

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

Report by the Secretariat

1. With only five years remaining to 2015, there are signs of progress towards the achievement of the health-related Millennium Development Goals in many countries. In others, progress has been limited because of conflict, poor governance, economic or humanitarian crises, and lack of resources. The effect of the global food, energy, financial and economic crises on health is still unfolding, but action is needed to protect health spending by governments and donors alike.

CURRENT STATUS AND TRENDS

2. **Undernutrition** is an underlying cause in more than one third of child deaths. Recent rises in food prices coupled with falling incomes have increased the risk of malnutrition, especially among children. Although the proportion of children under five years of age who were underweight (in comparison with the WHO Child Growth Standards) declined from 25% in 1990 to 18% in 2005, subsequent progress has been uneven. The prevalence of undernutrition has increased in some countries, and, globally, stunted growth still affects about 186 million children under five years of age.

3. Globally, **child mortality** continues to fall. In 2008, the total annual number of deaths in children under five years of age fell to 8.8 million, 30% less than the 12.4 million estimated to have occurred in 1990. Mortality in children under five years of age in 2008 was estimated at 65 per 1000 live births. Despite these encouraging trends, concerted efforts will be needed to achieve the target of a two thirds reduction from 1990 levels of mortality by the year 2015, especially in countries facing economic difficulties or armed conflict. Reducing child mortality increasingly depends on tackling neonatal mortality; globally, about 40% of deaths among children under five years of age are estimated to occur in the first month of life, most in the first week. Regional and national averages mask considerable inequities: the greatest reductions in child mortality have been recorded among the wealthiest households and in urban areas.

4. Increases have been recorded in the coverage of relatively new **child health interventions**, such as the use of insecticide-treated nets to prevent malaria, efforts to prevent the mother-to-child transmission of HIV, and vaccination against hepatitis B and *Haemophilus influenzae* type b infections. Gradual progress has also been recorded for several established interventions such as micronutrient supplementation, and the global coverage of measles immunization increased from 73% to 83% between 1990 and 2008. Despite these gains, the coverage of crucial interventions such as oral rehydration therapy for diarrhoea and case management with antibiotics for acute respiratory infections remains inadequate. As a result, diarrhoea and pneumonia still kill almost three million children under five years of age each year, especially in low-income countries. Most child deaths due

to pneumonia could be avoided if effective interventions were implemented on a broad scale and reached the most vulnerable populations. Currently, only 54% of children with pneumonia in developing countries are reportedly taken to a qualified health-care provider. Despite the essential role of antibiotics in reducing the number of child deaths from pneumonia, only 19% of children under five years of age with clinical signs of pneumonia receive antibiotics.

5. **Maternal mortality.** According to estimates made for the year 2005, half a million women – most of them in developing countries – die each year of complications during pregnancy or childbirth, a situation that globally has remained almost unchanged since 1990. The risk was highest in the African Region where there were 900 maternal deaths per 100 000 live births, compared with only 27 per 100 000 in the European Region. Half all maternal deaths occurred in the African Region and another third in the South-East Asia Region. Further analysis shows that between 1990 and 2005, no WHO region achieved the 5.5% annual decline in maternal mortality necessary to attain the Target 5.A¹ of Millennium Development Goal 5. Maternal mortality is the health indicator that shows the widest gaps between rich and poor, both between and within countries.

6. Interventions to reduce maternal mortality include ensuring that all pregnant women have access to family planning services and skilled care during pregnancy, childbirth and the postpartum period as well as emergency obstetric care for the management of complications. The proportion of births attended by skilled health personnel has increased globally. However, in both the African Region and South-East Asia Region, less than 50% of women receive skilled care during childbirth. Antenatal care offers numerous opportunities to improve the health of women; this includes prevention and management of HIV infection and malaria, the detection and management of eclampsia, and iron and folate supplementation – the last measure being particularly important in low- and middle-income countries where micronutrient deficiencies are common. Even so, less than half the pregnant women in the world receive the WHO-recommended minimum of four antenatal visits.

7. **Contraceptive prevalence**² in developing countries increased from 50% in 1990 to 62% in 2005. Despite this rise, continuing unmet needs for family planning remain. Over the period 2000–2007, globally there were an average 47 births per 1000 women aged 15–19 years. Factors that contribute to the fact that needs for family planning continue not to be met include a lack of decision-making power among women and a shortage of appropriate health services, especially for adolescent girls.

8. **Malaria.** In 2008, there were an estimated 243 million cases of malaria causing 863 000 deaths, mostly of children under five years of age. Despite increases in the supply of insecticide-treated bednets, their availability in that year was far below what was needed almost everywhere. The procurement of antimalarial medicines through public health services increased, but access to treatment (especially artemisinin-based combination therapy) was inadequate in all countries surveyed in 2007 and 2008. There are, however, indications that nine African countries and 29 countries outside Africa are on course to meet the Millennium Development Goal target³ for reducing the malaria burden, by 2010.

¹ Millennium Development Goal 5, Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

² Defined as the proportion of women, married or in union, aged 15–49 years, using any method of contraception.

³ Millennium Development Goal 6, Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

9. **Tuberculosis.** Latest estimates indicate that the incidence rate of tuberculosis has continued to decline slowly, falling to an estimated 140 cases per 100 000 population in 2008. The prevalence of all cases of tuberculosis and mortality rates among HIV-negative cases of tuberculosis are falling in all WHO regions. Globally, the estimated case-detection rate for new smear-positive cases of tuberculosis increased from 40% in 2000 to 62% in 2008. Even though there were some improvements in the African Region, less than 50% of cases of tuberculosis were reported in the Region in 2008. Data on treatment-success rates for new smear-positive cases indicate steady improvements, with the global rate rising from 69% in 2000 to 86% in 2007. However, multidrug-resistant tuberculosis and HIV-associated tuberculosis pose considerable challenges. Globally, there were an estimated 500 000 new cases of multidrug-resistant tuberculosis in 2007, with 27 countries accounting for 85% of the total.

10. **HIV/AIDS.** New HIV infections declined by 16% globally between 2000 and 2008, owing, at least in part, to successful HIV prevention efforts. In 2008 it was estimated that 2.7 million additional people were newly infected with HIV and that there were two million HIV/AIDS-related deaths. The availability and coverage of priority health-sector interventions for HIV prevention, treatment and care have continued to expand. In 2008, of the 1.4 million HIV-positive pregnant women in need of treatment, more than 628 000 received antiretroviral therapy to prevent transmission of HIV to their children: coverage of 45%, an increase of 10% compared with 2007. It is estimated that by the end of 2008 more than four million people in low- and middle-income countries were receiving antiretroviral therapy, a 10-fold expansion in five years, with the greatest growth in sub-Saharan Africa. Nonetheless, more than five million of the estimated 9.5 million people in low- and middle-income countries needing antiretroviral therapy were without access to treatment.

11. More than 1000 million people are affected by **neglected tropical diseases**. In 2008, 496 million people were treated for lymphatic filariasis out of the 695 million targeted. In 2008, only 4619 cases of dracunculiasis were reported; in the mid-1980s the estimated number of cases was 3.5 million. At the beginning of 2009, 213 036 cases of leprosy were reported, compared with 5.2 million in 1985.

12. The percentage of the world's population using "improved" **drinking-water** sources¹ increased from 77% to 87% between 1990 and 2008. This rate of improvement is sufficient to achieve the relevant Millennium Development Goal target² globally. In the African Region, however, although the percentage increased from 50% in 1990 to 61% in 2008, it remained well short of the 68% needed in that year to remain on course for achieving target 7.C. Progress in the Eastern Mediterranean Region appears to have stalled, and an annual rate of increase of 1.6% is needed to achieve the target by 2015. In 2008, 2600 million people were not using "improved" **sanitation** facilities,³ and of these 1100 million were defecating in the open, resulting in high levels of environmental contamination and exposure to the risks of helminth infestations (such as schistosomiasis) and microbial infections (such as trachoma, hepatitis and cholera). The situation was most severe in the African Region, where the

¹ "Improved" drinking-water sources include: piped water into dwelling, plot or yard; public tap or standpipe; borehole or tube well; protected dug well; protected spring; rainwater collection; and bottled water (if a secondary available source is also improved).

² Millennium Development Goal 7, Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking-water and basic sanitation.

³ "Improved" sanitation facilities are facilities that hygienically separate human excreta from human contact and include: flush or pour flush toilets or latrines connected to a sewer, septic tank or pit; ventilated pit latrines; pit latrines with a slab or platform of any material which covers the pit entirely except for the drop hole; and composting toilets/latrines.

percentage of the population using improved sanitation facilities increased very slowly, from 30% in 1990 to 34% in 2008.

13. Although nearly all countries publish an **essential medicines** list, the availability of medicines at public health facilities is often poor. Surveys in about 30 low-income countries indicate that availability of selected generic medicines at health facilities was only 44% in the public sector and 66% in the private sector. Lack of medicines in the public sector forces patients to purchase medicines privately. In the private sector, generic medicines cost on average 630% more than their international reference price, and originator brands are generally even more expensive. Common treatment regimens can cost a low-paid government worker in the developing world several days' wages. WHO is working with partners to monitor changes in medicine cost and consumption as one way of tracking the impact of the economic crisis.

The emerging health transition

14. **Noncommunicable diseases and injuries** caused an estimated 33 million deaths in developing countries in 2004 and will account for a growing proportion of total deaths in the future. Loss of health will also be caused by long-term chronic conditions, sensory and mental disorders and violence. Tackling risk factors such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol, and dealing with the socioeconomic impact of cardiovascular diseases, cancers, chronic respiratory diseases and diabetes depend not only on effective health-care services but also on actions in a variety of policy domains. Countries need to increase prevention efforts and improve access to services such as early detection and trauma care. Stronger surveillance systems will be critical. Efforts are under way to strengthen surveillance systems for noncommunicable diseases, including the identification of core indicators and use of standardized methods of data collection on risk factors and determinants, disease incidence, mortality by cause, health system indicators and coverage of key interventions.

LEARNING FROM SUCCESS

15. Successful disease-control programmes contribute to progress towards the achievement of several Millennium Development Goals. For example, the number of reported malaria-control successes in African countries is increasing. Malaria control is a component of poverty reduction (Goal 1), and contributes to better child health (Goal 4) and maternal health (Goal 5), as well as to fewer malaria cases and deaths (Goal 6). Similarly, widening access to antiretroviral therapy for people living with HIV/AIDS is having a broad range of beneficial effects.

16. Many of the countries that have made rapid progress in child health outcomes are those where child mortality rates in 2000 were already relatively low (below 100 per 1000 live births). More recently, however, there are signs of faster progress in countries with some of the highest levels of child mortality, such as Ethiopia and Liberia, where child mortality fell by 20% or more between 2000 and 2007.

17. Experiences from these settings can provide important lessons and focus attention on the importance of strengthening health systems so as to deliver an integrated package of services.

18. Without high-level political leadership and sustained support from development partners, this kind of integrated approach is unlikely to be put into practice. Progress is likely to be limited where

such conditions do not pertain, or are constrained by economic hardship and poverty, armed conflict, weak governance, and socioeconomic inequities, including gender inequality.

19. Improvements in health indicators are also closely related to other aspects of social and economic development. There is strong evidence that an increase in the education of girls and women is associated with improvements in health and reductions in child mortality.

ACHIEVEMENTS AND CHALLENGES: THE AGENDA TO 2015

Sustaining political momentum

20. The risk during recovery from the current economic crisis is that the world's attention will be diverted from the goal of reducing poverty and achieving the Millennium Development Goals. Rich nations will question whether they can sustain official development aid spending in the face of mounting debt. Low- and middle-income countries will struggle as they cope with rising demand for publicly-funded health care but falling domestic revenues.

21. The issue is to meet new health challenges – including those posed by pandemic influenza (H1N1) 2009 – and to recognize the growing health concerns related to climate change, while sustaining political and financial momentum. The focus on health in the 2009 Annual Ministerial Review of the United Nations Economic and Social Council was a vital first step. The declaration of G20 nations in Pittsburgh, United States of America, in September 2009, which confirmed support for the Millennium Development Goals and adherence (for G8 members) to the commitments agreed for 2010 made at the Gleneagles summit in 2005, is encouraging in the lead-up to the summit to review the Millennium Development Goals in 2010.

More money for health ...

22. Keeping to spending commitments requires action at national and international levels. While it is crucial not to cut levels of official development assistance at a time when it is most needed, it is also important that countries keep to agreed spending targets.

23. Since the last report to the Executive Board on monitoring of the achievement of the health-related Millennium Development Goals, noted by the Board at its 124th session,¹ the Taskforce on Innovative Financing for Health Systems has completed its work. At the sixty-fourth session of the United Nations General Assembly in 2009, the Taskforce announced a series of new financing measures, worth US\$ 5300 million, with a view to saving millions of women and children in developing countries whose lives were under increased threat because of the global economic crisis.

24. These resources are badly needed as funding shortfalls remain, particularly for programmes needed to meet Goal 5 (Improve maternal health). Recent data on trends in per capita official development assistance for health for the 46 countries in the African Region indicate that funding has increased significantly for Goal 6 (Combat HIV/AIDS, malaria and other diseases), but has remained unchanged for the other Goals. Moreover, one third of people living in absolute poverty reside in so-called fragile States that receive up to 40% less aid per capita than other low-income countries.

¹ See document EB124/2009/REC/2, summary records of the sixth meeting, section 2, and seventh meeting.

... more health for the money

25. WHO will continue to support the implementation of the Paris Declaration on Aid Effectiveness (2005) regarding ownership, harmonization, alignment, results and mutual accountability, as well as the Accra Agenda for Action (2008). WHO's support for the international commitments to health system strengthening – the International Health Partnership and Providing for Health – will promote the elaboration and use of national health strategies and plans as a means of increasing alignment with national priorities, and the provision of more consistent advice on domestic financing policies.

26. WHO has also been working with the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank to develop a common platform for health systems funding, in line with the recommendations of the High-Level Task Force on Innovative International Financing for Health Systems. A new mechanism, which will be tested in 2010, will seek to reduce transaction costs and streamline funding for national health strategies and plans.

Stronger health systems

27. The need for stronger health systems has been a feature of past reports on the Millennium Development Goals. In addition to continuing concerns in relation to human resources for health, two other priorities emerge: (1) reducing reliance on direct payments at the point of service, and (2) replacing direct payments with forms of prepayment and pooling. Action in these areas would help to accelerate the move to universal coverage. The financial and economic crisis has highlighted the need to increase the coverage of social health protection, because people in need cannot access the services they need or continue treatment if financial barriers remain high. Mechanisms to strengthen health systems also include improving services for diagnosis through national laboratory networks, better infection control in clinical settings and guidelines for the rational use of medicines.

28. Information and communication technologies are expected to have a profound influence on health systems and health surveillance. Electronic information systems and e-health applications have the potential to provide wider access to better quality care through appropriate use of electronic health records and mobile devices. These technologies are also changing the model of health information, prompting local ownership and access to data records at all levels of health systems. WHO will have a pivotal role in ensuring application of appropriate standards and progressive national policies in order that best use is made of these emerging opportunities.

Better information and intelligence

29. The ability to monitor the impact of the economic downturn on health is constrained by the lack of regular and timely data covering vulnerable populations. Currently, conclusions have to be drawn by piecing together fragmentary information from administrative sources, and through rapid qualitative assessments and household surveys. Yet such information is essential, given the accumulating evidence of the differential impacts of the economic downturn on men and women and across different socioeconomic groups.

30. WHO will continue to report on the most recent estimates for health-related statistics in its annual publication, *World health statistics*. However, the quality of reporting depends on the quality of national health-information systems, which are often weak. WHO is working with its partners and the Health Metrics Network to support national efforts to enhance the availability and quality of data on the Millennium Development Goals and other indicators.

31. In November 2009, WHO published a report on women and health, which provides an overview of knowledge about the health of women around the world over the life-course.¹ The report, one of the analytical and cross-cutting products of the WHO global health observatory, reflects the priority that the Organization places on the health of women. The report concludes that, despite considerable progress over the past two decades, societies are still failing women at key moments in their lives, and that these failures are most acute in poor countries and among the poorest women in all countries. The report draws attention to the role of gender inequality in increasing exposure and vulnerability to risk and harmful practices, in limiting access to health care and information, and in adversely affecting health outcomes. It represents a contribution to Millennium Development Goal 3 (Promote gender equity and improve health), as well as to women's health in general and the health-related Millennium Development Goals in particular.

32. In January 2010 at its 126th session the Executive Board discussed progress and challenges on the basis of an earlier version of this report² and adopted resolution EB126.R4.

ACTION BY THE HEALTH ASSEMBLY

33. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB126.R4.

= = =

¹ *Women and health: today's evidence, tomorrow's agenda*. Geneva, World Health Organization, 2009.

² See document EB126/2010/REC/2, summary record of the seventh meeting, section 2.