

The knowledge is there to achieve development goals, but is the will?

Interim reports published in September showed that — unless something dramatic happens — the world will fall far short of most of the Millennium Development Goals to reduce poverty and improve health in developing countries by 2015.

With a decade to go until the deadline for the Millennium Development Goals, it is clear that key targets on health agreed by heads of state in 2000 will be missed — not for want of knowledge and technical tools but lack of political will and resources.

Using a baseline of 1990, the targets state that by 2015: the number of people suffering from malnutrition and extreme poverty should be halved; infant and child mortality reduced by two-thirds; maternal mortality be slashed by three-quarters; and the spread of communicable diseases such as HIV/AIDS, tuberculosis and malaria reversed.

Other targets include gender equality; universal access to primary education; and more widespread sanitation and drinking-water.

In his annual report to the General Assembly on implementation of the Millennium Declaration, UN Secretary-General Kofi Annan said a “major breakthrough” would be needed in order to achieve the targets.

Much of Asia and North Africa was on track to halve extreme poverty, he said. Countries in Latin America, the Caribbean and West Asia were making good progress towards goals such as education but were less successful in combating poverty.

Sub-Saharan African and some least developed countries in other regions were “far from making adequate progress on most goals,” Annan’s report said.

“The record of the last 12 months for the poorest is hardly encouraging,” he said. “The number of HIV/AIDS infections was higher in the last calendar year than ever before, raising serious concerns about the development prospects for whole regions of the world in which hundreds of millions of people live.”

The document, released at the end of August, drew heavily on the findings of the draft interim reports from the individual task forces of the Millennium

Project, chaired by Professor Jeffrey Sachs of Columbia University, and on country reports.

While the interim reports did not provide significant new insights into novel forms of treatment or prevention, they helped draw attention to the lack of resources, according to Dr Andrew Cassels, Director of Health and Development Policy at WHO.

“The knowledge is already out there and being applied,” Cassels told the *Bulletin*. “What’s new is the recommendations on how the MDGs can be used to focus attention on the resources needed for their achievement.”

Jan Vandemoortele, Director for Poverty Reduction at the UN Development Programme (UNDP), said the interim reports helped put poverty and ill-health “on a front-burner”.

But their practical impact would depend on the ability of developing countries to tailor the accumulated knowledge to specific national and local needs, and whether donor governments are willing to finance that effort, he said.

The task force reports made it clear there were no quick fixes to lack of basic infrastructure and crumbling health systems, or the chronic shortage of health workers which was singled out as one of the biggest obstacles to tackling HIV/AIDS, malaria and tuberculosis.

They also reflected hurdles caused by political sensitivities over issues like reproductive health, which was not initially included in the targets, and access to essential medicines, which split the task force to such an extent that its two pharmaceutical industry members issued a dissenting statement.

Infant and maternal mortality

Task Force Four said the overall picture was “worrisome indeed,” with 10.8 million children under the age of five dying

each year and mortality rates in some parts of sub-Saharan Africa increasing.

It said deaths from diarrhoeal diseases and vaccine-preventable conditions had fallen since the 1970s, but there was little progress on acute respiratory infection. Only 16% of countries were on track to meet the child mortality targets, none of them in sub-Saharan Africa, it said.

The report cited studies published last year in the *Lancet* of 23 high-impact interventions. It said universal breastfeeding could prevent an estimated 1.3 million deaths (13% of the global total), followed by insecticide-treated materials at 691 000 (7%) and complementary feeding 587 000 (6%). In terms of therapy, the *Lancet* series calculated that oral rehydration therapy could save 1.477 million lives (15% of the total).

In short, 6 040 000 — or 60.6% — of the 9 992 000 deaths in the high burden countries in 2000 could have been prevented.

“Given that the MDG for child health is based on a two-thirds reduction of annual under-five year old mortality from 1990 levels, it is clear that the goal is theoretically achievable,” the task force said.

Overall levels of maternal mortality remained stubbornly high, with estimated deaths at approximately 530 000 per year, the task force said.

It said countries needed to build a functioning health system with trained community health workers and midwives as well as access to emergency obstetrics care, citing the examples of Malaysia and Sri Lanka which have slashed maternal mortality rates in recent decades.

Communicable diseases

Task Force Five said national and international responses to the AIDS epidemic, which killed three million people last

year, were “wholly inadequate.” It proposed two “demanding but attainable” targets for 2015: to reduce prevalence among young people to 5% in the most affected countries and by 50% elsewhere and to ensure that affordable and effective antiretroviral therapy is available to all who need it.

It said there was an urgent need to step up prevention and focus on vulnerable populations. In particular, it appealed to countries expected to suffer an upsurge in cases — including China, India, the Russian Federation and Ukraine — to stop criminalizing drug users and instead adopt “evidence-based public health approaches” such as needle exchange programmes and opiate substitution services.

“We now have a range of proven, effective ways to prolong life and control the spread of HIV. The task force believes that urgent scaling up of the interventions we have in hand could save millions of lives and bring the epidemic under control,” it said, stressing the need for sustained investment in health systems.

On tuberculosis, the task force said it was vital to scale up case detection, make treatment more widely available and step up adherence to this treatment. It said that TB/HIV co-infection and multidrug resistant tuberculosis should be adequately addressed and new drugs, vaccines and diagnostic technology should be developed.

On malaria, the task force also pleaded for a scaled-up, comprehensive approach, saying existing national efforts were fragmented and inadequate.

The draft task force reports are due to be finalized this year. Pilot projects have been launched as part of the Millennium Project in Cambodia, the Dominican Republic, Ethiopia, Ghana, Kenya, Senegal, Tajikistan and Yemen to try to integrate the MDGs into three to five-year poverty reduction strategies. None of the countries chosen was on target to achieve the goals on a “business as usual course”.

The results in the pilot projects are expected to be a key indicator of the overall success of the MDGs. Some of the interim national reports have been encouraging. For instance, the UN country team earlier this year predicted that China would reach most of the goals, with HIV/AIDS among its greatest challenges.

Thailand said it had already met the targets and introduced more ambitious “MDG Plus” targets including reducing poverty to below 4% by 2009 (a four-fifths reduction since 1990) and reducing HIV prevalence in adults to 1% by 2006. Specifically Thailand intended to focus on the most vulnerable people in the most vulnerable regions — an approach lauded by WHO, UNDP and The World Bank.

Specific success stories were highlighted in a recent study by the What Works working group of the Washington-based Center for Global Development. These included:

- measles immunization in seven southern African countries virtually eliminated the disease as a cause of childhood death, and helped reduce the number of cases from 60 000 in 1996 to just 117 in 2000;
- trachoma, the leading preventable cause of blindness, was cut by more than 90% in Morocco through a combined strategy of surgery, antibiotics, face-washing and environmental controls;
- malaria control in the United Republic of Tanzania was boosted by a social marketing campaign which dramatically increased the use of insecticide-treated bednets in rural areas and increased child survival by nearly one-third;
- a guinea worm eradication drive focused on behavioural change resulted in the reduction of disease prevalence by 98% in 20 endemic African and Asian countries;

- oral rehydration therapy in impoverished North-east Brazil cut child deaths due to diarrhoeal disease from 13% to 4%.

A separate study by the Center for Global Development contended that the MDG targets were unrealistically high and that this could jeopardize funding. Widespread failure to meet the goals risked giving donors an excuse for not funding vital projects, it argued.

Udaya S. Mishra, Takemi Fellow at Harvard School of Public Health, said that it was vital to achieve a balance between the quantitative and qualitative aspects of each target. “Often ‘how much’ dominates ‘how good’,” Mishra said.

There is particular disappointment at the lack of progress toward one of the most important goals: the responsibility of rich countries to offer fair trade, debt relief and increased aid.

Annan’s report said that only the Netherlands, Denmark, Luxembourg, Norway and Sweden had met the target of increasing overseas development aid to 0.7% of national income. Five more, Ireland, Belgium, France, Spain and the United Kingdom, have promised to do so over the next 10 years.

At a meeting in the Ethiopian capital, Addis Ababa in July, Jeffrey Sachs complained that key donors such as the United States, Japan and Germany were making no “concrete efforts” towards meeting the development aid targets. “Despite the promises of help, we are getting band-aids, not solutions,” Sachs said. ■

Clare Nullis-Kapp, *Cape Town*

Bulletin board: have your say

Readers now have the opportunity to comment on recently published articles that have appeared in the *Bulletin*, in the form of an informal letter to the editor. These comments will then be published on the *Bulletin's* web site, after quick editorial review, under our new “Bulletin board” section and a selection will be chosen to appear in the print version of the journal. Please visit our web site at <http://www.who.int/bulletin/en/> to access the latest articles and email your contributions to: bulletin@who.int.

Millennium Development Goals: Status 2004

Goals and Targets	Africa 840 million (Population 2002)		Asia 3,738 million				Oceania 8 million	Latin America & Caribbean 536 million	Commonwealth of Independent States (formerly republics of the Soviet Union) 281 million	
	Northern	sub-Saharan	Eastern	Southeastern	Southern	Western			Europe	Asia
POVERTY										
Reduce extreme poverty by half	on track	high, no change	met	on track	on track	increase	...	low, minimal improvement	increase	increase
Reduce extreme hunger by half	low, minimal improvement	very high, no change	on track	on track	progress but lagging	increase	moderate, no change	on track
PRIMARY EDUCATION										
Universal primary schooling	met	progress but lagging	met	met	progress but lagging	relatively high, no change	progress but lagging	met	decline	met
GENDER EQUALITY										
Equal girls' enrolment in primary schools	met	progress but lagging	met	met	on track	on track	met	met	met	met
Equal girls' enrolment in secondary schools	met	no significant change	...	met	no significant change	decline	on track	met	met	met
Literacy parity between young women and men	lagging	lagging	met	met	low	lagging	lagging	met	met	met
Women's equal representation in national parliaments	progress but lagging	progress but lagging	moderate, no change	progress but lagging	very low, no change	very low, no change	progress but lagging	progress but lagging	decline	decline
CHILD MORTALITY										
Reduce mortality of under-five-year olds by two thirds	on track	very high, no change	progress but lagging	on track	progress but lagging	moderate, no change	progress but lagging	on track	decline	decline
Measles immunization (85% of the population at risk)	met	low, no change	...	on track	progress but lagging	on track	moderate, no change	met	met	met
MATERNAL HEALTH										
Reduce maternal mortality by three quarters	moderate level	very high level	low level	high level	very high level	high level	very high level	high level
HIV/AIDS, MALARIA & OTHER DISEASES										
Halt and reverse spread of HIV/AIDS	threatened	some progress	some progress	some progress	significant increase	threatened	threatened	some progress	significant increase	threatened
Halt and reverse spread of malaria	continuing threat	pandemic	met	low level	low level	continuing threat	low level	met	low	low
ENVIRONMENTAL SUSTAINABILITY										
Reverse loss of forests		decline	met	decline	small decline		decline	decline (exc. Caribbean)	met	met
Halve proportion without clean drinking water in urban areas	met	no change	decline	high access but no change	met	met	high access but no change	met	met	met
Halve proportion without clean drinking water in rural areas	high access but little change	progress but lagging	progress but lagging	progress but lagging	on track	progress but lagging	low access, no change	progress but lagging	high access but limited change	high access but limited change
Halve proportion without sanitation in urban areas	on track	low, no change	progress but lagging	on track	progress but lagging	met	high but no significant change	high but no significant change	high but no significant change	high but no significant change
Halve proportion without sanitation in rural areas	progress but lagging	no significant change	progress but lagging	progress but lagging	progress but lagging	no significant change	decline	progress but lagging	decline	decline

compiled by: Statistics Division, UN DESA

UN Millennium Development Goals

- Goal 1 Eradicate extreme poverty and hunger
- Goal 2 Achieve universal primary education
- Goal 3 Promote gender equality and empower women
- Goal 4 Reduce child mortality
- Goal 5 Improve maternal health
- Goal 6 Combat HIV/AIDS, malaria and other diseases
- Goal 7 Ensure environmental sustainability
- Goal 8 A global partnership for development

The chart shows the targets set by the Millennium Development Goals for achievement by 2015 (or by 2005, in the case of equal access to schooling for girls).

A lack of data is shown by a blank box.

Sources: United Nations, based on data and estimates provided by: World Bank; Food and Agriculture Organization; UNESCO; Inter-Parliamentary Union; UNICEF; World Health Organization; UNAIDS.

Compiled by United Nations Statistics Division, Department of Economic and Social Affairs.
Produced by UN Department of Public Information - DPI/2363-A



United Nations

Social factors are key to eliminating health inequities

Governments have been quick to recognize that social factors are a key determinant of health, but few so far have attempted to tackle the problem head-on. WHO is creating a new commission on the social determinants of health next year to bridge that gap.

Take any of a series of social determinants such as wealth, education, ethnicity, gender, upbringing or job and the story is the same. People's health prospects worsen as they descend the social ladder.

Recognizing this is not new.

Edwin Chadwick's 1842 report on the sanitary conditions of working people in London showed the disparity in life spans between labourers and gentry, and the UK's 1980 Black Report showed that while the first 35 years of the UK's National Health Service had improved health across all classes, social status was still strongly correlated with infant mortality, life expectancy and use of medical services.

"The three main social determinants of health are income, social class and education," says Mel Bartley, Professor of Medical Sociology at University College London, who points out that the best measures of social class relate to a person's autonomy and freedom to decide what to do when.

"The link between social class and health is via the flight-fight mechanism," Bartley explains. For example, the less control you have the more insecure you feel, and the more you have others ordering you about the more times a day your heart rate goes up. Both insecurity and pressure cause increased levels of stress hormones.

These stress hormones cause peripheral arteries to narrow, thereby increasing blood pressure and triggering fats and sugars to flood into the bloodstream. Responses such as these may have aided the survival of early humans, but today they can contribute to heart disease.

Increased levels of stress hormones also suppress a person's immune system. From a biological point of view, there is no point fighting infections if you are about to be killed by an immediate aggressor. Individuals with increased levels of stress are more prone to many illnesses, including cancer, and people in vulnerable social positions experience these effects more often than the socially privileged. These and other

factors contribute to persistent socially determined inequities in health.

Governments are well aware of this situation but few have made any serious effort to tackle the social and economic determinants that underpin these health inequalities. And international comparisons expose a starker picture.

Take income, for example. While The World Bank announced in April 2004 that the proportion of the world's population living on less than US\$ 1 per day had dropped from 40% to 21% between 1981 and 2001, the progress was uneven.

In sub-Saharan Africa, for example, the numbers of people with this income had risen from 164 million to 314 million, an increase from 42% to 47% of the region's population.

Recognizing the problem, WHO hopes to engender change by setting up a new body called the Commission on Social Determinants of Health. The Commission is planned to run for three to five years starting early in 2005 and will look at the inequities within societies that create inequalities in health.

It also hopes to draw attention to examples of global, national and local policies that have strengthened health equity between and within countries.

"While the Commission will compile scientific evidence on the social patterns that generate health inequities, its main focus will be on action," says Jeanette Vega, head of WHO health equity team.

The Commission will work with political decision-makers, health planners and other stakeholders to identify interventions that really do improve the health of vulnerable populations through coordinated action on key social determinants of health.

This will include targeting issues such as early child development, nutrition, access to education, neighbourhood safety and safe working conditions. The Commission will also help mobilize expertise and resources from WHO and other partners to help countries that want to begin or expand implementation.

"Working with global partners, including other UN agencies, the Commission will also identify concrete steps to be taken at the global level to create an enabling environment for progress on social determinants," says Vega.

Looking for good practice in one part of the world and applying it to others depends on the similar factors having similar effects in different places.

Research published in the *Lancet* last month (2004;364:937-52) suggests that this may be possible.

It looked at 15 152 cases of myocardial infarction and 14 820 controls from 52 countries representing the full socioeconomic range.

The researchers found that a spectrum of nine risk factors, including psychosocial and dietary factors, accounted for 90% of the population-attributable risk in men and 94% in women. They conclude that this indicates that prevention policies can be based on similar principles worldwide.

The Commission has a few examples of success to draw on.

Beginning in the late 1990s, Sweden began a broad national consultative process involving all major political parties, as well as civil society and other stakeholders. The result has been a bold new national public health strategy that aims to create social conditions to ensure good health, on equal terms, for the entire population.

This strategy sets national health goals, targeting the determinants of disease and injury at the societal level and takes a multisectoral perspective. Instead of primarily focusing on reducing the prevalence of a specific set of diseases, it aims to strengthen conditions that broadly improve health in society that will, in turn, produce healthier individuals.

The programme includes strategies to reduce housing segregation and social isolation, as well as channelling extra resources to schools and other support structures for young people in socially disadvantaged housing areas. It fosters participation in healthy leisure

activities and creates safe and equal conditions in childhood for all children.

The strategy aims to reduce unemployment and eliminate hiring discrimination against immigrants. In addition, there is a drive to make the built environment safer and healthier, and to improve patterns of nutrition and exercise across all segments of the population.

The Commission can also look to the United Kingdom (UK), which since the arrival of the New Labour government in 1997 has not only set out to improve health for everyone, but also to narrow the gap between the worst off and everybody else.

The UK Government has set goals with numerical targets for reducing inequalities to be achieved by 2010, so it is too early to say whether they will be met.

"For the first time a government set out to develop policies aimed at reducing the gap between the best and worst," explains Sir Michael Marmot of University College London.

To do this the UK Government set up a major spending review that aimed to reduce inequalities in health.

To shift the focus of thinking from simply concentrating on health services to looking at the other social determinants the Treasury (finance ministry), not the Department of Health, chaired the review.

"I counted people from 16 different departments around the table: early child development, education, social exclusion unit, women's unit, Department of Environment, Home Office etc," says Marmot.

Issues such as stress, unemployment, social exclusion and poor transport all influence people's health.

A five-year project that ran in the socially disadvantaged Borough of Newham in east London put this thinking into practice.

Two problems in the area were high unemployment and job vacancies in the health services. A government-sponsored project called *Fit for Work* concentrated on training and employing local people. As a result it addressed some of the health service needs, tackled unemployment, and reduced unemployment-related ill health.

Lessons can also be learned from Kerala, a state in southern India, where the government in 1997 decided to let local people develop local solutions to locally important infrastructure, welfare and health issues. This is important, as being in control of your life is a potent social determinant.

"The project did succeed in a number of villages, while in others there were allegations of corruption and in yet others the political parties opposed the idea," says K. R. Nayar, associate professor at the Center of Social Medicine and Community Health at Jawaharlal Nehru University, New Delhi.

Subsequent governments have turned off the funding, closing the programmes. Nonetheless, Nayar believes the experience was valuable.

"Kerala may be considered as an expression of the democratic rights of people in an effort to counter the onslaught of globalization and centralization of governance," he says.

"To that extent, it could be considered as a lesson and a model for countries undergoing structural adjustment," Nayar says, adding that since people themselves plan for health care and the agenda is not imposed from above, it could be effectively used as a tool for strengthening primary health care.

According to Professor Barbara Starfield, the director of the Johns Hopkins University Primary Care Policy Center, Baltimore, health services are themselves social determinants and focusing on primary care, as opposed to specialty care, is critical for any government planning on reducing inequities.

"With the exception of Canada, most of the countries in the Americas don't have primary care systems," says Starfield.

In June 2000, Starfield founded the International Society for Equity in Health, which together with the Pan American Health Organization is developing specific programmes aimed at reducing inequities.

Marmot hopes that WHO's new Commission will be able to highlight best practice and enable willing governments to realize that health inequalities have their origins in social and economic factors.

"New policies should be based on a recognition that health is determined by factors other than healthcare," he says. ■

Pete Moore, *London*

Call for papers on Maternal and Child Health

The *Bulletin of the World Health Organization* is seeking Research and Policy and Practice papers dealing with maternal and child health for a projected issue on this topic to be published in the first half of 2005. We are particularly interested in papers that deal with the following topics: why it is important to invest in the health of women and children; how care for women and children has been affected by global policy change; assessment of the public health challenge; how to meet the needs for effective care of women and children; human resources aspects of maternal and child health; economic aspects of maternal and child health; and countries' responsibilities towards the health of mothers and children. We will also consider relevant submissions on this topic to the other sections of the *Bulletin*: Perspectives, Round Tables, and Public Health Reviews. Manuscripts should be submitted to <http://submit.bwho.org> by 1 November 2004, respecting the Guidelines for Contributors, and accompanied with a cover letter mentioning this call for papers.