World Health Organization

SIXTY-EIGHTH WORLD HEALTH ASSEMBLY **A68/13**
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Monitoring of the achievement of the health-related Millennium Development Goals

Report by the Secretariat

1. The Executive Board at its 136th session noted an earlier version of this report.[1] In particular, the information on Millennium Development Goals 6 and 7 has been updated.

2. The target year for achievement of the Millennium Development Goals is 2015. Globally, in the past decade, much progress has been made towards the health-related Millennium Development Goals.[2] There have been unprecedented declines in child mortality, and 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.

3. Progress, however, has been uneven. Although 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.

4. This report summarizes areas of progress towards achieving the health-related Millennium Development Goals and specific targets.[3] 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). Progress reports on newborn health and working towards universal coverage of maternal, newborn and child health interventions are available separately in accompanying document A68/36.

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[1] See document EB136/14, and the summary records of the Executive Board at its 136th session, tenth meeting, section 2.

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

3 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 1, Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

5. 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%; the number of stunted children declined globally by 37%, from 257 million to 161 million.

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

6. 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.

7. 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%), and neonatal infections (7%). Nearly half the deaths in under-five year olds are associated with undernutrition.[1]

8. In 2013, global coverage of measles vaccination 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.

9. In 2014, the Health Assembly in resolution WHA67.10 endorsed the newborn health action plan, which provides a road map of strategic actions for preventing newborn mortality, and will also contribute to reducing maternal mortality and stillbirths. Subsequently, several countries have developed new or sharpened national plans for newborn health. Globally, a coordination mechanism has been put in place to advance country implementation, monitoring and evaluation, and advocacy (see document A68/36, section H, for more details).

[1] Black RE, Victora CG, Walker SP, Bhutta ZA Christian P, de Onis M et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013;382:427–51.

10. The integrated global action plan for the prevention and control of pneumonia and diarrhoea[1] focuses on two leading causes of mortality in children under five years of age, which together account for 24% of all under-five deaths.[2] 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 rotavirus vaccine and pneumococcal vaccine, has been used as an opportunity for promoting a broader child health agenda, including for instance 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

11. The number of women dying because of complications during pregnancy and childbirth has decreased by 45%, from an estimated 523 000 in 1990 to 289 000 in 2013. The decrease 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 past 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 death. 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 infection, malaria, cardiac conditions and obesity.[3]

12. WHO and its partners have elaborated the elements of a post-2015 vision for ending preventable maternal mortality, 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 70/100 000 live births by 2030, with no country's maternal mortality ratio greater than twice the global average. To reach this target after 2015, and to contribute to the achievement of the ultimate goal of ending preventable maternal mortality, five strategic objectives were identified: (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 related disabilities; (4) strengthening health systems to

[1] 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)

[2] 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.

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

[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).

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

13. 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 (83%) for one visit, but drops to a disappointing rate of 62% for the recommended minimum of four visits. A skilled birth attendant is present at 51% of births in the African Region (which has the highest maternal mortality rate), but recent surveys are beginning to show improvements in several countries.

14. 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 resolution WHA64.28 in 2011 on youth and health risks, WHO launched the report, "Health for the world's adolescents" during the Sixty-seventh World Health Assembly.[1] The report is an online resource that provides regional and country data on adolescent health, gives links to all WHO's guidance concerning adolescents across the full spectrum of health issues, and explores universal health coverage for adolescents. To accelerate action in countries, the Secretariat is proposing to develop a global framework as the basis for coherent country plans and to align the contributions of relevant stakeholders for implementation (see document A68/15).

15. 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,[2] guidelines to promote a human rights-based approach to family planning programmes,[3] and policy briefs on key reproductive health subjects.[4]

16. 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

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

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

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

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

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 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.

17. 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.

18. The 11 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.

19. In September 2014, the independent Expert Review Group published its third report, "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. Its recommendations were discussed in greater detail during an accountability stakeholder meeting hosted in Geneva in November 2014, which resulted in recommendations to develop a new, broader and more inclusive global strategy for women's, children's and adolescents' health; to discuss the development of a results-based financing facility to sustain the global strategy; and to 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 is being developed through a broad-based consultation with country leadership, with the aim of presenting a document in September 2015, alongside the proposed 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

20. In 2013, an estimated 2.1 million people became newly infected with HIV, down from 2.5 million in 2009. Multiple preventive interventions are contributing to this decline, including the promotion of behavioural changes and biomedical interventions.

21. 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. These 11.7 million represent 36% of the 32.6 million people living with HIV in low- and middle-income countries. However, the recommendations in WHO's consolidated guidelines on the use of antiretroviral medicines, issued in 2013,[1] have resulted in much higher numbers of HIV-infected people needing treatment. Consequently, universal access to treatment will be more challenging in the foreseeable future. Nevertheless, at current trends, the target of placing 15 million people on antiretroviral therapy by 2015 in low- and middle-income countries will be exceeded.

22. 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 2.4 million in 2005 to an estimated 1.5 million in 2013. The population living with HIV will continue to grow as 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

23. At the global level, the malaria-specific Target has already been met. In terms of country-level progress, altogether 64 countries are currently on track to reverse the incidence of malaria nationally by 2015. Of these, 55 are on track to meet the target set by the Health Assembly and the Roll Back Malaria Partnership of reducing malaria incidence by 75% by 2015. In 2013, an estimated 198 million cases of malaria led to 584 000 deaths globally. Increasing coverage with interventions such as insecticide-treated bednets, indoor residual spraying, diagnostic testing and effective treatment contributed a decrease of malaria incidence by 30% globally between 2000 and 2013, and mortality rates fell by 47%. But significant challenges remain. In 2013, one third of households in areas with malaria transmission in sub-Saharan Africa did not have an insecticide-treated net. Insecticide resistance has been reported in 49 countries around the world. Progress has also been slow in scaling up preventive therapies for pregnant women, and in adopting recommended preventive therapies for children under five years of age and infants.[2]

24. 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 targets set for 2015 for a reduction in the

[1] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Geneva: World Health Organization; 2013.

[2] More information is in the World malaria report 2014, available at: http://www.who.int/malaria/publications/world_malaria_report_2014/en/ (accessed 31 March 2015).

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, with an estimated 1.5 million deaths, of whom 360 000 were HIV-positive.

25. Target 6.C includes neglected tropical diseases, a medically diverse group of infections caused by a variety of pathogens. With the numbers of cases of human African trypanosomiasis reaching their lowest levels in 50 years – only 6314 cases in 2013 – the disease is now targeted for elimination as a public health problem by 2020. Dracunculiasis is on the verge of eradication with a historic low of 126 cases in 2014; WHO maintains its target to interrupt transmission by the end of 2015. In Chad, Ethiopia, Mali and South Sudan, where dracunculiasis cases are still occurring, local solutions are immediately required to offset current challenges. Plans to eliminate leprosy worldwide as a public health problem by 2020 have been prepared, and their implementation is progressing. Elimination of visceral leishmaniasis as a public health problem by 2020 in the Indian subcontinent is on track with the number of incident cases reduced by more than 75% since the launch of the elimination programme in 2005. More than 5000 million treatments have been delivered since 2000 to stop the spread of lymphatic filariasis, targeted for elimination as a public health problem by 2020. Of the 73 countries known to be endemic, 39 are on track to achieve the elimination target. 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 arboviral infection – effective, long-term vector control and disease prevention measures (including vaccines, if and when licensed) 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.

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

26. Work to increase access to safe drinking water and basic sanitation is covered by Target 7.C. This target was met in 2010 for drinking water, as measured by the proxy indicator of access to improved drinking water sources. In 2012, 89% of the population used an improved source of drinking water compared with 76% in 1990. Although progress has been impressive, disparities exist across different regions, between urban and rural areas, and between rich and poor people. Coverage is at least 90% in four WHO regions, but remains low in the African and Eastern Mediterranean regions; at the current rate of progress, these two regions will fall short of the 2015 target. With regard to basic sanitation, 1950 million people have gained access to an improved sanitation facility since 1990; nevertheless, in 2012, about 2500 million people (more than one third of the global population) still lacked access. The current rate of progress is insufficient for the target to be met for sanitation globally. The United Nations Secretary-General has called for a doubling of efforts to achieve Target 7.C on sanitation. WHO is committed to mobilizing the health sector to resolve the crisis of sanitation, through advocacy, technical assistance and improved global monitoring.

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

27. 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 HEALTH ASSEMBLY

28. The Health Assembly is invited to note the report.

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