For Official Use **DCD/DAC(2002)25**

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

14-Oct-2002

English - Or. English

DEVELOPMENT CO-OPERATION DIRECTORATE
DEVELOPMENT ASSISTANCE COMMITTEE

DCD/DAC(2002)25
For Official Use

DRAFT DAC GUIDELINES ON POVERTY AND HEALTH

(Note by the Secretariat)

These draft DAC Guidelines on Poverty and Health are submitted at the meeting of the DAC Network on Poverty Reduction and its Subgroup on Poverty and Health on 21 October 2002 and at the DAC meeting on 5 November 2002. Pending further revisions to reflect comments made during these meetings, the DAC is requested to approve its submission to the Senior Level Meeting on 12 -13 December 2002. In view of questions raised on the approval process, a background note on the elaboration of these guidelines has been inserted in the text on page 2. A checklist of recommendations will be prepared for the next version

Contact: Stephanie Baile, DCD/POL [email: stephanie.baile@oecd.org; tel: (33) 1 45 24 90 30] and Jean Lennock (email: jean.lennock@oecd.org; tel: (33) 1 45 24 1887]

JT00133229

English - Or. English

BACKGROUND NOTE ON THE ELABORATION OF THE DAC GUIDELINES [GUIDANCE] ON POVERTY AND HEALTH

This draft of the DAC Guidelines [Guidance] on Poverty and Health is submitted for consideration at the DAC meeting on 5 November 2002. The draft, without the Summary, was distributed by e-mail to members of the POVNET and its subgroup on Poverty and Health on 4 October, for discussion at their meeting on 21 October (*). The DAC is requested to approve its submission to the Senior Level Meeting on 12 -13 December, subject to revisions to take account of comments at these meetings. The intention is to prepare a final version incorporating SLM comments for endorsement by the 2003 High Level Meeting.

The origin of this work comes from the DAC discussion of the 2001/2 Programme of Work and Budget in June 2000. DAC Members cited health and education as areas for targeted work by POVNET in support of the International Development Goals [DCD/DAC/M(2000)5/PROV]. This interest was further echoed at the POVNET meeting in October 2000, where one Member volunteered to take the lead on work on poverty and health. At a subsequent brainstorming meeting in January 2001, attended by fifteen DAC Delegates and some POVNET representatives, there was strong support for setting up a temporary subgroup within the POVNET to pursue work on poverty and health.

At that meeting, and in the subsequent POVNET and subgroup meetings, it was agreed that the ultimate purpose of this work would be to develop "guidance" on pro-poor health within a two-year time frame. This would be a natural extension of the *DAC Guidelines on Poverty Reduction* and a contribution to help achieve the health-related MDGs. It was also agreed that efforts should concentrate initially on producing thematic reference papers that could then be assembled in a broader document.

POVNET and its Subgroup have met periodically between June 2001 and July 2002 to discuss the series of reference papers and the draft guidance. The preparation was highly participatory. There were written contributions, as well as written and oral comments, at various stages from many Members, WHO, NGOs and public health experts from OECD and partner countries. In an effort to keep the DAC informed, the agendas of POVNET and subgroup meetings were distributed on OLIS and copied to DAC Members by electronic mail (**). The proposed guidance was also covered in documents addressed directly to the DAC, including the proposed Programme of Work and Budget for 2003/4, which listed the "Guidance on Poverty and Health" as a major output for the 2003 HLM [DCD/DAC (2002)15/REV1] (***).

The word "guidance" has been used up to now, but with the same intent to submit the document to the HLM for endorsement. To this end, the timetable has been build around being in time for submission to the 2002 SLM. This draft uses the term "guidelines" as it appears that the product is close to the existing DAC Guidelines, and that it is a DAC brand name. The DAC may, though, prefer to remain with "guidance", to signify being subsidiary to the Poverty Reduction Guidelines. What matters is not the term but the process of endorsement by the HLM as agreed DAC policy.

(*) Note that PART V: *Promoting Policy Coherence and Global Public Goods* in the Olis version has been revised partly to take into account the outcome of the OECD Workshop on Biotechnology for Infectious Diseases, held in Lisbon 7-9 October 2002.

(**) **Agendas:** 1st Meeting of the Subgroup on Poverty and Health – 28 June 2001 [DCD/DAC/POVNET/A(2001)2]; 8th POVNET Meeting and 2nd Meeting of the Subgroup on Poverty and Health - 10 October 2001 [DCD/DAC/POVNET/A(2001)4]; 3rd Meeting of the Subgroup on Poverty and Health -19-20 February 2002 [DCD/DAC/POVNET/A(2002)1]; 9th POVNET Meeting and 4th Meeting of the Subgroup on Poverty and Health – 1 July 2002 [DCD/DAC/POVNET/A(2002)2]; 5th Meeting of the Subgroup on Poverty and Health – 21 October 2002 [DCD/DAC/POVNET/A(2002)3].

(***) This includes: Summary of Discussions – Joint Meeting of the DAC and the Chairs of Subsidiary Bodies – 18 June 2001 [DCD/DAC(2001)17]; DAC Subsidiary Bodies Summary Annual Reports of 2001 [DCD/DAC(2001)34] and of 2002 [DCD/DAC(2002)20].

TABLE OF CONTENTS

Tables

Boxes

OVERVIEW AND PURPOSE OF THE DAC GUIDELINES ON POVERTY AND HEALTH

1. The DAC Guidelines on Poverty and Health are the outcome of a joint effort by DAC Members working together through the DAC Network on Poverty Reduction. It builds on bilateral agency experience and the work of leading organisations such as the World Health Organization (WHO), the World Bank and other United Nations agencies as well as non-governmental organisations (NGOs). It also draws selectively on the work of the Commission on Macroeconomics and Health (CMH), which represents the most systematic and up-to-date review of the evidence linking health to economic development and poverty reduction.

2. The Guidelines aim to further increase the effectiveness of development co-operation in improving the health of poor people as a means of reducing poverty and achieving the health-related Millennium Development Goals. It expands and deepens the *DAC Guidelines on Poverty Reduction,* which were endorsed by OECD Ministers of Development Co-operation and Heads of development agencies at the 2001 DAC High Level Meeting.

3. This set of policy recommendations is geared to a broad range of development agency staff working in policy and operations, at headquarters and in the field. It provides directions on the most effective ways of supporting a pro-poor health approach in partner countries.

- A pro-poor health approach is one that gives priority to promoting, protecting, and improving the health of the poor (Part One).
- It includes the provision of appropriate, quality health services, with equitable financing mechanisms (Part Two).
- It goes beyond the health sector to encompass policies in areas that disproportionately affect the health of the poor such as education, nutrition, water, and sanitation (Part Three).
- It is integrated in country-led poverty reduction strategies and health sector programmes (Part Four)
- Finally, it is concerned with global action on the effects of trade, intellectual property rights, and the funding of medical research as they impact on health and poverty reduction in developing countries (Part Five).

SUMMARY

I. Investing in health to reduce poverty

1. **Health is a human right, central to individual well being, to overall human development and to the process of poverty reduction.**[1] Indeed, three of the Millennium Development Goals call for specific health improvements by 2015: reducing child mortality, maternal deaths, and the spread of HIV/AIDS, malaria and tuberculosis.

2. **For poor people especially, health is also a crucially important asset**, one that is key to their livelihoods. When poor people become ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. This vulnerability is compounded by the high incidence of disease among the poor and their limited access to health care and social protection. Investment in health is also increasingly recognised as an important means of economic development and a prerequisite for developing countries to break out of the cycle of poverty. Evidence shows that good health contributes to development through a number of pathways by increasing labour productivity, educational attainment and investment, and by facilitating the demographic transition.

3. The human and economic rationale for investing in health is mirrored by a growing consensus on the need for a broad approach to improve the health of the poor. These Guidelines identify the key **components of a pro-poor health approach** and provide a framework for action within the health system, and beyond, through policies in other sectors and through global initiatives. Within this framework, development agency support will vary according to an assessment of the needs, capacities, and policies of each partner country, taking into account members' supplementary policies and priorities.

4. **Scaling up financial resources for health** should be a priority. Without money to buy vaccines and drugs, to build and equip facilities, to staff adequately, to manage the health system, and to increase investments in other sectors important for health, low-income countries will be unable to meet the health-related MDGs. Development agencies are more likely to mobilise additional resources in support of pro-poor health objectives where: (i) there is a clear political will on the part of the partner country to articulate and implement a poverty reduction strategy and a comprehensive health sector programme; (ii) serious efforts are being made to mobilise domestic resources; (iii) there is commitment to manage resources more effectively; and (iv) major stakeholders have an opportunity to participate in the planning, management and delivery of interventions.

II. Supporting pro-poor health systems

5. A pro-poor health approach gives priority to promoting, protecting and improving the health of poor people. It includes the provision of appropriate, quality health services, with equitable financing mechanisms that are essential to prevent the spiral from ill health to poverty. Development agencies should help partner countries develop pro-poor health systems by strengthening local capacity in several areas:

1. Universal Declaration of Human Rights 1948 and the Convention on the Rights of the Child 1990.

6. **Strengthening public sector capacity to carry out the core functions of policy maker, regulator and steward, purchaser, and provider of services** is central to the development and implementation of pro-poor health systems. Additionally, strong institutional and organisational capacity is necessary to track resource use and flow, and improve human resource strategies. These key issues go beyond the health ministry alone and reflect the need for health sector reforms to be placed within the context of broader governance reforms.

7. Improving the delivery of health services by both the public and the private sector requires the **development of services more responsive to the health needs and demands of poor people.** Priority should be given to communicable diseases such as malaria, TB, and HIV/AIDS that affect the poor disproportionately, as well as reproductive health and non-communicable diseases where the disease burden is significant. This should be complemented by a range of targeting strategies used to reach out to highly vulnerable groups such as migrants, adolescents, and displaced people, with effective health services. Additionally, measures are required to generate greater demand for health services while increasing health service accountability to poor communities. To accomplish these objectives, the voices of the poor, as well as NGOs and civil society organisations, need to be heard in the planning and implementation process.

8. **Better partnership with the private sector is critical**. Poor people make heavy use of private-for-profit and private-not-for-profit service providers. In many developing countries, governments have neither the capacity to deliver health services to the entire population or to ensure that health services delivered by the private sector promote pro-poor health objectives. The type of partnership that governments can develop with private providers will depend on utilisation patterns and the relative strength and quality of different kinds of providers. Governments may choose to contract out certain services to NGOs, or try to improve the quality of services available in the private-for-profit sector. This will require strengthening the capacity of governments to develop, implement, and monitor regulatory and contracting mechanisms.

9. **The design of equitable financing systems** is an essential part of improving access to health care and protecting the poor from the catastrophic cost of ill health. This argues in favour of effective social protection strategies, moving towards risk pooling and prepayment systems and away from out-of-pocket "fee for service" payment for primary health care, which discourage utilisation by the poor.

III. Focusing on key policy areas for pro-poor health

10. Ensuring that the poor have access to affordable and quality health services, however, is not sufficient in itself to improve the health of the poor because **the major determinants of their health depend on actions that lie outside the health sector**. Implementing effective pro-poor growth policies as outlined in the *DAC Guidelines on Poverty Reduction* is crucial. Without measures to address income poverty, poor people will not be able to afford food or health services. Without growth in revenues, governments will not increase their financing of health services. In addition, sectoral policies are critically important, especially education, food security, safe water, sanitation and energy. The health of the poor can also be improved by reducing their exposure to the risk of violence, road traffic injuries, addiction to tobacco, and the devastating impacts of conflict and natural disasters. Development agencies need to prioritise these areas, and assess the extent to which policies in key sectors undermine or promote health and broader poverty reduction objectives. This should result in efforts to strengthen capacity within those sectors for the delivery of health objectives.

11. Achievement of the three health-related MDGs, for instance, all hinge strongly on **reaching the education goals** of gender equality and universal primary school enrolment. Female education, in

particular, is strongly linked to improved health care for children, families and communities, and to lower fertility rates. Education is also one of the most effective preventive weapons against HIV/AIDS. Conversely, health is a major determinant of educational attainment having a direct impact on cognitive abilities and school attendance. Policy makers and agency staff in the two sectors, therefore, have a mutual interest in identifying strategies for collaboration both within the formal school system and through non-formal education.

12. **Food security and nutrition are critical factors influencing the health of the poor.** Nearly 800 million people in developing countries remain chronically hungry. Under-nutrition affects the immune system increasing the incidence and severity of diseases and is an associated factor in over one half of child mortality. Development agencies should support interventions that focus on improving food security through increased incomes and social services, as well as targeted maternal and child nutrition programmes.

13. **Poor people's health is also strongly affected by exposure to environmental threats**. Poor people often live in low quality urban settlements, remote villages or on marginal land with limited access to safe water and sanitation, and exposure to indoor as well as outdoor air pollution. These environmental conditions are the largest single cause of human sickness and death among poor people. The importance of these key links needs to be affirmed and integrated into development policies.

IV. Working through country-led strategic frameworks

14. The commitment by both developed and developing countries to support the health-related MDGs, and to work through country-led and owned programmes means that partners should engage in a long-term relationship to achieve sustainable health improvements that benefit the poor. Such co-operation needs to take place within commonly agreed overarching frameworks that set priorities for policies and programmes.

15. The **Poverty Reduction Strategy** (PRS) developed and owned by the partner country should be the key such framework to formulate the broad lines of a pro-poor health strategy. It should demonstrate a clear understanding of the causal links between better health and poverty reduction, and include explicit health objectives in key sectors that influence the health outcomes of the poor. In this way, the PRS has the unique potential to evolve into a framework that encourages links between health and other sector policies in order to promote pro-poor health objectives. The PRS, however, has limited space for detailed sectoral analysis. It should be supplemented by a more detailed health sector programme.

16. A **health sector programme** is essential for negotiating, co-ordinating and supporting priorities within the health sector, and, particularly for engaging in a dialogue on the policies and interventions likely to improve the health of the poor. It also provides a national framework for channelling external support in which a range of development co-operation instruments can be deployed (e.g. sector and budget support, technical co-operation, projects, funds from global initiatives and debt relief). Many health sector programmes still need a more explicit emphasis on pro-poor objectives. To do so, they should tighten links with the PRS, rely on poverty and gender analysis, emphasise policies and services that most affect the poor, encompass the private sector and civil society, integrate support from global health initiatives, and include substantial decentralisation.

17. There is broad agreement about the need for development assistance to fit within and support government-led health sector programme. This can be done with a variety of instruments, ranging from small technical assistance projects for capacity building, through large projects, to sector-wide financing that combines projects, fungible funding (SWAps), and overall budget support. Each instrument has

advantages and disadvantages depending on the country situation. The issue that is currently under debate is primarily one of balance, overall and for each development agency. **Sector wide approaches (SWAps)** in health merit special attention because they aim specifically to strengthen agency co-ordination. In SWAps, external partners buy into the government-led health programme and help support its development through common procedures for management, implementation and, to a large extent, funding. Many SWAps combine both basket funding and earmarked projects. Where SWAps are appropriate, they can help to promote greater ownership, accountability and capacity in partner countries. They also help reduce the administrative burden of dealing with multiple donor procedures and missions. The decision to engage in a SWAp, however, must result from a careful appraisal of policy and institutional conditions within the partner country. This kind of partnership is premised on creating an atmosphere of mutual trust, reducing attribution to single donors, and accepting joint accountability and higher levels of financial and institutional risk.

18. As part of their efforts to implement poverty reduction strategies and health sector programmes, partner countries need to **measure health system performance and health outcomes and the extent to which they are pro-poor**. Development agencies should give priority to strengthening national statistical and monitoring systems, which are often weak and inadequate to measure progress towards health and poverty reduction objectives.

V. Promoting policy coherence and global public goods

19. The health problems of the poor do not stop at national borders. A globalised world presents new risks to health as indicated by the rapid spread of HIV/AIDS or the threat of bio-terrorism. At the same time, it provides opportunities to prevent, treat or contain disease. Development agencies and partner countries must strengthen ways of working together at the global level.

20. One way is to **promote the development of Global Public Goods for health** (GPGs), which will benefit people in every country, but particularly those in low-income countries. This includes such actions as medical research and development focused on diseases that most affect the poor, as well as efforts to stem cross-border spread of communicable disease. The WHO has estimated that well under 10 percent of pharmaceutical research is for the health problems that primarily affect low-income countries. . Development agencies have a key role to play in promoting international initiatives that seek to produce new drugs, vaccines, and knowledge focussed on the health problems of the poor. They can provide critical financial resources and help in catalysing support within their own countries. Examples include more emphasis on diseases of poor countries in the health research budgets of OECD countries, partnerships with the private sector and civil society to raise funds, expertise for research on these diseases, and consideration of extension of OECD countries' "orphan drug" incentives to such diseases.

21. In addition, **trade in goods and services and multilateral trade agreements have increasing influence on the health of the poor**. Of special significance are those agreements dealing with trade-related intellectual property rights (TRIPS), trade in health services (GATS), and trade in hazardous substances. Development agencies could assist in assessing the impact of the Doha Declaration on access to patented medicines in developing countries and support initiatives that produce "tiered" pricing - with much lower prices for poor countries. They should also seek coherence in OECD country policies for global health and poverty reduction by engaging in discussions on relevant issues with government departments responsible for trade and health.

PART ONE

INVESTING IN HEALTH TO REDUCE POVERTY

1. Health is now higher on the international agenda than ever before, and concern for the health of poor people is becoming a central development issue. The Millennium Development Goals (MDGs), derived from the UN Millennium Declaration, commit countries to halving extreme income poverty and to achieving specific health improvements by 2015. Three of the eight goals are health-related, calling for a two-thirds reduction in child mortality, a three-quarters reduction in maternal deaths, and a halt to the spread of HIV/AIDS, malaria, and tuberculosis. In addition, the eighth goal calls for developing countries to have access to affordable essential drugs. Whilst each goal, in itself, contributes to the overall aim of poverty reduction, an essential message is that they are interdependent.

1.1. POVERTY AND HEALTH

2. First and foremost, **health is a human right, central to individual well being and to overall human development.** Health is a crucially important asset of poor people, one that is key to their livelihood. From this perspective, promoting, protecting and improving the health of the poor are central to the entire process of poverty reduction and human development. When a poor person becomes ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. The cascading effects may include diverting time from income generation or from schooling to care for the sick, and the forced sale of assets required for livelihoods. Poor people are more vulnerable to this downward spiral as their incidence of disease is much higher, and their access to health care and social insurance much lower.

3. The *DAC Guidelines on Poverty Reduction* present a practical definition of poverty, placing it in a broader framework of causes and appropriate policy actions. The five core dimensions of poverty basically reflect the deprivation of human capabilities: economic (income, livelihoods, decent work), human (health, education), political (empowerment, rights voice), socio-cultural (status, dignity) and protective (insecurity, risk, vulnerability). Mainstreaming gender and protecting the environment are essential for reducing poverty in all these dimensions. The DAC Guidelines emphasise that the social categories known for severe poverty are indigenous, minority and socially excluded groups, refugees or displaced persons, the mentally or physically disabled and people living with HIV/AIDS. Women and children are especially vulnerable, for example elderly widows and unsupported female- and child-headed households, and street children. These groups are among the poorest of the poor in many societies and require special attention in policy action for poverty reduction

1.2. THE ECONOMIC RATIONALE FOR INVESTING IN THE HEALTH OF THE POOR

4. Investment in health is also increasingly recognised as an important – and previously under-estimated - **means of economic development**. As the Commission on Macroeconomics and Health (CMH) has shown, substantially improved health outcomes are a pre-requisite for developing countries to break out of the cycle of poverty. Good health contributes to development through a number of pathways, which are partly overlapping but in each case add to the total impact:

- ***Higher labour productivity*.** Healthier workers are physically and mentally more productive, earn higher wages, and miss fewer days of work than those who are ill. This reduces turnover in the workforce, increases enterprise profitability and agricultural production.
- ***Higher rates of domestic and foreign investment***. Increased labour productivity in turn creates incentives for investment. In addition, controlling endemic and epidemic disease, such as HIV/AIDS, is likely to encourage greater foreign investment.
- ***Improved human capital***. Healthy children have greater cognitive potential. As health improves, rates of absenteeism and early school dropouts fall, leading to growth in the human capital base.
- ***Higher rates of national savings***. People who live longer save for retirement. These savings in turn provide funds for capital investment.
- ***Demographic changes*.** Improvements in both health and education contribute to lower rates of fertility and mortality and a reduced dependency ratio.

5. In addition to their positive macroeconomic impact, health improvements have inter-generational spill-over effects that are clearly shown at the microeconomic or household level. As infant and child mortality rates fall, parents no longer need to compensate for frequent loss of children through high fertility. Young people who escape the cognitive and physical consequences of childhood diseases are less likely to suffer disability and impairment in later life. They are therefore less likely to face catastrophic medical expenses and are more likely to maximise their earning potential. As healthy adults, they have more resources to invest in the care, health and education of their own children.

1.3. DEFINING A PRO-POOR HEALTH APPROACH

6. The multiple impact of health investment is mirrored by a growing consensus on the need for a broad approach to improve the health of the poor. The technical knowledge exists to address the main causes of ill-health, but the poor continue to carry a disproportionate burden of disease. If the health of poor people is to improve, the following key elements of a pro-poor approach must be in place, and priorities for development co-operation identified in this context.

What is a pro-poor health approach?

A pro-poor health approach is one that gives priority to promoting, protecting, and improving the health of the poor. It includes the provision of appropriate, quality health services, with equitable financing mechanisms. It goes beyond the health sector to encompass policies in areas that disproportionately affect the health of the poor such as education, nutrition, water, and sanitation. Finally, it is concerned with global action on the effects of trade in health services, intellectual property rights, and the funding of medical research as they impact on poverty reduction in developing countries.

7. **A pro-poor health approach builds on the following four pillars.**

- **Health services** comprise the promotive, preventive, curative, and rehabilitative services delivered by health personnel, and their support structures (e.g. drug procurement systems, cold chains). They include both public and private sector services (for profit and not-for-profit), formal and informal as well as traditional services, and home/family based care. The availability of services in many developing countries is fragmented and unsystematic, and their effectiveness variable, with the result that millions of the world's poor do not have access to health services. Improving quality and accessibility requires tackling gender, ethnic, socio-economic and other biases in service delivery, reaching vulnerable groups and groups with special needs.
- **Health financing systems** and broader social protection strategies are necessary to protect the poor from the impoverishing costs of health care. This requires increasing risk pooling, cross subsidy, and protection against health shocks in the context of a comprehensive review of the social protection needs of the poor. Health financing mechanisms are a function of the overall level of resources available for health.
- **Key policy areas beyond the health sector.** The health of poor people, in particular, is determined by a wide range of factors including income, education level, food security, environmental conditions, and access to water and sanitation. Economic, trade, and fiscal policies are also significant determinants of household incomes and nutritional status. They have an impact on inequality and exclusion, whether by gender, ethnicity, or socio-economic groups, and these in turn have a major impact on health status. It is, therefore, necessary to assess the health impact of policies and activities whose primary purpose is not health but which may have secondary and significant effects on health, positive or negative. Action will be needed to optimise positive impacts and eliminate or reduce the negative. National Poverty Reduction Strategies provide an important framework to connect policies outside the health sector with pro-poor health objectives.
- **Promoting policy coherence and global public goods.** A globalised world presents new risks to health, as indicated by the rapid spread of HIV/AIDS or the threat of bio-terrorism. At the same time, it provides opportunities to prevent, treat, or contain diseases. International action such as provision of global public goods, multilateral agreements on trade, investment, and environmental conventions need to complement other pro-poor health strategies.

8. The ways that development agencies can support a pro-poor health approach will be determined by the specific context of each partner country. Recommendations need to be set against a contextual assessment of the country concerned. Low and middle-income countries are experiencing different kinds of transition and starting from different levels of technical and human capital. A range of economic, political and social factors will have a major influence on what can be achieved and what kinds of interventions are appropriate.

1.4. MOBILISING RESOURCES FOR PRO-POOR HEALTH

9. Scaling-up financial resources for health should be a priority for partner countries committed to reducing poverty. As stated earlier, improving the health of the poor is an investment in economic growth and development. While it is true that improvements in efficiency and effectiveness of health spending are possible and necessary, lack of resources remains the most pressing constraint faced by poor countries. Without money to buy vaccines and drugs, to build and equip facilities, to staff adequately, and to manage the health system, governments in low- and middle-income countries will be unable to make progress in improving the health of the poor. Despite debate over levels, there is a consensus that substantially increased resources for health are required.

10. These resources should come from a combination of public, private, domestic and external sources, including ODA and global health initiatives. Some increases in government spending for health are possible in most partner countries through budget reallocations, efficiency savings and use of funds released from debt relief. However, in many cases the resources released through such means will be limited. **The poorest countries will remain unable to provide sufficient resources to meet pro-poor health objectives without significantly increased external financing.**

11. Development agencies are more likely to mobilise resources in support of pro-poor health objectives where: (i) there is a clear political will on the part of the partner country to articulate and implement a poverty reduction strategy and a closely-linked health sector programme; (ii) serious efforts are being made to mobilise domestic resources; (iii) there is commitment to manage resources more effectively; and (iv) major civil society stakeholders have an opportunity to participate in the planning, management and delivery of interventions.

1.5. IMPROVING THE EFFECTIVENESS OF DEVELOPMENT CO-OPERATION

12. Increasing resources for pro-poor health requires particular attention to overcoming constraints that limit the effectiveness of development co-operation. This includes a special emphasis on:

- **Capacity building and broader governance concerns.** Support for effective national health systems is critical to shift greater responsibility on partner countries to design, manage and implement their health policies and programmes. Capacity building should go well beyond the health sector. It requires viewing pro-poor health approaches in a larger context of political and economic restructuring, fiscal policy, administrative reform and strengthening of participation and democratic systems. ODA should play a catalytic role in all these areas if investments in health and poverty reduction are to be sustainable.
- **Policy dialogue** is an integral element of development co-operation that does not involve direct transfer of resources. Yet, it is essential to forge stronger partnerships around shared objectives and to elevate pro-poor health objectives on top of the political agenda. Since improving health outcomes require a multi-sectoral approach, policy dialogue must be extended to involve other ministries (dealing with water, sanitation, nutrition, transport and energy) taking into account the macroeconomic and cross-sectoral implications of pro-poor health objectives.

- **Local co-ordination** is essential in order to mobilise and concentrate resources on the MDGs and pro-poor health objectives. Co-ordination of external partners led by government magnifies the effectiveness of development co-operation programmes by encouraging development agencies to reinforce and complement their programmes in support of the objectives specified in the poverty reduction strategy and the health sector plan.
- **Programme support** is increasingly recognised as being effective in addressing sector-wide issues and to implement comprehensive inter-sectoral plans such as those required for pro-poor health. The harmonisation of donor procedures in this regard is critical in order to economise on scarce resources, lower transaction costs, and substantially reduce the burden on partner countries of having to comply with multiple and differing requirements.
- **Monitoring and evaluation.** In order to secure development agency long-term commitment and mobilise additional resources, special emphasis needs to be given to monitoring health system performance and health outcomes and the extent to which they are pro-poor.

PART TWO

PRO-POOR HEALTH SYSTEMS

2.1. INTRODUCTION

13. This part of the Guidelines focuses on how development agencies can support partner countries' efforts to promote pro-poor health objectives through the development of health systems that improve access to quality health services for poor men and women. Support for partner countries can be provided in four, complementary ways. Firstly, by strengthening government capacity in health policy and strategic management including strong stewardship and regulatory functions. Secondly, by strengthening the poverty focus of health service delivery, focussing on the needs and demands of the most vulnerable while increasing their participation. Thirdly, by helping countries manage a pluralist health system including the public sector, private-for-profit sector, and private not-for-profit sector, which all have roles in improving access and quality. Finally, by supporting a move towards more equitable health financing mechanisms based on prepayment and risk pooling.

14. Health services comprise promotion, prevention, curative, and rehabilitation services delivered by health workers and their support structures (e.g. drug procurement systems, cold chains). They include both public and private sector services (for profit and not-for-profit), formal and informal services, as well as traditional services, and home/family based care. The availability of these services in many countries is fragmented and unsystematic, and their effectiveness is limited and very variable, with the result that millions of the world's poor do not have access to the services they need. **Ensuring that people have access to effective and affordable health services is a key social protection measure that is essential in preventing the spiral from ill health to poverty.**

2.2. HEALTH SECTOR POLICY AND STRATEGIC MANAGEMENT

15. Development agencies are working closely with developing country governments to build strong partnerships for pro-poor health based on trust, mutual accountability, and a shared commitment to health objectives. The basis for good partnerships, which have the interests of the poor at the centre, have been set out in the *DAC Guidelines on Poverty Reduction* and include genuine dialogue and an emphasis on a more strategic approach to aid allocations, working through country owned poverty reduction strategies.

16. But developing country governments and specifically ministries of health carry the key responsibility for the performance of the health sector and the extent to which it meets pro-poor objectives. Beyond this, Ministries of Health need to take concerted action to ensure that the importance of health is recognised across government as being central to achieving poverty reduction and broader development objectives, and that this is reflected in poverty reduction strategies (see Part Four).

17. In many countries, the role of government in relation to health is changing and governments are redefining their role *vis-à-vis* the sector as a whole, focussing on core functions of policy maker, regulator, steward, purchaser, as well as service provider. Many health sector plans are taking reorganisation and redefinition of central line ministry functions as an early issue to be addressed (see Part Four). **The public sector core functions in health are briefly defined below.**

- **Policy Maker** - providing the vision and strategy for the health sector including priority setting, budget allocation, and expenditure tracking.
- **Regulator and Steward** – making the rules to implement the strategy and steering, supervising, and managing implementation of the overall strategy.
- **Purchaser** - making and monitoring contracts and agreements.
- **Service Provider** - providing specific services.

18. The effectiveness of these functions depends on the context in which they are performed and a range of factors such as per capita income; levels of poverty and degrees of inequality, the extent of political legitimacy, and instability due to conflict will have a major influence (see Part One for a more detailed discussion of important contextual factors). More specifically, the overall capacity of ministries of health, and the extent of consultation, collaboration, and co-ordination with the other parts of government such as ministries of planning and finance and those in charge of civil service reform, funding, and management are critical determinants. Finally, the extent to which the principles of good governance - transparency, accountability, participation, rule of law, and equity - guide the execution of these functions is key.

19. In many developing countries capacity to execute these multiple functions is limited and governance weak. Development agencies can support strategies to both increase capacity and improve governance across all five functions. Strategic management strengthening that has yielded positive results consists of training, the creation of an open environment for change, and improvements in communication among staff and between organisations or services.[2] In the most highly constrained countries with deficient government, weak rule of law, corruption, or previous or ongoing conflict, the ability to perform any of these functions will be severely limited. Special strategies are required to ensure that the urgent health needs of the poor are addressed (see Section 2.3), but measures to strengthen and develop ministry of health capacity, particularly lower level and decentralised management capacity, through education, training, and management strengthening, should not be neglected.

20. The formulation of **pro-poor health policy and strategies** should be carried out in consultation with a broad range of stakeholders across government, international partners and civil society, including the poor themselves. Health strategies should have an explicit focus on pro-poor health objectives, and include targets and indicators for measuring performance (see Part Four). They should clarify the role for all health service providers including the private-not-for-profit and private-for-profit sectors, and set out an equitable health financing strategy. In those countries with significant external assistance through a health sector programme or budget support, consultation and dialogue during policy design is important.

21. Chronic under-funding is a key constraint faced by the health sector in low-income countries. However, regardless of the level of funding available, an efficient allocation of funds will enable the health

2. For example, Ghana successfully decentralised health service management through the strengthening of district management systems and re-structuring of the Ministry of Health. The creation of a strong cadre of public health doctor/managers at all levels was an important element in this process, as were long term external funding and technical advice.

system to function at its best. Improving expenditure tracking and reducing leakage out of the system through the use of tools such as national health accounts and public expenditure tracking surveys should be a priority of government (see Part Four).

22. The **regulatory role** of governments is generally weak in relation to both design (many activities without an appropriate structure of regulation and policy) and implementation (regulations not enforced). However, regulation is a crucial function of government with the potential to improve overall governance and service delivery - in both the public and private sectors - while protecting the poor from high official and unofficial health care costs. By developing partnerships with the private health sector and using appropriate regulation, governments can enhance the contribution of the private sector to meeting pro-poor health objectives. This includes recognising the extent of utilisation of private sector services by the poor, particularly the informal private sector, while ensuring that private provision complements public provision, respects government priorities, and operates within legal and financial frameworks. This requires effective links with parts of the government responsible for such issues as company laws, financing, and taxation. Despite its importance, prescribing regulation in the absence of capacity to regulate will not move health systems forward. Development agencies need to focus on short term strategies for the health sector (see Section 2.4), while looking at longer term strategies to improve overall regulatory capacity across government.

23. Regulation needs to go hand in hand with **stewardship** - ensuring that there are clear systems to support, communicate and manage relationships, whether between public and private groups or central, regional or district level authorities. There also need to be clear and acceptable incentives and sanctions in place to facilitate compliance with policies whether budgets, contracts, or employment practices.

24. Debate exists about the extent to which the delivery of health services should be an exclusively government responsibility in developing countries. Regardless of the position taken, the reality of extensive private sector utilisation by the poor and limited capacity to expand government services has led to a greater focus on how ensure public priorities are met regardless of who delivers the services. This means increased attention to the government role as regulator and steward as discussed above, but also as purchaser. **Purchasing** is the process by which funds are paid to providers to deliver a specified or unspecified set of health interventions. Recently an active purchasing role has started to be introduced into several public health systems (see Section 2.4).[3] Purchasing services from the private sector, particularly from NGOs and faith based service providers, can improve the delivery of services to poor and vulnerable groups that are currently underserved as long as there are pro-poor benchmarks in contracts and monitoring.

25. As **service provider**, governments face considerable challenges in meeting pro-poor health objectives. The following sections addresses the priority health service needs of poor people, and how to best reach vulnerable groups. In addition, more complex issues such as improving drug supply, procurement, and logistics; upgrading national and local management information systems; and using quality assurance methods to facilitate improved service quality, have remained unresolved and warrant greater support for improved managerial and technical capacity.

26. Service provision is dependent on the availability and quality of human resources. Partner countries typically face a shortage of key health professionals, unsupervised personnel (including ghost workers), high attrition rates, low government salaries supplemented by informal cash payments, and sometimes conflicts of interest between private and public sector employment. A major part of the workforce is ill equipped and ill supported to meet the health challenge that lies before them. Health ministries face many obstacles to effective human resource policy including inflexible civil service policy,

3. WHO (2000) The World Health Report 2000. Health Systems: Improving Performance WHO: Geneva

limited autonomy and budget for the health sector to train and allocate staff, loss of staff to higher paid jobs overseas or in the private sector, and the impact of premature death due to HIV/AIDS. Improved human resource policies need to be integrated into health sector and wider civil service reforms.

27. Development agencies can support appropriate human resource strategies that address personnel requirements and skill mix, the structuring of pay and non-pay incentives, as well as broader issues of civil service reform. Strategies to improve job opportunities, pay and conditions are particularly important to attract health workers, especially women, to remote, under-served areas where the majority of poor people live and where the quantity and quality of services available is inadequate.[4] Improved and expanded use of information and communications technology (ICT) in training and education programmes for health service personnel would help address problems such as weak health worker training, limited continuing education, and lack of access to up to date information and techniques. In addition, it could reduce the heavy burden of data collection at health facilities[5].

28. The following table lists the range of challenges facing the health sector and highlights the extent of the task for governments and development agencies if health systems are to be improved and become pro-poor. Some of these challenges are discussed in detail in the following sections.

4. In Mali, for instance, communities were successfully given the right to hire health workers on their own and to negotiate conditions, which at the same time reinforced accountability of health workers *vis-à-vis* the local population.

5. Improving information and communication networks (through ICT) can create powerful social and economic networks and have a role to play in improving health systems. See Action Point 7 – ICT for health care, G8 Genoa plan of action.

Table 1. Health sector challenges

Level	Challenges
Context and environment	**Governance and overall policy framework** Corruption, weak government, weak rule of law and enforceability of contracts Political instability and insecurity Low priority attached to social sectors Weak structure for public accountability Lack of free press Insufficient resources for regulation and stewardship **Physical environment** Climatic and geographic predisposition to disease Physical environment unfavourable to service delivery
Public policies cutting across sectors	Weak government bureaucracy Poor availability of communication and transport infrastructure
Health sector policy and strategic management	Weak, overly centralised systems for planning and management Slow progress in public sector reform hampering better human resource planning Weak drug policies, supply and distribution systems An increasingly unregulated market in health care provision with blurred boundaries between public and private sectors Inadequate regulation of pharmaceuticals and improper industry practices Shortage of skills in management, inspection (for stewardship) Lack of intersectoral action and partnership for health between government and civil society Weak incentives to use inputs efficiently and respond to user needs and preferences Reliance on donor funding which reduces flexibility and ownership Rapidly changing donor practices which damage country policies
Health service delivery	Shortage and maldistribution of appropriately qualified staff Poor quality of technical and interpersonal skills in many facilities and weak quality control Weak technical guidance, programme management and supervision Inadequate supplies of drugs and medical supplies Fragmented supply agreements on certain drugs (e.g. for HIV/AIDS) Inefficient referral systems Lack of equipment and infrastructure (including laboratories and communications) Poor accessibility of health services
Community and household	Demand side barriers, such as physical inaccessibility, mistrust of service providers, formal and informal payments, gender biases in household resource allocation preventing women and girls from accessing services Limited community consultation and community management of health services

Source: Adapted from *Hanson et al*., 2001.

2.3. STRENGTHENING THE DELIVERY OF HEALTH SERVICES

2.3.1. Addressing the priority health needs of the poor

29. In low-income countries - and among the poor in middle income countries - **communicable diseases** particularly those associated with a poor environment, maternal, perinatal, and nutritional conditions account for the majority of ill health. Acute respiratory infection, diarrhoea, malaria and measles are responsible for most of childhood mortality and morbidity. Malaria causes the deaths of one million people each year and TB some two million. HIV/AIDS is an increasing cause of premature death across sub-Saharan Africa and Asia (see Box 1).

30. **Non-communicable diseases** such as diabetes, cardiovascular disease, respiratory problems caused by air pollution, and injuries from road traffic accidents (see Part Three) also have a significant impact on the health of poor populations.[6] Tobacco related diseases are strongly related to poverty and will cause an estimated with seven million deaths annually by 2030 in developing countries, 50 per cent of these in Asia (see Box 2).[7] As more developing countries complete the demographic transition, non-communicable diseases will increase in importance with many countries suffering the double burden of high rates of both communicable and non-communicable diseases.

Box 1: The Impact of HIV/AIDS

HIV/AIDS now threatens previous achievements in health, having already caused 22 million deaths worldwide. Forty million people are currently infected with the virus, 28.5 million of these in sub-Saharan Africa, and most are likely to die prematurely from AIDS related conditions. HIV/AIDS usually affects adults in their prime income generating or childbearing years. While poverty and gender inequality makes people more vulnerable to infection, HIV/AIDS has an impoverishing impact on households, can drive the near poor into poverty, and be devastating for the poorest groups.[8]

The types of health sector interventions that will reduce the spread and impact of HIV are well known but need significant expansion to reach those most vulnerable. Improved diagnosis and treatment of sexually transmitted diseases, voluntary counselling and testing, access to treatment for opportunistic infections, interventions to reduce mother to child transmission, access to condoms, and improved home based care and counselling are among the priorities. However, actions outside the health sector are also crucial and involve ministries of finance, education, agriculture, youth, and planning among others. HIV/AIDS prevention should feature prominently in poverty reduction strategies (see Part Four).

Box 2: Tobacco, Poverty and Health

Tobacco use is increasingly a leading preventable cause of death and disability amongst adults. Approximately four million people worldwide die each year as a result of tobacco-related illnesses and 900 million smokers live in developing countries, accounting for 70 per cent of global tobacco consumption. Tobacco use has a profound effect on poverty and malnutrition in low-income countries as poor families purchase addictive tobacco rather than food. There are grave poverty implications of high prevalence of tobacco use among men with low education and low incomes, that raises substantially their risks of serious diseases and premature death.

Policies and interventions to help smokers quit, and to discourage others from starting, are an important part of national and international efforts to improve the health and well being of poor people. Development agencies should use policy dialogue and technical and financial co-operation to support policy change, the most important being raising taxes on tobacco[9], bans on cigarette advertising and promotion, increased access to nicotine replacement therapies, and restrictions on exposure to second hand smoke. The first international treaty to address a health issue, the Framework Convention on Tobacco Control (FCTC), is currently being developed by WHO and could be ready for signature by 2003 (see Section 5.3.3).

6. Murray, C.J.L. and Lopez, A.D. (eds.) (1996), *Global Health Statistics* (Global Burden of Disease and Injury Series, Volume II), Cambridge, Massachusetts.

7. World Health Organisation (1997), *Tobacco or Health: A global status report*, WHO, Geneva.

8. A study of Burkina Faso, Rwanda, and Uganda calculated that AIDS will increase the percentage of people living in extreme poverty from 45 per cent in 2000 to 51 per cent in 2015, UNAIDS Fact Sheet, 2002.

9. Studies show that for every 10 per cent increase in prices via increased taxation, tobacco consumption goes down by about 5-8 per cent with poorer countries and people, at the upper end of that range. Tobacco smuggling reduces this impact, but only somewhat. (WG 5 Paper).

31. **Poor maternal health, sexually transmitted diseases, and limited access to family planning services** lead to a significant burden of ill health among poor women. On average, one woman dies every minute from pregnancy or childbirth. Maternal mortality, like child mortality, provides a telling proxy for the effects of poverty, gender inequality, and lack of accessible health services.[10] More than 99 per cent of the estimated 585 000 deaths annually from pregnancy and childbirth causes occur in developing countries[11].

32. The fundamental importance of **improved reproductive health** to the poverty reduction agenda makes it worthy of special mention. In the post Cairo vision, reproductive health is a major cross cutting issue integrating a comprehensive range of services and programmes, including HIV/AIDS and strategies for women's empowerment. Access to good quality, sensitively delivered and comprehensive family planning in the context of primary health care is also essential to women's and men's capacities to plan their livelihoods. Although, reproductive health was prominent in the DAC International Development Goals (IDGs) it was not retained as a target in the MDGs. This is a cause of concern to many agencies prioritising reproductive health. However, the MDGs do target a reduction by three-quarters in the maternal mortality ratio by 2015. Development agencies have paid insufficient attention to date to reducing maternal mortality and need to consider how to support measures to increase access to professionally supervised childbirth and emergency obstetric care at the secondary level.

33. Effective interventions exist that can have a major impact on the diseases and conditions outlined above. Health services should not be limited on the basis of these diseases, but **expanded and effective programmes focusing on the priority health needs of poor people could significantly improve their health.** The determination of national or local disease patterns through epidemiological surveys to facilitate priority setting can be supported by development agencies. In addition, agencies can support priority setting that takes into account the perspectives of poor people and are closely linked to actions that address their problems. For example, by involving local managers in survey design and analysis, and the development and monitoring of subsequent action plans. This is essential if programmes are to be well implemented and if communities are to be involved in holding health services accountable (see Section 2.3.3).

34. Delivering effective interventions in most cases requires strengthening health systems (see Section 2.2). Managing HIV/AIDS and reducing maternal mortality are major challenges and success depends particularly on the effectiveness of health systems including improved referral systems. Indeed, strengthening health services to reduce maternal mortality would ensure they are also capable of addressing a range of other health priorities[12].

35. Certain developing countries face more severe constraints to the delivery of effective health interventions than others, often in the face of greater need. Highly constrained countries such as Chad and Cambodia[13] have child and maternal mortality rates almost double those in other low-income countries, yet they have only one third of the number of nurses per capita and double the proportion of the population

10. Maternal mortality is generally defined as death while pregnant or within 42 days of termination of pregnancy from any cause related to, or aggravated by, the pregnancy or its management.

11. Gelband, H. *et. al.* (n.d.), "The Evidence Base for Interventions to Reduce Maternal and Neonatal Mortality in Low and Middle-Income Countries", *Commission on Macroeconomics and Health Working Paper Series, WG5.*

12. WHO, "Improving Health Outcomes of the Poor", *Commission on Macroeconomics and Health Working Paper Series, WG5*, WHO, Geneva.

13. These countries are highly constrained according to the list of constraints given in Table 1

living in poverty.[14] In such countries, a limited set of programmes or activities may best be delivered in the shorter term through selective use of vertical programmes. The advantages of vertical programmes under such circumstances are that they can provide specific technical and financial support targeted against priority diseases such as malaria and tuberculosis that can be more easily controlled and monitored. These programmes can be implemented in partnership with local NGOs who may have greater capacity to deliver general health services and targeted programmes than poorly functioning government systems (see Section 2.4). Recent attempts to control HIV/AIDS in Cambodia show that action is possible. However, alongside vertical programmes and NGO services, medium and longer-term measures to strengthen and develop general health systems are essential.

36. A number of Global Health Initiatives (GHIs) such as the Expanded Programme on Immunisation and Roll Back Malaria have targeted some of the diseases outlined above. Such programmes have contributed to reductions in disease rates but evidence on their longer-term impact is less clear. These GHIs have the potential to make a significant contribution if they take a longer-term view, place a greater emphasis on sustainability, and contribute to the building of national systems. GHIs such as Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to Fight AIDS, TB, and Malaria, have generated some additional resources from the private sector for targeted programmes, but this raises issues for prioritisation, co-ordination, and pooled financing (see Part Four).[15]

2.3.2. Reaching highly vulnerable groups

37. Improving service delivery by strengthening health systems and expanding programmes focused on the priority health needs of poor people should improve health outcomes. However, very vulnerable groups of poor people may need dedicated strategies to ensure they are reached. Identifying these groups is not possible through income based definitions of poverty, which rarely capture its complexity, or the way that people can move in and out of poverty or become vulnerable to the impoverishing impact of ill health. Data from household surveys, national indicators, poverty profiles, and participatory poverty assessments (PPAs) can provide a more comprehensive picture. The most vulnerable are likely to include the very poor (i.e. the poorest quintile of the population), indigenous people, migrants, adolescents, refugees, and socially excluded groups such as slum-dwellers.

38. These vulnerable groups are often effectively excluded from mainstream services for cultural, administrative, and/or geographical reasons. Moreover, there is substantial evidence that highly vulnerable groups are not given priority by health workers, and may be discouraged from attending for care. The accessibility of services may be improved by specially designed services, including outreach services that consider differences of age, gender, and ethnicity during policy design and implementation. Health worker training programmes, which emphasise improving responsiveness (as demonstrated in the health worker for change studies), as well as addressing pay and non-pay incentives for health staff (see Section 2.2) can also improve accessibility.[16]

39. In some countries an urban bias in health service delivery has left remote rural populations with limited access to public health and personal health services. Although poverty is not always geographically concentrated, poverty profiles can be used to facilitate the spatial targeting of vulnerable villages and communities through expanded service coverage, or the allocation of subsidies to non-government

14. WHO, o*p. cit.*, pp. 73-4.

15. The GFATM has received pledges totalling USD 2.1 billion, of which just under 5 per cent has been pledged by private donors.

16. Vlassoff, C. (ed.) (2001), "Health Workers for Change, A Quality of Care Intervention", *Health Policy and Planning*, No. 16 (Supplement No. 1).

providers to deliver services. Maintaining political support for pro-poor budget allocations can be difficult. However, if the general allocation of resources to the primary level appears to be less politically sensitive, this may achieve more equitable distribution than allocating by poverty profiles to the state or district level[17].

40. Refugees and the internally displaced are highly vulnerable to disease and ill health. In times of conflict infant mortality increases, preventable diseases such as measles become endemic, and the spread of HIV/AIDS is exacerbated. The vulnerability of women and young girls substantially rises as economic and social structures weaken, and violence and sexual abuse increase. As a result of violent conflict, there were 23 million refugees in 1997 and there are some 30 million internally displaced people at any one time.[18] These people lack access to their usual sources of health care, while the services of host countries are overwhelmed. Getting services to these groups is a priority and humanitarian organisations such as the UNHCR, ICRC, and NGOs are often best placed to deliver services in such contexts. However, care must be taken not to set up parallel systems. Consistent with WHO recommendations, development agencies should support the early identification of those most vulnerable, the strengthening of health systems, and the strict co-ordination of activities. "Days of Tranquillity", where fighting is suspended to enable the immunisation of children, have been negotiated during a number of conflicts, and have had a significant effect on the incidence of diseases such as measles and poliomyelitis.[19]

41. Evidence suggests that careful identification and targeting of the needs of these disadvantaged groups benefits the poor. However, it is also important to ensure that services and targeted programmes are of sufficient quality to be attractive to poorer groups or they will simply be underutilised (see Section 2.3.3).

2.3.3. Increasing demand and participation at community and household level

42. In many countries health service utilisation particularly in the formal public sector is low. Poor people increasingly turn to private providers for their health care. Whilst cost plays a major role in the decisions of poor people to withdraw from the public sector, there are other important reasons.[20]

- **Lack of physical access and inconvenient opening hours.** Particularly in sub-Saharan Africa, poor people especially women, mention long distances to facilities more often than problems of cost or quality.
- **Hidden costs of seeking treatment.** These include the opportunity costs of men and women's time spent in travel, waiting for treatment, and buying medicines as well as the costs of transport, drugs (supposedly free but often not available) and informal payments demanded by health workers and other staff. These are disincentives to going for treatment and "is aggravated by discrimination in favour of those of higher status and those who could pay bribes."[21]
- **Inadequate or broken equipment and dirty facilities.** The crisis in public sector health expenditure and routine underfunding of primary services has exacerbated this problem in many countries.

17. Ref?

18. WHR (2002), World *Report on Violence and Health*, WHO, Geneva.

19. WHO (2002), *World Report on Violence and Health*, WHO, Geneva.

20. Narayan, D. *et al*. (2000). *Voices of the poor crying out for change*, World Bank, Washington. Milimo, J., Shilito, T. and Brock, K. "Who would ever listen to the poor?", *Findings from participatory research on poverty in Zambia in the 1990s*.

21. Narayan, D. *ibid.*, pp. 101-2.

- **Absenteeism and lack of staff.** Doctors and other health workers are often absent from their posts.
- **The behaviour of medical and health staff.** Rude, disrespectful treatment of poor people is widespread and almost universally complained about. Public sector facilities are often singled out as particularly bad in this respect. For example, in Ethiopia government health centres and hospitals score very low on good staff attitude and behaviour. Staff of NGO and mission facilities are more frequently cited as providing better treatment.[22] Many studies of poor women's low utilisation of formal health services have emphasised the importance of respectful and sensitive treatment by providers.
- **Quality of services and availability of drugs.** For the poor, all of these problems combine into a general complaint about quality of care. For example, in Borg Meghezel, Egypt, people receive what is meant to be free medical care but villagers report "there isn't a single tablet in the clinic and the doctor has turned it into his private clinic."[23]

43. For all of the reasons stated above, health service utilisation is low and demand needs to be stimulated. Several strategies can be used, the most important of which is **to provide visibly effective quality interventions,** which leads to increased utilisation, and of itself stimulates demand. In the longer run, education of the poor, particularly of women, will help the poor to seek out health services and to campaign for improvements in coverage and quality. Increasing the client focus of health services with regard to improved responsiveness, confidentiality, quality, and availability of services is fundamental to increasing demand.

44. Demand may also be constrained by a lack of understanding about what is good and bad for health, as well as knowledge of where to access preventive and curative interventions. Greater use of strategies that improve the **availability and use of information in the community** is recommended including closely targeted information campaigns, especially those that involve the active participation of communities, and social marketing and social franchising programmes as described in Section 2.4.

45. Community health worker and health facilitator programmes, are – in some contexts – an effective vehicle for bringing more information on health promotion and services to households.[24] In turn, such programmes can channel information on the needs and demands of communities, especially the most vulnerable groups, back to local health services. The State of Andhra Pradesh in India has recorded some notable successes in using facilitators, usually women chosen by the community, in poor urban areas to raise awareness and act as a bridge between communities and facilities.

46. A greater emphasis also needs to be placed on **community participation**[25]. Although the health sector has been an area for pilot approaches in civil society participation for many years, poor people and communities typically have little voice in decisions about health service provision. In some countries, civil society has been too weak to address failures of government health provision, and health reforms have been decided without sufficient consultation with local stakeholders.

47. Partner governments and development co-operation agencies must work together to effect change. It is critical that the **voices of the poor**, particularly women, are given due attention both in the

22. Tolossa, A. & Lambert, R. (1997). *Participatory rural assessment of community perceptions of quality of health care services in East Haraghe, Ethiopia*, Save the Children Fund, London.

23. Narayan, D. *op cit.*, pp. 103-4.

24. Kahssay, Taylor, Berman (1998), *Community Health Workers: the way forward*, WHO, Geneva.

25. Oakley (1989), *Community Involvement in Health Development: an examination of the critical issues*, WHO, Geneva. Kahssay, Oakley (1999), *Community Involvement in Health Development: a review of the concept and practice*, WHO, Geneva.

targeting of resources, and in the design, content, and financing of pro-poor health services. Evidence shows that community participation and ownership of health services can contribute to increased utilisation rates, improved patient satisfaction and knowledge, and strengthened community capacities. Moreover, the active involvement of communities can be an effective tool for improving performance and strengthening links with health services at the peripheral level and can contribute to an overall improvement in governance, provided this involvement is not captured by elites to the detriment of poorer people's and particularly women's voices.

48. **The PRS process**, which emphasises the participation of local stakeholders and communities, may offer a new opportunity to improve consultation within the health sector, as a part of a broader approach to participation. In addition, improved education particularly of women will both increase appropriate utilisation and enable communities to vocalise their needs for effective health services to national and local governments.

2.4. PROVIDER PLURALISM AND THE CHALLENGE OF HEALTH SERVICE DELIVERY

49. Health service delivery has become increasingly diverse. In many countries, notably in sub-Saharan Africa and in the poorer parts of Asia, the private sector is a major provider of health services. Also in many countries, and notably in some transitional countries such as China and parts of the Newly Independent States, public health workers and facilities are in effect selling their services and acting as *de facto* private providers. Users are faced with an increasingly pluralistic set up in which many types of providers are available. These are generally described under the encompassing term of the "private sector" but it is important to be very clear as to the heterogeneity of "private" provision and thus of the policy and strategic challenges that it raises (see Box 3).

50. Utilisation of both private-for-profit and private-not-for-profit services by the poor is variable both across and within countries. There are examples of extensive use by poor people;[26] particularly high use rates are found in some countries for reproductive health related services and child health services[27], though in other countries private services may be more used for adult curative care. Use of private services may substitute for, or co-exist with, the use of public sector services by the poor.[28] In some countries poor women and girls are particularly likely to access private services from a wide range of providers because they are more convenient or accessible, more respectful in their treatment. It may be easier for women to visit such providers without a male escort, or there may be a gender bias towards treatment for men and boys from professional providers, and treatment of girls and women by unqualified or traditional practitioners. In all countries purchase of drugs from local or itinerant drug sellers is a common first line strategy for the poor, though there is little data available on precisely which types of private provision the poor use the most, and in what order of preference.

---

26. For example, a survey of private sector clinic patients in Ghana found 50 per cent were from the low-income group; a household survey in Rajasthan in India found that 80 per cent of the users of private sector child care were in the poorer income groups (quoted in Sharma, S. (2001) *The Private Sector and Child Health Care*, Carolina Consulting Corporation, Chapel Hill, NC, accessed at http://www.futuresgroup.com).

27. See *ibid.* on utilisation for child care. For reproductive health, see Rannan-Eliya, R.P., *et. al.* (June 2000), *Expenditures for Reproductive Health and Family Planning Services in Egypt and Sri Lanka*, accessed at www.policyproject.com

28. *Ibid.*, Sharma, S.

Box 3: What is the Private Health Sector?

The private sector is represented by a diversity of health service providers working outside the formal government sector, whether their aim is commercial or philanthropic. The private sector includes both registered and unregistered providers operating under a diversity of organisational and contractual arrangements:

- Not-for-profit providers include NGOs and faith based organisations, which operate primary health care clinics and secondary level hospitals. Many of these organisations provide services in rural and underserved areas and receive external finance, such as operating under a contract or agreement with the government.
- A range of non-profit making community based organisations, civil society groups, voluntary support groups, and other charitable institutions also provide health and support services. They may be formal or informal and may also be involved in awareness raising activities, counselling and home based care. The HIV/AIDS epidemic has led to the development of many small informal groups, which provide invaluable support to people living with HIV/AIDS.
- The for-profit sector includes qualified health and allied practitioners working individually or for profit based institutions such as clinics, hospitals, pharmacies, and laboratories. These generally operate under licence, although enforcement may be lax. A large proportion of these private practitioners may also work for the government. Unlicensed pharmacists and drug peddlers provide the first line of health services in many countries. They often number in the thousands, operate from home or small market stalls and provide a range of medical goods such as drugs (both restricted and unrestricted) and contraceptives.
- Finally, there are many community based traditional practitioners such as birth attendants and healers from various indigenous medical systems. They may charge a fee, take payment in kind, or offer services on a reciprocal basis. They are mostly unregulated by governments but some countries have set up registered practitioner associations.

51. Reasons for the drift from public provision will vary from context to context, but largely relate to the problems identified in Section 2.3.3 - service quality, lack of access, and costs of access, particularly in rural areas where facilities are spread thinly. In countries such as China where there has been a radical change in the nature of public services and rapid development of private markets, there has been a widespread increase in self-treatment manifest across all socio-economic groups. This in turn has brought other market players into the field. Commercial pharmacies, shopkeepers and local drug sellers now account for significant amounts of household health expenditure.

52. As noted above, the relationship between the public and private sectors is not straightforward and what is public and what is private is increasingly "porous." Public sector health staff frequently work privately, often unregistered and unsupervised. Public sector facilities are often chronically under-funded and staff have to market skills and services in order to make a living. This has been the case in a number of countries including Uganda[29]. In China, since fiscal decentralisation, only about 15 per cent of health workers' salaries are met by government funds and the remainder has to be made up by sales of drugs or other services.[30] The public sector in some countries resembles a private sector with a public subsidy.

53. In countries where there are problems of governance and where the public health sector has come under increasing strain due to economic crisis and transition, high levels of pluralism often indicate an

29. McPake, B., Asiimwe, D., Mwesigye, F. and Streefland, P. (1999), "Informal Economic Activities of Public Health Workers in Uganda: implications for quality and accessibility", *Social Science and Medicine* 49: pp. 849-865.

30. Bloom, G. and Gu, X. (1997) "Health Sector Reform: lessons from China", *Social Science and Medicine*, Vol. 45, No. 3, pp. 351-360.

unregulated or weakly regulated health care market with few or no checks on provider competence.[31] While regulation should be regarded as a positive function of government that goes beyond the health sector, it has been strongly associated with corruption in many countries and capacity for positive regulation and stewardship is limited. As a result, the private sector is often extremely diverse, both in its governance arrangements and its capacity to deliver appropriate, competent services. In some countries this allows both profit and non-profit making providers to provide the services that the public sector is unable to. On the other hand, this can also mean that while the better off can access good quality services in the private sector, the poor will have no safeguards.

54. Governments need to engage more pro-actively with the private sector to ensure that it is contributing to the achievement of pro-poor health objectives. The type of relationship that can be developed will depend on a contextual analysis of existing utilisation patterns, the relative strength and quality of different kinds of providers, and the capacity of government to develop and implement effective regulatory, contracting, and other mechanisms. A wide range of approaches have been used to date,[32] including co-operation with informal sector practitioners and offering training and supplies, the delegation of diagnostic tasks (e.g. laboratory and imaging services), and contracting out service provision. However, developing capacity to regulate and contract appropriately is a medium to long-term objective that development agencies can support both within the health sector and across government.

55. Countries with the weakest governments and institutions may lack a functioning public administration of any type; they may also lack well functioning private markets due to prolonged civil conflict or instability. Where government capacity to deliver health services is severely limited, concentrating on a limited set of specific programmes may be desirable (see Section 2.3), and where it is not possible to rely on governments as an effective intermediary, working through the private-for-profit sector or NGOs may be the best option.

56. Development partners can assist partner countries by supporting further experimentation and innovation with the private sector. Approaches that may have potential for expansion include:

- **Purchasing services from providers (which can include public sector ones) to deliver services against an agreed set of outputs**. Some governments now see the provision of public subsidies to non-government providers as an important mechanism for improving the quality of and access to services in under-served locations. Contracting out provision for specific services or for entire districts has been done on a pilot basis in Guatemala and Cambodia. In sub-Saharan Africa agreements have been made with church organisations that provide the mainstay of service delivery in some areas. In other countries, NGOs perform the same function; for example BEMFAM in Brazil is a major supplier of high quality reproductive health services in poor rural and urban localities. Specification of the quantity and quality of services needs to be built into such agreements, service delivery monitored, and capacity built in areas of national priority.
- **Working with informal and commercial providers such as traditional practitioners and pharmacies in defined areas of service delivery/distribution of goods**. Earlier examples of this, e.g. training of traditional birth attendants and other informal practitioners, have been supported by development co-operation agencies. Results have been mixed. More recently, the HIV/AIDS epidemic

31. Bloom, G. and Standing, H. (2001), "Pluralism and Marketisation in the Health Sector", *IDS Working Paper No. 136*, Institute of Development Studies, University of Sussex.

32. Mills, A., Brugha, R. F., Hanson, K. and McPake, B. I. (2002). "What can be done about the private health sector in low-income countries?", *Bulletin of the World Health Organisation*, Vol 80, No. 4, pp. 325-330. Smith, E. *et. al.* (2001) "Working with Private Sector Providers for Better Health Care: an introductory guide", Options/LSHTM, London.

has led to some innovative programmes. These include training unlicensed pharmacists as peer health educators because of their extensive contacts with youth and men, and supplying pre-packaged STD drugs to retail outlets. Traditional healers also assume important functions in home care for AIDS patients in highly affected countries in Africa.[33] Training has improved the TB diagnosis and treatment skills of private providers in India, and the appropriate provision of anti-malarials by shopkeepers in Kenya.

- **Using market mechanisms in some areas of health goods such as contraceptive delivery, malaria protection and basic test kits.** Social marketing has been successful in expanding demand for goods and services, and can be linked to supply through private distribution channels and retail outlets, as is being done for impregnated mosquito nets. Franchising of services is also being tried in some contexts. The aim is to develop "trusted" products and services by assuring quality to consumers. These methods seem to work best for middle income and moderately poor populations, and need to be complemented with other strategies to reach very poor populations. In some contexts a social marketing approach complemented with vouchers for vulnerable groups may be an option. The experience of the KINET social marketing project in Tanzania, which distributed vouchers through MCH clinics, enabling pregnant women to buy a treated mosquito net at a discount, suggests that voucher schemes can be successful under certain circumstances[34].

- **Using demand side measures to increase accountability of providers, e.g. civil society based monitoring of performance, consumers associations**. Given the absence of strong government regulatory enforcement, interest has turned to the potential of civil society groups to improve accountability of services, both public and private. This also has greater potential for advocacy on behalf of poor people, who cannot access legal or other formal means of redress. In Zimbabwe, a strong alliance of civil society stakeholders from trade unions, NGOs and informal associations has been involved in monitoring policies and expenditures across the health sector.[35]

- **Improving the access of poor users to information on provider performance and on safer purchasing of health goods and services.** Further attention should be given to ways of improving the availability of information to users trying to make choices in unregulated health markets. Examples include mandatory and clear posting of prices at facilities so that users can easily compare what they pay, the dissemination of simple and clear information on the technical quality of local providers and appropriately targeted information campaigns on safe use of over-the-counter drugs and on distinguishing fake or out-of-date supplies.

- **Developing improved regulatory frameworks and monitoring mechanisms for the private sector.** Most countries have regulatory frameworks of some kind (exceptions are where these have collapsed, as in failed or weak states, or where they are being renegotiated due to transition, such as China). However, they tend to focus on enforcement, which is a problem. The Consumer Protection Act in India (COPRA) is one attempt to create a legal framework of redress, albeit with limited impact. Frameworks are also not necessarily appropriate for the changing situation. For example, in Thailand in the context of an economic boom, a policy of encouraging private sector expansion of hospitals without an adequate regulatory environment had adverse consequences for the public health sector. These included a brain drain towards the private sector and the accumulation of high cost medical

33. Reference or delete.

34. Anne Mills getting reference.

35. Loewenson, R. (1999), "Public Participation in Health: making people matter", *IDS Working Paper No. 84*, IDS and TARSC.

technology that was under used[36]. A variety of mechanisms are needed, involving a range of different stakeholders, to enable more effective checks and balances to emerge.

57. One approach to contractual arrangements – an output based approach to aid – is being tested by the World Bank (see Box 4).

Box 4: Output Based Approaches to Aid

There is increasing discussion of the possibility of using output based approaches to aid (OBA) in the health sector whereby development agencies or governments delegate the delivery of services to the private sector (for-profit and not-for-profit). OBA is consistent with the service delivery activities of NGOs and civil society organisations that bilateral development agencies have been supporting for some time and which may have a comparative advantage in delivering services for the poor in under-served areas and during adverse conditions.

OBA is one of several means by which governments can finance the provision of services by non-government providers and should not be confused by the more traditional approach to contracting out the provision of services. The significant difference is that with OBA, payment is linked to the achievement of specific outputs. The objective is to provide a sharper focus on intended objectives, to improve incentives for efficiency, to enhance accountability in the use of public resources, and to create opportunities to mobilise private financing. Proponents argue that the likelihood of implementation is increased through payment by results, and benefits from market competition, though there is little consensus about the extent to which output based service delivery is appropriate, and for which type of services. It is likely to be most readily applicable where outputs can be easily defined and their relationship with health outcomes is clear (e.g. immunisation) and should be integrated into the overall health programme.

2.5. DEVELOPING EQUITABLE HEALTH FINANCING MECHANISMS

2.5.1. Health financing and social protection

58. The objective of health financing should be to assure the availability of funding, as well as to set the right incentives for providers, to ensure that all individuals have access to effective public health and personal health care. Existing resources allocated to health in developing countries are inadequate to finance a health system that meets the needs of poor people. Some increases in government spending for health are possible through budget reallocations, efficiency savings, and the use of funds released from debt relief. However, the poorest countries will remain unable to provide sufficient resources to meet pro-poor health objectives without significantly increased external financing. The budget available for health has important implications for the health financing strategy used.

59. Health financing systems have important consequences for the level of protection against ill health offered to the poor. An equitable financing strategy should ensure financial protection for everyone and eliminate the possibility of poor people being unable to pay for their health care, or becoming impoverished consequently. The design and implementation of health financing mechanisms is the responsibility of several government departments beyond the ministry of health such as ministries of finance and social welfare, and social security departments. Dialogue between all the key actors with regard to protecting the access of the poor is essential.

36. Bennett, S. and Tangcharoensathien, V. (1994) "A Shrinking State? Politics, Economics and Private Health Care in Thailand", *Public Administration and Development*, Vol. 14, No. 1, pp. 1-17.

60. The ways in which health systems are financed also have important gender dimensions. Women have less access to personal income (limiting their ability to pay user fees or insurance contributions) and a lower share of household expenditure for their health needs. In addition, they are disadvantaged by biases in insurance and other pre-payment schemes (e.g. computation of actuarial risk, exclusion of maternity conditions), whereas their need - particularly for reproductive health services - is higher than average.

61. Issues of health system financing are closely related to broader issues of social protection, which include considerations of macroeconomic stability at country level. Health-specific protection measures should be designed and implemented in conjunction with other approaches to provide basic protection against "shocks"[37] which are likely to lead to poverty and in turn worsen health status. The poor are exposed to multiple risks from different sources, which need different forms of risk management instruments and strategies for given populations (at family, community level or through NGOs, market institutions or government agencies).[38] In particular, as poor households need to prioritise their expenditure, the out-of-pocket costs of financing health care should be related to other livelihood social costs such as education.

62. Health services - whether involving public or private provision - are financed by a number of different mechanisms. Given low public expenditures on health in many partner countries, out-of-pocket expenditures (user fees and insurance payments) can account for 20-80 per cent of health expenditures.[39] The requirement for payment at the time of illness restricts access to health services by the poor, and may deny basic care to the poorest members of society. Even middle-income households are vulnerable to impoverishment if a member has a catastrophic illness requiring costly health care, or if an income earner cannot work due to sickness.

63. Health financing systems where prepayment plays a major role and where the financial risks of ill health are pooled are more equitable than those relying on out-of-pocket expenditures.[40] Prepayment and risk pooling predominate in developed countries where revenue is collected by general taxation or social insurance and the pool is large, but is rare in low-income countries that lack institutional and organisational capacity. Increasing the degree of prepayment or risk pooling will increase equity and improve access for the poor.

2.5.2. Risk-sharing and pre-payment approaches

64. Pooling is the accumulation and management of revenues in such a way as to ensure that the risk of having to pay for health care is borne by all members of the pool. It is traditionally known as the insurance function whether the insurance function is explicit (people subscribe to an insurance scheme) or implicit (through tax revenues). Large pools with cross subsidisation or well regulated multiple pools are preferable. Health financing policy needs to focus on creating the conditions for the development of the largest possible pooling arrangements.

65. The feasibility of pooling and risk sharing depends on the country context. In the many low-income countries that lack the organisational, financial or institutional capacity to have a large pool, policy

37. Such "shocks" include loss of income due to unemployment, loss of assets - e.g. due to natural disaster, as well as disability and lack of support in old age, due to loosening of family and kinship structures.

38. World Bank 2002 Social Protection Strategy.

39. WHO (2000), "Health Systems: Improving Performance", *The World Health Report 2000,* Annex 8, WHO, Geneva.

40. WHO (2000), "Health Systems: Improving Performance", *The World Health Report 2000*, WHO, Geneva.

makers with development agency support need to try and create the conditions for such pools. Even relatively small pools are preferable to pure out-of-pocket payment. Agencies can support the development of employment based contribution schemes and community or provider-based prepayment schemes as a transition to higher levels of pooling or more targeted subsidies. Some countries (e.g. China) are experimenting with rural household medical safety nets in designated poor areas to cover the costs of major illnesses, particularly hospital admissions by the very poor.

66. Community schemes - those managed by community groups or NGOs and serving people in a defined locality - must aim to build and draw on community solidarity, for example by ensuring widespread enrolment and community control mechanisms. In some cases, it may be possible to include health insurance in the programmes of broader community-based organisations such as income generating schemes. One advantage is that these organisations are likely to have stronger management capacity. Micro-insurance schemes provide important experience to build on. Community schemes have demonstrated some success on a small-scale, but more evaluation and efforts at larger scale replication are required.

67. In the poorest countries, where pre-payment and risk pooling cannot generate adequate social protection, health sector budgets supplemented by external assistance or debt relief channelled to the health sector may be the solution for the foreseeable future. This assumes that such additional resources will be allocated in a pro-poor fashion.

68. In middle-income countries, there is the possibility of developing tax based health financing. Alternatively, strengthening and expanding existing mandatory employment-based health insurance schemes to include more informal workers and subsidise their participation could improve access.

2.5.3. Cost sharing approaches and user fees

69. In many partner countries, resource constraints and concerns with the inefficiencies of public sector services have led to health financing reforms prioritising revenue generation and efficiency objectives over equity concerns. This has led to the introduction of, or increase in, user fees. As poverty reduction becomes central to government policy, ministries of health and finance are increasingly concerned with the ways that user fees affect the poor.

70. The evidence of the impact of user fees in the public sector largely demonstrates reduced utilisation of services by the poor and a failure of exemption systems to identify and protect the poor from the impact of charges[41]. The abolition of user fees in Uganda as part of the poverty reduction strategy resulted in a surge of utilisation by the poor, though in South Africa the withdrawal of user fees for maternal child health services did not lead to significantly increased utilisation[42]. However, given that government expenditures are currently too low to finance essential health services, and that private expenditures represent over half of health expenditures in many countries, user fees remain an important aspect of health financing policy in some countries. Indeed, budget constraints and political pressure have led to the reinstatement of previously withdrawn user fees[43].

41. Gilson, L. (1997), "The Lessons of User Fees Experience in Africa", *Health Policy and Planning,* Vol. 12, No. 4, pp. 273-285.

42. Schneider and Gilson, L. (1999).

43. Foster, M. and Mackintosh-Walker, S. (2001), "Sector Wide Programmes and Poverty Reduction", ODI, London.

71. User fees as a health financing mechanism therefore have to be approached cautiously in order to ensure that the access of the poor to quality health services is protected. Given this, a combination of approaches according to national circumstances may be appropriate. Subject to fiscal limits, these may include:

- **Free primary level services.** Accessing primary health care services is extremely important to poor people. User fees at the primary level have rarely been effective in generating sufficient amounts of resources to lead to sustained improvements in the quality of services. The use of primary services by the poor is already influenced by time and opportunity costs, user fees tend to *ration* use without *rationalising* use[44]. Encouraging free provision at this level will increase access.
- **Free services for targeted groups or communities.** The identification of highly vulnerable groups and communities has been discussed in Section 2.3. Targeting groups such as indigenous people, adolescents, or refugees with free services can be highly effective. In addition, identifying very poor communities or districts for free service provision can also improve access.
- **Free services for priority diseases and conditions.** Certain diseases and conditions are responsible for a considerable proportion of the disease burden of the poor (see Section 2.3) for which diagnosis and treatment could be exempt from charges, regardless of the level of service where interventions may be required. For example, exempting child health care, obstetric and reproductive health care, and the management of STDs and TB would have significant impact on the health outcomes of the poor. Criteria for exemptions would need to be determined according to local disease patterns and the priority needs of poor groups (see Section 2.3.1). This strategy has been used in Ghana, which led to increased coverage of the exempted interventions although the budget allocation for exemptions was inadequate.[45] However, the high costs associated with hospitalisation, even at the secondary level, is also a key source of impoverishment.
- **Charges for tertiary level services,** which are largely accessed by urban-based elites should not be subsidised with public funds although political considerations have often determined charging policy at this level. When poor people are referred to tertiary level facilities, some system of exemption from charges is clearly desirable.

72. Some countries are trying to develop objective and non-stigmatising exemption systems in order to allow some degree of cost recovery while maintaining access for poor people. For example, countries such as Uganda and Bangladesh are trying to develop hospital based exemption systems or the cross subsidisation of poorer patients by private patients. In the NGO sector, community involvement and monitoring, plus community setting of fee levels have led to a greater degree of success with user fees (see Box 5). Development agencies can support more innovative approaches to cost recovery and social insurance, while building capacity in social impact analysis to facilitate the early identification of any adverse impact on poor people and on women in particular.

73. Strategies to reduce the direct financial burden of seeking health care must also include tackling the unofficial fees imposed by health sector staff. These fees are often higher than official user fees, are demanded by allied staff (such as cleaners) and health professionals, and are a major deterrent to utilisation. The publication and posting of official charges, greater community involvement in health facility management, and improved governance will all contribute. In addition, addressing the incentives of health sector staff is important.

---

44. WHO (2000), "Health Systems: Improving Performance", *The World Health Report 2000*, WHO, Geneva.

45. Foster, M. and Mackintosh-Walker, S. (2001), "Sector Wide Programmes and Poverty Reduction", ODI, London, p. 6.

Box 5: The Aga Khan Health Services, Pakistan Experience of User Fees

The Aga Khan Health Services, Pakistan (AKHS,P) has an extensive network of primary health centres and first level referral facilities in the Northern Areas and Chitral District (Pakistan). These services are designed to meet the health care needs of women and children in remote villages principally reliant on subsistence agriculture. Services have been planned in close consultation with communities who provide in-kind support for the construction of the centres and who nominate persons to be trained as Community Health Workers by AKHS,P. Clients pay a fee for most services; however, the fees vary between communities and are negotiated with each community. In negotiating the fee, community leadership seeks to achieve a balance between setting a fee that is generally affordable in that particular village yet progressively contributes to covering an increasing percentage of the direct operating cost of providing the service. Some of the more prosperous villages have set fee levels that have enabled the community to cover direct operating costs within five years. For most villages, however, it is mutually agreed between the village leadership and AKHS,P that 10 to 15 years will be required to achieve this level of cost recovery. In the interim, AKHS,P subsidises the service.

Experience to date indicates that this approach covers most members of a given community but does not adequately ensure access to the poorest households in some villages. To reach the very poor, a welfare policy has to be put in place by the village leadership, supported by AKHS, P. The current welfare approach consists of exemptions for particularly disadvantaged families. However, it is threatened by downturns in regional economic performance and the seasonality of incomes. Additional approaches to welfare, including per capita contributions from the MoH for the very poor, are being explored.

2.6. SUMMARY

74. Part Two has examined how development agencies can support the strengthening of health systems in general and the re-orienting of those systems to improve the health outcomes of poor people. In addition to the need for increased financial resources for health, concerted action is required to improve the poverty focus of current health systems. Development agencies can support partner country efforts in the following five areas:

- Strengthen capacity in ministries of health to perform its key functions of policy making, regulation, stewardship, purchasing services, and providing services. The improved performance of health systems is necessary to underpin targeted efforts to reach poor people.
- Support partner country programmes to identify the poorest and most vulnerable groups, to support their health needs and to increase their accessibility to effective and affordable health services.
- Support further experimentation and innovation for working with the private sector including partnerships in service delivery, training, the provision of commodities, and improved regulatory frameworks.
- Support capacity to develop equitable health financing systems that are adequately resourced, set the right incentives for providers, protect access to health services, and prevent the impoverishing effect of health charges.

75. In addition to improving the pro-poor focus of health systems, staff of both ministries of health and development agencies need to focus attention on the importance of health to poverty reduction. Broader appreciation of the importance of those sectors which have a major impact on health and poverty reduction, and through which improved health can facilitate the achievement of sectoral objectives is necessary for an effective pro-poor health approach. A number of sectors are discussed in Part Three to highlight the importance of these linkages.

PART THREE

KEY POLICY AREAS FOR PRO-POOR HEALTH

76. Ensuring that the poor have access to effective and affordable health services is central to a pro-poor health approach. However, this is not sufficient in itself to improve the health of the poor. The reason is that the major determinants of their health depend on actions *beyond* the health sector. There is ample and longstanding evidence of the role of a range of sectoral policies and macro-economic practices in determining health outcomes. Sectoral policies that are critically important include education, food security, safe water, sanitation and energy. The health of the poor can also be improved by reducing their exposure to violence, road traffic injuries and the devastating impacts of conflict and natural disasters.

77. The contribution of sectoral policies to the achievement of heath objectives may be positive or negative and their impacts may be increased through synergistic effects between them. Consequently, development agencies need to prioritise those sectors that have a major impact on health and poverty reduction, and assess the extent to which policies undermine or promote both health and broader poverty reduction objectives. This may lead to the need to strengthen capacity within such sectors for the delivery of health objectives. The following sections highlight linkages between poverty, health and selected other sectors, and explore ways in which cross-sectoral collaboration may be enhanced to improve health outcomes.

3.1. EDUCATION AS A TOOL FOR IMPROVED HEALTH OUTCOMES

78. Education and health are fundamental to poverty reduction and feature directly in five of the eight Millennium Development Goals (MDGs)[46]. Achievement of the three health-related goals all hinge strongly on reaching the education goals of gender equality and universal primary school enrolment. The evidence demonstrating inter-linkages between investments in health and education and their synergetic effects on reducing poverty is compelling. Poor countries that have given priority to investments in education have lowered mortality levels far below those of countries with much higher per capita incomes but less educated populations.

79. The mind and the body - education and health - are the most important assets of poor people, enabling them to lead socially and economically productive lives. Even a few years of schooling provide basic skills that can have far-reaching implications for health seeking behaviour. Moreover, education emphasising health prevention and informed self-help is among the most effective ways of empowering the poor to take charge of their own lives.

46. Achieve universal primary education (II); promote gender equality in education (III); reduce child mortality (IV); improve maternal health (V); and combat HIV/AIDS, malaria and other diseases (VI)., In addition, under the global partnership for development (VIII) an indicator is to provide access to affordable, essential drugs in developing countries in co-operation with pharmaceutical companies.

3.1.1. Education is a major health determinant

80. Findings from numerous studies have clarified the nature of the link between education and health, showing that:

- **Female education is strongly related to improved health care for children, families, and communities**. One of the most powerful means to reduced child mortality is the literacy of mothers, itself the product of an education system that ensures access to education for the poor, girls as well as boys. Stronger receptivity and confidence as much as the knowledge acquired in school, enable women to apply the advice given by health personnel. Beyond the level of personal behaviour, the literacy of mothers is critical for all kinds of health interventions including access of the family members and the broader community to the formal health care system[47].
- **Education is related to lower fertility levels.** Education leads to changes in reproductive behaviour which produce a series of positive effects: lower maternal mortality, female empowerment, higher child survival rate, spacing of births, improved health of mothers and children, better care for children, lower desired and achieved fertility levels, and reduced poverty.
- **Education is one of the most effective preventive weapons against HIV/AIDS.** Since early age learning is critical in shaping future behaviour, young people are both especially vulnerable and open to change. This holds true for health where more than two-thirds of premature adult deaths are due to behaviour patterns acquired in adolescence. Information, education and communication campaigns[48], peer education, youth centres and community-based services may play a crucial role, especially in the case of sexual and reproductive health.

3.1.2. Exploiting the synergies between health and education

81. While education is essential for health improvement, health is also a major determinant of educational attainment having a direct impact on cognitive abilities and school attendance. Policy makers and staff in the two sectors, therefore, have a mutual interest in interacting closely and identifying strategies for collaboration using both the school system and informal education channels.

3.1.2.1. The role of formal education in promoting health

82. Many developing country governments recognise the potential of schools and other education centres for fulfilling multiple health functions. Development agencies can support the efforts of partner countries to strengthen **the use of schools for health promotion** by stepping up technical and financial assistance for the three key functions of school health programmes.

- The main elements of **school-based health services** are immunisation, health monitoring and referral, nutritional supplements, and feeding programmes. Schools can provide an important focus for improving nutrition. A well-functioning school health programme is one of the most cost-effective ways of preventing ill health. However the current state of both health and education systems in many low-income countries means that programmes are in many cases non-functional. Additional resources

47. Investment in basic education for girls has among the highest returns of all economic development programmes. Educated women, are more likely to send their children to school, have higher earnings, are more likely to participate in society and help protect the environment, and have fewer and healthier children. Societies that deny education to girls experience poorer health and poorer economic growth.

48. ICT may be a valuable tool in health education and can increase the use of community radio, broadcast media, telecoms etc. for wider dissemination of health messages.

are required, together with system reform, training, and close collaboration between the health and education sectors, at ministerial and school levels.

- **Health education in school** provides scope for joint initiatives and training by health workers and teachers. Teachers are in a position to transfer health knowledge and promote healthy behaviour. However, in countries where school children, particularly girls, have been shown to be vulnerable to sexual exploitation by teachers, health professionals or external inputs may be necessary. For their part, health professionals have a key role in designing appropriate school curricula and training teachers.
- **The school also has a role in community health,** particularly in rural areas, where it can be a means of introducing behavioural change and basic health concepts in the children's home. Education and health are both sectors that can motivate parental involvement and, by acting in synergy through school health programmes, can generate effective community participation and well being.

3.1.2.2. The role of non-formal education in promoting health

83. Since many poor people, especially girls and women, do not have access to formal education, it is important to also focus on those who are outside the school system. Efforts to promote health must reach vulnerable youths such as street children, sex workers and the million of orphans whose parents have died of AIDS or violent conflict. Integrating health education into **non-formal education** and functional literacy programmes offers the potential to reach these vulnerable groups. In addition, the use of the mass media and peer education deserves special attention.

3.1.2.3. Recommendations to development agencies

84. In order to develop the potential of education for protecting and improving the health of the poor, development agencies should capitalise on the synergies between health and education by giving priority to:

- **Promoting the achievement of the education-related MDGs** since primary education and female literacy are decisive factors influencing the health of the most vulnerable and poorest groups of population.
- Understanding and **tackling barriers to female education** at school level, such as personal safety of girls while travelling to school and within school, enabling pregnant girls to continue their schooling.
- Supporting the efforts of partner countries to strengthen **the use of schools for health promotion** by stepping up technical and **financial** assistance for school health programmes. This requires joint actions by education and health personnel to strengthen the school as a focal point for health education and health service delivery. Collaboration should include teachers' training, introduction of health topics in school curricula, provision of school meals and strengthening of school health services.
- Integrating health training into **non-formal education** and functional literacy programmes.

3.2. FOOD SECURITY, NUTRITION AND HEALTH

85. Hunger and malnutrition are among the most devastating problems facing the world today. The number of undernourished people has increased in most countries with the notable exception of China. The

international community is now committed to h*alving, by 2015, the proportion of people who suffer from hunger*[49].

A. The burden of disease

86. Malnutrition and food insecurity have very strong implications for health. Nearly 800 million people in developing countries are chronically hungry[50]. Hunger and malnutrition increase vulnerability to diseases and premature death, and reduces livelihood capabilities including cultivation and income generation. Malnutrition is both a major cause and effect, and a key indicator, of poverty and underdevelopment[51]. Moreover, a failure to treat the underlying causes of malnutrition and their consequences undermines the impact of other efforts to improve health, while ill health itself reduces the ability of the body to absorb nutrients from food.

87. Malnutrition affects one in three people worldwide, especially the poor and vulnerable. Sixty per cent of annual deaths among children under five are associated with underweight, while 161 million children are stunted in their linear growth. *Iodine deficiency* is the greatest single preventable cause of brain damage and mental retardation. *Iron deficiency* anaemia is second among leading causes of disability and may be a contributing factor in 20 per cent of all maternal deaths. *Vitamin A deficiency* causes irreversible blindness and deaths among millions of children every year.

B. Recommendations to development agencies

88. Agricultural development is essential to poverty reduction and improved food security. Development agencies play a major role in improving agricultural output and rural development by supporting partner country strategies to increase the income earning capacity of family farmers, generate rural employment, develop the rural non-farm economy, and enhance the availability and quality of food produced.[52] Hunger is related more to the availability of household income that to the availability of food. Improving food security is therefore essentially managing access to food or increasing purchasing power, which should be supported by development agencies through:[53]

- **The promotion of inclusiveness:** Increasing rural incomes of the poorest groups, particularly for women, is likely to have a significant impact on reducing malnutrition. Promoting empowerment by making institutions more responsive to the needs of the rural poor, particularly women and marginalised groups, and removing barriers that exclude individuals on the basis of gender, social class, or ethnicity from economic and social opportunities should be a priority.

---

49. The first Millennium Development Goal is to eradicate extreme poverty and hunger. The two indicators for measuring performance are Prevalence of underweight children (under five years of age) and Proportion of population below minimum level of dietary energy consumption.

50. Many of the hungry live in conflict areas, around 75 per cent live in rural areas, and over 60 per cent are women (4th Report on The World Nutrition Situation, UN Sub-Committee on Nutrition, ACC/SCN, and IFPRI, 2000).

51. In the World Bank study *Voices of the Poor*, which consulted over 60 000 poor women and men in over 60 countries, lack of food was the most frequently mentioned want. D. Narayan, R. Chambers, M.K. Shah, P. Petesch (2000), *Voices of the Poor: Crying out for Change*, World Bank, OUP.

52. While a focus on rural development is essential when addressing food insecurity, rapid urbanisation has led to a blurring of the boundaries between rural and urban. Rural households are increasingly likely to take employment opportunities in small towns, take seasonal employment in urban areas, and send remittances that supplement rural incomes. World Bank Draft Rural Development Strategy.

53. World Bank Draft Rural Development Strategy.

- **Investment in rural projects** such as irrigation, improved roads, and telecommunications reduce vulnerability of poor people in rural areas. During economic crisis, governments can provide employment in public-works programmes, which generally allow self-selection by offering wages slightly below market rates. The value to the poor of such programmes is not measured only in terms of income support but also in terms of the benefits they receive from the infrastructure created.
- **Development of social safety nets** are targeted transfers that convey income to the poor and vulnerable. While targeting and administering such programmes can be difficult, targeted food security programmes are generally more cost effective than generalised food subsidies. In most situations, cash transfers or the provision of vouchers allow recipients to purchase the food they require through normal market channels. Transfers can be made part of broader programmes aimed at the nutrition of vulnerable children and pregnant women.
- **Management of disaster and conflict:** Efforts to prevent disaster or resolve conflict rapidly can reduce the effects of famine and malnutrition.

89. In addition to food security measures, targeted nutritional programmes are required. These depend on improved access to effective health services with maternal and child health programmes. Improving school health programmes will also provide further avenues for health education and nutritional programmes. Programmes targeted towards groups with the highest prevalence of malnutrition and hunger include:

- **Designing special programmes for infants and children** including the promotion of breastfeeding, supplementary feeding, immunisation, treatment of diarrhoea, respiratory infections, and malaria. **For women and adolescent girls***:* nutritional supplements during pregnancy and breastfeeding such as iron, folic acid, iodised salt, food supplementation, and micronutrient-rich foods. Malaria and HIV/AIDS prevention and treatment is also particularly important.
- **Preventing micronutrient deficiencies** by designing and managing effective programmes for pre-school children and pregnant women to ensure sufficient intake of iodine, vitamin A, and iron.
- **Ensuring appropriate child feeding practices** by developing comprehensive national policies that ensure all health services protect, promote and support exclusive breastfeeding for six months.[54]
- **Managing nutrition during emergencies or conflict** for refugees, internally displaced people or other vulnerable groups. Nutritional programmes must be closely linked to priority health programmes such as immunisation and treatment for infectious diseases.
- **Improving emergency food aid** to enhance its crucial role in saving lives in acute crises caused by conflict, natural disaster, emergencies, or post-crisis rehabilitation. Food aid can also be useful as targeted assistance to highly food-insecure people in situations of poorly functioning fragile markets and serious institutional weakness.

54. *Resolution World Health Assembly 55.25 Global Strategy on Infant and Young Child Feeding*. It also emphasises the role of community attitudes which can be promoted through mother and child-friendly communities in hospitals and workplaces and implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions.

3.3 POVERTY, HEALTH AND THE ENVIRONMENT

90. Estimates suggest that at least 25 per cent of the global diseases burden may be attributed to environmental conditions.[55] This section focuses on two areas where the environmental/health/poverty links are particularly strong - water and sanitation, and air pollution - and where sector policies need to be assessed and improved to maximise opportunities for health promotion and protection.

3.3.1. Water and sanitation

A. The burden of disease

91. Almost 1.2 billion people lack access to safe drinking water and 2.4 billion people lack adequate sanitation[56]. Inadequate water quality leads to the transmission of diseases such as diarrhoea, cholera, trachoma, and onchocerciasis. Scabies and trachoma depend on the quantity of water available while stagnant water is a breeding ground for the vectors transmitting malaria and schistosomiasis[57]. Access to adequate quantities of water is also essential for food production, which in turn improves nutrition, health, and people's ability to withstand and recover from diseases. Lack of sanitation increases the transmission of excreta related illnesses. These include certain faecal-oral diseases such as cholera, soil transmitted helminths (e.g. roundworm, tapeworms), and water based helminths (e.g. schistosomiasis).

92. The majority of people affected by these diseases are poor. Most of the deaths are among children under-five and are concentrated in poorest households and communities. At any one time it is estimated that half of the urban population is suffering from one or more of the diseases associated with the provision of water and sanitation[58]. During conflicts and emergencies, people are even more vulnerable to water and sanitation related diseases.

93. Women are disproportionately affected. In rural areas, women spend many hours daily collecting and carrying water over long distances[59] while in urban areas, women wait in queues for water from wells and standpipes. The carrying of water leads to chronic back pain, frequent miscarriages, and uterine prolapse. Caring for sick family members and handling soiled clothes are particularly hazardous in the context of limited water supplies and lack of sanitation, while women's responsibility for the disposal of waste exposes them to disease. The provision of sanitation is important for women not only for their physical health but also for their safety and dignity. In many cultures, women and girls can only defecate outside after dark, which causes physical discomfort, serious illness, and exposes them to the risk of sexual abuse. A lack of sanitation facilities in schools, also, is a large contributing factor to preventing girls from attending school, increasingly so when they begin menstruation.

---

55. WEHAB Working Group (2002) A Framework for Action on Health and the Environment.

56. Sanitation is the safe management of waste. Hospitals and health facilities are themselves a source of hazardous waste which can be environmentally damaging and impact on the health of poor people.

57. Diarrhoeal diseases cause 3.3 million premature deaths per year, trachoma blinds 6-9 million people per year, and schistosomiasis affects 200 million people annually. WELL (1999) DFID Guidance Manual on Water Supply and Sanitation Programmes, WELL.

58. WHO (1996) Creating Health Cities in the 21st Century Background Paper prepared for the Dialogue on Health in Human Settlements For Habitat II, WHO, Geneva.

59. An estimated 26 per cent of rural household time is spent fetching water. DFID (2001), Addressing the Water Crisis: healthier and more productive lives for poor people.

B. Recommendations to development agencies

94. The targets of halving the proportion of people living without sustainable access to safe water by 2015 and halving the proportion of people without access to basic sanitation adopted by the international community[60] reflect the importance of improved access to water and sanitation to poverty reduction.

95. These targets will only be achieved through the concerted action of national governments in partnership with communities, civil society, the private sector, and international development agencies. Governments are responsible for developing better frameworks for integrated water resource management (IWRM) which includes designing and implementing policies that determine priorities, allocate water between uses, set prices, regulate private sector providers, develop appropriate legal and financial instruments, and ensure access to water especially for the poor. Development agencies can play a role in ensuring that poor people's interests are reflected in these frameworks as well as encourage greater links between sectoral policies, health outcomes, and poverty reduction strategies. They can also encourage governments to recognise the importance of involving communities, especially women, in the management and financing of water and sanitation systems. Development agencies can help build capacity in key government institutions. Specific areas of focus could include:

- The need for improved data on access to water and sanitation, use of water and sanitation , and demand for water in order to improve planning and management.
- The development of an appropriate approach to financing water supplies - including the use of cost recovery and subsidies – that covers recurrent costs while protecting access for poor people.
- Greater recognition of the potential role of the private sector in managing or expanding water and sanitation services through public-private partnerships with a range of private sector organisations. This may include NGOs and civil society groups which are service providers in some countries and which have a strong poverty focus. In addition, deeper understanding is needed of the role of those private sector organisations involved in small-scale water and sanitation provision, on which many poor people are dependent. In countries where the legal and policy environment is weak, development agencies can strengthen capacity for positive regulation of the private sector.
- The need for collaboration between environmental health and public health authorities within local authorities and international agencies on an integrated approach to water supply, sanitation, drainage, community education, and hygiene practices that emphasises the links between water, sanitation, health, and poverty. Carrying out a meaningful health analysis in all environmental assessment procedures by government and development agencies can sharpen attention to these links.
- The importance of promoting health and hygiene education, which can in turn stimulate demand for improved sanitation. Formal and non-formal education are important vehicles for locally designed health and hygiene promotion programmes, a key component of effective water and sanitation interventions. Lack of hygiene behaviour can remain a substantial risk to health even in the context of improved access and many programmes have failed due to insufficient attention being given to the local context.

96. Development agencies also need to help fill the resource gap if the water and sanitation targets are to be met. Estimates of needs vary significantly and further work is needed to develop more accurate estimates of the global financial requirements to meet the water and sanitation related targets[61]. The World Summit on Sustainable Development estimated that USD 111 billion per year is needed. The volume of

60. MDG Goal 7 target 10 and the Plan of Implementation of the World Summit on Sustainable Development.

61. WEHAB Working Group (2002) A Framework for Action on Water and Sanitation.

resources required means that in addition to public funds, development assistance and private sector financing will also be necessary.

3.3.2. Indoor and outdoor air pollution

97. Indoor and outdoor air pollution are major problems affecting poor people disproportionately. Poverty leads to a dependence on cheap traditional fuels for cooking and heating which combines with unventilated, overcrowded accommodation, to cause high levels of indoor pollution. In addition, in urban areas poor people live close to highly polluting industries and transport networks, which contribute significantly to ill health.

3.3.2.1. Indoor air pollution

A. The burden of disease

98. Around 3 billion people are exposed to indoor air pollution from the use of traditional fuels for household energy. Poor households in sub-Saharan Africa and Asia rely mostly on biomass, kerosene, or gas because of cost, while more affluent households use gas or electricity. Indoor air pollution causes an estimated 2.5 million deaths a year, mostly in developing countries. It primarily affects the poor in rural areas but exposure is rising among urban populations. Indoor air pollution is responsible for 60 per cent of acute respiratory infections particularly affecting women and children.

B. Recommendations to development agencies

99. A number of interventions have shown to be effective in reducing the impact of indoor air pollution, and yet development agency support for programmes has been limited. The success of these interventions depends not only on access to technology but also on decentralised management of programmes and training, combined with community involvement and ownership.[62] Development agencies should build on these evaluations and support further replication of the interventions listed below in order to reach greater numbers of poor people.

- The most significant reduction in indoor air pollution comes from increasing access to improved cooking stoves, which reduce particulate emissions from traditional fuels. Extensive improved stove programmes have been developed in China (reaching 120 million people) and India. Evaluation of such programmes has demonstrated that considerable gains have been achieved. Apart from the economic value of saving on fuel, cost-benefit analysis has shown that health improvements have produced further savings of around USD 25 to USD 100 per stove, per year.
- Increasing access to cleaner fuel, by increasing supply and distribution of fuels such as kerosene.
- Modifying the home environment to improve ventilation. For examples, cooking windows can reduce carbon monoxide emissions by 85 per cent at a cost of a few dollars.
- Behaviour change programmes, which increase understanding of the link between pollution and ill health and encourage children to be kept away from smoke during peak cooking times.

62. Kammen, D. (1995), *Cookstoves for the Developing World*, Scientific American, pp. 64-66.

3.3.2.2. Outdoor air pollution

A. The burden of disease

100. Approximately 1.5 billion people are exposed to urban air pollution the majority of these in developing countries. The most polluted cities are found in the developing world including Beijing, Cairo, and Lagos where children regularly experience levels of air pollution 2 to 8 times above the maximum WHO exposure guidelines. The burden of ill health caused by pollution in combination with sulphur dioxide is responsible for 4-5 million new cases of chronic bronchitis annually. Emissions from fossil fuel combustion and transportation are responsible for almost 90 per cent of emissions in urban areas. Inadequate regulation, rapid urbanisation, the proximity of industries to residential areas, and high population density exacerbate the degree of exposure of the poor.

B. Recommendations to development agencies

101. Addressing the health impact of urban air pollution is complex. Technical, legal, and economic instruments are being successfully used to control pollution in some countries[63] though capacity to develop the legal, institutional, and regulatory frameworks may be limited and support from development agencies appropriate. Major cities in China and India are increasing their use of cleaner energy, such as hydro power plants, solar panels and wind energy. In the field of transport, Phnom Penh and Harare have introduced positive incentives for bicycling, while Manila has increased fuel taxes and built a light railway, thus decreasing petrol consumption by 43 per cent over ten years.

102. Development agencies should work together with partner countries to promote multi-sectoral energy policies that combine both economic and regulatory approaches and are based on collaboration between public and private sectors and civil society.[64] This would include:

- A shift towards using modern energy sources and achieving more efficient energy utilisation.
- Investing in capacity building for the management and planning of energy resources.
- Ensuring that air pollution is addressed within poverty reduction strategies and energy policy.

3.4. VIOLENCE AND INJURIES AS A PUBLIC HEALTH ISSUE

103. Violence[65] is among the leading causes of death worldwide for people aged 15-44 years with over 90 per cent of deaths from violence taking place in developing countries. In 2000, an estimated 1.6 million people died as a result of violence: collective, interpersonal, and self-inflicted. Collective violence includes death and injury resulting from war and related violent conflicts. The impact of conflict both on the health of the poor and on health services is addressed in Section 2.3. In addition to violence, road traffic crashes

63. WEHAB Working Group (2002) A Framework for Action on Health and the Environment, p. 14.

64. WEHAB Working Group (2002) A Framework for Action on Health and the Environment.

65. Most of the evidence on violence is taken from the WHO (2002) World Report on Violence and Health.

are a significant cause of death and injury in developing countries[66] accounting for nearly 90 per cent of worldwide traffic-related deaths.[67]

104. People with the lowest socio-economic status are at greatest risk of violence. Factors related to poverty, such as bad housing, lack of education, and unemployment, increase the risk for violence. For example, statistically, poorer women are more at risk of intimate partner violence, and youth in poor communities are more likely to be involved in violence. Fatal violence, particularly of income earners, increases the risk of impoverishment and an increased dependency ratio. Poverty reduces the likelihood of access to health services, and injuries lead to reduced productivity and loss of income.

105. A public health approach to violence and injuries emphasises prevention. This section takes two examples - interpersonal violence and road traffic injuries - to highlight the impact on the health of poor people and the need for multi-sectoral interventions.

3.4.1. Interpersonal violence

A. The burden of disease

106. Poor women and girls are especially vulnerable to physical, sexual, and psychological violence. These include rape, female-genital mutilation, forced marriage and prostitution, widow abuse and the neglect of elderly women, and murder (of female infants, dowry related, honour related).[68] Interpersonal violence was responsible for 520 000 deaths in 2000, an underestimate of the true burden because of the problems of measuring non-fatal violence. In developing countries, women lose an estimated 5 per cent of their healthy life years as a consequence of rape and domestic violence.

107. Interpersonal violence can have direct consequences such as injury, which is compounded by women being denied access to health care. Being a victim of violence also increases women's risk of future ill health from a variety of diseases and conditions. In particular, sexual violence can lead to unwanted pregnancy and sexually transmitted diseases including HIV, and partner violence accounts for a substantial proportion of maternal mortality. Women victims of abuse are more likely to be long-term users of health services thereby increasing health care costs. In addition, several studies have estimated the economic burden of violence created by interpersonal violence and its health consequences. For example, in Nicaragua female victims of domestic abuse earned 46 per cent less than their unaffected counterparts, even after controlling for other factors that could affect earnings.

B. Recommendations for development agencies

108. Inter-personal violence can be substantially reduced.[69] Creating safe and healthy communities requires multi-sectoral commitment at the national and community levels to build awareness of the

66. Murray, C.J.L, Lopez, A.D. (1996), "Global health statistics: a compendium of incidence, prevalence and mortality estimates for over 200 conditions", *Harvard School of Public Health*, Harvard University Press, Boston.

67. Krug, E. (ed.) (1999), *Injury. A Leading Cause of the Global Burden of Disease*, WHO, Department of Injuries and Violence Prevention, Geneva.

68. Worldwide, 130 million women and girls are victims of female genital mutilation and 2 million are subjected to this harmful practice annually. Every year, thousands of women and girls are being killed by their relatives to protect the "family honour" and a further 2 million girls become victims of the international sex trade. *Gewalt gegen Frauen und Mädchen beenden*, GTZ, 2002.

69. Recommendations are derived from the World Report on Violence and Health and the experience of GTZ.

problem, to promote the design and testing of prevention programs, and to share lessons learned. Development agencies can support:

- An adequately resourced public health approach that focuses on prevention and contributes to reducing violence through the development of national plans and policies, the facilitation of data collection, and the development of multi-sectoral partnerships.
- The efforts of partner countries to integrate violence prevention into social, health and education policies.
- Training for health sector staff - who have a key role to play in caring for the victims of violence and detecting signs of violent incidents - on violence, including its consequences and prevention.

3.4.2. Road traffic injuries

A. The burden of disease

109. Road traffic crashes cause the death of over a million people annually in developing countries, while 10 million people are injured or disabled worldwide.[70] It is estimated that by 2020 road traffic accidents will be the third leading cause of the burden of disease worldwide. In developing countries, road traffic injuries are a leading cause of mortality and morbidity; they are responsible for an immense burden on national health systems. Those injured in crashes occupy 25 per cent of all hospital beds in developing countries at any one time, cause major economic and social consequences, and are a drain on limited national resources. [71]

110. The poor are at greater risk of road traffic injuries, particularly as vulnerable road-users, e.g. pedestrians, bicyclists, those on motorised two-wheelers, passengers in mini-buses. These make up some 90 per cent of fatalities in developing countries. The mix of unsafe vehicles, poor road infrastructure, and inefficient law enforcement sets the scene for an unprecedented confluence of risks on the road. Inadequate trauma care, poor public health infrastructure, and limited pre-hospital care exacerbates injuries, prolongs the need for treatment, and/or results in disabling sequelae.[72]

111. Injuries are concentrated in those under the age of 45 years and tend to affect productivity severely, particularly among the lowest income groups whose exposure to risk is greatest.[73] Loss of an income earner, the significant cost of prolonged medical care, particularly hospital care, and loss of household income due to disability can precipitate poverty in the affected household. The ripples of this

70. Murray, C.J.L, Lopez, A.D. (1996), "Global health statistics: a compendium of incidence, prevalence and mortality estimates for over 200 conditions", *Harvard School of Public Health*, Harvard University Press, Boston.

71. Andrews, C.N, Kobusingye, O.C, Lett, R. (1999), "Road traffic accident injuries in Kampala", E*ast African Medical Journal*; Vol. 76, No. 4, pp. 189-194; Hijar, M., Carrillo, C., Flores, M., Anaya, R., Lopez, V. (2000), "Risk factors in highway traffic accidents: a case control study", *Accident Analysis and Prevention*, Vol. 32, pp. 703-709; Hyder AA, Morrow RH.

72. Nantulya and Reich (2002) in *British Medical Journal*.

73. Jamison, D.T. (1996), "Investing in health research and development", *Report of the Ad Hoc Committee on World Health Organisation Health Research Relating to Future Intervention Options*, WHO, Geneva.

loss can be felt by the extended family and informal community social support systems that are often called upon to contribute towards medical bills and care for the bereaved family[74].

B. Recommendations to development agencies

112. More attention must be paid to making the environment safer for those not using a car yet at considerable risk of being hit by one. Since the types of road traffic crashes in developing countries differ significantly from those in the developed world, prevention strategies cannot simply be exported from developed countries. Effective traffic injury prevention programmes are being implemented in some countries, often as pilot projects. Development co-operation agencies can assist prevention by supporting the evaluation and replication of effective programmes including:

- The development of a multi-sectoral approach, for example, improving data collection through support for injury surveillance systems in hospitals, health clinics, and police stations. Groups involving health, police, transport, and education sectors should design interventions based on data analysis. Possible interventions include the promulgation and enforcement of regulations such as the use of seat belts, safety helmet laws, running lights, and alcohol laws.
- The use of health and education channels to raise awareness of the problem and promote greater safety focusing particularly on children and vulnerable road users.
- The improvement of roadways and other engineering measures such as roundabouts and bridges for pedestrians, which can reduce crashes.
- The development of appropriate financial risk management systems to protect low-income households from catastrophic health expenditure after road traffic crashes.

3.5. Summary

113. Part Three has examined a number of policy areas and highlighted the ways in which sectoral policies impact on health and poverty reduction, and the need to strengthen policy in each area to take account of health/poverty linkages. Across these sectors and others, development agencies should support the evaluation and replication of effective programmes and provide additional financial assistance that focus on the MDG targets. In addition, they can:

- Help generate increased political will and leadership at the highest level in partner countries for greater focus on these policy areas. This includes developing policies that focus on the synergies with health and on improving the health outcomes of poor people through sectoral action. Additional resources to meet health objectives should flow through line ministries.

74. Nantulya, V.M. and Muli-Musiime, F. (2001), "Kenya: Uncovering the social determinants of road traffic accidents" in Evans, T., Whitehead, M., Diderichsen, F., Bhuiya, A. and Wirth, M. (eds.) *Challenging Inequalities: From Ethics to Action*, OUP, New York, pp 211-225.

- Facilitate greater partnerships with the private sector (including private-for-profit and private-not-for-profit) and help support longer term capacity development for positive regulation.
- Finally, development agencies can take forward cross-sectoral policies in the design and implementation of PRS. Part IV, discusses how PRS and other aid instruments can provide an important framework to connect policies outside the health sector with pro-poor health objectives.

PART FOUR

FRAMEWORKS AND INSTRUMENTS FOR HEALTH PROGRAMMING AND MONITORING

4.1. FRAMEWORKS AND INSTRUMENTS FOR HEALTH PROGRAMMING

114. The commitment by both developed and developing countries to support the health-related MDGs implies that the partners engage in a long term relationship to achieve lasting health improvements. Development agencies need to focus on building partnerships in which they can **support pro-poor health policies owned by the country and co-ordinate with other bilateral and multilateral organisations** to ensure consistency between approaches.

115. To this end, development agencies may rely upon a range of co-operation instruments and approaches. These may include policy dialogue, budget support, sector programmes, projects, technical co-operation, debt relief or global health initiatives. **To be effective, development co-operation instruments and interventions need to be deployed within commonly agreed frameworks** that help to set priorities and focus the purpose of interventions. The overarching framework is the national poverty reduction strategy (PRS) which is discussed below. Within this, a health sector programme may be appropriate as a way of negotiating and supporting priorities within the health sector whilst creating an environment in which a range of development co-operation instruments can be deployed. The sector wide approach (SWAp) is discussed in this context since it aims specifically to strengthen agency co-ordination in support of improved government-led health policies and increasingly relies on government for management, implementation and funding procedures.

4.1.1. Development co-operation instruments for pro-poor health development

116. Development co-operation instruments should be used in combinations that fit national conditions. Each instrument has advantages and disadvantages, affording differing degrees and qualities of impact.

117. **As the mode of delivery moves 'upstream' towards programme aid and budget support**, there is the opportunity to shift to approaches that are led by governments, based on domestically developed policies and rooted in national systems and procedures. The further upstream the mode of delivery, however, the more the development agency needs to be convinced that there is: (i) consensus on government policies and resource allocation for health and poverty reduction; (ii) capacity and commitment to carry out the programme; (iii) financial and performance management systems to ensure that resources are spent as agreed in health sector expenditure frameworks; and (iv) adequate reporting and monitoring mechanisms to track expected health outcomes for the poor. Upstream budget support addresses fundamental policy and allocation issues and represents a significant investment in capacity building and policy reform. As such, it requires a long-term commitment by development partners if it is to have an impact on health outcomes.

118. **Downstream project support** can yield immediate measurable benefits for the targeted vulnerable groups but cannot always address systemic issues in health delivery, or the cross-cutting and deeply embedded problems of poverty. Agencies must be mindful to ensure that projects enhance rather than disable local capacity to plan and implement health service delivery. There is a need in this regard to avoid large numbers of projects, with separate missions and implementation arrangements, which tax the limited capacities of partner countries.

4.1.2. Poverty reduction strategies and health

119. The emphasis on poverty reduction promoted by processes such as the Poverty Reduction Strategy Papers (PRSP)[75] could have significant implications for the way that pro-poor health programmes are designed and funded. More broadly, poverty reduction strategies (hereafter PRS) could potentially provide an important framework for understanding the practical relationship between pro-poor health objectives and policies in other sectors. As suggested below, a number of challenges need to be overcome if the potential of PRS for promoting pro-poor health policies is to be realised. Development agencies, in particular, can support the following actions:

- **Involve health constituencies in PRS formulation.** Partner countries need time to lead, develop and own their poverty reduction strategies. Consultation across government and with civil society should be an intrinsic part of this process. Within government, PRS development is typically led by a small group based in the ministries of finance, economic affairs or planning, or in the President's office. This represents a welcome "upgrading" of poverty issues to the most senior levels of government. However, there is a corresponding danger that sectoral ministries may play too small a role. Experience from PRSPs[76] suggests that health ministries in particular have not yet contributed significantly to the overall development of PRS, and, in some cases, even to the health content. PRSPs should also take into account the potential role of women's affairs ministries as stakeholders in bringing forward a gender perspective in poverty reduction,[77] since they often hold briefs for health related policies and programmes. This points to a need for agencies to:
    - Heighten awareness in health ministries, and elsewhere in government, about the potential contribution of health to poverty reduction and growth.
    - Help build capacity on PRS issues in the health ministry, also ensuring that it takes a more pro-active role.
    - Make sure that the health concerns of civil society (parliament, local government, community organisations, women's health advocacy groups and the private sector) are reflected in policy choices and priorities.
- **Emphasise the causal links between better health and poverty reduction**. In PRS analysis, ill health tends to be described as a consequence of poverty, rather than a cause. Thus, many PRS provide data on health status by income quintile, describing ill-health as an important correlate of poverty, along with lack of education or living in remote areas. By contrast, few PRS discuss the impoverishing

75. National poverty reduction strategies (PRS) are required in all low-income countries receiving concessional support from the World Bank and IMF. They provide channels for debt relief expenditure at national and sectoral levels and have the potential to increase external funding for poverty focused programmes

76. See WHO study.

77. The World Bank's PRSP Sourcebook has a full chapter on gender. It makes four key points: 1. The importance of a gender differentiated understanding of poverty and access to resources (this equally applies to health), 2. The need for gender disaggregated data, tools and methods of analysis, 3. The need to incorporate women's voices into consultations, 4. The importance of integrating gender into monitoring and evaluation of PRS.

effects of ill-health such as out-of-pocket medical expenditure and the impact on family income when the income earners or caregivers fall ill. Nor do they cover the importance of the health of both women and men in fostering growth across a variety of sectors, for example, through raising household productivity by reducing the opportunity costs of women's unpaid care tasks, creating and sustaining rural livelihoods, and increasing educational achievement. Agencies should work with partner countries to move beyond traditional definitions of productive and non-productive sectors and ensure that the potential contributions of health (and education) to poverty reduction are reflected in PRS.

- **Improve links with health sector programmes and gender policies.** So far, the linkages between poverty reduction strategies, health sector programmes and gender policies have been weak. The PRS has limited space for detailed sector analysis and is often too unspecific to clearly prioritise or force hard decisions. In addition, there is often a mismatch of targets, or key targets in one framework are not carried forward into the other. Specific contributions from agencies to assist partner countries in making explicit links between health, gender and PRS include:
    - Ensure that PRS objectives and targets are reflected in health sector programmes and in national policy frameworks on gender equality and vice-versa, with robust strategies for achieving proposed outcomes.
    - Encourage the use of health sector specific analysis to inform national poverty reduction strategies and build capacity in health ministries for gender and poverty analysis.
    - Address limitations in gender analysis, policy and implementation by identifying gender issues at community (micro), at sector level (meso), and at national level (macro)[78].
    - Use the PRS framework to encourage links between health and other ministries, including women's ministries and departments responsible for water, sanitation, education and nutrition in order to develop multi-sectoral strategies that are known to have a major impact on poor people's health (see Part Three).

4.1.3. Health sector programmes and their effectiveness in reducing poverty

120. Health sector programmes provide a key framework to channel development co-operation in support of national health policies. They allow agencies to engage in a dialogue on the policies and interventions likely to improve the health of the poor. Where it is appropriate, taking a sector wide approach (SWAp) to support a comprehensive health programme in a tightly co-ordinated fashion, will provide greater opportunity to reflect pro-poor health objectives than does a projectised approach (where partners will not see the sum of multiple development initiatives in the sector). The sector wide approach will not, in and of itself, ensure that the programme improves the health of poor people. But, the process by which partners "buy into" the government defined programme and help support its development through common procedures can help promote greater ownership, accountability and capacity to effectively achieve pro-poor health outcomes. This section first reviews how to emphasise pro-poor objectives in health sector programmes and, second, examines how sector wide approaches can increase development co-operation effectiveness and the sustainability of health programmes.

78. Making use of material such as: Guidelines for gender assessment studies (micro/meso levels); Gender checklists for institutional sector and organisational analyses (meso level); Guidelines for gender aware budget analyses; Reference material for gender and macro-economic sector analyses; World Bank PRSP source book - gender chapter.

4.1.3.1. Focusing health sector programmes on pro-poor objectives

121. In order to meet the health needs and priorities of the poor, sector programmes need an explicit emphasis on pro-poor objectives and approaches. This can be achieved in several ways that development agencies should emphasise:

- **Decision-making on policies to improve poor people's health should rely on rigorous poverty and gender analysis.**[79] For example, there needs to be a greater understanding of what services the poor use and why, how gender affects access and impact of services, how funds are channelled to meet priority areas, and the likely impact of HIV/AIDS on financing. Agencies need to support capacity development in this area within both the line ministry and outside institutions, ensure that poverty and gender analysis are built into sector planning and review cycles, and encourage open dialogue on the results. Ownership by national governments should not exclude discussion about issues that may not yet be priority for governments, such as pro-poor health and gender equality. Policy dialogue can be informed by international agreed priorities, such as the UN conventions on gender, health and rights.

- **Responsive health systems presuppose a dynamic dialogue between policy makers and beneficiaries**. A sector programme may not always provide for stakeholder participation. However, agencies need to ensure that consultation and participation continue throughout the health sector planning and review cycles both through existing structures (local government, NGOs, community organisations and women's groups) and through innovative approaches designed to access the opinions of the poor, hard to reach and under-represented groups.

- **The sector programme should include those policies and services that most affect the poor directly** and poor women in particular (e.g. primary health care, essential obstetric care) as well as those for which the funding impacts on the overall resources available for services for the poor (e.g. tertiary care). Ideally the sector programme should move towards comprehensive coverage of key areas of provision for the poor, namely health services; financing and social protection; public and environmental health, as discussed in Parts Two and Three.

- **The coverage should not be limited to the public sector and should encompass the private sector including NGOs and the private-for-profit organisations**. The contribution of NGOs in the health sector often requires redefinition of relationships between government and NGOs, and also between NGOs and development agencies who may wish to encourage contractual forms of relationship by redirecting NGO funding through government systems. However, agencies need to consider the impact on piloting and innovation, often areas of excellence amongst NGOs, and on the political acceptability of funding services for minority or special interest groups.

- **Global Health Initiatives should be integrated into the sector programme.** GHIs provide significant funding to key programmes that affect the poor (see Part Two). However, their discrete policy stances and vertical funding modalities have made integration into national health planning processes challenging. Development agencies need to ensure that global initiatives do not distort country ownership or the growing ability to plan and finance without earmarking. This can be achieved by (i) ensuring that GHIs are included in the PRS process, national health strategies and Medium Term Expenditure Frameworks (MTEFs); (ii) addressing areas of inconsistency between GHI contributions and national accountability structures making use of common procedures for financing, monitoring and

79. The DAC Working Party on Gender Equality has produced guidance on gender equality and SWAps. This makes out a strong case for the links between poverty, gender equality and aid instruments such as MTEFs. In particular, it notes the need for SWAps to: move towards comprehensive gender equality concepts; link integration of gender equality in the sector to national frameworks; carry out institution building and capacity building for gender equality; co-ordinate donor agendas in support of gender equality in SWAps. This is particularly needed in the health sector, where capacity in gender analysis is often weak or non-existent.

evaluation; and (iii) Linking in-country co-ordination of GHI with Ministry of Health management structures, annual health sector reviews and monitoring arrangements.

- **The sector programme should operate within decentralised systems.** Decentralisation is seen in many countries, in health as in other areas, as the key to providing accessible services that are responsive to the needs of the poor. However, sector programmes are negotiated with central government and usually rely primarily on existing institutional arrangements for consultation with local authorities. These may be weak, lacking in accountability and unrepresentative. Development agencies can help ensure that sector programmes support decentralisation and greater capacity at local level to deliver appropriate services.

4.1.3.2. Taking a sector wide approach to health programming and delivery

122. The sector wide approach (SWAp) is one in which all significant funding for the sector supports a single policy and expenditure programme, government leads and owns the programme, and there is a common effort by external partners in support of that programme. Over time, some SWAps progress towards using government procedures to manage implementation and to disburse funds. In practice most programmes are in the process of drawing diverse channels of funding into the programme, making the coverage of the sector more comprehensive, bringing ongoing projects into line with sector priorities, developing common procedures, and placing increased reliance on government for management.

123. The decision to take a sector wide approach must be made as a result of careful appraisal of conditions within the partner country, specifically the macroeconomic, policy and institutional environment. **The environment in which a health sector wide approach is an appropriate and effective approach to promote pro-poor health, is one in which**:

- The partner country has developed a poverty reduction strategy and is committed to implementing it.
- Development agencies and government can reach agreement on policies and priorities to promote a pro-poor health approach.
- There is a supportive macro budget environment, and confidence amongst all parties that agreed government resources will be available for promoting a pro-poor health approach.
- Accounting as well as fiduciary arrangements are transparent.
- The external contribution to the health sector is large enough for co-ordination to be a problem, and for government to be willing to let development agencies influence policy. Government needs to perceive that leading on the management of combined development co-operation has greater advantages than brokering fragmented agency funding.
- There is a critical mass of development agencies with activities in the health sector prepared to harmonise approaches with regard to funding, monitoring and management arrangements.

124. In essence, a sector wide approach calls for a partnership in which government and development agencies change their relationships (from donor-led to government-led development) and interact at a policy rather than implementation level. This partnership should be premised on: creating an atmosphere of mutual trust and greater commitment; sharing responsibility for addressing problems; accepting joint accountability and relinquishing attribution; managing collectively, rather than agencies prescribing and administering each funded transaction; and accepting higher levels of financial and institutional risk. This presents distinct challenges to agencies in terms of the investments they need to make to promote ownership, help build capacity, and also to change their own practices to facilitate the development of a sector wide approach:

- **Promoting country ownership and accountability.** Strong government ownership is a clear goal of the sector wide approach and essential if the government is going to take leadership for improving health and addressing poverty. The process of sector-wide integrated planning, moving from fragmented projects to a unified system, provides an excellent vehicle for increasing government ownership and control. This implies that agencies must step back from their previous practices of strong direction and concern with detailed implementation, and focus on the intended outputs and the broad orientations to achieve them. Agencies' legitimate concerns on the use of their funds should be addressed by agreeing on performance indicators and building appropriate management systems, including the sector programme annual review process. New forms of partnerships for greater accountability aim to facilitate ownership whilst ensuring performance. These include earmarking of expenditure, graduated releases against agreed performance benchmarks, annual reviews and aide-memoires with agreed implementation targets, and formal ground rules through obligations agreed in 'Memoranda of Understanding' and 'Codes of Conduct'.

- **Building capacity within government.** The sector wide approach is essentially about capacity building within government – the capacity to own, lead, implement and sustain policy making and implementation. It affords an opportunity to invest in the capacity of core government systems even beyond the Ministry of Health (MoH). Many of the key problems that have stymied MoH lie in other ministries, more powerful than health. Agencies, therefore, need to work with governments more broadly to address such issues as staff appointments and performance, management, budgeting, accounting, and procurement. Agencies also need to look beyond their technical remits and share investments in capacity, moving away from micro initiatives, and being bold enough to tackle more fundamental issues. In as much as the sector wide approach removes agencies from the detail of project management, the partnership requires good dialogue on the larger policy issues.

- **Changing development agency practices.** Many agencies find that one of the biggest challenges to creating a conducive environment for sector wide approaches is in changing their behaviour and work practices. Supporting a sector wide approach, requires agencies to take part in co-ordination, sign up to the sector strategy, accept a degree of harmonisation in reporting, allow government to take the lead in implementing projects where they still exist, and in many cases, be willing to participate in new funding modalities. When agencies retain their individual reporting and management systems the sector wide approach cannot meet its full potential to increase ownership and capacity. A sector wide approach necessitates new lines of accountability, moving away from agency accountability to their domestic constituents for specific health gains achieved through discrete interventions, towards increased partner governments' accountability to their populations for the external funds they receive. This means greater capacity to manage the funds and their use, and ownership of the results.

125. For sector wide approaches to be sustainable it is important that development agencies resist their own demands for immediate results. Progress may not be immediately recognisable in traditional agency monitoring systems where the emphasis is on short term indicators. At the same time, the sector programme needs to build in rigorous monitoring - used by partner governments as well as development agencies - that measures more than processes (see next section).

4.2. MEASURING AND MONITORING PROGRESS

4.2.1. Measuring health system performance and health outcomes

126. As part of their efforts to implement poverty reduction strategies and health sector programmes, partner countries need to measure health system performance and health outcomes and monitor the extent to which they are pro-poor. While measuring *outcomes* is critical to judging the performance of health systems, indicators tracing *inputs and processes* are also needed to understand and monitor health systems performance towards pro-poor outcomes and to track budgetary allocations and service delivery.

127. In partner countries statistical systems are generally weak and most existing monitoring systems are inadequate for measuring poverty and health. Even when showing improvements in health outcomes, national figures can hide growing inequities. Lack of disaggregated data (by gender, income group, region) makes it difficult to capture the impact of policies and interventions - within and beyond the sector - on the health of the poor. National planning and implementation systems have seldom developed an institutional culture of using data derived from management information systems to implement their programmes more effectively in order to achieve desired outputs and outcomes. Often, poverty data generated by the national statistics office are not put in context with health data generated from the Ministry of Health. Furthermore, different ministries compete with one another on data collection. Externally conducted information systems like Demographic and Health Surveys (DHS), Living Standards Measurement Surveys (LSMS), and World Health Surveys are able to fill these gaps only partially as they are often not integrated in national health management information systems.

4.2.2. Adequate monitoring systems - meeting a hierarchy of need

128. Measuring health systems performance and pro-poor health outcomes requires a responsive information system that includes: (i) an analysis of poverty and health determinants, including gender; (ii) realistic quantitative targets and benchmarks (modelling); (iii) base line data; (iv) policy and programme monitoring (input/output/outcome); (v) benefit incidence analysis; (vi) impact evaluation; and (vii) feedback mechanisms.

129. **Partner countries require sound monitoring systems for a variety of purposes**. Information is needed for evidence-based planning, accountability, advocacy, communication and resource mobilisation. Ministries of Planning and Finance require an overview of the performance of all sectors to justify budgets, to gauge progress of national development efforts and to report against international obligations. A country's monitoring framework is reflected in the national development plan, increasingly elaborated in the poverty reduction strategy. At this level there are few process indicators. Partners in the health sector programme need to monitor progress across the whole sector and require limited data on programme components. Many countries have established core data sets of 20-25 sectoral indicators. Some are building second generation indicators sets based on experience and with greater focus on outcome measures. Health sector managers typically monitor a large number of indicators of input, process and output, and more intermittently, of outcome and impact with regard to programme operations and performance.

130. **Monitoring systems also need to reconcile national and international needs and obligations** The main objective should be to strengthen national data collection and analysis for local decision making and for monitoring the implementation of the poverty reduction strategy and the health sector programme. But countries also have international obligations, for example, to report on notifiable communicable

diseases. Furthermore, there is increasing consensus on the need to monitor a few core indicators linked closely to the eight ***Millennium Development Goals*** (with 18 targets and 48 indicators). Three of the eight MDGs refer to health, with four specific targets and 12 indicators. The MDGs reflect high-level impact indicators that monitor changes occurring only slowly over time. The indicators combine a mix of measures of impact (mortality rates) and process/output (immunisation, attended births, prevention measures). Also required are indicators able to measure short term (annual) or medium term (three-year) progress and to predict progress on the slower-moving outcome indicators of mortality. There is a tension between establishing common core standards and benchmarks across all countries to guide development co-operation and the primacy of country ownership.

Health-related Millennium Development Goals (MDGs)	
Goals and Targets of the Millennium Declaration	**Indicators for monitoring progress**
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	**1.** Under-five mortality rate **2.** Infant mortality rate **3.** Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	**4.** Maternal mortality ratio (WHO estimates) **5.** Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	**6.** HIV prevalence among 15-24 year old pregnant women **7.** Contraceptive prevalence rate **8.** Number of children orphaned by HIV/AIDS
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	**9.** Prevalence and death rates associated with malaria **10.** Proportion of population in malaria risk areas using effective malaria prevention and treatment measures **11.** Prevalence and death rates associated with tuberculosis **12.** Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

4.2.3. Collaborative efforts to strengthen statistical and monitoring capacity

131. A major effort is needed to strengthen statistical infrastructure and systems. This is best provided through a co-ordinated approach that is integrated into processes for the formulation, implementation and monitoring of poverty reduction strategies.

132. Changing approaches to development co-operation have highlighted the gaps in existing monitoring systems. Many donors are moving towards budget support linked to results, including defined improvements in health outcomes. New global initiatives such as the GAVI and the Global Fund to fight AIDS, Tuberculosis and Malaria, emphasis the achievement of outcomes. It is important, therefore, that these multiple data systems are integrated and embedded in an effective country-led system and that perverse incentives are avoided.

133. The PARIS21[80] Consortium, a partnership of policy makers, analysts, and statisticians specifically focuses on strengthening statistical systems and on promoting, in the longer term, a culture of

80. PARIS21 was launched at a meeting held in Paris in November 1999 at the initiative of the UN, OECD, World Bank, IMF and the EC in response to a UN ECOSOC resolution on indicators and statistical capacity building.

evidence-based policy making and monitoring in all countries, but especially in low-income developing countries. This in turn will serve to improve transparency, accountability and the quality of governance.

134. Work to select appropriate indicators for monitoring health systems performance and pro-poor health outcomes has been initiated through a joint programme (2003-2009) with participation from WHO, the World Bank, the European Community, USAID, the Rockefeller Foundation and others. The purpose is to improve capacity to measure poverty and health, to monitor health system performance, and to evaluate PRS and health sector reforms in achieving pro-poor health outcomes. The programme will run, on country request, in 8-12 selected countries in Africa, Asia, Latin America and transition countries. Country led processes are expected to allow following a sector wide approach in co-ordinating external support for performance and outcome monitoring and statistical capacity building.

4.2.4. Principles to guide development co-operation in monitoring progress

135. In supporting partner country efforts to build effective monitoring systems and to measure progress towards improving the health of the poor, development agencies need to consider the following guiding principles:

- **Where possible use and build on what is in place**. Avoid creating parallel systems. Any effort should reinforce national capacity and country ownership. A number of countries, where sector wide approaches in health are in place (Ghana, Mozambique, Uganda) have already selected about 20 sector-wide indicators that provide a basis for monitoring health outcomes[81].

- **Selection of indicators: measuring health outcomes and monitoring health system performance are equally important.** While there is an increased focus on health outcomes, it is also necessary to monitor how health systems interact with poverty and to what degree systems become pro-poor in terms of ensuring access, equity and fair financing. This requires a pro-poor follow-up on inputs, outputs *and* outcomes. It is necessary to monitor issues such as health care seeking patterns, willingness/ability to pay, efficiency, equity, access and utilisation by gender, quality, financial accessibility and distributional aspects of progress towards meeting the MDGs and to disaggregate these measures by gender. New intermediate indicators are needed to link health sector processes to pro-poor health outcomes and there is still considerable work to ensure that suggested indicators can be measured in a reliable and comparable way.

- **Co-ordination, collaborative efforts and harmonisation of procedures are important.** Indicators in PRS, health sector programmes, mid-term and annual plans, as well as development agency country strategies need to be consistent. Use core global indicators and guidelines agreed by all agencies and parties focused on a limited number of relevant and practical variables. Information provided should meet the needs of the policy process and good public administration. Indicators should be relevant, feasible to measure, able to track changes over time, and data collection should be inexpensive and involve no additional workload. Note that the increasing trends towards results-based disbursement may create perverse incentives.

- **Invest in building national information management capacity** within and outside the public sector. All programmes should budget adequately for Monitoring and Evaluation (M&E) activities through the PRS process. Facilitate joint working for performance assessment across government and civil society. The national health management information system can be complemented by work contracted out to

81. Ghana: 25 indicators measuring inputs, outputs and outcomes in terms of: access, quality, efficiency/effectiveness, partnership and financing. (Accorsi, EC Technical Assistance to the Health Sector in Ghana, Measuring health sector performance thorough indicators: toward evidence-based policy, March 2002)

independent universities or other research institutions. In some countries, there is an opportunity to expand existing sentinel surveillance sites, population laboratories and maximise potential benefits of special surveys such as DHS.

- **Accept a trade-off between statistical quality, completeness and the costs of collecting representative data.** Use proxy measures and build up an overall picture of progress from diverse and complementary data sources. Start with few robust quantitative indicators and good qualitative process indicators. Countries will need to fund data systems in the medium to long term. A limited system focussing on few core indicators will be more sustainable than a comprehensive system. In addition, not all the key data need to be measured each year, or even by the routine health management information system; intermittent monitoring is appropriate for some key variables.

PART FIVE

PROMOTING POLICY COHERENCE AND GLOBAL PUBLIC GOODS

136. The health problems of the poor do not stop at national borders. In a globalised world, people and information as well as goods and services travel across borders with increasing speed and ease. Thus, globalisation presents new risks to health as well as new opportunities to prevent, treat or contain disease. National governments, working at the regional and global level, must devise new ways of working together to address common threats to health.

137. As Part Three emphasised, the role of policies in other sectors must be considered in devising a coherent health and poverty reduction strategy at the national level. Macroeconomic policies have significant effects on the health of the poor and on the performance of health systems, by influencing the price of essential health inputs and the funding available for health expenditure, as well as by its impact on the real incomes of poor people. In addition, international trade in goods and services, and global rules governing such trade, play a major role in determining the availability and affordability of essential health products and services.

138. This part focuses on two key aspects of international co-operation needed to complement and reinforce the efforts of national governments to improve the health of the poor. First, it addresses global public goods (GPGs) for health, which will benefit people in every country, but particularly those in low-income countries. GPGs include medical research and development focused on diseases that most affect the poor, as well as efforts to stem cross-border spread of communicable disease. Second, it deals with the relevance of international agreements on trade to the health needs of the poor, particularly the agreements dealing with trade-related intellectual property rights, trade in health services, and trade in hazardous substances.

139. Development agencies have critical roles to play in fostering international collective action to improve the health of the poor. The recommendations identify areas in which development agencies can help to strengthen capacity in low-income countries to participate in the production of GPGs for health. These recommendations encourage support for international initiatives that bring together developed and developing countries along with private sector and civil society representatives to create new incentives and boost commitment to reducing the burden of disease in poor countries. Finally, they suggest that development agencies foster policy dialogue and provide technical assistance to developing country health and trade officials, and those in other relevant sectors, in order to design coherent national policies.

5.1. GLOBAL PUBLIC GOODS - THEIR SIGNIFICANCE FOR HEALTH

140. The importance of GPGs has been increasingly recognised in international development circles. The concept is used in various ways – from the original definitions of non-rivalry and non-excludability in

the economic theory of public goods[82] to almost anything that is broadly beneficial to people in more than a single country. Here, the Guidelines follow the international practice (e.g. CMH) and use the term Global Public Goods to denote products, services and activities that are under supplied by the market, are of broad international concern, and require international public action.

141. Global public goods for health can only be provided by countries working together, often in partnership with the private sector. The challenge facing development agencies is how to call government-wide attention to the need for global public goods for health for the benefit of all people and countries. The following sub-sections describe two examples of global public goods for health – the invention of new vaccines and medicines, and effective public health surveillance systems to detect and control the cross-border spread of communicable diseases – and identify what is needed to strengthen the incentives for their production. Another GPG for health, not discussed in any detail here, is knowledge about how best to organise and finance health services to improve health outcomes among the poor. These guidelines are a case in point.

5.1.1. Medical research and development

142. The invention and production of new drugs, vaccines and diagnostics is central to modern disease prevention and treatment. Yet, as documented in a 1990 report of the WHO Commission on Health Research and Development, there is a huge gap between the diseases most common in poor countries and the level of investment in new drugs, vaccines and diagnostics needed to combat those diseases. Only 10 percent of research and development (R&D) investment by the pharmaceutical industry is spent on the health problems of 90 percent of the world's population. Countries where the diseases are most prevalent are least able to afford public investment into R&D and because poor countries lack purchasing power, there is insufficient motivation for the pharmaceutical industry to invest in research against such diseases.

143. In defining priorities for bridging this "10:90 gap", incentives need to be matched with particular diseases. In this regard, a useful distinction was made in the CMH report between three categories of diseases:

- **Diseases common in both rich and poor countries** such as diabetes, hepatitis B and measles, for which incentives for private R&D already exist. The question is rather how to make the prices for newly invented drugs and vaccines to treat these diseases affordable to the poor in low-income countries. One way is voluntary or negotiated systems of differential pricing for drugs aimed at such diseases, in which poor countries pay lower prices and rich countries higher prices for expensive drugs under patent protection. Development agencies might consider ways of promoting this solution, which was endorsed by the CMH, within their own governments and in international fora. Where differential pricing mechanisms do not work, and prices for patented drugs remain beyond the reach of poor countries, certain trade remedies are possible, as discussed in Section 5.2.

- **Diseases common in both rich and poor countries but with the largest affected populations in the low-income countries**, such as HIV/AIDS. For these diseases, R&D incentives exist but the level of investment is disproportionate to the burden of disease in poor countries. In this situation, a combination of "push" and "pull" incentives may be necessary. Greater public investment in R&D at the global level in diseases that primarily affect the poor, channelled through international coalitions that can identify priorities and promising initiatives, could push the private sector and research

82. *Non-excludability* means that it is either impossible or prohibitively costly to exclude those who do not pay for consuming a good or service. *Non-rivalry* means that one person's consumption of a public good has no effect on the amount available to others. The corresponding concept of a *public bad* refers to goods or services that have a negative utility, which the community would benefit from preventing or reducing.

communities to spend more on these diseases. In some cases, commitments to purchase new drugs and vaccines targeted at neglected diseases might pull the research and development process faster along.

- **Diseases specific to poor countries in tropical climates**, such as malaria, Chagas Disease, sleeping sickness and onchocerciasis (river blindness). For these diseases, even greater efforts may be necessary to induce new R&D. Here increased public funding of basic biomedical research is needed as well as the "push"and "pull" measures above. One promising approach would be to extend programmes already in place in OECD countries for their own "orphan diseases" to cover diseases of poor countries as well. Orphan drug incentive programmes can include research grants, tax credits, or extensions of patent protection.[83]

144. Aligning the incentives to induce greater R&D investment on diseases that primarily affect the poor in low-income countries requires international co-operation and close collaboration between public and private sector actors. Currently, there is a wealth of initiatives underway to stimulate critically needed but under-provided medical R&D, but the share of research going to the health problems of poorer countries remains well under what is needed.[84]

145. While such initiatives may be based at multilateral institutions (WHO, UNAIDS, UNDP or the World Bank), they increasingly involve partnerships between international agencies, pharmaceutical companies, private non-profit organisations, bilateral aid agencies, research institutions and private foundations. When appropriately organised and motivated, such public-private partnerships (PPPs) constitute a key strategy to tackle neglected health issues in developing countries.

5.1.2. Cross-border spread of communicable diseases

146. Increased travel, migration, and trade in food and animals across borders makes the world more vulnerable to cross-border spread of communicable diseases. In addition to medical research and development, cross-border surveillance, prevention and control constitutes a key global health public good. Three types of collective action at the international level can help to prevent cross-border transmission of disease: i) disease surveillance; ii) the containment of anti-microbial resistance (AMR); and iii) disease eradication programmes. The effectiveness of all three activities depends largely on capacity at the national and regional level. Low capacity or poor performance in one country is a threat to all. Thus, the production of the global public good in this case calls for efforts to strengthen the weakest links in the communicable disease control chain.

5.1.2.1. Global and national disease surveillance

147. The first step in controlling cross-border disease transmission is to detect it. Countries have been co-operating in efforts to monitor and track the spread of communicable disease for more than a century. WHO's global outbreak alert and verification process, epidemic preparedness plans and stockpiles of essential medicines have reduced the need to use trade embargoes or travel restrictions to control cross-border disease transmission. Still, the current system remains fragmented and suffers from chronic under-funding. Low-income countries are the weakest link in the global surveillance chain. They lack sufficient laboratories and lab technicians, communications infrastructure, and disease reporting systems. Linkages between monitoring and response systems are also inadequate.

83. "Orphan diseases" are those that occur in such low incidence in developed countries that market incentives are lacking to induce R&D.

84. For a review of some of these initiatives, see the Global Forum on Health Research report, *The 10/90 Report on Health Research, 2001-2002*, Chapter 8, "Some networks in the priority research areas".

148. Efforts to address the problems in low-income countries have been ongoing for many years, aided by WHO and development agency support. These need further attention. But better trained health professionals cannot compensate for a global system that remains inadequate to the challenges presented by the emergence of new pathogens, the re-emergence of old ones, and the development of drug-resistant strains of microbes.

149. The WHO in 1995 started the process of revising the International Health Regulations (IHR), currently the only international health treaty, expanding the scope of notifications required of WHO Member States beyond just plague, cholera, and yellow fever, to cover "*public health emergencies of international concern*." Low-income countries need support to fully participate in the IHR negotiations and, once the revised IHR is adopted, to implementing changes required in their surveillance systems.

5.1.2.2. Global strategies for containing anti-microbial resistance

150. The ability of micro-organisms to develop resistance to antibiotics is a natural biological occurrence, but it has been exacerbated by the improper use of antibiotics. In several countries, tuberculosis strains have become resistant to at least two of the most effective drugs used against the disease. Elsewhere, commonly used anti-malarial drugs have become virtually useless because the malaria parasite has acquired resistance to them. When treatment fails, patients remain infective for longer periods of time, increasing the opportunity for the resistant strain to spread. Drugs needed to treat multi-drug resistant TB are nearly 100 times more expensive than drugs used to treat non-resistant strains.

151. Action taken in any one country will have positive results for all. In many developed countries, overuse of antibiotics must be reduced, while in many developing countries, misuse, or under-use are more important problems. International collective action is important for setting norms and standards to facilitate responsible national policies. In 2001, WHO launched a global strategy to contain the spread of drug resistance, involving over 50 recommendations for patients, health providers, hospital managers, agricultural sector representatives (antibiotics used for disease control and growth-promotion in animals contributes to human drug resistance), and health ministers.

152. Because most of the responsibility for implementing the recommendations lies at the national level, it is in the interest of developed countries to provide assistance to low-income countries that lack resources to take the necessary action. In addition, surveillance of anti-microbial use and anti-microbial resistance, including its containment, is an example of a global public good for health that merits broad development agency support.

5.1.2.3. Disease eradication and elimination programmes

153. Eradication is often cited as an example of a 'pure' global public good: once eradication has been achieved, all countries gain and they do not have to compete for their share of the benefits. There are also clear and lasting benefits to eradication: since the final eradication of smallpox in 1979, an estimated 30 million lives and USD 275 million in annual direct costs have been saved.

154. Eradication of polio is now 99 per cent complete, largely due to national mass immunisation campaigns, supported by a global coalition of international organisations and bilateral development agencies and civil society organisations. Once polio has been eradicated, savings on vaccination costs world-wide will amount to over USD 1 billion a year. The benefits of disease control efforts are greatest for countries that have already reduced disease prevalence rates within their borders to relatively low levels. However, only through global elimination will costs related to that disease disappear. For example, the United States stands to save around USD 250 million a year - the amount it now spends on polio immunisation every year to prevent the re-importation of a disease it has already eradicated.

155. A number of other diseases are amenable to disease eradication or elimination. Available and effective prevention or treatment is a precondition, as are sufficient means and motivation to extend vaccines or treatment to all. In addition to polio, global efforts are focused on eliminating (or to reducing the number of cases to less than 1 in 10 000 in the total population) filariasis, leprosy, guinea-worm disease, tetanus, Chagas disease, and measles. Development co-operation has helped to supplement these disease control initiatives in low-income countries. However, the resources remain small relative to need. Greater efforts are needed both at national and international levels as these efforts get closer to achieving their goal.

5.1.3. GPGs for Health - recommendations for development agencies

156. Development agencies have a key role to play in correcting the "incentive gap" for the production of global public goods for health. Recent developments suggest that appeals for financing and developing GPGs help increase support for aid for health and for aid overall. Since the benefits derived from GPGs for health accrue to rich countries as well as poor ones, **funding for GPGs should come not solely from international aid budgets, but also be drawn from sources other than ODA** (e.g. national health sector or research budgets) in OECD countries. This could provide enlarged funding and technical support to help tackle critical global health problems. Increased donor effectiveness requires, in part, assisting the achievement of enhanced global public goods for health.

157. Development co-operation agencies can help to close the gap between current R&D investment and the health problems of the poor by **supporting under-funded activities in low-income countries that are important to ensure global health benefits**. This would strengthen the capacity of developing countries to participate as partners in the production of global public goods for health. This could involve, for example:

- Assisting partner countries to develop the institutions necessary for testing and effectively using new health technologies.
- Fostering collaboration between research institutions in developed and developing countries for R&D on GPGs, with a focus on neglected diseases, and financial support for regional research and training centres.
- Promoting policy dialogue among developed and developing countries to help create an enabling environment for the provision of GPGs.
- Encouraging medical research councils in developing countries to focus more on the diseases of the poor.
- Supporting low-income countries' participation in the IHR revision process to ensure that their needs and priorities are reflected and helping with the implementation of any required changes in their surveillance systems.
- Strengthening national disease surveillance systems, to contain anti-microbial resistance, and to implement disease eradication and elimination programmes.

158. Development agencies can also provide **critical financial support to international initiatives that are seeking to produce new vaccines, drugs and knowledge focused on the health problems of the poor.** According to the CMH, USD 3 billion are needed by 2007 and USD 4 billion by 2015 for new vaccine and drug development. It is important that this funding be consistent. It can come through direct funding and through the range of "push" and "pull" incentives, including through "orphan drug" programmes discussed above. Donors could also consider whether part of this support could be for a new

Global Health Research Fund (GHRF), to support basic biomedical research. This would be, in effect, an international version of the United States National Institute of Health or Medical Research Councils in other countries. Appropriate governance of a new GHRF is an important issue in this regard.

159. Consideration should also be given to pilot projects to pre-commit funds to buy products of new research. These should include expert purchasers to negotiate with pharmaceutical companies so as to ensure the lowest viable commercial price.

5.2. HEALTH, TRADE AND DEVELOPMENT

160. Trade in goods and services, and the global, regional and bilateral agreements that have emerged to govern international trade, have increasing influence on the health of the poor. Because of their relevance to other actions discussed in this report, they warrant a brief overview so that development agencies can engage in discussions with government trade departments about policy coherence for global health. While the scope of trade and health issues is large,[85] this section focuses on: 1) intellectual property rights and access to essential medicines; 2) trade in services and its implications for access to health services by the poor; and 3) trade in hazardous commodities.

5.2.1. Intellectual property rights and access to essential medicines

161. Assuring access to essential medicines and vaccines depends on four critical elements: affordable prices, rational selection and use, sustainable financing, and reliable supply. In the context of trade agreements and providing access for poor people, the issue of price is most relevant. Lowering the price of essential medicines is vital to health in developing countries, which spend 25 to 65 per cent of total health expenditures on pharmaceuticals, but where health budgets are too small to buy enough medicines and poor people cannot afford to pay for them.

162. The WTO Agreement on *Trade-related Aspects of Intellectual Property Rights (TRIPs)* provides at least 20 years of patent protection for all inventions of products and processes in all WTO Member countries. During this period, patent owners retain certain rights regarding the sale and use of their inventions; they have the right to prevent competitors from using the information to produce the same products. For this reason, the price of patented drugs is usually much higher than the price that would prevail if generic competition were allowed. For the pharmaceutical R&D industry, such patent protection serves as an important incentive for the development of new medicines.

163. The TRIPS Agreement recognises the right of WTO Members to make exceptions to TRIPS rules for reasons of public order or morality, or for the protection of public health. It also provides WTO Members with flexibility to safeguard public health, and in particular to promote access to medicines for all. TRIPS allows for compulsory licensing, whereby a government may authorise production of a patented product or use a patented process without the consent of the patent owner, under certain conditions. Another way WTO Members can protect public health is through the use of parallel importation. This allows for the import of patented or trademarked products from countries where it is marketed by the right holder, or with its consent, at a price lower than that in the importing country.

85. See the 2002 report, WTO Agreements and Public Health: A Joint Report by the WHO and WTO Secretariats at: http://www.who.int/media/homepage/who_wto_e.pdf

164. At the November 2001 WTO Ministerial Conference in Qatar, the WTO adopted the ***Doha Declaration on the TRIPS Agreement and Public Health***, which made a number of important clarifications. It affirmed that each WTO Member is free to determine the grounds upon which compulsory licences may be granted, rather than only in an emergency. It clarified that in national emergencies or other circumstances of extreme urgency, countries are exempt from the usual condition that an effort must first be made to seek a voluntary licence. The Declaration also makes it clear that each Member has the right to determine what constitutes such situations, and that they can include HIV/AIDS, TB, malaria and other epidemics.

165. One issue left unresolved by the Declaration on TRIPS and public health is that TRIPS compulsory licensing rules require that products made under such licences be "authorised predominantly for the supply of the domestic market of the Member authorising such use" (Article 31.f). After 2005 when the TRIPS Agreement must be fully implemented in all WTO Member countries, the provisions of Article 31.f could mean that countries without sufficient domestic drug manufacturing capacity will not be able to grant compulsory licences for local production, nor will they be able to import generic versions of patented drugs. This is an important issue, which needs to be resolved in order to secure global policy coherence for pro-poor health.

166. **Member agencies should encourage their governments to monitor the implementation of the Doha Declaration on TRIPS and Public Health** to assess how well it assures the ability of developing countries to use TRIPS' safeguards to lower the price of essential drugs under patent protection. It will also be important to monitor the outcome of the debate in the WTO Council on TRIPS on the ability of countries with no drug manufacturing capacity to make effective use of compulsory licensing, in order to assess the implications for the availability and prices of essential drugs in low-income countries.

5.2.2. International trade in health services and GATS

167. International trade in health services appears to be rising, driven by a multitude of factors. Advances in communications technology make it possible to deliver telemedicine across borders while giving rise to new forms of health services trade, such as providing overnight medical transcription in India to physicians in the United States. Faster and less costly travel makes it easier to obtain care in other countries, and developing countries are marketing special packages to attract medical "tourists". Health care reforms in some countries have created opportunities for private health care suppliers - domestic and foreign owned - to provide services. And increasing numbers of health professionals are migrating from lower-income to higher-income countries in search of higher wages and better working conditions.

168. The WTO *General Agreement on Trade and Services (GATS)* provides WTO Members with a range of policy options to allow them to liberalise services trade on a gradual basis, in line with their development objectives. GATS negotiations underway in the WTO are intended to deepen and widen commitments in all sectors, and if this extends to health services, it could open up domestic health markets for foreign competition. This may generate either benefits or risks to poor people's access to health services.

169. Increased foreign investment in private health facilities may improve the standards of health care quality in recipient countries. But if this investment is on a large scale and supports hospitals and services that offer more attractive wages and working conditions, it may exacerbate staff shortages in the rural and public facilities on which the poor rely. The absence of empirical evidence on how trade liberalisation affects access to health services by the poor in low-income countries suggests the need for more research and monitoring. Lessons on the sequencing of privatisation suggest that to achieve equity and efficiency

goals, countries must put in place effective regulatory frameworks *prior* to privatisation and opening the market to foreign investors. This applies to the health sector as well.

170. It is essential to enhance the availability of professional medical staff in low-income countries through improved working conditions, including rehabilitation of facilities and equipment, human resource management reforms, support schemes for reinsertion of private sector practitioners and North-South institutional partnerships, including documentation and training programmes.

171. An inadequate supply of trained health professionals is the general rule among low-income countries. Although their professional education has usually been highly subsidised, health professionals often emigrate to benefit from better salaries and working conditions. In addition, some OECD countries facing their own shortages of professional staff have encouraged migration with active recruitment of those with appropriate professional and language skills, without explicit consideration of the shortages of professional staff in the source countries. This exacerbates health service delivery problems in these countries. In only a few countries (e.g. the Philippines), could a reasonable argument be made that remittances substantially offset the cost of reducing the domestic supply of health professionals. Some OECD countries are taking steps to address these issues, particularly that of active recruitment. It has also been suggested that WHO develop an ethical chart on the international recruitment of health professionals, including support for improved employment conditions in low-income source countries.

172. As international trade in health services grows and diversifies, and agreements concerning services trade expand to cover health care, developing countries need guidance on how to assess the benefits and risks, and the implications for health system regulation. Development agencies may consider how to **support the needs of low-income countries for specialised technical assistance on trade in health services and encourage dialogue between health and trade ministries to ensure national policy coherence**. Agencies might also search for opportunities to support credible research on the effects of trade liberalisation on access to health services by the poor, to expand the body of knowledge on this issue.

5.2.3. Trade in hazardous commodities

173. International trade in goods, products and commodities may involve public health concerns. WTO allows Members to make exceptions to the rules of free trade in order to protect human life or health and to protect the environment, even if manufacturers assert that the risk can be contained.[86] There are several international treaties that address trade in hazardous goods, reflecting the international community's common concern and responsibility for tackling transboundary or global environmental problems that affect human health.[87]

174. The first international treaty proposed to address a health issue is the Framework Convention on Tobacco Control (FCTC).[88] Among its trade-related features are those designed to: combat illegal trade and smuggling; phase out duty-free sales and increase and harmonise taxes internationally; exempt tobacco products from reduced tariff agreements; and, address various packaging, labelling and advertising issues.

86. A recent WTO dispute case involving asbestos – a well-established carcinogen – affirmed that countries could ban trade in goods hazardous to health. An account of this case is provided in the WTO -WHO 2002 report.

87. These include the Basel Convention on the Transboundary Movement of Hazardous Wastes, the Rotterdam Convention on Prior Informed Consent (PIC) for dangerous chemicals and the Stockholm Convention on Persistent Organic Pollutants (POPs).

88. See Box 2. FCTC was being negotiated in 2002 and expected to be ready to be submitted for signing by governments in 2003.

175. Development agencies concerned about promoting the health of the poor in developing countries through measures to reduce exposure to hazardous goods and commodities, including tobacco, should consult with colleagues in environment and trade departments. Such discussions should **seek coherence in OECD country policies on aid, trade, environment and health**.