
Monitoring the achievement of the health-related Millennium Development Goals

Report by the Secretariat

1. In response to requests in resolutions WHA63.15, WHA63.24 and WHA58.31, this report summarizes the latest trends in progress towards achievement of the health-related Millennium Development Goals and specific targets.¹ It also describes progress towards reducing child mortality through the prevention and treatment of pneumonia, as requested in resolution WHA63.24; reducing perinatal and neonatal mortality; and achieving universal coverage of maternal, newborn and child health interventions, as requested in resolution WHA58.31.

CURRENT STATUS AND TRENDS

2. More than a decade after world leaders adopted the Millennium Development Goals and their targets, substantial progress has been made in reducing child and maternal mortality, improving nutrition, and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria. Progress in many countries that have the highest rates of mortality has accelerated in recent years, although large gaps persist among and within countries. The current trends form a good basis for intensified collective action and expansion of successful approaches to overcome the challenges posed by multiple crises and large inequalities.

3. Malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under five years of age. The proportion of malnourished children in developing countries declined from 28% to 17% between 1990 and 2011. This rate of progress is close to what is required to meet the relevant target but varies between and within regions. In resolution WHA65.6, the World Health Assembly endorsed the implementation plan on maternal, infant and young child nutrition, which contains the new target for 2025 of a global 40% reduction in numbers of stunted children against 2010 baselines.² Between 1990 and 2011 stunting declined globally by 35%, from 253 million to 165 million.

¹ The relevant specific targets are: for Goal 1, Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger; for Goal 4, Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate; for Goal 5, Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, and Target 5.B: Achieve, by 2015, universal access to reproductive health; for Goal 6, Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS, Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it, and Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases; for Goal 7, Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking-water and basic sanitation; and for Goal 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

² See document WHA65/2012/REC/1, Annex 4.

4. Globally, substantial progress has been made in reducing mortality in children under five years of age. Between 1990 and 2011, under-five mortality declined by 41%, from an estimated rate of 87 to 51 deaths per 1000 live births. The global rate of decline has accelerated in the past decade, from 1.8% per annum between 1990 and 2000 to 3.2% per annum between 2000 and 2011, yet remains insufficient to reach the target of a two thirds reduction from 1990 levels of mortality by the year 2015. Globally, 44 out of 143 low-income and middle-income countries will have reached that target by 2015 if the pace of progress remains the same as that shown during the period 2005–2011.

5. In 2011, global measles immunization coverage was 84% among children aged 12–23 months. More countries are now achieving high levels of immunization coverage; in 2011, 64% of Member States reached at least 90% coverage. Between 2000 and 2010, the estimated number of measles deaths decreased by 76%, accounting for about one fifth of the overall decline in child mortality.

6. To support and facilitate the implementation of coordinated, expanded interventions for the control of pneumonia and diarrhoea among children under five years of age living in developing countries, WHO conducted four regional workshops (three in the African Region and one in the South-East Asia Region) in collaboration with health ministries from 34 countries, UNICEF and other partners. These regions carry the highest burden of mortality due to pneumonia and diarrhoea and include countries that are not on track to achieving Millennium Development Goal 4 (Reduce child mortality). Follow-up activities have been carried out in several countries to monitor progress. WHO and UNICEF in collaboration with various stakeholders are working to develop a global action plan for the prevention and control of pneumonia and diarrhoea, which will be ready in the second quarter of 2013.

7. WHO is working with UNICEF and other stakeholders to facilitate the availability of oral amoxicillin for treatment of pneumonia and oral rehydration salts and zinc for diarrhoea, in accordance with the recommendations made by the UN Commission on Life-Saving Commodities for Women and Children.¹ Nearly 20% of the deaths in children under five years of age – that are mostly due to pneumonia and diarrhoeal diseases – continue to be preventable by vaccines.

8. As requested by the Health Assembly in resolution WHA63.24, efforts are being made to expand access to interventions for the prevention and treatment of pneumonia, and against diarrhoeal diseases. A rapidly increasing number of countries in the African Region, the Region of the Americas and the Eastern Mediterranean Region have introduced pneumococcal conjugate vaccines in the past years with support from the GAVI Alliance. Joint statements by UNICEF and WHO on the clinical management of children with diarrhoea and pneumonia have been used by several countries to formulate policies on increasing access to care through trained and supervised community health workers. By 2012, 39 out of 75 countries being monitored by the Countdown to 2015 initiative² had adopted the policy on community case management of pneumonia and eight additional countries moved towards adopting and implementing the policy.

9. The reduction in maternal deaths has been noteworthy, from 543 000 deaths in 1990 to an estimated 287 000 in 2010; nevertheless, the rate of decline would need to double in order to achieve Target 5.A: Reducing the maternal mortality ratio by three quarters between 1990 and 2015. The rate

¹ See <http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities> (accessed 30 November 2012).

² Countdown to 2015 for Maternal, Newborn and Child Survival, see <http://www.countdown2015mnch.org/> (accessed 30 November 2012).

of decline in the maternal mortality ratio between 1990 and 2010 globally was 3.1% per annum, with lower rates in the Region of the Americas and the Eastern Mediterranean Region (2.5% and 2.6% per annum, respectively). Approximately a quarter of the countries with the highest maternal mortality ratio in 1990 (100 or more maternal deaths per 100 000 live births) have made insufficient progress or none. The adoption by countries of a systematic approach to maternal death surveillance and response, as recommended by the Commission on Information and Accountability, contributes to a more accurate measurement of maternal deaths.¹

10. In order to reduce maternal deaths, women need access to effective interventions and good-quality reproductive health care. Maternal death reviews undertaken recently have provided better information on the biomedical and social determinants of maternal mortality. In many Member States, programmes have been implemented to remove or reduce obstacles that prevent access to effective interventions. For the period 2005–2010, 63% of women in the 15–49 years age group who were married or in a consensual union were using some form of contraception. The proportion of women receiving antenatal care at least once during pregnancy was about 81% for the period 2005–2011, but the figure dropped to around 55% for the recommended minimum, which is four visits or more. There has been an increase in the utilization of facilities for deliveries. This has had a positive impact on the proportion of births attended by skilled personnel – crucial for reducing perinatal, neonatal and maternal deaths – which was above 90% in three of the six regions for the period 2005–2011. Improvements are nevertheless needed, for example, in the African Region, where coverage is still under 50%.

11. About 16 million adolescent girls between 15 years and 19 years give birth each year. Babies born to adolescent mothers account for roughly 11% of all births worldwide; 95% occur in developing countries. In low-income and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among adolescent girls in the mentioned age group. In 2008, there were an estimated 3 million unsafe abortions among girls in this age group. The adverse effects of adolescent childbearing also extend to the health of the infants. Perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers between 20 years and 29 years. The newborns of adolescent mothers are also more likely to have low birth weight, which may result in a higher rate of long-term health risks for the infants. WHO has issued guidelines on prevention of early pregnancies and poor reproductive outcomes among adolescents in developing countries in 2011 and is providing support to countries to include related activities in national action strategies and action plans.

12. WHO has been collaborating with its partners to support countries in the introduction of interventions critical to accelerating progress towards achieving universal access to reproductive health. As part of the commitments announced during the London Summit on Family Planning, WHO provided policy briefs on strategies to: optimize the health workforce for objective family planning services; increase the use of long-acting and permanent methods of contraception; expand access to services for adolescents; and strengthen the health system response.² WHO's other commitments included: expanding choice and method mix through contraceptive research and development; and scaling up the availability of quality contraceptive commodities through product prequalification and fast-track mechanisms.

¹ See the recommendations in *Keeping promises, measuring results* at http://www.who.int/topics/millennium_development_goals/accountability_commission/en/ (accessed 30 November 2012).

² See http://www.who.int/reproductivehealth/topics/family_planning/policybriefs/en/index.html (accessed 30 November 2012).

13. The total number of neonatal deaths decreased from 4.4 million in 1990 to 3.0 million in 2011. Neonatal mortality rates declined from 32 per 1000 live births to 22 per 1000 live births over the same period – a reduction of over 30%. This is a slower decline than for child mortality overall, and the proportion of deaths in children under five years that occur in the neonatal period increased from 36% in 1990 to 43% in 2011. Prematurity is the leading cause of newborn deaths and now the second leading cause of death in children under five years. WHO and its partners have released, for the first time, a global action report on preterm birth¹ that highlights scientifically proven solutions to save preterm lives, provide appropriate care for preterm babies and reduce the high rates of death and disability. The estimated global number of stillbirths fell from 3.0 million in 1995 to 2.6 million in 2009, with the rate of stillbirths declining by about 15%, from 22 per 1000 births in 1995 to 19 per 1000 births in 2009.

14. 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. WHO and its partners support the strengthening of capabilities of health care workers to prevent or manage the major maternal, perinatal and neonatal diseases, including the use of antenatal steroids for preterm labour, support for early initiation and exclusive breastfeeding, kangaroo mother care, and home visits to newborn children and their mothers. In addition, WHO is gathering more evidence on the most cost-effective interventions, including simpler antibiotic treatment regimens for treatment of neonatal sepsis.

15. Too often, affordable, effective medicines and simple health supplies do not reach the women and children who need them. The UN Commission on Life-Saving Commodities for Women and Children formulated 10 recommendations to increase access to life-saving medicines and health supplies for the world's most vulnerable people. An initial list of 13 affordable, effective, but underutilized life-saving commodities were identified.² Follow-on action will involve all stakeholders committed to the United Nations Secretary-General's Global Strategy for Women's and Children's Health and will focus on actions to shape global and local markets, strengthen quality, make regulation more efficient, increase supply and demand, and put in place innovative financing mechanisms. WHO has drawn up implementation plans to address related regulatory pathways and product quality issues, including prequalification, and expanding access to selected essential health products.

16. About half the world's population is at risk of contracting malaria, and an estimated 216 million cases of malaria led to 655 000 deaths in 2010, 86% of which concerned children under the age of five years. In the African Region, a total of eight countries and one area showed a reduction of more than 50% in either confirmed malaria cases or malaria admissions and deaths. In other regions, the number of reported cases of confirmed malaria decreased by more than 50% in 35 of the 53 countries with ongoing transmission between 2000 and 2010 and downward trends of 25%–50% were seen in four other countries. The estimated incidence of malaria fell by 17% globally between 2000 and 2010. Coverage with interventions such as the distribution of insecticide-treated bed nets and indoor residual spraying has greatly increased and needs to be sustained in order to prevent the resurgence of disease and deaths.

17. The annual global number of new cases of tuberculosis has been slowly declining since 2006; it fell 2.2% between 2010 and 2011. In 2011, there were an estimated 8.7 million new cases, of which about 13% involved people living with HIV. Mortality due to tuberculosis has fallen 41% since 1990 and the trend indicates that, globally, it will reach a 50% reduction by 2015. Incidence

¹ *Born too soon: the global action report on preterm birth*, Geneva, World Health Organization, 2012.

² See <http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities/life-saving-commodities> (accessed 30 November 2012).

rates are also falling in the six regions. Globally, treatment success rates have been sustained at high levels, at or above the target of 85% for the past four years (the target was first set by the Health Assembly in 1991).

18. Globally, in 2011, an estimated 2.5 million people were newly infected with HIV, 24% fewer than the 3.1 million people newly infected in 2001. Sub-Saharan Africa accounted for 70% of all the people who acquired HIV infection globally. There were an estimated 34 million people living with HIV in 2011, an increase from previous years. As access to antiretroviral therapy in low-income and middle-income countries improves (a little over 8 million people in low-income and middle-income countries received treatment in 2011), the population living with HIV will continue to grow since fewer people are dying from AIDS-related causes.

19. The term “neglected tropical diseases” refers to a group of 17 diseases that affect more than one billion people worldwide.¹ Although these diseases rarely cause outbreaks (excepting dengue and leishmaniasis), they thrive in the poorest, most marginalized communities, causing severe pain, permanent disability and death to millions of people. Through a coordinated and integrated approach since 2007, WHO has demonstrated that control, elimination and even eradication of these diseases are feasible. Dracunculiasis, for example, with fewer than 1058 cases reported in 2011, is on the verge of eradication without the use of any medication or vaccine.

20. Work on drinking-water and basic sanitation is covered by Target 7.C: Halve, by 2015, the proportion of the population without sustainable access to safe drinking-water. This target has been met; in 2010, 89% of the population used an improved source of drinking-water compared with 76% in 1990. Progress has been impressive, nevertheless, disparities exist among regions. Although coverage is above 90% in four of the six regions, it remains low in the African Region and the Eastern Mediterranean Region. Based on the current rate of progress, these two regions will fall short of the 2015 target. With regard to basic sanitation, current rates of progress are too slow for the target to be met, both globally and within regions (with the exception of the Western Pacific Region). In 2010, 2500 million people lacked access to improved sanitation facilities and 72% of these lived in rural areas. The number of people in urban areas without improved sanitation is increasing because of rapid growth in urban populations.

21. 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 from 2007 to 2011 indicated that the average availability of selected generic medicines in low-income and middle-income countries was only 51.8% in the public sector. Patient prices of the lowest priced generics in the private sector averaged five times international reference prices, ranging up to about 14 times higher in some countries. Even lowest priced generics can put common treatments beyond the reach of low income households in developing countries. The greatest price is paid by patients suffering chronic diseases. Effective treatments for the majority of the global chronic disease burden exist, yet universal access remains out of reach.

¹ See document EB132/19. The diseases concerned are: dengue, rabies, trachoma, Buruli ulcer, endemic treponematoses, leprosy, Chagas disease, human African trypanosomiasis, leishmaniasis, cysticercosis, dracunculiasis, echinococcosis, foodborne trematode infections, lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminthiasis.

HEALTH IN THE POST-2015 DEVELOPMENT AGENDA

22. A short time remains before the end of 2015, and it is clear that, despite the progress made, much needs to be done if the health-related Millennium Development Goals are to be achieved, and much needs to be done beyond 2015. At the same time, the world faces new challenges in reflecting the way in which progress is measured after 2015. The contribution of Member States is essential to help shape the debate on this subject, in order to ensure that the efforts to reach the health-related Millennium Development Goals will continue as part of the global development agenda.¹

ACTION BY THE EXECUTIVE BOARD

23. The Executive Board is invited to note this report.

= = =

¹ See document EB132/12.