Leading by Example – Protecting the most vulnerable during the economic crisis

The Global Campaign for the Health Millennium Development Goals 2009

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We acknowledge with gratitude the individual and collective contributions by the global and international leaders listed above.

The Global Campaign for the Health Millennium Development Goals brings together a number of actions and initiatives, all aimed at fulfilling the promises given by world leaders nine years ago.

The Report of 2009 provides an update on the efforts being made by countries and institutions in protecting women and children during the global economic crisis.

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Chapter One

Overview

Leading by example:
protecting the most vulnerable – women and children –during the economic crisis

This year, 2009, will be a key one for the world's poorest. The global economic crisis has already driven more than 50 million into extreme poverty, particularly women and children, so the need for action is urgent. From previous crises we know that set-backs for the poorest take a long time to put right.

The recent actions of governments, international agencies and civil society have begun to prioritise the health of mothers and children. This has given hope for accelerating progress towards the Millennium Development Goals 4 & 5 (aiming to reduce child mortality by two-thirds and maternal mortality by three-quarters by 2015), the most neglected and impeded of the MDGs. However, this progress is now threatened by the most severe global economic crisis since the 1930s, especially in low-income countries.

Social protection is immediately threatened when an economic crisis strikes. Mothers, infants and children are among the most vulnerable, so we and others are taking action to protect them – building on lessons from previous economic crises in our own countries and elsewhere. This period of economic crisis would be precisely the wrong time to step away from our commitments to meet the basic needs of the world's poorest people. These are times for increased commitment and actions, and for leadership through example.

The Network of Global Leaders includes 12 leaders from developing and donor countries. We are committed to provide political backing and advocacy at the highest possible level for the Global Campaign for the Health MDGs, and to increase our efforts to save women and children's lives and reach the MDGs 4 & 5. Our action includes:

Honouring our commitments

- Those of us that are developing countries are all maintaining our health budgets. Some of us (Brazil, Chile, Indonesia and Tanzania) are continuing to increase them. As a result, we may have to cut back in other areas of our budgets.
- Those of us that are members of the Organisation for Economic Co-operation and Development (OECD) are maintaining our commitments to targets for Official Development Assistance (ODA) as a percentage of GDP, and increasing our commitments to health.

Furthermore, we are all investing in frontloading mechanisms (advanced financing) and some of us are keeping to previously agreed sums. For example, the UK will keep the levels forecasted in 2007 – not only for the current financial year but also for 2010-2011. By then the UK's ODA will have reached the record amount of £9.1 billion, which is well in excess of the target of 0.6 percent of GDP. Norway will do the same and exceed its 1 percent target.

Prioritising social protection for the vulnerable

We are also committed to increasing targeted help for the most vulnerable people, particularly women and children, so various social protection programmes are being rolled out in our countries.

These include:

- Conditional cash transfer programmes for women and children in Brazil and Indonesia.
- Economic stimulus packages for small businesses in rural areas of Mozambique, Brazil and Indonesia.
- Food protection programmes in Tanzania, Mozambique, Senegal, Brazil and Indonesia.
- Free basic public health services for the vulnerable. These are key, but they create increased demand for public services. Tanzania is making plans for this increase.

At this time of economic crisis, it is important to ensure that our investments achieve the maximum possible protection for the most vulnerable people. We are making a start by cutting the costs of marginal activities such as meetings and travel, and are looking for other ways to make efficiency gains.

We commend the Global Fund for making very significant gains in this area by committing to cut 10 percent of expenditure. This saves US$250 million in relation to its eighth funding round application, without cutting programme delivery. In addition, the Global Fund is establishing a pooled procurement

mechanism to achieve efficiencies and better prices for medicines. Many of these approaches will provide excellent platforms for stronger actions for women and children after the crisis.

We are pleased to note that the World Bank has fast tracked and tripled financing for social protection, including International Development Association (IDA) frontloading. UN agencies (UNICEF and UNFPA) are prioritising countries with the highest maternal and child mortality rates and WHO is revising its budget in response to the crisis.

More effective collaborative action

- The health and development field is fragmented and has many actors. Therefore, consolidation is an important mechanism to achieve better value for money. We welcome the efforts now underway, including:
- Delivering as One – co-ordinating UN work at country level.
- The International Health Partnership (IHP+) – rallying support behind country health plans to strengthen service delivery.
- The Health 8 (H8) grouping of WHO, UNICEF, UNFPA, UNAIDS, the Global Fund, GAVI, the Bill and Melinda Gates Foundation, and the World Bank.
- Forging a consensus and a five-point agenda for maternal and child health through collective action by UNFPA, UNICEF, WHO and the World Bank (see chapter 5).
- The recently initiated work by three major funders (GAVI, the Global Fund and the World Bank) to develop a joint platform for the channelling of health-related finance. All three are providing new ways of delivering aid to obtain results.

As a result of new initiatives, developed during the last decade millions of lives have been saved. We will increasingly build our commitments around mechanisms that deliver results.

Statement by President Obama on global health initiative

In the 21st century, disease flows freely across borders and oceans, and, in recent days, the 2009 H1N1 virus has reminded us of the urgent need for action. We cannot wall ourselves off from the world and hope for the best, nor ignore the public health challenges beyond our borders. An outbreak in Indonesia can reach Indiana within days, and public health crises abroad can cause widespread suffering, conflict, and economic contraction. That is why I am asking Congress to approve my Fiscal Year 2010 Budget request of $8.6 billion – and $63 billion over six years – to shape a new, comprehensive global health strategy. We cannot simply confront individual preventable illnesses in isolation. The world is interconnected, and that demands an integrated approach to global health.

As a U.S. Senator, I joined a bipartisan majority in supporting the Bush Administration's effective President's Emergency Plan for AIDS Relief (PEPFAR). That plan has provided lifesaving medicines and prevention efforts to millions of people living in some of the world's most extreme conditions. Last summer, the Congress approved the Lantos-Hyde US Global Leadership Against HIV/AIDS Act – legislation that I was proud to cosponsor as a U.S. Senator and now carry out as President. But I also recognize that we will not be successful in our efforts to end deaths from AIDS, malaria, and tuberculosis unless we do more to improve health systems around the world, focus our efforts on child and maternal health, and ensure that best practices drive the funding for these programs.

My budget makes critical investments in a new, comprehensive global health strategy. We support the promise of PEPFAR while increasing and enhancing our efforts to combat diseases that claim the lives of 26,000 children each day. We cannot fix every problem. But we have a responsibility to protect the health of our people, while saving lives, reducing suffering, and supporting the health and dignity of people everywhere. America can make a significant difference in meeting these challenges, and that is why my Administration is committed to act.

May 5, 2009

The White House

Doing more for our common future

We have outlined here some of the actions we are taking to protect the most vulnerable from the further negative impacts of the crisis, and we expect that others are doing the same. At the same time, we have committed to do more to accelerate progress towards the MDGs, especially MDGs 4 & 5. We consider the High Level Task Force on Innovative International Financing for Health Systems to be a key vehicle for mobilising additional resources for the achievement of MDGs 4 & 5. We call on all concerned to rally behind its conclusions and recommendations in order to meet our common objectives.

We welcome the commitments of leaders that have contributed to this report as well as President Obama's global health initiative (see box). We stand ready to join in this effort to fulfil the President's desire to make this a truly collaborative global endeavour.

We urge all leaders to take measures to protect the most vulnerable, especially women and children, from the economic downturn. The global economic crisis demonstrates how inter-dependent we have become as a global community. This is the time to honour our commitments and invest in our common future.

Michelle Bachelet
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Luiz Inácio Lula da Silva
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Jan Peter Balkenende
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Ellen Johnson Sirleaf
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Gordon Brown
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Message from the UN Secretary-General to the Global Campaign for the Health MDGs

With just six years left to reach the Millennium Development Goals, the world has been plunged into one of the most severe financial and economic crises in recent history. At the same time, the outbreak of H1N1 has served as a grave reminder that health issues know no borders – and that international solidarity is more than a moral imperative; it is essential to our collective security and wellbeing.

At this time of financial pressure, we must carefully weigh the short-term temptation to cut public services against the long-term human cost. What we do today will have repercussions well into the future. Economies can and will rebound, but, as we learned from previous crises, it will be much more difficult and will take much longer for societies to recover from the health impacts of deep cuts. If we balk now in our efforts to achieve the health MDGs, we will put present and future generations at risk. But if we rise to the challenge, we can set the world on course for long-term prosperity and stability.

Nowhere is this more clear than in the area of maternal and child health in the developing world. Of all the MDGs, MDG 5 remains the one lagging furthest behind. Mothers and their babies historically suffer most during economic downturns. In too many parts of the world, childbirth is one of the greatest health risks that women face. The divide between developed and developing countries is stark: a woman in a least-developed country is 300 times more likely to die in childbirth or from pregnancy-related complications than her counterpart in a developed country.

These deaths – more than 10 million since 1990 – are all the more tragic in that they are largely preventable. That is why I call on the international community, and world leaders in particular, to join forces to put an end to these senseless deaths. I am grateful for the work of the Global Campaign for the Health MDGs to that end. We must ensure universal access to reproductive health and strengthen health systems so they can provide family planning, skilled attendance at birth and emergency obstetric care.

Mothers who are severely injured during labour, and newborns who have lost their mothers in childbirth, not only experience immeasurable human suffering; they face diminished chances of living a productive future. That slows progress on virtually every front, from education to employment and food security. Now more than ever, we must recommit to maternal and newborn health and to the health MDGs as a whole, pushing for progress at the highest levels of government.

The United Nations system, for its part, is doing its utmost to help countries make good on this commitment. United Nations agencies around the world – often operating under extremely adverse conditions – are taking new and creative approaches to ensuring that women and children receive the health care that they need. For the sake of all people, especially the mothers and children who hold our collective future in trust, we must succeed in this effort.

BAN Ki-moon
Secretary-General of the United Nations

Promoting Global Health at the L'Aquila G8 Summit 2009, Prime Minister Berlusconi

Since the launch of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002 Italy has played a crucial role in supporting progress towards the health-related Millennium Development Goals. The Italian G8 Presidency, in line with the previous Summits, continues to pay significant attention to global health, which remains a key theme on the G8 leaders' agenda.

So far, there have been significant improvements in achieving the health-related MDGs, especially the scaling up of universal access to HIV/AIDS prevention, treatment, care and support – as well as better results in the fields of tuberculosis and malaria and in reducing child mortality through immunisation. This shows that progress is possible.

At the same time, there are other trends that must not be ignored. As we all know, the MDGs related to child mortality and maternal health are still off-track, especially in sub-Saharan Africa. It is also evident that health systems in many countries cannot deliver essential interventions and approaches widely or well enough to reduce mortality nationwide.

For this reason, the health-related MDGs continue to be one of the key thematic areas of the Italian G8 Presidency. Along with all G8 partners, Italy is promoting a comprehensive and integrated approach which combines different actions on the MDGs, maximising synergies between health systems and global health initiatives. By recognising that weak health systems obstruct progress, it is essential to continue to strengthen health systems for promoting universal access to health services.

In this time of financial crisis, it is also crucial to send a strong message to the international community that the G8 will continue to maintain commitments and to improve the efficiency and effectiveness of its efforts. In addition, it is important to continue to explore the potential to extend the use of innovative financing mechanisms, such as the International Finance Facility for Immunisation, the Advance Market Commitments and UNITAID, for providing vaccines and drugs.

In this context, the Italian G8 Presidency, building on previous G8 Summits, is working closely with G8 partners to further improve the accountability exercise begun last year to monitor the fulfilment of G8 commitments. I am pleased to acknowledge that this year G8 health experts have made substantive improvements in defining a better common methodology.

In this overall scenario, I welcome the efforts of the Global Campaign for the Health MDGs to improve maternal, newborn and child health and to combat HIV/AIDS, malaria and other diseases. I will ensure that Italy continues to be engaged in addressing the challenges of global health.

Silvio Berlusconi

Prime Minister
Italy

Protecting women and children during the global economic crisis
The European Commission

The European Union is particularly concerned with the effects of the crisis on developing countries, and wishes to ensure continued progress towards the Millennium Development Goals. In the wake of its Communication of 8 April 2009 – Supporting developing countries in coping with the crisis[1] – the Commission is following the situation closely, paying particular attention to social and political impacts that extend beyond economic factors.

Background

In addition to the severe macroeconomic effects of the crisis, developing countries are facing serious social consequences. With an increasing imbalance in their public finances, governments are finding it difficult to maintain levels of social expenditure. Maintenance of public infrastructure is being postponed. Funding for social safety nets is in decline just when it is most needed, and the number of unemployed and working poor, especially in urban areas, is increasing exponentially. The global crisis is also likely to have gender-specific consequences for women in developing countries and their children.

While the crisis is affecting all developing countries, the extent of the impact, its symptoms and the ability to cope vary significantly across regions, countries and population groups. Many developing countries have pre-existing high rates of maternal, infant and child mortality, and low levels of female participation in schooling. This leaves women and children particularly vulnerable to the crisis. Declining economic growth rates and limited financial resources constrain the ability of developing governments to cushion the human impacts of the crisis. Also, the fall in household incomes could further increase infant and child deaths, disproportionately affecting women and girls. Children are more likely to be withdrawn from school during times of hardship, especially girls in countries with pre-existing low levels of female schooling.

The Commission's Communication of 8 April is currently being discussed by Member States in the European Council, European Committees and Parliament. The Communication proposes a set of comprehensive, co-ordinated, timely and targeted measures to cushion the human impact of the crisis and to boost economic growth in developing countries. These measures include: honouring aid commitments and leveraging new resources; implementing countercyclical measures; improving aid effectiveness; sustaining economic activity and employment; revitalising agriculture; investing in green growth; stimulating trade and private investment; working together for governance and stability; and protecting the most vulnerable.

Assessing the impacts

The European Commission has initiated a process aimed at better assessing the expected negative impacts of the crisis on developing countries, and identifying the countries that are potentially most vulnerable. This analysis follows a two-pronged methodology. The first element is an assessment of macroeconomic vulnerability and resilience to the crisis, and the second is an assessment of the social and political impacts, completing a broad and comprehensive perspective of vulnerability. In addition to this desk-based exercise, the Commission is working closely with its delegations in developing countries to obtain further feedback and more in-depth country-specific analysis of the expected relative impacts of the crisis. The main purpose is to gain a better understanding of the differentiated effects of the crisis on developing countries by gathering more qualitative information to confirm, or complete, the quantitative data for economic and financial effects. Qualitative analysis will focus on the social and political effects, with particular attention paid to the vulnerability of women and children.

The Commission is also promoting joint work with those EU Member States that are most active in this analytical exercise (Germany, France, the Netherlands and the UK) with the intention of providing a basis for a co-ordinated EU response to the crisis.

It is estimated that the current crisis could push a further 90 million people in developing countries into poverty in 2009[2], with women, children, the elderly and the disabled most at risk. Continued EU support in the fields of health, decent work and education is key to ensuring the most vulnerable are not left unprotected. The targeted social protection measures described in the Communication (such as the creation and strengthening of social safety nets, facilitation of direct cash transfers and enhancement of in-kind transfers) aim to help mitigate the negative effects of the crisis on vulnerable population groups, including women and children. Social safety nets, for example, help cushion the impact on household coping strategies and ensure that children are more likely to be kept in school.

Mechanisms to safeguard social spending have also been proposed in the Communication, such as the proposal to dedicate at least €500 million from the 10th European Development Fund to support those African, Caribbean and Pacific countries hardest hit by the crisis (ad hoc through the Vulnerability FLEX mechanism). This is part of the international effort to assist the most vulnerable countries in coping with the crisis.

José Manuel Barroso

President
The European Commission

1. COM (2009) 160, Brussels, 8th April 2009
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The World Bank

2009 will be a dangerous year. The first decline in the global economy since World War II. The largest decline in world trade in 80 years. What started as a financial crisis quickly spiraled into an economic crisis. Today, it is an unemployment crisis. This year, we forecast that economic growth in developing countries will slow sharply to 2.1 percent, down from 5.8 percent in 2008. Developing countries are being battered by successive waves radiating from contraction in growth and tightening of credit in the developed world. The global economy once helped to lift hundreds of millions out of poverty – today, we risk development in reverse.

These events could next become a social and human crisis, with political implications. The World Bank Group estimates that an additional 53 to 65 million people will be trapped in extreme poverty in 2009 because of the crisis. The number of chronically hungry people is expected to climb to over 1 billion this year. When poor families need to tighten their belts, they have to pull their children out of school, stop using health services, and cut back on providing nutritious food for their children. Women and girls suffer disproportionately. Our research shows that most of the eight Millennium Development Goals are unlikely to be met by 2015 – including those related to hunger and malnutrition, child and maternal mortality, education, and progress in combating HIV/AIDS, malaria, and other major diseases.

The World Bank Group has moved rapidly and flexibly, first to help countries respond to last year's food and fuel crises, and now to help protect developing countries from the worst effects of the global financial crisis. Last year, we implemented the Global Food Crisis Response Program (GFRP) and the IDA Fast Track initiative. This year, we have announced plans to triple support for social protection; put in place $55 billion of financing for infrastructure through the Infrastructure Recovery and Assets Platform and the IFC's Infrastructure Crisis Facility over three years; and we are boosting support for agriculture to $12 billion over the next two years to help ensure vital food security and safety. Other initiatives include support for microfinance to help poor borrowers, a global trade finance program, and a capitalization fund for developing country banks. The World Bank Group's crisis response now includes a *menu of options* to enable us to match the needs of developing countries with the interests and capacities of donors.

The Vulnerability Financing Facility (VFF) is part of this menu of options: a dedicated facility to streamline crisis support to the poor and vulnerable. The VFF organizes under one umbrella the existing *Global Food Crisis Response Program* (GFRP) and the new *Rapid Social Response* (RSR) Program focused on social interventions. It will leverage the World Bank Group's own resources, as well as seek donor contributions. For the poorest countries, the VFF will also alleviate current constraints on their IDA allocations by making available additional grant resources through a Multi-Donor Trust Fund (MDTF).

The VFF programs address two specific areas of vulnerability to crisis: first, agriculture, the main livelihood of over 75 percent of the world's poor; and second, employment, safety nets, and protection of basic social services including nutrition to help poor and vulnerable groups cope with crisis. The VFF builds upon the successes of safety net programs in protecting the assets and livelihoods of vulnerable households, including subsistence farmers and the urban poor, during crises. It aims to ensure that dedicated structures are in place so that adequate attention and resources flow to those who need them most.

Our experience from the GFRP suggests that such a facility is critical for focusing attention and ensuring that support is provided in a timely and targeted manner. Projects implemented under the GFRP have supported a broad range of social protection programs. In Liberia, for example, the GFRP grant is supporting school feeding programs that have distributed 300 to 400 tons of food to 60,000 school children since October 2008, as well as programs targeted to pregnant and lactating women and pre-school children. In Sierra Leone, the GFRP has funded 119 cash-for-work projects, providing employment for more than 5,300 people. The GFRP also provides support for smallholder food production by supplying farmers with seeds and fertilizer, rehabilitating small-scale irrigation, and supporting livestock-related activities that will

reach approximately 5.5 million farmers. In Tajikistan, for instance, 1,265 tons of high quality winter wheat planting seed has been distributed to 71,500 households.

As with these GFRP programs, VFF initiatives are designed to adapt flexibly to country needs and circumstances, so that targeted assistance is channeled to countries through the most effective means possible. In order to be nimble, we will not create new processes, but use existing coordination mechanisms at the country level, and fully integrate within country programs. The VFF is country-driven and supports a government-led approach with partners including the UN, other national and international agencies, and civil society. We look for close cooperation with regional initiatives such as the African Union's recently endorsed Social Policy Framework, the International Health Partnership (IHP+), and regional/national nutrition strategies. We will encourage South-South learning and capacity building initiatives. And we will respect the Paris Principles on aid effectiveness by supporting projects that are part of nationally agreed social protection/social services strategies, where these exist.

Donors have already pledged substantial support to the MDTF in support of the VFF, and others have expressed interest. We look forward to the generous involvement of other concerned donors over the coming weeks.

I do hope that you can join us in this collective endeavor in this time of crisis.

Robert B. Zoellick

President
The World Bank Group

Chapter Two

Key policy directions:

Lessons from previous crises for health and social protection

Previous crises offer valuable lessons for minimising the adverse effects of the present crisis, such as the importance of protecting budgets for the most basic and cost-effective services delivered to the poor. Social safety nets, such as cash transfers, nutrition programmes, fee waivers and subsidised prices, are known to be particularly effective. In previous crises, those countries that used them to protect the poor and vulnerable were able to move rapidly to universal coverage of health services once the economy started to grow again.

Based on experience in Asia, at least a 1.0 percent increase in spending on safety nets is needed to protect the poor, and spending of 2 percent or more of GDP could be required. Experience also highlights the importance of reducing financial barriers to accessing health care, and shows that specific interventions are needed to safeguard access while assuring adequate quality.

More broadly, access to timely information and monitoring systems is crucial for contingency planning in readiness for economic deterioration. As people's incomes decline, labour programmes – such as unemployment benefit, retraining, job clubs and labour-intensive public works – can provide critical support. And countries can get more health for the money spent, taking the opportunity to become more efficient by focusing on results.

Lessons from previous economic crises

The World Bank and World Health Organization

The current global economic crisis differs in some critical ways from past global recessions. Firstly, today's problems originated in financial markets in the developed rather than the developing world. Secondly, although these financial problems have spread to the real economy and many high-income countries are now in recession, the economies of low-income countries continue to grow, although at significantly lower rates than in the immediate past. However, successive estimates of global growth have been increasingly pessimistic, and there are already signs of economic and financial problems in developing countries. For example, government revenues from imports, exports and tourism have declined with the fall in global trade. Foreign direct investment has fallen. The amount of money sent home by people living abroad (which has held up well in some previous downturns) is already in decline. The currencies of a number of countries have been devalued.

It is important for low- and middle-income countries to anticipate the impact of these changes on health financing, on health systems, and ultimately on people's health and nutrition. Here, the Millennium Development Goals 1c, 4, 5 & 6 – relating respectively to child nutrition, child mortality, maternal health, and communicable diseases – are especially relevant. The global community needs to be prepared in case the situation deteriorates further, so it is valuable to draw on the experience of previous crises.

Lessons from previous crises

Where countries have been in recession, the following effects have typically been observed:

- Government revenues have fallen, with a corresponding reduction in government expenditures. This time, tax revenues have already fallen in some developing countries because of the decline in world trade. This will result in reduced overall government spending unless a country is in a sound enough macroeconomic position to provide demand-side stimuli.
- Government health expenditures have often fallen along with overall government expenditure, even if the proportion of government expenditure allocated to health has been maintained. When such reductions are accompanied by worsened exchange rates, spending in dollar terms has declined even more than nominal local currency-denominated spending. When imported goods, such as essential drugs, represent a sizable share of health spending, spending in real terms is also negatively affected.
- Nominal, real, and trade-affected reductions in government health spending can be mitigated. Some governments have made specific efforts during previous recessions to reinforce social safety nets, including specific provisions for health services for the poor. Policies and interventions that specifically address factors affecting access and quality of priority services for the poor are often more effective in protecting social programmes than generic measures to target sectoral budget shares.
- The capacity of the richer countries to provide official development assistance (ODA) has fallen. At this time no clear trend can be observed with health ODA, which has not always fallen during previous recessions. Although a number of countries have managed to maintain or increase the absolute levels of assistance in previous global crises, overall the real value of total commitments has fallen.
- Reduced household incomes and greater uncertainty typically mean lower ability and willingness to spend, including on health and nutrition. Many countries are reporting significant jumps in unemployment and declines in the amount of money sent home by people living abroad. Even in countries not yet experiencing very significant slowdowns, pockets of unemployment are being observed, particularly linked to banking, finance, and exports/imports.
- Reduced household incomes have been reflected in lower utilisation of private health services, with a switch to subsidised or free services. Therefore, the overall utilisation of government health services has often increased during recession, at a time when government expenditure to support these services has fallen. Falls in overall utilisation have been observed more frequently among the poor, who most feel the burden of the direct and indirect costs of service use. Without action to protect access, this may mean that non-poor groups capture an increasing share of public service delivery.

- Many countries have devalued their currencies in the past, making imports more expensive. For health, the main effect has been an increase in the price of imported medicines (or raw materials in countries that produce medicines), making them less affordable to the population and to government.
- Health and nutrition outcomes have been affected by previous severe economic slowdowns in low-income countries. The most commonly reported are increases in under nutrition (MDG 1c), particularly in women and children, and sometimes in infant mortality rates (MDG 4). Increases in under nutrition are particularly likely in the current recession, which follows closely on the recent food crisis. Reductions in services related to health outcomes, such as maternal health services, reduced schooling for girls (which could later impact maternal and child health outcomes), are also a cause for concern. In richer countries, mental health problems and suicides have sometimes increased, although death and illness caused by motor vehicles have sometimes decreased.

Proteting the poor and vulnerable

Social safety nets are particularly important in times of economic crisis because the poor, particularly women and children, are most at risk of adverse health outcomes. Previous experience has shown that some countries, for example Thailand during the Asian crisis of 1997-1998, used the opportunity to strengthen social safety nets. This allowed them to move rapidly to universal coverage of health services once the economy started to grow again. It illustrates that the impact of the crisis depends, at least in part, on how governments react to protect the health of the poor and vulnerable.

Even before the advent of the current crisis, in many parts of the developing world utilisation of services was sub-optimal, due in part to a variety of financial barriers. These barriers also cause financial hardship and even impoverishment for the people who do seek care. Many countries, sometimes with the assistance of multilateral and bilateral agencies and NGOs, have begun to take steps to reduce these financial barriers and to move towards universal coverage of health services. It is important that these gains are not put at risk in the current economic crisis, so specific interventions are needed to safeguard access, while assuring adequate quality. Countries can also use the opportunity to become more efficient by focusing on results, thereby getting more health for the money spent.

Continued international solidarity will be important. Aid for health doubled between 2000 and 2007, and this has been important in helping countries make progress towards the health-related MDGs, specifically: improving child nutrition (MDG 1c); reducing child mortality (MDG 4a); improving maternal health and reducing maternal mortality (MDG 5a&b); and reducing the burden of major communicable diseases (MDG 6a,b&c). These gains should not be lost. One area that may be amenable to early protective action is the ability of countries to secure adequate supplies of health care commodities in the face of adverse changes in exchange rates.

Monitoring, early warning, and better evidence on the effects of the crisis

The uncertainty surrounding the current crisis is probably greater than in any previous economic downturn. Although many developing countries are not yet showing severe economic declines, they need to be prepared and to have contingency plans in case the situation deteriorates. Previous recessions have shown some of the likely effects on health and health systems, and have provided indications of how countries can prepare to counter them. This requires them to have access to timely information in rapidly changing conditions. The international community is already working with countries to enhance their capacities to monitor key outcomes to allow a more rapid response. However, the current crisis also has many new features. International agencies and national authorities should collaborate on prospective evidence-gathering efforts to learn more about these conditions and the effectiveness of mitigation measures.

Health in times of global economic crisis: implications and recommendations for the WHO European Region

Oslo, Norway, 1-2 April 2009

1. Distribute wealth based on solidarity and equity

Health authorities across Europe are concerned that the present economic system does not distribute wealth on the basis of the values of solidarity and equity, thus hindering improvement in health outcomes. Health leaders call for changes in the economic system that support health improvement.

2. Increase official development assistance (ODA) in order to protect the most vulnerable

The poorer countries are the most vulnerable when it comes to health loss in times of crisis. The current crisis is no time for decreasing ODA, but, rather, for increasing it.

3. Invest in health to improve wealth; protect health budgets

Investing in health is investing in human development, social well-being and wealth. Better health improves welfare. Health investments create wealth. Protect health budgets, health insurance coverage and employment throughout the economic downturn. Include health- and environment-related investments in economic recovery plans.

4. "Every minister is a health minister"

Promote "Health in All Policies". Consider the health and distributional effects of all political reforms.

5. Protect cost-effective public health and primary health care services

If spending on health is reduced:

- protect spending on public health programmes;
- protect spending on primary health care;
- reduce spending on the least cost-effective services. These will normally be found among the most high-technology, high-cost services in hospitals. Delay investment plans for high-cost facilities and promote the use of generic drugs.

6. Ensure "more money for health and more health for the money"

Make more money available for health and ensure more health for the money. Improve quality through transparent monitoring and performance assessment. Strengthen evidence-based medicine and make health services safer.

7. Strengthen universal access to social protection programmes

Use the opportunity of the crisis to strengthen universal access to social protection programmes in a more coordinated way.

8. Ensure universal access to health services

Use the opportunity of the crisis to ensure universal access to health services. Ensure social safety nets for the most vulnerable social groups.

9. Promote universal, compulsory and redistributive forms of revenue collection

Strive for equity in the financing of health services through universal, compulsory and redistributive forms of revenue collection.

10. Consider introducing or raising taxes on tobacco, alcohol, sugar and salt

Consider improving population health through public health reforms using structural measures. Examples are to raise taxes on tobacco, alcohol, and products containing high levels of sugar or salt. This could help to finance the social protection systems and at the same time have a positive impact on public health.

11. Step up the education of health professionals and ensure ethical recruitment

Even during this crisis we must recognize the current shortages in the health workforce and the increasing need for health workforce in the future. Step up the education of health professionals and local health workers as appropriate. Use the crisis as an opportunity to attract new health workers. Continue supporting the development of a code for ethical recruitment across sectors and borders.

12. Encourage active public participation in the development of measures to mitigate the effects of the economic crisis on health

Health authorities call for more active public consultation and participation in defining, implementing and monitoring the execution of decisions regarding the crisis. Public participation may be direct (public debates, consultations) or indirect, through representative organizations, associations and unions.

Financing for social protection

The World Bank

Existing and future gains in human development are threatened in several ways by the current rapid succession of food, fuel and financial crises. First, falling real wages and growing unemployment make it difficult for households to provide adequate food and other necessities for family members. Second, the reduction of working opportunities abroad, and consequent decline in the amount of money sent home, further reduces the income of poor people. Third, the squeeze on government budgets typically reduces services to the poor, at a time when people are switching from private to public services.

If they don't receive assistance, households may be forced to sell assets on which their livelihoods depend, to withdraw their children from school, and to cut back on health care. Inadequate diets and poor health care cause malnutrition. Together, these situations hamper progress on MDG 1c (hunger and malnutrition), MDG 2 (education), and MDGs 4 & 5 (maternal and child health). Unless action is scaled-up, many millions will remain trapped in poverty, and progress toward the Millennium Development Goals will be slowed. Recent World Bank analysis suggests that the crisis will trap 53 million people in extreme poverty (below US$1.25 a day) in the developing world in 2009 – or 65 million if the US$2 a day measure is used. Some 200,000-400,000 more infants will die every year, women will be deprived of reproductive health services including family planning and pregnancy-related services, and many poor children will be malnourished or will lose the opportunity to attend school.

Social protection programmes can help mitigate the negative impacts of the crisis and forestall the increase in poverty and inequality. They can help households ensure better diets and care for their children, and maintain their spending on health, education and other essential services. Where social protection policies are seen as fair and compensatory, they can support social equilibrium and help people tolerate the measures needed to address the underlying problems.

A wide range of interventions are available, and countries should utilise the combination that best fits their circumstances. Among the most pertinent are safety nets and labour programmes to support people whose incomes are declining.

Safety-net programmes include:

- **Cash transfers (unconditional or conditional)** – these provide eligible households with cash benefits, such as child allowances and social pensions. Qualifying conditions include school enrolment, regular health checks and basic preventive health care and nutrition services.
- **School feeding** – in-kind food transfers provide meals or snacks for children at school to encourage their enrolment and enhance their ability to pay attention in class, thereby protecting progress towards MDG 2 (education).
- **Other in-kind transfers** – where appropriate and feasible, these provide targeted supplementary food rations and preventive vitamin and mineral supplements through health clinics or community-based nutrition services, especially to poor pregnant and lactating women or their young children, thereby protecting progress towards MDG 1c (hunger and malnutrition).
- **Labour-intensive public works** – income support for the poor is given as wages (in either cash or food) in exchange for work. These programmes typically provide short-term employment at low wages for unskilled and semi-skilled workers. Labour-intensive projects include road construction and maintenance, irrigation infrastructure, reforestation and soil conservation.
- **Fee waivers for essential services, such as education, health care, nutrition, heating and lighting** – measures to help households meet education costs include stipends (usually paid in cash to households), vouchers to purchase education, targeted bursaries and interventions related to tuition and textbooks. Fee waivers for health are granted to poor people to enable them to pay health care charges, thereby protecting progress towards MDGs 4 & 5 (maternal and child health, including reproductive health).
- **Subsidized prices for defined rations of food** – these may be available through open-market operations or 'fair price' shops, targeted geographically, demographically or by need.

Labour programmes include:

- **Non-contributory unemployment benefit programmes** – these provide income support to laid-off workers in a variety of forms, from cash transfers to laid-off workers for a fixed period, to the creation of individual unemployment insurance accounts.
- **Training for recently dismissed workers, or unemployed workers from vulnerable groups such as youth** – preferably based on comprehensive programmes that give young people technical skills training, job-readiness skills and internships, and are targeted to meet the needs of the local labour market. Models include the 'Jovenes' programmes in Colombia and the Dominican Republic.
- **Support for public employment services that provide job information and placement services for the recently unemployed** – including the establishment of job clubs and provision of job-search courses, counselling, testing and assessment, along the lines of the programmes instituted in Romania in the late 1990s.
- **Time-bound financing of shortened working weeks** – in which workers agree to shorten their working week in exchange for partial unemployment benefits for a fixed period. After this, firms decide whether to retain or release them.
- **Policy reforms to support international migrant workers** – including the establishment and monitoring of service standards for educational and preparation programmes.

These interventions may require prior investment in capacity for designing, monitoring, targeting and delivering services – especially in countries where social protection policies are underdeveloped. These investments in systems can form one of the lasting positive legacies of a crisis.

Continuous availability of basic health, nutrition and education services is required to safeguard populations and avoid irreversible damage to human capital, especially children. However, during crises governments face fiscal pressures that impede their ability to offer services, while across-the-board protection of budgets is likely to be neither feasible nor efficient. A more nuanced approach is required to monitor and protect key services within larger systems. These could include:

- **Nutrition programmes** –during the nutritional 'window of opportunity' from pre-pregnancy until two years of age, and especially during humanitarian crises and emergencies, and vitamin and mineral supplementation or fortification of commonly eaten foods.
- **Budget support** – that helps to 'crowd-in' public finance for basic services, such as vouchers to keep vulnerable children attending private and non-governmental organisation schools.
- **Protection of budgets** – for the most basic and cost-effective services delivered to the poor, where information and budgeting systems make it possible to distinguish these.

The amount of resource needed will vary from country to country. It will depend on the level of pre-existing extreme poverty, the size and nature of problems and the ability of programmes to tackle them. Recent calculations for Armenia suggest that a 0.4 percent increase in safety-nets spending is needed to protect the extremely poor, and 1 percent to protect all the poor. During the east Asian financial crisis, Indonesia's spending from 1998 to 1999 on its safety net for the poor was about 2.4 percent of GDP, including food subsidies, public works, targeted scholarships and fee waivers for health care (the bank bailout cost 50 percent of GDP). In Korea, spending on the safety net tripled from about 0.6 percent of GDP in 1997 to nearly 2 percent in 1999 (the bank bailout cost 27 percent of GDP). Usually the size of response is dictated by availability of funds rather than by need – something that international partners in development can help address.

Finding fiscal space to support such programmes is always a challenge, because needs increase just as budgets tighten. Some countries might be able to make savings – at least in the medium term – by switching from inefficient to efficient programmes e.g. from food or fuel price subsidies to targeted income support or nutrition programmes that target children under two years of age. Smaller savings might be achieved by merging small programmes or making changes to reduce costs. However, in most cases more budget resources will be needed, and the international development community has a role to play in helping countries find these resources. The World Bank is doing its part, by working through our normal instruments and establishing the vulnerability financing facility described in chapter one.

Chapter Three

Country action:

Leading by example

The global economic crisis is affecting countries in different ways, but many governments are taking important steps towards the enhanced protection of women and children in these troubled times. Those in developing countries are maintaining health and social budgets – even sometimes continuing to increase them. Donor countries are maintaining commitments to targets for Official Development Assistance as a percentage of GDP, and increasing commitments to health.

Countries are also committed to increasing targeted help for the most vulnerable people, particularly women and children, via social protection measures that include:

- *Conditional cash transfer programmes for women and children*
- *Economic stimulus packages for small businesses*
- *Food protection programmes targeted at children, vulnerable communities, rural areas and schools*
- *Free basic public health services for the vulnerable, creating increased demand for public services.*

France

France is highly committed to achieving the Millenium Development Goals, particularly those related to global health.

Since 2000, France has increased by four times its Development Aid dedicated to health. The healthcare sector represents, considering all the tools implemented by France, an annual average expenditure of 970 M€ in 2008. These sums are broken down into 73 percent for multilateral contributions and 23 percent for bilateral contributions.

Concerned by the little progress made in reducing child and maternal mortality, France has decided to strengten the efforts on MDG4 and MDG5.

With regard to MDG 4, France has made the choice to invest in vaccination programs, one of the main activities that enable preventing child mortality.

France is the second international donor for GAVI with 15 M € (from 2003 to 2006) and 1,3 billion € from 2007 to 2026, through its contribution to the International financial facility for immunization (IFFIm).

France is also the second largest donor at the Global Fund (300 M € from 2008 to 2010) and the first one at UNITAID (160 M € in 2008) .

While the Global Fund finances programs aiming at preventing HIV/aids transmission from mother to child, UNITAID contributes to decreasing the price of pediatric antiretroviral medicines. Both organisations also play an important role in decreasing child and maternal mortality through their activities against malaria.

Innovative financing constitutes crucial mechanisms which provide sustainable, predictable and additional ODA financing. France plays a leading role in this field and will organize, on 28 and 29 May, an international conference on innovative financing that will also welcome the third members meeting of the High level task force on innovative financing for health.

Maternal health is the MDG which has experienced less progress. In order to assist the international community in reaching this goal, France has invested 80 M euros in this sector from 2003 to 2008.

This contribution includes financing programs of multilateral organizations, such as UNFPA, WHO and UNICEF, mainly in the African region. France also provides technical assistance to these countries (in Niamey, Dakar, Addis-Ababa for instance) in order to assist them in designing and implementing their policies to fight maternal mortality.

France also plays an important role in terms of advocacy, defending access to reproductive health and rights, including family planning, in all international fora and partnerships. The promotion of gender equality and empowerment of women are also part of this advocacy.

France is also a member of the “Reproductive health Supplies Coalition” whose activities aim at promoting universal access to reproductive health services and commodities.

Finally, we are convinced that it will not be possible to reach the MDGs without having viable and strong health systems. Therefore, France provides active support to international partnerships and initiatives for health system development, especially the Providing for Health (P4H) initiative and has organized two international conferences in 2007 and 2008 in Paris, in order to build the momentum on social health protection worldwide.

Nicolas Sarkozy

President
France

Germany

Germany is committed to the global agenda of the internationally agreed development goals, including the Millennium Development Goals. Despite real progress in some areas, we are concerned about some important MDGs, in particular the health MDGs.

At the summit in Heiligendamm in 2007, Germany and the other G8 countries jointly pledged to make available US$60 billion for health projects in developing countries. Implementing this commitment Germany has increased its bilateral and multilateral commitments for MDGs 4, 5 & 6 and for health system development to over €500 million in 2008 compared to €300 million in 2006.

The economic and financial crisis has made additional efforts necessary to alleviate the financial and social impact on developing countries. Germany has supported a strong collective engagement at the G20 Summit in London. We will be making a substantial contribution to the World Bank's Vulnerability Framework. Germany is making US$130 million available to the Microfinance Enhancement Facility, and an additional US$600 million to the International Finance Corporation-administered Infrastructure Crisis Facility.

Moreover, Germany is committed to enhanced co-ordination of international aid and to strengthening health systems. We are providing active support to international partnerships and initiatives for health system development, especially the International Health Partnership (IHP) and the Providing for Health (P4H) initiative.

We know that it will not be possible to reach the MDGs through isolated disease-specific actions alone. Only if health programmes are linked to sustainability and human rights principles, and to the principle of gender equality, will lasting progress toward MDGs 4 & 5 be possible.

Germany will therefore increase its support for those programmes which contribute to securing universal access to health services, and thus also for mothers and children. In addition, drinking water and adequate sanitation in general – crucial for the achievement of both MDGs – is an important focus of Germany's development co-operation programmes, especially in sub-Saharan Africa.

We are convinced that the MDG challenges can only be overcome by a concerted effort of both developing country partners and donors, all fulfilling their respective obligations. Therefore, Germany welcomes the Italian G8 presidency's intention to put the achievement of MDGs 4 & 5 on the agenda of this year's G8 Summit.

The MDGs may be ambitious, but they can be achieved. Achieving them is not only a question of credibility but, ultimately and primarily, also one of humanity.

Angela Merkel

Federal Chancellor
Germany

Japan

In times of economic crisis, the most vulnerable in society, including women and children, are usually the ones who suffer the most. Too often they are the last in line to enjoy the fruits of growth and the first to feel the tightening grip of poverty and desolation. Now more than ever, governments must resist the temptation to look the other way and shortchange aid, because each country, developing or developed, has the responsibility not to let the progress towards the MDGs roll back.

This brings me right to the issue of global health including MDG 4 & 5; poverty and ill health are inextricably linked, and there is no addressing one without the other. With this in mind, when Japan held TICAD IV and the G8 Hokkaido Toyako Summit in 2008, Japan underlined the particular importance of a comprehensive approach to tackle the various challenges of global health, with a special focus on health systems strengthening as a prerequisite for improved maternal, newborn and child health. Measure such as saving the lives of 400,000 children and the promotion of continuum of care were announced which we are currently following up. The report entitled Global Action for Health System Strengthening issued by a taskforce of experts in January 2009 is another of such effort jointly conducted by the private sector and the Japanese Government. I hope that their findings will be adequately incorporated into international policy-making on health.

Although the international community is in a difficult period of global economic downturn, Japan is fully committed to what we announced at TICAD IV. Japan is expediting the implementation as early as possible of $2 billion of grant and technical assistance, which of course includes measures such as promotion of continuum of care among others. In addition, at the TICAD Ministerial Follow-up Meeting held in Botswana in March 2009, Japan announced the disbursement of approximately 200 million US dollars to the Global Fund to Fight AIDS, Tuberculosis and Malaria as part of an effort to mitigate the negative impact of the financial crisis.

Furthermore, 'Maternal and Child Health Handbook' is often quoted as one of Japan's successful efforts on maternal and child health. The Handbook is designed to provide an accurate account of the condition of mothers during pregnancy and growth of the child, so that health workers can refer to it in case of emergency or in different hospitals. If accompanied by a well-functioning health system, the Handbook has the potential to greatly contribute to the reduction of infant mortality, just like it did in post-war Japan. Good examples of this can be found in Morocco, Palestine, and Indonesia.

As a proponent of the concept of human security, Japan has always placed high priority on individuals and their potential to live out their full and dignified lives, through protection and empowerment of the people and their communities. I call on all stakeholders to embrace this basic principle in our shared efforts to achieve the MDGs. Guided by this principle, and together with donors, developing countries, international organizations, the civil society and other major stakeholders, Japan will continue to do its best to protect the health of women and children, and strengthen health systems for that very purpose.

Taro Aso

Prime Minister
Japan

United Kingdom

Protecting women and children during the economic downturn

100 million more people may be forced into poverty as a result of the global economic crisis. Half a million children a year could die as a result. The G20 London Summit put development and the poorest countries at the heart of international efforts to restore global growth and jobs. The UK is working with international partners to ensure that we protect the development gains made in recent years, and accelerate progress towards the health-related MDGs.

MDGs 4 & 5

At the UN High-Level Event last year, we pressed for accelerated action on maternal, newborn and child health. We are working with a range of partners to develop a Global Consensus. The Global Consensus will focus our collective efforts on those evidence-based and cost-effective interventions, that we know work, to get MDGs 4 & 5 on track – see Chapter 5 of this report.

The UK supports a comprehensive approach to improving maternal, newborn and child health, including increasing access to family planning, preventing unsafe abortion, and ensuring skilled attendance at birth, including access to emergency obstetric care when required.

Progress and challenges

Maternal mortality remains unacceptably high across much of the developing world. And, although globally we are making progress towards achieving MDG 4 – we are still not on track to achieve the target by 2015. Around 40 percent of all under-five deaths occur in the first month. The first day of life continues to carry the highest risk of death. This is why the UK is focusing efforts to improve maternal and newborn health, including through increasing financing and strengthening the health systems we know underpin progress.

Innovative financing

In September 2008, I launched, with other world leaders, the High Level Task Force on Innovative International Financing for Health Systems. The Task Force will help to mobilise extra money to support stronger health systems; contributing to the funding needed for over 1 million extra health workers, and for the additional costs of ensuring that 400 million extra births take place in quality assured clinics.

International Health Partnership and strengthening health systems

In September 2007, I launched the International Health Partnership (IHP+). The IHP+ aims to achieve better health results by mobilizing donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

In 2008, we committed to provide £6 billion in support of health systems and services over the seven year period to 2015.

Pulling together to secure our common futures

The global community faces enormous challenges in an interdependent world. The nature of this interdependence means that it has never been so important to invest in our common future. We are committed to ensuring that every pregnancy is wanted, every birth is safe, every newborn is healthy and every child has the opportunity to prosper and reach their full potential.

Gordon Brown

Prime Minister
United Kingdom

Tanzania

The global economic crisis is hurting Tanzania's previously buoyant economy, although the country's financial sector is unaffected because it is not closely integrated with the global financial system. Demand for exports has fallen due to the drop in real incomes in the developed world, which has negatively affected the prices of our export commodities and consequently our export earnings. For example, the prices of cotton and coffee have dropped by 45 percent and 30 percent respectively. The prices of minerals (except gold) have also decreased. Tourism is down 20 percent and some new investments have been postponed, which are areas of concern. As a result of the crisis, growth in real GDP is projected to slow to 5 percent in 2009.

The impact of the crisis on mothers, children and other vulnerable groups is felt through high food prices and inflation, which has eroded real household incomes. This makes food less affordable, which could lead to malnutrition, stunting, maternal complications and deaths. High inflation also raises the price of imports, including essential drugs, medicines and equipment – of which Tanzania imports about 89 percent of its requirement. Since women and children are disadvantaged in terms of ownership of resources, they could be deprived of access to drugs and services when the cost is high and supplies are limited. Public health facilities, which are cheaper, could become congested as many more people use them in a period of falling incomes.

To mitigate the impact of the crisis on vulnerable groups, the government has taken several steps including:

- Regulating the price of fuel, which directly affects transport and commodity prices.
- Allowing tax-free importation of key staples (maize and rice) temporarily from March to May.
- Providing free food to poor families faced with food shortages.
- Subsidising food production through subsidies on fertiliser, pesticides and high-yield seeds.

Most of the government's core or priority expenditures, including health, are protected from cuts, while the budget for agriculture has been increased. Unnecessary expenditures, such as the purchase of motor vehicles and financing of conspicuous workshops and seminars, have been reduced. The resources saved have been redirected to priority sectors such as health and agriculture. Our commitments for MDGs 4 & 5 are maintained, and special arrangements have been made to ensure adequate resource, especially to procure essential drugs, supplies, vaccines and contraceptives. For the financial year 2009-2010 there is a firm commitment to finance these priority items in full.

The way forward and challenges

We will strengthen partnerships between public, private, and non-governmental organisations and streamline the use of resources from the government, the Global Fund, PEPFAR, GAVI and other partners. We will also continue to advocate increased alignment of aid and government funds to support maternal, newborn and child health. The main challenges we foresee include sustaining government revenue during the deepening global economic crisis, ensuring predictability of donor support, and sustaining budget levels that will support increased usage of public health facilities.

Jakaya Mrisho Kikwete

President
Tanzania

Senegal

It is difficult to assess the impact of the global economic crisis on Senegal so far. However, like most developing countries, it faces the possibility of reduced economic growth and budgetary constraints in the medium and long term. This would impact negatively on people's lives and further compromise the achievement of the Millennium Development Goals (MDGs), to which Senegal is committed as it implements strategies for growth and poverty reduction.

Senegal has made significant progress to extend immunization coverage under the Expanded Program on Immunization, and in its fight against malnutrition and major diseases such as malaria and AIDS. However, levels of infant and child mortality rate under the age of five (121 per 1,000 live births[1]) and maternal mortality ratio (401 per 100,000 live births[1]) remain very high. These figures highlight the huge investment (US$933 million[2]) needed to implement health activities for mothers and children multiyear plan.

The government is committed to strengthening the fight against maternal and infant mortality by increasing access to care and by supporting free deliveries and caesareans. In addition, the Head of State has made a personal commitment to implementing a strategy to help women manage the health of their peers.

Progress has been made to improve health financing, and in recent years the health budget has increased to 10 percent of the national budget. Analysis of the health expenditure survey[3] shows that 36 percent of expenditure comes from public funds, 21 percent from external donors, and 43 percent from private households. The latter includes 38 percent in the form out-of-pocket payments for medicines and medical treatment.

Threat to health spending

There is a real risk that work to implement new strategies – such as scaling up health insurance and community empowerment – will be negated by the crisis. The effects of the crisis could threaten the commitments of partners and have a negative impact on efforts to improve health care. Vulnerable areas include care for mothers and infants (US$24 million[4]), the fight against disease (US$ 143,5 million[4]) and work to strengthen the health system (US$ 127,6 million[4]). Public health spending could also be hit by the slowing of economic growth, which would reduce the availability of funds for health. Households will suffer direct consequences because the crisis will squeeze earnings and reduce the amount of money received from family and friends living abroad – leaving less spare cash for out-of-pocket spending on health care.

The government has already begun to implement sector-based policies aimed at improving household living conditions. These include the accelerated growth strategy and the great agricultural offensive for food and abundance. Another policy aims to improve management of public funds, increase transparency in expenditure and enhance the effectiveness of internal and external controls. However, challenges and constraints such as variable rainfall, rising prices for oil and food, and the decline in external aid could undermine the efforts already made.

Abdoulaye Wade

President
Senegal

1. DHS IV, 2005
2. National Strategic Plan for Child Survival 2007-2015, July 2007
3. National Health Expenditure Survey, 2005
4. MTEF 2009-2011

Norway

Like others Norway is affected by the global economic crisis, which has intensified the predicted slowdown of the Norwegian economy after several years of very strong growth. We are experiencing a decline in economic activity, the worst effects of which are falling exports and rising unemployment. Comprehensive fiscal and monetary measures have been adopted to counteract the negative impacts of the crisis. We have also taken steps to support the banking sector and to ensure credit flows.

While an active fiscal policy will reduce job losses, it cannot prevent an economic downturn in 2009. However, Norway's economy is relatively healthy, and public finances are solid after many years of budget surpluses. This permits the government to undertake comprehensive countercyclical measures to combat the downturn and protect and increase social spending – which is even more important in times of economic hardship. Health budgets in Norway will continue to increase in 2009.

International initiatives

The Norwegian Government has taken a number of international measures to alleviate the negative impacts of the global economic crisis. These include:

- Maintaining and strengthening commitments to international development, including the Millennium Development Goals. Official Development Assistance (ODA) in 2009 will exceed the target of 1 percent of GNI, as the volume is maintained while the economy contracts is committed to maintaining the 2009 volume in 2010, thus also exceeding the 1 percent target in 2010.
- Increasing the aid budget with an additional NOK 200 million (US$30 million) to protect the most vulnerable during the economic crisis.
- Considering specific initiatives (together with the World Bank and other partners) to strengthen social protection for the most vulnerable – in particular women and children in developing countries.
- Offering a loan of up to NOK 30 billion (US$5 billion) to the IMF.
- Earmarking NOK 150 million (US$25 million) in the national fiscal stimulus package to increase Norwegian investments in developing countries.
- Making global health one of its main priorities in international development, with a special focus on the health MDGs. I am a member of the High Level Task Force on Innovative International Financing for Health Systems, and an initiator of the Network of Global Leaders working towards these objectives. Foreign Minister Jonas Gahr Støre is co-founder of a group of foreign ministers focused on diplomacy and health, which has already launched several initiatives to integrate global health issues into the agenda of foreign ministers.
- Advocating new and innovative financing mechanisms for global public priorities goods, such as climate and health.
- Actively promoting better and more effective use of resources by all key stakeholders in international health, through prioritisation, consolidation and collaboration.

At the regional level, Norway and WHO co-hosted a conference for European health ministers on health in times of global economic crisis. Participants at the Oslo meeting in early April discussed how the economic crisis will affect health and social protection. They identified measures to respond to the crisis, to promote health, and to reduce poverty and inequalities.

Jens Stoltenberg

Prime Minister
Norway

The Netherlands

The current global economic crisis affects us all, but the worst effects are undoubtedly felt in developing countries. They are faced with a downturn in export markets, a slowdown in economic growth and a reduction in the amount of money sent home by people living abroad. As a result, the number of people below the poverty line is sure to increase.

In line with the declaration of the G20 Summit in London on 2 April 2009, the Netherlands has reaffirmed the importance of the Millennium Development Goals and of existing commitments to development assistance. This means our commitments to health and the health-related MDGs 4, 5 & 6 should not falter. Our overall commitment to health amounted to €551 million in 2008.

Continued focus on maternal, newborn and child health

Maternal, newborn and child health (MDG 4 & 5) are particular areas of concern, as is MDG 3: empowerment of women and gender equality. Those are key to achieving all MDGs. The Netherlands attaches great importance to access for all people to reproductive health services including family planning. This is a way to contribute to lowering the number of unintended pregnancies, and hence lowering the demand for abortions which are mostly unsafe. Our priorities also include skilled attendance at birth and access to emergency obstetric care if needed. Together this will contribute to improving maternal and neonatal health.

A particular focus of our policy is to ensure access to sexual and reproductive health services for all who need them, including young people. This commitment is reflected by an increase in our contribution to the Global Programme on Reproductive Health Commodity Security (RHCS) to €30 million per year for a four-year period. With this contribution we aim to increase access to family planning and reduce the fast-growing gap between women's desire to use contraceptives and the availability of the means to do so.

In order to highlight progress and the challenges related to MDG 5, the Netherlands is collaborating with the United Nations Population Fund (UNFPA) to organise a high-level meeting in Cairo in October 2009. This will be a follow-up to the International Conference of Population and Development held in the same city in 1994.

In the fight against child mortality, the Netherlands recently committed €80 million to the International Finance Facility for Immunisation (IFFIm) for its vaccination campaigns. These funds will be disbursed through the GAVI Alliance and will be used to protect 500 million children – in the process saving an estimated 10 million lives. Our direct annual contribution to GAVI meanwhile remains at €25 million. Our contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria stands at €80 million for 2008.

The way forward and challenges

We are aware of the grave consequences that the current crisis will have for everyone. The Netherlands will, however, do its utmost to remain steadfast in its commitment to those most at risk from the crisis. This is reflected in our continued commitment of 0.8 percent of our GDP to development co-operation and in the increase of our overall health budget. The Netherlands encourages other actors, from both the public and private sectors, to remain committed to our common objectives.

Dr Jan Peter Balkenende

Prime Minister
The Kingdom of the Netherlands

Mozambique

The global economic crisis represents a significant threat to Mozambique, where economic growth has been slowing since September 2008. As global trade contracts, and commodity prices rise, our production and exports could fall and our unemployment levels increase. We also face the possibility of reduced growth in GDP and increased inflation, while a reduction in direct foreign investment could cause investment projects to be interrupted or postponed. A slackening in the flow of international aid and commercial loans would impact our ability to invest in poverty-reduction measures in priority areas such as education, health, gender and rural development.

Women and children consume a very high proportion of health care services in Mozambique, so this group would be particularly affected by any problems with service delivery caused by the economic crisis. Our challenge is to protect women and children by securing adequate financing for the health sector at this difficult time.

Other groups are also at risk, because the crisis may threaten our capability to offer good health care coverage for most vulnerable. There is a danger that malnutrition will become more prevalent due to lack of food, so a priority is to secure food supplies – especially for the most vulnerable. We need to prevent millions of families from falling into a vicious cycle of lack of food and nutrients, malnutrition and poverty.

Our health system depends on medicines and other consumables produced outside Mozambique. As many countries are already showing the impact of the economic crisis, our main concern is related to the possibility that these products will become more expensive and difficult to obtain.

The way forward and challenges

The scenario of decreased economic growth requires us to develop a strategy to minimise its impact. We continue to encourage the economic activities of small- and medium-sized producers in rural areas, in order to increase the availability of food and to guarantee employment for our people. Mozambique looks towards these small- and medium-sized entrepreneurs with hope.

My government has recently approved an action plan for food production as part of its strategy to secure sufficient and good-quality food for all. Meanwhile, we are engaged on drafting a national plan to secure food and micronutrient supplements for pregnant women and children under five. We will look to political, fiscal and monetary measures to encourage national investors.

Armando Emilio Guebuza

President
The Republic of Mozambique

Liberia

There is evidence that the global economic crisis is affecting the ability of the Government of Liberia to strengthen health outcomes and mobilise resources to attain the Millennium Development Goals. The possibility of reduced donor funding is one area of concern. Another is the threat that significant increases in the price of staple imports – coupled with lower global demand for certain exports – will compromise the ability of the government to meet its health-budget commitments. An example is the increase in the global price of rice, Liberia's staple food. This compelled the government to remove US$2 import tax on a 50kg bag of rice, with the aim of stabilising the price of rice and ensuring the poor have access to food. As a result, revenue generated by the tax on rice fell by US$3 million.

Other impacts of the crisis include a reduction in export earnings from commodities such as rubber and the delayed re-start of iron ore mining in the country. The government's export earnings on rubber have declined significantly as its domestic price has fallen from US$1,500 per metric ton to US$450. A US$6 billion investment in the iron ore industry – planned to employ over 4,000 workers and provide an important stimulus for economic growth – has also been slow to take off. Both of these developments will result in there being fewer government resources available to pay for health care.

Impact on women and children

Women and children are often worse hit by cuts in the health budget because they are among the most vulnerable in society, and are key users of our health system. Liberia has mortality rates of 111 per 1,000 live births for under-fives, and 994 per 100,000 live births for mothers. While there is evidence of a decline in the rate for under-fives, the disturbing rate at which women die in childbirth has yet to fall, and economic constraints limit the government's ability to tackle it. Worse still, many of our programmes aimed at the prevention and treatment of disease rely on external donor funding mechanisms, which are at risk of being affected by the global economic crisis.

The way forward and challenges

We are meeting the challenge of the crisis by working to reduce our dependency on imported goods and grow more food. By using the labour force for agriculture, we will help food prices become affordable and thereby improve the nutrition of women, children and the population as a whole. This shift in focus to agricultural production has the potential to increase financial reserves through the export of food products, and to minimise the need for taxes on imported food. The government has also prioritised the building and refurbishing of roads to aid the flow of goods around the country, and to make access to education and health care more equitable. With the additional resources we hope to generate from domestic production, the government has prioritised full implementation of the basic package of health services, which is the cornerstone of our national health plan. Our aim is to make all of the MDGs a reality in Liberia.

Ellen Johnson Sirleaf

President
Liberia

Indonesia

The full impact of the global economic crisis on Indonesia is not yet clear. However, it is possible that the already under-funded public health system will be further constrained by rising prices for drugs and medical supplies. Rising food prices could compromise nutrition, as access to health care becomes more difficult, especially for women and children. However, the government is committed to maintaining the 2009 health budget at 19 trillion rupiah ($US1 = 9,600 rupiah [Rp]).

To achieve MDGs 4 & 5, Indonesia aims to reduce live-birth mortality rates to 23 per 1,000 for infants, 33 per 1,000 for under-fives and 102 per 100,000 for mothers. To this end, the government has increased the 2009 budget for maternal, newborn and child health to Rp700 billion. It will fund the continuation of the continuum of care health framework for under-fives, which is focused on improving the ability of the health system to tackle the main causes of mortality in children. The government has also launched an 'Alert Village' programme. This encourages communities to share responsibility for health promotion and disease prevention by monitoring nutrition and taking steps to ensure the safe delivery of babies.

To mitigate the effect of the crisis and to maintain its pro-poor, pro-employment and pro-growth policies, the government has allocated Rp73.3 trillion to fiscal stimulus in 2009. It also recognises the importance of further strengthening the national programmes on poverty alleviation that relate to MDGs 4 & 5. These programmes are (2009 budgets in brackets):

- **Communal health insurance** – providing basic health care, including for pregnant women and children (Rp4.7 trillion)
- **National programme for community empowerment** – aiming to reduce poverty and improve local governance in rural areas for about 8-9 million people. It provides investment resources to support productive proposals developed by communities (Rp11.01 trillion)
- **Conditional cash transfer** – providing cash benefits to eligible households. Qualifying conditions include school enrolment, regular health checks and monitoring of nutrition for children and mothers
- **People-based small-business loan** – giving women preference as beneficiaries due to their financial prudence and significant role in the family's economy
- **Rice for the poor** – subsidising rice for poor families (more than Rp11 billion)
- **Cash transfer assistance** and **direct cash transfer** – providing direct financial assistance to poor families so they can provide better food and care for pregnant women and children.

In addition to national programmes, the efforts of regional and international partners should be further strengthened. There is a need to encourage rapid exchange of information among the countries worse hit by the crisis, to ensure that experience and best practice are widely shared and understood. This is particularly important to mitigate the impact of the crisis on efforts to achieve MDGs 4 & 5.

Equally important is the continuation of work to restructure the UN health-related agencies and international financial institutions, and to improve co-ordination between the UN bodies and global financial organisations that assist countries working towards MDGs 4 & 5. Furthermore, it is desirable for the meeting of the 'Sherpa' group of the Network of Global Leaders to establish a platform for more co-ordinated national programmes and international assistance in achieving MDGs 4 & 5.

Susilo Bambang Yudhoyono

President
Indonesia

Chile

Since the return to democracy in 1990, Chile's development strategy has followed the "growth with equity" model. With this concept in mind, the country has promoted a policy based on open and competitive markets but, at the same time, growing social investment. This has allowed average annual growth rates of over 5% as well as a drastic reduction in the poverty level, from almost 40% in 1990 to 13.7% in 2006, the last year for which figures are available.

This model has broken a longstanding myth in Latin America: There is no trade-off between growth and equity. Countries are not forced to choose either economic development or social inclusiveness. On the contrary, the Chilean experience demonstrates that both objectives can go hand in hand and that they reinforce each other.

This perspective has allowed the country to maintain its level of social spending even during the current international crisis. In recent years the country's fiscal responsibility has allowed it to continue investing in people. In real terms, the social budget in 2009 is increasing by 7.8%. This fiscal responsibility has also allowed the country to approve a fiscal stimulus plan that amounts to 2.8% of GDP – the fifth largest stimulus plan in the world.

Among the most relevant social policies are:

- The Universal Health Plan, that guarantees access, opportunity and quality for all Chileans with respect to 56 illnesses, regardless of the health insurance plan they use.
- A pension reform plan which, since 2008, has introduced a minimum pension for 60% of the most vulnerable, independent of the savings these individuals may have obtained during their working life. In 2009, the basic pension will be increased by 25%.
- The early childhood program, "Chile Crece Contigo" (Chile Grows With You), provides personal service to expecting mothers, early stimulus programs for young children and the construction of thousands of public and free child care centres all along the country. During the first three years of this government the number of child care centres has increased fivefold.

Commitment to Social Protection

Social protection has been without a doubt the hallmark of this government. But Chile wishes to go beyond its borders and participate actively within the international community in order to promote the implementation of the United Nations Millennium Development Goals.

MDGs represent a great effort and a significant step forward for the international community. This is the first time the UN system has given a strong signal to governments and international organizations devoted to development aid.

This effort must not be lost. The international economic crisis should not become an excuse for weakening the drive to reach these goals.

In Chile we have said that all our efforts to recover from the crisis must put people first. We must not allow that the economic collapse be followed by a social collapse with unimaginable consequences. We must not retreat on the MDGs because that would mean poverty, starvation, sicknesses and death for innocent people. That is why we need strong collective action and strong political leadership.

During these difficult times, Chile reaffirms its commitment to the most vulnerable all over the world. The Network of Global Leaders can count on us.

Michelle Bachelet

President
Chile

Brazil

Recent Brazilian experience provides an encouraging example of how good macroeconomic management and prioritising the health of mothers and children can go hand in hand. As a result of long-term stabilization policies, Brazil has made meaningful progress in recent years in controlling inflation, responsible fiscal policies, reducing the foreign debt and stabilizing the exchange rate regime.

At a time when progress in poverty reduction worldwide is threatened by the most severe global economic crisis since the 1930s, Brazil is well prepared to face these hard times. Despite the slowdown in GDP expansion in 2009, Brazil's growth rate should remain above the global average. This is explained by the fact that growth in Brazil is largely domestically driven, through higher levels of income, employment and access to credit, especially for small businesses. This trend has been further encouraged by a steady fall in inequality as a result of conditional cash transfer programs, such as Bolsa Familia. By reinforcing these mechanisms that protect against external shocks, Brazil has further reduced instability and opened the way to further accelerate progress towards the Millennium Development Goals 4 & 5.

The Brazilian agencies charged with dealing with child mortality and maternal health policy are the Ministry of Health and the Ministry of Social Development and Fight against Hunger (MDS). The Family Health Strategy Program, in conjunction with the Ministry of Health's Department of Basic Assistance, has played an important role in meeting Goal 4, by organizing primary health care; promoting therapeutic nutrition and breastfeeding; and providing supplementary nutrition and nutritional education. As a result, since 1990 child mortality has fallen from 57 to 19,3 per 1000 live births.

The Bolsa Família Program, which is overseen by MDS, has helped cut down child mortality by improving maternal health. This in turn is achieved by cash transfers conditional on a series of requirements, such as full access to health care for children, expectant mothers and beast feeding mothers. Despite the current challenges posed by the financial crises, these successful programs will be maintained and strengthened in 2009, in line with the Brazilian Government's commitment to expanded social expenditures for the most vulnerable segments of society.

Brazil's greatest challenge concerns Goal 5, where performance is poorest. Yet these targets are still within reach by 2015. To this end, the Ministry of Health has identified 207 maternity centers that are responsible for 50 percent of maternal hospital deaths. The 2009 and 2010 Plan of Action aims to improve health care services offered in those centers, which are mostly located in the Amazon and Northeast regions.

At the same time, current programs, such as the Family Health Strategy, the National Pact for the Reduction of Maternal and Child Morality and Bolsa Família, already embody a gender perspective and the principle of humanized labor, thus further contributing to achieving MDG 4 & 5. These various initiatives are mutually reinforcing in that they train health professionals to guarantee universal and qualified health assistance to mothers and newborns, while at the same time putting into place surveillance practices to overcome underreporting of maternal mortality.

Luiz Inácio Lula da Silva

President
Brazil

Australia

Developing countries in Asia-Pacific face serious challenges from the global economic crisis, with the IMF forecasting regional economic growth to slow to 4.8 percent in 2009 – roughly half that of 2007. We know that health outcomes deteriorate rapidly during economic slowdowns. With most of the world's poor living in the Asia-Pacific region, the crisis will severely challenge achievement of the health MDGs.

Just when developing countries need assistance the most, the crisis is putting real pressure on donors' aid budgets. Currency devaluations are also reducing the purchasing power of aid programmes, presenting serious challenges for basic service delivery.

Similarly, Asia-Pacific partner countries experiencing currency devaluation must pay more for imported health expenditures, such as medicines and hospital equipment. As slowing economic growth reduces government revenues, many partner governments will struggle to deliver core health services – just as demand for public health care increases due to falling remittances from overseas migrants and rising domestic unemployment, which will constrain private health expenditure.

Continued support

Australia is committed to helping partner countries respond to the crisis and is in dialogue with them, and other donors, about practical support. Calls for assistance – such as Indonesia's request for a US$1 billion standby loan – are increasing. While slower growth in our Gross National Income (GNI) and decline in our currency will reduce the assistance we can provide, the Australian Government remains committed to increasing Official Development Assistance to 0.5 percent of GNI by 2015. We are also considering innovative mechanisms that allow long-term commitments to be frontloaded and support continued progress towards the health MDGs.

We are reviewing AusAID programmes to ensure they are assisting vulnerable groups, such as women, children, the disabled and the mentally ill. An important focus is to monitor the flow of remittances from relatives and friends overseas, which help to finance out-of-pocket health care. To mitigate the impact of the crisis on people's health and on health infrastructure, we will continue to support basic service delivery, including recurrent costs for essential supplies, personnel and maintenance of equipment. This is vital for the long-term sustainability of health systems.

Australia's membership of the International Health Partnership (IHP+) reflects our strong commitment to supporting developing countries' national health plans. We also support steps to simplify the global health architecture. We are working to help partner governments embrace mutual accountability through results-based health financing and performance management frameworks. One element is to ensure health problems causing the greatest burden of disease receive adequate support.

Aiming to harmonise donor funding, Australia has helped establish sector-wide health programmes in Cambodia, Nepal, the Solomon Islands, Timor-Leste and elsewhere. These can enhance the efficiency of aid by reducing transaction costs and the associated burden on partner governments, while aligning donor and government monitoring systems.

Australia remains committed to protecting the vulnerable from the most damaging effects of the crisis. We will continue to work with partner countries and donors to improve the efficiency and effectiveness of aid programmes in confronting the challenges ahead.

Kevin Rudd

Prime Minister
Australia

China

Women are an important force driving the development of human society, and children represent the hope and future of the world. The welfare of women and children is an indicator of modern civilisation and social progress and their health bears directly on the future of mankind.

To respect women and care about children is a long-cherished tradition of the Chinese nation. It is also a basic principle that China follows in building a harmonious society. We have endeavoured to improve the living environment of women and children in all respects in line with our people-oriented policy and the principle of ensuring 'safe motherhood' and putting 'children first', and made important strides in meeting the United Nations Millennium Development Goals (MDGs) in the health sector.

Improve relevant mechanisms and put in place a sound legal regime

With the promulgation of the Law on Maternal and Infant Health Care and other laws and regulations, China has established a sound legal regime to protect the health of women and children. We have set up an inter-departmental mechanism for programmes related to women and children, and formulated and implemented the Outline for the Development of Chinese Women and the Outline for the Development of Children in China.

Increase input to, and expand the coverage of, health care services for women and children

The Chinese Government allocated US$400 million in 2008 alone to support the development of a rural health care system, including the building of health centres for women and children. Since 2000, China has carried out programmes to lower maternal mortality rate and eliminate neonatal tetanus in China's central and western regions. Up to 460 million people have benefited from these programmes.

Take a multi-pronged approach to improve the health of children

China has taken various measures and carried out international co-operation to effectively reduce the morbidity and mortality of children from common or frequently-occurring childhood illnesses. China has actively implemented the Integrated Management of Childhood Illness Programme advocated by the World Health Organization (WHO). We have promoted neonatal disease screening nationwide, and conducted neonatal resuscitation programmes in central and western China. Sample statistics show that China's infant mortality rate dropped from 33.1 percent in 1991 to 10.2 percent in 2008.

Take concrete actions to improve child nutrition

The Chinese Government has carried out an all-round campaign to publicise and promote breast-feeding in response to the calls of WHO and the United Nations Children's Fund (UNICEF). We have worked actively to set up 'baby friendly hospitals'. Up till now, over 7,000 such hospitals have been opened in China, accounting for roughly half of the world's total. In 2007, China drew up a Strategy for Infant and Young Child Feeding in China. Thanks to all these efforts, the nutrition level of Chinese children has markedly improved in the past decade or more.

After the massive earthquake in Wenchuan of Sichuan Province last year, the Chinese Government paid close attention to ensuring maternal and child health care in affected areas. We promptly provided ambulances and mobile delivery rooms for women in pregnancy or delivery, distributed nutrition-enhancing food urgently needed by pregnant women and children, and sent psychiatrists and social workers to provide post-quake psychological counselling and social support to children there. We also took full account of the special needs of women and children in formulating the master plan for post-quake reconstruction to help them get through the difficult time.

The development of health care for women and children in China, a populous developing country, is not yet sufficient and there are gaps to be closed between urban and rural areas and among different regions.

The ongoing global financial crisis has also posed severe challenges to China's economic and social development. But we will not scale down our input in development, especially in promoting the welfare of women and children.

To build a harmonious world of enduring peace and common prosperity calls for concerted efforts by the international community. China is ready to share experience and resources with other countries and relevant international organisations and work together with them to achieve the MDGs at an early date, and create an even better future for women and children.

Chen Zhu

Minister of Health
The People's Republic of China

Russia

Efforts of the Russian Federation to achieve the Millennium Development Goals in health care, and in particular to reduce child mortality and improve maternal health

Goal 4: Reduce child mortality

The indicators of child mortality of children under five are reducing. In 2006 the indicator of child mortality in the Russian Federation was 12.9 percent of 1000 children born alive, which is lower than the similar indicator in 2002 by 23.7 percent (16.9) and by 39.7 percent lower than the indicator in 1990 (21.4). The indicator of infant mortality in the period from 1990 to 2007 reduced by 46 percent and equalled 9.4 in 2007 (17.4 in 1990).

Goal 5: Improve maternal health

In recent years there has been a reduction in the indicators of maternal mortality. For example, in the period from 1990 to 2007 the indicator of maternal mortality reduced by 53.8 percent and equalled 21.9 in 2007 (47.4 in 1990). Gradually the share of child-bearing assisted by qualified staff is increasing e.g. in the last five years the number of deliveries in the hospitals increased by 10 percent.

Goal 6: Combat HIV/AIDS, malaria, and other diseases

There has been an increase in the number of new cases of infection, in the number of HIV-positive pregnant women and in the number of mother-to-child transmissions. Such data show the need to further improve the measures taken to prevent mother-to-child transmission of HIV, and how they are organised. There is also a need to improve the co-operation of medical, obstetric and paediatric services with HIV centres and social institutions, in order to provide a complex approach to giving medical and social help to HIV-positive pregnant women, mothers and children.

There is a positive dynamic in the improvement of the indicators of antiretroviral (ARV) prevention of HIV mother-to-child transmission. In 2008 ARV prevention was conducted in 81.4 percent of HIV-positive women during pregnancy (in 2007 – 81.4 percent; in 2006 – 73.5 percent;), 92.3 percent of HIV-positive women received ARV prevention during delivery (in 2007 – 92.3 percent; in 2006 – 89 percent), and 98 percent of new-born children from HIV-positive mothers received ARV prevention (in 2007 – 97.9 percent; in 2006 – 95.2 percent).

In the last five years the number of women of fertile age who used contraceptives increased by 4.6 percent.

Tatyana Alekseyevna Golikova

Minister of Health and Social Development
Russia

Chapter Four

Rising to the challenge

Specific actions by key stakeholders

Despite the worsening economic outlook, UN agencies, funds, civil society and the private sector are taking specific actions to mitigate the effects of the global economic crisis. They are prioritising countries with the highest maternal and child mortality rates, as well as fast tracking and frontloading funds for social protection. They are also working with donors and developing countries in the following initiatives to consolidate more effective collaborative action and ensure better value for money:

- *Prioritising the poorest countries – for example, UNICEF funds are increasingly focused on countries with the greatest number of child deaths*
- *Delivering as One – co-ordinating UN work at country level*
- *The International Health Partnership (IHP+) – rallying support behind country health plans to strengthen service delivery*
- *The Health 8 (H8) – co-ordinating work by WHO, UNICEF, UNFPA, UNAIDS, the Global Fund, GAVI, the Bill and Melinda Gates Foundation, and the World Bank*
- *The Health 4 (H4) – co-ordinating work by UNICEF, UNFPA, WHO and the World Bank in the area of maternal and child health*
- *Efficiency gains – for example, the Global Fund is committing to cut 10 percent of expenditure, saving US$250 million in relation to its eighth funding round application, without cutting programme delivery*
- *A joint platform is being developed by GAVI, the Global Fund and the World Bank for the channelling of broader health-related finance. All three are providing new ways of delivering aid to get the best results*
- *GlaxoSmithKline has pledged, on behalf of those in the private sector, to reduce prices for patented medicines in developing countries by taking a more flexible approach to intellectual property*
- *Civil society organisations are collectively raising awareness of pressing global challenges and holding governments accountable for funding and building effective health systems. By using their networks in developing countries, they have also been able to mobilise communities to take ownership of their own health care services and to provide essential health care services where governments are not yet able to do so*

GAVI

The GAVI Alliance provides long-term, predictable support for immunisation and health services in more than 70 of the world's poorest countries. Despite the current global economic crisis, it continues to make real progress in developing results-based approaches and innovative financing mechanisms, such as the International Finance Facility for Immunisation (IFFIm). IFFIm uses the capital markets to raise funds based on 20-year donor payment obligations. The triple-A-rated bonds continue to be highly sought after by investors as solid, profitable investments in otherwise turbulent markets. More than US$500 million was raised through two bond issuances in January and March 2009 alone.

IFFIm does more than just raise funds. Economists estimate that the financial predictability and frontloading that IFFIm provides yields a 22 percent return on investment in vaccines by enabling long-term planning and driving down vaccine prices.[1] This year will also see the finalisation of legal arrangements for, and commercial launch of, the first pilot Advance Market Commitment. This will make pneumococcal vaccine available at an affordable price in the poorest countries.

Affordable access to vaccines

GAVI support is already aligned with countries' planning frameworks and, to help make vaccines more affordable, it is exploring ways to lower their transaction costs. Under the auspices of the International Health Partnership, GAVI is working with the two countries that first signed national compacts – Mozambique and Ethiopia – to harmonise provision and monitoring of GAVI support more effectively. This will inform GAVI policy and support for other countries.

In March 2009, the High Level Task Force on Innovative Financing and Health System Strengthening welcomed a new proposal from GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). This aims to explore joint programming with the World Bank of resources for health systems strengthening. Working with the World Bank, GAVI and GFATM will draw on their experience of innovative results-based financing to develop a streamlined new approach to providing international assistance for the implementation of national health plans.

To date, the funds raised and channeled to countries through GAVI have yielded significant results. WHO estimates that 213 million children have been vaccinated with GAVI-supported vaccines, preventing 3.4 million premature deaths by the end of 2008.[2] Currently, powerful new vaccines against the child killers diarrhoea and pneumonia are being rolled out with GAVI support, which are projected to save the lives of an additional 1,135,000 children by 2015.[3] As vaccine uptake is projected to increase, several million additional lives will be saved after 2015.[4]

The new GAVI Alliance Board was officially launched in October 2008 after the merger between the old GAVI Alliance Board and the GAVI Fund Board. This will bring efficiency gains and strengthen the GAVI Alliance as a public-private partnership.

Julian Lob-Levyt

Chief Executive Officer
GAVI Alliance

1. Owen Barder and Etan Yeh: The Costs and Benefits of Front-Loading and Predictability of Immunization. Working Paper Number 80, January 2006. Washington DC: Center for Global Development.
2. WHO report on GAVI Progress 2000-2007 & Projected Achievements 2009-2010. Geneva: World Health Organization, October 2008.
3. Applied Strategies have estimated that pneumococcal and rotavirus vaccine introduction could prevent 900,000 pneumonia deaths and 235,000 diarrhoea deaths by 2015. Updated estimates will be available by mid-2009.
4. The pneumococcal vaccine is projected to avert 7 million deaths by 2030 (Pneumococcal Accelerated Development and Introduction Programme calculations, available on http://www.preventpneumo.org/*) and the rotavirus vaccine is projected to avert 1.4 million deaths by 2020 (Rotavirus Vaccine Programme calculations, available at* http://www.rotavirusvaccine.org/*).*

The Global Fund to Fight Aids, Tuberculosis and Malaria

Resource needs and efficiency gains

Since its creation in 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has become the world's leading funder of programmes to fight the three diseases, with grants worth US$15.6 billion supporting programmes in 140 countries.

The dramatic increase in funding for health in developing countries that has taken place over the past six years has already translated into unprecedented gains in health outcomes. Evidence from a number of countries in sub-Saharan Africa shows that mortality from AIDS has fallen dramatically as nearly four million people have gained access to HIV treatment. Countries that have rolled out comprehensive malaria-control programmes have seen a reduction of between 50 percent and 90 percent in mortality from the disease, mostly among small children. Several countries with a high burden of tuberculosis have experienced a moderate to dramatic reduction in prevalence rates and mortality. Evidence so far also indicates that this progress has strengthened countries' health systems.

Together, these early indications of impact nourish hope that the health-related Millennium Development Goals can be met for tuberculosis and exceeded for malaria, and that substantial progress will be seen for AIDS.

Ensuring value for money

Given the clear need to protect targets for improved health, while responding to the realities of the economic crisis, the Global Fund has initiated a number of initiatives to secure efficiency gains in its funding. For its eighth round of funding in 2008, the Global Fund mandated an average 10 percent saving in programme costs for new grants to save US$250 million in new grant funding – wherever possible ensuring that this is done without affecting the level of services and commodities provided. The Global Fund is also working with its partners to negotiate lower prices, or increase price competition, for drugs, long-lasting bed nets against malaria and other commodities.

The Global Fund has seen a steady increase in demand for its grants over the past seven years. Global Fund grant approvals have increased from US$613 million in 2002 to US$5.2 billion in 2008 and could reach between US$5.1 billion and US$8 billion in 2009, and between US$4.5 billion and US$7.5 billion in 2010. The Global Fund has so far received pledges and contributions of around US$20 billion, leading to a funding shortfall by the end of 2010 of between US$4 billion and US$10 billion.

The funding gap exists because countries around the world have improved their capacity to prepare and implement programmes that address real and urgent health needs. Countries have followed international calls for scaled-up action. These calls have been confirmed both by the G8 governments and by the United Nations, through the General Assembly and the Secretary-General. While the response to these calls must now compete with the need to stabilise the global economy, it is also clear that a failure to continue a scale-up of investments in health will betray the trust of millions of people who have been given hope of survival from deadly diseases by the promises of the international community.

Michel Kazatchkine

Executive Director
The Global Fund to Fight Aids, Tuberculosis and Malaria

UNAIDS

The global response to the HIV epidemic is at a crossroads. Universal access is the fundamental priority for UNAIDS, and it can be achieved in spite of the global economic crisis. We can gain greater efficiencies by focusing on approaches that achieve results for the Millennium Development Goals through the AIDS response and positively impact HIV transmission through other MDG responses.

The broad social, financial, political and technical mobilisation of stakeholders has spearheaded remarkable HIV and AIDS action and results. Hard-won gains are, however, fragile and must be protected, because the AIDS epidemic persists and progress in some critical areas remains too slow. These include areas where we have the tools and the knowledge to do better, such as the prevention of mother-to-child transmission. Work must continue to reduce the cost of antiretroviral treatment and to increase access.

New steps are being taken to improve synergies, within the health sector and across multiple sectors. UNAIDS will contribute proven approaches that have supported the AIDS response by building linkages with health systems development, such as in the context of the International Health Partnership (IHP+). However, renewed focus is needed on social, political and structural constraints, which must involve partners beyond the AIDS movement.

Substantial progress can be achieved on a number of the MDGs by taking the AIDS response out of isolation and integrating it with efforts to achieve broader human development, health and social justice goals. To this end, the new leadership of UNAIDS (with its Co-sponsors in the UN system) has endorsed a new, joint Outcome Framework for 2009-2011. This reflects a strong commitment from all agency heads to focus on eight priority areas.

UNAIDS has been at the forefront of identifying approaches for better alignment within the UN and across the complex organisational landscape of AIDS, health and development. These include the broadly accepted 'Three Ones' principles for AIDS and its contribution to the "Delivering as One" initiative, which co-ordinates the work of UN agencies and Co-sponsors at country level. Work is also in progress for taking the collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria to the next level, by focusing on country-level effectiveness, monitoring and evaluation.

UNAIDS welcomes a special focus on MDGs 4 & 5, because it is possible to prevent mothers from dying and babies from being infected with HIV. It can be done by aligning efforts to scale up access, and by using quality services to prevent mother-to-child transmission (PMTCT). However, PMTCT needs to be delivered as an integral part of comprehensive sexual and reproductive health services for women.

In tackling the impact of the economic crisis, UNAIDS is working with its Co-sponsors and civil society to gain support for protecting an essential level of social spending in developing countries. Global efforts to stimulate the economy should include a social component, which includes a focus on health and essential AIDS investments. UNAIDS will work to increase the effectiveness and efficiency of social-sector spending, strongly focusing on results and outcomes – especially for vulnerable groups – and building on the "AIDS dividend" for positive synergies.

UNAIDS is working with partners to generate support for mechanisms that assess the impact of the economic crisis. These include an "AIDS lens" that tracks continuity of treatment for AIDS and TB, country by country, and the effectiveness of measures to prevent mother-to-child transmission of HIV.

In the first months of 2009, the UNAIDS leadership consulted widely on how to optimise relationships between needs, financing, activities and outcomes for universal access and the MDGs. The results of the five-year impact evaluation are expected to provide additional evidence on how to improve effectiveness. UNAIDS is committed to working with partners to ensure that the AIDS response delivers results, country by country, for all MDGs.

Michel Sidibé

Executive Director
UNAIDS

UNFPA

To maintain progress towards the Millennium Development Goals (especially MDGs 4 & 5) in the context of the global economic crisis, UNFPA calls for increasing social investments – especially in the areas of reproductive health and rights. An adequate response must have a special focus on women and adolescent girls.

UNFPA, working with UN partners, will analyse the risk levels and vulnerability of each country, and will adjust its response accordingly in each case. Countries with high maternal and newborn mortality will remain a priority. In addition, UNFPA has identified five key strategies to mitigate the effect of the global crisis on sexual and reproductive health, including maternal and newborn health:

1. Advocating increased investments in health

UNFPA is calling for increases in health budgets and development assistance allocated to health, especially sexual and reproductive health. UNFPA aims to include MDG 5 in all government plans and budgets. The total package for sexual and reproductive health, including family planning and maternal health, is estimated to be US$23.5 billion in 2009, peaking at US$33.3 billion in 2014. Greater funding is needed for family planning. Research shows that globally each 10 percent shortfall in funding for family planning, computed on the basis of meeting existing unmet needs, results in an additional 1.8 million unsafe abortions and 19,000 maternal deaths.

2. Identifying priorities within the basic reproductive health package

Through its global programme to enhance reproductive health commodity security, UNFPA will help maintain a flow of reproductive health supplies in countries likely to be affected by short supply. A special focus on vulnerable and excluded youth, including young married adolescents, is necessary to enable them to develop positive social and health-seeking behaviour. UNFPA also promotes the linking of HIV/AIDS with sexual and reproductive health services to increase cost-effectiveness.

3. Using technology and data to target the poor, monitor impact and support technical assistance

UNFPA is using mapping technologies that contribute to the effective redirection of public resources. It also promotes the sharing of good practices from countries that have developed effective social insurance schemes and safety nets to target the poor, and expanded access to emergency obstetric care and facility based childbirth leading to improved woman's and newborn health outcomes.

4. Promoting rights-based approaches and community delivery

UNFPA is working closely with civil society to promote positive change in behaviours to increase the use of reproductive health services, especially among hard-to-reach groups. UNFPA and WHO are working together to improve civil society's involvement in national health processes and their monitoring.

5. Harmonising approaches through UN reform, partnerships and national capacity development

UNFPA is working closely with UN agencies and development partners to harmonise country-level programming in support of government priorities. As part of the joint agreement to accelerate progress in maternal health in priority countries, UNFPA is proactively working within the agreed division of labour among health partners. It is also focusing on health systems strengthening as a common goal. Priority countries are aligned with other initiatives, such as the International Health Partnership (IHP+).

These five strategies will be instrumental in upholding the hard-won gains in health that we have witnessed over the last decade, especially in reproductive health. People everywhere are looking to leaders to put people first. It is crucial to focus on social protection, human dignity and opportunity for the most vulnerable as we strive to reach the Millennium Development Goals and confront the global economic crisis.

Thoraya Obaid

Executive Director
UNFPA

UNICEF

In 2007, around 9.2 million children under the age of five died primarily of preventable causes. This figure, while still completely unacceptable, represents a drop of 27 percent in under-five mortality since 1990 – the baseline year for the MDGs. Indeed, for many domains within which UNICEF works in global health, progress has continued over the last year.

But progress has not been uniform. As highlighted in the 2009 State of the World's Children report, maternal and newborn health, which are of course inextricably linked, are areas of particular concern. More than 500,000 women die of pregnancy-related causes every year. Around 50 million or 40 percent of all births occur without a skilled health care worker in attendance. Currently only around 12 percent of HIV positive pregnant women who qualify for antiretroviral treatment are actually assessed for such treatment. A focus on maternal-newborn health, including sexual and gender-based violence, needs to be an integral component of our international systems for protecting human rights.

UNICEF remains extremely concerned about the ramifications of the global economic crisis for poor women and children. The organisational response can be summarised in terms of four main categories:

1. Focusing on core programmes
2. Policy advocacy
3. Engaging in more strategic partnerships
4. Monitoring and evaluation

Core programmes

Maternal and child health and nutrition are a priority area for UNICEF. In 2008, programme and procurement expenditures of US$2 billion in this area accounted for more than 50 percent of all expenditures. More than US$600 million was spent procuring key child survival commodities (such as vaccines, ITNs, ACTs, RUTFs, ARVs[1], and other essential medicines and medical kits), on behalf of governments using their own funds as well as funds from the World Bank, GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and UNITAID. Increasingly, UNICEF funds are focused on the countries with the greatest number of child deaths. Of the US$700,000 million in core resources spent in country programmes in 2008, almost two-thirds were spent in the 20 countries with the highest number of deaths among children under five.

Over the last year, and building upon work done with UNICEF offices in Africa, UNICEF has continued to focus on supporting governmental and non-governmental partners to expand integrated community-based programmes. Given that more than 40 percent of all maternal and child deaths occur in the Asia-Pacific region, a major priority has been to re-focus our programmes there on maternal and newborn health and on the major causes of death among children under five, particularly diarrhoea and pneumonia. Such a strategic shift will involve an expanded effort to address under nutrition and poor sanitation. In addition, UNICEF has played an important role in responding to the food price fluctuations of the past year. An additional US$50 million was allocated to 45 country programmes, in which children were especially vulnerable, to enhance nutrition security for children under five and for pregnant and lactating women.

Policy and advocacy

The 30th anniversary of the Alma Ata Declaration on Primary Health Care was in 2008. As WHO and UNICEF work with countries to revitalise primary health care, it has become clear that the core principles of multisectoral programming, community engagement and equity are as relevant today as they were in 1978. During the International Year of Sanitation in 2008, UNICEF also adopted an approach to sanitation programming that relies on demand creation and empowerment of communities and households. It holds great promise for dramatic increases in sanitation coverage. In addition, the economic crisis has further highlighted the issues of disparity and financial barriers to accessing health care. Out-of-pocket expenditure on health care is increasingly recognised as a major cause of impoverishment.

Collaboration and partnership

A major new effort on maternal and newborn survival, focused on the 25 countries with some of the highest maternal mortality ratios, was launched this year with WHO, the World Bank and UNFPA. UNICEF continued to be an active member of the steering committee and core group of the International Health Partnership, with many of our country offices taking a leadership role in the development of country compacts and country investment plans to reach the MDGs. Finally, partnerships with GFATM and GAVI were expanded, with UNICEF using its strong country presence to help "make the money work". One example has been the work UNICEF has led on behalf of the Roll Back Malaria partnership to assist countries in accessing and utilising GFATM malaria funding. Over the past year, this support to countries has leveraged more than US$3 billion of additional funding for malaria.

Monitoring and evaluation

UNICEF continues to support countries to carry out Multiple Indicator Cluster Surveys. Together with Demographic and Health Surveys, these provide the majority of data on the health-related MDGs. UNICEF co-chairs the Countdown Initiative and is working with the Inter-Parliamentary Union to ensure country data on the health-related MDGs act as a catalyst for action. In 2008, the findings of a major independent evaluation of the Accelerated Child Survival and Development programme in West Africa, conducted by Johns Hopkins and Harvard Universities, added impetus for redoubling efforts on the truly neglected diseases of childhood: pneumonia and diarrhoea. In addition, the Global Partners Forum, convened by UNICEF and the Irish Government, recommended strengthening social protection/cash transfer schemes and government child welfare systems – better linking these systems with community-based service providers. It concluded that AIDS-sensitive (but not AIDS-exclusive) interventions could best reach families caring for orphans and vulnerable children.

UNICEF will continue to monitor the effects of the crisis on the most vulnerable women and children, and respond in the most efficient and effective manner possible. However, it is also true that, with every crisis, opportunities exist that were not there before. A few years ago, calls for universal access to antiretroviral treatment appeared to some to be naïve. Today more than three million people with AIDS have access to such treatment, the majority in Africa. The crisis has highlighted not only the need to continue to invest in those areas of development that are producing results, such as global health, but also the moral imperative of protecting the most vulnerable. As the leading voice for women and children, UNICEF believes in universal access to a basic essential package of services for them – thus achieving the health-related MDGs with equity.

Ann M Veneman

Executive Director
UNICEF

1. Insecticide-Treated Nets; Artemisinin-based Combination Therapies; Ready-to-Use Therapeutic Foods; Antiretrovirals.

World Health Organization

As the global economic crisis deepened, WHO convened an organisation-wide task force in November 2008. The Director-General briefed ambassadors in Geneva before the November G20 meeting in Washington, and published an initial statement that set out five reasons for increasing investment in health and the social sector[1].

A high-level consultation for member states and partner organisations took place on 19 January, before the opening of WHO's Executive Board. The report of the consultation[2] suggests a five-point framework for action: 1. Leadership; 2. Monitoring and analysis; 3. Pro-poor and pro-health public spending; 4. Policies for the health sector; and 5. New ways of doing business in international health.

In the first quarter of 2009, the focus has been on rapidly collecting information about the impact of – and policy responses to – the crisis at country level. To this end, meetings have been held in four of the six WHO Regions – most recently in Europe, hosted by the Ministry of Health of Norway. A synthesis report will be presented at the World Health Assembly (WHA) in May 2009. WHO has ensured that the health impact of the crisis will be prominent in the high-level segment of the UN Economic and Social Council (ECOSOC), which this year focuses on health. The Director-General updated member states on the crisis before the London G20 Summit[3] in April 2009.

Information exchange is vital

WHO's work to combat the lasting impact of the crisis will follow the five-point framework above. Alongside monitoring and analysis, a key concern will be to facilitate rapid exchange of information on the range and effects of policy responses. A particular focus will be on those that aim for maximum health benefit from public spending programmes, those that strengthen social protection, and those that increase the effectiveness of health service spending. The crisis will give added momentum to on-going work to improve the effectiveness of aid for health (e.g. through the International Health Partnership), UN country teams, and the process of UN reform.

Women's health is a priority, and a status report will be released in 2009. A separate report, for WHA in May, will highlight the importance of primary health care in maternal, newborn and child health. At country level, WHO supports the preparation of costed, outcome-oriented national health plans that fully reflect national priorities. WHO uses country co-operation strategies to identify specific areas where it can add value to the work of others, and it supports member states as they seek to align health support from all development partners.

WHO has recently recommended an increase in the budget for maternal, newborn and child health, which should be protected from any subsequent reductions. The Director-General will present a revised budget to the WHA in May, and proposals for achieving greater efficiencies within the current budget will be discussed at the Assembly. These include plans to reduce travel and to control publications more tightly. The H8 global health agencies are seeking efficiencies through a clearer division of labour – particularly between WHO, UNICEF and UNFPA in the area of maternal, newborn and child health. Looking to the longer term, WHO senior management is reviewing options for fundamental changes to make the way WHO is financed more fit for purpose. This review will seek to address issues around prioritisation, poor alignment of funds, and increasing costs for administration and governance.

Margaret Chan
Director General

World Health Organization

1. http://www.who.int/mediacentre/news/statements/2008/s12/en/index.html
2. http://www.who.int/topics/financial_crisis/en/index.html
3. http://www.who.int/mediacentre/news/statements/2009/financial_crisis_20090401/en/index.html

Civil Society – Foundation for Community Development

Fighting an all-too-familiar crisis

Yes, the current global economic crisis might hit hard, affecting people struggling to get out of poverty. But by many it will not be noticed at all, since their life conditions cannot, by any means, be worsened. For these people the crisis will be an extension of the only reality they know: suffering (due to unfair causes) and death (that could be prevented).

Ours is a battle against the clock for the survival of every child and every mother, and the protection of every human being from any preventable disease. We are already late in our effort, and the present crisis cannot delay our advances.

In Mozambique, 138 children out of 1000 die before the age of five (WHO, 2008), and maternal mortality is still above 500 cases for every 100 000 live births (WHO, 2005).

New policies and better practices are in place, and these huge efforts from all stakeholders (developing countries, donors, implementing organisations, civil society and others) are producing results that can be measured with many lives saved – mostly among the most vulnerable.

Support for immunisation

However, the numbers above tell us we still have a long way to go. In March 2002, the Mozambique Ministry of Health (MISAU), VillageReach, and the Foundation for Community Development (FDC) launched a five-year project designed to ensure prompt and universal access to vaccines in the northern province of Cabo Delgado. Known as the Project to Support PAV, it supports the Expanded Programme on Immunisation (PAV, in Portuguese) – strengthening vaccine logistics by creating a simple delivery system, improving access and information flow and providing a reliable and clean source of energy.

In 2003, the DTP3 coverage rate in Cabo Delgado was 68.9 percent. In 2008, it was 95.4 percent. All other vaccines saw similar increases, resulting in 92.8 percent coverage for all vaccines given to children aged 24 to 35 months. In the neighbouring Nampula province, FDC and the MISAU launched the same programme, which is already covering all health units and achieving results.

We are making incredible progress, proving that children's lives can be saved with proper planning and funding, and good implementation. But we cannot allow this progress to falter. Other provinces can learn from the great experiences in northern Mozambique. By sustaining our commitments, we can make a difference, and protect all children's lives from preventable infectious diseases.

The MISAU has recently presented a comprehensive human resources development plan, stating the urgent need to increase the capacity of the workforce with improved skills and more personnel. Such a plan, if funded and deployed, can really help to bring health services close to the people, and improve not only children's vaccination rates but also the health condition of the whole population.

Despite any crisis, FDC will continue fighting. If we all persist and continue to work together in a co-ordinated manner – policy makers, planners, implementers and funders – we can make it happen.

Graça Machel
Founder and President of the Foundation for Community Development, Mozambique

Civil Society – International NGOs

For organisations committed to improving the health of women and children in developing countries, the current global economic crisis presents a range of new and heightened challenges:

Increasing need – as global economic conditions worsen, life among the world's poorest populations becomes increasingly fragile. In this environment, global health spending should be increased. This will not only improve health but also reduce poverty and allow for stronger economic growth.

Deteriorating services – just as needs increase dramatically, government revenues in developing countries are falling. With health systems already under developed and struggling in many countries, progress on urgent health priorities will likely slow or even reverse. Civil society organisations (CSOs) often provide a crucial safety net for vulnerable populations, so there would be a potentially devastating 'cascade' effect if civil society were unable to play this important complementary role to government action.

Declining individual donations – in northern countries, individual giving to CSOs has begun to drop. Many international CSOs rely on individual donors for funding, so this could disproportionately threaten organisational stability and sustainability.

Uncertain institutional funding – the crisis has also thrown into question the extent to which CSOs can depend on funding from bilateral and foundation donors, which are being squeezed by fiscal pressures and investment losses. These funding pressures have made it difficult for many organisations to plan for long-term programme strategies and maintain consistent and sufficient staffing.

In the face of these challenges, our three organisations – and our many CSO partners – remain more committed than ever to our urgently important missions, and to serving the most vulnerable populations. We continue to plan and implement innovative, progressive programmes, to manage our costs and seek new income sources, and to collaborate creatively with donors, governments, corporations and civil society.

Uniquely positioned

The role of civil society – at the global, regional, national, and local levels – remains critical to improving maternal, newborn, and child health and fulfilling the promise of the MDGs. Through advocacy work, capacity-building programmes, and service-delivery projects, CSOs are uniquely positioned to:

- Raise awareness of pressing global challenges
- Hold governments accountable for funding and building effective health systems
- Mobilise communities to take ownership of their own health care services
- Foster new leadership at the local level
- Work across sectors to ensure progress
- Develop innovative models for service delivery, health systems development, and community mobilisation, and methods for bringing them to scale
- Provide essential health care services where governments are not yet able to do so

Our organisations – together with the hundreds of global, national, and local CSOs with whom we work in partnership to build healthy families, communities, and economies – are committed to continuing this important work, until the time when all women and children can count on the life-saving health care that is their right and the world's obligation.

Joint statement by:

Theresa Shaver
White Ribbon Alliance

Ann Starrs
Family Care International

Marte Gerhardsen
CARE International Norway

Civil Society – Private sector

GlaxoSmithKline[1] (GSK) is a leading innovator and producer of vaccines, and a key stakeholder in the health care systems of many countries as they face the global economic crisis. We contribute to achieving Millennium Development Goal 4 by ensuring our vaccines are included in the Expanded Immunisation Programmes for the world's most vulnerable children.

Our contribution is based on:

- **Sustaining investment in developing pharmaceutical products for developing countries** – including medicines and vaccines for WHO's three priority diseases: HIV, tuberculosis and malaria.
- **Engaging with donor and developing world governments, multilateral agencies and other key stakeholders** – sustaining progress and driving further improvements in combating disease.
- **Supporting innovative mechanisms for sustainable and predictable health financing** – critical to minimising the time lag for introduction of new vaccines (historically 15 to 20 years between the developed and the developing worlds).
- **Delivering vaccines where needed** – in 2008, GSK produced approximately 1.1 billion doses of vaccines for use in 176 countries. Almost 80 percent went to the developing world.

Our commitment to the developing world shapes and drives how we do business. Our tiered-pricing framework for vaccines typically results in poorer countries paying up to 80-90 percent less than wealthier ones, and is guided by three principles:

1. **Availability** – to make all vaccines available wherever possible to all countries that need them as early as possible, producing enough quality vaccines to meet global demand.
2. **Affordability** – to set prices that allow countries across all income levels to purchase vaccines, regardless of who pays the bill.
3. **Sustainability** – to ensure the supply of innovative, high-quality vaccines to all who need them for as long as they are needed.

To address the pressing challenges of improving global public health, including during the current crisis, GSK chief executive Andrew Witty recently set out commitments to:

- **Take a more flexible approach to intellectual property in the Least Developed Countries (LDCs)** – such as a patent pool for medicines against neglected tropical diseases, and a "voluntary pooling" of small molecule compounds, or process patents.
- **Reduce prices for patented medicines in LDCs** – ensuring prices will be no higher than 25 percent of those in the developed world (providing the cost of goods is covered).
- **Build greater collaboration in fighting Diseases of the Developing World (DDW)** – we are willing to open up our DDW research centre in Tres Cantos to create a shared global centre of excellence for GSK and its partners, including governments, foundations and companies.
- **Move from being a supplier of drugs to being a partner in delivering solutions** – starting with reinvesting 20 percent of our profits from selling medicines to LDCs in infrastructure projects in LDCs.

These are some of the ways in which GSK seeks to help the world's most vulnerable populations. We seek not only to help them weather the global economic crisis, but also to be a partner in meeting the world's medical needs in good times and bad.

Jean Stephenne

President and General manager
GlaxoSmithKline Biologicals

1. GSK is representing the OECD private sector on the GAVI Board

The Partnership for Maternal, Newborn and Child Health

As the global economic crisis continues, it is critical to protect investments in maternal, newborn and child health (MNCH) in order to preserve recent health gains and continue to build on them. The Partnership for Maternal, Newborn and Child Health is ideally placed to mobilise a broad range of partners to help vulnerable people during the crisis. For example, the Partnership is working with key stakeholders such as investment bankers, parliamentarians and families. They can protect mothers and children by, respectively, influencing government budgets, passing legislation, and galvanising families and communities to demand basic health services.

Finance and budget decision makers

The report *Investing in Maternal, Newborn and Child Health – the Case for Asia and the Pacific* was launched at the 2009 meeting of the Asian Development Bank. It shows how governments can protect the poor, strengthen fragile health systems, and invest in long-term social and economic growth and social and political stability. It recommends practical steps for accelerating progress towards the Millennium Development Goals, which include implementation of intervention packages and 'best buys' that take account of local problems, priorities and costs. Detailed cost estimates show that at least US$15 billion is needed by 2015 to achieve MDGs 4 & 5 in Asia and the Pacific.

Law makers

Parliamentarians influence whether MNCH budgets are maintained during a crisis, so advocacy that targets them can yield great benefits. At the recent 120th Inter-Parliamentary Union in Addis Ababa, 1,200 parliamentarians from 154 countries were asked by the Countdown to 2015 partners to create and approve legislation designed to protect millions of mothers and children. Dr Tedros Adhanom – Minister of Health of Ethiopia, and co-chair of the Partnership – called upon parliamentarians to:

- Represent the voices of women and children
- Create and accelerate appropriate legislation to ensure universal access to essential care, including skilled care at birth
- Oversee government accountability to implement policies for mothers and children
- Provide adequate budgets for MNCH national policies and programmes
- Advocate the MDGs nationally and internationally.

Families and communities

Empowerment of women to seek good health care will influence health outcomes for them and their families and communities, especially during economic crises and times of special need. For example, education and community mobilisation are key to determining how and when a pregnant woman will seek antenatal care, or a young mother seek care for a sick child. In the state of Orissa, India, the Partnership is working with the 'Know Your Entitlements' campaign of the White Ribbon Alliance to sponsor an advocacy drive. It supports activities aimed at building MNCH capacity in Orissa, and includes media broadcasts that publicise positive MNCH behaviours and encourage community mobilisation. If successful, the initiative may be used in other Indian states.

Dr Flavia Bustreo

Acting Director
Partnership for Maternal, Newborn and Child Health
Secretariat in Geneva

Chapter Five

Forging a new MNCH Consensus and pulling together during the crisis

From previous crises we know that set-backs for the poorest take a long time to put right. MDGs 4&5 were already off track, but now they are also under serious threat from the global economic crisis – so the need for concerted, co-ordinated action is more urgent than ever.

The MNCH Consensus provides a framework for action at global, national and sub-national levels to align current momentum in politics and advocacy, finance and delivery and plans and capacity. The aim is to deliver a commonly agreed set of policies and priority interventions that will accelerate progress on the ground against the four objectives of increasing political mobilisation; ensuring adequate financing and effective delivery; streamlining and harmonising aid operations; and implementing the Consensus five-point checklist of policies and prioritised interventions.

The Consensus checklist brings all actors together around a common plan of action to ensure:

- *Political, operational and community leadership and engagement*
- *A quality package of evidence-based interventions through effective health systems along a continuum of care, with a priority on Quality Care at Birth*
- *Free services for women and children at the point of use and other access barriers removed*
- *Skilled and motivated health workers in the right place at the right time, with supporting infrastructure, drugs and equipment*
- *Accountability for results with robust monitoring and evaluation.*

Every pregnancy wanted, every birth safe, every newborn healthy

Maternal, newborn and child health (MNCH), as well as reproductive health is under serious threat from a lack of progress in many countries. Without more effort half a million women will continue to die from preventable complications in pregnancy and childbirth, over nine million children under age five, and up to 11 million unplanned pregnancies will occur each year worldwide. If the current global economic crisis persists it will not only threaten past gains, but may even lead eventually to an increase in the burden of mortality on mothers and children – the reverse to the purpose of the MDGs. So the need for concerted, co-ordinated action is now more urgent than ever. We cannot allow set-backs that we have learnt about from previous crises to drive more women and their families into poverty. We need to put Millennium Development Goals 4 & 5 back on track. Given that mortality risks for mothers and children are highest in the critical hours and first days around birth – it is important to focus on maternal and newborn health, more specifically Quality Care at Birth, including skilled attendance and emergency and neonatal care, as well as care in the immediate postnatal period and beyond, including family planning. As such a new consensus is now emerging which gives us a blueprint for moving forward at this difficult time. The Maternal Newborn Health (MNH) Consensus provides a framework for action at global, national and sub-national levels and recognises the need to align current momentum in politics, advocacy and finance, – behind a commonly agreed set of policies and priority interventions that will accelerate implementation and progress on the ground.

The MNH Consensus highlights key processes and actors under four objectives, which together share the goal of accelerating the implementation of a continuum of care for reproductive, maternal, newborn and child health outcomes:

1. Increased political mobilisation

- **Forge political, operational and community leadership** to translate commitments into action for maternal, newborn and child health, including a designated national champion. Leaders are rallying behind new financing mechanisms that will contribute to more and better resources for MNCH.
- **Secure international leadership** at various political platforms and opportunities (including the UN General Assembly, the African Union, the European Union, the G8 and the G20) to provide clear and consistent messaging on global MNCH priorities.
- **Promote 'health in all' policies and the message that 'every minister is a health minister'** – with a special focus on MNCH and the effects all political reforms have on health and distribution.
- **Engage with the new US administration** and the President's Global Health Initiative to explore how best we can join forces to make this a truly concerted effort.
- **Harness campaigns, convene platforms and take opportunities** provided by the Maternal Mortality Campaign, the Partnership for Maternal, Newborn and Child Health, Women Deliver and others to advocate MNCH.

2. Adequate and effective financing

- **Developing countries are protecting their health budgets** throughout the economic crisis and beyond – making more money available for MNCH and ensuring more MNCH for the money. Countries in sub-Saharan Africa are striving to honour their commitment towards the Abuja Declaration by securing domestic financing through protected health budgets. Priority will be put on protecting public health, primary health care and cost-effective services, especially MNCH services. In this way we grasp the opportunity of the crisis to focus on the most sensible investments, focusing on the most cost-effective services. Through history maternal mortality decline continued despite economic crises in several developed countries mainly due to appropriate safety mechanisms being put in place.
- **OECD countries will secure international finance for MNCH** through growth in Official Development Assistance (ODA). In times of uncertainty it is even more important to ensure a predictable flow of resources to poor countries. Donor countries are currently trying to maintain their commitments to targets for ODA as a percentage of GDP. Furthermore, there is an investment

in frontloading mechanisms and a commitment to abide by agreed sums. The economic crisis is a time for maintaining ODA commitments and where possible securing increases – not decreases.

- If spending on health is reduced then efforts will be made by developing countries and donors to **ensure that spending on MNCH care is protected.** The increase in health funding seen over the past few years was absorbed by commitments relating to MDG 6, leaving little for MDGs 4 & 5 and broader health systems support. While women and children are the most vulnerable victims of the crisis, they are also critical to the long-term economic recovery of their communities.
- Future **ODA will be focused on low-income countries with the worst health outcomes**, where MDGs 4 & 5 are least likely to be met. The countries that bear the heaviest burden are often those that are affected by conflict or humanitarian crisis. In the past these countries have been the direct recipients of only one-third of all ODA.
- In addition to domestic financing and traditional ODA commitments, **further international aid will be necessary**, including increased involvement of the private sector. The High Level Task Force on Innovative International Financing for Health Systems has indicated that if current relationships of health spending to GDP remain unchanged, the financing gap will be US$28-37 billion in 2015. To directly improve health and save lives at this time of economic downturn, additional funds will be linked to results, prioritized and deployed in order to protect the most vulnerable – women and children.
- **Funding from new financing mechanisms will be long-term and increasingly predictable. Additional frontloaded resources** remove bottlenecks in health systems development and complement mechanisms that need a longer time to provide resources.
- **Making better use of domestic and international resources** is a priority for developing countries and donors alike. All investments in health whether existing or new will be designed to maximise impact to address problems of inequity, inefficiency and poor quality care and services and so improve MNCH outcomes.
- **Social protection programmes will be rolled out** to increase targeted help for the most vulnerable people, particularly women and children. This is particularly important during the economic downturn. These programmes include conditional cash transfer programmes, food protection programmes, demand incentive initiatives and other means of providing free care at the point of health service delivery.

3. Streamlined and harmonised delivery

- Donors will increasingly **channel international finance for health through pooled approaches or consolidated mechanisms** that are proven to be efficient, such as those provided by GAVI, the Global Fund, the World Bank or bilateral agencies. Technical assistance currently accounts for a substantial proportion of health ODA (41 percent in 2006), which leads to a large number of small projects and activities. The resulting fragmentation and duplication seen particularly in the health sector adds to transaction costs at country level.
- Donors and governments are **supporting UNFPA, UNICEF, WHO and the World Bank (4H) around a common agenda for maternal and newborn health** to provide co-ordinated country support as an integral part of national health system development, as well as the UN reform of 'Delivering as One'. .
- An increasing number of donors are channeling resources to countries in line with the Accra Agenda for Action and the Paris Declaration on Aid Effectiveness, based on IHP+ principles. This means **one national plan, one budget, one results framework and one reporting mechanism**, linked with national efforts at raising domestic and international resources and ensuring that MNCH is at the core of health system development.
- **A mutual accountability framework is being developed** to ensure streamlined and harmonised aid operations for MNCH.

4. Implementation of the Consensus five-point checklist of policies and prioritised interventions

An emerging consensus[1] among stakeholders at national and global level has brought a renewed sense of urgency and solidarity to the push towards making accelerated progress on MDGs 4 & 5, especially at this time of economic crisis. The commonly agreed checklist for action comprises five essential ingredients to be provided through a health systems approach, as follows:

- *Political, operational and community leadership and engagement*

Sustained political commitment and leadership at all levels, especially by national and local-level champions, is vital to scale up care. Good leadership would ensure the translation of commitments – such as the rights of the child, the right to universal access to reproductive health services and to the MDGs – into effective service delivery and financial protection for all mothers and children. This requires overcoming implementation bottlenecks and so strengthening of the health sector and high-level multisectoral commitment to tackling the root causes of poor MNCH, including inequity, poverty, gender inequality, low education status and lack of respect for women's human rights.

- *A sound package of evidence-based interventions through effective health systems*

Central to the consensus is the **continuum of health care that extends across adolescence, pregnancy, childbirth and childhood**. The High Level Task Force for Innovative Financing of Health Systems has estimated the costs of scaling up health services, over and above what is currently spent in 49 low-income countries,[2] to be between US$ 36-45 billion in 2015, accumulatively US$114-251 billion during 2009-2015. The program cost for family planning during 2009 to 2015 is US$2.9-8.4 billion. While the specific program cost associated with **Maternal and Newborn Health** services is US$5.3-11.8 billion accumulatively for 2009-2015.[3] This investment is estimated to saving nearly 6 million mothers and babies. Other developing countries beyond these 49 that opt to scale-up services will also contribute to the global reduction in the unacceptable burden of mortality borne by mothers and babies.

The recommended five main packages of maternal and newborn health services for accelerated implementation are:

1. Comprehensive family planning, including advice, services and supplies
2. Safe abortion services, where abortion is legal
3. Antenatal care
4. Quality care at birth, including skilled attendance and emergency obstetric and neonatal care
5. Postnatal care for mother and baby.

These packages of care should be prioritised and provided across all levels of the health sector, from household to hospital levels, and cannot be implemented in isolation from strengthening the health system. The packages include health system interventions such as workforce management, development of infrastructure, and support for financing systems such as insurance and family incentive programmes – enabling access to medicines, supplies and diagnostic tests. Given that mortality risks for mothers and babies are highest in the critical hours before and the first 48 hours after birth – it is important to **focus on Quality Care at Birth**, including skilled attendance and emergency obstetric and neonatal care at delivery.

- *Free quality services for women and children at the point of use and other access barriers removed*

In many high-burden countries, women face many barriers to accessing health care, including financial, geographical, social and cultural barriers. Key barriers include the distance from the household to the health facility and the costs involved, both in terms of transport and using services. Fees may be formal or informal. Other barriers – such as gender discrimination within families and communities leading to a low priority for women's health – further compound the problem. Evidence is now mounting for the efficacy of a package of **free quality services at the point of care** to overcome the inequity that fee-for service inevitably breeds. This is one effective, evidence-based and equitable way to expand access to services to a greater proportion of the population.

- *Skilled and motivated health workers in the right place at the right time, with supporting infrastructure, drugs and equipment*

The human resource crisis is the most severe constraint to scaling up health care. Low pay and lack of incentives are chronic problems. The global economic crisis has further threatened the development of training institutions. Plans and policies need to be put in place to **address problems of understaffing, inappropriate skill mixes, poor-quality training and inequitable deployment of staff** between rural and urban areas. They are also needed to provide an enabling environment, including supporting infrastructure, drugs and equipment for health workers to carry out their work effectively.

- *Accountability for credible results*

Progress on the MDGs requires a health system that is accountable to government authorities and other funding sources, and to the people and communities it serves. **Robust monitoring and evaluation systems are currently being set up** to ensure data on reproductive, maternal and child mortality and morbidity are systematically collected and analysed, and that the appropriate stakeholders are held to account. Measuring the mortality of babies and pregnant women presents challenges but these can be overcome with commitment and with the recognition that "what you count is what you do". Good monitoring systems for births and deaths need to be established from the start of any initiative and integrated with the wider health information system. Furthermore an intensification of documentation and strong evaluation techniques will be employed to measure progress in implementing quality MNCH services and costs, as well as measuring attributable results in terms of lives saved and health improved. Data will also be made routinely available outside the health system to the broader public, to encourage civil society to play a constructive role in ensuring that the health system is responsive to people and accountable for results. It is essential that agreed outcome indicators are identified at a country level as a transparent means of measuring progress. These outcomes also act as a barometer of the wider health system and of society's valuing of mother, newborns and children.

5. Making it a reality: implementing the five-point plan in countries

By bringing political mobilisation, financing, plans and capacity together around a common five-point plan, there is much potential for moving forward. MDGs 4 & 5 will not be reached without country leadership, and the prioritisation of reproductive, maternal, newborn and child health at country level. National health plans require a comprehensive and monitorable reproductive, maternal, newborn and child health component. The work on a joint assessment tool for the IHP+ Compact could be used for this purpose. This plan should also include an investment strategy endorsed by all the main stakeholders, and clear mechanisms for addressing implementation barriers. At this time of crisis, issues of domestic financing volume, efficiencies and pro-poor targeting are also crucial. Assistance in drawing up plans should be based on Paris/IHP+ principles and a mutual accountability framework.

It is the role of governments to review and assess which of these actions are relevant in their own specific contexts at national and sub-national levels. It is the role of development partners to be ready with support for governments to translate commitments into action, with corresponding milestones and timetables. This is a moment of planning and moving ahead.

The Consensus for Maternal and Newborn Health

OUR AIM:

"Every pregnancy wanted, every birth safe, every newborn healthy"
Preventing nearly six million deaths among mothers and babies

How we can make it happen:

1. Political and operational leadership and community engagement and mobilization
2. Effective health systems with interventions in key areas[4] –
   - Comprehensive family planning – advice, services, supplies
   - Safe abortion services (where abortion is legal)
   - Antenatal care
   - Quality care at birth, including skilled attendance and emergency obstetric and neonatal care
   - Postnatal care for mother and baby
3. Removing barriers to access, with quality services for women and babies being free at the point of use where countries choose to provide it.
4. Skilled and motivated health workers in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations.
5. Accountability for credible results.

What it will take for the 49 low income countries during 2009-2015:

- Another 234 million births taking place in facilities that provide quality care for both normal and complicated births for both mother and newborn babies.
- An extra 276 million antenatal care visits.
- Additional 234 million postnatal care for mothers and their newborn babies
- 1.1 million additional health care professionals and managers with the resources to do their jobs effectively, helping progress towards the WHO target of at least 2.3 health workers per 1,000 of population.

What it will achieve during 2009-2015 for the 49 countries: [5]

- Preventing the death of 750 000 mothers
- Preventing the death of 3.4 million newborn babies
- Preventing 1.5 million stillbirths
- A fall of almost two thirds in the global number of unwanted births and of half the number of unsafe abortions
- The prevention of nearly 90 percent of abortion-related maternal deaths
- A rise of one third in the number of contraceptive users
- An effective end to unmet need for family planning services.

Endnotes to Chapter 5:

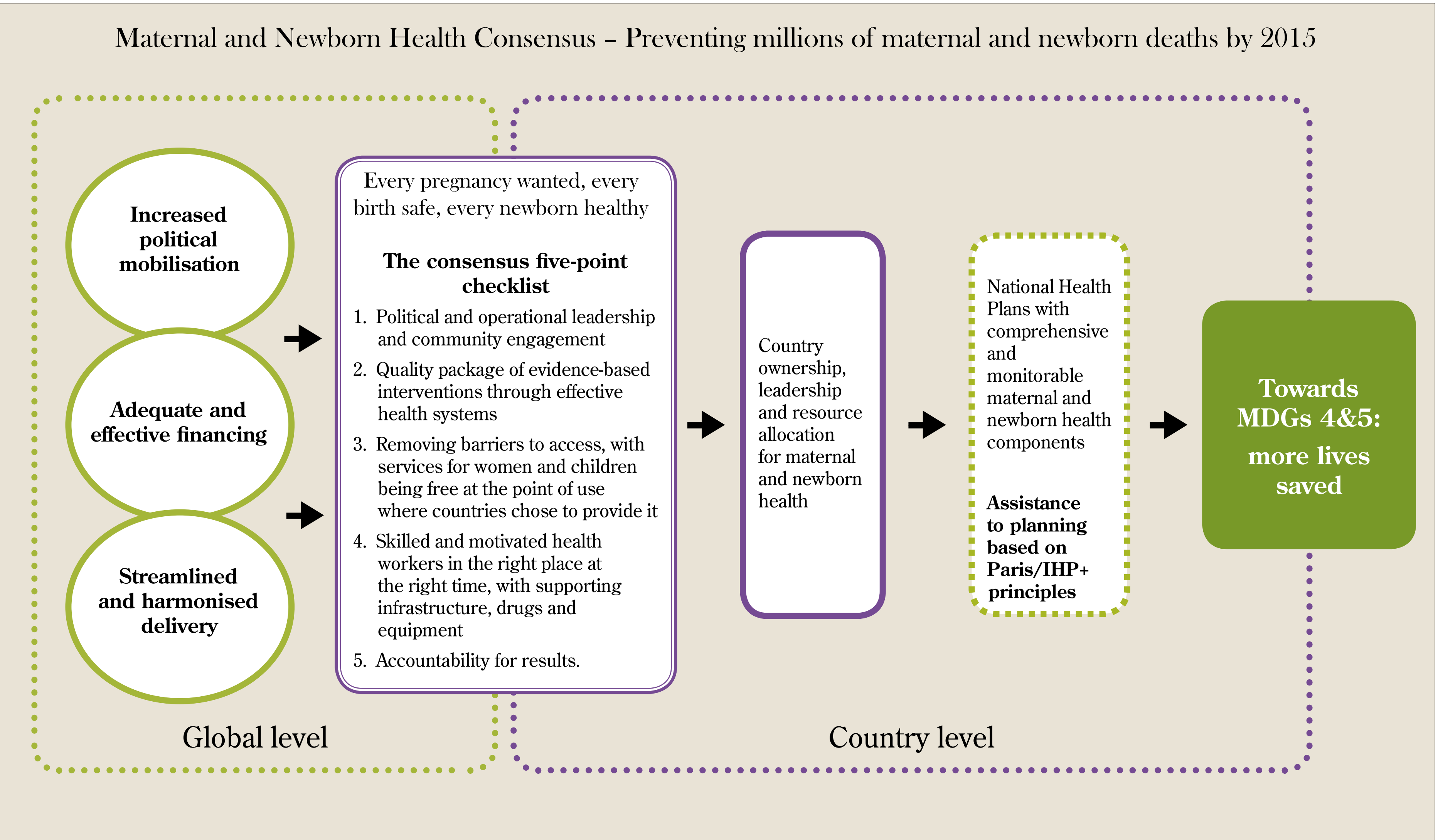
1. *Several meetings were held during the first half of 2009 where consensus was strongly built on the priority policies and interventions necessary to accelerate progress on MDGs 4 & 5. These included: 1). Sherpa meeting of the Network of Global Leaders, Oslo 15-17 April 2009, 2) Technical meeting organized by DFID in London from 23-24 April 2009 on* 'Accelerating the reduction in maternal and newborn mortality through better co-ordinated action at Global and Country level', *and 3) Special session during the World Health Assembly in May 2009, Geneva. Participants included countries in the Network of Global Leaders, as well as Bangladesh, Germany, Nigeria, Pakistan, Sweden, Uganda, and USA. The UN agencies and the World Bank were also represented.*

2. *Countries listed in Annex1 of the Main Report of the Taskforce on Innovative International Financing for Health Systems, May 2009*

3. *This estimate is different from the US$30 billion – 10 million lives saved in the Global Campaign report of 2008, as the High Level Task Force calculations include a different set of countries (e.g. do not include India, Indonesia, etc), as well as do not breakdown health systems cost according to the various packages.*

4. *Where it is clear that it will take some time to develop an effective health system, then it is essential a specific plan for MNH is created to ensure an interim approach.*

5. *Figures are drawn from the calculations done for the High Level Task Force on Innovative International Financing for Health Systems, May 2009.*


Maternal and Newborn Health Consensus – Preventing millions of maternal and newborn deaths by 2015
Increased political mobilisation
Adequate and effective financing
Streamlined and harmonised delivery
Every pregnancy wanted, every birth safe, every newborn healthy
The consensus five-point checklist
1. Political and operational leadership and community engagement
2. Quality package of evidence-based interventions through effective health systems
3. Removing barriers to access, with services for women and children being free at the point of use where countries chose to provide it
4. Skilled and motivated health workers in the right place at the right time, with supporting infrastructure, drugs and equipment
5. Accountability for results.
Country ownership, leadership and resource allocation for maternal and newborn health
National Health Plans with comprehensive and monitorable maternal and newborn health components
Assistance to planning based on Paris/IHP+ principles
Towards MDGs 4&5: more lives saved
Global level
Country level

This report was produced under the overall directions of Dr Tore Godal, Special Advisor to the Prime Minister of Norway in close collaboration with Sherpas and special advisors of the Network of Global Leaders, high level representatives of UN agencies and funds.

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PUBLISHED BY THE OFFICE OF THE PRIME MINISTER OF NORWAY
OSLO, JUNE, 2009
PRINTED AT MØKLEGAARDS TRYKKERI AS
TAYLOR-MADE COMMUNICATIONS - EDITORIAL SERVICES

FOR MORE INFORMATION AND ANNEXES:
www.norad.no/globalcampaign

“2009 will be a dangerous year”

Robert B. Zoellick
President
The World Bank Group