



**Joint Meeting of the Executive Boards
of UNDP, UNFPA, UNICEF and WFP
25 and 28 January 2008
United Nations, New York**

**Agenda item 1:
Progress towards achieving the Millennium Development Goals**

Background document

I. INTRODUCTION

1. This background document for the Joint Meeting of the Executive Boards of the United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and World Food Programme (WFP) presents summary information (in section II) on progress towards achieving the Millennium Development Goals (MDGs). It discusses achievements and gaps in working towards the MDGs, using selected indicators and drawing on new data that have recently become available through a large number of national household surveys and mapping. These include the UNICEF-supported Multiple Indicator Cluster Surveys (MICS), the Vulnerability Analysis and Mapping, and the Demographic and Health Surveys supported by the United States Agency for International Development, among others (see Annex 1)i.
2. The analyses presented also draw on the work of several inter-agency MDG monitoring groups that are responsible not only for developing joint estimates for MDG indicators but also for developing new methodologies, indicators and monitoring tools for data collection, building statistical capacity at the country level and harmonizing monitoring work among partners. These monitoring groups focus on areas such as under-five mortality, immunization, malaria, HIV/AIDS, water and sanitation, and maternal mortality.
3. Section III presents some successful national-scale programmes for achieving the MDGs. It underscores the feasibility of rapid progress if political leadership, sound strategies and adequate financing are all brought together. The information draws on official reports of Member States as well as on documentation from United Nations agencies on country progress in increasing the coverage of essential services to achieve the MDGs.
4. Section IV provides a brief analysis of key issues to be addressed in furthering the achievement of the MDGs and suggests how Member States might effectively intensify their efforts, drawing on recent successes. It also covers the roles that United Nations agencies and country teams might play in supporting the efforts of national partners.

II. OVERVIEW OF PROGRESS TOWARDS SELECTED MDG INDICATORS

5. Progress towards eradicating extreme poverty and hunger (MDG 1) is uneven. The proportion of people living in extreme poverty fell from nearly one third to less than one fifth between 1990 and 2004. If the trend is sustained, the MDG poverty reduction target will be met for the world as a whole and for most regions. In sub-Saharan Africa, the number of extremely poor people has levelled off, and the poverty rate has declined by nearly six percentage points since 2000. However, the region is not on track to reach the Goal of reducing poverty by half by 2015.
6. Since 1990, underweight prevalence among young children has declined from 32 per cent to 27 per cent in the developing world. The East Asia and Pacific region and the Central and Eastern Europe and Commonwealth of Independent States (CEE/CIS) region have made the greatest progress in reducing underweight prevalence, and 58 countries are on track to reach the MDG target (Annex 2). Yet 143 million children under 5 in the developing world continue to suffer from undernutrition, more than half of them in South Asia.

7. Most countries making slow progress in relation to the hunger target are in sub-Saharan Africa. However, there are encouraging signs – notwithstanding the formidable challenges, including climate change. African leaders have accorded agriculture, nutrition and food security high priority and are taking measures to accelerate implementation of the Comprehensive Africa Agricultural Development Programmeⁱⁱ and to ensure that the new generation of poverty reduction strategies reflects adequately the importance of food and nutrition security as a prerequisite for sustained development. Alarmed by high levels of malnutrition on the continent, a special African Union summit was devoted to food and nutrition security in December 2006. Natural and man-made disasters cause and exacerbate food and nutrition problems. The United Nations contributes to programmes helping to prevent and mitigate the effects of disasters and to build livelihoods to allow families and communities to adapt.
8. Many countries are on track to achieve universal primary education (MDG 2). Attendance data based on household surveys show that the number of children of primary-school age who are out of school has declined markedly in recent years and that many countries are close to delivering universal primary education (Annex 3). Yet for many other countries, particularly in parts of sub-Saharan Africa and South Asia, the task remains enormous.
9. There has also been progress towards eliminating gender disparity in primary and secondary education (MDG 3). Girls' education has been expanding all over the world (Annex 4), but not fast enough to ensure a basic education for the millions of girls still out of school. About two thirds of countries reached gender parity in primary education by the target year of 2005, but in many other countries, especially in sub-Saharan Africa, girls are still disadvantaged.
10. Regarding MDG 4, the reduction in child mortality, in 2006 – for the first time since records have been kept – the number of children dying before their fifth birthday fell below 10 million, to 9.7 million. This is an important milestone in child survival. Around 1960, an estimated 20 million children under age five were dying every year. This achievement highlights an important long-term decline in the global number of child deaths.
11. However, many countries, particularly in sub-Saharan Africa and South Asia, still have high levels of child mortality, and in recent years have made little or no progress in reducing the number of child deaths.
12. Global progress is currently insufficient to achieve MDG 4 (Annex 5). While every region has made progress in reducing under-five mortality since 1990, only three regions – East Asia and the Pacific, Latin America and the Caribbean and CEE/CIS – are on track to achieve the child survival target. The benefits of reaching MDG 4 are enormous. Achieving the goal will avert the deaths of 5.4 million children under 5 (as compared to the situation in 2006) in the year 2015 alone. But if current trends continue and the goal is not achieved, an additional 4.3 million child deaths could occur in 2015 alone.
13. The most recent survey data indicate significant improvements in several key child survival interventions that may result in measurable reductions in under-5 mortality during the next several years. More than four times as many children received the recommended two doses of vitamin A in 2005 compared to 1999 (Annex 6). All countries with trend data in sub-Saharan Africa made progress in expanding coverage of insecticide-treated mosquito nets, a key approach in halting malaria, with 16 of these 20 countries at least tripling coverage since 2000 (Annex 7). In the 47 countries where 95

per cent of measles deaths occur, measles immunization coverage increased from 57 per cent in 1990 to 68 per cent in 2006 (Annex 8). Rates of exclusive breastfeeding of infants have significantly improved in 16 countries of sub-Saharan Africa over the past decade, with 7 of these countries making gains of 20 percentage points or more (Annex 9). However, less progress has been made in expanding treatment coverage for major childhood diseases, such as pneumonia and malaria.

14. A review of recent evidence shows that while a number of middle-income countries have made progress in reducing maternal deaths (MDG 5), less progress has been achieved in low-income countries, particularly sub-Saharan Africa. Globally, maternal mortality decreased at an average of less than 1 per cent annually between 1990 and 2005 – far below the 5.5 per cent annual decline needed to achieve MDG 5.
15. Across the developing world, maternal mortality levels remain high, with more than 500,000 women dying every year due to complications of pregnancy and childbirth. About half of these deaths occur in sub-Saharan Africa and about one third in South Asia (Annex 10). In sub-Saharan Africa, a woman's lifetime risk of maternal death is 1 in 22, compared to 1 in 8,000 in industrialized countries.
16. However, progress has been made in expanding coverage of antenatal care and skilled care at delivery – both are critical for improving maternal health and well-being – with every region showing improvements during the past decade.
17. Regarding efforts to combat HIV and AIDS, malaria and other diseases (MDG 6), global HIV prevalence appears to have leveled off.ⁱⁱⁱ New estimates, just published in the *2007 AIDS Epidemic Update*, show the number of people living with HIV is now estimated at 33.2 million in 2007.^{iv} Over two thirds of people living with HIV are in sub-Saharan Africa (Annex 12). The 2007 AIDS estimates also show that some 2.5 million people were newly infected with the virus in 2007. HIV and sexual behaviour trends among young people aged 15-24 can offer a glimpse into the likely evolution of the HIV epidemic within countries.
18. Among youth in the most-affected countries, HIV prevalence in young pregnant women (15-24 years) attending antenatal clinics has declined in 11 of 15 countries (including Côte d'Ivoire, Kenya, Malawi and Zimbabwe) since 2000/2001. In Haiti and Kenya, the trend data indicate significant reductions in some forms of sexual behaviour that place people at risk of exposure to HIV. Encouraging behaviour trends in a few countries coupled with the evidence of significant declines in HIV prevalence among young pregnant women in urban and/or rural areas of five countries (Botswana, Côte d'Ivoire, Kenya, Malawi and Zimbabwe) suggest that prevention efforts are having an impact in several of the most-affected countries, making the prevention of HIV infection among young people key to an effective response.
19. Malaria kills more than 1 million people each year, with around 80 per cent of these deaths occurring in sub-Saharan Africa among children under five. All African countries with trend data on the use of insecticide-treated mosquito nets have expanded coverage, and 16 of these 20 countries have at least tripled coverage since 2000. But countries are still falling far short of global malaria goals. While coverage of malaria treatment for children with fever is moderately high in sub-Saharan Africa, many countries have made little progress in expanding coverage since 2000, and many children are still receiving less-effective medicines. However, since 2003 nearly all sub-Saharan African countries have adopted the more effective artemisinin-based combination therapy as the first-line

treatment, and procurement of these medicines has significantly increased since around 2005.

20. On ensuring environmental sustainability (MDG 7), more than 1.2 billion people gained access to improved sources of drinking water between 1990 and 2004. The proportion of the world's population using improved sources of drinking water increased from 78 per cent to 83 per cent during this period, putting the world on track – although barely – to achieve the target for MDG 7 (Annex 13). A further 1.1 billion people will need to gain access by 2015 to achieve the Goal.
21. Sanitation coverage increased from 49 per cent in 1990 to 59 per cent in 2004, but the rate of progress is insufficient to meet the 2015 target (Annex 14). If current trends continue, the target will be missed by more than half a billion people. In 2004, 41 per cent of the world's population – 2.6 billion people – did not use improved sanitation facilities.
22. On developing a global partnership for development (MDG 8), and following the 2002 International Conference on Financing for Development, the year 2005 saw landmark commitments by the G8 countries to double official development assistance (ODA) to Africa by 2010 and by the European Union to increase aid to 0.7 percent of gross national income (GNI) by 2015. Yet actual increases in aid since then have been incremental at best. If one-off debt relief as well as humanitarian and food aid are excluded, ODA to Africa has been flat since 2004. If the successful national examples presented in this document are to be replicated in other low-income countries, commitments to increase ODA will need to be honoured through predictable multi-year approaches.
23. Preferential market access has continued to stall for most developing countries, and in all regions, economies have failed to provide full employment for young people. However, connectivity is increasing, with the number of Internet users and telephone subscribers expanding worldwide.

III. PROMISING AND SUCCESSFUL NATIONAL PROGRAMMES

24. Progress in achieving the MDGs requires considerable expansion in coverage of essential services and core infrastructure. Scaling up promising and successful approaches to the provision of basic services and infrastructure is imperative for the achievement of the MDGs.
25. Experience in recent years shows that success is possible. Many national-scale programmes are now being implemented by governments in pursuit of the MDGs. These examples demonstrate the feasibility of rapid progress when government commitment and leadership are combined with rigorous national strategies, adequate domestic and external financing, clear implementation mechanisms, support for capacity development (where necessary) and functional monitoring and accountability frameworks.
26. As the following selected cases indicate, United Nations agencies together with bilateral and international finance institutions in a number of countries have been well-positioned to provide support for scaling up sector-based or integrated combinations of services with effective impact for the MDGs. Progress in taking sub-national programmes to national scale, and replicating such efforts across countries, will be contingent on ensuring that financing and capacity gaps are filled.

27. The *Fome Zero* (Zero Hunger) in *Brazil* and the *Oportunidades* (Opportunities) in *Mexico* are examples of programmes operating at scale with positive impact for MDG 1, as well as associated effects for MDGs 2 and 4. Brazil's programme, which was started in 2003, currently encompasses the largest conditional cash transfer programme in the world as well as one of the largest school feeding programmes, covering nearly 37 million children every year. It uses a twin-track approach to address both hunger and malnutrition. It also includes cash transfers, school and community health and nutrition programmes, food for work, support to agricultural production and market access, and microcredit schemes. *Oportunidades* provides conditional cash transfers to more than 4 million families, representing around one quarter of the population of Mexico, in exchange for regular school attendance by children, preventive health clinic visits and nutritional support.
28. *Kenya* is also implementing a cash transfer programme, on a limited scale so far, that promises to facilitate the achievement of MDGs 1, 2 and 3 as well as to support the most vulnerable children, including orphans. The programme currently reaches 10,000 children in 17 districts. It is expected to cover 30,000 children in 2008 and to expand tenfold by 2010.
29. *Malawi* has also worked strongly towards achieving MDG 1 by introducing a country-wide voucher scheme for fertilizer and improved seeds. Despite some challenges, this programme has led to a substantial increase in fertilizer use by smallholder farmers and a doubling of yields. Malawi is now the only food-exporting country in the Southern Africa region – having achieved a complete reversal of its traditional role as food importer. The programme has demonstrated the feasibility of rapid, large increases in agricultural productivity among smallholder farmers in Africa, especially when supported by measures to enhance access to markets so the farmers can earn reasonable returns to encourage reinvestment in the sector. *Nigeria* and *Ghana* have introduced their own school feeding and health initiatives that seek to achieve interconnected objectives in education and agricultural productivity by buying locally grown foods.
30. Many of the least developed countries have registered marked progress towards achieving MDGs 2 and 3. The abolition of school fees, often with bilateral donor and United Nations support, has been demonstrated to be a strategic quick-impact initiative by several African countries. Under the *School Fee Abolition Initiative*, for example, a number of African countries have significantly increased primary school enrolment rates by abolishing fees. This measure has proved especially powerful in boosting girls' enrolment and has been key in getting children affected by HIV/AIDS into school.
31. *Lebanon* dropped all registration fees for the preschool and primary cycles in 2003 and reduced the price of school books by 35 per cent in the basic education cycle and 45 per cent in the secondary cycle. These measures were complemented by legislative efforts, including alternative educational and rehabilitation measures that avoid incarcerating children in conflict with the law.
32. In *Chile*, the *Junta Nacional de Auxilio Escolar y Becas* programme (National Board for School Aid and Scholarships) uses a 'national educational vulnerability index' to provide an integrated package of services to identified children, including school feeding, school health and nutrition, scholarships, transport services and learning and recreational materials. The programme has seen a reduction in dropout rates (from 15 per cent in 1991 to 7.6 per cent in 2005) and has stabilized attendance. It has also contributed to improved nutritional status among school-age children.

33. Many of the successful national programmes that address child mortality (MDG 4) also combine services towards improving the nutritional status of children (MDG 1), improving maternal health (MDG 5) and combating HIV/AIDS, malaria and other diseases (MDG 6). However, it is possible to identify some specific programme interventions that are making a highly positive impact on the achievement of these health-related MDGs.
34. For example, exclusive breastfeeding for the first six months of life has the potential to avert 13 per cent of all under-five deaths in developing countries, making it the most effective single preventive method of saving children's lives. Nearly 40 per cent of all infants up to 6 months of age in the developing world are exclusively breastfed. The proportion has been increasing, particularly in sub-Saharan Africa, where it rose by more than one third over the 1996–2006 period, and in the CEE/CIS countries, where it almost doubled – though from a very low base.^v The strategy for scaling up has included a breastfeeding policy routinely communicated to health care staff, together with training for implementation; context-specific communication approaches that inform all pregnant women of the benefits of breastfeeding and how to carry it out successfully; and fostering the establishment of breastfeeding support groups to which mothers can be referred on discharge from a health facility.^{vi}
35. Measles and malaria campaigns across Africa have been intensified with the support of partners including the International Federation of Red Cross and Red Crescent Societies, UNICEF, the United States Centers for Disease Control and WHO. Successful measles vaccination campaigns have been coupled with free distribution of long-lasting insecticide-treated mosquito nets in many countries. There have also been promising 'keep up' campaigns to ensure continued effective use of the nets. The campaign against measles has been a remarkable success, most notably in Africa, where deaths due to measles decreased by some 75 per cent between 1999 and 2005.
36. Scaling up the distribution and use of insecticide-treated nets has been instrumental in reducing the incidence of malaria and young child deaths. Increasing their use in *Ghana* is part of a broader High Impact Rapid Delivery Programme, which comprises a package of cost-effective health and nutrition interventions, implemented to achieve MDGs 4 and 5 and elements of MDG 6. The package includes immunization, vitamin supplementation, exclusive breastfeeding, complementary feeding, use of insecticide-treated mosquito nets and treatment of malaria. Use of mosquito nets among children under 5 in Ghana jumped from some 4 per cent in 2003 to 22 per cent in 2006.
37. *Ethiopia* has also used innovative strategies to deliver preventive services and high-impact curative interventions towards MDG 4. The country distributed some 18 million insecticide-treated nets for families living in malaria-prone areas within a two-year period. It has also achieved rapid advances in immunization coverage, establishment of community health posts, treatment of malaria with artemisinin-based combination therapy and the assignment of health extension workers to provide preventive and promotive services at the community level.
38. In the *Philippines*, local government authorities are pursuing decentralized and targeted planning for the MDGs, including through the devolved health sector reform process. This process benefits from the use of a scorecard system as a targeting device and as a basis for local advocacy for the MDGs. These efforts are supported by sub-national MICS surveys, which have been carried out in 24 provinces and cities so far. The DevInfo tool

(formerly ChildInfo) has enabled the consolidation of a wide range of previously fragmented data and reporting from household surveys and other sources such as the health service information system. This information will be used as a basis for pursuing full coverage for key services such as community health and nutrition workers. It is hoped that local successes here will yield lessons that can inform national programmes.

39. In many countries, the majority of interventions required to reach MDGs 4, 5 and 6 can be administered by community health workers after short periods of training. Provided they are paid and their work is integrated with national health systems, these workers can make tremendous contributions towards meeting the health-related MDGs and reducing human resource bottlenecks. Since they can be deployed relatively quickly and are not subject to 'brain drain', community health workers are an ideal 'quick impact' initiative that could complement support for professional health cadres, such as the nurses and doctors in *Malawi* being supported by development partners. Countries such as *Mozambique* and *Ethiopia* are now implementing or expanding their national community health worker programmes.
40. *Cambodia's* Child Survival Strategy entails the provision of 12 cost-effective (or 'scorecard') interventions that have the greatest impact on reducing the mortality of children under five. Targets include 60 per cent for early initiation of breastfeeding, 95 per cent for complementary feeding and 95 per cent for malaria treatment. In *Kyrgyzstan*, the policy of providing free services to pregnant women and children under five years old is also expected to have major benefits for the health and well-being of families living below the poverty line.
41. Analysis shows that maternal mortality is one of the health outcomes most heavily dependent on skilled health workers, and achievement of MDG 5 therefore requires investments in health professionals. Focusing on mid-level providers is an effective strategy to increase coverage, as shown in many countries. In *Malaysia*, *Sri Lanka*, *Thailand* and most countries that have reduced maternal mortality, the sharp decline in maternal deaths has been attributed to having professional midwives assist deliveries; while in *Tunisia*, increasing skilled attendance at birth was central to maternal mortality reduction. Other non-specialist providers also helped in the provision of emergency obstetric care. National programmes in *India*, with the help of professional medical associations, focused on training of general practice physicians in emergency obstetric care to perform Caesarean sections and to give anesthesia. In the *United Republic of Tanzania*, *Malawi* and *Mozambique*, mid-level providers, including assistant medical officers, clinical officers and surgical technicians, were trained to provide emergency obstetric care, including Caesarean sections. In *Mozambique* this strategy was found to be more cost-effective than focusing on specialists while providing comparable levels of quality. These are examples with strong potential for scaling up.
42. Several country-specific studies have found that the investment in family planning needed to avert just one unintended birth yields monetary savings several times greater than the cost.^{vii} Investment in family planning programmes has contributed to reductions in maternal mortality in a number of countries. In *Bolivia*, *Egypt* and *Thailand*, addressing the unmet need for contraception resulted in reduction of overall maternal mortality by 20 per cent to 35 per cent.
43. Scaling up programmes to combat HIV appears to have been the hardest. Challenges in scaling up treatment and care to people living with HIV and AIDS are widespread in the developing world. In sub-Saharan Africa, where 85 per cent of HIV-infected pregnant

women live, coverage of programmes to prevent mother-to-child transmission of HIV in countries ranges from less than 1 per cent to 54 per cent – far less than what is needed to meet the agreed targets.^{viii}

44. *Botswana*, together with its supporting partners, has implemented successful approaches in scaling up provision of care and treatment for people affected by HIV and AIDS. By September 2006, some 74,000 Botswana living with HIV had started treatment. Of these, about 18 per cent were accessing treatment through the private sector.^{ix} Testing uptake among pregnant women attending antenatal care services increased from 79 per cent in 2004 to 92 per cent in 2006. This is believed to be a result of introducing routine HIV testing in 2004. The Botswana programme to prevent mother-to-child transmission is now one of the most effective in the developing world. Results of tests carried out between November 2006 and February 2007 indicate that less than 4 per cent of babies born to HIV-positive mothers were infected – a rate comparable with the United States and Western Europe.^x
45. The *Niger* afforestation program in support of MDG 7 has been credited with tremendous national-scale results in terms of increased tree coverage, higher soil fertility and moisture, and the slowing of deforestation. It appears to hold the promise of being a replicable and sustainable programme at national scale.
46. The difficulties faced in moving towards the sanitation target are due not to lack of technology nor entirely to funding shortfalls. They also lie in developing effective approaches to influence behaviour patterns on a large scale. Adapted variations of the ‘total sanitation approach’ that originated in *Bangladesh* are being promoted. These stress intensive mobilization efforts to reduce open defecation in communities and assist families to find solutions such as low-cost locally built latrines. In *India* there are indications that rural sanitation progress is rapidly accelerating – with coverage increased from 22 per cent in 2001 to 49 per cent in 2007 – due in part to the adoption of the total sanitation approach by national and state governments with support from the United Nations and other partners. This includes both the nationally funded Total Sanitation Campaign as well as the *Nirmal Gram Puraskar* (Clean Village Award). This is resulting in an exponential increase in villages without open defecation from tens in 2005 to thousands in 2007.
47. Examples of United Nations-supported national pilot initiatives to demonstrate new approaches in water supply are also numerous. *Egypt*, for example, is developing a methodology for providing water to poor households in rural communities and slums through a revolving fund mechanism. *Madagascar* has developed a detailed water and sanitation strategy, tailored to local community needs, though it has not yet been fully implemented due to financing constraints. Successful national-scale programmes for water provision have also been undertaken in *Senegal* and *Uganda*, among others. The United Nations and regional development finance institutions are also jointly mobilizing investments in water and sanitation in slums and informal settlements in cities such as Accra, Addis Ababa, Dakar, Dar es Salaam, Kampala and Lusaka. The United Nations provides a package of pre-investment interventions designed to build institutional arrangements among community organizations, private utility companies and local governments. These increase the capacity of local actors to use sizable investments from financing agencies.
48. Under MDG 8, innovative approaches are also being developed to improve aid predictability and reduce volatility in aid disbursements in concert with the aims of the

2005 Paris Declaration on Aid Effectiveness. For example, the United Kingdom, through its Department for International Development, has articulated and is implementing a clear timetable to reach the goal of 0.7 per cent of GNI being channelled to official development assistance by 2013. This is being done through country-level plans aimed at assisting recipient countries to develop medium-term expenditure frameworks for multi-year projects and programmes. Similarly, other European Union countries are developing 'MDG Compacts' that will provide a framework for multi-year development assistance programming. Nevertheless, survey data from the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD/DAC) indicate that cross-country scaling-up of aid flows, consistent with channelling 0.7 percent of GNI to ODA and the Gleneagles commitments by G8 governments, have not yet been realized.

IV. THE WAY FORWARD: A COLLECTIVE SENSE OF URGENCY

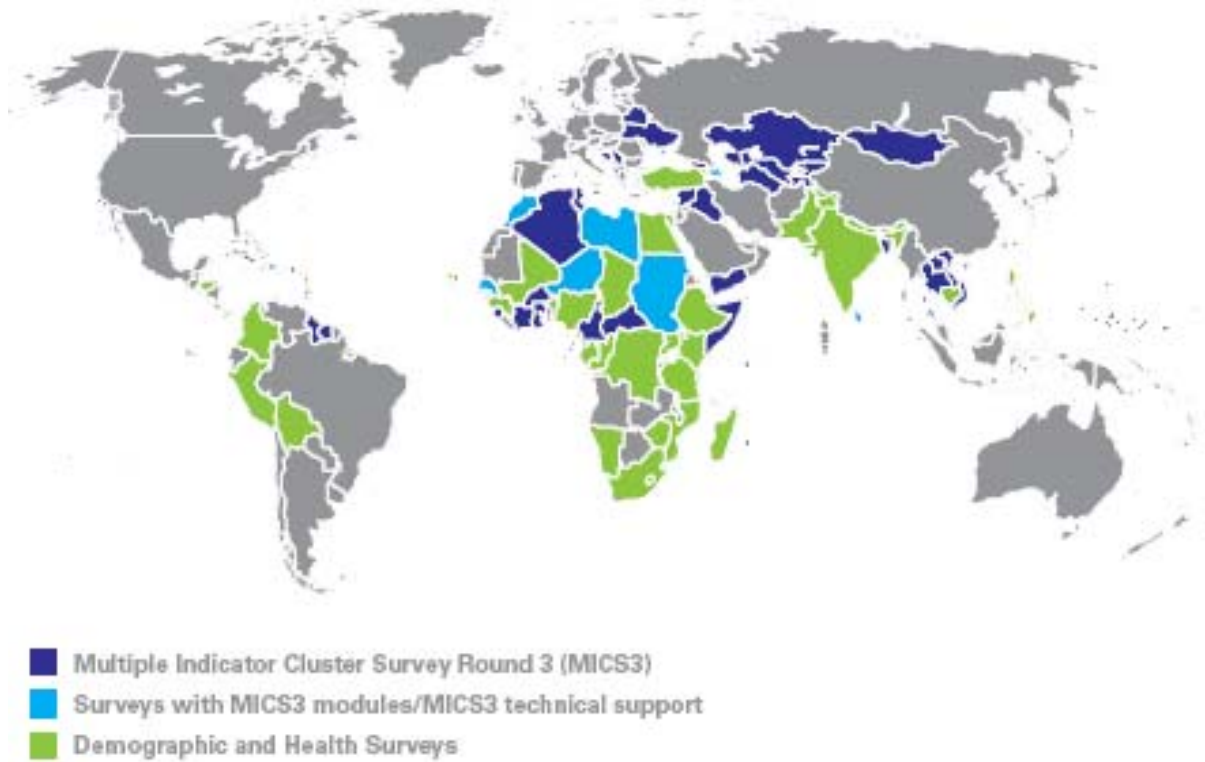
49. A few key insights emerge from the review of data and examples of successful programmes outlined above. First, the stock of knowledge and experience on strategies and designs that can work effectively for achievement of the MDGs – in an integrated way and across sectors – has continued to grow since the Millennium Declaration was adopted by the United Nations General Assembly in 2000. Partners have built a clear understanding of the kinds of interventions that can help achieve the MDGs at the international, national and local levels. In a number of cases these interventions have now been implemented at national scale. As a result, the organizational challenges faced in scaling up these interventions, and the means of overcoming them, are broadly understood. Complex challenges of capacity bottlenecks – for example, in scaling up critical programme interventions while including the most marginalized families and population groups – are gradually being tackled in more innovative ways, drawing on inter-country experience.
50. Second, many of the examples of national action outlined in this paper provide promising cases for adaptation in countries and regions. Such interventions can be implemented in a cost-effective and scaled-up manner, within MDG-oriented national budgets and existing donor commitments for ODA, should these commitments be fulfilled. The United Nations system, working closely together with bilateral donors and the international financing institutions, can provide vital support to this process of scaling up – including through more effective support, where needed, to improve national capacities for service delivery, infrastructure development, policy analysis and monitoring.
51. Third, the commitment at both national and international levels to internationally agreed development goals is strong and rising. Unfortunately, recent OECD/DAC data show that financing for development has barely risen since 2004, especially when excluding one-off debt relief, financing for 'geopolitical crises' and humanitarian assistance, which do not support long-term development. In addition, existing ODA financing is spread very unevenly across countries.
52. While recent progress has been significant in many areas, it has also been highly uneven among the Goals and indicators, as seen in the most recent data, outlined in section 1. *A collective sense of urgency is required if the Millennium Development Goals are to be met.* Even in the countries and regions showing the most rapid gains, significant disparities and inequalities (relating to gender, location, ethnicity or other factors) very often remain. To translate the MDGs into a truly universal achievement, they need to be reached at all levels; a situation in which broad national successes obscure pockets or issues of local exclusion is unacceptable. More countries, using increasingly good

disaggregated data on the status of each MDG, are now adopting strategies – often of a participatory nature – to address such inequalities.

53. In looking forward to 2015 and beyond, scaling up efforts to achieve and sustain the MDGs can be strongly reinforced by improvements in data and monitoring. Proven approaches include the use of Multiple Indicator Cluster Surveys, Demographic and Health Surveys and sector-based systems; strengthening of data management, including through national adaptations of DevInfo; consolidation and public discussion of data through local monitoring mechanisms such as MDG scorecards; and the use of information to identify priority groups and actions.
54. The identification of gaps and bottlenecks, which should also consider critical protection and human security challenges, needs to be linked to proven, innovative actions. The range of well-documented actions is now extensive. It includes, as seen above, cash transfer programmes, agricultural production incentives, school feeding and fee abolition, promotion of exclusive breastfeeding, immunization, distribution of insecticide-treated mosquito nets, appropriate use of community health workers and skilled birth attendants, the introduction of routine HIV testing, ‘total sanitation’ approaches and public-private partnerships for water supply, among others. Building a national consensus on immediate actions to address the MDGs should be supported by cooperating partners as needed, and reflected in poverty reduction strategies, medium-term expenditure frameworks and sector-wide approaches.
55. The collective sense of urgency about achieving the Millennium Development Goals, already evident among governments and families in all regions, must now be heightened further. As illustrated by this paper, the tools needed to achieve the MDGs are widely known. There are excellent examples of how to use these tools at the national level, and existing global financing commitments, if realized, should be adequate to support national-scale efforts in every region that requires them. The agencies of the United Nations system, operating with greater coherence, look forward to working with partners under national leadership to help achieve the major acceleration of progress that is needed.

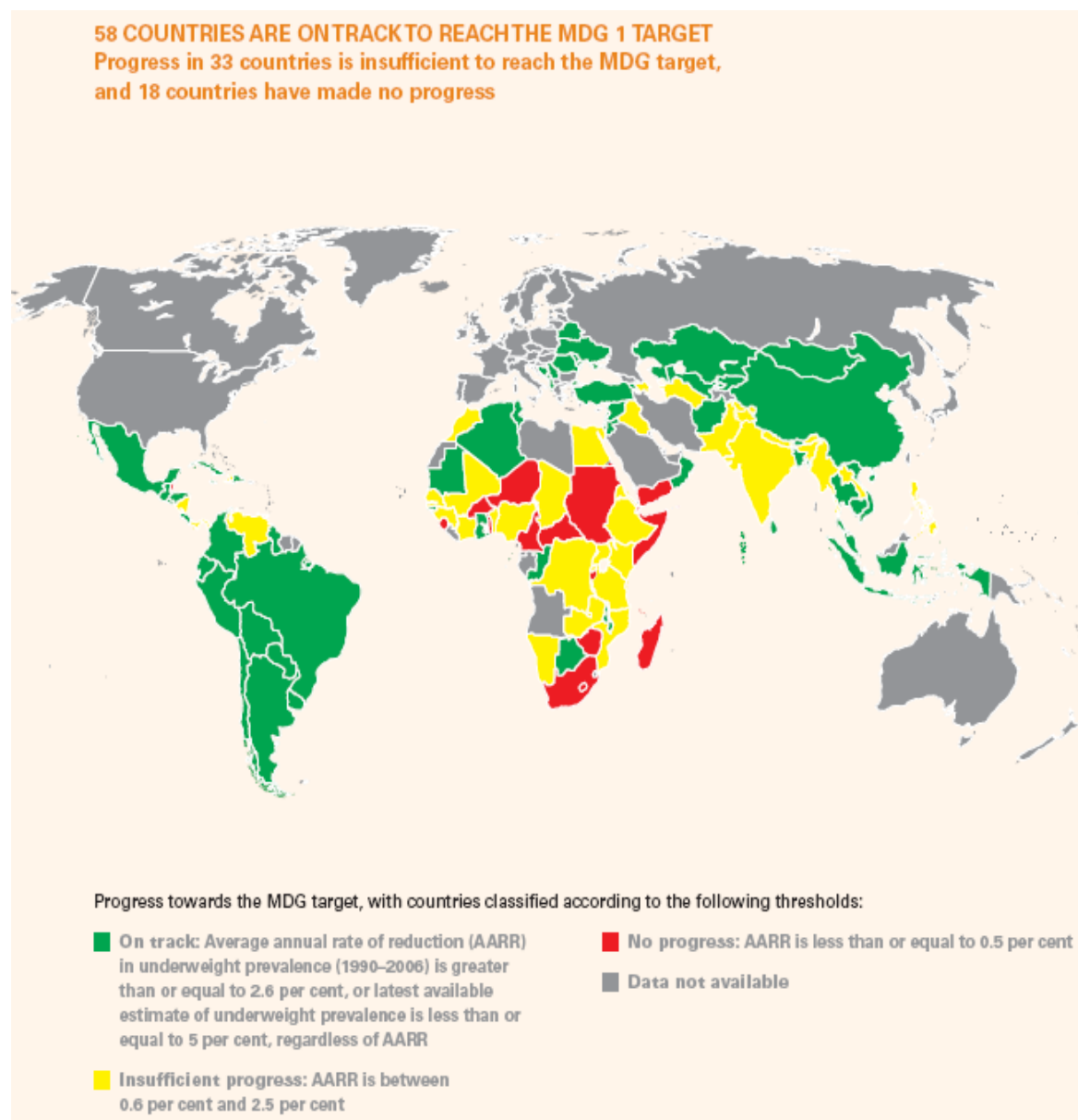
Annex 1: Countries taking part in recent national household surveys*

HOUSEHOLD SURVEY ACTIVITY (2003–2006)



*Note that the source for all graphs presented in these annexes, except for annex 11, is *Progress for Children – A World Fit for Children Statistical Review*, UNICEF, New York, 2007.

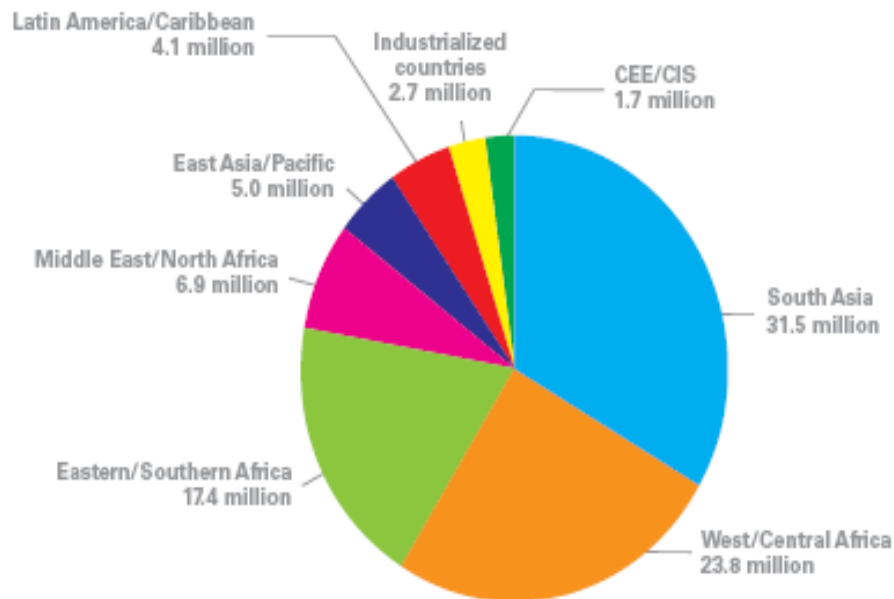
Annex 2: Progress towards MDG 1



Annex 3: Progress towards MDG 2

93 MILLION CHILDREN OF PRIMARY SCHOOLAGE ARE OUT OF SCHOOL

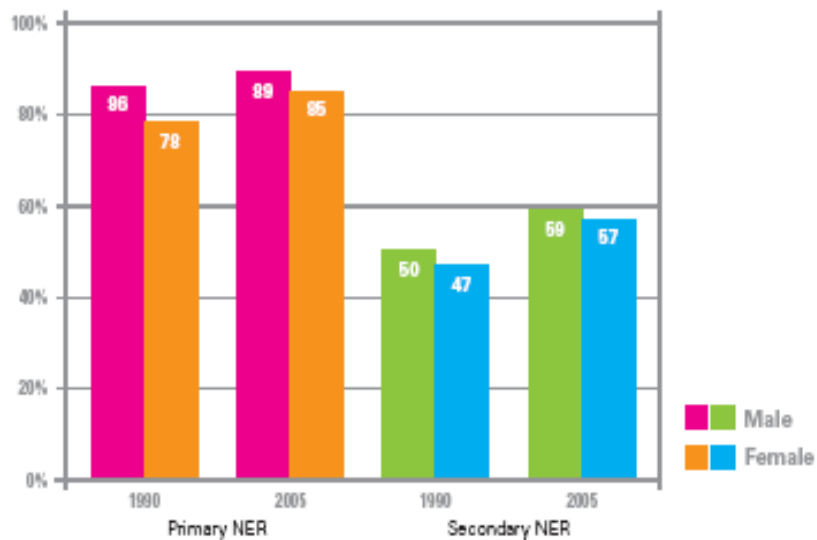
Number of primary-school-age children not in school, by region (2006)



Annex 4: Progress towards MDG 3

THE GENDER GAP IN EDUCATION IS DIMINISHING WITH INCREASED ENROLMENT

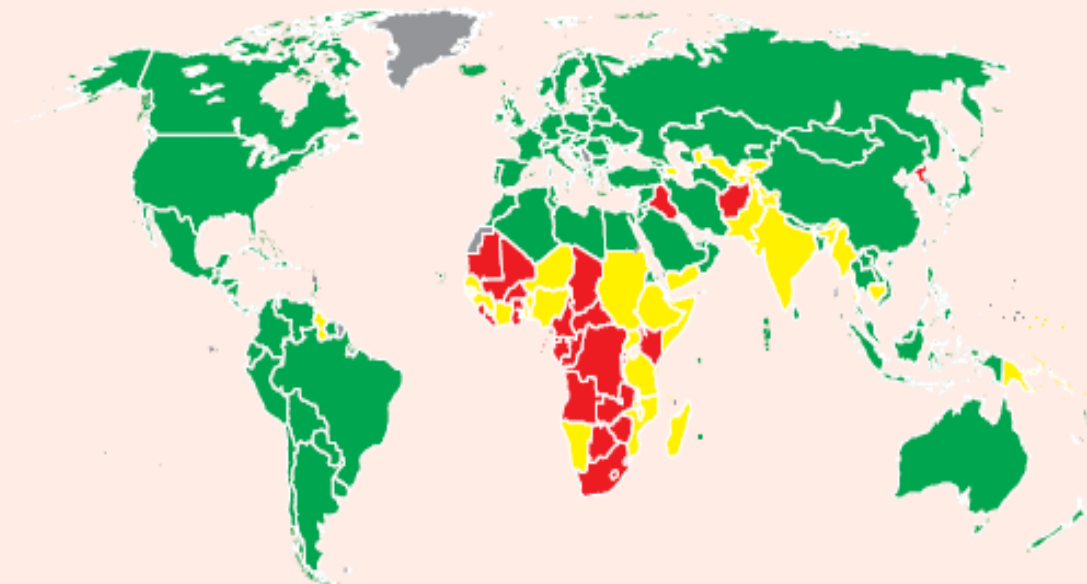
Primary and secondary net enrolment ratios (NER) of boys and girls (1990 and 2005)



Annex 5: Progress towards MDG 4

PROGRESS TOWARDS MDG 4 NEEDS TO ACCELERATE IN SUB-SAHARAN AFRICA AND SOUTH ASIA

Yet, many countries throughout the world are on track to reach the target



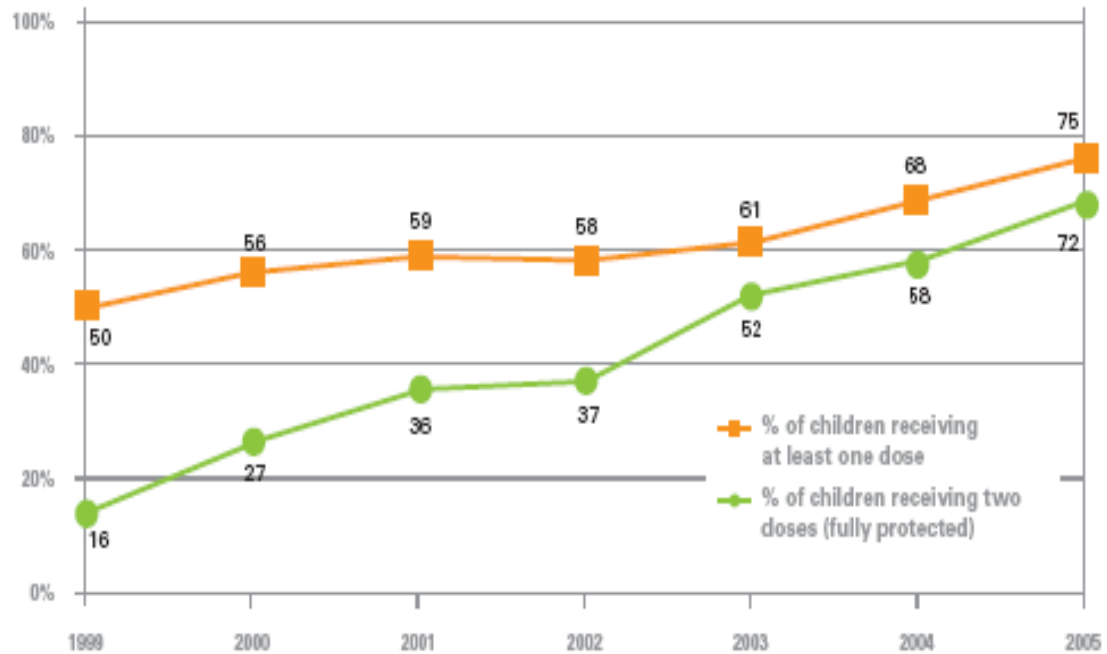
Progress towards MDG 4, with countries classified according to the following thresholds:

- On track: U5MR is less than 40, or U5MR is 40 or more and the average annual rate of reduction (AARR) in the under-five mortality rate observed for 1990–2006 is 4.0 per cent or more
- Insufficient progress: U5MR is 40 or more and AARR is between 1.0 per cent and 3.9 per cent
- No progress: U5MR is 40 or more and AARR is less than 1.0 per cent
- Data not available

Annex 6: Trends in vitamin A supplementation

MORE THAN A FOURFOLD INCREASE IN THE PROPORTION OF CHILDREN FULLY PROTECTED WITH TWO DOSES OF VITAMIN A

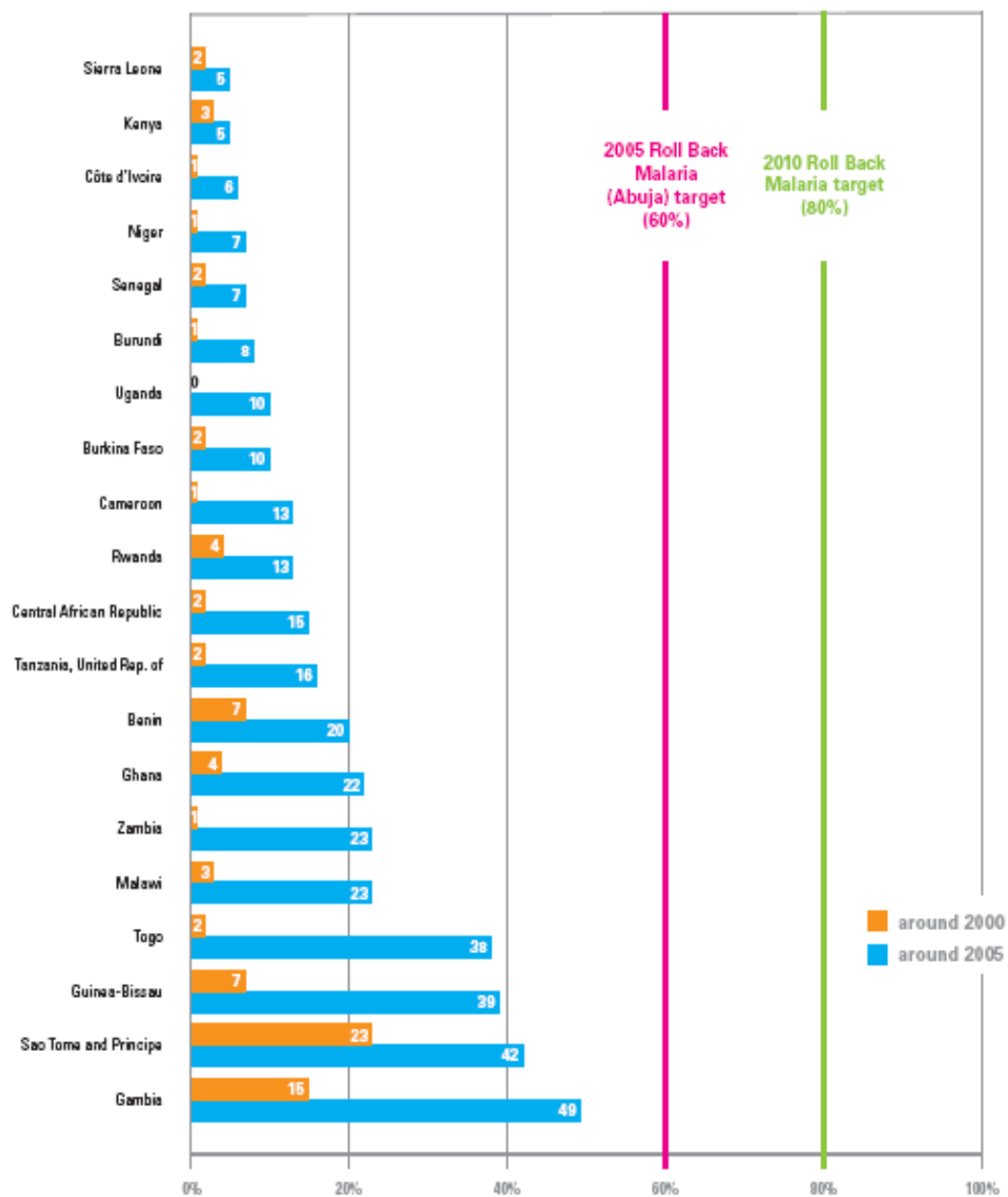
Global trends in vitamin A supplementation coverage (1999–2005)



Annex 7: Use of insecticide-treated mosquito nets

SUB-SAHARAN COUNTRIES ARE MAKING RAPID PROGRESS IN SCALING UP THE USE OF INSECTICIDE-TREATED NETS

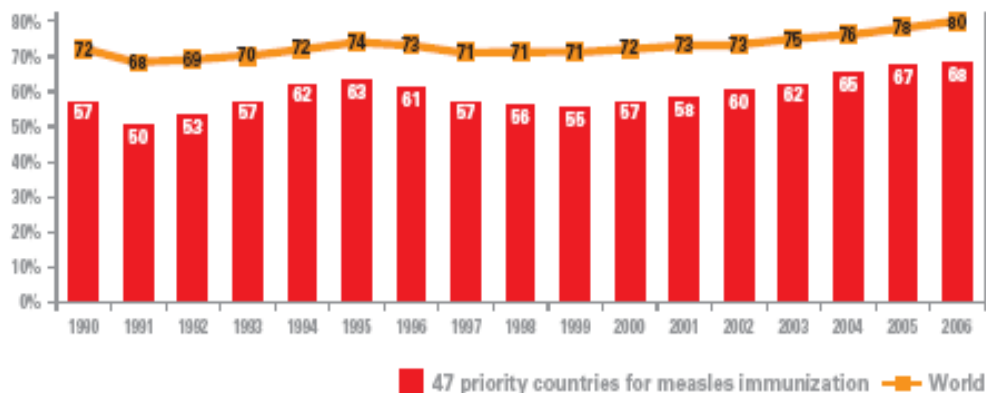
Percentage of children under five sleeping under insecticide-treated nets, all sub-Saharan countries where trend data were available (around 2000 and 2005)



Annex 8: Measles immunization coverage

MEASLES IMMUNIZATION COVERAGE HAS INCREASED STEADILY SINCE 1990 IN 47 PRIORITY COUNTRIES AND WORLDWIDE

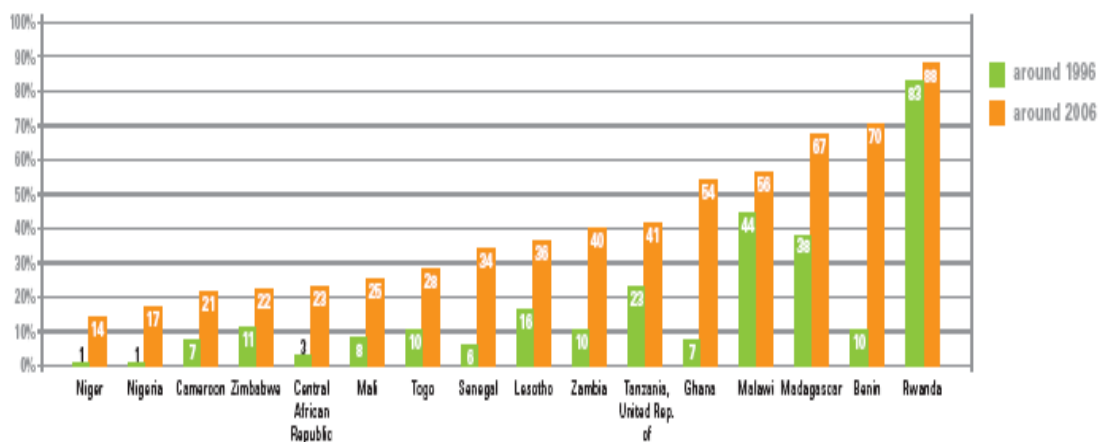
Trends in first-dose coverage of measles-containing vaccine (MCV; 1990–2006)



Annex 9: Increase in exclusive breastfeeding in sub-Saharan Africa

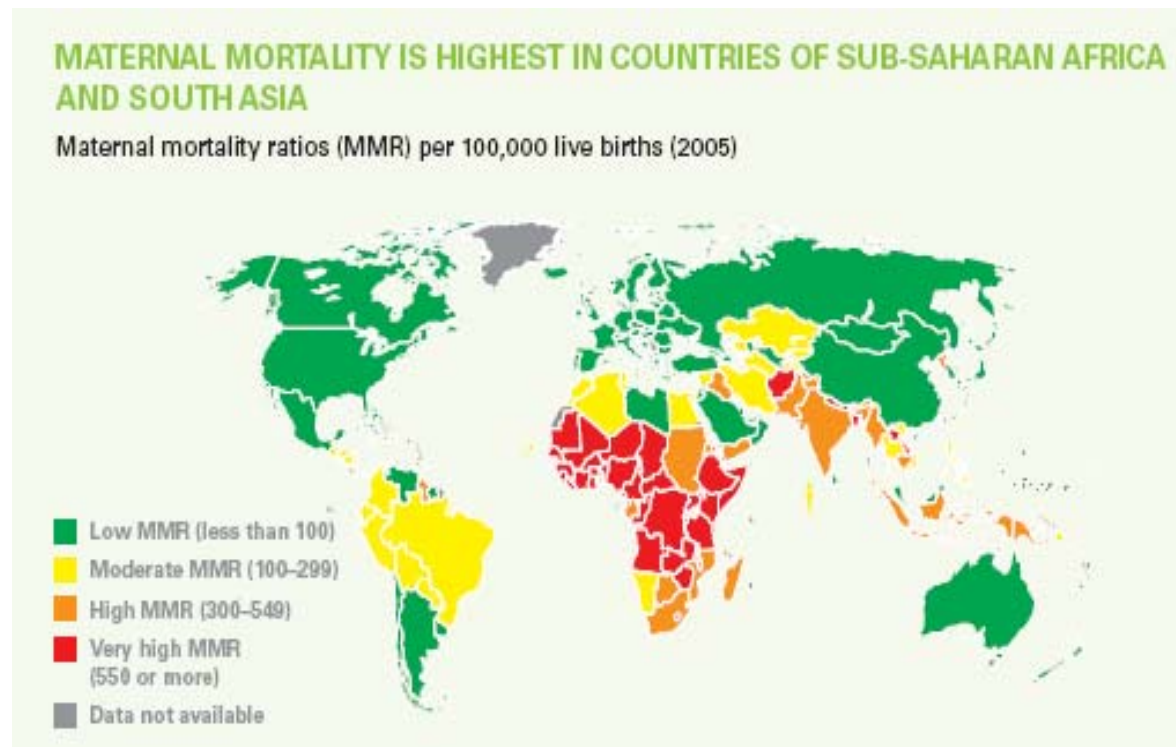
SIGNIFICANT INCREASES IN EXCLUSIVE BREASTFEEDING IN 16 SUB-SAHARAN AFRICAN COUNTRIES Seven countries posted gains of 20 percentage points or more

Percentage of infants exclusively breastfed for the first six months of life (around 1996 and around 2006)



Note: The chart includes countries with at least three data points in the time series, an average annual rate of change that is higher than 1 per cent (except Rwanda) and a current exclusive breastfeeding rate of more than 10 per cent.

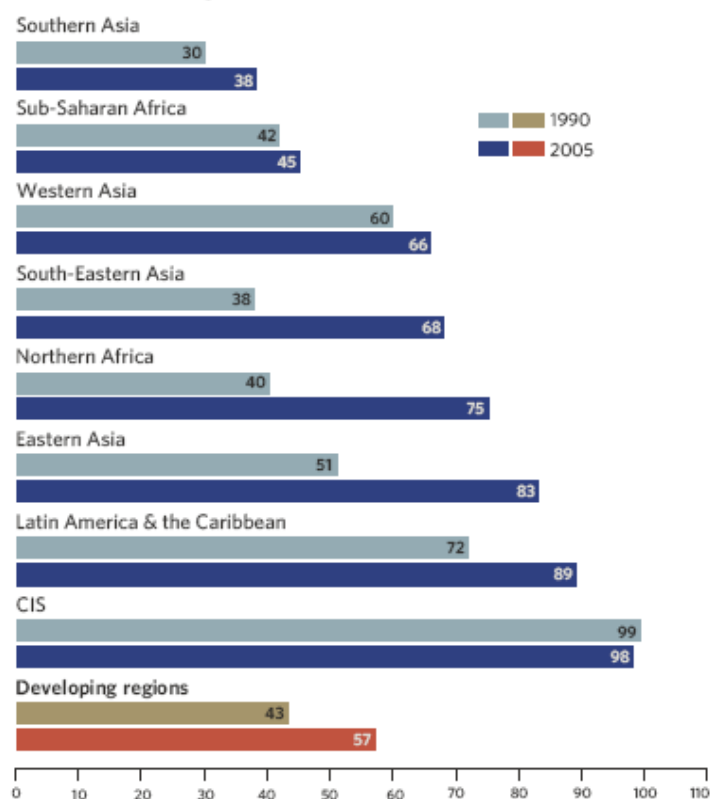
Annex 10: Maternal mortality ratio by country



Annex 11: Proportion of deliveries attended by skilled personnel

Health-care interventions can reduce maternal deaths, but need to be made more widely available

Proportion of deliveries attended by skilled health care personnel, 1990 and 2005 (Percentage)



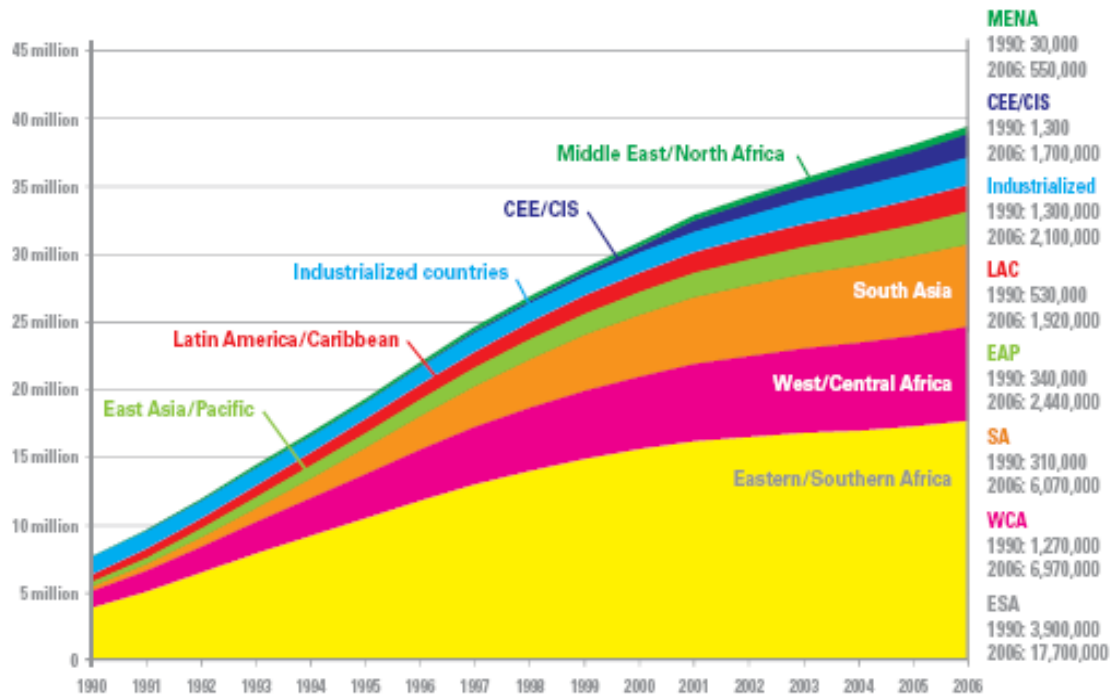
Source: United Nations 2007, "Millennium Development Goals Report 2007", United Nations, 2007.

Annex 12: People living with HIV

NOTE: these data are based on estimates as of 2006 and do not reflect the 2007 estimates made using a revised methodology.

SUB-SAHARAN AFRICA HAS THE MOST PEOPLE LIVING WITH HIV

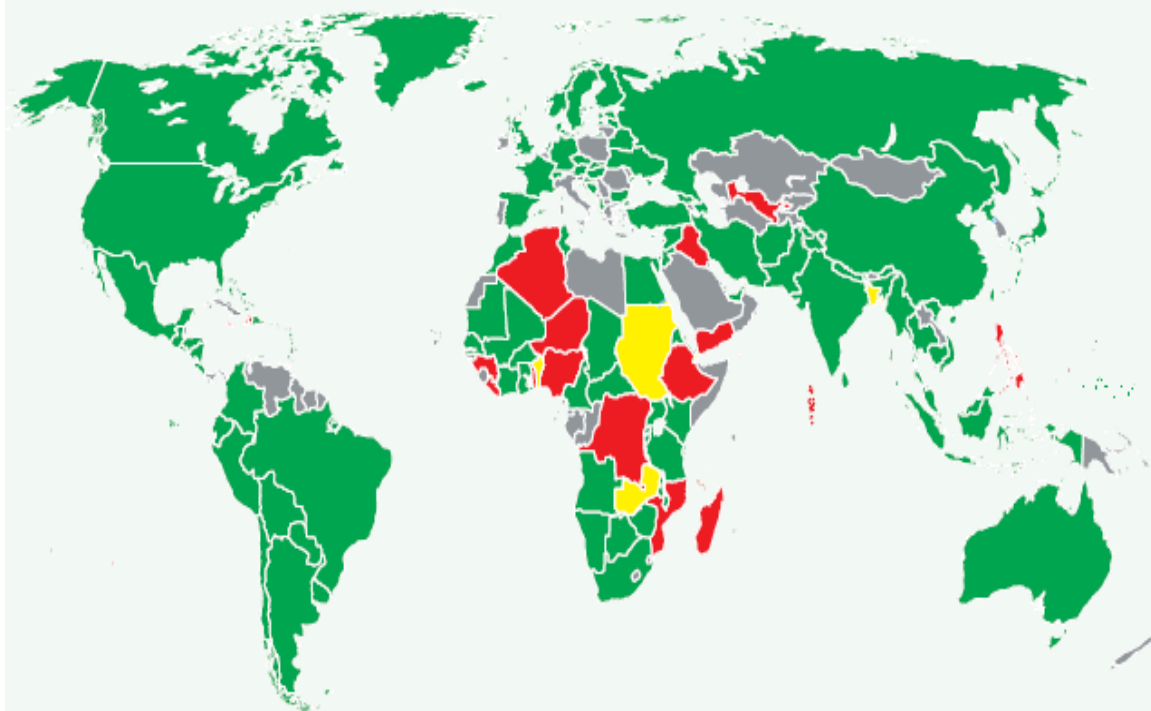
Estimated number of people living with HIV, by region (1990–2006)



Annex 13: Access to safe drinking water

76 DEVELOPING COUNTRIES ARE ON TRACK TO REACH THE MDG TARGET ON SAFE DRINKING WATER

Progress in 5 developing countries has been insufficient to reach the target, and 23 developing countries have made no progress

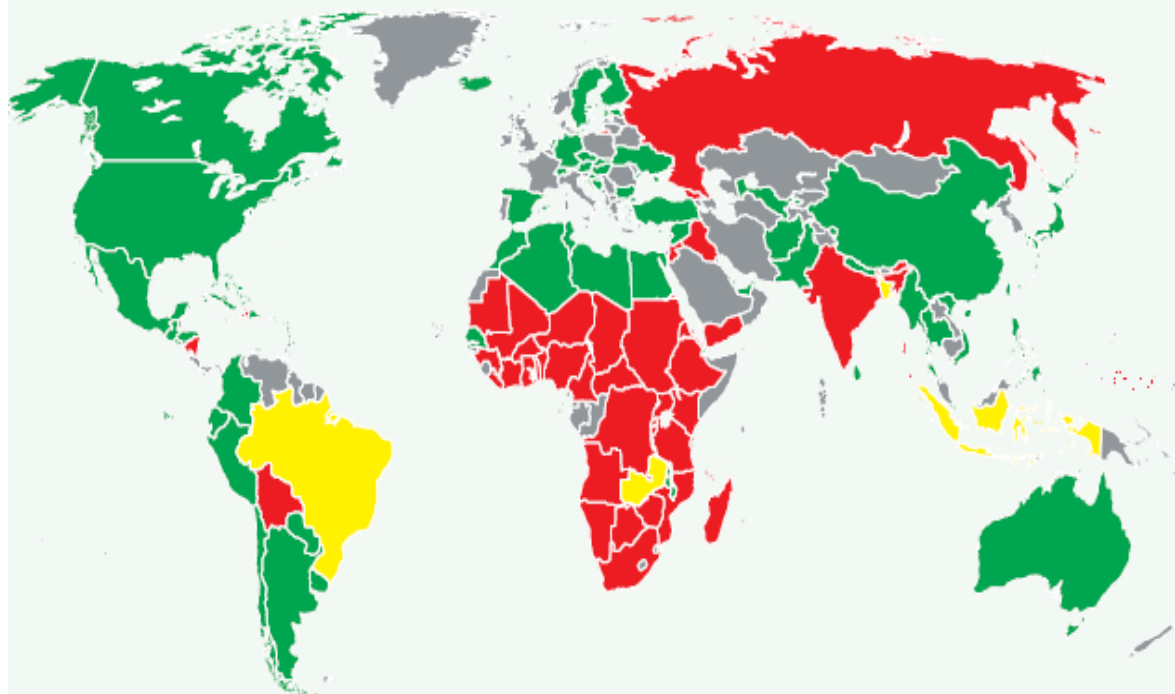


Progress towards the MDG target, with countries classified according to the following thresholds:

- | | |
|---|---|
| ■ On track: Use of improved sources of drinking water in 2004 was less than 5 per cent below the rate needed for the country to reach the MDG target, or use was 95 per cent or higher | ■ No progress: Use of improved sources of drinking water in 2004 was more than 10 per cent below the rate needed for the country to reach the MDG target, or the 1990–2004 trend shows unchanged or decreasing use |
| ■ Insufficient progress: Use of improved sources of drinking water in 2004 was 5 per cent to 10 per cent below the rate needed for the country to reach the MDG target | ■ Data were insufficient to estimate trends |

Annex 14: Access to basic sanitation

51 DEVELOPING COUNTRIES ARE ON TRACK TO REACH THE MDG TARGET ON BASIC SANITATION
Progress in 4 developing countries has been insufficient to reach the target,
and 41 developing countries have made no progress



Progress towards the MDG target with countries classified according to the following thresholds:

- | | |
|---|---|
| ■ On track: Use of improved sanitation facilities in 2004 was less than 5 per cent below the rate needed for the country to reach the MDG target, or use was 95 per cent or higher | ■ No progress: Use of improved sanitation facilities in 2004 was more than 10 per cent below the rate needed for the country to reach the MDG target, or the 1990–2004 trend shows unchanged or decreasing use |
| ■ Insufficient progress: Use of improved sanitation facilities in 2004 was 5 per cent to 10 per cent below the rate needed for the country to reach the MDG target | ■ Data were insufficient to estimate trends |

Endnotes

ⁱ New data on progress towards the Millennium Development Goals is published in *Progress for Children – A World Fit for Children Statistical Review*, UNICEF, New York, December 2007. These data may differ from those published in the recent United Nations Secretary-General's report *Children and the Millennium Development Goals: Progress towards A World Fit for Children* (2007), which was based on data available at the time of preparation. In addition, some estimates relating to HIV and AIDS have recently been recalculated by UNAIDS, using different statistical methods compared with the past.

ⁱⁱ This is the agreed framework adopted by the African Union Assembly in 2003 as a basis for resuscitating agriculture, food and nutrition security in Africa.

ⁱⁱⁱ UNAIDS/WHO, *2007 AIDS Epidemic Update*, pp. 3-4; 9-12. This finding is different from that reported in the 2007 *Progress for Children* report, which states that the number of people living with HIV worldwide has continued to rise. At the time of writing the *Progress for Children* report, the new HIV and AIDS estimates were not available. Due to changes in methodologies, the 2007 AIDS estimates are significantly lower than the 2006 numbers found in *Progress for Children*. The differences between estimates published in 2006 and in 2007 are due to refinements in methodology, rather than trends in the pandemic itself, and are therefore not comparable. However, the qualitative interpretation of the severity and implications of the pandemic have altered little.

^{iv} This is a reduction of 16 per cent compared with the estimate of 39.5 million published in 2006. Methodology revisions in India and sub-Saharan Africa have contributed to this reduction.

^v For details see *Progress for Children – A World Fit for Children Statistical Review*.

^{vi} For details see http://www.unicef.org/nutrition/index_breastfeeding.html.

^{vii} *Adding it Up: The benefits of investing in sexual and reproductive health care*, Guttmacher Institute, 2004

^{viii} <http://www.who.int/mediacentre/news/releases/2007/pr16/en/index.html>

^{ix} Botswana HIV/AIDS Response Information Management 2nd quarter report to the National AIDS Council, September 2006.

^x United Nations, *Children and the Millennium Development Goals: Progress towards A World Fit for Children*. Report of the Secretary-General of the United Nations, December 2007.