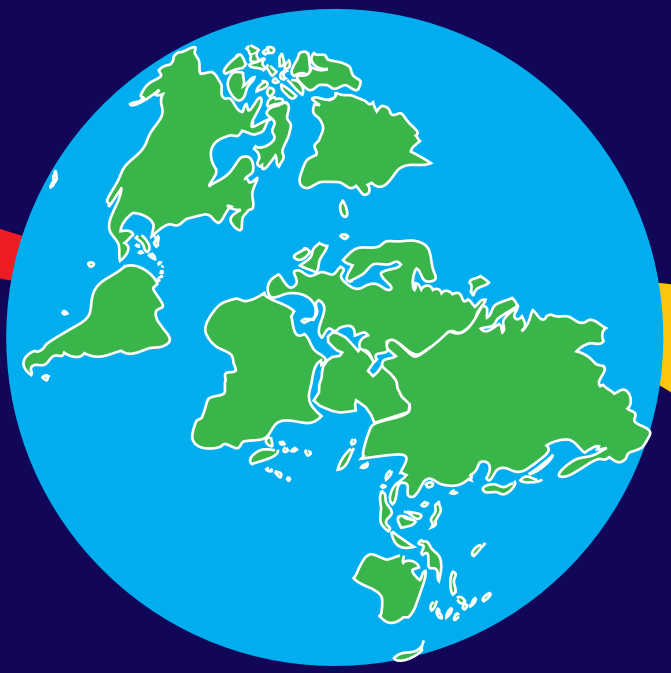
Brussels Programme of Action



Addressing the needs of the Least Developed Countries

UN-OHRLLS – United Nations Office of the High Representative for Least Developed Countries, Landlocked Developing Countries and Small Island Developing States

Brussels Programme of Action:
Addressing the Special Needs of the Least Developed Countries

UN-OHRLLS

United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS)

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Foreword

At the dawn of the century, in the Millennium Declaration, the leaders of the world who had gathered for the Millennium Summit at the United Nations Headquarters in 2000 in New York undertook to address the special needs of the Least Developed Countries (LDCs), 50 world poorest nations which faced specific constrains and had special needs in their development. The Programme of Action of the Least Developed Countries for the Decade 2001-2010 adopted at the Third United Nations Conference of the Least Developed Countries in 2001 in Brussels and often referred to as the Brussels Programme took those promises further by setting specific goals and targets and identifying policy actions by the LDCs and their development partners in support of those goals. Designed as a framework of partnership based on the shared but differentiated responsibilities of the LDCs and their development partners, it has become the first ever results-oriented comprehensive poverty reduction strategy tailored to the special needs of the LDCs. Those mutual responsibilities of the LDCs and their development partners are known now as commitments of the Programme of Action.

As we are heading for the High-level meeting on the midterm comprehensive global review of the implementation of the Brussels Programme in the sixty-first session of the General Assembly in September 2006 at the United Nations in New York it is worth to have a closer look at the achievements since the Third United Nations Conference and try to answer the following questions: to what extent the LDCs and development partners have achieved objectives, goals and targets of the Programme, what obstacles and challenges they are facing in its implementation, what lessons they have learned and whether there are good practices which have had a positive impact on reducing poverty and could be replicated elsewhere.

This aim of this publication has determined the structure of the chapters on the implementation of the Programme of Action which focus on progress, identify obstacles and constraints, challenges, and provide lessons learned and good practices in the implementation of each of seven commitments. The publication, by no means, aims at making an assessment. It leaves this to the upcoming the high-level meeting. Nor does it provide policy recommendations which have been clearly and in detail articulated in the Brussels Programme of Action. It identifies actions as a missing link between goals and commitments and aims to mobilize international action for attaining those goals and the overarching objective of the Brussels Programme to halve the proportion of people living in poverty and hunger by 2005.

Mr. Nelson Mandela, the Noble prize winner and the wise man of Africa, once said “Like slavery and apartheid, poverty is not natural. It is man-made and can be overcome and eradicated by actions of human beings”. He urged world leaders to act by saying: “Do not look the other way, do not hesitate. Recognize that the world is hungry for action, not words. Act with courage and vision”. I wholeheartedly support his words and sincerely hope they would be heard.

Anwarul K. Chowdhury
Under-Secretary-General and High Representative

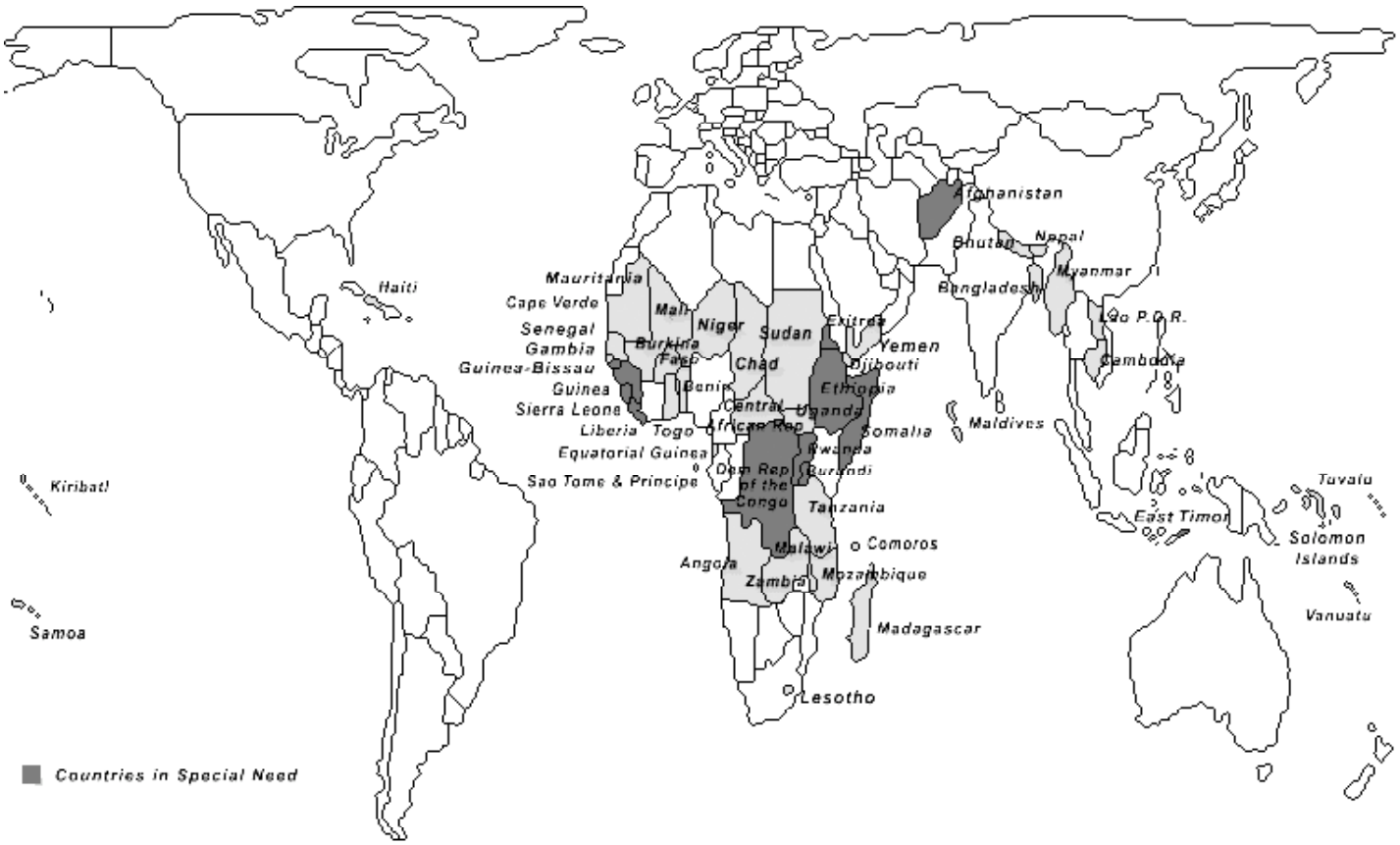
Glossary

AFD	Agence Française de Développement
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Treatment
BMZ	German Federal Ministry for Economic Cooperation and Development
BPoA	Brussels Program of Action
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DCs	Developing Countries
DDD	Digital Data Divide
DESA	Department of Economic and Social Affairs
DFID	UK Department of International Development
DOTS	Directly Observed Treatment Short-Course
DPA	Department of Political Affairs
EVI	Economic Vulnerability Index
FAO	Food and Agricultural Organization of the United Nations
FDI	Foreign Direct Investment
GCF	Gross Capital Formation
GDP	Gross Domestic Product
GFUSA	Grameen Foundation USA
GKP	Global Knowledge Partnership
GNI	Gross National Income
HAI	Human Assets Index
HBC	High Burden Country
HDPE	High-density Polyethylene
HIV	Human Immunodeficiency Virus
HYV	High Yield Variety
IADB	Inter-American Developing Bank
ICT	Information and Communications Technology
IDEA	Institute for Development in Economics and Administration
IDRC	International Development Research Centre
IFPRI	International Food Policy Research Institute
IFRC	International Federation of Red Cross
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ITU	International Telecommunication Union
IUCN	International Union for Conservation of Nature and Natural Resources
LDC	Least Developed Country
LLDC	Landlocked Developing Country
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
ORT	Oral Rehydration Therapy
OXFAM	Oxford Committee for Famine Relief
PMAS	Poverty Monitoring and Assessment Systems
SIDS	Small Island Developing States
TB	Tuberculosis
TBT	Technical Barriers to Trade
U5MR	Under-Five Mortality Rate
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
UNCTAD	United Nations Conference of Trade and Development
UNDP	United Nations Development Programme
UNEP	United Nations Environmental Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN/ISDR	United Nations International Strategy for Disaster Reduction
UN-OHRLLS	United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
UNRC	United Nations Resident Coordinator
USAID	US Agency for International Development
USD	United States Dollar
WB	The World Bank
WHO	World Health Organization
WRI	World Resources Institute
WTO	World Trade Organization
WWF	World Wildlife Fund for Nature

List of Least Developed Countries (LDCs)

1. Afghanistan
2. Angola
3. Bangladesh
4. Benin
5. Bhutan
6. Burkina Faso
7. Burundi
8. Cambodia
9. Cape Verde
10. Central African Republic
11. Chad
12. Comoros
13. Democratic Republic of Congo
14. Djibouti
15. Equatorial Guinea
16. Eritrea
17. Ethiopia
18. Gambia
19. Guinea
20. Guinea-Bissau
21. Haiti
22. Kiribati
23. Lao People's Democratic Republic
24. Lesotho
25. Liberia
26. Madagascar
27. Malawi
28. Maldives
29. Mali
30. Mauritania
31. Mozambique
32. Myanmar
33. Nepal
34. Niger
35. Rwanda
36. Samoa
37. São Tomé and Principe
38. Senegal
39. Sierra Leone
40. Solomon Islands
41. Somalia
42. Sudan
43. Timor Lesté
44. Togo
45. Tuvalu
46. Uganda
47. United Republic of Tanzania
48. Vanuatu
49. Yemen
50. Zambia

Map of the LDCs



Source: ITU (2005a)

1. The Socio-Economic Situation in LDCs

The group of the least developed countries (LDCs) comprises a wide range of countries in Africa (34) and Asia and Pacific (15). The Caribbean island of Haiti is the only LDC in the entire western hemisphere. The socio-economic situation facing these countries is not the same nor are the critical development problems which they face. Nevertheless, they do share a number of broad socio-economic characteristics which justify their grouping into a separate category.

These countries tend to be characterized by extreme poverty and structural weakness of their economies, often compounded by geographical handicap. They have limited human, institutional and productive capacity and are particularly vulnerable to external economic shocks, man made and natural disasters and communicable diseases. Other challenges facing LDCs include limited access to education, health and other social services, depletion of natural resources, poor infrastructure, and lack of access to information and communication technologies.

To classify for an LDC, a country must meet the following three criteria, established by the United Nations:

- First, a low-income criterion, based on a three-year average estimate of the gross national income (GNI) per capita (values for inclusion and graduation are $US 750 and $US 900 respectively);
- Second, a human resource weakness criterion, based on a composite Human Assets Index (HAI) comprised of: (a) nutrition; (b) health; (c) education; and (d) adult literacy (values for inclusion and graduation are 55 and 61, respectively);
- Third, an economic vulnerability criterion, involving a composite Economic Vulnerability Index (EVI) based on indicators of: (a) the instability of agricultural production; (b) the instability of exports of goods and services; (c) the economic importance of non-traditional activities (share of manufacturing and modern services in Gross Domestic Product (GDP)); (d) merchandise export concentration; and (e) the handicap of economic smallness (as measured through the population in logarithm) (values for inclusion and graduation are 37 and 33, respectively) A modified EVI has been adopted which includes one addition variable, namely the percentage of population displaced by natural disasters (values for inclusion and graduation are 38 and 34, respectively).

Table 1, below, presents values of the above indicators for individual LDCs in 2002.

The original list included only 24 LDCs. Since then this number has doubled. Timor Lesté was the last LDC to be added in 2003. Botswana is the only country to have graduated from LDC status. Maldives and Cape Verde were recommended for graduation in 2004 by the UN General Assembly.

Table 1 Select Socio-Economic Indicators for LDCs

	Population (millions) 2002	Per Capita GNI (USD) (2002)	HAI	EVI	EVI (modified)
Afghanistan	23.3	523	11.6	50.1	49.0
Angola	13.9	447	25.6	48.5	46.8
Bangladesh	143.4	363	45.3	22.9	29.5
Benin	6.6	367	40.2	57.0	56.4
Bhutan	2.2	600	40.4	40.6	41.0
Burkina Faso	12.2	217	26.5	49.3	47.0
Burundi	6.7	110	19.7	53.8	49.6
Cambodia	13.8	263	44.5	49.7	48.1
Cape Verde	0.4	1323	72.0	55.5	56.7
Central African Republic	3.8	277	29.9	43.1	42.0
Chad	8.4	203	26.1	59.2	56.6
Comoros	0.7	387	38.1	59.1	58.7
Democratic Republic of Congo	54.3	100	34.3	40.8	42.3
Djibouti	0.7	873	30.2	48.6	49.5
Equatorial Guinea	0.5	743	47.2	64.4	55.8
Eritrea	4.0	190	32.8	51.7	50.2
Ethiopia	66.0	100	25.2	42.0	40.7
Gambia	1.4	340	34.0	60.8	56.5
Guinea	8.4	447	30.3	42.1	40.0
Guinea-Bissau	1.3	170	31.2	64.6	60.7
Haiti	8.4	447	30.3	42.1	40.0
Kiribati	0.1	923	67.5	64.8	60.4
Lao People's Democratic Republic	5.5	297	46.4	43.9	43.4
Lesotho	2.1	573	45.4	44.2	44.5
Liberia	3.3	285	38.7	63.1	58.3
Madagascar	16.9	253	37.9	21.6	27.0
Malawi	11.8	177	39.0	49.0	49.4
Maldives	0.3	1983	65.2	33.6	37.5
Mali	12.0	230	19.9	47.5	45.4
Mauritania	2.8	377	38.2	38.9	37.7
Mozambique	19.0	220	20.0	35.6	39.2
Myanmar	49.0	282	60.0	45.4	45.6
Nepal	24.2	240	47.1	29.5	31.0
Niger	11.6	180	14.2	54.1	53.1
Rwanda	8.1	230	34.1	63.3	59.6
Samoa	0.2	1447	88.8	40.9	50.8
São Tomé and Principe	0.1	280	55.8	41.8	37.0
Senegal	9.9	490	38.1	38.4	38.8
Sierra Leone	4.8	130	21.7	45.7	43.3
Solomon Islands	0.5	657	47.3	46.7	49.1
Somalia	9.6	177	8.5	55.4	53.1
Sudan	32.6	333	46.4	45.2	46.5
Timor Lesté	0.8	478	36.4	n/a	n/a
Togo	4.8	293	48.6	41.5	42.8
Tuvalu	0.01	1383	63.7	70.3	67.3
Uganda	24.8	297	39.8	43.2	41.6
United Republic of Tanzania	36.8	263	41.1	28.3	30.2
Vanuatu	0.2	1083	57.4	44.5	46.4
Yemen	19.9	423	46.8	49.1	49.0
Zambia	10.9	317	43.4	49.3	47.6

Source: UN 2003b

2. The Brussels Programme of Action

On 20 May 2001, the Third United Nations Conference on the Least Developed Countries held in Brussels adopted the Programme of Action for the LDCs for the Decade 2001-2010 subsequently endorsed by the General Assembly in its resolution 55/279 of 12 July 2001. The overarching goal of the Programme is "to make substantial progress toward halving the proportion of people living in extreme poverty and suffering from hunger by 2015 and promote the sustainable development of the LDCs".

This Programme aims to improve the living conditions in the 50 LDCs by providing a framework and global partnership "to accelerate sustained economic growth and sustainable development in LDCs, to end marginalization by eradicating poverty, inequality and deprivation in these countries, and to enable them to integrate beneficially into the global economy".

This Programme contains 30 international development goals (Box 1), including those in the Millennium Declaration and mutual commitments of the LDCs and their development partners in seven interlinked areas: fostering a people-centred policy framework, ensuring good governance at national and international levels, building human and institutional capacities, enhancing the role of trade in development, reducing vulnerability and protecting the environment and mobilizing financial resources (Box 2).

The Programme also contains ten cross-cutting priority issues: poverty eradication, gender equality, employment, governance at national and international levels, capacity-building, sustainable development, special problems of landlocked and small island LDCs, and challenges faced by LDCs affected by conflict.

The following five guiding principles lie at the core of the Programme:

1. *An integrated approach:* The development process should be viewed in a comprehensive, coherent and long-term manner by LDCs and their partners, including the multilateral agencies within and outside the United Nations system. When addressing economic development and poverty eradication, there should be a balance between economic and other objectives of development. The implementation of the Programme of Action should be integrated into all international processes of concern to the LDCs.
2. *Genuine partnership:* With greater alignment between national policies and strategies in LDCs and the external assistance strategies of their partners, the scope for more effective dialogue between them has expanded. Open and transparent development cooperation, underpinned by strong political will, can help bring about rapid transformations in LDCs.
3. Country ownership: All efforts should be made by LDCs and their partners to ensure genuinely country-led development. This will be aided by the joint identification of development priorities by LDCs and their development partners. Also, LDCs will need to be effectively involved in areas such as aid coordination and debt relief.
4. *Market considerations:* While acknowledging the importance of market forces in the sustained process of economic growth and poverty reduction, there is a need to ensure an appropriate mix of public-private participation. However, this cannot be achieved without adequate attention to market weaknesses as well as government weaknesses, and consideration of the preparedness of the private sector. It is necessary to work towards a good balance between public action and private initiative. To be fully productive, however, a market must operate within a stable legal and economic framework.
5. *Result orientation:* Only positive concrete processes and outcomes can sustain public confidence in the development partnership between LDCs and their development partners. The process of identifying, assessing and monitoring progress on processes and concrete outcomes will be a key aspect of the implementation of the Programme of Action and its success will be judged by its contribution to progress of LDCs towards achieving international development targets, as well as their graduation from the list of LDCs.

Box 1 Goals and targets

1. Attain a GDP growth rate of at least 7 percent per annum.
2. Increase the ratio of investment to GDP to 25 percent per annum
3. Make substantial progress toward halving the proportion of people living in extreme poverty by 2015 (Millennium Development Goal (MDG) 1, T-1)
4. Make substantial progress towards halving the proportion of people who suffer from hunger by 2015 (MDG 1, T-2)
5. Making accessible, through the primary health system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015
6. Making available the widest achievable range of safe, effective, affordable and acceptable family planning and contraceptive methods
7. Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality (MDG 2, T-3)
8. Achieving a 50 percent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults
9. Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality (MDG 3, T-4)
10. Reducing the infant mortality rate below 35 per 1,000 live births by 2015 (MDG 4, T-5)
11. Reducing the under 5 mortality rate below 45 per 1,000 live births by 2015 (MDG 4, T-5)
12. Reducing the maternal mortality rate by three-quarters of the current rate by 2015 (MDG 5, T-6)
13. Reducing the number of undernourished people by half, by the year 2015
14. Reducing by half, by 2015, the proportion of people who are unable to reach or afford safe drinking water (MDG 7, T-10)
15. Reducing HIV infection rates in persons 15-24 years of age by 2005 in all countries, and by 25 percent in the most affected countries (MDG 6, T-7)
16. Increasing the percentage of women receiving maternal and prenatal care by 60 percent
17. Halving malnutrition among pregnant women and among pre-school children in LDCs by 2015
18. Substantially reducing infection rates from malaria, tuberculosis and other killer diseases in LDCs by the end of the decade; reducing tuberculosis (TB) deaths and prevalence of the disease by 50 percent by 2010; and reducing the burden of disease associated with malaria by 50 percent by 2010 (MDG 6, T-8)
19. Promoting child health and survival and reducing disparities between and within developed and developing countries as quickly as possible, with particular attention to eliminating the pattern of excess and preventable mortality among girl infants and children
20. Improving the health and nutritional status of infants and children
21. Promoting breast feeding as a child survival strategy
22. Increasing road networks or connections in LDCs to the current level of other developing countries and urban road capacities, including sewerage and other related facilities, by 2010.
23. Modernizing and expanding ports and airports and their ancillary facilities to enhance their capacities by 2010
24. Modernizing and expanding railway connections and facilities, increasing their capacities to the level of those in other developing countries by the end of the decade
25. Increasing LDCs' communication networks, including telecommunication and postal services, and improving access of the poor to such services in urban and rural areas to reach the current levels in other developing countries
26. Increasing computer literacy among students in higher institutions and universities by 50 percent and in junior and high schools by 25 percent, by 2015
27. Increasing average telephone density to 5 main lines per 100 inhabitants and Internet connections to 10 users per 100 inhabitants by the year 2010 (MDG 8, T-18)
28. Donor countries providing more than 0.20 percent of their GNP as ODA to LDCs: continue to do so and increase their efforts (MDG 8, T-13)
29. Other donor countries which have met the 0.15 percent target: undertake to reach 0.20 percent expeditiously
30. All other donor countries which have committed themselves to the 0.15 percent target: reaffirm their commitment and undertake either to achieve the target within the next five years or to make their best efforts to accelerate their endeavours to reach the target.

Box 2. Commitments

Commitment 1:	Fostering a people-centred policy framework
Commitment 2:	Good governance at national and international levels
Commitment 3:	Building human and institutional capacities
Commitment 4:	Building productive capacities to make globalization work for LDCs
Commitment 5:	Enhancing the role of trade in development
Commitment 6:	Reducing vulnerability and protecting the environment
Commitment 7	Mobilizing financial resources

The Programme recognizes that success will depend critically on effective follow-up, implementation, monitoring and review at the national, regional and global levels.

Follow-up and implementation of the PoA at the national level includes mainstreaming the Brussels Programme of Action in the national development framework and poverty eradication strategy, including where they exist, PRSPs, CCAs and UNDAF", identification of the national mechanism *(national forum)* that could provide a broad based platform for the regular follow-up, review and monitoring of the implementation of the PoA at the country level and, finally, ensuring linkages between the *national forum* and exiting country review mechanisms such as the World Bank's consultative group and UNDP round-table meetings that "should continue as principal coordination forums for development cooperation, as well as for mobilizing external development resources for LDCs". In this regard, the Programme emphasizes that "there should be "strong complementarities between the country review process and the national forums.

Regional follow-up should focus on cooperation between LDCs and other developing and developed countries and promote policy responses to better address the needs of the LDCs at the subregional and regional levels. The relevant UN regional economic commissions should mainstream the PoA in their work programmes and activities.

Follow-up at the global level includes assessing the economic and social performance of LDCs, monitoring the implementation of commitments by LDCs and their partners, reviewing the functioning of implementation and follow-up mechanisms at country, sub-regional, regional and sectoral levels, and policy developments at the global level with implications for LDCs.

To ensure effective follow-up to the Third United Nations Conference and effective implementation of the Programme of Action of the Least Developed the General Assembly by its resolution 56/227 has also established the United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS) at the United Nations Headquarters in New York.

The key functions of the UN-OHRLLS are as follows:

(a) To assist the Secretary-General in ensuring the full mobilization and coordination of all parts of the United Nations system, with a view to facilitating the coordinated implementation of and coherence in the follow-up and monitoring of the Programme of Action for the Least Developed Countries at the country, regional and global levels;

(b) To provide coordinated support to the Economic and Social Council as well as the General Assembly in assessing progress and in conducting the annual review of the implementation of the Programme of Action;

(c) To undertake appropriate advocacy work in favour of the least developed countries, in partnership with the relevant parts of the United Nations as well as with the civil society, media, academia and foundations;

(d) To assist in mobilizing international support and resources for the implementation of the Programme of Action for the Least Developed Countries and other programmes and initiatives for least developed countries;

(e) To provide appropriate support to group consultations of Least Developed Countries.

3. Implementation of the Brussels Programme of Action

3.1 Commitment 1: Fostering a People-Centred Policy Framework

> ***The overarching goal of the Brussels Programme of Action is to make substantial progress toward halving the proportion of people living in extreme poverty and suffering from hunger by 2015 and promote the sustainable development of the LDCs. This will require, among other things, significant and steady increases in GDP growth rates in LDCs*** (Brussels Programme of Action, para. 6).

Commitment 1 is central to the Brussels Programme of Action. Its aim is to create an enabling environment to "eradicate poverty and … put LDCs on a path of accelerated growth and sustainable development". It has adopted four goals relating to commitment 1, namely: 1) Attain a GDP growth rate of at least 7 percent per annum; 2) Increase the ratio of investment to GDP to 25 percent per annum[1]; 3) Make substantial progress toward halving the proportion of people living in extreme poverty by 2015 (MDG 1, T-1); 4) Make substantial progress towards halving the proportion of people who suffer from hunger by 2015 (MDG 1, T-2)

There are common elements within Commitment 1 and many of the other Commitments of the Brussels Programme of Action. The focus here is on economic growth and poverty reduction which, when combined, are often referred to as 'pro-poor growth'.

Pro-poor growth is important for two main reasons. First, it is virtually impossible to have significant reductions in poverty over the long term without economic growth. Second, economic growth does not guarantee poverty reduction. If growth is to improve living standards widely and reduce poverty, it requires the active participation of poor households as labourers, producers and service providers.

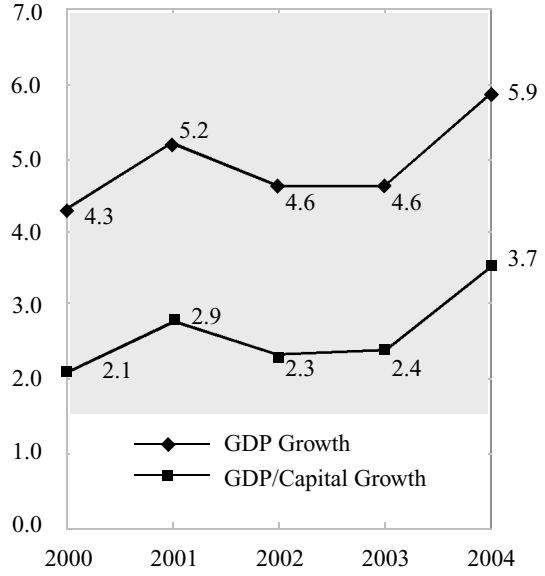
There is no consensus about the appropriate policy mix to ensure rapid growth in individual countries. Still, many would agree that growth tends to be facilitated by: a stable macroeconomic framework, technological change leading to increases in productivity, sound investments in physical and human capital including health and education, good governance and quality institutions.

Figure 1, Figure 2 and Table 2 present data on a number of key indicators of Commitment 1. Four points are particularly important:

- First, since 2000, rates of (gross domestic product) GDP growth and gross capital formation (GCF) has been generally positive, increasing around 2 percentage points for GDP growth and 1.5 percentage points for GCF.
- Second, the level of these indicators fall below target levels of the Brussels Programme of Action. The most recent figures show GDP growth of around 6% and GCF at around 21%.
- Third, there has been a real improvement when one compares the situation between 2000-04 and 1990-94. Both GDP and GCF have improved significantly.
- Fourth, GDP per capita has increased at a faster rate than GDP because population growth has slowed from 2.5% to 2.2% between 1990-99 and 2000-04.

[1]This indicator is a measure of investment, which is widely held to be an important source of long-term growth (though both the quantity and the quality of investment are important to growth).

Figure 1
GDP Growth Rates (LDCs)



Source: WB (2006)

Figure 2
Gross Capital Formation (GCF) (LDCs)

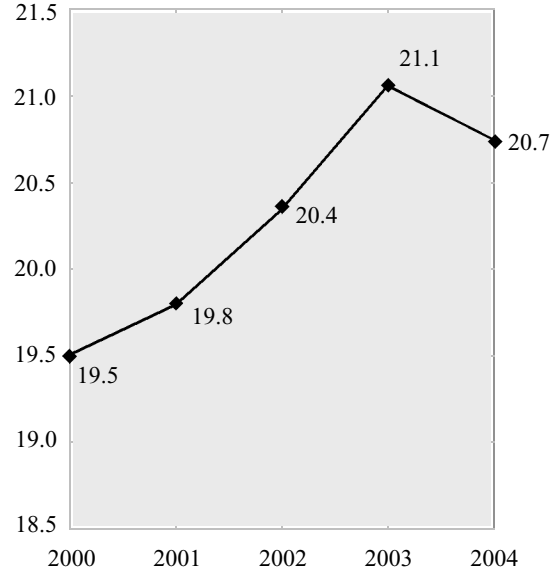


Table 2 Growth Rates in Selected Indicators of Commitment 1 (LDCs)

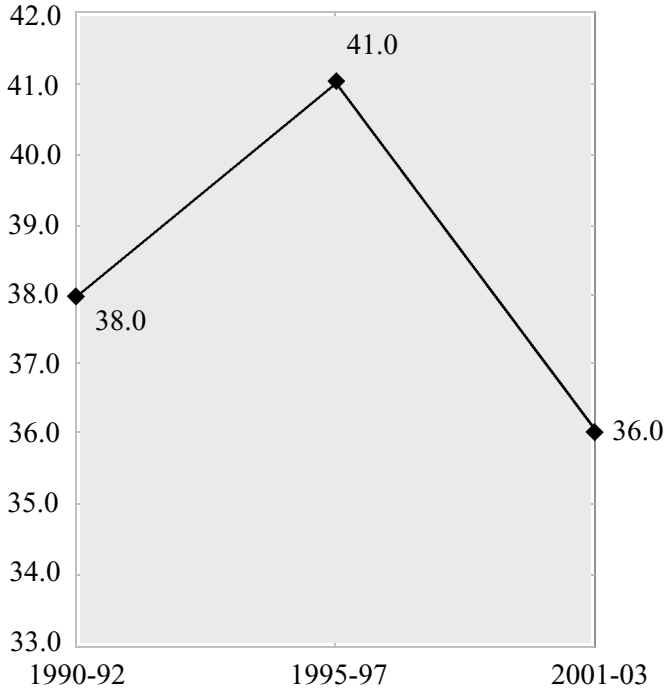
GDP	1990-1999	2000-2005
GDP per capita	3.1	4.9
GDP per capita	0.6	2.7
Population	2.5	2.2
GCF	5.1	7.2

Source: WB (2006)

Points 2, 3 and 4 above are very positive developments in that they point to significant improvements since 2000. An important question, however, is whether these changes have led to real improvements in living conditions of the poor in LDCs. One way to address this question is to examine what has happened to nutritional levels in LDCs. Figure 3 presents estimates of the proportion of the population below a minimum level of dietary energy consumption[2]. The indicator shows modest improvement from 1995-97 to 2001-2003 following declines between 1990-1992. As such, LDCs are not on track to reach the MDG/Brussels Programme of Action target of halving the proportion of undernourished persons by 2015. Points 2, 3 and 4 above are very positive developments in that they point to significant improvements since 2000. An important question, however, is whether these changes have led to real improvements in living conditions of the poor in LDCs. One way to address this question is to examine what has happened to nutritional levels in LDCs. Figure 3 presents estimates of the proportion of the population below a minimum level of dietary energy consumption. The indicator shows modest improvement from 1995-97 to 2001-2003 following declines between 1990-1992. As such, LDCs are not on track to reach the MDG/Brussels Programme of Action target of halving the proportion of undernourished persons by 2015.

[2]This indicator provides a rough guide because it is an estimate based on total food availability at national level and access to food at household level. It is not based on actual consumption or nutritional outcomes.

Figure 3 Proportion of Undernourished in Total Population (LDCs)



Source: FAO (2006)

In terms of consumption or income poverty, we cannot be sure about what has happened in LDCs since 2000 because of data constraints. It is possible, however, to make two inferences if we use information on the relationship between economic growth and poverty reduction which held in the 1990s:

- First, *on average*, the positive rates of GDP/capita growth since 2000, should have led to modest rates of poverty reduction in most LDCs. On average, a one percent increase in growth is associated with a 2-3% decline in $1 USD per day poverty.
- Second, in most sub-Saharan African LDCs, the rates of GDP/capita growth have not been high enough to meet the MDG/Brussels Programme of Action target of halving the proportion of people living in extreme poverty by 2015 which requires around 4-5% GDP/capita growth on average.

In those countries which have been successful in achieving pro-poor growth, a number of factors have been particularly important. Some of these include: maintenance of low/moderate levels of inequality; adoption of labour-using technology; strengthening of the role and position of women and girls; promotion of agricultural-based growth which have led to increases in agricultural productivity; creation of an appropriate incentive framework for producers; and, pro-poor investments in health and education.

The Mozambique case study in Box 3 provides a good example of a situation where many of these features of pro-poor growth have been present.

Box 3. Mozambique: Pro-Poor Growth

Over the past five years, the growth performance of Mozambique has far exceeded that of any other LDC. From 2000-2004, real per capita GDP growth has averaged over 7% compared to less than 3% for LDCs as a whole. In addition, the poverty headcount fell from around 70% in the mid-1990s to around 55% in 2002-3.

There are a number of factors which have contributed to Mozambique's very impressive growth performance including: macroeconomic stability, in particular, the reduction of inflation from around 60% in the mid-nineties to less than 10%; trade liberalisation which has facilitated very high rates of export growth; large inflows of Official Development Assistance (ODA), which account for around half of government spending and significant inflows of foreign direct investment in a number of large projects.

The high rates of growth have led to poverty reduction for two main reasons. First, the agricultural sector grew rapidly following the return of war refugees to their farms and the liberalisation of producer prices. Incomes of the rural poor increased directly though increased agricultural output and indirectly through increased on and off-farm employment. Second, public expenditure has focused on basic needs priorities in education, health, roads, water and agriculture with important linkages to poverty reduction.

While Mozambique has realized impressive gains, a number of important challenges lie ahead including addressing the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDs) pandemic whose prevalence stands at 16%, and further increasing productivity in agriculture and improving public finance management.

3.2 Commitment 2: Good Governance at National and International Levels

> ***Success in meeting the objectives of development and poverty eradication depends, inter alia, on good governance within each country. It also depends on good governance at the international level and on transparency in the financial, monetary and trading systems. We are committed to an open, equitable, rule-based, predictable and non-discriminatory multilateral trading and financial system. No effort will be spared to promote democracy and strengthen the rule of law, as well as respect for all internationally recognized human rights and fundamental freedoms, including the right to development.*** (Brussels Programme of Action, para. 25)

There are many components of good governance. In the Brussels Programme of Action, good governance includes such aspects as promotion of human rights, the rule of law, conflict resolution, people's participation, and empowerment of women, to name a few. Furthermore, it entails actions at both national and international levels for both LDCs and development partners.

One important aspect of good governance concerns the accountability of public institutions. Over the last decade, this aspect of good governance has been increasingly recognized as central to economic performance, poverty reduction and the improvement of living conditions in the developing world. In the words of anti-corruption crusader John Githongo the lack of accountability "undermines public faith in national institutions and leadership … [leading to] economic stagnation, political instability and social decay" (Githongo 2000)

In the context of public institutions, accountability requires that public officials be answerable for their actions and open to sanction if their conduct falls short of acceptable standards. It is harder to measure accountability than many of the other Brussels Programme of Action components. Parliamentary or presidential elections may be considered as one gauge of accountability in that they represent the most general mechanism to call public officials to account. Table 3 presents data on the number of LDCs that have held either legislative or presidential elections in the period 1998-2001 and 2002-present. It should be cautioned that these data do not provide information on the 'freedom or fairness' of the elections, nor on whether public accountability issues figures in electoral debates. Nevertheless, the data show a 15% increase in the number of LDCs who have held elections between the two periods of time.

Table 3 Number of LDCs Holding Elections (Legislative or Presidential)

1998-2001	2002-Present	% Change
32	37	+15

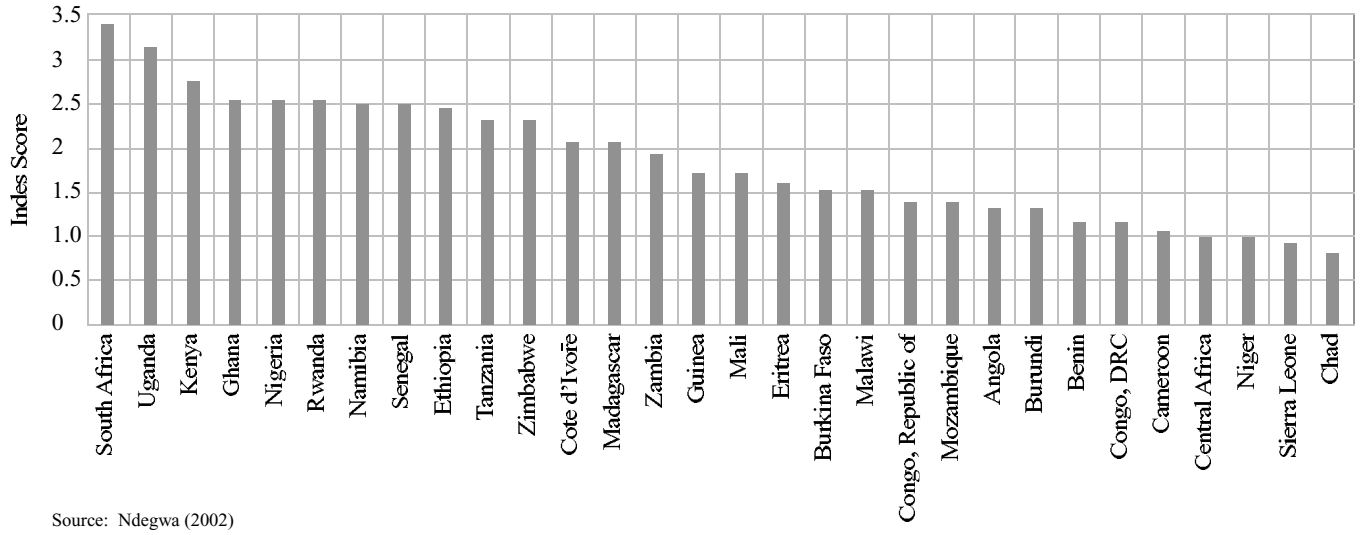
Source: www.electionguide.org

A second measure of accountability concerns the development and implementation of poverty monitoring and assessment systems (PMAS). Such systems have gained increasing importance in recent years as instruments of accountability in the context of the new paradigm of development assistance (see Section 3.7). This paradigm is based on four pillars: poverty reduction; national ownership and participation; new forms of partnerships and aid modalities; and results-based performance criteria.

PMASes usually have a number of components which: 1) monitor outcome or impact indicators such as poverty incidence, drawing primarily on survey and census data; 2) monitor the performance of government policies and programs related to poverty reduction, drawing heaving on administrative data; 3) assess the impact of particular policies or programs; 4) communicate/disseminate results to diverse stakeholders. As such, PMASes combine financial, administrative and citizen-based types of accountability. While it is too early to tell if these monitoring systems will impact significantly on public performance, it is significant that many LDCs have taken steps to develop or put them in place including: Benin, Bhutan, Burkina Faso, Cambodia, Cape Verde, Malawi, Mali, Mozambique, Nepal, Rwanda, Senegal, Uganda, Tanzania and Zambia.

Another potential measure of accountability is the extent of decentralization which has occurred in a country. By decentralization, we mean the transfer of public responsibilities and functions from higher to lower levels.. Decentralization *has the potential* to enhance accountability in that it brings government closer to the population whom it serves. Accordingly, people may be in a better position to monitor the activities of politicians and local officials as well as the quality of publicly-provided goods and services.

Figure 4 Decentralization in Sub-Saharan Africa



Source: Ndegwa (2002)

Figure 4 provides information on decentralization in sub-Saharan African nations, many of which are LDCs. It presents an index score of decentralization, which ranges from 0-4, based on the average score for administrative, financial and political decentralization. Two findings are particularly important.

- First, all the countries in question have undertaken some degree of decentralization though very few are well-advanced on this path (i.e. those who score above 3).
- Second, in general, LDCs lag behind developing countries in terms of decentralization. Nine of ten the lowest ranking nations and only five of ten of the highest ranking nations are LDCs .

A final point is that even where decentralization has occurred, it has sometimes had disappointing results in terms of fostering a climate of accountability and promoting poverty reduction. In those cases where decentralization has been more effective, a number of factors have been particularly important including: political commitment to local level democracy and participation; financial and administrative support to provide local government with the means to effectively provide goods and services; and, commitment to see the process through over the medium to long term.

Despite progress to date, public accountability continues to be a challenge for many LDCs. Progress has been uneven and there is room for further progress. Institutions and mechanisms to enhance accountability include: the legislature or parliament through the operation of opposition parties, oversight committees, etc.; government budgets, published data on public finances, annual accounts, audits, reviews and evaluations; internal procedures and mechanisms with the public service such as results-based management techniques to assess and reward public sector performance; the judiciary and the courts to sanction public officials in cases of unlawful conduct; direct involvement of citizen's groups to provide oversight through such instruments as participatory auditing, civil society funded service quality surveys (e.g. Report Cards), people's budgets, etc.

Uganda (Box 4 below), provides a good example of a success story in improving public finance management through mechanisms designed to enhance accountability.

Box 4. Uganda: Good Governance/Accountability

In Uganda, an expenditure tracking survey was undertaken in the mid-1990s to track the flow of public expenditures from release at central levels to receipt at the cost centre. It revealed that only around 15 percent of the annual grant for capital expenditure was reaching primary schools between 1991 and 1995. Upon receipt of these results, the Government of Uganda launched a major campaign to publicize financial flows which included the following measures:

i. publishing inter-governmental transfers of funds in major newspapers
ii. broadcasting on radio information on transfers
iii. requiring district centres and schools to post details of transfers on notice boards
iv. enshrining accountability and information dissemination in law in the Local Governance Act
v. delegating authority for procurement from district centres to individual schools.

Following this informational campaign, close to 80 percent of the grant was received by primary schools, a five hundred fold increase!

3.3 Building Human and Institutional Capacities

LDCs' greatest assets are their women, men and children, whose potential as both agents and beneficiaries of development must be fully realized. Efforts at development of human capacities in LDCs have been affected by low school enrolment and low health, nutrition, and sanitation status and by the prevalence of the HIV/AIDS pandemic, particularly in Africa, and malaria, tuberculosis and other communicable diseases, as well as by natural and man-made disasters. Making steady progress in this area will be a major objective during the decade. An immediate priority is to focus greater effort on fighting HIV/AIDS, malaria and tuberculosis and their social and economic impact. At the same time, longer-term policies and strategies must be pursued in health, education, employment and rural development, with due consideration for cross-sector synergies (Brussels Programme of Action, para. 30).

3.3.1 Tuberculosis (TB)

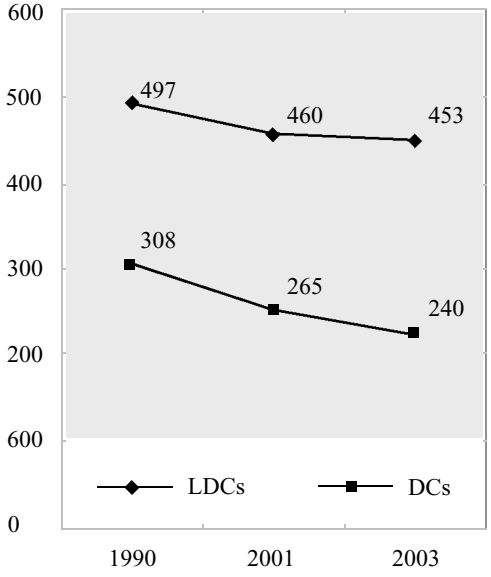
Reducing infection rates of tuberculosis, and associated deaths, are central objectives of the Brussels Programme of Action. It has adopted the MDG goals of reducing TB deaths and prevalence by 50% between 1990 and 2010.

TB is a contagious disease which spreads through the air. Around 10 percent of the 2 billion people infected go on to develop the disease. People with compromised immune systems are particularly susceptible. In fact, the HIV epidemic has greatly increased the number of tuberculosis cases. The World Health Organization (WHO) estimates that TB accounts for up to a third of AIDS deaths worldwide.

Poverty, a lack of basic health services, poor nutrition and inadequate living conditions are other factors which contribute to the spread of TB. In turn, illness and death from TB reinforces and deepens poverty in many communities. The disease strikes people during their most productive years. Three out of four deaths occur between the ages of 15 and 54.

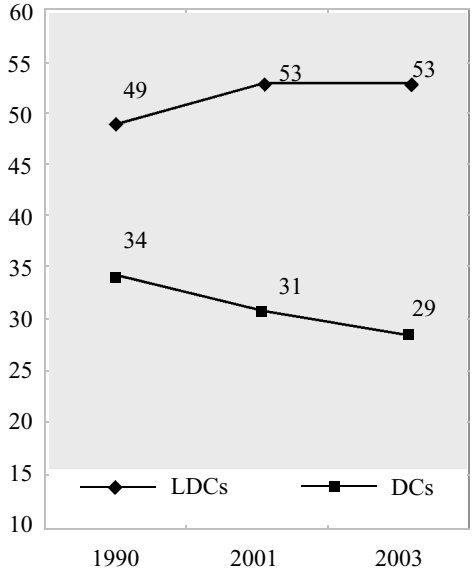
The WHO estimates that eight million people contract TB every year, of whom 95 percent live in Developing countries. About 2 million people die from TB every year, and almost half a million people are co-infected with HIV. As shown in Figure 5, the TB prevalence has fallen for LDCs by around 10% between 1990 and 2003 while the death rate has fallen by around 15% over this same period (Figure 6). These rates of reduction fall short of those required to meet the Brussels Programme of Action/MDG targets mentioned above.

Figure 5. Tuberculosis Prevalence Rates per 100,000 Population (excluding HIV-infected)



Sources: UN (2005a, b)

Figure 6. Tuberculosis Death Rates per 100,000 Population (excluding HIV-infected)



DOTS (Directly Observed Treatment Short-Course) is the internationally recommended strategy for TB control. It involves a number of measures designed to diagnose, treat and monitor the disease. Since DOTS was introduced on a global scale in 1991, more than 17 million people have received treatment. By the end of 2002, all 22 of the High Burden Countries (HBCs), which together have 80 percent of the world's estimated cases, had adopted the DOTS strategy. Nine of the HBCs are LDCs. Myanmar is a good example of how effective use of DOTS, along with other interventions, has lead to very significant reduction in TB prevalence (Box 5).

Box 5. The Maldives: Tuberculosis

Since 1997, the National TB Control Programme (NTCP) of the Maldives has achieved notable successes in the area of TB control. The country was the first in the South-East Asia Region to achieve the global TB targets set for 2005, and has continued to be very successful. Since 2000, the Maldives has maintained a case detection rate of over 100% and treatment success rates of over 90%. These successes are attributed to the programme's main focus on creating awareness and implementation of DOTS, as well as the participation of the community, private practitioners and government.

Mass awareness programmes using public media, such as TV, radio, leaflets and posters, have ensured that people are aware of the virus. The programme has helped reduce the stigma of TB among the community and has resulted in more people coming forward to seek treatment for the disease. In the words of one newly treated patient, "this is like having a new lease on life. I used to be so scared of getting treatment but now I am so glad I did. I'm practically back to normal".

Patients receive DOTS treatment and health education from their closest health facility. Throughout the entire course of their treatment, patients attend the clinic on a daily basis. In cases where patients are unable to make it to the clinics, health workers visit them at home also on a daily basis. The private sector has been well integrated in the NTCP through the establishment of a referral system. The government endures the majority of infrastructure costs, as well as staffing and operational costs. The WHO provides technical support in the form of training health workers, equipment, and medications.

Despite these very impressive accomplishments, there are challenges ahead. With increased travel in the regions and increased crowding in Malé, the capital city, there is a higher risk of transmission of the disease.

3.3.2 Malaria

Source: WB (2003)

Reducing infection rates and deaths from malaria are central objectives of the Brussels Programme of Action. It has adopted the goal of significantly reducing infection rates from malaria and the target of reducing the burden of disease associated with malaria by 50 percent by 2010.

Malaria is one of the world's most important public health concerns, resulting in up to 350-500 million cases and causing over a million deaths each year or approximately 3,000 deaths a day. Around 60 percent of the cases of clinical malaria, and over 80 percent of the deaths, occur in sub-Saharan Africa. Of the more than 1 million Africans who die from malaria each year, most are children under the age of 5. Malaria also contributes significantly to anaemia in children and pregnant women, adverse birth outcomes such as spontaneous abortion, stillbirth, premature delivery and low birth weight, and child mortality.

Unlike tuberculosis, malaria is not contagious. The most common method of transmission is through the bite of an infected mosquito. Today, more than 3 billion people live in malaria endemic areas. As of 2004, there are 107 countries and territories at risk of malaria transmission.

This disease takes a high toll on households and health care systems. It is estimated that in sub-Saharan Africa, malaria reduces GDP growth by approximately 1.3 percent per year. The poor are often most affected as they have less access to services, information and protective measures. Drug-resistance to affordable anti-malarial drugs is rising, and while more effective anti-malarials are available, they come at a significantly higher cost. The most cost-effective interventions against malaria today are rapid diagnosis and effective treatment, the use of insecticide-treated bed nets, treatment for pregnant women, and epidemic preparedness. Eritrea (Box 6) provides a good example of the successful implementation of many of these strategies.

Box 6. Eritrea & Niger: Malaria

Eritrea is one of the poorest nations in Africa. Approximately two-thirds of its 3.5 million people live in malaria endemic or epidemic-prone areas. The disease accounts for approximately 30 percent of clinic visits and hospital admissions. To reduce these numbers, Eritrea has used a range of proven strategies for malaria control, including: 1) early diagnosis and prompt treatment at health facility and community levels; 2) proper management of severe malaria at zoba(zone)/subzoba level; 3) provision of insecticide impregnated bed-nets to communities in all zones; 4) increase in community awareness in controlling malaria and health-seeking behaviour through the promotion of information, education, and communication (in local languages); and 5) environmental management through community participation and prevention.

Between 1999 and 2003, Eritrea witnessed a 63% decline in malaria morbidity. In 1999, over 179,000 cases were reported compared to just over 65,500 cases in 2003. Deaths from malaria fell from 176 in 1999 to 78 in 2003. This equates to a decrease in the mortality rate from 13.3 percent to 3.9 percent. In 1991, mortality among pregnant women from malaria was very high. Today it is practically non-existent. Mortality of children under five years of age dropped by 53 percent, in large part to the increased use of insect-treated bed nets. Bed net use increased from 20% of children in 2000 to 63% in 2003.

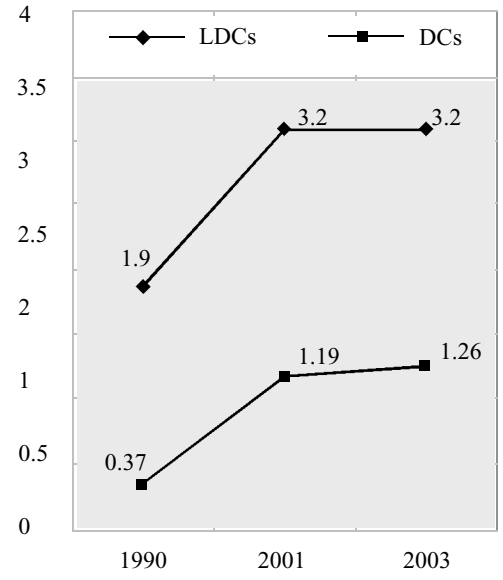
Further successes can be seen in Niger where 2,030,000 long-lasting insecticide-treated mosquito nets were distributed in a week-long campaign in December 2005. It was the biggest distribution ever carried out. The nets covered every child under five, a total of 3.5 million children, and every pregnant woman. Typically, one child in four does not reach her fifth birthday, due in large part to malaria-related deaths. These nets have the potential to drastically reduce these numbers.

3.3.3 HIV/AIDS

Reducing infection rates of HIV/AIDS, and associated deaths, are central objectives of the Brussels Programme of Action. It has adopted the MDG goal of reducing infection rates in persons 15-24 years of age by 2005 in all countries and by 25 percent in the most affected countries.

Over the past two decades, 30 million people have died from HIV/AIDS and another 40 million are infected. In 2003, the estimated prevalence rate of HIV/AIDS in LDCs was 3.2 percent (Figure 7). However, in most African LDCs, the prevalence rate among adults is much higher. This is especially true in sub-Saharan Africa where approximately 28.5 million people are infected. Among the LDCs with the highest official prevalence rates in the world, are Lesotho (28.9 percent), Zambia (16.5 percent), Malawi (14.2 percent) and the Central African Republic (13.5 percent).

Figure 7.
HIV Prevalence among Adults (aged 19-49)



Sources: UN (2005a, b)

Infection rates are especially high among women. According to the Joint UN Programme on HIV/AIDS (UNAIDS), African women between the ages of 15 to 24 are, on average, 3.4 times more likely to be sero-positive than their male peers. Additionally, women and girls often bear the brunt of its impact as they are the ones responsible for caring for the sick. An estimated 90 percent of the care of AIDS patients in many LDCs occurs in the home, placing extraordinary strains on women. Families are often forced to take children out of school as a means of bolstering their declining income.

HIV/AIDS is eroding the limited human financial resources LDCs possess by affecting the most economically productive segment of the population, i.e. those aged 15-64. The scale of the human capacity crisis caused by the pandemic in LDCs varies considerably. Some LDCs do not yet have a full-blown HIV epidemic, however, they must take the necessary steps to prevent the epidemic from spreading to the general population. A number of countries in the Asia Pacific and Africa regions have generalized epidemics which are already taking a very heavy economic, social and human toll.

The HIV/AIDS pandemic has also seriously weakened institutional capacity for management and delivery of services in many LDCs. This is largely due to AIDS-related deaths of public sector staff and ensuing vacancies that cannot be filled. For example, in Malawi 34 percent of the professional positions in the Ministry of Labour and Vocational Training remain vacant. AIDS causes between 19 and 53 percent of all government health employee deaths in African countries.

Effective strategies to combat HIV/AIDS need to address prevention, treatment and long-term care. Prevention entails increasing awareness of the disease and modifying social norms and behaviour which place individuals at risk. The most effective treatment involves the provision of antiretroviral treatment (ART) which at present is available to only 8% of the estimated 6 million people with AIDS. On World AIDS Day 2003, WHO and UNAIDS released a plan to reach the 3 by 5 target of three million people living with AIDS in Developing countries and those in transition by the end of 2005. Uganda provides an example where many of these elements came together with very impressive results (Box 7).

Box 7. Uganda: HIV/AIDS

Uganda is often heralded as a success story in the fight against HIV/AIDs. The country has not been spared, however, from the devastating effects of the disease. Since the onset of the epidemic in the late 1980s, over 2 million people have been infected with HIV/AIDS and close to 900,000 people have lost their lives to the disease. The government's response, however, was rapid and decisive.

Critical elements in Uganda's response included the very high level of political commitment, public awareness at all levels and the comprehensive health sector response. HIV interventions in Uganda have focused on prevention programmes, relying on spreading awareness and encouraging changes in behaviour through abstinence-based approaches and promoting condoms. The national strategy has also included preventing mother-to-child transmission, strengthening laboratory and blood transfusion services, managing sexually transmitted infections and establishing a range of comprehensive care that includes HIV testing and counselling, providing drugs for treating opportunistic infections and providing ART drugs. Since 2004, access to ART has expanded significantly.

This strategy has had extremely impressive results. The rate of HIV infection in Uganda has fallen from 18.0 percent in 1992 to an estimated 7.0 percent in 2005.

3.3.4 Infant and Under-Five Mortality

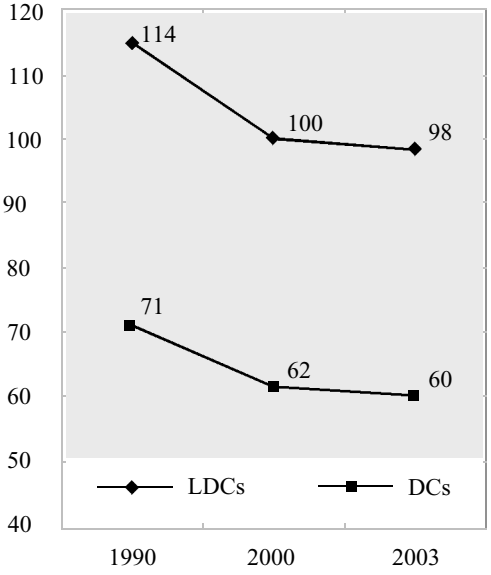
Reducing infant and under-five mortality rates are core goals of the Brussels Programme of Action. It has set targets of reducing infant mortality rates (IMRs) below 35 per 1,000 births and under five mortality rates (U5MRs) below 45 per 1,000 births by 2015.

When a country has high rates of infant and under-five deaths, it usually signals high mortality risk from infectious, parasitic, communicable, and other diseases associated with poor sanitary conditions and malnourishment. As a result, the IMR and U5MR are considered among the best measures of a nation's health.

The main causes of infant and child mortality in LDCs are pneumonia, dehydration from chronic diarrhoea, acute respiratory infections (ARI), infectious diseases (such as measles and malaria), and malnutrition. Dehydration was once the leading cause of infant and child mortality, but this has changed with the spread of Oral Rehydration Therapy (ORT), a mixture of salts, sugar and water.

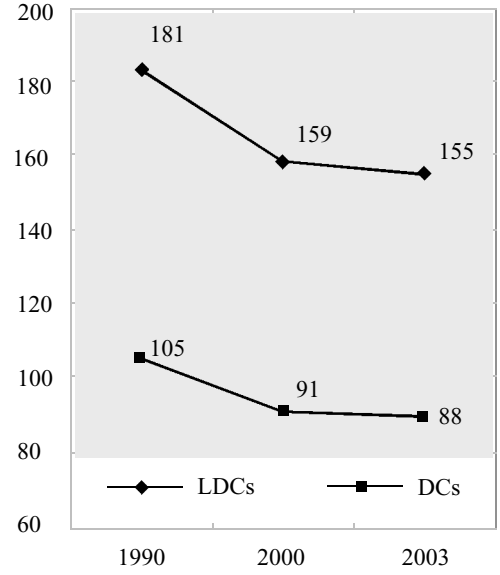
Approximately 10.5 million children under five years of age die every year globally. Nearly all infant and child deaths occur in Developing countries, with almost half of them in Africa. Although the number of deaths in children under five is significant, progress has been made since 1970, when the figure was more than 17 million. Between 1970 and 1990, the U5MR dropped by 20 percent every decade. Between 1990 and 2000, the rate of progress slowed to around 12-13% for both IMRs and U5MRs in both LDCs and Developing countries where it has remained (Figure 8 and Figure 9).

Figure 8.
Infant Mortality Rate (per 1000 Births)



Sources: UN (2005a, b); UNICEF (2004a, b)

Figure 9.
Under-Five Mortality Rate (per 1000 Births)



When LDCs are examined separately, nine countries (eight in Africa) have current levels which exceed those observed over two decades ago due largely to the spread of HIV/AIDS. On the other hand, eight countries in the region have reduced child mortality by more than 50 percent since 1970. Among these are Gabon, the Gambia and Ghana. Equatorial Guinea, Eritrea and Guinea achieved reductions of over 20 percent during this past decade, while Cape Verde and Comoros reduced its U5MR by one-third. Another LDC, the Maldives, reduced its IMR from 63 to 14 per 1,000 births between 1996 and 2003.

There are a wide range of potential strategies to reduce infant and child mortality such as measures addressing parental education, health, nutrition, housing and water/sanitation. Bangladesh provides an example of how some of these strategies can lead to very significant reductions in mortality rates (Box 8).

Box 8. Bangladesh: Infant and Under-Five Mortality Rates

Mortality is often considered as the best criterion for judging the success and failure of nations. Bangladesh has displayed considerable success in this respect, especially in reducing infant and child mortality. The IMR declined from 153 deaths per thousand live births in 1975 to 92 deaths in 1992, dropping further to 53 in 2002. Similarly, U5MR has declined from 144 per thousand live births in 1990 to 76 in 2002. This rate is now below that of neighbouring countries, and the rate of decline is sufficient for Bangladesh to be one of the few countries on track to meet the MDG target of a two-thirds reduction between 1990 and 2015. The pace of progress in infant and under-five mortality reduction in Bangladesh during the nineties was among the fastest in the developing world.

The decline in under-five mortality has benefited all groups of the population, by age, gender, location, and wealth. Although children of the poor are more likely to suffer premature death than their richer counterparts, this gap is narrowing, with mortality rates falling faster among the poor than the non-poor.

Bangladesh accomplished these results by focusing on immunization, creating and implementing national awareness campaigns on the treatment of diarrhoea, as well as special programmes to reduce pneumonia-related deaths. Other factors include better sanitation and access to safe water, strong community participation in the delivery of basic social services (both health and education), special scholarships for girls and the expansion of micro-credit for women.

In order for Bangladesh to maintain progress towards meeting the infant and child mortality MDGs, a number of trends need to be sustained. This includes: expanding immunization coverage to reach marginalized and hard-to-reach populations; consolidating and strengthening efforts to control diarrhoeal diseases and acute respiratory infections; and increasing access to antenatal care, skilled birth attendants and emergency obstetric care.

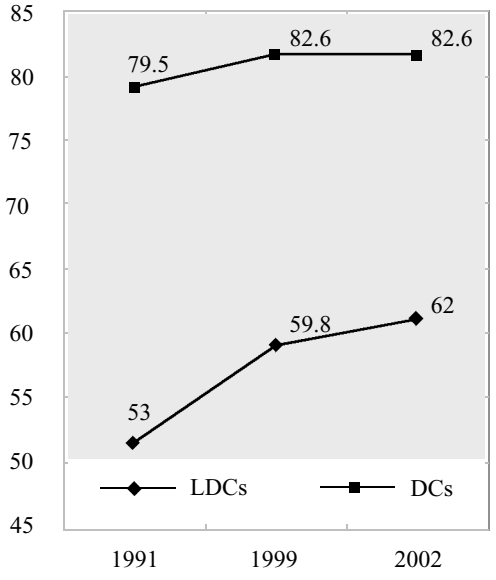
3.3.5 Primary Education

Education is a core concern of the Brussels Programme of Action. It has adopted two slightly modified MDG goals for primary education, namely: ensuring that by 2015 all children, particularly girls, in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality; eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.

Net enrolment rates in primary education measure the ratio of students of the official primary school age enrolled in primary school over the total population of that age group. They measure the coverage, efficiency and quality of the school system.

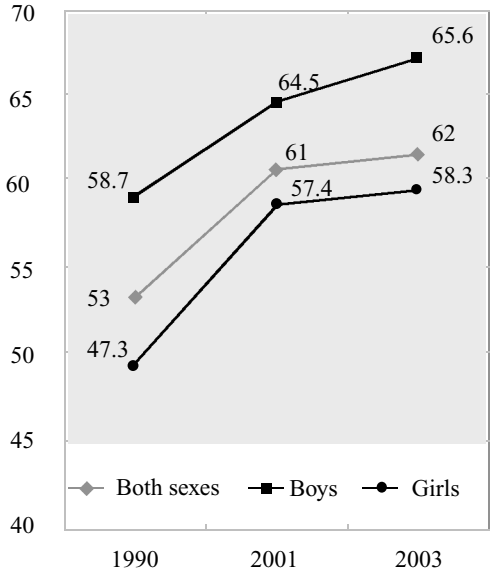
Although net enrolment rates in primary education within LDCs remain below that of other Developing countries, progress is being made. Enrolment rates continue to increase in LDCs, at a much faster rate than in Developing countries (Figure 10). The most dramatic increases have been observed in Bangladesh, Benin, Eritrea, the Gambia, the Lao People's Democratic Republic, Malawi, Mali, Rwanda, Senegal and Togo.

Figure 10 Net Enrolment Rate in Primary



Sources: UN (2005a, b)

Figure 11 Net Enrolment Rate in Primary by Gender (LDCs)



Many LDCs are characterized by a marked gender disparity in education, which is higher than in Developing countries in general (Figure 11). Primary enrolment has increased faster for boys than girls in a number of LDCs. Some LDCs, such as Guinea, Benin, Mali, Chad, the Gambia, Sierra Leone, Mauritania, Bangladesh, and Nepal, have achieved very significant gains in girls' education. Bangladesh has achieved gender parity in primary school enrolments and now has more girls than boys in secondary school.

There are a number of effective measures to enhance school enrolment including: increasing demand for education through school feeding programs and reduction of user fees; promoting curriculum change to reflect problems and life experience of local people and to provide graduates with relevant and functional skills; providing incentives to improve the quality of instruction and attendance of instructors; addressing infrastructural problems including lack of toilet facilities for girls; involving communities in school management. Benin provides a good example where some of these factors were present with impressive results (Box 9).

Box 9. Benin: Primary Enrolment and Completion Rates

By the late 1980's, the education system in Benin was in a state of collapse. A key event in the reform of Benin's education was the national Conference on Education held in 1990 which adopted a national policy and strategy to improve education.

Part of Benin's bold primary education system reform was a new curriculum that focused on the competencies and skills children should have, new teaching materials and textbooks, and a new student assessment system. From 1991 to 2004, Benin's primary education reform program was generously supported. It involved community involvement in school management, particularly focusing on a national programme of strengthening schools' parents associations. Communities also helped build their schools. In 2003, emphasis was placed on Mother's Associations to allow greater participation of mothers in education issues, especially in girls' education. A community-run school canteen program was also established. This programme reaches approximately 8,000 primary school students of which over 3,000 are girls, in 40 rural schools. Other innovations include a 'girl-to-girl' network where older girl volunteers help younger female students with schoolwork and their adjustment to school life. Evaluations of these programs suggest that greater community involvement in the school environment generates better school attendance.

The results have been impressive. Enrolment rates increased from 50 percent in 1990 to 96 percent in 2004. Girl's enrolment increased from 36 percent in 1990 to 84 percent in 2004..

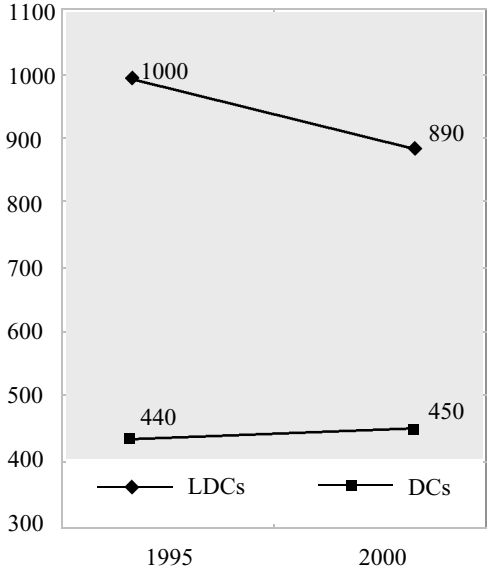
3.3.6 Reproductive Health

Issues of reproductive health figure prominently in the Brussels Programme of Action. Two goals and associated targets on reproductive health have been identified, namely: making accessible, through the primary health system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015; increasing the percentage of women receiving maternal and prenatal care by 60 percent.

Pregnancy, childbirth and their consequences are the leading health-related causes of death, disease and disability among women of reproductive age in developing countries. Every minute one woman dies of pregnancy-related causes, which adds up to more than a half million mothers lost each year. Seven countries account for approximately 25-30 percent of all maternal deaths annually, namely the Democratic Republic of the Congo, Ethiopia, the United Republic of Tanzania, Afghanistan, Bangladesh, Angola and Uganda.

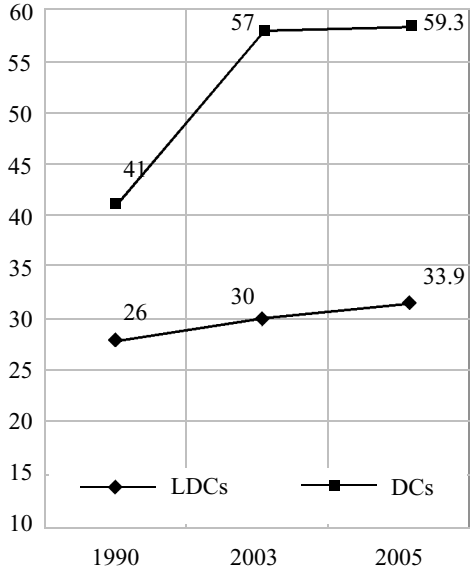
Data on maternal mortality must be viewed with caution because of problems associated with underreporting, misclassification and small sample sizes in surveys. The available data, however, do suggest an improvement in recent years in LDCs. As shown in Figure 12, the MMR in LDCs declined by 11 percent from 1000 to 890 per 100,000 live births over the period of 1995-2000. In Developing countries as a whole the MMR appeared to have increased slightly over this same time period.

Figure 12. Maternal Mortality Ratio (MMR) (per 100,000 live births)



Sources: UN (2005a, b); UNICEF (2001a); WHO (2005c)

Figure 13. Percentage of Births Attended by Skilled Personnel



Despite uncertainties about the data, the causes of maternal mortality are well known. Approximately 61 percent of maternal deaths take place during delivery or immediately after due to excessive bleeding, infections, hypertensive disorders, obstructed labour, or complications from unsafe abortions. Having access to a skilled attendant at childbirth has been shown to greatly reduce maternal deaths globally.

A skilled attendant generally refers to a doctor, nurse, midwife or other professionally trained individual who is able to manage a normal labour and delivery, recognize complications early on and perform any essential interventions, start treatment, and supervise the referral of mother and baby to the next level of care if necessary. These professionals may practice in a health-care facility or at home. In Developing countries and LDCs, skilled attendance at birth occurs in approximately 59 and 34 percent of cases, respectively (Figure 13). For LDCs, this represents a very significant increase of 30 percent between 1990 and 2005.

There exist vast differences in MMRs between LDCs that are only partly explained by income levels. Other differences relate to country commitment to address the problem. Countries that have succeeded in reducing maternal mortality have invested in developing equitable health systems while maintaining a focus on maternal health outcomes. They have accomplished this by providing: i) broad access to emergency obstetric care, ii) free or subsidized care and transport to care, iii) high levels of skilled attendance at delivery, iv) sustained political commitment and v) improved availability and use of data to raise public, professional and political awareness. Mali provides an example where a number of these elements have contributed to improving reproductive health (Box 10).

Box 10. Mali: Maternal Mortality Ratio & Skilled Personnel at Birth

In 2000, maternal mortality in Mali stood at an extremely high level. The number of maternal deaths was estimated at 6,000, the lifetime risk of maternal mortality was 1:10, and the MMR was 1,200 per 100,000 live births. As a result, a range of measures were put in place to address this situation.

The government, with support from various donors, developed a programme to bolster its medical referral system. Within this system, district hospitals and local health centres are linked by a two-way system of radio communication and transportation. A car equipped with a stretcher is available to transport women from health centres to district hospitals. As a result, the time required to transmit an urgent message and transport a patient is reduced from up to a day to just a few hours. Obstetric services are paid for on a cost-sharing basis between village health committees and district authorities. A post-payment arrangement ensures that financial barriers do not impede emergency care. Since its implementation, there has been a steady increase in the number of women referred to district level hospitals and in the proportion of caesarean sections to births per district, which is still quite low (1 to 2 percent). In 2001, 40.6 percent of births were attended by skilled professionals.

Another important development has been the active involvement of community groups in facilitating access to reproductive health care. In the district of Zegoua, women's producer associations pool revenue to pay for consultations to assess the health of babies and new mothers, and discuss family planning issues. If severe problems develop during a pregnancy, the expectant mother is transferred to a clinic equipped to deal with such emergencies. Preliminary results are encouraging. No cases of neonatal or maternal mortality have occurred in the period from January 2002 to August 2004!

3.3.7 Water

Access to safe water is a key objective of the Brussels Programme of Action. It has adopted the MDG goal of reducing by half, by 2015, the proportion of people who are unable to reach or afford safe drinking water.

Access to safe water is extremely important because it is closely related to a number of health and nutritional outcomes. Unsafe water is a direct cause of many diseases in LDCS including malaria, dysentery and cholera. It is also a major contributing factor to malnutrition, dehydration and diarrhoea.

More than a billion people gained access to safe water between 1990 and 2002. Gains were realized in all regions and global coverage reached 83% in 1992. Despite this extremely impressive accomplishment, the formidable challenge ahead is to provide access for the 1.1 billion people who remain without it. Eleven LDCs have made substantial progress in reaching their MDG and Brussels Programme of Action targets (Table 4). Most notably is Tanzania, which increased its access to safe water by 92% between 1990 and 2002.

Table 4. LDCs that increased safe drinking water coverage by at least 25 percent

Country	Drinking water coverage (%)		% Increase
	1990	2002	
Tanzania	38	73	92
Chad	20	34	70
Malawi	41	67	63
Angola	32	50	56
Central African Rep.	48	75	56
Eritrea	40	57	43
Mali	34	48	41
Mauritania	41	56	37
Burkina Faso	39	51	31
Uganda	44	56	27
Rwanda	58	73	26

Source: WHO and UNICEF (2004)

Meeting the MDG and Brussels Programme of Action targets, and reducing rural and urban disparities, will require providing safe water to a billion new urban dwellers and almost 900 million people living in rural communities, where progress has been slower. Many of these groups are among those hardest to reach: families living in remote rural areas and urban slums, families displaced by war and famine, and families mired in the poverty-disease trap. The Maldives provides an interesting example of how this can be done in the context of an extremely difficult natural environment (Box 11).

Box 11. The Maldives: Water & Sanitation

Island ecosystems, such as the Maldives', are among the most vulnerable on Earth The soil is highly porous and poor. Infiltration of rainwater is often immediate, with the rainwater forming a "lens" that floats on the saltwater table, rising and falling with the tide. This lens is the only source of water on Maldives' small coral islands. It is especially susceptible to rapid depletion and to pollution by human wastes, chemical fertilizers and pesticides, which can cause irreparable damage.

Over the past decade, access to safe water has increased significantly due, in large part, to a revolving fund enabling Maldivian households to purchase high-density polyethylene, or HDPE, rainwater tanks. A 2,500-litre tank is sufficient to ensure that each member of the average Maldivian family of eight would have 10 litres of safe drinking water per day, every day of the year. Households purchase tanks using a loan repayable over two years. At present, nearly 1 in 5 rural households have access to the tanks. The Government has adopted the distribution of household and community rainwater tanks as its own programme, and tanks are available on the open market.

The Maldives Water and Sanitation Authority's information, education and communications activities ensured that the success of the revolving fund was accompanied by safe rainwater collection practices and hygiene-related behaviour.

The December 2003 tsunami swept away many water sanitation facilities, storage tanks, and filled wells with seawater and other debris, leaving many of the island’s residents without safe drinking water. The Maldivian Government and development partners have begun the task of restoring what has proved to be a very effective means of ensuring safe water access.

3.4 Building Productive Capacities to Make Globalization Work for LDCs

> ***The capacity of LDCs to accelerate growth and sustainable development is impeded by various structural and supply-side constraints. Among these constraints are low productivity; insufficient financial resources; inadequate physical and social infrastructure; lack of skilled human resources; degradation of the environment; weak institutional capacities, including trade support services, in both public and private sectors; low technological capacity; lack of an enabling environment to support entrepreneurship and promote public and private partnership; and lack of access of the poor, particularly women, to productive resources and services. Geographical handicaps faced by landlocked and island LDCs aggravate the impact of these impediments. Critical factors to stimulate productive capacity include: stable macro-economic conditions, a conducive legal and regulatory framework, adequate institutional, physical and social infrastructure and a vibrant private sector. An effective dialogue between government and the private sector, as well as policy consistency within trade, investment and enterprise development, is needed to underpin an enabling environment for economic development. It is also important to encourage and promote good corporate practices. Concrete support should be based upon the national programmes of action or poverty eradication strategies of LDCs.*** (Brussels Programme of Action, para. 42)

The Brussels Programme of Action contains an extremely wide range of measures under Commitment 4 which are grouped under eight headings: i) Physical Infrastructure; ii) Technology; iii) Enterprise Development; iv) Energy; v) Agriculture and Agro-Industries; vi) Manufacturing and Mining; vii) Rural Development and Food Security and viii) Sustainable Tourism. The focus here is on a subset of issues related to technology namely, the use of Information and Communication Technologies (ICTs) for development and poverty reduction. This issue is of major importance to the Brussels Programme of Action and is reflected in its goal of "increasing average telephone density to 5 main lines per 100 inhabitants and Internet connections to 10 users per 100 inhabitants by the year 2010."

There is no standard definition of the term ICTs. It is defined here to cover internet services, information technology equipment and services and electronic networks. Most of the discussion will focus on the internet and internet-related activities.

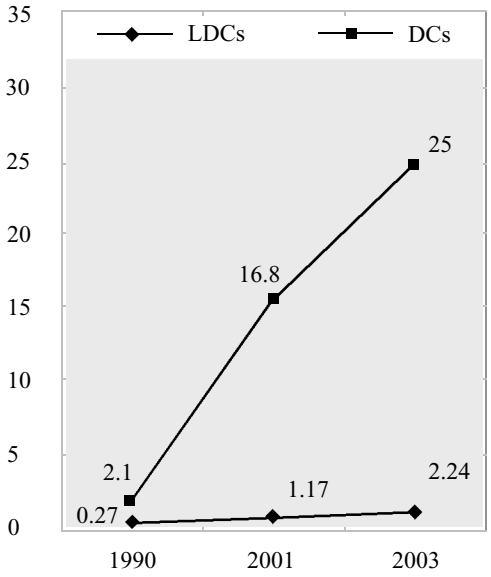
There are many ways that ICTs have served to spur economic and social development and poverty reduction in the LDC context.

- First, ICTs have reduced the costs of economic transactions. For example, access to price information by agricultural producers has helped them make informed marketing decisions concerning retails prices and/or the best markets in which to sell. This has the effect of better integrating markets nationally and internationally.
- Second, ICTs have facilitated the better utilization of human resources by creating new types of jobs and/or by providing better learning opportunities. Examples include the new opportunities created by the outsourcing of telephone and internet based customer support services.
- Third, ICTs have the potential to facilitate processes of empowerment through the diffusion of information and organization. Some examples include the use of electronic media to conduct political discussion and to support local access to information and public accountability exercises.
- Fourth, in certain cases, ICTs have changed the structure of markets and the delivery of public services. Examples include the use of electronic Management Information Systems within Ministries of Health or Education to monitor and manage heath and education services.
- Fifth, ICTs have had an important impact on education and human resource development in poor communities through such mechanisms as schoolnets, remote-area provisioning and distance learning.

- Sixth, in some cases ICTs have facilitated gender equality in poverty-relevant ways by facilitating female access to learning and by providing economic opportunities for women as in the Grameen Village Phone Initiative (see **Error! Reference source not found.)**.
- Seventh, ICTs can be used to support livelihoods, especially in agriculture and community development. For example, multipurpose community telecasters have been active in support of micro and family enterprises such as crafts, agriculture, etc., through networking and marketing, including e-commerce.

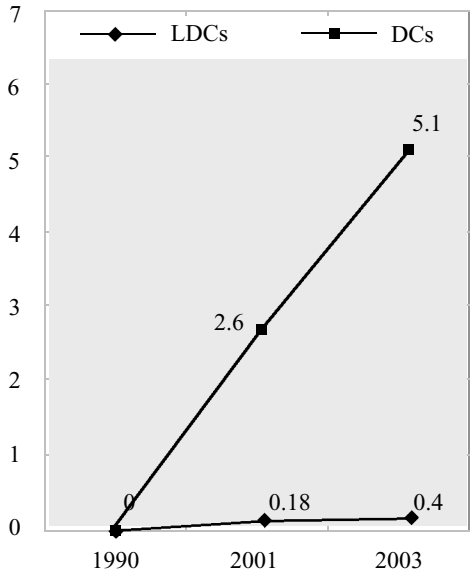
As shown in Figure 14 and Figure 15 above, rates of teledensity (telephone lines and cellular subscribers per 100 people) and internet use stood at 2.24 and 0.4 per 100 inhabitants respectively in 2003. They have increased rapidly since 1990, though at a slower rate than in Developing countries as a whole. This rate of increase will have to accelerate in order to meet the above-mentioned Brussels Programme of Action goals.

Figure 14. Telephone Lines and Cellular Subscribers (per 100 Inhabitants)



Sources: UN (2005a, b); UNDP (2003)

Figure 15. Internet Users (per 100 Inhabitants)



One striking statistic presented in Figure 14 and Figure 15 is the wide gap in the level of teledensity and internet use between LDCs and Developing countries as a whole. This phenomenon is known as the "digital divide", or the divide between digitized and non-digitized countries. The digital divide is also apparent between urban and rural areas within many LDCs. This disparity is especially problematic for landlocked territories, small islands and countries with large rural areas. Some of the factors contributing to the digital divide are a lack of telecommunications and connectivity infrastructure, the absence of a national strategy and regulatory regime and the relative lack of on-line content from domestic sources.

Connectivity infrastructure is critical. The existing telephone networks status varies considerably between LDCs. Some countries, like Botswana and Rwanda, which have made ICTs one of their priorities, are installing digital switches with optical fibre links between towns together with the most up to date cell and mobile telephone technology. In many other LDCs, the poor quality of the networks remains a fundamental impediment to rapid developments in these areas. It is encouraging to note however, that the spread of Wi-Fi technologies (broadband internet through radio frequency) and wireless text messaging have opened up opportunities for low-cost solutions to some of these infrastructural bottlenecks in LDCs.

The examples of Cambodia (Box 12) and Bangladesh (**Error! Reference source not found.**) below show how the creative application of ICTs has been an effective instrument of poverty reduction.

Box 12. Cambodia: Digital Data Divide (DDD)

Digital Data Divide (DDD) began in Phnom Penh in 2001. Its underlying philosophy was that the world must do more than build Internet lines and give computers. People need to be connected to ICT resources in a way that results in tangible benefits to their everyday lives. As a result, DDD connects young people facing particularly difficult circumstances in one of the world's LDCs, with the global economy. It provides jobs and educational opportunities by providing outsourced data services to business and public sector customers. DDD only hires individuals under 25 who are orphans, physically disabled or trafficked women.

After only nine months, DDD became a financially self-sustainable enterprise. From 2001 to 2004, DDD earned more than $US 450,000 in revenue and had over 170 staff. The benefits have been far reaching. DDD had created a significant number of well paying jobs and provided scholarships for education, health benefits and vocational counselling.

3.5 Enhancing the Role of Trade in Development

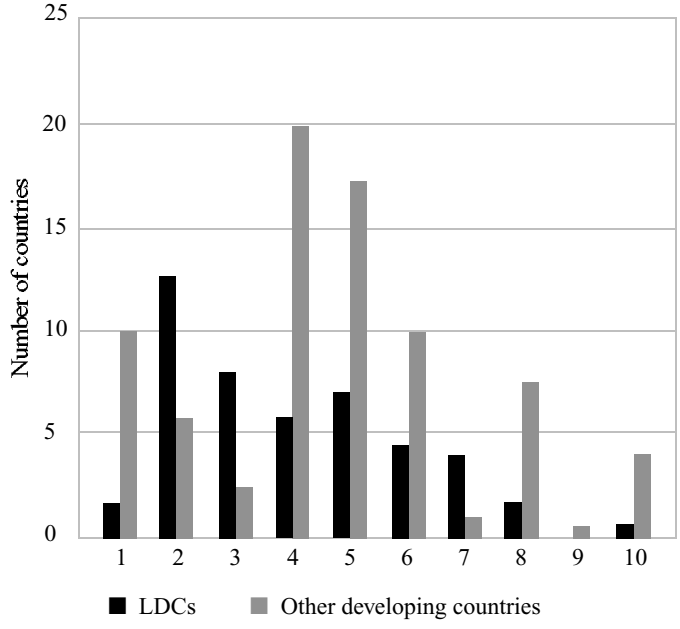
> ***Trade will increasingly continue to be relied upon by LDCs to generate the resources for financing growth and development to complement those from ODA and private capital flows. The share of trade in GDP remains relatively high in most LDCs compared with other developing countries. However, the participation of LDCs in international trade is severely limited by a number of factors, in particular demand and supply-side constraints, as well as unfavourable market access conditions in markets affecting the products of greatest export interest to them, which largely explain their marginal share of 0.4 per cent of world trade in 1998. Coping with increased global market competitiveness also presents an important and great policy challenge to LDCs, and how they respond to it will be decisive in their success in regional and global integration strategies. Concrete action by the LDCs themselves, as well as their development partners, will therefore be required in order to overcome these constraints and transform trade into a powerful engine for growth and poverty eradication, as well as an effective instrument for drawing benefits from globalization and trade liberalization.*** (Brussels Programme of Action, para. 65)

The promotion of trade is a central element in the Brussels Programme of Action. Trade can be a powerful tool to promote economic growth and poverty reduction if it contributes to a process of development whereby a country's resources are effectively used to create wealth and raise living standards. Unfortunately, trade does not guarantee that such a process will occur nor had it benefited LDCs equally.

Figure 16 and Figure 17 present two findings which are particularly important when considering the role of trade in LDCs.

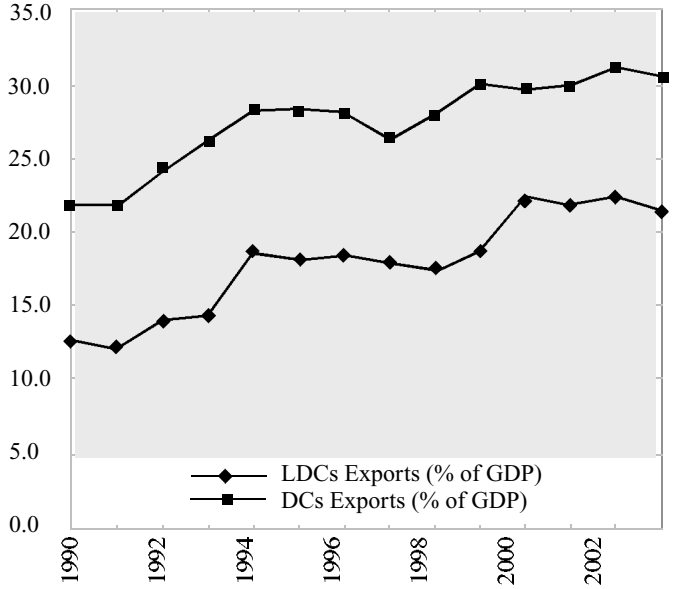
- First, openness to trade is quite high in LDCs. Figure 16 presents data on the International Monetary Funds' (IMF) trade restrictiveness index which measures tariff rates and non-tariff barriers across countries. As shown in this figure, LDCs as a group are much less restrictive than other developing countries.
- Second, LDC trade has been increasing since the 1990s. As shown in Figure 17, LDC imports and exports of goods and services have increased from around a third to over half of GDP between 1990 and 2004.

Figure 16
Trade Restrictive Index



Source: UNCTAD (2004)

Figure 17
LDC Trade/GDP (1990-2003)

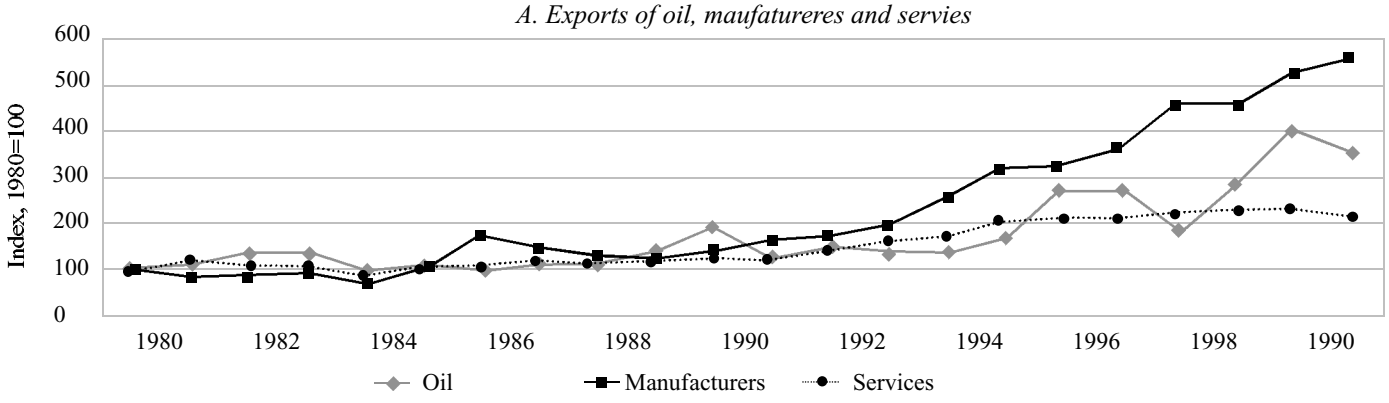


Source: World Bank (2006)

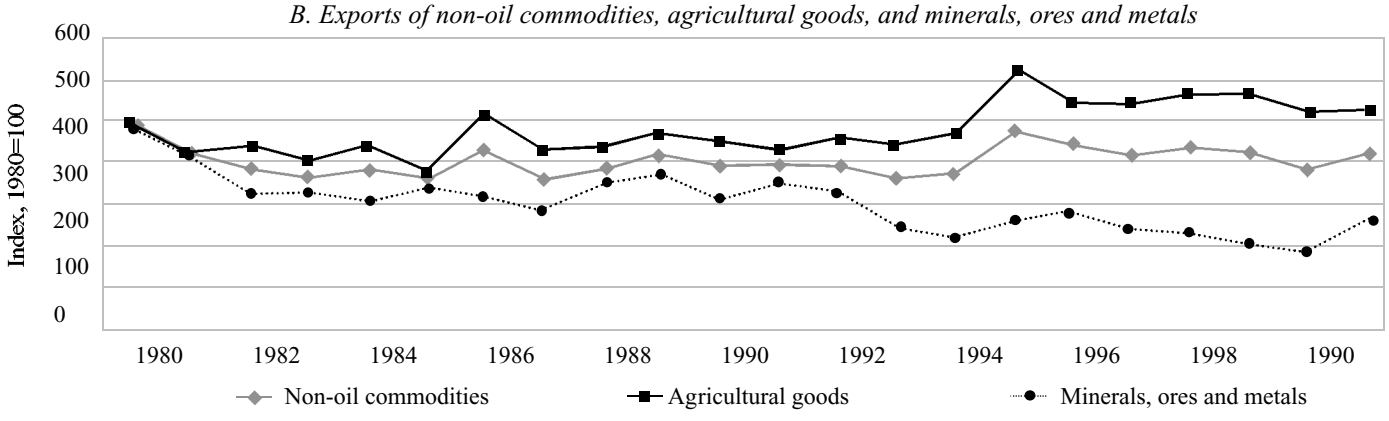
This impressive rate of growth hides important disparities, however, between subgroups of LDCs. As revealed by Figure 18, the performance of exporters of non-oil commodities, agricultural goods and minerals has been subject to many more ups and downs and has been far less impressive. There is a need to pay special attention to this subgroup of LDC countries when considering measures to promote trade.

Figure 18 Trends in LDC Exports

A. Exports of oil, maufatureres and servies



B. Exports of non-oil commodities, agricultural goods, and minerals, ores and metals



Source: UNCTAD (2004)

It should also be recognized that the poverty reduction performance has been very mixed even in those countries that have managed to expand exports. In the context of impact of trade on poverty in LDCs, the United Nations Conference on Trade and Development (UNCTAD) has identified three groups of countries according to their experiences: a virtuous trade group, where private consumption per capita and export expansion are both growing; an immiserising trade group, where exports are expanding yet private consumption per capital is falling and an ambiguous effect, where no clear trend is available. Private consumption per capita is used as a proxy for poverty reduction due to data constraints. Table 5 presents results for the periods 1990-95 and 1995-2000.

Table 5 Trade/Poverty Performance of LDCs (No. of Cases)

		Real Growth Rate of Private Consumption Per Capita					
		Virtuous (Greater than 1%)		Ambiguous (Btn. -1% and 1%)		Immiserising (Less than 1%)	
		1990-95	1995-2000	1995-2000	1995-2000	1995-2000	1995-2000
Real Export Growth Rate	**Positive**	10	12	5	7	10	8
	Negative	1	0	2	1	7	4

Source: UNCTAD (2004)

There are two main points which are important to note.

- Export growth is almost always associated with private consumption growth. There is only one case (Togo) where negative export growth is accompanied by consumption growth exceeding 1 percent.
- Export growth is not sufficient for poverty reduction. The immiserising and ambiguous trade subgroups account for 57 percent of cases (29 of 51) whereas virtuous subgroup accounts for the remaining 43 percent (22 of 51 cases).

These results suggest a dual track strategy is required that links trade promotion to national development generally and poverty reduction more specifically. This may entail:

- Making explicit links between trade and development by mainstreaming trade in national poverty reduction strategies and linking trade and poverty reduction targets;
- Redoubling efforts to ensure that the Doha round of the World Trade Organization (WTO) talk becomes the ‘development round’ with significant reduction in agricultural support mechanisms in the Organization for Economic Co-operation and Development (OECD) countries;
- Taking into account specific needs of commodity exporters such as measures to reduce vulnerability to drops in commodity prices and ensuring transparency in reporting of oil and mineral revenues;
- Strengthening preferential market access provisions for LDCs including: changes in rules of origin restrictions, helping countries meet sanitary and phytosanitary product standards, reduction in technical barriers to trade (TBTs), etc. At present, close to half of market access preferences granted to LDCs are not utilized because of these restrictions among other factors;
- Improving special and differential treatment measures for LDCs by better targeting of countries and the establishment of binding provisions.

Bangladesh provides an example of ‘virtuous trade’ whereby export expansion has translated into increases in living standards for over a decade (Box 13).

Box 13. Bangladesh: 'Virtuous Trade'

Bangladesh is one of only three countries to fall into the 'virtuous' trade category in 1990-95 and 1995-2000, whereby export expansion was accompanied by growth in private consumption. There are a number of reasons for this virtuous trade effect.

First, export growth was concentrated in manufacturing. Employment growth and wage increases in this sector led to relatively widespread gains. While there were job losses in sectors unable to compete with cheaper imports, these were more than offset by new job opportunities in the export sector.

Second, the export sector has been associated with productivity gains due to increases in efficiency and adoption of new technologies. The opening of trade has forced exporters as well as industries which compete with importers to be more productive in order to remain competitive. These 'dynamic' gains associated with trade have likely contributed to the high growth rates found in certain sectors and the economy more generally.

Third, the flow of remittances from overseas (a type of export) has had important effects at both macro and micro levels. At macro levels, it has reduced the dependence on foreign aid and eased pressure on the currency. At the micro level, remittances have been used for productive purposes such as buying land or agricultural inputs and investing in education and health.

3.6 Reducing Vulnerability and Protecting the Environment

> ***Long-term threats to the global environment are a common concern of all countries, and there is an urgent need to address this issue on the basis of the principle of common but differentiated responsibility. The LDCs are acutely vulnerable to a variety of natural shocks, including natural disasters, and severe structural handicaps, and are susceptible to global environmental phenomena such as the loss of biological diversity and adverse effects of climate change which inter alia exacerbates drought, desertification and sea level rise. LDCs are at present contributing the least to the emission of greenhouse gases, while they are the most vulnerable and have the least capacity to adapt to the adverse effects of climate change. Such vulnerabilities generate considerable uncertainties and impair the development prospects of these countries, and they tend to affect the poor most, in particular women and children. Environmental degradation in LDCs also results from poverty that deprives households, village communities or enterprises of the means and technology required to preserve the environment. Economic growth, social development and poverty eradication are the first and overriding priorities in LDCs and are themselves essential to meeting national and global sustainability objectives. Eradicating poverty is an indispensable requirement for sustainable development and has to be addressed in an integrated and comprehensive manner, taking fully into account the legitimate priority needs of LDCs.*** (Brussels Programme of Action, para. 73)

3.6.1 Protecting the Environment

The sixth commitment of the Brussels Programme of Action – Reducing Vulnerability and Protecting the Environment - sets out the program's agenda for protecting the environment. There are a wide range of issues addressed that relate to loss of biological diversity, drought, desertification, etc. Here, the focus is on the protection of ecosystems.

Ecosystems provide the foundation for all human survival. They produce the food, air, soil, and other materials that support life and they are central to achieving real progress in health, nutrition, sanitation, and environmental sustainability.

Ecosystems possess great socio-economic value because everyone, rich and poor, urban and rural, depends on the goods and services they provide. More than 1.3 billion people depend on fisheries, forests, and agriculture for employment. The dependence of livelihoods on natural systems is especially important among the rural poor, who

derive a significant proportion of their total income from them. Forests, fisheries (marine and freshwater), farm fields, livestock production, hunting, and mining provide sustenance and act as a fall-back when other sources of employment falter. As a result, the rural poor are especially vulnerable to ecosystem degradation.

Today, many ecosystem services are being used unsustainably, and the capacity of ecosystems to deliver these services is being persistently eroded at an unprecedented rate all around the world mainly due to desertification, soil erosion and deforestation (see Box 14). One element in the global strategy to reverse this trend is the creation of and/or expansion of protected areas. Protected areas are essential for conserving biodiversity, delivering vital ecosystem services, such as soil regeneration, nutrient cycling, pollination, pure water and maintenance of harvestable resources, providing protection and space for indigenous and local peoples to continue their traditional lifestyles (culturally, spiritually, and recreationally) that are often impossible elsewhere, and providing local people with additional sources of income, through increased tourism or employment opportunities offered in the protected space.

Box 14. Main Causes of Ecosystem Degradation

Desertification

Desertification is land degradation in arid, semi-arid and dry sub-humid areas resulting from climatic variations and human activities. Approximately 250 million people are directly affected by desertification, and a further 1.1 billion people indirectly affected. Desertification occurs because drylands, which cover more than 40% of the world's surface, are extremely vulnerable to over-exploitation and inappropriate land use, such as deforestation, overgrazing and bad irrigation practices.

Soil Erosion/Degradation

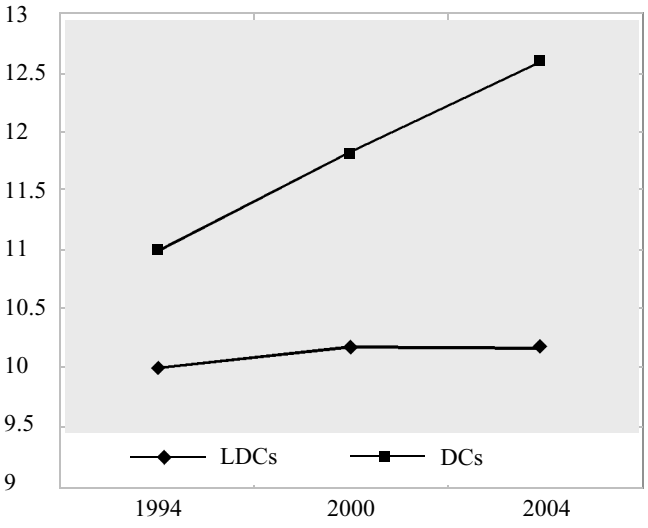
Soil degradation is the change induced by the natural decrease in the soils' potential for productive use. Improper land use and poor land management technologies have been singled out as its most important causes, resulting in reduced crop yields due to limited or no nutrients and water availability for plant growth, or, alternatively, due to a surplus of nutrients. However, indirect factors such as the poor economic conditions of the farmers share much of the blame; thereby preventing them from adopting better land management strategies.

Deforestation

Some of the negative outcomes of deforestation include loss of biodiversity, the destruction of forest-based-societies, and climatic disruption. These outcomes present multiple problems for societies and the environment today and in the future. Once forests have been cut down, essential nutrients are washed out of the soil, and without trees to keep the soil in place, soil erosion from rain and wind becomes prevalent, making the land unusable and more susceptible to disastrous. LDCs worst affected by deforestation are Benin, Burundi, Comoros, Guinea-Bissau, Liberia, Malawi, Sudan, Togo, Uganda, Zambia, Haiti, Myanmar, Nepal, and Samoa.

According to the International Union for Conservation of Nature and Natural Resources (IUCN), in 2004 there were 104,791 protected areas, covering over 12 percent of the Earth's land surface. The total area has increased from less than 3 million km^2 in 1970 to more than 20 million km2 in 2004. As shown in Figure 19, the protected area ratios in LDCs stand at around 10%, a level which has remained roughly constant over the past decade.

Figure 19. Ratio of Protected to Total Territorial Area (Terrestrial and Sea)



Source: UN (2005a)

The development and maintenance of protected areas face a number of challenges. Many protected areas lack political support and have inadequate financial resources, thereby existing in name only ('paper parks'). Even where they exist, regulations are often inadequate for preventing damaging activities, such as over-fishing. Additional external threats include pollution and climate change, irresponsible tourism, infrastructure development and ever increasing demands for land and water resources. Internal threats to protected areas include major habitat change caused by infringement, often by human settlement, and legal or illegal resource extraction resulting in the disappearance of the species or resource for which the protected area was created.

Mozambique provides an example of the successful establishment of protected areas to the apparent benefit of local communities (Box 15).

Box 15. Mozambique: Protected Areas

Mozambique has become one of Africa's brightest hopes and a rare success story. At present it has one of the fastest growing economies in the world and is a stable democracy. Two of Mozambique's most valuable assets are its stunning 2,500km coastline and its wildlife, which ironically the civil war helped to protect by rendering parts of the country inaccessible to tourists.

At the beginning of the decade, the government of Mozambique expanded the countries marine protected areas by enlarging the Bazaruto Archipelago National Park to 1,430 km2 in 2001, and establishing the Quirimbas National Park in 2002, which occupies a total area of 7,500 km2.

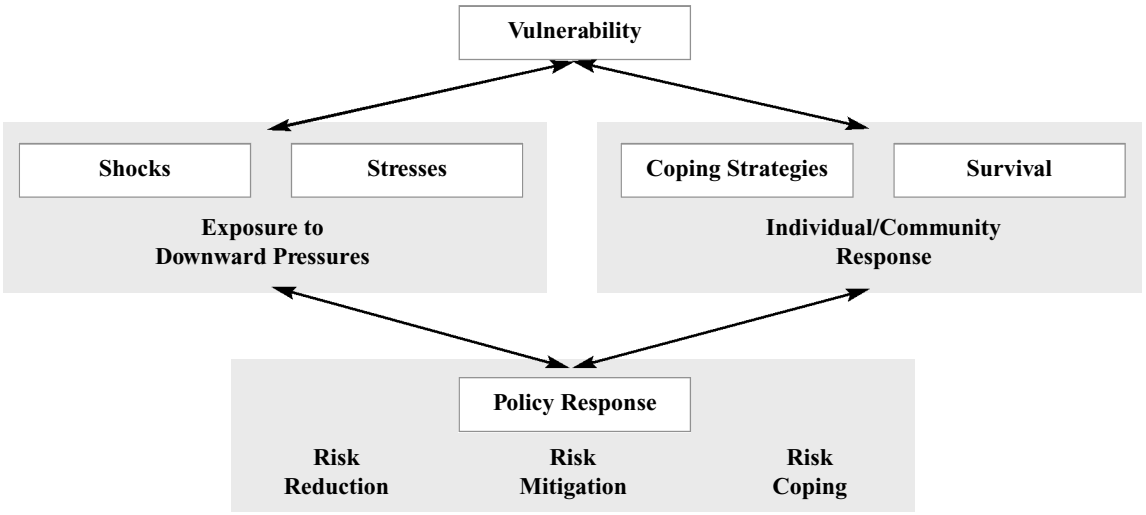
Quirimbas, the largest marine protected area in Africa, was established following requests of local residents and other stakeholders who realized that their livelihoods depended on the careful management and conservation of their natural resources. As a sign of their dedication and commitment to the success of the park, all surrounding communities agreed to cede some of their areas (on land and sea) for conservation and tourism. Before the park was established, conflicts between farmers and animals such as lions and elephants, and the erosion of traditional livelihoods through crop disease and soil erosion, had contributed to extreme poverty. Since then, marine sanctuaries have been established that are managed by local fishing communities to help recover fish stocks, which were on the verge of collapse due to over-fishing. The Total Protection Zone concept, which forbids any human activities to take place within the area, was implemented with the consent of the local people as a means of managing the park. The park is also managed through community co-management of the fisheries resources. Because of these efforts, fishermen have experienced noticeable improvements in fishing.

Since 2002, more than 30 rangers appointed by local communities have been trained, and human-animal conflict has been mitigated through the use of traditional methods. Local communities have additionally benefited through increased employment and incomes from tourism in the park.

3.6.2 Reducing Vulnerability

Vulnerability is a major feature of the lives of many of the LDC's inhabitants. As shown in Figure 20, by vulnerability we mean the likelihood of falling into poverty or into greater poverty. It is due to two main factors: exposure and response to downward pressures. Downward pressures include stresses and shocks, the former gradual and cumulative and latter sudden and unpredictable. There are many types of shocks and stresses, such as illness, violence, loss of employment, etc. though the focus here is on natural disasters. Responses to downward pressures are commonly referred to as coping or adaptive strategies. They may include such mechanisms as borrowing from friends or neighbours, migration, selling assets, drawing on savings, etc. The public policy response includes measures of: i) risk reduction, taken in advance of a shock or stress, that aim to reduce the likelihood that it will occur; ii) risk mitigation, taken in anticipation of a shock with a view to minimize its harmful consequences; and, iii) risk coping, taken after the occurrence of a shock, to reduce the human cost.

Figure 20 The Cycle of Vulnerability



Source: Shaffer (2004)

One of the most important stresses of our time is climate change which brings with it long-term shifts in weather conditions and the increasing frequency of extreme weather events, including floods, drought and tsunamis. On average, natural disasters cause 184 deaths per day. Eleven percent of those exposed to natural hazards live in poor countries, yet they account for more than 53 percent of the total number of recorded deaths. During the past two decades, LDCs with the highest annual per capita death rate from natural disasters were Mozambique (328 per million), Ethiopia (273), Bangladesh (69), Mauritania (53), and Afghanistan (49).

There is a two-way link between natural disasters and environmental degradation. Deforestation and soil erosion increase mudslides, landslides and flash flooding. Rises in sea level can result in substantial coastal flooding, salination of soils and drinking water, and the destruction of coral reefs and mangrove stands vital for fishing and coastal protection. They can also threaten crop production and livelihoods in countries with large areas of low-lying land, such as Bangladesh, thereby worsening food insecurity in many LDCs. In extreme cases, low-lying atolls in the Pacific, including those of Kiritabi, the Marshall Islands and Tuvalu may be submerged, as occurred in the Maldives. Furthermore, desertification increases drought, which often results in famine. LDCs, particularly SIDS, are especially vulnerable to the damages brought by climate change because they lack the resources and infrastructure to cope with the demands of their people in terms of health, food, and livelihoods.

Sustainable forestry and farming practices can help mitigate the impact of natural disasters. Forests, and all plants, soak up carbon released in the atmosphere by human activities. If increasing efforts are made to slow deforestation and increase reforestation between now and 2050, carbon dioxide emissions can be reduced by about 12 to 15 percent of all fossil fuel emissions. By improving agricultural practices the amount of carbon locked up in cropland soils, as soil organic matter from crop residues and manure, could rise by 50 percent by 2030.

Integrated climate risk management can serve to reduce and mitigate the associated with climate change. This could range in scale from actions to manage the local symptoms of global climate risk to global measures to reduce greenhouse gas emissions. It would need to include three main elements: preventative risk management to ensure that future development reduces rather than increases risk; compensatory measures to moderate the losses associated with existing risk; and reactive risk management to ensure that risks is not recur after disaster events.

In order for risk management to function successfully in practice, urgent actions must be taken at all levels: internationally, nationally and locally. Box 16 provides a discussion of measures of social risk management used to reduce the level of vulnerability faced by individuals and households.

Box 16. Reducing Vulnerability through Social Risk Management

Reducing vulnerability requires measures which effectively manage the risks facing households and communities. As mentioned above, three types of measures can be distinguished: i) risk reduction, taken in advance of a shock or stress, that aim to reduce the likelihood that it will occur; ii) risk mitigation, taken in anticipation of a shock with a view to minimize its harmful consequences; and, iii) risk coping, taken after the occurrence of a shock, to reduce the human cost.

Risk reduction strategies include many of the successful policy measures discussed throughout this document aimed at promoting macroeconomic stability, public health, education and training, water and sanitation, etc. Specific examples include building dams to forestall flooding, conducting immunisation programs to prevent diseases, etc. Niger's campaign to distribute over two million long-lasting insecticide-treated mosquito nets to prevent malaria is a good example (discussed in Box 6).

Risk mitigation often focuses on measures which promote livelihood diversification, insurance and access to credit. Livelihood diversification may entail cultivating a variety of crops on different plots; combining farm and off-farm employment; combining urban and rural employment through seasonal migration, etc. Insurance options cover risk related to ill-health, disability, death, unemployment, crop failure, etc. One interesting example is the Igunga Community Health Insurance Fund set up in North-West Tanzania by the Ministry of Health. The scheme requires active community participation and annual contributions by participant households (matched by the government). As of 1998, coverage had reached 50% of the community.

Risk coping strategies involve many different activities. From a public policy perspective, social assistance measures are critical. These may include cash payments (e.g. child benefits, pensions for widows), fee waivers (health, education, etc.) or in-kind transfers (supplemental feeding programs, school feeding programs, food stamps, etc.). School feeding programs in sub-Saharan African have received favourable reviews as a means of maintaining social progress in the face of economic or environmental crises. A recent review of one such program in Burkina Faso found positive impacts on attendance, nutrition and academic achievement.

3.7 Mobilizing Financial Resources

> ***There is an immediate need to mobilize the financial resources that are required to implement the objectives and priorities as well as the targets that are set out in this Programme of Action aimed at the sustainable development of the LDCs. However, there is very limited scope, in the foreseeable future, to meet the multiple development finance requirements of LDCs with domestic resources because of sluggish growth or economic stagnation, widespread poverty and a weak domestic corporate sector. The large investment requirements of LDCs imply a need for new and additional resources and efforts to increase ODA to LDCs supportive of national programmes of action, including poverty eradication strategies.*** (Brussels Programme of Action, para. 79)

The Brussels Programme of Action contains a number of measures in support of its commitment to mobilize financial resources which are grouped together under four headings: i) domestic resource mobilization; ii) Aid and its effectiveness; iii) external debt; iv) Foreign direct investment (FDI) and other private external flows. Here, the focus will be on overseas development assistance or aid.

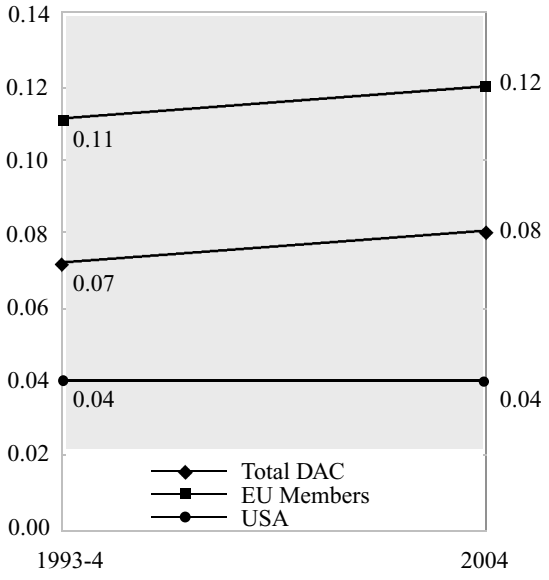
Three goals of the Brussels Programme of Action relate specifically to aid namely: 1) Donor countries proving more than 0.20 percent of their GDP as ODA to LDCs continue to do so and increase their efforts; 2) Other donor countries which have met the 0.15 target undertake to reach 0.20 percent expeditiously; and, 3) All other donor countries which have committed themselves to the 0.15 percent target reaffirm their commitment and undertake either to achieve the target within the next five years or to make their best efforts to accelerated their endeavours to reach the target.

Since the mid-1990s, concerns with aid effectiveness have led to a number of significant changes in the focus and delivery of development assistance. Four are particularly important:

- First, poverty reduction has emerged as a core objective of development assistance. This is due to the growing perception among the development community that government and donor efforts should focus on the core, pressing development needs.
- Second, national ownership of development policy has assumed central importance. The commitment to national ownership has been guided by the recognition that national commitment is essential for successful implementation of policies. In the absence of national commitment, appropriate policies are neither accepted nor implemented.
- Third, there has been a call for new forms of partnerships to supersede traditional donor-recipient relationships. This has entailed a greater reliance on national development frameworks and planning processes and a move away from project-based lending to sector wide approaches and direct budgetary support.
- Fourth, there has been a concerted move to judge performance using results-based criteria. In practice, this entails greater reliance on performance criteria based on outputs, outcomes or impacts. Impact evaluations, audits and public expenditure reviews are examples of the tools which have been used to bring about a results-based focus.

All of these changes reflect changes in the 'quality' of ODA with a view to make it more effective. Equally important are increases in the quantity of ODA to finance necessary investments in LDCs. Figure 21 and Table 6 present data on ODA disbursement to LDCs from the Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC) countries. As shown in Figure 21, for all donor countries, ODA as a percentage of GNI has risen slightly from 0.07 to 0.08 percent between 1993-94 and 2004, significantly below the Brussels Programme of Action targets of 0.15-0.20. As shown in Table 6, there is wide variation in individual country performance. Portugal increased it ODA/GNI ratio from 0.21 to 0.53 whereas the USA's ratio remained constant at 0.04% and Japan's fell from 0.05 to 0.04.

Figure 21.
ODA to LDCs (Percentage of Donor's GNI



Source: OECD/DAC (2006)

Table 6 DAC Country ODA to LDCs (Disbursements)

	1993-1994		2004	
	USD million	Percent of donor's GNI	USD million	Percent of donor's GNI
Australia	211	0.07	350	0.06
Austria	114	0.06	168	0.06
Belgium	255	0.12	645	0.18
Canada	556	0.10	702	0.07
Denmark	485	0.36	735	0.31
Finland	100	0.12	153	0.08
France	1 938	0.15	3 169	0.15
Germany	1 789	0.09	2 312	0.08
Greece	..	..	65	0.03
Ireland	38	0.09	322	0.21
Italy	625	0.06	788	0.05
Japan	2 276	0.05	1 684	0.04
Luxembourg	16	0.11	87	0.31
Netherlands	699	0.22	1 453	0.25
New Zealand	21	0.05	65	0.07
Norway	465	0.45	837	0.33
Portugal	178	0.21	878	0.53
Spain	119	0.03	424	0.04
Sweden	566	0.31	762	0.22
Switzerland	297	0.12	399	0.11
United Kingdom	806	0.08	2 988	0.14
United States	2 581	0.04	4 504	0.04
TOTAL DAC	**14 136**	**0.07**	**23 490**	**0.08**
of which: EU Members	7 729	0.11	14 949	0.12

Source: OECD/DAC (2006)

The Brussels Programme of Action has identified a range of measures to continue to enhance the effectiveness of aid. Donor countries should pursue practices which increase the impact of ODA such as untying aid, increasing transparency, sourcing goods and services in recipient countries and strive to meet the Brussels Programme of Action quantity targets. LDCs should redouble effects to integrate ODA into national planning frameworks and the budget and monitor its effective use. As discussed in Box 17, there is increasing evidence that aid can be effective when properly targeted and administered.

Box 17. New Thinking on Aid Effectiveness

In recent years, there has been considerable pessimism about the effectiveness of aid. It is not difficult to find examples of failed development projects. In addition, many statistical analyses have been unable to find a significant relationship between aid volumes and economic growth across countries. This lack of relationship should not be surprising in that a good deal of aid consists of technical and emergency assistance which can hardly be expected to contribute directly to higher economic growth. One recent study attempts to address this issue by examining the relationship between economic growth and those types of aid which can be expected to have economic and social benefits (excluding technical assistance, etc.). It found a positive and significant relationship between aid and economic growth. Drawing on the results of this analysis and other, the authors of the UN Millennium Project Report have forcefully concluded that: “foreign aid can play a hugely positive part in growth and poverty reduction when properly targeted and administered toward vital infrastructure and human capital. This finding is underlined by the recent experience of Mozambique, Tanzania and Uganda which all experienced substantial social sector improvement financed largely through development assistance” (UN Millennium Project 2005).

Building on the first High-level Forum on Aid Effectiveness held in Rome in 2003 the second High-level Forum held in Paris in 2004 reaffirmed donors’ commitment to improve ownership, alignment, harmonization and managing for results, and agreed on quantitative targets, to ensure aid quality.

4. Challenges for the Implementation of the Brussels Programme of Action

Despite some very impressive accomplishments, overall progress on meeting the goals and targets of the Brussels Programme of Action has been slow and uneven. As documented in Section 3, many of the specific targets and goals of the Brussels Programme of Action are unlikely to be met by LDCs as a group if current trends persist.

The challenges facing LDCs in implementing the Brussels Programme of Action are significant. Low levels of national income and low rates of economic growth make it difficult to reduce poverty and improve living conditions. Low levels of domestic savings, inadequate investment, slow adoption of productive technology, lack of physical, human and social capital, in turn, contribute to the low growth rates observed. Socio-economic development has been hampered by the absence of good governance, including accountability, rule of law, participation in decision-making, conflict resolution, empowerment of women, etc. Human and institutional capacities have been negatively affected by low education levels, inadequate nutrition outcomes, poor water and sanitation, high population growth, and poor health outcomes due in particular, to the HIV/AIDS pandemic, malaria, tuberculosis and other communicable diseases. Vulnerability to environmental shocks, including natural disasters and climate change, has led to the loss of biological diversity, drought, desertification and sea level rise. Lack of access to financial resources and high levels of debt are additional challenges facing LDCs.

Despite these challenges there are many examples of remarkable success documented in this report. Mozambique has experienced growth rates of per capita GDP of over 7% since 2004. Eritrea witnessed a 63% decline in malaria morbidity between 1999 and 2003. In Bangladesh, infant mortality declined 92 deaths per thousand live births in 1992 to 53 in 2002. Access to safe drinking water increased by 92% between 1990 and 2002 in Tanzania. **In all of these cases, effective public policies together with well administered development assistance were important factors in explaining success.**

The Brussels Programme of Action has set clear objectives, goals and targets to reach its development objectives. Equally clear commitments have been undertaken to put these into effect. The time is ripe to meet these commitments through concrete actions. ODA will remain a critical source for financing these actions and achieving the objectives of the Programme.

Chapter Sources

Map	ITU (2005a)
Chapter 1:	UNCTAD (2004)
Chapter 2:	UN (2001b, c, 2003); UN-OHRLLS (2005a)
Chapter 3:	
3.1:	AFD et al. (2005); Brück and van den Broeck (2006); FAO (2006); Ravallion (2001); Rodrik (1999); UN (2001a, c); WB (2005d), (2006); WB and IMF (2005)
3.2:	Booth and Lucas (2002); Crook and Sverrisson (2001); Dehn et al. (2003); Githongo (2000); Goetz and Gaventa (2001; IDEA and DANIDA (2004); Jütting et al. (2005); Ndegwa (2002); Premchand (1999a, b); UN (2005c)
3.3:	
3.3.1:	AVERT (2006); Davey (2000); Gates Foundation (2005); UNRCa (n.d.)WHO (2000a; 2005a, d, e, f, h)
3.3.2:	Bourgoing (1996); Haskew (2005); WB (2003, 2005a, b); WHO (2000b); WHO and UNICEF (2005a)
3.3.3:	UN (2005c); UNDP and UN-OHRLLS (2004); USAID (2003); WHO (2005b); WHO and UNAIDS (2005)
3.3.4:	UN (2005c); UNICEF (2004a, b, 2006); WB (2005c); WHO (2003, 2005g)
3.3.5:	Bruns et al. (2003); Lewis (2005); OXFAM (2000a); UNICEF (2001b 2003, 2005, 2006); USAID (2001)
3.3.6:	Cisse (2004); Graham et al. (2001); IMF et al. (2000); Serrano et al. (2004); UN (2005a, b); UNFPA (2003); UNICEF (2001a); WHO (2004a, 2005c, d)
3.3.7:	Narayan et al. (2000); UNRCb (n.d.); WHO (2004b, 2005g, 2006); WHO and UNICEF (2004, 2005b)
3.4:	Cambodia4Kids.org (2005); GFUSA (2006); GKP (2003); ITU (2005b); Kria-Chaker (2002); Sarrocco (2002); SDNP Bangladesh (2003); Spence (2003); UN (2005a, b, c); UNDP (2003)
3.5:	Ostry (2005); Rodrik (1999); Sen et al. (2004); UN (2005c); UNCTAD (2004); WB (2006)
3.6:	Salinger et al. (2005)
3.6.1:	IUCN (n.d.); Lurdes (2004); UN (2004, 2005a, b); WB (2004); WRI et al. (2005); WWF (2004a, b)
3.6.2:	Chambers and Conway (1991); Devereux (2002); FAO (2002); Kiwara (1999); OXFAM (2000b); Practical Action (2006); Shaffer (2004); Sinha and Lipton (1999); UN (2005c); UN/ISDR (2005, 2006); UNCTAD (2001); UNDP (2004a, b); WB (2000/1); Wikipedia (2006)
3.7:	Duflo (2004); IADB (2002); IDEA and DANIDA (2004); OECD/DAC (2003, 2006); UN Millennium Project (2005)
Chapter 4:	UN (2003); UNDP and UN-OHRLLS (2004); UNESCAP (2003); UN-OHRLLS (2005b)

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