VI. HEALTH AND MORTALITY

Increased longevity with better health and well-being has been one of the greatest human achievements of all times. Life expectancy at birth for the world's population has increased from 48 years in 1950–1955 to 68 years in 2005–2010, which has contributed to an increase in the world's population from about 2.5 billion in 1950 to more than 7 billion today (United Nations, 2011a). A major contributor to the increase in longevity has been the decline of child mortality. Mortality under age five has declined dramatically from an estimated 203 deaths per 1,000 live births in 1950–1955 to 66 deaths per 1,000 live births in 2005–2010 (United Nations, 2011a). These improvements in child mortality and longevity are associated with the "epidemiological transition", where the pattern of morbidity and mortality shifts from predominately infectious and parasitic diseases towards a pattern with a growing burden of chronic and degenerative diseases.

As with the demographic transition, individual countries are at different stages of the epidemiological transition. In Africa, for example, life expectancy at birth is the lowest in the world, at around 55 years, and an estimated 61 per cent of deaths in 2008 were caused either by communicable diseases or by maternal, perinatal and nutritional conditions, indicating that the region is still in the early stages of the epidemiological transition (World Health Organization, 2011a; United Nations, 2012b). In contrast, in developed countries, excluding transition countries of South-Eastern Europe, life expectancy at birth is around 80 years and 88 per cent of deaths in 2008 were estimated to be due to non-communicable diseases, indicating that these countries are in the later stages of the epidemiological transition. Non-communicable diseases also accounted for the majority of deaths in Asia (66 per cent) and in Latin America and the Caribbean (72 per cent). With the persistence of communicable diseases and a growing burden of non-communicable diseases, many developing countries are faced with a dual burden of disease that is straining their health systems and hindering development efforts.

Member States and the international community have been concerned for some time about unacceptably high rates of morbidity and mortality from preventable causes in many countries, as well as by persistent disparities in health and survival both within and across countries. Improving health and reducing mortality are regarded as major development objectives, as stated in the ICPD Programme of Action and included in the Millennium Development Goals (MDGs). More recently, in 2011, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (NCDs) has highlighted the rising prevalence, morbidity and mortality of non-communicable diseases worldwide and called for collective, multi-sectoral action by all Governments and other stakeholders (United Nations, General Assembly, 2011b).

This section presents Governments' views and concerns related to four out of the eight MDGs, namely, under-five mortality (Goal 4), undernutrition in children (Goal 1), maternal mortality (Goal 5), and tuberculosis, malaria and HIV/AIDS (Goal 6) (United Nations, 2012c), as well as measures adopted to address HIV/AIDS. In addition, it presents Governments' concerns about overweight and obesity and non-communicable diseases.

VIEWS ON LIFE EXPECTANCY AT BIRTH

Life expectancy is not only a key indicator of population health and economic development, but also an important component of public policy especially because many welfare entitlement programmes, such as social security and health care, are often age-based.

While life expectancy has increased in all countries since the 1950s, progress has been slow in some countries and large disparities remain across countries by level of development and within countries by social class and ethnicity. In 2005–2010, life expectancy at birth in developing countries was on average 11 years less than in developed countries (United Nations, 2011a).

The ICPD Programme of Action had called for increased healthy life-span and reduced disparities in life expectancy both between and within countries. The Programme of Action had set a goal for countries to achieve a life expectancy at birth greater than 70 years by 2005 and greater than 75 years by 2015 (United Nations, 1995). During 2005–2010, only 55 countries had managed to achieve a level of life expectancy at birth greater than 75 years, although life expectancy in an additional 58 countries had reached between 70 and 75 years. In the remaining 83 countries life expectancy at birth remained at 70 years or below in 2005–2010, including 45 countries where it was 65 years or lower (United Nations, 2011b). These countries are not likely to achieve the goal of life expectancy at birth greater than 75 years by the year 2015.

Many factors have contributed to a slower than desirable increase in life expectancy in some cases or even the decline observed in a few cases. These include expansion of the HIV/AIDS epidemic; persistence of major infectious diseases, such as malaria and diarrhoea; re-emergence of other diseases, such as tuberculosis and cholera; military and political conflicts; economic crises; socioeconomic restructuring; and unhealthy diets and lifestyles.

Government views on life expectancy at birth have been monitored since the mid-1970s. In spite of considerable reductions in mortality and consequent improvements in longevity in most countries, a majority of Governments (56 per cent) still viewed their level of life expectancy at birth as unacceptable in 2011, down only slightly from 63 per cent in 1976 (table VI.1). Government views regarding life expectancy at birth differed markedly according to the level of development. In 2011, about two thirds (65 per cent) of Governments in developed countries viewed life expectancy at birth in their countries as acceptable, compared with only about a third (37 per cent) in developing countries. While the percentage of Governments that viewed life expectancy at birth as acceptable has stagnated around the current level in developed countries since 1996, it has increased gradually in developing countries, from 24 per cent in 1976 to 37 per cent in 2011. Among least developed countries, almost all Governments (98 per cent) viewed life expectancy at birth as unacceptable in 2011.

In 2011, the percentage of Governments that viewed life expectancy at birth in their countries as acceptable ranged from a low of 11 per cent in Africa to 64 per cent in Europe and in Latin America and the Caribbean. Since the mid-1970s, Asia has observed a steady increase in the percentage of Governments that viewed life expectancy at birth as acceptable, from 35 per cent in 1976 to 51 per cent in 2011. A steady increase in this proportion was also observed for

Latin America and the Caribbean since the mid-1980s, but there was no clear trend for other regions (table VI.1).

VIEWS ON CHILD MORTALITY

Under-five mortality is a closely monitored population health indicator. It is not only a strong indicator of the health and well-being of children, but also of the entire population. A reduction in the under-five mortality rate by two thirds between 1990 and 2015 is one of the eight MDGs. While considerable progress has been made in reducing child mortality since 1990, some recent data from the World Health Organization have suggested that, of the eight MDGs, goal 4 (reducing child mortality) and goal 5 (improving maternal health) are the two furthest from being achieved by 2015 (World Health Organization, 2012b; United Nations, 2012c).

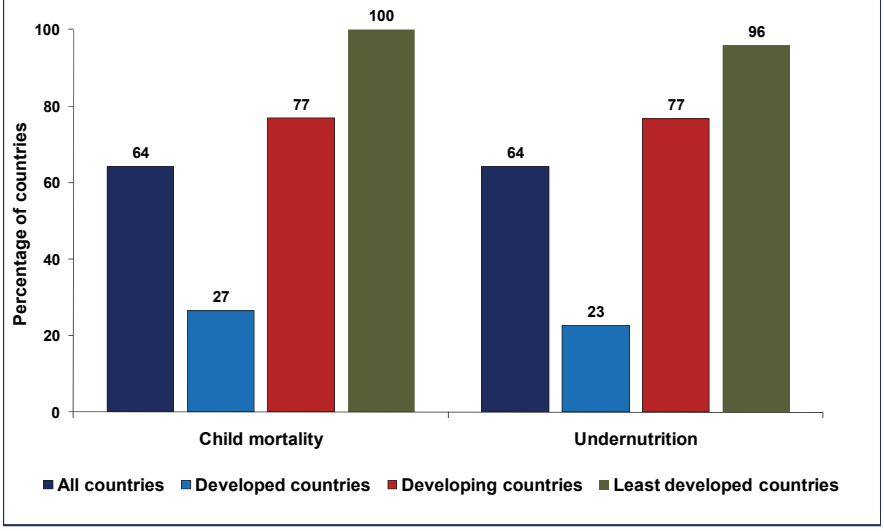
Overall, in developing countries, the under-five mortality rate has declined from 97 deaths per 1,000 live births in 1990 to 57 deaths per 1,000 live births in 2011 (United Nations Children's Fund, 2012a). Still, globally in 2011, 6.9 million children died before reaching their fifth birthday. Of these, 6.2 million child deaths (82 per cent) occurred in sub-Saharan Africa and Southern Asia. Most of these child deaths were caused by preventable diseases, such as acute respiratory infections, diarrhoea, measles and malaria (United Nations Children's Fund, 2012b). Some countries, particularly in Latin America and the Caribbean and South-Eastern Asia, have made remarkable progress in reducing under-five mortality.

In Latin America and the Caribbean, the under-five mortality rate fell from 53 deaths per 1,000 live births in 1990 to 19 deaths per 1,000 live births in 2011 (United Nations Children's Fund, 2012a). Brazil and Mexico, two countries with large child populations in the region, both managed to achieve the MDG 4 target by reducing their under-five mortality rate by two thirds, although through slightly different means. In the case of Brazil, under-five mortality rate was reduced from 58 deaths per 1,000 live births in 1990 to 16 deaths per 1,000 live births in 2011, while in the case of Mexico, under-five mortality rate was reduced from 49 deaths per 1,000 live births in 1990 to 16 deaths per 1,000 live births in 2011. The reduction in under-five mortality in Mexico was achieved through the implementation of a number of successful programmes to target diarrhoeal diseases (the distribution of oral rehydration salts, the Clean Water programme) and vaccine preventable diseases (national vaccination days, measles vaccination campaigns, the Universal Vaccination Programme, national health weeks), as well as a vitamin A supplementation programme (United Nations Children's Fund, 2007). In addition, Mexico adopted a conditional cash transfer programme in 2001 that was designed to provide financial incentives to five million households conditional on their regular attendance at health clinics that supply essential health and nutrition services. A similar conditional cash transfer programme was also adopted in Brazil in 2003 that reached approximately eight million households, at a cost of more than US$2 billion per year (Handa and Davis, 2006).

Improvements in child mortality have been associated with a growing number of Governments that viewed the level of child mortality in their countries as acceptable. Yet in 2011, about two thirds of all Governments (64 per cent) worldwide still considered the level of under-five mortality in their respective countries as unacceptable (table VI.2, figure VI.1).

Governments of developing countries (77 per cent) were about three times as likely as those of developed countries (27 per cent) to consider the level of under-five mortality in their countries as unacceptable.

Figure VI.1. Governments considering the level of mortality and undernutrition among children under age five as unacceptable, by level of development, 2011



All 49 Governments of least developed countries viewed the level of under-five mortality in their countries as unacceptable in 2011. Since the mid-1990s, the percentage of Governments that considered the level of under-five mortality as unacceptable has declined substantially in developed countries, from 54 per cent in 1996 to 27 per cent in 2011; while it has declined only slightly in developing countries in recent years, from 85 per cent in 2005 to 77 per cent in 2011.

Among the major world regions in 2011, Europe had the lowest percentage of Governments (27 per cent) that viewed their level of under-five mortality as unacceptable, compared with Africa, which had the highest (91 per cent). Even in Asia and Latin America and the Caribbean where many countries have seen large declines in child mortality, the percentage of Governments that were dissatisfied with their level of under-five mortality remained high at 64 per cent and 73 per cent, respectively, in 2011.

VIEWS ON UNDERNUTRITION IN CHILDREN

Undernutrition among children is a major barrier to development and to the achievement of the Millennium Development Goals, particularly MDG 1 (eradication of extreme poverty and hunger) and MDG 4 (reduction in child mortality). Undernourished children tend to have lowered resistance to infectious diseases and are more likely to die from childhood illnesses such as acute respiratory infections (primarily pneumonia), diarrhoea, malaria, and measles (United Nations Children's Fund, 2012b; Lutter, Chaparro and Muñoz, 2011). Moreover, chronic

undernutrition can cause developmental delays and impairment in children, including delays in physical growth and development of fine motor skills, as well as lowered intellectual quotient (IQ).

In 2011, 26 per cent (165 million) of children under age five were estimated to be chronically undernourished or stunted (low height for age), and 8 per cent (52 million) were acutely undernourished or wasted (low weight for height). Globally, about one in every three child deaths is attributable to undernutrition (United Nations Children's Fund, World Health Organization, and World Bank, 2012).

Among the 190 countries with information on Government views on childhood undernutrition in 2011, about two thirds (64 per cent) considered the level of undernutrition among children in their countries as unacceptable (table VI.3, figure VI.1). As in the case of child mortality, a much greater proportion of Governments in developing countries (77 per cent) considered the level of undernutrition among children in their countries as unacceptable as those in developed countries (23 per cent). Almost all Governments (96 per cent) in least developed countries viewed the level of childhood undernutrition as unacceptable.

The proportion of Governments considering the level of undernutrition among children in their countries as unacceptable varied widely by geographic region, from a low of 23 per cent in Europe to a high of 89 per cent in Africa (table VI.3).

VIEWS ON MATERNAL MORTALITY

Reducing maternal mortality ratio by three quarters, between 1990 and 2015, is one of the two targets under MDG 5 (improve maternal health). The inclusion of a target to reduce maternal mortality under the MDGs has heightened awareness among Governments about the need for quality reproductive health services to all women of reproductive age, and has contributed to the progress in reducing maternal deaths. Nevertheless, a recent World Bank report suggested that at present rate, only 24 per cent of developing countries (30 countries) have achieved or are on track to achieve the maternal mortality target. A further 37 per cent of countries (46 countries) are close to being on track, while the remaining 39 per cent (48 countries) are far behind and unlikely to achieve the target by 2015 (World Bank, 2012).

The major causes of maternal mortality include haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour. Preventing maternal deaths requires improved coverage of antenatal care, skilled birth attendance at delivery, access to emergency obstetric care when complications arise, timely postnatal care and universal access to family planning to prevent unintended pregnancies. An estimated 80 per cent of all maternal deaths related to pregnancy and childbirth are considered preventable.

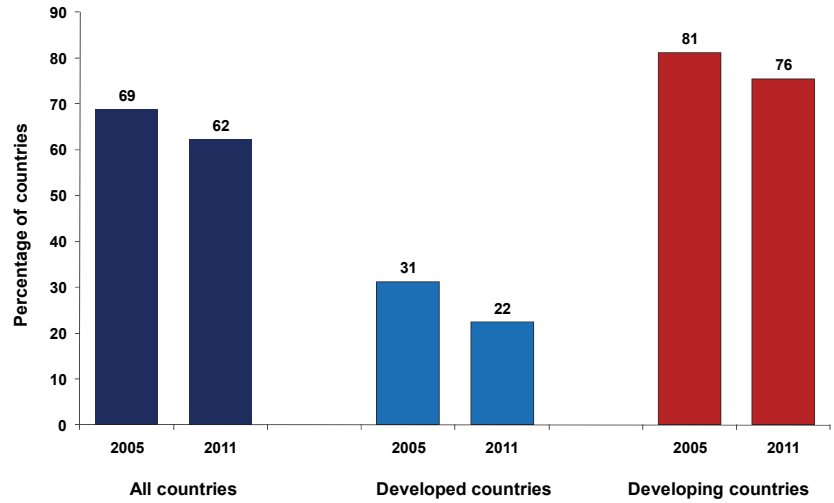
An estimated 287,000 maternal deaths occurred in 2010, a decline of 47 per cent from the level in 1990. A great majority of these deaths (99 per cent) occurred in developing countries, mainly in sub-Saharan Africa (56 per cent) and in Southern Asia (29 per cent). Maternal mortality was much lower in developed countries, averaging 16 maternal deaths per 100,000 live

births in 2010. Women in developing countries were about 15-times (31-times in sub-Saharan Africa) more likely to die from pregnancy and childbirth-related causes than those in developed countries. At the country level, India (56,000) and Nigeria (40,000) accounted for approximately a third of all global maternal deaths (World Health Organization, 2012c).

Although maternal mortality has been declining in most countries around the world, it remains a concern for many developing countries, especially in sub-Saharan Africa and in Southern Asia, where maternal mortality ratios remain high. In 2011, among the 196 countries considered, Governments of 122 countries (62 per cent) viewed the level of maternal mortality in their populations as unacceptable, down from 69 per cent in 2005 (table VI.4). By development level, more than three out of four Governments of developing countries considered their level of maternal mortality as unacceptable, compared with less than one out of four Governments in developed countries. All but two Governments (96 per cent) in least developed countries considered the level of maternal mortality in their populations as unacceptable.

Consistent with declining maternal mortality ratios in most countries, the percentage of Governments that were dissatisfied with the level of maternal mortality also declined between 2005 and 2011 in both developed countries (from 31 per cent to 22 per cent) and developing countries (from 81 per cent to 76 per cent) (figure VI.2). Only 4 per cent of Governments in sub-Saharan Africa considered their level of maternal mortality acceptable compared with 80 per cent in Europe. Northern America was an exception where both Governments in Canada and the United States of America considered their maternal mortality levels is unacceptable, despite having low levels.

Figure VI.2. Governments considering the level of maternal mortality as unacceptable, by level of development, 2005 and 2011

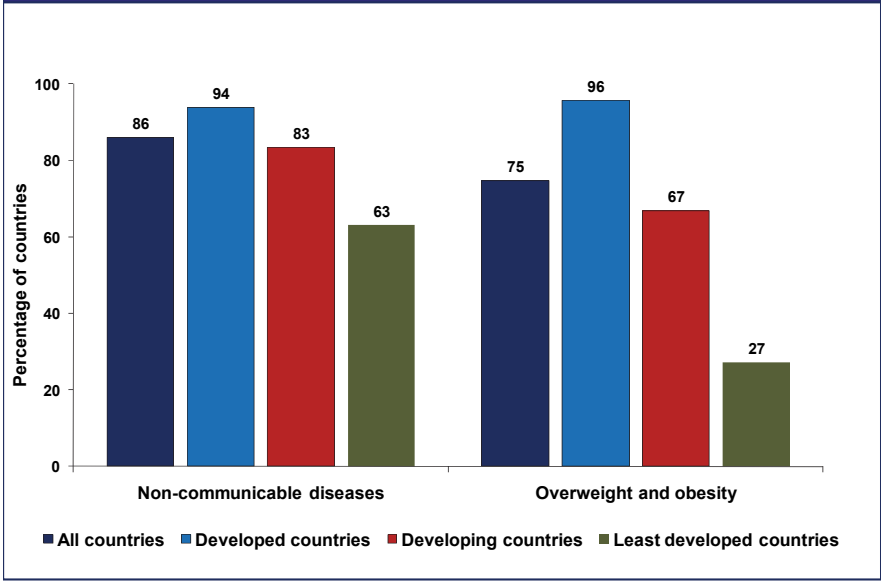


CONCERNS ABOUT NON-COMMUNICABLE DISEASES (NCDS)

Tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol are among the important modifiable behaviours that bring about metabolic changes, including overweight and obesity, hypertension, hyperglycemia and hyperlipidemia and cause major non-communicable diseases (NCDs) such as heart disease, type 2 diabetes, stroke, chronic lung disease and cancers. NCDs are the leading cause of death in the world. Of the 57 million deaths that occurred globally in 2008, 36 million—almost two thirds—were due to NCDs (World Health Organization, 2011b). Alarmingly, four out of five NCDs-related deaths occurred in low- and middle-income countries, and a third of these deaths were among people younger than 60 years. Overall, NCDs-related deaths occurred at earlier ages in developing countries than in developed countries: 29 per cent of NCDs-related deaths occurred before age 60 in developing countries, compared with 13 per cent in developed countries (Engelgau and others, 2011).

All of the 192 countries with information available in 2011 expressed some degree of concern about non-communicable diseases in their countries, and an overwhelming majority (86 per cent) expressed major concern (table VI.5, figure VI.3). Governments in developed countries were more likely to express a major concern about NCDs (94 per cent) than in developing countries (83 per cent). Even among least developed countries, 63 per cent of Governments expressed a major concern about NCDs and the remaining 37 per cent expressed a minor concern. Africa had the lowest percentage of Governments (75 per cent) that expressed a major concern about NCDs.

Figure VI.3. Governments considering the level of non-communicable diseases and overweight and obesity as a major concern, by level of development, 2011



CONCERNS ABOUT OVERWEIGHT AND OBESITY

Obesity is an independent risk factor of heart disease, stroke and diabetes, and it is known to increase the risk of cancers of esophagus, breast, endometrium, colon and rectum, kidney, pancreas, thyroid and gallbladder. Worldwide, in 2008, about a third of adults aged 20 years or older (34 per cent of men and 35 per cent of women) were estimated to be overweight (BMI $\geq$ 25 kg/m^2), and 10 per cent of men and 14 per cent of women were obese (BMI $\geq$ 30 kg/m^2) (World Health Organization, 2011b). In terms of absolute numbers, nearly 1.5 billion adults aged 20 years or older were estimated to be overweight or obese worldwide in 2008. The prevalence of obesity varied across regions, ranging from a high of 26 per cent in Northern America and Latin America and the Caribbean to only 3 per cent in South-East Asia.

In 2011, three quarters of all Governments worldwide considered the prevalence of overweight and obesity in their countries to be a major concern (table VI.6, figure VI.3). Almost all Governments of developed countries (96 per cent) considered overweight and obesity to be a major concern, compared with 67 per cent of Governments in developing countries and only 27 per cent in least developed countries. By geographic region, the percentage of Governments that viewed the prevalence of overweight and obesity in their populations as a major concern varied from a low of 40 per cent in Africa and 63 per cent in Asia to more than 90 per cent in other world regions.

CONCERNS ABOUT TUBERCULOSIS

Despite much progress in the past decade, infectious diseases, such as tuberculosis, malaria and HIV continue to cause preventable ill health and millions of deaths, especially in developing countries. Tuberculosis is a leading cause of death from a single infectious agent, second only to HIV. In 2011, there were 8.7 million new cases of tuberculosis and 1.4 million deaths from tuberculosis worldwide (World Health Organization, 2012d). More than 95 per cent of global tuberculosis deaths occurred in developing countries. Of the 8.7 million incident tuberculosis cases in 2011, about 1.1 million were among people living with HIV. The proportion of tuberculosis cases co-infected with HIV was highest in countries in Africa, which accounted for 79 per cent of all tuberculosis cases among people living with HIV. Globally, both the numbers of new cases and tuberculosis death rates have been declining in recent years; and if the current trends are sustained, the world will achieve the MDG target of halting the spread and beginning to reverse the epidemic by 2015, as well as the Stop TB Partnership target of halving the 1990 tuberculosis death rates by 2015 (United Nations, 2012c).

In 2011, Governments of two thirds (68 per cent) of the 195 countries with data considered tuberculosis to be a major concern in their countries (table VI.7). Consistent with much higher tuberculosis incidence and death rates in developing countries, Governments in developing countries were much more likely to express a major concern about tuberculosis (78 per cent) than in developed countries (38 per cent). All but two Governments in least developed countries (96 per cent) expressed a major concern about tuberculosis in 2011. The percentage of Governments that expressed a major concern about tuberculosis was highest in Africa (96 per

cent) and lowest in Europe (40 per cent) and in Northern America where neither of the two Governments considered tuberculosis to be a major concern.

CONCERNS ABOUT MALARIA

Worldwide, there were an estimated 216 million episodes of malaria and some 655,000 malaria deaths in 2010 (World Health Organization, 2011c). An overwhelming majority (91 per cent) of malaria deaths occurred in the African region, mostly among children under five years of age. In recent years, great strides have been made in malaria prevention, such as providing insecticide-treated mosquito nets and indoor residual spraying, in malaria endemic countries, which have contributed to a 17 per cent decline in malaria incidence and 26 per cent decline in malaria deaths worldwide since 2000. Yet, these advances were insufficient to achieve the internationally-agreed target of 50 per cent reduction in malaria deaths by 2010.

In 2011, among the 195 countries with information, 40 per cent of Governments considered malaria to be a major concern in their countries, and another 23 per cent considered malaria to be a minor concern (table VI.8). While none of the Governments in developed countries expressed a major concern about malaria, 53 per cent of Governments in developing countries and 88 per cent in least developed countries did so. In more than three quarters of developed countries, malaria was not a matter of concern to the Governments. The highest percentage of Governments that expressed a major concern about malaria was in Africa (80 per cent), followed by a distant 43 per cent in Asia, 36 per cent in Latin America and the Caribbean and only 19 per cent in Oceania. None of the Governments in Europe or Northern America expressed a major concern about malaria.

CONCERNS ABOUT HIV/AIDS

The Millennium Development Goals set ambitious targets to halt and reverse the spread of HIV by 2015 and to achieve universal access to treatment for HIV/AIDS for all those who needed it by 2010 (United Nations, 2012c). After years of sustained efforts to curb the HIV/AIDS epidemic, the world has seen dramatic improvements in reducing new HIV infections and lowering mortality from AIDS-related causes in recent years. Encouraged by this success and recognizing the opportunity to eliminate the epidemic, in the 2011 United Nations Political Declaration on HIV and AIDS, Governments renewed their commitment to fight the virus and pledged to further intensify their efforts to eliminate HIV and AIDS (United Nations, General Assembly, 2011c).

Despite the encouraging progress, HIV remains a major source of ill health and death worldwide. At the end of 2011, an estimated 34 million people (adults and children) were living with HIV, and 2.5 million people newly acquired HIV infection in 2011 (UNAIDS, 2012). While the number of new infections has declined by 20 per cent since 2001, the number of people living with HIV has increased by 17 per cent, due primarily to reduced mortality from AIDS-related causes as access to treatment has continued to improve. Sub-Saharan Africa remained the most severely affected region in the world where 71 per cent of all new HIV infections

worldwide occurred in 2011 and where 69 per cent of all HIV-infected people resided at the end of 2011.

In 2011, an overwhelming majority (80 per cent) of Governments expressed a major concern about HIV/AIDS in their countries (table VI.9). Governments in developing countries (82 per cent) were somewhat more likely than in developed countries (73 per cent) to express HIV/AIDS as a major concern. All Governments in least developed countries considered HIV/AIDS to be a major concern.

Over time, the proportion of Governments that expressed major concern about HIV/AIDS increased from 71 per cent in 1996 to 86 per cent in 2005 but then declined to 80 per cent in 2011. Similar declines in recent years were observed in both developed and developing countries, as well as in all major world regions, except Africa and Northern America (table VI.9). These recent declines in Government concerns about HIV/AIDS are in line with declining incidence rates, and increasing survival rates among people living with HIV due to improved availability of antiretroviral treatment.

MEASURES TO ADDRESS HIV/AIDS

In 2011, information was gathered on six key measures that Governments have adopted to address the HIV/AIDS epidemic. These included: (1) routine screening of the blood supply; (2) information, education and communication (IEC) campaigns on the prevention and treatment of HIV/AIDS; (3) provision of antiretroviral treatment (ART); (4) adoption of legal measures to protect against HIV/AIDS-related discrimination; (5) condom distribution programmes; and (6) prevention of mother-to-child transmission (PMTCT).

***Blood screening*:** Transmission of HIV and other infectious diseases via blood transfusions and other blood products pose a serious public health problem in many countries. In 2011, 194 of the 196 Governments (99 per cent) had programmes to routinely screen national blood supplies and blood products for HIV (table VI.10). Little difference was seen between developed and developing countries or among regions regarding the existence of routine blood screening for HIV. Nevertheless, national programmes ensuring the safety of blood products vary in coverage and comprehensiveness.

***Information and education campaigns*:** Governments have raised public awareness about how to prevent HIV infection through information, education and communication (IEC) programmes using the print media, theatre, radio, television and other means of transmitting messages. The participation of non-governmental organizations, people living with HIV, religious institutions, and international and bilateral donors has been critical to the success of such efforts. In fact, in 2011, Governments of all 196 countries worldwide reported having information and education campaigns about HIV prevention and treatment.

***Antiretroviral treatment*:** Antiretroviral therapy (ART) can significantly prolong life and alleviate suffering among people living with HIV. In 2011, 97 per cent of Governments—100 per cent of developed-country Governments and 96 per cent of developing-country

Governments—had programmes to provide ART to eligible HIV-infected people (table VI.10). In recent years, the availability of antiretroviral treatment has increased dramatically in developing countries, from 76 per cent in 2005 to 96 per cent in 2011 and even more dramatically in least developed countries (from 57 per cent in 2005 to 100 per cent in 2011). This is reflected in a twenty-fold increase since 2003 in the number of people receiving ART to 8 million by the end of 2011 (UNAIDS, 2012). An estimated 54 per cent of people eligible for ART in low and middle-income countries were receiving it by the end of 2011. The coverage was highest in Latin America (68 per cent), the Caribbean (67 per cent), and Oceania (69 per cent). Coverage in sub-Saharan Africa was modestly higher than the global average, with 56 per cent of eligible individuals receiving ART. However, coverage remained low in Eastern Europe and Central Asia (25 per cent) and in the Middle East and North Africa (15 per cent) (UNAIDS, 2012).

***Non-discrimination policies*:** Governments have increasingly enacted laws and adopted non-discrimination policies to protect people living with HIV. By 2011, 63 per cent of Governments had adopted legal measures to prevent HIV/AIDS-related discrimination (table VI.10). Governments of 73 per cent of developed countries had adopted such legal measures, whereas a smaller proportion of Governments of developing countries (60 per cent) and those of least developed countries (53 per cent) had done so. In Africa, where the epidemic is most widespread, 61 per cent of Governments had adopted legal measures to prevent discrimination on the basis of HIV status.

At the end of 2011, HIV prevalence data were available for 161 of the 196 countries considered (UNAIDS, 2012). Among these, 111 countries had a relatively low prevalence, concentrated epidemic (HIV prevalence below 1 per cent in the general population). Of the remaining 50 countries with a generalized epidemic (HIV prevalence of 1 per cent or greater), 37 had a prevalence of 1 to 5 per cent, and the remaining 13 had a prevalence of 5 per cent or more. Eighty-five out of the 111 countries with concentrated epidemics (77 per cent) had adopted legal provisions to prevent HIV/AIDS-related discrimination, compared with 31 out of 50 countries (62 per cent) with generalized epidemics (box VI.1). Among the 35 countries where HIV prevalence estimates were not available at the end of 2011, only eight countries (23 per cent) had adopted anti-discrimination legal measures. However, even when non-discrimination laws exist, their implementation in providing effective protection to people living with HIV may vary greatly across countries.

***Condom distribution*:** Programmes to promote condom use to protect against sexual transmission of HIV have become widespread. By 2011, 90 per cent of Governments—88 per cent of developed-country Governments and 91 per cent of developing-country Governments—had programmes to increase the availability of condoms in order to prevent HIV transmission (table VI.10). The percentage of Governments that have condom promotion programmes has increased in recent years in both developed and developing countries and in all major world regions. Nevertheless, supply shortages and poor quality of condoms distributed remain important concerns. In sub-Saharan Africa in 2011, for example, only nine donor-provided male condoms were available for every men aged 15–49 years and only one female condom for every 10 women aged 15–49 years per year (UNAIDS, 2012).

Box VI.1.

COUNTRIES WITH LEGAL MEASURES TO PREVENT HIV/AIDS-RELATED DISCRIMINATION, BY RATE OF ADULT HIV PREVALENCE, 2011

Adult HIV prevalence rate in 2011*	LEGAL MEASURES TO PROHIBIT HIV/AIDS-RELATED DISCRIMINATION IN 2011	
	No	*Yes*
Less than 1 per cent *(n=111)*	*26 countries*: Afghanistan, Bahrain, Bangladesh, Bulgaria, Cyprus, Eritrea, Fiji, Finland, Greece, Hungary, Indonesia, Iran (Islamic Republic of), Iraq, Libya, Madagascar, Malaysia, Maldives, Myanmar, Norway, Qatar, Serbia, Singapore, Slovakia, Somalia, Sri Lanka and Sudan	*85 countries*: Algeria, Argentina, Armenia, Australia, Austria, Azerbaijan, Barbados, Belarus, Belgium, Bhutan, Bolivia (Plurinational State of), Brazil, Cambodia, Canada, Chile, China, Colombia, Comoros, Costa Rica, Croatia, Cuba, Czech Republic, Denmark, Dominican Republic, Ecuador, Egypt, El Salvador, France, Georgia, Germany, Guatemala, Honduras, Iceland, India, Ireland, Israel, Italy, Japan, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, the Lao People's Democratic Republic, Latvia, Lebanon, Lithuania, Luxembourg, Malta, Mexico, Mongolia, Morocco, Nepal, the Netherlands, New Zealand, Nicaragua, Niger, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, the Republic of Korea, the Republic of Moldova, Romania, Senegal, Slovenia, Spain, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Tunisia, Turkey, Ukraine, United Arab Emirates, the United Kingdom, the United States of America, Uruguay, Venezuela (Bolivarian Republic of), Viet Nam and Yemen
1 to 5 per cent *(n=37)*	*17 countries*: Cameroon, Congo, Côte d'Ivoire, Equatorial Guinea, Estonia, Ethiopia, Gambia, Guinea-Bissau, Haiti, Jamaica, Liberia, Mauritania, Nigeria, Sao Tome and Principe, South Sudan, Suriname, and Trinidad and Tobago	*20 countries*: Angola, Bahamas, Belize, Benin, Burkina Faso, Burundi, Cape Verde, the Central African Republic, Chad, Djibouti, Ghana, Guinea, Guyana, Mali, Mauritius, Russian Federation, Rwanda, Sierra Leone, Thailand and Togo
5 to 10 per cent *(n=4)*	*1 country*: Gabon	*3 countries*: Kenya, Uganda and the United Republic of Tanzania
10 to 20 per cent *(n=6)*	–	*6 countries*: Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe
20 per cent or more *(n=3)*	*1 country*: Swaziland	*2 countries*: Botswana and Lesotho
HIV prevalence data not available *(n=35)*	*27 countries:* Antigua and Barbuda, Bosnia and Herzegovina, Brunei Darussalam, Democratic People's Republic of Korea, Democratic Republic of the Congo, Dominica, Grenada, Kiribati, Liechtenstein, Marshall Island, Micronesia (Federated States of), Monaco, Nauru, Niue, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, San Marino, Seychelles, Solomon Islands, The former Yugoslav Rep. of Macedonia, Timor-Leste, Tonga, Tuvalu, and Vanuatu	*8 countries:* Albania, Andorra, Cook Islands, Holy See, Montenegro, Palau Turkmenistan and Uzbekistan

* Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2012.

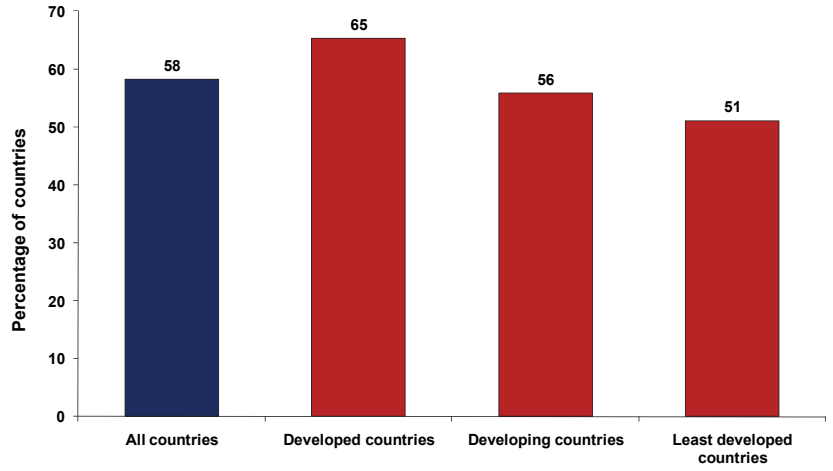
***Prevention of mother-to-child transmission (PMTCT)*:** In 2011, an estimated 330,000 children acquired the HIV infection from their mothers. A great majority of these children (90 per cent) lived in sub-Saharan Africa. The 2011 United Nations Political Declaration on HIV and

AIDS has called for the elimination of all new HIV infections among children by 2015 (United Nations, 2012c; UNAIDS, 2012).

By 2011, Governments of 185 of the 196 countries considered (94 per cent) had programmes to prevent mother-to-child transmission of HIV. This percentage varied little by the level of development or by geographic region. However, the coverage of effective antiretroviral regimens for preventing mother-to-child transmission varied by the level of development. In high-income countries, PMTCT coverage remained almost universal, whereas only 59 per cent of pregnant HIV-positive women in sub-Saharan Africa received antiretroviral therapy or prophylaxis. This percentage was substantially lower in South and South-East Asia (18 per cent) and in the Middle East and North Africa (7 per cent) (UNAIDS, 2012).

Overall, in 2011, 58 per cent of the Governments worldwide had adopted all six of the above measures to address HIV/AIDS (figure VI.4). This percentage was lower among developing countries (56 per cent) than among developed countries (65 per cent) and was even lower among least developed countries, where only about half of all Governments had adopted all six key measures to address HIV/AIDS.

Figure VI.4. Governments that have adopted all six key measures to address HIV/AIDS,* by level of development, 2011



* Key measures to address HIV/AIDS: (1) blood screening; (2) information/education campaigns; (3) antiretroviral treatment; (4) non-discrimination policies (legal measures); (5) distribution of condoms; (6) prevention of mother-to-child transmission (PMTCT)

Chapter VI
Tables

Table VI.1. Government views on the level of life expectancy at birth,[1] 1976–2011

Year	By level of development					
	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
World						
1976	55	95	150	37	63	100
1986	60	104	164	37	63	100
1996	77	116	193	40	60	100
2005	83	111	194	43	57	100
2011	86	110	196	44	56	100
More developed regions						
1976	27	7	34	79	21	100
1986	27	7	34	79	21	100
1996	30	18	48	63	38	100
2005	31	17	48	65	35	100
2011	32	17	49	65	35	100
Less developed regions						
1976	28	88	116	24	76	100
1986	33	97	130	25	75	100
1996	47	98	145	32	68	100
2005	52	94	146	36	64	100
2011	54	93	147	37	63	100
Least developed countries						
1976	2	40	42	5	95	100
1986	3	45	48	6	94	100
1996	1	48	49	2	98	100
2005	0	50	50	0	100	100
2011	1	48	49	2	98	100

Table VI.1. (Continued)

Year	By major area					
	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
Africa						
1976	2	46	48	4	96	100
1986	4	47	51	8	92	100
1996	7	46	53	13	87	100
2005	6	47	53	11	89	100
2011	6	48	54	11	89	100
Asia						
1976	13	24	37	35	65	100
1986	15	23	38	39	61	100
1996	19	27	46	41	59	100
2005	22	25	47	47	53	100
2011	24	23	47	51	49	100
Europe						
1976	22	7	29	76	24	100
1986	22	7	29	76	24	100
1996	28	15	43	65	35	100
2005	27	16	43	63	37	100
2011	28	16	44	64	36	100
Latin America and the Caribbean						
1976	11	16	27	41	59	100
1986	13	20	33	39	61	100
1996	17	16	33	52	48	100
2005	19	14	33	58	42	100
2011	21	12	33	64	36	100
Northern America						
1976	2	0	2	100	0	100
1986	2	0	2	100	0	100
1996	1	1	2	50	50	100
2005	1	1	2	50	50	100
2011	1	1	2	50	50	100
Oceania						
1976	5	2	7	71	29	100
1986	4	7	11	36	64	100
1996	5	11	16	31	69	100
2005	8	8	16	50	50	100
2011	6	10	16	38	63	100

[1] In previous revisions, "life expectancy at birth" was referred to as "mortality level".

Table VI.2. Government views on the level of under-five mortality, 1996–2011

Year	By level of development					
	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
			World			
1996	26	87	113	23	77	100
2005	53	138	191	28	72	100
2011	70	126	196	36	64	100
			More developed regions			
1996	13	15	28	46	54	100
2005	32	16	48	67	33	100
2011	36	13	49	73	27	100
			Less developed regions			
1996	13	72	85	15	85	100
2005	21	122	143	15	85	100
2011	34	113	147	23	77	100
			Least developed countries			
1996	0	34	34	0	100	100
2005	0	49	49	0	100	100
2011	0	49	49	0	100	100

Table VI.2. (Continued)

Year	By major area					
	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
Africa						
1996	2	39	41	5	95	100
2005	2	51	53	4	96	100
2011	5	49	54	9	91	100
Asia						
1996	8	17	25	32	68	100
2005	10	37	47	21	79	100
2011	17	30	47	36	64	100
Europe						
1996	13	11	24	54	46	100
2005	30	13	43	70	30	100
2011	32	12	44	73	27	100
Latin America and the Caribbean						
1996	3	16	19	16	84	100
2005	5	27	32	16	84	100
2011	9	24	33	27	73	100
Northern America						
1996	0	1	1	0	100	100
2005	1	1	2	50	50	100
2011	1	1	2	50	50	100
Oceania						
1996	0	3	3	0	100	100
2005	5	9	14	36	64	100
2011	6	10	16	38	63	100

Table VI.3. Government views on the level of undernutrition among children, 2011

Year	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
By level of development						
World						
2011	68	122	190	36	64	100
More developed regions						
2011	34	10	44	77	23	100
Less developed regions						
2011	34	112	146	23	77	100
Least developed countries						
2011	2	47	49	4	96	100
By major area						
Africa						
2011	6	48	54	11	89	100
Asia						
2011	13	33	46	28	72	100
Europe						
2011	30	9	39	77	23	100
Latin America and the Caribbean						
2011	10	23	33	30	70	100
Northern America						
2011	1	1	2	50	50	100
Oceania						
2011	8	8	16	50	50	100

Table VI.4. Government views on the level of maternal mortality, 2005 and 2011

Year	Number of countries			Percentage		
	Acceptable	*Unacceptable*	*Total*	*Acceptable*	*Unacceptable*	*Total*
By level of development						
World						
2005	60	132	192	31	69	100
2011	74	122	196	38	62	100
More developed regions						
2005	33	15	48	69	31	100
2011	38	11	49	78	22	100
Less developed regions						
2005	27	117	144	19	81	100
2011	36	111	147	24	76	100
Least developed countries						
2005	1	48	49	2	98	100
2011	2	47	49	4	96	100
By major area						
Africa						
2005	1	52	53	2	98	100
2011	2	52	54	4	96	100
Asia						
2005	12	35	47	26	74	100
2011	16	31	47	34	66	100
Europe						
2005	30	13	43	70	30	100
2011	35	9	44	80	20	100
Latin America and the Caribbean						
2005	9	24	33	27	73	100
2011	11	22	33	33	67	100
Northern America						
2005	1	1	2	50	50	100
2011	0	2	2	0	100	100
Oceania						
2005	7	7	14	50	50	100
2011	10	6	16	63	38	100

Table VI.5. Government level of concern about non-communicable diseases, 2011

Year	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
By level of development								
World								
2011	165	27	0	192	86	14	0	100
More developed regions								
2011	45	3	0	48	94	6	0	100
Less developed regions								
2011	120	24	0	144	83	17	0	100
Least developed countries								
2011	29	17	0	46	63	37	0	100
By major area								
Africa								
2011	38	13	0	51	75	25	0	100
Asia								
2011	40	7	0	47	85	15	0	100
Europe								
2011	40	3	0	43	93	7	0	100
Latin America and the Caribbean								
2011	30	3	0	33	91	9	0	100
Northern America								
2011	2	0	0	2	100	0	0	100
Oceania								
2011	15	1	0	16	94	6	0	100

Table VI.6. Government level of concern about overweight and obesity, 2011

Year	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
By level of development								
World								
2011	130	41	3	174	75	24	2	100
More developed regions								
2011	45	2	0	47	96	4	0	100
Less developed regions								
2011	85	39	3	127	67	31	2	100
Least developed countries								
2011	9	22	2	33	27	67	6	100
By major area								
Africa								
2011	14	20	1	35	40	57	3	100
Asia								
2011	29	15	2	46	63	33	4	100
Europe								
2011	40	2	0	42	95	5	0	100
Latin America and the Caribbean								
2011	30	3	0	33	91	9	0	100
Northern America								
2011	2	0	0	2	100	0	0	100
Oceania								
2011	15	1	0	16	94	6	0	100

Table VI.7. Government level of concern about tuberculosis, 2011

Year	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
By level of development								
World								
2011	133	52	10	195	68	27	5	100
More developed regions								
2011	18	23	7	48	38	48	15	100
Less developed regions								
2011	115	29	3	147	78	20	2	100
Least developed countries								
2011	47	2	0	49	96	4	0	100
By major area								
Africa								
2011	52	2	0	54	96	4	0	100
Asia								
2011	36	11	0	47	77	23	0	100
Europe								
2011	17	20	6	43	40	47	14	100
Latin America and the Caribbean								
2011	21	10	2	33	64	30	6	100
Northern America								
2011	0	1	1	2	0	50	50	100
Oceania								
2011	7	8	1	16	44	50	6	100

Table VI.8. Government level of concern about malaria, 2011

Year	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
By level of development								
World								
2011	78	45	72	195	40	23	37	100
More developed regions								
2011	0	11	37	48	0	23	77	100
Less developed regions								
2011	78	34	35	147	53	23	24	100
Least developed countries								
2011	43	2	4	49	88	4	8	100
By major area								
Africa								
2011	43	9	2	54	80	17	4	100
Asia								
2011	20	17	10	47	43	36	21	100
Europe								
2011	0	8	35	43	0	19	81	100
Latin America and the Caribbean								
2011	12	9	12	33	36	27	36	100
Northern America								
2011	0	1	1	2	0	50	50	100
Oceania								
2011	3	1	12	16	19	6	75	100

Table VI.9. Government level of concern about HIV/AIDS, 1996–2011

Year	By level of development							
	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
				World				
1996	89	34	2	125	71	27	2	100
2005	165	26	1	192	86	14	1	100
2011	156	39	0	195	80	20	0	100
				More developed regions				
1996	21	12	0	33	64	36	0	100
2005	37	10	0	47	79	21	0	100
2011	35	13	0	48	73	27	0	100
				Less developed regions				
1996	68	22	2	92	74	24	2	100
2005	128	16	1	145	88	11	1	100
2011	121	26	0	147	82	18	0	100
				Least developed countries				
1996	26	8	0	34	76	24	0	100
2005	48	1	0	49	98	2	0	100
2011	49	0	0	49	100	0	0	100

Table VI.9. (Continued)

Year	By major area							
	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
Africa								
1996	34	7	0	41	83	17	0	100
2005	46	5	1	52	88	10	2	100
2011	48	6	0	54	89	11	0	100
Asia								
1996	17	7	2	26	65	27	8	100
2005	39	8	0	47	83	17	0	100
2011	36	11	0	47	77	23	0	100
Europe								
1996	17	11	0	28	61	39	0	100
2005	32	10	0	42	76	24	0	100
2011	30	13	0	43	70	30	0	100
Latin America and the Caribbean								
1996	16	8	0	24	67	33	0	100
2005	30	3	0	33	91	9	0	100
2011	29	4	0	33	88	12	0	100
Northern America								
1996	2	0	0	2	100	0	0	100
2005	2	0	0	2	100	0	0	100
2011	2	0	0	2	100	0	0	100
Oceania								
1996	3	1	0	4	75	25	0	100
2005	16	0	0	16	100	0	0	100
2011	11	5	0	16	69	31	0	100

Table VI.10. Government measures adopted to address HIV/AIDS, 2005 and 2011

Year	By level of development												
	Number of countries							Percentage					
	Blood screening	*Information/ education campaigns*	*Antiretroviral treatment*	*Non-discrimination policies*[1]	*Distribution of condoms*	*PMTCT*	*Total number of countries*	*Blood screening*	*Information/ education campaigns*	*Antiretroviral treatment*	*Non-discrimination policies*[1]	*Distribution of condoms*	*PMTCT*
World													
2005	171	183	149	117	154	NC	189	90	97	79	62	81	NC
2011	194	196	190	124	177	185	196	99	100	97	63	90	94
More developed regions													
2005	46	47	42	37	41	NC	48	96	98	88	77	85	NC
2011	48	49	49	36	43	44	49	98	100	100	73	88	90
Less developed regions													
2005	125	136	107	80	113	NC	141	89	96	76	57	80	NC
2011	146	147	141	88	134	141	147	99	100	96	60	91	96
Least developed countries													
2005	39	43	26	18	36	NC	46	85	93	57	39	78	NC
2011	48	49	49	26	46	48	49	98	100	100	53	94	98

Table VI.10. (Continued)

Year	By major area												
	Number of countries							Percentage					
	Blood screening	Information/ education campaigns	Antiretroviral treatment	Non-discrimination policies [1]	Distribution of condoms	PMTCT	Total number of countries	Blood screening	Information/ education campaigns	Antiretroviral treatment	Non-discrimination policies [1]	Distribution of condoms	PMTCT
Africa													
2005	44	48	40	25	43	NC	50	88	96	80	50	86	NC
2011	53	54	54	33	50	53	54	98	100	100	61	93	98
Asia													
2005	47	45	32	32	38	NC	47	100	96	68	68	81	NC
2011	47	47	44	30	40	44	47	100	100	94	64	85	94
Europe													
2005	41	42	37	32	36	NC	43	95	98	86	74	84	NC
2011	43	44	44	31	38	39	44	98	100	100	70	86	89
Latin America and the Caribbean													
2005	30	33	29	20	28	NC	33	91	100	88	61	85	NC
2011	33	33	33	23	33	33	33	100	100	100	70	100	100
Northern America													
2005	2	2	2	2	2	NC	2	100	100	100	100	100	NC
2011	2	2	2	2	2	2	2	100	100	100	100	100	100
Oceania													
2005	7	13	9	6	7	NC	14	50	93	64	43	50	NC
2011	16	16	13	5	14	14	16	100	100	81	31	88	88

[1] Refers mostly to legal measures to prevent HIV/AIDS-related discrimination.
NC: Data on prevention of mother-to-child transmission (PMTCT) were not collected during the 2005 revision