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# The WHO Regional Office's Strategy on the Millennium Development Goals in Europe

The Millennium Development Goals (MDGs) have been adopted by all countries of the world in the fight against poverty and its consequences all over the planet. This document aims to provide an overview of how the MDGs can be better achieved in the WHO European Region by strategically considering the opportunities for and challenges to achieving them. It should be read in conjunction with other documents presented to the Regional Committee, notably the one on strengthening health systems.

Given the nature of the MDGs, the document focuses to some extent on the low- and middle-income countries of the Region. However, it must be clearly stated that the MDGs are also relevant for upper-middle- and high-income countries because disaggregations of national-level data by region, ethnic group, social class and other attributes reveal pockets where the targets are less likely to be achieved, even in industrialized countries. In other words, the MDGs are also relevant to poor people living in wealthy countries. Specific areas where the WHO Regional Office for Europe can support all countries in the Region in their efforts to achieve the MDGs are outlined.

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# Introduction

1. The United Nations Millennium Summit in 2000 was attended by representatives of 189 countries and 147 heads of state. The main outcome was the adoption of the United Nations Millennium Declaration, covering specific commitments and principles for action in key areas including peace, human rights, democracy, security, environment and good governance *(1)*. Eight of the 18 targets and 18 of the 48 indicators refer directly to health issues (see Annex 1 for an overview table). The fact that Goal 2 (Achieve universal primary education) and Goal 3 (Promote gender equality and empower women) are not measured in health terms, since their primary intent is not to improve (promote, restore or maintain) health, should by no means be interpreted as underplaying their importance from a health perspective. All eight Millennium Development Goals (MDGs) related to the Declaration's section on development and poverty reduction are relevant for the European Region.

2. In 2000, in parallel with the inception of the MDG process, WHO established the Commission on Macroeconomics and Health, showing the importance of health as a driver of economic development and poverty reduction. WHO's commitment to the Millennium Declaration was reaffirmed in 2002 at the Fifty-fifth World Health Assembly by resolution WHA55.19, and *The world health report 2003* highlighted the principles that guide WHO's work in relation to the MDGs *(2)*. The report indicated that WHO would support countries in developing and working towards health goals relevant to their particular circumstances and to the overall MDG framework.

3. The MDGs are important for WHO's European Region. A challenge, as well as a potential opportunity, for the Region is its economic heterogeneity. Poverty continues to demand attention in the richest, as well as the poorer, countries of the Region. The simultaneous presence of rich and poor countries, and rich and poor people in those countries, provides an opportunity for closer cooperation in combating poverty and tackling important health challenges.

# Status of the Millennium Development Goals in the WHO European Region

## A highly complex and quickly changing context

4. The approach to the MDGs in the European Region needs to begin with an understanding of its specific and quite complex situation, some of the main features of which are given below.

- About half of the Region has faced major economic turmoil over the last 15 years after the fall of the Soviet Union and military conflicts in the Balkans, the Caucasus and some of the central Asian republics. Poverty has increased substantially in a context of high literacy. This situation is hardly comparable to any witnessed in the Region in recent decades.
- Access to effective health care has been hampered by the disrupted functioning of the health systems in those countries, followed, in some cases, by substantial migration of the health workforce and a corresponding brain drain. This has worsened the already serious effects on health of poverty and related health determinants.
- As a consequence, although some low-income countries in the Region have public health concerns similar to those of other low-income countries in the world, in general their disease burden and public health challenges show a rather different pattern, within which noncommunicable diseases together with injuries account for a large share of the disease burden. The result is that low-income countries in the Region have one of the world's highest adult mortality rates, with a corresponding impact on family and child poverty.
- Major geopolitical realignments have continued to take place in recent years, substantially changing the configuration of the Region (e.g. a rapid growth in the number of countries in the

1990s and expansion of the European Union in the 2000s). As a result, the WHO European Region is currently comprised of 4 low-income countries, 15 lower-middle-income countries, 8 upper-middle-income countries, and 25 high-income countries.

## Progress towards the MDGs

5. Measuring progress in relation to the MDGs raises a number of serious methodological questions. First, there is the issue of measurement per se and the availability of reliable information, since very few health information systems in the Region have such data. Monitoring the MDGs in all 52 countries of the Region requires the table below to be completed for each Member State for the entire period covered by the MDGs (see Annex 1 for identification of the individual health indicators (HI)).

Table 1

| | HI 4 | HI 5 | HI 13 | HI14 | HI 15 | HI 16 | HI 17 | HI 18 | HI 19 | HI 20 | HI 21 | HI 22 | HI 23 | HI 24 | HI 30 | HI 31 | HI 46 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Country X | | | | | | | | | | | | | | | | | |

6. Completing this table for the last decade and onwards to provide a baseline for comparison raises the additional difficulty of de-aggregating data for countries that did not yet exist in 1990–1991 (e.g. in the case of the former Yugoslavia, the data should refer to the year of independence, which for Bosnia and Herzegovina would be 1995, immediately after the war).

7. Second, there is the problem of how to measure poverty in relative terms (see Annex 2 on MDG1 for more details).

8. With those caveats, a quick look at the MDGs in the Region gives the following picture:

- *Goal 1: Eradicate extreme poverty and hunger*
  Poverty has increased sharply in low- and middle-income countries of the European Region (faster than in any other region during the 1990s) and remains a problem even in the Region's richest countries. Although, as indicated, many countries have inadequate data, the limited information on poverty that is available indicates that several countries are unlikely to meet the Goals.
- *Goal 2: Achieve universal primary education*
  The majority of countries in the Region have attained or are on the way to attaining full primary school enrolment. However, trends are constant or deteriorating in a number of countries in Central Asia, the Caucasus and the Balkans, where significant work remains to be done to improve access and quality. This goal is not directly related to health.
- *Goal 3: Promote gender equality and empower women*
  In a major part of the Region, gender inequality in primary school is not an issue. In some countries, more boys than girls drop out of school. Overall, the gender equity goal is more likely to be met in the European Region of WHO than in other regions. This goal is not directly related to health.
- *Goal 4: Reduce child mortality*
  Mortality among children under five has been slowly declining but several countries in the Region, mainly in central Asia and the Caucasus, still face significant challenges in this area. A serious problem in many countries of the Commonwealth of Independent States (CIS) is, once again, the system of data recording.
- *Goal 5: Improve maternal health*
  Several countries are unlikely to achieve the targeted 75% reduction in maternal mortality. It is also important to note that, in some countries, high maternal mortality rates in particular regions or among disadvantaged social groups may be concealed by lower national data.

- *Goal 6: Combat HIV/AIDS, malaria and other diseases*
  HIV/AIDS poses a serious threat to public health, with a nine-fold increase registered for eastern Europe and central Asia in less than ten years. Tuberculosis re-emerged in the Region during the 1990s after 40 years of steady decline and is now a serious problem in many countries. More than half the low- and lower-middle-income countries of the Region appear unlikely to achieve this Goal.
- *Goal 7: Ensure environmental sustainability*
  The biggest challenge to meeting the environmental targets is in water supply and sanitation. Despite official data showing that very large percentages of people have access to improved water supplies and safe sanitation, evidence exists that water quality, in particular, remains a serious issue and a major health hazard for many.
- *Goal 8: Develop a global partnership for development*
  Recent global reviews have revealed that progress so far in achieving the MDGs is very uneven, and this is true of the European Region too. It raises the need for the international community to address developmental work on a more solid basis. Despite evident needs, the European Region receives the least official development assistance for health of all regions worldwide (see Annex 2 for data).

9. It should again be noted that the above overview would seem to focus attention on the situation in the low- and lower-middle-income countries of the Region, while upper-middle- and high-income countries have already achieved – or are likely to achieve – most of the MDG targets at national level. Even so, as previously mentioned, the MDGs are still relevant for them, as national data may mask large intra-country disparities. The Regional Office hereby invites Member States to address the issue and act accordingly; the MDGs provide a useful framework of reference for national authorities, civil society and the international community throughout the European Region.

## Objectives of the European strategy on the MDGs

10. The health-focused Goals highlight both areas of concern, where Member States have experienced difficulties, and areas where progress has been achieved. The limited progress made towards achieving the MDGs reveals a lack of funding and there is growing recognition that achieving the MDGs will require a significant increase in resources for health *(3)*. Health systems constraints are also impeding the implementation of major global initiatives for health and the attainment of the MDGs *(4)*. A recent WHO study *(5)* has highlighted the pressing need to increase health system capacity to deal with poverty issues at country level. According to the study, the increased capacity should then be used to carry out: (a) an examination of why existing policies and practices often fail to reach vulnerable groups; and (b) the reorientation of such policies to obtain better health outcomes for the poor. Increased health system capacity would also contribute to strengthening donor efforts to harmonize work towards the MDGs.

11. In this context, the objectives of this proposed European strategy on the MDGs are:

- to help Member States prioritize actions in their own countries and elsewhere in Europe towards achieving the MDGs;
- to refine the Regional Office's approach to the MDGs so as to provide more focused help to countries in their work towards achieving the MDGs;
- to offer Member States an ongoing dynamic assessment of the progress made towards achieving the MDGs as a critical contribution to the above two objectives.

## The proposed response from the WHO Regional Office for Europe

### Strategic focus

12. In September 2000, the WHO Regional Committee for Europe adopted resolution EUR/RC50/R5, by which it endorsed the European Country Strategy "*Matching services to new needs",* setting the challenges that: (i) every Member State should receive relevant services corresponding to its needs, including humanitarian assistance if required; (ii) this should be done through strengthening partnership for health with the many international organizations operating in countries (the European Union, the World Bank, United Nations bodies such as the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund, and the United Nations Food and Agriculture Organization) and civil society organizations; and (iii) this should be supported by technical assistance to help countries develop their health systems and health programmes. Soon afterwards, the Regional Office formulated its aim as being "to support Member States in developing their own health policies, health systems and public health programmes; preventing and overcoming threats to health; anticipating future challenges; and advocating public health".

13. There are, therefore, clear relationships between the MDGs and the foundations of the Regional Office Country Strategy, which has focused on adapting the organization to better serve the needs of eastern and western Member States while keeping programmatic work on the MDGs as intense as possible. Now that 2005 marks one third of the initial 2000–2015 timeframe for the MDGs and coincides with the new mandate of its Regional Director, the Office will put renewed emphasis on achieving the MDGs through its distinctive approach of:

- tailored country work
- work to strengthen health systems
- focused technical intervention in the areas relevant to the MDGs, and
- partnership among all international and national agencies.

14. The Regional Office wants most of all to ensure national ownership of the MDGs, with particular emphasis on improving the situation of vulnerable groups at country level. But, as *The world health report 2003* shows, the opportunities for and challenges to achieving the health-related MDGs need to be addressed not only through individual initiatives in areas such as maternal and child health, control of communicable diseases, HIV/AIDS, water and sanitation, or environmental health (in which WHO's normative role will obviously be needed), but mostly by adopting a coherent, systematic and sustainable approach. This has implications for cost, investment, human resources, and the overall management and future plans of WHO in all the Member States in the European Region. For better coordination of all MDG-related activities, a special Task Force, composed of members of the Executive Management, has been established at the Regional Office.

### A call for renewed emphasis on the MDGs

15. The MDGs offer the Office a benchmark against which to prioritize its support to Member States as part of its overall contribution to country health development strategies. Progress towards the MDGs at country level requires actions on the part of the Member States, the international community and the Regional Office.

16. On the part of the **countries**, a renewed effort is needed to develop their health systems, concentrating on focused priorities and improved intersectoral work for health. Improved governance and clear political will are critical factors here. It is recommended that special taskforces be set up at country level with a mandate to coordinate progress towards the achievement of the MDGs on a goal-by-goal basis.

17. On the part of the **international community** in general, attention should be focused on partnership around selected technical actions that should help each country to develop its own health system. In this respect, national planning frameworks known as Poverty Reduction Strategy Papers (PRSPs)[1] are an important vehicle in some countries. Since the beginning of the MDG process, about a dozen middle-low- and low-income European countries have been involved in preparing them.

18. The role of the **Regional Office** in supporting countries to help them achieve the MDGs will be structured around a multiyear plan (initially five years, from 2005 to 2009 inclusive) as a practical application of the Country Strategy towards all Member States. This will include:

- concentrating efforts on selected priorities jointly agreed upon by WHO and the Member State concerned (through the biennial collaborative agreements, where appropriate, and other mechanisms), including provision of training, and the sharing of best practices and know-how on various aspects of the MDGs and their link to overall public health policies in Europe;
- working with all Member States (in an effort led by the WHO unified country office wherever relevant) and efficiently managing increased country work budgets, with specific focus on the MDGs;
- working in partnership with other agencies and institutions; and
- delivering well selected, effective and focused technical interventions intended to help Member States develop their own health systems.

19. The strengthening of national health systems deserves special mention. In the words of a recently published paper, "Effective interventions exist for many priority health problems… prices are falling and funds are increasing. However progress towards the agreed health goals remains slow. There is increasing consensus that stronger health systems are key to achieving improved health outcomes" *(6)*.

20. The Regional Office's technical work with countries will thus be intensified to strengthen overall health systems along the lines mentioned above. Also, the Office as a whole, and country offices in middle- and low-income countries of the Region in particular, will continue to intensify their work in this area, taking special care to examine, together with each Member State, how the MDGs are inter-related in each specific context. For example, infant and maternal mortality will improve not only through the introduction of specific mother and child health interventions, but also through the adoption of a cross-cutting approach on health systems. This could focus, for example, on improvements in primary care through training for the workforce, and in hospital settings through better quality services, and on financing mechanisms to improve access for the poor to the essential services. All these approaches combined will contribute to achieving the MDGs.

21. Transparent follow-up of the MDGs is the core proposal that the Regional Office offers to Member States in order to articulate its efforts with those of all partners and donors. The cornerstone of this proposal is the follow-up mechanism described below.

- The Regional Office will continue to support all countries in the Region in building capacity to collect, analyse and, most critically, act upon information. Specific cooperation in this area will focus on tracking progress and measuring achievements towards the health-related MDGs on a goal-by-goal and target-by-target basis.
- WHO country offices, with appropriate support from the Regional Office and the centres, will pay increased attention to gathering the data available while supporting the health ministries and other agencies in collecting and preliminarily validating those data.

[1] Countries wishing to access concessional loans through the Poverty Reduction and Growth Facility (PRGF) or to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) Initiative are required to produce a PRSP.

- In the Regional Office (Division of Information, Evidence and Communication) emphasis will also be put on providing quality de-aggregated data in order to ensure comparability as well as to capture intra-country differences and related issues that could help to better focus the support that countries receive from the Office, again, on a goal-by-goal and target-by-target basis.

22. At global level, WHO will report on 17 of the 18 health-related MDG indicators. As stated in *The world health report 2003*, WHO and its regional offices will monitor MDG indicators as well as core additional health indicators covering the areas of public health that can better contextualize specific country progress (or lack of it) for a given health-related MDG.

23. The progress towards achievement of the MDGs in all 52 countries of the WHO European Region within the period 1990–2010 will be monitored and regularly presented to the Member States in the format of Table 1 above. Appropriate data will need to be collected for 1990–1991, 2000 and 2005 (or the most recent dates available) and on a yearly basis thereafter.

24. Everybody's support is needed in this important endeavour.

*Annex 1*

# Health in the MDGs

| Health Targets | | Health Indicators | |
|---|---|---|---|
| **GOAL 1:** | **ERADICATE EXTREME POVERTY AND HUNGER** | | |
| Target 1: | Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | | |
| **Target 2:** | **Halve, between 1990 and 2015, the proportion of people who suffer from hunger** | **4.**<br>**5.** | **Prevalence of underweight children under-five years of age**<br>**Proportion of population below minimum level of dietary energy consumption** |
| **GOAL 2:** | **ACHIEVE UNIVERSAL PRIMARY EDUCATION** | | |
| Target 3: | Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | | |
| **GOAL 3:** | **PROMOTE GENDER EQUALITY AND EMPOWER WOMEN** | | |
| Target 4: | Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 | | |
| **GOAL 4:** | **REDUCE CHILD MORTALITY** | | |
| **Target 5:** | **Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate** | **13.**<br>**14.**<br>**15.** | **Under-five mortality rate**<br>**Infant mortality rate**<br>**Proportion of one- year-old children immunised against measles** |
| **GOAL 5:** | **IMPROVE MATERNAL HEALTH** | | |
| **Target 6:** | **Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio** | **16.**<br>**17.** | **Maternal mortality ratio**<br>**Proportion of births attended by skilled health personnel** |
| **GOAL 6:** | **COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES** | | |
| **Target 7:** | **Have halted by 2015 and begun to reverse the spread of HIV/AIDS** | **18.**<br>**19.**<br>**20.** | **HIV prevalence among pregnant women aged 15–24 years**<br>**Condom use rate of the contraceptive prevalence rate**<br>**Ratio of school attendance of orphans to school attendance of nonorphans aged 10–14 years** |
| **Target 8:** | **Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases** | **21.**<br>**22.**<br>**23.**<br>**24.** | **Prevalence and death rates associated with malaria**<br>**Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures**<br>**Prevalence and death rates associated with tuberculosis**<br>**Proportion of tuberculosis cases detected and cured under DOTS (directly observed treatment short course)** |
| **GOAL 7:** | **ENSURE ENVIRONMENTAL SUSTAINABILITY** | | |
| Target 9: | Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | **29.** | **Proportion of population using solid fuels** |
| **Target 10:** | **Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation** | **30.**<br>**31.** | **Proportion of population with sustainable access to an improved water source, urban and rural**<br>**Proportion of population with access to improved sanitation, urban and rural** |
| **Target 11:** | **By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers** | | |
| **GOAL 8:** | **DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT** | | |
| Target 12: | Develop further an open, rule-based, predictable, non-discriminatory trading and financial system | | |
| Target 13: | Address the special needs of the least developed countries | | |
| Target 14: | Address the special needs of landlocked developing countries and small island developing States | | |
| Target 15: | Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term | | |
| Target 16: | In cooperation with developing countries, develop and implement strategies for decent and productive work for youth | | |
| **Target 17:** | **In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries** | **46.** | **Proportion of population with access to affordable essential drugs on a sustainable basis** |
| Target 18: | In cooperation with the private sector, make available the benefits of new technologies, especially information and communications | | |

Adapted from: *List of goals, targets, indicators (7)*

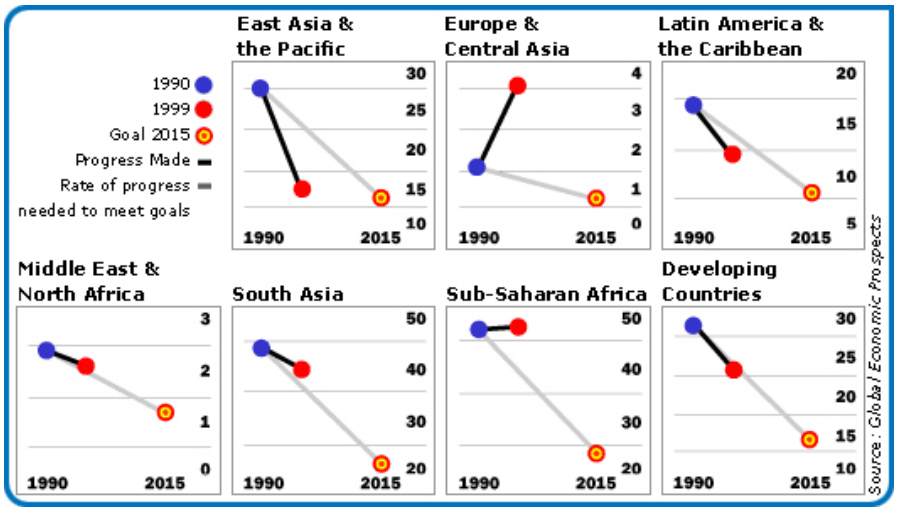
*Annex 2*

# Some facts related to the MDGs in the European Region

## MDG 1: Eradicate extreme poverty and hunger

Poverty trends since 1990 show that, on average, low- and middle-income countries in the Region have witnessed a sharp increase in poverty levels. In 1999, the Region was far off track in efforts to achieve MDG 1 (see Figure 1). It was indeed further off than other regions in the world. As of 2005, the situation had improved little.

Figure 1: The situation at the outset of the MDG process. Absolute poverty rates based on the US$ 1 international poverty line – progress and prospects in reaching the MDG




Source: *Millennium Development Goals (8)*
"Europe and Central Asia" refers to the low- and middle-income countries in the Region, which are predominantly the countries in central and eastern Europe and the CIS.

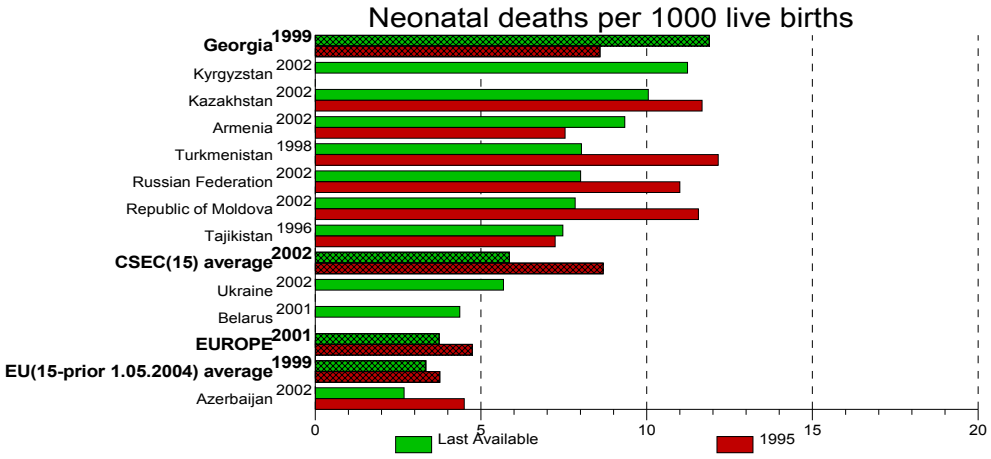
Not only the trends, but also the levels of poverty (around 4% of the population), if properly assessed, raise serious concerns. The worldwide benchmark of US$ 1 per day, below which per capita income poverty begins, is arguable for the European Region, as eastern Europe has a harsh climate and its inhabitants are required to spend more on housing, heating, clothes and food. Experts working in and on the Region conclude that US$ 2.15 or US$ 4.30 are more appropriate poverty lines. Using these alternative yardsticks, current poverty figures are close to 30% or 64%, respectively (more than 90 million or 210 million people in the countries of the European Region for which recent data was available) *(9)*.

This MDG is primarily meant to address the needs of low- and middle-income countries, where poverty is most widespread but it is also relevant in specific locations within specific western countries, where poverty continues to demand attention.

## MDG 4: Reduce child mortality, and MDG 5: improve maternal health

Several countries of the Region, mainly in central Asia and the Caucasus, appear to be facing significant challenges in reducing child and maternal mortality. The figure below, for example, shows neonatal death rates (children who die during their first month of life per 1000 live births).

Figure 2: Neonatal deaths in 1995 and most recent available data for selected European countries.




Source: *European Health for All database (10)*

Additionally, in some of the countries of central and eastern Europe (CEE) and the CIS, progress towards achieving Goals 4 and 5 has proved hard to assess due to lack of reliable data. Increased investment in surveillance activities and health information management with a particular focus on vulnerable or marginalized communities is essential for adequately gauging child and maternal mortality levels in many of the Region's low-income countries *(11)*.

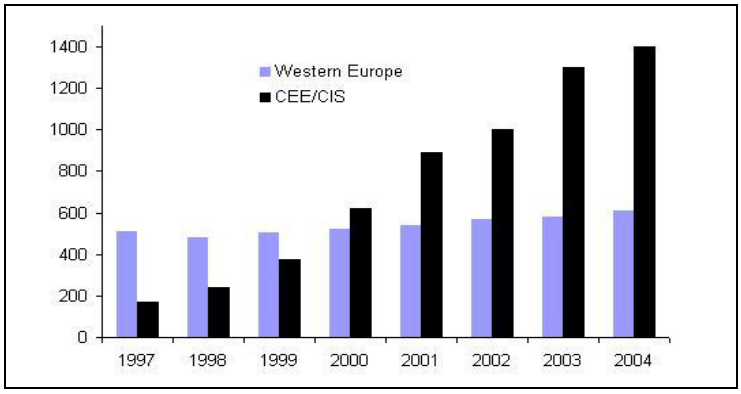
Lack of data, however, should not be a deterrent to introducing interventions; even the lowest available estimates of child and maternal mortality rates for some countries call for immediate action. For instance, in 2001, Georgia had 58.7 maternal deaths per 100 000 live births, while Italy (with the lowest rate in the Region) had only 2.07. Vulnerable groups such as the Roma have higher incidences of child and maternal mortality, and thus require targeted interventions.

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

HIV/AIDS poses a serious threat to public health, with a nine-fold increase registered in less than 10 years for eastern Europe and central Asia where, by the end of 2004, the number of HIV-infected people had reached an estimated 1.4 million. Several HIV epidemics are underway in the Region. The most firmly established is in Ukraine, which is experiencing a new surge of reported infections, while the largest is taking place in the Russian Federation *(12)*. Officially registered cases are considered to be but a fraction of actual infections. Using estimated rates rather than officially registered cases, Figure 3 shows that the CEE-CIS region has outpaced western Europe in terms of the estimated prevalence of people living with HIV/AIDS.

In countries where HIV is spreading very fast, such as Belarus, Estonia, Latvia, the Republic of Moldova, the Russian Federation, and Ukraine, the predominant share of infections has been transmitted via infected needles through intravenous drug use but there are already signs of the epidemic entering the general population, thereby rendering it more difficult to halt. HIV in the Region also mostly affects young people, even more so than in other regions of the world. While, in other parts of the Region (e.g. central Asia), HIV prevalence is low, there is no reason for complacency; many of the factors that caused the epidemic in eastern European countries are also present there *(13)*.

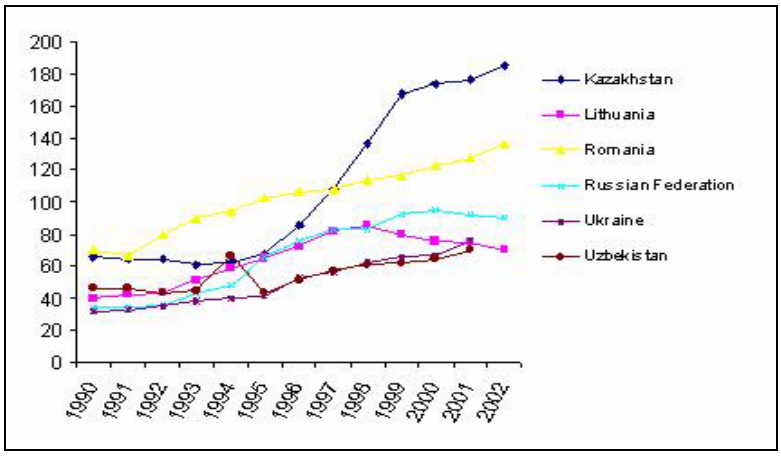
Figure 3: Estimated number of people living with HIV/AIDS in the CEE and CIS countries and in western Europe (in thousands).




Source: *Aids Epidemic Update (14)*

Tuberculosis re-emerged in the Region during the 1990s after 40 years of steady decline, and today it is a large and growing problem, with Kazakhstan, Romania, the Russian Federation, Ukraine and Uzbekistan the countries most affected, accounting for more than half of the tuberculosis cases in the Region. Ineffective approaches to diagnosis and treatment, poor coverage of effective treatment and protocols, and weak, deteriorating health systems have been cited as major contributors to the increase. According to official WHO statistics, more than 370 000 new tuberculosis cases were reported in the Region in 2004, the highest number in the past two decades. Of that figure, 80% occurred in the European and Asian countries of the CIS.

Figure 4: Tuberculosis incidence, newly registered cases per 100 000 population




Source: *European Health for All database (10)*

## MDG 7: Ensure environmental sustainability

The WHO/UNICEF Joint Monitoring Programme (JMP) for water supply and sanitation reports on access to improved water sources and to improved sanitation. Although it does not cover all the countries in the Region, its findings are relevant.

(a) Only 85% of the population of the EUR B countries[2] has access to an improved source of water supply, as opposed to 100% in the EUR A[3] and 96% in the EUR C[4] countries. For sanitation, only 76% of the population in EUR B has access to improved facilities, while 100% of EUR A and 89% of EUR C does.

[2] Low child and low adult mortality.
[3] Very low child and very low adult mortality.
[4] Low child and high adult mortality.

(b) The EUR B region shows negative growth of -1% in water supply coverage and -7% in sanitation coverage in the period 1990–2002, whereas a positive growth of +7% for water and +10% for sanitation is required to meet the MDGs.

(c) The EUR B region shows an urban – rural gap of 97% to 72% in access to an improved water supply, and 90% to 41% in access to improved sanitation. Rural populations are significantly disadvantaged and at a higher health risk from water-related diseases than are urban dwellers.

Networked services in the EUR B region often are of questionable integrity and subject to frequent and lengthy service interruption. As a result, microbiological and chemical failure rates of drinking-water at the point of consumption are high. Although there is no systematic data collection of water quality "at tap", data gathered during environmental performance review missions show microbiological failure rates of 71% in Tajikistan, 46.7% in Serbia and Montenegro, approximately 30% in Armenia and approximately 20% in Bosnia and Herzegovina. Similar anecdotal evidence is available from other countries. In non-networked services, typical for rural areas, failure rates are generally higher than in networked services, thus putting rural populations at a further disadvantage.

When comparing the EUR B region to an adjacent region of similar economic development status, such as northern Africa, it appears that, in all the years of the review period 1994–2003, EUR B received less official development assistance (ODA) funding allocated to water and sanitation than northern Africa. There is stagnation, if not a decrease, in the ODA flow to water and sanitation in the period under consideration. This worrying evolution is further compounded by the following factors:

(a) since the major part of ODA funding is in the form of loans for major infrastructure works, very little grant money is available to support health-promoting activities such as training of human resources, improvement in operation and management procedures, and strengthening of environmental and clinical laboratories;

(b) since the majority of investments go to networked services, rural community-based decentralized services remain excluded from vital support.

## MDG 8: Develop a global partnership for development

Despite evident needs, the European Region receives the least official development assistance for health (DAH) of all regions worldwide. The United Nations Millennium Project Report to the Secretary-General (January 2005) recommended an increase in ODA in order to come closer to the agreed target of 0.7% of gross national product of the donor countries. The Report also argued that much of the ODA going to poor countries lacks coherence and cohesion. For the situation in the European Region, an increase in ODA is a necessary but, by itself, insufficient condition for achieving the MDGs and strengthening the overall health system of low-income countries. At the outset of the MDG process, the CEE-CIS region as a whole received the least DAH of all recipient regions in the world, both in terms of the absolute per capita dollars going to health and in terms of the proportion of ODA designated to health (see Table 2 below).

Table 2: DAH per capita and DAH as a percent of total ODA commitments by region (1997–1999 average)

| Region | DAH p.c. | DAH in % of ODA |
|---|---|---|
| Oceania | 9.98 | 4.7 |
| Central America | 4.22 | 19.8 |
| Sub-Saharan Africa | 2.06 | 8.6 |
| South America | 1.64 | 16.5 |
| North Africa | 1.24 | 4.4 |
| South Asia | 0.84 | 16.8 |
| Middle East | 0.52 | 3.4 |
| Far East | 0.50 | 7.8 |
| ***CEE-CIS*** | ***0.34*** | ***1.7*** |
| AVERAGE | 1.00 | 8.9 |

Source: Suhrcke *(15)*

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