

## **Progress report on the achievement of the health-related Millennium Development Goals and global health goals after 2015**

1. The United Nations Millennium Development Goals (MDGs) have proven to be both challenging and catalytic, which was the intent of the 189 heads of government who endorsed the Millennium Declaration at the dawn of the 21st century. In signing on to the MDGs, leaders of low-income and middle-income countries pledged to significantly step up efforts to reduce poverty and improve quality of life for their most vulnerable people, while representatives of high-income countries promised to increase support for their efforts.

2. Ministries of health are committed to a series of actions in their countries and internationally, aimed at accelerating progress towards achieving the MDGs. These actions include promoting intersectoral partnerships, intensifying action on national health development and social protection, improving measurement and monitoring of MDGs progress, and promoting greater civil society involvement in efforts to advance the MDGs.

3. This report focuses on health-related MDGs, namely Goal 4 (reduce under-5 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). In the Eastern Mediterranean Region, Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, occupied Palestinian territory, Somalia, South Sudan, Sudan and Yemen are not on track to achieve some or all of the health-related goals. Table 1 shows progress towards achieving the MDGs in ten of these priority countries.

**Table 1. Progress towards achieving health-related Millennium Development Goals in priority countries, 2010/2011**

Health issue (related Goal no.)	Afghanistan	Djibouti	Egypt	Iraq	Morocco	Occupied Palestinian territory	Pakistan	Somalia	Sudan*	Yemen
Malnutrition (1)	L	L	P/L	L	L	T	P/L	L	L	L
Child health (4)	P/L	P/L	M	P/L	T	P/L	P/L	L	P/L	P/L
Maternal health (5)	T	P/L	M	P/L	M	T	P/L	P/L	T	T
Tuberculosis (6)	P/L	P/L	M	T**	M	T	T	P/L	P/L	M
Malaria (6)	P/L	P/L	M	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	P/L
Water/sanitation (7)	L	L	T	L	P/L	T	P/L	L	P/L	L

L: lagging (target will not be achieved by 2015), P/L: progress but lagging (target unlikely to be achieved by 2015 at current progress rate), T: on track (target is likely to be achieved by 2015), M: met (target has been achieved)

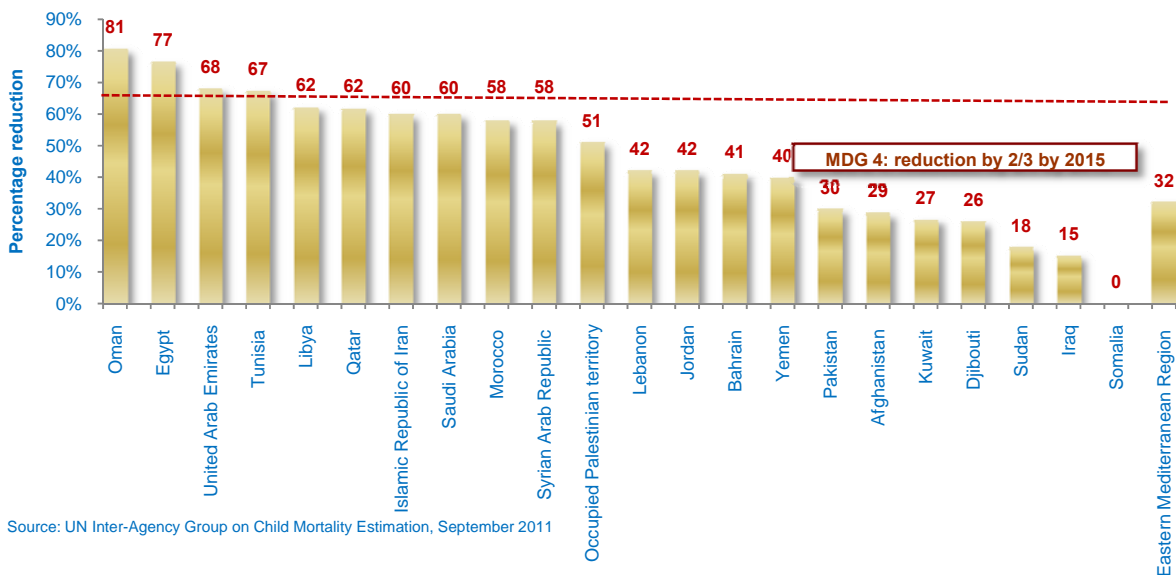
\* Including South Sudan; disaggregated data for Sudan and South Sudan are not available for 2010–2011.

\*\* Estimated incidence was revised from 64 to 45 per 100 000 population during 2010/2011 based on the results of a study reported in 2011. Related indicators are not yet finalized. However, based on the decrease in incidence progress is considered on track.

4. It is clear that universal coverage will only be reached if all people, whether poor or rich, living in urban or rural areas, have equitable access to quality health services. Moreover, a 2010 UNICEF report *Narrowing the gaps to meet the Goals* argues that MDGs 4 and 5 can be reached faster with investment that focuses on the poor. In particular, this report helps show that an equity-focused approach could bring vastly improved returns on investment by averting far more child and maternal deaths and episodes of under-nutrition and markedly expanding effective coverage of key primary health and nutrition interventions.

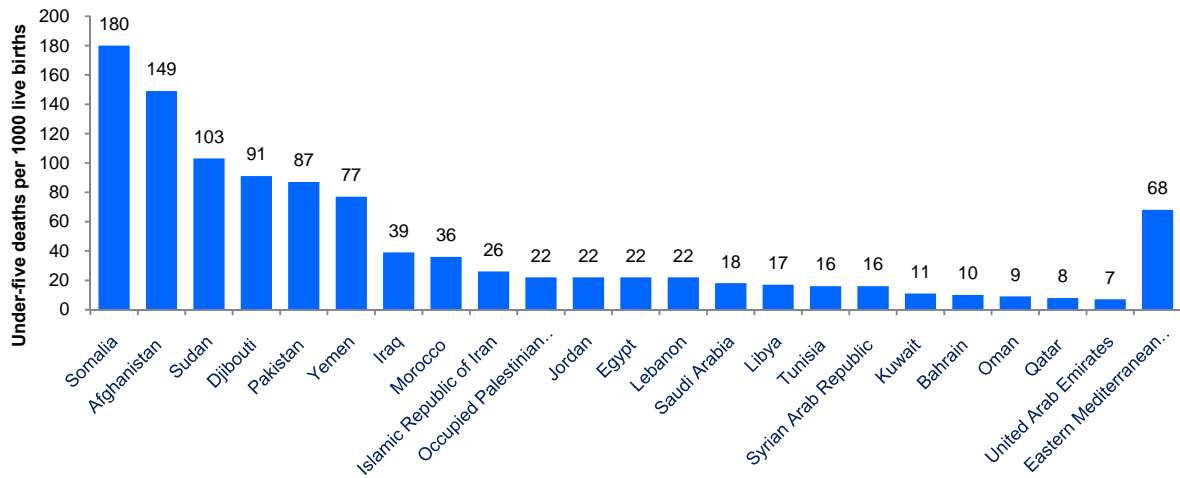
**Progress in countries of the Region**

5. With regard to MDG 4, an estimated reduction in under-5 mortality of 32% was achieved in the Region between 1990 and 2010, with an average annual rate of reduction of 1.9%. According to the latest estimates of the United Nations Inter-agency Group on Child Mortality Estimation released in September 2011, Egypt, Oman, Tunisia and the United Arab Emirates have already achieved more than a two-thirds reduction in under-5 mortality, the MDG4 target, and six more countries are on track to achieve it (Figure 1). As a subregion, the North African countries of the Region<sup>1</sup> had the best achievements globally over the period 1990–2010, with a 72% reduction in under-5 mortality and an average reduction rate of 6.3% per year. However, the remaining countries, including all countries with a high under-5 mortality rate, are unlikely to achieve the goal at the current pace of implementation of cost-effective interventions. Stunting and wasting are still prevalent in many countries. The Region as a whole has a stunting rate of 30%, with a range of 6% in Tunisia to more than 55% in Afghanistan and Yemen. Stunting is irreversible if it persists and therefore must be targeted from an early age (as early as 6 months of age). Exclusive breastfeeding rates remain low, contributing to malnutrition.



**Figure 1. Percentage reduction of under-5 mortality by country, 1990–2010**

<sup>1</sup> Egypt, Libya, Morocco and Tunisia

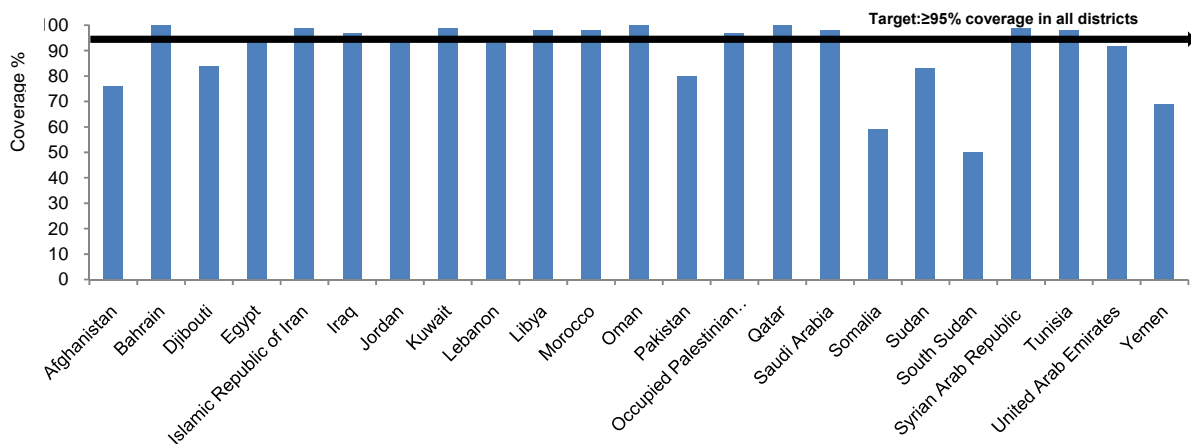


Source: UN Inter-agency Group for Child Mortality Estimation, September 2011

Figure 2. Under-5 mortality rates in countries, 2010

6. The implementation of interventions under the Integrated Management of Child Health (IMCI) strategy, which integrates among others the systematic early detection and treatment of pneumonia and other major causes of childhood death, is likely to have contributed to the substantial reduction in under-5 mortality rate observed in some of the countries in which under-five deaths have dropped (Figure 2).

7. Recent years have witnessed remarkable improvement in routine vaccination coverage in several countries of the Region. The average coverage with three doses of diphtheria–tetanus–pertussis vaccine (DTP) in the Region reached to 90% in 2010. Despite this progress, around 1.5 million infants did not receive their third dose of DTP in 2010 and the number of children who were not fully vaccinated in line with the national schedule may be higher. Sixteen countries in the Region achieved 90% measles vaccination coverage with first dose, and eight countries are close to reaching measles elimination. However the gains achieved (Figure 3) in measles mortality reduction might be lost unless measles



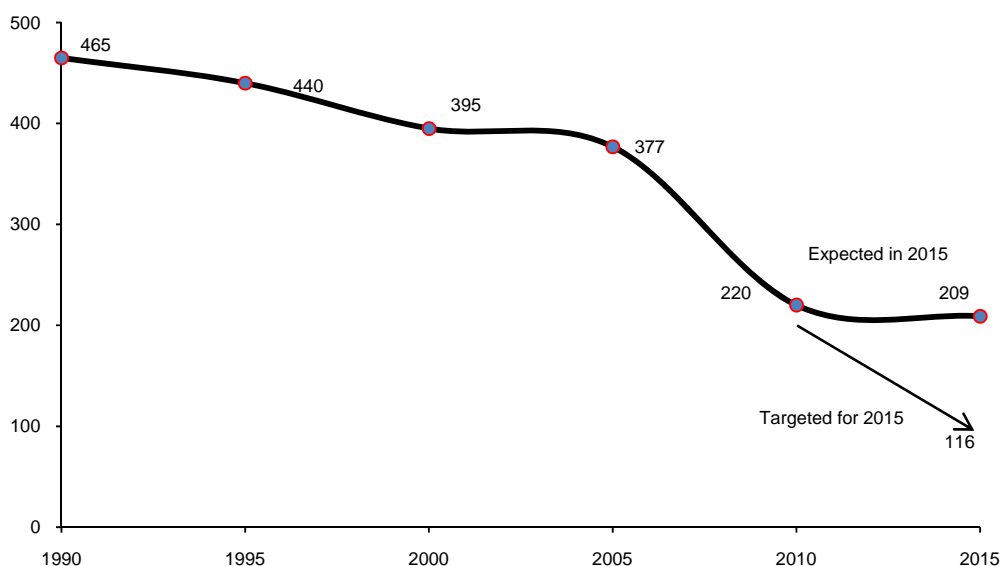
Source: WHO/UNICEF joint reporting form

Figure 3. Reported routine measles immunization, 2010

control and elimination efforts are sustained. The introduction of new life-saving vaccines gained momentum in recent years with the introduction of *Haemophilus influenzae* type b (Hib) vaccine in 19 countries, pneumococcal vaccine in nine countries and rotavirus vaccine in five countries accounting for access to approximately 75%, 12% and 19% of the annual births in the Region, respectively.

8. Introduction of new vaccines constitutes the major challenge being faced by middle-income countries. In order to increase access to quality health care services for children under 5 years of age, the Regional Office for the Eastern Mediterranean has developed a package of child health interventions to be delivered by the community health workers during vaccination campaigns. At present the package is being implemented in Sudan and Yemen. In addition a regional pooled vaccine procurement mechanism is in the process of being established to support introduction of new life-saving vaccines in middle-income countries.

9. With regard to MDG 5, it is estimated that 35 000 women and 450 000 newborns die every year in Region due to complications of pregnancy and childbirth.<sup>2</sup> There is great variation in maternal mortality levels between countries of the Region. The maternal mortality ratio is less than 100 maternal deaths per 100 000 live births in Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, occupied Palestinian territory, Saudi Arabia, Syrian Arab Republic and Tunisia. Five countries have a maternal mortality ratio of between 100 and 500 deaths per 100 000 live births: Afghanistan, Morocco, Pakistan, Sudan and Yemen. Three countries have a maternal mortality ratio higher than 500 deaths per 100 000 live births: Djibouti, Somalia and South Sudan. In 2006, the maternal mortality ratio in South Sudan was calculated at 2054 per 100 000 live births, one of the highest in the world.<sup>3</sup> In 2010, 47% of newborns in the Region were still delivered away from health care facilities, and 35% of deliveries were left unattended by skilled health personnel.<sup>2</sup> Figure 4 shows the trend in maternal mortality since 1990.



Source: Making pregnancy safer database, 2011

**Figure 4. Regional trend in maternal mortality, 1990–2015**

<sup>2</sup> WHO regional database on making pregnancy safer, 2011.

<sup>3</sup> Sudan household survey, 2006.

10. Achieving MDG 6 is essential since tuberculosis, malaria and AIDS result in the deaths of around 264 000 people annually in the Region. In 2010, the Region recorded its highest number of people newly infected with HIV – an estimated 82 000, or 48% more than the 43 000 estimated to have been newly infected in 2001. In the same period the estimated number of people living with HIV rose steeply, from 320 000 to 560 000, as did the number of people dying from AIDS-related causes, which increased from 22 000 in 2001 to 38 000 in 2010. The Region showed the lowest coverage rate of antiretroviral treatment (ART) among all WHO Regions: 10% for ART in adults and 5% for paediatric ART.

11. In 2010, an estimated 47% of the regional population was still living in malaria risk areas. In 2010, a total of 7 277 848 malaria cases were reported in the Region, of which only 28.5% were confirmed parasitologically. These figures represent a 28% decrease as compared to the total cases reported in 2000. Five countries accounted for 98% of the confirmed cases in 2010: South Sudan 43%, Sudan 35%, Pakistan 12%, Yemen 5% and Afghanistan 3%. Mortality from malaria in the Region was estimated to account for 2% of global mortality due to malaria in 2010; around 60% of deaths were among children under 5 years of age. In 2010, 94% of the reported malaria deaths were in Sudan and South Sudan.<sup>4</sup>

12. Population coverage with antimalarial prevention and treatment interventions in the 7 countries of the Region with high malaria burden (Afghanistan, Djibouti, Pakistan, Somalia, Sudan, South Sudan and Yemen) has risen as a result of increased investments. However it is still far below the target of 80%. Limited access to quality diagnosis, weak surveillance systems and the spread of resistance of parasites to antimalaria drugs and resistance of vectors to insecticides are major key challenges that require urgent consideration.

13. In 2010, the estimated number of incident tuberculosis cases was 650 000, accounting for 7% of the global tuberculosis burden. Nine countries contribute to 95% of the tuberculosis burden in the Region: Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen. Pakistan alone shoulders 61% the burden of tuberculosis in the Region. The estimated number of tuberculosis deaths in 2010 was 95 000.<sup>5</sup> Ten countries have halved the prevalence and/or the mortality rates in 2010 compared to 1990. The remaining countries vary in their progress towards the targets. The main challenge relates to the low case detection rates for drug-sensitive and drug-resistant tuberculosis, which were 63% and 6%, respectively, in 2010. This situation is mainly the result of underreporting of tuberculosis cases from private and public health care providers, suboptimal diagnosis and low awareness in the community about tuberculosis. The prevalence of tuberculosis in the Region has declined considerably since 1990, and the decline appears to have accelerated in 2000. Nevertheless, current forecasts suggest that the 2015 target will not be reached. The regional mortality rate due to tuberculosis was halved between 1990 and 2010 (Figure 5).

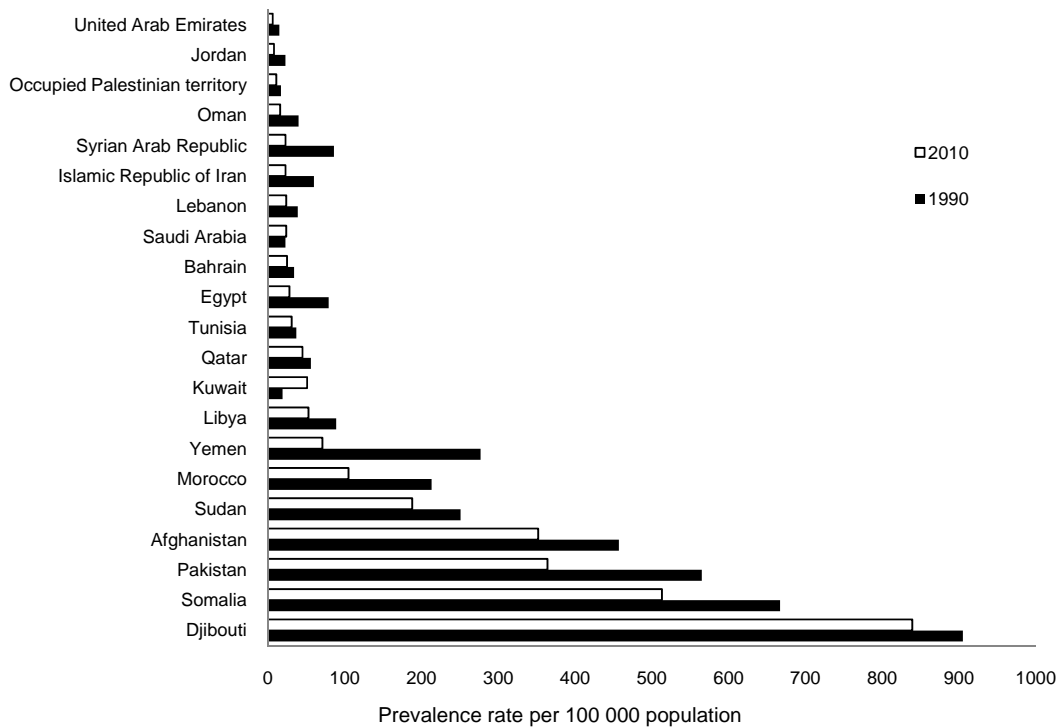
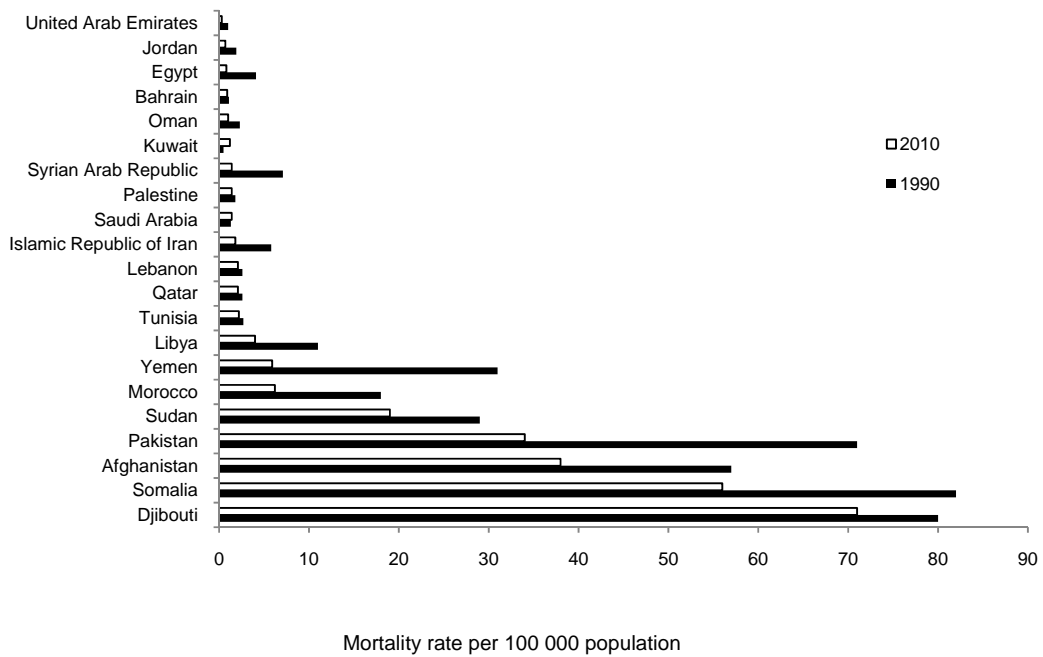
### **Challenges and conclusions**

14. The past two years witnessed multiple social, political and economic changes in the Region. As well, man-made and natural disasters negatively affected development gains and led to an increase in vulnerabilities and inequalities. The changes not only affected health but also led to changes in the stakeholders and partners that are working with the international community. Some middle-income countries were affected, as well as least developed countries with complex emergencies. The political changes may provide an opportunity to collaborate with new leaders who may be more willing to challenge the status quo and ensure that equity and social justice for health and social services become the guiding principles for development activities, including health-related MDGs.

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<sup>4</sup> *World malaria report 2011*. Geneva, World Health Organization, 2011.

<sup>5</sup> *Global tuberculosis control 2011*. Geneva, World Health Organization, 2011 (Document WHO/HTM/TB/2011.16)



Source: *Global tuberculosis control 2011*. Geneva, World Health Organization, 2011.

**Figure 5. Progress in reducing tuberculosis burden, 1990 and 2010**

15. The global financial crisis and global climate changes and economic consequences in many countries are likely to create additional challenges to the achievement of MDGs in the next few years, even in countries which are currently on track.

16. Opportunities to put health at the heart of the national health and development policy agenda exist, and it is time for all levels of government to work together towards 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 the Alma-Ata Declaration, Agenda 21 and the Rio Political Declaration on Social Determinants of Health to tackle unacceptable politically, socially and economically driven health inequities.

17. A major consideration for joint planning continues to be 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. Gender equality, the empowerment of women and women's full enjoyment of all human rights are essential to economic and social development.

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

19. WHO will assist countries to enhance 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. Strengthening health care systems is one of the top priorities for WHO and country collaboration.

20. Member States and WHO will continue working together 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.

21. Advancing related research, removing obstacles that block access to interventions and promoting community empowerment in local decision-making and active involvement of civil society in tackling health inequities are among the key interventions that need to be addressed by all Member States.

22. 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.

### **Future steps**

23. It is clear that many countries – particularly the poorest – will need sustained efforts beyond 2015 in order to achieve the targets of the MDGs. Moreover, the focus on inequities and their consequences for health will also become sharper. Issues such as rapid and unplanned urbanization, ageing populations, climate change, economic uncertainty, migration and unhealthy lifestyles are all factors that hinder progress towards the MDGs. In this regard, strong and sustained intersectoral collaboration is needed in tackling social determinants of health and translating into action the Rio Political Declaration.

24. WHO will advocate and provide the evidence for strong political commitment in order to reduce the adverse effects of social determinants of health such as unemployment, illiteracy, low access to water and sanitation and lack of economic growth and for strengthening mechanisms to monitor inequity in distribution of wealth and health in the countries. Considerable efforts are needed to boost effective

partnership, intersectoral collaboration, alignment of UN agencies and civil society involvement in achieving MDGs. Member States and WHO should continue their joint efforts in promoting universal access to quality primary health care services including social protection of the poor, particularly in the countries where progress is most lagging.

25. There is an urgent need for mobilizing domestic resources and accelerating the global movement towards poverty reduction, as the current support to the poorest countries is not sufficient to change the situation on the ground.