80 MILLION LIVES

Meeting the Millennium Development Goals in child and maternal survival

growup

free from poverty

international action against child poverty

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Meeting the Millennium Development Goals in child and maternal survival

The following non-governmental organisations and faith groups are members of the Grow Up Free from Poverty Coalition. They share a vision to end the outrage of child poverty. As part of their efforts to ensure that this vision is owned internationally they have prepared this report.

ActionAid

CAFOD

Christian Aid

Christian Socialist Movement

Connect Youth, The British Council

Consortium for Street Children

EveryChild

HelpAge International

Help the Aged

Justice, Art and Education

The Mothers' Union

National Council of Hindu Temples

PLAN International

Save the Children

Scottish Catholic International Aid Fund

Tearfund

United Reformed Church

Viva Network

World Vision

Published in 2003 by the Grow Up Free from Poverty Coalition

Produced on behalf of the Grow Up Free from Poverty Coalition by Save the Children

A copy of this report is downloadable from www.savethechildren.org.uk

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Acknowledgements

The report was commissioned by members of the Grow Up Free from Poverty Coalition and written in collaboration with the Centre for International Health Studies, Queen Margaret University College, Edinburgh. The coalition wishes to acknowledge the essential work done by colleagues in the member organisations, in particular members of the Grow Up Free From Poverty Conflict and Violence Working Group, in contributing information and case studies for the report, and finalising the text.

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Suzanne Fustukian would like to thank Margaret Leppard and Sarah Ssali from the Centre for International Health Studies, Queen Margaret University College, for their input into the sections on maternal mortality.

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Glossary and definitions

Child mortality rate: the number of children dying between one and four completed years of age, per 1,000 live births (Costello and White, 2001).

Infant mortality rate: the number of infants dying in the first 12 months, per 1,000 live births (Costello and White, 2001).

Maternal mortality rate: the number of women who die from complications of pregnancy, delivery, or related complications, per 100,000 live births (WHO et al., 2001).

MDG 4: Reduce by two-thirds, between 1990 and 2015 the under-5 mortality rate.

MDG 5: Reduce by three-quarters , between 1990 and 2015 the maternal mortality rate.

Neonatal death: the death of a liveborn infant during the period that commences at birth and ends 28 completed days after birth.

Neonatal mortality rate: the number of liveborn babies who die in the first 28 days after birth, per 1,000 live births.

Perinatal death: The death of a foetus weighing at least 500 grams (or for when birth weight is unavailable, after 22 completed weeks of gestation or with a crown–heel length of 25cm) or the death of an infant during the first week of life.

Sector-wide approaches: 'all significant funding for the sector supports a single policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disperse and account for the funds' (ODI, 2001).

Stillbirth: The death of a foetus weighing at least 500 grams (or for when birth weight is unavailable, after 22 completed weeks of gestation or with a crown–heel length of 25cm or more), before the complete expulsion or extraction from its mother.

Traditional Birth Attendant: a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants.

Under-five mortality rate (U5MR): the number of children dying between birth and four completed years of age per 1,000 live births (Ahmad et al., 2000).

Abbreviations

AAI	Accelerating Access Initiative
ARV	Antiretroviral
CAFOD	Catholic Agency for Overseas Development
CAP	Common Agricultural Policy
CBO	Community based organisation
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CMH	Commission on Macroeconomics and Health
CSO	Civil Society Organisation
DALY	Disability Adjusted Life Year
DFID	Department for International Development
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, TB and Malaria
GNP	Gross National Product
GUFP	Grow Up Free from Poverty coalition
HACI	Hope for African Children Initiative
HAI	HelpAge International
HDR	Human Development Report
HIPC	Heavily Indebted Poor Countries
IAACP	International Action Against Child Poverty
IDP	Internally displaced person
IDRC	International Development Research Centre
IDT	International Development Target

IFF	International Finance Facility
IMCI	Integrated Management of Childhood Illness
IPRSP	Interim Poverty Reduction Strategy Paper
JCRC	Joint Clinical Research Council
MDG	Millennium Development Goals
NGO	Non-governmental organisation
ODI	Overseas Development Institute
OECD	Organisation for Economic Cooperation and Development
PHC	Primary healthcare
PRSP	Poverty Reduction Strategy Paper
PSDS	Private Sector Development Strategy
STI	Sexually transmitted infection
SWAP	Sector-wide approach
TBA	Traditional Birth Attendant
TEHIP	Tanzania Essential Health Interventions Project
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
WB	World Bank
WDR	World Development Report
WHO	World Health Organization
WTO	World Trade Organisation
WV	World Vision
WVI	World Vision International

Executive summary

This report argues that the failures in healthcare over the last decade have been the result of flawed analysis and lack of political will. If we are to achieve the Millennium Development Goals (MDGs) we must now absorb the lessons we have learned, and refocus our attention on broad-based, sectorally-coordinated, primary healthcare (PHC) system development, located within a rights-based framework, to which all governments must give their commitment.

The need for primary healthcare systems

Twenty-five years ago the *Alma Ata Declaration* of 1978 set a target for "governments, international organizations and the whole world community":

> *"the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary healthcare is the key to attaining this target as part of development in the spirit of social justice."*

The Declaration set out an approach to healthcare provision that comprehensively and clearly defined the responsibility of the state to provide primary healthcare within a "comprehensive national health system", emphasising the importance of co-ordination between sectors in developing such a system.

This report shows how the Alma Ata aims have not been achieved because the primary healthcare systems that were proposed were not developed according to the underlying principles of equity and participation through a multisectoral approach. In countries like Sri Lanka, where the principles were adhered to, successful broad-based systems have been established. Sri Lanka, through a focus on PHC principles, has managed to achieve and maintain low maternal and child mortality rates with an outlay of approximately 2 per cent of Gross National Product (GNP). Failure to apply those principles has been directly responsible for the persistently high levels of child and maternal mortality seen in many developing and transition countries.

Ten years ago the World Development Report (WDR) *Investing in Health*, published by the World Bank, introduced a model that has had a significant influence on approaches to health provision during the last decade. In this

report, we suggest that the main impact of *Investing in Health* has been to divert focus from broad-based, co-ordinated primary healthcare policies, to a narrower focus on issues of financial efficiency, public expenditure reduction, and transfer of provider responsibility to the private sector. The technical approaches, such as the use of the 'DALY' (disability adjusted life years) as a key measurement to determine resource requirements and priorities, have created measures that *reduce the financial value of children's lives* (and those of old people), by reducing their priority in receiving benefits from state financed healthcare.

The methodologies and policies proposed in *Investing in Health* are inconsistent with the fourth MDG – to reduce infant mortality – and the fifth MDG – to reduce mortality rates of women in childbirth. We now need to rethink the approaches. In this report we focus on these two specific MDGs, while at the same time stressing multisectoral approaches. We believe it is only through considering links across sectors and links between levels of responsibility that there is any hope of achieving all the MDGs within the lifetime of the current generation of children.

The report therefore proposes a return to a *'social model' of healthcare provision* that is based on an understanding of the needs of the poor and other users of health services, and on dialogue with them to ensure that the model is relevant and effective.

At the current pace, sub-Saharan Africa will not reduce child mortality by two-thirds until 150 years later than 2015, the date set by the fourth MDG (MDG4).

Resources

We are also concerned that, despite awareness of the issue, the continuing failure to disaggregate sufficiently between countries, regions and different categories of the poor means that the MDGs are being pursued with an inappropriate 'one size fits all' approach. As a consequence, the delivery of basic services is neither sustainable nor equitable. Moreover, there are serious doubts about the ownership of the MDGs themselves at the level of ordinary citizens.

This failure is partly the consequence of lack of resources and partly the consequence of misconceived policies. This report looks at both resources and

policies and argues that, although we continue to call for more resources, financial investment alone will not put the MDGs on course. In our view, the policies that are now in place to achieve the MDGs are too narrowly focused and have not been designed with the sufficient participation of those whom they are intended to benefit.

Governments face significant fiscal constraints on expanding provision of healthcare, which is why their policies must be located in a framework that prioritises children. At the same time, additional financing needs to be available to them where needed, and within the limits that they can absorb. Significant expansion of aid flows can encourage aid dependency, and where aid is linked to conditions and cannot be relied on governments cannot reasonably be expected to increase their expenditure.

Moreover, governments face constraints on their capital budgets to expand required infrastructure, and on their recurrent budgets to finance materials, supplies and personnel. In order for them to plan adequately and to develop the sorts of approaches we have advocated and the commitment to following them, they need to treat foreign aid resources as their own and be able to predict them over longer periods. Not only are aid flows in many cases inadequate, they are also frequently not directed to the right purpose, and they are unstable and unpredictable.

This report supports the International Finance Facility (IFF) initiative because it aims to give recipient countries more stable and predictable external flows, and to encourage them to regard those flows as their own. Clearly, the need for direct additional external flows is reduced where debt payments are reduced, and this report reaffirms the need for more focus on debt relief so that countries can mobilise domestic resources to tackle the very serious problems we have described.

This report emphasises the fact that different countries face different needs, have different traditions and need to develop their own solutions. The nature and size of the fiscal gaps they face will vary, and where those gaps can be filled with external assistance, the resources must be available. This report argues that donor governments have tended not only to support the wrong policies for addressing poor healthcare provision, but also been slow to make long-term, stable commitments to provide the required level of resources.

Rights

This report re-states the *rights-based arguments for entitlement to healthcare*, which need to be taken together with, and balance the economic arguments for, financial and technical efficiency of provision. Rights-based approaches are a powerful way of focusing on distributive issues, so that the weaker and poorer in society do not become marginalised at the expense of gains in health status by the relatively better off. This is particularly important when measuring progress towards the health MDGs, which are stated in terms of averages across populations rather than in terms of the distribution of those gains as they affect the poorest.

The right to health is embedded in international human rights instruments, including the UN Convention on the Rights of the Child (UNCRC), which has almost universal ratification. The strength of the UNCRC is that it promotes holistic and multisectoral approaches to the child's right to health through its core principles of non-discrimination, the best interests of the child, the survival, protection, and development of the child, and participation. The African Charter on the Rights and Welfare of the Child was intended to complement and reinforce the UNCRC.

Simply stated, were individual states fulfilling the responsibilities to which they committed themselves when they signed and ratified the UNCRC, there would be little need for the additional MDG framework.

As a UK-based coalition, benefiting from an open dialogue with the UK Government, which is playing an influential role within many international institutions and groupings, the Grow Up Free from Poverty Coalition places particular weight on the introduction of the eighth MDG, which stresses the need for 'a global partnership for development'. It is clear that success in meeting the MDGs will also be a function of wider initiatives, including, as the 2003 Human Development Report sets out clearly, 'policy changes in rich countries for aid and debt, trade and technology transfers (MDG 8), which are essential to achieving the goals'.

As a northern coalition, many of the observations in this report are addressed to our own Government and the international institutions of which it is an important member. Governments and institutions must now ensure that new policies replace policies that clearly have not worked, and that are increasingly recognised not to have worked by those who originally designed them. The new policies must create a more flexible, comprehensive and relevant basis for government actions.

Every year more than 10 million children under five die of preventable illnesses: 30,000 a day. More than 500,000 women a year die in pregnancy and childbirth, with such deaths 100 times more likely in sub-Saharan Africa than in high-income OECD countries.

Introduction

The Millennium Development Goals (MDGs) are valuable in that they focus attention on outcomes and encourage scrutiny of a wide range of national and international policies in terms of the simple question, "Will this facilitate or hinder achievement of the MDGs?"

The Grow Up Free from Poverty coalition is made up of non-governmental organisations (NGOs), faith groups, and young people's and civil society organisations with a commitment to international development and human rights. It is based in the UK but has active partnerships in more than 140 countries throughout the world. We have been voicing our concerns over the achievement of the MDGs, and earlier sets of international targets, for some years (see, for example, Christian Aid's *Distant Targets*, Oxfam's *Missing the Targets*, and ActionAid's *Halfway There?: The G8 and the Millennium Development Goals in 2002*). These concerns have now been underscored by the most recent reports to be published on progress towards achieving the targets, particularly the UNDP 2003 Human Development Report, warning that the MDGs are off course and will not be achieved, especially in the most vulnerable countries that are furthest from the goals.

> *"Without much faster progress, the Millennium Development Goals… 4 – 6 will not be met… at the current pace sub-Saharan Africa will not reduce child mortality by two-thirds until 150 years later than the date set by the Goals."*

The Grow Up Free from Poverty Coalition came together for the 2001 Westminster Conference on international child poverty, on the basis of a six-point plan that emphasises a comprehensive approach to tackling child poverty and stresses the importance of policy coherence. Members of the coalition believe that six areas must be addressed simultaneously if child poverty is to be eliminated. Its core aims for each policy area are:

- macroeconomic and fiscal policies that result in better outcomes for children
- free, quality and appropriate education for all *now*
- the reform of national health systems through increased, predictable and co-ordinated resource flows
- child-focused strategies for tackling HIV/AIDS

- an equitable trade and investment regime
- addressing the root causes of conflict and violence to increase children's security.[1]

The Millennium Declaration established a framework for development that acknowledges that poverty is multi-dimensional. For this reason, poverty reduction strategies must also be multi-dimensional. Progress must be made across the goals simultaneously: eradicating hunger and extreme poverty; increasing access to primary education; ensuring gender equality and women's empowerment; reducing under-five and maternal mortality; combating HIV/AIDS, malaria and other diseases; ensuring access to safe water; and improving environmental sustainability.

In this report we have chosen to focus on two specific MDGs while continuing to stress the necessity of pursuing a multisectoral approach and recognising the importance of achieving all the MDGs, especially the first MDG, the goal of reducing by half the proportion of people living in absolute poverty. In fact, we believe it is only through considering links across sectors and links between levels of responsibility that there is any hope of achieving these MDGs within the lifetime of the current generation of children.

We have chosen to prioritise these two MDGs because of our concern that, despite recent international initiatives such as the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunizations (GAVI), there is still an incomprehensible complacency about the number of preventable deaths of children and mothers. Two anniversaries occurring in 2003 prompt a review of the approaches we have taken to dealing with the appalling mortality rates in the last quarter of a century. It is 25 years since the Alma Ata Declaration, and ten years since the release of the 1993 World Development Report, *Investing in Health*.

Twenty-five years ago the Alma Ata Declaration of 1978 set a target for "governments, international organizations and the whole world community":

> *"the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary healthcare is the key to attaining this target as part of development in the spirit of social justice."*

Failure to apply the principles of Alma Ata, based on primary healthcare, has been largely responsible for the persistently high levels of child and maternal

mortality seen in many developing and transition countries. MDGs 4 and 5 provide a forceful call to action on these two fronts by re-focusing attention on reducing the mortality of children under five and of women during childbirth – but only if we are prepared to commit to the principles of equity, participation and a multisectoral approach, embedded in the Alma Ata Declaration.

Ten years ago the World Development Report, *Investing in Health,* introduced a model that has had a significant influence on approaches to health provision during the last decade. One decade later, as the World Bank prepares to launch the 2003–04 World Development Report on the provision of basic services, we need to review the impact of *Investing in Health* and ensure that the appropriate lessons have been learned. In a presentation of the forthcoming World Development Report 2003-4,[2] one author stated that investment alone will not ensure MDG fulfilment. This report explores why financial investment alone is not enough and identifies obstacles to progress, including a brief examination of current health policy approaches.

As a UK-based coalition, benefiting from an open dialogue with the UK Government, which is playing an influential role within many international institutions and groupings, we place particular weight on the introduction of the eighth MDG, which stresses the need for 'a global partnership for development'. The 2003 Human Development Report echoes what many of our members have been stressing for some time: 'policy changes in rich countries for aid and debt, trade and technology transfers (MDG8) are essential to achieving the goals'. As a northern coalition, many of the observations in this report are addressed to our own Government and the international institutions of which it is an important member. We do not forget, however, that developing country governments share responsibility for the achievement of the MDGs with the northern governments that provide additional resources and have a preponderant role in shaping international development policies. It is the responsibility of developing country governments to establish the consultation and participation processes that lead to genuine dialogue and popular input into development policy. These, in turn, should lead to greater ownership of policies and better, more pro-poor outcomes.

Influences on the health status and care-seeking behaviour at household and community levels are extremely important: members of the coalition continuously see lack of information, economic pressure on time for care-giving, and maternal illiteracy as contributing factors to children's health status. Indeed, 80 per cent of childhood deaths in Africa occur before a child

reaches a health facility. Our direct experience and that of the children and communities with whom we work has contributed to the production of this report. In particular we will highlight women and children's voices in their fight to realise their right to health.

> *"Targets can be a way of operationalising people's rights, while a rights-based approach is a reminder that quality and sustainability of provision are as important as quantitative achievement."* Christian Aid[3]

> *"The International Development Targets should be viewed within an overall rights framework because the targets are only a small part of what the fulfilment of (children's rights) and long-term development comprise."* Save the Children[4]

> "*Nothing could be more important than health. If somebody is not healthy, they can't do anything. They can't study or work. Health comes first."* Abush, a 12-year-old boy from Ethiopia[5]

Notes

[1] International Action Against Child Poverty (February 2001) 'Meeting the 2015 Targets: A six-point plan for eliminating child poverty', prepared by UK NGOs and Faith Groups.

[2] Regina, K (May 2003) Notes on the WHO/Save the Children Pro Poor Health Policy Workshop at the World Health Assembly Save the Children.

[3] Christian Aid (1998) *Distant Targets? Making the 21st century development strategy work,* London: Christian Aid, available from http://www.christian-aid.org.uk/indepth/9810dist/distant2.htm#ex.

[4] Bhatia, R (2000) Save the Children Discussion Paper on the International Development Targets, Save the Children.

[5] O'Malley, K (2002) Ethiopian case studies and stories collected for Beat Poverty campaign, Save the Children.

1 Are we on track to achieve Millennium Development Goals 4 and 5?

The scale of the problem

Every three seconds one of the world's children dies from a preventable cause – dehydration, hunger, disease, violence – more than ten million a year. In Sierra Leone, where child mortality is highest in the world, one child in three will not see their fifth birthday.

Every minute a woman dies in pregnancy and childbirth – more than 500,000 a year. A pregnant woman is 100 times more likely to die in pregnancy and childbirth in sub-Saharan Africa than in a high-income OECD country.

Asked why she carries small stones in her pocket, Doña Francisca explains that they are an important reminder. Each stone represents a child who has died in her village, which is in the highlands (altiplano) of Bolivia. Unable to read or write, the grandmothers have the custom of keeping a record of child deaths through the stones. Her pockets get heavier and heavier. Doña Francisca rarely sees health providers in her village, which is 20 miles from Potosi, site of the closest health clinic. Bolivia's Poverty Reduction Strategy Paper includes support for improved health policies for older people and children through a youth and old age insurance scheme and improved health provision. Evidence to date (Human Rights Ombudsman report July 2002) shows that only about a third of those eligible access their entitlements. This is due to lack of information held by state providers and recipients, non-existent disbursement structures and poor or non-existent health facilities, especially in rural areas.

Doña Francisca Vicarra, a 73-year-old grandmother from Bolivia[1]

Progress towards Millennium Development Goal 4: Reduce child mortality

Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Indicator 13: Under-5 mortality rate (per 1,000 live births)
Indicator 14: Infant mortality rate (per 1,000 live births)
Indicator 15: Proportion of one-year-old children immunised against measles

Each year an estimated four million babies die before they reach the age of one month. Ninety-eight per cent of these newborn deaths take place in developing countries, and for the most part, these newborns die at home, in the absence of any skilled healthcare. These neonatal mortality figures do not include an extra four million children who are stillborn. A mother in Western Africa is 30 times more likely to lose her child in the first month of life than a woman in North America or Western Europe.

Every minute eight babies under one month old die.[2]

The global under-five mortality rate is estimated to have declined from 180 in the late 1950s to 70 in the late 1990s (see Table 1.1). In 1999, 10.5 million children under five died, "about 2.2 million or 17.5% fewer than a decade earlier".[3] UNICEF furthermore declared that, in 2001, "over 60 countries had achieved the targeted one-third reduction" in under-five mortality rate (U5MR) between 1990 and 2000 called for by the World Summit for Children in 1989.[4] This good news, however, is tempered by three observations:

- that the accelerated decline noted up to 1980 has stagnated or reversed in many less-developed countries in the last two decades
- that even within countries showing good progress, there are wide variations between rich and poor and between other social groups
- that global statistics conceal wide regional variations.

"Globally, a newborn baby in 1999 had about a 6.7% chance of dying before reaching the age of 5 years… On average about 15% of children born in Africa are expected to die before reaching their fifth birthday. This compares with 3–8% in many other parts of the developing world and less than 2% in Europe."[5]

Table 1.1 Global under-five mortality rates in five-year periods from 1955 until 1999

Country	Mortality rate (per 1000)								
	1955–59	1960–64	1965–69	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99
Means for:									
African Region	264	254	237	218	199	183	169	160	152
Region of the Americas	140	121	108	96	80	65	52	44	38
Eastern Mediterranean Region	238	204	181	158	127	106	89	81	71
European Region	63	53	44	38	33	29	25	21	19
South-East Asia Region	222	202	181	162	143	125	107	93	90
Western Pacific Region	154	128	106	94	90	72	62	54	48
Global means	180	160	143	128	112	97	84	76	70

Source: Ahmad et al., 2000

First, the accelerated decline in the U5MR and the infant mortality rate (IMR) noted in many countries up to the 1980s, which represented an average decline of 2.5 per cent per year between 1960 and 1980,[6] has since slowed and even reversed in some countries. For the IMR, the rate of decline since 1980 has slowed to 1.9 per cent.[7] Stagnating or increasing child mortality rates are noted for Botswana, Madagascar, Mauritania, Namibia, Niger, Zambia and Zimbabwe in the African region; Myanmar and the Democratic People's Republic of Korea in the South-East Asia region; and Mongolia and Papua New Guinea in the Western Pacific region.[8] While these show reversals in the decline in aggregate figures, such reversals are particularly noticeable in different vulnerable groups. It has been shown that the national U5MR in Zimbabwe masked a rise in the number of deaths of children in the poorest fifth of the population:

> *"...between 1988 and 1999, the national under-5 mortality rate decreased by a modest 4 percentage points, but that for the bottom quintile actually increased by some 20 percentage points. By 1999, children in the poorest quintile had a U5MR that was 4 times higher than that for their counterparts in the richest quintile. Thus, the average trend had little to do with the reality faced by poor Zimbabwean children during the 1990s."* [9]

What are children dying from?

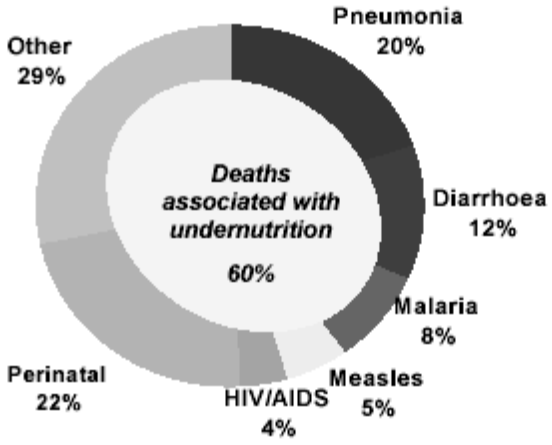
Children under five carry up to 30 per cent of the total burden of disease in developing countries.[10] Five biological causes account for half of all child deaths each year: diarrhoeal diseases, pneumonia, malaria, measles and HIV/AIDS (see Figure 1.1). Deaths in the first month of life account for approximately 22 per cent of the remaining total;[11] the main causes of death during this period are birth asphyxia (29 per cent), severe infections (24 per

cent), complications of prematurity (24 per cent) and tetanus (7 per cent).[12] Malnutrition, in the form of under-nutrition and micro-nutrient deficiencies, is an important underlying factor "that increases the risk of dying from these diseases".[13] Co-morbidity, the interaction of two health disorders, also occurs when an infant or child suffers from two infectious diseases, frequently diarrhoea and pneumonia.

The countries under-performing on achieving the MDGs are most likely to be conflict or post-conflict zones that have experienced severe cutbacks or total breakdown in public services. In 2001, only two-thirds of all officially counted births in Tajikistan were attended by skilled personnel, compared with 94 per cent in 1989 before the civil war. Weak institutional or policy capacity is also associated with countries immersed in, or recovering from, conflict. During the conflict in Bosnia/Herzegovina, less than 35 per cent of the children were immunised in 1994, compared with 94 per cent before the war.[14]

The distribution of the causes of death shown in Figure 1.1 varies according to region, country and national level of child health. Diarrhoeal diseases, pneumonia and perinatal conditions consistently cause the majority of deaths in most
developing countries, whereas malaria causes up to 25% of child mortality in sub-Saharan Africa[15] compared with a global figure of 9 per cent.[16] In countries with

Figure 1.1 Major causes of death globally among children under five in 2000[17]



high child mortality, neonatal deaths make up a smaller proportion of the total; as child mortality comes down, the proportion of neonatal deaths rises.[18] In a study in Maharashtra State, India, neonatal deaths contributed up to 75 per cent of the state's total IMR and 61.7 per cent of the U5MR.[19] The loss of carer, usually the child's mother, during early childhood can also raise U5MRs.

From our own experience in industrialised countries, we know that with the right resources and policies most of these diseases are preventable. The responsibility for correcting and reversing this failure to reduce this rate of child mortality should be shared globally, but making it a reality must be based on locally determined priorities and assessments of the determinants of child mortality. Something is going wrong. The Grow Up Free from Poverty coalition suggests that there should be a shift in policies governing the allocation of resources from those based on a disease-specific approaches to those based on a more pro-poor analysis. Key social determinants and service delivery factors are discussed in the next chapter.

Immunisation coverage declining

One of the major findings of the McKinsey review study on GAVI's achievements was that *"countries which are unlikely to reach their immunization targets face multiple system-wide barriers such as*

political/financial commitment, physical infrastructure, monitoring, management including human resources, and social mobilisation. It is therefore neither feasible nor cost effective to address these system barriers through an isolated focus on immunization specific action." Draft GAVI Strategic Framework, GAVI (2003)

Under-investment in general has contributed to serious deterioration in service capacity. This is clearly seen with declining immunisation coverage rates in developing countries. Immunisation is essential to reducing child mortality. The second MDG indicator for the U5MR target is the proportion of children of one year immunised against measles. Ideally, measles coverage should be at least 90 per cent to prevent measles outbreaks effectively.[20] These coverage levels have been reached in countries in Latin America and the Caribbean and East Asia.[21] Yet despite the success of the universal child immunisation (UCI) campaign in the 1980s, during which coverage increased to 73 per cent worldwide by the end of the 1980s,[22] coverage levels have since declined in many countries. Many children are thus unprotected from preventable diseases. In sub-Saharan Africa, only about 55 per cent of children under five are immunised against measles[23] and 47 per cent against diphtheria, pertussis and tetanus.[24] Furthermore, disparities in immunisation coverage have been noted within countries where "poor children in poor countries are typically far less likely to be immunized than better-off children."[25] A further problem is that "since immunizable diseases are generally thought to be concentrated primarily among the poor this means there is a significant mismatch between the population groups with the greatest burden of the diseases that immunizations prevent and the population groups that immunization programs most frequently serve."[26] Disparities in immunisation coverage are also noted by gender[27] and ethnicity.[28]

Will MDG 4 be achieved?

In 1990, the World Summit for Children called for a reduction of the infant and under-five mortality rate to under 70 per 1,000 live births by 2000 (or one-third if this was less). It has been shown that the mortality reduction target was reached for only five of 55 countries with a U5MR of 100 or more in 1990.[29] The MDG for under-five mortality calls for a two-thirds reduction, from the 1990 baseline of 103 per 1,000 live births to a 2015 target of 34 per 1,000 live births. Most studies assessing progress towards the MDGs for under-five mortality reduction are very pessimistic, predicting that they will not be achieved by 2015 unless dramatic improvements are made through more appropriate policy interventions and increased financing.[30]

The United Nations Development Programme (UNDP) estimates that **"at the current rate of progress, only about one-quarter, and not two-thirds of under-five mortality will be reduced by 2015.**"[31] Furthermore, it has been argued that at current rates the reduction in child mortality by 2015 worldwide will only amount to a 6 per cent reduction, not the two-thirds called for.[32] The report on the MDGs in Asia and the Pacific produced by the UN Economic and Social Commission for Asia and the Pacific and the UNDP also gives a pessimistic projection for reaching the two MDG targets for health in that region.[33]

Africa in particular is off track. As UNDP argues, "almost half of the under-5 deaths occur in sub-Saharan Africa, so that a sudden and dramatic improvement in child mortality in that region must come about if the global target is to be achieved."[34] The UNDP also indicates that the "global target of reducing under-five mortality by two-thirds between 1990 and 2015 is unlikely to be feasible in countries that are severely affected by HIV/AIDS or by the resurgence of malaria,"[35] which is the situation facing many countries in sub-Saharan Africa. The UNDP projects that on current trends the two-thirds reduction for 2015 won't happen until 2140.

Progress towards MDG 5: Improve maternal health

"Safe motherhood is a human right… our task… is to ensure that in the next decade safe motherhood is not regarded as a fringe issue but as a central one." James Wolfensohn, President of the World Bank[36]

For most women in the world, pregnancy and childbirth is a happy experience leading to a healthy child to love and nourish. However, this is not the case for more than 500,000 women each year who die through pregnancy-related complications. That is one for every minute of the day. In sub-Saharan Africa, for every 100 children born alive one mother will die.[37] For every woman who dies, 30 to 50 women suffer injury, infection, or disease. Pregnancy-related complications are among the leading causes of death and disability for women aged 15–49 in developing countries. When a mother dies, children lose their primary care-giver, communities are denied her paid and unpaid labour, and countries forego her contributions to economic and social development.[38]

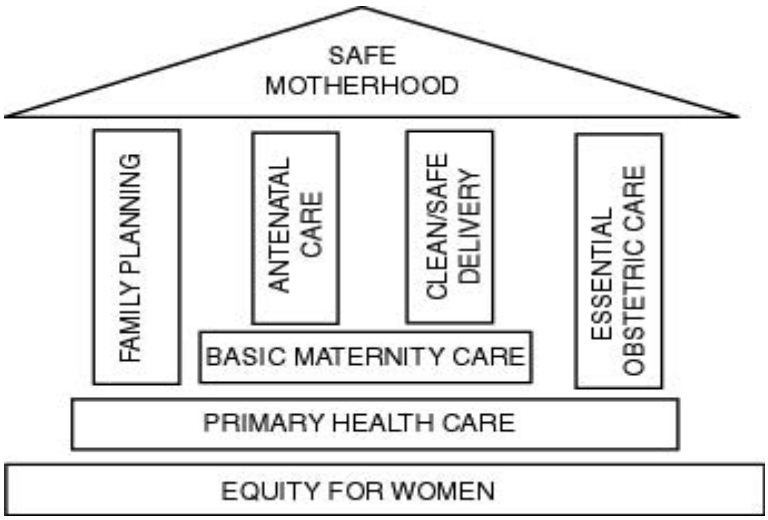
"When mothers survive and thrive, children survive and thrive…investments in safe motherhood programmes and practices and in education for girls and

women are perhaps the most essential. However, gender-based violence and the rising tide of HIV/AIDS continue to undermine efforts to improve the lives of women and girls."[39]

In 1987, in an attempt to address these appalling realities for women in the poorest countries, the Safe Motherhood Initiative was launched in Kenya. Its goal was to reduce maternal mortality by half by the year 2000. The principles of the initiative are illustrated opposite in Figure 1.2.

Recognising that significant gains were not being made in the decade following the establishment of the initiative, a technical conference was held in Sri Lanka in

Figure 1.2 Principles of the Safe Motherhood Initiative[40]



1997 to critically examine the constraints and discuss lessons learned in order to move their agenda forward.

Ten action messages were produced from this consultation:

- Advance safe motherhood through human rights.
- Empower women: ensure choices.
- Safe motherhood is a vital economic and social investment.
- Delay marriage and first birth.
- Every pregnancy faces risks.
- Ensure skilled attendance at delivery.
- Improve access to quality reproductive health services.

- Prevent unwanted pregnancy and address unsafe abortion.
- Measure progress.
- The power of partnership: "Safe motherhood must be a priority for governments, policy makers, health providers and civil society at large. Alliances need to be formed… with NGOs, donors, and other sectors of the government as well."[41]

Sadly, today, 16 years after the launch of the Safe Motherhood Initiative, we are no closer to that goal of reducing maternal mortality by half. However, we do have a new goal (MDG 5) and the goalposts have been moved once more.

MDG 5

Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 16: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio[42]

Indicator 17: Proportion of births attended by skilled personnel – a physician or a midwife[43]

Table 1.2 Estimates of maternal mortality, numbers of maternal deaths and lifetime risk by WHO regions[44]

Annex Table G: Estimates of maternal mortality, numbers of maternal deaths and lifetime risk, by WHO regions (1995)*

WHO region	Maternal mortality ratio (maternal deaths per 100,000 live births)	Number of maternal deaths	Lifetime risk of maternal death 1 in :
Regional Office for Africa (AFRO)	1,100	246,000	14
Regional Office for the Americas (AMRO)	140	22,000	240
Regional Office for the Eastern Mediterranean (EMRO)	440	161,000	60
Regional Office for Europe (EURO)	37	4,000	1,300
Regional Office for South-East Asia (SEARO)	380	57,000	47
Regional Office for the Western Pacific (WPRO)	85	25,000	490
World total	**400**	**515,000**	**75**

Figures may not add to total due to rounding.

What are women dying from?

DIRECT CAUSES

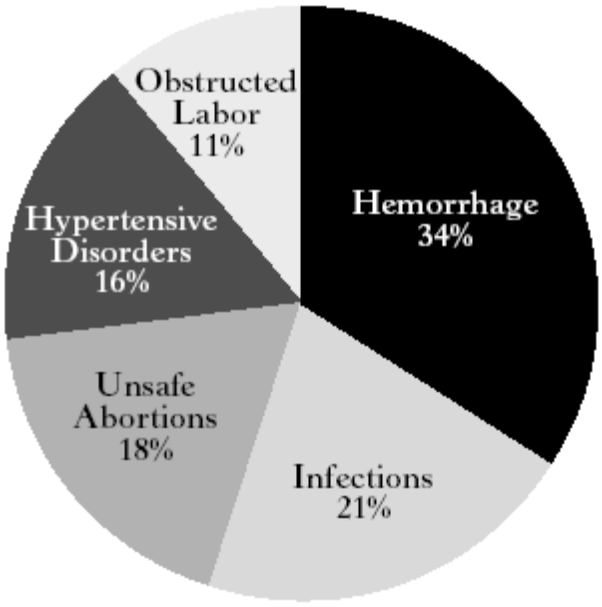
"Direct causes of maternal mortality are those resulting from obstetric complications of the pregnant state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment or from a change of events resulting from any of the above."[45]

The major causes of mortality are unsafe abortion, haemorrhage, infections, obstructed labour and hypertensive disease of pregnancy – primarily eclampsia.

INDIRECT CAUSES

Indirect causes of maternal mortality are those resulting from a previously existing disease or a disease that developed during pregnancy and which was not

Figure 1.3 Direct causes of maternal deaths



Source: World Health Organization, *Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF/ World Bank Statement* (Geneva: WHO, 1999).

due to direct obstetric causes but was aggravated by physiologic effects of pregnancy.[46] Indirect causes include:

- poor nutritional status of girls and women (eg, childhood stunting, anaemia, vitamin A and calcium deficiency)[47]
- HIV, TB, malaria, heart disease (often a sequel of rheumatic fever). HIV increases the likelihood of anaemia and infection, including malaria[48] and TB. HIV may also reduce access to services and quality of care because of the stigmatisation of HIV-positive women
- domestic violence: a 2003 study has illustrated that there is an increase in the incidence of domestic violence perpetrated on women once they have become pregnant (between 4 and 29 per cent of pregnant women had experienced violence).[49]

Apart from these direct and indirect causes as defined by WHO, there are less direct causes that contribute to the high rates of maternal mortality worldwide. These are covered in Chapter 4.

Progress towards achieving MDG 5

To date, progress towards achieving the goal of reduction of maternal mortality is slow. Ascertaining the progress towards reaching MDG 5 is hampered by the lack of reliable statistics.[50] Most of the available evidence shows 'sufficient' progress in East Asia and parts of South Asia, slow progress in Latin America, and retardation or regression in much of sub-Saharan Africa and large parts of Central Asia.[51]

There are countries and regions in the developing world that are making significant progress towards reducing maternal mortality, including Sri Lanka and Kerala in India, both long held up as models. These nations are joined by others, such as Vietnam, Malaysia, Honduras and regions of China.[52]

The recent Human Development Report 2003 by UNDP highlights three areas needing urgent attention: increasing access to skilled birth attendants; emergency obstetric services; and reproductive healthcare within a functioning health and referral system.[53] This system needs to have long-term resources and effective health information systems, which in the poorest countries are crumbling or collapsed. Data collection and storage must be supported and prioritised with national health services.

SKILLED ASSISTANCE AT DELIVERY

The latest WHO initiative for maternal health, Making Pregnancy Safer, has defined a skilled attendant as a person with midwifery obstetric skills who also has the skills and knowledge to supervise, give care to and advise women during pregnancy, labour and the postpartum period. They can conduct deliveries on their own and provide care for the mother and her newborn. This care includes the implementation of preventive measures and detection and referral of abnormal conditions in the mother and newborn. They should be trained and able to provide emergency measures as needed, as well as health counselling and education for women, their families and community members. Skilled attendants may practise in hospitals, clinics, health units, and homes or in any other service. Skilled attendants must be registered and/or legally licensed to practise. However, national requirements for training and licensing vary from country to country.

Table 1.3 shows the small but disparate regional rates of change that have occurred in proportions of deliveries conducted by skilled attendants.

EMERGENCY OBSTETRIC CARE

In the UK, a reduction in maternal mortality was brought about primarily by the development and expansion of the midwifery profession in the early 1900s and by the introduction of antibiotics, increasingly safe anaesthesia and safe blood transfusions in the 1940s. By 1990, the WHO had clearly formulated essential
obstetric care, which focused on the need for obstetric interventions to avert maternal deaths. In 1993 the limited value of risk factors detected on antenatal

Table 1.3 Trends in percentages of deliveries assisted by skilled attendants for 53 countries from 1989–99[54]

Annex Table G: Estimates of maternal mortality, numbers of maternal deaths and lifetime risk, by WHO regions (1995)*

WHO region	Maternal mortality ratio (maternal deaths per 100,000 live births)	Number of maternal deaths	Lifetime risk of maternal death 1 in :
Regional Office for Africa (AFRO)	1,100	246,000	14
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Regional Office for South-East Asia (SEARO)	380	57,000	47
Regional Office for the Western Pacific (WPRO)	85	25,000	490
World total	**400**	**515,000**	**75**

Figures may not add to total due to rounding.

examination as a predictor of obstetric complications was demonstrated – too young, too old, too many pregnancies, too short. This evidence led to the formulation of the notion of emergency obstetric care at two levels – basic and comprehensive.[55]

Basic emergency obstetric care facilities provide at least:

- parenteral antibiotics
- parenteral oxytocic drugs
- parenteral sedatives for eclampsia
- manual removal of the placenta
- manual removal of retained products.

Comprehensive emergency obstetric care facilities provide all the above *plus:*

- surgery
- anaesthesia
- blood transfusion.

Despite global recognition of the necessity of emergency obstetric care the situation in many of the poorest countries remains grim. One Liberian doctor reported that: *"Even if a woman comes here in an emergency, I have no diesel to run the generator and no anaesthetist to help perform an operation."* The

generator, donated by a 'caring' donor, was too large and was inappropriate for the needs of the doctor. The health staff in that country had not been paid for six months, yet they had all been turning up for work daily. Sadly, within a few months other donors hired the doctor to work for them and the hospital was left unstaffed.[56]

In Sri Lanka, the government has prioritised providing free inpatient care for all, promoting the Alma Ata principles of equity and participation through a multisectoral approach. It decided not to follow the World Bank's 'cost effective' advice to "privatise the inpatient services" and has managed to bring maternal mortality down to 0.2 per cent per 1,000 live births in the 1990s.[57]

REPRODUCTIVE HEALTH

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.[58] It includes antenatal and postnatal care, safe delivery, breastfeeding practices, the management of complications in pregnancy, education about sexual health and healthy development, the prevention and treatment of sexually transmitted diseases, including HIV infection, the provision of family planning services, reproductive health counselling, the management of infertility, addressing the issue of gender violence and the active discouragement of female genital mutilation.[59]

Reproductive healthcare has benefits not only for individuals but also for families, communities and nations. It can raise the health status of women, improve the outcome of pregnancy, reduce the burden of death and disease among women and therefore their children, and increase the range of choices available to couples who wish to plan their families. In line with the above definition of reproductive health, reproductive healthcare is defined as "the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems."[60] Good reproductive healthcare is also determined by the development and maintenance of strong health systems, which are often inaccessible to poorer and hard to reach populations.[61]

HEALTH INFORMATION SYSTEMS

With the growing interest since 1987 in the reduction of maternal mortality, there have been parallel attempts to improve the method of measuring mortality. In all studies, maternal deaths are often under-reported or mis-classified. This may be because research assistants are inadequately trained to interpret and code the incoming data. However, deliveries and consequent

deaths often occur outside formal health facilities.[62] Additionally, in some cultures there is reticence to discuss causes of death because of traditional beliefs.[63] Data on skilled attendance are also imprecise. While surveys frequently ask who conducted deliveries and where, qualitative studies indicate that those people described by community members as, for example, nurses and even doctors cannot be assumed to be skilled attendants. Some researchers, therefore, use place of delivery as an indicator of skilled attendance, but this may be an inadequate proxy because in many places untrained ancillary staff are conducting deliveries within facilities.[64] Mobilising communities to identify and engage in activities to promote safe motherhood is particularly important when attempting to tackle persistently high maternal death rates. Traditional beliefs, cultural and socio-economic factors have a powerful impact on health seeking behaviour, and therefore it is important to understand these before an intervention is introduced. Opting for a traditional birth attendant (TBA) or traditional healer may reflect the need for privacy, convenience, affordability or the need to resolve a perceived complication of labour by spiritual means. Maternal mortality will remain high unless women who experience complications can be identified and referred quickly to a centre which has personnel with the necessary skills and equipment.[65]

Notes

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2 If the Millennium Development Goals are the engine of development, where is the gas?

"Children cannot wait for growth to generate resources when they are faced with death from preventable causes." **UNDP, 2003**[1]

"No country committed to poverty reduction and good governance shall fail for lack of resources." **Africa Action Plan 2002**[2]

The Millennium Development Goals are not new. At the United Nations Millennium Summit in September 2000, all member states of the UN adopted the Millennium Declaration, a document that comprehensively profiles the challenges currently confronting human development, setting out a vision for enhanced co-operation and harmony. In the Declaration, the heads of State and Government re-affirmed their "collective responsibility to uphold the principles of human dignity, equality and equity at the global level", and their duty "to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs".[3] These goals were an amalgam of other targets, some dating from the World Summit on Children in 1990 and some from the World Social Summit in 1995.

The International Development Targets (IDTs) had already received wide acceptance from the 21 OECD countries including, in some instances, being integrated into official policy statements, such as the UK's Department for International Development (DFID) White Papers. However, the use of IDTs by developing countries was perceived as inappropriate, as they had emerged from a developed country organisation. Merged with the MDGs, through the medium of the United Nations General Assembly, the specified goals, targets, and indicators now have a broad base of global commitment and acceptance. When assessing progress as we did in Chapter 1, however, we are entitled to look at commitments that had been made long before that.

> *"These outcomes reflect the failure of governments to prioritise the interests of poor people in social and economic policies, as distinct from the rhetoric delivered at high-level conferences. Rich countries have failed to bring their trade, aid and financial policies into line with their commitments to poverty reduction. Southern governments have*

> *failed to prioritise the interests of poor people, either in public spending or in economic reform programmes."* Oxfam*, Missing the Targets,* 2000[4]

The MDGs, as conceived, represent global targets. They are, in turn, highly contingent on political decision-making rather than technical interventions, important as the latter are. The key political decisions required to reach the MDGs entail:

- increased resource flows from North to South, including trade reforms that will benefit developing countries, and, at the very least, the fulfilment of the promises contained in the World Trade Organisation (WTO) Doha Round (it is important to note that the MDGs have not been integrated into the WTO)
- faster and deeper progress on debt relief, and augmented flows of aid
- the resolve to increase expenditure on basic social services and related actions that benefit the poor
- the need to address issues of marginalisation and exclusion that undermine access to assets and service institutions by the poor
- the fundamental requirement for people who are responsible at all levels of society to be accountable to those whom their decisions affect.

In the year following the United Nations Millennium Summit, the Secretary General produced a 'road map' specifying more concrete strategies to meet the broad objectives for the seven areas of action. This stated that what was needed was not "more technical or feasibility studies" but "political *will* to carry out commitments already given and to implement strategies already worked out."[5]

In this chapter we provide an assessment of the extent to which governments have met the commitments made at various global platforms. This has particular saliency in that political will and commitment by all governments – both donors and recipients – is considered the main ingredient in meeting the MDGs:

> *"...without additional resources we will not meet the development goals"* James Wolfensohn, World Bank, 2002[6]

> *"If the MDGs are to be met, there will be no alternative to increasing aid..."* UNDP, 2002[7]

"There is now a growing credibility gap between the rhetoric of the G8 leaders, the World Bank and IMF, and the reality of development financing. They repeatedly stress their commitment to the MDGs and 'support' for countries striving to achieve them, but their own pledges on financing fall short of the levels of development assistance, including debt relief, that they themselves say are needed to achieve the MDGs." CAFOD, Christian Aid, Eurodad[8]

What is needed to achieve the Millennium Development Goals?

Estimates of the additional assistance needed range from $50 billion per year, according to the Zedillo report,[9] to an Oxfam estimate of $100 billion per year.[10] The wide range reflects the difficulty in costing the MDGs: the Zedillo report, commissioned for the International Conference on Financing in Development in Monterrey, 2002, gives only minimum estimates, leaving out the costs for the health MDGs and allocating no extra costs for meeting the MDG for access to safe water.[11] The Oxfam calculation includes $32 billion per year for the health MDGs, based on the recommendations of the WHO Commission on Macroeconomics and Health (CMH), and $9 billion to meet the MDG for water, based on World Bank estimates (see Table 2.1). Global estimates, however, were not built on country estimates.[12] One of the next steps for countries in producing MDG reports is to estimate the domestic cost of meeting the MDGs. In turn, this may influence further priority setting in both national budgets and international assistance.[13]

Table 2.1 Estimated additional assistance needed to achieve the MDGs[14]

	Additional aid financing requirements ($bn)
Halving income poverty	46
Reaching MDGs for public health	32
Universal primary education (including incentives for girls' education)	13
Access to water	9
Total	**100**

If all OECD donor countries were to reach the target for overseas aid of 0.7 per cent of GNP by 2007, an additional £131 billion per year would be available for development.[15] Oxfam argues that the donor community should

establish a time frame of five years within which to reach the 0.7 per cent target.[16] While it remains critically important to aim for this target, its implementation in the short term seems highly unlikely.

In many countries the budgets allocated to basic social services such as primary education and primary healthcare, are limited to a large extent by high levels of debt servicing as well as low political commitment to these services.[17] A UNDP study of public expenditure across 17 countries in Africa, Asia and Latin America concluded that basic social services accounted for an average of 12.3 per cent of government expenditure, including donor assistance.[18] Numerous reports (like the Commission on Macroeconomics and Health report and the Human Development Report 2003) have illustrated that, without significant increased resources from international donors, national-level funding for services will not be enough. This is very clear in the case of Ethiopia: even though the Government of Ethiopia allocates more than 20 per cent of its GNP to basic services, this amounts to less than $1.50 per person per year (while the CMH estimates that $30–40 per person per year is needed to achieve the health related MDGs).[19]

Development assistance

At the Financing for Development Conference held in Monterrey, Mexico, in March 2002, the European Commission called on member states to raise their overseas aid commitments to 0.39 per cent of GNP by 2006, ultimately raising an additional $7 billion in aid each year. At the same conference, George W Bush pledged to add a further $5 billion a year to US assistance, bringing it to 0.15% of GNP. This is still less than half the OECD average of 0.33 per cent and, of course, still further below the international target of 0.7 per cent of GNP.[20] This additional assistance is to be channelled through the Millennium Challenge Account (MCA), a new vehicle for aid with its own conditions. President Bush's pledge has been reduced still further by Republicans in the US Senate who reduced his request for $1.3 billion in the 2002/3 fiscal year to start the MCA to $800 million, arguing that he would not need the full amount in its first year.[21] The combined commitments of the European Union and the United States would increase total development assistance by $12 billion a year – still a long way short of the most conservative estimates of the resources needed to make the MDGs a reality.

It is encouraging, however, that overall development assistance increased by 4.9 per cent in 2002 after decreases in the previous two years.

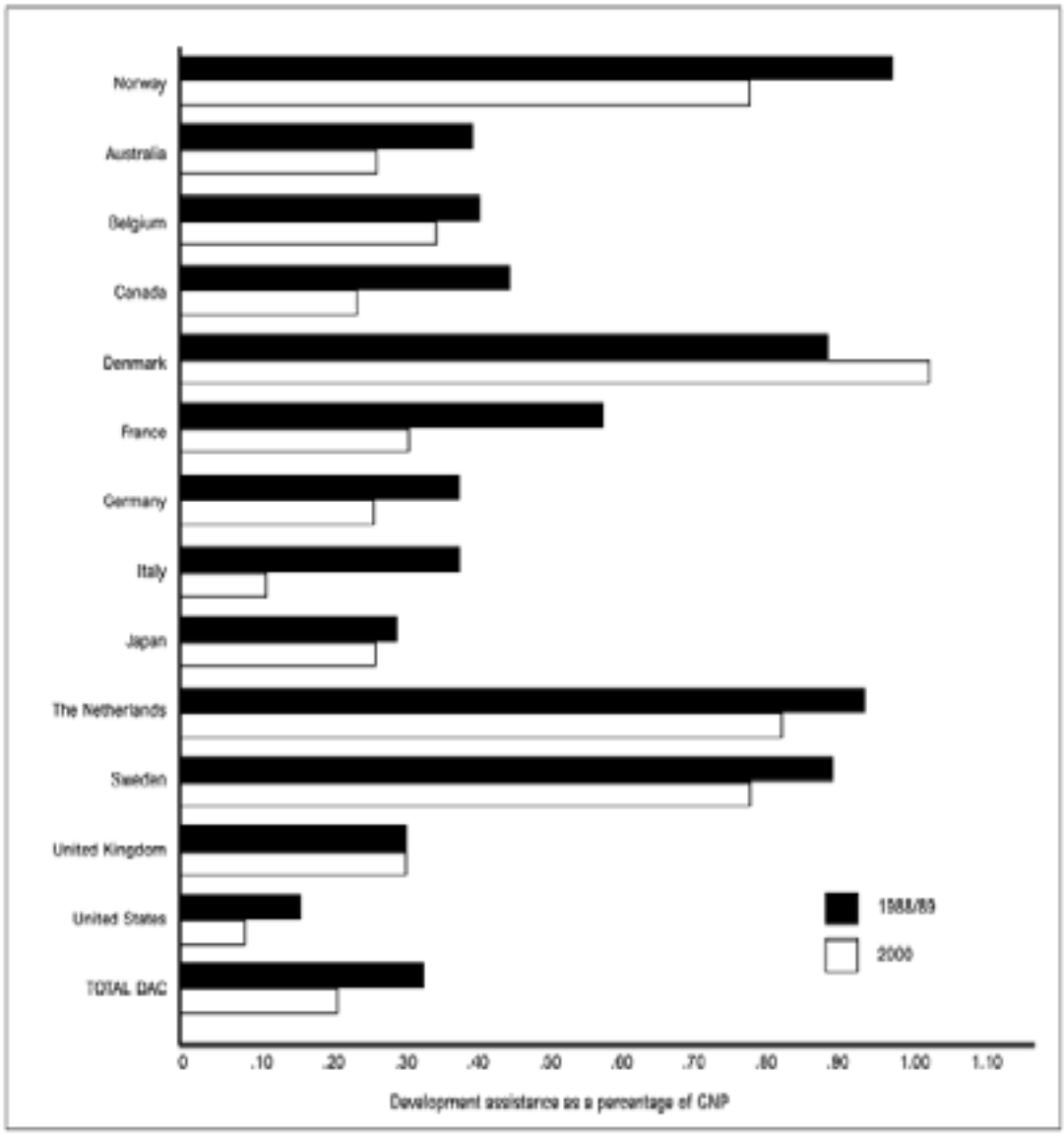
In agreeing the 'Monterrey Consensus', world leaders affirmed the commitments that underpin progress in achieving the MDGs, as reflected in MDG 8:

> *"We … commit ourselves to mobilizing domestic resources, attracting international flows, promoting international trade as an engine for development, increasing international financial and technical cooperation for development, sustainable debt financing and external debt relief, and enhancing the coherence and consistency of the international monetary, financial and trading systems."*[22]

While five countries have consistently met the UN 0.7 per cent target – Denmark, Netherlands, Sweden, Luxembourg and Norway – most OECD countries range between 0.20 per cent GNP (Greece) to 0.36 per cent (Belgium). Between 1988 and 2000 most countries, except Denmark, reduced the percentage of their GNP allocated to aid (see Figure 2.1). Since 2001, that trend for some countries –eg, the UK – has changed, as they have increased their aid spending. The UK's percentage of GNP allocated to overseas aid is currently 0.33%, expected to rise to 0.35% in 2004/5 and to 0.4% in 2005/6.[23]

> "*It is depressing that we spend more as a nation on ice cream than on overseas development assistance."* Caroline Spellman, Conservative Party Spokesperson on International Development[24]

Figure 2.1 Official development assistance as a percentage of GNP in selected OECD countries[25]



Sources: OECD Development Cooperation: 2000 report, and Development Assistance Committee database.

Debt relief

At Monterrey, governments agreed that: "Future reviews of debt sustainability should also bear in mind the impact of debt relief on progress towards the achievement of the development goals contained in the Millennium Declaration."[26]

The benefits of debt relief for health and education are already evident. For 2001–2003, the Heavily Indebted Poor Countries (HIPC) Initiative reduces the

average debt service paid by HIPC graduates by about one-third. Among these countries, social expenditure is expected to increase in 2000/3 from the levels in 1998/9. Where countries have had resources freed up from debt servicing, the proceeds have resulted in new health and education programmes.

- Mozambique has introduced a free immunisation programme for children.
- User fees for primary education have been abolished in Uganda, Malawi and Tanzania, as have user fees in rural areas of Benin.
- Mali, Mozambique and Senegal are due to increase spending on HIV/AIDS prevention.
- The requirement to engage in a consultation process in designing Poverty Reduction Strategies has helped to increase the potential for poor people to influence national resource allocation processes.

At the same time levels of debt relief under the HIPC initiative have disappointed activists and governments alike. According to Jubilee Research, four years after the G8 meeting in Cologne promised $100 billion in debt relief, total debt cancellation in 2003 amounts to only $36 billion. Governments in Rwanda, Niger and Ethiopia are now finding they cannot access the resources they need to achieve the MDGs without incurring further debts, which will push them over the threshold of unsustainable debt fixed by the World Bank. CAFOD and other agencies have proposed that the concept of debt sustainability be turned on its head, by calculating the resources that will be needed to enable a country to achieve the MDGs and determining that this should have priority over all other spending needs, reducing debt servicing to a residual that is paid only when the MDG financing needs have been met. Of course, at present the opposite is the case, with debt servicing taking the highest priority in governments' expenditure plans. Investment in health, education and pro-poor projects is undertaken with what remains in the budget and what donors are prepared to provide.

Debt servicing continues to overwhelm national resources available for basic social service. A study by the UNDP[27] of 17 countries showed an average debt service of 23.6 per cent of their national budget, ranging from 7.0 per cent in Uganda to 41.8 per cent in Chad, compared to an average of 12.3 per cent expenditure on basic social services for the same countries. On the other hand, as Table 2.2 shows, debt reduction works as a means to increase social sector budgets.

Table 2.2 Total spending on debt service and on education and health for ten African HIPCs[28]

($ million)	1998	1999	2000	2001	2002
Debt service	979	896	913	613	620
Health and education spending	1,395	1,505	1,610	1,844	2,102

Trade

Trade, as the Monterrey Consensus said, is frequently "the single most important external source of development financing".[29] Along with increased levels of aid, and a continuation of debt relief, there needs to be a re-balancing of the international trade system in order to create the conditions for achieving and sustaining in the longer term the improvements envisaged by the MDGs. The responsibility of the OECD donor countries in pursuing these goals was outlined in MDG 8 through a global partnership for development. Poston et al. underline this responsibility when they argue that, "Northern policy should be directed to promote trade and growth in and for the developing world,"[30] highlighting the need for heightened policy coherence between different segments of the global economy.

Trade, however, is not simply, nor even chiefly, a question of market opening. Far more important for developing countries is the issue of northern subsidies for agriculture. These undermine farmers' livelihoods in developing countries and push them out of third country markets. In June 2003, Blaise Compaore, the president of Burkina Faso, complained that subsidies for cotton producers in rich countries were impoverishing poor farmers in West Africa who, without subsidies, were able to produce cotton 50 per cent cheaper than their competitors from developed countries. "These subsidies," he said, "have caused economic and social crises in African cotton-producing countries. As a consequence of cotton subsidies, in 2001, Burkina lost 1 per cent of its GDP and 12 per cent of its export incomes, Mali 1.7 per cent and 8 per cent, and Benin 1.4 per cent and 9 per cent respectively."

The European Union, with heavy export subsidies for sugar and dairy products, and massive direct support for livestock and arable farmers, continues to be at fault. Its limp mid-term review of the Common Agricultural Policy in June 2003 has done little to convince developing countries that it is

serious about making significant reductions in the trade-distorting support it gives to its farmers, who account for no more than four per cent of the economically active EU population – and only one per cent in the UK.

The impact of dumping in Jamaica

Mr Winston Taylor, 49 years old, of Grey Ground district, near Mandeville in Manchester, Jamaica has been forced to stop his milk production activities and has sold his 25 milking cows to the butcher as no one else wanted them. He learned dairy farming from his grandparents and inherited land from them. Mr Taylor is divorced and has three children aged 24, 19 and 10.

The market for local fresh milk in Jamaica is falling and the first farmers to suffer have been the small farmers on the Nestle churn collection routes. Local manufacturers are turning to cheaper imported milk powder as world market prices are kept down by subsidies in developed countries like those in Europe.
There were 25 small dairy farmers on the Manchester routes three years ago and now only one farmer remains.

In January 2002 the milk price fell from J$18 per litre to J$14 per litre. Furthermore, farmers now have to deliver their milk in churns to a collection station 35km away, at their own expense. Mr Taylor had his own car to transport his four churns (120 litres) so he was one of the last farmers to fall from the scheme. But when the milk had to be delivered by 4.30am he could no longer milk his cows in time. Mr Taylor says he and many smaller farmers who depended only on their milk cheque every two weeks are frightened now as to what the future holds for them.

Mr Taylor says right now he is bankrupt. He put himself out to do dairying and it has failed. “There was no money from dairy to fall back on. I am waiting to see if the industry will come back. The pastures are already established. Everything has been done and we are waiting to see if anything can be done to put us back in business.”
Source: CAFOD (2002)[31]

In addition to opening up northern markets to exports from developing countries and eliminating northern subsidies, developing countries must be given special and differential treatment, which allows them to use trade policy in an interventionist and flexible manner in order to protect the development of domestic industry, promote diversification of the economy and generate sufficient wealth to lift their populations out of poverty.

Bittersweet: Sugar in South Africa

David Dlamini has been farming sugar cane in South Africa for the past 27 years. But the 66-year-old father of seven was forced to give up farming last year because he could no longer make ends meet. His sugar cane stands rotting in the fields north of Durban because he cannot afford to harvest it or transport it to the nearest mill. "It wasn't worth farming any more," he says. "You worked for about 20 months and when you looked at your expenses, you found you never covered your costs."

Although David's farm lies thousands of miles away from Europe, decisions made in Brussels have a direct impact on his livelihood. In 1975, when David first started farming, Europe imported most of its sugar from overseas. But today, encouraged by an annual £1.6 billion sterling from EU consumers and taxpayers under the Common Agricultural Policy, European farmers have become the second largest sugar exporters in the world — producing more than 20 million tons of sugar every year and dumping 5 million tons onto the world market at prices far below the costs of production.

Over the past decade, the South African Sugar Association estimates that the EU has depressed the world sugar price by 20 to 40 per cent, forcing small-scale farmers like David Dlamini out of business. "The price of sugar fluctuates all the time," says David. "When it declines, it affects the farmer directly. A lot of farmers are stopping and now they are going backwards. If we got a higher price for sugar, it would help us a lot."

There are 51,000 sugar cane growers in South Africa, most of them farming in the lush terrain along the Indian Ocean in the province of KwaZulu-Natal. Forty-nine thousand of those growers, like David Dlamini, are small-scale farmers with less than 30 hectares of land. Another 85,000 South Africans are dependent on jobs in the sugar industry – harvesting, milling or transporting sugar cane. It costs between US$250 and US$300 to produce one ton of sugar in South Africa. In Europe, it costs US$600. But in spite of the high costs, EU subsidies encourage European farmers to keep on growing sugar beet and dumping their excesses on the world market.
Source: CAFOD (2001)[32]

Innovative sources of finance

There have been a number of proposals for raising significant additional resources for development. They include a currency transaction tax (the Tobin

tax), a tax on airline travel, a carbon tax and the International Finance Facility (IFF). The Tobin tax has been the subject of a long-running campaign and is gradually acquiring widespread support as the considerable technical difficulties are worked on. It has yet to be endorsed by a major government and is known to be vehemently opposed by the United States.

International Finance Facility

The only scheme with the backing of a developed country is the IFF, a proposal launched in 2002 by the UK Treasury and Department for International Development and which now has the support of France and Belgium. This proposal acknowledges, perhaps too pessimistically, that there is no appetite among donor countries for further debt reduction, and that in the short term there is no possibility of moving more rapidly towards the 0.7 per cent aid target. In view of this, the IFF would issue bonds backed by governments, subject to a number of conditions, at double current levels of aid, making good the shortfall between current aid levels and those needed to achieve the MDGs. While the expenditure of the IFF would be almost entirely between now and 2015, the target date of the MDGs, income from governments to the IFF would be phased over 30 years.

> *"Presently the OECD countries are only at 0.2 per cent [of GNP] and if they are to meet the 2015 goals we cannot wait for all countries to achieve the 0.7 per cent target – we need to urgently increase the amount of aid now. That is why the UK Government has proposed an International Finance Facility (IFF). In return for developing countries pursuing anti-corruption policies for stability and economic development, developed countries would increase aid from $50 billion a year to $100 billion – the sum needed if we are to meet the goals. On the basis of long-term, binding commitments of aid from donor countries, the IFF would secure additional finance from the international capital markets, frontloading aid flows for disbursement in the years up to 2015 when it will have the most impact, and moving the developed world closer towards the 0.7 per cent target than would otherwise be possible."* Gordon Brown, British Chancellor of the Exchequer[33]

Such a scheme is to be welcomed, as it aims to secure predictable and sustainable flows of aid which will enable governments to contemplate expanding social sector budgets. However, it is not clear whether the scheme will overcome recurrent budget constraints, some of which have been

exacerbated by adjustment policies calling for deep cuts in government expenditure within short timeframes, thus creating distortions, since the easiest things to cut are not always the most unimportant.[34] High additional inflows of foreign aid to the recurrent budget will have an impact on budget deficits, defined as the difference between domestic revenues and recurrent expenditures, because expenditures will exceed revenues from domestic sources. This needs to be taken into account, for once governments make additional recurrent spending commitments, those commitments need to be sustained over time. To date, foreign aid has been notoriously unstable, and few governments are willing to commit themselves to such a degree of dependence on it under such circumstances: capital spending financed by foreign aid has fewer political problems, and can be cut if aid does not flow. Foreign aid is unstable for many reasons, but mainly because:

- it is contingent on conditions (eg, macro, IMF conditions, and micro, donor and creditor conditions)
- foreign aid institutions have been unable to overcome the procurement and disbursement problems that make their aid so problematic and cumbersome for recipient countries.

The IFF should focus strongly on these two issues. It needs to examine closely what measures need to be taken to create sustainable and predictable additional financial flows, devoid of conditions that create uncertainty and therefore reluctance by governments to take the aid; and it needs to be sure that the policies that it finances are the right policies, not necessarily those of the dominant models that have so often gone hand-in-hand with resources.

Notes

[1] UNDP (2003) *Human Development Report*, p. 11.

[2] The New Partnership for Africa's Development (NEPAD) Joint Action Plan 2002.

[3] United Nations General Assembly (2000) 'Resolution adopted by the General Assembly at the Fifty-fifth session: United Nations Millennium Declaration A/RES/55/2, 18 September 2000'.

[4] Oxfam (2000) *Missing the Target: The price of empty promises*, available from http://www.oxfam.org.uk/policy/papers/target/target2.htm

[5] United Nations General Assembly (2001) 'Road Map towards the implementation of the United Nations Millennium Declaration', Report of the Secretary General, Fifty-sixth session of the General Assembly A/56/326.

[6] Wolfensohn, J, World Bank press release dated 20/2/02, quoted in White, H (2002) 'Using the Millennium Development Goals as a basis for agency-level performance measurement', available from www.ids.ac.uk/ids/pvty/pdf-files/MDGs.pdf.

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[8] CAFOD, Christian Aid, Eurodad, 'A Joint Submission to the World Bank and IMF Review of HIPC and Debt Sustainability', August 2002.

[9] Poston, M, Conway, T and Christiansen, K (2003) 'The Millennium Development Goals and the IDC: driving and framing the Committee's work,' London: Overseas Development Institute, available from http://www.odi.org.uk/pppg/publications/papers_reports/other/IDC/IDC_MDG_public.pdf.

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[13] Ibid.

[14] Watkins (2002) op. cit.

[15] Ibid.

[16] Ibid.

[17] Harrington, J, Porter, C and Reddy, S (2001) 'Financing basic social services', in Grinspun, A (ed.) *Choices for the poor: Lessons from national poverty strategies,* New York: UNDP.

[18] Ibid.

[19] Save the Children (2002) *Too Poor to be Sick: The cost of coping with illness in East Haraghne District in Ethiopia.*

[20] Brainard, L, Graham, C, Purvis, N, Radelet, S, Smith, G (2003) *The Other War: Global poverty and the millennium challenge account*, Washington DC: The Brookings Institute, The Center for Global Development, available from http://www.brookings.edu/dybdocroot/gs/research/projects/mca/otherwar_manuscript.pdf.

[21] Allen, V (2003) 'House Rejects Bids to Boost Global AIDS Funds', available from http://www.reuters.com/newsArticle.jhtml?type=politicsNews&storyID=3147826.

[22] Birdsall, N and Clemens, M (2003) 'From promise to performance: how rich countries can help poor countries help themselves', *CGD Brief*, Vol. 2, No. 1 (April) Washington, DC: Center for Global Development, available from http://www.cgdev.org/briefs/cgdbrief005.pdf.

[23] See http://www.hmtreasury.gov.uk/Spending_Review/spend_sr02/report/spend_sr02_repchap14.cfm.

[24] Caroline Spellman, Conservative Party Spokesperson on International Development (2003), Westminster Weekly discussion help in Parliament on 17 July 2003 on Financing Development, available from http://www.parliament.the-stationary-office.co.uk/pa/cm0330717/haltext/30717202_head0.

[25] Watkins, op. cit.

[26] Report of the International Conference on Financing for Development, Monterrey, Mexico 18–22 March 2002, paragraph 49, p. 12, available at http://ods-dds-ny.un.org/doc/UNDOC/gen/no2/392/67/pdf

[27] Harrington et al., op. cit.

[28] Taken from Greenhill, R, Pettifor, A, Northover, H and Sinha, A (2003) 'Did the G8 drop the debt?', *Jubilee Research*, p. 20.

[29] Report of the International Conference on Financing for Development, op. cit., paragraph 27, p. 7.

[30] Poston et al., op. cit.

[31] CAFOD (2002) 'Importation of Milk Solids into Jamaica from the EU – A case study', available from http://www.cafod.org.uk/policy/jamaica20021202.shtml.

[32] CAFOD (2001) 'Dumping on the Poor – The Common Agricultural Policy, The WTO and International Development', available from http://www.cafod.org.uk/POLICY/dumpingonthepoor200209.pdf.

[33] BOND (2003) 'Financing the future: Gordon Brown makes the case for the IFF', available from http://www.bond.org.uk/networker/june03/gbrown.htm.

[34] Mehrotra, S and Jolly, R (1998) *Development with a Human Face: Experiences in Social Achievement and Economic Growth*, Oxford University Press, p. 65, "The vast majority of developing countries have examples of major hospitals whose operational costs resulted in the curtailment of health clinics and preventive services." Clearly there are differences between countries, and the definition of what constitutes a cut needs to be made: in some cases it involves a lower percentage of GDP; in others a reduction in the share of health in total discretionary expenditures; in other cases a cut in real financial terms; and in other cases per capita reductions that arise from per capita expenditure rising more slowly than population (note in this case that the changing age structure of populations means that the share of children in total population has risen).

3 What have we learned about targets?

The UNDP's recent claim that the MDGs have the potential to re-shape the political debate, and hence the programmatic framework for development, is significant to organisations committed to international development.[1] By setting a series of outcome targets as a means of measuring progress towards a diverse but inter-related set of development goals, questions can be asked about the policies and interventions in place. Do they facilitate or undermine progress towards the goals? Are the policies of different sectors coherent and harmonised, or working in opposition and thereby undermining potential progress in one or more of the other sectors? The implication of using the MDGs as benchmarks for estimating progress in human development, suggests the Administrator of the UNDP, Mark Malloch Brown, is that they allow a measure of accountability of national and global commitment:

> *"The benchmark of whether policies are working is whether they are impacting on key MDG targets: are more kids in school? Is maternal mortality declining? Is poverty dropping? Are we making progress on HIV/AIDS? If the MDG Reports show the answer to that is no, then it clearly points to the need of change in policies, if it is yes, then it provides a powerful vindication of current strategy."* Mark Malloch Brown 2003[2]

A number of broader concerns have been raised about the emphasis on quantitative outcome targets in measuring development progress. First, the selective nature of the targets may overlook other development goals not included, such as food security and the rising global burden of non-communicable diseases and conditions. Data collection and analysis may also, as a result, be skewed towards the measurement of the targets, neglecting issues excluded by the goals,[3] particularly those not easily measurable. Two groups of people routinely ignored in MDG and poverty analysis, to the detriment of policy-making, are those suffering from issues of conflict and violence and the older community.

Failure to plan how to tackle the impacts of conflict and violence on women and children will further slow the realisation of the MDGs in general. Policy responses to the commitment to halve poverty by 2015 are not easily applied to those living in or recovering from conflict. Every day, the health of millions

of children is affected by conflict and other types of violence which prevent them from accessing healthcare. Violence is routinely inflicted on children, including the female genital mutilation of girls and beatings within the home. In such cases, the negative consequences are damage to children's physical and psychological health. One of the limitations of the MDGs is their failure to acknowledge broader aspects of development.
Another marginalised group consists of the seven million older people struggling to contribute to the reduction of household poverty. *"The policy responses… do not recognise that generations live together and support each other; the poverty of older relatives will impact on the poverty of younger ones and vice versa*."[4]

A second concern is the lack of intermediate targets. It has been argued that, as a result, "the IDTs/MDGs do not provide a basis for monitoring performance on taking the steps necessary to achieve the outcomes."[5] Save the Children takes this further:

> *"… the absence of specific indicators on non-communicable diseases and health systems functioning… and the focus on outcome indicators should be augmented with process indicators which cross all sectors."*[6]

While outcome measures may contribute to greater accountability, there is an argument that they need to be associated with a logic model (eg, logical framework) linking inputs to outcomes, which "force the agency to examine a programme to see if it really will achieve the desired outcomes."[7] Often, policy decisions are based on models inappropriately transplanted from one context to a completely different policy environment resulting in unexpected and potentially poor outcomes.[8] The ability to develop policy that is based on sound and contextually relevant evidence should be one of the tests for assessing MDG progress.

Disaggregation: averages can be deceiving

Global targets are useful in assessing progress on a global scale, but such targets can also be deceiving. The monitoring of global targets relies heavily on regional and national averages that overlook disparities in meeting the MDGs among disadvantaged groups within countries, between countries within regions, and between regions at global level.[9] There is a danger, now widely recognised, that global targets will be misleading and dangerous if they were to assess progress mainly in countries with large populations, eg, China

and India, which are achieving progress mainly as a result of good rates of economic growth. An analysis of child mortality worldwide points out that "half of worldwide deaths in children younger than five years occur in only six countries."[10] These countries are India, Nigeria, China, Pakistan, the Democratic Republic of Congo and Ethiopia. While advances in reducing child poverty in populous countries such as India and China could result in favourable progress in reaching the MDG target globally, such a result could hide a lack of progress in other countries.

If data is not disaggregated along the lines outlined above, there is a danger of overlooking stark disparities. The potential danger of monitoring progress on the basis of averages collected at country, regional and global levels is to deny the rights of those most at risk of under-five child mortality.[11, 12] Averages can improve, while at the same time outcomes for the poorest and most at-risk are worsening. Support in building country capacity in data collection and analysis is therefore urgently needed. Data can then serve to guide action and policy development. WHO, UNDP, DFID and others are working together on this as part of the PARIS 21 Working Group, but there is a long way to go.

Additionally, country averages, in turn, conceal wide inequalities within domestic populations. Disparities are noted for socio-economic status, location (urban/rural), region, gender, age and ethnicity. Vandemoortele, leading the UNDP analysis of progress towards the goals, notes that in over 40 demographic and health surveys, "a child from a poor family is invariably more likely to die before age five than her counterpart from a rich family – on average about twice as likely."[13] Such inequalities across income groups have widened in many countries between 1980 and 2000.[14]

Rural/urban inequalities

Rural/urban inequalities in child mortality are also well known. Disaggregating Mozambique's national infant mortality rate (IMR) of 147 per 1,000 live births, for example, shows that in the rural areas, the IMR is 160 per 1,000 live births and in urban areas it is 101 per 1,000.[15] Many other countries show this rural/urban disparity,[16] but further disaggregation of urban statistics between the better-off and the urban poor often displays much worse statistics for those living in slums or shanty towns, sometimes even when compared with the rural areas, as indicated earlier in the report.[17, 18] The child mortality rate (CMR) of 150.6 per 1,000 live births in Nairobi's slums in Kenya was much higher than in the rural areas at 113.0 per 1,000 live births.[19]

Differences within countries

Regional disparities within countries can also be very wide. In Kenya's Nyanza province the IMR is 128 per 1,000 live births compared with 68 per 1,000 in the Coast Province (the next highest rate).[20] In 1996 in Zambia, infant mortality rates varied from 66 in one of the most prosperous of the country's nine provinces to 158 in one of the more remote provinces.[21] Different ethnic groups can also account for an overlap in regional and socio-economic disparities in some countries.[22]

Gender disparities

Gender disparities in under-five mortality are particularly noted for the 1–5 year age range. One study observed a "female disadvantage in almost 90 per cent of observations indicat[ing] its pervasiveness." [23] Such gender disparity, while noted in a number of regions,[24] is particularly prevalent in South Asia,[25] where "a girl in India is 30–50 per cent more likely to die between her first and fifth birthdays than is a boy."

Regional and international disparities

The U5MR has declined over 40 years but there are wide regional variations. Africa showed the least progress, at about 42 per cent, dropping from 264 to 152, compared to 60–72 per cent in other regions: dropping from 238 to 71 in the Eastern Mediterranean region; 222 to 90 in South-East Asia; 154 to 48 in the Western Pacific; 140 to 38 in the Americas; and 63 to 18 in Europe.[26] Figure 3.1, with estimates from 1999, indicates that 98 per cent of deaths in children under 5 in 1999 occurred in developing countries, again with significant regional variations: 36.2 per cent in Africa; 33.3 per cent in South-East Asia; 14.4 per cent in the Middle East/North Africa; 9.8 per cent in Western Pacific; and 4.3 per cent in Latin America and the Caribbean.[27] These figures show that the global disparity in child mortality between North and South and between regions remains unacceptably large. The gap in child death rates between Africa, the worst-affected region, and the industrialised countries increased from 20:1 in 1990 to 29:1 by 2000. In Africa, 175 out of 1,000 children were dying before their fifth birthday, compared with six in the industrialised countries.[28]

Figure 3.1 Under-5 mortality rate (per 1,000 live births)

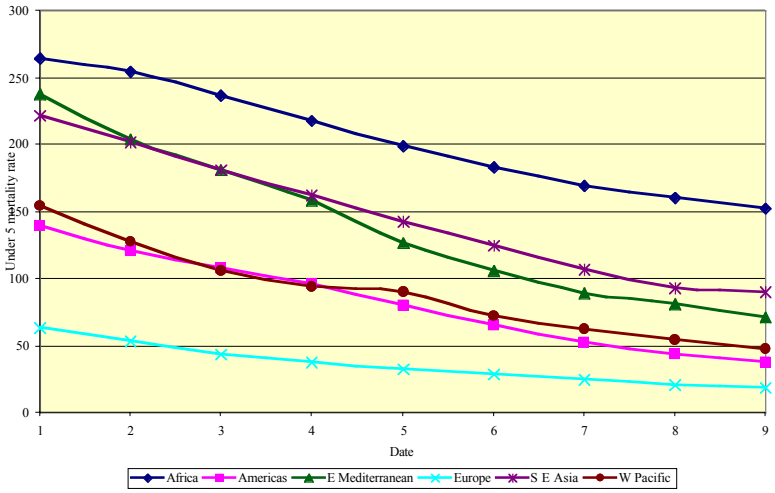

Table 3.1 Estimated mortality under age 5 according to WHO regions[29]

Region	Number of deaths	% of worldwide deaths	Mortality rate per thousand
Africa	3,806,000	36.2	150
Americas	453,000	4.3	34
Eastern Mediterranean	1,511,000	14.4	67
Europe	226,000	2.2	18
South-East Asia	3,502,000	33.3	88
Western Pacific	1,029,000	9.8	46
All	**10,527,000**	**100.0**	**67**

Figure 3.1 and Table 3.1 show the wide-ranging variations in U5MR between regions. There are also significant variations within regions. In the African region, Mauritius had a U5MR of 21 per 1,000 live births compared with Niger's 335; in South-East Asia, the lowest U5MR was 11 per 1,000 live births in the Republic of Korea, compared with 135 in Laos.[30] These figures show wide variations in mortality rates within regions for children under five, reflecting differing levels of development and national policy that impact on the ability of poor families to maintain the health of their children. In east and southern Africa, the devastating impact of AIDS has also had a major impact on child survival.[31] We return to some of these differences in Chapter 4.

For the reasons given above, disaggregated data needs to be built into the procedures for monitoring progress on the MDGs. If national data is not disaggregated, disparities by gender, age, ethnicity, religion, socio-economic status, location (urban/rural), and regions (within countries) can be overlooked. Although the majority of child deaths occur in rural areas, populations living in urban slums or shanty towns frequently have higher infant and child mortality rates than in rural areas,[32] a fact often overlooked when only aggregate figures are used for comparison. This highlights the need to reformulate health policy goals so that they point specifically to conditions among the poor and to poor–rich differences.[33] Advocates need to be alert to the need to continue to monitor country and intra-national variations in achievement. Highlighting sub-national disparities could potentially be a *"powerful trigger for public action*".[34]

The quality and coverage of country data, however, is often questionable. Of particular relevance to the health sector is the poor coverage of data on births,

deaths and causes of death that are available from registration systems and routine health facility reporting.[35] This has enormous impact on the ability of a country to collect reliable data.

National level policies and commitment

Following the final formulation of the global MDGs targets in 2001, the next step was to encourage Southern and transitional countries to prioritise the targets and put them into operation in their specific contexts. In doing so, the United Nations Development Group (2001) suggested that governments might consider three options:

> "*a) select those goals and targets as agreed at the global level;*
> *b) select the appropriate goals and targets but adapt them to the country circumstances; and*
> *c) add other goals and targets that are relevant to the country, if so desired."* [36]

Yet priorities set by donors on funding often do not encourage national priority setting.[37] The UN system presented the MDGs as "*indicators of progress rather than guides to action"*.[38] Countries were expected to identify the strategies most appropriate to reach the goals using the MDGs as a benchmark against which progress can be assessed and judged. Even with debt relief, total resources available for public expenditure in many low income countries are inadequate.[39] Additional donor funding directed to basic social services, based on national estimates of the local costs needed to meet the MDGs, will be essential for countries to meet the MDG targets.

Are global targets sustainable in the long run?

"One risk of overly emphasising targets is that the sustainability of progress made towards these targets may be jeopardised. For example, this became clear in UNICEF's experience with immunization. While some diseases, like smallpox and polio, are eradicable through immunization, others require a sustained, recurrent effort. When people are too focused on achieving targets, they may not consider how the tremendous efforts made to achieve these targets will be sustained in the long run. Recognising the right of a child to physical health would lead one to consider sustainability. It would lead to strengthening the local health system to provide appropriate immunization services and to ensuring domestic resources for vaccine procurement. Too often, in the enthusiasm to reach a target, governments and donors are lured into organising foreign-funded immunization drives that make the country look good in international statistics, but do little to deliver the comprehensive health of its children." Christian Aid, 2000

The MDGs depend on the way in which Southern and transitional countries prioritise them and put them into operation. There appears to be, on the one hand, reasonable flexibility to adapt globally defined targets to local contexts, but how much flexibility do countries really have? They may be hampered by a number of constraints, including insufficient resources, fragmented delivery systems, fragile social and political environments, and national economies frequently destabilised by external actions. As indicated above, priorities and policies, whether directed at the economy or the social sector, have often been pursued on the advice of global institutions and donor advisers. But developing countries have not had the flexibility in terms of policy or resources to take corrective action in the event of their failure to meet essential health needs. The recent initiative of the Poverty Reduction Strategy Papers (PRSPs), closely linked with the MDGs, is perceived as a vehicle to re-invigorate a poverty focus across key economic and social sectors. Time will tell whether the renewed interest in the poor will be followed through by national and global decision-makers.

The Poverty Reduction Strategy Papers (PRSPs) prepared by low-income countries are considered to be the logical process through which the MDGs can be pursued at national level. Coupled with both the HIPC debt relief process and new modes of lending from the World Bank and IMF, the PRSPs are supposed to outline broad strategies for national economic growth and poverty reduction. Each country is expected to specify pro-poor policies in key social sectors. Reviews of interim and full PRSPs, however, show that, in many cases, the PRSPs are not sufficiently pro-poor, with limited analysis of the institutional and social barriers experienced by the poor and limited commitment to redistribution of growth benefits.[40]

The health chapters in the PRSPs generally fail to provide a rigorous analysis of the health burden of the poor, while containing strategies that offer little that is new in meeting their healthcare needs. Of some positive benefit is the high profile being given to poverty reduction and the importance of multisectoral working to advance a pro-poor agenda. Innovative ways of estimating the costs of meeting the MDGs should be done at country level, with participatory processes, instead of relying on global estimates. Those poor communities least likely to have adequate access to health services are in the best position to identify their own health needs and the obstacles to meeting them, as has recently been illustrated by the experimental Tanzania Essential Health Interventions Project (TEHIP).[41]

National monitoring and reporting on MDG progress is to be undertaken periodically, supported by the UN Country Team to help inform public debate.

Many countries are currently involved in writing MDG reports and have been spurred on by the 2003 Human Development Report. Following the Africa launch of this at the Africa Heads of State meeting in Maputo in July 2003, individual African countries are in the process of developing strategies to raise awareness of the MDGs internally. At a recent workshop in Uganda, for example, the Vice-President pledged that the Government would create a forum to discuss mainstreaming and customising the MDGs within the country, in particular creating a social dialogue to take the MDGs to local council level. A national debate on issues such as gender, institutional arrangements, and appropriate skills is to be initiated.

Lessons for using global targets

In reviewing lessons from previous uses of targets, Christian Aid identified the following components that could be considered for the MDGs. These suggestions offer important insights to refine the targets and indicators to sustain planning, implementation and monitoring over the longer term.

- Setting interim targets, at five-year intervals for example, is a good way to maintain momentum and to provide regular updates on progress.
- Promoting widespread ownership of targets and operationalising them at local level with a wide selection of stakeholders is crucial to success.
- A target-based approach is more suitable for goals which require relatively simple, technological interventions than for goals which require complex, systemic change.
- Sustaining progress towards targets can be challenging and has to be addressed early on. Other approaches are needed to supplement a target-based approach to obtain sustainable results.
- Monitoring progress towards targets can be costly, especially where developing country statistical services need to be upgraded. Operational costs of monitoring should be borne in mind.
- Input targets, urging governments to allocate more resources to a particular purpose, do not yet have a successful track record. Creating the political will to allocate additional resources to the 21st-century strategy should be a priority.
- It is vital that monitoring progress towards internationally agreed targets includes NGO perspectives as a counterpoise to official views.

Source: Christian Aid, 1998[42]

NOTES

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4 Major constraints and challenges

How is progress to be made? A better understanding of what lies beneath the statistics is undoubtedly important. One of the concerns we expressed earlier was that the targets are framed within a narrow quantitative perspective. While statistics are critical to monitoring progress, particularly with disaggregated data, they provide limited information on the obstacles and constraints to progress, which are often of a qualitative nature. The ways in which poverty, vulnerability, exclusion and inequality interact with the proximate causes of ill health need to be better understood, as well as the perceptions and beliefs of communities which may affect health outcomes. It is also important to consider how policy-makers and health and social development practitioners understand the nature of their work, and how local and organisational culture influences their performance.

The key to action, however, is to understand the evidence and discern the most effective ways to meet the complexities it presents. In most cases, this will involve a shift in thinking away from a '*disease-specific mindset*'[1] and a willingness to critically examine current health policy approaches.

While acknowledging that effective technical interventions are essential in reducing child and maternal mortality, failure to mobilise them is a political issue, concerned with decisions about priorities and resource allocations. This is a problem very firmly embedded in the governance process within countries and in the nature of the contract between a country's citizens and their government. How national resources are utilised, whether for basic social services to directly benefit those less well-off or on tertiary level services that benefit the more privileged, is critically important to the achievement of the MDGs.

Recognising the politics of decision-making at national level inevitably highlights the inter-dependence of national and global health-related policy-making. Beyond aid flows, does global health policy support or divert attention from the necessary public actions that are needed to produce such massive shifts in health outcomes for poor children and women?

These issues are addressed in this chapter. The major constraints on progress to improving child and maternal mortality are reviewed on four levels:

household and community; health sector at local level; the health sector within the context of national public policy; and global health policy.

Figure 4.1 Factors influencing a child's health

Mother and child's environment

- Family income
- Nutrition
- Water
- Sanitation
- Housing conditions
- Age/gender
- Maternal literacy
- Decision-making within the household
- Orphan status
- HIV/Aids
- Survival tasks/child work
- Economic pressure on care-giver
- Lack of insurance
- Lack of information
- Abuse
- Violence
- Displacement

Community and local level facilities

- Prohibitive user fees
- Distance
- Time open
- Lack of community participation in designing programmes
- Clinical predominance over public health functions
- Practitioner behaviour
- Lack of control over staff appointments
- Rapid staff turnover
- Lack of supervision
- Poor health promotion
- No routine contact with other district health staff
- Lack of local authority involvement
- No effective exemption system
- Poor retention levels of competent staff
- Unsustainable, parallel NGO administrative structures
- Cost of public provision encourages use of traditional healers
- Local health management

Health sector at national level

- Structures
- Health policy
- Cost recovery policy
- Government staff attracted to donors/overseas
- Lack of national ownership of health policy/programmes
- Lack of co-ordination
- Corruption/mismanagement
- Impact of structural adjustment programmes on government (health) expenditure and infrastructure
- Promotion of interventions with insufficient evidence of impact or insufficient attention to institutional and financial sustainability
- Fragmentation of responsibilities (different ministries etc.)
- conflict

National level

- Revenue assignment to other factors:
- Water Supply
- Sanitation
- Agriculture
- Education
- Public sector salaries
- Centralised/decentralised management
- Internal and external debt repayments
- Funding of capital investment but nor recurrent costs
- Impact of donor conditionalities
- Diversion of potential revenue to private sector as private health care delivered by private companies/middle class seek private provision

International

- Aid
- Economic Reform
- Liberalisation
- Terms of trade
- Inward investment
- Debt relief

Constraints at the household and community level

Eighty per cent of childhood deaths in Africa occur before the child reaches a health facility.[2] The ability of households to protect the health of family members and access adequate healthcare is limited by a range of factors. Children and pregnant women are particularly vulnerable: poverty and socio-cultural norms interact synergistically, affecting health status and care-seeking for preventable diseases and pregnancy-related conditions. As so many child and maternal deaths still take place in the home, it is critical for the health sector to understand why these deaths are occurring. Better understanding can then be followed up by developing appropriate partnerships and outreach between communities and the health services.

> *"If you are rich you will be healthier. If you are poor you have no choice. If you don't have money in your pocket, you will not get treatment. It's not fair."* Alemstehay, 13-year-old Ethiopian girl[3]

Poverty and health have many interlocking features. The determinants of health are clearly embedded within the multidimensional conception of poverty, as defined at the UN Summit on Social Development in 1995: *"poverty has various manifestations, including lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments; and social discrimination and exclusion. It is also characterized by a lack of participation in decision-making and in civil, social and cultural life."* Child mortality is due to a combination of factors ranging from socio-economic status, environmental health conditions, maternal education, nutritional status and infant feeding practices, and use of health services by carers and children.

The association between high U5MR and levels of socio-economic development has been identified, for example in Maharashtra state in India, where the U5MR broadly followed the percentage of families below the poverty line.[4] High infant and child mortality rates are closely associated with residence in urban slums worldwide, linked to low income, poor housing and hazardous environmental conditions.[5] Addressing environmental factors, such as limited access to adequate, clean water and sanitation facilities, is particularly important for reducing child deaths. The use of unsafe water, poor hygiene practices and lack of sanitation facilities contributes up to "1.5 million child deaths and around 88 per cent of deaths from diarrhoea".[6] Improvements

in water supply and sanitation have been shown to lead to a reduction of 55.5 per cent in child mortality,[7] and water and sanitation improvements are synergistic "with impacts greater than either alone".[8] Acting on the determinants of ill health will arguably be more effective in the long term in reducing child mortality than an exclusive focus on the immediate causes. Such studies conclude that "current child survival interventions were designed to cure children of specific diseases and not to tackle disease complexes and their root causes…".[9]

"We didn't have any toilets… we had diseases like typhoid… we were angry because we had no money to build a latrine, so we complained to our government."[10]

Millennium Development Goal 7: Target: to halve the proportion of people without sustainable access to safe water is the only MDG target that is currently on track (UNDP 2002).

Ill health and the links to poverty

"It's simple – if you have money you will be cured. If you don't have money you will die. If my mother is alive, I will be alive. If my mother dies, what will become of me?" Yiwagu, 12-year-old Ethiopian girl, whose mother is sacrificing her own healthcare for the sake of her children's education.[11]

Long recognised as a consequence of poverty, ill health is increasingly acknowledged as a major contributor to poverty – sick people are less productive and incur increased family expenditure. In Mozambique, for example, a household survey in 1996–7 reported that poor households missed more days of work activity than the non-poor due to illness.[12] Poor people interviewed in participatory poverty assessments across 50 countries for a World Bank study said they dreaded poor health and illness, seeing them as "a source of destitution… because of a lack of healthcare, the costs of available healthcare, and the loss of livelihood due to illness".[13] It has been noted that "rises in out-of-pocket costs for public and private healthcare services are driving many families into poverty, and are increasing the poverty of those who are already poor".[14] Fees and other out-of-pocket costs are a significant deterrent for families seeking healthcare, leading to dangerous delays in seeking help outside the household for both children and pregnant women.[15] Save the Children is collecting increasing evidence in sub-Saharan Africa which highlights the inability of the poorest third of the population to access

any healthcare while the middle third are selling off finite capital assets to pay for healthcare, thus plunging communities into further poverty.[16]

Relationships within the family

Social relations at family, household and community levels can be influenced by social-cultural norms that may contribute to significant problems in child and maternal health. Age and gender inequalities, expressed through intra-household allocation of resources and care-seeking, a preference for traditional practitioners, and early marriage, are outlined below.

INTRA-HOUSEHOLD INEQUALITIES

In addition to a generalised lack of income within the household, intra-household allocation of resources according to age and gender may affect the ability of different family members to access food, healthcare and other materials that promote good health. For example, families may seek care less often for younger children as they fall sick more frequently.[17] The use of insecticide-treated nets (ITNs) against malaria may not be always be prioritised for use by younger children in many households even though they have been shown to reduce child mortality in different contexts.[18] Education and awareness-raising are important even where cost and availability are not problematic. In surveys in 22 African countries, a median of less than 2 per cent of children slept under ITNs the previous night. This needs to be more widely appreciated by ITN advocates; and ITN distribution needs to be accompanied by programmes designed to raise community awareness about their mortality-reducing purpose.[19]

Understanding and supporting reciprocal arrangements within households is key to effective policy responses for older people, who are often overlooked within families and by policy makers. The enormous contribution that older people make to the health of family members by caring and undertaking household tasks and production can often be forgotten. As both care-givers and care-receivers older people are integral to the achievement of the MDGs. Support for their contributive capacities, as well as provision for their basic needs, including health, should not be overlooked.

> *"The inclusion of all population groups is one that is key to achieving the MDGs. The absence of older persons in the Millennium goals needs to be addressed."* Johan Scholvinck, Director, Department of Economic and Social affairs, United Nations[20]

> *"It is important to examine the roles people play at household and community level. It is crazy for example to try and do AIDS work without involving carers – many of whom are older. Older people will not accept a benefit that does not impact on the wider family. In the same way young and old cannot see benefits in community activities if they do not relate to others. Children who demonstrate their support to the wider family group enjoy community patronage, and it is the same for older people."* Statement by Tavenga Nhongo, regional representative of HelpAge International, at Grow Up Free from Poverty side event at 2nd World Assembly on Ageing, April 2002

The HIV/AIDS pandemic has dramatically raised awareness about the role of older people in caring for children. The contribution of older people, however, is not limited to countries with a high prevalence of HIV/AIDS. In Guatemala for example, a country with low HIV/AIDS prevalence, the World Bank found that 60 per cent of orphans were living with their grandparents.

Caring for grandchildren

Seventy-nine-year-old Irene Lusiasi from Malawi lives in a village in Thyolo District, 10km south of Blantyre. All of her five children died of AIDS. Now she has eight orphaned grandchildren all under the age of 13 to care for.

Catharine, Irene's eldest granddaughter, describes how important her grandmother is. *"Our grandmother is so wonderful. She helps us in so many ways. She feeds us, dresses us, and brings us up properly. When we see her, we see our mother. If she were not here we would have been scattered around other families and would not be treated in the same way. We are so grateful that she is still with us."*

GENDER INEQUALITY

Intra-familial distribution of food and access to healthcare gives preference to men and boys. Discrimination against girls in intra-household food distribution results in their being more frequently malnourished than boys, leading to higher female child mortality in some countries,[21] including within South Asia, where studies have noted that girls are often brought to health facilities in more advanced stages of illness than boys, are taken to less-qualified doctors when they are ill, and less money is spent on medicines for them than for boys. A study in Zambia found that user fees selectively decreased hospital admission for female children in rural areas.[22] High neonatal, infant and child deaths often reflect the low status of women in many societies, a consequence of their lack of autonomy, limited education, nutritional status, poor access to health services, and early marriage/childbirth.[23]

The household gender division of labour in many societies means that women bear most of the domestic, farming and childcare roles.[24] This division of labour, rooted in social norms and values, may predispose nutritionally compromised pregnant women to fatigue, which in turn may predispose them

to potential fatal injury during pregnancy.[25] As many poor women are often heavily engaged in economic productive activities, particularly if they are the head of the family, they may have limited time for childcare, with implications for the child's nutrition and care during illness. Restriction of women's movement outside the home in some societies also limits their access to services.[26] Gender relations are also at the heart of domestic violence, which can also have fatal consequences for pregnant women.[27]

> *"I have 11 children and I am pregnant with another. The baby hasn't moved for weeks, I fear he is dead. But my husband doesn't let me go to see a doctor, he beats me if I am not in the house when he gets home… he says it is a shame to go to see a doctor. I'm scared for the baby".*[28]

> "*Economically, the parents of the initiated girls see their daughters as being ready for marriage – a source of wealth. In many cases they would expect her to get married as soon as possible… the priority for educating their children goes to the boys."* Told to EveryChild worker in Kosovo, 2003

Caldwell's study of Sri Lanka, China, Kerala state and Costa Rica in 1986 highlighted the importance of female autonomy to improved health outcomes. With greater autonomy, he argued that "a mother will make her own decision that something must be done when she identifies a child as sick… that she will venture outside the home to seek help, that she will struggle for adequate treatment with doctors and nurses, and that (at the same educational level) she will understand the advice and take responsibility for carrying it out".[29] Female education contributes to autonomy but the evidence from these four countries (as well as others) shows that greater autonomy is rooted in a wider context: "Female autonomy is greatest where both society and women themselves have little doubt about a woman's right to make decisions and to battle for her and her children's rights in the public arena."

Female education

Female education impacts on fertility and therefore maternal mortality by increasing women's autonomy:

- Knowledge autonomy – increased knowledge of and exposure to outside world expands the range of options from which a woman may choose.

- Decision-making autonomy – educated women usually have an increased capacity and status to participate in family decision-making.
- Physical autonomy – educated women have fewer constraints on physical mobility and increased self-confidence.
- Emotional autonomy – educated women shift in loyalties to conjugal family, with less emphasis on the extended family.

Economic and social autonomy and self reliance – education enhances access to and control over economic resources, increases self reliance.
Source: Jejeebhoy, 1995

EARLY MARRIAGE AND TEENAGE PREGNANCY

Early marriage holds attendant risks for young women not only of eclampsia and obstructed labour but also diminished life prospects, as they are removed from the education system early.

In a study of 19 countries,[30] the average age of marriage was reported to have risen by at least half a year. However, early marriage is still a feature of many societies and, although the same report suggests that researchers increasingly know more about teenage premarital sexual activity, the authors are concerned that "there has not been a parallel increase in the time elapsed between marriage and first birth". More broadly, it is crucial to recognise, first, that the "second decade of [girls'] lives is a period of critical capability-building and heightened vulnerability, which does not end with marriage and childbearing" and secondly, "that adolescent girls' lives are often governed by harmful, culturally sanctioned gender rules imposed by males, parents, and other elders and perpetuated at times by girls themselves". The study argues that reproductive behaviour is shaped by the extent and nature of "girls' social participation, schooling, and economic opportunities". However, although limited education leads to restricted opportunities for paid work and is associated with poorer health of a woman and her family members, it is also clear that, conversely, teenage girls' education is often curtailed because of marriage and pregnancy. The research concluded that the "large proportion of adolescent girls are already wives and mothers [who] need support and investment at least as much as do their unmarried female peers".

The epidemiology of maternal mortality and morbidity also presents stark facts. Teenage girls are at greater risk of sexually transmitted disease than teenage boys . Teenage girls are also more likely to have an unsafe abortion, with all its consequence, than their older sisters. If the pregnancy, whether intended or unintended, proceeds teenagers are more likely to develop eclampsia and have complicated obstructed labours. The World Bank

concludes: “Young mothers, aged 15–19, are twice as likely to die of pregnancy-related causes than women aged 20–24. The risk of death may be five times higher for girls aged 10–14 than for women 20–24.”

Young people’s involvement in awareness-raising of infant health issues contributing to a reduction in infant mortality in Malawi

The British Council’s Connect Youth International Youth and Poverty Programme aims to influence the policies of multilateral and bilateral agencies in favour of support to children and young people through the youth sector. It is piloting activities in Malawi where they support youth-led programmes of informal education with peer delivery, micro enterprises, and social action programmes focussing on health and the environment. The objective is to create and empower youth structures to deliver programmes, through peer action, to meet the MDGs insofar as they affect children and young people, while enhancing young people’s rights and responsibilities as active citizens.

With early pregnancy and young motherhood endemic in Malawi, the priority will be a widespread programme, working at national and local levels in close collaboration with health authorities, of locally-generated peer-delivered, quality assured, parenthood learning, offering basic information on healthy pregnancy, babycare practices, hygiene, nutrition and healthcare. The programme aims to achieve an increased number of: grant-aided projects focussed on reducing infant mortality; locally-generated programmes for awareness-raising and the empowerment of pregnant women and young mothers in hitherto poorly served areas; and experienced child health facilitators. Another objective is the collection and publication of sample materials to disseminate good practice at regional and national level by the National Youth Council.
British Council: Youth Connect International

Legislation and the activities of community groups, such as the Grameen Bank in Bangladesh, to change social norms and provide mutual support about the desired marriage age is an important strategy to prevent adolescent pregnancy and complications. Such interventions need to be embedded in initiatives so that families can increase their incomes to maintain girls longer at home than would be the case if they were married.

Millennium Goal 3 – gender equality – is key to achieving MDGs 4 and 5.

CARE SEEKING

Women, as the main health carers in the household, frequently make difficult choices about whether and when to seek healthcare. Given the social and economic constraints that women face in many societies, many postpone the decision to access healthcare for their children or themselves, preferring to self-medicate or use alternative options to allopathic public services[31] with potentially serious consequences for their own and their children's health. Various reasons given for not seeking care include cost,[32] distance to health facility;[33] lack of awareness about the severity of an illness,[34, 35] and traditional beliefs about causation of illness.[36, 37, 38]

The WHO Expert Committee on Malaria identified user fees with increased self-medication and use of private or informal practitioners for fever and anti-malarial drugs as some of the reasons for 'not seeking care'. In a study in Burkina Faso, treatment for malaria took place mostly in the home using drugs left from previous episodes or purchased as needed from local drug shops; limited use was made of formal health centres.[39] This pattern is found in many other countries.[40] Self-treatment is associated with under-dosing, leading to drug resistance, and with *"delay in seeking professional treatment and this delay can result in serious disease or death within a short period of time"*.[41] Traditional beliefs can lead to a lack of recognition of maternal risk and delays in seeking treatment for eclampsia and haemorrhage. The former may be attributed to spirit possession while in many places in South America and South Asia childbirth blood is considered ritually unclean and therefore a 'good bleed' is encouraged[42, 43, 44] or applications are applied to the birth canal.[45]

Although labour and delivery may proceed without a problem, in a crisis decision-making and the transfer to a suitable health facility may be delayed. While women are encouraged to seek hospital delivery, it may be customary to use traditional birth attendants or female relatives or neighbours at the time of delivery. In Nepal, for example, the majority of women give birth at home with female relatives in attendance.[46]

Accessing formal maternity services has been made more difficult in many countries by the introduction of user fees for maternity services. Due to the

perceived ‘normal’ nature of pregnancy and childbirth there are variations in the demand for modern, professional services in pregnancy and childbirth. In many places women have continued to use or have reverted to the use of traditional practitioners and/or relatives,[47] instead of paying the fees demanded for maternity services. By contrast, in Ecuador[48] demand has been found to be more steady and price increases have had no disproportionate impact on utilisation by poor women.

Integrating traditional health practices into maternal and child health services

In the Philippines, Plan International works with communities and local government to integrate positive traditional maternal and child health practices into local health services. A research programme was set up to identify, assess and document traditional health practices, develop materials to promote them and assess the outcome.

For example, acute respiratory tract infection is the main cause of child morbidity and mortality, and some traditional practices are effective at curing it. Messages and materials were developed to promote the use of positive traditional practices and a campaign was launched. This included the use of a drama performed by young people.

The integration of positive traditional health practices into health services is important for several reasons, including:

- the acceptability of health services and an improved relationship between professional health workers and communities
- increased willingness to stop harmful traditional practices if positive ones are acknowledged and respected
- the use of local resources are often cheaper and more easily available

Of course, not all traditional advice is harmful. The respect commanded by traditional midwives and healers has long been recognised by NGOs and health organisations, which have therefore sought to involve them in training and to eliminate harmful aspects of their practice.

Child survival and safe motherhood in Senegal

“*Now the advice the grandmothers give us includes both traditional and modern ideas. Now when you are pregnant they tell you to eat more and*

work less. Before there were certain foods they told us not to eat, and they forbade us from snacking between meals. Now they tell us to eat more, especially green, leafy vegetables, beans and small died fish so we'll be strong when we deliver our babies. Before, each women had to do her own work. Now, when a woman is pregnant they ask other women in the family to help out or they take on more of the work themselves. Now they understand us better and that is why we feel closer to them."
Joan, from Senegal, who has a 2 month old baby[49]

Addressing the factors that contribute to low access to preventive health services is essential. In Senegal, Plan is working with NGO partners and the Ministry of Health, and at local level through community health committees, mothers' committees, health workers and volunteers. Work involves: training community-based health volunteers and establishing sustainable community supply systems; building the capacity of community development committees to design, implement and sustain health projects; providing health professionals with refresher training to improve their skills and the support they provide to community volunteers; and carrying out health education for mothers to provide them with the knowledge and skills to improve child survival.

The project includes an innovative element which is the use of a traditional Senegalese game, 'WWW', which has been adapted so that it can be played by illiterate people with messages about safe motherhood and child survival. The game has cards that illustrate scenarios and the players must explain what action should follow in order to gain points – for example, a pregnant woman notices that she is bleeding and the correct action is that she should be immediately referred to hospital, and so on. The game also uses traditional folklore characters to help get messages across in a culturally sensitive and memorable way – for example, goats are used to depict an unhealthy pattern of having lots of children very close together (which is what goats do!) and elephants are used to depict the recommended birth spacing of two years (because this is what elephants do!). The game is very popular and competitions are organised between villages, providing enjoyment while reinforcing Child Survival and Safe Motherhood messages.
Source: Plan International (2003) *Child Survival and Safe Motherhood in Senegal*

Constraints in the health sector at local and central government level

We have seen that progress in achieving the MDGs has varied greatly across different countries. The least-developed countries, those marginalised in the global economy, and the poorest 20 per cent of the population across many other developing and transitional countries are doing extremely badly. While this is reflected in the reduced ability of poor and impoverished households to respond to different health risks in their environment, public health services have also failed to adequately protect women and children. At central government level problems include inadequate political commitment, a weak and often politicised bureaucracy, and low morale among civil servants and health planners, often due to very poor pay and conditions. At district health service level there is considerable variation in performance, suggesting that local management rather than resources alone is a critical factor. Surveys show clinical predominance over public health functions, lack of supervision, lack of control over staff appointments, and often a lack of primary healthcare skills. The lack of routine peer contact with other district health staff, and often the lack of involvement of local authorities and politicians leads to demoralisation and rapid staff turnover; especially when NGOs or foreign aid organisations can attract the most qualified with higher salaries.

> *"Medical services have broken down so much that if you go to hospital you have to take all you need – food, a carer, surgical gloves."* Malera Village in Soroti, Uganda, August 1998[50]

Declining investment in health workers

Reductions in health service budgets during the 1990s left many states, particularly in sub-Saharan Africa, without the capacity to respond to increasing social needs associated with rising poverty levels. The combination of staff retrenchment in the public sector, often a major element of reform, and loss of staff to the private sector or other destinations, sometimes prompted by recruitment drives from more affluent countries, has further reduced public sector capacity. This has impacted on a range of programmes, including the joint WHO/UNICEF Integrated Management of Childhood Illness (IMCI), launched in the early 1990s,[51] and the safe motherhood programme. Both programmes depend on well-trained and supervised staff working both in health facilities and through active outreach.

The components of the IMCI are to improve:

- the case management skills of health workers
- the health system supports required for high-quality care for children coming to health facilities or outreach sites
- household and community practices related to child health, nutrition and development.[52]

The programme aims to build an effective interface between communities and the health system – well-trained staff are its most important resource along with adequate supplies of essential drugs, vaccines, and other equipment. These resources, plus adequate outreach to communities, have been clearly linked with the local population seeking more care from the formal health services.[53] Lack of regular supervision and extremely high rates of staff turnover were identified as major obstacles in implementing the strategy.[54]

To build the capacity of the public sector, there needs to be investment in health workers. In research undertaken in Uganda, Save the Children UK concluded that: "Improving the quality of healthcare depends largely on the quality of the health staff. Initial training followed by continuous in-service training, regular supervision and adequate remuneration ensures commitment and enthusiasm. Relatively modest investments in support of health workers and communities can have a significant impact on the morale of health workers and the quality of care they offer. However, such impacts will only be maintained as long as the investment continues." [55]

Protecting maternal health

Reducing maternal mortality relies heavily on accessible and well-resourced emergency care service with skilled attendants. The availability of skilled attendants also contributes to reduced neonatal deaths.[56]

> *"The health services are too far away… Expectant mothers don't go to distant hospitals because they can't afford to go, and because they aren't used to travelling in a bus."*[57]

> *"Many die in childbirth, because they are attended only by traditional midwives who lack equipment and the knowledge to detect complications in time. There is no transport for rushing people to hospital…"*[58]

Reducing maternal mortality is not simply a factor of women accessing the facility when the problem has already become very serious. There is growing evidence that even in obstetric services delays occur and treatments are sometimes suboptimal, leading to maternal deaths within those facilities.[59] Training, supervision and monitoring are required to enable staff working in emergency obstetric services to deliver the services outlined in the box below, 'Protecting maternal health'.

Protecting maternal health
The promotion of maternal health and the management of obstetric emergencies require a seamless health system employing multidisciplinary teams to provide:

- **family planning**
- **effective antenatal care that includes:**
  - targeted behaviour change communication to different groups (women, male relatives, mother-in-law and community members – especially those with access to transport facilities)
  - early identification of complications
- **birth planning, including:**
  - the purchase of essential equipment such as soap, razor blade, plastic sheet, preparation of clean clothes, string for cord ties
  - decisions about place of birth and selection of skilled attendant
  - savings for an emergency
  - safe, clean services for 'uncomplicated' deliveries.
- **rapid and competent treatment of obstetric complications**
- **effective postnatal monitoring and management of**

Protecting infant health through immunisation

As indicated in Chapter 1, under-investment in general has contributed to declining immunisation rates in developing countries. In delivering immunisation as a vertical programme, the lack of integration and

strengthening of the health system as a whole undermined the sustainability of the programme in the long-term. Immunisation is now included in the IMCI programme in many countries, which emphasises curative, preventive and promotive care.

Directing increased resources to primary healthcare (PHC), particularly in rural areas, with adequate referral to higher levels, is urgently required to deliver programmes aimed at reducing child and maternal mortality. The main features of such a strategy are: extending coverage through the building or strengthening of health facilities; allocating appropriately trained and supervised health personnel to PHC, particularly in under-served areas; and ensuring sufficient drug supplies and other necessary equipment. Previous experience with vertical programmes illustrates the importance of integrating these programmes into broader health systems which take account of specific complexities with regard to sustainability. Service interventions, such as the IMCI, need to be identified at local level based on sound evidence of local priorities.

Children's participation in immunisation programmes

Koreizena is a small village in the Sahel region in the north of Burkina Faso. The Korezeina health centre serves around ten villages, with a total population of 10,000. The health centre staff have had difficulties achieving immunisation coverage targets for children under one year and women of reproductive age. After child-to-child training, pupils of Korezeina school (aged 10–12 years) decided to help tackle this issue. They organised themselves and asked for support from health centre staff, their teacher and a local NGO, Action Pour la Promotion des Droits de l'enfant au Burkina Faso (APRODEB), supported by Save the Children.

Now, every Sunday the children go to the village and do awareness-raising. Working in pairs, they visit all of the houses in the village. During these visits they register babies and women who are due be immunised and motivate mothers to attend the health centre later in the week. With this approach, the Koreizena schoolchildren have helped to make sure their brothers, sisters and mothers are immunised. They have also demonstrated what children can do when they are encouraged to participate in the development of their own village.[60]

Even when coverage is extended and relevant services provided, however, access and utilisation cannot be taken for granted. Institutional and social barriers to service use also need to be recognised and acted on. Better outreach services linking communities with the formal health system need to be supported as well as the creation of mechanisms to facilitate the community's voice and participation in health programming.

National level constraints and commitments

Insufficiency in basic social services

The recently published Bellagio reports in *The Lancet* clearly demonstrate that we have the technology to reduce the child mortality figures by two-thirds yet the systems that are needed to achieve this goal are inadequate and under-resourced.[61] A UNDP study argues that "insufficiencies often create inefficiencies,"[62] which relates to a "threshold level of spending",[63] without which it is difficult to achieve efficiency, effectiveness or equity. A Save the Children study of five developing countries also argued that efficiency gains "should not be regarded as a panacea for all shortcomings in the health system," but that absolute resource constraints also need to be recognised.[64]

Within resource constraints, governments also need to commit themselves to raising the level of funding for basic social services. In the study of 17 countries by the UNDP referred to in Chapter 2,[65] basic social services received an average of 12.3 per cent of the national budget compared to 31.6 per cent on general social expenditure. This indicates the low priority given to basic social services by governments. This finding is consistent with other benefit incidence studies showing that public expenditure is "biased against the poor".[66] Harrington and colleagues suggest even within the existing constraints of limited resources there is significant scope for re-allocation within national budgets to basic social services. A higher order of expenditure on primary healthcare is associated with a below-average under-five mortality.[67]

As indicated in earlier chapters, the Poverty Reduction Strategy Papers (PRSPs) are viewed as the means through which the MDGs will be operationalised:

> *"The growing emphasis on the importance of social protection in Washington is not reflected in most of these IPRSPs and PRSPs, suggesting that its role in poverty reduction is still understood in the main as limited and optional, rather than as an integral element ... overall this analysis suggests that few of the strategies reviewed here are likely to bring about substantial improvements for the poorest people ... the lack of social impact analysis or provision for it is a key concern."* [68]

Several of the PRSPs included targets for improved reproductive and child health linked to MDGs 4 and 5.[69] Reviews of the health content of selected PRSPs, however, indicate that the pro-poor content was insufficient, even non-existent in some instances, with limited analysis of who and where the poor are and what the specific constraints were in relation to the health sector, and with limited evidence about the kinds of interventions that would best meet the health needs of the poor.[70] WHO noted that sectoral ministries were often marginalised in the PRSP process and that most health targets were directed to improving average indicators rather than the health status of the poor.[71] Most disturbing in surveys conducted by WHO is the generally weak analytical base, the weak link from policy to analysis, and the lack of detail or costing of implementation of these strategies.[72] If the PRSPs are to prove to be useful as strategies for meeting the MDGs, greater disaggregation of data is necessary, along with more in-depth analysis of the obstacles faced by the poor in health improvement and accessing health services.

> *"We don't have services such as clean running water or rubbish collections and people often get sick. I give help and encouragement… to children my own age… so they will stay healthy and have better lives."* Rosa, 12-year-old Guatemalan volunteer health promoter[73]

Both the MDGs and the PRSPs offer national governments the opportunity to act on the main determinants of poor health, often linked with under-investment in social infrastructure (water, sanitation, public housing), public education, health services, and other social protection approaches.

Global health policy

The push towards meeting the MDGs is receiving significant attention from all those concerned with health policy. As benchmarks, the targets have received wide support, but targets do not signify strategies. What strategies will best

enable countries to meet the MDG targets in their particular contexts? Indeed, how relevant are the strategies that have dominated health policy since the early 1990s? Will they enable countries to meet the targets set out by the MDGs or are they part of the failure to improve maternal and child health? What part have they played in the deterioration of healthcare delivery systems?

Dominant policies of 'investing in health'

"Health spending is still predominantly prioritised using the DALY (Investing in Health) analysis of cost effective approaches. This analysis prioritises the economically productive populations, promoting increasing inequity for those already marginalised."[74]

"...factors other than wealth can be important in realising progress...government intervention in Sri Lanka has been multi-sectoral ... public provisioning of health and social sector services has been used as the crucial means of promoting progress in reducing child and maternal mortality without waiting for economic growth."[75]

The 1993 World Development Report, *Investing in Health,*[76] has had a major impact on global health policy over the last decade, with many countries designing reform programmes along the lines recommended by the World Bank, and containing some or all of the components outlined in Table 4.1. The reform agenda, in turn, emerged from structural adjustment policies that aimed to reduce public expenditure and, in so doing, generated fundamental change in the *"financing and patterns of ownership of the health sector"*.[77] Two prominent principles in *Investing in Health* directed the development of delivery strategies: first, efficiency and cost-effectiveness; and, second, diversity and competition.

Table 4.1 Components of health sector reform programmes[78]

Improving the performance of the civil service	Reducing staff numbers New pay and grading schemes Better job descriptions and appraisal systems Improved accounting systems Establishing executive agencies
Decentralisation	Delegating responsibility for the management and/or provision of healthcare to local government or to agencies Establishing self-governing hospitals or autonomous district boards
Improving the functioning of health ministries	Organisational restructuring Improving human and financial resource management Strengthen policy and planning functions Developing standards for healthcare provision and for monitoring performance Defining national disease priorities and cost-effective clinical and public health interventions
Broadening health financing options	Introducing user fees Community financing Voucher systems Social insurance schemes Private insurance
Introducing managed competition	Promoting competition between providers through single or multiple purchasers
Working with the private sector	Establishing systems for regulating, contracting or franchising private sector providers, including NGOs and commercial organisations

Efficiency and cost-effectiveness

First, public resources, it was argued in *Investing in Health*, should be used only to fund those activities that would do most to generate health (allocative efficiency), and should be implemented in ways that maximise health gain (technical efficiency). Such priority-setting, based on efficiency arguments, is inextricably linked with cost-effectiveness. Largely based on the disability-adjusted life year (DALY), which includes both epidemiological and economic analyses, a league table is produced of priority health interventions ranked by their heath gain per dollar.[79] In turn, these have been transformed into essential

packages of healthcare delivered by the public health sector in developing countries. The decisions on what was 'essential' were based on epidemiological evidence and cost-effectiveness criteria; the criteria and the priorities identified were the domain of experts.[80] No recognition was given to the need to gain community input based on the community's perceptions and preference for essential health services. This has often undermined utilisation of health services and therefore will potentially undermine the cost-effectiveness of a service.

The efficiency perspective promoted in *Investing in Health*, however, emphasised *aggregate* health gain as the primary public policy goal.[81] Focusing only on aggregate health gain overlooks the potential gaps in healthcare provision and disparity in health status confronting different groups in society. In Chapter 3, it was shown that "overall gains in a population's health frequently mask significant and worsening health outcomes for some population groups".[82] Priority-setting using burden of disease analysis, based on the DALY measure, equally overlooks distribution of ill health in the population according to socio-economic status, ethnicity or other social variable apart from age and gender. The DALY measure also tends to discount years of childhood and old age as being of 'low productive' value compared with an adult in their highly productive years.[83] In other words:

> *"an intervention that saves the life of very young and old people is rated as less efficient than another which saves the same number of adult lives."* [84]

This clearly represents a value judgement rather than an objective assessment, as the advocates of the burden of disease approach would claim.[85] In an analysis of the 1993 World Development Report, Save the Children UK identified five weaknesses embodied in the approach. One of these was "the use of the cost effective methodology to allocate scarce resources among health interventions… which may lead to the fragmentation of health services, inefficiency and wastage due to duplication, and a failure to build strong health systems capable of planning and implementation in a co-ordinated and integrated way".[86]

A narrowly focused approach also misses the importance of providing resources that might be quite modest but that enable older people, for instance, to care for children. Older people are often the main carers of babies, children and young people, yet find themselves unable to fulfil their caring responsibilities owing to lack of income, inaccessible social services and

exclusion from mainstream development programmes. They report that the health of their dependants, and of themselves, is especially compromised by poor access to and the cost of health services. The problems of long travelling distances, attitudes of health workers, lack of basic drugs and high cost of medication are being recorded by older people in the first phase of HelpAge International's older citizen's monitoring project funded by DFID.

Rationing resources using an approach based on a DALY calculation may well overlook critical health interventions required by specific groups in society if the disease burden ranks low compared to other diseases. For example, advocates of interventions to reduce maternal mortality often face the challenge that, as maternal mortality represents just 2.2 per cent of the global burden of disease measured by DALY loss,[87] it is competing with diseases or conditions that have a higher DALY value. Maternal mortality contrasts significantly, for example, with larger burdens of diarrhoea (7.3 per cent), respiratory infections (9 per cent) and neuropsychiatric disease (6.8 per cent). The DALY measure is also "poor at dealing with deaths due to multiple causes",[88] a common problem in childhood.

Finally, the DALY measure fails to consider the contextual impact of an individual death beyond the economic.[89] In relation to the death of a mother, the impact on the surviving child (or children) may be catastrophic.[90] Recent research on the impact of HIV/AIDS in South Africa provides an econometric analysis of the withering away of inter-generational socialisation as parents and ultimately their children succumb to HIV/AIDS-related infections.

Diversity and competition

The emphasis on diversity and competition in *Investing in Health* was considered a means of increasing consumer choice and increasing efficiency.[91] The state's role was to be limited increasingly to policy formulation and regulation of different service providers, but it would continue to respond to externalities such as communicable diseases and services for the poor (through the vehicle of essential health packages mentioned above).[92] Linked with the substantial cutbacks in public health service budgets during the 1990s, the private sector in many developing countries, including non-profit and for-profit providers, has grown exponentially (often with limited or no regulation), responding to the gap in state health provision.[93] In the absence of accessible services (whether determined by price, distance or other opportunity costs) provided by the public sector, evidence shows that the poorest members of society are also having to rely on private provision. The poorest 20 per cent of

the population in eight developing countries made an average of 47 per cent of visits to private providers.[94] In Pakistan and India, the percentage reached 78 per cent and 85 per cent respectively. With limited regulation or monitoring in place, concerns for quality of provision and costs of healthcare are raised. The impacts are also felt on the public sector, as practitioners work in both public and private practice, with the latter being parasitic on the former.[95]

An increased role for the private sector is also envisaged by the World Bank in its 'Private Sector Development Strategy' (PSDS). The PSDS emphasises "direct support to the private sector in order to increase its participation in the provision of basic services".[96] Besides the negative impact on quality and cost highlighted above, the introduction of a 'multiplicity' of actors in the healthcare system creates significant governance problems for the Ministry of Health, and is often beyond government capacity to manage.[97] Strengthening the capacity of central government to regulate the private sector is an important step in the current environment, but within decentralised healthcare systems local government also needs support and capacity-strengthening in this area.

In the absence of public health services of acceptable quality, however, many care-seekers have turned to the private sector. While this frequently results in significant negative outcomes,[98] a perspective which is gaining ground in health policy is that collaboration with private providers, provided certain quality standards are met, may bring dividends by more effectively reaching disadvantaged populations and increasing coverage.[99] It has been suggested that regulatory intervention can push the healthcare system toward increasing inclusiveness and probity, by valuing and involving good providers from all sectors, requiring a policy 'rethink' regarding collaboration between public and private sectors.[100] While the policy implications are unclear, such a step would require, without doubt, strong government capacity to manage and organise.[101]

System failure: 'supply-side' failure

With cutbacks in health and social services, the introduction of privatised services and user charges for health services, the poor pay disproportionately more for the 'right to exist' than the non-poor.[102] The 'de facto' exclusion of the poor from essential health services, in turn, worsens ill health and leads to greater impoverishment.[103] In a presentation on the forthcoming *World Development Report* (WDR), focusing on delivering basic services, the author pointed to significant inequalities in health outcomes between the poor and

disadvantaged compared with the rich, and suggested that the MDGs for health will not be reached by 2015 on current trends. Reviewing failures in the supply side of provision, through both public and market mechanisms, the WDR calls for better governance and accountability in the health sector through creating more effective demand mechanisms on the part of the poor, in other words, strengthening poor people's ability to claim their entitlement to 'adequate' healthcare. That governments do have an obligation to ensure that all citizens receive adequate health and education is clearly stated in the report. The WDR does not, however, propose a policy shift away from the main themes underlying the 1993 report: diversity, competition, and efficiency, which have, in no small part, contributed to the deterioration of public provision.

Governance and accountability[104]

"In the current macro-economic and policy environment, governance and accountability have become a key concern… It also marks a concern to reinstate the role of government as the regulator and guarantor of trustworthy services, but in a context of multiple actors and interests. In practical terms, this has shifted interest to different ways of holding governments and service providers to account, and particularly the role of civil society organisations in this process."

Sector-wide approaches

Sector-wide approaches (SWAPs) have been developed during the last decade as a means of maximising the effectiveness of available resources, and, in principle, to avoid vertical approaches. As most sector strategies seem to include and focus on the delivery of a package of essential health services, it is often hard to ascertain if the strategies are developed and owned by national governments or if they have been overly influenced by global and donor agendas. In several instances, NGOs observe that not all donors fully back the strategies and that their implementation is often parallel to other joint private public initiatives, especially in the health sector.

A key message from the experience so far is that the SWAP is, as the name implies, an approach rather than a blueprint. Overseas Development Institute (ODI) research into SWAPs observes that frustrating policy debates and lack of national ownership could result from donors' efforts to lead the process.[105] Clear implications from the experiences to date indicate that policy initiatives of this nature can only be successful through consultation, persuasion, and long-term alliance formulation. The process should also be informed by policy analysis and evidence of effective practice, which has not often been the case to date.

Another issue with specific relevance to NGOs and civil society is the increasing reduction of support to civil society through the implementation of these strategies. Mechanisms need to be forged which encourage, allow and support active civil society involvement in policy development, implementation and evaluation

HIV/AIDS

Over the last decade, as many countries struggled under resource constraints, the HIV/AIDS pandemic has compounded all the problems at each of the levels we have described. Clearly exacerbating poverty as it disables and kills the productive generation, HIV/AIDS is having a devastating impact on families and communities. Although HIV/AIDS directly contributes a relatively small percentage to under-five mortality, at around 3 per cent per annum,[106] through mother to child transmission,[107] in countries with very high HIV prevalence among the adult population (such as Botswana, Zambia and Zimbabwe where in excess of 30 per cent of the pregnant women who were tested anonymously for HIV antibodies were found to be positive), under-five

mortality has increased. The indirect effect of the pandemic on under-five mortality is assumed to be much greater through loss of carers and resources available to care for children.

HIV/AIDS must be seen as a children's issue. Those between the ages of 7 and 19 are the most vulnerable, unsupported, and marginalised group in HIV/AIDS prevention and care. In 2003, 42 million people are living with HIV/AIDS, half of them young people under the age of 25 years,[108] with a profound impact on life expectancy in the coming years. In some countries now in southern Africa it is considered necessary to train two teachers in the hope that one of them may survive to work many years in his or her profession. However, many countries do not see HIV prevention in children as a priority, and where they do children are often targeted too late. We are facing a worsening orphan situation. Today, 14 million children have lost one or both parents to AIDS. And although most of the orphans today will be adults in 2010 – due to the dramatic increase in number of deaths due to AIDS they will be replaced by 25 million other children who will have become orphaned by 2010.
In a recently completed review by UNICEF on orphans in 40 countries in sub-Saharan Africa it became clear that although the extended family is still taking care of orphans, extended family systems are being over-stretched and falling apart. Not only do orphans tend to live more and more in households with older caretakers, an increasing number are being taken care of by 'poorer', 'female headed households'. Even in countries where the *male* family members have the traditional responsibility to take care of these orphaned children, more and more orphans live in female-headed households. The burden is double for these women because not only are they much more likely to take care of orphans, they also take care of significantly more orphans per household than male-headed households do. 'Basic' needs are not being met in households with orphans. Results from studies in a large number of countries show that the most frequent reported problems by caretakers of orphans are schooling, food, clothing and healthcare. After school expenses, medical expenses and clothing were the next most common unmet needs identified by these households. Studies show that the majority of orphans are over five years old (15 per cent are under five). These older children are more likely to be out of school, under-nourished, working and open to exploitation, and at risk of becoming infected. The phenomenon of child-headed households is also increasingly found, with groups of children fending for themselves and their siblings.

Meeting the needs of all those infected with HIV/AIDS equitably, efficiently and within the existing resource constraints of most countries is impossible. The newest drugs for HIV-related conditions are still under patent and highly expensive, while the costs of even the non-proprietary medicines are impossible to cover in some developing countries. In many countries the health system infrastructure would be too weak to deliver the needed drugs even if they were made available at no cost.

> *"Why should we tell patients about ARVs* [antiretrovirals] *when they will not be able to buy them? It will just make them more depressed."*
> Dr Moses Kamya, Co-director Mulago hospital HIV clinic[109]

Uganda is considered a success story in combating HIV/AIDS, due to its early recognition of the implications of the disease and its vigorous public education programme. Yet there are between 1.5 and 2 million Ugandans infected by HIV who need treatment. The Accelerating Access Initiative (AAI) began in May 2000 with an agreement between the UN and five pharmaceutical companies to use price reductions to secure a rapid increase in access to antiretrovirals (ARVs) in developing countries. However, significant price reductions were not observed in Uganda until the importation of generic ARVs by the Joint Clinical Research Council (JCRC), the major centre among 14 accredited centres for the delivery of treatment in Uganda.

Access to treatment is a crucial element of national strategies to combat AIDS, and should co-exist with prevention and care. ARVs can increase the length and quality of life, as well as the productivity of infected patients, and thus their contribution to the national economy. Treatment can also offer hope for the future, which is often a necessary motivation for testing and accepting of safe sex education. ARV regimens at the time of delivery of HIV-positive mothers have been shown to reduce the chances of the baby becoming infected. But the high price of medicines is still an insurmountable barrier for the very poor, and women are severely disadvantaged in gaining access to this life-saving treatment.

A 2002 Oxfam study in Uganda showed that it was only when generic equivalents to branded drugs entered the market that the price of brand names came down significantly. Where an organised treatment system was in place, generic competition led to a 200 per cent increase in the number of patients using the medicines.

> *"Srey Net, aged 15, has been supporting her whole family ever since her mother had full blown AIDS. She sells food and drinks around her*

village and from in front of her tiny shack. Although she did very well at school… she has no alternative but to leave to look after her mother." [110]

Instability and conflict

In the last decade alone, armed conflicts have killed two million children and have disabled twice that number.[111] Conflicts also rob children of family life. In the 1990s, 20 million children were made homeless and one million were separated from their families. As of July 2002 there were 12 million refugees and over six million internally displaced people (IDPs).

In conflict situations, most deaths in populations of IDPs or refugees occur in children under five.[112] Child mortality rises due to reduced access to health services, reduced immunisation coverage and other preventive activities, destruction of health facilities, and the compromised nutrition of children and their mothers.[113] As with many long-running conflicts Angola had a very low level of immunisation coverage and widespread malnutrition, highlighting the difficulties of providing a humanitarian response in such situations.[114] However, when humanitarian agencies can adequately reach a displaced population they generally prioritise child survival in their response to complex emergencies.

Conflict creates some of the most vulnerable groups of people, specifically children, in terms of refugees and internally displaced persons. It places major constraints on access to food, increasing malnutrition and thus increasing child and maternal mortality rates. It has a direct and chilling impact on health service provision. The immediate effects include damaged or destroyed facilities, lack of supplies, personnel, security to attend clinics, heightened risk of sexual abuse, and, significantly, lack of long-term donor support to rebuild sustainable systems.

"Kintambo Hospital is the Democratic Republic of Congo's largest maternity hospital and its only referral facility. It has capacity for 250 beds but only 80 are functioning because the building is in such disrepair, and because supplies are sparse. Though haemorrhage is the most frequent problem for referral, and greatest cause of maternal death, Kintambo has no blood bank, nor any supplies of anticoagulant drugs. Its only access to safe tested blood is a clinic far across the pot-holed roads of the seven million-person city and, without an

> *ambulance or even a hospital car, it's up to the patient's family to pay for it and get it, and they are often unable or too late."* Save the Children[115]

The WHO report on violence and health identifies some key primary prevention responses such as: pre-natal and perinatal healthcare for mothers; training for good parenting practices and improved family functioning; measures to reduce firearm injuries and improve firearm-related safety; and media campaigns to change attitudes behaviours and social norms.[116]

The reproductive health needs of displaced women are often overlooked in crisis situations. Despite sustained efforts at international level to raise awareness about refugee women's specific health needs, at field level reproductive health is not considered an issue of survival and is therefore not a priority early in a complex emergency.[117] It has been argued that the dominance given to communicable disease control in emergency response "often blurs other important aspects of health, and women undergo the silent emergency of reproductive and sexual health problems."[118] Realising this was a priority, civil society collaborated with UN institutions to develop a manual on reproductive health in refugee situations. Although many best practice issues are covered in this manual, there is still difficulty in convincing donors to fund emergency reproductive health responses. Many NGOs have suggested that the new updated version of the SPHERE[119] standards include reproductive health as part of minimal standards of emergency response, but there is a long way to go to ensure these standards would be funded, prioritised and implemented with proficiency.

> *"I was only 15 when I was abducted by rebels. I lived in captivity for almost three years. Three days after my abduction I was given to a man to be his fourth wife… I had a baby girl… despite this I was given a gun and sent to the war front to fight with my baby strapped to my back"* [120]

In most conflict situations, social networks have broken down and social and moral controls are lost. Women are often left to care for the family without the help of a male partner or male relatives. According to several personal accounts, women fleeing conflict or violence face many hazards. Negotiating safe passage to refugee camps or safe havens in cities may involve putting themselves at risk of sexual violence. They may be forced to sell sex for money or basic resources as a survival strategy. Rape and coerced sex are frequent during conflict and displacement situations, leading to a rise in

unwanted pregnancy, STIs and HIV infection, psychosocial ill health and other consequences.[121]

> *"There is no way you are going to lock her in the house hungry, while men are offering her roast meat, left, right and center."* [122]

Since the International Conference on Population and Development in 1994, the sexual and reproductive health needs of refugees and displaced populations has been given a much higher profile in policy-making agendas. An interagency working group, comprising UNHCR and UNFPA, along with other UN agencies and NGOs, has collaborated on raising the profile of reproductive health needs. This group has:[123]

- established the Reproductive Health for Refugees Consortium, which provides a regular bulletin, small research grants, a field manual, a needs assessment manual and other materials
- developed a Minimum Initial Service Package, which includes essential drugs, supplies, basic surgical equipment
- produced emergency reproductive health kits stockpiled for distribution when needed.

Violence is a leading public health problem – a widespread if under-reported, direct cause of child death. Domestic violence tends to increase significantly in conflict and post-conflict settings, while reporting it becomes increasingly difficult due to failed systems, a sense of disempowerment and the heightened sense of loyalty to the community.

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5 Realising the right to health for women and children

In order to achieve the MDGs we not only need the resources, as described in Chapter 2, but we need to ensure our policies are appropriate at all levels, and implemented in accordance with the fundamental values and principles underpinning the broad objectives for action.

The right to health is embedded in international human rights instruments, including the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) (Appendix 2). Of particular importance is the UN Convention on the Rights of the Child (UNCRC) which has almost universal ratification. The emphasis on health is strong; not only is Article 24 which specifies the right of the child "to the enjoyment of the highest attainable standard of health" comprehensive, including appropriate pre-natal and postnatal healthcare for mothers but reference to the health and survival of the child is made in Articles 3, 6, 17, 23, 25, 27, 32 and 39 of the UNCRC. The strength of the UNCRC is that it promotes a holistic and multisectoral approach to the child's right to health through its core principles of non-discrimination and the best interests, survival, participation, protection and development of the child. The African Charter on the Rights and Welfare of the Child was intended to complement and reinforce the UNCRC. In some areas it raises standards; gives particular emphasis to the institution of the family and the role of women in bringing up children.

Simply stated, were individual states fulfilling the responsibilities clearly laid out both in Article 24, and also Article 4, which defines governments' obligations, to which they committed themselves when they signed and ratified the UNCRC, there would be little need for the additional MDG framework.

> *"States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources, and where needed, within the framework of international cooperation."* Article 4, UNCRC

The drafters of the UNCRC, recognising that the inevitable outcome of this article would be that children in affluent countries would have a higher standard of living than in poorer ones, intended this article to provide an important foundation stone for aid negotiations; one purpose of bilateral and multi-lateral co-operation agreements being to work jointly on the implementation of the rights of the child.[1]

Increasingly, rights-based approaches are being promoted by those seeking the improved status of children and women, and their improved access to health services. The human rights instruments listed above also include the right to education, which is strongly associated with a positive effect on maternal health. It has been suggested that human rights audits should be applied to the design and implementation of maternal health policies and programmes.[2] Within the last year WHO has begun work in collaboration with Save the Children on operationalising a rights-based approach to adolescent-friendly health services. More collaborative work, involving NGOs and faith groups, is required to develop rights-based health programmes.

Legislation giving girls and women the same rights as those enjoyed by boys and men lacks power unless it is equitably enforced. In addition, legislation should be enacted and enforced that pertains to the age of marriage; that outlaws and effectively enforces laws that prohibit female genital cutting, rape and sexual abuse; and that allows the woman to take autonomous decisions in respect of family planning and operative interventions for obstetric complications.

In his first report on progress towards the MDGs in October 2002, the UN Secretary-General, Kofi Annan, drew attention to a lack of progress in achieving Goals 4 and 5: “Most horrific of all are the statistics for child mortality…”. He pointed out that “A similarly dreadful picture emerges for maternal mortality”. As highlighted in Chapter 1, progress has been highly diverse across regions and countries, the latter reflecting large socio-economic disparities within countries. Women and children from poor families face a disproportionately high risk of premature death compared with those from wealthy families. Unlike other MDG targets, however, the health targets are stated in terms of improvement in societal averages rather than gains among poor populations. This means that improvements in any national population groups, including the better off, will lead to progress in the MDG targets – not necessarily reflecting improvements in conditions among the poor.

Clearly this is unacceptable. At the heart of the Millennium Declaration are the principles of solidarity and equality, unequivocally underlining the importance of *"equity and social justice"*, and that *"those who suffer or who benefit least deserve help from those who benefit most"*.[3]

What is required to realise the right to health for women and children?

Rights, as set out in the instruments listed above, embody an objectivity that is not dependent on competing theories of economics or human behaviour. As illustrated in Chapter 4, it is our belief that obligations pertain at every level, and that these rights are more likely to be fulfilled through an analysis that identifies responsibilities at all levels. In the following section we identify a number of issues which we believe must be addressed by those who are involved in bringing about change, in addition to the need for more, effectively used resources

Rights-based policies

A serious examination of current policies and strategies that have contributed to the failure to improve child and maternal health in many countries is urgently needed. While national programmes are often scrutinised by external agencies, greater scrutiny needs to be directed to the policies emerging from the main global institutions and donor countries. Civil society organisations have played key roles in highlighting the impact of these policies on vulnerable populations worldwide, but greater self-criticism is needed by powerful players. Save the Children's research pape*r Thin on the Ground,*[4] which examines the effectiveness of large-scale World Bank-funded nutrition projects, highlights the over-reliance on growth monitoring and promotion to prevent malnutrition. The weak evidence base behind these projects and their poor record of success due to the difficulty of implementing programmes to scale and the lack of analysis of the underlying causes of the malnutrition, raises concerns**.** Investments of this kind are being replicated in many countries, but in many instances they may be only contributing to an increased debt burden. The coalition urges WHO to take the lead in defining best practice in health, HIV and nutrition programme design and use its role to advocate for more cost-effective investments on the part of the governments, major donors and banks.

Recent research carried out by Tearfund and WaterAid[5] in poor communities in 12 Latin American, Asian and African countries, offers a further example: this showed that the current trend of promoting private sector participation to solve the crisis in water and sanitation provision is unlikely to benefit the countries and communities most in need of services. Only 5 per cent of water services are provided by the international private sector globally and less than 1 per cent in Africa. Private investment in the water sector is moving into medium-income developing countries but the poorest countries present conditions of high risk and low incentives for the private companies. It is unrealistic to assume that they will take a lead in developing water services, although their managerial, financial and operational capacity could play a role.

The study showed that the small-scale domestic private sector could play more of a role but currently this sector is badly regulated and rarely involves local communities or hygiene promotion. Experience has shown that local people must be part of the solution and local authorities must channel resources and promote technologies that result in affordable, appropriate and sustainable water and sanitation services. The tendency of the international community to promote PRSPs and make their acceptance a condition of aid and debt relief, undermines the provision of these services to the poor. The value of all stakeholders in maintaining open, constructive dialogue with each other was borne out at a round-table organised by the United Reformed Church (UK) in November 1992 around the issue of urban water sector reform in Ghana.

The recent OECD Poverty and Health Guidelines, in a five-step framework towards achieving pro-poor health policies, indicates a move towards policies based on the principles embodied in human rights instruments. The framework echoes previously agreed global agendas like the Alma Ata declaration on Health for All through the Primary Healthcare approach – inter-sectoral support for health with the participation of all stakeholders. The OECD guidelines expand this to include recommendations from the Commission on Macroeconomics and Health (CMH) such as calling for increased political commitment, pro-poor analysis of trade and economic global policies, and more long-term, secured resources to be firmly channelled through national strategies to build and strengthen national systems. These strategies need to be country-specific, with resources allocated prioritised with the help of strengthened national health information data, which has been disaggregated – as regional variations can cover up the growing global inequities. “Long-term improvements in health demand long-term investment over decades, and in response to local circumstance rather than international strategic preference.”[6]

Poor and sick, but hopeful[7]

By any standards, Tanzania is poor. In 2001 its 35 million citizens divided between them a national income of $9 billion – roughly what Americans spent on wallpaper. Annual health spending is about $8 a head. Two rural districts, Morogoro and Rufiji, with a combined population of about 700,000, were chosen for the Tanzania Essential Health Interventions Project (TEHIP), a joint venture of the Tanzanian Health Ministry and the Canadian International Development Research Centre (IDRC). In the two districts IDRC added $2 per head, on condition that the money was spent on tackling the diseases identified by the local population as the most important.

The traditional way of gathering health data in Tanzania is to collate records from clinics, but since most people die in their homes, this is not terribly accurate. Researchers on bicycles carried out a household survey which produced a 'burden of disease' profile which revealed that what the local authorities were spending on each disease bore no relation to the harm the disease inflicted on local people. Some diseases were neglected. Malaria, for example, accounted for 30 per cent of the years of life lost in Morogoro, but only 5 per cent of the health budget. Other conditions attracted more
than their fare share; tuberculosis, accounting for less than 4 per cent of years of life lost, received 22 per cent of the budget. The extra $2 a head allowed the district health authorities to make their spending reflect the disease burden, without cutting cost-effective or preventive measures, such as vaccination; more would not have been possible to absorb.

The results of this experiment were stunning. In Rufiji, infant mortality fell by 28 per cent between 1999 and 2000, from 100 deaths per 1,000 live births to 72. The number of children dying before their fifth birthday dropped from 140 per 1,000 to 120.

In nearby districts, and in Tanzania as a whole, there is no evidence of a similar improvement over the same period. And anecdotal evidence suggests that better health has made Morogoro and Rufiji less poor.

The need to ensure equity and efficiency

In the equity versus efficiency debate, it is necessary to re-focus our understanding of 'efficiency' in line with society's broader goals. Equity is concerned with redressing the unnecessary, avoidable unfair or unjust distribution of health outcomes and healthcare across the population.[8] It is clear from the earlier chapters that equitable policies on priority-setting, resource allocation, financing and service delivery are urgently needed to advance MDGs 4 and 5.

"What is important is to clearly establish goals, and then to find the most efficient way to fulfil these."[9] Rather than sacrificing equity to efficiency, an efficient approach to equity should be sought. Unlike the more narrow, medicalised vision of health gain of the efficiency-driven approach, "an equity-driven approach… promotes a broader vision for health policy-making".[10]

> *"The pursuit of equity forces consideration of decision-making procedures in society, and the extent to which they allow for broad representation and so expand choice."*[11]

Promoting an equity policy therefore needs to be considered as a major component of an integrated poverty reduction framework that recognises the interdependence of livelihood, peace and security and essential social support. National commitment to empowering local communities, and particularly disadvantaged groups, is a necessary requirement in poverty reduction, based on careful analysis and acknowledgement of the needs of different groups, arrived at with their participation, mobilising public awareness and involving strategic thinking about political obstacles.[12]

Case study: Sri Lanka's public healthcare system as an equitable system

"Equity applies to different aspects of the healthcare system. Writers note that Sri Lanka's system is equitable in several respects and that its equitable nature contributes to its success. Equity of access and service delivery is one of the system's strengths and has been achieved via several mechanisms. The expansion of a dense but well-dispersed network of health facilities has minimized travel costs to them. Hsiao (2000) states that most rural people live within 5–10km of a peripheral health facility. The proximity of health facilities has also meant that information and knowledge about their services and willingness to use them has spread quickly. Costly treatment is avoided by providing services free of charge. Even in the face of resource constraints, user fees remain an undesirable policy option partly because Sri Lanka's democratic system makes them politically costly.[13] The egalitarian values to which the political system responds has meant that equity of access has remained a priority, and given the government's resource constraints, it has been maintained by reducing unit costs. The rapid growth of a private hospital sector, which may cream off the best medical staff and leave the poor with access to inferior services, has been discouraged by maintaining the technical quality of government facilities at a level similar to that offered by private practitioners.[14, 15]

Multi-sectoral approaches

Key determinants of the health of poor women and children are found outside the health sector, requiring cross-sectoral action and coherence across policies in other sectors impacting on health – trade, finance, industry, agriculture – as well as the obvious social sectors. Instead of a disease orientation focus in relation to child and maternal health, it is necessary to engage with the many underlying social, economic and political determinants of ill health. This requires a social model of health that not only addresses the proximate biomedical causes of ill health but also acknowledges that health is socially constructed. In other words, that *"health is seen as being produced not just by individual biology and medical intervention, but by conditions in the wider natural, social, economic and political environment"*.[16] The health sector has a lead role in ensuring that a wider

vision of health is taken by communities, health workers, governments and development agencies.

The MDGs are considered *"mutually supportive and require multisectoral programmes that tackle each of the goals simultaneously*",[17] a concept at the heart of the approach taken by many social development workers, including members of the coalition. Through renewed global interest, national poverty reduction strategies have been given a higher profile, potentially backed up by additional poverty-focused aid. More coherent programming, both at global and national level, should ensure a focus on the poorest and most vulnerable through an appropriate choice of economic and social policies.

Such programming represents an endorsement of the Alma Ata Declaration of 1978,[18] which similarly acknowledged the importance of a multi-sectoral approach, while encouraging the participation of all stakeholders and emphasising equity. The Alma Ata Declaration acknowledged that unacceptable health inequalities, both in health status and in access to healthcare, existed between and within countries, and that reversing this inequality required political action.

A 1998 study of selected countries which did make remarkable achievements in social development[19] concluded that what was significant about these countries was that "they adopted the principles of primary healthcare as underlined in the declaration of Alma Ata long before they had been generally accepted by the world community". These countries focused on primary healthcare in the organisation of their health systems and attenuated the urban bias.

The corollary is that "while the majority of countries have, since the Alma Ata declaration, paid lip-service to promoting primary healthcare (eg, millions of health workers have been trained but left to their own devices) the majority of health resources are still not applied to achieving it."[20]

Proponents of the MDGs are now re-advocating the proposition that achieving equity will require sustained political action.

SOCIAL MODEL OF HEALTH

This leads us to a social model of health. Actions both to improve and sustain health gain require engaging with the complex reality of the links between health and poverty. A clear conceptual framework is required, which would describe the contextual factors that affect intervention delivery and the achievement of high and equitable coverage to meet pressing child survival

needs. A meaningful interface between the community and the health service is urgently needed: currently many health programmes suffer from a lack of effective outreach services. Substantial community input into health programming – both in design and management – can facilitate a more effective service. Health personnel, in particular, need to engage with the complex environment that influences health outcomes of different groups of people, in particular recognising that *"poor people's capacity to gain access to assets that maintain health and access to health service providers will relate to who they are in a given social context"*.[21] It necessitates further investigation into the 'health environment' of the poor – eg, what are the health bottlenecks that prevent a more healthy life? In the household, how and by whom are decisions made concerning health issues? What factors prevent access to quality healthcare? – and other key questions. Excluded groups and geographically isolated groups need specific attention to ensure their health needs are met. "*Different categories of poor people experience social discrimination and exclusion from health institutions in ways that have negative consequences for health-maintaining behaviour, for capacity to control fertility, and for support in times of illness."* This requires effective, participatory, qualitative research, which is analysed and acted upon in the establishment of health services.

The challenge for the health sector and the broader development community is to target the root causes of child and maternal mortality within their programming. Failure to do so will mean failing the millions of children and women whose lives depend on the courage and will of policy-makers to re-think current strategies.

Acknowledging intergenerational links

The powerful intergenerational links between child and carers, and the different stages of life, need to be firmly acknowledged in our approach to health. The health and quality of life of an individual at any one stage in their life is affected by previous circumstances and events. The health of an infant or child is influenced by the health of their carers, but our concern cannot end there. The cumulative effects of health interventions on health outcomes continues throughout the life cycle: "Sustaining improved outcomes at any stage of the life cycle depends on interventions occurring during several stages; that interventions in one generation can influence outcomes in later generations; and that clearly identifying the different stages of the life cycle facilitates the identification of risks for both individuals and families." [22]

The impact of ill health through the life cycle have to be taken into account and acted upon in order to ensure long-term and sustainable health interventions throughout life, along the lines of the World Health Organization's active ageing policy framework.[23] The cumulative effects of poverty and ill health coupled with disadvantages of gender, ethnicity and geography need to be well understood and tackled if poor people are to have good health throughout their life. Public action is necessary to ensure that entitlements to services are made on the basis of need and not ability to pay.

Investing in systems with a focus on people

The health of individuals, communities and nations is dependent upon the availability of adequate safe water, enough food, good sanitation, relevant education, protection from conflict and violence, and quality healthcare. If any one of these is not available, health will be compromised. To be effective. all of these components require a system of production, distribution and use. In the healthcare sector, the knowledge, medicines, vaccines and simple techniques for the diagnosis, prevention, treatment, and management of disease all exist – and they work. The problem is not so much about the global or national availability of these items, but in the availability of people (health workers[24]) trained and supported to be able to distribute and use them safely and effectively.

Although these health workers are the most important part of any system of healthcare delivery, they often receive little attention in healthcare planning. As a result, many healthcare interventions have a limited benefit and many more fail in the longer-term.[25]

Good healthcare depends upon having access to people with appropriate skills. Such a person may be a well-informed mother or relative, a community health worker, a district health officer, or an expert surgeon. A truly effective primary healthcare system will have access to all of these. The quality of healthcare depends largely on the quality of the health staff. Initial training followed by continuous in-service training, regular supervision and adequate remuneration ensures commitment and enthusiasm. Relatively modest investments in support of health workers and communities can have a significant impact on the morale of health workers and the quality of care they offer. However, such impacts will only be maintained for as long as the investment continues. Two problems consistently arise. The first is a gross lack of money available for healthcare and the second is a very limited capacity within the health sector to absorb large, but short-term investments from external donors.[26]

Fatou is a 38-year-old woman living in Liberia. She has given birth to seven children, three of whom have already died. [In Liberia, in 2001, 157 out of every 1,000 children did not reach their first birthday. Today this level is much higher.] Fatou is pregnant and due to deliver in one week's time. She is working in the garden when her labour begins. She sends her daughter to fetch the local midwife (who has been given training, resources and supervision). The midwife, Mary, helps Fatou to deliver a healthy child.

The role of civil society

Recognition and support for civil society's role in the development process can complement national government efforts. Particularly in resource-poor countries, governments need to ensure greater impact of the limited resources they command through better co-ordination of, and increased support for, civil society, including religious groups, which can enhance efforts to improve access for especially poor and high-risk groups. The decentralised planning process offers greater opportunities for the participation of civil society organisations (CSOs) operating close to families in harder-to-reach communities. National governments need to disseminate their planning policies more widely and develop tools and frameworks for participation and consultation, and should include discussion on the budgeting process. The costs of meeting the MDGs should be assessed at country level, with participatory processes, instead of relying on global estimates. The poor themselves are in the best position to identify their own health needs and the obstacles to meeting them. The growing attention to the MDGs is providing a new opportunity for public debate; consultation processes should be broadened at all levels to include civil society and private sector representation. It is possible to devise policies guiding relations between health ministries, CSOs and the for-profit sector.

In these processes it is also incumbent on CSOs to organise themselves, to develop codes of ethics and peer review systems, in keeping with the role they are seeking to play; in particular, putting forward citizen's demands and interests through the policy process and seeking to understand that process, its implementation and implications and how these will advance poverty reduction. In particular, CSOs may monitor the non-material aspects of deprivation and poverty, which tend to be neglected within the MDG

framework. Local groups often need support in accessing information and funding. Working collaboratively, international NGOs and CSOs can do much more in terms of information sharing and joint planning, especially at local level.

Hope for African Children Initiative

Throughout Africa, community organisations struggle to help more than 14 million children orphaned by the AIDS pandemic and the millions more whose parents are sick or dying of AIDS-related illnesses. In 2000, six organisations – CARE, Plan, World Conference on Religion and Peace, Save the Children, World Vision and the Society of Women and AIDS in Africa (SWAA) – established the Hope for African Children Initiative (HACI), to help local organisations expand their activities by leveraging public and private funds. HACI aims to build awareness and reduce the stigma surrounding HIV/AIDS; extend the length of time children can remain with their parents; prepare families for separation and death; and make practical provision for the children's future. In 2001, supported by a $10 million planning grant from a private foundation, HACI partner organisations were able to identify and build on several existing community-based programmes that offered proven and cost-effective services to children whose lives have been affected by HIV/AIDS.

Since then, HACI has been very active in the three start-up countries – Kenya, Uganda and Malawi – and has begun work in Cameroon, Mozambique and Senegal. Plans are under way to move into Ethiopia, Ghana and Tanzania. In each country there is a Country Program Council (CPC), which includes core partners as well as several local NGOs and community-based organisations with experience in community programming. The CPC identifies successful community-based programmes and develops a strategy to co-ordinate and scale up their efforts in family and educational support, HIV testing and counselling, and legal assistance.

> *"If we are to… attain the MDGs, if we are to change this divided, damaged, conflict-ridden world… we will only do so with the full participation of children and young people."* Carol Bellamy, *State of the World's Children 2003*, UNICEF

The United Nations General Assembly Special Session (UNGASS) on Children held in 2002 reviewed the progress on the goals set by governments at the 1990 World Summit for Children. The UNGASS was preceded by a remarkable preparatory process which involved children and young people

throughout the world. Members of the coalition believe that children and young people have the right not only to be listened to but also to show how they are social actors in their own right, making their own important social, economic and cultural contributions to their societies. Members of the coalition seek ways to empower children as active agents in the development process at all levels and to enable children, their families and communities to attain sustainable ways of addressing their needs and rights. In some of the world's poorest countries, the proportion of children aged under 15 is higher than 40 per cent: eg, 50 per cent in Uganda; 48 per cent in Yemen, Congo, Niger and Somalia; and 47 per cent in Malawi, Burkina Faso, Angola and Zambia.[27] Many of these young people are about to start having children of their own. Effective programmes and policies to protect children and young people must be based on sufficient knowledge of their lives.

The role of youth NGOs in Zambia

Zambia is an example of an African country whose economy came under severe strain as commodity prices tumbled. An escalating debt burden and accelerating inflation contributed to the collapse of education and health programmes which could no longer be afforded. In such circumstances, where major government departments are fighting for resources, the youth services come way down the pecking order. The total 2003 budget for three departments – the Ministries of Sport, Youth and Child Development – is £2 million. As a consequence, there is a general recognition that youth NGOs have a crucial role to play in both meeting the needs of young people and involving them in the development process.

The British Council Connect Youth International is providing support to a number of youth initiatives, many geared to HIV/AIDS peer education. The Mandevu Adolescent Reproductive Health Project, for example, operates from Mandevu Community School in a poor area of northern Lusaka. It aims to forge partnerships between young people and their parents to re-enforce awareness of HIV/AIDS and other aspects of reproductive health. The Edwin Mulongoti Basic School Anti-AIDS Club provides outreach peer support for those infected and affected in the Matero area of Lusaka, in a 'youth friendly' corner of the main health clinic.

Dr Kenneth Kaunda recently echoed civil society's continual calls for more inclusive participation. ***"…People from all walks of life need to be involved***

in finding the solutions to their lives… These include young persons, the elderly, women, people of various ethnic groups, people from other religions and spiritual beliefs, the poor, business persons, people with disability, and everyone…" [28]

Working at all levels

Simouy is a 13-year-old boy with malformed legs, with whom the Cambodian Association for the Development of Farmers and the Poor (CADFP) has worked for two years. A neighbour said of Simouy's situation now:

"It is so much better than before. If he wanted to go to school before he had to get on the shoulders of another boy. When there were floods he was put in a big pot and pushed to school. With a bike he can now manage by himself." [29]

Many children in Cambodia have physical disabilities, and there are many reasons for this. Children with disabilities are often viewed as an economic burden and ostracised by their families. They experience discrimination, are not accepted in mainstream society and may even be excluded from school. This situation is accentuated in rural communities, where poverty is more acute and schools further away.

One Cambodian organisation working with disabled children is the Cambodian Association for the Development of Farmers and the Poor (CADFP). CADFP is a Tearfund partner and belongs to a network in Cambodia, linked to Viva Network. It has been working to prevent children becoming disabled in the first place, while also ensuring the best possible quality of life for those already disabled.

CADFP currently works with 79 children throughout the Chhuk District in the south. Through home visits, it helps the children overcome their sense of isolation. It also provides practical assistance, including bicycles and books to help the children get to school, and soap and towels to improve their health and hygiene.

One of CADPF's main roles has been educating the local community – helping them understand the situations of children with disabilities and encouraging better integration into community life. Overcoming cultural

prejudice has been challenging but it helps that Sam Ouern, Executive Director of CADFP, has a disability himself because he serves as a role model to the children. "Children with disabilities can do many things in the same ways as other children, so their disabilities should not be an obstacle to studying or earning an income."

As well as working to change attitudes and provide basic needs, CADFP is active in influencing policy at local and national levels. At local level it has worked to persuade teachers to include children with disabilities in their classes, for a reduced fee or no fee at all. It has lobbied local commune leaders to include all children in school and community activities. At national level, it has networked with others to lobby the government for law reform to overcome disability discrimination.

In 2002, CADFP undertook research into attitudes towards disability within the local community. Workers interviewed eight different groups and discovered that, while many people understand the causes and effects of disability, children with disabilities are still excluded from mainstream society. CADFP is now lobbying for its research recommendations to go before the government.

The next step for CADFP will be to publicise its research and help communities integrate children with disabilities into everyday life. It is also considering producing a newsletter, to be written by children with disabilities, as a means of informing others and enabling the children to speak for themselves.[30]

Conflict and violence

To achieve the overarching goal of halving world poverty there must be more effective action to reduce armed conflict. In particular, investment is needed in post-conflict strategies to restore health services in areas where provision has been undermined over many years because of damaged and destroyed facilities, lack of basic supplies and personnel, and restricted freedom of movement. In many cases, special measures will be needed in the early stages of post-conflict reconstruction, as exemplified by the nationwide measles vaccination campaign in Afghanistan in 2002. This was the first time that such a campaign for a broad age range had been carried out in an emergency setting. It was made possible due to adequate resources being made available (UNICEF and WHO mobilised $8 million), careful planning and co-ordination (42 international agencies and NGOs assisted with the transport of

health teams and supplies) and appropriate training. In areas where conflict has wrought havoc over decades it has to be acknowledged that re-building effective systems and implementing new policies will take time, but successful emergency campaigns can be run while local capacity is re-built.

Afghanistan: Protecting 10 million children against measles

The public health structure in Afghanistan was devastated by 23 years of civil war. Its infant and under-5 mortality rates are among the highest in the world, with measles accounting for an estimated 30,000–35,000 deaths each year.

In 2002, the Ministry of Health of the Interim Government of Afghanistan, with the support of international organisations, organised a nationwide measles vaccination campaign for children aged 6 months to 12 years. The campaign was conducted in phases throughout that year, initially targeting high-risk districts and cities with the largest number of susceptible children, followed by the most remote and inaccessible villages. A core group of trainers trained 15,000 vaccinators. Community and religious leaders facilitated the social mobilisation, ensuring children were brought to some 1,200 fixed vaccination sites in markets, mosques, health centres and mobile clinics. By 31 December 2002 more than ten million children, representing over 90 per cent of the target population, had been vaccinated and the number of reported measles cases decreased from 8,762 in 2001 to 2,574 by the end of 2002.
Source: UNICEF Immunization Plus: Executive Summary June 2003

NOTES

[1] Article 24 (health) and Article 28 (education) contain similar language.

[2] Freedman, L P (2001) 'Using human rights in maternal mortality programs: from analysis to strategy', International Journal of Gynaecology and Obstetrics, Vol. 75, pp. 51–60.

[3] United Nations General Assembly (2002) Implementation of the United Nations Millennium Declaration Report of the Secretary-General to the Fifty-seventh session of the General Assembly, Document A/57/270.

[4] Save the Children (2003) *Thin on the Ground*, available from: www.savethechildren.org.uk or contact Anna Taylor: a.taylor@scfuk.org.uk. Save the Children, 17 Grove Lane, Camberwell, London SE5 8RD, UK.

[5] Calaguas, B et al. (2003) *New Rules, New Roles: Does PSP Benefit the Poor?,* Synthesis Report, Tearfund and WaterAid.

[6] Poore, P (2003) 'Health workers, poverty and the quality of healthcare in Arua, Moyo, Adjumani and Yumbe districts of the West Nile region of Uganda in 2002', Unpublished paper, Save the Children.

[7] *The Economist*, 15 August 2002

[8] Whitehead, M (1991) 'The concepts and principles of equity and health', *Health Promotion International*, Vol. 6, No. 3, pp. 217–226.

[9] Barker, C (1996) *The Health Care Policy Process*, London: Sage Publications.

[10] Gilson, L (1998) 'In defence and pursuit of equity', *Social Science and Medicine*, Vol. 47, Issue 12, pp. 1891–1896

[11] ibid.

[12] WHO (1996) *Revised 1990 estimates of Maternal Mortality: A New Approach by WHO and UNICEF*.

[13] Facing serious fiscal constraints in 1971, the Government reintroduced user fees, having abolished them in 1951. However, as their re-introduction was not matched by commensurate increases in funds, they were abolished in 1977 (World Bank (1998) *Investing in young lives: The role of reproductive health: Why invest in young people?*, available at http://www.worldbank.org/html/extdr/hnp/population/ynglives/ynglives.htm) Another funding option, the public financing of private providers, has never been seriously considered by the government (Save the Children (2003*) Bucking the Trend: Good Health at Low Cost in the 21st Century: How does Sri Lanka do it?*, Unpublished, Save the Children).

[14] We discuss the complementarity between Sri Lanka's public and private health systems in more detail below.

[15] Save the Children and IDS (2003) 'Good Health at Low Cost in the 21st Century: How does Sri Lanka do it?', Save the Children.

[16] Jones, L (1994) *The Social Context of Health and Health Work*, London: Macmillan.

[17] United Nations General Assembly (2001) Road Map towards the implementation of the United Nations Millennium Declaration, Report of the Secretary General, Fifty-sixth session of the General Assembly, A/56/326.

[18] WHO (1978) Primary Healthcare Report of the International Conference on Primary Healthcare Jointly sponsored by the World Health Organization and the United Nations Children's Fund, Alma Ata, USSR, 6-12 September, 1978, Geneva: WHO.

[19] Mehrotra S and Jolly R (1998) *Development with a Human Face: Experiences in social achievement and economic growth*, Oxford University Press.

[20] This study (and others) show that community health workers and traditional birth attendants assisting at home deliveries need to be supported by good health referral systems (Mehrotra and Jolly, op. cit., p. 100).

[21] Holland, J et al. (2000) *Becoming Poverty-Focused: Implications for health actors*, Working paper prepared for the Department for International Development by the Centre of Development Studies, Swansea and the UK DFID Health Systems Resource Centre.

[22] Claeson, M and Waldman, R J (2000) 'The evolution of child health programmes in developing countries: from targeting diseases to targeting people', *Bulletin of the World Health Organization*, Vol. 78, No. 10, pp. 1234–45.

[23] WHO (2002) Active Ageing Framework, available at http://www.who.int/hpr/ageing/ActiveAgeingPolicyFrame.pdf.

[24] For the purposes of this paper a 'healthcare worker' includes all professionally trained staff. However, there are many other people who are vital for the effective delivery of healthcare. They include managers, drivers, technicians, community health workers, cleaners, office staff etc.

[25] Poore P (2003) op. cit.; In a recent study of human resources for health in the public facilities, only 34 per cent of established positions were filled by qualified staff (Ugandan Ministry of Health, 1999).

[26] Poore P (2003) op. cit.

[27] UN Statistics Division, found at http://www.un.org/Depts/unsd/social/youth.htm

[28] Kaunda, Dr Kenneth Key note speech at the 'Sustainable Development in the Southern Africa: Mobilising Partnerships and Capacity for Achieving MDGs', conference organised by UNDP 2–4 July 2003 Johannesburg, South Africa.

[29] Miles, G (2003) Tearfund with the Viva Network Cambodia, case studies for the GUFP report on MDGs.

[30] Ibid.

Recommendations

Resources

Donor governments must increase development assistance and bring debt down to levels consistent with financing the MDGs. Innovative sources of finance, in particular, the International Finance Facility proposed by the UK government, should be supported to fill the remaining gap between current resource flows and what is needed to achieve the MDGs so that 'no country genuinely committed to poverty reduction, good governance and economic reform will be denied the chance to achieve the Millennium Goals through lack of finance" (G8 Africa Action Plan, Kananaskis, 27 June 2002). Resources and support also need to be 'sourced and sustained' to support those **countries with weak institutions or policy making abilities** (usually those recovering from or submerged in conflict situations). Many of these areas may be small but their poverty levels and the child and maternal mortality levels are stagnating or rising, reducing the likelihood of achieving the MDGs for the poorest countries.

Northern governments must abandon trade subsidies and protectionism in agriculture and textiles and take seriously their own commitment to trade liberalisation. At the same time they should allow developing countries the flexibility to protect their own infant industries and vulnerable sectors, such as small farmers.

National governments must allocate adequate proportions of their own resources to basic health services. Health sector financing should be a prominent aspect of PRSP deliberations. Health and finance ministries need to work together to ensure that all people, including children and women seeking maternal healthcare, have access to effective basic health services.

Policy

Health planning must be based on a social model of health, engaging with the many underlying social, economic and political determinants of ill health so that services are provided on the basis of equity and need. An urgent review of current international and national health policy priorities is required so that the fundamental building blocks of child and maternal health services such as immunisation are well integrated within government health services. There is

an urgent need for research on the impact of ten years of using the DALY analysis.

Health planning must be based on investment in skilled staff as the quality of healthcare depends largely on the quality of the health staff. Initial training should be followed by continuous in-service training, regular supervision and adequate remuneration to ensure staff commitment. Developed countries should cease recruitment drives which deplete the numbers of trained personnel in developing countries.

Health data coverage and quality must be urgently improved. At global and national level, data must be disaggregated for analysis by region, location (urban/rural), gender, age, socio-economic status, and ethnicity.

Accountability

National governments must monitor effectiveness of the services and be accountable to civil society, including the poor and children, for their performance. The media and non-governmental organisations must raise awareness of the goals among local communities. Process indicators are needed to accompany the quantitative targets currently embedded in the health MDGs. Institutional benchmarks are needed to monitor progress in strengthening health delivery systems. Northern governments and international institutions, especially the UNDP, are already providing technical assistance in data collection and analysis – but more needs to be done.

Duty-bearers in donor governments and international institutions must be held to account for their leadership and commitment to the MDGs. Health MDGs provide benchmarks to assess development progress on health. National monitoring of progress on health MDGs is needed to feed into regional and global reporting.

Civil society organisations at all levels should work collaboratively to further the MDGs.

Poverty

Poverty must be addressed through a focus on people's livelihoods. Without this, health interventions will not be sustainable. Institutions within and

outside the health sector need to work together with joint analysis and planning for sustainable improvements in livelihoods and health.

Appendix 1: Grow Up Free from Poverty Coalition

The Grow Up Free from Poverty Coalition,[1] currently made up of 21 NGOs, faith groups and civil society organisations with a commitment to children's rights and development, came together informally before the Westminster Conference of February 2001, a major international event on tackling child poverty worldwide, hosted by UK Chancellor of the Exchequer, Gordon Brown and the Secretary of State for Development, Clare Short. This group, based in the UK, but with partners all around the world, agreed on issues that must be tackled if the international community is to fulfil its commitments. It has worked together over the last two years intent on playing its part and taking up its own responsibilities. A strength of the coalition is its broad membership, which includes large and small development NGOs, young people's organisations, organisations committed to older people's rights, and diverse faith groups. It is committed to a rights-based, intergenerational and multisectoral approach based on the principles enshrined in the UN Convention on the Rights of the Child.

The coalition emphasises a comprehensive approach to tackling child poverty and stresses the importance of policy coherence and a multi-actor, multisectoral and intergenerational approach. In focusing on children, the coalition does not overlook interdependence in households. Older people increasingly perform important functions in childcare, and the implementation of policies which benefit women, giving a greater voice to mothers and older carers, is essential to poverty reduction. Anti-poverty policies must be based on a life-cycle perspective, recognising the needs of individuals at different ages and the cumulative nature of deprivation.

Since the Westminster Conference the coalition has established a dialogue with the Department for International Development (DFID) and HM Treasury on issues relating to international child poverty and the MDGs. It has published two reports, *A Six Point Plan for Eliminating Child Poverty* in February 2001 for the Westminster Conference and *Grow Up Free From Poverty: Meeting the 2015 Targets: a progress report* in February 2002, and in collaboration with HM Treasury ran a conference in February 2003 for young people in the UK on achieving the MDGs.

The coalition has agreed to a set of aims and principles to underpin action that will contribute to meeting the 2015 targets.

Vision: To end the outrage of child poverty

Action against child poverty is urgent. It is a moral imperative – children make up nearly 40 per cent of the world's population; 30,000 children die every day in developing countries and 183 million are malnourished. The burden of poverty,

conflict and economic decline falls heavily on children – education is sacrificed, nutrition eroded and medical care is an impossible dream for many.

Children have the right to grow up healthy, hopeful and educated, so that they can realise their own potential and contribute to their countries' development. The international community has set ambitious MDGs for 2015, including halving the proportion of the world's population living in extreme poverty (on less than one dollar a day) and, focusing on children, primary education for all children, reducing child and infant mortality by two thirds and, by 2005, parity between girls and boys in primary and secondary education.

Aims

Members of the Grow Up Free from Poverty Coalition will:

- work to ensure that this vision is owned internationally, in all the countries where the Millennium Development Goals have to be achieved; and in donor countries, by international organisations, national all levels of civil society. As civil society organisations ourselves, our primary links are with partner organisations and network members in the South and the North and our own supporters
- bring the Millennium Development Goals, and in particular the means to achieve the child focussed targets, to the forefront of development thinking, campaigning and action on the part of official and voluntary institutions. Each institution, including coalition members, needs to make clear commitments to the targets and how they will go about realising them in order to make themselves accountable to the people they serve and to their own members, whether these are governments or individual supporters.

Principles

Coalition members are committed to:

- rights-based development and child rights – recognising and actively promoting the rights of children established under the UN Convention on the Rights of the Child and using its guiding principles[2] as the framework for all policies and actions which impact on children
- participatory ways of working: involving those at every level of society and of all ages who will be affected by this initiative, particularly children, in decision-making and implementation
- inclusiveness – recognising the needs of all generations and involving the whole community, including the most marginalised, in discussion of and work towards the targets

- working closely with Southern partners. The success of this initiative will depend on governments and civil society organisations in the South becoming active and engaged in decision-making and implementation.

Objectives

Coalition members aim to:

- take forward the six point plan agreed in February 2001
- monitor the commitments made in February by governments, international organisations and international financial organisations and ensure that promised actions are taken
- raise public awareness in the UK and beyond of the outrage of child poverty and the structural causes of poverty and inequality
- build solid working relationships with partner organisations in the South to enable girls and boys, and the adults around them, to realise their rights and improve their lives
- encourage action by Southern partners to realise the Millennium Development Goals and to foster enabling environments so that the poorest and most marginalised children and adults can directly influence the decisions, processes and institutions that affect their lives
- promote participation, inclusion and child rights-based work within our own and each others' campaigns support each others' campaigns in order to ensure a co-ordinated and holistic approach to reducing child poverty
- assist governments and communities in developing sustainable and participatory solutions to improve the daily lives of poor children and their families
- target donors and the corporate sector where appropriate to encourage action on child poverty.

In 2003 the Coalition has a number of priorities: to campaign in the UK to raise public awareness about child poverty in low-income countries and the action required to meet the 2015 targets, especially among young people; to take an active part in international events which will aid progress in meeting the targets; to launch a report on the progress towards the targets relating to child and maternal health; and to initiate consultation processes with Southern partners and networks.

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Appendix 2: The right to health as stated in international instruments

Universal Declaration of Human Rights 1948

Article 25

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The International Covenant on Economic, Social and Cultural Rights 1966

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

Convention on the Elimination of All Forms of Discrimination against Women 1979

Article 11 (1) provides that State Parties shall take appropriate measures to eliminate discrimination against women in the enjoyment of the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12 (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.

United Nations Convention on the Rights of the Child (UNCRC) (1989)

Article 24

1. States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right to access such healthcare services. UNCRC Article 24

2. States Parties shall pursue full implementation of this right, and in particular shall take appropriate measures:
(a) to diminish infant and child mortality
(b) to ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare
(c) to combat disease and malnutrition, including within the framework of primary healthcare, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution.
(d) to ensure appropriate pre-natal and postnatal healthcare for mothers
(e) to ensure that all segments of society, in particular parents and children are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents
(f) to develop preventative healthcare, guidance for parents, and family planning education and services.

3. States Parties shall take all effective and appropriate measures… abolition of traditional practices prejudicial to the health of children.

Appendix 3: Global Burden of Disease, 2000

In the Global Burden of Disease estimates for 2000, perinatal conditions, lower respiratory infections, diarrhoeal diseases, and malaria are found in the ten leading causes of DALYs globally (Table A1), but with varying positions across different regions (Table A2).

Table A1: Ten leading causes of DALYs, Version 2 global estimates for 2000

		% of total DALYs
All countries		
1	Perinatal conditions	6.8%
2	Lower respiratory infections	6.3%
3	HIV/AIDS	5.5%
4	Unipolar depressive disorders	4.5%
5	Diarrhoeal diseases	4.4%
6	Ischaemic heart disease	4.0%
7	Cerebrovascular disease	3.1%
8	Malaria	2.9%
9	Road traffic accidents	2.6%
10	Tuberculosis	2.4%

Source: Mathers et al., 2002

Table A2: Leading causes of DALYs in WHO regions, Version 2 global estimates for 2000

African Region (AMRO)	% total DALYs	American Region (AMRO)	% total DALYs
HIV/AIDS	17.8%	Unipolar depressive disorders	8.0%
Malaria	10.3%	Perinatal conditions	5.0%
Lower respiratory infections	8.4%	Violence	4.7%
Perinatal conditions	6.3%	Ischaemic heart disease	4.5%
Diarrhoeal diseases	6.1%	Alcohol use disorders	4.3%
Measles	4.6%	Road traffic accidents	3.2%
Tuberculosis	2.4%	Cerebrovascular disease	2.8%
Whooping cough	1.9%	Congenital anomalies	2.5%
Road traffic accidents	1.8%	Diabetes mellitus	2.3%
Protein-energy malnutrition	1.6%	Lower respiratory infections	2.3%

War	1.5%	COPD	2.0%
Violence	1.4%	Diarrhoeal diseases	2.0%
Unipolar depressive disorders	1.2%	Hearing loss, adult onset	1.8%
Tetanus	1.1%	Asthma	1.8%
Congenital anomalies	1.1%	HIV/AIDS	1.6%
Eastern Mediterranean (EMRO)	**% total DALYs**	**European Region (EURO)**	**% total DALYs**
Perinatal conditions	9.3%	Ischaemic heart disease	10.5%
Lower respiratory infections	8.6%	Cerebrovascular disease	6.8%
Diarrhoeal diseases	7.6%	Unipolar depressive disorders	6.1%
Ischaemic heart disease	3.9%	Alzheimer and other dementias*	3.0%
Unipolar depressive disorders	3.5%	Alcohol use disorders	2.9%
Congenital anomalies	3.2%	Hearing loss, adult onset	2.6%
Road traffic accidents	2.8%	COPD	2.4%
Measles	2.4%	Road traffic accidents	2.4%
Tuberculosis	2.2%	Osteoarthritis	2.4%
Whooping cough	1.9%	Self-inflicted injuries	2.3%
Cerebrovascular disease	1.7%	Lower respiratory infections	2.3%
Protein-energy malnutrition	1.6%	Trachea, bronchus, lung cancers	2.2%
Hearing loss, adult onset	1.5%	Perinatal conditions	2.0%
Malaria	1.4%	Cirrhosis of the liver	1.7%
Tetanus	1.4%	Violence	1.6%
South East Asian Region (SEARO)	**% total DALYs**	**Western Pacific Region (WPRO)**	**% total DALYs**
Perinatal conditions	9.5%	Cerebrovascular disease	6.0%
Lower respiratory infections	7.6%	Unipolar depressive disorders	6.0%
Diarrhoeal diseases	5.6%	Perinatal conditions	5.6%
Unipolar depressive disorders	4.7%	COPD	5.2%
Ischaemic heart disease	4.7%	Lower respiratory infections	4.5%
Tuberculosis	3.7%	Road traffic accidents	3.4%
HIV/AIDS	2.9%	Ischaemic heart disease	2.8%
Road traffic accidents	2.7%	Self-inflicted injuries	2.5%

Cerebrovascular disease	2.3%	Congenital anomalies	2.4%
Congenital anomalies	2.1%	Hearing loss, adult onset	2.3%
Hearing loss, adult onset	2.1%	Alcohol use disorders	2.3%
Measles	1.7%	Tuberculosis	2.1%
COPD	1.7%	Osteoarthritis	1.9%
Self-inflicted injuries	1.6%	Stomach cancer	1.8%
Fires	1.5%	Diarrhoeal diseases	1.8%

Source: Mathers et al., 2002

Notes

[1] ActionAid, Bretton Woods Project, British Council Connect Youth International, CAFOD, Christian Aid, Christian Socialist Movement, Consortium for Street Children, HelpAge International, Help the Aged, EveryChild, Justice, Art & Education, The Mothers' Union, National Council of Hindu Temples, Oxfam, Plan International, Save the Children, SCIAF, Tearfund, UNICEF UK, United Reformed Church, Viva Network, World Development Movement, World Vision. (Please note that not all members of the coalition ascribe to all the positions in this report.)

[2] These are that: all rights apply to all children without discrimination of any kind; the best interests of the child shall be of primary consideration; the right of the child to survival and development; the right to participation.

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More than 10 million of the world's children die from preventable causes every year – two every second. And every year more than 500,000 women die in pregnancy and childbirth – one every minute.

If we were to meet the Millennium Development Goals, set in 2000, we would save 80 million lives by the target year of 2015. Approximately 76 million children and 4 million women would be saved from avoidable death.

But we are seriously off track from meeting these targets. How can the global community take action to save these lives? Not only are more resources needed, but also a careful analysis of why policies have failed in the past, and how we must implement new policies in the light of the principle of 'health for all'.

The Grow Up Free from Poverty coalition of NGOs and faith groups challenges all those with the responsibility and power to prevent 80 million unnecessary deaths.

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