WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale

منظمة الصحة العالمية
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Progress report on

Achievement of the Millennium Development Goals

Contents

1. Introduction

In September 2010, heads of government and representatives from 192 Member States gathered at the sixty-fifth session of the United Nations General Assembly and reaffirmed their commitment to achieving the Millennium Development Goals (MDGs). They also reaffirmed the importance of freedom, peace and security, respect for all human rights, including the right to development, the rule of law, gender equality and an overall commitment to democratic societies for development. At present, the number of people in the world, living in extreme poverty and hunger surpasses one billion and inequalities between and within countries remain a significant challenge. Poverty is the basis for not achieving MDGs in many countries of the world, including those in the WHO Eastern Mediterranean Region.

WHO and Member States are closely working together and are committed to making every effort to achieve the MDGs by 2015. However, multiple and interrelated crises such as the global financial crisis, climate change, and natural and manmade disasters experienced in 2010 have increased vulnerabilities and inequalities and adversely affected development gains, in particular in low-income countries of the Region.

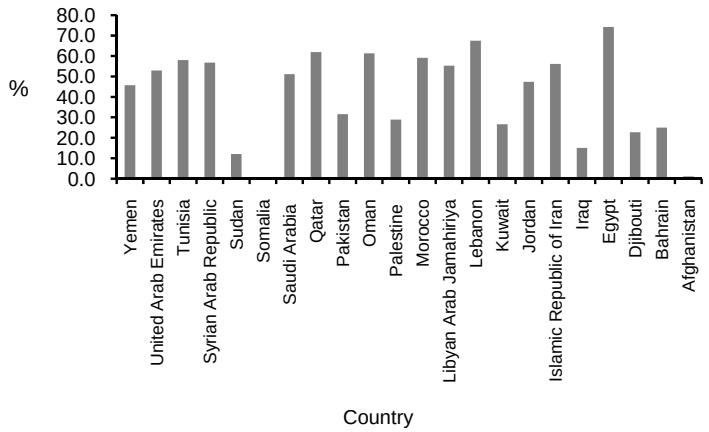
This report focuses on the targets of the health-related MDGs, namely Goal 4 (reduce under-five mortality by two thirds between 1990 and 2015), Goal 5 (reduce the maternal mortality ratio by three quarters between 1990 and 2015) and Goal 6 (have halted by 2015 the spread of HIV/AIDS, malaria and tuberculosis). Most countries of the Region continue to progress well towards achieving the targets set for 2015. However, 10 countries, namely Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Palestine, Somalia, Sudan and Yemen, are not yet on track to achieve some or all of the health-related Goals. Table 1 shows progress towards achieving the MDGs in nine of these priority countries.

Achieving the MDGs in low-income and some parts of the middle income countries in the Region will be difficult due to some common challenges such as: inadequate political commitment; lack of community ownership; inequitable distribution of qualified human resources across the country; severe poverty; complex emergencies; ineffective coordination and partnership; lack of universal access to quality primary health care services; and weak recording, monitoring and reporting systems.

Table 1. Progress towards achieving the health-related Millennium Development Goals in priority countries, 2011

Health issue (related Goal no.)	Afghanistan	Djibouti	Egypt	Iraq	Morocco	Pakistan	Somalia	Sudan	Yemen
Malnutrition (1)	L	L	P/L	L	NC	P/L	L	L	NC
Child health (4)	N/C	P/L	M	P/L	T	P/L	N/C	N/C	P/L
Maternal health (5)	NC	P/L	T	T	P/L	P/L	P/L	L	T
Tuberculosis (6)	P/L	P/L	M	L	M	T	P/L	P/L	M
Malaria (6)	P/L	P/L	M	M	M	P/L	P/L	P/L	P/L
AIDS (6)	P/L	P/L	P/L	P/L	P/L	P/L	P/L	P/L	P/L
Water/Sanitation (7)	L	L	T	L	P/L	P/L	L	P/L	L

L: lagging, P/L: progress but lagging, NC: no change, T: on track, M: met



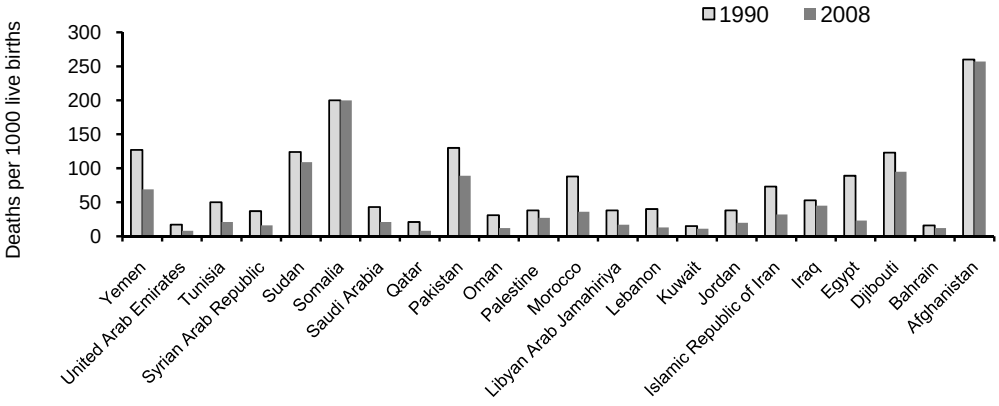
Sources: *World Health Statistics 2010* and UN Interagency Group for Child Mortality Estimation

Figure 1. Percentage reduction in under-five mortality, 1990–2008

2. Progress in countries of the Region

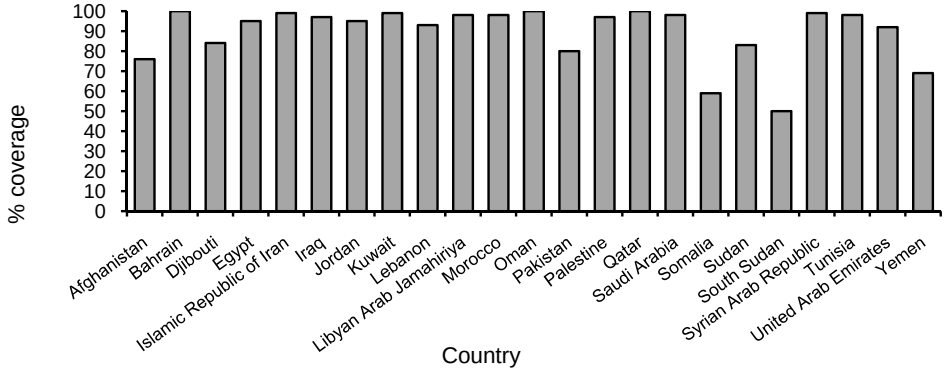
By end of 2009, the regional under-5 mortality rate had dropped by 30% since 1990 (Figure 1). Egypt, Lebanon and Oman have already surpassed the target for Millennium Development Goal 4, and Islamic Republic of Iran, Morocco, Syrian Arab Republic, Tunisia, and United Arab Emirates are on track to achieve it (Figure 2). However, efforts to achieve the target in other countries are compromised by many factors, including those mentioned above. If the same trend of mortality reduction continues over the next 5 years, the Region is expected to remain far below the target of Goal 4. Mortality gaps are evident between the poorest and richest quintiles, a sign of inequity in health.

Scaling up childhood vaccination is essential for achieving Goal 4 since vaccine-preventable diseases are responsible for more than 20% of under-5 mortality. The majority of these diseases can be prevented by *Haemophilus influenza* type b (Hib), pneumococcal and rotavirus vaccines. The Region achieved 93% reduction of measles mortality in 2008 compared to 2000. 16 countries have achieved 90% vaccination coverage with the first dose of measles vaccine among children



Source: *World health statistics 2010*. Geneva, World Health Organization, 2010.

Figure 2. Under-five mortality rates by country, 1990 and 2008



Source: Country data

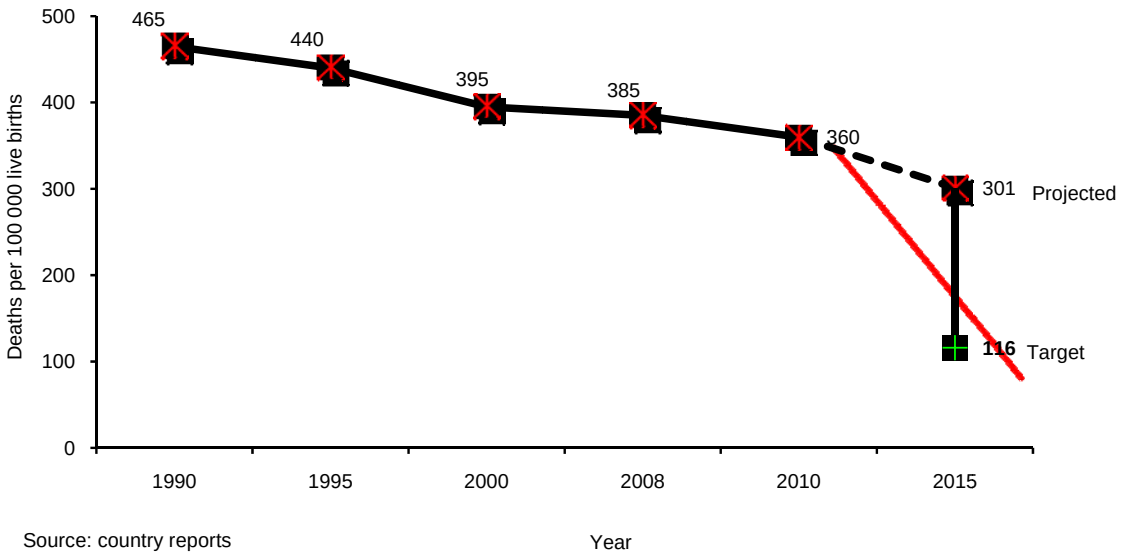
Figure 3. Coverage of the first dose of measles vaccine, 2009

under 1 year of age, and 3 countries are close to reaching it (Figure 3). The number of countries introducing new vaccines increased significantly in 2009 and 2010, especially with the support of the GAVI Alliance. Nevertheless, the reduction in measles mortality is at risk because the financial resources needed to implement measles follow-up vaccination campaigns are insufficient. In addition, uptake of the new vaccines is still low, especially in low-income and middle-income countries. Currently, Hib vaccine is not in use in 4 countries which represent 34% of the annual birth cohort of the Region. Moreover, pneumococcal and rotavirus vaccines are not offered to 93% and 96% of the infants born in the Region, respectively.

It is estimated that 52 000 women and 510 000 newborns die every year in the Region due to complications of pregnancy and childbirth. 50% of the newborns are still delivered away from health care facilities in the Region, and 40% of deliveries are left unattended by skilled health personnel. Meanwhile, on average in the Region only 31.1% of married couples are using modern contraceptives, with a total fertility rate as high as 4.0 children per woman. The Region still has second highest maternal mortality ratio among all WHO regions, at 360 maternal deaths per 100 000 live births. Afghanistan has one of the highest maternal mortality rates in the world, estimated at 1600 maternal deaths per 100 000 live births. Figure 4 shows the trend in regional maternal mortality since 1990.

Achieving Goal 6 is essential since tuberculosis, malaria and AIDS kill around 264 000 people annually in the Region. In 2009, an estimated 75 000 people in the Region became infected with HIV, and 24 000 AIDS-related deaths occurred, among them 4400 children below the age of 15. The total number of people living with HIV in the Region was estimated to be 460 000. Alarmed by studies showing increasing HIV prevalence among high-risk sexual and drug injecting populations in some countries, additional countries are now investing in HIV prevalence and behavioural studies among these groups. The data show concentrated epidemics among most-at-risk populations, and it is well understood that the epidemic cannot be reversed without reaching out and tailoring prevention services to their needs.

All countries made efforts to increase access to life-saving antiretroviral therapy (ART). Between 2007 and 2009, the number of people living with HIV on ART increased by 70%, from 7867 to 15 511. Of people living with HIV in need of ART who are identified and known to the health system, more than 80% actually receive ART. However, there is a wide gap between estimated



Source: country reports

Figure 4. Regional maternal mortality trend, 1990–2015

and known numbers of people living with HIV in need of ART. The regional ART coverage based on the estimated need remains approximately 10%, the lowest globally.

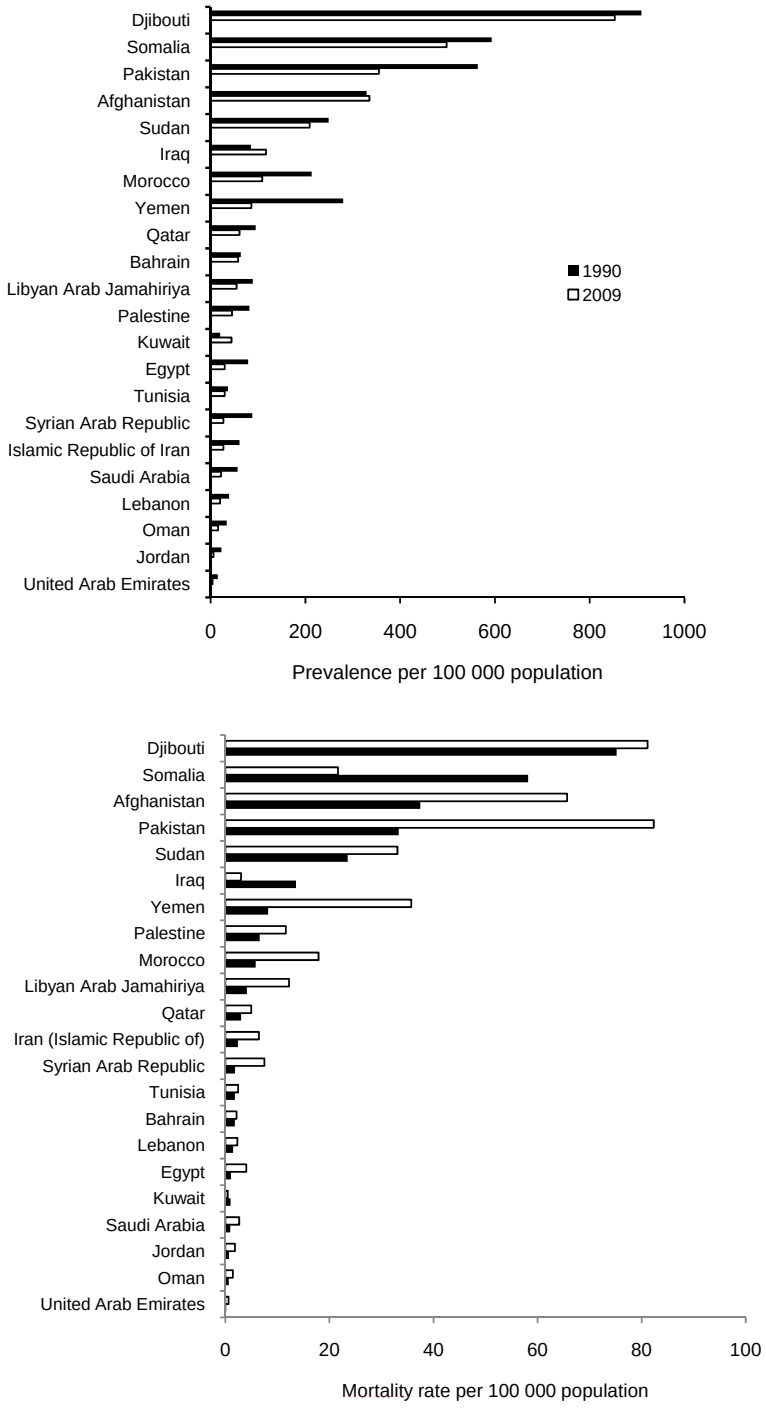
Although all countries in the Region offer some services for the prevention of mother to child transmission of HIV, those services remain fragmented and limited in many settings. In 2009, out of the 20 500 estimated pregnant women with HIV needing ART, less than 500 (only 2%) received it. Some countries, such as Djibouti and Oman, have integrated a voluntary HIV test in the package of services provided in antenatal care.

Malaria still remains endemic in 9 countries of the Region. Data from the routine health information systems show a 44% reduction in malaria burden compared to 2000. According to estimates from the World Malaria Report 2009, the major burden of morbidity is carried by Sudan (62%) and Pakistan (18%) followed by Somalia (9%), Afghanistan (8%), Yemen (3%). Prevalence data from a 2009 survey carried out in 10 northern states of Sudan showed a 38% reduction of parasite prevalence in 2009 compared to the same survey in 2005 (from 3.7% to 2.3%). The prevalence of malaria in Tihama area of Yemen is gradually decreasing, from 21.9% in 2000 (school survey) to 4.5% in 2009 (household survey). In 2009, Iraq reported zero local transmission, Saudi Arabia reported only 58 local cases and the Islamic Republic of Iran reported more than 70% reduction of local cases in comparison to year 2000.

2009 nationwide malaria surveys in Sudan showed that ownership of long-lasting insecticide-treated nets (LLIN) increased to 40.3%, and 43% of fever cases were treated with artemisinin-based combination therapies (ACT) while only 43% of facilities had functional microscopy and 10.5% had rapid diagnostic tests (RDT). In Yemen only 15% of households had at least one LLIN. These figures show that there is still a huge gap to reach universal coverage in priority countries.

In 2009, an estimated 660 000 tuberculosis cases emerged in the Region. Of these, 418 149 cases were detected, out of 5.8 million cases detected globally during the same year. Therefore, the Region shoulders 7% of the global tuberculosis burden. Afghanistan, Djibouti, Pakistan, Somalia and Sudan contribute 86% of the regional tuberculosis burden, with Pakistan alone harbouring 64% of the regional disease burden. It is estimated that 24 000 tuberculosis cases developed multidrug-resistant tuberculosis in 2009.

In 2009, the incidence of tuberculosis declined to 111 new cases per 100 000 population, compared to 121 per 100 000 population in 1990 (8% decrease). A more notable decrease in prevalence has been observed, dropping from 268 cases per 100 000 population in 1990 to 179 cases per 100 000 population in 2009 (33%). Mortality due to tuberculosis decreased from 34 deaths per 100 000 population in 1990 to 18 per 100 000 in 2009 (47%) (Figure 5). As well, countries were able to maintain the treatment success rate of smear positive pulmonary tuberculosis at 88%, above the global target, for 3 consecutive years.



Source: *Global tuberculosis control: 2010*. Geneva, World Health Organization, 2010.

Figure 5. Progress in reducing tuberculosis burden, 1990–2009

3. Challenges and conclusions

Countries witnessed challenges related to lack of productive capacity for sustained, inclusive and equitable economic growth and sustainable development. Opportunities exist to put health at the heart of the national health and development policy agenda, and it is time for all levels of government to work together toward innovative and effective solutions that mitigate health risks and increase health benefits. WHO, through its call for the renewal of primary health care, is moving forward with an agenda based on international commitments such as Agenda 21, the Alma-Ata Declaration and the Report of the Commission on Social Determinants of Health to tackle unacceptable politically, socially and economically driven health inequities. In 2010, WHO launched a year-long campaign to raise awareness of urban health issues and engage municipal leaders in the struggle against health inequities in urban settings, with special focus on the urban poor.

Community empowerment in local decision-making and active involvement of civil society to tackle health inequities, particularly those related to Goals 4, 5 and 6, are among the key challenges that has to be addressed by all Member States.

The need for data disaggregated by sex, age and geographical location, to ensure effective targeting of policies and programmes to address discrimination and the needs of disadvantaged and marginalized groups, should be considered in future joint planning. Gender equality, the empowerment of women and women's full enjoyment of all human rights are essential to economic and social development.

Universal access to social and health services, including social protection of the poor, is a vehicle to maintain health of the most vulnerable groups in the community, and has to be promoted in support of countries that are lagging most behind.

In conclusion there is an urgent need for mobilizing domestic resources and accelerate the global movement towards poverty reduction as the current support to the poorest countries is not sufficient to change the situation on the ground. Strengthening health systems, effective partnership and streamlining monitoring and reporting mechanisms are needed to move towards achieving the MDGs across the globe.

4. Next steps

From 2011 to 2015, the Regional Office will continue its support to Member States with focus on low-income and middle-income countries to strengthen intersectoral collaboration and civil society involvement in reducing child and maternal mortality, and mainstreaming the collection, analysis and use of disaggregated data. The Regional Office is establishing a regional pooled vaccine procurement mechanism to support introduction of new life-saving vaccines in middle-income countries. Countries will be encouraged to implement policies aimed at gender equality, the empowerment of women, women's full enjoyment of all human rights and the eradication of poverty. Member States will be supported for delivery of the family practice package of health and nutrition services including universal coverage with well known cost effective interventions for children and mothers such as the integrated management of child health and safe motherhood packages.

The Regional Office will continue to assist Member States to scale up and improve prevention, treatment, care and support interventions for HIV/AIDS, tuberculosis and malaria so as to achieve universal access in particular for seriously affected populations and vulnerable groups. It will also support Member States in advancing related research, removing obstacles that block access to interventions and impede their use and quality, and contributing to the broader strengthening of health systems.