# A Successful Failure: The Millennium Development Goal Project in Tanzania

Kirsten Davis
International Relations Master's Program
McCormack Graduate School of Policy and Global Studies
University of Massachusetts, Boston
May 16, 2011

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## Abbreviations

| | |
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| AIDS | Acquired Immune Deficiency Syndrome |
| ERCHI | National Package of Essential Reproductive and Child Health Interventions |
| FAO | Food and Agriculture Organization of the United Nations |
| FDI | Foreign Direct Investment |
| GDP | Gross National Product |
| HIV | Human Immunodeficiency Virus |
| ICT | Information and Communication Technology |
| IMF | International Monetary Fund |
| ITN | Insecticide Treated Nets |
| JDI | Japan Development Institute |
| MDGs | Millennium Development Goals |
| NACP | National AIDS Control Programme |
| NGO | Non-Government Organization |
| NICTP | National Information and Communications Technologies Policy |
| NRMSP | National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania |
| NSGRP I | National Strategy for Growth and Reduction of Poverty I |
| NSGRP II | National Strategy for Growth and Reduction of Poverty II |
| ODA | Official Development Assistance |
| OECD | Organization for Economic Cooperation and Development |
| PEDP | Primary Education Development Plan |
| PHSDP | Primary Health Services Development Program |
| PRSP | Poverty Reduction Strategy Paper |
| SEZ | Special Economic Zones |
| TB | Tuberculosis |
| TCAIDS | Tanzania Commission on AIDS |
| TMTP 2020 | Tanzania Mini-Tiger Plan 2020 |
| UNICEF | United National Children's Fund |
| USAID | United States Agency for International Development |
| VISION 2025 | Tanzania's Development Vision 2025 |
| WHO | World Health Organization |

*"Our mission was called a successful failure in that we returned safely but never made it to the moon."*
*Tom Hanks, Apollo 13*

## Introduction

Millions of people in the world suffer from absolute poverty, do not have access to clean water, live with unsatisfactory sanitary conditions, have no access to health care and die unnecessarily from disease. The Millennium Development Goal project (MDG) looked to change that. It is a fifteen year program whereby governments would establish and implement policy to change the conditions within their country, and donor nations would help fund the project. Now, with only four years remaining on the Millennium Development Goal project, many nations are showing improvements, but virtually all of Africa has not recorded the same success. The focus of the MDG program in Africa has now shifted to the failures of this program, but does not seem to acknowledge the successes within those failures, what I term a 'successful failure'.

This paper will give an understanding of why the MDG project was created, and using Tanzania[1] as a case study, provide an understanding of the problems within Tanzania itself, delve into the policy papers used for the project's implementation, focus on the successes, failures and successful failures of the project, and provide recommendations on how Tanzania can use this analysis to further its development. I acknowledge that in discussing the success and failure of the MDG program in Tanzania, it is not to be interpreted to blanket the entire MDG program, but only attributable to this one country.

[1] Due to the substantial differences in social and economic structure, environment, historical background, size, etc., the island of Zanzibar is treated under the MDGs as a separate entity. The Zanzibar data varies in such a large degree from mainland Tanzania, that to include it would misrepresent the actual conditions in mainland Tanzania. For this reason, the data collected on Zanzibar is separate and distinct from the mainland of Tanzania. This report focuses only on mainland Tanzania, and does not include or reference the island of Zanzibar.

In addition, this report uses data and information that pertains to Sub-Saharan Africa only, and any mention of 'Africa', should be understood to mean only the Sub-Saharan African nations, and not inclusive of the North African nations.

**Millennium Development Goals**

In September 2000, the General Assembly of the United Nations adopted Resolution 55/2 - United Nations Millennium Declaration. Resolution 55/2 acknowledged the need for the global community to protect those most vulnerable in the world. While the Resolution details the impediments to peace in the world, the basic standards of life that people should be afforded, and the commitment nations need to promote peace and tolerance, it also commits to changing the conditions that the world's most poor live under. This Resolution marks the stage where the international community takes notice of abject poverty in the world, and establishes a list of goals to reduce poverty, educate the world's children, reduce the spread of key infectious diseases, protect the environment and increase access to clean water. (United Nations, 2000)

The MDGs were developed by a team of United Nation backed task forces that relate to the specific goals listed below, the Secretariat of the program and innumerable contributors in government, financial organizations and NGOs. At the time of the undertaking of the MDG project more than 1 billion of the world's population lived in extreme poverty, defined as the inability for people to survive due to hunger, disease and other surrounding factors; 600 million suffered from hunger; millions of children died before their fifth birthday; and millions of mothers died giving birth to their children. In addition, millions of people had no access to clean water, basic health care or education. The MDGs looked to reduce these numbers, some by half, others by two-thirds, three quarters or even completely. The program is 'country-based' meaning that it is each country's responsibility to design and implement programs to succeed,

with outside actors acting only in a supporting role. This puts the responsibility onto a country's leadership to be accountable to its people for the improvement, or decline, of the nation's conditions under the MDG program. (UN Millennium Project, 2005) Donor countries committed to providing 0.7% of their gross national product to fund the MDG project, yet only 16 of 22 of the Organization for Economic Cooperation and Development (OECD) nations have created a timeline to provide such support. (Sachs & Schmidt-Traub, 2006)

The enactment of policy within each country was to be formulated in four steps. First, the country would need to collect data and map poverty levels by location and gender; conduct a needs assessment to determine what the country would have to invest in order to achieve the goals; establish a 10-year plan utilizing those investments; and lastly draft a short-term poverty reduction strategy plan. (UN Millennium Project, 2005)

Contrary to what many people believe, the MDG program is not an Africa-based program, it is a world program. The MDG project encompasses countries in Northern Africa, Sub-Saharan Africa, Latin America and the Caribbean, Western, Eastern, Southern and South-Eastern Asia, the Commonwealth of Independent States in Asia and Europe and the transitional countries of South-Eastern Europe. Unfortunately, unlike many of the other nations participating in the MDG program that have had success in reducing poverty, most African nations have actually deteriorated in the same time span. Africa rates the worst in every measurable indicator under the program: hunger, disease, gender gaps, health, infrastructure, environment, security, communication and access to water. (UN Millennium Project, 2005)

Unlike many nations that are represented under the MDGs, African countries' historical background of colonialism and slavery leads itself to challenges unlike other regional areas. The long term fallout of colonialism and slavery has resulted in most African nations being repressed,

with limited infrastructure and technology, lack of formal economies and major health care concerns, where something as simple as diarrhea is often deadly. It is these challenges that the MDG program hopes to overcome in Africa.

The following eight goals comprise the MDGs:

| | |
|---|---|
| Goal 1 | Eradicate extreme poverty and hunger |
| Goal 2 | Achieve universal primary education |
| Goal 3 | Promote gender equality and empower women |
| Goal 4 | Reduce child mortality |
| Goal 5 | Improve maternal health |
| Goal 6 | Combat HIV/AIDS, Malaria and other diseases |
| Goal 7 | Ensure environmental sustainability |
| Goal 8 | Develop a global partnership for development |

(United Nations, 2003)

The eight goals were further broken down into eighteen targets and forty-eight indicators, which are the quantitative units of measurement to track the progress of the MDGs. (See Appendix A for a complete list of the targets and indicators.) (United Nations, 2003) In 2006, the General Assembly of the United Nations voted to increase the targets to twenty-one, which included "full and productive employment and decent work for all," "universal access to reproductive health" and "significantly reduce the rate of loss of biodiversity." (United Nations, 2006) These goals are interconnected with each other. Much of the success of one goal is dependent and/or co-dependent on one or more of the other goals. For example, improvements in education may increase the ability to combat disease, which could then reduce child mortality.

The indicators were created by the World Bank Development Research Group. The data is collected utilizing household surveys, census data, data reported by agencies within the country, and also by other outside agencies such as UNICEF, WHO, FAO, USAID and other organizations who utilize surveys and other data collecting methods. The data is then applied into statistical formulas to extrapolate a quantitative number that is used to represent the country's data for that indicator. (United Nations, 2003) It is important to note however, that while the MDG program began in 2000, and since data requires significant time to collect, process and analyze, the program uses 1990 as the baseline year in order to show trends over a larger time frame. (United Nations, 2007)

There are some limitations and notes of interest regarding the data collected. The data that is generated and the final figures that are presented are country-level, and while internally the data collected is representative of both urban and rural living, as well as taking in gender related issues, among others, the final established indicator figure does not show the large differences between the two poles of information. (United Nations, 2003) For example, data under Indicator 1A (% of population below the national poverty line) is collected by showing the total percentage (i.e. 38.6%), but also by rural (40.8%) and urban (31.2%) percentages as well. (See Appendix B: Data, 1.1, lines 2-4) This further breakdown shows that there are actually sixty measurable indicators, which are then combined into the forty indicators discussed above, and as shown on Appendix A. (United Nations Statistical Division)

In addition, the household surveys can differ from year to year, and those administering them can do so differently from one geographic area to another or from one survey year to another. Also, definitions of indicator measurements (i.e. poverty) can be different between rural and urban areas, and in developing countries, the differences between urban and rural living are

significant. There are also many factors that are specific from household to household that are not taken into account, such as the individuals within the household and their understanding of the survey, their feelings of their status within the community, and the dynamics of the family relationship within the household. Lastly, when data is not available (i.e. inability to collect data in countries with active conflicts areas), estimates are calculated using data reported under other like-indicators. (United Nations, 2003)

**Tanzania**

Background

Tanzania, like most African nations, fell to colonial powers; first to Imperial Germany in the 1870s and then, after the German defeat in World War I, under British control. (Fabian, 2007) In 1961 Tanzania gained its independence from Britain and has, unlike many other post-independent African nations, enjoyed relative political stability since that time. Following independence, there was strong government control working with a socialist agenda. This agenda initially led to improved conditions within Tanzania, but the policies were not sustainable and the conditions began to deteriorate. The agenda then began shifting towards democratic governing. (U.S Department of State; United Republic of Tanzania, 2002) Currently, the country has a multiparty system with the presidential elections held every 5 years. (CIA, 2011)

Tanzania benefits from an 800 km long coastline on the Indian Ocean, borders eight African nations and contains 885,800 sq. km of land. It also benefits from having large bodies of water: Lake Tanganyika, Lake Victoria, Lake Nyasa and Lake Manyara, and Mount Kilimanjaro, as well as an abundance of wildlife. It suffers from flooding in the central plains, and has experienced severe droughts that have had significant impacts within the country. (CIA, 2011).

A general overview of the economic situation in Tanzania and the key issues facing the country follow.

***Economy***

The foundation of implementing policy and the success of the MDG program lies with a strong, sustainable and competitive economy. Unfortunately, while Tanzania has many resources available, it has failed to turn them into continued growth. The decade of 1998-2008 brought about a 3.3% increase in the annual rate of economic growth in the country, from 4.1% to 7.4%. The economy is supported by its natural resources, agriculture, the service sectors, and also by donor support. Currently, the most growth is in the services sector, while the agricultural sector has had limited growth. (Research and Analysis Working Group, 2009)

The global downturn, together with a drought in 2008/2009 resulted in a direct shock on Tanzania's economy. The increase in the cost of food, oil and other imports, and decreases in investments, donor funds, exports and tourism revenues, led to reduced economic growth, and was a serious impediment to reducing poverty. Prior to the economic downturn, Tanzania was averaging a 7% annual growth, in line with the projected growth under the NSGRP II to support development under the MDG project. (Ministry of Finance and Economic Affairs, 2010)

In 2006, Tanzania recorded an 11.7% national unemployment rate, with significantly higher rates in urban areas (16.5%) than in rural areas (7.5%). Women and youths tend to represent the majority of the unemployed. There are approximately 800,000 people entering the job market each year, with only 40,000 jobs available in the formal economy. This lack of growth in the formal economy is forcing individuals to find employment in the informal economy, thus less of a contribution to the overall economy. (Komba, 2008)

### *Agriculture*

Agriculture lies at the center of success and/or failure of the MDGs in Tanzania. Agriculture composes almost one-half of Tanzania's GDP, and rural areas are nearly completely dependent on agriculture for their basic needs. Given the conducive conditions in Tanzania for agriculture, it has the potential to bring significant change to the situation in the country, not only to feed its poor, but also become market-based and provide food exports to other nations. Currently, there are significant impediments in the agricultural sector. The country presently cultivates only one-third of its available land, and 70% of the agricultural work in rural areas is done by hand and entirely dependent on rainfall. Because of this reliance on rainfall, when the country suffers from drought it has a direct affect on the levels of food production. A negative change in food production leads to continued hunger, undernourishment, loss of wages/employment, and exacerbates the levels of poverty. (Ministry of Finance and Economic Affairs, 2010) (CIA, 2011) In order for the country to begin using agriculture to its advantage, it must make substantial investments in the country's infrastructure and agricultural technology, including irrigation.

Under the above circumstances, agriculture as it presently stands in Tanzania is an impediment to the success of the MDGs. However, with proper investment in technology, infrastructure and education, agriculture can be the tool for success in Tanzania. With increased and sustainable food production, those suffering from hunger (Goal 1) would decrease, which would then have impacts on maternal health (Goal 5), child mortality (Goal 4) and trickling affects on the remaining goals as well.

***Natural Resources/Mining***

Prior to economic reforms in the 1980s, the mining industry was state run. With the ongoing macroeconomic policy changes, the mining sector has been transforming in the country and becoming a magnet for foreign direct investment. As with mining in other natural resource rich countries in Africa, Tanzania contends with corruption and banditry of its resources. (Tanzania Chamber of Minerals and Energy)

Natural resources and mining in Tanzania is the core of Goal 7 of the MDGs: ensuring environmental sustainability. Tanzania is enriched with many minerals, such as diamonds, gold, iron, natural gas, oil and uranium. These resources, as with agriculture, have the potential to bring great wealth into the country. Unfortunately, the lack of technology, unskilled labor and proper resource management affects the progress in this sector. Mining is not performed in a sustainable fashion, and without proper regulations and training in place, Tanzania runs the risk of depleting its resources. In addition, without the proper mining methods, it also risks harming the environment. Not only is contaminated water a byproduct of improper mining methods, but forest depletion, carbon dioxide air pollution, and overuse of energy resources are harmful consequences. (Ministry of Finance and Economic Affairs, 2010; CIA, 2011)

***Services/Tourism***

While tourism is not part of the MDG program, it is a significant factor in the success of the program. Tourism receipts contribute 12.9% towards Tanzania's GDP, and account for 11.2% of employment in the country in services such as lodging, food, beverage, communication, car hire, shopping and tours. (Wold Travel & Tourism Council, 2011)

Tourism revolves around the country's wildlife and marine parks, game reserves and conservation protection areas, having allocated 25% of its land mass to be preserved, the most of

any country in the world. The country is also rich in historical and cultural elements, such as early human discoveries in Olduvai Gorge, Maasai handicrafts, museums depicting slave trade, in addition to the beautiful white sandy beaches along its long coast on the Indian Ocean. These elements provide for a strong tourism market in Tanzania. The following chart represents the number of visitors to Tanzania and the receipts attributable to those visitors. (Ministry of Natural Resources and Tourism, 2010)

| Year | Number of Visitors | Receipts (in millions) |
|---|---|---|
| 1995 | 295,312 | $259.44 |
| 2000 | 501,669 | $739.06 |
| 2005 | 612,754 | $823.05 |
| 2009 | 714,367 | $1,259.82 |

(Ministry of Natural Resources and Tourism, 2010)

The global economic decline had a negative effect on receipts from 2008 to 2009, but the industry appears to have regained strength in 2010, although formal statistics as shown above are not yet available. (Ministry of Natural Resources and Tourism, 2010)

Ensuring Tanzania's environmental sustainability (Goal 7) by protecting these resources is paramount to increasing tourism and economic growth in the country. In addition, the success of tourism will have a positive effect on the economy, thus helping to alleviate poverty.

***Poverty***

The Human Development Index measures "a long and healthy life, access to knowledge and a decent standard of living" to score nations level of human development. Tanzania ranks 148 out of 169. This ranking indicates that Tanzania's "growth, social well-being and governance" continue to be some of the lowest in the world. Without addressing these issues,

Tanzania will continue to be one of the poorest nations in the world. (United Nations Development Programme, 2010) Currently, more than 33% of the Tanzanian population falls below the basic needs poverty line, as the people do not have enough income to meet their basic daily needs. Nearly 98% of households in Tanzania spend less than $40 per adult per month on their basic needs. When taking into consideration the growth in population, the number of Tanzanians living in poverty during the life of the MDGs has actually increased over the life of this program, now at more than 12 million people. (Research and Analysis Working Group, 2009)

Clearly, given that the overall purpose of the MDG program is the alleviation of poverty, and Goal 1 specifically relates to the reduction of the world's poorest population by one-half percent during the life of the program, the fact that Tanzania's poor have actually increased over the life of the program would cause someone to deem the program a failure. This lack of decrease of the nation's poor has become what is referred to as the agriculture curse. Rural areas in the country account for 87% of the poor and, as shown above, the rural population relies mostly on agriculture for their sustenance and livelihood. (Ministry of Finance and Economic Affairs, 2005) This reliance on agriculture creates a direct link to poverty, and without the proper tools for increased agricultural output, will continue to have a negative impact on poverty levels in the country. When that impact is combined with one of the fastest rising populations in the world, it will lead to continued difficulty in improving child mortality (Goal 4), maternal health (Goal 5), disease control (Goal 6), and certainly would influence the remaining goals' success. (USAID Health Policy Initiative, 2010)

***Health/Water/Sanitation***

*Health*

The most damaging to life in Tanzania is the high rate of communicable diseases. Malaria, HIV/AIDS related illness, tuberculosis, pneumonia and diarrhea account for nearly 79% of the deaths in the country, with malaria being the main cause of death of children in Tanzania. (WHO, 2010) Statistics relating to HIV/AIDS are alarming: 1.4 million living with HIV, 1.1 million children who have lost a parent, or both, to AIDS-related causes, and the HIV rate in urban areas is twice that found in rural areas. There remains a significant stigma surrounding HIV/AIDS and those who are known to be positive suffer from bigotry and intolerance. (USAID Health Policy Initiative, 2010) AIDS prevalence in Tanzania is approximately 5.7% of the population. Not only is access to condoms addressed by the Tanzania Commission for AIDS, but also the social factors that contribute to the large number of those infected including lack of knowledge regarding transmission, cultural stereotypes, increased sex worker industry, substance abuse, violence against women and traditional cultural practices, including widow cleansing, whereby women are forced to have sex with relatives of their deceased husband in order to allow his spirit to be free. (United Republic of Tanzania, 2008) Malaria statistics are no less alarming. Due to the climate in Tanzania, conditions for malaria transmissions are quite favorable. In fact, 90% of the population of Tanzania is at risk for contracting malaria, the third highest risk in the African continent, only ahead of the Democratic Republic of Congo and Nigeria. (Ministry of Health and Social Welfare, 2010)

In addition to disease, basic health care is limited or non-existent, especially in the rural areas. There are only two doctors for every 100,000 people in Tanzania, and there are no emergency medical services in the country. (American College of Emergency Physicians, 2011; USAID, 2009) Traditional healers are utilized more in rural areas for not only spiritual purposes, but for serious medical concerns as well. During a visit to a traditional healer in Bagamoyo,

Tanzania, I learned that this healer recognized two different types of HIV/AIDS. One is the disease which would require medical intervention, and the second was bad spirits infiltrating the sick individual. Through a treatment of local plants mixed with water and spirits, and specific incantations, people with this second type of HIV/AIDS could be healed. These local treatments were also used for malaria, diarrhea and other life threatening illnesses. This reliance on traditional medicine for deadly illnesses, especially in rural areas, has an effect on the success of the MDGs, in particular mother and child mortality rates, and disease eradication.

The policy papers discussed below placed significant importance on health issues in the country, especially those falling within the time frame of the MDG program. These initiatives included awareness programs, education and even legislation to inform and protect individuals, and also to take steps to reverse the spread of these diseases, which is the target of Goal 6.

*Water*

With the change from a socialist agenda to a democratic macroeconomic agenda, the water industry in Tanzania became decentralized. The result of this swift decentralization was that the local governments now held the burden of supplying water to their people, but did not have the financial means or infrastructure to do so. Those who do provide water services are usually poorly managed, untrained and lack finances to provide better service. (UN World Water Assessment Programme, 2009) This lack of access for the people to clean water has become a significant problem in Tanzania. As the following indicates, not only does the lack of access to clean water affect the health of the people, but it also affects gender roles, education completion rates, maternal health, children mortality rates, environmental concerns and an increase in water-borne diseases – virtually every goal under the MDG is affected by the lack of access to clean water.

There is a significant disparity between urban and rural areas and access to clean water. In 2010, approximately 80% of the urban population had access to clean water, while less than 50% had access in rural areas. (WHO, 2010) In some rural areas, people are forced to use fresh water sources (i.e. lakes and rivers) for their water supply. These mostly stagnant bodies of water are teeming with bacteria and other waste that perpetuates health care issues in the country. In addition to health concerns, gender issues surround access to water. Since it is traditionally the women's role to supply water for the family, women sometimes are required to travel considerable distances for water, and even further during the dry season. This subjects the women to potential dangers of assault, injury and illness. Children are also expected to assist in procuring water, which normally takes precedence over their education. (WaterAid-Tanzania, 2002) Since rural households are less likely to have access to clean water, women and children in those areas are more at a disadvantage in development than their urban counterparts, thus perpetuating rural poverty levels. This remains one of the greatest challenges in Tanzania, and to the MDG project.

*Sanitation*

*"Vyoo vya bwana afya."* Toilets of the health officers

This saying refers to a problem that has plagued Tanzania for decades. There have been policies that govern sanitation that date back to independence. In order to meet the requirements of these policies, imaginary toilets (toilets that were said to exist but never actually did), were created and counted, and are known now as 'the toilets of the health officers'. While the idea of imaginary toilets may seem comical, the sanitary conditions in Tanzania are disturbingly serious. Also, statistical information is now either inaccurate due to these 'imaginary toilets' or does not exist, making an accurate analysis of the situation difficult. (WaterAid-Tanzania, 2002)

One issue that presents itself with respect to sanitation is the need for a behavior change and change in the hygiene culture of the people. This issue becomes a balance between the government providing proper sanitation to the people, and the people actually using it. This emphasizes the need for education (Goal 2) and programs in proper hygiene. Without knowing the link between sanitation and disease and other health concerns, people will continue to ignore what services are provided. (UN World Water Assessment Programme, 2009) The government also has considerable obstacles in providing proper sanitation facilities. Urban areas have limited space to build sanitation facilities on, and building costs are much higher than in urban areas. Also, digging pits, as done in rural areas, poses the potential threat of contaminating nearby water sources. Tanzania does not currently have a policy which funds latrine construction, so this falls onto the family to construct one for their own use. The estimated cost to build a proper pit latrine is approximately $50. (de Waal & Nkongo, 2005) Clearly, when a large percentage of the population spends less than $40 a month on their basic needs, building a $50 latrine is unlikely.

***Infrastructure***

Infrastructure also presents a large issue in Tanzania. The condition of the roadways in Tanzania is a major impediment to the flow of goods in the country, many of which are damaged yearly in the rainy seasons. There are 86,472 km of roadways and only 6,700 km of those are paved. (Ministry of Finance and Economic Affairs, 2010) Road conditions have a direct bearing on the financial situation and poverty levels within the country. When the flow of goods to be imported or exported is impeded due to insufficient roadways, trade and monetary flow is also diminished, and the actual cost of goods increases. Further, food and clean water are not able to be transported easily to those most in need in the rural areas. The railway system is productive,

but has remained virtually unchanged since the early 1900s, and operates at unsafe speeds and conditions. The major ports in Dar es Salaam, Mtwana and Tanga allow a significant amount of goods to be transported to and from the country, but as with the other infrastructure sectors, the lack of management, planning and training has kept most of these sectors working in a reduced capacity. (Thum, 2004) Much of the success of the MDG program in Tanzania relies on the improvements to the country's infrastructure. Without the ability to increase the flow of goods and access to markets and services, the eradication of poverty is unattainable.

***Education***

The key to the future success of Tanzania is educating its children, who will become the future leaders and contributors to society. Not only is primary education a necessity in the fight against poverty, but it has been shown that secondary education correlates to positive economic growth. There are also positive correlations between secondary education and child and maternal health (Goals 4 and 5) and gender equality (Goal 3). In fact, studies show when girls complete primary school, and continue on into secondary school, they have considerably higher incomes, 90% of which they reinvest in their families. (United Nations Children's Fund, 2011)

One key element in creating an educational system that all children are able to take advantage of, thus meeting the targets of Goal 2, is eliminating the fees for attending school, which Tanzania has done. (United Nations Children's Fund, 2011) Unfortunately, while fees have been eliminated for attending primary school, the same is not true for secondary schooling. In addition, those who are able to attend secondary school usually must do so away from their families. Due to financial constraints, students tend to reside together in unsanitary and unsafe conditions, and ultimately become targets for assault and harassment. (Pearson, 2011)

Currently, the net enrollment for primary school in mainland Tanzania is approximately 97%, thus Goal 2 will likely be met by 2015. Although they appear to be on track to meet the goal, the quality of education and the completion rates remain in question. (United Nations Children's Fund, 2009) Dropout rates remain high for both primary and secondary school, especially for young girls who become pregnant. Until recently, a law prevented young girls from returning to school post-pregnancy, but was repealed under pressure from UNICEF. (Bébien, 2010) In addition, there is a disparity between the quality of education in rural and urban areas, and also between boys and girls. In rural areas, there is not as high of an importance placed in educating females as with their male counterparts, and many schools do not have the facilities to accommodate females. (United Nations Children's Fund, 2009)

Tanzania/Millennium Development Goal Policy Papers

The MDG program is a self-help program. The international community recognized that the country must work to repair itself, and not just be handed the cure. This required each country under the MDG program to prepare its own strategy reduction papers and poverty reduction plans. These plans detailed what the country would be required to do in order to succeed under the Millennium Development Goal program, and also the level of funding required for success. In response to this, Tanzania prepared its poverty reduction plan, and two national strategy papers. These papers are the foundation for the MDG program in Tanzania, as they establish the current trends and statistics, and establish procedure on how to implement the MDG program. The papers detail a financial plan and the resources needed to implement the plan, whether from donor assistance or from domestic resources. The importance of these papers to the success of the MDG program is significant, due to the complexity of creating systems, legislations, programs and other initiatives to create workable solutions to existing elongated

problems. (Sachs & McArthur, 2005) In addition to these papers, Tanzania also drafted the Tanzania Development Vision and the Tanzania Mini Tiger Plan 2020, which are significant papers/projects in the development of Tanzania and its overall success in the MDG program. These five projects/programs are discussed in more detail below.

***Tanzania's Development Vision***

There is no real connection between a rural village in Tanzania and the world's globalization. This occurs for several reasons, some of the basics being just the lack of electricity and infrastructure, and also due to the lack of education, skill level, products/goods and money to negotiate with. (UN Millennium Project, 2005)

It is the Tanzania Development Vision 2025 (Vision 2025), drafted in 1995, which acknowledged this changing world, and also admitted that Tanzania did not have the capacity to grow with it. In its forward, President Benjamin William Mkapa stated:

> "We are standing at the threshold of the 21st Century, a Century that will be characterised by competition. It is clear, therefore, that it will be a Century dominated by those with advanced technological capacity, high productivity, modern and efficient transport and communication infrastructure and, above all highly skilled manpower imbued with initiative. If we are to be active participants in the global developments of the twenty-first century we must, as a Nation, find ways of improving and strengthening ourselves in all these areas." (The United Republic of Tanzania, 1995)

Vision 2025 observes that Tanzania had fallen into several negative patterns of behavior, not only from the government, but the public sector and its citizens as well. The country had become dependent on donor aid to support their economy and lift them out of their situation; allowed the national and local economies to be managed by those who did not have proper training or were corrupt; and allowed a steep decline in the quality of education. These behaviors had direct effects on the competency and capacity of Tanzania to benefit from globalization. Vision 2025 acknowledged that Tanzania was not without policy, but rather

encumbered with ineffective policy. The government needed to be held accountable for enacting effective policy which would invest in the country's roads, communication sectors, education, and all other human and natural resources that would help Tanzania become a middle-income nation and no longer one of the least developed nations in the world. (The United Republic of Tanzania, 1995)

While the Vision 2025 establishes what needs to be done to effectuate positive change, it does not create nor develop any policy in which to do so. It is more of a statement to the people of Tanzania that status quo was no longer acceptable, and the nation, the government and the people needed to change or be further left behind. All subsequent strategy documents note that they are drafted to further meet the goals of Vision 2025, which mirror those of the later developed MDGs.

***Poverty Reduction Strategy Paper***

The Poverty Reduction Strategy Paper (PRSP) details the policy reforms necessary to support poverty reduction, as well as the financial demands of implementing those policies. It was drafted in 2000 by the Tanzanian government, with the assistance of the World Bank and International Monetary Fund (IMF). At the time of the drafting of the PRSP, approximately 50% of Tanzanian people were unable to meet their basic food needs. This was an increase from 27% as indicated in the prior 1991 household survey. The PRSP acknowledged that poverty remained the principal problem in Tanzania, and mostly among the rural population who primarily relied upon agriculture for sustenance. Poverty was shown to be caused by inferior or nonexistent technology, lack of farming equipment, poor infrastructure, especially roadways, lack of access to credit and markets, and environmental disturbances. Education and health issues were ranked second and third under poverty for focus under the PRSP. The household surveys used in

preparing the PRSP indicate a need for involvement by the government in increasing the quality of education and to facilitate access to primary schooling. AIDS related deaths, as well as malaria and tuberculosis, remain high, with AIDS related deaths as high as 44.5% of those aged 15-59. The high rates of AIDS related deaths are leading to an increased number of orphans, numbered at 680,000. In an effort to decrease poverty, improve health and education, the PRSP has created economic reformations to support success. Focus on agriculture includes establishing farmer cooperatives, using a voucher system to aid farmers in obtaining fertilizers, and to assist communities in developing irrigation systems so not to be completely dependent on rainfall for food security. There is also a focus on restoring and expanding existing water supplies, and also to protect established water sources. The PRSP also notes that AIDS awareness programs need to be developed within schools to educate the youth on prevention. The government also will need to create and improve road conditions, give special consideration to the most deprived areas, provide training and research to support local communities and improve the flow of goods across the nation and over borders. In addition, the government is implementing computerized systems within the court system, reforming the utility industries to produce cheaper energy and reforming approaches in reducing corruption. (United Republic of Tanzania, 2000)

***Tanzania Mini-Tiger Plan 2020***

Tiger Plans are based on the Asian Economic Development Model, the purpose of which is to accelerate the alleviation of poverty. The plans establish special economic zones (SEZs) to attract investment specifically in the SEZ, as a way to increase development in that area. In the early 1990s, the World Bank approached the Japan Development Institute (JDI) to design a plan for Africa. Due to the political climate and unrest in Africa, the plan for Tanzania was not

designed until 2000. The Tanzania Mini-Tiger Plan 2020 (TMTP 2020) set up SEZs in the northern Tanzanian city of Arusha and in the economic capital of Dar es Salaam. Specifically, the goal of the TMTP 2020 was to increase economic growth to 8-10%; increase GDP, per capita income and export values; create millions of new job opportunities by 2020; and to establish 20-30 SEZs in Tanzania in that time frame. The initial projects, which are ongoing, are the production of plants used to make paper and bio-energy; a joint venture between the Japanese corporation, Sumitomo Chemical, and the local Tanzanian company, A to Z Textile Mills, to create insecticidal nets used to prevent the spread of malaria; and also the processing and refining of copper, gold and other metals in a developed and secure compound that can accommodate the industry. (JDI; Sumitomo Chemical, 2008; PRWeb, 2010; Kwayu, 2006)

***National Strategy for Growth and Reduction of Poverty***

In 2005, Tanzania drafted a National Strategy for Growth and Reduction of Poverty paper (NSGRP I) to continue its efforts to meet the MDGs. The NSGRP I looked to improve on the PRSP by increasing domestic resources through taxation, FDI, better economic policies, development of its private sectors, and an overall accountability of the resources in Tanzania. The NSGRP I also recognized that prior economic policies tended to support urban growth (i.e. manufacturing, wholesale and retail), which has led to a greater poverty gap between urban and rural areas. While the NSGRP I provided new policy initiatives, such as credit reform, reducing tariff barriers, reforming labor laws, reform existing economic sector policy, etc., to build on the prior strategy papers, similar challenges remained – prioritizing and obtaining financing of the needed policy changes. (Ministry of Finance and Economic Affairs, 2005)

Policies created under the NSGRP I were done so in order to achieve success of the MDG program. Policies are implemented through collaborations between the Tanzanian government

and its private sector, international donors and various domestic and international NGOs. Many policies that are generated under the NSGRP I are partnerships between Tanzania, the World Bank and IMF. The policies generally deal with health, agriculture, infrastructure, technology, and the financial sector on a national level. Of the policies created during the NSGRP I, 22 are still active (See Appendix D). (World Bank)

In addition to the national policies between the government and the WB, IMF and other large scale donors, additional policies are generated by the ministries whose task the issue falls under (i.e. policies regarding health issues are developed in the Ministry of Health and Social Welfare, education policies are formulated under the Ministry of Education and Vocational Training) and work on regional or district levels. (United Republic of Tanzania) One such policy example, the National TB & Leprosy Programme, worked in partnership with donor organizations and NGOs to establish the TB/HIV Project in October 2005. This project assessed the then-current TB concerns, promote education and testing, and properly train health care officials over an established 18 districts. (PATH) This policy, among other TB related programs has had positive results towards the TB-related MDG goal.

***National Strategy for Growth and Reduction of Poverty II***

This is the final, and current, strategy paper. It was drafted in 2010 and covers a five year period until the year of the end of the Millennium Development Goal project – 2015. Like the NSGRP I, the NSGRP II acknowledges the improvements that have been made over the prior five year period, and also recognizes that even with those improvements, poverty in the country was marginally reduced and the likelihood of succeeding the MDG goals is unlikely without refocusing and implementing more effective policy. The NSGRP II details a surge of over 300% in secondary education enrollment due to the building of over 2,000 new schools during the

NSGRP I phase. Unfortunately due to economic factors in the country, there is limited support for those schools (i.e. teachers and learning materials). In addition, while there is a great surge in enrollment, completion and/or pass rates have dropped, with a larger number of females not finishing school. This is leading to a larger gender gap between educated men and women in the country. With regard to health care, the government established the Primary Health Service Development Programme, which is working to provide health care services to people in rural areas that are unable to get to larger health care servicers. They have worked to pave roadways, although most of the work done was to maintain existing roadways and bridges, rather than create new or expanded roadway systems. (Ministry of Finance and Economic Affairs, 2010)

**Millennium Development Goals in Tanzania**

The data reported as part of the mid-way evaluation indicates that Tanzania is on target for some of the indicators, others have potential for meeting the goals, but many will not be achieved.

As indicated above, data is collected using household surveys, census data and data gathered by external agencies and organizations. The data is distributed among the sixty MDG indicators, and further compressed into forty-eight indicators. (United Nations, 2003) Those indicators then determine whether the target was reached; and the targets, based on whether or not they met, translate into a success or failure of that related goal (as shown on Appendix A).

The mid-way evaluation in 2008 indicates the potential success and failures of the MDGs by 2015:

| | | |
|---|---|---|
| Goal 1 | Eradicate extreme poverty and hunger | Unlikely to achieve |
| Goal 2 | Achieve universal primary education | Goal is achievable |
| Goal 3 | Promote gender equality and empower women | Goal is achievable |

| | | |
|---|---|---|
| Goal 4 | Reduce child mortality | Goal is achievable |
| Goal 5 | Improve maternal health | Unlikely to achieve |
| Goal 6 | Combat HIV/AIDS, Malaria and other diseases | Unlikely to achieve |
| Goal 7 | Ensure environmental sustainability | Unlikely to achieve |
| Goal 8 | Develop a global partnership for development | Unlikely to achieve |

(Ministry of Finance and Economic Affairs, 2008)

Overall, on the goal level, Tanzania is failing to meet most of the objectives of the MDG project. It is only on track to meet Goal Nos. 2, 3 and 4, while failing to meet Nos. 1, 5-8. On its face, I would evaluate the MDG program in Tanzania an overall failure, since it was unable to meet even 40% of its intended target. I think, however, that in order to accurately determine the success of the MDG program in Tanzania, one must look beyond goal-level, and instead look specifically at the sixty indicators to ascertain what successes have been made. Tanzania may not have been able to meet the target goal, but did it improve enough to call it a success, or what I would term a 'successful failure'. It is from these successful failures that we may be able to determine what actions propelled a positive movement, and potentially apply those actions to other non-successful indicators for future improvement.

In determining whether the indicator was a success, failure or successful failure, I calculated the percentage change from the first and last recorded data sets, as shown on Appendix B. Since data is collected from household surveys in differing years, and other data collecting methods from different time periods, the years of the baseline and current data set are not static for each indicator. As such, I have indicated the years that the data was recorded.

If the calculated percentage change will or is likely to meet the MDG goal, it was categorized as a success. If the percentage change was unfavorable it was categorized as a

failure. A positive change, but one that is not likely to meet the MDG goal, is classified as a successful failure. Data that had no measurable change (< ±8%) and those where the value remained constant, were so noted on Appendix C. As some indicators only record one set of data, those indicators are not included in this analysis since there is no way of determining a percentage change. Given those parameters, the following interpretation of the data set shows that the MDG program records several successful failures, which would otherwise be considered a failure of the overall goal. It is also notable the number of successes and failures within the program, both of which will addressed as well.

Successes

In its 2008 Millennium Development Goal Report, the Ministry of Finance and Economic Affairs of Tanzania stated that the country is on track to achieve Goal 2 (achieve universal primary education), Goal 3 (promote gender equality and empower women) and Goal 4 (reduce child mortality). (Ministry of Finance and Economic Affairs, 2008) However, when we look at the analysis in Appendix C, many of the indicator measurements within those goals (Indicators 2.1 through 4.3) were determined (using the criteria stated above) to be successful failures, rather than successes, and some indicators under those goals did not even register a significant change (> ±8%). What would be notable, however, is that not one of these indicators registered a failure. So it would not be unreasonable to presume that some indicators, while currently classified a successful failure in terms of this analysis, when grouped together, may prove in 2015 to be a success.

One indicator that did register a success was the enrollment in primary education. Enrollment among both boys and girls increased significantly, albeit it at a lower rate for girls. The increases bring the current enrollment rates to over 95%, which is in line to achieve Goal 2.

This success is due to the policies established under the NSGRP I, specifically the Primary Education Development Plan (PEDP). The PEDP focused not only on creating access to a primary education, but also to create a quality education program. One of the major successes of the PEDP was eliminating school fees and contribution requirements. This allowed many children the access to primary school that could not afford to pay the required fees previously. (Sumra, 2003) The plan also was developed to utilize teachers more effectively, expand programs in schools, establish new schools, conduct annual reviews and audits of the program, provide training and access to textbooks and other learning materials. (Ministry of Education and Vocational Training, 2002)

As stated earlier, malaria is the number one killer of children in Tanzania. Using ITNs has shown to have a 20-30% reduction in malaria-related deaths in children. (Erlandger, Enayati, Hemingway, Mshind, Tami, & Lengeler, 2004) In 1995, only 2.1% of children under five were sleeping with insecticide-treated nets (ITNs), yet in 2008, over one-quarter of all children were using ITNs, a percentage change of over 1123%! (Appendix C) The increase in access to ITNs is due, in part, to the National Malaria Control Program. The program initiated a voucher system allowing children under 5 and pregnant women to receive ITNs free of charge. Not only is the supply of ITNs addressed, but also education on the importance of using the nets on a daily basis, the continued proper care and maintenance, along with re-treatment is supported under the program. (Ministry of Health and Social Welfare, 2010) This ability for children to have access to nets, without cost, has helped to significantly increase the number of children who are now less at risk for contracting malaria.

Tuberculosis (TB) is a serious concern in Tanzania. The country has registered relative success in reducing the prevalence of TB. Every indicator relating to TB has registered positive

movement: lower incidences of death from TB, increased detection rates and decreased prevalence in the country. (Appendix B) While overall Goal 6 will fail due to the issues that remain with AIDS, HIV, and other diseases that are packaged in with the TB statistics, TB should be considered a success for having marked achievement over the course of the MDG program. This success can be attributed to the number of public and private programs that address TB. Tanzania's Ministry of Health and Social Welfare established the National TB and Leprosy Programme, which works with agencies such as USAID, the CDC, WHO and also with non-profit organizations such as Program for Appropriate Technology in Health (PATH). These programs segment Tanzania into districts, then provide testing services, referrals for treatments, counseling, and provide training to local health care agents within those districts. (PATH)

An addition success is medication coverage for antiviral therapy for people infected with HIV increasing by over 121%. Given that the target of Goal 6 was to halt and begin to reverse the spread of HIV/AIDS, this indicator meets that target by increasing the percentage of people who have access to this medicine from 14% to 31%. (United Nations Statistical Division) Unfortunately, as with TB, HIV antiviral therapy coverage is just one indicator among several for Goal 6, which ultimately will be considered a failure.

Another significant success in Tanzania is the establishment of cellular and internet networks in the country. There were no cellular or internet users in the baseline year, but by 2008 52,000 people had access to the internet and over 13 million were communicating with cellular telephones. (Appendix B) This rapid growth in the telecommunications sector is a result of industry privatization and liberal licensing policies developed in the National Information and Communications Technologies Policy (NICTP). The mission of the NICTP was to promote "economic growth and social progress" using information and communication technology (ICT).

The development of ICT began with the creation of a regulatory body and developing a legal and regulatory framework, and increased sector enhancement. Financially, the sector has benefitted from government, private sector and donor support. Foreign investment in ICT has allowed for the rapid expansion of the sector, which would not have been possible with the domestic private sector alone. Clearly, the policy changes and financial investments made in ICT have produced positive results. It is not unreasonable to link the significant number of people now benefitting from the improved ICT to the potential for "economic growth and social process," as they now have the ability to access global information and markets they previously had been excluded from. (Ministry of Communications and Transport, 2003; Mureithi, 2009)

Failures

Employment/unemployment is interdependent with many issues that fall under the MDG program. As I've noted within this paper, improvements in the agricultural sector is dependent on technology advancement, access to water, less dependency on rainfall, skilled workers, and improved infrastructure. Given that the majority of the population in Tanzania is employed within the agricultural sector, failures in improving technology and infrastructure will have a direct negative correlation to those who are unemployed. Add to that factor an increase in population without an adequate increase in jobs has actually caused over a 10% decline in the percentage of those employed in relation to the population of the nation. (Appendix B)

In addition to employment, the poverty gap ratio (percentage of people below the poverty line), is also linked by the same factors. An increase in population, without the requisite increase in employment opportunities, causes a larger unemployed population. Those unemployed are unable to meet their basic needs (population below $1 per day), thus they become part of those under the poverty line, causing a 57.58% increase in the poverty gap ratio (1992-2000).

Additionally, as more people are unable to meet their basic needs, it then affects the percentage of the population undernourished. As the data indicates, there was an increase by 25% of people undernourished from 1991 to 2005. (Appendix B)

One indicator under Goal 7 (ensure environmental sustainability) is to significantly improve the lives of slum dwellers. Unfortunately for Tanzania, it has over a 6% slum population annual growth rate, making it the third highest in Africa. The slum population is the sixth largest in Africa as well, with over 6 million people living in urban slums without clean water, proper sanitation, some even without housing. In addition, urban slums have increased health care concerns, including higher rates of HIV/AIDS infections. (Homeless International) Challenges to decreasing the number of slum dwellers are not specific to Tanzania. Land availability within urban areas to relocate slum populations is at a minimum, and the infrastructure is not available to address the water, sanitary and other issues within the slums themselves. In addition, urban economic improvement has not been focused on better the lives of those living in slums, and the perpetual poverty further fuels the number of slum dwellers in these urban areas. It is necessary for the government to connect economic betterment of the urban informal sector, housing and infrastructure projects in order to lessen the slum population. (UN-Habitat, 2003)

In 1992, nearly 70% of women sought antenatal care at least four times during their pregnancy, yet by 2005, there was an 11% decrease in that number. This may be due to the disconnect between health care providers and their patients, in addition to the lack of adequate and accessible health care resources. Given that many of the health care providers are not properly trained, they are unable to properly assess potential complications, and do not stress the importance of continued care during the pregnancy. Without proper counseling, patients are less

likely to return for follow up visits. (Pembe, Carlstedt, Urassa, Lindmark, Nyström, & Darj, 2010) In the future development of the health care system in Tanzania, along with proper training of health care workers, the importance of maternal health is in critical need to be addressed. Not only is the health of the mother and child at risk during pregnancy and childbirth, but the continued growth of the child, and the health of the mother post-pregnancy is dependent on a healthy pregnancy.

The number of AIDS orphans in Tanzania is staggering, along with the fact that there has been an 83% increase in seven years, qualifying it as a failure under the MDG program. In 2007, 970,000 children were orphaned by one or both parents. It is difficult to understand such a significant increase, despite a decrease in the number of AIDS related deaths (a successful failure). Orphans tend to be marginalized in society, often ending up homeless without any protection and subject to abuse. In addition, what care they do receive is provided by the state, thus adding further strain on an already overburdened system. (Tanzania Prime Minister's Office, 2007) Despite the health care initiatives that have been implemented in the country, AIDS remains a significant issue, and is directly causal to the failure of Goal ____. In hindsight, due to the overwhelming number of issues that result from the HIV/AIDS epidemic, this disease may have warranted its own target or goal even, within the MDG program.

As I've noted before, urban and rural Tanzania, while experiencing many of the same issues, often experience issues at different levels. In the data analysis, the proportion using improved drinking water in urban areas decreased by almost 15%, whereas in rural areas only decreased by 2%. Whereas the population that has access to improved sanitation improved by 18% in urban areas (successful failure), but decreased by 8% in rural areas. (Appendix B) These results show the disparity between urban and rural areas. The end result of the program is that

Goal 7 fails because it does not on the surface designate between the differences in urban and rural living.

Successful Failures

The argument of this paper is that there are successes in what would ultimately be deemed an overall failure of this program. My analysis indicates that there are a number of successful failures, some of which fall under goals that are on track to be met in the Millennium Development Goal project, and others that fall within goals that have other failing indicators which will result in a failure of the overall goal. It is the focus however, on these small, yet significant successes, within the failing system, that is important to recognize. It is these successful failures, described below in part, that if given the time and support of the international community, may be built further upon for dramatic successes in the future.

With regard to maternal mortality, Goal 5 looks to reduce the maternal mortality rate by three-fourths and achieve universal access to reproductive healthcare. (United Nations Development Programme) The majority of maternal mortalities are due to complications during pregnancy and childbirth, including hypertension, hemorrhages and sepsis. Many of these issues are preventable if women have access to proper health care facilities, trained physicians and emergency care, if necessary, during pregnancy and childbirth. (Ministry of Health and Social Welfare, 2007) The mid-way evaluation of the MDG program indicates that Tanzania will likely fail to meet this goal by 2015. (Ministry of Finance and Economic Affairs, 2008) My data analysis shows that many of the measurements under Indicators 5.1-5.6 are actually successful failures due to their improvement since the baseline year. Goal 5 measurements include the maternal mortality ratio, contraceptive use, antenatal care coverage and unmet family planning needs. Of these measurements, only antenatal care of four visits registers a failure. There was a

10% decrease in the number of maternal deaths, contraception use among women increased over 150%, there was a 21% increase in antenatal care (1 visit) and the unmet need for family planning decreased by 27%. (Appendix B) While these improvements do not meet the threshold to meet Goal 5, their improvements should be recognized as a positive improvement nonetheless. The improvements can be attributed to the Primary Health Services Development Programme (PHSDP). This program was established to increase access and quality to health care. Within the PHSDP, the National Package of Essential Reproductive and Child Health Interventions (ERCHI) focuses directly with the health concerns of women and children, including educating attendants, create working blood banks for emergency care, blood screening, increase ambulatory availability, and patient education on risks and danger signs of child birth. (Ministry of Health and Social Welfare, 2007) In addition, the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (NRMSP) creates a framework that not only the Tanzanian government can utilize to improve maternal and child health care concerns, but also NGOs, faith-based organizations, and also the private sector. This framework includes creating district-based programs that develop training for health care workers, education of mothers on the challenges of childbirth, and medical necessities, a working referral system, disease and inoculation information. This Plan is a recent construct, and needs to be given additional time to produce additional successful results in the future. (Ministry for Health and Social Welfare, 2008)

The AIDS epidemic is unlike any other factor in the world when it comes to development. It is a worldwide disease, and it is not subjective in who if affects. It is, however, without question, affecting the continent of Africa unlike no other. In my travels in Africa I have met people who do not use condoms because they honestly believe that white men have

purposely sabotaged them in order to spread the AIDS virus to eradicate black people. I have sat with people who drank the leaves and herbs from their local healer in order to heal them from symptoms that would later be known to be AIDs, and I have sat in a room where, unlike in developing countries, everyone was presumed to be HIV positive until otherwise proven. It is therefore, any positive change in AIDS/HIV statistics that I deem a successful failure. My analysis indicates that condom use between those at high risk has increased, as has men and women's comprehensive knowledge of the disease, and there is also an 11% decrease in the number of people living with HIV in the country. Add to that the number of people who have succumbed to death due to AIDS has decreased by almost 13%. (Appendix B) These are all positive steps. As indicated previously, cultural and social norms play a significant role in the success of AIDS/HIV education. Some cultural activities promote sexual promiscuity and even violence against women, and other social norms provide gateways to unhealthy sex and education. (Tanzania Prime Minister's Office, 2007) However, even with these detriments, there have been registered successes within the failures. It is these increases in condom use and availability, education and knowledge of the disease, and access to medication that has allowed for these successful failures. Some of the successful failures can be attributed to the National AIDS Control Programme (NACP) and its commitment to developing strategies toward the eradication of HIV/AIDS. Ever since the first case of AIDS was reported in 1983, Tanzania and its Ministry of Health has acknowledged the issues surrounding AIDS, including a national task force in 1985 and strategic plans to address the issue in 1987, 1992, 1999 and the establishment of the Tanzania Commission for AIDS (TCAIDS). After the continued and rapid spread of HIV/AIDS in Tanzania, in 2008, TCAIDS created the HIV and AIDS (Prevention and Control) Act. This act looked to dispel the misconceptions surrounding AIDS, establish testing centers

throughout the country, offer HIV counseling to pregnant women and promote testing to health care providers and traditional healers. The act goes further to create punishment for those who knowingly infect others, including spouses. It further discusses making anti-retroviral medications available for those infected and as an antenatal treatment for mothers. (Tanzania Commission on AIDS, 2008) Through the policies established under this act, among others, and the many domestic and international NGOs, foreign governments, and other donors, there have been some improvements with HIV/AIDS. Unfortunately, this disease continues to hold a death grip on the country, and that of the continent. This disease clearly remains a significant impediment to development and success in the country. The funds appropriated for this disease, if it were contained, could be used to further improve infrastructure and agriculture in the country, helping to reduce the poverty level, as discussed within. It is clear however, without the prevention and encapsulation of HIV/AIDS, Tanzania will continue to have considerable hurdles to overcome.

One of the successes of the program is the education of Tanzania's children. Goal ___ is on track to be met. As we've indicated earlier, policies enacted by the Ministry of Education have eliminated fees which allow children to now attend primary school free of charge. The challenge now is children completing primary school. Tanzania has shown success in that regard. There has been a 44% increase in children who complete the last grade of primary school during the life of the MDG program. (Appendix B) Many children are forced to leave school to work in the agriculture sector to help support their families. Again, we see that the agricultural sector has far reaching effects. Without improvement in that sector, universal completion of primary school will remain at a distance.

In support of gender equality and the empowerment of women, the MDG program measures the seats held by women in national parliament. In 2000, the country's constitution was amended to reserve thirty percent of the seats of parliament for women, which was an increase from the prior twenty percent of seats reserved. The 2005 elections brought about 30.4% election rate of women into parliament, which is the "highest percentage of women ever achieved under a majoritarian electoral system." (Inter-Parliamentary Union, 2005) These increases support Tanzania's empowerment of women, which has led to Goal 2 being on track to be achieved in 2015.

As noted in Appendix C, there are a number of successful failures, some of which I have detailed above. Some successful measurements even lie with failing measurements within an indicator. In the end, the failures will over shadow the successes and many of the successful failures will be overlooked all together. It is important to note what successes have been made within the failures, however, so that we can look towards the future. These successful failures are a direct result of the programs and policies initiated by the United Republic of Tanzania, its Ministries, international and domestic NGOs, and other actors who have devoted the time, financial resources and information to put Tanzania on a course, albeit slow, course to success.

**Conclusion/Policy Recommendations**

In order for the goals of the MDGs to be met, economic conditions in the country must support the growth and development within that country. Growth and development are linked to an increase in technological development, financial investment, domestic revenue, proper policy and accountability of those entrusted with the implementation of that policy. It is also linked to outside factors such as the global market, international regulations, and changes in climate and environment, including droughts. (UN Millennium Project, 2005)

Serious consideration and improvement needs to be made within the agriculture sector. As the majority of the population is employed within that sector, it is imperative that improvements are made. Appendix D and E list programs that were developed under NSGRP I and II which are still current, active programs. There are a number of programs that deal directly with supporting and improving the agriculture and infrastructure sectors in the country. These programs depend directly on ODA and the involvement of international actors that support those programs.

This paper has not focused on the Official Development Assistance (ODA) of donor nations. It is to me a certainty that continued and increased ODA is paramount to success in Tanzania. That being said, without proper governance, and the requisite policy from the governmental ministries, ODA will do nothing to improve the conditions in the country. Donors have reason to be alarmed at the lack of proper governance and levels of corruption in Tanzania. Tanzania's ranking of countries based on corruption, according to Transparency International, has declined from #88 in 2005 to #126 in 2009. (Transparency International, 2005; Transparency International, 2009) Aside from bad governance and corruption, the downturn of the world economy caused many donor nations to reevaluate their ODA. Donor aid contributes 33% to the Tanzanian budget, which in 2009/2010 was $840 million. In addition, 49% of the Tanzanian market comes from donor funds. These funds help directly support the projects implemented under the MDGs, such as the building of road systems, improvements in the agricultural sector, healthcare projects and education reforms. The pledge of funds was reduced in 2010 by over $220 million due to what the donors cite as weak governance and accountability, poorly regulated economic policy and rising corruption. This decrease in funds would not only cease most infrastructure, agricultural, educational and health related projects in the country, but it

would also weaken the already strained Tanzanian Shilling. Not only are cuts in donor aid affecting MDG related programs, but the change of aid grants into aid loans will create a debt crisis within the country. (Ng'wanakilala, 2010; Cropley, 2010)

It would appear based on the analysis that the problems that existed at the beginning of the MDG program continue to exist, albeit now in varying degrees. Overall poverty remains a significant problem, as does the lack of infrastructure, health care access and prevalence of disease. Tanzania has drafted policy to affect significant change, but it has yet been able to overwhelmingly make those improvements. A review of the policy that created positive change in the country should be replicated in other sectors to continue the improvement throughout the country. The policies drafted by the various ministries of Tanzania under the NSGRP I and II, including the Primary Education Development Plan, Health Care Development Program, National TB and Leprosy Program and National Information and Communications Technologies Policy should continue to be expanded and developed, including the reduction of fees for secondary education, developing a national HIV/AIDS curriculum in primary and secondary schools, create in-school feeding systems using locally grown produce, agriculture and health care skill building programs in each district and the increased availability of medication for HIV/AIDS, malaria, TB and other diseases.

In four years the MDG program is going to come to a close. It will be considered an overall failure in Tanzania. It is with great hope that donors will look beyond the overall failure, and to the successful failures within, and continue their support giving Tanzania additional time and resources to improve the lives of its people.

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## Appendix A: Goals, Targets and Indicators

| GOALS/TARGETS | INDICATORS |
|---|---|
| **GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER** | |
| TARGET 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | 1. Proportion of population below $1 (PPP) per day<br>1A. Poverty headcount ratio (percentage of population below the national poverty line)<br>2. Poverty gap ratio [incidence x depth of poverty]<br>3. Share of poorest quintile in national consumption |
| TARGET 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger | 4. Prevalence of underweight children under 5 years of age<br>5. Proportion of population below minimum level of dietary energy consumption |
| **GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION** | |
| TARGET 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | 6. Net enrolment ratio in primary education<br>7. Proportion of pupils starting grade 1 who reach grade 5<br>8. Literacy rate of 15–24 year-olds |
| **GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN** | |
| TARGET 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 | 9. Ratio of girls to boys in primary, secondary and tertiary education<br>10. Ratio of literate women to men, 15–24 years old<br>11. Share of women in wage employment in the non-agricultural sector<br>12. Proportion of seats held by women in national parliament |
| **GOAL 4: REDUCE CHILD MORTALITY** | |
| TARGET 5 :Reduce by two thirds, between 1990 and 2015, the under-five mortality rate | 13. Under-five mortality rate<br>14. Infant mortality rate<br>15. Proportion of 1 year-old children immunized against measles |
| **GOAL 5: IMPROVE MATERNAL HEALTH** | |
| TARGET 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio | 16. Maternal mortality ratio<br>17. Proportion of births attended by skilled health personnel |
| **GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES** | |
| TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS | 18. HIV prevalence among pregnant women aged 15–24 years<br>19. Condom use rate of the contraceptive prevalence rate<br>19A. Condom use at last high-risk sex<br>19B. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS<br>19C. Contraceptive prevalence rate<br>20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14years |
| TARGET 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases | 21. Prevalence and death rates associated with malaria<br>22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures<br>23. Prevalence and death rates associated with tuberculosis<br>24. Proportion of tuberculosis cases detected and cured under DOTS |
| **GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY** | |
| TARGET 9: Integrate the principles of sustainable | 25. Proportion of land area covered by forest |

| | |
|---|---|
| development into country policies and programmes and reverse the loss of environmental resources | 26. Ratio of area protected to maintain biological diversity to surface area<br>27. Energy use (kg oil equivalent) per $1 GDP (PPP)<br>28. Carbon dioxide emissions per capita and consumption of ozone-depleting CFCs (ODP tons)<br>29. Proportion of population using solid fuels |
| TARGET 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation | 30. Proportion of population with sustainable access to an improved water source, urban and rural<br>31. Proportion of population with access to improved sanitation, urban and rural |
| TARGET 11: By 2020, o t have achieved a significant improvement in the lives of at least 100 million slum dwellers | 32. Proportion of households with access to secure tenure |
| **GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT** | Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States. |
| TARGET 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system<br>Includes a commitment to good governance, development and poverty reduction – both nationally and internationally<br>TARGET 13: Address the special needs of the least developed countries<br>Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction<br>TARGET 14: 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 twenty-second special session of the General Assembly)<br>TARGET 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term | <u>Official development assistance</u><br>33. Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' gross national income<br>34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)<br>35. Proportion of bilateral official development assistance of OECD/DAC donors that is untied<br>36. ODA received in landlocked countries as a proportion of their gross national incomes<br>37. ODA received in small island developing States as proportion of their gross national incomes<br><u>Market access</u><br>38. Proportion of total developed country imports (by value and excluding arms) from developing countries and from the least developed countries, admitted free of duty<br>39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries<br>40. Agricultural support estimate for OECD countries as a percentage of their gross domestic product<br>41. Proportion of ODA provided to help build trade capacity<br><u>Debt sustainability</u><br>42. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)<br>43. Debt relief committed under HIPC Initiative<br>44. Debt service as a percentage of exports of goods and services |
| TARGET 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth | 45. Unemployment rate of young people aged 15-24 years, each sex and total |
| TARGET 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries | 46. Proportion of population with access to affordable essential drugs on a sustainable basis |
| TARGET 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications | 47. Telephone lines and cellular subscribers per 100 population<br>48A. Personal computers in use per 100 population and Internet users per 100 population<br>48B. Internet users per 100 population |

(United Nations, 2003)

## Appendix B: Data: Tanzania

| INDICATOR/MEASUREMENT | BASELINE | BASELINE YEAR | CURRENT | CURRENT YEAR | PERCENTAGE CHANGE |
|---|---|---|---|---|---|
| **1.1 Proportion of population below $1 (PPP) per day** | | | | | |
| Population below $1 (PPP) per day, percentage | 72.6 | 1992 | 88.5 | 2000 | 21.90% |
| Population below national poverty line, total, percentage | 38.6 | 1991 | 35.7 | 2001 | -7.51% |
| Population below national poverty line, urban, percentage | 31.2 | 1991 | 29.5 | 2001 | -5.45% |
| Population below national poverty line, rural, percentage | 40.8 | 1991 | 38.7 | 2001 | -5.15% |
| Purchasing power parities (PPP) conversion factor, local currency unit to international dollar | 92.502 | 1990 | 553.945 | 2008 | 498.85% |
| **1.2 Poverty gap ratio** | | | | | |
| Poverty gap ratio at $1 a day (PPP), percentage | 29.7 | 1992 | 46.8 | 2000 | 57.58% |
| **1.3 Share of poorest quintile in national consumption** | | | | | |
| Poorest quintile's share in national income or consumption, percentage | 7.4 | 1992 | 7.3 | 2000 | -1.35% |
| **1.4 Growth rate of GDP per person employed** | | | | | |
| Growth rate of GDP per person employed, percentage | No data | N/A | No data | N/A | |
| **1.5 Employment-to-population ratio** | | | | | |
| Employment-to-population ratio, both sexes, percentage | 87.4 | 1990 | 78 | 2008 | -10.76% |
| Employment-to-population ratio, men, percentage | 89.7 | 1990 | 80.3 | 2008 | -10.48% |
| Employment-to-population ratio, women, percentage | 85.3 | 1990 | 75.8 | 2008 | -11.14% |
| **1.6 Proportion of employed people living below $1 (PPP) per day** | | | | | |
| Proportion of employed people living below $1 (PPP) per day, percentage | 77.2 | 1991 | 90 | 2000 | 16.58% |
| **1.7 Proportion of own-account and contributing family workers in total employment** | | | | | |
| Proportion of own-account and contributing family workers in total employment, both sexes, percentage | 92.2 | 2001 | 87.7 | 2006 | -4.88% |
| Proportion of own-account and contributing family workers in total employment, women, percentage | 95.5 | 2001 | 92.9 | 2006 | -2.72% |
| Proportion of own-account and contributing family workers in total employment, men, percentage | 88.8 | 2001 | 82.1 | 2006 | -7.55% |

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| **1.8 Prevalence of underweight children under-five years of age** | | | | | |
| Children under 5 moderately or severely underweight, percentage | 28.8 | 1992 | 21.8 | 2005 | -24.31% |
| Children under 5 severely underweight, percentage | 7.1 | 1992 | 3.7 | 2004 | -47.89% |
| **[non-MDG] Unemployment rate of young people aged 15-24 years, each sex and total** | | | | | |
| Youth unemployment rate, aged 15-24, both sexes | 8.9 | 2001 | 8.8 | 2006 | -1.12% |
| Youth unemployment rate, aged 15-24, women | No data | N/A | 10.1 | 2006 | |
| Youth unemployment rate, aged 15-24, men | No data | N/A | 7.4 | 2006 | |
| Ratio of youth unemployment rate to adult unemployment rate, both sexes | 2.8 | 2001 | 2.9 | 2006 | 3.57% |
| Ratio of youth unemployment rate to adult unemployment rate, women | No data | N/A | 2.2 | 2006 | |
| Ratio of youth unemployment rate to adult unemployment rate, men | No data | N/A | 5.2 | 2006 | |
| Share of youth unemployed to total unemployed, both sexes | 57.2 | 2001 | 53.3 | 2006 | -6.82% |
| Share of youth unemployed to total unemployed, women | No data | N/A | 47.5 | 2006 | |
| Share of youth unemployed to total unemployed, men | No data | N/A | 66.2 | 2006 | |
| Share of youth unemployed to youth population, both sexes | 7.2 | 2001 | No data | N/A | |
| Share of youth unemployed to youth population, women | No data | N/A | No data | N/A | |
| Share of youth unemployed to youth population, men | No data | N/A | No data | N/A | |
| **1.9 Proportion of population below minimum level of dietary energy consumption** | | | | | |
| Population undernourished, percentage | 28 | 1991 | 35 | 2005 | 25.00% |
| Population undernourished, millions | 7 | 1991 | 14 | 2005 | 100.00% |
| **2.1 Net enrolment ratio in primary education** | | | | | |
| Total net enrolment ratio in primary education, both sexes | 50.7 | 1991 | 99.6 | 2008 | 96.45% |
| Total net enrolment ratio in primary education, boys | 50.3 | 1991 | 96.3 | 2006 | 91.45% |
| Total net enrolment ratio in primary education, girls | 51.1 | 1991 | 95.1 | 2006 | 86.11% |
| **2.2 Proportion of pupils starting grade 1 who reach last grade of primary** | | | | | |
| Percentage of pupils starting grade 1 who reach last grade of primary, both sexes | 73.9 | 2000 | 82.8 | 2006 | 12.04% |
| Percentage of pupils starting grade 1 who reach last grade of primary, | 71.4 | 2000 | 80.8 | 2006 | 13.17% |

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| boys | | | | | |
| Percentage of pupils starting grade 1 who reach last grade of primary, girls | 76.5 | 2000 | 84.9 | 2006 | 10.98% |
| Primary completion rate, both sexes | 57.2 | 1999 | 82.6 | 2007 | 44.41% |
| Primary completion rate, boys | 56 | 1999 | 84.5 | 2007 | 50.89% |
| Primary completion rate, girls | 58.5 | 1999 | 80.8 | 2007 | 38.12% |
| **2.3 Literacy rate of 15-24 year-olds, women and men** | | | | | |
| Literacy rates of 15-24 years old, both sexes, percentage | 78.4 | 2002 | 77.5 | 2008 | -1.15% |
| Literacy rates of 15-24 years old, men, percentage | 80.9 | 2002 | 78.7 | 2008 | -2.72% |
| Literacy rates of 15-24 years old, women, percentage | 76.2 | 2002 | 76.3 | 2008 | 0.13% |
| Women to men parity index, as ratio of literacy rates, 15-24 years old | 0.94 | 2002 | 0.97 | 2008 | 3.19% |
| **3.1 Ratio of girls to boys in primary, secondary and tertiary education** | | | | | |
| Gender Parity Index in primary level enrolment | 0.98 | 1991 | 0.99 | 2008 | 1.02% |
| Gender Parity Index in secondary level enrolment | 0.77 | 1991 | 0.82 | 1999 | 6.49% |
| Gender Parity Index in tertiary level enrolment | 0.19 | 1991 | 0.48 | 2007 | 152.63% |
| **3.2 Share of women in wage employment in the non-agricultural sector** | | | | | |
| Share of women in wage employment in the non-agricultural sector | 30.5 | 2006 | No data | N/A | |
| **3.3 Proportion of seats held by women in national parliament** | | | | | |
| Seats held by women in national parliament, percentage | 17.5 | 1997 | 30.7 | 2010 | 75.43% |
| Total number of seats in national parliament | 244 | 1990 | 323 | 2010 | 32.38% |
| Seats held by men in national parliament | 227 | 1997 | 224 | 2010 | -1.32% |
| Seats held by women in national parliament | 48 | 1997 | 99 | 2010 | 106.25% |
| **4.1 Under-five mortality rate** | | | | | |
| Children under five mortality rate per 1,000 live births | 162 | 1990 | 107.9 | 2009 | -33.40% |
| **4.2 Infant mortality rate** | | | | | |
| Infant mortality rate (0-1 year) per 1,000 live births | 97 | 1990 | 67 | 2008 | -30.93% |
| **4.3 Proportion of 1 year-old children immunized against measles** | | | | | |
| Children 1 year old immunized against measles, percentage | 80 | 1990 | 88 | 2008 | 10.00% |
| **5.1 Maternal mortality ratio** | | | | | |
| Maternal mortality ratio per 100,000 live births | 880 | 1990 | 790 | 2008 | -10.23% |

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| **5.2 Proportion of births attended by skilled health personnel** | | | | | |
| Births attended by skilled health personnel, percentage | 43.9 | 1992 | 43.4 | 2005 | -1.14% |
| **5.3 Contraceptive prevalence rate** | | | | | |
| Current contraceptive use among married women 15-49 years old, any method, percentage | 10.4 | 1992 | 26.4 | 2005 | 153.85% |
| Current contraceptive use among married women 15-49 years old, modern methods, percentage | 6.6 | 1992 | 19.5 | 2005 | 195.45% |
| Current contraceptive use among married women 15-49 years old, condom, percentage | 0.7 | 1992 | 2 | 2005 | 185.71% |
| **5.4 Adolescent birth rate** | | | | | |
| Adolescent birth rate, per 1,000 women | 139 | 1990 | 139 | 2003 | 0.00% |
| **5.5 Antenatal care coverage (at least one visit and at least four visits)** | | | | | |
| Antenatal care coverage, at least one visit, percentage | 62.2 | 1992 | 75.8 | 2008 | 21.86% |
| Antenatal care coverage, at least four visits, percentage | 69.5 | 1992 | 61.5 | 2005 | -11.51% |
| **5.6 Unmet need for family planning** | | | | | |
| Unmet need for family planning, total, percentage | 30.1 | 1992 | 21.8 | 2005 | -27.57% |
| Unmet need for family planning, spacing, percentage | 18 | 1992 | 15.1 | 2005 | -16.11% |
| Unmet need for family planning, limiting, percentage | 12.1 | 1992 | 6.7 | 2005 | -44.63% |
| **6.1 HIV prevalence among population aged 15-24 years** | | | | | |
| People living with HIV, 15-49 years old, percentage | 7 | 2001 | 6.2 | 2007 | -11.43% |
| HIV prevalence rate, women 15-49 years old, in national based surveys | 7.7 | 2004 | No data | N/A | |
| HIV prevalence rate, men 15-49 years old, in national based surveys | 6.3 | 2004 | No data | N/A | |
| AIDS deaths | 110000 | 2001 | 96000 | 2007 | -12.73% |
| **6.2 Condom use at the last high-risk sex** | | | | | |
| Condom use at last high-risk sex, 15-24 years old, women, percentage | 18.4 | 1996 | 46.3 | 2008 | 151.63% |
| Condom use at last high-risk sex, 15-24 years old, men, percentage | 31.4 | 1996 | 49 | 2008 | 56.05% |
| Condom use to overall contraceptive use among currently married women 15-49 years old, percentage | 6.7 | 1992 | 7.6 | 2005 | 13.43% |
| **6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS** | | | | | |
| Men 15-24 years old with | 23.2 | 1996 | 41.5 | 2008 | 78.88% |

| | | | | | |
|---|---|---|---|---|---|
| comprehensive correct knowledge of HIV/AIDS, percentage | | | | | |
| Women 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage | 22.9 | 1996 | 39.2 | 2008 | 71.18% |
| **6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years** | | | | | |
| Ratio of school attendance rate of orphans to school attendance rate of non orphans | 0.59 | 1992 | 0.97 | 2008 | 64.41% |
| School attendance rate of orphans aged 10-14 | 62.3 | 1996 | 86.4 | 2008 | 38.68% |
| School attendance rate of children aged 10-14 both of whose parents are alive and who live with at least one parent | 71.6 | 1996 | 89 | 2008 | 24.30% |
| AIDS orphans (one or both parents) | 530000 | 2000 | 970000 | 2007 | 83.02% |
| **6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs** | | | | | |
| Antiretroviral therapy coverage among people with advanced HIV infection, percentage | 14 | 2006 | 31 | 2007 | 121.43% |
| **6.6 Incidence and death rates associated with malaria** | | | | | |
| Notified cases of malaria per 100,000 population | 24088 | 2008 | No data | N/A | |
| Malaria death rate per 100,000 population, all ages | 84 | 2008 | No data | N/A | |
| Malaria death rate per 100,000 population, ages 0-4 | 68 | 2008 | No data | N/A | |
| **6.7 Proportion of children under 5 sleeping under insecticide-treated bednets** | | | | | |
| Children under 5 sleeping under insecticide-treated bed nets, percentage | 2.1 | 1995 | 25.7 | 2008 | 1123.81% |
| **6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs** | | | | | |
| Children under 5 with fever being treated with anti-malarial drugs, percentage | 53.4 | 1999 | 56.7 | 2008 | 6.18% |
| **6.9 Incidence, prevalence and death rates associated with tuberculosis** | | | | | |
| Tuberculosis prevalence rate per 100,000 population (mid-point) | 320 | 1990 | 130 | 2008 | -59.38% |
| Tuberculosis prevalence rate per 100,000 population (lower bound) | 210 | 1990 | 85 | 2008 | -59.52% |
| Tuberculosis prevalence rate per 100,000 population (upper bound) | 450 | 1990 | 180 | 2008 | -60.00% |
| Tuberculosis death rate per year per 100,000 population (mid-point) | 31 | 1990 | 13 | 2008 | -58.06% |
| Tuberculosis death rate per year per 100,000 population (lower bound) | 12 | 1990 | 6.1 | 2008 | -49.17% |

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|---|---|---|---|---|---|
| Tuberculosis death rate per year per 100,000 population (upper bound) | 57 | 1990 | 22 | 2008 | -61.40% |
| Tuberculosis incidence rate per year per 100,000 population (mid-point) | 230 | 1990 | 190 | 2008 | -17.39% |
| Tuberculosis incidence rate per year per 100,000 population (lower bound) | 200 | 1990 | 180 | 2008 | -10.00% |
| Tuberculosis incidence rate per year per 100,000 population (upper bound) | 270 | 1990 | 200 | 2008 | -25.93% |
| Tuberculosis detection rate under DOTS, percentage (lower bound) | 40 | 1990 | 65 | 2008 | 62.50% |
| Tuberculosis detection rate under DOTS, percentage (upper bound) | 54 | 1990 | 75 | 2008 | 38.89% |
| **6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course** | | | | | |
| Tuberculosis detection rate under DOTS, percentage (mid-point) | 47 | 1990 | 70 | 2008 | 48.94% |
| Tuberculosis treatment success rate under DOTS, percentage | 80 | 1994 | 88 | 2007 | 10.00% |
| **7.1 Proportion of land area covered by forest** | | | | | |
| Proportion of land area covered by forest, percentage | 46.9 | 1990 | 39.9 | 2005 | -14.93% |
| **7.2 Carbon dioxide emissions, total, per capita and per $1 GDP (PPP)** | | | | | |
| Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC) | 2373 | 1990 | 6043 | 2007 | 154.66% |
| Carbon dioxide emissions (CO2), thousand metric tons of CO2 (UNFCCC) | No data | N/A | No data | N/A | |
| Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC) | 0.0932 | 1990 | 0.1464 | 2007 | 57.08% |
| Carbon dioxide emissions (CO2), metric tons of CO2 per capita (UNFCCC) | No data | N/A | No data | N/A | |
| Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (CDIAC) | 0.1083 | 1990 | 0.1309 | 2007 | 20.87% |
| Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (UNFCCC) | No data | N/A | No data | N/A | |
| Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $) | 444 | 1990 | 396 | 2007 | -10.81% |
| **7.3 Consumption of ozone-depleting substances** | | | | | |
| Consumption of all Ozone-Depleting Substances in ODP metric tons | 0 | 1991 | 15.4 | 2008 | |
| Consumption of ozone-depleting CFCs in ODP metric tons | 185.3 | 1993 | 13.9 | 2008 | -92.50% |

| | | | | | |
|---|---|---|---|---|---|
| **7.4 Proportion of fish stocks within safe biological limits** | | | | | |
| Proportion of fish stocks within safe biological limits | No data | N/A | No data | N/A | |
| **7.5 Proportion of total water resources used** | | | | | |
| Proportion of total water resources used, percentage | 5.4 | 2000 | No data | N/A | |
| **[non-MDG] Proportion of population using solid fuels** | | | | | |
| Population using solid fuels, percentage | 95 | 1993 | 94 | 2007 | -1.05% |
| **7.6 Proportion of terrestrial and marine areas protected** | | | | | |
| Terrestrial and marine areas protected to total territorial area, percentage | 25.66 | 1990 | 27.03 | 2009 | 5.34% |
| Terrestrial and marine areas protected, sq. km. | 252494 | 1990 | 265972 | 2009 | 5.34% |
| Terrestrial areas protected to total surface area, percentage | 26.5 | 1990 | 27.7 | 2009 | 4.53% |
| Terrestrial areas protected, sq. km. | 251142 | 1990 | 262285 | 2009 | 4.44% |
| Marine areas protected to territorial waters, percentage | 3.7 | 1990 | 10 | 2009 | 170.27% |
| Marine areas protected, sq. km. | 1351 | 1990 | 3688 | 2009 | 172.98% |
| **7.7 Proportion of species threatened with extinction** | | | | | |
| Proportion of species threatened with extinction | No data | N/A | No data | N/A | |
| **7.8 Proportion of population using an improved drinking water source** | | | | | |
| Proportion of the population using improved drinking water sources, total | 55 | 1990 | 54 | 2008 | -1.82% |
| Proportion of the population using improved drinking water sources, urban | 94 | 1990 | 80 | 2008 | -14.89% |
| Proportion of the population using improved drinking water sources, rural | 46 | 1990 | 45 | 2008 | -2.17% |
| **7.9 Proportion of population using an improved sanitation facility** | | | | | |
| Proportion of the population using improved sanitation facilities, total | 24 | 1990 | 24 | 2008 | 0.00% |
| Proportion of the population using improved sanitation facilities, urban | 27 | 1990 | 32 | 2008 | 18.52% |
| Proportion of the population using improved sanitation facilities, rural | 23 | 1990 | 21 | 2008 | -8.70% |
| **7.10 Proportion of urban population living in slums** | | | | | |
| Slum population as percentage of urban, percentage | 77.4 | 1990 | 65 | 2007 | -16.02% |
| Slum population in urban areas | 3724616 | 1990 | 6579528 | 2007 | 76.65% |
| **8.1 Net ODA, total and to the least developed countries, as** | | | | | |

| | | | | |
|---|---|---|---|---|
| **percentage of OECD/DAC donors' gross national income** | | | | |
| Net ODA as percentage of OECD/DAC donors GNI | No data | N/A | No data | N/A |
| Net ODA to LDCs as percentage of OECD/DAC donors GNI | No data | N/A | No data | N/A |
| Net ODA, million US$ | No data | N/A | No data | N/A |
| Net ODA to LDCs, million US$ | No data | N/A | No data | N/A |
| **8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)** | | | | |
| ODA to basic social services as percentage of sector-allocable ODA | No data | N/A | No data | N/A |
| ODA to basic social services, million US$ | No data | N/A | No data | N/A |
| **8.3 Proportion of bilateral ODA of OECD/DAC donors that is untied** | | | | |
| ODA that is untied, percentage | No data | N/A | No data | N/A |
| ODA that is untied, million US$ | No data | N/A | No data | N/A |
| **8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes** | | | | |
| ODA received in landlocked developing countries as percentage of their GNI | No data | N/A | No data | N/A |
| ODA received in landlocked developing countries, million US$ | No data | N/A | No data | N/A |
| **8.5 ODA received in small island developing States as a proportion of their gross national incomes** | | | | |
| ODA received in small islands developing States as percentage of their GNI | No data | N/A | No data | N/A |
| ODA received in small islands developing States, million US$ | No data | N/A | No data | N/A |
| **8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and from the least developed countries, admitted free of duty** | | | | |
| Developed country imports from developing countries, admitted duty free, percentage | No data | N/A | No data | N/A |
| Developed country imports from the LDCs, admitted duty free, percentage | No data | N/A | No data | N/A |
| **8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Average tariffs imposed by developed countries on agricultural products from developing countries | No data | N/A | No data | N/A | |
| Average tariffs imposed by developed countries on textiles from developing countries | No data | N/A | No data | N/A | |
| Average tariffs imposed by developed countries on clothings from developing countries | No data | N/A | No data | N/A | |
| **8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product** | | | | | |
| Agriculture support estimate for OECD countries as percentage of their GDP | No data | N/A | No data | N/A | |
| Agriculture support estimate for OECD countries, million US$ | No data | N/A | No data | N/A | |
| **8.9 Proportion of ODA provided to help build trade capacity** | | | | | |
| ODA provided to help build trade capacity, percentage | No data | N/A | No data | N/A | |
| **8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)** | | | | | |
| Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) | No data | N/A | No data | N/A | |
| **8.11 Debt relief committed under HIPC and MDRI Initiatives** | | | | | |
| Debt relief committed under HIPC initiative, cumulative million US$ in end-2006 NPV terms | 2997 | 2010 | No data | N/A | |
| Debt relief delivered in full under MDRI initiative, cumulative million US$ in end-2006 NPV terms | 2124 | 2010 | No data | N/A | |
| **8.12 Debt service as a percentage of exports of goods and services** | | | | | |
| Debt service as percentage of exports of goods and services and net income | 31.3 | 1990 | 1.7 | 2008 | -94.57% |
| **8.13 Proportion of population with access to affordable essential drugs on a sustainable basis** | | | | | |
| Population with access to essential drugs, percentage | No data | N/A | No data | N/A | |
| **8.14 Telephone lines per 100 population** | | | | | |
| Telephone lines per 100 population | 0.29 | 1990 | 0.29 | 2008 | 0.00% |
| Telephone lines | 73011 | 1990 | 123809 | 2008 | 69.58% |
| **8.15 Cellular subscribers per 100 population** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Mobile cellular telephone subscriptions per 100 population | 0 | 1990 | 30.62 | 2008 | |
| Mobile cellular telephone subscriptions | 0 | 1990 | 13006793 | 2008 | |
| **8.16 Internet users per 100 population** | | | | | |
| Internet users per 100 population | 0 | 1990 | 1.22 | 2008 | |
| Internet users | 0 | 1990 | 520000 | 2008 | |
| Personal computers per 100 population | 0.16 | 1997 | 0.91 | 2005 | 468.75% |
| Personal computers | 50000 | 1997 | 356000 | 2005 | 612.00% |

(United Nations Statistical Division)

## Appendix C: Success/Failure/Successful Failure Classifications

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| **1.1 Proportion of population below $1 (PPP) per day** | | | | | | |
| Population below $1 (PPP) per day, percentage | 21.90% | | X | | | |
| Population below national poverty line, total, percentage | -7.51% | | | | X | |
| Population below national poverty line, urban, percentage | -5.45% | | | | X | |
| Population below national poverty line, rural, percentage | -5.15% | | | | X | |
| Purchasing power parities (PPP) conversion factor, local currency unit to international dollar | 498.85% | | X | | | |
| **1.2 Poverty gap ratio** | | | | | | |
| Poverty gap ratio at $1 a day (PPP), percentage | 57.58% | | X | | | |
| **1.3 Share of poorest quintile in national consumption** | | | | | | |
| Poorest quintile's share in national income or consumption, percentage | -1.35% | | | | X | |
| **1.4 Growth rate of GDP per person employed** | | | | | | |
| Growth rate of GDP per person employed, percentage | | | | | | X |
| **1.5 Employment-to-population ratio** | | | | | | |
| Employment-to-population ratio, both sexes, percentage | -10.76% | | X | | | |
| Employment-to-population ratio, men, percentage | -10.48% | | X | | | |
| Employment-to-population ratio, women, percentage | -11.14% | | X | | | |
| **1.6 Proportion of employed people living below $1 (PPP) per day** | | | | | | |
| Proportion of employed people living below $1 (PPP) per day, percentage | 16.58% | | X | | | |
| **1.7 Proportion of own-account and contributing family workers in total employment** | | | | | | |
| Proportion of own-account and contributing family workers in total employment, both sexes, percentage | -4.88% | | | | X | |
| Proportion of own-account and contributing family workers in total employment, women, | -2.72% | | | | X | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| percentage | | | | | | |
| Proportion of own-account and contributing family workers in total employment, men, percentage | -7.55% | | | | X | |
| **1.8 Prevalence of underweight children under-five years of age** | | | | | | |
| Children under 5 moderately or severely underweight, percentage | -24.31% | | | X | | |
| Children under 5 severely underweight, percentage | -47.89% | | | X | | |
| **[non-MDG] Unemployment rate of young people aged 15-24 years, each sex and total** | | | | | | |
| Youth unemployment rate, aged 15-24, both sexes | -1.12% | | | | X | |
| Youth unemployment rate, aged 15-24, women | | | | | | X |
| Youth unemployment rate, aged 15-24, men | | | | | | X |
| Ratio of youth unemployment rate to adult unemployment rate, both sexes | 3.57% | | | | X | |
| Ratio of youth unemployment rate to adult unemployment rate, women | | | | | | X |
| Ratio of youth unemployment rate to adult unemployment rate, men | | | | | | X |
| Share of youth unemployed to total unemployed, both sexes | -6.82% | | | | X | |
| Share of youth unemployed to total unemployed, women | | | | | | X |
| Share of youth unemployed to total unemployed, men | | | | | | X |
| Share of youth unemployed to youth population, both sexes | | | | | | X |
| Share of youth unemployed to youth population, women | | | | | | X |
| Share of youth unemployed to youth population, men | | | | | | X |
| **1.9 Proportion of population below minimum level of dietary energy consumption** | | | | | | |
| Population undernourished, percentage | 25.00% | | X | | | |
| Population undernourished, millions | 100.00% | | X | | | |
| **2.1 Net enrolment ratio in primary education** | | | | | | |
| Total net enrolment ratio in primary education, both sexes | 96.45% | X | | | | |
| Total net enrolment ratio in primary education, boys | 91.45% | X | | | | |
| Total net enrolment ratio in primary education, girls | 86.11% | X | | | | |
| **2.2 Proportion of pupils starting grade 1 who reach last grade of** | | | | | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| **primary** | | | | | | |
| Percentage of pupils starting grade 1 who reach last grade of primary, both sexes | 12.04% | | | X | | |
| Percentage of pupils starting grade 1 who reach last grade of primary, boys | 13.17% | | | X | | |
| Percentage of pupils starting grade 1 who reach last grade of primary, girls | 10.98% | | | X | | |
| Primary completion rate, both sexes | 44.41% | | | X | | |
| Primary completion rate, boys | 50.89% | | | X | | |
| Primary completion rate, girls | 38.12% | | | X | | |
| **2.3 Literacy rate of 15-24 year-olds, women and men** | | | | | | |
| Literacy rates of 15-24 years old, both sexes, percentage | -1.15% | | | | X | |
| Literacy rates of 15-24 years old, men, percentage | -2.72% | | | | X | |
| Literacy rates of 15-24 years old, women, percentage | 0.13% | | | | X | |
| Women to men parity index, as ratio of literacy rates, 15-24 years old | 3.19% | | | | X | |
| **3.1 Ratio of girls to boys in primary, secondary and tertiary education** | | | | | | |
| Gender Parity Index in primary level enrolment | 1.02% | | | | X | |
| Gender Parity Index in secondary level enrolment | 6.49% | | | | X | |
| Gender Parity Index in tertiary level enrolment | 152.63% | | | X | | |
| **3.2 Share of women in wage employment in the non-agricultural sector** | | | | | | |
| Share of women in wage employment in the non-agricultural sector | | | | | X | |
| **3.3 Proportion of seats held by women in national parliament** | | | | | | |
| Seats held by women in national parliament, percentage | 75.43% | | | X | | |
| Total number of seats in national parliament | 32.38% | | | X | | |
| Seats held by men in national parliament | -1.32% | | | | X | |
| Seats held by women in national parliament | 106.25% | | | X | | |
| **4.1 Under-five mortality rate** | | | | | | |
| Children under five mortality rate per 1,000 live births | -33.40% | | | X | | |
| **4.2 Infant mortality rate** | | | | | | |
| Infant mortality rate (0-1 year) per 1,000 live births | -30.93% | | | X | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| **4.3 Proportion of 1 year-old children immunized against measles** | | | | | | |
| Children 1 year old immunized against measles, percentage | 10.00% | | | X | | |
| **5.1 Maternal mortality ratio** | | | | | | |
| Maternal mortality ratio per 100,000 live births | -10.23% | | | X | | |
| **5.2 Proportion of births attended by skilled health personnel** | | | | | | |
| Births attended by skilled health personnel, percentage | -1.14% | | | | X | |
| **5.3 Contraceptive prevalence rate** | | | | | | |
| Current contraceptive use among married women 15-49 years old, any method, percentage | 153.85% | | | X | | |
| Current contraceptive use among married women 15-49 years old, modern methods, percentage | 195.45% | | | X | | |
| Current contraceptive use among married women 15-49 years old, condom, percentage | 185.71% | | | X | | |
| **5.4 Adolescent birth rate** | | | | | | |
| Adolescent birth rate, per 1,000 women | 0.00% | | | | X | |
| **5.5 Antenatal care coverage (at least one visit and at least four visits)** | | | | | | |
| Antenatal care coverage, at least one visit, percentage | 21.86% | | | X | | |
| Antenatal care coverage, at least four visits, percentage | -11.51% | | X | | | |
| **5.6 Unmet need for family planning** | | | | | | |
| Unmet need for family planning, total, percentage | -27.57% | | | X | | |
| Unmet need for family planning, spacing, percentage | -16.11% | | | X | | |
| Unmet need for family planning, limiting, percentage | -44.63% | | | X | | |
| **6.1 HIV prevalence among population aged 15-24 years** | | | | | | |
| People living with HIV, 15-49 years old, percentage | -11.43% | | | X | | |
| HIV prevalence rate, women 15-49 years old, in national based surveys | | | | | | X |
| HIV prevalence rate, men 15-49 years old, in national based surveys | | | | | | X |
| AIDS deaths | -12.73% | | | X | | |
| **6.2 Condom use at the last high-risk sex** | | | | | | |
| Condom use at last high-risk sex, 15-24 years old, women, | 151.63% | | | X | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| percentage | | | | | | |
| Condom use at last high-risk sex, 15-24 years old, men, percentage | 56.05% | | | X | | |
| Condom use to overall contraceptive use among currently married women 15-49 years old, percentage | 13.43% | | | X | | |
| **6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS** | | | | | | |
| Men 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage | 78.88% | | | X | | |
| Women 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage | 71.18% | | | X | | |
| **6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years** | | | | | | |
| Ratio of school attendance rate of orphans to school attendance rate of non orphans | 64.41% | | | X | | |
| School attendance rate of orphans aged 10-14 | 38.68% | | | X | | |
| School attendance rate of children aged 10-14 both of whose parents are alive and who live with at least one parent | 24.30% | | | X | | |
| AIDS orphans (one or both parents) | 83.02% | | X | | | |
| **6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs** | | | | | | |
| Antiretroviral therapy coverage among people with advanced HIV infection, percentage | 121.43% | X | | | | |
| **6.6 Incidence and death rates associated with malaria** | | | | | | |
| Notified cases of malaria per 100,000 population | | | | | | X |
| Malaria death rate per 100,000 population, all ages | | | | | | X |
| Malaria death rate per 100,000 population, ages 0-4 | | | | | | X |
| **6.7 Proportion of children under 5 sleeping under insecticide-treated bednets** | | | | | | |
| Children under 5 sleeping under insecticide-treated bed nets, percentage | 1123.81% | X | | | | |
| **6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs** | | | | | | |
| Children under 5 with fever being | 6.18% | | | | X | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| treated with anti-malarial drugs, percentage | | | | | | |
| **6.9 Incidence, prevalence and death rates associated with tuberculosis** | | | | | | |
| Tuberculosis prevalence rate per 100,000 population (mid-point) | -59.38% | X | | | | |
| Tuberculosis prevalence rate per 100,000 population (lower bound) | -59.52% | X | | | | |
| Tuberculosis prevalence rate per 100,000 population (upper bound) | -60.00% | X | | | | |
| Tuberculosis death rate per year per 100,000 population (mid-point) | -58.06% | X | | | | |
| Tuberculosis death rate per year per 100,000 population (lower bound) | -49.17% | X | | | | |
| Tuberculosis death rate per year per 100,000 population (upper bound) | -61.40% | X | | | | |
| Tuberculosis incidence rate per year per 100,000 population (mid-point) | -17.39% | X | | | | |
| Tuberculosis incidence rate per year per 100,000 population (lower bound) | -10.00% | X | | | | |
| Tuberculosis incidence rate per year per 100,000 population (upper bound) | -25.93% | X | | | | |
| Tuberculosis detection rate under DOTS, percentage (lower bound) | 62.50% | X | | | | |
| Tuberculosis detection rate under DOTS, percentage (upper bound) | 38.89% | X | | | | |
| **6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course** | | | | | | |
| Tuberculosis detection rate under DOTS, percentage (mid-point) | 48.94% | X | | | | |
| Tuberculosis treatment success rate under DOTS, percentage | 10.00% | X | | | | |
| **7.1 Proportion of land area covered by forest** | | | | | | |
| Proportion of land area covered by forest, percentage | -14.93% | | X | | | |
| **7.2 Carbon dioxide emissions, total, per capita and per $1 GDP (PPP)** | | | | | | |
| Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC) | 154.66% | | X | | | |
| Carbon dioxide emissions (CO2), thousand metric tons of CO2 (UNFCCC) | | | | | | X |
| Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC) | 57.08% | | X | | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| Carbon dioxide emissions (CO2), metric tons of CO2 per capita (UNFCCC) | | | | | | X |
| Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (CDIAC) | 20.87% | | X | | | |
| Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (UNFCCC) | | | | | | X |
| Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $) | -10.81% | | X | | | |
| **7.3 Consumption of ozone-depleting substances** | | | | | | |
| Consumption of all Ozone-Depleting Substances in ODP metric tons | | | | | | X |
| Consumption of ozone-depleting CFCs in ODP metric tons | -92.50% | | X | | | |
| **7.4 Proportion of fish stocks within safe biological limits** | | | | | | |
| Proportion of fish stocks within safe biological limits | | | | | | X |
| **7.5 Proportion of total water resources used** | | | | | | |
| Proportion of total water resources used, percentage | | | | | | X |
| **[non-MDG] Proportion of population using solid fuels** | | | | | | |
| Population using solid fuels, percentage | -1.05% | | | | X | |
| **7.6 Proportion of terrestrial and marine areas protected** | | | | | | |
| Terrestrial and marine areas protected to total territorial area, percentage | 5.34% | | | | X | |
| Terrestrial and marine areas protected, sq. km. | 5.34% | | | | X | |
| Terrestrial areas protected to total surface area, percentage | 4.53% | | | | X | |
| Terrestrial areas protected, sq. km. | 4.44% | | | | X | |
| Marine areas protected to territorial waters, percentage | 170.27% | | | X | | |
| Marine areas protected, sq. km. | 172.98% | | | X | | |
| **7.7 Proportion of species threatened with extinction** | | | | | | |
| Proportion of species threatened with extinction | | | | | | X |
| **7.8 Proportion of population using an improved drinking water source** | | | | | | |
| Proportion of the population using improved drinking water sources, total | -1.82% | | | | X | |
| Proportion of the population using improved drinking water sources, | -14.89% | | X | | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| urban | | | | | | |
| Proportion of the population using improved drinking water sources, rural | -2.17% | | | | X | |
| **7.9 Proportion of population using an improved sanitation facility** | | | | | | |
| Proportion of the population using improved sanitation facilities, total | 0.00% | | | | X | |
| Proportion of the population using improved sanitation facilities, urban | 18.52% | | | X | | |
| Proportion of the population using improved sanitation facilities, rural | -8.70% | | X | | | |
| **7.10 Proportion of urban population living in slums** | | | | | | |
| Slum population as percentage of urban, percentage | -16.02% | | | X | | |
| Slum population in urban areas | 76.65% | | X | | | |
| **8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income** | | | | | | |
| Net ODA as percentage of OECD/DAC donors GNI | | | | | | X |
| Net ODA to LDCs as percentage of OECD/DAC donors GNI | | | | | | X |
| Net ODA, million US$ | | | | | | X |
| Net ODA to LDCs, million US$ | | | | | | X |
| **8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)** | | | | | | |
| ODA to basic social services as percentage of sector-allocable ODA | | | | | | X |
| ODA to basic social services, million US$ | | | | | | X |
| **8.3 Proportion of bilateral ODA of OECD/DAC donors that is untied** | | | | | | |
| ODA that is untied, percentage | | | | | | X |
| ODA that is untied, million US$ | | | | | | X |
| **8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes** | | | | | | |
| ODA received in landlocked developing countries as percentage of their GNI | | | | | | X |
| ODA received in landlocked developing countries, million US$ | | | | | | X |
| **8.5 ODA received in small island developing States as a** | | | | | | |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| **proportion of their gross national incomes** | | | | | | |
| ODA received in small islands developing States as percentage of their GNI | | | | | | X |
| ODA received in small islands developing States, million US$ | | | | | | X |
| **8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and from the least developed countries, admitted free of duty** | | | | | | |
| Developed country imports from developing countries, admitted duty free, percentage | | | | | | X |
| Developed country imports from the LDCs, admitted duty free, percentage | | | | | | X |
| **8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries** | | | | | | |
| Average tariffs imposed by developed countries on agricultural products from developing countries | | | | | | X |
| Average tariffs imposed by developed countries on textiles from developing countries | | | | | | X |
| Average tariffs imposed by developed countries on clothings from developing countries | | | | | | X |
| **8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product** | | | | | | |
| Agriculture support estimate for OECD countries as percentage of their GDP | | | | | | X |
| Agriculture support estimate for OECD countries, million US$ | | | | | | X |
| **8.9 Proportion of ODA provided to help build trade capacity** | | | | | | |
| ODA provided to help build trade capacity, percentage | | | | | | X |
| **8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)** | | | | | | |
| Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion | | | | | | X |

| INDICATOR/MEASUREMENT | PERCENTAGE CHANGE | SUCCESS | FAILURE | SUCCESSFUL FAILURE | NO CHANGE | NO DATA |
|---|---|---|---|---|---|---|
| points (cumulative) | | | | | | |
| **8.11 Debt relief committed under HIPC and MDRI Initiatives** | | | | | | |
| Debt relief committed under HIPC initiative, cumulative million US$ in end-2006 NPV terms | | | | | | X |
| Debt relief delivered in full under MDRI initiative, cumulative million US$ in end-2006 NPV terms | | | | | | X |
| **8.12 Debt service as a percentage of exports of goods and services** | | | | | | |
| Debt service as percentage of exports of goods and services and net income | -94.57% | | X | | | |
| **8.13 Proportion of population with access to affordable essential drugs on a sustainable basis** | | | | | | |
| Population with access to essential drugs, percentage | | | | | | X |
| **8.14 Telephone lines per 100 population** | | | | | | |
| Telephone lines per 100 population | 0.00% | | | | X | |
| Telephone lines | 69.58% | X | | | | |
| **8.15 Cellular subscribers per 100 population** | | | | | | |
| Mobile cellular telephone subscriptions per 100 population | | X | | | | |
| Mobile cellular telephone subscriptions | | X | | | | |
| **8.16 Internet users per 100 population** | | | | | | |
| Internet users per 100 population | | X | | | | |
| Internet users | | X | | | | |
| Personal computers per 100 population | 468.75% | X | | | | |
| Personal computers | 612.00% | X | | | | |

(United Nations Statistical Division)

## Appendix D: Active Projects Under NGRSP I

| | |
|---|---|
| Tanzania Health Sector Development Project II - Additional Financing FY10 | 22-DEC-2009 |
| Additional Financing for Tanzania Second Social Action Fund (TASAF II) | 09-JUN-2009 |
| Additional Financing for Agricultural Sector Development Project | 09-JUN-2009 |
| Tanzania - Accelerated Food Security Project | 09-JUN-2009 |
| Sustainable Management of Mineral Resources | 09-JUN-2009 |
| Science & Technology Higher Education | 27-MAY-2008 |
| Second Central Transport Corridor Project | 27-MAY-2008 |
| TZ-GEF Energy Dvpt and Access Expansion | 13-DEC-2007 |
| TZ-Energy Development & Access Expansion | 13-DEC-2007 |
| Lower Kihansi Environmental Management Project 2 | 27-SEP-2007 |
| Performance Results and Accountability Project | 27-SEP-2007 |
| TZ-Health Sector Development II Scale-Up | 05-JUL-2007 |
| Zanzibar Basic Education Improvement Project | 24-APR-2007 |
| Water Sector Support Project | 13-FEB-2007 |
| Financial Sector Support Project | 15-JUN-2006 |
| Local Government Support Project - Scale-up | 15-JUN-2006 |
| Tanzania Agricultural Sector Development Project | 15-JUN-2006 |
| Accountability, Transparency & Integrity Program | 09-MAY-2006 |
| Private Sector/MSME Competitiveness | 15-DEC-2005 |
| Marine and Coastal Environment Management | 21-JUL-2005 |
| Marine and Coastal Environmental Management Project | 21-JUL-2005 |

(World Bank)

## Appendix E: Active Projects Under NGRSP II

| | |
|---|---|
| Development of a National Statistical System for Tanzania | 24-MAR-2011 |
| Zanzibar Urban Services Project | 24-FEB-2011 |
| Tanzania ICT and Services Incubator (AFR 5) | 03-SEP-2010 |
| Tanzania - Backbone Transmission Investment Project | 26-AUG-2010 |
| Second Additional Financing for TASAF II | 04-JUN-2010 |
| Second Additional Financing for Agriculture Sector Development Project | 28-MAY-2010 |
| Tanzania Strategic Cities Project | 27-MAY-2010 |
| Secondary Educ. Development Program II | 27-MAY-2010 |
| Transport Sector Support Project | 27-MAY-2010 |
| Tanzania: Extractive Industries Transparency Initiative | 22-APR-2010 |
| BEIA- Promotion of Charcoal Briquettes in Tanzania | 06-APR-2010 |
| Additional Financing - Energy Development and Access Expansion Project | 06-APR-2010 |
| Tanzania - Housing Finance Project | 09-MAR-2010 |

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