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The Millennium Development Goals in the WHO European Region: Health systems and health of mothers and children – lessons learned

The Millennium Development Goals (MDGs) are aimed at tackling poverty in all its forms; collectively they provide a comprehensive and mutually reinforcing approach designed to break the circle of poverty and ill-health. The World Health Organization (WHO) contributed to their elaboration, and has made a firm commitment to achieving the Millennium Declaration, adopted by the United Nations General Assembly in 2000.

The WHO Regional Office for Europe has promoted a specific strategy on MDGs in the WHO European Region. Health progress in the Region – including achievement of many of the MDGs – will require sustained multisectoral action addressing all the determinants of health and the involvement of all partners nationally and internationally. Experience at regional level, however, has shown that insufficient capacity in the area of health systems is an insurmountable barrier to achieving the health-related MDGs.

The discussion on the MDGs during the fifty-seventh session of the WHO Regional Committee for Europe is expected to assess the progress made towards achieving the MDGs in the 53 Member States in the European Region, to propose strategies to promote multisectoral action and evidence-sharing, and to produce specific recommendations on the adjustments to be made, where necessary. Special attention will be devoted to health systems strengthening as a particular approach to implementing programmes that address the health of mothers and children in the European Region.

A draft resolution calling for a scaling-up of efforts to achieve the MDGs in the European Region is submitted for the Regional Committee's consideration.

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Introduction

1. The Millennium Development Goals (MDGs) *(1)* are aimed at tackling poverty in all its forms; collectively, they provide a comprehensive and mutually reinforcing approach that is designed to break the circle of poverty and ill-health. Since the adoption of the Millennium Declaration *(2)* by the United Nations General Assembly in 2000, the Goals have become widely accepted benchmarks for the World Health Organization (WHO) in monitoring the progress of international development.

2. WHO contributed to the elaboration of the MDGs and has made a firm commitment to their achievement. More specifically, *The world health report 2003 (3)* highlighted the principles that guide WHO's work in relation to them. Its commitment to the Millennium Declaration was reaffirmed on a broader scale at the Fifty-eighth World Health Assembly in 2005 by the adoption of by resolution WHA58.30.

3. In recent years, the WHO Regional Office for Europe has promoted a specific strategy on the MDGs in the WHO European Region, with the following objectives:

- to help Member States prioritize their actions towards achieving the MDGs;
- to refine the approach to MDGs within the Regional Office and provide more focused support to countries to help them achieve the Goals; and
- to offer Member States an ongoing assessment of the prospects of achieving the MDGs, as a critical contribution to the above two objectives.

4. The main focus of the European Strategy on MDGs follows the key approaches and pillars of the work of the Regional Office, as reflected in this paper, namely:

- tailored country work
- strengthened health systems
- focused technical interventions
- partnership among all international and national agencies.

5. It is commonly understood that health progress in the Region – including achievement of many of the MDGs – will require sustained multisectoral action addressing all the determinants of health and the involvement of all partners nationally and internationally. Experience at WHO Regional level, however, has shown that insufficient capacity in the area of health systems is an insurmountable barrier to achieving the health-related MDGs. The lack of alignment between WHO's health systems agenda and the various health systems strategies of its 'vertical programmes' could affect the effectiveness, efficiency and coherence of WHO's support to countries. Also, recent publications[a] have reviewed and confirmed the importance of health systems in improving health in both men and women over the last 25 years in selected European Union (EU) countries.

6. Acknowledging the importance of health systems, WHO is now giving the issue higher priority on its agenda, as illustrated below.

- *The world health report 2000 (5)* was devoted to health systems, and substantial space has also been given to health systems in subsequent world health reports.
- The country cooperation strategies emphasize the need for WHO to change its way of working, paying more attention to the links between country work and health systems.
- A new WHO global health systems strategy is also under development. It builds on the key postulate that "health outcomes are unacceptably low across much of the developing world…A central element to this problem is the failure of the health systems concerned, which in many

[a] See for example McKee and Nolte, 2004 *(4)*.

countries are simply unable to provide drugs, vaccines, information and other forms of care to those who need them, or are accessible only to particular groups in the population".

7. Through the Health Systems Strategy, WHO intends, together with the World Bank, to mobilize international efforts to tackle the challenges identified in the High-Level Forum on the Health MDGs, with support from other agencies and global initiatives such as the GAVI Alliance and the Global Fund to fight AIDS, Tuberculosis and Malaria.

8. In the WHO European Region too, strengthening health systems has been considered by Member States to be an integral part of the Regional Office's interventions at country level *(6)*. The WHO Regional Committee for Europe, in its resolution EUR/RC55/R8, recently endorsed the Office's initiative to give high priority to health systems in all WHO interventions at country level.

9. The approach adopted – based on extensive experience of collaboration with Member States – analyses all WHO country support through the functional health systems framework (financing, service provision, resource creation and stewardship) developed in *The world health report 2000*. Efforts are therefore being made in the Regional Office for Europe to strengthen the linkages between health programmes (e.g. the tuberculosis control programme, or the maternal and child health programmes) and the health systems programmes. The WHO health systems framework recommends the identification of specific reforms that link possible changes in the functions performed by health systems to specific objectives through policy development and a carefully planned process.

Prospects of achieving the MDGs in the WHO European Region

10. Substantial efforts in terms of money, human resources and specific activities have been devoted to achieving the MDGs in the European Region. With less than a decade left to achieve the MDGs, it is important to take stock of the progress achieved so far, to identify the successes and failures, and to try to understand and tackle the bottlenecks that hinder the pace of development.

11. In overall terms, the European Region is doing well with regard to the MDGs, if progress is judged by regional averages.

12. However, if we look carefully at the national and subnational levels, much more inequitable pictures appear. There is certainly an observable pattern in terms of the relationship between the level of income and progress towards the health-related MDGs. The higher-income countries of the European Union and south-eastern Europe are much more advanced than the middle- and low-income countries of the Commonwealth of Independent States (CIS) – the former Soviet Union.

13. Despite the recent acceleration in economic growth, the countries of eastern Europe and central Asia, in particular, still face difficulties in achieving many of the MDGs. According to the latest Global Monitoring Report *(7)*, WHO's European Region has already achieved three of the eight development goals: those addressing poverty, education and gender. Eight countries are likely to achieve five of the eight MDGs; fourteen countries will probably achieve seven, and one country will not achieve any of the targets, if the pace of progress stays the same *(8)*.

14. The new EU member states have either already achieved all the MDGs at the national level or are likely to achieve more than 80% of them. The greatest challenge appears to be faced by the Baltic countries in relation to Millennium Development Goal 6 (MDG6) on curbing HIV/AIDS, tuberculosis and other diseases. This is mainly because of the increasing prevalence of HIV/AIDS. Estonia is unlikely to achieve that MDG, and it is uncertain whether Latvia and Lithuania will do so. For MDG2 (school enrolment) and MDG7 (water access), there is not enough data available to judge the progress achieved. However, it is very likely that these countries have already achieved the target or will do so *(7)*.

15. The countries of south-eastern Europe (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Romania, Serbia, The former Yugoslav Republic of Macedonia and Turkey) have achieved just over half of the MDGs. Progress towards MDG6 on HIV/AIDS and other diseases is rather slow in Albania, Bulgaria and Romania (it seems likely that Romania will not reach the target). Turkey's progress towards MDG3 on gender equality in schools is not sufficient to achieve the target. It is uncertain whether Albania and Romania will achieve MDG7 on water access *(7)*.

16. Middle-income countries in the CIS (Belarus, Kazakhstan, the Russian Federation and Ukraine) will probably achieve more than 50% of the MDGs. However, they are not going to reach 20% of the MDG targets. For the remaining 30%, it is uncertain whether they will achieve the targets, or the data is not available to assess the progress made. The greatest challenges for these countries are related to MDG6 (curbing HIV/AIDS and other diseases) and MDG4 (child mortality) *(7)*.

17. Progress towards the MDGs has been slowest in the low-income CIS countries (Armenia, Azerbaijan, Georgia, Kyrgyzstan, the Republic of Moldova, Tajikistan and Uzbekistan). Some of these countries will most probably miss more than four MDG targets. None of them will achieve MDG6 because of increasing levels of HIV/AIDS and tuberculosis *(7)*.

18. It is commonly believed that western European states do not have to worry about the health MDGs, as they have already reached the targets or are well on track. While this is generally true, some countries do show negative trends. For example, 10 western European countries were off-track on the maternal mortality target in 2000[b]. The mortality rates in these countries were already quite low in 1990 compared to the average in the Region. However, MDG5 calls for a reduction of the maternal mortality ratio by three quarters between 1990 and 2015, irrespective of the baseline value. Statistics for 2000, compared to those for 1990, showed a slower reduction than needed to achieve the targeted three quarters reduction by 2015. It is fair to say that a further reduction for countries that already have very low maternal mortality ratios may be difficult and therefore achieving the 2015 target may not be realistic. However, in some of these low mortality countries (e.g. France, the Netherlands, Norway, Switzerland, the United Kingdom), the maternal mortality ratio actually increased between 1990 and 2000, and that is certainly a matter for concern.

19. For MDG6 on HIV/AIDS and other diseases, if current rates and historical trends continue, none of the middle- or low-income CIS countries are likely to achieve the target. Of the new EU member states, only Estonia and Romania will not meet all the targets: Estonia will not achieve either the HIV/AIDS or the tuberculosis target, while Romania will not achieve the tuberculosis target.

20. The table below provides a more detailed picture of the progress towards seven MDGs in selected countries. Annex 1 gives an update of the situation in more detail, on a goal-by-goal basis.

[b] Author's calculation from WHO's European Health for All database *(9)*.

Table 1. Progress towards seven MDGs in selected Member States in the WHO European Region
(MDG8 is omitted due to lack of data)

	MDG1 Poverty	MDG2 School enrolment	MDG3 Gender equality in schools	MDG4 Child mortality	MDG5 Maternal mortality	MDG6 HIV/AIDS malaria, and other diseases	MDG7 Water access
New EU Members							
Bulgaria							
Czech Republic							
Estonia							
Hungary							
Latvia							
Lithuania							
Poland							
Romania							
Slovakia							
Slovenia							
Southeastern Europe							
Albania							
Bosnia and Herzegovina							
Croatia							
Montenegro							
Serbia							
The former Yugoslav Republic of Macedonia							
Turkey							
Middle-income CIS countries							
Belarus							
Kazakhstan							
Russian Federation							
Ukraine							
Lower-income CIS countries							
Armenia							
Azerbaijan							
Georgia							
Kyrgyzstan							
Republic of Moldova							
Tajikistan							
Uzbekistan							

	No data		Unlikely		Likely		Maybe

Source: *Millennium Development Goals. Progress and Prospects in Europe and Central Asia (10)*.

21. There are clear disparities among countries in the European Region with regard to their progress in achieving the health MDGs. However, beyond these intercountry disparities, there are also significant socioeconomic inequalities within individual countries in relation to the MDG targets. Even in those Member States which are well on track and most likely to reach the MDGs, there are certain population groups whose health indicators show much slower progress, or even deterioration, over time.

22. Unfortunately, disaggregated statistics on MDG targets and indicators are not readily available in most European countries but it does appear that ethnic minorities, people living in poverty, migrants and internally displaced people are systematically disadvantaged in terms of benefiting from progress

achieved on the MDGs. It is particularly difficult to obtain figures for different ethnic groups and migrants, who are often marginalized and have limited access to health services.

23. Wherever the data are available, the inequities are striking. One of the main reasons for socioeconomic inequalities in the achievement of the health-related MDG targets is thus limited access to health services. There is a direct relationship between family income and the percentage of people who do not seek health care when sick. A recent study in CIS countries showed that 61% of people in the lowest income quintile do not seek care when needed, compared to 33% in the highest income quintile *(12)*.

24. Such examples are a reminder of the importance of making specific efforts to improve equity when promoting the achievement of the MDGs.

The health of mothers and children – lessons learned

25. All the MDGs are relevant to the health and welfare of mothers and children, MDG4 (reduce child mortality by two thirds) and MDG5 (reduce maternal mortality by three quarters) specifically so. Particular reference will therefore be made to those two MDGs when addressing health systems and the health of mothers and children in the following section.

26. Despite substantial progress in recent decades, the WHO European Region still shows unacceptable disparities in maternal and child health both between and within countries. Mortality in children under five years of age in the country with the highest rate is 40 times higher than the level in the country with the lowest rate. A child born in the CIS is three times as likely to die before the age of five as a child born in the EU. The maternal mortality ratio in the central Asian republics remains at least double the Regional average and, although disparities between countries in the EU, the Nordic countries and other groups of countries have narrowed in recent years, there are still large differences.

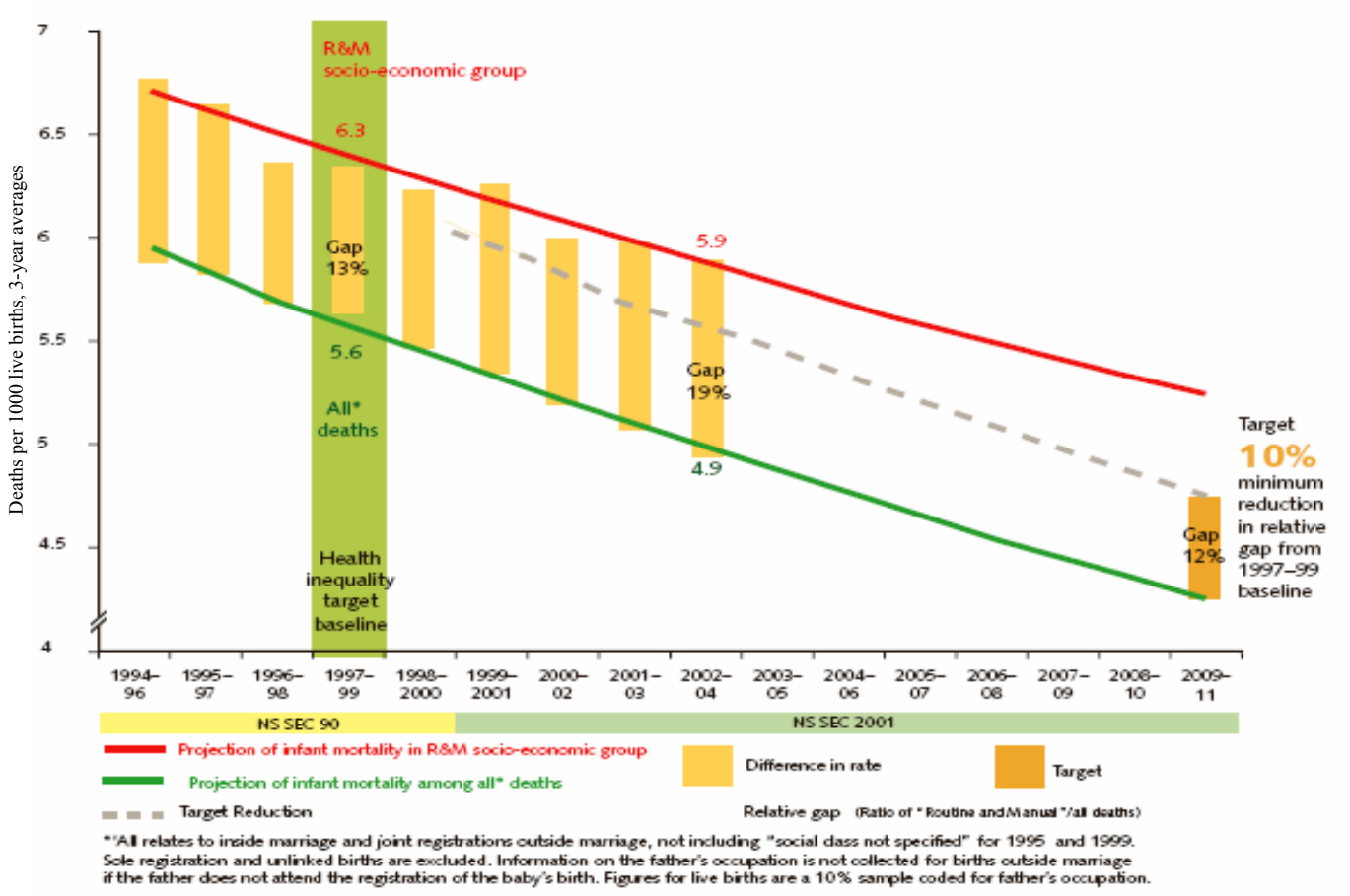
27. Differences between countries are only part of the story; within a country too, there can be staggering imbalances in mortality rates. In the European Region today, there are subgroups and districts where mortality rates for mothers and babies are just as serious as those seen in sub-Saharan Africa or southern Asia. Almost universally, rural populations have higher mortality than their urban counterparts, rates vary widely by ethnicity and wealth status, and remote areas bear a disproportionate burden of deaths.

28. For example, according to demographic and health survey data from 2000, in Azerbaijan, 18% of women with incomplete secondary education were not assisted by a skilled birth attendant during childbirth, as opposed to only 1% of women with postsecondary education *(13)*.

29. In the United Kingdom, although maternal mortality levels are low, women from black African ethnic groups are seven times more likely to die than white women. Within urban areas, the risk of maternal and perinatal death often differs significantly between women in poorer areas and those in wealthy suburbs. Recently arrived migrants, refugees and asylum seekers also suffer more in terms of care and sometimes conceal their pregnancies from the authorities, including the health services.

30. Similarly, infant mortality rates were found to be considerable higher in lower social groups than the national averages in England and Wales, and the gap was increasing. For example, in 2002–2004, the overall infant mortality rate was 4.9 per 1000 live births, while the rate for those in the routine and manual occupation group was 5.9. Infant mortality has been declining overall for all socioeconomic groups, but the rate of decline was slower for the routine and manual occupation group. The mortality gap between the routine and manual occupation group and the general population was 13% in 1997 but increased to 19% in 2004. In England and Wales, the infant mortality rate is 10.2 per 1000 live births if the mother is of Pakistani origin. This is twice the average rate for the general population and has led to the setting of national targets for reducing the gap in infant mortality rates in the United Kingdom (Fig. 1).

Figure 1. Infant mortality rates in England and Wales from 1994–2004 by socioeconomic group with projection to 2010 target



Source: Review of the health inequalities infant mortality PSA target (11).

31. In 1999, the officially reported infant mortality rate in Romania was 18.58 per 1000 live births *(9)*; however, the rate among ethnic Romanians was 27.1, that for ethnic Hungarians was 19.8, and the rate for the Roma population was 72.8 *(14)*. Similar inequities continue to exist even today in many eastern European countries and there are no signs of the gap narrowing.

Strengthening health systems to improve maternal and child health: Interventions and challenges

32. In line with the evidence demonstrated in the previous sections, a specific contribution by WHO in recent years is the reminder that, when health systems work at their best, they contribute to the reduction of avoidable infant and maternal mortality. *The world health report 2005 (15)* specifically addresses the health of mothers and children from a health systems perspective. It concludes that, for families to enjoy universal access to a continuum of care, health programmes have to work together but the fundamental prerequisite is that health systems must be extended and strengthened. The report further summarizes that, although an increasing number of countries have succeeded in improving the health and well-being of mothers, babies and children in recent years, those countries that started off with the highest burden of mortality and ill-health made least progress during the 1990s. The need for well-functioning health systems is also clear in this respect. Countries where health indicators for mothers, newborn babies and children have stagnated or reversed have often been unable to invest sufficiently in health systems.

33. When designing country support activities, each health and health system programme in the Regional Office aims to support Member States in their own efforts to build their health systems. Examples of such interventions across health systems functions for the case of maternal and child health are given below.

Service provision

34. The provision of quality health services is essential for improving maternal and child health, particularly in the critical stages of pregnancy, childbirth and early childhood. In many countries, this involves implementation of plans for restructuring personal and nonpersonal health services. Plans should comprise several components as shown below.

- *Evidence-based packages of interventions* and quality standards of care in accordance with international guidelines. These packages must include skilled care during pregnancy, birth, the postnatal period (for both mother and newborn child), family planning services and, where legal, abortion and post-abortion care. Interventions that include management of most common childhood illnesses are also needed.
- *Quality improvement mechanisms* are vital to ensure the provision of quality services. These mechanisms (the necessary checks, proper registers and a strong data management system, evaluation for effectiveness, etc.) must include criteria for appropriate referral and for rational use of drugs and appropriate use of technology. These activities will allow remedial action to be taken whenever necessary.
- *A well-functioning referral system to ensure continuity of care*. Between 9% and 15% of pregnant women encounter complications related to their pregnancy (some studies have made even higher estimates); they need to be referred as soon as possible to a health facility with the necessary skilled health professionals who have the necessary equipment. In approximately 5% of cases, women will require highly specialized, high-dependency care, and additional equipment and resources. Between 10% and 20% of newborn babies will also need specialized care, with 5% to 10% needing surgery or higher-level care. Although not all facilities will be able to provide high-level care, all facilities must have effective referral mechanisms for accessing such care.
- *Integration of maternal and child health care services* with other primary health care programmes to improve efficiency. Shifting the emphasis from hospitals to first-level care will be the key to successful reform and the establishment of appropriate maternal, newborn and child health services. Health education, environmental health, immunization, nutrition and family planning, as well as the prevention and treatment of sexually transmitted infections (especially syphilis), HIV/AIDS and malaria are more effectively and efficiently addressed by maximizing direct contacts with health personnel before and during pregnancy and birth and in early childhood.
- *Improved service delivery management*. A motivating working environment and good human resources management, including favourable conditions of employment and good supervision, are crucial to enhancing the skilled delivery of care. Special attention also needs to be focused on efforts to motivate and retain skilled health personnel. Remuneration levels need to be reconsidered in many countries of the Region. Some countries in the Region are implementing plans for restructuring substantial parts of their personal and nonpersonal health services.

Resources

35. Health service delivery requires a robust resource base in order to be effective and sustainable. National health systems need to produce, train and deploy those resources effectively, including by ensuring that the conditions below are met.

- *Sufficient numbers of health care professionals to deliver essential services at each level of care*. These include family doctors, health care professionals with obstetric, neonatal and paediatric skills, as well as anaesthesiologists, nurses and laboratory technicians. A key constraint in many countries is the lack of adequate numbers of midwives to provide appropriate care at primary level

in a woman's home or a care facility (birthing centre, birthing home, midwifery-led unit, health post or health clinic). Health economists, planners and management staff are also vital. Many countries in the Region have begun to address their human resource problems in recent years.

- *Staff with the right skill mix*. With the transition taking place in many countries from a hospital-based care approach to a primary health care approach in the area of maternal and child health, there is a further need to adapt the workforce to operate effectively in the new system. Many countries in transition have introduced a family doctor-based system for child care, replacing the previous hospital-based care. The number of family doctors and their skills in managing mothers and children in an integrated way are, however, still limited in many countries, and this represents a critical challenge to the sustainability of the reformed health system.
- *Adequate physical infrastructure*. To be optimally effective, health staff caring for mothers, babies and children need suitable facilities. In some countries, the physical infrastructure needs upgrading, with new or improved buildings, lay-out, and electricity and water supplies. Adequate investment in buildings is essential in both primary health care and hospitals.
- *Continuous availability of the right technologies*. Effective mother and child care depends on the availability of proper, affordable technological support. Neither primary nor hospital-based services can ensure quality care without a minimum of essential medicines, medical supplies and equipment.

Financing

36. A system ensuring continuity of care for all women, their newborn babies and children depends on adequate financing of those services. If sustainable financing mechanisms are not in place, actions to strengthen the health system will not result in healthier mothers and children. Attention must be paid to the aspects noted below.

- *A robust base of prepaid services*. Central to all financing models that preclude families from incurring catastrophic costs is the mobilization of funding sources that minimize direct out-of-pocket payments at the moment of use. Such funding sources include general and earmarked taxes, social insurance contributions, community insurance prepayment and private insurance premiums. Improving the coverage of quality skilled care will require not only extra financial investments but, more importantly, the reallocation of existing resources to implement cost-effective and evidence-based interventions that are known to improve maternal and newborn health.
- *The pooling of resources and risks in order to allow for solidarity*. A solid resource base is indispensable in transferring resources and funds across rich and poor as well as urban and rural mothers and children. Such a resource base can be established with sufficiently high numbers of contributors pooled together in a relatively small number of financing schemes. Universal coverage of quality skilled care could prevent most maternal and perinatal deaths, as well as many more cases of morbidity and disability in the Region. Increased availability of funds is also achieved through greater administrative cost–effectiveness.
- *Strategic resource allocation*. Quality in mother and child care needs to be supported by efficient resource allocation mechanisms, including methods for paying the professionals. Hospital and primary health care staff need to be paid according to schedules and systems that promote performance and responsiveness. In many countries in the European Region, payment methods are not able to provide the right incentives. New payments and incentives for family doctors and the introduction of per capita approaches in health budgeting are promoting the delivery of improved mother and child services.
- *Searching for efficiency*. Efficient financing mechanisms are the product of sustained efforts. There is a need to promote a culture of permanently searching for best practices and of increasing the accountability of the institutions responsible for managing health financing. As evidence becomes available, it should be used to assess the effectiveness of models in increasing service utilization and ensuring that maternal and newborn health services are within reach of the poor and the needy.

Many countries in the Region have reformed or are reforming their health financing schemes, including those related to mothers and children.

Stewardship and governance

37. Improving maternal and child health is a complex endeavour. On the one hand, ensuring the provision of services for all, and especially for the poor and the needy, is neither easy nor cheap, as shown by the findings from the European Region presented in this paper. On the other hand, many underlying determinants of ill-health in women and children lie beyond the direct reach of health care; for example, the socioeconomic status of women is a strong determinant of maternal and child health and survival.

- *An effective regulatory environment* is critical to ensure accountability for the provision of high quality care for all women and newborn babies in both the public and the private health sectors. Laws and policies may need to be reviewed and modified if necessary in order to facilitate full and equitable access to reproductive health services, including family planning, treatment of sexually transmitted infections and, where legal, abortion care, as well as information and education. In this context, partnerships between the health system and ministries of labour and social affairs should ensure that women can combine a working life with maternity. Proper standards need to be in place to guarantee that medicines, equipment and supplies that meet international quality standards are available on a consistent and equitable basis.
- *Political commitment* is crucial for providing the right policy vision. Strategic mother and child programmes need to be reviewed (or created, where necessary) with the right priorities. However, high maternal and child mortality in some countries of the Region is a painful reminder that, in spite of the ratification of WHO and United Nations documents, political commitment is not always adequate and that, in some Member States, there is no long-term, comprehensive approach in these spheres. A supporting policy environment at national, regional and local levels is crucial. The integration of policy measures and initiatives across levels and across sectors can ensure that supportive regulatory framework is coordinated and monitored.
- *Adequate intelligence*. A well functioning health information system based on international standards is key to setting priorities and monitoring the gaps and improvements in the health of mothers and children. Underreporting of maternal and infant death in official statistics is unfortunately a reality in many countries in the Region, including EU countries such as Austria, Finland, France and the United Kingdom, where published data suggest considerable underreporting of maternal death *(16,17,18)*. In other Member States, such as the CIS countries, underreporting of infant death is caused by differences in live birth definitions and sometimes fees for birth registration that deter less privileged families from registering births immediately. Tracking of process indicators, particularly in relation to utilization and quality of services and the coverage of skilled health professionals at birth, is also important for policy.
- *An attitude of transparency and accountability*. Although transparency in reporting in the field of maternal and child health has improved enormously in recent decades, problems still persist. Improved monitoring of maternal and neonatal deaths is a priority, especially where registration is faulty. Approaches should be tailored to country contexts, but the application of facility-based case reviews, special surveys of women of reproductive age, verbal autopsies and even special questions administered by census have all been used successfully.

Conclusion: the way ahead in the European Region

The need to make better progress towards the Millennium Development Goals

38. This paper has shown that achieving the MDGs is proving more difficult than initially foreseen. Contrary to the intuitive expectation that money and other resources were the main (if not the only) requirement, progress in many cases is slow, if not absent. The fear that many of the MDGs will not be

achieved, especially in the countries where they are most needed, is unfortunately not an exaggeration but a well-founded prediction unless dramatic progress takes place in the next eight years.

39. In summary, as we reach the halfway mark to the MDG target date of 2015, the global data show that:

- the proportion of women attended by a skilled medical person during delivery has increased in some regions (notably Asia), although from a low baseline;
- the use of insecticide-treated bed nets has risen; and
- the coverage of effective tuberculosis treatment has increased *(19)*.

40. But at the same time:

- no region in the developing world is currently on track to meet the child mortality target; and
- for maternal mortality, there is evidence that declines have been limited to countries with lower mortality levels, whereas countries with high maternal mortality ratios are facing stagnation or even reversals *(20)*.

41. The latest Global Monitoring Report for 2006 *(7)* has found that:

- the European Region is doing well overall, if progress is judged by regional averages, but the national and subnational levels give much more inequitable pictures;
- there is also an observable pattern in the relationship between income levels and progress towards the health MDGs, with higher-income countries of the EU and south-eastern Europe being much more advanced than middle- and low-income countries; and
- the WHO European Region has already achieved three of the eight development goals: for poverty, education and gender. However, eight countries are likely to achieve only five of the eight MDGs, fourteen countries will probably achieve seven, and one country will not achieve any of the targets if the pace of progress stays the same.

42. All the above seem to be a result from a number of factors, including:

- low absorption capacity on the part of the countries; and
- difficulties in reaching the target populations.

43. The most important development in the last few years however is that, until now, vertical approaches and disease-specific programmes have been the preferred option of the international community. Effective interventions now exist for many priority health problems; prices are falling and funds are increasing. However, progress towards the agreed health goals remains slow. Insufficient capacity in health systems is an insurmountable barrier to achieving the health-related MDGs *(21)*.

Current and future WHO initiatives in the field of maternal and child health

44. Learning from experience, the WHO Regional Office for Europe has developed several strategies in the area of maternal and child health, aiming to help Member States to create their own national policies and plans and set priorities for maternal and child health within the health systems. In addition to the documents on health systems previously mentioned, these include:

- the European Strategy for Child and Adolescent Health, adopted in 2005, and related tools;
- the European and global reproductive health strategies adopted in 2001 and 2004, respectively;
- the draft global gender strategy, endorsed by the Sixtieth World Health Assembly in 2007, to be adapted to the European Region;

- the draft strategy entitled *Improving maternal and perinatal health: the European strategic approach for making pregnancy safer*;
- the strategy on measles and rubella elimination adopted by the Regional Committee in 2005;
- the second European action plan for food and nutrition policy, with its emphasis on breastfeeding; and
- the Declaration of the Fourth Ministerial Conference on Environment and Health held in 2004.

45. These are meant to be implemented within the policy frameworks of national health systems, and the challenge for Member States is to translate these strategic frameworks into practical plans of action at various levels.

46. Also, there are a number of initiatives currently promoted by the Regional Office that integrate health systems and maternal and child health programmes, such as those being implemented in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Kazakhstan, Kyrgyzstan, Montenegro, the Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia. The Chuvash Republic in Russia has reported impressive results of restructuring carried out in this area.

47. The above-listed nine countries in south-eastern Europe (SEE), in particular, have started a concerted regional initiative, supported by the Government of Norway and the WHO Regional Office for Europe. The objective is to improve maternal and neonatal health through specific reforms and strengthened capacities of their health systems. Currently, the SEE countries are carrying out an in-depth evaluation related to maternal and child health and are identifying the bottlenecks in their general health systems with the aim of defining the reforms needed.

Towards the WHO European Ministerial Conference on Health Systems in 2008

48. The above measures are expected to have an impact on the way services are delivered to mothers and children in many Member States in the European Region. The Regional Office is convinced that sustainable and lasting results will only be obtained if robust structures and institutions are created in the countries concerned. Sectoral reforms such as those discussed in this paper regarding mothers and children are good by themselves but also need to be seen in the context of a broader health system reform.

49. In resolution EUR/RC55/R8 adopted at its fifty-fifth session in September 2005, the Regional Committee for Europe considered that the Regional Office is well placed to examine the role of health systems, and requested the Regional Director to organize a European ministerial conference on strengthening health systems in 2008 to discuss the above and related issues. The key objectives of the Conference are:

- to take stock of recent evidence on effective strategies to improve the performance of health systems (towards achieving objectives such as health improvement, equity and financial protection, responsiveness, efficiency and quality) in the light of ever-increasing pressures for sustainability and solidarity; and
- to provide greater understanding of the impact of health systems on health status in Europe, and hence on economic growth.

50. The Conference will be held in Tallinn, Estonia from 25 to 27 June 2008, and will be preceded by a series of preparatory meetings involving all Member States in the European Region and WHO partners.

Annex

Update in progress towards the MDGs in the WHO European Region

51. Countries do vary significantly in terms of their economic and social development and the level of health of their population. Therefore not all MDGs are applicable to the same extent to every United Nations member state. However, every country, even the most developed industrialized nation, can find at least one MDG relevant to its efforts to track development progress. There are some other possible targets that are not currently included in the MDGs but that could be extremely relevant to many high- and middle-income member states, especially in the WHO European Region. Each country has the possibility of monitoring its development progress by any additional targets relevant to its context; however the core MDG targets still merit particular attention at the global and national levels.

52. The situation concerning the MDGs in the European Region is described below on a goal-by-goal basis.

53. *Goal 1: Eradicate extreme poverty and hunger*: Poverty has increased sharply in low- and middle-income European countries (faster than in any other region during the 1990s) and it remains a problem even in the richest countries. Many countries have inadequate data but the limited information available indicates that several countries are unlikely to meet this Goal.

54. *Goal 2: Achieve universal primary education*: Most European countries have reached or are on the way to attaining full enrolment. However, trends are stagnant 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 however is not primarily related to health.

55. *Goal 3: Promote gender equality and empower women*: In most parts of the Region, gender inequality in primary school is not an issue but, in some countries, boys leave school earlier than girls. Overall, this goal is more likely to be met in the WHO European Region than in other regions. However, it is not primarily related to health.

56. *Goal 4: Reduce child mortality*: Mortality among children under the age of five has been slowly declining but several countries, mainly in central Asia and the Caucasus, face significant challenges in this respect. Eastern Europe and the central Asian subregion as a whole are not on track to achieve MDG4. Even though the average under-five mortality rate is the lowest of all developing regions, the pace of decline from the 1990 level is slower than needed to achieve the target. For the new EU member states, this will mean a reduction in the under-five mortality rate to a level below the current EU average. Most low- and middle-income countries of the CIS have made too little progress in reducing under-five mortality to reach the 2015 target *(10)*.

57. The availability of reliable official data from CIS countries on under-five mortality is limited. There are significant discrepancies between different sources. The official statistics usually provide much lower mortality figures than the survey data. This certainly has implications for the accuracy of measuring progress and making realistic projections. In some countries, the under-five mortality rate is decreasing according to the official statistics, while the survey data suggest increasing trends. The main reason for such discrepancies is weak health information systems in these countries. Part of the problem is also that the definition of live births used in the CIS countries differs from that used by WHO. The definition commonly used in many CIS countries underestimates neonatal mortality. In some countries, the vital registration systems do not function properly, resulting in underregistration of births and deaths. In some places, there are negative incentives for the population (e.g. registration fees) to register births and deaths at official registration offices.

58. *Goal 5: Improve maternal health*: Maternal mortality is extraordinarily variable. In the European Region, maternal mortality ratios range from 2 per 100 000 live births in Sweden to 210 in Kazakhstan. Trends indicate that most western and eastern European countries and the majority of middle-income CIS

countries are likely to achieve the target. However, the low-income CIS countries show too little progress to be able to reach the 2015 target. Recent estimates suggest that, in some low-income CIS countries, current maternal mortality ratios are higher than the baseline values of 1990. As in the case of under-five mortality, reaching the 2015 target for maternal mortality would, in many countries in the European Region, mean achieving levels far below the current EU average. While they are on track for this according to the historical trends, it is not certain whether the same pace can be maintained over the next decade. Two thirds of the countries will reach the MDG5 target.

59. Monitoring progress towards MDG5 is problematic because maternal mortality is difficult to measure, and the other indicator used for monitoring progress – skilled birth attendance – is an indicator of access to adequate maternity services. As with MDG4, discrepancies between the official statistics and external estimates are an issue with regard to MDG5 indicators.

60. *Goal 6: Combat HIV/AIDS, malaria and other diseases*: HIV/AIDS is a serious threat to public health, with a nine-fold increase in eastern Europe and central Asia in less than 10 years. After 40 years of decline, tuberculosis re-emerged in the Region during the 1990s and now is a serious problem in many countries. More than half of the low- and lower-middle-income countries in the European Region are unlikely to achieve this Goal.

61. The prevalence of HIV/AIDS is low in the European Region compared to the other regions. However, the HIV/AIDS rates are growing very fast in the CIS countries. Being relative newcomers to the HIV/AIDS epidemic, these countries now have the fastest growing rates in the world. The epidemic is concentrated mainly among the young and high-risk populations. The highest prevalence and incidence rates are observed among intravenous drug users and commercial sexworkers. Given the character of the injection drug-use epidemic, female and maternal infection rates are less pronounced. Therefore the indicator of HIV infection rates per million people is most relevant for monitoring HIV/AIDS dynamics in the European Region. After the precipitous growth of HIV/AIDS incidence in recent years, there are now signs in some countries of a slowdown. However, without reliable figures on trends in the numbers tested, it is difficult to say whether the slowdown is a real phenomenon or if it hides increasing rates of undetected cases.

62. Tuberculosis is another challenge to the CIS countries. The incidence of tuberculosis is increasing in all middle- and low-income countries in the CIS. In some countries, the rates have doubled since 1990, while decreasing substantially in the rest of the European Region. In some countries, the increase in tuberculosis incidence has been linked to the increase in HIV/AIDS incidence.

63. *Goal 7: Ensure environmental sustainability*: The WHO-UNICEF Joint Monitoring Programme is the designated instrument for monitoring progress in this area. Water supply and sanitation remain the biggest environmental challenge, despite official data showing that very large percentages of populations have full access to those infrastructures. Evidence exists that water quality, in particular, remains a serious issue and a major health hazard for many.

64. Access to water (recognized as a universal human right by the United Nations in 2002) has thus not been fully achieved for the entire population in the WHO European Region. It is often contingent on infrastructure development, operation and management under conditions of economic viability and is thus not achieved where there is poverty and neglect of rural areas. Equity in access remains a challenge for many subregions or local populations in the Member States.

65. In the Mediterranean, in particular, it has been estimated that, in addition to the 130 million inhabitants living permanently along the coastline and interacting frequently with the water, another 100 million visit the area annually. Unsatisfactory sanitation systems – lack of sanitation system, operation and maintenance failures, or lack of end-of-pipe treatment – create health-threatening conditions and raise concern especially for the health impact of recreational water and seafood grown or taken from those waters. WHO has shown that, for every dollar invested in water and sanitation, the return in economic terms is between US$3 and US$34. Investment in water and sanitation, therefore, is a lever for the world to achieve the MDGs. Meeting the sanitation targets will reduce the environmental impact on the

recipient waters, which in turn will reduce both thalassogenic diseases and diseases related to contaminated food resulting from aquaculture and near-coastal fisheries.

66. *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 assessment is quite applicable to the European Region. A rather striking finding is that the European Region receives the least official development assistance for health of all regions worldwide, as shown in the table below.

Region	Development assistance for health per capita	Development assistance for health in % of official development assistance
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
Europe and central Asia	0.34	1.7
AVERAGE	*1.00*	*8.9*

Source: Suhrcke M, Rechel B, Michaud C *(22)*.

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