

**HIGH-LEVEL FORUM ON  
THE HEALTH MILLENNIUM DEVELOPMENT GOALS**

**OVERVIEW OF PROGRESS TOWARDS MEETING THE HEALTH MDGS**

**ISSUES FOR DISCUSSION: SESSION 1**

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## **Overview of progress toward reaching the health MDGs**

The first session of the January 2004 High-Level Forum will provide an overview of the health and nutrition-centered Millennium Development Goals and lay out the key issues that need to be addressed by developing countries and their partners, if faster progress is to be achieved.

Despite the enormous progress of the past fifty years in improving health and nutritional status of populations around the world, the scale of death and ill health in the world today remains staggering. In 2000, nearly 11 million children died before their fifth birthday and in developing regions, more than one child in four was underweight, a staggering 150 million in all. In 2002, 5 more million people became infected with HIV, bringing the total number of people living with HIV/AIDS to 42 million, and over three million people died. In 2000, tuberculosis (TB) claimed two million lives, malaria claimed one million in Africa alone, and over half a million women in developing countries died during pregnancy or childbirth all conditions that are eminently preventable or treatable.

With the 1990s drawing to a close, the international community decided more needed to be done to address these problems. In September 2001 at the UN Millennium Summit, 147 heads of states endorsed the Millennium Development Goals (MDGs), nearly half of which concern—directly or indirectly—different aspects of health

The first session of the High-Level Forum will draw on an extensive background paper on the subject to review the results of the past 13 years, starting from the MDG baseline year of 1990 up to the present. It will show that while some countries have made impressive gains and are “on track” to reach the Millennium targets for 2015, most countries are falling behind in their quest for the goals related to lowering child and maternal death, reducing childhood malnutrition, and cutting the rates of infection from AIDS, malaria, and tuberculosis. The situation is somewhat better for the malnutrition goal but less encouraging for the child and maternal mortality and infectious disease goals, especially in sub-Saharan Africa. In the case of under-five mortality, for example, the developing world has managed only a 2.5% average annual rate of reduction during the 1990s, well short of the MDG target of 4.2%. Again, the situation is most alarming in Sub-Saharan Africa where under-five mortality has stagnated, and in the low-income countries which have rising trends in child mortality over the period. The lack of progress in sub-Saharan Africa is so stark that no country there is on target for the child mortality MDG. In the developing world as a whole, only 16% of countries are on track, and only 19% of the developing world’s population lives in an on-track country.

What are the chances that the “second half” from 2003 to 2015 will go better than the first half? The background paper and presentation at the High-Level Forum argue that even with higher rates of economic growth and faster progress on the non-health MDGs that have an impact on health outcomes – such as basic education, gender equality, and water and sanitation – it will still be hard for developing countries to make up ground and reach the health and nutrition MDGs, unless extraordinary actions are taken to improve the coverage and quality of health and nutrition services.

The presentation will then proceed to examine the key factors that determine faster progress on the health and nutrition Millennium outcomes. It will suggest that a number of determinants from outside the health sector are important – especially income growth, education of girls, water and sanitation, and rural transport and communications (the latter being particularly significant in reducing maternal deaths). Simultaneous action on each of these determinants will have the largest positive effect. Beyond this, a range of interventions in the health and nutrition field can have a major impact – immunization, breast-feeding, oral rehydration for diarrhoea, and anti-malarial drugs for fever to reduce childhood illness and death, for example; or the directly observed short-course drug therapy for tuberculosis, to give another example. These and other existing technologies work very well, as demonstrated in a number of country “successes” – but unfortunately these proven interventions are seriously underutilized, especially by poor households and communities.

How can governments, civil society groups, and donors work together to see that these effective interventions reach more of the people who need them in developing countries? The opening presentation at the High-Level Forum will analyse what is known about the importance of adequate and well-designed spending, sound sectoral policies in health and nutrition, and of strong and effective institutions, in creating the right conditions for expanded utilization of the key health and nutrition interventions. Among the main messages that are to be advanced and documented in the background paper and High-Level Forum session:

- Extra government spending is needed but is not enough -- incremental spending has a major positive impact on child mortality reduction and the other MDGs only in environments where governance is good and public institutions are well-functioning. Overall and sector governance arrangements, health policies, and institutions also need to be strengthened.
- Expenditure allocation and targeting must be improved – unfocused increases in government and donor spending for health will have only modest benefit in terms of faster MDG progress, whereas additional expenditures on addressing social inequities, on poor districts and communities, and on basic services primarily accessed by the poor will have a larger payoff. There are numerous examples of effective targeting on the basis of geographic and socioeconomic criteria, service characteristics, and the use of demand-side instruments – these examples can be multiplied.
- Increased financing for the MDGs must be achieved in a balanced and sustainable way, on the basis of long-term streams of likely domestic and external financing. Many developing countries have substantial scope for reallocating public spending from other purposes to health and nutrition activities, while at the same time donors can provide expanded and more predictable funding to match domestic efforts.
- Public policies to stimulate and support households must be brought front and centre – household demand for services and the simultaneous role of households as producers of better health have been largely neglected by governments and donors. Much more can be done through the lowering of price and physical barriers to access, while at the same time, education, information and income support can be used to enhance the performance of households, and especially of mothers, in improving the health of their own household members.

- Policies to improve service delivery for the poor need to be enacted – a range of approaches have been shown to strengthen management and supervision in the public sector, and to encourage NGOs and the private sector to provide high quality health and nutrition services.
- Essential public health functions must be supported with stronger policies and investments. At a time when many governments and donors are focusing on specific diseases and health conditions, it is vital that investments are made in key areas where the public sector must play a role, such as policy and programme formulation, disease surveillance, monitoring and evaluation, training and certification of health professionals, and regulation and accreditation of facilities and health insurance bodies.

The overview will finish by looking at the implications of this analysis of determinants and underlying policy and institutional choices for donors and development assistance for health (DAH). The presentation argues that while DAH has grown significantly in the past two years, more external support is needed to accelerate progress toward the MDGs. At the same time, many lessons have been learned about how to make DAH more effective, and these must be shared widely and applied in other developing countries. Broad budget support can work in countries with good governance, and in a number of environments, arrangements that pool donor funds and use a common framework for disbursement, procurement, monitoring, and reporting are helping to lower transaction costs and build national capacity. Under these circumstances, relatively new mechanisms for DAH including Poverty Reduction Support Credits and Sector-Wide Programmes (SWAPs), as well as instruments that link financing to measurable performance, are showing promise. At the same time, much more needs to be done to increase the long-run predictability of external financing for health and nutrition and find effective modes of external support for countries with weak governance, including those still involved in or emerging from conflicts. The common agenda on harmonization of implementation arrangements and procedures among donors also need to be pursued more vigorously and in more countries.

Following the presentation, a panel consisting of officials from two developing countries (Cambodia and Senegal) and from partner agencies (France and the European Commission) will provide their perspectives on the main policy implications of the MDG challenges and their suggestions for making faster progress at country level.

#### **Key issues for discussion in the first session**

High-Level Forum participants may wish to address several of the main issues raised in the presentation and companion background paper. They include:

- *Increasing the effectiveness of government and donor spending for health and nutrition – how to improve targeting.* If spending is to expand, how can governments ensure that a substantial share of incremental expenditure goes to those health and nutrition interventions that really work, and that these reach the poor and underserved? How well do approaches such as conditional cash transfers and community-driven development work in achieving such targeting? What information is needed to track the extent to which interventions are reaching their intended targets and health inequities are declining?

- *Raising the coherence and sustainability of financing for the health MDGs.* While it is widely agreed that all major sources of funding for health and nutrition should be consistent with national frameworks, including poverty reduction strategies and government expenditure programmes, what should be done in cases where the PRSPs lack ambition or where policies and spending plans are not well linked to faster progress on the MDGs? And while it is also widely accepted that financial sustainability is important, how should governments and donors think about sustainability in countries where current spending for health and nutrition may amount to less than US\$ 5 per capita annually, against estimates that run many times higher that may be needed to reach the MDGs? Can significantly increased external financing for the health MDGs be made compatible with sound macroeconomic management in low-income countries?
- *Identifying innovative and effective policies for improved service delivery.* Where the government currently plays an important role in delivering services that are vital for improved child and maternal health and disease control, prevention, and care, what are the models and examples of successful public provision that can be replicated? And where NGOs and the private sector are active and provide a substantial share of basic interventions, how can governments and donors stimulate these private actors to raise the coverage and quality of their services?
- *Capitalizing on the strengths of categorical health and nutrition programmes.* In recent years, the number of global and national programmes focusing resources on specific diseases (e.g. HIV/AIDS, malaria) and health and nutrition conditions (e.g. micronutrient deficiencies) has grown. While these “categorical” programmes are leading to the development of new and improved technologies (vaccines, drugs, diagnostics) and delivery systems, they also create certain risks and challenges for sustained progress toward the health and nutrition MDGs. There is a danger, for example, that heavy emphasis on the categorical programmes may divert attention and resources from vital public health functions that cut across the health and nutrition sectors, such as investing in stronger disease surveillance systems. In some countries, each categorical programme seems to compete with one another by placing uncoordinated demands on the same scarce pool of national health managers and technical staff, who are pulled in too many directions and end up neglecting other important health issues that receive lower levels of international financing and political support. How can these competing forces be reconciled at country level? And how can the considerable energy and resources of the categorical programmes be harnessed in order to strengthen broader health and nutrition systems while feeding into a coherent national programme that matches nationally-determined priorities?
- *Addressing the crisis of human resources for health and nutrition* (to be tabled again in the afternoon of 8 January). Shortages of human resources for health are proving to be a major bottleneck to faster MDG progress. These shortages are exacerbated by inadequate terms and conditions of employment in the public sector, weak supervision systems, out-migration, and attrition due to HIV/AIDS. What can governments and donors do to reverse this situation?