

Global Campaign
for the Health Millennium
Development Goals

Progress Report
April 2008



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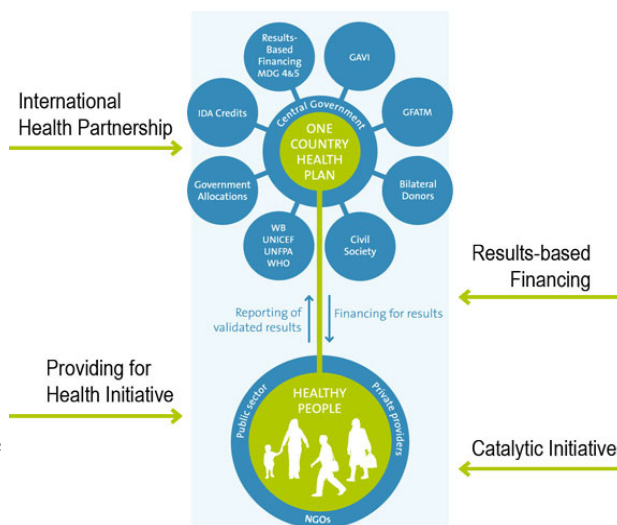
1. Overview

In New York on 26 September 2007, Norway's Prime Minister, Jens Stoltenberg, stood beside other global leaders to launch 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.

Actions that reinforce the Campaign

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 through:

1. More efficient collaboration; the International Health Partnership (IHP) was launched by UK's Prime Minister Gordon Brown in September 2007.
2. Extending essential services to reach more people with a focus on outreach at the community level; the Catalytic Initiative was launched by Canada's Prime Minister Stephen Harper in November 2007 (sponsored by Canada and UNICEF).
3. Find the most effective ways of spending money; the innovative Results-Based Financing Initiative was launched by Norway and the World Bank in November 2007.
4. Development of social health protection system; the Providing for Health Initiative by Germany and France will be launched late spring 2008.



They all fit together with a strong potential for synergy.

At the same time, advocacy efforts for women and children have been launched through the Network of Global Leaders and Deliver Now (sponsored by Norway and the Partnership for Maternal, Neonatal and Child Health). All this work combines with other initiatives such as the Global Health Workforce Alliance, reinforcing the push to surmount the critical barriers and overcome the bottlenecks that have impeded progress towards the health MDGs.

Today, half a year later, these initiatives are unfolding rapidly, building up a global movement committed to achieving the health MDGs, and finding new ways of supporting countries in achieving results. More than 30 countries have committed to actions related to the Global Campaign, and others have expressed an interest in joining (See Table 1a, p. 5). And the International Health Partnership is playing a key role in bringing together development partners, increasing accountability and co-ordinating support for stronger national health plans.

Building political momentum – internationally, regionally and locally

The political impetus is growing. Health is high on the agenda internationally, regionally and locally. Mr Fukuda, Japan's prime minister, has put the health of the poor on the agenda of the next G8 meeting in July. Political leaders have recently committed themselves. President Kikwete of Tanzania has raised the health MDGs, with a particular focus on women and children, high on the agenda in the African Union.

The President is planning to launch a roadmap for maternal, newborn and child health in Tanzania in April. The Organisation of the Islamic Conference's, chaired by President Wade of Senegal, has recently committed to achieving the health MDGs, with a particular focus on women and children. And in February 2008, Mozambique's President Guebuza launched his Presidential Initiative for the Health of Mothers and Children.

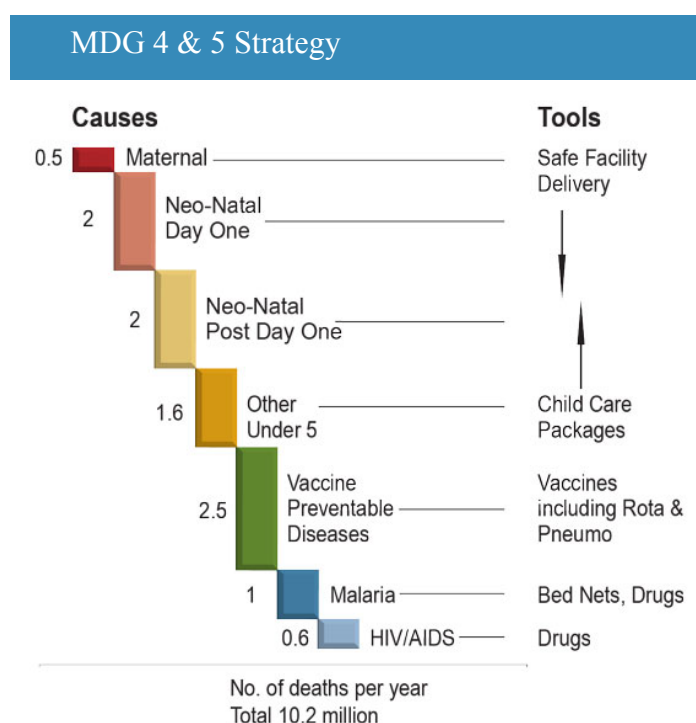
The principles

There are challenges in working together, to involve and find the role of the stakeholders at the various levels and not least mobilize the civil society. Success depends on keeping to the principles of the Global Campaign:

- Countries set their own priorities
- Agencies provide aid without adding to countries' administrative burdens
- Everyone ensures that money is well spent
- Agencies help to develop the country's whole health system
- All partners work in a transparent and accountable way

The Health eight agencies (H8) provide an important role to facilitate this process guided by these principles.

This progress report provides an update on the initiatives mentioned above, the status of their activities and milestones for the rest of 2008.



1a. Countries committed to one or several Initiatives in the Global Campaign*

Initiative Country	Inter- national Health Partnership UK - WHO & World Bank **	Network of Global Leaders Norway and UK	Deliver NOW for Women + Children, PMNCH	Norwegian MDG 4&5 bilateral program	Catalytic Initiative - Canada - UNICEF	Results- Based Financing World Bank - Norway ***	Providing for Health Germany and France ****
Africa							
Benin					X	X	
Burkina Faso					X		
Burundi	X					X	
DR Congo						X	
Djibouti						X	
Eritrea						X	
Ethiopia	X				X	X	
Ghana					X	X	
Kenya	X						
Liberia		X			X		
Madagascar						X	
Mali					X	X	
Mozambique	X	X			X	X	
Nigeria				X			
Rwanda						X	
Senegal		X				X	
Tanzania		X	X	X	X		
Zambia	X					X	
Asia							
Afghanistan					X	X	
Cambodia	X				X		
India			X	X			
Indonesia		X					
Nepal	X						
Pakistan				X	X		
Vietnam						X	
Yemen						X	
Latin America							
Brazil		X					
Chile		X					

* Update 2 April 2008

** IHP - UK, Norway, Germany, Canada, Italy, the Netherlands, France, Portugal

*** The country has submitted a proposal or expressed interest to the World Bank Innovative Results-based Financing for Health Initiative

**** All low and middle income countries will be eligible to apply to the Providing for Health Initiative for technical support

1b. 2008 Calendar of Events related to the Health MDG Initiatives

APRIL

- **UN High-level event on the Millennium Development Goals**, UNGA, New York (<http://www.un.org/ga/62/meetings.shtml>), 1-2 April
- **Countdown 2015**, Cape Town, presentation of 60-country report (<http://www.childsurvivalcountdown.com> – meeting report from 2005), 17-20 April
- **Harmonization for Health in Africa (HHA)** ministerial meeting, Ouagadougou, 25 April
- **Providing for Health (P4H)** draft plan of action available
- **Deliver Now** launches in India and Tanzania

MAY

- **WHO World Health Assembly**, Geneva (www.who.org), 19-24 May
- **IHP+ ministerial meeting** during the World Health Assembly, 19-23 May
- **TICAD IV – Tokyo International Conference on African Development**, Yokohama (<http://www.mofa.go.jp/region/africa/ticad/index.html>), 28-30 May
- **Providing for Health (P4H)** launches

JUNE

- **Network of Global Leaders**, Sherpa group meeting, Indonesia 2-3 June
- **UN General Assembly High-Level Meeting on HIV/AIDS**, New York, USA, 10-11 June

JULY

- **G8 Summit**, Toyako, Japan (<http://www.mofa.go.jp/policy/economy/summit/2008/index.html>), 7-9 July
- **US\$10 billion request for MNCH** (maternal, newborn and child health) presented by Deliver Now at G8 Summit
- **African Union Summit**, with possible special presentation on MDGs 4 and 5, Sharm el-Sheikh, Egypt

AUGUST

- **XVII International AIDS Conference**, 3-8 August, <http://www.aids2008.org/>

SEPTEMBER

- **OECD/DAC High-Level Forum on Aid Effectiveness**, Accra, Ghana, 2-4 September
- **Opening of the United Nations General Assembly**, New York (<http://www.un.org/ga/index.shtml>), 16 September
- **UN General debate**, New York, 23 September - 1 October
- **UN High-level meeting on the Millennium Development Goals (MDGs)**, New York, 25 September
- **Meetings of the WHO's regional committees (WPRO, SEARO and AFRO)**, September-October
- **Deliver Now's first regional launch**, Chile, hosted by President Bachelet in her role as a member of the Network of Global Leaders

UNDATED

- **Results-Based Financing's network of evaluation experts** is formed to provide guidance to all pilot projects
- **The Results-Based Financing Global Task Force** becomes operational

2. International Health Partnership (IHP)

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. As well as ensuring that everyone works toward the same goals, the IHP should simplify reporting demands, ensuring that health workers, civil servants and other valuable people spend less of their time on paperwork and more of their time doing their jobs. The compact also commits the governments of countries receiving aid to having practical, well-designed national health plans that are supported by citizens. The IHP is supported by donor governments and agencies representing half of the world's aid spending on health, totalling US\$14 billion.

Current status of activities

An Interregional Country Health-Sector Teams Meeting was held in Lusaka from 28 February to 1 March. There, thirteen country teams involved in the International Health Partnership and related initiatives (referred to as IHP+) and the Harmonization for Health in Africa (HHA) initiative met development partners and representatives of civil society. A great deal of important work was done at this meeting.

Participants clarified what country compacts consist of. They agreed that the process of developing a country compact is crucial for building trust between the various partners and harmonising their ways of working. A checklist was developed for running this process smoothly and successfully.

An important part of the country compact is the way monitoring and evaluation (M&E) are incorporated in it. A global M&E framework has been agreed, but this must be built in to country compacts, with enough investment apportioned to M&E systems.

It was agreed that for the IHP+ to be a success, and for them to honour the IHP's global compact, development partners will need to change the way they operate – by, for example, devolving authority and changing policies to encourage longer-term investments. An independent review of progress will encourage this. Both partners and countries will also need to involve civil society more, and it will now be represented in bi-monthly meetings.

Milestones for 2008

- HHA ministerial meeting in Ouagadougou, 25 April (TBC)
- IHP+ ministerial meeting during the World Health Assembly, 19-23 May
- Tokyo International Conference on African Development (TICAD) and G8 meetings, May-July
- Regional political forums, such as the African Union, July
- Meetings of the WHO's regional committees (WPRO, SEARO and AFRO), September-October
- The UN Secretary-General's meeting on the MDGs, September
- OECD/DAC High-Level Forum on Aid Effectiveness, September

3. The 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. It will do this by developing a framework for monitoring and evaluating services, so as to provide data that allows the effectiveness of one way of working to be compared with any other – no matter which country it takes place in or which health problem it tackles.

The Initiative is a concrete way of applying throughout a whole country the lessons that are being learned on the ground. The Initiative will act as a catalyst for the efforts of the International Health Partnership (IHP) working within the Global campaign for the Health MDGs, enabling their resources to achieve more.

The Catalytic Initiative was begun by a number of partners, including CIDA, UNICEF, Norway, the Bill and Melinda Gates Foundation, Australia, USAID, the Doris Duke Charitable Foundation, WHO and the World Bank. The first countries to have been identified to take part in the Initiative, and to which funding has been committed include Afghanistan, Burkina Faso, Benin, Ghana, Ethiopia, Malawi, Mali, Mozambique, Niger, Pakistan and Tanzania. The list is expected to grow.

Current status of activities

CIDA/ UNICEF

- UNICEF is working with the MOH in the countries supported by CIDA and UNICEF on plans to accelerate support and develop the capacity of country-led systems to scale up the delivery of a package of proven, high-impact and cost-effective interventions.
- Initial activities will begin to roll out in the coming months based on country level analysis of the bottlenecks, opportunities and strategies, identified in collaboration with the MOH, to take high impact health services to scale.
- Baseline data is being collected where information is not already available.

Milestones for 2008

- Partners working on health issues in Mozambique met to discuss how to work together – within the Catalytic Initiative and other elements of the Global Campaign – to reinforce national health plans and extend services that have proved to be effective for mothers and children. They also tried to ensure that the Initiative's monitoring and evaluation framework reinforced rather than duplicating that of Mozambique's health ministry.
- Discussions like those in Mozambique will be held with partners in several countries to decide.
- Catalytic Initiative partners will agree a framework for monitoring the effects of different services and projects, using the same set of indicators – including essential interventions and the effect on mortality rates.
- Work will continue on harmonising the Catalytic Initiative's evaluation framework with those of other initiatives. This work involves collaborating with the International Health Partnership (IHP) and the Maternal and Child Health Integrated Program (MCHIP), among others.

4. Innovative Results-Based Financing

Innovative Results-Based Financing (RBF) aims to help governments to achieve their national health goals by organising their health systems in different ways. The goal is to shift the emphasis away from distributing and using resources and move it to results. RBF is funded by the Norwegian government and managed by the World Bank, with funding linked to broader International Development Association (IDA) credits. It will support six governments in their work with partners on designing, implementing and sustaining the best RBF mechanisms for achieving objectives in their national health plans relating to Millennium Development Goals (MDGs) 1b, 4 and 5. The experience gained in these six countries will be shared with other RBF participants.

CURRENT STATUS OF ACTIVITIES

The six pilot countries will be selected in two rounds: the first in early 2008 will aim for a fully designed and approved project by the end of 2008, and the second in late 2008 or early 2009 will aim for approval in 2009 or 2010.

SELECTION OF PILOT COUNTRIES

Proposals have been submitted by nine candidate countries (Afghanistan, Benin, DR Congo, Eritrea, Ethiopia, Ghana, Madagascar, Rwanda and Zambia) with a strong interest in rapidly designing RBF programmes. Three or four pilot countries will be selected by a panel comprising Bank and external experts. The selection criteria are based on commitment and capacity, and the willingness to share learning and impact evaluations – as well as the expected effect on the country's health. Several countries are already expressing interest in submitting proposals in the second round, including Mozambique, Senegal, Vietnam and Yemen.

IMPACT EVALUATIONS

A network of evaluation experts is being formed to support the pilot countries, ensuring consistent methodology, high-quality evaluations and possibly the ability to compare countries' findings. This network will have links to global efforts to co-ordinate monitoring and evaluation of IHP+ and other Global Campaign initiatives.

GLOBAL TASK FORCE ON RBF

The Global Task Force on RBF has been established to engage development partners. Co-chaired by the Center for Global Development and the World Bank, the Task Force will promote knowledge-sharing, informal co-ordination, and the development of a limited set of global policy recommendations, to enable partners to be more responsive to countries' needs in RBF. The first meeting was on 26 and 27 March in Washington DC.

Milestones for 2008

- An RBF pilot, linked to IDA credits, will be approved and implemented in three countries, to accelerate progress on MDGs 4, 5 and 1b
- A network of evaluation experts will be formed to provide guidance to all pilot projects
- The RBF Global Task Force will become operational
- At least one regional training session or workshop will be held to share learning from RBF
- Draft case studies on what has been learned about process during the three pilots will be disseminated

5. Providing for Health

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. It will do this by ensuring that money is raised and pooled in a way that ensures people have access to the health services they need. Unless health-care systems in poor countries are reinforced, international efforts to fight contagious diseases in these countries could be in vain.

P4H's work will help to ensure that people do not suffer serious financial consequences as a result of making out-of-pocket payments for their care. Protecting people from the financial risks of illness is an essential part of developing health systems that help the poor.

P4H will also allow donors to discuss and collaborate on ways of supporting low- and middle-income countries in developing financial risk-protection. P4H will work with donors and collaborate closely with the International Health Partnership (IHP) and the Global Campaign for the Health MDGs to develop ways of ensuring that sources of finance – domestic and international – also support this goal.

Current status of activities

P4H's structure has not yet been agreed, but it has been suggested that its partners would be asked to second staff to the initiative. In its first year of being fully operational, P4H aims to have ten staff seconded from its partners for six months each, and to provide technical support to ten countries. Its work should also include evidence-gathering, advocacy and communication.

A meeting with potential partners was held in Bonn late in November 2007 and the draft report of the meeting has been circulated. After discussions in Germany, GTZ has seconded a staff member to the World Health Organization (WHO) to help develop a plan of action for discussion with these partners.

Milestones for 2008

- Early March: a staff member is seconded from GTZ to the WHO.
- Mid-April: the draft plan of action produced by this staff member is available for discussion. WHO would like to carry out some country consultations on this draft work plan, to be reflected in the final decision.
- Mid-May or earlier: P4H is launched.
- This year: funding for kick-off activities should become available.

6. The Network of Global Leaders for MDGs 4 and 5

The Network of Global Leaders was formed at the invitation of Norway's Prime Minister, Jens Stoltenberg, to provide political backing and advocacy at the highest possible level for the Global Campaign for the Health MDGs. Support of this kind will be crucial for the success of the Global Campaign – leading to better health and fewer deaths.

The Network consists of a small number of international leaders besides Mr Jens Stoltenberg. The other leaders are President Michelle Bachelet of Chile, Prime Minister Gordon Brown of the United Kingdom, President Armando Guebuza of Mozambique, President Jakaya Kikwete of Tanzania, President Luiz Inácio Lula da Silva of Brazil, President Ellen Johnson Sirleaf of Liberia, President Abdoulaye Wade of Senegal, President Susilo Bambang Yudhoyono of Indonesia, and Graça Machel, recipient of the UN's Nansen medal for her humanitarian work.

The Network does not convene regular meetings or conferences. Instead, each member ensures that his or her own country's commitment to achieve the health MDGs (MDGs 4 and 5) is sustained and followed up every day. When participating in summits and other high-level global events, they will push for action to achieve the health MDGs by 2015, keeping up the political pressure on behalf of the Global Campaign.

Current status of activities

Tanzania's President Jakaya Kikwete is currently chairman of the African Union, where he is putting the health MDGs high up on the agenda. Meanwhile, at the Organisation of the Islamic Conference, President Wade of Senegal is also using his chairmanship to champion the health MDGs.

The Network's members are currently developing combined efforts to promote the health MDGs at the G8's 2008 summit in Japan, as well as in the UN's General Assembly.

The members of the Network of Global Leaders are regularly briefed on the Campaign's progress. To follow progress more closely and report regularly to the Network, a "Sherpa" group has been formed of close collaborators among the Network's members. Dr Tore Godal of Norway's Office of the Prime Minister chairs this group. Its first meeting was held in Oslo in December last year.

Milestones for 2008

- The Sherpa group's next meeting will be held in Indonesia 2 - 3 June.
- World Health Assembly in Geneva 19 – 24 May
- TICAD IV -Tokyo International Conference on African Development 28 – 30 May
- Regional Political forums like the African Union Summit in July
- G8 Summit, Yokoyama, Japan 7 – 9 July
- High level event on the MDGs at UN HQ 25 September

7. Deliver Now for Women and Children

Deliver Now aims to reduce the number of mothers and children who die for lack of health care and services. It is an advocacy drive, intended to increase political commitment – especially in civil society and the private sector – and to support communities in demanding better access to good-quality health care and greater investment in health services. In this way, it intends to make the health of mothers, newborn babies, and children a prominent part of the development agenda.



Deliver Now is co-ordinated by the Partnership for Maternal, Newborn and Child Health (PMNCH), and works closely with the Network of Global Leaders on the Millennium Development Goals related to child mortality (MDG 4) and maternal health (MDG 5).

Current status of activities

GLOBAL

In September 2007, Deliver Now was launched in New York at a high-level panel of women leaders, introduced by the Prime Minister of Norway. Statements of commitment were given by many, including Asha-Rose Migiro, Deputy Secretary-General of the UN; Margaret Chan, Director-General of WHO; Thoraya Obaid, Executive Director of UNFPA; and M. Mwanawasa, Zambia's First Lady.

REGIONAL

The President of Chile has offered to host the first regional launch of Deliver Now in Latin America at the end of 2008. The announcement was made at the 52nd Commission for the Status of Women in New York in February 2008, an event dedicated to the health of mothers and children.

NATIONAL

Deliver Now supports national advocacy efforts. In Orissa, India, it is working to develop advocacy and leadership skills among NGOs, increase the media's capacity to report on the issues and conducting social mobilisation. The White Ribbon Alliance India is implementing the campaign, which is funded by the UK government through the PMNCH.

The Tanzanian PMNCH has developed a concept for advocacy, mobilisation and strategic communications work. This will increase the demand for more responsible, competent and accountable services in communities and within health facilities.

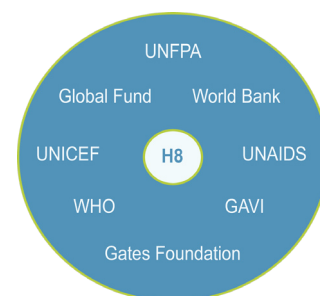
Milestones for 2008

GLOBAL, REGIONAL AND NATIONAL MILESTONES

- At the Tokyo G8 summit, Deliver Now – working with partners in Japan – will present a request for an extra US\$10 billion per year for maternal, newborn and child health (MNCH).
- Before the 11th summit of the Organisation of the Islamic Conference (OIC), Deliver Now will present a background document to governments, NGOs and journalists, requesting that Islamic Development Bank's Fund for Poverty Reduction increases funding for MNCH.
- In September, Deliver Now's first regional launch will be held in Chile, hosted by President Bachelet in her role as a member of the Network of Global Leaders.
- Deliver Now will be launched in India and Tanzania in April.

8. Facilitation by the Health 8 agencies

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. It focuses on better ways of working, particularly within institutions, which can lead to the MDGs being achieved more quickly. And it has a remit to ensure systematic and robust knowledge management and learning around the MDGs, and to seize opportunities presented by renewed interest in health systems.



Current status of activities

The H8 leaders last met in January to review recent developments in global public health and the strengthening of health systems. Projects reviewed included the International Health Partnership+; the Global Campaign for the Health MDGs; Harmonization for Health in Africa; the Catalytic Initiative; Providing for Health; and the UN Secretary-General's MDG Africa initiative.

The leaders repeated their commitment to fostering alignment and to using existing structures rather than forming new initiatives. They expressed strong support for the UN Secretary-General's role as a champion of global health, and reaffirmed their support for him on health-related issues.

The H8 leaders emphasised the need to focus vigorously on health outcomes in developing countries – specifically around MDGs. They agreed to a set of shared principles and commitments, including:

- Sharing ideas openly and keeping each other informed of key strategic directions.
- Creating opportunities to collaborate more closely, while recognising areas of overlap.
- Quickly identifying and resolving any issues and bottlenecks on joint projects.
- Maximising individual and collective efforts to help countries and partners achieve the MDGs.
- Aligning organisational processes and communication activities to achieve these ends.

Milestones for 2008

The H8 leaders, due to meet in the summer, identified several opportunities in 2008 to collaborate to:

- Develop and jointly disseminate common advocacy messages for key events in 2008, including the G-8 and TICAD IV.
- Reinforce links between the MDGs, between strategies for Africa, and between bilaterals and multilaterals, and to promote more South-South dialogue and cooperation.
- Assist the UN Secretary-General to identify health priorities for his engagement.
- Ensure complementarity between health systems-strengthening and disease control programmes – for example between HIV/AIDS and sexual and reproductive health services.
- Engage civil society and the private sector – recognising the dynamic value of public/private consultation.
- Ensure that country compacts are truly owned by countries, fully inclusive of all stakeholders, and use existing channels of implementation.
- Collaborate more intensively, for example in Sub-Saharan Africa.
- Develop common approaches for staff training and skills building.
- Create strong collaboration and sharing of data and statistics across the eight agencies.
- Harmonise health-related data collection, notably for 2010 censuses.
- Work with other stakeholders in developing criteria for the validation of evidence-based national health plans to achieve better results and outcomes.
- Work towards common approaches to identify and resolve financing gaps.

9. Commitment to the Global Campaign for the Health MDGs

The following countries, agencies and global initiatives have so far have committed themselves to actions in the Global Campaign:

Afghanistan	Madagascar
Benin	Mali
The Bill and Melinda Gates Foundation	Mozambique
Burkina Faso	Nepal
Brazil	The Netherlands
Burundi	Nigeria
Cambodia	Norway
Canada	Pakistan
Chile	Partnership for Maternal, Newborn and Child Health (PMNCH)
Democratic Republic of Congo	Rwanda
Djibouti	Senegal
Eritrea	United Republic of Tanzania
Ethiopia	UNAIDS – Joint United Nations Programme on HIV/AIDS
France	United Kingdom
Germany	United Nations Children’s Fund (UNICEF)
Ghana	United Nations Population Fund (UNFPA)
Global Alliance for Vaccines and Immunization (GAVI)	United States of America
Global Fund for AIDS, Tuberculosis and Malaria (GFATM)	Vietnam
India	World Bank (WB)
Indonesia	World Health Organisation (WHO)
Kenya	Yemen
Liberia	Zambia

Annex

4b. Country interest in Results-Based Financing for maternal, newborn and child health

Afghanistan: After years of neglect by the Taliban, the health system inherited by the new government of Afghanistan was barely functional and few health services reached rural communities. To address this problem, the government started contracting with NGOs to deliver a basic package of health services. In spite of progress, coverage of health services is still low by regional standards, and the under-five mortality rate (U5MR) and the maternal mortality ratio (MMR) are among the highest in the world. In order to improve coverage and service quality, two RBF mechanisms are proposed. First is a performance-linked bonus for contracting NGOs to increase the coverage of maternal and child health services. Second is a complementary bonus system for hospitals aimed at increasing the volume of maternal and child services.

Benin*: Because of significant progress in health, Benin's child and maternal mortality indicators are lower than average in sub-Saharan Africa. However, MDGs 4&5 will not be achieved without dramatic improvements in health system performance. Malaria is responsible for 20% of child mortality, but only 12% of children with malaria are prescribed ACT. Although Benin has one of the highest rates of assisted delivery in SSA, maternal mortality is still high at 450-500 per 100,000 births. Unlike most other SSA countries, Benin's health system is relatively strong both in the provision and demand for health services (as illustrated by the high level of assisted delivery). The primary bottlenecks to achieving result are availability of ACTs, accountability and quality of service. To explore ways to address these issues, the Government of Benin began piloting (2-3 districts) two RBF mechanisms in 2007: performance contracts for health facilities and an incentive package for health professionals willing to work in rural areas. The MoH is keen to build on the lessons of these initial pilots, scaling-up and building in more rigorous impact evaluation.

Burundi: Low levels of healthcare utilization by mothers and children have been identified as a critical barrier to achieving MDGs 4 and 5. Recent evaluations show that financial barriers and perceptions of poor quality of care are two primary reasons for low utilization. A presidential decree making services for pregnant women and children under five free of charge was a first step towards reducing barriers. To compensate for facilities' loss of income from the free services, the government put in place an ad-hoc system to reimburse some inputs to (public and non-profit) health facilities. However, this system focuses exclusively on curative services, and is cumbersome, slow (reimbursements take over nine months) and has no capacity to set targets or monitor quality of services provided. An RBF mechanism would help to overcome some of these challenges. The RBF mechanism would support performance-based contracts between the MOH and providers of basics services in public and non-for profit communities. Performance awards would be made on the basis of delivery of a basic package of maternal and child health services.

Djibouti: Djibouti is one of the poorest countries with more than 75% of the population living in poverty. Life expectancy is just 49 years and infant, child, and maternal mortality rates are among the highest in SSA. The Government is designing the new World Bank Health and AIDS project around RBF to support the achievement of three health related MDGs: (i) improve child health to reduce infant and child mortality rates (MDG4); (ii) improve maternal health to reduce maternal mortality rate (MDG5), and (iii) control the HIV/AIDS epidemic and other communicable diseases (MDG6). Most of the project funds will

be disbursed against the achievement of measurable results directly linked to the health-related MDGs. The Government envisions developing a SWAp through which donors could finance the inputs needed for the overall program complemented by others, such as the Bank, which would finance the overall program results.

DR Congo - With a newly-elected government, the Democratic Republic of Congo (DRC) (population 60 million) is pursuing social and economic recovery. Although there has been some improvement in health indicators in recent years, under-five mortality is estimated at 148 per 1,000 in 2007 and the most recent estimate for the maternal mortality ratio is 1,289 per 100,000 live births. Insufficient coverage, high financial barriers to care, and poor quality undermine health service effectiveness. The “Health Zone” system integrates primary and first-referral services, with public-private partnerships and considerable experience with RBF mechanisms, including NGO contracting and performance contracts with health facilities. The proposed financing of USD 15 million will leverage an additional USD 15 million from an existing IDA-financed project. Three types of RBF mechanisms, based on models already implemented in DRC under various programs, will finance services covering a population of approximately 2.5 million over three years. Impact on maternal and child health will be evaluated and compared to a control group. In the first group, all external support to the health facility will be tied to overall health service utilization. In the second group, all financing will be contingent on specific maternal and child health-related targets. Under the third mechanism, most support will be input-based, with a proportion of health worker incentives tied to a set of service quality and utilization indicators. The control group will receive traditional input-based support.

Eritrea* – The Eritrean healthcare system has been slowly rebuilt to repair the damages wrought during the struggle for independence. It still suffers from a number of constraints, including limited funding and human resource shortages. Within a relatively short period, health status has improved. For child survival, the under-five mortality rate fell dramatically from 136 in 1995 to 45 in 2003. Maternal mortality has fallen from 998 per 100,000 in 1995, to 752 in 2002/03 to 450 in 2008, but remains high, with great regional disparities. Immunization rates are some of the highest in the region, but some reproductive and child health services are still under-utilized. Eritrea proposes three demand-side and two supply-side RBF interventions. On the demand side there will be (i) incentives for pregnant women to use health services (e.g. incentive for the 4th antenatal care visit, transport vouchers for delivery, and food support during stays at delivery waiting rooms), (ii) bi-annual financial incentives based on immunization of children under five, growth monitoring, health check-ups, and absence of female genital mutilation in young girls, (iii) an annual lottery for those who have fulfilled the conditions under (i) and (ii). On the supply side, there will be performance-based incentives for (a) regional health authorities, based on the attainment of regional MCH performance targets, and (b) for the Ministry of Health based on the attainment of national MCH aggregate targets.

Ethiopia* – Although Ethiopia has made significant progress in health indicators over the last decade: the under-five mortality rates decreased from 140 per 1000 live births in 2000 to 123 in 2005 and the maternal mortality rate declined from 871 per 100,000 live births in 2000 to 673 in 2005. However, Ethiopia continues to face serious challenges as it strives to achieve the health and nutrition MDGs. In particular, the following challenges have been identified: limited resources for health, especially at the local level; an inequitable allocation of available resources across the country; difficulties in reaching the poor with those resources; poor motivation and productivity of service providers; and low levels of healthcare utilization. The Government of Ethiopia proposes to incorporate two types of RBF mechanisms into its national program: (i) performance-based contracting (PBC) and (ii) incentives for public sector frontline

providers, including salary top-ups for remote postings, rehabilitation of primary healthcare facilities, rehabilitation or construction of lodging, and provision of transport and communication. The RBF will be incorporated into the national program and utilize the existing SWAp (Protection of Basic Services) mechanisms.

Ghana: Maternal and child care health practices, combined with inefficient and low quality health care have contributed to stagnating maternal and child health indicators in Ghana in recent years. Public providers, who are paid a government salary, have little incentive to provide more or better care - a situation which could threaten the financial sustainability of the National Health Insurance Scheme (NHIS). With over 48% of the population enrolled, solutions to improve its effectiveness and efficiency are a national priority. The pilot RBF will introduce a performance-based incentive system for essential health and nutrition services targeting MDGs 1b, 4 and 5 into the NHIS. The pilot will also explore a demand-side RBF mechanism to assure better use of services. To better learn what works, the government proposes to pilot four different options: (a) transfer of fund from MOH/GHS to the District Health Management Teams conditional on the achievement of results; (b) an additional performance-based incentive payment is offered to health workers for providing key MCH services through NHIS (e.g., child and postpartum vitamin A supplementation, health and nutrition education continuous maternal care follow up, immunization of harder to reach populations, institutional delivery); (c) a combination scenario of (a) and (b); and (d) no change to provide a control. The pilot will be linked to the Nutrition and Malaria Control for Child Survival Project and the Health Insurance Project.

Madagascar*: Despite significant progress in health indicators, particularly child mortality, Madagascar continues to face serious challenges in the production, financing and delivery of health services. Maternal mortality has remained high at about 470 per 100,000 live births, and since 1997 the presence of skilled staff at birth has only increased from 47% to 54% percent. Challenges include limited resources for health, an inequitable allocation and distribution of resources, low productivity of service providers and poor healthcare utilization. Three RBF mechanisms are being considered. First are performance-based contracts with NGOs and private providers at the community level in poorly performing districts. Second is a set of performance bonuses in the form of (i) top-ups to the maximum bonus pool for healthcare providers, especially in under-served areas, and (ii) non-financial performance incentives for PHCs, e.g. facility rehabilitation, transport and communication. The third RBF mechanism is a conditional cash transfer (CCT) based on utilization of antenatal, natal and post-natal health services, as well as health service for infants and children under five.

Mali: The Ministry of Health in Mali currently only measures incompletely the results of its service delivery systems, and the country will not be able to achieve MDGs 4&5 given current trends and delivery mechanisms. Maternal mortality is one of the highest in the world and neonatal mortality accounts for 46% of deaths in the first year of life. The RBF grant will allow the MoH to increase its performance and to track and measure service delivery outcomes aimed at MDGw 4&5. The RBF pilot in three regions aims to improve demand, access and quality of maternal and child health care services, including increased family planning, improved nutrition for mothers and children, improved vaccination coverage, increased involvement of communities, and increased coverage of the population in health mutuelles. The pilot will consist of performance-based contracts between government and facilities (public and private sector, including NGOs) to operationalize their national strategy for performance contracting with privately-owned hospitals and clinics delivering maternal and newborn services. The government currently has a SWAp mechanism where this RBF has been discussed and developed. The

RBF pilot will be linked to the PRSC2 delivered to the Board in January 2008.

Mozambique: Maternal mortality in Mozambique has dropped from 1997 to 2003, with MMR at 408/100,000 live births in 2003 close to the MDG target of 365/100,000 for 2015. While prospects for improvement are good, the government will need to continue its efforts to increase coverage in underserved areas and to improve the quality of health services. One of the main reasons for the high MMR is that only about 50% of women deliver their babies in health facilities because of limiting factors including: (i) long distances and lack of transportation to health facilities; (ii) cultural barriers such as the need for spousal approval to give birth in a health facility; (iii) long waiting times; and (iv) the perception that the quality of care in health facilities is poor. The Government of Mozambique is interested in learning more about the Indian Universal Institutional Delivery Program (JSY1) which provides incentives to women to deliver babies in a government hospital. A joint Bank and Ministry of Health of Mozambique mission is planned for India in June 2008 to acquire a first-hand understanding of the Universal Institutional Delivery Program.

Rwanda Despite significant efforts in the health sector, Rwanda has one of the highest rates of infant and child mortality in sub-Saharan Africa and will be unable to achieve MDGs 4&5 with the existing health sector delivery strategies. The current RBF program which focuses on the supply-side (providers) has shown promising results but has had limited impact on institutional deliveries and does not address the cultural and financial barriers inhibiting women from seeking quality services. Three new RBF mechanisms are envisioned to focus on the hard to reach MDGs. One, a demand-side mechanism, targets pregnant women by providing incentives to use maternal health services including institutional deliveries. A second, targeted at the community level, enhances community response to infant, child, and maternal mortality focusing on a package of high impact interventions for MDG4 including a major push for family planning. A third, targeted at female health workers, provides additional incentives to work in rural areas. The proposed mechanisms will build on the existing foundation of RBF in the country, and focus on cost-effective activities that can be undertaken at community level.

Senegal: Persistent, high levels of infant and child mortality in Senegal are associated with under-nutrition and unfavorable community and family practices. The Nutrition Enhancement Program currently reaches 20% of <5 population of Senegal. Significant results can only be achieved through scaling up of the program to cover all 14 regions with a focus on rural areas and those with the highest rates of under-nutrition. The pilot RBF would expand upon the results-based management approach in Phase 1 where financing is contingent upon achievements related to a package of community services (e.g., growth monitoring, integrated promotion of maternal and child health, and CBD of ITNs and drugs). The Ministry of Health is deeply involved in the implementation of the program, and the budget has been formulated as part of the Poverty Reduction Strategy.

Vietnam: While Vietnam is on track to achieve the MDGs, national performance masks widening inequalities between the rich and poor. Results Based Financing (RBF) is a promising strategy for the government to supplement “mainstream” health policy initiatives. It would be designed to improve the delivery of essential curative and preventive health services to the poor by changing their health seeking behavior, lowering demand side constraints, and motivating service providers to supply quality service in underserved areas. The government is interested in RBF as a means to create supply-side incentives for community health stations to achieve performance benchmarks. The RBF can also be employed to make

private outpatient services (50% of all outpatient visits) more accessible to the population and accountable for performance and to scale up health promotion activities in district hospitals. Contracting private providers on the basis of clear performance criteria and giving demand-side incentives to the patients to use the services from public or private providers could improve access, quality and efficiency of care. Finally, RBF may be a tool to expand Vietnam's voluntary health insurance coverage among workers in the informal sector and the poor.

Yemen: Yemen faces a number of health challenges with increasing maternal mortality rates (351 to 365 per 100,000 live births between 1997 and 2003), high infant and child mortality rates, and almost a doubling in child malnutrition (underweight) from 1992 to 2003 (29% to 45.6%). The primary healthcare system, which is key to improving health status, suffers from a number of problems: delivery of PHC service delivery program is distributed across two sectors, service delivery is poor, decentralization at governorate level is incomplete, and vertical programs dominate governorate level service delivery disempowering governorate-level staff in the implementation of integrated PHC plans. To improve the quality of service delivery, a performance-based contracting RBF mechanism is proposed. Disbursements to eligible governmental and/ or non-governmental organizations will be based on the attainment of pre-defined enrollment targets, as well as on performance on measures of healthcare access, utilization and quality of care, especially those related to maternal and child health.

Zambia: Progress on reducing maternal and child mortality in Zambia has been poor. The maternal mortality rate is one of the highest in the world, at 720 per 100,000 live births, and has been increasing. Zambia also has one of the highest child mortality rates: the infant mortality rate and under-five mortality rates are 95 and 168 per 1,000 live births respectively. Coverage of effective interventions to address these challenges remains inadequate, and is attributable to supply-side factors such as a severe human resource crisis, health worker absenteeism, tardiness, poor morale and low productivity, as well as demand-side barriers (physical, financial and cultural) to accessing care. To improve service delivery and utilization, three different types of RBF mechanisms are proposed, operating at every level of healthcare provision. First are performance bonuses to District Health Management Teams, to health facility teams, to community health workers, and to traditional birth attendants based on the attainment of similar performance targets in order to align incentives and improve service delivery. Second is a league table competition for community health committees with non-financial awards in order to address lack of participation in community health activities. Third are a combination of transportation subsidies and non-financial incentives to promote institutional delivery and post-natal visits among pregnant women and new mothers.