
Monitoring of the achievement of the health-related Millennium Development Goals

Report by the Secretariat

1. The target year for the Millennium Development Goals is 2015. Globally, in the last decade, much progress has been made towards the health-related Millennium Development Goals.¹ In the same period of time, there have also been unprecedented declines in child mortality. The epidemics of HIV/AIDS, malaria and tuberculosis have been halted, with the scaling-up of preventive and treatment interventions resulting in fewer new cases and lower mortality rates than in 1990 and 2000.

2. Progress, however, has been uneven. While child and maternal mortality declined at similar rates since 1990, the decline in the rate of newborn mortality and stillbirth has been much slower. The reason is that there has been relatively lesser attention and investment in newborn-specific interventions, and their coverage remains low.

3. This report summarizes areas of progress towards achieving the health-related Millennium Development Goals and specific targets.² It also highlights the individual goals and targets, and describes progress towards reducing child mortality through the prevention and treatment of pneumonia, as requested in resolution WHA63.24; the prevention and reduction of perinatal and neonatal mortality (resolution WHA64.13); prevention and management of birth defects (resolution WHA63.17); and achieving universal coverage of maternal, newborn and child health care (resolution WHA58.31).

Goal 1, Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

4. Undernutrition causally contributes to an estimated 45% of all deaths among children under five years of age. Between 1990 and 2013, the proportion of underweight children in developing countries declined from 28% to 17%; stunting in children declined globally by 37%, from 257 million to 161 million.

¹ For the purposes of the present report, the baseline year for measuring progress is 1990.

² For a list of the relevant specific targets and statistics on the progress towards the targets, see the WHO Global Health Observatory: <http://www.who.int/research/en/> and http://www.who.int/topics/millennium_development_goals/en/ (accessed on 13 November 2014). For a fuller story and overview goal and targets not mentioned in the present report, see the United Nations Millennium Development Goals 2014 Report, at: <http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf> (accessed 16 December 2014).

Goal 4, Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

5. Globally, substantial progress has been made in reducing mortality in children under five years of age. Between 1990 and 2013, under-five mortality declined by 49%, falling from an estimated rate of 90 deaths per 1000 live births to 46 deaths per 1000 live births. The global rate of decline has accelerated greatly, from 1.2% per annum between 1990 and 1995 to 4.0% per annum between 2005 and 2013. About 17 000 fewer children died every day in 2013 than in 1990. Despite the evidence of progress, the gains remain insufficient to reach the target of a two-thirds reduction from 1990 levels of mortality by the year 2015.

6. The total number of neonatal deaths decreased from 4.7 million in 1990 to 2.8 million in 2013. Neonatal mortality rates per 1000 live births declined from 33 to 20 over the same period – a reduction of 39%. This decline is slower than that for child mortality overall, and the proportion of deaths in children under five years of age that occur in the neonatal period increased from 37% in 1990 to 44% in 2013. Leading causes of under-five mortality are prematurity (15%), acute respiratory infections (15%), birth asphyxia (11%), diarrhoea (9%), malaria (7%), neonatal infections (7%). Nearly half of all under-five deaths are associated with undernutrition, while low birth weight is associated with 80% of all newborn mortality.¹

7. In 2013, global coverage of measles immunization was 84% among children aged 12–23 months, and more countries were achieving high levels of vaccination coverage; 66% of Member States reached at least 90% coverage, compared with only 44% of Member States in 2000. Between 2000 and 2013, the estimated global number of measles deaths in children under five years decreased by 75% from 544 200 to 145 700. During that period of time, and compared to a scenario of no measles vaccination, an estimated 15.6 million deaths were prevented.

8. In 2014, the Sixty-seventh World Health Assembly endorsed the newborn health action plan,² which provides a roadmap of strategic actions for preventing newborn mortality, and will also contribute to reducing maternal mortality and stillbirths. Since the endorsement of the action plan, several countries have: finalized national newborn action plans (Ghana, India, Indonesia, Mongolia, Myanmar and Pakistan); hosted national newborn events (Ghana, India, Indonesia and Nigeria); sharpened their approach to national reproductive, maternal, newborn and child health with new, more ambitious goals (e.g. Philippines, Uganda and the United Republic of Tanzania); or taken part in regional events (in the Americas and South-East Asia). Other countries are developing national newborn action plans (Bangladesh, Ethiopia, Malawi and Nepal) or planned related events in 2014 (e.g. Bangladesh, China, Malawi and Pakistan).

9. The integrated global action plan for the prevention and control of pneumonia and diarrhoea³ focuses on two leading causes of mortality in children under five years of age, which together account

¹ See the WHO on the Global Health Observatory, at: http://www.who.int/gho/child_health/en/index.html (accessed 17 December 2014). For undernutrition: Black et al. Lancet, 2013.

² Resolution WHA67.10.

³ UNICEF/WHO. End preventable deaths: Global action plan for prevention and control of pneumonia and diarrhoea. Geneva: World Health Organization; 2013, at http://apps.who.int/iris/bitstream/10665/79200/1/9789241505239_eng.pdf?ua=1 (accessed 4 December 2014).

for 24% of all under-five deaths.¹ Following its launch in April 2013, several countries have integrated the strategic objectives of the plan into national and subnational child health strategies and implementation plans (Bangladesh, Uganda and Zambia). India hosted a workshop for selected high burden districts in four states to lay a foundation for accelerated and coordinated actions to tackle childhood pneumonia and diarrhoea. In many countries, the introduction of new vaccines, such as rota virus vaccine and pneumococcal vaccine, has been used as an opportunity for promoting a broader child health agenda, including through messaging on care seeking and treatment for pneumonia and diarrhoea, and the promotion of nutrition and safe water and sanitation interventions.

Goal 5, Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

10. The number of women dying due to complications during pregnancy and childbirth has decreased by 45%, from an estimated 523 000 in 1990 to 289 000 in 2013. The fall has been noteworthy, but falls well short of the target. The global rate of decline in the maternal mortality ratio between 1990 and 2013 was 2.6% per annum and accelerated in the last decade. Of the 89 countries with the highest maternal mortality ratio in 1990 (100 or more maternal deaths per 100 000 live births), 13 have made insufficient or no progress at all, with an average annual decline of less than 2% between 1990 and 2013. Direct obstetric causes, notably, haemorrhage (27%), hypertensive diseases of pregnancy (14%), and sepsis (11%), continue to be the leading causes of maternal deaths. Increasingly, however, deaths during pregnancy are attributed to other medical conditions. More than one in four maternal deaths are caused by medical conditions that can be aggravated by pregnancy, such as diabetes, HIV, malaria, cardiac conditions and obesity.²

11. WHO and partners have elaborated the elements of a post-2015 vision for “Ending preventable maternal mortality: Forging a consensus”,³ following consultations with Member States and public stakeholders.⁴ A consensus statement was issued that included outcomes, targets and objectives.⁵ Among them, the average global target was set: maternal mortality of less than 70 per 100 000 live births globally by 2030, with no country’s maternal mortality ratio greater than twice the global average. To reach this target post-2015, and to contribute to the achievement of the ultimate goal of ending preventable maternal mortality, five strategic objectives were identified:⁶ (1) addressing inequities in access to and quality of reproductive, maternal and newborn health care services; (2) ensuring universal health coverage for comprehensive reproductive, maternal and newborn health care; (3) addressing all causes of maternal mortality, reproductive and maternal morbidities, and

¹ Liu L, et al. Global, regional, and national causes of child mortality in 2000–2013, with projections to inform post-2015 priorities: an updated systematic analysis. *Lancet*. 2014) 1 October 2014. doi:10.1016/S0140-6736(14)61698-6 (accessed 3 November 2014).

² Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. 2014 Jun;2(6):323-33.

³ See *Ending preventable maternal mortality: Forging a consensus*, at: http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/ (accessed on 25 November 2014).

⁴ See http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/ (accessed 16 December 2014).

⁵ See the consensus statement at: http://apps.who.int/iris/bitstream/10665/130776/1/WHO_RHR_14.21_eng.pdf?ua=1&ua=1 (accessed 12 December 2014).

⁶ See the draft paper on strategies toward ending preventable maternal mortality (EMM), by the EPMM Working Group, at: http://who.int/reproductivehealth/topics/maternal_perinatal/strategies_epmm_comment.pdf?ua=1 (accessed 4 December 2014).

related disabilities; (4) strengthening health systems to respond to the needs and priorities of women and girls; and (5) ensuring accountability in order to improve quality of care and equity.

Goal 5, Target 5.B: Achieve, by 2015, universal access to reproductive health

12. In order to reduce maternal mortality and improve maternal health, women need access to effective interventions and good quality reproductive health care. In many Member States, programmes have been implemented to increase access to effective interventions. Contraceptive prevalence among women in the 15–49 year age group who were married or in a consensual union increased from 52% in 1990 to 63% in 2012 in developing regions of the world, but still 12% wanted to stop or postpone childbearing but were not using contraception. The proportion of women receiving antenatal care reflects a high rate for one visit, which drops to a disappointing rate of 56% for the recommended minimum of four visits. Skilled birth attendance is just under 50% in the African Region (which has the highest maternal mortality rate), however, recent surveys are beginning to show improvements in several countries.

13. About 16 million adolescent girls give birth each year. The adverse effects of adolescent childbearing also extend to the health of infants, for instance, through a higher incidence of low birth weight. In response to the 2013 recommendation to focus more on adolescent health by the independent Expert Review Group on Information and Accountability for Women's and Children's Health, and in the follow-up to the 2011 resolution on youth and health risks,¹ WHO launched the report, "Health for the world's adolescents" at the Sixty-seventh World Health Assembly.² The report is an online resource that provides regional and country data on adolescent health, gives links to all WHO guidance concerning adolescents across the full spectrum of health issues, and explores universal health coverage for adolescents.

14. WHO provides normative guidance and support to countries to accelerate progress towards universal access to reproductive health. Examples include guidelines on the prevention of early pregnancy and poor reproductive outcomes among adolescents in developing countries,³ guidelines to promote a human rights-based approach to family planning programmes,⁴ and policy briefs on key reproductive health subjects.⁵

15. Essential care during childbirth and in the early postnatal period is crucial for the prevention and management of conditions that cause maternal and neonatal death. Up-to-date, evidence-based guidelines for health care workers published by WHO cover many areas, including preterm birth, augmentation of labour, induction of labour, and the prevention and management of the major maternal, perinatal and neonatal conditions. Important research on areas supported by WHO include: efficacy of simplified management of suspected newborn sepsis in settings where referral is not

¹ Resolution WHA64.28.

² Health for the world's adolescents: A second chance in the second decade. Geneva: World Health Organization; 2014, at: <http://apps.who.int/adolescent/second-decade/> (accessed on 8 December 2014).

³ WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

⁴ For more information on relevant guidelines, see: http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/ (accessed on 16 December 2014).

⁵ See http://www.who.int/reproductivehealth/topics/family_planning/policybriefs/en/index.html (accessed 17 December 2014).

possible; efficacy of newer interventions to reduce newborn mortality; effect of early initiation of breastfeeding on mortality independent of its effect on increasing exclusive breastfeeding; use of antenatal corticosteroids in low- and middle-income settings; and on global use of maternal and newborn interventions. WHO coordinated research is ongoing to improve monitoring of labour to improve birth outcomes, scale up interventions (such as Kangaroo Mother Care), management of severe neonatal interventions, community case management of pneumonia and diarrhoea, and home-based management of severe acute malnutrition.

16. In 2014, in the third year of implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health, a shift to country-level action was demonstrated. Of the 75 focus countries, 65 have national accountability frameworks being implemented through catalytic funds received to support the Commission recommendations; 51 of the 75 countries conducted assessments of the civil registration and vital statistics systems in order to strengthen them; 45 countries now have maternal deaths notification policies; 58 countries are conducting annual health sector reviews with broad participation; 18 countries tracked expenditure on reproductive maternal newborn child health, and an additional 15 are expected to be able to do so by 2015; and 44 countries have a partnership agreement in place that formalize debate, coordination and decision making on health priorities and investments.

17. The eleven indicators recommended by the Commission on Information and Accountability are used in almost all countries. It is of concern, however, that only eight of the 75 countries had recent data for all coverage indicators in 2011–2012, and 37 countries had recent survey data for only one of them.

18. In September 2014, the independent Expert Review Group published its third report, entitled "Every woman, every child: a post-2015 vision",¹ which identified six recommendations. The report was presented at a side event during the United Nations General Assembly in New York in September 2014 and its recommendations discussed in greater detail during an accountability stakeholder meeting hosted in Geneva in November 2014. This resulted in recommendations to develop a new, broader, and more inclusive global strategy for women's, children's and adolescents' health; discuss the development of a results-based financing facility to sustain the global strategy; and enhance the dialogue with civil society to strengthen political accountability for women's and children's health. Work has begun towards the implementation of these three recommendations. The new global strategy will be developed through a broad-based consultation with country leadership, with the aim of presenting a document in September 2015, alongside the Sustainable Development Goals.

¹ The third report of the independent Expert Review Group on Information and Accountability for Women's and Children's health; Every woman, every child: a post-2015 vision, can be found at: http://apps.who.int/iris/bitstream/10665/132673/1/9789241507523_eng.pdf (accessed 8 December 2014).

Goal 6, Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS and Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

19. In 2013, an estimated 2.1 million people became newly HIV infected, down from 2.5 million in 2009.¹ Multiple preventive interventions are contributing to this decline, including the promotion of behavioural changes and biomedical intervention.

20. By the end of 2013, about 12.9 million people received antiretroviral therapy globally, 11.7 million of them in low- and middle-income countries. Those on antiretroviral therapy (numbering 11.7 million) represent 36% of the 32.6 million people living with HIV in low- and middle-income countries. At current trends, the target of placing 15 million people on antiretroviral therapy by 2015 in low- and middle-income countries will be exceeded.

21. The decrease in the number of those newly infected and the increase in availability of antiretroviral therapy has caused a decline in HIV mortality from a peak of 2.3 million in 2005 to an estimated 1.5 million in 2013. The population living with HIV will continue to grow since fewer people are dying from AIDS-related causes.

Goal 6, Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

22. In 2012, an estimated 207 million cases of malaria led to 627 000 deaths. Increasing coverage with interventions such as insecticide-treated bednets, indoor residual spraying, diagnostic testing and effective treatment contributed a decrease of malaria incidence by 29% globally between 2000 and 2012, and mortality rates fell by 42%.²

23. Globally, the number of new cases of tuberculosis fell at an average rate of about 1.5% per year between 2000 and 2013. Incidence rates are also falling in all WHO regions, meaning the target of halting and reversing incidence has been achieved. The mortality rate due to tuberculosis has fallen by 45% since 1990 and the prevalence rates fell by 41% over the same period. Three of the six WHO regions have met or are on track to meet all three 2015 targets for a reduction in the tuberculosis burden (incidence, prevalence and mortality). For the remaining three regions, the rates are falling but not fast enough to meet all targets. Globally, treatment success rates have been sustained since 2007 at high levels, that is, at or above 85%, which was the target first set by the Health Assembly in 1991, in resolution WHA44.8. The burden of tuberculosis remains high: there were an estimated 9 million new cases in 2013, of which about 12% were in people living with HIV; and with the estimated number of deaths was 1.5 million deaths, of whom 360 000 HIV-positive.

24. Target 6C includes neglected tropical diseases, a medically diverse group of infections caused by a variety of pathogens. Among them is human African trypanosomiasis, targeted for elimination as a public health problem by 2020 have reached their lowest level in 50 years, with 6314 new cases reported in 2013. While WHO maintains its target to interrupt transmission of dracunculiasis by the end

¹ For further details, see document WHA67/19, paragraph 22.

² More information is available at: http://www.who.int/malaria/publications/world_malaria_report_2013/en/ (accessed 13 November 2014).

of 2015, however, emerging challenges in Chad, Mali and South Sudan, where transmission is still occurring, require local solutions. Lymphatic filariasis is targeted for elimination as a public health problem by 2020. Plans to eliminate leprosy worldwide as a public health problem by 2020 have been prepared, and their implementation is progressing. Through preventive treatment campaigns, more than 807 million people received treatment for at least one disease in 2012. For dengue – the world’s fastest growing arbo-viral infection – effective, long-term vector control and disease prevention measures (including future vaccines) require strong, well-funded national programmes and strategies, and the support of partners in the global public health community to reduce morbidity and mortality by 2020. Viral haemorrhagic fevers are not considered part of the “classic” neglected tropical diseases, but share many of their features. During 2014, the world saw the largest outbreak of Ebola virus disease in history concentrated in three countries in western Africa.

Goal 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries

25. Many people continue to face a scarcity of medicines in the public sector, forcing them to the private sector where prices can be substantially higher. Surveys undertaken in the period 2007–2013 indicated that on average, selected essential (generic) medicines in 21 low- and middle-income countries were available in only 55% of public sector facilities. Patient prices increase as the wealth of the country increases: patients procuring medicines in the public sector of the low-income countries were paying on average twice the international reference prices, whereas in lower- and middle-income countries, patients were paying over three times international reference prices.

ACTION BY THE EXECUTIVE BOARD

26. The Board is invited to note the report.

= = =