The world is only three years away from 2015, the deadline for achieving the Millennium Development Goals (MDGs) and a broad stocktaking of the goals offers grounds for optimism. In 1990, when the MDGs were adopted, 43 percent of the population in developing countries lived in extreme poverty. The first MDG, to halve that percentage by 2015, was achieved in 2010, five years ahead of schedule. The developing world has also achieved the target to halve the percentage of people without access to clean drinking water. Encouraging progress has been made toward other MDGs even if some of the goals will prove difficult to achieve by 2015.

Credit for this impressive progress should go to the people in developing countries and their governments. Bold reforms and prudent macroeconomic policies during the 1990s unleashed extraordinary economic growth potential. By making education, health and water services available to a larger part of populations, all development indicators have improved, especially during the last 10 years. Although the results have been largely achieved by local actions, the global goals have helped in many ways. They helped donors focus on areas where the need was most dire. They triggered a uniform monitoring process that made cross-country comparisons possible and resources were increasingly drawn to areas that were lagging. The global goals also helped local governments, in cooperation with donors and multilateral organizations, set priorities. Moreover, the quantitative goals have helped shift policy making away from input to output targeting. It is not enough to merely aim for money spent in budgets. The targets clarify that policies are only successful if results are achieved in the form of, for example, improved outcomes. Ultimately, success is not about how much money is spent by health ministries, but how much mortality rates have declined.

However, the most important lesson from more than 10 years of experience with the MDGs is that new global targets after 2015 have to be firmly embedded in local strategies. Further results will only be possible if countries develop strategies that make the goals feasible. Those strategies should take into account the synergies across development areas (for example, good health outcomes are much easier to achieve with better education, better sanitation, and higher personal incomes). Those strategies should also, more and more, focus on the quality of services (ultimately, what counts is not how long kids are in school, but what they learn). Only with such a focus on local strategies can new ambitious global goals be turned into local results.
Stunted Growth – Stunted Future

By Leslie Elder  
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**What is stunting?** Simply put, it is the condition of very short height caused by chronic poor nutrition and health. It is identified by comparing the height of a child with the standard height for a healthy population of the same age and gender children. This comparison is possible because there is strong evidence that all children – no matter where they are born – can achieve their genetic height potential if their mothers have healthy pregnancies and they grow up in an environment where caregivers can provide adequate health, nutrition and care.

In the communities where children are most likely to become stunted, it is very frequently not even recognized as a problem by families or health workers because it becomes – de facto – the norm.

UNICEF Executive Director Anthony Lake has characterized stunting as “a silent emergency that is perhaps the least understood issue in development today.”

**Why does stunting matter?** It matters because of the cascade of negative outcomes that are associated with poor linear growth. It matters because a child’s brain is growing and developing at the same time that his or her body is gaining height. And it matters because the negative impacts of stunting occurring in the first 1000 days between pregnancy and two years are difficult to reverse.

Early stunting – often beginning in utero – is associated with a higher risk of illness and death for children. It is linked to impaired cognitive development, poor performance in school and reduced earning power as an adult.

And, as stunted girls become mothers, the negative fallout continues. At higher risk of poor birth outcomes, these too short and often too thin mothers are more likely to deliver low birth weight babies. And low birth weight is now understood to be associated with increased risk of later life obesity and the occurrence of diseases such as diabetes.

**Who is affected?** Released just last month, joint UNICEF, WHO, and World Bank estimates for child malnutrition reported a 35 percent reduction in the numbers of stunted children between 1990 and 2011. This is good news. Yet there are still more than one in four children -- 165 million -- around the world whose height is too short and whose future is jeopardized.

More than 90 percent of the world’s stunted children live in Africa and Asia, with the highest prevalence of stunting in Africa (36 percent). It is also important to note that income alone does not protect a child. Among the wealthiest households in Bangladesh, one fourth of children were stunted, according to the Bangladesh Demographic and Health Survey of 2007.

**What prevents stunting?** Normal growth of the fetus during pregnancy and the child in the first two years of life depends on the mother and child having adequate amounts of nutritious food and being generally free of infections. During pregnancy, in addition to poor nutrition and infections, anemia, indoor air pollution, and tobacco use are risk factors for restricted growth of the fetus.

Additional key determinants associated with the healthy growth of children include: household food security; access to clean water, sanitation, and nutrition knowledge; women’s education and gender equity; and accessible, quality health services among others.

**How should we respond?** Reduction of child stunting must be raised to the highest priority level if we are serious about human capital development, poverty reduction and economic growth in low income countries.

And the only option is prevention.

Countries must be supported to address poor maternal and child health and nutrition in the critical window of a child’s first 1000 days. Countries also need to tackle underlying determinants of stunting such as women’s status, including access to education.

We need to push harder to achieve MDG1c (Halve the proportion of people who suffer from hunger) and ensure its inclusion in global conversations about what comes after 2015. We need to make sure that this emergency is no longer a silent one.

1 The proportion of children with height-for-age below -2 standard deviations using the WHO Child Growth Standards (WHO 2006).
By Jos Verbeek
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The countdown to 2015, the deadline by which the Millennium Development Goals (MDGs) should be achieved, has begun but the challenges still remaining are many.

As things stand today, less than three of the 21 targets of the eight MDGs have been achieved. These are:

i. MDG1a: Halve by 2015, the proportion of people living on less than a dollar a day. This has been achieved, five years ahead of the 2015 deadline.

ii. MDG7c: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. Only half of this target, access to water, has been achieved.

iii. MDG7d: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers. This has been achieved.

Global progress towards the remaining targets, however, has been less than stellar, particularly the MDGs related to education and health. Of particular concern is the dismal progress on MDG4: Reduce by two-thirds (66 percent) between 1990 and 2015, the under-five mortality rate. The world is nowhere near achieving this target by 2015.

Globally, the child mortality rate stood at 87.3 deaths per 1000 live births in 1990. In 2011, the child death rate had been brought down to 51.4 per 1000, while the goal is to reach 29.1 by 2015. Considering that it has taken 11 years to achieve a 41 percent reduction, it seems highly unlikely that the remaining 25 percent reduction can be achieved in a matter of four years.

However, different developing regions have performed differently, with East Asia and the Pacific, Latin America and the Caribbean, and Europe and Central Asia expected to meet this MDG. In the Middle East and North Africa region, a doubling of the effort of the last five years would result in achievement of this MDG by 2015.

However, even a doubling of effort in South Asia and Sub-Saharan Africa would not allow these regions to meet the 2015 deadline.

Although progress on reducing child deaths in South Asia and Sub-Saharan Africa is lagging, it is understandable as the starting position of these regions was significantly worse than others. In Sub-Saharan Africa, child mortality in 1990 was twice the average for the world and well over three times the level in East Asia and the Pacific, Latin America and the Caribbean, and Europe and Central Asia. South Asia’s starting position in 1990 was twice the levels of East Asia, Latin America and Europe and Central Asia regions.

In fact, the greatest improvement in reducing child deaths, between 1990 and 2011, has come from South Asia (figure 1), while Sub-Saharan Africa has stepped up to the plate since 2006, contributing well over 40 percent to the global reduction in child mortality during 2006-2011 (figure 2). In contrast, progress has stagnated during this period in the Middle East and North Africa region.

However, despite the good progress being made, Sub-Saharan Africa, South Asia and, to a lesser extent, the Middle East and North Africa will need to more than double their efforts for the World, in aggregate, to achieve this MDG by 2015.
Country analysis key to MDGs

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As new international targets are defined for the post-2015 period, it is important to recognize that target setting is only the beginning. Analytical tools are also needed to better understand the feasibility and consequences of trying to achieve such targets. Given multiple links between initial conditions, growth, financing, aid, unit costs, and MDG outcomes, including links between the different MDGs (for example, water and sanitation may influence health while health may influence poverty), the bulk of practical analysis of MDG targeting has to be done at the level of individual countries.

Recognizing the need to think of MDGs as part of medium- to long-run country development, the World Bank has constructed a model called MAMS, which has been applied to some 50 developing countries. Most MAMS applications cover MDGs related to poverty, primary education, under-five and maternal mortality, water, and sanitation. In addition to international targets, simulations have addressed other targets and policy issues that are relevant to individual countries.

In MAMS, MDG outcomes depend on a set of determinants or “inputs,” identified in economic research. To exemplify, the inputs on which the under-five mortality rate depends include government and private health services, household per-capita incomes, infrastructure services, and water and sanitation MDGs. By providing part of the services, governments play a prominent role, but, given substitutability between different inputs, more rapid growth in private services and/or household per-capita incomes, reduce the need for government service provision and government spending.

This MDG module is embedded in a representation of the broader economy that covers production and incomes throughout the economy, links between education (including post-primary levels) and the labor market, as well as the constraints under which any economy and its actors operate: markets for factors and commodities, the government budget (including important roles for taxes, foreign aid, domestic/foreign debts and borrowing), savings-investment balances, and the balance of payments. Each application is based on a country-specific database tailor-made to country circumstances: the disaggregation, MDG coverage and rules defining how the economy functions (including the rules for government policies) vary widely across different country applications.

MAMS applications have generated a wide range of insights. With regard to MDG strategies, they confirm that initial country conditions are a major determinant of whether achievement of the MDGs is feasible or not. If full MDG achievement requires progress at speeds that go beyond the historical record of other countries, then the required expansion in grant aid and government services may go far beyond donor offerings and run into domestic capacity constraints. If required financing has to come from domestic sources (taxes and/or borrowing), trade-offs between different MDGs emerge; in particular, required financing may stifle growth in private production, incomes and consumption, slowing down poverty reduction while also making it more difficult to achieve non-poverty MDGs.

Other insights are related to the allocation of government spending, foreign aid and Dutch disease, and government efficiency. In the short and medium terms, infrastructure spending often faces less severe bottlenecks and may generate higher growth payoffs, with positive MDG effects. Labor markets are an important source of bottlenecks, as expansion in human development may push up the wages of the more educated, adding to MDG costs and income inequality while making the private sector less competitive.

Aid expansions may lead to Dutch Disease effects unless the aid is used to facilitate the production of tradables and finances spending with a large import component. With regard to government efficiency, strong gains in MDG performance may be possible if, over time, growth in government spending is biased in favor of human development and infrastructure at the expense of other areas.

MAMS is a flexible tool. Apart from MDG targeting, it has been used to address policy issues related natural resources, demography, FDI, food prices, foreign debt, gender, labor markets, and worker remittances. We expect to adapt MAMS to address the new set of international targets that the international community will decide on during the next few years.

2 MAMS stands for Maquette for MDG Simulations. Technically, MAMS is a dynamic recursive CGE (Computable General Equilibrium) model. For more on MAMS, visit www.worldbank.org/mams.