

Key elements for rapid scale-up

The UN Millennium Project recommends that the known interventions outlined in the previous chapter be implemented in the context of an MDG-based poverty reduction strategy, one that reaches the scale of investment needed to achieve the Goals. The implementation challenge has two main aspects. One is the sheer range of interventions that should be implemented simultaneously to achieve the Goals. The second is the need to reach large parts of the population to have a measurable impact on national outcomes. Here we describe the core elements of successful scale-up programs, citing examples that highlight the feasibility of reaching the Goals.

The need to scale up arises from the limited impact of pilot projects, or “islands of excellence” amidst a sea of inertia—small projects implemented at local or district levels without a measurable impact on national indicators (Uvin, Jain, and Brown 2000). National scale-up is the process of bringing essential services to most or all the population quickly, equitably, and lastingly (Carter and Currie-Alder n.d.). Equality and nondiscrimination, ensuring that the services reach all of the population, especially the most disadvantaged, are central.

National scale-up is a major managerial challenge for many developing countries. It is significantly more complex than planning and implementing a single project, no matter how large. Going to national scale demands an intersectoral approach and a carefully designed multiyear planning framework to ensure investments have the expected impact. For instance, expanding pre-service training is typically an immediate priority, since future implementation often cannot proceed without a dramatic expansion of human capacity to deliver services. Scaling up is of necessity a process of experimentation, requiring careful monitoring and mid-course corrections.

We stress that while governments have the primary responsibility for managing this complexity, by planning and funding the core services required to

reach the Goals, the services can often be delivered by NGOs or the private sector and with real input from civil society. Reaching the Goals thus requires a working partnership among all stakeholders.

Successful service scale-up to achieve the MDGs cannot begin without political leadership and strong government commitment. This is an absolutely necessary (though far from sufficient) condition. Once the government has committed to reaching the Goals, it must lead on four specific actions:

- Setting concrete objectives and plans of work.
- Building national and local capacity in public management, human resources, and infrastructure.
- Adopting replicable and locally appropriate delivery mechanisms.
- Monitoring to measure progress and allow for mid-course corrections.

The three other requirements for success are the involvement and ownership of communities and civil society organizations (chapter 8), mobilization of the private sector (chapter 9), and long-term and predictable funding commitments and technical assistance from donors to give countries the means to proceed (chapters 13 and 17).

Political leadership

In most of the successful scale-ups described in the previous chapter, political leadership was the primary impetus for progress, often starting with support from the head of state. A recent review of 17 large-scale successes in health by the Center for Global Development confirms that political leadership was important in nearly all cases (Levine and Kinder 2004). Heads of state and other leaders must thus establish scaling up for the Millennium Development Goals as a national priority. They can set an ambitious tone and encourage a culture of results-based management in the often inertia-bound bureaucracies of line ministries. They need support from a broad coalition of interest groups and must work to obtain that support through open communication and inclusive planning. In many countries this support hinges on a serious donor commitment to long-term predictable funding and technical support.

Uganda's success in bringing down the prevalence of HIV shows the power of political will in mobilizing national action. In the mid-1980s, when the HIV prevalence in Kampala was 15 percent and rising, President Yoweri Museveni set the stage for a national response to the epidemic by stressing that fighting AIDS was a patriotic duty of every Ugandan. He directly appealed to civic leaders for strong leadership and to the public for open communication to combat the stigma of infection. With this encouragement, the media picked up the story of "Slim," as the disease was known, emphasizing effective prevention strategies.

In 1992 the Uganda AIDS Commission was formed to coordinate a multi-sectoral response to the epidemic, and AIDS control programs were set up in the ministries of education, gender, defense, and social affairs (USAID 2002).

The president also encouraged community leaders to take up the fight and bring the message to every village and town. Today, HIV prevalence is 4.1 percent (UNAIDS 2004), which signals both a large number of deaths among the infected and a promising decline in new cases. The Uganda AIDS Commission is coordinating with 1,000 partner agencies to continue to drive down transmission and, increasingly, to provide antiretroviral treatment to those in need (Uganda AIDS Commission 2002).

There are, of course, many other important cases of political leadership leading national scale-up. In Brazil, for instance, presidential leadership and the commitment of central and local governments has been critical for addressing root causes of slums (box 6.1). Similarly, the Indian government's recent commitment in its federal budget to extending rural infrastructure and services for the Millennium Development Goals will provide a crucial mandate for broad action.

Setting concrete objectives and sequencing work plans

To ensure that the process is MDG-oriented and stays on track, it needs concrete long-term objectives and shorter term guideposts for monitoring progress. As described in chapter 4, each MDG scale-up strategy must begin with an understanding of the status of poverty and its manifestations in the country. Each country then needs to set ambitious coverage targets for 2015 that will lead to reaching the Goals. These targets should take into account the human rights obligations of the state, including the rights to health, education, and food for all. Interim coverage targets and process indicators—such as how many children have access to effective healthcare or primary education—will help in monitoring progress. Interim coverage targets and indicators should be

Box 6.1 **Transforming** **the lives of slum** **dwellers in Brazil**

Source: Caixa
Econômica Federal
2002; UN Millennium
Project 2005f.

Brazil's government has in recent years demonstrated an extraordinary commitment to ending the unchecked proliferation of squatter settlements and to encouraging sustainable urban development. In July 2001 the federal legislature passed "The City Statute," based on decades of local experimentation, to create a more equitable city. With these legislative conditions, the Secretariat for Housing and Urban Development then introduced its Slum Action Plan.

In April 2003 significant national government support for the items in the Slum Action Plan was secured when President Lula established a housing fund of \$1.6 billion for financing new housing construction and upgrading favela or slum neighborhoods. The fund was also charged with providing direct credit support to families investing in home improvement. A variety of financial instruments, ranging from microcredit to assisted loans, are available to low- and middle-income families.

The Secretariat is upgrading 30 slums and has approximately 31,000 housing units in various states of construction or rehabilitation. In scaling up these programs, priority will go to special zones of social interest, 600 of which have already been defined in São Paulo's new master plan.

disaggregated by sex, ethnicity, and income to ensure that services are reaching marginal groups at a pace equal to or faster than the rest of the population.

Sequencing investments is also a critical feature of the MDG work plans. Each country will need to decide on policy and investment priorities for early implementation, depending on local circumstances. These might be based, for example, on where the need is greatest, or where interventions can have the greatest immediate impact. The early investments should, however, include some of the Quick Wins described in chapter 5 as well as needed investments in infrastructure, human resources, and management systems. Clearly, long-term investments—such as training engineers and doctors or building roads and sanitation infrastructure—must begin early to yield results by 2015. Other long-term investments that require early implementation include improving management and statistical systems, and encouraging behavior change in the population. These investments can unlock what are often described as a system's capacity constraints and so must be made early to enable national scale-up.

Today's development planning instruments, like the PRSP's typical three-year time horizon, do not encourage planning for these kinds of long-term investments. As a result, key constraints for physical infrastructure and personnel—which, if left unaddressed, would block ambitious expansions of services—are taken as given. An MDG-based poverty reduction strategy should instead guide countries to assess these capacity constraints realistically and then to develop an MDG framework for relieving them over a 10-year period. With this 10-year horizon the "capacity" discussion can focus on how many people need to be trained and how much physical infrastructure must be built—not on how existing shortages limit the feasible scope of scaling up.

The MDG strategy group recommended in chapter 4—reporting to the head of state, the planning minister, or the finance minister—would be an important mechanism for ensuring coherence and progress in planning and implementation among government agencies and national and international NGO partners. It would be responsible for a high-level work plan that specifies the key actions of each ministry and identifies any nongovernmental partners for service delivery. Each ministry would in turn prepare detailed MDG-based work plans that include both longer term activities (training human resources or building power plants) and shorter term activities (purchasing and distributing essential drugs). In many instances public service managers will need to learn to work more closely with community-based organizations, which at a minimum should participate in the design and monitoring of scale-up plans through representation in the strategy group and through regular civil society consultations. To be sure, these complicated but necessary processes will be extremely challenging for the poorest countries with limited human resources, so international partners will often need to provide important technical support.

Building national and local implementation capacity

The short time left before 2015 means that national capacity to manage scale-up—and thus to absorb additional resources—will need to be strengthened at the same time as service delivery is expanded. The UN Millennium Project emphasizes the need for simultaneous investments in direct service delivery and in building capacity, here defined as public sector management and administration, infrastructure, and human resources.¹ These capacity investments will also have the effect of improving governance and transparency.

This two-pronged strategy is critical because waiting for capacity to grow organically or for reforms to be implemented before making the necessary investments will make it impossible to meet the 2015 deadline. Over the past decade, donors have often made funding for infrastructure and service delivery contingent on capacity building and institutional reform. But in many cases the acquired skills atrophied before the investments materialized—or the “reforms” were merely cosmetic. In other cases the aid or private investment in service delivery expected to follow institutional reforms never appeared. Allowing reforms and investments to take place simultaneously can help address the tension between the desire to have reforms in place before making investments and meet the Goals by 2015. It can also ensure that needed capacity building and reforms are grounded in reality.

Public sector management

Management systems are an essential part of service delivery, if often overlooked and underfunded. Also frequently overlooked is that the quality of public sector governance depends crucially on investments in public sector management systems. Even in countries with good governance, public management tends to suffer mightily from a lack of trained managers, poor information systems, rigid civil service procedures, and inadequate budgets to address these concerns.

The situation of public sector managers and civil service workers in many low-income countries has deteriorated over the past 20 years as a result of prolonged underfinancing of the public sector. Cash-strapped governments are often forced into draconian actions such as civil service hiring freezes, or across-the-board reductions in work forces and budgets to maintain macroeconomic balance. IMF and World Bank-supervised programs sometimes include those freezes because an increase in official development assistance that could ease the fiscal austerity is simply not forthcoming from donors. Even when IMF and World Bank staff recognize the deleterious aspects of such policies on the delivery of public services, the macroeconomic margin for maneuver may be limited unless increased ODA or debt relief are made available by the country's donors. We recommend that IMF and World Bank staff use the evidence of MDG-based needs assessments to highlight these constraints more forcefully to donor governments and to promote the needed overall increases in donor assistance (see chapters 13 and 17 for more on donor assistance needs).

In the poorest countries these fiscal austerity programs have often led to a catastrophic failure to improve public management processes. Macroeconomic stability may be achieved but the victory comes at great cost, since public services are deeply compromised (or the chance for improving public services is missed). What's more, development theory has not focused on this area. As the Shanghai Conference on Scaling Up noted, "The development literature...has largely ignored the underlying processes and systems for institutions to innovate, fail along the way, learn from that failure, and continue to expand" (Malhotra 2004). This makes reinvesting in public sector management an urgent need today. Our definition of public sector management includes planning, financial systems, human resource management, reporting and accountability structures, data and information systems to inform decisionmaking, and adequate record keeping.

Managerial roles should be clearly defined and supported, and managers should be given sufficient authority—over priorities, finances, and staff—to perform effectively. Specific management bottlenecks in many poor countries include a lack of information and communications technology and overly rigid organizational structures that discourage innovation. There is also a severe shortage of managers in most line ministries, especially at the district and community levels. Again, these are all issues amenable to investment.

Underlying good management is access to high quality data. Expanding national statistical services for data collection and monitoring measurable outcomes at the country level enables results-based management. The essence of managing for results is that good policies, based on empirical evidence and a clear understanding of the development process, lead to improved outcomes consistent with national priorities and objectives.

In many countries, decentralization has made building management capacity at regional, district, and municipal levels a particularly high priority. The intent of these reforms is correct: many aspects of program design and implementation are best carried out at more local levels of government, which are closer to those who require the services and have better access to local information. But local managers have often been given new responsibilities—for setting priorities, implementing and monitoring programs, and managing financial flows—without receiving appropriate training and without corresponding increases in their administrative budgets. Moreover, in some cases processes for ensuring the prompt flow of resources from the center to the periphery need to be streamlined, as severe bottlenecks have impeded the local use of allocated funds. Building the managerial capacity of local NGOs and developing more efficient procedures for channeling funds to them are also priorities, since these organizations are often best placed to deliver certain services, such as community HIV prevention or orphan support.

Some specific public sector functions and tools that require strengthening to improve the effectiveness of public sector managers in implementing an

ambitious scale-up of service delivery are listed below. As discussed further in chapter 7, these strategies are equally critical in promoting transparency and good governance.

- *Civil service planning.* Each country needs a merit-based civil service with adequate pay to attract and retain the human resources for scale-up within a global labor market. This requires careful human resource planning to eliminate redundancies and deploy civil servants in the most effective way possible.
- *Information technology and management systems.* Transparency and accountability mechanisms can ensure that civil servants at all levels of government have an incentive to perform. Setting up such systems requires political will but also increased resources for investing in information and communication technology and financial accounting systems to track implementation. In addition to improving transparency, those systems can make government processes such as budgeting, monitoring, and issuing such documents as licenses and registrations more efficient and responsive.
- *Monitoring and evaluation systems.* Monitoring and evaluation systems can ensure that different departments perform their tasks in the most effective manner possible. Such systems may need independent auditing structures and periodic reporting procedures. Civil society groups can be part of monitoring and evaluation at the local, regional, and national levels.

Human resources

People manage the systems of service delivery. And people deliver most services. In many poor countries the shortage of trained workers and managers is the binding constraint on scaling up services. To achieve the Goals, human resource needs across sectors have to be carefully assessed and strategies for recruitment and retention have to be created. Retention packages should reward high performance and include concrete incentives for service in rural areas. And preservice training (such as that in medical schools and teachers' colleges) will in most cases need to be vastly increased to scale up core services. Expanding tertiary training is expensive and time-consuming, and few donors have invested in this.

The human resource challenge has been perhaps most extensively researched in the health sector. The Joint Learning Initiative—an international effort to identify solutions to the human resource crisis in healthcare—reported a worldwide shortage of more than 4 million health workers (doctors, nurses, and midwives). The situation is particularly severe in Sub-Saharan Africa where numbers of health workers have stagnated or even fallen in the last three to four decades due to emigration, inadequate investment in training and salaries, and AIDS. The Joint Learning Initiative (2004) estimates that this region needs an additional 1 million health workers to effectively provide essential health services.

Training technical and professional workers is equally important in other service areas. Qualified teachers are in short supply in many countries, particularly in Sub-Saharan Africa. FAO estimates that there is a “critical need” for trained agricultural extension workers in developing countries (Van Crowder 1996). Training institutions for agricultural extension also need to be brought up to date, and those already working in the field need substantial upgrading to address new developments in agricultural technology and markets. Needs differ from context to context, but the general picture is the same nearly everywhere.

In addition to increasing the overall output of training programs, the curricula in many countries need to be overhauled to emphasize local priorities and solutions. For instance, medical schools in developing countries often use Western European or American curricula and textbooks that pay little attention to the tropical and infectious diseases the new doctors will spend most of their time treating. Similarly curricula may need updating and revision in other fields like education or agriculture.

In a series of recent interviews that the UN Millennium Project conducted with bilateral donor agency representatives on expanding capacity, very few mentioned assistance for preservice training as an area of focus. Training initiatives tend to focus much more on in-service programs, such as continuing education workshops for professionals. But there are early signs that this may be changing. Recently, the UK Department for International Development (DFID) announced a program to boost the supply of health workers in Malawi, a country particularly hard hit by AIDS. Among other initiatives, DFID is helping fund a 50 percent expansion of preservice training for doctors and nurses through investing in infrastructure and teaching staff at existing medical schools. The impact on the numbers of nurses will thus be seen within three years and on the number of physicians within five to seven (DFID 2004).

Another factor that contributes to the human resource crisis in many developing countries is the emigration of professional and skilled workers to countries offering a better wage and quality of life, also known as brain drain. This is particularly relevant in the health sector, since the global labor market for doctors and nurses has seen many low-income countries invest significantly in training outstanding young people for careers in healthcare, only to lose them to rich countries facing health professional shortages. While some migration will inevitably accompany globalization, rich countries have a responsibility not to fill their human resource gaps by draining the professional work forces of developing countries through aggressive recruiting. This is a priority for the ILO, which is seeking to develop recommendations that put more responsibility onto developed countries to train more staff of their own and to control recruitment from countries at risk of significant impact from brain drain (Lowell and Findlay 2001).

Some developed countries, like the United Kingdom, have made important strides to reduce brain drain. In 2001 the UK’s National Health Service adopted a code of practice that bans active recruitment of developing world physicians

and nurses and directs NHS employers not to use employment agencies that recruit in those countries (UK Department of Health 2004). In addition to such voluntary restrictions on recruiting in rich countries the Joint Learning Initiative recommends establishing a global educational reinvestment fund to support expansion and enhancement of training opportunities in developing countries (Joint Learning Initiative 2004).

Developing countries, for their part, should be creative in filling major human resource capacity gaps by delegating activities to lower level providers, such as nurses and clinical officers in health, and training additional cadres of frontline workers. In many cases this will require revising regulations restricting delegation. For instance, in many developing countries, nurses are taking on a much greater role in delivering antiretroviral therapy. In addition to skill delegation, countries can train special cadres of lower level providers, such as clinical officers, community health workers, and pharmacy technicians. These workers require less training than physicians or nurses and can provide important services, especially in rural and remote communities.

In many instances a basic level of competence can be achieved with only one or two years of postsecondary training. This is what the Ethiopian government is doing right now in training 20,000 secondary-school graduates as rural community health workers in a one-year training program. They will provide preventive and some curative care in hard-to-reach villages.

Community health workers should be trained as part of a healthcare team that reaches from the community to the district-level referral hospital (box 6.2). No element of the system can work in isolation. Clinics and hospitals will be

Box 6.2
Health workers to control malaria in Ethiopia

Source: Ghebreyesus and others 1966; Ghebreyesus and others 1999; Kidane and Morrow 2000.

The Tigray Region of northern Ethiopia has about 4 million people, 75 percent in sites vulnerable to malaria outbreaks, leading to high rates of malaria-induced illness and death. Health services there are poor—less than half the population lives within 10 kilometers of a health center.

The regional government introduced community-based malaria interventions for dealing promptly with malaria outbreaks. A network of 700 volunteer health workers was assigned the tasks of mobilizing communities, taking source-reduction measures, and providing clinical diagnosis and treatment. A package of interventions includes home management of cases by training of mothers and local village volunteers. District health management teams and malaria control personnel provide supervision, technical support, and free distribution of antimalarial drugs. All villages are mapped by geographic positioning systems, and HealthMapper software facilitates the surveillance of malaria and the analysis of trends.

More than a half million people receive free treatment for malaria each year through this network of volunteer health workers. Also successful is a program to recruit and train grandmothers to train neighborhood mothers in diagnosing and treating their children at home. This community-based approach led to a 40 percent reduction in deaths of children under five. It is now being implemented nationwide.

underused unless there is early recognition of conditions that require urgent care, such as serious illnesses in children and obstetrical emergencies, which often can be provided by well trained community workers. Conversely, village-level workers, who lack the skills required to provide care for serious conditions, will need to rely on functioning clinics and district hospitals.

The community worker approach is not new, but its application has tended to be piecemeal in resource-constrained settings. As part of an MDG-based poverty reduction strategy for building service delivery systems, we recommend a major scale-up of at least three types of community worker:

- Community health workers, as exemplified by China's famed "barefoot doctors."
- Community agricultural extension workers, to teach farmers about best practices in use of improved seeds, fertilizer, and small-scale water management and to mobilize communities to organize themselves to negotiate better prices for their products in local markets.
- Rural and urban community engineers, who can be trained in core tasks of infrastructure design, management, and maintenance. They would address village needs in irrigation, land reclamation, drinking water, sanitation, electricity, and vehicle and road maintenance.

Again, adequate oversight, ongoing training, and referral links to higher levels of the system should support these frontline workers.

Expanding human resources for publicly financed interventions will raise productivity and yield important macroeconomic multiplier benefits. At the same time, the public sector expansion strategy will need to be closely linked to overall employment strategies—since a major scale-up of the public labor force must be matched with the needs of the private labor market, so that private sector growth is sustained in the long term.

Infrastructure

The importance of infrastructure—including roads, ports, telecommunications networks, electricity plants and grids, public transportation, and water and sanitation networks—to achieving the Goals is emphasized throughout this report. Roads make it possible to rapidly transport women with labor complications to hospitals for emergency obstetric care and allow farmers to deliver crops to markets. Electricity grids power schools and hospitals. Water and sanitation services improve health. So scaling up interventions and coverage will be possible only if large-scale infrastructure investments are made in conjunction with the expansion of service delivery. Investments are required not only for construction, but also for operation and maintenance.

Over the past 20 years, donors have moved away from financing infrastructure for a variety of reasons, including corruption and adverse effects on communities and the environment. But there are some signs suggesting that development practice is shifting, as evidenced, for instance, by the arguments

for infrastructure in the World Bank's *World Development Report 2005* (World Bank 2004d). By integrating large-scale infrastructure into their poverty reduction strategies, developing countries can increase private investment and enable scale-up of services to meet the MDGs. Learning from experience, countries will need to mitigate the social and environmental impact of such investments and ensure transparent and accountable business practices.

As discussed in chapter 5, infrastructure projects are also a learning opportunity for countries to benefit from technology transfer. By managing the relationship with foreign firms brought in to build infrastructure, countries can make sure that domestic workers and managers develop their knowledge base (box 6.3) (UN Millennium Project 2005g).

In addition to large-scale infrastructure, countries need facilities for delivering social services, such as clinics, schools, and granaries. It is difficult to teach students without a school—and impossible to save the life of a woman with obstetrical complications who needs a caesarean section without a hospital. Development partners thus need to focus on helping countries overcome these key infrastructure bottlenecks. A challenge for developing countries is determining how many facilities to rehabilitate and build. As a general rule, facilities should be built early in the 10 years remaining to 2015, since they are so vital to delivering key interventions at scale.

To prepare draft investment plans, many countries use population-to-facility ratios as guidelines for determining how many of a given facility they need to build for their population. This is a good start. But in the final strategy,

Box 6.3
Transferring
infrastructure
technology
in Algeria

Source: UN Millennium
Project 2005g.

Algeria's construction industry has been one of the "industrializing industries" since the 1970s. The government encouraged the purchase of complex and advanced systems of technology from foreign firms. Turnkey and product-in-hand contracts were used to assemble and coordinate all project operations—from conception through implementation to installation—into one package. The aim was to transfer the entire responsibility to the foreign technology supplier.

These contracts did not lead to as much technology transfer as hoped for. The turnkey contracts did not include the sourcing or training of local skills. This meant continuing reliance on external assistance for management and skilled operations—or inefficient operation by local management.

Having learned from these experiences, the Algerian government later encouraged "decomposed" or "design and installation supervised" contracts, under which infrastructure projects are more fragmented and involve more local firms than under the integrated contracts. Local firms now take charge of the phases before installation (such as exploration and planning), previously done by foreign technology suppliers under integrated contracts. With the technical assistance and supervision of foreign suppliers, local managers now carry out the projects. This new approach reduces the uncertainty in implementation and facilitates the process of learning-by-doing in local firms, thus enhancing their technological capability. It also contributes to improving managerial capabilities of local managers, because they have more opportunities to participate in implementation.

countries will obviously need to conduct a more detailed analysis of where their facilities are located, and where and how many they need to build or rehabilitate. When building more facilities, countries also need to pay attention to equity of access. For example, many developing countries have first-rate hospitals and modern schools in their capital cities, but dilapidated facilities in their rural districts. A much more equitable distribution of resources is vital to achieving the Goals. Countries thus need to create investment plans that explicitly aim to increase the percentage of the population that has access to high quality facilities, such as the percentage of the rural population with access to a functioning clinic within 10 kilometers.

Replicable and locally appropriate delivery mechanisms

The scalability of services is aided by choosing highly replicable (or algorithmic) service protocols where possible. TB treatment protocols (such as directly observed treatment, short course, or DOTS) are typically standardized, as are malaria treatment regimens and fertilizer combinations. Standardization also enables comparison of performance across regions, enhancing quality control.

Of course one size does not fit all, and any algorithms (step-by-step procedures) will need to be adapted to local conditions. But clear and simple decision algorithms will be especially important if services are to be performed by less highly trained personnel, as suggested above. While healthcare and education have increasingly adopted standardized approaches, much remains to be done to encourage similar standardized strategies in other sectors. Academia has an important role in proposing guidelines and protocols, if there is an agreed-on best way to deliver an intervention. Where evidence is less clear, academia can work with governments to help disseminate best practices that have proven effective in simplifying the delivery of core services in local settings.

Services can be delivered through the public sector, the for-profit sector, and local or international nongovernmental organizations. The UN Millennium Project stresses the fundamental responsibility of national governments to guarantee and oversee the provision of the basic services required to meet the Goals. Actual delivery can be delegated to the private sector or civil society when it is more efficient, as is possible for such infrastructure services as water, energy, or transport in urban areas (chapters 8 and 9). Regardless of who delivers the services, the government must ensure effective access to the services by rich and poor alike. In some cases this will require targeted public subsidies, even if service delivery has been contracted out to an NGO or private company.

In choosing delivery strategies, policymakers should consider not only efficiency, but also the impact on other interventions and delivery systems. Some health interventions, such as childhood vaccinations, are traditionally delivered through freestanding vertical programs, circumventing the inefficiencies of many developing country health systems. It is also possible that more sophisticated health services, such as antiretroviral therapy, could also be

efficiently and rapidly scaled up by establishing dedicated treatment centers, supplied by dedicated distribution networks and funded directly by donors. Such a strategy would, however, endanger existing health services, and thus the provision of other critical interventions, by competing for limited resources in the short term, particularly trained staff. This approach would also squander an opportunity to strengthen all health services by building strong, unified systems that can sustain service delivery beyond 2015. Where possible, governments should identify synergies so that multiple interventions can be delivered with the same tools and infrastructure. More generally, the unified perspective of MDG-based planning requires taking into account the trade-offs between scaling up some services as rapidly as possible and building the systems required to meet all the Goals.

Monitoring and feedback

Improving the flow of information within the government is critical for increasing transparency, fighting corruption, and increasing the effectiveness of government. As part of their scale-up plans, countries need to develop strategies for improving data management and dissemination within and among all levels of public administration. These data will allow for monitoring progress and enable mid-course corrections. Sustained investments in modern information and communication technologies hold great promise for facilitating the dissemination of information to increase public sector transparency.

Investments in statistical services are also urgently needed. Today's ad hoc international statistical efforts are unreliable—often duplicative, inconsistent, and burdensome to national governments. Sustainable statistical capacities must be available to run population and housing censuses, conduct household surveys, set up vital statistics and health information systems, and compile indicators on food, agriculture, education, and the economy, among other areas.

Of 56 countries and areas in Africa, 19 have not conducted a population census in the last 10 years, nearly twice as many as in the previous 10. And many countries do not have a sustainable, coherent program of household surveys, or administrative systems to produce basic statistics routinely.² These are areas where technical assistance from development partners can be instrumental to success and where public-private partnerships can be especially fruitful. The recent Marrakech Action Plan for Statistics recommends a global framework for addressing current gaps in statistical capacity by mainstreaming strategic planning of national statistical development strategies, beginning rapid preparations for the upcoming census round in 2010, establishing an international household survey network, harmonizing donor support for survey programs, and increasing international financing for national statistical capacity building by approximately \$150 million a year (World Bank Development Data Group 2004).

Monitoring should focus on measuring the impact of investments and tracking the flow of funds. Communities are ideally positioned to report on

both. Community members know how often a doctor is in the clinic or how many children complete primary school. To reduce graft, district governments and local authorities should make funding flows transparent to community members. For example, publicly posted information on all budgetary outlays will allow local civil society to be a watchdog and provide advice to help direct funding to the area of greatest need.

MDG progress reports should be compiled periodically, with community participation, to share results within countries and internationally. This process is already well under way with the publication of MDG country reports by 90 countries. Once again, these reports should disaggregate results by sex, region, income, and, where relevant, ethnic group.

Another strategy is to use national and international human rights accountability mechanisms. This can complement the efforts of national economic and finance ministries to monitor progress toward the Goals. Using a rights-based approach, monitoring can measure achievement against a right, rather than a target. In other words, what did a given action or program contribute to the realization of the particular right? Evaluation often measures whether a given action contributes to reaching a target. But conceived in terms of rights, the same evaluation would measure not only those reached by a given action—but also the extent to which others are being educated about the right and are empowered to demand the right and whether the right is protected in legislation. (Human rights-based accountability mechanisms are discussed in detail in chapter 7.)

Putting communities at the center of scaling up

Supplying services to communities is only part of the equation in reaching the Goals. To have any impact, services must meet local needs and be appropriately used by communities. The best way to ensure that services are demanded and effective is to involve communities in planning and implementing their scaling up. So district and local authorities should consult their communities on the best ways to spend decentralized funds.

Information and education are essential in promoting community demand for services that may be unfamiliar or not considered a priority. Community members can be effective in providing such education—and in the implementation of programs and services, either as volunteers or as paid community workers. The message of a health program, for instance, can be stronger if delivered by a local person respected by the community. Nonspecialist community workers can perform important functions as well—for example, village traders can distribute free mosquito nets to the community. Beyond service planning and provision, communities can monitor government activity and ensure greater government accountability. To do this well they should have access to relevant information and meaningful recourse when governments do not deliver.

Cost can be an important barrier to the use of services by communities. Many countries, short of funds for delivering services, have user fees to help offset the

cost of service delivery. Most studies, including a recent one from Uganda where user fees were abolished, confirm that user fees for such essential services as health and education are a significant barrier to accessing services, particularly for the poor.³ To increase use of core services, indirect costs—say, for transportation and time away from work—may need to be covered for the poorest groups.

Promoting scale-up through long-term funding commitments and technical support

For any scale-up program for the Goals to work, funding has to be both adequate and predictable for the long term. For example, in many of the poorest countries, donors will need to support such recurrent costs as salaries (chapter 13). While donors are showing more interest in salary support, it needs to be put in place rapidly for eligible countries. In chapters 13 and 17 we discuss the required increases in ODA and improvements in the quality of aid that will be required to meet the Goals. Without sufficient funding for the next 10 years and probably beyond that, scaling up is impossible. A country cannot plan long-term investments in medical schools and water supply without guarantees that the funds will not suddenly dry up midway. Developing country governments frequently complain that planning for such long-term investments is extremely difficult because of uncertainty about a steady stream of donor funding. For their part, developing country governments need to increase long-term domestic resource mobilization and ensure budget transparency.

International momentum is growing to harmonize and align the planning and disbursement of donor aid to reduce the high “compliance costs” imposed on developing country governments by multiple sets of donor-imposed conditions and reporting requirements. Sectorwide approaches are one promising mechanism for harmonizing donor activity at the country level and for better aligning the funding with the government’s sectoral priorities. Using a sectorwide approach, several donors pool their funding and direct it to the budget of the relevant ministry—rather than to donor-defined projects. Most sectorwide approaches today are in health and education, but the potential exists for expanding them to other sectors as countries create long-term plans for scaling up (chapter 13).

Technical support from bilateral donors, multilateral organizations, and NGOs is also essential for scaling up services. Many UN agencies are well positioned to offer such assistance, and some, like WHO, are increasing their assistance to countries. Bilateral donors and NGOs also offer valuable technical assistance. In the context of scaling up, this technical support must focus on sharing best practices in management and oversight—as well as on more specific areas to ensure that countries quickly build the skills to expand service delivery. Such assistance may be needed for line ministries—which are often understaffed and overtaxed and require support to create and oversee the MDG-based work plans—and for civil service reform.