with some spending three to five times more on debt. In Sub-Saharan Africa, governments spend about twice as much to comply with their financial commitment vis-à-vis external creditors than to comply with their social obligation vis-à-vis their people. Debt servicing often absorbs between one third and one half of the national budget — making macro-economic stability an elusive goal. To spend more on external debt than on basic social services — when tens of millions of people see their fundamental human right denied — is ethically wrong and makes no economic sense. The HIPC initiative (Heavily Indebted Poor Countries) is a first attempt to resolve the debt problem comprehensively, but its implementation is painfully slow, while declining commodity prices are making it increasingly ineffective.[19] Slow debt relief will often mean slow MDG progress.

Summing Up

The MDGs are technically feasible and financially affordable. Yet, the world is off-track to meeting them by 2015. The MDGs are ambitious, but each and every target will be met by some countries, including a few low-income countries. If these countries can achieve the MDGs, there is no reason why others cannot.
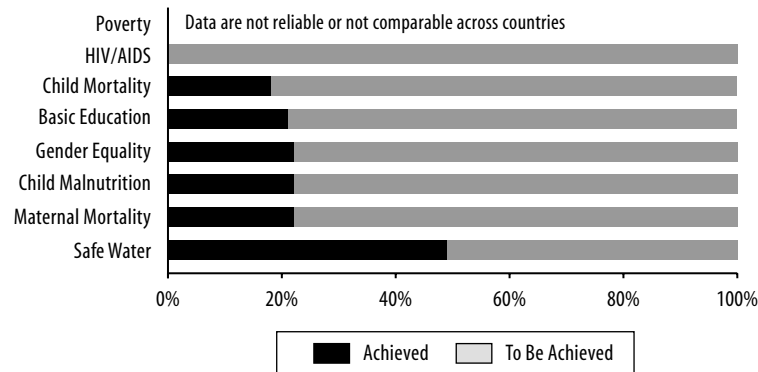
Diagram 6 summarises global MDG progress so far. Of the eight targets listed, only one is on track. Monitoring income-poverty at the global level is subject to serious conceptual and measurement constrains. Global estimates based on the norm of $1/day tend to under-estimate global poverty and over-state poverty reduction (Reddy and Pogge, 2002). Current data on global poverty are simply not robust enough to make an informed judgement as to whether the world is on track towards the 2015 target.[20]

Little or no progress was achieved in reversing the HIV/AIDS pandemic; HIV prevalence rates continue to rise in numerous countries. Only a few succeeded in reducing the spread of HIV, including Cambodia and Uganda. The HIV/AIDS pandemic is a major obstacle on the road towards the MDGs. Progress was slow for child mortality, basic education, malnutrition, maternal mortality and gender discrimination in primary school enrolment. They all recorded about one quarter or less of the agreed target; leaving three quarters or more be covered in the next 15 years. Since the MDGs are to be achieved between 1990 and 2015, 40% of the road should have been covered by 2000. Instead, they recorded just over half that level.

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[19] The criteria for eligibility under the HIPC initiative are exclusively trade-related, despite the obvious fact that it is government, not exporters, that repay external debt. The "enhanced" HIPC initiative does not take into account the fiscal burden of debt servicing in determining a country's external debt sustainability.

[20] Progress toward the poverty target is best measured on the basis of national poverty lines, although this will not readily produce internationally comparable poverty data. However, the quest for comparable data in this area has been rather elusive so far.

Diagram 6: Broken promises of the 1990s *(share of the target covered in the 1990s, unfinished agenda for 2000-15)*

Poverty	Data are not reliable or not comparable across countries	
HIV/AIDS		
Child Mortality		
Basic Education		
Gender Equality		
Child Malnutrition		
Maternal Mortality		
Safe Water		

0%   20%   40%   60%   80%   100%

■ Achieved   ▢ To Be Achieved

Only a fifth of the education target was achieved in the first 10 years, leaving 80% to be covered in 60% of the time period (between 2000 and 2015). No matter what the challenge is — HIV/AIDS, child mortality, malnutrition, income-poverty, maternal health, gender discrimination or environmental degradation — basic education is invariably at the centre of the solution. Failure to keep the promise to give each and every child a good basic education will undermine the chances of reaching the other MDGs.

There is no good reason why universal primary education should not yet be a practical reality. Progress toward that goal is truly discouraging: its global cost is perfectly affordable,[21] no new technology breakthroughs are needed to get all children in school; there is consensus that it makes good economic sense,[22] and basic education is a fundamental human right that must not be denied to any child.[23] But if these conditions are not enough to ensure success, then the question arises as to what it will take to meet the other MDGs.

Only one MDG is on track, the one of halving the proportion of people without access to safe water by 2015. However, the current rate of progress may not be sustainable; countless countries face acute water shortages in the near future if no swift and decisive action is taken soon. Wastage, population growth, urbanisation and desertification are gradually leading to looming water scarcity in many parts of the world; industrialisation and modern agriculture are adding to the risk of more water pollution. Future conflicts over the allocation of fresh water resources are likely to slow down progress in the years to come.

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[21] See Delamonica *et.al.* 2001.

[22] Numerous empirical studies have documented the critical role of basic education in the economic and social development in Europe, North America, Japan, and more recently in East Asia (e.g. World Bank, 1993)

[23] Perhaps it is the most "human" of all human rights, since it is reading and writing that sets homo sapiens most apart from all other species.

Not only was global progress inadequate in the 1990s, much of it bypassed the poor. Slow "average" progress was compounded by limited progress for the poorest and disadvantaged groups within countries. Global goals are primarily meant to help improve the situation of the poor and the disadvantaged, not only that of better-off and privileged people. Unfortunately, the poor have benefited proportionately little from "average" progress, as evidenced by widening disparities in terms of income, education and mortality.

In sum, the world is not on track to meeting the MDGs by 2015. In 2001, Nelson Mandela asked, "*Will the legacy of our generation be more than a series of broken promises?*" In opening the Children's Summit in May 2002, Kofi Annan, UN Secretary-General, stated, "We the grown-ups must reverse this list of failures." In 1993, the late James Grant, then UNICEF Executive Director, said, "The problem is not that we have tried to eradicate global poverty and failed; the problem is that no serious and concerted attempt has ever been made." Sadly, these words still ring true today.

But while the MDGs remain unfulfilled, they also remain feasible and affordable. Committed leadership, stronger partnerships, extra money, and deeper participation by the poor can bring the world back on track towards the MDGs. It is not too late to realise the dream by 2015.

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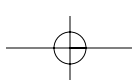
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