Chapter 5

# Monitoring Goals 4 and 5: targets and indicators

The purpose of targets and indicators is to monitor and measure progress toward meeting the Goals. But they are important for other reasons as well: in the public health field, what we count is often what we do. Indicators should not only reflect movement toward the Goals, they should encourage implementation of priority, evidence-based interventions. Equally important is the need to ensure that inappropriate indicators—or the inappropriate use of acceptable indicators—do not distort program or policy priorities. In addition, movement toward the target or indicator should occur in a fashion that promotes equity, so that marginalized groups, including the poor, progress toward better health outcomes at a pace that is faster compared to that of better-off groups. Finally, in the Millennium Development initiative, indicators are the basis for accountability.

The task force proposes several modifications to the targets and indicators for the child mortality and maternal health Goals. These modifications will help spur progress as countries adapt the Millennium Development Goals to their specific settings, working to incorporate them into poverty reduction strategies, and as the international community moves toward the major review of progress in achieving the Goals scheduled for 2005. Table 5.1 outlines the target and indicators proposed for each goal. The suggested modifications are explained in the sections that follow.

## What lies behind the averages? Monitoring equity

If MDG initiatives are to increase equity, the targets and indicators must incorporate an equity focus in their construction. For the global Millennium Development initiative as a whole, the task force proposes reframing the targets broadly to emphasize prioritization of the most disadvantaged and to encourage "faster progress among the poor and other marginalized groups" (as shown in table 5.1).

**Table 5.1**

**Proposed targets and indicators for the child health and maternal health Goals**

*Note:* Proposed modifications appear in italics.

| Goal | Targets | Indicators |
|---|---|---|
| Goal 4: Reduce child mortality | Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate, *ensuring faster progress among the poor and other marginalized groups* | Under-five mortality rate<br>Infant mortality rate<br>Proportion of 1-year-old children immunized against measles<br>*Neonatal mortality rate*<br>*Prevalence of underweight children under 5 (see Goal 1 indicator)* |
| Goal 5: Improve maternal health | Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, *ensuring faster progress among the poor and other marginalized groups*<br>*Universal access to reproductive health services by 2015 through the primary health-care system, ensuring faster progress among the poor and other marginalized groups* | Maternal mortality ratio<br>Proportion of births attended by skilled health personnel<br>*Coverage of emergency obstetric care*<br>*Proportion of desire for family planning satisfied*<br>*Adolescent fertility rate*<br>*Contraceptive prevalence rate*<br>*HIV prevalence among 15- to 24-year-old pregnant women (see Goal 6 indicator)* |

Particular attention should be paid to disadvantaged groups and geographically constrained areas, and data should be disaggregated accordingly. Obtaining baseline information on key equity indicators is feasible even in countries in which the data are poor. As a paper commissioned by the task force shows, multiple dimensions of inequity can be established using data collected in Demographic and Health Surveys and Multiple Indicator Cluster Surveys (Wirth and others 2004).

Indicators should be adapted to the local context, where possible identifying the specific disparities that policies and programs will aim to narrow. For example, a country might specify in its indicators that progress in maternal mortality for indigenous groups and groups in particular provinces, in addition to the poor, should be explicitly monitored. In all countries, it will be important to disaggregate all non-sex-specific indicators by gender.[1]

Several countries, such as Viet Nam, have already included equity considerations in their interpretations of the Millennium Development Goals, adding new goals, such as reducing vulnerability, improving governance for poverty reduction, reducing ethnic inequality, and ensuring pro-poor infrastructure development (Swinkels and Turk 2002). The task force endorses these country-led efforts and recommends that targets and indicators be framed in equity-sensitive terms wherever possible.

**The task force recommends adding neonatal mortality rate as an indicator**

### Goal 4: Child health, neonatal mortality and nutrition.

The current child health indicators are the under-five mortality rate, the infant mortality rate, and the proportion of one-year-old children immunized against measles.

There is increasing recognition that neonatal mortality (defined as death during the first 28 days of life) represents a significant proportion of child mortality—globally, an estimated 37 percent—and that the child health Goal will not be reached unless neonatal mortality is addressed. The causes of neonatal death are different from the causes of death among older children. Programs and policies at all levels must be adjusted to reflect the different strategies necessary to reduce neonatal mortality. To encourage explicit attention to such actions, the task force recommends that the neonatal mortality rate be added as a fourth indicator to Goal 4.

The underlying role of malnutrition in a large proportion of child mortality must also be stressed. The Goals currently include an indicator on the prevalence of underweight children under five years of age (the indicator falls under Goal 1 on eradicating extreme poverty and hunger). Although underweight children may be an appropriate indicator of poverty and hunger, this measure is as much a reflection of health and the health system as it is a reflection of other important goals. Child malnutrition is in part a result of low birthweight, maternal malnutrition, improper feeding practices, frequent illness in infancy and early childhood, and micronutrient deficiencies—all problems that are within the purview of the health system (Sethuraman, Shekar, and Burz 2003). For this reason, the indicator on prevalence of underweight children should be echoed in the child health Goal in country-level implementation of the Goals.

### Goal 5: Improving maternal health

The maternal health Goal is currently backed by one target (reduction of the maternal mortality ratio by three-quarters between 1990 and 2015) and two indicators (the maternal mortality ratio and the proportion of births attended by skilled health personnel). The maternal mortality ratio is extremely difficult to measure accurately, as the wide range of uncertainty in table 3.10 conveys.[2] The WHO therefore states that, while maternal mortality ratios help convey the scale of the problem, they cannot be used to track trends in maternal mortality.

The second indicator, the proportion of births attended by skilled health personnel ("skilled attendants") is also subject to multiple measurement problems (see chapter 3). Moreover, as detailed in a task force background paper (Freedman and others 2003), the proportion of skilled attendants does not vary consistently with maternal mortality ratios: particularly in very high-mortality countries, there is huge variation in the use of skilled attendants and little statistical correlation between the two indicators. Hence skilled attendants cannot be assumed to be a proxy for maternal mortality reduction.

**The task force recommends adding an indicator that explicitly tracks the coverage of emergency obstetric care**

The indicator is nevertheless important, as it is the only indicator in all of the Goals that explicitly relates to human resources. Skilled attendants will be a critical component of any strategy for reducing maternal mortality, and it is therefore important that it be included in the MDG indicators.

But the skilled attendant indicator should not be used by itself to track the reduction in maternal mortality ratio. If the core strategy for reducing maternal mortality relates to strengthening the facility-based health system, an indicator that tracks an intervention such as skilled attendants that can be (and often is) deployed *outside of that system* can lead to distortions in policy and program.

The task force therefore recommends that an indicator that explicitly tracks the coverage of emergency obstetric care be added. In 1997 UNICEF, the WHO, and UNFPA issued a set of process indicators designed to assess the availability and utilization of emergency obstetric care (UNICEF, WHO, and UNFPA 1997). For the purpose of monitoring the Goals, the task force recommends the use of the first indicator in this series, which sets a minimum standard of one comprehensive and four basic functioning emergency obstetric care facilities per 500,000 population.

The full set of emergency obstetric care process indicators gives a broad sense of a key aspect of health system development at the national level; it can also be used to sharpen policymakers' understanding of gaps in facility functioning. Over the past five years, dozens of countries have used these process indicators. A paper commissioned by the task force reviews this experience and contains the most comprehensive look at these data currently available (Paxton and others 2004). A second paper commissioned for the task force is a case study of Bangladesh. That study combines data on facility functioning generated by use of the emergency obstetric care process indicators with geographic mapping techniques to determine not only linear distance to facilities but also travel time, yielding a more nuanced picture of accessibility (Balk, Storeygard, and Booma 2004).

The ability to make evidence-based statements about the level of maternal mortality and its causes has been identified as a key factor in mobilizing the political will to address maternal mortality in many countries that have engineered dramatic declines (Koblinsky 2003b; Pathmanathan and others 2003). The invisibility—the phantom quality—of the death of women in pregnancy and childbirth is, in fact, one more dimension of the social devaluation of women (Graham and Hussein 2004). A strong, policy-relevant set of indicators for maternal mortality reduction is not just a sop to statisticians; it is a potentially powerful way to frame political demands for the fulfillment of women's right to the conditions necessary to survive pregnancy and childbirth.

#### *New target: reproductive health*

In operationalizing Goal 5, there is a serious problem of "fit" between the Goal and the target. Improving maternal health requires a policy vision and

**To dramatically reduce maternal mortality and meet the target, emergency care must be accessible and utilized**

programmatic interventions that include but go beyond those needed to reduce maternal mortality. In this respect, the maternal health Goal is markedly different from the child health Goal. The difference lies in the relationship between health and death. For infants and children, the biological causes of poor health are the same as the biological causes of most deaths. Child mortality can therefore be understood with a cumulative model: assaults of illness and poor health (such as infection and malnutrition) increasing in number or severity ultimately lead to death. Programs and policies that address the most important causes of poor health and poor development in children will, by definition, also address the causes of death.

Maternal health and maternal death have a fundamentally different relationship to each other. Pregnancy is not an illness. Yet the care a woman receives during pregnancy and delivery can influence how she experiences those events, both physically and emotionally, and so can do much to optimize her health. A woman's care during pregnancy and delivery can also have enormous influence on the survival and early health status of the child she bears. But, somewhat counterintuitively, most of the elements of routine care during pregnancy have little impact on the chance that a woman will experience a life-threatening obstetric complication—and once a woman does experience a complication, the routine care given in pregnancy will not save her life. To dramatically reduce maternal mortality and meet the target, emergency care must be accessible to and utilized by pregnant women who experience complications.

Consequently, the strategies for reducing maternal mortality and meeting the target will be quite different from the strategies for protecting and promoting other aspects of maternal health and meeting the maternal health Goal overall. Those aspects are best captured by the broader concept of sexual and reproductive health endorsed at the Cairo and Beijing conferences. Protecting and promoting sexual and reproductive health has ramifications not just for health but also for multiple other Goals, including poverty reduction (UNFPA 2002c) and gender empowerment. Although sexual and reproductive health requires action in multiple sectors, health sector interventions are at the core of sexual and reproductive health strategies.

To ensure that development strategies built around the Goals capture the nonmortality aspects of sexual and reproductive health, the task force proposes adding a target modeled on the target endorsed by the global community during the International Conference on Population and Development and International Conference on Population and Development + 5 conferences, with the additional modification of ensuring that priority is given to the critical issue of equity.

> New Target for Maternal Health Goal 5: Universal access to reproductive and sexual health services through the primary healthcare system by 2015, ensuring faster progress among the poor and other marginalized groups.

**A new proposed target: universal access to reproductive and sexual health services through the primary healthcare system by 2015**

The Task Force on Education and Gender Equality has also endorsed universal access to reproductive health services through the primary healthcare system by 2015 as a critical aspect of women's capability (UN Millennium Project 2005b). That task force views access to reproductive health services as an essential component of the capabilities domain of gender equality and essential to human well-being and to sexual and reproductive health and rights.

### *Indicators for sexual and reproductive health and rights*

How best to measure access to reproductive health services is a subject of considerable debate. In the reproductive health field, there is a long history of dissatisfaction with indicators that have distorted programs by focusing only on contraceptive coverage and fertility rates. Coercion and discrimination in population programs that center on contraceptive delivery is not an historical artifact. It continues to be a live issue in many parts of the world today (Miranda and Yamin 2004; Murthy 2003). Transition from a demographic to a reproductive health and woman-centered paradigm, including its rights dimensions, requires that any indicator for measuring progress in access to contraceptive services include indicators that focus on users of those health services, their needs as they (and not the state or any other actor) understand and express them, and the ability of the health system to meet those needs.

The UN Millennium Project has identified an indicator that measures and monitors women's ability to bring into effect their stated fertility preferences as a key reproductive health-related measure of gender equality. The UN's Division on the Advancement of Women, the WHO, UNICEF, and the United Nations Population Fund (UNFPA) strongly support the addition of this indicator to the Millennium Development Goals. Choices about the number, timing, and spacing of one's children are related to consensus human rights, poverty alleviation, maternal health and child health, nutritional status, women's social and economic participation, and other aspects of the Goals (Bernstein 2004; UN 2002).

As in other areas, the choice of indicators is complicated by data availability (or lack thereof) and methodological problems. There is no perfect single indicator for sexual and reproductive health and rights. The task force therefore supports the Millennium Project's proposal to use a set of indicators, noting that these measures are to be used together and not as independent measures of progress.

The first new indicator is the Proportion of Desires (for family planning) Satisfied (PDS). This measure conveys the proportion of women who wish to space or limit childbearing and who utilize effective means of doing so. The indicator measures how well a country is able to satisfy the family planning desires of women both to space births and to limit further fertility—an outcome on which countries too often fail miserably (Ravindran and Mishra 2000). This indicator has the advantage of being useful in different cultural contexts, since it does not prejudge the expressed preferences of the women for large or small

**The first proposed new indicator is the Proportion of Desires (for family planning) Satisfied**

families but monitors their ability to translate their preferences into action (for more detailed information on the construction of the indicator and its advantages over "unmet need," see Bernstein 2004). Analyses testing the indicator show a strong association between the measure and poverty status: the poor are least likely to be able to act on their preferences (Bernstein 2004; UN 2002).

The second new indicator is the adolescent fertility rate. Adolescents are of particular concern because of their unique vulnerabilities, their greater likelihood of dying in childbirth or having unsafe abortions, and the fact that their births are more likely to be unintended and premature (UN Millennium Project 2005b).

Finally, given the huge toll that unsafe abortion has on health and on mortality, countries should also consider taking steps to track the prevalence and outcomes of unsafe abortions.

### Monitoring health systems

A central argument of this report is that a new and different focus on health systems is needed to meet the Goals. Although health has a strong presence in the Millennium Development Goals, the Goals are disease- or health status-based—improve maternal health, reduce child mortality, reduce HIV/AIDS, malaria, and tuberculosis—and all of the indicators track and reflect discrete interventions or outcomes. None reflects progress in strengthening health systems. This is a potentially serious problem. Short-term, disease-specific interventions are not necessarily the building blocks for long-term development of the health system. In fact, in some cases short-term interventions may even retard progress toward long-term goals. It is therefore essential that the indicators reflect some key aspects of health system strengthening. For example, the introduction of the emergency obstetric care indicator could possibly function as a "tracer," or sentinel marker, for a functioning health system more generally (Knippenberg, Soucat, and Van Lerberghe 2003).

Fortunately, within the international health field, attention is now being paid to the challenge of measuring the equity and strength of health systems. The task force supports the WHO's initiative to develop meaningful health systems indicators that are sensitive to equity concerns (WHO 2004c). Those health systems indicators will be most useful when they are integrated into policy and budget cycles and can inform tools for accountability.

In many countries over the past several decades, health systems have borne the brunt of macroeconomic policies determined outside the health sector and of well intentioned disease-specific initiatives designed to have a quick impact on health status. Far too often, the threat to health system functioning posed by such policies goes unnoticed until the damage is done. In other cases, the damage can be (and is) anticipated, but it remains invisible or suppressed in the policymaking process. Although some civil society groups are able to sound the alarm about the likelihood of detrimental impact, the information and data to conduct a serious assessment are often missing or inaccessible.

The task force proposes the development of a health system impact statement

This is a serious issue of accountability that must be addressed. The task force proposes the development of a health system impact statement modeled on similar tools, such as environmental impact statements, used in other sectors.

## Monitoring the Goals: the role of health information

The measurement of progress toward the Goals is only as accurate as the data allow. In the case of maternal mortality and skilled birth attendance in particular, the data are grossly inadequate, with many countries having no reliable data on these measures.

### *Vital statistics and civil registration systems*

While modeling and population-based surveys can augment our understanding of general levels and trends, they are not a substitute for strong, country-owned vital statistics and civil registration systems. Information is a theme echoed by other task forces of the UN Millennium Project. This task force seconds the call for information, starting with a simple accounting of who is born and who dies, as a critical crosscutting investment necessary for reaching the Goals. In Sub-Saharan Africa the void in health information is immense: fewer than 10 countries have viable vital registration systems (Evans and Stansfield 2004). And yet, these systems—which count and accurately classify every birth and death—are precisely what are needed to accurately measure trends in infant, child, and maternal mortality over short periods of time (Campbell 1999).

### *Population-based surveys*

Population-based surveys provide useful snapshots of health data. They are particularly important in countries in which vital registration systems are weak. In many cases, surveys such as Demographic and Health Surveys supply the data for gauging national levels of maternal mortality and resulting trends between surveys. Such surveys can play a powerful role in spurring action or political will, as was the case in Indonesia after the 1994 survey revealed an unexpectedly high maternal mortality ratio (Schiffman 2003). In addition, surveys such as Multiple Indicator Cluster Survey and Demographic and Health Surveys may well be the primary means of measuring many of the MDG indicators. Such surveys often contain data on ethnic group, region, age, sex, the educational level of mothers, and wealth quintile and thus lend themselves to equity analyses that would reveal how population groups fare relative to one another on key outcomes, including the health Goals. In keeping with this report's focus on equity, the task force advocates more extensive use of population-based surveys for this purpose.

### *Confidential enquiries into maternal deaths*

A simple accounting of maternal deaths, a difficult task in and of itself, is only the start of a well conceived strategy for reducing maternal mortality. The

**A simple accounting of maternal deaths is only part of a well conceived strategy**

death toll must be explained, through a careful evaluation of the avoidable factors that lead to maternal deaths (WHO 2004a).

Several approaches are available for investigating the causes of individual maternal deaths, including community-based maternal death reviews (often called verbal autopsies) in settings in which most births take place at home; facility-based maternal death reviews; confidential enquiries into maternal deaths; surveys of severe morbidity; and clinical audits. The rationale for each approach and its advantages and disadvantages are outlined in a WHO report entitled “Beyond the Numbers” (WHO 2004a).

Importantly, the defining characteristic of all these approaches is the emphasis on confidentiality in order to ensure open, detailed reports of the sequence of events culminating in a maternal death or “near-miss” event (a severe obstetric complication that requires interventions to save the mother’s life) (WHO 2004a). In countries that have enjoyed some success in reducing maternal mortality, confidential enquiries or audits have been identified as a key tool in raising public awareness and pointing to avoidable factors that provided a starting point for action. Often maternal death notification processes or maternal perinatal audits are put in place at the district or provincial level as a quality of care mechanism designed to reduce avoidable maternal deaths (Jackson and others 2004; McCoy and others 2004; Supratikto and others 2002). Near misses are another important source of information on the quality of care provided by the health system in instances of obstetric emergencies.

# Global policy and funding frameworks

Equitable and well functioning health systems depend on supportive policy environments and funding mechanisms at both the national and international levels. For low-income countries the international policy environment and external financial support are closely intertwined, either directly, through policy conditions on the receipt of external loans and grants, or indirectly, from the type of policy advice, technical assistance, or project and program support that particular donors offer.

Health systems in low-income countries are already highly dependent on external support from a variety of sources, including UN specialized agencies, funds, and programs; the World Bank and regional development banks; bilateral donors; international NGOs; and private foundations. To reach the health-related Goals, low-income countries will need even greater financial support and more coherent and visionary technical support from external sources. Inevitably, even in countries that have acted boldly to take control over the process, health systems will continue to be strongly influenced by the policy agendas and priorities of major donors.

This chapter considers some of the main policy and funding frameworks for donor support to the Goals. It examines inherent tensions within these frameworks that obstruct the strengthening of health systems and identifies how these frameworks could better support long-term investments in equitable and effective health systems.

## Influence of international financial institutions

While the World Bank is the largest single donor to the health sector, in aggregate bilateral donors provide the largest portion of official development assistance to health sectors in low-income countries. Direct loans and grants to the health sector by development banks, particularly the World Bank,

**Low-income countries will need even greater financial support from external sources**

have increased in recent years, but they still represent a small percentage of the banks' overall assistance to low- and middle-income countries (Michaud 2003).[1] Considerable technical and program support is provided by UN specialized agencies and funds, such as the WHO, UNICEF, and UNFPA.

The IMF provides no direct support to the health sector. But together with the development banks (often referred to collectively as the international financial institutions), it wields significant direct and indirect influence over the health sectors in low- and middle-income countries—and all other key sectors for that matter—through the policy conditions attached to the various types of loans they provide.

Because their support to countries is mainly in the form of loans, the main counterpart agency for the international financial institutions is the ministry of finance, typically one of the most powerful ministries in the government. This partnership tends to reinforce the influence of the international financial institutions over other ministries, including the ministry of health.

The IMF also exerts influence over borrowing governments through its functional role as the international institution that evaluates countries' macroeconomic frameworks for absorbing official development assistance and other external finance. At least since the debt crisis of the 1980s, there has been an understanding among donors that financial assistance to a low-income country is contingent on IMF approval of the country's macroeconomic situation. IMF approval is also a condition for debt rescheduling by official and commercial lenders, and it influences the ratings assigned to a country's external debt by credit rating agencies, which significantly affect the country's access to commercial loans and international capital markets.

At the policy level, the IMF and World Bank play dominant roles in donor consultative groups. Recently, they have also taken the lead in coordinating external debt relief and promoting national Poverty Reduction Strategy Papers (PRSPs) as a development planning tool. In addition, the World Bank plays a leading role in policy research and the development of various assessment tools for use by development planners.

In terms of the content of their policy prescriptions, the IMF and World Bank previously took the lead in promoting the so-called Washington consensus, which prioritized fiscal discipline, financial and exchange rate liberalization, trade liberalization and foreign direct investment, privatization, deregulation, and protection of property rights (Williamson 1993). This agenda has been tempered in recent years by a direct emphasis on poverty reduction, which highlights the need to improve poor people's opportunities, empowerment, and security (World Bank 2000). The international financial institutions focus on economic growth as the key long-term driver for poverty reduction and for achieving the Goals, as reflected in recent World Bank publications on infrastructure, trade, and private sector development, including *World Development Report 2005* (IMF and World Bank 2004a; World Bank 2004c).

**The challenge is to seek opportunities to shift the dominant discourse toward sustainable, inclusive health systems**

In the health sector the World Bank has been extremely influential in conceptualizing healthcare as a marketable (and tradable) commodity (World Bank 2003b) and in promoting various reforms based on principles of health economics, cost-effectiveness analysis, and the experience of industrialized countries such as New Zealand, the United Kingdom, and the United States (Kumaranayake and Walker 2002; Lee and Goodman 2002; Standing 2002b; World Bank 1993). This approach contrasts with the arguments set forth in this report, which acknowledges healthcare as a right and conceptualizes health systems as fundamentally social institutions that should strive to promote equity and inclusion as core values and health policymaking as a political process in which participation of the people directly affected is an important goal. Given the significant influence of the IMF and World Bank on health policies at the national level, the challenge for the health sector and all health stakeholders is to seek opportunities to shift this dominant discourse and use the development assistance frameworks in a manner that supports long-term investments in sustainable, inclusive health systems.

### Debt relief, poverty reduction, and public expenditure management

Much international development assistance in recent years has been focused on a few closely linked initiatives promoted by the international financial institutions and bilateral donors. These initiatives include external debt relief, mainly through the Heavily Indebted Poor Countries (HIPC) initiative; Poverty Reduction Strategy Papers; and public financial management (involving public expenditure reviews and medium-term expenditure frameworks). These initiatives now form the framework for external assistance to low-income countries, including support for pursuing the Goals.

At the same time, the international financial institutions, the UN system, and bilateral donors (acting through the Development Assistance Committee of the Organisation for Economic Co-operation and Development) have begun to harmonize their policies and procedures and to align their assistance programs in individual countries, in order to reduce the considerable burden on recipient countries of managing official development assistance. Taken together, these initiatives are leading the development banks and some other donors to move away from financing individual projects toward providing more programmatic support to governments. This trend can be seen in the emergence of sectorwide approaches in health and other sectors and new instruments for providing general budget support to governments (such as the World Bank's Poverty Reduction Support Credits). Meanwhile, some new donor funding mechanisms, such as the United States' Millennium Challenge Account, are also more selective about the countries they support.

All of these processes have implications for the health Goals and for health systems. As these processes evolve and are adapted in individual countries, they present new opportunities and challenges for ministries of health and other

**The actual relief obtained from the HIPC initiative has been less than needed**

key stakeholders in health systems. The international financial institutions and other donors have critical roles to play in ensuring that health systems are strengthened and made more inclusive through these processes.

### *External debt relief and the HIPC initiative*

The HIPC initiative, launched by the IMF and World Bank in 1996, is an external debt reduction program for poor countries with "unsustainable debt burdens." In principle, debt relief frees up scarce resources that HIPC governments can reallocate to health, education, and other sectors. Although the benefits of debt relief have likely been significant, in practice, it has not yet been possible to quantify the direct benefits of the HIPC initiative to the health sector. Countries that have qualified for full or partial HIPC relief increased their poverty-reducing expenditures from 6.5 percent of GDP in 1999 to 7.9 percent of GDP in 2003, which is about three times the amount the countries spent on debt service. Although the definitions of "poverty-reducing expenditures" vary across countries, basic healthcare is commonly included (IMF and International Development Agency 2004).

The HIPC initiative has been criticized on several grounds, including the criteria used to identify HIPCs, the macroeconomic and other conditions imposed, and the slow pace of implementation. In particular, macroeconomic and other targets set for debt relief may restrict some HIPCs from accessing additional external resources, especially loans, for health and other social spending; from hiring additional healthcare workers; and from raising healthcare workers' salaries. In Zambia, for example, the UN Special Envoy for HIV/AIDS in Africa complained publicly in June 2004 that IMF prescriptions for HIPC debt relief were preventing the health ministry from hiring more staff, at a time when 20 percent of municipal districts had no doctors or nurses. Oxfam has also argued that without the fiscal surplus targets required by the IMF, several HIPCs could already have doubled their health budgets (Oxfam 2003). These concerns are likely to remain, especially as the IMF and World Bank establish a more formal debt sustainability framework for HIPCs and other low-income countries under conditions of inadequate donor support (IMF and World Bank 2004b).

The HIPC initiative is significant not only for the 25 countries that have received debt relief but also because the initiative has triggered other processes, such as the Poverty Reduction Strategy Papers, that affect a much larger number of countries. Regrettably, the process for obtaining HIPC relief has been complicated and time consuming, and the actual relief obtained has been less than needed (due in part to the number of creditors not yet participating). For countries still in the process of qualifying for debt relief, it will be important for the IMF to be as flexible as possible in setting macroeconomic targets and other conditions that are consistent with achieving the health Goals.

**PRSPs need to focus on more ambitious, MDG-based poverty reduction scenarios**

***Poverty Reduction Strategy Papers and the Goals***

Poverty Reduction Strategy Papers (PRSPs), introduced in 1999 as one of the core requirements for HIPC debt relief, have become a requirement for all concessional loans from the World Bank and the IMF. Poverty reduction strategies are also now agreed upon as the main country-level framework for low-income countries to map out plans to achieve the Goals.

This means that substantially more attention needs to be given to the poverty reduction strategy process if the Goals are to be met. While many observers have viewed the principles underlying the PRSP approach as a basis for improving participatory, outcome-focused, comprehensive national planning and priority setting to better serve poor and marginalized groups, including through improvements in basic healthcare (World Bank 2004a), in practice, the PRSP process has varied considerably from country to country.

Recent studies have confirmed that in many countries the PRSP process has improved governments' capacity to conduct poverty analysis and opened up space for greater involvement of civil society groups in the national planning process (IMF Independent Evaluation Office 2004; World Bank Operations Evaluation Department 2004). But these studies also confirmed that the poverty reduction strategy process has predominantly been externally driven. Macroeconomic assumptions and targets underlying the PRSPs have generally been insulated from the consultation and timetables for the production of the PRSP, and PRSPs often have not coincided with the development of national plans and sector strategies. Country ownership of the PRSP process and the building of in-country capacity for poverty analysis and pro-poor planning has often been limited by the IMF and World Bank's emphasis on producing "high-quality" PRSP documents—typically with the assistance of consultants. Ministries of finance and planning have led the process, with varying levels of involvement by line ministries and nongovernmental groups and little input from legislative bodies. Finally, many donors have not yet aligned their country programs with countries' PRSP priorities and are unwilling or unable to provide firm, multiyear commitments of assistance.

All of these problems represent obstacles to achieving the Goals. But the most significant problem is the tension over whether the PRSP is intended to map a country's poverty reduction "needs" (as proposed by the UN Millennium Project) or to identify priorities for poverty reduction within a country's "available resources." The latter approach has previously been endorsed by the IMF and World Bank, which have encouraged countries to avoid structuring their PRSPs as "wish lists," but now these institutions have endorsed the need for PRSPs to include more ambitious poverty reduction strategy scenarios for when increased donor resources are forthcoming. It is important for these more ambitious scenarios to be MDG-based, because priority-setting based on "realistic" projections of resource availability can lead to modest, incremental changes in public expenditures that may have little impact on poverty

**It is vital that health ministries and other health stakeholders continue to engage in the PRSP process**

reduction and progress toward the Goals—and will let donors justify maintaining low levels of assistance.

*Challenges for the health sector.* The World Bank's recent evaluation of the PRSP process concluded that the first generation of strategies overemphasized public investment in social sectors such as health and paid insufficient attention to growth-related activities. This conclusion is at odds with desk surveys of PRSPs by the WHO, UNFPA, DFID, and others, which have generally found the treatment of health and poverty to be uneven and often superficial (Laterveer, Niessen, and Yazbeck 2003; UNFPA 2002a; Walford 2002; WHO 2004e). With respect to population, reproductive health, and adolescent health issues, the World Bank itself recently found that PRSPs pay a "reasonable level of attention" to these issues but that "the scope and quality of the inclusion varies enormously" (World Bank 2004b).

The WHO's second synthesis report on health in PRSPs found that many do not systematically analyze the health situation of poor people and the barriers that prevent poor women in particular from accessing reproductive healthcare. PRSPs generally recommend expanding coverage of basic health services, especially in rural areas, and providing fee exemptions for the poor, but they include little analysis of why similar approaches have failed in the past. The WHO also found that although health spending is rising in all countries in nominal terms, projected changes in health spending as a proportion of GDP are typically small and health is not generally increasing in importance within the priority sectors identified for poverty reduction. Although the IMF and World Bank have recently called for scaling up to accelerate progress toward the Goals and their leadership has been vocal on the need for a dramatic scale-up of official development assistance, their country-level processes are not yet advocating the major increases in public health spending (including large increases in donor spending) needed to achieve the Goals. Instead, they tend to recommend better targeting of proven interventions (such as skilled attendants at births to reduce maternal mortality) to reach poor and vulnerable groups, accompanied by improvements in health policies and institutions (IMF and World Bank 2004a; Wagstaff and Claeson 2004).

Despite the uneven treatment of the health Goals, health equity, and health systems in PRSPs, it is vital that health ministries and other health stakeholders continue to engage in the process, as the poverty reduction strategy becomes the main vehicle for making progress toward the Goals and aligning donor assistance. At the same time, the merger of the poverty reduction strategy process with the national planning process could inadvertently diminish the attention paid to healthcare and health systems, since the health sector historically has had a low priority in most national plans and budgets.

In this policy environment, health ministries and other health stakeholders are likely to face challenges arguing for substantial, long-term public

**Medium-term expenditure frameworks require substantial capacity to implement**

investments in the health sector. They will need to be forceful in articulating to their ministries of finance and planning not only the particular health needs and constraints of poor people but also the impoverishing effect of ill health on the majority of the population in the absence of an equitable, well financed, and well managed health system. Within the poverty reduction strategy framework, it will also be important for donors to maintain and improve their direct support to health systems, ideally through coordinated support of a national health sector strategy that is founded on principles of inclusion, equity, and rights.

### *Public expenditure management and medium-term expenditure frameworks*

Public expenditure reviews and medium-term expenditure frameworks form the third set of initiatives making up the framework for external assistance to low-income countries. Both have been widely promoted by the international financial institutions and some bilateral donors through loans and technical assistance.

Public expenditure reviews and medium-term expenditure frameworks are highly technocratic processes, typically introduced and supported by consultants and driven mainly by national finance or planning ministries. Health and other line ministries play an important but subordinate role, although this role can be enhanced where the medium-term expenditure frameworks approach is "piloted" in a few sectors. In Cambodia and Ghana, for example, the medium-term expenditure framework process was first piloted in health and one or two other sectors (Holmes and Evans 2003).

In theory, a medium-term expenditure framework aligns national policies, planning, and budgeting within a medium-term perspective (usually three to five years). The national finance ministry, the planning ministry, or both first estimate the government's total "resource envelope" for the period and establish sector allocations within that envelope. Line ministries then develop estimates of the current and future costs of their sector priorities, usually through an iterative process involving negotiation between central and line ministries. These sector costs are then reconciled with the estimates of available resources.

In practice, the medium-term expenditure framework approach has proved difficult to implement because of the substantial capacity required in all ministries and offices concerned. The results have been mixed (Le Houerou and Taliercio 2002; Oxford Policy Management 2000). Some countries, such as South Africa, are quite far along in fully institutionalizing the framework, while others, such as Burkina Faso, Cameroon, and Ghana, are at early and faltering pilot stages (Holmes and Evans 2003). Case studies confirm that the medium-term expenditure framework is effective where there is clarity about the objectives and priorities of government policy, realistic forecasting of the resources available for allocation and planning, and analysis directly linked to the allocation of resources (Conway and others 2002).

**It will be very important for health ministries to be knowledgeable about the medium-term expenditure framework process**

The medium-term expenditure framework has been criticized as a top-down, nonparticipatory approach, in which finance and planning ministries generally control the process and determine the indicative and final allocations to sectors. There has been criticism of the inflexibility of the "resource envelope" calculation that typically starts the process. This inflexibility can be particularly hard on the health sector, because health ministries tend to have relatively weak positions within government, especially compared with finance and planning ministries. This is compounded when donors, NGOs, and other funders of the health system do not provide medium-term estimates of their commitments. External assistance tends to be fragmented among a large number of multilateral and bilateral donors, international and national NGOs, and global health initiatives, most of which have their own planning and funding cycles. These commitment gaps effectively shrink the health ministry's "external resource envelope" for planning purposes and inhibit the ministry from fully costing the priorities in its health sector strategy. This can lead to a mismatch between a comprehensive health sector strategy—which is often developed with donor support—and the health sector medium-term expenditure frameworks.

*Challenges for the health sector.* With the introduction of the PRSP, medium-term expenditure frameworks have taken on a new life, with international financial institutions, some bilateral donors, and indeed the UN Millennium Project now promoting them as the "budget side" of the PRSP (Holmes and Evans 2003; IMF and World Bank 2004c; UN Millennium Project 2005a). Despite their mixed success in implementation, medium-term expenditure frameworks are likely to become even more important as donors shift toward general budget support rather than project or sector support to some low-income governments (through general loans or block grants to support a PRSP, for example). In this case donors are likely to rely on the medium-term expenditure frameworks as the budget framework for their assistance. Critical to this process are mechanisms for tracking health sector budgetary allocations and spending through the medium-term expenditure framework, in order to be able to hold governments accountable for realizing health needs. In South Africa initiatives to monitor government allocations and expenditures relating to children, women, and HIV/AIDS have served to hold government accountable to their stated priorities as well as their legal obligations (Streak 2004).

In this policy environment it will be very important for health ministries to be knowledgeable about the medium-term expenditure framework process and to be active in negotiating with their finance and planning ministries and with donors for steadily increasing allocations of resources to the health system. The international financial institutions and other donors to the health sector have a critical role in helping health ministries navigate through this challenging process. At a minimum, and as a matter of urgency, they should provide multiyear commitments to the health sector for incorporation in the medium-term expenditure frameworks.

**Poverty reduction loans can restrict social sector spending**

### Poverty reduction loans and poverty and social impact assessments

With the introduction of the HIPC and PRSP processes in many countries, both the IMF and World Bank have "adjusted" their structural adjustment loan facilities to better support poverty reduction. These "adjusted" poverty reduction loans (the IMF's Poverty Reduction and Growth Facility loans and the World Bank's Poverty Reduction Support Credits) are intended to support a country's poverty reduction program, as outlined in its poverty reduction strategy.

Poverty reduction loans and other forms of direct budget support to low-income countries—such as that contemplated in DFID's new poverty reduction budget support policy (DFID 2004)—provide mechanisms for donors to directly support national poverty reduction strategies, including the PRSPs (and therefore national Millennium Development Goals, to the extent they are reflected in a country's poverty reduction strategy). While supporting government ownership of the poverty reduction strategy, these direct financing mechanisms also have the potential to reduce the administrative costs to low-income governments of negotiating and implementing multiple projects funded by the same donor. In this respect, these general budget support mechanisms can be seen as a continuation of the trend away from project-based support, which began with the introduction of sector investment programs and later sector-wide approaches.[2]

By their nature general poverty reduction loans do not provide direct funding to health or other sectors. For example, the Poverty Reduction Support Credit funding mechanism provides for the transfer of funds from the World Bank to a single government account. Unless specifically negotiated and included in the Poverty Reduction Support Credit documents, there is no mechanism to ensure that any portion of the Poverty Reduction Support Credit will be allocated to the health sector (or any other sector).

Poverty reduction loans have also been criticized for containing stringent macroeconomic targets that can restrict social sector spending, including bans on hiring additional healthcare workers and raising healthcare workers' salaries (EURODAD 2003; Oxfam 2003, 2004; Stewart and Wang 2003). Although intended to support national priorities for poverty reduction, Poverty Reduction and Growth Facility loans and Poverty Reduction Support Credits, like the structural adjustment loans before them, also support a wide range of public sector and economic reforms that can have negative as well as positive impacts on health systems. For example, the Ghana Poverty Reduction Support Credit negotiated in 2003 with the World Bank includes a number of policy conditions related to governance, public sector management, and health. While there are general references in the document to "improving staff motivation and health worker incentives," the Poverty Reduction and Growth Facility arrangement negotiated in parallel with the IMF includes a strict ceiling on the public wage bill. As a condition for the release of additional funds by the IMF in July 2004, Ghana had to roll back part of an agreed wage increase

**Macroeconomic targets should allow as much flexibility as possible for the health sector**

to registered nurses and other core public servants in order to stay within the wage bill ceiling. Ghana is thus another country in which needed investments in the health system are subordinated to macroeconomic targets resulting from inadequate donor financing (IMF 2004; IDA 2003).

### *Challenges for the health sector*

Poverty Reduction Support Credits and other forms of general budget support appear to provide relatively limited, indirect support for health systems. In the absence of a strong national commitment to the health sector—reflected in steady and substantial allocations of budget to the health ministry—development banks and other donors should continue to provide direct support to the health ministry. Even within Poverty Reduction Support Credits, provisions can be included to ensure a certain level of health expenditures and to address significant barriers to healthcare access, especially for women and other disadvantaged groups. Macroeconomic targets that are conditions for Poverty Reduction and Growth Facility loans, Poverty Reduction Support Credits, or other forms of direct budget support to low-income countries should be as flexible as possible. Health sector expenditures (especially for human resources) should be exempted from these targets on the basis that they are poverty-reducing expenditures necessary to achieve the health-related Goals.

In response to criticisms of the economic reforms they have promoted, the IMF and World Bank, with support from bilateral donors such as DFID, have been developing tools for analyzing the poverty and social impact of these reforms. Poverty and Social Impact Analyses analyze the distributional impact of a policy reform, especially on poor and vulnerable groups (World Bank 2003a). The first set of pilot Poverty and Social Impact Analyses undertaken by the World Bank and DFID did not directly address health sector issues. There is considerable potential for using them to analyze the poverty and social impact of health sector policies or proposed changes in those policies.[3] Similar tools could also be developed to analyze the impact of broader policy changes—for example, fiscal targets, public sector reforms, or trade liberalization measures—on the health system. These tools should analyze broader distributional and equity effects on the health system, not simply the effects on the poorest groups in the population. It is also important for civil society organizations, development institutions, and others to undertake these types of impact assessments.

## Donor coordination and harmonization

For some time the international financial institutions, organizations within the UN system, bilateral donors, and international NGOs have acknowledged the significant burden on low-income countries of negotiating and implementing separate programs and projects, accommodating visits by headquarters teams and liaising with their in-country offices, and complying with their separate procurement, disbursement, and reporting requirements. This problem is especially

**It is imperative that donors provide firmer, longer term commitments of support to the health sector**

acute in the health sector, where numerous UN agencies and programs, most bilateral donors, the World Bank and regional development banks, and an expanding number of international and national NGOs are active (Buse and Walt 1997; Peter and Chao 1998). Low-income country governments, including health and other line ministries, can also be caught between competing interests and conflicting priorities of these external actors. The health sector is particularly vulnerable to these types of conflicts, given the professional debates and ideological differences on matters such as the efficacy of certain vaccines, approaches to family planning and HIV/AIDS prevention, access to safe abortion services, and healthcare financing schemes (Mayhew 2002; Walt and others 1999).

At the international level, the Rome Declaration on Harmonization, adopted in 2003 by heads of multilateral and bilateral development institutions, the international financial institutions, and partner countries, has spurred a number of efforts to harmonize donor practices and better coordinate their in-country activities in alignment with national and sector priorities. This includes continued efforts by the United Nations to strengthen in-country coordination of its agencies and programs through the UN Development Group.

Within countries, various steps are being taken to improve the functioning of donor coordination groups, NGO coordination groups, and sector working groups (which often include government and civil society representatives) (Aid Harmonization and Alignment 2004). Some donors have also been testing various types of joint funding and support of sectorwide programs, and more recently they have been experimenting with joint development assistance frameworks and joint funding of the poverty reduction strategy through direct budget support.

*Challenges for the health sector.* In the health sector, donors and ministries of health have experimented with different forms of coordination and joint activity to reduce administrative costs and improve health outcomes. These efforts have included geographical zoning of donor activities, lead agency and sector working group arrangements, joint and parallel funding of programs such as the Integrated Management of Childhood Illness and the Safe Motherhood Initiative, and various levels of participation in sectorwide programs (Buse and Walt 1997; Walt and others 1999).

Although progress is being made in several countries to harmonize donor procedures and shift from project-based to programmatic funding in the health sector, a number of key donors continue to operate outside these coordination mechanisms and to finance stand-alone projects with separate implementation units, management information systems, and reporting requirements. It is extremely important that these agencies better align their activities with the national health strategy or health sector plan and harmonize their procedures with other donors. It is also imperative that donors and large international NGOs provide firmer, longer term commitments of support to the health sector, so that ministries of health, in coordination with other ministries, can develop longer

**Donors and large NGOs must refrain from "poaching" health managers from the public health system to supervise their projects**

term investment plans for the health sector. This is particularly true in human resource development, where there is an urgent need for donors to support long-term, cross-sectoral human resource planning for health systems.

Donors and large NGOs also need to examine more critically their own practices relating to salary supplements, per diems for short training courses, and other incentives provided to health ministry staff. They must also refrain from "poaching" health managers from the public health system to supervise their projects, which can debilitate and demoralize the daily functioning of public health systems. In Mozambique, for example, donor and NGO practices caused such severe problems that a code of conduct to regulate their practices was ultimately created (Pfeiffer 2003).

International financial institutions and other donors also need to more effectively support the strengthening of health ministries' regulatory functions. These functions are essential to ensure some level of equity and inclusion in an increasingly fragmented and commercialized health sector.

#### Sectorwide approaches need to be promoted

Sectorwide approaches in the health sector, vigorously promoted by the World Bank, the WHO, DFID, and other donors, are at various stages of implementation in about 20 countries (IMF and World Bank 2004a). The sectorwide approach is a fluid concept, but it generally consists of a collaborative program of work for government, donors, and other stakeholders, including the joint development of sector policies and strategies, medium-term projections of available resources and likely expenditures, establishment of common management systems, and institutional improvements and capacity building in the sector (Cassels 1997). In practice, sectorwide approaches to health have evolved quite differently across countries. The successes they have enjoyed and the challenges they have faced have varied, depending on the local political context, the institutional climate within donor organizations and government, the level of interest of individual health ministry officials and donor representatives, relationships between local actors, and other factors. Variations in funding arrangements for health sectorwide approaches are particularly large, ranging from parallel funding of specific activities or programs to various pooling or basket arrangements.

In general, implementation of these sectorwide approaches has proceeded more slowly and involved greater financial and human investments by both government and donors than proponents expected. There is an ongoing tension between the sectorwide approach, which aims to coordinate health initiatives, particularly at the district level, and old and new vertical health programs (including new global health initiatives, such as the Global Fund to Fight AIDS, Malaria and Tuberculosis) (Peter and Chao 1998).

Some NGOs have complained that they have been excluded from sectorwide approaches and have lost direct funding from donors who have shifted their health sector budgets into sectorwide programs (Reality of Aid 2004).

**The sectorwide approach provides a framework for long-term health sector planning**

Although sectorwide approaches appear to be strengthening the planning, budgeting, and management systems within health ministries and to be raising levels of funding to the health sector, there is so far little evidence that they have improved the delivery of health services or the health status of poor and marginalized groups (Toole and others 2003).

It is unclear why they have not yet improved health services. Since all these sectorwide approaches are relatively new mechanisms, it may simply be too early to observe positive impacts at the service delivery level. It could also be that most have concentrated on systems improvements at the central level and have not tackled access, equity, and quality of care issues at the district and local levels. This is an important issue that merits further monitoring and analysis.

Despite its slow and uneven progress, the sectorwide approach is the only model of sector coordination that directly promotes government ownership and alignment of donor support with national sector priorities and processes (Walt and others 1999). In contrast to other types of coordination, the sectorwide approach also provides a broad platform for addressing fundamental health system weaknesses and constraints as well as a flexible framework in which health ministries can work with donors, NGOs, and other stakeholders to make the long-term improvements in their health systems that will allow them to meet the Goals.

Concerns have been raised about the absence of emphasis on maternal mortality in donor-supported sectorwide approaches, even where maternal health problems are significant (Hill 2002). Goodburn and Campbell (2001) nevertheless argue for continued promotion of "safe motherhood" through sectorwide approaches, for two reasons. First, there is a greater potential for increased funding to address maternal mortality, because of the considerable resources invested by donors in sectorwide approaches. Second, given the dependence of emergency obstetric care on health systems, linking maternal health programs to sectorwide approaches at an early stage "may mean that the implications of proposed solutions to providing better care can be tested and considered in an integrated fashion" (Goodburn and Campbell 2001, p. 919).

In light of the challenging economic and policy environment in which health systems now operate, a health sectorwide approach or other sector support mechanism can provide health ministries in low-income countries with the long-term technical, financial, and political support they need to improve access to quality healthcare, especially for vulnerable groups. Health ministries and their sectorwide approach partners should also strongly encourage more donors and nongovernment providers of healthcare to participate in the approach to the fullest extent their charters permit.

### Other global initiatives' impact on the health sector

The liberalization of trade, spurred by multilateral, regional, and bilateral trade agreements, can have direct and indirect effects on health systems (Koivusalo 2003; Ranson and others 2002). Considerable attention has focused on the

**New disease-specific initiatives can strain fragile health systems**

liberalization of health services under the WTO General Agreement on Trade in Services (GATS) and similar trade agreements (Drager and Fidler 2004; PAHO 2002; UNCTAD 1997) and on the mandated patenting of pharmaceutical drugs under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs Agreement) (Correa 2002). Other trade agreements, such as the WTO Agreements on the Application of Sanitary and Phytosanitary Measures and Technical Barriers to Trade, also limit governments' flexibility to adopt health regulations and standards that are deemed "trade restrictive." While much attention has focused on these WTO agreements, health sectors have been opening to cross-border investment and other forms of commercialization for some time, under health sector reform programs, regional and bilateral trade agreements, and various public-private arrangements.

Large private funders, such as the Bill & Melinda Gates Foundation, and new funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, are injecting much-needed resources into health research and health sector activity in low-income countries, mainly to combat specific diseases. But some of these new disease-specific initiatives, administered through vertical programs, can strain fragile health systems and divert healthcare workers from primary care to disease-specific activities. Where large-scale programs for HIV/AIDS treatment are being introduced, reproductive healthcare may be seriously compromised, because the healthcare workers providing reproductive health services are among those most likely to be recruited for new HIV/AIDS programs. Concerns have also been raised about the extent to which the new global disease initiatives skew the allocation of global resources for health research and development (toward new drug therapies, for example, rather than toward microbicides that could prevent HIV infections in large numbers of women worldwide) and crowd out other potential sources of funding that could strengthen health systems. Health system impact assessments, codes of conduct, and other measures are needed to ensure that these new health initiatives support rather than undermine health systems, especially at the district and community levels (Buse and Walt 2002; Unger, De Paepe, and Green 2003).

Ultimately, the kind of transformational change required to meet the Goals at the national level requires that finance and planning ministries and the officials of international financial institutions with whom they negotiate have a profoundly different appreciation of the importance of health and health systems for economic growth, poverty reduction, and the building of democratic societies. While acknowledging the importance of efficiency and effectiveness in the functioning of the health system, the task force argues against the deeply unequalizing economic approach to health systems that focuses on competitive markets as the predominant framework for healthcare delivery. Fundamental rethinking and significant new investment are required to build equitable, well functioning health systems.

Chapter 7

# Conclusions and recommendations

The essential conclusion of the task force is that the Millennium Development Goals for child mortality and maternal health are attainable—but not without extraordinary effort. The technical interventions for achieving these Goals exist; they must now be implemented at a scale and in a manner that will reach those who need them most. Access to safe, effective, and affordable interventions must be provided to all, through functioning health systems; barriers to the utilization of competent, professionally delivered services must be lowered or eliminated.

The principal recommendations for achieving these ambitious goals are as follows:

*1. Health systems, particularly at the district level, must be strengthened and prioritized in strategies for reaching the child health and maternal health Goals.* Doing so demands a radical shift in the way health systems are addressed:

- Health systems must be understood not only as mechanisms for delivering technical interventions but also as core social institutions that are indispensable for reducing poverty, social exclusion, and inequity and advancing democratic development and human rights.
- For health systems to increase inclusion and close the equity gap, policies implemented in the context of good governance must:
  - Strengthen rather than undermine government legitimacy.
  - Prevent excessive segmentation of the health system.
  - Increase the power of the poor and other marginalized groups to make claims for healthcare.

*2. Strengthening health systems will require considerable additional funding.*

- To progress at the speed required to meet the Goals in the poorest countries, both bilateral donors and international financial institutions must

vastly increase foreign assistance to the health sector for the foreseeable future.

- User fees at the primary care level should be abolished; health system financing should not be an additional burden on the backs of already impoverished populations.
- Countries should be encouraged to shift additional funds into the social sectors, to the extent possible.

*3. The health workforce must be developed according to the goals of the health system, with the rights and livelihoods of healthcare workers addressed.*

- These principles must also inform strategies to address brain drain, low morale, and loss of productivity due to illness and death (often from HIV/AIDS), factors that are limiting the ability of governments to provide their populations with access to good-quality healthcare.
- Effective management and operational systems that seek to improve quality and increase trust in the health system should accompany the development of the health workforce.
- Medium- to long-term plans for building a cadre of skilled birth attendants—the health workers key to reducing maternal deaths—must form an explicit part of all health workforce plans.
- "Scope of profession" regulations and practice must be changed to empower mid-level providers, including skilled birth attendants, to perform life-saving procedures safely and effectively.

*4. Sexual and reproductive health and rights are essential to meeting all the Goals, including those on child health and maternal health.*

- Countries should take steps to ensure universal access to sexual and reproductive health services.
- Initiatives addressing the HIV/AIDS pandemic should be integrated with sexual and reproductive health and rights programs.
- Adolescents must receive explicit attention with services that are sensitive to their increased vulnerabilities and designed to meet their needs.
- In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion.
- Governments and other relevant actors should review and revise laws, regulations, and practices, including on abortion, that jeopardize women's health.

*5. Effective intervention to reduce child mortality requires scaling up availability and utilization to 100 percent of the population in poor countries.*

- Child health interventions must be increasingly offered within the community. Policies need to be reformulated to allow services to be

delivered as close to patients as possible. Community health workers need to be trained and permitted to encourage preventive behaviors, to care for a larger proportion of nonsevere childhood illnesses, and to ensure early referral to appropriate facilities for the treatment of severe illnesses.

- More attention must be paid to child nutrition, including micronutrients, as the relationship between nutritional status and mortality is becoming increasingly evident.
- Governments must increase investments in interventions aimed at reducing neonatal deaths.

*6. Maternal mortality strategies should focus on building a functioning health system that ensures access to emergency obstetric care for all women who experience complications.*

- The system should supply, support, and supervise the skilled birth attendants who should be the backbone of that system, whether they are based in facilities or in communities.
- Strategies to ensure skilled attendants for all deliveries must be premised on integration of the skilled attendant into a functioning district health system.
- Skilled attendant strategies cannot be allowed to substitute for strategies to strengthen the health system, including emergency obstetric care.

*7. Information systems are an essential element in building equitable health systems.*

- Indicators of health system functioning—including equity—must be developed alongside disease-specific indicators and then integrated into policy and budget cycles.
- Health information systems must able to provide appropriate, accurate, and timely information that is used to inform management and policy decisions.
- Countries must take steps to strengthen vital registration systems.

*8. The targets and indicators of Goals 4 and 5 should be modified as follows:*

- All targets should be framed in equity-sensitive terms, providing that the rate of progress toward the target be faster among the poor and other marginalized groups than for the better-off.
- For Goal 4 on child mortality:
  - Neonatal mortality rate should be added as an indicator.
  - Prevalence of underweight children under-five (now an indicator for Goal 1) should be monitored.
- For Goal 5 on maternal health:
  - "Coverage of emergency obstetric care" should be added as an indicator for the maternal mortality target.

    - "Universal access to reproductive health services" should be added as a new target.
- The full set of indicators to meet Goal 5 include:
    - Contraceptive prevalence rate.
    - Proportion of desire for family planning satisfied.
    - Adolescent fertility rate.
    - HIV prevalence among 15- to 24-year-old pregnant women.
    - Coverage of emergency obstetric care.
    - Proportion of births attended by skilled health personnel.
    - Maternal mortality ratio.

*9. Global institutions are critical partners. Poverty reduction strategy processes and funding mechanisms should support and promote actions that strengthen rather than undermine equitable access to good-quality healthcare.* To do so, global institutions will need to:

- Commit to long-term investments.
- Remove restrictions on funding of salaries and other recurrent costs.
- Align funding from donors and international financial institutions with national health programs to meet the Goals.
- Allow health stakeholders to fully participate in the development of funding plans.