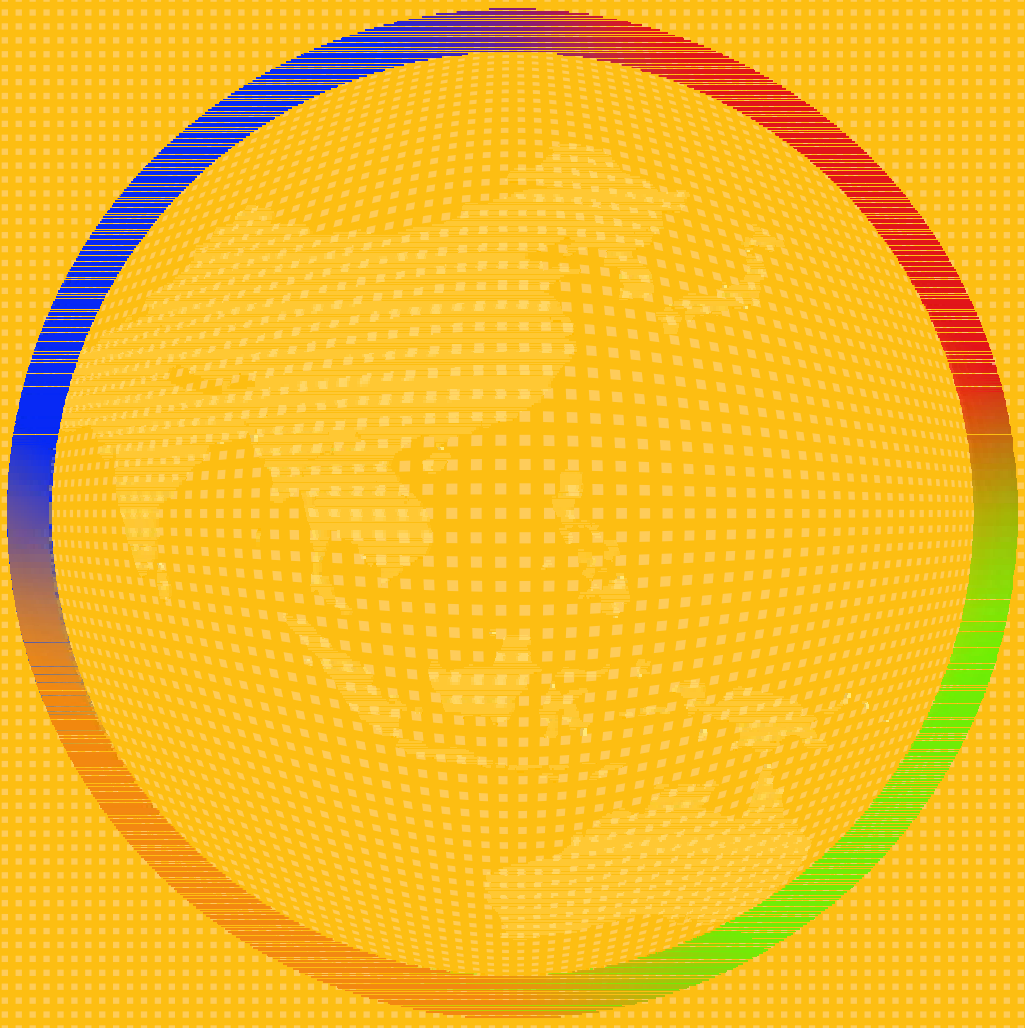
Turning Promises into Progress

Attaining the Health MDGs in Asia and the Pacific



Turning Promises into Progress

Attaining the Health MDGs in Asia and the Pacific

Photo Credits:
Pages vi and 1: www.asiatours.net. Pages vi and 5: www.aitaiwan.org.tw. Pages vi and 7: www.artemis.austincollege.edu. Pages vi and 12: FAO/18211/J. Villamora. Pages vi and 17: FAO/17283/J. Holmes. Page 20: Asian Development Bank. Pages vi and 22: www.tropicalislands.de. Pages vi and 27: WHO–WPRO.

Contents

BOXES

FIGURES

MAPS

TABLES

ABBREVIATIONS

ACIPAC	Asian Centre for International Parasite Control
AIDS	Acquired immunodeficiency syndrome
ARI	Acute respiratory infection
DAC	Development Assistance Committee
DOTS	Directly observed treatment, short course
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross domestic product
GNP	Gross national product
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
JBIC	Japan Bank for International Cooperation
MDG	Millennium Development Goals
MMR	Maternal mortality ratio
MTEF	Medium-Term Expenditure Framework
NGO	Nongovernmental organisation
ODA	Official development assistance
PDR	People's Democratic Republic
PPMD	Public-private mix DOTS
PRSP	Poverty reduction strategy papers
SEWA	Self-Employed Women's Association
TB	Tuberculosis
TRIPS	Trade-Related Aspects of International Property Rights
WHO	World Health Organization
WTO	World Trade Organization

Note: In this paper, $ refers to US dollars.

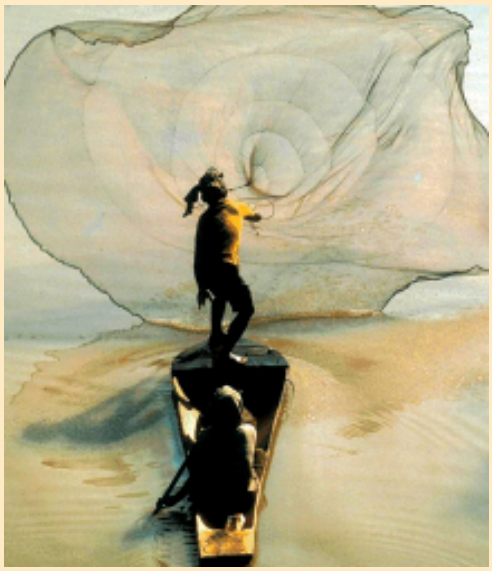
Acknowledgements

This paper was prepared for the High Level Forum on the Health MDGs in Asia and the Pacific, held in Tokyo on 21–22 June 2005 and hosted by the Government of Japan in collaboration with the Asian Development Bank, the World Bank, and the World Health Organization.

The paper was prepared by a team at the World Health Organization Regional Office for the Western Pacific, comprising Justine Sass (consultant and principal author), Anjana Bhushan (Technical Officer, Poverty, Gender and Human Rights), and Francisco Flores (Short Term Professional, Health Information), under the guidance of Soe Nyunt U (Director, Health Sector Development), and Y.C. Chong (Regional Adviser, Health Information).

The authors gratefully acknowledge the many thoughtful comments and helpful inputs by: Anabela Abreu, Carla Abou-Zahr, Dong Il Ahn, Afsar Akal, Kjerstin Andreasen, Henrik Axelson, Xu Baert, Jacques Baudouy, Dorjsuren Bayarsaikhan, Henk Bekedam, Misha Belkindas, David Bell, Sekhar Bonu, Eduard Bos, Hana Brixi, Carmen Casanovas, Andrew Cassels, Tommaso Cavalli-Sforza, Shiladitya Chatterjee, Rebecca Dodd, Vincent de Wit, Yuriko Egami, Bernard Fabre-Teste, Anton Fric, Kathleen Fritsch, Gauden Galea, Davidson Gwatkin, Rie Hiraoka, Frances Harper, Robert Hagan, Graham Harrison, Michaela Herinkova, Steven Iddings, Quazi Islam, Jak Jabes, Jacques Jeugmans, Pernille Jøergensen, Kei Kawabata, Khine Latt, Xavier Leus, William Loxley, Margaret Maier, Steven Mecartney, Bjørn Melgaard, Janet Nassim, Richard Nesbit, Ezekiel Nukuro, Hisashi Ogawa, Jean-Marc Olivé, Ruyan Pang, Guillermo Paraje, Arturo Pesigan, Nguyen Phuong, Amit Prasad, Annette Prüss-Üstün, Jumana Qamruddin, Ravindra Rannan-Eliya, Gabrielle Ross, Stéphane Rousseau, Fadia Saadah, Reijo Salmela, Yuenwah San, Budiono Santoso, Jouko Sarvi, George Schieber, K.E. Seetharam, Nihal Singh, Howard Sobel, U Than Sein, Ernest Smith, Emi Suzuki, Angelica Sousa, Niko Speybroeck, Ajay Tandon, Waranya Teokul, Terrence Thompson, Pieter van Maaren, Jeanette Vega, Michael Voniatis, Richard Wah, Clay Wescott, Baoping Yang, Takako Yasukawa, Jun Yoshida, and Junping Yu.

Marc Crowe edited the paper. Alexander Pascual handled the design and layout.



Key messages

1
- Progress toward the Millennium Development Goals (MDGs) has been uneven across goals, across countries, and within countries in Asia and the Pacific. Low-income countries have shown the slowest progress.
- Tackling the MDGs is critically important, given the region's absolute contribution to the global burden of disease.
- Effective technical interventions exist to reach the health MDGs—the key challenge is to ensure that they reach those who need them most.

2
- New and emerging diseases, non-communicable conditions, conflicts, and disasters pose additional challenges to public health and economic development in the region.
- Multifaceted approaches are required to address the medium- and long-term impacts that region-specific health challenges pose. Key components include: cooperation across sectors and geographic areas, preventive health information and services, disaster preparedness and management mechanisms, and a special focus on vulnerable populations.

3
- Improvements in the accessibility, quality, and efficiency of health systems are crucial for better health outcomes.
- Strong health systems require stewardship; timely, accurate, and disaggregated information and analyses to monitor progress and plan accordingly; stable health financing mechanisms for essential health services; and a health workforce that is appropriately recruited, trained, regulated, motivated, and deployed.
- Engagement with the private sector and communities can extend the coverage of interventions and improve the overall performance of health systems.

4
- Inequalities in health status and in access to health services hamper the efforts of countries to achieve the MDGs.
- Some countries might be able to achieve the health MDGs while still having populations or areas with poor outcomes.
- An approach based in human security is important in addressing disparity. This could include documenting and analysing inequities, targeting specific populations or areas, increasing the availability and quality of health services, promoting primary and essential care, and establishing risk-sharing arrangements.

5
- Because social and other non-health factors significantly determine health, meeting the health MDGs will require cross-sectoral investments and actions in areas such as poverty reduction, educational achievement, gender equality, water and sanitation, and infrastructure.
- Developing the institutional mechanisms to steer cross-sectoral actions to improve health is a particularly important challenge. Key components include: tools to assess the evidence on cross-sectoral links; improved coordination among and between ministries, local authorities, and the private sector; supportive legal and regulatory environments; and policy coherence among donors.

6
- Progress on the health MDGs will depend on increasing domestic and external investments in health, and improving the effectiveness of available resources.
- Policy and institutional reforms, reallocations in spending patterns, and improved macroeconomic environments give governments the fiscal space to focus on health investments.
- External resources are more effective when closely aligned to broader national development processes and priorities, directed toward system-wide approaches and policy and institutional reforms, provided on a timely and predictable basis through harmonised and simplified donor policies, and "untied" from the procurement of goods and services in donor countries.

7
- Enhanced regional cooperation can contribute to greater progress on the MDGs through shared learning and adaptation of good practices, improved collaboration on cross-border and regional health challenges, and enhanced economic growth and poverty reduction.
- Country ownership of MDG-based strategies is central to their progress, and requires the involvement of multiple stakeholders, including governments, nongovernmental organisations, civil society, the private sector, and other interested parties.

Introduction

The Millennium Development Goals (MDGs), contained in a declaration[1] adopted unanimously by United Nations Member States in September 2000, reaffirm commitments made during preceding decades towards poverty reduction and sustainable development.

The MDGs consist of eight goals, accompanied by specific time-bound targets and indicators to measure progress toward the targets by 2015. Goals 1 to 7, which are interconnected and mutually reinforcing, focus on reducing poverty, hunger, illiteracy, gender inequalities, child and maternal mortality, disease, and environmental degradation. Goal 8 aims to strengthen the means to achieve the first seven goals by establishing a global partnership for development.

Three of the eight MDGs (Goals 4, 5, and 6) refer explicitly to health, while three others (Goals 1, 7, and 8) are health-related (*see Table 1*). Moreover, better health is central to the achievement of all the MDGs[2]—as an end in itself and as a major contributor to the overarching goal of poverty reduction. Improvements in health also depend on, and contribute to, the achievement of other goals in areas such as education and the environment.

This report reviews key issues and challenges faced by countries in Asia and the Pacific[3] as they seek to achieve the health MDGs, and identifies actions to accelerate progress. It demonstrates that inequalities in health status and in access to quality services hamper achievement of the MDGs. The report also shows that improvements in health outcomes are unlikely without improvements in health care delivery systems, and that cross-sectoral approaches are required to address the multiple determinants of health. Further, the report argues that progress will depend on increasing the availability of resources and improving the effectiveness of aid and on local actions buttressed by national, regional, and global support. ■

Table 1. MDGs with health-related indicators

Goal 1: Eradicate Extreme Poverty and Hunger

- Prevalence of underweight children under 5 years of age
- Proportion of population below minimum level of dietary energy consumption

Goal 4: Reduce Child Mortality

- Under-5 mortality rate
- Infant mortality rate
- Proportion of 1-year-old children immunised against measles

Goal 5: Improve Maternal Health

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases

- HIV prevalence among young people aged 15–24
- Condom use rate of the contraceptive prevalence rate
- Number of children orphaned by HIV/AIDS
- Prevalence and death rates associated with malaria
- Proportion of population in malaria risk areas using effective malaria prevention and treatment measures
- Proportion of tuberculosis (TB) cases detected and cured under directly observed treatment, short course (DOTS)
- Prevalence and death rates associated with TB

Goal 7: Ensure Environmental Sustainability

- Proportion of population using solid fuels
- Proportion of population with sustainable access to improved water source, urban and rural
- Proportion of population with access to improved sanitation

Goal 8: Develop a Global Partnership for Development

- Proportion of population with access to affordable essential drugs on a sustainable basis.

Legend: Health MDG; Health-related MDG

Source: World Health Organization (WHO) 2003c

1

Issues and challenges in meeting the health MDGs in Asia and the Pacific

KEY MESSAGES

- Progress toward the Millennium Development Goals (MDGs) has been uneven across goals, across countries, and within countries in Asia and the Pacific. Low-income countries have shown the slowest progress.
- Tackling the MDGs is critically important, given the region's absolute contribution to the global burden of disease.
- Effective technical interventions exist to reach the health MDGs—the key challenge is to ensure that they reach those who need them most.

Home to nearly two thirds of the world's population, Asia and the Pacific are characterised by exceptional geographic, economic, and cultural diversity, as well as significant variations in levels and rates of development.[4] The region also abounds in intra-country diversity across socioeconomic groups and geographical areas, particularly in the populous or larger countries, leading to differences in the use of services and in health outcomes.

The countries in Asia and the Pacific, as a group, have moved toward achieving many of the MDGs (*see Table 2*). However, progress has been uneven across goals, across countries, and within countries. Beyond the impact that progress toward the MDGs makes on health and well-being at individual, household, community, and national levels, reaching the MDGs is also critically important given the region's contribution to the global burden of disease.

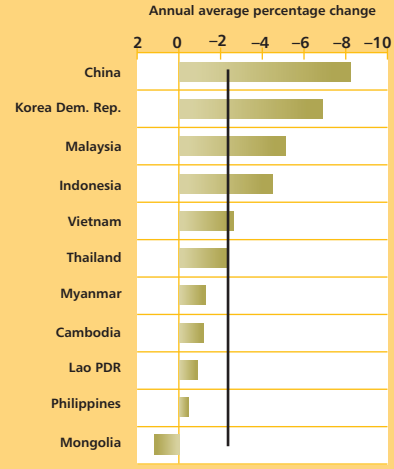
Table 2. Major trends in selected health MDGs, by region

Major trends in the Goals, by region			AFRICA		ASIA				OCEANIA	LATIN AMERICA & CARRIBEAN	COMMONWEALTH OF INDEPENDENT STATES	
			Northern	Sub-Saharan	Eastern	South-eastern	Southern	Western			Europe	Asia
Goal 1	Eradicate Extreme Poverty and Hunger	Reduce extreme poverty by half	ON TRACK	HIGH, NO CHANGE	MET	ON TRACK	ON TRACK	INCREASING	NO DATA	LOW, MINIMAL IMPROVEMENT	INCREASING	INCREASING
		Reduce hunger by half	HIGH, NO CHANGE	VERY HIGH, LITTLE CHANGE	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	INCREASING	MODERATE, NO CHANGE	ON TRACK	LOW, NO CHANGE	INCREASING
Goal 4	Reduce child mortality	Reduce mortality of under-five-year-olds by two-thirds	ON TRACK	VERY HIGH, NO CHANGE	PROGRESS BUT LAGGING	ON TRACK	PROGRESS BUT LAGGING	MODERATE, NO CHANGE	MODERATE, NO CHANGE	ON TRACK	LOW, NO CHANGE	INCREASING
		Reduce hunger by half	MET	LOW, NO CHANGE	NO DATA	ON TRACK	PROGRESS BUT LAGGING	ON TRACK	DECLINING	MET	MET	MET
Goal 5	Improve maternal health	Reduce maternal mortality by three-quarters	MODERATE	VERY HIGH	LOW	HIGH	VERY HIGH	MODERATE	HIGH	MODERATE	LOW	LOW
Goal 6	Combat HIV/AIDS, malaria, and other diseases	Halt and reverse spread of HIV/AIDS	NO DATA	STABLE	INCREASING	STABLE	INCREASING	NO DATA	INCREASING	STABLE	INCREASING	INCREASING
		Halt and reverse spread of malaria	LOW	HIGH	MODERATE	MODERATE	MODERATE	LOW	LOW	MODERATE	LOW	LOW
		Halt and reverse spread of TB	LOW, DECLINING	HIGH, INCREASING	MODERATE, DECLINING	HIGH, DECLINING	HIGH, DECLINING	LOW, DECLINING	HIGH, INCREASING	LOW, DECLINING	MODERATE, INCREASING	MODERATE, INCREASING
Goal 7	Ensure environmental sustainability	Halve proportion without improved drinking water in urban areas	MET	NO CHANGE	DECLINING ACCESS	HIGH ACCESS, NO CHANGE	MET	MET	HIGH ACCESS, NO CHANGE	MET	MET	MET
		Halve proportion without improved drinking water in rural areas	HIGH ACCESS, LITTLE CHANGE	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	ON TRACK	PROGRESS BUT LAGGING	LOW ACCESS, NO CHANGE	PROGRESS BUT LAGGING	HIGH ACCESS, LIMITED CHANGE	HIGH ACCESS, LIMITED CHANGE
		Halve proportion without sanitation in urban areas	ON TRACK	LOW ACCESS, NO CHANGE	PROGRESS BUT LAGGING	ON TRACK	ON TRACK	MET	HIGH ACCESS, NO CHANGE	HIGH ACCESS, NO CHANGE	HIGH ACCESS, NO CHANGE	HIGH ACCESS, NO CHANGE
		Halve proportion without sanitation in rural areas	PROGRESS BUT LAGGING	NO CHANGE	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	PROGRESS BUT LAGGING	NO CHANGE	NO CHANGE	PROGRESS BUT LAGGING	LITTLE CHANGE	LITTLE CHANGE

MET OR ON TRACK | PROGRESS, BUT TOO SLOW | NO OR NEGATIVE CHANGE | NO DATA

Source: UN Statistics Division, UNDESA 2004 in United Nations Millennium Project 2005

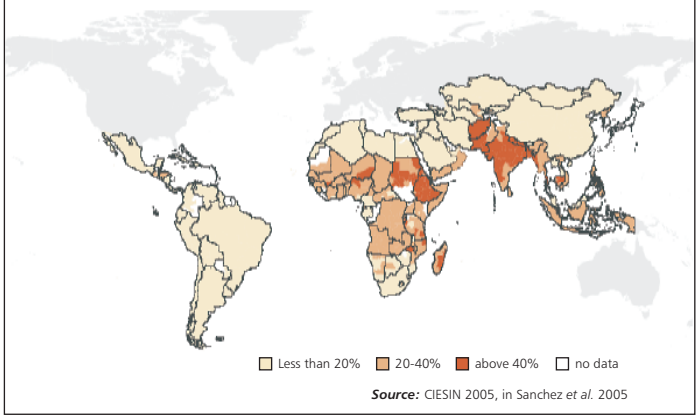
Figure 1. Progress in Asia and the Pacific toward the malnutrition goal, selected countries



Source: Wagstaff and Claeson 2004

Effective technical interventions exist—the key challenge is to ensure that they reach those wh o need them most. Accelerating progress toward the MDGs will require steps to ensure equity, secure resources and improve effectiveness, strengthen health systems, and promote cross-sectoral actions. Another key is a commitment across all sectors to address better the determinants of health, such as Goal 3, related to gender equality and women's empowerment.

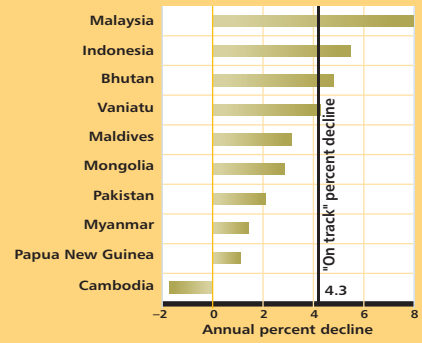
Map 1. Hunger hotspots: areas with more than 20% underweight children under age 5



Source: CIESIN 2005, in Sanchez *et al.* 2005

Country ownership and leadership of strategies to meet the MDGs are crucial. Some countries have established country development goals, while others have gone beyond the MDGs to establish additional development goals. Viet Nam, for example, has established Viet Nam Development Goals for 2005 and 2010, aimed at guiding progress towards the MDGs.[5] Countries on track to meet the MDG targets, such as Malaysia and Thailand, have introduced additional or more ambitious "MDG-plus" targets related to quality of life, educational attainment, and health outcomes.[6] For example, Thailand has set a target of reducing HIV prevalence among adults to 1% by 2006,[7] while Malaysia has committed to eradicating poverty by 2009.[8] For these countries, going beyond the MDGs to ensure improved outcomes for poor and vulnerable populations remains a priority.

Figure 2. Percent decline in under-five mortality, 1990-2000



Source: Tandon 2005

Eradicating hunger

A number of countries in the region have reached the required annual rate of reduction necessary to achieve the target of halving the proportion of people suffering from hunger between 1990 and 2015 (*see Figure 1*). However, low-income countries have been progressing more slowly. Child malnutrition is of particular concern in South Asia where—despite higher levels of growth, agricultural production, infrastructure, and public services—the prevalence of underweight children under age 5 is higher (47%) than in sub-Saharan Africa (31%).[9] Other "hunger hotspots" in the region can be seen in Map 1.[10]

Interventions to eradicate hunger require collaboration across multiple sectors to improve agricultural productivity and food security; ensure access to markets, financial services, and social safety nets; promote women's well-being, empowerment and education; reduce micronutrient deficiencies and promote immunisation.[11]

Reducing child mortality

Of all the deaths of children under 5 worldwide, 42 countries account for 90%, including 10[12] in Asia and the Pacific. Concerted efforts are required in South Asia, where about 9 of 100 children die before their fifth birthday.[13]

Evidence suggests that less than 30% of countries in Asia and the Pacific are on track to meet the MDG target of reducing under-5 mortality by two thirds between 1990 and 2015.[14] Middle- and high-income countries have fared better than lower-income countries (*see Figure 2*), demonstrating that large percentage reductions are possible even at low rates of mortality.[15]

Recent studies have shown that the MDGs related to child survival will not be met without substantial reductions in neonatal mortality.[16] Indonesia, Sri Lanka, and Viet Nam have achieved low neonatal mortality rates despite

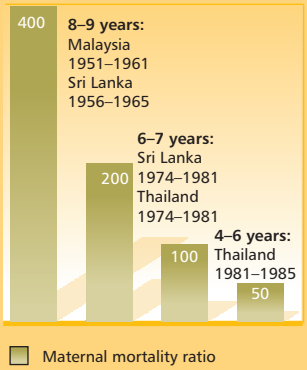
limited resources. In Sri Lanka, improvements occurred largely through sustained inputs into and use of primary care services; equitable access to health care facilities; and high-quality services.[17] Other interventions that contribute to reductions in child mortality include skilled assistance at delivery; immunisation against infectious diseases; improved maternal and child nutrition; and improved access to quality care.[18]

Improving maternal health

Asia and the Pacific account for nearly half of all maternal deaths worldwide, and India alone accounts for more than a quarter of the global total.[19] The maternal mortality ratio (MMR), a measure of the obstetric risk associated with each pregnancy, exceeds 400 maternal deaths per 100,000 live births in seven countries in the region.[20]

A shortage of trend data in most countries makes it difficult to appraise the likelihood of attaining the maternal health target of reducing the MMR by three quarters by 2015. Most countries are not on track to meet the target, according to most analyses.[21]

Figure 3. Number of years to halve maternal mortality, selected countries



Source: WHO 2005b

Some countries have demonstrated that progress is possible, even with limited resources (*see Figure 3*), though time and commitment are required.[22] Successful reductions in these and other countries were largely due to skilled attendance at delivery,[23] functioning referral systems, available essential obstetric care, and policies promoting equitable access to reproductive health services, including family planning, and antenatal, delivery, and postpartum care.[24]

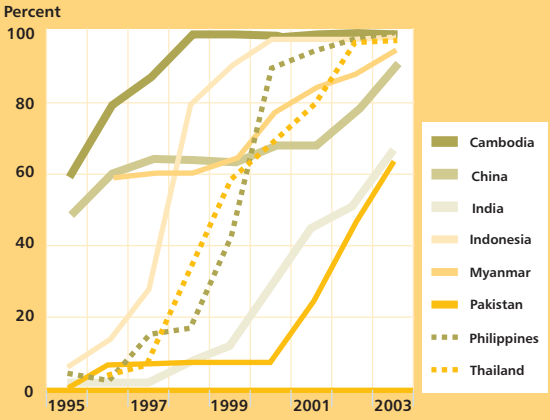
Halting and reversing the spread of HIV/AIDS, tuberculosis, and malaria

Evidence suggests that most heavily affected countries in the region are unlikely to meet the goal of halting or reversing the spread of HIV. Large-scale prevention programmes have helped to avert new infections and slow the growth of the epidemic in Cambodia and Thailand. However, mounting infection rates can be found throughout the region, including in Myanmar, Nepal, Papua New Guinea, Viet Nam, and in some Central Asian Republics, including Kyrgyzstan.[25] The populous countries of China, India, and Indonesia are of particular concern as low national prevalence rates might mask serious hidden epidemics in provinces, territories, and states.

Of the 22 high-burden countries for tuberculosis (TB), 10 are in Asia and the Pacific.[26] Viet Nam is one of the few high-burden countries that has surpassed the 2005 global targets for TB detection and treatment,[27] though Cambodia, China, Myanmar, and the Philippines are expected to reach them in 2–3 years.[28] A major challenge for these countries will be to sustain progress to reach the MDG by 2015. All countries in the region will need to take steps to improve case detection; expand access to directly observed treatment, short course (DOTS) (*see Figure 4*), monitor drug-resistant strains of TB; and promote synergies between TB and HIV/AIDS prevention and care activities.[29]

The Indian subcontinent and South-East Asia bear the heaviest malaria burden outside of Africa.[30] In many countries, progress toward the MDG target of reducing or halting the spread of malaria has been achieved through various interventions. These include the free distribution and treatment of bednets, improved access to more effective anti-malarial medications,[31] better training for health workers, and the application of indoor residual spraying. In Viet Nam, for example, an integrated package of interventions contributed to reductions in mortality and morbidity rates by 97% and 60%, respectively, over 5 years.[32] Despite such improvements, population movements and rising rates of multi-drug resistant strains

Figure 4. Progress in DOTS implementation, 1995–2003, selected countries



Source: Tandon 2005

pose formidable challenges for malaria control, especially in the Greater Mekong Subregion.[33] Access to prevention and treatment by remote populations, where malaria is often concentrated, is also a concern. In coming years, better access to treatment and improved case detection might lead to stagnant or rising malaria prevalence rates, while the true burden of disease is declining. As such, care must be taken in the interpretation of these data.

Ensuring environmental sustainability

The combustion of solid fuels, including biomass (wood, dung, crop residues, and charcoal) and coal, for cooking and heating has been linked to high levels of indoor air pollution and associated morbidity and mortality, particularly among women and children in poor households.[36] Solid fuel use is greatest in low-income countries (*see Table 3*), and evidence suggests that poverty remains one of the main barriers to the adoption of cleaner fuels.[37] Interventions that improve access to cleaner fuels and energy practices make multiple contributions to the MDGs through, for example, improving health outcomes, reducing poverty, empowering women, and protecting the environment.[38]

Table 3. Proportion of population using solid fuels, by income level,[34] selected countries

< 5%	Between 50%–94%		≤ 95%
Australia	China	Bangladesh	Cambodia
Guam	Samoa	India	Lao People's Democratic Republic (PDR)
Singapore	Sri Lanka	Indonesia	Myamnmar
New Zealand	Thailand	Mongolia	Solomon Islands
Republic of Korea	Tonga	Nepal	
Malaysia	Vanuatu	Pakistan	
		Papua New Guinea	
		Viet Nam	

Legend: High-Income Country; Middle-Income Country; Low-Income Country

Source: United Nations Department of Economic and Social Affairs 2005, WHO estimates[35]

Despite efforts to increase water supply coverage in Asia during the past decade, nearly two thirds of the region's people lack access to safe water, including 300 million in China alone.[39] South Asia has made the greatest progress over the past decade in expanding coverage (from 68% to 86%), due mainly to improved access in India.[40] Many parts of Asia are not on track to improve sanitation largely due to limited progress in rural areas. Coverage rates are 34% in South Asia and 48% in East Asia and the Pacific.[41] Improvements will require investments—particularly in rural areas where the needs are greatest—in the provision and maintenance of infrastructure, and in awareness-raising and education to increase household demand for services.

Providing access to affordable essential drugs

Improving access to essential medicines is a key element to achieving the MDGs. Progress has been made in the past decade due largely to India's mass production of generic drugs serving the region; and collaborative efforts between governments, bilateral and multilateral agencies, public-private partnerships, nongovernmental organisations (NGOs), professional associations, and others (*see Table 4*). Many life saving drugs' patents have expired recently, and 600 or more are to expire between 2005 and 2010.[42] The World Trade Organization's (WTO) Agreement on Trade-Related Aspects of International Property Rights (TRIPS),[43] and other multilateral and bilateral trade agreement negotiations, accord high priority to public health safeguards for access to medicines. ■

Table 4. Access to essential medicines, by number of countries in different regions, 1999[44]

	Percent of population with regular access to esential medicines				
	Very low access (<50%)	Low to medium access (50%–80%)	Medium to high access (81%–95%)	Very high access (>95%)	Total countries
Africa	14	23	5	3	45
Americas	7	14	7	7	35
Eastern Mediterranean	2	7	5	8	22
Europe	3	12	6	25	46
South-East Asia	2	4	3	0	9
Western Pacific	1	8	8	9	26
Total countries	**29**	**68**	**34**	**52**	**183**

Source: WHO 2004f

2

Region-specific health challenges

KEY MESSAGES

- New and emerging diseases, non-communicable conditions, conflicts, and disasters pose additional challenges to public health and economic development in the region.
- Multifaceted approaches are required to address the medium- and long-term impacts that region-specific health challenges pose. Key components include: cooperation across sectors and geographic areas, preventive health information and services, disaster preparedness and management mechanisms, and a special focus on vulnerable populations.

Rapid changes in the region have the potential to affect health outcomes greatly. These include increased trade and globalisation, the steady ageing of populations, and rapid rural-to-urban migration (particularly in Asia), which is contributing to the rise of several megacities[45] and urban poverty. At the same time, sparse populations and the isolation of far-flung communities is a challenge for health services, particularly in the Pacific and countries such as Mongolia.

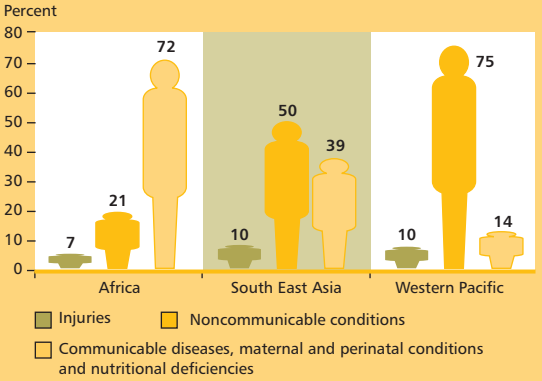
Within this context, countries in Asia and the Pacific are leading, monitoring, and coordinating strategies to meet the global compact for development embodied in the MDGs. In addition, they will need to adapt and respond to other region-specific health challenges including:

Emerging communicable diseases

Many low-income countries in the region traditionally face a heavy burden of known communicable diseases such as TB, HIV/AIDS, and malaria. Simultaneously, new and emerging diseases, including severe acute respiratory syndrome and avian influenza, pose significant challenges to public health and economic development. Demographic and ecological changes in the region that favour the spread of these diseases include increased population growth and mobility (within and beyond borders), urban crowding and poor sanitation, mass food production and global distribution, and increased exposure to animals and other disease vectors and reservoirs.[46] Experience has shown that the keys to controlling the spread of these emerging diseases are prompt and transparent information exchange; rapid case detection and vigorous contact tracing; government commitment at the highest level; and regional, global, and inter-sectoral collaboration, including in the animal husbandry sector (*see Section 5*).[47]

Non-communicable conditions

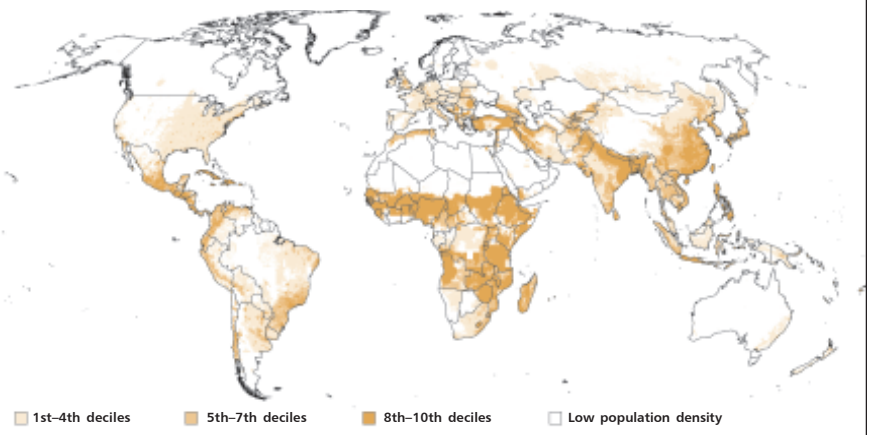
Figure 5. Percent distribution of deaths by cause, selected regions[48], 2002



Source: WHO 2004d

The burden of non-communicable conditions, such as obesity, diabetes mellitus, cardiovascular disease, hypertension, stroke, and cancer, is increasing in Asia and the Pacific. The growth of these conditions has outpaced communicable diseases, including in many low-income countries (*see Figure 5*). These trends are largely due to lifestyle changes associated

Map 2. Areas at highest natural disaster-related mortality risk, by mortality decile



Note: A decile divides a distribution of ranked scores into equal intervals where each interval contains one-tenth of the scores.

Source: Dilley *et al.* 2005, in United Nations Millennium Project 2005

with developments in global trade and marketing; rural-to-urban migration; increased tobacco use; dietary shifts toward foods high in saturated fat, sugar, and salt; and reduced physical activity.[49] In Australia, China, and some Pacific island countries, obesity rates have risen three-fold or more since 1980.[50] In China, cancer-related deaths have increased by nearly 30% over two decades, making cancer a leading cause of death.[51]

In many countries, the combination of non-communicable conditions and communicable diseases has imposed a double burden of disease, disability, and premature death.[52] For example, India has the highest number of diabetics in the world (31.7 million). At the same time, 2.5 million Indian children die from infections, such as pneumonia, diarrhoea, and malaria every year.[53] In Mongolia, cardiovascular disease and cancer accounted for more than 58% of all deaths in 2002, while acute respiratory infections (ARI) and diarrhoea remained the leading cause of death among infants.[54] A multifaceted approach, including nutrition education, preventive health care, tobacco control, and improved access to health services, is required to reduce the burden of non-communicable conditions on countries in the region.

Conflicts and disasters

Asia and the Pacific account for a large share of the world's conflicts and natural disasters (*see Map 2*). Conflicts within countries often occur along religious, ethnic, linguistic, and other social lines. Areas suffering from conflict, including parts of Indonesia, Nepal, the Philippines, and Sri Lanka, have lower levels of human development and higher levels of poverty.[55] Two of these areas, Aceh province in Indonesia and the predominantly Tamil regions of northeast Sri Lanka, were hit hard by the tsunami of December 2004. In addition to efforts to rebuild lives and livelihoods, investments in conflict resolution will be critical to long-term stability.

The experience of the tsunami also has shown that countries in the region need better preparedness and management mechanisms, including those to address the immediate and long-term impacts of natural disasters on human and economic development.[56] Particular care is required to ensure that the most vulnerable groups are not marginalised further in this effort. ■

3

Strengthening health systems

KEY MESSAGES

- Improvements in the accessibility, quality, and efficiency of health systems are crucial for better health outcomes.
- Strong health systems require stewardship; timely, accurate, and disaggregated information and analyses to monitor progress and plan accordingly; stable health financing mechanisms for essential health services; and a health workforce that is appropriately recruited, trained, regulated, motivated, and deployed.
- Engagement with the private sector and communities can extend the coverage of interventions and improve the overall performance of health systems.

Significant improvements in health outcomes are unlikely without major improvements in the accessibility, quality, and efficiency of health systems. Strengthening health systems is a continuous process in all countries in the region. Some countries in the Central Asian Republics, and others decentralising health sector functions or progressing toward more democratic and participatory governments, are adapting their health systems to new contexts and environments. These changes pose opportunities and threats to the achievement of the health MDGs.

Health systems development is a complex issue, which requires country-specific policy and programmatic responses. While a single blueprint cannot be used for all countries, the most critical components include:

Providing stewardship for health systems

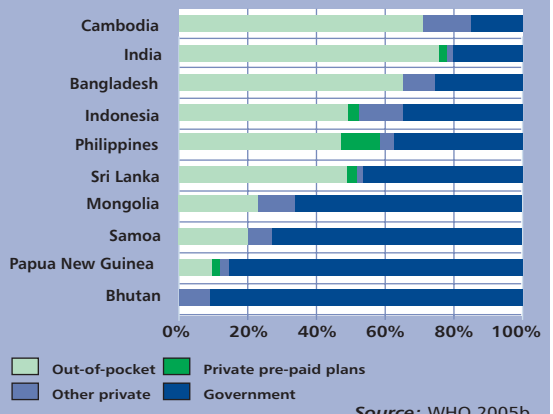
Stewardship can be understood as the government's responsibility for managing the health and well-being of its populations, and guiding the health system as a whole.[57] This requires oversight, regulation and accountability of all actors—public and private—involved in service delivery, resource mobilisation, financing, and oversight. Health system outcomes are influenced by how well or poorly a government executes its different stewardship functions, including collecting and using information; formulating strategic policy frameworks; ensuring tools for policy implementation; building and sustaining coalitions and partnerships; creating congruence between policy objectives and organisational structure and cultures; and ensuring accountability.[58]

The lack of rigorous, standardised approaches to assess and monitor governments' stewardship limits cross-country comparisons and trend analyses. However, evidence suggests that critical challenges impeding more effective stewardship include: lack of long-term vision and planning; poor coordination with public providers and those outside the health sector; weak health system responsiveness to health service users; and limited enforcement of regulations.[59] Further efforts to develop coherent assessment frameworks will improve understanding of the different components of stewardship and their effects on health system performance.

Improving data quality and use

Measuring progress toward the health MDGs and other development goals requires timely, accurate, and disaggregated information; reliable analyses; and a firm knowledge base (*see also Section 3, Documenting and analysing inequities*). Yet in many countries, considerable challenges are posed by an absence of basic data on births, deaths, and other demographic information; inadequate infrastructure for data collection and analysis; insufficient financing for data collection, analysis, and dissemination; and weak systems—including health information systems—to track MDG indicators.[60] Efforts are underway to simplify, coordinate, and orient data collection efforts toward country priorities and needs; to improve tracking and monitoring of progress and performance; to strengthen data analysis, communication, and dissemination capabilities; and to encourage evidence-based policy- and decision-making (*see Box 1*).

Figure 6. Sources of health financing as a proportion of total expenditure on health, selected countries, 2002



Source: WHO 2005b

Securing stable health financing mechanisms

Securing stable health financing mechanisms that raise sufficient revenues for essential health services and provide financial protection against catastrophic illness costs in an equitable, efficient, and sustainable manner is one of the most important policy objectives in the region. Health financing involves the basic functions of revenue collection and pooling of resources, as well as the purchasing of services from public and private providers.[64] Most countries in Asia and the Pacific finance health services through a mixture of government budget; health insurance; and private sources, including nongovernmental arrangements, out-of-pocket payments, and external funding (*see Section 6, Table 5*).

Out-of-pocket health payments are an unacceptably large source of financing in a number of countries (*see Figure 6*),[65] despite considerable evidence that they are inequitable and inefficient, and impose a major financial burden that serves as a barrier to utilisation of health services, especially by the poor.[66] Out-of-pocket payments also are one of the major factors pushing low-income households into poverty. As many as 178 million people suffer financial catastrophe as a result of these payments each year, and 104 million are forced into poverty due to health expenditures alone, according to estimates.[67]

Health systems that are predominantly funded by public sources, including general

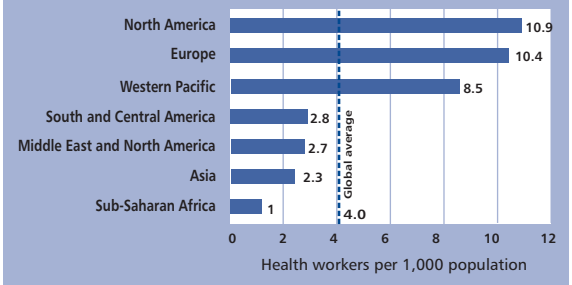
Box 1 Initiatives to improve data quality and use

- **Partnership in Statistics for Development in the 21st Century (PARIS21)** supports countries in preparing national strategies for the development of statistics that assess the state of the national statistical system; set objectives for improvements; and outline actions required to achieve these objectives. In Asia, PARIS21 will take this forward with United Nations Economic and Social Commission for Asia and the Pacific and other partners through regional workshops, advocacy, partnership, and reporting. The first of four subregional workshops will be held in September 2005.[61]
- **STATCAP**, the World Bank's lending programme for statistical capacity building, finances improvements in statistical policy, regulatory, and institutional frameworks; capacity building and institutional strengthening related to statistical operations and procedures; and physical infrastructure and equipment. In the region, India and Sri Lanka are preparing STATCAP projects.[62]
- **Health Metrics Network**, launched at the 58th World Health Assembly in May 2005, identifies approaches to improve data access and quality; provides technical and financial support to enhance health information systems; and supports improved access to, and use of, information for policymaking and planning. Pilot testing of monitoring and assessment tools is underway in the region in parts of India, Thailand, and Viet Nam. Future projects will be determined in the coming months.[63]

tax and social health insurance, can protect individuals against catastrophic financial losses caused by illness and injury. They also provide more equitable access to services. Several countries, including Japan, Mongolia, and the Republic of Korea,[68] have developed universal social health insurance schemes. Other countries, such as China, Lao People's Democratic Republic (PDR), the Philippines, and Viet Nam, have schemes in place, but with lower coverage rates.[69] The establishment or the expansion of social health insurance also has been included in recent poverty reduction strategy papers (PRSP) for Cambodia, Indonesia, Kyrgyzstan, Lao PDR, Mongolia, Nepal, Sri Lanka, and Viet Nam.[70] *(For information on taxation, see Section 6, Public sector investments.*)

Other risk-pooling arrangements explored to different degrees in the region include voluntary private health insurance and social security organisations (predominantly in middle- and high-income countries), community-based health insurance,[71] and the use of ministries of health as functioning national health services that provide basic care to entire populations with limited budgets (predominantly in low-income countries).[72]

Figure 7. Health worker density by region[76]



Source: Joint Learning Initiative 2004, WHO 2004e estimates

Strengthening human resources for health

Health systems require a well-trained and motivated workforce of an appropriate size and mix. Shortages of health workers are particular regional concerns (*see Figure 7*), and are approaching crisis level in some Pacific island countries due to emigration.[73] In the Philippines, one of the world's leading exporters of registered nurses,[74] an increasing number of doctors are studying to become nurses to take advantage of lucrative international recruitment opportunities.[75]

Health worker shortages are also acute in rural and remote regions. In Cambodia, 85% of the population reside in rural areas, yet only 13% of government health professionals work there.[77] In Nepal, only 20% of rural physician posts are filled, compared with 96% in urban areas.[78] At the same time, recent evidence demonstrates that the density of workers in a population impacts the effectiveness of MDG interventions. For example, the prospects for achieving 80% coverage of measles immunisations and skilled attendants at birth are greatly enhanced when worker density exceeds 2.5 workers per 1,000 population.[79]

Inequalities in the distribution of health professionals are often compounded by a skewed skill mix and composition of the workforce. Bangladesh, China, Mongolia, and Pakistan have more doctors than nurses,[80] while Kyrgyzstan has an oversupply of specialist physicians and a shortage of general practitioners.[81]Indonesia and Sri Lanka have reported a shortage of health professionals capable of treating chronic and emerging diseases.[82] Many countries urgently need to update health workers' knowledge and skills to meet the complex and changing health needs. (*see Section 2, Region-specific health challenges.*)

A number of countries have put in place policies or programmes to strengthen human resources for health. Some Pacific island countries have trained and deployed mid-level practitioners to remote or sparsely populated areas where placing a doctor would not be cost-effective.[83] China and Thailand have encouraged medical professionals to return from overseas through investments in research and development and monetary incentives.[84]

Better collection and analyses of workforce data and the factors that influence the health workforce—such as labour market forces, economic development, education, and attrition rates—can help countries plan to meet their workforce needs.[85] In many countries, this will require improvements in health workforce management information systems, as existing systems are generally insufficient for workforce analysis, policy formulation, and planning. Bilateral and multilateral agreements are also needed to help low-income countries manage emigration of health professionals and accompanying workforce shortages. Other

steps to retain quality staff include the provision of adequate salaries and incentive schemes, appropriate performance rewards, and high-quality professional education and training (including distance and flexible learning opportunities, mentoring schemes, and the use of information and communication technologies).[86]

Ensuring more effective public sector management of health

Faced with limited budgetary and human resources to address high demands for services, public health care systems must optimise their performance to deliver essential public health functions. These include disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development.[87] Effective public sector management of health requires:

- health information systems to support programming, planning and management of health services
- communication and information infrastructure to facilitate contact between peripheral and central levels
- capacity building in priority setting and evidence-based planning and decision-making
- procurement and logistical systems to ensure reliable access to essential medicines
- transparent and accountable financial flows

Lao PDR and Papua New Guinea, for example, have supported the development of standard drug kits to ensure adequate drug and medicinal supplies at the lowest levels of the public health systems.[88] In Lao PDR, a recent evaluation determined that the kits, administered by village health volunteers, increased access to quality essential drugs, lowered household expenditures on medicines, and improved the rational use of drugs.[89]

Decentralisation has made building management capacity at regional, district, and municipal levels a high priority. Evidence has shown that decentralised, first-level facilities can avert, contain, or solve many life threatening problems associated with childbirth and reduce maternal deaths. However, a long-term commitment and investment are required to obtain sustained results.[90] In a recent evaluation of a 5-year project in Fiji to improve health service delivery through decentralisation and improved management capacity, the quality and depth of local leadership and decision-making were also identified as critical components.[91]

Engaging the private sector

Many countries are developing new ways to engage the private sector in extending the coverage of interventions, and improving the performance of health systems. In Cambodia, government contracts with NGOs in selected districts have increased health facility utilisation significantly, increased efficiency, improved health outcomes, and established more equitable services.[92] Public and private

Box 2 Public private collaboration for tuberculosis control

In the Philippines, the country with the eighth highest tuberculosis (TB) burden in the world, between one third and one half of TB patients turn to the private sector for care. However, limited equipment and follow-up mechanisms in the private sector often lead to poor diagnosis and treatment.

To improve the situation, the Philippines' Department of Health has established a public-private mix DOTS (PPMD) strategy. In close collaboration with partners, such as the nongovernmental Philippine Coalition Against Tuberculosis, different PPMD models have been piloted. As a result of successful expansion, more than 50 PPMD sites operate across the Philippines.[96]

Under the programme, private sector providers refer suspected TB cases to the public sector for diagnosis using microscopy services. Once diagnosed, private physicians can either refer patients to DOTS clinics for free treatment or, if trained and accredited, administer free treatment provided by the national programme.

An external evaluation of PPMD in early 2005 suggested that private sector involvement can increase in-case detection by up to 20% with treatment success rates well above the global target of 85%.[97]

Case reporting has also improved in China and the Republic of Korea through the establishment of online reporting systems for private providers. In the Republic of Korea, the system has increased case reporting by 40% since 2001. In China, case detection has improved from 30% in 2002 to 60% in 2004, and is expected to reach the global target of 70% by the end of 2005.[98]

sector collaboration for TB control in China, the Philippines, and the Republic of Korea has improved case detection and treatment (*see Box 2*). Other cooperative initiatives, such as Medicines for Malaria,[93] the Accelerating Access Initiative,[94] and the Global Alliance for Vaccines and Immunization (GAVI),[95] have expanded the availability of affordable drugs, vaccines, and diagnostics.

Involving communities

Many of the interventions critical to achieving the MDGs can be delivered by community health workers provided with training, supervision, and support. The Bangladeshi NGO, BRAC,[99] has trained more than 30,000 village health workers to administer health education, diagnose basic ailments, and provide essential health commodities and basic curative services.[100] A recent evaluation of BRAC's community-based ARI programme found that health workers could effectively diagnose and treat ARIs when provided with basic training and supervision.[101] Community-based health workers have increased exclusive breastfeeding rates in Haryana, India, and reduced rates of diarrhoeal disease.[102] In the Makwanpur district of Nepal, support for a network of women's groups led to a 30% reduction in neonatal mortality rates, largely through increased use of services and improved home care of newborns.[103]

Community-based monitoring mechanisms, including report cards and citizen management groups, can also improve provider accountability and quality of services, empower communities to demand and affect change, and create a sense of local ownership. In Bangalore, India, a civil society group introduced report cards in 1994 to rate users' experiences with public services. The media widely publicised the results, which exposed poor quality, corruption, limited access, and hidden costs of services. Government and public agencies responded by launching reforms to improve infrastructure and services, and to monitor performance. The report card approach has been replicated and adopted in 23 other Indian states, as well as in the Philippines and Viet Nam.[104] The inclusion of poor and vulnerable groups in such efforts is important to ensuring that services reach disadvantaged groups more equitably and effectively.[105] ■

4

Ensuring equity

KEY MESSAGES

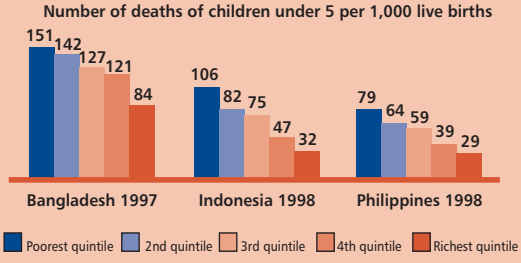
- Inequalities in health status and in access to health services hamper the efforts of countries to achieve the MDGs.
- Some countries might be able to achieve the health MDGs while still having populations or areas with poor outcomes.
- An approach based in human security is important in addressing disparity. This could include documenting and analysing inequities, targeting specific populations or areas, increasing the availability and quality of health services, promoting primary and essential care, and establishing risk-sharing arrangements.

Inequalities in health status and in access to quality health services have widened in recent decades, both within and between countries.[106] These inequalities could hamper the efforts of countries to achieve the health MDGs. At the same time, some countries might be able to achieve the targets while still having striking variations between the health outcomes of the rich and the poor, of men and women, of various ethnic groups, and of those living in urban or rural areas (or different geographic locations). The challenge is to ensure progress for entire populations, and an approach based in human security is important in addressing disparity.

Inequalities across economic, gender, ethnic, and geographic lines

Within countries, health status and health service use vary considerably between poorer and better-off people.[107] For example, in Bangladesh, Indonesia, and the Philippines, childhood survival prospects are worse for children born into poor families than those born into better-off families (*see Figure 8*).[108] A review of more than 60 countries reported similar findings, although the size of the gap varied widely across countries.[109]

Figure 8. Under-5 mortality rates by economic quintile, selected countries

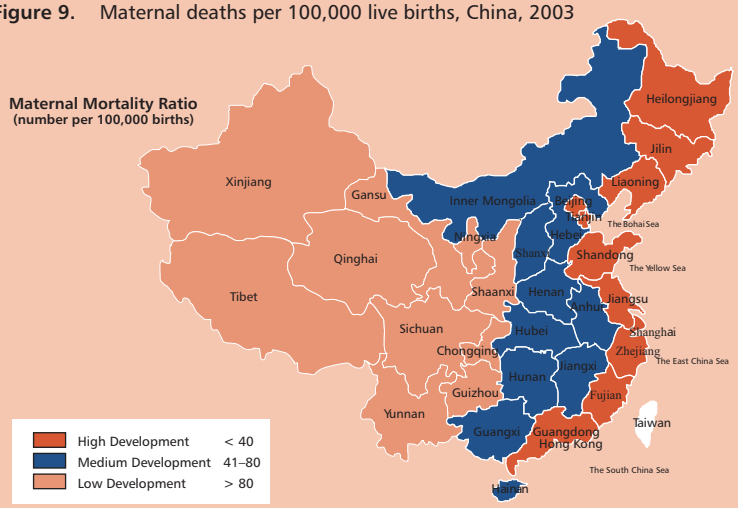


Source: Equity Team, Evidence and Information for Policy, WHO

Although gender inequalities in health have decreased substantially in recent decades, important gaps persist, particularly in South Asia.[110] For example, according to a recent study in India, girls were 1.5 times less likely to be hospitalised than boys for childhood illnesses.[111] In China, India, Nepal, and Pakistan, child mortality in girls exceeds that of boys, possibly reflecting societal disadvantages in health care-seeking behaviour and nutrition.[112] HIV infection rates have increased by 10% among Asian women in the past 2 years,[113] while in some areas, such as the Greater Mekong Subregion,[114] women are now becoming infected at a faster rate than men.[115] Recent research has also demonstrated that malnutrition among women can create ripple effects across generations, leading to low birth weight children at greater risk of disease and early death.[116]

Ethnic minorities often face poorer health outcomes due to distance, linguistic, or

Figure 9. Maternal deaths per 100,000 live births, China, 2003



Source: UN System, based on MCH Sentinal Surveillance System, in UN Country Team, China 2004

cultural barriers to health services; limited political or social influence; and environmental factors.[117] For example, immunisation rates for children between 12 and 23 months vary between ethnic communities in Lao PDR—ranging from 23% for Tai-Kadai and 19% for Khmou to 4% for Hmong.[118] In Viet Nam, wide reductions in poverty at the national level (from 58% to 37% from 1995 to 2000) have not translated into reduced poverty among ethnic minorities. For this population, poverty dropped from 86% to 75% over the same period.[119]

Disparities also exist within countries by province, state, or geographic region, and between urban and rural areas. For example, in Cambodia, Kiribati, Lao PDR, Mongolia, and Papua New Guinea, coverage of safe water facilities in rural areas is less than half of that in urban areas.[120] In China's eastern coastal areas, many indicators rival those of industrialised countries, but its western provinces lag behind. Women in remote parts of western provinces face greater risk of maternal death due largely to limited access to essential obstetric care and skilled assistance at delivery (*see Figure 9*).[121]

Approaches to close the gap

Many health inequalities are thought to amount to inequities, meaning the differences in health are avoidable and, therefore, unfair or unjust.[122] Inequities usually reflect different socioeconomic constraints and opportunities, rather than individual choices or behaviours.[123] Some examples are available that suggest ways to tackle inequities including:

Documenting and analysing inequities

Increasingly, countries are taking steps to collect and analyse data that are disaggregated by various indicators of social exclusion, including socioeconomic status, gender, ethnicity, residence, and age. However, poor quality and the lack of systematic disaggregation across indicators significantly constrain the analyses of disparities.[126] Demographic and health surveys, conducted in more than 70 developing countries (and in many countries multiple times), recently have been used to explore equity in trends in health status and health service

Box 3 Reaching the Poor Programme

The World Bank's Reaching the Poor Programme assesses how well programmes and policies are reaching disadvantaged populations, and identifies ways to reorient health programmes to reach these groups more effectively.[124] Recent studies include the effects of: [125]

- Inequalities in utilisation of maternal health care services in Matlab, Bangladesh
- NGO contracting of primary health services in Cambodia
- Quality improvements in health service utilisation and patient satisfaction in Uttar Pradesh, India
- Self-Employed Women's Association's (SEWA) health services on health service utilisation by poor populations in Gujarat, India
- Participatory approaches to planning and delivering reproductive health services for disadvantaged youth in Nepal

Results for these and other promising approaches can be found in the "Reaching the Poor Programme" section of the World Bank's health and poverty website: www.worldbank.org/povertyandhealth

Box 4 Viet Nam's Health Care Fund for the Poor

In October 2002, Viet Nam's Prime Minister declared[131] the establishment of a Health Care Fund for the Poor to promote equity and to improve efficiency in the financing and delivery of health care. The fund entitles identified beneficiaries to free in- and out-patient services, as well as approved drugs, through the provision of health insurance cards or direct reimbursement to health facilities for expenses incurred by beneficiaries for health services and drugs.[132]

By March 2004, the fund had been established at all levels of the health system nationwide, reaching 11 million people, or 77% of the target beneficiaries.[133] The fund's long-term impact on health care utilisation or financial protection against health expenditures for the poor cannot be determined yet. However, a preliminary evaluation of the fund in two provinces demonstrated that it has:[134]

- reached almost 100% of the target population in Bac Giang province and 86% in Hai Duong province;
- increased the usage of health services, as reported by beneficiaries;
- lowered health care costs significantly for those using the insurance cards compared to those who did not;
- decreased the burden of health care expenditures.

Further monitoring of outcomes will be required to determine the long-term impact and sustainability of the fund, and the relevance of similar financing mechanisms for the poor within and outside the region.

utilisation.[127] The World Bank has also contributed significantly in recent years to the evidence base on inequities and their policy and programmatic implications (*see Box 3*). Its annual *World Development Report* for 2006 explores the role of equity in development.

Targeting specified populations or areas

Governments and donors increasingly are combining and analysing data collected through census, health information systems, and other surveys to target interventions and expenditures at vulnerable populations and areas. Locating poor health outcomes or poor service use can assist in determining targeted policy responses. For example, Cambodia's Ministry of Planning has developed poverty maps in collaboration with the World Food Programme to target communities most in need of food aid.[128] Viet Nam's MDG progress assessments led it to adapt its development targets to focus on disadvantaged areas, such as to "reduce the maternal mortality rate to 80 per 100,000 live births by 2005 and 70 by 2010 with particular attention to disadvantaged areas" and to "reduce the infant mortality rate...at a more rapid rate in disadvantaged regions."[129]

Considerable evidence suggests that, just as geographical targeting is likely to narrow regional disparities, targeting by gender can help reduce inequalities between men and women. The Japan Bank for International Cooperation (JBIC) and the World Bank are supporting participatory rural projects that address the post-conflict health, education, and various infrastructure (such as water, sanitation, and roads) needs of communities in Mindanao, the Philippines with an aim to reduce poverty and consolidate peace and stability. Women, particularly widows, are strongly encouraged to participate in the planning and implementation. Improved access to educational opportunities for girls has also been shown to reduce gender disparities in the health, educational, and nutritional outcomes of future generations.[130]

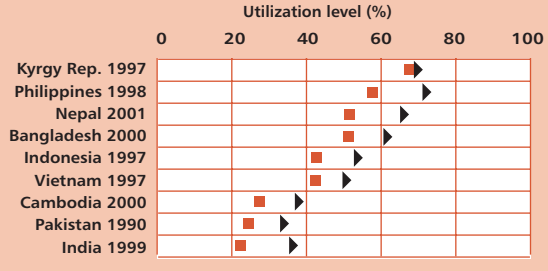
Programmes are also targeting individuals or households by economic level, social criteria, or medical categories (for example pregnant women, young children, or those suffering from TB). In Cambodia,[135] Indonesia,[136] and Viet Nam (*see Box 4*), a combination of user fee exemption mechanisms and free health cards has been established for poor and vulnerable populations.

Studies have demonstrated that publicly financed services often do not reach the intended recipients. For example, in Indonesia in 1989, the poorest fifth of the population were found to receive only 12% of the benefits from this kind of spending, while the richest fifth received as much as 29%.[137] Malaysia was more successful—29% of the benefits reached the poorest fifth of the population the same year, compared to 11% for the richest fifth.[138]

Experience suggests that successful targeting programmes: [139]

- Provide formal, concrete eligibility criteria

Figure 10. Proportion of children aged 12–23 months who received basic immunisation coverage, poorest 20% vs. population as a whole



Source: Wagstaff and Claeson 2004

- Disseminate information about fee waiver availability and procedures to potential beneficiaries
- Involve local and/or central officials in determining eligibility
- Review regularly beneficiaries' exemption status
- Budget funds to reimburse facilities for lost revenues and provide timely reimbursements

Increasing the availability and quality of health services

Inequity in access to services is a critical factor behind inequalities in health outcomes. Evidence from numerous countries in the region demonstrates that the poor and other vulnerable groups are less likely to use basic health services such as immunisation (*see Figure 10*), family planning, and skilled assistance at delivery.[140] In many countries, distance and long travel times to facilities present key barriers, particularly in rural areas and urban slums. In Bangladesh, women residing 1–2 kilometres from facilities were 55% less likely to use skilled delivery services than those residing less than 1 kilometre from the centres.[141] Limited or inaccessible (due to education, linguistic, or cultural barriers) information among poor and vulnerable groups can result in low demand for health services. In Cambodia, two of five women reported not knowing where to go for health care.[142] Women in rural areas and those with no education cited this problem most often.[143] Ample evidence suggests that, even where health services are available, the poor often forego the care they need because they cannot afford it (*see also Section 3, Securing stable health financing mechanisms*).[144]

Public-private partnerships, civil society organisations, and cross-sectoral actions can help reduce disparities in the use of health services and in health outcomes (*see Section 5, Supporting cross-sectoral actions)*. Pakistan's Lady Health Worker Programme, covering approximately one fifth of the population,[145] has improved coverage of primary health care services through home visits in rural communities. A recent evaluation demonstrated that women served by the programme were 1.5 times more likely to use modern contraceptives than those outside the coverage area.[146] In Lao PDR, improvements in the quality and coverage of child health services enhanced the accessibility of services for the poor and improved child survival. The infant mortality rate in the project area decreased to half the national average over 10 years.[147] Investments in other sectors, such as transport and roads, can also improve access to health facilities through more frequent and affordable public transport, shorter travel times, and more comfortable travelling conditions.

Improvements in quality of care (such as improved staff attitudes, decreased waiting times, and increased confidentiality) can increase the uptake of services and improve health systems' responsiveness. In Indonesia, a "Smart Patient" intervention that provided coaching to female family planning clients on their right to seek information, ask questions, express concerns, and request clarification raised women's assertiveness in discussing family planning with clinicians, and improved client-provider interactions.[148] Information, education, and communication (IEC) campaigns can create informed clients, stimulate demand for services, and encourage communities to expect quality care. However, concerted efforts are required to ensure that IEC strategies and messages are culturally and linguistically appropriate for target communities.

Promoting primary and essential health care

Primary health care, identified in the 1970s as critical for achieving Health for All by 2000,[149] is also an important strategy for reducing disparities and achieving the MDGs.[150] The New Zealand Government recently initiated a set of primary care reforms aimed at improving the health outcomes of Maori New Zealanders. These included reducing the relatively small fixed

fee the patient pays (co-payments), moving from fee-for-service to uniform payments (capitation), and developing non-profit primary health care infrastructures (primary health organisations) for service delivery. An evaluation 15 months into the reforms found that more than 2 million people had enrolled in the organisations, and more than 400,000 people (half of them in vulnerable groups) gained improved access to subsidies.[151]

Achieving universal access to essential health services is one of the most effective ways to ensure the poor have equal access to quality services in middle-income and developed countries.[152] However, this approach might be wasteful in low-income countries if it does not reach those most in need.[153] Malaysia, Sri Lanka, and Thailand have demonstrated that the provision of universal coverage can be achieved in low-income settings. These countries have been highly successful at reaching poor and vulnerable populations.[154] In settings where universal coverage is not feasible, health programmes can consider prioritising investments in diseases and health conditions that disproportionately affect the poor, such as malnutrition, communicable diseases, childhood illness, and maternal and perinatal conditions.[155]

Establishing risk-sharing schemes

Risk-sharing schemes that pool and manage financial resources can protect members from large, unpredictable health expenditures and improve access to care.[156] Most low- and middle-income countries in the region have public and private schemes that offer varying degrees of protection (*see Section 3, Securing stable health financing mechanisms)*. In China, community health funds in rural areas provide seasonal workers with regular, year-round access to health care.[157] In Gujarat, India, the Self-Employed Women's Association (SEWA) has been providing an integrated insurance scheme to members and their families since 1992.[158] In Indonesia, the state-owned microfinancing scheme, Dana Sehat, has reached around 12 million people since its introduction in the 1970s, although expansion of the scheme was halted recently due to concerns about sustainability.[159] Such social funds, community-based insurance, and other community health financing schemes will likely continue to be important for pooling funds, particularly in low-income countries. However, they should not replace larger, publicly-funded insurance schemes with administrative structures capable of coordination and regulatory oversight, and revenue pooling and collection. ■

5

Promoting cross-sectoral actions

KEY MESSAGES

- Because social and other non-health factors significantly determine health, meeting the health MDGs will require cross-sectoral investments and actions in areas such as poverty reduction, educational achievement, gender equality, water and sanitation, and infrastructure.
- Developing the institutional mechanisms to steer cross-sectoral actions to improve health is a particularly important challenge. Key components include: tools to assess the evidence on cross-sectoral links; improved coordination among and between ministries, local authorities, and the private sector; supportive legal and regulatory environments; and policy coherence among donors.

Because social and other non-health factors significantly determine health, meeting the health MDGs will require cross-sectoral investments and actions in areas such as poverty reduction, educational achievement, gender equality, water and sanitation, and infrastructure. However, it is not always equally well appreciated that non-health sector actions are needed to successfully address health challenges.

Evidence suggests that increased public investment in health alone, even at very high and sustained levels, is not sufficient to achieve the health MDGs by 2015.[161] Parallel investments are required in non-health-related sectors to promote development and to improve the health of the world's poor and vulnerable populations. For example, increased investments in diverse sectors such as water, education, infrastructure (including energy and transport), and the economy have improved child survival (*see Box 5*).[162]

Box 5 Investments in multiple sectors improve child survival

A recent study found that, holding other factors constant, child mortality declines by:[160]

- 3%–4% if access to drinking water improves by 10%
- 3% if years of schooling among women rise by 10%
- 0.8%–1.5% if government health spending rises by 10%
- 1%–1.5% if the density of paved roads rises by 10%
- 2%–3% if per capita income growth rises by 10%

Much of health lending is being incorporated into health components of other sectors, such as transportation, social protection, water supply, and sanitation. For example, in fiscal year 2003 about 44% of the World Bank's health lending was for projects and programmes outside the health sector.[163] The Asian Development Bank's loans increasingly provide cross-sectoral support to related public sectors, e.g., water and sanitation, education and health, transportation and communications, and tourism and health (notably HIV/AIDS). JBIC has incorporated health-related components into infrastructure projects. In Cambodia, Lao PDR, and Thailand, JBIC incorporated HIV prevention activities, such as awareness-raising on sexually transmitted infections/HIV, behaviour change communication programmes, and voluntary counseling and

testing services, into bridge and port construction projects. In addition, the JBIC-funded Rengali Irrigation Project in India is a collaboration with the State Health Department to prevent malaria and schistosomiasis infections through measures including the provision of insecticide-treated nets, malaria testing, and capacity building for community involvement. In the past decade, JBIC-funded water and sanitation projects aimed at improving health outcomes have reached areas inhabited by an estimated 80 million people.[164] Similarly, the JBIC-supported Mindanao Sustainable Settlement Area Development Project in the Philippines adopts a comprehensive approach that combines sectoral investments in irrigation, transport, health, and education.

Developing institutionalised and sustainable mechanisms to direct cross-sectoral actions to improve health remains a particularly important challenge. The development of such mechanisms requires promoting tools to assess cross-sectoral impacts; expanding the evidence base on cross-sectoral links; supporting inter-ministerial planning; engaging local authorities; encouraging public-private partnerships; creating supportive regulatory and legislative environments; and supporting policy coherence among donors.

Promoting tools to assess cross-sectoral impacts

Major advances have been made in the past decade in the development of tools to assess cross-sectoral impacts. However, their use—and the application of the findings—need to be strengthened in most countries. Health impact assessments have been proposed as an interdisciplinary tool for evaluating and improving the health consequences of projects, programmes, and policies in non-health sectors, such as agriculture, urban planning, water resource management, and transport.[165] In Thailand, for example, the impacts of a hydropower dam on livelihoods and food security was assessed, producing evidence-based recommendations for public policy.[166] JBIC's evaluation of a road construction project in two villages in Indonesia found that improved access to paved roads increased the proportion of women seeking antenatal care.[167]

Widening the usage of health impact assessments in the region has been slow as coordination mechanisms are frequently lacking at national, regional, and local levels. Similarly, mechanisms are often not in place to ensure that such information, once obtained, is transmitted to other sectors for action. Linking assessments to management plans facilitates cost-effective policies and strategies inside and outside the health sector.[168]

Expanding the evidence base on cross-sectoral links

The provision of technical support to collect, analyse, and report on data related to cross-sectoral links is important to evidence-based planning and decision-making. In some cases, this may require extended support for longitudinal impact evaluations. For example, a 10-year study in Rajasthan, India determined that investments in roads and transport had improved access to maternal health services. However, challenges remained to reducing maternal deaths, partly because the quality of care at the facility level had not improved significantly. This study reinforced the need for performance improvements across multiple sectors to upgrade health outcomes.

Recognising that health outcomes are "shaped by people's different positions in society," in March 2005, the World Health Organization launched the Commission on Social Determinants of Health. This 3-year, high-level commission aims to:[169]

- compile evidence on the social factors that prevent poor and disadvantaged people from improved health and well-being, and on successful policies and interventions that address key social dimensions of health;
- raise debate and advocate the implementation of policies and programmes that address the social determinants of health by political leaders, health officials, civil society groups, and other stakeholders;
- define a medium- and long-term action agenda for incorporating social determinants of health interventions/approaches into the agency's planning, policy, and technical work.

Supporting inter-ministerial planning

To address the multiple dimensions of health and poverty issues, interactions beyond ministries of health are necessary. Sectors or ministries with particularly promising potential for synergies with health include education, water and sanitation, agriculture, animal husbandry, industry, trade and commerce, transport, energy, and infrastructure development, and women's empowerment.

PRSPs or other multi-sectoral planning instruments can theoretically support such interactions, as they provide an opportunity for dialogue between ministries of health, oversight ministries (e.g., finance and planning), line ministries (e.g., education, agriculture, etc.), and policy coordination units (such as those in the Prime Minister's office). PRSPs can also increase policy coherence and joint planning to address multiple determinants of health. However, a recent review of PRSPs determined that, although the value of a cross-sectoral approach to health is often recognised in PRSPs, little evidence exists that this recognition is translated into multi-sectoral strategies.[170] Similarly, a recent external evaluation of the World Bank's support to the PRSP process found that PRSPs have raised awareness about exploring synergies across sectors, but that cross-sectoral links "began from a weak starting point" and that PRSPs "do not give much consideration to tradeoffs among sector priorities."[171]

Additional development and technical assistance might be required to build the capacity of ministries to effectively encourage, define, and coordinate cross-sectoral interventions. In a recent inter-sectoral and inter-ministerial meeting, representatives of health, finance, and planning ministries from nine countries in Asia and the Pacific[172] voiced the need for stronger advocacy to promote the centrality of health in development initiatives, for complementary investments across sectors, and for mechanisms to generate stronger country-level ownership for inter-sectoral collaboration.[173]

Engaging local authorities

Cross-sectoral actions require engaging local authorities. Although local decision-makers and providers have participated sparingly in the MDGs in the past, their involvement has become more pronounced with increased decentralisation. For example, responding to chronic difficulties in reducing poverty and delivering basic education, health, and water and sanitation services, the Government of Pakistan initiated a sweeping reform programme in 2001 that devolved authority and responsibility for these services to the district level. Since 2003, a number of provinces have supported cross-sectoral partnerships between public service sectors to achieve the MDGs related to poverty, gender, education, health, and water and sanitation.[174] Programme components focus on: improving inter-government planning and cooperation; strengthening district governments to improve service delivery; empowering communities; and enacting policy reforms aligning national, provincial and district priorities to the MDGs. A comprehensive ex-post evaluation of the Japanese ODA loan projects, implemented since the 1970s in Metro Cebu, Philippines, revealed that multi-sectoral economic development projects were highly successful in strengthening the planning, implementation, and coordination capacities of local officials faced with decentralisation (*see Box 6 for other promising approaches*). Improvements in

Box 6 Community–driven development

Community-driven development aims to empower communities and local governments with resources, and the authority to use them flexibly. Typically, investments are made for multi-sectoral projects, enabling communities to develop strategies and interventions based on local priorities and needs.

In Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines, and Viet Nam, grants have been provided directly to the sub-district levels for projects proposed by villages and hamlets. The largest programme in the region, in Kecamatan, Indonesia, has reached almost half of the 65,000 villages in Indonesia, and is generally institutionalising a participatory and sustainable approach to local development.[175]

Experience suggests these approaches are successful in getting resources to their intended beneficiaries and in achieving rapid impacts. However, care is required to ensure adequate coordination and integration with broader public sector service provision and governance initiatives.[176]

health outcomes, however, were more difficult to realise due to rapid urbanisation and migration, and limited growth in the surrounding areas.

Encouraging public and private partnerships

Promising examples of public and private sector, and civil society partnerships are also emerging. For example, the Global Public-Private Partnership for Handwashing with Soap combines corporate marketing expertise and products with major public health campaigns to reduce diarrhoeal disease in poor communities.[177] Results from partnerships in Nepal and Kerala, India are forthcoming. In Guatemala, however, such a programme led to an estimated reduction of 300,000 cases of diarrhoea a year among poor children.[178] JBIC and the United States Agency for International Development are joining efforts in promoting private sector financing of water.[179] Business alliances or coalitions on AIDS have been established in numerous countries in the region, including in China, India, Indonesia, Myanmar, Singapore, and Thailand. They are supporting a range of activities, including workplace programmes, community outreach, corporate advocacy, in-kind donations, and direct financial support related to HIV/AIDS prevention, treatment, care, and support activities.

Many countries in the region have adopted a "settings approach" to health promotion and protection. This approach recognises that people spend a large portion of their time in specific settings, such as cities, villages, food markets, and workplaces. As such, these venues can be used for inter-sectoral action and community participation to improve health. In Cambodia, Lao PDR, and Papua New Guinea, ministry of health staff have worked with market managers, committees, vendors, and consumers to improve the safety and nutritional quality of foods sold in urban markets.[180] The Alliance for Healthy Cities[181] has supported health sectors in numerous countries in the region, such as Mongolia and the Republic of Korea, in advocating the incorporation of health considerations into urban development and management.[182] Experience suggests that key "good practice" components of settings approaches include: widespread participation in planning and implementation; use of participatory methods for skills and knowledge development; broad political commitment; and established links between health and development.

Creating supportive environments for cross-sectoral actions

Many countries in the region have succeeded in establishing functioning health systems. The challenge is to ensure the legal, financial, and political environments that make cross-sectoral actions for improving health possible and effective. Good governance is an essential part of this environment (*see Section 6, Support policy and institutional reforms*).

Legal agreements and laws can act as major obstacles to improved health or powerful instruments to support better health and well-being. This depends largely on: the way the legal framework has been designed; how it is implemented; and how well health professionals understand this legal and political context.[183] For example, major changes in international trade and intellectual property protections are providing opportunities, but also posing challenges for developing countries.

Access to essential drugs, critical for real improvements in health status, has increased dramatically with the development of generic drugs. However, most countries—including major producers of generic drugs in Asia, such as China and India—are members of the

WTO. WTO Member States are obliged to comply with the 1994 TRIPS agreement strengthening patent rights. However, TRIPS-related public health flexibilities established in Doha in 2003—including parallel importation, compulsory licenses, and government-use orders—can provide a means for legal access to medicines.

Actions to shape the legal and regulatory environments for improved access to medicines under TRIPS include: the establishment of appropriate administrative structures to enable efficient and accurate drug regulation; the development of new approaches for producing, evaluating, and registering generic medicines; and advocacy with pharmaceutical companies to explore further investment in low-cost production of medicines, and technology transfer to developing countries.[184] Above all, improving access needs qualified human resources able to identify obstacles and available solutions. In the case of TRIPS and safeguarding access to essential drugs, clinicians and public health specialists will require the assistance of lawyers, pharmacists, and trade specialists.

Supporting policy coherence among donors

Cross-sectoral actions will also require developing new relationships and improving policy coherence between international agencies, including donors, financial institutions, and the United Nations (*see Section 6, Harmonise and align funds*). The multi-partner initiative Focusing Resources on Effective School Health[185] has been successful in coordinating activities with ministries of health and education at national and district levels in the areas of school policy development; school environment (including safe water and sanitation); skills-based health education; and school-based health and nutrition services.[186] Developing countries can also take the lead in encouraging cross-sectoral approaches during their dialogue with donors.

Successful cross-sectoral approaches will also require building the internal capacity of these agencies. For example, the World Bank has organised special training and coaching for multi-sectoral teams, and is examining budgeting and performance techniques to encourage more effective coordination in a multi-sectoral environment.[187] ■

6

Securing resources and improving effectiveness

KEY MESSAGES

- Progress on the health MDGs will depend on increasing domestic and external investments in health, and improving the effectiveness of available resources.
- Policy and institutional reforms, reallocations in spending patterns, and improved macroeconomic environments give governments the fiscal space to focus on health investments.
- External resources are more effective when closely aligned to broader national development processes and priorities, directed toward system-wide approaches and policy and institutional reforms, provided on a timely and predictable basis through harmonised and simplified donor policies, and "untied" from the procurement of goods and services in donor countries.

A substantial gap exists between available resources and the requirements to meet the health MDGs. Progress towards the goals will depend on increasing the availability of resources and investments in health from internal and external sources, while promoting policy and institutional reforms to ensure fiscal sustainability, and taking steps to improve the effectiveness of resources.

A growing body of work suggests how much is needed. The United Nations Millennium Project, an independent advisory body for the United Nations on achieving the MDGs, estimated that a typical low-income country needs to invest $70–$80 per person per year in 2006, and increase this figure to $120–$160 per year by 2015 to meet the goals.[188] Although these estimates are for meeting all of the MDGs, one of the largest line items is for health. Health-related investment needs, such as domestic water supply, sanitation, electricity, improved cooking fuels, and transport, together account for roughly 35% to 50% of MDG investment needs.[189]

Public sector investments

A country's capacity to generate more revenues for health is based largely on its economic structures, tax collection capacities, and internal and external debt and debt-servicing burden.[190] Many countries in the region spend less than 5% of gross domestic product (GDP) on health—or less than the $30–$40 per capita that the Commission on Macroeconomics and Health estimated is necessary to ensure the delivery of an essential package of services (*see Table 5*).[191]

Table 5. Public expenditures and external resources for health in selected countries, 2002

	Total expenditure on health as % of GDP	Per capita government expenditure on health at average exchange rate ($)	Government expenditure on health as % of total government expenditure	External resources for health as % of total expenditure on health
Australia	9.5	$1,354	17.7	0
Bangladesh	3.1	$3	4.4	13.5
China	5.8	$21	10	0.1
Fiji	4.2	$60	7.5	5.6
Japan	7.9	$2,022	17	0
Kyrgyzstan	4.3	$7	10.2	14
Malaysia	3.8	$80	6.9	0
New Zealand	8.5	$978	7.5	0
Pakistan	3.2	$5	18	1.8
Philippines	2.9	$11	4.7	2.8
Thailand	4.4	$63	17.1	0.2
Viet Nam	5.2	$7	8.1	1.8

GDP = gross domestic product

Source: WHO 2005c

In a number of countries, the share of government spending on health has been decreasing over the past 10–15 years, not necessarily due to budget cuts, but to increases in private health spending.[192] The Government of Malaysia, on the other hand, has raised its health-related spending from 1.1% of total government spending in 1980 to 6.9% in 2002 through its efforts to increase the proportion of total public development expenditure allotted to the social sector.[193]

Box 7 Taxing to improve public health

Some countries, including the Republic of Korea and Thailand, have obtained significant funding for health promotion by subjecting items that have an adverse impact on health, such as tobacco and alcohol, to a punitive rate of tax.[194] This has a twofold benefit, generating revenue for health promotion and other health-related expenditure, while reducing the consumption of items that have harmful effects on health.

The Commission on Macroeconomics and Health recommends that low- and middle-income countries mobilise domestic resources for health, of the order of an additional 1% of gross national product (GNP) by 2007 and an additional 2% of GNP by 2015 relative to 2001 levels.[195] Increased domestic mobilisation can be achieved largely through broad-based revenue sources, such as value-added, general, and earmarked taxes[196] (*see Box 7*); social health insurance programmes; and reallocations in spending patterns.

Tax-based mechanisms, complemented by social health insurance, community-based financing, and other prepayment schemes, are generally thought to be effective for achieving universal coverage.[197] Universal coverage has been achieved through a mixture of general and earmarked taxation and social health insurance in Australia, Japan, and New Zealand; and to a large extent in Thailand and the Republic of Korea.[198] Tax-funded government health spending in Hong Kong (China), Malaysia, and Sri Lanka was found to have particular benefits for the poor, including improved access to services and reduced catastrophic health spending.[199]

Low-income countries generally face considerable challenges mobilising resources through taxation due to large informal sectors that fall outside of the tax net, lack of knowledge about the potential impact of tax reform due to poor data, and ineffective tax administration and revenue collection.[200] For example, Nepal's tax revenues in 2002 amounted to only 9% of GDP, while New Zealand's were 30%.[201]

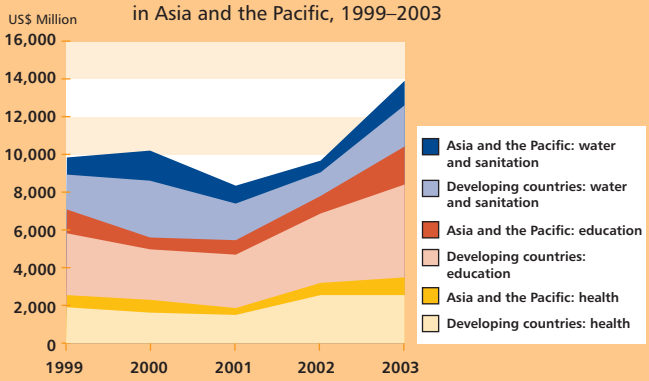
Development assistance can help low- and middle-income countries to mobilise domestic resources better by providing policy dialogue and technical support on tax reform, encouraging increased government commitment to health in public expenditure allocations, and providing financial assistance to close the needs gap between current and affordable spending.[202]

Increased donor support

Even in countries with considerable domestic resource mobilisation, additional financial assistance will be needed from private sources, civil society, and ODA. One recent estimate indicates that ODA will need to rise to $135 billion by 2006 and $195 billion globally by 2015 if all countries are to meet the MDGs.[203] The majority of this support will need to be directed toward supporting low-income countries, although modest increases are required for middle-income countries as well. Towards this end, action to fulfill past commitments needs to be accelerated. These include commitments made at the International Conference on Financing for Development in Monterrey regarding increasing the volume, and enhancing the coherence and consistency, of development assistance; and supporting trade policy reforms to improve market access for developing countries.[204] International agencies, donors, and governments must realign their budget allocations towards national efforts to meet the MDGs. Such realignment will require larger investments in resources directed at effective interventions that are known but underutilised, coupled with better targeting and capacity building.

Development Assistance Committee (DAC) member countries provided $803 million in ODA for the health sector in developing countries in Asia and the Pacific in 2003, an increase from $705

Figure 11. ODA in health, education, and water and sanitation in Asia and the Pacific, 1999–2003



Source: International Development Statistics

million in 2002 (*see Figure 11*). For water supply and sanitation, DAC member countries provided $1,130 million in 2003, more than double the $497 million provided in 2002. For education, they provided $1,867 million in 2003, an increase from $939 million in 2002.

In January 2005, major creditor nations offered countries affected by the December 2004 tsunami a temporary moratorium on debt repayments to enable them to concentrate on rebuilding and reconstruction.

In Asia and the Pacific, as investments in health rise, questions about sequencing and pacing investments, and targeting poor and vulnerable populations, will need to be addressed. The sequencing of investments will depend on policy and investment priorities based, for example, on where the need is greatest or which interventions will have the largest immediate impact.[205] Initial investments might be required to upgrade infrastructure, establish or enhance management systems, and strengthen human resources for health. Further, the need to front-load resources to address critical issues should not detract attention from strengthening sustainable systems and long-term commitments.[206]

Improved effectiveness of available resources

In addition to increased spending in the health sector, improved effectiveness of available resources is also needed urgently.[207] This can be undertaken through efforts to:

Improve budget allocation

With weak health systems under increasing strain, available resources are not always allocated optimally. In many countries, the allocation of public funds for rural health is not commensurate with the health care needs or the size of the population. In Nepal, for example, only 52% of public expenditures on health in 2001–2002 were allocated to rural areas, where 85% of the population lived.[208] Countries also often misallocate funds toward high-tech and high-cost curative services that benefit a few in urban areas, at the expense of essential services to control communicable diseases or to improve maternal and child health. The collection of accurate information through national health accounts and other mechanisms, and the analysis of equity in health financing, will assist countries in prioritising spending on interventions that disproportionately benefit poor and vulnerable populations. The EQUITAP project[209] is providing important analyses to this end in select countries and territories in Asia and the Pacific.

Align investments to national policies and priorities

Investments should be closely aligned to broader national priorities and development processes, such as PRSPs or national socioeconomic development plans in low-income countries and equivalent national development strategies for middle-income countries (*see Box 8*). PRSPs or national development plans can be powerful tools for

Box 8 Global health initiatives

New and relatively large financing sources have emerged to combat major health threats. These include the Global Fund to Fight AIDS, TB, and Malaria; the Global Alliance for Vaccines and Immunisations (GAVI); and the U.S. President's Emergency Plan for AIDS Relief. The response to these initiatives has been generally positive, although some concerns have been raised that these global health initiatives are increasing the burden of aid management; distorting sector priorities; and undermining the capacities of ministries of health for coherent planning, financing, personnel deployment, and administration.[210] Care should be taken to ensure that these initiatives are properly integrated into PRSPs or other national development strategies; aligned with country disease priorities; and reliant, wherever possible, on existing country planning, coordination, implementing and monitoring systems.[211]

achieving the MDGs when they identify the macroeconomic, structural, and social policies and programmes needed, as well as the associated investments required to meet the goals.

Countries are increasingly integrating the MDGs into their PRSPs, but the links between the two need to be strengthened and the investments required to meet the goals must be identified.[212] Viet Nam's PRSP[213] recognises that progress towards the MDGs will depend on local actions. As such, MDG progress indicators and indices are being monitored down to the sub-provincial level. The Government of Viet Nam also has proposed the development of provincial-level MDG indices, as more and higher quality provincial data become available, to improve targeting of resources toward the achievement of the MDGs.[214]

Important to all MDG-based PRSPs is the development of long-term investment plans that work backward from the goals to identify the needed sequence of investments and policies.[215] A recent evaluation of PRSPs found that priority expenditures in the PRSPs are rarely translated into budget priorities, because the three-way link of the PRSP, the budget, and the Medium Term Expenditure Framework (MTEF) is typically weak or absent.[216] The alignment of PRSPs with MTEFs and budget processes is still in the early stages. Bangladesh, Lao PDR, and Nepal recently undertook costing exercises to identify the required inputs and their costs, forecast resource availability, and determine the financing gap.[217] An important—and perhaps the most difficult—step for all countries undertaking this process is identifying policy and financing options to close those gaps.

Address the health sector as a whole

System-wide approaches are more appropriate than fragmented, single-purpose projects, unless these are developed in the context of a wider strategic framework. Addressing the health sector as a whole strengthens country leadership, and institutional and management capacity; reduces duplication of resources and programmes; and improves health sector efficiency.[218] Unfortunately, these benefits take longer to accrue, and require significant management and long-term vision.[219] In its fifth round of proposals, the Global Fund added a fourth component category to the three disease-oriented components (HIV/AIDS, TB, and malaria). Under the fourth category, applicants can formulate proposals that focus on "system-wide approaches and cross-cutting responses to strengthen health systems."[220] The Government of Japan has worked with a number of countries in the region, including Lao PDR, Mongolia, and Sri Lanka, to develop 10- to 15-year health sector master plans. Successful implementation of these and other sector-wide programmes will depend on investments in long-term capacity building, institutional support, and donor coordination.

Support policy and institutional reforms

Experience has demonstrated that additional resources will be spent most effectively in countries with strong policies and institutions. For example, the World Bank has estimated that an additional dollar of government spending in Bangladesh after improvements in governance could reduce under-5 mortality by 14%; without such improvements, under-5 mortality would fall just 9%.[221] Lower levels of government effectiveness also have helped explain poorer health system efficiency.[222] While focusing on countries that can deliver results is important, "fragile states" (countries emerging from conflict, and those with weak structures and institutions) should not be neglected. These countries require targeted approaches to improve accountability, participation, transparency, and to minimise corruption.[223]

Improvements in policy frameworks and institutional performance enhance countries' capacities to absorb, or use, additional resources. A recent assessment of the capacity of 18 well-performing, low-income countries to use more aid effectively to achieve the MDGs found that Bangladesh, India, Indonesia, Pakistan, and Viet Nam could absorb an immediate doubling or more of development assistance.[224] Absorptive capacity has reportedly improved over the past 10 years in a number of countries in the region, although political instability, civil conflict, and high levels of debt remain important challenges.[225] Absorptive capacity is not static. Financial and technical assistance can be instrumental in building capacity when directed towards improving macroeconomic policies and fiscal management, and developing national and regional capacities in project implementation

and management.[226] Better public expenditure management will also create more fiscal space for priority expenditures, while ensuring fiscal sustainability.[227]

Harmonise and align funds

Harmonising and simplifying donor policies, and aligning development assistance toward country priorities, institutions, and systems, are important to improving the effectiveness of aid. Reducing the administrative burden for recipient countries encourages country ownership and public support, and helps to minimise duplication of efforts and wasted resources. This can be achieved through simpler and shared reporting systems and procurement and disbursement procedures, and improved donor coordination. The United Nations has taken steps to this end in numerous countries in the region through Common Country Assessments and United Nations Development Assistance Framework.[228] At the recent High Level Forum on Joint Progress Toward Enhanced Aid Effectiveness, developing and donor countries, financial institutions, and the United Nations made 50 commitments to improve aid quality, to be monitored by 12 indicators. Under one of the provisional targets for harmonisation, for example, at least 25% of aid by 2010 will be in the form of programme-base approaches using common arrangements or procedures.[229]

Developing countries can lead the aid effectiveness and harmonisation agenda by raising the issue during their talks with donors, among other ways. Bangladesh, Cambodia, Kyrgyzstan, Nepal, and Viet Nam have developed reform agendas or actions plans adopting the harmonisation principles (ownership, alignment, streamlining) outlined in the recent forums. The Government of Samoa has developed a memorandum of understanding with several donors for collaboration and cooperation in the health sector.[230] Implementation and monitoring of progress in coming years will measure how well these commitments translate into improved coordination.

Improve the predictability of aid flows

With aid flows being much more volatile than domestic fiscal revenue, the lack of predictability in assistance is a key problem for developing countries.[231] Uncertainty about aid disbursements undermines effective and efficient budget management and long-term planning. In worst-case scenarios, countries unable to offset unexpected non-disbursements must resort to costly and possibly inefficient fiscal adjustment.[232] Late disbursal of programme support was noted as a problem in Cambodia and Viet Nam, where only 20% and 57% of donors, respectively, reportedly made timely disbursements. In Bangladesh, Cambodia, and Viet Nam, less than 60% of donors make multiyear commitments on budget support, key to planning medium-term macroeconomic and fiscal projections.[233]

Donors can address aid unpredictability by aligning their disbursement and commitment cycles with those of recipient countries; providing technical assistance to develop countries' budgetary and financial management capacity; providing longer-term commitments when recipient performance warrants it; and fostering more transparent and predictable implementation structures.[234] In the Paris Declaration on Aid Effectiveness, donors committed to provisional targets for making aid more predictable, including that 75% of aid by 2010 will be disbursed according to agreed-upon schedules.[235] At the same time, recipient countries can help by assessing the likely resource envelope and framing budget discussions within this amount, and by developing contingent spending plans that indicate how additional funds would be spent, if available.[236]

Untie aid

In 2001, the Organisation for Economic Co-operation and Development's Development Assistance Committee recommended untying all aid, excluding technical cooperation and food aid, to the least developed countries. Recent assessments have determined that most donor countries have implemented provisions to untie aid.[237] In general, untying aid can improve aid effectiveness through the positive effects on (i) co-ordinated and effective partnership with developing countries, (ii) strengthened ownership and responsibility of partner countries in the development process, and (iii) improved value for money in aid procurement. ■

7

Looking to the future

KEY MESSAGES

- Enhanced regional cooperation can contribute to greater progress on the MDGs through shared learning and adaptation of good practices, improved collaboration on cross-border and regional health challenges, and enhanced economic growth and poverty reduction.
- Country ownership of MDG-based strategies is central to their progress, and requires the involvement of multiple stakeholders, including governments, nongovernmental organisations, civil society, the private sector, and other interested parties.

To achieve the health-related MDGs in Asia and the Pacific by 2015, strategic partnerships must be developed or strengthened—among governments, international agencies, bilateral partners, civil society organisations, communities, and the private sector; between countries and regions; and across sectors. Each of these stakeholders will have to take steps toward promoting regional cooperation, and supporting local ownership of the MDGs, for progress to accelerate.

Supporting local ownership of the MDGs

Ownership of the MDGs at national and subnational levels is critical to their achievement. High-level political commitment is important for the development of policies and plans, as well as implementation mechanisms and enforcement measures. However, governments cannot act alone—consultation and collaboration across a range of sectors and actors, including civil society and the private sector, add substantial value. In low-income countries, the preparation of a PRSP can provide this framework, as can country-specific processes in middle-income countries.[238] The Millennium Campaign, launched in 2002, has helped to mobilise public support and foster country ownership for the MDGs through collaborative partnerships with NGOs and faith-based organisations, local authorities, youth groups, parliamentarians, the media, and the public.[239]

Promoting regional cooperation

Sharing knowledge and information from experiences, both within the region and with other regions, can enable learning and adaptation of good practices. In this context, the promotion of cooperation between developing countries, including emerging economies, is important. Japan International Cooperation Agency (JICA) has been supporting the Asian Centre for International Parasite Control (ACIPAC) in Thailand. Through information sharing, research, and human resource development, ACIPAC serves as an important hub for promoting school-based de-worming and health care among the neighbouring countries faced with common challenges. ACIPAC has expanded its cooperation to the Eastern and Southern Africa Center of International Parasite Control and the West African Centre of International Parasite Control to share the region's experience and knowledge with its African counterparts.

Similarly, JICA has been striving to extend the good practices and models developed under the comprehensive HIV/AIDS prevention and care project, which it has supported in northern Thailand, to neighbouring countries with similar challenges. The Asian Collaborative Training Network for Malaria, an informal network of 11 national malaria control programmes,[240] has contributed to networking and capacity building among

members. Development assistance can support this process by increasing funding for inter-country consultations, colloquiums, and regional networks; and by aligning global or regional programmes with the priorities of individual countries (*see Section 6, Align investments to national policies and priorities*). This, however, will require a shift in the practices of donors, which direct almost all of their assistance to individual countries instead of regional or global programmes. [241]

Enhanced regional cooperation can potentially enable countries in the region to better address regional public goods, including public health, through improved collaboration on cross-border and regional health challenges, and enhanced economic growth and poverty reduction. Regional and sub-regional networks that could be used to facilitate greater regional cooperation on health and the MDGs include the Asia-Pacific Economic Cooperation,[242] the Association of Southeast Asian Nations,[243] the Pacific Islands Forum Secretariat,[244] the South Asian Association for Regional Cooperation,[245] and the Secretariat of the Pacific Community.[246]

Commitment to the MDGs requires local actions buttressed by national, regional, and global support. These include steps to make health facilities, goods, and services more available, accessible, and higher quality; mobilise contributions from multiple sectors, and incorporate cross-cutting perspectives; secure increased resources for health; and reduce disparities in health outcomes and in utilisation of health services. Countries in Asia and the Pacific have made progress toward these ends since the adoption of the Millennium Declaration in September 2000. Now the promise of partnership needs to be translated into concrete achievements. ■

References

Alliance for Healthy Cities. Awards homepage (http://www.alliance-healthycities.com/html/awards.htm, accessed online 24 April 2005).

Anwar ATMI *et al. Bangladesh: Inequalities in utilisation of maternal health care services—Evidence from Matlab*. Health, Nutrition and Population Paper. Reaching the Poor Program Paper N° 2. Washington, DC, World Bank, 2004.

Asian Collaborative Training Network for Malaria. Asian Collaborative Training Network for Malaria homepage (http://www.actmalaria.org, accessed 24 April 2005).

Asian Development Bank. *Report and recommendation of the President to the Board of Directors on Proposed Program Loans and Technical Assistance Grant to the Islamic Republic of Pakistan for the Punjab Devolved Social Services Program.* Manila, Asian Development Bank, 2004 (unpublished).

Asian Development Bank. *Millennium Development Goals in the Pacific: Relevance and Progress.* Manila, Asian Development Bank, 2003.

Asian Development Bank. *Use of ADF IX Resources.* Asian Development Fund (ADF). ADF IX Donors' Meeting. Tokyo, 9–11 December, 2003 (unpublished).

Asian Development Bank. *Health and Education Needs of Ethnic Minorities in the Greater Mekong Subregion.* Manila, Asian Development Bank, 2000.

Atkinson AB. *New Sources of Development Finance: Funding the Millennium Development Goals*. WIDER Policy Brief 10. Helsinki, United Nations University, World Institute for Development Economics Research, 2004.

Auffret P *et al. Making services work in East Asia and the Pacific*. Washington, DC, World Bank, 2004.

Aus Health International. *Fiji Health Management Reform Project: Activity completion report*. Canberra, Aus Health International, 2004.

BBC. *Sri Lanka wants more debt relief.* (http://news.bbc.co.uk/2/hi/business/4339839.stm, accessed online 11 March 2005).

BRAC. *BRAC Health Program 2003 Annual Report.* Dhaka, BRAC, 2003.

Bach S. *International migration of health workers: Labour and social issues*. Geneva, International Labour Office, 2003.

Bartram J *et al.* Focusing on improved water and sanitation for health. *The Lancet* 2005, 365 (9461):810-812.

Basnayar B, Rajapasha LC. Cardiovascular and infectious diseases in South Asia: the double whammy. *British Medical Journal*, 2004, 328:781.

Baudouy J. *Monitoring the health MDGs.* High Level Forum on the Health Millennium Development Goals. Geneva, 8–9 January 2004 (PowerPoint presentation).

Bhan G *et al.* The effect of maternal education on gender bias in care-seeking for common childhood illness. *Social Science and Medicine*, 2005, 60(4):175-724.

Bhandari *et al.* Effect of community-based promotion of exclusive breastfeeding on diarrhoeal illness and growth: a cluster randomised controlled trial. *The Lancet,* 2003, 361: 1418-1423.

Bhushan I, Keller S, Schwartz B. *Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia.* ERD Policy Brief Series 6. Manila, Asian Development Bank, 2002.

Bigdeli *et al. Operational research on village revolving drug funds in Lao PDR: Do village revolving drug funds improve access and rational use of drugs in remote areas in Lao PDR?* Vientiane, World Health Organization and Food and Drug Department, Ministry of Health, Lao PDR, 2004.

Birdsall N; Seven Deadly Sins: Reflections on Donor Failings. Working Paper N° 50, Washington, DC, Center for Global Development, 2004.

Birley MH. *The Health Impact Assessment of Development Projects*. London, HMSO Publications, 1995.

Bitrán R, Giedion U. *Waivers and exemptions for health services in developing countries*. Social Protection Discussion Paper Series. Washington DC, Social Protection Unit, Human Development Network, World Bank, 2003.

Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year? *The Lancet*, 2003, 361(9376): 2226-2234.

Bloom G. *Health and social protection: Meeting the needs of the very poor.* Paper presented at the Conference on Social Protection for Chronic Poverty, Manchester, UK, Institute for Development Policy and Management, 23–24 February, 2005.

Brown RPC, Connell J. The Migration of Doctors and Nurses from South Pacific Island Nations. *Social Science and Medicine*, 2004, 58: 2193-2210.

Bruce W, Perez-Padilla R, Albalak R. Indoor air pollution in developing countries: a major environmental and public health challenge. *Bulletin of the World Health Organization*, 2000, 78(9): 1078-1092.

Buchan J, Parkin T, Sochalski J. *International nurse mobility. Trends and policy implications*. Geneva, World Health Organization, 2003.

Bulíø A, Hamann AJ. Aid Volatility: An Empirical Assessment. *IMF Staff Papers,* 2003, 50(1).

Bulíø A, Lane D. *Aid and Fiscal Management.* IMF Working Paper 02/112. Washington, DC, International Monetary Fund, 2002.

Buse K, Walt G. An unruly mélange? Coordinating external resources to the health sector: a review. *Social Science and Medicine* 1997, 45:449-463.

CIESIN (Center for International Earth Science Information Network). *Global distribution of child malnutrition.* New York, Columbia University, 2005 (ref. cited but unread) in: Sanchez P *et al. Halving Hunger: It Can Be Done.* New York, Task Force on Hunger, United Nations Millennium Project, 2005.

Carr D. Improving the Health of the World's Poorest People. *Health Bulletin* 1. Washington, DC, Population Reference Bureau, 2004.

Carrin G. *Community based health insurance schemes in developing countries: Facts, problems and perspectives.* Health Financing Policy Issues Paper. Geneva, World Health Organization, Evidence and Information for Policy, 2003.

Carrin G *et al.* The Reform of the Rural Cooperative Medical System in the People's Republic of China: Interim experience in 14 pilot countries. *Social Science and Medicine*, 1999, 48: 961-972.

Carrin G, James C. *Reaching universal coverage via social health insurance: Key design features in the transition period.* Health Financing Policy Issue Paper. Geneva, World Health Organization, 2004.

Cassels A. *A guide to sector-wide approaches for health development: Concepts, issues, and working arrangements.* Geneva, World Health Organization, 1997.

Cassels A, Janovsky K. Better health in developing countries: are sector-wide approaches the way of the future? *The Lancet* 1998, 352(9142):1777-1779.

Chen J, ed. *Control of Communicable Diseases Manual.* 17th edition. Washington, DC, American Public Health Association, 2000.

Choo V. Philippines losing its nurses, and now maybe its doctors. *The Lancet*, 2003, 361(9366): 1356.

Chowdury M, Rosenfield A. *Interim Report of Task 4 on Child Health and Maternal Health.* New York, United Nations Millennium Project, 2004.

Claeson M *et al.* Reducing child mortality in India in the new millennium. *Bulletin of the World Health Organization*, 2000, 78:1192-1199.

Crossland A, Conway T. *Review of mechanisms to improve equity in access to health care.* London: Department for International Development (DFID) Health Systems Resource Center, 2002.

Demographic and Health Surveys Program (MEASURE DHS+). DHS and World Bank use wealth index to measure socioeconomic status. *DHS Dimensions*, Fall 2002, 4(2).

Demographic and Health Surveys Program (MEASURE DHS+). Demographic and Health Surveys' homepage (http://www.measuredhs.com, accessed 23 April 2005).

Department of Health, National Center for Disease Prevention and Control. Philippines Coalition against Tuberculosis. 2004. *Public-Private Mix DOTS: Forging Partnership Against TB.* Manila, Department of Health, 2004.

Department for International Development. *Access to medicines in under-served markets: What are the implications of changes in intellectual property rights, trade and drug registration policy?* London, Department for International Development, 2004a.

Department for International Development. *Reducing maternal deaths: Evidence and action. A strategy for DFID.* London, Department for International Development, 2004b.

Dilley M *et al.* Natural Disaster Hotspots: A Global Risk Analysis. Washington, DC, World Bank, 2004 (ref. cited but unread) in: United Nations Millennium Project. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals.* New York, United Nations Millennium Project, 2005.

Douthwaite M, Ward P. Increasing contraceptive use in rural Pakistan: An evaluation of the Lady Health Worker Programme. *Health Policy and Planning*, 2005, 20(2):117-23.

East West Center. *The Future of Population in Asia.* Honolulu, East West Center, 2002.

Economic Planning Unit, Prime Minister's Department, Malaysia, United Nations Development Programme. *Malaysia: Achieving the Millennium Development Goals: Successes and Challenges.* Kuala Lumpur, United Nations Development Programme, 2005.

Egger D, Lipson D, Adams O. *Workforce policy. Achieving the right balance. The role of policy-making processes in managing human resources for health problems.* Geneva, World Health Organization, 2000.

Evans T, Stansfield S. Health information in the new millennium: a gathering storm? *Bulletin of the World Health Organization*, 2003, 81(12): 856.

Evans T *et al.* Introduction. In: Evans T *et al.*, eds. *Challenging Inequities in Health: From Ethics to Action.* New York, Oxford University Press, 2001.

Freedman LP *et al.* Transforming health systems to improve the lives of women and children. *The Lancet*, 2005, 365(9463): 997-1000.

Fu W. *Health care for China's rural poor, international policy programme.* Washington, World Bank, 1999 (ref. cited but unread) in: Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *The Lancet*, 2001, 358: 833-836.

Gillespie A *et al. Focusing Resources on Effective School Health: A FRESH Start to Enhancing HIV/AIDS Prevention.* New York: UNICEF, 2002.

Global Alliance for Vaccines and Immunization. Global Alliance for Vaccines and Immunization homepage (http://www.vaccinealliance.org, accessed 2 April 2005).

Global Education. *Primary Health Care in Laos: Case Study*. Australian Agency for International Development (AusAID). Melbourne, Global Education, 2003.

Global Fund to Fight AIDS, Tuberculosis and Malaria. *Guidelines for proposals: Fifth call for proposals.* Geneva, Global Fund to fight AIDS, Tuberculosis and Malaria, 15 March 2005.

Global Public-Private Partnership for Handwashing with Soap. The Global Public-Private Partnership for Handwashing with Soap homepage (http://www.globalhandwashing.org, accessed 20 April 2005).

Government of Mongolia, United Nations Development Programme, Mongolia. *Human Development Report Mongolia 2003: Urban-rural disparities in Mongolia.* Ulan Bator, Government of Mongolia, United Nations Development Programme, Mongolia, 2003.

Gupta S, Verhoeven M, Tiongson ER. Public spending on health care and the poor. *Health Economics*, 2003, 12(8):685-696.

Gupta S, Verhoeven M, Tiongson E. *Does higher government spending buy better results in education and health care?* IMF Working Paper No. WP/99/21. Washington, DC: International Monetary Fund, 1999.

Gwatkin D. *Who would gain most from efforts to reach the Millennium Development Goals for health?* Health, Nutrition and Population Discussion Paper. Washington, DC, World Bank, 2002.

Gwatkin D. Health inequalities and the health of the poor: What do we know? What can we do? *Bulletin of the Word Health Organization*, 2000, 78:3-18.

Gwatkin DR, Wagstaff A, Yazbeck AS, eds. *Reaching the poor with effective health, nutrition, and population services: What works, what doesn't, and why*. Washington, World Bank, forthcoming.

Gwatkin DR, Bhuiya A, Victora C. Making health systems more equitable. *The Lancet*, 2004, 364(9465):1273-1280.

Gwatkin D *et al. Initial Country-Level Information About Socio-Economic Differences in Health, Nutrition, and Population*. Volumes I and II. Washington, DC, World Bank, 2003a.

Gwatkin D *et al. Socioeconomic Differences in Health, Nutrition and Population.* Health, Nutrition and Population Discussion Paper. Washington, DC, World Bank, 2003b.

Hadi A. Management of acute respiratory infections by community health volunteers: Experience of Bangladesh Rural Advancement Committee (BRAC). *Bulletin of the World Health Organization*, 2003, 81(3):183-189.

Hammer J, Nabi I, Cercone J. Distributional Effects of Social Expenditures in Malaysia, 1974 to 1989. In: Van de Walle D, Nead K, eds. *Public Spending and the Poor: Theory and Evidence.* Baltimore and London, Johns Hopkins University Press for the World Bank, 1995: 521-554.

Hefford M, Crampton P, Foley J. Reducing health disparities through primary care reform: The New Zealand experiment. *Health Policy*, 2005, 72(1):9-23.

Henning N, Snel M. *Where are the poor? Experiences with the development and use of poverty maps.* Washington, DC, World Resources Institute, 2002.

High Level Forum on Joint Progress toward Enhanced Aid Effectiveness (Harmonisation, Alignment, and Results). Forum homepage, (www.aidharmonisation.org, accessed 27 April, 2005).

Hsiao W, Liu Y. Health Care Financing: Assessing Its Relationship to Health Equity. In: Evans T *et al.*, eds. *Challenging Inequalities in Health: From Ethics to Action.* New York, Oxford University Press, 2001.

Institute for Health Science. Yunnan, China, 1980-1999. In: Koblinsky MA, ed. 2003. *Reducing Maternal Mortality: Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, and Zimbabwe.* Washington, DC, World Bank, 2003, 41–50.

International Monetary Fund. *2004 Government Finance Statistics.* Washington, DC, International Monetary Fund, 2004.

International Monetary Fund, World Bank. *Aid Effectiveness and Financing Modalities*. Report prepared for the 2004 Annual Meetings of the International Monetary Fund and the World Bank, October 2–3, 2004, Washington, DC.

International Development Statistics (IDS) online Databases on aid and resource flows. (http://www.oecd.org/dac/stats/idsonline).

Iyer A, Sen G. Health sector changes and health equity in the 1990s in India. In: Roghuram S, ed. *Health and equity*. Technical Report Series 1.8. Bangalore, HIVOS, 2000 (ref. cited but unread) in: Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *The Lancet*, 2001, 358: 833-836.

Izard J, Dugue M. *Moving Toward a Sector-Wide Approach. Papua New Guinea. The Health Sector Development Program Experience*. Manila, Asian Development Bank, 2003.

Jayasuriya R, Wodon Q. *Efficiency in Reaching the Millennium Development Goals*. World Bank Working Paper No. 9. Washington, DC, World Bank, 2003.

Joint Learning Initiative. *Human Resources for Health: Overcoming the Crisis*. Boston, Harvard University Press, 2004.

Joint United Nations Programme on HIV/AIDS. *AIDS Epidemic Update 2004*. Geneva, Joint United Nations Programme on HIV/AIDS, 2004.

Joint United Nations Programme on HIV/AIDS/ United Nations Fund for Women. *Women in Mekong Region faced with higher rates of HIV infection than men.* Press Release. Bangkok, Joint United Nations Programme on HIV/AIDS/United Nations Fund for Women, 8 March 2004.

Jørgensen S, Domelen JV. Helping the Poor Manage Risk Better: The Role of Social Funds. In: Lustig N, ed. *Shielding the Poor: Social Protection in the Developing World*. Washington, DC, Brookings Institution Press, 2000.

Kekki P. *Primary health care and the Millennium Development Goals: Issues for discussion.* Geneva, World Health Organization, undated.

Khaleghian P, Das Gupta M. *Public management and essential public health functions.* Policy Research Working Paper 3220. Washington, DC, World Bank Development Research Group, 2004.

Kim YM *et al*. Client communication behaviours with health care provides in Indonesia. *Patient Education and Counseling,* 2001, 45(1): 59-68.

Kim YM *et al*. Self-Assessment and Peer Review: Improving Indonesian Service Providers' Communication with Clients. *International Family Planning Perspectives,* 2000, 26(1): 4-12.

Koblinsky MA, Campbell O. Factors affecting the reduction of maternal mortality. In: Koblinsky MA ed. 2003. *Reducing Maternal Mortality: Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, and Zimbabwe.* Washington, DC, World Bank, 2003: 5-37.

Kutzin J, Cashin C. Health system funding. In: McKee M, Healy J, Falkingham J, eds. *Health Care in Central Asia.* European Observatory on Health Care Systems Series. Geneva, World Health Organization, 2002: 92-107.

Lawn JE, Cousens S, Zupan J. 4 million neonatal deaths: When? Where? Why? *The Lancet* 2005, 365(9462): 891-900.

Lenton R, Wright AM, Lewis K. *Health, Dignity, and Development: What Will It Take?* New York, Task Force on Water and Sanitation, 2005.

Liljestrand J, Pathmanathan I. Reducing Maternal Mortality: Can we derive policy guidance from developing country experience? *Journal of Public Health Policy*, 2004, 25(3/4), 299-314.

Lock K. Health Impact Assessment. *British Medical Journal,* 2000, 320: 1395-1398.

Loevinsohn B, Harding A. *Contracting for health service delivery: A review of developing country experience and results.* Health, Nutrition, Population Discussion Paper. Washington, DC, World Bank, 2004.

Lule E *et al. Achieving the Millennium Development Goal of Improving Maternal Health: Determinants, Interventions and Challenges.* Health, Nutrition, and Population Discussion Paper. Washington, DC, World Bank, 2005.

Manandhar DS *et al.* Effect of a participatory intervention with women's groups on birth outcomes in Nepal: Cluster-randomised control trial. *The Lancet*, 2004, 364(9438):970-979.

Manning R. OECD-DAC's work on agency performance. *High Level Forum on Health MDGs*. Geneva, 8–9 January 2004 (PowerPoint presentation).

Martines *et al.* Neonatal survival: A call for action. *The Lancet,* 2005, 365: 1189-1197.

Ministry of Health Nepal, Health Economics and Financing Unit, District Health Strengthening Project. *Public expenditure review of the health sector.* Kathmandu, British Council, 2003.

Ministry of Health, Viet Nam. *Assessment of 1-year implementation of examination and treatment for the poor.* Hanoi, Ministry of Health Viet Nam, March 2004.

Nallari R. *Lessons learned on costing, prioritization and operationalisation: PRSPs and MDGs.* Vientiane, 20 October 2004 (PowerPoint presentation).

Narasimhan V *et al*. Responding to the global human resources crisis. *The Lancet*, 2004, 363(9419): 1469-1472.

National Institute of Statistics, Directorate General for Health (Cambodia), ORC Macro. *Cambodia Demographic and Health Survey 2000*. Phnom Penh and Calverton, National Institute of Statistics, Directorate General for Health (Cambodia), ORC Macro.

Office of the National Economic and Social Development Board, United Nations Country Team, Thailand. *Thailand Millennium Development Goals Report 2004*. Bangkok, Office of the National Economic and Social Development Board, Thailand, United Nations Country Team, Thailand, 2004.

Organisation for Economic Co-operation and Development, Development Assistance Committee. *Paris declaration on aid effectiveness: Ownership, harmonisation, alignment, results and mutual accountability*. Presented at the High Level Forum on Joint Progress toward Enhanced Aid Effectiveness (Harmonisation, Alignment, and Results). Paris, 2005a.

Organisation for Economic Co-operation and Development, Development Assistance Committee. *Survey on harmonisation and alignment: Measuring aid harmonisation and alignment in 14 partner countries.* Preliminary Edition. Paris, Organisation for Economic Co-operation and Development, Development Assistance Committee, 2005b.

Organisation for Economic Co-operation and Development, Development Assistance Committee. *Implementing the 2001 DAC recommendation on untying official development assistance to the least*

developed countries. 2004 progress report. Paris, Organisation for Economic Co-operation and Development, Development Assistance Committee, 2004.

Organisation for Economic Co-operation and Development, Development Assistance Committee. *Untying aid to the least developed countries.* Policy Brief. Paris, Organisation for Economic Co-operation and Development, Development Assistance Committee, 2001.

Osmani S, Sen A. The hidden penalties of gender inequality: Fetal origins of ill-health. *Economics and Human Biology*, 2003, 1: 105-121.

Oxfam America. *Sri Lanka After the Tsunami: The Challenges Ahead*. Oxfam Briefing Note. Boston, Oxfam America, February 2005.

Oxfam Great Britain. *Cambodia Land Study Project.* Oxfam and the Ministry of Health of Cambodia, 2000.

Oxford Policy Management. *Pakistan: Evaluation of the Prime Minister's programme for family planning and primary health care*. Interim report. Oxford, Oxford Policy Management, 2000 (ref. cited but unread) in: World Health Organization. *World Health Report 2005: Make every mother and child count.* Geneva, World Health Organization, 2005.

Pathmanathan I *et al. Investing in maternal health: learning from Malaysia and Sri Lanka*. Washington, DC, World Bank, 2003.

Paul S. *Holding the State to Account through Citizen Report Cards in India.* A case study from Scaling Up Poverty Reduction: A Global Learning Process and Conference. Shanghai, China, 25–27 May 2004. Washington, DC, World Bank, 2004.

Pendse V. Maternal Deaths in an Indian Hospital: A Decade of (No) Change? *Reproductive Health Matters* (Special Issue on Safe Motherhood Initiatives), 1999.

Pradhan M, Prescott N. Social risk management options for medical care in Indonesia. *Health Economics,* 2002, 11: 431—446.

Preker AS *et al. Financing the Millennium Development Goals: Expenditure Gaps and Development Traps.* Health, Nutrition and Population Discussion Paper. Washington, DC, World Bank, March 2005.

Pukrittayakamee S *et al.* Therapeutic responses to antimalarial and antibacterial drugs in vivax malaria. *Acta Tropica,* 2004, 8(3):351–356.

Racaniello VR. Emerging infectious diseases. *Journal of Clinical Investigation*, 2004, 113(6): 796-798.

Rajkumar A, Swaroop V. *Public Spending and Outcomes: Does Governance Matter?* Policy Research Working Paper 2840. Washington, DC, World Bank, 2004.

Rannin-Eliya R, Somanathan A. *Access of the very poor to health services in Asia: Evidence on the role of health systems from Equitap.* Meeting the health related needs of the very poor workshop, 14–15 February 2005. London, Department for International Development (DFID), 2005 (PowerPoint presentation).

Ranson MK. Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. *Bulletin of the World Health Organization*, 2002, 80: 613–621.

Ravindra A. *An Assessment of the Impact of Bangalore Citizen Report Cards on the Performance of Public Agencies*. ECD Working Paper Series 12. Washington, DC, World Bank, 2004.

Ruxrungtham K, Brown T, Phanupah P. HIV/AIDS in Asia. *The Lancet*, 2004, 364(9428): 69–82.

Sachs JD. *Macroeconomics and Health: Investing in Health for Economic Development.* Report of the Commission on Macroeconomics and Health. Geneva, World Health Organization, 2001.

Sanchez P *et al. Halving hunger: It can be done.* New York, Task Force on Hunger, United Nations Millennium Project, 2005.

Saravia NG, Miranda JF. Plumbing the brain drain. *Bulletin of the World Health Organization*, 2004, 82(8):608–615.

Savedoff, W; *How Much Should Countries Spend on Health?* WHO Health Financing Technical Brief. Geneva, World Health Organization, 2003.

Schapira A. Determinants of Malaria in Oceania and East Asia. In: Casman EA, Dowlatabadi H, eds. *The Contextual Determinants of Malaria*. Washington, DC, Resources for the Future, 2002.

Schenker I. *Focusing Resources on Effective School Health: A FRESH Start to Improving the Quality and Equity of Education: HIV/AIDS as a Model*. Paris, UNESCO, 2000.

Schieber G *et al.* Financing health systems in the 21st Century. In: Jamison *et al.* eds. *Disease control priorities in developing countries, second edition.* Oxford and New York: Oxford University Press for the World Bank, forthcoming.

Scott C. *Measuring Up to the Measurement Problem. The role of statistics in evidence-based policy-making.* Paris: Partnership in Statistics for Development in the 21st Century (PARIS21), 2005.

Self-Employed Women's Association. VIMO SEWA homepage (http://www.sewainsurance.org/vimosewa.htm, accessed 28 April, 2005).

Self-Employed Women's Association. SEWA Insurance Products homepage (http://sewa.org/insurance/products.htm, accessed 28 April, 2005).

Somanathan A. *Who benefits from public health care in Asia?* Presentation at the Reaching the Poor Conference, Washington DC, 19 February 2004 (PowerPoint presentation).

Tandon A. *Attaining Millennium Development Goals in Health: Isn't Economic Growth Enough?* ERD Policy

Brief No. 35. Manila, Asian Development Bank, 2005.

Tanzi V, Zee H. Tax Policy for Developing Countries. *Economic Issues* 27. International Monetary Fund, Washington, DC, 2001.

Teklehaimanot *et al. Coming to grips with malaria in the new millennium.* New York, Task Force on HIV/AIDS, Malaria, TB and Access to Essential Medicines. Working Group on Malaria, United Nations Millennium Project, 2005.

Thabrany H. *Social health insurance in Indonesia: Current status and the proposed national health insurance*. Presented at the Social Health Insurance Workshop, World Health Organization South-East Asia Regional Office, New Delhi, 13–15 March 2003 (ref. cited but unread) in: Scheil-Adlung X. *Sharpening the Focus on the Poor: Policy Options for Advancing Social Health Protection in Indonesia.* ESS Paper N° 19. Geneva, International Labour Office, 2004.

Tien M, Chee G. *Literature Review and Findings: Implementation of Waiver Policies*. Washington, Partners for Health Reformplus, Abt Associates, 2002.

Travis P *et al*. Overcoming health-systems constraints to achieve the Millennium Development Goals. *The Lancet*, 2004, 634(9437):900-906.

Travis P *et al*. Towards better stewardship: concepts and critical issues in Murray C, Evans D, eds. *Health Systems Performance Assessment: Debates, Methods and Empiricism*. Geneva World Health Organization, 2002:289–300.

United Nations. *Report of the International Conference on Financing for Development.* A/CONF.198/11. Monterrey, Mexico, 18–22 March, 2002. New York, United Nations 2002.

United Nations. *United Nations Millennium Declaration.* A/RES/55/2, New York, United Nations, 2000.

United Nations Country Team, China. *Millennium Development Goals: China's Progress 2003*. Beijing, United Nations Country Team, China, Office of the United Nations Resident Coordinator, 2004.

United Nations Country Team, Malaysia. *Malaysia: Achieving the Millennium Development Goals: Successes and Challenges.* Kuala Lumpur, United Nations Development Programme, 2005.

United Nations Country Team, Viet Nam. *Millennium Development Goals: Bringing the MDGs Closer to the People.* Ha Noi, United Nations Country Team, Viet Nam, 2004.

United Nations Country Team, Viet Nam. *Millennium Development Goals: Closing the Millennium Gaps.* Ha Noi, United Nations Country Team, Viet Nam, 2003.

United Nations Country Team, Viet Nam. *IDT/MDG Progress: Viet Nam.* Ha Noi, United Nations Country Team, Viet Nam, 2001.

United Nations Department of Economic and Social Affairs, Population Division. *World Population Prospects: The 2004 Revision*. Population Database. New York, United Nations Department of Economic and Social Affairs, Population Division 2005 (http://esa.un.org/unpp/, accessed online 22 April, 2005).

United Nations Department of Economic and Social Affairs, Statistics Division. *Millennium Indicators Database*. New York, United Nations Department of Economic and Social Affairs, Statistics Division, 2005 (http://millenniumindicators.un.org,. accessed online 22 April, 2005).

United Nations Development Programme. *Reducing Disaster Risk: A Challenge for Development.* New York, United Nations Development Programme, 2004.

United Nations Development Programme. Millennium Development Goals: A compact among nations to end human poverty. *Human Development Report 2003*. New York, United Nations Development Programme, 2003.

United Nations Development Programme Evaluation Office. *Evaluation of UNDP's role in the PRSP process. Volumes I and II.* New York, United Nations Development Programme Evaluation Office (ref. cited but unread) in: World Bank. *The Poverty Reduction Strategy Initiative: An Independent Evaluation of World Bank's Support Through 2003.* Washington, DC, World Bank, 2004.

United Nations Development Programme. *National Human Development Report Lao PDR 2001: Advancing Rural Development.* Vientiane, United Nations Development Programme, 2001.

United Nations Educational, Scientific and Cultural Organization. Focusing Resources on Effective School Health (FRESH) homepage (http://www.unesco.org/education/fresh, accessed online 24 April 2005).

United Nations Economic and Social Commission for Asia and the Pacific. *Selected issues concerning the promotion of health and development in the ESCAP region. Health and development: The development determinants of health. Note by the secretariat*. E/ESCAP/SHD/1. United Nations Economic and Social Council, Subcommittee on Health and Development, First Session, Bangkok, 1–3 December, 2004. Bangkok, United Nations Economic and Social Commission for Asia and the Pacific, 2004a.

United Nations Economic and Social Commission for Asia and the Pacific. *Selected issues concerning the promotion of health and development in the ESCAP region. Increasing investment for health in development*. E/ESCAP/SHD/2. United Nations Economic and Social Council, Subcommittee on Health and Development, First Session, Bangkok, 1–3 December, 2004. Bangkok, United Nations Economic and Social Commission for Asia and the Pacific, 2004b.

United Nations Economic and Social Commission for Asia and the Pacific, United Nations Development Programme. *Promoting the Millennium*

Development Goals in Asia and the Pacific. ST/ESCAP/2253. Bangkok, United Nations Economic and Social Commission for Asia and the Pacific, United Nations Development Programme, 2003.

United Nations Millennium Campaign. United Nations Millennium Campaign homepage (http://www.millenniumcampaign.org, accessed 27 April, 2005).

United Nations Millennium Project. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York, United Nations Millennium Project, 2005.

UN Office of the Higher Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States. CCA/UNDAF/PRSP homepage (http://www.un.org/special-rep/ohrlls/ohrlls/cca_undaf_prsp.htm, accessed 7 May 2005).

United States Food and Drug Administration, Center for Drug Evaluation and Research. *Patent and exclusivity terms*. Rockville, United States Food and Drug Administration, Center for Drug Evaluation and Research, 19 March 2004 (http://www.fda.gov/cder/orange/patex.htm, accessed 01 April 2005).

Vandemoortele J. Are the MDGs feasible? New York, UNDP, 2002 (http://www.undp.org/mdg/Are%20the%20MDGs%20feasible.doc, accessed 16 May 2005).

Van de Walle D. The Distribution of Subsidies through Public Health Services in Indonesia, 1978–87 *The World Bank Economic Review*, 1994, 8(1):279–309.

Von Schirnding Y. Health and sustainable development: Can we rise to the challenge? *The Lancet* 2002, 360(9333): 632-637.

Wagstaff A. *Intersectoral Synergies and the Health MDGs: Preliminary Cross-Country Findings, Collaboration and Policy Simulations*. Paper prepared for Development Committee Paper on Accelerating Progress towards the HNP MDGs. Washington, DC World Bank and IDS, 2002.

Wagstaff A. Poverty and health sector inequalities. *Bulletin of the World Health Organization* 2001, 80(2):19–29.

Wagstaff A. Socioeconomic inequalities in child mortality: Comparisons across nine developing countries. *Bulletin of the World Health Organization* 2000, 78(1):19–29.

Wagstaff A, Claeson M. *The Millennium Development Goals for Health—Rising to the Challenge*. Washington, DC, World Bank, 2004.

Wagstaff A, Van Doorslaer E. Catastrophe and Impoverishment in Paying for Health Care: With Applications to Vietnam 1993–98. *Health Economics*, 2003, 12(11): 921–934.

Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *The Lancet*, 2001, 358: 833–836.

Whitehead M *et al*. Developing the policy response to inequities in health: a global perspective. In: Evans T *et al.*, eds. *Challenging Inequities in Health: From Ethics to Action*. New York, Oxford University Press, 2001.

Wilbulpolprasert S, Pengpaibon P. Integrated strategies to tackle the inequitable distribution of doctors in Thailand: Four decades of experience. *Human Resources for Health*, 2003, 1(12).

Wild S *et al*. Global Prevalence of Diabetes: Estimates for the year 2000 and projections for 2030. *Diabetes Care*, 2004, 27: 1047–1053.

Wilkes A *et al*. *Coping with the Costs of Severe Illness in Rural China*. IDS Working Paper No. 58. Brighton, Institute of Development Studies, 1997.

Willis CY. *Means Testing in Cost Recovery of Health Services in Developing Countries*. Washington, DC, Abt Associates, 1993.

World Bank. Community Driven Development homepage (http://www.worldbank.org/cdd, accessed 20 April 2005).

World Bank. Country Classification homepage (http://www.worldbank.org/data/countryclass/countryclass.html, accessed on 24 April 2005).

World Bank. Debt Department homepage (http://www.worldbank.org/debt, accessed 24 April 2005).

World Bank. Poverty and Health homepage (http://www.worldbank.org/povertyandhealth, accessed 14 April 2005).

World Bank. Poverty Net's PRSP Document Library (http://poverty.worldbank.org/prsp, accessed 24 April 2005).

World Bank. *Global Monitoring Report 2005: Millennium Development Goals: From Consensus to Momentum*. Washington, DC: World Bank, 2005a.

World Bank. *The Poverty Reduction Strategy Initiative. Findings from 10 Country Case Studies of World Bank and IMF Support*. Washington, DC: World Bank, 2005b.

World Bank. *Project concept note: Sri Lanka. Sri Lanka statistical capacity building*. Washington, DC, World Bank, 2004 (unpublished).

World Bank. *Global Monitoring Report 2004: Policies and Actions for Achieving the Millennium Development Goals and Related Outcomes*. Washington, DC: World Bank, 2004a.

World Bank. *Local Development Discussion Paper*. Prepared for the International Conference on Local Development, Washington, DC 16–18, 2004. Washington, DC, Human Development, Social Development and Public Sector Management Networks, World Bank, 2004b.

World Bank. *The Poverty Reduction Strategy Initiative: An Independent Evaluation of World Bank's Support through 2003*. Washington, DC, World Bank, 2004c.

World Bank. *World Development Report 2004: Making Services Work for Poor People.* Washington, DC, World Bank, 2004d.

World Bank. 2003 Country Policy and Institutional Assessment (CPIA) Ratings. Accessed online at http://siteresources.worldbank.org/IDA/Resources/Quintiles2003CPIA.pdf (accessed 1 May, 2005).

World Bank. *Supporting Sound Policies with Adequate and Appropriate Financing: Implementing the Monterrey Consensus at the Country Level.* Washington, DC, World Bank, 12 September, 2003.

World Bank. *Annual Review of Development Effectiveness. Achieving Development Outcomes: The Millennium Challenge.* Washington, DC, World Bank, 2002.

World Bank. *Engendering Development through Gender Equality in Rights, Resources and Voice.* World Bank Policy Research Report. Washington, DC, World Bank, 2001a.

World Bank. *Filipino Report Card on Pro-Poor Services*. Washington, DC, World Bank, Environment and Social Development, East Asia and Pacific Region, 2001b.

World Bank. The Kyrgyz Republic: Participatory poverty assessment, prepared for the global synthesis workshop poverty programme. Washington, World Bank, 1999 (ref. cited but unread) in: Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *The Lancet*, 2001, 358: 833–836.

World Health Organization. Health Impact Assessment homepage (http://www.who.int/hia, accessed 23 April 2005).

World Health Organization. *Global tuberculosis control: Surveillance, planning financing. WHO report 2005.* Geneva, World Health Organization, 2005a.

World Health Organization. *Social health insurance: Sustainable health financing, universal coverage and social health insurance*. Report by the Secretariat to the 58th World Health Assembly, 7 April 2005. Geneva, World Health Organization, 2005b.

World Health Organization. *World Health Report 2005: Make every mother and child count.* Geneva, World Health Organization, 2005c.

World Health Organization. *Health Metrics Network newsletter: Update on activities June-October 2004.* Geneva, Health Metrics Network, World Health Organization, 2004a.

World Health Organization. *Indoor air pollution, household energy and the Millennium Development Goals.* Indoor Air Thematic Briefing 1. Geneva, World Health Organization, 2004b.

World Health Organization. *Mix for DOTS. Global progress.* Report of the second meeting of the PPM Subgroup for DOTS Expansion, 3-5 February 2004, New Delhi, India. Geneva, World Health Organization, 2004c.

World Health Organization. *PRSPs, their significance for health: Second synthesis report.* Geneva, World Health Organization, 2004d.

World Health Organization. *WHO estimates of health personnel: Physicians, nurses, midwives, dentists, pharmacists.* Geneva, World Health Organization, 2004e (www.who.int/globalatlas/autologin/hrh_login.asp) (ref. cited but unread) in:

Joint Learning Initiative. *Human resources for health: Overcoming the crisis*. Boston, Harvard University Press, 2004.

World Health Organization. *The world's medicines situation.* Geneva, World Health Organization, 2004f.

World Health Organization. *Diet, nutrition and the prevention of chronic diseases*. Report of a Joint WHO/FAO Expert Consultation. WHO Technical Report Series 916. Geneva, World Health Organization, 2003a.

World Health Organization. *World Health Report 2003. Shaping the Future*. Geneva: World Health Organization, 2003b.

World Health Organization. *World Health Report 2002. Reducing Risks, Promoting Healthy Life*. Geneva, World Health Organization, 2002.

World Health Organization. *Public-private partnerships for health: Medicines for malaria*. Geneva, World Health Organization, 2000a.

World Health Organization. *World Health Report 2000. Health Systems: Improving Performance*. Geneva: World Health Organization, 2000b.

World Health Organization. Declaration of Alma Alta. International Conference on Primary Health Care, Alma-Alta, USSR, 6–12 September 1978. Geneva, World Health Organization, 1978.

World Health Organization, Joint United Nations Programme on HIV/AIDS. *Accelerating Access Initiative: Widening access to care and support for people living with HIV/AIDS. Progress report.* World Health Organization, Joint United Nations Programme on HIV/AIDS, 2002.

World Health Organization, United Nations Children Fund, United Nations Population Fund. *Maternal mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA*. Geneva, World Health Organization, United Nations Children Fund, United Nations Population Fund, 2003.

World Health Organization Regional Office for the Western Pacific. *Health workforce issues in the Western Pacific Region.* Draft. Manila, World Health Organization Regional Office of the Western Pacific, forthcoming a.

World Health Organization Regional Office for the Western Pacific. *Integrating poverty and gender into health programmes: A sourcebook for health professionals; Foundational module on poverty and health.* Manila, World Health Organization Regional Office for the Western Pacific, forthcoming b.

World Health Organization Regional Office for the Western Pacific. *Reaching the poor: Challenges for child health in the Western Pacific Region*. Manila, World Health Organization Regional Office for the Western Pacific, forthcoming c.

World Health Organization Regional Office for the Western Pacific. *Find TB. Cure TB. Cure starts with detection*. Manila, World Health Organization Regional Office for the Western Pacific, 2004a.

World Health Organization Regional Office for the Western Pacific. *Healthy marketplaces in the Western Pacific: Guiding future action. Applying a settings approach to the promotion of health in marketplaces*. Manila, World Health Organization Regional Office for Western Pacific, 2004b

World Health Organization Regional Office for the Western Pacific. *The migration of skilled health personnel in the Pacific region. A summary report*. Manila, World Health Organization Regional Office for the Western Pacific, 2004c.

World Health Organization Regional Office for the Western Pacific. *Women, girls, HIV & AIDS. Advocacy Note. World AIDS day campaign*. Manila, World Health Organization Regional Office for the Western Pacific, 2004d.

World Health Organization Regional Office for the Western Pacific. *Essential public health functions: A three-country study in the Western Pacific Region*. Manila, World Health Organization Regional Office for the Western Pacific, 2003.

World Health Organization Regional Office for the Western Pacific. *Essential public health functions: The role of Ministries of Health*. WPR/RC53/10. Manila, World Health Organization Regional Office for the Western Pacific, 2002.

World Health Organization Regional Office for the Western Pacific. *Mid-level and nurse practioners in the Pacific: Models and Issues*. Manila, World Health Organization Regional Office for the Western Pacific, 2001a.

World Health Organization Regional Office for the Western Pacific. *Report on the informal consultation on monitoring of resistance to anti-malarial drugs in the Mekong region*. Manila, World Health Organization Regional Office for the Western Pacific, 2001b.

World Health Organization Regional Office for the Western Pacific. *A story to be shared: The successful fight against malaria in Vietnam*. Manila, World Health Organization Regional Office for the Western Pacific, 2000.

World Health Organization Secretariat of the Commission on Social Determinants of Health. Commission on Social Determinants of Health homepage (http://www.who.int/social_determinants, accessed online 22 April 2005).

World Health Organization Secretariat of the Commission on Social Determinants of Health. *Action on the social determinants of health: Learning from previous experience*. Background paper prepared for the Commission on Social Determinants of Health. Geneva, WHO Secretariat of the Commission on Social Determinants of Health, 2005.

World Health Organization Secretariat of the Commission on Social Determinants of Health. *Concept paper*. Geneva, WHO Secretariat of the Commission on Social Determinants of Health, 2004 (unpublished).

World Health Organization South-East Asia Regional Office. *Progress towards achieving Millennium Development Goals in WHO South-East Asia Region*. SEA/HHM/Meet.22/4. 22nd Meeting of Ministers of Health, Male, Maldives, 5–6 September 2004. New Delhi, WHO South-East Asia Regional Office, 2004.

World Health Organization South-East Asia Regional Office. *Macroeconomics and health*. Report of a regional consultation, SEARO, New Delhi, India, 18–19 August 2003. New Delhi, WHO South-East Asia Regional Office, 2003.

World Health Organization South-East Asia and Western Pacific Regional Offices. *Core indicators 2005: Health situation in the South-East Asia and Western Pacific Regions*. New Delhi and Manila, World Health Organization South-East Asia and Western Pacific Regional Offices, 2005a.

World Health Organization South-East Asia and Western Pacific Regional Offices. *Health-related Millennium Development Goals 2005*. New Delhi and Manila, World Health Organization South-East Asia and Western Pacific Regional Offices, 2005b.

World Health Organization Western Pacific and South-East Asia Regional Offices. *Social health insurance: Selected case studies from Asia and the Pacific*. Manila and New Delhi, World Health Organization Western Pacific and South-East Asia Regional Offices, forthcoming c.

World Health Organization Western Pacific and South-East Asia Regional Offices. *Strategy on health care financing for countries of the Western Pacific and South-East Asia regions (2006-2010)*. Draft. Manila and New Delhi, World Health Organization Western Pacific and South-East Asia Regional Offices, 2005 (unpublished).

World Trade Organization. *Declaration on the TRIPS Agreement and Public Health*. Geneva, World Trade Organization, 2001.

Xu K. *et al*. Household catastrophic health expenditure: a multi-country analysis. *The Lancet*, 2003, 362(9378): 111–117.

Yach D, *et al*. The Global Burden of Chronic Diseases. Overcoming Impediments to Prevention and Control. *The Journal of the American Medical Association*, 2004, 281(21):2616–2622.

Endnotes

[1] United Nations Millennium Declaration. See UN 2000.

[2] Goal 2 aims to achieve universal primary education, while Goal 3 focuses on promoting gender equality and empowering women..

[3] Different terms are used to refer to the region of the world with which this document is concerned. For the sake of simplicity, this paper uses the terms "Asia and the Pacific" and "the region" or "regional" in its discussion. This term should not be taken to refer to any particular configuration of countries that may be used by any of the four co-sponsoring agencies of the High Level Forum on Health MDGs in Asia and the Pacific, for which this paper has been prepared. Readers are advised that specific regional configurations vary across co-sponsoring agencies of the Forum, namely the Asian Development Bank, the Government of Japan, the World Bank, and the World Health Organization. Agency-wise lists of countries or areas by region are available at: http://www.adb.org/Countries/default.asp (for the Asian Development Bank); http://www.mofa.go.jp/region/index.html (for the Government of Japan's Ministry of Foreign Affairs); http://www.worldbank.org/countries (for the World Bank); http://www.wpro.who.int/countries (for WHO's Regional Office for the Western Pacific); and at http://w3.whosea.org/en/section313.htm (for WHO's South-East Asia Regional Office).

[4] UNDESA Population Division 2005.

[5] UN Country Team, Viet Nam 2003, and UN Country Team, Viet Nam 2004.

[6] UN Millennium Project 2005.

[7] Office of the National Economic and Social Development Board, UN Country Team, Thailand 2004.

[8] UN Country Team, Malaysia 2005.

[9] Sanchez *et al.* 2005.

[10] See also UNDESA Statistics Division 2005 for country level data from UNICEF's State of the World's Children (annual).

[11] Sanchez *et al.* 2005.

[12] Black, Morris, Bryce, 2003. Bangladesh, Cambodia, China, India, Indonesia, Myanmar, Nepal, Pakistan, the Philippines, and Viet Nam.

[13] UN Millennium Project 2005: Child mortality rate in South Asia is 93 per 1,000 live births. Black, Morris, Bryce, 2003: Nearly 2.5 of the approximate 10 million child deaths occur in India alone.

[14] Wagstaff, Claeson 2004. Data based on World Bank classifications for South Asia and East Asia and the Pacific, see endnote 3 for the breakdown of countries and regions.

[15] Wagstaff, Claeson 2004.

[16] Lawn, Cousens, Zupan 2005, WHO 2005c.

[17] Martines *et al.* 2005.

[18] Lawn, Cousens, Zupan, 2005, Lule *et al.* 2005, and WHO 2005c.

[19] WHO, UNICEF, UNFPA, 2003. Of the estimated 529,000 annual deaths, 253,530 occur in Asia and the Pacific. An estimated 136,000 maternal deaths occur annually in India alone.

[20] WHO, UNICEF, UNFPA, 2003. The seven countries include: Bhutan, Cambodia, India, Lao PDR, Nepal, Pakistan, and Timor Leste.

[21] Wagstaff, Claeson 2004, UN Millennium Project 2005, World Bank 2005a.

[22] Note: Malaysia, Sri Lanka, and Thailand were classified as low-income countries at the time when progress on maternal health was made, although current World Bank classifications place them as middle-income countries (for link to World Bank classifications, see endnote 3).

[23] "Skilled attendants" refers exclusively to people with midwifery skills (e.g., doctors, midwives, and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer complications.

[24] Koblinsky, Campbell in: Koblinsky, ed. 2003, WHO 2005c, Liljestrand, Pathmanathan 2004, Pathmanathan *et al.* 2003, Institute for Health Science in: Koblinsky, ed. 2003, DFID 2004b.

[25] UNAIDS 2004, and Ruxrungtham, Brown, Phanupah, 2004. Papua New Guinea has the highest prevalence of HIV infection in the Pacific, and the annual number of new cases has been increasing progressively since the mid-1990s. Note: Readers are reminded that countries in the Central Asian Republics have diverse health care systems, demographic and epidemiological profiles, and levels of economic and social development. The authors discourage readers from making generalisations with regard to the Central Asian Republics based on the experience of Kyrgyzstan.

[26] WHO 2005. High burden countries together account for approximately 80% of the global TB burden. Those in the region include: Bangladesh, Cambodia, China, India, Indonesia, Myanmar, Pakistan, the Philippines, Thailand, and Viet Nam.

[27] By 2005, to detect 70% of new smear-positive cases and successfully treat 85% of these cases.

[28] WHO 2005a, and Pieter Johannes Van Maaren, personal communication 12 April 2005.

[29] Chen 2000. Coinfection with HIV increases the risk of a latent TB infection progressing to active TB from 10% to 60%–80%.

[30] Teklehaimanot *et al.* 2005.

[31] Artemisinin combination therapies. David Bell, personal communication, 8 April 2005.

[32] WHO Regional Office for the Western Pacific 2000. The package of interventions was evaluated over 5 years, from 1992 to 1997.

[33] Schapira 2002, WHO South-East Asia Regional Office 2004, Pukrittayakamee *et al.* 2004, and WHO Regional Office for the Western Pacific 2001b. The Greater Mekong Subregion is comprised of Cambodia, China (Yunnan province), Lao PDR, Myanmar, Thailand, and Viet Nam.

[34] Income levels determined by World Bank classifications (See World Bank Country Classification homepage at http://www.worldbank.org/data/countryclass/countryclass.html, accessed on 24 April 2005). Middle-income countries include lower middle and upper middle income countries.

[35] UNDESA 2005. Data from WHO. World Health Report (annual). Note: No data are available for a number of countries in the region, including many Pacific island countries. Hishashi Ogawa, personal communication, 11 April 2005.

[36] WHO 2002. Indoor air pollution has been estimated to cause 36% of lower respiratory infections, 22% of chronic obstructive pulmonary disease, and 1.5% of lung cancers. It may also be associated with TB, cataracts, and asthma. See also WHO 2004b.

[37] Bruce, Perez-Padilla, Albalak, 2000.

[38] WHO 2004b.

[39] Lenton, Wright, Lewis, 2005.

[40] UNDP 2003.

[41] Wagstaff and Claeson. Data are presented by World Bank regional configurations (see endnote 3).

[42] United States Food and Drug Administration, Center for Drug Evaluation and Research 2004.

[43] WTO 2001.

[44] Data are presented by WHO regional configurations. Lists of countries or areas by region are available at: http://www.who.int/about/regions/en/.

[45] Megacities are defined as cities with more than 10 million people. According to the East West Center 2002, by 2015, 15 of the world's megacities will be in Asia.

[46] Racaniello 2004.

[47] WHO 2003b.

[48] Data are presented by WHO regional configurations (see endnote 44).

[49] UNESCAP 2004a, WHO 2003b.

[50] WHO 2003a, ADB 2003.

[51] UNESCAP 2004a.

[52] Personal communication, Gauden Galea, 12 April 2005.

[53] Basnayar, Rajapasha 2004, Wild *et al.* 2004, and Yach *et al.* 2004.

[54] Government of Mongolia, UNDP 2003.

[55] UNDP 2003.

[56] UNDP 2004, and Arturo Pesigan, personal communication, 11 April 2005.

[57] WHO 2000b, Graham Harrison, personal communication, 25April 2005.

[58] Travis *et al.* 2002.

[59] WHO 2000b.

[60] Baudouy 2004.

[61] Scott 2005, and Frances Harper, personal communication, 24 March 2005.

[62] World Bank 2004 (unpublished), and Emi Suzuki, personal communication, 23 March 2005.

[63] WHO 2004a, and Waranya Teokul, personal communication, 25 March 2005.

[64] WHO 2000b, and Schieber *et al.* forthcoming.

[65] Schieber *et al.* forthcoming. This point is illustrated by Figure 6, although a caveat must be placed with regard to Bhutan and Papua New Guinea, which receive substantial external financing. For example, external resources for health as a percentage of total expenditure on health are 18.7% in Bhutan, and 34.3% in Papua New Guinea.

[66] Xu *et al.* 2003, Wagstaff, Van Doorslaer 2003, Wilkes *et al.* 1997, Oxfam Great Britain 2000.

[67] WHO 2005c, and Dorjsuren Bayarsaikhan, personal communication 13 April 2005.

[68] WHO Western Pacific and South-East Asia Regional Offices 2005 (unpublished). Note: Mongolia has experienced recent declines in coverage, to 78%. See also Carrin, James 2004.

[69] WHO Western Pacific and South-East Asia Regional Offices forthcoming c.

[70] Cambodia PRSP 2003, Indonesia PRSP 2003, Kyrgyzstan PRSP 2003, Lao PRSP 2004, Mongolia PRSP 2003, Nepal PRSP 2003, Sri Lanka PRSP 2003, and Viet Nam PRSP 2004 can be found online on the World Bank Poverty Net's PRSP Document Library (http://poverty.worldbank.org/prsp, accessed 24 April, 2005).

[71] Carrin 2003. For examples of countries' experience using community-based insurance mechanisms, see Carrin *et al.* 1999 (China), Bloom 2005, and Ranson 2002 (India), and Pradhan, Prescott 2002 (Indonesia).

[72] Schieber *et al.* forthcoming, and Schieber, personal communication, 10 April 2005.

[73] WHO Regional Office for the Western Pacific 2004c, and Brown, Connell 2004.

[74] Bach 2003, and Buchan, Parkin, Sochalski, 2003.

[75] Choo 2003, and Joint Learning Initiative 2004. Unofficial estimates placed the number of doctors switching professions in 2003 at 2,000. This trend is fairly new, so the impact is not yet fully understood.

[76] Data are presented by WHO regional configurations. See endnote 44.

[77] UNDP 2003.

[78] WHO 2002.

[79] Learning Initiative 2004. Regression analysis based on worker density and health outputs suggest that a density of about 1.5 workers per 1,000 population is associated with 80% coverage of measles immunisation, and 2.5 workers per 1,000 population with 80% coverage of births with skilled attendants. The authors suggest that a density of 2.5 workers can be considered a threshold of worker density necessary to attain adequate coverage of some essential health interventions and core MDG-related health services.

[80] Wilbulpolprasert, Pengpaibon 2002, WHO Regional Office for the Western Pacific forthcoming a.

[81] Egger, Lipson, Adams, 2000, and Kutzin, Cashin 2002.

[82] Egger, Lipson, Adams, 2000.

[83] WHO Regional Office for the Western Pacific 2001a, and Kathleen Fritsch, personal communication, 13 April 2005. For example, WHO has supported the training of medical assistants in Kiribati, health assistants in the Marshall Islands and Micronesia, the Federated States of, nurse practioners or their equivalent in the Cook Islands, Fiji, Samoa, and Vanuatu, and health officers in Tonga.

[84] Wilbulpolprasert, Pengpaibon 2002, and Saravia and Miranda 2004.

[85] Joint Learning Initiative 2004.

[86] Basing training programmes in communities enhances the relevance of the training and improves worker retention. Joint Learning Initiative 2004, and Richard Wah, personal communication, 13 April 2005.

[87] For more on essential public health functions, see Khaleghian, Das Gupta 2004, WHO Regional Office for the Western Pacific 2003, and WHO Regional Office for the Western Pacific 2002.

[88] Izard, Dugue 2003, and Bigdeli *et al.* 2004.

[89] Bigdeli *et al.* 2004.

[90] WHO 2005c.

[91] Aus Health International 2004.

[92] Bhushan, Keller, Schwartz, 2002, and Loevinsohn, Harding 2004.

[93] WHO 2000a.

[94] WHO, UNAIDS 2002. The initiative emerged out of a partnership between the UN (UNAIDS, UNICEF, UNFPA, WHO, and World Bank) and five pharmaceutical companies (Boehringer-Ingelheim, Bristol-Myers Squibb, F. Hoffman-La Roche, GlaxoSmithKline, and Merck & Co., Inc), and has since been broadened to include other members of the pharmaceutical industry.

[95] GAVI leverages private and public sector resources aimed at developing and distributing vaccines to ensure that all children have equal access to vaccines and immunisations. GAVI homepage (http://www.vaccinealliance.org, accessed 2 April 2005), and WHO 2000b.

[96] Pieter Johannes Van Maaren, personal communication, 12 April 2005.

[97] Pieter Johannes Van Maaren, personal communication, 12 April 2005.

[98] WHO 2004c, WHO Regional Office for the Western Pacific 2004a, Department of Health, National Center for Disease Prevention and Control, Philippines Coalition against Tuberculosis 2004, and Dong Il Ahn, personal communication 15 March 2005. Note: While China does not have a private sector per se, general hospitals operate much like the private sector, collecting user fees, providing higher salary levels for health personnel, etc.

[99] Formerly known as the Bangladesh Rural Advancement Committee.

[100] BRAC 2003, and Narasimhan *et al.* 2004.

[101] Hadi 2003.

[102] Bhandari *et al.* 2003. This randomised controlled trial of 895 children found that, at 3 months, exclusive breastfeeding rates were 79% in the intervention and 48% in the control communities (OR=4.02, 95% CI=3.01-5.35, p<0.0001). The 7-day diarrhoea prevalence was lower in the intervention than in the control communities at 3 months (OR=0.64, 95% CI=0.44-0.95, p=0.028), and 6 months (OR=0.85, 95% CI=0.72-0.99, p=0.04).

[103] Manandhar DS *et al.* 2004. This study included a random sample of 24 village development committees, divided into 12 pair intervention and control clusters (average population cluster=7000).

[104] Ravindra 2004, Paul 2004, and World Bank 2001b.

[105] Gwatkin, Bhuiya, Victora, 2004, and World Bank 2004d.

[106] Evans *et al.* 2001, Vandemoortele 2002, and Carr 2004.

[107] Wagstaff 2000, Gwatkin 2000, Gwatkin et al 2003b, and Freedman 2005.

[108] The division of population into quintile, or income groups, is determined using the household wealth index composed from data on household asset, services, and other data from Demographic and Health Surveys.

[109] WHO 2003b.

[110] Wagstaff, Claeson 2004: as measured by gender gaps in education and health. See also Claeson *et al.* 2000.

[111] Bhan *et al.* 2005: New Delhi, India. Of the 4418 children who were hospitalised at least once over the course of this randomised control trial, 64.6% were males and only 35.4% were females, indicating a significantly lower rate of care-seeking for females (p<0.00). See also Claeson *et al.* 2000.

[112] WHO 2003b. Given female biological advantage at birth, child mortality rates are expected to be higher among boys than among girls.

[113] WHO Regional Office for the Western Pacific 2004c.

[114] The Greater Mekong Subregion is comprised of Cambodia, China (Yunnan province), Lao PDR, Myanmar, Thailand, and Viet Nam.

[115] UNAIDS/UNIFEM 2004.

[116] Osmani, Sen 2003.

[117] ADB 2000.

[118] UNDP 2001.

[119] UN Country Team, Viet Nam 2001.

[120] UNDESA Statistics Division 2005, from WHO, UNICEF. Water Supply and Sanitation Collaborative Council. Global water supply and sanitation assessment, 2000 Report. Geneva and New York, WHO and UNICEF, 2000. Gaps in coverage between urban and rural populations remain large in most of Asia apart from many Pacific island countries and South Asia.

[121] UN Country Team, China 2004.

[122] Whitehead *et al.* 2001.

[123] Wagstaff 2001.

[124] Gwatkin, Wagstaff, Yazbeck, eds. forthcoming, and World Bank Poverty and Health homepage (http://www.worldbank.org/povertyandhealth, accessed 14 April 2005).

[125] Gwatkin, Wagstaff, Yazbeck, eds. forthcoming.

[126] WHO 2000b.

[127] Demographic and Health Surveys Program 2002. See also Demographic and Health Surveys' homepage (http://www.measuredhs.com, accessed 23 April 2005).

[128] Henning, Snel 2002.

[129] UN Country Team, Viet Nam 2003.

[130] World Bank 2001a.

[131] Decision 139, Decision of the Prime Minister about provision of health services for the poor.

[132] In 2005, the Ministry of Health recommended that the fund be used only for the provision of health insurance cards. However, as of April 2005, provincial authorities were still able to opt for either/both schemes. Henrik Axelson and Nguyen Phuong, personal communication, 14 April 2005.

[133] Ministry of Health Viet Nam 2004.

[134] Henrik Axelson, personal communication, 31 March 2005. Burden of health care expenditure was measured by the ratio of total health care household expenditure and total non-food household expenditure.

[135] Crossland, Conway 2002. Note: Health equity funds are largely donor-financed compared to the largely public-financed programmes in Indonesia and Viet Nam.

[136] Xu *et al.* 2003, and Hsiao, Liu 2001, in Evans 2001.

[137] Van de Walle 1994.

[138] Hammer, Nabi, Cercone in: Van de Walle, Nead, eds. 1995.

[139] Bitrán, Giedion 2003, Carr 2004.

[140] Wagstaff, Claeson 2004, Gwatkin *et al.* 2003a.

[141] Anwar *et al.* 2004.

[142] National Institute of Statistics, Directorate General for Health (Cambodia), ORC Macro, 2001.

[143] Institute of Statistics, Directorate General for Health (Cambodia), ORC Macro, 2001. This problem was cited more often by women with no education (46%) as compared to 37% of women with secondary and higher education, and those in rural areas (43%) as compared to 39% of women in urban areas.

[144] The costs of care should be understood to include direct costs such as user fees, indirect costs such as transportation and food, and the opportunity costs such as time away from work. See, for example, World Bank 1999 (Kyrgyzstan), Iyer, Sen 2000 (rural India), and Fu 1999 (China).

[145] Oxford Policy Management 2000 (ref. cited but unread) in WHO 2005c.

[146] Douthwaite, Ward 2005. This study included a random sample survey of 4,277 women living in households served by the programme and those in control areas. Those served by the programme were significantly more likely to use a modern reversible method than the control groups (OR=1.50, 95% CI=1.04-2.16, p=0.031), after controlling for various household and individual characteristics.

[147] Global Education 2003. Contributing factors to this success included immunisation rates over 60% among children under 1 year old and the provision of tetanus toxoid immunisation to 70% of women.

[148] Kim *et al.* 2000, Kim *et al.* 2001. Clients who received coaching asked significantly more questions than those in the control group. Providers were more likely to give tailored communication (defined as information and advice related to clients' needs and circumstances) to clients from the intervention group.

[149] WHO 1978.

[150] Kekki undated, and Freedman 2005.

[151] Hefford, Crampton, Foley, 2005.

[152] Gwatkin 2002, WHO 2000b, and Sachs 2001.

[153] See Hsiao and Liu 2001, Wagstaff, Claeson 2004, and Somanathan 2004 (powerpoint presentation).

[154] Rannin-Eliya, Somanathan 2005 (powerpoint presentation), Schieber *et al.* forthcoming.

[155] Gwatkin 2002, WHO Regional Office for the Western Pacific forthcoming a.

[156] Jørgenson, Domelen 2001, Tien, Chee 2002, Willis 1993, and World Bank 2004a.

[157] Carr 2004.

[158] VIMO SEWA homepage (http://www.sewainsurance.org/vimosewa.htm, accessed 28 April, 2005), SEWA Insurance Products homepage (http://sewa.org/insurance/products.htm, accessed 28 April, 2005). The plan covers life, asset loss, widowhood, personal accident, sickness, and maternity benefits for SEWA members. Health insurance has been provided for members' husbands since 2002, and for members' children since 2003. Members can pay their annual insurance premiums directly or through fixed deposit accounts established at SEWA Bank.

[159] WHO Western Pacific and South-East Asia Regional Offices forthcoming c, Thabrany 2003 (ref. cited but unread) in Scheil-Adlung 2004. Sustainability concerns were related to high dropout rates among the insured; significant underfunding of the programme; low quality benefits, limited largely to outpatient care; and access problems by the poor. The Dana Sehat scheme has been widely replaced by a social assistance programme that provides government subsidies to the poor, to midwives, and to community health services.

[160] Wagstaff 2002.

[161] Wagstaff 2002, UN Millennium Project 2005.

[162] Chowdury, Rosenfield 2004, WHO Regional Office for the Western Pacific forthcoming b, and WHO Regional Office for the Western Pacific forthcoming c.

[163] Wagstaff, Claeson 2004.

[164] Ministry of Foreign Affairs, Government of Japan, personal communication, 9 May 2005.

[165] Lock 2000, Bartram *et al.* 2005, and Birley 1995.

[166] WHO Health Impact Assessment homepage (http://www.who.int/hia, accessed 23 April 2005).

[167] Ministry of Foreign Affairs, Government of Japan, personal communication, 9 May 2005.

[168] Von Schirnding 2002.

[169] WHO Secretariat of the Commission on Social Determinants of Health 2005, WHO Secretariat of the Commission on Social Determinants of Health 2004 (unpublished), WHO Secretariat of the Commission on Social Determinants of Health. Commission on Social Determinants of Health homepage (http://www.who.int/social_determinants, accessed online 22 April 2005).

[170] WHO 2004d.

[171] World Bank 2004c: 28. See World Bank 2005b for findings from 10 case studies on the PRSP process, including those for Cambodia and Viet Nam.

[172] WHO South-East Asia Regional Office 2003. The Regional Consultation on Macroeconomics and Health for the South-East Asian Region was held in New Delhi 18–19 August 2003 and brought together ministerial representatives from Bangladesh, Bhutan, India, Indonesia, the Maldives, Myanmar, Nepal, Sri Lanka, and Thailand. Timor Leste was represented by the WHO country office director.

[173] WHO South-East Asia Regional Office 2003.

[174] Sekhar Bonu, personal communication, 21 April 2005.ADB has been supporting a multi-sector programme in Sindh since 2003 and in Punjab since 2004. Additional loans are planned for Balochistan in 2005, and the North-Western Frontier Province in 2006.

[175] See World Bank Community Driven Development website www.worldbank.org/cdd, and Auffret 2004.

[175] World Bank 2004b.

[176] The Global Public-Private Partnership for Handwashing with Soap homepage (http://www.globalhandwashing.org, accessed 20 April 2005). Developed by the World Bank, the Water and Sanitation Program, the London School of Hygiene and Tropical Medicine, the Academy for Educational Development and the private sector, in collaboration with USAID, UNICEF, and the Bank-Netherlands Water Partnership.

[178] Wagstaff, Claeson 2004.

[179] Ministry of Foreign Affairs, Government of Japan, personal communication, 9 May 2005.

[180] WHO Regional Office for the Western Pacific 2004b.

[181] Founded in 2003, the Alliance for Healthy Cities is an international network of mayors, governors, public health and urban planning professionals, academic institutions, and community groups aimed at protecting and enhancing the health of city dwellers. The approach was initiated by the WHO's Regional Office for the Western Pacific and dates to the 1980s.

[182] Alliance for Healthy Cities. Awards homepage (http://www.alliance-healthycities.com/html/awards.htm, accessed online 24 April 2005).

[183] Jacques Jeugmans, personal communication, 14 May 2005.

[184] DFID 2004a.

[185] Launched at the Dakar World Education Forum, partners now include the Food and Agriculture Organisation, Roll Back Malaria, UNAIDS, UNESCO, UNICEF, UN Office on Drugs and Crime, WHO, World Bank, World Food Programme, and NGOs including Education International and the Partnership for Health.

[186] UNESCO FRESH homepage (http://www.unesco.org/education/fresh, accessed online 24 April 2005), Gillespie *et al.* 2002, and Schenker 2000.

[187] Wagstaff, Claeson 2004.

[188] UN Millennium Project 2005. Note: Estimates are based on preliminary MDG needs assessments conducted in Bangladesh, Cambodia, Ghana, Tanzania, and Uganda.

[189] UN Millennium Project 2005.

[190] Sachs 2001.

[191] Savedoff 2003. Although WHO has never adopted a recommended level of health spending, various citations have taken 5% of GDP as rule-of-thumb benchmark level of spending needed for an essential package of health services.

[192] WHO Western Pacific and South-East Asia Regional Offices 2005 (unpublished).

[193] Economic Planning Unit, Prime Minister's Department, Malaysia, UN Development Programme, 2005, and WHO 2005c.

[194] UNESCAP 2004b.

[195] Sachs 2001.

[196] Earmarked taxes are taxes in which the contribution is dedicated to health or to a particular function.

[197] WHO Western Pacific and South-East Asia Regional Offices 2005 (unpublished).

[198] WHO Regional Office for the Western Pacific forthcoming b, Anton Fric, personal communication, 15 April 2005.

[199] Rannan-Eliya, Somanathan 2005 (PowerPoint presentation), Somanathan 2004 (PowerPoint presentation). WHO defines catastrophic payments to be the situation in which a household spends more than 40% of its income on health after paying for subsistence needs (e.g., food).

[200] Tanzi, Zee 2001.

[201] International Monetary Fund 2004.

[202] World Bank 2005a.

[203] UN Millennium Project 2005. Note: these estimates are for meeting all of the MDGs, not only the health-related MDGs, and will likely approach the target for donor countries to provide 0.7% of GDP as ODA, a longstanding commitment affirmed by UN Member States in UN Resolution 2626 (XXV) of the UN General Assembly, 24 October 1970.

[204] United Nations 2002.

[205] UN Millennium Project 2005. See chapter 5 on "Quick Wins".

[206] World Bank 2005a, and Wagstaff, Claeson 2004.

[207] Gupta, Verhoeven, Tiongson, 2003, Jayasuriya, Wodon 2003, Preker et al 2005, Gupta, Verhoeven, Tiongson, 1999, and UNESCAP, UNDP 2003.

[208] Ministry of Health Nepal, Health Economics and Financing Unit, District Health Strengthening Project 2003. Notably, this figure fell from 60% in 1999–2000, while public expenditure in urban areas rose over the same period by 5%. Rural people may benefit, however, from programmes such as TB control, iodine supplementation, and medical treatment that cover both rural and urban areas.

[209] The EQUITAP Project, established in April 2001, is implemented by the Asia Pacific National Health Accounts Network, and aims to develop national health accounts in a standard manner; estimate equity of financing and delivery of service in the participatingcountries; and examine the impact of policy change on equity. Participating countries include Bangladesh, China, Indonesia, Japan, Kyrgyzstan, Mongolia, Nepal, the Republic of Korea, Taiwan (China), and Thailand.

[210] World Bank 2005a, Travis *et al.* 2004.

[211] UN Millennium Project 2005, and World Bank 2005a.

[212] Sachs 2001, UN Millennium Project 2005, UNDP Evaluation Office 2003 (ref. cited but unread) in World Bank 2004c, and Wagstaff, Claeson 2004.

[213] Called the Comprehensive Poverty Reduction and Growth Strategy.

[214] UN Country Team, Viet Nam 2003, and UN Country Team, Viet Nam 2004.

[215] UN Millennium Project 2005.

[216] World Bank 2004c.

[217] Nallari 2004 (PowerPoint presentation), and UN Millennium Project 2005.

[218] Buse, Walt 1997, Cassels 1997, Cassels, Janovsky 1998, WHO 2000b, and Travis *et al.* 2004.

[219] Travis *et al.* 2004, and UNDP 2003.

[220] Global Fund to Fight AIDS, Tuberculosis and Malaria 2005, and Stéphane Rousseau, personal communication, 13 April 2005.

[221] Wagstaff, Claeson 2004. See also Rajkumar, Swaroop 2004.

[222] Evans *et al.* 2003.

[223] World Bank 2005a, UN Millennium Project 2005.

[224] World Bank 2003.

[225] ADB 2003 (unpublished). See 2003 World Bank's Country Policy and Institutional Assessment (CPIA) quintiles at http://siteresources.worldbank.org/IDA/Resources/Quintiles2003CPIA.pdf (accessed 1 May, 2005).

[226] World Bank 2005a, and ADB 2003 (unpublished).

[227] World Bank 2005a.

[228] For a list of countries that have completed Common Country Assessments and UN Development Assistance Frameworks, see the CCA/UNDAF/PRSP homepage of the UN Office of the Higher Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (http://www.un.org/special-rep/ohrlls/ohrlls/cca_undaf_prsp.htm, accessed 7 May 2005).

[229] Organisation for Economic Co-operation and Development, Development Assistance Committee 2005a.

[230] High Level Forum on Joint Progress toward Enhanced Aid Effectiveness (Harmonisation, Alignment, and Results homepage, (www.aidharmonisation.org, accessed 27 April, 2005), World Bank 2005a. Donors include the government of Australia, the World Bank, and WHO.

[231] Bulíø, Lane 2002. Aid has been found to be up to seven times more volatile than domestic fiscal revenue, in the case of heavily aid-dependent countries.

[232] Bulíø, Hamann 2003.

[233] Organisation for Economic Co-operation and Development, Development Assistance Committee 2005b: Bangladesh (40%), Cambodia (50%), and Viet Nam (58%).

[234] Atkinson 2004, International Monetary Fund, World Bank 2004a, Schieber *et al.* 2005, and UN Millennium Project 2005.

[235] Organisation for Economic Co-operation and Development, Development Assistance Committee 2005a.

[236] Manning 2004 (PowerPoint presentation).

[237] Organisation for Economic Co-operation and Development Development Assistance Committee 2004.

[238] World Bank 2004c, World Bank 2005b.

[239] UN Millennium Campaign homepage (http://www.millenniumcampaign.org, accessed 27 April, 2005).

[240] Asian Collaborative Training Network for Malaria homepage (http://www.actmalaria.org, accessed 24 April 2005). Countries include Bangladesh, Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Viet Nam.

[241] Birdsall 2004.

[242] Established in 1989, includes 21 member countries across Asia and the Pacific.

[243] Established in 1967, comprising Brunei Darussalum, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Viet Nam.

[244] Established in 1971, includes Australia, Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, the Federated States of, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

[245] Established in 1985, includes Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka.

[246] Established in 1947 as the South Pacific Commission, includes 22 Pacific Island countries and territories along with the five remaining founding partners (Australia, France, New Zealand, the United Kingdom, and the United States of America).


ENSURING EQUITY
STRENGTHENING HEALTH SYSTEMS
SECURING RESOURCES AND IMPROVING EFFECTIVENESS
PROMOTING CROSS-SECTORAL ACTIONS
Goal 1: Eradicate Extreme Poverty and Hunger
Goal 4: Reduce Child Mortality
Goal 5: Improve Maternal Health
Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases
Goal 7: Ensure Environmental Sustainability
Goal 8: Develop a Global Partnership for Development