DRAFT REPORT OF THE OSSAP-MDGs/HOUSE OF REPRESENTATIVES COMMITTEE ON MILLENNIUM DEVELOPMENT GOALS (MDGs) STUDY TOUR TO INDIA

26TH MARCH-7TH APRIL 2010

SPONSORED BY OFFICE OF THE SENIOR SPECIAL ASSISSTANT TO THE PRESIDENT ON MILLENEUM DEVELOPMENT GOALS

(OSSAP-MDGs)

ORGANIZED BY THE HEALTH REFORM FOUNDATION OF NIGERIA

(HERFON)

ACKNOWLEDGEMENTS

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This tour would not have been possible without the support and collaboration of the Ministry of Foreign Affairs, Nigerian High Commission in New Delhi, Indian High Commission in Abuja, Chairman of the house Committee on MDGs and her staff, Staff of the MDGs office and several others too numerous to mention. We remain grateful to you all.

LIST OF ABBREVIATIONS AND ACRONYMS

UN	United Nations
OSSAP	Office of senior special Assistant
MDGs	Millennium Development Goals
NASS	National Assembly
HIV	Human immune virus
AIDS	Acquired immune deficiency disease
HERFON	Health Reform Foundation of Nigeria
IMA	Indian medical Association
UNICEF	United Nation Children's fund
WHO	World Health Organization
UNDP	United Nations Development Programme
NACO	National Aids control organization
NACP	National Aids control Programme
USD	United States Dollar
STIs	Sexually transmitted infections
FSW	Female sex workers
MSW	Male sex workers
TB	Tuberculosis

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EXECUTIVE SUMMARY

In 2000, at the United Nations Millennium Summit, 189 world leaders adopted the Millennium Declaration and agreed to collective commitments to overcome poverty through a set of eight mutually reinforcing interrelated time-bound goals (MDGs) with related targets.

The tour was organized for members of the House of Representatives committee on Millennium Development Goals (MDGs) to among other things expose members of the NASS to international best practices in the implementation of MDGs share Knowledge with other stakeholders on the journey so far in Nigeria and build members' capacity for effective legislation and implementation of MDGs related interventions.

The tour covered Five (5) of the Eight (8) Millennium Development goals including: Poverty and hunger, Basic Education, Infant mortality, maternal mortality and HIV/AIDs, Malaria and Tuberculosis Control

The study tour was conducted in two (2) phases; Pre tour activities and briefing and the main tour events. During the **Pre tour event**, the Consulting firm (HERFON) facilitated a pre tour event, which was used to prepare the participants on what to expect during the tour outside the shores of Nigeria.

The **main tour** activity provided opportunity for the participants to experience best practices in MDGs intervention in its entire ramification but with special emphasis on MDGs 1, 2, 4, 5 and 6. International consultants of repute on MDGs were recruited to facilitate the process in India. In addition to the technical inputs, briefs and discussions, participants also had opportunity to visit historical places and met with members of the Nigerian embassy/consulate in New Delhi, India

Although OSSAP/MDGs office and the Nigerian Government are doing everything possible to achieve the MDGs by 2015, there is still a very huge challenge and gaps that needs to be addressed. The following recommendations are proffered for consideration by both the OSSAP/MDGs and the House of Representatives committee on MDGs.

1. There is the need for greater commitment to the attainment of the MDGs in Nigeria by all stakeholders
2. The House of Representatives committee has a critical role to play in ensuring the fast tracking of the MDGs
3. More study tours and capacity building are requires for the Honourable members to be able to discharge their legislative and oversight function on MDGs
4. The Federal Government should consider the possibility of institutionalizing the MDGs office beyond 2015
5. Patriotism and Nationalism are essential ingredients for a speedy and successful attainment of the MDGs by 2015

PART ONE

BACKGROUND

In 2000, at the United Nations Millennium Summit, 189 world leaders adopted the Millennium Declaration and agreed to collective commitments to overcome poverty through a set of eight mutually reinforcing interrelated time-bound goals (MDGs) with related targets.

The MDGs synthesize the goals of 1990s global UN conferences and provide an accountability framework and global partnership for progressively eradicating poverty in all its dimensions. The MDGs are at the forefront of the global development agenda and represent the international community's commitment to eradicate poverty by 2015.

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

In September 2005, the UN World Summit resoundingly endorsed the MDGs. In the outcome document of the Summit, it was agreed that by 2006, all developing countries will prepare bold national strategies to achieve the MDGs, and that developed countries would increase their assistance to developing countries, particularly through higher levels of ODA.

The situation of MDG in Nigeria can be seen from two main sources: the Nigeria MDG report 2004 and the Nigeria MDG report 2005. We can also assess the situation from MDG office especially the Debt Relief Gains as provided in the 2006 annual budget. The 2004 report which was Nigeria's first report on the MDGs states that "based on available information it is unlikely that the country will be able to meet most of the goals by 2015 especially the goals related to eradicating extreme poverty and hunger, reducing child and maternal mortality and combating HIV/AIDS, malaria and other diseases". It further states that "for most of the other goals (i.e. apart from goal 1) up- to- date data exists which shows that if the current trend continues, it will be difficult for the country to achieve the MDG targets by 2015".

The Nigeria Millennium Development Goals 2005 report is the second in the series of annual reports on the MDGs in Nigeria. The report which addressed the eight MDGs highlights the current status

and trends of each of the MDGs, the challenges and opportunities in attaining the goal, the promising initiatives that are creating a supportive environment and priorities for development assistance. The report concluded that:

> There is high potential to attain some of the Millennium Development Targets namely,
>
> - Achieving universal primary education
> - Ensuring environmental stability
> - Developing a global partnership for development
>
> Given the current policy environment and strong political will, there is also the likelihood of eradicating extreme poverty and hunger.
>
> However, based on available information, there is the need for sustained efforts to ensure that the country meets the following goals by year 2015:
>
> - Achieving gender equality and women empowerment
> - Reducing child mortality
> - Improving maternal health; and
> - Combating HIV/AIDs, malaria and other diseases

The conclusion of the MDG 2005 report is very remarkable and gives hope that there is possibility for achieving all the MDGs in Nigeria with sustained effort. This conclusion is quite different from the conclusions reached by the first report in 2004. It is intriguing that without providing the basis and reason for the dramatic change, the 2005 states that there is high potential to achieve 3 of the goals (Goals 2, 7 and 8) likelihood to achieve one with strong political will (Goal 1) and the need for sustained efforts to ensure that the country meets the remaining four goals (Goals 3, 4, 5, and 6).

JUSTIFICATION

The National Assembly (NASS) has a critical role in ensuring that the MDGs are given legislative backing and that all the necessary resources needed are appropriated within the country's budget. In addition to these, the NASS also have an oversight function on all MDG interventions across the length and breadth of Nigeria. It is thus very critical and important that this important arm of Government is equipped with all the necessary information and expertise needed to ensure the country's attainment of the MDGs by 2015

SCOPE OF THE TOUR

The tour covered Five (5) of the Eight (8) Millennium Development goals including: Poverty and hunger, Basic Education, Infant mortality, maternal mortality and HIV/AIDs, Malaria and Tuberculosis Control

OBJECTIVES OF THE TOUR

1. To expose members of the NASS to international best practices in the implementation of MDGs
2. To share Knowledge with other stakeholders on the journey so far in Nigeria

3. To build members capacity for effective legislation and implementation of MDGs related interventions

Purpose of the tour

The overall purpose of the study tour is to ensure effective legislation and ultimate attainment of the Millennium Development Goals in Nigeria by 2015

Expected outcome

The participants are expected to come back home with improved knowledge and understanding of the MDGs and how the process of legislation will further enhance the Country's ability to attain the MDGs by 2015

Design of Tour Activities

The design of the tour was achieved after an extensive study of the terms of reference and an interactive discussion with the leadership of the MDGs house committee and the Indian High Commissioner to Nigeria. Emphasis was placed on poverty reduction approaches in India, health and education related intervention. The programme schedule is attached in annex 2

Political and Socioeconomic History of Nigeria and India

Nigeria (pronounced /naɪˈdʒɪəriə/), officially the **Federal Republic of Nigeria**, is a federal constitutional republic comprising thirty-six states and its Federal Capital Territory, Abuja. The country is located in West Africa and shares land borders with the Republic of Benin in the west, Chad and Cameroon in the east, and Niger in the north. Its coast in the south lies on the Gulf of Guinea on the Atlantic Ocean. The three largest and most influential ethnic groups in Nigeria are the Hausa, Igbo and Yoruba. In terms of religion Nigeria is roughly split half and half between Muslims and Christians with a very small minority who practice traditional religions.

The people of Nigeria have an extensive history. Archaeological evidence shows that human habitation of the area dates back to at least 9000 BC.[4] The area around the Benue and Cross River is thought to be the original homeland of the Bantu migrants who spread across most of central and southern Africa in waves between the 1st millennium BC and the 2nd millennium.

The name *Nigeria* was taken from the Niger River running through the country. This name was coined by Flora Shaw, the future wife of Baron Lugard, a British colonial administrator, in the late 19th century.

Nigeria is the most populous country in Africa, the eighth most populous country in the world, and the most populous country in the world in which the majority of the population is black. It is listed among the "Next Eleven" economies, and is a member of the Commonwealth of Nations. The economy of Nigeria is one of the fastest growing in the world, with the International Monetary Fund projecting a growth of 9% in 2008 and 8.3% in 2009.[5][6][7][8] It is the third largest economy in Africa, and is a regional power that is also the hegemon in West Africa.

India

India acquired independence on 15 August 1947 though sections of the country were carved out and stitched together to create another new country, Pakistan. The "institutional" road to independence

was perhaps laid down by the Government of India Act of 1935, where the gradual emergence of India as a self-governing entity had first been partly envisioned. Following India's independence in 1947, the Constituent Assembly deliberated over the precise constitutional future of India. On 26 January 1950, India became a Republic, and the Constitution of India was promulgated. Jawaharlal Nehru had become the country's first Prime Minister in 1947, and in 1952, in the country's first general election with a universal franchise, Nehru led the Indian National Congress to a clear victory. The Congress had long been the principal political party in India, providing the leadership to the struggle for independence, and under Nehru's stewardship it remained the largest and most influential party over the next three decades. In 1957, Nehru was elected to yet another five-year term as a member of the Lok Sabha and chosen to head the government. His 'regime' was marked by the advent of five-year plans, designed to bring big science and industry to India; in Nehru's own language, steel mills and dams were to be the temples of modern India. Relations with Pakistan remained chilling, and the purported friendship of India and China proved to be something of a hoax. China's invasion of India's borders in 1962 is said to have dealt a mortal blow to Nehru.

METHODOLOGY

The study tour was conducted in two (2) phases

- ✓ Pre tour activities and briefing
- ✓ The main tour events

Selection of Participants

Selection of participants was done by the OSSAP-MDGs in conjunction with the Leadership of the House of Representatives committee on MDGs. The delegation comprised of twelve Members, a secretariat staff, two staff of the office of the senior special assistant to the president on Millennium Development Goals and two consultants. It was led by Hon. Adewale Aribisala, the House MGDs Committee Deputy Chairman.

During the **Pre tour event**, the Consulting firm (HERFON) facilitated a pre tour discussion, which was used to prepare the participants on what to expect during the tour outside the shores of Nigeria. Adequate information about all the MDGs and targets was discussed through an interactive fashion with the participants taking a major stage in the process. This approach ensured that all participants were at same level on basic information regarding MDGs in principles, concepts and application.

The **main tour** activity provided opportunity for the participants to experience best practices in MDGs intervention in its entire ramification but with special emphasis on MDGs 1, 2, 4, 5 and 6. International consultants of repute on MDGs were recruited in India to facilitate the process. In addition to the technical inputs, participants also had the opportunity to visit historical places and met with members of the Nigerian embassy/consulate.

PART TWO

ACTIVITIES IN INDIA

The delegation visit accompanied by key officials of the Nigerian High Commission in New Delhi visited a number of places, which include:

1. Some historical places in Delhi
2. Nigerian High Commision in Delhi
3. Ministry of Rural Development
4. Ministry of Health and Family Welfare
5. Maternal Health, Malaria and Tuberculosis divisions
6. Indian Medical Association
7. National Aids Control Program
8. Primary Health Care Center
9. Department of School Education and Literacy and
10. Primus Specialist Hospital

1.Historical Visits

QUTB MINAR AND HUMAYUN'S TOMB

Qutb Minar is the highest stone tower reaching about 72.5 metres high containing 1650 steers inside. A tragedy occurred 20 years ago in the tower leaving 45 school children dead and made the tower permanently closed. The Humayun's tomb called Mausoleum of Mughal Emperor built in 1564 looks like a structure of twenty years ago.

2. NIGERIAN HIGH COMMISSION IN INDIA

The ambassador of Nigeria in India welcomed the delegates and wished them a happy stay. He furthered informed them that many of Nigerians are living in India without having a legitimate means of income, but engaged in criminal activities. He stressed on the good relationship with the government of India. He finally prayed for a successful program in India and back home.

The team leader responded by expressing his appreciation on behalf of the team, for the efforts and the necessary arrangements to receive the delegation at the airport and to meet with the various agencies and organisations.

3.MATERNAL HEALTH, MALARIA TUBERCULOSIS DIVISION

The Director General welcomed Members and expressed his happiness for visiting India and the centre. He stressed that India and Nigeria have a lot of things in common and Nigeria must adopt a similar work plan to meet the 2015 target. He informed the delegation that government policy, technical assistance, consultant, cash benefit scheme (money benefit giving to below poverty to gain access to medical care) and implementation by the general health system contributed enormously

for the success of the fight against these diseases. The Director General told Members on the various measures implored to supplement the above parameters, and these are:

1. The creation of various centres in the village (near to community), district, local, state and national levels with efficient and sufficient equipment and drugs.
2. Regular treatment with the support of NGO and community organisation help in bringing people with early sickness, at least two weeks infection.
3. Coordinating mechanism between the tuberculosis and HIV at both level.
4. Protection from early bite using mosquitoes' nets, fumigating the breeding site, indoor residual spray and space spray.
5. When outbreak, the use of chloroquine and artesunate.

4.WOMAN / CHILD MORTALITY RATE

He informed the delegation that at the year 2004 – 2006, 254 woman/child mortality rates was achieved and by 2010 there will be 190 – 200 at the northern and central belt of India respectively. He informed the delegation that 51% of safe delivery is through intervention and strategies and made up of:

1. Primary Health Care are under the community
2. Secondary Health Care is upgraded to sub centre with paediatrics doctors to a standard with facility for delivery.
3. District centre with surgical facilities take care of any complication during or after delivery.
4. Training paramedical staff to be able to receive delivery.
5. Extra attention on malaria and diarrhoea

A typical Primary Health Care visited contained all the necessary requirements for a medical institution. It has all the sections and units ranges from registry, immunization unit for new born babies, injection room, anti natal section, family planning division, consulting room, pharmacy unit, dispensing room, three laboratories (tuberculosis, HIV and routine test) and a separate malaria clinic and five medical practitioners from medical college India. All the services here are rendered free including cash benefit to below poverty level people.

In his response, the Deputy Chairman thanked the Director General and his team and informed them that the delegation is in India to see how and what are the strategies and modality the Government of India applied to curb the infant/maternal mortality rate and other diseases, so that to add up to what the Committee is doing in Nigeria to achieved the goals.

5. INDIAN MEDICAL ASSOCIATION

The Chairman informed the Indian Medical Association (IMA) on the progress of achievement recorded in the field of human medicine by the Indian medical practitioners in major areas and motivated members to visit them. This was also in order to get acquainted with these measures to determine if they can be implemented in Nigeria in order to bring the MDG's 2015 attainment to reality.

The Joint Secretary IMA Dr. ANIL BANSAL informed members that the IMA is the largest and longest body found in 1958 with branches in the 35 states and the 1700 local branches in India. The IMA is not only in India but also in many countries. The IMA have a 40,000 membership in many countries. The Joint Secretary further stated that the IMA have a good working relationship with the Government in areas of tuberculosis, malaria, polio and other diseases.

The association undergoes para-medical courses; it sends doctors to rural areas to render free medical services to people who do not have access to medical facilities. Dr. ANIL BANSAL indicated that the IMA is in association with UNICEF, WHO, UNDP. The Government provides finance for the program organised by the IMA.

The Chairman requested to know if the traditional system of medicine is incorporated into the IMA. The secretary informed members that the traditional practice has no scientific bases, but there are about 700,000 traditional practitioners mostly in villages.

6. NATIONAL AIDS CONTROL ORGANISATION

The Chairman informed the secretary that National Assembly delegation are in India to interact and share ideas on things of common interest including the deadly disease (HIV/AIDS).

The secretary welcomed the Chairman and the delegation and informed them that the National Aids Control Organisation (NACO)was established in 1991 – 1992. He stated that NACO is located in all the 35 states and 592 districts of India. He informed the delegates that the activities of NACO has been translated into the 16 approved languages to help propagate the campaign. He stressed the Indian prime minister's statement on HIV/AIDS viz 'The National Aids Control Programme must move out of the narrow confines of the health department and become an integral part of all government departments and programmes to create a national response, which can help reverse the epidemic.' He stressed that by now universal access to treatment of HIV/AIDS for all and by now 2015 reverse the spread of HIV/AIDS.

The HIV/AIDS India's response was in 1992 when the first case of death detected from the disease, world bank was approached for the sum of eighty four million USD ($84m) loan under the National AIDS Control Programme I (NACPI). Between 1999-2006 the NACP II was in place for the sum of two hundred and fifty million USD ($250m) from the World Bank. The NACP III came between 2007-2012 to engulf the sum of two billion three hundred million USD ($2.3bn) of which one billion seven hundred million USD ($1.7bn) from the Government.

The objectives and strategies of NACP III are:

- To reduce new infection by 60% in high prevalence states so as to obtain the reversal of the epidemic and 40% in the vulnerable states so as to stabilize the epidemic.
- Two-thirds of the resources and efforts towards prevention and the rest for care, support and treatment.
- Prevention of high and low risk population involved the targeted intervention for high risk groups (e) trackers, immigrants, FSW & MSW.
- Link worker scheme for rural population.
- Prevention and control of Sexually Transmitted Infections (STI's).

- Condom promotion.
- Blood safety.
- Counselling and training services.

Under the care, support and treatment strategies, people living with HIV/AIDS enjoyed:

- First line and second line APT
- Community Care Centre
- HIV/TB Coordination Centre
- Treatment of opportunistic infections.

RED RIBBON EXPRESS

This is a specially design exhibition train for mass mobilization against HIV/AIDS. The train is planned to stop at 152 stations in 22 states in one year. The second phase was launched 1st December 2009. The programme has embarked on training of district resource persons and outreach activities in villages through cinema van and folk troupes. This is linked with services like HIV testing, STI's treatment, general health check-up, mobile health clinic and doctors. He expressed a massive response with the aid of mobilization from the political leaders.

7. PRIMUS SUPER SPECIALITY HOSPITAL

This is an International associated centre for specialised surgeries. The institution specialises in orthopaedics, spine, neurology and cochlear implants surgeries. Delegates were shown round the hospital and interacted with the surgeons. The hospital has the most advanced medical technologies and follows the international patient service protocols.

8. HUMAN RESOURCE DEVELOPMENT (LITERACY CENTRE)

The secretary ANSHU VAISH welcome delegates to the centre and expressed her appreciation for taken India as a focal point. Ansau Vaish informed delegates that the Indian government introduced **SARVA SHIKSHA ABHIYAN** (SSA) "Free and compulsory elementary education", a fundamental right for children aged between 6-14 years, to obtain an elementary education. The system is the most important programme for the universalisation of elementary education, universal access and retention, bridging of gender and social category groups in elementary education and achieving significant enhancement in learning levels of children.

The programme is implemented in partnership with the state government and teachers across the country.

The secretary reminded delegates on MDG's Goal 2 to "Achieve Universal Primary Education", in line with this the government of India enacted the free and compulsory elementary education. Under the law, the following are included:

- The right to free and compulsory education till completion of elementary level.
- Prohibits physical punishment, mental harassment and screening procedures for admission.
- Introduction of child friendly and child centred learning system.

The system is supported by a programme of a midday meal scheme. A full meal to the satisfaction of each child that attended the elementary education daily and yield increase in children attending elementary education also breaking social barriers.

OBJECTIVES

The objectives of the scheme are:

- Driving hunger out of school.
- Help children concentrate on classroom activities.
- Encourage children to attend school regularly, particularly those of the disadvantaged groups.
- Provide nutritional support to children.
- Providing social harmony.

The chairman of the delegation wanted to know the source of financial implications of the schemes.

In the response, the secretary pointed out that the financial components of the system are borne entirely by central government.

CONCLUSION

India and Nigeria share similar characteristics in the sense that both are developing countries operating a democratic system of Government. Whereas India is the second most populous country in the world and the first in the Indian sub continent, Nigeria is the most populous black nation on earth and also the first in African sub continent in terms of population size. Both countries have serious challenges concerning human development indicators. Both countries have taken a giant strides aimed at achieving the MDGs, however, the level of attainment of these goals are slightly higher in India compared to Nigeria. Some of the recognized factors responsible for these successes despite their huge population include the following

1. India accepts she is poor but is determined to get out of poverty by the purposeful manner she is working towards MDG targets.
2. Those at the helm of affairs are highly committed to the welfare of India/Indians.
3. Those at the helm of affairs live a simple life and the cost of running Government are minimal [see official vehicles used by top government officials).
4. The government makes much revenue from tax/duty collection.
5. There is a deliberate effort by the Indian government to encourage local industries by discouraging importation of foreign products.
6. Small scale industries are easily seen everywhere which provides employment opportunities for their teeming population.

7. There is a high level of community involvement in almost all government programmes.

RECOMMENDATIONS

Although OSSAP/MDGs office and the Nigerian Government is doing everything possible to achieve the MDGs by 2015, there is still a very huge challenge and gaps that needs to be addressed. The following recommendations are proffered for consideration by both the OSSAP/MDGs and the House of Representatives committee on MDGs.

6. There is the need for greater commitment to the attainment of the MDGs in Nigeria by all stakeholders
7. The House of Representatives committee has a critical role to play in ensuring the fast tracking of the MDGs
8. More study tours and capacity building are requires for the Honourable members to be able to discharge their legislative and oversight function on MDGs
9. The Federal Government should consider the possibility of institutionalizing the MDGs office beyond 2015
10. Patriotism and Nationalism are essential ingredients for a speedy and successful attainment of the MDGs by 2015

ANNEX

Annex 1 List of participants

DELEGATES

Hon. Adewale Aribisala	Leader of the delegation
Hon. Abubakar S Bunu	Member
Hon. Godfrey A. Gaiya	Member
Hon. Henry Shawulu	Member
Hon. Olukolu Ganiyu	Member
Hon. Ajatta J. Joseph	Member
Hon. Isu O. Christopher	Member
Hon. Mudashiru K. Akinlabi	Member
Hon. Leonard Dilkon	Member
Hon. Chuedu Eluuemono	Member
Hon. Suleiman A. Kokoki	Member
Hon. Zakariyau Galadima	Member
Aliyu Z. Katuka	Asst. Committee Clerk
Fesse B. Tarlumun	OSSAP – MDGs
Offie K. Nwadiudo	OSSAP – MDG
Dr. Ahmed M. Gana	Lead Facilitator
Dr. Lamido Manomi	Co- Facilitator

Anne x 2 Programme of activities in India

TENTATIVE AGENDA FOR STUDY TOUR OF INDIA (MDGs) BY MEMBERS OF NATIONAL ASSEMBLY HOUSE COMMITTEE ON MDGs

26th FEBRUARY – 7st MARCH 2010

DATE / TIME	**AGENDA**
28th February	Arrival in New Delhi, India. Check into Hotel
1st March	Public Holiday (Holi festival of colours) Guided sightseeing trip of Delhi***
2nd March 2010	Courtesy Call - Nigerian High Commission, New Delhi, India - Ministry Of Foreign Affairs, India - Visit to Cedpa India
3rd March 2010	10.00-11.30 Visit to Ministry of health and Family welfare To Discuss the following topics: • Maternal mortality • Infant mortality • HIV/AIDs, Malaria and TB control 12.00Noon Visit to Indian Medical Association 12.30pm Visit to National AIDS Control Programme 4.00pm Visit to Indian Council on Medical Research - Visit to Primus Specialist Hospital - Visit to a sub urban PHC
4th March 2010	11.00am Visit Primary Health Center, Palam 2.00pm

	Visit to Primus Specialist Hospital 3.00pm -Visit to National Rural Employment Guarantee Scheme (NREGA)
5th March 2010	Whole Day Trip of Agra festival and other interesting tourist spots*** - -Gala Dinner (Indian Restaurant)***
6th March 2010	Shopping and Rest
7th March 2010	- Departure from Hotel to Nigeria

Annex 3 MDGs Indicators

Official list of MDG indicators

All indicators should be disaggregated by sex and urban/rural as far as possible.

Effective 15 January 2008

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	**Indicators for monitoring progress**
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day[a] 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and	3.1 Ratios of girls to boys in primary, secondary and tertiary education

in all levels of education no later than 2015	3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis

	6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums[b]
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction - both nationally and internationally Target 8.B: Address the special needs of the least developed countries 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	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.* Official development assistance (ODA) 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 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) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes

Target 8.C: Address the special needs of landlocked developing 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) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.5 ODA received in small island developing States as a proportion of their gross national incomes Market access 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity Debt sustainability 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1, http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries "to create an environment - at the national and global levels alike - which is conducive to development and the elimination of poverty".