

The Global Campaign for the Health
Millennium Development Goals
– Report 2013

Accelerating progress in saving
the lives of Women and Children



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We acknowledge with gratitude the individual and collective contributions by the global and international leaders listed above.

The Global Campaign for the Health Millennium Development Goals brings together a number of actions and initiatives, all aimed at fulfilling the promises given by world leaders in 2000.

The report of 2013 provides an update on the significant developments and new commitments since 2010, when the United Nations Secretary-General launched his Global Strategy for Women's and Children's Health. It sets out how initiatives will be further developed in a coordinated and effective manner, with a view to accelerating the significant progress that is now being made in reducing maternal and child deaths.

For more information: www.everywomaneverychild.org/ and www.norad.no/globalcampaign

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The Secretary-General

MESSAGE TO “ACCELERATING PROGRESS IN SAVING THE LIVES OF WOMEN AND CHILDREN”, GLOBAL CAMPAIGN FOR HEALTH MDGs REPORT 2013

January 2013

In 2010, together with global leaders, I launched the *Global Strategy for Women's and Children's Health*. Two hundred sixty partners -- encompassing governments, the private sector, civil society, the United Nations and multilateral organizations -- have now joined forces under the *Every Woman Every Child* banner in a concerted effort to ensure that women and children do not die needlessly from preventable diseases and conditions.

Every Woman Every Child has focused on firm commitments from global leaders; determination from partners to support implementation efforts; accountability for resources and results; long-term, predictable investments; and innovation. The initiative has generated tangible progress for women and children worldwide, but there is still a tremendous amount of work to do to meet our goal of saving 16 million lives by the year 2015.

Nigeria's *Saving One Million Lives* campaign, India's push to end child diarrheal deaths and Malawi's Presidential Initiative on Safe Motherhood are blazing a trail for others. Strategic public-private partnerships are working to sustain progress beyond 2015 with efforts that include preventing preterm births, providing access to voluntary family planning for 120 million women and girls, and eliminating new HIV infections among children while keeping their mothers alive.

Global leaders have raised the visibility of women's and children's health and elevated the issue on the development agenda. An independent Expert Review Group established in response to the recommendations of the Commission on Information and Accountability tracks resources and results. The UN Commission on Life-Saving Commodities for Women and Children is working to ensure that more people can access and use life-saving health commodities.

Together, these efforts are testament to our collective commitment to ensure that more children live past their fifth birthday and fewer women die or suffer complications during pregnancy and childbirth.

Investing in the health of women and children is critical for development. We have generated considerable momentum. Our challenge now is to maintain and accelerate it, as we step into this new era for the health of women and children.

Ban Ki-moon

Secretary-General of the United Nations

Overview

A tipping point for change: saving millions more lives in 2013 and beyond

In recent years we have seen gratifying progress towards Millennium Development Goals 4 (child health) and 5 (maternal health). The number of child deaths is down from about 12 million in 1990 to 7 million in 2011 and maternal deaths are down from 500 000 in 1990 to under 300 000 in 2010.

As a result, the number of children's lives saved every year through our joint efforts is close to the number of children born each year in Nigeria – or equivalent to the whole population of Norway. Nevertheless, we are off track to reach our goals of reducing child deaths by 67% and maternal deaths by 75% by 2015. However, recent initiatives promise to accelerate the progress made to date.

2010 was a landmark year, with the United Nations Secretary-General launching the Every Woman Every Child initiative and the G8, under Canadian leadership, placing maternal and child health at the top of its agenda. The African Union's July 2010 Summit on Maternal and Child Health raised the profile of this important issue across Africa. We are pleased that in 2012 the global community built on this momentum by launching significant initiatives to ensure progress towards MDGs 4 and 5.

These included: The Child Survival Call to Action in Washington DC in June; The London Summit on Family Planning in July; the Saving Mothers, Giving Life partnership meeting at the Global Health Conference in Oslo in June; the launch of Nigeria's Saving One Million Lives Initiative in Abuja in October; and the launch of the Open Health Initiative in December. The latter calls for the mobilization of further sub-regional action in East Africa for women's and children's health.

We also had the honour of co-chairing the United Nations Commission on Life-Saving Commodities for Women and Children. This Commission is contributing to the United Nations Secretary-General's Global Strategy.

The Commission estimated that an ambitious scaling up of 13 life-saving and essential commodities over five years would cumulatively save over 6 million lives. This would include averting 230 000 maternal deaths through increased access to family planning. Achieving these goals would further reduce the estimated child deaths to 5.3 million and maternal deaths to close to 200 000 per year.

We are pleased to report that [the Commission's] recommendations have been enthusiastically received, and significant implementation efforts have already begun.

The estimated costs per lives saved are low and represent excellent value for money. For example, more than 1.5 million children could be saved in the next five years with two effective treatments: oral rehydration solution and zinc, costing less than US\$ 0.50 per treatment.

In September we delivered the Commission's report to the Deputy Secretary-General, Jan Eliasson, at the United Nations General Assembly. We recommended 10 time-bound actions to dramatically improve access to the commodities. These included ensuring that quality-certified products are available, incentivizing health-care professionals to follow the latest national guidance for care and promoting, at regional and national levels, the manufacture and supply of appropriate commodities.

We are pleased to report that these recommendations have been enthusiastically received, and that significant implementation efforts have already begun in the short time since the launch of the report. Specifically, eight countries – Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Tanzania and Uganda – have committed to implement the Commission's recommendations as adjusted for local needs and priorities through the Abuja Declaration. In addition, global implementation plans have been developed, financed and commenced.

An excellent example of a country-led implementation of the relevant recommendations is Nigeria's Saving One Million Lives initiative. This aims to save 1 million lives by 2015 through an ambitious

and comprehensive scaling up of access to essential primary health services and commodities for women and children. It is the result of a careful analysis of Nigeria's needs and priorities and a nationally designed plan – which is supplemented, as necessary and desirable, by other partners.

Such national initiatives as Saving One Million Lives in Nigeria, the National Rural Health Mission of India and Safe Motherhood in Malawi are characterized by strong national political backing at the highest level and clear national priority setting.

This allows any international partner to discuss with the host country how it can fit into the initiative based on its own comparative advantage, before more concrete and detailed national plans are drawn up. We believe these initiatives point the way to how international collaboration will operate over the next one or two decades.

Such national initiatives as Saving One Million Lives in Nigeria, the National Rural Health Mission of India and Safe Motherhood in Malawi are characterized by strong national political backing at the highest level and clear national priority setting.

It is important that the synergies between these new global and national developments are capitalized on to ensure effective collaboration and tangible, timely results. We are, therefore, pleased to publish this new report of the Global Campaign for the Health Millennium Development Goals, highlighting the recent developments as well as new commitments and new approaches by national and global leaders. These commitments come from wide-ranging stakeholders including governments, multilateral organizations, nongovernmental organizations, the private sector and academic institutions.

In September, for example, we were pleased to partner with the Bill & Melinda Gates Foundation, the Children's Investment Fund Foundation, the Clinton Health Access Initiative, the UK and Sweden in announcing the volume guarantee for the contraceptive implant, Jadelle, with the manufacturer, Bayer HealthCare, which halved the price of the popular family planning method.

If we can ensure effective collaboration between these efforts, through innovative national leaderships, we are convinced we will together achieve a dramatically accelerated reduction in maternal and child deaths. We hope that we can look back on 2013 as the tipping point – when the bulk of the Every Women Every Child countries accelerated progress towards MDGs 4 and 5.

Goodluck Ebele Jonathan
President of the Federal Republic of Nigeria

Jens Stoltenberg
Prime Minister of Norway

Towards eliminating preventable deaths

United States

Delivering results for global health

In the Universal Declaration of Human Rights, our nations recognized the inherent dignity and rights of every individual. This includes our health and well-being, and that of our families, especially our children. Over the past half century, we've achieved great progress – eradicating smallpox, expanding health care around the world, increasing access to clean water, and reducing new cases of HIV/AIDS, malaria and tuberculosis. Millions of lives have been saved, and we've seen a remarkable drop in childhood deaths.

Yet as this report of the *Global Campaign for the Health Millennium Development Goals* makes clear, progress has not come as quickly in other areas. Every year, hundreds of thousands of mothers still die in child birth. Millions of children still die from malnutrition. Nearly a billion people still suffer from chronic hunger. In their name, we simply must do better.

That is why, as President, I've committed the United States to a new approach to development and global health. We are guided by science and evidence of which interventions save lives and have the greatest impact. We are partnering with countries that step up and take the lead. We are forging new collaborations that harness the unique capabilities of international institutions, governments, academia, NGOs and the private sector. Most of all, we're focused on results – not simply treating diseases, but helping people lead healthier lives.

For the United States, development and global health will continue to be a strategic, economic and moral imperative.

In partnership with others, our Global Health Initiative is helping countries strengthen their public health systems to deliver better care to mothers and children. Our *Feed the Future* initiative is reaching more than 10 million children and reducing malnutrition, while our malaria programmes are providing effective prevention measures to over 58 million people. Through *Saving Mothers, Giving Lives*, we're focused on improving care during the most critical moments of childbirth, and with the *Child Survival Call to Action* we have set a global goal to eliminate preventable child deaths. Focused on the new goals I announced last year, we are also moving closer to eliminating all new HIV infections among children and the possibility of an AIDS-free generation.

None of this will be easy, and none of us can do this alone. Meeting our Millennium Development Goals and accelerating progress beyond 2015 will require serious and sustained commitment. It will also demand collaboration that reflects our shared responsibility – most importantly by nations on the front lines of this fight.

For the United States, development and global health will continue to be a strategic, economic and moral imperative. In the 21st century, no child in the world deserves to die from a preventable disease. No mother deserves to die simply from giving birth. No person deserves to die from hunger. These are the lives – the millions of lives – that we can save. Our conscience and our national interests compel us to act and, so long as I am President, the United States will continue to be a leader in this global effort.

Barack Obama

President of the United States

Federal Democratic Republic of Ethiopia

MDGs 4 and 5: towards eliminating preventable deaths

In the past two decades, Ethiopia has witnessed steady social and economic development together with rapid expansion of rural health services.

Absolute poverty reduced from 39% in 2004/05 to 29% in 2010/11, with the sharpest decline in rural areas. More than 2500 health centres have been constructed, and 34 000 health extension workers are deployed over 15 000 health posts, providing basic preventive and curative services at community and household levels.

The under-five mortality rate (U5MR) declined from 166 to 77/1000 live births between 2000 and 2011. Reductions in malnutrition, increases in vaccinations and vitamin A supplementation and improvements in hygiene and sanitation were the main contributors to the past success. In addition, the increase in insecticide-treated nets has reduced the malaria burden by at least 50%. Currently, significant efforts are being made to increase the number of women who give birth in health facilities, in order to achieve MDG 5 by 2015.

The Government of Ethiopia is committed to improving the health of its people, with particular emphasis on women and children.

Although Ethiopia is on track to achieve MDG 4, further accelerations in reducing child mortality can be made. Ethiopia's five-year Growth and Transformation

Plan and Health Sector Development Programme IV have prioritized maternal, newborn and child health. Ethiopia is committed to reducing the U5MR to less than 20/1000 live births by 2035, by scaling up all the currently known health, nutrition and WASH (water, sanitation and hygiene) interventions to 95% by 2025. Scaling up family planning access for all women, and utilization by approximately 65% by 2015, will avert some 73 000 under-five deaths a year.

Strategies

The Government of Ethiopia is committed to improving the health of its people, with particular emphasis on women and children. This will be achieved through continued political commitment and economic growth – including strengthened leadership at all levels – delivery of high-impact MNCH interventions, and securing additional finance for accelerated reduction of maternal and child mortalities.

Ethiopia's health policy focuses on disease prevention and health promotion. For this purpose, ensuring community ownership is paramount. This will be achieved by strengthening the development of a "women-centred" health system (launched in 2010), which empowers women to look after their own health and that of their families through "women's development teams". These are empowered to monitor the health and well-being of every mother and every child in their communities.

The government is also committed to pursuing its pro-poor development strategies, such as: universal secondary education for boys and girls; an effective agriculture sector to ensure all people have access to good nutrition; expansion of infrastructure, including electricity, water supply, road and communication; and social welfare and protection systems.

The government also promotes the involvement of the private sector. It provides incentive mechanisms for the expansion of the private sector in the delivery of health-care services, and in the production and distribution of medicines and other medical supplies.

Hailemariam Desalegn

Prime Minister of the Federal Democratic Republic of Ethiopia

Closing the gap in women's and children's health

The World Bank

Improving women's and children's health is a priority for the World Bank and key to our mission to end poverty and build shared prosperity. Over the past few years we have stepped up support to developing countries so that all women and children can have access to basic, quality, affordable health care.

The Bank aims to achieve better health outcomes through policy and implementation advice, technical assistance and funding. Over the past five years, we have committed more than US\$ 1.4 billion to improve child health, and almost US\$ 1 billion more for reproductive and maternal health. At the 2010 United Nations MDGs Summit, we pledged more than US\$ 600 million over five years in results-based financing programmes to address the challenges of high fertility, poor child and maternal health and nutrition in 35 of the highest-burden countries. As of December 2012, over US\$ 400 million had either already been committed or was in the pipeline toward this pledge.

The Bank aims to achieve better health outcomes through policy and implementation advice, technical assistance and funding.

However, more progress is urgently needed. So, after an appeal from the Partnership for Maternal, Newborn & Child Health, President Jim Yong Kim announced in September 2012 that the Bank would establish a mechanism to enable donors to scale up funding for pressing needs related to MDGs 4 and 5. The Bank is working with interested donors to realize this goal as soon as possible.

Since the launch of our five-year Reproductive Health Action Plan in 2010, all of our new country strategies and 70% of our health projects in countries with high maternal mortality and/or high fertility now address reproductive health, including 11 new projects. A committed partner in the global Scaling Up Nutrition (SUN) movement, we have also stepped up support for early childhood nutrition, with 53 active projects. Our work is strengthening the continuum of care from family planning, pregnancy and safe delivery, to postnatal care, newborn and child health and nutrition.

Through the Health Results Innovation Trust Fund (HRITF), with generous support from Norway and the United Kingdom – together with concessional financing through our International Development Association (IDA) – the Bank is designing innovative programmes that connect financing to results, and producing dramatic gains in access and quality of health care. For example, in Burundi, results-based financing has led in just one year to remarkable increases in births at health facilities (25%), prenatal consultations (20%) and family planning services (27%).

To ensure these investments are sustainable and achieve maximum impact, the Bank is helping countries build strong health systems – and investing beyond the health sector in areas vital to health such as water, sanitation, education and safety nets.

Poor health and high out-of-pocket spending for health care are among the leading causes of poverty – while access to affordable, quality care is both a basic human right and a catalyst for inclusive economic growth. The World Bank remains committed to work with countries and development partners to give every woman and every child the opportunity to lead a healthy, productive life.

Tamar Manuelyan Atinc
Vice President
Human Development Network, the World Bank

The way forward on family planning; building on the London Summit

Bill & Melinda Gates Foundation

Keeping our promise to 120 million women and girls

In July 2012, our foundation co-sponsored the London Summit on Family Planning with the UK's Department for International Development. The Summit's ambitious goal was to give an additional 120 million women and girls access to contraceptives by 2020. It also symbolized a different approach to global health goals by centring-in on the needs of women and girls, and building on bold leadership in developing countries where the majority of the work will take place.

Dozens of partners made pledges in July, but the hard work has now begun to turn pledges into progress. In September, a group of donors announced a US\$ 230 million volume guarantee for Bayer's Jadelle contraceptive implant that will lower the cost by more than 50%, making it much more practical for developing countries to offer as part of their family planning programmes.

In October, Nigerian President Goodluck Jonathan announced the Saving One Million Lives initiative, which provides a roadmap for achieving his pledge of nearly tripling funding for contraceptive access over five years, sparing 700 000 women and girls in Nigeria from serious injury and long-term complications from childbirth.

Similar preparations are underway in about two dozen other countries to help create detailed plans for providing women and girls with the opportunity to plan their families through access to contraceptives and information about family planning. The proven tactics to expand access range from lowering the costs of commodities to improving supply chains and increasing demand by educating consumers about their options. The overarching strategy is to maintain firm political commitment to driving reform, while increasing action in countries and measuring the progress.

We aim to demonstrate the approaches that generate the best results and then work with the government to scale them up for tens of millions of women.

Our foundation is investing in several key areas where we believe we can make a unique contribution. We're working in India's Bihar State with the government and CARE to test innovative approaches to family health in eight districts. We aim to demonstrate the approaches that generate the best results and then work with the government to scale them up for tens of millions of women.

Research and development into new contraceptives is also vital in giving women more and better options that last longer, are easier to use and have fewer side effects. We are funding specific efforts to create new contraceptives and working to increase the number of scientists specializing in the field.

One of the most exciting aspects of the work to deliver contraceptives to the women who need them is how far-reaching the benefits can be – both the immediate gains in health, such as those that Nigeria will see in the coming years, and the long-term contribution to economic stability and growth at the community and national levels. Other impacts, such as increases in women's empowerment, may be harder to quantify but will have a ripple effect on almost every aspect of life in developing countries.

That's why I say that contraceptives are one of the best investments a country can make in its future – and why I am personally committed to helping us keep our promise to 120 million women and girls.

Melinda Gates

Co-chair and Trustee

Bill & Melinda Gates Foundation

United Kingdom of Great Britain and Northern Ireland

The way forward on family planning; building on the London Summit

In July 2012, Melinda Gates and I co-chaired the London Summit on Family Planning. We brought together developing countries, donors and civil society to commit to meet the needs of an additional 120 million women and girls in the poorest countries. In the UK, we put US\$ 800 million on the table to help meet our global goal: of cutting the number of unwanted pregnancies by over 110 million by 2020, reducing the number of women dying in pregnancy and childbirth by 200 000 and ensuring 3 million fewer babies die in their first year of life.

We did this because we believe that access to family planning for millions of girls and women in the world's poorest countries must be one of our top priorities. It's not some "nice to have", or an add-on to our development goals. Enabling women to choose how many children they have, and when, is absolutely fundamental to combating global poverty – for three reasons.

First, access to family planning stops so many young girls from dying needlessly in childbirth. Second, it puts women in control. This is crucial, because we know that women who can plan the number and timing of their pregnancies are likely to have fewer children, and to bring them up healthier and better educated. And third, because it allows women to reach their full potential, giving them the chance to stay in school, start a business or get involved in their local communities. In short, family planning can help unlock incredible resources and potential.

[Family planning] allows women to reach their full potential, giving them the chance to stay in school, start a business or get involved in their local communities. In short, family planning can help unlock incredible resources and potential.

It is for this reason that, as co-chair of the United Nations Secretary-General's High Level Panel on what should replace the Millennium Development Goals, I want to ensure that the health and rights of women and girls are at the heart of this agenda.

We have a lot of work to do to bring family planning to the poorest parts of the world, and we need sustained international leadership. That is why my Secretary of State for International Development, Justine Greening, will champion family planning and drive progress on the Summit Commitments. We will align firmly behind the United Nations Secretary-General's overarching Global Strategy for Women's and Children's Health: Every Woman Every Child. Together, we can work for a better future for millions of women and children around the world.

David Cameron,

Prime Minister of the United Kingdom of Great Britain and Northern Ireland

Expanding access to affordable contraception for women and girls

Bayer HealthCare

Improving maternal health and reducing child mortality remain significant challenges in developing countries. At present, more than 200 million women in developing countries have no access to effective contraception.

As the leading company in the field of hormonal contraception, Bayer HealthCare has a long-standing commitment to family planning and maternal health. Over the past 50 years, we have partnered with a large network of public and private sector organizations to enhance access to contraceptives, and we actively support family planning programmes in more than 130 countries.

According to the World Health Organization, women who wait at least two-to-three years between each pregnancy improve their own health and give their babies a better chance of long, healthy lives. In this respect, we firmly believe that women, their families and their communities benefit significantly

We firmly believe that women, their families and their communities benefit significantly when they are guaranteed access to high-quality and effective contraception.

when they are guaranteed access to high-quality and effective contraception. Our Family Planning lighthouse project addresses three of the eight Millennium Development Goals (MDGs) set by the United Nations General Assembly in 2000: strengthening equal opportunities, reducing the number of infant and young child deaths by two thirds and improving maternal health by 2015.

Bayer HealthCare has recently joined a new global initiative for Better Access to Safe and Effective Contraception, as part of its work to increase engagement with the MDGs. The initiative is a joint effort with the Bill & Melinda Gates Foundation, supported by the Clinton Health Access Initiative, the governments of Norway, Sweden, the UK and the US and the Children Investment Fund Foundation. It aims at expanding access to contraception to 27 million women in low-income countries.

Under the agreement, which will be effective starting January 2013, Bayer HealthCare will supply over the next six years a long-acting, reversible method of contraception. It will be supplied at 50% of its current price, subject to certain volume guarantees.

This partnership is expected to prevent almost 30 million unwanted pregnancies from 2013 to 2018 and save an estimated US\$ 250 million in global health costs. When fully implemented, it will avert more than 280 000 child and 30 000 maternal deaths thanks to improved birth spacing.

The initiative targets 42 of the world's poorest countries that are thought least likely to meet the MDGs by 2015. The new partnership will also seek to remove some of the barriers to contraception by providing health workers with training and counselling in family planning and ensuring that affordable modern contraception is available.

We at Bayer HealthCare are delighted to make our life-enhancing products accessible to as many people as possible – regardless of their income or where they live – thus making a substantial contribution to achieving the United Nations MDGs.

Jörg Reinhardt

CEO

Bayer HealthCare AG

Innovating to save women's and children's lives

MSD

MSD (known as Merck in the United States and Canada) is working diligently to share ideas, technologies and financial resources with the global movement to improve health.

We are committed to partnering with others – in both the private and public sectors – to find new ways of doing business that ensure essential medicines reach people in need, when and in the form they need them, anywhere in the world.

MSD's legacy of innovative science has led to medicines and vaccines that are helping save millions of lives. They improve the health of people at risk of formidable diseases, such as HIV, hepatitis B, diabetes, measles, cervical cancer and rotavirus.

MSD's legacy of innovative science has led to medicines and vaccines that are helping save millions of lives.

These scientific innovations reach every corner of the globe through pioneering partnerships with United Nations agencies, national governments and NGOs. We are well known today for our work with our partners in the MECTIZAN® Donation Programme which began 25 years ago. Our hope was to help create a world where hundreds of millions of people would maintain their sight throughout their lifetime. Today, that vision is close to becoming a reality – we are near to eliminating river blindness in many regions. We are now bringing these lessons to new programmes designed to help the world meet its MDG goals for women's and children's health.

Just over a year ago, we launched a new effort dedicated to creating a world where no woman dies during pregnancy and childbirth. Our *MSD for Mothers* initiative – a 10-year, US\$ 500 million dollar effort – leverages the whole of our business and scientific expertise to develop new maternal health innovations and expand access to life-saving technologies, care and medicines. Our strategy is based on an intensive listening and learning approach – we are grateful to the 200-plus stakeholders who graciously shared their time and insights.

MSD for Mothers is our company's most comprehensive effort to save women's lives during pregnancy and childbirth. In the first 14 months we have:

- Pledged more than US\$ 110 million to initiate over 30 projects in more than 20 countries;
- Collaborated with more than 75 implementing partners and advocacy organizations;
- Committed to advance innovations – both as a member of the United Nations Commission on Life-Saving Commodities and through a collaboration with PATH to evaluate 40 maternal health innovations with potential to save women's lives in low-resource settings;
- Become a founding partner and secretariat of *Saving Mothers, Giving Life*, a major public-private partnership with the US Government, the Government of Norway, the American College of Obstetricians and Gynecologists and Every Mother Counts to reduce maternal mortality dramatically in sub-Saharan Africa; and
- Teamed with the Bill & Melinda Gates Foundation to expand access to family planning – a critical step in improving the health of women around the world.

I personally look forward to MSD's continued collaborations with the United Nations and a broad range of national governments, scientists, advocates, NGOs and communities as we succeed together in helping the world be well.

Kenneth Frazier
Chairman and CEO
MSD

Country reports

Republic of Malawi

Promoting positive behaviour change will help women and children

It is with great pleasure that I write this statement on a great milestone that has been initiated to improve maternal and neonatal health-care service provision in Malawi.

Pregnancy and child delivery are not diseases. These are natural processes and should remain such. I have repeatedly expressed my deepest conviction that no woman should die while giving birth to life, and this is at the heart of the Safe Motherhood movement worldwide.

The Government of Malawi has over the years provided sexual and reproductive health services, including maternal and newborn health care, to its people. Despite all these efforts, maternal mortality has been declining at a disappointingly slow rate.

Currently Malawi is one of the countries with the highest maternal mortality ratio globally, estimated at 675/100 000 births. However, it is also important to note that Malawi has made significant progress in realizing the child-related MDG 4. Results show a sharp decline in infant and under-five mortality rates per 1000 live births, from 81 and 145 deaths in 2000 to 66 and 112 in 2010 respectively. If the current trend is anything to go by, Malawi is likely to achieve the MDG 4 target of reducing infant and child mortality by two thirds – but unfortunately not MDG 5.

I launched the Presidential Initiative on Maternal Health and Safe Motherhood soon after assuming office in April 2012.

To accelerate the reduction of maternal and neonatal morbidity and mortality towards the achievement of the Millennium Development Goals, and also as a step towards universal access to reproductive health services, I launched the Presidential Initiative on Maternal Health and Safe Motherhood soon after assuming office in April 2012.

This initiative seeks to complement the efforts of the Ministry of Health to increase availability, accessibility and utilization of maternal and newborn health-care services through community involvement. It mostly targets chiefs as opinion leaders who can accelerate behaviour change and encourage community participation, and promote cultural habits that influence health-seeking behaviour and community attitudes towards family planning, pregnancy and delivery. These changes can help to preserve women's dignity by stopping defilement and other forms of violence that make women insecure and unstable in their lives. By utilizing them effectively, thousands of lives can be saved.

No woman or child should die from easily preventable and treatable conditions. The time for action is now.

Joyce Banda

State President of the Republic of Malawi

IMPLEMENTATION MEETING OF THE UN COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN

ABUJA, NIGERIA, OCTOBER 14-16, 2012

Ministerial communique

We, the Ministers of Health from the Democratic Republic of Congo, the Federal Democratic Republic of Ethiopia, the Federal Republic of Nigeria, Senegal, Sierra Leone, United Republic of Tanzania and Uganda, applaud the Government of the Federal Republic of Nigeria and the Government of Norway, for their leadership in the United Nations Commission on Life-Saving Commodities (UNCC). We acknowledge the UNCC Secretariat – the United Nations Population Fund and United Nations Children Fund – for their immense support.

We invite our Ministers of Health from other countries to join this initiative;

Recalling the objectives and the recommendations of the UNCC; the UN Secretary General's Global Strategy for Women and Children's Health; the Every Woman Every Child (EWEC) movement and building on the pledges made as part of A Promise Renewed for Child Survival and Family Planning 2020;

Recognizing the need for immediate action to increase access to life-saving commodities for all women and children;

Acknowledging that as Government Officials we have a responsibility to guarantee health for women and children in our respective countries;

Building on Nigeria's "Saving One Million Lives" initiative, and other best practices from member states, through enhanced South-South Cooperation and innovative practices including the strategic use of Information and Communication Technologies;

And using existing harmonization mechanisms to align policies and normative processes.

We commit to:

- Undertake a review of the status of the thirteen life-saving commodities, opportunities, bottlenecks and gaps in our respective countries;
- Engage national stakeholders including Parliamentarians, private sector, civil society, technical and financial development partners;
- Develop effective scale-up plans founded on evidence-based strategies, leading to the prioritization of high impact interventions;
- Reconvene in April 2013 to discuss our respective progress;
- Work with development partners and other stakeholders to carry-out the necessary actions to ensure sustainable and equitable access to and use of life saving commodities to all women and children in our respective countries by 2015, including relevant systems strengthening, demand creation (as part of a long-term strategic plan);
- Continue to engage our respective Governments to allocate additional funding and sustainable budget lines for life-saving commodities by 2015.

Signed in Abuja, October 16, 2012

Democratic Republic of Congo
Dr Felix Kabange Numbi
Minister of Health

Federal Democratic Republic of Ethiopia
Dr Tedros Adhanom Ghebreyesus
Minister of Health

Federal Republic of Nigeria
Dr Muhammad Ali Pate
Minister of State for Health

Senegal
Professor Awa Marie Coll Seck
Minister of Health

Sierra Leone
Hon. Tamba M. Borbor-Sawyer
Acting Minister of Health and Sanitation

United Republic of Tanzania
Hon. Dr Hussein Ali Mwinyi
Minister of Health and Social Welfare

Uganda
Hon. Sarah Achieng Opendi
Minister of State for Primary Health Care

Hon. Juma Duni Haji,
Minister of Health, Zanzibar

Indonesia

Indonesia: a continued effort to put commitments into action

Improving women's and children's health remains a high priority in Indonesia, particularly in the context of achieving the MDGs by 2015. Maternal and child health is improving across the country, but the rate of progress needs to be accelerated to achieve the targets of MDGs 4 and 5. The challenges are daunting, but the Government has put in place a wide range of necessary policies and strategies to deal with these problems.

It is heartening that many MDGs stakeholders across the country are increasingly aware of women's and children's health as central to the overall MDGs achievement. Women's and children's health is now recognized as an essential pre-condition and foundation for achievement of various MDGs targets.

The Government's commitments to improve maternal and child health continue to be realized and expanded. Chief among them is the national flagship programme for reducing maternal and child mortality rates through Universal Delivery Care (nationally known as Jampersal). Since roll-out in 2011 this nationwide programme has increasingly benefited poor communities where access to safe delivery services is a problem. In 2012 it aimed to provide free delivery services for 2.5 million less-privileged mothers.

At the sub-national level, commitments to reduce maternal and child mortality have led to actions tailored to local needs in the provinces and districts, where maternal and child health is still a concern. Sub-nationally, the main priorities include: capacity building, provision of appropriate facilities, distribution of skilled birth attendants, health financing and good governance.

Women's and children's health is now recognized as an essential pre-condition and foundation for achievement of various MDGs targets.

The private sector and civil society are increasingly committed to improving women's and children's health, and substantial partnerships have been forged between non-state actors and the Government. Through the Office of the Special Envoy on MDGs, the Government has initiated an integrated model programme (*Pencerah Nusantara*) in seven community health centres (*Puskesmas*) across six different regions. This pilot programme addresses health problems typically encountered at the primary health care level, and increases the resilience and independence of communities. It employs information and communication technology, collection of individuals' health data and monitoring and evaluation to ensure a sustainable improvement in community health. The seven *Puskesmas* use United Nations Life-Saving Commodities as a basic reference for inventory of required commodities.

Another milestone in 2012 was the launch of the EMAS (Expanding Maternal and Neonatal Survival) programme – a four-year collaboration between Indonesia's Ministry of Health and USAID. It aims to accelerate the reduction of maternal and neonatal mortality rates at the secondary health care level (regional hospitals) in six selected provinces, which account for roughly 50% of the country's maternal mortality rate.

The various efforts across different levels of government, at national and regional level, are aimed toward the implementation of Universal Health Coverage, planned to commence in 2014. Our overall strengthening of the national health system, across a wide spectrum of health-care deliveries (including health infrastructure, capacity building of health-care professionals and health financing) is being undertaken to achieve health equity in Indonesia.

Susilo Bambang Yudhoyono
President of Indonesia

Regional and inter-parliamentary commitments

African Union Commission

Accelerating progress in saving the lives of women and children

Improving maternal and child health is a priority for Africa. In May 2009, the African Union Commission (AUC) launched the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) with the theme: “Africa cares: No woman should Die while Giving Life”. This promotes the renewed and effective implementation of the Continental Policy on Sexual Reproductive Health and Rights and the Maputo Plan of Action to attain MDG 5.

Over 500 000 women die every year from pregnancy- and delivery-related complications, and 80% of these deaths are in Africa. However, most could be avoided. I am glad to note that, as of May 2012, 37 Member States had launched CARMMA, which the AUC has now expanded to include child mortality.

Following the 15th Ordinary Session of their Assembly in 2010 in Kampala, the AU Heads of State and Government sanctioned the extension to 2015 of the AU’s two continental policy instruments. This aligned them with MDGs reporting – particularly for MDGs 3, 4, 5 and 6. The first progress report on Maternal Newborn and Child Health was submitted to the Assembly in July 2012, while the report on the Abuja Call is due in May 2013.

Despite the increased political leadership, partnership and progress in maternal and child health, African women and children are still suffering and dying disproportionately – and many of these deaths are from preventable conditions. In most African countries, access to critical life-saving, affordable medicines is compromised by poor supply and distribution systems, insufficient health facilities and staff, low investment in health and high cost of medicines.

We should not establish a vertical system and must, therefore, reach out and achieve the full support and buy-in of all AU Member States ... The AUC stands ready to facilitate the implementation of the key recommendations of the report.

Against this background the AUC welcomed the establishment of the United Nations Commission on Life-Saving Commodities for Women and Children. It is noteworthy that its report has defined a list of overlooked life-saving commodities, and identified key barriers to access and use. It also recommended innovative action to rapidly increase access to and use of quality life-saving commodities through: (a) improved markets; (b) improved national delivery; and (c) improved integration of private sector and consumer needs.

The report also included an implementation plan with priority actions at global and country levels, which I’m sure will be fully discussed with countries and national partners in Africa with the full involvement of the AUC. We should not establish a vertical system and must, therefore, reach out and achieve the full support and buy-in of all AU Member States. The implementation plan provides another opportunity to take CARMMA to the next level as a means of reducing maternal and child mortality in Africa. The AUC stands ready to facilitate the implementation of the key recommendations of the report.

Similarly, through its Pharmaceutical Manufacturing Plan for Africa (PMPA), the AUC will continue to advocate at the highest levels for increased availability, affordability and accessibility of essential but underutilized supplies for maternal and child health. The AUC remains committed to garnering the required political will to effect the desired change.

Nkosazana Dlamini Zuma

Chairperson of the African Union Commission

East African Community

Increased accountability and transparency will accelerate progress

When leaders of country governments sign political commitments such as the Millennium Development Goals (MDGs), they make commitments not only to the global community but also, more importantly, to people whose lives depend on them.

The countries of the East African Community (EAC) have an opportunity to improve reproductive, maternal, newborn and child health, and are committed to doing so. The context is stunting rates for under-fives at 58% in Burundi; maternal mortality at 488/100 000 live births in Kenya; child mortality at 76/1000 live births in Rwanda; 27% unmet need for contraceptives in Tanzania; and skilled attendants at only 59% of births in Uganda.

We can achieve improvements by leveraging the collective market size of the region, and its knowledge and continual successes in RMNCH. The aim is to meet – and improve beyond – the targets identified in recent political commitments. I applaud the leadership of the United Nations Secretary-General as well as the commitment of East Africa's leaders to focus on RMNCH.

We must do more with the resources and knowledge we have by increasing accountability and the efficiency of resources and by decreasing duplication of effort.

Accelerating progress in saving the lives of women and children to 2015 and beyond requires that we try different approaches. An example in East Africa is the Open Health Initiative (OHI). This aims to help the EAC Partner States reach their goals for women's and children's health by focusing on three thematic areas: Accountability for Results and Resources; Results-based Financing; and Innovation.

The OHI prioritizes increased accountability and transparency for results and resources by all stakeholders – which are essential to improving women's and children's health and achieving MDGs 4 and 5. Only through quality data, including vital registration, can we measure, target and scale up successful interventions. The current financial context demands that we use existing funds – domestic and external – more efficiently and effectively to improve women's and children's health.

As part of the OHI, we shall strengthen and maintain political momentum, best practices and knowledge sharing for action, and establish an Acceleration Fund for maternal and child health.

In a clear and decisive step in prioritizing the health of women and children, the OHI was approved by all five EAC Heads of State in November 2012, with implementation set to begin in January 2013.

The Global Community made important commitments in agreeing MDGs 4 and 5. It must be accountable for delivery.

Accountability encompasses: political accountability to previous commitments; performance accountability to meet targets; economic accountability for reporting financial information; and, most importantly, accountability to provide quality care to patients.

Standards and commitments alone will not improve accountability and the health of women and children. Actions must be taken within countries to ensure that data are properly recorded and reported, and that financial information is tracked and shared. Given current global financial constraints, we must do more with the resources and knowledge we have by increasing accountability and the efficiency of resources and by decreasing duplication of effort. Women and children expect no less.

Richard Sezibera
Secretary-General
East African Community

Inter-Parliamentary Union

The role of the Inter-Parliamentary Union in addressing key challenges to securing the health of mothers and children

Parliaments and their members are fundamental to development efforts because they represent the people and their concerns. They also shape policies, make laws, approve budgets and oversee the proper use of resources by governments.

The Inter-Parliamentary Union (IPU) has mobilized political support among parliaments worldwide for more robust action on women's and children's health – in line with the Global Strategy on Women's and Children's Health. Political pronouncements by the IPU that support the Global Strategy and MDGs include the declaration of the 3rd World Conference of Speakers of Parliament (2010); the Bern Initiative for Global parliamentary Action on Maternal and Child Health adopted by the 6th Annual Meeting of Women Speakers of Parliament (2010); and the Kampala Resolution on the Role of Parliaments in Women's and Children's Health (2012). The IPU has also led efforts to strengthen parliaments' capacities to implement this policy framework.

Accelerating progress

With other parliamentary bodies, the IPU is mobilizing parliaments to create a global policy environment that strongly supports and promotes the adequate provision and accountable use of resources for women's and children's health. This includes supporting the implementation of the recommendations of the Commission on Information and Accountability, and integrating them within relevant country-level policy frameworks and plans. The IPU has also contributed to the first report of the independent Expert Review Group.

The IPU is mobilizing parliaments to create a global policy environment that strongly supports and promotes the adequate provision and accountable use of resources for women's and children's health.

The IPU's commitment to the Global Strategy centres on mobilizing support within the global parliamentary community to enhance access to, and accountability for, improved health for women and children. To this end it launched a global parliamentary dialogue on women's and children's health, which culminated (at the April 2012 Kampala Assembly) in the resolution, Access to health as a basic right: The role of Parliaments in addressing key challenges to securing the health of women and children. The resolution catalogues measures that parliaments can take – including allocating adequate funding, revising national health policies and overseeing improved service delivery. Significantly, it incorporates provision for an accountability mechanism to track implementation by national and other parliamentary bodies. The resolution has already begun to catalyse action in parliaments and regional parliamentary bodies, providing the basis for collaboration between the IPU and new partners.

At the national level, parliaments are showing encouraging signs of increasing their contributions to women's and children's health. Since 2010, the IPU has progressively increased the resources it makes available for support to national and regional parliaments to deepen accountability and improve results for women's and children's health. This assistance has included capacity-building, training seminars and workshops, help designing national parliamentary strategies, legislative audits to identify gaps, and the development of tools to promote maternal and child health. In 2012, IPU support was focused primarily on priority African countries, but in 2013 will be extended to parliaments in Asia. The IPU will continue to work with partners to broaden and strengthen parliamentary action on women's and children's health.

Abdelwahad Radi

President of the Inter-Parliamentary Union

Civil society has many roles to play as we approach 2015 – advocating for commitment to life-saving commodities for women and children

World Vision International, IPPF, White Ribbon Alliance for Safe Motherhood and Save the Children

Civil society has many roles to play as we approach 2015

Since 2010, when the United Nations Secretary-General launched Every Woman Every Child, we have seen a growing global movement committed to preventing the needless deaths of women and children.

As we approach the Millennium Development Goals target date of 2015 the world needs to intensify its efforts to end preventable maternal and child deaths, and ensure that we learn from examples of success. There is cause for cautious optimism. For the first time the number of recorded child deaths has fallen below 7 million, and 24 high-burden countries are now on track to achieve MDG 4. Maternal mortality has reduced by nearly 50% since 1990, and progress towards both MDGs 4 and 5 is accelerating. This progress has been strengthened by the Every Woman Every Child initiative.

Yet formidable challenges remain. Millions of women still give birth each year without a skilled health worker in attendance. Over 220 million women have an unmet need for modern contraceptive methods. Every year 15 million babies are born too soon and over 1 million children die due to complications of preterm birth. Over 20 million children are bypassed by routine immunization – mostly the poorest and hardest to reach – and 170 million children are chronically malnourished.

The world needs to intensify its efforts to end preventable maternal and child deaths, and ensure that we learn from examples of success. There is cause for cautious optimism.

Tackling these challenges and accelerating progress will take an enormous effort, but it can be done with enough will and commitment. Civil society is poised and ready to take this forward, by working with governments, parliamentarians and with the communities

which lie beyond the reach of governments to provide services, particularly to the hard-to-reach and most marginalized communities. This includes acting as a watch dog; tracking progress towards meeting the commitments; advocating for change with governments and other stakeholders; celebrating success but also challenging failure – including empowering communities to hold their own leaders to account for failure to deliver.

In 2013 our different organizations, working in our areas of expertise and working closely with others, in partnership, will do this in many ways – starting by giving women and girls the means to plan their own lives by ensuring that they have access to contraception; one of the most cost-effective health and development interventions. In 2012, the London Summit on Family Planning committed to meeting the contraceptive needs of an additional 120 million women by 2020. We will contribute towards this goal through our programmes, and we will advocate for others to meet their commitments; keeping in mind that prematurity is the leading cause of newborn deaths (babies in the first four weeks of life) and is now the second leading cause of death after pneumonia in children under the age of five.

We will support a renewed emphasis on ending preventable child deaths through ensuring children have access to life-saving vaccines and the launch of a new global action plan on the prevention and control of pneumonia and diarrhoea. In 2011, donors pledged US\$ 4.3 billion through the GAVI replenishment. We will support the roll-out of pneumococcal and rotavirus vaccines to the children at greatest risk of vaccine-preventable disease, with the potential to save 4 million lives by 2015.

In line with the recommendations of the United Nations Commission on Life-Saving Commodities, we will ensure that women and children have access to essential but under-used health commodities such as antenatal corticosteroids (ANCS) and amoxicillin. For example, a simple injection can prevent a woman bleeding to death after childbirth. Quick treatment with antibiotics will save many more babies and children from dying of pneumonia. And we will support national and local advocates to push for the delivery and financing of these commitments and to ensure that women and families know their rights to quality health care.

Finally, we will build support for more and better-supported health workers, to deliver the quality services promised, and work towards an ambitious, equitable and accountable post-2015 framework for health. This will build on the discussions started in A Promise Renewed and place women and children at its heart.

Kevin Jenkins

President and CEO
World Vision International

Tewodros Melesse

Director-General
IPPF – International Planned Parenthood Federation

Theresa Shaver

President
White Ribbon Alliance for Safe Motherhood

Jasmine Whitbread

CEO
Save the Children

Our agencies are all represented on the Board of the *Partnership for Maternal, Newborn & Child Health* – a unique alliance bringing together over 500 members from seven different constituencies, NGOs, governments, the private sector, multilaterals, donors and foundations, the academic and research community and health-care professionals.

Joining forces for family planning and maternal, newborn and child health

WHO, UNFPA and UNICEF

Maternal and child mortality have declined dramatically in the past 20 years. Maternal deaths have dropped from 543 000 a year in 1990 to 287 000 in 2010, and child deaths from 12 million to 7.6 million over the same period. Estimates for child deaths in 2011 indicate that the numbers fell even further to 6.9 million. However, to reach MDGs 4 and 5, progress needs to accelerate in the three years to 2015.

As we take stock of the progress, new opportunities are being created. The launching of the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010 prompted the commitment of more than US\$ 43 billion for maternal, newborn and child health and created a framework for action to accelerate survival gains.

In response to the Global Strategy, the Commission on Information and Accountability for Women's and Children's Health delivered 10 recommendations to fast track results for women's and children's health. The Commission called for an independent Expert Review Group (iERG) to operate until 2015, reporting annually to the United Nations Secretary-General on results and resources related to the Global Strategy and on progress in implementing the Commission's recommendations. The iERG's first report, in September 2012, included recommendations to strengthen global governance and develop an investment framework for women's and children's health.

Major events in 2012 advocated and catalysed action. In May, the launch of *Born Too Soon: The Global Action Report on Preterm Birth* highlighted the importance of preventing and managing preterm births. In June, 166 countries and multiple partners pledged, through *A Promise Renewed*, to reduce child mortality to below 20/1000 live births in every country by 2035. In July, at the London Summit on Family Planning, global leaders united to provide 120 million women in the poorest

countries with access to modern contraceptives. These events and catalytic initiatives have been supported by the WHO Member States' endorsement of the Decade of Vaccines: Global Vaccine Action Plan, and development of an implementation plan on maternal, infant and young child nutrition.

The launching of the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010 prompted the commitment of more than US\$ 43 billion for maternal, newborn and child health and created a framework for action to accelerate survival gains.

The collective strengths and comparative advantages of six United Nations entities (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank) have been brought together under the H4+ initiative. H4+ provides for coordinated and harmonized support to accelerate progress towards MDGs 4 and 5. In line with the Global Strategy, H4+ work focuses on countries with the highest rates of maternal, newborn and child mortality. The H4+ CIDA collaboration project supports implementation of the Global Strategy in five countries: Burkina Faso, the Democratic Republic of Congo, Sierra Leone, Zambia and Zimbabwe.

Further collaboration with the French Muskoka Initiative supports efforts to accelerate implementation in: Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Guinea, Haiti, Mali, Niger, Senegal and Togo. The focus is on the identification of health systems bottlenecks and the prioritization of interventions known to be effective in improving maternal and newborn health.

The H4+ also strongly focuses on human resources for maternal, newborn and child health, in particular within the midwifery workforce. As a follow-up to the launch of the State of the World's Midwifery report in 2011, an initiative for high-burden countries is working with eight countries to produce the data the governments need to plan effectively for development of the midwifery workforce. Ultimately this should increase access to skilled birth attendance at childbirth; one of the three key strategies to reduce maternal and newborn mortality.

Progress was reviewed in September 2012, with the launch of reports of the Partnership for Maternal, Newborn & Child Health (Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health) and the Countdown to 2015 (Building a Future for Women and Children). Also in September, the United Nations Commission on Life-saving Commodities for Women and Children launched its report. It set out 10 practical, high-impact recommendations for improving the supply of 13 commodities for reducing maternal, newborn and child mortality by taking action in the areas of market shaping, regulation, supply and demand.

The H4+ also strongly focuses on human resources for maternal, newborn and child health, in particular within the midwifery workforce.

The collaboration of the three agencies will continue with a common two-pronged focus: ending preventable maternal and child deaths and supporting countries to implement strategies to achieve equitable coverage with effective interventions.

All of us, including many millions of mothers and children, are grateful for the strong support shown by an expanding community of partners and by the rapid growth of innovative initiatives that address long-standing problems – with a good chance of success.

Margaret Chan
Director-General
WHO

Babatunde Osotimehin
Executive Director
UNFPA

Anthony Lake
Executive Director
UNICEF

Getting more health for the money

GAVI

The fully immunized child is our new objective

A dramatic change is sweeping across the developing world. Vaccines against the worst forms of the two biggest child killers, pneumonia and diarrhoea, are being rapidly introduced into routine immunization programmes.

In February 2011, President Kibaki launched pneumococcal vaccine in Kenya. This came just 18 months after its first use in high-income countries – so the historical 15-year-plus time lag in equitable access to new vaccines is being closed. Since then, over 20 more countries have introduced the vaccine.

In July 2011 Sudan became the first African country to introduce rotavirus vaccine. 2012 saw two historic introductions, with Ghana and Tanzania each introducing pneumococcal and rotavirus vaccines simultaneously. In December 2012 in Nigeria, the 100 millionth person received the new meningitis A vaccine, within two years of the vaccine becoming available. An end to the devastation of meningitis epidemics is in sight. By 2014, the ground-breaking five-in-one pentavalent vaccine will be in routine use across all 73 GAVI-supported countries.

Together, these represent a momentous advance in global public health. Vaccines for women will be a major focus in 2013 as GAVI initiates support for developing countries to introduce rubella and human papillomavirus (HPV) vaccines.

Immunization is one of the most successful and cost-effective public health interventions in human history.

The HPV vaccine, which prevents cervical cancer, will reach a critical cohort of adolescent girls, who until now have had little regular contact with health-care providers. By integrating other sexual and reproductive health services into the immunization contact, we can further extend the value of the vaccines – potentially delivering “more health for the money”.

Immunization is one of the most successful and cost-effective public health interventions in human history. New studies estimate that, over the decade to 2020, immunization will save more than US\$ 2.6 billion in treatment costs and by averting lost caretaker wages and lost productivity in the world's poorest countries.

With the support of the GAVI Alliance, 370 million additional children have been immunized against leading vaccine-preventable diseases in the world's poorest countries since 2000, saving over 5.5 million lives. We expect to accelerate this by helping countries to immunize 245 million children between 2011 and 2015, preventing an additional 4 million deaths.

The design of the post-2015 development agenda presents an opportunity to reset our ambitions for immunization. For 40 years, the global community has measured success by diphtheria-tetanus-pertussis and measles vaccine coverage rates.

However, new vaccines allow us to shift standard immunization indicators into the 21st century. That is why GAVI is advocating for a new measure of vaccine coverage – the fully immunized child. It is time to challenge the world to ensure that all children benefit from the protection of all available vaccines.

While recent advances in vaccine access are historic, it is sobering that this year more than 22 million children went unvaccinated against basic childhood illnesses. One in five children is not immunized. Reaching the fifth child is the compelling challenge of the decade – but as she is not standing next to the other four, a special effort will be needed.

Seth Berkley

**Chief Executive Officer
GAVI**

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Investing for impact across a range of interventions

Making mothers and children healthy can have a tremendous effect on a country's long-term development. For this reason, the Global Fund has made improving the maternal and child health an explicit objective of its new strategy of investing for impact.

Most of the people who receive treatment for HIV in sub-Saharan Africa are female, and AIDS-related illness remains the biggest cause of death among women of child-bearing age. As a result, health workers treating women with HIV automatically look for synergies between MDGs 4, 5 and 6. And it's an approach that works.

By the end of 2012, 1.7 million pregnant women living with HIV were receiving antiretroviral treatment to prevent mother-to-child transmission. How was this achieved? In countries with the biggest gains – such as Rwanda and Tanzania – the greatest progress came when government-led efforts were supported by the right technical expertise and help from multilateral and bilateral supporters and other partners.

Similarly, Ethiopia used this combined approach to extend basic health coverage from 50% to 92% of its population between 2005 and 2010. It achieved reductions in HIV, tuberculosis and malaria mortality, while maternal mortality declined by 31%.

Protecting pregnant women and reducing child mortality are also primary aims of malaria prevention and treatment. In eight countries in Africa, malaria cases and deaths have declined by over 50% since 2005, and success is again found where government-led programmes receive good support from partners.

It makes sense to support health programmes that cover a range of interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth and infant and child care.

In the Global Fund's experience, it makes sense to support health programmes that cover a range of interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth and infant and child care. Based on disbursements made for 12 key interventions, approximately 42% of the total disbursements from the Global Fund (around US\$ 6.5 billion) have contributed to maternal and child health globally.

The Global Fund also contributes actively to stronger health systems, through specific programmes that support health workers, procurement, logistics and monitoring. In addition, programmes that reduce the sizable burden placed on health centres by malaria and AIDS cases can dramatically strengthen the capacity of health workers to treat other diseases and promote greater health overall. In Namibia, for instance, an 80% decline in AIDS cases in hospitals has freed up hospital beds for other health conditions.

Overall, by the end of 2012, health programmes supported by Global Fund grants had provided: 4.2 million people with antiretroviral treatment for AIDS; 310 million insecticide-treated nets to protect families from malaria; and 9.7 million tuberculosis cases detected and treated. We estimate that programmes supported by Global Fund grants have resulted in over 8.7 million lives being saved.

In recent years, there has been considerable progress in reducing the global prevalence of HIV, tuberculosis and malaria. By investing for impact, with strong synergies across MDGs 4, 5 and 6, women's and children's health can be further improved.

Mark Dybul

Executive Director

The Global Fund to Fight AIDS, Tuberculosis and Malaria

UNITAID

Shaping markets for women and children

UNITAID was created in 2006 to shape markets for life-saving commodities for HIV/AIDS, malaria and tuberculosis. Our goal is to make them more available, more affordable and more suited to some of the world's poorest – often women and children.

Markets often fail women and children and deny them access to vital medicines. Unfortunately, under “natural” market conditions, manufacturers have no incentive to produce products tailored to the poor – such as child-friendly tuberculosis treatments or simple community-level diagnostics for HIV or malaria. Despite large-scale need, the result for millions of women and children is often high prices, low quality and poorly-adapted products for these preventable and treatable diseases.

UNITAID gathers rigorous market intelligence on product markets to identify where investment is needed. Once intervention areas are selected, our main fundraising instrument – the air ticket levy – provides a reliable source of funds for correcting market failures.

This sustainable stream of revenue has allowed for an impressive scale-up of life-saving commodities for women and children. For instance: 8 million HIV tests for pregnant women; over 1 million paediatric tuberculosis medicines; and almost 200 million artemisinin combination therapies to combat malaria. But above and beyond the scale-up provided by this innovative financing instrument, real added value is found when these funds are channelled through targeted market interventions to create new conditions that are sustainable in the long term.

The lack of paediatric HIV in wealthy countries meant there was little incentive for companies to develop child-friendly antiretrovirals.

One example is UNITAID's creation of the paediatric HIV treatment market. The lack of paediatric HIV in wealthy countries meant there was little incentive for companies to develop child-friendly antiretrovirals. UNITAID identified this gap and invested heavily in paediatric antiretrovirals for people in developing countries, using pooled procurement to incentivize suppliers to manufacture new child-adapted formulations. Several generic suppliers entered the market – negotiations with these manufacturers and increased competition led to price reductions of up to 80%.

Other interventions have also led to great impact. UNITAID's support for the WHO Prequalification Programme (ensuring access to medicines that meet unified standards) has facilitated market entry of generic manufacturers, while preserving products' high quality. The Medicines Patent Pool, created by UNITAID, is working with patent holders to make intellectual property work for public health. Its mission is to reduce the prices of HIV medicines and facilitate development of better-adapted HIV medicines.

These investments come with a “multiplier effect,” allowing other global health funders and countries to take advantage of improved availability of better products or lower prices. With considerable UNITAID support to establish paediatric HIV treatment programmes, countries like Botswana are on the path to fully funding their paediatric antiretroviral needs domestically.

The United Nations Commission on Life-Saving Commodities for Women and Children has advanced understanding that market-based approaches can provide the best health for women and children for the money available. UNITAID stands ready to associate with the Commission's work, as each case of market failure for medicines for women and children calls for specific solutions that UNITAID's experience can help to identify and solve.

Denis Broun
Executive Director
UNITAID

Implementing the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children

Turning recommendations into action for women and children

We, the convening organizations, endorse the report of the United Nations Commission on Life-Saving Commodities for Women and Children and are determined to take action to increase the accessibility of the 13 commodities, in anticipation that these actions can save over six million lives during the next five years.

Each convening organization has developed specific global-level action plans with the aim that these actions will support the country-led and determined efforts within each of the Every Women Every Child countries. These global supporting actions are summarized below by recommendation. The commodity-level activities are incorporated in the recommendations for the sake of brevity.

- 1. Shaping global markets: By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.** In 2013 an analysis will be performed of which commodities are most likely to benefit from global market shaping interventions, meaning that a commodity's availability can be greatly improved through global interventions to either reduce the price or ensure a consistent supply. The commodities anticipated to most benefit from global market shaping are amoxicillin, contraceptive implants, female condoms and oxytocin in a pre-filled dispenser. The global market shaping intervention per commodity will be designed, validated and implemented. In addition, a web-based solution will be made available informing on commodity availability and pricing by geographic location.
- 2. Shaping local delivery markets: By 2014, local health providers and private sector actors in all EWEC countries are incentivized to increase production, distribution and appropriate promotion of the 13 commodities.** In 2013 comprehensive local market-shaping interventions for ORS and zinc will be rolled out in at least six to eight countries. This may include increasing the number of local producers as well as implementing supplier incentives. In addition, local market-shaping opportunities for other commodities (such as chlorhexidine) will be explored, and a strategy will be developed to more effectively utilize local private sector distribution chains.
- 3. Innovative financing: By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.** In 2013, the use of existing results-based initiatives and funds in order to improve access to the commodities will be reviewed as well as country input and interest gathered. Scorecards and other accountability mechanisms will be developed in order to measure results.
- 4. Quality strengthening: By 2015, at least three manufacturers per commodity are manufacturing and marketing quality-certified and affordable products.** In 2013, the quality of a sample of all commodities will be analysed in as many as 10 countries. Quality issues and interventions will be identified. WHO's Expert Review Panel (ERP) will assess the quality risks of specific commodities whose manufacturers have not yet met stringent quality requirements. Based on standardized and transparent criteria the ERP will then advise whether each product would be acceptable for procurement in the near-term. Commodities targeted for ERP beginning in 2013 are dispersible amoxicillin, emergency contraception and oxytocin. Manufacturers will begin to receive technical assistance as necessary.



5. **Regulatory efficiency: By 2015, all EWEC countries have standardized and streamlined their registration requirements and assessment processes for the 13 life-saving commodities with support from stringent regulatory authorities, the World Health Organization and regional collaboration.** In 2013, an investigation of the regulatory status of all of the commodities will be performed in target countries. This will identify how many of the nationally available products have gone through a national or international quality certification process. Based upon the findings, regulatory pathways per commodity will be recommended. In addition, streamlined regional regulatory approaches will be advanced in order to simplify the administrative burden of applying for national regulatory approval. Support will also be given to national essential medicine list review processes and policy adoption to ensure that the latest evidence is being used.
6. **Supply and awareness: By 2015, all EWEC countries have improved the supply of life-saving commodities and build on information and communication technology (ICT) best practices for making these improvements.** In 2013 evidence surrounding best practices in supply chain management both for the public and private sector will be synthesized and disseminated. Guidance for quantification and forecasting of all commodities will be developed. ICT solutions will be developed to integrate the commodities into the existing national systems, and these solutions will be piloted in at least one country. Efforts will be made to include oxytocin into the global vaccine cold chain. Finally, guidance will be developed for integrating chlorhexidine, female condoms and resuscitation devices into existing public sector health supply systems.
7. **Demand and utilization: By 2014, all EWEC countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilization of health services and products, particularly among underserved populations.** In 2013 evidence surrounding best practices in generating demand for the commodities will be synthesized and disseminated. Quick-start demand generation toolkits will be developed for targeted commodities like antenatal corticosteroids, chlorhexidine, emergency contraception, magnesium sulphate and ORS/zinc. Commitments will be secured from the private sector to support the design and implementation of demand generation activities per commodity in five Pathfinder countries.
8. **Reaching women and children: By 2014, all EWEC countries are addressing financial barriers to ensure the poorest members of society have access to the life-saving commodities.** In 2013 a review of existing mechanisms to increase access to the commodities amongst the poor and the young, like conditional cash transfers and insurance schemes, will be performed and disseminated. Countries will be invited to an information-sharing event where they can receive technical assistance to design approaches that meet national needs.
9. **Performance and accountability: By end 2013, all EWEC countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines.** In 2013 available guidelines, job aids, checklists and relevant e- and mHealth support mechanisms applicable to the commodities (such as those addressing the time of birth and instances of fever) within EWEC countries will be gathered, assessed and gaps identified. New content and tools will be developed as appropriate, tested and rolled out. In addition, existing monitoring systems for performance measurement and accountability will be reviewed jointly with the Secretariat and other conveners and adapted to assess progress in the use and distribution of commodities.
10. **Product innovation: By 2014, research and development for improved life-saving commodities has been prioritized, funded and commenced.** In 2013 the commodities will be reviewed to identify those that require additional innovations. These innovations will be prioritized with the highest priority projects commenced and financed. Likely candidates include injectable antibiotics, magnesium sulphate, misoprostol, oxytocin, resuscitation devices and diagnostics for pneumonia.

We... are determined to take action to increase the accessibility of the 13 commodities, in anticipation that these actions can save over six million lives during the next five years.

We, the convening organizations, commit to convene the following global implementation areas as specified.

Area	Convening Organization	Contact person
Recommendation 1 – Shaping global markets	British Department for International Development	James Droop
	Clinton Health Access Initiative	Hema Srinivasan
Recommendation 2 – Shaping local delivery markets	Government of Nigeria	Minister Muhammad Ali Pate
	Clinton Health Access Initiative	Pascal Bijleveld
Recommendation 3 – Innovative financing	Norwegian Agency for Development Cooperation	Ingvar Theo Olsen
	World Bank	Monique Vledder
Recommendation 4 – Quality strengthening	World Health Organization	Lisa Hedman
	Nigerian National Agency for Food and Drug Administration and Control	Paul Orhii
Recommendation 5 – Regulation efficiency	World Health Organization	Lisa Hedman
	Nigerian National Agency for Food and Drug Administration and Control	Paul Orhii
Recommendation 6 – Supply and awareness	USAID	Jennifer Bergeson-Lockwood
	UNFPA	Jagdish Upadhyay
Recommendation 7 – Demand and awareness	USAID	Hope Hempstone
	Government of the United Republic of Tanzania	TBD
Recommendation 8 – Reaching women and children	Government of Uganda	TBD
	Save the Children	Francesco Aureli
	UNFPA	UNFPA Uganda Country Office (in support role)
Recommendation 9 – Performance and accountability	mHealth Alliance, UN Foundation	Patricia Mechael
	African Medical and Research Foundation	John Nduba
Recommendation 10 – Product innovation	PATH	Catharine Taylor
Amoxicillin	UNICEF	Francisco Blanco
Antenatal Corticosteroids	Save the Children	Joy Lawn
Chlorhexidine	PATH	Patricia Coffey
Contraceptive Implants	British Department for International Development	James Droop
	Bill & Melinda Gates Foundation	Robyn Sneeringer
Emergency Contraception	World Health Organization	Lale Say
Female Condoms	UNFPA	Bidia Deperthes
Injectable Antibiotics	Save the Children	Steve Wall
Oral Rehydration Salts	Clinton Health Access Initiative	Nancy Goh
Oxytocin	USAID	Deborah Armbruster
Magnesium Sulphate	USAID	Deborah Armbruster
Misoprostol	UNFPA	Jagdish Upadhyay,
		Kabir Ahmed
Newborn resuscitation equipment	USAID	Lily Kak
Zinc	Clinton Health Access Initiative	Nancy Goh

Accountability, information and results

Canada

Delivering results for women and children

Annually over 280 000 women, and nearly 7 million children, die entirely preventable deaths. Despite important and recent progress, these deaths are still unacceptable. We know that the health of mothers, newborns and children are inextricably linked, and that when women prosper, through good health and opportunities, they and their families can live with greater dignity.

I am proud that Canada chose, in 2010, to lead by making maternal, newborn and child health an urgent priority for the global development community. We used our G8 Presidency in 2010 to champion the Muskoka Initiative on Maternal, Newborn and Child Health, which attracted more than US\$ 7.3 billion in new and additional funding from G8 members, like-minded donors and other donor organizations.

And these commitments catalysed a broader effort led by United Nations Secretary-General Ban Ki-moon – and involving partners from developing countries, donor nations, the private sector and nongovernmental organizations – to help women and children in developing countries. Not only did Canada help mobilize significant new resources, we contributed to strengthening accountability for the resources pledged and the results promised. I was pleased to co-chair with President Kikwete of Tanzania, in early 2011, the Commission on Information and Accountability for Women's and Children's Health, which recommended practical actions to deliver better results from our shared actions. The Commission proposed a simple but powerful framework of accountability – monitor, review and act – and Canada is doing just that.

Canada committed to reduce maternal and child mortality by strengthening health systems, reducing the burden of disease and improving nutrition – an underlying cause of 35% of maternal and child deaths.

In Ethiopia, we are helping to train more than 4000 community health workers to provide life-saving nutritional support and supplements for close to 3 million pregnant and nursing women, and their children. In Haiti, we are helping to provide basic health care for a further 3 million people and we are building 10 new maternity clinics. In Mozambique, we helped 3.9 million children be vaccinated against measles – a preventable disease that is one of the major killer of children.

I am proud that Canada chose, in 2010, to lead by making maternal, newborn and child health an urgent priority for the global development community.

Canada is committed to acting to improve our results. CIDA has brought together over 60 Canadian organizations – NGOs, hospitals, researchers, and associations of health professionals – in the Canadian Network on Maternal, Newborn and Child Health, to strengthen their collaboration and help improve our impact through a "whole-of-Canada" approach. We are contributing to public-private partnerships, supporting innovative solutions to save newborn lives, and helping long-standing partners expand their reach to more mothers and children. And we continue to work with our partners to advance the implementation of the Commission's recommendations. For example, following the earthquake in Haiti, CIDA has been working with the Organization of American States to develop and maintain a national civil registration system, which will advance the Commission's recommendation on vital events.

In 2010 I promised that "[Canada's] contribution will make significant, tangible differences in the lives of the world's most vulnerable people." Canada is delivering on our promise. We are making a difference.

Stephen Harper
Prime Minister of Canada

United Republic of Tanzania

Accounting for commitments and results

Sub-Saharan Africa is making the least progress towards MDGs 4 and 5, but a few countries in the region are on track – particularly for child health.

Tanzania, for example, has made significant progress in child health since 2000 and is now on track for MDG 4. According to WHO, the under-five mortality rate in Tanzania declined from 81/1000 live births in 2010 to 65.2/1000 in 2011 – closer to the MDG target of 54/1000. Similarly, infant mortality declined from 51/1000 live births in 2010 to 45/1000 in 2011.

This achievement is partly due to sustained high coverage for immunization and vitamin A supplementation, and improved malaria control and treatment. The coverage for three-doses of pentavalent vaccine, was 92% in 2011. Malaria control reduced the disease in children under five from 18% in 2007/08 to 10% in 2012. Currently, 72% of children under five sleep under insecticide-treated nets, meeting the targets for universal coverage.

However, we recognize that, even if we achieve MDG 4, the number of under-five deaths will still be unacceptably high – while progress towards MDG 5 for maternal health has been too slow.

We recognize that, even if we achieve MDG 4, the number of under-five deaths will still be unacceptably high – while progress towards MDG 5 for maternal health has been too slow.

I had the honour of co-chairing the Commission on Information and Accountability for Women's and Children's Health with Prime Minister Stephen Harper of Canada. This made 10 recommendations for implementation, and defined effective accountability in a cycle of monitor, review and action. The 10 recommendations focus on:

- (i) **Better information for better results.** Timely, accurate and reliable data to inform policy-making and planning by ensuring efficient use of resources for planning;
- (ii) **Better tracking of resources.** To ensure commitments are honoured and funds are allocated efficiently;
- (iii) **Global and national oversight.** The independent Expert Review Group – recommended by the Commission – produced its first report in 2012. It noted that progress in implementing the 10 recommendations has been slow, so I call upon all stakeholders to prioritize and accelerate our efforts.

Tanzania remains strongly committed to women's and children's health. We are rolling out the electronic District Health Information System (DHIS) to improve timeliness and reliability of data. Our initiatives to strengthen birth registration and maternal death surveillance, and to institutionalize national health accounts, are ongoing. And we are implementing the Primary Health Service Development Programme to improve access to health facilities and women's access to emergency obstetric care. Health training and recruitment are also key areas of focus, and we continue efforts to increase family planning coverage.

To save the lives of even more children, we will focus on newborn care and the prevention, control and management of pneumonia and diarrhoea. Immunization programmes for two vaccines – pneumococcal and rotavirus – has been introduced in January 2013. We are also scaling up nutrition for both women and children.

My wish is that we will all continue to hold ourselves and each other accountable to the promises we have made to women and children around the globe.

Jakaya Mrisho Kikwete

President of the United Republic of Tanzania

The independent Expert Review Group

The iERG: an innovation in accountability

As the era of the Millennium Development Goals draws to an end, it is right that countries and the global community compose a balance sheet of credit and debit. To proceed with confidence beyond 2015, towards sustainable development, we need to understand what has worked and what has not in our efforts to defeat diseases of poverty.

Undoubtedly, progress has been achieved in many areas. Spectacular reductions in under-five child mortality show what can be achieved when the global community displays political will, a commitment to translate research evidence into practice and an ability to scale up interventions for effective and equitable coverage.

But not all spheres of global health have shown similar progress. Reductions in maternal mortality have taken place but are hampered by persistent weaknesses in struggling health systems. In recognition of the need to hold all partners accountable for their promises to make progress, the Commission on Information and Accountability for Women's and Children's Health established (in 2011) an independent Expert Review Group (iERG) to monitor progress, to review successes and obstacles to success, and to offer remedies to overcome those obstacles. The iERG published its first report in 2012.

The iERG, co-chaired by Joy Phumaphi and myself, Richard Horton, made six recommendations to accelerate improvements in reproductive, maternal, newborn and child health. First, the welcome proliferation of initiatives around MDGs 4 and 5 mean that global governance frameworks for women's and children's health must be strengthened to avoid fragmentation, duplication and inefficiency.

Second, to take advantage of commitments already made, a global investment framework for women's and children's health should be devised. This framework will identify the most cost-effective interventions, as well as critical enablers, to ensure that interventions are fully and effectively delivered.

Third, to speed up progress in countries, clearer country-specific strategic priorities need to be set, including testing innovative mechanisms for delivering these priorities.

If the value of the iERG can be proven to partners, perhaps the notion of independent accountability could be strengthened further in future arrangements for global health.

Fourth, countries, with the help of partners, can make further progress by accelerating the uptake of eHealth and mHealth technologies – e.g. to strengthen civil registration and vital statistics systems.

Fifth, all partners must strengthen human rights tools and frameworks to achieve better health and accountability for women and children. Finally, there needs to be a far greater commitment to evaluation. Unless we know what works and why it works, we will be condemned to repeat failures and to miss opportunities to translate reliable evidence into the service of women and children.

In their second report, to be published at the United Nations General Assembly in 2013, the iERG will review the progress made on these recommendations. They will also focus on two new areas: adolescent health and country accountability. The iERG is a time-bound accountability mechanism, ending in 2015. It is an experiment. But if the value of the iERG can be proven to partners, perhaps the notion of independent accountability could be strengthened further in future arrangements for global health.

Richard Horton

**Co-Chair, the independent Expert Review Group
Editor-in-Chief of The Lancet**

Progress on MDG 4 and MDG 5: Insights from the Global Burden of Disease Study 2010

By Professor Christopher Murray

Director, Institute for Health Metrics and Evaluation, and lead author of the GBD study 2010 on behalf of the GBD 2010 Collaborators

What is the Global Burden of Disease Study 2010? (GBD 2010)

GBD 2010 is the largest ever systematic and rigorous study of the world's major diseases, injuries and health risk factors. Nearly 500 scientists from more than 300 institutions in 50 countries were involved.

Launched in 2007, GBD 2010 is a consortium of seven partners: Harvard University; the Institute for Health Metrics and Evaluation (IHME) at the University of Washington, Seattle; Johns Hopkins University; the University of Queensland; Imperial College London; the University of Tokyo; and WHO.

The study (published 13 December 2012) analyses data from 187 countries to explain why some causes of death and injury have declined since 1990, while others have increased. It examines 291 diseases and injuries and 67 risk factors that determine the patterns of disease and injury.

Lancet Editor-in-Chief Dr Richard Horton described GBD 2010 as: “a critical contribution to our understanding of present and future health priorities for countries and the global community.”

Summary of key findings

- Deaths from infectious diseases, maternal and child illness and malnutrition decreased by about 17% between 1990 and 2010.
- However, deaths and injury from noncommunicable diseases, such as cancer and heart disease, increased to become the dominant causes of death and disability worldwide.
- “Lifestyle” risks such as tobacco use and alcohol consumption are increasing rapidly.
- Noncommunicable diseases accounted for nearly two out of every three deaths worldwide in 2010, compared with around one in two in 1990.
- Since 1970, men and women worldwide have gained slightly more than 10 years of life expectancy overall, but spend more years living with injury and illness.



Changing patterns of global health

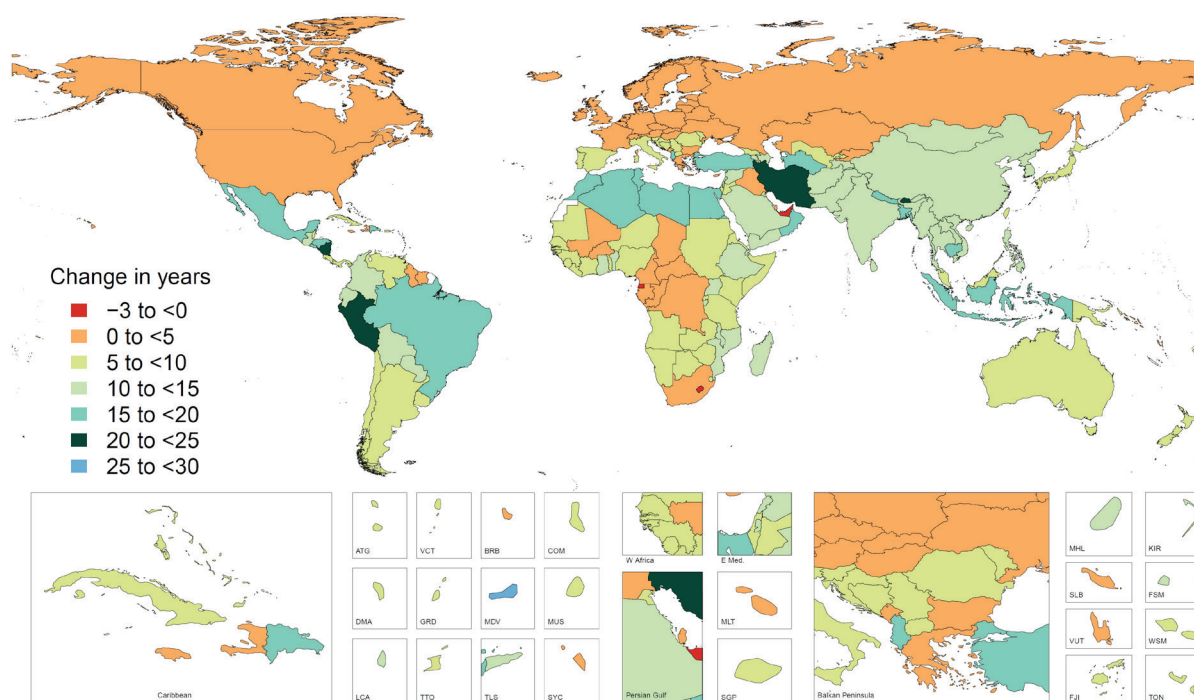
Five broad findings from GBD 2010 explain why patterns of health have changed in different parts of the world, and highlight the ongoing challenges for public health.

1. Health systems and training of health personnel struggle to keep pace with demographic change

Changes in populations are creating new challenges for health systems and health-care workers. For example, improvements in public health and medical care and lower birth rates mean that the average age at death is increasing in most of Latin America, North Africa and the Middle-East, South-east Asia and East Asia. In Brazil, the mean age of death has more than doubled in the last 40 years, from 30.5 in 1970 to 63.1 in 2010.

These demographic changes are happening so fast that health system organization and the training of health-care workers often cannot keep pace. People trained to deal with the dominant health problems of 20 years ago may face a completely different set of challenges today, and ministries of health in some countries are still organized around the leading health challenges of a generation ago. Figure 1 shows the change from 1990 to 2010 in the mean age at death by country; highlighting where demographic change is most rapid.

Figure 1. Change in mean age at death, 1990-2010

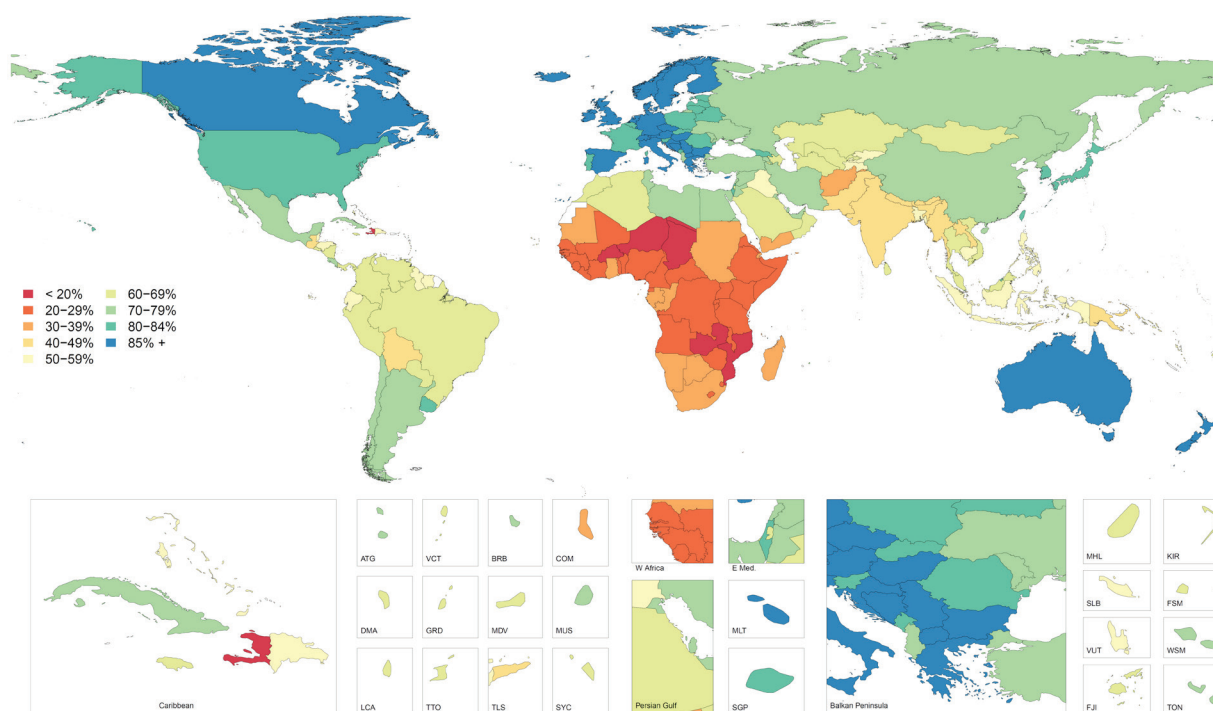


2. Noncommunicable causes increase as communicable diseases decrease

Noncommunicable causes of death and sickness are rapidly becoming dominant (outside of sub-Saharan Africa, South Asia and a few other regions) – as communicable diseases and maternal and neonatal deaths decline. The underlying reason is the faster progress made by the global community in combating communicable, neonatal and maternal causes compared with death and disability from noncommunicable causes.

GBD 2010 analyses the extent to which disease and injury cause individuals to lose years of healthy and productive life (measured as Disability Adjusted Life Years: DALYs). Figure 2 shows the percentage of DALYs due to noncommunicable diseases for each country in 2010, reflecting a substantial increase compared with 1990, the baseline year for the MDGs.

Figure 2. Percent of national DALYs due to noncommunicable diseases, 2010



3. More people are living with chronic disability

All regions of the world are witnessing increases in diseases that cause chronic disability rather than death. These conditions include mental disorders, substance abuse, musculoskeletal disorders, vision loss, hearing loss, anaemia and some neurological disorders. The shift towards disability is most marked in high-income regions – where more than 50% of the disease burden may be from these conditions – but is also present in most middle-income countries.

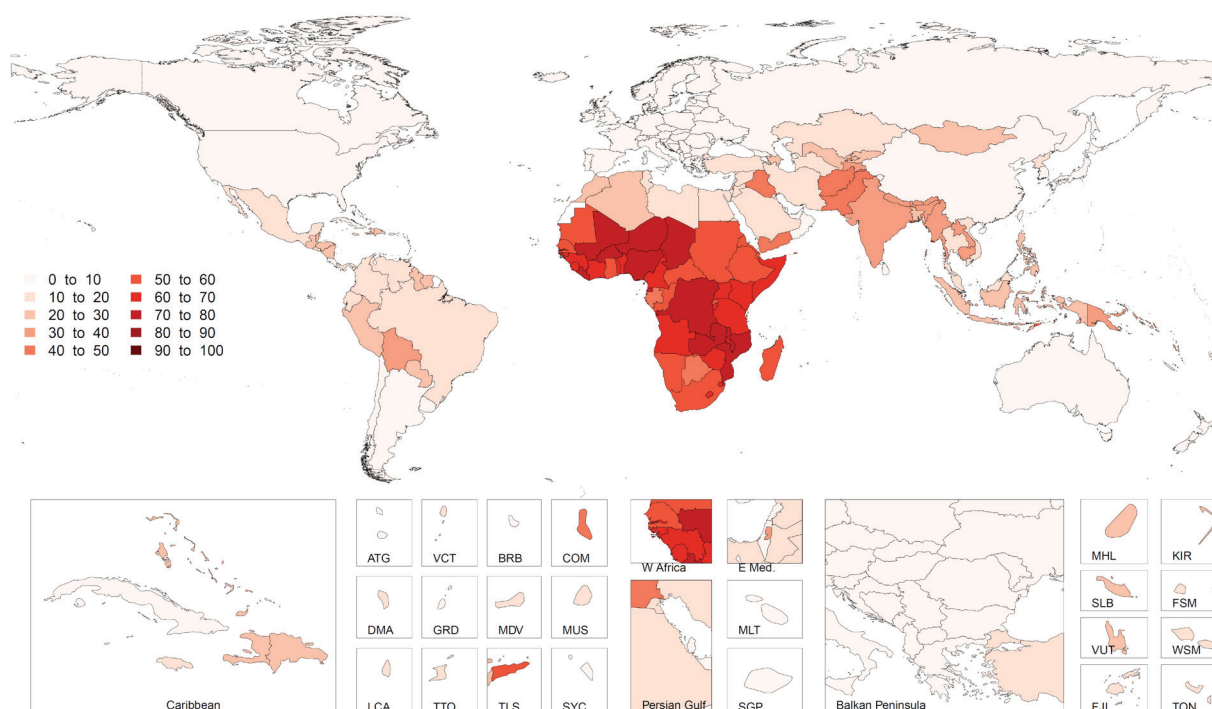
4. Major new “lifestyle” risk factors are emerging

Lifestyle risks such as high blood pressure, tobacco use and alcohol consumption are becoming much more prominent globally. In 1990, the leading global health risk was being underweight in childhood, but by 2010 this had dropped to the eighth largest risk factor. Similar large drops have also been observed in risks such as inadequate breast feeding, poor water and sanitation, and deficiencies in vitamin A and zinc.

5. Sub-Saharan African lags behind the global trend

The burden of disease in sub-Saharan Africa is still dominated by risks related to MDGs 4, 5 and 6 – despite real progress since 1990 in reducing child mortality and combating diseases such as malaria and HIV. Figure 3 indicates the impact of the three health-related MDGs in 2010 in DALYs. In South Asia, the MDGs-related burden is under half that in sub-Saharan Africa, but still large, while other health issues dominate elsewhere.

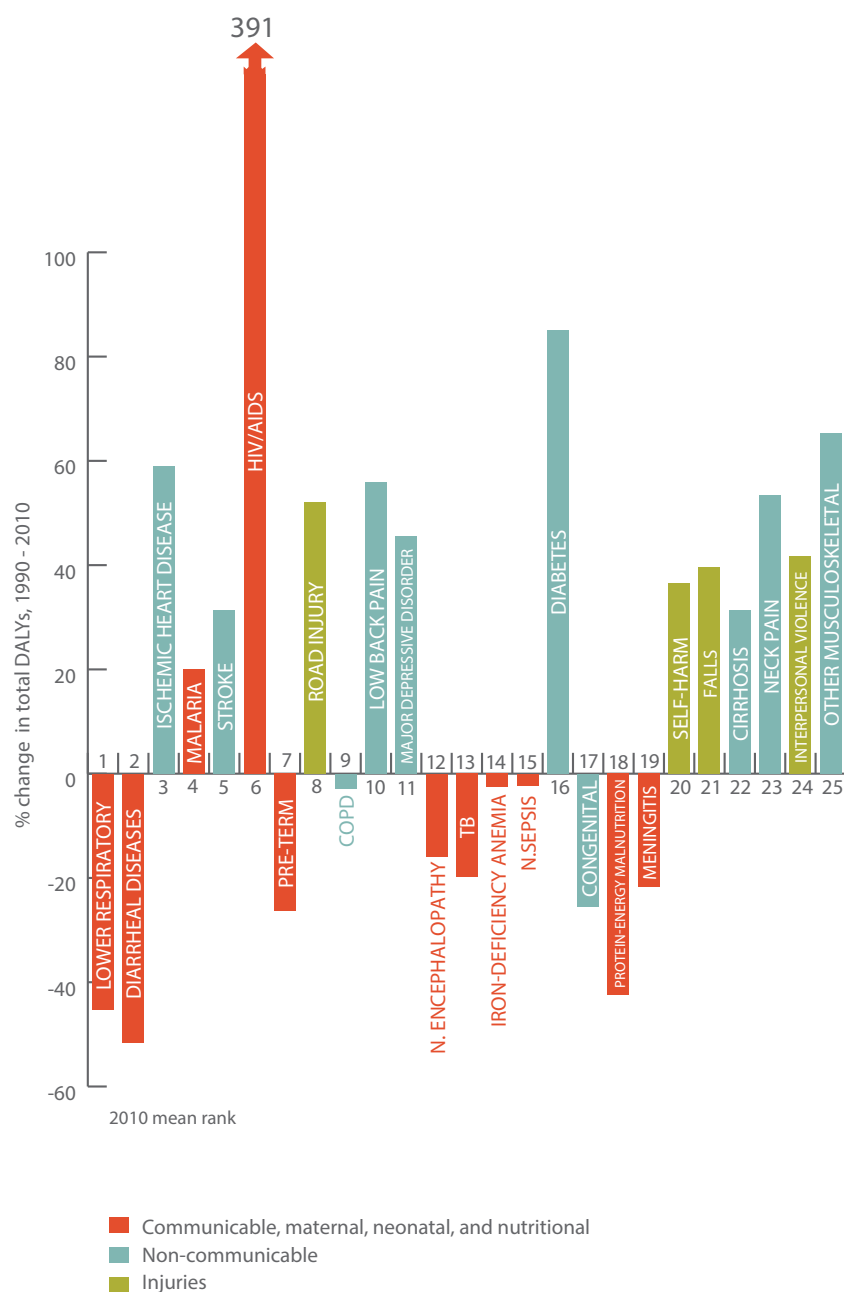
Figure 3. Percent of national DALYs due to MDGs 4, 5, and 6, 2010



Patterns confirm the rise in noncommunicable causes of disease and injury

The combined effects of these five patterns on the relative importance of specific diseases and injuries are shown for developing countries in Figure 4. The height of the bars represents the percentage change in burden of disease from 1990 to 2010. Each disease is ordered from left to right by the magnitude in the developing world. Comparing 2010 with 1990, the massive increase in HIV dominates the rates of change. However, there have been large declines in pneumonia, diarrhoea, preterm birth, tuberculosis and malnutrition. The burden from heart disease, stroke, depression, diabetes, lung cancer and cirrhosis is increasing. The figure illustrates how, taken together, the countries of the developing world are experiencing a rapid shift in the leading health problems – although these aggregate figures mask huge national and regional variation in health trends.

Figure 4. Diseases and injuries in developing countries ranked by global DALYs, 2010



Specific findings for MDGs 4 and 5

MDG 4 – decline in under-fives death rate may mask an increase in the number of deaths

Figure 5 shows how, even in countries where there is progress in reducing the under-five death rate, the number of under-five deaths may be increasing. Put simply, this is due to the number of births increasing more rapidly than the under-five death rate is declining.

For example, Burkina Faso, Congo and the Democratic Republic of Congo have all managed to decrease the under-five death rate by 0.72%, 1.29% and 0.85% respectively. However, because of even faster increases in the annual numbers of newborns, numbers of under-five deaths have been increasing in these countries at annualized rates of 1.7%, 1.0% and 1.3% respectively.

Figure 5. Annualized rate of decline in under-five deaths and mortality rate, 1990-2010

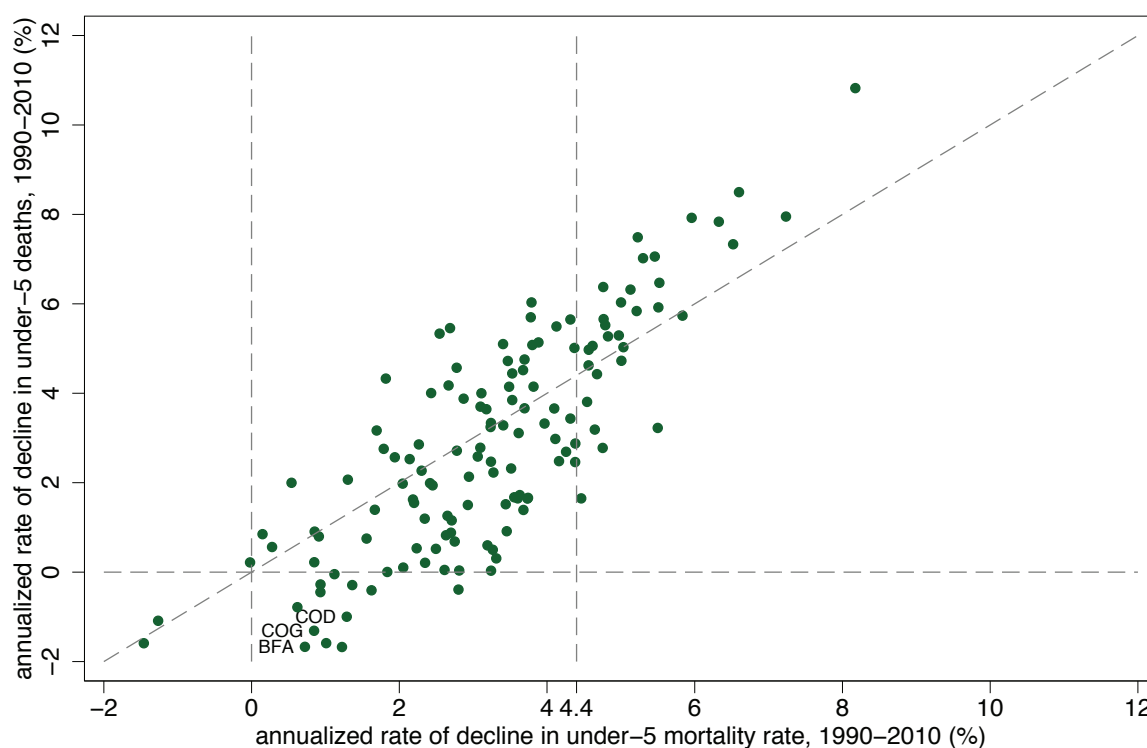


Figure 6 shows that although the target for MDG 4 was set lower than for MDG 5, most countries have made faster progress in reducing child mortality compared with maternal mortality. The annual rates of decline required to achieve the targets (5.5% for MDG 5 and 4.4% for MDG 4) are shown as green lines for reference. The shaded area represents where countries have been achieving the pace of progress needed to achieve both MDG 4 and MDG 5. This high-performing group comprises six countries including Egypt, Maldives, Syria, Turkey, Vietnam, and Oman. No country in sub-Saharan Africa is expected to achieve both MDGs. Three other countries are close to achieving MDGs 4 and 5: China, Slovenia and Morocco.

In 2011, the highest MMR was seen in Central Africa, Eritrea, Somalia and Burundi, and the lowest in Denmark, Sweden and Estonia. However, in addition to measuring the rate itself, it is becoming increasingly important to measure the annual rate of change and predict whether MDG 5 will be achieved. Based on 2011 data, 17 countries appear likely to achieve the target by 2015: Estonia, Syria, Maldives, Iceland, Poland, United Arab Emirates, Oman, Latvia, Rwanda, Romania, Qatar, Lithuania, Vietnam, Turkey, Egypt, Bahrain and Macedonia.

Figure 6. Annualized rate of decline in under-five mortality and Maternal mortality Ratio, 1990-2011



Resources

Every Woman Every Child
www.everywomaneverychild.org

United Nations Secretary-General's Global Strategy for Women's and Children's Health
www.everywomaneverychild.org/images/content/files/global_strategy/full/20100914_gswch_en.pdf

UN Commission on Life-Saving Commodities for Women and Children
www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities

Commission on Information and Accountability for Women's and Children's Health
www.everywomaneverychild.org/resources/accountability-commission

Independent Expert Review Group
www.everywomaneverychild.org/resources/independent-expert-review-group

Partnership for Maternal Newborn & Child Health
www.pmnch.org

United Nations Foundation
www.unfoundation.org

Global Campaign for the Health MDGs
www.norad.no/globalcampaign
– *Includes an electronic version of this report*

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Acknowledgments

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*Surviving childbirth and
growing up healthy should not
be a matter of luck or where you
live or how much money you
have. It should be a fact for
every woman everywhere.*

Hillary Rodham Clinton
US Secretary of State

Remarks at *A World in Transition: Charting a New Path in Global Health*

Oslo, Norway, 1 June 2012