

# PROGRESS TOWARDS THE MILLENNIUM DEVELOPMENT GOALS

At the heart of the work of the Department for International Development (DFID) is the set of eight mutually-reinforcing Millennium Development Goals (MDGs). These are internationally agreed objectives for reducing global poverty which 189 nations signed up to in September 2000 in the Millennium Declaration. 2005 will see the first major review of progress towards these objectives and DFID is at the forefront of agencies working to ensure that the international development community delivers the political will and resources required to achieve them.

Achieving the MDGs requires improving the lives of the poorest people in the world by: reducing levels of poverty and hunger, ensuring a basic level of education for all, promoting gender equality, reducing childhood and maternal deaths and addressing issues of environmental sustainability. It is a challenge that requires considerable commitment from both developed and developing countries.

The MDGs were set in 2000 and the targets they embody are generally framed in terms of progress to be achieved by 2015 from a baseline of 1990. Today, in 2004, we are just over half way through this period.

This article reports on current progress towards the MDGs. Part 1 gives an overview of progress for each of the eight goals, with their associated 18 targets and 48 indicators (a full list of all the goals, targets and

indicators is found on pages 23-24). Part 2 then provides a more detailed analysis of progress towards the health goals and highlights their relevance to the achievement of the MDGs as a whole. A number of the goals have a very obvious health link: reducing child mortality, improving maternal health, and reducing the impact of the major communicable diseases such as HIV/AIDS and malaria. Yet better health is also integral to the goals of reducing poverty and improving nutrition and access to education. Underpinning progress on all eight goals is ensuring the right of universal access to sexual and reproductive health.

## **PART 1: AN OVERVIEW OF PROGRESS TOWARDS THE MDGs**

### **Summary**

The targets set by the MDGs are challenging and progress between countries and across goals is variable. Whilst some countries have experienced dramatic improvements, taking the developing world as a whole, renewed effort and resources are required to tackle the deep-rooted but solvable problems which are hampering progress. The sub-Saharan region of Africa faces particular problems. Not least because of the impact of HIV/AIDS.

Globally progress has been most noticeable in reducing income poverty and if current trends

continue then this target is on track to be met. The goal of promoting gender equality and empowering women has also seen notable improvement although faster progress is needed to meet the stated targets by 2015. The water and sanitation targets for MDG 7 have also moved in the right direction since 1990, but progress would need to be accelerated for these targets to be reached globally by 2015.

The prospects for universal primary education and improving child and maternal health are less good. Individual countries have made great strides demonstrating that with political will and resources these goals are achievable. However current trends worldwide are disappointing and the targets set for 2015 will not be met without dramatic improvement.

Progress and future trends on Goal 6, which combats HIV/AIDS, malaria and other diseases, cannot be reliably estimated because of a lack of data. However the information that does exist suggests a similar picture to education and child health with individual countries showing great success in rolling back malaria and HIV/AIDS but poor progress overall. More positively, a new treatment strategy for tuberculosis is proving effective.

Goal 8 highlights action required by developed countries and progress is evident with increased official development assistance, debt relief and improved terms of trade, but further effort is still needed.

Overall, progress to date has been slow and it is legitimate to ask whether we can meet the MDGs by 2015. However even in sub-Saharan Africa, where the burden of HIV/AIDS has made the achievement of the MDGs particularly challenging, countries are found where commitment combined with effective use of resources demonstrate that much can be achieved. There is still time to put in place the conditions and resources needed to achieve the 2015 MDG targets. However, the development community needs to make more determined efforts to resolve the constraints that prevent faster progress towards achievement of the MDGs including ensuring the necessary funding and other resources are in place.

A more detailed analysis by goal follows, finishing with a UN-produced chart (Figure 2) estimating when each goal will be achieved at a global and regional level, assuming current rates of progress continue.

## **Goal 1: Eradicate extreme poverty and hunger**

Ensuring people have sufficient income to meet their basic needs is essential if poverty is to be eliminated. Income poverty and hunger have a direct impact on many of the other MDGs since, for example, poor or hungry people will be more likely to suffer poor health and be absent from school. The first MDG target aims to halve the proportion of people living on less than \$1 a day. Current estimates suggest that in 2001, 21

per cent of people in developing countries had incomes below \$1 a day, down from 28 per cent in 1990. If progress continues at this rate the target will be met by 2015. Poverty rates by region are shown in Figure 1.

The second target is to halve the proportion of people who suffer from hunger and a faster rate of progress is required if it is to be met. The UN's Food and Agricultural Organisation estimates that the prevalence of undernourishment in developing countries fell from 21 per cent to 17 per cent between 1990-92 and 1999-01. Unless progress accelerates there could still be more than 600 million undernourished people in 2015, far higher than the target of 400 million.

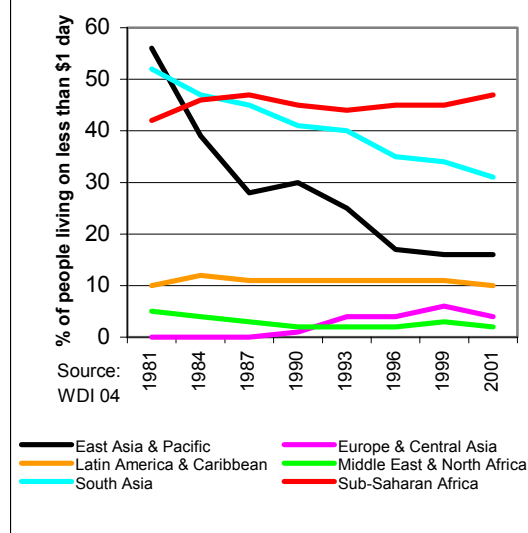
As many observers have noted, progress in sub-Saharan Africa has stalled since 1990. In 2001, just under half the population lived on less than \$1 a day (47 per cent). This has been due to a range of factors, notably conflict and HIV/AIDS and other constraints to faster economic growth. However, there are signs that more widespread progress will be made in the coming decade. The latest forecasts predict a significant reduction in income poverty by 2015, although much less than would be required to halve the 1990 level.

## Goal 2: Achieve universal primary education

Access to a basic education is a human right and offers people both the opportunity to participate fully in society and to lift

themselves out of poverty. It is positively associated with health gains. In 2001, between 8 and 9 out of every 10 primary school age children were enrolled in school, while around 100 million children did not have the opportunity of a primary education. Although there have been significant increases in the *numbers* of children going to school, these have barely managed to keep pace with rising populations, meaning there has been little improvement in the *proportion* of primary school age children enrolled in school. Without a determined effort universal primary education will not be achieved by 2015. However there are grounds for hope as Kenya and Bangladesh, amongst other countries, have demonstrated that a great deal can be achieved in a short space of time in opening up education for all. With sufficient funding and commitment this MDG might yet be turned around.

**Figure 1:  
Poverty rates by region**



### **Goal 3: Promote gender equality and empower women**

Gender equity underpins many of the other MDGs as better educated women with more rights are likely to have a substantial impact in reducing poverty, reducing the rate of childhood diseases and reducing the spread of HIV/AIDS.

The aim of MDG 3 is to eradicate gender disparity in primary and secondary education by 2005 and to achieve gender equality at all levels by 2015. At the start of the 21<sup>st</sup> century, developing countries had around 9 girls for every 10 boys in both primary and secondary school. Between 1990 and 2000 gender equality in education improved across the developing world, including sub-Saharan Africa. However, the current rates of progress are too slow to reach the target of gender equity at the primary and secondary levels by 2005 and enhanced efforts would be required to bring this about by 2015.

MDG 3 also monitors the proportion of seats in national parliaments that are held by women. In 2003, the proportion for developing countries was 13.5 per cent, compared with 11.5 per cent in 1990. There is no specific target for this indicator but much faster progress would be needed to bring about equity on this measure by 2015. However it is worth noting that inequality in the political arena is by no means confined to developing countries as the corresponding

figure for developed countries in 2003 was only 19 per cent.

### **Goal 4: Reduce child mortality**

The objective here is to reduce the under-5 mortality rate by two thirds to 34 per 1000 live births. In 1990, 103 in every 1000 children born alive in developing countries died before the age of 5. By 2002, the corresponding figure had fallen to 88 in every 1000. This is significant progress but even so the mortality rate in 2015 is likely to have fallen to only around 72 deaths per 1000, well short of the target which, on current trends, will not be achieved until 2045. Interestingly, while there was considerable progress in reducing the rate of child mortality in the decades prior to 1990, the rate of decline since then has slowed – and in the case of sub-Saharan Africa, has stopped entirely. Part 2 of this article explores the reasons for this and discusses ways in which progress towards this goal might be encouraged.

### **Goal 5: Improve maternal health**

This goal aims to reduce the number of women dying as a result of pregnancy or childbirth by three quarters between 1990 and 2015. So far there has been very little progress. In 2000, there were estimated to be 440 maternal deaths for every 100,000 live births in developing countries, compared with 430 in 1990. Over this time the proportion of births assisted by a skilled attendant has risen, reaching 56 per cent in 2002. We know

how to reduce maternal mortality and ways of stimulating progress are suggested in Part 2. However the fact that the situation has not really changed since 1990 emphasises the need for greater political will to give maternal health the priority it deserves and get this objective back on track.

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

The HIV/AIDS epidemic is key to understanding the lack of progress towards meeting many of the other MDGs for sub-Saharan Africa. It is also a serious threat to progress in other regions such as Asia where infection rates are increasing. The target for HIV/AIDS is to have halted, and begun to reverse, the spread of the disease by 2015. Unfortunately, although the global community is able to estimate the prevalence of HIV in women aged 15-24 in 2001 (1.6 per cent in developing countries and 9.3 per cent in sub-Saharan Africa) we do not know the corresponding position for 1990 and so are unable to accurately assess trends over this period.

However, UNAIDS reports that the HIV/AIDS epidemic remains extremely dynamic and estimates that more than 6000 young people contract the virus every day. While countries such as Brazil, Thailand and Uganda have managed to halt the spread of the disease, it is clear that millions more people will become infected as the global community works to gain control over the HIV/AIDS epidemic.

Sparse data also prevent a robust understanding of progress towards halting and reversing the spread of malaria. Data on detection and cure rates for tuberculosis are however now available in many countries for recent years and show that substantial progress has been made in a number of countries since 1998. For example, detection rates have increased in India and the Philippines and cure rates in Sudan and Bolivia.

### **Goal 7: Ensure environmental sustainability**

Goal 7 aims to ensure environmental sustainability, to provide access to safe drinking water and basic sanitation, and to improve the lives of at least 100 million slum dwellers.

By 2003, 78 countries were in the process of implementing or drafting national strategies for sustainable development. Despite this, many environmental resources are still in dramatic decline: global forest cover shrank by 94 million hectares (an area equivalent to the size of Tanzania) over the last 10 years; biodiversity loss is continuing despite a steady increase in the number and extent of protected areas; and global carbon dioxide emissions are still climbing, the highest levels coming from the most developed countries.

There has been a substantial improvement in access to an improved water source in rural areas of developing countries in Asia.

However unless progress on sanitation is accelerated, 2.4 billion people will still lack access to basic sanitation in 2015 (against the target figure of 1.9 billion). Without much greater effort neither the sanitation nor water targets will be met in sub-Saharan Africa.

We will not meet the target for improving the lives of 100 million slum dwellers without radical changes to current policies and approaches. It is estimated that the number of slum dwellers could double from about 900 million today to almost 2 billion by 2020.

Access to affordable and reliable energy is essential to economic growth and achievement of the MDGs, and global demand for energy continues to rise. Per capita energy consumption and access to modern energy are lowest in the poorest countries, where energy use is also least efficient. Low carbon energy technologies and improved efficiency will be essential to limit impacts on the global environment.

### **Goal 8: Develop a global partnership for development**

MDG 8 aims to develop a global partnership for development and includes targets on increasing official development assistance (oda), making it easier for developing countries to trade on world markets and debt relief.

Total oda to developing countries increased by almost 4 per cent in real terms from 2002

to 2003, continuing the increase from the 2001 low point. The provisional estimate for 2003 is £42 billion, the highest level ever. This represented 0.25 per cent of donors' combined gross national incomes (GNI) in 2003, still below the official UN target of 0.7 per cent.

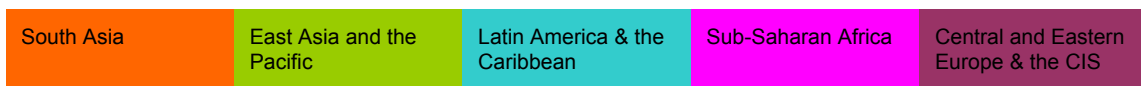
UK oda is expected to increase to nearly £6.5 billion a year by 2007/08, equivalent to 0.47 per cent of GNI. The Government wishes to continue to raise UK oda at this rate, which would mean achieving the UN target by 2013.

The Heavily Indebted Poor Countries (HIPC) Initiative was launched in 1999 and has had considerable success in delivering debt relief and ensuring that the money saved goes towards reducing poverty. To date, relief totalling more than US\$70 billion has been agreed for 27 countries.

The UK, along with other donor countries, is currently in the process of drafting a detailed report on our contributions towards meeting MDG 8 and this report will be available on the DFID website early in 2005.

**Figure 2: When will the Millennium Development Goals be achieved if progress does not accelerate?**

	Poverty	Hunger	Primary education	Gender equality	Child mortality	Access to water	Access to sanitation
<b>ACHIEVED</b>	Arab States EAP	CEE & CIS	LAC CEE & CIS EAP	LAC		CEE & CIS	
2000	World S Asia	EAP			LAC	S Asia World LAC	
2015					EAP	EAP	S Asia World LAC EAP
2020		LAC World	EAP S Asia	Arab States S Asia	S Asia Arab States World	SSA	
2050			Arab States World				
2100		S Asia SSA		SSA			
2220				CEE & CIS			
<b>REVERSAL</b>	LAC SSA CEE & CIS	Arab States					SSA



Source: Human Development Report 2003, UNDP <http://www.undp.org/hdr2003>

## **PART 2: HEALTH AND THE MDGs**

This section focuses on the health MDGs. It discusses the main causes of child and maternal deaths, which are often entirely preventable, and what can be done to improve the situation and goes on to note that some countries have made dramatic progress in specific areas. With the 2005 Millennium Review and renewed commitment to achieve the goals, the priority is to ensure that many more countries can join these success stories. While better health is integral to 'non-health' MDGs, such as reducing poverty and improving education enrolment, improved health outcomes are, in turn, also dependent on progress elsewhere; in higher incomes, better access to clean water and sanitation, and in changes in education and behaviour.

A number of low income countries have demonstrated that progress is possible, for example Vietnam and Mozambique on child mortality and some of the middle income countries including China, Bolivia, Honduras and Egypt on maternal mortality. However, the overall rate of progress on the health MDGs does give cause for concern.

### **What is the relationship between ill health and poverty?**

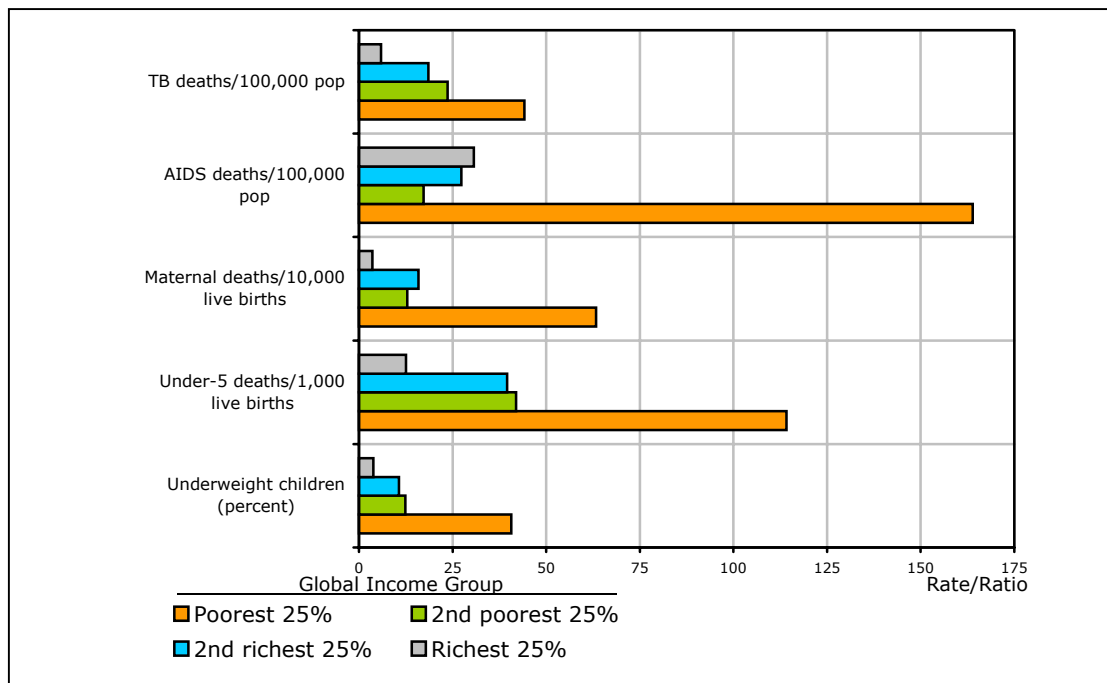
The relationship between ill health and poverty is circular. Health is not only an important aspect of human and social development but also a critical factor in economic growth. The poor are ill more often

and ill health, particularly the catastrophic expenditure of acute illness, can push people from a state of economic survival into one of deep poverty from which they are unable to escape. Poor people suffer greater levels of ill health, disability and death. The death rate of the under 5s among the poorest quarter of the world's population is 10 times that of the richest quarter. The discrepancy for maternal death is even more extreme with a twenty-fold difference. In the poorest countries as many as 250 children out of every 1000 born will die before reaching their fifth birthday: whilst in industrialised countries that figure is as low as 5 per 1000. See Figure 3 overleaf.

### **What are the causes of death?**

The major causes of global mortality are non-communicable diseases (59 per cent), communicable diseases (32 per cent), and injuries (9 per cent). Poor countries face a disproportionate burden of communicable diseases with more than half of all deaths being due to 5 preventable or readily treatable diseases: acute respiratory infections, malaria, diarrhoea, measles and AIDS; and malnutrition is associated with half of all childhood deaths. Each year 3 million people die from AIDS, 2 million from TB and more than one million from malaria, all of which can be prevented or easily treated. Poor countries also suffer rising rates of the non-communicable diseases that are predominant in industrialised countries such as high blood pressure, heart disease, diabetes and the effects of smoking.

**Figure 3: Key health indicators by Global Income Group**



### How could child deaths be prevented?

Childhood illness accounts for a large proportion of the global burden of disease. Almost 11 million children die each year before their fifth birthday with 4.5 million dying in the first month of life. Three quarters of these deaths occur in sub-Saharan Africa and South Asia. There has been major progress in reducing child deaths over the past 30 years but the rate of improvement has now slowed and in some countries even reversed. While the immediate causes of death are clear, more distant social and economic factors play a major role, particularly level of education, income, access to clean water and sanitation.

Over recent years increasing attention has been paid to addressing the major communicable diseases, which has led to the proliferation of a number of high profile partnerships such as Roll Back Malaria and the Global Fund to fight HIV/AIDS, TB and Malaria. Yet childhood malnutrition, a co-factor in more than 60 per cent of deaths and an underpinning constraint undermining progress towards the first six MDGs, has not received the same level of attention. Aside from the progress in reducing the proportion of people lacking key vitamins and minerals, the overall situation is declining in much of sub-Saharan Africa and South Asia. Malnutrition is a key driver in transmitting poverty down generations - an infant born to an undernourished mother will be born malnourished, will be more susceptible to

repeated infections and his/her ability to learn and develop life skills will be irreversibly damaged. A child born malnourished is too often a child born into poverty.

Affordable and effective interventions exist to prevent or treat the main causes of childhood ill health and death but remain massively under-used. The World Bank estimates that ensuring universal access to a range of existing interventions delivered in the home or through community or formal health services could reduce child mortality by more than 60 per cent. A list of 10 key child health interventions is given in the box below.

#### **Ways of reducing child deaths**

1. Clean delivery/ care of newborn
2. Breast feeding
3. Impregnated bed-nets to protect against malaria
4. Anti-malarial drugs
5. Micronutrients: Vitamin A/ Zinc/ Iodine
6. Complementary feeding
7. Antibiotics – to treat sepsis, pneumonia, dysentery
8. Vaccination – tetanus, HiB, measles
9. Clean water/ sanitation
10. Oral rehydration therapy

#### **How could maternal deaths be prevented?**

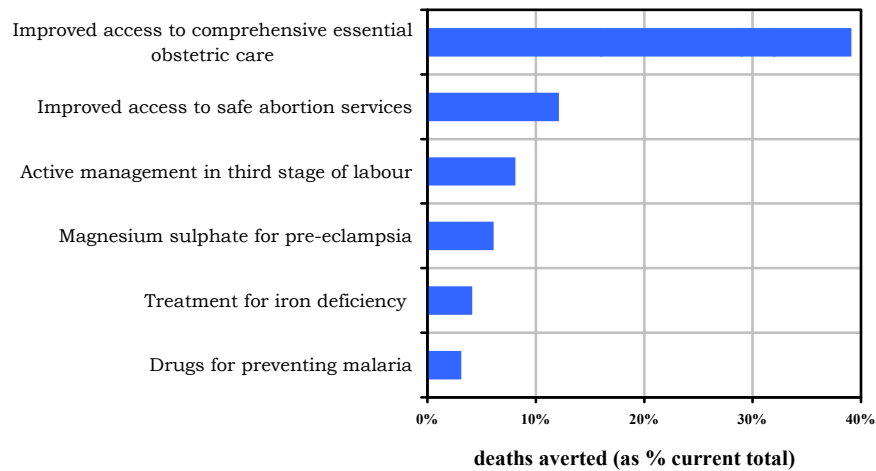
Well over half a million women die in childbirth each year – 99 per cent of them in developing countries, and a quarter of them in

India alone - and a further 1.5 million women are left with a disability as a result of complications of childbirth. Two million children are left motherless. There has been no significant improvement in low income countries in reducing deaths from pregnancy related causes in recent years; indeed in many countries maternal mortality has worsened considerably. However improvement has been seen in some middle income countries, such as China and Bolivia.

The majority of maternal deaths occur because of avoidable delays: delays in the home in deciding to seek care; delays in reaching a health facility because of poor communication and transport links; or delays in receiving effective health care where trained staff, equipment and medicines may be in short supply. The tragedy is that almost all these deaths are preventable. To reduce these high levels of maternal death requires effective health services that provide access to quality reproductive health services to prevent and safely manage unwanted pregnancies, that ensure skilled attendance for every birth and ready access to emergency obstetric care.

It has been estimated that maternal deaths would fall by 73 per cent if coverage of key interventions rose to 99 per cent. Examples of such interventions are shown in Figure 4, along with the proportion of deaths that might be averted if they were available.

**Figure 4 - Potential impact of key interventions on maternal deaths**



Source: The World Bank (2004) *The Millennium Development Goals for Health: Rising to the Challenges*.

### **What kind of health systems are needed?**

At the core of a successful effort to realise the health MDGs is gathering the political will to support country efforts to build more effective health systems that meet the challenges of delivering quality care in resource starved settings. Such systems need to provide high, ideally universal, levels of access to affordable and high quality health services that deal with the major causes of ill health and death. The technology and know-how to reach the health MDGs exists but these are not put to effective use.

In many poor countries much of the population has no access to formal health services or does not use them. Many seek

care through non-government providers or through traditional sources. Household decisions on health care are influenced by many factors such as local belief and knowledge, the costs of care, access to services, the availability of skilled staff, and treatment options, including the availability of essential drugs in health facilities. We need a better understanding of how these factors come together as barriers that limit the use of health services and effective action to stimulate demand. Beyond demand there are further barriers in the supply of services - finance, trained staff, planning and management systems - that need to be addressed.

Levels of spending on health are extremely low, with governments in poor countries

typically spending less than £5 per head of population on health services each year. (The UK spends more than £1500 per person.) The funds that are available may not be used effectively with disproportionate amounts going to urban hospitals and too little getting to the district and primary level, particularly in rural areas. The focus of spending needs to change with adequate funding of a strong integrated district health system that provides basic care at the primary and first referral level. Also much more funding is needed – with estimates of a minimum effective health care system nearer to £30 than £5 per head.

Many countries face shortages of health professionals with the staffing crisis most severe in rural areas. The causes are well understood and include poor terms of service, the impact of HIV/AIDS, and migration to richer countries. There is an urgent need to increase the numbers and distribution of staff in these countries, particularly to ensure strong cadres of nurses and midwives. Imaginative approaches are required to improve staff retention and to attract staff to work in under-served areas.

Supply of critical health commodities, such as essential drugs, is often weak, while inadequate budgets and inefficiencies within procurement and distribution systems often lead to shortage in supplies of vital drugs.

There has been increased attention to disease specific interventions in recent years but such targeted approaches can work both

ways with the potential to both strengthen and undermine health systems. For example, increasing earmarked funds for AIDS treatment or malaria may lead to the migration of skilled staff from the health service to disease specific programmes. The arrival of very large sums for AIDS could also massively distort policy and practice priorities. If not handled sensitively then, perversely, the result may be more people accessing AIDS care but fewer workers providing a broad range of preventative and curative health services.

Non-state providers – non-governmental organisations, faith based organisations and the private sector - serve many people. Yet their potential remains under-utilised with donors increasingly providing resources through government budgets that only support the public sector. While governments need to provide oversight and regulate the provision of health services they do not have the capacity to directly provide everything. They should be encouraged to improve their ability to identify impediments to provision of services and to generate more flexible solutions. In support of this it is important to strengthen health information systems so that countries can better understand the problems they face and measure the effectiveness of their response.

Donors need to ensure that their support, however delivered, strengthens local health systems rather than destabilises them. Increasingly that support is being provided in a more co-ordinated manner, often into the

government budget but such assistance needs to be more predictable and long term.

Finally more than 500 million people live in difficult environments, where government is non-existent or weak and often additional suffering is caused by ongoing or recent conflict. The international response to these situations is inadequate and there is a need to find more effective ways to provide services in these settings.

### **Will the health MDGs be met?**

There are 11 years left to achieve the MDGs and it is clear that a greater sense of urgency is needed if the health targets are to be met. While there are many successes, particularly in dealing with specific diseases, there is a need for a quantum leap in the years ahead to 2015. There is a real risk that many countries will fall far short on many goals. Nevertheless experience shows that much can be achieved when countries are in the driving seat, where health is prioritised in national development strategies and where policies and practice are good and development assistance used effectively.

Successful replication of these conditions elsewhere to the extent needed to achieve the health goals will require donors to work together to support national priorities, to provide substantially more assistance – ideally into the budget of the country – and to improve the predictability of aid so that countries can spend against their own

priorities. While much progress will arise from factors outside of the health sector – through rising incomes, better nutrition, and access to water and sanitation – there remains a massive potential impact in ensuring universal access to a range of tested cost effective preventive and curative interventions delivered at the household, community and health facility levels.