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Millennium Development Goals for health – will we reach them by 2015?

PERSPECTIVES

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The Millennium Summit at the UN headquarters in September 2000 has passed into the annals of history. At the beginning of the new millennium, 189 heads of state and government reached agreement on the Millennium Declaration. The Millennium Development Goals (MDGs) have inspired, mobilized, involved and not least facilitated the funding of key initiatives on a scale the world has not previously experienced. But will we reach the goals by 2015?

The UN Millennium Development Goals are formulated on the basis of Chapter 3 of the Millennium Declaration on development and on the elimination of poverty (1, 2) (Box 1). All the goals share the aim of combating poverty and the grotesque differences in living conditions between countries and within the individual country. It is not surprising that the Millennium goals saw the light of day in 2000. The term is self-explanatory, and the goals are a «birthday present» from government leaders to the inhabitants of the world. Quicker and more direct access to information had helped to reveal global injustice; TV reports had shown suffering and need in an increasingly direct and confrontational manner; Human Rights had become more than just fine words on paper. The Child Convention, adopted in 1989, had been ratified by all countries with the exception of two, and more and more influential actors were demanding that action be taken.

Box 1

UN Millennium Development Goals

- 1. *Eradicate extreme poverty and hunger*. Reduce by half the proportion of people living on less than a dollar a day by 2015. During the same period reduce by half the proportion of the world?s population who suffer from hunger
- 2. *Achieve universal primary education*. Ensure that all boys and girls complete a full course of primary education by 2015
- 3. *Promote gender equality and empower women*. Promote equality between men and women, and give women greater opportunities.

Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.

- 4. *Reduce child mortality*. Reduce by two thirds the mortality rate among children under five between 1990 and 2015
- 5. *Improve maternal health*. Reduce by three quarters the maternal mortality ratio between 1990 and 2015[1]
- 6. *Combat HIV/AIDS, malaria, and other diseases*
- 7. *Ensure environmental sustainability*. Reduce by half the proportion of people without sustainable access to safe drinking water by 2015. Achieve significant improvement in the lives of at least 100 million slum dwellers by 2020
- 8. *Develop a Global Partnership for Development*. Develop further an open, rule-based, predictable, non-discriminatory trading and financial system that addresses the special needs of the least developed countries.

[1] *5b (added at a later date)*. Achieve universal access to reproductive health

From empty words...

All the goals are accompanied by indicators that can be measured underway. The starting point was 1990, when the World Summit for Children provided excellent data on children's situation in the various regions. In September 1990 a larger number of government leaders (71) and ministers (88) than at any time previously gathered in New York to discuss the situation of children. The UN Declaration on the survival, protection and development of children and an action plan were adopted almost unanimously. However, little progress was made. The MDGs were formulated on the basis of this and other factors. The target date is 2015.

With four years to go, there is little doubt that many poor countries will not achieve the MDGs. But there is no doubt that the goals have inspired and promoted the funding of key initiatives on a level the world has not witnessed previously. In a number of low-income and medium-income countries child mortality has fallen considerably. This article gives a short overview of the actors, the funding and status of the so-called health-related goals, i.e. MDGs 4, 5 and 6.

Actors

Key actors in the intensified efforts are the entire UN family, the World Bank, many governments and not least the medical journal *The Lancet*. With editor Richard Horton at the helm, since 2003 *The Lancet* has issued a range of series dealing with the health-related goals. Time and time again strong criticism of

global injustice has been voiced and focus directed at the tragic loss of almost nine million young lives every year due to poverty. The series have undoubtedly contributed to a debate that continues to increase in intensity.

New partnerships have been established. Two of the most important are Partnership for Maternal, Newborn and Child Health (PMNCH) (3) and «Count-down» meetings (4). PMNCH is an umbrella organization anchored in WHO. It was established in 2005 and currently has almost 400 members from public and non-governmental organizations. Its main task is lobbying and also providing a knowledge base for effective interventions. «Count-down» is a loosely knit constellation that arranges large conferences every second year which monitor the extent to which various countries are on target to reach MDGs 4 and 5 and in what areas.

Funding

A major analysis of health and the economy was published in *The Lancet* in 2009 (5). Development assistance from public and private sources targeting maternal and child health increased from $5.6 billion in1990 to $ 21.8 billion in 2007 – and continued to grow in the following years. However, the development assistance channelled through the UN system has declined. New financial actors have appeared, such as the global funds for vaccines (GAVI Alliance) and for fighting AIDS, tuberculosis and malaria (GFATM). Private philanthropists have also played a more prominent role – e.g. the Bill & Melinda Gates Foundation. This has altered the global health architecture considerably – and a number of the UN organizations are experiencing financial strain. This is discussed in another of the articles in this series in the journal (6).

Progress to date

The current status is closely monitored. Every year the UN issues *The Millennium Development Goals Report*, in which the progress to date of each of the eight MDGs is estimated (7).

Children

One of the many actors is the UN Inter-agency Group for Child Mortality Estimation (IGME), of which UNICEF, WHO, World Bank and the United Nations Population Division are members (8). They claim that the number of children who die before they reach the age of five has fallen from 12.4 million in 1990 to 8.1 million in 2009. The decline in mortality for children under the age of five (under-5 mortality rate) has accelerated more after 2000 than in the1990s. More than half of the deaths occur in the first year of life. The major causes of death in children under five are still pneumonia (18 %) and diarrhoea (15 %).

Mothers

MDG 5 has finally received greater attention. In addition to the original goal, which was to reduce maternal mortality by three quarters by 2015, a sub-goal – universal access to reproductive health – was added after a protracted power struggle. Maternal mortality is the indicator which best marks the intolerable difference between rich and poor countries, and it also says a lot about access to adequate health services (9, 10).

According to recent figures there were 359 000 maternal deaths in 2008, a decrease of 34 % from 1990 (9, 10). Altogether 99 % of these deaths continue to take place in the developing world. Sub-Saharan Africa and Southern Asia account for 87 %. The risk that a 15-year old woman will die as a result of pregnancy during her reproductive years is approximately 10 % in Afghanistan and over 3 % in sub-Saharan Africa. The minimal decline in maternal mortality in Africa can be attributed to the fact that fertility is high and that far too few have trained, qualified birth attendants to assist them during the birth. However, new figures indicate that maternal mortality would be considerably lower also in sub-Saharan Africa were it not for the aggressive HIV epidemics (9, 10).

The most usual causes of maternal mortality are illegal abortions, failure to progress in labour, bleeding, eclampsia and sepsis. Abortion is and remains controversial. But the proportion of deaths is declining because a greater number have access to medicamental abortion. Perhaps particularly unacceptable is the high proportion of pregnancies among very young girls in the majority of the world's poorest countries. In India more than 40 % of females are married before the age of 18 – and 25 % before they are 16 (11). For females who are still in the process of growth and development, the risk of complications is five times higher than in women in their twenties. Another challenge, but also one which offers hope for future change, is the close link between maternal morbidity and perinatal mortality. Good obstetric help is still deficient and this would not only reduce maternal mortality but also the number of stillborn babies in addition to a decline in newborn morbidity and mortality (9, 10, 12).

An important health indicator that has not been included in the MDG list is the number of stillborn births. Every year there are over 2.7 stillborn births. Once again the poorest with the most inadequate health care are hit hardest. Women who suffer from illness during their pregnancy incur a greater risk of experiencing a stillbirth, and poor maternity care and birthing assistance increase the incidence (12) – (14).

HIV/AIDS and malaria

MDG 6, which concerns combating HIV/AIDS, tuberculosis and malaria, is also within reach in a number of countries but much remains to be accomplished. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was established by the UN's general secretariat in 2002. Up to the present, $21.7 billion has been granted to 150 countries. At the end of 2000, 36.1 million people had HIV, as against 33.3 million at the end of 2009. There is reason to

believe that the bulk of the reduction is due to changed sexual behaviour and the fact that the most aggressive epidemics among young people in sub-Saharan Africa are advancing to later stages with a less virulent spread of infection. A total of 68 % of HIV positive people live in sub-Saharan Africa (15).

The main strategies are increased prevention and treatment. From HIV/AIDS being a disease that also largely affected people in the upper social classes in sub-Saharan Africa, a change is in process whereby people with more education profit from preventive measures, while the same decline in risk cannot be seen in the case of those with little or no education (7). Figure 1 shows that the growth in the number of people infected with HIV has levelled out – and that the incidence is now falling (7). Greater use of antiretroviral treatment will also help considerably to prevent the spread of infection.

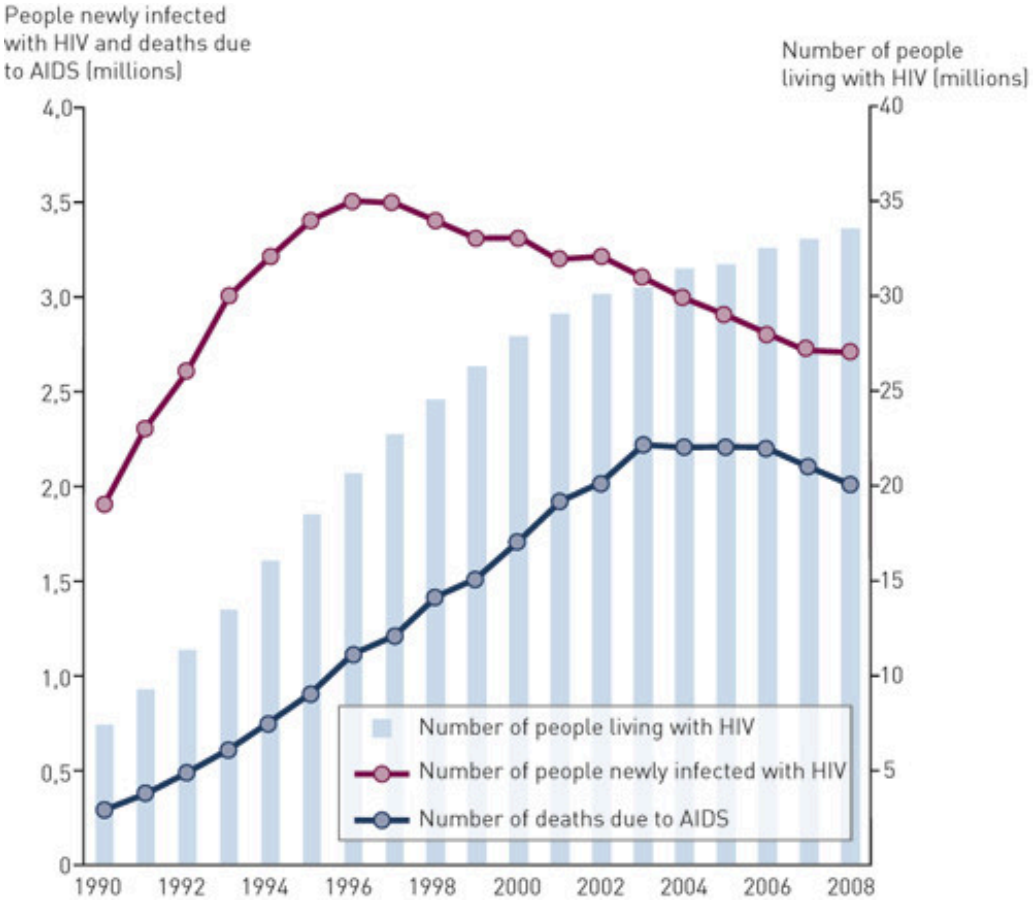

Figure 1 Development in the number of people infected with HIV and the number of deaths due to AIDS in recent years. Based on a figure in the 2010 UN report (7, p. 40). Reproduced with permission

The global distribution of mosquito netting increased from 1.35 million in 2004 to 18 million in 2006. Nonetheless, one child dies every 30 seconds of malaria. Altogether 90 % of deaths from malaria take place in sub-Saharan Africa, where the disease is responsible for one in five child deaths. There has been a huge increase in the number of donors and in the funding of measures to combat malaria: investments rose from US $50 million to $800 million from 1997 to 2007. Deaths from malaria dropped dramatically between 2001 and 2006, for example in Rwanda (45 % reduction) and the Philippines (76 % reduction) (7).

What role can Norway play?

There are enormous challenges and each individual country is responsible for expediting the achievement of the goals. Political pressure and global campaigns must go hand-in-hand with development assistance and the mobilization of resources. In many ways Norway has spearheaded a large-scale international mobilization. There are new and diversified initiatives, starting with the establishment of GAVI (Global Alliance for Vaccines and Immunization) in 2000. In conjunction with the Bill & Melinda Gates Foundation, a platform was established to ensure and increase the use of effective vaccines in poor countries. Since then, Norway has contributed NOK 500 million annually to this initiative.

Gradually partnerships have been established with four large countries (India, Pakistan, Nigeria and Tanzania) with the aim of supporting these countries' own programmes to improve maternal and child health. The programmes have a budgetary framework of NOK 250 million annually. Many countries, including Norway, believe that 5 – 10 % of large investments in health-promoting activities in developing countries should be invested in evidence-based measurements of how upscaling is carried out and in measuring the effect. These aspects are discussed in another article in this series in the journal (16).

The increasing involvement of a number of countries in global initiatives culminated in the UN General Assembly in September 2010, when a global strategy for maternal and child health was launched (17). Not only did this receive overwhelming support – but $40 billion in financial commitments was pledged to support the work. Poverty-related diseases should continue to be the central focus. Norway's official development assistance for health – targeted especially at mother and child – more than tripled from 1990 to 2009, from NOK 912 million to NOK 3.1 billion. A budget framework of NOK 1.595 billion for global health and vaccination initiatives has been adopted from 2011, while the combined UN system has a framework budget of over 4 billion. UNICEF alone will receive approximately NOK 1 billion in 2011. This makes Norway the second largest donor – with *no* correction for population size.

Extensive, wide-ranging political efforts are targeted at the global situation. Norway's Prime Minister heads a network of government leaders whose task it is to maintain and if possible, increase efforts to improve maternal and child health. The Foreign Minister has established a network of foreign ministers from seven countries focusing on the theme of health and foreign policy. New initiatives continually emerge. For example, in April 2011 a new partnership was launched between the Bill & Melinda Gates Foundation, the World Bank and the Norwegian government. This time, attention is focused on newborn babies – and in particular how new technology can be employed to develop and improve care at the first, crucial stage of a person's life. The budget for the first five years is over USD $ 50 million.

Reflections

Never before have we witnessed such a strong commitment to maternal and child health as is currently the case. Never before have we witnessed so much money on the table and never before have activities been more visible. If you google «Millennium Development Goals» – you will get 3.4 million hits. However, there are some paradoxes that need to be mentioned. Fortunately large areas will reach the health-related goals without foreign development assistance playing a significant role. This applies to the whole of Latin-America, China, North Africa and South-East Asia.

The major challenge is sub-Saharan Africa, Pakistan and large parts of India. If we are to speak of the global achievement of these goals, these countries must improve their performance soon. Perhaps the main bottleneck is the malfunctioning of their health systems. A healthcare centre may be well staffed, have adequate premises and shelves full of medication and equipment, but all this will soon fall into decay if the staff are not paid, if the supply of equipments and medication is deficient, and if the temptations of the private sector lure the employees. It will be very exciting to see whether the global strategy (17) and its follow-up are of decisive importance.

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