INTRODUCTION

1. At the Millennium Summit in 2000, 147 Heads of State and representatives from 189 countries adopted the Millennium Development Declaration, committing themselves to a world in which sustaining development and eliminating poverty would have the highest priority. The Declaration proposed eight development goals now commonly referred to as the Millennium Development Goals (MDGs). The MDGs provide the framework for measuring development progress and are an integral part of the road map towards the implementation of the United Nations Millennium Declaration.

2. The goals and targets summarize key commitments agreed upon in various global conferences and summits during the 1990s. They are also linked to the earlier primary health care approach, basic health-care package and health-for-all initiatives.

3. There are both health Millennium Development Goals and health-related Millennium Development Goals. The three health MDGs are:

Goal 4: Reduce child mortality;
Goal 5: Improve maternal health;
Goal 6: Combat HIV/AIDS, malaria and other diseases.

The five health-related MDGs are:

Goal 1: Eradicate extreme poverty and hunger;
Goal 2: Achieve universal primary education;
Goal 3: Promote gender equality and empower women;
Goal 7: Ensure environmental sustainability;
Goal 8: Develop a global partnership for development.

The MDGs give high prominence to health. Three of the eight goals, 9 of the 18 targets and 18 of the 48 indicators relate directly to health[1] (Annex 1).

4. This document focuses on the three health MDGs, describes the current situation regarding progress, discusses challenges being faced and proposes accelerated action.

SITUATION ANALYSIS

5. Many countries in the African Region have prepared their development frameworks and instruments incorporating the Millennium Development Goals. About 30 countries have developed poverty reduction strategy papers (PRSPs). Over 30 have published their MDG status reports, many indicating potential achievements. Some of the goals have already been met or will be met by 2015 (Annex 2).

6. Countries are implementing many approaches to the MDGs. These include Integrated Management of Childhood Illnesses; immunization against measles, tuberculosis, tetanus and polio; promotion of exclusive breastfeeding and improved nutrition and vitamin A supplementation; the Road Map for reduction of maternal and neonatal mortality; disease prevention and control campaigns for HIV/AIDS, malaria, TB and others. Measures being taken by countries in relation to gender equality and women's empowerment, the girl child and universal primary education, environmental policies and political and economic liberalization all serve the cause of achieving the MDGs.

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[1] Lee JW, WHO and the Millennium Development Goals, Geneva, World Health Organization, 2004.

7. Progress towards achievement of the health MDGs, however, is very slow. Weak or malfunctioning health systems; extreme levels of poverty; inadequate resources; economic and political governance problems, including civil strife in some countries; gender inequalities; environmental determinants; lack of awareness by some key stakeholders; inadequate infrastructure and technology; and low development indicators, among others, have contributed to the slow progress.

Goal 4: Reduce child mortality

8. Child mortality in the African Region is not decreasing rapidly enough, standing at 174 deaths per 1000 live births compared to 186 in 1990.[2] Between 1990 and 2001, child mortality did not improve in seven African countries and actually increased in nine.[3] Overall, 14 African countries experience higher child mortality now than in 1990, and more than 35% of children are at higher risk of death than they were 10 years ago. In 2002, sub-Saharan Africa accounted for 42% of all under-five deaths occurring globally. Currently, three of the six countries accounting for 50% of all under-five deaths globally are in the African Region. The newborn mortality rate also remains high, estimated at 45 deaths per 1000 live births; the proportion of those immunized against measles was 57% in 1990 and 61% in 2003.[4] From these data, it is estimated that Goal 4 may not be achieved until 2165 in most developing countries.[5]

9. A survey done in 2000 reveals that 13.7% to 29.2% of the children aged five years or less were underweight, 24.6% to 44.4% were stunted, and 4.9% to 10.3% had wasting.[6] Perinatal conditions, lower respiratory tract infections, diarrhoeal diseases and malaria played a major role, largely driven by malnutrition, poverty and HIV/AIDS.[7] Protein energy malnutrition and micronutrient deficiencies[8] exacerbate the situation.[9]

Goal 5: Improve maternal health

10. When the Safe Motherhood Initiative was launched in 1987, the target was to reduce by 50% the 1990 maternal mortality ratios by the year 2000. Unfortunately, the present estimate of 1000 deaths per 100 000 live births exceeds the 1987 figure of 870 deaths per 100 000. The single most effective intervention for maternal mortality reduction is ensuring access to skilled attendance during pregnancy, childbirth and postpartum. Currently, only 43% of deliveries are attended by skilled health personnel as compared to 40% in 1990.[10] Figure 1 shows the insignificant change in access to skilled care during delivery in sub-Saharan Africa as compared to other regions.

11. High fertility rates, adolescent childbearing and weak national health systems increase the risk of maternal death in Africa where it is estimated at 1:16 compared to 1:2000 in Europe and 1:3500 in northern America. The situation is made worse by low socioeconomic status, weak decision-making and control of resources by women, and delays in seeking and receiving appropriate health care.

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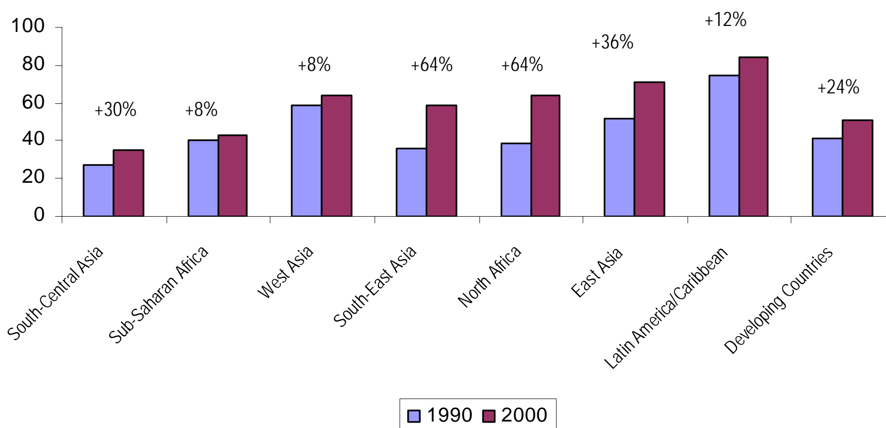
[2] UN, *Report of the Secretary-General,* New York, United Nations, 2004.
[3] UNDP, *The human development report 2003,* New York, United Nations Development Programme, 2003.
[4] UN, *Report of the Secretary-General*, New York, United Nations, 2004.
[5] WHO, *The world health report 2003: Shaping the future*, Geneva, World Health Organization, 2003.
[6] SCN, *Nutrition for improved development outcome: Fifth report on the world nutrition situation,* Geneva, Standing Committee on Nutrition, 2004.
[7] WHO, *The world health report 2003: Shaping the future*, Geneva, World Health Organization, 2003.
[8] WHO, *Status of infant and young child feeding in sub-Saharan Africa*, Brazzaville, World Health Organization, Regional Office for Africa, 2001.
[9] UN, *Report of the Secretary-General,* New York, United Nations, 2004.
[10] UN, *Report of the Secretary-General,* New York, United Nations, 2004.

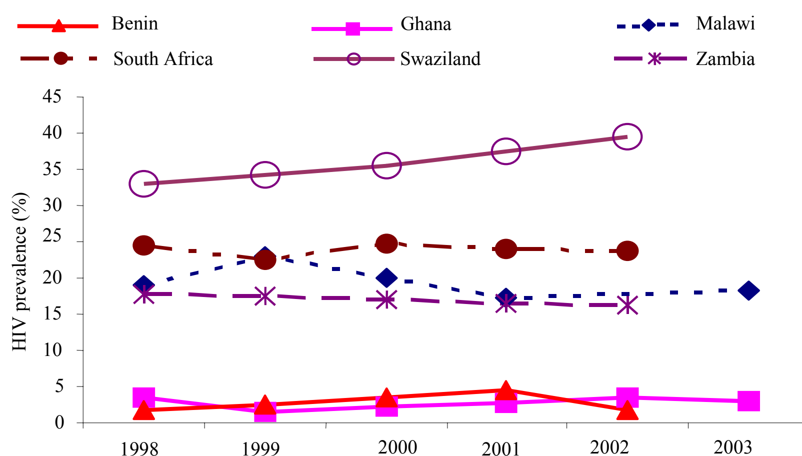
Figure 1: Percentage of deliveries with skilled health personnel



Goal 6: Combat HIV/AIDS, malaria and other major diseases

12. HIV/AIDS is a leading cause of morbidity and mortality in the African Region. In 2003, an estimated 3.2 million people became newly infected with HIV while another 2.3 million died of AIDS. The epidemic remains most severe in southern Africa where a 20% prevalence rate is reported among pregnant women aged 15–24 years. HIV prevalence shows little or no evidence of decline (Figure 2). Inadequate health systems and lack of financial and human resources to scale up country HIV/AIDS programmes are the main problems blocking access to prevention, treatment and care services.

Figure 2: Trends in median HIV prevalence among women aged 15–24 attending antenatal clinics in selected countries, 1998–2003

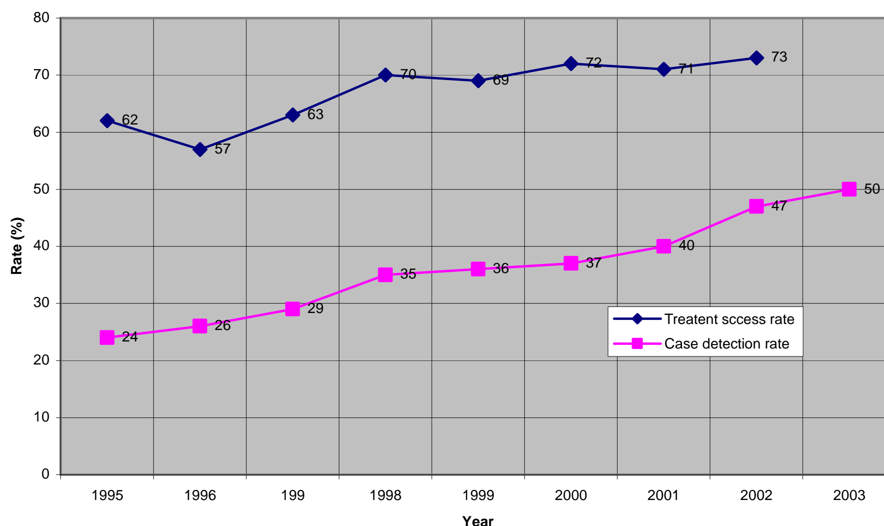


Source: WHO, Regional Office for Africa, Division of Communicable Diseases Prevention and Control, Harare, surveillance data, 2004.

13. Malaria continues to be a major health concern in sub-Saharan Africa, despite continuous control efforts.[11] It disproportionately affects young children and pregnant women, especially in rural areas where there is limited access to health care services. Africa bears over 90% of the global malaria disease burden. Insecticide-treated net usage currently ranges between 0.1% and 63% among countries who have adopted them for children under five years old. Only 13% of countries are fully implementing intermittent preventive treatment for pregnant women. Few people receive effective antimalarial medicines within 24 hours of onset of symptoms, and there is growing resistance to currently used monotherapies. Currently, 23 countries have adopted artemisinin-based combination therapies, and only four of these are currently implementing them. Some countries in Africa are using indoor residual spraying with good results.

14. The epidemiological burden of tuberculosis in the African Region is one of the highest in the world with 492 cases per 100 000 population in sub-Saharan Africa in 2002 as compared to 52 cases in northern Africa.[12] At least one million new cases and 100 000 deaths occur every year. In the African Region, 34 countries have estimated TB incidence rates of 300 or more cases per 100 000 population. Nine of the 22 countries responsible for 80% of the world's reported TB cases are in the Region. The internationally-recommended TB directly-observed treatment short-course (DOTS) has been almost universally adopted, and treatment success and case detection rates have been increasing over time (Figure 3). However, case detection and treatment success rates for the Region remain below the World Health Assembly targets of 70% and 85%, respectively, set in 1993. For the 2003 and 2002 cohorts, these stood at 50% and 73%, respectively.

Figure 3: TB treatment success and case detection rates (%), African Region 1995-2003



Source: WHO, *Global tuberculosis control surveillance, planning and financing,* Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005. 349).

15. It is estimated that 49% of the African population had sustainable access to improved water sources and 32% to improved sanitation in 1990 as compared to 58% and 36%, respectively, in 2002.[13] These low percentages, coupled with the effects of climate change and environmental

[11] WHO and UNICEF, *The Africa malaria report 2003,* Geneva, World Health Organization, 2003.
[12] UN, *Report of the Secretary-General,* New York, United Nations, 2004.
[13] UN, *Report of the Secretary-General,* New York, United Nations, 2004, p.44.

degradation, is likely to result in increased diseases such as cholera and vector-borne illness. In addition, noncommunicable diseases are becoming a major concern. Cardiovascular diseases, effects of tobacco and road traffic injuries are all on the rise.

Opportunities for achieving the MDGs

16. There is growing recognition globally and nationally that health plays a central role in national development efforts. This is reflected in the central role the MDGs accord health. Therefore ministries of health and their partners such as WHO have an opportunity to influence the development agendas of countries and to generate adequate resources locally and internationally for achieving the health MDGs. Other opportunities include growing political will, increased number of global funding mechanisms and philanthropic activities, and increased emphasis on regional and subregional efforts to achieve the goals through initiatives such as the New Partnership for Africa's Development.

Challenges to achieving the health Millennium Development Goals

17. The health MDGs cannot be achieved independently of the other goals. Consequently, countries should adopt a holistic approach. The main challenges for countries are the following:

- Marshalling the required resources;
- Strengthening health systems and institutions;
- Scaling up effective priority interventions;
- Empowering women and girls;
- Mitigating food insecurity and reducing hunger and malnutrition;
- Ensuring good governance and effective leadership in the stewardship of resources for development and health;
- Improving water and sanitation services;
- Ensuring a motivated workforce.

PERSPECTIVES

Guiding principles

18. National authorities should provide strong stewardship and leadership for scaling up strategies and interventions in both preventive and curative services which emphasize primary health care. They should use a multidisciplinary, multisectoral human rights-based approach to provide health care for all.

Health systems development

19. Many actions to strengthen health systems at district and community levels, where service delivery is most integrated, will increase the capacity to provide services required to meet the health MDGs. In order to address the health needs of the poor, the following issues need to be resolved: resource mobilization; drug procurement and distribution; hospital management and referral systems; district health systems; case management; human resources development and management; basic health-care package and social health insurance. It is imperative that countries conduct thorough needs assessments to gauge the levels of health system strengthening and investment required to achieve the MDGs. This information should be used for strategic planning and resource mobilization.

Scaling up priority interventions

20. To reduce under-five mortality, it is important to scale up Integrated Management of Childhood Illnesses; immunize against measles, TB, tetanus and polio; promote exclusive breastfeeding; and improve nutrition and vitamin A supplementation. To reduce maternal and newborn mortality, all countries should scale up implementation of the Road Map. For HIV/AIDS, tuberculosis and malaria, countries should scale up prevention campaigns, The 3 by 5 Initiative, DOTS, and Roll Back Malaria initiatives, and take full advantage of the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as other global initiatives such as the Millennium Challenge Account.

21. Increased, aggressive health promotion is critical for dealing with noncommunicable, new and re-emerging diseases. Enhanced advocacy, public awareness and empowerment of individuals and communities to adopt lifestyles that promote health and reduce risk are priority programmes requiring much greater attention.

Governance and stewardship

22. Many of the diseases and illnesses experienced in the African Region are linked to poverty. These diseases are likely to continue as poverty worsens. Heavy investments in health will be needed to combat poverty by rolling back these diseases. Poverty reduction is mainly a governance and stewardship issue for the national authorities who should provide sound economic and financial management of domestic and foreign resources and exercise leadership in the coordination of multiple players and health financing mechanisms such as sector-wide approaches.

23. A basic health-care package should be incorporated into the on-going national development initiatives such as the national poverty reduction strategies and medium term expenditure frameworks. The package should be well costed to fit into the overall strategy for resource mobilization for the achievement of the goals.

24. Peace and security emanating from good political governance, ensuring the human rights of individuals and groups, access to social and human services for all citizens, equitable distribution of income, and good management and stewardship of the development process are key to achievement of the MDGs.

25. Better and more effective implementation of existing and new national policies, international conventions, declarations, and agreements (such as those on human rights of women, children and other groups) is crucial for achievement of the MDGs. In most cases, the MDGs will not be achieved not for lack of ideas or compacts but for lack of implementation. Serious efforts should be made to address poor implementation of what is already known or agreed.

26. Education and empowerment of women and girls will serve other goals such as food security and nutrition, maternal and child mortality as well as prevention and cure of communicable diseases. Intensifying advocacy for the role of health in economic growth, poverty reduction, development and strengthening intersectoral cooperation will help address poverty, hunger and malnutrition. The regional poverty strategy[14] provides guidance on the way forward.

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[14] WHO, *Poverty and health: A strategy for the African Region,* Brazzaville, World Health Organization, Regional Office for Africa, 2003 (AFR/RC52/11).

27. Improving the physical and socioeconomic environments in which people live can avert many illnesses. There is therefore need to strengthen the environmental health units in ministries of health, intensify existing interventions and initiatives and work with other sectors such as agriculture and industry to reduce environmental hazards to health.

28. Many African countries can achieve a lot through exercising proper leadership and stewardship of domestic resources, which include national natural, human and material resources. High quality management of social and community capital and private-public sector relationships can go a long way in addressing the MDGs. Natural resources can generate adequate financial resources required for social and human development if exploited and managed properly. These could provide part of the estimated US$ 27 billion[15] required for health development from the donor community or the US$ 36-40 per capita health expenditure estimated by the Commission on Macroeconomics and Health.

29. Full compliance with the 2001 Abuja target of 15% of national budget allocation to health would also go a long way in raising funds for health. African countries can augment their resources by making best use of global initiatives such as the British-led African Commission; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the American Millennium Challenge Account; Monterrey agreements; and the Doha agreements. It is important to channel most of the HIPC resources and those from recent debt forgiveness into health.

30. The global partners, on the other hand, should honour their promise of giving 0.7% of their gross domestic product to the least developed countries and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Developed Countries (Brussels, 2001). They should also simplify and streamline their rules, requirements and conditions for tapping into the global funding mechanisms so that the funds can be "absorbed" more speedily by the African countries.

MONITORING AND EVALUATION

31. The indicators for monitoring and evaluating were provided in each MDG (Annex 1). However, other indicators can be proposed to track performance of certain critical processes such as access to services and financial flows into priority pro-poor interventions.

ROLES AND RESPONSIBILITIES

National governments

32. Achieving the Millennium Development Goals is primarily the responsibility of national governments. Governments should provide an enabling environment. Good governance and stewardship of local and foreign resources, abiding by the Abuja (2001) targets, and ensuring that debt relief funds are fully allocated to social services, especially health, could help provide this enabling environment. Governments should also scale up priority interventions that address the health MDGs and comply with the health-related recommendations of the Millennium Project Report to the UN Secretary-General.

[15] WHO, *The world health report 2003: Shaping the future*, Geneva, World Health Organization, 2003, p.32.

33. Countries need to set up very clear and strong coordination and monitoring mechanisms to track health financing issues. This will help not only in tracking the sources and effects of domestic and donor health financing funds and the impact of the health sector on the overall economy, but will also reveal if pro-poor health is being sacrificed at the expense of macroeconomic concerns. Governments should strengthen their health information systems, research capacities and community-based surveys in order to provide up-to-date information.

Development partners

34. Development partners can offer opportunities for Africa to acquire more resources from global partners. Global partners should devise effective strategies aimed at strengthening health systems, for example, those to retain health personnel in Africa. Partners can begin by honouring their promises to substantially increase development aid and by addressing the international financial and trade imbalances which perpetuate poverty in Africa.

WHO

35. WHO programmes should intensify the best and most effective ways of accelerating technical support to countries for meeting the goals in full collaboration with other WHO programmes and partners, especially within the United Nations Country Teams. Focus should be put on the Country Cooperation Strategies, the strategic directions given at the one-hundred-and-fifteenth session of the Executive Board and the elements outlined in the perspectives above. It is important to reconsider how best to work with local communities, nongovernmental organizations, private sector and civil society in support of governments to achieve the MDGs. This will ensure that action is also taken in those areas where WHO does not have the traditional comparative advantage.

CONCLUSION

36. The ultimate responsibility to achieve the MDGs, to monitor and report on progress, lies with national governments. Effective leadership and appropriate stewardship of national and foreign resources for development, in general, and health development, in particular, are the keys for achieving the MDGs. There is need for strengthening health systems at all levels. Development partners should play their role by providing the funding promised at many international forums.

37. The Regional Committee is requested to review and discuss this situation analysis and perspectives for achieving the health Millennium Development Goals in the African Region.

ANNEX 1

MILLENNIUM DEVELOPMENT GOALS, TARGETS AND INDICATORS

Millennium Development Goals		
Goals and targets		**Indicators**[a]
Goal 1	**Eradicate extreme poverty and hunger**	
	Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	• Proportion of population below $1 a day • Poverty gap ratio *(incidence x depth of poverty)* • Share of poorest quintile in national consumption
	Halve between 1990 and 2015, the proportion of people who, suffer from hunger	• Prevalence of underweight in children (under five years of age) • Proportion of population below minimum level of dietary energy consumption
Goal 2	**Achieve universal primary education**	
	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Net enrolment ratio in primary education • Proportion of pupils starting grade 1 who reach grade 5 • Literacy rate of 15 to 24-year-olds
Goal 3	**Promote gender equality and empower women**	
	Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015	• Ratio of girls to boys in primary, secondary, and tertiary education • Ratio of literate females to males among 15- to 24-year-olds • Share of women in wage employment in the non-agricultural sector • Proportion of seats held by women in national parliament
Goal 4	**Reduce child mortality**	
	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of one-year-old children immunized against measles
Goal 5	**Improve maternal health**	
	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6	**Combat HIV/AIDS, malaria and other diseases**	
	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	• HIV prevalence among 15- to 24-year-old pregnant women • Contraceptive prevalence rate[b] • Number of children orphaned by HIV/AIDS
	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• Prevalence and death rates associated with malaria • Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures • Prevalence and death rates associated with tuberculosis • Proportion of TB cases detected and cured under DOTS

Millennium Development Goals		
Goals and targets		**Indicators**[a]
Goal 7	**Ensure environmental sustainability**	
	Integrate the principles of sustainable development into country policies and program and reverse the loss of environmental resources	• Proportion of population using solid fuels. • Change in land area covered by forest • Land area protected to maintain biological diversity • GDP per unit of energy use • Carbon dioxide emissions (per capita)
	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	• Proportion of population with sustainable access to an improved water source
	Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	• Proportion of population with access to improved sanitation • Proportion of population with access to secure tenure [Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]
Goal 8	**Develop a global partnership for development**	
	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)	Some of the indicators listed below will be monitored separately for the least developed countries, Africa, landlocked countries, and small island developing states. • Net ODA as a percentage of DAC donors' gross national income • Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water, and sanitation) • Proportion of ODA that is untied • Proportion of ODA for environment in small island developing states • Proportion of ODA for the transport sector in landlocked countries
	Official development assistance Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)	
	Market access Address the special needs of landlocked countries and small island developing states (through the Barbados Programme and 22nd General Assembly provisions)	• Proportion of exports (by value, excluding arms) admitted free of duties and quotas • Average tariffs and quotas on agricultural products and textiles and clothing • Domestic and export agricultural subsidies in OECD countries • Proportion of ODA provided to help build trade capacity
	Debt sustainability Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	• Proportion of official bilateral HIPC debt cancelled • Debt service as a percentage of exports of goods and services • Proportion of ODA provided as debt relief • Number of countries reaching HIPC decision and completion points
	Other In cooperation with developing countries, develop and implement strategies for decent and productive work for youth In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	• Unemployment rate of 15- to 24-year-olds • Proportion of population with access to affordable, essential drugs on a sustainable basis • Telephone lines per 1,000 people • Personal computers per 1,000 people

Millennium Development Goals		
Goals and targets		**Indicators**[a]
	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	

[a] Some indicators, particularly for goals 7 and 8, remain under discussion. Additions or revisions to the list may be made in the future.
[b] Only one form of contraception—condoms—is effective in reducing the spread of HIV.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
ESCRITÓRIO REGIONAL AFRICANO

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ACHIEVING HEALTH MILLENNIUM DEVELOPMENT GOALS: SITUATION ANALYSIS AND PERSPECTIVES IN THE AFRICAN REGION

Report of the Regional Director

EXECUTIVE SUMMARY

1. The Millennium Development Goals (MDGs) put health at the centre of the global and national development agenda. The need for ministries of health to play a leading role in national development efforts has therefore increased significantly.

2. Many countries in the African Region have prepared their development frameworks and instruments incorporating the MDGs. Reports from the countries so far indicate that many can potentially achieve the MDGs; some of the goals have already been met or will be met by 2015.

3. Progress has been slow mainly due to weak health systems and inadequate resources. Other constraints include civil strife, high disease burden, high fertility rates and poor socioeconomic conditions. The challenges are diverse and complex, but they are not insurmountable with the right mix of policies, approaches and emphases on effective implementation by Member States as well as significant support from global partners.

4. The responsibility to achieve, monitor and report progress towards MDGs lies with national governments. However, development partners, including WHO, are urged to provide technical and financial support for scaling up effective interventions and priority programmes, especially those emphasizing Primary Health Care.

5. The Regional Committee is requested to review and discuss this situation analysis and perspectives for achieving the health-related Millennium Development Goals at country level in the African Region.

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