



WORLD HEALTH STATISTICS 2014

Part I

Health-related Millennium Development Goals

Summary of status and trends

With one year to go until the 2015 target date for achieving the MDGs, substantial progress can be reported on many health-related goals. The global target of halving the proportion of people without access to improved sources of drinking water was met in 2010, with remarkable progress also having been made in reducing child mortality, improving nutrition, and combating HIV, tuberculosis and malaria.

Between 1990 and 2012, mortality in children under 5 years of age declined by 47%, from an estimated rate of 90 deaths per 1000 live births to 48 deaths per 1000 live births. This translates into 17 000 fewer children dying every day in 2012 than in 1990. The risk of a child dying before their fifth birthday is still highest in the WHO African Region (95 per 1000 live births) – eight times higher than that in the WHO European Region (12 per 1000 live births). There are, however, signs of progress in the region as the pace of decline in the under-five mortality rate has accelerated over time; increasing from 0.6% per year between 1990 and 1995 to 4.2% per year between 2005 and 2012. The global rate of decline during the same two periods was 1.2% per year and 3.8% per year, respectively.

Nevertheless, nearly 18 000 children worldwide died every day in 2012, and the global speed of decline in mortality rate remains insufficient to reach the target of a two-thirds reduction in the 1990 levels of mortality by the year 2015. **Table 1** shows the number of countries that have achieved this target; those that are on track to meet the target by 2015 if the current rate of progress is maintained; those that are at least halfway to achieving a two-thirds reduction in the 1990 level of mortality but are unlikely to achieve it by 2015 at the current rate of progress; and those that are less than halfway to meeting the target. Less than one-third of all countries have achieved or are on track to meet the MDG target by 2015.

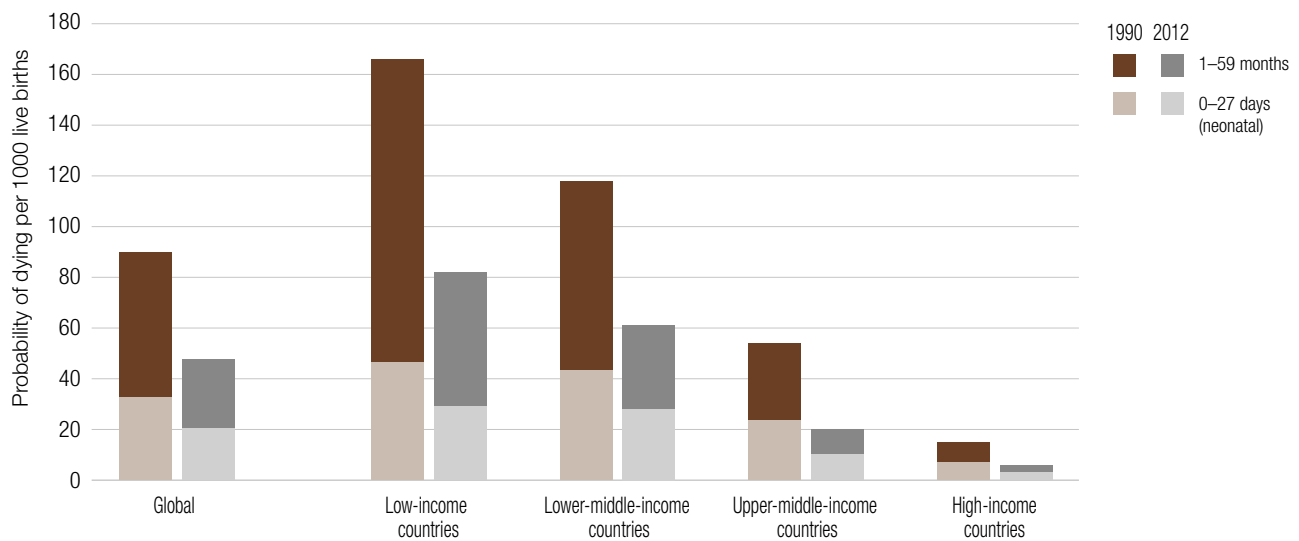
Inequities in child mortality between high-income and low-income countries remain large. In 2012, the under-five mortality rate in low-income countries was 82 deaths per 1000 live births – more than 13 times the average rate in high-income countries (**Fig. 1**). Reducing these inequities across countries and saving the lives of more children by ending preventable child deaths are key priorities.

Table 1. Number of countries according to MDG Target 4.A achievement status, by WHO region, 2012

WHO region	MDG Target 4.A – achievement status				Total
	Achieved	On track	Halfway or more	Less than halfway	
African Region (AFR)	3	6	21	16	46
Region of the Americas (AMR)	5	3	22	5	35
South-East Asia Region (SEAR)	4	3	4	0	11
European Region (EUR)	17	8	28	0	53
Eastern Mediterranean Region (EMR)	6	2	11	3	22
Western Pacific Region (WPR)	2	1	18	6	27
Global	37 (19%)	23 (12%)	104 (54%)	30 (15%)	194 (100%)

Calculated using unrounded under-five mortality rates, 1990 and 2012.

Figure 1. Neonatal and under-five mortality rates – globally and by country income group, 1990 and 2012



Each bar indicates the total under-five mortality rate as the sum of the neonatal mortality rate (0–27 days; lighter-shaded bars) plus the combined mortality rate for infants aged 1–11 months and children aged 1–4 years (darker-shaded bars).

The first 28 days of life – the neonatal period – represent the most vulnerable time for a child’s survival. In 2012, around 44% of under-five deaths occurred during this period, up from 37% in 1990 (Fig. 1). As overall under-five mortality rates decline the proportion of such deaths occurring during the neonatal period is increasing. This highlights the crucial need for health interventions that specifically address the major causes of neonatal deaths, particularly as these typically differ from the interventions needed to address other under-five deaths.

Current evidence indicates that undernutrition¹ is the underlying cause of death in an estimated 45% of all deaths among children under 5 years of age.² The number of underweight children globally declined from 160 million in 1990 to 99 million in 2012, representing a decline in the proportion of underweight children from 25% to 15%. This rate of progress is close to that required to meet the

relevant MDG target, but varies between regions (Fig. 2). Beyond the MDGs, a new global target was recently set for a 40% reduction in the number of stunted children by 2025 against the 2010 baseline, along with five other targets on maternal, infant and young-child nutrition.³ Between 1990 and 2012, the number of children affected by stunting declined from 257 million to 162 million, representing a global decrease of 37%.

In 2012, global measles immunization coverage reached 84% among children aged 12–23 months. More countries are now achieving high levels of vaccination coverage, with 66% of WHO Member States reaching at least 90% coverage in 2012, up from only 43% in 2000. Between 2000 and 2012, the estimated number of total measles deaths worldwide decreased by 78% from 562 000 to 122 000.

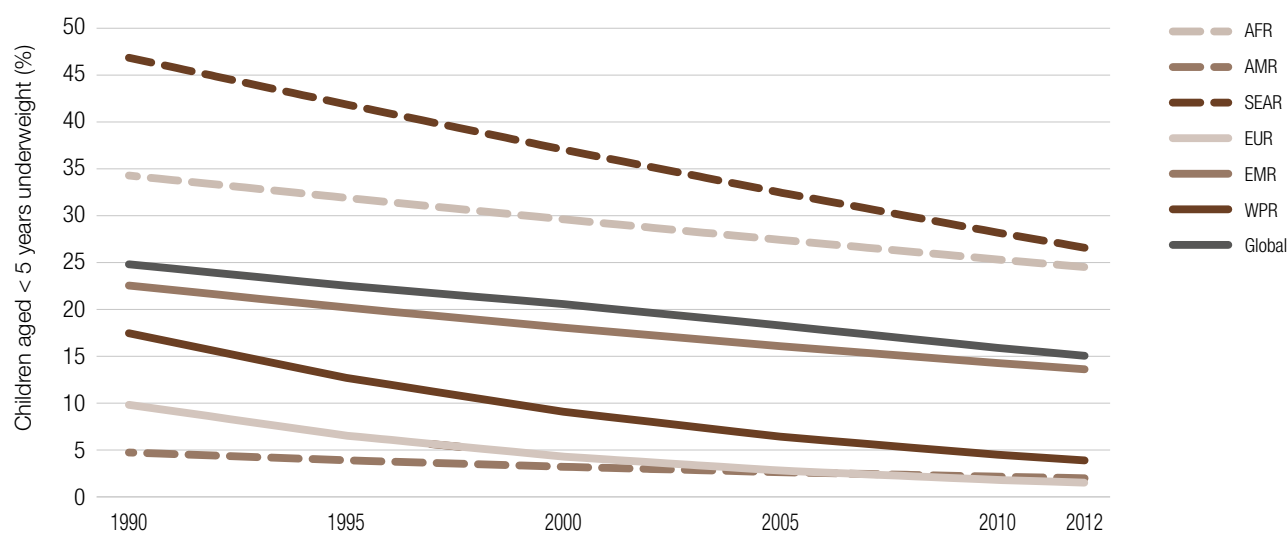
MDG 5 – Improve maternal health – sets out the targets of reducing the maternal mortality ratio from its 1990 level by three quarters and achieving universal access to reproductive-health services by the year 2015. The

¹ Including fetal growth restriction, stunting, wasting, and deficiencies of vitamin A and zinc, along with suboptimal breastfeeding.

² Black RE, Victora CG, Walker SP, Bhutta ZA Christian P, de Onis M et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet*. 3 August 2013;382(9890):427–51. doi:10.1016/S0140-6736(13)60937-X (<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2960937-X/abstract>, accessed 12 March 2014).

³ Comprehensive implementation plan on maternal, infant and young child nutrition. Sixty-fifth World Health Assembly, WHA resolution 65.6 and Annex 2. Geneva: World Health Organization; 2012. (WHA65/2012/REC/1; http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf, accessed 7 April 2014).

Figure 2. Prevalence of underweight children under 5 years of age – globally and by WHO region, 1990–2012



number of women dying due to complications during pregnancy and childbirth decreased by nearly 50% from an estimated 523 000 in 1990 to 289 000 in 2013. While such progress is notable, the average annual rate of decline (AARD) is far below that needed to achieve the MDG target (5.5%), and the number of deaths remains unacceptably high. In 2013, nearly 800 women died every day from maternal causes. Almost all of these deaths (99%) occur in developing countries, and most can be avoided as the necessary medical interventions exist and are well known. The key obstacle is the lack of access to quality care by pregnant women before, during and after childbirth.

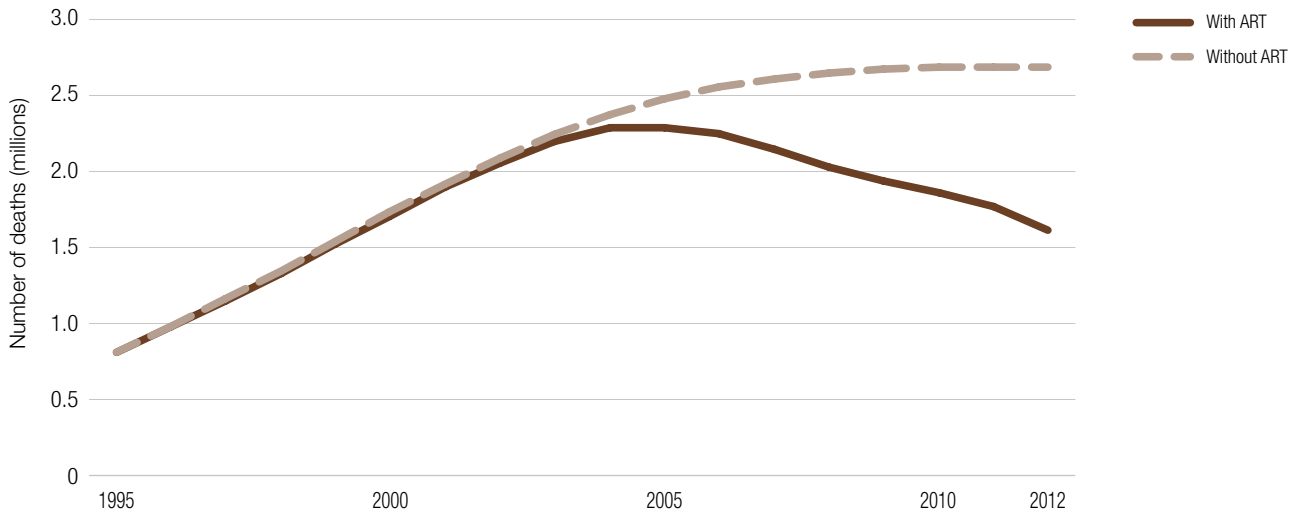
In many countries, programmes have been implemented to eliminate or reduce the barriers that prevent access to effective reproductive-health interventions. Despite increasing overall levels of contraceptive use, there still remain significant gaps between the desire of women to delay or avoid having children and their actual use of contraception. Globally in 2011, around one in every eight women aged 15–49 years who were married or in a union had an unmet need for family planning. In the WHO African Region, the figure was around one in four. Although the proportion of women receiving antenatal care at least once during pregnancy was 81% globally for the period 2006–2013, the figure dropped to around 56% for

the recommended minimum of four visits or more. Around seven in every 10 births globally are attended by skilled health personnel. However, coverage varies sharply across country-income level from almost all births (99%) in high-income countries to less than half of births (46%) in low-income countries.

Despite progress in reducing the birth rate among adolescents, more than 15 million of the estimated 135 million live births worldwide are to girls aged 15–19 years. Pregnant adolescents are more likely than adults to have unsafe abortions, and early childbearing increases risks for both mothers and their newborns. Complications from pregnancy and childbirth are a major cause of death among girls aged 15–19 in low- and middle-income countries.

Globally, an estimated 2.3 million people were newly infected with HIV in 2012 – representing a 33% decline compared with the 3.4 million new infections estimated for 2001. People living in sub-Saharan Africa accounted for 70% of all new infections. As access to antiretroviral therapy (ART) improves, the population living with HIV increases as fewer people die from AIDS-related causes. In 2012, an estimated 35.3 million people were living with HIV – with 9.7 million people in low- and middle-income countries receiving ART. It has been estimated that during the

Figure 3. Impact of ART use on the estimated number of deaths due to HIV/AIDS (millions) that would otherwise have occurred in low- and middle-income countries, 1995–2012¹



period 1995–2012, ART cumulatively averted 5.5 million deaths in such countries (**Fig. 3**). Globally, an estimated 1.6 million people died of HIV/AIDS in 2012; down from the peak of 2.3 million in 2005.

In 2012, an estimated 8.6 million people developed tuberculosis and 1.3 million died from the disease (including 320 000 deaths among HIV-positive people).² The rate of new tuberculosis cases worldwide has been falling for about a decade, thus achieving MDG target 6.C to reverse the spread of the disease by 2015. In addition, two WHO regions – the WHO Region of the Americas and the WHO Western Pacific Region – have also achieved related 2015 targets³ to reduce tuberculosis incidence, prevalence and mortality rates (**Fig. 4**). Globally, the tuberculosis mortality rate has fallen by 45% since 1990 and the target of a

50% reduction by 2015 is within reach. Nevertheless, despite this decline in mortality rate, the number of tuberculosis deaths remains unacceptably high given that most are preventable.

Between 1995 and 2012, 56 million people were successfully treated for tuberculosis and 22 million lives were saved. However, multi-drug resistant tuberculosis (MDR-TB), which emerged primarily as a result of inadequate treatment, continues to pose problems. In 2012, an estimated 450 000 people worldwide developed MDR-TB, but only 94 000 were newly detected. Treatment options for MDR-TB are often limited and expensive, and recommended medicines are not always available or may cause numerous adverse side-effects.

Infection with HIV is the strongest risk factor for developing active tuberculosis disease. Many countries have made considerable progress in addressing the tuberculosis and HIV co-epidemic. However, less than half of notified tuberculosis patients had a documented HIV test result in 2012, with only 57% of those who tested positive being on ART or started on ART.

In 2012, almost half of the world's population – 3.4 billion people – was estimated to be at risk of malaria. Of these, 1.2 billion people were considered to be at high risk, with more than one case of malaria occur-

¹ Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2013.

² **Table 2** in **Part III** presents data on mortality due to tuberculosis among HIV-negative people. Tuberculosis-related deaths among HIV-positive people are included in the mortality data for HIV/AIDS.

³ Stop TB Partnership targets linked to the MDG target 6.C of halting and beginning to reverse the incidence of major diseases such as tuberculosis by 2015, include reducing tuberculosis prevalence and deaths by 50% by 2015 compared with the 1990 baseline.

Figure 4. Reductions in tuberculosis incidence, prevalence and mortality, by WHO region, 1990–2012

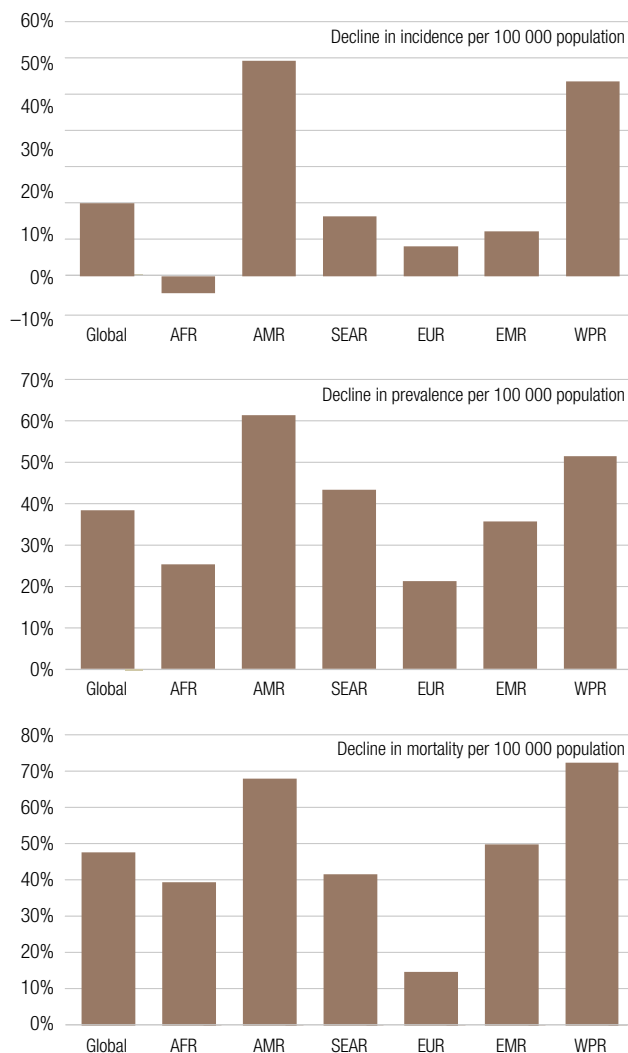
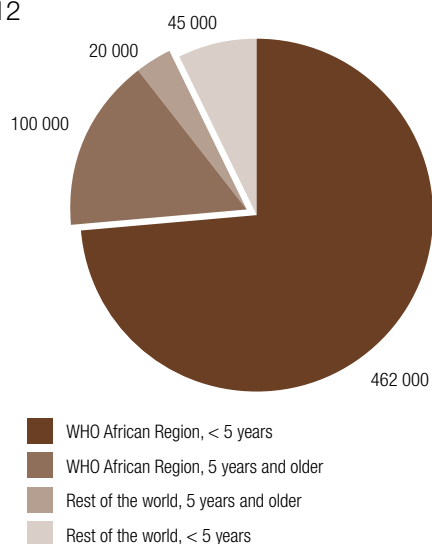


Figure 5. Estimated number of deaths due to malaria, 2012



ring per 1000 population. The WHO African Region bears the highest burden of malaria, with 80% of the estimated 207 million cases and 90% of the estimated 627 000 malaria deaths worldwide occurring in this region in 2012. More than three quarters (77%) of all malaria deaths occur in children under 5 years of age (Fig. 5).

During the period 2000–2012, malaria incidence rates among populations at risk¹ are estimated to have fallen by 25% globally and by 31% in the WHO African Region. Over the same period, estimated malaria mortality rates¹ decreased by 42% globally, by 49% in the WHO African Region and by 48% in children under 5 years of age globally. An estimated 3.3 million lives were saved as a result of scaling-up malaria interventions during the same period. If the annual rate of decrease is maintained, malaria mortality rates are projected to decrease by 52% globally, and by 62% in the WHO African Region and by 60% in children under 5 years of age, by 2015. Of 103 countries that had ongoing malaria transmission in 2000, 62 have produced reliable trend data indicating that 59 are meeting the MDG target of reversing its incidence. In the other 41 countries – accounting for 80% of estimated cases of malaria – it is not possible to reliably assess national malaria trends using the data reported to WHO.

Neglected tropical diseases (NTDs)² are endemic in 149 countries, often cause multiple infections in a single individual, and can lead to severe pain, permanent disability and death. Many of these diseases can be prevented, eliminated or even eradicated with improved access to existing safe and cost-effective tools. The reported number of cases of human African trypanosomiasis dropped to less than 10 000 in 2009 – the lowest level in 50 years. In 2013, the number of cases of dracunculiasis worldwide

1. The percentage changes shown in this paragraph are based upon malaria incidence rates defined as cases per 1000 population at risk, and mortality rates as deaths per 100 000 population at risk. Elsewhere in this report, malaria incidence and mortality rates are calculated per 100 000 population.

2. The diseases concerned are: Buruli ulcer; Chagas disease; cysticercosis; dengue; dracunculiasis; echinococcosis; endemic treponematoses; foodborne trematode infections; human African trypanosomiasis; leishmaniasis; leprosy; lymphatic filariasis, onchocerciasis; rabies; schistosomiasis; soil-transmitted helminthiasis; and trachoma.

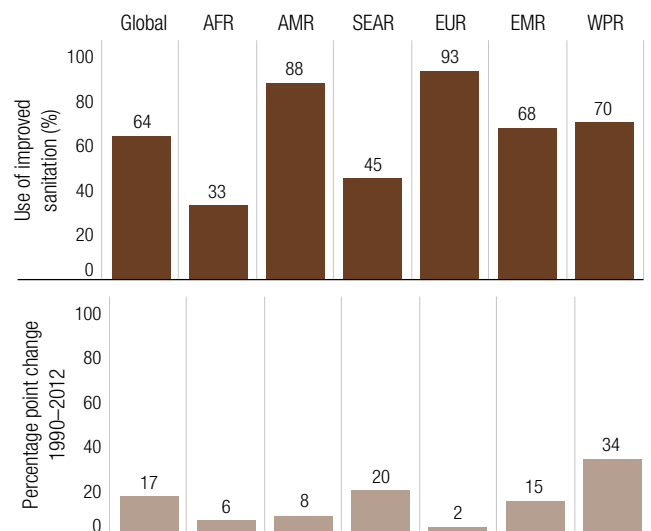
fell below 150 for the first time. Leprosy has now been eliminated as a public health problem in 119 out of the 122 countries where it was previously endemic, and 728 million people worldwide were treated for at least one NTD through preventive chemotherapy in 2011. However, NTDs still affect more than one billion people worldwide, weaken impoverished populations, and frustrate the achievement of the health-related MDGs and other desirable global public health outcomes. In the case of dengue – the world’s fastest growing viral infection – more than 2.5 billion people are estimated to be at risk.

The MDG target 7.C in relation to drinking-water, as measured by the proxy indicator of access to improved drinking-water sources, was met in 2010. Nevertheless, despite 2.3 billion people gaining access over the last 22 years as part of attaining the target, 748 million people remain un-served. This number increases to the order of billions if water quality and service sustainability are taken into account. Additionally, despite impressive progress, wide disparities exist between different regions, between urban and rural areas and between different socioeconomic groups – particularly between the rich and the poor. With regard to basic sanitation, more than 1949 million people have gained access to an improved sanitation facility since 1990. However, in 2012, 2523 million people (more than one third of the global population) still lacked such access. The current rate of progress is not sufficient to meet the sanitation target globally, which is projected to be missed by the order of 620 million people. The WHO Western Pacific Region is the only WHO region where access to basic sanitation has increased for more than one third of the population since 1990 (**Fig. 6**). In this region, the proportion of population using improved sanitation increased from 36% in 1990 to 70% in 2012 representing an increase of 34 percentage points.

Increasing access to affordable essential medicines¹ is vitally important in achieving the health-related MDGs. However, several factors undermine the availability of such medicines in a number of countries, including poor medicine supply and distribution systems, insufficient health facilities and staff, low investment in health and

¹ Essential medicines are medicines that help meet the priority health-care needs of a population. They are selected with regard to disease prevalence, and evidence of their efficacy, safety and comparative cost-effectiveness.

Figure 6. Proportion of population with access to improved sanitation in 2012 and corresponding percentage change 1990–2012 – globally and by WHO region



the high cost of medicines. Surveys undertaken from 2007 to 2012 indicated that selected generic medicines were only available in 56% of public outlets in low- and middle-income countries. Prices to patients of the lowest-priced generics in the private sector averaged five times the international reference prices, ranging upwards to around 14 times higher in some countries. As a result, the treatment of diseases with even the lowest-priced generics becomes impossible for many low-income households. The problem is aggravated when several household members become ill at the same time.

In conclusion, encouraging accomplishments across a broad range of international health-related goals and targets have clearly demonstrated that focused global actions can make a difference. At the same time, much remains to be done, and efforts continue to be needed to accelerate progress in achieving the MDGs and related objectives. Furthermore, efforts to improve health, and to achieve health equity, will continue well beyond 2015. This undertaking goes hand-in-hand with efforts to ensure universal health coverage – an aspiration backed by a United Nations General Assembly resolution adopted in December 2012 which urges governments to move towards providing all people with access to affordable good-quality health-care services.

Regional and country charts

Following the global and WHO regional summary shown in Figure 7, charts 1–13 provide country-by-country summaries of national trends in MDG indicators for which data are available.

Depending on the availability of data for each indicator, there are two types of chart:

Chart type I

For six indicators – under-five mortality rate; maternal mortality ratio; HIV prevalence; tuberculosis mortality rate; proportion of population without access to improved drinking-water sources; and proportion of population without access to improved sanitation – the charts show the average annual rate of decline (AARD) since 1990 up to the latest available year (or for the year range indicated), and the overall AARD required for the country to achieve the relevant MDG by 2015. The country figures show data for the latest available year.

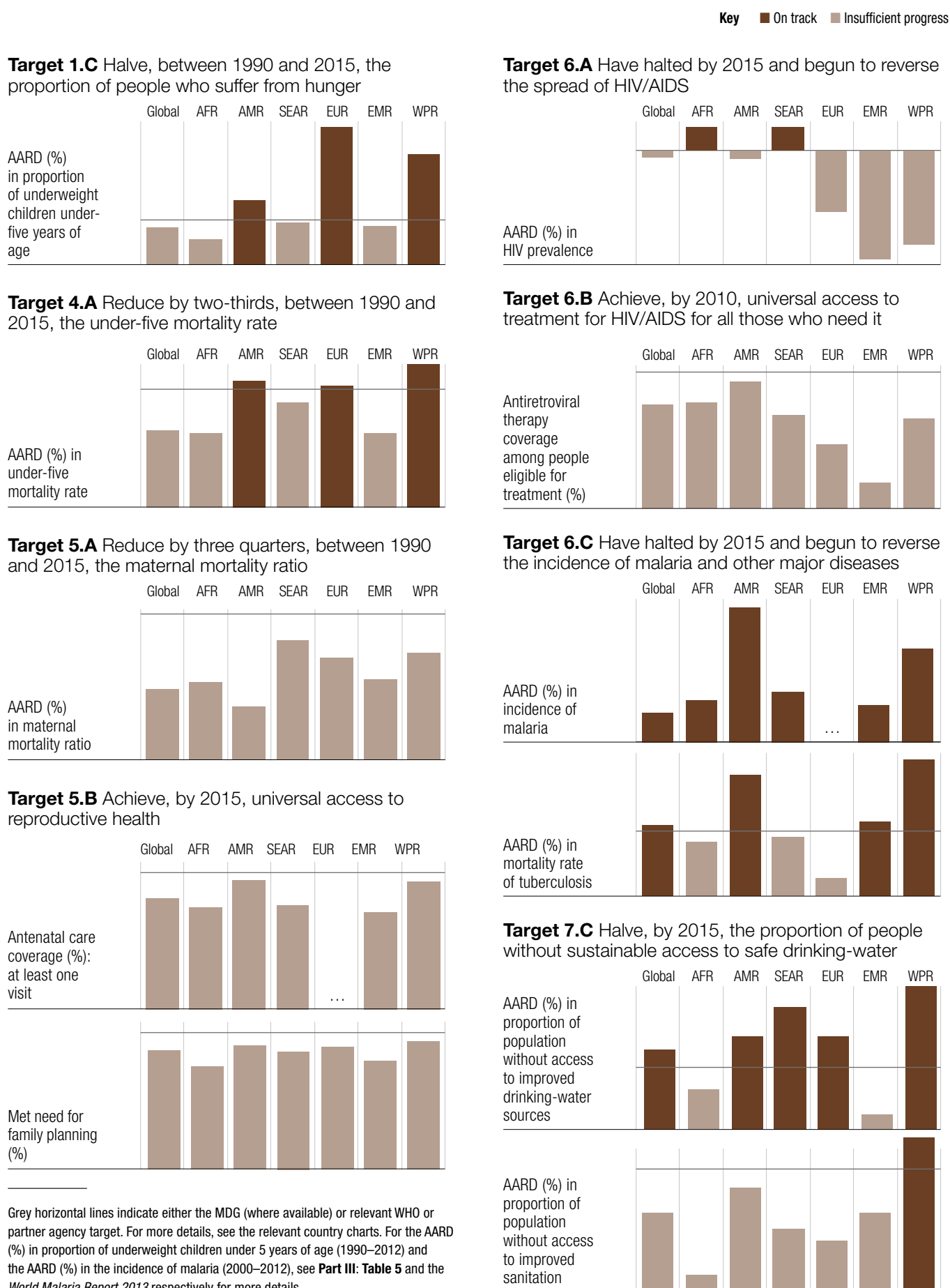
Chart type II

For seven indicators – measles immunization coverage among 1-year-olds; births attended by skilled health personnel; antenatal care coverage; unmet need for family planning; antiretroviral therapy coverage among people eligible for treatment; children aged < 5 years sleeping under insecticide-treated nets; and children aged < 5 years with fever who received treatment with any antimalarial – the charts show only data for the latest available year, along with an indication of a WHO or partner agency target.

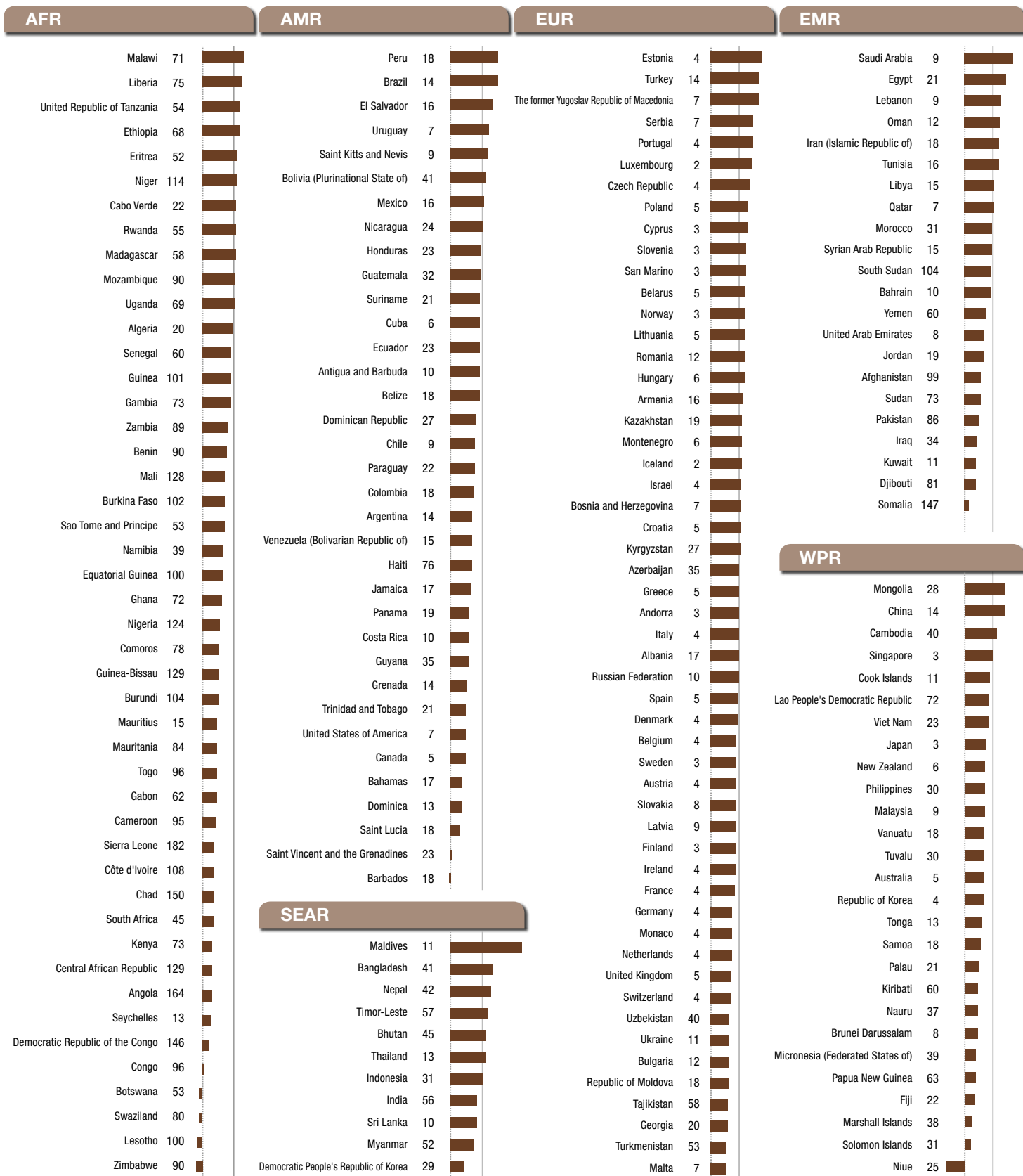
... indicates data not available or not applicable.

Further details can be found in the country tables shown in **Part III** as indicated below each chart.

Figure 7. Global and WHO regional progress towards the achievement of health-related MDGs



1 | AARD (%) in under-five mortality rate, 1990–2012



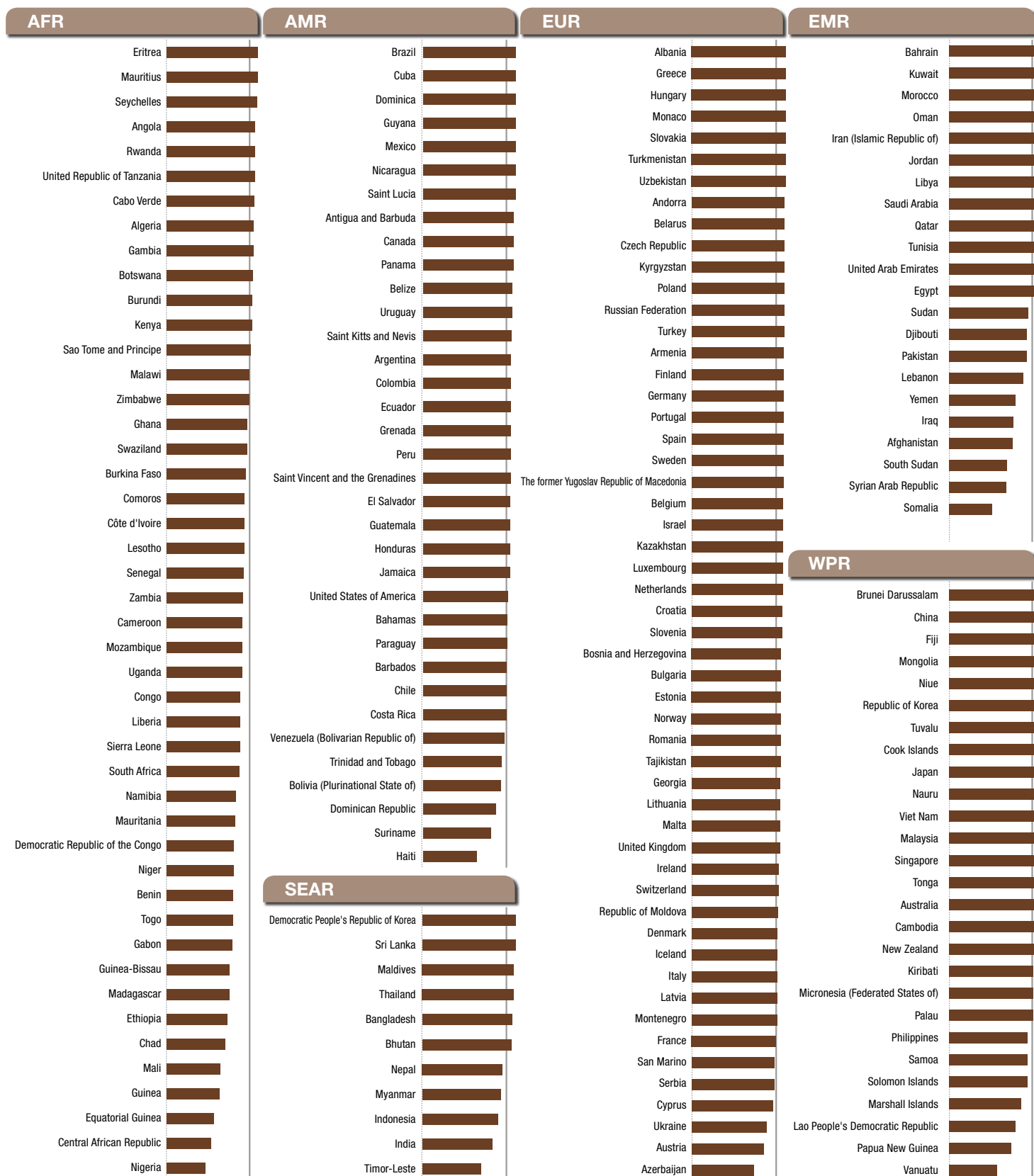
The under-five mortality rate is defined as the probability of dying by age 5 expressed as the total number of such deaths per 1000 live births. Within each WHO region countries are sorted in descending order based on the AARD in this rate.

In order to reach the MDG target of reducing by two thirds the under-five mortality rate between 1990 and 2015, an AARD of 4.3% is needed and this is denoted by the vertical line. The numerical values show the estimated under-five mortality rate in each country in 2012. For countries with low levels of under-five mortality, the target AARD may not be applicable.

Further details may be found in **Part III: Table 1**.

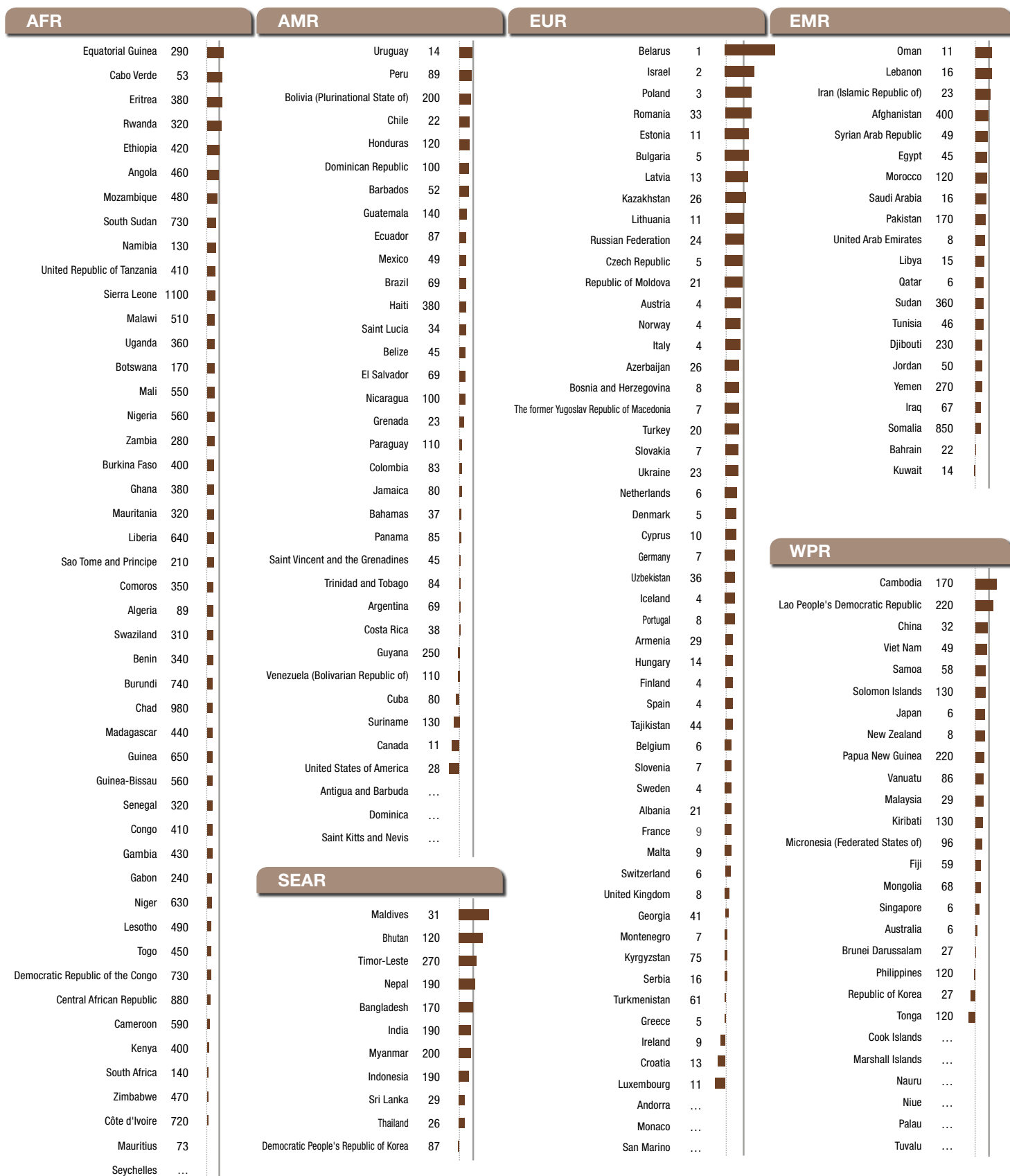
2 | Measles immunization coverage among 1-year-olds (%)

WORLD HEALTH
STATISTICS
2014



This chart shows the percentage of 1-year-olds fully immunized against measles. Within each WHO region countries are sorted by the 2012 level. The vertical line denotes the target of 90% coverage by 2015 set at the 2010 World Health Assembly. Further details may be found in **Part III: Table 4**.

3 | AARD (%) in maternal mortality ratio, 1990–2013



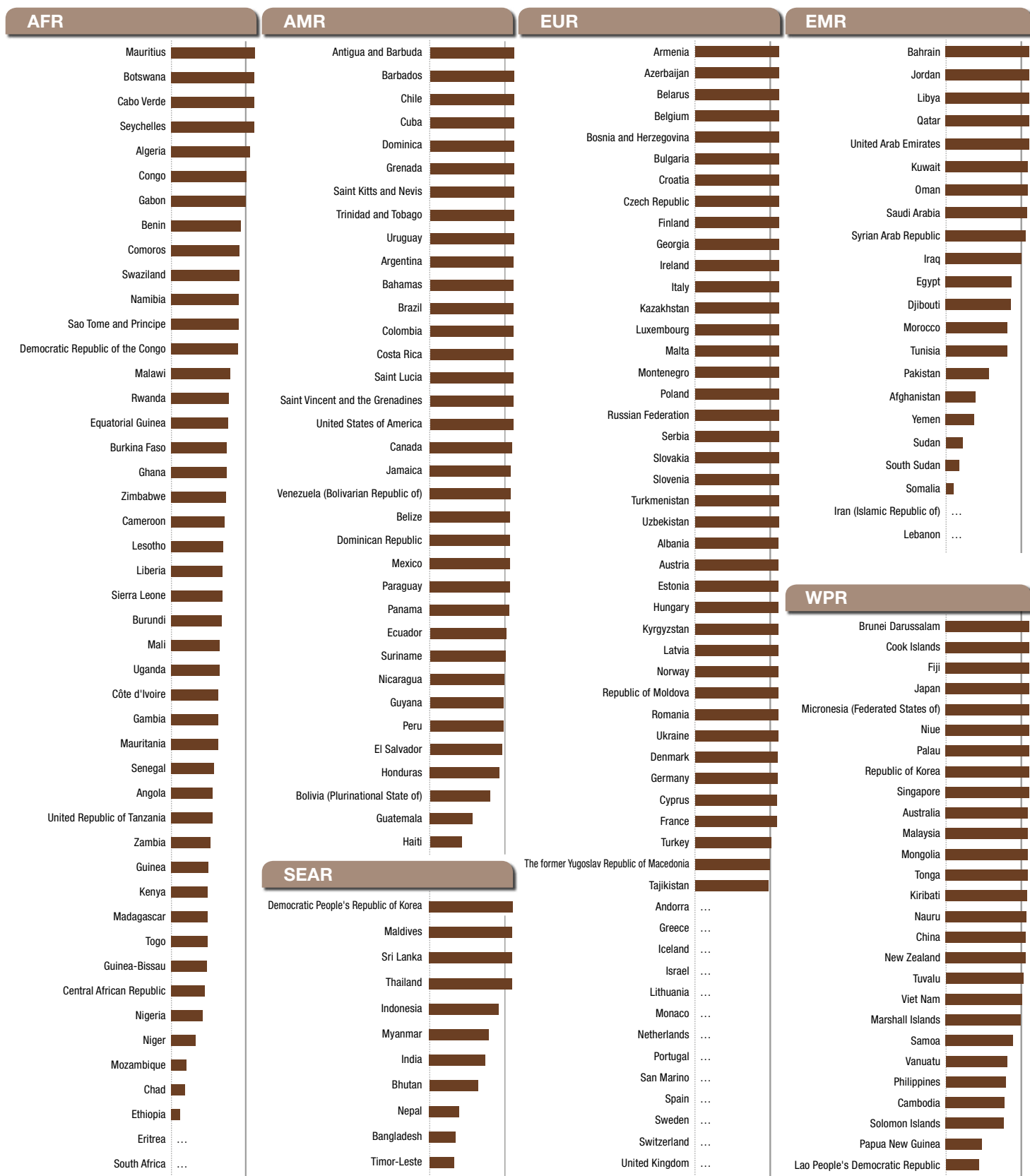
The maternal mortality ratio is defined as the number of maternal deaths per 100 000 live births. Within each WHO region countries are sorted in descending order based on the AARD in this ratio. Unrounded values have been used to calculate the AARD.

In order to reach the MDG target of reducing the maternal mortality ratio by three quarters between 1990 and 2015, an AARD of 5.5% is needed and this is denoted by the vertical line. For countries with low levels of maternal mortality, the target AARD may not be applicable.

The numerical values show the estimated maternal mortality ratio for 2013. South Sudan was reassigned to the WHO African Region in May 2013 and is therefore listed accordingly in the above chart.

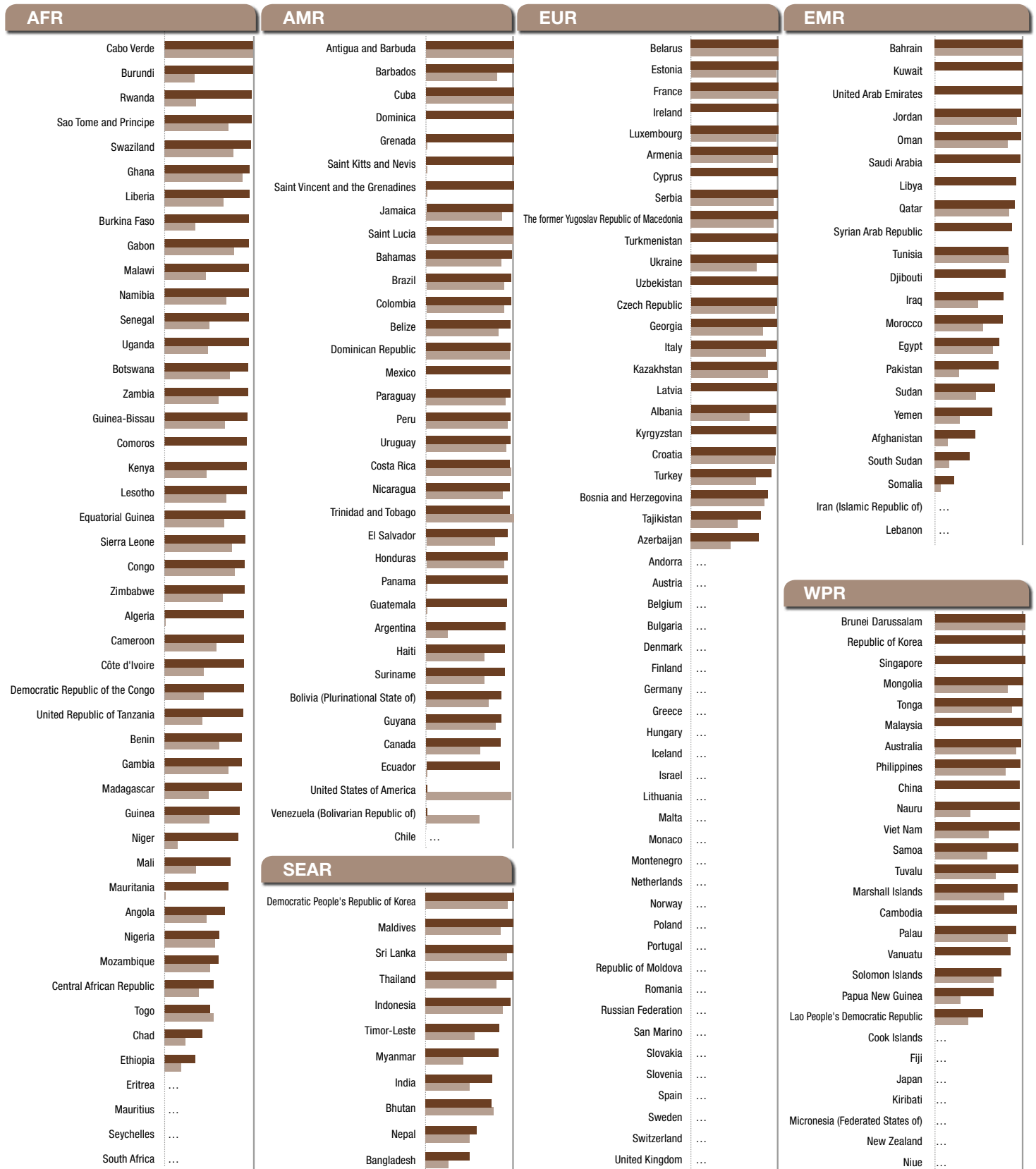
Further details may be found in **Part III: Table 2**.

4 Births attended by skilled health personnel (%)



This chart shows the percentage of births attended by skilled health personnel. Within each WHO region countries are sorted by the latest available data since 2006. The vertical line denotes the global target of 90% coverage by 2015 set by the International Conference on Population and Development (ICPD-5). Further details may be found in **Part III Table 4**.

5 Antenatal care coverage (%): at least one visit and at least four visits

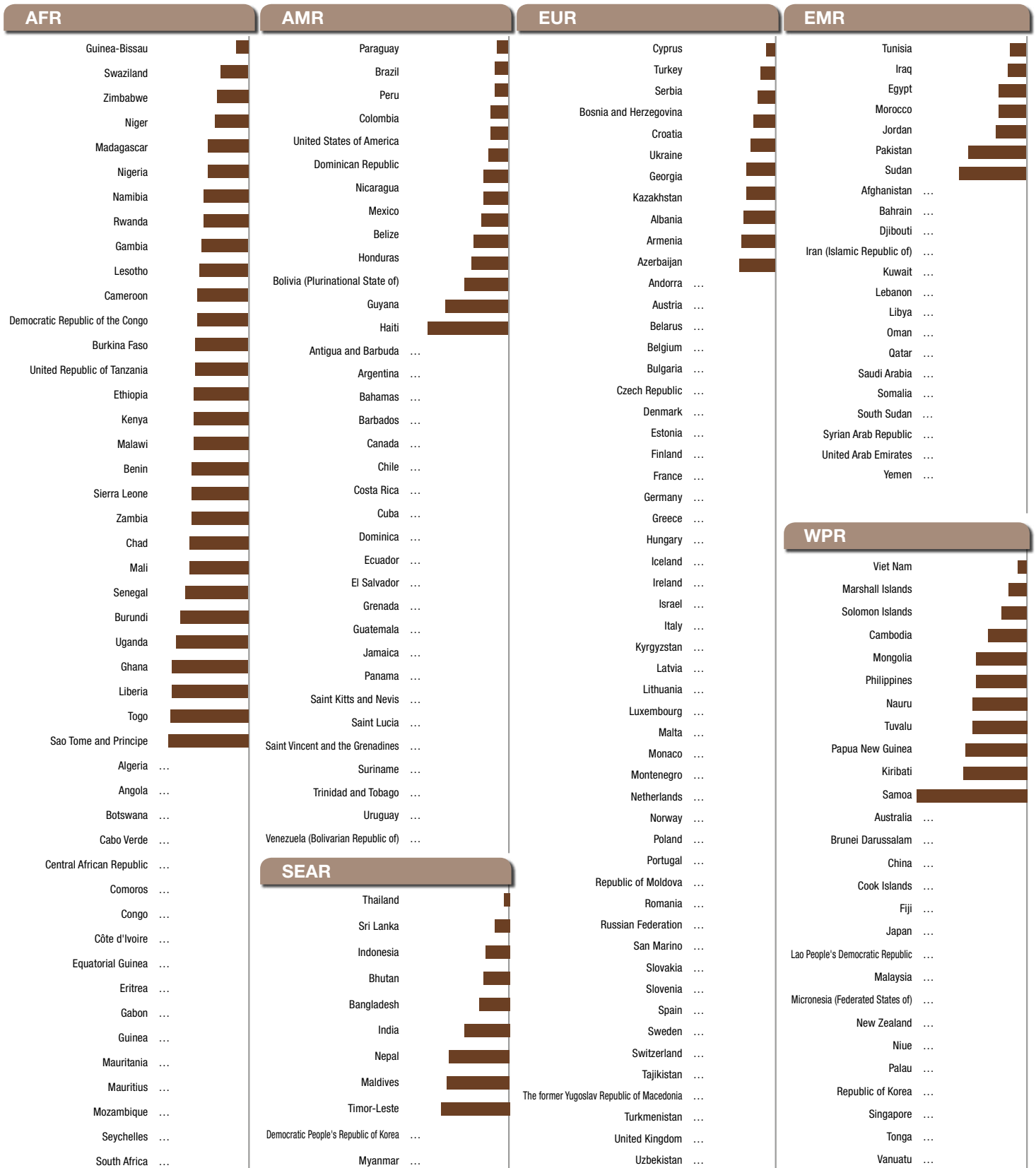


This chart shows the percentage of women who received antenatal care from skilled health personnel at least once and at least four times during pregnancy. Within each WHO region countries are sorted by the latest available data since 2006 for at least one visit.

■ At least one visit
■ At least four visits

The vertical line denotes the global target of 100% coverage by 2015 set by the International Conference on Population and Development (ICPD+5). South Sudan was reassigned to the WHO African Region in May 2013 and is therefore grouped accordingly in the above chart. Further details may be found in **Part III: Table 4**.

6 | Unmet need for family planning (%)

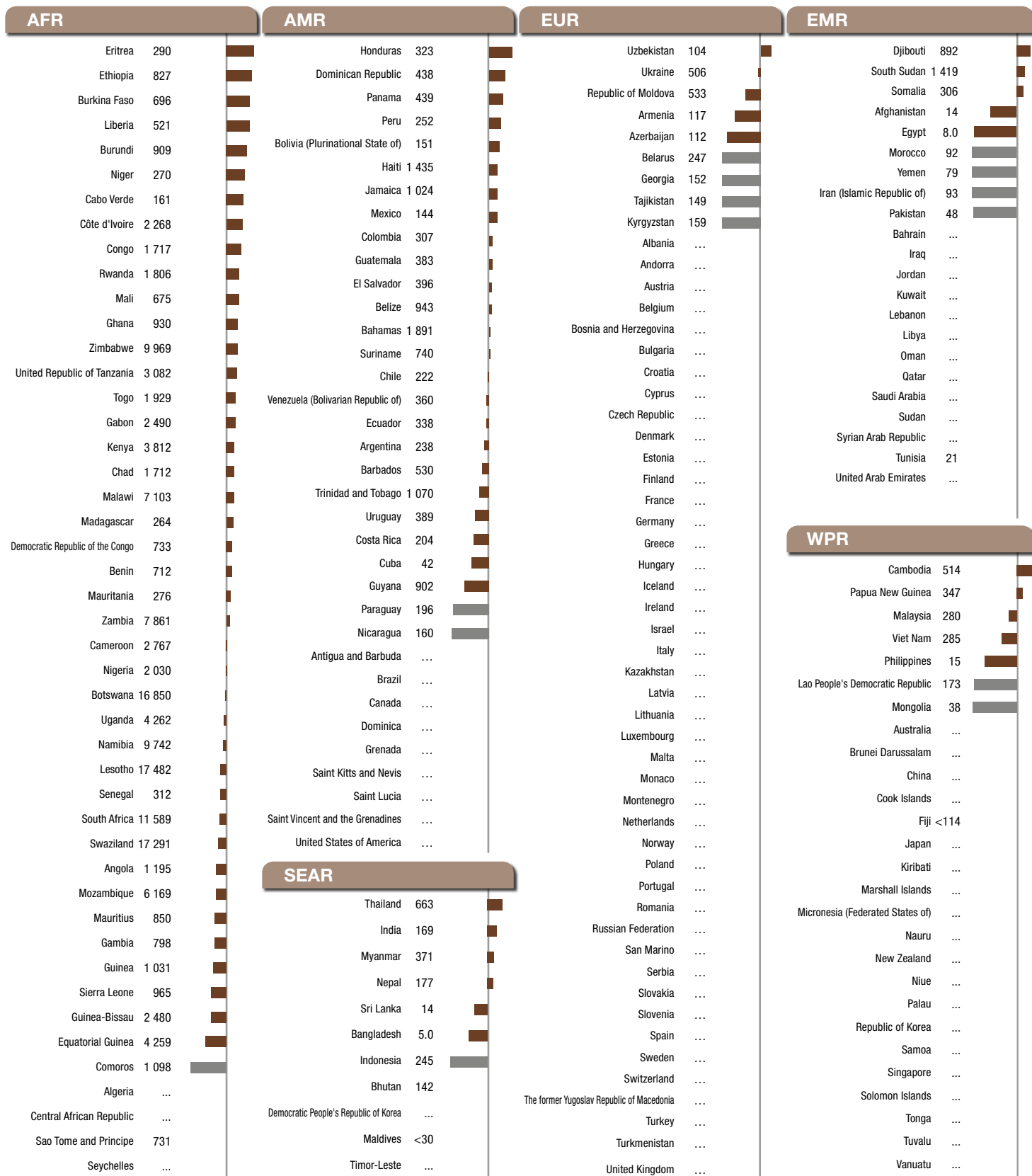


This chart shows the percentage of women who are fecund and sexually active but who want to stop or delay childbearing and are not using any method of contraception. Within each WHO region countries are sorted by the latest available data since 2006.

Achieving the MDG target of universal access to reproductive-health services by 2015 can be interpreted as 0% unmet need. The vertical line corresponds to 0% with the percentage of unmet need shown to the left of this line with a range of 50%.

Further details may be found in **Part III: Table 4**.

7 | AARD (%) in HIV prevalence, 2001–2012

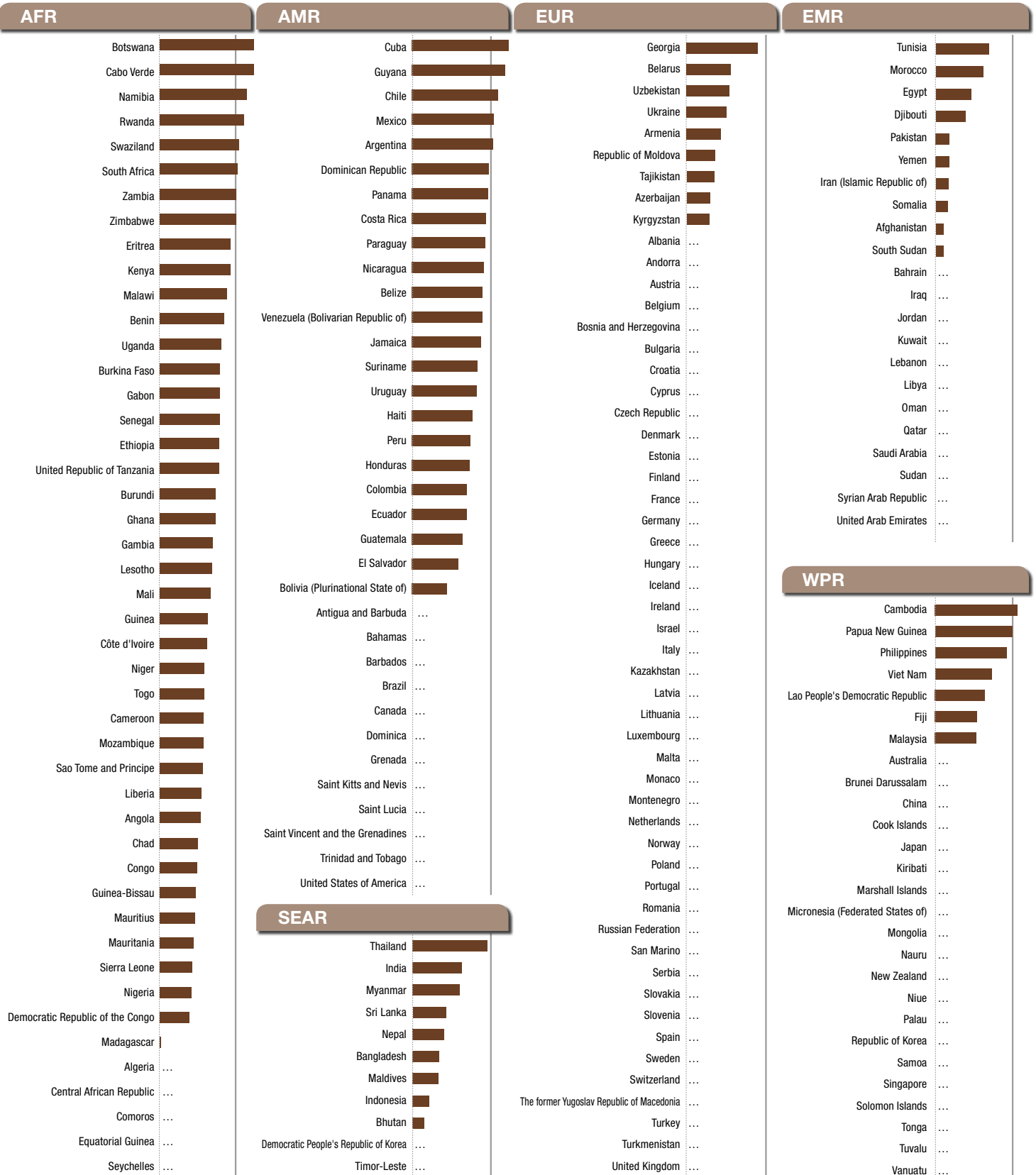


This chart shows the AARD in the estimated prevalence of HIV infections per 100 000 population per year for the period 2001–2012. Within each WHO region countries are sorted in descending order based on the AARD in this rate.

The MDG target to halt by 2015 and begin to reverse the spread of HIV/AIDS can be interpreted as any AARD greater than 0%. The vertical line corresponds to an AARD of 0% with cut-off points of $\pm 10\%$ on either side. Grey bars indicate countries in which the AARD was less than -10% . The numerical values show estimated HIV prevalence per 100 000 population for 2012.

Further details may be found in **Part III: Table 2**.

8 Antiretroviral therapy coverage among people eligible for treatment (%)

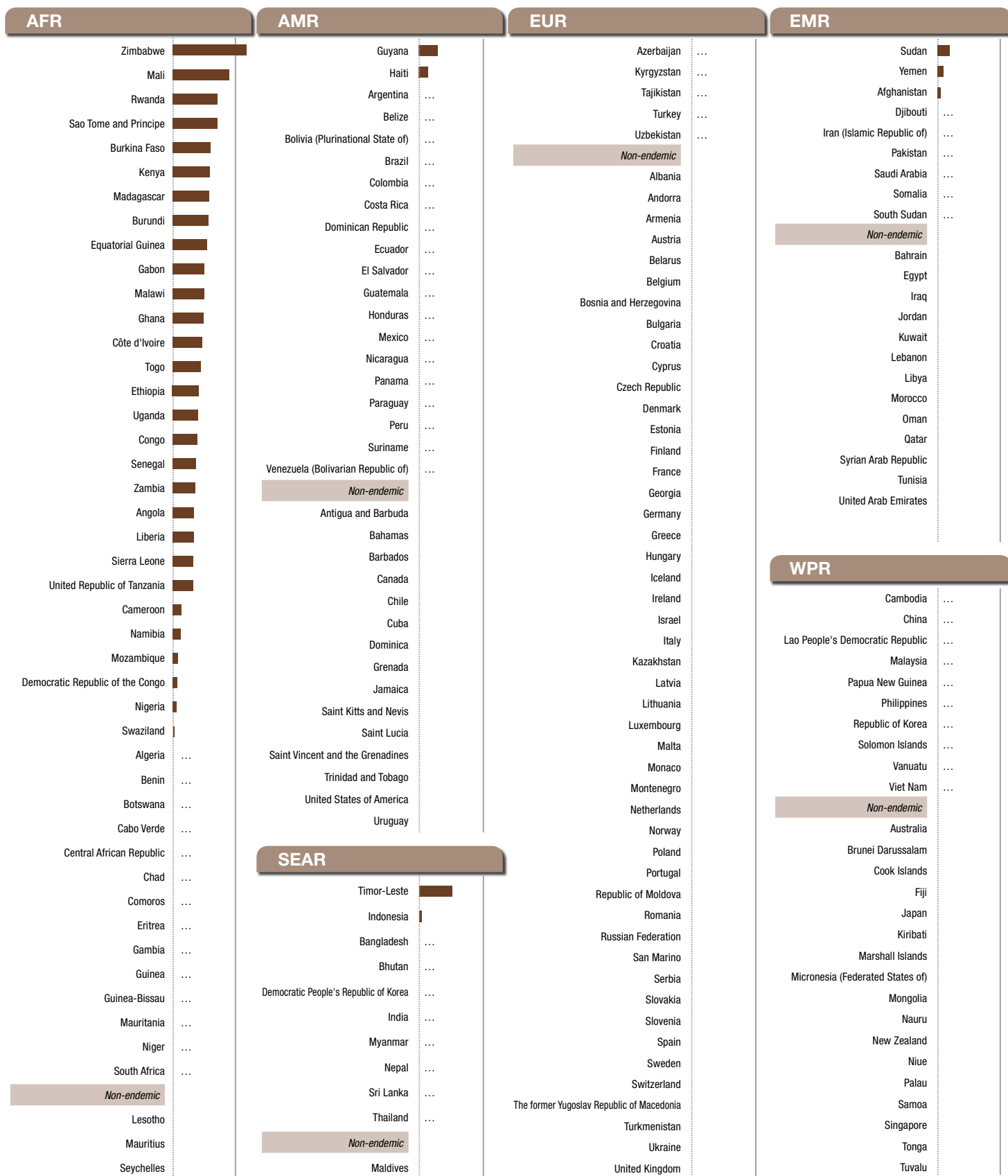


This chart shows estimated antiretroviral therapy coverage in 2012 based on the standards for treatment set out in the 2010 guidelines of the Joint United Nations Programme on HIV/AIDS. Within each WHO region countries are sorted in descending order by the level of coverage achieved.

The vertical line denotes the target of universal access to antiretroviral therapy, defined as providing antiretroviral therapy to at least 80% of patients in need.

Further details may be found in **Part III: Table 4**.

9 Children aged < 5 years sleeping under insecticide-treated nets (%)



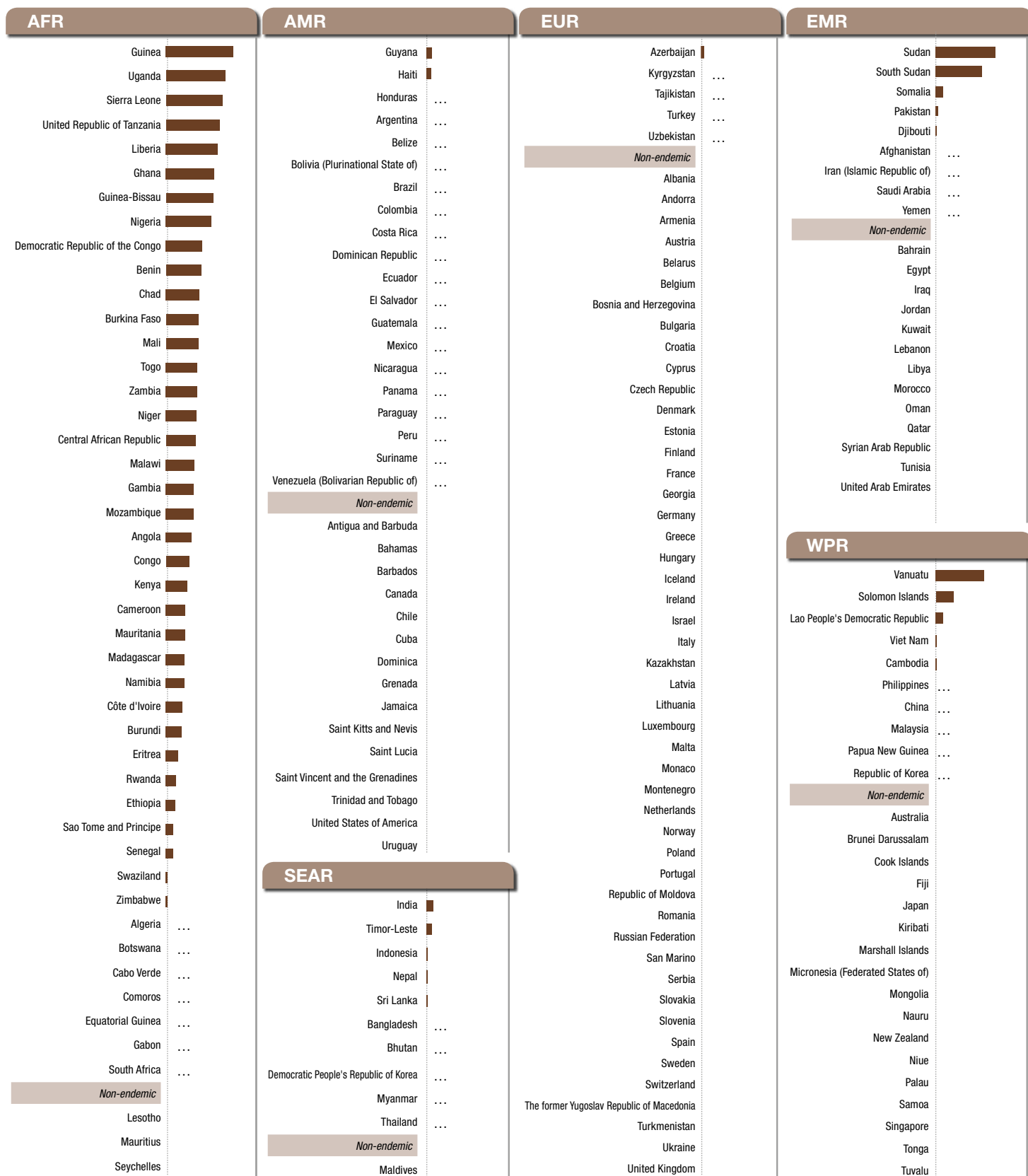
This chart shows the percentage of children under 5 years old that slept under an insecticide-treated net the night prior to the survey. Within each WHO region countries are sorted by the latest available data since 2006.

The vertical line denotes the target of 80% coverage set by WHO and the Roll Back Malaria Partnership.

Further details may be found in **Part III: Table 4**.

10 Children aged <5 years with fever who received treatment with any antimalarial (%)

WORLD HEALTH
STATISTICS
2014

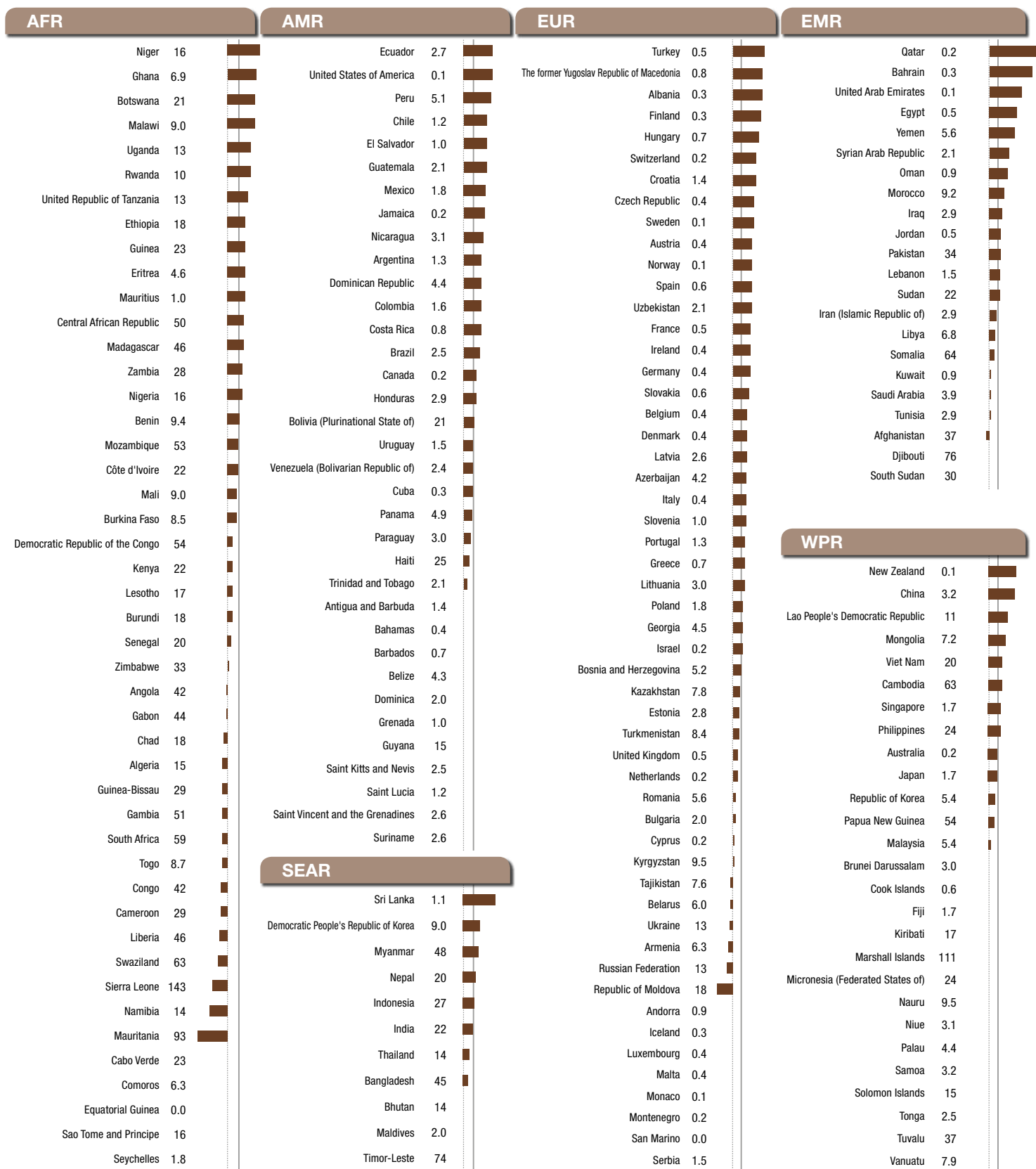


This chart shows the percentage of children under 5 years old with fever in the two weeks prior to the survey who received any antimalarial medicine. Within each WHO region countries are sorted by the latest available data since 2006.

The vertical line denotes the target of 100% coverage set by WHO and the Roll Back Malaria Partnership.

Further details may be found in **Part III: Table 4**.

11 | AARD (%) in tuberculosis mortality rate, 1990–2012



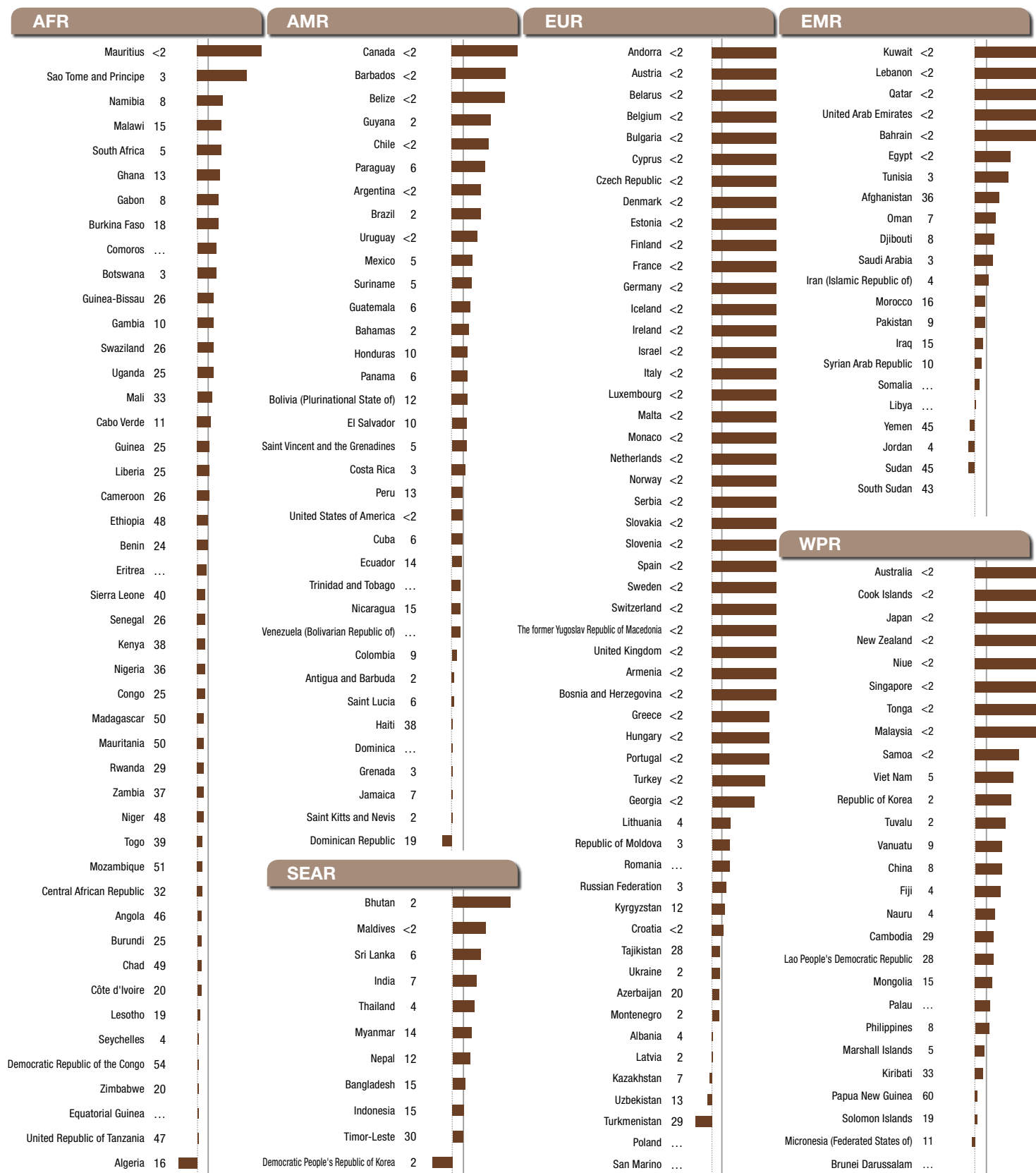
This chart shows the AARD in the estimated tuberculosis mortality rate per 100 000 population (excluding deaths among HIV-positive people) for the period 1990–2012. Within each WHO region countries are sorted in descending order based on the AARD in estimated tuberculosis mortality rates.

In order to reach the target of a 50% reduction between 1990 and 2015 set by the Stop TB Partnership, an AARD of 2.7% is needed and this is denoted by the vertical line. The numerical values shown are estimated tuberculosis mortality rates per 100 000 population in 2012. For countries with small populations, the AARD may not be applicable and only the 2012 estimated mortality rate is shown.

Further details may be found in **Part III: Table 2**.

12 | AARD (%) in proportion of population without access to improved drinking-water sources

WORLD HEALTH
STATISTICS
2014

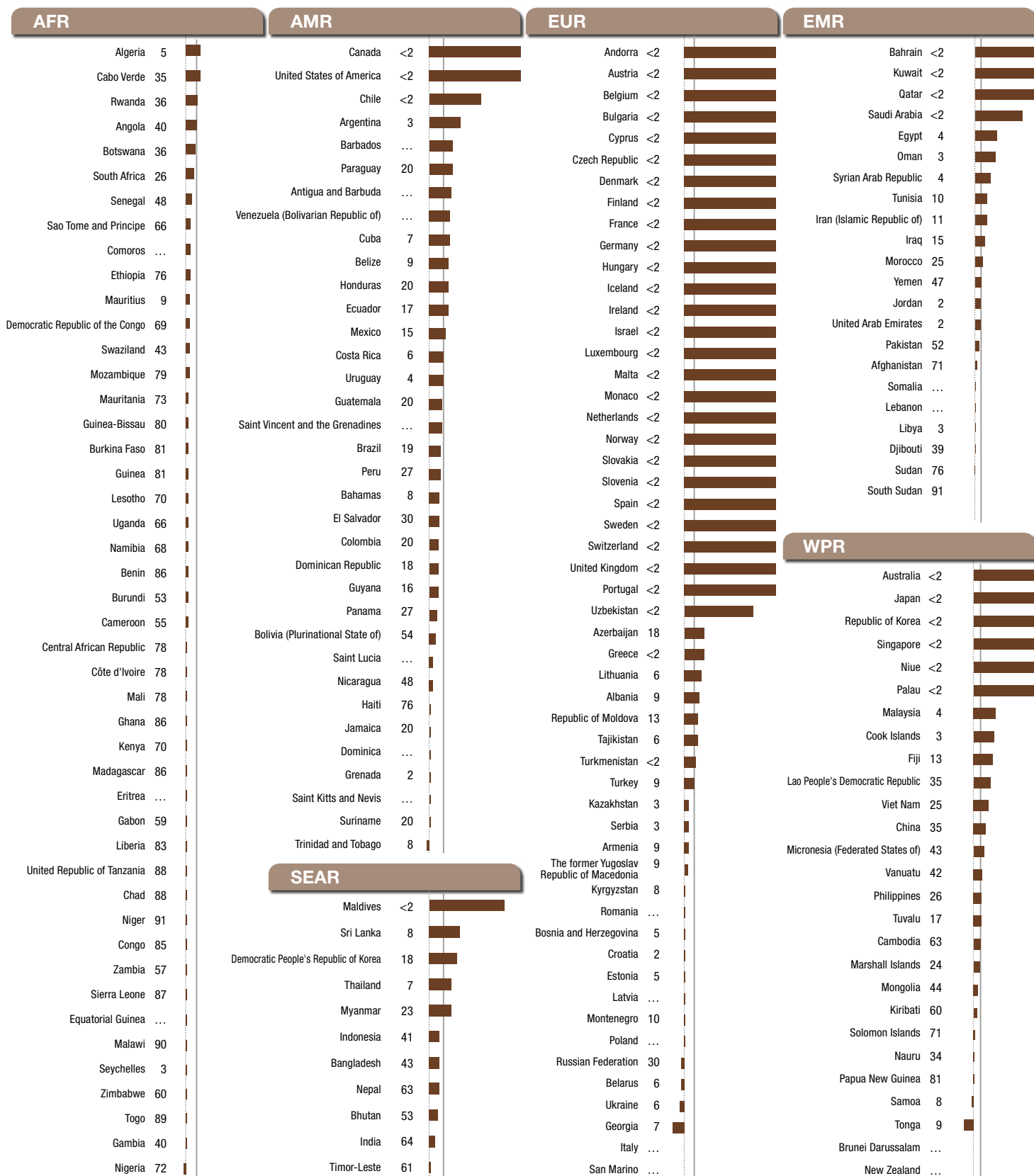


The AARD in the proportion of the population without access to improved drinking-water sources was calculated using the complement of the estimated proportion using an improved drinking-water source, for the period 1990–2012 (or any minimum period of five years since 1990). Within each WHO region countries are sorted in descending order based on this rate of decline.

In order to reach the MDG target of halving, by 2015, the proportion of people without sustainable access to safe drinking-water, an AARD of 2.7% will be required and is denoted by the vertical line. Countries with sustained low levels of proportion of population without access to improved drinking-water sources (< 2%) can be considered to have met the target and are shown with the maximum AARD at the beginning of their respective regional listing. The numerical values show the estimated percentage of the population not using improved drinking-water sources in 2012.

Further details may be found in **Part III: Table 5**.

13 | AARD (%) in proportion of population without access to improved sanitation



The AARD in the proportion of the population without access to improved sanitation was calculated using the complement of the estimated proportion using improved sanitation, for the period 1990–2012 (or any minimum period of five years since 1990). Within each WHO region countries are sorted in descending order based on this rate of decline.

In order to reach the MDG target of halving, by 2015, the proportion of people without sustainable access to basic sanitation, an AARD of 2.7% will be required and is denoted by the vertical line. Countries with sustained low levels of proportion of population without access to improved sanitation (< 2%) can be considered to have met the target and are shown with the maximum AARD at the beginning of their respective regional listing. The numerical values show the estimated percentage of the population not using improved sanitation in 2012.

Further details may be found in **Part III: Table 5**.