Better health for poor people

Strategies for achieving the international development targets
The international development targets

Economic well-being
- a reduction by one-half in the proportion of people living in extreme poverty by 2015.

Social and human development
- universal primary education in all countries by 2015;
- demonstrated progress towards gender equality and the empowerment of women by eliminating gender disparity in primary and secondary education by 2005;
- a reduction by two-thirds in the mortality rates for infants and children under age 5 by 2015;
- a reduction by three-fourths in maternal mortality by 2015;
- access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015.

Environmental sustainability and regeneration
- the implementation of national strategies for sustainable development in all countries by 2005, so as to ensure that current trends in the loss of environmental resources are effectively reversed at both global and national levels by 2015.

While not amenable to quantification, there is a range of qualitative elements of development that are essential to the attainment of the quantitative goals. These include democratic accountability, the protection of human rights and the rule of law.
Better health for poor people

Strategies for achieving the international development targets
The Department for International Development (DFID) is the British government department responsible for promoting development and the reduction of poverty. The government elected in May 1997 increased its commitment to development by strengthening the department and increasing its budget.

The policy of the government was set out in the White Paper on International Development, published in November 1997. The central focus of the policy is a commitment to the internationally agreed target to halve the proportion of people living in extreme poverty by 2015, together with the associated targets including basic health care provision and universal access to primary education by the same date.

DFID seeks to work in partnership with governments which are committed to the international targets, and seeks to work with business, civil society and the research community to encourage progress which will help reduce poverty. We also work with multilateral institutions including the World Bank, United Nations agencies and the European Commission. The bulk of our assistance is concentrated on the poorest countries in Asia and sub-Saharan Africa.

We are also contributing to poverty elimination and sustainable development in middle income countries, and helping the transition countries in Central and Eastern Europe to try to ensure that the widest number of people benefit from the process of change.

As well as its headquarters in London and East Kilbride, DFID has offices in New Delhi, Bangkok, Dhaka, Kathmandu, Nairobi, Dar-es-Salaam, Kampala, Harare, Abuja, Pretoria, Suva and Bridgetown. In other parts of the world, DFID works through staff based in British embassies and high commissions.

Department for International Development
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This paper is one of a set. Together, they spell out actions which could transform the lives of hundreds of millions of poor people and make the planet a better and safer place for our children and grandchildren. They say what needs to be done to achieve key targets for international development.

These International Development Targets have been agreed by the entire United Nations membership, following a series of summit meetings held by the UN and its specialised agencies over the past ten years or so. The meetings discussed progress in poverty reduction and sustainable development and set targets for measuring that progress.

In the past, targets have often been set and then disregarded. This time, however, the international community is giving them greater weight. In 1996, all the main Western donor countries, grouped together in the Organisation for Economic Co-operation and Development (OECD), committed themselves to a partnership with developing countries and with countries in transition from centrally planned economies. The success of this partnership would be measured against key targets from the UN summits. In the following year, the new UK Government made these targets the centrepiece of its 1997 White Paper on International Development. More recently the World Bank and the International Monetary Fund (IMF) decided to co-ordinate their development efforts behind the targets. These targets are listed on the inside front cover.

Neither the United Kingdom nor any other individual donor country can achieve the targets alone. The targets are challenging, some particularly so. But if, by working together, we can increase the effectiveness of the international community, our assessment is that these targets are achievable for developing and transition countries as a group by the target date, or soon after in some cases, even though they may not be achieved in each region or country individually. It is clear that each developing country must lead the effort if the targets are to be achieved. If this commitment is lacking, civil society institutions need to press their governments to take action as, without a local lead, progress cannot be achieved. The international community, in turn, must provide support for those governments committed to the reforms which are necessary to achieve the targets. Most countries should be able to register very considerable progress towards meeting the targets by the due dates.

The present paper is about health. It looks at the four key international targets – for reducing infant and child mortality; reducing maternal mortality; providing universal access to reproductive health services; and reducing HIV infection rates. It concludes that with the right policies, actions and resources, great progress can be made on each of these, though the maternal mortality target is particularly challenging and the impact of the HIV/AIDS epidemic will have severe effects on progress in many areas.

Targets need to be used intelligently. They cannot capture the full richness and complexity of individual and collective transformation that makes for sustainable development. Individual countries should select and debate, in normal democratic ways, their own measures of achievement. But regular public assessment of how countries, as a group and by region, are performing against a simple standard is essential in order to focus development assistance on achieving real outputs. Doing so will show what works and what does not, will provide accountability for the efforts being made in the name of development, and will give impetus to extending basic life opportunities that should be available to all.

Targets also need to be grounded in reality. For this, we should not underestimate the value of good statistics. The political debate in Britain was strongly influenced by nineteenth and early twentieth century surveys documenting the reality of grinding poverty in our own society. A similar effort of political will is needed in many developing and transition countries if they are to give sufficient emphasis to the needs of their own poor people. Better quality and more accessible information on people’s standards of living is one essential element in creating that will. Much work is needed to improve the collection of reliable and comparable data, and to strengthen local statistical capacity.

These papers do not attempt to provide detailed plans; they will follow, country by country and institution by institution, from discussions with developing countries and the relevant institutions. Many detailed proposals for action in pursuit of the targets are published, or soon will be, as Country and Institutional Strategy Papers. Our bilateral programmes are being reshaped. We are also encouraging the multilateral development institutions in the same direction. One example of this is the policy of the International Development Association – the concessional lending arm of the World Bank – which,
following its Twelfth Replenishment, now focuses on poverty elimination in the context of the International Development Targets. Another example is the enhanced Heavily Indebted Poor Countries Debt Initiative, agreed at the IMF and the World Bank in September 1999, which has started to deliver faster, deeper and broader debt relief to countries committed to eradicating poverty. The G8 Summit in Okinawa endorsed the targets and asked for annual reports on progress.

We must also take advantage of the increased wealth being generated by ‘globalisation’, to help achieve the International Development Targets. In December 2000, the UK Government will publish a second White Paper on International Development, focusing on managing the process of globalisation to the benefit of poor people.

This paper and the others in the collection assess the challenge and set out an overall approach and strategy for our involvement in achieving the development targets in a clear, focused and realistic way. Each reflects a process of consultation in the United Kingdom and overseas.

I hope that you will find them a valuable statement of what the UK Government will do and how the United Kingdom seeks to use its influence to make a reality of the targets, to which we and the rest of the United Nations membership are committed. We stand ready to be judged against our delivery of this strategy. And the whole development community – governments, international agencies, civil society organisations – should be judged collectively against delivery of the targets.

CLARE SHORT
Secretary of State for International Development
Executive summary

1. The last one hundred years have seen a greater improvement in health than at any time in the last three millennia. In the last 25 years, the pace of global health improvement has accelerated, as increasing numbers of people gain access to the benefits of new health technologies, health services, better household environments and to education – in particular female education.

2. However, not all have benefited equally from these gains. The poorest 20% of people in the world are roughly ten times more likely to die before the age of 14 than the richest 20%. Women in the poorest countries of the world are 500 times more likely to die in childbirth than are women in the rich countries of the West. Poor countries, and sub-Saharan Africa in particular, share a disproportionate burden of avoidable mortality and disability. More than 90% of maternal and child deaths continue to occur in developing countries. The emergence of HIV as a global threat in a connected world threatens to reverse and will certainly compromise social and economic development in many parts of the world.

3. Countries need clear national policies and strategies to protect and promote health. Without these, even with economic growth, they risk exacerbating health inequalities and slowing or even reversing health improvements in their countries.

4. Better health for poor people is about how we can make a difference. It demonstrates that greater commitment, partnership and leadership can make a difference to the health of poor people; enable poor people to escape from poverty through better health; prevent people from falling into poverty through catastrophic or chronic illness; and equip individuals and societies to maximise their potential and to capture the benefits of globalisation.

5. This paper is not a detailed action plan for DFID. However, it does set out a clear framework for how we shall respond and expect others to take up their responsibilities. The first half of this paper presents the challenge and an analysis of where we are now and what has been learnt. The second half presents the global response required to meet this challenge, DFID’s role in that response and how we will measure if we are on target.

The analysis

6. Section 1 of this paper is about the importance of the International Development Targets.

7. There are three fundamental requirements for achieving the poverty reduction target – economic growth, equity and security. Health and population activities contribute in two important ways to these requirements:
   - Pro-poor growth and equity. Equitable, pro-poor growth means giving poor people opportunities, and this includes enhancing their chances of good health and control over their fertility. Investment in good health is now known to make a vital contribution to both social and economic development.
   - Security. Ill-health can drive households deeper into poverty, or take the non-poor into poverty. Whenever the poor are consulted, they themselves identify good health and access to affordable and quality services as vital to their security. People require effective health care and a system of paying for care which avoids catastrophically large expenditures for poor families.

8. The International Development Targets that refer specifically to health are, by 2015, to:
   - reduce by two-thirds the rate of infant and child mortality
   - reduce by three-quarters the rate of maternal mortality
   - attain universal access to reproductive health services

2 Voices of the Poor, World Bank, 2000.
In 1999 the International Conference on Population and Development + 5, added a further key target:

- **achieve a 25% reduction in HIV infection rates among 15–24 year olds in worst affected countries by 2005 and globally by 2015**

9. The International Development Targets have captured the imagination of political leaders and international institutions. They were developed during the great international conferences of the last two decades and are supported by all nations.

In addition to the International Development Targets, the World Health Organisation (WHO) called for, and the G8 endorsed at Okinawa in July 2000, an effort to:

- **achieve a 50% reduction in TB and malaria mortality by 2010.**

The targets provide a focus that guides and informs the response to the priority health needs of both the poor, and of nations as a whole. There is no doubt that they are ambitious. Some, for example reducing maternal mortality and HIV/AIDS, will be more difficult to attain than others. But it is right to be ambitious. Their achievement will require a global effort on the same scale that was needed to eradicate smallpox, an effort that is now being applied to eliminate polio and other diseases of poverty. With political will and appropriate resources, significant progress can be made.

10. DFID is committed to using progress against the International Development Targets as a key measure of its own effectiveness.

11. **Section 2 of this paper** considers the nature of the burden of disease and how it is distributed across the world and across societies. This section also considers the determinants of good health, the impact of globalisation, and the proliferation of actors in the international system.

12. Good health is determined by many factors, the most important of which is reaching and sustaining a reasonable level of income and consumption. Female education, clean water and, most importantly, sanitation have an important and well documented impact on (in particular) child survival. Female empowerment is vital to enable women and families access to health care. Good governance and sound macroeconomic policies are required to generate the resources, accountability and access to better health. Social sector service provision and its response to community needs are sensitive indicators of good government.

13. The burden of disease borne by the poor is largely due to communicable diseases such as tuberculosis, malaria, infectious diseases of childhood and, more recently, the impact of HIV/AIDS. Poor women also bear the unacceptable burden of maternal mortality and morbidity. This disease burden is disproportionately borne by the poorest in developing countries. But whilst communicable disease should remain our priority it is now recognised that there is an increasing global burden of non-communicable disease. For the poorest this is being driven by a global smoking epidemic, and more recently the recognition of the importance of mental illness among the poor.

14. Poor people need to be protected by sound social policies and strategies. Increasing health inequality in many countries is a cause for concern. A healthy, well-educated population is a pre-requisite for nations to extract the potential benefits of globalisation.

15. **Section 3 of this paper** considers the progress made and lessons learned. There now exists a remarkable international consensus on priorities, policies and strategies that work and how to go about maximising health development. We are also beginning to witness an increasing amount of resources flowing to the health sector from national governments, charitable foundations and through public-private partnerships. There is a greater recognition of the importance of private as well as public sector health provision for poor people.

16. We are better able to measure performance than ever before. For example, the World Health Organisation’s 2000 *World Health Report* is a milestone document. It highlights the importance of health systems for health outcomes in a society. For the first time, a methodology has been introduced that ranks governments not merely by health attainment, but by how successful they are in maximising health achievements, given the resources and social policies they have in place. It is a relative index as measured by potential performance. Thus a poor country can compare how well it is performing in terms of relative achievement rather than absolute gain, comparing itself not only with similarly poor countries but also the better off economies.
17. Both donors and governments have an important role to play in responding to this favourable environment. This will require an enhanced framework for co-operation – one that better manages the increasing flow of resources to health, the mushrooming of new initiatives in both the public and private sectors, and the increasing importance of charitable foundations to the funding of research and health programmes. We require a step leap in our response to this challenge. This is the subject of the second half on this paper.

The response
18. Section 4 of this paper is concerned with effective international and national action required to take forward this agenda. Better international leadership and co-ordination, not only in the UN but also in the international financial institutions, is crucial.

19. The need for new initiatives and incentives to develop a new range of international public goods is vital. 90% of pharmaceutical research is targeted at diseases of concern mainly to rich countries, diseases that account for only 10% of global disease burden. There is an urgent need for new drugs and vaccines for tuberculosis, malaria and HIV/AIDS. A number of innovative public-private partnerships are underway. Increased resources and appropriate incentives are needed to meet the escalating cost of developing new technologies, and to ensure the purchase of effective and affordable technologies.

20. Better international commitment and co-ordination will only meet the needs of the poor through effective national action and local leadership. Furthermore, sustained improvements in health will only be achieved through national policies and strategies that result in broad-based social sector investments in health, education, human rights, equity and gender awareness, economic well being, food security and nutrition and community action.

21. Section 5 of this paper sets out how DFID will respond to this challenge and Section 6 how we will measure progress.

22. This response is outcome driven, sets priorities, and will be addressed through partnerships. It is tightly focused on:

- **Response one**: Addressing the priority health problems of poor people; strengthening access to care, services and products
- **Response two**: Investment in strong, efficient and effective health systems (public, private and informal)
- **Response three**: A more effective global response to HIV/AIDS
- **Response four**: Supporting the necessary social, political and physical environments that enable poor people to maximise access to better health

23. This paper emphasises the importance of national efforts and leadership. DFID will support such efforts, with governments at the country level and also through partnership with global institutions – nationally, regionally and internationally.

24. HIV/AIDS is highlighted as a new and overarching challenge to development. The epidemic of HIV/AIDS challenges the goals of development in all domains. In some parts of the world, notably sub-Saharan Africa, there is no single greater threat to the achievement of the international development goals. It is clear that the nature of the epidemic requires a co-ordinated response across many sectors.

25. DFID is but one of many actors in the international community. To achieve the International Development Targets, the international community will have to work collectively and in close collaboration. The enormous potential of the UN system, the international financial institutions and bilateral agencies will have to be harnessed in new ways. New partnerships and methods of collaboration, led by national governments and civil society, and bound by shared priorities will have to be built and supported effectively by this community. New roles and responsibilities will have to be defined. DFID will play its full part in building this new collaboration.
1. Targets

1.1 International development targets and the White Paper

The International Development Targets that refer specifically to health are, by 2015, to:

- reduce by two-thirds the rate of infant and child mortality
- reduce by three-quarters the rate of maternal mortality
- attain universal access to reproductive health services

The International Conference on Population and Development +5 in 1999 added a further key target:

- achieve a 25% reduction in HIV infection rates among 15-24 year olds in worst affected countries by 2005 and globally by 2015

The World Health Organisation (WHO) has further identified TB and malaria as priorities and set a target to:

- reduce TB and malaria mortality by 50% by 2010

At the G8 meeting at Okinawa (2000), the G8 leaders endorsed the last two targets.

Health has long been recognised as a fundamental human right and is reflected in the Universal Declaration for Human Rights. Yet every year the world is witness to over 10 million child deaths, half a million women die every year in pregnancy or childbirth and life expectancy at birth in the poorest countries stands at less than 50 years. 99% of global child and maternal deaths occur in the developing world – a stark illustration of the global inequalities in health and of the fragility of the lives and livelihoods of the world’s poor people.

The 1978 declaration at Alma Ata lent new impetus to the global effort to tackle ill-health. Over the two decades which followed, immunisation rose from 20% to 80%, access to safe water and sanitation expanded dramatically and infant mortality fell by 36%. The International Development Targets signify a renewal of international commitment to accelerate this progress in health as one of the cornerstones of poverty reduction.

1.2 Health and poverty

There is a clear moral case for investing in health – especially where the burden of ill-health is greatest.

Huge disparities exist in health between the rich and poor world, and between rich and poor within developing countries. Poor health is closely associated with poverty. Across and within countries, differences in income can account for as much as 70% of variance in infant mortality. The poor are most vulnerable to ill-health, and have the least means to combat it. But this is not the whole picture. The experiences of many countries demonstrate the positive impact that pro-poor health and social policies have for better health (section 2.1.2).

Ill-health is not simply a consequence of poverty, it is an aspect of it. Better health contributes directly to diminishing poverty by improving quality of life, expanding opportunities and safeguarding livelihoods.

The case for investing in health has been further strengthened by a growing body of evidence which shows that better health contributes to greater economic security and growth. At the micro level, better health means less time and expense invested in caring for ill family members, improved physical and intellectual development, enhanced school attendance and learning and higher productivity at work. Vector control can render whole areas of productive land habitable. At the macro level, human development, and the demographic transition which is its consequence, is now widely accepted as a central long-term driver of economic growth.

The complex relationship between poverty and ill-health is illustrated in figure 1. Better health reduces poverty, and reduced poverty improves health.
Fig. 1 – Poverty and ill-health: the vicious circle

Global progress on health is also in the developed world’s interest. Communicable diseases cross national borders. And the continued efficacy of antibiotics and other health technologies depends upon responsible use of antibiotics and the containment of antibiotic-resistant disease worldwide.

1.3 Specifying targets

On the one hand, the concept of health is straightforward: longer life expectancy, less illness, less disability and the opportunity to exercise reproductive choice. But despite its apparent simplicity, it is difficult to capture health progress in a single measure.

The International Development Targets on health focus on four measures. They are not intended as exclusive objectives; wider morbidity and disability issues also matter. But they are effective indicators of the extent to which the broad goal of better health for poor people is being met. The health targets are also mutually interdependent. Progress on child mortality will require gains in maternal mortality to reduce perinatal deaths and disability.

1.3.1 Infant and child mortality

The health of infants and children is a good barometer of overall population health. And the indices themselves have a profound effect on other summary measures of population health such as life expectancy at birth and disability adjusted life years lost (DALYs).³

Infant mortality rates (IMR) and under-five mortality rates (USMR) are also very sensitive to poverty. The poorest 20% of the global population have a tenfold higher risk of death in childhood than the richest 20%, compared with a two to fourfold difference in adult mortality (except for maternal mortality, where the differential between rich and poor is largest of all).

The International Development Target is to reduce by two-thirds the rate of infant and child mortality by the year 2015 (base year 1990).

1.3.2 Maternal mortality

Maternal mortality illustrates most vividly the health divide between rich and poor. In much of Africa the lifetime risk of dying in pregnancy is 1 in 12, compared to 1 in 4,000 in Europe.⁴ Like child health, the maternal mortality measure is highly sensitive to the poverty divide between rich and poor within and between nations.⁵

Maternal mortality contributes directly to poverty by jeopardising the welfare of children who are orphaned. Where there are high rates of maternal mortality, there will also be high levels of long-term disability related to complications of pregnancy and birth. Maternal mortality is intimately associated with perinatal survival and child health. Finally, maternal mortality is widely regarded as a good indicator of accessible and functional health services, without which obstetric emergencies frequently prove fatal.

The International Development Target is to reduce by three-quarters the rate of maternal mortality by 2015 (base year 1990).

1.3.3 Reproductive health

The reproductive health target embraces all reproductive health services: safe motherhood, prevention and treatment of sexually transmitted diseases (STDs), as well as family planning services.

It differs from the other targets in that it focuses on the importance of access to family planning services and the opportunity to exercise reproductive choices rather than on actual health outcomes – since actual fertility rates or contraceptive prevalence rates depend upon preferred family size as well as accessible services.

The International Development Target is to attain universal access to reproductive health services before 2015 (base year 1994).

³DALY=Disability Adjusted Life Year, a measure which combines the number of years life and the quality of life.
⁵Of all of these indicators, maternal mortality is the one which is most difficult to measure and monitor reliably. The current international data set suffers from many gaps and very wide margins of confidence.
1.3.4 HIV/AIDS
The HIV epidemic represents a real global threat which will slow, or even reverse, health gains in the most affected countries. In addition to its direct impact on health, HIV, as with other communicable diseases, impoverishes families through the expense of managing chronic disease and the loss of “breadwinners” and carers. Across national economies HIV threatens to overwhelm medical services and deplete the supply of productive labour.

The most recent of the International Development Targets was adopted in 1999 at the five-year follow-up to Cairo: to achieve a 25% reduction in HIV infection rates among 15–24 year olds in the worst affected countries by 2005, and globally by 2010 (base year 1999).

1.3.5 Tuberculosis and malaria
The resurgence of communicable disease, notably TB and malaria, their particular impact on the poor and the association of TB with HIV requires specific attention. Seven to eight million people become sick with TB each year of whom about two million die. The biggest burden of TB is in South East Asia, but sub-Saharan Africa is also badly affected. Nearly 500 million people suffer from acute malaria each year, of whom 1 million will die – the majority of victims are children. Nine out of ten cases occur in sub-Saharan Africa. Tackling these diseases will result in substantial benefits for poor people.

WHO set a target to cut TB and malaria mortality by 50% by 2010 (base year 1999), which the G8 leaders endorsed at the G8 meeting in Okinawa in July 2000.

1.3.6 Focus on poverty
It is clear that the International Development Targets, and in this paper those relating to health, need to be seen as part of the over-arching goal of poverty reduction. We are concerned with improving health outcomes of the poor, and with improving health as a means of investing in the well-being and future prosperity of poor people.

We must, therefore, take explicit account of inequalities in health within countries – because poorer people are more vulnerable to disease, because they are most likely to be excluded from health services, because their livelihoods are more acutely threatened by illness and premature death, and because they have the least financial means to cope with ill-health. A focus on poverty will necessarily also mean a focus on women, who constitute almost 70% of the world’s 1.3 billion poor people.

This does not mean that we will concern ourselves with the poorest to the exclusion of all others. The poor are clearly most vulnerable to disease and poor health. But poor health is in itself an aspect of poverty, and all people are entitled to lead full and healthy lives. There is, for example, clear evidence that the non-poor can be dragged into poverty through poor health. It means that we have a duty to ensure that investment in the health sector will deliver pro-poor health sectors and more equitable health outcomes within countries. Across countries, there is a clear case for focusing international assistance more sharply on those countries with greatest health needs – and least domestic resources.

1.4 Are the international development targets for health achievable?
As figure 2a illustrates, meeting the target for infant and under-five mortality requires more rapid progress than in the past – particularly in least developed countries. The target, though ambitious, is achievable as long as national and international effort is intensified, global economic conditions are favourable and the impact of HIV on infant and under-five mortality can be contained. With HIV in Africa now at epidemic levels, prevention of HIV infection in children requires a bold and substantially enhanced response. (See annex 1 for regional breakdown.)

Fig 2a – The path to 2015: under-five mortality

Source: World Development Indicators 2000
Annex 1 shows a regional breakdown of progress to date.

The maternal mortality target is much more difficult (figure 2b). Only Malaysia, Singapore and some states such as Kerala in India have achieved the rate of progress required for a three quarter reduction over twenty-five years. While measures to prevent maternal deaths are cost effective, they will require investments in obstetric services that are carefully focused to remain within the means of many poor countries.
Access to reproductive health services is difficult to measure. The rapid growth in contraceptive use and the onset of the demographic transition suggest grounds for optimism. Nonetheless, there is a very long way to go – particularly in the poorest countries where the prevalence of modern contraception, ante-natal services, delivery and post-natal care are barely in double figures.

The feasibility of the HIV target in high prevalence contexts has already been demonstrated by the success of Thailand, Senegal and Uganda in slowing the epidemic. New and encouraging data is also emerging from other countries. This target can be achieved, particularly in countries where the epidemic is already advanced. But progress will depend critically on the success of measures to influence the behaviour of adolescents and on an intensification of national and international effort – including the development of new technologies.

The TB and Malaria targets are challenging but achievable. New partnerships and international collaboration based on national priorities such as 'Roll Back Malaria' and 'STOP TB', are the foundation for achieving these targets.

Ensuring that the increasing need for health commodities (contraceptives, vaccines and drugs) for the poor will be available without major disruptions in international supply has never been more important.

1.5 The cost of achieving the international development targets

Although some costing work is underway, we are not yet clear enough about the overall cost of implementing the International Development Targets, how this compares to the resources available, and how additional resources are to be secured. These are questions which governments and the international community must address urgently if the 2015 vision is to be realised. The existing data (see below) has methodological flaws and is in urgent need of updating. Such work forms part of the objectives of an international effort through the Commission on Macroeconomics and Health which is supported by WHO.

In 1993, the World Bank estimated that a minimum essential package of health care could be provided for all at a cost of $12 per person per year ($14.3 in current prices). In all countries, difficult choices will need to be made in setting priorities between and within sectors. In the poorest countries in particular, the $14.3 benchmark can only be realistically attained through greater, long-term external support.

But even this level of spending may not be enough to attain the International Development Targets. The figure does not include spending on public health goods such as water and sanitation. More recent estimates by WHO suggest that the level of spending required could be considerably more. A 32% reduction in the burden of disease, which the Bank estimates implementation of the package would produce, surely falls short of a two-thirds reduction in infant and under-five mortality.

The United Nations Population Fund (UNFPA) has estimated the resources required to meet the reproductive health targets. These calculations put the annual resource requirements for the year 2000 at $19.2 billion in current prices – of which $12.8 billion is required from developing countries and $6.4 billion from donors. This would mean a doubling of domestic expenditures and a tripling of international assistance for reproductive health over their respective levels in 1996. The report calls for a substantial increase in aid for reproductive health and a reallocation of these resources to target countries with the greatest needs.

What is clear, is that the efficiency of health sectors and how priorities are set within a situation of limited resources remains vital. The provision of healthcare involves putting together a considerable number of resource inputs to deliver an extraordinary array of different service options. Few, if any, manufacturing
processes match the variety and rate of change of production possibilities in health.” (World Health Report 2000).

1.6 Financing sources

Limited health budgets and growing health needs are forcing developing country governments to make strategic decisions on the use of both domestic and foreign funds. Many governments should allocate more to the social sectors. Within the health sector, ministries should preferentially allocate resources to primary and secondary care, rather than to tertiary care. However, where absolute domestic budgets are small, the room for manoeuvre is limited.

Governments have responsibility for ensuring that resources from multiple, diverse sources are utilised to support the same, common set of objectives. Financing sources can include local and national taxation, international grants and loans (from bilateral and multilateral institutions and foundations), national and international non-governmental organisations (NGOs), business and private out of pocket payments. Aid plays a relatively small role in terms of overall financing of health needs in developing countries, but in the poorest countries it can be significant. Aid accounts for 70% of the Mozambique health budget; in Uganda 33% of recurrent and 90% of development budget.

When the public sector fails to meet the health care needs of the poor, out of pocket expenditure rapidly exceeds public expenditure. Payments for private health care can be considerable: up to 90% of household expenditure on health in India is in the private sector, with the poor paying proportionately more than the rich. This can drive poor households further into poverty and drag the non-poor into poverty. There is insufficient understanding of this process, but the consequences are twofold. Firstly, reducing the crippling financial burden of the poor is essential. Secondly, new regulatory frameworks and incentives are required to ensure high quality, appropriate care when the poor have no alternative but to pay for health services.

Community insurance and user fees can be important parts of health financing systems but they are both partial solutions – neither will cover the bulk of health expenditure. The experience of the 1980s and 1990s has illustrated that their potential for revenue generation and redistribution was less than expected: they have not proved to be the panacea that some envisaged.

Clearly, this analysis is not uniform. Unlike much of sub-Saharan Africa, in Latin America, parts of the former communist economies and Asia, the challenges are more about re-prioritising public expenditure and reforming institutions to address the changing health needs. All countries require political commitment, action to adjust public expenditure priorities and efforts to increase revenue and reduce fraud and inefficiency.

The implications of this brief analysis are twofold. Firstly, countries which have committed themselves to the International Development Targets (both developing countries and donors) need to match those commitments with real increases in funding. Secondly, the attention that has been paid in the past to reallocating domestic resources must be turned to include reallocating aid. Shifting the balance of aid flows towards those countries in greatest need (in both health and resource terms) would significantly improve the prospects for meeting the targets.8

In aid-dependent countries, donors will need to be prepared to make long-term commitments to fund the recurrent, as well as the capital, costs of accelerating progress. In middle income countries where there are still poor people, support may more appropriately take the form of broader development co-operation, particularly for institution building, and the sharing of skills, experience and knowledge. In both aid-dependent and middle income countries, donors, multilateral institutions and foundations need to work more closely with governments to ensure that health resources, from whatever the source, address the health needs of the poorest households.

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2. The challenge

2.1 Disease distribution and the burden of the poor

2.1.1 The burden of ill-health and the health of the excluded billion

The scale of unmet health need is vast. If all children had the same life chances, 11 million fewer children in developing countries would die each year. More women die from a pregnancy-related cause in India in a week than in the whole of Europe in a year. A hundred and twenty million couples still have no access to family planning. And the last decade has seen the arrival of HIV/AIDS, which in 1998 is estimated to have infected 16,000 people every day.

So despite dramatic health gains in the last 50 years, the world’s poorest people still live in the shadow of ill-health and early death. Health for all by 2000 has not been achieved. For the 1.2 billion people who live on less than $1 per day, it remains elusive.

2.1.2 Broader determinants of health and the links to other sectors

Health services play an important role in promoting and protecting health. But, in the long term, economic security, education, nutrition, water, sanitation and the broader physical and social environment are the arbiters of population health prospects. These factors tend to move together. Their combined impact is illustrated by the well-known relationship between income and infant mortality shown below.

But this is only a part of the story. Some low income countries such as China, Sri Lanka and Kerala in India, for example, have been able to improve health status significantly, while other countries of similar or higher income status have failed to achieve such gains. This has been attributed to rising income and nutrition, good agricultural policies, effective preventive health programmes, high levels of education and literacy (particularly among females) and equity of access to medical care.9 Strong political and social support to health was essential.

The range of factors which impact on health are illustrated in figure 4. Determinants are arranged concentrically, moving outwards from immutable individual factors, to lifestyle, social networks, a range of living and working conditions, and finally the broader social, cultural and physical environment.

Fig 4 – The main determinants of health


Female education, water, sanitation and nutrition have a major impact on health status. Improved access for girls to education is clearly associated with better health of both women and their children. One study in Africa found that a 10% increase in female education led to a 10% decline in child mortality. But girls are still less likely to be educated than their brothers. In India and Bangladesh women over the age of 25 have had, on average, less than half the years of schooling enjoyed by men.

Improved water and sanitation, nutrition and effective oral rehydration therapy has brought about a 50% reduction in child diarrhoeal mortality. Yet in Cambodia, for example, only 13% of the population have access to safe water.

9Good health at low cost, Halstead et al., Rockerfeller Foundation, 1985. In the case of Sri Lanka, rapid progress in malaria control was particularly important.
Although donors can, and do, provide significant support, long-term sustainability depends critically on the political will and resource mobilisation efforts of developing country governments. Sound macroeconomic and social policies are needed to generate and apply the additional resources required, and external assistance needs to be managed effectively. Democratic and participatory mechanisms and accountability to citizens are indispensable if the state is to support development.

Communities and families have an important influence on the health and welfare of their members – particularly the most vulnerable. The only social security is founded on mutual care and obligation in many poor societies. Gender relations have far-reaching effects on the health of girls and women, and their ability to exercise free choices that affect their health. Local government services, including those responsible for health, should be both accountable and responsive to the demands and expectations of communities. Few are.

Achieving the targets and ensuring sustainable progress on health will, therefore, require a multi-sectoral approach, with concerted action on key fronts like governance, education, nutrition, water, sanitation, economic security and the physical and social environment (see associated papers in this series). Such an approach must be both properly funded and designed to promote equity. Although the health sector cannot take responsibility for undertaking all of these actions, it has advocacy and advisory roles, as well as traditional public health tasks such as safeguarding health standards in water, food safety and the disposal of industrial waste. These are areas where the record is not good and there is very little evidence of best practice.

### 2.1.3 The health divide

The poorest 20% of the world’s population are roughly ten times more likely to die before they are aged 14 than the richest 20%. Even beyond this age, poorer people are between twice and four times more likely to die than the richest 20%. The result is that in 1995 the least developed countries (with average per capita GNP of $220) accounted for just 10% of the world population, but 35% of under-five deaths, and 46% of maternal deaths.

The regional picture is illustrated in figures 5 and 6. Despite its smaller population, sub-Saharan Africa contributes a similar number of under-five and maternal deaths to the much larger South Asian region. Industrialised countries, in contrast, account for less than 1% of the annual toll of maternal and child deaths.

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10 Poverty and inequalities in health within developing countries’, Gwatkin, D., paper presented at the 9th Annual Public Health Forum at LSHTM, April 1999. (Table 6), 1996.

respectively (*State of the World’s Children, 1996*). Annexes 2 and 3 illustrate the variability in child and maternal mortality rates between countries.

Similarly, within countries, there are marked health inequalities between rich and poor. In developing countries, the poorest 20% account for over a third of infant and child deaths. Infant and child mortality rates among the poorest 20% are typically double those of the richest, although the extent of inequalities varies widely between countries. Differentials of similar magnitude are found between the children of mothers with no education as compared with those with secondary education, and between households where the father’s principal occupation is agricultural as compared to professional or technical.

Nowhere is inequality greater than in maternal mortality. A poor mother in a poor country is 500 times more likely to die in childbirth during her life than is a rich woman in a rich country.

The picture which emerges is of very sharp global inequalities in health, with the greatest absolute burden of ill-health being concentrated in sub-Saharan Africa and South Asia. Within other regions, though, some countries suffer very high rates of poverty and ill-health. And within all countries the health of the poor tends to be considerably worse than that of the rich, and disturbingly despite economic growth, in many countries, health inequality is increasing.

### 2.1.4 The gender divide

The gender divide is important and real. Almost 70% of the 1.2 billion people living in extreme poverty are women. Women, especially poor women, are often trapped in a cycle of ill-health exacerbated by child-bearing and hard physical labour. A World Bank study of women’s health in India clearly demonstrates that women experience more illness and are less likely to receive medical treatment before the illness is well-advanced. The nutritional status of women and girls is compromised by unequal access to food, heavy work demands and special nutritional needs (such as for iron). As a result, they are particularly susceptible to illness, especially anaemia.

This has consequences not just for the women themselves but also for the well-being of their children, especially girls.

Gender relations have a far-reaching effect on the health of girls and women, and on their ability to freely exercise choices that affect their own health. There is a growing consensus that improving the health and overall status of women will provide substantial benefits in terms of human welfare, poverty reduction and economic growth.

### 2.1.5 Health priorities

The pattern of disease varies significantly between geographical regions. In poor countries, and among poor populations within middle income countries, the ‘category 1’ diseases (communicable disease, maternal, perinatal and nutrition-related conditions) account for the majority of ill-health. Even here, though, injuries and mental health conditions are responsible for a significant proportion of the burden of disease.

In the West and in countries such as China and all of Latin America where population growth is stabilising and where the major impact from communicable diseases have been overcome, non-communicable diseases (particularly cardio-vascular disease, mental illness in women and cancers) and injuries account for the majority of the disease burden (figure 7).

![Fig 7 – Composition of disease burden by region, 1990](image-url)
There are, of course, many countries at a transition stage between the two scenarios above, such as India, which are suffering a “double burden of disease”: Communicable disease is still a significant problem, and non-communicable disease, particularly among non-poor populations, is also on the rise.

But within the poorest 20% of the world’s population, it is clear that communicable diseases represent the greatest challenge. Among this group, they were responsible for 59% of deaths and 64% of DALYs lost. Among the richest 20% of the globe, the figures are 8% and 11% respectively.\footnote{The Burden of Disease among the Global Poor – current situation, future trends, and implications for strategy, Gwatkin, D. and Guillot, M., Global Forum for Health Research/World Bank, 2000.}

HIV/AIDS now threatens past success in reducing mortality rates. An analysis of deaths in children under five shows that they are still predominantly caused by preventable and easily treated diseases such as acute respiratory infections, diarrhoea, measles and malaria. Malaria and TB, the latter closely related to HIV, dominate the landscape of adult mortality and morbidity.

This, of course, does not mean that poor people do not suffer from non-communicable diseases – they do. But they are not the principal cause of the excessive morbidity and mortality suffered by the poor. And the influence of richer people is likely to bias governments towards a focus on non-communicable disease, further reinforcing the argument for special attention towards communicable disease. There is also a need for further data to explore the impact of communicable disease in adulthood on poverty.

Some aspects of reproductive health (sexually transmitted infections, HIV) fall into the communicable disease category. Others – safe motherhood and reproductive choice – do not. In the case of maternal health, the case has already been made that differentials between rich and poor are more severe for maternal mortality than for any other indicator. Ninety-nine per cent of the 570,000 maternal deaths which occur every year are in the developing world.

The developmental, ethical and economic arguments for promoting reproductive choice are overwhelming. There remains a considerable gap between desired and actual family sizes. Lower fertility is associated with better child health and lower lifetime risk of pregnancy-related death and disability. Large family size (especially at the stage when children are young) is closely associated with poverty.\footnote{Evidence cited in Special Programme on Africa.}

There is strong macroeconomic evidence for the ‘demographic gift’ as lower dependency ratios feed through to higher per capita income, savings and investment.

Strategic decisions, under the significant resource constraints that exist in developing countries, should be determined not only by the burden of disease among the poor but also by the cost effectiveness of health interventions in terms of health benefits gained. The 1993 World Development Report clearly illustrated that, in countries with large population growth, interventions to tackle HIV prevention, short-course TB treatment and malaria control all rank highly in terms of cost-effectiveness.\footnote{For detailed cost-effectiveness rankings see table B.6 and B.7, and the World Development Report, 1993.}

Whilst global rankings of cost-effectiveness must be subject to numerous provisos, these data reinforce the case for focusing resources on the principal diseases of the global poor, and on the most cost-effective interventions.

Three caveats are in order before concluding this discussion. Firstly, the patterns cited above are only a very broad guide to the pattern of health needs. Individual country patterns will vary from the average and will each exhibit specific disease priorities according to their ecological, social, economic conditions and other factors.

Secondly, the process of setting public health priorities cannot rely entirely on ‘professional’ judgement. Epidemiological and economic criteria for decision-making have an important role, but in the absence of genuine public participation and accountability, the policy process is at risk of capture by professional interests. Moreover, public policy needs to be politically acceptable. What is rational from an epidemiological and economic perspective may not accord with the popular perception or political feasibility. And the choices of individuals and communities have a vital role – both in upholding norms, standards and accountability, and in safeguarding and promoting health. Thus the use of empirical measures of health needs to be tempered by consideration of perceived priorities if health policies and plans are to empower communities and health service providers to deliver maximum benefits.

Thirdly, the picture painted in this report is a ‘snapshot’ in time. The rapid spread of HIV and other emergent or resurgent disease may change patterns quite fundamentally. Similarly, the onset and progression of the epidemiological transition will undoubtedly continue to shift patterns of disease. For example, mental illness in the poor is increasingly recognised as a major problem, and effective interventions for the poor are becoming available. There will be a vital need for continuous research and dissemination of knowledge to ensure that the health
priorities of the poor are constantly reviewed and appropriate action taken.

In conclusion, arguments based on the burden of disease, equity, efficiency and political economy all point in the same direction – towards focusing on poorer countries, on poor people within those countries, and on the principal causes of the disease burden of the poor and reproductive health, including family planning.

2.1.6 The challenge of HIV/AIDS

The speed at which HIV/AIDS is devastating the developing world has exceeded that predicted by many commentators in the early stages of the epidemic. We must face up to the massive implications of the virus for development. The numbers with HIV and dying of AIDS continue to increase. It will get worse before it gets better.

HIV/AIDS is adding hugely to the difficult task the world faces in making progress towards achieving the International Development Targets. Table 1 illustrates how much better health indicators would have looked in 1998 without the AIDS pandemic.

In the worst affected countries, HIV has already had a profound impact on existing rates of infant, child and maternal mortality. Containing the epidemic is vital if we are to have any prospect of meeting these targets.

As with other major communicable diseases, the impact of HIV/AIDS goes beyond health. The epidemic is having a big effect on the demand for education. Children have to support sick parents. As parents die the numbers of street orphans increases. As teachers die in ever increasing numbers, children are denied education. It will make the poverty reduction target more difficult by consuming precious resources available to government in caring for those infected. And it will deplete the productive labour force and increase the dependency ratio. Health service staff are at particular risk from infection, and in some countries, staff are dying faster than can be trained.

Table 1: Demographic indicators with and without AIDS, 1998

<table>
<thead>
<tr>
<th>Country</th>
<th>Growth rate (per cent)</th>
<th>Life expectancy (years)</th>
<th>Crude death rate (per thousand)</th>
<th>Infant mortality rate (per thousand)</th>
<th>Child mortality rate (per thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With AIDS</td>
<td>Without AIDS</td>
<td>With AIDS</td>
<td>Without AIDS</td>
<td>With AIDS</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2.2</td>
<td>2.9</td>
<td>40.9</td>
<td>50.9</td>
<td>21.3</td>
</tr>
<tr>
<td>Kenya</td>
<td>1.7</td>
<td>2.5</td>
<td>47.6</td>
<td>65.6</td>
<td>14.2</td>
</tr>
<tr>
<td>Nigeria</td>
<td>3.0</td>
<td>3.2</td>
<td>53.6</td>
<td>57.8</td>
<td>13.0</td>
</tr>
<tr>
<td>South Africa</td>
<td>1.4</td>
<td>1.9</td>
<td>55.7</td>
<td>65.4</td>
<td>12.3</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1.1</td>
<td>2.5</td>
<td>39.2</td>
<td>64.9</td>
<td>20.1</td>
</tr>
<tr>
<td>Honduras</td>
<td>2.3</td>
<td>2.5</td>
<td>65.0</td>
<td>69.2</td>
<td>7.0</td>
</tr>
<tr>
<td>Cambodia</td>
<td>2.5</td>
<td>2.7</td>
<td>48.0</td>
<td>50.7</td>
<td>16.5</td>
</tr>
</tbody>
</table>

2.2 The international environment

2.2.1 Globalisation: health threats and opportunities

Globalisation – the increased movement of goods, services, capital, people and information across national borders – has led to a world that is more connected than ever before. Change within countries is inevitable, and the pace is increasing. How we shape this change to ensure that there are more winners than losers, and that opportunities created by globalisation are captured by the poor, is crucial. Effective national and international social sector policies are essential if the poor are to extract the maximum benefits from globalisation.

To date globalisation has had both positive and negative impacts on the health of poor people. The increased availability of new technologies and the development of health systems to deliver them has led to a 50% reduction in child mortality in the last 20 years. The globalisation of pharmaceutical markets has increased the availability of drugs through both public and private sectors in some of the remotest areas of the world. Pharmaceutical companies are increasingly involved in direct support to global health programmes. Yet it is also clear that a globalised industry has failed to generate the new drugs and vaccines needed in developing countries, notably for HIV, TB and malaria. New public–private partnerships have been created in an attempt to resolve this failure and to generate new public goods in health for developing countries (section 4.2.3).

Increased communication, conflict, movement and migration of people, and associated social and behavioural changes have changed disease dynamics. Global warming and environmental change has extended the reach of vector borne diseases. This new dynamic has led to a more rapid transmission of disease and has driven the spread of HIV. New and resurgent diseases are in large part attributable to globalisation. Cholera has reappeared...
in Latin America for the first time in 100 years. Microbial resistance against drugs for TB, malaria and HIV/AIDS is now a global threat.

Increased mobility has facilitated the movement of qualified staff from rural to urban areas, and from poor to rich countries. The recruitment of doctors and nurses by developed countries from South Africa has a knock-on effect as South Africa recruits from neighbouring poorer countries. Recent regional agreements in Southern Africa have sought to redress this problem. In Bangladesh and elsewhere, governments actively encourage the export of health staff, particularly nurses and doctors. This can have subtle effects. Because international qualifications are required in ‘importing’ countries, national policy in training and in the overall system in which training is provided has to be adapted, often with disregard to local priorities, in order to meet the standards and priorities of the West.

The tobacco industry has been able to shift its focus from western countries to developing country markets, with major implications for health.

Globalisation offers massive potential benefits for poor people, but international and national efforts are needed to manage the process so that the poor are not excluded. Strong national social policies are an important part of this effort.

2.2.2 Conflict
Conflict and natural disasters have also brought about health problems associated with large population movements, loss of traditional social networks and adaptation to new environments. Displaced populations are extremely vulnerable to communicable diseases such as malaria, meningitis, pneumonia and diarrhoea. Conflict and rapid population movement are also associated with an increase in sexually transmitted diseases, in particular HIV/AIDS. Crises have a major impact on health status. In Mozambique, between 1980 and 1988 for example, child mortality rates increased rapidly as health and social services fell apart. School enrolment declined from almost 100% to around 69% and calorie consumption declined sharply, hampering the prospects of recovery in the long term.

The United Nations High Commission for Refugees (UNHCR) estimated that there were 12 million refugees around the world, as well as one million asylum seekers, 3.5 million recently returned refugees and millions more displaced within their own countries. In 1998, an estimated 315 million people were affected by natural disaster and a further 103 million by ongoing complex emergencies. The annual estimated cost of natural disasters is in excess of $80 billion, with international support to combat its effects at around $3 billion per annum.

2.2.3 International assistance for health: a need for better co-ordination
There has been a proliferation of institutions responding to global health needs. To name but a few, the World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA) and United Nations Programme on HIV/AIDS (UNAIDS), in some cases with support also from the United Nations Development Programme, all focus primarily on the health sector. These UN agencies have been joined by the multilateral development banks, bilateral donors, the European Commission and also by international non-governmental organisations (NGOs) and private industry. The international financial institutions have come to play an increasingly important role in health, both in financing terms but also as an intellectual resource. As a result, mandates and responsibilities overlap.

Numerous international public-private partnerships, such as Bill Gates’ vaccine initiative, represent a further elaboration of an already complex web of actors in the international health effort.

Looking back, international development assistance has made a massive difference during the past half century. Without aid, smallpox could not have been eradicated, child immunisation levels would be a fraction of the current figures, and we would not be able to imagine the imminent eradication of polio. Looking forward, even greater external assistance targeted to support committed governments will be required to accelerate progress towards the International Development Targets in the poorest countries.

International donor agencies bring to the table funds, knowledge, technical and management expertise and leadership. But the quality of external assistance is as important as the quantity. Developing countries have often been burdened with inappropriate projects, advice and equipment, not to mention the administrative complexity of co-ordinating a multitude of donors, each with their own project cycles, procedures and special interests. The financial leverage of donor agencies in recipient countries, coupled with low levels of political profile and scrutiny ‘at home’, combine to create a hazardous vacuum of accountability. Even with the best intentions, large bureaucracies take time to adapt their approaches in the face of changing circumstances and new knowledge. Yet official development assistance constitutes a vital resource which must be harnessed if the targets are to be reached.
Added to these players is the civil society sector: the media, advocacy groups, national and international NGOs, philanthropic trusts and foundations, community organisations and other interested parties. Academic institutions in both the North and South play an important role in generating new knowledge on many of the key international health issues. Although the private sector has received much criticism, it has a critical role to play: harnessing the private sector for the public good is a key theme in international health. An example of good practice is the provision, by a pharmaceutical company, of Ivermectin to treat river blindness in West Africa. Some public-private partnerships have been forged. The amounts involved may be highly significant: the Bill and Melinda Gates Foundation, for example, donated $100 million to the Children’s Vaccine Initiative, an amount similar to the annual budget of the WHO’s Global Programme on Vaccines.

The challenge facing the international health community is to mould these key actors – often pursuing radically different agendas – into an integrated whole. There is a need for global leadership – setting out the key priorities and acting on them – but also a need for willingness to act in a more co-ordinated fashion to minimise duplication and cover gaps in the international effort. The solution lies in strong country leadership of coherent poverty reduction strategies, around which the international system can rally and from which various parts of the system can derive their individual roles. We return to this agenda in section 4 of this paper.
3. Experience to date

3.1 Progress made

The 20th century witnessed more rapid progress in global health than in any previous period of human history. In the last half century, life expectancy in developing countries has risen from 40 to 63 years and under-five mortality has fallen from one in four to one in ten. Between 1960 and 1996, the fertility rate fell from 6.0 children per woman to 3.2. Smallpox, which had previously affected ten million people per year, claimed its last victim in 1977. Programmes to eliminate polio, river blindness and guinea worm have chalked up dramatic progress.

Much of this progress is attributable to better income, water, sanitation and education. But health services and science have also made spectacular gains. Scientific advance alone accounts for nearly half the decline in under-five mortality in developing countries between 1960 and 1990.\(^\text{20}\) Immunisation now saves an estimated three million children’s lives annually and the eradication of polio – which previously devastated the lives of hundreds and thousands of children and their families – is within reach. New technologies – from new vaccines and medicines to ‘kangaroo care’ for pre-term babies – continue to offer new hope and possibilities.

At the same time, greater understanding of the links between risk factors and disease offers individuals and communities the opportunity to promote and protect their own health. In the medical field, the gap between scientific knowledge and practice continues to narrow as the prerogative of clinical judgement gradually gives way to ‘evidence-based medicine’. The application of economics, political economy and management sciences brings new perspectives on setting public priorities and reforming health systems.

As new knowledge has come to light in the technical field, so have lessons been learned in managing the process of health development.

3.2 Lessons learned

3.2.1 Sustainable services need better health systems

A major lesson we have learned is that the early achievements of extending delivery of specific interventions (like childhood immunisation) cannot be sustained if they do not become an integral part of national health systems. This requires adequate budgetary allocations, human resources, logistical systems and monitoring and supervision mechanisms. Health systems need to be developed in a way that ensures that services are delivered to the poor people who need them.

However, health systems and health service providers can have a tendency to develop a life and momentum of their own. This reduces their ability to use scarce resources to address the needs of the poor. Experience shows that health systems and health resources tend to be ‘captured’ by the most vocal and most wealthy in society. In addition, scarce resources are often allocated according to historical precedent, rather than on recent assessments of how best to maximise the health of the poor. This tends to favour the large, existing tertiary services, attracting a disproportionately high share of resources away from services which address the major diseases of the poor.

The performance of health systems can be further limited by ingrained vested interests and corruption which limit responsiveness and openness to change.

The obstacles to health systems functioning efficiently and equitably are not insurmountable. There is a growing body of knowledge on interventions which enable policymakers to ensure that health systems address the health of the poor in a transparent, accountable, responsive way.

3.2.2 Health sector reform: from ideology to pragmatism

Over the past decade, many countries have grappled with re-examining health priorities, strengthening health systems, raising additional resources and improving efficiency. This ‘health sector reform’ agenda was strongly influenced by new public management trends in Europe and brought to the fore new approaches to the role of the state, decentralisation and managerial autonomy, contracting and internal market mechanisms.

The impact of such reforms has seldom been empirically evaluated. But early enthusiasm for the health sector reform agenda has been dampened to some extent by concerns about the transferability of health reform models. In particular, we have learned that new roles of government may require more (and different) government

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capacity — not less. More generally, it is increasingly apparent that health sector reforms must be closely tailored to poverty-focused health outcomes and local circumstances, not only because of different historical legacies and capacities, but also because of the political nature of such reforms.

3.2.3 Efficiency, equity, or both?
Pro-poor health systems have to be both efficient and equitable — in other words, it is important that they produce as much improvement in health as possible per $1 spent and that the benefits are distributed amongst the people according to need. As section 2 illustrates, there are many win-win scenarios — where focusing on poor people will target the concentration of ill-health, and those health problems for which there exists particularly cost-effective remedies. By developing such strategies, it is possible to better define what we understand by pro-poor health systems.

3.2.4 Health financing
‘Health financing’ refers to who collects money for health care and how its spending is organised. Health financing arrangements can vary from a national system based on tax to one patient simply paying one private provider for the whole cost of treatment.

Five basic questions should be asked about any financing scheme:

- How much money does it raise – enough to make it worthwhile?
- What kind of service does it encourage to be delivered – one that provides priority interventions for the many or expensive care for the few?
- Does it redistribute resources so that health care is available at least to some extent according to need, rather than ability to pay?
- What happens to the poor? Are they protected from catastrophically large medical bills which might aggravate – or cause – absolute poverty?
- Is it administratively feasible? Does it rely on a more complex administrative system than can reasonably be expected in a particular situation?

All methods of financing have their strengths and weaknesses, though we know that progressive taxation-based systems and social insurance are generally the most equitable and efficient in countries which can provide the necessary infrastructure.

The best method of financing a particular health activity depends on a variety of issues, including local circumstances and culture, the nature of the health activity and the strength of the public system. For example, people in northern and southern Vietnam have very different attitudes to, and uptake of, health insurance. Cost recovery may be more relevant to the operations of district health systems rather than national public health actions.

3.2.5 Supply side or demand side?
Another legacy of health sector reform in practice is the recognition that the reorganisation of the ‘supply side’ does not necessarily feed through to more accessible and effective health care for poor people. There is now more recognition that the health behaviour of individuals, social networks and community initiatives have an immediate and important impact on health risks and prospects, and that quality, participation, transparency and accountability of services are vital. Matching an effective and efficient ‘supply side’ to a pro-active ‘demand side’ is another emerging challenge for health policy in the decade ahead.

3.2.6 Role of non-state actors
Any strategy must take account of the wide array of non-state actors involved in the health sector, including academia, NGOs, civil society and the private sector.

The role of NGOs is rapidly evolving. NGO’s need to define their roles in the new millennium. With the recent increase in support to health as a vital component of development, we are witnessing a resurgent interest from NGOs to tackle the health of the poor. It is doubtful whether northern NGOs continue to have a role in direct service delivery with perhaps the exception of emergency relief. Capacity-building of local NGOs would seem to be a greater priority but such initiatives rarely achieve national coverage of the poor at a reasonable cost. NGOs continue to have an important role in advocacy for action on poverty and health, and locally to develop systems for better governance of health systems, including accountability. The international role of NGOs in advocacy for reproductive health rights remains vital.

The role of the private sector is an aspect of health policy which came to particular prominence during the 1990s. We now know that in many low income countries private spending by the poor exceeds state spending, and that formal, informal and traditional private practitioners often service a significant proportion of demand for curative care. Deliberate expansion of private for profit services can be at odds with equity objectives. In the
absence of public subsidy or social insurance, private health systems typically allocate services inversely to health needs and place a relatively higher financing burden on the poor.

We also recognise that the combination of limited state resources and private choice means that the private sector is not only here to stay but that it can only grow. Far too little attention has been paid to effective means of securing better health outcomes from the private sector, or to obtaining greater complementarity between private and public sectors.

There is now a wealth of experience on what private sector mechanisms may have to offer. Whether it be public-private partnership, franchising, contracting, social marketing or targeted subsidies, governments and ministries of health now need the capacity to harness the potential of the private sector. Other issues surrounding the private sector still require imaginative new work and exploration – how, for example, can large numbers of informal providers be encouraged to improve their quality of care?

The growth of the private sector has important messages for how public facilities, whether a hospital in a major city or a clinic in a remote village in Africa, should be run, staffed and resourced. At present, too few donors and governments have faced up to the way poor people have already made their choice. Empty public hospitals and clinics contrast with profitable but poor quality drug sellers and pharmacists in the slums of Dhaka.

3.2.7 Aid effectiveness

Other lessons are more generic but just as valid to health development. The World Bank’s influential study Assessing Aid documents how critical the domestic environment is for aid (and domestic resources) to contribute to better outcomes. A sound policy environment and effective public institutions are highlighted as the twin parameters of overwhelming influence. Development assistance would be more effective, the report argues, if it were focused on countries with good policy environments in general, and on low income countries with large poor populations in particular.

The other clear lesson coming from the aid effectiveness literature is the recognition that the ‘projectisation’ of aid comes with costs as well as benefits, especially in aid-dependent countries. Sector-wide approaches and approaches such as the Comprehensive Development Framework hold out the promise of reduced transaction costs, reduced duplication and fragmentation of policies and systems and greater focus on the overall effectiveness of the sector. In concert with this, donors recognise that policy only translates into practice if it is locally owned and championed. The result is not just a change in the form which aid takes, but a fundamental shift in the aid relationship – from dispensing aid and managing projects, to facilitation and support in the context of a development partnership.

3.2.8 Effectiveness of the UN system

Other lessons may be less fully shared by the international community. The consequences of a period of poor leadership and performance within a UN agency are plain to see. Many donors withhold their support, and other agencies encroach upon, or usurp, the vulnerable agency’s mandate. If, as this strategy argues, the UN system is a vital part of the international response to the development challenge, then the UN system and member states need to be more ready to engage constructively to improve performance. This process has begun and is reflected in recent positive developments. We are witnessing a resurgent WHO, at least centrally, that has reasserted its intellectual capability and leadership role in health. The most recent World Health Report (2000) is a good example. There are other encouraging signs of reform and co-operation in the UN systems, but there remains a long way to go.

3.3 Emerging policy consensus

The conclusion from this section is that we have learned many lessons about what works and what doesn’t work, and on best practice, in taking forward and implementing a health development agenda. There is emerging international consensus on the main issues:

- how to address the causes and not just the symptoms of ill-health
- how to remove barriers which prevent the poor accessing services
- how to assure standards, accountability and responsiveness to health service users and potential users
- how to strengthen the state as both policy-maker/regulator and as provider of services for poor people
- how to encourage the private sector to deliver appropriate services to poor people.

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Experience to date

We also recognise that our approach must be based upon more effective co-operation, which requires:
- stronger consensus on key objectives, principles and strategies
- better understanding of partners’ needs and priorities
- more honest recognition of the strengths and weakness of different organisations as a basis for dividing up the work in a more sensible way.

This shift reflects recognition that previous approaches have done too little to address poverty and equity concerns. Translating these principles into reality on the ground is the challenge that lies ahead.
4. Meeting the challenge

4.1 Effective national action

The international health movement has reached a unique time. There is now a stronger consensus, both nationally and internationally, that poverty reduction should be at the core of international health policy. There is emerging agreement on which priorities we need to address and there is growing evidence on how best to address them. In addition, the international community recognises that it needs to invest significant resources to improve the health of the poor, and is showing greater preparedness to do so. The challenge is to learn from our lessons and take this opportunity, working at the national and international levels.

4.1.1 Local leadership and poverty reduction strategies

In taking forward this strategy national governments, accountable to their citizens through democratic processes, must be in the lead. Support from external sources must be co-ordinated to fit within the context of nationally owned and implemented planning. External partners need to work with governments to empower, assist and enhance their capacity to lead, while avoiding the donor-driven approaches of the past.

The Poverty Reduction Strategy Papers launched late in 1999 by the World Bank and the International Monetary Fund offer a new way of working that captures much of the best approach to delivering the poverty and health agenda. The intention is that they should be:

- **country driven**: with governments leading a transparent process with broad-based participation by local people in the adoption and monitoring of the resulting strategy;

- **results orientated**: identifying desired outcomes and planning the way towards them;

- **comprehensive**: taking account of the multidimensional nature of poverty;

- **long-term in approach**: recognising the depth and complexity of some of the changes needed;

- **based on partnership**: between governments and other actors in civil society, the private sector and the donor community.

Whilst currently linked to ongoing debt relief, such initiatives which are fully consistent with the ways of working advocated under the Comprehensive Development Framework will be important to deliver the International Development Targets in health. Ministries of health will need to be supported and strengthened in order to engage on these new agendas. The World Health Organisation has provided limited support to capacity-building, but more needs to be done.

4.1.2 Good governance

Good governance is a key policy issue. Health sector investment should be set in a context of overall public service reforms which enable a full range of stakeholders to participate in identifying priority needs and allocating resources and setting and monitoring service delivery standards and targets. This requires support to strengthen governmental planning, management and budgeting systems and for governmental efforts to promote national standards. Monitoring progress against service delivery targets in terms of improved outcomes, and the distribution of those outcomes, is crucial. Mechanisms to ensure transparency and accountability on spending and services are necessary to enable citizens and civil society to determine which services they need and whether governments are using resources effectively to ensure people can enact their economic and social rights.

Governments also need to redefine their role and enable civil society and the private sector to take on a more effective role in service provision. In general the private sector, so often overlooked, needs to be encouraged to provide greater efficiency and quality in privately financed health care. Governments can take a lead through effective legislative and regulatory frameworks, through improving consumer rights and information, and through encouraging quality assurance mechanisms.

“Making government work for poor people”, deals with these issues in detail. The responsibility of governments for the equitable and universal provision of effective basic services is one of seven key capabilities of good governance identified in that paper.

4.1.3 Flawed policy environments

In countries that lack systems for good governance, the challenge is how to address health and poverty in poor policy environments. Yet polio eradication has been successfully tackled in some of the most challenging policy environments that can be found, even in parts of
the world paralysed by conflict. The lesson to draw from such experiences is that disease-focused initiatives can be effective when locally adapted, especially when field-based organisations such as UNICEF, local community groups and NGOs are mobilised. In a globally connected world, solutions have to be found to tackle the spread of HIV, drug resistance and diseases such as malaria and tuberculosis.

Even in countries with overall poor governance there may be effective ministries and committed individuals in some sectors; focused interventions may still have a part to play. Relatively complex interventions such as access to reproductive health care can be put in place, as has been demonstrated over a long period of time in Bangladesh. In these circumstances, the role of civil society in service delivery is important, but only successful if tackled on an ambitious scale. In Bangladesh, in addition to working through NGOs, new parallel state structures were set up, which were funded entirely off budget by donors. Despite recent difficulties in integrating such programmes into the national budget, access to reproductive health care has been sustained.

The sustainability of complex interventions in such environments remains uncertain. More needs to be learnt from experiences with reproductive health and TB, and then applied to malaria and even safe motherhood initiatives.

### 4.1.4 Capacity development

Investment in human capacity and institutional development is needed to ensure that sustainability enables partners to make the best long-term use of external support. An area much neglected in health has been building capacity to manage change and new ways of working. The complexities of regulating the private sector and building new innovative public-private partnerships have shown just how critical such capacity is.

### 4.2 Effective international action

The key to success in delivering the International Development Targets will be linking national commitment and effective policy and delivery mechanisms to the massive potential of an enhanced international effort. International commitment and co-ordination is improving, new initiatives and additional resources are being mobilised. We need a better framework that links national and international efforts.

#### 4.2.1 Leadership

International leadership, with the authority to ask countries to account for the achievement of the international targets, will be critical. We look to WHO to provide intellectual leadership in public health and its normative role for standard setting to address the priority health problems of poor people, including making pregnancy safer; to UNICEF and WHO to lead on child survival; to UNFPA to champion greater access to essential reproductive health commodities and services; and to UNAIDS to galvanise a global response to HIV/AIDS.

We challenge the European Commission to lead by example by making more effective use of its substantial resources so as to work in partnership to make a difference to the health of poor people in developing countries. A new multilateralism of this kind has the potential to yield huge dividends. However, much remains to be done to achieve the quantum leap in collective performance which will translate ambitious, aspirational development targets into concrete improvements in the health and well-being of poor people.

#### 4.2.2 Co-ordination and complementarity

Better aid outcomes will require the continued development of effective forms of international co-operation in the health sector and across sectors. International fora of all kinds – including the EU, G8 and the Development Assistance Committee of the Organisation for Economic Co-operation and Development, and regional fora like the Southern African Development Community, Organisaton of African Unity, Economic Community of West African States, and the south-south networks – have a part to play.

Such approaches need to embrace the international players, including academia, the private sector, and national and international NGOs. Co-ordination and complementarity at all levels will be key.

The development and implementation of the Comprehensive Development Framework, the UN Development Assistance Framework and sector-wide approaches all offer the potential for more joined-up working in the context of locally-owned strategies, and for eliminating wasteful duplication and ineffective donor activity. Importantly, they allow for better priority setting and joined-up working on poverty reduction. Countries with limited administrative capacity should not have to negotiate separate plans with each of a range of donors. But this potential is, as yet, far from fully realised. Intensive and collaborative effort is needed to ensure these new mechanisms deliver major benefits. Partner governments need to commit effort to the policies and capacities that
are needed for effective implementation to give donors the confidence to move away from supporting specific projects and programmes towards more strategic investments.

Progressive elimination of tied aid would further enhance the effectiveness of external assistance. The World Bank has estimated that untying aid increases value for money by about 25% through procurement savings. In addition, the costs of inventory control and maintenance are massively reduced if countries are able to standardise makes and specifications for vehicles, medical equipment and supplies.

4.2.3 International public goods

In an increasingly interconnected world, challenges that would previously have been considered local or national concerns are now recognised as requiring globally co-ordinated responses. These responses (such as polio eradication), and the associated technologies (such as heat stable polio vaccine), are usefully categorised as international public goods. An international public good is a benefit to the world as a whole. In the case of polio the benefits extend far beyond those countries where polio remains endemic.

Public goods in health include: vaccines to protect both the individual and communities; disease eradication programmes such as smallpox and polio and the effective management of major communicable diseases such as TB and HIV. Strategies to prevent drug resistance to common disease, the sharing and transfer of knowledge, the collection and analysis of statistics, the setting of international norms and standards are also examples of public goods in health.

There is no doubt that the developing world has benefited from new knowledge and technology resulting from research. Much of the substantial reduction in mortality and morbidity in the last 25 years can be attributed to such knowledge and technology. What is new is the pace of innovation and change. But many new technologies such as biogenetic engineering and advances in diagnostics have been targeted at ‘western disease’ rather than the needs of developing countries. Some 90% of global health research is targeted at 10% of global diseases that are of greatest concern to developed countries.

New affordable and effective drugs and vaccines are needed for HIV, tuberculosis, malaria and other communicable disease. There are needs not only for entirely new technologies such as a vaccine for HIV, but also new drugs to tackle the increasing spread of antimicrobial resistance. In the last decade a pharmaceutical industry dominated by the private sector has failed to produce such technologies.

A truly new drug or vaccines can cost as much as £300 million to develop. It is obviously legitimate that industry should expect that these costs be recovered. But it is clear that in the face of such high costs, current incentive structures do not favour research to develop and produce these public goods for developing countries.

Developing a new incentive framework will require interventions in several domains. There are no simple solutions. Both ‘push and pull’ mechanisms are required. Push mechanisms refer to investments in research and the testing of new technologies. These can be in the form of public-private partnerships in basic research, public funding or tax incentives. Pull mechanisms refer to global funds with a commitment to purchase new technology once developed. Securing intellectual property rights is part of this framework, but needs to be accompanied by industry commitment to respond to the needs of developing countries.

In the West (particularly the EU and US) extended exclusive marketing rights are offered for rare diseases affecting few people where without such protection drug companies would have no incentive to fund research. This is termed ‘orphan drug’ legislation. Extending orphan drug legislation to diseases that affect developing countries, like TB and malaria, is under active consideration. The purchase of existing products, including vaccines such as hepatitis B, can send important signals on demand for new technology. The Global Alliance for Vaccines Initiative (GAVI) is just such a response.

An increasing recognition of the need for international public goods is resulting in new public-private partnerships with industry, developing countries, donors and charitable foundations. Initiatives include the Medicine for Malaria Venture (MMV), the International AIDS Vaccine Initiative (IAVI) and GAVI.

The rapid increase in size and number of such initiatives is in itself a challenge, not least for developing countries. Further work is required to strengthen the governance and accountability of such initiatives.

Finally, the importance of knowledge generation and research cannot be over-estimated. The contribution of public health research, in its broadest sense, has resulted in a situation where there has been a greater consensus on this issue, the challenge and importantly, how to respond.
Meeting the challenge

4.3 Broad-based social policy and principles

Sustained improvements in health and well-being will require broad-based social sector investments. Education, livelihood opportunities, food security and social integration activities in particular will need to complement health sector policies and programmes at country and global level. Actions in these sectors are treated more fully in the other strategy papers in this series and are therefore discussed only briefly below.

Education: The synergy deriving from the complementary efforts of the health and education sectors can have a significant impact. Educated citizens are more likely to have healthier lifestyles and smaller families, and to demand quality health services. The achievement of the target of universal access to quality primary education by 2015 is vital. Of equal importance will be the efforts to achieve the DAC target of the elimination of gender inequalities in primary and secondary education by 2005. Schooling systems (both formal and informal) provide excellent opportunities to educate individuals on health and population issues; continuing support will be required to efforts for effective complimentary health and education systems.

Human rights: Vulnerability to ill-health and poverty often depends on the extent to which human rights are realised, and human dignity respected. This strategy will be taken forward in a manner which protects, promotes and fulfils human rights. Action is required that upholds the rights of poor people to good quality, affordable, and accessible basic health care. This entails supporting and promoting policy frameworks which set goals for the progressive realisation of people’s rights to adequate basic health services and accountable service providers. This means supporting broad-based participation in the development and delivery of health and related services through the following: public consultation processes for national and regional needs assessment; policy formulation and standard-setting; the development of local-level governance structures that help to strengthen accountability; and the establishment of benchmarks for service quality.

Community action: The poor themselves are key actors in securing better health outcomes. Lifestyle choices and health-related behaviour impinge directly on their health prospects. Social networks, local institutions and community action substitute for, supplement and interact with formal service provision. Empowerment and community participation are, therefore, key components of the strategy for the future. Local action supported by education can play a major role in influencing individual and collective health behaviour. Health policies need to acknowledge and build upon community resources and resourcefulness by empowering individuals and communities, reinforcing social networks, understanding livelihoods, and responding sensitively to needs.

Equity and gender awareness: Social integration of the poorest demands a focus on the social relations, processes and institutions that cause deprivation, including discrimination based on gender, race, class or caste, disability and age. Women also suffer an additional disease burden related to reproductive health. They are also vulnerable to specific abuses with health consequences, notably female genital mutilation.

The 1995 Beijing Conference on Women mapped out in detail an internationally agreed agenda to promote gender equality and the comprehensive rights of women and girls. In line with this, we aim to reduce gender disparities in human development, encourage equal participation in decision-making and leadership roles, and seek greater equality under the law. Support is required for the promotion of gender awareness and greater knowledge of gender differentiated risk factors and behaviours which bear on health and well-being.

We will encourage closer collaboration between health and education providers on gender equality and rights issues, encouraging positive attitudes among youth towards sex roles and gender relations.

Economic well-being. Economic growth is essential for poverty reduction, and the structure and evolution of inequality within society is also important. Growth will be more sustainable, and will move more people out of poverty if it is built around utilising the assets of poor people. Changing the pattern of growth is difficult, but can be achieved by tackling the nexus of political, social and economic inequalities and constraints that prevent poor people from contributing to growth.

Food security & nutrition. Millions of poor people do not have enough food to meet their basic nutritional requirements. Ensuring people’s physical and economic access to food is vital to ensure optimal growth, health and development. This in turn requires a political, economic and trade environment which creates conditions for achieving household food security. Targeted food and employment-based safety nets are particularly important to protect the most vulnerable households in the context of unstable situations and structural adjustment.
**Improving the environment.** Global environmental change impacts on the lives of poor people and directly on their health. With global warming, the reach of vector-borne disease such as malaria and dengue is extending. In some countries, indoor air pollution from cooking with basic fossil fuels is an important risk factor in childhood respiratory disease. Inadequate water quality and, in particular, poor sanitation are major causes of childhood diarrhoea, accounting for a substantial proportion of under-five deaths.
5. Priorities for DFID

5.1 Introduction
This document has set out the enormous challenge of an unfinished agenda if all people are to realise their potential in healthy and productive lives. It has identified the factors that lie behind the strategic choices that DFID needs to make. Section 4 sets out a framework for effective international and national action, within which DFID will work. This section asks what specific actions the UK, in partnership with the international community should be investing in now.

We believe that there are four key responses that, taken together and vigorously pursued at national and international levels would truly impact on the health and wealth of nations and their people. These responses will guide both our work internationally and our country programmes.

- **Response one**: Addressing the priority health problems of poor people; strengthening access to care, services and products.
- **Response two**: Investment in strong, efficient and effective health systems (public, private and informal).
- **Response three**: A more effective global response to HIV/AIDS.
- **Response four**: Supporting the necessary social, political and physical environments that enable poor people to maximise access to better health.

These responses reflect the collective action required by DFID. They are not narrowly limited to action in the health sector or one department (Health and Population Department) alone. They challenge DFID itself to work in different ways. DFID’s strong record of interdisciplinary teamwork will be applied to work across different sectors to achieve the International Development Targets on health. The responses outlined will require focused actions in a number of sectors or domains and offer an opportunity to ratchet up the impact of interventions beyond those of the health sector alone.

**Framework for action**: These responses are set within a framework that requires clear health outcomes for the poor. These outcomes will be met by working with and promoting collaboration between both public and private sectors, and with civil society. They will depend upon effective and efficient health systems. Where public systems are weak we will work through innovative and accountable organisations to increase access by the poor, whilst at the same time building national health system capacity. Secure access to basic health commodities will be vital (drugs, vaccines, diagnostics and reproductive health supplies).

We will support international partnership and collaboration, to mobilise additional resources, to strengthen the framework for action and support efforts to generate the new drugs and vaccines that are required to tackle communicable disease. At the national level, we will work on a country by country basis, supporting national priorities, capacity and leadership within the framework outlined here. We recognise that internally we must do more to ensure that international efforts and national work is better integrated and linked better to meet national priorities.

5.2 Priority areas for action

**Response one: **
Addressing the priority health problems of poor people; strengthening access to care, services and products

*International Development Target: A three-quarters reduction in maternal mortality by 2015*

*International Development Target: Universal access to reproductive health services by 2015*

*International Development Target: A two-thirds reduction in child mortality by 2015*

*A 50% reduction in malaria and TB mortality by 2010*

**a. Making pregnancy safer**
Insufficient attention is being paid to maternal mortality. We will support WHO in its work to raise the international profile of maternal health, and extend our own efforts in this area. Whilst our programmes are limited, together with USAID we are one of the few bilateral organisations that has explored the development of comprehensive maternal health programmes. Maternal mortality and morbidity are sensitive indicators of a functioning health system and such health systems will be
Priorities for DFID

essential if mortality is to be reduced. However, inter-sectoral approaches including education of women, enhancing women’s status in communities, increasing demand and access to care must also be tackled. Work on maternal health will impact directly on child survival, and is the third most important determinant of child survival.

b. Child health
A further two million child deaths could be averted by improving existing coverage and, where appropriate, through the addition of new vaccines to existing EPI programmes. We will encourage international action which supports national governments’ priorities. We will look to the Global Alliance for Vaccines Initiative to advance this agenda. We will also work with WHO and UNICEF to strengthen programmes such as the integrated management of the sick child and appropriate nutritional interventions.

A new agenda will be to increase our work in environmental interventions that are a major determinant of child survival, in particular water and sanitation but also in other areas. We will work across sectors to ensure that such interventions are designed to maximise child survival.

c. Improving reproductive and sexual health
We will work with countries to develop better access for poor people to good quality reproductive and sexual health services, particularly contraceptive choice and the prevention and diagnosis of sexually transmitted infection. We will support initiatives including school-based programmes to help young people obtain the information, services and skills they need to protect their sexual and reproductive health, and avoid unwanted pregnancies. We will also support work to develop more effective, affordable and acceptable methods of contraception and protection from sexually transmitted infection.

d. Communicable disease
This area will form an increasingly important part of our work. We will continue to support global partnerships such as Roll Back Malaria, and evolving partnerships in reducing TB mortality. We will continue our support to the final eradication of polio and explore and support similar efforts in filariasis, onchocerciasis and other areas. However, we will demand from WHO, and other partners, clearer evidence of national impact. Internally, we will work to ensure that our international work is better linked to, supportive of, and supported by our country-level programmes.

We will continue to support innovative partnerships between the public and private sectors for the development of new drugs and vaccines for, in particular, HIV, TB and malaria.

e. Non-communicable disease
The emerging non-communicable disease agenda will be a new area of work. In the first instance, this work will be largely confined to advocacy and scoping studies and research to identify areas for support. Identified priorities include mental ill-health in women and support for the WHO Tobacco-Free Initiative.

Response two:
Investment in strong, efficient and effective health systems (public, private and informal)

Effective, affordable and accessible health systems must be one of the key investments of the 21st century. Such systems will determine whether the poor will have access to the services that will enable them to lead healthy and secure lives. DFID has a strong track record on health system development, its organisation, financing and management. When appropriate DFID support will shift towards longer-term, sector commitments where governments have given priority to the health of the poor within a sustainable medium-term expenditure framework and where, even with improved efficiency, there remains a shortage of resources to enable sustainable health systems to contribute to the International Development Targets.

WHO and the World Bank are the key institutions with whom we work on system issues. Centrally, there are early but encouraging signs of greater capacity and leadership in WHO on this area, but as in so many areas WHO needs to focus and strengthen its role at the country level where it remains particularly weak.

a. Health outcomes
For too long, health sector reform has been dominated by structural issues rather than better health for poor people. We will continue to support the development of health systems at the country level that better meet the health needs of poor people and are strongly focused on the management, delivery and monitoring of health outcomes. Where systems are effective and efficient we will encourage and support governments to give greater priority to funding of the health sector. Where feasible, we will work through sector-wide type approaches and work with ministries of health, finance and others to build local capacity to lead the process.
b. Public-private frameworks
The impact on the poor of high cost, poor quality private health care is devastating. We will pay particular attention to the role of the state in supporting and developing a regulatory environment for public–private collaboration and subsidy, in both the private for-profit and private non-profit sectors. We will support and extend work on innovative mechanisms for increasing access to health by the poor, such as franchising, social marketing and voucher schemes.

c. Quality and accountability
At the same time, we will pay greater attention to poor peoples’ perceptions of quality of health care, their knowledge and their health care seeking behaviour. We will pay particular attention to the access and accountability of health services to poor people. Our work on governance and its importance for access to quality services will develop into a new and important programme of work in this area.

Response three:
A more effective global response to HIV/AIDS

The HIV/AIDS epidemic threatens overall development and in some parts of the world, notably Southern Africa, it is a serious barrier to the achievement of the International Development Targets.

Until recently HIV/AIDS programmes have been largely confined to the health sector, but the nature of the HIV/AIDS challenge is drawing an organisation-wide response from DFID. This is reflected in the forthcoming strategy document outlining DFID’s response to HIV/AIDS, which is guided by a clear focus on what works and what does not.

DFID is committed to intensifying its contribution to the global response to HIV/AIDS. We look to UNAIDS to facilitate better coordination, and to promote national and international leadership. We will support actions in the following areas:

a. Raising the profile
At international, regional and national levels, we will engage effectively with policy-makers and leaders on the urgent need to address HIV/AIDS, to stop going backwards on development. We will work with the EC and other partners to further develop multi-sectoral approaches to HIV. At the same time, we will support advocacy for the poor and those infected with and vulnerable to HIV, keeping these issues at the forefront of the international development agenda.

b. Enabling environments for HIV prevention and control
Through a gender equity and rights-based approach we will encourage governments and civil society to create environments to enable poor people to reduce risk and vulnerability to HIV infections. We will use an inter-sectoral approach to focus on the needs of young people not yet affected by the epidemic, where preventive behaviour has proven effective in reducing HIV incidence. We will also support interventions to reduce stigma and discrimination against people with HIV/AIDS. We will also work on harm reduction with intravenous drug users.

c. Care for people living with HIV/AIDS
Working at the international, regional and national levels, we will support policy, development and implementation of programmes for the care of people living with AIDS. This support will extend to areas of improved access to both preventive and care services, including prevention and treatment of sexually transmitted infections, reduction of parent to child transmission, voluntary and confidential counselling, availability of safe blood, and secure supply of male and female condoms. In terms of care, we will promote linkages among the array of care providers, particularly home-based care linked to health systems. This will include provision of essential drugs for the treatment of opportunistic infections.

d. Improving knowledge and technology
Our strong commitment to the development of effective vaccines, available and affordable to poor people, is evident from our immediate support to the International AIDS Vaccine Initiative. We will continue to support the development of microbicides for preventive use, particularly for women. We will also continue supporting behavioural research to understand how to impact on risk behaviours.

Response four:
Creating social, political and physical environments to improve health

Environmental conditions, in particular safe water and sanitation, are a major determinant of health in general and of child survival in particular. It is believed that a significant proportion of the global burden of diarrhoeal disease could be eliminated through better nutrition, water and sanitation and wider use of oral rehydration therapy.
Other water-related illnesses include trachoma, schistosomiasis, and guinea worm infestation; poor drainage provides mosquito-breeding sites, leading to malaria and dengue fever. Collection of water, mainly by women and young girls, diverts them from other livelihood activities, childcare or school. Clean sanitation facilities provide dignity and safety for women.


The World Summit for Children in 1990, the 1995 Beijing Conference on Women, and the 1996 Habitat II Conference have set out an internationally agreed agenda for universal water supply and sanitation coverage. Together with Agenda 21, these strategies emphasise the need for urgent national and international action to fulfil water and sanitation commitments. DFID is committed to the four guiding (Dublin) principles, agreed internationally, for sustainable progress in the delivery of water supply and sanitation. The principles are: that water is a finite resource; water management should be based on a participatory approach; women play a central role in provision, management and protection; and water should be recognised as an economic good.

The importance of safe physical and social environments to good health is well understood. Yet one billion people lack access to adequate shelter and live in conditions where their physical and social environments are threatened.

DFID will support actions, through an inter-sectoral programme which will:

**a. Promote safe shelter policies and actions**
In some countries, overcrowded, poorly ventilated houses can contribute to respiratory illness and death. Improved housing design can prevent such illnesses. In order to reduce indoor air pollution better stoves with smoke venting, and where appropriate the promotion of cleaner fuels, will be explored. Unprotected fires cause many burn injuries, especially among young children. For the poorest who cannot afford alternatives to wood fires, we will support programmes exploring affordable alternatives.

**b. Increase access to adequate supplies of clean water, and sanitation for all communities, especially the poorest**
This requires higher levels of investment in rural and marginalised urban areas. It also means recovering more of the cost of water and sanitation from those willing and able to pay for services and changing the inequitable distribution of subsidies. This will improve the sustainability of provision and help to target scarce public funds on extending basic levels of service.

**c. Ensure that hygiene promotion is integral to water and sanitation projects**
Hygiene promotion helps people adopt hygiene practices that are safer for the household and the wider community. Hand-washing and the hygienic disposal of excreta both reduce diarrhoeal illnesses. A better understanding of the illnesses caused by unclean water and unsafe faecal disposal contributes to the demand for water and sanitation services. We will particularly look to support school programmes involving children.

**d. Place an emphasis on empowerment and community participation**
This involves public education and developing awareness; partnerships between external actors (public and private), and encouraging ownership. Providing a choice of technologies is more likely to result in a sustainable impact and fundamental to accountability and good governance.

### 5.3 Strategic choices

Framing DFID’s response, as part of the international response to the challenge of the International Development Targets, requires us to make choices not only in those priority areas identified in 5.2 but also in:

- the balance between country-level and international work.
- the country focus of the bilateral programme.

This section addresses these issues.

#### 5.3.1 Greater focus on partnership with other agencies

We recognise that the scale of progress required to meet the International Development Targets can only be achieved through an international effort which is more than the sum of its parts. DFID will seek to achieve the outcomes described in this strategy in partnership with others, looking to build alliances to enhance both our own impact and that of our partners.
We will devote an increasing proportion of our resources and effort towards actions which will benefit global progress towards better health for poor people, including support for:

- international leadership and new forms of international action which promise to galvanise the international response to priority problems;
- new mechanisms to strengthen international collaboration, such as UN reform, sector-wide approaches and Poverty Reduction Strategy paper approaches;
- initiatives from within the UN family and other multilateral organisations to undertake institutional reforms, clarify roles and strategies and improve performance;
- production, synthesis and communication of new knowledge, technologies and products which will benefit the health of the poorest billion;
- the setting and dissemination of international norms, standards and best-practice guides, based on scientific evidence; and
- collection and sharing of international statistics on health and health care (disaggregated by gender and socio-economic status) of adequate quality to inform decision-making and monitor progress towards the International Development Targets.

We will pursue these goals through partnerships at country, regional and global levels, through our engagement in international summits and fora, drawing on DFID’s field experience and network of health professionals. We will work jointly with others on country, regional and global initiatives. We will build on strong working relationships with key institutions through secondments and exchanges, professional dialogue at all levels and joint working in countries. We will continue to play an active role in executive boards and in formal consultations.

To achieve these objectives we will need to achieve greater synergy between our three relationships with multilateral organisations – as collaborators on specific projects and programmes, as professional interlocutors, and as a “shareholder”.

We will need to find new ways of involving DFID’s field-based health professionals in inter-agency dialogue. We will need to apply our human and financial resources strategically by focusing on key international objectives and a limited range of organisations.

We will continue to build on our already strong relationship with key bilateral institutions and with WHO, UNAIDS, the World Bank, EC and UNFPA.

We will look to develop more effective relationships with the European Commission, the regional development banks and the other UN agencies, particularly UNICEF.

We will also look for new partnerships, which have not previously been a strong feature of our work. These will include civil society organisations, both North and South, and the private sector. We will look to identify areas where we can work closely with these constituents of the international community to make the greatest progress towards international goals. Consideration of the comparative advantage of each party will be critical in locating roles. When appropriate we will work with the international business community to take forward this strategy.

However, we will continue to value our bilateral work highly. The nature of this work will change towards more strategic engagement at country level, but it will be even more vital to inform our international engagement and partnerships. Our bilateral programme remains our reality check, the work from which we gain our credibility and our own human resource skills as an organisation. We value no partnership more highly than that with our developing country partners.

**5.3.2 Country focus of the bilateral programme**

The greatest challenges for achieving the International Development Targets lie in the poorest countries – where there is a coincidence of high levels of poverty, poor health status and meagre national resources. It is in this group of countries that the bilateral programme should be primarily focused. This is entirely consistent with DFID’s Public Service Agreement which not only holds DFID accountable for its contribution towards the achievement of the International Development Targets, but also requires a steady increase in the proportion of bilateral resources targeted to poor countries.

Figure 8 shows the current geographical distribution of DFID bilateral expenditure on projects and programmes in the health sector. The chart shows that the majority of medium and large country programmes are clustered in countries with low GNP and high health needs (as measured by under-five mortality rates). Annex 4 shows the top 20 bilateral health programmes by expenditure in 1997/8.
While the resource allocation process in DFID continues to be first by country, then by sector (within the country/regional aid framework), it is important that the overall pattern is consistent with directing our resources where the health needs are greatest and domestic resources most meagre – bearing in mind also the size of population, the policy environment, severity of income and health inequalities, other aid flows and the health impact of investment in other sectors.

This analysis does throw into relief the question of what the nature of our involvement should be in countries like South Africa, Russia, Peru and Brazil. Each has large numbers of poor people with acute health needs, yet external assistance in these cases will make little difference to the absolute quantum of resources available. The reallocation of domestic resources to achieve greater health equity is the principal challenge. If we are to retain health programmes in these countries, there is a strong case for ‘high leverage’ technical assistance rather than large-scale resource transfer. Thus the case for continuing support to middle income countries lies not so much with how much we spend, but rather with how effectively we work to address the particular problems of health and poverty in these countries.

Conversely, in the poorest countries the paucity of domestic resources means that rapid progress towards the International Development Targets can only be achieved if external resources are used to fund health care provision as well as investment. Long-term commitments in the context of agreed sector programmes will be particularly relevant in these cases. Our challenge will be how to manage the necessary year on year increase in resources required to deliver health outcomes for the poorest.

More generally, it will be important to avoid spreading the bilateral effort too thinly. Resources are already highly focused. The top 30 countries account for 90% of the current total bilateral health programme and the top 14 countries for 78%. We should continue at least this degree of focus.22

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22 These figures count total existing commitments and pipeline projects with a ‘health sector’ economic classification, excluding emergencies and regional programmes.
6. How will we know if we are on target?

6.1 Measuring performance

The measurement of progress towards achieving the International Development Targets is crucial. In the years ahead it is vitally important that countries and donors gain a better understanding of what works and what does not, which interventions have the greatest impact, and who is best placed to deliver them.

Measuring performance is a dynamic process leading to change. Through partnership at the global level, it is vital that the international community ensures its systems for measuring performance are both efficient and appropriate. It must also continue to support capacity-building within national governments to enable policy and planning decisions to be based on a full range of relevant information (inputs, outputs and outcomes).

6.2 Agreeing milestones

As a member of the international community, DFID already makes a significant contribution to measurement of progress towards the International Development Targets. We participate in negotiations to define the International Development Targets and their benchmarks, and in the development of process indicators to measure them.

The set of core International Development Target indicators used to measure performance include:

- infant mortality rate,
- under-five mortality rate,
- maternal mortality rate,
- births attended by skilled health personnel,
- contraceptive prevalence rate, and
- HIV prevalence in 15–24 year old pregnant women.

Annex 3 shows the global and regional position for a number of other International Development Targets.

The key challenge at the international level is to continue to review progress against the International Development Targets and to explore with countries how these can be translated into meaningful indicators they can use. Countries themselves need to establish appropriate, realistic and meaningful interim targets and indicators.

DFID alone cannot achieve these targets. Much depends upon the effectiveness of our development partners’ policies and the wider development community. A real challenge for DFID is to help build local capacity to monitor performance, improve policy and in doing so improve both performance and performance measurement systems at the country and global level.

6.3 Strengthening capacity to measure performance

At the country level, the ability to measure progress against the International Development Targets is variable. Whilst information on infant and child mortality is available for most countries, obtaining reliable statistics for contraceptive prevalence, maternal mortality and the prevalence of HIV is more problematic. For the latter two, model-based data can be used as proxy measures.

However, data to monitor these indicators is not the only information that is required at the country level. In order to develop, monitor and improve policies that will ultimately impact on the International Development Targets, policy-makers and those planning government services require other types of information:

- information on inputs – the level of resources assigned to services,
- outputs – the delivery of services, and
- outcomes – which population groups are benefiting from the policies and how these benefits are distributed across society.

This information is available only when and where appropriate information gathering systems exist. Those countries most in need of this data are usually the least able to afford the costly administrative and statistical exercises involved.

The need to monitor progress towards the International Development Targets (which includes input and output level information) has highlighted the gap between the ability to measure, and the demand for, statistical information. In many cases, statistical capacity is not seen as a priority for funding by national governments, although reliable and timely statistics should provide the basis for national evidence-based decision-making, ensuring that available resources are used effectively and efficiently.

DFID is working closely with the World Bank and the United Nations in an effort to raise the priority of capacity-building in this area. We recognise that there is a need for technical assistance in statistics which needs to be addressed both in terms of monitoring progress towards the International Development Targets, and providing a
sounder basis for development planning. We are also taking stock of existing country systems through our bilateral programmes, and hope to raise awareness within governments of the importance of national statistics. We fully appreciate that increased national funding will not happen unless policy-makers and civil society value and use the statistics produced by their statistical and sectoral offices.

6.4 Constraints to measuring effectiveness

Measuring short to medium-term success against broad, long-term targets can be problematic. Work has been initiated to assess the achievability of the International Development Targets globally, but understanding their achievability at the country level is still limited. There is concern that international targets and indicators can distort priorities and that local ownership of these targets is limited (although the targets were originally set at UN Global Conferences with endorsement from the majority of the world). Countries need to consider what performance indicators are relevant to their circumstances to measure progress towards the UN global conference goals.

Country-level capacity to measure success and failure is a significant restraint on the global ability to track progress. Efforts to raise awareness of the importance of national statistics within governments and to build capacity within their departments have begun not least through the PARIS21 Consortium. It is vital that DFID, as part of the international community, encourages the development of locally generated and owned targets, linked (where possible) to the achievement of the International Development Targets.

6.5 Understanding what works well

DFID is committed to assessing its own contribution to progress towards the International Development Targets. The linkages between DFID’s inputs – our spending and activities – and ‘real world’ results in terms of progress towards the targets are complex and difficult to quantify. However, the PSA provides a coherent and logical basis for linking the performance of DFID programmes with the achievement of our overall objectives, and in consequence with the contribution we are making towards reaching the International Development Targets.

In addition to the broad indicators of progress required by the International Development Targets, DFID has developed its own mechanisms for measuring achievements. This allows judgements to be made about performance, and provides the opportunity to reflect on successes and failures at the corporate, departmental, and country level.

The Health and Population Department has supplemented this system through the development of its own evaluation mechanisms. These systematically capture monitoring information, making it possible to identify examples of best practice and develop benchmarks for comparison of performance. The department seeks to take the lead in sharing experiences from the field using ‘snapshots’ and project reviews.

Existing mechanisms include:

- **Routine monitoring procedures** – these capture project-level performance information, including successes, failures and lessons learnt. This information is used to monitor achievement more widely, identifying best practice for future work.

- **Health and Population monitoring procedures** – these capture detailed project-level performance data, providing in-depth analyses of individual outputs.

- **Reviews of country strategies** – these capture country-level performance across sectors, including health.

- **Evaluation Department’s health syntheses work** – this focuses on DFID’s experience across regions.

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23PARIS21 (Partnerships in statistics for development in the 21st century) is a new international process to build statistical capacity as the foundation for effective development policies. The PARIS21 Consortium has representation from both countries and donors with the long-term objectives of (a) developing an evidence-based culture for setting and monitoring policy, and (b) developing well-managed statistical systems, utilising available resources effectively.

24All Departments in the UK Government are required by HM Treasury to prepare Public Service Agreements, against which performance is reported annually. Linked to each PSA is a Service Delivery Agreement (SDA) which sets out operational targets and indicators, again for annual reporting.
DFID’s Centre for Health Information (CHI) brings these different mechanisms for measuring performance together in a meaningful way. It looks to build on previous successes by collating and sharing effectiveness information which is generated beyond the more formal information systems and reporting cycles. CHI offers a unique opportunity for DFID to monitor and improve performance through information sharing, and has paved the way for a DFID-wide portfolio monitoring system, PRISM.

DFID’s Health and Population Department has always emphasised the importance of measuring effectiveness. The recent portfolio overview exercise, and the establishment of the new CHI system demonstrates its continued commitment to monitoring achievement. The health and population group will strive to improve its ability to achieve results through understanding its successes and failures. This will be achieved by establishing productive partnerships at all levels of DFID to utilise existing and new mechanisms for measuring performance and tracking progress.

6.6 Taking the agenda forward

The importance of measuring our performance against targets is widely accepted to be an important part of the international effort to combat illness and disease. DFID has played a significant role in defining the indicators used to do this, and in developing mechanisms for measuring performance.

As an experienced advocate of performance assessment, DFID should continue to work to raise awareness of the importance of statistical capacity in dialogues with partner countries through highlighting the importance of good statistics for policy, management and monitoring. DFID fully supports the PARIS21 initiative for statistical capacity-building. We should also exploit our partnerships within the international community to ensure this remains a priority.

In the coming years, DFID will be expected to demonstrate that it has made a significant contribution to the global effort to meet the International Development Targets and other global conference targets. It is vitally important that during this process we reassess the relevance of the indicators used to measure progress, to ensure that they remain meaningful measures of success.
Annex 1

Target – to reduce child mortality rates by two-thirds by 2015

Under-five mortality rates (deaths per 1,000 live births)

![Graphs showing under-five mortality rates for different regions: East Asia and the Pacific, Eastern Europe and Central Asia, Latin America and the Caribbean, Middle East and North Africa, South Asia, Sub-Saharan Africa, and Total Developing Countries.]

Source: 2000 World Development Indicators CD-ROM, World Bank. Produced by DFID Statistics Department
Annex 2

Under-five mortality, 1996


Maternal mortality ratio, 1990

### Annex 3

**Global and regional indicators of development progress for the international development targets**

<table>
<thead>
<tr>
<th></th>
<th>World total</th>
<th>Developing country total</th>
<th>East Asia &amp; Pacific</th>
<th>Latin America and Caribbean</th>
<th>Middle East &amp; North Africa</th>
<th>South Asia</th>
<th>Sub Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>4,430</td>
<td>3,641</td>
<td>1,398</td>
<td>426</td>
<td>360</td>
<td>174</td>
<td>903</td>
</tr>
<tr>
<td>1990</td>
<td>5,255</td>
<td>4,414</td>
<td>1,641</td>
<td>466</td>
<td>439</td>
<td>238</td>
<td>1,122</td>
</tr>
<tr>
<td>1998</td>
<td>5,897</td>
<td>5,011</td>
<td>1,817</td>
<td>475</td>
<td>502</td>
<td>286</td>
<td>1,305</td>
</tr>
</tbody>
</table>

**Reducing Extreme Poverty**

- **Population covered by at least one survey for poverty data [%]**
  - 1985–98: 88.1, 90.8, 81.7, 88.0, 52.5, 97.9, 72.9
- **Population living on less than $1 a day [millions]**
  - 1987: 1,183.2, 417.5, 1.1, 63.7, 9.3, 474.4, 217.2
  - 1990: 1,276.4, 452.4, 7.1, 73.8, 5.7, 495.1, 242.3
  - 1993: 1,304.3, 431.9, 18.3, 70.8, 5.0, 505.1, 273.3
  - 1996: 1,190.6, 265.1, 23.8, 76.0, 5.0, 531.7, 289.0
  - Estimates for 1998: 1,198.9, 278.3, 24.0, 78.2, 5.5, 522.0, 290.9
- **Population living on less than $1 a day [%]**
  - 1987: 28.3, 26.6, 0.2, 15.3, 4.3, 44.9, 46.6
  - 1990: 29.0, 27.6, 1.6, 16.8, 2.4, 44.0, 47.7
  - 1993: 28.1, 25.2, 4.0, 15.3, 1.9, 42.4, 49.7
  - 1996: 24.5, 14.9, 5.1, 15.6, 1.8, 42.3, 48.5
  - Estimates for 1998: 24.0, 15.3, 5.1, 15.6, 1.9, 40.0, 46.3
- **Poverty Gap [%]**
  - 1987: 8.6, 6.8, 0.1, 5.2, 1.0, 13.0, 20.0
  - 1990: 9.0, 7.6, 1.0, 6.0, 0.5, 12.0, 20.4
  - 1993: 8.9, 7.5, 1.3, 5.8, 0.4, 11.2, 21.7
  - Estimates for 1998: 7.5, 4.0, 1.5, 5.3, 0.4, 10.6, 21.5
- **National income/consumption by poorest 20% [share that accrues to the bottom 20% of the population]**
  - 1980s: 6.3, 9.8, 3.7, 6.6, 7.9, 5.7
  - 1990s: 6.9, 8.8, 4.5, 6.9, 8.8, 5.2

**Prevalence of child malnutrition, weight for age**

<table>
<thead>
<tr>
<th></th>
<th>1992–98</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children under 5 years old</td>
<td>30</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>31</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>22</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>8</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>8</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>15</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>51</td>
</tr>
<tr>
<td>% of children under 5 years old</td>
<td>33</td>
</tr>
</tbody>
</table>
### Universal Primary Education

#### Net primary school enrolment [school age in school as % of all school age children]

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>77</td>
<td>86</td>
<td>81</td>
</tr>
<tr>
<td>1990</td>
<td>72</td>
<td>91</td>
<td>86</td>
</tr>
<tr>
<td>1997</td>
<td>72</td>
<td>86</td>
<td>79</td>
</tr>
</tbody>
</table>

#### Persistence to grade 5 [% of children enrolled at Grade 1 who reach Grade 5]

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990–1995b</td>
<td>77</td>
<td>81</td>
<td>79</td>
</tr>
</tbody>
</table>

#### Youth literacy rate [% of people 15–24]

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>70</td>
<td>83</td>
<td>77</td>
</tr>
<tr>
<td>1990</td>
<td>69</td>
<td>83</td>
<td>77</td>
</tr>
<tr>
<td>1998</td>
<td>67</td>
<td>82</td>
<td>74</td>
</tr>
</tbody>
</table>

#### Adult literacy rate [% of people 15+]

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>54</td>
<td>72</td>
<td>63</td>
</tr>
<tr>
<td>1990</td>
<td>52</td>
<td>71</td>
<td>62</td>
</tr>
<tr>
<td>1998</td>
<td>52</td>
<td>78</td>
<td>65</td>
</tr>
</tbody>
</table>

### Gender Equality

#### Gender equality in school [female gross enrolment ratio as % of male]

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>1994–1998b</td>
<td>94</td>
<td>94</td>
</tr>
</tbody>
</table>

#### Gender equality in adult literacy [female literacy rate as % of male literacy rate]

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>75</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>1990</td>
<td>79</td>
<td>78</td>
<td>79</td>
</tr>
<tr>
<td>1998</td>
<td>83</td>
<td>82</td>
<td>82</td>
</tr>
</tbody>
</table>
### Infant and Child Mortality

<table>
<thead>
<tr>
<th></th>
<th>World total</th>
<th>Developing country total</th>
<th>East Asia &amp; Pacific</th>
<th>Eastern Europe and Central Asia</th>
<th>Latin America and Caribbean</th>
<th>Middle East &amp; North Africa</th>
<th>South Asia</th>
<th>Sub Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[per 1,000 live births]</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>80</td>
<td>87</td>
<td>55</td>
<td>41</td>
<td>61</td>
<td>95</td>
<td>119</td>
<td>115</td>
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<tr>
<td>1990</td>
<td>60</td>
<td>65</td>
<td>40</td>
<td>28</td>
<td>41</td>
<td>60</td>
<td>87</td>
<td>101</td>
</tr>
<tr>
<td>1998</td>
<td>54</td>
<td>59</td>
<td>35</td>
<td>32</td>
<td>31</td>
<td>45</td>
<td>75</td>
<td>92</td>
</tr>
</tbody>
</table>

| Under-5 mortality rate |             |                          |                    |                                 |                            |                           |            |                   |
| [per 1,000 live births]|             |                          |                    |                                 |                            |                           |            |                   |
| 1980                   | 123         | 135                      | 82                 | „                              | 78                         | 136                       | 180        | 188               |
| 1990                   | 87          | 91                       | 55                 | 34                              | 49                         | 71                        | 121        | 155               |
| 1998                   | 75          | 79                       | 43                 | 26                              | 38                         | 55                        | 89         | 151               |

### Maternal Mortality

| Maternal mortality ratio |           |                          |                    |                                 |                            |                           |            |                   |
| [per 100,000 live births]|           |                          |                    |                                 |                            |                           |            |                   |
| 1990                   | 430        | 480                      | 210                | 95                              | 190                        | 320                       | 610        | 980               |

| Births attended by health staff |           |                          |                    |                                 |                            |                           |            |                   |
| [% of total]                  |           |                          |                    |                                 |                            |                           |            |                   |
| 1990                           | „          | 49                       | 58                 | „                              | 58                         | 39                        | „          | „                 |
| 1996-1998                     | 52         | 47                       | „                  | 92                             | 78                         | 62                        | 29         | 38                |

### Reproductive Health

| Contraceptive prevalence |           |                          |                    |                                 |                            |                           |            |                   |
| [% of women 15–49]        |           |                          |                    |                                 |                            |                           |            |                   |
| 1997-1998                 | 49         | 48                       | 52                 | 67                              | 59                         | 55                        | 49         | 21                |

| HIV prevalence 4 |           |                          |                    |                                 |                            |                           |            |                   |
| [Percentage of adults (15–49 years) living with HIV/AIDS in 1999] |   |                           |                    |                                 |                            |                           |            |                   |
| 1999                     | 1.1       | „                        | 0.07               | 0.14                           | „                          | 0.13                      | „          | 8.0               |

### Environment

| National strategies for sustainable development |           |                          |                    |                                 |                            |                           |            |                   |
| [countries with effective processes for sustainable development] |   |                           |                    |                                 |                            |                           |            |                   |
| 1998                           | „          | „                        | „                  | „                              | „                          | „                         | „          | „                 |

| Safe water [% of population with access] |           |                          |                    |                                 |                            |                           |            |                   |
| Urban 1990-98 | 90 | 89           | 95                 | „                              | 88                         | 97                        | 86         | 77                |
| Rural 1990-98 | 62 | 62           | 58                 | „                              | 42                         | 72                        | 78         | 39                |
| Total 1990-98 | 72 | 72           | 69                 | „                              | 78                         | 85                        | 80         | 50                |

| Forest Area [% of National Surface Area] |           |                          |                    |                                 |                            |                           |            |                   |
| 1995 | 25 | 26           | 24                 | 36                             | 45                         | 1                         | 16         | 17                |

| Biodiversity: land area protected [% of total land area] |   |                           |                    |                                 |                            |                           |            |                   |
| 1994 | 6.7 | 5.1          | 6.2                | 3.6                            | 6.5                        | 3.0                        | 4.4         | 5.8               |
| 1996 | 6.6 | 5.3          | 6.9                | 3.2                            | 7.3                        | 2.2                        | 4.5         | 6.2               |

| Energy efficiency: GDP per unit of energy use |   |                           |                    |                                 |                            |                           |            |                   |
| 1997 | „ | „            | „                  | 0.7                            | „                          | 1.5                        | „          | „                 |

| Industrial Carbon Dioxide emissions [tonnes per capita] |   |                           |                    |                                 |                            |                           |            |                   |
| 1980 | 3.4 | 1.5          | 1.4                | „                              | 2.4                        | 3.0                        | 0.4         | 0.9               |
| 1990 | 3.3 | 1.7          | 2.0                | „                              | 2.2                        | 3.3                        | 0.7         | 0.9               |
| 1996 | 4.0 | 2.5          | 2.7                | 7.4                            | 2.5                        | 3.9                        | 0.9         | 0.8               |
|----------------------------------|------|------|------|
| **General Indicators**           |      |      |      |
| **Life Expectancy at Birth**     |      |      |      |
| [in years]                       |      |      |      |
| **Female**                       | 64   | 68   | 69   |
| **1990**                         | 68   | 71   | 73   |
| **1998**                         | 69   | 74   | 73   |
| **Male**                         | 59   | 63   | 65   |
| **1990**                         | 63   | 66   | 65   |
| **1998**                         | 65   | 67   | 67   |
| **Total**                        | 61   | 68   | 70   |
| **Fertility Rate**               |      |      |      |
| [births per woman]               |      |      |      |
| **1980**                         | 3.7  | 3.1  | 2.7  |
| **1990**                         | 4.1  | 3.4  | 2.9  |
| **1998**                         | 4.1  | 2.4  | 2.1  |
| **GNP per capita**               |      |      |      |
| [Atlas method (current US$)]     |      |      |      |
| **1980**                         | 2,530| 790  | 330  |
| **1990**                         | 4,030| 940  | 570  |
| **1998**                         | 4,890| 1,250| 990  |

- Combined figure for low and middle income countries used as a proxy for developing countries with the exception of the indicators for persistence to Grade 5, maternal mortality ratio and safe water where a true developing countries figure is used.
- Data refer to the most recent year available within the specified period.
- At 1993 purchasing power parities (PPPs) adjusted to current price terms.
- The poverty gap is the mean shortfall below the poverty line (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line. The measure reflects the depth of poverty as well as its incidence.
- Data are for nearest available year.
- Figures are based on net enrolment ratios.
- The indicator actually relates to HIV prevalence in 15 to 24 year old pregnant women. However, until satisfactory data coverage is achieved on this indicator, the prevalence of HIV infection in all adults will be used.
- Data may refer to earlier years.
- Not available.

World Bank & UN Sources
DFID Statistics Department
### Top 20 bilateral health and population programmes by expenditure in 1998/9

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Health and population expenditure £ million</th>
<th>% of Total health and population expenditure</th>
<th>Under-5 mortality rate per 1,000 live births</th>
<th>GNP per capita (current US$)</th>
<th>Population 1998</th>
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Source: 2000 World Development Indicators and DFID Statistics Database
Prepared by Statistics Department July 2000
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