



**Joint Meeting of the Executive Boards
of UNDP/UNFPA, UNICEF and WFP
15 and 18 January 2010**

Stocktaking on the Millennium Development Goals

**Background document prepared jointly by
UNDP, UNFPA, UNICEF (co-ordinator) and WFP**

Introduction

1. This background document for the 2010 joint meeting of the Executive Boards of the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Food Programme (WFP) presents summary information on progress towards achieving the Millennium Development Goals (MDGs). It highlights initiatives that have achieved results and illustrates innovative strategies where the synergies among development partners under national leadership have made a significant contribution to accelerating and sustaining progress towards the Goals.

2. The Millennium Declaration set 2015 as the target date for achieving most of the MDGs, including the ambitious quantitative benchmark to halve extreme poverty in all its forms. As the date approaches, less than five years away, the world has found itself challenged by an economic crisis that is unprecedented in recent history in its severity and global dimensions. Progress towards the Goals is now threatened by sluggish – or even negative – economic growth, leading to diminished resources, fewer trade opportunities for developing countries and possible reductions in aid flows from donor nations. At the same time, the effects of climate change are becoming increasingly apparent, with a potentially devastating impact on many countries and communities. Today, more than ever, the commitment to building the global partnership for development embodied in the Millennium Declaration must guide our collective actions.

3. This paper has four sections: part I provides a summary of progress and an update on the challenges; part II presents success stories, innovative strategies and country examples; part III describes the contribution of the four agencies to the forthcoming high-level plenary meeting of the General Assembly for the MDG review in 2010; and part IV makes recommendations on how to move forward to realize the Goals.

I. Progress and update on the challenges

4. Regarding progress towards MDG 1 (eradicate extreme poverty and hunger), the percentage of the population living in extreme poverty in the developing regions accounted for slightly more than a quarter of the developing world's population in 2005, compared to almost half in 1990. In terms of actual numbers, the number of people in developing regions living in extreme poverty – defined as living on less than \$1.25 a day (2005 prices) – fell from 1.8 billion in 1990 to 1.4 billion in 2005. Regional trends can also be observed. For example, Eastern Asia has more than halved extreme poverty (from 36 per cent to 16 per cent) between 1997 and 2005. In contrast, during the same period, sub-Saharan Africa has reduced it only marginally, from 58 per cent to 51 per cent, although, with population growth, there has been an actual increase of 27 million people living in extreme poverty in that region.

5. The global financial and economic crisis has provided an additional challenge to maintaining this pace of progress against poverty. Although the overall poverty rates in the developing world were expected to fall in 2009, the number of people living in extreme poverty was

expected to increase by 55 to 90 million, partly due to the crisis.¹ High prices for food and energy, exacerbated by the global economic crisis, are also likely to have a significant negative impact on the proportion of working people living in extreme poverty. In all regions, economies have failed to provide full employment for young people. The prospects for the physical, social and economic access to safe, nutritious and affordable food by all people are worrisome. Several forecasts predict that food prices will remain volatile and continue to increase in years to come. Climate change is also expected to have a negative effect on food production in many developing countries. Natural disasters, political turmoil and conflicts have compounded these effects for millions of vulnerable people and families.

6. Progress towards the targets related to hunger is measured using two indicators. One indicator aims to assess the number of hungry people in the world, which has increased from 873 million in 2004–2006 to 1.02 billion during 2009 – the highest level ever – partly as a result of high food prices and the global financial and economic crisis. The other indicator used to assess progress is the percentage of children under the age of 5 who suffer from undernutrition, as indicated by being underweight, which has declined from 31 per cent in 1990 to 26 per cent in 2008. According to the latest estimates, 129 million children under 5 years of age are underweight and 195 million children are stunted. Some 63 countries (out of the 117 with available data) are on track to achieving the MDG 1 target of a 50-per cent reduction of underweight prevalence among children under 5 between 1990 and 2015.

7. Regarding progress towards MDG 2 (achieve universal primary education), the number of children of primary-school age who are out of school has declined markedly in recent years, yet upwards of 72 million children around the world – about half in sub-Saharan Africa – remain out of school. Unequal opportunities resulting from biases based on gender, ethnicity, income, language or disabilities represent major obstacles to universal education. In developing countries, children in the poorest 20 per cent of the population are three times less likely to be enrolled in primary school than children in the wealthiest 20 per cent.

8. One in six children of secondary-school age attending primary school started school late or had to repeat grades. These children are effectively occupying places that could accommodate children of primary-school age currently out of school. This underlines inefficiencies within education systems that need to be addressed. For countries that have exceeded the threshold of 90 per cent of children enrolled in primary school, reaching the last 10 per cent of children out of school will continue to be a particular challenge, often requiring innovative strategies as well as concerted effort and investment. Although public investment in education has been increasing, it is still low compared to what is needed for quality education to reach all children. External aid constitutes a significant proportion of total public expenditure on education. The financing gap, previously estimated at around \$11 billion annually will need to be revised significantly upwards, reflecting the implications of past shortfalls as well as the additional cost of reaching the most marginalized children.

9. Regarding MDG 3 (promote gender equality and empower women), progress has been made, but inequalities due to gender continue to be seen, based on (and also beyond) the core indicators included in the MDGs. Access to financial resources, unequal power relations,

¹ *The Millennium Development Goals Report 2009*, the United Nations, July 2009.

discrimination and stigma, gender stereotypes and violence all contribute to impede women's progress towards several MDGs. In 2007, the proportion of girls among the out-of-school population was 54 per cent. The gender gap in school enrolment has narrowed in the past 10 years, although at a very slow pace, with over 95 girls of primary-school age in school for every 100 boys in 2007, compared to 91 in 1999. Only 53 of the 171 countries with available data have achieved gender parity in primary and secondary education.² Girls from poor and rural households face higher barriers to education. Cultural attitudes and practices that promote early marriage, encourage seclusion of young girls or attach greater value to educating boys than girls create major barriers to assuring gender parity.

10. Women's political representation is slowly growing, with women holding close to 18 per cent of seats across all chambers of parliament in 2009, although one quarter of all parliament chambers still have less than 10 per cent female members. Parliamentary seats held by women in North Africa and Western Asia amount to less than 10 per cent, while it is more than 20 per cent in Latin America and the Caribbean. Women still make up the larger portion of the millions of illiterate adults in the world, and are more likely to have dropped out of school before completing the primary cycle. Women are more likely to be poor, have less access to medical care, property ownership and employment. Women are also less likely than men to be politically active and far more likely to be victims of abuse and violence. Paid employment for women continues to expand only very slowly and remains meager in many regions. Recent data suggest that women's unemployment is likely to continue to increase at a rapid pace, while the rate of increase of men's unemployment is slowing. The financial slowdown is now hitting female-dominated industries and services in some countries and may affect women more profoundly over the long term.

11. The MDGs should be important instruments to focus on girls and women, since they often shoulder the greatest burdens of extreme poverty, hunger and disease. Critical actions are needed to focus on overarching priorities for gender equality, including challenges to women's political representation, legal rights and the intolerable ongoing epidemic of violence against women and girls. A gender-equal environment for MDG realization needs to be established everywhere.

12. Substantial progress has been made towards MDG 4 (reducing child mortality). According to the new estimates generated by the Inter-agency Group for Child Mortality Estimation (IGME), 10,000 fewer children under the age of 5 died every day in 2008 than in 1990, the baseline year for the MDGs. The rate of decline increased for the period 2000–2008, compared with the 1990s (the average annual rate of decline for 2000–2008 was 2.3 per cent, compared to 1.4 per cent for 1990–2000). Still, this is still grossly insufficient to reach MDG 4 by 2015.

13. In 2008, some 8.8 million children born alive across the world died before their fifth birthday. Most of these children lived in developing countries, dying from a disease or a combination of diseases that could easily have been prevented or treated. Undernutrition contributes to over a third of these deaths. The child mortality rate in Central and Eastern European and the Commonwealth of Independent States is estimated at 23 per 1,000 live births, compared to 76 per 1,000 live births in South Asia. It is alarming that among the 67 countries with high mortality rates (more than 40 per 1,000 live births), only 10 are on track to meeting MDG 4. In addition, under-five mortality is increasingly concentrated: 75 per cent of the world's under-five deaths in 2008 occurred

² David Gartner, 'A Global Fund for Education: Achieving Education for All', *Brookings Policy Brief 169*, Brookings Institute, 2009.

in only 18 countries. Half of these deaths occurred in only five countries: China, the Democratic Republic of the Congo, India, Nigeria and Pakistan together account for nearly one third of the total number of under-five deaths worldwide. Africa and Asia combined represent 93 per cent of all under-five deaths (51 per cent and 42 per cent, respectively).

14. Regarding MDG 5 (improving maternal health), the world will fall well short of the target related to maternal mortality at the present rate of progress. The data suggest that to reach the target, the global maternal mortality ratio (MMR) would have had to be reduced by an average 5.5 per cent per year between 1990 and 2015. The current average rate of reduction is less than 1 per cent per year. The highest maternal mortality ratios are found in South Asia and sub-Saharan Africa. Six countries (Afghanistan, Bangladesh, the Democratic Republic of Congo, Ethiopia, India and Nigeria) account for half of all maternal deaths.

15. More than half a million women die each year because of complications related to pregnancy and childbirth. Of the estimated 536,000 maternal deaths worldwide in 2005, developing countries accounted for more than 99 per cent. About half of the maternal deaths (265,000) occurred in sub-Saharan Africa alone and one-third in South Asia (187,000). Thus, sub-Saharan Africa and South Asia accounted for 84 per cent of global maternal deaths, with haemorrhage the leading cause of death in these regions. The maternal mortality rate in East Asia and the Pacific is estimated at 150 per 100,000 live births, compared to 900 per 100,000 live births in sub-Saharan Africa. Sepsis, prolonged or obstructed labour, the hypertensive disorders of pregnancy, especially eclampsia, and complications of unsafe abortion claim further lives. These complications can occur without warning during pregnancy and childbirth. And for every woman who dies, approximately 20 more suffer injuries, infection and disabilities. Complications require immediate access to quality emergency obstetric services equipped to provide lifesaving drugs, antibiotics and transfusions and to perform Caesarean sections and other surgical interventions.

16. Regarding universal access to reproductive health by 2015 – second target for MDG 5 – indicators address family planning (contraceptive prevalence and unmet need for family planning); adolescent birth rate; and coverage of antenatal care. Contraceptive prevalence has increased in developing countries from 50 per cent to 62 per cent in developing regions, although unmet need has only declined from 14 to 11 per cent. In sub-Saharan Africa, contraceptive prevalence increased from 16 to 22 per cent since 1995, but unmet need has remained stable at nearly 25 per cent, with almost half of the monitored countries showing a higher unmet need than contraceptive use. Globally, some 215 million women want to avoid or delay another pregnancy but are not using a modern method of contraception. Adolescents' pregnancy rates remain high in countries where they have been historically elevated and their unmet need for family planning is higher than for older age groups. These indicators tend to show large differentials by wealth of the family. Access to family planning information and services impacts poverty reduction, education, gender equality, survival and environmental sustainability goals and targets.

17. While at least one antenatal visit is becoming extremely common, the recommended course of four visits remains less common, at around 50 per cent globally, particularly in resource-poor settings. This points to the need to emphasize a full continuum of care and strengthening health systems to provide services from pre-pregnancy to two years post-partum, and to women through their life cycle.

18. Regarding efforts to combat HIV and AIDS, malaria and other diseases (MDG 6), global HIV prevalence appears to have stabilized at 33.4 million in 2008, comprising 31.3 million adults and 2.1 million children under the age of 15.³ There were 2.7 million new infections in 2008, with 430,000 new infections occurring among children younger than 15 years of age. *Children and AIDS – Fourth Stocktaking Report, 2009* suggests that there has been a significant increase in comprehensive and correct knowledge about HIV and how to avoid transmission; yet an estimated 45 per cent of all new HIV cases in people aged 15 years or older were found among young people between the ages of 15 and 24.⁴ Overall, it is estimated that, in 2008, a total of 4.9 million young people aged 15–24 were living with HIV in low- and middle-income countries. Girls in sub-Saharan Africa are disproportionately vulnerable to HIV infection, particularly in ‘hyper-endemic’ countries in southern Africa, where prevalence is greater than 15 per cent. Two thirds of the 33 million people living with HIV in 2008 were in sub-Saharan Africa, most of them female. In 2007, an estimated 17.5 million children worldwide – nearly 14.1 million of them in sub-Saharan Africa – had lost one or both parents to HIV and AIDS.

19. Antiretroviral (ARV) regimens for the prevention of mother-to-child transmission of HIV (PMTCT) are now reaching nearly half of HIV-positive pregnant women globally. Coverage of HIV testing among pregnant women is 78 per cent in South Africa, 87 per cent in Botswana and 90 per cent in Namibia – all countries with high HIV prevalence. In 2008, 19 countries had reached coverage rates of 80 per cent for HIV testing and counselling among pregnant women in need of services to prevent transmission of HIV to their infants. Overall, 21 per cent of the estimated number of pregnant women living in low- and middle-income countries were tested for HIV (an increase from 13 per cent in 2006) and some 45 per cent of pregnant women living with HIV in these countries received ARV – including antiretroviral therapy for their own health – to prevent the transmission of the virus to their infants, up from 24 per cent in 2006. Improving the uptake of AIDS-related interventions requires enhancing health systems and linking them with communities. Behaviour change requires shared social norms that support safer behaviour endorsed by the community. Attention also needs to be given to ensuring that the family-planning needs of persons living with HIV/AIDS are addressed. Men and women should be able to voluntarily space or limit their childbearing according to their preferences, shaped by their life and medical conditions.

20. By the end of 2008, 9 out of the 39 countries with generalised epidemic had attained at least 40 per cent coverage of paediatric antiretroviral therapy (ART). Given new evidence suggesting that peak AIDS mortality in infants may come at a very young age – two to three months in one study – there is even more urgency for early infant diagnosis. Many countries are in the process of scaling up accordingly. In 2008, 83 of 123 reporting countries had the capacity to provide HIV viral testing to infants within two months of birth, up from 57 of 109 countries in 2007. In addition to improved access to early infant diagnosis and ART, other paediatric HIV care interventions have also been accelerated. Initiation of co-trimoxazole prophylaxis within two months of birth for HIV-exposed children increased, from an estimated 4 per cent reporting in 2007 to 8 per cent at the end of 2008, although still at a very low level.

21. Malaria is still a significant threat to nearly half of the world’s population – 3.3 billion people living in 109 countries are at risk of contracting the disease. The World Health Organization

³ 2009 AIDS Epidemic Update, UNAIDS and WHO, November 2009.

⁴ *Children and AIDS, Fourth Stocktaking Report, 2009*, joint UNICEF, UNAIDS, WHO and UNFPA publication.

(WHO) estimates that in 2006 there were between 190 and 330 million episodes of malaria.⁵ About 90 per cent of all malaria deaths occur in sub-Saharan Africa, mostly among children under five. In addition, it is a major cause of anaemia, low birth weight, premature birth, infant mortality and maternal deaths. Some 50 million pregnant women are exposed to malaria each year, with malaria in pregnancy contributing to nearly 20 per cent of low birth weight babies in endemic areas. Malaria in pregnancy can also lead to still birth and maternal death. Substantial increases were registered in the coverage of key interventions, notably insecticide-treated mosquito nets, rising from 2 per cent in 2000 to 20 per cent in 2006. Manufacturers' estimates indicate that more than 150 million nets were delivered to African countries between 2004 and 2008, and are available for use, out of the more than 340 million nets needed to achieve universal coverage in areas with malaria transmission (defined as one net for every two people). Based on these estimates, endemic African countries overall had received enough nets by 2008 to cover more than 40 per cent of their at-risk populations. Most of these nets have been distributed through maternal and child health services, such as antenatal care and immunization.

22. On ensuring environmental sustainability (MDG 7), the world is on track to achieving the MDG drinking water target.⁶ Today, 87 per cent of the world's population uses drinking water from improved sources: 54 per cent uses a piped connection in their dwelling (plot or yard), and 33 per cent uses other improved drinking water sources. This translates into 5.7 billion people worldwide who are now using drinking water from an improved source, an increase of 1.6 billion since 1990. About 3.6 billion people use a piped connection that provides running water in or near their homes. Estimates for 2006 show that the population still reliant on unimproved drinking water sources has fallen below one billion, and now stands at 884 million. However, improved drinking water coverage in sub-Saharan Africa is still considerably lower than in other regions. Nevertheless, it has increased, from 49 per cent in 1990 to 58 per cent in 2006, which means that an additional 207 million Africans are now using safe sources of drinking water.

23. Sanitation coverage, however, is far from satisfactory. The world is not on track to meeting the MDG sanitation target, and 2.5 billion people still lack access to improved sanitation, including 1.2 billion who have no facilities at all. The message is clear: there is a need to greatly accelerate progress in sanitation, particularly in sub-Saharan Africa and South Asia. Some 18 per cent of the world's population practices indiscriminate or open defecation. Open defecation is still most widely practiced in South Asia and sub-Saharan Africa – by 48 per cent and 28 per cent of the population, respectively. In contrast, this practice is common among only 3 per cent of the population in Eastern Asia.

24. Further progress has been made towards fulfilling the promises embodied in MDG 8.⁷ However, the global partnership for development has suffered significant setbacks, mostly arising from the recent state of the world economy. In the countdown to 2015, urgent responses are needed to bridge the existing implementation gaps to make good on the promises made to achieve the Millennium Development Goals. Although official development assistance (ODA) reached its highest level ever in 2008, there remain large delivery gaps in meeting existing commitments. The 2010 Gleneagles target is approximately \$154 billion in present values; additional flows of \$17 billion a year would be required to achieve this target. Aid to Africa reached some \$26 billion in

⁵ WHO *World Malaria Report 2008*; Roll Back Malaria, *Global Malaria Action Plan*, 2008.

⁶ *Progress on drinking water and sanitation: special focus on sanitation*, UNICEF and WHO, 2008.

⁷ *Strengthening the Global Partnership for Development in a Time of Crisis*, MDG Gap Task Force Report, 2009.

2008 but is still about \$20 billion short of being on track. Future flows of ODA to poor countries are at risk at a time when they need to be increased both to protect hard-won progress towards the MDGs and to counter the effects of the global economic and financial crisis.

25. Developing countries' duty-free access to the markets of developed countries continued to increase in 2007, mainly through the continued elimination of tariffs on a most-favoured-nation (MFN) basis. There are large regional and sectoral variations in duty-free access among and within least developed countries. Since 2007, the multilateral trading system has come under heightened pressure, as the food and the global financial and economic crises have given rise to new waves of protectionism. Both developed and developing countries have taken a variety of protectionist measures in response to these crises, including a range of tariff and non-tariff measures and through certain elements of national stimulus packages that either limit trade or are a source of unfair trade.

26. Many essential medicines are inaccessible to the poor in developing countries for two main reasons: first, there are large gaps in availability in both the public and private sectors; second, the prices of the medicines that are available are not affordable to the poor. Connectivity continues to increase, with internet users and telephone subscribers, especially for mobile telephones, expanding worldwide. Newer applications of technology for a wide range of developmental efforts are also being experimented within various parts of the world, including for rapid assessments, real-time monitoring and social data transmission, and response to emergencies.

II. Success stories, innovative strategies and country examples

27. Sharing evidence related to successful interventions can facilitate the expansion of coverage through government-led partnerships and the adoption of initiatives into relevant national programmes. Furthermore, the sustainability of programmes often rests on ensuring the involvement of all key stakeholders in the planning and management of initiatives. This is particularly the case with multidimensional programmes directed towards the accomplishment of the MDGs. The combined efforts and partnerships of Governments, local groups and international agencies have considerably helped efforts towards achieving the Goals, facilitating the expansion of many successful initiatives. This section provides examples of the countries that undertook such initiatives and strengthened their efforts to achieve the MDGs, including by reorienting budgets and policies as well as adjusting the design and focus of programmes.

28. In relation to MDG 1, several innovations in the field of food and nutrition in recent years have proven to be very effective. Micronutrient supplementation, including vitamin A, iron, zinc and folic acid, and food fortification efforts have helped to reduce micronutrient deficiencies and thereby contributed to child growth and cognitive development and to reductions in morbidity and mortality among children and women. Community-based treatment and prevention of moderate and acute malnutrition have proven to be very effective, and need to be scaled up. Examples include initiatives taking place in Burkina Faso, Ethiopia, Kyrgyzstan, Malawi, Rwanda and Zambia.

29. Under the MERET programme in Ethiopia,⁸ chronically food-insecure communities participate in environmental rehabilitation and income-generating activities designed to improve

⁸ A joint venture between the Ethiopian Government and WFP, the acronym for the programme draws its name from the Amharic word for land: MERET – Managing Environmental Resources to Enable Transitions to More Sustainable Livelihoods.

livelihoods through the sustainable use of natural resources. Its primary objective is to build resilience to the kind of shocks that struck Ethiopia in 2008. Some of those shocks were economic, such as high prices for food and fuel, while others were environmental – a prolonged drought related, according to experts, to climate change. Among the programme's many activities are measures to build and rehabilitate feeder roads, reforest barren hillsides, restore springs and rainwater ponds and to reconstruct and refurbish agricultural terraces. The programme provides food and materials for those involved in implementing the projects, as well as expert advice on building local capacity. Since 2000, the programme has been implemented in 600 communities across Ethiopia and, in addition to supporting poor families, has reclaimed more than 300,000 hectares of degraded land.

30. In Burkina Faso, Mali and Niger, small-scale irrigation technologies have helped small-scale farmers to secure food and horticulture production by stabilizing their water supply, directly benefiting 10,000 to 15,000 farmers per country. In Burkina Faso, the initiative, which is supported by the United Nations, led to the development of a national small-scale irrigation programme by the Government; Mali and Niger are focusing on developing similar programmes.

31. In the last five years, as a part of the effort to care for orphans and children made vulnerable by HIV and AIDS, social protection programmes, including conditional and unconditional cash transfers, food for work and other initiatives – often using successful models from the Americas and elsewhere – are gaining ground in other regions, including parts of sub-Saharan Africa, Central and Eastern Europe and the Commonwealth of Independent States. School meal programmes were scaled-up in many countries in recent years in response to high food prices, providing an important social safety net reaching millions of vulnerable children and families. Cash transfer programmes are being carried out on a pilot basis in Kenya, Mozambique, Tanzania and Zambia. Ethiopia's social protection programme is among the largest on the African continent outside of South Africa. In addition to improving household food security, these programmes have contributed to increasing the household capacity for health and education expenditures as well as the time available for children to pursue an education, and have resulted in a decline in child work rates.

32. The Social Cash Transfer Scheme (SCTS) in Malawi aims to reduce poverty and hunger in the most vulnerable households and targets those who are ultra-poor (living on less than \$0.10 per day) and at the same time labour-constrained (unable to work due to disability, age or chronic illness). Beneficiaries receive a monthly disbursement of cash, the amount of which is based upon the size of their household and number of school-going children therein. Between September 2006 and March 2009, the SCTS reached 24,051 households in seven districts. The scheme, if scaled-up to all 28 districts in Malawi, has the potential to reach the poorest 10 per cent of all households, or approximately 1.3 million people, at a cost of \$60 million annually.

33. In Moldova, marked progress has been made in early child development (ECD) through investments in programmes advancing efforts towards achieving MDG 2. Through significant policy improvements that targeted training, supply distribution and the policy framework itself, children's access to ECD programmes has increased, from 63 per cent in 2003 to 74 per cent in 2008. New policy documents have been distributed to nearly all preschool institutions and implementation of the improved policies has been applied in 90 per cent of preschool institutions. Policy reform around ECD in Romania has had similar success in transforming the early education opportunities and standards offered to children.

34. School fee abolition initiatives are further accelerating progress for primary education in a number of countries. Kenya, Malawi, Tanzania and Uganda have abolished user fees in primary education, enabling in each country more than one million additional children to enroll in primary school. In Yemen, a policy to extend fee abolition to grades 1 to 9 for girls and 1 to 6 for boys was implemented in 2008. This was accompanied by the introduction of grants for all schools nationwide. Togo officially announced school fee abolition for public pre-primary and primary education in 2008. A preliminary assessment of the effects of abolition revealed a 12 per cent enrolment increase in public primary schools. For Burkina Faso, 2008 represented the second year of implementation of education reforms aimed at extending free education in 45 pilot departments. The Basic Education Programme continued to focus on increasing demand in education through infrastructure, supply and quality interventions. In the Republic of the Congo, the Government declared public education free at the beginning of 2008. In India, the Parliament approved in August 2009 the 'Right to Education Bill' providing free and compulsory primary education for children aged 6–14. The Bill also stipulated that 25 per cent of seats in private schools be reserved for children from vulnerable segments.

35. Armenia's 'Capacity-building of Inclusive Schools' programme targets the country's limited number of special schools and boarding schools and provides educational opportunities to children with special needs. The installation of ramps improved access to school buildings for non-ambulatory children and the provision of transportation enabled students to access three resource, counseling and training community centres. Multi-professional support teams and teachers trained with special skills for addressing children with disabilities were provided with additional resources to facilitate their work. In 2008, with government and supplemental funding, this inclusive education programme was expanded to six provinces.

36. Equal access to education has moved forward in Bosnia and Herzegovina, where health and education initiatives focusing on socially excluded families have benefited roughly 16,500 children. Strategic documents in education have been revised with the contribution of the United Nations, and the related policy now includes a focus on promoting equal access to education.

37. The number of programme countries that have national education plans that include measures to reduce gender and other disparities has increased rapidly, from 74 in 2005 to 110 in 2008. If this trend continues, over 90 per cent of countries will have plans by 2015. Where there are reasonably strong partnerships, work has focused on research studies (Madagascar, Viet Nam), policy development for national education and gender (Burundi, Rwanda), policy advocacy (Nepal), campaigns to build national consensus around social change in favor of girls' education (Yemen), and gender audits in the education sector.

38. In respect of MDG 4, much of the progress in reducing child mortality is attributable to the scaling-up of specific interventions, such as measles immunization, provision of bed nets and vitamin A supplementation. Further acceleration will require strengthening of health systems to deliver a continuum of care. Improvements in coverage were the focus of Governments and partners. These have included promoting integrated campaigns, whether through supplementary immunization activities (24 countries in 2008) or through the child health days and weeks (34 countries in 2008), which have become a successful delivery method used particularly in Africa.

Trends in the coverage of immunization continue to be positive: global immunization rates are at their highest level ever (82 per cent in 2008).

39. In 1999, 'A Good Start in Life' was initiated in five regions of Peru.⁹ The programme focuses on reaching pregnant women and lactating women through community-based interventions, including antenatal care, promotion of adequate food intake, promotion of exclusive breastfeeding of infants under 6 months of age and of improved complementary feeding from six months onwards, growth promotion, reduction of iron and vitamin A deficiencies, promotion of iodized salt, and personal and family hygiene practices. By 2004, the programme covered 223 poor rural communities. The stunting rate among children below the age of 3 declined from 54 per cent to 37 per cent, with similar reductions in anaemia levels. The success has inspired the design and implementation of a national programme. Similar efforts for integrated child health and nutrition efforts in Malawi, Mozambique and Zambia are providing potential lessons for both MDG 1 and MDG 4 targets.

40. Benin, Botswana, Cameroon and, more recently, Malawi, Mozambique and Tanzania are among the countries with notable successes in reducing under-five mortality. Some of the greatest progress has been with measles. In Africa, deaths from measles have fallen by 77 per cent since 2000. Botswana, Malawi, Namibia and South Africa, among other countries, have adopted effective anti-measles strategies and reduced related deaths to nearly zero. According to the Sudan National Malaria Control Programme (NMCP), it is estimated that 80 per cent of the population are at risk of malaria and that the disease alone accounted for one-fifth of hospital deaths. Malaria was also identified as one of the major determinants of poverty in Sudan, with estimated out-of-pocket expenditures amounting to \$19–21 per capita for fever or malaria treatment. The NMCP in 2005 was able to secure funds for five years from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), amounting to \$33 million to support malaria prevention and control in 11 states. Joint efforts of the NMCP and partners on the ground resulted in a 55 per cent decrease in morbidity rates and a 52 per cent decrease in mortality rates related to malaria.

41. Mongolia's National Reproductive Health Programme, addressing MDGs 4, 5 and 6, supports sustainable population growth by providing high-quality health and social services in an equitable, accessible and reliable manner. The programme – with support from United Nations agencies, including UNFPA and WHO, the Asian Development Bank and the German Agency for Technical Cooperation – has introduced subsidies for pregnant women from poorer families. Encouraging intersectoral collaboration among various agencies responsible for health, social welfare, labour, education and statistical services in the country, the programme also includes elements of telemedicine for maternal and newborn health in a country challenged by vast distances and poor infrastructure. Initial results suggest a reduction of the MMR from 69.7 to 49.0 per 100,000 live births and increased antenatal coverage in the first trimester to 82 per cent. The programme should lay the foundations for Mongolia achieving MDG 5 and the other health-related Goals.

42. In Rwanda, strong political commitment, increased allocation of human and financial resources and innovative approaches, including conditional cash transfers, have spurred improvements in the health system. Since 2000, according to national estimates, infant mortality has

⁹ Aaron Lechtig et al., "Decreasing Stunting, Anaemia, and Vitamin A Deficiency in Peru: Results of the 'Good Start in Life' Programme", *Food and Nutrition Bulletin*, Vol. 30, No. 1 (March 2009): 37-48.

declined, from 107 deaths per 1,000 live births to 62 per 1,000 live births; delivery in health facilities has increased, from 28 per cent to 52 per cent; contraceptive prevalence has increased, from 4 per cent to 27 per cent; and the MMR has decreased, from 1,071 per 100,000 live births to less than 750 per 100,000 live births.

43. Many innovative approaches have been used in accelerating progress towards MDGs 4 and 5. For a lasting impact on maternal and child survival, the continuum of care – from pre-pregnancy to two years post-partum for women and their children – provides many points for intervention. Countries use various strategies to provide these timely interventions. The surge to combat maternal and child mortality has spawned over 80 national and international partnership initiatives. These partnerships are indicative of a common, strong commitment to support proven interventions that will achieve results in saving and improving lives.

44. The Health Eight (H8), an informal group of heads of eight health-related organizations – WHO, UNICEF, UNFPA, UNAIDS, GFATM, the GAVI Alliance, the Bill & Melinda Gates Foundation and the World Bank – have agreed to stimulate a global collective sense of urgency for reaching the health-related MDGs; modify institutional ways of doing business (coordination and teamwork); foster a more systematic and robust approach to knowledge management and learning; recognize the important opportunity presented by the renewed interest in health systems; and realize that the role of civil society and the private sector will be critical for success.

45. In addition, within the International Health Partnership's related initiatives, a sector framework has been agreed upon and a common framework for monitoring the health sector established. Plans have been developed in participating countries (Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria and Zambia) that have harmonized approaches to costing national programmes and also prioritized the scaling-up of health service delivery to reach the MDGs. Bottleneck analysis, scaling-up scenarios, impact estimation and financial mapping are identified as among the main attributes of a technically strong and credible approach. As an interim measure, in order to respond to immediate country requests, upgrading and revising of the Marginal Budgeting for Bottlenecks tool has been prioritized. Several agencies have been collaborating on a unified health model to provide a single unified tool for policy dialogue and also to support planning and programming in the health sector.

46. Progress towards the health-related MDGs is currently impeded by insufficient funding, inefficient use of resources, unbalanced funding of different services and fragmented funding flows. Low-income countries on average currently spend only \$24 per capita on health; of this \$11 comes from family out-of-pocket payments and \$6 from external funding. In 2006, more than half of external funding for health provided directly to countries was in support of MDG 6 (primarily for programmes addressing HIV/AIDS, tuberculosis and malaria), leaving only \$2.25 per capita for all other health-related goals and targets. Some of the gains that have been made in certain areas, such as measles, yellow fever, maternal and neonatal tetanus elimination, are facing a stagnation in funding and require concerted efforts to ensure that sufficient resources are available for a scaled-up response to achieve MDGs 4, 5 and 6.

47. In relation to MDG 6, Cambodia, which has, along with Thailand, one of the highest HIV prevalence rates in Asia, has used a package of participatory techniques – Community Capacity Enhancement (CCE) – that has proved successful at generating community responses. Villages

where CCE has been implemented have experienced a major breakthrough, with people living with HIV and AIDS now talking openly about their HIV status and publicly discussing taboos around sexuality and other socio-economic issues, such as gender inequality, domestic violence and poverty. As villages understand the complex nature of the epidemic, they have overcome stigma and discriminatory attitudes and are now providing care to those infected with HIV and support to families affected by AIDS.

48. Increasing male participation in HIV Voluntary Counselling and Testing (VCT) in Rwanda has been critical to the country's success in scaling up the PMTCT of HIV Programme. During the first four years of the programme (1999–2003), the proportion of male partners tested for HIV through the programme remained below 13 per cent. Low male participation in VCT is associated with low acceptance of the HIV test by pregnant women, which can jeopardize the quality of the follow-up for HIV-positive women and their exposed infants. The National PMTCT programme embarked on a rapid scale-up phase during 2004–2005, coupled with a comprehensive strategy to increase male participation as part of a family-centered approach to PMTCT services delivery. Between 2005 and 2008, the number of couples tested for HIV through the PMTCT programme increased fourfold.

49. In relation to MDG 7, schools have an important part to play in environmental education. Following the Indian Ocean Tsunami in December 2004, as a part of the 'Disaster Risk Reduction starts at school' campaign in China, India, Indonesia, Japan, Philippines, Sri Lanka, Thailand and Vanuatu, national institutes have analysed policies, programmes, curricula and school-based activities in order to strengthen disaster risk reduction and environmental education components and to integrate them in teacher education curricula and classroom activities.

50. An initiative to improve basic services for poor communities in Bobo Dioulasso, Burkina Faso, has promoted public-private partnerships for better management of solid household refuse and waste water, along with improved drainage and better supplies of drinking water. This initiative has now expanded to four other urban communities. Senegal has subsidized 140,000 new drinking water access points in poor urban neighbourhoods. As a result of these and other activities, access to safe water increased, from around 80 per cent in 1996 to over 98 per cent in 2006, and water loss, principally from leakages, was reduced from 32 per cent to 20 per cent. In 2008, the African Water Association identified Senegal as one of the 10 African countries most likely to reach MDG 7 targets.

51. The School-led Total Sanitation (SLTS) programme in Nepal aims to provide a complete package for school and community sanitation and hygiene through a child-to-family approach. In a country with over half the population having no access to any sanitary means of disposing human waste, the programme has reached over 500,000 people in 15 districts through 300 schools and 730 child clubs. As a result, over 1,000 settlements from 250 school catchment areas have been declared 'open-defecation free'. Based on the success of this initiative, the Government's Sanitation Master Plan has adopted a strategy for implementation in all 75 districts. Budgetary provisions have been made for villages that become 'open-defecation free' to receive grants for developing child-friendly facilities.

52. Within the framework of MDG 8, the international community should continue to explore more flexible and innovative ways of financing development, using the most effective mixes of

public and private finance. Official development assistance (ODA) is now coming from a more diverse range of countries, including those that in recent years have joined the European Union. Poland, for example, in 2004 launched a new campaign, ‘Millennium Development Goals: time to help others’, and between 2003 and 2006 increased ODA nearly nine-fold, from \$27 million to \$230 million. During 2007-2008, the Polish campaign was complemented by all 12 new Member States of the European Union.

III. The high-level MDG review in 2010

53. The high-level plenary meeting of the sixty-fifth General Assembly in September 2010 will be a significant opportunity to galvanize commitment, rally support and spur collective action in order to reach the MDGs by 2015. Taking into account the progress made with regard to the internationally agreed development goals, the high-level meeting will undertake a comprehensive review of successes, best practices and lessons learned, obstacles and gaps, challenges and opportunities, in order to identify concrete strategies for action in accelerating progress towards achievement of the MDGs.

54. As members of the United Nations Development Group, UNDP, UNFPA, UNICEF and WFP are working together in contributing to the forthcoming high-level plenary meeting, providing inputs to the comprehensive report of the Secretary-General, the annual report on the Millennium Development Goals and the report by the MDG Gap Task Force. The agencies will also provide inputs to the background papers for the interactive round-table sessions and the informal interactive hearings. The agencies will facilitate national reviews in preparation for the high-level plenary meeting and support regional events in preparation to the meeting.

IV. Making it happen – the way forward

55. Although there has been notable progress towards the MDGs at the global level and in most countries, reaching the most marginalized individuals and families will continue to be a challenge and requires specific focus and strategies. Data show marked inequalities between the richest and poorest population groups, as well as by gender, both in outcomes and in relation to the coverage of basic services. In order to reach the MDGs and to advance a rights-based approach to development, focused effort must be directed towards including the poorest and most vulnerable and empowering them, for example through social protection and safety net programmes that ensure affordable access to food, nutrition and health care.

56. One of the key lessons learned of the last 20 years is that making rapid gains in reducing hunger and undernutrition is eminently possible, including in resource-constrained settings. The range of interventions required for ending undernutrition and reaching the underweight target of MDG 1 have largely been established and agreed upon. These include high-impact interventions that are based on both prevention and treatment. Nutrition, particularly in vulnerable populations, must be given higher priority in national development. Food and nutrition-assistance interventions need to expand to enhance access to affordable and nutritious food for all population groups, particularly in times of crisis, so that they can meet their nutritional requirements.

57. Proven prevention-based interventions include promoting exclusive breastfeeding for the first six months of an infant’s life (starting within one hour of birth); timely and appropriate

complementary feeding (starting at six months of age); and continued breastfeeding (up to 2 years of age and beyond). Other interventions include improved nutrition, sanitation and hygiene practices, zinc, iron and folic acid supplementation and use of iodized salt. Focusing on preventing low birth weight is also important. The nutritional status of mothers before and during pregnancy is a key determinant of the newborn's chances for survival, growth, long-term health and psychosocial development. Countries and regions with the highest prevalence of malnutrition among children and newborns with low birth weight should pay particular attention to young child development and community-based nutrition initiatives to diagnose and treat severe and acute malnutrition, including health strategies such as deworming and timely care of children with diarrhoea and acute respiratory infections.

58. For primary education, public policies designed to reach the poorest and most disadvantaged groups have proven effective in many countries. Remarkable progress has been made in increasing enrolment of the poorest children by abolishing school fees; constructing schools in underserved areas, ensuring sanitary facilities for both girls and boys; boosting the recruitment of teachers; and providing school meals. In many countries, school systems are chronically underfinanced and underresourced and often fail to deliver quality education. As a result, children either do not learn or drop out early. Sub-Saharan Africa alone will require an estimated 3.8 million more teachers to achieve universal primary education.

59. Targeted public policies, together with communication to tackle negative attitudes and practices, can help overcome gender inequalities. Removing school fees and providing incentives for girls to attend school can alleviate financial pressures on households. Developing child-friendly schools, paying attention to girls' hygiene and offering segregated sanitation facilities in schools, building schools closer to underserved communities and recruiting local teachers, including women in primary schools, all can help to narrow gender gaps.

60. Experience suggests that successful strategies will achieve acceleration in progress towards MDG 3 as well as ensure an overall sustainable social and economic development of countries. Among the most effective strategies are removing key barriers to girls' education; removing obstacles for women's full and productive participation in the work force together with gender-responsive labour laws; affirmative action to enhance the number of women active in the political sphere; reducing women's burden through investment in infrastructure and gender-responsive economic stimulus packages; ending violence against women; and removing all barriers for equitable access to services, including health, education and HIV/AIDS treatment.

61. Just five diseases – pneumonia, diarrhoea, malaria, measles and AIDS – account for half of all under-five deaths. Pneumonia and diarrhoeal diseases together account for 37 per cent of all deaths among children under the age of 5. Expanding low-cost prevention and treatment measures could save most of these lives. These include antibiotics for acute respiratory infections, oral rehydration for diarrhoea, immunization and the use of insecticide-treated mosquito nets and appropriate drugs for malaria. Ensuring proper nutrition is part of disease prevention because malnutrition increases the risk of dying from these diseases. Improvements in public-health services, including safe water and better sanitation, are essential. Education, especially for girls and mothers, will also save children's lives. Raising household incomes is essential but not sufficient unless greater effort is made to ensure that services reach those who need them most.

62. Based on current trends, many countries are unlikely to achieve the MDG health targets by 2015. A growing consensus agrees that efficient and equitable health systems are the missing link to effectively scaling up the disease-prevention and control programmes required to meet the specific goals on reducing child and maternal mortality, on rolling back HIV/AIDS, tuberculosis and malaria and on improving access to reproductive health. As noted in the 2005 WHO report on the health MDGs, vertical approaches have often resulted in duplication, distortions, disruptions and distractions.¹⁰ Only by comprehensively strengthening health systems will it be possible to overcome structural challenges to service delivery, in particular the shortage of health workers.¹¹ Furthermore, strengthening health systems is essential if the current increase in aid for health is to be utilized effectively and progress sustained in the future. Several constraints will have to be addressed if health systems are to perform effectively, including ensuring appropriate levels of funding, trained human resources, effective policies and management, basic infrastructure, equipment and supplies.

63. Accelerating progress on MDG 5 involves the following critical approaches: preventing or treating complications during pregnancy through high-quality reproductive health services; increasing the availability of skilled health personnel to assist deliveries; good antenatal care; and ensuring access to emergency obstetric care. Ensuring immediate access to high-quality emergency obstetric care is crucial so that referral services and higher level of care is provided in a timely manner when life-threatening complications arise. The reduction of early marriage, teenage pregnancies, female genital cutting and the improvement of birth timing and spacing are other interventions that can considerably improve maternal health and prevent maternal morbidity and mortality.

64. Reliable and consistent availability of high-quality, culturally-sensitive and affordable contraceptive services, including family planning and other reproductive health supplies, as part of essential medical service and supply packages, would also accelerate progress on the health-related MDGs. Strong political commitment and information campaigns promoting sexual and reproductive health reinforce demand and legitimize services through the full continuum of care, including vulnerable and underserved (rural, poor and young) populations, and also help to reverse the HIV/AIDS pandemic. Addressing unmet needs for family planning could lead to an estimated 70 per cent drop in the number of maternal deaths and a 44 per cent drop in newborn births.¹² Contraceptive use rates have increased in a number of countries but still remain low in sub-Saharan Africa. Community-based distribution, promotion of information exchange and the involvement of men in family planning fosters the expression of family-size preferences by individuals and encourages couples to implement their birth intentions. During spells of economic crisis, the ability of women to make voluntary and informed decisions to delay their pregnancies can ameliorate the impact on the welfare of women and children and directly improve their health.

65. Sustainability in both sanitation and water supply remains a major challenge. Although community-led approaches to sanitation have shown remarkable progress in improving sanitation

¹⁰ *Health and the Millennium Development Goals*. WHO 2005.

¹¹ *Help wanted. Confronting the health care worker crisis to expand access to HIV/AIDS treatment: MSF experience in southern Africa*. Médecins sans Frontières, May 2007.

¹² Susheela Singh, Jacqueline E. Darroch, Lori S. Ashford and Michael Vlassof, *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York: Guttmacher Institute and UNFPA, December 2009.

practices, the sustainability of practices continues to be a priority concern. Ensuring access to an improved water source and promoting positive behaviors related to hygiene and sanitation will contribute significantly to improvements in health and nutrition indicators as well. Further work is required to promote strategies that can support people to move up the ‘sanitation ladder’ by improving their sanitary conditions, from elimination of open defecation to use of durable toilets. The sustainability of water systems also remains a challenge and will continue to be a focus of cooperation.

66. It is clear from country experience that a considerable knowledge on effective strategies and designs for the achievement of the MDGs exists and continues to grow. Partnerships have built upon a consistent and clear understanding of the required interventions towards achieving the MDGs at local, national, regional and international levels. Many of these interventions are now promoted and implemented at the national scale. Challenges for scaling-up are increasingly understood and capacities of national partners need to be further strengthened not only to identify and overcome bottlenecks, but also to address the needs of the most vulnerable and marginalized families and population groups as a priority.

67. Commitment is increasing at national and international levels to help national actors scale up interventions for achieving the MDGs. Participatory processes should be facilitated and platforms developed, which enroll all stakeholders through inclusive partnerships, including within communities and at the national level, in order to accelerate progress and address disparities. The private sector is increasingly contributing to bridging the gap, notably through foundations. The uneven progress across nations, regions and the MDGs can only be addressed if there is a collective sense of urgency among all stakeholders. Efforts of families and national partners will need to be accelerated with enhanced support from the members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development and through South-South cooperation. Many MDGs will require greater attention in countries and societies acutely affected by chronic emergencies, climate change and long-standing conflicts.

68. In the years since the adoption of the Millennium Declaration by the United Nations General Assembly in 2000, the MDGs have increasingly shown their value as mobilizing instruments at national and international levels and as a framework for the complementary efforts of Governments, civil society, the private sector and community organizations in development. The Goals and their associated targets and indicators have also provided critical benchmarks and measures of progress and success, around which many countries have increasingly oriented their expenditures and policies as well as their programmatic and monitoring efforts. A wide range of successful, innovative and promising examples of such intensified efforts now provide Governments and their partners with valuable experience and encouragement to move forward with accelerated, goal-oriented efforts to tackle poverty, deprivation, lack of sustainability and other major challenges in development.
