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DFID Department for International Development

plans

International Development Target Strategy Paper

Better Health for Poor People

November 1999

consultation document

This consultation paper is the first of the Target Strategy Papers (TSPs) to go out to public consultation. We intend to publish this paper in the first quarter of 2000. Therefore we would be grateful for your comments by 21 January 2000. These should be sent to:

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This paper can be also found on the DFID internet website (www.dfid.gov.uk) under 'What We Do' followed by 'Strategy Papers'. The consultation versions of other draft Target Strategy Papers (economic well-being, education, gender, human rights, governance, water and sanitation and the environment) are due to be published on the same page in the next 2-3 months when they are ready.

November 1999

Department for International Development

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, Nairobi, Harare, Pretoria, Dhaka, Kathmandu, Suva and Bridgetown. In other parts of the world, DFID works through staff based in British embassies and high commissions.

Department for International Development

November 1999

INTERNATIONAL DEVELOPMENT STRATEGY
BETTER HEALTH FOR POOR PEOPLE: TARGET STRATEGY PAPER (CONSULTATION DOCUMENT)

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INTERNATIONAL DEVELOPMENT STRATEGY
BETTER HEALTH FOR POOR PEOPLE: TARGET STRATEGY PAPER (CONSULTATION DOCUMENT)

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AIDS	Acquired Immune Deficiency Syndrome
CDF	Comprehensive Development Framework
CEE	Central and Eastern Europe
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
DALY	Disability Adjusted Life Year
DFID	Department for International Development
GNP	Gross National Product
HIV	Human Immune-deficiency Virus
ICPD	International Conference on Population and Development (Cairo)
ICPD+5	Five-year follow up to Cairo Conference
IDG	International Development Goal
IDT	International Development Target
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
MDB	Multilateral Development Bank
MMR	Maternal Mortality Rate
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
OPA	Output and Performance Analysis
OPR	Output to Purpose Review
PSA	Public Service Agreement
SIDA	Swedish International Development Agency
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAP	Sector-wide Approach
TB	Tuberculosis
U5MR	Under-Five Mortality Rate
UK	United Kingdom
UNAIDS	United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation
WTO	World Trade Organisation

This paper is one of a set designed to spell out the action needed to achieve the agreed targets for international development that 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.

Over the past ten years or so, there has been a series of great international summits held by the United Nations and its specialised agencies, at which the entire UN membership has discussed the need for greater progress in poverty reduction and sustainable development. These summits have set numerous targets for measuring that progress. These have been accepted by the full UN membership.

In the past, targets have often been set and then disregarded. Some were over-ambitious. Some did not command the full support needed to achieve them. This time however the international community is giving them greater weight. In 1996 the countries of the Organisation for Economic Co-operation and Development (OECD), which includes all the main Western donor countries, committed themselves to a partnership with developing and transition countries, the success of which would be measured against key targets from the UN Summits. In 1997, the new UK Government made them the centrepiece of its White Paper on International Development. The purpose of the present paper and of the others in the set is to assess the challenge presented by each of these key targets, to lay out the international strategy required for achieving it, and to set out what the British Government will do to contribute towards this international effort.

In each case, as the White Paper recognised, neither the UK, nor any other individual donor country, can achieve the targets alone. The targets are difficult, some particularly so. But if we can work together and therefore increase the effectiveness of the international community to achieve real progress, our assessment is that these targets are achievable for developing and transition countries as a group by, or in some cases soon after, the relevant date, even though they may not be achieved in each country individually. It is clear that each developing country must lead the effort - otherwise the targets can not be achieved. The international community must provide support for the governments committed to the reform necessary to achieve the poverty eradication target. If national governments lack this commitment then civil society must press them to take action as without a local lead progress cannot be achieved. In all cases countries should be able to achieve very considerable progress towards the targets by the target date.

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 in an intelligent way. They cannot capture the full richness and complexity of the process of individual and collective transformation that makes for sustainable development. Individual countries can and should select and debate in the normal democratic process their own measures of achievement. But regular public assessment of how developing and transition countries as a group and region by region are performing against a simple and intelligible standard is essential in order to move to output rather than input driven development assistance. It will highlight areas of comparative success and failure, provide a form of accountability to people everywhere for the effort being put into development, and give energy to the process of broadening to everyone basic life opportunities that should be available to all.

Targets also need to be grounded in reality. Much work is needed to improve the collection of reliable and comparable data, and to strengthen local statistical capacity. We should not underestimate the value of good statistics. The political debate in Britain was strongly affected by the surveys carried out in the 19th and early 20th centuries which documented 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, and better quality and more accessible information on standards of living is likely to be one essential element in achieving that will.

These papers do not seek to set out the detailed activities which we will undertake in the pursuit of the various targets. These will follow as we discuss, country by country and institution by institution, how we should work with our partners in poor countries and in the international community. Much work is already in place to this end, and we will continue to consult on and to publish our proposals in detail, in the form of Country and Institutional Strategy Papers. Our bilateral programmes have been extensively reshaped in the light of the White Paper. We and our partners have worked to realign the work of international agencies in the same direction, as was done for example in the mandate for the latest replenishment of the largest collective donor programme, the soft loan arm of the World Bank. It is equally important that we achieve a better international environment for pro-poor economic growth, for example in the next World Trade Round.

The papers do however set out an overall approach and a strategy for our own involvement which is designed to be clear, focused and realistic. Each reflects a process of consultation with a wide range of stakeholders in the United Kingdom and overseas. I hope that you will find this paper and its companions a valuable statement of how the UK, will seek to use its influence to make a reality of the targets to which we and the rest of the United Nations membership is committed. We stand ready to be judged against our delivery of this strategy. The whole development community - people, civil society organisations, governments, international agencies - can and should be judged against our collective delivery of the targets themselves.

1. This paper is about the international development target (IDT) of reducing by one half the proportion of people living in extreme poverty by 2015. It focuses on the health dimension of poverty reduction and sets out a strategy for achieving 'Better health for poor people'. It is complementary to the other papers in this series that focus on the full range of international development targets.

2. The IDT's for health are to:

- **reduce by two-thirds the rate of infant and child mortality by the year 2015**
- **reduce by three-quarters the rate of maternal mortality by 2015**
- **attain universal access to reproductive health services before 2015**
- **achieve a 25% reduction in HIV infection rates among 15-24 year-olds in worse affected countries by 2005, and globally by 2010.**

3. The health dimension of the required collective response is further defined by the 1992 Rio de Janeiro UN Conference on the Environment and Development and safer social environments reflected in the World Summit for Social Development, Copenhagen 1995.

4. The international development targets provide a powerful framework and an opportunity to guide our response to the overall target of lifting the poorest billion people from poverty. However they are not end points in themselves, and if taken in isolation do not fully address the priority needs of the poor.

5. Achieving these targets will require effort on an unprecedented scale. Though ambitious, with political will and appropriate resources, significant progress can be made. This strategy describes:

- **our analysis of the challenge which the international development targets represent**
- **our view of the international response required, drawing on lessons learned**
- **the actions on which DFID should focus within this global agenda to make the greatest difference.**

6. The strategy for achieving these targets is underpinned by three considerations:

- firstly, a requirement to address the fundamentals for successful development by ***creating conducive social, political and physical environments that enable poor people.***
- secondly, a requirement to define and then address ***the priority problems of the poorest billion, through strengthening access to care, services and products.***
- and lastly, a requirement to ***support investment in strong, efficient and effective health systems (public, private and informal).***

7. However there remains one new and overarching challenge to development. HIV/AIDS. The pandemic of HIV/AIDS challenges the goals of development in all domains. Already in some parts of the world, notably Southern Africa, there is no single greater threat to the achievement of the international development goals. Until recently the response has been largely confined to the health sector. DFID recognises that this is no longer appropriate. It is clear that the nature of the challenge, more than in any other single area, requires a department wide response from DFID. As a result, in this paper, HIV/AIDS is subject to a separate analysis and inter-sectoral response that will be required from the international community, the national and local levels and DFID itself.

8. Section one analyses the validity of the International Development Targets and the relationship between poverty and health. In particular it explores the importance of increasing inequity and the distributional aspects of poor health. For example, in no other domain than maternal mortality is inequity at its greatest. The risk of a poor woman in a poor country dying in pregnancy remains up to 500 times greater than for a rich woman in a rich country.

9. Section two examines the challenge posed by the disease burden of the poor, the broader determinants of health and its links to other sectors, health priorities of the poor and the international environment in which health and development exists.

10. Sections three and four draw on the significant progress that has been made in health to date, the lessons that have been learnt, and the emerging international and national consensus on better ways of working together.

11. Finally but most importantly, in section five, this paper challenges DFID to work in new ways and to address new priorities and in section six how we will ensure capacity to determine if we are on target.

12. Maternal mortality itself, in the context of reproductive health and perinatal survival, is highlighted as an area where least progress has been made, and massive new efforts are required. Existing and emerging disease priorities for the poor are highlighted. HIV/AIDS is now the fundamental challenge to development in many parts of the world. Child health and that of young people remains an unfinished agenda. The importance of effective pro-poor health sectors and systems, as part of the problem and also part of the solution for the health of poor people, remains central to our thinking.

13. DFID remains but one of many actors in the international community. To achieve the IDTs will require the international community 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 and exciting ways. New partnerships and methods of collaboration, led by national governments and civil society, 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. The opportunity is there to be seized.

14. Framing our response by the IDTs will require DFID and others to ensure that all sectors focus on, and play their full part in, meeting the overall goal of poverty reduction. The potential of non-health sector interventions to "synergise" with and ratchet up the impact of specific health sector interventions, is the only way that significant progress will be made in achieving the International Development Targets. In perhaps no other area is this more important than in HIV/AIDS.

INTERNATIONAL DEVELOPMENT TARGETS FOR HEALTH

1. Reduce by two-thirds the rate of infant and child mortality by the year 2015
2. Reduce by three-quarters the rate of maternal mortality by 2015
3. Attain universal access to reproductive health services before 2015
4. Achieve a 25% reduction in HIV infection rates among 15-24 year-olds in the worst affected countries by 2005, and globally by 2010

1.1 International Development Targets and the White Paper

Health has long been recognised as a fundamental human right. Yet every year the world is witness to over 11 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 reminder 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.

In 1997 the UK's White Paper on International Development was published. In it, the elimination of poverty is identified as the overarching goal of DFID. The other international development targets, including those on health, are explicitly affirmed as organisational objectives.

1.2 Health and Poverty

The right to health, enshrined in the Universal Declaration and further reinforced by the declaration at Alma Ata and subsequent international summits, declares freedom from avoidable ill-health and premature mortality as an intrinsic part of human well-being and a central development goal in its own right.

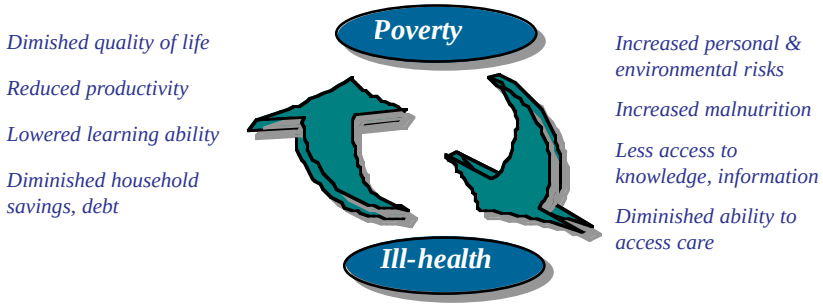
There is clear moral case for investing in health - especially where the burden of ill-health is greatest.

Huge disparities in health between the rich and poor world, and between rich and poor within developing countries, demonstrate clearly that ill-health is a product of poverty. Across and within countries, differences in income typically account for around 70% of variance in infant mortality. The poor are most vulnerable to ill-health, and have the least means to combat it.

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.

Fig. 1 *Poverty & ill-health: the vicious cycle*



The complex inter-relationship between poverty and ill-health is illustrated in figure 1. Improving health would transform this from a vicious to a virtual cycle whereby better health reduces poverty, and reduced poverty improves health.

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 containment of antibiotic-resistant disease world-wide.

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 health international development targets 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.

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 years of healthy life lost (DALYs[1]).

Infant mortality rates (IMR) and under-five mortality rates (U5MR) are also very sensitive to poverty. The poorest 20% of the global population have a ten-fold higher risk of death in childhood than the richest 20%, compared to a two to four-fold 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.

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 one in 12, compared to one in 4,000 in Europe[2]. Like child health, the maternal mortality measure is thus highly sensitive to the poverty divide between rich and poor within and between nations[3]. 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. 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.

[1] DALY: Disability-adjusted life year, a measure which combines the number of years of life lost through premature mortality and the quality of life in terms of degree of disablity.
[2] Revised estimates of maternal mortality for 1990, UNICEF/WHO 1999.
[3] Of 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.

1.3.3 Reproductive Health

The reproductive health target embraces all reproductive health services: safe motherhood, prevention and treatment of 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.

1.3.4 HIV

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 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.

1.3.5 Focus on Poverty

In contrast to some of the international development targets[4], the health targets for health do not explicitly take account of who benefits - rich or poor. While this may be a failing, it is clear that the targets need to be seen as part of the over-arching goal of poverty reduction. We are therefore 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 20% to the exclusion of all others. But it does mean that we have a duty to ensure that investment in the health sector will promote 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.

1.3.6 Collective Commitment

The targets are important not only as indicators of progress but because they represent a collective commitment by the international community to work towards global progress. This presents us, for the first time in the history of international development, with a common platform for more effective international co-operation to secure shared objectives.

DFID will assess its own performance on the basis of its contribution towards these goals - and will be held to account by Government through the Output and Performance Analysis (OPA) and the Public Service Agreement.

[4] e.g. share of national income accruing to the poorest 20%

1.4 Are the International Development Targets for Health Achievable?

As figure 2 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.

The maternal mortality target is much more difficult. Only Malaysia and Singapore have achieved the rate of progress required for a three quarter reduction over 25 years. While measures to prevent maternal deaths are cost effective, they will require investments in obstetric services that are well beyond the present 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 offer 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 Thailand and Uganda. 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.

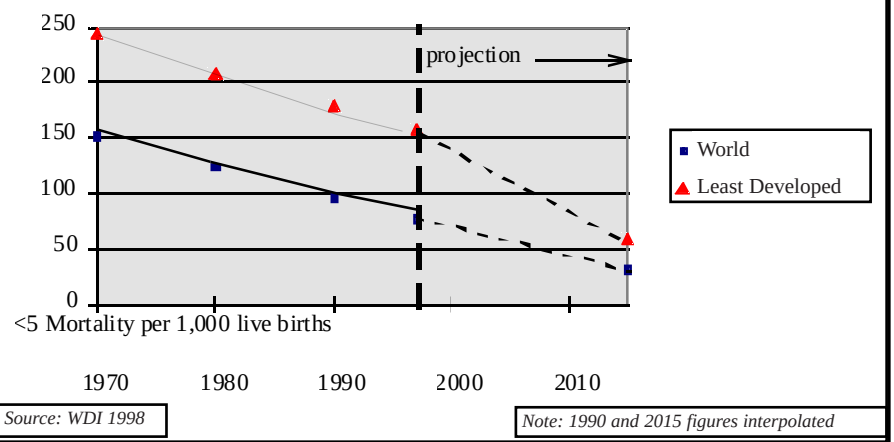
1.5 The Cost of Achieving the International Development Targets

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.

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, sanitation or vector control. And 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.

Fig. 2 **The path to 2015: under-five mortality**



Source: WDI 1998

Note: 1990 and 2015 figures interpolated

ESTIMATED COST OF A MINIMUM ESSENTIAL PACKAGE OF HEALTH SERVICES IN A LOW INCOME COUNTRY (WORLD BANK, 1993)

Package Elements	Cost/person/year (US$, 1990)
Public Health Package	$4.2
EPI plus	
School health including deworming	
Micronutrient supplementation	
Health education	
Information on health, nutrition, FP	
Tobacco and alcohol control programmes	
Disease monitoring & surveillence	
Vector control	
AIDS prevention	
Minimum essential clinical services	$7.8
Short-course TB treatment	
Management of the sick child	
Prenatal and delivery care	
Family Planning	
STD treatment	
Limited care for other ailments	
TOTAL	$12.0

UNFPA has estimated the resources required to meet the reproductive health targets.[5] 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.[6]

1.6 Financing Sources

Yet, whilst the financing requirements increase, the actual funds available have been in stagnation. Modest increases in domestic financing for health have been recorded in many developing countries over the past ten years, though this has been offset by population growth. In many African countries, this represents a "catch up" after more than a decade of decline and spending in real terms is barely above that of the 1970s. A subset of developing countries have witnessed continued decline in public spending on health. The decline in some transition countries has been most precipitous.

Current trends in aid flows provide no grounds for optimism. Total flows of international development assistance (ODA) grew rapidly during the 1980s, peaked in the late 1980s and have since declined to just over $50 billion in 1996 and 1997. If total aid flows were restored to their 1991 level, there would be 50% more funding for international health work, or an extra $2bn per annum. Bilateral support continues to dominate, although funds are increasingly being channelled through multilaterals. Donors spending on health and population has increased as a share of the total, off-setting the overall decline. In 1996 bilateral assistance for health and population amounted to $3.9 billion - or 7% of total bilateral ODA. A further $3.7 billion was devoted to water and sanitation.

[5] UNFPA Global Population Assistance Report 1996. Note: this estimate does not fully reflect the costs of safe motherhood interventions.
[6] "Paying their fair share? Donor countries and international population assistance." Conli S. R & de Silva S., Population Action International, 1998.

While aid plays a relatively small role in terms of overall health financing in developing countries as a group, it is a significant source of finance in the low income country group and indispensable to the poorest countries. Aid accounts for 70% of the health budget in Mozambique; 33% of recurrent expenditure and 90% of development expenditure in Uganda. In the medium term, countries such as these will continue to require external assistance to finance essential health services and other health-related investments.

Nor can we anticipate a sudden improvement in domestic health financing prospects. The experience of the 1980s and 1990s has illustrated that user charges or insurance are not the panacea that some envisaged. Experience also shows how difficult it is in practice to achieve a radical reallocation of resources within the sector.

The implications of this brief analysis are three-fold. 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. Urgent work is needed to refine likely estimates of cost.

Second, more attention has been paid in the past to reallocation of domestic resources than reallocation of aid. Shifting the balance of aid flows towards those countries in greatest need (both in health and resource terms) would significantly improve the prospects for meeting the targets in those countries. 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. There are, of course, many poor people in middle income countries. Support for these countries may more appropriately take the form of a broader development co-operation, particularly for institution building, sharing skills, experience and knowledge.

Third, if we are to avoid the mistakes of the 1970s, the approach to setting national targets and resource requirements needs to be pragmatic. Health planning which is not founded on a realistic appraisal of resources available will exacerbate sustainability problems and drive service quality and efficiency down.

2.1 Disease 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. 120 million couples still have no access to family planning. And the last decade has seen the arrival of the challenge of the HIV/AIDS, which in 1998 is estimated to have infected 16,000 people *every day.*

So despite dramatic health gains in the last fifty 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 1.3 billion people who live on less than $1 per day, it remains most elusive.

2.1.2 Broader determinants of health and the links to other sectors

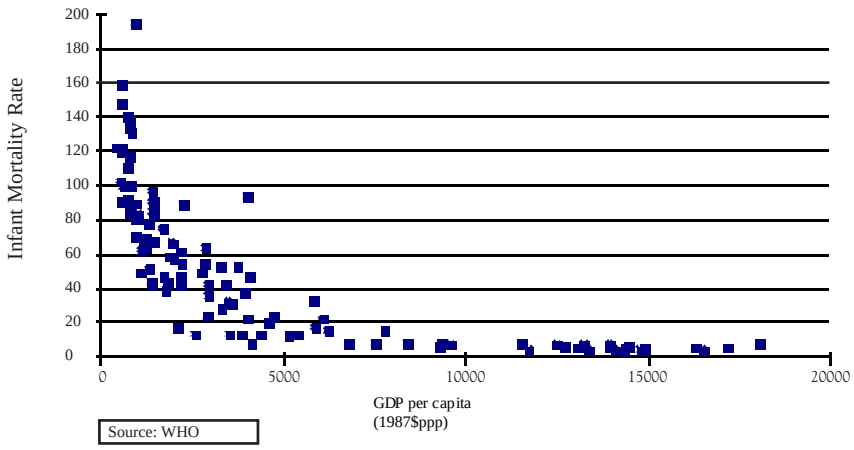
Health services play an important role in promoting and protecting health. But, in the long term, economic security, education, nutrition, water, sanitation and the broader physical and social environment are the arbiters of population health prospects. These factors tend to move together, but their 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 and Sri Lanka and Kerala state in India, for example, have been able to significantly improve health status whilst other countries of similar or higher income status have failed to achieve such gains. Halstead et al (1985) attribute this 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.[7]

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

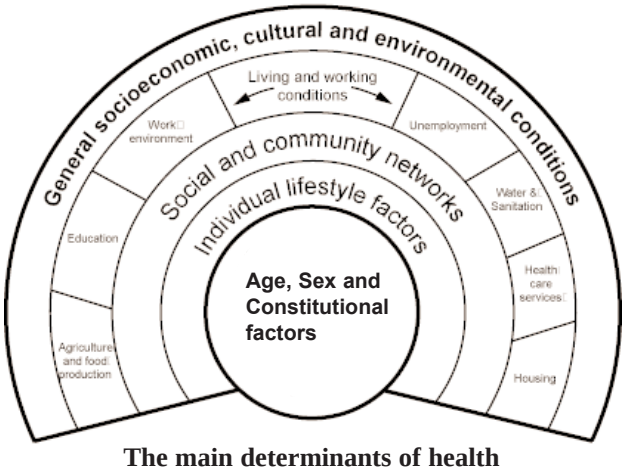
Fig. 3.

Infant mortality and income, 1990



[7] In the case of Sri Lanka, rapid progress in malaria control was particularly important

Fig. 4.



The main determinants of health

Source Dahlgren G and Whitehead M (1991)

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 leads 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 have been shown to bring about 50% - 80% reductions in child diarrhoeal mortality. Yet in Cambodia, for example, only 13% of the population have access to safe water.

The nutrition of women affects child health outcomes. Babies born underweight are at increased risk of dying in infancy (and may be more prone to non-communicable disease as adults). Under-nutrition compromises immune function and contributes to half of all child deaths. Micronutrient deficiencies impair children's cognitive development and can cause mental retardation and blindness. In South Asia, 33% of babies are underweight at birth and up to half of all young children are malnourished.

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 macro economic 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 enable development.

Steps also have to be taken to enable individuals to protect their health and access services. Communities and families have a huge influence on the health and welfare of their members - particularly the most vulnerable. Social security founded on mutual care and obligation is the only safety net available in many poor societies. And the demands and expectations of communities are a powerful force for change in promoting health and accessing services. Gender relations have far reaching effects on the health of girls and women, and their ability to exercise freely choices affecting their health.

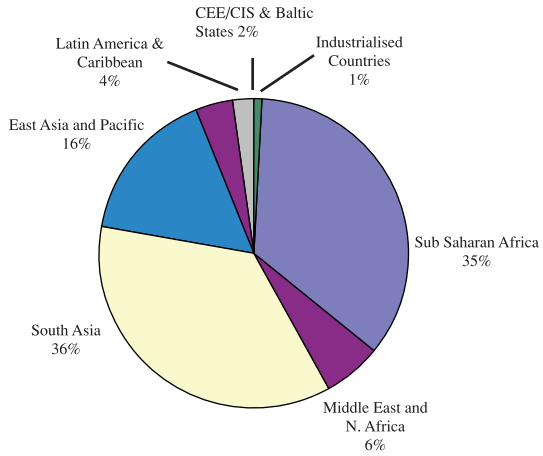
Achieving the targets and ensuring sustainable progress on health will therefore require a multi-sectoral approach, with concerted action on key fronts like education, nutrition, water, sanitation, economic security and the physical and social environment. Such an approach must be both properly funded and concerned 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 to safeguard 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 good 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 as likely to die than the richest 20%.[8] 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.[9]

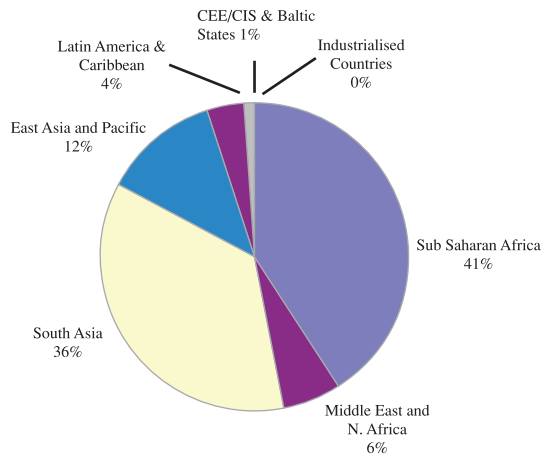
The regional picture is illustrated in figures 5 and 6. Despite its smaller population, sub-Saharan Africa contributes a similar number of under-five and maternal deaths to the much larger South Asian region. Industrialised countries, in contrast, account for less than 1% of the annual toll of maternal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

Fig 5 Number of under-five deaths per annum by region 1996



TOTAL UNDER-FIVE DEATHS: 11.7 MILLION P.A.

Fig 6 Number of maternal deaths per annum by region 1996



[8] Gwatkin (1996) Poverty and inequalities in health within developing countries. A paper presented at the 9th Annual Public Health Forum at LSHTM, April 1999. (Table 6)
[9] UNICEF (1998) State of the World's Children (Tables 1, 5,7)

These aggregate statistics conceal sharp contrasts within regions. The East Asia and Pacific Region statistics, for example, are heavily weighted by the relatively good performance of China (under-five mortality rate of 47 per 1,000). But in the same region, Cambodia and Laos have under-five mortality rates of 170 and 128 per 1,000 respectively. Annexes 1 and 2 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.[10] 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 agriculture as compared to professional or technical.[11]

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[12]. And within all countries the health of the poor tends to be considerably worse than that of the relatively rich[13].

2.1.4 The Gender Divide

There is simultaneously a significant gender divide which we are committed to address. Our goal of achieving equity between men and women is based on fundamental principles of human rights and social justice.

It is also a matter of practicality. Almost 70% of the 1.3 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[14] clearly demonstrates that women experience more illness and are less likely to receive medical treatment before the illness is well-advanced. Because 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), 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. For example, the nutrition of women affects child health outcomes. Babies born underweight are at increased risk of dying in infancy and may be more prone to non-communicable disease as adults. Under-nutrition compromises immune function and contributes to half of all child deaths. Micronutrient deficiencies impair children's cognitive development and can cause mental retardation and blindness. In South Asia, 33% of babies are underweight at birth and up to half of all young children are malnourished.

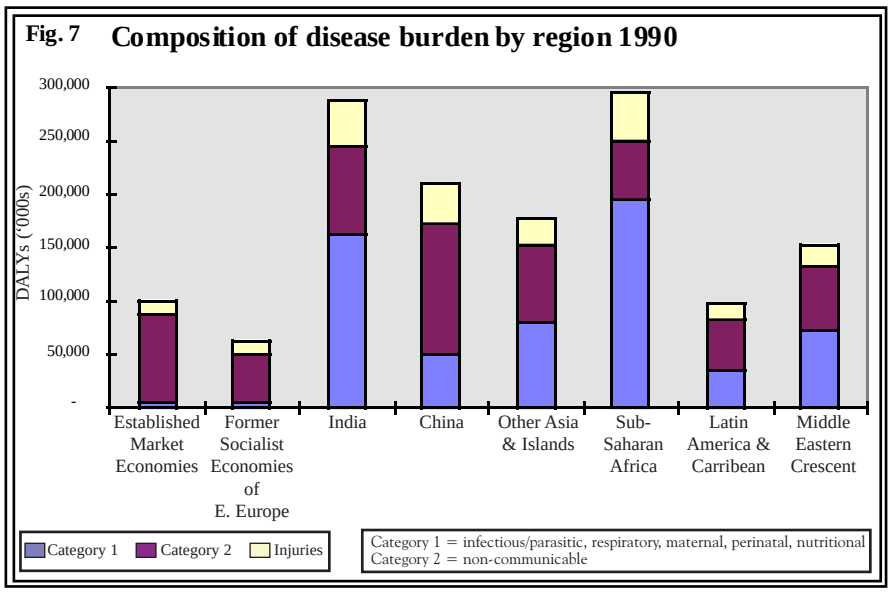
Gender relations have a far-reaching effect on the health of girls and women, and on their ability freely to exercise choices affecting their own health. There is now a growing consensus that improving the health and overall status of women will provide substantial benefits in terms of human welfare,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

2.1.5 Health Priorities

The pattern of disease varies significantly between geographical regions. In countries and regions where the demographic and epidemiological transition is already advanced, non-communicable disease (particularly cardiovascular disease, mental illness and cancers) and injuries account for the majority of the disease burden.

In poorer countries, and among poorer populations within poor 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.

[10] Gwatkin (1996) op. cit. (Table 1)
[11] Gwatkin (1996) op. cit. (Tables 2,3)
[12] e.g. Haiti in the Caribbean region, Yemen in the Middle East Region, Laos and Cambodia in the South East Asia Region.
[13] This is also true of UK, as documented in the Black Report of 1979 and the Acheson Report in 1999
[14] Development in Practice: Improving Women's Health in India, 1995, World Bank



Source: Murray & Lopez (1996), Global Burden of Disease (table 9)

There are, of course, many countries undergoing the epidemiological transition and which suffer a "double burden of disease": communicable disease is still a significant problem, yet non-communicable disease 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, communicable diseases were responsible for 59% of deaths and 64% of DALYs[15] lost. Among the richest 20% of the globe, the figures are 8% and 11% respectively.[16]

An alternative perspective is to ask what diseases account for the health gap between rich and poor. Here the message is even clearer. Communicable diseases are responsible for 79% of the rich-poor health divide (measured in DALYs).

HIV/AIDS is the major new challenge, threatening past success in reducing mortality rates. Beyond that, deaths of children under five are still predominantly caused by preventable and easily treated diseases such as acute respiratory infections, diarrhoea, measles and malaria. Malaria and TB, and the close relationship of the latter with 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 disproportionate political 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.

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. 99% 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 better child health and lower lifetime risk of pregnancy-related death and disability. Large family size (especially when children are young) is closely associated with poverty[17]. And there is strong macro-economic evidence for the 'demographic gift' as lower dependency ratios feed through to higher per capita income, savings and investment.

The burden of disease is only a part of the equation. To secure greatest benefit resources need to be directed towards those health interventions which offer greatest value for

[15] DALY=Disability Adjusted Life Year, a measure which incorporates both the number of years lost through premature mortality, and the quality of life in terms of degree of disability
[16] Gwatkin, Guillot & Heuveline (in draft): The Burden of Disease among the Global Poor.
[17] Evidence cited in Special Programme on Africa

money in terms of health benefits. The World Development Report 1993 clearly illustrated that, in demographically developing countries, interventions to tackle the 'category 1' conditions rank among the most cost effective of all health interventions, with costs in the order of less than $100 per DALY saved[18]. HIV prevention, short-course TB treatment and malaria control all rank highly in terms of cost-effectiveness. Whilst global rankings of cost-effectiveness must be subject to numerous provisos, these data do at least serve to reinforce the case for focusing resources on the global poor, 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 is increasingly recognised as a major problem, and cost-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. Whatever the prophets had to say, we must face up to the massive developmental implications of the virus, economically, socially , politically and culturally. The numbers with HIV and dying of AIDS continues to increase. It will get worse before it gets better. The important thing is that we can do something about it, and we have a pretty good idea what that something is.

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. Thus, in looking for a reduction by two thirds, we now need to work a lot harder to achieve our target.

Research in progress at the Overseas Development Institute has emphasised the scale of the HIV challenge. It has provided compelling evidence that the trend in HIV will have a profound impact on future rates of infant, child and maternal mortality, and concludes that containing the epidemic is vital if we are to have any prospect of meeting these targets.

The impact of HIV/AIDS goes beyond health. The epidemic is having a big effect on the demand for education, and it will also affect the supply. It will make the poverty reduction goal 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.

[18] For detailed cost-effectiveness rankings see table B.6 and B.7, WDR 1993.

TABLE 1.

DEMOGRAPHIC INDICATORS WITH AND WITHOUT AIDS: 1998

	Growth Rate		Life Expectancy		Crude Death Rate		Infant Mortality Rate		Child Mortality	
Country	With AIDS	With-out AIDS	With AIDS	With-out AIDS	With AIDS	With-out AIDS	With AIDS	With-out AIDS	With AIDS	With-out AIDS
Ethiopia	2.2	2.9	40.9	50.9	21.3	15.0	125.7	115.4	197.6	169.2
Kenya	1.7	2.5	47.6	65.6	14.2	6.2	59.4	44.7	107.0	64.9
Nigeria	3.0	3.2	53.6	57.8	13.0	10.9	70.7	65.9	139.0	124.4
South Africa	1.4	1.9	55.7	65.4	12.3	7.8	52.0	43.3	95.5	69.7
Zimbabwe	1.1	2.5	39.2	64.9	20.1	6.2	61.8	35.9	123.4	50.5
Honduras	2.3	2.5	65.0	69.2	7.0	5.5	41.9	38.6	61.2	50.4
Cambodia	2.5	2.7	48.0	50.7	16.5	15.0	106.8	104.2	179.7	171.9

Source: US Bureau of Census Population Profile

2.2 THE INTERNATIONAL ENVIRONMENT

2.2.1 GLOBALISATION: HEALTH THREATS AND OPPORTUNITIES

National policies and systems are only part of the picture. Broader international trends can reinforce, or undo, much good work. The impact differs widely region by region – some trends offer opportunities, others threats

Increased globalisation, for example, has had a number of major health effects as people, money and goods have become more mobile. Increased opportunities for travel has changed disease dynamics allowing for more rapid transmission e.g. of malaria and HIV/AIDS. International trade, and the dependence of some communities on single export crops can lead to malnutrition and vulnerability to external shocks. Globalisation has also made countries more vulnerable to severe swings in capital flows as seen recently in South East Asia. The poor in these countries, who have relied upon sustained economic growth to meet their basic needs have, suffered as the traditional safety nets have withered and not been replaced. The economic and political crisis in Indonesia has resulted in an increase in poverty incidence (from 11% in 1997 to 14% in 1998) and significant reductions in health expenditure (by 8% in real terms in 1997/8 and a further 12% in 1998/9). Similarly, the economic shocks associated with rapid liberalisation have resulted in sharp falls in health expenditure. Since 1990, real per capita health expenditure has fallen by nearly two thirds in Kazakhstan and the Kyrgyz Republic, and by a third in Uzbekistan.

Globalisation has also brought about international markets for health. Not only do people travel overseas for their health care – health personnel do the same in search of jobs. In some cases (Bangladesh) this has been an explicit policy. In others it has contributed significantly to brain drain (there are about a third as many Ugandan doctors in South Africa as in Uganda). Although this may be to the advantage of the individual, the nation and its people lose out.

Increased migration whether for economic or political reasons, conflict and natural disasters has also brought about health problems associated with such population movements, loss of traditional safety networks and the adaptation to new environments. The United Nations High Commissioner for Refugees (UNHCR) last year estimated that there were 12 million refugees around the world, as well as 1million asylum seekers, 3.5 million recently returned refugees and millions more displaced within their own countries. An estimated 315 million people were affected by natural disaster and a further 103 million by ongoing complex emergencies in 1998. The annual estimated cost of natural disasters are in excess of

$80bn – international support to combat its effects is running around $3bn per annum.

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. Serious ongoing crises have a major impact on health status. In Mozambique, between 1980 and 1988, 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 globalisation of pharmaceutical markets has both positive and negative aspects. On the one hand, private sector makes drugs available to people in all corners of the earth. Drug companies are increasingly involved in direct support to global health programmes and a new spirit of public-private partnership is emerging. On the other hand, consolidation of the industry and intellectual property rights reinforce the market power of the major manufacturers, driving up the price of proprietary products. The economics of the pharmaceutical industry offer little incentive for research and development of products to tackle the tropical diseases, or the strains of HIV which prevail in the South.

No nation can prosper in isolation. The benefits of open international markets in goods, services and capital are indisputable if developing countries are able to participate on a level global playing field. The regulation of international trading legislation and practice - the purview of World Trade Organisation - will have a critical influence on the capability of developing nations to reap the benefits of globalisation, including access to new medical technology at affordable prices.

The prospects for debt reduction appear brighter now than for some period although actual implementation to date has been rather limited. Tied to the introduction of appropriate economic reforms and commitment to investment in human capital, such measures could have major direct and indirect effects on health sectors. Implemented effectively debt relief could stimulate private investment flows and reduce the need for development assistance in many of the middle income countries

2.2.2 International Assistance for Health: too many cooks?

There has been a proliferation of the actors responding to global health needs over the last 20 years. The WHO, UNICEF, UNFPA, UN Development Programme (UNDP) and UNAIDS, all focusing primarily on the health sector have been joined by the multilateral development banks (MDBs), the European Commission and also by international NGOs and private industry. As a result mandates and responsibilities have become blurred, resulting in overlap and confusion. 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 and child immunisation levels would be a fraction of the current figures. Looking forward, even greater external assistance will be required to accelerate progress towards the IDTs 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 IDTs 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 - each pursuing often 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.

3.1 Progress Made

The 20th century has witnessed more rapid progress in global health than in any previous period of human history. In 1960, 216 of every 1,000 children born in a developing country would die before their fifth birthday. By 1996 this had fallen to 97. Over the same period, the fertility rate fell from 6.0 children per woman to 3.2. Smallpox, which had previously affected 10 million 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[19]. Immunisation now saves an estimated 3 million children's lives annually and the prospect of eradicating 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 practice continues to narrow as the prerogative of clinical judgement gradually gives way to "evidence-based medicine". And 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 health systems

The present international health agenda bears close resemblance to the aspirations of the Primary Health Care (PHC) declaration of 1978. As it was translated into practice during a period of severe financial constraints, the original PHC agenda was overtaken by "selective PHC" with its emphasis on extending delivery of a few specific interventions.

While this approach produced rapid progress in areas such as childhood immunisation, its limitations became evident during the 1990s as sustainability problems came to the fore. We learned that over the long term priority programmes can only be sustained when they are seen as an integral part of national health systems and are supported by adequate budgetary allocations, human resources, logistical systems and monitoring and supervision mechanisms.

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

3.2.3 Cost recovery

Cost recovery - enthusiastically promoted and adopted around the developing world - has rapidly fallen out of favour. This is only partly due to disappointing revenue yields. The main concern centres on equity consequences. Instead of improving equity, as some exponents claimed, the

[19] World Health Report. WHO, 1999

price signal has tended to exclude poorer patients, further concentrating the benefit of the public subsidies among the non-poor.

3.2.4 Efficiency, Equity, or both?

Concern about user charges has become particularly acute as equity has become more prominent among health policy objectives. This clearly relates to adoption by the international community of poverty elimination as the overarching development goal. What remains unclear is how 'pro-poor health policy' might translate into practice, and how equity objectives coincide, or run counter to, efficiency objectives. As section 2 illustrates, there are probably many win-win scenarios - where focusing on poor people will target the concentration of ill-health and those health problems with particularly cost-effective remedies.

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. A much greater focus on quality, participation, transparency and accountability is already evident in international health policy debate. This resonates also with recognition that the health behaviour of individuals, social networks and community initiative have an immediate and important impact on health risks and prospects. Achieving a meeting between an effective and efficient "supply side" with 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 the private sector in particular is an aspect of health policy which came to prominence during the 1990s. We now know that in many low income countries private spending 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 is probably 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 here to stay. 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. Public-private partnerships (public subsidy, private delivery) have proved to be particularly effective in the social marketing of contraceptives and associated services. There is certainly scope for extending the social marketing model to other health-related commodities.

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'[20] 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 the low income countries among them 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 (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.

[20] 'Assessing Aid: what works, what doesn't, and why'. World Bank, 1998

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 member states need to be more ready to engage constructively with UN agencies to improve performance.

3.2.9 Role of international targets

Finally, the power of international agreement on specific targets and indicators cannot be underestimated. The series of summits - from the World Summit for Children in 1990 to 'Cairo plus five' have galvanised global commitment, focused effort and assured a consistency of objectives which would otherwise have been unattainable. But a note of caution is in order. Global targets cannot substitute for local popular and political commitment to action. Nor do they obviate the need for pragmatic planning at country level to reconcile targets with the resources available to achieve and sustain them.

3.3 Emerging Policy Consensus

Approaches to international health have changed over time with biomedical, economic and institutional approaches all enjoying periods of ascendancy. But there is now consensus that poverty reduction should be at the core of international health policy and there is emerging consensus on the main challenges:

- 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

And a recognition that more effective co-operation will require:

- stronger consensus on key objectives, principles and strategies
- better understanding of partners needs and priorities
- more honest recognition of strengths and weakness of different organisations as a basis for dividing up the work in a more sensible way

This shift reflects partly a recognition that previous approaches have done too little to address poverty and equity concerns but also through renewed efforts by the international community under some pressure from development partners, the NGO community and civil society. This has resulted in fora such as the World Summit for Social Development in Copenhagen (1995) and the World Conference on Women in Beijing (1995) which brought issues of poverty eradication and women's right to health care to the fore and the International Conference on Population and Development in Cairo (1994) which spelt out the reproductive health agenda. Such approaches require a fine balance to be drawn between advocacy and identifying clear, specific and achievable strategies. These international conferences have resulted in agreements between governments that if implemented would transform the lives of poor women and men. Translating agreed human rights principles into reality on the ground is the challenge that lies ahead.

4.1 Effective International Action

4.1.1 Leadership

The next fifteen years offer the opportunity to transform the health prospects of poorer countries. But success will depend upon a reinvigorated, co-ordinated, coherent response across the international agencies as a whole. It will also require concerted action at international, national and local level to make a real impact on poverty and the health targets.

International leadership, with the authority to hold countries to account for the achievement of the international targets will be critical. We look to WHO for leadership in making pregnancy safer; to UNICEF and WHO to lead on child survival; to UNFPA to champion the availability of contraception and other reproductive health services; and to UNAIDS to galvanise a global response to HIV/AIDS. A new multi-lateralism 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.

4.1.2 International Public Goods

Knowledge, research and technology underpin the successes of the developed world. Collective action by the international health leadership to redress the profound imbalance in the global production and application of knowledge is long overdue.

We see scope for a range of international public goods with the potential for major benefit. Some would utilise current knowledge more effectively, others focus on key unresolved problems. A simple example would be support for the production and dissemination of material on the effectiveness of development assistance in different policy environments. Other examples of public goods would include research into new technologies and products, setting norms and standards, collecting and analysing statistics on health status and sharing knowledge on best practice.

There is a call for international health leadership to mobilise global science and technology – which is currently directed by rich countries for rich country markets – to tackle poor country problems. One example is the urgent need for a malaria vaccine which would be among the most effective public health interventions possible. Other goals might be vaccines for TB and AIDs, and aggressive research on food production in food scarce countries.

Creative new approaches of this kind pose considerable challenges: the development of new alliances (including partnerships between the public, the charitable and the private sectors), incentives, funding, organisation, intellectual property rights, sustainability and so on. But we see developments of this kind as fundamental to achieving a step change in tackling the most serious problems of the world's poor people.

4.1.3 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, DAC, and regional fora like SADCC, ECOWAS, and the south-south networks – have a part to play.

Such approaches need to embrace all elements in the mix of 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 mechanisms such as the comprehensive development framework (CDF), the UN development assistance framework (UNDAF) and sector-wide approaches (SWAPs) 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. 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 assist these new mechanisms to deliver major benefits. And there must be an onus on the

partner governments to demonstrate the policies and capacity for effective implementation which will give donors confidence to move away from supporting specific programmes to providing resources more strategically in support of sector-wide programmes.

We will work closely with a range of bilateral and multilateral partners in pursuit of more effective development assistance. This will include participation in concerted international initiatives such as Roll Back Malaria, Making Pregnancy Safer, the International Partnership on HIV/AIDS in Africa, and support for the development of a new HIV vaccine.

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.

The quality of development assistance will be improved still further if, taking inspiration from the World Bank's declared intentions, agencies are more responsive to development partner needs, commit themselves to greater openness and accountability – which should prove an important element in driving up performance - , and increase access to local as well as international technical assistance. Over the longer-term the aim should be to reduce the need for technical assistance but it is likely to continue to play a useful role in the short term.

4.2 Effective National Action:

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

Good Governance: Paragraph 4.1.4 above discusses the importance of the policy environment. Good governance is a key policy issue. DFID will support health sector investment in the context of overall public service reforms which enable a full range of stakeholders to participate in identifying priority needs and allocating resources, as well as the setting and monitoring of service delivery standards and targets. We will support stronger governmental planning, management and budgeting systems; and facilitate governmental efforts to promote national standards through charter type arrangements. Monitoring progress against service delivery targets in terms of improved outcomes, and the distribution of those outcomes, is crucial. Transparency and accountability on spending and services are important mechanisms for citizens and civil society to determine whether governments are using resources effectively and meeting entitlements to economic and social rights.

We will also encourage governments 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.

Capacity development: We will continually look for opportunities to strengthen human capacity and encourage institutional development of partners, to ensure that sustainability is enhanced and that partners are enabled to make best long term use of our support.

Efficiency: In taking forward this strategy we will work to ensure efficient use of DFID's limited resources, as well as to maximise the value of overall resource use at country level. We are committed to ensuring maximum improvement in poor people's health per unit of investment.

4.3. Broad-based Social Policy and Principles

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

Education: The synergy deriving from the complementary efforts of the health and education sectors can have significant impact. DFID's approach to education is spelt out in the accompanying Education international strategy paper in this series. Educated citizens are more likely to have healthier lifestyles, smaller families, and to demand quality health services. Towards this end, DFID will work towards the achievement of the target of universal access to quality primary education by 2015; of equal importance will be our efforts to achieve the OECD's Development Assistance Committee (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; therefore DFID will continue to support efforts towards 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 and promotes human rights. We will support action that upholds the rights of poor people to good quality, affordable, and accessible basic health care. This entails supporting and promoting the setting of policy frameworks which set goals for the progressive realisation of people's rights to adequate basic health services and accountable service providers. We will promote broad-based participation in the development and delivery of health and related services through: 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.

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. Addressing forms of inequality, particularly that rooted in gender, will underpin DFID's work.

The Beijing Conference 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. DFID will seek to promote 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.

A separate paper in this series sets out DFID's approach to gender equity in full.

Economic well-being: Economic growth is essential for poverty reduction, but 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 a sufficient level of quality food is vital to ensure optimal growth, health and development. This in turn requires an enabling political, economic and trade environment which creates conditions for achieving national

and intra-national 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.

Community action: The poor themselves are key actors in securing better health outcomes. Through lifestyle choices and health related behaviour, people take daily choices which 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.

5.1 Introduction

This document has set out the enormous challenges that the world faces if all people of the twenty-first century 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 four set out a framework for effective international and national action, within which DFID will work. This section asks what specific actions we should be investing in now: in partnership with the international community; as partners of national governments, as members of national and international civil society. We believe that there are four key responses that, taken together and vigorously pursued at national and international level would truly impact on the health and wealth of nations and their people. These actions need to be understood within the context of a framework for effective action at national and international action identified in Section four.

The case for investment in health as a key component of the poverty complex has been made and is internationally accepted. There is a clear link between health investments and poverty reduction. How we invest in health now includes more than ensuring an effective and efficient health system response. This reflects a clearer understanding of the demand side for health, how to respond to the priorities of the poor, and the collective co-ordinated investments required across all sectors.

5.2 Strategic Choices

Framing DFID's response, as part of the international response to the challenge of the IDTs, requires us to make choices in three areas:

- the balance between bilateral and international work
- the country focus of the bilateral programme
- the set of actions which we will focus on in both bilateral and international work

The IDTs are a significant opportunity to frame our response and set out priorities. The context within which they are set is the overarching goal of lifting one half of the poorest people of the world from poverty by 2015. This remains the principle goal for DFID collaboration in the collective international, national and local response to this challenge. ***The IDTs are not end points in themselves, nor are they comprehensive,*** but they powerfully frame the process by which we meet the demands of the poor.

5.3 Greater focus on Partnership with other Agencies

Almost half of DFID's total budget is now channelled to multilateral organisations and this proportion is likely to rise over time. Yet our bilateral programme continues to absorb a disproportionate share of our organisational effort and attention.

We recognise that the scale of progress required to meet the IDTs 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 or 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 with the authority to hold countries to account for the achievement of the international development targets.
- 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
- 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 IDTs
- new forms of international action - such as Roll Back Malaria and the Africa AIDS Partnership -

which promise to galvanise the international response to priority problems
- new mechanisms to strengthen international collaboration, such as UN reform, sector wide approaches, UNDAF and CDF.
- initiatives from within the UN family and other multilaterals to undertake institutional reforms, clarify roles and strategies and improve performance

We will pursue these goals through partnerships at country level, regional level and global level through:

- pro-active engagement in international summits and fora, drawing on DFID's field experience and network of health professionals
- joint working on country, regional and global initiatives
- extra-budgetary funding
- secondments and exchanges
- strengthening inter-institutional communication through professional dialogue at all levels; joint working in countries and an active role in executive boards and 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 "shareholder".

We will need to find new ways of involving DFID's field-based health professionals in inter-agency dialogue. We will need a substantial increase in HQ based professional and administrative staff to pursue strategically the facets of international working described above. And 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 relationships with the World Health Organisation, UNAIDS, the World Bank, UNFPA and the International Planned Parenthood Federation (IPPF). 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 particularly 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.

5.4 Country Focus of the Bilateral Programme

The greatest challenges for achieving the IDTs 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 IDTs, but also requires a steady increase in the proportion of bilateral resources targeted to poor countries.

Figure 8 below 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). Table 2 shows the top 20 bilateral health programmes by expenditure in 1997/8.

Fig. 8 **Distribution of DFID bilateral health spend 1998/99**

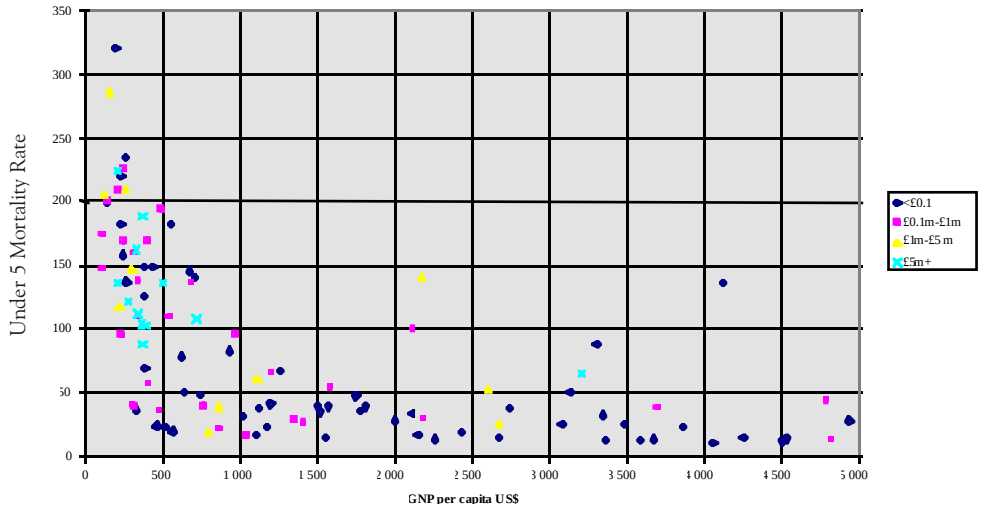


TABLE 2.

TOP 20 BILATERAL HEALTH PROGRAMMES BY EXPENDITURE IN 1997/8

Country	£ Millions	% 1,000	USMR per (US$0	GNP per capita	Pop 1997
India	£16.4	%10	8.8	370	962.4
Bangladesh	£11.4	%7	104	360	123.6
Ghana	£9.9	%6	102	390	18.0
Pakistan	£9.7	%6	136	500	128.5
Uganda	£9.6	%6	162	330	20.3
Zimbabwe	£7.0	%4	108	720	11.5
Tanzania	£6.7	%4	136	210	31.3
Zambia	£6.2	%4	189	370	9.4
Malawi	£6.0	%4	224	210	10.3
Kenya	£5.7	%3	112	340	28.6
South Africa	£5.4	%3	65	3,210	40.6
Nigeria	£5.0	%3	122	280	117.9
China	£4.4	%3	39	860	1227.2
Russian Federation	£3.0	%2	25	2,680	147.3
Cambodia	£2.7	%2	147	300	10.5
Nepal	£2.6	%2	117	220	22.3
Peru	£2.2	%1	52	2,610	24.4
West Bank and Gaza	£1.9	%1	28		2.6
Brazil	£1.3	%1	44	4,790	163.7
Angola	£1.3	%1	109	260	11.7
Other	£48.2	%29			
TOTAL	£166.6	%100			
Emergency Spend	£32.5				
GRAND TOTAL	£199.1				

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 may have 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 principle 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.

Conversely, in the poorest countries the paucity of domestic resources means that rapid progress towards the IDTs 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.

More generally, it will be important to avoid spreading the bilateral effort too thinly. Resources are already highly focused and should remain so. The top 30 countries account for 90% of the current total bilateral health programme[21] and the top 14 countries for 78%.

5.5 Priority Areas for Action

This section asks what specific actions we should be investing in now - as an international community; as national governments, as national and international civil society. We believe that there are four key responses that, taken together and vigorously pursued at national and international level would truly impact on the health and wealth of nations and their people.

The responses are based upon the determinants and distribution of poverty, poor health and disease across regions, countries and people living within those countries. They avoid traditional dichotomous considerations of developed versus least developed countries, but rather attempt to shape our response in recognition of increasing inequities and how we need carefully to measure and evaluate our responses to ensure that the poor capture the maximum benefits from our collective interventions. They are based upon an analysis of the main determinants of poor health in poor people. They focus on priority actions that will reduce the burden of disease of the poor and on the diseases with the greatest social and economic impact.

These responses reflect the collective action required by DFID. They thus 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. DFID, and HPD in particular, recognises that it will be held collectively responsible to the British tax payer for an internationally agreed series of health outcomes.

These responses are as follows:

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

Some of this agenda has already been mapped out and agreed by the international conferences of the 1990s. Some of it - particularly the health of the poorest billion, and how to go about improving it effectively - is emerging as the key issue in international health. We are still working to agree consensus as to the best way to proceed. What has become clear is that none of these actions can be effectively supported by single actors.

[21] These figures count total existing commitments and pipeline projects with a 'health sector' economic classification, excluding emergencies and regional programmes

Therefore, within this framework DFID will work with national governments committed to contributing to achievement of the IDTs; with international agencies willing to commit resources and provide leadership to further the effort towards achievement of the IDTs; with private sector organisations willing to harness private assets for the public good; with international and national civil society organisations working effectively on international development; and with other donor governments to ensure synergy, consistency, and sustained commitment.

Response one: Addressing the priority problems of the poorest billion: strengthening access to care, services and products

Reproductive and sexual ill-health, communicable diseases and respiratory infections take a massive toll on health in the developing world. Two thirds of under five deaths are caused by acute respiratory infections, diarrhoea, malnutrition, measles, perinatal causes and malaria. Systematic action to address these problems is essential to achieve the international development targets to lower maternal and child mortality and ensure universal reproductive health.

Addressing this so-called 'unfinished agenda' requires co-ordinated community, national and international action to identify and promote priority services. The great international conferences of the 1990s have framed the necessary agreements for action. The international challenge now is to operationalise and institutionalise these agreements to the benefit of the poorest.

We look to WHO for leadership on the communicable disease agenda; and for leadership on making pregnancy safer. We look to UNICEF and WHO for leadership on reducing child mortality; and to UNFPA for leadership on making reproductive health services available to all.

DFID's approach will support action within the context of strengthening health systems - encompassing the public, private and informal sectors - to improve poor people's access to the care, services and essential health products to safeguard their health. We will:

- support action to make the best use of available knowledge and evidence, to generate new knowledge, and deal with the links between health problems.
- support innovative partnerships to find new ways of delivering care and services
- encourage new forms of international action and global leadership on health priorities – *Making Pregnancy Safer, Roll Back Malaria, International Partnership on HIV/AIDS in Africa* - to support effective country led action
- support development of more effective and more affordable products for prevention, diagnosis and treatment of disease

Specific priorities are:-

Making Pregnancy Safer and Improving Reproductive and Sexual Health

Reproductive health is now recognised as more than just family planning and treatment of sexually transmitted infections. 600,000 women continue to die each year from pregnancy related causes.

IDT : A Three Quarters Reduction in Maternal Mortality by 2015

DFID will:

- ensure that the international global architecture is best strengthened to ensure that the failures of the last 10 years in reducing the toll of maternal death are not repeated
- in particular, support WHO global leadership and international advocacy to ensure that maternal health receives high international and national priority
- ensure that this results in the appropriate development of local policies and strategies, based on effective regional and local analysis
- through education, rights based and gender approaches, ensure that women, communities and

families are empowered to respond to the needs of women in pregnancy

- in recognition of the fact that reductions in maternal mortality are principally determined (unlike most other areas) by the quality of the health system and sector response, ensure that maternal mortality is recognised and utilised as the key indicator of functioning health systems. This requires substantial support for efforts to build health systems to provide better access to essential and emergency obstetric care - including abortion complications (see response two)
- ensure recognition that high quality care during delivery is a major determinant of perinatal survival, quality of life and prevention of disability. The Maternal and Child Health IDTs are thus intimately related.

IDT : Universal Access to Reproductive Health Services by 2015

- ensure universal female education
- work with countries to develop better access for poor people to good quality reproductive and sexual health services, particularly contraceptive choice; and prevention, diagnosis and treatment of sexually transmitted infection
- support the development of more effective, more affordable and more acceptable methods of contraception
- support global action that enables greater availability of essential reproductive health commodities, such as condoms
- seek to ensure that young people's sexual and reproductive health gets the attention it needs. We will support initiatives - including school based programmes - to help young people get the information and services to protect their sexual and reproductive health and avoid unwanted pregnancy.
- support efforts to ensure that individuals, families and communities have information to facilitate decision making during pregnancy and delivery.
- support actions outside of the health sector to promote gender equity and better education as strategies to have a positive impact on the health of women.

CHILD HEALTH

IDT : A Two Thirds Reduction in Child Mortality by 2015

DFID will support:

- universal female education, as a major determinant of child survival
- universal access to safe water and sanitation (see response three)
- the global leadership of UNICEF and WHO in promoting child health
- work that builds health systems to provide effective preventive and treatment measures for major childhood illnesses, notably malaria, ALRI and diarrhoeal diseases, EPI, (through, for example, the Integrated Management of Childhood Illness (IMCI) initiative)
- actions to address morbidity and mortality in the first months of life (peri-natal interventions) and ensure quality care in delivery (above)
- immunisation against vaccine preventable diseases through international and national actions
- advocacy for effective and evidence-based nutrition programmes including micronutrient supplementation and food fortification strategies to prevent the deficiencies of vitamin A, iodine and iron
- action to combat diarrhoea and make oral rehydration therapies more widely available.

COMMUNICABLE DISEASES

DFID will support:

- global leadership and international action to combat communicable disease: malaria, tuberculosis,

sexually transmitted infections (STIs) including HIV/AIDS and other communicable diseases
- intensified collaboration to bring about substantial and sustainable reductions in ill-health and mortality from malaria, in particular through Roll Back Malaria
- intensified collaboration to bring about substantial and sustainable progress in meeting the WHO-set targets for global TB control
- the co-ordination of HIV/AIDS and TB programmes
- effective measures to decrease transmission of STIs, including the promotion of behaviour change and improved access to STI services
- work leading to the eradication of polio, onchocerciasis, guinea worm, and lymphatic filariasis
- development of new knowledge concerning the feasibility, acceptability, effectiveness and equity implications of interventions (including behaviour change) for the control of priority communicable diseases.

Injuries and non-communicable diseases (NCDs)

While the focus of DFID's work will be on communicable disease, child health and reproductive and sexual health, we will also explore ways of addressing the emerging agenda of injuries and non-communicable disease. This recognises the growing burden affecting poor populations, notably the emerging recognition of mental health illness as a major burden of disease of the poor.

DFID will:

- contribute to the knowledge base on the extent, causes and nature of violence against women and children, and support advocacy to increase awareness and the development of strategies to tackle it
- continue to support the WHO Tobacco-Free Initiative
- support research activities aimed at providing the evidence base to inform social policy and health policy regarding affordable treatment for non-communicable disease.
- support new knowledge to better determine the impact of NCDs (including mental illness) on the poor.

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

Effective, affordable and available health systems must be one of the key investments of the twenty first century. This goes beyond Health for All. It means taking a view of what we have learnt since Alma Ata, about affordability and public subsidies; sustainability; public-private partnerships; the health sector in the context of public sector reform; and provider behaviour and client-oriented services. It means applying systematically what we have learnt in the last twenty five years. Within this agenda, the WHO has a particularly important role to play in working with others to make technical expertise and best practice available to national governments. Delivering on this response requires changes in donor behaviour, so that all externally funded actions in the health sector build coherent systems rather than fracturing effort.

DFID will support actions which will build the capacity to deliver rapid but sustainable improvements in health outcomes, with a special emphasis on the health of the poor. This objective can best be met by health systems which:

- are institutionally and financially sustainable within the constraints of the resources and capacity likely to be available
- set clear health sector policies and priorities through mechanisms which are technically sound, politically sustainable and publicly accountable
- promote and support inter-sectoral actions to address the determinants of health with a view to improving overall population health status and narrowing health inequalities between rich and poor
- utilise public subsidies to assure equal access to health services for equal need
- allocate public resources for health to programmes and services offering greatest value for money[22], as long as this is consistent with promoting greater health equity

[22] Value for money is defined here as offering greatest health output (eg. in terms of DALYs or deaths averted) per $1 spent

- organise, finance and manage health services in a way which promotes effective and efficient provider behaviour and encourages services to be client-oriented and accountable, especially towards the poor
- enable poor people to gain access to the knowledge and information they need to improve the health of themselves and their children
- encourage greater efficiency and quality in privately financed health care through effective legislative and regulatory frameworks, through improving consumer information and rights, and through encouraging quality assurance mechanisms
- actively pursue evidence-based reforms of organisational, financial and managerial arrangements to improve overall health sector performance in terms of equity, efficiency and effectiveness
- pro-actively manage external assistance to pursue joint priorities, whilst assuring the effective, efficient and transparent use of aid resources, and
- enhance the poverty and gender focus of health programmes through specific attention to strengthening accountability to socially excluded groups.

Because health systems have evolved over time and because they need to respond to the interests of multiple stakeholders, it is usually neither feasible not desirable to 'reinvent' health systems. Instead, reforms will usually be incremental and often opportunistic.

DFID will contribute to the sustainable improvement of health systems in poor countries through a range of activities including:

- funding national and international research to improve the evidence base for improving the organisation, financing and management of health systems
- continuing to develop understanding of the feasibility, effectiveness and equity implications of health sector reform
- gaining a better understanding of health-related behaviour and service utilisation, leading to the identification of ways in which appropriate behavioural responses to illness can be promoted
- fostering the exchange (between countries and agencies) of knowledge, information and experience which will accelerate the development of equitable, efficient and effective health systems
- encouraging more effective co-ordination of external assistance to the health sector at national and international levels
- providing financial and technical support to poor countries to build equitable, effective, efficient and sustainable health systems as the basis for the optimal use of health resources towards meeting the IDTs.

Response three: Creating conducive social, political and physical environments that enable poor people

Under-pinning these responses lie fundamental requirements for development, without which significant progress towards meeting poverty reduction goals will not be made. These are the subject of a separate set of DFID Target Strategy Papers that will be published shortly, including, but not confined to:

- economic well being
- education
- good governance
- environment
- gender.

In this context, the response under this sections highlights a number of areas for intervention that have an important impact both direct and indirect on the enabling environment required for people to lead healthy lives. These will be the subject of DFID's collective response, frequently led from without but informed by the traditional organisational structures for health in DFID.

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. Environmental hazards include physical, chemical and

biological factors eg flooding, exposure to industrial pollution, or noxious gases and waterborne disease such as schistosomiasis. The poorest experience a disproportionate burden of the negative effects of environmental health hazards. By improving people's physical environments a significant proportion of disease could be eliminated.

In 1990, one in four people in developing countries had no access to safe water and one in two lacked safe sanitation. Rural areas and marginal urban areas have least access and most disease. There are wide inequalities of access, both within and between countries. Both quantity and quality of water are important. It is believed that up to 90% of the global burden of diarrhoeal disease could be eliminated through better water and sanitation. Other water-related illness comes from trachoma, schistosomiasis, and guinea worm infestation; poor drainage provides mosquito-breeding sites, leading to malaria and dengue fever. Collecting water is done mainly by women and young girls, and diverts them from other livelihood activities, childcare or school. Clean sanitation facilities provide dignity and safety for women.

The programme of action agreed for reducing health risks from environmental hazards was set out in Agenda 21 during the 1992 Rio de Janeiro UN conference on the Environment and Development. Safer social environments figure prominently in the World Summit for Social Development in Copenhagen in 1995.

In taking forward work in this area, DFID will:

- **contribute to improvements in understanding the impact of environmental hazards on health,** and the most cost effective strategies for the prevention of illnesses due to environmental hazards (including mitigation of behavioural, social and environmental risks). This will cover issues such as road safety, health impact of climate change, and safety and violence in the home and community.
- **promote safe shelter policies and actions.** Overcrowded, poorly ventilated, houses contribute to respiratory illnesses 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 encouraged. 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.
- **promote safer social environments,** which are free from violence and harm, in the home and in public places. Freedom from physical and mental harm falls outside the traditional development agenda but clearly underpins people's rights to avoidable ill health and premature mortality.
- **promote safe workplace policies,** in order to reduce occupational injury and disability amongst children as well as adults This goes largely unrecorded and unchecked. The UK has an significant background in occupational health policy, practice and regulation, and where appropriate this experience should be used to inform approaches in poorer countries.
- **work with governments on regulatory and fiscal mechanisms to encourage responsible agricultural, industrial and municipal waste management and pollution control through education and incentives.** Businesses contribute to polluted land, environmental degradation, outdoor air pollution and radiation accidents. DFID will support the setting of appropriate and affordable standards, and their subsequent monitoring and implementation.
- **work with governments to promote road and vehicle safety.** Vehicle registration is increasing globally, and road traffic accidents are predicted to become the third commonest cause of DALY loss by 2020. Environmental engineering, and vehicle safety regulations are cost effective measures. We will support the stricter regulations of vehicle emissions.

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.

DFID will support actions which:

- **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 iniquitous distribution of subsidies. This will improve the sustainability of provision and help to target scarce public funds on extending basic levels of service.
- **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.
- **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. Giving a choice of technologies is more likely to result in a sustainable impact.

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

The pandemic of HIV/AIDS challenges the goals of development in all domains. Already in some parts of the world, notably Southern Africa, there is no single greater threat to the achievement of the international development goals. Until recently the response has been largely confined to the health sector. DFID recognises that this is no longer appropriate. It is clear that the nature of the challenge, more than in any other single area, requires a department wide response from DFID. The response is now the subject of a separate publication, "Fighting Back. A Strategic Framework for DFID's Response to HIV/AIDS".

HIV/AIDS continues to have a devastating impact on human and economic development, particularly in the poorest countries. Because of its urgency and magnitude, its complex socio-economic and cultural determinants, and discrimination and human rights violations experienced by affected people, HIV/AIDS is a unique global problem. We still have too few examples of effective national responses. The epidemic demands that we make maximum use of limited resources, which in turn requires properly co-ordinated national and international action. As an international community, we have a long way to go before our response is effectively co-ordinated, and synergistic, rather than fragmented and patchy. We look to UNAIDS for international leadership in this regard.

The newly agreed HIV/AIDS target at the ICPD+5 conference should focus the international and national response on young people, not yet affected by the epidemic, as the most effective way of reducing its longer-term impact.

DFID is committed to intensifying its contribution to the global response to HIV/AIDS. In intensifying its effort, DFID will support actions that seek to achieve the following:

Raising the profile

- keep the crippling burden of HIV/AIDS in poor countries at the forefront of the international development agenda, and work towards sound policy responses from those involved in global and national governance
- at global/regional level seek more effective institutional structures for monitoring, co-ordinating and facilitating a global response
- use available opportunities for advocacy with global policy makers and national leaders on behalf of the

poor and those infected with and vulnerable to HIV infection
- at national level seek to support better sector analysis, looking to clarify the functions of different levels of government, the role of the state and other actors in addressing the epidemic, and outcomes expected from investment of public funds.
- recognising the impact of HIV/AIDS on education systems and the role of education systems in prevention and control.

Enabling environments for HIV prevention and control

- encourage governments and civil society to create environments which enable people to reduce risk and vulnerability to HIV infection, especially in their youth
- in seeking to create an enabling environment for reduced risk and vulnerability, support approaches which recognise the need to promote and protect human rights. We will look to interventions which will reduce stigma and discrimination against people with HIV/AIDS.
- accord particularly vulnerable groups - especially vulnerable women, children and adolescents - special attention. Gender equity will be a key feature. The education sector will play a key role in raising awareness and informing individuals.

Care for people living with HIV/AIDS

- improve access of poor people and those at risk, to services for prevention of HIV and care and support for people living with HIV/AIDS
- support the provision of key services for HIV prevention, linked to care and support eg condom supply (both male and female), prevention and treatment of sexually transmitted infections, activities to reduce parent-to-child transmission, access to voluntary and confidential counselling and testing, support to behaviour change and safe blood
- promote care across a continuum, to link an array of providers and services that can address the care needs of people living with HIV/AIDS and their carers. Where appropriate, promote home based care which delivers benefits to people living with HIV/AIDS and their families, as well as to health systems. Provision of essential drugs for treatment of opportunistic infections is a core action and is an essential aspect of the continuum. Strengthening health systems to improve access to essential drugs and treatments of the most common opportunistic infections in general populations is an essential part of the strategy.

Improving knowledge and technology

- support the development of a vaccine which is effective, available, and affordable to poor people. DFID believes that the public sector has a role in encouraging the private sector to expand its role to produce public goods
- support the development of microbicides, which offer a preventive option women can more easily control
- strengthen understanding of social and behavioural science. Few areas of behavioural research have been as neglected as the study of sexuality. Knowledge of HIV infection has had limited impact on risk behaviour. We need to understand better why, and how we bridge this gap. The formal education system may provide a good forum to capture current understandings and perceptions.

5.6 From Strategy to Action

This strategy will be taken forward in a way which engenders broad ownership and which inspires action throughout DFID. It will provide the basis to match decentralised and responsive decision-making with global goals and focus.

This strategy is not a prescription but a set of principles and choices which provide a framework to maximise DFID's contribution to improving the health of poor people. At all levels specific priorities will be set, guided by the analysis contained in this strategy. It will be important to focus effort on what DFID does best, where the needs are greatest and

where the returns on our investment will yield the highest contribution to progress towards our targets. Financial and human resource investment will follow key priorities.

Bilateral programmes will be refocused on the areas identified in this strategy, in order to maximise sustainable improvements in poor people's health. At the same time we need to take a more strategic approach to co-operation with key multilateral agencies.

At every stage, opportunities will be sought to strengthen inter-sectoral working, recognising that achievement of health outcomes relies upon issues beyond the domain of the health sector. This will require institutional and cultural changes within DFID to promote closer working between professional disciplines and between the geographical and functional parts of the Department.

6.1 Measuring performance

The measurement of our progress towards achieving the IDTs is crucial. In the years ahead it is vitally important that we gain a better understanding of what works and what does not; which interventions have the greatest impact; and who is best able to deliver them.

The international community strives to achieve this by measuring performance against a working core set of indicators. These are:

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

Annex 3 shows the global and regional position with respect to each of these indicators. Our ability to measure progress against these indicators is variable. Information on infant and child mortality is available for most countries. However, obtaining reliable statistics for contraceptive prevalence, maternal mortality and HIV prevalence is more problematic. For the latter two it is usual for model-based estimates to be used as proxy indicators. Those countries most in need of basic health data are usually the least able to implement the statistical exercises required.

Data to monitor these indicators is not the only information that is required at the country level. In order to develop and monitor policies that will ultimately impact on the IDTs, 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 to what extent.

6.2 Strengthening capacity to measure performance

The need to monitor progress towards the targets has highlighted gaps in statistics and the poor quality of data available on many countries. In many cases statistical capacity is not seen as a priority for funding by national governments. We have identified statistics as an international public good, vital for policy, management and monitoring. Increased national funding will not happen unless national policy makers and civil society use and value the statistics produced.

There is a need to provide more and better co-ordinated technical assistance to support country efforts to develop statistical capacity. There is currently a global shortfall of technical assistance in this area which needs to be addressed both to monitor progress towards the IDTs and to provide a sounder basis for development planning in order to achieve that progress.

DFID is working closely with the World Bank and the UN in an effort to raise the priority of capacity building in this area. 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.

6.3 Agreeing milestones

DFID makes a significant and on-going contribution to international discussion on the IDTs. We participate in negotiations to define the targets themselves, and contribute to the development of the indicators to measure them. DFID's health and population division for example, played a key role in the ICPD +5 negotiations and the formulation of the new benchmark indicator on HIV. It will seek to work as a matter of priority with WHO and others in agreeing indicators for maternal mortality.

As with all other Government Departments, DFID is also committed to producing an annual Output and Performance Analysis (OPA) Statement. The OPA will set out DFID's performance against key departmental objectives. This includes progress towards the IDTs. Although direct causal links between DFID's spending and progress towards the targets are complex and not easy to document, the OPA provides an organised and logical basis for linking the performance of DFID programmes with the achievement of our wider objectives, and in turn with the contribution we are making to progress towards the IDTs.

6.4 Learning Lessons

In addition to the broad indicators of progress required by the IDTs, DFID has developed its own mechanisms for measuring its 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 it's 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 reviews of how far projects are achieving the outcomes for which they were designed.

Existing mechanisms include:

Routine monitoring procedures - these capture project-level performance information, including successes, failures and lessons learnt. This information is used to identify best practice for future work.

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

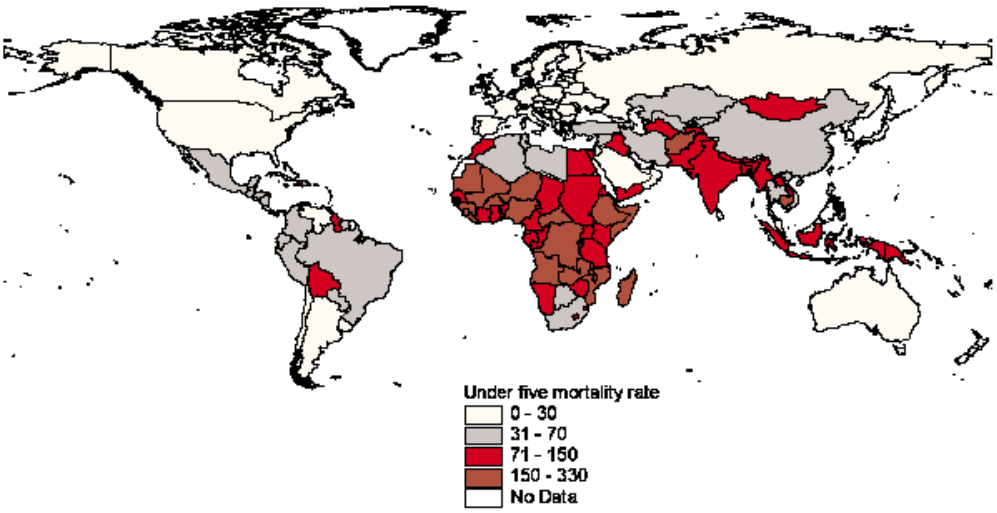
Reviews of country strategies - these capture country-level performance across sectors, including health.

Evaluation department's health synthesis work - this focuses on DFID's experience across regions, or within sectors.

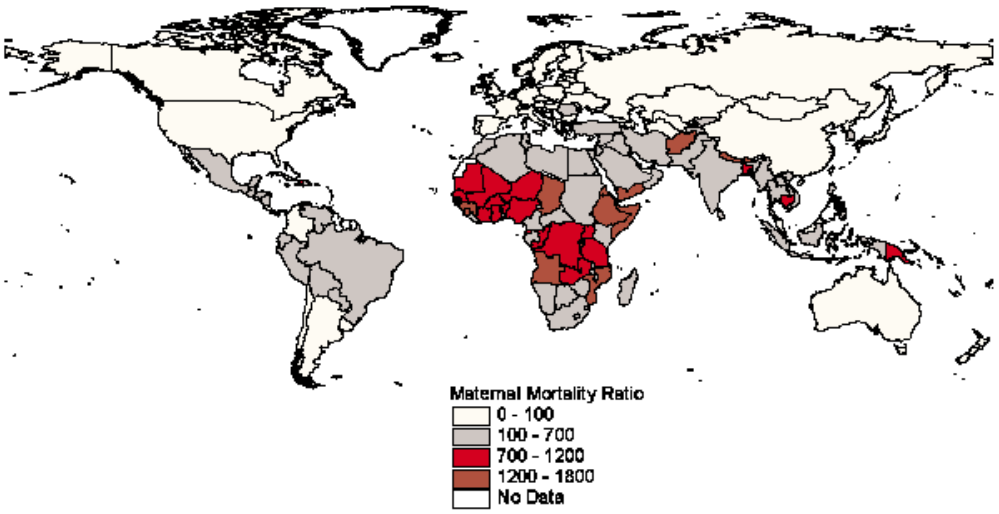
The Health and Population Group's Centre for Health Information (CHI) brings these different mechanisms for measuring performance together. It is building on previous successes by collating and sharing effectiveness information which is generated beyond the more formal information systems and reporting cycles. Using an integrated computer-based system which also serves as an analytical tool, the CHI is able to pull together information from these different sources in a meaningful way. This offers a unique opportunity for the health and population group to monitor and improve performance through information sharing.

The 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. Through productive partnerships at all levels of the department, existing mechanisms for measuring performance, and new instruments for tracking progress, the health and population group will strive to improve its ability to achieve results through understanding its successes and failures.

Under-Five Mortality, 1996



Maternal Mortality Ratio, 1990



REGIONAL AND GLOBAL INDICATORS OF DEVELOPMENT PROGRESS FOR THE INTERNATIONAL DEVELOPMENT TARGETS

			World total	Developing country total	East Asia and Pacific	Europe and Central Asia	Latin America and Caribbean	Middle East and North Africa	South Africa	Sub-Saharan Africa
Population [millions]		1980	4,430		1,359	426	360	174	903	381
		1990	5,257		1,597	466	439	237	1,125	508
		1997	5,820		1,751	474	494	280	1,281	612
REDUCING EXTREME POVERTY										
Population covered by at least one survey for poverty data (%)				85	88	86	84	47	98	66
Population below $1 a day at 1985 purchasing power parities adjusted to current price terms										
Numbers of poor in millions		1987		1,227.1	464.0	2.2	91.2	10.3	479.9	179.6
		1990			468.2		101.0	10.4	480.4	201.2
		1993		1,313.9	445.8	14.5	109.6	10.7	514.7	218.6
Headcount index (%) [% of people below the poverty line in that region]		1987		30.1	28.2	0.6	22.0	4.7	45.4	38.5
		1990			28.5		23.0	4.3	43.0	39.3
		1993		29.4	26.0	3.5	23.5	4.1	43.1	39.1
Poverty gap [mean distance below the poverty line as a % of the poverty line]		1987		9.5	8.3	0.2	8.2	0.9	14.1	14.4
		1990		9.0	8.0		9.0	0.7	12.3	14.5
		1993		9.2	7.8	1.1	9.1	0.6	12.6	15.3
National income/ consumption by poorest 10%		1980			6.3	9.8	3.7	6.6	7.9	5.7
		1990			6.9	8.8	4.5	6.9	8.8	5.2
Prevalence of child malnutrition [weight for age of under 5's]					19.8 (1995)		8.2 (1996)	14.5 (1995)	53.2 (1993)	
UNIVERSAL PRIMARY EDUCATION										
Net primary school enrolment	Female	1980								
		1996			102	92		83		
	Male	1980								
		1996			101	93		91		
	Total	1990		(Estimates)	100	92 (1994)	91 (1994)	87	80 (1995)	57 (1995)
		1996		85	100	92	91	87	80	57
Persistence to grade 4	Female				94			84	55	
					95			(1981)	(1993)	
	Male				93			88	62	
					95			(1985)	(1993)	
	Total				94		59	88	59	
					95		(1981)	(1981)	(1993)	
Youth literacy rate [% of people 15-24]	Female	1980	69		85	95	89	48	36	45
		1997	80		96	98	94	73	52	71
	Male	1980	83		95	99	89	74	64	66
		1997	88		98	99	93	86	75	80
Adult literacy rate [% of people 15+]	Female	1990	62		71	93	83	41	31	41
		1997	77		78	94	86	51	37	50
	Male	1990	79		88	98	86	67	60	60
		1997	82		91	98	88	74	64	66
	Total	1990	70	67	80	95	85	55	46	50
		1997	74	70 [1995]	84	96	87	62	51	58

			World total	Developing country total	East Asia and Pacific	Europe and Central Asia	Latin America and Caribbean	Middle East and North Africa	South Africa	Sub-Saharan Africa
GENDER EQUALITY										
Gender equality in school [female enrollment as % of total enrollment]	Primary	1990		(Estimates)	46	50	50	44	41	45
		1996			47	48 (1994)	50 (1989)	45	43 (1994)	45 (1994)
	Secondary	1990		(Estimates)	44	49	48	43	38	44
		1996			47	50 (1994)	50 (1989)	46	40 (1994)	46 (1994)
Gender equality in adult literacy [male - female difference in literacy]		1990	17		17	5	3	26	28	19
		1997	15		14	4	2	23	27	16
INFANT AND CHILD MORTALITY										
Infant mortality rate [per 1,000 live births]		1980		80	56	41	60	95	119	115
		1990	61	66	41	28	41	60	87	100
		1997	56	60	37	23	32	49	77	91
Under-5 mortality rate [per 1,000 live births]		1980	125	133	75		82	141	174	193
		1990			56	35				
		1997	79		47	30	41	63	100	147
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			57	..	..	58	38	
REPRODUCTIVE HEALTH										
Contraceptive prevalence [% of women 15-49]		1990	36		50 (1991)	34 (1992)	48	40	14	8
		1997	51	..	57	67	65	53	49	10
HIV infection rates 15-24 year olds		No data is currently available								
ENVIRONMENT										
National strategies for sustainable development [numbers of countries with a strategy in place]			85		18	5	17	4	7	34
Safe water [% of population with access]		1990			70		79 (1988)	85	50 (1985)	
		1996	75 93		77 (1993)		75 (1995)		81 (1993)	47 (1993)
Annual freshwater withdrawals [% of total resources]		1980-1996								
Biodiversity: land area protected [% of total land area]		1994	6.7		6.2	3.6	6.5	3.0	4.4	5.8
		1996	6.6		6.9	3.2	7.3	2.2	4.5	6.2
Energy efficiency: GDP per unit of energy use		1995	3.2		1.0	0.8	3.2	1.6	0.9	0.9
Industrial Carbon Dioxide emissions [tons per capita]		1980	3.4		1.3		2.4	3.0	0.4	0.9
		1996	4.0		2.5	7.4	2.5	3.9	0.9	0.8

		World total	Developing country total	East Asia and Pacific	Europe and Central Asia	Latin America and Caribbean	Middle East and North Africa	South Africa	Sub-Saharan Africa
General Indicators									
Life Expectancy at Birth	1990	65		67	69	68	65	59	50
	1997	67	65	69	69	70	67	62	51
Fertility Rate	1990	3.1		2.4	2.3	3.1	4.7	4.1	6.0
[births per women]	1997	2.8		2.1	1.7	2.5	3.6	3.5	5.5

World Bank & UN Sources
Statistics Department
Sep-99