First year report 2008

# The Global Campaign for the Health Millennium Development Goals

## First year report 2008

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We acknowledge with gratitude the individual and collective contributions by the global and international leaders listed above.

The Global Campaign for the Health Millennium Development Goals brings together a number of actions and initiatives, all aimed at fulfilling the promises given by world leaders eight years ago.

The Campaign was launched in New York 26 September last year. This First Year Report provides an update of major activities during the last year, and highlights concrete actions that are required to accelerate the necessary progress if we are to reach the health related MDGs by 2015.

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Chapter One

# *Campaign overview*

## Message from the Network of Global Leaders

In New York on 26 September 2007, a group of global leaders met to launch the Global Campaign for the Health Millennium Development Goals (MDGs), aiming to give renewed impetus to MDGs 4, 5 and 6. These focus on the urgent need to improve maternal, newborn and child health and to combat HIV/AIDS, malaria and other diseases.

The last year has seen some remarkable progress:

- For the first time since the AIDS epidemic began, the number of people newly infected in a year has declined.
- Malaria nets are being distributed much more rapidly, with the aim of saving close to a million children from dying of malaria.
- More vaccines are reaching more children than ever before.
- Unprecedented financial commitments have been made. For instance, the US Government has pledged US$48 billion to combat AIDS, malaria and tuberculosis, while India this year has allocated US$3 billion to improve the health of the rural poor.

In terms of organisation, the Global Campaign and its partnerships have helped to consolidate the complex architecture of global health aid, enabling it to focus more effectively on the health MDGs. And there has been much greater collaboration across bilateral and multilateral agencies involved in international health, such as WHO, the World Bank, UNICEF, UNFPA and UNAIDS.

Dedicated global funds continue to play a vital role in progress towards the MDGs, as shown by the work of GAVI, the Global Fund to Fight AIDS, Malaria and Tuberculosis, and others. And there is a move towards allocating more funding to health systems through results-based financing, broader sector funding and harmonised budget support.

The innovative financing pilot mechanisms launched in 2006 and 2007 have started to make important contributions. For instance, the International Financing Facility for Immunisation has made it possible to save even more people from death by measles and to expand work to prevent meningitis (HIB). Meanwhile, UNITAID has ensured the development and deployment of tailor-made medicines for children with AIDS and malaria. And the Advanced Market Commitments mechanism has secured the introduction of pneumonia vaccines, which in the long term will save the lives of over half a million children each year.

In spite of all this good work, we are still not making enough progress on the health of women and children generally, and on maternal and newborn health in particular. We are therefore working hard to ensure that maternal and newborn health are given higher priority nationally, regionally and globally. Some of us have launched national campaigns and have participated in such launches on all three continents.

Most importantly, for the first time in its history, the G8, under the leadership of Japan, has emphasised a comprehensive approach to addressing maternal, newborn and child health, health systems strengthening and infectious diseases, including the urgent need to accelerate progress towards achieving MDGs 4 and 5. Now the time has come to translate this need into action.

We already know that to improve maternal and neonatal health you require a well-functioning health system, where skilled workers and facilities are available day and night, seven days a week. They need appropriate equipment to do their work, and transport must be available to help women access specialist care. But now we are gaining new insights into how to make this happen, using a variety of tools and techniques.

For instance, lessons from India show that women in poverty must be given financial support to access health services. Also, although health workers are in short supply in India, new arrangements are being made to ensure they are deployed to maximum effect. In some parts of the country, people can now use their mobile phones to call for transport to take them to health appointments, while innovative arrangements are making wider use of private-sector health workers.

The UN and the World Bank have developed estimates of the needs of the 51 poorest high-priority countries (see Chapter 4). There are various options, with minimum needs of US$2-7 billion per year over the next seven years to save 10 million lives of mothers and newborns. This includes, for example, ramping up the capacity to ensure quality deliveries, with an additional million trained midwives, nurses and doctors. We are committed to playing our part in making sure that these needs are met in the most effective ways, drawing on the lessons learned over the last eight years.

*Michelle Bachelet*
**President of Chile**

*Jan Peter Balkenende*
**Prime Minister of the Netherlands**

*Gordon Brown*
**Prime Minister of the United Kingdom**

*Armando Guebuza*
**President of Mozambique**

*Jakaya Kikwete*
**President of Tanzania**

*Luiz Inácio Lula da Silva*
**President of Brazil**

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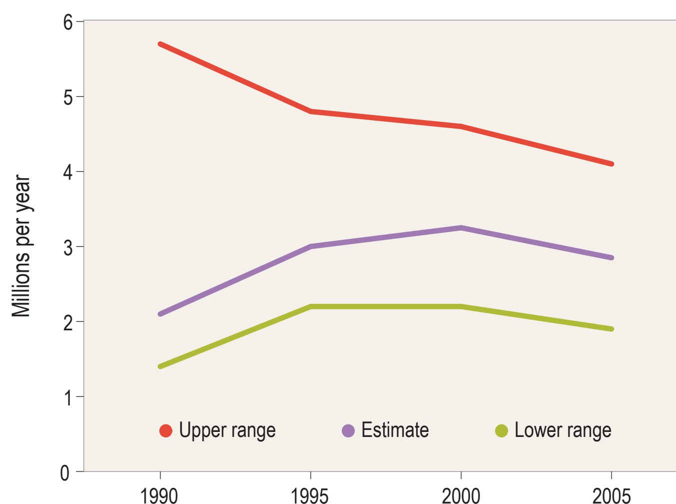
*Abdoulaye Wade*
**President of Senegal**

*Susilo Bambang Yudhoyono*
**President of Indonesia**

*Graça Machel*
**Recipient of the UN's Nansen medal for her humanitarian work**

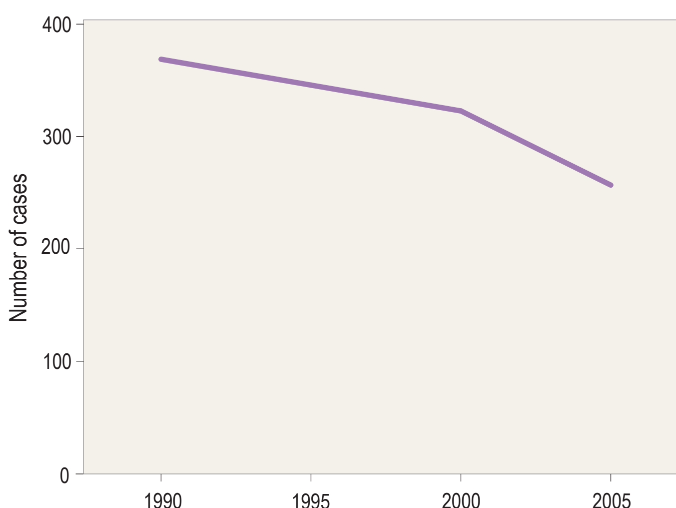
The graph shows an estimate of the total number of new cases of HIV occuring annually from 1990-2006. Whilst there is obvious uncertainty in the estimates presented, follow-ing a peak in the late 1990s there has been a considerable decrease in the number of new cases of HIV occuring globally.

*Source: UNAIDS (2007): AIDS epidemic update. UNAIDS report.*



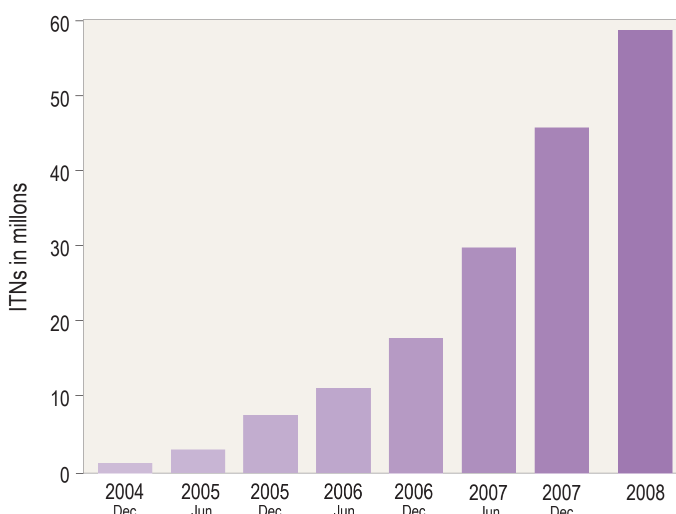

The figure shows the number of people living with TB per 100,000 population in developing regions, excluding individuals who are HIV positive. It shows that there has been a steady decline since 1990 but that that further efforts are still required.

*Source: UN (2007): Millennium Development Goals Report 2007.*

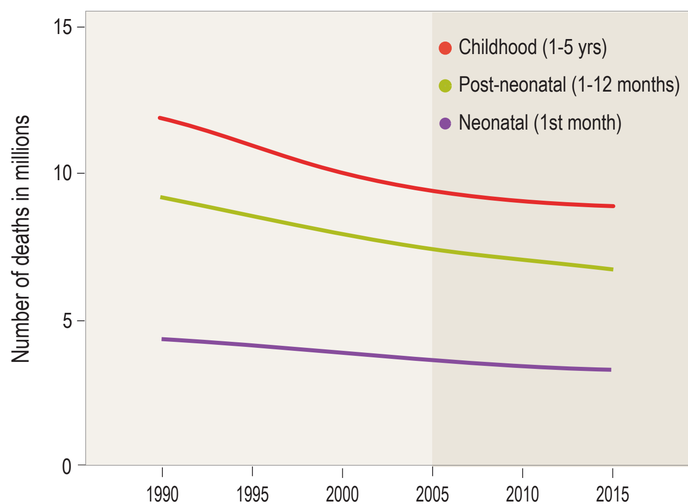



The figure shows the number of insecticide treated mosquito nets (ITN) distributed by the Global Fund for AIDS, TB and Malaria between 2004 and 2008. There was a sharp increase in the number of nets distributed after June 2004 as the programs supported by the Fund matured. The G8 target for 2010 100 million nets distributed.

*Source: GFATM (2007): Partners in Impact Results Report 2007.*



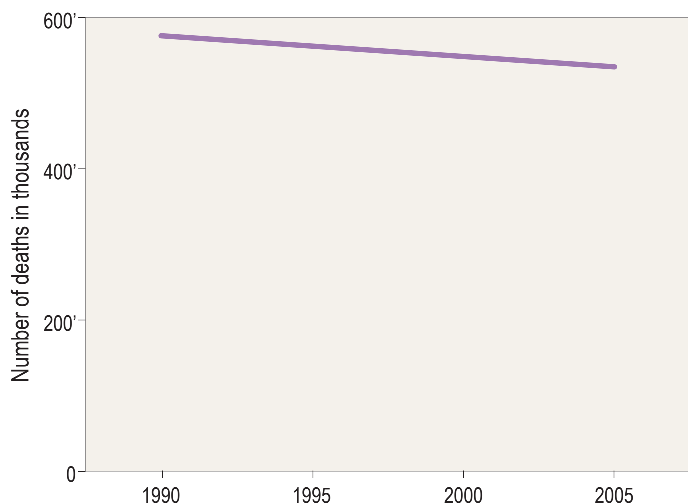
**Child mortality: progress by age-group**




The figure shows the shows the trend in the number of deaths for occuring in the neonatal, post-neonatal and childhood periods from 1990 to 2015. Whilst the results should be interpreted cautiously, they appear to suggest the greater progress has been made in reducing post-neonatal deaths and childhood deaths, than in the neonatal period.

*Source: "Murray C. et al. Can we achieve Millennium Development Goal 4? New analysis of country trends and forecasts of under-5 mortality to 2015. Lancet 2007; 370: 1040–54"*

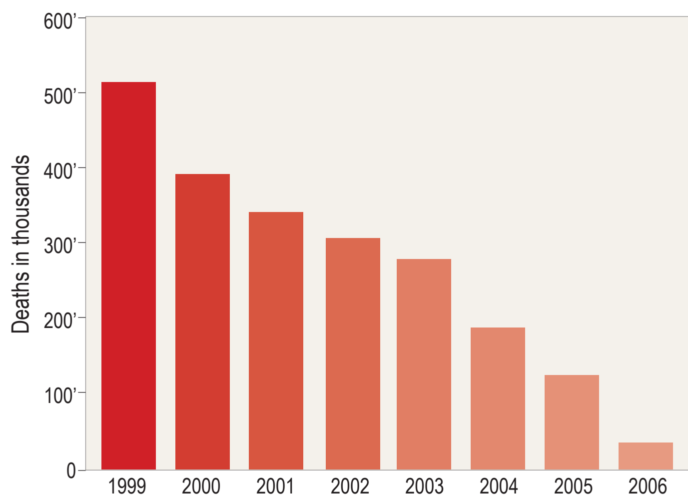
**Maternal mortality over time**




The figure illustrates the alarming lack of progress in reducing maternal deaths that occurred between 1990 and 2005.

*Source: WHO (2007): Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA, and the World Bank.*

**Measles mortality in Africa**




The figure illustrates the estimated number of measles-related deaths that occurred in Africa in the period between 1999 and 2006. The graph shows a sharp reduction in deaths and a continuing downward trend.

*Source: WHO: Weekly epidemiological record, no. 9, 4 March 2005; WHO: Weekly epidemiological record, no. 48, 30 November 2007*

## Message from the UN Secretary-General to the Global Campaign for the Health MDGs

As we pass the mid-point in race to reach the Millennium Development Goals, much has been achieved, but much more needs to be done. Millions continue to live in poverty, suffering from hunger and malnutrition. Millions die each year of infectious diseases that are often treatable or easily preventable. It is particularly alarming that half a million women die each year while giving birth, when we know what could save them.

Health is at the core of the MDGs. Promoting and securing health is both an ethical imperative, and a prerequisite for prosperity, poverty reduction, stability and security. That is why I made progress on global health a key priority for my tenure.

Progress has been made on many fronts, from reducing child deaths and increasing access to treatment for AIDS, from reversing the tuberculosis epidemic in many countries to advancing the eradication of polio and Guinea Worm, from reducing measles in Africa to increasing access to immunization and contraceptive use. Several African countries have made critical strides in malaria control.

But we have a long way to go. I am heartened by the initiative of the Global Campaign for the Health MDGs to put us on course – particularly in accelerating progress in maternal health. Among all the MDGs, maternal health is where we have made the least progress. The death toll each year is unacceptable, and its impact on newborn and child health is unconscionable.

We know what it takes. We must scale up high impact interventions, and to do so, we need functioning and affordable health systems with the necessary workforce. We must prevent growing inequalities and protect the gains we have made. As with other global threats, it is the poor, women and children, who suffer the most. And we must harmonize and align global health initiatives to ensure that as donors increase their commitments, we make the resources work where they are most needed. All this becomes even more urgent as we face new challenges – rapidly rising food and fuel prices, food shortages and the effects of climate change.

Let us work together, with urgent and coordinated action, to ensure good health for all.

*BAN Ki-moon*
**Secretary-General of the United Nations**

Chapter Two

# *Closing the Gap on the Health MDGs*

*When the MDGs were launched in 2000, global action was already being considered on vaccination and the three major infectious diseases: AIDS, malaria and tuberculosis. At the halfway point to 2015, these diseases have become the priority.*

*This chapter focuses on:*

- *Progress*
  *Very substantive progress has been made, especially during the last year, in these areas – though the new challenges lie ahead in achieving universal access.*

- *Commitment*
  *The major international funders – the G8, European Union and US – are continuing and expanding their commitment.*

- *Increasing efficiency*
  *The main actors in international health are taking action to reduce fragmentation, increase efficiency and meet the demands made of fragile health systems to deliver an increasing range of services.*

- *Foreign policy*
  *Foreign ministers can make an important contribution to health.*

# *Scaling up towards Universal Access: AIDS, Malaria, Tuberculosis and Immunisation*

## UNAIDS

AIDS is inextricably linked to the other MDGs: education, gender equality and poverty eradication are all vital for fighting it. And in many countries reducing HIV infections and deaths from AIDS is essential for making progress on other MDGs.

By the end of 2007, the global number of new HIV infections and AIDS-related deaths had begun to decline – largely the result of action on political commitments. At the G8 summits in 2005 and 2008, and at the UN High-Level Meeting on HIV/AIDS in 2006, leaders agreed to scale up to universal access to HIV prevention, treatment, care and support by 2010.

There are now 105 countries with national targets for universal access, and 147 countries submitted progress reports this year. In 2007, investment in HIV programmes reached US$10 billion, up from US$8.3 billion in 2005. Extraordinary efforts resulted in three million people in low- and middle-income countries receiving anti-retroviral treatment in 2007 – a million more than in 2006.

Several heavily affected countries are making progress on HIV prevention. There are falls in the number of people having more than one partner in the last year, increases in condom use among promiscuous young people, and, in sub-Saharan Africa, signs that people are beginning to have sex at a later age.

Access has improved to antiretroviral drugs that prevent mother-to-child transmission (PMTCT) of HIV. In low- and middle-income countries, a third of women who need the drugs can get them – up from 14% in 2005. Some countries, including Argentina, Botswana, Georgia and the Russian Federation, have achieved close to universal access, with PMTCT services at more than 75% coverage. In Botswana, just 4% of children born to HIV-positive mothers are infected.

Other prevention efforts are also improving. Of 39 countries reporting on it, coverage of HIV-prevention services for sex workers is 60%. For people who inject drugs coverage is nearly 50% in 15 countries, and for men who have sex with other men it is 40% in 27 countries.

In many countries AIDS programmes are supporting fragile health systems, improving service delivery, staff, information systems, governance and the procurement and management of drugs. We recommend using a third of HIV/AIDS resources to strengthen health systems.

There is more to do. In low- and middle-income countries, two-thirds of people requiring antiretroviral drugs cannot get them. For every two people starting HIV treatment, five become infected. AIDS remains the biggest killer of African adults (25-49) and is among the top ten killers worldwide. Like climate change, AIDS will require a long-term response. We need to build on progress and strengthen links with other health programmes, notably tuberculosis, sexual and reproductive health, and maternal and child health.

This will require more money: over 50% more by 2010 to maintain the current pace of growth in prevention and treatment. The price is worth paying.

*Peter Piot*

Executive Director
**UNAIDS**

## The Global Fund to Fight AIDS, Tuberculosis and Malaria

Our aims coincide exactly with MDG 6. Since its creation in 2002, the Fund has dramatically increased the resources available to fight AIDS, malaria and tuberculosis – diseases that kill over six million people a year – approving grants worth US$11.4 billion for 136 countries. We now provide 25% of international financing for fighting AIDS, 75% for malaria, and 66% for tuberculosis.

The Global Fund's investments have saved an estimated 2.5 million lives, or more. This is not simply a number. These are women, men and children: active members of society, productive citizens, loved members of families and communities. And they would not be alive today without the programmes we have funded.

**Malaria**

For the first time, evidence consistently shows a decline in malaria and child mortality. In countries with good prevention and treatment coverage, malaria cases – and deaths – have declined by 50%. These include Rwanda, Zanzibar, Eritrea, Burundi, and parts of Mozambique and Swaziland. Ethiopia, Ghana, Kenya, and Zambia have also dramatically reduced mortality. We are the world's largest financier of insecticide-treated bed nets (59 million have been distributed), and have delivered 60 million drug treatments.

**HIV/AIDS**

Our support means 1.75 million people can access antiretroviral (ARV) therapy – a large proportion of the three million receiving ARV treatment globally. Because of ARVs, hospital beds in countries such as Botswana, Tanzania and Zambia lie empty for the first time in a decade. But the epidemic can only be stopped if new infections decline, so we support prevention and outreach. Programmes we support have provided counselling and testing for 46 million people, and community outreach services for 65 million people.

**Tuberculosis**

The Global Fund has helped to treat 3.9 million people's tuberculosis. The Stop TB Partnership's targets for case detection and cure rates are being reached. Prevalence and death rates are falling, and the estimated number of new cases per capita is starting to decline. These achievements are mainly due to progress in high-burden countries, including India, China and Indonesia. If the trend continues, MDG target 6C (halting and reversing TB's incidence) will be achieved before 2015.

**Partnership**

Partnership is central to the way the Fund works. Progress has been the result of concerted efforts by governments, civil society, communities, international partners and the private sector. We encourage applications supporting countries' own strategies and programmes – 82% of funds are aligned with national monitoring and evaluation (M&E) systems. We work hard to harmonise our efforts with our partners', monitoring and improving our performance on the Paris indicators, and we participate in initiatives such as the International Health Partnership.

To achieve MDG 6, all this work must be accelerated. We reaffirm our commitment to doing that.

*Michel Kazatchkine*

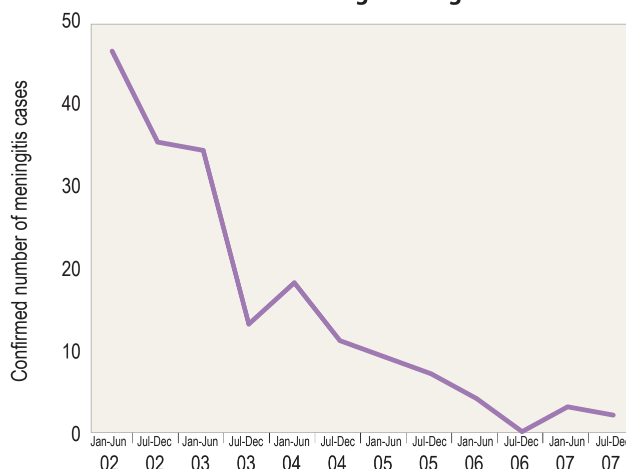
Executive Director
**The Global Fund to Fight AIDS, Tuberculosis and Malaria**

## The GAVI Alliance

After declining to 65% in 2000, immunisation rates in the poorest countries have been rising steadily, reaching 75% in 2007. WHO estimates that in 2007 more than 11 million children in 70 countries were immunised against diphtheria, tetanus and pertussis with the support of the GAVI Alliance. In the same year the number of children dying, largely from preventable causes, fell below 10 million – and around 600,000 premature deaths were prevented as a result of increased access to vaccines such as hepatitis B, Hib and yellow fever.

Over the past seven years almost 160 million children have been immunised against hepatitis B in 67 countries. The figure for yellow fever is more than 26 million in 17 countries, and for Hib (which causes pneumonia and meningitis) it is 28 million in 44 countries. Almost three million lives have been saved.

However, over 2.5 million children die every year from vaccine-preventable diseases such as pneumonia and diarrhoea and millions more repeatedly fall ill because of these and other avoidable infections.




Just five years after Haemophilus influenzae type b (Hib) conjugate vaccine was introduced nationwide in Uganda, Hib meningitis has been virtually eliminated in children under five years of age.

*Source: GAVI (2007): GAVI Alliance Progress Report 2007*

**The role of innovative financing**

Between 2000 and 2006, global mortality from measles declined by 68%, from 757,000 to 242,000, and in Africa it fell 91%. The expansion of measles immunisation was fuelled in part by support from the innovative International Finance Facility for Immunisation (IFFIm). Since November 2006, IFFIm has raised over US$1.2 billion from the capital markets in bond proceeds. These funds have gone straight to national immunisation and health-system strengthening programmes.

In partnership with the GAVI Alliance and the World Bank, five government donors, together with the Bill & Melinda Gates Foundation, have launched a pilot Advance Market Commitment (AMC) for a pneumonia vaccine, pledging a total of US$1.5 billion. The AMC establishes a financial commitment for future purchase of the new vaccine, stimulating the development and manufacture of the product needed, so that protection against this major killer can be made available quickly and affordably in the poorest countries. By reducing the vaccine's introduction period from 15 years to three, the AMC is expected to save seven million lives by 2030.

**The future**

The GAVI Alliance has committed US$4 billion to its programmes over 15 years in over 70 countries. By 2011, it will have spent $800 million of this on strengthening health systems in the poorest countries, so they can deliver immunisation and other basic health services. At the same time, GAVI will be implementing a new investment strategy to determine which vaccines it will offer in the future. It is the Alliance's hope that the work done through this strategy will help to achieve the MDGs by 2015.

*Julian Lob-Levyt*

Executive Secretary
**GAVI Alliance**

# *Global Commitments*

## The European Commission

The European Commission is firmly committed to continue its efforts to achieve the MDG targets. We welcome all efforts to achieve this shared goal and we remain fully supportive of the principles and commitments stated a year ago by the Global Campaign for the Health MDGs.

Today, one year later, we review here in New York the progress made, the lessons to be learnt and the challenges ahead of us. We note that the health MDGs, particularly in sub-Saharan Africa, are possibly the most seriously off-track and constitute a basic challenge if we wish to achieve the MDGs globally.

The Global Campaign for the Health MDGs envisaged clearly the challenge and identified two main needs. On one hand, the development of a country-led health plan ensuring access to basic health services. On the other hand, the mobilization of additional funds from governments and the international community to finance those plans and to ensure the roll-out of health services, especially targeting children and mothers. The European Union is committed to this approach which involves not only reaching an agreed global target, but also preventing over 10 million premature deaths every year, most of them from preventable causes.

As regards the alignment around national health plans, the Commission and eight Member States signed the International Health Partnership, also one year ago. We are collaborating in the first tests in Ethiopia, Mozambique and Mali, and are encouraging other Member States, other non-EU donors and multilateral agencies and initiatives to become associated with these efforts.

In addition to the political will and respect for our partner countries' institutions and plans, the challenge is becoming very clear in the need to mobilise significant additional ODA for health. Following this line, the European Council of 24 June adopted the Agenda for Action on MDGs. This Agenda commits the European Union to link the commitments of additional EU ODA by 2010, with the key sectors to progress on the MDGs. Health is prominent in our commitments within the Agenda for Action on MDGs.

We need to encourage and support our partner countries' efforts to focus more on health. The best way is by complementing their efforts with increased international support for the health sector. However, even if partner countries increase the proportion of their national budgets allocated to health up to *15%,* (according to their Abuja commitments), we estimate a public sector financing gap for health in at least 50 developing countries (most of them in sub-Saharan Africa) amounting in total to over € 13 billion annually.

Given the EU's present share of 60% of global ODA, we are committed to secure an additional € 8 billion (€ 6 billion for Africa), by 2010, to support the funding of national health plans delivering basic health care.

Our commitments in Paris and earlier this month in Accra, together with our commitments in Monterrey and Barcelona, plus the specific path agreed under the International Health Partnership and the recent commitments by the European Council, provide us with the tools to lower this unacceptable death toll, and to help children and mothers throughout the developing world enjoy long and healthy lives.

*José Manuel Barroso*

President
**European Commission**

## TICAD IV and G8 Hokkaido Toyako Summit

I would like to share with you some of my thoughts as this year's G8 Chair, on the occasion of the launching of the annual report of the Global Campaign for the Health MDGs.

In January 2008, as Japan took over the G8 Chair, I decided to focus on global health and take the lead in stepping up comprehensive efforts to achieve MDGs 4, 5 and 6. I take very seriously the fact that, although international awareness on global health has increased considerably after the G8 Kyushu Okinawa Summit in 2000, many children and pregnant women still lose their lives from avoidable causes, especially in sub-Saharan Africa.

At the Fourth Tokyo International Conference on African Development (TICAD IV) held in Japan in May, the Yokohama Action Plan was developed with the participation of many African countries, development partners and Asian countries, and international and regional organizations, private sector and civil society organizations. Japan announced concrete measures on training health workers and improving maternal, newborn and child health among others, as part of this Action Plan.

At the G8 Hokkaido Toyako Summit, G8 stressed the importance of a comprehensive approach to address maternal, newborn and child health, health systems strengthening and infectious diseases, and announced new commitments. The Toyako Framework for Action on Global Health - Report of the G8 Health Experts Group -, which presented a set of detailed and concrete recommendations on health goals, is a major outcome of this Summit. The annex of this Report also deserves particular attention, for it shows G8 implementation of their past commitments to ensure accountability.

Japan will continue to be actively engaged in addressing the issue of global health. And it is my earnest hope that all stakeholders will take this great opportunity of the MDGs High Level Event in accelerating their efforts in achieving the health-related MDGs.

*Yasuo Fukuda*

Prime Minister
**Japan**

## Commitments from the European Union, G8 and PEPFAR

### The European Union

At the European Council in June 2008, the presidency's conclusions welcomed the EU Agenda for Action on the MDGs. The EU proposed that its development partners share this agenda, which sets out timetables for attaining specific milestones and taking action in the context of pro-poor and pro-growth development. These will contribute to achieving the MDGs by 2015. They include reducing poverty and hunger, improving education, health, the environment, water, agriculture, infrastructure, the private sector, gender equality and the empowerment of women.

**Aid to reach 0.7% of GNI**

Leaders strongly reaffirmed the EU's commitments that aid reach 0.7% of GNI by 2013, an average of 0.56% by 2010, and a minimum for each member state of 0.51% by 2010. EU aid will thus increase to **€66 billion** by 2010.

Member states also agreed to establish indicative timetables for how they will achieve these EU targets. The EU Agenda for Action includes a number of important EU milestones and targets, including increasing health spending to €8 billion.

This level of increased investment by the EU in this sector would be expected to contribute to the provision of :

- 75 million more bednets in Africa,
- additional funding for national plans, including through International Health Partnership and in the framework of the "Providing for Health Initiative".
- increased investment would be expected to contribute to the scaling up and empowerment of the health workforce, the development of sustainable financing health systems, including social protection in health, an increased coverage of Integrated Management of Childhood Illnesses programmes and support country effort to reach universal coverage with effective interventions to control malaria.

www.eu.int

### G8

In the Chair's summary at the Hokkaido Toyako G8 Summit in July 2008, the G8 leaders welcomed the Health Experts Group's report. This report contained matrices showing the implementation of past G8 commitments, and set forth the Toyako Framework for Action, which includes the principles for action on health. The G8 leaders also agreed to provide, over five years, the US$60 billion they had pledged at last year's Summit. And to help prevent malaria, the leaders agreed to provide 100 million mosquito nets by the end of 2010, which will help to save 600,000 lives.

The African leaders pointed out that various commitments made in previous G8 summits have not been sufficiently implemented. The G8 leaders reaffirmed the importance they attach to following up these commitments, and are considering the best way of doing so.

**Gleneagles commitments reaffirmed**

**US$25 billion** in aid for Africa, **US$50 billion** globally, and universal access to AIDS treatment, all by 2010.

African health package

The package will help recruit and train 1.5 million health workers in Africa and ensure 80% of births are attended by a trained health worker.

This includes a commitment to reach 2.3 health workers per 1,000 people in the 36 African countries that have critical shortages.

Skilled birth attendants

The G8 agreed to the Health Experts Group's recommendation that 90% of all births be assisted by skilled attendants by 2015, and backed by access to emergency obstetric care. This bears in mind the target agreed at the ICPD+5 in 1999.

The aim is to reach the MDG target of a 75% reduction in maternal deaths between 1990 and 2015.

www.g8summit.go.jp/eng

**PEPFAR**

In 2003, President Bush launched the US President's Emergency Plan for AIDS Relief (PEPFAR) to combat global HIV/AIDS, committing US$15 billion over five years. In 2008 the US government extended its commitment to the programme for another five years, to 2013. The US is authorised to spend up to **US$48 billion** for the global fight against HIV/AIDS, tuberculosis, and malaria. This breaks down as follows.

**Up to US$39 billion** to:

- PEPFAR bilateral HIV/AIDS programmes
- The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

**Up to US$5 billion** to:

- The President's Malaria Initiative, fighting malaria through bilateral programmes around the world

**Up to US$4 billion** to:

Bilateral programmes to fight tuberculosis, the leading killer of Africans living with HIV

Bilateral HIV/AIDS funds will pay for:

- Treatment for at least three million people
- Prevention of 12 million new infections
- Care for 12 million people, including five million orphans and vulnerable children
- Training of 140,000 new healthcare workers in HIV/AIDS prevention, treatment and care

www.pepfar.gov

## Alignment around Stronger Health Systems: Health 8

Health is at the core of the MDGs, especially MDGs 1, 4, 5, and 6. Promoting and securing health is a foundation for prosperity and stability. Better health is both a key to poverty reduction and a contribution to collective security. A world that is greatly out of balance in matters of health is neither stable nor secure. Just past the half-way point to 2015, achievement of the health MDGs is contingent on increased aid for health, increased effectiveness of that aid, and countries meeting agreed-upon commitments for financing their own healthcare.

In addition, achieving the health-related MDGs will require increased emphasis on collaboration. An informal group of heads of eight health-related organizations that play a significant role in influencing health policy and financing (WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Bill & Melinda Gates Foundation, and the World Bank - the so-called 'H8') was formed and has met informally over the 18 months to discuss ways in which their agencies can coordinate more effectively to support the attainment of the health related MDGs. Encompassing key UN agencies, public-private partnerships and the major private foundation working in health, the H8 group is a reflection of the more complex global health architecture that has emerged in recent years.

A number of recent global initiatives from Norway, the UK, Canada, Germany and France are highlighting the need to accelerate action towards the attainment of the health MDGs, including bridging equity gaps in access, maternal and child health, better harmonization of activities by bilateral and multilateral agencies and coordination with country needs, more systematic involvement of civil society and the private sector, and social protection. Strong communication and coordination is important to ensure that these initiatives make a strong collective contribution to the attainment of the MDGs.

Each member of the H8 began this work within their own organizations, but the group also used its collective voice to ensure that health remained a priority for the G8 at its 2008 summit in Toyako, Japan. We believe that maintaining a high level of political commitment will be essential if the health-related MDGs are to be attained. The H8 has also served as a moderating influence in the ongoing debate between advocates for health systems strengthening and disease-specific programs, in an attempt to avoid the type of fragmentation that could prove devastating as we enter into this critical period for reaching the MDGs.

*Margaret Chan*

Director-General
**WHO**

*Michel Kazatchkine*

Executive Director
**Global Fund**

*Julian Lob-Levyt*

Executive Secretary
**GAVI Alliance**

*Thoraya Obaid*

Executive Director
**UNFPA**

*Joy Phumaphi*

Vice-President - Health, Nutrition and Population
**World Bank**

*Peter Piot*

Executive Director
**UNAIDS**

*Ann Veneman*

Executive Director
**UNICEF**

*Tachi Yamada*

President - Global Health
**Bill and Melinda Gates Foundation**

## Foreign policy and global health

In March 2007, the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand met in Oslo. They called attention to the need to broaden the scope of foreign policy to include pressing health challenges, maximize the opportunities to protect and promote public health and contribute to improved health outcomes. These seven foreign ministers have together set out an agenda to:

- **Build capacity** – increasing global health security by better preparedness, control of emerging infectious diseases, and meeting the world's shortage of health workers.
- **Face threats** – protecting health security despite conflict and during peace-building, tackling natural disasters and responding to HIV/AIDS.
- **Make globalisation work for all** – making the commitment to health and development a strong and obvious part of international relations, and making trade policies and global governance serve public health.

Support has been growing for the principle that foreign policy should contribute to the fundamental right of every human being to the highest attainable standard of health. At the same time, there is an increasing realisation that measures of health and nutrition are the ultimate means through which people's well being and opportunity can be assessed and described.

That's why it is important to look at foreign policy in terms of its impact on health and livelihoods. These issues should underpin peacekeeping operations and humanitarian action. Diplomacy is also needed to ensure access to pandemic vaccines and virus sample sharing, to HIV medicines and diagnostics, and for solving the global health workforce crisis. Without health-responsive diplomacy, trade and intellectual property disputes mean that health outcomes deteriorate.

To bring health and foreign affairs together, new ways of co-operating that link national and international policy processes and agreements are needed. To focus on this and to invite broader participation and dialogue, there have been several well attended meetings, including one with a broader group of foreign ministers in New York in 2007. Through their expert group and through the engagement of their diplomats working in Geneva, the seven foreign ministers have been supporting negotiation processes in the areas of virus sharing, property rights and innovation - and engaged with think-tanks, academic institutions and UN agencies to focus on key challenges to foreign policy and build the knowledge base.

Now, South Africa, on behalf of the seven countries, is leading work towards a resolution in the UN General Assembly to improve the way health policy is co-ordinated between the UN's centres in Geneva and New York. In the past the centres have drawn on different sets of ministers and institutions, thus separating the outcomes of policy processes and critical implementation issues, often resulting in insufficient co-ordination at the national and the global level. The resolution will call for mechanisms and commitments to improve co-ordination and align action.

*Jonas Gahr Støre*

Minister of Foreign Affairs
**Norway**

*Bernard Kouchner*

Minister of Foreign Affairs
**France**

Chapter Three

# *Accelerating Progress on MDGs 4 and 5*

*While we have seen much progress in recent years, our goals of reducing child and maternal mortality remain the most off-track.*

*Accelerating progress towards these goals will require action across all sectors. Women's status, education, water and nutrition all play important roles, but the health sector is pivotal. It is here that women, infants and children can receive life-saving services, such as quality care and emergency obstetric services at birth. But in many of the poorest countries, the coverage of health services is very low and the people who need them most (notably women and children) use them least.*

*We are not starting from scratch. We know now more about what works and what must be done. This chapter sets out what those most promising approaches are.*

*Achieve universal coverage of health care services is an ambitious goal, but one we must work towards. This chapter sets out a number of critical components.*

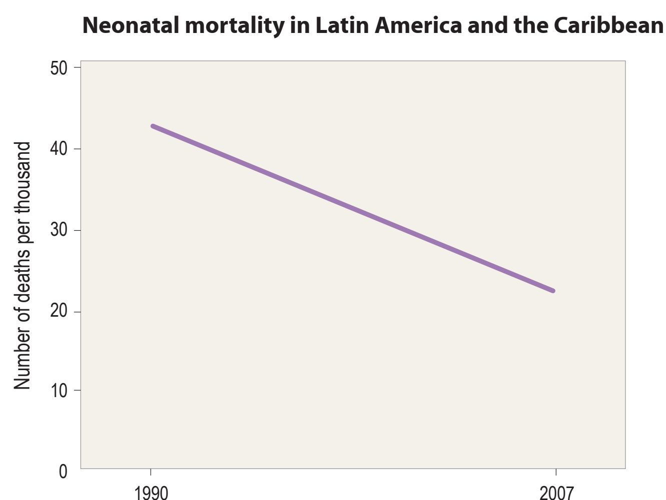
- *The importance of national leadership. The primary responsibility for delivering the health goals lies with national governments themselves.*
- *Tackling the health workforce crisis in the developing world.*
- *Maximising the impact and effectiveness of investments in health through the International Health Partnership and other initiatives*
- *Providing additional external resources for health systems and MDG4&5, including through innovative financing mechanisms.*
- *Remove the barriers that prevent the most vulnerable groups and disadvantaged members of society, women and children to access heath services.*

*It is only through this combination of increasing the availability of quality services while removing access barriers that we can, finally, keep our promise to the millions of women, infants and children in the poorest countries.*

# *National Leadership*

## Brazil

Brazil is committed to reducing the under-five mortality rate by two-thirds between 1990 and 2015. The federal government's main initiatives for achieving this are the Family Health Strategy, the Community Health Agents Programme, the National Pact for the Reduction of Maternal and Neonatal Mortality, and the National Immunisation Programme. All have been developed by the health ministry's Unified Health System (SUS). Together, these programmes have improved health, the environment, education and information systems – all contributing to a 61% reduction in under-five mortality.




*Source: CEPAL (2008): Objetos de Desarrollo del Milenio - La Progresión hacia el derecho a la salud en América Latina y el Caribe.*

In 1990, Brazil's child mortality rate was 53.7 per thousand live births. To fulfil its commitment, the country must reduce this rate to less than 18. In 2007, improvements in living conditions and the expanded coverage of the Unified Health System reduced the rate to 20. We are thus very close to achieving the UN's target. Brazil, once the world's 86th worst country for child mortality, is now 113th. Moreover, 99% of children under a year old are immunised against measles.

Despite improvements in child mortality, our rate is still high compared with developed countries'. And, reflecting variations in living conditions, there are still large regional inequalities: the northeast's mortality rate is twice the south's. Because the inequalities are greatest in post-neonatal mortality, in 2006 the federal government created the North-Northeast Network of Perinatal Health to assess healthcare units' work. The Network also provides consultancy, monitoring and supervision, supporting initiatives relating to neonatal services' management and organisation.

**MDG 5: Improve maternal health**

On maternal health, Brazil's own targets are more ambitious than MDG 5's. By 2015, we are committed to reducing the maternal mortality rate by 75% (compared with 1990), establishing universal coverage of sexual and reproductive health services, and containing the growth of mortality from breast and cervical cancer. This is the reason for the National Pact for Reduction of Maternal and Neonatal Mortality.

Between 1997 and 2005, maternal mortality fell from 61.2 to 53.4 per 100,000 live births. The health ministry financed research on maternal mortality among women aged 10 to 49. Carried out in Brazil's state capitals in 2002, this showed that maternal death is underreported. If this underreporting is taken into account, Brazil's true figure for 2004 would be 73.9 deaths per 100,000 live births.

The Action Plan for Cervical and Breast Cancer Control 2005-2007 is an innovative way of incorporating early detection of the cancers into the Unified Health System's routines. It is still too early to see results.

The challenge is to ensure comprehensive, high-quality health care for women, by improving professionals' capacity – in the country's largest maternal wards – to implement strategies that humanise obstetric and neonatal care, and incorporate new practices.

*Luiz Inácio Lula da Silva*

President
**Brazil**

# Chile

Since the return to democracy in 1990, Chile has made headway on the successful path of democracy, growth and equity that has allowed us to quadruple our economy, triple social investment and reduce poverty from 38.6% to 13.7% in 2006.

Today the country is making substantive strides toward a new phase of development. The primary objective of my government is the creation of a Social Protection System which provides social protection to our citizens from infancy through old age, ensuring social rights for all citizens. From this perspective, the objectives of the Social Protection System dovetail perfectly with our commitments at the Millennium Summit in 2000.

Chile has already met a majority of its Millennium Development Goals (MDGs) and is slated to fulfil many of those remaining well ahead of schedule.

In the area of children's health, national indicators show a positive trend. Social and economic interventions have significantly reduced infant diarrhoea, undernourishment and acute respiratory diseases. Between 1990 and 2006, the infant mortality rate plummeted from 16 to 7.6 per thousand live births -a 50% reduction. Among under-fives, mortality has fallen from 21 to 9 per thousand live births -a drop of 57%. Infant undernourishment has declined from 0.7% to 0.3%.

Maternal mortality rates have also fallen, from 40 to 19.8 per 100,000 live births – again a 50% improvement. And 99% of deliveries are attended by a skilled professional. Promoting greater equity in health for women is one of the Chilean government's top priorities.

Over the past two years there has been a noticeable improvement in women's access to higher education and to good, stable jobs. More women now hold public and government positions. This improvement in women's situation is a key part of achieving MDGs 4 and 5.

Chile is one of the seven countries in the Action against Poverty and Hunger initiative, as well as contributing to the international UNITAID initiative by donating US$ 2 for each international flight. These funds focus on providing medication and nutritional support for children suffering from AIDS.

My government and I joined the Norwegian-led Network of Global Leaders, supporting the Global Campaign, and the regional and global activities promoted by the Partnership for Maternal, Newborn and Child Health. This includes the regional launch of the "Deliver Now" initiative and the implementation of a South-South Plan for Co-operation on Maternal and Child Health, together with Bolivia, Brazil, Ecuador, Nicaragua, Paraguay, Peru, Uruguay, and eventually other Latin American and Caribbean countries.

The world must overcome tremendous challenges in order to meet the Millennium Development Goals in 2015, particularly MDGs 4 and 5. Nonetheless, we have witnessed significant advances in the building of the global public goods that will make the 21st Century an era of progress.

This is why I am enthusiastic. Chile is ready and committed to working with the international community to build a more inclusive and equitable globalization. Achieving the Millennium Development Goals will be a major milestone in the road ahead.

*Michelle Bachelet*

President
**The Republic of Chile**

## India

Over the last two decades India's economic growth has been strong. The country is developing quickly, but 70% of its people still live in rural areas. To be inclusive, economic growth must go hand in hand with social development, making the fight against malnutrition, ill-health and ignorance India's top priority.

### The National Rural Health Mission

To this end, India's government launched the National Rural Health Mission (NRHM) in April 2005 to provide high-quality healthcare in rural areas by making health services accessible, affordable and accountable. The Mission runs from 2005 to 2012, during which time NRHM's budget will be increasing, from US$1.25 billion in its first year to US$3 billion in 2008/9 and US$8 billion in 2012.

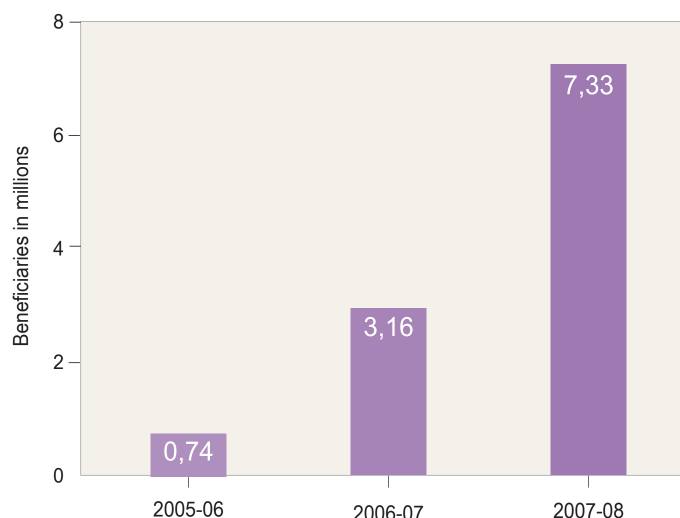
The budget increases will be accompanied by a revolution in management. The health system has brought in MBAs, chartered and public-health accountants, systems analysts, e-professionals and social-work graduates. Their role is to make the system more efficient and to support medical staff with essential housekeeping and logistics.

Financial and administrative processes are being redesigned to improve accountability, the flow of funds, and the speed and reliability of transactions – all helping the public health system to increase the coverage and range of services it provides. At the same time, the healthcare system is being decentralised and put into the people's hands. This is known as *Panchayati Raj* or rural local self-government. Public institutions are now given flexible financial resources to ensure that service guarantees are met, and public health standards ensure that every facility has the people, infrastructure and equipment it needs. This decentralisation and the empowerment of local primary and secondary health institutions is one of the key strategies for improving services and accountability.

### Achievements so far

During NRHM's first three years, advances in many of the country's provinces have been nothing short of dramatic. These provinces, with populations greater than many large countries', have shown great improvements and made determined efforts to improve their health systems – even those which have always had unsatisfactory health indicators in the past. Thanks to more-flexible funding, public facilities have been transformed. Over the last three years, more than 10,000 doctors, 40,000 nurses, 4,000 managers and 600,000 community health workers have been brought into the system.

**Beneficiaries of Maternity Safety Plan (JSY)**




The number of beneficiaries (in millions) of the Janani Suraksha Yojana (JSY) Safe Motherhood scheme in India. The scheme promotes institutional deliveries by providing cash assistance, both to the pregnant women living under the poverty line and to the health workers, who motivate and accompany these women to the institutions for the deliveries. Since 2005 there has been a remarkable 10-fold increase in the number of women who received assistance under the scheme.

*Source: Government of India: Statel-level routine data*

NRHM has used demand-side financing to put unprecedented pressure on the public system to deliver high-quality maternity services. These services are bound up in the *Janani Surakshya Yojana* or Maternity Safety Plan. The result has been an increase in the number of women using the services – from 700,000 in 2005/6 to more than seven million in 2007/8. Graph) The change has been greatest where maternal and infant mortality were highest. In Madhya Pradesh, with a population 30% tribal, coverage has risen from 27% to 62% in three years, and is still increasing quickly. In many provinces ambulances and emergency transport arrangements now connect households and health facilities more effectively. And many primary healthcare centres that used to be open for a few hours in the morning are now full of patients throughout the day and night. The increase in the take-up of maternity services has been a visible sign that the institutions have changed, spurring others to use them.

**Partnerships**

Partnerships with non-governmental organisations and the private sector have improved outreach services such as diagnostics and ambulances and brought in privately practicing obstetricians for care of poor women during delivery. In remote areas some primary healthcare centres have been handed over to these organisations, and private providers deliver babies in properly equipped institutions, free for women below the poverty line. In the province of Orissa, immunisation coverage has jumped from 50% to 70%. And the formation of patient welfare societies gives local communities the flexibility and funding to manage their health services.

Because many factors influence people's health, NRHM has set up a monthly "Health and Nutrition" day as well as a Health and Sanitation Committee in each village. They have the resources to take action on a wide range of issues that are relevant to public health, including water, sanitation, education, literacy, nutrition and women's empowerment. Communities are also encouraged to contribute their own funding and resources. This makes medical staff more directly accountable to the local community, as well as involving the community in supporting their local health centre. Health services thus respond to the community's changing needs as a centralised system never could.

**The future**

NRHM is about many elements working together: society, non-governmental organisations, institutions, traditional Indian medicine, community and many more. Thirty years after the Alma-Ata declaration established the importance of primary care in achieving health for all, NRHM is demonstrating the effectiveness of the approach. India is determined to achieve the MDGs, and is prioritising services for mothers and children while building a strong system able to achieve other health goals, such as its successful TB and HIV/AIDS programmes.

The challenge now is to consolidate NRHM's various initiatives into sustainable institutional arrangements so that the gains are maintained. Reforms to strengthen the health system, increased public-sector investment, and public-private partnerships need to continue. There is a great deal still to do. In many outreach areas, the quality and coverage of services vary greatly. The response time for emergency care must be further improved. And, India must recognise the role of nurse-midwives as a potent tool for rural and outreach healthcare. With all this, India is well on way to achieve MDGs 4 and 5.

*Dr. Ambumani Ramadoss*

Health Minister
**India**

## Indonesia

My government strives to improve healthcare services, particularly for mothers and children. However, because Indonesia is spread over thousands of islands, we address MDGs 4 and 5 also in concert with our efforts to alleviate poverty and provide education.

According to 2007's Indonesia Demographic and Health Survey (IDHS), infant mortality was 34 per thousand live births and under-five mortality 44. However, rates vary across region and socio economic background.

Maternal mortality was 228 per 100,000 births in 2007. As there are 4.8 million births annually, this means 10,914 women die due to pregnancy and delivery. The most common cause is obstetric haemorrhage, generally in post-partum, puerperal infections, poor delivery hygiene or untreated reproductive tract infections.

In our effort to reduce child and maternal mortality rates to meet MDG 4 and 5, my government has formulated four policies and strategies, consistently with the Healthy Indonesia Plan 2010, the Grand Strategy of reducing the levels of mortality and improve the quality of life as well as a Continuum Health of Care Framework. These policies and strategies consists of (1) improving the access and the scope of cost-effective quality maternal and newborn baby healthcare (2) building effective partnership through cross program and cross sector cooperation to conduct advocacy for Making Pregnancy Safer (MPS) planning and activity coordination; (3) encouraging women, family and community empowerment through knowledge improvement to assure healthy behaviour and (4) enhancing program management through surveillance, monitoring and evaluation.

In my recent address to the House of Representatives, I pledged to improve basic healthcare, education and rural infrastructure by investing US$15,5 billion, with US$7.1 billion for eradicating poverty and US$1.8 billion for rural development. This will reduce the proportion of people living in poverty to 12-14%, increase numbers of students in primary and tertiary education, expand public transport, extend education up to 9 year level and provide free community healthcare, particularly for poorer people and *Puskemas* (community health center) in-patients. We are empowering regional governments to play a key role in this, with their budgets tripling to US$31,9 billion. Indonesia's health budget also tripled to US$1,7 billion. The bulk is allocated to *Puskesmas*, integrated health services (*Posyandu*) and community health assurance (*Jamkesmas*). We provide health assistance to 76.4 million poorer people, and minimise prices of generic medicines. *Jamkesmas* programme also aims to increase rural access to health services.

We hope our national efforts will be supported by international and regional activities, with collaboration from international organisations and pooling of global resources.

*Susilo Bambang Yudhoyono*

President
**Indonesia**

## Liberia

Liberia's poverty-reduction strategy aims, by 2010, to reduce child mortality by 15% and maternal mortality by 10%. Our National Health Plan gives us a roadmap for achieving this, despite the challenges: poverty, illiteracy (particularly among women) and a lack of medical professionals and facilities. Food insecurity, exacerbated by the global fuel crisis, adds to these challenges.

**Children**

Over the last five years, Liberia has made tremendous efforts to reduce child mortality. Thanks to co-ordination between the government and its development partners, infant mortality fell from 156 to 111 per 1,000 live births. Meanwhile, under-five mortality dropped from 156 to 72. The proportion of one-year-olds immunised against measles increased from 52% in 2000 to 63% in 2006. This year, children's immunisation coverage will exceed 80%.

Our national nutrition policy and child survival strategy includes training health workers and facilities in Integrated Management of Childhood Illness (IMCI). Children's primary healthcare is free, and we distribute insecticide-treated mosquito nets and strongly encourage breastfeeding. Although five diseases – pneumonia, diarrhoea, malaria, measles and AIDS – cause half the deaths among under-fives, trends suggest Liberia achieving MDG 4 by 2015.

**Mothers**

Liberia's maternal mortality is unacceptably high: between 2004 and 2007 it rose from 556 to 994 per 100,000 live births. Causes include poverty, malnutrition, teenage pregnancy, poor roads and an inadequate referral system. The shortage of health professionals means they assist in only 46% of births.

We have a national strategic plan to improve the situation. Health workers, including 500 midwives, are learning basic lifesaving skills, and two new training sites have been established. More facilities are arriving, including four fistula rehabilitation units, 79 HIV counselling and testing centres, 15 antiretroviral therapy sites and 25 programmes to prevent mother-to-child transmission of HIV.

**Action**

We have suspended primary healthcare fees and introduced the Basic Package of Health Services (BPHS). Based on decentralised primary care, this focuses on children, newborns, mothers, adolescents, family and reproductive health, and communicable disease. In 2008, we will strengthen the BPHS, implementing it in 40% of facilities and training 4,000 health workers in it, as well as opening two new midwifery schools. We will also improve access to vaccines, cold-chain equipment, transport and communication, and address the shortage of healthcare workers. Our comprehensive human resources plan will help us to recruit and deploy 500 health workers and 50 doctors. We will also refurbish 84 facilities and create drug depots in each county to maintain uninterrupted supplies. This will also help to provide vitamin A supplements for all children, backed by a national nutritional surveillance system.

Meanwhile, emergency obstetric care will be improved, with 21 new ambulances, five new emergency centres, and better services in 15 hospitals and 50 care centres.

*Ellen Johnson-Sirleaf*

President
**Liberia**

# Mozambique

In the first half of 2008, Mozambique has taken a great deal of action on MDGs 4 and 5. In January, we tabled a draft resolution on maternal, neonatal and infant health at the African Union Summit. The resolution calls for African leaders to use all available means – including the UN – to raise the profile of the plight of women and children. The resolution was adopted.

In February I launched an initiative to raise awareness of women's and children's health in Mozambique. This initiative involved the participation of different groups, including health workers, community leaders, religious leaders, politicians, and women's groups and associations.

In April, I attended the Southern African Development Community's summit in Mauritius. Here I met Norway's prime minister, Jens Stoltenberg, to review progress on MDGs 4 and 5 and to sign the global leaders' letter to the G8 at their meeting in Hokkaido, Japan.

In May, I visited Chile, where President Bachelet and I committed ourselves to raising the profile of MDGs 4 and 5. Later that same month, at TICAD IV, I called on the G8 and other global leaders to pay attention to the health of women and children.

At around the same time, our health ministry launched the "Road Map to Accelerate the Reduction of Maternal, Newborn and Child Deaths in Mozambique". Meanwhile, the design of the Joint Plan for MDGs 4 and 5 was underway. This plan will cover all interventions on maternal and child health, co-ordinating the various initiatives within the country during 2008 and 2009. Discussions have already begun on improving facility-based deliveries of babies. This will be done by establishing temporary homes that provide good food and accommodation for pregnant women to live in as their birth approaches.

*Armando Guebuza*

President
**Mozambique**

## The Netherlands

We take MDGs 4 and 5 seriously, and we prove that by investing in them. In 2007, the total Dutch development budget for health – including HIV/AIDS and sexual and reproductive health and rights (SRHR) – was €424 million. We have also dedicated an additional €50 million to MDG 5 between 2008 and 2010.

Meanwhile, our annual budget for GAVI stands at €25 million, and our contribution to the Global Fund for Tuberculosis, AIDS and Malaria has reached €60 million this year, rising to €80 million in 2009 and €90 million in 2010. We are currently in the process of increasing our contribution to the Global Programme on Reproductive Health Commodity Security (RHCS), which is €5 million per year at the moment. This contribution to RHCS will help to reduce the fast growing gap between women's desire to use contraceptives and the availability of the means. We are also committing additional funding (€ 4.95 mln for 2008-2011) to UNFPA and the International Confederation of Midwives (ICM) in order to strengthen midwifery.

Of all our official development assistance (ODA), 15% is spent on education. This is essential for improvements – in the longer term - in maternal, newborn and child health, not least because there is a clear correlation between poor education for girls/women and early pregnancy. Another basic need that is particularly important to the health of children/mothers is sanitation and safe drinking water, on which we spend an annual average of €135 million.

Overall, Dutch ODA accounts for 0.8% of our country's GDP – higher than the 0.7% towards which most donor countries are working.

Much of our ODA is given in direct (sector) budget support or spent through specialist partners, such as GAVI and multilateral organisations as UNFPA, WHO, UNAIDS and UNICEF. This means that it can be difficult to point to specific outcomes that are direct results of Dutch aid. In addition we support (international) NGO's, that are in a position to undertake complementary actions, in particular for sensitive issues related to sexual and reproductive health and rights, and key to success on MDG 5 and related MDG 4 and 6.

At national level we do take specific action. The Schokland Accord on MDG 5 is a partnership that brings together public and private actors, in support of programmes and activities that promote maternal health. This year the 2nd "Mothersnight" was organised in Amsterdam - an evening of debate, stories, music and performances to raise awareness for MDG 5, before celebrating "Mothersday" on Sunday. We also ran a radio and TV campaign to highlight the MDGs, especially MDG 5. The crucial role of midwives in attaining MDG 5, was this years theme of mothersnight.

The Netherlands is contributing to the development of heat-stable oxytocin, an essential medicine which can be used to prevent post-partum haemorrhage, thus reducing maternal mortality due to excessive bleeding. In addition, we took the initiative to support the development of an affordable female condom – an important product, to increase women's choice to avoid unwanted pregnancy and to protect against hiv infections.

We are also committed to organising – in the framework of the 15 year commemoration of the International Conference on Population and Development in 2009 - an international event to highlight progress and challenges related to MDG 5.

We believe that by committing funds, taking action and focusing the world's attention on the MDGs, especially 4 and 5, they can be achieved.

*Jan Peter Balkenende*

Prime Minister
**The Netherlands**

## Norway

Since the Millennium Development Goals were adopted in 2000, they have guided the priorities of Norway's development assistance, and we have paid particular attention to the health MDGs. Progress has been made, but there are still major obstacles to achieving the MDGs and reducing the appallingly high number of newborns, infants and mothers who die every day.

This is why Norway has developed a policy focusing particularly on MDGs 4 and 5. I have pledged that Norway will contribute US$1 billion over ten years to reduce child and maternal mortality. This is in addition to a pledge of US$1 billion between 2000 and 2015 for vaccinating children in poor countries.

The policy combines several interlinked elements. There will be continued support, mainly through GAVI and GFATM, for immunisation programmes and treatment of AIDS, tuberculosis and malaria. We are also establishing bilateral partnerships with India, Pakistan, Tanzania and Nigeria. The focus is on providing catalytic and strategic support for their efforts to attain MDGs 4 and 5. Of these, the partnerships with India and Tanzania are most advanced.

We have established a trust fund with the World Bank to support results-based financing. Within a country's national health plan, this fund helps to design, implement and sustain the most effective mechanisms for reducing maternal and newborn child mortality.  Many countries have shown keen interest, and Rwanda, Eritrea, Afghanistan and DR Congo are already participating.

In addition, we are co-operating closely with other partners, international organisations and donors to make development assistance on MDGs 4 and 5 more efficient. A number of research activities are being supported and financed. And we are using bilateral and multilateral channels at all levels to urge other donors to increase resources for MDGs 4 and 5.

In September 2007 the Global Campaign for the Health-Related MDGs was launched in New York together with other world leaders. Its aim to accelerate progress towards MDG 4,5 and 6.

To sustain the Campaign and reduce mortality rates, political advocacy at the highest level is crucial. For this reason, a small number of international leaders have joined together in a Network of Global Leaders for MDGs 4 and 5. Members ensure that their own countries' commitments are  actively pursued. They are also expected to contribute actively to the international Campaign by promoting MDG 4&5 in summits and other high-level events.

To promote the health MDGs the members of the Network signed a joint letter to Prime Minster Fukuda at the G8 Summit in Japan in June 2008.

*Jens Stoltenberg*

Prime Minister
**Norway**

## Tanzania

Improving maternal, newborn and child health (MNCH) is an important part of Tanzania's plans – both its five-year National Strategy for Growth and Reduction of Poverty, and its longer-term Vision 2025. Policies include free treatment and preventative care for women and children.

**Children**

As a result, our progress on the health MDGs is improving. The under-five mortality rate (per thousand live births) fell from 141 in 1990 to 112 in 2004, and a recent Lancet report suggests that this will put us on track to achieve MDG 4. We plan to reduce under-five mortality to 47 per 1,000 live births by 2015, building on our success so far:

- Vaccination – coverage is greater than 80%.
- Integrated management of childhood illness (IMCI) – used by 93.8% of districts in 2005, up from 17.5% in 1999.
- Malaria – coverage of insecticide-treated nets increased from 2% in 1999 to 23% in 2005.
- Vitamin A supplements – reached 92% of under-fives in 2005, up from 21% in 1999.
- Oral rehydration therapy (ORT) – coverage increased from 55% in 1999 to 70% in 2004.
- Exclusive breastfeeding – increased from 11% of babies in 1999 to 47% in 2005.

**Mothers**

According to health survey data, the maternal mortality rate has risen from 529 (per 100,000 live births) in 1996 to 578 in 2004. However, among the 47% of mothers who gave birth in health facilities the rate was 214. A major part of the strategy is thus to improve access to services. The main causes of death are bleeding, obstructed labour, hypertension, infections and abortion complications. These are exacerbated by the fact that 10% of women of childbearing age are underweight, and 58% are anaemic.

The strategy is clear, but needs time to work. We are promoting family planning, extending emergency obstetric care, improving the referral system, recruiting and training more health workers and doing advocacy work to get more people (including men) involved in supporting pregnant women.

**Government commitment**

Health is a budget priority, accounting for 11.1% of all spending. We have doubled public health spending and decentralised it, strengthening district health services and their links with civil society. This has been vital to reducing child mortality, allowing districts to scale up high-impact interventions.

I officially launched the One Plan for MNCH in April 2008 to improve co-ordination and access. A new Primary Health Programme will complement this, bringing health services nearer to the people – in ten years everyone should be within 5km of a health facility. MNCH has always been important to me, and I have championed MDGs 4 and 5 at TICAD, as well as at AU and G8 summits.

*Jakaya Kikwete*

President

**Tanzania**

## United Kingdom

If we are to meet our goals of reducing child mortality by two-thirds and maternal mortality by three-quarters by 2015, we need to transform our trajectory of progress. To do this, the UK will use its aid programmes and its voice in global forums, focusing on four priorities.

**Health-system strengthening**

This will provide critical services, including life-saving emergency obstetric care. In September 2007, we joined with others in launching the International Health Partnership (IHP) to support national health plans. We are also working together on the health worker crisis: in April 2008, the UK and US announced a joint commitment to support more health workers in four IHP countries – the UK contributing at least £210m. In June 2008, we committed £6 billion for health systems and services to 2015. This is in addition to our £1 billion commitment to the Global Fund to Fight AIDS, TB and Malaria between 2008 and 2015.

**Targeted investments in high-impact interventions**

We will work with others to halve the unmet demand for family planning by 2010, and to achieve universal access by 2015. The UK has contributed £100 million to UNFPA for reproductive health commodities. We have also provided £4m to the Safe Abortion Action Fund and £6.5m to Ipas.

We have committed £30 million to the GAVI Alliance for 2006 to 2008, and are working with other donors to increase support for innovative financing mechanisms, including the International Finance Facility for Immunisation (IFFIm) and the pilot Advance Market Commitment (AMC) for pneumococcal vaccines.

Over £200m will support social protection programmes over the next three years, helping give more orphans and vulnerable children access to better nutrition, health and education. And in April 2008, the UK committed to providing 20 million long-lasting insecticide-treated nets to save mothers and children from malaria.

**High-level advocacy to mobilise international effort on MDGs 4 and 5**

In July 2008, the Toyako G8 Summit recognised that "achieving the MDGs on child mortality and maternal health is seriously off-track" and reaffirmed the importance of improving sexual and reproductive health. At the UN High-Level Event in September 2008, we will press for accelerated action on maternal, newborn and child health.

**Support for civil society to establish new alliances and partners**

We have supported the Partnership for Maternal, Newborn and Child Health with £1 million, as well as supporting Women and Children First (a UK-based NGO). We continue to support civil-society groups, such as the White Ribbon Alliance, that hold governments accountable for effective maternal services.

To overcome our greatest failure, we must summon our greatest effort. Fifteen years were allocated for achieving the MDGs. Fewer than half remain. We need a new, collective endeavour to mobilise the political will, resources and creativity behind our common goal: safe motherhood.

*Douglas Alexander MP*

Secretary of State for International Development
**United Kingdom**

# *Targeted interventions for maternal and newborn health*

## The Lancet

The accumulated evidence on how to improve maternal, newborn and child survival rates has reached a critical mass. Packages of interventions delivered to clinics, outpatients, communities and families can accelerate progress towards MDGs 4 and 5.

Scaling up these programmes is now an urgent global priority. Results from the most comprehensive attempt to monitor maternal and child survival indicate that although 16 of 68 priority nations are on track to achieve MDG 4, progress is inadequate in 52 low-and middle-income countries. Worse, progress on maternal mortality is stubbornly poor.

Opportunities are being missed to combine the delivery of interventions. One of the major causes of this disappointing progress is the problem of weak health systems, which also contributes to the great inequities one sees in service delivery. At the same time, assistance from donors is volatile and poorly targeted to need. Aid also remains largely focused on projects, thus missing important determinants of child and maternal health, such as nutrition. Monitoring of policies indicates that if the MDGs are to be achieved, the priorities should be to increase political commitment, financial assistance, and technical support for countries.

One of the most neglected areas for technical, financial, policy and political intervention is nutrition. Each year, stunting, wasting, and intra-uterine growth restriction are responsible for 2.2 million deaths of children under five. In total, nutrition-related factors account for 35% of all child deaths in the world today.

Thirty years after the Alma-Ata Declaration on the role of primary care in promoting health for all, important new data confirming the critical value of primary care services are at last available. These data help us to assess the progress of child health since the declaration. They show that substantial health gains can be made by consistently investing in primary care, by developing agreed packages of interventions, and by introducing these packages in phases at the district level.

Integrated packages of care delivered to vulnerable communities are particularly feasible and effective, reducing maternal deaths by up to 30%, newborn deaths by 20%, and post-neonatal deaths by as much as 40%. These remarkable results should encourage all of us to redouble our commitments to maternal and child survival.

In summary, there are now sufficient data to show that we can deliver rapid and equitable health improvements and make measurable, even dramatic, progress towards MDGs 4 and 5. The way to do this is clear: to scale up investments in maternal, newborn, and child health by strengthening services at the primary-care level. We are entering a period of unprecedented opportunity. The vision of Alma-Ata is within our reach.

*Richard Horton*

Editor
**The Lancet**

## UNICEF

One of UNICEF's major priorities is child survival, growth and development. More than 50 per cent of UNICEF's annual budget is allocated to child survival, growth and development programs, with a focus on integrated and community-based approaches. Over 90 per cent of under-five mortality occurs in Africa and Asia.

UNICEF's five major commitments are:

1. Contributing to policy development and the evidence base;
2. Measuring results;
3. Scaling up national programmes for women and children;
4. Forging and leveraging strategic alliances and partnerships;
5. Communication and advocacy.

Progress is being made. In 2007, the number of deaths among children under five continued to decline to an estimated 9.2 million – a more than 60% fall in the child mortality rate since 1960. As they have become more available, basic preventative and curative services have contributed to this decline, especially in the following areas:

- Measles – a 91% decrease in sub-Saharan Africa, achieving the goal for measles mortality reduction in the region.
- Drinking water – the number of people without access to improved sources fell below a billion for the first time since records began in 1990.
- Vitamin A, immunisation and insecticide-treated nets – between 2000 and 2007, in 16 countries in sub-Saharan Africa, the number of children using nets tripled.
- HIV/Aids – Unite For Children, Unite Against Aids focussed on preventing transmission of HIV from mothers to children, and increasing coverage of antiretroviral treatment among children. In southern and eastern Africa, the proportion of HIV+ pregnant women receiving antiretroviral prophylaxis increased from 11% in 2004 to 31% in 2006.
- Nutrition – From 2006 to 2007, UNICEF doubled its procurement of ready-to-use therapeutic foods to US$18 million, distributing them to 41 countries.

This year, UNICEF and its partners launched Countdown to 2015 in Cape Town, South Africa, to focus on the health-related MDGs in the 68 countries that account for more than 98% of deaths among mothers and children. The launch was held in conjunction with the annual meeting of the Inter-Parliamentary Union. UNICEF is now working with parliamentarians in all 68 countries to ensure focus on these issues.

Countdown's data shows that we need to target the perinatal period, expanding care for mothers and newborn babies. This is the focus of a joint programme of work undertaken by WHO, UNFPA, the World Bank and UNICEF.

For progress to continue, health systems need to be strengthened. Various initiatives are underway, including the Catalytic Initiative, implemented by UNICEF and Canada under the framework of the International Health Partnership. To help with this, we have established two new teams in New York: one to strengthen health systems by improving financial and human resources, the other to focus on expanding the evidence base through implementation research including finding out why some countries are progressing better than others.

Finally, with global food price increases, nutrition is an even more urgent challenge, particularly for vulnerable children and pregnant women. To combat this, we have allocated additional resources to 40 countries.

*Ann M Veneman*

Executive Director
**UNICEF**

## UNFPA

No woman should die giving life. Advocating for maternal health and supporting countries to accelerate progress towards MDG5 is at the core of UNFPA's mandate and is a key component of UNFPA's advocacy and country programmes, especially in the 60-70 countries with high rates of maternal mortality. This work is part of a comprehensive approach to achieve universal access to reproductive health, including preventing HIV – especially its transmission from mother to child. We put special focus on youth, to address the high adolescent fertility and high maternal mortality in many countries.

In 2007, universal access to reproductive health was added as a new target under MDG5; this is of direct relevance to decreasing the lifetime risk of maternal death, including by meeting the unmet need for family planning and thus avoiding pregnancies that are too early, too late, and too frequent.

Over the past two years, UNFPA – together with WHO and UNICEF – has supported 40 African countries to develop and implement national road maps for maternal and newborn health. Our Global Programme on Reproductive Health Commodity Security has helped to strengthen countries' supply systems. The programme, in concert with partners of the RH Supplies Coalition, rapidly improved more than 30 countries' logistics, management and information systems, ensuring less stock-outs of contraceptives and other supplies.

In September 2007, UNFPA announced the creation of a Maternal Health Thematic Fund to boost support for priority countries on MDG 5. The Fund began operating in January 2008, and is already supporting 11 countries. Our goal is to use this fund to provide US$500 million of targeted support over the next four years. Maternal mortality is a good indication of a health system's functioning, so our approach can be described as MDG-driven, results-based health-system strengthening. It is one of our key contributions to the International Health Partnership, building on UNFPA's participation in sector-wide approaches.

Over the past year, we have intensified our work with WHO, UNICEF and the World Bank to accelerate progress on maternal and newborn health. In July, we agreed on a clearer division of labor among our organizations and plans for accelerated support in maternal health. This support will focus on 60-70 countries with high maternal mortality. Work will begin in 25 of them before the end of 2009, including countries facing humanitarian emergencies. Building on previous co-operation, UNFPA has recently signed a memorandum of understanding with UNICEF and Columbia University on accelerated country support and capacity building for emergency obstetric and newborn care.

UNFPA also carries out global advocacy and media work on maternal health, helping to make it an international priority. We played a key role in including maternal survival in the Countdown to 2015 process, and led UN work on the topic for the G8 Health Experts Group, resulting in maternal and child health being included in the 2008 G8 Statement. We were also active in the Partnership for Maternal, Newborn and Child Health and the landmark "Women Deliver" conference and initiative.

While progress is being made, much remains to be done to accelerate the scale-up towards universal access to quality family planning, skilled attendance at delivery and emergency obstetric and newborn care. Supporting national health systems, mustering the required financial resources and scaling-up the production of skilled health workers, particularly midwives, will be critical to the success of this effort.

*Thoraya Obaid*

Executive Director
**UNFPA**

## World Health Organization

**Measles**

In 2005, a new goal was decided by the World Health Assembly and UNICEF's Executive Board: measles mortality should fall 90% between 2000 and 2010. Figures announced in 2007 showed that the previous goal of a 50% reduction between 1999 and 2005 had been exceeded by 10%. What's more, the new goal was achieved four years early in Africa. This monumental success was achieved in only six years, by committed countries and the Measles Initiative, a highly effective global partnership.

**Countdown to 2015: maternal, newborn and child survival**

The Countdown is a means of tracking progress in the 68 countries with the highest maternal and child mortality – together accounting for 97% of the world's total. Its 13 indicators of health systems and policy showed that very few countries have adopted policies vital for scaling up MNCH interventions. Health-service delivery was very poor in half of the countries, and in the majority of them financing and the workforce were also poor. Indicators like these must guide our programmes' actions.

**Monitoring progress on MDG 5**

One of the targets for MDG 5 is a 75% reduction in maternal mortality by 2015, but there has not been enough data to estimate the global change since 1990. So, in 2007, WHO worked with other agencies to analyse maternal mortality trends between 1990 and 2005. Progress has been uneven. An annual decline of 5.5% would be necessary to achieve the goal. In East Asia it was 4.2%, in North Africa 3%, in South-East Asia 2.6% and in Latin America and the Caribbean 2%. In sub-Saharan Africa, it was just 0.1%. WHO also carried out secondary analysis of demographic and health survey data from 71 countries. This showed inequity within countries between rich and poor, and urban and rural areas, in accessing maternal and newborn care services.

**A new MDG 5 target**

The new target, 5b, is to achieve universal access to reproductive health services by 2015. WHO worked with partners to design indicators for it: contraceptive use, unmet need for family planning, antenatal care coverage, and adolescent fertility. This will affect guidance on MDG 4 as well as 5, because of the influence of interventions such as family planning and maternal care.

**Female genital mutilation**

WHO led in developing and publishing a statement on female genital mutilation signed by nine other UN agencies – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM. It calls for all states, organisations and communities to uphold the rights of girls and women and to take action to end the practice. The statement was a result of WHO research that showed mutilation significantly increased health risks for mother and baby during childbirth. A resolution of the World Health Assembly reinforced the statement.

## The Catalytic Initiative to Save a Million Lives

The Catalytic Initiative brings donors together to support countries' health systems in order to accelerate progress towards MDGs 4 and 5. This Initiative is a coordinated effort with a common focus on high-impact interventions and a commitment to mortality monitoring. The Initiative should be viewed within the context of the International health Partnership (IHP) as a concrete program for country-level scale-up with a focus on programme monitoring and results tracking, in order to demonstrate lessons learned. It is not a legal entity with a Fund, as all work will be carried out through existing channels.

Over US$400 million has been mobilised for country activities from partners including CIDA, UNICEF, the Doris Duke Foundation, Norway, AusAid and the Bill and Melinda Gates Foundation. So far funds have been committed to Afghanistan, Burkina Faso, Benin, Ghana, Ethiopia, Malawi, Mali, Mozambique, Niger, Pakistan and Tanzania.

**County activities**

Partners have programs underway, and in many countries activities are rolling out. Examples of county activities underway include:

In Mozambique, partners are working with the health ministry to identify gaps in basic services at the community level. Initial work addresses immediate gaps identified by the MoH, such as vaccinations, vitamin A supplements, insecticide-treated bed nets, treatment for pneumonia, diarrhoea and malaria, and breastfeeding education. While at the same time, supporting community planning to ensure adequate staff, supplies and transport. The support will help to accelerate the government's plans to scale up high-impact interventions. Already over 400,000 long-lasting mosquito nets have been distributed to children and pregnant women.

As part of Malawi's five-year plan for child survival and development, partners are working with the health ministry to train close to 6,000 health surveillance assistants/ community health workers in 2008. Key drugs – such as anti-malarials, antibiotics, and oral rehydration salts – will be distributed by the new personnel, strengthening community-based drug supply and management systems.

Funding through the Initiative will accelerate Ghana's High Impact, Rapid Delivery (HIRD) programme. Funding will support the training of additional community health workers, supply critical drugs to fill gaps identified by the government, facilitate breastfeeding education programmes, and improve supervision of community health workers. In 2008, CI funds will be used to supply 25,000 doses of anti-malaria drugs (ACTs) and help to train close to 4000 additional community health workers.

**Monitoring and valuation**

Johns Hopkins University is cooperating with CI partners and others to develop a common monitoring and evaluation framework and common indicators for the Catalytic Initiative team and the International Health Partnership.

This work has included participation in the Common Monitoring and Evaluation Framework roundtable at Countdown to 2015 in April 2008. This roundtable aimed at consolidating an impact-evaluation framework for large initiatives on MDGs 4 and 5.

## The Role of Innovation

The world has made extraordinary progress towards improving health since the Millennium Development Goals were adopted in 2000. Most of this progress has been driven by increasing access to proven health solutions, saving millions of lives every year.

Many of the biggest improvements in health have come from childhood vaccines, including a remarkable 91% drop in measles deaths in Africa from 2000 to 2006. This inspiring success is built on the foundation laid by Edward Jenner, inventor of the first vaccine more than 200 years ago.

However, it's clear that we cannot overcome all of today's health challenges by relying on the breakthroughs of the past. We also need new, out-of-the box ideas – innovations – that will transform the world as completely as Jenner's discovery once did.

To capture such transformative ideas for global health, we must be willing to take many risks and fail often, for innovation frequently arises from the lessons of repeated failure. Setbacks are a natural part of success, for example in our search for an HIV vaccine, and it is important to stay the course and not give up. We must recognize that innovation comes from every corner of the world – no one country or region has a monopoly on creative thinking. We must also acknowledge that innovation can come from any discipline – an engineer or a physicist could just as well have brilliant insights into a difficult biomedical problem.

Reaching the Millennium Development Goals, and then building on that success to achieve true global health equity, will require innovation in three distinct areas:

First, we must find new ways to deliver health services to those in need. Current health systems leave far too many people with access to little or no health care.

Second, we must develop tools that are cheaper and easier to use in the poorest parts of the world.

Finally, we must discover brand-new approaches and strategies to overcome the most difficult health challenges.

We believe that a new wave of innovation in global health has begun, and we're already starting to see the first fruits of that effort. For example, the world's most advanced malaria vaccine candidate will soon enter late-stage clinical trials. Even if it's only partially successful, it would represent an extraordinary step forward – the first-ever vaccine against a parasitic disease. It would pave the way for future generations of malaria vaccines with the potential to wipe out one of the world's deadliest scourges.

We hope to see many more transformative ideas for global health in the years to come, with support from the global community of scientists, government, industry, and philanthropy. To this end, the Gates Foundation recently established the Grand Challenges Explorations initiative, which will fund hundreds of innovative, early-stage projects. We hope to hear new ideas from people around the world, especially young investigators and those who don't traditionally work in global health. At the same time, complementing these more radical possibilities, we will continue to invest in innovative twists on tried and true approaches.

Innovation is not the only solution to global health problems – it must go hand-in-hand with our continued efforts to expand access to existing solutions. But if we are to build on the successes we have already achieved in immunization, treatment and care, we must never lose sight of the transformative potential of new ideas.

*Tachi Yamada*

President, Global Health Program
**Bill & Melinda Gates Foundation**

# *Financing*

## Resourcing health systems to accelerate progress on reducing child and maternal mortality

Development assistance for health has more than doubled since 2000, producing significant results: in 2006, for the first time, fewer than 10 million children under five died. However, if we are to meet the health MDGs, more needs to be done, especially on maternal and child health. In 2006, 4.8 million children under five died in sub-Saharan Africa, and 4 million died in South Asia, East Asia and the Pacific. In 2005, for every 100,000 children born in low-income countries, 600 women died. Most of these maternal and child deaths could have been prevented by increased access to proven, affordable interventions.

Australia, like many governments, gives high priority to reducing maternal and child mortality. We are committed to increasing our health development assistance significantly, accelerating progress towards MDGs 4 and 5, and working with our neighbours East Timor and Papua New Guinea, which both face considerable health-system challenges. The International Health Partnership, which Australia supports, is revealing a clear need for additional resources to support national health plans. Some of this investment must support the underlying human resources, financing and procurement systems that enable health services to be delivered effectively.

Mobilising resources will require a collective effort by donors, as well as a commitment from partner countries to increase domestic investment in health. We also need to ensure that resources are used more effectively. New approaches such as results-based financing are promising. Development assistance for health must be better harmonised and aligned with country-defined priorities. National health plans should be made more results-focused, with maternal and child health indicators used to track health-system performance.

The 2008 UN MDG meeting in New York is expected to establish a High-Level Task Force on International Financing for Health Systems. This will explore ways to mobilise and manage additional resources using existing mechanisms – such as bilateral assistance and support from the Global Fund and GAVI Alliance for strengthening health systems. It will also consider innovative new financing options such as a Multi-Donor Trust Fund for Health Systems Strengthening. The Task Force should also assess whether new mechanisms deliver additional resources, promote the Paris principles on aid effectiveness, provide flexible and predictable financing, produce benefits that justify the transaction costs, and are administratively simple and transparent.

Ultimately, investments in health must be judged on their outcomes and contributions to the health MDGs. This will be critical for sustaining support within donor countries for health development assistance. Measuring outcomes is also critical for making donors and partner countries' governments accountable to the poor and vulnerable who die unnecessary and preventable deaths because they cannot access the healthcare they need.

*Kevin Rudd*

Prime Minister
**Australia**

## We can do more to remove barriers to the use of high impact health care

Poor people use maternal and child health services such as antenatal care and assisted deliveries less than richer groups. Even free services – typically antenatal care and immunization – are used more by wealthier groups. However, payment for services is only one of the obstacles faced by the poor. Barriers are greatest in rural areas due to physical isolation and poor transportation.

On the supply side, health workers are often poorly trained and ill-equipped. Public management systems often provide insufficient support. Corruption, including informal payments, also squanders resources. Financial and non-financial incentives may need to be modified to deliver better results.

On the demand side, poor women often may not be able to afford transport to the health facility, or to buy drugs, or to compensate the health provider - formally or informally. The financial burden may be increased by the opportunity cost of forgone income. Health worker absenteeism exacerbates these costs if women have to return several times to receive health services. Costly hospital services for emergency obstetric care can lead to impoverishment. Limited awareness of services, harmful traditional practices, and discrimination facing women and the poor also constrain demand.

We are seeing significant progress in improving access to priority maternal and child health interventions. Further progress requires appropriate supply and demand-side instruments. Poor households can be given direct financial support through a cash transfer or an entitlement. Cash transfers to create incentives for households to seek services have been successful in several Latin American and Asian countries. Community funds can be established to pay for transport and service fees. A number of countries are scaling up insurance mechanisms and equity funds. Health insurance premia for the poor can be publicly subsidized. Governments could ease access by the poor by reducing user fees when there are adequate replacement resources and fiduciary controls.

Programs which mobilize households and community organizations and provide sound information can empower poor women and their families.

Innovative applications of “pay for performance” approaches, such as linking budget provision to service coverage and performance-based contracting, demonstrate that public systems can stimulate productivity and quality to increase access and results.

Achieving the health MDGs is a challenge to all of us. Increasing resources is a necessary, but insufficient condition. We must redouble efforts to ensure that vital health services are available to those most in need. There is progress, but much more is needed.

*Graeme Wheeler*

Managing Director, Operations
**The World Bank**

## Results-Based Financing for Maternal and Child health

Results-based financing (RBF) is an innovative financing strategy that can increase the impact of investments in health by providing a cash or in-kind reward conditional upon achievement of agreed performance goals. RBF is an umbrella term that includes output-based aid, performance-based financing, provider payment incentives (Supply-side interventions), vouchers, contracting and conditional cash payments and transfers to households (demand-side interventions). In some countries, RBF may take the form of paying a bonus to health facilities that meet certain quantity or quality targets such as percent of women delivering in a facility. Other countries are designing their RBF mechanisms to support the poor who require extra funding to overcome barriers to using services. RBF is not a goal in itself, but a mechanism to improve maternal and child health in the wider context of performance management.

**The Rwanda Case**

As an example, the Government of Rwanda has designed and implemented a comprehensive package of reforms that includes health insurance, budget and civil service reform and an RBF mechanism that contracts and pays "performance bonuses" to public and NGO health facilities and hospitals conditional on the provision of high quality, priority services. The additional costs of the RBF program are roughly $2.15/ capita on top of the current $34 total expenditure per capita. This has produced impressive changes in health worker behavior and dramatic improvements in health programme results as measured by Demographic and Health Surveys in 2005 and 2008. The results include an increase in deliveries in facilities from 39% go 52%, a major increase in the use of insecticide treated bednets in under 5 year old children from 4% to 67%, and an increase in modern contraception use from 10% to 28%. The improved uptake of priority health interventions probably explains the documented decline in under 5 mortality from 152 per 100,000 to 103 per 100,000 over this same period

**World Bank Health Results Innovation Trust Fund**

A multi donor trust fund has been established in the World Bank (Health, Nutrition, Population unit) by Norway (US$ 105 million over six years). The trust fund is linked to IDA credits, and provides financing to national authorities to pilot innovative RBF programmes.

Selected interested countries have been asked to develop brief proposals outlining how they would use grants to strengthen the health system to deliver results. Country interest has been overwhelming, and five out of 16 interested countries were selected in the first selection round, including Afghanistan, Eritrea, Rwanda, Zambia and some limited funds for Democratic Republic of Congo. These countries receive funds and technical assistance to design, implement, monitor and evaluate their RBF schemes with the long term goal of taking them to scale if they prove successful. Proposals address issues such as the critical bottlenecks to delivering health services and an RBF mechanism to address them. The effort also supports governments to re-orient their finance and information systems toward results.

Countries are encouraged to implement the RBF programme in close partnership with international agencies (WHO, UNICEF, bilateral agencies, etc.). Country experiences will be widely disseminated to governments, civil society, and development partners to promote learning on RBF.

## Providing for Health Initiative

The vast majority of people in developing countries have poor access to health services. Providing for Health (P4H) aims to protect people against the often catastrophically high cost of healthcare by creating and extending sustainable systems of social health protection. Its principles are universality, equity and solidarity.

In P4H's second technical meeting, held in Geneva in July 2008, we reached consensus on the organisation's framework and management structure. P4H will support partner countries in their efforts to incorporate social health protection in national plans and programmes – including those financed internationally. P4H will thus help to harmonise outside assistance (in accordance with the Paris Agenda) and will collaborate with IHP+ and other initiatives. Its innovation is to promote social health protection by linking domestic financing systems and external funds.

Globally, management will be light, consisting of a steering group and a technical co-ordination group. The steering group will provide political oversight, advocacy and strategic guidance, fostering political support and ensuring that P4H complements other initiatives. The technical co-ordination group will help countries technically, as well as doing advocacy and communication work, and identifying and facilitating funding – both domestic and international. It will also help to monitor activities and disseminate best practice.

**What we will do and achieve**

We will help countries formulate policy options and national plans, working with other development partners, as well as providing technical support in designing and implementing social health-protection strategies. We will also support countries in applying for funds, co-operating with global financing institutions such as GFATM, GAVI, and the Bill & Melinda Gates Foundation. In addition, we will carry out advocacy and communication work, as well as monitoring and evaluating activities using performance-assessment tools. This will support experimentation and help everyone involved to learn from experience.

Our work will help to align outside assistance with national policies, plans and strategies. It will help to improve the use of domestic and international resources (such as vertical funds and sector-wide approaches) for developing equitable and sustainable structures for social health protection. This will increase awareness among countries, development partners and the public, as well as helping countries to learn from each other. Partner countries will also increase their capacity to make strategic decisions based on evidence.

**Next steps**

All partners have committed to supporting countries strategically and technically. Germany and France will support P4H's co-ordination function globally and in the field, providing experts for short periods. ILO and WHO will provide substantial human resources support, and WHO will host the technical co-ordination group, which will begin operating in the second half of 2008. We also welcome support from other agencies, and are currently talking to several potential partners.

## UNITAID: innovative financial mechanism

In 2004, a group of 44 pioneering countries agreed on the need for additional stable resources for development. They committed themselves to establishing innovative financial mechanisms to close the gap between aspiration and achievement on the MDGs. Norway, France and Brazil, along with other countries and international organisations, opened a discussion on the need to facilitate access to drugs for the world's people in low income and lower middle income countries as part of the fight against the major pandemic diseases.

In 2006, France, Brazil, Chile, Norway and the United Kingdom launched an innovative partnership to supply people in low income and lower middle income countries, at lower cost, with life-saving medicines for AIDS, tuberculosis and malaria. UNITAID was established as an international drug-purchase facility, aiming to secure substantial price reductions and wider access to high-quality medicines and health products – currently unaffordable for most people in developing countries. UNITAID raises funds innovatively from long-term and predictable sources such as taxes on airline tickets. This allows sustained and strategic intervention in markets to reduce prices, improve the quality of drugs and diagnostics, and make them available to patients.

Hosted by the World Health Organization, UNITAID is a success story: in less than two years we have collected more than US$500 million from the air travel tax and other long-term financial contributions. In co-operation with its partners, UNITAID has reduced the price of second-line and paediatric antiretroviral drugs to treat HIV/AIDS in children. It has also increased the number of medicines for HIV and tuberculosis that are pre-qualified by WHO, as well as providing funding to combat malaria and multi-drugs-resistant tuberculosis.

**The Voluntary Solidarity Contribution and the Millennium Foundation**

UNITAID is now exploring the feasibility and revenue potential of a worldwide mechanism enabling individual citizens to contribute. This is the Voluntary Solidarity Contribution, and its aim is to raise funds from individuals and corporations who purchase airline tickets in travel agencies or online. A single low contribution of two euros, dollars or pounds per ticket would be simple, voluntary and hassle-free. This mechanism uses Internet technology to enable the citizens of the world to contribute directly to a better world.

The project has already attracted support from major personalities and institutions, including the Bill & Melinda Gates Foundation, the Clinton Foundation, Google, and the airline central reservation systems provided by Amadeus and Travelport. Preliminary assessments by McKinsey suggest that by 2011 the Voluntary Solidarity Contribution could be raising US$1 billion per year.

This sustainable additional revenue will bring the Millennium Development Goals closer.

*Philippe Douste-Blazy*

President
**UNITAID**

## The International Health Partnership - IHP+

The International Health Partnership, launched in September 2007, brings together international agencies, bilateral donors, partner countries, civil society organisations and the private sector. The IHP calls on them to accelerate progress on the health MDGs, including universal access commitments, and increasing coverage and use of health services. We also co-ordinate our work with related initiatives set up at the same time, and the combination is known as IHP+. Between us, we've made a great deal of progress.

**Country compacts**

Three country compacts – Ethiopia, Mozambique and Mali – will have been completed by the end of October 2008. More will be signed over the next few months, and we are setting up a schedule so that governments and donors can use high-level global events to announce financial support.

**Harmonising support**

Several agencies are working together to harmonise their efforts in countries, agreeing common appraisal processes for national plans, linked to compact agreements, results and decisions on financial support.

**Greater co-ordination on health**

The Scaling Up Reference Group is the IHP+'s light global governance structure, involving international health agencies, civil society and development partners. Work has begun on strengthening country health-sector teams, initially focusing on engaging civil society, and now looking at incentives and country-specific opportunities to improve collaboration.

**Monitoring performance and accountability**

A common approach and strategic framework has helped us focus on improving data-collection systems. The IHP+ has had its first annual external review, and a North-South Consortium will soon be chosen to prepare the next three reviews using the new strategic framework. Progress reports have been prepared for ministers at the World Health Assembly in May 2008 and for the informal meetings of the Health 8 in January and July of this year. However, there are still issues to solve.

**Mobilising new funds**

More long-term, predictable financing is needed for country compacts, linked to results-oriented and costed health plans. A high-level task force will look at innovative ways of mobilising resources.

**Global commitment to compacts**

Joint-agency missions will visit countries after they sign compacts, demonstrating support and considering ways of covering financing gaps and changes in how agencies work.

**Agreeing appraisal processes for countries' health plans**

This will help to increase the number of development partners able to invest in national health plans – including the Global Fund, which is one of the leads on this work.

**Country-level implementation challenges**

It is difficult for country health-sector teams to be responsive to countries' needs *and* represent stakeholders. Civil society and the private sector need to be engaged better, with strong local partnerships and broader representation of stakeholders at the country level.

**Removing bottlenecks and reducing transaction costs**

Agencies will have to be proactive to make this happen. The external review suggests investing in change management to help country teams work more efficiently.

## Health workers: the cornerstone of reliable health systems

To achieve health and development goals, everyone must have access to skilled, motivated health workers in a functioning health system. But 57 countries, most in Africa, have critical shortages estimated at 2.4 million doctors, nurses and midwives – excluding skilled managers, community health workers and other staff.

This crisis has profound policy and implementation challenges, including quickly scaling up education and training, managing health-worker migration and retention, and assigning roles to the public, private and voluntary sectors.

The Global Health Workforce Alliance held its first Global Forum on Human Resources for Health in March 2008. The Alliance has emerged as a global forum and convener for advocacy, learning and action across a multiplicity of stakeholders. Its Kampala Declaration and Agenda for Global Action set a framework for assessment of needs and action on human resources for health over the next decade. Within this, the World Health Organization (WHO) is developing a voluntary code of practice on ethical recruitment, with web-based public hearings in September 2008.

Solving the health workforce crisis will cost billions. In July 2008 the G8 leaders committed themselves to action. Japan, the United Kingdom and the United States have made concrete commitments, including the US AIDS programme's commitment to training and retaining 140,000 healthcare workers.

The 2008 International AIDS Conference reaffirmed the need for AIDS and health communities to work together, maximising resources to achieve universal access to HIV services and strengthen health systems – and combating discrimination which also seen within the health professions.

Donors should support countries' national health strategies where they include good, costed plans for health workers. The International Health Partnership's (IHP's) country compacts offer a framework for these agreements. The first three will soon have been signed – all with costed workforce plans.

Ethiopia's IHP compact identifies a gap of US$2.84 billion over the next three years to get on track to meet the health MDGs. The plan includes training and deploying 30,000 health extension workers (1 for every 2,500 people) and increasing midwife numbers to one for every 6,759 women aged 15-49.

Mozambique will sign its IHP compact in September 2008. Its plan will increase the health workforce from 26,000 in 2007 to 46,000 in 2015 – requiring an extra US$50 million in 2009, rising to US$150 million by 2015. Skilled birth attendants' numbers should rise 67% to one for every 5,049 women aged 15-49.

Mali will sign its IHP compact in October 2008. Its national plan, like Zambia's includes human resources. Zambia has acted to reduce emigration, revamp training, improve public-sector management and tackle HIV/AIDS.

At the UN's MDG event and at "Financing For Development", partners should make specific commitments to close financing gaps in countries with costed health workforce plans, including those with IHP country compacts.

*Mubashar Sheikh*

Executive Director
**Global Health Workforce Alliance**

## Advocacy: Partnership for Maternal, Newborn and Child Health

The Partnership for Maternal, Newborn and Child Health (PMNCH) is an alliance of 260 countries, organisations and experts working to help mothers and their children thrive. We coordinate *Deliver Now*, using advocacy to boost political commitment to mothers and children. Deliver Now supports communities to demand better access to healthcare, and more investment in it. This year Deliver Now was launched in India and Tanzania, with Latin America following at the end of September.

**Deliver Now India**

Partners developed a "checklist of entitlements" to government benefits, for increasing civil society organisations' advocacy and communication capacity. The Partnership also engaged a consultancy firm to develop a media campaign, in collaboration with a national broadcasting corporation. We have conducted a baseline survey of knowledge, attitudes and behaviour, and plan a follow-up to measure the campaign's effect.

**Deliver Now Tanzania**

In Tanzania, Deliver Now supports the government's recently published "Road Map" to reduce mother and child deaths between 2008 and 2015. By mobilising political will and contributing to policy design, we aim to strengthen the capacity of both the "demand side" – civil society – and the "supply side" – the government. The advocacy plan is ready, and we discussed roles and responsibilities in stakeholder meetings chaired by the Ministry of Health and Social Welfare in July and August.

**Deliver Now Latin America and the Caribbean**

The launch will be hosted by Chile's President Bachelet and attended by Norway's prime minister and representatives of other countries, agencies and institutions. A new initiative, with the governments of Chile, Bolivia, Ecuador and Brazil, will focus on promotion, communications, financing, technical co-operation, exchanging experiences, advocacy and community mobilisation.

**Countdown to 2015**

Holding governments to account is at the heart of the Partnership's work. As part of the "Countdown to 2015" initiative, we monitor progress on the MDGs, including coverage and health outcomes. We shared data with the Inter-Parliamentary Union (IPU), a global body of parliamentarians, and there are plans for countries to report their progress at a future IPU meeting.

**Women Deliver**

In 2007, leaders from 115 countries participated in the London "Women Deliver" conference to mobilise resources and political will. Participants shared lessons learned about improving the health of women and their newborn, advancing human rights, expanding financial resources, building political will, and using education and leadership development to promote women. The organizing partner was Family Care International.

**Costing tools**

We commissioned a technical review of 13 tools used by countries to cost health MDGs. This showed that more transparency is needed in background and user documentation. A subsequent meeting of users and developers identified some of the challenges in applying the tools. A website is now available allowing access to all the tools with spreadsheets and guidance, allowing features, training requirements and lessons to be shared.

*Francisco Songane*

Director
**Partnership for Maternal Newborn and Child Health**

## Civil Society: The Foundation for Community Development

The Foundation for Community Development (FDC) is a private non-profit-making institution which aims to strengthen the capacity of underprivileged communities, in order to defeat poverty and promote social justice in Mozambique.

**The Enlarged Immunisation Programme**

In 2001, the FDC launched the Enlarged Immunisation Programme (*Programa Alargado de Vacinacao* or PAV) in the northern province of Cabo Delgado. The province, which is home to around 1.5 million people, spans 30,000 square miles. Its per-capita income is among the lowest in Mozambique, and until recently its immunisation coverage was the country's lowest. In 2006, PAV was extended to Nampula province, which has a population of three million. The programme's purpose is to reduce infant mortality in general by improving communities' access to immunisation. It is an effective and efficient system for storing, distributing and managing vaccines.

**The results**

The programme operates fixed vaccination posts: 90 in Cabo Delgado and 172 in Nampula provinces. These serve 5,417,384 people – more than 25% of Mozambique's population. All posts have bivalent fridges as well as lamps for maternity units and cookers for sterilisation, all maintained monthly. By 2007, FDC – in partnership with the health ministry – had delivered doses of the five different vaccines (BCG, DPPT, hepatitis B, polio, tetanus and measles), 179,489 syringes, over 1,500 incinerator boxes and 11,500kg of propane, as well as other medical supplies.

Because electricity supplies are limited in Cabo Delgado and Nampula, FDC established VidaGas to provide dependable, affordable, clean fuel for powering essential equipment in remote health facilities and for maintaining the "cold chain" of refrigerators for vaccines. And FDC provides training and supervision for PFV staff all year round.

**Challenges and next steps**

The challenge now is to scale up: FDC and the health ministry are expanding the programme to Zambezia and Niassa provinces. This brings a new test: reaching more than 50% of the country's population. US$5 million is needed to establish the cold chain, train health staff, support health authorities in the new provinces and mobilise communities around the programme.

Work is also continuing on MDG 5, as FDC and its partners build women's coalitions to work with government and local health services in the two provinces with the highest maternal mortality. FDC's advocacy strategy targets parliamentarians, government officials, civil society and the media to ensure more resources are allocated to MDG5. FDC works with partners to develop, test and implement services, and to demonstrate their effectiveness and feasibility. It will also strengthen the health system's ability to deliver a wide range of high-quality maternal health services. Raising awareness and mobilising communities will empower women to exercise their right to maternal health.

*Graça Machel*

President and Founder
**Foundation for Community Development**
**Mozambique**

## Countries that have now committed to one or several initiatives in the Global Campaign for the Health MDGs*

| Country | International Health Partnership UK - WHO & World Bank ** | Deliver NOW for Women + Children, PMNCH | USAID - Pepfar *** | Catalytic Initiative - Canada - UNICEF | Results-Based Financing World Bank - Norway **** |
|---|---|---|---|---|---|
| **Africa** | | | | | |
| Benin | | | | X | X |
| Burkina Faso | | | | X | |
| Botswana | | | X | | |
| Burundi | X | | | | X |
| Cote d'Ivoire | | | X | | |
| DR Congo | | | | | X |
| Djibouti | | | | | X |
| Eritrea | | | | | X |
| Ethiopia | X | | X | X | X |
| Ghana | | | | X | X |
| Guyana | | | X | | |
| Kenya | X | | X | | |
| Liberia | | | | X | |
| Madagascar | | | | | X |
| Mali | | | | X | X |
| Mozambique | X | | X | X | X |
| Namibia | | | X | | |
| Nigeria | | | X | | |
| Rwanda | | | X | | X |
| Senegal | | | | | X |
| South Africa | | | X | | |
| Tanzania | | X | X | X | |
| Uganda | | | X | | |
| Yemen | | | | | X |
| Zambia | X | | X | | X |
| **Asia** | | | | | |
| Afghanistan | | | | X | X |
| Cambodia | X | | | X | |
| India | | X | | | |
| Indonesia | | | | | |
| Nepal | X | | | | |
| Pakistan | | | | X | |
| Vietnam | | | X | | X |
| **Latin America** | | | | | |
| Brazil | | X | | | |
| Chile | | X | | | |
| Haiti | | | X | | |

** Update by 9 September 2008*
*** IHP - UK, Norway, Germany, Canada, Italy, the Netherlands, France, Portugal*
**** 15 focus countries http://www.pepfar.gov/countries/*
*****The country has submitted a proposal or expressed interest to the World Bank's Innovative*

Chapter Four

# *Achieving MDGs 4 & 5 — at the dawn of a new era*

*As we enter the second half period up to 2015 we have unique opportunities to accelerate progress towards MDG 4 and 5:*

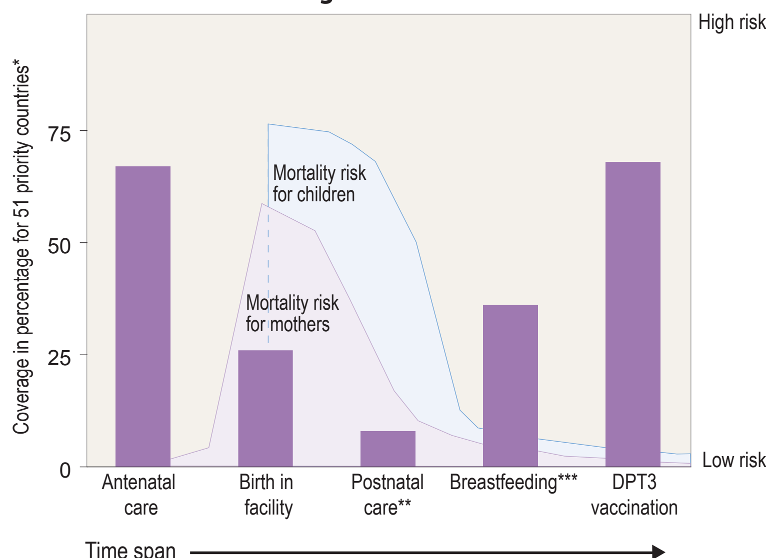
- *The key priorities and policies for making the most decisive progress around the time of highest risk - the Birth - is clear.*
- *We know how to overcome some of the key barriers that impede progress.*
- *Simple solutions have been found by countries that have achieved results quickly.*
- *The investment levels required to allow those most in need- poor mothers and babies- to access different packages of services have been advanced.*
- *With an additional investment of 2.4 billion in 2009 rising to 7 billion in 2015 would allow 95% of women to have safe births in equipped clinics staffed around the clock in 51 low income countries. We would need to train an additional million midwifes and other professional health workers. The lives of close to 3 million mothers and over 7 million newborn babies would be saved.*

## The tasks ahead for MDGs 4 and 5

Despite accelerating progress in tackling infectious diseases, the global death toll for children, newborns, and mothers remains a disgrace - currently 9,2 million children per year die while another 3 million babies are born dead. More than half a million women every year are still dying while pregnant, while giving birth, or shortly afterwards. Meanwhile, over 300 million women in poor countries suffer from short term or long term illness caused by pregnancy and childbirth[1] and more than one billion children are currently severely deprived of the bare necessities they need to survive, grow and develop. For each of the 4 million newborn babies that die every year, 20 more face illness or disability from conditions such as birth injury, infection and the complications of premature birth. One of the enduring injustices of this situation is that women who do not want children so often find themselves risking life and health simply through lack of access to effective family planning methods.

Progress towards MDGs 4 and 5 is inadequate and 2015 is rapidly approaching. In particular the pregnancy-related deaths of mothers have continued at a similar rate for the past 20 years – with only marginal reductions since the year 2000. Mortality is very much concentrated in 68 poorer, high fertility countries (mostly in sub Saharan Africa and parts of south East Asia) – where an overwhelming 97% of the world's maternal, newborn and child deaths occur.[2] Shockingly the most basic health care for mothers and children only reaches a minority in poor countries. Many pregnancies remain unplanned, and care at the time of birth - when both mothers and babies are more likely to die – is particularly inadequate (see Fig below). Yet again women and children stand at the end of the queue of global progress in health.

**The highest risk of mortality for mothers and babies occurs when coverage of health interventions is lowest**




The graph shows estimates of care coverage for the 51 most indebted countries along a continuum from pregnancy through to birth and the care of the child through newborn care, breastfeeding and immunisation. Superimposed is an illustrative diagram of the risk of mortality for mothers and children loosely based on Demographic and Health Surveys and selected studies. The diagram shows that health care is accessed least where the risks are highest for women and their babies - at the time of birth.

** Most recent available data where data exists*
*** Postnatal care within 2 days, only measured for home births in most data sources*
**** Exclusive breastfeeding first six months*

*Sources:*
*Mortality distribution is schematic but shape is based on 1) for newborns -DHS survey data where available for 51 countries 2) for mothers: Faveau V., Koenig M., Chakraborty J and Chowdhury A. Cause of maternal mortality in rural Bangladesh, Bulletin of the World Health Organisation, 66 (5) 643-651, 1988.*

*Coverage data are weighted averages for 51 countries where data available from household surveys as collated by UNICEF and WHO. Postpartum care coverage estimate is a weighted average for 51 countries where data available derived from Fort, Alfredo L., Monica T. Kothari, and Noureddine Abderrahim. 2006. Postpartum Care: Levels and Determinants in Developing Countries. Calverton, Maryland, USA: Macro International Inc.*

Death rates for mothers and newborn babies drop significantly if women give birth in quality assured health facilities - Home births attended by non-professional healthcare workers are now known to be inadequate to protect the health and survival around the time of birth – for mother as well as baby. Yet in high burden, low income countries where data are available, less than 25% of women – that is 1 in 4 give birth in health facilities. Even for those who do reach a health centre or hospital – the skills of health workers, and the equipment, drugs and supplies are often not good enough to safeguard either their own lives or that of their newborn babies.

The best place for most women to give birth is in an accessible health facility staffed by teams of professional midwives around the clock. Here women and their babies can be monitored during labour and after the birth and many complications can be managed rapidly on-site. If a more serious problem arises for mother or for baby, such as the need for a ceasarian section or a blood transfusion or if the baby is born too early or too small, then a transfer to hospital can be managed safely and quickly. Indeed for nearly 1 in 7 women - unpredictable and severe problems do suddenly occur. Quality-assured care during childbirth in health facilities is both more effective and efficient than alternatives since all the needed care is on hand and can serve more women. Part of assuring quality at childbirth involves grasping the opportunity to tell mothers about healthy lifestyles – information that may be critical in improving nutrition, preventing and dealing with illness and accessing suitable family planning.

Evidence is also plentiful for effective ways to reduce the deaths of babies and children. More home visits are needed by health workers based in local communities that bring adequate and safe care to families' doorsteps. More care in health centres and hospitals for children with life threatening conditions is also urgently needed. The persistence of dangerously short intervals between births is testament to the need for better family planning. Millions of child deaths will be prevented each year if all children enter this world in the safety of a quality-assured health facility, and that care is available throughout childhood to prevent ill health and protect life.

There is a need not only for health services, but also the system that support them. Health systems are the basic building blocks that are needed to keep services running for mothers, newborn babies and children. This means health workers, managers, drugs, supplies, health facility buildings, power supply, clean water, transportation, communication and health financing systems. In countries where health systems are fragile, health workers salaries are insufficient to prevent some of them from engaging in dual practice, or worse – exploiting women and children. Often health workers are insufficiently skilled and inadequately managed and trained. The result is a demotivated and demoralised workforce- concentrated in urban affluent areas. To add to this, ineffective financial systems exclude poor women and children from accessing health services.

Local leadership is vital. Delivering for women and children depends on strong leadership at all levels – but too often local level leaders who are crucial agents for change go unnoticed. Professional work with vulnerable communities and willingness to serve despite difficult conditions are the hallmarks of inspiring examples such as those from Tanzania and elsewhere. These dedicated local leaders who change the dynamics that so often undermine health services are a crucial part of the formula for success. Their efforts must be acknowledged, rewarded, supported and multiplied through nurturing the next generation of leaders by strategic investments of domestic and international funds.

Too poor to meet the price of survival - poor families too often face financial barriers which effectively exclude them from getting the care they need - transport costs to the health facility, drug and commodity costs, the need to pay health workers for their services-whether over or under the table- or for purchasing an insurance premium. The cost barrier is particularly high when hospital services for life-saving care such as ceasarian section or blood transfusions are needed, often leading to a dramatic impoverishment of households. Other barriers also prevent women from getting care for themselves or their children at a health facility – it may be too far away, and be perceived as not needed – or worse – with a reputation of poor quality and hostility towards women and children. All too often the physical, cultural and financial obstacles that women face are insurmountable and care – especially around the days of childbirth - is only accessed by the privileged few.

## Inadequate progress has been made in stemming the tide of maternal, newborn and child mortality — Why can we succeed now having failed in the past?

We stand at a time when new innovative financing mechanisms for health are becoming increasingly effective: In the last few years there have been several new mechanisms proposed for financing health improvements in developing countries. Some of these, such as advanced market commitments (AMCs) and the international financing facility for immunisation (IFFIm) are new means for delivering official development assistance. Together these mechanisms offer the potential to make real progress to funding health improvements and achieving the health-related MDGs. Others such as UNITAID and the associated voluntary solidarity contribution (VSC) complement AMCs and the IFFm by providing entirely new resources for health.

We are starting to find new ways to get better value for money: Simply raising new funds is only one step. That money must translate into tangible results. There are new and promising methods including Results-Based Financing, Public Private Partnership for service provision, health insurance etc being piloted. Crucially, methods such as Rwanda's results-based financing scheme build on reforms such as the delinking of health workers from the civil service system, providing them with the autonomy and flexibility to manage health systems resources to achieve results.

Simple solutions have been shown to achieve results quickly. The quite outstanding impact of simple solutions has recently shown us that these barriers are far from insurmountable. India- where around 1 in every 5 of the world's maternal deaths occur, - is rapidly breaking down the barriers between women and the care that they need for themselves or their children. In just 2 years in some states of India many more poor women are arriving at health facilities to give birth since the introduction of cash payment incentives. Innovative partnerships with the private sector have also contributed to the significant changes whereby private obstetricians are contracted to provide care for poor women. Ensuring that the care received is good quality will enable substantial additional benefits to be reaped in terms of fewer deaths to mothers and babies. The ready availability, for example, of facility delivery kits comprising essential supplies for providers to deliver best practises around childbirth, is one element to boost quality, at an estimated cost per kit of US$3-4 per birth or less than US15 cents per capita (see Panel 1).[3]

**Panel 1: Kits for Quality Facility Birth**

Facilities are the best place for women to give birth where the necessary drugs, equipment, supplies and skilled health personnel are available around the clock, and back up is accessible to hospitals when serious complications arise. One common shortfall in facilities, however, is in essential supplies which are often missing, incomplete or not readily to hand. One innovative way to address this gap is to provide kits which are made available to each woman when she arrives at the facility in labour. The proposed content of a kit is shown below.

It is estimated that for most settings the total cost for the kit contents will be US$3-4 pr delivery (or US$0.10-0.14 per capita ). Such basic supplies cannot alone assure a healthy mother and newborn - a professional midwife must implement best practices in using the kit and the health facility must be equipped adequately. Nevertheless, the availability of quality facility birth kits will play an important part in helping to prevent deaths from complications of bleeding, infection of both mother and baby, prolonged labour, and asphyxia for babies.

Basic kit for quality facility birth (QFB)

- Hand-held birth record with partograph
- Gloves
- Birth cloth
- Chlorhexidine swabs
- Disposable cord clamps
- Sterile blade
- Oxytocin injection
- Mucus extractor
- Sanitary pads

## How much will it cost to implement key solutions in the most needy countries

Some high mortality countries, such as Brazil, China and Mexico are now implementing accelerated programmes to achieve MDG4 and 5 and have raised funds both domestically and internationally in recognition of the pressing need to reach their 2015 goals. India is making progress in the same direction. But in 51 countries[4] with lowest income (those that are eligible for IDA loans)[5] current provision is completely inadequate – as they struggle to provide services with fragile or poorly functioning health infrastructures. The cost for scaling up the care that is needed to 95%[6] in these 51 aid dependent countries is estimated at 7.2 US$ billion in 2009 rising to 18.4 billion in 2015 (see Fig 2).[78] Country specific costings conducted for both African and Asian countries concur with these estimates - confirming that US$3-5 per capita by 2010 rising to US$ 10 per capita in 2015 would need to be allocated to these services in addition to current expenditure to reach near universal coverage.[9] To fill the funding gaps in these countries would mean raising health expenditure well beyond the reach of domestic budgets.[10]

The bulk of these costs – amounting to more than 40% - will be needed for strengthening health systems and would bring benefits not only for the health of mothers, babies and children, but also the health of the whole population. Such costs cover the most basic building blocks of health systems in these countries - clinic and hospital building, equipment and maintenance, electricity, running water and vehicles, salaries and incentives for both existing and new needed staff and keeping drugs stocked in facilities. Added to this, the more direct costs relating to Family Planning represents 9% of the total, Antenatal Care 7%, Quality Facility Births 18%, Postnatal Care 3% and Child Health Care 23%.

Inputs and impacts of the additional maternal, newborn, child and family planning services in the 51 priority countries are detailed in Panel 2. We would like to emphasise that this costing and impact work is work-in-progress and will undergo further refinements, but it gives an illustration of the level of investment that would be required to achieve extraordinary benefits.

**Panel 2: Investing in MDGs 4 and 5: INPUTS and IMPACTS as it relates to scaling up maternal, newborn, child and family planning services to universal coverage**

INPUTS – How would the extra resources be spent?

If this funding gap were filled 2009-2015, it would allow a total of

- 400 million extra births to take place in quality assured facilities (including care for normal births and for complications when needed)
- 470 million extra antenatal care visits
- Approximately 113 million extra women/couples who are in need of family planning will get effective contraceptive methods
- 400 million newborns will also receive quality care at birth and during the postnatal period.
- A million extra health care professionals (midwives, doctors, and specialists) and managers will be needed.

It will also be vital that health workers should be able to do their jobs properly. If these extra health professionals were trained and deployed in poor countries – we would be well on the way towards the WHO target of at least 2.3 health workers per 1000 population .

IMPACTS - Reaping the benefits of investment

This investment has been estimated to save nearly twenty one million lives – including

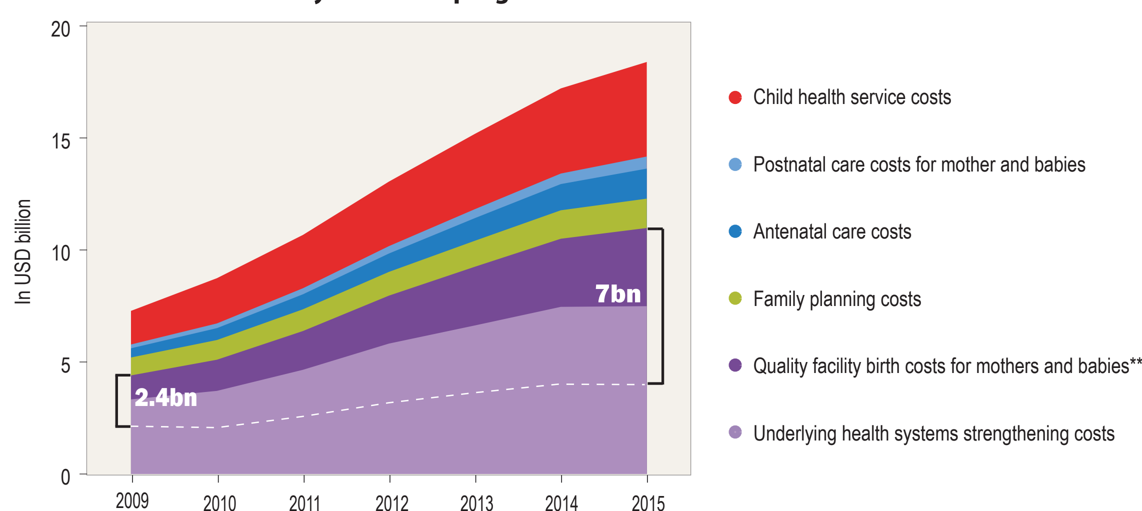
- 3 million mothers,
- 15m children
- 3m stillbirths
- 61% of the global unwanted births would be averted along with half of the world's recourse to abortion.
- 88% of worldwide abortion-related maternal deaths would be eliminated
- increase of 36% in contraceptive users
- effectively eliminating the current unmet need for family planning
- a 60% drop in child deaths

**Resources needed to reduce mortality at the most risky time for mothers and babies**

Given that it is the critical hours and first days around birth that mortality risks for mothers and babies are highest – it makes sense to estimate how much of these costs would cover the provision of Quality Facility Births. Delivering these services in 51 aid-dependant countries together with addressing the critical health systems gaps will cost US$ 2.4 billion in 2009 rising to US$ 7 billion in 2015. These required costs are needed from both domestic and external sources combined. Among the regional groups, 40% of the investment would be needed in the 37 African countries in the list of 51 aid-dependent nations.

If this funding gap of US$ 2.4 – 7 billion was filled, it would allow 400 million extra births taking place in quality assured facilities (including care for normal births and for complications when needed). This allow over one million professional health care workers to be trained and recruited. This investment has been estimated to save ten million lives – close to 3 million mothers and over 7 million newborns. In 2015 over half a million mothers would be saved and 2.3 million newborns saved, making major contributions to the achievement of MDG4&5. This represents a 70% reduction in death rate for mothers and babies and would ensure the achievement of both MDG 4&5 for a great majority of the poorest countries.

**Additional health systems and programme costs needed 2009-2015 in 51 countries***




** If costing for malaria, vaccines and PMTCT within child health programs are excluded from the above costs then the total will be 1,15 billion US$ less in 2009 and 1,8 billion less in 2015*

*** Estimating the cost of provision of Quality Facility Birth services, with addressing the critical health systems gaps, will together cost US$2.4 billion in 2009 rising to US$7 billion in 2015.*

The graph shows the total estimated cost of scaling up family planning, antenatal, postnatal and child health care along with care at birth (quality facility birth) for 51 of the world's poorest countries from in billions of US dollars. The total cost rises from 2.4bn in 2009 to 7bn in 2015 with the underlying health systems costs as the biggest component. The graph highlights costs for the scaling up of quality facility births to reduce mortality risks at the most dangerous time for mothers and babies.

*Source: MDG4&5 costing and impact estimate group (2008), "Approach taken to update WHR 2005/ MNCH+FP costs for the first year report of The Global Campaign For The Health MDGs" WHO, UNFPA, UNICEF, UNAIDS, World Bank, Aberdeen University, Southampton University, John Hopkins University, and NORAD www.norad.no/globalcampaign*

## Facility-based deliveries

WHO's Global Survey on Maternal and Perinatal Health has published its initial findings on over 100,000 deliveries (out of about 300,000 studied to date). It shows the increased health risks, for both mother and newborn, of unnecessary caesarean sections. WHO also plans to investigate other issues related to the care women receive during childbirth. This will improve the evidence base, enabling better guidance to be given to countries trying to achieve MDGs 4 and 5.

Our recommendation, and one of the indicators for MDG 5, is that every birth be attended by a skilled health professional. This should be a midwife, doctor or nurse who has been trained to proficiency in managing normal pregnancy, birth and the period immediately afterwards, as well as in identifying, managing and referring complications.

For optimum safety, every woman, without exception, needs this care, given in an appropriate environment (usually in decentralised, first-level facilities) close to her home, in a way that respects her culture. This can avert, contain or solve many of the life-threatening problems that may arise during childbirth. It can reduce maternal mortality to surprisingly low levels.

There is a close correlation between skilled birth attendance and institutional deliveries. Experience – from countries as diverse as Botswana, China, Cuba, Honduras, Malaysia, the Netherlands, South Africa, Sri Lanka, Sweden, Thailand and the UK – provides ample information on the benefits of facility deliveries and their significant impact in reducing maternal and newborn mortality. In countries that have increased their coverage of skilled birth attendants, facility-based delivery was the option chosen by women, and by policy-makers.

The advantages of facility-based deliveries – both from a technical perspective and from systematic analysis of mothers' experiences – are many. They enable teamwork, so that midwives can attend far more births than if would be possible in home deliveries. They also enable non-professionals, such as assistants and auxiliaries, to help, making care more cost-effective. This allows a single midwife to attend up to 220 deliveries per year, compared with less than 100 for a single-handed midwife visiting mothers at home. In addition, the mixture of professionals in a facility means that life-saving emergency care can be given quickly. Skilled care at facilities also ensures safety, cleanliness and the availability of supplies. Other work can be performed, and referrals are easier, as is emergency transport.

Wherever the baby is delivered, it is essential that the person who helps has the core competencies for safe delivery, has the necessary equipment and supplies, and has the option to refer to a functioning facility offering emergency obstetric and newborn care.

*Margaret Chan*

Director General
**World Health Organization**

## Footnotes

1. *World Health Report 2005, Geneva, p. 10*
2. *Countdown to 2015: Tracking Progress in Maternal, Newborn & Child Survival The 2008 Report, UNICEF, New York, p. 8*
3. *Assuming a Crude Birth Rate of 35 per 1000 population.*
4. *Afghanistan, Angola, Azerbaijan, Bangladesh, Benin,, Bolivia, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Kenya, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria Pakistan, Papua New Guinea, Rwanda, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia, Zimbabwe*
5. *The International Development Association formed in 1960 to make long-term (up to 50 years) loans at low interest rates to the countries with lowest income. The IDA is supported by periodic contributions from World Bank member countries.*
6. *The minimum level of care that is needed is near universal coverage of care at 95% of mothers, newborns and children.*
7. *Assuming 3% inflation*
8. *A "MDG4&5 costing and impact estimate group" was established and requested by the office of the Prime Minister of Norway to estimate the cost and impact (health gains and number of deaths averted) of scaling up to priority family planning, maternal and newborn health services as well as child health interventions in countries with the greatest burden, with an emphasis on low income countries. Members of this group have included experts from WHO, UNFPA, UNICEF, the World Bank, Aberdeen University, Southampton University, , and Norad. In addition inputs have been received from UNAIDS and John Hopkins University. A detailed technical report delineating the methods and assumptions used is available on www.norad.no/globalcampaign.*
9. *Investing in Maternal, Newborn and Child Health – The Case for Asia and the Pacific,; Joint UNICEF, WHO and World Bank Strategic Framework for reaching the Child Survival and other health MDG's in Sub Saharan Africa.*
10. *However, considering that aid for vaccines, malaria and PMTCT is often provided on a separate funding stream, the price tag would reduce by 1.2 US$ billion in 2009 rising to 1.8 US$ billion in 2015 if these direct inputs from alternative funding sources are taken into account.*

**The Global Campaign**

In New York on 26 September 2007, Norway's Prime Minister, Jens Stoltenberg launched the Global Campaign for the Health Millennium Development Goals. In accordance with Millennium Development Goals (MDGs) 4 and 5, the Campaign attaches special importance to the health of women and children, whose needs remain the most neglected.

The Global Campaign consists of several other international initiatives, all seeking to accelerate progress towards achieving the health MDGs together with all major stakeholders and global funds. A progress report was launched in April 2008.

www.norad.no/globalcampaign/

**CI - Catalytic Initiative to Save A Million Lives**

The Catalytic Initiative aims to save lives by identifying and scaling up health services, initiatives and projects that have proved effective. It will support and develop the capacity of a country's health system to provide services that are demonstrably high-impact and cost-effective.

**Countdown to 2015**

The mission of The Countdown to 2015 is to track progress made towards the achievement of the United Nations Millennium Development Goals 1, 4 and 5 and promote evidence-based information for better health investments and decisions by policy-makers regarding health needs at the country level.

www.countdown2015mnch.org/

**H8 – Health 8**

Health 8 (H8) is an informal group of eight health-related organisations, WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Bill and Melinda Gates Foundation, and the World Bank created in mid-2007 to stimulate a global sense of urgency for reaching the health-related MDGs.

**IHP+ - The International Health Partnership plus**

The International Health Partnership's global compact was signed in September 2007, committing the world's leaders, donors, agencies – and the countries receiving aid – to working together in a more effective way to support countries' national health plans.

www.internationalhealthpartnership.net

**Providing for Health Initiative**

The aim of the Providing for Health (P4H) initiative is to support the development of poor countries' health-financing systems. Its contribution is to coordinate donor efforts to provide technical advice on health financing to developing countries.

**PMNCH - The Partnership for Maternal, Newborn & Child Health**

The Partnership for Maternal, Newborn and Child Health is a global health partnership launched in September 2005 and joins the maternal, newborn and child health (MNCH) communities into an alliance of almost 260 members to ensure that all women, infants and children not only remain healthy, but thrive.

www.pmnch.org

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*It always seems impossible until its done.*

- Nelson Mandela