

Monitoring the achievement of the health-related Millennium Development Goals

Report by the Secretariat

1. The Executive Board at its 134th session noted an earlier version of this report.¹ The version of the report that follows has been updated (in particular, paragraphs 2, 4, 6, 10, 14, 19, 20, 22, 23, 24 and 26) in the light of comments made during the session and new information available.

2. In response to requests in resolutions WHA58.31, WHA63.15, WHA63.17, WHA63.24, WHA64.13 and WHA65.7, this report summarizes progress towards achievement of the health-related Millennium Development Goals and specific targets.² 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 (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).

CURRENT STATUS AND TRENDS

3. 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.

4. Undernutrition is the underlying cause of death in an estimated 45% of all deaths among children under five years of age. The proportion of underweight children in developing countries declined from 28% to 17% between 1990 and 2012. This rate of progress is close to what is required

¹ See document EB134/17 and the summary records of the Executive Board at its 134th session, fourth meeting, section 4 and seventh meeting (document EB134/2014/REC/2).

² 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 medicines in developing countries.

to meet the relevant target but varies between and within regions. In resolution WHA65.6, the Health Assembly endorsed the comprehensive 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 the 2010 baseline.¹ Between 1990 and 2012, stunting declined globally by 37%, from 257 million to 162 million. The plan also established targets on reduction of wasting, low birth weight and maternal anaemia, prevention of child overweight, and improvement in rates of breastfeeding.

5. Globally, substantial progress has been made in reducing mortality in children under five years of age. Between 1990 and 2012, under-five mortality declined by 47%, falling from an estimated rate of 90 deaths per 1000 live births to 48 deaths per 1000 live births. The global rate of decline has accelerated, from 1.2% per annum between 1990 and 1995 to 3.9% per annum between 2005 and 2012; nevertheless, it remains insufficient to reach the target of a two-thirds reduction from 1990 levels of mortality by the year 2015.

6. In 2012, 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 43% of Member States in 2000. Between 2000 and 2012, the estimated global number of measles deaths decreased by 78% from 562 000 to 122 000.

7. The new integrated global action plan for the prevention and control of pneumonia and diarrhoea² gives the global community an historic opportunity to end preventable child deaths, by focusing on pneumonia and diarrhoea in particular, which together account for 26% of all under-five deaths. The plan was launched in April 2013 in parallel with *The Lancet* series on childhood pneumonia and diarrhoea. The plan is primarily intended to guide national governments and their partners. Following the launch, a communiqué issued by UNICEF, WHO and the United States Agency for International Development was disseminated to country offices and programmes. The communiqué calls for close collaboration with all partners, by fully using existing opportunities around national events and initiatives, such as Committing to Child Survival: A Promise Renewed, and working with the United Nations Commission on Life-Saving Commodities for Women and Children, to introduce new vaccines. Tools and guidelines are being developed and disseminated with the aim of supporting the implementation of integrated approaches and resolving supply issues for key commodities, such as zinc.³ WHO is updating technical and policy briefs on the management of pneumonia. Partners are supporting the plan's strategic approaches through the application of innovative, integrated modes of delivery of vaccination, nutrition, case management, and water and sanitation interventions at the district level. For instance, market research is being done in Nigeria in order to assess and find ways to increase demand; support is being provided to increasing demand for and supply of oral rehydration salts, zinc and amoxicillin in Democratic Republic of the Congo, Ethiopia, India, Kenya, Niger and United Republic of Tanzania through means that include public–private partnerships.

8. 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 recent years

¹ Document WHA65/2012/REC/1, Annex 2.

² UNICEF/WHO. End preventable deaths: Global action plan for prevention and control of pneumonia and diarrhoea. Geneva: World Health Organization; 2013.

³ See <http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities>.

with support from the GAVI Alliance. Introduction of new vaccines (pneumococcal and rotavirus) provided opportunities for introduction and implementation of coordinated interventions against pneumonia and diarrhoea. Joint statements issued by UNICEF and WHO on the clinical management of children with diarrhoea and pneumonia have been used by several countries as the basis for policies on increasing access to care through trained and supervised community health workers. By the end of 2012, 39 out of 75 countries being monitored by the Countdown to 2015 initiative¹ had adopted the policy on community case management of pneumonia and eight additional countries had moved towards adopting and implementing the policy.

9. The fall in the number of 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 nearly double in order to achieve Target 5.A. The global rate of decline in the maternal mortality ratio between 1990 and 2010 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). About 25% of the countries with the highest maternal mortality ratio in 1990 (100 or more maternal deaths per 100 000 live births) have made insufficient or no progress. The adoption by countries of a systematic approach to maternal death surveillance and response, as recommended by the Commission on Information and Accountability for Women's and Children's Health, contributes to a more accurate measurement of maternal deaths.²

10. In order to reduce maternal mortality, women need access to effective interventions and good-quality reproductive health care. Recent reviews of maternal deaths have provided better information on the biomedical and social determinants of maternal mortality. In many Member States, programmes have been implemented to remove or lower obstacles to access to effective interventions. In 2011, 63% of women in the 15–49 year age group who were married or in a consensual union were using some form of contraception, while 12% wanted to stop or postpone childbearing but were not using contraception. The proportion of women receiving antenatal care at least once during pregnancy was about 81% for the period 2006–2013, but the figure was only around 56% for the recommended minimum of four visits or more. The increased use of facilities for deliveries 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 WHO regions, with a global average of 72% in 2012. Improvements are needed in, for example, the African Region, where coverage is just under 50%.

11. About 16 million adolescent girls aged between 15 and 19 years give birth each year. Babies born to adolescent mothers account for about 11% of all births worldwide, 95% in developing countries. In low- and middle-income countries, complications from pregnancy and childbirth are among the leading causes of death among girls aged 15–19 years. In 2008, there were an estimated three million unsafe abortions among girls in that age group. The adverse effects of adolescent childbearing also extend to the health of infants. Perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged between 20 years and 29 years. Adolescent mothers' newborns are also more likely to have low birth weight, which may result in a higher rate of long-term health risks for the infants concerned. In 2011, WHO issued guidelines on the prevention of early pregnancy and poor reproductive outcomes among adolescents in developing

¹ Countdown to 2015: Maternal, Newborn & Child Survival, at <http://www.countdown2015mnch.org/> (accessed 29 October 2013).

² See the recommendations in "Keeping promises, measuring results" at http://www.who.int/topics/millennium_development_goals/accountability_commission/en/ (accessed 17 October 2013).

countries¹ and is providing support to countries for including related activities in national strategies and action plans.

12. The Secretariat is providing support to countries in introducing interventions that are crucial for accelerating progress towards universal access to reproductive health. As a contribution towards the commitments announced during the London Summit on Family Planning (London, 11 July 2012), WHO has issued 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 contraceptive choice and the number of different types of contraceptive methods available through research and development, and increasing the availability of good-quality contraceptive commodities through product prequalification and fast-track mechanisms.

13. The total number of neonatal deaths decreased from 4.6 million in 1990 to 2.9 million in 2012. Neonatal mortality rates per 1000 live births declined from 33 to 21 over the same period – a reduction of 37%. 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 2012. Prematurity is the leading cause of neonatal deaths and is now the second leading cause of death in children under five years of age. WHO and its partners have released the first global action report on preterm birth³ that highlights scientifically proven approaches to saving preterm lives, providing appropriate care for preterm babies and reducing 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 is updating guidelines for health care workers on the prevention and management of the major maternal, perinatal and neonatal diseases, which include the use of antenatal corticosteroids for preterm labour, support for early initiation and exclusive breastfeeding, kangaroo mother care, and home visits to neonates and their mothers. WHO has updated guidelines on postnatal care⁴ related to minimum stay after delivery in a facility and the content, number and timing of postnatal care contacts, which provide harmonized recommendations for the mother and child.

15. WHO has engaged with partners to develop the draft action plan “Every newborn: an action plan to end preventable deaths”⁵ as an international response to the urgent need to accelerate the reduction of neonatal mortality in the last 1000 days before the deadline for attaining the Millennium Development Goals, and beyond. The plan was developed through a broad consultation process with Member States and international umbrella organizations of health professional associations. The Regional Committee for the Western Pacific noted at its sixty-fourth session (Manila, 21–25 October 2013)

¹ WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

² See http://www.who.int/reproductivehealth/topics/family_planning/policybriefs/en/index.html (accessed 17 October 2013).

³ Born too soon: the global action report on preterm birth. Geneva: World Health Organization; 2012.

⁴ WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization; 2014.

⁵ The draft action plan is submitted in document A67/21.

the action plan for healthy newborns in the Western Pacific (2014–2020),¹ which had been developed by WHO and UNICEF.

16. In response to the request in resolution WHA63.17, the Secretariat has published a fact sheet on congenital anomalies and created a relevant health topic on the WHO website.² It has produced a manual and has built capacity on surveillance of those conditions at headquarters and in the regions in collaboration with international partners. WHO has updated cut-off values for serum folate and erythrocyte folate concentrations associated with preventable neural tube defects in women of reproductive age and has organized public awareness events on spina bifida and hydrocephalus. The Secretariat is supporting surveillance of toxicity of antiretroviral agents in pregnancy and during breastfeeding. WHO remains engaged in the Measles and Rubella Initiative, which is a collaborative effort with UNICEF, the United Nations Foundation, American Red Cross, and the Centers for Disease Control and Prevention in the United States of America. The Regional Office for South-East Asia is particularly active in the area of documenting and capacity-building for the prevention and detection of congenital anomalies. The Regional Office for the Americas continues to pursue its work with UNICEF and other partners on the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean.

17. WHO, in collaboration with the Office of the High Commissioner for Human Rights, UNICEF, the Partnership for Maternal, Newborn and Child Health and other partners, has played a key role in further articulating and strengthening a human rights-based approach to improving women's and children's health. WHO supported the Committee on the Rights of the Child in its preparation of a general comment on children's right to health, and the United Nations Human Rights Council in the preparation of technical guidance on the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity. At the invitation of the Council, WHO prepared a report on mortality in under-five-year-olds as a human rights concern, leading to the adoption of a Council resolution on under-five mortality, and a call for the preparation of technical guidance on the application of a human rights-based approach to reduce preventable under-five mortality and morbidity. In May 2013, WHO launched the monograph with evidence of the impact of a human rights-based approach on women's and children's health, demonstrating that applying such an approach helps governments to comply with their binding national and international obligations, and contributes to improving the health of women and children.

18. The independent Expert Review Group on Information and Accountability for Women's and Children's Health published in September 2013 its second report, which the Director-General submitted to the United Nations Secretary-General at the sixty-eighth session of the United Nations General Assembly. The main recommendations of the report included that health ministers, with partners, must (1) prioritize and evaluate country-led, inclusive, transparent and participatory national oversight mechanisms for advancing women's and children's health; (2) advocate an independent accountability mechanism to monitor, review and continuously improve actions towards delivering the post-2015 sustainable development agenda; (3) include an adolescent indicator in all monitoring mechanisms for women's and children's health, and meaningfully involve young people in all policy-making bodies affecting women and children; (4) prioritize quality of care so as to reinforce the value of a human rights based approach to women's and children's health; (5) expand and strengthen the health workforce in order to serve women and children with measurable impact, especially in

¹ Document WPR/RC64/9.

² Available at <http://www.who.int/mediacentre/factsheets/fs370/en/> (accessed 18 March 2014).

sub-Saharan Africa; and (6) launch a new movement for better data, making universal and effective civil registration and vital statistics systems an explicit post-2015 development target.

19. A global investment framework for women's and children's health, produced in response to a recommendation of the independent Expert Review Group in its first report (2012),¹ has been published in an academic journal.² The framework reviews the costs, impact and economic returns on the 50 interventions known to improve women's and children's health directly. It reveals that by investing an additional US\$ 5 per person per year from 2013 to 2035, 32 million stillbirths and the deaths of 147 million children and 5 million women could be prevented. In 2013, the second 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, 68 have completed national accountability frameworks and roadmaps, and 56 have received catalytic funding in support of the national accountability frameworks. Political support for strengthening civil registration and vital statistics systems is increasing, with 40 countries completing assessments to guide their systems improvement. Fifty-three countries are conducting regular national health sector reviews, which are increasingly bringing together multiple partners, including civil society partners. Twenty-seven countries have national e-health strategies, most of which include a focus on reproductive, maternal, newborn and child health. Twenty-five countries are tracking resources using a harmonized approach based on the OECD/EUROSTAT/WHO System of Health Accounts 2011 methodology. There has been a shift in approach from using maternal death reviews to using maternal death surveillance and response systems, which have been introduced in more than 50 countries. Forty countries have signed a compact or an equivalent agreement with development partners. Many countries have strengthened health information systems and are using most of the 11 indicators recommended by the Commission. Partners such as the European Union, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the United States' President's Emergency Plan For AIDS Relief are increasingly investing directly in national capacities for monitoring of results and reviews, including health information systems, data quality and analytical capacity-building for stronger health reviews and policy dialogue.

20. About half the world's population is at risk of contracting malaria, and in 2012 an estimated 207 million cases of malaria led to 627 000 deaths. Owing to an unprecedented expansion of measures to prevent and control malaria, incidence rates decreased by an estimated 29% globally between 2000 and 2012, and mortality rates fell by 42%. An estimated 3.3 million lives were saved between 2000 and 2012 – mostly in high-burden countries – and 52 countries are on track to reduce their malaria case incidence by more than 75% by 2015, in line with the target set by the Health Assembly in resolution WHA58.2. However, 41 countries worldwide lack sufficient data to track progress, highlighting the need for greater efforts to improve malaria diagnostic testing and surveillance. Estimates available for 2012 show that about 80% of cases of malaria occur in 18 countries and more than 80% of malaria deaths occur in just 17 countries. Coverage with interventions such as insecticide-treated bednets, indoor residual spraying, diagnostic testing and effective treatment needs to be expanded and sustained in order to prevent a resurgence of both the disease and related deaths.

¹ Every woman, every child: from commitments to action: the first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. Geneva: World Health Organization; 2012.

² Stenberg K, Axelson H, Sheehan P, Anderson A, Metin Gülmezoglu A, Temmerman M et al. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *The Lancet*. 2013. doi:10.1016/S0140-6736(13)62231-X.

21. The annual global number of new cases of tuberculosis has been slowly declining since 2006, falling by 2.4% between 2011 and 2012. Incidence rates are also falling in all six WHO regions. The mortality rate due to tuberculosis has fallen by 45% since 1990 and the trend indicates that a 50% global reduction will be achieved by 2015. Globally, treatment success rates have been sustained since 2007 at high levels, at or above 85% (the target first set by the Health Assembly in resolution WHA44.8 in 1991). However, the burden of tuberculosis remains high, with an estimated 8.6 million new cases in 2012, of which about 13% were in people living with HIV, and with an estimated 1.3 million deaths (including 320 000 HIV-positive people).

22. Globally, an estimated 2.3 million people were newly infected with HIV in 2012, a 33% reduction from the figure of 3.4 million people in 2001. Sub-Saharan Africa accounted for 70% of all the people who acquired HIV infection globally. New infections and increased access to life-saving antiretroviral therapy have led to an increasing number of people living with HIV infection (an estimated 35 million in 2012). In 2012, 9.7 million people in low- and middle-income countries received treatment. More people living with HIV infection are now eligible for treatment under the 2013 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.¹

23. WHO is working to eliminate a group of 17 neglected tropical diseases that are endemic in 149 countries. These chronic infections affect more than 1000 million people in tropical and subtropical environments and cause multiple infections in a single individual. Reported numbers of cases of human African trypanosomiasis have dropped to fewer than 10 000, their lowest level in 50 years. Two diseases – dracunculiasis and yaws – are targeted for eradication in 2015 and 2020, respectively. Lymphatic filariasis is targeted for elimination as a public health problem by 2020, and leprosy has been eliminated as a public health problem in 119 out of 122 countries where it was endemic. Although the diversity of neglected tropical diseases poses challenges, it offers opportunities to strengthen health systems and enhance universal access to treatment. Thanks to WHO-led campaigns, hundreds of millions of people are being treated annually with preventive medicines. Efforts are being made to harmonize prevention and control of dengue – the world's fastest growing viral infection – through WHO's new global strategy for dengue prevention and control, 2012–2020, which aims to reduce both morbidity and mortality by 2020. In May 2013, the Sixty-sixth World Health Assembly in resolution WHA66.12 resolved to accelerate efforts to overcome the 17 diseases by urging Member States and international partners to intensify support for controlling, eliminating and eradicating this diverse group of diseases by focusing on leadership and ownership of programmes in affected countries.

24. 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; with 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

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

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.

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 2007–2012 indicated that on average selected essential (generic) medicines in low- and middle-income countries were available in only 57% of public sector facilities. Prices of the lowest-priced generics to patients in the private sector were on average five times higher than international reference prices (and can be as much as 16 times higher in some countries). Even the lowest-priced generics can put common treatments beyond the reach of low-income households in developing countries. The highest price is paid by patients with chronic diseases. Effective treatments for the conditions that constitute most of the global chronic disease burden exist, yet universal access remains out of reach.

26. The analysis of the global and regional picture is based on country data available to WHO, complemented by statistical modelling to fill data gaps. Many countries still lack reliable and timely data to track progress and performance at national and subnational levels. There is an urgent need to strengthen country health information systems in order to accurately monitor progress towards achieving targets at global, national and subnational levels.

ACTION BY THE HEALTH ASSEMBLY

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

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