

Development Committee 2003 Spring Meetings

**Accelerating Progress Towards the Health, Nutrition
and Population Millennium Development Goals**

Addendum 4

ABBREVIATIONS AND ACRONYMS

CBO	Community-Based Organization
CDD	Community Driven Development
DAH	Development Assistance for Health
DOTS	Directly Observed Treatment, Short Course
ESW	Economic and Sector Work
FBO	Faith-Based Organization
FHP	Family Health Program
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP	Health, Nutrition and Population
IMCI	Integrated Management of Childhood Illness
ITN	Insecticed-Treated Nets
MDG	Millennium Development Goal
MTEF	Mid-Term Expenditure Framework
NGO	Non-Governmental Organizations
ORT	Oral Rehydration Therapy
PETS	Public Expenditure Tracking Survey
PRSP	Poverty Reduction Strategy Paper
R&D	Research and Development
SWAP	Sector-Wide Approach
TB	Tuberculosis

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Accelerating Progress Towards the Health, Nutrition, and Population Millennium Development Goals

1. As a follow-up to the September 2002 meeting of the Development Committee, this paper presents the challenges for the health related Millennium Development Goals (MDGs), describes progress and problems to date, and analyzes the main obstacles to faster progress and what can be done to address them. The paper then proposes what developing countries, the Bank, and donor partners can do that can help accelerate progress toward achieving the goals and thus potentially save millions of lives. The key messages that emerge are that strengthening health systems and using a multisectoral approach, will be essential for accelerating progress, and that a partnership of governments, the Bank, and other donors has a major role to play to achieve this.

A. THE HEALTH MDGS MATTER

Challenges

2. When we analyze the challenges, which the health MDGs pose, it is clear that the scale of the task is daunting and the inequities to be addressed many:

- In 2002, almost 11 million children died before their fifth birthday. 99% of these deaths occurred in developing countries: 4.5 million (42%) were in Sub-Saharan Africa alone, with the bulk of the remaining deaths in South Asia (35%). The under-five mortality rate among the poorest quarter of the world's population is ten times that among the richest quarter.
- An estimated 140 million children under the age of five are underweight, almost half of these (65 million) in South Asia. In 1998, an estimated 843 million people were considered to be undernourished based on their food intake.
- In 2000, 520,000 women died during pregnancy or childbirth: only 1,000 of these deaths occurred in the industrialized developing world; 252,000 took place in Sub-Saharan Africa. The maternal mortality ratio is twenty times higher among the poorest quarter of the world's population than among the richest quarter.
- In 2001, 3 million people died from HIV/AIDS. The great majority (99%) of these deaths occurred in the developing world—73% in Sub-Saharan Africa alone. Life expectancy has declined by as much as 20 years in the countries with the highest infection rates, and decade-long improvements in child mortality reversed.
- Tuberculosis (TB) claimed another 2 million lives, and malaria is associated with over 1 million deaths.
- In middle-income countries, the burden of disease has shifted to noncommunicable diseases, such as diabetes, cancers, and cardiovascular diseases, requiring an increased focus on prevention.
- Better health—less morbidity, longer lives—is arguably one of the greatest prizes to be had from economic growth. But better health is also a means to an end—death and illness act as a brake on economic growth, and contribute to income

poverty. As an Egyptian woman put it in *Voices of the Poor*, “We face a calamity when my husband gets ill. Our life comes to a halt until he recovers and goes back to work.” It has been estimated that health and demographic variables accounted for as much as half of the difference in growth rates between Africa and the rest of the world over the period 1965-1990.

3. The prominence of health, nutrition, and population (HNP) in the MDGs, and their solid endorsement by the international community, reflects the growing appreciation of the importance of health in the process of development. Nearly half of the millennium goals and targets concern, directly or indirectly, health, nutrition, and population (see Box 1).

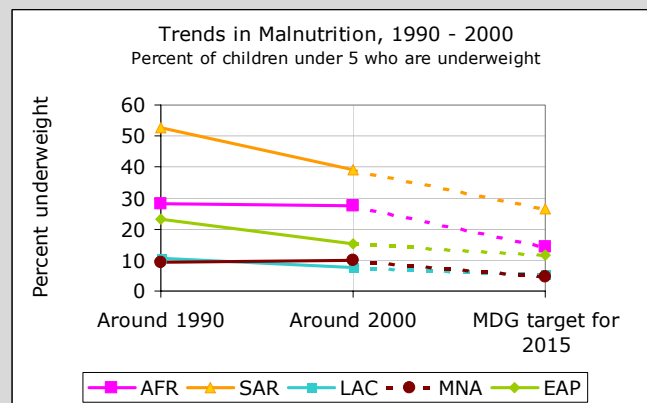
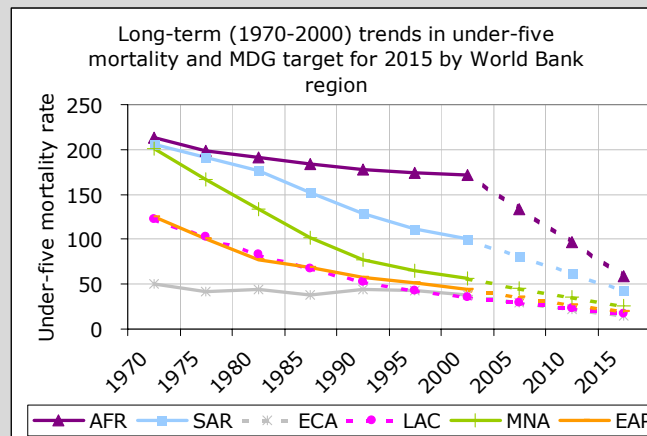
Box 1: Health, nutrition, and population feature prominently in the MDGs		
MDG	TARGETS	INDICATORS
Goal 1: Eradicate extreme poverty and hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under five years of age Proportion of population below minimum level of dietary energy consumption
Goal 4: Reduce child mortality	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	Under- five mortality rate Measles immunization among children under one
Goal 5: Improve maternal health	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	HIV prevalence among 15-24-year old pregnant women Condom use rate of the contraceptive prevalence rate Number of children orphaned by HIV/AIDS
	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Prevalence and death rate associated with malaria Proportion of population in malaria risk areas using effective malaria prevention and treatment measures Prevalence and death rates associated with tuberculosis Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 8: Develop a global partnership for development	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on a sustainable basis.

B. PROGRESS TO DATE

4. Present trends in child and maternal mortality and disease incidence are not sufficiently rapid to meet the improvements demanded by the MDGs between 1990 and 2015. Only 17% of low-income countries are currently "on target" for the under-five

mortality goal. In terms of regional averages, Latin America (LAC) and the Middle East and North Africa (MNA) are on target, but the goal will not be reached until 2018 in East Asia and Pacific (EAP), 2021 in South Asia (SAR), and 2032 in Europe and Central Asia (ECA). On present trends, Sub-Saharan Africa as a whole will take 100 years to achieve the under-five mortality MDG. Worryingly, in all regions other than ECA, the under-five mortality rate declined faster during the 1980s than it did during the 1990s. The slowdown was particularly pronounced in Africa (AFR) and the Middle East (see Box 2).

Box 2: Uneven progress towards the health MDGs



5. There is also growing evidence that improvements in child mortality and malnutrition have been greatest among the better off, leaving the poorest behind. In Vietnam, during the 1990s under-five mortality barely changed among poor people, but fell among the better off, while in Bolivia under-five mortality fell by 34% amongst the richest quintile but by only 8% amongst the poorest quintile.

6. The global experience with child mortality reduction and the other health MDGs is not, however, all negative. There are successes that can be multiplied. If we include middle-income countries, 40% of the developing world as a whole is on track to achieve the required two-thirds reduction in under-five mortality. And among the low-income countries, there is a small number of exemplars which went into the 1990s with an already relatively low under-five mortality rate (in the range 36-66 per 1000) but still

managed to achieve sizeable annual percentage reductions. There is a further piece of hopeful news – a number of countries currently off track for the child health MDG did manage to achieve the required annual percentage reduction in under-five mortality during the 1980s but fell back during the 1990s – suggesting that they could succeed if they can regain their earlier momentum.

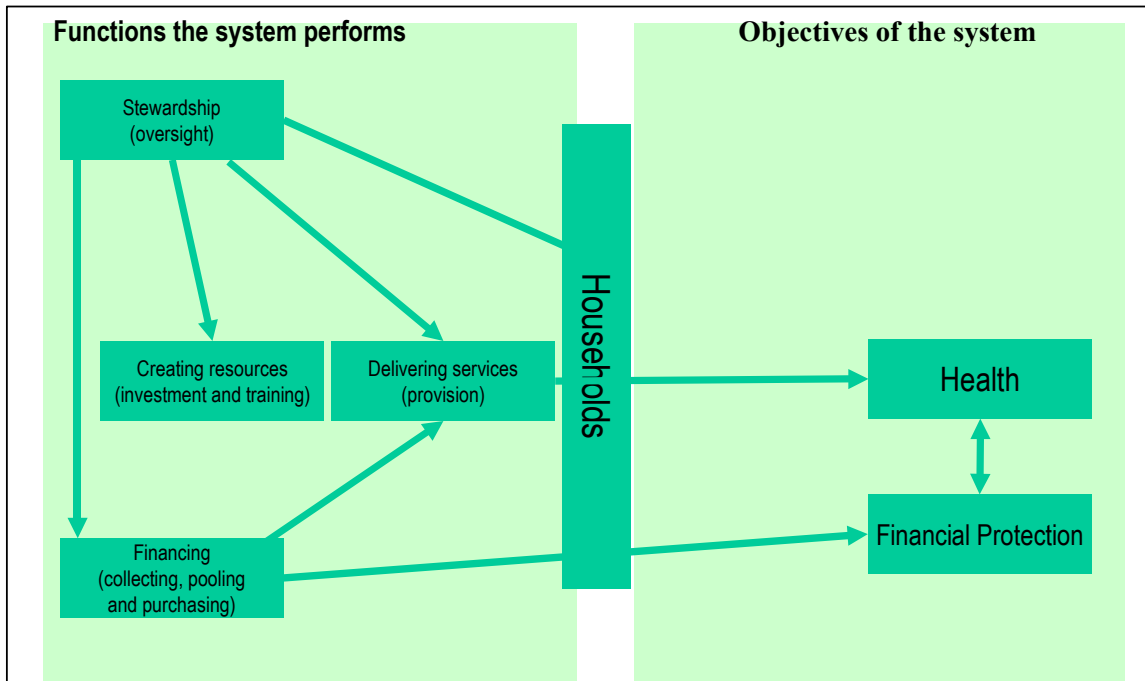
7. There are also modest examples of success on the other MDGs. Globally, the TB case detection rate increased steadily through the late 1990s under the directly observed treatment, short course (DOTS) program—from 7.5% in 1995 to 30% in 2001. Sustained reductions in HIV infection have been achieved in Thailand through government efforts to promote safe sex, and HIV prevalence among 13-19 year old girls in Uganda and Zambia has fallen in recent years. Free treatment and insecticide-treated nets (ITNs) have reduced malaria deaths in Vietnam in and coastal Kenya, while insecticide spraying and effective case management have helped control malaria in Azerbaijan.

8. While prospects of reaching the MDGs on current trends look bleak for most countries, the way forward is to learn from the success stories and scale up efforts to accelerate progress. This has to be done at the country level, and it has to be based on a thorough understanding of the impediments to faster progress. Highly effective and often inexpensive interventions are available to prevent sickness and death among children, such as immunization, good nutrition, and use of safe drinking water. For each MDG, there are many relevant preventive activities, and effective treatments are available, as well as proven systemic changes, which can facilitate progress. Monitorable indicators have been defined to assess progress in implementing effective interventions (see Annex 1).

9. If medical technology alone could save lives, and all potentially effective interventions were utilized around the world, levels of mortality and malnutrition would be a tiny fraction of what they are now. However, medical technology and expertise alone cannot save lives—they are necessary, but not sufficient. Many children do not receive the right preventive care—many, for example, are never immunized at all. Many adults do not take the appropriate preventive measures that would reduce the risk of becoming infected with HIV/AIDS. Moreover, when they do fall sick, people frequently fail to seek treatment. Those who do seek care are often not correctly diagnosed or do not receive the correct treatment.

10. Why does this happen? There is a straightforward answer. Health interventions are delivered by health care providers—qualified and unqualified—and by mothers. Providers need resources and skills to be able to work effectively, and need to be properly motivated. Households do not use services that are too costly, too far away, or of poor quality. Collectively this complex web of influences on the supply of and demand for health interventions is known as the *health system* (see Figure 1).

Figure 1. Elements of Health Systems



C. FUNCTIONS AND OBJECTIVES OF HEALTH SYSTEMS

11. Health systems have two fundamental *objectives*. First, they are intended to improve the health of the population they serve. Second, they provide financial protection against the cost of illness. In order to achieve these objectives, health systems are expected to carry out a number of *functions*. Among the most important functions of a health system are the provision of personal and public health services; raising, pooling, and allocating the financial resources for purchasing these services; and investing in people, equipment, pharmaceuticals, and other consumables. Finally, an overarching function of health systems, affecting all other functions, is the provision of stewardship, or oversight, through regulation, policies, and collection and dissemination of information.

12. When parts of the health system are not functioning properly, interventions do not reach the people who need them. And when this happens, illness and death may result. Ultimately, doing better on the MDGs means identifying which elements of the health system are broken, working out how they can best be fixed in a given country context, and making the necessary changes. Sometimes the changes required are small, and large results can be achieved quickly. More often, though, the changes required are complex, and the reforms take time to yield returns. A long-term commitment—on the part of governments and donors alike—is vital.

D. THE HEALTH SYSTEM: SUPPLY AND DEMAND CONSTRAINTS

(I) Supply constraints

13. Health systems are more than providers of health services. Adequate financing, investments in human resources, drugs and consumables, and stewardship affect which services will be provided. What providers can deliver depends to some degree on the input market—whether, for example, nurses can be hired at the prevailing wage, or whether, as in many African countries today, there are serious shortages. It depends too on their efficiency, which depends in turn on the quality of management, skills, and the incentive environment in which they operate. A number of factors have an effect on the supply of health services:

- *Human resources.* The staffing situation in much of Africa is bad and worsening. In part this is a consequence of HIV/AIDS, which has killed health workers and causes sickness, absence, and undermines morale. It also reflects a growing brain drain to the developed world, to meet the needs of their labor markets affected by changing demographics and expanding health and old age care services. Much needs to be done to reconcile these labor market dynamics in developed countries and the imperative of retaining scarce health personnel in poor countries.

The causes of staff shortages are tied up with other human resource issues, such as morale, motivation and training, and with broader issues of governance and government links with provider organizations discussed below. They also reflect issues over which a typical ministry of health may have only limited influence, because they are highly constrained by civil service rules and regulations on wages and other terms of employment.

- *Government spending.* Committed governments can exert a substantial positive influence on the health sector through decisions on how much to spend and on what items. Governments need to give priority to financing, though not necessarily delivering, services that give rise to externalities, such as immunization, HIV/AIDS prevention and TB treatment programs.

It is not just what governments buy, but where it spends money that matters. In Mozambique, Zambezia Province receives over seven times less government spending on health per capita than Maputo City. In Lesotho, the poorest district receives only a fifth of the amount the capital city receives in per capita health allocations. Geographic resource-allocation formulae have the potential to reduce these gaps. Such formulae have narrowed regional gaps in industrialized countries. In the developing world, they have not been widely used, though a scheme was introduced in Mexico in 1998, and plans are at an advanced stage in several other countries.

- *Government and publicly financed service delivery.* The influence of government goes well beyond its spending decisions, to a set of strategic choices about how publicly financed services are to be delivered. There is the traditional option of a government-run network of providers. This has worked in some countries, such as Sri Lanka, but often results in limited coverage, poor quality of service, and

inefficient resource use. One alternative is the autonomous public hospital model, used in Colombia, Ghana, India, Indonesia, Kenya, Zambia and Zimbabwe. There are large variations across these countries in what autonomous hospitals can decide, including pay rates, hiring and firing, choice of services to be provided, and fee levels. There is still incomplete evidence on the effects of autonomous decision-making on quality, efficiency, equity and health outcomes, but autonomy seems to strengthen financial management within the hospital, including computerization, training, and audit procedures.

- *The private sector.* The private sector plays an important role in health in many developing countries. However, developing countries seldom have clear policies towards the private sector. Governments can thus go a step further and contract with private organizations to deliver health care or support services. Ministries of Health in several African countries have contractual agreements with facilities of faith-based organizations (FBO): in Lesotho, Malawi and Zambia, these organizations provide 50% of health care. Brazil's family health program (FHP) provides a promising example of government contracting with private providers. An evaluation suggests the FHP has reduced child mortality in program municipalities, while those outside saw increases. In Thailand, the expansion of coverage to underserved areas during the early 1980s was achieved in part through extensive collaboration with NGOs and community-based organizations (CBOs), including village committees, sanitation cooperatives, and youth and women's groups. Public and Private sector partnerships are vital to improving health outcomes.
- *Improving community participation.* Involving local communities in the decisions over resource allocation, service delivery strategies, and performance monitoring can make the providers more client-focused and improve performance. This approach is sometimes referred to as *community driven development* (CDD). In it communities forge partnerships – through dialogue and participation – with local governments and service providers, ensuring improved service delivery. CDD has worked well in nutrition programs, which have emphasized the prevention side of care. Such programs based at the community level have had success in reducing child malnutrition rates in Senegal and Madagascar.
- *Government stewardship and regulation.* Stewardship (that is, the oversight function of governments) is needed to achieve better health system performance. Governments need to implement measures that protect patients from providers who, because of their position, might otherwise be tempted to provide poor-quality, if not dangerous, care. Limiting the adverse effects of this informational asymmetry does not necessarily require the government provision of services. Options include a strongly enforced quality assurance program, accreditation, the granting of malpractice review powers to a regulatory authority, and other regulatory actions. A recent study in Tanzania and Zimbabwe concluded that the majority of regulations focusing on entry restrictions for health personnel, drugs and technologies, have been largely ineffective. Realistic and practical approaches to health regulation in developing countries thus need to be further tested and the lessons disseminated. Better stewardship requires good functioning health

- information systems, effective monitoring and evaluation, and ensured accountability.
- *Drug and consumables management and supply.* The availability of non-labor inputs, especially drugs, is a major obstacle. A recent report concluded that in Guinea, despite efforts to implement a low-cost essential drugs policy, the drugs supply system has deteriorated. As with human resources, problems of drug availability are linked in part to broader management and resource allocation. For example, two surveys in Uganda suggest that on average around 70% of medical supplies and drugs in public facilities were appropriated by staff for use in their private work. There are also issues over which provider organizations have little control, such as procurement rules determined by developing country governments or international donor agencies. International agreements and actions also matter, such as patent waivers and equity pricing that may offer a global solution to the drug affordability in the developing world.
 - *Improving management.* A number of aspects of the “production process” of delivering health services can be improved through good management. A recent report from India sheds light on how morale can be better understood and improved. Making facilities more user-friendly by making staff more client-focused can be done, as in Malaysia where each service and support unit is required to develop and exhibit its own charter. Financial and resource management is often weak, but can be addressed through the provision of information to the public. A public expenditure tracking survey (PETS) in Uganda over the period 1991-95 revealed that an average of only 13% of the total annual capitation grant for schools actually reached them. To change this, the government started publishing the monthly transfers to the districts in newspapers, broadcasting them on the radio, and requiring primary schools to post information on received funds in public places in the schools. As a result, the share of capitation payments reaching the schools increased dramatically. The same can be done for health.

(II) Demand constraints

14. The existence of health facilities offering health services does not assure that people will use them. Health systems fail when the supply of health services is not aligned with the quality and responsiveness expected by those seeking health care. The demand for preventive and curative care is not fixed, and a range of policies can help improve demand. The following factors are among the most important affecting demand. Some are within the health sector, and some are in the domain of other sectors; a multisectoral approach in developing these policies is vital.

- *Knowledge and behavior.* Knowledge and behavior play an important part in shaping health outcomes, through their impact on preventive activities, health-seeking behaviors, and compliance during treatment. The use of almost all child health interventions is higher in households with better-educated mothers, including supplementary food nutrient intake amongst infants, hand-washing and appropriate disposal of excreta, the likelihood of receiving antenatal care, the

likelihood of a baby being delivered away from home and by a trained person, and the likelihood of a child being immunized and of a caregiver seeking care for a child with fever.

Increasing education—especially among girls—is thus likely to lead to better health. But health knowledge is also provided through the health sector, focusing especially on those who lack general literacy and numeracy skills. In Brazil, health workers trained in the Integrated Management of Childhood Illness (IMCI) provided information and counseling at both health facilities and in the community. Health knowledge among mothers improved, as did feeding practices and child nutrition.

- *Affordability.* Out-of-pocket expenditures for health services can be substantial. A normal hospital delivery in Dhaka, Bangladesh, costs the equivalent of a quarter of an average monthly income. These high prices tend to reduce demand, especially among poor people, unless accompanied by improvements in service quality. In Georgia, in 1997, 94% of those who did not seek care when ill said it was the high cost that prevented them from doing so. Affordability was the most frequently cited reason for not owning a mosquito net in Tanzania. Several options for making health services more affordable exist:
 - On efficiency grounds, it makes good sense to *subsidize* activities that reduce communicable diseases, such as mosquito nets and the insecticide used to treat them. Equity provides another reason for subsidization. One approach is to use general revenues to finance all government health services for everyone, with the aim that poor people will benefit disproportionately. If this is the hope, the reality in many developing countries is rather different. In general, it is the better off who benefit most in cost terms. Who benefits most in health terms is less clear. There is some evidence suggesting that it is poor people. This may be because although government subsidies tend to go mostly to the hospital sector, where the pro-rich bias is especially pronounced, the greatest health impact of spending is in the primary care sector, where the bias is least pronounced.
 - An alternative is to *target subsidies* for certain groups, for example, through a voucher-type scheme. Fee-waiver schemes are typically intended to exempt poor people but in practice often end up exempting the near poor or other non-poor (e.g., civil servants, military families, etc.). But there are some successes, such as the health card scheme operating in Indonesia, and Egypt's school health insurance program.
 - Beyond subsidies, there is also a case to be made for *health insurance*. People are typically risk-averse, and would prefer to trade the uncertainty of future health expenses for the certainty of a fixed premium. Despite this, health insurance, of whatever type, is rare in the developing world. On average, only 6% of total health spending is financed through a private or social insurance plan in the developing world. Mostly these schemes are in Eastern Europe and Latin America, though a few countries in other regions have schemes. There is also strong interest in so-called community insurance schemes, which

collect premiums from community members on a voluntary basis. Sustaining both types of schemes is far from straightforward, due to the problem of risk selection.

- *Geographic inaccessibility.* Demand is sensitive to time as well as money. Travel time depends on distance, but also on the transportation system, the road infrastructure, and geography. In rural communities, where the roads are poor and the transport unreliable, the time spent waiting for the transport may be as great as, if not greater, than the time spent traveling to and waiting at the facility. Time costs are a major issue for maternal mortality as many health centers lack appropriate obstetrical care, and women have to travel to distant hospitals to get such care.

Access to health facilities can be improved in a number of ways. Brazil has made major investments in ambulances to facilitate rapid referral from a primary care facility to hospital. Outreach led to significantly higher levels of immunization coverage in Benin. Most governments have relied—albeit to varying degrees—on the construction and staffing of new government facilities to expand coverage to rural areas. Malaysia and Thailand, for example, built up extensive public sector delivery systems in the 1960s and early 1970s, involving district-level community hospitals and primary health care centers and clinics.

- *Lack of empowerment for women.* Women's control over household income also matters. Women who exert little control over household financial resources are less likely, holding all else constant, to receive antenatal care, have fewer antenatal visits, and are less likely to have visits in the first trimester of pregnancy.

E. MULTISECTORAL DETERMINANTS OF HEALTH OUTCOMES

15. Health systems hold the key to providing services and information that can both prevent and treat illness. Households play a central role in determining health outcomes, through their demand of services and by providing household level interventions. But health outcomes may remain below what might be achievable even when a health system is performing relatively well, given the significance of actions and policies in other sectors - in particular, education, access to water and sanitation, and infrastructure which are strong determinants of health outcomes.

16. Research on the determinants of child survival across low-income countries has consistently shown the importance of mother's education. Mother's education raises the demand for health care and the ability to seek out and use new approaches to preventing illness within the family. Moreover, experience suggests that there are substitutes for basic literacy and numeracy in promoting some aspects of health behavior. Mothers' knowledge can be influenced by concerted, targeted health promotion campaigns. But educating girls, giving them literacy and numeracy skills is central, and enables them to acquire health-specific knowledge, and provides them with a basis for seeking out, understanding and applying information that keeps their children healthy.

17. A review of 42 studies finds access to clean water reduces the probability of child mortality by an average of 55%. Accessible safe water supplies reduces the incidence of diarrhea, a major proximate cause of child mortality, and provides the quantities of water needed to maintain basic hygiene. Such access is uncommon in poor communities where child mortality is highest. Poor quality water and water sources that require carrying water to the household not only have negative effects on health and hygiene, but pose a high opportunity cost in terms of girls' education (since girls typically carry the water). A recent study in India showed that piped water resulted in a lower incidence of diarrheal disease only among children whose mother's had at least primary education.

18. Recent quantitative and qualitative evidence provide a link with infrastructure investments as well. Studies in Vietnam and El Salvador suggest the importance of roads in allowing households access to services and providers a way to reach clinics that serve those households. Cross country evidence suggests a role not only for roads but for energy, the latter to promote modern forms of energy – electricity, gas or even improved cooking stoves - which can improve household air quality that is linked to respiratory illness, a leading cause of child mortality in a number of countries. Electricity can help maintain food quality and facilitate safe water use through boiling, something that is much more difficult and often avoided when fuel wood is used to purify water through boiling. Such factors can play a central role in promoting child health and survival, but their effects have often been overlooked.

19. Investments in sectors other than health are frequently synergistic with direct investments in health. For example, by lowering the time costs associated with health service visits, road improvements may make the difference between people using a health facility and not using it – between, for example, a woman receiving emergency obstetric care and surviving, and not receiving it and dying. The same is true for investments in education. Increasing education levels among girls, for example, will have health payoffs for future generations of children. In part these will come about through better hygiene and better quality home management of sick children. But in part they will be achieved through increased use of professionally delivered interventions, such as immunizations, antibiotics, and antimalarials.

F. ACCELERATING PROGRESS

What developing countries can do

20. For countries committed to faster progress on the health MDGs, what can be done will depend on several factors which vary from one country to the next. This needs to be carefully analyzed as part of the overall MDG strategy embedded in the larger national poverty strategy and public spending program. The factors include: the scope for improving the productivity of existing government health spending; progress outside the health sector, economic growth, water and sanitation, female education, rural transport, etc. which depends, in turn, at least partly on development assistance for these other sectors; the scope for bringing about reductions in mortality and malnutrition by careful targeting of additional spending on the removal of key impediments; the amount of

additional spending that the country can be reasonably expected to finance itself; and the amount of additional development assistance for health (DAH) that the country can realistically absorb.

21. The next step is to mobilize at the country level and this would typically include the following set of actions:

- *Developing a credible strategy.* Countries would prepare, as part of the PRSP process, a credible strategy and implementation plan for achieving faster progress towards the health MDGs, based on a solid analysis of the impediments and constraints to faster progress, and a thorough assessment of policy options.
- *Tackling key constraints.* Although constraints are context specific, some common cross-cutting issues include human resources, safe and predictable supply of drugs, stronger management systems, and more effective public-private interactions.
- *Adopting a strong multisectoral framework* within and beyond the health sector. A multisectoral framework needs to be explicit about (i) policy changes beyond health that will support health systems building, e.g., overall public administration reform, and (ii) other multisectoral activities, e.g., in education, water and sanitation, that can contribute to the health MDGs if undertaken alongside measures to improve the functioning of health systems.
- *A commitment to improving governance and policies.* Countries would commit to a series of actions to enhance governance and policies influencing progress toward the health MDGs.
- *Strengthening transparency, monitoring and evaluation.* Countries would commit to open and transparent reporting on progress and problems, and donors would likewise agree to independent scrutiny of their performance in backing developing countries.
- *Providing voice to citizens – especially poor people.* Government would provide a voice to its people -and poor people in particular- in the formulation of its strategy and its implementation. The consultations would be undertaken as part of the PRSP process and otherwise, and include NGOs and communities.

What the World Bank can do

22. Through diagnosis of the various demand and supply factors mentioned above, countries and donors can identify the impediments to faster progress toward the MDGs, and estimate the costs and impacts of removing them. The World Bank is well positioned to help address some of the challenges for the achievement of the health related MDGs.

The World Bank's comparative advantage

23. The Bank possesses a unique combination of strengths and capabilities that it should use to contribute to the achievements of the MDGs. The most important, and where the Bank has a comparative advantage, is the ability to combine financing

capabilities with knowledge management; strong skills in economic analysis; and the capacity to conduct sectoral and cross-sectoral work based on extensive international experience. Among the core competencies that the Bank brings to the analysis of how to overcome constraints in health are:

- Taking an economic and multisectoral perspective on public health performance. This includes working on immunization, childhood diseases, communicable diseases and maternal health from a cross-cutting perspective which addresses issues such as decentralization, civil service reform, and the political economy of reform.
- Strengthening health service financing and delivery. The Bank can assist in diagnostic exercises at country level, in connection with Poverty Reduction Strategies or other similar national studies, as a way to identify the optimum mix of improved services, policies, and governance changes that would lead to notable improvements in reducing child and maternal deaths, malnutrition, and major communicable diseases. The cost of such a broad, multi-sectoral assault on the MDGs could also be estimated, and a financing plan developed covering both domestic and external sources of funding.
- Cross-sectoral work towards enhancing nutritional status. The Bank's work across agriculture, food production and distribution, micro-credits activities for women, and especially knowledge for behavior change on feeding practices, can facilitate the improvement of nutritional status among the most disadvantaged women and children.

Turning competencies into action: the World Bank's instruments

24. The Bank has several instruments it can draw on:

- Economic and Sector Work (ESW) is used for analytical work in identifying obstacles and transferring best practices and cutting-edge knowledge to clients. Increasingly, this work is done in collaboration with local experts.
- The Bank also provides strategic financing to support policy reform, assist in building capacity, and mobilize other donors.
- PRSPs and some of the newer aid instruments also facilitate donor coordination.
- Sector-wide approaches (SWAPs) recognize the importance of building common implementation arrangements, pooling donor funding, and supporting the entire sector expenditure program through the annual budget cycle and the MTEF. There is some evidence that SWAPs in the health sector have contributed to greater sectoral policy coherence, enhanced ownership, and improved resource allocations. Reviews of the Ghana health program SWAP have also documented progress in program transparency, reproductive health services, and the quality of basic care.
- The Development *Grant Facility* promotes partnerships with key players in the development arena, including NGOs and civil society organizations.

What other donors can do

25. In 2002, US\$6.7 billion was spent on DAH. While this represented an increase in assistance, compared to the 1990s, this level pales in comparison with the estimated extra \$15-30 billion which countries will need to invest to reach the health MDGs. The case for additional DAH will certainly be strengthened if developing countries and donors can improve the efficiency with which existing assistance is utilized.

26. Over the past three decades of external aid for HNP, two important lessons have been learned about the country environment. One is that development assistance does improve health, but not where governance and social and economic policies are weak. There is therefore a trade-off between targeting assistance on the most needy countries and achieving the greatest impact.

27. Second, aid for health can nurture reform by committed governments, but it cannot buy it. At the end of the day, governments themselves have to sustain commitment to a reform program. The Bank's experience in Bangladesh in the nutrition field illustrates this point. Together with UNICEF, the Bank agreed with government officials that the country could not achieve its economic goals unless it reduced malnutrition, and that a national nutrition program was a sound investment. However, long-term commitment never took root, and five years later Bangladesh's national nutrition program has weakened considerably.

28. Improving the predictability of external financing is also important. DAH has not been as reliable or sustained as often claimed, even under new "long-term" arrangements. In some countries, decreases in DAH have been sharp. DAH depends upon donor budgets that are subject to the usual business, legislative and political cycles. Further work is needed in designing DAH mechanisms that provide greater assurance of sustained, long-term financial support

29. Global initiatives in HNP, such as the Global Fund to fight AIDS, TB and Malaria (GFATM), Stop TB and the Global Alliance for Vaccines and Immunization (GAVI), can complement the activities of bilaterals and multilaterals in a number of areas by driving down drug prices, improving procurement and distribution, assisting in staff training, raising awareness of specific diseases, mobilizing additional resources, developing new treatment strategies, and stimulating R&D. However, these global initiatives can also create difficulties for countries striving to reach the MDGs. Funding to developing countries from, for example, GFATM is earmarked and typically supports certain types of expenditure, such as materials and consumables, but not salaries or capital costs. This runs the risk of creating unbalanced input mixes, especially when the grants involved can be large relative to government health budgets. Although the overall envelope for development assistance in health has increased, and new funding mechanisms such as GFATM have been established, many national health systems, especially in Sub-Saharan Africa have deteriorated since the late 1990s as shown by faltering immunization rates and declines in other service coverage rates, resulting in an increase in the gap between the MDG trends of rich and poor populations.

In this context, actions required by donors include:

- *Building on existing mechanisms* at the country level, including PRSPs and sector-wide approaches, bilateral and multilateral funding streams, and those emanating from the global health initiatives.
- *Harmonizing donor efforts* to overcome funding gaps, fungibility issues, rigidity in financing recurrent expenditures, and lack of predictability on aid flows. Accelerated progress requires harmonization of donor efforts at country level within PRSPs and ensuring space for multiple aid instruments consistent with such approaches.
- *Donor buy-in and coherence.* Donors would, together, subscribe to the country-based health MDG strategy, including its goals and targets, policy actions, financing proposals, and monitoring arrangements, within a framework guided by the PRSP and associated sectoral strategies.
- *Incremental financing.* Donors in each country would commit to providing additional long-term financial assistance. Such assistance would be disbursed through existing multilateral and bilateral channels and instruments. No new funding body would be envisaged. Donors would move towards long-term assistance in a reliable and timely manner, including further support for recurrent expenditures.
- *NGOs and communities.* Donors would increase efforts to work with NGOs and communities.
- *Lowering transactions costs.* Country governments and donors would work together to reduce the transactions costs of DAH, by seeking to harmonize reporting requirements, procurement rules, and financial management systems.
- *Monitoring and evaluation.* Donors would support capacity building for results-oriented monitoring and evaluation. Donors would also commit to an independent review of the concerted actions after, say three years and to sharing the lessons of this review with other stakeholders.

G. CONCLUSIONS AND WAY FORWARD

30. Three key messages emerge from this paper. First, the need to improve *health systems* to enable more developing countries to make faster progress towards achieving the health MDGs. There is strong agreement in the international community about the need to address failing health systems in order to rise to the challenge of HIV/AIDS, the human resource crisis in the health sector, unequal access to medicines and vaccines, and inadequate progress in maternal mortality reduction.

Second, multisectoral approaches are needed to address multisectoral problems. Recent analysis of determinants of health outcomes and review of impediments during implementation show that scaling up of available health interventions in combination with enhancing other key factors outside the health sector will make a significant

contribution towards achieving the MDGs. Recent case studies of country success are encouraging and provide valuable lessons for scaling up elsewhere.

Third, partners (governments, donors, the NGO community) need to be prepared for capitalizing on new commitments to the MDGs and related areas through leadership and effective interventions, country ownership, channels for aid to reach the "front lines", and predictability of external assistance flows. New processes and mechanisms, including PRSPs, SWAPs, budget support and medium-term expenditure frameworks, more predictable long term financing, and DAH harmonization guidelines, are emerging to improve donor harmonization and increase aid effectiveness; these need to be applied in pursuing the MDGs.

31. Concerted action is required at the country level, backed up at the global level. A shared vision and set of principles for such action has evolved among governments, development agencies, bilateral donors, NGOs, foundations and global health initiatives. A common focus is to meet the needs of developing countries by scaling up collective efforts to realize the health and poverty related MDGs, through building effective health systems. This now needs to be operationalized and scaled up at the country level. This would comprise country strategies and implementation plans, including a strong commitment to improving policies influencing progress towards the health MDGs. Donors would be asked to subscribe to these country-based health strategies, commit to provide additional long-term financing, and harmonize their support.

32. *Issues for the Development Committee:* For a concerted effort between countries and donors to accelerate progress towards the health MDG goals several issues emerge for consideration by the Development Committee.

- Incremental investments in improving health outcomes and a commitment to provide timely and reliable incremental financing to close the funding gap at the country level.
- A coordinated approach between donors and countries to address implementation challenges to improve performance of health systems within a common country framework and assist countries to work multisectorally.
- Improved and sustained political commitment at the global and country levels for improved health outcomes, as they are formulated in the Millenium Declaration.

Annex 1: Key Intermediate Indicators of Progress

Millennium Development Health and Nutrition Targets	Recommended options: Examples of intermediate or “proxy” indicators
Target: Halve, between 1990 and 2015 the proportion of people who suffer from hunger	<ul style="list-style-type: none"> • Prevalence of underweight children under five • Proportion of infants under six months who are exclusively breastfed • Percent of children 6 – 59 months who received one dose of vitamin A in the past six months
Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	<ul style="list-style-type: none"> • Proportion of 1 year old children immunized against measles • Proportion of children with diarrhea in the past two weeks who received ORT • Proportion of children with fast or difficult breathing in the past two weeks who received an appropriate antibiotic
Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	<ul style="list-style-type: none"> • Proportion of pregnant women with any antenatal care • Percentage of births with skilled birth attendant and or institutional delivery • Contraceptive prevalence rate
Target: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	<ul style="list-style-type: none"> • Percent of persons using a condom at last higher risk sex • Percent of sexually transmitted infection clients who are appropriately diagnosed and treated • Percent of HIV-positive women receiving antiretroviral treatment during pregnancy
Target: Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases	<ul style="list-style-type: none"> • Percent of patients with uncomplicated malaria who received treatment within 24 hours of onset of symptoms • Percent of children/ pregnant women sleeping under insecticide treated nets • Proportion of women receiving antenatal care who receive at least two or three intermittent preventive malaria treatments during pregnancy • Percent of registered new smear positive TB cases in a cohort that were successfully treated • Percent of estimated new smear positive TB cases that were registered under DOTS approach
For a complete list of recommended core intermediate and optional indicators, see report <i>Health, Nutrition, and Population Development Goals. Measuring Progress Using the Poverty Reduction Strategy Framework</i> , November 2001	