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REALITY CHECK: WHAT THE UK, EU AND AFRICA MUST DO TO PUT THE HEALTH-RELATED MDGS BACK ON TRACK

Action for Global Health UK Policy Conference | 28th June 2010

ACKNOWLEDGEMENTS

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This report was written by Juliet Heller on behalf of Action for Global Health. All photographs are by Charles Oriba on behalf of Action for Global Health unless otherwise noted. All charts and graphs are from speakers' presentations.

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ABBREVIATIONS

ARV	Anti-Retroviral
BMGF	Bill & Melinda Gates Foundation
CBO	Community-based organisation
CSO	Civil society organisation
DFID	UK Department for International Development
GDP	Gross Domestic Product
EC	European Commission
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisation
HSS	Health system strengthening
IHP+	International Health Partnership and Related Initiatives
MDG	Millennium Development Goal
NGO	Non-governmental organisation
ODA	Official development assistance
TB	Tuberculosis
UN	United Nations
WHO	World Health Organisation

INTRODUCTION

About Action for Global Health

Action for Global Health (AfGH) is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in developing countries. AfGH takes an integrated approach to health and advocates for the fulfilment of the right to health for all, the achievement of which requires full funding, fair access and strong systems. In the UK AfGH is coordinated by the International HIV/AIDS Alliance, Interact Worldwide and TB Alert.

Aims of the Conference

This is the third in a series of annual policy conferences organised by Action for Global Health UK to improve dialogue between donors and civil society on the health-related Millennium Development Goals (MDGs.)

The aim of this year's conference was to engage with the UK Government and other key donor agencies in order to galvanise and shape the debate in the run up to the United Nations' MDG Review Summit in September 2010. There was a specific focus on what is needed to reach the three main health-related MDGs: MDG4 ((to reduce child mortality), MDG5 (to improve maternal health) and MDG6 (to combat HIV/AIDS, malaria and other diseases).

There were four sessions on key themes of relevance to the health-related MDGs, with speakers representing civil society and government from the global North and South, as well as health financing experts and donors. The conference was attended by over 80 participants, including academics, civil society from the UK, Europe and Africa, UK policy-makers and representatives of global health institutions.

SESSION ONE:
Barriers to achieving the health MDGs and how these can be overcome

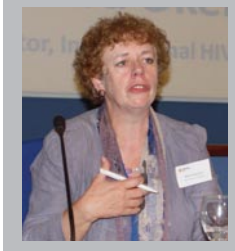
Overview

Chair: Marie Staunton, Chief Executive, Interact Worldwide and Plan UK

Speakers: Marta Monteso, Coordinator, Action for Global Health
Leonard Okello, Programme Director, International HIV/AIDS Alliance, Uganda
Dr Devi Sridhar, Director, Global Health Governance, Oxford University
Dr Isabelle de Zoysa, Senior Advisor for HIV/AIDS, World Health Organisation

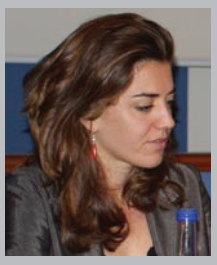
The session highlighted some of the financial and political challenges faced by developing countries in reaching the health-related MDGs, and ways these could be addressed. Drs Devi Sridhar and Isabelle de Zoysa outlined key trends in global health indicators, in particular around maternal, newborn and child health and the multiple constraints to making progress on these targets. Several speakers suggested new approaches that could be used to galvanise governments, civil society, politicians and others in making progress over the five years that remain to meet the MDGs. The discussion focused on the interconnectedness of the health-related MDGs and the critical need to address them in an integrated way.

Welcome: Marie Staunton, Chief Executive, Interact Worldwide and Plan UK



At the just-finished G8 Conference in Canada, the Muskoka Initiative on Maternal, Newborn and Child Health announced commitments of world leaders to the tune of $5 billion for maternal and newborn child health. Staunton questioned whether this would be the game-changer that is needed to make progress on these key goals. She suggested that the Action for Global Health UK policy conference would put forward concrete ideas on what is needed for the health MDGs to be met, including some of the breakthrough actions to push for and suggestions on where the financing could come from. She highlighted that the day's panels would include a wide range of civil society organisations, politicians, health financing experts and donors.

Marta Monteso, Coordinator, Action for Global Health



Monteso drew attention to the recent AfGH policy report, "2010 Reality Check: Time is running out to meet the health MDGs". Key points include:

- All of the health-related MDGs are off-track. In order to make progress on them they must be addressed in a holistic way, recognising the inherent interconnectedness of the targets.
- Developing countries and donors alike need to see the broader picture and pursue a holistic approach to achieve positive development outcomes. There is not just one strategy or solution, but rather specific and appropriate measures responding to need and the national context.
- The health-related MDGs are the minimum targets, and in some cases they are less ambitious than some goals countries have set for themselves. ***There is no excuse for failure to meet the targets.***

In addition, there are a number of policies that are cost-effective, urgently needed and could make a massive difference to achieving the health-related MDGs by 2015. These are:

- User fees must be abolished as they exclude the poorest and most marginalised from accessing health services.
- The health workforce needs to be strengthened with policies that aid retention and training of health workers.
- There needs to be a focus on empowering poor and marginalised communities to realise their human rights, including ensuring they have resources to hold their governments to account.
- There must be a stronger role for civil society in making health decisions, not just applied to local level decisions but influencing higher level decision-making as well.

Monteso went on to clarify what is meant by an integrated approach. This involves avoiding shortcuts and taking a holistic approach to an individual's health needs, and recognising there is a web of complex inter-linkages when working on public health issues. Poor countries are no different – we have to avoid compartmentalising. The context is complex – environmental, economic and social issues come into play. Gender inequality and human rights violations all affect the health MDGs.

A comment made in New York City at the recent UN civil society meeting is pertinent to these issues: ***"How are we going to reach the MDGs if more money is going into repaying of official creditors abroad than on health and education?"***

Leonard Okello, Programme Director, International HIV/AIDS Alliance, Uganda

Okello focused on the experience of Uganda and particularly the involvement of international organisations and donor agencies in developing countries. He argued passionately against the "projectisation" of health and development and for the integration of the three health-related MDGs, taking into account poverty and the cultural, social and economic context.

Key points include:

- There is a crisis in the growing 'projectisation' of health and development. This must shift to broader approaches that recognise human life as a lifetime project, not a three-year project.
- 'Projectisation' may not deliver either health for all or the MDGs, as it fails to address the overall picture, and narrows our thinking into numbers.
- A more integrated approach needs to take into account cultural, social and economic issues on the ground. The example given was that people will buy food instead of condoms if they are poor and have to make choices.
- Accountability needs to shift from donors who fund projects, to people who are meant to benefit from health interventions. With too many organisations involved, it is not clear who is doing what. We must also avoid 'branded' projects that aren't accountable to local people.
- Okello highlighted the changes in administrative structures in Uganda. He noted that basic health and hygiene education was once taught in schools, churches, and at household levels. This has now changed and these services are now delivered by NGOs, thus removing these basic skills from the general society.

Dr Devi Sridhar, Director, Global Health Governance, University of Oxford

Dr. Sridhar provided the broader picture on the health-related MDGs and focused on how to make progress on the goals. As countries approach the final five years of meeting the MDGs, Dr Sridhar observed that child mortality is falling, HIV/AIDS treatments are more widely available but inequality is still widespread. If we are to achieve the health MDGs, action must start at the national level and be supported at the international level. Better mechanisms for financing are essential. The key messages were a call to institutionalise the 'Social Contract', move beyond aid and bring in a new Framework Convention on Global Health. NGOs were encouraged to push further on these.

Sharing success: two countries progressing towards the MDGs

Universal healthcare in Rwanda

Rwanda is doing well on many health indicators in relation to other countries with similar financial indicators. A national health insurance cover is available to 92% of the population. There is a premium of US$2 a year for basic health care. Life expectancy has risen despite high HIV/AIDS rates; maternal mortality and malaria cases have fallen; all medicines on the WHO essential drugs list are available. But a key question is who is paying for these positive outcomes? The government cost is around US$20 per person but 53% comes from donors such as the US and the Global Fund to Fight AIDS, TB and Malaria.

Oportunidades programme in Mexico

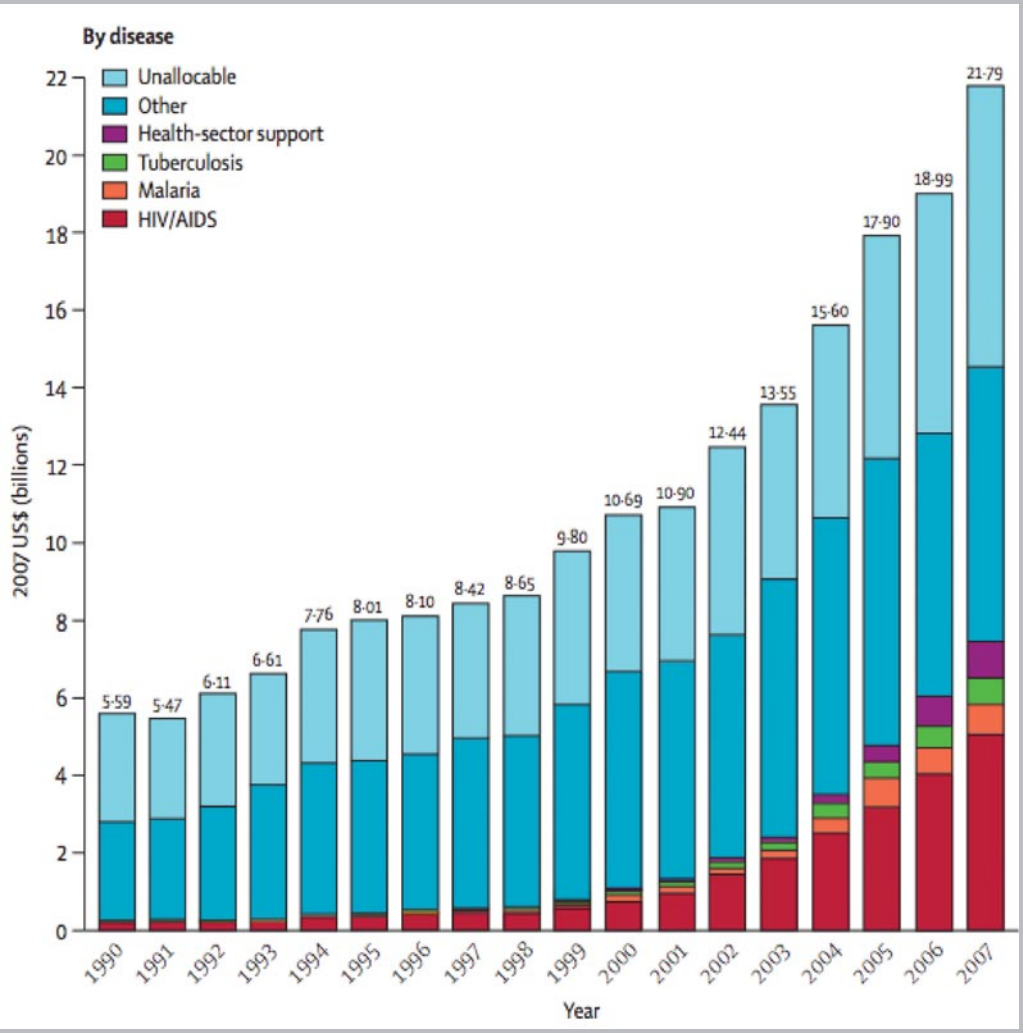
This is essentially a conditional cash transfer programme. Put simply, money is given to mothers if they attend health check ups and if children attend school – health, nutrition and education are packaged together. The programme delivers purchasing power. Five million families have been helped, but the approach is expensive.
In 2000 funding was US$1 billion a year – 20% of the federal budget or 0.2% of GDP. In 2008 the budget was US$3.8 billion and the Government took a loan from the American Development Bank to pay for this.

Lessons learned:

- The role of money in the schemes is key – not the only solution but a significant element
- The public sector is important – the government needs to play a key role
- An integrated approach to health works
- Technology is important but not the only focus
- Local knowledge and ownership are also important elements
- Solidarity is important, i.e. each member of society thinking *"I could be in that position"*

Dr Sridhar argued for a more integrated approach to global health based on basic rights, moving away from the current approach that is disease-specific, aid dependent and emphasises the split between donor and recipient. She suggested that institutionalising a 'Social Contract' as part of a Framework Convention on Global Health (as proposed by Larry Gostin) would create momentum and channel more resources towards health. This would act as a 'global health insurance' with each country contributing fairly to achieve health security for all.

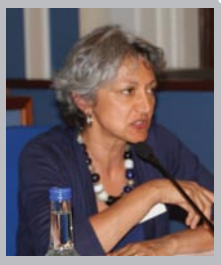
The question of who pays is key. The WHO estimates around US$40 per person per year is needed to deliver a basic health package to all. While there is cause to celebrate the US$22 billion committed to global health, this needs to be looked at in relation to other expenditure. Recent bank bailouts, for example, cost US$11 trillion while the war in Afghanistan costs US$280 billion.



Global financing for health 'Development Assistance for Health 1990-2007'

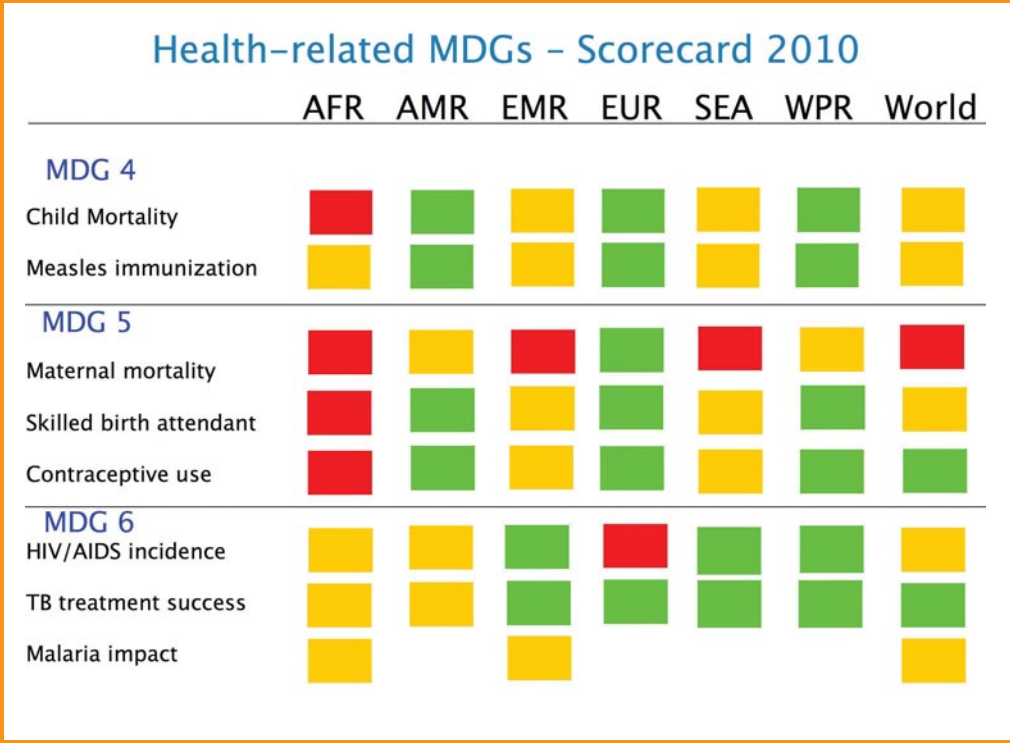
It is also important to more closely to examine foreign assistance budgets and which countries the money goes to. For instance, there is great tension in the fact that India is a large recipient of foreign assistance funds yet spends a huge amount of its own domestic resources on defence. The US has promised US$63 billion over six years to eight countries, based on good governance and other criteria. Sixty four percent of this will go to three countries – Afghanistan, Pakistan and Iraq.

Dr Isabelle de Zoysa, Senior Advisor for HIV/AIDS, World Health Organisation (WHO)



The presentation gave a global snapshot of regional progress towards the health-related MDGs, and trends on HIV/AIDS and maternal mortality, using WHO data. Dr. de Zoysa commented that the WHO believes all the MDGs are health-related, and all have an impact on health, although WHO focuses in particular on MDGs 4, 5 and 6.

MDGs Scorecard: progress on the health MDGs by world region



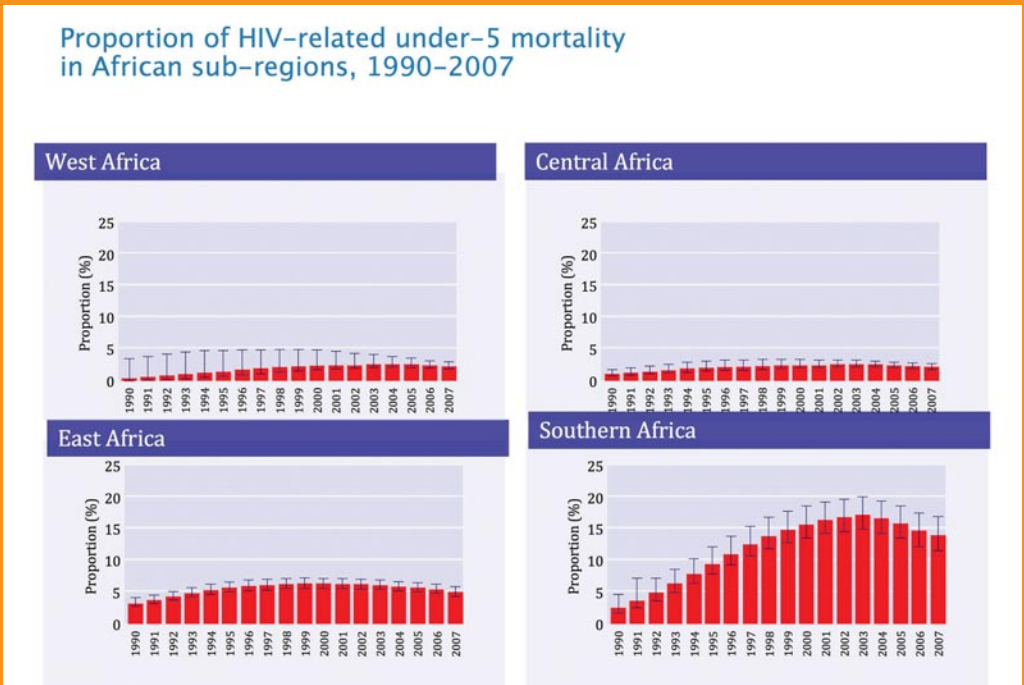
Globally, three regions are making good progress towards MDG4 on child mortality – the Americas region, the Europe region and the South-east Asia region. By contrast, the Africa region has made insufficient progress on **MDG 4**.

The Americas region, Europe region and Western Pacific region are also doing well in relation to MDG5 on maternal health. Three regions – Africa, Eastern Mediterranean, and South-East Asia – are facing challenges regarding **MDG5**.

For **MDG6**, on HIV/AIDS, TB and malaria, the WHO Eastern Mediterranean, South-East Asia and Western Pacific regions are making good progress.

For other indicators, while there has been some progress, it is often uneven and fragile. Overall, the weakest progress is in Africa.

Global trends in HIV/AIDS



AIDS is associated with an estimated 2% of childhood deaths globally, a rate that doubles in Africa with 4% of under-five deaths associated with HIV and AIDS. In sub-Saharan Africa the proportion of HIV–related child deaths under five years of age reached a peak at 5.6% in 2003 and began to decline to 4.6% in 2007. The direct relationship between HIV and child mortality is therefore relatively small. However, in Southern Africa, high HIV prevalence and lower levels of under-five mortality due to non-AIDS related causes means that the overall proportion of under-five deaths that are indirectly related to HIV is larger. Numbers of AIDS deaths among children are high to very high in a number of African countries.

In 2003, an estimated 17.2% of all deaths among children less than five in Southern Africa were HIV-related. By 2007 this figure had declined to 14%. This decline is due to family planning, successes in HIV prevention among adults, and prevention of mother-to-child transmission, among other factors.
Source: Black et al., 2010 for the Child Health Epidemiology Reference Group of WHO&UNICEF

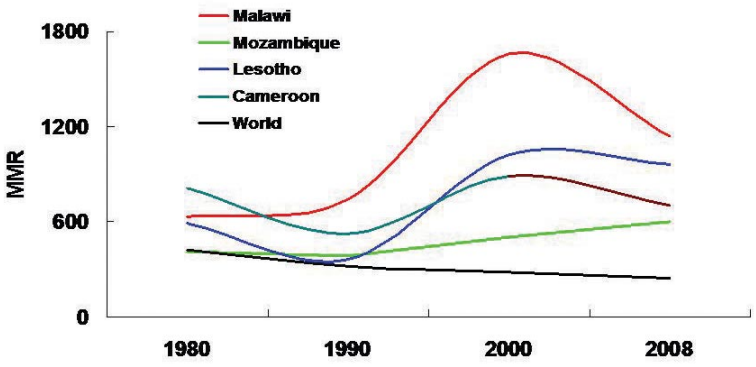
Global trends in leading causes of women's mortality

Leading causes of death among women of reproductive age (15–44 yrs)

World			
Rank	Cause	Deaths(000s)	%
1	HIV/AIDS	682	19.2
2	Maternal conditions	516	14.6
3	Tuberculosis	228	6.4
4	Self-inflicted injuries	168	4.7
5	Road traffic accidents	132	3.7

Source: Women and Health report, WHO, 2009

Maternal Mortality Trends, 1980-2008



Source: Hogan et al, 2010

The three leading causes of death in women of reproductive age are HIV, maternal mortality and TB. Maternal mortality has increased significantly because of HIV/AIDS in countries like Lesotho and Malawi.

Recent estimates draw attention to the important adverse effect of the HIV epidemic on maternal mortality, especially in countries in Southern Africa with large HIV epidemics (60,000 deaths among women with HIV who were pregnant in 2008).
As these figures show, women living with HIV experience increased vulnerability to complications, and even death, during pregnancy, childbirth and shortly thereafter. The AIDS epidemic in Southern Africa has slowed progress in reducing maternal mortality in sub-Saharan Africa (and therefore globally) and is threatening progress toward MDG5, though there are hopeful signs that some countries are reversing this trend.
Source: Abdool-Karim et al. 2010

Dr de Zoysa outlined current concerns over reaching the MDGs.

At the country level she highlighted concerns over fragmentation of aid and health services compounded by inequality, and a backlash against the withdrawal of the state that is stirring a major political debate, not just restricted to the health sector.

At the global level, there is a general concern over failure to reach the MDGs and the focus on limited and packaged aid interventions that are seen as short-sighted. There is growing interest in creating country-specific plans for health with one funding mechanism.

For integration to work she called for strong leadership and aid harmonisation. There is a need for greater political commitment to health policy and action, and building stronger health systems.

She ended by outlining a range of opportunities to make a difference:

- Regional commitments (such as the Maputo Plan of Action and Campaign on Accelerated Reduction of Maternal Mortality in Africa)
- The UN Secretary-General's Global Strategy for Women's and Children's Health and accountability framework
- The Muskoka Initiative, intended to generate additional funding for a comprehensive and integrated approach to accelerate progress towards MDGs 4 & 5
- Commitment to integrating approaches to maximise health outcomes related to MDGs 4, 5 and 6, while strengthening health systems
- Global mobilisation around scaling up prevention of mother-to-child transmission of HIV with the aim of moving towards elimination of this mode of HIV infection
- The Global Fund Board's decision to explore options for optimising synergies with Maternal and Child Health; Global Fund replenishment
- Other programming and financing opportunities (e.g. the US Government's Global Health Initiative and the President's Emergency Plan for AIDS Relief).

SESSION ONE DISCUSSION

Financing

A representative from DFID commented that we need to encourage free health services for pregnant women and children. The Sierra Leone experience shows that now, with health user fees banned, health centres are packed with women and immunisation of children has trebled.

Dr. Sridhar suggested that the global community needs to work towards more sustainable financing models for health, aiming in 20-30 years to finance health from domestic not donor budgets. Health ministers, economists and donors should sit down together and look at these questions. Donors currently see health as a black hole that they pour money into, but it is not clear what a sustainable model for supporting the provision of healthcare would look like.

The point was made that governments need to strengthen health systems at the national level. Although we see some progress in stronger states, there is not enough financing for fragile states and they are getting further left behind.

Accountability to citizens

In response to Okello's presentation the question was raised, if the proliferation of health and development charities is smothering local health initiatives, should more money therefore go towards supporting local initiatives? In response, Okello suggested that:

"When money is provided by donors, they need to consider where it is needed most. NGOs need to be more accountable to local governments and donors more accountable to citizens. Investment is needed in primary health care, not workshops in cities."

Another participant asked about how civil society is funded and how it can participate and be integrated into national strategies and structures? Okello made the point that the term civil society is broader than NGOs as it incorporates all citizens. We need national integration and communities to work together to achieve the Social Contract or people become too focused on money instead, he said.

One speaker pointed out that civil society is different in the North and South. In developing countries people don't have the same freedom of speech and rights. In the North, civil society acts as a whistle-blower to raise issues and expects parliament to take them up - the link between government and civil society is important. The reality of democratic processes is very different in developing countries and the concept of NGOs is fairly young in Africa.

The real issue is how to mobilise people and communities. The biggest changes have come from within social movements, such as in Brazil.

SESSION 2 –
The EU MDG position and implications for the UK

Overview

Chair: Paul Sommerfeld, Action for Global Health and Chair of TB Alert

Speakers: Marielle Hart, Head of EU policy, Stop AIDS Alliance
Dr Jenny Amery, Head of Health Profession, DFID
David Mepham, Director of Policy, Save the Children UK

This session aimed to put forward the EU and UK Government's priorities for the United Nations' MDG Review Summit[1], alongside UK and European civil society's expectations for the Summit. Additionally, it aimed to highlight issues that could affect the Summit delivering a strong, unified and ambitious way forward to achieving the health MDGs by 2015, and consider how any obstacles could be avoided.

Chair: Paul Sommerfeld, Action for Global Health and Chair of TB Alert

Sommerfeld explained that the session would address how key players, namely the EU and UK, have been preparing for the September Summit, what they are likely to emphasise and how NGOs could respond. The session aimed to inform organisations about the decision-making processes and what advocates could do to influence the positioning of both the EU and UK. In recognition of the fact that the EU is the largest donor source for overseas assistance, EU citizens have the responsibility to influence – through our governments and decision-makers – how European Member States and the EU collectively act on the MDGs.

1The UN MDG Review Summit will be taking place in New York from 20-22 September 2010. It presents a critical opportunity for world leaders to come together and commit to accelerating progress towards the MDGs.

Marielle Hart, Head of EU policy, Stop AIDS Alliance

Hart set out clearly the opportunities and challenges of the EU position for the MDG Review Summit in September. Hart outlined what the EU's current positions are, how they were reached, what the process leading up to September will be and the potential fora for NGOs to influence the outcomes of the Summit. She also drew attention to some remaining issues of concern for NGOs to focus their advocacy work on.

The current EU position comes from months of negotiation between the 27 Member States which incorporated the following steps:

- Adoption of the EC "April package" – a 12 point Action Plan for international development
- Adoption of thematic European Commission Communications on health, gender, education and food security
- Adoption of Council Conclusions by Foreign Affairs Ministers
- Adoption of European Council Conclusions

Process:

- European Commission proposal (annual April package)
- Consultations with member states, UN, civil society
- European Parliament advising
- Council of Foreign Ministers negotiations and adoption of the Council Conclusions (these are often less ambitious as they are a compromise between 27 member states).

Hart highlighted some key aspects of the EU position for the MDG Review Summit that she identified as positive. Within the position there is recognition of the inter-linkages between the MDGs, with a strong focus on the responsibility of (developing country) partner countries and a clear rights-based approach to health access. There is also recognition of the need for democratic governance and meaningful involvement of key stakeholders in the process of achieving the MDGs, with an emphasis on the need for broad inclusive partnerships with civil society regarding decision-making.

Regarding developing countries, there is special attention given to countries most off-track on the MDGs and there will be a list of priority countries. There will be a re-affirmation of ODA commitments (0.7 percent by 2015) and ODA will be on the agenda of the European Council annually for the first time with yearly reporting requirements.

In addition, there is recognition of the need for innovative financing for global health and the need to increase attention to the aid effectiveness principles of mutual accountability and transparency.

There is further evidence of the EU's positioning around global health from the recent European Council Conclusions, 'The EU's Role in Global Health' and highlights here include:

- Strong promotion of the right to health
- Support for social protection mechanisms and the removal of user fees
- Support for increased leadership of WHO

- IHP+ (International Health Partnership and Related Initiatives) acknowledged as the preferred framework for delivering effective aid
- One monetary framework for the health sector

Despite these positive signs, there are some serious concerns about the EU position. First among these is that there are too many calls, yet no concrete actions or clear financial commitments proposed. Hart called for a detailed EC Action Plan to support the achievement of the health-related MDGs. Of particular concern is the lack of clarity on how the EU will support social protection, human rights and the inter-linkages between MDGs, as well as what criteria will be used to select priority countries, for the EC's official development assistance (ODA) for health.

The EU's position for the Summit makes no reference to national ODA legislation (as in UK and Belgium) or binding national yearly timetables. There is no reference to the EU Agenda for Action on MDGs adopted in 2008 after much work by NGOs. There is a lack of emphasis on managing for results regarding the aid effectiveness agenda and a lack of clarity on innovative financing for development.

Next steps will include Member States preparing their bilateral positions and commitments for September; the preparation of the EU MDG Action Plan after the Summit; a proposal for reallocation of €700M to achievement of the MDGs; and plans for an EU/US dialogue on the MDGs, with a common road map for 2010-11.

Dr Jenny Amery, Head of Health Profession, DFID

The presentation focused on the UK Government's expectations for the MDG Review Summit, their priorities and areas of concern. Despite some good progress on the MDGs, a great deal remains to be done. Following the Coalition Government's announcement that it will protect development funding, Amery highlighted the valuable role the NGO sector can play by both holding the government accountable and helping communicate to the UK public the importance of international development in difficult economic circumstances. There is still an opportunity to influence decisions as budgetary reviews are taking place.

Dr. Amery thanked AfGH for the opportunity to speak. The new Coalition Government was barely six weeks into office, but so far the signs were very encouraging. Andrew Mitchell, the Secretary of State for International Development, is highly committed to the health agenda and the Prime Minister has put MDG5 on reproductive health at the top of his agenda. Amery acknowledged the widespread disappointment with the outcomes of the recent G8 and G20 meetings as lost opportunities to focus resources on maternal and child heath. However, despite failure to come up with funding commitments, she felt there were some positive agreements made.

The Government is undertaking three spending reviews, which will include bilateral and multilateral funding commitments, to be finalised in the autumn. Currently, the UK does not have finalised budgetary commitments after 2011. The US is also unable to make funding commitments as it does not have congressional budgetary approval after 2011. Amery acknowledged that this leaves a sense of uncertainty about the future, but it would be vital to build on the lessons of the reviews and not just carry on as before. She was reasonably hopeful the reviews would come up with an encouraging outcome.

The Government sees the MDG Summit as an opportunity to advance progress on MDG5 on reproductive health in particular. Amery confirmed that:

"At the Summit, the Government will renew its commitment to ODA of 0.7 percent by 2013, and renew the commitment to legislation for this. But, in the context of the economic downturn, we all need to communicate effectively about the importance of development work, as well as the moral imperative for overseas development aid."

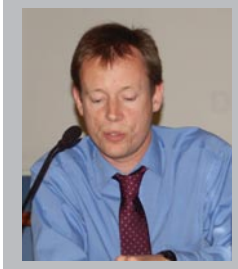
DFID will have to ensure that projects have maximum impact on the ground. Amongst the Government's priority global health issues will be nutrition, reproductive health, family planning, safe abortion and malaria.

There will be four 'headline' issues for DFID:

- **Transparency** – informing on what is spent
- ***Results*** - what has been achieved
- **Innovation** – not more of the same
- **Value for money**

Amery ended by observing that although it was early days for the new Government, she was encouraged that the UK has the leadership required to accelerate progress towards the MDGs. However, as public sector cuts become a reality, it will be essential to work with civil society to show that money is being spent effectively and can make a difference.

David Mepham, Director of Policy, Save the Children UK



Mepham's presentation provided an NGO perspective on the MDG Summit. He outlined six key areas of concern regarding the health-related MDGs which still require advocacy efforts. He expressed disappointment at the lack of commitments made at the recent G8 Summit, given the scale of need, but commended the Canadian and British governments on pushing for maternal, newborn and child health. Civil society would need to push hard for change in the run-up to the MDG Summit in September.

Six key points on the health MDGs:

1. Priority to maternal, newborn and child health
MDGs 4 and 5 are most off track and the human and development costs are enormous. Around nine million under-fives die every year and around 500,000 women die in childbirth and as a result of complications in pregnancy. The pace of progress is too slow. There is a need to direct more resources to child health. Simple interventions exist that can save almost all these lives.

2. Continuum of care
Maternal and child health are inextricably linked, but need stronger and more integrated health systems providing a continuum of care, and not sectoral or vertical responses to specific diseases. There is a growing focus on MDG5 on maternal mortality, but this cannot be tackled in isolation from newborn and child health, nor the broader agenda of strengthening health systems and delivery mechanisms. In recent years DFID has been an effective champion of this approach and Mepham stressed that he hoped the new Government will continue to support this. He welcomed the Government's focus on family planning. In the context of sexual and reproductive health and rights family planning has been neglected for too long. Support needs to be given to health systems and services that can provide preventive and curative treatments. DFID has been a leader on this in recent years.

3. Broader determinants of health
Health advocates should push the UK Government and EU to tackle the broader determinants of health such as malnutrition, water and sanitation. Thirty five percent of child mortality is linked to maternal and child malnutrition. New momentum is building on nutrition. Mepham commended DFID's excellent strategy on nutrition, and highlighted a recent speech by Hilary Clinton and a forthcoming EU strategy as evidence of the incorporation of the broader determinants of health.

4. Equity matters
There are still huge disparities between different countries and sectors of society regarding maternal mortality rates. Gender equity and overcoming poverty are key.
Mortality can be two or three times higher amongst the poorest 20% compared to the richest. But cost, caused for example by user fees, is a barrier to achieving better health outcomes. What is needed is a basic package of care, free at the point of use and targets for reducing inequality. Save the Children's work suggests that putting more focus on the very poorest can help accelerate progress towards MDGs 4 and 5.

5. Increase resources
There are widely different estimates for what is needed to achieve the health-related MDGs. The High Level Taskforce on Innovative International Financing for Health Systems estimated that it was US$31 billion in 2008, and needs to rise to US$67-76 billion by 2015. So there is a significant gap – governments in low- and middle-income countries need to be generating revenue so that they are not just relying on donor resources to meet this gap.

6. Accountability
The role of civil society is important in ensuring accountability of donors and governments. There needs to be progress on work with civil society partners in developing countries in order to put pressure on all our governments over the next five years to meet the MDGs.

SESSION 2 DISCUSSION

Financing and fragile states

The panel were asked for their positions on changing the mandate of the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) and GAVI. Mepham suggested broadening the Global Fund mandate to global health rather than being restricted to HIV/AIDS, malaria and TB. Hart responded that the EU's support to the Global Fund has achieved significant results and the European Commission itself supports the broadening of the Global Fund mandate.

The point was made from the floor that the role of philanthropy in countries like India could be important in the future. There should be a push for sustainable financing and moving away from fickle changes in financing.

The important question was raised in relation to Amery's presentation - how can donors marry "value for money" with the need to support fragile states? Amery agreed that this was a valid important point and the "value for money" approach should not apply to fragile states. Hart questioned how the EU would distribute the €700 million set aside for priority countries, would these be fragile states?

Climate change

A junior doctor from London drew attention to the fact that the link between climate change and health had not been mentioned in the session. It was important to recognise the impact of our high carbon world on reproductive health, water, malaria etc. Mepham agreed, highlighting a Lancet study that concluded that climate change would seriously impact on disease and development. This is a much neglected connection. Amery agreed that the health dividend of low carbon economies is very important. DFID is having discussions on how to mainstream climate change and health.

MDG Summit expectations

Panellists were asked what they thought would be a successful outcome of the MDG Review Summit. Amery stated that a good outcome from DFID's point of view would be a renewed commitment in money and what governments are trying to achieve. She is reasonably optimistic. Hart thought that a successful outcome would be a clear commitment to an Action Plan and specific, concrete commitments. Mepham said equity and disparities must be highlighted and targets agreed. Accountability is vital – governments must report back regularly on their progress.

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SESSION 3:
Meeting the health MDGs in sub-Saharan Africa and the African expectations for the UN MDG Summit

Overview

Chair: Caroline Halmshaw, Head of Policy & Advocacy, Interact Worldwide

Speakers: His Excellency Berhanu Kebede, Ethiopian Ambassador to the UK
Rotimi Sankore, Coordinator, African Public Health Alliance/15%+ Campaign (Nigeria)
Gerald Tushabe, Health and Human Rights Advisor, Action Group for Health, Human Rights & HIV/AIDS (Uganda)
Hon Saudatu Sani MP, Chair of Network of African Parliamentarians on the MDGs (Nigeria)

The third session of the day focused on what progress has already been made towards the health-related MDGs and the serious challenges that remain in many countries. It provided a range of perspectives and opinions from Ethiopia, Uganda and Nigeria on African expectations for the MDG Review Summit. In particular the session highlighted the role that African governments and civil society could play in ensuring the health-related MDGs are met.

Chair: Caroline Halmshaw, Head of Policy & Advocacy, Interact Worldwide

Halmshaw emphasised that this session would be a pivotal one for the day's discussions, aiming to highlight the priority issues in Africa and providing an insight into African countries' preparations for the MDG Review Summit.

His Excellency Berhanu Kebede, Ethiopian Ambassador to the UK

His Excellency presented the Ethiopian government's approach to the health-related MDGs, some of the significant progress that had been made, and what priorities would be with five years remaining to meet the MDGs. His Excellency's perspective was that Ethiopia is one of the best-performing countries on the MDGs with MDG4 – child survival – likely to be met by 2015. In Ethiopia the MDGs are linked to the national development strategy and health sector development programme. This shows clear linkages between poverty alleviation and health improvements. The emphasis is on the least privileged, particularly pastoralists who make up 83% of the population.

His Excellency said it was an honour to speak about Ethiopia's achievements in working towards the health-related MDGs.

Ethiopia's strategy for meeting the health-related MDGs includes:

- A new health extension programme providing community health services in rural, urban and pastoralist communities
- Expansion of primary healthcare centres
- A national reproductive health strategy
- A child survival strategy
- A national HIV/AIDS strategy
- A healthcare insurance and financing strategy.

His Excellency expressed that Ethiopia is taking an **innovative approach** to meeting the MDGs. Their **Health Extension Programme** ensures access and equity at all levels of society. It is family and community-based, targeting households to improve health status, using technology and encouraging community involvement. Over 31,000 health workers have been trained and deployed throughout the country.

Ethiopia has one of the highest child mortality rates in the world. Their target is to reduce child mortality by two thirds between 1990 and 2015. The National Child Survival Strategy addresses major causes such as pneumonia, malaria, and HIV. It is focused on the poorest and most marginalised children. A comprehensive expanded programme on immunisation has been set up, increasing vaccine coverage. Studies now show child mortality rates are declining significantly and Ethiopia is one of the countries expected to meet MDG4 by 2015.

Ethiopia is a country with one of the highest maternal mortality rates in the world. There are ambitious targets to reduce rates by 2015, with the National Reproductive Health Strategy aiming to reduce maternal mortality rates by three quarters by 2015.

To reach MDG6, there is a plan of action for Universal Access to HIV Prevention and Treatment. This will enhance implementation, increase social mobilisation and integrate services to alleviate the impact of HIV and AIDS. A malaria prevention and control programme has been developed as part of the WHO Roll Back Malaria campaign. Free malaria nets were distributed to each household. On TB control, Ethiopia needs to do more as detection rates are only 31%.

During the five years remaining to meet the MDGs, Ethiopia hopes to build on what has been achieved so far, especially to improve areas such as maternal mortality on which there has been limited progress. His Excellency made special mention of the British government to thank them for their support in helping Ethiopia to move forward on the health-related MDGs.

Rotimi Sankore, Coordinator, African Public Health Alliance/15%+ Campaign (Nigeria)

Sankore's presentation gave hard-hitting evidence on the scale of the challenges Africa faces to meet the MDGs. Sankore highlighted the importance of gathering accurate data and setting priorities in order to have a realistic picture of how to proceed.

Sankore began by stressing the importance of establishing the scale of the challenges in Africa in order to put the problems into perspective. When the 15%+ Campaign was launched in 2006, it went through all the relevant reports to try to scope the health and development challenges, to understand the extent of the problems before deciding what needed to be done. They found that in the previous four to five years, Africa was losing around eight million lives a year from HIV/AIDS, TB, malaria and child mortality. The picture became even more alarming when they put together all the modelling. It was equivalent to wiping out a large country like Kenya in one year. But there have been some improvements, and the calculations are getting more accurate.

What is being spent on health promotion globally?

The WHO recommends that governments spend at least US$40 per capita on health in order to provide a universal basic package of services. African countries spend an average of US$34 per capita on health while some countries invest as little as US$2 per capita. In total, 34 African countries spend less than the US$40 per capita recommended by the WHO. In comparison, the average government per capita investment in health in Europe is US$1,252.

Sankore argued strongly that investing in health cannot be separated from investing in the economy and society as a whole:

"A country cannot grow if its people are dying or sick. It is unacceptable that disease prevalence is so high in some countries that people finish their education then start dying. In a few years some of these countries may not exist at all, the disease burden is so enormous."

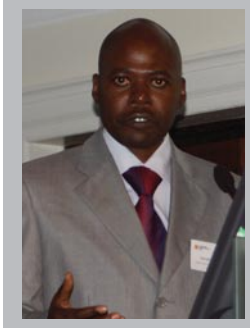
Other key points raised include:

- There is a need to improve on the Abuja Target of 15% of the national budget allocated to health.
- Without adequate doctors and nurses nothing will be achieved. For example, Malawi has 270 doctors for a population of just under 13 million people, whereas Cuba has 72,000 doctors for a similar population.
- Europe needs to train more health workers instead of taking them away from developing countries. Cuba trains some doctors and nurses for free and exports them to other developing countries. Europe should do the same.
- For the MDG Review Summit:

"Governments need to assess country-by-country what the priorities are and set targets corresponding to national needs, not international ones. How many more doctors do we need? What are the gaps and how long will it take to fill them?"

Sankore concluded by stressing that the basic groundwork for governments measuring and knowing what they need to do to meet the MDGs has not been done. This is key as global solidarity is not enough.

Gerald Tushabe, Health and Human Rights Advisor, Action Group for Health, Human Rights & HIV/AIDS (Uganda)



Tushabe presented a detailed examination of the challenges facing Uganda in making progress on the health-related MDGs. In his assessment, the likelihood is that most African countries will not meet most of the health-related MDGs in the next 5 years, despite some improvements, such as on child mortality. The euphoria of agreeing to the MDGs waned as it became clear that achieving them would be problematic. A holistic approach will be needed for long-term development. Despite the Abuja target, 41 sub-Saharan African governments allocate less than 15% of their national budgets to health. In 2008 Uganda allocated only 8.2% of its national budget to health.

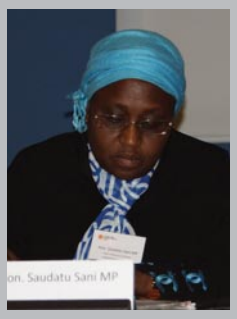
Key points raised include:

- Amongst the challenges to progress faced are that many sub-Saharan African countries are dependent on aid, human resources are unequal, there are severe drug shortages and the infrastructure is weak.
- Despite a desperate need for them, some health funds are not used in full. The Ugandan government, for example, failed to spend some health funds that it had.
- There are prolonged procurement procedures.
- Mismanagement of public resources and failure to promote accountability is a big problem. For example, in Uganda in 2005, five Global Fund grants worth US$213 million were suspended.
- Human resources for health challenges are significant with staff levels low, including shortages of key categories of staff. Only 56% of health positions are filled and there is skewed distribution with higher levels of skilled personnel near cities but not enough in rural areas.

Recommendations to overcome these challenges include:

- Advocacy to bring attention to national budgeting processes
- Strengthening instruments of accountability such as audit and procurement procedures
- Empowering parliamentarians so that they can better exert their influence
- Promoting the role of civil society
- Directing more attention to training skilled health workers and creating conducive conditions to retain them

Hon Saudatu Sani MP, Chair of Network of African Parliamentarians on MDGs (Nigeria)



Hon Sani presented Nigeria's approach towards the health MDGs and, in particular, the role of Parliamentarians in working with government and civil society to make progress. In 2005 Nigeria was able to negotiate for debt relief to be channelled to development and help the country make progress in meeting the MDGs. Funding for the MDGs has increased through the annual budget and Nigeria now has an annual health budget of approximately US$1 billion.

In 2010 the Network of African Parliamentarians was set up and Hon Sani was elected as Chair. Her election was based on Nigeria being a country with an MDG Committee in its House of Representatives. The Network oversees the work of African parliaments around the MDGs and improves accountability.

Nigeria has a funding gap of US$248 billion that needs to be filled if the MDGs are to be met by 2015. But rather than just waiting for aid to come in, Nigeria is keen to work in partnership with donors and others to improve progress towards the MDGs. Nigeria is encouraging other African countries to set up parliamentary MDG Committees to work alongside government and civil society, addressing corruption and aiming to end poverty.

Lessons learned from Nigeria's experience with the MDGs:

- National ownership of development strategies is essential to success and international cooperation should support national development strategies.
- Economic growth is necessary but not sufficient for progress. The growth process must be inclusive and equitable to maximise poverty reduction.
- Hard-earned gains can be reversed by economic and other shocks. Hence, countries need forward-looking macroeconomic policies to support broad-based stable growth.
- Adequate, consistent and predictable financial support is needed, with a coherent and predictable policy environment, both at national and international levels.

The challenges faced by Nigeria in making progress on the MDGs include:

- Lack of political will when the MDGs were first introduced, hampering adequate resource allocation
- Environmental hazards caused by climate change
- Lack of adequate and predictable international financing
- The global economic crisis affecting Africa's economies at the same time as overseas development aid has been reduced because of the crisis.

Other key points that Hon Sani stressed include that African countries must come together with a renewed commitment to build on achievements so far and bridge the gaps identified. What is needed is an accountability framework that consolidates global aid commitments, linking them to results with timelines, and establishes monitoring and enforcement mechanisms. There should be a further focus on building strategic partnerships amongst African countries with a view to enhancing Africa's visibility in development platforms. She stressed that the African Union Summit in Uganda should address mismanagement of funds.

In concluding, Hon Sani said the current impetus – if sustained and accelerated – can achieve major progress on poverty, education, water, maternal health and child health. African governments need to invest in their infrastructure, build their human resources and be more accountable. Above all, organisations in the North and South need to work in partnership for the MDGs to be achieved.

SESSION 3 DISCUSSION

Role of Parliamentarians

A representative from the Global Fund commented that some parliamentarians do not appear to know what the Global Fund is doing in their countries. He asked how the organisation could strengthen its accountability and raise awareness, and whether the African Network of Parliamentarians for the MDGs is tackling this problem. Hon Sani responded that they were asking governments to bring all funds through Parliament so that they can monitor government decisions. They would be happy to work with the Global Fund on this issue.

Another questioner from the floor asked whether DFID has a bilateral agreement with Nigeria and whether it involves Parliament when making funding commitments. Hon. Sani commented that this type of direct consultation was not in place at the moment but that parliamentarians have asked for this information to ensure greater accountability over donor funding and what it was being used for.

His Excellency Kebede commented that in Ethiopia all bilateral funding goes through Parliament. Parliament has the right to ask members of the executive branch at any time to report on their activities.

Criminalisation of homosexuality as a barrier to healthcare

A participant asked the panel whether they thought the criminalisation of sexual behaviour was hindering HIV/AIDS prevention efforts. Hon Sani commented that in Nigeria the issue of same-sex marriage had led to volatile debates as many want to protect the institution of marriage. Poverty is a greater priority for most people. Sankore added that this is a global problem and not peculiar to Africa, in addition human rights in a broader sense will have to be improved. The reality is that life and death issues have to come first.

SESSION 4: The changing global health architecture and what this means for achieving the health MDGs

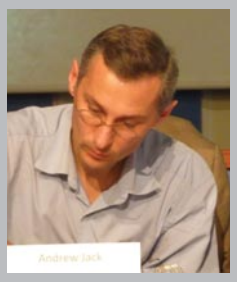
Overview

Chair: Andrew Jack, Health Correspondent, Financial Times

Speakers: Joe Cerrell, Director, Europe Office, Bill & Melinda Gates Foundation
Richard Manning, Vice Chair of Replenishment, Global Fund to Fight AIDS, TB and Malaria
Dr Alvaro Bermejo, Executive Director, International HIV/AIDS Alliance

This session reflected on the discussions and debates that had taken place during the day, and presented ideas on changes to the global health architecture that could help to ensure that the health-related MDGs will be met by 2015. In particular, the session explored how existing health financing mechanisms and new innovative forms of financing could support the achievement of the health MDGs.

Andrew Jack, Health Correspondent, Financial Times



Jack reflected on the useful discussions that had taken place throughout the day and emphasised that the role of this session was to bring out the broader advocacy and policy messages for the MDG Review Summit. He highlighted that this is not an easy time for international funding for development with difficult discussions taking place about the structure of international agencies, and funding efficiency and effectivene

Joe Cerrell, Director, Europe Office, Bill & Melinda Gates Foundation

Cerrell's presentation focused on the work of the Bill & Melinda Gates Foundation (BMGF) and the challenges facing financing organisations in a difficult economic climate. He emphasised two key points - that development actors need to get better at conveying the impact and results of investments, and that more work needs to be done to find future innovative solutions to development, and health, challenges. He commented that:

"Development actors need to be more efficient, get more out of aid, and need to show donors the money is being used effectively."

Cerrell expressed his pleasure in addressing the meeting as the BMGF was involved in the creation of AfGH and continues to fund the network. Cerrell now runs the European office for the Foundation, based in London, and is keen to connect European donors with US ones.

The BMGF is passionate about vaccines and immunisation. Cerrell highlighted smallpox eradication and the reduction of polio incidence by 99% as examples of what can be achieved. The BMGF is particularly excited about two new vaccines for Pneumococcus and Rotavirus. A video was shown on the BMGF Rotavirus vaccination project in Nicaragua where 80% of children under five have been vaccinated against Rotavirus. GAVI plans to get the vaccine to 44 of the poorest countries globally by 2015.

Amazing progress has been witnessed in some areas. Child mortality rates have dropped dramatically, but there are still big challenges ahead. Organisations will have to become more efficient and get more out of existing aid flows.

On maternal and child health, some donors are increasing their commitments – the BMGF has committed US$1.5 million over the next 5 years. But beyond aid there need to be more creative mechanisms for funding health, including a financial transaction tax, or following the example of 'Massive Good', a new air traveller voluntary levy. Cerrell also flagged the replenishment of GAVI and the Global Fund as key opportunities to make more aid for health available.

Richard Manning, Vice Chair of Replenishment, Global Fund to Fight AIDS, TB and Malaria

Manning focused on the forthcoming replenishment of the Global Fund taking place in October 2010, a key event for focusing advocacy efforts. At a difficult time economically, the future is unpredictable and donor countries need convincing of the importance of development and global health work.

Key points raised throughout the presentation include that there is a need for a mix of aid instruments in order to make progress on the health-related MDGs. Different donor and recipient priorities need to be addressed. Additionally, donors need to be more consistent in what they say in different fora.

Manning stressed the inter-relationship among MDG outcomes. His view is that there are major advantages in multilateral approaches, such as those taken by GAVI and the Global Fund. Local-led decision making mechanisms are important and they have to make sense at the country level.

The Global Fund has become the main vehicle for donors to channel massive new resources to HIV/AIDS, TB and malaria. It has created a development financing mechanism that works. It is also the largest multilateral contributor to the MDGs, providing two-thirds of international funding for malaria and TB and a fifth of global funding to HIV.

The question was raised earlier in the day: should the Global Fund expand to cover broader global health? Clearly this would only be possible if additional resources are made available. He warned that the global health 'community' should think twice before adding new funding mechanisms into an already complicated mix of structures.

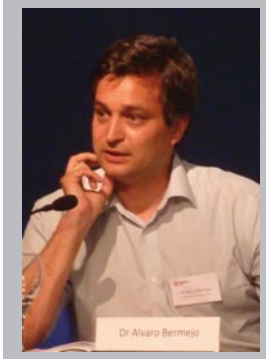
Around US$13 billion to US$20 billion is needed for the upcoming Global Fund replenishment. In the last replenishment US$10 billion was pledged. This year's replenishment conference takes place on 4-5th October 2010 in New York with the Director General of the WHO chairing.

There are some encouraging signs in regards to the Global Fund replenishment. Japan and the EU have indicated that they will probably increase their pledges for 2010. But the overall picture is mixed.

"It will be a major challenge to get close to any of the three funding scenarios without some donors shifting their positions significantly. So health advocates still have a lot of work to do."

Innovative financing could help (for example Debt2Health), but 95% of the Global Fund's financing comes from traditional public sector donors. It will be necessary to broaden the base to bring in more funds from the private sector, foundations and emerging economies. The UK has said it will maintain ODA levels, and they are reviewing their multilateral commitments, but advocacy by civil society will be important in order to ensure that the Coalition Government makes a significant contribution to the Global Fund.

Dr Alvaro Bermejo, Executive Director, International HIV/AIDS Alliance



Bermejo's presentation emphasised the interdependence of the health MDGs and the need to respond to them as a whole, as well as the importance of accountability.

Key points raised include:

- The criminalisation of some groups in society is having a detrimental effect on HIV and AIDS work and donors should be looking at which countries they fund and address this issue.
- With an increasingly complex health architecture, more needs to be done to ensure that the patient and the community remain the driving force of work around global health.
- Advocates need to address the lack of transparency of global corporations and the signing of secret contracts between governments and corporations.
- The 'projectisation' and start-stop nature of aid is one of major causes of inefficiencies and failure to make progress on development goals.
- Whether or not the Global Fund expands its mandate, it can do even more with its current mandate.

Bermejo concluded by stating that the stark reality of health in Africa is that the poorest are paying out-of-pocket to access health care. They are the ones who can least afford it. He recommended that the way forward should be to build on the Abuja target, create a 'Social Contract' as mentioned earlier, and establish a financial transactions tax to support it. People have said this would be impossible to collect but the same was said about bringing in income tax in the UK and this was done successfully.

SESSION 4 DISCUSSION

A question was directed to Joe Cerrell, representing the BMGF, and Richard Manning from the Global Fund: would they like to see user fees eradicated? Cerrell responded that they do not work on in-country policies.

Another participant raised the issue of corporate accountability and the role of the private sector, arguing that pharmaceutical companies have a key role to play. Manning agreed and commented that the largest source of drug supply for the Global Fund comes from Indian pharmaceutical firms and they are included on the Global Fund board. Continuing, Manning said that the Global Fund would like the private sector to boost its contribution to the Global Fund in this replenishment cycle. Cerrell added that the BMGF has funded a ranked index on medicines and are doing another on nutrition. Collaboration works best when it is not just a corporate social responsibility effort but involves the whole organisation up to the CEO.

Another question was raised: how do you measure quality outcomes of the MDG Review Summit? Cerrell responded that his big ask for the Summit, and what would be the measure of its success, was a universal package of basic healthcare free at the point of service. Manning suggested the successful replenishment of the Global Fund as a key first step to show real outcomes from the Summit. Bermejo called for putting the mechanics in place to finance a basic universal health package.

SUMMARY AND CLOSING REMARKS

Mike Mandelbaum, Chief Executive, TB Alert

Mandelbaum highlighted the wide range of perspectives that had been shared throughout the day.

He summarised three main advocacy points from the day's proceedings:

1. The EC positions around meeting the health-related MDGs and the September MDG Review Summit are good but they need to be linked to a **concrete EC action plan on the MDGs.**

2. In the UK, the health worker issue has been raised and there is a **call for the UK to train more of its own health workers**. Health advocates are used to working with DFID but not the Department of Health. There is a need to think in new ways, which mechanisms to use, and who to work with.

3. Jenny Amery from DFID suggested we **work together to communicate to the public** and convince them of the need for overseas aid budgets, while other government departments face stark budget cuts. This should not imply a trade off between services in the communities and money on international development. The public will be asking development advocates questions and they need to be ready to respond.

4. We need to focus efforts on the **Global Fund Replenishment** process and push on pledges made in October to be a first show of commitment to follow on from the MDG Review Summit.

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