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Report of the Secretary-General**

Summary

Health is at the heart of the Millennium Development Goals. It is the specific subject of three Goals and a critical precondition for progress on most of them. Coherence and partnerships among United Nations entities, national and international actors, including governments, civil society, the private sector, philanthropy and academia is crucial to helping countries achieve their health priorities.

Progress has been made in some areas, but much remains to be done. For many countries meeting the health goals remains a daunting task, especially since improving health outcomes is linked not only to the provision of health services, but also to interventions outside the health sector.

With more resources and greater political will, health targets can be reached. However, in this time of financial and economic crisis there is a danger that social goals like health will be neglected. If this occurs, previous gains will be jeopardized and in both high- and low-income countries, it will be the most vulnerable groups of society that will be most negatively affected.

Progress in achieving the Millennium Development Goals must be sustained, but this will require new energy and stronger commitment. The report highlights priority actions and recommendations to achieve the health Millennium Development Goals and to ensure progress in the areas of universal health

coverage, health system strengthening, and aid delivery and effectiveness.

*E/2009/100
** The report is delayed in submission to allow for extensive consultations within the UN system.

Contents

I. Introduction

II. Global health today

III. Sustaining progress in times of crises

- A. Impacts of the food crisis on health
- B. Climate change and health
- C. Countries emerging from conflict and natural disaster and health
- D. The current financial and economic crisis and health

IV. Development cooperation for health

V. The challenge of inequities in health and access to health services

- A. Inequities in health outcomes
- B. Towards universal coverage

VI. Strengthening systems for health

VII. Health in all policies

VIII. Widening the circle of partnerships for health and enhancing their impact

IX. Priority actions and recommendations

X. Conclusion

I. Introduction

1) Promoting and securing health is an ethical imperative and a foundation for prosperity, stability and poverty reduction. Health is at the heart of the Millennium Development Goals (MDGs) and a critical pre-condition for progress on most MDGs.

2) Over the past decade, progress in improving global health has been mixed. The Gains in the prevention and treatment of HIV/AIDS, TB and malaria are encouraging. However, other areas like improving maternal and newborn health still need much more attention. Similarly, diseases of the poor like neglected tropical diseases and a growing number of health problems associated with non-communicable diseases continue to be widespread, notwithstanding the fact that for the most part they are easy to prevent and treat.

3) Across the board, inequities in health outcomes persist among and within countries. Most of the difference is attributable to the conditions in which people are born, grow, live, work, and age. Underlying problems of gender inequality are a crucial part of these inequities, reflected in the great differences in the health of women and girls who are often lagging behind men and boys.

4) Functioning, accessible and affordable health systems are essential to the delivery of health services, both preventive and therapeutic. The complexity and the difficulty to quantify interventions for health system strengthening in terms of objectives and discrete actions, have limited effort and investment in this area. Yet, health systems are a central building block for global health. Human resources are a key element of health systems that merit particular attention.

5) The Secretary-General has made global health a priority for the United Nations. He has brought together the leaders of UN health-related agencies and non-UN global health leaders from civil society, the private sector, foundations, along with researchers and academics. Together, they have looked into recent trends in global health, focused on critical priorities requiring immediate and long-term attention and explored how best to intervene to ensure the necessary progress.

6) Financial resources for health have increased dramatically in recent years, in large part channeled through the multilateral efforts of the Global Fund to Fight AIDS, TB and Malaria, the work of the Global Alliance for Vaccines Initiative (GAVI), the engagement of the Gates Foundation, bilateral initiatives such as PEPFAR, and innovative financing mechanisms such as UNITAID. The dramatic expansion of funding, the surge of many players in the global health arena, as well as the high priority given to the issue by the Secretary-General, provide an important opportunity for progress.

7) At the same time, the growing number of new initiatives poses a challenge for coherence and coordination. These initiatives have also left the global health sector fragmented and without long-term predictable financing to support the underlying

health system. For this reason, greater coherence across initiatives and across sectors that contribute to improving health and the support and coordinated involvement from all areas of society are essential.

8) The current global financial crisis poses a new set of challenges to the achievement of the health goals. As resources shrink, the pressure for national governments and international partners to cut their resource allocations to the health sector will be high. In response, we will need to make a special effort to ensure that previous commitments are not abandoned, seek new ways of financing health expenditures, and find smarter ways of working with limited resources. New technologies offer huge potential for doing more in a resource constrained environment.

II. Global health today

9) In the past decade, progress in advancing global health has been uneven. Some success stories can be found in the global response to HIV/AIDS, malaria, and tuberculosis. In contrast, less forward movement has been evident in the prevention, treatment and control of neglected tropical diseases and non-communicable diseases. The greatest disappointment is found in the area of maternal and newborn health where the persistence of high mortality rates is unacceptable. The current H1N1 flu outbreak reminds us that many diseases do not respect borders and can only be addressed through global cooperative action.

10) As a result of improvements in prevention programmes, the number of people newly infected with HIV declined from 3 million in 2001 to 2.7 million in 2007. Also, with the expansion of antiretroviral treatment services, the number of people who die from AIDS has started to decline, from 2.2 million in 2005 to 2 million in 2007. Following almost two decades of rapid epidemic expansion, these reversals constitute significant progress. HIV prevention has been successful in reducing high risk sexual behaviours in the general population of many countries. Programmes to prevent mother-to-child transmission have also expanded. However, other indicators are less encouraging and much more needs to be done to achieve the full impact of scaled up prevention programmes. Coverage of interventions to prevent HIV among drug injectors has remained low. Stigma and discrimination persist. The vast majority of those living with HIV are in sub-Saharan Africa. Globally, women account for 50% of people living with HIV and, in sub-Saharan Africa, the proportion of women is as high as 60%. By the end of 2007, less than a third of the 9.7 million people in need of AIDS treatment in developing countries were receiving the necessary drugs.

11) As far as malaria is concerned, there has been tremendous progress in prevention so far but much still is left to be done, particularly in treating the disease. The number of insecticide-treated mosquito nets produced worldwide jumped from 30 million in 2004 to 95 million in 2007, which has led to a rapid rise in the number of mosquito nets distributed. As a result, out of 20 sub-Saharan African countries for which there are trend data, 16 have more

than tripled their coverage since around 2000. Despite this progress, use of insecticide-treated mosquito nets falls short of global targets and efforts in this regard must increase.

12) Success in eradicating tuberculosis rests on early detection of new cases and effective treatment. Between 2005 and 2006 progress in detection slowed, the detection rate increased only marginally. Africa, China and India collectively account for more than two thirds of undetected tuberculosis cases. The detection rate in Africa – 46 per cent in 2006 – is furthest from the target. Despite its success, Directly Observed Treatment Shortcourse (DOTS) has not yet had the impact on worldwide transmission and incidence needed to achieve the targets of halving the world's 1990 prevalence and death rates by 2015. To accomplish the targets, regions lagging behind will have to improve both the extent and timeliness of the diagnosis of active tuberculosis and increase the rate of successful treatment, including diagnosis and treatment of HIV-associated tuberculosis and multidrug resistant tuberculosis. Diagnosis and successful treatment of multidrug resistance is of particular concern and lagging behind globally, especially in the three countries that account for 57% of global cases.

13) About 1.2 billion of the world's poorest populations continue to suffer from the crippling effects of neglected tropical diseases. These diseases are no longer found only in tropical areas. They are diseases of the world's poor, as they affect the most vulnerable globally, including the poorest in some developed countries. For the most part, these diseases are relatively easy to prevent and treat. As they are both cause and perpetrators of poverty, addressing these diseases is an important poverty reduction strategy. Some of the initiatives taken to tackle them are excellent examples of what can be achieved through public-private partnerships.

14) It will be impossible to improve global health without addressing the growing burden of health problems associated with non-communicable diseases. Chronic diseases such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths, with 80% of these deaths in low- and middle-income countries. These diseases are preventable but require concerted action by all.

15) The least progress has been made in improving maternal and newborn health. Maternal mortality remains unacceptably high across much of the developing world. In 2005, more than half a million women died as a result of pregnancy-related complications. Ninety-nine per cent of these deaths occurred in the developing regions, with sub-Saharan Africa and Southern Asia accounting for 86 per cent of them.

16) An important cause of pregnancy-related death is the absence of skilled health workers (doctors, nurses or midwives). In 2006, nearly 61 per cent of births in the developing world were attended by skilled health personnel, up from less than half in 1990. Coverage, however, remains low in Southern Asia and sub-Saharan Africa– the two regions with the greatest number of maternal deaths.

17) The increased share of attended births contributes to declines in maternal mortality rates. Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period. Increasing attended births helps decrease the maternal mortality rate. Twenty-one of 23 countries in Europe and Central Asia and 19 of 26 countries in Latin America and the Caribbean have achieved the target to lower the non-attendance rate to 10 percent by 2015, but most South Asian and Sub-Saharan African countries are not on track.

18) Maternal death is correlated with poor health care during pregnancy and childbirth. Prenatal care coverage is the percentage of women attended during pregnancy by skilled health personnel for pregnancy-related issues. One of the regions with the highest maternal mortality rates, South Asia, has shown improvements in the percentage of pregnant women who have received prenatal care at least once, increasing from 47 to 69 percent from 1990 to 2007. Although this shows progress, a healthy pregnancy requires much more than one or two prenatal visits. The number of women who received prenatal care at least four times increased only marginally, from 26 to 34 percent between the two years.

19) Despite progress in reducing child mortality in all regions except sub-Saharan Africa, deaths of children under five remain very high. Between 1990 and 2006, about 27 countries – mostly in sub-Saharan Africa – made no progress in reducing childhood deaths.

20) Maternal and newborn health are areas that lack sufficient resources, the necessary political will and high-level leadership. Greater investment in well-managed health systems, particularly primary care will be essential if progress is to be made.

21) The recent crisis in the shape of H1N1 flu outbreak is a reminder that diseases know no borders and that collective, global action is necessary to deal with them. The current situation in particular has once again made it clear that preparedness and timely information are key to managing and containing potential pandemics. In order to improve our current response and preparedness for future outbreaks, the international community must take three immediate steps. First states must reach agreement on sharing samples of viral and other materials, as well as data on outbreaks, in line with the International Health Regulation. Second, they must agree to establish coordinated long-term financing mechanisms for supporting poorer countries so that they are able to build their defenses against global health threats. And third, they must ensure that WHO has all the resources it needs, when it needs them.

III. Sustaining progress in times of crises[1]

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[1] This section is to be read in conjunction with the Annual Report of the Secretary-General on the Work of the Organization A/64/1, the Report of the Secretary-General on the Theme of the 2009 high-level segment of the

22) The past two years have seen a dramatic sequence of global crises which have and will continue to affect our efforts to improve global health: food insecurity, climate change, conflict, and most recently the economic crisis. The interplay between these dynamics is testimony to the increasing complexity and interconnectedness of the global threats we face and points to the need for solutions that cross-sectoral and national boundaries and engage a wide-range of stakeholders.

A. Impacts of the food crisis on health

23) Last year's high food prices lead to an alarming increase in food insecurity around the world. Higher food prices added 115 million hungry people in 2007 and 2008 to the 130-155 million people already driven into poverty between late 2005 and early 2008, raising the total to close to 1 billion people[2]. Rising food prices threatened the limited gains in alleviating child malnutrition. By 2006, the number of children in developing countries who were underweight exceeded 140 million and this global situation will be exacerbated by higher food prices. These trends have seriously jeopardized the achievement of MDG 1 on poverty and hunger, and will have an impact on the health MDGs as well. While the escalation of prices in food has abated somewhat, the damage has been done and structural issues persist, affecting the poor more severely.

24) While international food prices have declined from their peaks of 2008, they remain volatile and may spike again as droughts and floods and other climate related events affect harvests. More notably, domestic prices in most developing countries have not fallen as much as international prices. In the long term the world is facing an important challenge of how to feed more than 9 billion people in 2050 in the face of increasing demand for food and climate change which, among other impacts, will put further constraints on already scarce water resources.

25) Hunger and under-nutrition are major threats to public health. Eating fewer and less nutritious food can cause a range of negative health conditions and can have long term consequences on vulnerable populations, in particular pregnant women, nursing mothers, infants and young children as well as people living with HIV/AIDS and tuberculosis. It worsens people's health status and leads to chronic illnesses. Malnutrition can permanently stunt physical and cognitive growth in the first years of a child's life, and is associated with at least one third of all child deaths.

26) The High-Level Task Force on the Global Food Security Crisis, established by the UN Secretary-General in April 2008 and composed of the heads of the United Nations specialized agencies, funds and programmes, Bretton Woods institutions and relevant parts of the UN Secretariat, promotes a unified response to the challenge of achieving global food security. In its 'Comprehensive Framework for Action', it outlines a twin-track approach – investing in food assistance and social safety nets for

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Economic and Social Council: Current global and national trends and their impact on social development, including public health , the Millennium Development Goals Report 2008 and 2009.

[2] FAO, 2008

those most in need, and at the same time scaling up in investment in agriculture in developing countries, increasing opportunities for people and enabling them to feed themselves, ensure adequate nutrition and sustain an increase in income. Continued priority to the food and nutrition security of vulnerable groups is necessary to meet MDG1, as well as all health MDGs and the MDGs as a whole.

B. Climate change and health

27) Climate change modifies the physical and socio-economic conditions within which life occurs, thus influencing human health. A changing climate impacts on fresh water supply, agricultural productivity, frequency and distribution of disastrous weather events, as well as characteristics and occurrence of vector-borne diseases. These in turn affect directly and indirectly socio-economic conditions. The impacts can be positive or negative depending on the geographical location of human life. However, the overall effect is expected to be negative. Changes in climate are lengthening the transmission seasons of important vector-borne diseases such as, malaria and dengue fever, and altering their geographic range. The may result in devastating consequences as new previously unexposed populations with low immunities and/or lacking strong public health infrastructures face infection. The link between increases in flooding, which climate change will intensify, and higher rates of water-borne diseases and acute diarrhoea has long been recognized. Over time, climate change is expected to exacerbate shortages of potable water worldwide, which will have a profound impact on human health.

28) In the long run the greatest health impacts may not be from acute shocks such as natural disasters or epidemics, but from the accumulated effects of a changing climate on those systems that sustain health, and which are already under stress in much of the developing world. Increasing temperatures and more variable precipitation are expected to reduce crop yields in many tropical developing regions. In some African countries, yields from rain-fed agriculture could be reduced by up to 50% by 2020. This is likely to aggravate the burden of under nutrition in developing countries. Extreme high air temperatures can kill directly; it has been estimated that more than 70, 000 excess deaths were recorded in the extreme heat of summer 2003 in Europe. By the second half of this century, such extreme temperatures will be the norm. In addition, rising air temperatures will increase levels of important air pollutants such as ground-level ozone, particularly in areas that are already polluted.

29) In order to minimize the increase of health risks, help communities cope, particularly those most vulnerable, and make progress towards achieving the MDGs, it is an imperative that the intergovernmental negotiations on climate change under UNFCCC are successful with regard to mitigation of and adaptation to climate change. This is the responsibility of Governments who must show increasing determination to live up to this responsibility. They must dedicate more time and effort to these negotiations and work together towards sealing the deal in Copenhagen, Denmark, at the end of this year.

C. *Countries emerging from conflict and natural disaster and health*

30) Inequities in health increase during times of crises, requiring special efforts to meet the needs of the poorest and most vulnerable. The situation is worse for countries in, or emerging from, conflict or those that have experienced natural disasters.

31) Evidence has shown that the countries farthest from reaching the MDGs are in, or are emerging from, conflict. The lack of progress in health in these countries is undermining global progress on the health and non-health MDGs. Political violence and conflict generate health risks in the short run. However, it is in the longer term that the impact of the conflict on health is most devastating, especially with respect to mental health. Serious interruptions and even collapse of the health care systems also prevent access to basic health care, despite the increased needs related to the crisis. Attempts to accelerate past achievements in the health related MDGs may be hampered by the loss of capacity and, in some cases, near collapse of the public health systems.

32) Frequently, conflict has a negative impact on development work in other areas linked to health and health care delivery. For example, it is not uncommon for relief and reconstruction efforts to be hampered by a multitude of problems, ranging from communications and logistics to governance at national and local levels. The transition from relief to development poses unique challenges for the health sector and requires the adoption of measures directed at reestablishing the regular course of economic and social life. Extra efforts to strengthen institutional capacity to pursue longer-term health development goals and discharge essential public health functions must be part of the broader recovery strategy.

33) The fact remains that in developing countries as a whole, health spending must be protected; but at the same time, employment, education, agriculture, and basic social services can not be neglected as they are important both for health and for minimizing the impact of the economic crisis on development and stability. Mechanisms to protect health and income must be a priority. Whether the crisis is global or local, a man-made or a natural disaster, the key to protecting the poor and vulnerable - who are always the hardest hit - is a strong health system that can carry out basic public health functions and can continue to provide vital services.

D. *The current financial and economic crisis and health*

34) The scale and reach of the current financial crisis has left the world economy facing a rapidly deteriorating outlook. The financial crisis has lead to a credit crunch and lowered asset values, constraining household spending and curtailing production and trade. Global output and trade plummeted in the final months of 2008. The world economy is forecast to contract by about 2.0 per cent in 2009. Under a more pessimistic scenario, however, world gross product is expected to decline by 3.5 per cent this year[3]. Growth in emerging and developing economies is expected to slow from 6¼ percent in 2008 to 3¼ percent in 2009, owing to falling export demand and financing, lower commodity prices, and much tighter

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2 World Economic Situation and Prospects as of Mid-2009, UN/DESA, forthcoming.

external financing constraints [4]. The World Trade Organization (WTO) estimates that global exports volume will decline by approximately 9 per cent--the largest decline since World War II. Developed economy exports are expected to fall by some 10 per cent on average and developing country exports are expected to shrink by 2-3 per cent.

35) Amidst this grim prognosis, an overriding concern of the international community is the fate of the internationally agreed development goals, including the MDGs. Most developing countries' efforts to achieve the MDGs have benefited from the improved economic growth and relatively low inflation that characterized the first years of this millennium. With a downturn in the global economy the gains achieved in the past decade are likely to unravel and in some instances this reversal has already begun. New estimates of the World Bank for 2009 suggest that 46 million more people will fall below $1.25-a-day poverty line and an extra 53 million people will be forced to live on less than $2 a day compared to the estimates before the crisis unfolded.[5]

36) Under these conditions, achieving the Millennium Development Goal of halving extreme poverty and hunger in the world by 2015 will be difficult. The crisis will affect all countries with a serious and disproportionate impact on the poorest and those most isolated. Livelihoods of rural and urban poor families are already deteriorating rapidly. Government expenditures and social protection systems will be negatively impacted. Jobs are being lost in most parts of the world at a quick pace, with women being disproportionally affected in the developing world where almost 2/3 work in vulnerable jobs and as unpaid family workers. Women are also disproportionately represented in part-time, seasonal and short-term informal jobs and therefore are deprived of job security and benefits.

37) It is therefore imperative to counter this period of economic downturn by increasing investment in health and the social sectors and building on our past successes. There are several strong reasons supporting this line of action.

First, to protect the poor: The global economic crisis, along with food insecurity and some of the impacts of climate change, has critical implications for global public health. Reductions in health care expenditures - that in "good" times push more than 100 million persons annually into poverty - are likely to increase dramatically. Inevitably, it is the most vulnerable who suffer the most; the poor, the marginalized, children, women, disabled, the elderly, and those with chronic illness.

Second, to promote economic recovery: Investment in social sectors is investment in human capital. Healthy human capital is the foundation of economic productivity and can accelerate recovery towards economic stability.

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[4] World Economic Outlook, *Update*, 28 January 2009

[5] World Bank, "Crisis Hitting Poor Hard in Developing World", Press Release No. 2009/220/EXC, Washington, D.C., 12 February 2009.

Third, to promote social stability: Equitable distribution of health care is a critical contributor to social cohesion. Social cohesion is the best protection against social unrest, nationally and internationally. Healthy, productive, and stable populations are always an asset, especially in time of crisis.

Fourth, to generate efficiency: Pre-payment with pooling of resources is the most efficient way of financing health expenditure. Out-of-pocket expenditure at the point of service is the least efficient, and the most impoverishing one - already pushing millions below the poverty line each year. A commitment to universal coverage not only protects the poor, it is the most affordable and efficient way of using limited resources.

38) In this time of crisis, all governments and political leaders must maintain their efforts to strengthen and improve the performance of their health systems, protect the health of the people of the world, and in particular of those who are most fragile.

III. Development cooperation for health

39) In many countries, responsibilities for health and social services are at the local level. However, increasingly, policies that affect the health and social service sector e.g., financial, trade, industrial and agricultural policies are forged at the international level. As a consequence, health determinants as well as national public policies and priorities are often influenced by international policies and developments. Various ministries, including health, agriculture, finance, trade and foreign affairs are now cooperating to see how they can best provide input when policy decisions are taken, and weigh the costs and benefits of alternative policy options on health, the economy and the future of their people. The challenge is to ensure that policy making is inclusive of all actors and sectors, responsive to local needs and demands, accountable, and oriented towards health equity.

Aid

40) Aid, trade and debt relief are vital for developing countries that are already burdened with straitened financial circumstances and competing needs. Total ODA flows from DAC countries increased to US$ 119.8 billion in 2008 from US$ 103.7 billion in 2007. Till 2006, an increasing share of all ODA was being devoted to health. Total bilateral commitments to health in 1980–1984 averaged US$ 2.8 billion (constant 2006 dollars) – or 5.3% of all ODA. This increased to an average of US$ 6.4 billion in the five years to 2006, equivalent to 7.8% of all ODA, after remaining unchanged in all of the 1990s[6].

[6] Effective Aid, Better Health: Report prepared for the Accra High Level Forum on Aid Effectiveness, 2-4 September 2008, WHO, World Bank, OECD

41) In recent years, total aid for health from official and private sources has more than doubled, standing at around US$ 16.7 billion in 2006, up from $6.8 billion in 2000. There are however disparities between the amount of aid for health received by countries - Zambia receives US$20 per person for health, Chad just $1.59. The challenge now is to scale up aid to levels that will make it possible to achieve the Millennium Development Goals. For this to happen, aid needs to be used more effectively and challenges highlighted in the Paris Declaration need to be addressed.

42) Aid targeted towards the health sector has made a significant contribution to health gains achieved so far, particularly in the area of HIV/AIDS, malaria and tuberculosis. But much more needs to be done, both by donor countries and recipients. Analysis of trends over the past ten years shows aid for health is fragmented into large numbers of small projects; more than two-thirds of all commitments were for less than $500,000. Relatively little is provided directly into countries' budgets. This makes it harder for developing countries to influence what aid is provided for or how it is provided. Aid for health still needs to be much more aligned to countries' priorities and, where possible, channeled through their national health plans. At the global level there needs to be a better match between the needs of individual countries and the support they receive from donors to address them.

43) At present, more partnerships, and diverse and innovative mechanisms of financing are devoted to the cause of health, which have led to increased money for health. Yet, such large numbers of resource channels may pose challenges for coordination and alignment with country priorities. For instance, some developing countries are becoming dependent on individual donors, and increasingly vulnerable to any changes in their behaviour. High profile initiatives and programmes need to put more of their funding directly into countries' own health strategies and plans, and focus on making these funds as long term as possible.

44) The health sector embodies all of the key challenges of making aid more effective. Its strong focus on results provides a constant reminder of the fundamental purpose of aid effectiveness efforts. Its benchmarks against which to measure success could not be more powerful: to protect people from ill health, to provide appropriate and quality health care; ultimately, to save lives.

Trade

45) Trade remains an important engine of growth and prosperity for most developing countries. Yet, there has been little progress recently in reducing the barriers to exports from developing countries to developed countries. Moreover, with the global economic and financial crises, new risks of protectionism have emerged threatening the international trading system. Trade financing which is critical to many developing countries, especially the least developed has been seriously affected.

46) The WTO agreements that have implications for health include the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); WTO Agreement on the Application of Sanitary and Phytosanitary Measures; Agreement on Technical Barriers to Trade; and the General Agreement on Trade in Services (GATS). The patent protection of medicines and other health-related products could potentially lead to high prices for medicines, thereby affecting affordability and accessibility. The Doha ministerial conference in November 2001 adopted a declaration allowing members to take measures to protect public health (a waiver providing this flexibility was agreed on 30 August 2003). The agreement has significantly contributed to improving access to affordable anti-retroviral drugs. It also has implications for traditional medicine.

Debt relief

47) ODA in 2005 was boosted by the exceptional debt-relief initiatives for heavily indebted poor countries (HIPC). Donors will need to increase programmable aid (which excludes debt relief) in order to meet the 2010 aid target to increase total aid by $50 billion overall and aid to Sub-Saharan Africa by $25 billion a year (in 2004 dollars). The HIPC Initiative and Multilateral Debt Relief Initiative (MDRI) have drastically decreased the debt burdens of debt relief under the HIPC Initiative reduced burdens of external debt service for 34 post-decision-point highly indebted poor countries. Assistance under the MDRI Initiative further reduced the external debt of 23 post-completion-point counties. High commodity prices and strong growth in the world economy before the onset of the global financial crisis have improved export revenues of many developing countries. The debt-service-to-export ratios for all developing country groups including HIPCs, middle-income countries and low-income countries, excluding HIPCs have declined since 1990, with low-income countries and HIPCs enjoying the largest declines[7], but maintaining long-term debt sustainability will be difficult

V. The challenge of inequities in health and access to health services

A. Inequities in health outcomes

48) Deep inequities in health outcomes – the unfair and avoidable differences in health status seen within and between countries – persist. For example, differences in life expectancy between the richest and poorest countries exceed 40 years. The lifetime risk of maternal death in Ireland is 1 in 47,600; in Afghanistan it is 1 in 8. Even within a given country, inequities can be great. Maternal mortality is three to four times higher among the poor compared to the rich in Indonesia. Although some of the inequities in health outcomes are due to differences in access to health services, the majority is attributable to the conditions in which people are born, grow, live, work, and age. In turn, poor and unequal living conditions are largely the result of poor social

[7] Global Monitoring Report, Annex (World Bank, 2009)

policies and programmes, unfair economic arrangements, and politics driven by narrow interests.

49) Achieving the MDGs will address many of the social determinants of health, and will certainly improve health outcomes. However, the MDG indicators do not measure inequities, particularly within a country. Because national averages are used, it is possible to achieve the MDGs while worsening health inequities, unless interventions are targeted particularly at the poor, vulnerable, and marginalized. It is important to measure and understand the problem of health inequities and their determinants, and keep track of the impact of action.

50) The role of governments in reducing health inequities includes ensuring provision of basic services, and protecting and promoting human rights, such as entitlements to services of health care and education, and the right to a decent standard of living. Governments are responsible for legislative and regulatory frameworks that influence these factors and should monitor health status among different populations groups, thus documenting the extent of the problem and the impact of action.

51) Civil society should contribute by assisting governments in taking action in this area. Evidence shows that engagement of communities in decisions that affect their health, including health services, increases the likelihood that policies and actions will be appropriate, acceptable, and effective. In addition, in some countries NGOs provide a substantial share of health services. Civil society organizations can have an impact through advocacy, monitoring, and giving a voice to the most disadvantaged. Women's organizations and AIDS activists have been among the most successful of such groups. Labour organizations also have a role to play.

52) The strategy for addressing health outcomes must be comprehensive: as the Commission on Social Determinants of Health concluded in its recent report, it is not possible to reduce inequities in health outcomes without improving the conditions of daily life and the inequitable distribution of power, money and resources.

B. Towards universal coverage

53) Scaling up services towards universal access is also fundamental to reducing health inequities. Universal coverage means access of all people to a full range of health services, with social health protection. Progress with increasing coverage for interventions which could make a difference to the major health problems faced especially by poor and more vulnerable people is still patchy and uneven. In addition to increasing the supply of services, financial and other barriers to access have to be eliminated and people given predictable financial protection against the costs of seeking care. To attain the financial protection that has to go with universal access, countries need to move away from user fees, and generalize prepayment and pooling schemes.

54) Universal coverage carries particular significance for women. They face higher health costs than men, associated with their higher use of health care. Yet women are

more likely than men to be poor, unemployed or else engaged in part-time work or in the informal sector, without health benefits. For example, where there are user fees for maternal health services, households pay a substantial proportion of the cost of facility-based services, and the expense of complicated deliveries is often catastrophic. The removal of user fees and the provision of universal coverage for maternal health, especially for deliveries, will increase access and help reduce maternal deaths.

VI. Strengthening systems for health

55) Without urgent improvements and long-term commitments to make health systems functioning, accessible and affordable, the health MDGs will be difficult to achieve. The Secretary General has identified the need to strengthen health systems as a critical area that needs concerted action across and beyond the United Nations system, and has made this as priority for his tenure. He has engaged in particular in the efforts to address the human resource crisis and in social health protection, which is essential to protect the poor from catastrophic out of pocket health expenditures.

56) Health systems provide the base for the dramatic scale-up of interventions that is needed to meet the health MDGs. Contribution from disease-specific programmes is essential. There is a lot to learn from the work of global health initiatives such as the Global Fund to fight AIDS, TB, and Malaria (GFATM), the Global Alliance for Vaccines Initiative (GAVI), and PEPFAR, among others. Their focus on a specific disease is complementary and includes efforts to ensure well-managed, adequately staffed and well equipped health systems with the capacity for delivering prevention and care interventions. The challenge is to scale up and strengthen services for health in a coherent manner beyond these initiatives.

57) Health systems are weak in far too many countries because of decades of poor planning, poorly thought-out investment, and poorly coordinated aid. They are weak because of a long-term failure to invest in basic health infrastructures, services, and staff. These weaknesses have become much more visible because of the unprecedented drive to improve health.

58) Although health systems are highly context-specific, those that function well have certain shared characteristics. These are: a) good health services that are available and affordable for all; b) a well-performing health workforce; c) equitable access to essential medical products, vaccines, and technologies of assured quality; d) dissemination of evidence-based health information; effective monitoring of performance and outcomes, accountability to service beneficiaries; and f) leadership and effective governance. Community participation has been shown repeatedly to be critical to building a successful health system. The focus of designing health services must be on both demand and supply, and the most vulnerable need to be engaged as active participants in decision making processes affecting their health.

59) The health workforce crisis merits particular mention. The challenges are to

manage the national and international migration of health workers, to attract and motivate health workers to remain in their workplaces, and to encourage them to work effectively and productively. Health worker international migration has been increasing worldwide over the past decades, especially from lower income countries whose health systems are already very fragile. To address this situation, the World Health Assembly called for the development of a Code of Practice on the International Recruitment of Health Personnel[8]. A multi-stakeholder process to articulate the content of the Code has been initiated. Actions are needed in both the host and the home country of skilled health professionals. Predictable, sustained and increasing resource flows can help home governments to adequately equip and retain their health workforce. It is also vital to support countries in solid planning, management and deployment for competent and motivated health workers, including a considerable scale-up in education and training facilities. A comprehensive approach is needed for the recruitment, training, support and retention of all levels of health workers. Much more attention should be dedicated to support the work of community health workers, whose role is particularly critical in ensuring service delivery to the most vulnerable.

VII. Health in all policies

60) It has become clear that policies and actions outside of the health sector have an enormous effect on health, either a detrimental effect (e.g. air pollution or environmental contamination) or a positive effect (e.g., education, gender equality, healthy environmental policies). Yet, ministries of health in many countries have struggled to coordinate with other sectors or to influence policies beyond the health system for which they are responsible. Decision makers should approach their policies by considering the effects on health, from educational, agricultural, fiscal, housing, transport and other policies. Where such inter-sectoral collaboration has been successful, the health benefits have been considerable.

61) There are problems in encouraging greater inter-sectoral collaboration which must be addressed. These include countering divisive activities by well-resourced lobbies, as has been the case for efforts to control tobacco, regulate waste, and limit the marketing of food to children. In addition, it is difficult to coordinate across multiple institutions and sectors. Many countries have limited capacity. Moreover, policy makers in other sectors are too often unaware of the health consequences of their policies, and of the potential benefits that could be derived from them.

VIII. Widening the circle of partnerships for health and enhancing their impact

62) Global health issues are receiving greater attention than ever before, with more players contributing to a multitude of initiatives that aim to address both specific diseases as well as health systems issues. The increase in multistakeholder initiatives is

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[8] Resolution WHA57.19

welcome but brings challenges for coordination and coherence. There is a growing need to work together across traditional boundaries and in new ways.

63) The Secretary General has made explicit the need for Member States and the United Nations to involve and work with civil society, the private sector, foundations and academia. To that end, he has brought together leaders of UN entities, representatives from key civil society organizations, CEOs of private sector institutions, heads of major foundations and representatives from the academic world active in global health issues to join forces for priority global health issues. He has underlined the need for common messages in advocacy and communications efforts, and has raised the political attention of key health issues, such as maternal health, neglected tropical diseases, non-communicable diseases and health system strengthening also thanks to the joint work with all the concerned actors.

64) One of the best examples of the potential power of partnerships is the response to HIV/AIDS, which saw groundbreaking involvement of a wide range of groups previously excluded from policy formulation, decision making, and even resource mobilization. In particular, the involvement of people directly affected by AIDS, in addition to community groups and NGOs, proved to be critical to reaching out to people and addressing culturally sensitive issues that governments initially had difficulty acknowledging.

65) Another example of the power of partnerships to transform global efforts in public health is that of malaria. The work of the Secretary-General's Special Envoy on Malaria and the efforts of the Roll Back Malaria Partnership, bringing together a wide range of partners, including malaria-endemic countries, bilateral and multilateral development partners, the private sector, non-governmental and community-based organizations, foundations, and research and academic institutions, has brought not only a formidable assembly of expertise, infrastructure and funds into the fight against the disease, but most importantly a new way to do business.

66) There are lessons to be learned from the partnerships forged to deal with AIDS and with malaria. First, it is possible for very different groups to work together around a common cause, and one that seems complex and daunting. Second, with such partnerships, scaling up is possible. Third, it is important to involve those directly affected by the issue in developing policies and planning action. Fourth, partnerships are important at all levels - community, national, and international - to address the different challenges at each level. Global health partnerships such as the Global Fund on AIDS, TB and Malaria (GFATM), UNITAID, and GAVI have made major contributions to increasing the resources available and bringing new dynamics into the public health sector. The potential power of partnerships to mobilize different players to work together in new ways needs to be explored further.

Box:1

Five country-led regional meetings[9] were held in support of preparations towards the AMR in ECOSOC in July. These meetings provided an opportunity for multi stakeholder engagement, including -- governments, civil society, UN system institutions and the private sector. They also provided an opportunity to prepare the launch of new partnership initiatives at the AMR July 2009 session, in Geneva.

- A South Asia regional preparatory meeting on the theme *"Financing Strategies for Health Care"* was held in Colombo on 16-18 March 2009, by the Government of Democratic Socialist Republic of Sri Lanka. Issues discussed at this meeting were: a) Domestic financing for healthcare; b) External financing for health care; c) Challenges for health systems in countries in or following crisis; d) Progress and challenges in achieving the MDGs.
- An Asia Pacific regional ministerial meeting on the theme *"Promoting Health Literacy"* was held on 29-30 April 2009 in Beijing, China. The focus of the meeting was the following: a) The challenges of health literacy in Asia and the Pacific; b) Promoting multisectoral actions; c) Promoting health literacy through media and empowerment; d) Building capacity to increase health literacy.
- A Western Asia regional ministerial meeting was held in Doha, Qatar on 10-11 May on the *theme "Addressing non-communicable diseases and injuries: major challenges to sustainable development in the 21st century"*. The issues discussed at the meeting were: a) The global and regional magnitude of non communicable diseases and injuries and their impact on socio-economic development and poverty reduction strategies; b) Integrating the care of noncommunicable diseases into primary care; c) Multi-stakeholder approaches to meet the challenges of non communicable diseases and injuries; d) New initiatives to address noncommunicable diseases and injuries.
- A regional ministerial in Latin America and the Caribbean (LAC) was held in Kingston, Jamaica on the progress in the reduction of the HIV/AIDS pandemic and its interconnection with regional public health and development goals on 5-6 June 2009. The meeting discussed the following key topics: a) The status of the HIV/AIDS epidemic in LAC; b) Lessons learnt and 'best practices' in the response to HIV/AIDS; c) Response of Governments in the region to current global and regional economic trends and the likely implications for the fight against HIV/AIDS.
- An African regional ministerial meeting was held in Accra, Ghana in May/June 2009. The meeting focused on E-Health. The following topics were examined at the meeting: a) Strengthening policies for provision of ICTs for health; b) Supporting equity of access and protection for all; c) Promoting the growth of e-Health capacity, tools and services.

IX. Priority actions and recommendations

[9] Outcomes of these meetings will be presented as a CRP after their conclusion.

Recommendations and priority messages

Political leadership at the highest levels can make the greatest difference in galvanizing global and national efforts to promote and protect health, reduce inequities in health outcomes and access to services, and to achieve the MDGs. For this reason, World leaders should call for joint action on health and in particular on the following:

1. Developing a comprehensive and integrated approach to achieving the MDGs which:

- Strengthens efforts to improve women's health, and in particular maternal and newborn health.
- Protects and sustains gains achieved in combating AIDS, TB, and malaria, including dealing with new threats such as MDR or XDR TB.
- Makes prevention, treatment and control of NTDs and NCDs an integral part of the achievements of the health-related MDGs.
- Invests in infrastructure and delivery systems to expand impact of and build synergies with vertical health programmes.
- Invests in public health systems required for surveillance and responses to potential outbreaks of disease and other public health emergencies under the International Health Regulations (IHR)
- Strengthens local authorities in environmental sanitation and waste management in collaboration with health authorities.

2. Strengthening health systems through primary health care to advance the goal of universal access to health services. This would include:

- Progressively expanding access to a comprehensive package of health services (including adequate health workforce, financing, and information)
- Providing financial protection from catastrophic health costs, moving away from user fees in developing countries and promoting prepayment and pooling schemes.
- Working towards finding innovative ways for recruiting, training and retaining health workers and professionals.
- Supporting an international mechanism to track movements of health care workers, nurses and doctors and conduct studies on migration trends to be able to assist governments in developing targeted interventions to promote brain-drain "reversals".
- Building and strengthening health information systems for identifying and understanding gaps, successes, trends and for accountability.
- Investing in information and communication technologies (ICT) and health education to a) establish direct communication networks among experts, therapists, care takers and patients; b) support system-wide implementation strategies for treatment and preventive practices; and c) make populations aware of health risks and health services provided.
- Supporting affordable public transportation services and access to energy to ensure accessibility and availability of health care services.

3. **Promoting health as an outcome of all policies through:**

- Taking action in many areas of policy to reduce the growing burden of non-communicable diseases and other health problems such as maternal mortality, AIDS, etc.
- Mainstreaming health concerns and awareness into all sectors that ultimately affect health e.g., the financial and trade sectors.
- Establishing and pro-actively promoting inter-sectoral committees at national and local levels to formulate health-related policies and guidelines.
- Increasing the resilience to crises through taking action to address food shortages, conflict, climate change etc.
- Routinely assessing the impact on health of all policies, programmes, initiatives.

4. **Promoting greater coherence through:**

- Promoting new ways of working with a range of traditional and non-traditional stakeholders including civil society, the private sector and other non-state actors.
- Promoting greater coordination among donors, including adherence to the Paris Declaration and Accra Agreement.

5. **Building and strengthening Partnerships through:**

- Finding ways to bring in new partners and build synergies.
- Building productive and people-centered partnerships with the private sector in the maintenance of health-care facilities and utilization of virtual and mobile technology to provide health advice and services and raise health awareness.
- Exploring operational partnership with faith-based organizations to reach communities in disseminating information and coaching on health.
- Providing a platform to connect policy-makers, researchers, health promoters, educators, and parents to exchange up-to-date science and best practices for prevention, treatment and control.

5. **Sustaining and enhancing financing for health and development by:**

- Allocating adequate resources despite the economic downturn to reach the poorest and most vulnerable.
- Ensuring national and community ownership by harmonizing allocations of national budgets and external aid. Monitoring and evaluation should feed into nationally led planning processes.
- Focusing on the implementation and monitoring of international commitments.

- Making external funding more predictable and well-aligned with countries national priorities and channelling resources to recipient countries in ways that strengthen national financing systems.
- Promoting collective actions by all stakeholders in order to ensure higher levels of funding for meeting the challenges of global public health, including alliances for innovative funding.

IX. Conclusion

67) Addressing the challenges in reaching the health MDGs will require simultaneous action on many fronts with multiple actors. It is expected that ECOSOC will bring together various organisations within the UN system and shape a unified approach towards bringing the benefits of good health to all. Only a well coordinated approach will bring results. The Secretary General's leadership in reaching out to civil society, the private sector, foundations, academia, and other sectors is an example of forging such an approach. Likewise, government leaders can be more proactive both in fostering more cross-sectoral collaboration within government and in reaching out to work more closely with civil society, academia, the private sectors and others, to make greater strides towards improving the health of their populations.

68) ECOSOC, through preparations for its substantive session, has helped illuminate various aspects of public health including strengthening health systems, strengthening partnerships to help achieve the health goals and promoting approaches that have a direct or indirect impact on health outcomes. They have also underscored the need for inter-governmental action on issues such as migration and education of skilled health personnel. The consideration of the recommendations in the report and the adoption of a ministerial declaration will greatly enhance our efforts to promote public health. Urgent action is called for in these difficult times characterized by the co-existence of multiple crises.