

**Investing in health of the poor**  
**Regional Strategy for Sustainable Health Development and Poverty Reduction**

***Executive Summary***

Multiple challenges are impeding the efforts and progress towards the attainment of good health and sustainable development in EMR. Poverty has been shown to have a direct relationship on the efforts for the poor to attain better quality of life. Pro-poor policies can deliver more effectively if these challenges are addressed and diseases affecting the poor more than the rich are targeted. There is no doubt that more resources are required, in addition to improving the performance and efficiency of individual programs. Multi-lateral and bilateral agencies, global funds and commissions, UN Organizations and affluent countries will have to accelerate their efforts to assist policies and initiatives that attack the poverty trap and enhance the social status of the poor communities.

It will be important to merge at national level the different process of implementing the international development agenda (MDGs, PRSP, HIPC). The health sector can take the leadership, building on its cross sectoral aspect to demonstrate that objectives of reducing poverty are very much consistent with the content of improving the health outcomes of the poor and implementing health reforms that are required in many poor countries. The ministries of health are also called upon to play a more proactive role by influencing policies made outside the health sector. This not only requires the health ministries to become advocate for good health outside their domains but also places an onus on them to support their argument with evidence and information. It is pertinent to capitalize on the existing interventions and resources. Of particular importance to the EMR are the ongoing Community Based Initiatives that can effectively be used as a springboard for formulating pro-poor policies and executing the recommended strategic directions (both intrinsic and extrinsic).

## **1. Introduction**

There has been a paradigm shift in the perception and vocabulary of development in recent years. Where once development was equated with economic growth, which was seen as the ultimate goal, poverty reduction is now seen as the over-arching achievement of development. Where the route to economic growth was once seen as running through investment in physical capital, it is now recognised that many forms of capital, including human and social capital, contribute to the growth of output. Poverty itself is recognised as a multifaceted concept, not simply a matter of insufficient income, but also a matter of insufficient or inappropriate earning capacities in relation to ill-health, ignorance, and lack of power and voice. Where once it was assumed that the benefits of economic growth would eventually “trickle down” to the poor, the delivery of welfare to the poor in the forms of improved livelihoods, social services, and benevolent governance is now seen as both a direct assault on those multiple deprivations and as an investment in the capacities of the poor to lift themselves out of poverty. Economic growth is still perceived as desirable, but it is for its instrumental value in enhancing the resource base to deliver social services, productive employment opportunities and better governance, not as an end in itself.

This paradigm shift is reflected in the Millennium Development Goals (MDGs), adopted unanimously by all countries of the world at the United Nations in September 2000. The first goal is the halving of the proportion of the population living in extreme poverty. Three of the supporting goals are concerned with health, one each with education, gender equality, and environmental sustainability, and the last is the instrumental goal of forging a global partnership for development. These goals are not free standing, but are mutually synergistic. The implication is that achievement of the over-arching goal of poverty reduction will not occur unless the supporting goals are also met. Recent thinking has sought to bring health to the centre of the development debate by asserting that poor health is a manifestation, as well as both a consequence and a cause, of poverty<sup>1</sup>. It is therefore a challenge to all health authorities, national and international, to deliver the gains which are supporting pillars to the overall achievement of poverty reduction and human development. National poverty reduction strategies are expected to demonstrate how the benefits of development will reach the poor, and to put in place monitoring systems and the processes by which these benefits are delivered. Ministries of health, alone, cannot play an effective role to curtail the ill effects of poverty and improve health of the poor unless a wide base partnership is available. This can be facilitated through a coherent response by existing global processes like CMH, PRSPs, GFATM and GAVI.

Appreciating the critical nexus between health, sustainable development and poverty reduction is not sufficient. Also required is embarking on the crucial steps to move from analysis to policy, and from policy to action. Realizing the need to widen the scope from only health-focused goals towards the attainment of better quality of life, the WHO WHO Eastern Mediterranean Region (EMR) has been advocating poverty reduction as one of the most effective approaches to achieve equitable development and health improvements. Community Based Initiatives such as Basic Development Needs, Healthy Cities and Healthy Villages have been promoted in the Region in pursuit of this objective.

The development of a Regional Strategy on Sustainable Health Development and Poverty Reduction is an effort to build on the experience of CBI, aiming to move from micro level initiatives to macro level policies by creating partnerships on a wider spectrum. The Regional Strategy is expected to inspire Member States and partners to reshape their policies and redouble their efforts, and consider the means by which they can be supported in these endeavours by WHO and others.

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<sup>1</sup> WHO Bulletin 78 (1)-2000.

## **2. Situation analysis**

### **2.1. Linkages between health and poverty**

In common with other regions, the EMR comprises countries with variable levels of health and income. The region contains oil-rich states which achieve a high level of well-being for the great majority of their citizens, very poor countries in which a significant proportion of the population live below the \$1 a day level, and a varied group of middle income countries in which poverty and sub optimal health is a widespread concern, albeit at less extreme levels of deprivation.

Comparing regional Member States at the level of national averages, there are positive associations of per capita income, life expectancy, health expenditure and primary health care coverage<sup>2</sup>. Although there is a fairly strong implication that health differences between countries of varying prosperity are reflected in differences between socio-economic strata within each country, there is very little direct evidence bearing on this point, as the information is scanty on the poverty situation in most countries of the region. Data<sup>3</sup> about income ratio of the richest to the poorest amongst selected Arab countries (Table 1) reveals a wide disparity between the rich and the poor even in comparatively affluent countries of the Region.

**Table 1**

Income ratios of the richest to the poorest, selected Arab countries

<b>Country</b>	<b>Richest 10% to Poorest 10%<sup>a</sup></b>	<b>Richest 20% to Poorest 20%<sup>a</sup></b>	<b>Gini index<sup>b</sup></b>
Jordan –1997	9.1	5.9	36.4
Tunisia – 1995	13.8	8.5	41.7
Algeria – 1995	9.6	6.1	35.3
Egypt – 1995	5.7	4.0	28.9
Morocco-1998-99	11.7	7.2	39.5
Yemen – 1998	8.6	5.6	33.4
Mauritania – 1995	11.2	6.9	37.3

a. Data show the ratio of income or consumption share of the richest group to that of the poorest.

b. The Gini index measures inequality over the entire distribution of income or consumption

*A value of 0 represents perfect equality, and a value of 100, perfect inequality.*

Also, the analysis of original DHS data from Morocco and Pakistan, using an index of household assets and dividing the survey samples into quintiles by socio-economic status, the corresponding health status and service utilisation measures, permits some exploration of the relation between health status measures and socio-economic status<sup>4</sup> (Table 2).

**Table 2**

<b>Morocco (1993)</b>			<b>Pakistan (1990/91)</b>		
Lowest	Highest	Ratio	Lowest	Highest	Ratio

<sup>2</sup> A Background Document has been prepared to provide information to the reader about the existing social indicators and a more detailed insight into the Strategy Paper. The document contains data that has been summed up from WHO EMR as well as HQ and UNDP and WORLD Bank websites.

<sup>3</sup> UNDP 2002: **Arab Human Development Report**

<sup>4</sup> World Health Organization EMR (1999)

	Quintile	Quintile	L/H	Quintile	Quintile	L/H
IMR	79.7	35.1	2.27	88.7	62.5	1.42
<5MR	111.6	39.2	2.85	124.5	73.8	1.67
% <5 stunted	39.2	8.1	4.84	61.1	32.9	1.86

This is the clearest evidence that exists of the strong relationship which exists between health status and socioeconomic status within countries. Ideally, such information should be available for all countries, and be frequently updated as almost all the available health indicators are undifferentiated national averages (a rare exception is access to health services, which shows in some instances rural access substantially inferior to access in urban areas)<sup>5</sup>, but even this type of data is not available for all countries in the case of the more demanding indicators, such as the maternal mortality ratio.

## 2.2. Challenges

Like many parts of the world, widespread poverty, poor health status, environmental degradation and water scarcity are among the important challenges affecting social development in EMR. Challenges and issues intrinsic and specific to the region pose additional impediments to achieve sustainable poverty reduction and health development. Military conflicts and wars, sanctions and embargoes have affected many economies of the region, causing declines in productivity and disrupting markets<sup>6</sup>. Some countries struggling to recover from the ravages of war have emerged with substantial debts, limiting options for public expenditure.

Ethnic minorities and refugees account for a sizable population in the region. A major challenge faced at the moment is drafting policies taking into account the perceived health and economic needs of these populations.

Policies formulated in the social and economic sectors have started to take into account gender sensitive approaches but still these appear not to be uniformly applied and therefore do not yield the desired results. The additional factor of cultural barriers and taboos further complicates the situation. This not only impedes the implementation of economic policies but also results in the under utilization of healthcare delivery systems.

Equity concerns do not always receive the attention they should. Inequitable distribution of services (be that geographical, cultural, social or economic) tends to increase the already existing imbalance in favour of the more affluent at the expense of health and development of the poor.

Globalisation and the growth of new technologies have put additional strain on the already overburdened economies of the Region. Developments in the area of genome and genetic engineering not only add to economic and scientific challenges for the less developed economies but also have strong ethical ramifications---which seem to be more pronounced in poor populations since they have little or no access to evidence and information about the newer technologies.

A major challenge facing WHO and countries of the region is the deficient state of information and evidence about the magnitude of poverty, its distribution among different groups, the effect of poverty on health and development and the impact of poverty on the overall economy.

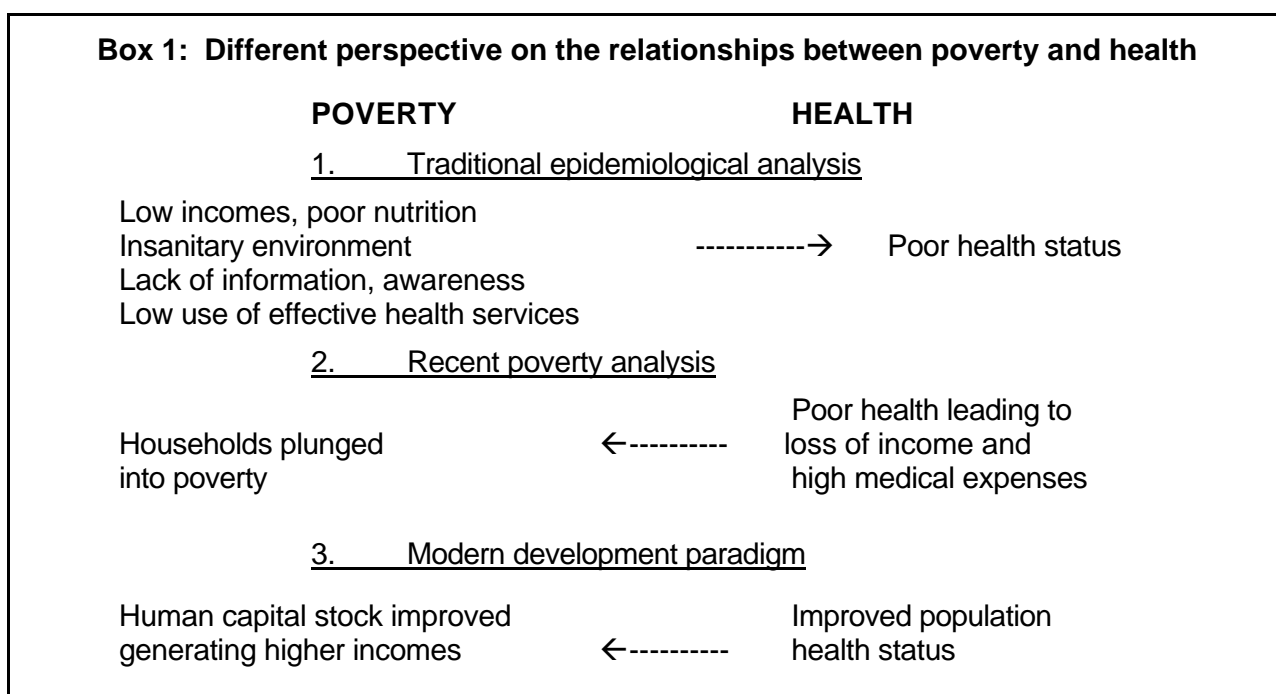
## **3. Strategic framework**

<sup>5</sup> UNDP Website.

<sup>6</sup> UNDP (2002). **Arab Human Development Report**

### 3.1. Mission and principles

The *mission* of the regional strategy on sustainable health development and poverty reduction is to spur a commitment from the member states to improve the health of the poor. Health refers to health status, not just the provision of health services. The health of the poor cannot be isolated from the health of the entire population. But experience also provides the lesson that, if no special attention is given to the poor, if the mission is defined, as simply to optimise health in general, then the outcome is that the health of the poor remains worse than the health of the non-poor, and the health status gap may even widen. The *objective* of the regional strategy is to avoid this sub-optimum outcome and to seek the maximum gain in the health of the population, and particularly its poorest members, by the application of pro-poor national health policies. A suggested definition of a pro-poor policy is a policy which, when implemented, generates proportionately greater benefits for the poorer members of society. The reason why the objective should incorporate a distributional concern is because of the intimate connections between health and poverty (see Box 1).



It is now commonplace to observe that the association runs in both directions: from poverty to ill-health, because there are consistent observations that the poor carry a disproportionate share of the burden of ill health, and from health to poverty, because of the causal links between poor health status and income poverty. More positively stated, there are clear demonstrations of health improvement as a means of generating income growth, as the return on improved human capital. Both of these associations are important, but the one which is most open to policy intervention by the health authorities is the connection that runs from improved health status to poverty reduction. The most direct contribution, which the health sector can make to poverty reduction, is by improving the health status of poor households.

Key *principles* to achieve the mission stated above include the following:

1. Supporting the Member States in developing a shared vision for health and development

and in formulating national strategies focusing on health of the poor based on poverty analysis and measurement;

2. Creating synergy for pro-poor policies by integrating different initiatives and developing methodologies and approaches aiming at health improvement, poverty reduction, gender mainstreaming, human and social development and environmental health.
3. Assisting the national authorities and civil society in reducing health inequities and poverty through dynamic intersectoral collaboration and building and expanding existing partnerships so as to tackle challenges pertaining to globalization, human rights and emerging technologies and resource constraints;
4. Helping in empowering communities and vulnerable groups, particularly women to play the leading role in health and development;
5. Assisting and motivating member countries in incorporating community development approaches and pro-poor health policies in national poverty reduction policies and programmes;

The agenda set out in the above mission and supporting principles require a more proactive role not only for the WHO but for the member states as well. WHO EMR will continue to assist the member states and other partners towards achieving better health for the people of the region for successful march towards economic prosperity and sustainable development.

### **3.2. Supporting sustainable health development and poverty reduction --- 4 domains of action, 5 strategic directions**

The regional strategy identifies five critical directions distributed over four domains of action. The first four strategic directions are intrinsic to the health sector where, although wide sectoral collaboration is sought, it is primarily the responsibility of health sector to execute policies and programmes. The fifth strategic direction however, is extrinsic to health sector, as it requires multisectoral efforts to attain maximum health gains by addressing the wider health determinants and risks that disproportionately affect the poor. It is therefore essential that governments, and specifically Ministries of Health, should take a wider view of their responsibilities than is traditional. Whereas they traditionally focus on actions mentioned on the upper left quadrant in Box 2 (public hospitals and clinics), this strategy urges them to: -

- Engage with non government providers of medical care
- Revitalise and expand public health functions
- Advocate and participate in inter-sectoral action to promote health

#### **Box 2: Four domains of health action**

Public Hospitals  
and clinics

Non-government  
hospitals, clinics  
and pharmacies

MEDICAL  
CARE

Public health functions: environmental regulation and health promotion	Inter-sectoral action to promote health	WIDER DETERMINANTS OF HEALTH
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The modes of intervention that are available differ across these four domains. While the Ministry of Health can give direct instructions and budgetary allocations to the public provider system, including its public health component, when it engages with other sectors and non-government providers, it cannot give direct orders. It can influence the conduct of these providers by a mix of various forms of regulatory action ranging from restrictive licensing to positive accreditation, subsidy, exhortation, and collaborative agreement. Similarly, it cannot give direct instructions even to public agencies in other sectors, still less to other types of partners. The main tool, which it can deploy, is advocacy by providing evidence, the presentation of arguments for actions in other sectors such as education, agriculture, nutrition, environment, energy, transport, water supply and sanitation along with better economic opportunities, which will produce health benefits. In some cases, the Ministry of Health can offer participatory action in collaboration with other Ministries and relevant governmental or non-governmental entities, which have the prime jurisdiction in the sector concerned. For example, there are many opportunities for collaboration between the health and education sectors. The important point is that the Ministry of Health must initiate and inspire inter-sectoral action for health, because health is not at the top of the agenda in other jurisdictions. Without pressure from the Ministry of Health, the opportunities to work for better health outcomes through interventions in other sectors would be lost.

The strategic directions recommended by the regional strategy are summarised in Box 3.

### **Box 3: Five strategic directions for pro-poor health policy**

<b>1. <u>Reallocate resources and services by targeting poor and vulnerable people directly</u></b>	<ul style="list-style-type: none"><li>• reallocating resources by geographic areas (e.g. population related resource allocation formulae)</li><li>• developing and adequately funding universally accessible systems of primary health care supported by appropriate referral hospitals</li><li>• countering imbalanced and inequitable distribution of human resources</li><li>• encouraging non-government provision in under-served areas</li><li>• adapting services to specific needs of poor (pastoralists, refugees street children)</li></ul>
<b>2. <u>Concentrate on the diseases and conditions of the poor</u></b>	<ul style="list-style-type: none"><li>• combating the high impact communicable diseases (TB, malaria, HIV/AIDS)</li><li>• providing reproductive health (pregnancy and delivery care, STIs, family planning)</li><li>• preventing childhood diseases (EPI, IMCI)</li><li>• reducing malnutrition (PEM, micronutrients)</li><li>• extending support for non-communicable diseases where supported by evidence of disease burden on the poor</li></ul>
<b>3. <u>Reduce the burden of direct out of pocket payment for health services</u></b>	<ul style="list-style-type: none"><li>• increasing budget and donor funding as share of total</li><li>• operating graduated fees and fee exemptions</li><li>• discouraging unofficial fees</li><li>• encouraging collective risk sharing, pre-payment mechanisms (both formal insurance, and community schemes for the informal sector)</li></ul>
<b>4. <u>Improve the supply and effectiveness of non-personal public health services</u></b>	<ul style="list-style-type: none"><li>• expanding public information and promotion of healthy lifestyles</li><li>• undertaking food fortification programmes (iodine, iron, zinc)</li><li>• setting and applying standards for air, water and soil quality; occupational health and food and chemical safety</li></ul>
<b>5. <u>Advocate and participate in inter-sectoral action to achieve health gains</u></b>	<ul style="list-style-type: none"><li>• expanding water supply and sanitation</li><li>• preventing road traffic accidents (victims in many cases are poor pedestrians, bus passengers)</li><li>• reducing tobacco consumption</li><li>• increasing female education</li><li>• raising incomes of poor (support livelihoods, cash and in kind transfers)</li><li>• promoting local integrated community development (BDN, Healthy Villages)</li></ul>

### **3.3. Potential interventions for strategic directions**

The outlined strategic framework covers all four main components of WHO corporate policy by employing a broader public health approach to reduce risks to health, focusing on health problems disproportionately affecting the poor, making policy development responsive to the wider determinants of health and ensuring that health systems serve the poor more effectively. It tends to underpin the efforts so far made towards the achievement of 'Health for All' endeavouring to provide universal access to social, physical, economic mental and spiritual well-being. Below, for each of the strategic directions, potential interventions are identified.

### *3.3.1. Reallocate resources and services by targeting poor and vulnerable people directly:*

Institute mechanisms to provide cost effective healthcare service to the poor eliminating both the financial as well as geographical barriers. Efforts should be made to reallocate resources to the lower tiers of the service delivery pyramid, which are generally not served by high level facilities. Supporting non-government service providers in underserved areas and redistribution within the public provider system of health personnel also tend to reach poor more than the rich. Making services more geographically accessible is by nature a pro poor policy. Strengthening the Primary Health Care services and establishing effective community linkages are major strategies to reach the un-reached. An alternative approach is to provide specifically adapted services for particular groups of the poor and vulnerable, who do not readily use conventional services. Countries and WHO need to operationalize the recommendations of the Commission on Macro Economic and Health and develop health component of Poverty Reduction Strategic Papers to secure adequate assistance from the donors

### *3.3.2. Concentrate on the diseases and conditions of the poor:*

Employ programs and policies leading to integrated and sustainable delivery of services that effectively reach the poor strata of the society, particularly women and children, at a place and cost which they can afford. Strategies like IMCI, Safe Motherhood, Nutritional support through food fortification and food subsidies have been shown to reach the poor more effectively. Defining a package of essential services, giving preferential allocations to its components and ensuring a high rate of its utilization will offset the burden caused by these diseases. An important source of contribution is access to the GFATM and GAVI. Actions towards combating noncommunicable disease should also be instituted wherever evidence suggest the need.

### *3.3.3. Reduce the burden of direct out of pocket payment for health services:*

Financial barriers to access health services are as important as physical. In EMR out of pocket payment as a percentage of all financing resources ranges from a low of 4% to a high of 79%<sup>7</sup>. The recommended solution is to move to greater reliance on various forms of collective pre-payment. Social insurance is one such option in which the rich pays for the poor. Alternatively, the state pays premium for the poor or otherwise disadvantage groups, either at the normal rate or concessional rate. Operate fee exemptions for the poor or provide financial incentives for the services most commonly used by the poor to mitigate the negative impact of user fee. Special focus is required for ethnic minorities and more disadvantage groups like refugees.

### *3.3.4. Improve the supply and effectiveness of non-personal public health services:*

Establishing mechanisms for informing the public about risks to health and expanding the existing information to the poor enable them to be participative and responsive to modify lifestyles detrimental to health. Regulating the environment, be it control of pollution of air, water

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<sup>7</sup> UNDP & World Bank (2000). *Spinning Off for Sustainable Microfinance*-A case study by Regional Bureau of Arab States UNDP in cooperation with World Bank.

or soil, occupational health and food safety, produce benefits for all citizens, but particularly poor, who are most exposed to the hazards of polluted environment. Caution should, however, be observed not to limit such interventions to the major cities and the affluent suburbs but it is necessary that environmental protection measures extend to the slums and the rural settings. Fortification of staple foods with minerals like iodine, iron and zinc is not only an extremely cost-effective way of ensuring protective levels of intake for the entire population, but its value is particularly great for the poor whose normal diet does not guarantee the required intakes.

#### *3.3.5. Advocate and participate in inter-sectoral action to achieve health gains:*

The Ministries of Health need to advocate action by, or collaborate with, partners in other sectors of government, with enterprises and civil society to achieve health related goals like provision of safe drinking water and improved waste management, making healthy public policies (regulation on smoking), mitigating environmental pollution and increase opportunities for female education. Offsetting the social pressure by engaging the poor communities in economic development schemes will narrow down this gradient and improve not only the social well being of the poor communities but will resultantly improve their chances of access to better environment. Community Based Initiatives can be regarded as one of the tool implementing the concept of intersectoral collaboration to generate sustainable livelihoods and improve social conditions, including health outcomes. In the long term, community mobilization will form an important ingredient for sustainability, not of only health services, but of all development benefits.

### **3.4. Pre-requisites for success**

The very considerable agenda for pro-poor health action outlined above does imply the need for additional resources, specifically in the public sector, both from domestic budget allocation and donors assistance.. For some of the poorer countries, additional resources might come from the debt relief offered to countries qualifying for enhanced Heavily Indebted Poor Countries (HIPIC) initiative. Debt relief per se does not create a new inflow of resources; what it does is allow governments to reallocate funds previously earmarked for external debt service to domestic expenditure, thus making possible higher expenditure on health and other social services among other uses. Under the new arrangements announced in 1999, debt relief has been linked to poverty reduction by making the grant of debt relief conditional on the production of a PRSP, a comprehensive document prepared by the national authorities setting out a national strategy for poverty reduction and proposed changes in resource allocation. The requirement to produce PRSPs is now extended to many countries, which sought to use the concessional finance facilities of the IMF and World Bank. Under the PRSP agreements, up to 25% of the incremental resources can be applied to the health sector. It is expected that countries with well-constructed PRSPs would attract additional bilateral and multilateral funding. An important role for WHO is therefore to assist Ministries of Health in developing efficient and evidenced based health contents of the country PRSPs.

A second possible source of additional resources might be enhanced donor transfers, as recommended by the report of the Commission on Macroeconomics and Health. The report argues that countries might be expected to find an additional 1-2 per cent of GDP for health, by 2007, but acknowledges that even this daunting achievement would still leave many of the poorer countries short of the target of \$30-40 per capita annual expenditure. The difference could only be made up by vastly increased donor support to the health sector, up from \$2 billions to \$20 billions annually. Although doubts remain that such a vast increase in donor generosity will occur, two recently introduced grant mechanisms provide sufficient hope and promise for the future. These are the Global Fund for AIDS, TB and Malaria (GAFTM) and the Global Alliance for

Vaccines and Immunisation (GAVI). Similar efforts can be replicated in the region including a possible Regional Fund for supporting pro-poor health policies and interventions.

Taking these sources together (debt relief, domestic budgetary increases, and increased donor flows) there is at least the prospect that some of the incremental resources required to implement the proposed strategy can be found. An implication of the new international arrangements is that funds will flow preferentially to those countries which can demonstrate that their policies are genuinely pro-poor, and that are able to meet donor and civil society expectations of probity, transparency and accountability in the management of resources.

Efforts towards poverty reduction employed by different institutions/organizations/countries are often plagued with bad governance when it comes at implementation of programmes. Good fiscal controls, effective human resource development, meaningful management reforms, concrete accountability measures, good rapport between the community and public sector, gender sensitive policies and plans are all directions adding complementarity to the resource mobilization efforts. Much can be achieved by employing simple techniques taking cognisance of the externalities, which may have, at times, more important bearings on poverty reduction than mere making more resources available. Good health promoting practices and designing programmes and interventions which tend to focus on cost effectiveness and cost efficiency are pragmatic measures for achieving desired results.

Since poverty reduction and sustainable health and development are multi-dimensional issues, wide spectrum partnerships are required with clearly outlined roles and responsibilities. Institutions (World Bank, Asian/African/Islamic Development Banks), organizations (WHO, UNDP, UNICEF, UNIDO), funds and consortium (GAVI, CMH, GAFTM), countries, NGOs and civil society have to take a more proactive role and build on the pro-poor policies and interventions to break major barriers towards sustainable development.

What is important to realize is that activities and interventions are integrated at macro and micro level reinforcing actions towards sustainable health and development. Integration within and outward would draw mutual strengths and would reduce the resource gap towards the attainment of national strategies. Equity implications can only be addressed when integrated actions and policy formulation are instituted at the corporate and country level.

#### **4. Rationale and contribution of existing programmes**

With a view to identifying the potential for sharper policy focus or resource reallocation in the region for the strategic framework suggested above, a review undertaken of the current (2002-2003) and prospective (2004-2005) EMRO Programme Budgets points that almost all programme areas remain under funded. Over the recent years, EMRO has suffered the double squeeze of the progressive erosion through inflation of the real value of a fixed nominal regular budget, and the reallocation of resources from the region to others consequent on the passage of resolution WHA51.31 that will have produced a cumulative reduction of 9.6% in the regional allocation by 2004. Although 50% of the region's population lives in low-income countries, it is receiving very limited access to voluntary contributions to support country level activities particularly in the areas of poverty reduction, healthy environment and health system development. Consequently it remains the case that each programme area is exiguously staffed at the Regional Office, and has little discretionary funding to support major initiatives.

Although the overall priorities in the Regional Office are in line with the requirements of support to a pro-poor reform strategy and these appropriate emphases are carried through to the content of individual programmes, yet there is increased realization of the fact that these can no longer be

sustained in the existing manner. The cumulative benefit to poor population can be transferred only if contribution by different programmes is reinforced-something which can be done only with more resources. A uniform thinking within the organization, not only at the regional level but at the HQ level as well, needs to be developed about the issue of resource allocation so that individual programmes do not suffer at each other's expense. For additional funding, the priority areas in terms of the ability to support national pro-poor health reform efforts include health financing, health service management including relations with non-government providers, health promotion, health system strengthening and environmental health.

The distinctive feature of the CBI (Basic Development Needs, Healthy Villages, Healthy Cities), which is an important vehicle for implementing strategic directions at local level, requires at the same time scaling up since it is not only in line with the global efforts of poverty reduction and sustainable health & development but also a progressive tool towards the attainment of MDGs.

## **5. Capacity building**

The regional strategy proposed here assumes that national governments, and specifically their Ministries of Health, will need to take on a much wider range of functions than they have traditionally. This implies the need for institutional development (the creation or expansion of specialized units within the Ministry and possibly coordinating agencies such as the Ministries of Finance, Planning, Education, Trade and Industry, Agriculture, Housing), and the staffing of those units with personnel deploying relevant skills. It may be anticipated that needs will be identified for greater capacities in policy analysis, information systems, health advocacy and inter-sectoral working, negotiation and analytical skills, behaviour change communications, environmental health, health programme planning and health financing. Moreover, building the skills and capacities of the community to respond effectively to these disciplines also seems to be critical because of the strong partnership role communities tend to exhibit.

In the light of the dearth of relevant information to support policy making, it may be assumed that strengthening information systems will become a major component of support to countries. As we are critically highlighting the importance of wide sectoral partnerships, globalisation, gender mainstreaming, human rights and ethnic concerns, evidence on the relation of these issues to health and health services is required to effectively reach informed decisions. Capacities at the country level, at the moment, for searching and accumulating such evidence are scant. The challenge for WHO will be to support the development of new skills and methods of working in the organization and in the countries. It is important to stress that it is not just the Regional Office but also HQ whose resources can be deployed in support of the national authorities. All available means for disseminating new ideas can be used including:

- Consultation visits by staff of Regional Office and HQ
- Consultation visits by external consultants
- Training workshops organised at sub-regional, regional, inter-regional and local levels
- Exchanges of experience and distillation of best practice
- Preparation and dissemination of tools, survey instruments, operational guidelines
- Information exchange using web based systems
- Building alliances and partnerships with academic and research centres, civil society and international NGOs, in and beyond the region

## **6. Monitoring and evaluation**

The system for monitoring the adoption and implementation of pro-poor health reforms should be

designed to avoid burdening national governments with excessive investigation or reporting requirements. It should focus on maximum exploitation of existing data systems, and it should not expect rigorous measurement of changes in health status to be reported at frequent intervals. Indicators of progress on an annual basis might include: adoption of formal policy positions; evidence of participation by civil society organisations in national decision-making, (re) allocations of resources in pursuit of strategic objectives; measures of activities, including utilisation of services of various types; demographic indicators (where data systems of adequate reliability exist); and periodically, the results of population based surveys, such as the DHS.

It is important to note that the Millennium Development Goals do not provide a wholly satisfactory framework for monitoring the implementation of pro-poor health policies. This is because the Goals themselves are framed in terms of national averages, whereas the definition of pro-poor action proposed here is that which generates disproportionate benefits for poor people. It is therefore desirable that information on MDGs is collected by adopting the process and tools that allows for disaggregation by socioeconomic group, or by some proxy such as rural/urban or regional distribution.

The Millennium Development Goals are largely expressed in terms of health status outcomes, and so are the corresponding targets and measurable indicators. These are appropriately the ultimate test of successful policy implementation, but by their nature, population related data are not generated by routine administrative processes (other than comprehensive vital statistics systems) and they are difficult to measure at frequent intervals. There is therefore a need to make periodic special efforts, usually involving household survey methods, in order to measure final outputs in the form of health status changes. An appropriate balance needs to be maintained between the frequent reporting of the process indicators discussed above (monitoring) and the periodic measurement of final outputs and outcomes (evaluation).

## **GLOSSARY**

<b>ADB</b>	Asian Development Bank
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>BDN</b>	Basic Development Need
<b>CBI</b>	Community Based Initiative
<b>CMH</b>	Commission for Macroeconomic and Health
<b>DHS</b>	Demographic and Health Survey
<b>EMR</b>	Eastern Mediterranean Region
<b>EPI</b>	Expanded Programme on Immunization
<b>GAFTM</b>	Global Fund for AIDS, TB & Malaria
<b>GAVI</b>	Global Alliance for Vaccine & Immunization
<b>GDP</b>	Gross Domestic Product
<b>GNP</b>	Gross National Product
<b>HCP</b>	Healthy City Programme
<b>HIPIC</b>	Heavily Indebted Poor Countries
<b>HIV</b>	Human Immune Deficiency Virus
<b>HQ</b>	Headquarter
<b>HVP</b>	Healthy Village Programme
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IMF</b>	International Monetary Fund
<b>MDG</b>	Millennium Development Goal
<b>NGO</b>	Non Government Organization
<b>PEM</b>	Protein Energy Malnutrition
<b>PRSP</b>	Poverty Reduction Strategic Paper
<b>STI</b>	Sexually Transmitted Diseases
<b>TB</b>	Tuberculosis
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization